



Media Clips

COVERED CALIFORNIA BOARD CLIPS

Nov. 17, 2019 – Jan. 16, 2020

Since the Nov. 21 board meeting, open enrollment continued as Covered California’s crucial Dec. 15 deadline push made headlines. The national health care discussion focused parts of the Affordable Care Act being ruled unconstitutional in Texas.

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News Release

Nov. 22, 2019

Covered California Names Jim Watkins as New Chief Financial Officer

- *Watkins comes with 26 years of experience in state service, including 24 at the Department of Health Care Services.*
- *Watkins will be responsible for managing and administering the overall financial activities of Covered California, including its strategy for financial sustainability*
- *Watkins replaces the retiring Dora Mejia who helped launch Covered California and set it on strong financial footing.*

SACRAMENTO, Calif. — On Thursday, Covered California Executive Director Peter V. Lee announced to the agency’s board the appointment of Jim Watkins as its new chief financial officer.

As the CFO, Watkins will be responsible for managing and administering the overall financial activities of Covered California, including its strategy for financial sustainability. Watkins will be responsible for planning, implementing, managing and controlling all finance-related activities of Covered California. He will have direct responsibility for accounting, finance, forecasting, budgeting and related government compliance. As a key member of the Executive Management team, Watkins will advise executive leadership on all financial matters for the organization.

Watkins had served as the deputy director of Financial Planning and Forecasting Operations within the Financial Management Division at Covered California since October, and prior to that was the chief of the Research and Analytic Studies division at the Department of Health Care Services for 12 years.

“Jim has shown deep understanding of health care, independent judgement and strong analytic skill in leadership roles, along with an ability to work in politically sensitive areas under significant pressure and timeframes,” Lee said. “He will be an asset to Covered California and build on the solid foundation we’ve developed.”

Watkins will be replacing the retiring Dora Mejia, who began her service with Covered California as deputy director of financial operations in 2013, just months before the agency began making health insurance policies available to consumers.

Under Mejia Covered California transitioned from an agency initially funded with, and reliant on, a federal grant to a self-sustaining and fiscally sound organization with revenues generated from fees charged to health care plans. She managed a \$340.2 million operating budget that supports marketing programs, our consumer service centers, sales, information technology and a host of other services that has helped make health insurance affordable and accessible.

Watkins is a Certified Public Accountant and received his Bachelor of Science degree from University of San Francisco and his Master of Public Policy and Administration from California State University, Sacramento. He has 16 years of high-level experience managing both fiscal and health policy issues in state government. He will earn \$180,000 annually, effective December 1, 2019.



News Release

Dec. 10, 2019

Covered California and the Challenged Athletes Foundation Team Up to Promote Open Enrollment and the Dec. 15 Deadline for Coverage During All of 2020

- *While Covered California's Open Enrollment period runs through Jan. 31, 2020, consumers must enroll by the end of Dec. 15 to have their coverage begin on Jan. 1.*
- *Covered California is teaming up with the Challenged Athletes Foundation, to host a Holiday Boot Camp to promote the importance of health, fitness and the open enrollment period.*
- *The Boot Camp will be led by Paralympian, 2019 Parapan Gold Medalist and World Record Holder Scout Bassett and Nike Master Trainer Betina Gozo.*
- *Californians who choose to go without coverage could face a penalty when they file their 2020 taxes.*

SAN DIEGO, Calif. — Covered California continued its statewide open enrollment campaign by teaming up with the Challenged Athletes Foundation in San Diego for its Holiday Boot Camp on Tuesday. The event comes as Covered California alerts consumers about a critical upcoming deadline. Consumers must sign up by Dec. 15 if they want their coverage to start on Jan. 1.

“We want all Californians to know that if they want coverage for all of 2020, the deadline to sign up is this Sunday,” said Covered California Executive Director Peter V. Lee said. “Now is the time to check if you qualify for the new state subsidies that are available for the first time this year, which are lowering costs for hundreds of thousands of Californians, and ring in the New Year with a quality health care plan.”

The event continues Covered California's campaign of teaming up with well-known Californians who promote healthy lifestyles and understand the importance of access to quality care.

Scout Bassett will share her awe-inspiring story of perseverance and courage, which saw her go from being adopted as an amputee from a chemical fire in Nanjing, China to growing up with a family in the United States, and eventually becoming a World Record-holding Paralympian in the 400 meters and American record-holder in 100-meter and 200-meter sprints.

The Challenged Athletes Foundation (CAF) was established in 1997 and assists, supports, and provides opportunity to people with physical challenges — like Bassett and hundreds and others — so that they can lead active lifestyles and compete in athletic events.

“CAF believes all people deserve the right to a healthy lifestyle and wellness through sports. We are excited to host an inclusive Holiday Bootcamp with Covered California to showcase our commitment to athletes of all ages and abilities, and a shared priority for staying healthy”, says Bob Babbitt, Co-Founder of CAF.

In addition, Covered California will be joined by Betina Gozo at the Boot Camp. Gozo began learning dance, performing and music at a very young age and used her love of fitness to become a Nike Master Trainer. She has traveled the country working to help people become the best versions of themselves through fitness and health.

Covered California also wants to make sure that consumers know that California has 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.”

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.

Open enrollment runs through Jan. 31, 2020.



News Release

Dec. 11, 2019

Covered California Executive Director Peter V. Lee Named One of the 100 Most Influential People in Healthcare for 2019 by Modern Healthcare

- *Ranked No. 66, it's Lee's third consecutive appearance on the annual list.*
- *Lee was the only state official to be ranked in the top 100.*
- *The rankings include some of the most powerful names in the industry from government officials to health care executives from around the nation.*

SACRAMENTO, Calif. — Covered California is proud to announce that Executive Director Peter V. Lee was recognized by Modern Healthcare as one of 2019's 100 Most Influential People.

This is Lee's third consecutive year on the list and the complete rankings are featured in this week's issue of Modern Healthcare magazine and online. Modern Healthcare says the list "honors individuals in healthcare who are deemed by their peers and the senior editors of Modern Healthcare to be the most influential individuals in the industry, in terms of leadership and impact."

The list features prominent elected officials, presidential cabinet members and leaders of prominent healthcare companies and associations.

"Being on this list is truly an honor and speaks to the progress California has made in the Affordable Care Act era," said Lee, who was ranked No. 66 on the 2019 list. "Covered California is part of a broader approach throughout California to focus on not only making the ACA work for Americans, but to build on it in pursuit of universal coverage. My influence rests on the foundation of a great team at Covered California, the leadership of the Governor and many other elected officials, and thousands across the state who have leaned in to put consumers first."

Lee strives for Covered California to be a nimble organization that can properly react to the numerous changes that occur year-to-year in the healthcare industry and keep coverage as accessible and affordable for Californians as possible.

That includes two major changes for consumers in 2020, a new state subsidy program for low- and middle-income Californians that will help lower the cost of coverage for almost 1 million Californians, and the return of the individual mandate which once again makes it the law to have health coverage or face a penalty administered by the Franchise Tax Board when consumers file their 2020 taxes in the spring of 2021.

Lee is currently leading Covered California through its seventh Open Enrollment period, which runs until Jan. 31, with events throughout the state. He was named the exchange's first executive director in 2011 following the passage of the Patient Protection and Affordable Care Act.

Prior to his current role at Covered California, Lee served as the deputy director for the Center for Medicare and Medicaid Innovation at the Centers for Medicare and Medicaid Services in Washington, D.C. and before that he was the Director of Delivery System Reform for the Office of Health Reform for the U.S. Department of Health and Human Services. Prior positions include serving as the Chief Executive Officer of the Pacific Business Group on Health and Executive Director of the Center for Health Care Rights.



News Release

Dec. 12, 2019

Nearly Half a Million Consumers Have Already Qualified for New State Financial Help to Buy Health Insurance; Californians Are Urged to See If They Are Eligible Before Sunday's Key Deadline

- *With a key open-enrollment deadline coming up, Covered California announced that 486,000 people will receive new state subsidies that will make quality health care coverage more affordable in 2020.*
- *In addition, more than 130,000 people have newly selected a plan during this year's open-enrollment period — up 16 percent over last year.*
- *Covered California is the only place where people can see if they qualify for federal tax credits and new state subsidies to lower the cost of their coverage.*
- *Consumers must sign up by Dec. 15 to have health care coverage starting on Jan. 1.*
- *Covered California is working with the Franchise Tax Board to make sure Californians know that they may have to pay a penalty in 2020 if they can afford insurance but choose to go without coverage.*

SACRAMENTO, Calif. — With just four days left until a key deadline, Covered California is urging all Californians to see if they qualify for financial help to buy health insurance. Nearly 500,000 people have benefited from the new state help to lower their monthly premiums.

“Nearly half a million Californians have already signed up and will benefit from new state subsidies in 2020, including tens of thousands in the middle class who are eligible for help for the first time,” said Covered California Executive Director Peter V. Lee.

“We have a key deadline coming up, and we want to tell everyone — whether you need health insurance or know someone who does — that now is the time to see if you are eligible for this new money so you can ring in the New Year with a quality health plan.”

The announcement comes as the first of Covered California’s key deadlines approaches. While Covered California’s open-enrollment period runs through Jan. 31, 2020, consumers must sign up before the end of Sunday, Dec. 15, if they want their coverage to begin on Jan. 1.

Lee said the new state subsidies and the restoration of the individual mandate penalty are key reasons why this year’s new plan selections are up 16 percent over last year, with 133,092 plan selections through Dec. 7, compared to 114,306 for the same time period a year ago. In addition, more than 1.13 million existing consumers have had their plans renewed for the upcoming year. Covered California is still processing its renewals and will have a full accounting at the end of open enrollment.

More than 486,000 individuals have been determined eligible for the new state subsidy, including about 23,000 in the 400 to 600 percent range of the federal poverty level, which could extend to an individual making up to \$74,940 and family of four with a household income of up to \$154,500. Of those in this income range who have signed up through Covered California, 44 percent have been found eligible for the state financial assistance.

“This is great news, and Californians are benefiting from these new policies that are helping them get covered and stay covered,” said Secretary of California Health and Human Services and Covered California Board Chair Dr. Mark Ghaly. “Together we are increasing access to care by making coverage more affordable for hundreds of thousands of people.”

The increase in enrollment over last year is in stark contrast to what is being seen in the 38 states served by the federally facilitated marketplace. The Centers for Medicare and Medicaid Services report a drop of 4 percent from last year in those states.

“The early signs in California are that the state policies are doing just what they were intended to do — boost enrollment,” said Lee. “That means lower costs for all Californians.”

California is the first state in the nation to offer subsidies to eligible middle-income consumers who previously did not receive any financial assistance because they exceeded federal income requirements.

On average, consumers between 200 and 400 percent of the federal poverty level will be receiving \$21 per household, per month on top of their federal tax

credits. Consumers who earn between 400 and 600 percent of the federal poverty level will be receiving an average of \$460 per month, per household.

Here are a few examples of how the new state subsidies are lowering the cost of coverage for consumers:

- Don in San Jose is paying about \$2,800 per month for COBRA coverage in 2019 for him and his wife. Thanks to a state subsidy of \$1,282 per month, starting in January they will see their premium drop to \$1,900 per month next year.
- David from Northridge is currently paying \$727 per month for a Bronze plan directly from a carrier. He checked out Covered California and found that he is eligible for a new state subsidy of \$509 and will be paying \$195 per month for the same plan in 2020.
- Syd in Elk Grove is paying \$1,499 per month for a Bronze plan for him and his wife. They were considering giving up their coverage until they realized they would receive a new state subsidy of \$872 per month in 2020, which will allow them to pay \$1,184 and upgrade to a Silver plan next year.

See and download Syd's story [here](#).

“We are seeing a strong increase in new enrollment, with thousands of people signing up each day, but we believe people are still leaving money on the table,” Lee said. “If you have checked Covered California out before, check again, because you could be eligible for new financial help that will lower the cost of your coverage by hundreds of dollars a month.”

Covered California is the only place people can go to see if they qualify for federal financial assistance or the new state subsidies. An estimated 1.1 million uninsured Californians are eligible for health insurance, either through Covered California or Medi-Cal.

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, meaning consumers who do not get covered could face a penalty 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.

Covered California is working with the Franchise Tax Board, which will administer the penalty, to help alert Californians about the new law and reduce the number of uninsured people in our state.

Getting Help Enrolling

Consumers will need to sign up by Dec. 15 in order to have their coverage begin on Jan. 1. 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.

Open enrollment runs through Jan. 31, 2020.



News Release

Dec. 16, 2019

Amid a Surge in Enrollment Last Week, Covered California Extends Deadline for Jan. 1 Coverage Through Friday

- *With tens of thousands of people enrolling late last week, Covered California extended its deadline to accommodate the high demand.*
- *The new deadline to enroll is Friday, Dec. 20, for health coverage starting Jan. 1.*
- *California and five other state-based exchanges remain open through at least this week. California's open enrollment ends on Jan. 31 for coverage starting Feb. 1.*
- *Governor Gavin Newsom urged Californians to check and see if they are eligible for new financial help that is available for the first time this year.*

SACRAMENTO, Calif. — In response to a strong surge in enrollment, Covered California extended the deadline for consumers to sign up for health insurance that would start on Jan. 1. They will now have through Friday, Dec. 20, to sign up and have their coverage go into effect on New Year's Day.

“Covered California is still open for business and making sure consumers can have a health plan in place on Jan. 1,” said Covered California Executive Director Peter V. Lee. “Covered California is putting consumers first, making sure they have time to find the plan that best fits their needs.”

Beginning late last week, Covered California saw tens of thousands of people sign up for coverage on Wednesday, Thursday and Friday.

“Open enrollment is full-steam ahead, and this year's enrollment period is more important than before,” Lee said. “Sign up now and you may be eligible for new financial

help that is available for the first time, and you can avoid the possibility of paying a significant penalty for not being covered.”

Governor Gavin Newsom Amplifies Message

Governor Newsom took to social media this weekend to help remind all Californians they can get help paying for their health insurance. In [this Twitter](#) video, the governor used the holiday season as a way to spread the news about the first in the nation state subsidies that are available and that Californians have until the end of Friday to sign up for coverage that begins Jan. 1.

Restoring the Individual Mandate

California lawmakers put two new policies in place for 2020 that were designed to encourage enrollment and lower costs.

First, they restored the individual mandate penalty that was part of the Patient Protection and Affordable Care Act from 2014 to 2018, meaning consumers who do not get covered could face a penalty 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.

Covered California is working with the Franchise Tax Board, which will administer the penalty, to alert Californians about the new law and reduce the number of uninsured people in our state.

New State Subsidies

The second new policy for 2020 is new financial help for eligible Californians that will lower the cost of their coverage. Last week, Covered California announced that nearly 500,000 people who had already signed up for coverage in 2020 will be receiving the new subsidies.

On average, consumers between 200 and 400 percent of the federal poverty level will receive \$21 per household, per month on top of their federal tax credits. Meanwhile, for the first time in the nation, people who earn between 400 and 600 percent of the federal poverty level will be receiving an average of \$460 per month, per household.

“California will be making history this year, becoming the first state in the nation to make coverage more affordable for middle-income people like small-businesses owners and entrepreneurs,” Lee said. “If you have checked Covered California out before, check

again, because you could be eligible for new financial help that will lower the cost of your coverage by hundreds of dollars a month.”

Getting Help Enrolling

Consumers can easily find out if they are eligible for financial help and see which plans are available in their area by entering their ZIP code, household income and the ages of those who need coverage into Covered California’s [Shop and Compare Tool](#).

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.

California’s open-enrollment period continues through Jan. 31, 2020, but people who enroll after Dec. 20 will have their coverage start Feb. 1.

Residents of Minnesota, Rhode Island, Colorado, Massachusetts, New York and the District of Columbia should visit www.HealthCare.gov to be directed to their state exchange to enroll. Enrollment in Idaho’s health exchange ends today.



News Release

Dec. 18, 2019

Covered California Releases New Enrollment Data and Issues Reports on Five Years of Improving Affordability, Access and Accountability

- *Covered California announced that there are more than 230,000 new plan selections during the current open enrollment period – up approximately 16 percent over this time last year. More than 1.15 million people have also renewed their coverage.*
- *In addition, more than 540,000 people will receive new state subsidies that will make quality health care coverage more affordable in 2020.*
- *The agency also released two extensive reports that detail Covered California's impacts on lowering costs and assuring quality care in its implementation of the Affordable Care Act.*
- *Since 2013, California has reduced its uninsured rate by more than any other state in the nation has by expanding Medi-Cal, investing in marketing and outreach and keeping costs low for consumers.*
- *California's individual market consistently ranks among the healthiest in the nation, helping unsubsidized consumers save about \$1,550 annually in 2018 on their premiums compared to consumers in the federal marketplace.*
- *Covered California's open-enrollment period runs through Jan. 31. Consumers must sign up before the end of Dec. 20 for their coverage to start on Jan. 1. California is one of 10 state marketplaces that are still open for business, representing 28 percent of Americans.*

SACRAMENTO, Calif. — Following the close of open enrollment in 38 states served by the federally facilitated marketplace, Covered California released new data at the halfway point of its current open-enrollment period and issued two extensive reports

that detail the results of its efforts to lower costs, hold health plans accountable and assure consumers receive quality health care.

A total of 230,000 consumers have selected a plan through Dec. 16, which is an increase of approximately 16 percent. In addition, more than 1.15 million existing consumers have renewed their plans for the upcoming year, giving Covered California approximately 1.38 million plan selections for 2020. Covered California is only halfway through its open enrollment period and still processing its renewals. A full accounting and comparison will be available after open enrollment closes.

“California has acted on its commitment to help people get good coverage that they can afford,” said Covered California Executive Director Peter V. Lee. “The new state subsidies build on and go beyond the Affordable Care Act and restore the individual mandate penalty, and we are seeing the positive results of those policies as we approach one of our key deadlines. In the past week, Covered California saw thousands of people come through its doors, with the majority receiving new financial help from the state, from federal tax credits, or from both.”

Starting in 2020, California will be providing financial help to eligible consumers. It is the first state to offer subsidies to many middle-income consumers who previously did not receive any financial assistance because they exceeded federal income requirements.

More than 540,000 people have been determined eligible for the new state subsidy, including about 28,000 in the middle-income range of 400 to 600 percent of the federal poverty level, which could extend to an individual making up to \$74,940 and a family of four with a household income of up to \$154,500. Of those in this income range who have signed up through Covered California, 46 percent have been found eligible for the state subsidies.

“In 2019, California led the nation in enacting progressive health care reforms — taking a big step toward universal coverage and passing first-in-the-nation measures to make health care more affordable for families,” said Gov. Gavin Newsom. “The contrast with what is happening in Washington couldn’t be clearer. While the federal government is trying to roll back the Affordable Care Act and take away coverage, California is building on the success of the Affordable Care Act and creating a healthier state.”

The data release comes on the same day that Covered California issued two new reports that detail how California has used all the tools of the Affordable Care Act to benefit millions of Californians. The first report, [“Covered California’s First Five Years: Improving Access, Affordability and Accountability,”](#) highlights the key strategies undertaken by the state and Covered California to hold health insurance companies accountable, lower costs and build on the Affordable Care Act. The other report, [“Covered California Holding Health Plans Accountable for Quality and Delivery System Reform,”](#) summarizes how the 11 health insurance companies Covered California

contracts with have met the contractual requirements imposed on them to foster better quality, healthier populations and lower costs, with particular attention to health equity and their efforts to promote changes in how health care is delivered.

In addition to the two reports, Covered California released a [chart pack](#) that illustrates many of the improvements made in the past five years.

“These reports are important because implementing the Affordable Care Act effectively is not about just one open-enrollment period or changes of one year to the next,” said Lee. “These reports detail the actions taken over five years and the impacts of those actions, demonstrating how California has put consumers first, saving individual Californians thousands of dollars and holding health insurance companies accountable. These results show the Affordable Care Act going strong and working well in California despite concerted national efforts to take us and the rest of the nation backward.”

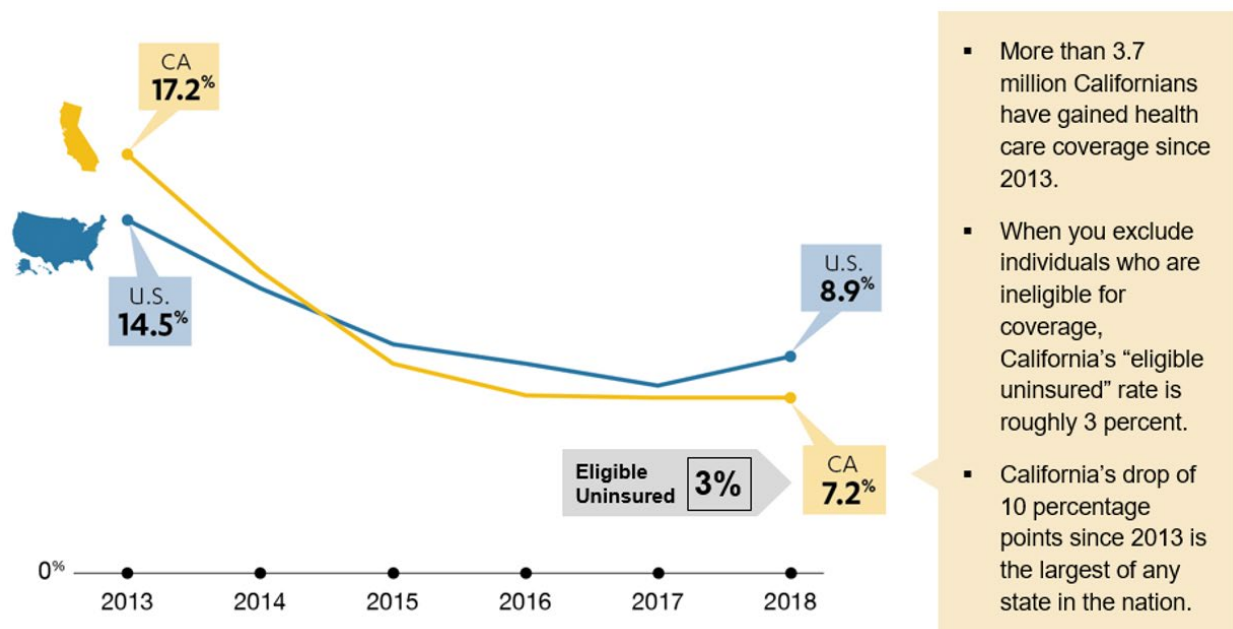
Together the reports show how California implemented the Affordable Care Act — by expanding Medicaid and establishing a state-based marketplace in Covered California — and went beyond the law by providing state-funded subsidies and restoring the individual mandate.

Nation’s Largest Drop in Uninsured

One of the key goals of the Affordable Care Act was to expand coverage. California’s uninsured rate decreased from 17.2 percent in 2013 before the implementation of the Affordable Care Act to 7.2 percent in 2018, representing the largest overall drop in the nation, with 3.7 million people gaining coverage during that time. Taking into consideration the fact that a large portion of the remaining uninsured are undocumented and therefore ineligible for state and federal programs, California’s eligible uninsured rate is approximately 3 percent (see Figure 1: Comparison of California and National Uninsured Rate, 2013-2018).

“California embraced the Affordable Care Act, and it is working well for millions of people,” Lee said. “Covered California was built by Californians for Californians, we are a public entity that is holding plans publicly accountable for delivering quality and cost-effective care.”

Figure 1: Comparison of California and National Uninsured Rate, 2013-2018



The People Behind the Numbers

One of those consumers who got covered is Sheila, an entrepreneur from Oakland. A free preventive care visit revealed that she was prediabetic, and she immediately began to get the care she needed to get healthy and stay healthy. You can watch and download Sheila's story [here](#).

The covers of the two reports issued include the images of dozens of consumers helped by Covered California. Their stories and those of others that put faces on the numbers in the reports can be found at <https://www.coveredca.com/real-stories/>.

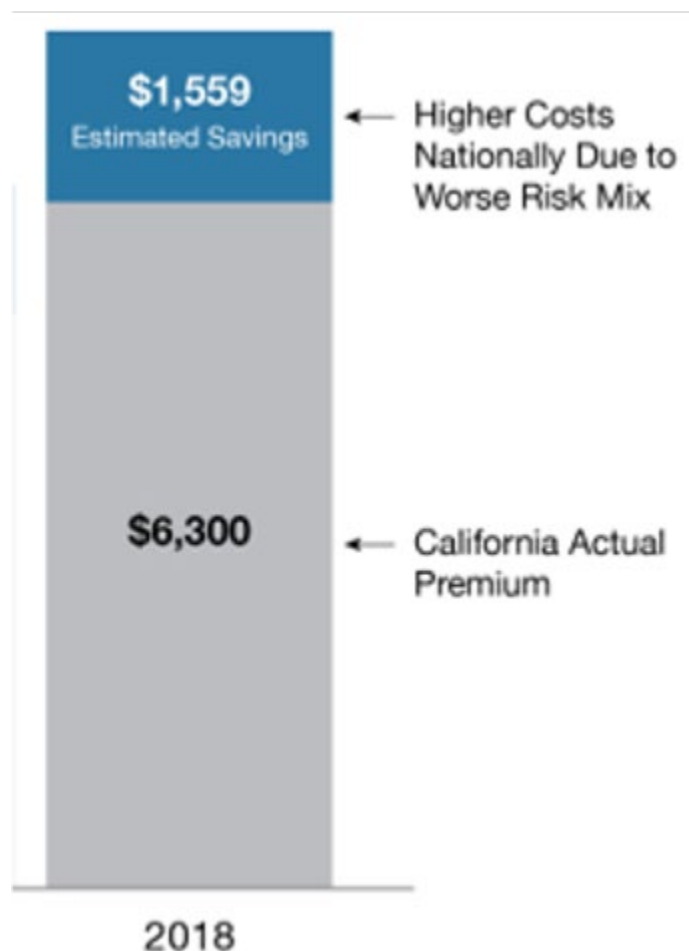
"We continue to see what is possible when you focus on getting the best value for your consumers, when you hold health plan issuers accountable and work to increase enrollment," Lee said. "While Covered California's first five years of work have led to significant improvements in quality and savings for consumers, we have just begun to make meaningful change for Californians."

****Lower Costs for Consumers and the Federal Government ****

California's historic drop in its uninsured rate is due in part to Covered California's significant investments in marketing and outreach to educate and enroll consumers. By enrolling more people, on average the total group insured is healthier, which means they are lower-cost than if they were a smaller number with a higher concentration of sicker individuals. The most recent data shows California had the third-lowest "average

plan liability risk score” in 2018, placing it among the five healthiest state populations for the fifth year in a row.

Figure 3: California’s Healthier Risk Mix Leading to Lower Premiums for Unsubsidized Insureds



California’s actions to promote enrollment, encourage retention and foster stability in the marketplace have resulted in a consistently healthier risk mix that has caused California to have 20 percent lower costs on average than if the state had the same risk mix as the rest of the nation. In 2018, this meant unsubsidized consumers saved an average of \$1,559 per year on their coverage (see Figure 3: California’s Healthier Risk Mix Leading to Lower Premiums for Unsubsidized Insureds), compared to what they would have spent if California had the same risk mix as the rest of the nation. Overall, California’s healthier risk mix resulted in estimated savings to enrollees and the federal government of \$12.5 billion from 2014 to 2018.

“The reality is that millions of Americans are dealing with the repercussions of federal decisions to cut back on marketing and outreach while promoting cheap, subpar

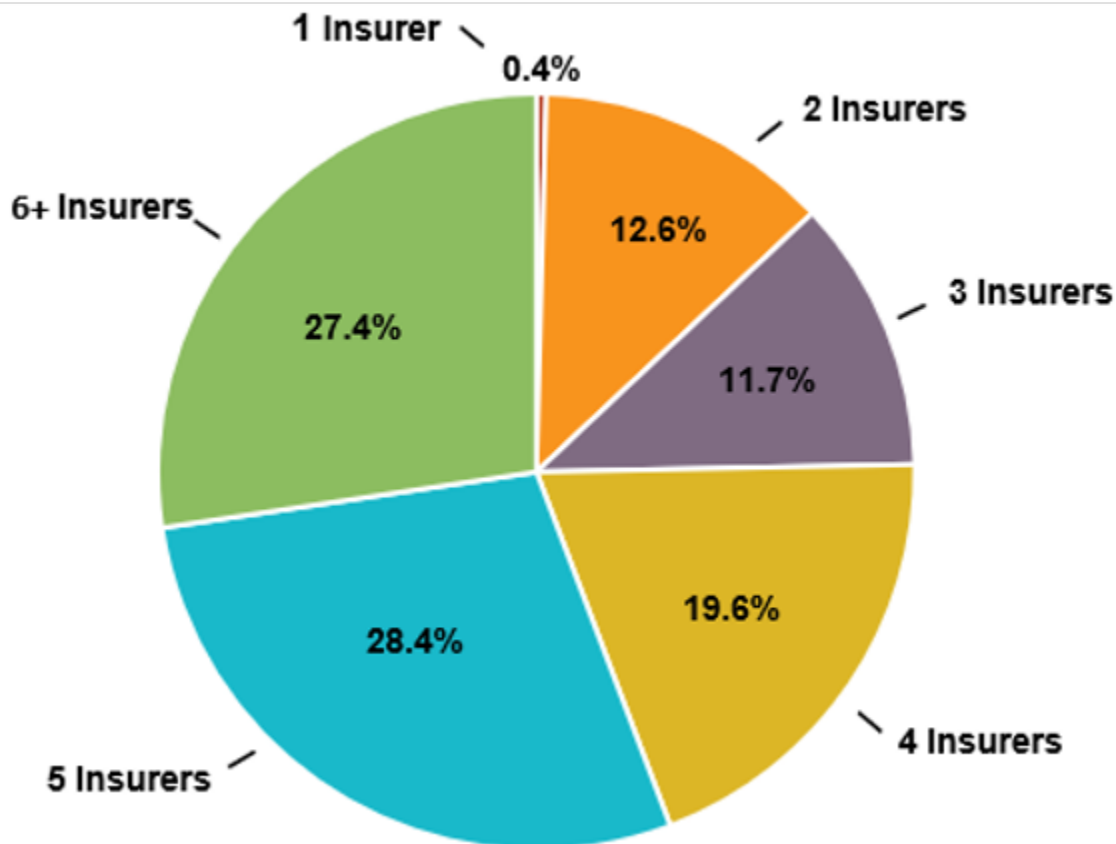
coverage,” Lee said. “The result is that many consumers the nation, particularly those in states that rely on the federal marketplace, have been priced out of coverage as the unsubsidized individual markets have become in effect expensive high-risk pools, and some have opted to buy short-term or other non-Affordable Care Act insurance products. These consumers are gambling on what is often junk coverage that excludes those with pre-existing conditions and won’t be there to cover expensive care that some of them will need.”

Consumer Choice, Competition and Stability

Since first launching in 2014, Covered California has conducted active and extensive vetting and negotiations with health insurance companies to ensure that consumers have a choice among multiple insurers that are stable and provide value. The result has been continuous participation by 10 health insurance companies, with an additional insurer joining in 2016. The stability and robust competition in the marketplace promote choice, which also helps keep costs low for consumers.

In 2020, not only will nearly all consumers be able to choose from two or more plans, but 75 percent will have four or more choices, and more than half of consumers (56 percent) will be able to choose from five plans or more (see Figure 4: Number of Health Plans Available to Covered California Consumers).

Figure 4: Number of Health Plans Available to Covered California Consumers



“California’s individual insurance market is robust and competitive, with consumers able to vote with their feet,” Lee said. “We have nonprofit, for-profit, public and privately-run health plans competing with one another, and Covered California holds them all accountable in delivering quality care.”

Meaningful Coverage

The Affordable Care Act established new rules for insurers, such as protections for those with pre-existing conditions, new annual or lifetime limits on benefits and standards for comprehensive coverage. Covered California goes beyond this new floor and also negotiates “patient-centered” benefit designs to promote access, enable comparison shopping and provide “first-dollar” coverage for all outpatient services — meaning care that does not need to meet the deductible — for the majority of its consumers. Currently, more than 70 percent of Covered California enrollees are in plans where most outpatient care, such as primary care visits, outpatient services and lab tests are not subject to a deductible.

The People Behind the Numbers

One consumer who benefited from Covered California's coverage was Charly from La Mesa. The little girl suffered severe bruising on her arms after playing in the pool. Blood tests showed that Charly had leukemia and she quickly began undergoing chemotherapy and other treatments which totaled \$275,000 in the first six months. [Watch and download Charly's story.](#)

The state also took the important step of working to protect the stability of the individual market by banning short-term plans, which are being recommended by Navigators in the federally facilitated marketplace. These plans have coverage caps, provide no mental health coverage, can deny coverage based on applicants' pre-existing conditions and can expose consumers to risk of rescission.

"Short-term plans can short-change consumers," Lee said. "It's no mystery: Coverage is cheaper when you strip out all the benefits and protections of the Affordable Care Act."

Covered California also recently announced it would require any insurance agent that is certified to sell its products, and makes available health sharing ministries, be required to alert consumers about the dangers sharing ministries "products" which are not regulated, not considered insurance and could leave people exposed to high medical bills.

Holding Health Plans Accountable

The Affordable Care Act established standards for health plans, including setting limits on what plans can spend on administration, executive compensation and profits, and some reporting requirements related to issuer activities to address quality. Covered California goes beyond these standards to actively foster a market that works for consumers, holding health plans accountable for delivering quality care, addressing health care disparities and promoting changes in the delivery of care that will benefit all Californians.

In "[Covered California Holding Health Plans Accountable for Quality and Delivery System Reform](#)", Covered California summarizes the performance of its 11 health insurance companies over their first five years of providing services. The report details plan-specific performance information on clinical measures, patients' reported experience with care and on how the companies are addressing Covered California's requirements to reduce health care disparities, change payments and engage in collaborative initiatives to improve care across the entire population.

The report finds that some health insurers' clinical and patient-reported performance ranks among the very best in the nation — particularly Kaiser Permanente and Sharp Health Plan — while among the other plans there is wide variation depending on the performance measure. Covered California identified areas for improvement and is using this information to inform a major revision to its contracts that are now in development.

The expectations for health insurance companies go beyond just their reporting on standard performance indicators. For example, health insurance companies are required to provide consumers tools to understand the costs of treatments they are considering (with tools available now to virtually all Covered California enrollees). The companies must change their payments to providers over time to move from fee-for-service arrangements to promoting value. Additionally, the companies must promote enrollment in systems of care that foster coordination, such as accountable care organizations.

“Thanks to the continued efforts of Covered California to push its participating health plan issuers to improve quality and promote delivery system reform, California leads the country in terms of participation in integrated delivery systems and accountable care organizations,” said Elliott Fisher, professor of Health Policy at the Dartmouth Institute and an advisor to Covered California.

Covered California also details how it has aligned with other stakeholders to help achieve important gains in hospital patient safety, such as reducing hospital-acquired infections, reducing unnecessary caesarean sections and improving the treatment of opioid use disorders.

Appreciation for Broad Engagement and Dedication to Bernard J. Tyson

In a letter to introduce the report on Covered California’s first five years, Peter Lee acknowledged the fact that California’s progress is the result of engagement by thousands, with particular recognition to Bernard J. Tyson, the recently passed away CEO of Kaiser Permanente:

There have been many individuals and organizations that have contributed to Covered California’s achievements to the benefit of California consumers — policymakers, health insurers, consumer advocates, counties, community-based organizations and agents, to name a few. This said, Covered California specially dedicates this report to Bernard J. Tyson CEO, of Kaiser Permanente, who recently passed away. Bernard embodied unparalleled passion and leadership. His work to transform health care delivery, and his drive for justice in health care and quality have left a lasting imprint on California and the nation.

“Every state and the federal government can do what California has done to maintain the core principles of the Affordable Care Act, which means good benefit designs, no coverage caps and guaranteeing coverage for those with pre-existing conditions,” Lee said. “The sad reality is that in the past few years, many federal actions have sought to take the nation back to the pre-Affordable Care Act world of unaccountable health plans and costs for health care that were out of reach for many millions of consumers.”

Open Enrollment in California

The reports come out during the middle of Covered California's open-enrollment period and when nine other states are continuing to enroll consumers. Consumers who need health insurance have through Dec. 20 in order to get coverage that begins 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.

Open enrollment in California runs through Jan. 31, 2020. In addition, the state of California restored the penalty for consumers who can afford health care coverage but choose to remain uninsured. Those who go without coverage in 2020 could be subject to a penalty when they file their state taxes with the Franchise Tax Board.

Open Enrollment in Other States

Nationally, several states announced open-enrollment extensions this week. California is now one of 10 marketplaces, representing about 28 percent of the nation's population, that will continue to allow people to sign up for health care coverage to take effect in 2020.

The following state marketplaces remain open for residents to enroll in coverage for 2020 (listed in order of enrollment cutoff):

1. **Nevada:** [Nevada Health Link](#) is allowing consumers who have started an application until Dec. 20 to enroll and get Jan. 1 coverage. Contact Janel Davis at j-davis@exchange.nv.gov or (775) 687-9934 for more information.
2. **Minnesota:** Minnesota's [MNSure](#) will enroll consumers through Dec. 23. Contact Marie Harmon at Marie.Harmon@state.mn.us for more information.
3. **Washington:** [Washington Healthplanfinder](#) extended its open-enrollment period through Dec. 30. Contact Shawna Bruce at shawna.bruce@wahbexchange.org for more information.
4. **Rhode Island:** Rhode Island's [HealthSourceRI](#) will be accepting applications through Dec. 31. Contact Robin Dionne at robin.dionne@exchange.ri.gov or (401) 383-5542, ext. 5542, for more information.

5. **Colorado:**[Connect for Health Colorado](#) extended its deadline for Jan. 1 coverage until tonight. The exchange's open-enrollment period runs through Jan. 15. Contact Monica Caballeros at mcaballeros@c4hco.com or (720) 496-2574.
6. **Connecticut:** Connecticut's [Access Health CT](#) extended its open-enrollment period through Jan. 15. Contact Kathleen Tallarita at Kathleen.Tallarita@ct.gov or (860) 757-5339 for more information.
7. **Massachusetts:** The [Massachusetts Health Connector](#) will be accepting applications through Jan. 23. Contact Jason Lefferts at (617) 933-3141 for more information.
8. **New York:**[New York State of Health's](#) open-enrollment period runs through Jan. 31. The exchange can be contacted at press@health.ny.gov or (518) 474-7354, Ext. 1.
9. **The District of Columbia:** The District of Columbia of Columbia's [DC Health Link](#) extended its deadline for Jan. 1 coverage until tonight. The exchange's open-enrollment period runs through Jan. 31. Contact Linda Wharton-Boyd at Linda.Wharton-Boyd@dc.gov or (202) 741-5201.



News Release

Dec. 20, 2019

New Enrollment Data Shows Relative Stability in Federal Marketplace After Three Years of Major Declines, Putting a Spotlight on Covered California’s Growth in New Enrollment

- *Despite the stability of the federal marketplace from 2019 to 2020, there are 1.3 million fewer Americans enrolled than there were in 2016.*
- *In addition, the number of new consumers signing up for coverage has dropped by nearly 50 percent since 2016.*
- *By comparison, Covered California is only partially through its open enrollment period and new plan selections for 2020 are up approximately 16 percent, bolstered by policies that embrace the Affordable Care Act.*
- *Californians have until the end of Friday, Dec. 20 to sign up for coverage that starts Jan. 1, and open enrollment continues through Jan. 31, 2020.*

SACRAMENTO, Calif. — New preliminary data from the Centers for Medicare and Medicaid Services indicates that the federal marketplace saw relatively stable enrollment during the open-enrollment period that closed Wednesday, following three years of very significant declines, particularly among new enrollees. Overall, enrollment in the federal marketplace has declined from 9.6 million in 2016 to 8.3 million in 2020, a drop of 14 percent. In addition, new enrollment has dropped from 4 million in 2016 to 2.1 million in 2020, a decrease of 49 percent.

“While things may appear to be holding steady in the federal marketplace, this is not a one-year story, as millions of people have been priced out of coverage by federal policies that have hurt enrollment,” said Covered California Executive Director Peter V. Lee. “The lack of marketing and outreach at the federal level means fewer healthy

people have enrolled, driving up premiums and forcing unsubsidized people to either drop their coverage or sign up with junk plans.”

The federal marketplace, which handles Affordable Care Act enrollment in 38 states, wrapped up its open-enrollment period on Wednesday, which was extended by more than two days because of technical problems on www.healthcare.gov. Compared to last year, new enrollment increased by 2 percent, while the number of renewing consumers dropped 3 percent. Overall enrollment decreased by 2 percent compared to last year.

It is important to note that this data is not final and does not account for the fact that the federal marketplace no longer includes Nevada, which transferred to a state-based marketplace for 2020, and that Maine and Virginia expanded their Medicaid programs, meaning those eligible consumers would not need to purchase coverage on the federal marketplace.

However, the slight increase in year-to-year new enrollment contrasts with the steep losses the federal marketplace has seen recently.

“New enrollment is the lifeblood of any individual market because those consumers who are not signing up are more likely to be healthier, which means a sicker risk mix and higher premiums for everyone” Lee said. “In California, we have enacted new policies and our marketplace has shown stability in the face of multiple policies that are aimed at undercutting the Affordable Care Act.”

While Covered California is a little more than halfway through its open enrollment period, which runs through Jan. 31, the exchange recently reported that 230,000 new consumers had signed up for coverage through Dec. 16. The total is approximately 16 percent over last year’s total at the same time.

Lee noted that Covered California saw a 31 percent decline in new enrollments from 2016-2019. However, most of that came during the 2019 open enrollment period after Congress removed the individual mandate penalty. From 2016-2018 Covered California saw only a 9.2 percent decrease in new enrollment, compared to a drop of 38.9 percent in the federal marketplace.

“Policies matter and the decisions at the federal level have undercut the Affordable Care Act across the country,” Lee said. “California remains an example of what the Affordable Care Act can do – and is doing – when it is allowed to work.”

Last week, Covered California released two extensive reports which detailed how the state has used all the tools of the Affordable Care Act to benefit millions of Californians. The first report, [“Covered California’s First Five Years: Improving Access, Affordability and Accountability,”](#) highlights the key strategies undertaken by the state and Covered California to hold health insurance companies accountable, lower costs and build on the

Affordable Care Act. The other report, "[Covered California Holding Health Plans Accountable for Quality and Delivery System Reform](#)," summarizes how the 11 health insurance companies Covered California contracts with have met the contractual requirements imposed on them to foster better quality, healthier populations and lower costs, with particular attention to health equity and their efforts to promote changes in how health care is delivered.

In addition to the two reports, Covered California released a [chart pack](#) that illustrates many of the improvements made in the past five years.

"These reports are important because implementing the Affordable Care Act effectively is not about just one open-enrollment period or changes of one year to the next," said Lee. "These reports detail the actions taken over five years and the impacts of those actions, demonstrating how California has put consumers first, saving individual Californians thousands of dollars and holding health insurance companies accountable. These results show the Affordable Care Act going strong and working well in California despite concerted national efforts to take us and the rest of the nation backward."

California Enacts New Policies to Encourage Enrollment

While the open-enrollment period in the federal marketplace is closed, Californians can still sign up for coverage. Those who enroll before the end of today will have their coverage start on Jan. 1. Covered California's open-enrollment period runs through Jan. 31.

Heading into the new year, California lawmakers put two new policies in place for 2020 that were designed to encourage enrollment and lower costs.

First, they restored the individual mandate penalty that was part of the Affordable Care Act from 2014 to 2018, meaning consumers who do not get covered could face a penalty 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.

Covered California is working with the Franchise Tax Board, which will administer the penalty, to alert Californians about the new law and reduce the number of uninsured people in our state.

The second new policy for 2020 is new financial help for eligible Californians that will lower the cost of their coverage. Last week, Covered California announced that nearly 540,000 people who had already signed up for coverage in 2020 will be receiving the new subsidies.

On average, consumers between 200 and 400 percent of the federal poverty level will receive \$21 per household, per month on top of their federal tax credits. Meanwhile, for the first time in the nation, people who earn between 400 and 600 percent of the federal poverty level will be receiving an average of \$460 per month, per household.

Californians Can Still Enroll

While the open enrollment period in the federal marketplace is closed, Californians can still sign up for coverage. Those who enroll before the end of Friday, Dec. 20 will have their coverage start on Jan. 1. Covered California's open enrollment period runs through Jan. 31.

Consumers can easily find out if they are eligible for financial help and see which plans are available in their area by entering their ZIP code, household income and the ages of those who need coverage into Covered California's [Shop and Compare Tool](#).

Those interested in learning more about their coverage options can:

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Open Enrollment in Other States

Nationally, several states announced open-enrollment extensions this week. California is now one of 10 marketplaces, representing about 28 percent of the nation's population, that will continue to allow people to sign up for health care coverage to take effect in 2020.

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2. **Minnesota:** [MNsure](#) will enroll consumers through Dec. 23. Contact Marie Harmon at Marie.Harmon@state.mn.us for more information.

3. **Washington:**[Washington Healthplanfinder](#) extended its open-enrollment period through Dec. 30. Contact Shawna Bruce at shawna.bruce@wahbexchange.org for more information.
4. **Rhode Island:**[HealthSourceRI](#) will be accepting applications through Dec. 31. Contact Robin Dionne at robin.dionne@exchange.ri.gov or (401) 383-5542, ext. 5542, for more information.
5. **Colorado:**[Connect for Health Colorado](#) extended its deadline for Jan. 1 coverage until tonight. The exchange's open-enrollment period runs through Jan. 15. Contact Monica Caballeros at mcaballeros@c4hco.com or (720) 496-2574.
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8. **New York:**[New York State of Health's](#) open-enrollment period runs through Jan. 31. The exchange can be contacted at press@health.ny.gov or (518) 474-7354, Ext. 1.
9. **The District of Columbia:**[DC Health Link](#) extended its deadline for Jan. 1 coverage until tonight. The exchange's open-enrollment period runs through Jan. 31. Contact Linda Wharton-Boyd at Linda.Wharton-Boyd@dc.gov or (202) 741-5201.



News Release

Dec. 23, 2019

New Health Laws for 2020 to Start on Jan. 1, Including Requirement That Californians Have Health Insurance

- *Californians are encouraged to enroll by Jan. 31 or face a penalty if they choose to go without health care coverage in 2020.*
- *The penalty, which can be \$2,000 or more for a family of four, will be applied starting Jan. 1.*
- *The penalty — enacted in state law and administered by the California Franchise Tax Board — remains in place despite the recent U.S. Circuit Court ruling in the federal Affordable Care Act case.*
- *There is new financial help available to eligible consumers, including middle-income consumers who previously did not receive any assistance.*
- *More than 540,000 people have already been found eligible for the new financial help.*

SACRAMENTO, Calif. — While a federal court ruling last week leaves the federal individual mandate in legal limbo, Californians are reminded that a state law will take effect on Jan. 1 requiring all Californians to have health insurance.

“Open enrollment is underway right now. That means now is the time to sign up for a quality health plan through Covered California so you are protected in case you get sick or injured, and so you do not have to worry about a possible penalty,” said Covered California Executive Director Peter V. Lee. “Writing a check to the Franchise Tax Board when you file your 2020 taxes isn’t the real penalty — it’s getting hurt or ill and ending up with \$50,000 hospital bill.”

California created a new state individual mandate penalty that is similar to the Patient Protection and Affordable Care Act's penalty. It will be administered by the Franchise Tax Board (FTB) and collected when people file their 2020 taxes starting in 2021.

"It's important that everyone acts now to get health insurance starting in January 2020 to avoid the penalty when filing state tax returns in 2021," said FTB Executive Officer Selvi Stanislaus.

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.

The return of the penalty was an important element in Covered California's record-low rate change of 0.8 percent in 2020, meaning consumers have already benefited from the new policy.

New Financial Help

In addition to the penalty, California is making new financial help available to eligible consumers to help further lower the cost of their coverage. On average, consumers between 200 and 400 percent of the federal poverty level will receive \$21 per household, per month on top of their federal tax credits. Meanwhile, for the first time in the nation, people who earn between 400 and 600 percent of the federal poverty level will be receiving an average of \$460 per household, per month.

"More than half a million Californians have already found out they will benefit from this new money," Lee said. "Consumers have through the end of January to see what plans are available to them and whether they qualify for financial help from the federal government, the state, or both."

Gov. Gavin Newsom also reiterated his support of the Affordable Care Act when he joined Covered California during a teleconference last week.

"The Affordable Care Act is alive and well here in the state of California," Newsom said. "We are saving lives, we're expanding coverage, we're deepening subsidies, and we're doubling down on our commitment to fulfill the law's promise and its potential."

Californians already set to benefit from the state subsidy program include:

- Yuriana and Hector, who say their daughter is a Covered California miracle because without their health insurance they would not have been able to afford getting pregnant.

Watch and download Yuriana and Hector's story [in Spanish](#) or [in English](#).

- Shannon and John, who were surprised when they received the news in the mail that they would be saving more than \$1,200 a month because of the new state subsidies. Now they are able to focus on completing a longtime dream.

Watch and download [Shannon and John's story](#).

“We do not want people to miss out on this opportunity. We don’t want them to leave money on the table, and we don’t want them to get stuck with a big bill when they pay their taxes in 2021,” Lee said.

Recent Court Ruling

California’s individual mandate and penalty remain in place as state leaders prepare to respond to the recent ruling by a three-judge panel of the U.S. 5th Circuit Court of Appeals. On Wednesday, the panel ruled that the individual mandate was unconstitutional, but remanded the case to a lower court.

“The court ruling will not impact California and should not deter anyone from signing up during the current open-enrollment period,” Lee said. “The legal battle will continue for the foreseeable future, and Covered California will be working to educate people about the penalty and enroll as many as possible.”

Getting Help Enrolling

Consumers can easily find out if they are eligible for financial help and see which plans are available in their area by entering their ZIP code, household income and the ages of those who need coverage into Covered California’s [Shop and Compare Tool](#).

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.

California’s open-enrollment period continues through Jan. 31, 2020.

New Health Laws for 2020

Critical new laws will affect Californians and their health care in 2020.

Senate Bill (SB) 106 provides the appropriations for the state subsidy program, along with income eligibility and specified funding allocation by eligibility levels. (SB 106, Committee on Budget and Fiscal Review, Chapter 55, Statutes of 2019.)

SB 78 is the omnibus health trailer bill that establishes the individual mandate and penalty, as well as the requirements for the state subsidy program. (SB 78, Committee on Budget and Fiscal Review, Chapter 38, Statutes of 2019.)

Assembly Bill (AB) 1309 expands the individual market open-enrollment period to Nov. 1 to Jan. 31. It sets Feb. 1 as the effectuation date for those who enroll between Dec. 16 and Jan. 31. This will give consumers additional time to sign up for coverage, thereby helping more Californians to become insured. (AB 1309, Bauer-Kahan, Chapter 828, Statutes of 2019.)

AB 5 limits California companies' use of workers as independent contractors rather than as employees. This bill may affect the provision of health insurance to these employees. (AB5, Gonzalez, Chapter 296, Statutes of 2019.)

SB 104 authorizes the provision of full-scope Medi-Cal to adults aged 19-25 regardless of their immigration status. (SB 104, Committee on Budget and Fiscal Review, Chapter 67, Statutes of 2019.)

SB 276 standardized the provision of medical exemptions for vaccination by requiring the California Department of Public Health to develop a statewide electronic request form, tracking school immunization levels and addressing physicians who submit an unusually high number of medical exemption forms. (SB 276, Pan, Chapter 278, Statutes of 2019.)



News Release

Jan. 9, 2020

With New Research Showing Californians Are Still Unaware of a Penalty for Going Without Health Coverage, Franchise Tax Board Chair Betty T. Yee and Covered California Urge Californians to Get Covered Right Away

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- *A new survey shows 56 percent of uninsured Californians are unaware that California requires its residents to have health care coverage in 2020 or face a penalty.*
 - *The survey found that avoiding the penalty motivates those with health insurance to keep their coverage and encourages the uninsured to sign up.*
 - *Most people surveyed, including 62 percent of those uninsured, are not aware that they can get financial help to pay for their health coverage in 2020.*
 - *In addition, most of the uninsured have not checked to see if they are eligible for the financial help offered through Covered California.*

SACRAMENTO, Calif. — Covered California Executive Director Peter V. Lee and State Controller and Franchise Tax Board Chair Betty T. Yee urged Californians on Thursday to get health coverage to avoid paying the new penalty now in effect for 2020. Their urging comes as new research released by Covered California shows that many still do not know about the law that took effect on Jan. 1.

The research also shows that many of those without health coverage do not know there is more financial help than ever before to buy health insurance, including new help for middle-income Californians.

“We all have work to do to make sure people in California know that if they can afford health insurance, they have to buy it this year or they will face a penalty next year,” said Covered California Executive Director Peter V. Lee. “Open enrollment is underway, and there’s more help than ever before. Now is the time to enroll to avoid the penalty and ensure you have the coverage you need.”

Controller Yee, who joined Lee at Thursday’s press conference, said taxpayers need to be aware of the penalty, known as the Individual Shared Responsibility Penalty, so they can take steps to avoid it when they file their taxes next year.

“I encourage everyone to secure qualifying health care coverage as soon as possible so they are not surprised with a state penalty when filing 2020 state tax returns in 2021,” Yee said. “There are lots of ways to get coverage, including through Covered California, where open enrollment continues through Jan. 31, and I urge you to look at all the options to get coverage as soon as you can.”

For those facing a penalty, a family of four could pay at least \$2,000 for not having health insurance. Controller Yee said there is an [estimator](#) on the Franchise Tax Board website to assist consumers in understanding what they could pay. In addition, Covered California and Franchise Tax Board have developed a [fact sheet](#) with more information about the penalty.

For 2020, Gov. Newsom and the state Legislature are making new financial help available to eligible consumers to help further lower the cost of their coverage. More than 500,000 Californians have already qualified for the new subsidies.

A market research [report released by Covered California](#), “Californians’ Understanding of the Mandate to Have Health Coverage and the Awareness of Financial Help,” was conducted by Greenberg Brand Strategy from Dec. 6 to 18, 2019.

Among the findings:

- 1. Many Californians — especially the uninsured — are unaware of the state penalty.**

Many Californians reported being unaware of the requirement to have health insurance coverage in 2020 or else pay a penalty, including a majority of the *uninsured* (56 percent).

2. The uninsured are more likely to enroll in coverage if they are aware of the state mandate.

Among the *uninsured*, 64 percent are more likely to enroll in health insurance to avoid the penalty. This is an increase of intent to enroll from 46 percent when *uninsured* respondents were asked at the beginning of the survey whether they plan to have health coverage in 2020.

The state mandate encourages already insured Californians to keep their coverage.

Among the *insured* population, almost all respondents (91 percent) will keep their health insurance in 2020, and almost half (46 percent) state that avoiding the penalty is a factor in maintaining their coverage.

3. Many uninsured people are unaware that financial help is available.

Among the *uninsured*, 62 percent are unaware that Covered California offers financial help to help pay for health insurance.

4. The uninsured are even less likely to know about the new financial help.

Among the *uninsured*, only 27 percent are aware that Californians can receive even more financial help than ever before for health coverage, compared to the 38 percent who generally know that financial help is available.

5. Many uninsured Californians who could get financial help are not finding out if they are eligible.

Nearly all the *uninsured* respondents surveyed (93 percent) could qualify for financial help. However, most uninsured respondents (62 percent) have not looked to see if they qualify for financial help.

6. Uninsured Californians are far more likely to enroll in coverage if given financial help.

More than two-thirds of *uninsured* respondents stated that subsidies of \$500 per month would make them likely to enroll in a health plan.

Uninsured middle-income Californians (making between 401 and 600 percent of the federal poverty level) are even more likely to enroll in coverage if they knew they were eligible for a \$500 per month subsidy.

The average subsidy for eligible consumers earning less than 400 percent of the federal poverty level is \$447 per month; the average state subsidy for eligible middle-income consumers is \$460 per month.

With research showing that most of the uninsured have not checked to see if they are eligible for financial help, Lee encouraged Californians to look into it.

“You can find out in just a few minutes whether you are eligible for financial help from the federal government, the state, or both,” Lee said. “Do not leave money on the table; do not put yourself at risk if you get sick or ill; do not get stuck with a big bill when you pay your taxes in 2021.”

Lee said the population of the uninsured changes every year: With new people turning 26, moving to the state or leaving employer-based coverage to work on their own, there is a new group of Californians to inform every year. That group now includes people with higher incomes who qualify for financial help for the first time.

“California made a commitment to encourage more people to get covered through the penalty and by making that coverage more affordable through new financial help,” Lee said. “Together the penalty and new subsidies are powerful tools to making sure that Californians follow the law and sign up for a health insurance plan that will protect them and their family. We want to make sure they know about it.”

Californians Can Still Enroll

Covered California’s open-enrollment period runs through Jan. 31. Consumers can easily find out if they are eligible for financial help and see which plans are available in their area by entering their ZIP code, household income and the ages of those who need coverage into Covered California’s [Shop and Compare Tool](#).

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

Jan. 16, 2020

Covered California Continues to See Strong Interest and Reminds Consumers That Penalty Is Back for 2020 as Open-Enrollment Deadline Approaches

- *More than 269,000 consumers have newly enrolled during the current open-enrollment period, which continues in California through Jan. 31.*
- *A new law requires Californians to have health insurance in 2020 or face a penalty when they file their taxes with the Franchise Tax Board in 2021.*
- *The penalty can be \$2,000 or more for a family of four.*
- *New research shows that many Californians, particularly the uninsured, are unaware of the new penalty or the new financial help that is available for the first time this year.*

SACRAMENTO, Calif. — Covered California announced new data as it approaches the final two weeks of the annual open-enrollment period and reminded consumers about the new state penalty and additional financial help that went into effect with the new year.

As of Saturday, Jan. 4, more than 269,000 consumers had newly signed up for health insurance through Covered California during the current open-enrollment period, which is an increase of 18 percent above the number of consumers who had enrolled at this time last year. In addition, more than 1.15 million existing Covered California members have renewed their coverage for 2020.

“Covered California continues to sign up thousands of people every day, but time is running out, so you need to act now if you want health insurance this year,” said Covered California Executive Director Peter V. Lee. “We know that deadlines matter to

people. Californians have through the end of the month to sign up and select a plan that will protect them and their families.”

The open-enrollment period runs through Jan. 31. It is the one time of the year when consumers can freely sign up for coverage without having to experience a qualifying life change. People who sign up by the deadline will have their coverage start on Feb. 1.

Having a health insurance plan in place this year is critical because of a new law that the state of California enacted that requires Californians to have coverage in 2020. Those who can afford coverage, but choose to go without it, could face a penalty when they file their taxes with the California Franchise Tax Board in 2021. The penalty can be more than \$2,000 for a family of four.

“We do not want Californians to face a penalty; we want them to have quality health insurance that gives them access to some of the best doctors and facilities in the nation,” Lee said. “Unfortunately, far too many Californians are unaware of the new law or its consequences. That’s why we are working hard to get the message out while there is still time for people to enroll.”

A recent survey released by Covered California, [Californians’ Understanding of the Mandate to Have Health Coverage and the Awareness of Financial Help](#), found the following:

Many Californians, especially the uninsured, are unaware of the penalty.

Many Californians reported being unaware of the new requirement to have health coverage in 2020 or face a penalty, including a majority of the *uninsured* (56 percent).

Knowledge of the penalty increases the likelihood the uninsured will enroll.

Among the *uninsured*, once informed about the penalty, 64 percent said they were more likely to enroll in health insurance for 2020. This compares to only 46 percent of *uninsured* respondents who said they planned to have health coverage in 2020 when asked at the beginning of the survey.

“The real penalty for not having health insurance is getting sick or injured and facing medical bills that are in the tens or even hundreds of thousands of dollars,” Lee said. “Health insurance provides security and peace of mind, and this year there is new financial help available to make that coverage more affordable.”

In addition to the state penalty, California also expanded the amount of financial help available to many consumers, including a first-in-the-nation program to help middle-income consumers afford coverage.

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

Right now, the average subsidy for eligible consumers earning less than 400 percent of the federal poverty level is \$447 per month; the average state subsidy for eligible middle-income consumers is \$469 per month.

The Jaramillo family in Salinas is one of the nearly 560,000 families benefiting from the new financial help. Thanks to federal tax credits and a new state subsidy of \$45, they will be paying \$57 a month for coverage that they say has already changed their lives.

“After we had the insurance, we were able to plan our second baby,” Yuriana Jaramillo said. “It was a blessing because without that insurance we wouldn’t be able to have our daughter.”

Click [here](#) to view and download the Jaramillos’ story.

“All it takes is just a few minutes to find out whether you are eligible for financial help from the federal government, the state, or both,” Lee said. “Do not leave money on the table; do not put yourself at risk if you get sick or ill; do not get stuck with a big bill when you pay your taxes in 2021.”

Californians Can Still Enroll

Covered California’s open-enrollment period runs through Jan. 31. Consumers can easily find out if they are eligible for financial help and see which plans are available in their area by entering their ZIP code, household income and the ages of those who need coverage into Covered California’s [Shop and Compare Tool](#).

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PD Editorial: The Affordable Care Act keeps getting better

Editorial Board

Despite President Donald Trump's best efforts at sabotage, the Affordable Care Act marketplaces appear to be doing quite well. Obamacare plan holders across the nation will average premium increases of less than 1% in 2020.

That news might make people covered by employer-based plans jealous. They're looking at an average increase of 5% for next year.

In California, the average rate increase in the Obamacare marketplace is expected to be about \$5 a month. The rate stabilization — compared with 28% increases just two years ago — is good news for those thinking about enrolling. The open enrollment period for 2020 is underway runs through Jan. 31, though anyone wanting coverage to begin on Jan. 1 must enroll by Dec. 15.

Any Californian currently without insurance should visit Covered California (coveredca.com) not just because having health insurance is a good thing but because it's also the law here. Beginning Jan. 1, anyone in the state without health coverage will be subject to a tax penalty after the Legislature passed a statewide individual mandate. The Legislature also expanded Obamacare subsidies to cover more households. There's never been a better time for the uninsured to obtain the security and peace of mind of health care coverage.

That is not to say, however, that it's all sunshine and flowers in Obamacare Land. The Trump administration and elected Republicans continue to assault President Barack Obama's signature policy achievement on every front possible.

Republicans eliminated the federal individual mandate penalty. Trump's administration has approved the use of junk insurance plans that provide very little real coverage and siphon off healthier users from real plans.

Most dangerously, Trump's Justice Department not only refused to defend Obamacare against a potentially lethal lawsuit brought by a group of Republican attorneys general from conservative states, it also filed a brief agreeing that the entire law is unconstitutional without a penalty for violating the individual mandate.

This lawsuit poses an incredibly serious threat to health care coverage for millions of Americans. A panel of the 5th U.S. Circuit Court of Appeals heard arguments in June after a federal judge in Texas found the entire Affordable Care Act is invalid.

Recall that Obamacare barely survived the initial challenge to its constitutionality at the U.S. Supreme Court before it even took effect. Chief Justice John Roberts provided the deciding vote ruling that the individual penalty was actually a tax, making Obamacare a valid exercise of Congress' taxation power.

But then a GOP Congress — unable to find the votes to repeal Obamacare outright — zeroed out the penalty for the individual mandate. Now they are arguing that, with no revenue coming from it, the mandate can't be considered a tax and is therefore unconstitutional.

The Texas judge not only agreed but found that without the mandate, the entire law collapsed. California is leading the states defending the law, along with the U.S. House of representatives. Whatever the 5th Circuit decides, there's a high probability this winds up back at the Supreme Court.

But, for now, Obamacare is in place and helping millions of Americans. The markets are stabilizing, and premiums are holding flat — and even coming down in some places. If you don't have health insurance, it is certainly in your best interest to see whether coverage under Covered California or Medi-Cal is within your reach.

"A man in debt is so far a slave"
-Emerson

THE SAN BERNARDINO
AMERICAN
NEWSPAPER

A Community Newspaper Serving San Bernardino, Riverside & Los Angeles Counties

Covered California was off to the Races with J.R. Todd at the National Hot Rod Association (NHRA) Finals in Pomona

Staff

Pomona, Calif. – Covered California partnered with Kalitta Motorsports and J.R. Todd, the first African American and NHRA Funny Car champion, at the NHRA season finals at the Pomona Auto Club Raceway, to raise awareness about health care coverage options in California. Peter V. Lee, executive director of Covered California, was on hand spreading the message that Covered California wants to make sure consumers are aware they are in their corner providing affordable, quality healthcare coverage.

There is more financial help available than ever, but those are not the only changes including early a million Californians will qualify for financial assistance to get coverage during open enrollment, middle-income individuals and families who make between \$50,000 and \$150,000 annually are eligible for help for the first time and California also restored the individual mandate, which lowered the cost of coverage, by requiring most people to get covered or pay a penalty.



Covered California: What You Need To Know

Eric Kahnert

SAN DIEGO — Deductibles, premiums, subsidies, oh my! This time of year can be very confusing when it comes to health insurance.

Perhaps you are not covered, or you are not sure if you qualify for the state's healthcare plan, Covered California. Did you know that if you make up to \$154,000 a year, you could qualify for financial assistance?

Here is what you need to know to protect you and your family.

Barry Kaplan is the proud dad to twin toddler boys, Benjamin and Joshua. Everyone is happy and healthy now, but the two boys were born premature, spending the first few months of their life in the hospital.

Barry says the state's insurance plan, Covered California, helped lower the medical bills from the hospital stay. Right now, Barry, a clinical psychologist who makes a minimal income pays around \$400 a month for his plan. Barry said, "I am a single dad with nanny's and a lot of expenses, and I needed some assistance with healthcare."

Peter Lee, Executive Director of Covered California, says that is what the Affordable Care Act as done. "It lets people like Barry know that if something happens to his twins he can't be turned away and will get the best healthcare possible.

Here is what is different this year.

Rates are going up .2% in our region and if you don't have insurance in 2020 there is a state penalty which will be assessed come tax time. Lee claims that "by everyone getting insurance, it lowers the cost for everyone."

Now there is state financial help on top of federal help. That means middle income consumers who did not get help previously, may now be eligible.

Individuals qualify if they make around \$49,960-\$74,940 a year. A family of four would be eligible with a household income between \$103,000-\$154,500.

Barry says it is worth it for consumers to go through the application process. “People think that if they are middle class, they won’t be eligible, but you actually are eligible and you can get a substantial reduction on your health insurance.

Lee says one in three middle class San Diegans are eligible for financial help, which averages about \$400 a month to lower their costs.

Open enrollment lasts a few more months, but if you want insurance to begin January 1, you need to sign up by the December 15 deadline.

For more information or to apply for Covered California, [click here](#).



Covered California’s new state subsidies program provides relief for middle-income Californians

Staff

Open enrollment for 2020 is underway, and more Californians than ever before are eligible for financial help for their health insurance.

The reason is a new state subsidy program. It will help lower the cost of coverage for almost 1 million people, including for some middle-income Californians for the first time since the Patient Protection and Affordable Care Act became law in 2014.

“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 people like small-businesses owners, early retirees and the self-employed,” Executive Director Peter V. Lee said. “Whether you never thought you could get financial help, or you have checked before, you need to check again because there is new money available that may dramatically reduce the cost of your coverage.”

So far during open enrollment, eligible low-income consumers who qualified for a subsidy are receiving an average of \$19 per month per household on top of any federal assistance they receive, while eligible middle-income Californians who have received a state subsidy are getting an average of \$526 per month, per household.

For someone like Don from San Jose, who worked in the tech industry for years before retiring early to pursue his passion in history and literature, the state subsidy program is a much-needed financial lifeline. Since his decision to retire, Don has been paying over \$33,000 a year for a COBRA Blue Shield PPO Silver plan for himself and his wife. In 2020, they will be receiving \$1,282 a month through the state subsidy program. They will pay a net premium of \$1,900 per month.

“I feel a weight has come off our financial shoulders, and I have more freedom to pursue my new passion,” Don said. “I’d like to give heartfelt thanks to Gov. Newsom and the state of California for making this possible. I applaud all the resulting help, relief and new opportunities that will be given to other Californians.”

Another big change for 2020 is the restoration of the individual mandate here in California. People 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. A family of four would pay at least a \$2,000 penalty, and potentially more, for not having health insurance throughout 2020.

These 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.

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 or get free and confidential in-person assistance, in a variety of languages, from a certified enroller. They can also have a certified enroller call them and help them for free, or they can call Covered California at (800) 300-1506.

Open enrollment runs through Jan. 31, 2020.

Covered California names new CFO

Felicia Alvarez

Covered California is bringing aboard a new chief financial officer, after its current CFO announced her retirement on Friday.

The agency operates California's individual health plan marketplace, which has 1.39 million enrollees.

Dora Mejia has been CFO of Covered California for the last two years, and first joined the agency in 2013 as a deputy director of financial operations. During Mejia's tenure, she watched Covered California grow from an agency that was funded by, and reliant, on federal grants, to a self-sustaining organization with a \$340 million operating budget, according to Covered California.

Mejia was also named one of the Business Journal's CFO of the Year honorees this year.

Jim Watkins has been selected as the next CFO of Covered California. Watkins joined Covered California last month as a deputy director of financial planning and forecasting operations. Prior to that, he spent much of the last 12 years working with the California Department of Health Care Services as its chief of research and analytical studies.

"Jim has shown deep understanding of health care, independent judgment and strong analytic skill in leadership roles, along with an ability to work in politically sensitive areas under significant pressure and timeframes," said Peter Lee, executive director of Covered California, in a written statement. "He will be an asset to Covered California and build on the solid foundation we've developed."

Watkins' responsibilities will include managing and administering the overall financial activities of Covered California, including its strategy for financial sustainability. He will have direct responsibility for accounting, finance, forecasting, budgeting and related government compliance, according to the agency.

Mejia's last day will be Nov. 29,. Watkins will take up the post on Dec. 1. His annual salary is set at \$180,000, according to Covered California.

Covered California is anticipating a boost to its enrollment for 2020, after the agency saw its number of new enrollees drop this year. The 23.7% decline was attributed to the removal of the Affordable Care Act's individual mandate, that had required individuals to have health insurance. The individual mandate was done away with under the 2017 federal tax overhaul.

Covered California is projecting growth in enrollment next year, after Gov Gavin Newsom and the California Legislature approved a 2019-20 state budget with new subsidies to help middle-income earners buy health care. Covered California projects that about 235,000 Californians who previously did not qualify for financial help will be eligible for the subsidies. California is also reinstating an individual mandate for health insurance coverage, to take effect in 2020.

Observer

GROUP NEWSPAPERS OF SOUTHERN CALIFORNIA

Covered California Health Plans Help Prevent Disease in African American Communities

Staff

Sheila Head has been an entrepreneur in Oakland, California for 36 years.

"I love what I do," said the hairstylist and owner of Head Designs.

But while her business was relatively healthy, Head's body was not.

"I only would go (to the doctor) when I absolutely had to go," Head said. "Then Covered California came around, and I jumped on it. My life seemed to blossom."

Open enrollment is underway for consumers to sign up for health insurance through Covered California. A key deadline is Dec. 15 for consumers who want their coverage to begin on Jan. 1. Open enrollment runs through Jan. 31.

A free health screening revealed that Head was prediabetic. "Oh, no. I don't want to have anything to do with diabetes," said Head. Diabetes is one of the diseases that disproportionately affects African Americans. The U.S. Office of Minority Health estimates that African Americans are 80 percent more likely than other races to get diabetes and are twice as likely to die from the disease. Sheila Head

This year's open-enrollment period features some of the biggest changes since Covered California first began offering health 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.

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. About 50 percent of middle-class Californians across the state with household incomes between 400 and 600 percent of the federal poverty level are finding out they are eligible to receive a state subsidy starting in January.

"We have heard from people across the state who will be saving hundreds of dollars a month because California is putting its people first," Covered California Executive Director Peter V. 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 are already helping consumers who have selected a plan for 2020. 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 more than \$500 per month, per household.

Enrolling for coverage now is critical because California restored the penalty that was part of the federal Patient Protection and Affordable Care Act from 2014 to 2018. That means most consumers who do not get covered could face a fine when they file their 2020 taxes in the spring of 2021. A family of four would pay a penalty of at least \$2,000, and potentially more, for not having health insurance throughout 2020.

The penalty aside, Lee and Head focused on the positive aspects of being insured, including free health screenings, an annual checkup and peace of mind knowing that if a health crisis occurs, you won't go bankrupt when bills pile up.

Free preventative health care services offered by all Covered California health plans helped Head make wise choices to stay healthy, and she is now an active participant in an innovative diabetes-prevention program offered through her health provider, Blue Shield.

"Covered California gave me, like, my own health care team," Head said. "I hope everyone will have the opportunity to feel like I've been feeling."

Covered California Open Enrollment Information

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's Service Center at (800) 300-1506.

Open enrollment runs through Jan. 31, 2020. Enroll by Dec. 15 to have coverage start on Jan. 1.

The Mercury News

Middle-income Californians can soon receive health insurance benefits

Shomik Mukherjee

Tax credits for health insurance will expand in 2020 to middle-income earners while penalties for not opting into insurance will once again be enforced, an insurance marketplace spokesperson said Wednesday.

Covered California, the state's primary health insurance marketplace, will begin subsidizing insurance premiums in January 2020 to residents who are between 400% and 600% of the state poverty line. Previously, only those below 400% of the poverty line qualified under the federal Affordable Care Act.

Open enrollment is currently being offered across the state and will last until Jan. 31. But to begin receiving the credits at the very start of the year, residents will need to sign up for insurance by Dec. 15. The rules apply to state residents who don't already receive health insurance through their employer.

California Covered spokesperson James Scullary said Wednesday that all residents should check if they qualify for breaks under the new rules.

"It's entirely possible that people on the North Coast have come around before, but we're encouraging people to come around again," Scullary said. "We want to make sure that people understand that there's new money available to help bring the costs for the middle-income group down."

Meanwhile, California has restored penalties for those who remain uninsured, a feature of Obamacare that the U.S. Congress neutered in a 2017 vote. Now the penalty is back, which Scullary said has prompted health care companies to reduce rates by several percentage points.

Those who don't opt into private health insurance through California Covered will begin seeing fines added to their spring 2021 taxes.

Scullary said Wednesday it's "understandable" if residents are unhappy about the penalty, but argued its overall effect on costs is worth it.

"The real penalty is when someone is faced with the choice, if they're injured or ill, of not having access to quality care or ending up in an emergency room with a \$50,000 or \$100,000 bill," Scullary said.

Humboldt County's insurance premiums are higher than other areas in the state, largely because the county is in a rural region and its residents tend to be less healthy. A public health report published earlier this year indicated a significant disparity between Humboldt County and other regions in California.

The health care available to Humboldt County residents has also been sparse, with large community health centers opening up to replace vanishing private medical practices.

In a statement, the county's Department of Health and Human Services said the office is open to helping people sign up for Covered California and determine their health care needs.

"We encourage people to come to one of our offices or call our Call Center at 877-410-8809," DHHS staff Kelly Hampton said in a statement. "A DHHS Eligibility Specialist can talk to you about if you qualify for Medi-Cal, as well as help navigate the Covered California health plans."

Scullary acknowledged the issues facing Humboldt County, saying it's all the more reason for people to check if they now qualify for Covered California subsidies.

While individual premium costs vary depending on the person, Scullary noted that the previous federal tax credits through the Affordable Care Act, often referred to as Obamacare, covered 80% of a person's monthly premiums.

"We have a commitment to ensure we cover as many patients as possible," Scullary said.

Proposed health care policies being negotiated on the country's presidential debate stages may soon alter the future of healthcare. But Scullary noted that any large-scale changes won't be anything close to immediate.

"We deal with the here and now," he said. "Covered California has become part of the state's health care system and it plays a vital role. I don't think that's going to change, especially because these things do take time."



100 Most Influential People in Healthcare - 2019

Staff

The 100 Most Influential People in Healthcare awards & recognition program honors individuals in healthcare who are deemed by their peers and the senior editors of Modern Healthcare to be the most influential individuals in the industry, in terms of leadership and impact. This program allows for readers to vote for their top choices and selected honorees will be published in Modern Healthcare's annual ranking.

Rank: 66

Peter Lee, Executive director, Covered California

Lee has been Covered California's executive director since 2011. He oversees the planning, development, ongoing administration and evaluation of the state's insurance exchange and its efforts to improve the affordability and accessibility of quality healthcare for Californians. In October, Lee said there will be critical changes to Covered California like a state penalty coming back into law in January 2020.

Los Angeles Times

Californians with no health insurance face penalties. Not everyone has to pay

Bernard Wolfson, Kaiser Health News

Californians, be warned: A new state law could make you liable for a hefty tax penalty if you do not have health insurance next year and beyond.

But the law contains several exemptions that will allow certain people to avoid the penalty, among them prisoners, low-income residents and those living abroad.

“It will be really important that people get clear guidance and instruction to make sure they don’t inadvertently pay a penalty when they are eligible for an exemption,” says Laurel Lucia, director of the Health Care Program at UC Berkeley’s Center for Labor Research and Education.

California’s penalty is modeled on the one originally in the federal Affordable Care Act. Congress eliminated the federal penalty, effective this year.

The Golden State will join Massachusetts, New Jersey, Rhode Island, Vermont and Washington, D.C., in requiring its residents to have health coverage and dinging those without it.

Most types of insurance, including Medi-Cal, Medicare and employer-sponsored coverage, will satisfy California’s requirement. People who purchase insurance for themselves and their families, either through Covered California, the state’s health insurance exchange, or the open market, will have until Jan. 31 to buy a plan for 2020.

If you aren’t covered and owe a penalty for 2020, it will be due when you file your tax return in 2021. The penalty will amount to \$695 for an adult and half that much for dependent children, or 2.5% of household income, whichever is greater. That could make the penalty quite a bit heftier for some people.

Penalty payments are expected to raise \$317 million in the first year they are collected, according to the state Legislative Analyst’s Office. The money will help pay for new state subsidies intended to make insurance more affordable for some people.

You won’t have to pay the penalty if you are uninsured for three consecutive months or less during the year, or if you are incarcerated or are Native American. Likewise, if you

are in the U.S. illegally. Undocumented immigrants are not eligible for federal tax credits to help them pay the premiums on health plans sold through Covered California.

General hardship exemptions also are available if you are facing personal or family difficulties, including homelessness, domestic violence, bankruptcy, eviction or the consequences of a natural disaster.

And you're off the hook if your household income is below the threshold for filing a tax return. This was the most common exemption from the federal penalty, according to Internal Revenue Service data based on 2016 returns. It might be even more popular under the California law, since the state's filing threshold is higher than the federal one, Lucia says. The 2020 California filing thresholds are not available yet. For 2019, the threshold is \$18,241 for a single childless individual under 65 and \$58,535 for a married couple under 65 with two or more dependents. That compares to federal thresholds of \$12,200 for a single individual and \$24,400 for a married couple filing jointly.

You can also claim an exemption if you would have to spend more than 8.24% of your income on insurance premiums in 2020. This so-called affordability exemption was also among the most common under the federal law.

How you claim an exemption depends on the type you are seeking.

Covered California will handle three types of exemptions: religious conscience, general hardship and affordability. Each will require filling out a different application, and the applications will be available starting in January, says James Scullary, an exchange spokesman.

For other exemptions, you'll need to apply when you file your 2020 return with the Franchise Tax Board in early 2021. A tax board spokeswoman promises that "our tax forms and instructions will include information for all exemptions claimed on the tax return."

You can also apply to the tax board for an affordability exemption when you file your return.

Gerald Kominski, a senior fellow at the UCLA Center for Health Policy Research, says the 8%-plus threshold for the affordability exemption is too high and pushes many middle-class families to pay a penalty even when they are hard-pressed to buy insurance.

Steven Morelock, a resident of Los Angeles, paid hundreds of dollars in federal penalties for several years because he felt too financially stressed to plunk down \$250 a

month for a high-deductible health plan. He was already shelling out nearly half of his \$2,500-a-month salary in rent alone.

“I would have had to change my habits very dramatically,” says Morelock, 41, a labor organizer. “It would have cut the amount of money I had for non-fixed costs by about half.” He finally got employer-sponsored insurance late last year.

Another exemption that has stirred some debate is for membership in a healthcare sharing ministry — an association of religiously like-minded people, primarily Christians, who cover one another’s medical costs.

Legislators and others who opposed including this exemption in California’s law argue that the ministries are subject to little regulatory scrutiny, the coverage they offer is limited, and it’s not guaranteed. More recently, concerns have arisen about sham ministries engaged in deceptive business practices.

Dr. Dave Weldon, president of the Alliance of Health Care Sharing Ministries, acknowledges some of the limitations and says the organizations he represents “all counsel their members that this is not insurance, there’s no contract, there’s no obligation to pay.”

Bob Stedman, 55, says he and his family were exempt from the federal penalty every year because of their membership in Samaritan Ministries International. The Lake Forest resident plans to take the same exemption under the California law.

Stedman figures he’s saving about \$1,000 to \$1,500 a month in premiums compared with regular insurance, and was pleased when the \$50,000 bill he received following a stroke was heavily discounted by the hospital and then almost entirely covered by other ministry members. And knowing his money is not being used to finance abortions, which most commercial health plans in California are required to cover, gives him “the benefit of a clear conscience,” he says.

Weldon says the exemption is warranted on those grounds alone. “This nation has a long history of religious accommodation,” he says.

If you’re not sure whether you might qualify for an exemption, you can get more information from Covered California or the tax board.

Contact Covered California at its website or by phone: (800) 300-1506. You can log on to the tax board site, or call (800) 852-5711.

But don't limit yourself to those two agencies. Insurance agents and tax preparers across the state are trying to master the details of the new law, and they can help.

For a list of insurance agents whose help is free, log on to the Covered California website and click on "find help," or go to the website of the National Association of Health Underwriters and select "find an agent." The California Society of Tax Consultants and the California Society of CPAs can help you find a tax preparer.



Californians Need Health Insurance By Jan. 1 Or Risk Paying A New Penalty

Sammy Caiola

Updated Dec. 16: Covered California announced it has extended the deadline for health coverage starting Jan. 1. The new deadline to enroll is Friday, Dec. 20. This story has been updated to reflect that.

Californians must carry health insurance in 2020, or face a state-imposed penalty starting at \$695 in 2021.

Covered California and the California Franchise Tax Board are encouraging the state's uninsured to enroll in a plan by Dec. 20. That's the deadline for coverage that kicks in Jan. 1. The Covered California enrollment season lasts until Jan. 31.

"We want to help people be aware of what's coming for tax year 2020," said Jason Montiel, a spokesperson for the tax board. "We don't want people to get into the summer and realize they didn't have coverage and then find they'll face a penalty."

The deadline was originally Dec. 15, but Covered California extended it on Monday after it said it received "tens of thousands" of enrollments late last week.

The state mandate replaces a federal penalty for being uninsured, which was created under the Affordable Care Act. The Trump administration zeroed out that penalty effective 2019, so people who went uninsured this year will not pay a fine during when they pay their taxes next year.

But starting Jan. 1, 2020, Californians must enroll in a health insurance plan or risk paying a penalty when they file taxes in 2021. The penalties start at \$695 for individuals

and \$2,085 for a family of four, according to the California Franchise Tax Board. There are allowances for some low-income Californians, and people who are without coverage less than three months. Non-citizens and members of federally-recognized Indian tribes including Alaskan Natives are also exempt.

Gov. Gavin Newsom pushed for the state mandate, arguing fewer uninsured people would lead to a healthier California. He also proposed using the revenue from the penalty — estimated at about \$317 million for next year — to subsidize health insurance for low and middle income patients buying through Covered California, the state's health insurance exchange.

But some experts have questioned whether the threat of a penalty will be enough to convince the state's remaining 3.5 million uninsured to enroll in coverage. A large portion of that group — roughly 1.5 million according to the Legislative Analyst's Office — is not eligible for most health insurance due to immigration status.

And Stanford University health policy expert Lanhee Chen said people will most likely just choose whatever option is cheaper: enrolling in a plan, or eating the penalty.

“A mandate is not in and of itself a workable way to expand affordability or, frankly, compel coverage for those who don't want it,” he said.

Still, many California advocates argue the mandate is key to achieving universal health care, the idea of getting everyone insured. The new coverage requirement is California's latest attempt to combat the Trump administration's moves against the ACA.

The state is already offering the extra premium assistance that Newsom says the penalty revenue will help fund.



More people signing up for health insurance in California

Adam Beam

SACRAMENTO, Calif. (AP) — More than 130,000 people have purchased health insurance through California's state-run marketplace for the first time, a 16% increase from last year now that the state is offering more money to help people pay their monthly premiums and will begin taxing people next year who refuse to buy insurance.

Covered California released the numbers on Thursday ahead of a Sunday deadline for people to purchase insurance and have their plans effective Jan. 1. Plans purchased after Sunday would take effect Feb. 1. California's open enrollment period closes Jan. 31.

In addition to the new enrollments, more than 1.13 million people in California have renewed their plans for next year.

Former President Barack Obama's health care law created marketplaces where people who don't get insurance through their employer can shop and compare prices. Most states let the federal government operate their marketplaces. California is one of 13 states that operates its own marketplace.

The federal government helps some people who purchase their health insurance on these marketplaces pay their monthly premiums. To be eligible, people must earn less than 400% of the federal poverty level, or \$25,750 for a family of four.

California offers additional help. For people who earn up to 400% of the federal poverty level, the state will chip in an extra \$21 per month for payment of monthly premiums. So far, that's about 460,000 people.

And this year, California became the first state in the country to give premium assistance to households earning up to 600% of the federal poverty level. That means families of four with an annual household income of up to \$154,500 per year would be eligible.

Covered California Executive Director Peter V. Lee announced about 44% of people in that income range who have purchased insurance on the state marketplace have qualified for assistance. That's about 23,000 people. But Lee said he expects the number to grow considerably in coming weeks.

California pays for those subsidies mostly by taxing people who refuse to purchase insurance, with some exceptions. The tax would be at least \$2,000 for a family of four. The federal government once imposed a similar tax until the Republican-controlled Congress repealed it as part of a 2017 overhaul to the tax code.

Lee estimated the tax will generate between \$300 million and \$400 million for California. That will not cover all of the state's subsidies, but the state will pay for the rest from its general fund.

“The goal is to have no one pay that penalty. We’d rather have everyone with insurance,” Lee said.

California’s numbers come while the federal marketplace that covers 38 states has experienced a 3.5% drop in new enrollments compared to last year.

But the enrollment period for the federal marketplace is one day shorter this year. The federal marketplace also no longer includes Nevada, which now operates its own exchange. Plus, Maine and Virginia have since expanded their Medicaid programs, meaning fewer people in those states will need to purchase insurance.

When factoring in those things, new enrollments for the federal marketplace are close to last year’s numbers — which would break a multi-year trend of decline, according to Joshua Peck, co-founder of the nonprofit Get America Covered and former chief marketing officer for the Centers for Medicare & Medicaid Services under President Obama.

“The fact California is up 16% is really something they should be proud of,” Peck said.

POLITICO PRO

Covered California sees sign-up increases for 2020 — with 7 weeks left in enrollment

Victoria Colliver

Covered California said today new plan selections have jumped by 16 percent year over year due to California’s expanded health subsidies and the reinstatement of its individual penalty for the 2020 open enrollment period.

“These policies are working and making a huge impact,” Peter Lee, the state exchange’s executive director, told reporters on a press call.

While open enrollment for the 38 states on the federal Obamacare marketplace ends Sunday, Californians can sign up for coverage through Jan. 31. Lee said the extended period — along with the mandate and the new state subsidies — has helped boost the state’s enrollment over those in the federal marketplace, which is running about 4 percent behind last year’s pace.

Last year, California’s overall enrollment for 2019 remained steady at about 1.5 million, but new enrollment plunged 23.7 percent. Lee blamed the drop primarily on the removal of the individual mandate penalty. But this year, Gov. Gavin Newsom and the

Legislature restored the individual penalty, which Congress in 2017 zeroed out, and dedicated \$1.5 billion in state funds to expand premium subsidies for low- and middle-income people.

More than 133,000 new enrollees selected plans in Covered California through Dec. 7, compared with about 114,300 a year ago, and more than 1.13 million existing consumers have had their plans renewed. More than 486,000 of the people are eligible for the new state subsidy — including about 23,000 middle-income Californians living in households earning between 400 to 600 percent range of the federal poverty line, exchange officials said.

The mandate renewal is also expected to help. California along with Massachusetts, New Jersey, Rhode Island, Vermont and Washington, D.C., require their residents to have health coverage or pay a penalty. The penalty for not having coverage in 2020 will amount to \$695 for adults and half that amount per child, or 2.5 percent of annual household income, whichever is higher.



Some Rejoice Over New California Health Insurance Subsidies. Others Get Shut Out.

Ana B. Ibarra

Syd Winlock bought one of the cheapest health insurance policies he could find for himself and his wife, Lisa, this year: a high-deductible plan with lousy coverage and a \$1,500-per-month price tag.

For coverage next year, the Elk Grove, Calif., resident qualifies for new state-funded health insurance subsidies totaling about \$870 per month. This aid allows him to buy a better plan with a lower deductible for about \$1,200 per month.

That's still high, he said, but any help is welcome.

"It made a huge difference," said Winlock, 61, a small-business owner who provides accounting and point-of-sales systems to other businesses. "We were thinking that in 2020 we wouldn't be able to keep our plan," let alone afford an upgrade, he said.

Heather Altman, an independent environmental consultant in Long Beach, also hoped to qualify for the new state financial aid. But, after checking with a health insurance agent, she learned she won't get anything. "At first I thought it might be a mistake," she said. "It was disappointing."

Starting Jan. 1, California will offer financial aid to some consumers who buy health coverage through Covered California, the state's Affordable Care Act insurance exchange.

Some of the subsidies will go to people who already qualify for the federal tax credits available to some Covered California consumers, primarily those with low incomes. But the assistance will also be extended to middle-income people such as Winlock who make too much money to qualify for the federal tax credits and have had to bear the entire cost of their premiums. California will be the first state to offer such help to middle-class consumers.

With open enrollment for Covered California going full steam — sign-ups for 2020 coverage end Jan. 31 — consumers are eagerly trying to determine whether they might qualify for the new aid and, if so, how much.

The results are mixed.

“It's brought higher-income earners to call me, but most still earn too much” to qualify, said Kevin Knauss, a Sacramento-area insurance agent who also has clients in Los Angeles and the Bay Area. “Others are picking up \$15 to \$25.”

More than 486,000 people have already qualified for the new state subsidies, with more expected as open enrollment continues, Covered California announced Thursday. This includes about 23,000 middle-income enrollees who make too much to qualify for federal tax credits, said Covered California Executive Director Peter Lee.

Lee added that new enrollment is up by 16% compared with this time last year, largely due to the new state financial aid and insurance requirement.

This “is a small slice of who will sign up,” he said. “We're optimistic there will be many, many more people covered by these state subsidies for the middle class.”

Earlier this year, Gov. Gavin Newsom signed a 2019-20 state budget that includes nearly \$429 million for the subsidies. To help pay for them, the state is imposing a tax penalty starting next year on people who don't have health insurance — similar to the federal penalty the Republican-controlled Congress eliminated effective this year.

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

Some of the aid 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 \$21 a month, Covered California estimates.

The majority of the state assistance, however, will go to people 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 \$460 a month, according to Covered California.

But falling into this income bracket doesn't guarantee subsidies, as Altman learned.

She estimated she will make \$60,000 next year, which puts her within the income range to qualify as an individual, but she won't be getting any aid, and she doesn't quite understand why.

Besides income, household size, location and age play a role in eligibility for the subsidies, Covered California's Lee explained. For example, older people who live in areas with high health care costs have a higher chance of getting help, he said.

Altman, 47, who has severe asthma and is on multiple medications, said she can't go without coverage, so she will pay \$640 every month for a health plan next year, up \$70 from this year.

"I was just glad that it was only an 11% increase," she said. "In previous years, I've seen a 20-something percent increase."

Winlock said he feels grateful he qualified for the state financial aid because it allowed him to buy a better plan. Now he can seek care that he has been avoiding.

"We're pretty healthy, and I'm very active, but I do have an issue with arthritis that I haven't been pursuing because just testing alone is very expensive," he said.

Evette Tsang, an insurance agent in Sacramento, said that while news of financial aid is driving some customers to her office, the new insurance requirement — and the accompanying tax penalty — are ultimately motivating most people to sign up.

People who don't have insurance in 2020 will have to pay the penalty when they file their state tax returns in 2021. The penalty will amount to \$695 for an adult and half that much for dependent children. Some people with higher incomes instead will have to pay 2.5% of their income, which could make their penalty quite a bit heftier.

Tsang saw clients drop their coverage when the federal penalty was eliminated. "Now they're coming back," she said.



7 On Your Side and panel of experts answer your Covered California questions

Michael Finney and Randall Yip

SAN FRANCISCO (KGO) -- 7 On Your Side's Michael Finney and a panel of experts are hosted a hotline on Wednesday to answer all your Covered California questions.

They took calls and questions via social media and email about getting government subsidized health coverage in time for the New Year.

Enrollment experts from Asian Health Services, California Certified African American Insurance Roundtable, Covered California, Lifelong Medical Care, LifeMoves , Tiburcio Vasquez Health Center and Tri-City Health Center will be on hand to take your calls and answer your questions.

Go here to enroll in Covered California.

San Francisco Chronicle

California will mandate health coverage next year. Here's what that means

Catherine Ho

In a significant new change, California will require people to buy health insurance next year or pay a tax penalty.

State-level mandates for health coverage already exist in Massachusetts, New Jersey and Washington, D.C., which have sought to make sure all residents have insurance. In addition to California, Rhode Island and Vermont will implement health mandates next year.

California will be providing financial help for middle-income earners, who make up to about \$75,000 a year, so they can pay insurance premiums. Most of the aid money is expected to come from penalties collected from those who decide not to get insurance.

Californians have until the end of Sunday to sign up for coverage that takes effect in January.

Massachusetts pioneered the idea of a state-level health mandate in 2007, when it required residents to buy insurance and provided state subsidies to help them do so.

Massachusetts' mandate and subsidies helped make the state's uninsured rate the lowest in the nation, around 3%, though they were implemented at the same time a state employer mandate also went into effect — making it difficult to determine whether the individual mandate alone is responsible for getting more people insured, said Laurel Lucia, director of the health care program at the UC Berkeley Labor Center.

New Jersey and Washington, D.C., both instituted mandates in January. It's too early to say whether they led to lower rates of uninsured or how many people will be paying the penalty. More information will be available when residents file their taxes in April.

President Barack Obama helped push through a federal health-insurance mandate in 2010, when he signed the Affordable Care Act into law. But Congress repealed the mandate in late 2017, as part of a broader tax bill, by removing the tax penalty. The Affordable Care Act's employer mandate remains in place, requiring companies with at least 50 full-time workers to provide health insurance or pay a penalty.

A lot of Californians aren't aware of the new state mandate or subsidies, said Mulugeta Mahray, an insurance broker in Oakland. He said he'll be texting his clients, most of whom are on plans from Covered California or other individual markets, to make sure they know about the changes.

Officials with Covered California, the state insurance exchange, are encouraging people to check to see if they qualify for subsidies before signing up or forgoing insurance. Covered California said Thursday that about 486,000 people have signed up for plans and will receive state subsidies to help pay for the premiums. Most of them will receive a combination of federal and state assistance; about 23,000 people have signed up to get the state subsidies alone because they are in the new, higher income bracket eligible for state assistance.

About 133,000 new consumers have signed up for Covered California plans through Dec. 7, a 16% increase over the same period last year, according to the agency.

One of them is San Francisco resident Tyler Breisacher. Breisacher, 32, left his job over the summer and has since been covered under COBRA — the federal law that allows workers who lose their jobs to keep the same employer-provided health insurance for up to 18 months, though workers typically have to pay the full premiums themselves.

He decided to enroll in a Covered California plan for 2020 because he recently went back to school, studying journalism at City College, instead of going to another job. COBRA is expensive, costing him nearly \$600 a month. The new plan will be about \$400 a month.

Breisacher said he didn't seriously consider going without insurance "because you never know what will happen."

Here's what Californians need to know about the new changes:

Whom do the new state mandate and subsidies affect?

The new state requirement will affect a relatively small slice of California's population.

Currently, about 1.1 million residents buy plans through the individual market (either through Covered California, the state insurance marketplace, or directly from health insurers) because they don't get insurance through work or through Medi-Cal, the public health insurance program for the poor. About 3 million Californians are currently uninsured, though some will qualify for exemptions.

Who is eligible for subsidies?

Some people will get federal subsidies only, some will get federal and state subsidies and some will get state subsidies only.

People who earn between between 138% and 400% of the federal poverty level (between about \$17,000 and \$50,000 a year) are eligible for a federal subsidy.

People who earn between 200% and 400% of the federal poverty level (between about \$25,000 and \$50,000) are eligible for federal and state subsidies.

People who earn between 400% and 600% of the federal poverty level (\$50,000 to \$75,000) are eligible for state subsidies.

When do I need to sign up for insurance?

The deadline is Dec. 15, end of the day, for your coverage to take effect Jan. 1. The deadline is Jan. 31 for your plan to take effect Feb. 1. You will not be charged a tax penalty if you lack coverage for one month.

Are there any exceptions?

Yes. The exemptions allowed by the state are roughly the same as those allowed by the federal government under the Affordable Care Act, before the federal mandate was repealed. You can see the full list of California exemptions on Covered California's website or the Franchise Tax Board website. Most can be claimed on a state income tax return when filing your taxes. Some additional exemptions will be offered through Covered California; for those, individuals will need to fill out a form and submit it to Covered California. The forms will be available in January.

Some of the most common exemptions under the Affordable Care Act were if your income is too low to file taxes, if you are living abroad, or if you are uninsured for less than three consecutive months.

How much is the California penalty?

\$695 per adult, \$347.50 for each child under 18, or 2.5% of your annual income, whichever is higher — same as the federal penalty.

In tax year 2017, the last year for which data is available, about 553,000 tax filers in California paid the federal penalty, according to the IRS.

How much will subsidies cost the state?

The state subsidies will cost an estimated \$429 million in 2020. Most of that amount, \$317 million, is expected to come from penalties paid by people who don't get insurance.

The rest will come out of the state general fund. The state has committed to helping pay the subsidies for three years.



Key California deadline looms Sunday: Sign up now to ensure health coverage starts Jan. 1

Cathie Anderson

Three-quarters of Californians who are eligible for a subsidy to defray the cost of health insurance either don't know they qualify or don't know just how much they could get, and if you haven't checked, Covered California leader Peter V. Lee wants you to stop what you're doing and go to the agency's website by Sunday.

That's because you must sign up for a policy by Dec. 15 if you want your coverage to start on Jan. 1.

"Nearly half a million Californians have already signed up and will benefit from new state subsidies in 2020, including tens of thousands in the middle class who are eligible for help for the first time," Lee said. "We have a key deadline coming up, and we want to tell everyone — whether you need health insurance or know someone who does — that now is the time to see if you are eligible for this new money so you can ring in the new year with a quality health plan."

While consumers can still sign up for health coverage through Jan. 31, those policies won't go into effect until later in the new year. To sign up, visit www.coveredca.com or call 800-300-1506.

Open enrollment began in mid-October, and Covered California has seen a surge of interest from uninsured people. The agency reported that 133,092 people had enrolled in new plans by Dec. 7, 16% more than in the comparable enrollment period last year.

While the new state subsidies are sparking interest, Lee said, Covered California and insurance agents on the private market are also fielding more calls because a new state mandate requires that all California residents have health insurance coverage in 2020 or face a tax penalty.

TAX PENALTY IS BACK

Lee said he considers it remarkable that Gov. Gavin Newsom, in less than a year's time, was able to work with the Legislature to get subsidies for the middle class, restore stability to the market with the mandate requiring individual coverage and expand Medi-Cal coverage to undocumented immigrants ages 18 to 26.

"About 40% of the people who are enrolling are getting state subsidies, and many of them are what I call the forgotten middle class," Lee said, adding that these enrollees are often emotional when talking about the difference the subsidies make.

"It's sort of like year one. In year one, we had people crying on the telephone, saying, 'Oh, my God, I've been denied coverage because of a pre-existing condition. Now, I can get health care.' We're seeing that same thing emotionally from people who are 55 years old saying, 'It has been really hard. I make \$80,000, which sounds like a lot of money, but I've got to cover me and my wife or me and my husband or me and my kids, and it's taking 25% of my budget. This help is huge.'"

This year, consumers can no longer receive federal subsidies if they are a single individual earning more than \$48,560, a married couple with no children earning \$65,840, a family of three with income of \$83,120 or a family of four making \$100,400.

The average 40-year-old in Northern California pays an average of \$9,600 a year for health care coverage, Lee said, and a 60-year-old pays an average of \$14,400. Insurance costs can eat up a sizable chunk of a middle-class family's income, he said.

Using first names only, Covered California shared information on some people who have benefited from the new subsidies. For instance, Syd in Elk Grove is paying \$1,499 per month this year for a bronze plan for himself and his wife, the lowest level of coverage, on the private market. After checking with Covered California, Syd learned that he was eligible for a subsidy of \$872 a month in 2020. With those funds, Syd upgraded to a silver plan and is paying \$1,184 a month for a plan with greater benefits.

ACCESS TO INSURANCE GROWS

Dr. Mark Ghaly, secretary of the California Health and Human Services Department and the board chair of Covered California, said: "Together we are increasing access to care by making coverage more affordable for hundreds of thousands of people."

Roughly 3 million people are uninsured in California, but about 60% of them are not eligible for insurance through Covered California because they are undocumented immigrants. That leaves about 1.1 million uninsured Californians for Lee to reach. The uninsured rate has dropped to 7.2% from 17.2% in 2013.

Insurers are expecting a big increase in the numbers of people enrolling for coverage in 2020, Lee said, so premium increases are relatively flat, averaging just 0.8% statewide. This is what can happen, Lee said, when you build on the Affordable Care Act.

Lee's stature on the national health care scene has increased as California's health insurance exchange has thrived despite moves by the Trump administration and congressional Republicans to eliminate the federal tax penalty, cut advertising for open enrollment and reduce the enrollment period to six weeks from 12. Modern Healthcare magazine recently named Lee a third time to its list of the 100 Most Influential People in the health care arena.

California has maintained most of its unsubsidized policyholders, Lee said, because insurance rates have increased much less here — 45% — than in the nation as a whole — 85% — over the five years since the nation's health exchanges began operating.

"The unsubsidized market in places like Texas or Florida is disappearing because the only people buying insurance who don't get subsidies are sick people," Lee said. "If I've got cancer, I'm going to get coverage, but if they're healthy, people say, 'I just can't afford it.' California has not had that happen. We still have about 800,000 or 900,000 people without subsidies."

California legislators also expanded the open enrollment period to three months, and they passed legislation to keep junk insurance plans that place many limits on coverage. And, Covered California has put an advertising budget of more than \$100 million to work annually to get the word out about open enrollment and hammering home the message that, when unexpected calamities happen, only the insured are prepared.



Deadline for Covered California enrollment approaching

Staff

A life-altering letter in the mail from Covered California has changed John and Shannon's outlook for 2020.

The retirees are about "95 percent" done with building their dream home in Red Bluff, but monthly health care insurance bills were stalling their project and making Shannon considering going back to work full-time.

That harsh reality was put aside when the couple received a letter from Covered California this fall informing them that they were eligible for the new state subsidy program for middle-income Californians and that their bills would come down to \$287 a month in 2020 – after they will spend over \$18,000 on monthly premiums this year.

“It’s been a blessing, it’s been a godsend really,” Shannon said. “We still get the exact same coverage that we had before. We can stay retired and enjoy our lives because we worked hard, raised our kids and now it’s our time. We want to travel and enjoy our grandkids and build our dream house.”

Open enrollment is underway for consumers to sign up for health insurance through Covered California. A key deadline is Dec. 15 for consumers who want their coverage to begin on Jan. 1.

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.

“We have heard from people across the state who will be saving hundreds of dollars a month because California is putting its people first,” Covered California Executive Director Peter V. 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 are already helping consumers who have selected a plan for 2020. New data shows that 500,000 people have already signed up to benefit from the program. Eligible low-income consumers who qualify for a subsidy are receiving an average of \$21 per month per household, while eligible middle-income Californians who receive a subsidy are getting an average of \$460 per month per household.

While Covered California’s open enrollment period runs through Jan. 31, 2020, consumers must sign up before the end of Sunday, Dec. 15 to have their coverage begin on Jan. 1.

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.

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.

Open enrollment runs through Jan. 31, 2020.



California extends deadline to purchase health insurance

AP

Californians have a little more time to purchase health insurance plans that take effect with the new year.

Sunday was the original deadline to purchase insurance plans from Covered California that take effect Jan. 1. But state officials announced Monday that they have extended the deadline through Friday.

Covered California Executive Director Peter Lee said officials extended the deadline after seeing a strong surge in enrollment last week.

Covered California is the state's health insurance marketplace. Some people who purchase plans through Covered California are eligible to get help paying their monthly premiums.

Next year, California has increased the amount of subsidies available for some people. Plus, the state will begin taxing people who don't have health insurance. Together, state officials said those two things have driven a 16% increase in new enrollments through Covered California.

The final deadline to purchase health insurance through Covered California is Jan. 31. Plans purchased after Friday's deadline won't take effect until Feb. 1.



UPDATE: Covered California Has Extended Deadline to Friday, Officials Say New Subsidies and Eligibility Requirements Are Available

Thadeus Greenson

The state has extended the deadline to sign up and receive Covered California coverage beginning Jan. 1 until Friday due to a surge in enrollment.

According to a press release, “Covered California saw tens of thousands of people sign up for coverage” beginning late last week.

“Open enrollment is full-steam ahead, and this year’s enrollment period is more important than before,” Covered California Executive Director Peter V. Lee said. “Sign up now and you may be eligible for new financial help that is available for the first time, and you can avoid the possibility of paying a significant penalty for not being covered.”

The full Covered California release on the extension can be found at the bottom of the story.

PREVIOUS:

If you want to sign up for health insurance through Covered California and enter 2020 insured, you’re running out of time.

The Dec. 15 deadline (extended to Dec. 20) to sign up in time to start the New Year with coverage is approaching and state officials are reminding California residents without health insurance that they will face a penalty next year. While Congress reduced the penalty for failing to get insured under the individual mandate in the Affordable Care Act, the California Legislature enacted its own version this year, meaning residents who don’t have health insurance next year could face penalties of up to \$695 per person.

But the looming penalties promise to bring more people into the insurance pool, which will reduce costs, said Covered California spokesperson James Scullary. Rates for next year are only going up 0.8 percent statewide, Scullary said, the lowest rate change in the program’s history. And in Humboldt County, he said, the average rate change is a 1.7-percent reduction.

There are also more subsidies available than in previous years, Scullary said, and they are available to a wider swath of customers.

Customers who make less than 400 percent of the federal poverty level — which equates to about \$49,960 for an individual or \$103,000 for a family of four — on average receive subsidies that cover 80 percent of their insurance costs, Scullary said. Further, he said individuals making up to \$75,000 and families of four with incomes up to \$154,000 are now eligible.

Scullary said he's heard from lots of people in Humboldt County who assumed they were ineligible for Covered California and/or subsidies because that was the case a couple of years ago.

"We're really encouraging them to check again because things have changed substantially," he said. "That could make a big difference in people's lives."

To find out if you're eligible, visit www.coveredcalifornia.com or call (800) 300-1506. Scullary said the website also has a tool that allows people to anonymously enter their zip code, household income and ages of household residents in order to see the assortment of plans available and what federal and state subsidies may be available.

Open enrollment for Covered California extends through Jan. 31, though, again, customers must sign up by Dec. 15 to be insured by Jan. 1. As of March, Scullary said about 5,900 Humboldt County residents were enrolled in the program.



After enrollment surge, Covered California extends deadline for Jan. 1 health coverage

Cathie Anderson

After seeing a strong surge in enrollment last week, Covered California has extended the deadline until Friday for state residents to sign up for a health insurance policy that would begin covering them on Jan. 1. The original deadline was Sunday.

"Covered California is still open for business and making sure consumers can have a health plan in place on Jan. 1," said Peter V. Lee, Covered California executive director. "Covered California is putting consumers first, making sure they have time to find the plan that best fits their needs."

Lee said tens of thousands signed up for coverage Wednesday, Thursday and Friday of last week. Many middle-class Californians, he said, are just realizing they now qualify for new state subsidies that will help them cover the cost of their insurance premiums.

Even Gov. Gavin Newsom sent out a reminder that Californians about the new subsidies, tweeting out a video Monday where his chief of staff, Ann O'Leary, hands him a holiday checklist that includes reminders to buy his son, Dutch, that scooter he

wants for Christmas – and to, oh yeah, tell his family and friends that, if they sign up by Friday, their insurance coverage will still start Jan. 1.

“Yeah, but what about this thing on health care?” Newsom asks. “What’s this deadline?”

After O’Leary obligingly “reminds” him what the item means, Newsom touts “first-in-the-nation subsidies that only California’s providing” and reminds O’Leary that it was a good thing that she had insurance when she unexpectedly broke her leg. The video also features a Marvel Comics-style outtake after a screen flashes telling viewers they can sign up at coveredca.com.

Nearly 500,000 Californians are eligible for the subsidies. Covered California estimates that, for the first time in any state, people who earn between 400 and 600 percent of the federal poverty line will be receiving an average of \$460 per month per household.

Insurers are expecting a big increase in the numbers of people enrolling for coverage in 2020, Lee said, so premium increases are relatively flat, averaging just 0.8% statewide. This is what can happen, Lee said, when you build on the Affordable Care Act, informally known as Obamacare.

Lee urged everyone to go to coveredca.com and check the shop-and-compare tool to determine whether they are eligible, saying many people have been surprised to learn they qualify for help. If you need further help with enrollment, call (800) 300-1506.

Although California’s open enrollment period will continue through Jan. 31, 2020, coverage won’t start until Feb. 1 for those who sign up Saturday and thereafter.

Californians who don’t have health insurance will face a tax penalty that would amount to at least \$2,000 for a family of four. That’s because Newsom signed a bill this year that instituted a state mandate that all individuals be insured.

THE ORANGE COUNTY REGISTER

Many Californians say they still can’t afford health insurance, but will 2020 reforms provide relief?

Michael Finch II

Even with access to health insurance at a historic high in the state, a growing share of uninsured Californians say they struggle to afford coverage, according to new survey results.

The new data show the share of people in the state who say cost is their main reason for being uninsured inched upward for the third consecutive year in 2018, according to UCLA's California Health Interview Survey.

Nearly four out of every 10 uninsured residents, or 37%, said the price of insurance was the leading reason for not having coverage. The second most frequent reason, accounting for 19%, was either confusion or they were in the process of learning about and getting insurance. And 17% of people surveyed said they didn't believe in or need it.

The findings came as no surprise to some health providers and policy experts who said the cost of health care remains an underlying challenge in California and beyond. The state's high cost of living, which already weighs heavily on family budgets, is another factor.

However, a number of new laws aimed at shoring up the state's health insurance exchange could provide some relief, they said.

Gov. Gavin Newsom signed legislation this year that will allow people with incomes too high to qualify for Affordable Care Act subsidies to receive financial assistance through the state's health insurance marketplace, as well as grant supplemental help to many who already qualify for the federal tax credits. Another law will penalize those who choose to go without insurance.

It remains to be seen if this mix of policy solutions, which do not apply to employer-provided coverage, will be enough to nudge the state's stagnant uninsurance rate down further.

"The state has created these new premium subsidies that are going to bring down the monthly cost of buying health insurance through Covered California," said Scott Graves, a health care researcher at the California Budget and Policy Center. "That's going to be a huge benefit for a lot of Californians who feel like they have been priced out of the health insurance market in recent years."

But most Californians still access health insurance through their employers, where premiums, deductibles and out-of-pocket costs have continued to rise in recent years, far outpacing wage gains. Workers who are eligible for insurance through their employer do not qualify for the Covered California subsidies.

"The bottom line for employees is that they pay more and more," said Niall Brennan, who runs the Health Care Cost Institute, a nonprofit think tank. "Premiums are going up every year. Deductibles are getting higher and higher."

He added that it's now routine for an individual or a family to have to pay thousands of dollars on their deductible for certain medical services before they can use their coverage. Brennan said it's one of the shortcomings of the Affordable Care Act, which prioritized offering coverage over cost control.

“That’s not really insurance in the traditional sense,” he said. “It’s more like catastrophic coverage — if something really bad happens to you, then the coverage kicks in.”

After years of steady declines, the state’s uninsurance rate has stalled out at about 7%, according to the latest census data. As many as 3.5 million people younger than 65 are expected to remain uninsured by 2022, including undocumented residents, according to the latest estimates from UCLA and UC Berkeley.

“This is really affecting people who are low income and middle class, tremendously,” said Melissa Marshall, CEO of CommuniCare Health Centers based in Davis. “What it takes to provide for your family and then on top of it pay for insurance sometimes is untenable for folks.”

The new reforms, in some ways, are designed to patch weak spots.

The financial assistance from the state comes with a hefty price: More than \$420 million could be spent through the new subsidies to cover 922,000 more people, according to projections by Covered California. Most of the people who could benefit earn between \$50,000 and \$75,000, the analysis shows.

Although it’s not the largest group of uninsured residents, people who lose their Medi-Cal coverage after their earnings grow have always been a concern. Health providers say moving from a public program such as Medi-Cal to private insurance is a risky transition, and people can easily drop out of the health system.

A single mother, for example, who earns \$17,000 and receives a \$5,000 raise after a promotion would be forced to move from largely free Medi-Cal to a more costly private plan, either through her employer or Covered California. The effort needed to understand insurance options and access care can be overwhelming, providers say. And the out-of-pocket expenses associated with private insurance can create additional hardship for those already living paycheck to paycheck.

“We refer to it as the churn — that area around 138% of the federal poverty level where people are getting employment and picking up commercial coverage,” said Jonathan Porteus, CEO of WellSpace Health, a network of community health centers in the Sacramento region.

“They go into that category, but it’s very hard for them to find something to afford.”

Nearly 80% of WellSpace’s 70,000 patients use Medi-Cal, and 14%, including undocumented residents, receive discounted services, he said. The federal and state government reward health centers like WellSpace with more favorable reimbursement rates to help offset the cost of serving the poor.

However, undocumented residents have limited access to taxpayer-funded insurance programs. They are not eligible for Covered California plans, and, even with recently

passed legislation, only those under 26 in California are generally eligible to apply for Medi-Cal.

Health providers and policymakers hope that with the size of premium increases in Covered California plans shrinking, and in some cases premiums declining, more people will buy coverage. Exchange plans will see an average rate increase of less than 1% in 2020, projections show.

If that doesn't work, the state's new tax penalty for people without insurance might motivate some holdouts. The law goes into effect in January and will cost families as much as \$2,100 per year if they go without insurance.

Covered California officials said new insurance signups were already up by 16% over last year as of Dec. 7, accounting for 133,000 policies. More than 1 million consumers have also renewed their coverage.

The federal individual mandate, before it was repealed by a tax reform law passed by Congress in 2017, was supposed to be an incentive to buy insurance. But those fined were often low- to moderate-income people earning less than \$50,000 annually, according to IRS data.

Will the state's new penalty be any different?

Jason Levitis, a researcher who studied state-created tax penalties, said the evidence from other places, namely Massachusetts, suggests California's penalty is more likely to succeed.

"What's important to understand about the (federal health law) penalty is it was never given a chance to work because it phased in over three years," Levitis said. "It started off really small in 2014 and 2015, and finally, in 2016, it reached its full size."

The repeal went into effect this year.

"It's hard to say we got any real results from the experiment with the federal individual mandate. It was never really given a chance to see what it will do," he said.

Levitis said Massachusetts, which provides financial support above what's offered by the federal government, has the lowest uninsured rate in the country and its marketplace insurance premiums have some of the lowest costs. The state also created its own tax penalty in 2007.

"(Massachusetts has) had really impressive outcomes," Levitis said. "Hopefully, California ends up in the same place."



State seeing surge of sign-ups for Covered California health insurance

Ashley Zavala

SACRAMENTO (KRON) — The state is seeing a surge in Californians signing up for its health insurance.

“Getting people signed up is a win-win,” said Peter Lee, director of Covered California.

California officials Monday say they’re encouraged by the numbers they’re seeing so far this open enrollment period.

Lee is the executive director of Covered California.

“We all benefit when more people sign up, health care costs go down, that’s the equation that lead to us having the lowest premium increase in our history,” he said.

Officials say so far this year there’s been a 16 percent increase in the number of people signed up for state health care coverage than this time last year.

The state legislature and governor this year brought back a mandate requiring Californians to have health insurance or else pay a fine.

The state also expanded coverage access to undocumented immigrants under the age of 26.

Lee says what helped boost the numbers the most was a \$1 billion investment into subsidies.

“The Governor said we know there are middle class Californians spending 25 percent of their income on their healthcare, we’re going to help those people, up to 600 percent of poverty: for an individual that means \$75,000 income. For a family of four, it’s \$150,000,” Lee said.

Californians who want state health care coverage by the first of the year should sign up by Friday.

More Californians are buying health care through the state's insurance marketplace

Sophia Bollag

California's health insurance marketplace is on track to enroll more people this year than last year, state officials said Wednesday.

As of Monday, about 230,000 people had newly enrolled in coverage through Covered California, the state's insurance marketplace, a roughly 16 percent increase from this time last year.

Covered California's open enrollment period lasts through Jan. 31, but Californians must sign up by Friday for their coverage to start Jan. 1. About halfway through the enrollment period, Californians have signed up for about 1.38 million plans, according to Covered California.

On a call with reporters, Gov. Gavin Newsom credited the state's efforts to boost enrollment for the coverage gains and keeping costs down.

To encourage more sign-ups, this year's state budget created new subsidies for people making up to 600 percent of the poverty level, about \$75,000 for an individual or \$154,500 for a family of four, who buy insurance on the marketplace.

California also re-instated a fine called the individual mandate for people who don't sign up for health insurance. Congress first created the individual mandate at the federal level through the Affordable Care Act, otherwise known as Obamacare, but repealed it in 2017.

Newsom and Covered California director Peter Lee announced the new numbers the same day a U.S. appeals court ruled the federal individual mandate unconstitutional. California Attorney General Xavier Becerra criticized that decision Wednesday, saying he plans to appeal to the U.S. Supreme Court.

The ruling on the federal individual mandate does not affect California's individual mandate, Becerra said. However, he said continued litigation over the Affordable Care Act perpetuates uncertainty about California's health care system, which relies heavily on authority and funding in the federal law.

Enrolling more healthy people in coverage to offset costs to care for sick people has resulted in a healthier pool in Covered California compared to the federal insurance marketplace, Lee said. That's keeping premium costs down, he said.

“We’re making investments that are saving Californians money,” Lee said during the call.

Newsom said in 2020 he’ll focus on improving Medi-Cal, the state’s health insurance program for low-income Californians, calling it the “core driver of our work into the new year.”

Newsom said he’ll ask the Trump administration for changes to the waiver that lets California operate Medi-Cal separately from the federal low-income insurance program Medicaid, but declined to give details and told reporters he’ll announce more in the coming weeks.

Next year, Newsom said he’ll also look to reduce prescription drug costs, crack down on surprise medical billing and expand coverage to more undocumented adults. Undocumented children can already enroll in Medi-Cal, and undocumented young adults under 26 can access the program in 2020.

Newsom is expected to release a more detailed health agenda in January as part of his 2020-21 budget proposal, which is expected to benefit from a \$7 billion surplus.

Californians can sign up for health insurance through the state marketplace and find out if they qualify for new subsidies at www.coveredca.com or by calling 800-300-1506.

San Francisco Chronicle

Gov. Newsom announces commission will look into single-payer for California

Catherine Ho

Gov. Gavin Newsom has long touted a single-payer health system, and campaigned on it during his successful gubernatorial run.

On Tuesday, he announced a step toward exploring a single-payer financing model and other policies that could get Californians closer to universal health coverage.

Newsom announced the formation of the Healthy California For All Commission, a 17-person body that will begin meeting in January to look into ways to expand health coverage, including, but not limited to, a single-payer model. Members include the head of the Department of Health Care Services, which administers Medi-Cal, the chairmen of health committees in the state Senate and Assembly, the executive director of the health insurance exchange Covered California, as well as academics and health advocates.

Newsom said the commission will look into national health insurance programs in other countries, including Canada and Germany, and consider what might work in California.

“We’ll be exploring in our commission the hybrids in the rest of the world and consider tenets that may work in California,” Newsom said during a call with reporters and Covered California executive director Peter Lee to discuss Covered California open enrollment. “All in the backdrop of reality.”

To enact a single-payer system, California would need federal approval on various components, even if the Legislature were to approve it — and that is all but guaranteed to be rejected by a Republican White House. The state has already enacted changes that take effect in 2020 that didn’t need federal approval — such as new financial assistance for middle-income Californians to pay for health care premiums and expanding the Medi-Cal insurance program for the poor to cover undocumented residents up to age 26.

The commission “allows the governor to explore what direction to take the health care system in for California to potentially get ready for a Democrat in the White House in 2021, which could give the state more leeway,” said Larry Levitt, a health policy analyst at the Kaiser Family Foundation.

“The governor was very outspoken in his support for single-payer health care in the campaign and has not moved the debate forward during his time in office yet,” Levitt said. “This commission may be a way to buy him some time — the political equivalent of ‘the check’s in the mail.’”

The Legislature in 2017 considered a bill that would have created a single-payer system with a price tag of roughly \$400 billion a year, but it was widely criticized by many policy experts because it did not include a detailed financing plan. Assembly Speaker Anthony Rendon, D-Lakewood (Los Angeles County), shelved the bill, calling it “woefully incomplete.”

THE ORANGE COUNTY REGISTER

As health insurance rates continue to rise, some turn to a new model for care
Nicole Hayden

To anyone looking at Laura Campbell’s life from the outside, it might be hard to see any sign of strain. She lives in a nice neighborhood in Huntington Beach and works for a small publishing company. She took an end-of-summer road trip with her kids.

But for the widowed mom of teenage twins, health coverage is just out of reach. The company she works for is not obligated to provide health benefits and doesn’t do so,

and she thinks the cost of insurance would be overwhelming if she enrolled on her own through the state's health insurance marketplace, Covered California.

So, Campbell has opted for what she considers the next best thing: a "direct primary care membership" at Elevated Health in Huntington Beach.

Direct primary care, or DPC, is a growing family medicine business model that has gained popularity in the past decade.

It is like a subscription service for basic care. Patients pay physicians a monthly or annual fee that covers most primary care services, including clinical visits and lab tests. The doctors opt out of dealing with insurance carriers. But it does not cover major, complicated medical situations, such as cancer treatments, emergency room visits, surgeries, and specialty care.

Proponents say DPC fills a gap in current insurance offerings. And, unlike typical insurance-based models where medical services are billed for separately, DPC physicians have no financial incentive to provide more treatments and tests than necessary. On the flip side, this also gives little incentive to provide robust, thorough care.

"You have no idea sometimes what you will actually be paying for care at the hospital," Campbell said. "I love the fact that there is full disclosure of costs upfront, and the membership is so much more affordable for me. ... I also have a real relationship with my doctor, so I feel like I am receiving better care since they know much more about me."

An option for the uninsured

If Campbell signed up for health coverage through Covered California, the state's health insurance marketplace, she would pay from \$580 to \$1,728 a month for her family of three, depending on the level of coverage. She makes about \$90,000 annually, which qualifies her for income-based state subsidies for her family. The least-expensive plan would be considered a "catastrophic" insurance option with higher out-of-pocket costs.

At Elevated Health, she pays \$135 a month for herself and two children. That membership covers typical annual exams in addition to a list of other routine services such as EKGs, urinalysis, glucose checks and mononucleosis tests, among other things. Physicians are typically accessible after hours via phone or email, and some offer telemedicine services.

The membership also lets patients access care like one would order food off a menu. The prescription and lab costs are transparent and offered at wholesale price. A pap smear is \$60, an STD panel is \$41, an ultrasound is \$85, a mammogram is \$85, an X-ray is \$40 to \$60, and a flu shot is \$20.

The savings on prescriptions range from 5% to 98%, depending on the retail price.

Elevated Health has three family physicians, one ultrasound technician, two nurses, a psychologist, a chiropractor and a physician assistant. It serves about 1,000 patients.

The practice also offers counseling with its psychologist, at wholesale prices. The cost is \$80 an hour, compared with about \$180 for other counselors in the Huntington Beach area.

Patients have used funds from their pre-tax health savings accounts to pay for membership fees and services, though the tax code here has been unclear for some time. But in June, President Donald Trump signed a health care executive order designed to make health care prices more transparent, and it lets patients use their HSA accounts for direct primary care services.

A direct primary care membership, however, does not replace health insurance. In California, if people opt out of insurance coverage, they will have to pay a tax penalty under the state's individual mandate, which goes into effect Jan. 1. Campbell will have to pay this penalty if she continues to forgo insurance. For her, the penalty would be just under \$2,000.

DPC physicians still recommend their patients enroll in an insurance plan that at least covers catastrophic emergencies, specialists or other large medical expenses such as cancer treatment. For Campbell, it would have cost an additional \$580 a month to have catastrophic coverage for her family of three.

But direct primary care can be an option for people who can't afford or don't qualify for employer-based plans or coverage through Medicaid or Covered California.

Matthew Abinante, the physician who founded Elevated Health in 2016, said about 40% of its 1,000 patients are uninsured. Some are undocumented immigrants, and a handful, such as Campbell, are employees at small businesses. Some businesses contract with Elevated Health and pay the membership fee for their employees instead of offering insurance, which is often much more expensive.

The other 60% of its patient portfolio consists of insured patients who want a better relationship with their physician, and some are even Medi-Cal patients who had a hard time getting in to see a doctor and opted to pay for a DPC plan. Medi-Cal is California's version of Medicaid, the free or low-cost federal insurance program for low-income residents.

"A lot of my uninsured patients are expressing their frustrations with the new (insurance) mandate because they can't afford a \$300 insurance premium each month that doesn't cover anything," Abinante said.

According to a 2013 report by the California Health Care Foundation, a high percentage of DPC consumers are uninsured or have a high-deductible insurance plan. And DPC remains an option for individuals, such as undocumented immigrants, who are not eligible for insurance programs created under the Affordable Care Act.

For Linda Ramos, 66, of Westminster, direct primary care was a viable option following her divorce when she lost the health insurance she had through her husband.

“I was on certain medication that was costing me hundreds of dollars a month, and a friend referred me to Elevated Health,” Ramos said. “I was paying \$200 a month for medication for restless leg syndrome, and now I am paying \$10.”

Ramos did apply for Medicare but was quoted \$135 per month for a plan, so she opted out of that because Elevated Health was more affordable at \$100 per month.

“I also didn’t want to go to any of the doctors that Medicare said I could go to — they were all so far away, and I appreciated the relationship I had with (Abinante),” Ramos said.

Campbell, who hasn’t had health insurance for many years, plans to sign up her family for a minimal “catastrophic” plan to avoid the state penalty that takes effect next year. Nonetheless, she plans to continue seeking care at Elevated Health for all primary care needs.

“I love the fact that it’s compassionate and the doctor has personal knowledge of you, and I consider my doctor there a friend,” Campbell said. “When I needed to get my kids in for their vaccines before school, they fit me in at the last minute.”

But what Campbell really loves is the way the business is run – she thinks the pricing is much more transparent than how health insurance companies bill patients.

And as far as quality and accountability, Gary LeRoy, president of the American Academy of Family Physicians, said DPC practices are still subject to state medical board requirements.

“It is not some voodoo medicine that is independent of state, federal or local regulations,” LeRoy said. “It is just relieving the practice of the administrative burden of insurance. It’s not relieving them of medical liability or of the Hippocratic oath.”

The business model

With enough patients, direct primary care can be a sustainable business model without having to contract with insurance.

The average annual salary for a family physician in California is about \$220,000, Abinante said. The 35-year-old is paying himself less than half of that but hopes that physician salaries will grow along with his practice.

Abinante spent his residency at an insurance-based family medicine practice and then worked for one year at an urgent care clinic after residency before deciding to launch his DPC practice. He saw about 60 patients a day at the urgent care practice but left because he wanted to develop deeper relationships with patients.

“I took an oath to do no harm, though, so I think that also means to do no financial harm to patients, either,” Abinante said. “I take a lower-than-average salary because I believe in this model so much.”

Of the American Academy of Family Physicians’ 134,600 members nationwide, 3% practice in direct primary care models, said LeRoy, whose group focuses on providing continued training to physicians and policy advocacy.

There are currently about 1,000 DPC practices across 48 states, serving around 300,000 patients, according to the Direct Primary Care Coalition, which lobbies for legislation and policies that support the model. The coalition also tracks DPC locations throughout the country.

Of the DPC practices in operation, 72% have been open less than three years and 11% have been open less than one year. Fewer than 10% have been open for four or more years, according to the AAFP.

Paul Thomas, who in 2016 launched Plum Health, a direct primary care office, said it has been exciting to be part of the growth. When he first opened, he was one of about 400 practices in the country.

The business model comes with a 60% savings on overhead and administrative costs, compared with fee-for-service models, because much of that cost is typically accrued from the administrative tasks of billing insurance companies, according to the AAFP.

Standard primary care physicians spend two-thirds of their time on non-clinical tasks and just one-third with patients, according to the American Medical Association. Non-clinical tasks include things such as typing up patient notes.

Physicians also typically spend an average of 86 minutes at home each night typing up electronic records. Thomas said the DPC model gives him much more flexibility with his time in and out of the office.

“I think it really takes courage for doctors to sacrifice one to two years of a full income to build a practice of their dreams to take care of their patients and deliver the highest-quality care possible,” he said. “I think DPC has saved a lot of doctors from getting burned out, allowing them to practice better and have better relationships with their patients.”

Thomas’ office serves about 550 patients between two doctors. That’s common among most DPC businesses. According to the AAFP, most DPCs serve about 345 patients, but the average target to break even in costs is 596 patients.

A handful of DPC corporations have capitalized on the model by directly contracting with employers instead of individuals. These companies have anywhere from 3,000 to 450,000 patients.

While the small, self-financed DPC offices have continued to grow over the past decade, some of the biggest DPC corporations have shuttered, including those that have tapped financing from investors and venture capitalists.

Qliance Medical Management, based out of Seattle, served 13,000 patients before shutting down in 2017 amid financial problems. Some of its largest employer contracts were with United Food and Commercial Workers and Expedia. Qliance attracted investors such as Amazon CEO Jeff Bezos and Zillow Chairman Rich Barton, among other funders, according to a 2017 Seattle Times article.

In the past few years, White Glove Health, which served about 500,000 patients, shuttered its DPC business, and MedLion, which served about 3,000 patients, is now mostly a telemedicine service.

But other large corporations have leaned into the industry.

Colorado-based Paladina Health, which was originally funded by DaVita in 2011 before being acquired by New Enterprise Associates in 2018, now serves 170,000 patients in 18 states. In 2013, it had 7,200 patients.

“We directly contract with large and small employer groups, which is what sets us apart from the mom and pops,” said Chris Miller, Paladina Health CEO. “We build clinics directly for employer groups, sometimes on-site or near site that more than one employer can use. The employer contracts directly with us, and the employee receives free wrap-around primary care.”

Those employers typically couple that with a high-deductible health insurance plan, but that is up to the employer to decide, not Paladina.

The financing model for large DPC businesses is unique but allows them to provide more care, Miller said.

“There are a lot of health care technology companies funded by private equity and venture capitalists, but not many primary care companies are funded that way,” Miller said. “Because of that, we are able to fully (fund) our physicians’ salaries — instead of relying on an insurance company — and create incentives for better outcomes.”

At Paladina, physicians get financial bonuses for better outcomes and better patient-satisfaction scores.

Miller said he expects the model to continue to grow, especially with the Centers for Medicare and Medicaid Services set to launch a DPC pilot program in 2020 to serve the Medicare population, though what exactly that will look like isn't yet clear.

Support from the AAFP has continued to push the growth of the smaller businesses, too.

LeRoy said his organization hosts an annual DPC summit where it provides interested physicians with DPC tool kits to help them get started.

New physicians trying to set up a DPC practice for the first time might have a rocky start as they work to gain patients and introduce communities to this new model of health care.

Anecdotally, LeRoy said he has seen DPC models with just 600 to 800 patients that are as financially successful as traditional family medicine practices that might carry 2,500 patients at a time. This is possible because the physicians are able to collect the payments directly instead of going through insurance, where reimbursement rates are lower.

At the heart of the DPC model, LeRoy said, is an urge to reconnect with the humanity of medicine.

“Physicians have this problem with burnout and loss of their joy of medicine,” LeRoy said. “The ones that have transitioned to DPC seem to be very happy and wouldn’t want to go back. It returns the joy of taking care of patients, which is why we went into medicine in the first place.”



New health law requiring all Californians have health insurance kicks in Jan. 1 Andy Krauss

CALIFORNIA — California's new health laws will kick in on Jan. 1, 2020, including a requirement that all Californians have health insurance, according to Covered California.

The state created a new state individual mandate penalty that is similar to the Patient Protection and Affordable Care Act's penalty. It will be administered by the Franchise Tax Board and collected when people file their 2020 taxes starting in 2021. A family of four facing a penalty would pay at least \$2,000, and potentially more, for not having health insurance throughout 2020, Covered California stated.

Californians are encouraged to enroll by Jan. 31, before the state's open enrollment period ends, or face the penalty if they go without healthcare coverage in 2020.

"Open enrollment is underway right now. That means now is the time to sign up for a quality health plan through Covered California so you are protected in case you get sick or injured, and so you do not have to worry about a possible penalty," Covered California Executive Director Peter V. Lee said. "Writing a check to the Franchise Tax Board when you file your 2020 taxes isn't the real penalty. It's getting hurt or ill and ending up with a \$50,000 hospital bill."

Covered California says the return of the penalty was an important element in the organization's record-low rate change of 0.8% in 2020, which they say means consumers have already benefited from the new policy.

In addition to the penalty, Covered California says the state is making new financial help available to eligible consumers to help further lower the cost of their coverage. On average, consumers between 200 and 400 percent of the federal poverty level will receive \$21 per household per month on top of their federal tax credits, while people who earn between 400 and 600 percent of the federal poverty level will receive an average of \$460 per household per month, according to Covered California.

Covered California says more than 540,000 people have already been found eligible for the new financial help.

"More than half a million Californians have already found out they will benefit from this new money," Lee said. "Consumers have through the end of January to see what plans are available to them and whether they qualify for financial help from the federal government, the state or both."

"The Affordable Care Act is alive and well here in the state of California," Gov. Gavin Newsom said. "We are saving lives, we're expanding coverage, we're deepening subsidies and we're doubling down on our commitment to fulfill the law's promise and its potential."

Those interested in learning more about their coverage options can visit Covered California's website. Consumers can also find out if they are eligible for financial help and see which plans are available in their area by entering their zip code, household income and ages of those who need coverage in the organization's shop and compare tool.

New law means California households without health insurance could lose thousands of dollars

Andy Krauss

Uninsured Californians who think the 2017 repeal of the federal tax on people who refuse to obtain health insurance takes them off the hook could face a painful surprise when they pay their 2020 state taxes.

A new California law that went into effect on Wednesday resuscitates the requirement that people obtain health coverage or face tax penalties. An adult who is uninsured in 2020 face could be hit with a state tax charge of \$695 or 2.5% of his or her gross income.

A family of four could pay a penalty of at least \$2,085.

The penalty is designed to help fund more than \$400 million in new annual state insurance subsidies, including first-time assistance aimed at middle-income households. Though leaders of the Covered California insurance exchange are emphasizing the penalties, some local observers contend many people still don't know about them.

"I barely know," said Connie Kline, a Simi Valley tax preparer insured through Covered California. "I can pretty much tell you the public doesn't know about it."

Covered California spokesman James Scullary contended the new subsidies and the penalties are part of the reason sign-ups are up in an enrollment season that ends on Jan. 31. But some of the agents helping people say many of their clients come in unaware.

"I would say about half and half," said Roger Hayek, a Newbury Park insurance agent.

How does it work?

Households could pay a flat fine — \$695 for each uninsured adult and \$347.50 for each child — or 2.5% of their income, whichever is higher. The penalties will be paid to the California Franchise Tax Board when 2020 taxes are paid in the year 2021.

Who is exempt?

People uninsured for no more than three consecutive months are exempt. People who don't make enough to file state taxes also avoid penalties as do households where coverage cost would be more than 8.24% of income.

Other exemptions include general hardships that can range from bankruptcy to death of a loved one, membership to a group that relies solely on religious methods of healing, incarceration and membership in a federally recognized American Indian tribe. For a full list, go to <https://tinyurl.com/wjxsqt8>.

Why is there a penalty?

The penalty was included in the California budget as a way to provide for new state insurance subsidies. The help includes state aid for people who qualify for federal help and first-time subsidies for middle-income families.

The latter subsidies are available to many families who earn between 400% and 600% of the federal poverty level — about \$50,000 to \$75,000 a year for an individual. Eligibility is also affected by factors including the cost of health care in an area.

Covered California officials say the the middle-income families eligible for the subsidies could receive an average of \$460 a month.

What happened to the federal mandate?

The Affordable Care Act also known as Obamacare included a requirement that people obtain insurance or face federal tax penalties. Congress reduced the penalty to \$0 in a 2017 action that kicked in last year.

A federal appeals court in New Orleans ruled in December that the federal insurance mandate was rendered unconstitutional by the congressional action. Supporters of the mandate and the Affordable Care Act say they will appeal to the U.S. Supreme Court.

What are the deadlines?

Open enrollment for Covered California ends on Jan. 31 though late enrollment is an option for people who meet exemptions that range from being newly married to recently moving to California. People who want to find local experts who can help them enroll can go to <https://www.coveredca.com/find-help/>.

POLITICOPRO

California legislation would preserve Obamacare preventative benefits

Angela Hart

State Sen. Richard Pan proposed legislation today to enshrine existing federal health care protections mandating health insurers cover a broad range of preventive services, even if Obamacare is struck down by the courts.

CA SB406 (19R) would "indefinitely" extend Affordable Care Act provisions requiring health plans in California to cover preventive care, from breast cancer screenings to tobacco use counseling, without patient cost-sharing such as co-pays or deductibles, according to the legislation.

It comes as Republican-led states, backed by President Donald Trump, have asked courts to dismantle Obamacare. Democratic states, led by California, are asking the U.S. Supreme Court to quickly take up the legal challenge, which could decide the fate of the federal health care law.

Pan (D-Sacramento) told POLITICO today that he gutted and amended his bill because of the legal challenge to Obamacare.

"We want to make sure that doesn't get upended and we have it in state law that people should have access to preventive services without having cost-sharing," Pan said in an interview. "Certainly it's being driven by attacks on the Affordable Care Act."

Pan didn't rule out additional state measures preserving Obamacare features, including popular protections for people with pre-existing conditions.

"We'll have to evaluate other options. We want to see where the courts are going," he said. "But right now we wouldn't want to have a situation where people lose access to preventive services because of the [Trump] administration or some court decision."



Poll: On Health Care, Democrats and Democratic-Leaning Independents Trust Sen. Sanders the Most, but Significantly More People Support a Public Option than Medicare-for-All

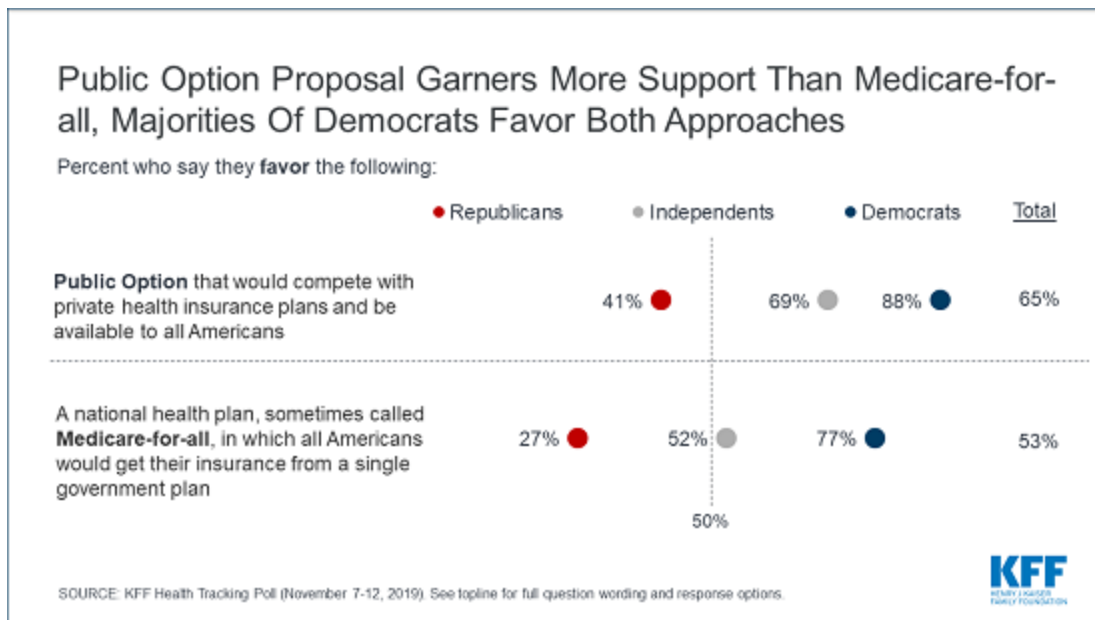
Craig Palosky

3 in 4 Americans Do Not Expect Congress to Take Action to Lower Drug Costs Before the 2020 Election

Ahead of tonight's Democratic presidential debate, Sen. Bernie Sanders is the candidate most trusted on health care by Democrats and Democratic-leaning independents, though the Medicare-for-all plan he has championed is significantly less popular than the "public option" approach put forward by some other candidates, [the latest KFF Health Tracking Poll](#) finds.

Among the overall public, a narrow majority (53%) support the idea of a Medicare-for-all plan that would cover all Americans through a single government plan. At the same time, two-thirds (65%) say they support a government-run health plan that would compete with private insurance, often called a public option. Large majorities of Democrats support both a public option (88%) and Medicare-for-all (77%).

Most Republicans oppose both approaches to expanding coverage, but more of them favor a public option (41%) than Medicare-for-all (27%). Majorities of independents support both options, though a larger share favors a public option.



The poll also examines the public’s views towards Medicare-for-all when they are provided descriptions that include the trade-offs under consideration.

When a Medicare-for-all plan is described as requiring many employers and some individuals to pay more in taxes while eliminating both out-of-pocket costs and premiums for all Americans, the public is split with equal shares (48%) supporting and opposing it. The public is also divided when the plan is described as increasing taxes individuals will personally pay, but decreasing their overall costs for health care (47% in favor, 48% opposed).

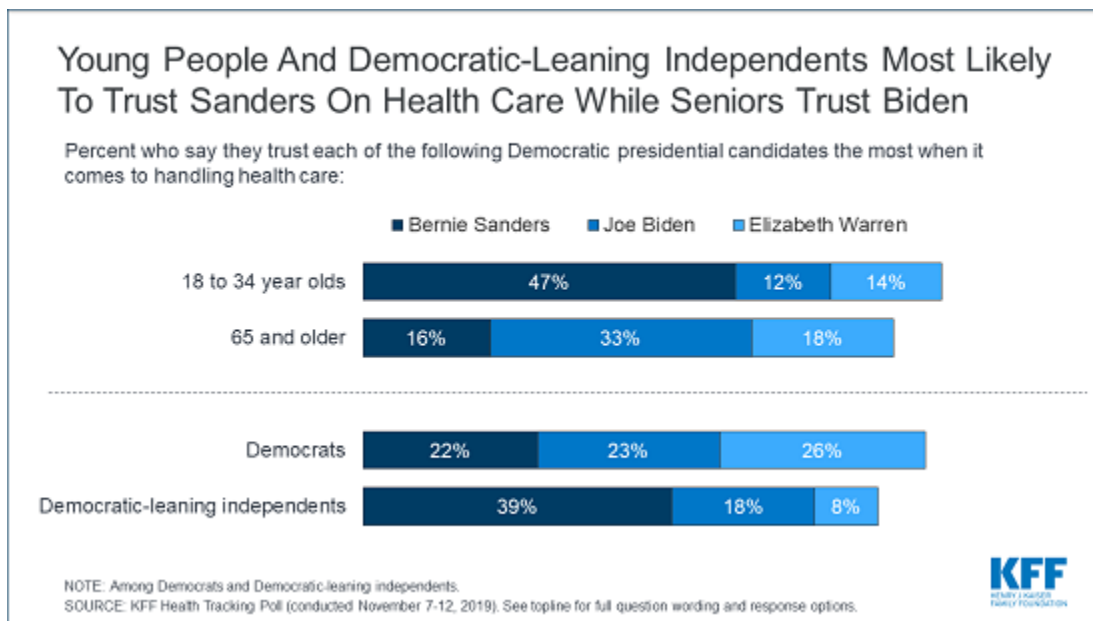
In Primary Race, Sen. Sanders is Most Trusted by Younger Adults; VP Biden Leads among Seniors

The poll finds that Sen. Sanders, who has drawn national attention to his Medicare-for-all plan since his 2016 presidential run, has built a significant trust advantage among Democrats and Democratic-leaning independents.

When asked which candidate they trust the most to handle health care, nearly three in 10 (29%) name Sen. Sanders, with former Vice President Joe Biden (21%) and Sen. Elizabeth Warren (19%) not far behind. No other presidential candidate comes close.

Sen. Sanders is by far the most trusted candidate among those ages 18-34, named by nearly half (47%) of this group. Vice President Biden is the most trusted among seniors by a wide margin (33%, with Warren next at 18%). Sen. Sanders holds a clear advantage among independents who lean Democratic, with four in 10 (39%) naming his as their most trusted candidate on health care while pure Democrats are divided, with

similar shares saying they trust Sen. Warren (26%), Vice President Biden (23%) and Sen. Sanders (22%).



Health care remains Democrats’ top issue, with one in four (24%) Democrats and Democratic-leaning independents offering it as the issue they most want to hear candidates discuss in the next debate. Smaller shares name the environment/climate change/energy (12%), immigration (6%), the economy and jobs (5%), education (4%) or gun control (4%).

Large shares of Democrats and Democratic-leaning independents say the candidates are spending too little time talking about how their health care plans will affect seniors on Medicare (50%), how to pay for proposed changes (47%), whether their plans would increase taxes on the middle class (45%), and how they will work with Congress to enact their plans (45%).

Most Say Washington Isn’t Doing Enough to Lower Drug Costs and Doubt Congress Will Pass Anything

In spite of White House and Congressional proposals to lower what people pay for prescription, the poll finds that large majorities believe President Trump and his administration (70%), Democrats in Congress (75%) and Republicans in Congress (77%) are not doing enough to lower drug costs.

Seven in 10 Americans (72%) say it’s unlikely that Congress will pass legislation to lower drug costs in the next year. Majorities of Democrats, Republicans and independents are pessimistic about the prospects for enacting drug-cost legislation.

Despite ACA Marketplace Premiums Falling, Few Think That Is the Case

The Affordable Care Act's 2020 open enrollment period began this month, allowing people who buy their own coverage or are uninsured an opportunity to sign up for Marketplace coverage.

Premiums on average are somewhat lower this year than last year, though few people know it. The poll finds just 6% of the overall public believe premiums on average are lower this year, a fraction of the share (44%) who say premiums are up this year.

When assessing how well the health insurance marketplaces in the nation are working, the public is divided with similar shares saying they are working well (45%) as saying they are not working well (47%).

People are somewhat more positive about their state's marketplace, with half (52%) saying it is working well. People living in states that run their own marketplaces are more likely to say their marketplace is working well (58%) than those living in states relying on the federal government's HealthCare.gov marketplace (48%).



Critics say 'junk plans' are being pushed on ACA exchanges

Yasmeen Abutaleb

The Trump administration is encouraging consumers on the Obamacare individual market to seek help from private brokers, who are permitted to sell short-term health plans that critics deride as "junk" because they don't protect people with preexisting conditions, or cover costly services such as hospital care, in many cases.

Consumers looking at their health insurance options on the website for the federal marketplace, called healthcare.gov, may be redirected to other enrollment sites, some of which allow consumers to click a tab entitled "short-term plans" and see a list of those plans, often with significantly cheaper premiums. Short-term plans were once barred from the exchanges because they were considered inadequate coverage and do not meet the insurance requirements laid out under the Affordable Care Act. If consumers select a short-term plan, they are directed to call a phone number to finish signing up, according to screenshots provided to The Post.

Critics say that both the sale of short-term plans through private brokers and consumers' ability to select such plans are the latest examples of Trump administration efforts to weaken the ACA after failing to repeal and replace the law in Congress. The president has repeatedly contended that short-term plans provide "relief" from expensive individual market insurance plans that are unaffordable to many consumers. The rule allowing the sale of such plans was finalized late last year, just weeks before open enrollment, so this is the first year they are widely available.

In addition to these efforts, the administration is also seeking to void the law in court, siding with a group of Republican state attorneys general who argue it is unconstitutional since Congress zeroed out the penalty for not having insurance in its 2017 tax overhaul legislation. A trial court in Texas ruled the entire law invalid late last year, and an opinion is expected at any time from the U.S. Court of Appeals for the 5th Circuit. The law is likely to end up in front of the Supreme Court for a third time, possibly amid the 2020 presidential election.

Under the ACA, all health insurance plans have to cover 10 essential health benefits, including maternity and newborn care, prescription drugs, emergency room services and mental health. Short-term health plans do not have to cover those services, can discriminate against those with preexisting conditions and set caps on how much they are willing to pay, which is prohibited for Obamacare plans.

Brokers often make higher commissions on short-term plans, health policy experts said, which gives them an incentive to sell them. They are supposed to present ACA-compliant plans to consumers, but are allowed to provide other options, including short-term plans. Some brokers make clear that such plans are not as comprehensive as ACA plans, but experiences differ.

“The whole business model is signing people up for coverage and getting a cut of what they sell, and the place they’re going to make their money is selling these short-term plans,” said Nicholas Bagley, a professor of law at the University of Michigan and proponent of the ACA. Consumers “don’t fully understand the lack of protections if they go over some annual or lifetime [insurance] limit. These plans don’t cover preexisting conditions.”

The administration’s use of outside brokers has prompted nearly two dozen Senate Democrats, including Democratic presidential candidates Elizabeth Warren, Kamala D. Harris and Amy Klobuchar, to send a letter to CMS on Wednesday expressing their concern over the promotion of short-term health plans.

“We are concerned that [CMS] is not only failing to conduct sufficient oversight to protect customers, but is actively emailing consumers to encourage them to obtain coverage through third-party agents and brokers instead of the HealthCare.gov website,” the senators wrote in a letter. Democratic New Hampshire Senator Jeanne Shaheen orchestrated the effort.

Such plans were previously available for periods of three months or less and could not be renewed, but the administration late last year finalized a rule that allowed for the plans’ availability for up to 12 months, with the option to renew them for up to three years. A federal judge sided with the administration in a court challenge to their expanded availability and upheld the rule in July. Consumers still cannot use government subsidies to purchase short-term plans, however.

“For most of the people buying on the exchanges, this would be worse than what they’ve been buying, especially because the majority of people who buy on exchanges

get help with their premiums,” said Allison Hoffman, a law professor at the University of Pennsylvania Law School.

The Centers for Medicare and Medicaid Services has sent at least five emails so far to individual market consumers encouraging them to use outside brokers, including through a service called Help on Demand, to sign up for health insurance, according to emails obtained by The Post from a recipient of ACA market emails. The agents and brokers must be registered with the federal exchanges, CMS said in a statement, and they help consumers sign up for individual market plans.

“While agents and brokers are required to provide assistance with Exchange, Medicaid and CHIP coverage and are directed to enroll consumers in such coverage options whenever possible, they are not prohibited from sharing information on other coverage options, such as those offered off-Exchange,” a CMS spokeswoman said.

Some critics of the policy say the expanded sale of short-term plans may be one of the factors depressing enrollment in Obamacare plans, which dropped 13 percent in the first three weeks of the sign-up period, compared to the same period last year, according to federal data released Wednesday. During the 2019 open enrollment, 1,924,476 people signed up for individual market plans in the first two weeks of enrollment, compared to 1,669,401 for 2020. Open enrollment ends on Dec. 15.

CMS said it has used Help on Demand for three years, but the agency has increasingly encouraged consumers to seek their advice through emails directing them to the service’s website.

The Trump administration has drastically cut federal funding for “navigators” — grass roots organizations that help people sign up for ACA plans, including those who may not otherwise know they are eligible for coverage. .

Premiums for the most common type of Obamacare plan dropped by 4 percent for 2020, CMS said last month, and the vast majority of consumers on the individual market qualify for government tax subsidies that help cover the cost of their insurance. However, consumers complain about high deductibles and premiums in individual market plans.

San Francisco Chronicle

Health care costs for California workers are growing far faster than incomes

Catherine Ho

Californians who get health insurance through their jobs are having to spend a greater share of their paychecks on health care costs, according to a new analysis of employer-

sponsored health plans to be released Thursday by the Commonwealth Fund, a nonprofit foundation that researches health industry trends.

California workers went from spending 8% of their income on health insurance premiums and deductibles in 2008, about \$4,100, to nearly 12% of their income on premiums and deductibles in 2018, about \$6,900. That is a 68% jump in employees' health care spending over the past decade — which far outpaces wage growth during the same period. Between 2008 and 2018, median household income in the state grew just 16%, from about \$52,000 to \$60,000, according to the report.

Workers in California went from paying on average \$2,600 in premiums in 2008 to paying \$4,100 in premiums in 2018. Their deductible costs went up \$1,450 to nearly \$2,800 during the same period.

The analysis provides data for each state and was based on responses from 40,000 private sector U.S. employers that provide health plans for their workers. Employer-sponsored health plans cover about half of Americans under age 65, or roughly 164 million people.

California's figures largely mirror the national trend. Nationally, employees' contributions to insurance premiums and deductibles jumped from about 8% of median household income in 2008 to nearly 12% of median household income in 2018, according to the report.

The report does not specify how much more employers are paying for their workers' health care, but companies typically pay between 70% and 80% of premiums, so they too are shouldering the burden of rising health care costs.

The primary driver of rising health care prices is hospitals raising their prices for commercial health plans — in part because they are often the only medical provider in town and have leverage to do so — and passing those costs onto employers, the report's authors said.

Prices for health care services, such as medical procedures and hospital stays, are negotiated privately between hospitals and the insurers or employers that pay for their workers' care. Even huge employers like Walmart and Amazon have limited leverage when negotiating with hospitals outside of the few regions where they employ large portions of the population, said Dr. David Blumenthal, president of the Commonwealth Fund.

"Amazon may dominate Seattle but doesn't dominate anywhere else, and the same is true for Walmart," he said. "So when they go to the local hospital and say, 'Give us a better price,' the local hospital says, 'No thanks.' They can live without that segment of the population. That's the nature of our health care markets. There is little restraint on pricing."

Hospital consolidation has given providers more ability to set prices, he said.

Most “hospital markets in the U.S. are high concentrated, meaning there’s no competition,” Blumenthal said. “So the Walmarts of the world can’t say to the hospital that refused to lower prices, ‘OK, we’ll go to the hospital down the street.’ There is no hospital down the street.”

In California, concerns over anticompetitive pricing by large hospital chains prompted Attorney General Xavier Becerra to sue Sutter Health, Northern California’s largest health system, alleging that it used its market power to raise prices — a charge that Sutter denied. The state and Sutter reached a confidential settlement last month.



It’s Obamacare Season. Here’s What You Need To Know.

Shefali Luthra

During Wednesday night’s Democratic presidential debate, candidates touched on “Medicare for All,” “Medicare for all who want it” and other ways to reform the American health system.

But in the backdrop, it’s once again Obamacare sign-up season.

Despite repeated efforts by Republicans in Congress to undo the Affordable Care Act, the controversial law’s seventh open-enrollment period launched this month to relatively little fanfare. It ends Dec. 15.

Individual plans for 2020 are cheaper — premiums are lower, on average, and in some areas people who qualify for government subsidies could end up with no monthly payment. Meanwhile, a pending court case threatens to overturn the entire law, with no clear replacement plan in the works. All these factors have combined to create a cloud of confusion and misunderstanding — some even say misinformation — about the availability of this health coverage.

Here’s what consumers need to know.

The ACA is intact — at least for now.

The Affordable Care Act is still the law of the land.

The GOP-led Congress gutted a key part of the law — the penalty for the individual mandate — that required everyone to have coverage. But other key tenets of the ACA

remain in place, including the individual marketplace it created where people can shop for health coverage.

You might not hear much about that. The Trump administration has dramatically scaled back its outreach and marketing budget for the 2020 open-enrollment season — allotting about \$10 million for such efforts, compared with the more than \$100 million the Obama administration spent.

Lack of outreach, combined with Republican efforts to overturn or undermine the law, could give consumers a wrong impression, said Katie Keith, a health policy consultant who frequently writes about the health law.

So far, about 930,000 people have signed up for coverage. That's still slightly lower than where things were last year — and first-day website glitches may have played a role, suggested Sabrina Corlette, a research professor at Georgetown University's Center on Health Insurance Reforms.

“The irony is, things are really stable, and depending on your state, you can really save,” Keith said. “Without advertising and information, folks are going to miss out on the deals they could get.”

You can get a cheaper plan this year, but it will probably require a bit of work.

Those deals can be pretty significant. On average, premiums are down 4% nationally over last year for silver-level plans sold through the federal marketplace. In some states, they're even cheaper.

Many people don't realize that if their incomes are below 400% of the federal poverty level (just under \$50,000 for an individual or about \$103,000 for a family of four) they qualify for federal subsidies — tax credits that help them pay for individual marketplace plans, Corlette said. The federal government has an online calculator that indicates whether you fall into this bracket.

That tax break can make it easier to find affordable, comprehensive coverage, Corlette said, and she recommended that people who have 2019 ACA plans shop around the marketplace to make sure they get the best deal going into 2020. (What plans charge can change each year.)

People who bought coverage last year and don't shop around will be automatically reenrolled in their old plans — which may not be the best for their needs and may be more expensive than other options.

Also worth noting: Federal courts recently blocked a rule that would have penalized recent legal immigrants who use those subsidies. Known as the “public charge” rule, it would have counted that subsidy against people looking to stay longer in the United States.

The court ruling means that, at least for now, legal immigrants should also be able to purchase subsidized health insurance with no penalty, Corlette said.

“If you have concerns or are worried, you should consult an immigration attorney. But assuming you are a legal resident, nothing has changed in terms of your entitlement,” she said.

Not everything that looks like an Obamacare plan actually is one.

Consumers should be wary of plans that appear to meet ACA standards but actually fall short.

The Trump administration has loosened restrictions on non-ACA policies — “short-term plans” — so that they can last up to 12 months. (Previously they lasted only three months and were treated as bare-bones, stopgap insurance.)

Pitched as a cheaper alternative to ACA coverage, they are allowed to factor in preexisting medical conditions — and can reject people because of their medical history. They also generally cover a much narrower range of benefits. Some have lifetime caps on benefits, and they typically don’t cover prescription drugs.

These plans are not eligible for federal subsidies.

“If you were to Google something like ‘ACA plan’ or ‘Obamacare plan,’ the first results will return insurances that are not ACA coverage,” Corlette warned. “A lot of it is going to be junky, skimpy coverage.”

One easy way to distinguish ACA-compliant plans from others: Make sure you’re shopping through [healthcare.gov](https://www.healthcare.gov) or an alternative site set up by some states. Consumers who work with an insurance broker should be sure to communicate their desire to choose an ACA-compliant plan.

Meanwhile, federal courts are weighing a legal challenge that could strike down the ACA. It’s not clear what would happen if that transpired. For now, the case shouldn’t affect your coverage decisions.

A group of Republican attorneys general and governors filed a lawsuit in 2018 arguing that since the Supreme Court upheld the ACA in 2012 specifically because its individual mandate was deemed a valid exercise of Congress’ taxing power, reducing that tax to zero — as Congress did — makes the entire law unconstitutional. It’s an argument that many legal experts say is shaky, but a federal judge in Texas agreed with those who brought the suit.

The case, known as *Texas v. Azar*, is awaiting a ruling from the 5th Circuit Court of Appeals. The administration, meanwhile, has declined to defend the federal law. A group of Democratic attorneys general has stepped in, in their stead.

If the appellate court sides with the trial judge to overturn the law, the decision would likely be stayed and the case appealed to the Supreme Court. That could drag things out until next summer at the earliest.

The administration hasn't indicated what it might do if the health law is struck down — a scenario that would gut the individual marketplace and eliminate the ACA's consumer protections. But most experts agree it is also not likely to affect the 2020 coverage year.

Earlier this month, Joe Grogan, who heads the White House's Domestic Policy Council, reiterated that the administration "will be prepared after that decision comes down" — adding that "nothing's going to happen immediately."

"This will surely go to the Supreme Court," Grogan said. "It may or may not be decided, probably not decided, before the election."

But it's unclear what a White House response would involve. Neither President Donald Trump nor Republicans in Congress have put forth a health care proposal that would maintain the protections Obamacare put in place.

That could be worrisome down the line, Keith and Corlette said. But any impact is far enough away that it shouldn't weigh on how consumers approach buying health insurance for the next year.

"Nothing will change right away, and it shouldn't affect anybody anytime soon," Keith said. "Go enroll. Pay your premiums."



Health-care sharing ministries promise relief from high insurance costs. But there's a catch.

Helaine Olen

This past March, you may have seen a video of President Trump bounding onto the stage at the 2019 Conservative Political Action Conference and hugging the American flag. And if you looked in the corner of some of the shots, you would have seen the name "Liberty HealthShare."

Liberty is one of the faster-growing players in the world of health-care sharing ministries, through which an estimated 1 million Americans pay their medical bills. The company has exhibited at CPAC for a number of years, and in 2019 paid \$250,000 for a platinum sponsorship. In the past, it's explained its participation in the far-right conference as an opportunity to share its offering with "an audience that is invested in religious and economic liberty." When CEO Larry Foster also spoke at the 2019 conference, he told

them, “Health sharing is a uniquely American idea that’s based on choice, freedom and access.”

The “freedom” on offer? Freedom from health insurance and the Affordable Care Act. Sharing ministries are not health insurance. They are not bound by government insurance regulations. They need not maintain the financial reserves required of a health insurer. They frequently fall into “a regulatory vacuum,” in the words of JoAnn Volk, a professor at Georgetown University’s Center on Health Insurance Reforms.

In fact, the months after Liberty promoted itself at CPAC, complaints about unpaid member bills proliferated, so much so that Foster felt compelled to address the issues in a September blog post. When I recently asked why Liberty would spend money to sponsor CPAC even as members were facing unprocessed medical claims, company spokesperson Terrie Ipson told me in an email, “Marketing dollars do not come from the members’ sharing dollars so it has no impact on the sharing of medical expenses.”

The growth of health-care sharing ministries is one of the more surprising stories of the world made by the Affordable Care Act. A cross between a GoFundMe, a mutual aid society and a lending circle, people who are enrolled pay the medical bills of other members. The groups, which originated during the 1980s in small religious communities like the Mennonites, were exempted from following coverage guidelines mandated by the ACA. At the time, they were used by an estimated 100,000 Americans.

So what accounts for the large increase in membership? Well, health-care sharing appeals to the American tradition of self-reliance, and the belief that personal charity can substitute for government action. But more importantly, it gives enrollees the chance to save a buck.

As costs increased for plans on the ACA exchanges, health-care sharing plans experienced more moderate inflation. A family would pay \$529 a month for Liberty’s Complete offering, which offers \$1 million in coverage per medical incident, after the family meets an “annual unshared amount” of \$2,250. Compare that with the exchanges, where a family not eligible for subsidies would almost certainly pay — at a minimum — several hundred dollars more a month.

So how can they do this? Well, a traditional health insurer needs to take all comers and offer a basic package of benefits. Health-care sharing ministries, exempt from the ACA, don’t have to do any such thing. They don’t need to — and almost always don’t — pay for birth control or abortion services. They can say no to mammograms and mental health services. They can impose yearly and lifetime caps on spending.

They may also ask for religious or behavioral commitments. There are ministries that demand enrollees attend church services regularly or make an explicit religious commitment, or that they refrain from taking illegal drugs, drinking alcohol, smoking or engaging in premarital sex. Liberty won’t even pay for injuries resulting from what they term “hazardous hobbies” such as rock climbing.

The health-care sharing ministries are, for the most part upfront about the fact they are not health insurance and state that fact clearly on both their websites, enrollment forms and membership cards. But confusion persists among many people about how they are different.

Take Lindsay Bideaux, an Omaha hairdresser. Liberty cost her half of what an ACA exchange plan would, she told me. The ministry, which Bideaux first heard about from a co-worker, “was the kind of insurance that would work for me.” But unlike insurance, “neither the organization or any participant can be compelled by law to contribute toward your medical bills,” as Nebraska’s Department of Insurance put it in a consumer alert issued last year.

When Bideaux got pregnant, there were months-long lags in the payment of some of her medical invoices. Pediatrician bills for her daughter, born in March, remain entirely unpaid. Two providers, including the pediatrician’s office, reported Bideaux to a collection agency when no payment came after several months. “They’ve definitely left me in a bind,” she said. Randy Romanik, Bideaux’s partner, who has his own separate policy with the company, has called Liberty constantly, trying to get resolution. (The company told the family Thursday those bills finally had been processed.)

Ipson, the spokeswoman for Liberty, would not comment specifically on Bideaux’s situation, citing medical privacy laws, but did tell me in an email that “implementation of new technology to better manage members’ records earlier this year caused issues with some previously submitted bills.” She added, “We have been transparent with our members in acknowledging the problems and continue to work diligently to identify these bills and share them as quickly as possible.”

Even people who are financially savvy can find themselves surprised by the ins and outs of this coverage. Ryder Meehan, a San Francisco entrepreneur, signed up for one after reading about them on a blog devoted to the FIRE (“Financial Independence, Retire Early”) movement, only to realize after his wife got pregnant that the hospital she hoped to deliver at considered ministry plans the equivalent of self-pay and asked for a hefty deposit up front. This is not uncommon. “We cannot negotiate group rates with [health-care sharing ministries],” says Elizabeth Fernandez, a spokeswoman for the University of California at San Francisco, home to three medical centers. “For hospital procedures, we try to collect the entire amount before service.”

Health-care sharing plans often spin their non-ACA compliance as a positive. As Foster said at the 2019 CPAC, “The simple idea all of us in this room believe is that government doesn’t know best.” I heard variations of this repeatedly while reporting this piece. Rob Hessler, an artist in Savannah, Georgia, told me the insurance broker who sold his family a health-care sharing plan with Alera Health Care said, “something like they are not subject to all the exact same rules and stuff but he was making that sound as though he was completely presenting that as a positive.”

Some “positive.” Hessler and his wife Gretchen Hilmers spent almost the entirety of her recent pregnancy battling with Alera over unpaid bills, in part because the firm initially

denied many of their claims, saying the couple was no longer enrolled in the plan, a situation that was only partially resolved within the past month. Even more concerning, the family almost lacked any coverage for the baby's birth. Alera recently canceled their sharing option, as a result of a court agreement they reached with the ministry the company was partnered with at the time the couple originally signed up. But when Hessler and Hilmers sought to reenroll in another Alera offering, they discovered Hilmers's pregnancy would be considered a preexisting condition. Here they experienced a bit of luck: Because the cancellation was considered a break in coverage, the couple was able to enroll in an ACA-compliant plan before the child's birth. "Thank God for Obamacare," Hessler told me.

Alera spokesman David White told me that privacy laws prevented him from commenting on the specific situation but that, "to be eligible for maternity services ... a member would have had to be on the program for 10 months of continuous membership," adding that the company "will review each situation on a case-by-case basis and exceptions are made." The next morning, the company called the couple and offered to renew their coverage. They declined.

In fact, Alera is the rare health-care sharing outfit that's had its wings clipped by several states. Washington state banned Alera and its current partner ministry, Trinity Healthshare, from enrolling new members in the state, citing "misleading" sales practices that led to consumers to believe the company's offering was ACA-compliant. Colorado did the same in August. Alera has also agreed not to accept new business in Texas, after the state filed a lawsuit making similar claims. Alera denies all this and sent me a statement saying, "Alera will continue to vigorously defend against false claims made about the administrative, marketing and other support services." White also pointed toward a plan brochure that said "This is not insurance" on every page — albeit at the bottom of the page, in very small print.

To be fair, there are thousands of Americans satisfied with health-care sharing. Many ministries attract few member complaints. But satisfied testimonials can't compensate for a greater truth. For all the talk of charity and biblical values, health-care sharing ministries are promulgating a peculiar notion of collective welfare. The less-than-healthy and those who don't subscribe to the beliefs of a particular sharing ministry need not apply. At the same time, they are relying on the trope that voluntary charity can replace a government safety net.

It could be argued the growth of these non-insurance health-care offerings is a reflection of the success of the Affordable Care Act. Many health-care analysts believed membership in health-care sharing ministries would drop off after the Trump administration did away with the ACA's individual mandate. That did not happen. Americans want health-care coverage. The issue is that many believe they can't afford it. That these plans exist is a consequence of our failure to make health care a right, something that makes the United States unique among first-world countries. No amount of appeals to charity or freedom can make up for that awful truth. True liberty isn't a health-care sharing ministry. It's not needing to worry about personal health-care expenses at all.

THE ACA TIMES

What To Expect From California's Individual Mandate

Robert Sheen

The new year is almost upon us and a number of states including California will have their statewide Individual Mandate take effect.

Come January 1, 2020 employers and employees alike will have to comply with California's rather stringent Individual Mandate. For California residents, this law effectively replaces the ACA's Federal Individual Mandate which had its penalty eliminated at the start of 2019.

California's Individual Mandate will require state residents, and any spouse or dependent, to enroll in qualified insurance coverage for each month of the year, with exemptions for individuals on the basis of financial hardship or religious beliefs as determined by the state's healthcare exchange, Covered California or face a penalty.

The penalty state residents will face for failing to comply is calculated at a rate of \$695 per adult and \$347.50 per child or 2.5% of gross income above the filing threshold, whichever is higher.

The law also puts California out front as the state offers subsidies to individuals and families with income between 400% and 600% of the federal poverty level. According to a post by Mercer, "this range equates to 2019 household income of approximately \$50,000 to \$75,000 for a single individual and \$103,000 to \$155,000 for a family of four."

The move to expand the subsidies is an effort to help address health insurance affordability issues. Elsewhere in the United States, only individuals and families with an income between 100% and 400% are eligible for government subsidies for purchasing health insurance through Healthcare.gov or a state-exchange.

Employers will also have new state level ACA reporting requirements to comply with.

For the 2020 tax year, self-funded employers will need to report on the employees that had health coverage throughout the year. The information must be furnished to employees by January 31, 2021 and filed with California's Franchise Tax Board by March 31, 2021.

These are reporting requirements in addition to those of the Employer Mandate, which need to be submitted annually with the IRS.

Under the ACA's Employer Mandate, Applicable Large Employers (ALEs) (organizations with 50 or more full-time employees and full-time equivalent employees) are required to offer Minimum Essential Coverage (MEC) to at least 95% of their full-time workforce (and their dependents) whereby such coverage meets Minimum Value (MV) and is Affordable for the employee or be subject to Internal Revenue Code (IRC) Section 4980H penalties.

Several other states including the District of Columbia, Massachusetts, New Jersey, Rhode Island, and Vermont have also written into law statewide Individual Mandates. Many of them also have penalties in place for employers and residents that fail to comply. You can read about them here.

Employers, if you have operations in the state of California or any of the other aforementioned states, keep in mind the state level Individual Mandate as the new year approaches. Some third-party organizations will handle the state-level reporting in addition to filing with the IRS each year at no extra cost.

To learn more about ACA compliance for the 2019 tax year, [click here](#).

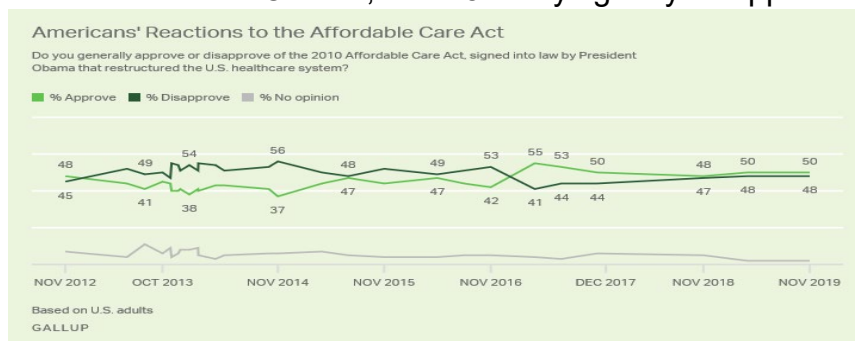
For ACA reporting deadlines in 2020 for the 2019 tax year, organizations should review [this link](#) for important dates and requirements.



Americans Remain Divided on "Obamacare"

Mohamed Younis

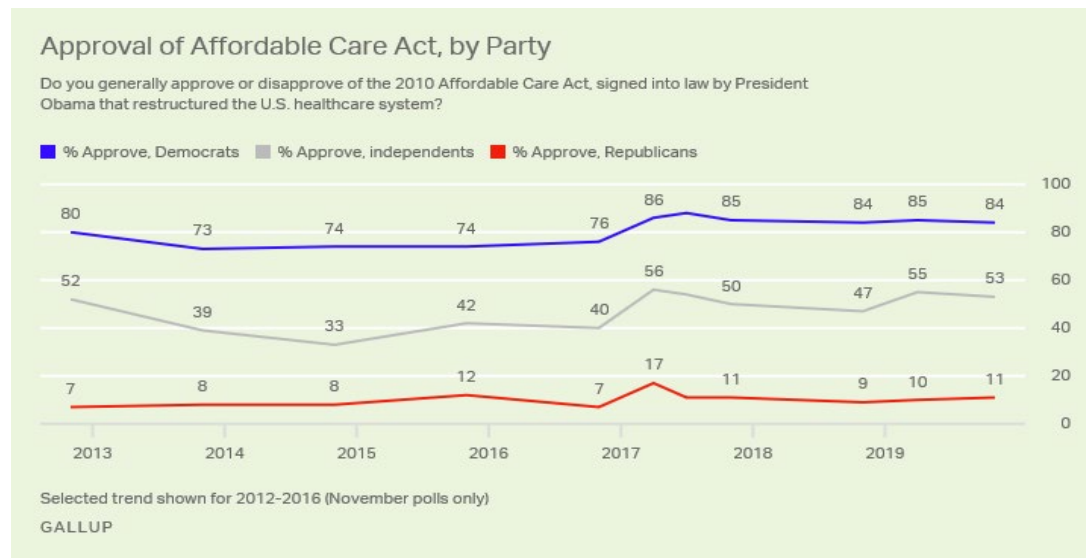
WASHINGTON, D.C. -- Americans continue to give the Affordable Care Act a split decision, with 50% telling Gallup they approve of the healthcare law brought about by President Barack Obama, and 48% saying they disapprove.



The latest data are from a Gallup poll conducted Nov. 1-14.

Since Gallup first asked about the Affordable Care Act with this wording in 2012, public opinion has gone through three general phases.

- More Americans disapproved than approved of the law from 2013 to 2016, spanning the ACA's troubled website rollout and uncertainty about the law's survival because of various legal challenges in federal court.
- Attitudes flipped to [more Americans approving than disapproving](#) throughout 2017 as Republicans tried to repeal the law at the start of Donald Trump's presidency. This was mainly attributable to increased support from Democrats and independents throughout the year.
- A third phase has been evident since November 2018, in which Americans have been evenly divided on the law.



Support for ACA Higher Among Those With Preexisting Conditions

While the sharp differences in ACA ratings along political party lines are well established, Gallup also finds that those who report having private insurance are as likely as those on a Medicaid or Medicare plan to say they approve of the ACA.

Also, Americans who report having a long-term illness or disease that a health insurance company would consider a "preexisting condition" are more likely to approve of the ACA (55%) than those who do not suffer from such a condition (49%).

ACA Views by Party ID and Insurance Circumstance

	Approve %	Disapprove %
Party ID		
Republican	11	87
Independent	53	44

	Approve	Disapprove
	%	%
Democrat	84	15
Insurance circumstance		
Medicaid/Medicare	50	47
Private insurance	50	48
Preexisting condition (self)	55	43
No preexisting condition	49	50

GALLUP, NOV. 1-14, 2019

Bottom Line

The ACA continues to divide Americans. In the early years after its troubled rollout in 2014, the law failed to receive approval from most Americans. While the law enjoyed a brief period of majority approval while Trump and the Republicans unsuccessfully tried to repeal it, 2018 and 2019 have shown [a more divided outlook among the public on the law commonly known as "Obamacare."](#) Despite claims that the law would somehow break the private insurance market, Americans with private as well as publicly funded healthcare plans equally approve, and disapprove, of the ACA.

THE WALL STREET JOURNAL.

More Uninsured People, Faster Growth in Health-Care Spending Due to ACA Tax, Report Says

Stephanie Armour

More Americans are going without health coverage and the pace of spending on health care nationally is rising in part because of an Affordable Care Act tax on insurers, Trump administration officials said Thursday.

A federal report from actuaries at the Centers for Medicare and Medicaid Services documented trends that are likely to further fuel the battle between Republicans and Democrats over how to slow health-care spending growth that has already put the U.S. far ahead of most comparable wealthy countries.

Overall, national health-care spending rose to \$3.65 trillion in 2018, up 4.6% from 2017. The U.S. spent \$11,172 per person, and national health-care spending accounted for 17.7% of the economy last year, compared with 17.9% in 2017.

The data indicate some notable shifts related to changes in insurance coverage, the price of drugs and legislative actions.

Retail prescription drug prices declined by 1% in 2018, the first drop since 1973. The decrease reflects a decline in generic drug prices and relatively slow growth in prices for brand-name drugs, officials said. President Trump has angered Democrats by taking credit for prescription-drug prices he says are falling, and the data may fuel further scrutiny over the effectiveness of administrative policies to spur greater use of generics.

The number of people without insurance rose by 1 million in 2018 for the second consecutive year, with 30.7 million individuals uninsured. Democrats have criticized Mr. Trump for his efforts—including ending billions of dollars in payments to insurers and expanding health plans that are cheaper but don't provide the health law's consumer protections—to roll back the 2010 Obama-era health law that expanded coverage to an estimated 20 million people.

While the overall acceleration in national health-care spending wasn't that large relative to other years, an Affordable Care Act tax accounts for most of the increase, according to the report. The tax, an annual fee on all health insurers, is among several imposed under the law to cover its estimated 10-year cost of more than \$1 trillion.

The tax has been controversial, with consumer and industry groups saying it will raise premiums and hurt consumers. Congress suspended the tax in 2017 and 2019. It is slated to kick in again in 2020.

Federal officials on Thursday linked the tax to a rise in the net cost of private insurance, which includes factors such as insurers' costs for premium taxes and bills. The cost grew 15.3% last year to \$164 billion, its fastest rate of increase in 15 years.

Officials said the growth in the net cost of insurance was also behind some of the growth in spending on Medicaid, a federal-state program for low-income and disabled people. Overall spending on the program increased 3% to about \$598 billion in 2018.

The impact of the tax in 2018, when it was in effect, could provide a glimpse at its implications for future years and galvanize its opponents. A coalition of industry and consumer groups are lobbying for a two-year delay. The levy, known as the "HIT tax," is expected to generate \$15.5 billion in 2020, according to the Internal Revenue Service.

Officials also said the tax played a role in a 6.7% increase in spending last year on per-enrollee private health insurance—the amount spent per person on health coverage, including premiums paid to managed care, self-insured health plans and others—which is the highest growth rate since 7.5% in 2004.

"It was responsible for a significant portion of the rise we saw," said Micah Hartman, the report's lead author.

The national spending data provides a window into the areas of the industry that are driving increases as well as the factors behind that rise.

On average, wealthy European countries spend about half as much per person on health care than the U.S. does, according to the Kaiser Family Foundation. In 2016, the U.S. had the lowest life expectancy of 12 comparable countries despite the higher spending.

Health-care spending is expected to accelerate as baby boomers age and as prices for medical services grow. Health care's share of the economy is projected to climb to 19.4% by 2027 from 17.9% in 2017, according to a federal report from February.

The rise in federal health-care spending is evident now. Last year, growth in Medicare spending rose 6.4% compared with 4.2% in 2017, reaching \$750.2 billion. Enrollment in the federal health program for seniors and the disabled was largely unchanged.

One factor driving spending increases is medical prices, such as the cost of procedures. The 2.1% growth in medical prices last year, which was largely caused by inflation, was the most rapid since 2011.

Personal health-care spending grew at the same rate in 2018 as in 2017, as slower growth in the use of services was offset by faster growth in prices. Last year, the increase in U.S. per capita spending rose to 4%, up from 3.5% in 2017, in large part because of rising growth in medical prices, officials said.

In addition, retail prescription drug spending rose 2.5% last year, up from 1.4% in 2017, as spending on new cancer and autoimmune drugs was offset by a decline in price growth and more use of generic drugs.



Column: Obamacare study proves that having health insurance reduces U.S. death rates

Michael Hiltzik

The relentless conservative attack on the Affordable Care Act has been based on two deeply-held beliefs: That the individual mandate didn't prompt people to buy health insurance, and that having coverage does nothing to make people healthier.

A new study conducted by a Stanford University researcher with the help of the Internal Revenue Service explodes both notions. It found that Americans who failed to respond to the individual mandate penalty when it was in effect (through 2018), tended to sign up for coverage when they were reminded about it; and that among those who did sign up, mortality rates fell.

The study is significant for two reasons. First, it undercuts Republican actions that led to the elimination of the penalty by the 2017 tax cut bill, effective in January 2019, while supporting legislation in California, two other states and the District of Columbia that reinstates the penalty within their borders.

Second, it's the most statistically valid study showing that mortality rates are lower for people with coverage. Indeed, the study found that among those 49 to 64 years old, acquiring health insurance showed up in lower death rates within a year or two.

As David Anderson, the health insurance expert at Duke University, notes, "There has been a cottage industry arguing that the public paying for health care is buying no health." Until now, however, there had been no good randomized study showing the contrary. Now there's proof that "being able to pay for health care leads to better health."

These findings underscore the folly and cynicism of the systematic hollowing-out of outreach programs for the ACA under Trump. In 2017, the federal budget for such outreach was \$100 million; Trump cut it to \$10 million in 2018.

Some states have taken up the slack — in California, outreach spending for Covered California, the state's ACA exchange, was \$111 million in 2018. The effort shows: Exchange enrollments have been declining in states where it's managed by the federal government, but remain stronger in California and other states that have taken the matter in hand.

More to the point, Covered California estimated that by keeping younger and healthier enrollees in the statewide risk pool, the outreach "likely lowered premiums by 6 percent to 8 percent."

The new study, led by Jacob Goldin of Stanford Law School, was resourceful. It used data from an IRS initiative to send letters to 3.9 million households that had incurred the individual mandate penalty in 2016, reminding them of the tax penalty they faced if they failed to acquire coverage in 2017.

The letters advised them to visit the federal enrollment website, [healthcare.gov](https://www.healthcare.gov), or their state's enrollment site to investigate their coverage options. About 8.9 million individuals resided in those households, creating a large sample population.

Different forms of the letter were sent out at random. Some calculated the 2017 penalty for the recipients and others merely warned them that there would be a cost. The 2017 penalty was set at 2.5% of household adjusted gross income, or \$695 per adult and \$347.50 per child, whichever was greater, up to a maximum \$2,085. It was the same in 2018, but cut to zero starting in 2019.

The initiative bore fruit. Those who received the letter were 1.3 percentage points more likely to enroll in coverage the following year than those in a control group who received no letter. That translates to "one additional year of coverage per 87 letters sent."

As Duke's Anderson observes, sending out 87 letters to achieve one enrollment is a "cheap and effective outreach effort," especially since the rule of human inertia means that once a household signs up for coverage, it's likely to keep it year after year.

Most striking is the study's finding that health insurance yielded lower mortality rates for the newly insured. The study focused on the 49-64 age group, it says, because the overall mortality rate in that age range is higher than for younger people and the impact of insurance coverage statistically easier to detect.

The study didn't find reduced mortality among younger people, but the study says that one fewer death occurred in the 49-64 group for every 1,648 individuals who received a letter.

That adds measurably to our understanding of the health effects of coverage. Previous studies have been inconclusive, in part because they didn't have the statistical power to identify the effects or focused on younger populations where the evidence was likely to be lost in statistical noise.

That's an oft-cited flaw in the so-called Oregon study, a 2010 research project that failed to identify solid improvement in certain health metrics among a population that obtained coverage for the first time through Medicaid. As Goldin and his colleagues observe, the average age in the Oregon sample was 41, compared with 53 in the new study; gains in health outcomes therefore may have been more difficult to pinpoint in the Oregon population.

Nevertheless, the Oregon study has been cited incessantly on the right wing as proof that health insurance — especially Medicaid, a continuing target of conservative attacks — does little for one's health.

A more recent study of Medicaid in California, where it's known as Medi-Cal, did find that Medicaid substantially reduced in-hospital mortality for patients who gained coverage, while putting hospitals on a firmer financial footing and improving access to care, and better care, for millions of state residents.

The Stanford/IRS findings will bolster the conclusion that expanding medical coverage makes for a healthier America, and that the financial incentive to prompt enrollment actually did work.

They also point to the loose strings left from the original Obamacare rules, frayed further by Trump's sabotage: The individual mandate penalty was too easily ignored and too low to bring everyone into the insurance pool, and we are still way too short of the ideal of coverage for everybody.



Obama tweets about Obamacare plans for \$10 or less ahead of deadline

Tami Luhby

(CNN) It's that time of year again!

Former President Barack Obama released his now-annual video to spur people to sign up for Obamacare before the December 15 deadline.

This year's theme is the former President's holiday shopping list of gifts for \$10 or less -- which, he says, includes health care coverage.

Obama called attention to the fact that two-thirds of those with coverage on federal exchange, Healthcare.gov, can find 2020 plans with monthly premiums of \$10 or less thanks to premium subsidies, according to federal data.

"I thought it was about time I share my holiday gift list -- a few practical items, all \$10 or less. The best one? Health care for you or somebody you care about," Obama said in a tweet, which featured the video.

Obama also touts the benefits of the Affordable Care Act -- which President Donald Trump is continuing to undermine -- such as protections for those with pre-existing conditions and free preventative care.

Signups could use a boost this year. Nearly 2.9 million people have selected plans through November 30, according to the most recent data available from the Centers for Medicare & Medicaid Services. That's down 7% on an average daily basis from last year's open enrollment period.

Those actively renewing has dropped, but current enrollees will be automatically signed up for 2020 plans just after open enrollment ends.

One somewhat bright spot: The number of new people selecting plans has fallen less than in previous years. It's down only 2% so far from a year ago.

One reason why Obama has gotten involved in pushing people to sign up ahead of the enrollment deadline is because the Trump administration cut the Obamacare advertising budget by 90%, starting in 2017. Advocates say this has greatly hurt enrollment.

While the landmark health reform law has proved resilient, signups slid to 11.4 million in 2019, down from a high of 12.7 million in 2016.

While most people with coverage have re-enrolled over the years, fewer new consumers have signed up. Also, those who don't receive premium subsidies are leaving the individual market, particularly after insurers hiked rates several years in a row.

For 2020, the average premium for the benchmark plan will drop 4% -- the second year in a row of lower rates -- while 20 more insurers are offering policies, bringing the total to 175.

Open enrollment runs through December 15 in the 38 states using the federal exchange. Some states that run their own marketplaces have later enrollment deadlines.



How Many of the Uninsured Can Purchase a Marketplace Plan for Free in 2020?

Rachel Fehr, Cynthia Cox and Matthew Rae

While the percent of the population without health coverage has decreased since the major coverage expansion in the ACA, at least 10% of the non-elderly population is still uninsured. This analysis looks at how many of the remaining uninsured are eligible for premium subsidies large enough to cover the entire cost of a bronze plan, which is the minimum level of coverage available on the Marketplaces.

The premium tax credits that subsidize Marketplace coverage are calculated using the second-lowest cost silver plan in each rating area as a benchmark. As was the case in 2019, many unsubsidized silver plans continue to be priced relatively high because insurers generally loaded the cost from the termination of federal cost-sharing reduction payments entirely onto the silver tier (a practice sometimes called “silver loading”). The relatively higher price for silver plans means subsidy-eligible Marketplace enrollees will continue to receive large premium tax credits in 2020. These subsidies – which can be used towards the premium of any Marketplace plan – also continue to make lower premium bronze plans more likely to be available for \$0 than before cost-sharing reduction payments were terminated.

In this analysis, we focus specifically on the approximately 16.7 million uninsured people who could be shopping on the Marketplace, regardless of whether or not they are eligible for a subsidy.¹ We therefore exclude people who are eligible for Medicaid, those over the age of 65, and those who are undocumented immigrants (who are not permitted to buy Marketplace coverage).

We estimate that 28% of uninsured individuals who could shop on the Marketplace, or 4.7 million people nationwide, are eligible to purchase a bronze plan with \$0 premiums after subsidies in 2020. This figure is similar to 2019, when 27% of uninsured individuals, or 4.2 million people, could purchase a no-premium bronze plan.

As shown on the map and table below, the availability of free bronze plans varies widely between states. More than half of the uninsured who could get a free bronze plan live in Texas, Florida, North Carolina, or Georgia. Other states with large shares of uninsured residents who could sign up for a no-premium bronze plan include Iowa (59%), Alaska (45%), Wyoming (44%), Idaho (41%), and South Dakota (41%).

Rather than continuing to go without insurance, the 4.7 million uninsured people eligible for no-premium bronze plans would benefit from the financial protection health insurance offers. While bronze plans have high deductibles, they all cover preventive care with no out-of-pocket costs, and a number of bronze plans cover additional services, such as a few physician visits, before the deductible. If a low-income enrollee in a bronze plan needs a hospitalization, they will likely have difficulty affording the deductible, but the deductible will also likely be much less than the cost of a hospitalization without insurance.

Bronze plans have an average deductible of \$6,506, and many people eligible for a \$0 bronze premium would also be eligible for significant cost-sharing assistance by instead purchasing a silver plan. Single individuals with incomes below 250% of the poverty level can purchase benchmark silver plans with cost-sharing reductions (CSR) for \$20 to \$215 per month after subsidies in 2020, on average, depending on an enrollee's income. Silver CSR plans have average annual deductibles ranging from \$209 to \$3,268 in 2020, also depending on income, and have reduced copays and coinsurance. It is therefore important for potential enrollees, particularly those with significant health needs, to not only consider the premium, but also the significant cost-sharing assistance that is only available if they enroll in a silver plan.

San Francisco Chronicle

Kaiser names new CEO a month after unexpected death of previous leader

Catherine Ho

Kaiser Permanente has named Gregory Adams its new chairman and CEO, one month after the unexpected death of the health care giant's previous chairman and CEO Bernard Tyson.

Adams had been serving as the interim chairman and CEO since Tyson's death Nov. 10, and prior to that he was an executive vice president and group president, working closely with Tyson for many years. He joined Kaiser in 1999. Adams' appointment was announced by Kaiser's board of directors Tuesday evening.

"Mr. Adams is an accomplished leader with deep experience across Kaiser Permanente's health plan and hospital operations," Edward Pei, chair of the Executive Committee, said in a statement. "The board's decision to name Mr. Adams to the position demonstrates Kaiser Permanente's strong internal succession planning process. For more than a decade, Mr. Adams worked on a wide variety of major

initiatives and areas of focus, and has led Kaiser Permanente's work on growing membership, affordability for our members, and transforming and expanding access to care.”

In a statement, Adams said he is honored to follow Tyson, who was Kaiser’s chairman and CEO since 2013 and oversaw major expansions in the health care system’s membership, workforce, revenue and ambitious investments in social issues including homelessness, affordable housing and gun violence.

“Kaiser Permanente will continue to move forward together to deliver on our mission: providing high-quality, affordable health care services, improving the health of our members and the communities we serve, and transforming American health and health care,” Adams said.

Kaiser, based in Oakland, is the nation’s largest integrated health care system — combining health insurance with medical services at hospitals and medical centers — with 12.3 million members and 200,000 employees. Its 2018 revenue was nearly \$80 billion.

Adams is Kaiser’s sixth CEO in the health system’s 74-year history. Kaiser has typically promoted within, with previous CEOs having risen up in management ranks for decades before being tapped for the top leadership position. The one exception was Tyson’s predecessor George Halvorson, who came from the Minnesota health system Health Partners in 2002 and retired from Kaiser in 2013.

The Alliance of Health Care Unions, a coalition of unions representing 50,000 Kaiser employees, praised the board’s decision, calling Adams the “best choice to lead Kaiser Permanente seamlessly and boldly forward.”

“We are confident that with Greg’s record of commitment to labor management partnership, together we will continue to ensure that Kaiser Permanente is the best place to receive care and the best place to work,” Peter DiCicco, the coalition’s executive director, said in a statement.

The New York Times

The I.R.S. Sent a Letter to 3.9 Million People. It Saved Some of Their Lives.

Sarah Kliff

Three years ago, 3.9 million Americans received a plain-looking envelope from the Internal Revenue Service. Inside was a letter stating that they had recently paid a fine for not carrying health insurance and suggesting possible ways to enroll in coverage.

New research concludes that the bureaucratic mailing saved lives.

Three Treasury Department economists have published a working paper finding that these notices increased health insurance sign-ups. Obtaining insurance, they say, reduced premature deaths by an amount that exceeded any of their expectations. Americans between 45 and 64 benefited the most: For every 1,648 who received a letter, one fewer death occurred than among those who hadn't received a letter.

In all, the researchers estimated that the letters may have wound up saving 700 lives.

The experiment, an unintended result of a budget shortfall, is the first rigorous experiment to find that health coverage leads to fewer deaths, a claim that politicians and economists have fiercely debated in recent years as they assess the effects of the Affordable Care Act's coverage expansion. The results also provide belated vindication for the much-despised individual mandate that was part of Obamacare until December 2017, when Congress did away with the fine for people who don't carry health insurance.

"There has been a lot of skepticism, especially in economics, that health insurance has a mortality impact," said Sarah Miller, an assistant professor at the University of Michigan who researches the topic and was not involved with the Treasury research. "It's really important that this is a randomized controlled trial. It's a really high standard of evidence that you can't just dismiss."

The uninsured rate for Americans is rising for the first time in a decade, as states tighten eligibility rules for Medicaid, and as the Trump administration cuts back on health care outreach.

"It's an innovation to know that just sending a letter to people with information about what it means to be insured versus uninsured can substantially change coverage rates," said Katherine Baicker, dean of the University of Chicago Harris School of Public Policy. "That is really important, new information."

Previous research has found a link between expanded health insurance access and fewer deaths. Multiple studies showed a decline in mortality rates after states expanded Medicaid, but none could tie the outcome directly to the policy change, since states typically cannot randomly pick which residents do and don't receive Medicaid. That makes the accidental Treasury experiment distinctively useful.

The most prominent similar study, the Oregon Health Experiment, was much smaller and more equivocal. In 2008, Oregon ran a lottery for slots in a Medicaid expansion. Those who gained health coverage in the lottery reported feeling better and having fewer unpaid medical bills. They were more likely to fill their medication prescriptions for conditions like diabetes and cardiovascular disease.

But researchers did not produce evidence that Medicaid enrollees in Oregon had a lower risk of death, something they attribute to the fact that death is a rare event (especially so for the under-65 population typically enrolled in Medicaid). Finding any change requires a very large sample to study.

“What we ended up producing had such wide confidence intervals — they were not really useful for policymaking,” said Ms. Baicker, one of the economists who closely studied the Oregon Health Experiment.

Some economists had cast doubt on the connection between health coverage and mortality, noting that even an uninsured person is not completely excluded from the health care system. Federal law requires emergency rooms to treat all patients regardless of their ability to pay. One recent study showed that hospitals spend an additional \$900 on free care for each extra uninsured patient they treat. It describes hospitals as “the insurers of last resort.”

“It’s not clear that every person who gets new health insurance will cut their probability of dying by a large amount,” said Kosali Simon, a health economist at Indiana University.

The Obama administration had planned to send letters to all 4.5 million Americans paying tax fines for not carrying health coverage, only to learn the budget was not quite big enough. About 600,000 uninsured taxpayers were randomly left out of the mailing.

This created a randomized controlled trial, which researchers generally view as the gold standard for studying the results of a specific policy intervention — in this case, the effects of being nudged to get health coverage.

“I was definitely torn about it,” said Jacob Goldin, a co-author of the paper who worked as an economist at the Treasury Department and is now an associate professor at Stanford. “We were hoping the letters would be beneficial, and wanted them to go to everybody. But it was also an exciting research opportunity.”

The letters went out in two batches, in December 2016 and January 2017, in one of the Obama administration’s final efforts to increase awareness of the Affordable Care Act’s coverage options.

The subsequent research, published by Mr. Goldin with the Treasury economists Ithai Lurie and Janet McCubbin, found that gaining coverage was associated with a 12 percent decline in mortality over the two-year study period (the first months of coverage seemed to be most important, presumably because people could get caught up on various appointments and treatments they might have been missing).

Months later, in August 2017, the Trump administration cut the health law’s outreach budget by 72 percent.

And at the end of 2017, Congress passed legislation eliminating the health law’s fines for not carrying health insurance, a change that probably guarantees that the I.R.S. letters will remain a one-time experiment.

POLITICOPRO

Obamacare's boring enrollment season

Dan Goldberg

The latest Obamacare enrollment season comes to a close this weekend with little fanfare and little drama — the latest sign the once-endangered law is withstanding the Trump administration's attacks.

Average premiums across the country were down for the second straight year, and more insurers came back to the marketplaces after abandoning them in the law's rockier early years. Though enrollment appears to be headed for another modest decline, Obamacare supporters no longer worry whether the once-turbulent insurance marketplaces will come crashing down.

"If the numbers keep up through the end of open enrollment, we might see the most stable year that HealthCare.gov has seen in a while," said Josh Peck of Get America Covered, an Obamacare advocacy group.

Even as President Donald Trump supports an ongoing lawsuit that could wreck the Affordable Care Act, his top health officials now boast about how well they're running the law. Health insurance alternatives promoted by the administration — including cheaper short-term plans that typically skim on benefits and weaken protections for preexisting conditions — don't seem to have dented Obamacare enrollment in a significant way.

Nearly 3.9 million people have signed up for 2020 coverage through HealthCare.gov, putting sign-ups about 6 percent behind last year's pace on the federal enrollment website serving 38 states. But enrollment accelerated in the last week, with 1 million people choosing health plans, and a major surge is expected ahead of the Dec. 15 deadline as in previous years.

Most observers expecting another small enrollment decline cited numerous factors. Insurance premiums and deductibles remain high for low- and middle-income people who don't receive the law's generous federal subsidies. The unemployment rate has also ticked lower, meaning previous Obamacare customers may now get insurance through a job. There are also tens of thousands fewer customers on the federal website this year after Nevada took control of its exchange and Maine expanded Medicaid, pulling some people out of the individual insurance market.

Obamacare supporters suggested that Trump administration policies are also depressing enrollment. HHS has shrunk the budget for enrollment outreach and in-person enrollment aides to a fraction of what the Obama administration spent, and it cut the sign-up window in half.

The administration has said it has run enrollment more efficiently, but supporters of the law say the government is missing a chance to reach potential customers. Some pointed

to a new Kaiser Family Foundation study finding that about 4.7 million uninsured people this year can get subsidized Obamacare coverage with no monthly premium, though the plans likely come with high out-of-pocket costs.

“So instead of going up each year — as enrollment did through 2016 — we drop a little each year and [Trump administration officials] take a victory lap,” said Katie Keith, a researcher with Georgetown University’s Center on Health Insurance Reforms.

It will likely be weeks before the administration reports the final enrollment tally, including numbers for state-run marketplaces. In all, 11.4 million signed up through HealthCare.gov and state-based marketplaces in last year’s enrollment season.

Some state-run marketplaces, which set their own enrollment windows, are allowing people to sign up through next month. These marketplaces, which operate in 12 states and Washington, D.C., have so far released little information on current enrollment figures.

This latest enrollment season has played out while a federal appeals court weighs whether to uphold a judge’s earlier ruling that declared Obamacare unconstitutional in a case brought by conservative state attorneys general. There’s no sign that legal uncertainty hanging over the law has depressed enrollment, and the Trump administration — while arguing the law should be overturned — has said it would enforce Obamacare until the legal challenge is resolved. The Supreme Court could have the final word on this lawsuit next year.

But the Obamacare enrollment season itself has become routine — a far cry from the law’s rocky first few years. Aside from small technical glitches on the first day this year, the enrollment season has grabbed few headlines.

“We have all the insurers not just staying in our market, but they are really competing to grow the enrollment they have,” said Jessica Altman, Pennsylvania’s insurance commissioner. “That wasn’t necessarily what we saw a couple years ago.”

Enrollment in Pennsylvania is about 13 percent off last year’s pace, but Altman isn’t concerned about a sharp drop-off. Altman said she expects more people may be satisfied with their coverage and allow themselves to be automatically reenrolled at the end of the sign-up window.

Altman said she does worry about the interest she’s heard from people about cheaper short-term plans that don’t have to follow Obamacare rules. Her department said it won’t have a reliable count of short-term plan enrollment until next summer.

“There is a lot of marketing going on of those products,” Altman said. “It makes me scared every time I hear about those families.”

Insurance experts say there isn’t yet reliable data on take up of short-term plans, but they haven’t seen evidence they’re siphoning away large numbers of Obamacare customers. The Trump administration last year issued rules expanding the availability of

this coverage, arguing that people priced out of Obamacare plans needed cheaper options. Democrats have derided those plans as “junk” coverage that leaves people with unexpectedly high medical bills.

In Kansas, where enrollment numbers are 16 percent off last year’s pace, a new law allows people to buy skimpier and cheaper plans through the state’s farm bureau. Those plans in Kansas, which are separate from the short-term plans pushed by Trump, are not required to cover Obamacare’s robust set of benefits and can exclude people with preexisting conditions.

Lower premiums for popular, middle-tier coverage known as “benchmark plans” may also explain why some states like Michigan and Illinois are seeing roughly 15 percent fewer enrollees than at this point last year. When the prices of the benchmark plans come down, the federal subsidy in those areas also shrinks. That means people in cheaper coverage levels have to pay more out of pocket for monthly premiums.

While the enrollment pace is down in most states this year, it’s roughly on track for two of the largest HealthCare.gov states, Florida and Texas, which account for 40 percent of enrollment through the federal site.

“Our local consumers have a lot more options this year than last year, and with prices being consistent, that’s good news for local consumers,” said Kori Hattermer of the Austin-based Foundation Communities, which receives federal “navigator” funding to help people enroll.

Average premiums for the popular benchmark plans in the area have declined about 3 percent from last year. Her group has so far signed up about 3,500 people this season, about roughly the same as last year at a similar point in the enrollment season.

But given Texas’s high uninsured rate and the availability of low-cost options for subsidized customers, Hattermer wonders why her group isn’t even busier.

“We should be seeing a lot more people,” she said.



House Democrats pass drug price cap bill, escalating 2020 health care wars

Tami Luhby

(CNN) House Democrats can now say they've taken action to lower drug costs.

The chamber on Thursday passed a drug price bill backed by Speaker Nancy Pelosi by a 230 to 192 vote.

That's as far as the legislation is likely to go, since both Senate Majority Leader Mitch McConnell and the Trump administration have said they do not support the effort. But it allows House Democrats to say on the campaign trail next year that they fulfilled one of their main promises from the 2018 election.

Pelosi had a tough time locking down support from members of the progressive faction, who complained the bill wasn't aggressive enough. She reached a last-minute deal earlier this week with the Congressional Progressive Caucus, including two changes that the group had been advocating for.

The bill, titled the Elijah E. Cummings Lower Drug Costs Now Act in memory of the Maryland congressman who passed away earlier this year, would empower the Health & Human Services secretary to negotiate annually for the best prices on at least 50 costly brand-name drugs and up to 250 medications, including insulin. Prices would be capped at 1.2 times their cost in certain other developed countries.

And it would require drug companies to pay a rebate to the federal government if their prices increase faster than inflation. The plan would impact drug prices for all Americans, not just Medicare enrollees.

"The historic Lower Drug Costs Now Act will empower Medicare to negotiate drug prices for the first time in the history of the program and makes those prices available to all Americans with insurance," said Energy and Commerce Chairman Frank Pallone, Jr., Democrat of New Jersey.

The legislation also caps seniors' out-of-pocket costs on prescription medications at \$2,000 per year.

The negotiation provisions would lower spending by about \$456 billion over a decade, but the bill calls for plowing about \$358 billion into providing dental, vision and hearing coverage for Medicare enrollees, according to a Congressional Budget Office report released Tuesday.

A more controversial finding is that the bill would lead to eight fewer drugs being introduced over the next decade and about 30 fewer medications over the subsequent decade.

Republicans, who are pushing their own legislation -- the Lower Costs, More Cures Act - argued on the House floor that limiting prices for select drugs would make the private sector less likely to invest in research and development for new treatments and cures.

The pharmaceutical industry also slammed the bill, noting that a single section would cut revenues by \$1 trillion.

"This would lead to the loss of anywhere from 30 to 100 or more new medicines over the next 10 years, leaving patients with some of the serious diseases, like Alzheimer's, ALS and cancer, without hope for the treatments and cures they need," said Stephen Uhl, CEO of PhRMA, a lobbying group.

Senate Finance Committee Chair Chuck Grassley, Republican of Iowa, is trying to drum up support for a bipartisan bill he crafted with ranking member Sen. Ron Wyden, Democrat of Oregon. White House officials praised the legislation last week, but it still faces a tough path forward.

Last week, the senators issued an updated version of their legislation, which would reduce the amount Medicare enrollees have to pay in the initial phase of the drug benefit to 20%, from 25%. And it would limit the amount seniors pay for drugs to \$3,100 annually, but also cap the amount they pay out of pocket on drugs in any given month. The legislation would also require drug makers to pay rebates to Medicare if they raise prices on certain drugs by more than inflation, a provision that does not sit well with GOP lawmakers.



In 2020, the healthcare debate will be inescapable

Michael Hiltzik

Ben Franklin may have been wiser than he knew. When he declared in 1789 that the only certainties in life were death and taxes, did he foresee that both would still be at the center of America's politics 230 years hence, in the guise of our seemingly interminable debate over healthcare reform?

Healthcare was a dominant theme in the six Democratic presidential debates staged from June through December, and it's a fair bet that it will continue to play a central role throughout the coming presidential election year. The reason is obvious: The issue touches everyone, regardless of race, creed, color or wealth.

The variations among the plans proposed by candidates Bernie Sanders, Elizabeth Warren, Joe Biden and Kamala Harris (who has since dropped out of the race) have been almost infinite and the proposals themselves, perhaps with the exception of Sander's, fluid. Pundits have punished candidates for sticking with their initial proposals, or for backing off or doubling down.

Was Warren's recent slide in opinion polls due to her original plan, or to her acknowledgment, via a "transition" proposal, that even under the most favorable political conditions, the U.S. won't be changing from its private insurance system to single-payer in the blink of an eye, but only over a period of years? Who can say? (In her proposal, Warren said she would reverse President Trump's "sabotage of healthcare" while

making Medicare free for children younger than 18 and low-income households, on the way to making government health coverage free to everyone by the end of her first term.)

The proposals have all revolved around a nebulous idea known as “Medicare for all.” To the extent that the candidates have faltered in their approaches, it’s because they’ve tried to define Medicare for all. At this stage, however, that’s impossible. Whatever reform program ultimately emerges, it will be the product of intense legislative compromise, with the input of myriad stakeholders — doctors, hospitals, drug companies, wheelchair makers, insurers and patient advocates.

Consequently, it’s best to think of Medicare for all as a binder holding the points that all the Democratic proposals share in common: universal coverage, the reduction or elimination of out-of-pocket costs such as deductibles and co-pays, the replacement of those costs and premiums with taxes and less spending overall.

How costs will be wrung out of the system and out of whose hide — caps on doctor fees? On hospital billing? On drug prices? — are impossible to pinpoint today. The more detail any candidates try to offer, the more they’re providing attack points for their adversaries.

What’s most important is that they recognize that there’s one real obstacle to crafting a fair, universal healthcare system like the ones enjoyed by residents of France, Germany and Britain, or even to preserving the reforms brought about through the Affordable Care Act. That’s Republican and conservative opposition.

Trump has tried systematically to erode the consumer protections created by the ACA, including safeguarding access to coverage for people with preexisting medical conditions and guaranteeing that health insurance plans provide for a roll of “essential benefits,” including maternity care, hospital coverage, prescription drugs and mental health and substance abuse treatment.

The Trump administration has taken steps to undercut that standard by expanding the availability of short-term health plans, which are cheaper than traditional Obamacare plans but don’t offer the full range of benefits and can reject applicants with preexisting conditions.

The most serious threat to the ACA comes from a lawsuit brought by Texas and 19 other red states seeking to overturn the law, on the grounds that Congress’ elimination of the individual mandate penalty as part of the 2017 tax cut rendered the law unconstitutional.

The conservative U.S. 5th Circuit Court of Appeals in New Orleans could hand down a ruling on that claim any day now. Legal experts say the court could uphold the ACA, invalidate it in its entirety, or nullify it in only the 20 plaintiff states.

If the judges choose the last option, America would have a two-tier health system — one for 20 red states, another for California and other blue states. Whatever the outcome,

the case seems destined to land at the U.S. Supreme Court, which has upheld the ACA twice, with arguments possibly scheduled just around the time of the November elections. As Franklin seemingly foretold, the healthcare debate will be with us well into the next year, and possibly beyond.



ObamaCare shows resilience despite Trump attacks

Jessie Hellmann

ObamaCare is showing signs of stability as its seventh open enrollment period draws to a close despite actions taken by the Trump administration to undermine the health care law.

While signups for ObamaCare plans are down slightly from last year, experts say enrollment appears to be relatively stable, partly due to lower premiums and more insurer participation.

“People need and want health insurance, and by and large, the marketplaces are working,” said Jennifer Tolbert, director of state health reform for the Kaiser Family Foundation (KFF).

For the 38 states that use healthcare.gov, Sunday is the last day to sign up for ObamaCare plans.

As of Dec. 7, more than 3.9 million people had signed up for plans, a 6 percent drop compared to a similar time period last year.

But the last few days of open enrollment typically bring a surge of signups, meaning that gap could shrink.

Still, experts don’t expect overall enrollment to top last year’s, when 8.4 million people signed up.

Enrollment on healthcare.gov has been steadily dropping since 2016.

“It does look like we’re on track to fall just shy of last year’s enrollment figures,” said Josh Peck, who oversaw ObamaCare enrollment efforts for the Obama administration from 2014 to 2017.

But, he noted, if that were to happen, it would buck a multi-year trend where enrollment decreased by hundreds of thousands of people. ObamaCare enrollment has dropped by 1.2 million since President Trump took office.

Democrats and others blame Trump, pointing to his administration's decisions to cut funding for marketing and outreach efforts, expand the sale of short-term plans that don't meet ObamaCare requirements, end payments to insurers that go toward reducing costs for low-income customers.

The president also signed the 2017 tax law, which ended the penalty for not having insurance, and his administration is backing a lawsuit filed by Republican attorneys general that seeks to overturn the health care law.

That case has unnerved Republicans, many of whom worry about the fallout if the law is struck down ahead of the 2020 election.

Given that, experts expected this year's enrollment to continue to drop. The question was by how much.

"There's definitely been some erosion, but perhaps not the cratering that some predicted back when the Trump administration announced some of their policy changes affect the ACA," said Sabrina Corlette, a research professor and founder of Georgetown University's Center on Health Insurance Reforms.

The administration's actions appear to be balanced out by the fact that premiums for healthcare.gov plans have decreased, on average, from last year.

According to a KFF analysis, 4.7 million people who currently don't have insurance could get a bronze plan while paying nothing for premiums, after factoring in tax credits.

More insurers are participating this year than last year: 18 states will see 26 new insurers entering their markets, according to KFF.

And while total enrollment is down slightly from last year, new customers are still selecting plans on healthcare.gov.

"It suggests that consumers still view coverage through the marketplace as an important source of coverage," Tolbert said.

Still, Trump will argue ObamaCare is failing as he tries to rally his base ahead of 2020, while also claiming he has improved it.

"It's horrible, by the way, but we've made it very acceptable," Trump said last month while appearing on the Dan Bongino show.

"Sometimes you'll hear people say it's not bad. That's because of getting rid of the individual mandate... We've really done a good job of management of it. It's a disaster."

The also promised to unveil a cheaper and better plan if he is reelected.

Trump and his administration have focused their ObamaCare agenda on people who don't qualify for subsidies because they make too much money.

Premiums are down this year, on average, but that's cold comfort for people who don't get any help at all from the government to pay for their plans.

"The base premiums are still pretty darn high going into 2020," Corlette said.

"While premiums dropped somewhat, they're dropping from a really high base for your average person."



What Would Happen If The ACA Went Away?

Julie Rovner

Any day now, the 5th Circuit Court of Appeals in New Orleans could rule the entire Affordable Care Act unconstitutional.

At least it seemed that two of the three appeals court judges were leaning that way during oral arguments in the case, *State of Texas v. USA*, in July.

Trump administration health officials have said they will continue to enforce the health law pending a final ruling from the Supreme Court. But that is not a guarantee that President Donald Trump won't change his mind. That's what he did in 2017 in canceling some payments to health insurers.

There's no doubt that invalidating the ACA in whole or in large part would have a dramatic effect on the nation's health system — and not just for those 20 million or so Americans whose coverage directly flows from the law.

"Billions of dollars of private and public investment — impacting every corner of the American health system — have been made based on the existence of the ACA," said a brief filed by a bipartisan group of health policy experts. Declaring the law null and void "would upend all of those settled expectations and throw healthcare markets, and 1/5 of the economy, into chaos," they wrote.

And with health care continuing to be a top issue in the presidential campaign, both Democrats and Republicans could find themselves scrambling for a fast stopgap solution if the law were to suddenly go away.

First, Some Background

At issue in the ACA case is whether the language in the 2017 GOP tax bill reducing to zero the tax penalty imposed for failing to have health insurance should render the rest of the law invalid.

A group of Republican state attorneys general and governors say it should. They argued that without the tax, the Supreme Court's justification for upholding the law in 2012 no longer exists and so the law is now unconstitutional. U.S. District Judge Reed O'Connor agreed with them last December.

Supporters of the law — including not just Democratic attorneys general, but also the Democratic-led U.S. House — and bipartisan groups of legal and health policy scholars say that's just nonsense, that the law not only can function without the individual mandate penalty but is functioning now.

What would go away — meaning which provisions consumers have become accustomed to — if the law is eventually struck down? Let's take a look.

Insurance Protections

Most people think the health law directly affects only those Americans who purchase their own insurance through the exchanges the law created (and who get subsidies if their incomes are between 100% and 400% of the poverty level). That's about 10 million to 12 million households.

But many of the insurance protections in the law also protect those who have insurance through their jobs. These provisions include allowing adult children to stay on their parents' health plans and requiring that insurers cover people who have preexisting health conditions at no additional charge to those patients. The law also requires that ACA-compliant policies provide preventive care with no out-of-pocket cost, and bans annual and lifetime insurance coverage limits.

It also limits insurers' amounts of profit and administrative expenses. That makes for a lot of chaos right there should the entire law disappear. But there is more.

Medicare And Medicaid

Most people with a passing familiarity with the health law know it expanded the Medicaid program for those with incomes up to 138% of the poverty level (at least in states that opted into the program).

The law also made big changes to the Medicare program, including closing the notorious "doughnut hole" that left some seniors with big drug bills despite having insurance. The ACA also extended coverage of more preventive benefits for people with Medicare coverage.

Generic Biologics

An important, though frequently overlooked, portion of the health law created the first legal framework and regulatory pathway for copies of expensive, already FDA-approved biologic drugs, called biosimilars, to reach the market. Biologic drugs are among the most expensive medications and treat life-threatening ailments such as cancer, rheumatoid arthritis and macular degeneration. It is unclear what would happen to the stream of biosimilars already approved if the law is struck down — will their approvals be revoked? What about medications currently in the approval pipeline?

Funding For The Indian Health Service And Training More Health Professionals

Among other little-known features of the ACA is a provision that permanently authorized the U.S. Indian Health Service, which provides health coverage for more than 2.5 million American Indians and Alaska Natives. An overturn of the law could leave in doubt the legality of some of the program's operations.

Here's one more provision you may not have thought about. On the theory that if more people have health insurance more people will seek medical care, the ACA has an entire section devoted to increasing the supply of not just physicians, but nurses, therapists, dentists and community health centers. Many of these training programs could founder if the ACA is overturned.

And those now-ubiquitous calorie counts on restaurant menus? Those are there because of the ACA. Some people may not be sad to see those go away. But if the ACA is invalidated, the health system will likely change in ways that no one can predict.

THE WALL STREET JOURNAL.

The Affordable Care Act's Legacy, Nearly 10 Years Later

Anna Wilde Mathews

Nearly a decade after its passage along party lines under President Obama, the Affordable Care Act is deeply ingrained in the U.S. health-care system, influencing everything from seniors' drug costs to calorie disclosures on restaurant menus. It added about 20 million people to the ranks of the insured.

But it also remains a political flashpoint. After a decade of funding fights and a series of court challenges, the ACA faces a fresh legal case, brought by a group of Republican-led states and backed by the Trump administration, that aims to strike it down.

That suit could mark the sixth time that the ACA has come before the Supreme Court. Those legal attacks, along with whipsawing regulatory approaches to the law, have sowed confusion for insurers and consumers. The number of people who gained health coverage is smaller than some originally predicted, partly because some states declined to expand their Medicaid programs after the Supreme Court said they could opt out.

“One of the overarching themes of the ACA has been that it was created amid such partisan rancor,” says Larry Levitt, executive vice president at the Kaiser Family Foundation. “That has colored almost everything that has happened with the ACA since its passage.”

Under the law, 36 states and the District of Columbia have expanded Medicaid. The ACA’s signature marketplaces, where people can buy insurance and many get federal subsidies to help with the cost, have recently seen relatively stable premiums and an expanding number of insurers, after a messy launch and several big rate increases and withdrawals in previous years. The repeal of the ACA’s penalty for going uninsured hasn’t caused the marketplaces to crater.

“The ACA has now taken us to a next level in reduction of the uninsured,” says David Blumenthal, a former Obama administration health official who is president of the Commonwealth Fund, a health-research nonprofit.

Most Americans, particularly those with workplace coverage or Medicare, have felt only limited impact from the ACA—despite predictions that it might lead many employers to drop insurance or significantly hurt Medicare. Employer insurance began covering preventive care for members, free of charge, while young adults up to 26 years old were added to their families’ coverage. Medicare beneficiaries saw their costs in the drug-plan “doughnut hole” go down. Private Medicare plans have flourished despite cutbacks in the law.

The law’s effects also have been uneven, because of states’ varying approaches to Medicaid and other aspects of the ACA. Some states have seen far greater coverage expansions than others. “The legacy in California is very different from the legacy in Houston,” says Peter Lee, executive director of Covered California, the state’s insurance marketplace.

Nationally, the ACA’s biggest transformation has been in the individual insurance market, where consumers buy their own plans. Before the law, insurers could refuse to sell plans to people with pre-existing health conditions, or charge them more than healthier people. The ACA ended that, and those protections have become so popular that even Republican critics of the law say they want to maintain them.

“It is now etched in stone that we’re going to protect people with pre-existing conditions,” says Joseph Antos, a scholar at the American Enterprise Institute, a conservative think tank.

The changes in the individual insurance market also have squeezed some consumers. Though premiums have generally been steadier recently, many markets saw steep increases a few years ago. Their effects were blunted for people whose incomes were low enough to make them eligible for federal subsidies, but others bore the full brunt of the increases.

“There are winners and losers,” says Ken Goulet, a former top insurance-industry executive. While people with pre-existing conditions and those who get federal subsidies generally benefited from the individual-market overhaul, some middle-income people who make too much to receive subsidies now feel they can’t afford coverage, he says.

It also isn’t clear that the ACA has significantly affected health costs, though many of the law’s supporters say it did slow their growth. The ACA included cutbacks in some Medicare reimbursement, and it encouraged moves to link payments to quality and efficiency. One of the law’s most powerful cost-reduction efforts, a tax on higher-cost employer plans, has so far been blocked by Congress.

Overall, the ACA “has had almost no impact on health-care spending trends,” says Gerard Anderson, a health-care economist at Johns Hopkins University. “Spending did continue to go up, but at the normal rate.”

The law also has coincided with growing consolidation among health-care providers, particularly hospital systems, a trend that many researchers have linked to rising health-care prices. The hospital industry has pushed back, saying its mergers don’t drive higher costs.

The New York Times

Obamacare Insurance Mandate Is Struck Down by Federal Appeals Court

Abby Goodnough

WASHINGTON — A federal appeals court on Wednesday struck down a central provision of the Affordable Care Act, ruling that the requirement that people have health insurance was unconstitutional.

But the appeals panel did not invalidate the rest of the law, instead sending the case back to a federal district judge in Texas to “conduct a more searching inquiry” into which of the law’s many parts could survive without the mandate.

The 2-1 decision, by a panel of the United States Court of Appeals for the Fifth Circuit in New Orleans, left the fate of the nearly decade-old health law in limbo even as access to health care has become a central issue in the presidential race. Republicans, for whom a decision to throw out the law heading into the presidential election year could have been a political nightmare, seemed relieved, while Democrats issued a flurry of statements emphasizing that the law was still in grave danger.

The ruling was issued almost exactly a year after Judge Reed O’Connor of the Federal District Court in Fort Worth struck down the entire law, saying the individual mandate could not be severed from the rest of the Affordable Care Act because it was “the keystone” of the law, essential to its regulation of the health insurance market. With

Judge O'Connor now facing a time-consuming assignment from the appellate court, the case is unlikely to be resolved before next year's presidential election.

But Xavier Becerra, the California attorney general who led 21 states that intervened in the case and argued to preserve the law, made clear that he planned to challenge the appeals court decision by petitioning the Supreme Court to take the case.

"For now, the president got the gift he wanted — uncertainty in the health care market and a pathway to repeal," Mr. Becerra said in a call with reporters on Wednesday night.

In a statement that showed just how consequential the issue is for him, President Trump tried to appeal both to opponents of the law and voters concerned about losing their health care. He described the ruling as "a big win for all Americans," but said it would not alter the health care system. Mr. Trump also said he wanted to protect people with pre-existing conditions, as the Affordable Care Act that he has repeatedly sought to kill does.

"Providing affordable, high-quality health care will always be my priority," he said.

Two of the three appellate judges, Jennifer Walker Elrod, appointed by President George W. Bush in 2007, and Kurt Engelhardt, appointed by President Trump in 2018, joined the ruling. The third, Carolyn Dineen King, appointed by President Jimmy Carter in 1979, dissented.

Some 17 million Americans could lose the coverage gained through the Affordable Care Act if the law were thrown out, more than 50 million people with pre-existing medical conditions could again be denied health insurance and insurers would no longer have to cover people up to age 26 under their parents' plans.

A central question in the case was whether the Affordable Care Act's "individual mandate" requiring most Americans to buy health insurance or pay a penalty became unconstitutional after Congress reduced the penalty to zero dollars as part of the tax overhaul bill enacted in 2017. When the Supreme Court upheld the mandate in its landmark 2012 ruling that saved the law, it was based on Congress's power to impose taxes.

A second, much more consequential question was whether, if the mandate were ruled unconstitutional, the entire law — including popular protections for people with pre-existing medical conditions, subsidies to help people afford health coverage and other measures — had to fall. Judge O'Connor ruled that it did, saying that both Congress and the Obama administration considered the mandate inextricably linked with the rest of the law when it was passed in 2010.

The ruling essentially asked him to justify such a sweeping decision, requesting that he "employ a finer-toothed comb."

For example, their ruling noted, one provision requires certain chain restaurants to post calorie counts for menu items, while another sets certain bars for convicting someone of health care fraud.

“Without more detailed analysis from the district court opinion,” the ruling said, “it is unclear how provisions like these — which certainly do not directly regulate the health insurance marketplace — were intended to work ‘together’ with the individual mandate.”

A longstanding legal doctrine called “severability” holds that when a court excises one provision of a statute, it should leave the rest of the law in place unless Congress explicitly stated that the statute could not survive without that provision. But legal experts on both sides of previous A.C.A. battles said that Judge O’Connor’s reasoning was badly flawed in striking down the entire health care law based on how the penalty provision became moot by the 2017 tax legislation.

In Wednesday’s ruling, the appellate judges also asked Judge O’Connor to consider a proposal that the Justice Department, which had sided with the states seeking to overturn the law, quietly put forth earlier this year. It recommended blocking only the parts of the law found to harm those states and the other plaintiffs, or to declare the law unconstitutional only in the plaintiff states. The states are Texas and 17 others with Republican governors or attorneys general, and two self-employed men in Texas who say the law still requires them to purchase health insurance that they otherwise would not buy, even though there is no longer a penalty for going uninsured.

While not hinting one way or another what they thought about the severability question, the appellate judges noted the huge stakes involved.

“It may still be that none of the A.C.A. is severable from the individual mandate, even after this inquiry is concluded,” the two judges in the majority wrote. “But it is no small thing for unelected, life-tenured judges to declare duly enacted legislation passed by the elected representatives of the American people unconstitutional.”

Importantly, the ruling also asked Judge O’Connor to consider the intent of Congress when it zeroed out the mandate’s tax penalty in 2017: Did the lawmakers consider the insurance mandate inseparable from the rest of the law? At oral arguments on the appeal in July, the intervening defendants pointed to statements from members of Congress at the time indicating they wanted the rest of the law to remain intact.

On Wednesday night, Senator Lamar Alexander, Republican of Tennessee, loudly joined that argument. “I am not aware of a single senator who said they were voting to repeal Obamacare when they voted to eliminate the individual mandate penalty” as part of the 2017 tax overhaul, Mr. Alexander said in a statement.

Ken Paxton, the Texas attorney general who led the state plaintiffs in the case, applauded the decision and promised to continue fighting.

“We look forward to the opportunity to further demonstrate that Congress made the individual mandate the centerpiece of Obamacare and the rest of the law cannot stand without it,” he said in a statement.

The Trump administration has yet to respond to the ruling. It took the highly unusual step of refusing to defend the law after the case was brought against the government early last year and sided with the plaintiffs — at first only partially, but after the lower court ruling invalidated the law, entirely.

That left the 21 intervening states, all with Democratic attorneys general, to appeal the lawsuit, joined by the House of Representatives after Democrats won control last fall. They maintained that the individual mandate remained constitutional, but even if the courts disagreed, they said, the rest of the law could remain.

Although the law has significantly reduced the ranks of the uninsured, it has not lived up to its promise for some groups who were supposed to benefit, particularly middle-class people who don’t get insurance through a job, earn too much to qualify for the premium subsidies the law provides and often struggle to afford coverage.

For now, the law stands and the government continues to enforce it. The Trump administration did not object and said it would continue to enforce the law until all appeals were exhausted.

Health care is playing a pivotal role in the Democratic presidential primary race, with some candidates calling for improving the Affordable Care Act, others aiming to replace it with a government-run system, but all planning to criticize Mr. Trump for supporting the lawsuit should they win their party’s nomination.

Abbe R. Gluck, a health care expert at Yale Law School who supports the health law, said she was heartened that the appeals panel “recognized some of the glaring weaknesses in the lower court opinion,” but frustrated that the law’s future would remain uncertain, and for now, in the hands of a lower-court judge who already tried to overturn it.

“The result is that the uncertainty about the A.C.A.’s future will continue,” she said, “and continue to harm the health care markets, and that we are highly unlikely to get any final ruling on the A.C.A.’s fate until after the 2020 election.”

The New York Times

Sutter Health to Pay \$575 Million to Settle Antitrust Lawsuit

Katie Thomas

Sutter Health, the large hospital system in Northern California, said Friday that it had agreed to pay \$575 million to settle claims of anti-competitive behavior brought by the California state attorney general as well as unions and employers.

In addition to the settlement amount — which will go to compensate employers, unions and the state and federal governments — Sutter will also be prohibited from engaging in several practices that the state attorney general and others said the hospital system used to ensure its dominance.

It will be barred from so-called “all or nothing” agreements, which the attorney general said required insurers to include all of Sutter’s medical facilities if they wanted to include some of the system’s hospitals. And it will be required to limit what it can charge patients for out-of-network services, which the state said would prevent people from facing surprise medical bills.

“If we’re going to treat something that’s precious and lifesaving like a business, then the marketplace for health care must be vibrant and competitive so that the best in the business can rise to the top naturally,” Xavier Becerra, California’s attorney general, said in a news conference Friday. “This first-in-the-nation settlement is one of the largest actions against anti-competitive conduct in the health care marketplace across the country.”

The UFCW & Employers Benefit, the group of unions and employers who also brought the suit, said in a statement: “From the outset, our goal has been to not only achieve justice for the members of the class, but to also put an end to the anticompetitive behavior that has allowed Sutter to charge inflated prices.”

Representatives for Sutter said the settlement did not acknowledge wrongdoing. “We were able to resolve this matter in a way that enables Sutter Health to maintain our integrated network and ability to provide patients with access to affordable, high-quality care,” said Flo Di Benedetto, Sutter’s senior vice president and general counsel, in a statement.

The health system also said it never required insurers to agree to “all or nothing” arrangements.

A tentative settlement was announced in October, just as the trial was to begin. The class-action lawsuit had accused Sutter of using its regional dominance to corral insurers so that patients could not go elsewhere for less expensive or higher quality care.

The settlement will need to be approved by a court, and a hearing is scheduled for Feb. 25 in the Superior Court of California in San Francisco. An independent monitor will ensure the agreement is followed.

The lawsuit represented a fresh legal attack on health systems accused of using their size to thwart competition and had been highly anticipated by both hospitals and health insurers.

Sutter had long been viewed as a classic example of a hospital system that grew too big, leading to higher prices in the region. For instance, hospital care for a heart attack costs around \$25,000 in San Francisco, where Sutter has facilities, but the price is closer to \$15,000 in parts of Los Angeles.

Sutter denied that it engaged in any activities that harmed competition in the region.

Sutter continues to face a federal antitrust lawsuit.



Democrats seize on Obamacare court ruling to regain a 2020 health care advantage

Staff

(Reuters) - Enrollments for 2020 insurance plans, under the Affordable Care Act (ACA), on the HealthCare.gov website fell by about 200,000 from last year to 8.3 million, the U.S. government said on Friday, citing preliminary data.

The data, as of Dec. 17, includes consumers who were granted an extension because they were unable to complete the enrollment process on Dec. 15, the initial deadline for open enrollment.

These numbers are preliminary and do not represent final 2020 Exchange Open Enrollment figures, the Centers for Medicare & Medicaid Services (CMS) said.

On Monday, the CMS extended the deadline for enrollment via the website by three days to Dec. 18 after people faced technical issues during the final hours of the enrollment deadline.

Over half a million consumers signed up on Sunday, the initial deadline for open enrollment, according to the CMS.

Last year, 8.5 million people signed up for 2019 health plans, about 4% lower than the preceding year.

“Through the first six weeks of open enrollment, the comparable daily average number of plan selections was running 2.5% behind last year’s pace,” Evercore ISI analyst Michael Newshel said in a note earlier this week.

The CMS runs enrollment for insurance plans created by the ACA, often referred to as Obamacare, through the online marketplace HealthCare.gov for 38 states. Thirteen states, including District of Columbia, have separate state-based exchanges for enrollment with their own deadlines.

The Healthcare.gov platform accounts for 73% of national enrollment, while state-based exchanges represent 24%, according to Newshel.

“Similar to prior years, many of these states are seeing better growth than the federal platform,” Newshel said on Monday, citing reports from 8 of the 13 state-based exchanges.

The ACA, often considered the signature domestic achievement of former President Barack Obama, faced fierce opposition from the Trump administration that sought to overturn it in Congress and via courts.

In October, the government said monthly premiums for an average 2020 Obamacare health insurance plan will fall by about 4% from this year.

CMS plans to release an updated snapshot during the second week of January with the final enrollment data.

POLITICOPRO

Democrats seize on Obamacare court ruling to regain a 2020 health care advantage

Alice Miranda Ollstein and James Arkin

A federal appeals court ruling last week putting the Affordable Care Act further in jeopardy may provide the opening Democrats have been waiting for to regain the upper hand on health care and turn the tables back on Republicans going into the 2020 election.

At the most recent Democratic primary debate, candidates vying for the White House largely avoided discussing the lawsuit or Republicans’ years-long efforts to dismantle Obamacare, and instead continued their intraparty battle over Medicare for All.

But Senate Democrats, Democratic candidates and outside groups backing them immediately jumped on the news of the ruling — blasting out ads and statements reminding voters of Republicans' votes to repeal the 2010 health care law, support the lawsuit and confirm the judges who may bring about Obamacare's demise.

"I think it's an opportunity to reset with the new year to remind people that there's a very real threat to tens of millions of Americans," Sen. Brian Schatz (D-Hawaii) said in an interview. "We Democrats are always striving to improve the system, but at a minimum the American people expect us to protect what they already have."

In 2018, Democrats won the House majority and several governorships largely on a message of protecting Obamacare and its popular protections for preexisting conditions. This year continued the trend, with Kentucky's staunchly anti-Obamacare governor, Matt Bevin, losing to Democratic now-Gov. Andy Beshear.

The landscape in 2020 may be more challenging for Democrats than it was in 2018, when Republicans had more recently voted to repeal the Affordable Care Act. Republicans also say they now have more ammunition to push back on Democrats' arguments with the party's divisions over single-payer health care, which would replace Obamacare, shaping the presidential race.

Moreover, the appeals court's ruling — which in all likelihood punted any final disposition on the case until after the 2020 elections — eliminates what some Republicans saw as a nightmare scenario: If the court had embraced a lower court ruling striking down the law in its entirety, it would have put the issue before the Supreme Court during the heat of the election, putting tens of millions of Americans' health insurance at risk.

Still, Democrats believe they can win the political battle over health care, especially in Senate races. At least a half-dozen GOP senators are up for reelection, and Democrats need to net three seats to win back control of the chamber if they also win back the presidency. Democratic strategists and candidates are eager to run a health care playbook that mirrors that of the party's House takeover in 2018, and say Republicans are uniquely vulnerable after admitting this year that they have no real plan for dealing with the potential fallout of courts striking down Obamacare.

Within a day of the ruling, the pro-Obamacare advocacy group Protect Our Care cut a national TV and digital ad featuring images of Sens. Susan Collins (R-Maine) and Cory Gardner (R-Colo.), warning that if the lawsuit succeeds, "135 million Americans with preexisting conditions will be stripped of protections, 20 million Americans will lose coverage and costs will go up for millions more."

Other state-based progressive groups tell POLITICO they're readying their own ads going after individual Senate Republicans over the 5th Circuit's ruling.

Protect Our Care director Brad Woodhouse predicts that it's just a preview of the wave of attention the issue will get in the months ahead, as Democratic candidates and outside groups alike hammer the GOP on the threat their lawsuit poses to Obamacare.

“If there is one issue in American politics that is going to flip the Senate from Republican to Democratic in 2020, it’s this issue,” he said. “Our message is simple: President [Donald] Trump and Republicans are in court right now, suing to take away the ACA, take away your health care. And if Cory Gardner or Thom Tillis or any of them don’t think that’s an indefensible position, they should ask the 40-plus House Republicans who lost their seats in 2018.”

More than a dozen Republican state attorneys general, backed by the Trump administration, have been arguing in federal court for more than a year that Congress rendered the entire Affordable Care Act untenable when they voted as part of the 2017 tax bill to drop the penalty for not buying insurance down to zero. A district judge in Texas sided with them last year in a sweeping ruling declaring all of Obamacare unconstitutional.

Last week, an appeals court agreed that the elimination of the penalty made the individual mandate unconstitutional, but sent the case back down to the district court to decide whether any of the law could be separated out and preserved. The move all but guarantees the case won’t reach the Supreme Court until after the election, but it maintains the cloud of uncertainty hanging over the health law that experts say drives up the cost of insurance.

Though no one is in danger of losing their health coverage imminently, Democratic challengers in nearly every Senate battleground race, including Arizona, North Carolina, Maine and Iowa, jumped on the court ruling as an opportunity to attack Republicans on health care.

"Democrats have been in the fight to ensure that people across this country have access to affordable health care," said Sen. Catherine Cortez Masto of Nevada, the chair of the DSCC. "This opinion does not help the Republicans."

Sara Gideon, Democrats’ preferred candidate in Maine to take on Collins, called the lawsuit a “direct threat to the protections countless Mainers and Americans depend on. She has been reminding voters that Collins’ vote on the 2017 tax reform law triggered the ACA lawsuit in the first place, and she voted to confirm one of the 5th Circuit judges that recently sided with the Trump administration’s arguments against the law.

Unlike the vast majority of her GOP colleagues in the upper chamber, Collins has spoken up against the lawsuit. She has written multiple times to Attorney General Bill Bar, urging him to defend the ACA in court. Collins told POLITICO the day after the ruling that it was “significant” that the 5th Circuit judges were clearly “very uneasy with the thought of striking down the entire law” and instead sent the case back down to the lower court for reconsideration. Collins’ campaign spokesman both emphasized that she believes the government should defend the law and criticized Democrats for defending the unpopular individual mandate.

Tillis, the vulnerable North Carolina senator, said the lawsuit gave Republicans “breathing room” to find a viable replacement for Obamacare and attempted to flip the attack on Democrats by tying them to their presidential contenders.

“I think the fact that they all raised their hands and said we need Medicare for All is also raising their hands and saying the Affordable Care Act has failed,” Tillis said.

Though most of the 2020 presidential candidates have come out against Medicare for All, and more Democratic voters favor a choice between private insurance and a public option, the single-payer debate has given Republicans a potent line of attack that they’re turning to more than ever in the wake of the court’s ruling.

“Obamacare failed to lower health care costs for millions of Americans, and now Democrats want a complete government takeover of our health care system,” said Jesse Hunt, a spokesman for the National Republican Senatorial Committee. “They spent all of 2019 defending their socialist plan to eliminate employer-based health care coverage, and those problems will not subside anytime soon.”

The effectiveness of the GOP attacks will depend largely on the Democratic nominee for president — if it is someone who backs Medicare for All, it will be much more difficult for Senate candidates who don’t support the policy to separate themselves from it. But Democratic activists say they’re confident the GOP’s actions in court will sway voters more than their claims about Medicare for All.

“We can prepare for and counter those attacks by reminding voters that [Republicans are] fighting actively to take health care away,” said Kelly Dietrich, the founder and CEO of the National Democratic Training Committee, which coached more than 17,000 candidates for federal and state office in 2019. “Republicans’ ability to use fear as a tool to win elections should never be underestimated. But the antidote is to fight back just as hard.”



3 years in, no sign of Trump’s replacement for Obamacare

Aamer Madhani and Ricardo Alonso-Zaldivar

WASHINGTON (AP) — As a candidate for the White House, Donald Trump repeatedly promised that he would “immediately” replace President Barack Obama’s health care law with a plan of his own that would provide “insurance for everybody.”

Back then, Trump made it sound that his plan — “much less expensive and much better” than the Affordable Care Act — was imminent. And he put drug companies on notice that their pricing power no longer would be “politically protected.”

Nearly three years after taking office, Americans still are waiting for Trump's big health insurance reveal. Prescription drug prices have edged lower, but with major legislation stuck in Congress it's unclear if that relief is the start of a trend or merely a blip.

Meantime the uninsured rate has gone up on Trump's watch, rising in 2018 for the first time in nearly a decade to 8.5% of the population, or 27.5 million people, according to the Census Bureau.

"Every time Trump utters the words ACA or Obamacare, he ends up frightening more people," said Andy Slavitt, who served as acting administrator of the Centers for Medicare and Medicaid Services during the Obama administration. He's "deepening their fear of what they have to lose."

White House officials argue that the president is improving the health care system in other ways, without dismantling private health care.

White House spokesman Judd Deere noted Trump's signing of the "Right-to-Try" act that allows some patients facing life-threatening diseases to access unapproved treatment, revamping the U.S. kidney donation system and the FDA approving more generic drugs as key improvements. Trump has also launched a drive to end the HIV/AIDS epidemic.

"The president's policies are improving the American health care system for everyone, not just those in the individual market," Deere said.

But as Trump gears up for his reelection campaign, the lack of a health care plan is an issue that Democrats believe they can use against him. Particularly since he's still seeking to overturn "Obamacare" in court.

This month, a federal appeals court struck down the ACA's individual mandate, the requirement that Americans carry health insurance, but sidestepped a ruling on the law's overall constitutionality. The attorneys general of Texas and 18 other Republican-led states filed the underlying lawsuit, which was defended by Democrats and the U.S. House. Texas argued that due to the unlawfulness of the individual mandate, "Obamacare" must be entirely scrapped.

Trump welcomed the ruling as a major victory. *Texas v. United States* appears destined to be taken up by the Supreme Court, potentially teeing up a constitutional showdown before the 2020 presidential election.

In a letter Monday to Democratic lawmakers, House Speaker Nancy Pelosi singled out the court case. "The Trump administration continues to firmly support the recent ruling in the 5th Circuit, which they hope will move them one step closer to obliterating every protection and benefit of the Affordable Care Act," Pelosi wrote, urging Democrats to keep health care front and center in 2020.

Accused of trying to dismantle his predecessor's health care law with no provision for millions who depend on it, Trump and senior administration officials have periodically teased that a plan was just around the corner.

In August, the administrator of the Centers for Medicare and Medicaid Services, Seema Verma, said officials were "actively engaged in conversations and working on things," while Trump adviser Kellyanne Conway suggested that same month an announcement was on the horizon.

In June, Trump told ABC News that he'd roll out his "phenomenal health care plan" in a couple of months, and that it would be a central part of his reelection pitch.

The country is still waiting. Meantime Trump officials say the administration has made strides by championing transparency on hospital prices, pursuing a range of actions to curb prescription drug costs, and expanding lower-cost health insurance alternatives for small businesses and individuals.

One of Trump's small business options — association health plans — is tied up in court. And taken together, the administration's health insurance options are modest when compared with Trump's original goal of rolling back the ACA.

Since Trump has not come through on his promise of a big plan, internecine skirmishes among 2020 Democratic presidential hopefuls have largely driven the health care debate in recent months.

Bernie Sanders and Elizabeth Warren are leading the push among liberals for a "Medicare for All" plan that would effectively end private health insurance while more moderate candidates, like Joe Biden, Pete Buttigieg and Amy Klobuchar, advocate for what they contend is a more attainable expansion of Medicare.

Brad Woodhouse, a former Democratic National Committee official and executive director of the Obamacare advocacy group Protect Our Care, said it is important for Democrats to "put down the knives they've been wielding against one another on health care."

"Instead turn their attention to this president and Republicans who are trying to take it away," Woodhouse counseled.

Some Democratic hopefuls appear to be doing just that.

During a campaign stop in Memphis, Tennessee, this month, former New York Mayor Michael Bloomberg called out Trump on health care, saying the president is "determined to throw Americans off the boat, without giving them a lifeline."

Polling suggests Trump's failure to follow through on his promise to deliver a revamped health care system could be a drag on his reelection effort.

Voters have consistently named health care as one of their highest concerns in polling. And more narrowly, a recent Gallup-West Health poll found that 66% of adults believe the Trump administration has made little or no progress curtailing prescription drug costs.

Prescription drug prices did drop 1% in 2018, according to nonpartisan experts at U.S. Health and Human Services.

That was the first such price drop in 45 years, driven by declines for generic drugs, which account for nearly 9 out of 10 prescriptions dispensed. Prices continued to rise for brand-name drugs, although at a more moderate pace.

Trump's broadsides against the pharmaceutical industry might well have helped check prices, though drug companies have been hammered by every major Democrat as well as many Republican lawmakers.

Trump says a health insurance overhaul can be done in a second term if voters give him a Republican Congress as well as a reelection win.

But Trump and the GOP had that chance when they were in full control and unable to deliver, because Republicans don't agree among themselves.

Trump could still score a big win on prescription drugs before the 2020 election. He's backing a bipartisan Senate bill that would limit what Medicare recipients pay out of pocket for their medicines and require drug companies to pay rebates to the government if they increase prices above inflation.

Passing it would require the cooperation of Pelosi, harshly criticized by Trump over impeachment.



Tenth Circuit Upholds HHS Risk Adjustment Methodology

Katie Keith

On December 31, 2019, a three-judge panel of the Tenth Circuit Court of Appeals upheld the methodology adopted by the Department of Health and Human Services (HHS) to administer the risk adjustment program under the Affordable Care Act (ACA). A district court in New Mexico had previously concluded that part of the methodology—the use of statewide average premiums—was arbitrary and capricious. The district court struck down this part of the formula for the years from 2014 to 2018 until HHS could justify its rationale for adopting a budget-neutral risk adjustment program. This decision

led to the temporary suspension of about \$10.4 billion in risk adjustment payments in summer 2018.

The Tenth Circuit disagreed with the district court's determination, concluding that HHS' use of the statewide average premium was not arbitrary or capricious, that the risk adjustment program must be budget neutral, and that HHS should have been given more deference. The ruling reinstates HHS' risk adjustment methodology and means HHS need not take additional action to justify its methodology for 2014 through 2016. (As explained in more detail below, HHS actions subsequent to the district court decision has rendered the case moot for the years 2017 and 2018.) Risk adjustment payments based on the methodology will continue without disruption.

From here, New Mexico Health Connections (NMHC), the CO-OP in New Mexico that brought the challenge, could ask that the case be reheard en banc by the entirety of the Tenth Circuit or appeal directly to the Supreme Court (although it is unclear that the Court would grant such a request). The Tenth Circuit's decision may be the final word on litigation over the risk adjustment methodology.

Background On Risk Adjustment

The goal of the ACA's permanent risk adjustment program is to discourage insurers from cherry picking healthier enrollees over less healthy enrollees. To accomplish this, the risk adjustment program transfers funds from non-grandfathered plans with healthier enrollees in the individual and small group markets to non-grandfathered plans with less healthy enrollees. States that operate their own marketplaces can operate their own risk adjustment program, but none currently do so.

Section 1343 of the ACA directs HHS to develop standards for the risk adjustment program, including a formula to make these payment transfers between plans. HHS issues its risk adjustment formula, along with any updates to the formula, in annual regulations that go through the notice-and-comment rulemaking process.

A few insurers, namely CO-OPs, have challenged parts of this formula laid out in HHS regulations. Insurers particularly took issue with HHS' decision to base transfers on statewide average premiums—rather than each plan's premium—in its risk adjustment formula. These insurers argue that the use of a statewide average premium disadvantages smaller, newer, and lower-priced health plans in favor of larger, well-established, higher-premium plans. Indeed, CO-OPs have typically owed millions of dollars in risk adjustment payments to larger insurers such as Blue Cross Blue Shield affiliates. Although risk adjustment was not the only factor in the decline of Co-Ops across the country, risk adjustment outlays contributed to the problem.

Brief Litigation History

To date, courts have reached different conclusions on challenges to HHS' risk adjustment formula. In January 2018, a district court in Massachusetts upheld the risk adjustment formula against a challenge brought by Minuteman Health, a CO-OP that offered marketplace coverage in Massachusetts and New Hampshire that has since gone into receivership. Judge Dennis Saylor of the U.S. District Court of Massachusetts

concluded that HHS acted within the scope of its authority in developing its risk adjustment formula, including its decision to use a statewide average premium.

One month later, a district court in New Mexico reached a different conclusion. Judge James O. Browning of the U.S. District Court of New Mexico partially agreed with NMHC regarding HHS' use of a statewide average premium. Judge Browning found that this part of the HHS formula was arbitrary and capricious because the agency had not fully justified its assumptions during the notice-and-comment rulemaking process. In particular, Judge Browning concluded that HHS' rationale for using the statewide average premium relied on the assumption of budget neutrality. Although the federal government might have strong policy reasons for adopting a budget-neutral risk adjustment program, this was not required by the ACA and HHS never justified its decision to adopt a budget-neutral program. Because HHS failed to justify its assumption, Judge Browning set aside this part of the formula for the risk adjustment rules from 2014 through 2018. (The 2019 formula was not yet final when the decision was issued).

In late March 2018, the federal government asked Judge Browning to reconsider his decision, arguing that the case was wrongly decided and that the risk adjustment formula was not arbitrary and capricious. As noted above, the decision led HHS to briefly suspend about \$10.4 billion in risk adjustment transfers in July 2018. Judge Browning denied this request in October 2018, and the federal government appealed to the Tenth Circuit.

In the meantime, HHS issued a new final rule for the 2017 methodology and a proposed and final rule for the 2018 methodology. NMHC separately challenged the 2017 final rule. Since the district court decision, HHS has taken precautions in its 2019 and 2020 payment rules to justify its decision to base transfers on the statewide average premium. Much of HHS' rationale tracks the reasoning outlined in the Massachusetts decision that upheld the risk adjustment formula. Although HHS took steps to justify its rationale for the methodology for 2017 onwards, it had not done so for 2014 through 2016.

On appeal to the Tenth Circuit, oral arguments were held in September 2019 before a three-judge panel of Judges Carlos F. Lucero, Harris L. Hartz, and Scott M. Matheson, Jr. The panel seemed particularly interested in whether an agency must justify its assumptions even if no party questioned those assumptions during the rulemaking process. Other questions raised by the panel were whether an omission of budget neutrality is an obvious flaw and whether there are limits on federal funding sources for the risk adjustment program. The panel generally seemed sympathetic to the arguments put forward by the federal government.

The Decision

On December 31, the Tenth Circuit upheld HHS' risk adjustment methodology, concluding that HHS' use of a statewide average premium and the adoption of a budget-neutral program were not arbitrary and capricious. HHS acted reasonably in explaining why it used the statewide average premium in the risk adjustment methodology for 2014 through 2016. Because HHS subsequently issued new rules covering the 2017 and

2018 methodologies, the challenges over the rules for those years are moot. Judge Matheson wrote the decision on behalf of the panel.

No Concern Over Administrative Remand Rule

After concluding that the risk adjustment methodology was arbitrary and capricious, Judge Browning had remanded this issue back to HHS. This led to a question of whether the Tenth Circuit had jurisdiction to hear the government's appeal since a district court's decision to remand to an agency is not a final decision and generally not appealable. In addressing whether it had jurisdiction to hear the appeal, the Tenth Circuit concluded that it does because Judge Browning's decision was a final, appealable order rather than an administrative remand "in the typical sense."

Challenges Over the 2017 And 2018 Rules Are Moot

As noted above, the Tenth Circuit found NMHC's challenges over the methodology for 2017 and 2018 to be moot after HHS issued new, superseding rules for those years. Judge Matheson noted that HHS' additional explanation in the new rules "cured the defects" identified by the district court and will likely be incorporated into future rules that rely on the same formula. The Tenth Circuit then remanded the 2017 and 2018 rules back to the district court to vacate that part of its judgment and dismiss those claims. (NMHC separately challenged the new 2017 rule; that challenge was stayed pending this appeal. NMHC will not challenge the new 2018 rule because it has no risk adjustment liability for 2018 and thus has not been injured by the methodology.)

The Rules From 2014 Through 2016 Were Reasonable

Turning to the risk adjustment methodology for 2014 through 2016, the Tenth Circuit reversed Judge Browning's decision and ruled in favor of the federal government. HHS did not act arbitrarily and capriciously in using the statewide average premium for its formula or in adopting a budget-neutral risk adjustment program, the appellate court found.

NMHC had argued that HHS failed to justify its use of the statewide average premium. Judge Matheson disagreed, noting that the administrative record is "replete with reasoned explanations" for this portion of the formula. He pointed primarily to a white paper issued by HHS in September 2011 that discussed the advantages and disadvantages of using statewide average premiums or a plan's own premium (among other options) as the baseline for the risk adjustment formula. HHS relied on this analysis (and comments on the white paper) when explaining its decision to use the statewide average premium in a proposed rule for 2014.

Judge Matheson then identified at least six explanations that HHS gave for incorporating the statewide average premium over other options. These reasons included maintaining "a straightforward and predictable benchmark for estimating transfers" each year and the need to avoid causing "unintended distortions" in risk adjustment transfers. HHS received supportive comments but no negative comments on its decision to use the statewide average premium.

HHS generally maintained the same risk adjustment methodology each year, using the 2014 methodology as its "blueprint." Because HHS relied on the same reasoning as in

the 2014 rule, it included no additional explanation about its decision to use the statewide average premium or adopt a budget-neutral program in the rules for 2015 or 2016. As with the 2014 rule, HHS received no comments on these aspects of the risk adjustment program.

Based on this administrative history and record, the Tenth Circuit concluded that HHS acted reasonably in choosing to incorporate the statewide average premium into its formula: The agency considered a variety of relevant factors, weighed risks and benefits, and gave satisfactory explanations for its decision in the administrative record. Judge Matheson suggested that the absence of negative comments on the use of the statewide average premium for the rules from 2014 through 2016 further bolsters the conclusion that HHS acted reasonably in implementing its methodology.

No Additional Justification Of Budget Neutrality Was Needed

Judge Browning held that HHS' use of statewide average premiums was arbitrary and capricious because HHS wrongly assumed that the ACA requires the program to be budget neutral. As he put it, HHS' assumption that the ACA required budget neutrality "infects its analysis of the relative merits of using a state's average premium." He went on to recognize that HHS may have strong policy reasons for adopting a budget-neutral program but concluded that HHS "did not actually make such a decision" to structure the program this way. Instead, HHS assumed that the program must be budget neutral and then only considered alternatives that were also budget neutral.

The Tenth Circuit disagreed, concluding that HHS did not act arbitrarily and capriciously in adopting a budget-neutral risk adjustment program for 2014 through 2016. The panel also took issue with some of the conclusions reached by Judge Browning. First, Judge Matheson cited evidence from the administrative record that HHS would have adopted a budget-neutral program even if it had used plans' own premiums (rather than the statewide average premium). The Tenth Circuit concluded that HHS was owed more deference and less second guessing, than it received from the district court.

Second, Judge Matheson stated that implementation of a budget-neutral risk adjustment program was not a policy choice made by HHS (as Judge Browning had characterized it) but a necessity as a result of funding constraints put on the program by Congress. Said another way, the Tenth Circuit concluded that HHS had to adopt a budget-neutral program because there was no explicit congressional appropriation for the risk adjustment program. Although agencies must explain their decisions when they exercise discretion, HHS did not have discretion here to adopt a non-budget-neutral risk adjustment program. This, the Tenth Circuit suggested, may be why no commenters questioned the program's budget neutrality until the 2018 rule.

Issue Exhaustion

Although the Tenth Circuit did not reach this issue, Judge Matheson noted HHS' defense of issue exhaustion. Issue exhaustion is the idea that an issue must have been raised to an agency before a party can ask for judicial review of agency action on that issue. In this instance, it was not until the 2017 rule that HHS received comments opposing its use of the statewide average premium. HHS received additional comments

on the use of the statewide average premium in its 2018 rule and, for the first time, comments on the budget-neutral nature of the risk adjustment program.

The New York Times

It Looks Like Health Insurance, but It's Not. 'Just Trust God,' Buyers Are Told.

Reed Abelson

Eight-year-old Blake Collie was at the swimming pool when he got a frightening headache. His parents rushed him to the emergency room only to learn he had a brain aneurysm. Blake spent nearly two months in the hospital.

His family did not have traditional health insurance. "We could not afford it," said his father, Mark Collie, a freelance photographer in Washington, N.C.

Instead, they pay about \$530 a month through a Christian health care sharing organization to pay members' medical bills. But the group capped payments for members at \$250,000, almost certainly far less than the final tally of Blake's mounting medical bills.

"Just trust God," the nonprofit group, Samaritan Ministries, in Peoria, Ill., said in a statement about its coverage, and advises its members that "there is no coverage, no guarantee of payment."

More than one million Americans, struggling to cope with the rising cost of health insurance, have joined such groups, attracted by prices that are far lower than the premiums for policies that must meet strict requirements, like guaranteed coverage for pre-existing conditions, established by the Affordable Care Act. The groups say they permit people of a common religious or ethical belief to share medical costs, and many were grandfathered in under the federal health care law mainly through a religious exemption.

These Christian nonprofit groups offer far lower rates because they are not classified as insurance and are under no legal obligation to pay medical claims. They generally decline to cover people with pre-existing illnesses. They can set limits on how much their members will pay, and they can legally refuse to cover treatments for specialties like mental health.

"Nothing is guaranteed," said Dr. Carolyn McClanahan, a physician who is also a financial planner in Jacksonville, Fla. "You have to depend on the largess of the program."

The main requirement for membership is adherence to a Christian lifestyle. And the alternative sharing plans keep flourishing, especially now that the Trump administration has relaxed rules to permit alternatives to the A.C.A. that don't provide such generous coverage.

But state regulators in New Hampshire, Colorado and Texas are beginning to question some of the ministries' aggressive marketing tactics, often using call centers, and said in some cases people who joined them were misled or did not understand how little coverage they would receive if they or a family member had a catastrophic illness.

On Monday, [Washington State fined one of the larger health-sharing ministries, Trinity Healthshare, \\$150,000 and banned it from offering its product to state residents](#) because it was operating as an unauthorized insurer.

In December, Nevada insurance regulators warned consumers to beware of these plans. "They may seem enticing because they may be cheap, look and sound like they are in compliance with the Affordable Care Act ('A.C.A. '), when in reality these plans are not even insurance products," the department said.

The Texas attorney general brought a lawsuit last summer against Alera Healthcare, which marketed Trinity's ministry program, to stop it from offering "unregulated insurance products to the public." [The Houston Chronicle featured one couple who was left with more than \\$100,000 in unpaid medical bills](#). Trinity said most members are satisfied with its services.

Alera, which says it has stopped offering its plans in Texas, said it is working with regulators to resolve their concerns. The company says it has taken steps to make sure its customers are not confused about what they are buying.

Because the groups are not technically considered insurance, they operate with no government oversight. "Regulators haven't been willing to assert any control or regulatory authority over these plans," said Katie Keith, who serves as a consumer representative to the National Association of Insurance Commissioners and teaches health law at Georgetown University. "They feel their hands are tied. At the end of the day, it's not insurance."

Families who have joined the groups recount winding up with medical bills not covered by the ministries, with no legal way to appeal decisions to reject coverage for care. Some groups ask their members to push hospitals and doctors to write off their bills rather than use members' money to pay their expenses.

"These plans offer a false sense of security," said Jenny Chumbley Hogue, who runs an insurance agency in the north Dallas area of Texas. She refuses to offer them to her clients.

Several states have taken action against one ministry they say has deceived people about what they are buying. "The nature of what we're hearing from consumers around the state is absolutely heart breaking," said Kate Harris, chief deputy insurance commissioner in Colorado, one state that is trying to prevent the ministry from operating there.

But health-share ministries have become particularly attractive to people like the Collie family who don't qualify for a federal subsidy and can't afford an A.C.A. plan. Even

though premiums in the A.C.A. market have stabilized, critics of the law insist people need alternatives. “That’s the real driver behind the growth,” said Dr. Dave Weldon, a former Republican congressman from Florida who is president of the Alliance of Health Care Sharing Ministries, which represents the two largest groups.

When Dan Plato left his job to become self-employed as a consultant, he discovered that an A.C.A. policy for 2018 would cost his family around \$1,300 a month. “It was very expensive and beyond our needs,” he said. Membership in Liberty Healthshare, a ministry established by Mennonites in Canton, Ohio, was less than half the price, according to Mr. Plato, who [blogged about his experience](#).

But some Liberty members reported trouble getting their medical bills covered. Mr. Plato says a small bill for flu shots went unpaid and ended up in collection. At the end of the year, he was left wondering if Liberty would be able to cover the family in the event of a serious medical emergency. “It’s not something we could trust in that situation,” said Mr. Plato, who switched to one of the plans offered by United Healthcare also exempt from the A.C.A. rules for 2019.

Robyn Lytle, who works as an event planner in Chicago, joined Liberty for 2018, only to find that her daughter’s medical tests were never paid. “It’s been a year and a half, and I’ve been sent to collection,” said Ms. Lytle, who says Liberty had covered some of her family’s other expenses. She switched to an A.C.A. plan for 2019.

Liberty Healthshare declined to comment.

Other people complain that the ministries can be vague about coverage. Greg Snider and his wife joined Medi-Share, the program offered by Christian Care Ministry. Based in West Melbourne, Fla., Medi-Share says it has more than 400,000 members across the country.

Mr. Snider said he had just dropped traditional coverage when his wife was diagnosed with a heart condition, but he says he was assured by Medi-Share that her care could still be covered. She underwent surgery last year to address an abnormal heart rhythm. “After the procedure, the bills start rolling in,” Mr. Snider said, including \$177,000 for the surgery alone.

Mr. Snider says Medi-Share urged him to plead with the hospital after determining he would owe more than \$100,000. He said he had assumed the \$800 a month he paid into a pool would help cover the expenses. After he tweeted his frustrations, the ministry told him that he would owe only \$1,500 for the surgery because the hospital had forgiven the rest, he said. He now owes thousands of dollars in related medical bills and is unsure of their status.

If Medi-Share decides not to pay, Mr. Snider knows he has little recourse: “It is completely and solely up to them.” He has since gotten a job where he is covered under his employer.

Medi-Share says that more than 80 percent of the \$774 million it collected last year went to members' medical bills. "We take great care to ensure prospective members understand what is considered a pre-existing condition and what is eligible for sharing," it said.

It does its part to reduce medical spending, it says, through negotiating with doctors and hospitals and claims it saved members more than \$500 million last year. "We consider this process to be one way in which we contribute to the overall objective of reducing medical costs," the ministry said in a statement.

Medi-Share says it has an extensive network of more than 700,000 providers. But even if a member goes to an in-network provider, the ministry may still decide not to pay the bill. "Fundamentally, we have found that there is often a lack of understanding of what is covered," said Brendan Miller, an executive with MultiPlan, which arranges networks for Medi-Share as well as insurers.

That uncertainty has led some hospitals and doctors in the MultiPlan network to refuse to treat ministry patients rather than absorb unpaid costs.

Colorado is one of several states, including Washington, Texas and New Hampshire, that are trying to stop Trinity Healthshare, and its administrator, Alera Healthcare, from operating in their states because they say the ministry is misleading its residents.

In a statement, Alera said "it's deeply disappointing to see state regulators working to deny their residents access to more affordable alternatives offered by health care sharing ministries."

Trinity says its website makes clear that the ministry does not offer health insurance.

Regulators also worry about these plans siphoning off healthy individuals from the A.C.A. marketplaces, leading to higher premiums for Obamacare policies.

"The ministries have been very concerned about bad actors invading this space," said Dr. Weldon, the alliance president, who says his members are very clear that they are not insurance companies. "They all operate call centers, and they all bend over backward to inform people inquiring that it is not insurance," he said.

In the case of Samaritan, which says it covers 271,000 people, the ministry pointed to its Save to Share program, where members can contribute extra to cover more of their bills.

With Blake's bills likely to far exceed the cap — Mr. Collie has not yet tallied them — he created a GoFundMe account to help pay for his son's care.

Mr. Collie says the ministry remains a viable alternative, noting it paid for numerous medical bills before his son's hospitalization. "Every single person has prayed for me and my family," he said. But he was enormously relieved when he found out recently his son qualified for Medicaid, the state-federal insurance program, which will cover the boy's full medical care.

In some states, officials are starting to consider requiring the groups to register, to obtain more information for consumers.

Peter V. Lee, a former Obama administration official who now runs the California A.C.A. marketplace, said ministries should be subject to some oversight, including disclosure of how much of the money collected is spent on care.

“There should not be a religious exemption for transparency — where the money goes and if it will be there if consumers need it,” he said.

California is also requiring brokers, who are paid hefty commissions by some of the ministries to enroll members, to make sure their clients understand they are not buying insurance.

Some ministries, like Samaritan, say they do not use brokers or agents. “We also have never, nor will we ever, use insurance agents or brokers to sell Samaritan because we don’t want people to confuse us with insurance,” it said.



Column: Hospital mergers reduce patient care and drive up prices, new data show

Michael Hiltzik

The new year is certain to bring a new wave of hospital mergers, as does almost every year — at the pace of about 100 deals annually.

But 2020 also brings us new data on the effects of these mergers. According to a team from Harvard and two Boston hospitals, the deals resulted in worse patient experiences and no improvement in clinical outcomes.

As the researchers point out, abundant studies have shown that mergers drive up prices, typically by giving merged systems more bargaining power with payers such as insurance plans.

“These findings challenge arguments that hospital consolidation, which is known to increase prices, also improves quality,” the authors, led by Nancy D. Beaulieu and Leemore S. Dafny of Harvard, wrote in an article published Thursday in the *New England Journal of Medicine*.

The research is important because the rate of hospital mergers shows no signs of abating; the pace of deals remains strong and their value has been consistently increasing as big hospital systems sweep up smaller chains.

As the healthcare merger and acquisition firm Kaufman, Hall & Associates has reported, 2018 saw a surge in “mega-mergers,” with the size of the acquired systems continuing a decadelong upward trend. The [average revenue of the acquired systems reached \\$600 million](#) in the second quarter of 2019, half again as large as the \$400-million average of 2018.

Those deals may make financial sense for the participating systems, but not necessarily for patients. Their tendency to push up prices has long been known. A perfect example is what has been seen in Northern California from the expansion of the Sutter Health system through aggressive acquisitions.

Sutter late last year [settled an antitrust lawsuit](#) brought by California Atty. Gen. Xavier Becerra along with employers and unions for \$575 million. Becerra had alleged that Sutter, a nonprofit chain that is the dominant hospital system in Northern California, [ruthlessly exploited its size and reach](#) to extract “illegally inflated prices” from insurers, employers and patients. The result was in-patient costs in Northern California that are [as much as 70% higher than in Southern California](#), where Sutter has no presence.

In the settlement, Sutter agreed to end practices that were at the core of the lawsuit, including all-or-nothing terms requiring insurers to contract with all Sutter hospitals if they wanted to contract with any of them. Sutter didn’t admit wrongdoing in settling the case.

The clinical impact of hospital mergers has been harder to pin down than the financial consequences. The new study compared patient experiences and outcomes at 246 hospitals acquired from 2009 through 2013 with similar data from 1,986 unacquired control hospitals. The sample comprised short-term, acute-care hospitals with at least 25 beds and at least 100 Medicare admissions per year.

The researchers found what they called a “modest” but consistent decline in patient experience measures over the four years following the acquisitions. The “decline in performance,” they wrote, “was not a continuation of preexisting trends, was not explained by changes in the patient populations ... and is consistent with expectations that some acquired hospitals face less competition after acquisition.” They wrote that they were unable to pinpoint why these changes occurred.

The patient experience measurements were those used by [Medicare’s Hospital Consumer Assessment survey](#), which covers such categories as communication with nurses and doctors, responsiveness of hospital staff, cleanliness and quietness of the hospital environment and communication about medicines. These are important because they’re factors that patients will notice without professional input.

The researchers also found, however, “no evidence of quality improvement attributable to changes in ownership.” That included “no detectable changes in readmission or mortality rates at acquired hospitals.” Those are key measures of hospital inpatient outcomes, but involve professional analysis rather than laypersons’ impressions.

But the fundamental conclusion is especially valuable: When big hospital systems promise that their mergers will bring terrific benefits to patients, don't take them at face value.



The Health 202: Obamacare is turning 10. But its cheerleaders are focused on the problems it didn't fix.

Paige Winfield Cunningham

The Affordable Care Act turns a decade old this year. But the Democrats who passed it are spending more time talking about what the law didn't fix than what it did.

They point out that 27 million Americans still [lack coverage](#). And for those with insurance, they repeatedly bemoan the various costs associated with their plans that are on a rapidly ascending escalator.

There's no denying the sweeping 2010 health-care law resulted in palpable changes to the U.S. health-care system, despite some major stumbles and roadblocks along the way. It nearly halved the country's now-[8.5 percent](#) uninsured rate. It guaranteed coverage for the [50 million Americans](#) with preexisting conditions. It mandated more generous coverage for millions more.

And the law's insurance marketplaces appear more stable than ever before, with enrollment remaining relatively steady between 2019 and 2020. About 8.3 million people signed up in the 38 states that rely on Healthcare.gov, the Centers for Medicare and Medicaid Services [announced](#) last month — a dip of less than 2 percent compared with last year.

"The law was never meant as the final step to giving Americans quality, affordable coverage, but it's taken us a long way," said Leslie Dach, chairman of the Democratic-aligned group Protect Our Care and a former Health and Human Services adviser on the ACA. "The law was a dramatic and historic step forward when it was passed, and it is incredibly strong."

There will undoubtedly be some applause and toasts in March, the anniversary of when Congress passed the ACA and President Barack Obama signed it. Democrats have been particularly eager to highlight the law's preexisting-condition protections, which are threatened by a Trump administration-backed lawsuit, which a federal judge is taking a second look at.

(On Friday, the Democrat-led states who are defending the ACA in that lawsuit [asked](#) the Supreme Court to consider the case during its current term, hoping to get a final ruling on the law this year.)

But it's also easy to forget that the health-care overhaul was Obama's biggest domestic accomplishment. The Democratic presidential candidates are devoting much of their airtime these days to discussing Americans' persistent struggles with costs — a troubling problem the ACA didn't solve. And they're looking to go beyond the ACA by adopting a Medicare-for-all system in which the government would become the single largest payer in the system.

"If you're part of a typical American household, your family spent almost \$12,000 on health care last year," Sen. Elizabeth Warren (D-Mass.) said in New Year's Eve address. "About one in five of you — including people with insurance — didn't fill a prescription because you couldn't afford it."

"So now, imagine an America where Medicare-for-all ensures health care is a basic human right," she continued. "Imagine an America where you could get your prescriptions filled, without worrying about the cost."

It's typical for political candidates to spend more time talking about what's wrong with the country rather than what's right. After all, they need to motivate voters to turn out at the polls. But in taking that approach with health care, the Democratic candidates have inadvertently highlighted the ACA's glaring shortcoming: It didn't lower the fundamental cost of medical services and health insurance.

Christopher Robertson, a health law expert at the University of Arizona, told me he'd give the ACA "a solid B" because of its coverage expansions. But it didn't tackle health-care costs, and those have been growing unabated ever since the law's inception, he noted.

"The quality of the coverage has gotten worse and worse," Robertson said. "We're seeing a hollowing-out of insurance, even by the people who have it."

The cost growth has been particularly marked among employer-sponsored plans, which cover about half of all Americans.

Average family premiums for workplace plans increased 22 percent over the past five years and 54 percent of the past decade, according to [research](#) by the Kaiser Family Foundation. It's a similar story for annual deductibles, which have increased 36 percent over the past five years and 100 percent in the last 10.

So easing health-care costs has become a top Democratic promise, one the candidates will continue to focus on in 2020. During debates and on the campaign trail, they've rarely brought up the ACA, instead preferring to discuss ways of expanding affordable coverage either via Medicare-for-all or by adding a government-sponsored "public option" plan to the marketplaces.

The only candidate who regularly goes out of his way to applaud the ACA's progress has been Joe Biden, who served as vice president when it was passed and once famously told Obama it was "a big, f---ing deal."

Biden has become increasingly critical of Sens. Elizabeth Warren (Mass.) and Bernie Sanders (Vt.) for saying Obamacare should be replaced with Medicare-for-all.

"I'm for Barack. I think the Obamacare worked," Biden said at the September presidential debate.

In contrast, Warren and Sanders — who both voted for the ACA in the Senate — continually castigate the country's system of private coverage, which the ACA expanded dramatically. Though Warren seems to have paid a price [in the polls](#) for her aggressive advocacy of Medicare-for-all, and release of dramatic cost estimates to pay for it.

"At a time when we're spending twice as much per capita on health care as any other nation, when 87 million people are uninsured or underinsured, when 30,000 people are dying each year because they don't get to a doctor when they should, and when a half a million people are going bankrupt because of the dysfunctional and cruel system that we currently have, you know what?" [Sanders said](#) at the December presidential debate.

"I think we will pass a Medicare-for-all single-payer system, and I will introduce that legislation in my first week in office," he said.



Supreme Court orders quick response in Obamacare challenge

Pete Williams

WASHINGTON — The Supreme Court on Monday ordered the Trump administration and [states challenging Obamacare](#) to respond by Friday to an appeal filed by defenders of the health care law.

Such a highly abbreviated timeline — the rules normally allow a month for filing a response — gives the court the option to take up the case during its current term, which would mean a ruling on a contentious issue this spring, just as the presidential campaign heats up.

Nineteen blue states, led by California, [asked the Supreme Court last week](#) for a quick decision on whether to take the case. They're appealing last month's ruling by a federal appeals court that said Obamacare's individual mandate is unconstitutional and that the rest of the law cannot survive without it.

The states said that ruling "created uncertainty about the future of the entire Affordable Care Act, and that uncertainty threatens adverse consequences for our nation's health care system, including for patients, doctors, insurers, and state and local governments."

They asked the court to take the case and hear it on April 26, the last scheduled day for oral argument, or to add an extra argument day in May, something the court rarely does.

The law was challenged by Texas and 17 other red states. They argued that the individual mandate, which requires all Americans to buy insurance or pay a penalty on their income tax, was unconstitutional. By a 2-1 vote, the 5th Circuit Court of Appeals in New Orleans agreed.

The Supreme Court ordered the red states and the Trump administration, which joined them in challenging the law, to file their response to the proposed appeal by 4 p.m. Friday. Under normal practice, any case not granted by mid-January will not be heard during the court's current term.



Obamacare Is Finally Stable. Too Bad There's That Lawsuit Trying to Kill It.

Jordan Weissmann

When Republicans effectively repealed Obamacare's individual mandate two years ago, it seemed like a rash move that augured [serious trouble](#) for the law's insurance markets. The requirement that Americans either buy a health plan or pay a fine was considered by many to be a linchpin of the law. Without it, the Congressional Budget Office [predicted](#) millions more Americans would go without coverage and premiums would rise significantly.

But as data have rolled in for 2019, the first year that the mandate's penalties were phased out, it's become increasingly evident that killing off the rule had less of an impact than some worried it might. This fact has [been apparent](#) for several months now, but this week it became even clearer.

Health-care experts used to believe that repealing Obamacare's mandate would lead younger, healthier Americans to drop their coverage, which in turn would force insurers to raise their premiums, pricing out more customers. In a worst-case scenario, some markets might even see a "death spiral" where increasing costs and declining enrollment caused insurers to just give up and leave.

In reality, pretty much the opposite occurred in 2019.

First, premiums didn't skyrocket. Rather, they fell for the first time since Obamacare's exchanges revved up in 2014, with the average cost of a benchmark silver plan on Healthcare.gov dropping by an [average of 1.5 percent](#). This was just a modest decline, and there was a good deal of regional variation. But it was a sign that insurers weren't worried that the mandate's demise was about to destabilize the market.

Second, enrollment in the marketplaces held up. As the Kaiser Family Foundation reported this summer, 10.6 million people were enrolled in coverage through Obamacare's exchanges in 2019, [the same](#) as the year before.

And third, insurers made a healthy profit. On Monday, a [new Kaiser report](#) showed that carriers earned a healthy \$131 in gross margins per enrollee in 2019. This was important, because insurers are only going to sell coverage on Obamacare's exchanges if they can make money on it. When many carriers were racking up losses and dropping out of the market, the entire system's sustainability seemed to be in doubt. That's no longer a concern.

In fact, insofar as insurers had any problems last year, it was that they earned *too much* money. Yes, that's actually a concern. Under Obamacare, carriers are required to spend 80 percent of the premiums they take in on medical claims, leaving 20 percent for overhead expenses and profits (this rule is called the "medical loss ratio"). If they fail to hit the 80 percent mark, they are required to rebate the extra that they charged back to customers.

And for the past two years, insurers have had to pay out a lot of rebates. In 2018, medical loss ratios fell to 71 percent, way below the necessary mark. In 2019, the average was 75 percent, still less than that magic 80 percent.

That probably goes a long way toward explaining why average premiums [fell once again](#) for 2020; insurers quite literally had no choice but to lower their prices for the second year in a row. Falling costs for consumers also seem to have helped keep enrollment figures fairly stable; according to the government, 8.3 million Americans signed up for coverage on the federal exchange this year. That's a [slight, 2 percent drop](#) from 2019, but we have yet to see complete data from states that run their own marketplaces, which could change the picture.

All of this positive news has ultimately drawn more insurers into Obamacare's markets. The average number of insurers per state and share of customers with three or more carriers to pick from rose for [both 2019 and 2020](#). Again, this is the opposite of a death spiral.

It is possible that the market for Obamacare coverage shrank last year in ways that just don't show up in the data yet. We still don't have any data on how many shoppers bought coverage [off of the exchanges](#), either through brokers or directly from insurers, for instance. That group was fairly large in 2018—2.5 million enrollees—and given that people in it don't qualify for Obamacare's insurance subsidies, they might have been

especially likely to drop their health plans the moment the mandate was gone. But for now, Kaiser [is guesstimating](#) their numbers have held above 2 million.

Take it all together, there's simply no real sign of a post-mandate crisis. Premiums are down two years running. Enrollment is steady on the exchanges. Insurers are making money and hopping into the market. Why has the mandate's disappearance been such a nonissue? The answer appears to be pretty straightforward. The vast majority of people buying coverage on the ACA market—9.3 million of them in 2019—receive subsidies that cap their premiums as a share of income. For them, the insurance is still a pretty good deal, and they've kept buying it even though they're no longer threatened with a fine if they don't. That durable customer base has kept the whole thing standing. The subsidies have turned out to be the key, not the threat of a tax penalty.

This whole situation underlines a couple of things. First, Obamacare appears to be stabilizing at precisely the moment that yet another Republican-backed lawsuit is [threatening to strike it down](#). Ironically, the case is premised on the idea that the statutory rump of the individual mandate that the Republicans left behind when they effectively ended it is now unconstitutional, and that the rest of the law cannot be separated from it, so must be struck down, too. We are now getting a real life demonstration that, in fact, the mandate isn't all that important to Obamacare, if it ever was.

What it also suggests is that, if Obamacare survives and Democrats decide to reform it rather than scrap the whole system and start their next health-care reform [is] from scratch, they don't have to bring back the mandate, which was never politically popular. If absolutely all else fails, they could probably pass a pretty uncontroversial and popular bill that mostly just increases the value of the law's subsidies and extends them to many more families. That wouldn't deal with the deep dysfunctions underpinning America's health care cost crisis and would be deeply unsatisfying to those of use who spend a lot of time thinking and writing about far-out ideas in health-care reform. But if congressional moderates killed off anything more ambitious, a bulked up, more generous version of the system we have now would at least work. Which is something.



REUTERS

U.S. court blocks Trump from enforcing 'public charge' immigration rule

Mica Rosenberg and Jonathan Stempel

NEW YORK (Reuters) - A federal appeals court on Wednesday refused to set aside an injunction blocking the Trump administration from enforcing a rule that would withhold green cards from immigrants likely to require government assistance such as Medicaid or food stamps.

In a brief order, the 2nd U.S. Circuit Court of Appeals in Manhattan also set an expedited schedule for the White House's appeal of a lower court ruling against the rule, with legal papers to be submitted by Feb. 14 and oral arguments to be held soon afterward.

The "public charge" rule unveiled last year would make it harder for immigrants who are poor or need government help to secure residency and stay in the country.

Critics have said the rule would keep out disproportionately large numbers of people from Latin American, African and Asian countries.

Neither the U.S. Department of Justice nor the U.S. Department of Homeland Security immediately responded to requests for comment.

The rule had been challenged in this case by New York state, New York City, Connecticut, Vermont and several nonprofits.

New York City's corporation counsel, James Johnson, said the city was pleased with the order. He called the rule "an affront to the city's values" and said it would "immeasurably harm its immigrant communities."

President Donald Trump has made immigration a centerpiece of his administration and 2020 re-election campaign, and the public charge rule has been among his signature policies to curtail immigration.

Several other lawsuits challenging the rule are pending around the country. Two other federal appeals courts previously ruled for the administration by staying nationwide injunctions ordered by lower courts, while a third appeals court let stand an injunction covering Illinois.

Because the New York case also involved a nationwide injunction, Wednesday's order means the rule cannot be enforced anywhere.

When U.S. District Judge George Daniels in Manhattan ordered an injunction on Oct. 11, he called the rule "repugnant to the American Dream" and a "policy of exclusion in search of a justification."

The case is *New York et al v U.S. Department of Homeland Security et al*, 2nd U.S. Circuit Court of Appeals, No. 19-3591.