COVERED CALIFORNIA Media Clips

COVERED CALIFORNIA BOARD CLIPS

Sept. 11, 2020 – Nov. 19, 2020

Since the September board meeting, Covered California has released its Dental Rates for 2021 as well as rates for Covered California for Small Business and both were record-lows and launched the national "Get Covered 2021" campaign. The exchange was recognized for its efforts to reach the diverse, ethnic communities throughout the state. Covered California also finalized its 2021 for the individual market at a record-low 0.5 percent and launched its OE Kickoff Campaign on Nov. 9. The national news included the death of Supreme Court Justice Ruth Bader Ginsburg and the fallout affecting the future of the Affordable Care Act and a Supreme Court hearing.

PRESS RELEASES

PRINT

Articles of Significance

COVERED CALIFORNIA

News Release

Sept. 17, 2020

Covered California Announces a 2.3 Percent Rate Change for Dental Plans and Adds Two New Carriers for 2021 Coverage

- *Covered California's weighted average rate change for dental coverage in 2021 is 2.3 percent, continuing the trend of holding costs steady for consumers.*
- *More than 200,000 Covered California customers have supplemented their health insurance by purchasing optional adult dental coverage.*
- *Consumers can add dental coverage to their plan when they sign up for health insurance through Covered California.*

SACRAMENTO – Covered California announced today that the statewide average rate increase for dental coverage in 2021 will be just 2.3 percent, continuing the trend of holding costs steady for consumers. Family dental coverage offered through Covered California remains an affordable option for many California individuals and families.

"Covered California knows that consumers value taking care of both their health and dental needs," said Covered California Executive Director Peter V. Lee. "Whether people are coming to us for the first time, or plan to renew their dental coverage this fall, they will once again see stable and competitive prices."

The standard benefits for all Covered California enrollees include dental coverage for children, but not for adults. Consumers can purchase optional family dental coverage as an "add-on" to their Covered California health plan. The family dental coverage is offered on a "guaranteed issue" basis, meaning the coverage is available to anyone who wants it regardless of any pre-existing oral health conditions.

Covered California offers both dental health maintenance organization (DHMO) and dental preferred provider organization (DPPO) plans, giving consumers a choice in the type of plan that will work best for them.

New for 2021, Blue Shield of California and Guardian Life Insurance Company of America will join Covered California's participating dental carriers, which include Access Dental Plan, Anthem Blue Cross, California Dental Network, Delta Dental of California, Dental Health Services and Liberty Dental Plan. Blue Shield will offer a new DHMO product in 18 regions and a new DPPO product in all 19 regions. Guardian will also offer a new DPPO product in all 19 regions.

Premier Access will leave the exchange at the end of 2020. Premier Access's members have been notified of the plan withdrawal and will be offered the opportunity to pick any plan available to them. They will also be provided the automatic renewal option of the lowest-cost DPPO in their ZIP code.

"Consumers have a wide variety of choices for their dental coverage, and the prices are more affordable than you might think," Lee said. "Dental coverage is the right choice for many, and we're proud to offer such good options for those enrolled in plans through Covered California."

The benefits and rates of Covered California's family dental plans can be viewed at https://hbex.coveredca.com/insurance-companies/.

Covered California's open-enrollment period begins on Nov. 1. Consumers who are interested in enrolling can visit www.CoveredCA.com to explore their options and get a quote by using the Shop and Compare Tool. They can also get free and confidential enrollment assistance by visiting www.coveredca.com/find-help/ and searching among the 800 storefronts statewide or the more than 10,000 Certified Insurance Agents who can help consumers in their community in a variety of languages.

In addition, consumers can reach the Covered California service center by calling (800) 300-1506. Those who complete their enrollment by Dec. 15 will have their coverage begin on Jan. 1, 2021.

The family dental plan is optional and comes at an additional cost. While nine out of 10 consumers with health insurance through Covered California get help paying for it, financial help from the federal government or the state is not available for dental coverage. All health plans purchased through Covered California include dental coverage for members under the age of 19. Parents can enroll their children in an optional family dental plan for additional dental coverage.

COVERED CALIFORNIA

News Release

Sept. 22, 2020

Covered California Hits Record Enrollment, Providing Important Lessons for the Nation on Meeting Americans' Health Care Needs During the Pandemic and Major Economic Downturn

- *Covered California's investments in marketing and outreach, along with consumer-first policies, helped it reach a record enrollment of 1.53 million people.*
- *The record enrollment was bolstered by 289,000 people who signed up for coverage during the COVID-19 special-enrollment period, including 21 percent who were previously uninsured and likely ineligible to enroll under federal rules.*
- *Covered California's analysis found the federal marketplace would have insured 500,000 more people during the pandemic if it had equaled California's pace.*
- *More than half of those who enrolled during Covered California's COVID-19 special-enrollment period previously had job-based coverage, highlighting the fragility of employer coverage, while one in four people left the marketplace to become uninsured — the highest rate in the past six years — indicating coverage affordability is a bigger concern than ever in a down economy.*
- *Congress will hear testimony from Executive Director Peter V. Lee on lessons learned from the pandemic and how to improve the Affordable Care Act.*

SACRAMENTO, Calif. — Covered California issued a new report on Tuesday that detailed how it set a record for enrollment by meeting the needs of Californians and promoting enrollment in the face of pandemic and recession. The report, "Coverage When You Need It: Lessons From Insurance Coverage Transitions in California's Individual Marketplace Pre- and Post- the COVID-19 Pandemic," shows that as of June 2020, 1.53 million people were actively enrolled in Covered California, which represents the highest figure since the marketplace first opened its doors in 2014.

"This recession is the first test for the Affordable Care Act in a down economy, and while the economic toll has been grim, we are glad to see that Covered California is serving as the resource it is intended to be," said Peter V. Lee, executive director of Covered California. "We do not celebrate higher enrollment, since it is evidence of too many people losing job-based coverage, but we are showing that when people need us most, Covered California is here to help."

Covered California's 1.53 million consumers represents an 8 percent increase over its previous high of 1.4 million in March of 2018. The record enrollment has been driven by significant investments in marketing and outreach throughout its history, along with patient-first policies during the pandemic and recession. Covered California established a COVID-19 special-enrollment period from March 20 to Aug. 31, which allowed any eligible uninsured individual to enroll. In addition, the exchange spent $9 million on an ad campaign to spread the word to those who needed coverage during the crisis. A total of 289,460 people signed up for health care coverage during that time, which is more than twice the number who signed up during the same period last year.

"At a time when some are questioning the value of the Affordable Care Act, the COVID-19 pandemic underscores why health care for all is not only the right thing to do, but it is also sound public health policy," said Lee. "Covered California should be seeing record enrollment because a safety net is of utmost importance during a health crisis and recession. However, for that safety net to work right, you need sound policies like a robust marketing and outreach plan, Medicaid expansion and protection from junk short-term plans. Now is the time to build on the Affordable Care Act, and not turn away from a law that has helped so many."

In contrast to the enrollment growth seen in California, the federally facilitated marketplace saw only a 27 percent increase in the number of consumers signing up for coverage through the end of May[1]. The federal marketplace — which is operated by the Centers for Medicare and Medicaid Services and provides coverage to Americans in 38 states — has cut back on marketing and outreach and opted not to offer a special enrollment period specific to COVID-19.

Covered California's analysis found an additional 500,000 Americans would have been insured during the pandemic if the federal marketplace had equaled California's pace.

"The sad reality is that hundreds of thousands of Americans are facing the pandemic without insurance because of decisions made in Washington to undermine, rather than embrace, the Affordable Care Act," said Lee. "Policies matter, and the goal of any exchange should be to promote enrollment and ensure that people have the coverage they need to protect themselves and their family."

[1] CMS, June 2020, "Special Trends Report: Enrollment Data and Coverage Options for Consumers During the COVID-19 Public Health Emergency," - https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SEP-Report-June-2020.pdf

Since first offering coverage in 2014, Covered California has used all the tools of the Affordable Care Act to build a strong and sustainable individual market that helps keep health care premiums as low as possible. Covered California's 11 contracted qualified health plans vie for consumers based on price and quality. Significant investments in marketing and outreach have led to steady enrollment and a consumer pool that is consistently among the healthiest in the nation. In addition, California expanded its Medicaid program (known as Medi-Cal) and outlawed short-term plans that do not cover pre-existing conditions or provide essential health benefits.

As a result, the individual market in California has enjoyed two consecutive years of record-low rate changes with only a 0.8 percent rate change for the 2020 coverage year, and based on preliminary rates, an increase of only 0.6 percent for 2021. Compared to the rest of the nation, California's individual market health care premiums are estimated to be about 20 percent lower than what they would have been if the state's enrollment looked more like that of the federally facilitated marketplace, which has enrolled fewer consumers who also have a less-healthy risk profile.

"The test of how marketplaces are serving Americans is the product of whether that marketplace has taken actions to implement and strengthen the Affordable Care Act or acted to undercut the availability of coverage," Lee said. "What we are seeing now is a reflection of the past several years where California has leaned in to promote and build on the Affordable Care Act while the federal marketplace has gone in the opposite direction."

Other major findings of the report are:

- More than half of new Covered California consumers (57 percent) who signed up during the COVID-19 special-enrollment period were previously enrolled in employer-sponsored insurance. This compares to 34 percent during open enrollment in 2018 and 39 percent during the 2019 open-enrollment period, which highlights the fragility of employer coverage during an economic downturn.
- While the majority of those enrolling during the COVID-19 special-enrollment period would have been eligible to sign up under normal rules, over one-fifth (21 percent) report having been previously uninsured. This means that more than 60,000 Californians benefited from getting insurance rather than being made to wait until the next open-enrollment period, resulting in not only peace of mind but also in consumers being able to get tested and, if needed, treated for COVID-19, helping keep the community at large safer.
- Among members who have recently left Covered California, only one in seven report leaving because they got a job that offered employer-sponsored insurance, compared to more than half of all disenrolling consumers in 2019. This is an indication that the weak economy means consumers are losing employer-sponsored insurance and that they are more likely to need the safety net of marketplace coverage longer because there are fewer employers hiring.

- In addition, about 24 percent reported they left the marketplace and became uninsured, compared to only 10 percent in 2018, an indication that insurance affordability challenges — even in the subsidized marketplace — may be even more pronounced during the economic crisis.

The complete survey and analysis can be found here.

Covered California's Lee is also taking the lessons from California to Congress, where he will testify tomorrow at the House of Representatives Committee on Energy and Commerce Subcommittee on Health. During the hearing, titled "Health Care Lifeline: The Affordable Care Act and the COVID-19 Pandemic," Lee's submitted written testimony focused on how Covered California has built on and gone beyond the Affordable Care Act, how it has responded to the first critical test of the law and the lessons learned during this pandemic and economic downturn.

Lee called on Congress to look at national solutions to lower premiums and make coverage more affordable by expanding the subsidies available through marketplaces, as well as providing Americans with inadequate employer-sponsored insurance an option to have truly meaningful coverage, and address the health-related inequities and disparities spotlighted by the COVID-19 pandemic faced by communities of color throughout the nation.

"The pandemic and recession have shined a spotlight on the fragility for many of relying on employer-sponsored insurance and the barriers consumers face when they need care — whether it is for COVID-19, diabetes or cancer," Lee said. "We need national policies that build on the Affordable Care Act's tools to address the issues of affordability and comprehensive coverage, both in marketplaces and employer-sponsored plans."

Click here to read Mr. Lee's written testimony.

COVERED CALIFORNIA

News Release

Oct. 6, 2020

Covered California for Small Business Announces a Record-Low Weighted Average Rate Change of 1.5 Percent for 2021

- *The 1.5 percent weighted average rate change for Covered California for Small Business plans is the lowest since the exchange opened in 2014 — and it comes as Covered California's individual market premiums increased by only 0.6 percent.*

- *Covered California's small-business marketplace continues to grow, with more than 62,000 members to date and double-digit membership growth for six consecutive years.*

- *Covered California for Small Business announces plans to launch a new enrollment platform in the spring of 2021, with new tools and capabilities that will meet and, in some cases, exceed market standards.*

SACRAMENTO, Calif. — Covered California for Small Business unveiled the health plan choices and rates for small-business employers and their employees for the upcoming 2021 plan year. The statewide weighted average rate change will be 1.5 percent, which represents the lowest annual increase in the program's seven-year history, and is significantly lower than national projected increases for larger employers.

"Covered California for Small Business continues to meet the needs of employers and their employees across the state," said Peter V. Lee, executive director of Covered California. "In addition to driving down premiums, we will be upgrading our platform to continue to provide small-business consumers with even more value and choice."

This year's rate change of 1.5 percent is lower than the recent projection of 5.0 percent that larger employers expect to see in 2021 (see Table 1: Covered California for Small Business Average Rate Change, by Year). The program's five-year average rate change is 4.3 percent.

“The sustained growth of Covered California for Small Business is another example of how the Affordable Care Act continues to work for Californians,” Lee said. “The growth of Covered California for Small Business, coupled with only small rate changes, helps all small business employers and their employees by putting competitive pressure on plans across the state.”

Table 1: Covered California for Small Business Average Rate Change, by Year

Year	Rate Increase (Percentage)
2021	**1.5**
2020	4.1
2019	4.6
2018	5.6
2017	5.9
2016	7.9
2015	5.2
Projected Large-Business Rate Change in 2021[2]	**5.0**

Covered California for Small Business will continue to offer five plans in 2021, including two preferred provider organization (PPO) plans from Blue Shield of California and Health Net, both offering their broadest provider networks, and two health maintenance organization (HMO) plans — which are provider- and hospital-based — from Kaiser Permanente and Blue Shield.

The 2021 portfolio of health plans also includes Sharp Health Plan in San Diego and Oscar Health Plan of California, which will be offering coverage in Los Angeles and Orange counties. In addition, Blue Shield will also provide HMO plans to residents of Fresno, Kings and Madera counties.

Covered California for Small Business has experienced double-digit percentage growth

[2] National Business Group on Health, “2020 Large Employers’ Health Care Strategy and Plan Design Survey.”

in membership for six consecutive years. Currently, more than 62,000 individuals have insurance through Covered California for Small Business, representing a growth of approximately 7,000 individuals, or a 12.7 percent gain in membership over this time last year.

“As we enter into open enrollment for the individual market with state subsidies again available, we want to be sure small-business owners know their options and opportunities with Covered California,” Lee said.

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

“Our weighted average rate change this year is again the lowest rate increase ever,” said Terri Convey, director of Covered California’s Outreach and Sales division. “We’ve been able to have low increases for the last five years, proving that our employee choice platform is working well for small businesses.”

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

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

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

COVERED CALIFORNIA

News Release

Oct. 9, 2020

Covered California Recognized for Efforts to Reach Diverse Ethnic Communities to Promote Insurance Coverage

- *The Spanish-language ad, "Muleta," was honored by the Radio Mercury Awards as the Best Creative Radio Spot in its category.*
- *The ad highlighted how quality health insurance is available to every eligible Californian who needs coverage and is not just a luxury for the privileged.*
- *Covered California was also recognized by PRNEWS for its work in reaching out to African-American, Asian-Pacific Islander and Latino communities.*

SACRAMENTO, Calif. — For the third time in four years, the prestigious Radio Mercury Awards honored Covered California for its creative marketing, this time for an ad titled "Muleta." The Spanish-language radio spot, which used humor to inform consumers that they may eligible for financial assistance to help pay for quality health insurance coverage through Covered California, was named Best Creative Radio Spot in the Nongeneral Market category.

"Covered California invests in marketing tailored to our state's diversity," said Peter V. Lee, executive director of Covered California. "We appreciate this recognition for our efforts targeting the Latino community, but are even more grateful that we are helping people get the best 'award' for their families – affordable health care coverage."

The ad begins with the announcer telling the audience that he has a special gift for those that seek exclusivity when they suffer a leg injury: a delicate piece carved from pinewood, with plenty of armpit support, and caps made of rubber. The announcer says "Muleta, la forma refinada de apoyarse," which translates to "Crutch, the sophisticated way to lean."

The announcer then informs the audience that health care is no longer an unattainable luxury that's just for the elite, and with the new state subsidies, more financial help than ever before is available to help reduce their monthly payment. The spot aired during the most recent open-enrollment period on Pandora, iHeartRadio, Univision, Entravision and other digital platforms, as well as prominent Spanish-language radio stations in Los Angeles and the Riverside-San Bernardino area. Covered California estimates the ad was heard 55 million times.

The ad was produced by Casanova-McCann, a marketing subcontractor engaged by Covered California to work in partnership with prime contractor Campbell Ewald to reach broad audiences in California, including Spanish-speaking Latinos.

To hear the "Muleta" spot, visit the Radio Mercury Awards page at http://radiomercuryawards.com/2020Winners.cfm.

The Radio Mercury Awards were established in 1992 as "the only competition exclusively devoted to radio… to encourage and reward the development of effective and creative radio commercials." The national competition - which honors the best in radio creativity from advertising agencies, production houses, radio stations and educational institutions across the country – describes itself as "the biggest, richest, creative competition for radio."

In addition, PRNEWS recently named Covered California as a finalist for its 2020 Platinum PR Awards in the Multicultural Campaign category for its outreach efforts into diverse communities. As part of its outreach, Covered California produced and provided collateral specifically targeting African-American, diverse Asian and Pacific Islander and Latino communities through live events, hosted roundtables, interviews and articles.

"Connecting with the state's diverse communities has been a part of Covered California's mission since we first opened our doors," Lee said. "The COVID-19 pandemic puts an appropriate spotlight on the troubling disparities in health care in California and across the country, we believe that we can help address those issues by effectively reaching out to enroll all Californians."

PRNEWS has been a valued resource for communications, marketing and public relations professionals for more than 75 years. The PRNEWS Platinum Awards recognize "the most imaginative messaging campaigns, exceptional communicators and top-notch teams in the PR space." Entrants include U.S.-based and international public relations agencies, corporations, nonprofits, associations and government organizations worldwide and award winners set industry benchmarks for excellence across all areas of communications.

The full list of nominees is here and winners will be announced on Oct. 27.

Covered California is currently preparing for the upcoming open-enrollment period for the 2021 coverage year. Open enrollment will run from Nov. 1, 2020 through Jan. 31,

2021. Covered California will be launching a new ad campaign on Nov. 9, and has budgeted $157 million for marketing, sales and outreach during the current fiscal year.

Consumers can easily find out if they are eligible for Covered California or Medi-Cal – and see whether they qualify for financial help and which plans are available in their area – by using the CoveredCA.Com Shop and Compare Tool and entering their ZIP code, household income and the ages of those who need coverage.

Those interested in learning more about their coverage options can also:

- Visit www.CoveredCA.com.
- Get free and confidential assistance over the phone, 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.

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

COVERED CALIFORNIA

News Release

Oct. 13, 2020

Covered California Begins Renewal of More Consumers Than Ever Before and Announces Final 2021 Rate Change at All-Time Low of 0.5 Percent

- *Covered California is starting renewal of the largest number of consumers in its six years — with more than 1.5 million consumers being notified they have until Dec. 15 to finalize their 2021 plan choice.*
- *After going through regulatory review, Covered California's final statewide weighted average rate change is a new record-low of 0.5 percent for the upcoming 2021 plan year, after being revised down from the preliminary change of 0.6 percent.*
- *Covered California also unveiled a new CoveredCA.com, including an updated Shop and Compare Tool, where consumers can see their 2021 options, find out whether they are eligible for financial help to lower the cost of their monthly premium **and** see if they are eligible for coverage for the balance of 2020.*

SACRAMENTO, Calif. — With the start of Covered California's open-enrollment period just a few weeks away, the exchange announced that the renewal process for a record number of enrollees is now underway — with more than 1.5 million Californians eligible to renew their coverage. In addition, the preliminary rate change that Covered California previously announced in August has been revised downward to a new all-time low of 0.5 percent for the 2021 plan year.

"Covered California heads into the upcoming open-enrollment period with more consumers than ever, and we will be doing so with the lowest rate change in our history," said Peter V. Lee, executive director of Covered California. "California has built on and strengthened the Affordable Care Act, and right now this means that Californians facing a pandemic and recession are finding the security of having access to quality, affordable health care coverage."

The latest data shows that Covered California had a record 1.5 million enrollees in June of 2020. When compared to historical data, Covered California's highest enrollment total in October, which is when the renewal process begins, was 1.3 million in 2018. Current enrollees can begin renewing their coverage now, and they have until Dec. 15 to finalize their 2021 plan choice. People who do not actively select a plan for 2021, will be renewed in their current plan, so they do not suffer a gap in coverage.

"During a pandemic and recession, it is no surprise that Covered California is seeing record enrollment, because we are a safety net to help people get quality health care coverage," Lee said.

New Record-Low Rate Change

Covered California also announced that after the reviews by the California Department of Managed Health Care and the California Department of Insurance, the statewide weighted average rate change was revised downward from 0.6 percent to a new record-low of 0.5 percent.

The lower rate change is the result of reduced rates for Health Net's EPO and PPO products, which are subject to review the California Department of Insurance, in Contra Costa, El Dorado, Los Angeles, Marin, Mariposa, Merced, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare and Yolo counties (see Table 1: California Individual Market Rate Changes for 2021 by Rating Region).

Consumers both on and off the exchange benefit from Covered California's competitive marketplace, which allows them to shop for the best value and benefit from lower increases. In addition, many consumers can save more by shopping and switching to a lower-cost health plan. With the reduction in the statewide average rate change, the average rate change for unsubsidized consumers who shop and switch to the lowest-cost plan in the same metal tier is now -7.4 percent, which means many Californians can get a lower gross premium if they shop and switch. The average rate change varies by region and by an individual's personal situation.

Nearly nine out of every 10 consumers who enroll through Covered California receive financial help — in the form of federal tax credits, state subsidies, or both — which help make health care more affordable. California's state-specific enhanced subsidies, which were introduced for the first time in 2020, are benefiting about 590,000 enrollees in Covered California and are available again for both new and renewing members in 2021.

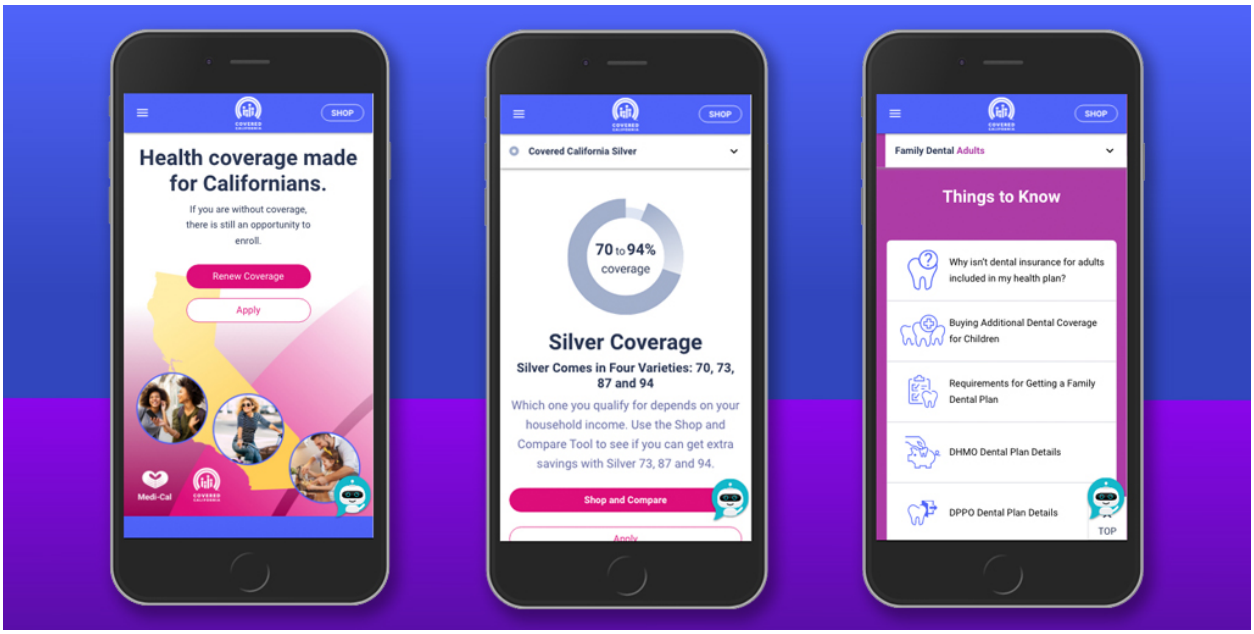
"The bold policy choices made in California to build on and strengthen the Affordable Care Act have led to a very competitive market that is full of choice for consumers," Lee said. "Covered California continues to provide stability and lower costs in the face of national uncertainty in health care."

In 2021, all 11 carriers will continue offering products across the state, and two companies will expand their coverage areas, providing increased competition and consumer choice. Nearly all Californians (99.8 percent) will have two or more choices and over three-quarter of Californians (77 percent) will have four or more choices.

Improved Website and Consumer Tools

In order to further help new and renewing consumers, Covered California also overhauled its website, www.CoveredCA.com, to make it easier for people to learn about their health insurance options and sign up for quality coverage.

The upgrades include a modern redesign, more-intuitive navigation, condensed and simplified language and enhancements in accessibility and mobile responsiveness. The improvements mark the first complete overhaul of the website since the exchange opened in 2013.



"The new and improved version of CoveredCA.com is built to help Californians find the best health insurance option, no matter what device they are using," Lee said. "In this day and age when more and more people are conducting business on their phones and tablets, these upgrades will make it easier for them to get the information they need and to sign up for the health care coverage they deserve."

The new website is the result of extensive user testing and feedback from consumers, internal program staff, the Department of Health Care Services and various stakeholders. Testing with real users began in early 2017 and continues to be conducted at every stage of design and development. The design was led by Covered California's Office of Communications and Public Relations and functional development was led by Covered California's office of Information Technology.

Video b-roll of the new website is available for download here.

Current enrollees and those interested in applying for coverage can explore their coverage options — and find out whether they are eligible for financial help — in just a few minutes by using the website's Shop and Compare Tool. All they need to do is enter their ZIP code, household income and the ages of those who need coverage to find out which plans are available in their area.

Open Enrollment and Opportunities for Enroll Now

Open enrollment for the upcoming year will begin Nov. 1, 2020, and run through Jan. 31. Open enrollment is the one time of the year where eligible consumers cannot be turned away from coverage for any reason. Covered California will be launching a new ad campaign on Nov. 9 and has budgeted $157 million for marketing, sales and outreach during the current fiscal year — an increase of more than $30 million from last year.

In addition, consumers who need coverage earlier may be eligible for the special-enrollment period that is currently underway. Consumers who experience a qualifying life event, such as: losing their health care coverage, losing their job, suffering a loss of income, moving or being a wildfire victim, could be eligible to sign up for coverage that begins in November or December.

"When the worst is happening in health care, we want to make sure that people have a path to coverage, whether it is through Covered California or Medi-Cal," Lee said.

Those interested in learning more about their coverage options can also:

- Visit www.CoveredCA.com.
- Get free and confidential assistance over the phone, 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.

Table 1. California Individual Market Rate Changes for 2021 by Rating Region

Rating Region	Total enrollment[1]	Avg. rate change	Shop and Switch[2]
Statewide Total	**1,533,250**	**0.5%**	**- 7.4%**
Region 1 Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne and Yuba counties	**57,360**	2.6%	- 0.4%
Region 2 Marin, Napa, Solano and Sonoma counties	**55,310**	2.3%	- 1.8%
Region 3 Sacramento, Placer, El Dorado and Yolo counties	**90,260**	1.8%	- 2.4%
Region 4 San Francisco County	**36,960**	1.4%	- 3.7%
Region 5 Contra Costa County	**52,890**	1.9%	- 2.6%
Region 6 Alameda County	**74,170**	2.4%	- 0.7%
Region 7 Santa Clara County	**62,740**	5.6%	- 5.5%
Region 8 San Mateo County	**27,870**	2.0%	- 2.8%
Region 9 Monterey, San Benito and Santa Cruz counties	**28,270**	0.0%	- 3.0%
Region 10 San Joaquin, Stanislaus, Merced, Mariposa and Tulare counties	**78,270**	4.2%	1.4%
Region 11 Fresno, Kings and Madera counties	**37,190**	-0.1%	- 3.0%

Region 12 San Luis Obispo, Santa Barbara and Ventura counties	**69,230**	2.3%	- 2.2%
Region 13 Mono, Inyo and Imperial counties	**14,960**	- 2.6%	- 4.7%
Region 14 Kern County	**20,330**	- 0.2%	- 2.8%
Region 15 Los Angeles County (northeast)	**197,030**	- 1.1%	- 10.7%
Region 16 Los Angeles County (southwest)	**237,690**	- 2.1%	- 13.4%
Region 17 San Bernardino and Riverside counties	**135,930**	0.4%	- 9.9%
Region 18 Orange County	**143,460**	0.5%	- 11.5%
Region 19 San Diego County	**113,340**	- 1.5%	- 13.3%

[1] Effectuated enrollment for coverage in the month of June 2020: See https://hbex.coveredca.com/data-research/library/active-member-profiles/CC_Membership_Profile_2020_06_R83120.xlsx for full data profile.

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

Table 2: California Individual Market Rate Changes by Carrier[i]

Carrier	Weighted Average Rate Change
Anthem Blue Cross	6.0
Blue Shield of California	- 2.4
Chinese Community Health Plan	- 1.3
Health Net	2.8
Kaiser Permanente	1.0
LA Care Health Plan	- 4.6
Molina Healthcare	- 3.8
Oscar Health Plan of California	7.6
Sharp Health Plan	- 0.5
Valley Health Plan	9.0
Western Health Advantage	- 2.6
Overall	**0.5**

COVERED CALIFORNIA

News Release

Oct. 30, 2020

Covered California Starts Open-Enrollment and Consumers Can Begin Signing Up for 2021 Health Care Coverage on Sunday

- *Covered California's open-enrollment period, which begins on Nov. 1 and runs through Jan. 31, is the one-time of the year when anyone eligible can sign up for health care coverage for 2021.*
- *Covered California consumers will see a record-low 0.5 average statewide rate change and increased choices in Imperial, Inyo, Kern, Mono, Orange and San Mateo counties.*
- *Consumers can check their options and see if they qualify for financial help by using the Shop & Compare tool on the revamped CoveredCA.com.*
- *The start of open enrollment coincides with Covered California being honored for a second time this month for its work on reaching multi-cultural communities.*
- *Covered California will kick off its statewide open enrollment campaign and launch new television ads on Monday, Nov. 9.*

SACRAMENTO, Calif. — Covered California's annual open-enrollment period officially begins on Sunday, Nov. 1, providing uninsured consumers with their first opportunity to sign up for health care coverage that will begin in 2021. The open-enrollment period runs through Jan. 31, 2021 and is among the longest open-enrollment periods in the country, twice as long as what is offered in the federal marketplace.

"Open enrollment is the one and only time of the year where all eligible Californians can sign up for quality health care coverage without needing to meet any special circumstances," said Peter V. Lee, executive director of Covered California. "Covered California is the place Californians can go to see if they are eligible for financial assistance to help bring the cost of that quality coverage within reach."

Eligible consumers who sign up through Covered California can qualify for financial help from the federal government, the state of California, or both. Consumers can visit and find out if they are eligible for either lower cost private plans through Covered California or free coverage through Medi-Cal (which is open year-round). Right now, a record 1.5 million Californians are enrolled in Covered California and are in the process of renewing their coverage, with nearly 90 percent receiving some level of financial assistance.

“Affordability is the number one issue for consumers, and the financial help available through Covered California helps bring the cost of coverage within reach,” Lee said.

For consumers who need to sign up for 2021 health care coverage, the premiums will remain relatively unchanged for many as Covered California announced a record-low rate change of 0.5 percent. In addition, some consumers will have more competition in their markets as two carriers announced they would be expanding their coverage in Imperial, Inyo, Kern, Mono, Orange and San Mateo counties. In 2021, nearly all Californians (99.8 percent) will be able to choose from two or more carriers and over three-quarter of Californians (77 percent) will have four or more choices.

“In the midst of this global health crisis and resulting economic recession, we want everyone to be insured, regardless of their race or economic status, and no matter what situation they find themselves in,” Lee said. “Open enrollment is underway, and now is the time to sign up for quality health coverage.”

Financial Help Lowers Costs for Consumers

In addition to the record-low rate change, 2021 will be the second year that California’s state subsidy program will be available to further lower the cost of coverage for eligible consumers. Nearly 600,000 Californians are benefiting from the new subsidies, which for the first time, extended to many middle-income consumers. The program is the only one in the nation to provide subsidies to eligible consumers, who earn between 400 percent and 600 percent of the federal poverty level, who had previously been ineligible for financial help because they exceeded the federal income requirements.

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

The state individual mandate penalty will also return for 2021. Consumers who can afford health care coverage, but choose to go without, could pay a penalty when they file their state taxes in 2022. The penalty is administered by California’s Franchise Tax Board, and could be as much as $2,250 for a family of four.

Shop and Compare

Those interested in applying for coverage can explore their options, and find out whether they are eligible for financial help, in just a few minutes by using the Shop and Compare

Tool at CoveredCA.com. All they need to do is enter their ZIP code, household income and the ages of those who need coverage to find out which plans are available in their area.

Covered California unveiled a new and improved CoveredCA.com website earlier this month, which features a modern redesign, more-intuitive navigation, condensed and simplified language and enhancements in accessibility and mobile responsiveness.

New Television Ad Campaign

In addition, Covered California will be launching a virtual statewide campaign on Nov. 9. The agency will also a debut a statewide new television ad campaign on the same day to promote open enrollment to help make consumers in every community aware of their health care options.

Getting Help Enrolling

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

Covered California Honored for Outreach Targeting California's Diversity

For the second time this month, Covered California has been honored for its efforts in reaching the state's diverse population. On Tuesday, Covered California won the PRNews Platinum PR Award for the Best Multicultural Campaign for its Targeted Segment Outreach. The award was based on outreach and collateral material specifically targeting African-American, diverse Asian and Pacific Islander and Latino communities, through live events, hosted roundtables, interviews and articles.

"From day one Covered California has worked hard to connect with the state's diverse communities," Lee said. "We believe that part of addressing the disparities exposed by the pandemic is by effectively reaching out to enroll all Californians."

The PRNEWS award follows Covered California being honored earlier this month by the Radio Mercury Awards for a Spanish-language ad titled "Muleta." The radio spot, which used humor to inform consumers that they may eligible for financial assistance to help pay for quality health insurance coverage through Covered California, was named Best Creative Radio Spot in the Non-general Market category.

In addition, Covered California's employee newsletter, titled "All Things Covered," was named Best Internal Publication and Honorable Mention in the Employee Relations/Customer Relations category.

PRNEWS has been a resource for communications, marketing and public relations professionals for more than 75 years. The PRNEWS Platinum PR Awards recognize "the most imaginative messaging campaigns, exceptional communicators and top-notch teams in the PR space." Entrants include U.S.-based and international public relations agencies, corporations, nonprofits, associations and government organizations worldwide and award winners set industry benchmarks for excellence across all areas of communications.

COVERED CALIFORNIA

News Release

Nov. 9, 2020

Covered California Officially Launches Open Enrollment with Millions of Masks to Encourage Californians to "Get Covered/Stay Covered" and a New Ad Campaign

- *Covered California's open-enrollment campaign focuses on the intersection of the COVID-19 pandemic and insurance coverage, with 2 million Californians about to receive masks emblazoned with the message "Get Covered/Stay Covered," to encourage them to stay safe and get health insurance coverage.*
- *Even with California's dramatic coverage gains over the years, 1.2 million people in the state are currently uninsured, despite being eligible for financial help through either Covered California or Medi-Cal.*
- *Covered California announced a new ad campaign to encourage those consumers to check their options and see if they qualify for financial help by using the Shop and Compare Tool on the new CoveredCA.com website.*
- *The pandemic, along with the fact that the President-elect will focus on COVID-19 and the Patient Protection and Affordable Care Act, means that California's open enrollment is a bellwether for the nation and the new administration.*
- *The statewide effort also comes on the eve of a U.S. Supreme Court hearing that will highlight the role of the Affordable Care Act in providing coverage to millions and protections for 133 million Americans who live with pre-existing conditions.*

SACRAMENTO, Calif. — Covered California officially kicked off its annual open-enrollment period on Monday with a statewide effort to encourage Californians to protect themselves, their families and their friends from the COVID-19 pandemic by wearing a mask and signing up for health care coverage. The campaign includes sending face masks, emblazoned with the message "Get Covered/Stay Covered," to every Covered California enrollee who is renewing their coverage as well as all new enrollees.

“The pandemic shines a light on the importance of health insurance and access to quality care, and now is the time when people can sign up for coverage through Covered California,” said Peter V. Lee, executive director of Covered California. “We will be reaching into every corner of the state to encourage Californians to keep COVID-safe and to get health coverage now.”

An estimated 1.2 million uninsured people in the state are either eligible for financial help through the exchange, or they qualify for low-cost or no-cost coverage through Medi-Cal. Of those eligible for subsidies through Covered California, more than half are believed to be Latino (see Table 1: Estimated Number of Uninsured Californians Eligible for Financial Help Through Covered California or Medi-Cal [by Race and Ethnicity]).

“Providing access to affordable health care coverage is more critical than ever as our state and nation continue to navigate this pandemic,” said Gov. Gavin Newsom. “Covered California opens the door to quality care by making financial assistance available to help Californians get the coverage they need. Now is the time to get covered and stay covered.”

Implications of the Presidential Election and Context of Supreme Court Hearing

The launch of the statewide campaign comes in the midst of two critical developments regarding the future of the Affordable Care Act. Most importantly, President-elect Joe Biden campaigned on two core health care issues — responding effectively to the COVID pandemic and building on the health care law to make it work better, including expanding financial help and coverage options for millions of Americans.

“President-elect Biden ran a campaign focused on the importance of responding well to the COVID pandemic and building on the Affordable Care Act,” Lee said. “In many ways, you can say that the health and health care of America was on the ballot in 2021 — and health care won.”

California has been on the forefront nationally of implementing and protecting the Affordable Care Act. While the inauguration of Biden will take place after open enrollment has closed for much of the nation, Californians will be able to sign up through Jan. 31.

“California’s open enrollment will be a bellwether for the nation and a model for the Biden administration as it takes office with a commitment to build on the Affordable Care Act,” said Lee. “California has shown how to go beyond the law with new state subsidies and investments in marketing and outreach that have resulted in record-low rate changes for two consecutive years.”

In addition, the U.S. Supreme Court will hear oral arguments on Tuesday in the case of Texas vs. California. The case centers on the question of whether Congress’s decision to reduce the individual mandate penalty to zero invalidates the entire law.

A decision to invalidate the Affordable Care Act could have a significant effect on consumers by jeopardizing the federal subsidies that help bring the cost of health insurance coverage within reach to not only 1.3 million Californians, but many more across the nation; the protections for the 133 million Americans with pre-existing conditions; the Medicaid expansion; Medicare prescription savings; critical health programs to fight the COVID-19 pandemic; and a range of other programs.

California's Attorney General Xavier Becerra is leading a coalition of 20 states and the District of Columbia in defending the Affordable Care Act.

"On Nov. 10, we're taking our fight to defend the Affordable Care Act and health care for all Americans to the United States Supreme Court," said Attorney General Becerra. "Here in California, the ACA helped create Covered California, a health care marketplace that has helped millions of Californians access quality health care coverage they can afford. Let's not stop there — open enrollment is happening now, and I encourage all Californians who qualify to sign up and get covered."

The Supreme Court is expected to make its decision sometime next year and Attorney General Becerra has indicated that he would request a stay of any impending actions, so that no one would be at risk of immediately losing their coverage if the law were struck down.

"We have been through this before, and the one thing that consumers need to know is that their coverage will be rock solid for 2021, and the time to sign up is now," Lee said.

Get Covered, Stay Covered

In an effort to promote open enrollment and make clear the connection between insurance coverage and the COVID pandemic, Covered California will be mailing masks (see right) to its record 1.5 million enrollees throughout the month of November, and provide them to all new consumers who sign up during the open-enrollment period.

All consumers will be asked to wear the masks to prevent the spread of the virus, while spreading the word about open enrollment.

"The pandemic is front and center in all of our lives, which means the issues of health and wellbeing are more important than ever before," Lee said. "Getting covered with a mask will help protect Californians and their families and friends; getting covered with a health plan will help protect people if they get sick."

While Covered California's open-enrollment campaign was launched "virtually," the focus of the event was Los Angeles, the state's largest metropolitan area. While Los Angeles has benefited from the Affordable Care Act, an estimated 338,000 people in the city's metro area remain uninsured even though they are eligible for financial help through Covered California or Medi-Cal (see Table 2: Estimated Number of Uninsured Eligible for Financial Help Through Covered California or Medi-Cal [by Metro Region].

"The COVID-19 pandemic has reaffirmed what we've long known: affordable health care coverage can make the difference between health and illness, economic security and financial ruin, life and death," said Los Angeles Mayor Eric Garcetti. "Covered California is a direct route to the ability to see a doctor and get treatment, and it provides a little peace of mind for millions of struggling families across our city and state — and now is the time for all Angelenos and Californians to get covered and stay covered."

New Covered California Ad Campaign

Covered California launched its statewide campaign in conjunction with a new ad campaign that began airing statewide on Monday. The ads center on the experiences of real Californians who've struggled to get health insurance in the past. The campaign acknowledges that getting health insurance hasn't always been easy and addresses the hurdles so many Californians face with practical, scalable solutions.

Five new television spots, directed by Academy-award winning director Errol Morris, unfold as in-home vignettes that offer a window into the everyday lives and concerns of real families. The spots include a newly unemployed father worried about securing coverage for his family; a man living with depression for whom mental health coverage has meant everything; a Latinx woman who has always translated for her parents, but needed help understanding their health insurance options; and a single mother who has struggled to afford health insurance in the past.

Click here to see the television ads, which were produced in English, Spanish, Cantonese, Mandarin, Korean and Vietnamese.

The ads are part of Covered California's $157 million investment in marketing, sales and outreach.

"These are unprecedented times, and Covered California is stepping up to answer the call for the millions of Californians who have been affected by this recession and pandemic," Lee said. "We have increased our investments in marketing and outreach to make sure people know that Covered California is here for them if they need health insurance."

Record-Low Rate Change and Increased Choices

Consumers who shop for coverage during open enrollment will benefit from Covered California's record-low rate change of 0.5 percent for 2021.

Consumers both on and off the exchange also benefit from Covered California's competitive marketplace, which allows them to shop for the best value. In addition, existing consumers can save more by shopping and switching to a lower-cost health plan. For unsubsidized consumers who shop and switch to the lowest-cost plan in the same metal tier, on average they would see a 7.4 percent decrease in their premium, which means many Californians can get a lower gross premium if they shop and switch.

The average rate change varies by region and by an individual's personal situation.

In addition, all 11 carriers will continue offering products across the state in 2021, and two companies will expand their coverage areas, providing increased competition and consumer choice. Nearly all Californians (99.8 percent) will have two or more choices and over three-quarter of Californians (77 percent) will have four or more choices.

Financial Help Lowers Costs for Consumers

In addition to the record-low rate change, roughly nine out of every 10 consumers who enroll through Covered California receive financial assistance — in the form of federal tax credits, state subsidies, or both — which helps make health care more affordable. California's state subsidies, which first became available in 2020, are benefiting nearly 600,000 consumers — including more than 41,000 middle-income consumers who had previously been ineligible for financial help because they exceeded the federal income requirements.

The latest data shows that, with the combination of federal tax credits and state subsidies, the average consumer receiving financial help paid an average of $127 per month for their coverage (with federal and state assistance reducing their costs by $454 or nearly 80 percent).

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

Shop and Compare

Those interested in applying for coverage can explore their options — and find out whether they are eligible for financial help — in just a few minutes by using the Shop and Compare Tool at CoveredCA.com. All they need to do is enter their ZIP code, household income and the ages of those who need coverage to find out which plans are available in their area.

Covered California unveiled a new and improved CoveredCA.com website last month, which features a modern redesign, more-intuitive navigation, condensed and simplified language and enhancements in accessibility and mobile responsiveness.

Getting Help Enrolling

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

Table 1: Estimated Number of Uninsured in California Eligible for Financial Help Through Covered California or Medi-Cal (by Race and Ethnicity)

Race and Ethnicity	Uninsured Californians Eligible for Financial Help
Latino	650,000
Caucasian	367,000
Asian	89,000
African American	67,000
Other	29,000
Total	**1,202,000**

Table 2: Estimated Number of Uninsured Eligible for Financial Help Through Covered California or Medi-Cal (by Metro Region)

Metro Region	Uninsured Californians Eligible for Financial Help
Northern California & Sacramento Valley	139,000
Greater Bay Area	122,000
Central Coast	60,000
San Joaquin, Central Valley, Eastern, Kern	163,000
Los Angeles	338,000
Inland Empire	192,000
Orange	88,000
San Diego	100,000
Total	**1,202,000**

Note: Tables 1 and 2 reflect best estimates for 2021 baseline *before* accounting for the COVID-19 pandemic and recession. Changes in the number and mix of uninsured caused by the COVID-19 recession are not reflected in these figures and are subject to significant uncertainty.

COVERED CALIFORNIA

News Release

Nov. 18, 2020

Covered California Names Dr. Alice Hm Chen as Its New Chief Medical Officer

- *Dr. Chen comes to Covered California after helping lead the state's response to the COVID-19 pandemic as the deputy secretary for policy and planning and chief of clinical affairs at the California Health and Human Services Agency.*
- *Prior to that, Dr. Chen served as the chief medical officer for the San Francisco Health Network since 2015 and has been a professor of Medicine at the University of California, San Francisco School of Medicine since 2005.*
- *Dr. Chen replaces the retired Dr. Lance Lang, who served with the agency since May of 2015.*

SACRAMENTO, Calif. — Covered California's Board of Directors has appointed Alice Hm Chen, MD, MPH, as its new chief medical officer. Dr. Chen comes to Covered California after serving as the deputy secretary for policy and planning and chief of clinical affairs at the California Health and Human Services Agency. During her time with the state of California, she played a critical role in the state's response to the COVID-19 pandemic in the areas of strategic reopening, hospital surge planning, data analytics and therapeutics. She also has a long history of leadership in improving care delivery with a focus on addressing the needs of underserved populations.

"Dr. Chen joins us from the front lines of the pandemic, where she has been working tirelessly to protect Californians across the state," said Peter V. Lee, executive director of Covered California. "She brings a commitment and set of skills that are perfectly suited to Covered California's work to promote changes in how health care is delivered in order to address both cost and quality gaps that affect all Californians, but have a higher burden on communities of color."

During her time at the California Health and Human Services Agency, Dr. Chen led signature health policy initiatives on affordability and access, including the Office of Health Care Affordability, generic drug manufacturing and the Healthy California for All Commission.

Dr. Alice Chen

As Covered California's chief medical officer, Dr. Chen will be responsible for health care strategy, medical policy, medical management and other clinical operations to continuously improve not only the health services provided through Covered California's contracted health plans but also California's delivery system. The chief medical officer is also responsible for ensuring that the health care strategy, tactics, and resources are in place to successfully advance the mission of Covered California and help the agency improve the evolving health care landscape. As part of hiring Dr. Chen, Covered California announced that she would join the executive leadership team, reporting directly to Peter Lee.

"Dr. Chen brings a wealth of experience in making a positive difference in the health of Californians," said Dr. Mark Ghaly, the California Health and Human Services secretary and chair of the Covered California Board of Directors. "She is not only dedicated to Covered California's mission of making coverage more affordable and accessible, but also brings unique experience to help us amplify our work on value, quality, outcomes and disparities. She also brings vital skills and the ability to work in close partnership with state agencies, health care providers and consumer advocates, while holding health plans to a high bar."

Dr. Chen is known for her work with vulnerable populations. Before being appointed to the California Health and Human Services Agency, she was the deputy director and chief medical officer for the San Francisco Department of Public Health's San Francisco Health Network. The $2 billion-a-year publicly funded delivery system includes acute care, mental health services, primary care, long-term care, specialty care, substance abuse treatment, trauma care, jail health services and homeless health care services. Among her past board positions include the California Pan-Ethnic Health Network (CPEHN) and Health Access, on which she served as board chair.

A graduate of Yale University, Stanford University Medical School and the Harvard School of Public Health, Dr. Chen maintains an active primary care practice at Zuckerberg San Francisco General Hospital and holds an appointment as clinical professor of Medicine at the University of California, San Francisco. She is also proficient in Mandarin and Spanish.

Dr. Chen will be replacing Dr. Lance Lang, who retired in June after serving in the position since May of 2015. She will earn $395,000 annually, effective Dec. 14, 2020.

COVERED CALIFORNIA

News Release

Nov. 19, 2020

National Coalition Launches "Get Covered 2021" Urging To Focus on COVID and Coverage for 16 million Americans Eligible for Financial Help Now

- *"Get Covered" is a call to wear a mask to prevent the spread of COVID as well as a public statement that you want your family and friends to get health insurance.*
- *COVID underscores why insurance matters - but not just because of the pandemic -coverage can help people stay healthy and provide a pathway to care for diseases like cancer, diabetes, and many others that impact people's lives.*
- *Get Covered 2021 will focus on getting the estimated 16 million uninsured people across America eligible for financial help – through their Affordable Care Act marketplace, or free coverage through Medicaid – insurance coverage now.*
- *The Get Covered 2021 coalition announced that December 10th will be Get Covered America Day -- a day of action where everyone will be encouraged to keep wearing their mask and post a picture of themselves on social media, including a personal message about how friends, family and neighbors can get financial help for insurance now, sharing the website GetCovered2021.org and using the hashtag #GetCovered2021.*

WASHINGTON DC, SACRAMENTO, CA AND FRANKFORT, KY - Today, a broad coalition of states, consumer and patient groups, and health care providers from across the country launched Get Covered 2021, a new national initiative designed to help uninsured Americans enroll into health insurance and promote COVID-19 safe practices (see Attachment 1. Coalition Partners) As part of today's launch, Get Covered 2021 announced tools and information available through a new website www.GetCovered2021.org, where Americans will be connected to their state or federal marketplace to enroll immediately in coverage provided through the Affordable Care Act.

Get Covered 2021 is co-chaired by Get America Covered Co-Founder Joshua Peck, Kentucky Cabinet for Health and Family Services Deputy Secretary Carrie Banahan, and Covered California Executive Director Peter V. Lee.

“COVID focused everyone’s attention on the need for access to health care. Without

comprehensive, high-quality, and affordable coverage, care for COVID or anything else can be out of reach for millions of people in this country,” Peck said. “COVID underscores why getting covered matters but not just because of the pandemic. Coverage is much more affordable than people think, with millions of consumers qualifying for plans that cost them zero dollars per month. Anyone who wants insurance should visit GetCovered2021.org, shop around, and find the option that is right for them. Together, let’s mask up, get covered, and ensure Americans have the health care they need when they need it the most.”

Current data shows that of the 28 million Americans currently uninsured, more than half of them -- over 16 million -- are eligible for financial help to pay for their health insurance costs or for free coverage through Medicaid (see Attachment 2. Uninsured, Yet Still Eligible for Help – State-by-State Detail on the Opportunity to Cover Millions for 2021 and Attachment 3. 16 Million Uninsured Americans Eligible Now). With the President-elect committing to build on the progress made under the Affordable Care Act, Get Covered 2021 is focused on the 16 million who are eligible right now financial help to lower their health insurance costs.

Of those eligible for financial help, 6.7 million are eligible for free or very low-cost coverage through their state’s Medicaid program and 9.2 million are eligible for financial assistance through their state or the federal insurance marketplace. Currently among those enrolled with coverage through marketplaces, 86 percent receive financial assistance and the average monthly help per household is $742 – covering 85 percent of the total premium -- leaving the average household responsible for less than $130 per month in premium costs (see Attachment 4. Financial Help for Those in Marketplaces Lowers Consumer Costs Dramatically).

The Get Covered 2021 initiative is supported by elected officials, national health leaders, health care providers, and celebrities committed to raising awareness of the inextricable link between health and coverage, and that financial help is available for millions of Americans who might not know it.

“The Affordable Care Act has reduced the number of uninsured from 45 to 28 million by

providing financial help and a wide variety of coverage options, but even so, we must do more to increase awareness of these options, especially in diverse communities,” Lee said. “The COVID pandemic has put a new spotlight on a long-standing problem – the fact that too many Latinos and African-Americans face worse health outcomes. Getting health coverage to all Americans is essential to our efforts to address health disparities. We’re asking America’s governors and mayors, celebrities to join with millions of Americans to help spread the word and get people enrolled.”

From today’s launch, Get Covered 2021 is driving toward a national “Get Covered America Day” on December 10th, and will continue through the open enrollment period and into the new year. The goal on December 10th is to drive enrollment across the nation, through united voices in the press and on social media.

“December 10 is Get Covered America Day, and on that day, we’re urging everyone to wear a mask and post a picture of themselves on social media, including a personal message about why having insurance matters, sharing our website GetCovered2021.org and using the hashtag #GetCovered2021,” Banahan said. “We all know someone whose life has been changed because of the lifesaving care they received. It could be your mother, grandfather, daughter, or best friend. So, right now, as we face the challenges of COVID, let us also work to make sure everyone has the same access to care that is provided by having insurance coverage.”

The organizations and individuals that endorse Get Covered 2021 are unified in their

commitment to ensuring Americans have coverage that keeps them safe, healthy, and strong. This commitment is based on the recognition that both responding effectively to COVID and getting everyone possible insurance coverage is about health equity and addressing the disparities in health status and care delivery. Health equity begins with access to care, and access to care comes with having health insurance. Get Covered 2021 is committed to getting all Americans, who are eligible for coverage today, covered.

These groups come together in their agreement on the need to address the COVID pandemic and in the need to provide coverage to Americans to prevent and address other health conditions – including many that have higher impacts on communities of color. If the 16 million uninsured Americans eligible for financial help have the same health profile as Americans generally, not only would about 525,000 of them have been infected by COVID – with many being admitted to the hospital, but 1.8 million would be living with diabetes and over 85,000 would be living with and needing care and treatment for some form of cancer (see Attachment 5. Estimated Uninsured by Condition).

“America today understands that achieving health equity means ensuring that all people have the same access to insurance coverage and clinical care,” American Public Health Association Executive Director Georges C. Benjamin, MD said. “COVID exposed for all to see the significant health disparities facing communities of color. Get Covered 2021’s focus on helping people get quality, affordable health insurance coverage is essential to helping all people stay healthy during this terrible pandemic. Coverage for all is also a critical step towards ensuring a more equitable society.”

CALIFORNIA GLOBE

California's Eight Health Entities: What's the Difference?
Chris Micheli

California has eight health-related entities: Health and Human Services Agency, Department of Managed Health Care, Department of Health Care Services, Department of Public Health, Office of Health Information Integrity, California Health Facilities Financing Authority, Office of Statewide Health Planning and Development, and California Health Benefit Exchange. What's the difference?

Health and Human Services Agency
Government Code Title 2, Division 3, Part 2.5, Chapter 1, Section 12806 provides that the California Health and Human Services Agency succeeds to and is vested with all of the duties, powers, responsibilities, and jurisdiction vested in the prior Health and Welfare Agency.

Department of Managed Health Care
Health and Safety Code Division 2, Chapter 2.2, Article 1, Section 1341 specifies that there is in state government, in the California Health and Human Services Agency, a Department of Managed Health Care that is charged with executing the laws of California related to health care service plans and their business. The chief officer of the DMC is the Director, who is appointed by the Governor and holds office at the Governor's pleasure.

Pursuant to Section 1342.6, it is the intent of the Legislature to ensure that the citizens of this state receive high-quality health care coverage in the most efficient and cost-effective manner possible. In furtherance of this intent, the Legislature finds and declares that it is in the public interest to promote various types of contracts between public or private payers of health care coverage, and institutional or professional providers of health care services.

Department of Health Care Services
Health and Safety Code Division 101, Part 1, in Sections 100100 to 100922 provides for the California Department of Health Services. Chapter 1 concerns the organization of the DHCS. Section 100100 states that there is in the state government, in the California Health and Human Services Agency, a State Department of Health Care Services.

Pursuant to Section 100105, the DHCS is under the control of an executive officer known as the Director of Health Care Services, who is appointed by the Governor and confirmed by the State Senate. The director can appoint two chief deputies. Per Section 100115, there is a Division of Rural Health.

Department of Public Health
Health and Safety Code Division 112, Part 1, Chapter 1 specifies the organization of the State Department of Public Health in Sections 131000 to 131020. Section 131000 specifies that there is in the California Health and Human Service Agency a State Department of Public Health.

Office of Health Information Integrity
Health and Safety Code Division 109 created the Office of Health Information Integrity in Section 130200. Section 130220 specifies that there is established within the California Health and Human Services Agency the Office of Health Information Integrity to ensure the enforcement of state law mandating the confidentiality of medical information. In addition, the Office is administered by a director who is appointed by the Secretary of California Health and Human Services.

California Health Facilities Financing Authority
Government Code Title 2, Division 3, Part 7.2 establishes the Health Facilities Financing Authority Act. Section 15430 is the citation to the Act. Section 15431 provides that the California Health Facilities Authority is continued in state government as the California Health Facilities Financing Authority, which constitutes a “public instrumentality” and the exercise of its powers are deemed to be performing an essential public function.

Section 15438.6 created the Cedillo-Alarcon Community Clinic Investment Act of 2000. As part of this Act, the Legislature made certain findings and declarations. Among others, the states the Authority may award grants to any eligible clinic for purposes of financing capital outlay projects. The maximum grant amount is $250,000.

Office of Statewide Health Planning and Development
Health and Safety Code Division 107, Part 1 establishes the Office of Statewide Health Planning and Development in Section 127000 to 127050. Chapter 1 contains general provisions and Section 127000 provides that there is in the state government, in the Health and Human Services Agency, an Office of Statewide Health Planning and Development.

Pursuant to Section 127005, OSHPD is under the control of an executive officer known as the Director of Statewide Health Planning and Development, who is appointed by the Governor and confirmed by the State Senate. OSHPD succeeded to the duties, powers,

and jurisdiction of the State Department of Health relating to health planning and research development, as well as the Facilities Construction Unit.

California Health Benefit Exchange
Government Code Title 22 provides for the California Health Benefit Exchange in Sections 100500 to 100522. Section 100500 specifies that there is in state government the California Health Benefit Exchange, which is an independent public entity not affiliated with any other agency or department and it known as Covered California.

Covered California is governed by an executive board consisting of five members who are residents of California. Of the members of the board, two are appointed by the Governor, one is appointed by the Senate Committee Rules, and one is appointed by the Speaker of the Assembly. The Secretary of the California Health and Human Services Agency serves as a voting, ex officio member of the board.

These board members are appointed for a term of four years and these appointees must have demonstrated and acknowledged expertise in at least two areas, such as health care coverage, benefits and plan administration, administering a health care delivery system, marketing insurance products, IT systems, etc.

Among other responsibilities, the board is responsible for using the funds awarded by the United States Secretary of Health and Human Services for planning and establishing the Exchange.

Bloomberg LAW

California's Obamacare Exchange Hits Record During Covid Crisis
Tiffany Stecker and Sara Hansard

Covered California reached record enrollment as hundreds of thousands of residents signed up for health insurance during the Covid-19 pandemic, the state's health-care insurance marketplace announced Tuesday.

Almost 290,000 Californians have signed up since March 20, according to a new report from Covered California, and 1.53 million total are enrolled, the highest level since its launch in 2014.

Covered California Executive Director Peter Lee said the milestone wasn't a reason to celebrate because it shows the high number of people who lost health insurance when they lost their jobs. Almost 60% of people who have signed up did so after losing their employer-backed health care, Lee said on a conference call.

Lee called on the federal government to do more to help Americans nationwide have access to insurance through the Affordable Care Act.

"States do not substitute for national solutions," he said.

About 20% of those who signed up had been uninsured previously, Lee said. Despite the large increase in new enrollments, about 2.9% of people with Covered California health insurance left in 2020, according to the report, roughly the same percentage as last year. About one-quarter of those who left now have no health insurance, Lee said.

California is one of 12 states and the District of Columbia that operate a state-based health care exchange. Covered California extended its deadline for new enrollments in the system by two months last March—from April 30 to June 30—to help those affected by the pandemic. The exchange also announced a $9 million ad campaign in May to encourage people to sign up during the Covid-19 crisis.

The report also noted that the 38 states that rely on the federally facilitated Healthcare.gov could have signed up nearly 500,000 Americans if the federal exchange had initiated a special enrollment during the pandemic.

The Centers for Medicare & Medicaid Services, which operates the federal marketplace, didn't respond to a request for comment. Lee will testify Wednesday at a U.S. House Energy and Commerce subcommittee hearing on the Affordable Care Act and the pandemic.

STATE OF REFORM

Covered California hits record enrollment
Staff

Covered California issued a new report on Tuesday that detailed how it set a record for enrollment by meeting the needs of Californians and promoting enrollment in the face of pandemic and recession. The report, “Coverage When You Need It: Lessons From Insurance Coverage Transitions in California’s Individual Marketplace Pre- and Post-the COVID-19 Pandemic,” shows that as of June 2020, 1.53 million people were actively enrolled in Covered California, which represents the highest figure since the marketplace first opened its doors in 2014.

“This recession is the first test for the Affordable Care Act in a down economy, and while the economic toll has been grim, we are glad to see that Covered California is serving as the resource it is intended to be,” said Peter V. Lee, executive director of Covered California. “We do not celebrate higher enrollment, since it is evidence of too many people losing job-based coverage, but we are showing that when people need us most, Covered California is here to help.”

Covered California’s 1.53 million consumers represents an 8 percent increase over its previous high of 1.4 million in March of 2018. The record enrollment has been driven by significant investments in marketing and outreach throughout its history, along with patient-first policies during the pandemic and recession. Covered California established a COVID-19 special-enrollment period from March 20 to Aug. 31, which allowed any eligible uninsured individual to enroll. In addition, the exchange spent $9 million on an ad campaign to spread the word to those who needed coverage during the crisis. A total of 289,460 people signed up for health care coverage during that time, which is more than twice the number who signed up during the same period last year.

“At a time when some are questioning the value of the Affordable Care Act, the COVID-19 pandemic underscores why health care for all is not only the right thing to do, but it is also sound public health policy,” said Lee. “Covered California should be seeing record enrollment because a safety net is of utmost importance during a health crisis and recession. However, for that safety net to work right, you need sound policies like a robust marketing and outreach plan, Medicaid expansion and protection from junk short-term plans. Now is the time to build on the Affordable Care Act, and not turn away from a law that has helped so many.”

In contrast to the enrollment growth seen in California, the federally facilitated marketplace saw only a 27 percent increase in the number of consumers signing up for coverage through the end of May1. The federal marketplace — which is operated by the Centers for Medicare and Medicaid Services and provides coverage to Americans in 38 states — has cut back on marketing and outreach and opted not to offer a special enrollment period specific to COVID-19.

Covered California's analysis found an additional 500,000 Americans would have been insured during the pandemic if the federal marketplace had equaled California's pace.

"The sad reality is that hundreds of thousands of Americans are facing the pandemic without insurance because of decisions made in Washington to undermine, rather than embrace, the Affordable Care Act," said Lee. "Policies matter, and the goal of any exchange should be to promote enrollment and ensure that people have the coverage they need to protect themselves and their family."

Since first offering coverage in 2014, Covered California has used all the tools of the Affordable Care Act to build a strong and sustainable individual market that helps keep health care premiums as low as possible. Covered California's 11 contracted qualified health plans vie for consumers based on price and quality. Significant investments in marketing and outreach have led to steady enrollment and a consumer pool that is consistently among the healthiest in the nation. In addition, California expanded its Medicaid program (known as Medi-Cal) and outlawed short-term plans that do not cover pre-existing conditions or provide essential health benefits.

As a result, the individual market in California has enjoyed two consecutive years of record-low rate changes with only a 0.8 percent rate change for the 2020 coverage year, and based on preliminary rates, an increase of only 0.6 percent for 2021. Compared to the rest of the nation, California's individual market health care premiums are estimated to be about 20 percent lower than what they would have been if the state's enrollment looked more like that of the federally facilitated marketplace, which has enrolled fewer consumers who also have a less-healthy risk profile.

"The test of how marketplaces are serving Americans is the product of whether that marketplace has taken actions to implement and strengthen the Affordable Care Act or acted to undercut the availability of coverage," Lee said. "What we are seeing now is a reflection of the past several years where California has leaned in to promote and build on the Affordable Care Act while the federal marketplace has gone in the opposite direction."

Other major findings of the report are:

More than half of new Covered California consumers (57 percent) who signed up during the COVID-19 special-enrollment period were previously enrolled in employer-sponsored insurance. This compares to 34 percent during open enrollment in 2018 and 39 percent during the 2019 open-enrollment period, which highlights the fragility of employer coverage during an economic downturn.

While the majority of those enrolling during the COVID-19 special-enrollment period would have been eligible to sign up under normal rules, over one-fifth (21 percent) report having been previously uninsured. This means that more than 60,000 Californians benefited from getting insurance rather than being made to wait until the next open-enrollment period, resulting in not only peace of mind but also in consumers being able to get tested and, if needed, treated for COVID-19, helping keep the community at large safer.

Among members who have recently left Covered California, only one in seven report leaving because they got a job that offered employer-sponsored insurance, compared to more than half of all disenrolling consumers in 2019. This is an indication that the weak economy means consumers are losing employer-sponsored insurance and that they are more likely to need the safety net of marketplace coverage longer because there are fewer employers hiring.

In addition, about 24 percent reported they left the marketplace and became uninsured, compared to only 10 percent in 2018, an indication that insurance affordability challenges — even in the subsidized marketplace — may be even more pronounced during the economic crisis.

The complete survey and analysis can be found here.

Covered California's Lee is also taking the lessons from California to Congress, where he will testify tomorrow at the House of Representatives Committee on Energy and Commerce Subcommittee on Health. During the hearing, titled "Health Care Lifeline: The Affordable Care Act and the COVID-19 Pandemic," Lee's submitted written testimony focused on how Covered California has built on and gone beyond the Affordable Care Act, how it has responded to the first critical test of the law and the lessons learned during this pandemic and economic downturn.

Lee called on Congress to look at national solutions to lower premiums and make coverage more affordable by expanding the subsidies available through marketplaces, as well as providing Americans with inadequate employer-sponsored insurance an option to have truly meaningful coverage, and address the health-related inequities and disparities spotlighted by the COVID-19 pandemic faced by communities of color throughout the nation.

"The pandemic and recession have shined a spotlight on the fragility for many of relying on employer-sponsored insurance and the barriers consumers face when they need care — whether it is for COVID-19, diabetes or cancer," Lee said. "We need national

policies that build on the Affordable Care Act's tools to address the issues of affordability and comprehensive coverage, both in marketplaces and employer-sponsored plans."

Covered CA Head Touts Record Enrollment, Calls For Nationwide Fixes
Amy Lotven

About 1.53 million people have insurance purchased through Covered California, the highest number since the exchange went live in 2014, which indicates the Affordable Care Act is providing the safety net that Congress intended, exchange executive director Peter Lee announced Tuesday (Sept. 22), a day before he urged Congress to adopt nationwide solutions to lower marketplace premiums, provide options to consumers with inadequate employer coverage and address the health disparities exposed by the pandemic.

The 1.53 million number of enrollees is an 8% increase over the previous high of 1.4 million in March 2018 and was driven by investing in marketing and outreach as well as policy decisions that promoted coverage during the pandemic. For example, 289,460 residents signed up for coverage during a broad special enrollment period (SEP) created because of COVID-19 that ran from March 20 through Aug. 31.

"This recession is the first test for the Affordable Care Act in a down economy, and while the economic toll has been grim, we are glad to see that Covered California is serving as the resource it is intended to be," Lee said.

The exchange recently reopened the SEP through the rest of the year.

The nation's largest exchange also released a report that discusses lessons learned about coverage transitions in the individual market before and during the COVID-19 pandemic.

The analysis found that 57% of SEP enrollees were previously enrolled in employer coverage, compared to 39% in 2019 and 34% in 2018 open enrollment. And while a majority of those who enrolled during the SEP might have been eligible for an existing SEP, about 21% were previously uninsured. But the study also found that nearly a quarter (24%) of people who left the market became uninsured, compared to just 10%

in 2018. This indicates that the affordability challenges, even in the subsidized marketplace, may be more pronounced during the economic crisis, the exchange says.

Lee encouraged Congress to tackle affordably and other issues in testimony at Wednesday's House Energy & Commerce health subcommittee hearing on the ACA and the pandemic.

The committee also heard from Aviva Aron Dine of the Center on Budget and Policy Priorities, Douglas Holtz Eakin of the American Action Forum, Harvard Professor Benjamin Sommers and Idaho Insurance Commissioner Dean Cameron.

Do You Report The Extra $300 Lost Wages Assistance to Medi-Cal or Covered California?
Kevin Knauss

On August 8, 2020, President Trump instructed Homeland Security, through the Federal Emergency Management Agency (FEMA), to make available funds for a Lost Wages Assistance (LWA) program. FEMA does distribute the money to individuals. California will distribute a payment of $300 per week through the Unemployment Insurance Benefits program administered by the Employment Development Department (EDD.)

The LWA is a supplement payment and not all individuals receiving unemployment benefits are eligible to receive the additional LWA money. California, according to the Department of Health Care Services All County Welfare Directors Letter No. 20-16, was approved for the LWA grant from FEMA on August 22, 2020. EDD began processing the LWA supplemental payments on September 7, 2020. Eligible recipients will receive the $300 per week supplement, in addition to their weekly unemployment insurance benefits for a minimum of three weeks.

Reporting Income To Medi-Cal & Covered California

California policy states that Disaster and Emergency assistance payments received from federal, state, or local government agencies is exempt from both Modified Adjusted Gross Income (MAGI) and non-MAGI Medi-Cal programs. Consequently, county

Welfare Directors have been directed to disregard the LWA when making income eligibility determinations.

However, for Covered California, the LWA money is counted as taxable income for eligibility and calculation of the monthly Advance Premium Tax Credit subsidy (federal) and the California Premium subsidy.

All MAGI Medi-Cal: Everyone in the household is eligible

If you have MAGI Medi-Cal, there is no harm in reporting the LWA income. If you properly document the source of the income, it should be disregarded by your local county Medi-Cal cases worker.

Mixed MAGI Medi-Cal and Covered California: adults on Covered California with subsidies, children on Medi-Cal

If there are adults receiving a Covered California subsidy and dependent children are on MAGI Medi-Cal, the income should be reported to your local county Medi-Cal case worker. All changes to the household must go through Medi-Cal. Changes to your Covered California application, if not made by Medi-Cal, will either be ignored or reversed.

All Covered California: Everyone eligible for subsidies

If everyone in the household – adults and children – are eligible for the health insurance subsidies through Covered California, you may need to report the LWA income. What is important is that the income you receive from either the PUA or the LWA does not make your final annual income higher than you estimated on your Covered California application. If your income is higher than you estimated, then you may have to repay some or all of the federal and state subsidies back on your 2020 tax returns.

There is no harm in properly updating your income on your Covered California application. You may have lost employment, started getting unemployment insurance, the PUA, and the LWA income. If the new income is lower, you and your children may qualify for MAGI Medi-Cal. If the income is higher than initially estimated, your monthly subsidy, which reduces your health insurance premium, will be reduced.

If you do make changes to the income section of your Covered California application, carefully review that section during the renewal period for 2021. The income stated for 2020 can rollover for 2021. If your income has, or will, pop back up, a low-income estimate will mean you will receive too much subsidy in 2021. If the income is too high for 2021, you are artificially reducing the monthly subsidy you are entitled to lower your health insurance premium.

California: @CoveredCA hits record enrollment, provides #COVID19/recession impact on healthcare needs
Charles Gaba

There's a lot to unpack in this press release from Covered California:

Covered California Hits Record Enrollment, Providing Important Lessons for the Nation on Meeting Americans' Health Care Needs During the Pandemic and Major Economic Downturn

- *Covered California's investments in marketing and outreach, along with consumer-first polices, helped it reach a* ***record enrollment of 1.53 million people.***

- *The record enrollment was bolstered by* ***289,000 people who signed up for coverage during the COVID-19 special-enrollment period****, including* ***21 percent who were previously uninsured and likely ineligible to enroll under federal rules.***

That's roughly 61,000 Californians who were able to enroll in ACA exchange policies specifically due to CA having an **open** SEP (that is, no requirement of coverage loss/etc. to do so).

- *Covered California's analysis found* ***the federal marketplace would have insured 500,000 more people*** *during the pandemic if it had equaled California's pace.*

Remember, the federal exchange only covers 38 states at the moment, representing roughly 73% of total ACA enrollees. **I had previously confirmed at least 370,000 COVID-specific SEP enrollments** across 9 states (including California), so this brings the total to **at least 387,000** across those states.

Covered CA's 500K estimate for HC.gov also **perfectly matches my own estimate of between 440,000 - 640,000 more** who'd have been enrolled by now if CMS had allowed a 2-month COVID SEP.

- ***More than half of those who enrolled during Covered California's COVID-19 special-enrollment period previously had job-based coverage,*** *highlighting the fragility of employer coverage, while* ***one in four people left the marketplace to become uninsured*** *— the highest rate in the past six years —*

indicating coverage affordability is a bigger concern than ever in a down economy.

- *Congress will hear testimony from Executive Director Peter V. Lee on lessons learned from the pandemic and how to improve the Affordable Care Act.*

Covered California issued a new report on Tuesday that detailed how it set a record for enrollment by meeting the needs of Californians and promoting enrollment in the face of pandemic and recession. The report, ***"Coverage When You Need It: Lessons From Insurance Coverage Transitions in California's Individual Marketplace Pre- and Post- the COVID-19 Pandemic,"*** *shows that* ***as of June 2020, 1.53 million people were actively enrolled in Covered California****, which represents the highest figure since the marketplace first opened its doors in 2014.*

It's important to note that "actively enrolled" (aka "effectuated") isn't the same as the number of people who **selected policies** during the Open Enrollment Period, which **has ranged between 1.4 - 1.6 million** in California since the first OEP in 2013-2014. Usually between 5-10% of those who select plans don't ever end up paying their first monthly premium, and there's generally some net enrollment attrition over the course of the year as more people drop off their exchange coverage than those who newly enroll via Special Enrollment Periods.

"This recession is the first test for the Affordable Care Act in a down economy, and while the economic toll has been grim, we are glad to see that Covered California is serving as the resource it is intended to be," said Peter V. Lee, executive director of Covered California. "We do not celebrate higher enrollment, since it is evidence of too many people losing job-based coverage, but we are showing that ***when people need us most, Covered California is here to help."***

Covered California's 1.53 million consumers represents an ***8 percent increase over its previous high of 1.4 million in March of 2018****. The record enrollment has been driven by significant investments in marketing and outreach throughout its history, along with patient-first policies during the pandemic and recession. Covered California established a* ***COVID-19 special-enrollment period from March 20 to Aug. 31****, which allowed any eligible uninsured individual to enroll. In addition,* ***the exchange spent $9 million on an ad campaign to spread the word*** *to those who needed coverage during the crisis. A total of* ***289,460 people signed up for health care coverage during that time****, which is* ***more than twice the number*** *who signed up during the same period last year.*

Again, Covered CA's 2018 OEP total was **1.514 million people** as of the end of January 2018; around 8% of those either never paid their first premium or dropped out after the first month or two.

"At a time when some are questioning the value of the Affordable Care Act, the COVID-19 pandemic underscores why ***health care for all is not only the right thing to do, but it is also sound public health policy****," said Lee. "Covered California should be seeing record enrollment because a safety net is of utmost importance during a health*

crisis and recession. However, for that safety net to work right, ***you need sound policies like a robust marketing and outreach plan, Medicaid expansion and protection from junk short-term plans.*** *Now is the time to build on the Affordable Care Act, and not turn away from a law that has helped so many."*

In contrast to the enrollment growth seen in California, ***the federally facilitated marketplace saw only a 27 percent increase in the number of consumers signing up for coverage through the end of May****[1]. The federal marketplace — which is operated by the Centers for Medicare and Medicaid Services and provides coverage to Americans in 38 states —* ***has cut back on marketing and outreach*** *and opted not to offer a special enrollment period specific to COVID-19.*

I've written a lot about CMS's refusal to create an "open" SEP for HC.gov. I haven't really noted that they've also been nearly radio silent about the **standard** SEP available for those who've lost their coverage.

Covered California's analysis found ***an additional 500,000 Americans would have been insured during the pandemic if the federal marketplace had equaled California's pace.***

"The sad reality is that hundreds of thousands of Americans are facing the pandemic without insurance because of decisions made in Washington to undermine, rather than embrace, the Affordable Care Act," said Lee. "Policies matter, and the goal of any exchange should be to promote enrollment and ensure that people have the coverage they need to protect themselves and their family."

Since first offering coverage in 2014, Covered California has used all the tools of the Affordable Care Act to build a strong and sustainable individual market that helps keep health care premiums as low as possible. Covered California's ***11 contracted qualified health plans*** *vie for consumers based on price and quality. Significant investments in marketing and outreach have led to steady enrollment and a consumer pool that is consistently among the healthiest in the nation. In addition, California expanded its Medicaid program (known as Medi-Cal) and outlawed short-term plans that do not cover pre-existing conditions or provide essential health benefits.*

As a result, the individual market in California has enjoyed ***two consecutive years of record-low rate changes with only a 0.8 percent rate change for the 2020 coverage year****, and based on preliminary rates, an increase of* ***only 0.6 percent for 2021****. Compared to the rest of the nation, California's individual market health care premiums are estimated to be about* ***20 percent lower than what they would have been if the state's enrollment looked more like that of the federally facilitated marketplace****, which has enrolled fewer consumers who also have a less-healthy risk profile.*

Interesting! I'll definitely have to dig into the analysis...

"The test of how marketplaces are serving Americans is the product of whether that marketplace has taken actions to implement and strengthen the Affordable Care Act or

acted to undercut the availability of coverage," Lee said. "What we are seeing now is a reflection of the past several years where California has leaned in to promote and build on the Affordable Care Act while the federal marketplace has gone in the opposite direction."

Other major findings of the report are:

- *More than half of new Covered California consumers **(57 percent) who signed up during the COVID-19 special-enrollment period were previously enrolled in employer-sponsored insurance**. This compares to **34 percent during open enrollment in 2018** and **39 percent during the 2019 open-enrollment period**, which highlights the fragility of employer coverage during an economic downturn.*

- *While the majority of those enrolling during the COVID-19 special-enrollment period would have been eligible to sign up under normal rules, over one-fifth (21 percent) report having been previously uninsured. This means that **more than 60,000 Californians benefited from getting insurance rather than being made to wait until the next open-enrollment period**, resulting in not only peace of mind but also in consumers being able to get tested and, if needed, treated for COVID-19, helping keep the community at large safer.*

This is a reasonable philosophical debate; after all, the entire point of the limited-time Open Enrollment Period is to prevent gaming of the system. However, **as I've noted before**:

*The point of a deadline is a) to prevent people from trying to game the system by deliberately waiting until they're sick/injured before enrolling in coverage (thus driving up premiums for everyone else) and b) to goad people into actually taking action (deadlines do have a clear positive impact on enrollment). With the COVID-19 pandemic having thrown the entire healthcare system into disarray, **neither of those seem to be much of a factor this year.***

Back to the press release...

- *Among members who have recently **left** Covered California, **only one in seven report leaving because they got a job that offered employer-sponsored insurance**, compared to **more than half of all disenrolling consumers in 2019**. This is an indication that the weak economy means consumers are losing employer-sponsored insurance and that they are **more likely to need the safety net of marketplace coverage longer** because there are fewer employers hiring.*

- *In addition, about **24 percent reported they left the marketplace and became uninsured**, compared to **only 10 percent in 2018,** an indication that insurance affordability challenges — even in the subsidized marketplace — may be even more pronounced during the economic crisis.*

This is a good reminder that one of the challenges of the individual market both before **and** under the ACA is that it functions as **both** long-term health insurance for many self-employed people like my wife and I **and** as temporary coverage for people who are between jobs or experiencing other life transitions. In that sense, for many people, ACA exchange plans **are** the "short-term plans" that the Trump Administration keeps trying to push so hard...it's just that **ACA** plans still include allof the protections regardless of whether you're enrolled in one for one month, six months or five years straight.

Covered California's Lee is also taking the lessons from California to Congress, where he will testify tomorrow at the House of Representatives Committee on Energy and Commerce Subcommittee on Health. During the hearing, titled "Health Care Lifeline: The Affordable Care Act and the COVID-19 Pandemic," Lee's submitted written testimony focused on how Covered California has built on and gone beyond the Affordable Care Act, how it has responded to the first critical test of the law and the lessons learned during this pandemic and economic downturn.

Lee called on Congress to look at national solutions to lower premiums and make coverage more affordable by ***expanding the subsidies available*** *through marketplaces, as well as* ***providing Americans with inadequate employer-sponsored insurance an option to have truly meaningful coverage****, and address the* ***health-related inequities and disparities*** *spotlighted by the COVID-19 pandemic faced by communities of color throughout the nation.*

The first two of these refer to killing the subsidy cliff & beefing up the subsidy formula (already done in H.R. 1425 passed by the House in July, gathering dust in the Senate) as well as fixing the "Family Glitch" (also addressed by H.R. 1425, I believe).

"The pandemic and recession have shined a spotlight on the fragility for many of relying on employer-sponsored insurance and the barriers consumers face when they need care — whether it is for COVID-19, diabetes or cancer," Lee said. "We need national policies that build on the Affordable Care Act's tools to address the issues of affordability and comprehensive coverage, both in marketplaces and employer-sponsored plans."

ThinkAdvisor

Agents Keep Health Rates Down: California Exchange Chief to Congress
Allison Bell

An Affordable Care Act (ACA) universe celebrity told members of Congress Wednesday that health insurance agents help keep commercial health insurance affordable.

Peter Lee, the executive director of Covered California — California's ACA public health insurance exchange program, or web-based health insurance supermarket — testified at

a House hearing that advertising, operating local storefronts, sponsoring nonprofit navigators, and working with 10,000 agents are all ways to stabilize health insurance markets, by persuading low-risk people to pay for coverage before they feel sick.

“People know we’re there,” Lee said. “It’s because we support navigators and agents.”

All successful organizations need to market themselves, Lee said.

“Beyond that, health care is different,” Lee said. “People don’t want health insurance, because they don’t think they’re to get sick.”

Someone has to cajole people into getting covered, Lee said.

A Matter of Life and Death

Covered California’s marketing and outreach programs, including efforts to work with agents, have probably saved some California residents from dying of COVID-19, Lee said.

When people get COVID-19, “early diagnosis and treatment are critical to getting good care,” Lee said.

Having Medicaid, commercial health insurance or some other source of coverage may increase the odds that people will get good care quickly, and that shows why managers of HealthCare.gov — the arm of the the U.S. Department of Health and Human Services (HHS) that handles ACA exchange plan enrollment and account administration duties for states without their own locally run ACA exchange programs — need to do a better job of marketing HealthCare.gov, Lee said.

HealthCare.gov has helped about 11 million people sign up and pay for commercial health coverage this year.

Lee estimated that, based on Covered California’s 2020 enrollment experience, HealthCare.gov would have helped 500,000 more people get covered if it were marketing HealthCare.gov as aggressively as Covered California is marketing its services.

Lee said Covered California gets about half of its business through agents and navigators.

EHealth, a commercial web broker, has estimated that it may earn about $258 per ACA exchange plan enrollee over the lifetime of eHealth’s relationship with that enrollee. That implies that HealthCare.gov marketing support weakness may have cost agents and brokers more than $60 million in commission and fee revenue.

Lee talked at the hearing about the human cost of weak marketing support for HealthCare.gov.

“This failure to act is a matter of life and death,” Lee said.

Aside from the fact that good care helps the patient, “the public benefits by having potentially infectious individuals tested and treated,” Lee said.

The Hearing

Lee appeared at a hearing with the title “Health Care Lifeline: The Affordable Care Act and the COVID-19 Pandemic” that was organized by the House Energy and Commerce health subcommittee.

The subcommittee held the hearing online, with a “virtual” format.

Democrats warned about the possibility that the U.S. Supreme Court could use the Texas v. California case to strike down all of the ACA, and, possibly, eliminate programs that now provide coverage for hundreds of thousands of people.

Eliminating the ACA could also wipe out health insurance benefits and pricing standards that help tens of millions of Americans with health problems, including high blood pressure and obesity, get access to coverage at the same price everyone else pays, Democrats on the panel said.

Republicans countered that they, too, have said over and over again that they support maintaining protections for people with pre-existing conditions.

But subcommittee members also tried to reach across party lines, and through the virtual conference system, to try to support each other.

The son of one subcommittee member, Rep. Markwayne Mullin, R-Okla., suffered severe injuries in March while riding a utility terrain vehicle on the Mullin family’s ranch.

Rep. Anna Eshoo, D-California, the subcommittee chair, took time to mention that.

“You know, Markwayne, that our prayers follow your son,” Eshoo told Mullin.

Mullin said his son is on track to come home from the hospital Oct. 8.

The hearing might be the last the health subcommittee will hold before the Nov. 3 general elections, and Eshoo also made a point of talking about the subcommittee members who will be leaving, either because they have retired or because they have lost primaries.

Eshoo gave an especially warm farewell for Rep. Susan Brooks, R-Ind., who is retiring.

“It’s a pleasure to recognize, really, just a superb member of our subcommittee,” Eshoo said. “We are going to miss her, miss her, miss her.”

Brooks acknowledged that the subcommittee's ACA lifeline hearing was highly partisan, but she said that members of the House and their aides had worked well together, in a genuinely bipartisan way, and succeeded at getting many important bills, including the 21st Century Cures Act, signed into law.

Going to forward, "we all have to do better to find the common ground," Brooks said.

It now appears that everyone who recovers from COVID-19 will have what insurers will see as a pre-existing condition, Brooks said.

Both Democrats and Republicans want to protect people with pre-existing conditions, Brooks said.

Now that having had COVID-19 will be pre-existing condition, "we've got to make sure we get this right," Brooks said.

ACA Exchange Program

Dean Cameron, the Republican director of the Idaho Department of Insurance, talked about how Idaho is the only Republican-dominated state with a locally run individual ACA exchange program, and that it is built a successful exchange program by relying on collaboration and creativity.

In Idaho, for example, the five major health insurers in the market agreed on their own to waive cost-sharing for COVID-19 testing, Cameron said.

Idaho has also developed a short-term health insurance policy that meets many of the same standards as policies that meet the ACA individual major medical insurance standards and cost half as much, Cameron said.

Douglas Holtz-Eakin, president of the American Action Forum, said working through the ACA public exchange program is a logical way to help people who face covered problems as a result of the COVID-19 pandemic.

Holtz-Eakin, who served as a senior staff economist on President George H.W. Bush's Council of Economic Advisers, and as director of the Congressional Budget Office from 2003 through 2005, told Rep. Michael Burgess, R-Texas, who is the highest ranking Republican on the House Energy health subcommittee, that Medicaid, the ACA exchange program and COBRA employer coverage continuation subsidy programs could all play a role in getting people through the turmoil.

"To date, I think that the safety net has help up pretty well," Holtz-Eakin said.

Economists worry that the turmoil will leave many people without health coverage, but, so far, Census Bureau figures suggest that number of people with health coverage may have increased slightly, Holtz-Eakin said.

Interview: Trump's America First Healthcare plan
Sonseeahray Tonsall

He hasn't offered a lot of specific detail yet, but late last week President Donald Trump presented the country with his America First Healthcare agenda.

Some say it answers the questions that may be left out there after the Supreme Court he's remade likely does away with the Affordable Care Act.

The first-in-history executive order the president signed declares that it is the policy of the federal government to protect individuals with pre-existing conditions, and give them access to care they can afford.

Sonseeahray spoke to Covered California President Peter Lee about the president's healthcare agenda and how it compares to what's already available in California.

California's Health Coverage Gains under the Affordable Care Act: What's at Stake in California v. Texas?
Laurel Lucia, Miranda Dietz and Ken Jacobs

This fact sheet highlights the key health coverage gains made in California under the state's robust implementation of the Affordable Care Act (ACA) since it was enacted over 10 years ago on March 23, 2010. These achievements show how much is at stake in California v. Texas, the case the Supreme Court is scheduled to hear on November 10, 2020, under which the ACA could be overturned.[1]

Millions of Californians gained coverage under the ACA

California had the largest reduction in its uninsured rate under the ACA of any state as of 2017.[2]

The number of uninsured Californians under the age of 65 fell from 6.5 million in 2012 to 3.5 million in 2017.[3]

As of March 2020, over 3.3 million low-income adults were enrolled in full Medi-Cal benefits due to the ACA expansion.[4]

Nearly 1.2 million Californians received federal financial assistance to make coverage through Covered California more affordable as of June 2019.[5]

Hundreds of thousands of California young adults are able to enroll in a parent's plan until age 26.[6]

ACA coverage is benefiting many Californians during the COVID-19 pandemic and recession

Research has shown that people with insurance are more likely to seek testing and the care they need than those who are uninsured,[7] which means that the reduced uninsured rate under the ACA benefits us all, especially during a public health emergency.

An estimated 24 percent of Californians at risk of losing their jobs in this recession already had Medi-Cal coverage prior to the pandemic, in part due to the ACA.[8]

An estimated 16 percent of California essential/frontline workers are enrolled in Medi-Cal, including ACA expansion coverage.[9]

The ACA reduced uninsured rates for unemployed workers prior to this recession, and many Californians are anticipated to enroll in Medi-Cal and subsidized insurance through Covered California as they lose job-based coverage due to this recession. Among unemployed California adults ages 19 to 64 who were looking for work, the uninsured rate fell from 39 percent in 2011-2013 to 21 percent in 2014-2018 after the ACA coverage expansions were implemented.[10]

Coverage inequities narrowed under the ACA

Uninsured rates fell for all California racial and ethnic groups under the ACA, with Latinos experiencing the largest reduction in uninsured rate, from 26.3 percent in 2013 to 11.6 percent in 2017. While the ACA significantly narrowed inequities in coverage rates between racial and ethnic groups, the uninsured rate for Latinos (11.6 percent), American Indians and Alaska Natives (11.1 percent), and Blacks (5.7 percent) continued to be higher than the rate for non-Latino whites (3.9 percent) in California in 2017.[11]

Low-income Californians with income at or below two times the Federal Poverty Level ($25,520 for a single individual) experienced a larger drop in the uninsured rate (from 29 percent in 2013 to 11 percent in 2017) than Californians at or above that income level (from 12 percent in 2013 to 5 percent in 2017).[12]

The San Joaquin Valley experienced the largest decline in uninsured rate of any California region, from 18.1 percent in 2013 to 7.6 percent in 2017.[13]

The uninsured rate of self-employed Californians fell significantly under the ACA from 33.8 percent in 2013 to 17.9 percent in 2015.[14]

The uninsured rate of small business employees in California fell significantly under the ACA from 31.0 percent in 2013 to 18.8 percent in 2015.[15]

Californians with private insurance gained new protections

Due to the ACA's "guaranteed issue" provision, over 6 million California adults do not have to worry about being denied coverage based on a pre-existing condition.[16] Californians who have tested positive for COVID (over 780,000 as of September 20, 2020) will not be denied coverage in the future as a result of having been infected.

Many of the 18 million Californians with job-based coverage[17] now have an affordable fallback option through the ACA Medi-Cal expansion or Covered California if they lose their job-based coverage.

Californians with job-based or individual market coverage can access certain preventive services with no cost sharing. Nearly 16 million Californians benefited from this provision in 2015.[18]

Insurers can no longer limit the amount of benefits paid in a year or a lifetime. Prior to the ACA, 40 percent of California workers with job-based coverage in 2010 had a lifetime cap on benefits.[19]

The ACA limits annual out-of-pocket spending to $8,150 for individuals and $16,300 for families in 2020. Reaching these limits is rare but many families that incur expenses at this level are likely to struggle to afford out-of-pocket costs even with these maximum limits. However, before passage of the ACA, researchers estimated that about 1 in 5 California workers with job-based coverage in 2010 had an out-of-pocket limit even higher than those limits required by the ACA.[20]

The ACA brings $27 billion in federal investment in our state's health care and economy each year

California is projected to receive over $20 billion in federal support for the ACA Medi-Cal expansion in budget year 2020-21.[21]

Californians received nearly $7 billion in federally-funded premium subsidies (advanced premium tax credits) for insurance through Covered California in 2019.[22]

The potential loss of $27 billion in federal investment is enormous in the context of the state budget. To put this amount in perspective, it approaches the $29 billion in total projected state spending on Corrections and Rehabilitation and Higher Education

(University of California, California State University, and Community Colleges) combined in 2020-21.[23]

This federal spending has an economic ripple effect throughout the state economy and supports hundreds of thousands of jobs in the state, not only in health care but also in other industries.[24]

While the pandemic has further demonstrated the importance of the ACA to California, it has also reinforced that despite California's progress, there is much work still to be done to achieve health care access and affordability for all Californians. Even before the pandemic, approximately 3.5 million Californians continued to lack insurance, many Californians with insurance struggled to afford coverage and care, and inequities in access to and affordability of coverage and care persisted for low-income and immigrant families and communities of color. The pandemic and associated recession are likely to exacerbate these problems. California has continued to build on the ACA through such policies as expanding Medi-Cal to undocumented children and young adults and providing state subsidies to improve affordability of insurance through Covered California. But further progress is needed, both nationally and at the state level, in order to ensure that health care is accessible and affordable for all.

However, if the Supreme Court in California v. Texas overturns major provisions or the entirety of the ACA, California would be facing a situation in which millions lose their health insurance and millions of others lose the important protections provided under the law. Inequities in access to health coverage would grow, with likely reversals in the coverage gains made under the ACA for Latinos, Blacks, and American Indians and Alaska Natives, along with low-income Californians. To make matters worse, these major losses in health care access and affordability would occur in the middle of a recession, during which great numbers may lose job-based coverage and income, as well as the middle of a global pandemic, during which access to care could not be more crucial for individual and community health and well-being.

CaliforniaHealthline

New Laws Keep Pandemic-Weary California at Forefront of Health Policy Innovation
Samantha Young and Angela Hart

SACRAMENTO — Though COVID-19 forced California leaders to scale back their ambitious health care agenda, they still managed to enact significant new laws intended to lower consumer health care spending and expand access to health coverage.

When Democratic Gov. Gavin Newsom concluded the chaotic legislative year Wednesday — his deadline to sign or veto bills — what emerged wasn't the sweeping platform he and state lawmakers had outlined at the beginning of the year. But the dozens of health care measures they approved included first-in-the-nation policies to

require more comprehensive coverage of mental health and addiction, and thrusting the state into the generic drug-making business.

“We had less time, less money and less focus, but COVID makes the causes of expanding coverage and trying to control health care costs that much more important,” said Anthony Wright, executive director of Health Access California, a Sacramento-based consumer advocacy group.

The governor also signed into law a raft of COVID-related bills intended to address the biggest public health emergency in a century, such as measures to stockpile protective gear for health care workers.

This year’s legislative season took place against the backdrop of an unprecedented pandemic that sparked a statewide stay-at-home order, back-to-back emergency legislative recesses, the Capitol’s first foray into remote voting and a projected $54 billion budget deficit.

Among the most controversial changes Newsom signed into law was the largest expansion of the state’s family leave program since it was enacted in 2014, an upgrade opposed by the state’s business interests. The tobacco industry also took a hit when Newsom approved a measure banning retail sale of flavored tobacco products, including menthol, with exceptions made for flavored hookah products. And Newsom bucked the powerful doctors’ lobby by granting nurse practitioners the ability to practice without physician supervision.

But several contentious health bills stalled in the legislature and never made it to Newsom’s desk, including measures that would have given the state attorney general more authority to reject hospital consolidations, expanded the state’s Medicaid program, called Medi-Cal, to unauthorized immigrants ages 65 and up, and capped consumers’ out-of-pocket costs for insulin.

Among Newsom’s vetoes were a pair of bills that sought to expand telemedicine, as well as legislation to adopt patient privacy protections for COVID-19 genetic testing.

“I think we all wish we’d had more opportunities to move more things forward,” said Assembly member Jim Wood (D-Santa Rosa), who chairs the Assembly Health Committee. “Under the circumstances, I think we did a good job.”

Here’s a look at some of the major health measures Newsom signed into law this year. Most will take effect on Jan. 1.

Behavioral Health

Lawmakers made significant changes to mental health coverage, and perhaps the most consequential is a mental health parity bill. SB-855 requires state-regulated health insurers in California to cover all treatment deemed medically necessary for mental

health and substance abuse disorders, from depression to opioid addiction. Health insurers opposed the bill, arguing it would drive up health care spending.

Mental health parity is already enshrined in state and federal law, but advocates say insurers regularly don't cover the critical care that patients need.

Julie Snyder, a lobbyist for the Sacramento-based Steinberg Institute, which advocates for mental health care policy changes, called the new law a model for the rest of the country.

"There's no other state that has anything this comprehensive," Snyder said.

Another bill, SB-803, will allow peer providers — people with their own histories of mental illness or substance abuse who help other Californians navigate behavioral health issues — to be certified by the state. Once certified, they can bill Medi-Cal for their services.

Scope of Practice

Newsom gave nurse practitioners, who are nurses with advanced training and degrees, the power to practice independently, after years of failed attempts and despite major opposition from the California Medical Association, which represents doctors. Supporters say AB-890 will help address health care provider shortages, especially in rural and underserved communities.

Certified nurse-midwives will also be allowed to attend low-risk pregnancies in both hospital and home settings without a physician's supervision under SB-1237.

Cutting Health Care Costs

California will enter the highly competitive generic drug market as a result of SB-852, a first-in-the-nation law that will put the state government in direct competition with private drug manufacturers.

"The cost of health care is way too high," Newsom said in a statement upon signing the bill.

By January, California must forge partnerships with one or more drug companies to make or distribute a broad range of generic and biosimilar drugs that are cheaper than brand-name products. The bill specifically calls for the production of the diabetes medicine insulin, because makers have hiked prices sharply in recent years.

Newsom also approved an under-the-radar health care transparency measure requiring the state to collect data on the amount state-regulated health insurers pay for specific medical services, from knee replacements to asthma treatments. The data could help policymakers identify excessive spending on certain treatments and provide fodder for proposals to control health care costs.

“While the examination of cost has slowed down, it hasn’t ended,” said state Sen. Richard Pan (D-Sacramento), who chairs the Senate Health Committee.

Newsom also signed legislation cementing into state law key provisions in the Affordable Care Act, a move guaranteeing Californians will not lose coverage protections should the U.S. Supreme Court strike down the law.

SB-406 will ban health insurers in California from imposing annual or lifetime limits on coverage, and also requires health insurers to cover a range of preventive care services, from cholesterol and blood pressure screenings to immunizations, without charging patients copays or deductibles.

COVID-19

As California continues to grapple with the highest COVID-19 case counts in the country, lawmakers approved a suite of bills in response to the pandemic, largely intended to protect essential workers.

Employers will have to provide written notice within one business day to employees who may have been exposed to the COVID-19 virus at their worksite. They must also report the details of workplace outbreaks to local public health authorities within 48 hours. AB-685 was prompted by major outbreaks this year at food-processing plants.

Newsom also signed legislation making it easier for firefighters, health care workers and other front-line workers infected with the coronavirus to get workers’ compensation. SB-1159 took effect Sept. 17, the day the governor signed it.

State law now presumes these front-line workers were infected with the virus on the job unless their employers prove otherwise.

Certain employees who have been exposed to the virus will also have more paid sick leave time. Under AB-1867, food-processing companies with at least 500 workers must provide two weeks of paid sick leave to workers who have been exposed to COVID-19 or have been advised to quarantine.

The law also grants health care workers and emergency responders two weeks of paid sick leave, closing a loophole in a COVID-relief bill Congress approved this spring.

Two new laws will address another major challenge exposed by the coronavirus pandemic: the lack of adequate personal protective gear for health care workers. AB-2537 will require hospitals to stockpile a three-month supply of protective gear by April, while SB-275 mandates that the California Department of Public Health establish an additional stockpile for health and other essential workers to last 90 days during a pandemic.

Nursing homes, which have been at the epicenter of COVID-19 deaths, will be required to have a full-time “infection preventionist” on staff to help stem the spread of disease.

The bill, AB-2644, also will require nursing homes to report deaths from a communicable disease to the state within 24 hours during an emergency related to that disease.

And California's roughly 40,000 licensed pharmacists will be allowed to administer COVID-19 vaccines that have been approved by the Food and Drug Administration under AB-1710.

2021 Covered California Renewal and Open Enrollment Changes
Kevin Knauss

The renewal period in Covered California can be fraught with peril when making changes to your application. For 2021, it looks like Covered California has done a good job of separating 2021 from 2020 when it comes time for renewal. This should reduce errors from changes made inadvertently to the current year, when they were meant for the renewal year.

Renewing Covered California Coverage

Consumers can renew their health plans with changes to their household beginning on October 1st. Then on October 31st, the Covered California systems will begin automatically renewing existing members into their current health plan for 2021 with the current household information. Open Enrollment for anyone not already in Covered California begins November 1st.

Even if you have been automatically renewed, you can still make changes to your household application (add or delete family members, change estimated income, etc.) for 2021. You can also change your health plan. But you must switch to a different plan by December 15th if you want it to be effective January 1, 2021.

Health Plan Changes

There are very few changes to the standard benefit metal health plans for 2021. The biggest change is that the maximum out-of-pocket amounts for the Bronze, Silver, and Gold plans are increasing from $7,800 to $8,200 per individual, double for family. There were modest changes to the Gold plan copayments for primary and urgent care visits, plus imaging. The Bronze HDHP maximum out-of-pocket is increasing from $6,900 to $7,000. For a complete summary visit Covered California Health Plan Summary.

2021 Health Benefit Design by Metal Tier

Metal Tier	Bronze	Silver	Gold	Platinum
	Covers 60% average annual cost	Covers 70% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Annual Wellness Exam	$0	$0	$0	$0
Primary Care Visit	$65*	$40	~~$30~~ ~~$35~~	$15
Urgent Care	$65*	$40	~~$30~~ ~~$35~~	$15
Specialist Visit	$95*	$80	$65	$30
Emergency Room Facility	40% after deductible is met	$400	$350	$150
Laboratory Tests	$40	$40	$40	$15
X-Rays and Diagnostics	40% after deductible is met	$85	$75	$30
Imaging		$325	~~$275~~ $150 copay or 20% coinsurance*	$75 copay or 10% coinsurance***
Medical Deductible	Individual: $6,300 Family: $12,600	Individual: $4,000 Family: $8,000	N/A	N/A
Pharmacy Deductible	Individual: $500 Family: $1,000	Individual: $300 Family: $600	N/A	N/A
Annual Out-of-Pocket Maximum	~~$7,800~~ $8,200 individual ~~$15,600~~ $16,400 family	~~$7,800~~ $8,200 individual ~~$15,600~~ $16,400 family	~~$7,800~~ $8,200 individual ~~$15,600~~ $16,400 family	$4,500 individual $9,000 family

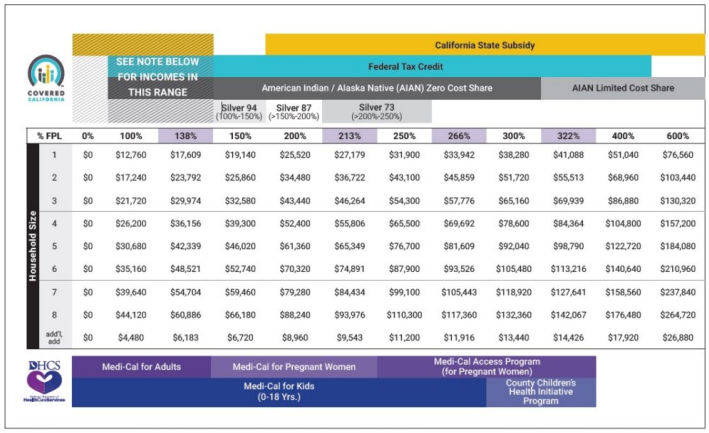
Benefits in blue are NOT subject to a deductible. Benefits in blue with white corner are subject to deductible after first three visits
*Copay is for any combination of services (primary care, specialist, urgent care) for the first three visits. After three visits, future visits will be at the full cost until the medical deductible is met
***See plan evidence of coverage for imaging cost share

Income Update

It is very important to check your estimated income, especially if it is very low. For example, if you are a single individual, and your estimated annual income is $17,600 – which is Medi-Cal territory – you will be put into a Carry Forward Status. If you don't increase your income, you will be determined Medi-Cal eligible for 2021. This is the same if you have children and your income falls below 266 percent of the federal poverty level under the new income chart.

Program Eligibility by Federal Poverty Level for 2021

Medi-Cal and Covered California have various programs with overlapping income limits.



% FPL	0%	100%	138%	150%	200%	213%	250%	266%	300%	322%	400%	600%
1	$0	$12,760	$17,609	$19,140	$25,520	$27,179	$31,900	$33,942	$38,280	$41,088	$51,040	$76,560
2	$0	$17,240	$23,792	$25,860	$34,480	$36,722	$43,100	$45,859	$51,720	$55,513	$68,960	$103,440
3	$0	$21,720	$29,974	$32,580	$43,440	$46,264	$54,300	$57,776	$65,160	$69,939	$86,880	$130,320
4	$0	$26,200	$36,156	$39,300	$52,400	$55,806	$65,500	$69,692	$78,600	$84,364	$104,800	$157,200
5	$0	$30,680	$42,339	$46,020	$61,360	$65,349	$76,700	$81,609	$92,040	$98,790	$122,720	$184,080
6	$0	$35,160	$48,521	$52,740	$70,320	$74,891	$87,900	$93,526	$105,480	$113,216	$140,640	$210,960
7	$0	$39,640	$54,704	$59,460	$79,280	$84,434	$99,100	$105,443	$118,920	$127,641	$158,560	$237,840
8	$0	$44,120	$60,886	$66,180	$88,240	$93,976	$110,300	$117,360	$132,360	$142,067	$176,480	$264,720
add'l add	$0	$4,480	$6,183	$6,720	$8,960	$9,543	$11,200	$11,916	$13,440	$14,426	$17,920	$26,880

Note: Most consumers up to 138% FPL will be eligible for Medi-Cal. If ineligible for Medi-Cal, consumers may qualify for a Covered California health plan with financial help including: federal tax credit, California state subsidy, Silver (94, 87, 73) plans and AIAN plans.

Income amounts when applying for 2021 coverage during the 2020 Open Enrollment Period.

10/2020

The latest Covered California income chart is for 2020 enrollment for the 2021 plan year. Once the federal government announces the new 2021 federal poverty levels, which will be slightly higher, then Covered California will adjust the income chart to reflect the new income amounts. The new 2021 income amounts will apply to people applying for coverage in 2021.

Consumers enrolling in 2020 for 2021 coverage fall under the existing published income guidelines. Those income amounts will hold through out 2021 unless you make a change to your Covered California account, and then, the higher 2021 income levels will be applied.

Covered California expanded some informational responses on their application. When reviewing your application, make sure everything is properly checked marked. For instance, the is a an expanded information section on the tax filing status of household individuals. Otherwise, the renewal process is like submitting your application for the first time where you have to read and check mark all the disclaimers and then get an eligibility determination.

For the 2021 plan year, the default is your 2020 health plan. The system will not automatically give you a comparison. You need to “Go Shopping” and use the Shop and Compare Tool to view your options. However, in the Shop and Compare Tool, it will highlight your existing plan.

Shop and Compare Tool within the Covered California account for renewal will show your current plan if you go shopping.

Shop and Compare Tool within the Covered California account for renewal will show your current plan if you go shopping.

Health Plans Expand in California

You may see some plans that were not available in 2020.

Anthem Blue Cross will be offering HMO plans in Orange County

Anthem Blue Cross will expand their EPO plans to Imperial, Inyo, Kern, and Mono counties

Oscar will expand their EPO plans into San Mateo County

For adult dental options, Blue Shield DPPO and DHMO plans will be offered in most regions of the state. Guardian DPPO will take over for Premier Access. If you have Premier Access DPPO it may be terminated and you have to enroll in Guardian. Otherwise, the dental selection, if still offered for 2021, should rollover into the new year.

Rate Increase?

Pay no attention to any reports of increasing or decreasing health insurance premiums for 2021 when it comes to subsidized Covered California enrollment. First, your rate will increase because you, and everybody in your household is another year older. Rates are based on age. Second, the subsidy is based on the Second Lowest Cost Silver Plan.

If the Second Lowest Cost Silver Plan (SLCSP) increased by more than your plan, your subsidy will be larger. As in this example, Kaiser is the SLCSP. If you have the Blue Shield PPO Silver that had a premium decrease, and your income is the same as last year, you will receive a larger monthly subsidy. This larger subsidy may off set the increase for the age rate increase.

If the second lowest cost silver plan rate increases and your selected plan decreases, you will get more subsidy and may have a lower monthly premium in 2021.

If the second lowest cost silver plan rate increases and your selected plan decreases, you will get more subsidy and may have a lower monthly premium in 2021.

If the SLCSP rate decreased, from 2020 to 2021, but your health plan rate increased, the subsidy will drop. In this example, the SLCSP Blue Shield PPO has a rate decrease of 2.2 percent, while the Kaiser Silver plan increased by 3.7 percent. Some Kaiser members may realize a rate increase greater than the Kaiser rate increase because the SLCSP plan decreased. The SLCSP can change every year, and can be different for different ages.

If the second lowest cost silver plan rate decreases, and your select plan rate increases, you will receive less subsidy, higher rate.

If the second lowest cost silver plan rate decreases, and your selected plan rate increases, you will receive less subsidy, higher rate.

Medi-Cal continues to be a complicated situation with Covered California. If, through the renewal process or Open Enrollment, you are erroneously determined eligible for Medi-Cal (usually caused by an income date error), guidance states you have until 8 PM that evening to make a correction in the Covered California application. After the cut-off time, the information is sent to the county Medi-Cal office and no changes can be made.

Once you or one of your household members has been determined eligible for MAGI Medi-Cal, you must work your county Medi-Cal office to change that determination. If you attempt to report changes on your Covered California application, they will eventually be disregarded. All changes must go through Medi-Cal even ones not related to income such as a change of address or adding a new family member.

Here Are The 2020 Mercury Award Winners
Staff

Winners for the 2020 Radio Mercury Awards were announced virtually Tuesday evening at the 29th annual awards event.

“The innovation and creativity that we heard with this year’s winning audio truly impressed the jury,” said Robin Fitzgerald, chief judge and CCO, BBDO Atlanta. “From at-home recording to using bots as talent, these winners showcased what it means to convey a brand’s message in a way that is both storytelling and story-doing.”

“Tonight’s awards presentation reflects the power of radio creative and its ability to deliver for listeners and advertisers,” said Erica Farber, president and CEO, Radio Advertising Bureau, and chair of the Radio Creative Fund. “Despite these unprecedented times, the Radio Mercury Awards winners continued to bring their all to this year’s awards and pushed the medium forward.”

Below is the list of the winning spots. To listen to all the work awarded at tonight’s event, **click here**. For an encore viewing of the event, click here.

Best Creative Radio Spot – General Market, Agency/Production Company/Advertiser-Produced
Motel 6 Feet Apart
Motel 6
The Richards Group

Best Creative Radio Spot- General Market, Radio Station/Group-Produced
Disco Colonoscopy
Kansas Medical Clinic
Alpha Media

Best Creative Radio Spot – Nongeneral Market, Agency/Production Company/Advertiser/Radio Station/Radio Group-Produced
Muleta
Covered California
Casanova//McCann

Best Brand Action Spot
Extra Dedications

Extra Gum, Mars Inc.
Energy BBDO

Best Spot for a Cause – Agency/Production Company-Produced
Whatever Gets You Talking
Seize the Awkward
The Ad Council and Droga5

Best Spot for a Cause – Radio Station/Group-Produced
Black Voices of Humboldt County #2
In-House PSA
Lost Coast Communications Inc.

Best Use of Humor in a Spot
Daa Tadaa Birthdaaa
Progressive Insurance
Arnold Worldwide

Best DIY Radio Spot
It is Okay
Colorado Broadcasters Association
Sukle Advertising

Best Use of Audio
Radio Recliner
Bridge Senior Living
Luckie

Best Use of Sound/Music
Sometimes
Pittsburgh Guitars
Garrison Hughes

Best Radio Station/Group Promotional Spot
We Don't Want To See Your Face
Cumulus Media/KQRS
Cumulus Media

Best Student Radio Script
Careless Whisper
Florida International University and Miami Ad School
Maria Diaz

ADWEEK

Covered California Awards $400 Million Contract to Duncan Channon
Erik Oster

Covered California, the first and largest state health insurance marketplace in the country, has named San Francisco independent agency Duncan Channon its creative and media agency of record.

The five-year contract is worth around $400 million. Duncan Channon will be responsible for developing creative campaigns to convince Californians to sign up for Covered California healthcare plans, including driving behavioral change in viewers who believe healthcare isn't right for them or too expensive for them to secure.

"It takes the whole agency, every type of talent we have, to think about a problem like this and work on this business, helping more of our fellow Californians have access to quality, comprehensive insurance. That was always very attractive," Duncan Channon CCO Michael Lemme told Adweek.

"We put all of our energy, heart and talent into winning it, and we have been putting that into every moment of getting the best work that we can," he added. "We are in a time when the ability to have insurance is harder for more people, with so many losing their jobs."

The appointment follows a competitive review earlier this year between seven agencies, including incumbent Campbell Ewald, and concluded before the pandemic's impact.

Covered California director of marketing Colleen Stevens cited Duncan Channon's history of "strong creative and ads that can emotionally engage people," which she explained were important points in convincing an audience that has used internal justifications for going without health insurance for years.

"Self-elimination is our biggest problem," she said. "That's why emotional engagement is so important. We have to override their predetermined thought processes."

"Covered California is an organization that believes in the power of marketing. We think a big chunk of our success is due to marketing," Stevens added. "We're trying to change social norms and get people who don't think this applies to them to investigate further."

Duncan Channon currently works with another state client, California Tobacco Control Program. The agency developed a "Flavors Hook Kids" campaign examining flavored vaping products' role in youth addiction and a subsequent "Outbreak" campaign focused around the outbreak of vaping-related illness in 2019.

Stevens also stressed the importance of picking an agency with the ability to deliver messaging across California's diverse population. Duncan Channon's first campaign for Covered California features ads in multiple languages including Spanish, Chinese, Vietnamese and Korean, as well as English, she said.

The campaign's process was shaped by the pandemic's limitations, with the agency relying heavily on remote shoots, and both photo sessions and video production featuring real families—something Stevens said lent the effort a sense of intimacy.

The campaign debuts across several media channels on Nov. 9 and runs to Jan. 31. Stevens explained that the campaign was timed to the open enrollment period beginning on Nov. 1, but that the organization wanted to wait until after the election to avoid the message being drowned out.

The campaign arrives as the Supreme Court prepares to hear a case challenging the Affordable Care Act, responsible for the creation of Covered California and other exchanges around the country, shortly after the election next month.

"In terms of the political climate, we made a conscious decision not to do any messaging around the Supreme Court hearing the ACA case, the election and how the election might change things. Our commitment is to convince Californians that Covered California is strong, stable, has financial resources to make sure people will be covered, [and] that we have good, quality plans," Stevens said. "On the other hand, California has taken a leadership position in adjusting to changes happening nationally to provide quality service and plans since the beginning."

While none of the campaign's messaging addresses the issue, the landmark legislation's possible termination does lend the effort an added sense of urgency and importance.

"All we can really do is make this program as successful as it deserves to be," Lemme said. "We're going to make this program as successful as it can be for the sake of Californians, and to the degree that helps move a broader conversation, then that's not just a nice thing but part of our intention."

"Especially now, people are really glad to work on something that has a real tangible benefit and outcome for our neighbors, selves, state and maybe for the nation," he added.

Covered California for Small Business announces a record-low weighted average rate change of 1.5 percent for 2021
Staff

SACRAMENTO – Covered California for Small Business unveiled the health plan choices and rates for small-business employers and their employees for the upcoming 2021 plan year. The statewide weighted average rate change will be 1.5 percent, which represents the lowest annual increase in the program's seven-year history, and is significantly lower than national projected increases for larger employers.

"Covered California for Small Business continues to meet the needs of employers and their employees across the state," said Peter V. Lee, executive director of Covered California. "In addition to driving down premiums, we will be upgrading our platform to continue to provide small-business consumers with even more value and choice."

This year's rate change of 1.5 percent is lower than the recent projection of 5.0 percent that larger employers expect to see in 2021 (see Table 1: Covered California for Small Business Average Rate Change, by Year). The program's five-year average rate change is 4.3 percent.

"The sustained growth of Covered California for Small Business is another example of how the Affordable Care Act continues to work for Californians," Lee said. "The growth of Covered California for Small Business, coupled with only small rate changes, helps all small business employers and their employees by putting competitive pressure on plans across the state."

Covered California for Small Business will continue to offer five plans in 2021, including two preferred provider organization (PPO) plans from Blue Shield of California and Health Net, both offering their broadest provider networks, and two health maintenance organization (HMO) plans — which are provider- and hospital-based — from Kaiser Permanente and Blue Shield.

The 2021 portfolio of health plans also includes Sharp Health Plan in San Diego and Oscar Health Plan of California, which will be offering coverage in Los Angeles and Orange counties. In addition, Blue Shield will also provide HMO plans to residents of Fresno, Kings and Madera counties.

Covered California for Small Business has experienced double-digit percentage growth in membership for six consecutive years. Currently, more than 62,000 individuals have insurance through Covered California for Small Business, representing a growth of approximately 7,000 individuals, or a 12.7 percent gain in membership over this time last year.

“As we enter into open enrollment for the individual market with state subsidies again available, we want to be sure small-business owners know their options and opportunities with Covered California,” Lee said.

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

“Our weighted average rate change this year is again the lowest rate increase ever,” said Terri Convey, director of Covered California’s Outreach and Sales division. “We’ve been able to have low increases for the last five years, proving that our employee choice platform is working well for small businesses.”

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

Businesses with up to 100 full-time equivalent employees can apply for health insurance coverage for their workers through Covered California for Small Business. Federal tax credits may be available to employers with 25 or fewer employees.

Visit www.CoveredCA.com/forsmallbusiness/ for information on how to apply.

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

Covered California is the state’s health insurance marketplace, where Californians can find affordable, high-quality insurance from top insurance companies. Covered California is the only place where individuals who qualify can get financial assistance on a sliding scale to reduce premium costs. Consumers can then compare health insurance plans and choose the plan that works best for their health needs and budget. Depending on their income, some consumers may qualify for the low-cost or no-cost Medi-Cal program.

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California’s consumers. It is overseen by a

five-member board appointed by the governor and the legislature. For more information about Covered California, please visit www.CoveredCA.com.

UC BERKELEY LABOR CENTER

California could lose 269,000 jobs if the ACA is overturned
Laurel Lucia

On November 10, the Supreme Court is scheduled to hear oral arguments in the case California v. Texas, one possible outcome of which is the Affordable Care Act (ACA) being struck down in its entirety. Under that scenario, 4.5 million Californians could lose their Medi-Cal coverage through the ACA expansion or subsidized insurance through Covered California, and millions of Californians could lose the ACA protection against being denied coverage or charged higher premiums due to a pre-existing condition. Overturning the ACA would reduce annual federal funding to California by $28.8 billion in 2022, the year of focus for this analysis.

Many Californians' jobs are also at stake should the ACA be overturned. California would be projected to have 269,000 fewer jobs, $29.3 billion less in state GDP, and $2.2 billion less in state and local tax revenue, compared to if the ACA remains in effect. These projections are based on analysis using IMPLAN economic modeling software. Click on the map image below to view tables showing projected job losses in 2022 for California's medium and large counties and all congressional districts.

These economic losses would come at a time when California's economy is likely to still be recovering from the massive job losses incurred due to COVID-19. Statewide, the projected job losses with elimination of the ACA would be equivalent to a 1.4% decrease in employment (if the California labor force is 19.1 million in 2022, in line with national Congressional Budget Office labor force projections). This job loss would be on top of the 6.6% unemployment rate projected by the UCLA Anderson Forecast for California in 2022.

Most of the lost jobs—159,000 or 59%—would be in the health care industry, including jobs at hospitals, clinics and doctors' offices, labs, other health care settings, and insurance companies. The projected loss in health care jobs reflects the elimination of some jobs that exist today, as well as the creation of fewer new jobs due to slower-than-expected job growth.

Employment in non-health care industries would be reduced by 110,000 jobs due to economic spillover effects. In particular, job loss would be most likely to occur at businesses that are suppliers of the health care industry, such as food service, janitorial, and accounting firms, and at local businesses at which health care workers spend their income, such as retail stores. This analysis is based on pre-COVID industry and household spending patterns. If spending patterns in 2022 continue to be significantly altered due to COVID-19, the economic impacts would be somewhat lower than shown here but the differences would be small. (See methodology for more details.)

These numbers reflect a net loss of 269,000 jobs. The projected loss of jobs due to the eliminated health care spending (-293,000 jobs) would be minimally offset by economic gains from the repeal of certain ACA taxes, which would keep an estimated $6.2 billion within the state and add new jobs (+24,000 jobs). The vast majority of these tax cuts would go to the highest-income households, and the additional income for these households and certain corporations would result in some increased spending and additional jobs. The impact is limited, though, for two reasons: the value of the tax and penalty repeals is substantially less than the value of the health care spending cut, and health care spending cuts have a more severe impact on jobs than equivalent tax increases.

These estimates assume that California is unable to backfill the loss of federal funds if the ACA is overturned. The potential loss of nearly $29 billion in federal investment in 2022 is enormous in the context of the state budget. To put this amount in perspective, it is similar to the $29 billion in total projected state spending on Corrections and Rehabilitation and Higher Education (University of California, California State University, and Community Colleges) combined in 2020-21.

If the ACA is overturned, not only would Californians fear losing their health coverage, they would also have good reason to worry more about losing their jobs.

Covered California rates Kaiser Permanente 5-stars for quality
Karl Sonkin

For the second year in a row, Kaiser Permanente received the highest rating in the state for overall quality in health plan ratings for 2021 by Covered California – the state's marketplace for the Affordable Care Act.

Kaiser Permanente Northern California combined with Kaiser Permanente Southern California to earn 5 stars – the highest possible score. Kaiser Permanente remains the only health plan in the state with this 5-star rating.

"We are proud to be recognized for the high-quality care and service we provide," said Tom Hanenburg, interim president Kaiser Permanente Northern California. "Our top scores speak to our commitment to deliver exceptional, compassionate care to our members and patients even through the pandemic, which has left many people in even greater need of high-quality, affordable health care."

In addition to the highest marks for overall quality, Kaiser Permanente received 5 stars for members' responses to "Getting the Right Care" and "Plan Services for Members."

"Our 5-star rating is a reflection of the exceptional work being done by our physicians and staff working together to deliver the highest levels of quality care and service," said Richard S. Isaacs, MD, CEO and executive director of The Permanente Medical Group. "Our clinical excellence combined with our integrated and technologically enabled approach to care is leading to healthier outcomes for our members, patients and the communities we serve."

This is the latest of several accolades and awards Kaiser Permanente Northern California has received. Kaiser Permanente Northern California hospitals have been rated among the best in the nation for maternity care and treatment of stroke and heart failure patients. Most recently, Kaiser Permanente is the only Medicare health plan in California to receive a 5-star rating, according to the Centers for Medicare and Medicaid Services.

UC BERKELEY LABOR CENTER

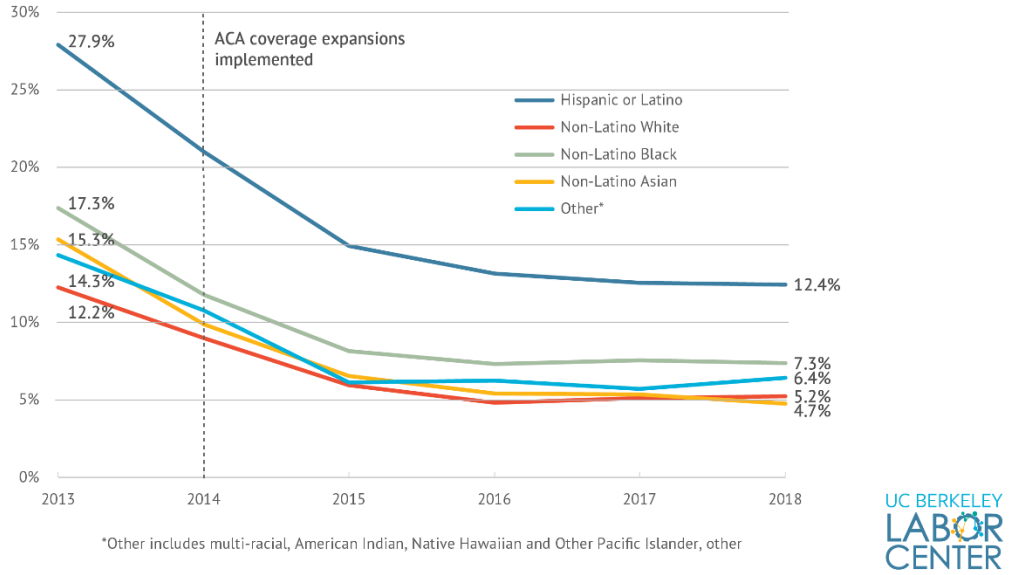
Racial and ethnic health coverage inequities in California would widen if ACA is overturned

Laurel Lucia, Miranda Dietz, Srikanth Kadiyala, Tynan Challenor and Gerald F. Kominski

The Affordable Care Act (ACA) reduced uninsured rates for all racial and ethnic groups in California, while also narrowing, but not eliminating, the coverage gaps for Latino and Black Californians in this state. If the ACA is ultimately overturned due to the California v. Texas case, scheduled to be heard by the Supreme Court starting on November 10, the progress on racial and ethnic health coverage disparities would be reversed. These

coverage losses and widening inequity would occur in the middle of a pandemic and recession that have disproportionately harmed communities of color.

The uninsured rate fell between 2013 and 2018 under the ACA for all racial and ethnic groups in California. Latinos experienced the largest reduction in uninsured rate, though their rate continues to be the highest of all racial and ethnic groups. The gap in uninsured rates between non-Latino whites and all other racial and ethnic groups also narrowed under the ACA, though Black Californians still have higher rates of uninsured than non-Latino whites and Asians.



Source: Authors' analysis of American Community Survey data

Approximately 4.7 million Californians relied on ACA coverage as of June 2018, including 3.5 million with Medi-Cal expansion coverage, and 1.2 million with insurance through Covered California with premium subsidies. Approximately one out of five Black (23%), Latino (21%), and Asian / Pacific Islander (18%) California adults under age 65 were enrolled in the Medi-Cal expansion or Covered California with subsidies in 2018, compared to 14% of non-Latino whites, based on analysis of administrative enrollment data and American Community Survey data. Latino and Black Californians are more likely to be eligible for and enrolled in ACA coverage for a variety of reasons such as lower rates of having job-based coverage, in part due to lower offer rates in the industries and occupations in which they work, and higher rates of low-wage work which makes income eligibility for ACA coverage more likely. Federal policy excluding undocumented immigrants from Medicaid and Marketplace coverage is part of the reason for the continued high uninsured rate among Latinos.

If the courts overturn the ACA during the middle of this pandemic and recession, Latino and Black Californians would not only be among the hardest hit by the loss of ACA coverage, but those coverage losses would be compounded by employment and COVID

trends that are inordinately hurting these same groups. Job losses in the first half of 2020 were concentrated among Latino, Black, and Asian Californians whose unemployment rates increased more than the unemployment rate for non-Latino whites. Even as jobs begin to return to the economy, there is reason to believe that this recession and its recovery will exacerbate racial inequity. Latinos have experienced a disproportionate share of COVID infections in California, and Latino and Black Californians make up a disproportionate share of those who have died from COVID. Furthermore, if the ACA is overturned, insurers could once again deny coverage or charge higher premiums for people with pre-existing conditions, which could include COVID.

The ACA covered millions of people and reduced the racial and ethnic disparities in health coverage in California; to take away these coverage options especially during a global pandemic and recession would exacerbate racial and ethnic inequality in California.

California Could Lose Out More Than Other States If Affordable Care Act Overturned
Sammy Caiola

Five days after the November election, the Supreme Court is set to rule on a case that could overturn the Affordable Care Act. In California, which whole-heartedly embraced the landmark health statute, advocates say the end of the act could mean millions of low-income people lose their insurance or face higher costs for care.

Established by President Barack Obama's administration in 2010, the ACA — sometimes referred to as Obamacare — significantly expanded eligibility for Medicaid, the government-subsidized health program that was formerly only available to pregnant women, children, disabled people and elderly people.

The law also made it illegal for health insurance companies to deny people insurance or charge them more for coverage due to a pre-existing condition. It also allowed states to create their own federally supported health insurance exchanges for low and middle-income residents hoping to buy on the individual market.

What Could Happen To Californians

California expanded Medicaid eligibility under the ACA more than any other state, and would risk the most people losing coverage if the law was overturned.

The number of uninsured people in the state decreased from 6.5 million people in 2012 to 3.5 million people in 2017 as health advocates urged middle and low-income people to sign up for Medi-Cal and Covered California, the marketplace created under Obamacare.

“California not just implemented but improved upon the law,” said Anthony Wright, executive director of consumer advocacy group Health Access. “Just as we took advantage to gain the most under the Affordable Care Act, we in California have the most to lose from the Affordable Care Act being struck down.”

How easily people can afford insurance on the marketplace depends heavily on how much the federal government chips in to help people pay their premiums. About 1.2 million people statewide were receiving that federal help in June 2019, according to Covered California. If the statute is overturned, California stands to lose $27 billion in federal assistance that currently goes toward subsidizing premiums and supporting expanded Medi-Cal eligibility.

Experts say if the state can’t backfill that assistance, they might have to adjust Medi-Cal eligibility. That means people who’ve been eligible for Medi-Cal since the ACA took effect could lose their insurance because the state wouldn't be able to pay for their coverage. It also means people who've been affording Covered California with federal help would see much higher premiums and may opt to ditch their plans.

California still has a requirement that people carry health insurance, so anyone who became uninsured in a post-ACA world would likely still have to pay the state a fine.

The Legal Challenge

At issue in the Supreme Court case is the federal requirement that people carry health insurance, also known as an individual mandate. In 2017 the Trump administration eliminated the financial penalty for not carrying insurance, while keeping the requirement language in place. A group of Republican attorneys general is now arguing that since the fine has been zeroed out, the whole statute is invalid.

California Attorney General Xavier Becerra attempted to refute that argument at a press conference Thursday.

“Even if you zero out the money in the individual mandate, why should 133 million people lose their protections against discrimination based on pre-existing conditions?” he said. ‘Why should seniors no longer have better coverage for prescription drugs and better access to preventive care? Why should young people under the age of 26 who are on their parents' insurance lose that insurance?”

Experts say the Supreme Court is more likely to overturn the ACA if nominee Amy Coney Barrett is confirmed, both due to the fact that a tie would be less likely and based on her previous record with health care.

“There are indications from her past writings and statements that make people concerned that she would support overturning the ACA,” said Laurel Lucia, health care program director with the UC Berkeley Labor Center.

How California Might Respond

Lucia says the state would likely make efforts to backfill losses in that scenario, but it will be especially difficult during the pandemic.

“If the ACA is overturned, policymakers would be facing a lot of hard decisions about how to respond,” she said. “Over $28 billion in federal funding would be very difficult for the state to replace.”

The ACA roughly halved the number of African American and Asian Americans in California who are uninsured, according to the California Pan Ethnic Health Network. Latinx Californians also gained coverage under the policy, though the reduction was less dramatic because undocumented adults age 26 and over are still ineligible for Medi-Cal.

Representatives from LGBTQ groups also spoke at the Thursday preference about the protections for gender transition care that would disappear in a post-ACA world, and Planned Parenthood staff laid out how access to contraception and other forms of reproductive care could be limited if the Supreme Court strikes down the law.

‘Death spiral’: What happens in California if the Supreme Court invalidates Obamacare?
Kate Irby

Nearly 17 million Californians with pre-existing conditions could face higher health costs or loss of benefits.

Five million Californians could lose health insurance coverage completely.

California would lose $27 billion to cover health care costs for low-income families.

That’s what California Democrats Sens. Dianne Feinstein and Kamala Harris say is at stake if the U.S. Supreme Court invalidates the Affordable Care Act.

“Now, the bottom line is this: There have been 70 attempts to repeal the ACA,” Feinstein said in the hearings on the nomination of Amy Coney Barrett to the court. “But clearly the effort to dismantle the law continues, and they are asking the Supreme Court to strike down the Affordable Care Act.”

California health care experts say the senators are actually understating what repeal would mean, capturing the “immediate” effects – not the long-term effects that would affect even some Californians who have health insurance covered by their employers.

The state has passed some of its own state-level protections, including an individual mandate that requires everyone to have health insurance or pay a penalty.

Yet those changes are mostly tied to the the federal law, health care advocates say, meaning they become useless if the Supreme Court repeals the ACA. While state officials could pass additional protections of its own, such as requiring coverage of pre-existing conditions, they say there’s little the state could do to make up for the loss of $27 billion a year in federal funding for health care.

“About 4 to 5 million people would lose their coverage in an instant, but the impacts go far beyond that,” said Anthony Wright, executive director of Health Access, a consumer advocacy organization in California. “If anything, Sen. Feinstein is understating the impact, because this would not just be a shock to the system, but will create a death spiral in our insurance market of raising premiums and pressure to reduce access to care.”

The Supreme Court will hear a case on Nov. 10 in which President Donald Trump’s administration is arguing to repeal the entirety of the ACA, so if Barrett is on the court by then she’ll be in place to rule on the future of the health care law.

Feinstein and other Democrats repeatedly argued at Senate Judiciary Committee hearings this week that Barrett would help to repeal the ACA if she, as expected, is confirmed to the court.

That’s an assumption, not a fact. Barrett, following typical procedure for Supreme Court nominees, declined to say how she would act on the ACA case if confirmed.

In the case, Texas v. California, the Department of Justice and certain Republican-controlled states are asking the Supreme Court to invalidate the entirety of the ACA. To make that ruling, the Supreme Court will have to decide first if the individual mandate is constitutional, and then whether the rest of the law can stand without the individual mandate. It’s unclear how Barrett would rule on that question.

Abbe Gluck, professor and faculty director of the Yale Law School Solomon Center for Health Law and Policy, said though Barrett has not shown how she would rule in the future case, she has made past comments.

In one essay, she wrote that a previous Supreme Court ruling had worked too hard to save the statute, pushing the ACA “beyond its plausible meaning.”

“She made two comments in the past that aligned herself with the views of the dissenting justices, in the two previous ACA challenges,” Gluck said. “And those

opinions would have either eliminated the ACA entirely, or significantly changed its financial structure."

Gluck said from her time watching ACA lawsuits, she's learned it's "impossible" to predict how the Supreme Court will rule. But "the fact that the case was admitted to the Court was cause for concern before Justice Ginsburg died, and that concern is magnified now."

WHAT CAN CALIFORNIA DO?

California Attorney General Xavier Becerra said in a press call Thursday that if the Supreme Court did invalidate the ACA, the state's leaders would take action to preserve health care.

"We have progressive leaders that, regardless of where we end up, we're going to act," Becerra said.

But California officials could do little to sew up what will become a gaping financial wound, according to Wright and Peter Lee, executive director of Covered California.

"Many of the actions that California has taken, such as outlawing short term health plans or having a robust marketplace like Covered California, which makes sure people know to sign up and have options, would become meaningless without federal dollars, which is an essential element of making affordable coverage real," Lee said.

The expansion of Medicaid only worked because the federal government provides $20 billion per year to California cover those extra people, so expanding MediCal, California's version of Medicaid, without those extra funds would be next to impossible.

Laws to protect coverage for those with pre-existing conditions aren't effective without subsidies to drive the costs of their health care down — if insurance companies have to cover people with pre-existing conditions but can simply price them out of plans, it's not an effective mandate, Lee said. To provide subsidies without the ACA, California would have to make up a loss of $7 billion per year.

"If we were to lose it, that is almost the amount of money as the state of California spends on all of higher education and prisons combined," Wright said. Raising taxes enough to cover that loss would also be next to impossible — California recently raised the tobacco tax by $2, which only raised $1 billion for MediCal, Wright said.

Five million Californians is about 12 percent of the state's population, but Wright said it's naive to think repealing the ACA would not also affect those on employer-sponsored plans or other coverage such as Medicare.

In Fresno, for example, 51 percent of the population is on MediCal. If a significant portion of those people lost health care coverage, current demand for health care

services in the area shoots down, possibly causing hospitals and doctors' offices in the area to shut down.

"There's a chaos to this," Wright said. "It's hard, after a decade, to imagine how the health system of California would fare if it just suddenly lost $27 billion. Hospitals and clinics have beefed up operations to meet real needs that were out there, employ more people, and to lose $27 billion, it's almost impossible to imagine how that would not impact the health system we all rely on."

Healthcare for millions of Californians is on the line in the election
Noam No. Levey

WASHINGTON — California has done more over the last decade than almost any other state to expand health insurance, bolster services for its most vulnerable residents and improve the quality of its clinics and hospitals.

Sick patients are getting more help managing diabetes, heart disease and other chronic illnesses. Women are giving birth more safely, health records show. And the share of working-age Californians without health coverage tumbled from nearly 1 in 4 to just 1 in 10 before the current economic crisis — one of the steepest declines in the nation.

But the gains — largely made possible by the Affordable Care Act, or Obamacare — now hang in the balance of the presidential election.

The Supreme Court, poised to get another justice appointed by President Trump, is weighing whether to scrap the healthcare law. And Trump, who has pledged for four years to dismantle it, hasn't indicated how he'd replace its core protections should he win a second term.

"The stakes have never been higher," said California Atty. Gen. Xavier Becerra, who is defending the law at the Supreme Court against an effort to nullify it by the Trump administration and a group of Republican-led states. Becerra and others in California are also fighting to stop administration efforts to relax rules dictating protections that health insurers must provide.

For his part, Trump insists he will safeguard sick Americans. "Will always protect pre-existing conditions!!!" he tweeted recently.

Despite years of promises, however, the president has never produced a plan to do that. And he has made little secret of his hostility to California, claiming in another recent Twitter post that the state is "going to hell."

Trump's antipathy has fueled widespread concerns among California healthcare leaders about what a second Trump term might bring, especially if the Supreme Court invalidates all or part of the healthcare law.

"California has made a lot of progress in recent years, but people don't fully appreciate how much of that depends on the financing and framework of the Affordable Care Act," said Anthony Wright, executive director of Health Access California, one of the state's leading advocacy groups for patients. "If the law is wiped away, much of California's progress collapses with it."

Former Vice President Joe Biden, the Democratic nominee, has defended the 2010 law, proposing a host of initiatives to build on its protections.

Biden has also said he would work to restore women's access to abortion and other reproductive health services, reversing a four-year effort by the Trump administration to restrict abortion and shift federal money to organizations like so-called crisis pregnancy centers that don't offer a full range of family-planning services.

"If this administration has a second term, I'm afraid it will have grave impact on Californians' access to sexual and reproductive health," warned Julie Rabinovitz, president of Essential Access Health, a leading family-planning advocate.

The most visible sign of California's healthcare progress is the expansion of coverage fueled by the state's decision to expand Medicaid eligibility and build Covered California, the state's insurance marketplace.

Although insurance premiums have risen for some Californians as access has expanded, medical care has also become more affordable for many. Between 2013 and 2017, the share of Californians who skipped care in the previous year because of cost dropped by a quarter, according to data from the nonprofit Commonwealth Fund.

The insurance gains also translated into better care for many Californians, said Thomas Priselac, a leading hospital executive in the state who has headed the Cedars-Sinai Health System in Los Angeles for more than 25 years. "Quality medical care starts with having access to it," he said.

California's coverage expansion has had broader effects as well, driving profound changes in how patients — rich and poor — receive care.

At Northeast Valley Health Corp., a network of clinics serving low-income patients in the San Fernando and Santa Clarita valleys, doctors and nurses now work with clinical pharmacists to help diabetics better manage their blood sugar, a change the healthcare law helped bring about.

The clinics have also added care coordinators to keep track of patients with chronic diseases and prevent them from ending up in the hospital or emergency room.

“The Affordable Care Act was terrific in helping us serve more patients,” said Kim Wyard, Northeast Valley Health’s chief executive. “Also embedded in it was this sense of transforming the healthcare system.”

At Mission Hospital, a community hospital off the San Diego Freeway in Mission Viejo, yet another transformation is underway, this one in how women give birth.

The hospital, part of the Providence Health system, based in Washington state, has been working aggressively to reduce the number of babies delivered by caesarean section.

The effort — supported by a midwife program, specially equipped birthing rooms for natural deliveries and new protocols to identify obstetricians with high C-section rates — reflects the growing scientific consensus that overuse of C-sections in recent decades exposed mothers and newborns to unnecessary risks, some potentially deadly.

Mission Hospital had another incentive, as well: Covered California in 2016 signaled that hospitals with high elective C-section rates could be excluded from health plans on the marketplace.

“That put everyone on notice,” said Dr. David Lagrew, who has helped lead efforts to reduce the number of caesarean deliveries at Providence Health’s 10 hospitals in Southern California. “It was a big deal.”

Between 2014 and 2018, California reduced its share of caesarean deliveries by 5.5% — faster than all but two other states, according to data from the U.S. Centers for Disease Control and Prevention.

President Trump inspects proposed border wall prototypes near San Diego on March 13.

The state has taken other steps to bolster insurance protections, beyond what the federal government mandates.

Covered California, for example, requires health plans to exempt some services from deductibles so patients won’t skip needed care. Roughly 1.5 million people get coverage through Covered California, and more than 70% are now in a plan in which primary care visits, lab tests or other outpatient services aren’t subject to a deductible.

The state also has begun offering insurance subsidies to middle-income Californians, bolstering federal aid provided by the 2010 law to address the difficulties faced by some consumers who earn too much to qualify for federal subsidies.

Some of California’s healthcare improvement initiatives might persist even if the Trump administration succeeds in eliminating the healthcare law.

Nevertheless, California healthcare officials warn that preserving protections for people with preexisting medical conditions is considerably more complicated than simply directing health insurers to cover sick patients, as Trump has suggested he would do.

The current law doesn't just bar insurers from turning away sick consumers. It also prohibits insurers from charging sick people more, restricts how much more older customers can be charged and mandates that all plans cover a basic set of benefits, another protection that prohibits insurers from discriminating against people with preexisting conditions.

The law also provides billions of dollars to help low- and moderate-income people afford health plans, which are more expensive now that plans aren't allowed to cover only healthy customers.

All of these pieces are critical to really protecting people, said Peter Lee, executive director of Covered California.

"When this administration says it will preserve preexisting condition protections and throw out the rest of the law, that's like saying to people on an airplane in midair, 'Don't worry, we're going to keep the wings, but get rid of the rudder and the landing gear and everything else,'" Lee said.

Perhaps most difficult to replace would be the billions of dollars in federal money that have made Medicaid expansion and the Covered California marketplace possible.

California receives some $27 billion a year from the federal government to subsidize insurance coverage for low- and moderate-income Californians, an amount roughly equivalent to what the state spends annually on prisons, colleges and universities, according to estimates by the UC Berkeley Labor Center.

If the federal government stopped providing that money, picking up the tab would be virtually impossible for California to do on its own, said Dr. Mark Ghaly, the state's Health and Human Services secretary.

"Elections matter a great deal," Ghaly added. "And what happens in the next few weeks could be vital to the future of healthcare in California."

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Covered California announces final 2021 rate change at all-time low of 0.5%
Staff

SACRAMENTO — With the start of Covered California's open-enrollment period just a few weeks away, the exchange announced that the renewal process for a record number of enrollees is now underway — with more than 1.5 million Californians eligible to renew their coverage. In addition, the preliminary rate change that Covered California previously announced in August has been revised downward to a new all-time low of 0.5 percent for the 2021 plan year.

"Covered California heads into the upcoming open-enrollment period with more consumers than ever, and we will be doing so with the lowest rate change in our history," said Peter Lee, executive director of Covered California. "California has built on and strengthened the Affordable Care Act, and right now this means that Californians facing a pandemic and recession are finding the security of having access to quality, affordable health care coverage."

The latest data shows that Covered California had a record 1.5 million enrollees in June of 2020. When compared to historical data, Covered California's highest enrollment total in October, which is when the renewal process begins, was 1.3 million in 2018. Current enrollees can begin renewing their coverage now, and they have until December 15 to finalize their 2021 plan choice. People who do not actively select a plan for 2021, will be renewed in their current plan, so they do not suffer a gap in coverage.

"During a pandemic and recession, it is no surprise that Covered California is seeing record enrollment, because we are a safety net to help people get quality health care coverage," Lee said.

New record-low rate change

Covered California also announced that after the reviews by the California Department of Managed Health Care and the California Department of Insurance, the statewide weighted average rate change was revised downward from 0.6 percent to a new record-low of 0.5 percent.

The lower rate change is the result of reduced rates for Health Net's EPO and PPO products, which are subject to review the California Department of Insurance, in Contra Costa, El Dorado, Los Angeles, Marin, Mariposa, Merced, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare and Yolo

counties (see Table 1: California Individual Market Rate Changes for 2021 by Rating Region).

Consumers both on and off the exchange benefit from Covered California's competitive marketplace, which allows them to shop for the best value and benefit from lower increases. In addition, many consumers can save more by shopping and switching to a lower-cost health plan. With the reduction in the statewide average rate change, the average rate change for unsubsidized consumers who shop and switch to the lowest-cost plan in the same metal tier is now -7.4 percent, which means many Californians can get a lower gross premium if they shop and switch. The average rate change varies by region and by an individual's personal situation.

Nearly nine out of every 10 consumers who enroll through Covered California receive financial help — in the form of federal tax credits, state subsidies, or both — which help make health care more affordable. California's state-specific enhanced subsidies, which were introduced for the first time in 2020, are benefiting about 590,000 enrollees in Covered California and are available again for both new and renewing members in 2021.

"The bold policy choices made in California to build on and strengthen the Affordable Care Act have led to a very competitive market that is full of choice for consumers," Lee said. "Covered California continues to provide stability and lower costs in the face of national uncertainty in health care."

In 2021, all 11 carriers will continue offering products across the state, and two companies will expand their coverage areas, providing increased competition and consumer choice. Nearly all Californians (99.8 percent) will have two or more choices and over three-quarter of Californians (77 percent) will have four or more choices.

Improved Website and Consumer Tools

In order to further help new and renewing consumers, Covered California also overhauled its website, www.CoveredCA.com, to make it easier for people to learn about their health insurance options and sign up for quality coverage.

The upgrades include a modern redesign, more-intuitive navigation, condensed and simplified language and enhancements in accessibility and mobile responsiveness. The improvements mark the first complete overhaul of the website since the exchange opened in 2013.

"The new and improved version of CoveredCA.com is built to help Californians find the best health insurance option, no matter what device they are using," Lee said. "In this day and age when more and more people are conducting business on their phones and tablets, these upgrades will make it easier for them to get the information they need and to sign up for the health care coverage they deserve."

The new website is the result of extensive user testing and feedback from consumers, internal program staff, the Department of Health Care Services and various stakeholders. Testing with real users began in early 2017 and continues to be conducted at every stage of design and development. The design was led by Covered California's Office of Communications and Public Relations and functional development was led by Covered California's office of Information Technology.

Current enrollees and those interested in applying for coverage can explore their coverage options — and find out whether they are eligible for financial help — in just a few minutes by using the website's Shop and Compare Tool. All they need to do is enter their ZIP code, household income and the ages of those who need coverage to find out which plans are available in their area.

Open Enrollment and Opportunities for Enroll Now

Open enrollment for the upcoming year will begin November 1 and run through January 31. Open enrollment is the one time of the year where eligible consumers cannot be turned away from coverage for any reason. Covered California will be launching a new ad campaign on November 9 and has budgeted $157 million for marketing, sales and outreach during the current fiscal year — an increase of more than $30 million from last year.

In addition, consumers who need coverage earlier may be eligible for the special-enrollment period that is currently underway. Consumers who experience a qualifying life event, such as: losing their health care coverage, losing their job, suffering a loss of income, moving or being a wildfire victim, could be eligible to sign up for coverage that begins in November or December.

"When the worst is happening in health care, we want to make sure that people have a path to coverage, whether it is through Covered California or Medi-Cal," Lee said.

Those interested in learning more about their coverage options can also:

Visit CoveredCA.com.

- Get free and confidential assistance over the phone, 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 stands to lose $25 billion annually in federal funds if ACA is overturned
Emily Boerger

California stands to lose over $25 billion in annual federal funds if the Supreme Court overturns the Affordable Care At (ACA) in its entirety, according to a report released by the Legislative Analyst's Office. Oral arguments in California v. Texas, which threatens the health law, are scheduled to begin next month.

If the ACA is overturned without a replacement option passed by Congress, the state could lose $17.5 billion in Medi-Cal program funding, $7.7 billion in Covered California premium subsidies, and $46 million in prevention and public health funding.

Under the ACA, Medi-Cal enrollment grew from 7.9 million in 2012-13 to 13 million in 2019-2020.

"Over this same time period," reads the report, "total annual funding for Medi-Cal has roughly doubled from $50 billion to $100 billion, with federal funds accounting for over 75 percent of the growth in total funding."

If the ACA is eliminated, roughly 3.7 million individuals who became newly eligible through Medi-Cal expansion would lose coverage. This would result in a loss of at least $17 billion in federal funding.

The brief also notes that the ACA has helped reduce the number of uninsured Californians – including formerly incarcerated individuals. Between 2012 and 2016, the percent of individuals released from department of corrections institutions who enrolled in Medi-Cal increased from 25% to 61%.

The ACA has also increased health care access for individuals with mild to severe mental health conditions.

"For example, in 2019-20, 45 percent more adult Medi-Cal beneficiaries with severe mental health conditions received county services than in 2012-13. Over this same time period, funding for county mental health services increased by 46 percent from $5.4 billion to $7.9 billion," reads the report.

Outside of the Medi-Cal program, about 1.2 million Californians receive federally subsidized coverage through Covered California, the state's health benefit exchange. The federal subsidies equaled about $7.7 billion in 2019-20, and on average reduce the

cost of premiums for eligible customers by at least 78% (from $841 per month to $184 per month).

Without the ACA, and the federal subsidies that come along with it, the LAO brief warns that premiums would become more expensive and policyholders might choose to drop their Covered California coverage and choose go without health insurance instead.

The Prevention and Public Health Fund established through the ACA is also at risk of elimination. The fund supports community prevention activities aimed at improving health, behavioral health screenings, public health infrastructure, and data collection. Last year, California state government and local agencies received about $46 million of this funding.

THE SACRAMENTO BEE

Californians can start shopping for health insurance coverage for 2021 starting Sunday
Cathie Anderson

Peter Lee, executive director of Covered California, the state's health insurance exchange, talks at a news conference in 2013. On Tuesday, Lee announced health insurance premiums for people who purchase coverage through the state marketplace will increase an average of 0.6% in 2021. Residents of El Dorado, Placer, Sacramento and Yolo counties will see their premiums increase an average of 2.3%. AP

Covered California will launch open enrollment for 2021 health insurance coverage starting Sunday and will continue accepting applications for coverage until Jan. 31.

"Open enrollment is the one and only time of the year where all eligible Californians can sign up for quality health care coverage without needing to meet any special circumstances," said Peter V. Lee, the executive director of Covered California.

Earlier this year, Lee announced that premiums statewide would remain relatively unchanged with an average increase of 0.5%, for health care policies. In the Sacramento region, premiums will go up about 2.3% on average.

In a news release issued by the exchange on Friday, Lee stressed that many Californians will be eligible for financial assistance to help bring the cost of coverage within reach.

This year, the state of California joined the federal government in offering financial assistance, Lee said, and that greatly expanded eligibility for help offsetting costs. Of the record 1.5 million Californians now enrolled through the state exchange, he said, nearly 90% have gotten some level of financial assistance.

Almost 600,000 California residents are benefiting from the state subsidies because state legislators attempted to make health insurance more affordable for even middle-class residents.

“Affordability is the number one issue for consumers, and the financial help available through Covered California helps bring the cost of coverage within reach,” Lee said.

The state health insurance exchange has had a particularly busy year in 2020 as it has offered special enrollment periods for wildfire victims as well as for those who lost work as a result of business closures during California’s coronavirus lockdown.

Even now, consumers who lose their jobs or other sources of income may qualify this year to sign up for a policy, regardless of whether they had insurance coverage.

State law required that, starting in 2020, all Californians must be insured, and those who are not face a penalty on their state taxes. Known as an individual mandate, that penalty could come to as much as $2,250 for a family of four.

Help is available at www.coveredca.com or at (800) 300-1506. To be eligible for coverage starting Jan. 1, consumers must enroll by Dec. 15

Consumers will begin seeing online and television advertising from Covered California promoting health insurance coverage starting Nov. 9. Lee has said in the past that the agency spends millions of dollars on marketing coverage in order to assure a healthy pool of insured people who will help to keep rates down for all.

The sickest people will sign up right away, Lee has said, but healthy people need to understand that they are one mishap away from incurring an expense that could wreck them financially for years to come.

It’s Open Enrollment. Here’s What You Need to Know
Bernard J. Wolfson

California’s annual health insurance enrollment season for individuals and families kicks off this week against a dramatic backdrop: the hotly contested presidential election; a pandemic raging out of control in much of the U.S.; and, on Nov. 10, a Supreme Court hearing of a case that could end the Affordable Care Act and strand millions without coverage.

The massive unemployment caused by the pandemic has already stripped employer-based health insurance from millions nationwide and induced severe financial anxiety as families struggle to pay rent and buy food.

One question hovering over enrollment for 2021 health plans is whether the large-scale loss of medical coverage will generate a surge of sign-ups, or if more pressing financial worries for many people will push insurance lower down their priority list.

“People have so many things to deal with: They’ve lost jobs, they’ve lost a lot of income, and in California they’re also facing fires. I don’t think health insurance has been top of mind for people,” says Cheryl Fish-Parcham, director of access initiatives at Families USA, a consumer health care advocacy organization.

But Peter Lee, executive director of Covered California, the state’s ACA marketplace, is confident it will match the 40% increase in new sign-ups it had for 2020 coverage.

“It is clear that COVID is on Californians’ minds,” he says. “You cannot have COVID on your mind without also having coverage on your mind.”

A Supreme Court decision on the future of the ACA probably won’t come until well into next year, and it is unlikely to affect your 2021 coverage. “So people should feel confident in looking for a health plan,” says Sara Collins, vice president for health care coverage and access at the Commonwealth Fund.

If you are 65 or older, you probably qualify for Medicare, the federal program for seniors, which is entirely separate from the ACA exchanges and broader individual market. Open enrollment for the private Medicare Advantage plans and Part D drug plans is also underway and ends Dec. 7. Insurance agents can usually help you with Medicare, and you can get advice by calling 1-800-434-0222.

If you are under 65, live in the Golden State and want to buy insurance for you and your family, start with Covered California. You can get federal and state assistance to cover some or all of your premiums, if you meet certain income criteria.

The enrollment period for Covered California, and for the individual market outside the exchange, started Nov. 1 and runs through Jan. 31. In states whose exchanges are operated by the federal government, the enrollment window shuts Dec. 15.

If you lost coverage and need it for the month of December this year, you can still get it through Covered California if you sign up by Nov. 30. For regular annual coverage that starts Jan. 1, you must sign up by Dec. 15. If you miss that deadline, you can still get coverage starting Feb. 1 if you enroll by the final Jan. 31 deadline.

Many people leave money on the table because they aren’t aware of the financial assistance or think they earn too much to qualify. But you don’t need to be poor to get aid.

The federal subsidies, which are tax credits typically provided in the form of reduced monthly premiums, are available to individuals with annual income up to about $51,000 and a family of four with income up to nearly $105,000.

California has supplemented the federal aid with state-funded assistance that extends further into the middle class: up to around $76,500 for an individual and $157,000 for a family of four.

If you log on to Covered California's website, www.coveredca.com, you can check how much financial help you qualify for and compare health plans. Or, an insurance agent or certified enroller can do the legwork work for you — at no charge. You can find one on the website. You can also call Covered California directly at 800-300-1506.

If your income is below 138% of the federal poverty level, you will probably qualify for Medi-Cal, the government insurance program for people of limited means. The Covered California website — or an enroller — will let you know if you do and walk you through signing up. You can also contact your county's Medi-Cal office. If you don't qualify for Medi-Cal, your children might, because the income threshold is higher for them.

If you are looking for exchange-sponsored coverage, click the "shop and compare" tab on the Covered California website, which takes you to a screen that asks your age, income, ZIP code and family size and shows the health plans available, their premiums and your aid amount.

The website also provides quality ratings of the participating health plans. And you can check for plans that have your doctors in their networks — though, as the website warns, that information is not always up to date.

Comparison shopping on the website is straightforward, because at each of the four levels of coverage — bronze, silver, gold and platinum — benefits are uniform from insurer to insurer. So once you've decided which metal tier is best for you, you only need to think about the price and whether your providers are in the network.

If you have a Covered California health plan already, shop around rather than automatically renew the one you're in. "The best deal last year is not necessarily the best deal this year," says Anthony Wright, executive director of Health Access California.

Covered California announced a 0.5% average statewide premium increase last month, but actual rate changes vary across the state and among carriers.

Anthem Blue Cross, for example, will hike rates by a statewide average of 6%, and the Oscar Health Plan of California by 7.6%, while Blue Shield of California will cut rates by an average of 2.4% and the L.A. Care Health Plan by 4.6%.

If you switch to the lowest-cost plan in your current metal tier, you could reduce your premium by as much as 7.4%, according to Covered California.

Keep in mind that the lowest premium, a bronze plan, is not necessarily the wisest — or cheapest — choice.

Tom Freker, a Huntington Beach insurance agent, counsels people not to buy bronze, because its higher deductibles and coinsurance rates could cost more than a higher-premium plan if you fall ill or have a serious accident.

Freker recommends you enroll in Covered California rather than the off-exchange market, even if you don't initially qualify for aid. That's because if your income drops and you report it to the exchange, you might then qualify and get a break on premiums for the rest of the year or a tax credit the following April, he says.

If your income rises during the year you also should report it, so your monthly premium subsidy is reduced, helping you avoid a potentially hefty tax bill come April.

Your initial aid amount, if you qualify, will be based on your projected 2021 income. In this period of pandemic-driven furloughs, slashed hours and job loss, that might be difficult to predict.

Maria Weston, a massage therapist in Long Beach, said her income has fluctuated week to week since the pandemic started and is down about 50% overall.

Her priority for 2021 was to find a less expensive option, so she switched to a cheaper silver plan last month (current enrollees were allowed to make their health plan choices starting Oct. 1).

Weston's new health plan will save her nearly $1,700 a year on premiums. "I could put that in my retirement account — or eat," she says. "One of the two."

Dr. Philip Lee Is Dead at 96; Engineered Introduction of Medicare
Sam Roberts

Dr. Philip R. Lee, who as a leading federal health official and fighter for social justice under President Lyndon B. Johnson wielded government Medicare money as a cudgel to desegregate the nation's hospitals in the 1960s, died on Oct. 27 in a hospital in Manhattan. He was 96.

The cause was heart arrhythmia, his wife, Dr. Roz Lasker, said.

From his office at the Department of Health, Education and Welfare, as the assistant secretary for health and scientific affairs from 1965 to 1969, Dr. Lee engineered the introduction of Medicare, which was established for older Americans in 1965, one year after Johnson had bulldozed his landmark civil-rights bill through Congress.

“To Phil, Medicare wasn’t just a ‘big law’ expanding coverage; it was a vehicle to address racial and economic injustice,” his nephew Peter Lee, the executive director of Covered California, which runs the state’s health care marketplace under the Affordable Care Act, was quoted as saying in a tribute by the University of California, San Francisco. Dr. Lee was the university’s chancellor from 1969 to 1972, after leaving the Johnson administration.

Dr. Lee’s use of Medicare funding to desegregate hospitals “changed the economic lives of millions of seniors,” Mr. Lee added.

Provisions in the Medicare legislation subjected 7,000 hospitals nationwide to rules barring discrimination against patients on the basis of race, creed or national origin. The law required equal treatment across the board — from medical and nursing care to bed assignments and cafeteria and restroom privileges — and barred discrimination in hiring, training or promotion.

Before the law took effect in 1966, fewer than half the hospitals in the country met the desegregation standard and less than 25 percent did in the South.

“I remember during one of my visits,” Dr. Lee told the journal of the American Society on Aging in 2015, “a cardiologist at Georgia Baptist Hospital told me, ‘Well, you know, Dr. Lee, if I put a nigger in with one of my white patients, it would kill the patient. My patient would die of a heart attack.’”

By February 1967, a year or less after many of the law’s provisions had taken effect, 95 percent of hospitals were compliant, Dr. Lee said.

“He was largely responsible for that effort,” said Professor David Barton Smith of Drexel University and author of “The Power to Heal: Civil Rights, Medicare and the Struggle to Transform America’s Health System” (2016).

Dr. Lee hailed from a family of physicians — his father and four siblings were doctors — and while working in the Palo Alto Medical Clinic (now the Palo Alto Medical Foundation), which his father founded, he saw firsthand the effects on the poor and the elderly of inadequate health care and the lack of insurance coverage.

As early as 1961, he was a consultant on aging to the Santa Clara Department of Welfare in California, and as a member of the American Medical Association and a Republican at the time, he defied both the A.M.A. and his party in testifying before Congress on behalf of a precursor to Medicare that would have helped pay for hospital and nursing home care through Social Security for patients over 65.

Dr. Lee was branded a socialist and a Communist (no matter that he had served as a doctor in the Korean War).

In 1987, after leading the University of California, San Francisco, and heading health policy and research programs there as a professor of social medicine, he further riled fellow physicians when, as chairman of Congressional commission, he recommended a standardized national limit on how much doctors enrolled in the Medicare program, with a vast pool of patients available to them, could charge above a fixed schedule.

He was called back to Washington in 1993, again to be an assistant secretary, this time of the renamed Department of Health and Human Services under the Clinton administration. Serving until 1997, he advised the White House on its ultimately failed effort on health care reform.

In 2015 he endorsed the Obama administration's Affordable Care Act and suggested that the country could go even further in guaranteeing universal health care.

"In 1967, President Johnson said we would continue to work until equality of treatment is the rule," Dr. Lee wrote in Generations: Journal of the American Society on Aging. "By making Medicare an option for all Americans, the kind of care I receive could be available to everyone."

Philip Randolph Lee was born in San Francisco on April 17, 1924, to Dr. Russell Van Arsdale Lee, who had lobbied for national health insurance as a member of a commission appointed by President Harry S. Truman, and Dorothy (Womack) Lee, an amateur musician.

His interest in medicine, he told Stanford Medicine Magazine in 2004, "began with house calls with my dad from the age of 6 or 7."

He earned his bachelor's and medical degrees at Stanford University in 1945 and 1948. As a member of the Naval Reserve, he was on active duty as a doctor at the end of World War II and again from 1949 to 1951, during the Inchon invasion in Korea. He received a master of science degree from the University of Minnesota in 1955 and had fellowships at the Rusk Institute of Rehabilitation Medicine in New York and the Mayo Clinic.

"Phil moved from clinical medicine to health policy and then devoted his life to addressing issues at the nexus of civil rights, social justice and health," Dr. Lasker, his wife, said in an email.

His prominent role in shaping Medicare and other federal health policies was preceded by a stint, 1963-65, as director of health for the Agency for International Development. As chancellor of the University of California, San Francisco, he was credited with increasing racial diversity among its staff, faculty and student body.

In 2007, the university named its Institute for Health Policy Studies, which he founded in 1972, in his honor.

He was also lauded for his aggressive role in confronting the AIDS epidemic as the president of the newly-formed Health Commission of the City and County of San Francisco from 1985 to 1989.

The author of a half-dozen books, Dr. Lee was an early critic of the pharmaceutical industry in “Pills, Profits and Politics” (1974, with Milton Silverman).

Dr. Lee’s first two marriages, to Catherine Lockridge and Carroll Estes, ended in divorce. In addition to his wife, he is survived by five children from his first marriage, Dorothy, Paul, Margaret, Theodore Lee and Amy Lee Pinneo; a stepdaughter, Duskie Estes, from his second marriage; five grandchildren; two step-grandchildren; and two great-grandchildren.

Covered California open enrollment underway | Here's what you need to know
Samantha Solomon

CALIFORNIA, USA — Perhaps more popularly known as the Affordable Care Act, aka Obamacare, Covered California has launched its open enrollment period to get Californians health insurance for 2021.

As the coronavirus pandemic rages on and flu season is underway, it is important to make sure you and your family are covered.

From Nov. 1, 2020, to Jan. 31, 2021, California residents can purchase health insurance for the upcoming year. During this period only, you can apply without a qualifying life event — a list of criteria which people typically have to meet. This is also the only place where a California resident can apply to see if he or she qualifies for the government to help pay for medical insurance through a tax credit or subsidy.

Here are Covered California's recommended steps to purchasing health insurance through the program:

Start by getting California health insurance quotes and see if you qualify for the government to help you pay for your insurance.

Select a plan. If you aren't sure which plan would be best, you can take a look at the Obamacare Plans and Prices before you start to get a general idea of cost and benefits.

Submit your online application.

Though the enrollment period extends until late January, Covered California actually recommends getting insurance before Dec. 15. This way, coverage begins on Jan. 1, 2021, which allows you to take also full advantage of your annual medical deductible which works on a calendar year

Those in need of health insurance have a couple of options. You can:

- Buy a plan through Covered California. If you qualify for a tax credit to help offset your premiums, you may consider buying a plan through the marketplace. Qualifying usually depends on your income and household size.
- Renew or change your current plan. During the open enrollment period, you can renew your existing plan. You will not have to do anything if you want to keep what you have. But if your current plan is changing—for instance, your primary care physician is leaving the network, or your medications are no longer covered—then you may want to think about switching to a plan that best suits your current needs.
- Enroll in Medi-Cal. If your income is below 128% of the Federal Poverty Level, you qualify for Medi-Cal, which is Medicaid for Californians.

It important to note that enrolling in Medi-Cal is not limited to the open enrollment period. If you are eligible for the insurance program, you can enroll at anytime. The same is true for CHIP, the Children's Health Insurance Program.

However, if you choose to not purchase health insurance with Covered California's during the open enrollment period, you have to qualify for special enrollment in order to get coverage. Special enrollment only allows certain exceptions:

- Losing your job
- Moving to a new state
- Getting married or divorced
- Becoming a widow or widower
- Aging off your parent's plan
- Having a new baby

This is why it is so important to buy health insurance during open enrollment: you may not know where you will be when you suddenly need coverage.

ADWEEK®

Covered California Ads Directed by Errol Morris Cut Right to the Chase About Health Insurance
Erik Oster

Covered California, the state's health insurance marketplace, has launched a campaign to reach all residents with a direct message about accessibility.

Covered California appointed Duncan Channon as its agency of record last month, awarding the San Francisco agency a five-year contract following a review. "This Way to Health Insurance" is the shop's first work for the new client.

The campaign is centered on series of TV ads directed remotely by Errol Morris and features real Californians, providing a clear and direct message about how Covered California can help make health insurance a reality amid a pandemic and economic crisis.

"At a time when people are rightfully concerned about their health, their jobs and their financial constraints, we want Californians to know that health insurance is one area where options and support are available," Covered California marketing director Colleen Stevens said in a statement. "Our mission is to make sure not a single Californian goes without health insurance because they think it won't make a difference, or is financially out of reach."

"People know they want health insurance. The trick is that for a lot of people it feels out of reach, and for fewer people unnecessary," Duncan Channon CCO Michael Lemme told Adweek. "It's ever more important that we cut to chase."

Lemme explained that the campaign was designed to reach all Californians, even those who currently have health insurance through an employer. At the same time, the campaign works hardest to convince those who think health insurance might be financially out of reach or otherwise unattainable.

One ad that tells the story of a man who recently lost his job and was unsure whether he could afford health insurance for himself and his family is a clear example of how the agency reaches both audiences. It speaks directly to how Covered California provides financial assistance to those otherwise unable to afford health insurance, while a wider audience can recognize a scenario that many fear as a possibility.

"We want people to recognize themselves in these stories but they're seeing people that have gotten it done, and hopefully that creates some hope and optimism," Lemme said,

explaining the hope was that telling the stories from the perspective of those who have successfully applied would create a sense of optimism. “The premise of the campaign is how to get this done as quickly and directly as possible.”

Duncan Channon partnered with a series of multicultural agencies in an attempt to reach the diverse population of the state with an effort running in six languages. Those agencies—APartnership, Barú and Quantasy—collaborated closely with Duncan Channon throughout the creative process.

“The work from the beginning was co-created with those agencies. From the onset our strategists and their team and our teams had the same brief at the same time,” Lemme explained. “It’s a lot of people to organize but it was important to us that we were leveraging all of that expertise and then discussing with each other which [approaches] have resonance because California is a multicultural community and in order to be effective we have to understand all those different populations.”

Lemme explained that the campaign evolved from two ideas presented when Duncan Channon pitched for the account, but that the direction of the campaign was shaped by the pandemic in a variety of ways. A virtual testing process made it clear that audiences didn’t need a message with elevated emotion about the need for health insurance, and the authenticity of the campaign was aided in part by the necessity of working with real families. In many cases, their personal stories helped shape the ads. In casting, Lemme explained that Morris would engage actors in conversations about their own experiences, many of which informed the final scripts for the ads.

The campaign also includes digital display, OOH and print ads featuring photography shot by We Are the Rhoads, as well radio ads.

“That gave us the opportunity to widen the aperture a bit and expose some of Covered California’s view of what health insurance can give to people, what its mission and offer is,” Lemme said. “Those messages are in the foreground. We don’t want to be subtle.”

One OOH ad, for example, informs Californians that 9 out of 10 applicants received financial help. Lemme explained that a good deal of care was put into the messaging and placement of OOH ads to reach audiences they might not with TV ads or digital display.

Duncan Channon’s work promoting Covered California is far from over. The agency is already hard at work on its campaign for the special enrollment period, which begins as soon as open enrollment ends at the end of January, with events like job loss and the birth of a child remaining an important focus. Covered California is also working closely with the agency on data/analytics to measure the reaction to the campaign and inform future efforts.

Garcetti, Health Officials Kickoff 2021 Covered California Enrollment Period
City News Service

Mayor Eric Garcetti joined state health officials Monday to kick off the Covered California health insurance open enrollment period, noting that 1.2 million people in the state are currently uninsured amid the COVID-19 pandemic, despite being eligible for financial help through either Covered California or Medi-Cal.

"This has been a year full of a lot of pain and stress," Garcetti said. "These sorts of conversations help people realize that this (health care coverage) isn't out of their reach. In fact, it makes us all healthier, makes us all stronger."

The open enrollment period began Nov. 1 and runs through Jan. 31, but people must be registered by Dec. 15 for their health insurance to take effect on Jan. 1.

"Those who are hospitalized because of COVID, and do not have health insurance and the special cost-sharing protections that have been put in place for COVID, could walk out with very large bill," said Dr. Mark Ghaly secretary of the state's Health and Human Services Agency and Covered California board chair.

Covered California, in partnership with the California Department of Health Care Services, helps people determine whether they are eligible for premium assistance that is available on a sliding-scale basis to reduce insurance costs or whether they are eligible for low-cost or no-cost Medi-Cal.

Covered California is the state's marketplace for the federal Patient Protection and Affordable Care Act.

As part of the open enrollment kick-off, Covered California is mailing masks this month to its enrollees and those who sign up during the open enrollment period.

The kick-off event and mask campaign were announced a day before the U.S. Supreme Court is scheduled to hear arguments in a case that could undo the Affordable Care Act. The effects that would have on Covered California are not yet known.

A ruling from the court isn't expected for another six to eight months, Covered California officials said, and people will still be assessed for health insurance when they sign up for the 2021 plans.

Covered California officials said that as of today, a record 1.5 million residents are enrolled in Covered California and are in the process of renewing their coverage, with almost 90% receiving some level of financial assistance.

According to the Covered California website, the premium charges for health insurance plans should not change significantly compared to last year because the enrollment is high enough to maintain them.

People can enroll, change their plans and find out more information about Covered California at coveredca.com.

The Bakersfield Californian
A MEMBER OF THE TBC MEDIA FAMILY

Covered California open enrollment period kicks off Monday
Quinn Wilson

Covered California's open enrollment period kicked off Monday in an effort to get health coverage to the more than 1 million uninsured Californians who are eligible for assistance.

An estimated 1.2 million uninsured people in the state are either eligible for financial help through Covered California or qualify for low-cost or no-cost coverage through Medi-Cal, according to Covered California. In Bakersfield, an estimated 33,420 people were uninsured last year, according to the U.S. Census Bureau.

Peter Lee, executive director of Covered California, said that they are looking to continue their work to drastically reduce the state's uninsured rate.

"California has reduced the rate of the uninsured more than any place in the nation," Lee said during a Monday morning teleconference.

During the open enrollment period, Covered California will be sending out masks to 2 million people statewide, according to Lee, and $157 million is going into this year's open enrollment advertisement campaign.

During the teleconference, Dr. Mark Ghaly, secretary of California's Health and Human Services Agency, emphasized the importance of continuing to wear a mask. He also

addressed the various minority communities that have been disproportionately impacted by COVID-19 in the state.

“The pandemic is shining a new spotlight on an old problem,” Ghaly said. “These disparities cannot be accepted.”

Los Angeles Mayor Eric Garcetti also spoke at the Monday teleconference where he shared the success Covered California has had in helping reduce the city's uninsured rate. However, he noted that there's still work to be done.

“The late great Kobe Bryant always said, ‘The job’s not finished,’” Garcetti said. “I won’t rest, and you shouldn’t rest, until every Angeleno, and every Californian, can get the health care they need.”

Concerns were brought up to the speakers regarding the Affordable Care Act scheduled to be heard by the U.S. Supreme Court. Beginning Tuesday, the court will begin hearing a request from the Trump administration for the high court to throw out the Obama-era health care law, according to The Associated Press.

However, Lee emphasized there should not be any immediate panic over what could possibly be on the horizon.

“Tomorrow is a hearing, but a ruling won't be until six to eight months away,” Lee said. “The idea that a supreme court would undercut the coverage protecting 32 million Americans would be legally cuckoo.”

A variety of Covered California recipients spoke during the teleconference and each of them had signed up for the program after losing their employment and insurance during the pandemic.

“During these times it’s very important to have health care coverage, especially for me because I am expecting (a baby),” said Lizeth Gonzalez, a Covered California recipient from Merced.

Covered California currently has 1.5 million enrollees, which is a 7.5 percent increase, according to Lee. The open enrollment period will last until Jan. 31, 2021.

LOS ANGELES SENTINEL

Covered California Kicks Off Open Enrollment
Betti Halsell

Covered California announced their open enrollment on Monday, November 9. Los Angeles Mayor, Eric Garcetti virtually attended the Webinar meeting, along with many other diverse community leaders, to discuss the importance of accessible healthcare during one of the most unexpected health-related crises seen in our time. There is a new pressure applied to having health coverage and maintaining a fresh perspective on the quality of life.

The virtual event took place before one of the most important discussions happening in the U.S. Supreme Court; referencing the Affordable Care Act which will be the measurement of assistance with health care giving millions access through programs such as Covered California and Medi-Cal. Covered California wants to make health care easy; every plan has a custom development to meet the individual in the middle.

Public leadership gathered to discuss what affordable healthcare means to each individual. Executive Director of Covered California Peter Lee invited the chief executive officer of the California Black Women's Health Project Sonya Young Aadam, Mayor Garcetti, and many others in public leaders to elaborate on how health care accessibility varies in different communities. Covered California is looking to fill those gaps and provide optimal accessibility for all.

Covered California is looking to be a "marketplace" for anyone in need for health coverage. Operating since 2004, this certified insurance agency can be found online, and the process is described to be simple and quick. The first step is reviewing equitable plans that fit the family budget, transitioning to the application steps. Covered California offers to calculate government subsidies, resulting in finding out the measurement of federal assistance. They are looking to help everyone find a budget that is custom to their needs.

The open enrollment launched one day before the U.S. Supreme Court deliberated on one of the most controversial measurements, the federal reach into public healthcare accessibility. There is new awareness surrounding healthcare; it's a direct reflection on the quality of life that seems to vary in different ethnic groups. The Affordable Care Act was a bold approach to bring balance to a lack of coverage due to overly-priced health insurance.

Mayor Eric Garcetti virtually attended the webinar meeting along with many other diverse community members in leadership roles, to discuss the importance of accessible healthcare during one of the most unexpected health related crises seen in our time.

In October of 2013, the first open enrollment time was commemorated at the Los Angeles Union Station. Mayor Garcetti reflected on that time, stating, “These are people’s lives. This is a matter of life or death, these are not statistics, these are stories.”

Garcetti went on to explain the touch of humanity the nation’s health care system needs as it’s being considered in the Supreme court. Mayor Garcetti stated, “This has been a year filled with a lot of pain and stress.” He continued, “Covered California will give a range of amazing options, plans that fit your family.”

People are looking for more security in health insurance, with the world entering a new “COVID Era,” the subject of medical affordability and access has taken priority. There is an established understanding that health conditions can change unexpectedly and instantly. The nation’s disparities continue to grow, especially for those who live below the poverty line. COVID-19 highlighted a sad truth; not being able to afford health insurance can have a fatal outcome.

The state of California has reflected their competency of the issue, by utilizing the Affordable Care Act and making it work. Millions of Californians benefited from the funnel to affordable healthcare that Covered California provides. Accessing healthcare should be an obliging experience for all, Covered California has held enrollment events across the state, working with republican and democratic parties, and setting the example for the rest of the nation.

Out of all of the states California shown the urgency for the need of medical availability, by finding a way to accommodate different family budgets and medical needs. Covered California wants to see all of California covered, they contributed 157-million dollars to promote open enrollment dates and contributed masks. The goal for Covered California is for “Everyone to have coverage.”

COVID-19 displayed disproportionate affects among certain racial groups, for example among African American communities, the risk of a fatal outcome due to the coronavirus is 50% higher than it is for White Americans in California. In Latin-X communities, they make up approximately 50% the COVID-19 cases and nearly 60% of all COVID related deaths.

The health care system needs to cover everyone, Covered California is looking to be a prime example on how that can be possible. The focus is to bring awareness to the opportunity for affordable health coverage, by taking the range of family budgets into consideration. There is a more severe emphasis on accessibility since many lives have been lost due to the COVID-19 outbreak.

Guests can compare health insurance plans and make a choice that best fit their needs; some people may qualify for the low-cost or no-cost Medi-Cal program. Open enrollment is the time to sign-up and make the family's well-being, the main priority.

The nation shares the narrative of this abrupt change, therefore all policies moving forward mirror the new ethics and priority; the awareness surrounding healthcare. California has had one of the largest drops in the uninsured population.

Through the virtual event, the masks were highly encouraged to be worn. It was explained that wearing a mask "is not a political statement" but a necessity to keep community transmission at bay. Covered CA has a foundation of "doing the right thing," that can be displayed by wearing a mask; everyone is held accountable for the protection of others.

The pandemic is shining a new spotlight on an archaic issue, the disparities in life quality that lives among the nation. Covered California believes that these differences in healthcare access should not be accepted. This is a state-wide effort to accommodate all family dynamics, in order for every Californian to be covered with health insurance.

The Californian
PART OF THE USA TODAY NETWORK

Supreme Court hears Affordable Care Act arguments, here's how it affects California
Angelica Cabral

The Supreme Court began hearing arguments this week on a potential repeal of the Affordable Care Act, ACA, also known as Obamacare.

What's on the table is whether or not the mandate of ACA, requiring people who can afford it to buy health insurance, should be struck down as unconstitutional.

The Supreme Court appeared likely Tuesday to uphold the act for the third time in eight years, even with the Trump administration urging its elimination.

In 2012, Chief Justice John Roberts and the Supreme Court said the mandate constituted a tax so the ACA could stay. In 2017, Congress took away the penalty that people used to have to pay if they didn't have health insurance.

If the ACA is struck down, health coverage for more than 20 million people and protections for millions more with preexisting conditions is at risk. A ruling is not expected until the middle of next year.

While the justices convened, Covered California, our state's health insurance marketplace, opened the 2021 enrollment period.

Covered California

When the ACA passed, there were two options, states could set up their own marketplace or the federal government could set it up for them.

California chose to set up its own marketplace.

"We don't just get the money in the hands of the consumers so they can buy a plan, we make sure the plans play by rules that benefit consumers," said Peter Lee, director of Covered California.

Lee believes the conversation shouldn't be focused on the Supreme Court decision, but instead on Californians being 100% covered in 2021.

"The chances of people losing their coverage, even in the most extreme ruling are virtually nil," he said. "California has a state requirement to buy coverage, if you can afford it, that would not be affected by the Supreme Court."

Lee has a passion for health care. He was recruited from his work in the Obama administration to come back to his native state to help launch Covered California.

"California is on the cutting edge of saying 'let's move as rapidly as possible to true universal coverage,'" Lee said. "You see it as more than just talk."

He's hopeful for the future, saying that for the first time in four years, California won't be playing defense.

"Imagine what we can do with an administration saying 'let's make this law work better.' That's the more present issue before Californians," he added.

Undocumented residents are also eligible for coverage, just in a slightly different way.

An undocumented person can enroll in the individual market, but they can't get a subsidy. However, Medi-Cal, California's Medicaid program serving low-income residents, was expanded to be made available to undocumented people under the age of 26.

"That's on the pathway to wanting to have every Californian covered regardless of immigration status," Lee said. "Coverage is the right thing for the person who gets the coverage, but it's also the right thing for everyone in the community."

What It Means To Cover Preexisting Conditions
Katie Keith

Protections for people with preexisting medical conditions will continue to be a hot topic as the 2020 election cycle heats up. Unsurprisingly, ensuring that people with preexisting conditions have access to affordable, quality health insurance is widely supported by the public. Given broad public support, politicians of all stripes and persuasions now pledge to protect those with health issues. But protecting people with preexisting conditions is easier said than done.

This post discusses what it means to cover preexisting medical conditions, offers a tool to assess candidate claims, and reviews a set of congressional proposals that purport to offer Affordable Care Act (ACA) alternatives that protect people with preexisting conditions but that ultimately fall short. With coverage for millions of people at stake, we should not simply take a candidate's word for it.

Background

Millions of Americans have a preexisting medical condition. The Kaiser Family Foundation estimated that at least 53.8 million adults under age 65—27 percent of non-elderly adults—have a preexisting condition that would make them uninsurable. Another study estimated that more than 102 million Americans—50 percent of those not enrolled in public programs—could face medical underwriting or be denied coverage or care due to a preexisting condition. And a 2017 analysis from the Department of Health and Human Services estimated that up to 133 million people—51 percent of all Americans—had a condition that could make them uninsurable.

The global pandemic likely increases these statistics: COVID-19 could be considered a preexisting condition in the future, especially for those who face long-term effects of the virus. Other preexisting conditions include episodic illnesses such as cancer or a heart attack as well as common chronic diseases such as hypertension, diabetes, depression, epilepsy, or asthma. Some preexisting conditions are present before or at birth (such as a congenital heart defect). Others (such as Huntington's disease or cystic fibrosis) are inherited. Still other conditions (such as cancer and asthma) develop or manifest in childhood or adulthood. Even temporary conditions (such as pregnancy) were treated as a preexisting condition. Preexisting conditions are most common among older adults, and women are more likely than men to have preexisting conditions.

Prior to the ACA, millions with preexisting conditions faced significant barriers in accessing individual market coverage. Health insurers in the individual market in nearly all states could refuse to issue a policy, charge higher premiums, and exclude coverage for specific illnesses and the body parts and systems they affect. Millions were left uninsured or underinsured as a result.

The ACA addressed these gaps by improving the availability, affordability, and adequacy of private health insurance. Beginning in 2014, the ACA banned insurers from denying coverage or benefits or charging higher premiums because of a patient's preexisting condition or health status. The law also capped annual out-of-pocket expenses for covered services, required plans to cover a package of 10 essential health benefits, and banned lifetime and annual dollar limits on covered benefits.

Each of these provisions has been important to ensuring that consumers, including those with preexisting medical conditions, have access to affordable, quality insurance. These parts of the law, as well as subsidies for low- and middle-income people and Medicaid expansion, have been critical in extending health insurance to 20 million Americans since the ACA was enacted in 2010.

What Does It Mean To Cover Preexisting Conditions?

Covering preexisting conditions is a challenge that is unique to the private health insurance system. The question of whether preexisting conditions are covered is not an issue in public coverage programs, such as Medicaid or Medicare. (Medigap policies, private supplemental coverage for Medicare enrollees, can impose limited exclusions for preexisting conditions.) Said another way, public coverage programs are designed to cover people with preexisting conditions (such as older Americans or people with disabilities), and Medicare and Medicaid eligibility has been expanded over time to cover those with specific conditions (such as end-stage renal disease or breast cancer).

Protecting privately insured consumers with preexisting conditions means ensuring that those with health conditions are treated the same as those without health conditions in terms of access, affordability, and adequacy of coverage. Given the complexity of private health insurance, this requires a series of interrelated provisions that collectively prohibit insurers from treating enrollees or potential enrollees differently based on health status in at least three distinct but related areas of insurance regulation: the issuance of coverage, rating, and benefit design.

A level playing field across insurers and premium subsidies are also important. Without a level playing field, insurers will use the tools at their disposal to attract healthy people and limit enrollment of less healthy people in order to avoid adverse selection. When the same rules apply to all insurers, they are forced to compete on price and quality (rather than benefit design and cherry-picking healthy consumers). And prior state experience suggests that reforms alone are insufficient: there must be some mechanism, such as premium subsidies, to encourage healthy people to enroll and avoid either very high premiums or a death spiral.

Issuance Of Coverage

Guaranteed issue protections require insurers to issue a health plan to any applicant regardless of their health status or other factors. Guaranteed issue was adopted in the small group market under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and then extended to the individual market under the ACA. (HIPAA also included protections for some people in need of individual market coverage, but these protections were limited to those who were losing job-based coverage and maintained "continuous coverage.")

Comprehensive guaranteed issue protections prevent insurers from picking their enrollees. Without guaranteed issue, insurers could return to medical underwriting and ask invasive medical questions of applicants. Insurers maintained lists of health conditions that triggered the denial of an application and outright reject anyone with a preexisting condition or not otherwise in perfect health. Denials were common for conditions such as HIV, substance use, hemophilia, lupus, multiple sclerosis, stroke, and more. An estimated 27 percent of non-elderly adults currently have a health condition that would make them uninsurable under prior individual market rules.

Rating

Even if a consumer could secure an individual market policy prior to the ACA, most states had no restrictions on what insurers could charge in monthly premiums. Thus, insurers were able to charge higher rates based on health status or medical history, demographic information (such as age and gender), and a person's occupation, among other factors. Health status rating meant prohibitively expensive premiums for those with chronic conditions such as hypertension, high cholesterol, asthma, arthritis, depression, diabetes, obesity, and more. But health status rating also extended to those with mild health conditions, such as seasonal hay fever, situational depression, or chronic ear infections. And insurers used durational rating to raise rates at renewal, forcing enrollees to reapply for new coverage and re-undergo medical underwriting.

The ACA banned these practices and ushered in community rating where rates in the individual and small group markets can vary based solely on four factors: family size, geographic location, age, and tobacco use. Although rates can vary for age and tobacco use, variation is capped. These reforms made coverage more affordable for many with preexisting conditions who could no longer be rated out of coverage entirely. At the same time, this policy led to higher premiums for some people who had benefitted from health status rating while they were healthy. Without community rating, individuals could be charged more based on their health status or medical history and rates could change as health status changed, leaving consumers with preexisting conditions at the mercy of insurance companies.

Benefit Design

Prior to the ACA, people who could secure an individual market policy that they could afford faced significant benefit restrictions. For those who were able to pass medical

underwriting, benefits were limited through preexisting condition exclusions, exclusionary riders, higher deductibles, or modified benefits, among other benefit design tools.

In most states, insurers broadly excluded coverage of preexisting conditions, the definition of which varied by state but often extended even to conditions that were undiagnosed. Insurers also used “post-claims underwriting” to investigate whether a claim for treatment was for a preexisting condition (even if previously undiagnosed) to try to rescind coverage for those patients. Thus, medical needs that were or could be considered preexisting were simply not covered by insurers, forcing enrollees to pay out-of-pocket for those health care needs. This type of exclusion could be coupled with an exclusionary rider that denied coverage for treatment for a specific condition, body part, or system.

At the same time, insurers routinely excluded major categories of health benefits, such as maternity care, mental health services, and prescription drugs. Even when coverage was provided, some policies had significant limits or restrictions on those benefits. These restrictions applied for all enrollees but often targeted health care services that people with preexisting chronic conditions would need, providing a further disincentive for these individuals not to enroll in coverage and furthering the likelihood that insurers would not have to pay high claims even if they did enroll.

While there had been some federal benefit standards that predated the ACA, these protections were far from comprehensive. This changed significantly under the ACA which, beginning in 2014, banned insurers from using preexisting condition exclusions, required individual and small group plans to cover a package of at least 10 essential health benefits, banned lifetime and annual dollar limits on covered health care benefits, and capped annual out-of-pocket expenses for covered health care services. Without these comprehensive benefit standards and protections, individuals with preexisting conditions faced daunting barriers to obtaining coverage that was affordable and that would cover care they need.

Assessing The Proposals

Protections for people with preexisting conditions are popular. Majorities of all partisans say it is “very important” to ensure that people with preexisting condition cannot be denied coverage based on their medical history or charged more based on a preexisting condition. Support for these protections remains high even after hearing that these protections lead to increased insurance costs for some healthy people. It is then perhaps unsurprising that continuing the ACA’s protections for people with preexisting conditions is among the public’s top health care priorities. An even more recent poll of independent voters found that 79 percent of Republicans support ACA repeal but that support drops to 45 percent if the policy leads to losing protections for people with preexisting conditions.

Reflecting the popularity of protecting people with preexisting conditions, politicians on both sides of the aisle have pledged their support. But protecting people with preexisting conditions is easier said than done, and candidates should be judged on the policies they propose and whether those policies would provide meaningful health insurance protection to people with preexisting conditions. Candidate proposals should be evaluated based on at least the following questions:

Can insurers turn an applicant away based on health status?

Will someone with a health issue be charged higher premiums or face higher overall out-of-pocket costs?

Can insurers exclude coverage for preexisting conditions?

Can insurers exclude key benefit categories that are needed by people with preexisting conditions (such as prescription drugs)?

Does the proposal lack a mechanism, such as premium subsidies, to encourage healthy people to enroll in coverage?

If the answer to any of these questions is yes, the proposal will not protect people with preexisting conditions as well as the ACA. These answers are even more important during a pandemic that will have long-lasting health effects for millions of Americans. Based on these metrics, many current proposals discussed below give only lip service to protecting people with preexisting conditions and would leave gaps for those in need of affordable, comprehensive health insurance.

Democratic Proposals

Congressional Democrats have passed legislation to strengthen and expand the ACA by, for instance, extending subsidies to those with higher incomes and making premium tax credits more generous. Former Vice President Biden's health care campaign proposals would build upon the ACA. These proposals would not disturb the ACA's underlying protections for people with preexisting conditions, which include guaranteed issue, community rating, the ban on preexisting condition exclusions, the coverage of essential health benefits, the cap on out-of-pocket costs, and the ban on annual and lifetime limits on care. Proposals that would go further than the ACA—ranging from a single payer system to public options or buy-ins—would expand public coverage programs such as Medicare or Medicaid that, as noted above, fully cover preexisting medical conditions.

Republican Proposals

ACA critics argue that there are other options to protect people with preexisting conditions without imposing the ACA's market reforms. But the challenges of finding an alternative policy that does so were laid bare during unsuccessful efforts to repeal the ACA in 2017. Each of the bills that were considered—from the American Health Care

Act in the House to the Better Care Reconciliation Act and the Graham-Cassidy proposal in the Senate—failed in part because of opposition to weakening protections for people with preexisting conditions and significant coverage losses. Much has been written about these proposals, but the bills would have eroded the ACA's protections for people with preexisting conditions by allowing states to waive the market reforms (including community rating and essential health benefits), allowing older Americans to be charged higher premiums, and adopting flat tax credits that would not keep pace with premiums, among many other changes.

Given efforts to repeal the ACA, Republicans were considered vulnerable on this issue during the 2018 midterm election cycle. In response, congressional Republicans have introduced legislation and offered proposals on preexisting conditions, and President Trump has made campaign promises to protect people with preexisting conditions. Republican state legislators, governors, and attorneys general have done the same, often framed as a direct response to the possibility that Congress will still repeal the ACA or the Supreme Court will invalidate the law. As a result, some of the federal and state proposals only go into effect if and when all or parts of the ACA is struck down or repealed.

While these proposals make for good messaging, each has gaps that would leave people with preexisting conditions vulnerable to higher premiums, higher out-of-pocket costs, and denied benefits relative to the ACA. Because each proposal would provide flexibility (in one way or another) for insurers to treat people differently based on their health status, none comprehensively prohibit health insurers from discriminating against people with preexisting conditions.

Trump Administration Proposals

President Trump continues to falsely claim that he "saved" preexisting condition protections. As discussed more here, undermining the ACA has been a consistent priority for the Trump administration. The administration has also dramatically expanded access to short-term, limited duration insurance, a product that does not have to comply with any of the ACA's consumer protections and allows discrimination against individuals with preexisting conditions in the issuance of coverage, rating, and benefit design. Concerns about this type of coverage are well-documented, and short-term plans are akin to pre-ACA products that were unavailable to people with preexisting conditions.

Further, the Trump administration has taken a highly unusual legal position to argue that the entire ACA should be declared invalid in California v. Texas, a lawsuit filed by Republican state attorneys general in 2018. The Trump administration agreed with these states, arguing first that the ACA's provisions on guaranteed issue, community rating, the ban on preexisting condition exclusions, and nondiscrimination were severable from the rest of the law and should be struck down while the rest of the law should be preserved. The government later broadened its position to argue that the entire ACA should be invalidated. President Trump took that position (and has maintained that position even during the pandemic) over objections from his senior staff.

Texas is currently pending before the Supreme Court, which will hear oral argument on November 10 and issue a decision in 2021. About 57 percent of adults are worried that they or someone in their family will lose coverage in the future if the Supreme Court invalidates the law's protections for people with preexisting conditions.

Legislative Proposals

Some of the proposals—such as bills sponsored by Sen. Thom Tillis (R-NC) and Rep. Greg Walden (R-OR)—would maintain the ACA's guaranteed issue protections and ban preexisting condition exclusions but would not restore the ACA's benefit design standards, such as the ban on lifetime and annual dollar limits. On rating, these bills would readopt a provision of HIPAA that bars discrimination based on health status-related factors. This protection prevents individual members of a group plan (i.e., individual employees) from being singled out for higher premiums because of their health status relative to their colleagues. But the legislation would not otherwise limit overall premiums because of the group's health status (i.e., group premiums could still be higher because of health status). Each bill would also allow rating on other factors (such as gender, age, and occupation) and potentially other proxies for health status (based on, say, personal consumer data).

(It is worth noting that HIPAA nondiscrimination does not prohibit policies that discriminate against all employees: so long as benefits are uniformly available to all similarly situated individuals, coverage is not discriminatory. As an example, a plan could not adopt a lower lifetime dollar cap solely for an HIV-positive employee, but it could cap coverage of HIV-related expenses for all group members. It is also unclear how this provision would be applied in the individual market. This provision applied in the group market under HIPAA and was only extended to the individual market under the ACA. Because the ACA's other provisions on guaranteed issue, community rating, and benefit design are more explicit, this provision has not been interpreted in the individual market, and we do not know how "similarly situated individuals" would be defined for purposes of the individual market.)

Others—such as a bill sponsored by Sen. Cory Gardner (R-CO)—would maintain rating protections and ban preexisting condition exclusions but not explicitly require guaranteed issue. So, people with preexisting conditions could not be charged more (at least not based on health status), but, without explicit guaranteed issue, they may not be healthy enough to be issued a policy in the first place.

Still others—such as legislation sponsored by Rep. Riggleman (R-VA)—would adopt provisions that mirror the ACA and HIPAA on guaranteed issue, community rating, preexisting condition exclusions, and nondiscrimination but would not address minimum benefit standards, such as the essential health benefits. A bill sponsored by Rep. David Joyce (R-OH) would add a limited severability clause to the ACA to specify that current protections for guaranteed issue and renewability, community rating, preexisting condition exclusions, and nondiscrimination would not be affected by a ruling that the individual mandate was unconstitutional. But as with Rep. Riggleman's bill, this legislation would not extend to maintaining the ACA's benefit standards. Without federal

benefit standards, state-specific benefit standards would apply, leaving a patchwork of benefits that would vary based on where one lived and that might not meet the needs of all those with preexisting conditions.

White Papers

Although not a formal legislative proposal, a white paper from the Republican Study Committee insists it can “neutralize” the issue of preexisting conditions while eliminating what it believes are burdensome ACA requirements. But this proposal would eliminate community rating and many of the ACA’s benefit design requirements (specifically essential health benefits, the ban on annual and lifetime limits, the coverage of preventive services, dependent coverage, and actuarial value). Instead of guaranteed issue and a ban on preexisting condition exclusions, the Committee would require “continuous coverage” where those who fail to maintain a full year of prior coverage could have their preexisting conditions excluded for a period up to the next 12 months.

Encouraging continuous coverage is a laudable goal. Ideally, everyone would be covered at all times. But this proposal would not help those who are currently uninsured and ignores that coverage gaps are common for those with private coverage. In 2016, 30 million adults reported a gap in coverage that was longer than three months. Continuous coverage seems especially unworkable considering the COVID-19 pandemic, which has dramatically increased the risk of coverage loss and coverage gaps as more than 30 million Americans have lost their job. A truly seamless coverage system—where individuals can easily access job-based coverage, marketplace coverage, and Medicaid—would be needed to ensure that individuals with preexisting conditions would not be unduly penalized under a continuous coverage system.

Overall, the Republican Study Committee’s proposal, if adopted, would result in higher premiums for those with preexisting conditions, significant benefit gaps, and coverage exclusions unless states stepped in to say otherwise.

Another oft-touted feature of Republican proposals—including the Republican Study Committee proposal—is to encourage “guaranteed coverage pools” supported by federal funding to the tune of $17 billion annually. This is a new name for an old idea known as high-risk pools, which were in place in many states prior to the ACA and failed to cover the millions of people in need of individual market coverage due to chronic underfunding.

Although high-risk pools could work if adequately funded, this has not been the experience of state high-risk pools to date. Prior experience shows that state high-risk pools were plagued by high costs, low enrollment, and benefit limitations. By the end of 2011, enrollment in 35 state high-risk pools reached less than 227,000 individuals (compared to the more than 11 million people enrolled in marketplace plans today). Even with low enrollment, high enrollee health care costs led high-risk pools to impose premiums, limit coverage, or both. High-risk pool premiums were up to double the market rate, and nearly all high-risk pools excluded coverage of preexisting conditions, typically for six to 12 months. This meant that individuals fortunate enough to afford a

policy through the high-risk pool would not actually have coverage for the health care services they needed to treat their preexisting condition.

Bloomberg LAW

Obamacare Boost Expected From New Trump Administration Health Plans
Sara Hansard

Growing business interest in a new type of health-care arrangement is expected to boost Obamacare enrollment, lower costs, and ensure some employees stay covered during the pandemic, state exchange officials say.

Individual coverage health reimbursement arrangements (ICHRAs) allow employers to reimburse their workers tax-free for individual health insurance that they purchase on the exchanges. The Trump administration created ICHRAs through regulation in an effort to provide cheaper, alternative health options for consumers.

Businesses are finding that they can save themselves and their employees money by using ICHRAs to fund individual plans in the Affordable Care Act market, Kevin Patterson, CEO of Connect for Health Colorado, the state's health insurance marketplace, said. That in turn is expected to lead to more ACA enrollment through the exchanges, rather than in insurance plans that companies have traditionally funded.

"They can at least come through with an ICHRA and actually find something that we would help them find on the exchange," Patterson said. "That's a way to actually grow the individual market pool," which keeps premiums competitive, he said.

Individual plans are likely more affordable for employers than having to cover each employee through small group health insurance plans, industry officials say. With so many businesses struggling to survive during the Covid-19 crisis, ICHRAs offer them an opportunity to keep workers insured.

"We're definitely seeing some interest" in ICHRAs from companies with 10 to 300 employees, particularly in areas where small group premiums rose in 2020 and individual rates are falling, Catherine Perez, co-founder and chief product officer of health insurance web broker HealthSherpa, said.

"We're mostly seeing that kind of really take off on the small group side," she said.

HealthSherpa, based in Sacramento, Calif., handled more than 15% of the volume on the federal HealthCare.gov marketplace during the open enrollment period for 2020.

Affordable Alternative

Under a health reimbursement arrangement, employers can set up accounts for workers to use for out-of-pocket medical expenses. The administration's regulation expanded employers' ability to offer those accounts by creating ICHRAs, which can be used to buy individual insurance coverage. The regulation applies to the 2020 plan year and beyond.

The new arrangement can be an affordable alternative for large and small companies to retain coverage for employees as they grapple with how to maintain their businesses during the Covid-19 pandemic, said Heather Korbulic, executive director of Silver State Health Insurance Exchange, which operates Nevada Health Link.

Millions of people throughout the country are losing job-based health insurance during the crisis. ICHRAs can't help those who lost their jobs, but they can help those who are still employed yet face the risk that their employers won't have enough funds to keep their insurance going, Korbulic said.

"What we're really trying to do at Nevada Health Link is show up for these people in a way that allows for us to not only capture them when they fall off of their employer-sponsored insurance, but to also show up for companies," Korbulic said.

The Nevada exchange is training brokers and navigators, who help people enroll in ACA plans, to understand ICHRAs and has posted information about them on its website. About 77,000 people enrolled in Nevada's individual exchange as of early this year, she said.

"We want to help businesses that are willing to offer their employees ICHRAs an opportunity to learn about them now and see if that might end up being a savings for them," Korbulic said.

Making the Switch

Small businesses and nonprofits in Colorado, among other states, are already planning to offer ICHRAs to their employees.

Team Summit Colorado, a nonprofit youth development organization based in Frisco that coaches skiers and snowboarders for competition, will cover its employees through an ICHRA in October, executive director C.B. Bechtel said.

Bechtel said he expects the company can expand its health insurance coverage to 16 employees for about the same $30,000 a year that it now spends on an Anthem small group plan covering seven employees.

Employees can choose their own plan on the state exchange or they can buy an ACA-compliant plan through a broker, Bechtel said. Most will likely use the state exchange because it will give them more choices, he said.

Peak Health Alliance in Keystone, Col., a health-care purchasing collaborative that negotiates rates with providers and insurers, is also turning its focus from small group plans to ICHRAs, according to CEO Tamara Pogue.

The alliance offered a small group product in partnership with Rocky Mountain Health Plans this year that cost about 15% less than prior small group plans, Pogue said. “But what we heard from our small employers was that that still was not enough of a decrease to actually make health insurance attainable,” she said.

Premiums in the individual market in one county of western Colorado are 20% less than per-employee costs for small group plans, Pogue said. For 2021, Peak Health Alliance will only offer individual plans to members rather than small group plans, she said.

“The way small businesses can access those plans is through ICHRAs.” Pogue said. “Preliminarily we’re hearing a great deal of interest.”

POLITICO

Biden wants to restore Obamacare. He may have trouble.
Susannah Luthi

Joe Biden may not be able to unwind everything President Donald Trump has done to diminish Obamacare.

Despite Trump’s failure to repeal Obamacare, he’s forced changes on the health care system that Biden will find hard to immediately reverse, if at all. Trump’s expansion of skimpier health insurance alternatives to Obamacare, curbs on reproductive health funding and rollback of contraception coverage have been upheld in the courts. Efforts to reverse those policies are likely to draw legal battles in a court system that will bear the imprint of Trump’s conservative appointees for years.

And it’s no sure bet that Biden’s plan to build on Obamacare has a clear path in Congress, especially if Republicans keep their hold on the Senate. The unrelenting partisan divide over Obamacare has left lawmakers unable to make minor fixes to the law a decade since its passage, let alone a major revamp of how Americans get coverage. Powerful health care lobbies, despite backing Biden’s call for more Obamacare funding, have been preparing a ferocious assault against the public option, a centerpiece of Biden’s health plan.

Biden’s campaign and Democratic strategists insist that the coronavirus emergency, which has left millions more jobless and lacking health insurance, has boosted support for comprehensive legislative action on health care. “The pandemic has made clear to people how important it has to have consistent health coverage,” said Biden policy adviser Stef Feldman.

But Democratic health care experts are also zeroing in on quicker, unilateral fixes that may let Biden navigate around a potentially paralyzed Congress to beef up health care coverage. In the face of congressional intransigence, both Trump and former President Barack Obama wielded executive power to influence the health care system with varying degrees of success.

“I think [Biden] will want to do what he can by legislation and otherwise look to regulations to fulfill his promises and try to reshape the health care system,” said Henry Waxman, a longtime former Democratic lawmaker who helped write Obamacare and now runs a lobbying firm.

Here’s how those experts think Biden could push forward his health agenda without Congress — and where he may have trouble reversing Trump policies.

Bolstering Obamacare

Biden’s campaign said it is already considering immediate steps to get more people covered during a pandemic that’s expected to stretch into next year, even if by his inauguration there’s an approved coronavirus vaccine that’s just starting to reach people. Biden could take emergency action Trump has rejected, like broadly reopening Obamacare’s insurance marketplaces to the uninsured and restoring funds for enrollment outreach that Trump gutted. Those measures would be relatively easy to push through.

Kavita Patel, a Brookings Institution fellow who advised Kamala Harris' presidential campaign on health care, also suggested Biden may be able to use emergency powers — the same powers Trump used for border wall construction — to temporarily fund more subsidies to help make health insurance more affordable.

However, cutting off a Trump-backed alternative to Obamacare health plans may be more difficult. Trump two years ago issued rules greatly expanding the availability of short-term health insurance plans, which are typically cheaper than Obamacare plans because they cover fewer benefits and typically don’t cover preexisting conditions. Republicans say the plans provide an affordable alternative to people priced out of Obamacare coverage, but Democrats contend they provide only the illusion of coverage and would undermine the Obamacare marketplaces.

A federal appeals court this summer upheld the Trump short-term plan rules, finding that the policy didn't conflict with Obamacare. Biden's efforts to reverse Trump's expansion would likely draw a challenge. Hundreds of thousands of people are believed to have enrolled in the expanded short-term plans.

"The argument was expanding short-term plans is going to hurt the exchanges, and that just hasn't been the case," said Brian Blase, a former Trump health policy adviser who helped shape the administration's short-term plan policy.

Democrats may also look curtail short-term plans through legislation. A House-approved bill this summer included a provision striking down Trump's expansion of short-term plans, but it went nowhere in the GOP-led Senate.

The biggest wild card remains a looming Supreme Court case involving a GOP-backed challenge to Obamacare. The justices, who will hear the case exactly one week after Election Day, aren't likely to throw out the entire law when they render a verdict, likely early next year. However, legal observers say it's possible the conservative-leaning court could pick apart coverage protections for preexisting conditions, which could force a major scramble to shore up the insurance markets.

Medicaid work rules

Trump's approval of the first-ever Medicaid rules requiring some people to work or volunteer as a condition of coverage were a major victory for conservatives who opposed Obamacare's massive expansion of the safety net program to poor adults. However, after court rulings against work rules, the policies have been on hold in the roughly dozen, predominately GOP-led states that had received permission from the Trump administration.

The work rules aren't entirely dead yet, though. The Supreme Court is expected to soon decide whether to hear the administration's request to revive them. Legal experts are skeptical the justices will take the case, given the strong decisions against the work rules in lower courts. But if they do, and the Supreme Court's conservative majority upholds the work rules, the states that have already won approval from the Trump administration could insist on keeping them — even if Biden's administration would forbid additional states from implementing the policy.

Meanwhile, Biden is resolved to extend coverage to millions of poor adults who have been shut out of Medicaid expansion in the dozen states that have refused the program. His public option plan would automatically provide zero-premium coverage to poor adults in those Medicaid expansion holdout states.

Should he fail to get the public option through Congress, Biden is likely to explore policies that could help convince conservative governors to expand Medicaid, a former Obama administration official said.

“If one door closes, he’ll look at others,” the official said.

Culture wars

A Biden administration would face pressure from Democratic-aligned groups to eradicate a slate of socially conservative health care policies advance by the Trump administration. That’s not likely to happen quickly, given the slow pace of overhauling regulations and lawsuits likely to follow.

The Supreme Court this summer upheld the Trump administration’s sweeping exemption from the contraceptive coverage mandate under Obamacare. The decision, which lets employers broadly claim a religious or moral exemption to providing free birth control to female employees, could result in 126,000 women losing contraceptive coverage.

The case was the third time the coverage mandate came before the Supreme Court since 2014, and its liberal wing suggested that the matter hasn’t been entirely settled.

Biden will also seek to reverse Trump’s decision to cut out Planned Parenthood and other abortion providers from the $250 million-plus Title X family planning program. Planned Parenthood, which was the single-largest recipient of Title X funding, and some states withdrew after Trump’s restrictions took effect.

Trump’s rollback of anti-discrimination rules for transgender patients — as well as his broad protections for doctors, hospitals and others who refuse to perform abortions, gender transitions or other services that violate their conscience — are all embroiled in litigation that promise to drag out for years. Biden’s expected reversals of these regulations would invite more legal challenges from red states.

"[California Attorney General Xavier] Becerra is celebrating the 100th lawsuit against Trump — [Texas AG Ken] Paxton will be just as excited,” said Katie Keith, a health law professor at Georgetown University. “Republicans won’t be any less litigious, and then you remember the 200 judges Trump has appointed — whatever challenges will be argued before arguably more sympathetic judges.”

Immigration

Biden plans to wipe away one of Trump's most bitterly contested immigration policies, which could limit health care coverage and other public benefits for groups hit especially hard by the pandemic.

The administration's "public charge" rule, which makes it harder for immigrants who rely on Medicaid, food stamps and other programs to get permanent residency status, has been in effect since early this year, even as Democratic attorneys general and immigration advocates battle the policy in court. It's unclear how many people may be affected by the rule, but advocates said it discouraged some immigrants to seek out

benefits even before it took effect. About 20 percent of immigrants with children said they had skipped food stamps, Medicaid or housing subsidies because they feared losing out on a green card, according to an Urban Institute analysis last year.

Medicaid law expert Sara Rosenbaum of George Washington University said Biden could freeze the public charge rule in light of the pandemic while rewriting it — though that's likely to spark another legal battle from the right. The Trump administration already said it would partially ease enforcement during the pandemic, declaring that an immigrant's status wouldn't be affected by seeking out Covid-19 care.

“Quite frankly, Trump showed us the way,” Rosenbaum said.

Bloomberg
GOVERNMENT

Ballooning Ranks of Uninsured Endanger GOP Health-Care Message
Alex Ruoff

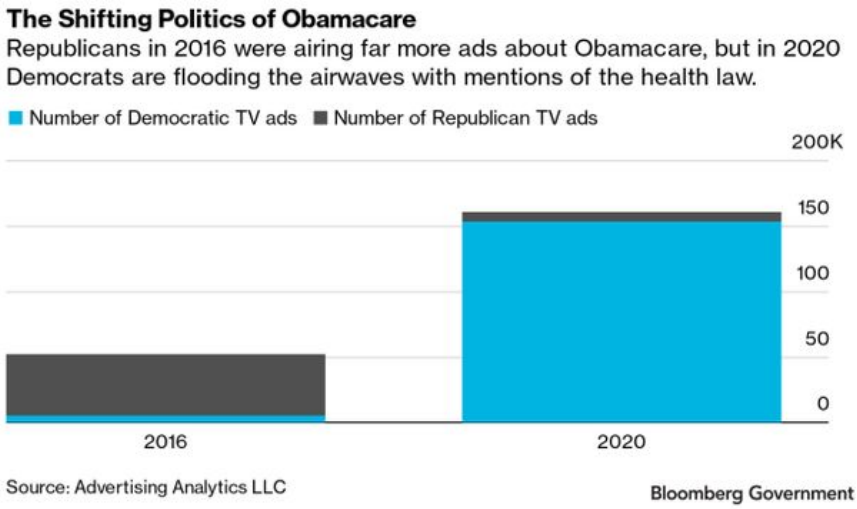
The number of Americans without health insurance has grown steadily under the Trump administration and it’s creating headaches for Republicans who once championed efforts to roll back Obamacare.

Republican leaders Tuesday unveiled a policy platform centered around defeating the coronavirus and improving the economy, with no mention of their long-time pledge to roll back the Affordable Care Act. Democrats, in contrast, are sticking with the message that won them a House majority in 2018: a promise to extend health-insurance coverage to more Americans through the ACA.

Health-care politics this year is almost a polar opposite of 2016, when the U.S. hit an all-time low in the number of people without insurance coverage. Democrats are hoping this shift will win over voters uneasy about being able to afford health care.

“Fewer people insured means a lot more anxious voters,” said Leslie Dach, chair of Protect Our Care, a group aligned with Democrats that advocates for Obamacare. “The loss of coverage and the fear of loss of coverage is a big deal in a Covid world.”

Almost 30 million Americans lacked health insurance at some point in 2019, an increase of 1 million people from 2018, according to Census data released Tuesday. The number of insured people declined in 19 states, most of which have congressional delegations largely made up of Republicans, such as Texas, Oklahoma, and Wyoming.



Rise in Uninsured

As many as 6 million Americans may have lost their insurance as the coronavirus shuttered businesses and swelled the jobless ranks this year, the Economic Policy Institute estimated.

During the 2016 election, Republicans aired 47,000 political ads mentioning the ACA or Obamacare compared with Democrats who aired just 5,000 such ads, according to the ad-tracking firm Advertising Analytics. In 2020, Republicans aired 7,000 spots mentioning the health-care law while Democrats aired 153,000 such ads.

President Donald Trump's administration, supported by Republicans in Congress, has contributed to eroding the number of people who have insurance by spending less on promoting the ACA's annual open enrollment season, by supporting restrictions on Medicaid coverage, and by ending the penalty for failing to have coverage, Larry Levitt, executive vice president for health policy at the Kaiser Family Foundation, said.

Repealing Obamacare was an early goal of the Trump administration in 2017 and a main party pledge for Republicans at the time. However, after an unsuccessful push to overturn the health law by Congress, the ACA remained popular. Democrats capitalized on that popularity in the 2018 midterm elections, when they won control of the House after campaigning on health-care issues.

Preexisting Conditions

Some Republicans seeking re-election are trying to walk a delicate line, as their party has more Senate seats to defend in November. Sen. Cory Gardner (R-Colo.) in August introduced a bill (S. 4506) that promises to maintain the ACA's protections for people with preexisting health conditions.

In an ad unveiled this week, Gardner says his bill would keep the protections “no matter what happens to Obamacare.”

Sen. David Perdue (R-Ga.) similarly launched an ad in August that said he supports preexisting condition protections. Perdue and Gardner both backed efforts to roll back Obamacare and its preexisting condition protections, which are stronger than those offered under the Gardner bill.

These ads are meant to tell voters they can keep the parts of Obamacare they like and also get something less expensive under Republican policies, Ford O’Connell, a GOP strategist who served as an adviser on the late Sen. John McCain’s 2008 presidential bid, said.

“Most voters don’t know what Obamacare entails but they know its most-popular provision, which is preexisting conditions,” O’Connell said.

Republican leaders this week said they’re focused on the economy and combating the coronavirus pandemic by accelerating development of a vaccine. They’re aiming to showcase gains in household income under the Trump administration as a sign people are better off voting Republican.

“Republicans will restore our way of life,” Kevin McCarthy (R-Calif.), the House Republican leader, told reporters Tuesday. “We will defeat the coronavirus.”

Column: GAO finds the selling of junk health plans favored by Trump is rife with deception
Michael Hiltzik

One of the great features of the Affordable Care Act is that it clearly sets forth its consumer protection features, making it harder for unscrupulous health plan marketers to cheat the public.

It has been well understood that the Trump administration’s energetic promotion of ACA-exempt health plans has the capacity to undermine this crucial safeguard.

Now the Government Accountability Office has put meat on the bones of that expectation, with a report detailing how its undercover staff were repeatedly misled by health plan sales representatives in sales calls.

Among other deceptions, sales reps repeatedly told the GAO agents that their plans would cover their preexisting diabetes. The plans, in fact, excluded coverage, limited its value, or required lengthy waiting periods before the coverage would kick in.

Trump has consistently claimed that he has a plan coming out that will guarantee coverage of people's preexisting medical conditions.

Based on the fact that he has never released any such plan despite promises that it's imminent, and based on his support of a red-state lawsuit that would extinguish the ACA in its entirely, that claim is a flagrant lie.

The GAO's experience with sales representatives of exactly the kinds of health plans Trump and his minions, such as Health and Human Services Secretary Alex Azar, are pushing on the American public exposes the deception at the heart of Trump's promise.

We've reported before on the administration's drive to weaken the standards imposed by the ACA by promoting noncompliant health plans, through executive orders and proposed regulatory changes.

For example, the White House has pushed to liberalize the rules governing short-term health plans, which are traditionally designed as a bridge between full-service health insurance and are meant to last a few months at most; Trump has moved to extend their terms to as long as a year and allow them to be renewed.

Trump also has proposed liberalizing the rules governing faith-based health plans. These "sharing plans" are arrangements that don't guarantee that enrollees' claims will be paid at all.

The Trump pitch is that these plans carry lower premiums or payments, so they're more affordable for lower-income households.

What the administration doesn't make very clear is that the plans are not required to offer all the essential health benefits required of ACA-compliant plans, including hospitalization, maternity care, prescriptions and mental health services.

If your needs fall into any of those categories, you may find yourself on your own. In other words, the supposed savings may be entirely illusory.

Because these details are murky, consumers seeking such plans can be easily misled. That's what the GAO documented.

The GAO's investigation was prompted by a request from Democratic Sens. Bob Casey of Pennsylvania and Debbie Stabenow of Michigan. The agency's undercover staff contacted 31 marketers of ACA-exempt plans while posing as potential customers with low incomes and preexisting diagnoses of diabetes.

Of the 31 targets, 21 properly steered the callers to ACA-compliant plans that would cover their diabetes. Some also explained that the callers' income would make them eligible for government subsidies that would bring their insurance costs down.

Of the 10 others, however, two provided inconsistent or confusing information about what the GAO agents were buying. The other eight sales calls were even more troubling.

In all eight cases, the sales representatives told the callers that their diabetes would be covered, even though plan documents the GAO later received made clear that diabetes would be excluded as a preexisting condition, wouldn't be covered for 12 months, or that the plan limited the number of covered doctor visits.

In one case, the sales rep filled out the coverage application for the caller, falsely stating on the application that the caller had not been treated for or diagnosed with diabetes for the past five years. This salesperson also falsely told the caller that the plan's limitations on coverage of preexisting conditions applied only to pregnancy or cancer cases.

That salesperson also falsely told the caller that the ACA was no longer in effect as of this year.

Some sales representatives refused to provide the callers with plan documents until they signed up.

The agency cautions that its investigative results "cannot be generalized to all sales representatives, any particular state, or the PPACA-exempt industry at large," using the ACA's formal designation as the Patient Protection and Affordable Care Act. It refers to the sales pitches neutrally as "potentially deceptive marketing practices."

But the GAO also makes the consequences of this behavior plain: "Potentially deceptive sales practices ... could lead a consumer to make poor decisions with the potential to incur significant and unexpected costs if plans purchased do not meet their health coverage needs."

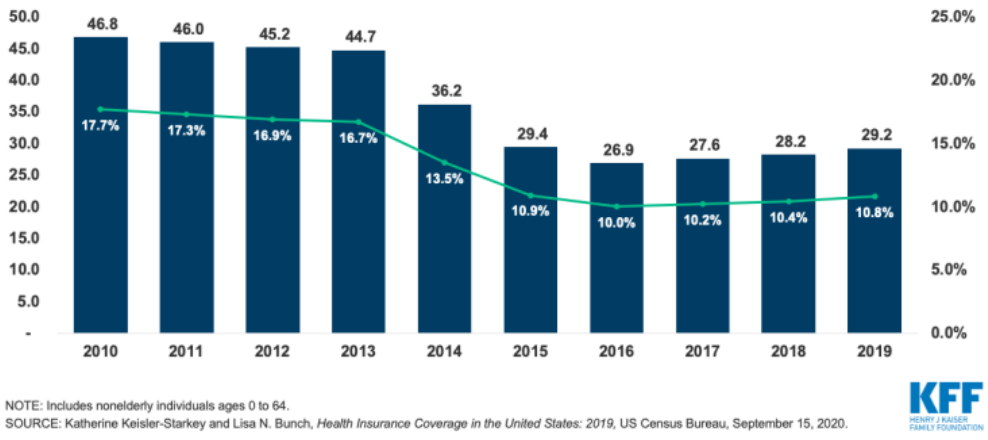
No kidding? The Trump administration's strategy from the moment it took office is to undermine the Affordable Care Act by promoting alternative coverage that barely ranks as coverage at all. The GAO's report shows what consumers face when they step into this tank of sharks.

What We Do and Don't Know About Recent Trends in Health Insurance Coverage in the US
Rachel Garfield and Jennifer Tolbert

The usually highly anticipated release of the Census Bureau's annual health insurance estimates, which occurred this past Tuesday for 2019 data, felt a bit different this year. While researchers and policymakers are accustomed to dealing with somewhat outdated data from federal surveys, the unprecedented social and economic changes that have occurred since the data were collected amplified the time lag and made the estimates seem even older than in past years. Current data on insurance coverage in the US is needed to design an adequate response to the pandemic and economic crisis, but the 2019 estimates still provide a useful baseline for interpreting what's happening during the pandemic.

Prior to the pandemic, the uninsured rate had been increasing incrementally for several years despite an improving economy. After historic declines in the number of uninsured people and the uninsured rate following the adoption and implementation of the 2010 Affordable Care Act (ACA), resulting in nearly 20 million more people covered through 2016, the number and rate of nonelderly uninsured people began to increase in 2017. The uninsured count grew from 26.7 million (10.0%) in 2016 to 27.6 million (10.2%) in 2017, 28.2 million (10.4%) in 2018, and, as was announced this week, 29.2 million (10.8%) in 2019 (Figure 1).

Figure 1



The 2.3 million person growth in the number of uninsured occurred despite improvements in several household economic measures, including median household income, earnings, and poverty and despite small gains in employer-based coverage over this period, which were offset by declines in Medicaid and direct purchase coverage. This pattern likely reflects a combination of factors, including rollback of outreach and enrollment efforts for ACA coverage, changes to Medicaid renewal processes, public charge policies, and elimination of the individual mandate penalty for health coverage. Notably, recent declines in coverage have occurred among both adults and children.

Because most people in the US still get their health coverage as a fringe benefit of a job, the recent economic downturn may disrupt coverage for millions of people. The economic fallout of the coronavirus pandemic has led to historic levels of job loss, with over 50 million people filing for unemployment insurance benefits since March 21st. Prior to the pandemic, nearly six in ten nonelderly people in the US received their health coverage through their job or a family member's job. Early KFF estimates of the implications of job loss found that nearly 27 million people were at risk of losing employer-sponsored health coverage due to job loss. Other modeled estimates similarly predict millions losing employer health coverage, though the scale varies somewhat. Many of these people may have retained their coverage, at least in the short term, under furlough agreements or employers continuing benefits after layoffs. Indeed, recent KFF analysis of enrollment in the fully-insured group market found that enrollment in that market declined by just 1.3% from March to June 2020. Employer-based insurance losses could mount if unemployment remains high.

The availability of health coverage through the Affordable Care Act during this economic downturn means people losing their coverage have other options, but policy actions to scale back the ACA may mean people are unaware of or have difficulty accessing that coverage. Expanded coverage through Medicaid in the 37 states that have implemented the Medicaid expansion along with the availability of subsidized and unsubsidized coverage through the Marketplaces will enable many people losing their job-based insurance to retain health coverage. Following enrollment declines in 2018 and 2019, recent data indicate Medicaid enrollment increased by 2.3 million or 3.2% from February 2020 to May 2020. Additionally, as of May 2020, enrollment data reveal nearly 500,000 people had gained Marketplace coverage through a special enrollment period (SEP), in most cases due to the loss of job-based coverage. The number of people gaining Marketplace coverage through a SEP in April 2020 was up 139% compared to April 2019 and up 43% in May 2020 compared to May 2019. While millions of people are gaining coverage through Medicaid and the Marketplaces, reductions in outreach and enrollment assistance have reduced the availability of on-the-ground assistance for consumers who have lost coverage meaning many others may not be enrolling because they are not aware this coverage is available or don't know how to enroll.

The pandemic has disrupted not only people's health coverage but also the ability of federal surveys to measure coverage. Understanding real-time changes in insurance coverage is a key input into policy actions to address the implications of the pandemic on people's health and well-being. However, to date, limited data is available on this

topic. Large national surveys—those typically used as the basis for such information—are lagged, with the most recent data reflecting the first quarter of 2020, just prior to the pandemic. Many real-time surveys have faced challenges of high rates of survey nonresponse (not responding to the survey at all) particularly among populations most likely affected by the economic downturn, or unusually high rates of item nonresponse (skipping particular survey questions). In the Census Bureau's Household Pulse Survey, designed to provide quick turnaround data on issues related to the pandemic, most weeks had a larger number of responses of "don't know" or "did not report" to the question about health coverage than the number of uninsured. These measurement challenges may reflect people's confusion about their current coverage amidst layoffs and job uncertainty or operational challenges in administering surveys that ask about health coverage (e.g., inability to conduct in person surveys).

While current survey data is limited and administrative and claims data are showing only moderate shifts in coverage, it is likely that large shifts in health coverage in the US are underway or imminent given loss of employment in recent months. It is possible that many of the people in families experiencing job loss were already uninsured, but given that prior to the pandemic the uninsured population in a family with a full-time worker totaled 20.2 million, there are still people among the 50 million who filed for unemployment benefits that may lose their employer coverage if they do not regain their jobs. In the midst of a health and economic crisis, the gap in real-time data to assess changes in health coverage poses a challenge.

Without Ginsburg, Supreme Court Could Rule Three Ways on Obamacare
Sarah Kliff and Margot Sanger-Katz

The death of Justice Ruth Bader Ginsburg means the Supreme Court will have a smaller liberal wing when it hears the latest Obamacare challenge in November.

That case, California v. Texas, could unwind Obamacare completely if the Supreme Court rules in favor of 20 Republican-led states and the Trump administration's Justice Department. The Democratic nominee for president, Joseph R. Biden Jr., has already begun linking the court vacancy to Obamacare's future, telling a crowd in Philadelphia this weekend that "health care hangs in the balance" with this year's election. A more conservative court may invite further litigation against the health law, which has faced multiple Supreme Court challenges in its decade-long existence.

Those who have followed the case for years, however, do not expect the Affordable Care Act to be overturned with this case. "Replacing Ginsburg could have big effects in lots of areas," said Jonathan Adler, a law professor at Case Western Reserve University. "I'm just not sure this case is one of them."

The case centers on changes that Congress made to the health law as part of its 2017 tax bill. That law eliminated financial penalties associated with Obamacare's mandate that Americans obtain health insurance.

The plaintiffs argue that the mandate becomes unconstitutional without those fines and that, if the court agrees, the rest of the law must come down with it. In legal terms, they make the case that the mandate is "inseverable" — so crucial to Obamacare that the law, including a provision banning insurers from rejecting patients with pre-existing conditions, cannot stand without it.

When experts make their best guesses on California v. Texas, they see three possible outcomes: a ruling in the law's favor, a deadlocked vote or a decision that takes down Obamacare. The first two generally seem more likely than the third.

The conservative justices are not persuaded

Just because many Republican-led states and the Republican White House have brought this case does not mean that Republican-appointed justices on the court will take their side. A majority of the court may still uphold the A.C.A.

That's because many scholars see the case as legally weak. Unlike the two previous cases involving the health law — when the court's liberal and conservative justices tended to disagree on major legal issues — this case centers on areas of law that are less disputed and less ideological.

A majority of the justices could rule that the mandate, now lacking a penalty, is unconstitutional. But, alone, such a finding would have no practical effects. What matters more is what happens to the rest of the law if the mandate is overturned.

Chief Justice John Roberts and Justice Samuel Alito have ruled in several recent cases that courts should try to preserve existing laws as much as possible when eliminating problematic provisions. And Justice Brett Kavanaugh wrote a majority opinion this term — while the Texas case was pending — agreeing with such reasoning.

"The court presumes that an unconstitutional provision in a law is severable from the remainder of the law or statute," Justice Kavanaugh wrote in the majority opinion upholding a congressional ban on robocalls. (He was joined by Justice Alito and Chief Justice Roberts.)

His opinion says the court's duty should be "to salvage rather than destroy the rest of the law passed by Congress and signed by the president."

Mr. Adler is one of many legal scholars who supported earlier legal efforts to overturn the Affordable Care Act but who have sided with the law's defenders on this case. In considering possible outcomes, he said he would not rule out a unanimous decision upholding the law.

There's a deadlock, postponing a judgment

The Supreme Court is scheduled to hear oral arguments in California v. Texas on Nov. 10. If a new justice is not confirmed and seated by then, the case will be decided by the remaining eight members. A ninth justice who joined the court after oral arguments but before a decision would still not cast a vote.

An eight-member court raises the possibility that California v. Texas could end in a tie at the Supreme Court. When that happens, the appellate court's decision typically stands. But in this instance, the appellate court did not rule on the key issues in the case; it ruled instead to send the case back to the original trial judge in Texas for more analysis.

The group of Democratic states defending the health law rushed it to the Supreme Court anyway, arguing that the court could end the "uncertainty already caused by this litigation." That means that a tie could lead to years of litigation as the case is re-argued, potentially resulting in another Supreme Court hearing years from now. The health care law would be left standing in the meantime, with the justices skirting a political controversy in the short term.

"The advantage is there is no opinion, just a one-sentence ruling saying the lower court is affirmed," said Josh Blackman, a law professor at South Texas College of Law who has submitted an amicus brief on behalf of the challengers. "They don't weigh the issues. You don't know why they ruled the way that they ruled."

Such a tie would most likely occur if Chief Justice Roberts sides with the court's three Democratic appointees, and the other Republican-appointed justices vote the other way. Barring a recusal, a tie would not occur if a new justice were seated before November, bringing the number of justices back to nine. But there is a chance a majority of the justices simply affirm the appellate court's ruling, sending the case back through the process again in the same way.

Obamacare is overturned, in whole or in part

Though many legal observers predict Chief Justice Roberts will find against the Republican states, the Supreme Court was controlled by five Republican-appointed justices even before Justice Ginsburg's death. That is why advocates for the Affordable Care Act and Democratic politicians have been concerned about this case all along.

"It is still unlikely to prevail, but the small chance of a very bad thing happening is worth worrying about," said Nicholas Bagley, a law professor at the University of Michigan, who supports Obamacare.

There are a few different ways such a decision might work. Texas and the Trump administration have asked the court to overturn the entire Affordable Care Act. The Supreme Court could make such a ruling. But it's also possible the court will rule to overturn some parts of the health law while leaving others untouched. Early in the litigation, the Trump administration's lawyers suggested leaving most of Obamacare

intact, but eliminating the provisions providing protections for Americans with pre-existing health conditions, for example.

Any such ruling would have major practical and political effects. The Affordable Care Act is a complex law with tentacles across nearly every area of health policy — including state Medicaid funding; Medicare beneficiaries' drug costs; and F.D.A. approvals for generic-like copies of biologic drugs.

But even a ruling that only touched pre-existing conditions would have huge effects, especially during a pandemic when so many Americans have lost their job-based insurance.

That resulting chaos may also weigh on the justices. Amy Howe, a co-founder of Scotusblog, said a group of justices that includes Chief Justice Roberts and Justice Kavanaugh are concerned about the reputation of the Supreme Court as an institution.

"This is happening in such a fraught time, right after Election Day," she said. "I do think the politics of the moment are not even at the back of their minds, but in the middle of their minds."

If the court did amend Obamacare, the government could pass new legislation to restore coverage options, and any new policy would most likely take different forms depending on who controls the White House and Congress. Mr. Biden supports creating a public option — more people could get government insurance, but only if they want it — while the Trump administration has repeatedly promoted a "wonderful plan" for health care while releasing no details.

A less ambitious Congress interested in preserving the health law could also resurrect it by restoring a penalty for people who don't buy insurance — even one as low as $1.

If the Supreme Court Ends Obamacare, Here's What It Would Mean
Reed Abelson and Abby Goodnough

What would happen if the Supreme Court struck down the Affordable Care Act?

The fate of the sprawling, decade-old health law known as Obamacare was already in question, with the high court expected to hear arguments a week after the presidential election in the latest case seeking to overturn it. But now, the death of Justice Ruth Bader Ginsburg increases the possibility that the court could abolish it, even as millions of people are losing job-based health coverage during the coronavirus pandemic.

A federal judge in Texas invalidated the entire law in 2018. The Trump administration, which had initially supported eliminating only some parts of the law, then changed its position and agreed with the judge's ruling. Earlier this year the Supreme Court agreed to take the case.

Mr. Trump has vowed to replace Justice Ginsburg, a stalwart defender of the law, before the election. If he is successful in placing a sixth conservative on the court, its new composition could provide the necessary five votes to uphold the Texas decision.

Many millions more people would be affected by such a ruling than those who rely on the law for health insurance. Its many provisions touch the lives of most Americans, from nursing mothers to people who eat at chain restaurants.

Here are some potential consequences, based on estimates by various groups.

133 MILLION

Americans with protected pre-existing conditions

As many as 133 million Americans — roughly half the population under the age of 65 — have pre-existing medical conditions that could disqualify them from buying a health insurance policy or cause them to pay significantly higher premiums if the health law were overturned, according to a government analysis done in 2017. An existing medical condition includes such common ailments as high blood pressure or asthma, any of which could require those buying insurance on their own to pay much more for a policy, if they could get one at all.

The coronavirus, which has infected nearly seven million Americans to date and may have long-term health implications for many of those who become ill, could also become one of the many medical histories that would make it challenging for someone to find insurance.

Under the A.C.A., no one can be denied coverage under any circumstance, and insurance companies cannot retroactively cancel a policy unless they find evidence of fraud. The Kaiser Family Foundation estimated that 54 million people have conditions serious enough that insurers would outright deny them coverage if the A.C.A. were not in effect, according to an analysis it did in 2019. Its estimates are based on the guidelines insurers had in place about whom to cover before the law was enacted.

Most Americans would still be able to get coverage under a plan provided by an employer or under a federal program, as they did before the law was passed, but protections for pre-existing conditions are particularly important during an economic downturn or to those who want to start their own businesses or retire early. Before the A.C.A., employers would sometimes refuse to cover certain conditions. If the law went away, companies would have to decide if they would drop any of the conditions they are now required to cover.

The need to protect people with existing medical conditions from discrimination by insurers was a central theme in the 2018 midterm elections, and Democrats attributed much of their success in reclaiming control of the House of Representatives to voters' desire to safeguard those protections. Mr. Trump and many Republicans promise to keep this provision of the law, but have not said how they would do that. Before the law, some individuals were sent to high-risk pools operated by states, but even that coverage was often inadequate.

21 MILLION

People who could lose their health insurance

Of the 23 million people who either buy health insurance through the marketplaces set up by the law (roughly 11 million) or receive coverage through the expansion of Medicaid (12 million), about 21 million are at serious risk of becoming uninsured if Obamacare is struck down. That includes more than nine million who receive federal subsidies.

On average, the subsidies cover $492 of a $576 monthly premium this year, according to a report from the Department of Health and Human Services. If the marketplaces and subsidies go away, a comprehensive health plan would become unaffordable for most of those people and many of them would become uninsured.

States could not possibly replace the full amount of federal subsidies with state funds.

12 MILLION

Adults who could lose Medicaid coverage

Medicaid, the government insurance program for the poor that is jointly funded by the federal government and the states, has been the workhorse of Obamacare. If the health law were struck down, more than 12 million low-income adults who have gained Medicaid coverage through the law's expansion of the program could lose it.

In all, according to the Urban Institute, enrollment in the program would drop by more than 15 million, including roughly three million children who got Medicaid or the Children's Health Insurance Program when their parents signed up for coverage.

The law ensures that states will never have to pay more than 10 percent of costs for their expanded Medicaid population; few if any states would be able to pick up the remaining 90 percent to keep their programs going. Over all, the federal government's tab was $66 billion last year, according to the Congressional Budget Office.

Losing free health insurance would, of course, also mean worse access to care and, quite possibly, worse health for the millions who would be affected. Among other things, studies have found that Medicaid expansion has led to better access to preventive screenings, medications and mental health services.

People with opioid addiction getting treatment through Medicaid

The health law took effect just as the opioid epidemic was spreading to all corners of the country, and health officials in many states say that one of its biggest benefits has been providing access to addiction treatment. It requires insurance companies to cover substance abuse treatment, and they could stop if the law were struck down.

The biggest group able to get access to addiction treatment under the law is adults who have gained Medicaid coverage. The Kaiser Family Foundation estimated that 40 percent of people from 18 to 65 with opioid addiction — roughly 800,000 — are on Medicaid, many or most of whom became eligible for it through the health law. Kaiser also found that in 2016, Americans with Medicaid coverage were twice as likely as those with no insurance to receive any treatment for addiction.

States with expanded Medicaid are spending much more on medications that treat opioid addiction than they used to. From 2013 through 2017, Medicaid spending on prescriptions for two medications that treat opioid addiction more than doubled: It reached $887 million, up from nearly $358 million in 2013, according to the Urban Institute.

The growing insured population in many states has also drawn more treatment providers, including methadone clinics, inpatient programs and primary care doctors who prescribe two other anti-craving medications, buprenorphine and naltrexone. These significant expansions of addiction care could shrink if the law were struck down, leaving a handful of federal grant programs as the main sources of funds.

165 MILLION

Americans who no longer face caps on expensive treatments

The law protects many Americans from caps that insurers and employers once used to limit how much they had to pay out in coverage each year or over a lifetime. Among them are those who get coverage through an employer — more than 150 million before the pandemic caused widespread job loss — as well as roughly 15 million enrolled in Obamacare and other plans in the individual insurance market.

Before the A.C.A., people with conditions like cancer or hemophilia that were very expensive to treat often faced enormous out-of-pocket costs once their medical bills reached these caps.

While not all health coverage was capped, most companies had some sort of limit in place in 2009. A 2017 Brookings analysis estimated that 109 million people would face lifetime limits on their coverage without the health law, with some companies saying they would cover no more than $1 million in medical bills per employee. The vast majority of people never hit those limits, but some who did were forced into bankruptcy or went without treatment.

60 MILLION

Medicare beneficiaries would face changes to medical care and possibly higher premiums

About 60 million people are covered under Medicare, the federal health insurance program for people 65 and older and people of all ages with disabilities. Even though the main aim of the A.C.A. was to overhaul the health insurance markets, the law “touches virtually every part of Medicare,” said Tricia Neuman, a senior vice president for the Kaiser Family Foundation, which did an analysis of the law’s repeal. Overturning the law would be “very disruptive,” she said.

If the A.C.A. is struck down, Medicare beneficiaries would have to pay more for preventive care, like a wellness visit or diabetes check, which are now free. They would also have to pay more toward their prescription drugs. About five million people faced the so-called Medicare doughnut hole, or coverage gap, in 2016, which the A.C.A. sought to eliminate. If the law were overturned, that coverage gap would widen again.

The law also made other changes, like cutting the amount the federal government paid hospitals and other providers as well as private Medicare Advantage plans. Undoing the cuts could increase the program’s overall costs by hundreds of billions of dollars, according to Ms. Neuman. Premiums under the program could go up as a result.

The A.C.A. was also responsible for promoting experiments into new ways of paying hospitals and doctors, creating vehicles like accountable care organizations to help hospitals, doctors and others to better coordinate patients’ care.

If the groups save Medicare money on the care they provide, they get to keep some of those savings. About 11 million people are now enrolled in these Medicare groups, and it is unclear what would happen to these experiments if the law were deemed unconstitutional. Some of Mr. Trump’s initiatives, like the efforts to lower drug prices, would also be hindered without the federal authority established under the A.C.A.

Repealing the law would also eliminate a 0.9 percent increase in the payroll tax for high earners, which would mean less money coming into the Medicare trust fund. The fund is already heading toward insolvency — partly because other taxes created by the law that had provided revenue for the fund have already been repealed — by 2024.

2 MILLION

Young adults with coverage through their parents’ plans

The A.C.A. required employers to cover their employees’ children under the age of 26, and it is one of the law’s most popular provisions. Roughly two million young adults are covered under a parent’s insurance plan, according to a 2016 government estimate. If the law were struck down, employers would have to decide if they would continue to

offer the coverage. Dorian Smith, a partner at Mercer, a benefits consulting firm, predicted that many companies would most likely continue.

$50 BILLION

Medical care for the uninsured could cost billions more

Doctors and hospitals could lose a crucial source of revenue, as more people lose insurance during an economic downturn. The Urban Institute estimated that nationwide, without the A.C.A., the cost of care for people who cannot pay for it could increase as much as $50.2 billion.

Hospitals and other medical providers, many of whom are already struggling financially because of the pandemic, would incur losses, as many now have higher revenues and reduced costs for uncompensated care in states that expanded Medicaid. A study in 2017 by the Commonwealth Fund found that for every dollar of uncompensated care costs those states had in 2013, the health law had erased 40 cents by 2015, or a total of $6.2 billion.

The health insurance industry would be upended by the elimination of A.C.A. requirements. Insurers in many markets could again deny coverage or charge higher premiums to people with pre-existing medical conditions, and they could charge women higher rates. States could still regulate insurance, but consumers would see more variation from state to state. Insurers would also probably see lower revenues and fewer members in the plans they operate in the individual market and for state Medicaid programs at a time when millions of people are losing their job-based coverage.

1,000 CALORIES

Menu labels are among dozens of the law’s provisions that are less well known

The A.C.A. requires nutrition labeling and calorie counts on menu items at chain restaurants.

It requires many employers to provide “reasonable break time” and a private space for nursing mothers to pump breast milk.

It created a pathway for federal approval of biosimilars, which are near-copies of biologic drugs, made from living cells.

These and other measures would have no legal mandate to continue if the A.C.A. is eliminated.

The New York Times

America's Health Care Is Under Existential Threat
Andy Slavitt and Nicholas Bagley

Justice Ruth Bader Ginsburg's death could not have come at a worse time for the millions of Americans who get their health insurance through the Affordable Care Act.

One week after the election, the Supreme Court is scheduled to hear yet another case about whether the law is constitutional. The case was worrisome enough when Chief Justice John Roberts held the swing vote. But if President Trump succeeds in seating a new justice, the political gravity of the court will lurch even further to the right. A case that once looked like a Hail Mary would stand a real chance of success.

That means more than ever, health care is on the ballot. Joe Biden has already tied the battle over President Trump's Supreme Court appointee to the fate of health reform, and Democrats should keep banging that drum until Election Day.

What's at stake is not just the coverage that millions of Americans have gained through the new insurance exchanges and the Medicaid expansion but also the parts of the law that protect Americans with pre-existing conditions.

Other popular provisions hang in the balance, including those that guarantee preventive care with no out-of-pocket payments; end lifetime caps; allow kids to stay on their parents' insurance through age 26; and make vaccines free to patients. Even some key improvements to Medicare — including a reduction in prescription drug costs for beneficiaries — would be gone.

Overnight, if the Affordable Care Act is eliminated, we will return to the health care system of 2010 — all this as we battle a virus that has killed more than 200,000 Americans.

Indeed, contracting the virus is the ultimate pre-existing condition. The disease can bring with it mysterious complications and affect virtually every organ system, the immune system and even the limbs. Young, otherwise healthy people may find themselves uninsurable if the Affordable Care Act is struck down. Testing and contact tracing will also suffer if people become reluctant to disclose their illnesses, as happened routinely before Obamacare.

The lawsuit stems from Congress's tax cut legislation in late 2017, which ended the tax penalty for going without health insurance. The Affordable Care Act, however, still had language saying that people "shall" buy health insurance. Without the penalty, the "shall" instruction was meaningless — a vestige of an earlier version of Obamacare.

A group of red states led by Texas, however, built a tortured argument on top of that one word. By keeping “shall” while ending the penalty, they said, Congress must have meant to coerce people into buying insurance. And that kind of congressional coercion is unconstitutional. Furthermore, they claimed that the entire law must go because one part of it couldn’t be legally “severed” from another.

This whole line of argument is preposterous. Commentators and legal scholars on the left and right agree on that point. The Republican-controlled Congress didn’t vote to make the individual mandate more coercive than it was before. It voted to make it less coercive by scotching the only mechanism for enforcing it.

Instead of defending the law against the attack, however, President Trump decided to use the lawsuit as a vehicle for undoing the Affordable Care Act in the courts.

Yet even as President Trump has tried to eliminate Obamacare, the law has only grown in popularity. The more the law is threatened, the more the public realizes its value.

That’s why Republicans don’t want to talk about health care in this election. The topic typically ranks as the single most important issue for voters, who view Democrats more favorably on it. Indeed, Republican losses in the 2018 midterms were widely attributed to the party’s stance on health reform.

But President Trump’s support for a dangerous Supreme Court case offers a simple, clear way to explain to voters that Republicans are lying when they say they support protections for people with pre-existing conditions. The explanation will land with particular force in a country suffering from a botched response to the coronavirus pandemic.

Keeping health care in the news will also focus attention on all the other ways that the Trump administration has worked to make Americans feel less secure: imposing onerous paperwork requirements on Medicaid beneficiaries; crippling the health care exchanges; and sowing discord in the insurance markets. The percentage of Americans without health insurance has ticked up every year since President Trump took office.

The details are complicated. But the Supreme Court case is mercifully easy to grasp. The lawsuit poses an existential threat to the nation’s health care system, and President Trump should be judged for recklessly supporting it.

Democrats could put all of this nonsense to an end — but only if they win big in the election. The Supreme Court is scheduled to hear the case in November, but it won’t issue its decision until the spring.

If Mr. Biden wins the White House and Democrats take the Senate, they could pass a law that either imposes a financial penalty (even a $1 penalty) for not having insurance or wipes the “shall” language from the books. Such a law would make the lawsuit moot before the Supreme Court acts. But if the Republicans manage to hold on to the

presidency or either chamber, there is no guarantee the Affordable Care Act, its coverage or its protections will survive.

Passing a law would require Democrats to overcome a likely Republican filibuster — either by proceeding via a special procedure called reconciliation or by eliminating the filibuster. Depending on how the election breaks, however, Democrats may have the votes to do it.

Which is why this year's election will — yet again — be a referendum on health reform. In the coming weeks, the Affordable Care Act's supporters have a chance to highlight President Trump's opposition to protections for people with pre-existing conditions, to demonstrate that ending the law would be a calamity for millions of Americans and to prove that Republicans can't win elections if they relentlessly oppose the principle that everyone — sick and poor alike — is entitled to health coverage.

Column: The Supreme Court could kill protection for preexisting conditions. You should be terrified
Michael Hiltzik

President Trump is putting out the word that he has a plan to protect Americans with preexisting medical conditions from losing their health coverage, especially if the Supreme Court invalidates the Affordable Care Act.

It's possible that Trump will pull a rabbit out of his hat and produce something via executive order that would achieve that goal.

But the truth is that there's virtually nothing he can do by executive order to accomplish what he says he wants. It would take legislation, and the record of Trump's promises on healthcare, and those of Republicans on Capitol Hill who have made the same promises over the years, suggests that the smart way to bet is that this is a lie. Trump is gaslighting the public.

The GOP's past proposals invariably would have turned the clock on preexisting condition protections back to the Stone Age — that is, the period before the ACA's enactment in 2010. More on that in a moment.

The urgency of the goal has increased with the passing of Supreme Court Justice Ruth Bader Ginsburg, who was always a rock-solid vote to preserve the ACA. Almost certainly, Trump will nominate a new justice hostile to the healthcare reform law.

That's important, because the court has scheduled oral arguments Nov. 10 on a lawsuit brought by Texas and other red states seeking to invalidate the ACA in its entirety.

Legal scholars consider the grounds of the case to be absurd, but if another hard-right justice is confirmed in time to hear it, the ACA could be hanging by a thread. If no new justice is confirmed in time, a 4-4 tie on the Court would leave in place a lower court ruling that declared the ACA unconstitutional.

For millions of Americans, the paramount threat of an ACA invalidation would be the loss of its protection for people with preexisting conditions. This is important for all Americans for two reasons.

As the Kaiser Family Foundation observed in 2001, "anyone can find himself or herself in need of individual market coverage at some point in their lives," for reasons that include job loss, self-employment, early retirement, divorce or loss of a breadwinning spouse.

Second, the chance of having a preexisting condition increases with age. According to the foundation, an average of about 15% of those aged 18-24 have a preexisting condition, rising to 47% among those aged 60-64.

Let's add a third reason: the pandemic. A COVID-19 diagnosis or even a past infection could well be considered a preexisting condition for the purpose of applying for coverage. At the latest count, about 6.9 million Americans have been infected.

So let's take a look at the consequences of a loss of the ACA's protection. We don't have to look far, because the very business model of the pre-ACA individual insurance market was based on rejecting applicants based on their medical history, excluding coverage for their conditions, or jacking up premiums for them to the point that coverage was unaffordable.

Insurance companies instructed their agents and underwriters on whether to accept or reject applicants based on their medical histories.

The guidelines issued by Blue Shield of California ran to 25 pages. The "declinable conditions" — those for which applicants could be rejected without further medical review — included "adoption in progress," kidney stones, depression, arthritis and psoriasis.

These rejections weren't theoretical. In 2001, Georgetown University and the Kaiser Family Foundation ran a test by applying for coverage in the individual market from 19 insurers in eight local markets, on behalf of seven hypothetical applicants with health issues.

The ostensible conditions, one each, were hay fever, a knee injury, asthma (one child in a family), past cancer, depression, hypertension and HIV. Each putative enrollee made 60 applications.

Not a single applicant received 60 “clean” offers — acceptances without premium surcharges or coverage exclusions. “Alice,” the hay fever victim, received three clean offers, five outright rejections and 46 offers that excluded coverage of her hay fever or even any claim related to her upper respiratory system. Others demanded higher deductibles, premiums or other costs.

“Greg,” who was HIV-positive, was rejected by 100% of the insurers. “Denise,” a breast cancer survivor who had undergone a mastectomy, was rejected 26 times. Among insurers who accepted her, 18 excluded coverage for any cancer and 18 demanded higher premiums.

The “Crane” family, whose 12-year-old son “Colin” suffered from asthma, was accepted by all 60 insurers, but nine refused to cover Colin and 46 refused to cover his asthma or other respiratory claims.

Republicans know well that Americans rank protection for those with medical conditions more highly than any other feature of the ACA. So they’ve generally tried to pair their efforts to repeal the healthcare law with provisions preserving that protection. These so-called safeguards, however, have been thin gruel indeed.

Some have guaranteed protection only for those who maintain their insurance coverage without a break of, say, 60 days. In practice, that can be hard to achieve. Most Americans who have lost their coverage say it’s because they can’t afford to keep it, and nothing in the GOP proposals would help households get over the cost hump—unlike the ACA, which provides subsidies for millions of lower-income families.

Some proposals forbade insurers to reject applicants with medical histories, but didn’t prevent them from charging those customers more.

A proposal introduced in 2018 by Sen. Thom Tillis (R-N.C.) and nine other red-state senators was billed as the “Ensuring Coverage for Patients with Pre-Existing Conditions Act.”

As I noted at the time, this measure had a loophole that even the dimmest insurance company could drive a hearse through: While it prohibited insurers from rejecting applicants with preexisting conditions, it didn’t require that the insurer provide for treatment of the condition. An insurer couldn’t reject a cancer patient’s application for insurance — but could provide that patient with coverage for everything except cancer.

What does Trump have in store? Vice President Mike Pence hinted in a CBS News interview Tuesday that Trump plans to institute this all-important consumer protection via an executive order within the next few weeks, so that “those that are facing preexisting conditions … will not be denied coverage.”

These words were typically weaselly — they would accommodate Tillis’ act as well as all those other GOP proposals. But they wouldn’t provide the solid safeguards of the ACA, which prohibits any rejection of any applicant for coverage in the individual market, and

allows differentials in premium charges to be based only on an applicant's age (within strict limits) and for smoking.

Trump and Pence are almost certainly blowing smoke at you. If they were serious about protecting Americans, they would drop their challenge to the ACA. They're not. If they have their way, the prospect is that Americans seeking insurance in the individual market will face the terrifying prospect of being closed off from health coverage, because of their health.

Reopening the ACA debate is politically risky for GOP
Caitlin Owens

The sudden uncertainty surrounding the future of the Affordable Care Act could be an enormous political liability for Republicans in key states come November.

Between the lines: Millions of people in crucial presidential and Senate battlegrounds would lose their health care coverage if the Supreme Court strikes down the law, as the Trump administration is urging it to.

The chart above shows the number of people enrolled in the ACA's insurance marketplaces or covered through its Medicaid expansion.

These options have become especially important over the last six months, as millions of Americans lost their jobs — and thus their employer insurance — due to the pandemic.

And more than a quarter of non-elderly Americans have a pre-existing condition that insurers in the individual market could refuse to cover without the ACA, per the Kaiser Family Foundation.

The big picture: Republicans paid a steep electoral price for trying to repeal parts of the ACA in 2017. Republicans' lawsuit against the health care law, if it succeeds, would boot even more people off of their coverage and undo even more of the ACA's regulations.

What to watch: Several vulnerable Republicans, including Sens. Susan Collins, Martha McSally, and Cory Gardner,, represent purple states that expanded Medicaid and would therefore see steep coverage losses. And the broader fight over the Supreme Court has made it impossible to ignore those stakes.

"With the Court setting Nov 10 as the date for hearing California v. Texas, Republicans caught a break not having it front and center right before the election. Now it is very much front and center," said Rodney Whitlock, a former health aide for Sen. Chuck Grassley.

"Debates over protection of pre-existing conditions have generally not gone positively for Republicans in purple states/district," he added.

After years of promising his own health care plan, Trump settles for rebranding rather than repealing Obamacare
Toluse Olorunnipa

President Trump capped his fruitless four-year journey to abolish and replace the Affordable Care Act by signing an executive order Thursday that aims to enshrine the law's most popular feature while pivoting away from a broader effort to overhaul the nation's health insurance system.

The order declares it is the policy of the United States for people with preexisting health conditions to be protected, avoiding the thorny details of how to ensure such protections without either leaving the ACA, or Obamacare, in place or crafting new comprehensive legislation.

Trump announced the move during a trip to North Carolina, outlining his "vision" for revamping parts of the nation's health care. During the speech, which came shortly before a campaign swing to Florida, Trump barely veiled the political nature of his intent.

"The historic action I'm taking today includes the first-ever executive order to affirm it is the official policy of the United States government to protect patients with preexisting conditions," Trump said, despite the fact such protections are already enshrined in law. "We're making that official. We're putting it down in a stamp, because our opponents, the Democrats, like to constantly talk about it."

The speech and executive order stood as a tacit admission that Trump had failed to keep his 2016 promise to replace his predecessor's signature achievement with a conservative alternative. For a president who campaigned in 2016 pledging to "repeal and replace" the ACA, Trump's 2020 signature health-care speech instead expressed a willingness to keep the law largely in place. Unable to repeal the law, Trump appeared open to simply rebranding it.

“Obamacare is no longer Obamacare, as we worked on it and managed it very well,” Trump said of the law that continues to provide coverage for more than 20 million Americans. “What we have now is a much better plan. It is no longer Obamacare because we got rid of the worse part of it — the individual mandate.”

While Trump’s 2017 tax law did eliminate the requirement that virtually all Americans maintain insurance, the ACA remains in place with its expansion of Medicaid and insurance markets covering millions.

The failure to repeal and replace the ACA has not stopped Trump from repeatedly promising a soon-to-come health-care plan in a repetitive cycle of boastful pledges and missed deadlines that intensified in recent weeks ahead of the November election.

Trump’s speech and executive action Thursday constituted his most concrete effort yet to make good on those pledges by spelling out his health-care principles and criticizing his opponents.

“We’ve really become the health-care party — the Republican Party,” Trump said before reading a list of his accomplishments that pointedly did not include replacing the Affordable Care Act.

But even as other Republicans have tried to avoid the issue of health care — with some appearing to defend components of the ACA in political ads — Trump has continued to raise the subject and promise a soon-to-come comprehensive proposal.

Health care, long a top issue for voters, has taken on fresh urgency with less than five weeks to go before the November election.

The ongoing coronavirus pandemic has killed more than 200,000 Americans and caused millions to lose their jobs and health insurance. A pending Supreme Court case over the constitutionality of the ACA is set to be heard in November, and the death of justice Ruth Bader Ginsburg last week has raised the prospect that the law could be invalidated.

Trump said he supported the lawsuit but also claimed he would be fine maintaining the core of Obamacare “if we lose,” the first time he has openly expressed a willingness to abandon his original promise to “completely repeal” President Barack Obama’s most significant domestic achievement.

Democrats have been talking about health care constantly, while Republicans have largely steered clear of the issue, a phenomenon that tracks with public polling showing Americans trust the party responsible for passing the last major health-care legislation over the party that has tried to repeal it without offering an alternative.

Trump has sought to cut into that advantage ahead of the vote, touting his record and signing executive actions just days before he is set to face Democratic presidential nominee Joe Biden in a debate next week.

But the vision Trump laid out Thursday was a far cry from the “full and complete” plan he has promised repeatedly in recent months — each time failing to meet his self-imposed deadlines.

In addition to the executive action on preexisting conditions, Trump also promised millions of older Americans would receive $200 toward the cost of prescription drugs and signed executive orders he said would somehow prevent unexpected medical bills and protect insurance coverage for preexisting medical problems. The White House released no details of how the $200 program would work, how it would be funded and whether this was a long-term plan or one-time payment to seniors ahead of the election.

Both actions fall short of a comprehensive health-care overhaul. By comparison, the Affordable Care Act revamped much of the nation’s health-care and insurance systems for the first time in decades.

After entering office determined to undo the law and quickly replace it with a conservative alternative, Trump swiftly ran into obstacles.

In 2017, Republicans were repeatedly forced to abandon their proposals to repeal the ACA when they failed to reach a consensus on a replacement despite holding majorities in the House and Senate. Trump has expressed frustration at the late senator John McCain (R-Ariz.) for torpedoing the last GOP attempt to replace the law, but the lack of consensus was widespread in the party.

In the years since, Trump has taken some action on health care using his executive authority, including symbolic executive orders intended to lower drug prices and changes to Medicare billing practices.

In June 2018, Trump said he would unveil a health-care plan “in a very short period of time.”

A year later, he said such a plan would be out “over the next four weeks.” A month after that, he said a “phenomenal” plan would arrive “in about two months.”

While no such plan arrived, the pandemic and the upcoming election have only increased the frequency with which Trump has reiterated his promises.

In July, Trump told “Fox News Sunday” anchor Chris Wallace that he would be “signing a health-care plan within two weeks, a full and complete health-care plan.”

Two weeks came and went with no plan. During a town hall that aired on ABC on Sept. 15, Trump was confronted by a voter who told him that she would die if the ACA’s protections for preexisting conditions were eliminated

Again, Trump said his own plan preserving those protections would be out soon.

“We’re going to be doing a health-care plan very strongly and protect people with preexisting conditions,” Trump said.

Pressed by ABC News anchor George Stephanopoulos about the ever-shifting deadline for the plan, Trump claimed to have already formulated it.

“I have it all ready. I have it all ready,” he said.

Democrats and the Biden campaign have seized on health care, highlighting the Trump administration’s decision to back a lawsuit from a group of Republican attorneys general to have the entire ACA declared unconstitutional by the Supreme Court while offering no alternative.

In a memo released Thursday, party leaders including Democratic National Committee Chairman Tom Perez highlighted the wave of Democratic victories in 2018, noting that health care was an animating issue across the country.

The pandemic and the prospect of the ACA’s demise have revived similar sentiments, allowing the party to go on offense even as Republicans struggle to find a unified message, the memo said.

Biden’s campaign criticized Trump on Thursday for so far failing to put forward a full health-care plan just weeks before the election, saying his administration’s attempt to repeal the ACA could leave millions of Americans without coverage during a global pandemic.

In the aftermath of Ginsburg’s death, Biden has opted to avoid questions about potential Democratic court-packing plans and instead focus on how a more solidly conservative court might undermine the ACA.

“I think we should focus on what this is going to mean for health care, what it’s going to mean to once again have to say if you’re pregnant it’s a preexisting condition, to be able to charge women more for the same procedure as men,” Biden told reporters Wednesday when asked about Trump’s potential Supreme Court nominee. Biden has pledged to build on the ACA if elected.

Some of Trump’s allies have been dismissive of health care as a motivating factor in an upcoming election they believe will be determined by the state of the economy and the spread of unrest in communities.

“Health care is way, way, way down on the list,” said one official at a Trump-aligned super PAC, speaking on the condition of anonymity to discuss internal strategy. “It is right up there for Democrats, but we’re not looking at Democrats to take us to 270” electoral votes.

healthline

Obamacare: Everything You Need to Know About the ACA Before You Vote
Brian Mastroianni

On March 23, 2010, the Affordable Care Act (ACA) was signed into law, the most significant national healthcare reform in the United States in about half a century.

Though its goal is to provide all U.S. citizens with health insurance, the ACA has hit some stumbling blocks over the decade since it was first signed into law by President Barack Obama.

Used as a political punching bag, “Obamacare” has faced multiple threats of being repealed by Republican politicians, many of them happening over the past 3 years during the Trump administration.

Today, its fate is once again imperiled by the fight to fill an open Supreme Court seat following the death of Justice Ruth Bader Ginsburg, compounded by a contentious presidential election.

On top of all this, the COVID-19 pandemic is putting unprecedented strain on our nation’s healthcare system.

Once again, healthcare is at the center of American politics.

Often lost sight of in all of the political debates is the fact that the ACA has made healthcare available to millions more people. Because of the ACA, affordable coverage is accessible to Americans with lower incomes, people who are unemployed, and those living with preexisting conditions, like chronic illnesses.

While the ACA has become a key part of healthcare for millions of Americans, it has remained at the center of political discourse.

Yet a lot of people are still confused about what it is, how it works, and what possibilities are out there to expand and improve it.

Here’s an overview of where the ACA stands in 2020, a decade after its introduction, and what may happen to healthcare for millions of Americans if it’s soon repealed.

A 2010 article in the journal Health Affairs calls the ACA “the most important health care legislation since the 1965 law that created Medicare and Medicaid.”

Despite this historic significance, many people don’t really know what this health legislation even is.

The ACA essentially is the name for the overall health reform legislation signed into law in 2010.

It was enacted in two parts: the Patient Protection and Affordable Care Act, signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act, signed days later on March 30.

To expand coverage to as many Americans as possible, the legislation was designed to address several perceived gaps in America's existing health insurance system.

One was to provide tax credits to lower healthcare costs for households with incomes somewhere between 100 percent and 400 percent of the federal poverty line.

The second was to expand Medicaid coverage to U.S. adults with incomes 138 percent below the poverty level.

One caveat of this is that not all states have expanded Medicaid. Right now, 38 states and the District of Columbia have adopted Medicaid expansion, the Kaiser Family Foundation (KFF) reports.

This expansion of services to people and families with low income levels has been shown to be a great boon to overall public health. A recent study found that Medicaid expansion led to earlier cancer detection rates.

Additionally, the ACA put in place several healthcare delivery system reforms to help lower costs overall.

How do you get "Obamacare" coverage? Every year there is an open enrollment period for coverage that begins January 1 of the upcoming new year.

To apply for a health insurance program, you need to go through the Health Insurance Marketplace, where you are able to see what plans are available in your state. Some states run their own marketplaces, once known as "exchanges."

For 2021 coverage, the enrollment period runs from November 1 to December 15 this year.

If you miss the deadline, certain situations might allow you to qualify for a "special enrollment" period. For instance, maybe you had a child or lost your job.

People who qualify for Medicaid or the Children's Health Insurance Program (CHIP) can apply for a plan at any time.

Once you're on your plan, it will run for the rest of the year. You can then renew your plan during the next enrollment period the following fall.

A report from earlier this year showed that 8.3 million people either signed up for or renewed health insurance via the ACA for 2020 coverage.

Oftentimes, how “Obamacare” is discussed and framed has led to misunderstanding of the ACA.

The legislation is a series of provisions, opening up a marketplace of different tiered plans from which citizens can choose. It’s not a health insurance plan in and of itself, the way some anti-ACA-leaning media outlets tend to depict it.

When asked why there tends to be so much confusion over what exactly “Obamacare” is, John McDonough, DrPH, MPA, a professor of public health practice in the Department of Health Policy & Management at the Harvard T.H. Chan School of Public Health and director of executive and continuing professional education, said it’s because American healthcare is confusing to begin with.

“Ask Americans to explain Medicare and or Medicaid, and you will observe at least as much befuddlement as with the ACA. Our U.S. healthcare system is the most complicated and impenetrable to understand and make sense of on the planet,” McDonough told Healthline.

He should know. McDonough was there at the beginning.

He worked on the development and passage of the ACA in the role of a senior advisor on national health reform to the U.S. Senate Committee on Health, Education, Labor, and Pensions.

“In the early days around 2010, when people would complain to me that they didn’t understand the ACA, I would ask them — politely — how well they understand the U.S. health system in general,” he said.

“100 percent would indicate that they didn’t understand that at all either. So if you don’t understand the core system, it shouldn’t be surprising that understanding the reform of that system is also hard to grasp.”

McDonough explained that partisan politics and inaccurate media framing of the law added to immense confusion, but added that he doesn’t “see those as the prime perpetrators.”

Leighton Ku, PhD, MPH, professor and director of the Center for Health Policy Research at the Milken Institute School of Public Health at George Washington University, told Healthline that the ACA has become a “litmus test” for “how you feel about Democrats and Republican, liberals and conservatives” rather than a method for enabling access to healthcare.

He said the country is unfortunately split somewhat “down the middle” between those who approve and disapprove of the ACA.

“The polls tend to say when you bring up specific issues under the Affordable Care Act, things like preexisting conditions, Medicaid expansion, by and large, a pretty substantial majority of Americans support all those things,” Ku said.

“But when it’s all packaged together into ‘Obamacare,’ suddenly a lot of people see red when they see that banner being waved.”

ELECTION 2020

Voting feels good.

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Anya Rader Wallack, PhD, associate director of the Center for Evidence Synthesis in Health (CESH) and a professor of the practice in the Department of Health Services, Policy and Practice within Brown University’s School of Public Health, told Healthline the controversy surrounding “Obamacare” is ironic to her, given that it is “not one of the more radical proposals” for health reform.

Progressive critics of the ACA say it doesn’t go far enough in guaranteeing healthcare for all citizens. It falls short of the vision of a single-payer system like Medicare for All, which would mean a sole public health system would exist, like those in Canada and some countries in Europe.

While the ACA might not fall in that category of reform, Wallack said that it did “set a new bar in terms of fairness across the (healthcare) market.”

While she said total 50-statewide Medicaid expansion — as was originally intended — would have been significant, the fact that the majority of states have now chosen that option is, in her view, “the most radical part of the law.”

Wallack said this means a single parent or a pregnant woman or a child, for instance, has that added level of security in knowing they can get covered. She said states that enabled this resulted in “the most significant bump” in coverage, like what was witnessed in her own state of Rhode Island.

She added that it was also “a big deal” that the tax credits given to people whose income is at up to 400 percent of the poverty line to buy coverage through the marketplace was also a game changer.

Beyond this, the law’s provision that a young person can stay on their parents’ insurance until the age of 26 also helped level the playing field. This is especially true for young people just out of school who might not have employment or might be experiencing poverty.

From his vantage point, McDonough said that, until recent attacks on the ACA from the Trump administration and the impact on healthcare and the economy from COVID-19, “the rate of un-insurance in the U.S. had dropped to its lowest level since we started counting in the 1960s, between 8 to 9 percent overall.”

He added, “The highest level of drops were among the lower income categories with the greatest unmet needs. Not as much as we had predicted or hoped for, though the 2012 U.S. Supreme Court decision making the ACA’s Medicaid expansion optional for states knocked off between 3 to 5 million people who would otherwise have gotten coverage, and we would have come damn close to the 2010 projections.”

Despite its critics, the ACA “triggered a massive and broad set of initiatives to move the U.S. medical care delivery system away from fee-for-service payment that only rewards quantity of services provided and toward value-based payment that rewards quality, efficiency, and effectiveness,” McDonough stressed.

He said while “progress has been lower than anticipated or desired,” this incremental method of improvement has been in the right direction.

Ku said that the access given to lower income people has been impactful, given that “it’s poor people who run into the biggest problems if they can’t afford to have health insurance.”

Of course, in general, healthcare costs remain incredibly high in this country, and Ku added that is something not fixed by any kind of reform seen so far.

For instance, if you purchase a bronze-level plan through the marketplace, it brings with it high premiums. You could see yourself paying incredibly high rates before “receiving any kind of actual care,” he said.

Since it passed, the ACA has been under attack. From the Obama years through the current first term of President Donald Trump, Republican lawmakers have tried very hard to repeal the law.

The problem is no real concrete replacement legislation has ever been proposed.

The journal Health Affairs writes that while efforts to fully repeal the ACA have failed in the past, come chipping away has occurred.

For instance, lawmakers in individual states have tried to prevent Medicaid expansion. In 2017, a congressional tax bill was passed that cut out the ACA penalty for people who didn’t have insurance.

Wallack said that the Supreme Court’s ruling that it was “optional” for states to expand Medicaid was also a blow to the ACA.

All of that being said, it remains standing despite immense opposition. Why?

“Honestly, I think while there have been attacks that have wounded the ACA, most of the attacks are in the ‘political ether,’ the President can’t even tell us what his plan is, [and there have] been crickets on the Republican side in terms of replacement,” Wallack said.

“Besides, who is going to kick 20 million people off their coverage, particularly now when you have all these people on unemployment like we’ve never seen in our lifetime?”

Wallack said that the economy’s decimation of small businesses also comes into play. Many will most likely have to drop coverage for employees.

In this period of “financial struggle they’ve never seen,” she suggests that Republican lawmakers might attempt to repeal the act, but she doesn’t think they would do it pre-election or even post-election.

“It’s political suicide to take that coverage away from people,” Wallack added.

Ku said perhaps the most vivid moment in the “repeal and replace” ACA debate came in 2017 when Sen. John McCain famously made his “thumbs-down” vote on the Senate floor, saving the ACA for another day.

Right now, McDonough cites the upcoming Supreme Court case that will have oral arguments from 20 Republican attorneys general on November 10, days after the presidential election.

That to him is the “primary existential threat” to the ACA. The death of Ginsburg “may or may not have a consequential impact on the fate of that lawsuit.”

He added that many “objective observers” on both sides predicted the effort would fail until Ginsburg’s death in September.

“Beyond that, since 2015, Donald Trump has promised more times than I can count that he will be unveiling some magnificent replacement system ‘within 2 weeks,’ ” McDonough said.

“His utter failure over 5 years to present a replacement system for the ACA is a recognition that the administration and Republicans in Congress have no idea what to do.”

What if the enemies of the ACA do succeed?

Ku said that it wouldn’t be an immediate shift — there wouldn’t be a moment when all healthcare access is suddenly stripped from people.

That being said, he stressed it could be “chaos” if efforts to repeal the law succeeded without any clear replacement system put in place.

For people with preexisting conditions and for low-income individuals, he said it's almost impossible to know what would happen in this kind of hypothetical situation.

Just yesterday, Trump announced his version of healthcare reform, which doesn't offer much change from what exists. He will sign executive orders to protect preexisting conditions and prevent so-called "surprise billing," reports NBC News.

The catch? As detailed above, preexisting conditions are already protected by the ACA. Think of it as somewhat of a relabeling of something that already exists.

During the 2020 Democratic presidential primaries, contenders were divided between embracing a single-payer plan, like those advocated by Sens. Bernie Sanders and Elizabeth Warren, and expansions upon the ACA, as supported by former Vice President Joe Biden, who is now the nominee competing against Trump.

Biden has made adding a government-paid public option to the ACA, which would compete against private insurance, part of his platform.

Wallack and Ku said it all depends on the makeup of the new Congress whether such a proposal would come into existence, even if there were a Biden presidency.

Wallack said a public option would be straightforward if it just means expanding on eligibility requirements for existing programs.

For instance, rather than Medicare eligibility standing at age 65, it could be dropped down to age 55 or 50 years. However, some resistance to expansion of Medicare comes from doctors who say it doesn't pay enough as private insurance companies.

She said it would be more controversial if a large portion of the population shifted from employer coverage to a Medicaid buy-in. She said Medicaid typically is "bottom of the barrel" for physician payments, and that would cause more pushback from providers.

McDonough said that if Democrats control the White House and both chambers of Congress in January 2021, we will see "significant legislation" to expand affordability of healthcare and access to financial assistance for people who can't afford insurance at all today.

This could include a public option or lowering Medicare eligibility.

If this doesn't happen and there's a more "divided government," he added that "prospects for significant reforms are starkly diminished, and we can expect to see continuation of the minimalist trench warfare witnessed since 2010 — excepting for 2017, when Trump and [Republicans] attempted total repeal."

Ku added that the big issue at hand is COVID-19 and the great health disparities it's revealing and entrenching.

He stressed that it's an unfortunate distraction there even is a fight over repealing or maintaining the ACA as a pandemic rages on. Particularly vulnerable groups to COVID-19, like immigrants who are uninsured, are the groups most ignored by our system right now, he said.

"I wish the real public policy right now was how to fix the problems occurring that we could fix now. They could be fixed relatively inexpensively, without big fights," Ku explained.

"There are other things we can do to ensure we can fill gaps in our current system," Ku added.

"Look, the ACA narrowed gaps, and I think we can do a better job of narrowing those gaps to make the overall public safer. But things get in the way of those discussions."

Obamacare Returns as Galvanizing Issue After Ginsburg Death and Barrett Nomination
Abby Goodnough

WASHINGTON — Less than six weeks before the election, the death of Justice Ruth Bader Ginsburg has injected fresh urgency into an issue that had dropped down the list of voter priorities this year: the future of the Affordable Care Act.

The Supreme Court is scheduled to hear arguments on Nov. 10 in a case, which the Trump administration has filed briefs supporting, that seeks to overturn the law. Mr. Trump's nomination of Amy Coney Barrett, who has criticized the court's 2012 decision to uphold it, increases the chance of that happening.

Liberal advocacy groups are using the prospect to whip up new advertisements declaring that President Trump "wants to rush a justice onto the court who will repeal our health care," as one says. Democrats in Congress have sprung into action with news conferences and pep talks to campaign volunteers featuring people with pre-existing medical conditions who were able to get coverage because of the law. The Biden campaign, too, made clear upon Justice Ginsburg's death that it would frame the court fight largely as one about health care.

Even if Democrats have little chance of blocking Judge Barrett's confirmation, they are hoping to reignite the public passion to protect the law that helped Democrats recapture the House in 2018, a year after Republicans in Congress came close to repealing it. This time, party leaders are quick to point out, the election is coming amid a pandemic that has left many Americans requiring expensive medical care, including for potentially

long-term health problems that insurers could refuse to cover if the law and its protections with people for pre-existing conditions were repealed.

“That was the issue that drove the 2018 campaign so substantially — it came right after a very, very clear threat,” said Chris Jennings, a longtime Democratic strategist on health care who is advising Joseph R. Biden’s campaign. “This time, the fear of a takeaway was not as great. But now it’s re-engaged and credible.”

The number of uninsured people in the United States decreased by 20 million from 2010 to 2016, as the A.C.A. went into effect. Its major provisions include allowing states to expand Medicaid to cover more low-income adults, setting up insurance markets where individuals earning less than about $51,000 a year can get subsidies to help pay their premiums and barring insurers from placing annual or lifetime limits on how much care they would cover. But 42 percent of Americans still view it unfavorably, according to one recent poll, likely including many middle-class families who earn too much for the law’s financial assistance and find the high level of coverage it requires unaffordable.

Mr. Trump, attempting to neutralize the threat to his campaign posed by the pre-existing conditions issue — one that affects as many as 133 million Americans — signed an executive order on Thursday declaring it is the policy of the United States for people with pre-existing health conditions to be protected. But he offered no details on how he planned to assure that while also seeking to invalidate the A.C.A. His own Justice Department filed a brief in June asking the Supreme Court to overturn the entire law, including its pre-existing conditions protections.

In 2017, Judge Coney Barrett wrote an academic article questioning a Supreme Court decision that upheld the law in 2012. She also signed a petition in 2012 protesting the law’s requirement that insurance plans offered by most employers cover contraception; the Trump administration has since expanded exemptions to the rule, a move upheld by the high court.

In the weeks before Justice Ginsburg’s death, poll respondents listed health care below the economy and the coronavirus response as an issue of importance to them. A poll conducted in early September by the Kaiser Family Foundation, a nonpartisan health research organization, found that only 10 percent of registered voters considered health care the most important issue in deciding their vote for president. In a NBC/Wall Street Journal poll conducted shortly before Justice Ginsburg’s death last week, 24 percent listed health care as a top issue, compared with 40 percent for the economy.

With most voters already firmly in Mr. Trump’s or Mr. Biden’s camp — and the election a referendum on Mr. Trump more than any one issue — it is not clear how much the court vacancy will change the equation, even around the margins. But Democrats are not alone in seeing the vacancy as a potential flame to reignite fervor for protecting the law and especially its most popular provision: protecting people with pre-existing conditions from getting charged more or rejected by insurance companies.

Mr. Trump on Thursday devoted a speech in North Carolina to the subject, leaning into a much-repeated promise to continue protections for people with pre-existing conditions by issuing an executive order, a largely symbolic document that does not have the teeth of legislation. People priced out of coverage by the law cannot benefit from those protections anyway, his aides told reporters on a briefing call before the speech.

That argument should resonate with people like Rafael Gonzalez, an independent voter who owns a small landscaping company in Miami. At 53, he is uninsured after deciding he could not afford the $700 monthly premiums for the plans available to him under the law. He does not qualify for federal subsidies to offset the cost because his income is over the cutoff, making him just the type of voter whom Trump health officials are targeting when they point out that the Affordable Care Act protections are meaningless to people who can't afford to buy insurance.

Yet Mr. Gonzalez is leaning toward supporting Mr. Biden, not least because he does not want the law to be completely wiped out.

"Maybe Obamacare is not perfect, but it's only a start," Mr. Gonzalez said in an interview this week. "Trump is trying to terminate Obamacare, but he hasn't shown another plan. He does not inspire any confidence in me."

In North Carolina, one of the most hotly contested states in the presidential race, another undecided voter, Taft Turner, 59, of Greensboro, said the court vacancy made him more likely to choose Mr. Biden over a third-party candidate. He had already ruled out Mr. Trump and has been wavering on Mr. Biden, he said, in part because as a Black man he felt let down by both major parties.

"That seat concerns me a great deal," said Mr. Turner, a cancer survivor, adding of the possibility of the court overturning the law, "What's important enough to gain by doing something that would harm so many people?"

Democrats are intent on using the A.C.A. to gain advantage in Senate races across the country, especially against vulnerable Republican incumbents like Thom Tillis in North Carolina, Martha McSally in Arizona and Cory Gardner in Colorado — who has run an ad promising to protect pre-existing conditions even though he voted in 2017 to repeal the Affordable Care Act. Protect Our Care, a liberal advocacy group focused on preserving the health law, is preparing to run television ads in all three incumbents' states warning that they want "to rush a justice onto the court who will repeal our health care," after digital ads this week.

Similar ads are running against Republican senators in tighter-than-expected races in Alaska, Iowa, Georgia, Montana, South Carolina and Texas. Winning both the White House and the Senate, where Republicans currently hold a three-seat majority, could allow Democrats to fix the law in a way that might help save it from being overturned by the Supreme Court, by reinstating a financial penalty for people who go without health insurance. The crux of the legal case is that when Congress zeroed out the penalty in

2017, the law's requirement that most Americans have insurance became unconstitutional, and that without that mandate the rest of the law could not stand.

The issue of the health law aside, Joel White, a Republican strategist, said he thought the court vacancy would actually help Republicans in tight Senate races "where their base is looking for a reason to be excited," and in conservative states like Georgia and Montana, "by motivating partisans." More important, he said, the vacancy could galvanize evangelical voters who may otherwise have been reluctant to vote for Mr. Trump.

James DiPaolo, an independent voter in Jacksonville, Fla., said he had been considering voting for Mr. Biden — even though he dislikes the Affordable Care Act's requirement that insurance plans offer comprehensive coverage, which can make them more expensive — because Mr. Trump "says things that are atrocious." But the court vacancy he said, has changed his calculation because he is a devout Catholic and "big fan" of Judge Barrett.

"Her being a woman of faith, that's important to me," Mr. DiPaolo, 36, said of Judge Barrett, who is also Catholic.

Mr. DiPaolo did point to one piece of the health law that he strongly supports: its protections for people with pre-existing conditions. His grandfather had diabetes, as does his father, he said, adding, "I'm hoping it skips me but I don't know, so I think protections for that are key."

He did not connect a vote for Mr. Trump with the possibility of losing those protections.

"I don't see him getting rid of that," he said.

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Trump's Executive Order on Preexisting Conditions Lacks Teeth, Experts Say
Jon Greenberg

Protecting people with preexisting medical conditions is an issue that has followed President Donald Trump his entire first term. Now, Trump has signed an executive order that he says locks in coverage regardless of anyone's health history. "Any health care reform legislation that comes to my desk from Congress must protect the preexisting conditions or I won't sign it," Trump said at a Sept. 24 signing event.

With the executive order, Trump said, “This is affirmed, signed and done, so we can put that to rest.”

Health law and health policy experts say Trump has put nothing to rest.

Here’s why.

The core text of the order is brief.

“It has been and will continue to be the policy of the United States to give Americans seeking healthcare more choice, lower costs, and better care and to ensure that Americans with pre-existing conditions can obtain the insurance of their choice at affordable rates.”

Joe Antos with the American Enterprise Institute, a market-oriented think tank, said the order “has no technical content.”

“All it really is, is a statement that he wants one or more of his departments to come up with a plan. And he doesn’t give any guidance or the vaguest outline of what that plan should be.”

It takes more than a bill title to actually deliver guaranteed coverage. A Republican measure in the Senate is a good example. It’s called the Protect Act, but it has loopholes that would allow insurance companies to drop coverage of certain expensive diseases from all their policies.

So far, Republican proposals have not matched what the Affordable Care Act already provides. And University of Pennsylvania law professor Allison Hoffman said Trump’s executive order doesn’t change that.

“The language itself guarantees nothing near the protections in the Affordable Care Act, and such sweeping protections are only possible by congressional action, not regulation,” Hoffman said.

Trump and other Republicans on the campaign trail have faced repeated questioning about what will happen if the U.S. Supreme Court invalidates the Affordable Care Act. The White House is strongly behind a legal case to declare it unconstitutional. Oral arguments before the court are scheduled for Nov. 10.

Indiana University health law professor David Gamage said the executive order is no stopgap should the White House win that argument.

“Were the court to hold the Affordable Care Act unconstitutional, the executive order would still do nothing, because it has no enforcement power,” Gamage said.

Larry Levitt, head of health policy at KFF, a widely used source of neutral health care data, called Trump's order "a pinky promise to protect people with preexisting conditions."

Trump's critics have said the order runs counter to the administration's goal of undoing the Affordable Care Act. But as Levitt and others point out, there are other ways to guarantee coverage to everyone.

Lanhee Chen at Stanford University's Hoover Institution said high-risk pools remain a popular idea in conservative circles.

"Most conservative analysts, for example, have supported a system of well-funded high-risk pools at the state level to provide protections for the impacted population," Chen said.

High-risk pools have been around for decades. With them, the government, rather than a private insurance company, pays for a person's care. But as with everything in health care, you don't get something for nothing. State high-risk pools in the past lacked enough money to cover the large number of people with needs.

Hoffman said some high-risk pools charged very high premiums, making them unaffordable to many people.

Coverage for preexisting conditions is a persistent issue because so many Americans have them or fear having them in the future.

KFF estimates that 54 million Americans have a preexisting condition that would have led to a denial of coverage in the individual insurance market before the Affordable Care Act took effect.

Study: Obamacare cut out-of-pocket costs, but many still struggle
HealthDay

High out-of-pocket health care costs for low- and middle-income Americans with kids have fallen due to "Obamacare," but more needs to be done to reduce their medical-related financial struggles, a new study claims.

The researchers examined data from 2000 to 2017 on more than 92,000 U.S. families with one or more children under 18 and one or more adult parents or guardians.

Families with out-of-pocket health care costs above a set percentage of their annual income -- for example, 3.5% of incomes below $20,000, or 8.4% of those at $75,000 -- were said to have high financial burdens. Those whose out-of-pocket costs exceeded 10% of their annual income were classified as having extreme financial burdens.

Before the 2014 implementation of health insurance marketplaces and Medicaid expansion under the Affordable Care Act, over 35% of the lowest-income families had burdensome out-of-pocket costs. This fell to just under 24% after the measures took effect, the study found.

The proportion of families facing burdensome costs fell from about 25% to 17% among low-income families, and from 6% to 4.6% among middle-income families. Among high-income families, it remained relatively stable, falling from 1.1% to 0.9%, according to the study published Sept. 28 in JAMA Pediatrics.

The study's lead author was Lauren Wisk, an assistant professor at the University of California, Los Angeles School of Medicine.

The findings show that the ACA significantly improved access to coverage and was associated with a large reduction in financial burdens for families with children, the study authors said in a university news release.

But, Wisk's team added, low- and middle-income families still face substantial burdens and require more help to ease them.

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Return of Health Discrimination to Insurance Markets Could Affect Millions of People
Gary Claxton

With the Trump administration’s challenge to invalidate the Affordable Care Act (ACA) having moved to the Supreme Court in the midst of nomination fight, there has been a renewed focus on the number of people with pre-existing health conditions and how they might be treated in health insurance markets if the administration’s arguments prevail.

Prior to the ACA, people with pre-existing health conditions could be denied coverage or charged higher premiums if they sought coverage outside of their workplace, and small employers could be charged much higher premiums if their workers or their family members had or developed serious or chronic health conditions.

If the law is overturned, these practices may return. A substantial share of non-elderly adults have pre-existing health conditions that would see them declined for coverage under pre-ACA medical screening rules in the non-group market. In a previous study, we found that 27% of non-elderly adults, almost 54 million people, had a declinable pre-existing medical condition in 2018. Some groups are at higher risk; for example:

- **Older adults are more likely to have declinable conditions than younger people**

Age	Share with a Pre-Existing Condition
Ages 18 to 34	18%
Ages 35 to 44	24%
Ages 45 to 54	29%
Ages 55 to 64	44%
Source: KFF analysis of 2018 National Health Interview Survey. See Methodology below.	

- **Women, particularly younger women, are more likely than men to have declinable conditions, in part because pregnancy was considered a pre-existing condition**

Gender	Age	Share with a Pre-Existing Condition
Female	Ages 18 to 34	22%
Male	Ages 18 to 34	15%
Female	Ages 35 to 44	27%
Male	Ages 35 to 44	20%
Female	Ages 45 to 54	32%
Male	Ages 45 to 54	27%
Female	Ages 55 to 64	44%
Male	Ages 55 to 64	44%

Source: KFF analysis of 2018 National Health Interview Survey. See Methodology below.

- **Adults living in non-metropolitan counties are more likely to have declinable conditions than people in metropolitan areas**

Metro Status	Share with a Pre-Existing Condition
Live in Metro County	26%
Live in Non-Metro County	32%

Source: KFF analysis of 2018 National Health Interview Survey and 2018 Behavioral Risk Factor Surveillance Survey. See Methodology below.

Without the ACA, there is nothing in federal law to assure people with pre-existing health conditions access to affordable non-group coverage should they need it. The President recently instructed his administration to work with Congress to find ways to protect people with pre-existing conditions, but no concrete proposals were included. Were the Court to overturn the ACA provisions relating to pre-existing conditions, millions of people could face discrimination in health insurance markets unless or until the federal or state governments fashion new protections.

Even before pandemic struck, more US adults were uninsured
Ricardo Alonso-Zaldivar

WASHINGTON (AP) — About 2.5 million more working-age Americans were uninsured last year, even before the coronavirus pandemic struck, according to a government report issued Wednesday.

The study from the Centers for Disease Control and Prevention found that 14.5% of adults ages 18 to 64 were uninsured in 2019, a statistically significant increase from 2018, when 13.3% lacked coverage.

The increase in the uninsured rate came even as the economy was chugging along in an extended period of low unemployment. The findings suggest that even during good

times, the U.S. was losing ground on coverage gains from the Obama-era health care overhaul.

Health insurance coverage has eroded under President Donald Trump, who is still trying to overturn the Affordable Care Act, or “Obamacare.” By contrast, Democratic presidential candidate Joe Biden wants to expand the ACA and add a new public plan in a push to eventually cover all Americans.

The new numbers come from the CDC’s National Health Interview Survey, which is considered one of the government’s most authoritative reports. Lack of affordable coverage was the top reason given for being uninsured, cited by nearly 3 out of 4 surveyed.

In 2018, 26.3 million adults ages 18 to 64 were uninsured. Last year, that number rose to 28.8 million, CDC said.

The situation has only worsened since COVID-19 began to spread in the U.S. early this year, forcing a sudden economic shutdown that left millions out of work. How much worse is not yet known, because government surveys like the CDC’s have a significant lag time.

Initial estimates from private experts that suggested more than 25 million people could have become uninsured due to pandemic job losses appear to have been too high.

More recent estimates suggest there are 5 million to 10 million newly uninsured. In the midst of a pandemic, that would still represent a sharp increase in the number of people who may face problems getting medical attention. Uninsured people often postpone going to see a doctor until their symptoms become severe.

Experts say there could be several reasons why coverage losses due to the pandemic have not been as deep as initial feared, including people switching to a spouse’s plan and more people qualifying for Medicaid or for an ACA “special enrollment period.”

The Trump administration has resisted calls to fully open the ACA insurance markets during the ongoing public health emergency.

The CDC report found that adults who were uninsured last year because coverage was not affordable were more likely to be in poor health, a group that’s at higher risk of serious complications from COVID-19. Uninsured women were more likely to cite affordability problems than men, and those 50 and older were also more likely than the group under 30 to report a financial hardship.

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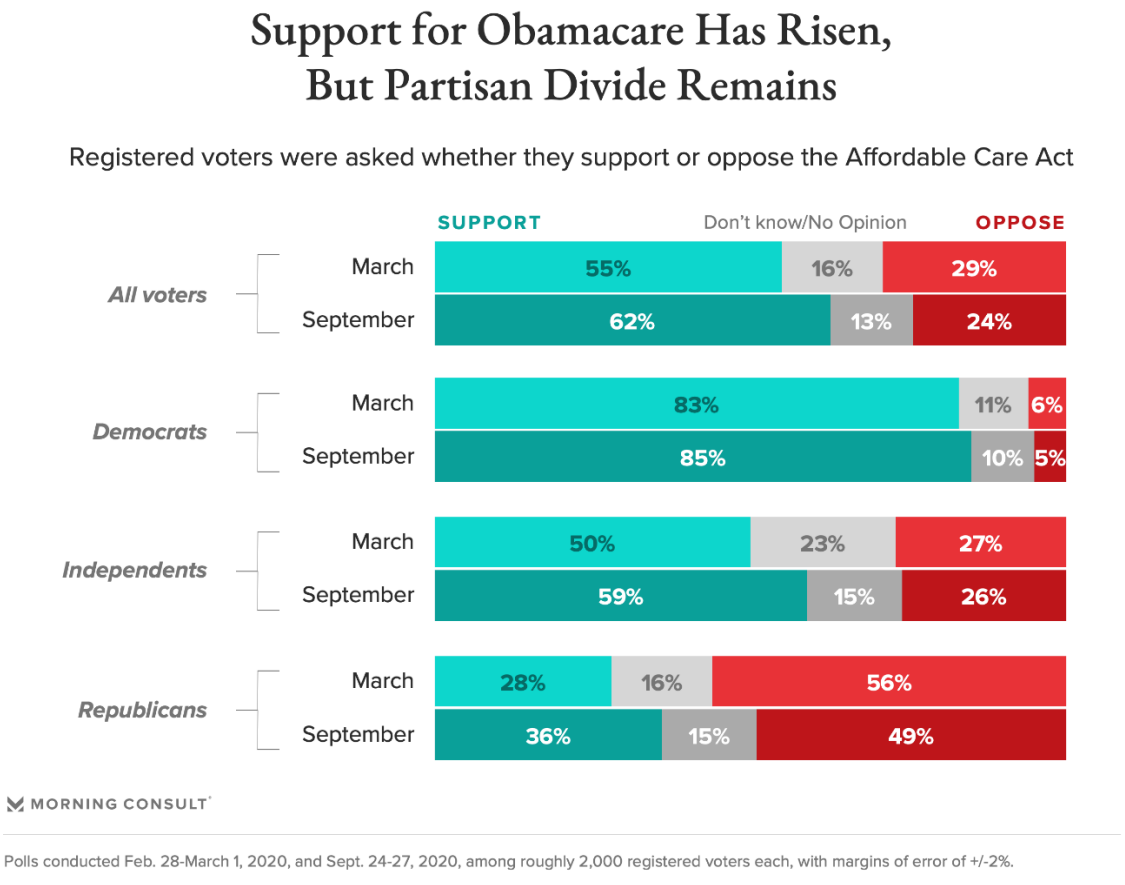
Obamacare Support Hits Record High as Supreme Court Faces Ideological Shift
Gaby Galvin

With the survival of the Affordable Care Act in jeopardy following President Donald Trump's nomination of conservative Judge Amy Coney Barrett to replace the late Justice Ruth Bader Ginsburg on the Supreme Court, a new Morning Consult poll finds a record-high 62 percent of voters in support of the 2010 health law.

That level of backing, which is up 7 percentage points from a Morning Consult survey conducted in the first quarter of 2020, comes as the ACA, also known as Obamacare, re-emerged as a flashpoint issue in the Nov. 3 elections: The Supreme Court is preparing to hear arguments Nov. 10 in a case that could entirely overturn the landmark health law. The lawsuit, brought by Republican-led states and backed by the Trump administration, hinges on the GOP's 2017 tax law that wiped out the ACA's individual mandate penalty, an unpopular provision that required all Americans to have health insurance or pay a fine. Without it, the lawsuit argues, the entire law is invalid.



Barrett, a federal appellate judge and Notre Dame law professor, has previously criticized a 2012 court decision that upheld the ACA, and Democrats are framing her nomination to the court as a threat to Americans' health care.

The poll, conducted Sept. 24-27, indicates the ACA is top of mind for voters, regardless of whether they support or oppose the law, which has seen a roughly 20-point increase in support since 2013. Among the 62 percent of voters who strongly or somewhat support the ACA, 90 percent said protecting and strengthening the law was an important factor in casting their vote in the 2020 elections. Among the 24 percent of voters who oppose the law, 83 percent said repealing and replacing it was an important election issue.

"There is a smorgasbord of issues in this election," said Larry Levitt, executive vice president for health policy at the nonpartisan Kaiser Family Foundation. "The ACA had been taking a bit of a back seat, but I think the Supreme Court confirmation fight coming at the same time as the latest legal threat to the ACA has pushed the issue to the front."

The record-high level of ACA support in the latest poll of 1,991 registered voters was fueled by increases among independents and Republicans: 36 percent of GOP voters said they support Obamacare, up 8 points from earlier this year, and backing from independents increased 9 points, to 59 percent. The vast majority of Democrats support the ACA, at 85 percent, and roughly half of Republicans (49 percent) oppose the law.

Voters were mixed when asked about the health law's fate, the poll shows, with 42 percent saying they think it's likely the Supreme Court will strike down the ACA, while 32 percent said they think it's unlikely.

Yet more than half of voters (56 percent) think Obamacare should be improved and strengthened, while 20 percent said the law should be struck down in the upcoming Supreme Court case California v. Texas and 9 percent said it should be left as is. Republicans were the most divided, with 42 percent saying the ACA should be struck down and 33 percent saying the law should be improved and strengthened.

That compares to 4 percent and 75 percent, respectively, among Democrats. Just 11 percent of Democrats and 8 percent of Republicans said the ACA should be left as is.

"If you could divorce it from the partisan sloganeering, which is very hard to do, most people on both sides of the aisle would say that there are improvements to be made in the ACA," said Dr. Katherine Baicker, a health economist and dean of the University of Chicago Harris School of Public Policy.

One of the ACA's key provisions has much broader support than the law itself: 79 percent of voters favor ensuring health coverage for people with pre-existing conditions, including 91 percent of Democrats and 63 percent of Republicans.

“Most of the individual elements of the ACA have always been more popular than the ACA itself,” Levitt said. “Nearly half of adults either have a pre-existing condition, or someone in their family does. It’s an issue that touches a lot of people’s lives.”

With Election Day approaching, Republicans have taken steps in recent weeks to try and neutralize attacks from Democrats who say the administration’s backing of the latest ACA lawsuit amounts to an assault on those protections.

Trump, who has promised throughout his term and as recently as Sunday to replace the ACA with a “much better” and “far cheaper” plan, signed an executive order last week stating it is the “policy of the United States” to ensure coverage for people with pre-existing conditions, a move policy experts said carries little enforcement power.

The president has his work cut out for him in convincing voters that he is the candidate to safeguard those protections, according to the survey: 61 percent of voters said they trusted Democratic presidential nominee Joe Biden more to protect insurance coverage for Americans with underlying conditions, compared with 29 percent who said they trusted Trump. Similarly, voters were more likely to trust Democrats in Congress (49 percent) than Republicans in Congress (35 percent) to handle health care for the country.

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Loss of the Affordable Care Act Would Widen Racial Disparities in Health Coverage
Samantha Artiga

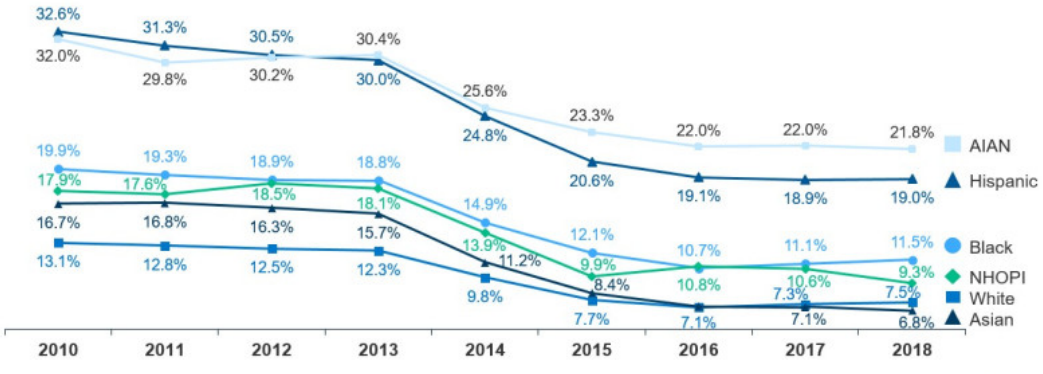
In November, the Supreme Court is scheduled to hear arguments on a legal challenge, supported by the Trump administration, that seeks to overturn the Affordable Care Act (ACA). As noted in a previous KFF analysis, the outcome will have major effects throughout the health care system as the law’s provisions have affected nearly all Americans in some way. One of the most significant aspects of the ACA has been its expansion of health coverage options through the Medicaid expansion to low-income adults and the creation of the health insurance marketplaces with subsidies to help people purchase coverage. This analysis shows that these new coverage options have contributed to large gains in coverage, particularly among people of color, helping to narrow longstanding racial disparities in health coverage. The loss of these coverage pathways, particularly the Medicaid expansion, would likely lead to disproportionate coverage losses among people of color, which would widen disparities in coverage, access to care, and health outcomes.

Prior to the ACA, people of color were significantly more likely to be uninsured than White people. The higher uninsured rates among groups of color reflected limited access to affordable health coverage options. Although the majority of individuals have at least one full-time worker in the family across racial and ethnic groups, people of color are more likely to live in low-income families that do not have coverage offered by an employer or to have difficulty affording private coverage when it is available. While Medicaid helped fill some of this gap in private coverage for groups of color, before the ACA, Medicaid eligibility for parents was limited to those with very low incomes (often below 50% of the poverty level), and adults without dependent children—regardless of how poor—were ineligible under federal rules.

People of color experienced large coverage gains under the ACA that helped to narrow but did not eliminate disparities in health coverage. Coverage rates increased for all racial/ethnic groups between 2010 and 2016, with the largest increases occurring after implementation of the ACA Medicaid and Marketplace coverage expansions in 2014 (Figure 1). Overall, nearly 20 million nonelderly people gained coverage over this period, including nearly 3 million Black people, over 5 million Hispanic people, and over 1 million Asian people. Among the nonelderly population, Hispanic individuals had the largest percentage point decrease in their uninsured rate, which fell from 32.6% to 19.1% between 2010 and 2016. Black, Asian, American Indian and Alaska Native (AIAN), and Native Hawaiian or Other Pacific Islander (NHOPI) people also had larger percentage point decreases in their uninsured rates compared to their White counterparts over that period. These coverage gains reduced percentage point differences in uninsured rates between some groups of color and White people, but disparities persisted. Most groups of color remained more likely to be uninsured compared to White people. Moreover, the relative risk of being uninsured compared to White people did not improve for some groups. For example, Black people remained 1.5 times more likely to be uninsured than White people, and the uninsured rate among Hispanic people remained over 2.5 times higher than the rate for White people.

Figure 1

Uninsured Rates for the Nonelderly Population by Race and Ethnicity, 2010-2018



NOTE: Includes individuals ages 0 to 64. AIAN refers to American Indians and Alaska Natives, NHOPI refers to Native Hawaiians and Other Pacific Islanders.
SOURCE: KFF analysis of the 2010-2018 American Community Survey.

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Between 2016 and 2017, and continuing in 2018, coverage gains stalled and began reversing for some groups. Over this period there were small but statistically significant increases in the uninsured rates for White and Black people among the nonelderly population, which rose from 7.1% to 7.5% and from 10.7% to 11.5% respectively. Among children, there was also a statistically significant increase in the uninsured rate for Hispanic children, which rose from 7.6% to 8.0% between 2016 and 2018. Recent data further show that the number of uninsured continued to grow in 2019 despite improvements in household economic measures, and indicate the largest increases between 2018 and 2019 were among Hispanic people. The growth in the uninsured likely reflects a combination of factors, including rollback of outreach and enrollment efforts for ACA coverage, changes to Medicaid renewal processes, public charge policies, and elimination of the individual mandate penalty for health coverage.

The ACA provides coverage options for people losing jobs amid the economic downturn associated with the pandemic. The economic fallout of the coronavirus pandemic has led to historic levels of job loss. As people lose jobs, many may face disruptions in their health coverage since most people in the U.S. get their insurance through their job. Early KFF estimates of the implications of job loss found that nearly 27 million people were at risk of losing employer-sponsored health coverage due to job loss. Many of these people may have retained their coverage, at least in the short term, under furlough agreements or employers continuing benefits after layoffs. However, the health coverage options made available through the ACA have provided options for people losing employer-sponsored coverage who might otherwise become uninsured. Following enrollment declines in 2018 and 2019, recent data indicate Medicaid enrollment increased by 2.3 million or 3.2% from February 2020 to May 2020. Additionally, as of May 2020, enrollment data reveal nearly 500,000 people had gained Marketplace coverage through a special enrollment period (SEP), in most cases due to the loss of job-based coverage. The number of people gaining Marketplace coverage through a SEP in April 2020 was up 139% compared to April 2019 and up 43% in May 2020 compared to May 2019.

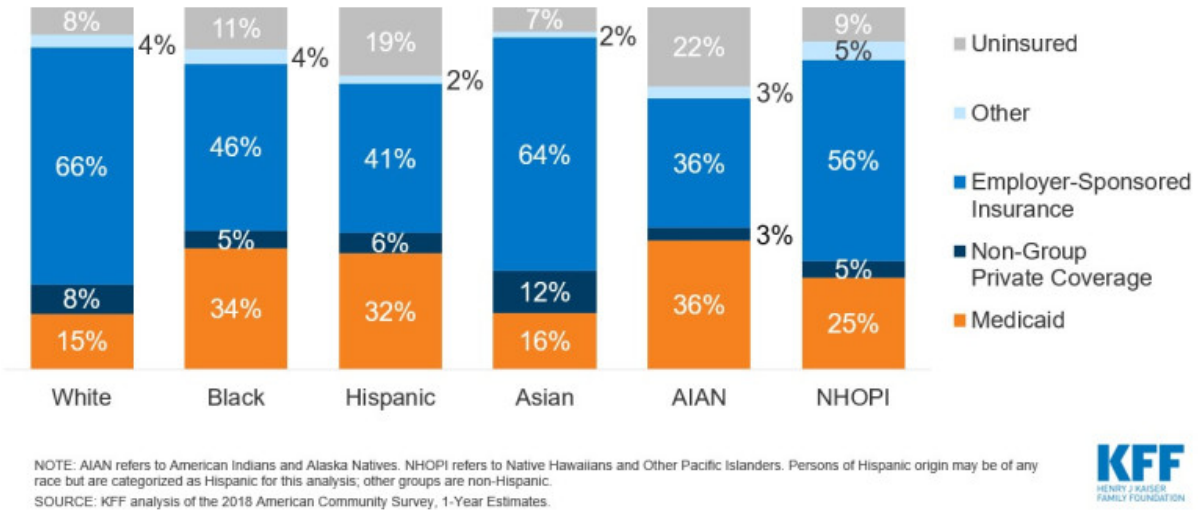
People of color would likely experience the largest coverage losses if the ACA coverage options were eliminated. In the absence of the ACA, states would lose a pathway to cover adults without dependent children through Medicaid under federal rules. They also would lose access to the enhanced federal funding provided to cover expansion adults. As such, states would face challenges to maintain coverage for adults without dependent children and parents and many would likely roll back this coverage, eliminating a coverage option for millions of low-income parents and childless adults who do not have access to other affordable coverage. Moreover, without the federal subsidies, many people would not be able to afford private coverage. Since people of color experienced larger gains in coverage under the ACA compared to their White counterparts, they would likely also experience larger coverage losses if these coverage options were eliminated.

Loss of the Medicaid expansion, in particular, would likely lead to disproportionate coverage losses among people of color, contributing to

widening disparities in coverage, access to and use of care, and health outcomes. Overall, among the nonelderly population, roughly one in three Black, Hispanic, and AIAN people are covered by Medicaid compared to 15% of White people (Figure 2). Further, research shows that the ACA Medicaid expansion to low-income adults has helped to narrow racial disparities in health coverage, contributed to improvements in access to and use of care across groups, and narrowed disparities in health outcomes for Black and Hispanic individuals, particularly for measures of maternal health.

Figure 2

Health Insurance Coverage of the Nonelderly Population by Race/Ethnicity, 2018



NOTE: AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.
SOURCE: KFF analysis of the 2018 American Community Survey, 1-Year Estimates.

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In sum, the outcome of the pending legal challenge to overturn the ACA will have effects that extend broadly across the health care system and touch nearly all Americans. These effects could include widening racial disparities in health coverage and health care, at a time when there is a growing focus on prioritizing and advancing health equity and in the middle of a pandemic that has disproportionately affected people of color in the US. Without the ACA coverage expansions, people of color would likely face widening gaps in health insurance coverage, which would contribute to greater barriers to health care and worse health outcomes and leave them at increased risk for medical debt and financial challenges due to health care costs.

Analysis: 'Silver loading' led to exodus to bronze-tier plans in majority of states
Robert King

The practice of "silver loading" on the Affordable Care Act's (ACA's) insurance exchanges has led more consumers to migrate from silver plans toward bronze-tier plans that have lower premiums but higher out-of-pocket costs, a new analysis finds.

The analysis, released Wednesday from the Robert Wood Johnson Foundation, explores the impact of President Donald Trump's late 2017 decision to halt reimbursements to insurers for cost-sharing assistance. The analysis stressed that more funding is needed for enrollment assistance to help customers learn more about the issues with selecting a bronze-tier plan.

"One consequence of the administration's elimination of cost-sharing subsidies in the ACA marketplace has been a shift toward greater enrollment in bronze plans," said Katherine Hempstead, senior policy adviser at the Robert Wood Johnson Foundation, in a statement.

Insurers are required to lower the out-of-pocket costs for low-income ACA customers, but the Obama administration reimbursed the insurers. Trump halted the reimbursements, but insurers were still required to offer this cost-sharing assistance.

In response, most states allowed insurers to add the cost for this assistance onto the second-cheapest silver plan, a method called "silver loading." The law ties premium tax credits to the cost of that silver plan, so the move increased the tax credits.

"This approach increased silver premiums relative to other levels of coverage, increasing the federal cost of providing premium subsidies and making silver plans more expensive relative to other tiers of insurance offered," the analysis said.

Researchers looked at data released by the Centers for Medicare & Medicaid Services (CMS) in late 2019 on the enrollment trends in the 39 states that rely on HealthCare.gov to sign up residents for ACA coverage.

They found that, in 2018, the average silver plan premium rose by 38% above the cheapest bronze-tier plan. This major shift sparked an 11 percentage point drop in the enrollees getting silver plans.

Most of those customers decided to go for a bronze plan, which may have lower premiums but offer much higher out-of-pocket costs, the analysis found.

Silver remained the most popular tier of plans on the exchanges in 2018 in the states studied, with 64% of enrollees in a plan in the tier. Bronze tier plans enrolled 28% and gold 7%.

Another problem has been that customers may not know about the higher costs in bronze plans because the Trump administration dramatically decreased funding to the ACA's navigators that offer enrollment assistance. People who are eligible for tax credits if their income is below 250% of the federal poverty level are also eligible for out-of-pocket cost subsidies, but only if they enroll in a silver plan.

Researchers presumed that many consumers could be unaware of the financial implications of getting a bronze plan instead of silver.

"Better enrollment assistance might help low-income customers choose a plan where high out-of-pocket costs do not reduce the value of the coverage," Hempstead said.

The foundation noted that the price and enrollment issues are likely to continue this year and beyond, "highlighting the need for additional support for consumers navigating the trade-offs between premiums and out-of-pocket costs."

It also remains unclear whether CMS will make changes to silver loading. The agency toyed with outlawing the practice in early 2019 but decided against it after major pushback from insurers and providers.

Refuge in the Storm? ACA's Role as Safety Net Is Tested by COVID Recession
Steven Findlay

The Affordable Care Act, facing its first test during a deep recession, is providing a refuge for some — but by no means all — people who have lost health coverage as the economy has been battered by the coronavirus pandemic.

New studies, from both federal and private research groups, generally indicate that when the country marked precipitous job losses from March to May — with more than 25 million people forced out of work — the loss of health insurance was less dramatic.

That's partly because large numbers of mostly low-income workers who lost employment during the crisis were in jobs that already did not provide health insurance. It helped that many employers chose to leave furloughed and temporarily laid-off workers on the company insurance plan.

And others who lost health benefits along with their job immediately sought alternatives, such as coverage through a spouse's or parent's job, Medicaid or plans offered on the state-based ACA marketplaces.

From June to September, however, things weren't as rosy. Even as the unemployment rate declined from 14.7% in April to 8.4% in August, many temporary job losses became permanent, some people who found a new job didn't get one that came with health insurance, and others just couldn't afford coverage.

The upshot, studies indicate, is that even with the new options and expanded safety net created by the ACA, by the end of summer a record number of people were poised to become newly uninsured.

What's more, those losses could deepen in the months ahead, and into 2021, if the economy doesn't improve and Congress offers no further assistance, health policy experts and insurers say.

"It's a very fluid situation," said Sara Collins, vice president for health care coverage and access at the Commonwealth Fund, a New York-based health research group. "The ACA provides an important cushion, but we don't know how much of one yet, since this is first real test of the law as a safety net in a serious recession."

Collins also noted that accurately tracking health insurance coverage and shifts is difficult in the best of times; amid an economic meltdown, it becomes even more precarious.

Coverage Was Already on the Decline

Some 20 million people gained coverage between 2010 and 2016 under the ACA's expansion of Medicaid and its insurance marketplaces for people without employer-based coverage. A gradually booming economy after the 2008-2009 recession also helped. The percentage of the population without health insurance declined from about 15% in 2010 to 8.8% in 2016.

But then, even as the economy continued to grow after 2016, coverage began to decline when the Trump administration and some Republican-led states took steps that undermined the law's main aim: to expand coverage.

In 2018, 1.9 million people joined the ranks of the uninsured, and the Census Bureau reported earlier this month that an additional 1 million Americans lost coverage in 2019.

The accelerating decline is helping fuel anxiety over the fate of the ACA in the wake of the death of Supreme Court Justice Ruth Bader Ginsburg. The high court is scheduled to hear a case in November brought by Republican state officials, and supported by the Trump administration, that seeks to nullify the entire law.

In July, researchers at the Urban Institute, a Washington, D.C., think tank, forecast that around 10 million workers and their dependents would lose employer coverage in 2020. But they estimated that two-thirds of them will have found new coverage by year's end — leaving about 3.3 million uninsured.

A more recent Urban Institute report, released Sept. 18, and using 2020 data from the Census Bureau, calculated that of the roughly 3 million people under age 65 who had lost job-based insurance between May and July, 1.4 million found coverage elsewhere — most through Medicaid — and 1.9 million became newly uninsured. Notably, 2.2 million of those who lost their coverage were between 18 and 39 years old; 1.6 million were Hispanic.

Another recent study, using different methods, reported higher numbers for the same period. The analysis released by the Economic Policy Institute last month determined that between April and July 6.2 million people lost employer coverage. The authors didn't calculate how many found alternative coverage via Medicaid or the ACA, however.

Other findings support the notion that the health insurance loss trend shifted by mid summer. KFF, for example, published an analysis Sept. 11 showing that most companies that offered coverage to begin with chose to continue insuring furloughed and temporarily laid-off workers between March and the end of June. But as the virus continued to batter the economy, employers moved to permanently shed those jobs. (KHN is an editorially independent program of KFF.)

“The issue now is that the temporary layoffs have greatly decreased and permanent job losses, including jobs that came with health coverage, are increasing,” said Cynthia Cox, a KFF vice president and director for the Program on the ACA.

Many low-income workers who lose their jobs and don’t have coverage through a spouse or parent turn to Medicaid, the federal-state health program for low-income people. The Centers for Medicare & Medicaid Services reported last week that enrollment in Medicaid and the Children’s Health Insurance Program grew by 4 million between February and June, a nearly 6% increase since the beginning of the coronavirus crisis.

The Impact of the Marketplaces

Gains and losses of coverage in the ACA marketplace are not yet clear, experts say. The Trump administration issued a report in June indicating that 487,000 people had, between January and June, enrolled in an ACA plan via the federal website, healthcare.gov. But that report failed to say how many people dropped an ACA plan in that period — for example, because they could no longer afford the premiums.

A study by Avalere, a health research and consulting firm in Washington, D.C., has estimated that enrollment in the ACA marketplaces since March could have swelled by around 1 million. That includes new enrollees in the 13 ACA marketplaces that states, plus the District of Columbia, operate. Many of those states held a “special enrollment period” when the pandemic hit. Healthcare.gov, run by the Trump administration, did not offer a special enrollment period.

About 11 million were enrolled in an ACA plan in February. Open enrollment for coverage that would start on Jan. 1, 2021, begins Nov. 1.

Jessica Banthin, a senior health policy researcher at the Urban Institute and until 2019 deputy director for health at the Congressional Budget Office, said it’s anyone’s guess how many people who lost their job-based coverage this year will choose this option. She said numerous factors will influence people’s health insurance decisions this fall, and into 2021.

Chief among them is gauging whether they might soon get a new job, or get back an old job, that offers insurance. That may hold some people back from enrolling in an ACA plan this fall, Banthin said. Plus, buying insurance may be too expensive, especially for families more concerned with paying for housing, food and child care while going without a paycheck.

“Health insurance may not be their immediate concern,” Banthin said. “Many people’s lives have been disrupted as never before. There’s a lot of trauma out there.”

Collins of the Commonwealth Fund said that, even before the pandemic, a growing proportion of families were vulnerable to loss of coverage and care.

In a survey of more than 4,000 adults early this year, Collins and colleagues found a "persistent vulnerability among working-age adults in their ability to afford coverage and health care that could worsen if the economic downturn continues."

In large part, that's because 1 in 5 respondents who had coverage were "underinsured." Underinsurance reflects the extent to which coverage leaves people at risk of high out-of-pocket costs — a situation exacerbated by widespread job loss.

"Now is absolutely not be the time for the ACA to be further undermined, let alone killed outright," said Stan Dorn, director of the National Center for Coverage Innovation at Families USA.

Tracking the Uninsured Rate In 2019 And 2020
Katie Keith

Federal data shows that the uninsured rate has been rising since 2016 and rose again in 2019. New analyses of the uninsured population in 2019 show that consumers were struggling with coverage affordability even before the COVID-19 pandemic. And recent surveys and media reports suggest a deepening affordability crisis in 2020 as millions have been laid off from work or lost income. Enrollment in Medicaid and the Children's Health Insurance Program is rising, and some state-based marketplaces have reported much higher enrollment throughout 2020. In the meantime, the federal government still has not authorized a broad special enrollment period through HealthCare.gov where anyone who is uninsured could enroll in marketplace coverage.

The uninsured rate continued to rise in 2019. Two new analyses—one from the Centers for Disease Control and Prevention (CDC) and the other from the Congressional Budget Office (CBO)—discuss who was uninsured in 2019 and why. Consistent with a prior CDC analysis, an estimated 14.5 percent of non-elderly adults were uninsured in 2019. Men, young adults, Hispanic adults, and those in fair or poor health were more likely to be uninsured (compared to women, older adults, white adults, and those in better health, respectively).

CDC Analysis Delves Into Reasons For Uninsurance

But the latest CDC analysis went further to assess why adults were uninsured in 2019. The most common reason? Coverage was not affordable. Affordability was cited by an overwhelming 73.7 percent of respondents as their reason for being uninsured. Affordability challenges increased with age: 80.9 percent of those aged 50 to 64 cited

affordability challenges, compared to 66.8 percent of those aged 18 to 29. Even so, young adults were more likely to be uninsured than older adults.

Beyond affordability, about one-quarter of respondents were uninsured because they were ineligible for coverage; this rate was higher among Hispanic adults relative to non-Hispanic white adults and higher among women relative to men. About one-fifth of uninsured adults reported not needing or wanting coverage: this rate was far higher for men and those in better health than for women and those in fair or poor health. Other reasons for being uninsured were that enrolling in coverage was too difficult or confusing, the individual could not find a plan that met their needs, or the individual applied for coverage but it had not yet gone into effect.

CBO Report Finds Many Uninsured Adults Eligible For, But Not Enrolled In, Job-Based Coverage

The CBO released a similar analysis on who went without health insurance and why. Low-income people were more likely than others to be uninsured in 2019, and employment status was not strongly linked to coverage in 2019. In fact, the vast majority of uninsured people had at least one full-time worker in their family in 2019. Of the estimated 29.8 million uninsured people in 2019, 67 percent (20 million) were eligible for subsidized coverage whether through Medicaid, the marketplace, or job-based coverage. Most of these individuals—31 percent (9.4 million people)—were eligible for but not enrolled in job-based coverage. Of the remaining 33 percent (9.8 million) who were not eligible for subsidized coverage, 13 percent were not lawfully present in the United States and thus ineligible, 11 percent were in the Medicaid coverage gap, and 9 percent had incomes too high to qualify for marketplace subsidies.

Consistent with the CDC analysis, the CBO found that many uninsured people do not enroll in coverage because of cost. About one-third of uninsured single adults would have to contribute more than 10 percent of their income towards health insurance. Others do not realize they qualify for subsidies or are deterred by the complexity of the enrollment process. Still others qualified for marketplace subsidies but could not afford to enroll in coverage; this was especially true for those whose income is over 250 percent of the federal poverty level. The public charge rule may also have discouraged recent immigrants from enrolling eligible children in Medicaid coverage because of the perceived impact on their ability to become a permanent legal resident.

The CBO also looked at the length of time that individuals remain uninsured. The vast majority of the uninsured—80 percent—went without coverage for one year or more, 11 percent were uninsured for 1 to 5 months, and another 9 percent were uninsured for 6 to 11 months. This suggests that many uninsured people are chronically uninsured for long stretches of time.

Significant Coverage Losses Ahead?

Although definitive data will not be available until 2021, numerous studies have estimated the effect of the 2020 recession on job-based coverage and the uninsured

rate. Analyses have been conducted by Avalere Health, the Commonwealth Fund, the Economic Policy Institute, Families USA, the Kaiser Family Foundation, and the Urban Institute, among others. The Urban Institute even conducted a separate analysis of some of these studies to compare their assumptions and estimates.

Most of these studies suggest significant coverage losses already, as economic upheaval from the pandemic has led consumers to lose their job-based coverage or a family member's job-based coverage. Covered California, for instance, reports record-high numbers of covered members and enrolled nearly 290,000 Californians since late March 2020.

Others, such as a Commonwealth Fund survey through early June 2020, did not show significant coverage changes relative to prior years (although it did show persistent affordability challenges). The CBO expects the number of uninsured people to increase to only about 31 million in 2020, with coverage losses mitigated by a range of factors, including the fact that the Affordable Care Act has enabled many would-be uninsured people to obtain Medicaid or marketplace coverage. And while nationwide enrollment through Medicaid and CHIP has grown by nearly 4 million people since March, observers believe that this growth is driven not by the newly uninsured but by a requirement that states freeze disenrollment during the public health crisis under the Families First Coronavirus Response Act.

Coverage losses may have been blunted so far for several reasons. Some employers, for instance, continue to provide coverage to laid-off and furloughed employees, but this trend may not last for long as the pandemic and recession continue. Media reports warn of looming cutoffs, especially as employers grapple with end-of-year coverage renewal deadlines. And many consumers who find their way to the individual market, including those eligible for premium tax credits, may not be able to afford even subsidized coverage. Some state-based marketplaces that allowed broad enrollment during COVID-19 found that consumers who selected a plan were unable to pay their first month's premium, and Covered California reports affordability challenges (including for consumers who receive subsidies) even though the state offers supplemental subsidies for low- and middle-income consumers.

These challenges—for employers and individuals—are among the reasons why stakeholders have urged Congress to further enhance federal funding for Medicaid programs, provide COBRA subsidies for employees, and require a broad special enrollment period through HealthCare.gov. Some of these priorities were in the revised Heroes Act passed by the U.S. House of Representatives in early October.

Silver-Loading Likely To Continue Following Federal Circuit Decision On CSRs
Aviva Aron-Dine and Christen Linke Young

Insurance companies recently won a narrow victory in the Federal Circuit Court of Appeals. The court held that insurers were entitled to recover unpaid cost-sharing reduction (CSR) payments that the Trump Administration withheld, but only to the extent insurers had not recouped their losses through higher premiums. In this piece, we examine the likely consequences of the decision.

We expect lengthy legal proceedings, at the end of which most insurers will not receive much—if any—compensation for 2018 to the present, since they successfully recouped the costs of CSRs, usually through the approach known as "silver loading." We further expect both regulators and insurers to conclude that silver loading should continue in the wake of the decision. But since the decision could create some uncertainty and confusion, regulators may wish to issue additional clarifying guidance on silver loading, confirming that insurers are expected to price to fully mitigate the loss of CSRs.

Background

The Affordable Care Act (ACA) requires insurers to reduce deductibles and other cost-sharing charges for certain lower-income individuals enrolled in silver-level plans. Prior to 2017, the federal government compensated insurance companies directly for the value of these cost-sharing reductions (CSRs) by making periodic payments to insurers, totaling about $7 billion per year. In October 2017, the Trump Administration announced it would no longer make CSR payments to insurers due to an ongoing dispute about whether federal law provided an appropriation for the payments.

Beginning in 2018, insurers responded to the cessation of payments by increasing their premiums to compensate for the revenue they would have otherwise received. By 2019, insurers in almost all states were silver loading, applying premium increases only to silver plans. However, three states in 2019 (and several more in 2018) directed insurers to distribute increases across all plans ("broad loading").

Some insurers also sued the federal government to recover unpaid CSRs.

The Federal Circuit's Decisions

In August 2020, the Federal Circuit decided two cases, Sanford Health Plan v. U.S., which addressed unpaid CSRs for the last three months of 2017, before insurers had

the opportunity to adjust their premiums, and Community Health Choice v. U.S., which primarily addressed CSRs for 2018 and beyond. The court in Sanford concluded that regardless of whether or not the ACA provides an appropriation to pay CSRs, the CSR statute "falls comfortably within the class of moneymandating statutes," and private parties may sue the federal government for damages if payments are not made. Therefore, for 2017, insurers are entitled to a damages award for the amount of the CSR payments they should have received.

For 2018 and beyond, however, the court in Community Health Choice recognized the insurers could and generally did mitigate their losses by increasing premiums, and their damages must be offset by the amount of mitigation. Specifically, the court concluded that the CSR statute imposes "contract-like obligations," and therefore general principles of contract law should govern the calculation of the damages owed. A key such principle is that a plaintiff should not receive a judicially created "windfall," so if a plaintiff has been able to mitigate the loss caused by a breach of contract, the defendant's payment should be reduced by an equivalent amount.

The decision remanded the case back to the trial court to determine the amount of mitigation. It instructed the lower courts to focus on the "amount of premium increases (and resultant premium tax credits [or PTCs]) attributable to the government's failure to make cost-sharing reduction payments." Based on one of its precedent from 2001, Hughes Communications Galaxy v. U.S., the Federal Circuit in parts of its opinion suggested that only amounts insurers recovered from the federal government via higher PTCs—and not amounts recovered directly from consumers—constitute mitigation, but the decision does not reflect a clear holding on this point. (See Note 1)

The Federal Circuit's decision also provided three general principles that should guide the lower courts in calculating damages and mitigation. First, the lower courts should consider the specific facts associated with premium increases and attempt to determine the amount actually associated with CSRs. Second, the Federal Circuit found that the insurers will have the burden of persuasion to show that they did not fully recover CSR costs, versus the government having the burden to show that insurers did recover. Third, the appellate court noted that the lower court should generally count enhanced PTCs paid for non-silver plans as mitigation in states where broad loading occurred, and would need to determine if that was also true in cases where premium increases were limited to silver plans. (See Note 2)

Finally, note that contract law also generally conveys a "duty to mitigate": if a tenant breaks their lease, the landlord must at least try to find a new tenant. The Federal Circuit did not address whether that doctrine also applied in these cases, noting that it need not decide the issue because the insurers had in fact mitigated.

Lengthy court proceedings will likely follow. The insurers have asked the full Federal Circuit to reconsider the court's decision in Community Health Choice. Assuming the ruling stands, the case will be remanded to the lower court to determine payments owed. The Federal Circuit's principles do not amount to concrete instructions. The lower courts will first have to decide how they are determining damages. In particular, will the

degree of mitigation—and, thus, damages—be determined based on the change in insurers' premium collections, total PTC payments, or PTC payments exclusively for silver plans? Under any of these standards, the courts will then have to wrestle with the complex empirical question of how premiums and other outcomes changed as a result of the federal government's decision not to pay CSRs. At some point, insurers and the government may enter into settlement discussions, but the process is likely to be extensive and time-consuming. It is perhaps instructive that the contract breach at issue in Hughes occurred in 1986, and litigation on the remedy continued until at least 2001.

Considerations In Determining Damages

Regardless of which approach the lower courts ultimately take to determine damages, most insurers are likely to receive limited, if any, compensation for years after 2017.

To see why, it's helpful to take a short detour into the economics of silver-loading, starting with a stylized case where insurers make optimal pricing decisions and consumers make optimal plan selection decisions in response to the cessation of CSR payments. As outlined here, the result is that only CSR-eligible consumers enroll in silver plans, insurers increase silver-plan premiums by the average cost of CSRs, and PTCs increase by that amount as well. That means the federal government covers the full cost of CSRs through higher silver-plan PTC payments. Meanwhile, consumers who are not eligible for CSRs use the larger PTCs to purchase non-silver plans at lower net costs, which, as explained elsewhere, leads to higher enrollment by these consumers.

The economic conclusion is that insurers end up strictly better off without CSR payments: they collect the full cost of CSRs through higher PTCs, while their net revenue increases due to higher enrollment. The legal analysis in the stylized case is also straightforward: whether mitigation is determined based on premiums, total PTCs, or silver-plan PTCs, insurers are not entitled to damages.

Differences between reality and the stylized case introduce some additional complications. For example, some unsubsidized consumers are still buying silver plans, so insurers are recovering CSR costs partly through higher premiums paid by these consumers, rather than entirely through higher PTC payments. Additionally, insurers may not have priced optimally in response to the loss of CSRs, for example if they failed to predict consumer responses to premium changes.

Nonetheless, under any of the three standards discussed above, most insurers are unlikely to collect significant damages, at least in the large majority of states where insurers silver loaded.

If the courts assess the degree of mitigation based on total PTC payments, then insurers more than mitigated their losses. In aggregate, annual federal PTC spending has increased by about $10 billion more than the full cost of CSRs because the federal government is making higher PTC payments for all eligible consumers, not just the subset who are CSR-eligible. While there may be unusual cases where a given insurer

is receiving less in additional PTCs than it would have been owed in CSRs, these cases should be rare.

If the courts instead base damages on silver-plan PTCs or premium collections, pricing mistakes could be more consequential. On average, however, insurers appear to have priced roughly correctly for the loss of CSRs even in 2018, or perhaps slightly overpriced—measures of the extent of silver-loading declined slightly in 2020, suggesting that insurers concluded, on average, that they had slightly overcorrected.

And importantly, as noted above, the Federal Circuit put the burden of persuasion on insurers to demonstrate that they have not recouped the full cost of CSRs. Particularly for later years, it would be reasonable for the courts to require insurers to present strong evidence to overcome the presumption that they would have set prices to fully mitigate CSR losses, given that they had all the information necessary to do so.

Of note, even where insurers' rate filings break out the impact of silver loading on premiums, courts should not necessarily take these stated rating factors as dispositive, since they may not capture the true economic impact of the non-payment of CSRs. As one example, Indiana regulators continue to instruct insurers to broad load rather than silver load. But premium gaps between silver and bronze plans have risen significantly since 2017, suggesting insurers may have found a way to silver-load anyway.

Moreover, the court suggested insurers are responsible for comparing their "financial picture… to what it hypothetically might have been if the [cost-sharing reduction reimbursements] had been timely paid." This seems to suggest insurers in silver-loading states might also have to show they didn't recover from higher enrollment (due to higher subsidies for non-silver plans), adding to their burden.

Finally, if the courts instead compute damages based on silver plan PTC payments only, they will have to take into account that insurers are recovering CSR costs partly through higher premiums paid by unsubsidized consumers. Again, however, the practical significance may be limited, since unsubsidized consumers account for only about 5 percent of marketplace silver-plan purchases .

Courts may also need to address damages in the small number of states that instructed insurers to broad load rather than silver load. Where broad-loading has occurred, insurers are recovering CSR costs through higher premiums paid by all enrollees, with unsubsidized consumers paying a share roughly equal to the unsubsidized share of total enrollment. Thus, if courts decide to count only PTC payments as mitigation, insurers in these states could recover a meaningful fraction of CSR costs through the courts. But note that this would be a clear double payment: consumers have already paid these costs in the form of higher premiums (though perhaps with slightly depressed enrollment).

In 2018, regulators in a few other impacted states also sought to prevent insurers from building CSR costs into premiums at all. To the extent they succeeded, these insurers may have a strong claim to damages for 2018.

Implications For Individual Market Pricing Going Forward

Both regulators and insurers are likely to conclude that the best path forward following the Federal Circuit decision is to continue silver loading.

Given the likely duration of litigation and the uncertainty around how courts will calculate damages, attempting to end silver-loading would likely result in confusion, high-risk premia, and possible withdrawal from the market by small insurers that couldn't afford to wait out litigation, all in addition to making plans less affordable for many consumers. Regulators, focused on market stability and ensuring consumer access to coverage, will likely prefer to continue the status quo.

Insurers will likely also conclude that continuing to silver load is their best option. While insurers might consider attempting to undercut their competitors by not silver loading and instead trying to recover their full CSR costs through the courts, they risk large losses by doing so. Most importantly, if courts conclude that insurers have a duty to mitigate CSR losses through premium increases to the extent they are able, an insurer that chooses not to silver-load would not recover. And indeed, it seems that a court forced to confront the question would conclude such a duty applies. The Community Health Choice decision embraces a contract law theory of remedies, so it is unclear what principle would excuse insurers from the usual duty to mitigate.

Even if a court were to decide otherwise, the burden would be on the insurer to show that it truly did not build CSR costs into premiums. And if the lower courts decide to base damages on total federal subsidies, the insurer might have to show that its competitors' pricing did not increase the benchmark premium and therefore PTCs, which would increase its collections as well. Moreover, as discussed above, the legal process is likely to play out over years, not months.

Given this logic, silver loading should continue even if regulators take no action. But to reduce the possibility of confusion, regulators may wish to issue additional guidance on silver loading, making explicit that insurers are expected to price to fully mitigate the loss of CSRs and that the expectation is that insurers are obtaining full compensation through their pricing.

Note 1

In Hughes, NASA breached a contract associated with launching satellites. The government argued that while the satellites were ultimately launched at higher costs, the manufacturer had mitigated its damages because users paid higher fees to offset the higher launch cost. The Federal Circuit disagreed, concluding that it would focus only on the cost of the services covered by the contract (the launch of the satellites) and that the mitigation "inquiry is best ended at 'the first step.'" It is somewhat unclear how the Hughes holding should be applied to the CSR cases. The Community Health Choice opinion at times seems to treat Hughes as standing for the proposition that costs borne by consumers will generally not be treated as mitigation, but is not conclusive on this point. One could argue that unlike in the NASA case, insurers setting higher premiums is

the “first step” in the mitigation of unpaid CSRs, and the premium (not the tax credit) is the relevant yardstick to measure the costs of the items covered by the “contract.”

Note 2

The court says:

“As previously mentioned, increasing the premium rates for silver plans resulted in an increase in premium tax credits for all plans on the exchange. In some states, state regulators have also allowed insurers to recoup part of their lost cost-sharing reduction reimbursements by increasing premiums for other, non-silver plans on the exchange. In these circumstances, the tax credits for these other plans (attributable to the silver plan premium increase) are still caused by the elimination of costsharing reduction payments and will, of course, reduce the government’s liability. But we do not address whether in situations where, as here, there have been no premium increases for other plans, the government’s liability should be reduced for the increased tax credit payments with respect to other plans. We leave that issue to the Claims Court in the first instance.”

This language raises some questions. Higher PTCs for bronze plans are largely unrelated to an insurer’s decisions about pricing for those plans. Instead, they largely reflect its own (and its competitors’) decisions about pricing of silver plans alone. Thus, it is unclear what distinction the Federal Circuit is asking the lower court to consider.

Bloomberg

This Essential Part of Obamacare Needs Expanding
Cathy O’Neil

The nomination of Amy Coney Barrett to the Supreme Court, and the related existential threat to the Affordable Care Act, got me to thinking about something even more troubling: the many ways in which society takes information about people — often on qualities or events that are irrelevant or out of their control — and uses it against them.

It’s a tendency that we need to curb.

The ACA is a notable case where Congress did something to restrict how personal information can be used. The law forbids health insurers to deny coverage or charge extra to people with pre-existing conditions — or even to ask customers about their medical histories. This makes sense, because if the companies can avoid anyone who might get sick, insurance ceases to be insurance, and a single illness can become the beginning of an inexorable spiral into penury.

Politicians on both sides of the aisle seem to recognize the importance of the pre-existing condition clause. Ted Cruz recently supported keeping it even if the Supreme Court strikes down the ACA, and President Donald Trump has promised to do so through an executive order (not that his word means much). Tens of millions of Americans have pre-existing conditions, and they'll rightly blame Republicans if they get dinged or priced out of insurance.

This is particularly crucial in the time of Covid-19. Infections have added a pre-existing condition to the records of millions of people, many of whom have also lost their jobs and will be seeking health insurance in the coming months. If insurers can demand medical histories — or get information on infections from tracing apps, which are vulnerable to hacking and aren't necessarily covered by medical privacy laws — the pandemic will vastly expand the ranks of the dis-insured.

So limiting the information that companies can see and use has huge benefits in health care. But why stop there? Other types of pre-existing conditions — the neighborhood where a person lives, a person's network of friends — are regularly used to make decisions such as who gets a job interview, who gets an apartment, who gets a loan and who gets granted parole. All too often, the information is biased in ways irrelevant to the decision being made, or serves as a proxy for protected characteristics such as race, age or gender.

I'm not suggesting banning the use of valuable background information. Rather, the kind, scope and age of information allowable should be carefully circumscribed, keeping in mind what is appropriate for a given situation.

Consider the millions of Americans, disproportionately Black and Hispanic, who will suffer eviction during the coronavirus crisis. What might have been a temporary setback, completely beyond their control, could end up haunting them for years, as third-party data brokers report it to potential landlords. A "pre-existing conditions" rule in housing could at the very least remove such events from a person's record after a designated period of time — as credit reporting bureaus already do with late payments for the purpose of computing credit scores.

Restrictions should also apply to using data to infer information about people. In "Ban the Box" states that forbid asking about a job applicant's criminal record, for example, employers can infer the likelihood of convictions from other indicators, such as ZIP codes and gaps in consumer histories. This is similar to what Facebook does to target ads, classifying people primarily by demography instead of understanding specific qualifications. It makes lucky people luckier while denying opportunities to people born in the wrong place. In a nutshell, it short-circuits the American Dream.

A more generalized approach to "pre-existing conditions" would help prevent irrelevant or old information from being unfairly used against us, just as the ACA's pre-existing condition clause prevents insurance companies from discriminating against the most vulnerable among us.

POLITICO

Not just Obamacare: How Supreme Court's conservative majority could remake American health care
Susannah Luthi

Across four days of hearings, senators reviewing Amy Coney Barrett's nomination to the Supreme Court sparred extensively over Obamacare's future. Left largely unmentioned, though, is the many ways the court's buttressed 6-3 conservative majority could quickly steer America's health care system to the right even if Obamacare survives its looming legal showdown.

On tap for the justices to consider are rules to require people on Medicaid to work or lose their benefits, skimpier insurance alternatives for Obamacare that the Trump administration has championed, and cuts to federal funding for Planned Parenthood clinics.

Barrett appears on track to join the Supreme Court by its Nov. 10 hearing on the Affordable Care Act and before it weighs whether to take up a raft of health care cases that advance conservatives' goals of paring the health care safety net. While the court's ideological wings don't always vote as monolithic blocs, Barrett would represent another reliably conservative vote for the court – and it takes just four justices to agree to hear a case.

"Regardless of where you think the chief justice and Brett Kavanaugh are on these issues, the realignment means that there are four justices potentially to the right of them," said liberal Yale law professor Abbe Gluck.

Democrats during this week's hearings have sought clues on how Barret would approach abortion cases and the Trump-backed lawsuit against Obamacare. Much to Democrats' frustration, she provided few indications of how she might rule, though she acknowledged how a legal doctrine could save Obamacare from its latest challenge.

Meanwhile, much of Trump's broader health agenda remains at stake in the courts, as do new controversies that may arise during the coronavirus pandemic. Just this week, health experts in JAMA looked at whether coronavirus vaccine distribution plans that prioritize vulnerable minority populations hard hit by the virus could face legal challenges. A case involving pandemic-related abortion rules that was turned away by the Supreme Court just last week is still expected to move quickly through lower courts and could come back before the justices.

A solidly conservative bench may be more likely to preserve an appeals court ruling that upheld Trump's expansion of short-term health plans, which are cheaper than Obamacare coverage because they typically exclude the law's protections, including those for preexisting conditions. A similar challenge involving another Obamacare alternative known as association health plans is still winding through lower courts. Republican-appointed judges who've reviewed those cases have rejected challengers' claims that the health plans are invalid because they undermine Obamacare.

The Supreme Court is also widely expected to back the administration's position in challenges to its rules cutting off federal family planning funds to Planned Parenthood and other abortion providers. A conservative-leaning panel of the 9th Circuit Court of Appeals has allowed the policy to take effect nationwide, while another appellate court has blocked it only in Maryland. Abortion rights supporters have asked the Supreme Court to overturn the Trump rules.

The court could also soon take up Trump's "public charge" rule that would make it more challenging for legal immigrants to get green cards if they use public benefits like Medicaid. The Supreme Court earlier this year allowed the rule to take effect while ongoing challenges played out in lower courts, but the administration has asked the court to rule on the merits of the policy.

Barrett would have to recuse herself from Supreme Court review of public charge, since she previously ruled in the administration's favor in a lawsuit she heard at the 7th Circuit Court of Appeals. In her ruling, which was opposed by the appellate panel's two other judges, Barrett said the courts weren't the appropriate venue to settle what she said amounted to a policy dispute.

There's no guarantee of which cases the Supreme Court might accept, but conservatives' strong majority will give them a major advantage in setting the court's docket.

Still, lower court decisions will factor into their decisions about which cases to take up. Medicaid work rules, the Trump administration's signature effort to shrink enrollment in the low-income health care program, have been rejected by two lower courts. Those decisions found approvals of the work rules were "arbitrary and capricious" and didn't adequately consider how many people might lose coverage because of them. This could make the administration's challenge to those rulings less attractive to the Supreme Court, although the justices usually give more deference to executive branch requests to review cases. About 20 states, predominately Republican-led, have received or sought the Trump administration's permission to enact work rules for some enrollees.

Conservative legal experts pointed out that the court's conservatives might look unfavorably on some health care policies the Trump administration has advanced. Some of these, like an overhaul of Medicare payments to discourage hospital consolidation and rules forcing hospitals to disclose negotiated insurance rates, have bipartisan appeal but test the bounds of executive power to force change through regulation. An administration policy requiring drugmakers to include prices in television ads has already

been rebuked by two federal courts who said the health department lacked the power to do so.

“Some of the things that the Trump administration was trying to do involved aggressive interpretations of statutory authority,” said Jonathan Adler, a law professor at Case Western University. “That’s unlikely to find a favorable ear from more conservative justices.”

Meanwhile, no matter who wins the presidential election, long-running legal battles over Obamacare’s “culture war” issues are likely to continue. The Trump administration’s rewrite of the law’s antidiscrimination provisions to remove care guarantees for transgender patients is facing numerous challenges in lower courts. So are Trump rules that would expand “conscience” protections for doctors and other providers who object to performing certain procedures, like gender transition services and abortion.

If Joe Biden wins the presidency, he’ll seek to roll back much of Trump’s regulatory changes to the health care system. But that will trigger a new wave of legal challenges that will come before a federal judiciary that’s been filled with conservative Trump appointees.

“In health care, it’s all going to the courts,” said Georgetown law professor Katie Keith. “And that’s what you have to prepare for.”

Forbes

Poll: Obamacare More Popular Than Ever As SCOTUS Vote Looms
Bruce Japsen

The Affordable Care Act wins 55% support among the public for its highest level ever recorded since becoming law a decade ago, according to the latest Kaiser Family Foundation tracking poll released Friday.

The poll finds growing support for the ACA, also known as Obamacare, across the political spectrum, including Republicans, who don’t want the law’s protections for Americans with pre-existing medical conditions to go away. The ACA was signed into law in 2010 by President Barack Obama and has expanded health insurance coverage to more than 20 million Americans.

The survey showed 55% of the public has a favorable view of the ACA, “matching the highest share ever recorded in 10 years of (Kaiser Family Foundation) polling,” the foundation said. That compares to 39% who now hold “unfavorable views” of the law.

Just last month, support of the ACA was at 49%, Kaiser said, but the presidential election campaign, the spread of Covid-19 and worsening pandemic have contributed to the law's increasing popularity.

The poll comes as the U.S. Senate weighs confirmation of Judge Amy Coney Barrett's nomination by Donald Trump to the U.S. Supreme Court. The ACA is also a key issue in the presidential race with Democrat Joe Biden campaigning to protect the law and expand its patient protections and coverage while Trump wants to get rid of it without a replacement plan.

Should Barrett win Senate confirmation, she could be a key vote when the high court considers a lawsuit pushed by Republican attorneys general and backed by the Trump administration that would overturn the ACA.

The ACA created public exchanges that allow Americans to buy individual coverage and many get federal government subsidies to do so that are based on income. The ACA included generous funding to allow more states to expand their Medicaid coverage for the poor and all but 12 Republican-leaning states have done so.

But perhaps more than anything, Americans worry about the potential for the ACA's patient protections to disappear.

"Many Americans worry about what could happen to them if insurance companies were able to discriminate against family members with pre-existing conditions, and that's why the issue has become a flashpoint in the election," Kaiser Family Foundation chief executive Drew Altman said in a statement accompanying the poll results.

Trump keeps chipping away at Obamacare with only weeks until the election -- and a Supreme Court hearing
Tami Luhby

(CNN) The Trump administration has taken a step to weaken the Affordable Care Act in a key battleground state, with only weeks to go until Election Day as well as Supreme Court arguments that could determine the landmark law's future.

The administration this week approved Georgia's waiver request to provide Medicaid coverage to certain low-income residents if they work or participate in other qualifying activities for at least 80 hours a month. It's the latest state to receive permission to require work as a condition of coverage, though implementation elsewhere has been halted by federal courts or state officials.

Also, the Centers for Medicare and Medicaid Services announced it had completed its review of Georgia's more controversial request to make fundamental changes to the state's Affordable Care Act exchange. The agency, which opened the door for states to create alternatives to Obamacare in 2018, is still finalizing the terms for approval.

The Peach State, which has the nation's third highest uninsured rate at 13.4%, is the first to seek this enhanced power to reshape its individual market.

Georgia and federal officials say that these efforts will make coverage more available and affordable to residents, but consumer advocates say they are the latest attempts to undercut the law.

"It's a road map of what they would allow were the ACA to be struck down and were they to win election again," said Judy Solomon, senior fellow at the Center on Budget and Policy Priorities.

These moves come as health care takes center stage in the 2020 presidential campaign. Former Vice President Joe Biden's campaign has hammered Trump for trying to take down the landmark health reform law and its protections for those with pre-existing conditions. Trump has repeatedly said he has a replacement plan that would continue those safeguards but has yet to produce one.

Also, Trump's Justice Department is backing a coalition of Republican-led attorneys general, who argue that Obamacare's individual mandate was rendered unconstitutional after Congress reduced the penalty for not having insurance to zero as part of the 2017 tax cut law. As a result, the entire health reform law must fall, they argue. The Supreme Court will hear oral arguments in the case on November 10.

The administration has pursued multiple avenues to overturn the Affordable Care Act in its first term. After efforts to repeal the law in Congress failed in 2017, officials started undermining it from within, including shortening the annual enrollment period to obtain coverage on the exchanges and slashing the budget for outreach and assistance. It also broadened the availability of alternative plans, primarily short-term health insurance policies that typically have lower premiums but are allowed to base coverage and premiums on people's medical histories.

Also, officials took the unprecedented step in 2018 of allowing states to institute work requirements in Medicaid, a longtime Republican goal. However, the effort has been set aside by federal courts in four states, prompting the six others that had received

approval (prior to Georgia) to stop implementation. Another eight states are awaiting permission from the Centers for Medicare and Medicaid Services.

What Georgia wants to do

Georgia is not looking to expand Medicaid under the Affordable Care Act. The waiver only applies to those earning up to the poverty level, or $12,760 for an individual. Many will also have to pay monthly premiums.

The federal approval also allows the state to pick up part of the tab for employer coverage if eligible residents have access.

Implementation will begin July 1. Nearly 65,000 Georgians will gain coverage, according to state estimates.

Nearly 650,000 residents could enroll if the state fully expanded Medicaid to those earning up to 138% of the poverty level, according to an Urban Institute estimate, which does not take into account changes wrought by the coronavirus pandemic.

The administration did not approve the state's request to receive the more generous federal match that comes with full Medicaid expansion.

Georgia is also seeking to make two changes to its individual market. It is looking to implement a reinsurance program, which typically reduces premiums by protecting insurers from high-cost patients. More than a dozen states have received federal approval to do this.

But the Peach State also wants to shift the platform used for enrollment in the Affordable Care Act individual market from the federal exchange, healthcare.gov, to a private sector one called the Georgia Access Model in 2023.

State officials argue that the move will give residents access to a broader array of options from web brokers, health insurance companies and traditional agents. Advocates, however, fear that it could shift healthier people to less comprehensive, non-Obamacare plans and leave those with pre-existing conditions facing higher premiums for Affordable Care Act policies.

Obamacare premiums decline for 3rd year in a row as Trump seeks to take down the landmark law
Tami Luhby

(CNN) Even as the Trump administration seeks to kill the Affordable Care Act, it is taking credit for making it more attractive to consumers.

The average premium for the benchmark plan will drop by 2% next year in the 36 states using the federal exchange, the third year in a row of declines, the Centers for Medicare and Medicaid Services announced Monday. Premiums have declined a total of 8% since 2018.

Also, many consumers will have a greater choice of plans. Some 22 more issuers will offer coverage next year, when considering states that are also participating in the federal exchange this year. That brings the total to 181. The share of counties with only one participating insurer will drop to 9% next year, down from 50% in 2018.

The trend is a marked turnaround from the early days of the Affordable Care Act exchanges, which launched in 2014. Many insurers underestimated the health needs of enrollees and priced their plans too low, causing them to suffer big losses. Some left the market, while others raised rates by double digits to stem the bleeding.

Also, President Donald Trump's efforts to undermine the health care law in the first year of his administration were a factor in carriers raising the average premium for the benchmark plan by 37% in 2018.

Since then, the market has stabilized and become more attractive, drawing insurers back into the exchanges and prompting new carriers to offer policies. In addition, the Trump administration has approved more than a dozen state requests to enact reinsurance programs, which lower premiums by shielding insurers from high-cost patients.

The average monthly cost of the benchmark plan next year will be $379 for a 27-year-old and $1,486 for a family of four. However, those who qualify for federal subsidies will pay less than 10% of their income. Some 88% of enrollees on Healthcare.gov receive assistance.

For next year, an individual earning less than $51,040 and a family of four making less than $104,800 are eligible for subsidies.

Open enrollment starts November 1 and runs through December 15 in the states using the federal exchange. Pennsylvania and New Jersey are leaving Healthcare.gov next year, joining 12 other states and the District of Columbia in running their own exchanges.

About 11.4 million people signed up for coverage on the exchanges for 2020, down from a high of 12.7 million in 2016.

The Affordable Care Act remains in effect while its future is decided in the courts. The Supreme Court will hear oral arguments in a case seeking to overturn Obamacare on November 10.

KHN
KAISER HEALTH NEWS

Even With ACA's Fate in Flux, Open Enrollment Starts Soon. Here's What's New.
Julie Appleby

Facing a pandemic, record unemployment and unknown future costs for COVID-19 treatments, health insurers selling Affordable Care Act plans to individuals reacted by lowering rates in some areas and, overall, issuing only modest premium increases for 2021.

"What's been fascinating is that carriers in general are not projecting much impact from the pandemic for their 2021 premium rates," said Sabrina Corlette, a research professor at the Center on Health Insurance Reforms at Georgetown University in Washington, D.C.

Although final rates have yet to be analyzed in all states, those who study the market say the premium increases they have seen to date will be in the low single digits — and decreases are not uncommon.

That's good news for the more than 10 million Americans who purchase their own ACA health insurance through federal and state marketplaces. The federal market, which serves 36 states, opens for 2021 enrollment Nov. 1, with sign-up season ending Dec. 15. Some of the 14 states and the District of Columbia that operate their own markets have longer enrollment periods.

The flip side of flat or declining premiums is that some consumers who qualify for subsidies to help them purchase coverage may also see a reduction in that aid.

Here are a few things to know about 2021 coverage:

It might cost about the same this year — or even less.

Despite the ongoing debate about the ACA — compounded by a Supreme Court challenge brought by 20 Republican states and supported by the Trump administration — enrollment and premium prices are not forecast to shift much.

“It’s the third year in a row with premiums staying pretty stable,” said Louise Norris, an insurance broker in Colorado who follows rates nationwide and writes about insurance trends. “We’ve seen modest rate changes and influx of new insurers.”

That relative stability followed ups and downs, with the last big increases coming in 2018, partly in response to the Trump administration cutting some payments to insurers.

Those increases priced out some enrollees, particularly people who don’t qualify for subsidies, which are tied both to income and the cost of premiums. ACA enrollment has fallen since its peak in 2016.

Charles Gaba, a web developer who has since late 2013 tracked enrollment data in the ACA on his ACASignups.net website, follows premium changes based on filings with state regulators. Each summer, insurers must file their proposed rates for the following year with states, which have varying oversight powers.

Gaba said the average requested increase next year nationwide is 2.1%. When he looked at 18 states for which regulators have approved insurers’ requested rates, the percentage is lower, at 0.4%.

Another study, by KFF, of preliminary premiums filed this summer had similar findings: Premium changes in 2021 would be modest, only a few percentage points up or down. (KHN is an editorially independent program of KFF.)

It’s still worth it to shop around.

Actuaries and other experts say premiums vary by state or region — even by insurer — for a number of reasons, including the number and relative market power of insurers or hospitals in an area, which affects the ability of insurers to negotiate rates with providers.

Because subsidies are tied to each region’s benchmark plan, and those premium costs may have gone down, subsidies also could decrease. (Benchmark plans are the second-lowest-priced silver plan in a region.)

Switching to the benchmark plan can help consumers maintain how much they spend in premiums.

Enrollees should update their financial information, particularly this year when many are affected by work reduction or job losses. “They might be eligible for a bigger” subsidy, said Myra Simon, executive director of commercial policies for America’s Health Insurance Plans, the industry lobbying group.

Enrollees can update their information online, or call their federal or state marketplace for assistance. Insurance brokers, too, can aid people in signing up for ACA plans. When shopping, consumers should check whether the doctors and hospitals they want to use are included in the plan’s network.

Premiums are just one part of the equation. Consumers should also look closely at annual deductibles, because the trade-off of going with a lower-cost premium may well be higher annual deductibles that must be met before much of the coverage kicks in.

“We encourage people to consider all their options,” said Simon.

What’s behind the variation.

Enrollees in some states next year will see premium decreases, according to Gaba’s website: Maine, for example, shows a 13% drop in weighted average premium prices, while Maryland’s is down almost 12%. At the same time, Indiana’s average is up 10%. And Kentucky is up 5%.

Both Maine and Maryland attribute the decrease to state programs that provide reinsurance payments to health insurers to help offset high-cost medical claims.

In Florida, regulators say insurance premiums will rise about 3%, while the state exchange in California is reporting just over a half-percent increase, its lowest average increase since opening in 2014. Officials in California cite factors that include an influx of healthier enrollees and a reduction in fees that insurers pay.

Other factors affecting rates include how much state regulators step in to alter initial rate filings, along with a provision of the ACA that requires insurers to spend at least 80% of revenue on direct medical care. If insurers don’t meet that standard, they must issue rebates to policyholders. Many insurers were already on the hook to return money in 2020 for previous years.

Most insurers did not cite additional COVID treatment or testing costs as factors in their requested rate increase, Gaba said. Even those that did, however, mainly found them unnecessary because of reduced expenditures resulting from patients delaying elective care during the spring and summer.

Indeed, many insurers in the second quarter posted record profits.

“Some of them thought, ‘We’re going to make more than we thought this year in profits, so let’s not be aggressive with pricing next year,’” said Donna Novak, a member of the American Academy of Actuaries’ Individual and Small Group Markets Committee.

A smaller factor may be the repeal of a fee paid by insurers on premiums. Part of the ACA, the fee was permanently eliminated by the Trump administration effective for 2021.

Your choice of insurers may have widened.

More insurers, including UnitedHealth Group, either stepped back into that individual market or expanded into new counties.

“Insurers are seeing a profit or potential for it,” said John Dodd, an insurance broker in Columbus and past president of the Ohio Association of Health Underwriters.

Rates are down in general across his state for ACA plans, he said, and he expects agents to be busier than ever, simply because there are more plan offerings and choices to make and people want help.

Insurers, he said, like the way the ACA is working.

“People on TV who say it’s not working, they don’t know what they’re talking about,” said Dodd. “It’s working well [for insurers] and every year it gets better.”

New stuff in some states, including a public option.

Residents of New Jersey and Pennsylvania will buy coverage from new state-based marketplaces for 2021, after those states pulled out of the federal healthcare.gov, which now covers 36 states.

Lawmakers in those states said running their own marketplaces gives them more control and may save them money over time.

In 19 Washington state counties, insurers are offering “public option plans,” which have all the standard benefits, including lower deductibles, and must meet additional quality standards.

As envisioned, the public option plans aimed to be less expensive, with the legislation tying payment rates to Medicare. Insurers offering a public option must stick to an aggregate cap of paying doctors, hospitals and other medical providers an average of 160% of what Medicare would pay for the same services.

When the premium rates came in, however, the five insurers offering the plans had varying prices. Not all parts of the state have the option, but where they do, two of the public option insurers have premiums that are either lower than other plans in the area or are the lowest-cost plan the insurer offers.

But three are more expensive.

The state's marketplace staff said the higher prices may reflect a number of things, from difficulty getting the program started during COVID-19 to a lack of incentives to get providers to participate.

It could also just be normal first-year jitters.

"It's Year One. As with any market entry strategy, people are pretty conservative," said Michael Marchand, chief marketing officer of the Washington Health Benefit Exchange.

Premiums Drop Slightly As 2021 Open Enrollment Period Draws Near
Katie Keith

Even with the election and oral argument in California v. Texas looming, the 2021 open enrollment period will soon be upon us. In all states except California (where the open enrollment period began on October 15), the 2021 open enrollment season begins on November 1, 2020 with a deadline of December 15 in the 36 states that use HealthCare.gov. States with their own marketplaces—including New Jersey and Pennsylvania, which newly opened their own marketplaces—have set their deadlines later in December 2020 or January 2021.

Ahead of open enrollment, the Centers for Medicare and Medicaid (CMS) released new data on HealthCare.gov marketplace premiums and insurer participation for 2021. CMS's analysis includes an issue brief on premiums, landscape plan data, and a map on insurer participation. (Public use files do not appear to be posted yet but will be available here when they are.) CMS also released the scheduled maintenance windows for HealthCare.gov the 2021 open enrollment period.

Overall, premiums are expected to drop by 2 percent for a 27-year old for a silver benchmark marketplace plan sold through HealthCare.gov. This builds on a 4 percent decline for 2020 and a 2 percent decline for 2019. The unsubsidized average benchmark plan premium for a 27-year old will be $369/month for 2021 (compared to $388/month for 2020). In four states, silver benchmark premiums will decline by double-digits: Iowa (29 percent), Maine (14 percent), New Hampshire (18 percent), and Wyoming (10 percent). Only North Dakota will see an average benchmark plan premium increase of 10 percent or more (29 percent).

Lower premiums are expected even with the pandemic. First, Congress repealed the health insurance tax beginning with 2021, which should result in premium savings that are passed along to consumers. Second, insurers continue to owe record-high medical loss ratio rebates in the individual market. This suggests that insurers are overpricing their products and that premium reductions are warranted. Third, more states have adopted state-based reinsurance programs: currently, 14 states have received a waiver to operate a reinsurance program. Fourth, the pandemic has led to higher profits for many insurers, further incentivizing premium reductions. These factors made it unsurprising that many insurers would reduce their premiums for 2021.

Insurer participation continues to increase. Six more insurers will offer marketplace coverage through HealthCare.gov, increasing the total number of participating insurers to 181 for 2021. (Even so, this metric continues to lag earlier years in ACA implementation, remaining well below the high of 237 participating insurers for 2016.) Of the 36 states that use HealthCare.gov, 16 states will have more insurers compared to 2020 and 27 states will have counties with more insurers relative to 2020. Only Arkansas, New Mexico, and Wyoming will have an additional insurer offer statewide coverage. Four states have counties with fewer insurers in 2021 relative to 2020 while Delaware is now the only state with just one insurer (down from two states for 2020). Only four percent of enrollees will have access to only one insurer compared to 12 percent of enrollees for 2018 and 20 percent of enrollees for 2019.

Average premium reductions and higher insurer participation are encouraging. The uninsured rate was on the rise long before the pandemic, and robust individual market coverage options will be especially important in 2021 with millions of people losing their job or health insurance. Fortunately, many low-income consumers will continue to have options in 2021. CMS estimates that 30 percent of subsidy-eligible enrollees can find a marketplace plan for $10/month or less, and 71 percent can find a plan for $75/month or less. Of those not eligible for subsidies, 27 percent can find a plan for $300/month or less.

At the same time, deductibles continue to rise. For bronze plans, the median individual deductible increased from $6,755 for 2020 to $6,992 for 2021. For silver plans, deductibles rose from $4,630 to $4,879. And gold plan deductibles rose from $1,432 to $1,533. Consistent with prior years, nearly all enrollees will have access to a health savings account-eligible marketplace plan in 2021.

Finally, potential maintenance for HealthCare.gov has been scheduled for early morning on November 1 (to make final preparations ahead of the start of open enrollment) and each Sunday from 12am to 12pm ET except on November 1 and December 13. Federal officials selected the Sunday morning time period because this is when the website receives the least amount of traffic. During any website downtime, HealthCare.gov will be unavailable for consumers to select a plan and enroll in coverage. As in prior years, CMS anticipates that actual maintenance periods will be much shorter than the scheduled slots. Despite the maximum allocation of 72 hours of maintenance last year, the website was down for only 24.5 hours and HealthCare.gov was reportedly available 96.9 percent of the time.

THE NEW YORKER

A President Looks Back on His Toughest Fight
Barack Obama

Our first spring in the White House arrived early. As the weather warmed, the South Lawn became almost like a private park to explore. There were acres of lush grass ringed by massive, shady oaks and elms and a tiny pond tucked behind the hedges, with the handprints of Presidential children and grandchildren pressed into the paved pathway that led to it. There were nooks and crannies for games of tag and hide-and-go-seek, and there was even a bit of wildlife—not just squirrels and rabbits but a red-tailed hawk and a slender, long-legged fox that occasionally got bold enough to wander down the colonnade.

Cooped up as we'd been through the winter of 2009, we took full advantage of the new back yard. We had a swing set installed for Sasha and Malia directly in front of the Oval Office. Looking up from a late-afternoon meeting on this or that crisis, I might glimpse the girls playing outside, their faces set in bliss as they soared high on the swings.

But, of all the pleasures that first year in the White House would deliver, none quite compared to the mid-April arrival of Bo, a huggable, four-legged black bundle of fur, with a snowy-white chest and front paws. Malia and Sasha, who'd been lobbying for a puppy since before the campaign, squealed with delight upon seeing him for the first time, letting him lick their ears and faces as the three of them rolled around on the floor.

With Bo, I got what someone once described as the only reliable friend a politician can have in Washington. He also gave me an added excuse to put off my evening paperwork and join my family on meandering after-dinner walks around the South Lawn. It was during those moments—with the light fading into streaks of purple and gold, Michelle smiling and squeezing my hand as Bo bounded in and out of the bushes with the girls giving chase—that I felt normal and whole and as lucky as any man has a right to expect.

Bo had come to us as a gift from Ted Kennedy and his wife, Vicki, part of a litter that was related to Teddy's own beloved pair of Portuguese water dogs. It was a truly thoughtful gesture—not only because the breed was hypoallergenic (a necessity, owing to Malia's allergies) but also because the Kennedys had made sure that Bo was housebroken before he came to us. When I called to thank them, though, it was only Vicki I could speak with. It had been almost a year since Teddy was diagnosed with a malignant brain tumor, and although he was still receiving treatment in Boston, it was clear to everyone—Teddy included—that the prognosis was not good.

I'd seen him in March, when he'd made a surprise appearance at a White House conference we held to get the ball rolling on universal-health-care legislation. Teddy's walk was unsteady that day; his suit draped loosely on him after all the weight he'd lost, and despite his cheerful demeanor his pinched, cloudy eyes showed the strain it took just to hold himself upright. And yet he'd insisted on coming anyway, because thirty-five years earlier the cause of getting everyone decent, affordable health care had become personal for him. His son Teddy, Jr., had been diagnosed with a bone cancer that led to a leg amputation at the age of twelve. While at the hospital, Teddy had come to know other parents whose children were just as ill but who had no idea how they'd pay the mounting medical bills. Then and there, he had vowed to do something to change that.

Through seven Presidents, Teddy had fought the good fight. During the Clinton Administration, he helped secure passage of the Children's Health Insurance Program. Over the objections of some in his own party, he worked with President George W. Bush to get drug coverage for seniors. But, for all his power and legislative skill, the dream of establishing universal health care—a system that delivered good-quality medical care to all people, regardless of their ability to pay—continued to elude him.

Which is why he had forced himself out of bed to come to our conference, knowing his brief but symbolic presence might have an effect. Sure enough, when he walked into the East Room, the hundred and fifty people who were present erupted into lengthy applause. His remarks were short; his baritone didn't boom quite as loudly as it used to when he'd roared on the Senate floor. By the time we'd moved on to the third or fourth speaker, Vicki had quietly escorted him out the door.

I saw him only once more in person, six weeks later, at a signing ceremony for a bill expanding national-service programs, which Republicans and Democrats alike had named in his honor. But I would think of Teddy sometimes when Bo wandered into the Treaty Room and curled up at my feet. And I'd recall what Teddy had told me that day, just before we walked into the East Room together. "This is the time, Mr. President," he had said. "Don't let it slip away."

The quest for some form of universal health care in the United States dates back to 1912, when Theodore Roosevelt, who had previously served nearly eight years as a Republican President, decided to run again—this time on a progressive ticket and with a platform that called for the establishment of a centralized national health service. At the time, few people had or felt the need for private health insurance. Most Americans paid their doctors visit by visit, but the field of medicine was quickly growing more sophisticated, and as more diagnostic tests and surgeries became available the attendant costs began to rise, tying health more obviously to wealth. Both the United Kingdom and Germany had addressed similar issues by instituting national health-insurance systems, and other European nations would eventually follow suit. Although Roosevelt ultimately lost the 1912 election, his party's progressive ideals planted a seed: accessible and affordable medical care might one day be viewed as a right more than a privilege. It wasn't long, however, before doctors and Southern politicians vocally

opposed any type of government involvement in health care, branding it as a form of Bolshevism.

After Franklin Delano Roosevelt imposed a nationwide wage freeze, during the Second World War, meant to stem inflation, many companies began offering private health insurance and pension benefits as a way to compete for the limited number of workers not deployed overseas. Once the war ended, this employer-based system continued, in no small part because labor unions used the more generous benefit packages negotiated under collective-bargaining agreements as a selling point to recruit new members. The downside was that those unions then had little motivation to push for government-sponsored health programs that might help everybody else. Harry Truman proposed a national health-care system twice, once in 1945 and again as part of his Fair Deal package, in 1949, but his appeal for public support was no match for the well-financed P.R. efforts of the American Medical Association and other industry lobbyists. Opponents didn't just kill Truman's effort. They convinced a large swath of the public that "socialized medicine" would lead to rationing, to the loss of the family doctor and of the freedoms Americans hold so dear.

Rather than challenging private insurance head on, progressives shifted their energy to helping those populations the marketplace had left behind. These efforts bore fruit during Lyndon Johnson's Great Society campaign, when a universal single-payer program partially funded by payroll-tax revenue was introduced for seniors (Medicare) and a not so comprehensive program based on a combination of federal and state funding was set up for the poor (Medicaid). During the nineteen-seventies and early eighties, this patchwork system functioned well enough, with roughly eighty per cent of Americans covered through either their jobs or one of these two programs. Meanwhile, defenders of the status quo could point to the many innovations brought to market by the for-profit medical industry, from MRIs to lifesaving drugs.

Useful as these innovations were, though, they also drove up health-care costs. And, with insurers footing the nation's medical bills, patients had little incentive to question whether drug companies were overcharging or whether doctors and hospitals were ordering redundant tests and unnecessary treatments in order to pad their bottom lines. At the same time, nearly a fifth of the country lived just an illness or an accident away from potential financial ruin. Unable to afford regular checkups and preventive care, the uninsured often waited until they were very sick before seeking attention at hospital emergency rooms, where more advanced illnesses meant more expensive treatment. Hospitals made up for this uncompensated care by increasing prices for insured customers, which further jacked up premiums.

All this explained why the United States spent a lot more money per person on health care than any other advanced economy (eighty-seven per cent more than Canada, a hundred and two per cent more than France, a hundred and eighty-two per cent more than Japan), and for similar or worse results. The difference amounted to hundreds of billions of dollars a year—money that could have been used instead to provide child care for American families, or to reduce college tuition, or to eliminate a good chunk of the federal deficit. Spiraling health-care costs also burdened American businesses:

Japanese and German automakers didn't have to worry about the extra fifteen hundred dollars in worker and retiree health-care costs that Detroit had to build into the price of every car rolling off the assembly line.

In fact, it was in response to foreign competition that U.S. companies began off-loading rising insurance costs onto their employees in the late nineteen-eighties and nineties, replacing traditional plans that had few, if any, out-of-pocket costs with cheaper versions that included co-pays, lifetime limits, higher deductibles, and other unpleasant surprises hidden in the fine print. Unions often found themselves able to preserve their traditional benefit plans only by agreeing to forgo increases in wages. Small businesses found it tough to provide their workers with health benefits at all. Meanwhile, insurance companies that operated in the individual market perfected the art of rejecting customers who, according to their actuarial data, were most likely to make use of the health-care system, especially anyone with a "preëxisting condition"—which they often defined as anything from a previous bout of cancer to asthma and chronic allergies.

It's no wonder, then, that by the time I took office there were very few people ready to defend the existing system. More than forty-three million Americans were now uninsured, premiums for family coverage had risen ninety-seven per cent since 2000, and costs were only continuing to climb. And yet the prospect of trying to get a big health-care-reform bill through Congress at the height of a historic recession made my team nervous. Even my adviser David Axelrod—who had experienced the challenges of getting specialized care for a daughter with severe epilepsy and had left journalism to become a political consultant in part to pay for her treatment—had his doubts.

"The data's pretty clear," he said when we discussed the topic with Rahm Emanuel, my chief of staff. "People may hate the way things work in general, but most of them have insurance. They don't really think about the flaws in the system until somebody in their own family gets sick. They like their doctor. They don't trust Washington to fix anything. And, even if they think you're sincere, they worry that any changes you make will cost them money and help somebody else."

"What Axe is trying to say, Mr. President," Rahm interrupted, his face screwed up in a frown, "is that this can blow up in our faces."

We were already using up precious political capital, Rahm said, in order to fast-track the passage of the Recovery Act, a major economic-stimulus package. As an adviser in the Clinton White House, he'd had a front-row seat at the last push for universal health care, when Hillary Clinton's legislative proposal crashed and burned, and he was quick to remind us that the backlash had contributed to Democrats' losing control of the House in the 1994 midterms. "Republicans will say health care is a big new liberal spending binge, and that it's a distraction from solving the economic crisis," Rahm said.

"Unless I'm missing something," I said, "we're doing everything we can do on the economy."

"I know that, Mr. President. But the American people don't know that."

“So what are we saying here?” I asked. “That despite having the biggest Democratic majorities in decades, despite the promises we made during the campaign, we shouldn’t try to get health care done?”

Rahm looked to Axe for help.

“We all think we should try,” Axe said. “You just need to know that, if we lose, your Presidency will be badly weakened. And nobody understands that better than McConnell and Boehner.”

I stood up, signaling that the meeting was over. “We better not lose, then,” I said.

When I think back to those early conversations, it’s hard to deny my overconfidence. I was convinced that the logic of health-care reform was so obvious that even in the face of well-organized opposition I could rally the American people’s support. Other big initiatives—like immigration reform and climate-change legislation—would probably be even harder to get through Congress; I figured that scoring a victory on the item that most affected people’s day-to-day lives was our best shot at building momentum for the rest of my legislative agenda. As for the political hazards that Axe and Rahm worried about, the recession virtually guaranteed that my poll numbers were going to take a hit anyway. Being timid wouldn’t change that reality. Even if it did, passing up a chance to help millions of people just because it might hurt my reëlection prospects—well, that was exactly the kind of myopic, self-preserving behavior I’d vowed to reject.

My interest in health care went beyond policy or politics; it was personal, just as it was for Teddy. Each time I met a parent struggling to come up with the money to get treatment for a sick child, I thought back to the night Michelle and I had to take three-month-old Sasha to the emergency room for what turned out to be viral meningitis. I remembered the terror and the helplessness we felt as the nurses whisked her away for a spinal tap, and the realization that we might never have caught the infection in time had the girls not had a regular pediatrician we felt comfortable calling in the middle of the night. Most of all, I thought about my mom, who had died in 1995, of uterine cancer.

In mid-June, I headed to Green Bay, Wisconsin, for the first in a series of health-care town-hall meetings we would hold around the country, hoping to solicit citizen input and educate people on the possibilities for reform. Introducing me that day was a local resident named Laura Klitzka, who was thirty-five years old and had been diagnosed with aggressive breast cancer that had spread to her bones. Even though she was on her husband’s insurance plan, repeated rounds of surgery, radiation, and chemo had bumped her up against the policy’s lifetime limits, leaving the couple with twelve thousand dollars in unpaid medical bills. Over the objections of her husband, Peter, she was now pondering whether more treatment was worth it. Sitting in their living room before we headed for the event, she smiled wanly as we watched Peter doing his best to keep track of their two young kids playing on the floor.

“I want as much time with them as I can get, but I don’t want to leave them with a mountain of debt,” she said to me. “It feels selfish.” Her eyes started misting, and I held

her hand, remembering my mom wasting away in those final months: the times she'd put off checkups that might have caught her disease because she was in between consulting contracts and didn't have coverage; the stress she carried to her hospital bed when her insurer refused to pay her disability claim, arguing that she had failed to disclose a preëxisting condition, despite the fact that she hadn't even been diagnosed when her policy started. The unspoken regrets.

Passing a health-care bill wouldn't bring my mom back. It wouldn't douse the guilt I still felt for not having been at her side when she took her last breath. It would probably come too late to help Laura Klitzka and her family. But it would save somebody's mom, somewhere down the line. And that was worth fighting for.

The question was whether we could get it done. Any major health-care bill meant rejiggering a sixth of the American economy. Legislation of this scope was guaranteed to involve hundreds of pages of endlessly fussed-over amendments and regulations. A single provision tucked inside the bill could translate to billions of dollars in gains or losses for some sector of the health-care industry. A shift in one number, a zero here or a decimal point there, could mean a million more families getting coverage—or not. Across the country, insurance companies were major employers, and local hospitals served as the economic anchor for many small towns and counties. People had good reasons—life-and-death reasons—to worry about how any change would affect them.

There was also the question of how to pay for the changes. To cover more people, I argued, America didn't need to spend more money on health care; we just needed to use that money more wisely. In theory, that was true. But one person's waste and inefficiency was another person's profit or convenience; spending on coverage would show up on the federal books much sooner than the savings from reform; and, unlike the insurance companies or Big Pharma, whose shareholders expected them to be on guard against any change that might cost them a dime, most of the potential beneficiaries of reform—the waitress, the family farmer, the independent contractor, the cancer survivor—didn't have gaggles of well-paid and experienced lobbyists roaming the halls of Congress.

In other words, both the politics and the substance of health care were mind-numbingly complicated. I was going to have to explain to the American people, including those with high-quality health insurance, why and how reform could work. For this reason, I thought we'd use as open and transparent a process as possible. "Everyone will have a seat at the table," I'd told voters during the campaign. "Not negotiating behind closed doors, but bringing all parties together, and broadcasting those negotiations on C-SPAN, so that the American people can see what the choices are." When I later brought this idea up with Rahm, he looked like he wished I weren't the President, just so he could more vividly explain the stupidity of my plan. If we were going to get a bill passed, he told me, the process would involve dozens of deals and compromises along the way—and it wasn't going to be conducted like a civics seminar.

"Making sausage isn't pretty, Mr. President," he said. "And you're asking for a really big piece of sausage."

One thing Rahm and I did agree on was that we had months of work ahead of us, and we needed a topnotch health-care team to keep us on track. Luckily, we were able to recruit a remarkable trio of women to help run the show. Kathleen Sebelius, the two-term Democratic governor of Republican-leaning Kansas, came on as Secretary of Health and Human Services. Jeanne Lambrew, a professor at the University of Texas and an expert on Medicare and Medicaid, became the director of the H.H.S. Office of Health Reform, basically our chief policy adviser.

It was Nancy-Ann DeParle whom I would come to rely on most as our campaign took shape. A Tennessee lawyer who had run that state's health programs before serving as the Medicare administrator in the Clinton Administration, Nancy-Ann carried herself with the crisp professionalism of someone accustomed to seeing hard work translate into success. How much of that drive could be traced to her experiences growing up Chinese-American in a tiny Tennessee town, I couldn't say. I did know that when she was seventeen her mom died of lung cancer. It seems I wasn't the only one for whom getting health care passed was personal.

Our team began to map out a legislative strategy. Based on our experiences with the Recovery Act, we had no doubt that Mitch McConnell would do everything he could to torpedo our efforts, and that the chances of getting Republican votes in the Senate were slim. We could take heart from the fact that, instead of the fifty-eight senators who were caucusing with the Democrats when we passed the stimulus bill, we were likely to have sixty by the time any health-care bill actually came to a vote. Al Franken had finally taken his seat after a contentious election recount in Minnesota, and Arlen Specter had decided to switch parties after being effectively driven out of the G.O.P. for supporting the Recovery Act.

This would give us a filibuster-proof majority, but our head count was tenuous: it included the terminally ill Ted Kennedy and the frail and ailing Robert Byrd, of West Virginia, not to mention conservative Democrats like Nebraska's Ben Nelson (a former insurance-company executive), who could go sideways on us at any minute. Beyond wanting some margin for error, I also knew that passing something as monumental as health-care reform on a purely party-line vote would make the law politically more vulnerable down the road. So we thought it made sense to shape our legislative proposal in such a way that it at least had a chance of winning over a handful of Republicans.

Fortunately, we had a model to work with—one that, ironically, had grown out of a partnership between Ted Kennedy and the former Massachusetts governor Mitt Romney. A few years earlier, confronting budget shortfalls and the prospect of losing Medicaid funding, Romney had become fixated on finding a way to get more Massachusetts residents properly insured, which would then reduce state spending on emergency care for the uninsured and, ideally, lead to a healthier population in general.

He and his staff came up with a multipronged approach in which every person would be required to purchase health insurance (an "individual mandate"), the same way every car owner was required to carry auto insurance. Middle-income people who couldn't get

insurance through their job, didn't qualify for Medicare or Medicaid, and were unable to afford insurance on their own would get a government subsidy to buy coverage. Subsidies would be determined on a sliding scale according to each person's income, and a central online marketplace—an "exchange"—would be set up so that consumers could shop for the best insurance deal. Insurers, meanwhile, would no longer be allowed to deny coverage based on pre-existing conditions.

These two ideas—the individual mandate and protecting people with pre-existing conditions—went hand in hand. With a huge new pool of government-subsidized customers, insurers no longer had a financial incentive for trying to cherry-pick only the young and the healthy for coverage. And the mandate would prevent people from gaming the system by waiting until they got sick to purchase insurance. Touting the plan to reporters, Romney called the individual mandate "the ultimate conservative idea," because it promoted personal responsibility.

Not surprisingly, Massachusetts's Democratic-controlled state legislature had initially been suspicious of the Romney plan, and not just because a Republican had proposed it; among many progressives, the need to replace private insurance and for-profit health care with a single-payer system like Canada's was an article of faith. Had we been starting from scratch, I would have agreed with them; the evidence from other countries showed that a single, national system—basically, Medicare for All—was a cost-effective way to deliver health care. But neither Massachusetts nor the United States was starting from scratch. Teddy, who despite his reputation as a wide-eyed liberal was ever practical, understood that trying to dismantle the existing system and replace it with an entirely new one would be both a nonstarter politically and hugely disruptive to the economy. Instead, he'd embraced the Romney proposal and helped the Governor line up the Democratic votes in the state legislature required to get it passed into law.

"Romneycare," as it eventually became known, was now two years old and had been a clear success, driving the uninsured rate in Massachusetts down to just under four per cent, the lowest in the country. Teddy had used it as the basis for draft legislation he had started preparing many months ahead of the election, in his role as the chair of the Senate Health and Education Committee. And, though Axe and my campaign manager, David Plouffe, had persuaded me to hold off on endorsing the Massachusetts approach during my run for President—the idea of requiring people to buy insurance was extremely unpopular with voters, and I'd instead focussed my plan on lowering costs—I was now convinced, as were most health-care advocates, that Romney's model offered us the best chance of achieving universal coverage.

People still differed on the details of what a national version of the Massachusetts plan might look like, and a number of advocates urged us to settle these issues early by putting out a specific White House proposal for Congress to follow. We decided against that. One of the lessons from the Clintons' failed effort was the need to involve key Democrats in the process, so that they would feel a sense of ownership of the bill. Insufficient coördination, we knew, could result in legislative death by a thousand cuts.

On the House side, this meant working with old-school liberals like Henry Waxman, the wily, pugnacious congressman from California and the head of the Energy and Commerce Committee, which had jurisdiction over health care. In the Senate, the landscape was different: with Teddy convalescing, the main player was Max Baucus, a conservative Democrat from Montana, who chaired the powerful Finance Committee, and had a close friendship with the Iowa senator Chuck Grassley, the Finance Committee's ranking Republican. Baucus was optimistic that he could win Grassley's support for a bill.

"Trust me, Mr. President," Baucus said. "Chuck and I have already discussed it. We're going to have this thing done by July."

Every job has its share of surprises. A key piece of equipment breaks down. A traffic accident forces a change in delivery routes. A client calls to say you've won the contract—but they need the order filled three months earlier than planned. No matter where you work, you need to be able to improvise to meet your objectives, or at least to cut your losses.

The Presidency was no different. In the course of the spring and summer of that first year, as we wrestled with the financial crisis, two wars, and the push for health-care reform, another unexpected item got added to an already overloaded agenda. In April, reports surfaced of a worrying flu outbreak in Mexico. The flu virus usually hits vulnerable populations like the elderly, infants, and asthma sufferers hardest, but this strain appeared to strike young, healthy people—and was killing them at a higher than usual rate. Within weeks, people in the United States were falling ill with the virus: one in Ohio, two in Kansas, eight in a single high school in New York City. By the end of the month, both our own Centers for Disease Control and the World Health Organization had confirmed that we were dealing with a variation of the H1N1 virus. In June, the W.H.O. officially declared the first global pandemic in forty years.

I had more than a passing knowledge of H1N1 after working on U.S. pandemic preparedness when I was in the Senate. What I knew scared the hell out of me. Starting in 1918, a strain of H1N1 that came to be known as the "Spanish flu" had infected an estimated half a billion people and killed as many as a hundred million—around five per cent of the world's population. In Philadelphia alone, more than twelve thousand died in the span of a few weeks. The effects of the pandemic went beyond the stunning death tolls and the shutdown of economic activity; later research revealed that those who were in utero during the pandemic grew up to have lower incomes, poorer educational outcomes, and higher rates of physical disability.

It was too early to tell how deadly this new virus would be. But I wasn't interested in taking any chances. On the same day that Kathleen Sebelius was confirmed as H.H.S. Secretary, we sent a plane to pick her up from Kansas, flew her to Washington to be sworn in at a makeshift ceremony in the Oval Office, and immediately asked her to lead a two-hour conference call with W.H.O. officials and health ministers from Mexico and Canada. A few days later, we pulled together an interagency team to evaluate how ready the United States was for a worst-case scenario.

The answer was that we weren't at all ready. Annual flu shots didn't provide much protection against H1N1, it turned out, and, because vaccines generally weren't a moneymaker for drug companies, the few U.S. vaccine-makers that existed had a limited capacity to ramp up production of a new one. Then, we faced questions of how to distribute antiviral medicines, what guidelines hospitals used in treating cases of the flu, and even how we'd handle the possibility of closing schools and imposing quarantines if things got significantly worse. Several veterans of the Ford Administration's 1976 swine-flu response team warned us of the difficulties involved in getting out in front of an outbreak without overreacting or triggering a panic. Apparently, President Ford, wanting to act decisively in the middle of a reëlection campaign, had fast-tracked vaccinations before the severity of the pandemic had been determined, with the result that more Americans developed a neurological disorder connected to the vaccine than died from the flu.

"You need to be involved, Mr. President," one of Ford's staffers advised, "but you need to let the experts run the process."

My instructions to the public-health team were simple: decisions would be made based on the best available science, and we were going to explain to the public each step of our response—including detailing what we did and didn't know. Over the course of the next six months, we did exactly that. A summertime dip in H1N1 cases gave the team time to work with drugmakers and incentivize new processes for quicker vaccine production. They pre-positioned medical supplies across regions and gave hospitals increased flexibility to manage a surge in flu cases. They evaluated—and ultimately rejected—the idea of closing schools for the rest of the year, but worked with school districts, businesses, and state and local officials to make sure that everyone had the resources they needed to respond in the event of an outbreak.

Although the United States did not escape unscathed—more than twelve thousand Americans lost their lives—we were fortunate that this particular strain of H1N1 turned out to be less deadly than the experts had feared. News that the pandemic had abated by mid-2010 didn't generate headlines. Still, I took great pride in how well our team had performed. Without fanfare or fuss, they not only helped keep the virus contained but strengthened our readiness for any future public-health emergency—which would make all the difference several years later, when the Ebola outbreak in West Africa triggered a full-blown panic.

This, I was coming to realize, was the nature of the Presidency: sometimes your most important work involved the stuff nobody noticed.

The slow march toward health-care reform consumed much of the summer. As the legislation lumbered through Congress, we looked for any opportunity to help keep the process on track. The good news was that the key Democratic chairs—especially Baucus and Waxman—were working hard to craft bills that they could pass out of their respective committees before the traditional August recess. The bad news was that the more everyone dug into the details of reform, the more differences in substance and strategy emerged—not just between Democrats and Republicans but between House

and Senate Democrats, between the White House and congressional Democrats, and even between members of my own team.

Most of the arguments revolved around the issue of how to generate a mixture of savings and new revenue to pay for expanding coverage to millions of uninsured Americans. Baucus, given his interest in producing a bipartisan bill, hoped to avoid anything that could be characterized as a tax increase. Instead, he and his staff had calculated the windfall profits that a new flood of insured customers would bring to hospitals, drug companies, and insurers, and had used those figures as a basis for negotiating billions of dollars in up-front contributions—through fees or Medicare-billing reductions—from each industry. To sweeten the deal, Baucus was also prepared to make certain policy concessions. For example, he promised the pharmaceutical lobbyists that his bill wouldn't include provisions allowing the reimportation of drugs from Canada—a popular Democratic proposal that highlighted the way Canadian and European government-run health-care systems used their immense bargaining power to negotiate much lower prices than Big Pharma charged in the United States.

Politically and emotionally, I would have found it a lot more satisfying to just go after the drug and insurance companies and see if we could beat them into submission. They were wildly unpopular with voters, and for good reason. But, as a practical matter, it was hard to argue with Baucus's more conciliatory approach. We had no way to get to sixty votes in the Senate for a major health-care bill without at least the tacit agreement of the big industry players. Drug reimportation was a great political issue, but, at the end of the day, we didn't have the votes for it, partly because plenty of Democrats had major pharmaceutical companies headquartered or operating in their states.

With these realities in mind, I signed off on having Rahm, Nancy-Ann, and my deputy chief of staff, Jim Messina, sit in on Baucus's negotiations with health-care-industry representatives. By the end of June, they'd hashed out a deal, securing hundreds of billions of dollars in givebacks and broader drug discounts for seniors using Medicare. Just as important, they'd gotten a commitment from the hospitals, insurers, and drug companies to support—or at least not oppose—the emerging bill.

It was a big hurdle to clear, a case of politics as the art of the possible. But for some of the more liberal Democrats in the House, where no one had to worry about a filibuster, and among progressive advocacy groups that were still hoping to lay the groundwork for a single-payer health-care system, our compromises smacked of capitulation, a deal with the devil. It didn't help that, as Rahm had predicted, none of the negotiations with the industry had been broadcast on C-SPAN. The press started reporting on details of what they called "backroom deals." More than a few constituents wrote in to ask whether I'd gone over to the dark side. And Waxman made a point of saying he didn't consider his work bound by whatever concessions Baucus or the White House had made to industry lobbyists.

Quick as the House Democrats were to mount their high horse, they were also more than willing to protect the status quo when it secured their prerogatives or benefitted politically influential constituencies. For example, more or less every health-care

economist agreed that it wasn't enough just to pry money out of insurance- and drug-company profits and use it to cover more people; in order for reform to work, we also had to do something about the skyrocketing costs charged by doctors and hospitals. Otherwise, any new money put into the system would yield less and less care for fewer and fewer people over time. One of the best ways to "bend the cost curve" was to establish an independent board, shielded from politics and special-interest lobbying, that would set reimbursement rates for Medicare based on the comparative effectiveness of particular treatments.

House Democrats hated the idea. It would mean giving away their power to determine what Medicare did and didn't cover (along with the potential campaign fund-raising opportunities that came with that power). They also worried that they'd get blamed by cranky seniors who found themselves unable to get the latest drug or diagnostic test advertised on TV, even if an expert could prove that it was actually a waste of money.

They were similarly skeptical of the other big proposal to control costs: a cap on the tax deductibility of so-called Cadillac insurance plans—high-cost, employer-provided policies that paid for all sorts of premium services but didn't improve health outcomes. Other than corporate managers and well-paid professionals, union members made up the main group covered by such plans, and the unions were adamantly opposed to what would come to be known as "the Cadillac tax." It didn't matter to labor leaders that their members might be willing to trade a deluxe hospital suite or a second, unnecessary MRI for a chance at higher take-home pay. And so long as the unions were opposed to the Cadillac tax, most House Democrats were going to be, too.

The squabbles quickly found their way into the press, making the whole process appear messy and convoluted. By late July, polls showed that more Americans disapproved than approved of the way I was handling health-care reform, prompting me to complain to Axe about our communications strategy. "We're on the right side of this stuff," I insisted. "We just have to explain it better to voters."

Axe was irritated that his shop was seemingly getting blamed for the very problem he'd warned me about from the start. "You can explain it till you're blue in the face," he told me. "But people who already have health care are skeptical that reform will benefit them, and a whole bunch of facts and figures won't change that."

Toward the end of the month, versions of the health-care bill had passed out of all the relevant House committees. The Senate Health and Education Committee had completed its work as well. All that remained was getting a bill through Max Baucus's Senate Finance Committee. Once that was done, we could consolidate the different versions into one House and one Senate bill, ideally passing each before the August recess, with the goal of having a final version of the legislation on my desk for signing before the end of the year.

No matter how hard we pressed, though, we couldn't get Baucus to complete his work. As the summer wore on, his optimism that he could produce a bipartisan bill began to look delusional. The Republican Minority Leaders, McConnell and John Boehner, had

already announced their vigorous opposition to our legislative efforts, arguing that they represented an attempted “government takeover” of the health-care system. Frank Luntz, a well-known Republican strategist, had circulated a memo stating that, after market-testing some thirty anti-reform messages, he’d concluded that invoking a government takeover was the best way to discredit the health-care legislation. From that point on, conservatives followed the script, repeating the phrase like an incantation.

Senator Jim DeMint, the conservative firebrand from South Carolina, was more transparent about his party’s intentions. “If we’re able to stop Obama on this, it will be his Waterloo,” he announced on a nationwide conference call with conservative activists. “It will break him.”

Unsurprisingly, given the atmosphere, the group of three G.O.P. senators who had been invited to participate in bipartisan talks with Baucus was now down to two: Chuck Grassley and Olympia Snowe, the moderate from Maine. My team and I did everything we could to help Baucus win their support. I had Grassley and Snowe over to the White House repeatedly and called them every few weeks to take their temperature. We signed off on scores of changes they wanted made to Baucus’s draft bill. Nancy-Ann became a permanent fixture in their Senate offices and took Snowe out to dinner so often that we joked that her husband was getting jealous.

“Tell Olympia she can write the whole damn bill!” I said to Nancy-Ann as she was leaving for one such meeting. “We’ll call it the Snowe plan. Tell her if she votes for the bill she can have the White House—Michelle and I will move to an apartment!”

And still we were getting nowhere. Snowe took pride in her centrist reputation, but the Republican Party’s sharp rightward tilt had left her increasingly isolated within her own caucus.

Grassley was a different story. He talked a good game about wanting to help the family farmers back in Iowa who had trouble getting insurance they could count on, and when Hillary Clinton had pushed health-care reform, in the nineties, Grassley had actually co-sponsored an alternative that in many ways resembled the Massachusetts-style plan we were proposing, complete with an individual mandate. But, unlike Snowe, Grassley rarely bucked his party’s leadership on tough issues. With his long, hangdog face and throaty Midwestern drawl, he would hem and haw about this or that problem he had with the bill without ever telling us what exactly it would take to get him to yes. Phil Schiliro, who ran the White House’s legislative-affairs department, thought that Grassley was just stringing Baucus along at McConnell’s behest, trying to stall the process and prevent us from moving on to the rest of our agenda. Even I, the resident White House optimist, finally got fed up and asked Baucus to come by for a visit.

“Time’s up, Max,” I told him in the Oval during a meeting in late July. “You’ve given it your best shot. Grassley’s gone. He just hasn’t broken the news to you yet.”

Baucus shook his head. “I respectfully disagree, Mr. President,” he said. “I know Chuck. I think we’re this close to getting him.” He held his thumb and index finger an inch apart,

smiling at me like someone who's discovered a cure for cancer and is forced to deal with foolish skeptics. "Let's just give Chuck a little more time and have the vote when we get back from recess."

A part of me wanted to get up, grab Baucus by the shoulders, and shake him till he came to his senses. I decided that this wouldn't work. Another part of me considered threatening to withhold my political support the next time he ran for reëlection, but since he polled higher than I did in his home state of Montana, I figured that wouldn't work, either. Instead, I argued and cajoled for another half hour, finally agreeing to his plan to delay an immediate party-line vote and instead call the bill to a vote within the first two weeks of Congress's reconvening in September.

With the House and the Senate adjourned and both votes still looming, we decided I'd spend the first two weeks of August on the road, holding health-care town halls in places like Montana and Colorado, where public support for reform was shakiest. As a sweetener, my team suggested that Michelle and the girls join me, and that we visit some national parks along the way.

I was thrilled by the suggestion. It's not as if Malia and Sasha were deprived of fatherly attention or in need of extra summer fun—they'd had plenty of both, with playdates and movies and a whole lot of loafing. Often, I'd come home in the evening and go up to the third floor to find the solarium overtaken by pajama-clad eight- or eleven-year-old girls settling in for a sleepover, bouncing on inflatable mattresses, scattering popcorn and toys everywhere, giggling non-stop at whatever was on Nickelodeon.

But, as much as Michelle and I (with the help of infinitely patient Secret Service agents) tried to approximate a normal childhood for our daughters, it was hard, if not impossible, for me to take them places like an ordinary dad would. We couldn't go to an amusement park together, making an impromptu stop for burgers along the way. I couldn't take them, as I once had, on lazy Sunday-afternoon bike rides. A trip to get ice cream or a visit to a bookstore was now a major production, involving road closures, tactical teams, and the omnipresent press pool.

If the girls felt a sense of loss over this, they didn't show it. But I felt it acutely. I especially mourned the fact that I'd probably never get a chance to take Malia and Sasha on the sort of long summer road trip I'd made when I was eleven, after my mother and my grandmother, Toot, decided it was time for Maya and me to see the mainland of the United States. It had lasted a month and burned a lasting impression into my mind—and not just because we went to Disneyland (although that was obviously outstanding). We had dug for clams during low tide in Puget Sound, ridden horses through a creek at the base of Canyon de Chelly, in Arizona, watched the endless Kansas prairie unfold from a train window, spotted a herd of bison on a dusky plain in Yellowstone, and ended each day with the simple pleasures of a motel ice machine, the occasional swimming pool, or just air-conditioning and clean sheets. That one trip gave me a glimpse of the dizzying freedom of the open road, how vast America was, and how full of wonder.

I couldn't duplicate that experience for my daughters—not when we flew on Air Force One, rode in motorcades, and never bunked down in a place like Howard Johnson's. Getting from point A to point B happened too fast and too comfortably, and the days were too stuffed with prescheduled, staff-monitored activity—absent that familiar mixture of surprises, misadventures, and boredom—to fully qualify as a road trip. But in the course of an August week we watched Old Faithful blow, and looked out over the ochre expanse of the Grand Canyon. The girls went inner-tubing. At night, we played board games and tried to name the constellations. Tucking my daughters into bed, I hoped that, despite all the fuss that surrounded us, their minds were storing away a vision of life's possibilities and the beauty of the American landscape, just as mine once had; and that they might someday think back on our trips together and be reminded that they were so worthy of love, so fascinating and electric with life, that there was nothing their parents would rather do than share those vistas with them.

Of course, one of the things Malia and Sasha had to put up with on the trip out West was their dad peeling off every other day to talk about health care. The town halls themselves weren't very different from the ones I'd held in the spring. People shared stories about how the existing health-care system had failed their families, and asked questions about how the emerging bill might affect their own insurance. Even those who opposed our effort listened attentively to what I had to say.

Outside, though, the atmosphere was very different. We were in the middle of what came to be known as the "Tea Party summer," an organized effort to marry people's honest fears about a changing America with a right-wing political agenda. Heading to and from every venue, we were greeted by dozens of angry protesters. Some shouted through bullhorns. Others flashed a single-fingered salute. Many held up signs with messages like "OBAMACARE SUCKS" or the unintentionally ironic "KEEP GOVERNMENT OUT OF MY MEDICARE." Some waved doctored pictures of me looking like Heath Ledger's Joker, in "The Dark Knight," with blackened eyes and thickly caked makeup, appearing almost demonic. Still others wore Colonial-era patriot costumes and hoisted the "DON'T TREAD ON ME" flag. All of them seemed most interested in expressing their general contempt for me, a sentiment best summed up by a refashioning of the famous Shepard Fairey poster from our campaign: the same red-white-and-blue rendering of my face, but with the word "HOPE" replaced by "NOPE."

This new and suddenly potent force in American politics had started months earlier, as a handful of ragtag, small-scale protests against bank bailouts and the Recovery Act. A number of the early participants had apparently migrated from the quixotic, libertarian Presidential campaign of the Republican congressman Ron Paul, who called for the elimination of the federal income tax and the Federal Reserve, a return to the gold standard, and withdrawal from the U.N. and NATO. The group was now focussed on stopping the abomination they called "Obamacare," which they insisted would introduce a socialistic, oppressive new order to America. As I was conducting my relatively sedate health-care town halls out West, newscasts started broadcasting scenes from parallel congressional events around the country, with House and Senate members suddenly confronted by angry, heckling crowds in their home districts, and Tea Party members

deliberately disrupting the proceedings, rattling some of the politicians enough that they were cancelling public appearances altogether.

It was hard to decide what to make of all this. The Tea Party's anti-tax, anti-regulation, anti-government manifesto was hardly new; its basic story line—that corrupt liberal élites had hijacked the federal government to take money out of the pockets of hardworking Americans in order to finance welfare patronage and reward corporate cronies—was one that Republican politicians and the conservative media had been peddling for years. Nor, it turned out, was the Tea Party the spontaneous, grassroots movement it purported to be. From the outset, the Koch brothers and affiliates like Americans for Prosperity, along with other billionaire conservatives, had carefully nurtured the movement, providing much of the Tea Party's financing, infrastructure, and strategic direction.

Still, there was no denying that the Tea Party represented a genuine populist surge within the Republican Party. It was made up of true believers, possessed with the same grassroots enthusiasm and jagged fury we'd seen in Sarah Palin's supporters during the closing days of the Presidential campaign. Some of that anger I understood, even if I considered it misdirected. Many of the working- and middle-class whites gravitating to the Tea Party had suffered for decades from sluggish wages, rising costs, and the loss of the steady blue-collar work that provided secure retirement. George W. Bush and establishment Republicans hadn't done anything for them, and the financial crisis had further hollowed out their communities. And so far, at least, the economy had grown steadily worse with me in charge, despite more than a trillion dollars channelled into stimulus spending and bailouts. For those already predisposed toward conservative ideas, the notion that my policies were designed to help others at their expense—that the game was rigged and I was part of the rigging—must have seemed entirely plausible.

I also had a grudging respect for how rapidly Tea Party leaders had mobilized a strong following and managed to dominate the news coverage, using some of the same social-media and grassroots-organizing strategies we had deployed during my own campaign. I'd spent my entire political career promoting civic participation as a cure for much of what ailed our democracy. I could hardly complain, I told myself, just because it was opposition to my agenda that was now spurring such passionate citizen involvement.

As time went on, though, it became hard to ignore some of the more troubling impulses driving the movement. As had been true at Palin rallies, reporters at Tea Party events caught attendees comparing me to animals or Hitler. Signs turned up showing me dressed like an African witch doctor with a bone through my nose. Conspiracy theories abounded: that my health-care bill would set up "death panels" to evaluate whether people deserved treatment, clearing the way for "government-encouraged euthanasia," or that it would benefit illegal immigrants, in the service of my larger goal of flooding the country with welfare-dependent, reliably Democratic voters. The Tea Party also resurrected an old rumor from the campaign: that I was not only Muslim but had actually been born in Kenya, and was therefore constitutionally barred from serving as President. By September, the question of how much nativism and racism explained the Tea Party's

rise had become a major topic of debate on the cable shows—especially after the former President and lifelong Southerner Jimmy Carter offered up the opinion that the extreme vitriol directed toward me was at least in part spawned by racist views.

At the White House, we made a point of not commenting on any of this—and not just because Axe had reams of data telling us that white voters, including many who supported me, reacted poorly to lectures about race. As a matter of principle, I didn't believe a President should ever publicly whine about criticism from voters—it's what you signed up for in taking the job—and I was quick to remind both reporters and friends that my white predecessors had all endured their share of vicious personal attacks and obstructionism.

More practically, I saw no way to sort out people's motives, especially given that racial attitudes were woven into every aspect of our nation's history. Did that Tea Party member support "states' rights" because he genuinely thought it was the best way to promote liberty, or because he continued to resent how federal intervention had led to desegregation and rising Black political power in the South? Did that conservative activist oppose any expansion of the social-welfare state because she believed it sapped individual initiative or because she was convinced that it would benefit only brown people who had just crossed the border? Whatever my instincts might tell me, whatever truths the history books might suggest, I knew I wasn't going to win over any voters by labelling my opponents racist.

One thing felt certain: a pretty big chunk of the American people, including some of the very folks I was trying to help, didn't trust a word I said. One night, I watched a news report on a charitable organization called Remote Area Medical, which provided medical services in temporary pop-up clinics around the country, operating out of trailers parked at fairgrounds and arenas. Almost all the patients in the report were white Southerners from places like Tennessee and Georgia—men and women who had jobs but no employer-based insurance or had insurance with deductibles they couldn't afford. Many had driven hundreds of miles to join crowds of people lined up before dawn to see one of the volunteer doctors, who might pull an infected tooth, diagnose debilitating abdominal pain, or examine a breast lump. The demand was so great that patients who arrived after sunup sometimes got turned away.

I found the story both heartbreaking and maddening, an indictment of a wealthy nation that failed too many of its citizens. And yet I knew that almost every one of those people waiting to see a free doctor came from a deep-red Republican district, the sort of place where opposition to our health-care bill, along with support of the Tea Party, was likely to be strongest. There had been a time—back when I was still a state senator driving around southern Illinois or, later, travelling through rural Iowa during the earliest days of the Presidential campaign—when I could reach such voters. I wasn't yet well known enough to be the target of caricature, which meant that whatever preconceptions people may have had about a Black guy from Chicago with a foreign name could be dispelled by a simple conversation, a small gesture of kindness.

I wondered if any of that was still possible, now that I lived locked behind gates and guardsmen, my image filtered through Fox News and other media outlets whose entire business model depended on making their audience angry and fearful. I wanted to believe that the ability to connect was still there. My wife wasn't so sure. One night, Michelle caught a glimpse of a Tea Party rally on TV—with its enraged flag-waving and inflammatory slogans. She seized the remote and turned off the set, her expression hovering somewhere between rage and resignation.

"It's a trip, isn't it?" she said.

"What is?"

"That they're scared of you. Scared of us." She shook her head and headed for bed.

Ted Kennedy died on August 25th. The morning of his funeral, the skies over Boston darkened, and by the time our flight landed the streets were shrouded in thick sheets of rain. The scene inside the church befitted the largeness of Teddy's life: the pews packed with former Presidents and heads of state, senators and members of Congress, hundreds of current and former staffers. But the stories told by his children mattered most that day. Patrick Kennedy recalled his father tending to him during crippling asthma attacks. He described how his father would take him out to sail, even in stormy seas. Teddy, Jr., told the story of how, after he'd lost his leg to cancer, his father had insisted they go sledding, trudging with him up a snowy hill, picking him up when he fell, and telling him "there is nothing you can't do." Collectively, it was a portrait of a man driven by great appetites and ambitions but also by great loss and doubt—a man making up for things.

"My father believed in redemption," Teddy, Jr., said. "And he never surrendered, never stopped trying to right wrongs, be they the results of his own failings or of ours."

I carried those words with me back to Washington, where a spirit of surrender increasingly prevailed—at least, when it came to getting a health-care bill passed. A preliminary report by the Congressional Budget Office, the independent, professionally staffed operation charged with scoring the cost of all federal legislation, priced the initial House version of the health-care bill at an eye-popping one trillion dollars. Although the C.B.O. score would eventually come down as the bill was revised and clarified, the headlines gave opponents a handy stick with which to beat us over the head. Democrats from swing districts were now running scared, convinced that pushing forward with the bill amounted to a suicide mission. Republicans abandoned all pretense of wanting to negotiate, with members of Congress regularly echoing the Tea Party's claim that I wanted to put Grandma to sleep.

The only upside to all this was that it helped me cure Max Baucus of his obsession with trying to placate Chuck Grassley. In a last-stab Oval Office meeting with the two of them in early September, I listened patiently as Grassley ticked off five new reasons that he still had problems with the latest version of the bill.

“Let me ask you a question, Chuck,” I said finally. “If Max took every one of your latest suggestions, could you support the bill?”

“Well . . .”

“Are there any changes—any at all—that would get us your vote?”

There was an awkward silence before Grassley looked up and met my gaze. “I guess not, Mr. President.”

I guess not.

At the White House, the mood rapidly darkened. Some of my team began asking whether it was time to fold our hand. Rahm was especially dour. Having been to this rodeo before, he understood all too well what my declining poll numbers might mean for the reëlection prospects of swing-district Democrats, many of whom he had personally recruited and helped elect, not to mention my own prospects in 2012. Rahm proposed that we try to cut a deal with Republicans for a significantly scaled-back piece of legislation—perhaps allowing people between sixty and sixty-five to buy into Medicare or widening the reach of the Children’s Health Insurance Program. “It won’t be everything you wanted, Mr. President,” he said. “But it’ll still help a lot of people, and it’ll give us a better chance to make progress on the rest of your agenda.”

Some in the room agreed. Others felt it was too early to give up. Phil Schiliro said he thought there was still a path to passing a comprehensive law with only Democratic votes, but he admitted that it was no sure thing.

“I guess the question for you, Mr. President, is, Do you feel lucky?”

I looked at him. “Where are we, Phil?”

Phil hesitated, wondering if it was a trick question. “The Oval Office?”

“And what’s my name?”

“Barack Obama.”

I smiled. “Barack Hussein Obama. And I’m here with you in the Oval Office. Brother, I always feel lucky.”

I told the team that we were staying the course. But my decision didn’t have much to do with how lucky I felt. Rahm wasn’t wrong about the risks, and perhaps in a different political environment, on a different issue, I might have accepted his advice. On this issue, though, I saw no indication that Republican leaders would throw us a lifeline. We were wounded, their base wanted blood, and, no matter how modest the reform we proposed, they were sure to find a whole new set of reasons for not working with us.

More than that, a scaled-down bill wasn't going to help millions of people who were desperate. The idea of letting them down—of leaving them to fend for themselves because their President hadn't been sufficiently brave, skilled, or persuasive to cut through the political noise and get what he knew to be the right thing done—was something I couldn't stomach.

Knowing we had to try something big to reset the health-care debate, Axe suggested that I deliver a prime-time address before a special joint session of Congress. It was a high-stakes gambit, he explained, used only twice in the past sixteen years, but it would give me a chance to speak directly to millions of viewers. I asked what the other two joint addresses had been about.

"The most recent was when Bush announced the war on terror after 9/11."

"And the other?"

"Bill Clinton talking about his health-care bill."

I laughed. "Well, that worked out great, didn't it?"

Despite the inauspicious precedent, we decided it was worth a shot.

Two days after Labor Day, Michelle and I climbed into the back seat of the Presidential S.U.V., known as the Beast, drove up to the Capitol's east entrance, and retraced the steps we had taken seven months earlier to the doors of the House chamber, where I'd given my first address to a joint session of Congress, back in February. The mood in the chamber felt different this time—the smiles a little forced, a murmur of tension and doubt in the air. Or maybe it was just that my mood was different. Whatever giddiness or sense of personal triumph I'd felt shortly after taking office had now been burned away, replaced by something sturdier: a determination to see a job through.

For an hour that evening, I explained as straightforwardly as I could what our reform plan would mean for the families who were watching—how it would provide affordable insurance to those who needed it but also give critical protections to those who already had insurance; how it would prevent insurance companies from discriminating against people with preëxisting conditions and eliminate the kind of lifetime limits that burdened families like Laura Klitzka's. I detailed how the plan would help seniors pay for lifesaving drugs and require insurers to cover routine checkups and preventive care at no extra charge. I explained that the talk about a government takeover and death panels was nonsense, that the legislation wouldn't add a dime to the deficit, and that the time to make this happen was now. But in the back of my mind was a letter from Ted Kennedy I'd received a few days earlier. He'd written it in May but had instructed Vicki to wait until after his death to pass it along. It was a farewell letter, two pages long, in which he thanked me for taking up the cause of health-care reform, referring to it as "the great unfinished business of our society" and the cause of his life. He added that he would die with some comfort, believing that what he'd spent years working toward would now, under my watch, finally happen.

I ended my speech that night by quoting from Teddy's letter, hoping that his words would bolster the nation just as they had bolstered me. "What we face," he'd written, "is above all a moral issue; that at stake are not just the details of policy, but fundamental principles of social justice and the character of our country."

According to poll data, my address to Congress boosted public support for the health-care bill, at least temporarily. Even more important for our purposes, it seemed to stiffen the spine of wavering congressional Democrats. It did not, however, change the mind of a single Republican in the chamber. This was clear less than thirty minutes into the speech, when—as I debunked the phony claim that the bill would insure undocumented immigrants—a relatively obscure five-term Republican congressman from South Carolina named Joe Wilson leaned forward in his seat, pointed in my direction, and shouted, his face flushed with fury, "You lie!"

For the briefest moment, a stunned silence fell over the chamber. I turned to look for the heckler (as did Speaker Pelosi and Joe Biden, Nancy aghast and Joe shaking his head). I was tempted to exit my perch, make my way down the aisle, and smack the guy in the head. Instead, I simply responded by saying, "It's not true," and then carried on with my speech as Democrats hurled boos in Wilson's direction.

As far as anyone could remember, nothing like that had ever happened before a joint-session address—at least, not in modern times. Congressional criticism was swift and bipartisan, and, by the next morning, Wilson had apologized publicly for the breach of decorum, calling Rahm and asking that his regrets get passed on to me as well. I downplayed the matter, telling a reporter that I appreciated the apology and was a big believer that we all make mistakes.

And yet I couldn't help noticing the news reports saying that online contributions to Wilson's reëlection campaign spiked sharply in the week following his outburst. Apparently, for many Republican voters out there, he was a hero, speaking truth to power. It was an indication that the Tea Party and its media allies had accomplished more than just their goal of demonizing the health-care bill. They had demonized me and, in doing so, had delivered a message to all Republican office-holders: when it came to opposing my Administration, the old rules no longer applied.

Despite having grown up in Hawaii, I have never learned to sail a boat; it wasn't a pastime my family could afford. Still, for the next three and a half months, I felt the way I imagine sailors feel on the open seas after a brutal storm has passed. The work remained arduous and sometimes monotonous, made tougher by the need to patch leaks and bail water. But, for a span of time, we had in us the thankfulness of survivors, propelled in our daily tasks by a renewed belief that we might make it to port after all.

For starters, after months of delay, Baucus finally opened debate on a health-care bill in the Senate Finance Committee. His version, which tracked the Massachusetts model we had all been using, was stingier with its subsidies to the uninsured than we would have preferred, and we insisted that he replace a tax on high-value employer-based insurance plans with increased taxes on the wealthy. But, to everyone's credit, the

deliberations were generally substantive and free of grandstanding. After three weeks of exhaustive work, the bill passed out of committee by a fourteen-to-nine margin. The lone Republican vote we got came from Olympia Snowe.

Speaker Pelosi then engineered the quick passage of a consolidated House bill against overwhelming and boisterous G.O.P. opposition, with a vote held on November 7, 2009. If we could get the full Senate to pass a similarly consolidated version of its bill before the Christmas recess, we figured, we could then use January to negotiate the differences between the Senate and House versions, send a merged bill to both chambers for approval, and, with any luck, have the final legislation on my desk for signing by February.

It was a big if—and one largely dependent on my old friend Harry Reid. True to his generally dim view of human nature, the Senate Majority Leader assumed that Olympia Snowe couldn't be counted on once a final version of the health-care bill hit the floor. ("When McConnell really puts the screws to her," he told me matter-of-factly, "she'll fold like a cheap suit.") To overcome the possibility of a filibuster, Harry couldn't afford to lose a single member of his sixty-person caucus. And, as had been true with the Recovery Act, this fact gave each one of those members enormous leverage to demand changes to the bill, regardless of how parochial or ill-considered their requests might be.

This wouldn't be a situation conducive to high-minded policy considerations, which was just fine with Harry, who could maneuver, cut deals, and apply pressure like nobody else. For the next six weeks, as the consolidated bill was introduced on the Senate floor and lengthy debates commenced on procedural matters, the only action that really mattered took place behind closed doors in Harry's office, where he met with the holdouts one by one to find out what it would take to get them to yes. Some wanted funding for well-intentioned but marginally useful pet projects. Several of the Senate's most liberal members, who liked to rail against the outsized profits of Big Pharma and private insurers, suddenly had no problem at all with the outsized profits of medical-device manufacturers with facilities in their home states and were pushing Harry to scale back a proposed tax on the industry. Senators Mary Landrieu and Ben Nelson made their votes contingent on hundreds of millions of additional Medicaid dollars specifically for Louisiana and Nebraska, concessions that the Republicans cleverly labelled "the Louisiana Purchase" and "the Cornhusker Kickback."

Whatever it took, Harry was game. Sometimes too game. Occasionally, he'd dig his heels in on some deal he wanted to cut, and I'd have to intervene with a call. Listening to my objections, he'd usually relent, but not without some grumbling, wondering how on earth he would get the bill passed if he did things my way.

"Mr. President, you know a lot more than I do about health-care policy," he said at one point. "But I know the Senate, O.K.?"

Compared with the egregious pork-barrelling, logrolling, and patronage-dispensing tactics that Senate leaders had traditionally used to pass big, controversial bills like the Civil Rights Act or Ronald Reagan's 1986 Tax Reform Act, or a package like the New

Deal, Harry's methods were fairly benign. But those bills had passed during a time when most Washington horse-trading stayed out of the papers, before the advent of the twenty-four-hour news cycle. For us, the slog through the Senate was a P.R. nightmare. Each time Harry's bill was altered to mollify another senator, reporters cranked out a new round of stories about "backroom deals." And things got markedly worse when Harry decided, with my blessing, to strip the bill of something called the "public option."

From the very start of the health-care debate, policy wonks on the left had pushed us to modify the Massachusetts model by giving consumers the choice to buy coverage on the online "exchange," not just from the likes of Aetna and Blue Cross Blue Shield but also from a newly formed insurer owned and operated by the government. Unsurprisingly, insurance companies had balked at the idea of a public option, arguing that they would not be able to compete against a government insurance plan that could operate without the pressures of making a profit. Of course, for public-option proponents, that was exactly the point. By highlighting the cost-effectiveness of government insurance and exposing the bloated waste and immorality of the private-insurance market, they hoped the public option would pave the way for a single-payer system.

It was a clever idea, and one with enough traction that Nancy Pelosi had included it in the House bill. But, on the Senate side, we were nowhere close to having sixty votes for a public option. There was a watered-down version in the Senate Health and Education Committee bill, requiring any government-run insurer to charge the same rates as private insurers, but, of course, that would have defeated the whole purpose of a public option. My team and I thought a possible compromise might involve offering a public option only in those parts of the country where there were too few insurers to provide real competition and a public entity could help drive down premium prices over all. But even that was too much for the more conservative members of the Democratic caucus to swallow, including Joe Lieberman, of Connecticut, who announced shortly before Thanksgiving that under no circumstances would he vote for a package containing a public option.

When word got out that the public option had been removed from the Senate bill, activists on the left went ballistic. Howard Dean, the former Vermont governor and onetime Presidential candidate, declared it "essentially the collapse of health-care reform in the United States Senate." They were especially outraged that Harry and I appeared to be catering to the whims of Joe Lieberman, whose apparent power to dictate the terms of health-care reform reinforced the view among some Democrats that I treated enemies better than allies.

I found the whole brouhaha exasperating. "What is it about sixty votes these folks don't understand?" I groused to my staff. "Should I tell the thirty million people who can't get covered that they're going to have to wait another ten years because we can't get them a public option?"

It wasn't just that criticism from friends always stung the most. The carping carried immediate political consequences for Democrats. It confused our base (which, generally

speaking, had no idea what the hell a public option was) and divided our caucus. It also ignored the fact that all the great social-welfare advances in American history, including Social Security and Medicare, had started off incomplete and had been built upon gradually, over time. By preëmptively spinning what could be a monumental, if imperfect, victory into a bitter defeat, the criticism contributed to a potential long-term demoralization of Democratic voters—otherwise known as the “What’s the point of voting if nothing ever changes?” syndrome—making it even harder for us to win elections and move progressive legislation forward in the future.

There was a reason, I told my adviser Valerie Jarrett, that Republicans tended to do the opposite—that Ronald Reagan could preside over huge increases in the federal budget, the federal deficit, and the federal workforce and still be lionized by the G.O.P. faithful as the guy who successfully shrank the federal government. They understood that, in politics, the stories told were often as important as the substance achieved.

We made none of these arguments publicly, though for the rest of my Presidency the phrase “public option” became a useful shorthand inside the White House anytime Democratic interest groups complained about us failing to defy political gravity and securing less than a hundred per cent of whatever they were asking for. Instead, we did our best to calm folks down, reminding disgruntled supporters that we would have plenty of time to fine-tune the legislation when we merged the House and Senate bills. Harry kept doing Harry stuff, including keeping the Senate in session weeks past the scheduled adjournment for the holidays.

As he’d predicted, Olympia Snowe braved a blizzard to stop by the Oval and tell us in person that she’d be voting no. But it didn’t matter. On Christmas Eve, after twenty-four days of debate, with Washington blanketed in snow and the streets all but empty, the Senate passed its health-care bill, titled the Patient Protection and Affordable Care Act—the A.C.A.—with exactly sixty votes. It was the first Christmas Eve vote in the Senate since 1895.

A few hours later, I settled back in my seat on Air Force One, listening to Michelle and the girls discuss how well Bo was adjusting to his first plane ride as we headed to Hawaii for the holiday break. I felt myself starting to relax just a little. We were going to make it, I thought. We weren’t docked yet—not even close, it would turn out—but thanks to my team, thanks to Nancy, Harry, and a whole bunch of congressional Democrats who’d taken tough votes, we finally had land within our sights.

The New York Times

Trump's 'Public Charge' Immigration Rule Is Vacated by Federal Judge
Miriam Jordan

A federal judge on Monday ordered the Trump administration to vacate a policy that allowed officials to deny green cards to immigrants who might need public assistance, such as food stamps and housing vouchers, saying it exceeded the authority of the executive branch.

In a 14-page ruling, Judge Gary Feinerman of the U.S. District Court for the Northern District of Illinois cited "numerous unexplained flaws" that made the rule "arbitrary and capricious," including an interpretation of self-sufficiency that had no basis in the statute it purportedly interpreted, and the failure to consider the "predictable collateral consequences" of its implementation.

The policy, known as the public charge rule, was announced in September 2018 and effectively created a wealth test for immigrants seeking permanent residency by rendering inadmissible applicants deemed likely to use a broad range of safety net programs. In addition to reaching beyond the power of the executive branch, Judge Feinerman wrote, the rule ran afoul of the Administrative Procedure Act, which governs how regulations are developed and rolled out.

The Trump administration is expected to appeal the decision, and the case could end up before the Supreme Court. Meanwhile, the United States Citizenship and Immigration Services, whose officers adjudicate green cards, cannot apply the new standard in reviewing applications. The agency's spokesman, Dan Hetlage, said the agency would fully comply with the decision and issue additional forthcoming guidance after reviewing it.

Advocates who had feared that the policy would harm tens of thousands of poor people, particularly those affected by widespread job loss because of the coronavirus pandemic, hailed the court decision.

The fear and confusion the policy created "led to decreased participation in public programs and placed a heavy burden on local governments and community-based organizations to replace them," said Militza M. Pagán, a staff lawyer at the Shriver Center on Poverty Law who represented the plaintiffs.

Cook County and the Illinois Coalition for Immigrant and Refugee Rights filed a lawsuit in September 2019 challenging the legality of the public charge rule. Along with several other federal courts across the country that enjoined the rule, Judge Feinerman blocked it the following month, a day before the rule was to take effect.

But the Supreme Court set aside the injunctions and allowed the rule to go into effect in February, until a final ruling on the merits.

The Trump administration first announced in September 2018 its intention to change the guidance on how to identify a potential “public charge,” a noncitizen dependent on the government for subsistence. In August 2019, the Department of Homeland Security published a final rule that amended the regulations.

The new rule stated that any applicant likely to use housing vouchers, food stamps and nonemergency Medicaid, among other public benefits, for certain amounts of time could be denied a green card. Administration officials said it was in the best interest of the United States to ensure that new, legal immigrants were self-sufficient.

The measure was also intended to deter public benefits from luring people to seek residency in the United States, they said, and to help contain the government’s budget deficit.

The public charge rule fulfilled one of President Trump’s priorities — to bolster the legal immigration of well-to-do people. More green cards would go to immigrants who were educated, and fewer would be granted merely because someone has a family member in the United States, the foundation for the current system.

Though the idea of public charges is a longstanding principle of U.S. immigration law, it historically was applied to those deemed likely to primarily depend on the federal government for survival, such as through public cash assistance or institutionalized long-term care.

“Congress never intended that you be denied a green card if you ever touch a food stamp, which is what the Trump administration has tried to do by dramatically expanding the meaning of public charge,” said Doug Rand, a founder of Boundless Immigration, a technology company in Seattle that helps immigrants obtain green cards and citizenship.

A study released last month by Health Affairs, a health policy journal, found that nearly 79,000 children have withdrawn from Medicaid insurance in five states — California, New Jersey, Tennessee, Texas and Washington, representing 29 percent of all U.S. children — since the rule was announced. Based on that finding, researchers for Health Affairs estimated that 260,000 children nationwide have been removed by their parents from nutrition and health care programs as a result of the new rule.

In his ruling, Judge Feinerman cited an earlier ruling by the U.S. Court of Appeals for the Seventh Circuit that found that Mr. Trump’s interpretation of the public charge statute did “violence to the English language and the statutory context.”

That appellate court also determined the Department of Homeland Security did not have “unfettered discretion” to redefine public charge, despite “the ambiguity in the public-charge provision.”

“We find that the interpretation reflected in the rule falls outside the boundaries set by the statute,” it found in June.

On Monday, Judge Feinerman vacated the rule based on two grounds while allowing plaintiffs to continue pursuing a third claim, namely that the rule was discriminatory under the equal protection clause because it was rooted in animus against nonwhite immigrants.

The Department of Homeland Security argued that the rule should only be vacated in Illinois, but the court said that the government itself had conceded it had violated the Administrative Procedure Act and that the rule must be set aside in its entirety when that occurs.

“By the A.P.A.’s plain terms, an agency rule found unlawful in whole is not set aside just for certain plaintiffs or geographic areas; rather, the rule shall be set aside, period,” wrote Judge Feinerman, who was appointed by President Barack Obama.

Justice Amy Coney Barrett, who was recently confirmed to the Supreme Court, was on the three-judge panel of the appellate court that upheld the preliminary injunction. She wrote the dissenting opinion and is likely to recuse herself if the case goes before the Supreme Court.

Key Justices Signal Support for Affordable Care Act
Adam Liptak

WASHINGTON — At least five Supreme Court justices, including two members of its conservative majority, indicated on Tuesday that they would reject attempts by Republicans and the Trump administration to kill the Affordable Care Act.

It was not clear whether the court would strike down a provision of the act that initially required most Americans to obtain insurance or pay a penalty, a requirement that was rendered toothless in 2017 after Congress zeroed out the penalty. But the bulk of the sprawling 2010 health care law, President Barack Obama’s defining domestic legacy, appeared likely to survive its latest encounter with the court.

Both Chief Justice John G. Roberts Jr. and Justice Brett M. Kavanaugh said striking down the so-called individual mandate did not require the rest of the law to be struck down as well.

“Congress left the rest of the law intact when it lowered the penalty to zero,” Chief Justice Roberts said.

Justice Kavanaugh made a similar point. “It does seem fairly clear that the proper remedy would be to sever the mandate provision and leave the rest of the act in place — the provisions regarding pre-existing conditions and the rest,” he said.

The court’s three-member liberal wing — Justices Stephen G. Breyer, Sonia Sotomayor and Elena Kagan — also indicated their support for the law. That suggested there were at least five votes to uphold almost all of it.

Three members of the court’s conservative majority, Justices Clarence Thomas, Samuel A. Alito Jr. and Neil M. Gorsuch, seemed poised to vote to strike down the law. The court’s newest member, Justice Amy Coney Barrett, was harder to read, though she has been publicly critical of earlier rulings sustaining key provisions of the law.

Striking down the Affordable Care Act would expand the ranks of the uninsured in the United States by about 21.1 million people — a nearly 70 percent increase — according to new estimates from the Urban Institute.

The biggest loss of coverage would be among low-income adults who became eligible for Medicaid under the law after all but a dozen states expanded the program to include them. But millions of Americans would also lose private insurance, including young adults whom the law allowed to stay on their parents’ plans until they turned 26 and families whose income was modest enough to qualify for subsidies that help pay their monthly premiums.

In the decade since the enactment of the health care law, Republicans have worked hard to destroy it, and President Trump has repeatedly criticized it. But attempts to repeal it failed, as did two earlier Supreme Court challenges, in 2012 and 2015. With the passing years, the law has gained in popularity and been woven into the fabric of the health care system in ways big and small.

President-elect Joseph R. Biden Jr. vowed Tuesday to preserve and expand the law when he takes office on Jan. 20, and he assailed the arguments made in court by lawyers for Republican officials and the Trump administration.

Mr. Biden lashed out at what he called “far-right ideologues” in the administration who had asked the court to strike down the law, saying the impact of such a move for millions of Americans would be severe.

Campaigning for president, Mr. Biden said he wanted to strengthen the law by offering a public option that allows people to receive coverage the way Medicare enrollees do,

through a system of government-run insurance. People who would prefer to stay on private insurance would be able to do so.

The new case, California v. Texas, No. 19-840, was brought by Republican officials who said the mandate requiring insurance became unconstitutional after Congress in 2017 eliminated the penalty for failing to obtain health insurance because it could no longer be justified as a tax.

They went on to argue that the mandate was a crucial feature of the law, and so the entire law should be thrown out.

The challenge has largely succeeded in the lower courts. A federal judge in Texas ruled that the entire law was invalid, but he postponed the effects of his ruling until the case could be appealed. In December, the United States Court of Appeals for the Fifth Circuit, in New Orleans, agreed that the mandate was unconstitutional but declined to rule on the fate of the remainder of the health law, asking the lower court to reconsider the question in more detail.

Officials in states led by Democrats instead asked the Supreme Court to hear the case, saying the justices should act to resolve the uncertainty created by the appeals court's ruling.

The law includes popular provisions on guaranteed coverage for pre-existing medical conditions, emergency care, prescription drugs and maternity care. A lawyer for Texas and other Republican-led states, supported by a lawyer for the Trump administration, argued that all of those provisions should be ended as a consequence of the 2017 change to the individual mandate.

Those arguments were largely based on a decision in an earlier Supreme Court case, in 2012, when the court upheld the law's requirement that most Americans obtain insurance or pay a penalty. The vote was 5 to 4, with Chief Justice Roberts writing the controlling opinion, which said the mandate was authorized by Congress's power to assess taxes. He was joined by what was at the time the court's four-member liberal wing.

Since the mandate no longer raises revenue, said Kyle D. Hawkins, Texas's solicitor general, it cannot be justified as a tax and was therefore unconstitutional.

In assessing the narrow question of the constitutionality of the revised mandate, the justices discussed hypothetical laws that merely urged people to do things without penalizing them if they disobeyed.

Michael J. Mongan, California's solicitor general, said that without penalties for noncompliance, such laws present no constitutional problems. As for the revised mandate, he said, "it doesn't require anybody to do anything."

At Justice Barrett's confirmation hearings last month, Democratic senators questioned her closely about critical statements she had made about the two major Supreme Court decisions sustaining the law. At Tuesday's argument, she questioned the constitutionality of the mandate.

"Why can't we say that when Congress zeroed out the tax, it was no longer a tax because it generated no revenue and, therefore, it could no longer be justified as a taxing power?" she asked.

But Justice Barrett did not tip her hand on the more important issue of whether the rest of the law should survive if the mandate is struck down.

Justice Kagan noted what she said was a curious features of the challengers' argument. In 2012, she said, the Supreme Court had ruled that the mandate backed by a penalty was not an unconstitutional command. In 2017, she said, the law became less coercive.

"How does it make sense to say that what was not an unconstitutional command before has become an unconstitutional command now, given the far lesser degree of coercive force?" she asked.

Chief Justice Roberts noted that the mandate had in the earlier case been said to be "the key to the whole act." Justice Thomas said the court had been told that "this provision was the heart and soul of the Affordable Care Act."

Indeed, when the earlier challenge to the health care law was argued in 2012, the Obama administration did say that the mandate could not be severed from two related provisions, one prohibiting insurers from turning away applicants and the other barring them from taking account of pre-existing conditions.

Donald B. Verrilli Jr., who successfully defended the law in 2012 as solicitor general in the Obama administration and appeared as a lawyer for the House of Representatives on Tuesday, said experience had shown that the practical importance of the mandate had been overstated.

The health care law, he said, included both carrots, like subsidies, and the stick that was the mandate. "It's turned out that the carrots worked without the stick," he said.

The elimination of the law's financial penalty for going without health insurance has indeed had little effect on how many people signed up for coverage through the law's marketplaces. Enrollment in the marketplaces has decreased slightly since 2017, but it

has not shown any signs of a “death spiral,” when only sick people buy coverage and costs skyrockets as a result.

Whether the mandate was now unconstitutional or not, Mr. Verrilli said, the balance of the law must stand. It was far-fetched, he said, that Congress had intended to doom the law by adjusting a monetary penalty as opposed to repealing it outright.

“There were efforts to repeal the entire A.C.A.,” Mr. Verrilli said, “Those efforts failed.”

Chief Justice Roberts said that adjusting the penalty while leaving the rest of law in place was telling. “It’s hard for you to argue that Congress intended the entire act to fall if the mandate were struck down,” the chief justice told Mr. Hawkins, “when the same Congress that lowered the penalty to zero did not even try to repeal the rest of the act.”

Justice Kavanaugh also said that the whole law was not tied to the fate of the mandate. “I tend to agree with you,” he told Mr. Verrilli, “that it’s a very straightforward case for severability under our precedents.”

The law’s defenders hoped that the Republican challengers could not run the table on three separate legal arguments they would need to win: that they have suffered the sort of injury that gives them standing to sue; that the zeroing out of the tax penalty made the individual mandate unconstitutional; and that the rest of the law cannot stand without the individual mandate.

Judging by the questioning on Tuesday, in an argument that lasted for two hours, the law’s defenders seemed poised to prevail on at least the third issue. A ruling is expected by June.