Media Clips

COVERED CALIFORNIA BOARD CLIPS
Sept. 19 – Nov. 18, 2019

Since the Sept. 19 board meeting, Open Enrollment began on Oct. 15 as did Covered California's marketing push on Nov. 4 with an event in downtown Los Angeles. The national health care conversation focused on costs, the Affordable Care Act still being challenged in the courts and early returns during open enrollment.

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COVERED CALIFORNIA™ News Release

Oct. 17, 2019

California Launches Open Enrollment With New Initiatives That Make Health Insurance More Affordable for Millions

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- *New financial help is available to more Californians than ever before, and Covered California makes it easy to see if you are eligible.*
- *Many people who have never qualified before will be eligible for new financial help from the state of California that will lower the cost of their coverage.*
- *75 percent of Covered California's existing consumers could pay less than they are paying now if they switch to the lowest-cost plan in the same metal tier.*
- *California restored the law that requires people to have health insurance, which led to savings for the entire individual market and a record-low rate increase.*
- *The new law extends open enrollment through Jan. 31, 2020. Consumers who sign up by Dec. 15 will have coverage starting Jan. 1.*

SACRAMENTO, Calif. — Covered California kicked off open enrollment Tuesday for the upcoming 2020 coverage year, which features some of the biggest changes in the exchange's history.

“Open enrollment is underway, and now is the time to sign up for quality health coverage that will begin on Jan. 1,” said Covered California Executive Director Peter V. Lee. “We want to make sure Californians know about the new state subsidies that mean almost 1 million people can get more help with their premiums, and the restoration of the individual mandate law, which requires people to have health insurance if they can afford it.”

The two new state initiatives, the state subsidy program and the restoration of the individual mandate, are key elements in Covered California’s record-low 0.8 percent rate increase for the upcoming year.

The new state subsidies will help lower the cost of coverage for almost 1 million California consumers. The main groups of people who are projected to benefit are:

- Middle-income Californians who previously did not qualify for financial help because their incomes exceeded federal limits. The amount of their subsidy will vary based on their age and income and the health care costs in their region. While the state subsidy for this group will average $172 per household, per month, consumers will need to input their information to see what amount they would receive. For example, while some consumers may get a monthly state subsidy of $50, others could get $150, and some could receive a $750 or more.

- Covered California enrollees who currently receive federal financial help could be eligible to receive an average of an additional $15 per household, per month.

“California will be making history this year, becoming the first state in the nation to make coverage more affordable for middle-income families like small-businesses owners, entrepreneurs, contractors and gig economy workers,” Lee said. “During our first day of renewal, a family of two from Sonoma received a state subsidy of $630 per month, which is why it’s so important for people to see if they qualify.”

In addition, a Covered California analysis found that 75 percent of existing consumers will be able to reduce their cost of coverage and receive the same level of benefits if they switch to the lowest-cost plan in the same metal tier.

“Covered California puts consumers in the driver’s seat, and a majority of our current enrollees could pay less than they did last year because they can shop around and get a better deal,” Lee said.

Covered California will begin its statewide outreach campaign on Oct. 30 with a new marketing campaign that includes television ads will debut Nov. 4. The ads, titled “You Shouldn’t Have To,” center on the idea that when you have health insurance, you do not need to make tough choices like whether to try self-treatment or see a doctor.

Also new in the campaign this year is a reminder that Covered California is “in your corner,” and is a free service that helps people find the health insurance that’s right for them.

“Our name is well known, but every year the research continues to show that some consumers still don’t understand the role Covered California plays in helping them find comprehensive, affordable health insurance,” Lee said. “We want Californians to know that we are a free service that helps them get health coverage that works for them.”

In addition, research shows that some consumers still do not know they qualify financial help.

“You can get a quote within minutes by using our Shop and Compare Tool, so even if you have checked before, the new financial help available makes it worth it to check again,” Lee said. “Don’t leave money on the table when you may be able to get health coverage for less than you think.”

The outreach effort will include traveling throughout California to promote enrollment by visiting enrollment locations, meeting with partners and conducting 10 televised phone banks in Spanish and Mandarin.

New this year is a partnership between Covered California and well-known California athletes. There will be live events at four locations across the state where these trusted voices, who are committed to healthy lifestyles, will help spread the word that now is the time to sign up for health coverage through Covered California. More details about the events will be announced as they approach.

“Once again, we are making a significant investment to make sure all Californians know there are big changes this year, with new financial support and a new law that requires everyone to have coverage,” Lee said. “We will be on television and radio, in newspapers and online, and increasingly in the digital world, where more and more Californians get their information.”

Restoring the Individual Mandate

In addition, California restored the individual mandate that was part of the Patient Protection and Affordable Care Act from 2014 through 2018, once again making it the law to have health coverage starting in 2020. Consumers who do not get covered could face a penalty administered by the Franchise Tax Board when they file their 2020 taxes in the spring of 2021.

“Nearly nine out of 10 Covered California consumers receive financial help, which saves them an average of 80 percent off the price of their coverage,” Lee said. “If you choose

to go uninsured next year, even though you can afford the coverage, you could face a penalty that could climb into the thousands of dollars."

For those facing a penalty, a family of four would pay at least $2,000, and potentially more, for not having health insurance throughout 2020.

"Consumers need to take action now during open enrollment," Lee said. "This is when people can sign up to get health insurance and avoid the potential of a big surprise when they file their taxes in 2021."

Getting Help Enrolling

Consumers will need to sign up by Dec. 15 in order to have their coverage begin on Jan. 1, 2020. Those interested in learning more about their coverage options can:

- Visit www.CoveredCA.com.
- Get free and confidential in-person assistance, in a variety of languages, from a certified enroller.
- Have a certified enroller call them and help them for free.
- Call Covered California at (800) 300-1506.

News Release

Covered California for Small Business Announces Expanded Choices and an Average Rate Change of 4.1 Percent for 2020

- *The 4.1 percent weighted average rate change for Covered California for Small Business plans is the lowest in the six years since the exchange launched in 2014 – at same time individual market premiums increased by only 0.8 percent.*
- *Covered California for Small Business continues to grow, with double-digit growth in membership for five consecutive years, and more than 55,000 members to date.*
- *A new carrier is joining Covered California for Small Business in 2020, offering more coverage options for employees in Southern California, and an existing carrier is expanding in the Central Valley.*

SACRAMENTO, Calif. — Covered California for Small Business unveiled the health plan choices and rates for small-business employers and their employees for the upcoming 2020 plan year. The statewide weighted average rate change will be 4.1 percent, which represents the lowest annual increase in the program's six-year history and is significantly lower than national projected increases for larger employers.

"Once again, Covered California for Small Business is meeting the needs of employers and their employees across the state," said Covered California Executive Director Peter V. Lee. "We are continuing to drive premiums down and expand our coverage options as we work to provide small-business consumers with value and choice."

This year's rate change of 4.1 percent is lower than the recent projection of 6 percent that larger employers expect to see in 2020 (see Table 1: Covered California for Small Business Average Rate Change, by Year). The program's five-year average increase is 5.6 percent.

"The continued success of Covered California for Small Business is another example of how the Affordable Care Act and this new era of health care are working for Californians," Lee said. "As we continue to grow and provide relatively low increases, it

helps all small employers and their employees by putting competitive pressure on plans across the state."

Table 1: Covered California for Small Business Average Rate Change, by Year	
Year	**Rate Increase (Percentage)**
2020	**4.1**
2019	4.6
2018	5.6
2017	5.9
2016	7.9
2015	5.2
Projected Large-Business Rate Change in 2020[1]	**6.0**

Covered California for Small Business will be offering five plans in 2020, including two preferred provider organization (PPO) plans from Blue Shield of California and Health Net, both offering their broadest provider networks, and two health maintenance organization (HMO) plans — which are provider- and hospital-based — from Kaiser Permanente and Blue Shield.

Rounding out the 2020 portfolio of health plans are Sharp Health Plan in San Diego and newcomer Oscar Health Plan of California, which will be offering coverage in Los Angeles and Orange counties. In addition, Blue Shield will expand its HMO plans to Fresno, Kings and Madera counties.

Covered California for Small Business has experienced double-digit percentage growth in membership for five consecutive years. Currently, more than 55,000 individuals have insurance through Covered California for Small Business, representing a growth of approximately 7,000 individuals, or a 15 percent gain in membership over this time last year.

"As we enter into open enrollment for the individual market, with new state subsidies and

[1] National Business Group on Health, "2020 Large Employers' Health Care Strategy and Plan Design Survey."

the new state requirement to have coverage, we want to be sure small-business owners know their options and opportunities in Covered California," said Lee.

The new state requirement to have coverage in California applies only to individuals, and it does not impose new obligations on small businesses or change federal law related to which employers might be subject to a penalty for not offering coverage.

The steady growth makes Covered California for Small Business one of the largest small-business health options programs in the nation.

"Our weighted average rate change this year is the lowest rate increase since the program's inception," said Terri Convey, director of Covered California's Outreach and Sales division. "We've been on this winning track of low increases for the last five years, proving that our employee choice platform is working well for small businesses."

Just like in Covered California's individual market, consumers may be able to limit increases in their rates, or perhaps even save money on their premiums, by shopping and switching to the lowest-cost plan in the same metal tier.

Businesses with up to 100 full-time equivalent employees can apply for health insurance coverage for their workers through Covered California for Small Business. Federal tax credits may be available to employers with 25 or fewer employees. Visit www.CoveredCA.com/forsmallbusiness/ for information on how to apply.

Family dental plans are optional and are provided by Delta Dental of California, Liberty Dental Plan of California, Dental Health Services, and California Dental Network.

News Release

Covered California Begins Statewide Marketing and Outreach Campaign to Promote Open Enrollment for 2020 and Launches New Television Ads to Promote State Subsidies

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- *Covered California is beginning its statewide marketing and outreach campaign to educate consumers about the open enrollment period for 2020 and the new state subsidies that are available for the first time.*
- *New television ads titled "You Shouldn't Have To," will begin airing today and focus on the idea that consumers should not have to choose between the life they have built and the care they need.*
- *New data shows that eligible middle-income families who qualify for a state subsidy are receiving an average of $526 per month per household.*
- *Covered California is also partnering with sport celebrities, such as Laila Ali and boxing champion Leo Santa Cruz, to get the word out and encourage consumers to see if they are eligible for new financial help.*
- *Consumers who sign up by Dec. 15 will have coverage starting Jan. 1. Open enrollment runs through Jan. 31, 2020 and consumers who choose to go without coverage could face a penalty when they file their taxes.*

SACRAMENTO, Calif. — Covered California launched its statewide marketing and outreach campaign on Monday, to educate consumers about the current open enrollment period and the new state subsidies that are available for the first time.

"We want to make sure that everyone knows about the new state subsidies that are already helping people across the state save money on their monthly health insurance premiums," said Covered California Executive Director Peter V. Lee. "California is making coverage more affordable for low-income families, and we are making history by

becoming the first state in the nation to provide financial help to middle-income families like small-businesses owners and the self-employed."

New Television Ad Campaign

Covered California's television ad campaign, titled "You Shouldn't Have To," will begin airing statewide today. The ads center around the idea that you should not have to make tough choices just because you do not have health insurance. The ads state, "You shouldn't have to live with pain. You shouldn't have to pretend you're fine… You shouldn't have to choose between the life you've built and the care you need."

See the new television ads in English and Spanish here.

"These ads seek to bring to life the reality still faced by too many uninsured Californians," said Lee, "Getting coverage is the path to avoid living with pain, missing preventive care and worrying about dollars instead of getting the treatment you deserve."

In addition, Covered California is also launching ads titled, "In Your Corner," which detail how Covered California works for consumers and their families by providing access to quality care and protecting them from financial risk if they ever have expensive medical bills.

Those ads will air in English, Spanish, Cantonese, Mandarin, Vietnamese and Korean.

New State Subsidies

This year's open enrollment period features some of the biggest changes since Covered California first began offering coverage in 2014. First, two new state initiatives – the state subsidy program and the restoration of the individual mandate – were key elements in Covered California's record-low 0.8 percent rate increase for the upcoming year.

The new state subsidies are already helping consumers who have selected a plan for 2020. New data shows that the over 600,000 eligible low-income consumers who qualify for a subsidy are receiving an average of $19 per month per household, while eligible middle-income Californians who receive a subsidy are getting an average of $526 per month per household.

Open enrollment started just under three weeks ago. While preliminary, early data shows that 85 percent of eligible low-income Californians are qualifying for a state subsidy on top of their federal tax credits, and about 50 percent of middle-class Californians across the state with household incomes between 400 and 600 percent federal poverty level are finding out they are eligible to receive a state subsidy starting in January. In general, those not qualifying for a state subsidy either chose a plan that

already costs only $1 per member per month after federal credits, or already have a benchmark silver plan that costs less per month as a share of household income than the required contribution under the new law and will benefit directly from the low premium increase.

"We have heard from people across the state who will be saving hundreds of dollars a month because California is putting its people first," Lee said. "Whether you never thought you could get financial help, or if you have checked before, you need to check again because there is new money available that may dramatically reduce the cost of your coverage."

The new state subsidies could extend to an individual making up to $74,940 and family of four with a household income of up to $154,500.

See the table that shows which incomes could qualify for the California State Subsidy.

Teaming Up with Sport Celebrities

Finally, Covered California is also teaming up with sport celebrities who are trusted voices and committed to healthy lifestyles to help spread the word that now is the time to sign up for health coverage through Covered California.

On Monday Covered California joined Laila Ali and Leo Santa Cruz at an event at The Bloc in downtown Los Angeles to highlight the importance of being healthy.

Ali is a world-class athlete, fitness and wellness advocate, television host, a four-time undefeated boxing world champion, and the daughter of the global icon and humanitarian, Muhammad Ali.

Santa Cruz is the current World Boxing Association Featherweight Super Champion. Raised and based in Los Angeles, he's described as "one of the must-see fighters of his generation" and well-known for this non-stop effort in the ring.

Both Ali and Santa Cruz know how important health is to not only their own athletic and fitness careers, but also their families as both have been touched by health-related issues. Muhammad Ali fought Parkinson's Disease for more than 30 years, while Santa Cruz's father and trainer – Jose – has been battling multiple myeloma cancer since 2016.

"In every area of my life, I put my health first. Whether it's by staying active, eating healthy or, most importantly, getting health insurance," Ali said. "Covered California makes it easy to get enrolled in affordable coverage that works for you and your family - so you can succeed at home, work and play."

"As an athlete, health care has always been an important part of my life, and with Covered California it's easier now than ever to get covered," Santa Cruz added. "I am so thankful that when my dad was diagnosed with cancer 3 years ago, we never had to wonder how our medical bills would be paid or if a treatment would be covered. I want the best team in my corner when I'm boxing, and with Covered California everyone has a true advocate in their corner."

Enroll Now

Enrolling for coverage now is critical because California restored the penalty that was part of the Patient Protection and Affordable Care Act from 2014 through 2018, meaning consumers who do not get covered could face a fine when they file their 2020 taxes in the spring of 2021.

For those facing a penalty, a family of four would pay at least $2,000, and potentially more, for not having health insurance throughout 2020.

"Consumers need to take action now during open enrollment," Lee said. "This is when people can sign up to get health insurance and avoid the potential of a big surprise when they file their taxes in 2021."

Consumers will need to sign up by Dec. 15 in order to have their coverage begin on Jan. 1, 2020. Those interested in learning more about their coverage options can:

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- Get free and confidential in-person assistance, in a variety of languages, from a certified enroller.
- Have a certified enroller call them and help them for free.
- Call Covered California at (800) 300-1506.

Open enrollment runs through Jan. 31, 2020.

Covered California Executive Director Peter V. Lee on the Passing of Bernard Tyson, Chairman and CEO of Kaiser Permanente

SACRAMENTO, Calif. — Covered California Executive Director Peter V. Lee issued the following statement Sunday:

"We at Covered California are deeply saddened by the passing of Bernard Tyson, chairman and CEO of Kaiser Permanente. Bernard's vision and laser focus on increasing access, quality and affordable health care coverage for all has helped transform Kaiser and had a positive impact on the entire health care system. He truly 'walked the talk' in his concern for making health care not just a right, but something that is affordable and centered on the great diversity of patients. His efforts will have a lasting imprint on California and the nation. Our thoughts go out to his family and the broader Kaiser community he led."

Bernard Tyson, CEO and chairman of Kaiser Permanente, dies at 60
Staff Reports

Bernard J. Tyson, the chairman and chief executive of Kaiser Permanente, one of the country's largest nonprofit health-care providers and insurers, died Nov. 10 at 60.

The Oakland, Calif.-based company said he died in his sleep but did not provide additional information. He had recently spoken at the AfroTech conference in Oakland, tweeting the day before his death in support of health care that "is high-tech and high-touch."

Mr. Tyson was the first African American CEO of Kaiser when he took that position in 2013, after nearly three decades at the company. He had previously worked as a

hospital administrator and chief operating officer, and was included on Time magazine’s 2017 list of the world’s most influential people.

Under Mr. Tyson, Kaiser grew from 9.1 million members and 174,000 employees to 12.3 million members and 218,000 employees, increasing annual revenue from $53 billion to more than $82.8 billion, according to the company.

His death occurred the day before a planned five-day strike by 4,000 mental health professionals at 100 Kaiser clinics in California, amid a contract dispute over retirement and health benefits. Union officials voted Sunday to postpone the strike.

Peter V. Lee, the head of Covered California, an independent state agency that focuses on health insurance, said Mr. Tyson’s “vision and laser focus on increasing access, quality and affordable health care coverage for all has helped transform Kaiser and had a positive impact on the entire health care system.”

Mr. Tyson also was on the boards of the American Heart Association and Salesforce. He was a member of the American Academy of Arts and Sciences and deputy chairman of the Americas of the International Federation of Health Plans.

Bernard James Tyson was born in Vallejo, Calif., on Jan. 20, 1959. His father was a carpenter and minister; his mother had diabetes, leading Mr. Tyson to spend time in hospitals growing up. He eventually decided that he wanted to run one of his own.

Mr. Tyson received a bachelor’s degree in health service management in 1982 and an MBA in 1984, with a focus in health service administration, from Golden Gate University in San Francisco.

He joined Kaiser three years later and worked as an assistant administrator for its San Francisco medical center and CEO of the Kaiser Foundation Hospital in Santa Rosa, Calif. “I still do hospital visits, and I can tell how well it’s run in a couple minutes,” he told Bloomberg in 2015. “How clean are the floors? How does the staff respond? What’s the vibe?”

While at Kaiser, he was a member of the Bay Area Council, a business-led public policy organization advocating for a strong economy for area residents. He became Kaiser Permanente’s chairman in 2014, the year after he was named CEO.

On Sunday, the company’s board of directors named Executive Vice President Gregory Adams as interim chairman and CEO.

Mr. Tyson's marriage to Carla Robinson ended in divorce. Survivors include his wife, Denise Bradley-Tyson, and three sons from his earlier marriage, Alexander, Charles and Bernard J. Tyson Jr.

- Also: https://www.nytimes.com/2019/11/11/business/bernard-j-tyson-dead.html
- https://www.sfchronicle.com/business/article/Bernard-Tyson-Kaiser-Permanente-CEO-dead-at-60-14824231.php
- https://www.sacbee.com/news/local/health-and-medicine/article237224474.html
- https://www.wsj.com/articles/death-of-ceo-comes-at-a-time-of-expansion-big-bets-for-kaiser-permanente-11573559679
- https://www.cnn.com/2019/11/10/business/kaiser-permanente-ceo-bernard-tyson-obit/index.html
- https://www.usatoday.com/story/money/2019/11/10/kaiser-permanente-ceo-bernard-tyson-dies-unexpectedly-60/2556756001/
- https://www.cnbc.com/2019/11/11/kaiser-permanente-ceo-bernard-tyson-unexpectedly-dies-at-age-60.html
- https://www.reuters.com/article/us-people-bernard-tyson/kaiser-permanente-ceo-bernard-tyson-dies-unexpectedly-at-60-idUSKBN1XL05U
- https://www.mercurynews.com/2019/11/10/kaiser-permanente-ceo-bernard-tyson-dies-at-60/

Editorial: Health insurance reform is real in California, not in Washington, D.C.
Editorial Board

Open-enrollment season is now underway for health insurance plans across the country, which means many Americans will be receiving unpleasant news about how much more their coverage will cost in the coming year. But for one group of consumers, premiums will actually go down for the second straight year.

Those would be individuals and families whose healthcare isn't covered by their employers, and so shop in the insurance exchanges created by the 2010 Affordable Care Act (better known as Obamacare). At the 28 state exchanges run by the federal government, the average premium for the "benchmark" plan — a policy covering roughly 70% of a person's expected medical expenses for the year — will be 4% less expensive in 2020 than it was this year.

California, which runs its own insurance exchange, will see an average increase in its benchmark plans of a little less than 1% in 2020. But don't leap to the conclusion that

the Trump administration is doing a better job holding down premiums than California is. Californians in the individual market will still pay less for insurance than the average American in that market does. And one reason is because California and the Trump administration are heading in opposite directions on the Affordable Care Act.

Simply put, California is trying to make the law work. But in other states that have relied on the federal government to operate their health insurance marketplaces, the law is working despite the Trump administration's efforts to make it fail.

We're not arguing that the ACA was a perfect piece of legislation or that it effectively held down healthcare costs. It wasn't and it didn't; premiums can still take too large a bite out of middle-class families with incomes just above the cutoff for subsidies. But it was a step in the right direction, and California's aggressive implementation has done a far better job making insurance affordable to people not covered by employer health benefits than the Trump administration's wrecking-ball approach to the law.

Even as he crowed about the reduction in premiums on the federal exchanges, Health and Human Services Secretary Alex Azar declared the law a failure. "The ACA simply doesn't work and it is still unaffordable for far too many," he said in a statement. "But until Congress gets around to replacing it, President Trump will do what he can to fix the problems created by this system for millions of Americans." Too bad "fix" in this case means "worsen."

More than a third of U.S. households aren't insured by an employer plan or by Medicare. The ACA sought to make coverage available and affordable to that group by barring insurers from discriminating against people with preexisting conditions, providing subsidies for poor and lower-income consumers, and requiring all adults to sign up for comprehensive coverage unless it posed a financial hardship.

President Trump has undermined the law repeatedly since taking office, ending federal efforts to enroll people in Obamacare plans, steering younger, healthier Americans into plans that offer less protection and signing into law a tax bill that eliminated the tax penalty for not obtaining coverage. These steps exacerbated the problems in the state exchanges, where insurers had already been hit with higher-than-expected claims and were responding with hefty premium increases. But the uncertainty created by the administration's real and threatened attacks on the ACA led insurers to charge more than they needed to for coverage in 2018, hence the premium cuts for 2019 and 2020.

California's exchange, known as Covered California, also saw some large increases in its first few years. But state leaders managed to hold the exchange's rates below the national average by working to keep healthier people in Covered California, rather than pushing them into thinner, cheaper plans. According to the state exchange, its pool of

customers has consistently been 20% healthier — as measured by the cost of its insurance claims — than the federal average, cutting premiums by about $7.5 billion from 2014 to 2018. Because the bulk of the shoppers on the exchange are receiving federal subsidies, most of those savings went back to federal taxpayers in the form of lower subsidy costs.

Just as important, the lower premiums and policies that exempt basic forms of care from deductibles have kept more Californians who aren't eligible for subsidies from dropping their insurance coverage. According to federal data analyzed by Covered California, the number of unsubsidized people who bought insurance in the individual market fell by 44% from 2014 to 2018 nationally, but only 17% in California.

The state also took two steps this year that should help hold down premium increases in future years. To shore up the federal mandate, it enacted a law requiring adult Californians to carry comprehensive health insurance. And to make that coverage affordable for more people, it created a state subsidy program to help moderate-income people whose earnings are higher than the federal subsidy cutoff. Those are the sorts of steps the federal government ought to be taking as part of a broad and long-term focused approach to bringing healthcare within all Americans' reach.

ThinkAdvisor

California Issuers May Push Off-Exchange Enrollees Toward Exchange
Allison Bell

Managers of Covered California say participating health plans will be encouraging off-exchange enrollees who qualify for exchange subsidies to switch to exchange coverage.

"Issuer-to-consumer outreach includes renewal packages highlighting the state subsidy, referral to the agent of record, and direction to CoveredCa.com to check subsidy eligibility," according to a meeting slidedeck posted by Peter Lee, Covered California's executive director, on the Covered California's board website.

Issuers and Covered California are working with agents to increase consumer awareness of subsidies, Lee says in the slidedeck.
"Commission rates are being reviewed on a plan-by-plan basis to assure agents are paid for the effort of moving consumers from off-exchange to Covered California," Lee says.

Covered California is California's state-based Affordable Care Act (ACA) public exchange program. It has helped 1.5 million state residents sign up for coverage this year.

An ACA public exchange uses federal premium tax credit subsidy money to help consumers who earn up to 400% of the federal poverty level to pay for coverage from private health coverage issuers.

California recently added a state subsidy that will make subsidies available to residents earning up to 600% of the federal poverty level.

That means premium subsidies will be available to one-person California households with annual income of up to almost $75,000, and four-person households with annual income up to about $155,000.

California To Provide Financial Boost To Help Buy Health Coverage
Bernard J. Wolfson

If you are among the Californians who buy your own health insurance, a surprise may await you as the enrollment period for 2020 coverage opens this week.

Starting Jan. 1, California will become the first state to offer subsidies to middle-income people who make too much money to qualify for the federal tax credits that help consumers buy health coverage through Covered California, the state's Affordable Care Act insurance exchange.

Many people in the middle class have struggled to afford health insurance, often shouldering the entire cost of premiums that can surpass $1,000 a month.

"The law is going to do what it is intended to do, which is to help out those people who didn't qualify for any assistance when in reality they should have gotten something," says Jonathan Edewards, president of Citrust Insurance Agency in Pasadena, Calif. "And those people really got hammered."

Covered California estimates that nearly 1 million Californians could benefit from the new state money.

Also starting next year, state residents will be on the hook for a tax penalty if they are uninsured for more than three months, unless they qualify for one of several exemptions.

The penalty will mirror the federal one that was nullified — effective this year —by the 2017 federal tax reform law. In many cases, it will amount to $695 for a single adult and about $2,000 for a family of four. But for a lot of people, the financial hit could be substantially larger.

In California the deadline to enroll in coverage through Covered California or the open market is Jan. 31, but if you want the coverage to begin Jan. 1, you must sign up by Dec. 15.

Some of the $429 million worth of state subsidies available in 2020 will go to low- and moderate-income people who earn between 200% and 400% of the federal poverty level, or roughly $25,000 to $50,000 for an individual and $51,500 to $103,000 for a family of four, based on 2019 figures. This group also qualifies for federal tax credits. The average household state subsidy in this category would be $15 a month, Covered California estimates.

The lion's share will go to those whose incomes are between 400% and 600% of the poverty level — too high for federal aid but still low enough to make health care financially challenging. That's between about $50,000 and $75,000 a year for an individual and $103,000 to $154,500 for a family of four. The average state assistance for this group will be about $170 a month, says Peter Lee, Covered California's executive director.

Say, for example, you are a married couple in Sacramento, both 55 years old, with an annual income of $80,000. You would not have qualified for a federal tax credit this year and would have been responsible for the entire $1,654 monthly premium for a Blue Shield of California Silver 70 HMO, the second lowest level of coverage. In 2020, you would pay $995 per month after a $688 subsidy from the state — a savings of $659 a month, despite a 1.7% increase in the premium.

You could pocket those savings, or you could bump yourselves up to a higher level of coverage with lower deductibles and copays.

For a do-it-yourself estimate of what your financial assistance might be, go to the Covered California site (www.coveredca.com) and click on "Shop and Compare." You will be asked to enter your ZIP code, the number and ages of people in your household, and your family income.

The tool will show you a list of health plans, how much you would pay per month for each and the subsidy amount, if any, labeled "monthly savings." Hover on that, and you will see a breakdown of state vs. federal dollars.

But before you sign up, seek free help from an insurance agent or enrollment counselor, who can guide you through the complexities of the process. Find one in your area by visiting the Covered California website and clicking on the "Find Help" tab. You can also

search for local insurance agents at the National Association of Health Underwriters website (www.nahu.org) under “Membership.”

A word of caution: Be careful estimating your income. If you end up making more than you guessed, you may have to pay back some or all of the financial aid.

That has been the case for the federal tax credits since the health insurance exchanges debuted in 2014.

“That’s caused a lot of stress. I have two people this year who owe about 20 grand,” says Larry Pon, a certified public accountant in Redwood City, Calif.

You may also have to pay back some or all of your state aid if your income exceeds your estimate, but the details of how much you will owe are being finalized.

On the flip side, if you make less than expected, you can retroactively claim the credit, whether state or federal, when you file your taxes — but only if you enrolled in a health plan through Covered California.

So if you don’t seem to qualify for financial aid but think your income might drop, or you’re just not sure, strongly consider signing up with Covered California — even with no initial subsidy — instead of buying a plan through the open market.

“I am putting anybody on Covered California if there is any potential for their income to fall,” says Tom Freker, a Huntington Beach, Calif.-based insurance agent.

Maribeth Shannon and her husband, residents of Napa, Calif., plan to switch to Covered California in 2020. They are paying $1,671 out of pocket each month for a Kaiser Permanente bronze HMO that they purchased outside the exchange, and they just learned it will rise to $1,834 in 2020. (Kaiser Health News, which produces California Healthline, is not affiliated with Kaiser Permanante.)

Shannon, 63, is retired. Her husband, also 63, is self-employed, and his income fluctuates. She thinks that by working less, he can reduce it enough next year to qualify for a state subsidy. He’s been wanting to cut back anyway, “and this has really given us the motivation to speed up his retirement plan,” she says.

San Francisco Chronicle

More middle-income Californians can now get health insurance subsidies
Catherine Ho

Open enrollment for Covered California, the state marketplace that sells subsidized health insurance to Californians who do not get insurance through their employer, begins Tuesday and ends Jan. 31.

Those who sign up by Dec. 15 will have their health coverage take effect Jan. 1. Those who sign up from Dec. 16 to Jan. 31 will have coverage take effect Feb. 1.

About 235,000 middle-income Californians will be newly eligible for financial assistance in 2020 because California will be providing state subsidies for the first time. Until now, people bought plans with the help of federal subsidies, which are available for individuals who make roughly $17,000 to $50,000 a year, or 138% to 400% of the federal poverty level.

The new state subsidies will be available for people who earn $50,000 to $75,000 per person, or 400% to 600% of the federal poverty level. The exact amount a person gets in subsidies is tied to income; the higher the income, the lower the subsidy.

About 1 million Californians currently receive federal subsidies to buy insurance. About 663,000 of them are now eligible to receive an additional state subsidy, but the exact amount will depend on their age and how much health care costs in their region. Covered California officials estimate that the average state subsidy this group will receive is $15 per household per month, on top of the federal subsidy they currently receive.

The state subsidies will cost California about $429 million in 2020, and officials expect much of that amount — $317 million — to come from new tax penalties paid by people who don't buy health insurance.

California has a state individual mandate, which takes effect in 2020, requiring people to buy insurance or pay a penalty of $695 per adult and $347.50 per child, or 2.5% of annual household income, whichever is higher, to the Franchise Tax Board. The move is in response to Congress repealing the federal individual mandate, required under the Affordable Care Act, in 2017.

Average premiums for Covered California health plans are expected to rise less than 1% in 2020.

Covered California to help consumers find affordable health coverage (video)
Staff

SAN DIEGO (KUSI) – The Executive Director of Covered California stopped by Good Morning San Diego to give the latest updates on San Diego health care costs and how Covered California can help consumers find affordable, quality health coverage.

THE ORANGE COUNTY
REGISTER

Signing up for Covered California or Medi-Cal?: Here's what you need to know
Nicole Hayden

Starting in January, Californians will be required to sign up for health insurance or face a $695 tax penalty under the new state mandate.

Covered California open enrollment for 2020 runs from Oct. 15 through Jan. 15. If the enrollment period is missed, people won't be able to sign up for coverage unless they qualify for a special enrollment period because of a major life event, such as having a baby, getting married or losing other coverage.

Enrollment for Medi-Cal, the state's free or reduced-cost taxpayer-funded health insurance program, can be done at any time.

Researchers estimate that 730,000 people who are eligible for Medi-Cal in 2020 will not enroll, according to a report from UC Berkeley and UCLA. In 2016-17, about 543,000 Californians were eligible but not enrolled.

The number of uninsured people is expected to increase because the federal individual mandate was repealed. California's new state mandate is one method policymakers are using to push people to sign up for insurance.

California also will offer new subsidies in 2020 aimed at making health coverage more affordable for middle-income individuals and families. The subsidies are for individual

Californians who earn between $50,000 and $75,000 and families of four earning $103,000 to $155,000.

Also new in the coming year, low-income undocumented young adults ages 19 to 25 will be able to sign up for Medi-Cal.

Despite these moves to make subsidized coverage accessible to a larger swath of people, experts predict that many still will not enroll because of lack of knowledge about the programs, confusion about how to sign up, or unfounded fears that signing up could expose family members who are undocumented to deportation.

This guide is meant to explain what coverage options you might qualify for and how to do so. If you qualify for coverage, signing up will not put undocumented family members in danger of deportation or punishment because health providers are not allowed to give personal information to immigration authorities.

Any U.S. citizen or green card holder living in California who does not have insurance offered by their employer can enroll in health care regardless of income through Covered California, the state's health insurance marketplace. Income determines whether you are eligible for free or reduced-cost health insurance or if you qualify for a subsidy (subsidized coverage may depend on whether a person has access to insurance through an employer). If you don't qualify for financial assistance, you can still purchase private health insurance through Covered California.

What do I qualify for?

Medi-Cal: The free or low-cost state health insurance program. It's California's version of the federal Medicaid program.
Qualifications: An individual earning less than $17,237 a year or a family of four with an annual household income less than $35,535 qualifies for Medi-Cal. Individuals may automatically be eligible for Medi-Cal if they receive cash assistance through Supplemental Security Income, CalWORKS, Refugee Cash Assistance, foster care, Adoption Assistance Program, or Kin-GAP. Individuals who fall under Deferred Action for Childhood Arrivals (DACA) may qualify for Medi-Cal.

Medi-Cal for low-income pregnant women: This program provides immediate no-cost pregnancy-related care to low-income women while their application is evaluated for ongoing post-pregnancy Medi-Cal coverage.
Qualifications: Single women qualify if they are earning an annual income of less than $26,604, or are part of a family of four with a household income of $54,848 or less.

Medi-Cal Access Program for Infants and Mothers (AIM): AIM is a low-cost health insurance program for pregnant women who don't have health insurance and whose income is too high for no-cost Medi-Cal. It's aimed at providing health insurance to middle-income pregnant women.
Qualifications: Single women qualify if they make between $26,604 and $40,218, or if they are part of a family of four with a household income between $54,848 and $82,915. This program is also available to women who have private health insurance plans with a maternity-only deductible or copay greater than $500.

Medi-Cal for children: This program provides coverage for children under age 21, based on their parents' income.
Qualifications: Children are covered in a family of four with a household income of $68,495 or less. Children qualify regardless of their immigration status.

C-CHIP, the County Children's Health Initiative Program, provided through all counties in California: This program provides coverage for children up to age 19 who don't meet the income requirements for Medi-Cal for children.
Qualifications: Children qualify if they are part of a family of four with a household income between $68,495 and $82,915. Children qualify regardless of their legal immigration status.

Medi-Cal for legally undocumented young adults ages 19 to 25: This coverage option starts Jan. 1, 2020, and is for any undocumented young adult, including those who fall under Deferred Action for Childhood Arrivals (DACA).
Qualifications: Young undocumented adults would qualify based on the same income guidelines as Medi-Cal for adults.

American Indian/Alaska Native zero cost share: If American Indian or Alaskan Natives choose to purchase coverage through Covered California, many will not have to pay out-of-pocket costs such as copays and deductibles. If people choose not to enroll in coverage through Covered California, they will be exempt from the individual mandate tax penalty if they receive care from an Indian Health Services provider.
Qualifications: American Indian and Alaskan Native individuals who earn no more than $37,470, or a family of four with a household income at or below $77,250. For those making above those thresholds, there is also a limited cost share plan for American Indians and Alaskan Natives that helps lessen the cost.

Covered California's four private health insurance plan groups:
Platinum plans have the highest premium, or monthly fee, but they cover about 90% of your health care expenses. Gold plans pay about 80%, silver plans pay about 70%, and bronze plans, with the lowest premium, cover about 60% of health costs.

Qualifications: Any U.S. citizen in California, a lawfully present immigrant, or a green card holder. Income guidelines are the same for everyone who qualifies. (DACA recipients do not qualify to purchase insurance through Covered California, but they may qualify for Medi-Cal.)

Covered California has several subsidized enhanced silver plans that have income requirements. They are:

Covered California, Silver Enhanced 94 Plan: This plan covers 94% of the average annual cost. A primary care or urgent care visit carries a $5 copay. Qualifications: An individual earning more than $17,237 but not more than $18,735, or a family of four earning more than $35,535 but not more than $38,625. (These plans are for people who narrowly exceed the income limits for Medi-Cal.)

Covered California, Silver Enhanced 87 Plan: This plan covers 87% of the average annual cost. A primary care or urgent care visit would cost $15. Qualifications: An individual earning from $18,736 to $24,980, or a family of four earning from $38,626 to $51,500.

Covered California, Silver Enhanced 73 Plan: This plan covers 73% of the average annual cost. A primary care or urgent care visit would cost $35. Qualifications: An individual earning from $24,981 to $31,225, or a family of four earning from $50,501 to $64,375.

Covered California State Subsidies: California is offering new subsidies in 2020 aimed at making health coverage more affordable for middle-income individuals and families. Qualifications: An individual who earns between $50,000 and $75,000, or a family of four earning from $103,000 to $155,000.

Medicare: This is the federal health care program for seniors.
Qualifications: U.S. citizens 65 or older or permanent legal residents who have lived in the United States for at least five years. To receive full benefits, a person or the person's spouse must have worked long enough to be eligible for Social Security or railroad retirement benefits. For more information, medicare.gov

How can I apply?
By visiting the website CoveredCA.com
By calling your local county human services office.

By visiting a local county human services office in person. Find a location nearest you by calling 800-300-1506 or by going to https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx

By filling out a 36-page form and mailing it to: Covered California, P.O. Box 989725, West Sacramento, CA 95798. Find the application at coveredca.com/PDFs/paper-application/CA-SingleStreamApp_92MAX.pdf

Private health insurance brokers can help people navigate Covered California while health navigators at local nonprofits and federally qualified health centers are able to help patients sign up for Medi-Cal. After applying, the state will send you a letter within 45 days to tell you which program you and your family members qualify for.

What documents and information do I need?
Demographic information: Including name, address, phone number, and information about a spouse, children who live with you, and anyone else on your federal tax return.

Other insurance: Information about any job-related insurance you may qualify for or about health insurance others in your household receive through a job or elsewhere.

Social Security number: A Social Security number if you are a U.S. citizen.

Legal immigration documents: Documentation information for immigrants with eligible status. Families that include immigrants can apply. Parents who aren't eligible for

coverage can still apply for their children. Applying for your eligible child won't affect your immigration status or chances of becoming a permanent resident or citizen.

Income information: Employer and income information for everyone in the family, such as W-9 forms.

Federal tax information: Including the person who files taxes as head of household and dependents claimed on your taxes. If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal.

Proof of identification: Driver's license, passport, or state identification card.

Proof of finances: This could include pay stubs or bank statements.

If you don't have all the information needed, send in your application anyway. An enrollment agent will call to help finish the application process.

How California's new health care laws will affect you, from vaccines to premiums
Sophia Bollag

Now that California legislators and Gov. Gavin Newsom are done making new laws for the year, here's a look at how the policies they created will affect your health care.

They fall short of the universal health care Newsom campaigned on, but many of the new laws are aimed at getting more people insured, cutting costs and making it harder to forego vaccines and insurance.

VACCINE REQUIREMENTS
It will be harder for California parents to avoid vaccinating their kids. New rules cracking down on medical exemptions for childhood vaccines require the state to investigate doctors who give out more than five exemptions in a year and schools with immunization rates under 95 percent.

The author of the new vaccine laws, Sen. Richard Pan, D-Sacramento, argues they are necessary to prevent fraudulent exemptions some doctors are selling to families of children who should be vaccinated. The measures build on a 2015 law that prevents parents from skipping vaccines for their kids based solely on their personal beliefs. Students without exemptions must be vaccinated to attend school in California.

The new vaccine rules prompted raucous protests at the Capitol that culminated in an anti-vaccine demonstrator dropping a menstrual cup filled with blood on lawmakers in the Senate chamber.

POTENTIALLY LOWER HEALTH COSTS

Californians could see lower prices for insurance and prescription drugs, if new laws work as intended.

Newsom signed a high profile bill over opposition from pharmaceutical companies that aims to crack down on a practice known as “pay for delay,” when one pharmaceutical company pays another to delay the release of a lower-cost generic equivalent of a brand-name drug.

Assembly Bill 824 forces drug companies to prove they aren’t engaging in anti-competitive behavior when they strike deals with generics companies, a move intended to make “pay for delay” cases easier to prosecute.

The drug companies argue that the new law will have unintended consequences and prevent deals between companies that allow generic versions of drugs to be sold before an original drug’s patent expires.

Newsom also signed two new laws aimed at increasing public oversight of insurance plans, Assembly Bills 929 and 731, which supporters argue will drive down insurance costs. The insurance plans opposed both new laws, arguing they will place a costly burden on the health plans and jeopardize patient data.

NEW RULES FOR KIDNEY PATIENT CARE

Supporters say another new law capping payment rates for dialysis treatment will lower insurance costs, but opponents argue it will prevent kidney patients from accessing needed care.

Late-stage kidney-failure patients in the United States are eligible for government health insurance to cover their dialysis treatment, which filters blood for people whose kidneys have stopped working. Some low-income dialysis patients who qualify through Medi-Cal can have all of their treatment costs covered by the government.

The nonprofit American Kidney Fund, which pays medical expenses for some kidney patients and is funded by dialysis companies, has been accused of steering patients to private insurance plans with higher payment rates for the dialysis companies.

Having to cover high-cost dialysis patients causes private insurance companies to raise rates for everyone, argues the new law’s author, Assemblyman Jim Wood.

His legislation will cap payment rates for the dialysis companies in situations where a third-party like the American Kidney Fund is paying a patient’s premiums. It will also affect drug addiction treatment centers.

American Kidney Fund President LaVarne Burton announced Sunday evening shortly after Newsom signed that bill that the charity would pull funding for all California dialysis patients Jan. 1 in response to the new law.

The nonprofit says it pays medical bills for about 3,700 kidney patients in California.

In a signing statement, Newsom said he approved the new law to curb rising health care costs and urged charities like the American Kidney Fund not to cut aid for California patients.

“Charities that purport to impartially provide patient assistance, and the providers that substantially fund these charities, should act in good faith and continue providing assistance,” he wrote.

MORE TIME TO SIGN UP FOR INSURANCE

Californians who purchase insurance plans through the Covered California marketplace will have two more weeks to enroll in health coverage next year.

A new law Newsom signed Sunday will extend the enrollment deadline from January 15 to January 31 in an effort to make it easier for people to sign up for insurance.

The enrollment period to sign up for 2020 insurance begins Oct. 15.

FINES FOR THE UNINSURED

Other Californians will have to pay fines for not having health insurance. The budget Newsom signed in June includes an “individual mandate,” modeled on the one in the Affordable Care Act that requires people to buy coverage or pay a penalty. In 2016, the penalty was $695 per adult or 2.5 percent of yearly household income, whichever was higher.

That part of “Obamacare” has since been rolled back at the federal level. The California version of the mandate is estimated to raise about $1 billion over three years and will help fund health insurance subsidies for middle-income people.

People who fall below a certain income threshold will be exempt from paying the fine.

PREMIUM COST ASSISTANCE

Middle-income Californians have new help paying their premiums under the state budget Newsom signed in June. It includes nearly $1.5 billion in state health care subsidies for plans purchased through the state’s Covered California insurance marketplace. Most of that money will go to people making four to six times the federal poverty level, which is about $103,000 to $154,000 for a family of four.

People making between 200 and 400 percent of the poverty level will also receive state subsidies on top of the federal assistance they already receive.

Californians can see if they will likely qualify for the new subsidies through the Covered California website, coveredca.com.

UNDOCUMENTED IMMIGRANT CARE

Undocumented immigrants under age 26 can sign up for state's low-income health insurance program starting Jan. 1 under the state budget Newsom signed in June. To qualify, they will need to make less than 138 percent of the federal poverty level, which is about $17,200 or $35,500 for a family of four.

Undocumented children were already eligible for the program.

Californians Must Have Health Insurance In 2020, Or Face Penalty (podcast)
Brooke Ruth, Maureen Cavanaugh

A new state law going into effect Jan. 1 requires Californians to have health insurance in 2020 or face a penalty on their state taxes.

This follows the repeal of the individual mandate at the federal level, which took effect in 2019. California's individual mandate is part of a state budget deal struck by Democratic legislative leaders and Gov. Gavin Newsom over the summer.

Covered California was created in 2014 to offer state residents subsidized health insurance under the Affordable Care Act. Covered California's enrollment period for health coverage in 2020 starts Tuesday and runs through Jan. 31.

The executive director of Covered California, Peter Lee, joined Midday Edition on Monday to discuss who's eligible for health insurance subsidies and how to enroll.

Tax penalty returns next year. But health coverage will cost less in Stanislaus County
Ken Carlson

Middle income residents for the first time are eligible for financial help to lower health insurance costs, as the enrollment window opens for Covered California health plans for 2020.

The subsidies for individuals earning $50,000 to $75,000 a year, plus a state mandate requiring people to have health insurance, are the new particulars of individual market coverage next year in California.

Covered California, the state's health exchange created under the Affordable Care Act, said the state-funded subsidies for moderate income households will average $172 a month and some could receive $750 or more in monthly premium assistance. A family of four with earnings between $103,000 and $154,500 is eligible for the financial help.

The enrollment period opened Tuesday and runs through Dec. 15 for coverage starting Jan. 1. An extended enrollment is through Jan. 31 for coverage to start later.

Lawmakers decided to make health insurance mandatory in California after the federal mandate in the Affordable Care Act was erased by a GOP-supported tax bill. Though it was one of the more unpopular elements of the ACA, restoration of the mandate in California is one reason for a negligible increase in premiums in the coming year, the exchange said.

The Legislature approved state premium subsidies for the middle class to assist consumers who were squeezed by rising health insurance costs.

“We want to make sure Californians know about the new state subsidies that mean almost a million people can get more help with their premiums,” said Peter Lee, executive director of Covered California.

Those without coverage next year could be charged a penalty on their state income taxes in 2021. The penalty could be $2,000 or more for a four-member family. Under Senate Bill 78, the penalty is waived if a household's cost for insurance is more than 8.3 percent of income.

Covered California said the state financial assistance varies depending on the region where applicants live, their age and income and the health care costs in that area.

For individuals, the cost savings in the pricing region that includes Modesto are found at income levels below $60,000 annually. According a “Shop and Compare” online tool, a 55-year-old earning $55,000 annually is eligible for a $159 subsidy, lowering the monthly premiums to: $570 for the Kaiser Permanente Silver HMO; $603 for the Anthem Blue Cross Silver EPO; $872 for the Blue Shield Silver HMO; and $930 for the Blue Shield Silver PPO.

Anthem Blue Cross, Kaiser Permanente, Blue Shield of California and Health Net are the insurers on the exchange offering coverage in Stanislaus and San Joaquin counties. The health plans are in different metal tiers — bronze, silver, gold and platinum — and silver plans are a popular option.

A married couple in Modesto, both 60 years old, with income of $75,000 a year, could get a subsidy totaling $1,017 a month, according to the online tool.

In the Modesto region, a 55-year-old resident earning $60,000 annually gets no more than a $2.50 state subsidy for health coverage. The same person in Sonoma is eligible for $179 in monthly state cost savings. Because of regional pricing variations, the cost difference between Modesto and Sonoma is not that wide — the Kaiser Silver HMO costs $679 a month in Sonoma with the subsidy and the same plan in Modesto is $728 a month with the puny subsidy.

The state assistance is expected to cost taxpayers more than $400 million next year, though tax penalties paid by the uninsured could cover three-fourths of the cost.

A 5.7 percent reduction in rates is projected for the 72,300 people enrolled in the pricing region including Stanislaus, San Joaquin, Merced, Mariposa and Tulare counties. About 95 percent of those residents have their premiums subsidized by the federal government and those households will be eligible for some additional state costs savings averaging $15 a month.

People can inquire about Covered California insurance by calling 800-300-1506 or visit www.CoveredCA.com.

California is giving financial help to give everyone health coverage
Wealthy Gener

FRESNO, California – (KSEE) – Open enrollment began last week and millions more people are eligible…and Covered California is urging everyone to re-evaluate and take advantage of the savings you could be getting.

“We know that three-quarters of the people eligible for financial help, don’t know it–or are wrong about it because they checked two years ago and their circumstances have changed,” Peter V. Lee, Executive Director of Covered California said.

If you made too much money or not enough in the past to qualify, the new law could change that and if you’re already eligible and benefiting–premiums could be lowered.

“In the Central Valley, premiums, instead of going up 6-7 percent, going up a percent or two and for many people, premiums will actually go down,” Lee added.

Starting January 1st, California will become the first state to offer subsidies to middle-income people who did not qualify for the federal tax credits for health coverage through Covered California–the state’s Affordable Care Act insurance exchange.

“What’s new this year is middle-class folks–individuals making more than 50 thousand, a family of 4 making more than a hundred thousand, they can get financial help through state subsidies, ” Lee said.

California restored the law that requires people to have health insurance which is giving the entire individual market a record-low rate increase. The first deadline is December 15th…for more information, go to CoveredCA.com.

Big changes to Covered California: Everything you need to know as enrollment kicks off, from financial help to penalties
Joe Goldeen

STOCKTON — Some critical changes to Covered California — the state’s health insurance marketplace — are so important this year that the agency’s boss came to Stockton last week for the sole purpose of explaining them.

“In many ways, this open enrollment period for 2020 is the biggest year since our first year in 2014. This year there is new state subsidies on top of federal subsidies that will benefit about a million Californians, and this year we have a penalty coming back into law,” said Peter Lee, Covered California’s executive director.

“So federally last year — 2019 — the penalty went away. This year, there is a state penalty. The Franchise Tax Board will basically make you pay $2,000 for your family of four or more if you decide to go without health insurance you can afford,” Lee said.

The new law that takes effect Jan. 1 requires most residents to get health insurance or face a penalty when you file your state taxes in 2021. The penalty is based upon income and household size. The penalties are as follows:

• For an individual making less than $45,500, you may pay $695.

• For a married couple making less than $91,000, you may pay $1,390.

• For a family of four making less than $140,200, you may pay $2,085.

There are exceptions, such as not having to pay a penalty if the cost of your health care coverage exceeds a certain percentage of your income.

According to Lee, the best way to avoid a tax penalty is to buy health insurance during Covered California’s open enrollment period now through Jan. 31. But in order to have coverage beginning Jan. 1, you will need to sign up by Dec. 15. You can do that by

visiting CoveredCA.com or get free, confidential assistance from a certified enroller in a variety of languages. Call Covered California at (800) 300-1506.

The good news, Lee explained, is that many Californians who never qualified for a subsidy in the past will now be eligible for new financial help from the state that will lower the cost of their coverage. And about 75 percent of current enrollees could pay less than they paid in 2019 if they switch to the lowest-cost plan in the same tier.

This includes middle-class families that previously did not qualify for financial help because their incomes exceeded federal limits.

And, for the first time due to the state-imposed mandate, insurance premiums are going down. While rates statewide are dropping an average of 0.8 percent, in San Joaquin County they are dropping by 5.7 percent, according to Covered California data.

And existing consumers in San Joaquin County will see an average reduction of 9.3 percent if they switch to the lowest-cost plan at the same benefit level. Lee shared one example specific to a Stockton couple ages 61 and 62 making $70,000 a year.

In 2019, they did not qualify for federal tax credits because their income exceeded 400 percent of the Federal Poverty Level, and the lowest-cost Silver plan would be $1,967 per month or nearly $24,000 per year.

The same couple in 2020 would be eligible for $1,310 in monthly state subsidies, or nearly $16,000 per year, and the lowest cost Silver plan would cost $551.

Lee believes Covered California, especially with the changes coming in 2020, “is a model for the nation. This helps everybody — individuals, older folks, early retirees, small business owners.”

He said up to 75 percent of residents who are eligible for the new subsidies don’t know about them, so that’s why Covered California will begin a massive statewide outreach campaign beginning this week with a new marketing campaign that includes television ads starting Nov. 4 with the theme, “You Shouldn’t Have To.”

The idea is that when you have health insurance, you shouldn’t have to make tough choices like whether to try self-treatment or see a doctor.

States Woo Obamacare Customers With Greater Subsidies, Outreach
Sara Hansard

States are aggressively seeking to pull more people into the Obamacare markets as open enrollment nears for 2020.

States from Pennsylvania to California are setting up their own exchanges, expanding subsidies, and bolstering their outreach in an effort to boost enrollment and take greater control over their health insurance markets.

The efforts come as the Affordable Care Act markets continue to show signs of stabilizing for 2020 after experiencing turbulence in their early years.

Average premiums for "benchmark" plans on which premium subsidies are based will drop 4% for 2020 in the 38 states using the federal HealthCare.gov exchange, the Department of Health and Human Services reported earlier this month. In addition, 20 more insurers are selling plans in those states, the HHS said.

Open enrollment in those states is set for Nov. 1-Dec. 15. In 2019, 10.6 million people enrolled in both the federal and state-based exchanges. HealthCare.gov opened for "window shopping" Oct. 25, allowing consumers to view plan offerings and prices before open enrollment begins.

State-Based Exchanges
Twelve states and the District of Columbia will fully operate their own state-based exchanges in 2020, with Nevada joining the group.

Nevada will save money by setting up its own state-based exchange, Heather Korbulic, executive director of Nevada Health Link, said in an interview. The Nevada exchange enrolled about 83,000 people in 2019.

For plan year 2019 Nevada expects to spend about $12 million on HealthCare.gov, but its 2020 plan year expenditures are only expected to be $5 million operating its own exchange.

In 2020 Nevada also is offering dental plans on its exchange without requiring consumers to buy ACA plans, which is likely to be useful for Medicare beneficiaries, Korbulic said.

In addition, six states are moving to partially operate a state-based market. Under that model, states take on more responsibility for running their health insurance market by

engaging in activities such as outreach and promotion, but they continue to use HealthCare.gov to enroll people and determine eligibility for subsidies.

Of those six states, New Jersey, New Mexico, Oregon, and Pennsylvania are Democratic-leaning, but Arkansas and Kentucky are also on the list, indicating some Republican states may be warming a bit to more involvement with the ACA.

Meanwhile, some states are also taking steps to steer people who need individual market coverage into ACA plans, such as by adopting their own penalties for individuals who don't have health coverage. Republicans in Washington reduced the federal penalty to zero as of 2018.

One of those states is California.

Carrots and Sticks

California, where Covered California is the largest state-based marketplace with 1.4 million enrollees, is making dramatic changes for 2020.

The state will become the first to expand premium subsidies to help people with incomes up to 600% of the federal poverty level. The federal government offers subsidies to those making up to 400% of the poverty level. The state will also fund higher subsidies for households with incomes between 200% and 400% of the poverty level.

The increased subsidies will provide help to families earning up to $150,000 a year.

The subsidies for people between 400% and 600% of the poverty level will help about 230,000 people, Peter Lee, executive director of Covered California, said in an interview.

"Many of those people have insurance today," but many are expected to move from the off-exchange individual market to Covered California to take advantage of the subsidies, he said.

The $420 million estimated cost for 2020—the first year of the three-year program—is to be partly funded by $300 million in penalties the state expects to collect from people who don't have qualified health insurance, Lee said.

"Both of those factors—the adding subsidies and bringing back the requirement to have health insurance—the main thing both will do, we hope, is encourage people to see how affordable health care is," Lee said.

Three-quarters of people eligible to get federal support don't know or think they're not eligible, he said.

Outreach, Marketing

States are also taking a greater role in marketing and outreach efforts.

The Trump administration has reduced funding for outreach and taken other steps that could reduce enrollment for the federal marketplace, Rachel Schwab, a research associate at the Georgetown University Health Policy Institute, said in an interview.

At the same time, “Many states that run their own marketplaces, you’re seeing them dig their heels in and make sure that they’re funding their navigator programs, making sure that they’re funding their outreach and marketing efforts,” and some states are expanding enrollment periods, Schwab said.

One of the partial state exchanges, Pennsylvania, will spend $400,000 on navigators who will help people get enrolled for the upcoming sign-up period, insurance commissioner Jessica Altman said.

That’s $100,000 more than would have been spent by the federal government, Altman said.

Pennsylvania expects to have a full state-based exchange by plan year 2021, she said.

Role of Web Brokers
The 2020 plan year will also be the first year that web-based brokers and health insurance companies can fully enroll people in ACA plans without having to redirect them to HealthCare.gov to determine their subsidy eligibility.

Web broker Stride Health, headquartered in San Francisco, sells health insurance and other benefits to people in the “gig” economy who work for themselves. That includes people who are independent contractors for Uber, Doordash, Postmates, and Instacart, as well as for self-employed professionals with companies such as realtor Keller Williams.

Stride Health expects to assist millions of those workers during the open enrollment period, most of whom receive ACA subsidies, Noah Lang, chief executive officer and co-founder, said in an interview.

“You’re going to see more of the private sector, I think, leaning in to help grow the market this year as a result,” he said.

Covered California hires IPG trio Weber, Golin, Axis for enrollment push
Sara Hansard

SACRAMENTO, CA: State health insurance marketplace Covered California has brought on an integrated Interpublic Group PR agency team of Weber Shandwick, Golin and the Axis Agency as its PR AOR.

The IPG agency team will work with IW Group and Lagrant Communications on external comms strategy for Covered California.

The three-year contract has a budget of $2.5 million per year with an option to renew for three additional one-year periods, Amy Palmer, Covered California's director of communications and PR, told PRWeek in March. The agencies were selected in June, following a three-stage RFP process. Firms picked for the final round made presentations in early May.

"We chose to bring a best-in-class agency team together with folks who have the right skill sets from several IPG PR agencies, complemented by a couple other partners that we worked with before that brought more specialized audience expertise to round out the team," said Pam Jenkins, president of Weber's global public affairs practice. "We felt that was a great way to bring the right people to be really client focused and to bring all the various expertise you need in a state as diverse as California."

Ogilvy was the incumbent on the account. The agency worked with Covered California on a four-year contract with an option to renew the pact for another year. However, the changing state of healthcare law prompted the state to put the review up for bid, Palmer told PRWeek in a previous interview.

Ogilvy, which was invited to re-bid for the work, no longer works with Covered California. The WPP firm declined to comment.

The IPG team will supply Covered California with digital and influencer work, event management and media relations assistance. The agencies will aid Covered California with external visibility, focusing on raising awareness of healthcare coverage options for state residents, promoting enrollment and coverage retention and highlighting the exchange model.

"The main purpose of the contract is to enroll people across the state in health insurance working through Covered California," said Jenkins.

There are two new affordability initiatives in California: the restoration of the individual mandate and new state subsidies that could lead to hundreds of thousands of people gaining coverage with lower premiums and more financial help.

"Under Covered California's leadership, the state expanded the subsidies so that many middle-income individuals and families who make $50,000 to $150,000 are eligible for help for the first time," said Jenkins. "It's important for us to reach Californians who qualify for financial assistance."

The agencies are setting up earned media interviews, working with California influencers, creating content for social and digital media channels and activities in all media markets in the state, including a partnership between Covered California and well-known athletes.

There will be live events at four locations across the state where influencers will help to spread the word that now is the time to sign up for health coverage through Covered California. The first event is scheduled for November 4 in Los Angeles.

The agencies are also conducting media relations for general news and specialized media that reach younger and diverse audience segments.

The account lead is Jennifer Baker-Asiddao, executive director at Golin in Los Angeles. Jenkins is executive sponsor on the account, with overarching responsibility for it.

For 2019 coverage, Covered California reported a 7.5% increase in healthcare plan renewals compared with the previous year, although 23.7% fewer consumers signed up for new coverage. Covered California executive director Peter Lee said the removal of the federal individual mandate penalty was the reason that fewer people signed up.

Campbell Ewald handles marketing for Covered California.

Obamacare's Star Ratings Offer A Glimmer Of Insight — But Not For All
Lauren Weber and Phil Galewitz

ST. LOUIS — As millions of Americans start shopping Friday for individual health insurance for 2020, they will see federal ratings comparing the quality of health plans on the Affordable Care Act's insurance marketplaces.

But Christina Rinehart of Moberly, Mo., who has bought coverage on the federal insurance exchange for several years, won't be swayed by the new five-star rating system.

That's because only one insurer sells on the exchange where the 50-year-old former public school kitchen manager lives in central Missouri. Anthem Blue Cross Blue Shield in Missouri was not ranked by the Centers for Medicare & Medicaid Services.

"I'm pleased with the service I get with that and the coverage I have," she said, noting she focuses on cost and whether her medications and checkups are covered.

Rinehart's case illustrates one reason why the star ratings are unlikely to play a big role in people's decision-making for the first year of the national rollout. Nearly a third of health plans on the federal exchanges don't yet have a quality rating — including all the plans in Iowa, Kansas and Nebraska. Only one insurer is available in nearly a quarter of counties across the U.S. And consumers may not find the information behind the star ratings valuable without additional details, insurance experts say.

Across Missouri, Cigna is the only one of seven insurers to get ratings. The others have not yet been in the marketplace for the three years needed to merit a score.

Missouri is one of eight states that don't have any health plans that earned at least three stars. The others are Iowa, Kansas, Nebraska, Nevada, New Mexico, West Virginia and Wyoming. States with the most three-star or higher health plans are New York (12), Michigan (10), Pennsylvania (9), Massachusetts (8) and California (7).

The star ratings are largely new to the federal exchanges, which operate in 39 states. About 80% of plans in the federal marketplaces earned three or more stars overall, CMS said. Only 1% earned five stars.

The new federal star ratings are based on three main areas: evaluations of the plans' administration, such as customer service; clinical measures that include how often the plans provide preventive screenings; and surveys of members' perception of their plan and its doctors.

Ratings can be viewed at healthcare.gov, where consumers review plans' benefits and prices. Open enrollment runs from Friday through Dec. 15 for the federal exchange states, though enrollment lasts longer in the District of Columbia and most of the 11 states that operate their own marketplaces.

Last year, about 11.4 million people bought coverage on all the exchanges, with more than 80% getting federal subsidies to lower their premiums.

The good news for consumers is premium prices on the federal exchanges are dropping by about 4% on average for 2020.

And consumers generally will have a wider array of choices as more companies enter the markets. Nationally, the average number of health plan choices per customer has risen from 26 to 38, according to Joshua Peck, co-founder of Get America Covered, a nonprofit that helps people enroll and find coverage. Missouri, for example, will have 28 plans from its seven insurers, he said, up from 14 this past year.

Jodi Ray, who runs Florida's largest patient navigator program as director of Florida Covering Kids & Families at the University of South Florida, is skeptical consumers will use the new ratings. Instead, she said, they will likely focus first on whether their doctor is on the plan, if their medications are covered, the size of the deductible and the monthly costs.

"The star ratings may fall out the door at that point," she said.

Many of the states that operate their own exchanges have already offered quality ratings, which were required under the ACA. California's insurance exchange has been providing quality ratings for several years, though it's unclear how much weight consumers give them.

"They have a limited effect on consumers but have a significant effect on health plans," said Peter Lee, executive director of Covered California, the state's insurance exchange. "It does tip health plans to focus on what they can do to improve care, and I think that is a positive effect."

Kaiser Permanente (which is not affiliated with Kaiser Health News) is the only insurer in the California exchange to garner the maximum five stars, Lee said. It also has the most enrollment of any plan in the state's exchange. But, he noted, the plan has a lower share of the enrollment in Southern California partly because its prices are higher compared with rival insurers, indicating low cost may trump high rankings in attracting enrollees.

"It's good news that nationally the federal marketplace is putting quality data out there for consumers," Lee said. Still, he added, customers would want to see the specific criteria that matter to them, such as how well plans care for patients with diabetes. Currently, that data is not immediately accessible for consumers at healthcare.gov.

Consumers tend to stick with their insurer even when prices and benefits change, said Katherine Hempstead, a senior policy adviser at the Robert Wood Johnson Foundation, the nation's largest public health philanthropy. "People think changing health insurance plans is a huge pain and they don't know if things will get better or worse." But, she added, "people respond to consumer ratings and reviews."

The federal government already uses star ratings to help consumers choose a Medicare Advantage plan as well as compare hospitals. It began testing the exchange ratings in a handful of states over the past two years.

Heather Korbulic, executive director of the Nevada health exchange, worries the ratings could be steered by a relatively small number of member surveys. “It’s such a narrow sample,” she said, noting one plan’s rating was partly based on just 200 member reviews.

Even though many counties have only one insurer in 2020 — most of them rural areas or clustered in the Southeast — the number of enrollees with access to just one insurer is falling to 12% next year from 20% now.

In Missouri, that’s the case in more than two-thirds of the counties. Sidney Watson, director of the Center for Health Law Studies at St. Louis University, attributes the lack of choices in Missouri to the failure to expand eligibility for Medicaid. People who earn between 100% and 138% of the poverty line who would be eligible under Medicaid expansion instead are enrolling in marketplace plans, she said. Since they tend to be less healthy, they drive up premiums in the marketplaces.

States that have not expanded Medicaid see premiums that are 7% higher than states that have, according to a 2016 study from the U.S. Department of Health and Human Services.

“If you look at Arkansas, they’ve got nice competition in their marketplace, but they’ve also expanded Medicaid,” Watson said. “We look a lot like Mississippi, which is struggling to get insurance in rural counties.”

That leaves people, like Rinehart, stuck with one insurer.

Rinehart remains loyal to Anthem particularly after it helped her get care and deal with the costs of suffering four heart attacks in 24 hours nearly three years ago. She’s thrilled Anthem’s prices are down slightly for 2020.

“I wasn’t able to afford insurance before [the Affordable Care Act],” she said, “so it was a blessing to have.”

Covered California Marks Beginning Of Open Enrollment with Community Fitness Event in Downtown Los Angeles
Staff

Laila Ali, world class athlete, right, and Leo Santa Cruz, professional Mexican-American boxer, left, joined Covered California Executive Director, Peter V. Lee to spread the word about Open Enrollment and the new California initiatives that lower health care

costs for millions of Californians at the Covered California Open Enrollment Kickoff event at The Bloc.

“In every area of my life, I put my health first. Whether it’s by staying active, eating healthy or, most importantly, getting health insurance,” Ali said. “Covered California makes it easy to get enrolled in affordable coverage that works for you and your family – so you can succeed at home, work and play.” - Laila Ali

Nearly a million Californians will qualify for financial assistance to get coverage during open enrollment, which runs through Jan. 31, 2020. Consumers who sign up by Dec. 15 will have coverage starting Jan. 1. and consumers who choose to go without coverage could face a penalty when they file their taxes.

“We want to make sure that everyone knows about the new state subsidies that are already helping people across the state save money on their monthly health insurance premiums. California is making coverage more affordable for low-income families, and we are making history by becoming the first state in the nation to provide financial help to middle-income families like small-businesses owners and the self-employed.” - Covered California Executive Director Peter V. Lee.

NewsConference: New Financial Help for Covered Californians
Video

It’s that time of the year—open enrollment to pick a healthcare agency. NBC4’s Conan Nolan talks with Peter Lee, the Executive Director of Covered California about the biggest change for over a million Californians since 2014. “There is new financial help…and if they don’t there could be a penalty,” says Lee.

Covered California Enrollment Opens This Week, With New State Financial Aid For Some
Sammy Caiola

People buying insurance through Covered California might see lower prices this time around, following changes in Gov. Gavin Newsom's most recent state budget.

Enrollment for the state's health benefit exchange begins Oct. 15. Certain low-income Californians are already eligible for subsidies from the federal government to help pay their premiums, but this year there are new state dollars to help low and middle income residents.

Earlier this year the Care4All California coalition, which supports insuring all Californians regardless of income or immigration status, made a push for state-level premium assistance on top of the federal aid. Many low and middle-income consumers say they earn just a little too much to qualify for federal assistance, but not enough to comfortably pay for health insurance. Others say the federal help they get still isn't enough to make ends meet.

In the budget, Newsom established new state credits for individuals making less than $17,000 a year and between $24,000 and $49,000 a year. Those Californians already receive federal assistance but will now get between $10 and $25 a month in new state aid. People who make between $17,000 and $24,000 are only eligible for federal subsidies.

And he created new subsidies, to the tune of about $120 a month, for individuals earning up to $73,000, who don't currently get federal help. Economic experts say California is pioneering this kind of subsidy expansion.

Anthony Wright of the Care4All coalition said some enrollees will see these changes reflected when they look for plans using Covered California's "shop and prepare" tool this year.

"They may actually see a decrease because of the new affordability assistance," he said.

Two bills that won Newsom's signature this weekend also aim to boost health insurance enrollment.

SB 260 is designed to help people stay insured when they experience a life change, such as a new job or a raise. Starting in 2021, Covered California will be able to reach out directly to people who are at risk of losing Medi-Cal coverage and inform them of their options on the individual market. Supporters of the policy say it will be crucial when California's minimum wage increases, potentially bumping people above the income threshold for Medi-Cal.

Another new law, AB 1309, extends Covered California's enrollment window by two weeks. Sign-ups typically close on Jan.15, but this cycle they'll extend until Jan. 31. Starting next season, enrollment will be open from Nov. 1 to Jan. 31. The Trump administration recently reduced the federal Medicaid enrollment window down to six weeks, from 12 weeks.

USC Annenberg Media

Covered California is "jumping" into this year's health insurance open enrollment period

Brogan Kroener

Covered California kicked off this year's open enrollment period with literal kicks. The health insurance marketplace held a workout event hosted by world-class athlete Laila Ali and World Championship boxer Leo Santa Cruz promoting this year's opportunity to check out various health insurance agencies. According to Covered California Executive Director Peter V. Lee, this is the only time of the year where any and everyone can look into health insurance options without being turned down. It's now a law in California that everyone who can afford health insurance, must get it or they'll pay a fine.

However, Lee said it's the unexpected ER visits that boast heavy medical bills that are the real penalty people should be concerned about. Mother-of-two Olivia Perrine knows first hand the dangers of not having proper health coverage. When her doctor switched her from brand-name to generic medication for her thyroids, it was cheaper but not as effective. She fought with insurance companies and eventually got approved to take the brand-name medication and pay much less. Covered California allows people like Perrine to shop around different health insurance companies and find the one that best fits their lifestyle and annual income so that they don't have to live with pain or any other health concern. The enrollment period goes until the end of January, but you have to sign up by December 15th if you want to be ensured by the start of next year.

College Won't Be Fun If You're Not Healthy. Some Advice About Health Insurance
Bernard J. Wolfson

Are you among the 400,000 freshmen in California — or 2.9 million nationwide — who have just started college, or are about to? As you buy your books, ponder the best meal plan or wonder whether you will get along with your roommate, don't forget about health insurance.

Whether you're an undergrad or graduate student, your options will depend on where you go to college, if you already have coverage through a family or individual health plan, and how much money you make.

It might surprise you to know you could qualify for no-cost Medicaid, the public health insurance program for people with low incomes.

"The good news is there are a few good options," says Paul Rooney, vice president of carrier relations at eHealth, an online health insurance broker based in Santa Clara, Calif.

Since health plans vary from region to region and state to state, your first call might be to an insurance agent in the market where your college is located to discuss your options. The help is free. In California, you can find certified insurance agents on the "Find Help" tab of the website of California's Obamacare marketplace, Covered California: www.coveredca.com

Sometimes, staying on your family's plan is the best option — and you can do so up to age 26.

If you are on your family's plan, or you have your own insurance, call the customer service number on your insurance card to ask about the level of coverage, if any, it will provide if you attend college in another region or state.

If your family health plan is a preferred provider organization (PPO) with a national insurance company — Cigna, Aetna or UnitedHealthcare, for example — you often can get full medical services at in-network prices in other regions of the country where your insurer operates.

But it also has to work financially. Parents, ask your employer or your insurer if taking your child off the family PPO will lower your premium. If the answer is no, and he will have full network coverage while away at college, it makes sense to keep him on the plan.

If the answer is yes, do the math.

Keith Wakeman, CEO of a Chicago-based mental health app startup called SuperBetter, learned he would save $1,900 this year by taking his son Jack off the family's Blue Cross PPO and buying him the student plan offered by Purdue University, where he is a freshman.

"The plan is much better for Jack in terms of deductibles and copays — and also includes vision and dental," Wakeman says. "It was a no-brainer for us."

It probably also makes sense to take your student off the family plan if it is a health maintenance organization (HMO) or an exclusive provider organization, both of which restrict their networks more than PPOs.

There are exceptions: Some insurers allow HMO enrollees to get full medical services at no extra cost in other regions or states where they operate. Ask your health plan if that's possible.

If it's not, the health plan offered by your college could be a good option.

Student health plans have improved in recent years, in part because they almost always comply with the Affordable Care Act's coverage requirements. That means most offer a comprehensive range of medical services at a high level of coverage, says Stephen Beckley, a senior partner with Fort Collins, Colo.-based Hodgkins Beckley Consulting, which works with colleges on student health programs.

The University of California system's health plan is "exceptional," Beckley says, "because of its highly favorable cost and the addition of vision and dental benefits."

Nationally, costs vary widely from college to college, and some are very high, Beckley says.

The cost of this year's UC undergraduate student health insurance plan, which includes all campuses except Berkeley, ranges from $1,773 to $3,537 for 12 months of coverage, according to Zina Slaughter, the plan's director. Stanford University, by contrast, charges $5,592 for undergraduate and graduate students.

Beware: Many universities, the UC system and Stanford included, will enroll you in their health plan automatically, and you must obtain a waiver — by proving you have other acceptable coverage — to avoid the charges.

"We tell people that you should make sure you're not being opted into services you won't use," says Erin Hemlin, director of health and policy advocacy for Young Invincibles, which promotes the interests of young adults.

If your family plan doesn’t work for you anymore and your college plan is too expensive, check to see if you qualify for no-cost Medicaid, which goes by the name Medi-Cal in California and insures one-third of the state’s residents.

This goes for students at private universities and public schools, including the 481,000 students at the 23 campuses of the California State University system and the 2 million-plus who attend one of the state’s 115 community colleges.

In the more than 30 states that have expanded Medicaid, including California, individuals who make up to about $17,200 annually are eligible for the program. It helps if your parents do not claim you as a dependent on their tax returns; otherwise, you must report their income.

Check with the health department in your county to see if you qualify. Find a list of California county offices at www.dhcs.ca.gov.

If your income is too high for Medicaid, you might still qualify for a subsidy to buy a health plan through your state’s Obamacare insurance exchange. In California, log onto the Covered California website or call 800-300-1506 to research options.

Enrollment in 2020 Obamacare exchange plans starts Oct. 15 for Covered California and Nov. 1 in most of the rest of the country.

Experts say a viable option for some students who are on their family’s plan is to stay on it, getting emergency care at a local hospital if necessary and basic primary care at the on-campus clinic (access is often included in student fees). They can wait to get physical checkups and other non-urgent care until they visit home.

Giorgia Winters, a resident of Long Beach, Calif., says that’s the decision she and her husband made for their son Matthew, 18, who just entered Embry-Riddle Aeronautical University in Prescott, Ariz. They don’t worry about his health: He had to pass a Federal Aviation Administration fitness test to pursue his pilot’s license at the school.

“He’ll come fairly often, because Prescott is an hour or so away by airplane,” Winters says. “I don’t know how much better it is financially, but it was more comfortable for us.”

POLITICOPRO

California isn't ensuring low-income kids have adequate health care, new report finds

Angela Hart

SACRAMENTO — California is failing to ensure that millions of low-income Californians have access to high-quality health care, according to a new report from the California Health Care Foundation.

CHCF analyzed 41 Medi-Cal managed care quality measures meant to ensure that poor kids receive well-child visits and immunizations; women are screened for cervical cancer; and people with diabetes get treatment, among dozens of other requirements. But from 2009 to 2018, the state not only failed to improve quality, but allowed it to decline in some cases.

Nearly 60 percent of the 41 performance measures remained stagnant or grew worse, the report found.

"This says to me that the actions that the [Department of Health Care Services] takes to ensure quality of care for its members aren't working as they should," said Chris Perrone, director of CHCF's "Improving Access" team. "We need to set the bar higher. ... No one expects Medi-Cal to be perfect, but we do all expect Medi-Cal to improve over time."

The state contracts with 24 Medi-Cal managed care plans to administer a range of health care benefits to 10.5 million enrollees, according to DHCS. The department has been slammed in back-to-back audits this year by State Auditor Elaine Howle that found millions of children aren't receiving preventive health services and that rural Medi-Cal patients lack adequate access to care.

DHCS spokesperson Anthony Cava told POLITICO the department has not yet reviewed the report, but that it “strives to deliver the right care in the right setting at the right time.”

“To hold providers accountable, DHCS is requiring managed care plans to strengthen their onsite reviews of provider offices and ensure that appropriate preventive services are delivered to children,” Cava said in a statement. “DHCS is committed to providing high-quality, timely care and essential services to everyone covered by Medi-Cal.”

The findings come as California has vastly expanded Medi-Cal to childless adults under Obamacare and has extended benefits and coverage to undocumented kids and young adults.

Of particular concern, Perrone said, is that health care quality declined or remained flat for kids — a population that Medi-Cal has always covered.

"For adults, there's a lot of new patients in that mix that Medi-Cal hadn't been serving before ... but that doesn't explain why we're not seeing improvements in quality of care for children because that's not a new population."

CHCF recommends in the report that California create new financial incentives for health plans to improve. Gov. Gavin Newsom has expanded a value-based payment system rewarding doctors and other providers for accepting new Medi-Cal patients, but the incentives don't apply to insurers.

"Plans do many more things than just pay providers," Perrone said. He said plans would have more incentive to invest in quality and access "if they had some skin in the game."

The report comes as Newsom is considering two bills aimed at improving Medi-Cal mental health services and quality across the overall system.

CA AB1175 (19R) by Assemblyman Jim Wood (D-Santa Rosa) seeks to improve mental and physical health care coordination.

CA AB1642 (19R), also authored by Wood, seeks to help DHCS hold plans more accountable by giving it greater authority to sanction plans if they continuously miss care quality measures. DHCS earlier this year imposed sanctions on 10 county mental health plans for not providing enough mental health practitioners to treat patients with serious conditions.

Both await a signature or veto from the governor.

The New York Times

In California, a 'Surprise' Billing Law Is Protecting Patients and Angering Doctors
Sarah Kliff and Margot Sanger-Katz

Three years ago, California passed one of the strongest laws in the country to outlaw surprise medical billing. That legislation made sure that when patients went to a hospital covered by their insurance, doctors couldn't later ambush them with unexpected bills.

Now lawmakers who want to ban surprise bills nationally are gravitating toward a California-style approach, making the California experience a key exhibit in the debate.

"Every single office I'd go into, I would start talking about our experience in California," said Anthony Wright, executive director of the California patient advocate group Health Access, who spent part of this summer lobbying members of Congress on the issue. "And they would stop me and say, yeah, you're the fifth person who has come in to talk to us about that."

The parties who have watched California's performance disagree, sometimes vehemently, on whether the prospect is rosy or grim. Doctor groups, particularly those representing specialties like anesthesia and emergency medicine, argue that a national version of a law like California's would disrupt medical care so much that patients would have difficulty finding a doctor.

California's surprise billing law limited the payments for out-of-network doctors to a formula based on what other doctors were being paid. Bipartisan bills passed by

committees in both the U.S. House and Senate this summer use a roughly similar approach, often described as benchmarking.

The legislation, which has yet to advance to the floor of either the House or the Senate, has enemies. One dramatic television advertisement, run by a dark money group called Doctor Patient Unity, shows an ambulance pull up to an abandoned emergency room, warning that benchmarking could mean closed hospitals. The group, which is funded by two large private equity-backed physician staffing firms, has spent more than $28 million to oppose the bills.

A letter to Congress from the California Medical Association described the California law as “failing,” and provided four pages of examples of insurance companies dropping doctors from their networks or demanding substantial payment cuts. “The California law is reducing access for patients to in-network physicians and jeopardizing access to on-call physician specialists needed in medical emergencies,” the letter says.

But new data from California state regulators and other sources suggest that the situation isn’t as dire as the doctors’ groups describe. Since the California law took effect in 2017, there has been little evidence that patients’ access to health care has suffered.

“It is possible that there are cases where they are receiving less money for in-network and out-of-network services,” said Erin Duffy, an adjunct policy researcher at the RAND Corporation and a research fellow at the U.S.C. Schaeffer Center for Health Policy and Economics, who has studied California’s surprise billing law. “They may be experiencing marginal losses and, while loss aversion is real, I don’t think providers are going to be exiting the practice of medicine over this.”

A new analysis, from researchers at the U.S.C.-Brookings Schaeffer Initiative for Health Policy, examined a large sample of insurance claims data from the company FAIR Health to see whether the law had caused insurers to drop doctors from their networks. In contrast with the claims from the California Medical Association, that study found the opposite had occurred: Compared with the period before the law was enacted, the percentage of anesthesiologists, pathologists, assistant surgeons, radiologists and neonatologists whose work was covered by insurance increased by an average of 17 percent. The research team included Ms. Duffy.

A study published by the insurance industry last month in the American Journal of Managed Care also found that the number of California doctors in their networks had increased, not declined, since the law kicked in.

Consumer complaints to the state’s Department of Managed Health Care have been largely flat. A report ordered by the state legislature found that between zero and 20 percent of patients who were treated at an in-network hospital were still receiving out-of-network care, depending on the insurer. Those numbers, which could not be compared with previous rates, were published in March to little fanfare. Only a tiny fraction of doctors have used an appeals process to dispute their benchmark payments. Those

state indicators were highlighted in a new white paper from Health Access published Thursday.

“We have not seen evidence indicating negative impacts for consumers’ access to care as a result of this new law,” said Rachel Arrezola, a spokeswoman for the department, in an email.

The California Medical Association noted that the state agency hadn’t examined the full universe of health plans that might have been affected by the law. Around 10 percent of health plans in the state are regulated by a different agency.

There is less data about what doctors are being paid under the new system. The letter from the California Medical Association provides examples of insurers that are demanding rate cuts as high as 40 percent. Blue Shield of California, one of the state’s largest insurers, told Senate staff in a letter that its payment rates had increased since the law went into effect, even as the number of doctors in their network increased. But its experience may not be universal. The Congressional Budget Office estimates that the average payment to affected doctors could end up falling by between 15 percent and 20 percent if the bill before the Senate becomes law.

A recent survey from the Kaiser Family Foundation found that 78 percent of adults favor a solution to surprise medical bills. When told this could reduce doctors’ pay, 57 percent still support the idea.

Michael Champeau, the president of the Associated Anesthesiologists Medical Group in Palo Alto, said he was the first physician to try out California’s appeals process. After the law passed, it prompted his practice to try to sign contracts with all the nearby insurance companies, most of which obliged, offering similar prices. Blue Shield, he said, was the exception. “We made several calls to their contracting officer,” he said. “No one ever returned our phone calls. They just refused to acknowledge we existed.”

Matthew Yi, a spokesman for Blue Shield, said the company did respond to Dr. Champeau’s company in the summer of 2016, with a request for materials to begin a contract negotiation. He said the practice did not reply for several months, and then only to update its address.

After his practice treated Blue Shield patients at Stanford Hospital, Dr. Champeau received an automatic payment 35 percent lower than what the other insurers pay him, he said. After a long process, he lost the appeal. “Why on earth would they want to contract with me for the average going rate in my area when they knew they were going to be able to pay me 35 percent less?” he said.

Dr. Champeau, who is now the treasurer for the American Society of Anesthesiologists, has been to Washington and discussed his experience with Anna Eshoo, the chairwoman of the Energy and Commerce Health Subcommittee, and with Speaker Nancy Pelosi.

Ms. Duffy, the RAND researcher, said this was a common refrain from the doctors she interviewed for her study, who lamented that the new law meant they had less leverage in contract negotiations.

“They said the tenor of the conversation had changed,” she said. “It had been made clear to them they were in a weak position. And that was very upsetting to them.”

With the Affordable Care Act’s future in doubt, evidence grows that it has saved lives
Amy Goldstein

DETROIT — Poor people in Michigan with asthma and diabetes were admitted to hospitals less often after they joined Medicaid under the Affordable Care Act. More than 25,000 Ohio smokers got help through the state’s Medicaid expansion that led them to quit. And around the country, patients with advanced kidney disease who went on dialysis were more likely to be alive a year later if they lived in a Medicaid-expansion state.

Such findings are part of an emerging mosaic of evidence that, nearly a decade after it became one of the most polarizing health-care laws in U.S. history, the ACA is making some Americans healthier — and less likely to die.

The evidence is accumulating just as the ACA’s future is, once again, being cast into doubt. The most immediate threat arises from a federal lawsuit, brought by a group of Republican state attorneys general, that challenges the law’s constitutionality. A trial court judge in Texas ruled late last year that the entire law is invalid, and an opinion on the case is expected at any time from the U.S. Court of Appeals for the 5th Circuit. The case could well put the ACA before the Supreme Court for a third time.

President Trump has dismantled as much of the law as his administration can, by expanding the availability of skimpy, inexpensive health plans that skirt ACA rules, for example, and slashing federal aid to help people sign up for coverage through ACA insurance marketplaces.

And some 2020 Democratic presidential candidates contend the country needs further-reaching health reforms than the ACA’s, calling for a government-financed system they call Medicare-for-all.

The ACA’s supporters have not taken political advantage of the signs that the law is translating into better health — at least, not yet.

When the sprawling 2010 statute was new, a central question was whether it would help more people gain affordable health coverage, as intended.

With about 20 million Americans now covered through private health plans under the ACA's insurance marketplaces or Medicaid expansions, researchers have been focusing on a question that was not an explicit goal of the law: whether anyone is healthier as a result.

It is difficult to prove conclusively that the law has made a difference in people's health, but strong evidence has emerged in the past few years. Compared with similar people who have stable coverage through their jobs, previously uninsured people who bought ACA health plans with federal subsidies had a big jump in detection of high blood pressure and in the number of prescriptions they had filled, according to a 2018 study in the journal Health Affairs.

And after the law allowed young adults to stay longer on their parents' insurance policies, fewer 19- to 25-year-olds with asthma failed to see a doctor because it cost too much, according to an analysis of survey results published earlier this year by researchers at the Centers for Disease Control and Prevention.

Most of the emerging evidence concentrates on the health effects of joining Medicaid under the law's expansion of the safety-net program. Medicaid is an appealing research focus because a 2012 Supreme Court decision gave each state the option to widen eligibility to people who are somewhat less poor, allowing comparisons between the three dozen states that have expanded and the rest that have not. In addition, low-income people without insurance are most likely to have built-up medical problems that get treated once they get covered.

Michigan has emerged as a hub for understanding the ACA's effects on health because University of Michigan researchers have been rigorously evaluating the Healthy Michigan Plan, as the state calls its Medicaid expansion covering about 650,000 people.

One 2017 study compared heart surgery patients in Michigan and Virginia, which had not yet expanded Medicaid at the time. It found that those who had cardiac bypasses or valve operations in Michigan had fewer complications afterward than similar people in Virginia, where more were uninsured.

One in three Michigan women said that, after joining Medicaid, they could more easily get birth control. And four in 10 people in Healthy Michigan with a chronic health condition — such as high blood pressure, a mood disorder or chronic lung disease — learned of it only after getting the coverage, according to survey results published last month.

In a few neighborhoods here in Detroit, the consequences for patients and their doctors are clear.

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Bonnie Sparks, dripping sweat in a mint-green -T-shirt, reached the finish line of the CHASS community health center's 5K run/walk. As she trudged the final steps, the center's chief medical officer, Richard Bryce, urged workers and some medical students to walk alongside her in the 97-degree heat, chanting her name. Then, Bryce wrapped Sparks in a hug.

Sparks came in last of the event's 270 runners and walkers in late July in a southwest Detroit neighborhood pocked with vacant lots. She was halfway to Clark Park when the center's executive director found her at the back of the pack and offered a ride. "No way," Sparks said, insisting on continuing under her own power.

The miracle was that, at 47, she walked the course at all.

CHASS has been a medical haven in Detroit's Mexicantown for a half-century, since the city's riots prompted hospitals to close and physicians to move to the suburbs. Five years ago, when Bryce, a family physician, arrived and took over Sparks's care, she weighed more than 300 pounds and could not get from the clinic parking lot to the front door without help. She'd had her first heart attack at 34. Her anxiety was so sharp she often could not leave her apartment.

On a rare family road trip — to Daytona Beach — she waded into Florida waters where flesh-eating bacteria infected an open sore on her right leg. Back home, she landed in a hospital for 3½ weeks.

For 13 years, Sparks had worked for a defense contractor, NCI Information Systems, overseeing two computer help desks. But when the company lost a contract, her job ended in late 2010, and her good HMO insurance disappeared.

Living on unemployment, she kept taking pills for her diabetes and high blood pressure because she could get the prescriptions for $4 a month through a Walmart discount. But she did not have the $300 a month to pay for Plavix — a blood thinner she needed because of a stent put in her heart — so she stopped.

"I talked to my doctor at the time. I said, 'I can't afford this,' " recalls Sparks. "He said, 'You could have another heart attack.'

"And I did."

The second heart attack, in early 2012, was serious. Afterward, her doctors told her she should not work. She applied for Medicaid twice and received form letters telling her she was denied because she was not under 21, pregnant, blind or taking care of a child.

The following year, she appealed in writing, then asked for a hearing, but a state administrative law judge concluded that, though Sparks had a solid job history and significant medical problems that made it difficult for her to work, she was not technically disabled, so did not qualify for insurance.

“I felt abandoned,” Sparks recalls. “I nearly died. I kept thinking, ‘I am just sick right now.’ ”

So Sparks was uninsured when her boyfriend rushed her to an emergency room for a second time within days after the Florida trip. This time, she was diagnosed with the flesh-eating necrotizing fasciitis. She was having breathing distress and kidney failure because of the infection and was placed in a medically induced coma for most of her time in the Henry Ford Hospital.

But the day she was admitted, April 3, 2014, was the third day the state had begun accepting applications for the Healthy Michigan Plan. On April 29, Sparks got a letter. She was insured.

Medicaid paid her $132,000 hospital bill.

Since then, social workers and a psychologist have helped ease her out of her smoking habit and her anxiety. She met with a bariatric surgeon to consider a gastric bypass but, by that point, had started to lose so much weight by improving her diet and walking that she decided she did not need the surgery. By August, she was down to 234 pounds.

Sparks has an endocrinologist for her diabetes. A cardiologist approved a catheterization when she had more chest pains — and inserted additional stents. And she has an OB/GYN who treated her worsening fibroids and, when they got too severe, made sure she got a hysterectomy.

Bryce, who arrived at CHASS at about the time of Sparks’s infection, says she was like many sick and uninsured patients who can get primary care through the health center but have trouble finding medical specialists willing to treat them.

If not for the health plan she has through Healthy Michigan and Medicare, which she has had since the state eventually classified her as disabled, Sparks said, “I would be dead, or I would be financially ruined.”

On the east side of Detroit, the part of town where poverty and illness are most common and life expectancy is shortest, Healthy Michigan has transformed the lives of patients at the Mercy Primary Care Center. Like Sparks, David Brown says that, without it, “I probably would not be here. I would have had a heart attack and died.”

Before Medicaid expanded, all of Mercy’s patients were uninsured. Now, at 55, Brown is among the half at the clinic covered by Healthy Michigan.

Right after he got laid off in 2007 from a job with Wayne County, driving trucks and front-end loaders at the airport, he began having spells in which his chest was tight, his head spinning. Finally, a friend took him to an emergency room. He was prescribed rest and ordered to follow up with his primary care doctor. Except he did not have one.

Over the next few years, the spells came more often, and he was going to emergency rooms around town, dizzy and with headaches, two or three times a month. When the bills showed up, he stored them, unpaid, in the brown plastic crates where he keeps files.

He does not remember anyone checking his blood sugar, even though his favorite foods were fried chicken, Burger King, cinnamon doughnuts, chocolate milk and — especially — Snickers bars.

Finally, during an emergency room visit, someone mentioned he might be borderline diabetic.

When he finally heard about Mercy and was diagnosed with diabetes by Pamela Williams, a staff physician, Brown recalls, "she started telling me what could happen — amputation, kidney failure, heart failure. I was like, 'I could lose my foot, my hand?' I had never heard of anything like that."

On a Mediterranean diet, Brown, also a licensed pastor who does online counseling, has gone from 340 pounds to 215. His blood sugar has been under control the past few years.

"But unfortunately, the damage was done when he didn't have insurance," Williams says.

With coverage from Healthy Michigan, Brown sees a nephrologist for his chronic kidney disease, a cardiologist for his congestive heart failure, an ophthalmologist for eye damage — all downstream effects of the years he did not know he had out-of-control diabetes.

Brown now has three stents in his heart, including a new one this summer after he had balloon angioplasty to open a clogged artery. He takes medicines that, if he had to pay retail, would cost about $2,400 a month.

"This stuff was not available to me without insurance," Brown says. "I am grateful for it."

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Understanding the ways the ACA has affected Americans' health is a work in progress. In the law's first years, results were mixed, but signs of improvements have accelerated lately, as people uninsured before now have more years of coverage, giving researchers better data to study.

It is too soon to know whether the patterns might reverse with new U.S. Census Bureau data showing that the uninsured rate rose significantly last year for the first time since the ACA has existed.

The findings that exist are not perfect. One National Bureau of Economic Research paper in July, looking at deaths from all causes among adults from their mid-50s to mid-60s, found that dying in a given year has been significantly less common in the states that expanded Medicaid. The paper said that perhaps 15,600 deaths could have been avoided if the expansion had been nationwide, but it cautioned that is a rough estimate in part because the study was unable to look specifically at the people who signed up for Medicaid.

Similarly, a study last year found that infant deaths — especially among black babies — were dropping more rapidly in parts of the country that had expanded Medicaid. But the study does not distinguish families that got coverage through the ACA expansions.

The University of Michigan work, including on trends in hospital stays for four main chronic diseases, was able to focus specifically on people who had joined Healthy Michigan. It found that from the first year in the program to the second, hospital stays for asthma plummeted by half and also fell for diabetes complications. But hospital stays for heart failure became more common. The researchers have not yet looked at the patterns for additional years.

Still, John Ayanian, director of the University of Michigan's Institute for Healthcare Policy and Innovation, said, "the weight of evidence is on the positive side."

Obamacare Premiums Forecast to Rise 2.5%; Insurers Expand Offerings
Sara Hansard

Average Obamacare premiums for 2020 should rise no more than 2.5% as insurers expand their presence in the Affordable Care Act markets amid greater stability and profitability.

That's the assessment of analysts who follow the ACA exchanges, and it comes less a month before the 45-day open enrollment period begins Nov. 1.

The individual market for policies that meet the ACA's coverage requirements is continuing to display the stability first seen in 2019, with increased insurer offerings and more modest premium hikes. But the number of enrollees—most of whom receive subsidies—is declining gradually, and making coverage affordable for people who don't receive substantial subsidies remains a major challenge.

In 2019, 10.6 million people were enrolled through the exchanges.

“2020 is shaping up to be generally a positive year with respect to both rates and competition,” Chad Brooker, associate principal at health-care policy consulting firm Avalere Health, said in an interview.

In the early years of the marketplaces, insurers priced premiums too low for an exchange population that was older and sicker than expected. As a result, they experienced heavy losses and many left the markets.

Premiums then rose sharply, with double-digit increases common in 2017 and 2018. But beginning in 2019, monthly premiums for an individual dropped for the first time by 1% on average to $594.17, according to the Centers for Medicare & Medicaid Services.

Now, with six years of data, “insurers have a really good idea about what the risk pool looks like in the individual market,” and how to price for it, Brooker said.

The reinsurance programs that will be in effect in 12 states in 2020, including five new states, are contributing to rate declines in 2020, Brooker said. The programs, in which states reimburse insurers for the costs of covering high-cost claims, typically reduce premiums by nearly 20% on average in the first year they are in place, Avalere reports.

In addition to enjoying a more stable market and improved profits, insurers are expanding into more ACA territories with an eye toward providing a landing place for people who may enter the individual market with health reimbursement arrangement funding from employers, as well as for individuals getting close to the eligibility age for the Medicare Advantage market.

Small Premium Increases
Based on rates from 23 states, the median increase for 2020 is about 2.5%, Kris Haltmeyer, vice president of legislative and regulatory policy for the Blue Cross Blue Shield Association, said at a press briefing Oct. 3. The rates range from a drop of 18% in Colorado, where the state is starting a reinsurance program in 2020, to a 13% increase in New Mexico, he said.

David Dillon, who helped review rates for seven states and the District of Columbia, expects premiums to rise a mere 0.5% to 1% on average in 2020.

Dillon is senior vice president and principal of Allen, Texas-based actuarial consulting firm Lewis & Ellis Inc. and a fellow with the Society of Actuaries.

The steep rate hikes of 2018 are the primary factor driving lower premiums for 2020, Dillon said.

The 2018 increases led to large profits for insurers. As a result, insurers are expected to pay an estimated $1.3 billion in rebates to consumers under the ACA’s medical-loss ratio provision, according to a recent Kaiser Family Foundation report. That provision requires insurers to spend at least 80% of premiums on claims or quality improvements.

The need to limit those rebates is prompting insurers to curb premium increases for 2020, according to Brooker.

Justin Giovannelli, associate research professor at Georgetown University, believes average premiums could even go down in 2020.

But, for people who aren't receiving substantial financial assistance, "premiums are still awfully high for you, and as a practical matter for many people, unaffordable," he said.

The CMS reports 87% of the enrollees receive subsidies to help pay their premiums or out-of-pocket costs. The number of unsubsidized people declined 2.5 million, or 40%, between 2016 and 2018.

Expanding Their Footprint

Centene Corp., the largest provider of plans in the marketplaces, is making a large expansion in 2020, as are relative newcomers to the industry Oscar Health and Bright Health, according to the Robert Wood Johnson Foundation.

National carriers Cigna Corp. and Anthem Inc. also are increasing their territory.

In some states Blue Cross Blue Shield plans are expanding their footprint. That marks a reversal from a few years ago when regulators had to cajole them to cover markets that otherwise would have had no carriers.

The number of counties with only a single insurer in the individual market will decline by more than 13% in 2020, Katherine Hempstead, a senior policy adviser at the Robert Wood Johnson Foundation, said in an interview. The foundation is tracking insurer involvement in the marketplaces.

"Some of the worst parts of the individual market have gotten better," Hempstead said.

Tennessee is a case in point. Several years ago the state faced the possibility of no coverage in some areas. But in 2020, "It's gotten to be one of the hottest markets in the country," partly because of interest in the Nashville market, she said.

New Territory for Cigna

Cigna will add coverage in 2020 in Kansas and Utah, as well as in the south Florida exchange market, and in new counties in Tennessee and Virginia, Lisa Lough, general manager of the individual and family plans business, said in an interview. The Bloomfield, Conn.-based company, which has about 250,000 ACA enrollees, is in eight states for 2019.

Cigna expects the average price of its premiums to drop just under 1%, Lough said. Its ACA rates won't be publicly available until close to the start of open enrollment.

Cigna looks for markets where they can enter into value-based arrangements with doctors and hospitals, in which incentives are aligned with outcomes at an affordable price, Lough said.

The company has primarily focused on larger metropolitan areas in states, such as Salt Lake City in Utah and the Kansas City area of Kansas, she said.

Cigna also is looking ahead to what may happen in the market for health reimbursement arrangements (HRAs), Lough said. Beginning in 2020, under a new Trump administration rule, employers can contribute funds to HRAs that employees can use to buy insurance in the exchanges or pay out-of-pocket costs.

Cost-Effective Partnerships
Bright Health, which began offering health plans in 2017 as it entered the ACA markets, is focused on expanding in areas where it can enter into cost-effective partnerships that enhance the brand of the health systems it works with, Jon Watson, president of the Minneapolis-based company's individual and family plans, said in an interview.

Bright Health, which covers between 60,000 and 80,000 ACA enrollees, will expand from four states in 2019 to nine in 2020. Premiums "on average are pretty flat across the marketplace," Watson said.

Bright Health also hopes its ACA customers will choose its Medicare Advantage (MA) plans when they reach Medicare age. "It's a very natural path to continue in MA," Watson said.

California Health REPORT

Opinion: The 'Public Charge' Rule Creates a Chilling Effect that Threatens Us All
John Baackes

Immigrant rights groups are calling the new "public charge" rule another brick in the Trump administration's invisible wall, which sends the message that some people are not welcome in this country.

Not long after the election, the administration started rolling out proposals and policies designed to keep more people out of the U.S. Federal officials created a travel ban, added citizenship question to the Census, tried to overturn the Deferred Action for Childhood Arrivals program and reduced refugee admissions.

The courts have intervened in most of these cases, and they may do so again for the new "public charge" rule. But while we wait for that, our immigrant families are feeling threatened—which also impacts the larger community.

When someone applies to enter the country or become a permanent resident (green card holder), immigration officials use what they call a “public charge test” to determine if the person is likely to become primarily dependent on the government for subsistence. For more than 100 years, immigration officials only considered whether people had received public cash assistance and long-term institutional care when they made these decisions.

But starting Oct. 15, immigration officials will also consider whether people have enrolled in Medicaid, a low-income health program known as Medi-Cal in California; Supplemental Nutrition Assistance Program, known as CalFresh here; and housing assistance. All of these benefits impact the health and wellbeing of the recipients.

The new rule is doubly harmful because it is spreading fear to many who might not be impacted by the rule at all. It has already created a devastating chilling effect in certain communities. The Urban Institute reported that one in seven low-income immigrant families were afraid to access public benefits after the rule was first proposed last year. One legal analysis of the American Community Survey estimated that as many as 26 million people in families with immigrants might be dissuaded from participating in programs.

Of course, for those who are directly impacted, the results could be devastating. The Kaiser Family Foundation reports that nationwide, 13.5 million Medicaid and Children’s Health Insurance Program enrollees, including 7.6 million children, live in a household with a noncitizen or are noncitizens themselves and may be at risk for decreased enrollment as a result of the rule.

Remember, this rule is targeting people who are in this country legally. It is specifically targeting immigrants who have legal clearance to be here but are part of the working poor.

It is a cruel policy, and it threatens to harm the broader community. Health care costs will certainly rise for everyone if people drop off Medicaid rolls. People without health coverage will forgo regular health care and will end up with much costlier episodic care in the emergency room. Some will forgo vaccinations, which has the potential of creating outbreaks of preventable diseases.

As a health plan that is committed to providing access to health care for some of our most vulnerable populations, including immigrants, L.A. Care Health Plan has implemented an informational campaign to try to limit harm from the new rule. Our call center employees, staff at our Family Resource Centers and our member advisory committees have been armed with general information and a list of legal resources to pass on to any member who inquires about the new rule.

We also enlisted the National Immigration Law Center to conduct a webinar for our providers. About 300 providers participated, many of whom had witnessed their patients’ fear firsthand. They, too, received general information about the rule, a list of

legal resources to pass along to anyone with questions about their status, and information about how to respond should immigration enforcement officials show up at their offices.

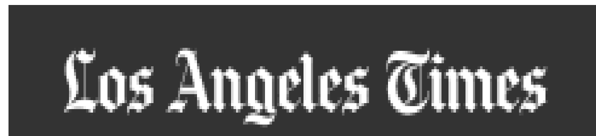
It's disheartening to think that this informational campaign is necessary. We have to wonder, why would our government implement a policy that so clearly threatens the health of the country?

The new "public charge" rule has left some of our L.A. Care members with an agonizing choice to make—forgo public benefits, including health care, or risk their chance at permanent residency in the future. It is a personal choice. We can only help provide some of the information they need to make an informed choice.

Numerous lawsuits have been filed, and it's possible that the new "public charge" rule will not take effect on Oct. 15 as scheduled. But it's also clear that the Trump administration's efforts to curtail immigration will continue.

Immigrant rights advocates vow to keep up the fight against all rules and policy proposals that unfairly target these vulnerable populations.

Health care leaders must lend their voice to the fight.



HIV prevention drugs will be available without a prescription in California
Melody Gutierrez

SACRAMENTO — California will expand access to HIV prevention drugs by allowing pharmacies to offer the medications without a prescription under a law signed by Gov. Gavin Newsom on Monday.

Senate Bill 159 by Sen. Scott Wiener (D-San Francisco) and Assemblyman Todd Gloria (D-San Diego) allows pharmacists to dispense pre-exposure prophylaxis, known as PrEP, and post-exposure prophylaxis, known as PEP, in a way similar to birth control and emergency contraceptives. The law will also bar insurance companies from requiring prior authorization before the HIV prevention drugs are provided.

"Recent breakthroughs in the prevention and treatment of HIV can literally save lives," Newsom said in a statement. "All Californians deserve access to PrEP and PEP, two treatments that have transformed our fight against HIV and AIDS. I applaud the Legislature for taking action to expand access to these treatments and getting us close to ending HIV and AIDS for good."

Studies have shown that people who take the daily medication PrEP dramatically reduce their chances of being infected by an HIV-positive person or from intravenous drug use. For a person who has been exposed to HIV, a pharmacist can dispense PEP, a 28-day supply of daily medication that has been shown to be highly effective.

Supporters of the bill said it removes barriers for people to take the drug, such as having to wait for a doctor's appointment, which could take weeks. The California Health Benefit Review Program estimated that the bill would result in more than 700 people obtaining the HIV prevention drugs, leading to 25 fewer cases of new HIV transmissions in the first year of the law's implementation.

Wiener made news in 2014 when, as a member of the San Francisco Board of Supervisors, he disclosed that he was taking the drug Truvada to protect himself from HIV.

"I went on PrEP to further protect and take personal responsibility for my health," Wiener wrote in a 2014 Huffington Post column. "I'm HIV-negative, and I want to remain that way."

Now a senator who chairs the LGBTQ caucus, Wiener said expanding access to the drug will keep more Californians HIV-negative.

"To end new HIV infections, we must dramatically expand access to PrEP and PEP, yet far too many Californians who need these drugs struggle to access them," Wiener said.

The U.S. Preventive Services Task Force recommended that doctors offer daily HIV prevention pills to healthy people who are at high risk for contracting HIV. However, few of those who meet the criteria obtain a prescription for the drug. In California, the number of new diagnosed cases of HIV has risen by 0.8% — from 4,752 cases in 2013 to 4,791 in 2017. In Los Angeles County, there were 1,731 newly diagnosed cases of HIV in 2017, according to the most recent California HIV Surveillance Report published by the California Department of Public Health. That was down from 1,818 in 2013.

Equality California Executive Director Rick Zbur said access to the drug is particularly limited in rural communities and among minorities.

"But with Gov. Newsom's signature, SB 159 is a giant step forward in getting to zero transmissions, zero deaths and zero stigma," Zbur said.

Newsom also signed two other healthcare bills on Monday. AB 824 by Assemblyman Jim Wood (D-Healdsburg) will prohibit financial agreements between brand-name drug companies and their rivals producing generics that lead to a delay in lower cost prescriptions coming to market. California is the first state to pass legislation attempting to end a practice known as "pay for delay."

"California will use our market power and our moral power to take on big drug companies and prevent them from keeping affordable generic drugs out of the hands of

people who need them," Newsom said. "Competition in the pharmaceutical industry helps lower prices for Californians who rely on lifesaving treatments."

SB 464 by Sen. Holly Mitchell (D-Los Angeles) requires perinatal healthcare workers to complete implicit bias training to improve preventable maternal mortality rates among black women. The law will also require additional data collection by the California Department of Public Health on pregnancy-related deaths.

"California is sending a clear message that discrimination has no place in our healthcare system," Newsom said. "We know that black women have been dying at alarming rates during and after giving birth. The disproportionate effect of the maternal mortality rate on this community is a public health crisis and a major health equity issue."

The New York Times

The Huge Waste in the U.S. Health System
Austin Frakt

Even a divided America can agree on this goal: a health system that is cheaper but doesn't sacrifice quality. In other words, just get rid of the waste.

A new study, published Monday in JAMA, finds that roughly 20 percent to 25 percent of American health care spending is wasteful. It's a startling number but not a new finding. What is surprising is how little we know about how to prevent it.

William Shrank, a physician who is chief medical officer of the health insurer Humana and the lead author of the study, said, "One contribution of our study is that we show that we have good evidence on how to eliminate some kinds of waste, but not all of it."

Following the best available evidence, as reviewed in the study, would eliminate only one-quarter of the waste — reducing health spending by about 5 percent.

Because American health spending is so high — almost 18 percent of the economy and over $10,000 per person per year — even small percentages in savings translate into huge dollars.

The estimated waste is at least $760 billion per year. That's comparable to government spending on Medicare and exceeds national military spending, as well as total primary and secondary education spending.

If we followed the evidence available, we would save about $200 billion per year, about what is spent on the medical care for veterans, the Department of Education and the

Department of Energy, combined. That amount could provide health insurance for at least 20 million Americans, or three-quarters of the currently uninsured population.

The largest source of waste, according to the study, is administrative costs, totaling $266 billion a year. This includes time and resources devoted to billing and reporting to insurers and public programs. Despite this high cost, the authors found no studies that evaluate approaches to reducing it.

“That doesn’t mean we have no ideas about how to reduce administrative costs,” said Don Berwick, a physician and senior fellow at the Institute for Healthcare Improvement and author of an editorial on the JAMA study.

Moving to a single-payer system, he suggested, would largely eliminate the vast administrative complexity required by attending to the payment and reporting requirements of various private payers and public programs. But doing so would run up against powerful stakeholders whose incomes derive from the status quo. “What stands in the way of reducing waste — especially administrative waste and out-of-control prices — is much more a lack of political will than a lack of ideas about how to do it.”

While the lead author works for Humana, he also has experience in government and academia, and this is being seen as a major attempt to refine previous studies of health care waste. Reflecting the study’s importance, JAMA published several accompanying editorials. A co-author of one editorial, Ashish Jha of the Harvard Global Health Institute and the Harvard T.H. Chan School of Public Health, said: “It’s perfectly possible to reduce administrative waste in a system with private insurance. In fact, Switzerland, the Netherlands and other countries with private payers have much lower administrative costs than we do. We should focus our energies on administrative simplification, not whether it’s in a single-payer system or not.”

After administrative costs, prices are the next largest area that the JAMA study identified as waste. The authors’ estimate for this is $231 billion to $241 billion per year, on prices that are higher than what would be expected in more competitive health care markets or if we imposed price controls common in many other countries. The study points to high brand drug prices as the major contributor. Although not explicitly raised in the study, consolidated hospital markets also contribute to higher prices.

A variety of approaches could push prices downward, but something might be lost in doing so. “High drug prices do motivate investment and innovation,” said Rachel Sachs, an associate professor of law at Washington University in St. Louis.

That doesn’t mean all innovation is good or worth the price. “It means we should be aware of how we reduce prices, taking into consideration which kinds of products and which populations it might affect,” she said.

Likewise, studies show that when hospitals are paid less, quality can degrade, even leading to higher mortality rates.

Other categories of waste examined by the JAMA study encompass inefficient, low-value and uncoordinated care. Together, these total at least $205 billion.

With more than half of medical treatments lacking solid evidence of effectiveness, it's not surprising that these areas add up to a large total. They include things like hospital-acquired infections; use of high-cost services when lower-cost ones would suffice; low rates of preventive care; avoidable complications and avoidable hospital admissions and readmissions; and services that provide little to no benefit.

In addition to wasting money, these problems can have direct adverse health effects; lead to unwarranted patient anxiety and stress; and lower patient satisfaction and trust in the health system.

Here the study's findings are relatively more optimistic. It found evidence on approaches that could eliminate up to half of waste in these categories. The current movement toward value-based payment, promoted by the Affordable Care Act, is intended to address these issues while removing their associated waste. The idea is to pay hospitals and doctors in ways that incentivize efficiency and good outcomes, rather than paying for every service regardless of need or results.

Putting this theory into practice has proved difficult. "Value-based payment hasn't been as effective as people had hoped," said Karen Joynt Maddox, a physician and co-director of the Center for Health Economics and Policy at Washington University in St. Louis and a co-author of another editorial of the JAMA study.

So far, only a few value-based payment approaches seem to produce savings, and not a lot. Some of the more promising approaches are those that give hospitals and doctors a single payment "as opposed to paying for individual services," said Zirui Song, a physician and a health economist with Harvard Medical School.

"Savings tend to come from physicians referring patients to lower-priced facilities or cutting back on potentially lower-value care in areas such as procedures, tests or post-acute service," he said.

There is evidence of savings from some bundled payment programs. These provide a fixed overall budget for care related to a procedure over a specific period, like 90 days of hip replacement care. Accountable care organizations also seem to drive out a little waste. These give health groups the chance to earn bonuses for accepting financial risk and if they reach some targets on quality of care.

The final area of waste illuminated by the JAMA study is fraud and abuse, accounting for $59 billion to $84 billion a year. As much as politicians love to say they'll tackle this, it's a relatively small fraction of overall health care waste, around 10 percent. More could be spent on reducing it, but there's an obvious drawback if it costs more than a dollar to save a dollar in fraud.

Because health care waste comes from many sources, no single policy will address it. Most important, we have evidence on how to reduce only a small fraction of the waste — we need to do a better job of amassing evidence about what works.

The Health 202: Here are all the ways a court could stymie Obamacare
Paige Winfield Cunningham

Any day now, a federal appeals court could rule on a lawsuit seeking to strike down Obamacare — a decision sure to inject even more drama into the fraught 2020 election.

Legally, the Trump administration wants the Affordable Care Act wiped out. But politically, it's a different story.

The administration plans to seek a stay if the U.S. Court of Appeals for the 5th Circuit invalidates all or part of the Affordable Care Act in the coming weeks — and may even try to delay a potential Supreme Court hearing on the matter until after the November 2020 election, as I reported over the weekend with my colleague Yasmeen Abutaleb.

Here's why: Eliminating health coverage for around 20 million Americans who receive it through Obamacare isn't exactly a winning political prospect — and many in the administration know that. As I reported last month, it was only at the last minute and against the advice of some top officials that President Trump decided to side entirely with the GOP states trying to topple the law, instead of opposing them.

"There will be a stay — it's not like the decision is going to come down and the world is going to change," a senior administration official told me.

The administration also hopes to slow the case's progress to the Supreme Court, two former administration officials said, speaking on the condition of anonymity to discuss White House strategy. Tommy Binion, vice president of government relations for the Heritage Foundation, told me if the possibility of a Supreme Court decision looms over the election, he thinks Republican messaging about Obamacare "would be buoyed."

"The Democrats are offering Medicare-for-all as their vision for health care," Binion said. "If it looks like the Supreme Court could strike down the ACA, then Republicans will be offering their vision for health care in this country."

Here's why the administration isn't eager for a quick Supreme Court hearing: If the justices heard the case as early as next spring, they could potentially hand down a ruling to invalidate all or parts of the ACA smack dab in the middle of Trump's effort to get reelected. The administration could try to avoid such a scenario by first asking the

appeals court for a hearing by the full panel, instead of appealing immediately to the Supreme Court.

Let's back up a minute. Trump's Justice Department is siding with 18 Republican states that are arguing all of the ACA is unconstitutional without its penalty for lacking coverage — the basis the Supreme Court used to uphold the law back in 2012.

Last year, a federal district judge in Texas ruled the entire law is unconstitutional, including its protections for people with preexisting conditions and its expansion of coverage through federally subsidized marketplaces and Medicaid expansion. A three-judge panel for the 5th Circuit is expected to issue an opinion on the case any day — although there's no deadline for it to act, and a ruling could hypothetically be delayed until next year.

As if this case weren't already complicated enough, there are a number of decisions the appeals court could arrive at. (Check out this Health 202 for a look at the three judges on the panel.) Here are four ways the court could rule:

1. The whole law is unconstitutional.

The three judges could agree with federal district judge Reed O'Connor that the whole law must fall because Congress zeroed out its financial penalty for lacking health coverage as part of its 2017 tax overhaul.

Supreme Court Chief Justice John G. Roberts Jr. seized upon this penalty as a reason to uphold the ACA in 2012, when he declared it a tax under Congress's broad powers to impose levies. Now that the penalty is gone, the basis of the ACA's constitutionality is also gone, so the GOP states are arguing.

To reach this conclusion, the appeals court would have to rule the rest of the ACA is not "severable" (to use a legal term) from the mandate and the preexisting condition protections.

2. The mandate, plus the protections for patients with preexisting conditions, are unconstitutional, but the rest of the ACA can stay.

This is the original position the Trump administration took. It's long been argued (by the Obama administration and others) that preexisting condition protections must be paired with the mandate. The idea is that requiring insurers to cover patients with expensive medical conditions only works if all consumers — including the healthy ones — are required to buy coverage.

But now there's essentially no mandate to buy coverage, so it could follow that insurers should no longer be required to cover people with preexisting conditions.

The panel could adopt this reasoning, while allowing the rest of the law to remain in effect by ruling it's severable from the mandate and the preexisting condition protections.

3. Only the mandate is unconstitutional, but the rest of the ACA can stay.

If the appeals court ruled this way, it would be a big sigh of relief for Democrats and ACA advocates. Getting rid of the mandate would have little practical effect on the availability of health insurance. The mandate already lacks teeth, since Congress took the penalty away.

4. The lower district court should consider the case again.

The appeals court could also kick the case back down to O'Connor, who issued the initial ruling striking the whole law. But O'Connor's ruling was only a partial judgment, so he could feasibly revisit the case with the intention of issuing a broader ruling on the case's merits.

This outcome would be disappointing to the Democrat-led states defending the law, as it would dramatically lengthen the timeline for the lawsuit to be resolved — and put it back in the hands of a judge who has already shown a willingness to strike down the whole ACA.

The New York Times

Judges Strike Several Blows to Trump Immigration Policies
Miriam Jordan

President Trump's immigration agenda ran into legal blockades in courts around the country on Friday as judges in four states barred his administration from trying to withhold green cards from people who use public benefits and rejected his plan to divert funds to erect a border wall.

In three rulings, federal judges in New York, California and Washington State issued injunctions temporarily blocking the "public charge" rule, which would impose serious impediments to legal residency for those who use benefits such as Medicaid or those deemed likely to use them in the future.

The rule, widely seen as an attempt to keep out immigrants who are poor or in need of help, was one of the Trump administration's signature immigration policies — and it ran into a legal brick wall in three corners of the country on a single day.

Lawsuits filed by 21 states and the District of Columbia argued that the new regulations, which had been due to take effect on Tuesday, discriminate against low-income people

from developing countries and undermine the well-being of children whose families might avoid using nutritional, health and other programs.

President Trump faced yet another legal setback in Texas, where a senior federal judge in El Paso ruled on Friday that he had acted unlawfully in announcing he would tap $3.6 billion in Pentagon money intended for military construction to build a barrier along the nation's southwestern border.

The issues are top priorities in the administration's efforts to curb immigration, both legal and illegal, and the rulings are likely to be swiftly appealed by the Justice Department.

"The court rulings today represent at least a temporary setback in the Trump administration's attacks on both legal and illegal immigrants," Steve Yale-Loehr, an immigration professor at Cornell Law School, said of the day's decisions. "Ultimately, I predict these issues will go all the way to the Supreme Court."

While Friday's legal setbacks add to several recent immigration initiatives blocked by the courts, the Trump administration has nonetheless been able to roll out policies that restrict asylum, tighten requirements for skilled-work visas and slash the number of refugees the country will accept.

But the public charge regulations will not go into effect as quickly as the Trump administration desired. Two of the judges on Friday issued nationwide injunctions on enacting the policy, while the judge in California limited her ruling to the nine western states within the Ninth Circuit.

"The rule is simply a new agency policy of exclusion in search of a justification," Judge George B. Daniels of the Federal District Court in Manhattan wrote in his ruling. "It is repugnant to the American Dream of the opportunity for prosperity and success through hard work and upward mobility."

The regulations published by the Department of Homeland Security on Aug. 14 expand the definition of what it means to be a "public charge," making it more difficult for immigrants to be approved for a green card if they have received benefits such as Medicaid, housing assistance or food stamps, or are deemed likely to receive them in the future.

For a nation that has long welcomed immigrants from poor countries seeking to improve their lot, the new rule could drastically change the composition of newcomers admitted to the United States. The rule would favor those who are educated and wealthy, more likely to hail from Europe than from the developing world.

The new standards would directly affect about 1.2 million applicants annually, including about 500,000 who are already in the country. But that figure does not include millions of family members and others who might also be affected. Immigration experts said the rules would disproportionately affect applicants from Africa and Latin America.

Federal immigration policy has long allowed the authorities to consider, when admitting new immigrants, the degree to which they might be a burden on the public purse. For the last 20 years, a public charge has been defined as a person “primarily dependent” on the government for subsistence, either by receiving public cash assistance or long-term institutional care.

The new regulations would lower the bar for how much assistance an immigrant might receive — or be likely to need in the future — before being deemed ineligible for legal residence.

In a statement on Friday, the White House said the court rulings prevented the government from carrying out what it said was a longstanding provision of federal law. “The rulings today prevent our nation’s immigration officers from ensuring that immigrants seeking entry to the United States will be self-sufficient,” the statement said, “and instead allow noncitizens to continue taking advantage of our generous but limited public resources reserved for vulnerable Americans.”

It said recent court rulings blocking the administration’s attempts to deport criminals, deter migrant families and tighten asylum standards, in addition to Friday’s rulings, are examples of the administration “being ordered to comply with the flawed or lawless guidance of a previous administration instead of the actual laws passed by Congress.”

The other injunctions against putting the public charge rule into effect came from Judge Phyllis J. Hamilton of the Federal District Court in Northern California and Judge Rosanna M. Peterson of the Federal District Court in the Eastern District of Washington; all of Friday’s rulings came from judges appointed by Presidents Bill Clinton and Barack Obama.

The administration had argued that the public charge rule, developed by Stephen Miller, the White House aide who is the architect of several of the government’s hard-line immigration policies, was designed to ensure that immigrants are self-sufficient and do not become a drain on the nation’s coffers.

Judge Peterson said the new regulations would undermine the interest of the states in promoting the health and well-being of their residents, as well as their financial security.

“The harms to children, including U.S. citizen children, from reduced access to medical care, food assistance, and housing support,” she wrote, are a threat to states that must reallocate resources to deal with those needs.

New York’s attorney general, Letitia James, who brought the case decided in New York, said the rule would have had a “devastating impact” on citizens and noncitizens alike.

“The history of our nation is inextricably tied to our immigrant communities, and because of today’s decision, so too will be our future,” she said in a statement. “Once again, the courts have thwarted the Trump administration’s attempts to enact rules that violate both our laws and our values.”

This month, the president also moved to deny immigrant visas to those who cannot prove that they will either have health insurance or can afford to pay for their own health care.

Mr. Trump said then that legal immigrants were three times as likely as American citizens to lack health insurance, making them a burden on hospitals and taxpayers.

The Migration Policy Institute, a nonpartisan think tank, estimated that the health insurance directive, set to take effect on Nov. 3, could exclude two-thirds of future immigrants.

“Over all, the new Trump insurance requirement could be an even stricter test for new immigrants than the public charge rule,” the think tank said in an analysis.

The public charge regulation had been roundly condemned by immigrant advocacy groups and the medical establishment, which argued that the rule would discourage immigrants from seeking government assistance when they may need help buying food or seeing a doctor.

Standards for public assistance were “never intended to exclude working-class immigrants from developing countries,” said Charles Wheeler, a director of the Catholic Legal Immigration Network, one of the plaintiffs in the case. “This ruling confirms that the American dream remains open to them.”

The policy as the administration proposed it would consider a “totality of circumstances” in assessing green card applicants based on a list of “positive” and “negative” factors. Negative factors include being unemployed, not completing high school and lacking proficiency in English. Assets, personal debts and credit score are also taken into account.

Judge Daniels was critical in his ruling of some of the weighting factors. “It is simply offensive to contend that English proficiency is a valid predictor of self-sufficiency,” he wrote.

Column: America’s healthcare system is failing because competition is disappearing
Michael Hiltzik

[Update, Oct. 13: Gov. Newsom on Sunday signed AB 290, the measure to cap reimbursements to dialysis firms that was aimed at the big chains, DaVita and Fresenius.

[In his signing message, Newsom leveled criticism at the bill's opponents for threatening to end charity assistance for Californians undergoing dialysis if the bill had been signed. The threat was mde by the American Kidney Foundation, which is largely funded by DaVita and Fresenius. "Charities that purport to impartially provide patient assistance, and the providers that substantially fund these charities, should act in good faith and continue providing assistance to patients," Newsom wrote.]

The two major afflictions besetting the U.S. healthcare system are that its prices are too high, and that although big spending should give us better quality of care, it doesn't.

These two conditions arise from the same cause: American healthcare is becoming less competitive. Hospital chains are growing larger, and within some specialties, providers have become more concentrated.

The result is that Americans get the worst of all possible worlds. Only two conditions can keep prices in check--competition, or regulation. The utility sector is monopolistic, but also price-regulated. As American healthcare becomes increasingly monopolistic, the absence of utility-style price controls means the sky's the limit.

The late healthcare economist Uwe Reinhardt, and his colleagues saw the consequences clearly in his seminal paper on the fundamental malady of our system. It was titled, "It's the Prices, Stupid."

Lack of oversight result not only in higher prices, but lower quality. As a new study of the dialysis industry asserts, the acquisition of thousands of dialysis centers by major commercial firms resulted in higher hospitalization and mortality rates of patients and less access to kidney transplants.

"For-profit acquirers' explicit mandate to maximize profits may lead them to sacrifice patient outcomes," says the study, prepared by a team from Duke University on a grant from the National Science Foundation.

Their peer-reviewed paper is scheduled to be published by Harvard's Quarterly Journal of Economics in an upcoming issue. The firms say the study is based on old data and outdated practices, and fails to acknowledge overall improvements in the health of dialysis patients over the years.

The Duke study is based on data from 1998 through 2010. The cutoff point was chosen because the reimbursement system of Medicare, the principal payer for dialysis, changed in 2011 — a change largely dictated by alleged financial abuses by dialysis centers.

That change and other improvements in standards and technology "make the historic data in this study not reflective of the current state of care," Brad Puffer, a spokesman for Fresenius Medical Care, one of the two major commercial dialysis providers in the

U.S., told me. The research team says it's continuing its work to cover the post-2011 period.

In a prepared statement, DaVita Kidney Care, the second major provider, said it has "improved clinical outcomes for over 20 years." The firm pointed to a 2010 study in a peer-reviewed medical journal that showed improved patient mortality after two years in clinics acquired by the firm in 2005. The study was co-written by five DaVita executives and used internal DaVita data.

Denver-based DaVita and the German conglomerate Fresenius own or operate more than 5,000 dialysis clinics in the U.S., accounting for more than 60% of the U.S. locations, and collect roughly 90% of the sector's revenues. During the period under study, they acquired 1,200 formerly independent dialysis facilities.

Increasing healthcare concentration and its consequences are beginning to face closer scrutiny in California. A San Francisco state court jury is scheduled to start hearing testimony this week in lawsuits alleging that the sprawling Sutter Health hospital chain ruthlessly exploited its regional dominance to fix prices. (A case brought by several Northern California employers and another filed by Atty. Gen. Xavier Becerra were combined for the trial.) Sutter is technically a nonprofit provider, but that doesn't mean its management lacks incentives to maximize the chain's income.

As for the dialysis industry, healthcare reformers have tried for years to rein in the profits enjoyed by the commercial dialysis industry.

A California ballot measure that would have capped their profits failed in 2018 after one of the most expensive ballot campaigns in history — about $130 million in total spending, including $100 million in opposition funding contributed by the two big dialysis firms alone. A bill that would cap insurance reimbursements for dialysis passed the Legislature this year and is awaiting a decision by Gov. Gavin Newsom.

The Sutter and dialysis situations raise somewhat different issues. The Sutter case is in the mainstream of antitrust law. It turns on the question of how the chain profited from its position in a regional market. (Sutter's defense is that the prices in its contracts with insurers and other payers reflect conditions that have nothing to do with its market dominance.)

The roll-up of independent dialysis centers by the two big firms doesn't have the same effect on regional markets, the Duke study acknowledges. Dialysis centers are typically too small, even in the aggregate, to fall within traditional antitrust law.

"Any individual facility is not going to move market concentration," says Ryan C. McDevitt, an associate professor at Duke and one of the paper's authors. He says that it would be more relevant to examine the concentration of the dialysis industry on a national scale.

The dialysis firms point to government statistics showing that overall mortality among dialysis patients has declined by nearly 30% from 2001 to 2016. (The rate is adjusted for the increasing age of the patients.) But that's not necessarily inconsistent with a rise in mortality among patients at dialysis centers that have transitioned to chain ownership, McDevitt says.

Dialysis, which uses a machine to filter waste products from the blood when a patient's kidneys can no longer do that job, has long been a special case among medical procedures. Patients typically undergo the hours-long procedure three times a week at a specialized clinic, although home dialysis is gradually becoming more common. It's generally the only procedure that can keep patients alive until and unless they can secure a kidney transplant, for which waiting lists can be years long.

Because dialysis costs about $90,000 a year, renal patients used to be uninsurable. In 1973, Congress made those patients eligible for Medicare at any age. The procedure soon ranked among the program's largest annual expenditures and Epogen (EPO), an anti-anemia drug needed by the patients, became Medicare's largest single annual prescription expenditure.

Under the Affordable Care Act, however, private insurers could no longer refuse to cover kidney patients. DaVita and Fresenius have acknowledged that they profited from the change, because private insurers pay them as much as five times as much per treatment as the roughly $260 paid by Medicare. DaVita, for example, reported last year that while commercial insurers covered only 10% of the firm's patients, they provided about 30% of its income.

One other change in this system is notable. Through 2010, Medicare paid only about $128 per dialysis session but covered injectable drugs separately. That led to accusations that dialysis providers were gaming the drug reimbursements by discarding partially filled containers instead of using up the contents, so they could charge Medicare for the additional vials. In 2015, DaVita agreed to pay up to $495 million to settle allegations that it inflated prescription billings to Medicare by "creating unnecessary waste."

The company didn't admit to the allegations, but the settlement was so large that it reduced DaVita's annual profit by more than half. In announcing the settlement, federal prosecutors observed that after Medicare changed its reimbursement system in 2011 to bundle dialysis treatments and the drugs into a single payment of $260 per treatment, "wastage derived from single-use vials was no longer profitable, and, as a result, DaVita allegedly changed its practices and reduced its drug wastage dramatically."

The Duke study appears to document a sharp increase in drug usage at dialysis centers acquired by big chains prior to 2011. "Perhaps reflecting the profits at stake," the study says, EPO doses more than doubled at independent dialysis centers after they were acquired. DaVita says that drug prescriptions were dictated by physicians, not the firm. But those physicians typically were paid by the firms, and the whistleblower complaint

that led to the 2015 settlement alleged that DaVita corporate protocols dictated how dosages were to be drawn from individual vials and ampules to maximize billings.

What's most telling about the study is its conclusions about how the policies and protocols of the acquiring companies infiltrate the formerly independent dialysis centers they acquire. Using patient-level data from the Centers for Medicare and Medicaid Services (with the patients' names kept confidential), the researchers found that patients at acquired facilities were 4.2% more likely to be hospitalized in a given month, while their survival rates fell by as much as 2.9%.

New patients who start dialysis at an acquired center were 8.5% less likely to receive a kidney transplant or be placed on a transplant waiting list during their first year of dialysis.

That was a "reflection of worse care," the study says, "because transplants provide both a better quality of life and a longer life expectancy than dialysis."

The study found that acquired facilities tended to have fewer nurses and more "less-skilled technicians," and treated more patients per employee, "stretching resources and potentially reducing the quality of care received by patients."

The study's findings match some earlier research into changes in dialysis centers' ownership. A 2014 survey of the kidney transplant landscape, for example, found that patients at facilities owned by for-profit chains were 13% less likely to be enrolled in transplant waiting lists, compared to those in facilities run by nonprofit chains.

"For-profit ownership of dialysis chain facilities appears to be a significant impediment to access to renal transplants," the study concluded, but it could only conjecture about the reasons. The authors speculated that publicly-traded dialysis firms might be wary of referring patients for kidney transplants because ending their need for dialysis would result in "removing a constant stream of revenue from their facility."

It's true that great strides have been made in the quality of life and survivability of patients facing the burden of renal disease and dialysis. But much of the improvement can be attributed to the government's role in the field and its incentives to control costs and improve outcomes. Some of its innovations in payment, for instance, were aimed at reducing the incentives of for-profit providers to extract greater revenues regardless of the health of their patients.

DaVita in its statement attributes improvements in its dialysis results to its "large-scale clinical investments," including "investments that standardize clinical and infection control practices, support staff training and improve IT infrastructures." The question is whether the for-profit dialysis industry would have undertaken these investments on its own, or it had to be pushed to do so by government pressure. The profit motive in American healthcare is still as troublesome as it ever was.

KFF Health Tracking Poll – October 2019: Health Care In The Democratic Debates, Congress, And The Courts

Lunna Lopes, Liz Hamel, Audrey Kearney, and Mollyann Brodie

Key Findings:

- In the lead up to the fourth round of Democratic primary debates, majorities of Democrats and Democratic-leaning independents say Democratic candidates for president are spending too little time talking about women's health care and surprise medical bills, while most feel they are spending the right amount or too much time talking about coverage expansions and Medicare-for-all.
- Support for Medicare-for-all has narrowed in recent months, with 51% now saying they favor a national health plan and 47% opposed. At the same time, support for a public option has inched up since July, with 73% now saying they favor a government plan that would compete with private health care plans and 24% opposed.
- Fewer than four in ten adults (37%) are aware that President Trump has promised to release a health care plan to replace the Affordable Care Act, while most say the president has not promised such a plan or are unsure. Most (62%) are not too confident or not at all confident that the president will be able to deliver on his promise that Americans will get better health care at a lower cost under his plan.
- Following House Speaker Nancy Pelosi's announcement of a formal impeachment inquiry into President Trump, the public is divided on whether an impeachment investigation will keep Congress from addressing key health care issues (47%) or whether Congress can work on impeachment and pass legislation to address issues such as prescription drug costs and surprise medical bills at the same time (45%). Partisans diverge, but among independents, more think that working on impeachment will keep Congress from passing legislation than say Congress can work on both at the same time (53% vs. 40%).

- Large majorities of the public favor various policy options aimed at lowering the cost of prescription drugs, including over eight in ten who favor allowing the federal government to negotiate with drug companies to get a lower price on medications for people with Medicare and allowing negotiations that would apply to both Medicare and private insurance. However, support can shift with arguments for and against government negotiation of drug prices.

Health Care And The 2020 Election

Democratic Presidential Primary Debates

In recent KFF Health Tracking Polls health care has consistently emerged as a top issue that Democrats and Democratic-leaning independents want to hear the 2020 Democratic presidential candidates address. This month's tracking poll, conducted in the week prior to the fourth round of Democratic presidential debates, finds a majority of Democrats and Democratic-leaning independents say the Democratic candidates for president are spending too little time talking about women's health care (58%) and surprise medical bills (52%) and half say the candidates are spending too little time discussing ways to lower health care costs (50%). Nearly half say candidates are spending too little time discussing the cost of prescription drugs (47%), the opioid epidemic (46%), and the future of the ACA (46%). The upcoming debates present an opportunity for Democratic candidates to address other health care issues that Democrats and Democratic-leaning independents want to hear more about as most say the candidates have spent the right amount of time or too much time talking about Medicare-for-all and ways to provide health insurance coverage to all Americans—two topics which have dominated health care discussions in the past three rounds of Democratic debates.

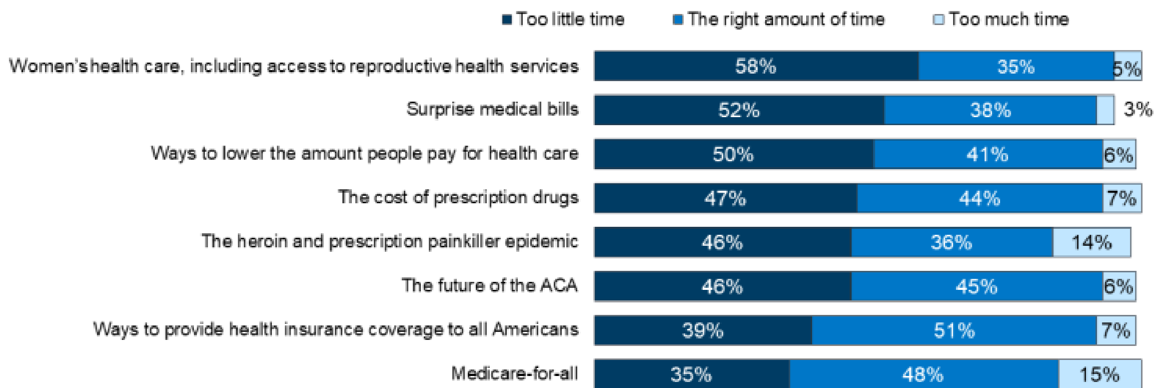


Figure 1: Democrats and Dem-Leaning Independents Want To Hear More From Candidates On Women's Health Care, Cost Issues

Support For Medicare-for-all Narrows, While Support For Public Option Grows

Support for a national health plan, or Medicare-for-all, appears to have narrowed somewhat in recent months. This month's poll finds about half the public (51%) favors a national Medicare-for-all plan while 47% are opposed. This is the narrowest gap between those who favor and oppose such a plan measured in KFF polls since 2017, and represents a 5-percentage point drop in the share in favor and an 8-percentage point increase in the share opposed since April.

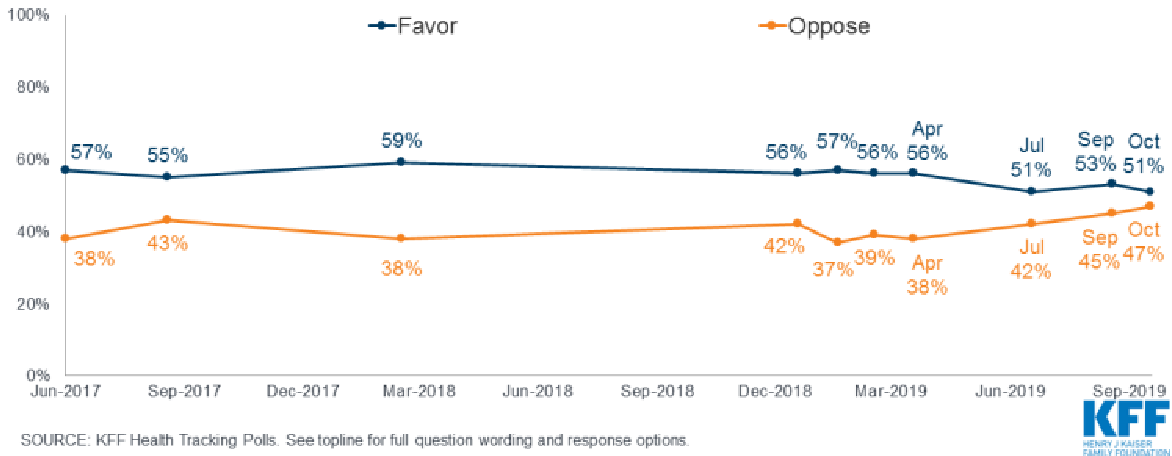


Figure 2: Support for Medicare-for-all Has Narrowed Over Time

By contrast, support for a so-called “public option” plan in which a government-administered plan would compete with private health insurance appears to be inching up. Since July, there has been an 8-percentage point increase in the share in favor of such a plan, from 65% to 73%.

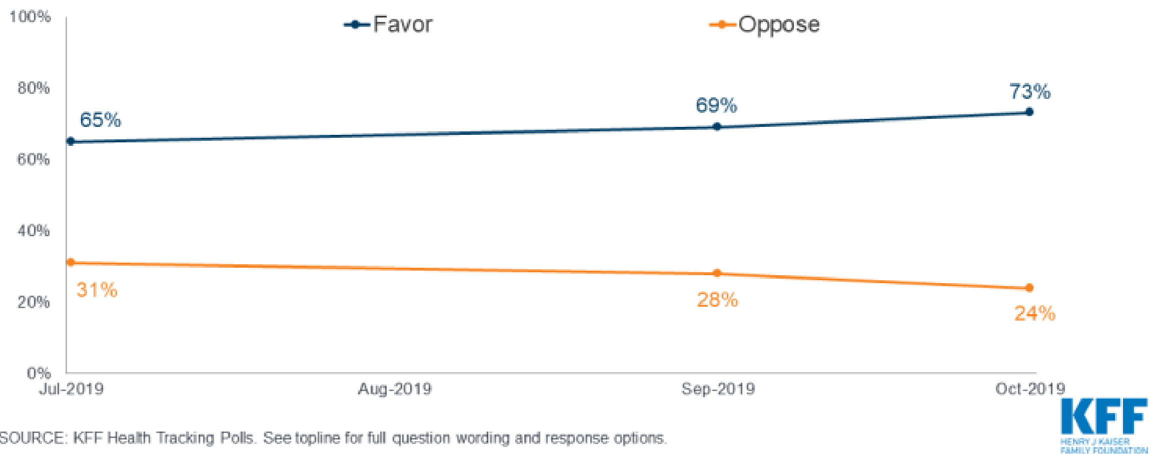


Figure 3: Support For A Public Option Has Increased Since July

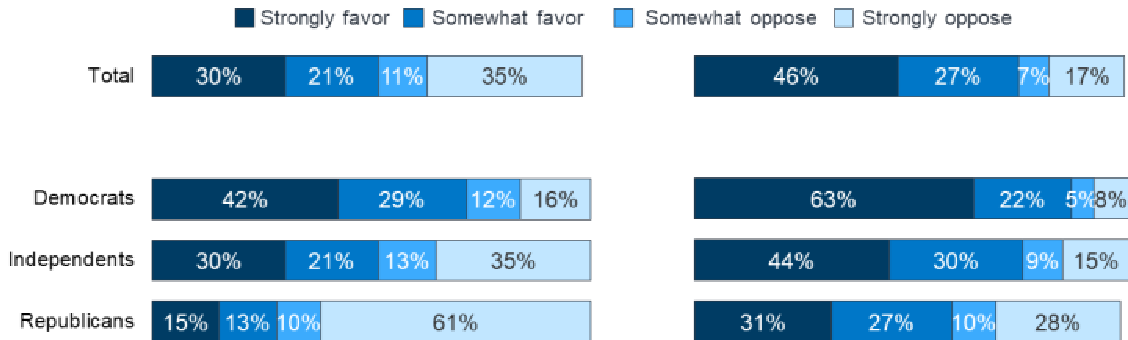
Large majorities of Democrats continue to favor both Medicare-for-all (71%) and a public option (85%). While a Medicare-for-all proposal is less popular among independents (50%) and Republicans (28%), majorities in both groups favor a public option that would compete with private health insurance plans (73% of independents and 58% of Republicans).

Figure 4

Partisans Divide On Medicare-for-all, Public Option

Do you favor or oppose having a national health plan, sometimes called **Medicare-for-all**, in which all Americans would get their insurance from a single government plan?

Do you favor or oppose having a government-administered health plan, sometimes called a **public option**, that would compete with private health insurance plans and be available to all Americans?



SOURCE: KFF Health Tracking Poll (conducted October 3-8, 2019). See topline for full question wording and response options.

Figure 4: Partisans Divide On Medicare-for-all, Public Option

President Trump's Health Care Plan

In March, President Trump stated that the Republican Party will become "the party of health care."[1] In April, he indicated that a Republican health care plan was forthcoming and that a vote would be planned following the 2020 election.[2] Fewer than four in ten adults (37%) are aware that President Trump has promised to release a health care plan to replace the Affordable Care Act, while most say he has not promised to release a plan (39%) or they are unsure (23%). Notably, Republicans are more likely than Democrats and independents to know that President Trump has promised to release a health care plan to replace the ACA.

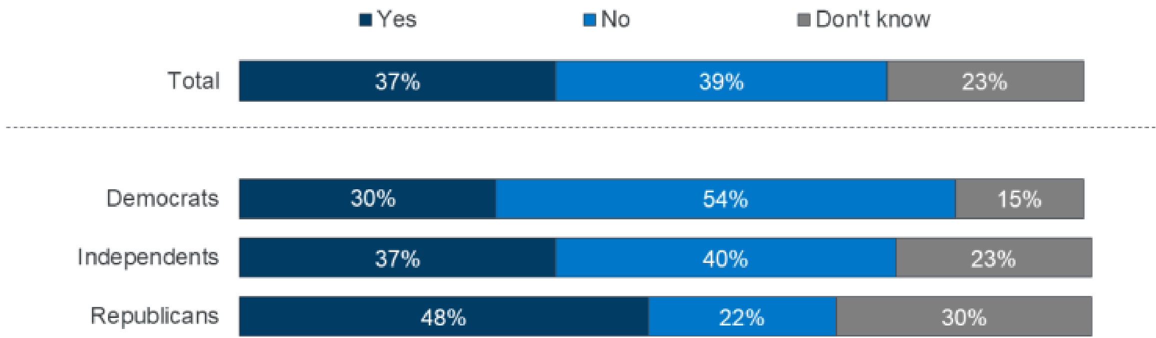


Figure 5: Most Are Unaware President Trump Has Promised To Release A Health Care Plan

About three in ten (29%) know that President Trump has promised to release a health care plan and that he has not yet released the details of his plan. Moreover, only 9% of adults think it is very or somewhat likely that Trump will release the details of his promised health care plan to replace the ACA by the end of the year.

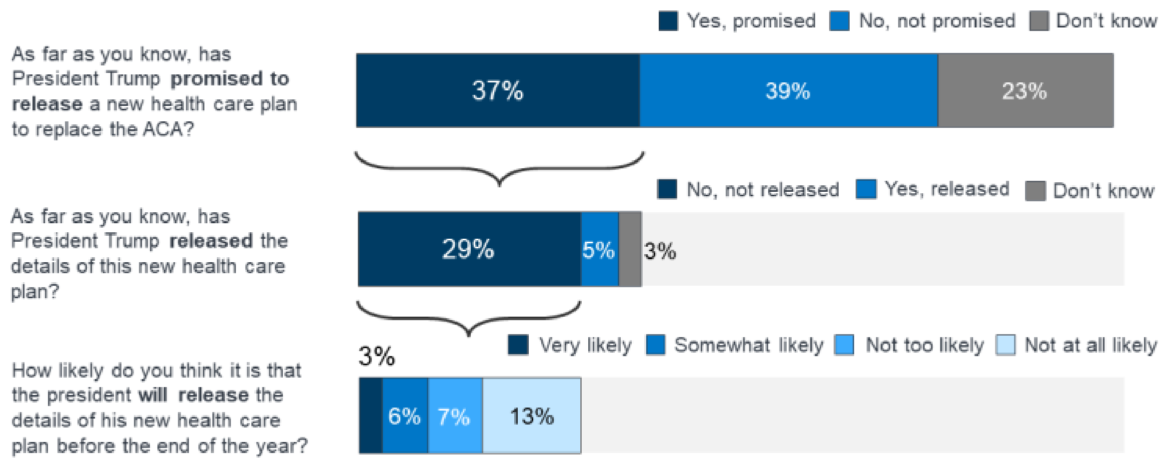


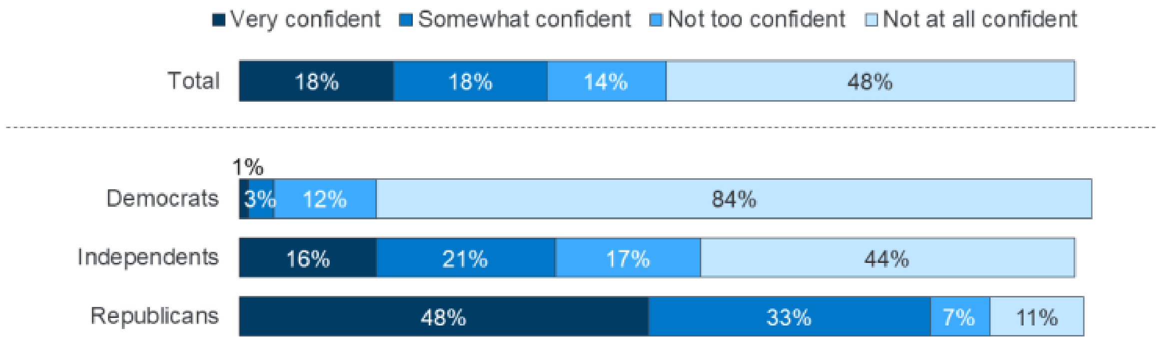
Figure 6: Few Think It Is Likely That President Trump Will Release A Health Care Plan This Year

President Trump has stated that under his health care plan, Americans will get better health care at a lower cost than they currently pay[3]. About three in ten adults are very or somewhat confident the President will deliver on his promise while a majority (62%) say they are not too confident or not at all confident. While most Republicans are either very confident (48%) or somewhat confident (33%) that President Trump will be able to deliver on his promise, majorities of Democrats and independents say they are not confident that the President will be able to deliver on this.

Figure 7

Majority Are Not Confident Trump Can Deliver On Promise Of Better Health Care At Lower Cost, Though Partisans Differ

President Trump has said under his plan, Americans will get better health care at a lower cost than they pay now. How confident are you that he will deliver on this promise?



SOURCE: KFF Health Tracking Poll (conducted October 3-8, 2019). See topline for full question wording and response options.

Figure 7: Majority Are Not Confident Trump Can Deliver On Promise Of Better Health Care At Lower Cost, Though Partisans Differ

Public More Likely To Trust Democratic Party On Health Care

When it comes to health care, the public continues to give the Democratic Party the edge over the Republican Party. Larger shares say they trust the Democrats than the Republicans when it comes to handling health care (44% vs. 29%), lowering the cost of prescription drugs (49% vs. 30%), determining the future of Medicare (47% vs. 35%), and making sure seniors on Medicare are able to get the health care they need (51% vs. 32%). Unsurprisingly, majorities of partisans trust their own party to do a better job on each of these issues. While independents are more likely to trust the Democratic Party than the Republican Party, nearly one third (32%) say they trust neither party when it comes to handling health care.

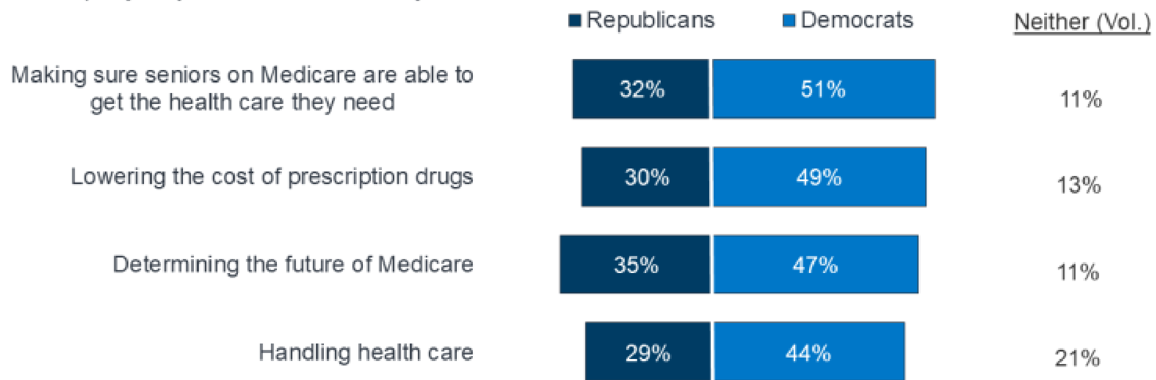


Figure 8: Public More Likely to Trust Democrats Than Republicans On Health Care, Medicare

Despite President Trump's health care speech in Florida earlier this month telling older adults that Democrats would harm their health care[4], those ages 65 and older are more likely to trust the Democratic Party than the Republican Party to do a better job handling health care (45% vs. 35%), making sure seniors are able to get the health care they need (49% vs. 33%), and lowering the cost of prescription drugs (46% vs. 34%).

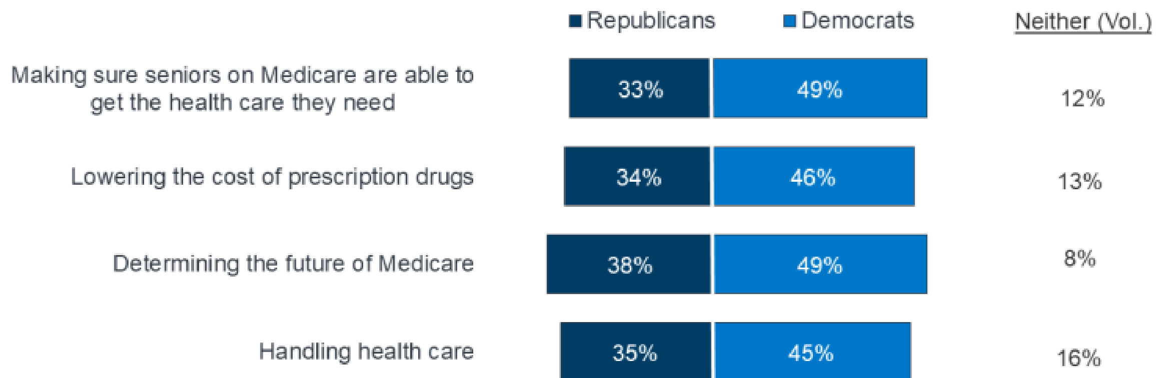


Figure 9: Older Adults Are Also More Likely To Trust Democrats Over Republicans On Health Care, Medicare

Health Care And The Congress: Impeachment And Lowering Prescription Drug Prices

Public Divided On Whether Impeachment Will Prevent Congressional Action On Prescription Drugs, Surprise Bills

On September 24th, House Speaker Nancy Pelosi announced the House would begin a formal impeachment inquiry into President Trump. The public is divided on whether the recently launched impeachment investigation will keep Congress from addressing key health care issues. Forty-five percent of adults say Congress can work on impeachment and pass legislation to address issues such as prescription drug costs and surprise medical bills at the same time, while a similar proportion (47%) say impeachment will keep Congress from passing legislation to address these issues.

There are stark partisan differences, with nearly eight in ten Republicans (78%) saying impeachment will keep Congress from addressing health care issues while a similar share of Democrats (79%) say Congress can both work on impeachment and pass legislation at the same time. Independents are more likely to say that impeachment will keep Congress from passing legislation than to say they can do both (53% vs. 40%).

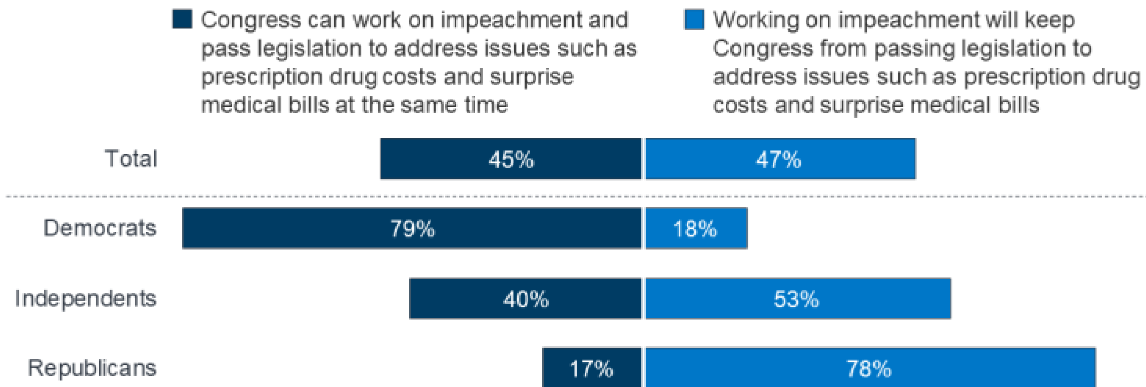


Figure 10: Public Divided On Whether Impeachment Will Prevent Action On Prescription Drug Costs, Surprise Medical Bills

Majorities Support Various Approaches To Lowering Drug Costs, But Support Is Malleable

KFF's September Health Tracking Poll found that lowering prescription drug costs remain a priority for the public, with majorities across parties saying this was an important issue for Congress to address. This issue has been a focus of lawmakers, with hearings held in both the House and Senate, proposals put forward by the Trump administration, and most recently a prescription drug policy proposal unveiled by House Speaker Nancy Pelosi. About eight in ten Americans (78%) say the cost of prescription drugs is unreasonable and majorities favor most of policy options aimed at lowering the cost of prescription drugs included in this month's survey.

Nearly nine in ten Americans favor allowing the federal government to negotiate with drug companies to get a lower price on medications for people on Medicare (88%). A similar proportion favor allowing the federal government to negotiate prices with drug companies that would apply to both Medicare and private insurance (85%). Both of these policy proposals are supported by large majorities of Democrats, independents, and Republicans. Moreover, seven in ten adults (72%) favor increasing taxes on drug

companies that refuse to negotiate with the federal government, including majorities of Democrats (79%), independents (71%), and Republicans (69%).

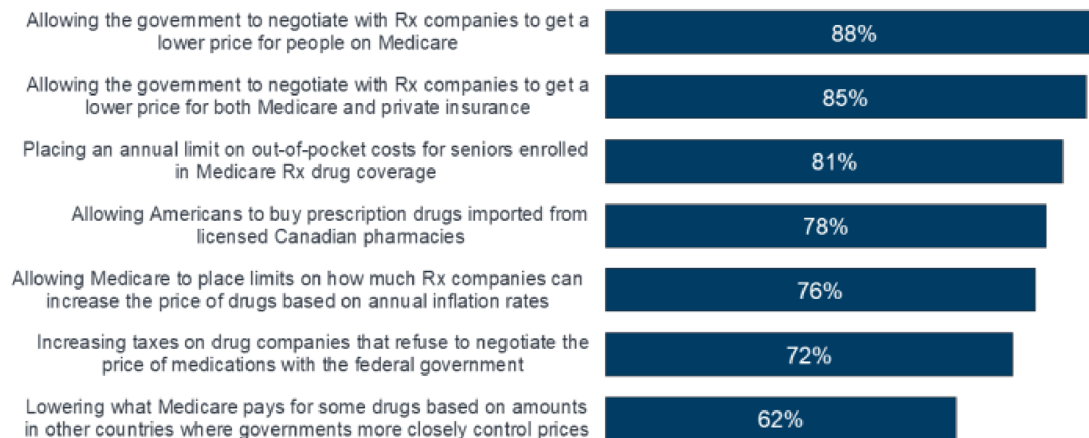


Figure 11: Majorities Favor Policy Proposals to Keep Rx Drug Costs Down

While allowing the federal government to negotiate prices with prescription drug companies is a popular policy proposal, attitudes can shift after hearing potential arguments that have been made both in favor and against the proposal. Support for government negotiations is 89% after hearing the argument that this could help people save money on their prescription drugs. In contrast, opposition is as high as two-thirds after hearing the argument that allowing government negotiation could limit access to new prescription drugs. It is important to note that these arguments do not include specific details about different approaches and constraints that could be imposed on potential negotiations, details of which may influence the public’s attitudes.

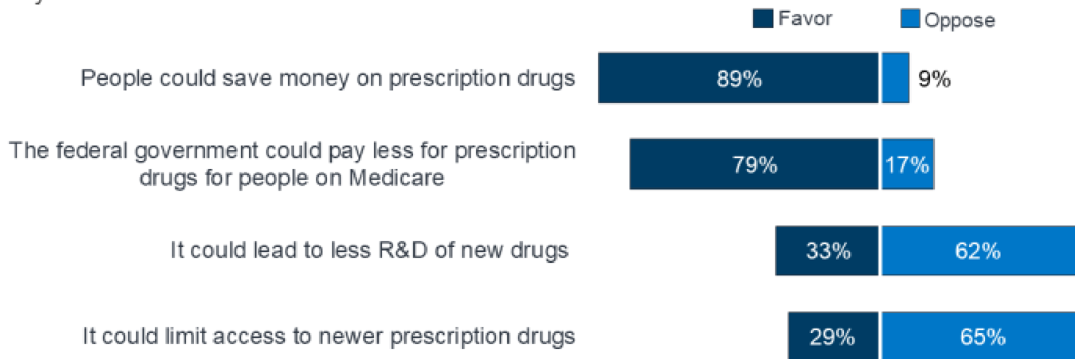


Figure 12: Support For Government Negotiations With Drug Companies Can Shift With Arguments

Other proposals aimed at lowering prescription drug costs are also popular among the public. At least three in four favor allowing Medicare to place limits on how much drug companies can increase the price of drugs every year based on annual inflation rates (76%), allowing Americans to buy drugs imported from licensed Canadian pharmacies (78%), and placing an annual limit on out-of-pocket costs for seniors enrolled in Medicare prescription drug coverage (81%). About six in ten (62%) favor lowering what Medicare pays based on amounts paid in other countries where governments more closely control prices. Notably, majorities of Democrats, Republicans and independents favor each of these proposals.

The ACA And The Courts

In December 2018, a federal district court judge in Texas issued a ruling siding with Republican state attorneys general that declared the Affordable Care Act invalid since Congress zeroed out the penalty for not having health insurance. In March 2019, the Trump administration filed a brief stating that the administration supports the federal judge's ruling that all of the ACA is invalid. The Trump administration had previously

stated that as part of the lawsuit known as Texas v. United States, it will no longer defend the ACA's protections for people with pre-existing medical conditions.

Overall, 63% of the public do not want to see the Supreme Court overturn the ACA's pre-existing condition protections; yet the public is more divided on whether they want the Court to overturn the entire law (43% would like to see it overturned and 48% would not). While about seven in ten Democrats and about half of independents do not want to see the 2010 health care law overturned, three in four Republicans say they would like to see the courts overturn the law. However, fewer than half of Republicans (47%) want to see the ACA's protections for people with pre-existing conditions overturned.

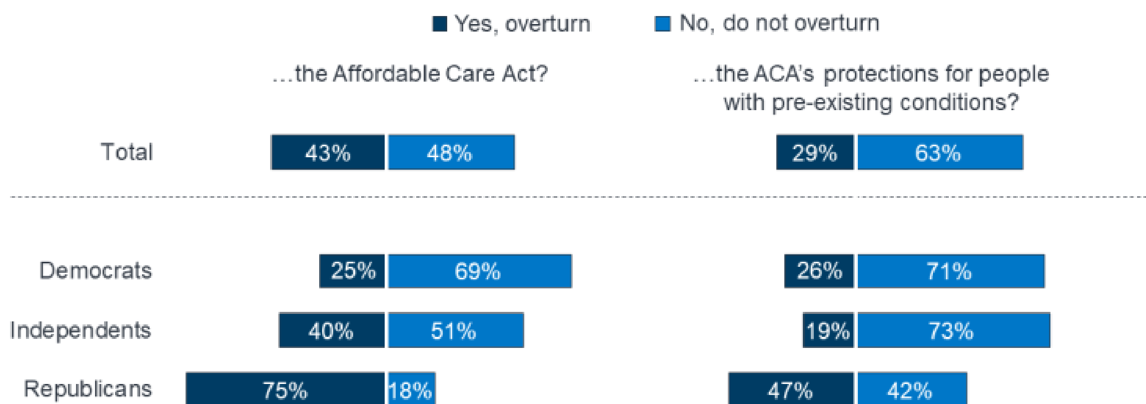


Figure 13: Six in Ten Do Not Want Courts To Overturn ACA's Protections For People With Pre-existing Conditions

Overall opinions of the Affordable Care Act have remained relatively unchanged for the past two years since the Republican efforts to repeal the law. Half of the public (51%) this month hold favorable opinions of the ACA while four in ten hold a negative opinion of the law. The public still holds largely partisan views of the ACA as eight in ten Democrats (81%) have a favorable view of the ACA compared to half of independents (51%) and about one-sixth of Republicans (15%).

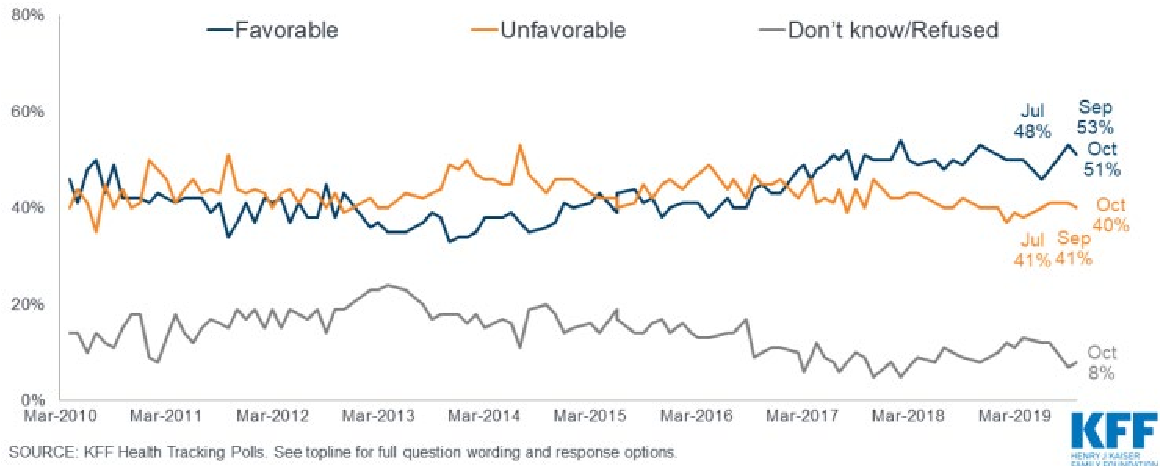


Figure 14: Larger Share Of Public View ACA Favorably Than Unfavorably

Trump's hard-line immigration rule could disproportionately hurt Asian immigrants
Kimmy Yam

A hard-line Trump administration immigration policy that would deny immigrants residency if they are deemed likely to become a “public charge,” or need public assistance, could significantly affect the Asian American community.

The Department of Homeland Security rule, which was published in August, greatly expanded the definition of who is considered a public charge. Given the community’s use of certain social services, high rates of limited English proficiency, and heavy reliance on the family reunification system to come to the United States, immigration advocates fear that the rule would create serious barriers for Asian immigrants or those who wish to change their status.

Research from the Migration Policy Institute reveals more than 941,000 recent green card holders would have fallen under the Trump administration rule had it been in effect when they applied. Of those, 300,000 are from Asian countries.

A federal judge temporarily blocked the rule earlier this month, allowing a total of 15 days — which ends Friday — for parties to submit filings. The policy is currently enjoined and cannot be implemented by the administration, but it has already impacted many in the community who fear their use of public benefits could compromise their immigration status.

"The policy itself, the mere suggestion that the administration was considering the policy, has resulted in Asian immigrants and other immigrants pulling out of public benefits," John C. Yang, executive director of the civil rights nonprofit Asian Americans Advancing Justice | AAJC, told NBC News.

Yang added: "This [rule], to us, is just a made-up reason to exclude certain classes of immigrants."

The current definition of public charge is rather specific. Those who would need cash assistance or institutionalized care would fall under the category. However the Trump administration's expanded definition would include individuals who would need food stamps, Medicaid, and Section 8 housing. The administration rationalized the rule, claiming that "self-sufficiency has long been a basic principle of U.S. immigration law."

Roughly 70 percent to 80 percent of Asian immigrants come to the U.S. through family-based immigration, which means they would be scrutinized under the Trump administration rule. Of the more than 420,000 green cards that were granted to Asian immigrants in Fiscal Year 2017, almost 40 percent were given to immediate family members, while more than 20 percent were given to family-sponsored waiting list registrants.

In some urban areas, the Asian American community experiences particularly high rates of poverty. In New York City, Asian Americans have the highest poverty rate compared to all other racial groups. The racial group has one of the fastest growing populations in poverty. Between 2007 and 2011, the number of Asian Americans in poverty grew by 37 percent and Pacific Islander poverty ballooned by 60 percent, higher compared to any other group. The national increase was significantly lower at 27 percent.

Almost 18 percent of those who participate in government assistance programs are Asian Americans. However those in the community already underuse social services, Jo-Ann Yoo, executive director of the New York City-based social services nonprofit Asian American Federation, said. Not only would underprivileged immigrants meet challenges in obtaining permanent residency, but Yoo said that the proposed rule would further intimidate them from utilizing public services.

According to the new public charge rule, immigrants would also be assessed on English proficiency. The Asian American population already has the highest proportion of residents who speak a language other than English at home. And more than one-third of Asian American and Pacific Islanders have limited English proficiency.

“The Trump administration has a very narrow view of what types of immigrants are so-called desirable in the United States and frankly it is a racist and xenophobic view,” Yang told NBC News. “That view is that only people who are desirable are already proficient in English, already have a certain level of wealth or high skills.”

Since the rule was proposed back in 2018, roughly 13 percent of immigrant adults are reported to have withdrawn their use of public benefits out of fear of risking their future green card status, according to a report by Urban Institute. Yang added that some individuals who would not be subject to the rule have actually pulled out of public services due to misinformation.

“It does not affect refugees. It does not affect existing citizens,” he said. “We don’t want people to be fearful of using public benefits when they are entitled to use them.”

Asian Americans have long confronted restrictive immigration policies tied to the potential use of social services. The first public charge rule in U.S. history coincided with the passage of the Chinese Exclusion Act of 1882. The two separate legal rules ultimately carried the same function.

“There’s an absolute linkage between the discrimination of Asians and public charge,” Yang said. “[The first public charge rule and the Chinese Exclusion Act] were rooted in the same thing: which was this notion that Chinese immigrants were coming into the country in numbers that were too large and that they were somehow deemed to be undesirable."

Yang pointed out that since that time, public charge has been used to exclude other immigrant communities, including Mexican immigrants and those in the Jewish community.

The Health 202: Kids are losing health coverage despite the strong economy
Paige Winfield Cunningham

A strong economy usually means more children have health insurance. Instead, precisely the opposite is happening right now in the U.S.: Kids are losing coverage.

A small but significant decline in the number of insured children has started attracting the notice of lawmakers and policymakers, who are partly blaming actions — or inaction — by the Trump administration for why 400,000 fewer kids had health coverage last year than in 2016.

U.S. census data indicate that 5.2 percent of those under 19 now lack health insurance, up from 4.7 percent two years ago. The coverage loses are detectable in 15 states and

most sizable in southern states that didn’t expand their Medicaid programs and already have above average uninsured rates, according to a report released today by Georgetown University’s Center for Children and Families. Just one state, North Dakota, saw an increase in health coverage in that age group over the two-year time frame.

The trend is not exactly what experts had expected, given how the economy is thriving and recent legislation expanding coverage. The unemployment rate is at a nearly 50-year low of 3.5 percent, which means more American families have access to employer-sponsored plans. And the country has seen coverage gains over the past decade because of the Affordable Care Act, which roughly cut the uninsured rate in half.

“Things will likely get worse for children before they get better,” said Joan Alker, the center’s executive director. “These losses came amid strong economic growth and low unemployment … should an economic downturn occur the losses would accelerate.”

Top administration officials, increasingly facing questions about the trend, have tried to advance a positive message: that more children are moving from public insurance programs for the low-income to employer-sponsored coverage as their parents get jobs.

“What is happening is under the Trump economy, the economy is the best that we’ve had in 50 years, unemployment is down, there’s less people living in poverty,” Seema Verma, administrator of the Centers for Medicare and Medicaid Services, said at a congressional hearing last week in response to questions from Rep. Yvette Clarke (D-N.Y.).

Verma was partly right. The share of kids with employer-sponsored coverage has increased by nearly a full percentage point, from 46.7 percent in 2016 to 47.6 percent last year, according to census data.

But that improvement is more than erased by a more sizable increase in the share of children dropping off both public health programs and the Obamacare marketplaces.

Between 2016 and 2018, children’s enrollment in Medicaid and the Children’s Health Insurance Program dropped from 35 percent to 34.3 percent. Enrollment in health plans purchased on the individual market declined from 5.8 percent to 5.2 percent during the same time period.

There are a number of possible reasons for this decline. For one thing, Americans are no longer penalized if they lack health coverage, after Congress repealed that part of the Affordable Care Act at the end of 2017. So families who find marketplace coverage unaffordable, especially if they're ineligible for federal subsidies, might be deciding to forgo it altogether.

Researchers and activists also pointed to Republican-led states that are requiring more documentation from Medicaid-eligible families, putting them at risk from being dropped from the program. For example, Texas allows only 10 days from the time it mails a

notice to families to when they must return requested documents, said Adriana Kohler, a senior health policy associate with Texans Care for Children.

“One of the problems here in Texas that state leaders should tackle is the extra round of red tape that knocks eligible kids off Medicaid,” Kohler said.

Those concerned about the coverage declines have also described a “chilling effect” on Latino families as President Trump has tightened regulations around immigrants and public benefits. The coverage declines have been most pronounced among Latino and white children, according to the Georgetown report.

“These findings should be a clear call for action among our political leaders if they care about children’s health,” Alker said.

Democrats in Congress are increasingly seizing on the data to mount a new line of health-care attacks on Trump. Two committee chairmen blamed the administration for the coverage declines in a letter sent yesterday to Health and Human Services Secretary Alex Azar. The letter said the administration has “applauded” the enrollment declines among children.

“We believe that these historic coverage loses among children are the result of overly burdensome and faulty eligibility and renewal processes, diminished resources for outreach and enrollment assistance and policies that instill fear and confusion among immigrants and mixed status families,” wrote Senate Finance Committee Chairman Ron Wyden (D-Ore.) and House Energy and Commerce Committee Chairman Frank Pallone (D-N.J.).

The New York Times

How Americans Split on Health Care: It’s a 3-Way Tie
Margot Sanger-Katz

When Americans are asked whether they support a “Medicare for all” system that would replace all current insurance with a generous government program, a majority often say yes. But when they’re asked follow-up questions, they often reveal that they’re not familiar with the details of that plan — or that they would also be happy with other Democratic policy proposals.

In a new survey from The New York Times as well as the Commonwealth Fund and the Harvard T.H. Chan School of Public Health, we forced the issue. We asked a panel of 2,005 adults to pick their favorite plan from three choices. One resembled the Medicare for all proposal; one was like more incremental Democratic proposals; and one was like

a plan proposed by congressional Republicans, which would reduce federal involvement in the health system and give more money and autonomy to states.

The share of the public supporting each option wound up being almost identical — around 30 percent each.

That means that most Americans support Democratic approaches to changing the health care system. But that group is about evenly split between an expansive set of changes under the Medicare for all proposal favored by Senators Elizabeth Warren and Bernie Sanders, and a less sweeping overhaul that would simply move the country closer to universal coverage, such as those from Joe Biden and Pete Buttigieg. (Not every politician's health plan fits neatly in these categories. Kamala Harris, for example, has proposed a system that would eliminate most existing insurance arrangements, but replace them with a system with both public and private coverage options.)

They don't like the health system
The group that preferred Medicare for all was more disgruntled with the current system than other groups, and more comfortable with drastic change. Only 21 percent said they thought the United States had the best health care system in the world, compared with 55 percent among those supporting the Republican plan. Majorities of the Medicare for all group said they were dissatisfied with the cost of their health care and worried about their ability to pay if they became ill in the next year. Still, a majority of this group also said they were satisfied with the quality of their care and their current insurance.

Robert Blendon, a professor of health policy and political analysis at the Harvard School of Public Health, who helped write the study, said the overlap between dissatisfaction and support for the proposal showed that Medicare for all's strong supporters understand that it would cause substantial disruption of the current system. Critics have said that the proposal goes too far because it would involve eliminating most private health insurance and could reshuffle the finances of major health care companies.

"There's no question that the level of dissatisfaction leads to interest in big proposals," he said, describing their perspective. "When I'm really dissatisfied, I'm interested in Canada. I want to do big new things."

The Republican proposal would also cause large disruptions in the system, upending the current Medicaid expansion and the markets for people who buy their own insurance. The survey respondents who favored that plan seemed largely satisfied with the status quo. That may be because they do not think those changes will affect them personally. It may also be because a Republican is in the White House now, so the status quo seems rosier to them than it did a few years ago.

They think taxes are a fair trade-off for coverage
Supporters of Medicare for all were more approving of socialism and showed stronger support for the notion that the government should be responsible for ensuring universal access to health care for all Americans. When asked if they were comfortable paying

higher taxes in exchange for health coverage for everyone, 79 percent said they would be willing, a substantially higher proportion than respondents in the other two groups.

Those findings suggest that critiques based on the high cost of the proposal probably won't do much to deter its strongest supporters. But the idea of higher taxes was less popular over all. Fifty-three percent of all respondents said they would personally pay more taxes so that everyone could have health care. Only 23 percent of those favoring the Republican plan said they would.

They think the government should play a bigger role

All three groups showed consensus on some points. Large majorities thought the government should require insurers to continue offering coverage to people with pre-existing health conditions. That answer, consistent with some other recent surveys, represents a shift. The Affordable Care Act first provided robust consumer protections for such people, and as recently as two years ago, most Republicans in Congress voted for legislation that would have substantially weakened those protections. Obamacare itself now consistently enjoys majority support in surveys, after years of being under water.

"Protection for people with pre-existing conditions is the status quo, and it can't be taken away except at a huge political cost," said David Blumenthal, the president of the Commonwealth Fund.

There was also relatively broad agreement that health care is a right. When asked whether all Americans should have a right to health care regardless of their ability to pay, nearly 80 percent of all respondents agreed. Sixty percent of those favoring the Republican health plan believed health care was a right, but among those favoring the two Democratic proposals, support exceeded 90 percent.

Where the groups differed was in how a universal health care system should be achieved. Eighty-five percent of the Medicare for all enthusiasts thought it was the responsibility of government to ensure all Americans had health coverage. Only 73 percent of those supporting more incremental Democratic reforms agreed. Among those supporting the Republican plan, the number was 20 percent. Sixty-five percent of people in that group said the government should become less involved in health care in the future.

Will their ranks grow?

On many questions about policy and values, there was broad overlap between the supporters of Medicare for all and supporters of a more incremental approach to coverage expansion. And many survey respondents struggled to express a strong preference between the two choices.

Those factors lead Mr. Blendon to believe there are immediate opportunities for Democrats to devise a plan with broad appeal. The underlying shared values endorsed by supporters of both Democratic approaches — about rights to health care, protections

for the sick, and a larger role for the government in ensuring equity — could be paired with a more modest set of policy changes.

In the long term, however, the appeal of Medicare for all may hinge on how well the current health care system serves the public. Recent research has found that employer health plans, the most common and popular form of health insurance for working-age Americans, have become substantially less affordable. More Americans are now what experts call “underinsured,” meaning that their coverage still leaves them exposed to a damaging financial hit if they get sick. If those trends continue, a greater share of Americans may find themselves dissatisfied with the system and fearful about how it will treat them if they need it.

“Most Americans want everyone to have coverage, but some people are willing to sacrifice more to get there than others,” Mr. Blumenthal said. “The people who are willing to sacrifice more are the people who have less to lose.”

If the status quo gets bad enough, the number of people seeking big changes could grow.

Stable costs but more uninsured as ‘Obamacare’ sign-ups open
Ricardo Alonso-Zaldivar

WASHINGTON (AP) — More Americans are going without health insurance, and stable premiums plus greater choice next year under the Obama health law aren’t likely to reverse that.

As sign-up season starts on Friday, the Affordable Care Act has shown remarkable resiliency, but it has also fallen short of expectations. Even many Democrats want to move on.

President Donald Trump doesn’t conceal his disdain for “Obamacare” and keeps trying to dismantle the program.

During President Barack Obama’s tenure, open enrollment involved a national campaign to get people signed up. The program’s complexity was always a problem, and many lower-income people still don’t understand they can get financial help with premiums.

That can translate to several million uninsured people unaware they qualify for help. An analysis Thursday from the consulting firm Avalere Health found that low-income

residents in 96% of counties served by HealthCare.gov can find a basic “bronze” plan at no cost to them, factoring in subsidies. Bronze plans are skimpy, but experts say it beats going uninsured.

Standard “silver” plans are available at no additional cost in 25% of counties, and people eligible for generous subsidies can find more robust “gold” plans for zero premium in 23% of counties, the study found.

But the Trump administration says it’s not specifically advertising that. Early on, it slashed the Obamacare ad budget. Officials say they’re focused on providing a quality sign-up experience and keeping the HealthCare.gov website running smoothly.

Democrats who once touted the health overhaul as a generational achievement now see it as a stepping stone, not the final word.

Presidential candidates Bernie Sanders and Elizabeth Warren would bring the 20 million people covered under the law into a new government-run system for all Americans. “It’s time for the next step,” says Warren.

Former Vice President Joe Biden, who asserts “Obamacare is working,” is proposing a major expansion of current ACA subsidies and a whole new “public option” insurance program.

For John Gold, a self-employed graphic designer from Maine, health care that’s stable, affordable and comprehensive still feels more like a goal than a reality. He’s been covered by the ACA since 2014.

“It’s a great start, but it’s not the be-all and end-all of health care,” he said.

Health care “takes up too much of my budget, and it doesn’t need to,” explained Gold, who lives near Portland. “There are appointments my doctor suggests, that I turn down because it’s going to cost me $300.”

Gold’s income fluctuates, and when he makes too much to qualify for subsidized premiums, he must pay full freight. He’s in his 50s, so his monthly cost is higher, about $700. On top of that, the plan comes with a $4,000 deductible and an $8,000 out-of-pocket limit, potentially leaving him on the hook for a lot more.

Nonetheless, Gold said he hasn’t looked at the cheaper alternative the Trump administration is touting, though it can cost up to 60% less. One reason is “short-term plans” don’t have to cover pre-existing medical conditions.

With the economy strong, it’s unusual for progress to falter on America’s uninsured rate. Yet the Census Bureau reported that 27.5 million people were uninsured in 2018, an increase of nearly 1.9 million from 2017, and the first time the rate went up in a decade.

Caroline Pearson, a health insurance expert with NORC at the University of Chicago, a nonpartisan research organization, said she doesn't expect to see ACA coverage gains in 2020.

"Premiums are still expensive for people who have other costs," said Pearson. "It's a challenging proposition unless you are getting a big subsidy or really need insurance."

Enrollment has been slowly eroding since Trump took office, from 12.2 million in 2017 to 11.4 million this year. The drop has come mainly in HealthCare.gov states, where the federal government runs sign-up season. State-run insurance markets have held their own.

But Trump administration officials say they're doing just fine managing Obamacare. They recently announced that premiums for a hypothetical 27-year-old choosing a standard plan will decline 4% on average in 2020 in HealthCare.gov states.

Despite relatively good news on premiums, Trump's actions still cast a shadow over the ACA's future.

His administration is asking a federal appeals court in New Orleans to strike down the entire law as unconstitutional. The White House has released no plans to replace it.

Seema Verma, the top administration official overseeing the health law, sounded confident in a recent appearance before a House committee.

"The president has made clear that we will have a plan of action to make sure Americans will have access to health care," Verma, head of the Centers for Medicare and Medicaid Services, said when asked about the court case. But she added, "I'm not going to get into any specifics."

A decision in the court case could come any day. Whatever they decide, it's likely to go to the Supreme Court.

Gold, the graphic designer from Maine, is worried. "I do not trust them to replace it with something better," he said.

Sign-up season ends Dec. 15 in most states. Coverage starts Jan. 1.

Trump rule on health insurance leaves immigrants, companies scrambling for answers
Kristina Cooke, Mica Rosenberg

LOS ANGELES/NEW YORK (Reuters) - Nearly a decade after receiving U.S. citizenship, Guatemalan-born Mayra Lopez thought she had cleared all the hurdles for her parents to join her in the United States.

Then on Oct. 4 U.S. President Donald Trump changed the rules she and others had been complying with: Trump signed a proclamation requiring all prospective immigrants to prove they will have U.S. health insurance within 30 days of their arrival or enough money to pay for “reasonably foreseeable medical costs.”

The new requirement, part of Republican Trump’s hard-line policies on immigration, goes into effect on Nov. 3 and prospective immigrants are scrambling to figure out how to get the necessary coverage, navigating a complex healthcare bureaucracy that has, for the most part, not previously catered to those who are not yet in the country.

The administration gave scant detail about how the new requirements would be implemented beyond a bullet-point list of the types of insurance plans that would be accepted.

A State Department notice on Oct. 29 said consular officers will verbally ask immigrant visa applicants to identify a specific health insurance plan, the date coverage will begin, and “other information related to the insurance plan as the consular officer deems necessary,” but gave the public only two days to comment on that plan instead of the usual several months.

Lopez, 40, who works as a family assistant in California, and many others are finding few options exist for them.

Lopez received a letter for her parents’ appointment to be interviewed on Nov. 25 at the U.S. embassy in Guatemala. Near the top it read: “inability to meet this requirement will result in the denial of the visa application,” according to the letter seen by Reuters.

She immediately called her own insurer, Kaiser Permanente, but she said she was told her parents, both in their 60s with no serious health problems, would not be eligible because they did not have U.S. social security numbers and even if they did, it would

cost more than $1,600 a month to cover both of them, according to interviews with Lopez and her attorney.

Lopez then called five other insurers and began to panic when they all told her variations on the same thing, she said.

Tony Barrueta, a Senior Vice President at Kaiser Permanente, said in a statement that a social security number is not required to apply for Kaiser Permanente coverage, but the company may request that information.

Barrueta said the company acknowledges the complexity of the proclamation and other recent actions "and the confusion they may have created for many immigrants and their families." He said they were continuing to educate their front-line staff on how to address questions.

California's health insurance marketplace, Covered California, said "consumers must be lawfully present in order to apply for coverage."

Many prospective immigrants seeking to enter the country legally, including those who do not have lawyers, may not be aware of the new requirements and could end up being denied, immigration advocates said.

When asked about the concerns, a State Department official repeated the guidelines in the proclamation, which are posted on the department's website.

The White House did not respond to a request for comment.

COVERAGE GAPS

Long term-plans on the state insurance marketplaces are not available to immigrants before they are in the country lawfully, according to the eligibility requirements outlined in the Affordable Care Act (ACA), Democratic President Barack Obama's signature health care legislation.

The proclamation does not accept subsidized health plans, meaning immigrant applicants would be barred from using income-based subsidies for the purchase of individual coverage, a main tenet of the ACA.

Short-term insurance plans are banned in four states and 20 others limit their duration to less than 364 days, the amount of time required by the proclamation, according to the Commonwealth Fund, a nonprofit research group.

Even where they are available, short-term plans often have large gaps in coverage and can have exclusions for pre-existing conditions, said Pennsylvania Insurance Commissioner Jessica Altman.

Trump has tested the boundaries of established policy, aiming to fulfill his 2016 campaign pledge to curb both legal and illegal immigration, including a yet to be

constructed wall along the U.S.-Mexico border. Immigration rights lawyers and civil liberties groups have challenged his policies in court, sometimes with success.

“This order overrides about 100 years of law that has always promoted the ability to live with your immediate family members and targets people in a way that Congress didn’t intend,” said Jesse Bless from the American Immigration Lawyers Association.

“Congress has made rules that has allowed people to come in based on self sufficiency not wealth or health.”

On Wednesday, seven U.S. citizens petitioning for their family members and immigrant advocacy groups filed a lawsuit in Oregon seeking to halt the proclamation.

The proclamation appears squarely focused at limiting family-based migration, which the President has repeatedly derided as “chain migration,” said Xiao Wang, co-founder of the immigration firm Boundless.

The administration issued a rule earlier this year that would limit legal immigration by expanding who could be found to be a “public charge” and barred from residency. The measure has been temporarily halted by federal courts.

FAMILY REUNIFICATION DELAYS

Some immigration lawyers are telling their clients to consider rescheduling their visa interviews until there is more clarity about how the new health insurance rules would be implemented – potentially delaying family reunification.

Some other wealthy countries, such as Germany, require people applying for visas and residency to provide proof of health insurance. But those countries do not have the same healthcare costs and insurance system as the United States.

The Trump proclamation said it aims to stop healthcare providers and taxpayers from bearing “substantial costs in paying for medical expenses incurred by people who lack health insurance or the ability to pay for their healthcare.” It cited data that “lawful immigrants are about three times more likely than United States citizens to lack health insurance.”

Healthcare policy experts say immigrants use the U.S. system less often than Americans. According to an analysis by Leighton Ku, Director of the Center for Health Policy Research at George Washington University, recent immigrants without insurance accounted for less than one-tenth of 1% of U.S. medical expenditures in 2017.

Sometimes having short-term plans that provide only limited coverage can be as costly to the healthcare system as not having insurance at all, Pennsylvania’s Altman said.

The Trump administration has expanded short-term health plans and made them renewable, which experts say undermines the ACA.

Rajeev Shrivastava, the chief executive of VisitorsCoverage, which sells travel insurance policies to U.S. visitors and immigrants, said online search traffic for immigrant plans on his website increased by 150% after the proclamation.

He said the new policy "creates an opportunity" for insurance companies to develop plans for incoming immigrants, though some are waiting for more clarity from the government.

For U.S. citizens married to immigrants who have been living in the country without legal status there are additional considerations. Jorge, 45, has been in the United States for almost 20 years and is married to a U.S. citizen. He has been granted a so-called unlawful presence waiver that would allow him to leave and apply to become a legal resident without facing a multi-year bar.

His visa interview in Colombia is scheduled for later this year. At least 10 insurers have told him he cannot apply unless he can prove he is in the country legally, Jorge said. He also does not qualify for travel insurance, he said, because he is currently in the United States.

"This has been very stressful," said Jorge, who spoke to Reuters on the condition that his last name not be used.

One option available to him, a short-term health insurance plan that offers limited coverage, is only available for six months in Illinois and the proclamation requires coverage for 364 days. He bought it anyway.

Many enrolled in California healthcare plan lack interpretation services, surveys show
Theodora Yu

Half of the non-English speaking people enrolled in a California healthcare plan reported they could never get a medical interpreter when they needed one, according to a survey conducted by San Francisco State University.

The program, Cal MediConnect, is an all-in-one pilot managed care plan that serves people who are eligible for both Medicare and Medi-Cal. An initial three-year demonstration program that runs through Dec. 31, the plan covers medical, prescription drugs and other long-term services, linking enrollees to providers within the plan's network.

The program is available in seven California counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara. While it is not available in

Sacramento County, a new statewide medical plan called CalAim that proposes to move all 1.2 million eligible Californians into the Medi-Cal managed care will build on what works well in Cal MediConnect.

The Department of Health Care Services will implement a broad delivery system and payment reform across the Medi-Cal program and apply it to all 58 counties in 2023.

But survey respondents have found interpretation services with the Cal MediConnect plan ineffective.

More than 40 percent of the program's enrollees with limited English proficiency responded in the survey that it was harder to get an interpreter in 2017 than it was a year ago when they used Cal MediConnect services.

Another survey conducted by the Scan Foundation shows up to 40 percent of Asian and Pacific Islander enrollees indicated that their doctor or provider did not speak their language, or an interpreter was not available in 2018, as compared to 9 percent of Hispanic enrollees. Hispanic and Asian and Pacific Islander enrollees were the least likely to be "very satisfied" with their ability to call a health provider, regardless of the time of day, according to the survey.

"Our experience in Cal MediConnect can be used to predict where potential language access barriers might be in this new model 'CalAim'," said Denny Chan, senior staff attorney at Justice in Aging, a national nonprofit that fights senior poverty through law. "Sooner or later, this will affect all duals across California. The agencies want to move people to managed care plans across the state, so it is important for us to make sure these problems don't continue."

The issues with communications between physicians and patients are multifaceted, said Esther Lara, a medical social worker who works with patients over age 65 at the UC Davis Health Alzheimer's Disease Center.

Many seniors in minority communities tend to be under-diagnosed if an interpreter is not present to translate, Lara said. Often they don't come in with family members or a caregiver, or the caregiver is not included in the conversation. It is important for the patient to have someone who can verify information and make sure he or she understand and can carry the information home, so the caregiver can later read it and note the potential side effects.

The right to language access services is "enshrined in federal and state laws," Justice in Aging stated in a letter addressing the department on Oct. 28.

While state agencies have done timely access surveys on Medi-Cal medical providers and call center staff members on whether they are aware of the rights to language access services for enrollees, Chan said they have yet to survey Cal MediConnect beneficiaries.

“The evaluation data (for Medi-Cal) tell us this is a problem. The state has an obligation to understand the barriers (of Cal MediConnect) and work on the policies on what to improve,” Chan said.

The Department of Health Care Services is not planning to conduct a timely access survey of Cal MediConnect providers, according to the department’s response to The Sacramento Bee’s inquiry.

The reply further stated a team of state and federal staff will work to resolve issues in response to complaints on access to care. The team will provide technical assistance on providing interpretation services and require plans to update and submit their respective interpreter policies and procedures.

Call centers are the critical connection point between healthcare providers and patients to ensure they get set up with timely medical services, Chan said, so it’s crucial for call center staff members to know patients’ rights to language access and schedule interpretation services before the appointment.

“(Enrollees) are likely have to make important decisions on your healthcare – whether you need to delay treatment, how regular do you have to take a drug, money – these are important details people want to know. And even one detail makes a difference,” Chan said.

Obamacare early sign-ups drop 20% as Trump-backed lawsuit challenges constitutionality
Berkeley Lovelace Jr.

Obamacare sign-ups on the federal health insurance marketplace fell 20% in the first two weeks of the 2020 enrollment season compared with last year, according to new federal data released Wednesday.

In the first nine days of open enrollment, 932,049 people chose a plan for the 2020 coverage year on HealthCare.gov, the federal health insurance exchange that serves much of the United States, according to data published by the Centers for Medicare and Medicaid Services.

That compares with 1,176,232 consumers who selected their coverage through the exchange during the first two weeks, or 10 days, last year, according to federal data released at the time.

More than 680,000 existing customers renewed their coverage on the marketplace, while 244,928 new consumers chose an insurance plan on HealthCare.gov. About 8.5 million people enrolled in Obamacare during last fiscal year.

Open enrollment began Nov. 1 and will run until Dec. 15 for most states. People who do not sign up for an Obamacare plan by the end of open enrollment will not be able to obtain coverage until the fall of 2020, unless they have a so-called qualifying life event, such as getting married or having a child.

The tally comes as a federal appeals court in New Orleans is expected to issue a decision any day now on a lower court ruling that overturned Obamacare, formally known as the Affordable Care Act, in a case known as Texas vs. the United States.

Health and Human Services Secretary Alex Azar has told reporters that 2020 open enrollment will continue even if the 5th U.S. Circuit Court of Appeals upholds the ruling that found the health-care law unconstitutional. The health law was ruled unconstitutional during the final days of open enrollment last year, but the judge in the case issued a stay.

Americans shopping for 2020 health plans will find premiums edging lower for the second straight year, down 4% on average, and more insurers to choose from.

The average premium for a 27-year-old who buys a benchmark silver plan will be $388 a month in 2020 before subsidies, down from the current $406, according to CMS. The number of insurers offering plans on Healthcare.gov rose from 155 last year to 175.

Obamacare exchanges are seeing stability after years of regulatory concerns, said Tara Straw, a senior policy analyst at the Center on Budget and Policy Priorities.

“People understand the value of health insurance, and there are a lot of good deals in the marketplace,” she said.

The New Orleans federal appeals court decision is “definitely a concern,” Straw said, adding the ruling could cause some confusion among consumers.

This is the second enrollment season since Congress reduced Obamacare’s individual mandate fee to $0. The mandate imposed a tax penalty on consumers who went uninsured and was a key part of the health-care law.

Obamacare sign-ups sank 4% year over year during open enrollment last year.

The end of the mandate, along with President Donald Trump’s push for cheaper, less comprehensive short-term health plans and a substantial slash in outreach funding, was expected by health policy analysts to put a damper on Obamacare enrollment rates.

Joshua Peck, co-founder of Get America Covered and former chief marketing officer for HealthCare.gov, said technical problems on the site on the first day of enrollment also could have played a role in fewer sign-ups.

Does Gavin Newsom have the answer to Democrats' health-care fights?
Angela Hart

A year and a half ago, Gavin Newsom was in the same place as Elizabeth Warren and Bernie Sanders, running in a tough Democratic primary and vowing “it’s about time” for a single-payer health care system while dismissing his critics as “can’t-do Democrats” who refuse to think big.

Now he’s in a different place.

The sleek businessman with the wavy pompadour has changed his rhetoric and slowed his pace. “These things take time,” he acknowledged after his primary victory.

As governor, Newsom’s health care program has been more incremental than promised, annoying some allies in the single-payer movement while winning some unexpected praise from industry groups. But he also may have found something larger than his own agenda: A health-care path that builds on past successes, enacts fresh reforms and may eventually lead to a single-payer system – without the political earthquake that so many predict under Sanders’ complicated bill or Warren’s financing plan.

Newsom’s is by far the most relevant — and revelatory — experiential test of the Democratic health care ideas that will be so hotly debated on the Atlanta debate stage Wednesday night. And it offers something for everyone in the race to chew on: A testament to the power that a promise of a single-payer system can have in galvanizing the party’s base; the unforgiving realities that make a quick conversion to single-payer practically, and probably politically, impossible; and a way for a leader to win broader support for incremental steps that — if pursued diligently enough — could lead to universal coverage.

“This is the signature issue of the progressive left, and it’s absolutely driven by what’s happening in California,” said Doug Herman, a Democratic strategist based in Los Angeles, who attests to the appeal of single-payer as an issue. “Medicare for All could help Bernie and Elizabeth in the Democratic primary the same way it helped Gavin Newsom win the primary in California. But the deeper you go, the harder it is to explain how you’re going to pay for it.”

Newsom’s alternative steps include a return of the individual mandate requiring people to buy insurance or pay a tax penalty; stricter coverage requirements on mental-health parity; expanded subsidies to help low- and middle-income people purchase coverage; more Medicaid spending to cover undocumented immigrants; and the creation of a much larger state-operated group-purchasing plan to drive down prescription-drug costs.

These will be followed, if Newsom sticks to his intentions, by additional reforms generated by a 2020 commission of stakeholders that could lead to a much more highly regulated system. And that, some health experts believe, can put him on the doorstep of the Democrats’ Holy Grail: a universal, single-payer system.

“The governor continues to insist that we move forward towards system that will cover everyone, that will be more affordable and that will be high quality. Single-payer is one point on the horizon to help to get us there,” top Newsom adviser Daniel Zingale told POLITICO. “Folks who are die-hard proponents of single-payer should not despair – that continues to be a guiding beacon for where we’re trying to go.”

* * *

Speaking to a home state crowd of more than 4,000 liberal activists in San Diego in early 2018, Newsom, the dynamic former San Francisco mayor who had spent eight years as lieutenant governor waiting for his chance at the top job, took a shot at his chief primary opponent, former Los Angeles Mayor Antonio Villaraigosa, who was on a crusade to convince voters that single-payer was too expensive and impossible to achieve in California.

“My opponents, they call it snake oil. I call it single-payer,” Newsom said, borrowing a phrase Villaraigosa had employed to criticize Newsom’s lack of specifics in his health care agenda.

“It’s about access, it’s about affordability — it’s about time, Democrats,” Newsom said, buoyed by an electric, cheering crowd a few months before the primary election. “If these can’t-do Democrats were in charge, we would have never had Medicare and Social Security.”

Newsom’s early embrace, both of Sanders’ Medicare for All proposal and a $400 billion single-payer health care bill propped up in the state Legislature by the influential California Nurses Association, earned Newsom highly coveted backing from Sanders supporters and other skeptics on the left who worried he was too moderate.

He has long cultivated an image as a political risk-taker willing to battle his own party, in earlier eras pushing gay marriage and legalization of marijuana to the forefront of the Democratic agenda in California.

Newsom said his single-payer message was about “more than a political campaign,” it was about “Democrats acting like Democrats” in a battle for the soul of America against “a president that doesn’t have one.”

"Democrats do not succeed by playing it safe," Newsom said in the campaign. He went on to defeat Villaraigosa by more than 20 points, and barely flinched at the general election challenge from Republican real estate investor John Cox.

“It was an ideological purity test, and Newsom won it,” said Mike Madrid, a Sacramento-based Republican strategist who led Villaraigosa’s campaign. “Health care is something that has defined the Democratic Party since at least the 1970s, but this was new. I was shocked to see the desire Democratic primary voters had to be lied to.”

After the primary, Newsom largely ignored his Republican opponent, instead pouring time and resources into helping down-ticket Democratic candidates beat Republicans in House and state legislative districts. Democrats ended up unseating six Republicans in the Legislature, solidifying its Democratic supermajority, and flipping seven Republican-held battleground seats in the U.S. House.

Andrew Acosta, a Sacramento-based political consultant, said disdain for President Donald Trump fueled those races, but that Newsom did help fire up the Democratic base in traditional Republican strongholds, including in the Central Valley and Orange County.

“I don’t think he was ever in any trouble with Cox, so he was able to do other things,” Acosta told POLITICO.

Newsom’s fiercest allies, meanwhile, were focused on keeping him committed to single-payer. The California Nurses Association and others on the left were growing increasingly anxious that he’d moved too far to the middle, even as they pumped money into a campaign bus with the slogan: “Nurses trust Newsom.”

“He did not run on being an incrementalist governor,” said Stephanie Roberson, chief lobbyist for the California Nurses Association in Sacramento. “If he bit off more than he can chew, he should say that.”

She referenced a series of single-payer campaign promises Newsom had made in seeking their support early in his campaign. “I’m a Californian. I don’t like waiting,” Newsom said early-on. “When I’m governor, I will not wait for federal action ... I’m tired of politicians saying they support single-payer but that it’s too soon, too expensive or someone else’s problem.”

Newsom later began to shift his message away from single-payer, instead brandishing his reputation as the former two-term San Francisco mayor who took on the city’s business elite, passing a universal health care program for city residents regardless of their immigration status or ability to pay, funded in part by fees on employers.

Newsom remained firm on his goal of adopting a universal-care system for California. But single-payer would take much, much longer, if it was even possible. Weeks before the 2018 election, he argued that it was “lazy” for supporters to interpret his single-payer campaign pledge as a promise that was “achievable overnight.”

“It was always about universal health care. That’s the goal,” Newsom said. “I’ve always believed that single-payer financing is the most effective, efficient way to achieve it.”

But, he said, he’d “deeply discovered” that “single-payer financing means a million different things to a million different people.”

Democratic and Republican strategists told POLITICO that the way single-payer played out in the Newsom-Villaraigosa contest is exactly how they see the fight between the liberal presidential candidates touting Medicare for All and the moderates vowing to improve Obamacare: First, promise Medicare for All. Win the primary. Then move to the middle to pick up more middle-of-the-road voters, and start explaining how you were misunderstood all along.

“In this Trump era and a time of immense tribalism, once you start to question numbers and math, you become a heretic,” said Madrid, the Republican strategist. “We saw that in the 2018 California Democratic primary and that’s what’s on full display in the 2020 presidential fight with Bernie Sanders and Elizabeth Warren.”

“People didn’t want a centrist,” he said, recalling the Newsom-Villaraigosa fight. “They wanted an ideological warrior.”

* * *

They may have gotten a warrior, but some of the ideology got left behind.

Industry groups worried about Newsom coming in to office. Now, they see a governor growing more moderate, one who has come around to their side and with his actions decided that building a universal health care system using the current network of payers and providers is much more realistic and politically palatable.

“The reality ... and the governor knows this, is that the federal roadblocks and the state roadblocks to single-payer are real,” said Charles Bacchi, president and CEO of the California Association of Health Plans, which represents major health insurers across the state.

The first day Newsom took office, he staked out major health care priorities on the wish list of industry groups, including insurers, hospitals and doctors: Bringing back the individual health insurance mandate after a Republican-led legal fight had gutted it nationally. Higher provider reimbursement rates. An expansion of Medicaid to cover undocumented immigrants up to age 26, alleviating pressure on public hospitals and emergency rooms saddled with millions of dollars each year in uncompensated care.

Instead of cutting insurance companies out, Newsom has helped bolster their business by restoring a state-based health coverage mandate and expanding taxpayer-financed insurance subsidies for middle-class Californians — even higher than those allowed under Obamacare.

He argues such measures will further stabilize the insurance market and help more people struggling to afford coverage.

He suggested to POLITICO earlier this year that he may go even further next year by covering undocumented seniors. And he is also developing incentives, including higher provider pay, for doctors who do a better job of keeping people healthy by reducing chronic disease and improving care for mothers and babies.

He's spearheading a massive overhaul of public-private drug purchasing, leading initiatives to drive down soaring pharmaceutical costs, he hopes, by creating a single state bulk purchasing system to negotiate deeper discounts with drug makers. Four major counties have joined, including Los Angeles, San Francisco, Alameda and Santa Clara.

And his administration is beginning a major transformation of the state's Medicaid program to better serve the 13 million low-income Californians who depend on it.

These initiatives could provide a workable template for a Democratic health reform agenda that presidential candidates backing single-payer should study and learn from, health policy experts say.

"You can't just wipe out the existing system and start over," said Joe Kutzin, who leads the health care financing team at the World Health Organization, working on establishing universal systems of care around the globe.

In most developed countries — even those held up as ideal single-payer systems — large-scale change happens more incrementally, given what Kutzin described as immense political difficulty implementing "big-bang reform."

"Winning the argument about universal coverage first, I think, is really important," he said. "Is there agreement that no one should become poor or die because they don't have health coverage? The United States political system doesn't have agreement on that basic principle, and that can get derailed by discussions about wiping out the insurance industry."

Kutzin said the Affordable Care Act advanced the national conversation about whether health care should be a basic right — a belief that every major Democratic presidential contender says they're for — but health care is still ingrained in the United States as an earned benefit attached to employment. And, 14 Republican-controlled states still haven't expanded Medicaid to childless adults, while others are making it more difficult for poor people to qualify.

Like faithful single-payer advocates, Kutzin believes a uniform financing system can achieve universal coverage, and deliver it cheaper. But that ignores political realities.

"Getting to single-payer from where you are now, I'm afraid, generates a lot of resistance that risks losing the objective of universal care," he said. "The reality, and I think the difficulty, is the system is so messy right now that almost any path to those goals are extremely painful. But standing still is really painful too."

Tsung-Mei Cheng, a health policy researcher at Princeton who studies single-payer systems around the world, said policies Newsom has advanced can eventually lead to single-payer.

"Fix Obamacare – California is doing this," she said. "Going from private health insurance to single-payer is a tall order. It would be different if people living in Alabama and Tennessee and all these Republican states agreed that health care is a right, but in our country, we are split."

She said steps Newsom has taken are in line with pragmatic measures she and her late husband, Princeton economist Uwe Reinhardt, believed states could do under Obamacare. Reinhardt helped craft Taiwan's single-payer system and broadened America's understanding of why the United States spends more money on health care than any other industrialized country yet has worse health outcomes, in his study on uncontrolled prices.

Cheng said if California can eventually achieve universal coverage, and pass tight cost control mechanisms to reduce overall health care spending, it can serve as a model for other states and possibly, provide a state and national template for single-payer.

"You're almost there," she said. "The one big downside of California and Obamacare is there really isn't any cost control mechanism, and that is necessary. If you can manage to get universal care and costs under control, then you're there."

But, she said, the piecemeal steps California is taking "can be a morale booster for the whole country" as Democrats and Republicans fight over the right approach.

The state has already cut its uninsured rate to about 7 percent, down 10 percentage points from the early days of Obamacare. Measures taken this year are expected to further expand coverage and access.

It could be the best any state could hope for in the immediate future. Going to all-out war with the health care industry over single-payer would be political suicide, Cheng suggested.

"Our political system allows itself to be influenced by these interest groups, and they're very powerful," Cheng said. "We in the United States have this congenital defect, and we're stuck with it."

She said regulating the market by paying all health care providers the same, regardless of coverage, and creating a public insurance option are good ideas for California to build on what the state has already done.

California is already considering those options under a single-payer health care commission established by Newsom and state Legislature this year. Experts have said models in place in other countries can drive a more equitable, efficient delivery system for less money.

The commission is expected to begin its work in 2020, with its charge to consider a path forward on single-payer and tight cost control mechanisms, including a global budgeting system that establishes a fixed amount of health care spending for the state.

* * *

In unscripted moments last year during campaign bus tours through Los Angeles and California's Central Valley — communities that are home to California's largest uninsured population — Newsom alluded to reasons why he envisioned a slower path forward on single-payer.

He said he was eyeing different health care models used throughout the world, all of which included a major role for government as primary payer for health care. The so-called "Bismarck model," used by Germany, Switzerland and Japan was the most appealing for California, he said.

In general, it finances health coverage through a joint employer-employee payroll deduction, and retains a role for private doctors and hospitals. Some countries use a single government payer, while others have multiple insurers, but it provides no profits for health insurance companies and everyone is covered. A key feature is tight cost-control mechanisms on overall health care spending.

"Bismarck has more interesting tenets to what we do in California," Newsom said last year.

He was also analyzing other systems, including a socialized medicine model under which the government owns hospitals, employs doctors and pays for health care as it does education and public safety. And he'd been studying traditional single-payer systems, like those in place in Canada and Taiwan.

Each model, he said, is better than the existing system. A key feature of any future initiative must include tight cost controls, Newsom says.

"There's pieces of all three systems...that are easily categorized as versions of single-payer financing," Newsom said. "Aspects of all three — that's what we're looking at for California.

In office, he has insisted that he remains committed to the idea of single-payer.

"I committed to this, and I want folks to know that I was serious about it," the governor said on Inauguration Day.

Single-payer supporters and industry groups who reject the idea, meanwhile, are jockeying for inclusion in those discussions.

That could present political challenges for Newsom as he eyes larger changes ahead. His allies with the nurses' union have already begun to publicly attack him, telling POLITICO earlier this year that its relationship with the governor is "on shaky ground."

"The time is now, and I think he's missing a moment to actually lead," said Bonnie Castillo, executive director of the National Nurses United, which recently endorsed Sanders for president.

A California congressman with whom Newsom has had deep single-payer discussions suggested in an interview with POLITICO recently that the governor is dragging his feet.

"Our state of California should deliver on single-payer," said Democratic Rep. Ro Khanna, who represents a vast swath of the ritzy Silicon Valley. "If California, where you have the biggest political support for the single-payer movement, isn't going to lead, then where are we going to do it?"

Deep-pocketed industry groups such as the California Medical Association — major financial donors to Newsom during his campaign — say the governor hasn't pleased them on everything, and they remain somewhat concerned about the longer-term prospect of single-payer, but generally they're happy with steps he's taken.

"When many people say single-payer, they're really talking about a payment system that may ultimately reimburse at government-set levels that pay less than cost — that will be a challenge for hospitals," said Carmela Coyle, president and CEO of the California Hospital Association, in an interview.

She said hospitals have "serious concerns" about politicians advancing single-payer at both the state and federal level.

"California's hospitals will be involved and engaged," Coyle said. "We have a tremendous opportunity to look at the issue of affordability that does not necessarily put at risk the care we're able to provide to the population today."

Bacchi, the president and CEO of the California Association of Health Plans, said the plans would fight back against any single-payer effort.

"What California's health plans believe about transforming our health care system is that we should focus on building and improving the health care that's working for millions of Californians, not starting from scratch and putting at risk the care that so many

Californians rely on," he told POLITICO. "Obviously, we're concerned that single-payer might distract from all the other work we may need to do."

Sara Flocks, chief lobbyist for the California Labor Federation, which backs single-payer, characterized Newsom as "untested" on health industry fights. Although he has gone after the pharmaceutical industry and soaring drug prices, that is a more politically popular stance than going after insurers, doctors and hospitals, she said.

But ultimately, if Newsom wants to control rising health care costs and expand the system in a sustainable way, that's what he may have to do. The rough political terrain ahead could rival California's bruising 2017 health care battle, during which the leader of the state Assembly denied a contentious single-payer bill a hearing that prevented it from advancing.

That fight, brought by the nurses, set the stage for Newsom's forceful stance on the issue, and will continue shaping the future debate, Flocks said.

"Senate Bill 562 was a watershed moment for California," said Flocks, an appointed member of the single-payer commission. "It opened a lot of doors to get to where we are today. What's at stake is how we shape the national conversation."

Newsom, faced with charges about backtracking on his single-payer promise, said last year "I haven't lost my idealism."

"But it's one thing to campaign," he added. "It's another thing to govern."