COVERED CALIFORNIA Media Clips

COVERED CALIFORNIA BOARD CLIPS

June 24, 2020 – Sept. 10, 2020

Since the June board meeting, Covered California has unveiled its record-low preliminary rates for 2020, concluded its COVID-19 Special Enrollment Period at the end of August, having enrolled over 271,000 Californians affected by the pandemic. The national news included a post-Election date being set for the next Supreme Court hearing for the challenge to the Affordable Care Act.

PRESS RELEASES

PRINT

Articles of Significance

COVERED CALIFORNIA

News Release

July 6, 2020

Covered California Names Kevin Cornish Its New Chief Information Officer

- Cornish comes to Covered California from the Office of the President at the University of California, where he served as its chief technology officer.
- Cornish brings 31 years of technology-related experience with him and will be responsible for Covered California's information technology strategy as the head of the Information Technology division.
- Cornish replaces the retiring Karen Ruiz, who helped launch Covered California and has led the agency's Information Technology division since May of 2013.

SACRAMENTO, Calif. — On Monday, Covered California announced the appointment of Kevin Cornish as the agency's new chief information officer (CIO).

As the CIO, Cornish will be responsible for the overall design, development and execution of Covered California's information technology strategy. The CIO provides executive leadership over complex enterprise-wide business information technology solutions within a consumer-facing sales environment. Cornish will also represent Covered California's information technology initiatives with stakeholders, including state and federal government agencies, vendors, health insurance companies and other users of the systems.

"Kevin has spent more than three decades helping organizations build and expand their information technology infrastructure," said Covered California Executive Director Peter V. Lee. "His knowledge, experience and passion will serve us well as Covered California continues its efforts to use technology to make health care work better for consumers and to support our team in serving millions of Californians."

Cornish has 31 years of experience in the field, coming to the exchange from the Office of the President at the University of California, where he was its chief technology officer since August of 2017. Earlier in his career, as the vice president of the IT Infrastructure

Program at Kaiser Permanente, Cornish helped lead a multibillion-dollar initiative to remediate and transform the technology foundation supporting Kaiser's integrated health care delivery model.

Cornish will be replacing the retiring Karen Ruiz, who began her service with Covered California as the CalHEERS project director in May of 2013, helping build the enrollment portal at CoveredCA.com from the ground up along with joint-venture partners from the Department of Health Care Services, Office of Systems Integration and Accenture. She became the agency's chief information officer in March of 2015 and was named CIO of the Year in 2019 by the Public Sector CIO Academy Awards for her outstanding leadership and innovation.

Cornish graduated with a Bachelor of Arts degree in Human Information Processing from the University of California, San Diego in 1988. He worked for private software companies until 2010 before joining Kaiser Permanente and then the University of California, Berkeley as the CIO of the Haas School of Business in 2014. He will earn $260,000 annually, effective Aug. 1, 2020.

COVERED CALIFORNIA

News Release

July 16, 2020

Covered California Increases Investments in Marketing and Outreach to Reach Uninsured Californians During the COVID-19 Pandemic

- Covered California approved a $440 million budget for fiscal year 2020-21 that includes a $30 million increase in marketing investments and $13 million for additional customer service upgrades to meet the needs of consumers.
- The increased spending, which represents a 16 percent increase over last year's budget, comes amid continued uncertainty in the lives and livelihoods of Californians as public health officials fight against the spread of COVID-19.
- The budget also calls for greater investments in information technology to improve efficiency, as well as increased efforts to help inform state and national policy on health care-related issues.
- More than 209,000 people have signed up for coverage through Covered California since the exchange announced a special-enrollment period, which runs through the end of July, in response to the COVID-19 pandemic.

SACRAMENTO, Calif. — Covered California announced that it will submit its budget and annual report to Gov. Gavin Newsom and the state Legislature on Thursday. The $440 million budget for fiscal year (FY) 2020-21 highlights the agency's ongoing stability and increases its significant investments in marketing and outreach to connect with consumers during the current recession and ongoing pandemic.

"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," said Peter V. Lee, executive director of Covered California. "We are increasing our investments in marketing and outreach to make sure people know that Covered California is here for them if they need health insurance."

Covered California's budget for FY 2020-21 contains no state funding because the agency's revenue comes exclusively from a small monthly surcharge that health insurance companies pay for each enrollee. The budget calls for spending $440 million in FY 2020-21, which represents a 16 percent increase over last year, and includes a continued commitment to reaching consumers, with more than $157 million devoted to marketing, sales and outreach.

During the pandemic, California's unemployment rate jumped to a record 16.4 percent in April 2020. The University of California, Berkeley Labor Center also estimated that 2.6 million people and their dependents also lost the health care coverage that came with those jobs.

"California is committed to helping people get access to the health care they need, and Covered California looks forward to building on the state's policies to make a difference in the lives of Californians who need coverage," said Lee. "We want everyone to know that they have a path to coverage, whether it is through Covered California or Medi-Cal. Investing more in getting our message out there is the right thing to do."

Among the highlights of the FY 2020-21 budget:

- Investments associated with Marketing, Sales and Outreach will total $157.6 million and account for 36 percent of total operating expenses.
- Spending on the Service Center and Consumer Experience will total $135.4 million and account for 31 percent of total expenses.
- Spending for Technology (IT and Consumer Enrollment System) will total $61.4 million and represent 14 percent of total operating expenses.

Covered California's annual report summarizes the agency's accomplishments during the 2019-20 fiscal year, which included a record-low 0.8 percent rate change for the 2020 coverage year. The low rate change, which benefited consumers on- and off-exchange as well as those who were ineligible for federal financial help, was driven by California's implementation of new state subsidies and a state-level individual mandate penalty. As a result, Covered California experienced a 41 percent increase in the number of consumers who signed up for coverage during the most recent open-enrollment period.

"California is building on and going beyond the Affordable Care Act, continuing state subsidies and providing help consumers when they need it most," Lee said. "We want everyone to know that, whether they are uninsured or recently lost their health care coverage due to the pandemic and recession, that Covered California and Medi-Cal stand ready to help them access quality health care coverage."

Special Enrollment Continues to Attract Thousands

Covered California is currently holding a special-enrollment period due to the COVID-19 national emergency. Anyone who meets Covered California's eligibility requirements,

which are similar to those in place during the annual open-enrollment period, can sign up for coverage through July 31.

The most recent data shows that 209,770 people signed up for health care coverage between March 20 and July 11, which is more than twice the number who signed up during the same time last year.

Every year Covered California provides eligible consumers the opportunity to sign up for health care coverage, outside of the traditional open-enrollment period, if they experience a qualifying life event. These can include events like losing your health care coverage, moving, getting married or having a baby.

Overall, 277,330 people signed up for coverage since Covered California ended its open-enrollment period on Jan. 31 through July 11, which is nearly twice as many as seen during the same time period as last year.

People who sign up through Covered California will have access to private health insurance plans with monthly premiums that may be lowered due to federal and new state financial help that became effective in 2020. After selecting a plan, their coverage would begin on the first of the following month — meaning individuals losing job-based coverage would not face a gap in coverage.

In addition, consumers who sign up through CoveredCA.com may find out that they are eligible for no-cost or low-cost coverage through Medi-Cal, which they can enroll in online. Those eligible for Medi-Cal can have coverage that is immediately effective.

New State Subsidies Help Californians Lower Their Health Care Costs

Californians who sign up for coverage may be able to benefit from a new state subsidy program that expanded the amount of financial help available to many people. The subsidies are already benefiting about 625,000 Covered California consumers. Roughly 576,000 lower-income consumers, who earn between 200 and 400 percent of the federal poverty level (FPL), are receiving an average of $608 per month, per household in federal tax credits and new state subsidies (which averages $23 per household). The financial assistance lowers the average household monthly premium from $881 per month to $272, a decrease of 70 percent.

In addition, nearly 32,000 middle-income consumers have already qualified for new state subsidies, with average state subsidy to eligible households is $504 per month, lowering their monthly premium by nearly half.

Many of those eligible for the new middle-income state subsidies are an estimated 280,000 Californians who are likely eligible for new state or existing federal subsidies but kept their “off-exchange” coverage. They are also eligible to switch to Covered California and benefit from the financial help. During this special-enrollment period, Covered California, its health insurance companies and certified agents will be reaching out to these Californians to let them know how they can save money on their premiums — which will help them keep their coverage in challenging financial times.

Staying Safe While Getting Help Enrolling

Covered California is working with the more than 10,000 Certified Insurance Agents who help Californians sign up and understand their coverage options through phone-based service models.

“We continue to be in a different world right now, but social distancing does not mean you cannot get personal help,” Lee said. “Health insurance is just a phone call away, and our agents and staff are ready to help people get the coverage they need.”

Consumers can easily find out if they are eligible for Medi-Cal or other forms of financial help and see 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.

COVERED CALIFORNIA

News Release

July 29, 2020

California to Give Consumers More Time to Sign Up for Health Care Coverage by Extending Special-Enrollment Deadline During COVID-19 Pandemic

- Consumers who are uninsured and eligible to enroll in health care coverage through Covered California will now be able to sign up through the end of August.
- The moves come during ongoing uncertainty in the lives and livelihoods of Californians as public health officials fight against the spread of COVID-19. to sign up through the end of August.
- The extension will also apply to consumers who enroll in off-exchange plans, outside of Covered California, to ensure that people enrolling in the entire individual market in California will have access to coverage during the pandemic.
- All screening and testing for COVID-19 is free of charge, and all health plans available through Medi-Cal and Covered California offer telehealth options.
- More than 231,000 people have signed up for coverage through Covered California since the exchange announced a special-enrollment period in response to the COVID-19 pandemic

SACRAMENTO, Calif. — Due to the recent surge in COVID-19 cases throughout the state, Covered California announced on Wednesday that it would give consumers additional time to sign up for health care coverage during the pandemic by extending the current special-enrollment deadline to the end of August.

“We are all doing our part in this health crisis, by wearing masks and practicing social distancing, and Covered California is committed to helping people access the health care they need,” said Peter V. Lee, executive director of Covered California. “As the battle against the pandemic continues, we want to give people every possible

opportunity to get health care coverage, whether it is through Covered California or Medi-Cal."

Covered California initially responded to the COVID-19 emergency by opening the health insurance exchange to any eligible uninsured individuals who needed health care coverage from March 20 to June 30, which was then extended to July 31.

The most recent data shows that 231,040 people have signed up through Covered California for health care coverage between March 20 and July 25, which is more than twice the number who signed up during the same time last year.

Every year, Covered California provides eligible consumers the opportunity to sign up for health care coverage outside of the traditional open-enrollment period if they experience a qualifying life event. These can include events like losing your health insurance, moving, getting married or having a baby.

Overall, 298,600 people have signed up for coverage since Jan. 31, when Covered California ended its open-enrollment period, through July 25, which is nearly twice as many as seen during the same time period last year.

The latest data from California's Employment Development Department shows that 8.7 million unemployment claims have been processed in the state since the pandemic started. People who sign up through Covered California will have access to private health insurance plans with monthly premiums that may be lowered due to federal and new state financial help that became effective in 2020. After selecting a plan, their coverage would begin on the first day of the following month — meaning individuals losing job-based coverage would not face a gap in coverage.

"Covered California is always open and available for people who lose their job-based health insurance," Lee said. "During this time, we also want to make sure that those who do not have health insurance also have access to the care in the middle of a pandemic."

Medi-Cal and Off-Exchange Coverage

In addition, consumers who sign up through CoveredCA.com may find out that they are eligible for no-cost or low-cost coverage through Medi-Cal, which they can enroll in online. Those eligible for Medi-Cal can have coverage that is immediately effective.

California has halted Medi-Cal renewal reviews and discontinuances through the end of the public health emergency, ensuring that those already enrolled can continue their coverage. The decision will free up county resources to process new enrollments. The Department of Health Care Services (DHCS) also received expanded authority to expedite enrollment for seniors and other vulnerable populations through Hospital Presumptive Eligibility; expand the use of telehealth; and to provide COVID-19 testing, testing-related services and treatment to the uninsured, among other steps to make it easier to access care.

"Since the beginning of the COVID-19 emergency, DHCS has worked to make our system more flexible to help get services to Medi-Cal beneficiaries in virtually every way possible," said Will Lightbourne, director of the Department of Health Care Services. "We want to meet people where they are, whether they are dealing with COVID-19

exposure or they have other health care needs that have become more difficult to address because of COVID-19."

DHCS oversees Medi-Cal, California's version of Medicaid, which provides coverage for about 13 million Californians. Medi-Cal enrollment is available year-round.

The California Department of Managed Health Care (DMHC) and the California Department of Insurance have also extended the special-enrollment period through Aug. 31, 2020, which applies to all health plans on the individual market, including off-exchange health plans.

"California is continuing to feel the impacts of this pandemic, and the DMHC is committed to helping those affected by the COVID-19 emergency," said acting DMHC Director Mary Watanabe. "Extending the special-enrollment period will provide continued access to comprehensive and affordable health care coverage options for those who need it."

"Our latest action to extend the enrollment period is good news for workers and families experiencing the stress of job loss due to the pandemic," said Insurance Commissioner Ricardo Lara. "Even if your income has dropped, premium subsidies are available to help you afford quality insurance coverage."

All Covered California and Medi-Cal Plans Offer Telehealth Options

All health plans available through Covered California and Medi-Cal provide telehealth options for enrollees, giving individuals the ability to connect with a health care professional by phone or video without having to personally visit a doctor's office or hospital.

All screening and testing for COVID-19 is free of charge. This includes telehealth or doctor's office visits, as well as network emergency room or urgent care visits for the purpose of screening and testing for COVID-19. In addition, Medi-Cal covers costs associated with COVID-19 in both its managed care plans and with fee-for-service providers. Covered California health plans will help cover costs that arise from any required treatment or hospitalization.

New State Subsidies Help Californians Lower Their Health Care Costs

Californians who sign up for coverage may be able to benefit from a new state subsidy program that expanded the amount of financial help available to many people. The subsidies are already benefiting about 625,000 Covered California consumers. Roughly 576,000 lower-income consumers, who earn between 200 to 400 percent of the federal poverty level (FPL), are receiving an average of $608 per month, per household in federal tax credits and new state subsidies (which averages $23 per household). The financial help lowers the average household monthly premium from $881 to $272, a decrease of 70 percent.

In addition, nearly 32,000 middle-income consumers have qualified for new state subsidies, with an average state subsidy to eligible households of $504 per month, lowering their monthly premium by nearly half.

Many of those eligible for the new middle-income state subsidies are an estimated 280,000 Californians who are likely eligible for new state or existing federal subsidies but kept their “off-exchange” coverage. They are also eligible to switch to Covered California and benefit from the financial help.

Staying Safe While Getting Help Enrolling

Covered California is working with the more than 10,000 Certified Insurance Agents that help Californians sign up and understand their coverage options through phone-based service models.

“Health insurance is just a phone call away, and our agents and staff stand ready to help people get the coverage they need,” Lee said.

Consumers can easily find out if they are eligible Medi-Cal or other forms of financial help and see 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.

COVERED CALIFORNIA

News Release

Aug. 4, 2020

California's Efforts to Build on the Affordable Care Act Lead to a Record-Low Rate Change for the Second Consecutive Year

- The preliminary rate change for California's individual market will be 0.6 percent in 2021, which marks a record low for the second consecutive year and follows California's reforms to build on and strengthen the Affordable Care Act.
- Covered California's increased enrollment, driven by state policies and significant investments in marketing and outreach, has resulted in California having one of the healthiest individual market consumer pools and lower costs for consumers.
- The impact of COVID-19 on health plans' costs has been less than anticipated as many people deferred or avoided health care services in 2020, and while those costs are rebounding, it now appears the pandemic will have little effect on the total costs of care in California's individual market for 2020 and 2021.
- All 11 health insurance companies will return to the market for 2021, and two carriers will expand their coverage areas, giving virtually all Californians a choice of two carriers and 88 percent the ability to choose from three carriers or more.

SACRAMENTO, Calif. — Covered California announced on Tuesday a record-low insurance premium rate change for the second consecutive year. The preliminary average rate change for California's individual market is 0.6 percent for the upcoming 2021 plan year, which is the lowest mark since the launch of the Affordable Care Act and follows a rate change of only 0.8 percent in 2020.

"California continues to show the nation what can be done when you build on and strengthen the Affordable Care Act," said Peter V. Lee, executive director of Covered California. "California's bold policies to provide additional state financial help, to reinstate the penalty to encourage consumers to enroll in health care, and to make significant

marketing investments in Covered California are providing stability and lower costs in the face of national uncertainty."

The historically low rate change was driven by California's efforts to build on the Affordable Care Act through affordability initiatives — the state subsidies and the individual mandate enforcement provision that went into effect in 2020 — as well as ongoing investments in marketing and outreach that have led to increased enrollment and one of the healthiest consumer pools in the nation. The most recent data from the Centers for Medicare and Medicaid Services found that California has the second lowest "State Average Plan Liability Risk Score" in the nation, which marked the sixth straight year that California has been among the top five healthiest states.

"Access to affordable health care coverage is more critical than ever as our nation and state navigate the COVID-19 pandemic," said Gov. Gavin Newsom. "Covered California is leading the nation by eliminating barriers to access and providing Californians real opportunities to get the care and coverage they need."

California's Individual Market Rate Change for 2021

California's individual market consists of approximately 2.3 million people, including 1.5 million enrolled through Covered California. Nearly nine out of 10 (88 percent) of those enrolled through the marketplace are getting federal or state subsidies, or both, to lower their costs; the rest are buying coverage directly from carriers in the individual market.

The preliminary average rate change of 0.6 percent varies by region and by an individual's personal situation (see Table 2: Covered California Rate Changes by Rating Region).

"Health care costs are never a one-year story, and California has shown — again and again — that it can provide stability and lower costs in the face of federal policy changes that could have resulted in dramatic rate increases," Lee said. "The past three years can serve as a roadmap for the rest of the nation when it comes to successfully responding to federal challenges, reducing prices and encouraging enrollment."

Table 1: California's Individual Market Rate Changes (Percentages)[i]

	2015	2016	2017	2018[ii]	2019	2020	2021	Overall Average	3 Year Average (2019-2021)
Weight Avg	4.2	4.0	13.2	12.5	8.7	0.8	0.6	**6.3**	**3.3**
Shop & Switch	—	- 4.5	- 1.2	3.3	- 0.7	- 9.0	- 7.3	**- 3.2**	**- 5.7**

The main factors that contributed to the low rate change include the following:

- **Increases in Health Care Costs:** The underlying trend for health care costs — absent the impact of COVID-19 — for 2021 was generally projected to be in the 4 to 8 percent range across Covered California's 11 contracted health insurance companies.

- **COVID-19 Impact:** Covered California reviewed the experiences of health plans through 2020 and their projections for 2021 related to COVID-19 health care costs. While carriers did incur increased costs for COVID-19 treatments, increased telehealth provider services and extended grace periods for consumers enrolled during the current year, the costs were offset by a decrease in the volume of medical care and elective procedures as many people decided to stay home during the pandemic. While there continues to be considerable uncertainty about the pandemic and resulting health care costs, the latest information shows that health care costs will likely end up being close to what was originally priced for in California. For 2021, most plans project that caring for enrolled members with COVID-19 and the impacts of the pandemic on other care will have no to little net impact on premiums.

- **Strong and Healthy Enrollment:** Covered California saw a surge of new sign-ups during both the 2020 open-enrollment period (a 41 percent increase over the previous year) and the current special-enrollment period, during which more than 230,000 people have signed up for coverage since March 20, which is more than double the rate seen during the same period last year. The risk and demographic analysis of the new consumers indicates that both cohorts of incoming consumers are "healthier" on average than the equivalent cohorts from 2019.

- **Removal of Federal Health Plan Tax:** The repeal of the Health Insurer Tax lowered premiums by 0 percent to 3.3 percent across carriers, with the weighted average decrease to premiums at 1.7 percent.

- **Exchange Fee**: The participation fee Covered California charges qualified health plan issuers was reduced for 2021 from 3.5 percent to 3.25 percent, leading to a further reduction in premium.

“After a large increase in 2019 caused by the federal action that zeroed out the penalty on individuals failing to have insurance coverage, California has seen two years of less than 1 percent premium increases,” Lee said. “Covered California’s ability to provide stability and lower costs to consumers is the product of strong state policies, a competitive market and major investments in marketing.”

“State policies make a difference, and California is showing how you can keep health care costs under control and bring coverage within reach of more people,” said California Health and Human Services Secretary and Covered California Board Chair, Dr. Mark Ghaly. “Making more financial help available and encouraging consumers to get covered means fewer people without insurance and lower health care costs for everybody.”

Consumers both on and off the exchange will benefit from Covered California’s competitive marketplace, which allows them to shop for the best value and save money if they switch plans. The average rate change for unsubsidized consumers who shop and switch to the lowest-cost plan in the same metal tier is -7.3 percent, which means many Californians may be able to get a lower gross premium than they have now if they shop and switch (see Table 1: California’s Individual Market Rate Changes).

“Shopping for the best deal will once again be important for consumers because as our carriers become more competitive on pricing and the cost of the second-lowest Silver plan decreases, consumers may find that the amount of their financial help is lowered,” Lee said.

The preliminary rates will be filed with California’s regulators, the Department of Managed Health Care and the Department of Insurance, and are subject to their final reviews.

Financial Help Lowers Costs for Consumers

Roughly 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 are benefiting about 590,000 consumers out of the current 1.5 million enrollees in Covered California. In 2020, with the combination of federal tax credits and state subsidies, the average consumer receiving financial help were paying only $130 per month of their total premium of $587 (with federal and state assistance reducing their costs by $457 or nearly 80 percent).

In addition, nearly 38,000 middle-income consumers have qualified for new state subsidies, with an average state subsidy to eligible households of $475 per month, lowering their monthly premium by nearly 44 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.

Increased Competition and Consumer Choice

In the coming year, all 11 carriers will continue offering products across the state, and two carriers will expand their coverage areas, providing increased competition and consumer choice. In 2021, 99.8 percent of Californians will have two or more choices, 88 percent will be able to choose from three carriers or more, and over three-fourths of Californians (77 percent) will have four or more choices.

Anthem Blue Cross will expand into Imperial, Inyo, Kern, Mono and Orange counties, and Oscar Health Insurance will expand into San Mateo County.

“A competitive market means virtually everyone across California will have a choice in coverage and is further proof that the Affordable Care Act is working in California for both consumers and health plans,” Lee said.

Consumers can find out what they will pay for their 2021 coverage starting during the renewal period in October, when they can visit Covered California’s website at www.CoveredCA.com and begin using the Shop and Compare Tool.

Staying Safe While Getting Help Enrolling

Covered California is currently in a special-enrollment period due to the COVID-19 pandemic, which allows the uninsured to sign up for coverage if they are eligible to enroll in the exchange. The most recent data shows that 231,040 people have signed up through Covered California for health care coverage between March 20 and July 25, which is more than twice the number who signed up during the same time last year. The special-enrollment period is available through the end of August.

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.

Table 2. California Individual Market Rate Changes by Rating Region

Rating Region	Total enrollment[1]	Avg. rate change	Shop and Switch[2]
Statewide Total	**1,480,020**	**0.6%**	**- 7.3%**
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	56,150	2.6%	- 0.4%
Region 2 Marin, Napa, Solano and Sonoma counties	53,340	2.3%	- 1.8%
Region 3 Sacramento, Placer, El Dorado and Yolo counties	86,920	1.8%	- 2.4%
Region 4 San Francisco County	34,690	1.4%	- 3.7%
Region 5 Contra Costa County	50,050	1.9%	- 2.6%
Region 6 Alameda County	70,090	2.4%	- 0.7%
Region 7 Santa Clara County	61,200	5.6%	- 5.5%
Region 8 San Mateo County	26,150	2.0%	- 2.8%
Region 9 Monterey, San Benito and Santa Cruz counties	27,860	0.1%	- 3.0%
Region 10 San Joaquin, Stanislaus, Merced, Mariposa and Tulare counties	75,000	4.2%	- 1.4%
Region 11 Fresno, Kings and Madera counties	36,200	-0.1%	- 3.0%
Region 12 San Luis Obispo, Santa Barbara and Ventura counties	67,580	2.3%	- 2.2%
Region 13 Mono, Inyo and Imperial counties	14,300	- 2.6%	- 4.7%
Region 14 Kern County	19,410	- 0.2%	- 2.8%
Region 15 Los Angeles County (northeast)	190,330	- 0.9%	- 10.7%
Region 16 Los Angeles County (southwest)	229,190	- 2.1%	- 13.4%
Region 17 San Bernardino and Riverside counties	131,290	0.8%	- 9.2%
Region 18 Orange County	139,820	0.7%	- 11.5%
Region 19 San Diego County	110,450	- 1.5%	- 13.3%

[1] Effectuated enrollment for coverage in the month of March 2020: See https://hbex.coveredca.com/data-research/library/active-member-profiles/CC_Membership_Profile_2020_03.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 3: California Individual Market Rate Changes by Carrier[iii]

Carrier	**Weighted Average Rate Change**
Anthem Blue Cross	6.0
Blue Shield of California	- 2.4
Chinese Community Health Plan	- 1.3
Health Net	3.4
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	**0.6**

COVERED CALIFORNIA

News Release

Aug. 24, 2020

Covered California Opens New Paths to Coverage for Wildfire Victims and Those Who Lose Their Job or Income During the Pandemic and Recession

- *Covered California establishes a new special-enrollment period to benefit victims of the 500+ wildfires raging across the state.*
- *In addition, Covered California announced new paths to coverage that will run through the end of 2020, for Californians who have lost employment or income due to the pandemic and resulting recession.*
- *The moves come during ongoing uncertainty in the lives of Californians caused by the wildfires and the continuing fight against COVID-19.*
- *More than 271,000 people have signed up for coverage through Covered California since the exchange's initial announcement of a special-enrollment period in response to the pandemic.*

SACRAMENTO, Calif. — In an effort to help Californians who have been impacted by the wildfires burning across the state, and to build on the help provided to those affected by the COVID-19 pandemic and the ensuing recession, Covered California announced the establishment of new paths to coverage during the current special-enrollment period. Consumers who are victims of the wildfires, or who lose their jobs — even if they do not receive health care coverage through their employer — and those who suffer a loss of income, could be eligible to sign up for coverage.

"Right now, many Californians face a triple threat, with hundreds of wildfires burning during a pandemic and recession, and Covered California wants to make sure they have access to the health care they need," said Peter V. Lee, executive director of Covered California. "Providing these paths to coverage will ensure that those who have lost jobs,

suffered a loss of income, or have been affected by wildfires have an opportunity to get health care coverage, whether it is through Covered California or Medi-Cal."

Covered California's regulations allow it to establish a special-enrollment period for people affected by the current statewide state of emergency. As of Friday, there were approximately 560 wildfires raging across the state, including two of the biggest in state history, sparked by nearly 12,000 lightning strikes.

"The emergencies facing our state right now will continue to have a long-lasting impact on Californians, and Covered California is doing what it can to meet people's health care needs, so they have one less thing to worry about," Lee said. "If you have been affected by the wildfires, or lost your job or income because of the pandemic and recession, we're opening our doors for eligible individuals to get health coverage through Covered California or Medi-Cal."

Covered California initially responded to the COVID-19 emergency by opening the health insurance exchange from March 20 to Aug. 31 to any eligible uninsured individuals who needed health care coverage. With that special-enrollment period expiring at the end of the month, the new qualifying life events will continue to help consumers sign up for health care coverage during this turbulent time.

The most recent data shows that 271,820 people signed up through Covered California for health care coverage between March 20 and Aug. 20, which is more than twice the number who signed up during the same time last year.

Every year, Covered California provides eligible consumers the opportunity to sign up for health care coverage outside of the traditional open-enrollment period if they experience a qualifying life event. These can include events like losing your health insurance, moving, getting married or having a baby.

Overall, 339,530 people have signed up for coverage since Covered California ended its open-enrollment period on Jan. 31, which is nearly twice as many as seen during the same time period last year.

While millions of Californians have lost employment or income due to the recession, Covered California's announcement comes on the heels of that state announcing that many receiving unemployment benefits will get at additional $300 per week. People who sign up through Covered California will have access to private health insurance plans with monthly premiums that may be lowered due to federal and new state financial help that became effective in 2020. After selecting a plan, their coverage would begin on the first day of the following month — meaning individuals losing job-based coverage would not face a gap in coverage.

Medi-Cal Coverage

Consumers who sign up through CoveredCA.com may find out that they are eligible for no-cost or low-cost coverage through Medi-Cal, which they can enroll in online. Those eligible for Medi-Cal can have coverage that is immediately effective.

California has halted Medi-Cal renewal reviews and discontinuances through the end of the public health emergency, ensuring that those already enrolled can continue their coverage. The decision will free up county resources to process new enrollments. The Department of Health Care Services also received expanded authority to expedite enrollment for seniors and other vulnerable populations through Hospital Presumptive Eligibility; expand the use of telehealth; and to provide COVID-19 testing, testing-related services and treatment to the uninsured, among other steps to make it easier to access care.

All Covered California and Medi-Cal Plans Offer Telehealth Options

All health plans available through Covered California and Medi-Cal provide telehealth options for enrollees, giving individuals the ability to connect with a health care professional by phone or video without having to personally visit a doctor's office or hospital.

All medically needed screening and testing for COVID-19 is free of charge. This includes telehealth or doctor's office visits, as well as network emergency room or urgent care visits for the purpose of screening and testing for COVID-19. In addition, Medi-Cal covers costs associated with COVID-19 in both its managed care plans and with fee-for-service providers. Covered California health plans will help cover costs that arise from any required treatment or hospitalization.

New State Subsidies Help Californians Lower Their Health Care Costs

Californians who sign up for coverage may be able to benefit from a new state subsidy program that expanded the amount of financial help available to many people. The subsidies are already benefiting about 625,000 Covered California consumers. Roughly 576,000 lower-income consumers, who earn between 200 and 400 percent of the federal poverty level (FPL), are receiving an average of $608 per month, per household in federal tax credits and new state subsidies (which averages $23 per household). The financial help lowers the average household monthly premium from $881 to $272, a decrease of 70 percent.

In addition, nearly 32,000 middle-income consumers have qualified for new state subsidies, with an average state subsidy to eligible households of $504 per month, lowering their monthly premium by nearly half.

Many of those eligible for the new middle-income state subsidies are an estimated 280,000 Californians who are likely eligible for new state or existing federal subsidies but kept their "off-exchange" coverage. They are also eligible to switch to Covered California and benefit from the financial help.

Staying Safe While Getting Help Enrolling

Covered California is working with the more than 10,000 Certified Insurance Agents who help Californians sign up and understand their coverage options through phone-based service models.

“Over the past several months, our staff and insurance agents across the state have been working to help thousands of people over the phone or through virtual meetings to help people get the coverage they need,” Lee said. “Health care coverage through Covered California of Medi-Cal can be just a phone call away.”

Consumers can easily find out if they are eligible Medi-Cal or other forms of financial help and see 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.

Sept. 10, 2020

Pacific Business Group On Health Commits To Long-Term Effort To Creating Health Equity

San Francisco, Sept. 10, 2020 (GLOBE NEWSWIRE) -- The board of directors of the Pacific Business Group on Health (PBGH) and the PBGH leadership have made a long-term commitment to reduce and eliminate health disparities in the United States.

The initiative will bring together PBGH members, who include some of the largest U.S. employers and public and private health care purchasers, and the community-at-large in implementing effective solutions designed to mitigate access, outcomes and experience-of-care disparities faced by people of color.

“We are living through a painful time in our history as we grapple with both an unprecedented pandemic and the human toll of long-ignored inequities and injustices,” said Elizabeth Mitchell, president and CEO of PBGH. “The good news is that an incredible opportunity has emerged to finally address the enduring stain of racial injustice. That’s why PBGH’s board recently voted unanimously to add health equity as an organizational strategic focus.”

Doug McKeever, chief deputy executive director with Covered California and a PBGH board member, said reducing health disparities has been a part of his agency’s mission since it first opened its doors in 2014.

“We are all in this together and Covered California’s mission is to go beyond getting everyone covered -- not just during a pandemic or recession -- but assuring every American gets the right care at the right time, regardless of their race or economic status,” McKeever said. “Having public and private purchasers join together to work to reduce the health disparities that impact too many in California and across the nation is the right thing to do and we look forward to partnering on this important initiative.”

Racial health disparities are well documented and have persisted in the U.S. for decades, and range from coverage and access shortfalls to substantially higher rates of chronic illness and death. These gaps have been further exposed by the COVID-19 pandemic, which has produced greater infection and mortality rates in communities of color than in other racial groups.

PBGH is well positioned to make a difference in addressing systemic health inequities due to its programmatic expertise and influential members, as well as its long history of improving quality, affordability and patient experience for all individuals.

PBGH members clearly see a leadership role for PBGH and themselves in ensuring health equity. In a recent survey of PBGH member organizations, 100% stated they are taking action to address social and health inequity. Eighty percent of PBGH member organizations are creating Board and/or C-suite accountability and initiatives to address inequity, and two-thirds are working with their local communities on the issue. Two-thirds also are evaluating their benefits and wellness programs to ensure equity in health care access and use, and the vast majority (85%) intend to address social determinants of health as a lever.

PBGH and its members are working together to take concrete actions to reduce disparities and to implement a roadmap for accelerated employer and health care purchaser impact on this critical need. Early actions include:

Expanding provider networks to ensure access for communities of color and expanding sites of care to include more community-based care and providers

Holding health plans and health care providers accountable for equitable access and outcomes

Investing in primary care and primary care payment reform

Evaluating salary-based health insurance contributions and premiums

Expanding benefits for non-medical services (transportation, nutrition)

“We are combining the momentum and commitment of large employers and health care purchasers with subject matter expertise, and we look forward to marshalling our resources and those of our members to bring about real and lasting change in this critical area,” Mitchell said.

Covered California extends enrollment deadline through July
Ashley Valenzuela

SACRAMENTO, Calif. — According to Covered California, consumers who meet eligibility requirements have more time to sign up for health coverage during the pandemic, the enrollment deadline was extended to July 31.

“Covered California is committed to helping people get access to the health care they need, and while California is reopening parts of the state, there is still a lot of uncertainty out there due to the pandemic,” said Peter V. Lee, executive director of Covered California. “We want to make sure that people have a path to coverage, whether it is through Covered California or Medi-Cal, and giving people more time to sign up is the right thing to do.”

The California Department of Managed Health Care and the California Department of Insurance also extended the special-enrollment period through July 31.

“With Californians continuing to experience job loss and, with it, the loss of employer-based insurance, the ability to access individual health insurance coverage is even more critical," said Insurance Commissioner Ricardo Lara. "Substantial federal and state premium subsidies are available through Covered California to continue to keep quality, essential coverage within reach, especially during these extremely challenging times.”

Those interested in learning more about their coverage options can also visit the Covered California website or call Covered California at (800) 300-1506.

THE SACRAMENTO BEE

Covered California extends time for uninsured residents to sign up for health coverage

Cathie Anderson

Covered California announced Tuesday that it would extend a special enrollment period to July 31 to give Californians additional time to sign up for health insurance. It had been set to end June 30.

As cases of COVID-19 surged in California, the agency's board voted to give all uninsured Californians the opportunity to sign up for coverage. Typically, after open enrollment ends in January, only people who have a qualifying life event such as a job loss are eligible to get coverage.

COVID-19, the respiratory illness caused by the new coronavirus, has killed roughly 5,600 people in California and has sickened more than 183,000. After a brief decline in the number of cases, infections are once again on the rise.

"Covered California is committed to helping people get access to the health care they need, and while California is reopening parts of the state, there is still a lot of uncertainty out there due to the pandemic," said Peter V. Lee, executive director of Covered California. "We want to make sure that people have a path to coverage, whether it is through Covered California or Medi-Cal, and giving people more time to sign up is the right thing to do."

Roughly 175,030 people signed up for health care coverage between March 20 and June 20, more than twice the number who signed up during the same time last year, according to the latest data collected by the agency. Coverage starts on the first day of the month following enrollment, so individuals who have lost their job-based insurance would not face a gap in coverage.

Covered California offers private health insurance plans with monthly premiums that can be offset by financial help from the federal and state governments. State subsidies are being offered for the first time this year.

Consumer advocate Anthony Wright, executive director of Health Access California, said that even though health coverage is crucial at all times, it's especially essential in the middle of a global pandemic to ensure the health and well-being of families.

“Californians should take advantage of the new state investment, making care as affordable as ever for many low- and middle-income households,” Wright said. “We urge everyone to take this opportunity to connect with crucial coverage and care.”

A new state mandate requiring health insurance went into effect this year, and those who do not have coverage will face a state tax penalty when they file their annual income returns in 2021.

Nearly half a million people flocked to Obamacare after losing coverage this year
Tami Luhby

(CNN)Nearly half a million Americans turned to the federal Obamacare exchanges after losing health insurance coverage this year, new federal data shows.

Sign-ups spiked in April to more than double the number in prior Aprils, as millions of workers lost their jobs amid the coronavirus pandemic. More people also enrolled in May than in prior years.

Overall, enrollment jumped 46% in the first five months of 2020 compared to the same period the year before.

While open enrollment for 2020 plans ended in mid-December, those who lose coverage can sign up for Obamacare policies within 60 days at any point in the year.

At least some workers who were furloughed or temporarily laid off, however, were able to maintain their job-based health coverage. And others are now returning to work. But still others are learning their layoffs are permanent or are losing their positions in new waves of downsizings.

President Donald Trump has come under fire for not reopening the Affordable Care Act exchanges so the uninsured could purchase plans, despite pleas from elected officials from both parties, insurers and consumer advocates. Instead, the President said the federal government will reimburse hospitals for treating uninsured coronavirus patients using funds from Congress' rescue package.

Eleven states that run their own exchanges launched special enrollment periods to allow anyone to sign up for policies once the pandemic hit.

For instance, more than 175,000 Californians signed up for health care coverage between March 20 and June 20, more than double the number who did over the same time the year before, according to Covered California, the state exchange. Residents have until the end of July to sign up.

The New York Times

Obamacare Faces Unprecedented Test as Economy Sinks
Abby Goodnough and Reed Abelson

The Affordable Care Act, the landmark health law that has been a subject of caustic debate for more than a decade, is being tested as never before, as millions of Americans lose their jobs and medical coverage in the midst of the nation's gravest health crisis in a century.

The law is offering a vast majority of newly unemployed people a path to stopgap health coverage, providing a cushion that did not exist during the last crushing recession — or ever before. But the crisis has also highlighted fundamental weaknesses with its patchwork system — ones magnified by Republican efforts to undermine and dismantle it, but also seized on by some Democrats pushing for a sweeping overhaul.

On Thursday, as the coronavirus pandemic surged and the country reported a daily record in new virus cases, the Trump administration continued the Republican Party's push to abolish the law. Shortly before midnight, the Justice Department filed a brief asking the Supreme Court to overturn the law, in a case brought by a group of Republican attorneys general.

The case is likely to be argued this fall during the closing stages of a bitter presidential election in which health care is certain to be a galvanizing issue. Joseph R. Biden Jr., the presumptive Democratic nominee, continues to support improving and expanding the A.C.A. with an option to buy a public plan, rather than replacing it with a "Medicare for all" system preferred by many in the left wing of the party.

As those political and legal battles play out, how the law actually works in the coming months of intense need could go a long way toward determining its durability and future.

"This is the first test of the A.C.A. in an economic downturn," said Peter V. Lee, the executive director of Covered California, the state's insurance marketplace created under the law. "But it's not just a test — it's a national study of what happens in states that implemented the A.C.A. as opposed to those that didn't."

Four out of every five people who have lost employer-provided health insurance during the coronavirus pandemic are eligible for free coverage through expanded Medicaid

programs or government-subsidized private insurance, according to the Kaiser Family Foundation, a nonpartisan health research group. And many jobless 20-somethings have been able to join their parents' plans. All three options were made possible by the law.

Yet others have fallen through the holes in the law's safety net. Nearly three million low-income people are ineligible for assistance in the 14 states that have declined to expand Medicaid under the law, including Texas, Florida and others, mostly in the South, where coronavirus cases are now spiking. Many people who have qualified for government subsidies to buy private plans still face unaffordable co-pays and deductibles.

David Exum, of Kannapolis, N.C., has experienced both the benefits and the shortcomings of the law. He lost his health coverage when he was laid off from his job as a web content coordinator in March. He is now paying just $1 a month for a subsidized plan.

It is a big improvement from the last recession, he said, when he became uninsured for several years after losing his job and getting divorced. But for Mr. Exum, 53, the law is imperfect.

His plan is cheap because it has a high deductible — $6,900 a year. Worse, if his unemployment benefits expire before he finds a new job, and his income drops below the poverty line, he will lose his premium subsidies and will no longer be able to afford the plan. But because of a quirk in the law, he would not be eligible for Medicaid in that situation, because North Carolina has not expanded the program to cover many low-income men.

"I know there are millions in the same boat," said Mr. Exum, who has been walking a mile or two a day to stay healthy during the pandemic. "It's just really scary."

The strange glitch exists because the law originally required all states to expand Medicaid, and thus did not set up a system of subsidies for the poorest Americans to buy private coverage. The Supreme Court ultimately ruled that states could opt out of expanding Medicaid, but Congress, bitterly divided over the law, never fixed the glitch.

"The pandemic has exposed some of the glaring weaknesses in the A.C.A.," said Paul Starr, a professor of sociology and public affairs at Princeton who served as a health policy adviser to the Clinton administration. "When millions of workers lose their jobs, most of them also lose their health coverage, and the A.C.A. does not provide for any automatic backup or means of transferring coverage to a publicly subsidized alternative."

"To be sure, we are better off with the A.C.A. than without it," Mr. Starr added, "but we ought to be prepared to go beyond it and create a system that doesn't leave so many Americans in the lurch."

The A.C.A. brought the country's uninsured rate down to record lows several years after it was enacted in 2010, but even before the pandemic some 28 million people had no coverage. Still, an analysis by the Kaiser Family Foundation estimated that 27 million Americans could have lost job-based health coverage between March and May, and that a vast majority of them — 79 percent — are eligible for new coverage from Medicaid or subsidized private plans.

In the 36 states that expanded Medicaid, the Kaiser analysis predicted that 14 million people would qualify for the free program and another 3.5 million would qualify for subsidized A.C.A. plans.

Some states are already seeing spikes in Medicaid enrollment — in May alone, enrollment jumped by 8.4 percent in Minnesota and by 8.2 percent in Kentucky, according to the Georgetown Center for Children and Families — and experts anticipate bigger jumps, straining state budgets, in the coming months. So far, during the pandemic, nearly 800,000 people have signed up for new private plans through the law's marketplaces.

In Boise, Idaho, Jeremy Bratsman was laid off from his job as a regional manager in January, and was still searching for work when the economy started shutting down in March. Mr. Bratsman, 43, has Type 1 diabetes; a few years ago, he paid $15,000 for insulin and other supplies over the course of a year while uninsured. Now, though, he qualifies for Medicaid with his wife and four sons because Idaho expanded the program in January.

"I've talked to other uninsured diabetics," his wife, Rebecca Bratsman, said. "And when they are in one of those states that hasn't expanded, I just tell them to move. They don't have any option."

In states that do not run their own A.C.A. marketplaces, Republican efforts to weaken the law have made enrollment in new private plans during the pandemic more challenging. For example, the Trump administration all but eliminated funding for outreach in those states, including grants to nonprofit organizations that help people enroll in new coverage. Anyone who becomes uninsured after losing a job is eligible to sign up for a marketplace plan for 60 days afterward, but the administration has done little to raise awareness.

Morgan Childers, of Cullowhee, N.C., tried navigating the federal marketplace's website, HealthCare.gov, after she lost her job at a university in late March. Her income was low enough to qualify for premium subsidies, but she did not figure that out and mistakenly thought her cheapest option would cost $610 a month.

So Ms. Childers, 30, signed up for Cobra, which lets laid-off workers stay on their former employer's health plan for 18 months under federal law, but requires them to pay the full cost unless the employer chooses to help. She is paying $560 a month — substantially more than a subsidized plan would cost at her income level, and an amount she will not

be able to afford for long. She has several autoimmune conditions, and without insurance, would owe at least $3,000 a month just for her oral medications; she also gets regular infusions that cost even more.

“If my unemployment runs out and I don’t have a job,” she said, “I don’t know what I’ll do.”

In contrast, most of the 13 states that operate their own A.C.A. marketplaces not only opened enrollment to everyone during the pandemic, but worked hard to publicize the option. In California, where the special enrollment period started on March 15 and was recently extended through the end of July, the marketplace devoted $9 million to advertising the opportunity, including two television spots. People on unemployment get a flyer advertising the marketplace with every check, and dozens of community groups help people enroll. So far, more than 175,000 have done so.

In the District of Columbia, where the special enrollment period will extend through September, the marketplace is contacting businesses that are cutting jobs to offer affected employees help applying for Medicaid or premium subsidies. In Maryland, where the marketplace just extended its special enrollment period through July 15, people can check a box on their tax form to find out if they are eligible for free or subsidized coverage.

A new report from the Trump administration said that, by the end of May, about 487,000 people who had lost their job-based coverage had signed up through the federal marketplace.

Unlike during the last recession, many employers are trying to maintain coverage for workers whom they have furloughed or laid off, hoping they can bring them back when the economy improves. About half of employers, asked in an April survey whether they planned to continue paying for health benefits for furloughed employees, said they would for a month or longer, according to an informal survey from Mercer, a benefits consultant.

There are no estimates of how many newly jobless people have enrolled in Cobra. Many employers are pushing Congress to pay people’s premiums under Cobra during the pandemic so workers can keep the coverage they had through work.

Proponents — including Republican opponents of the Affordable Care Act — say the idea is gaining momentum and could be included in the next coronavirus legislation. The latest estimate for the cost of covering the premiums in full is $98 billion.

But House Democrats are also pushing an alternative: a bill that would increase federal premium subsidies to buy plans through the A.C.A. marketplaces and make them available to people who earn more than 400 percent of the poverty level, the current cutoff for assistance. The legislation mirrors what Mr. Biden has proposed. It has no

chance of passing the Republican-controlled Senate, but Democrats hope it will bolster their election-year case against Mr. Trump and other Republicans.

Even before the pandemic, one out of every 10 people in the United States had no health insurance, despite the uninsured rate reaching a record low in 2016. They included undocumented immigrants and those in the Medicaid coverage gap, but also people whose income was too high to qualify for marketplace subsidies or who could not afford even a subsidized plan.

Brian Golembiewski, 47, who works for a land brokerage company in Ludington, Mich., said he could not afford the insurance through his job or a subsidized A.C.A. plan for his wife and himself.

“I like that they made an effort with Obamacare,” he said, “but it fell way short.”

Interview: Unemployment and health care concerns
Sonseeahray Tonsall

When people lose their jobs, they often lose their health insurance.

That’s why when the coronavirus outbreak started, Covered California extended its special-enrollment deadline to the end of this month so that more families might be able to get the help they need.

In California alone, at least 6.3 million unemployment claims have been processed since the pandemic started.

But late last Thursday, President Trump made a move that could undo what many of those folks have come to count on since March.

Sonseeahray spoke to Peter Lee, the director of Covered California, about what’s at risk for families in the Golden State if this program ends.

Despite the pending legal challenge, you can call 1-800-300-1506 to enroll.

techwire
INSIDE CALIFORNIA'S $11B GOVERNMENT IT MARKET

Health Agency Plucks New Tech Leader From Education
Theo Douglas

There's a new tech leader at California's health insurance marketplace.

Kevin Cornish is the new chief information officer at Covered California, the agency announced Monday. He replaces Karen Ruiz, its CIO of seven years, who is retiring. Cornish, who was previously chief technology officer for the Office of the President at the University of California, will be charged with the design, development and execution of Covered California's IT strategy. He'll also be called on to deliver "executive leadership over complex enterprise-wide business information technology solutions within a consumer-facing sales environment," the agency said in a news release. The new CIO will also represent the agency's IT initiatives with stakeholders including state and federal government agencies, vendors, health insurance companies and others.

Cornish will start Aug. 1, and his salary will be $260,000 per year. Ruiz's last day will be July 31.

"Kevin has spent more than three decades helping organizations build and expand their information technology infrastructure," Covered California Executive Director Peter V. Lee said in a statement about Cornish, who has 31 years' experience in the field, including nearly three as CTO at the Office of the President. "His knowledge, experience and passion will serve us well as Covered California continues its efforts to use technology to make health care work better for consumers and to support our team in serving millions of Californians."

At the Office of the President, where he was named CTO in August 2017, Cornish led "cloud transformation, technology convergence and Oracle Financials Cloud implementations" for the university and for the state's fourth-largest health-care delivery system, he said in his LinkedIn profile. Before that, Cornish was CIO for nearly four years at the UC Berkeley Haas School of Business, where he helped transform IT into a "strategic function supporting disruptive innovation." And before UC Berkeley, he was vice president for IT infrastructure at Kaiser Permanente IT, where he led multi-year, multibillion-dollar work to "remediate and transform" the technology foundation for the health-care provider.

Cornish, who worked for private software companies until 2010, the agency said, has a bachelor's degree in Human Information Processing from the University of California, San Diego.

THE ACA TIMES

Californians Beware, The Individual ACA Penalty Has Increased
Robert Sheen

California residents that fail to obtain qualified health coverage this year will receive a penalty from the state for an amount larger than first projected.

Per California's Individual Mandate, beginning January of this year, state residents can be charged a penalty based on the California Consumer Price Index. For the 2020 tax year, the flat penalty amount is $750 per adult in the household and $375 per child. Remember that the California Individual Mandate penalty is either a flat penalty per household member or 2.5% of gross household income that exceeds California's filing threshold, whichever is higher. That means a family of four in California would face a minimum penalty of $2,250.

Some California residents will be exempt from penalty assessments, including individuals whose income is below the tax filing threshold, are a member of a health care sharing ministry, or are incarcerated. A full list of residents exempt from an individual penalty assessment can be found here.

State residents interested in seeing their estimated penalty for the 2020 tax year should review the Individual Shared Responsibility Penalty Estimator.

The state of California, having introduced the country's first special enrollment period, has made obtaining health coverage increasingly available to Americans in need. The state has also expanded subsidies to individuals and families with incomes beyond 400% of the FPL, capping now at 600%. The expansion may take shape across the entire U.S. if the ACA Enhancements Act is passed.

Employers too, have responsibilities to comply with under California's Individual Mandate. For the 2020 tax year, self-funded employers will need to report on the employees that had health coverage throughout the year. The information must be furnished to employees by January 31, 2021 and filed with California's Franchise Tax

Board by March 31, 2021. These are reporting requirements in addition to those of the Employer Mandate, which need to be submitted annually with the IRS.

Under the ACA's Employer Mandate, Applicable Large Employers (ALEs) (organizations with 50 or more full-time employees and full-time equivalent employees) are required to offer Minimum Essential Coverage (MEC) to at least 95% of their full-time workforce (and their dependents) whereby such coverage meets Minimum Value (MV) and is Affordable for the employee or be subject to Internal Revenue Code (IRC) Section 4980H penalties. The IRS is issuing these penalties through Letter 226J.

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

Employers, if you have operations in the state of California or any of the other aforementioned states, keep in mind the state level Individual Mandate when reviewing your ACA compliance on a monthly basis. And with businesses returning back to work amid COVID-19, be sure your organization is in compliance with the ACA to avoid receiving any IRS penalty assessments. If you're unsure of your current ACA compliance status, contact us to receive an ACA Penalty Risk Assessment.

To learn more about ACA compliance in 2020, click here.

California Blues earned $1B ACA risk adjustment payment last year. Here's how other insurers fared
Paige Minemyer

Risk adjustment transfers totaled $10.8 billion in 2019, with some insurers on the ACA's exchanges earning substantial payouts, according to new data from the Trump administration.

The Centers for Medicare & Medicaid Services released (PDF) its annual look at the Affordable Care Act's risk adjustment program, and said that 561 insurers participated in 2019. The $10.8 billion was split evenly between payments made to insurers and payments to CMS to maintain budget neutrality.

The individual market accounted for the largest share of transfers, or about $7.98 billion.

Payments made to some insurers were significant; for example, Blue Shield of California earned more than $1 billion in risk adjustment, with the bulk coming from an $873.8 million payout for its individual market plans.

Blue Cross Blue Shield of Texas earned a payout of nearly $400 million, and Independence Blue Cross raked in about $41 million.

Some also paid the government back at a high levels. In California, for instance, Kaiser Foundation health plans paid nearly $796.5 million into the program, and in Maryland, Kaiser's plans paid in $150 million.

Blue Care Network of Michigan paid $43.8 million into the program, according to CMS' report.

The risk adjustment program aims to allocate funds from insurers who take on larger numbers of low-risk enrollees to those who take on higher numbers of high-risk enrollees on the ACA's exchanges. The goal is to prevent insurers from avoiding high-risk members.

CMS said in the report that risk adjustment operated smoothly in 2019, saying trends in the program were largely on par with the year prior. Transfers accounted for about 7% of premiums, as was the case in 2018.

About $10.4 billion in risk adjustment transfers were made in 2018.

"The risk adjustment program is working as intended by more evenly spreading the financial risk carried by issuers that enrolled higher-risk individuals in a particular state market risk pool, thereby protecting issuers against adverse selection and supporting them in offering products that serve all types of consumers," according to the report.

Keeping unemployment, health coverage in California: questions answered
Kathleen Pender

Questions about unemployment in California keep rolling in, so in this column I'll answer ones on how to get extended benefits when your first 26 weeks run out, when the state

will require people on unemployment to begin looking for work and what the differences between COBRA and Cal-COBRA health care continuation are.

Q: I got laid off at the end of January and have been on unemployment ever since. On Monday I got an email that said, “You have received all benefits payable to you at this time. You cannot file another California unemployment insurance claim until your current benefit year ends.” Why is EDD cutting me off after 26 weeks? Your July 1 column said you can now get up to 59 weeks in California.

A: The Employment Development Department also started getting questions like this, so starting July 16, it added this information near the end of its weekly news release on jobless claims, EDD spokeswoman Loree Levy said:

“If you run out of the up to 26 weeks associated with a regular UI claim, another up to 13 weeks of benefits is available in the Pandemic Emergency Unemployment Compensation (PEUC) extension provided by the federal government until the end of the year.

“If you are still within your 12-month benefit period of your claim and you run out of benefits, the EDD will automatically file a PEUC claim for you and you should get a notice by mail 5-7 business days later with more information. For faster updates and to certify for benefits, check your UI Online account inbox.

“If your 12-month benefit period has expired and you run out of your benefits, you must reapply for benefits and the quickest way to do so is through UI Online.”

The EDD will first “check to see if you have earned enough wages to qualify for a new regular claim. If you don’t, you will get a $0 award notice in the mail on that new claim. But within a few days, you will get another notice showing that we automatically filed a PEUC extension for you and advising you that you need to certify for benefits. You can also check your UI Online account for updates.”

At the end of this 13-week extension, if you are still unemployed, you could be eligible for a “Fed-Ed” extension for up to 20 more weeks. The EDD “is sweeping the system daily to identify” people who meet the “slightly different eligibility requirements” for Fed-Ed. If you qualify, the EDD will automatically file a Fed-Ed extension and mail you a notice. You will then need to complete the usual biweekly certification.

If you don’t qualify for a Fed-Ed extension you “will receive a notice about that disqualification but the EDD will proactively reopen their PUA claim if they already had one established.” PUA, which stands for Pandemic Unemployment Assistance, is a federal program that provides unemployment benefits for people who don’t qualify for or

have run out of regular state unemployment benefits. “For those who have not previously established a PUA claim, the Department will proactively file a PUA claim in order to help maintain the availability of benefits.”

Q: At what point will EDD require a benefit recipient to actively look for work in order to keep receiving payments?

A: This has not been decided. “We’re still in a situation of businesses closed down so answering ‘No’ to whether or not you are looking for work won’t prevent payment at this point. But, an individual does have to remain able and available to work,” Levy said in an email.

She added: “We noticed a lot of people were making mistakes on the first two questions of the bi-weekly certification for benefits, unnecessarily delaying benefits, so we included some additional text in the UI Online certification app.” For more tips, go to bit.ly/eddcoronavirusclaims and under Step 2, click on the drop-down menu titled “What mistakes can I avoid when I certify so my payments aren’t delayed?”

Q: My husband lost his job with a six-person company due to the COVID pandemic and is being offered continuation of health benefits through Cal-COBRA. We are interested in the possible extension of the 60 days in which you typically have to sign up for COBRA. Your June 13 article said recent Department of Labor guidance gives laid-off workers much more time to choose and pay for COBRA coverage. Is Cal-COBRA also subject to the Department of Labor change or do they operate independently?

A: The new Labor Department rules do not apply to Cal-COBRA, because it’s a state law.

COBRA, on the other hand, is a federal law officially called the Consolidated Omnibus Budget Reconciliation Act. It lets most employees who quit or lose their job stay on their former employer’s medical, dental or vision plan, generally for up to 18 months. They almost always have to pay the full premium themselves, plus an administrative fee. Federal COBRA generally applies to group health plans maintained by private-sector employers with 20 or more employees, and by state or local government employers.

Cal-COBRA applies to state-regulated health plans offered by employers with two to 19 employees. It lets their ex-employees stay in the group health plan, again at their own expense, for up to 36 months.

Cal-COBRA also lets eligible people who exhaust federal COBRA stay in their old group health plan for an additional 18 months. However, Cal-COBRA does not cover self-insured employers (those who pay employee medical costs themselves) because their

plans are not state-regulated. So their former workers cannot move from federal to Cal-COBRA after 18 months. Many nonprofits and large companies self-insure, whether their workers know it or not.

Normally, once people receive a notice that they're eligible for COBRA or Cal-COBRA (or to move from federal to Cal-COBRA), they have 60 days to enroll and 45 days after enrolling to begin paying premiums.

Because of the pandemic, the Labor Department gave COBRA-eligible employees a longer time period to enroll in COBRA and pay premiums. The new deadline is 60 days after the national COVID-19 emergency declaration ends or March 1, whichever comes first. My previous column explained how people might use this longer period to their advantage.

Unfortunately, the state has not extended the time frame for Cal-COBRA, so the old deadlines still apply, according to state regulators.

If you lose your job or have certain other life-changing events, you can enroll in health care through Covered California within 60 days, even if it's outside the annual enrollment period. Because of the pandemic, Covered California is letting any eligible individual apply through the end of July, even if they had no life-changing event.

Congress could add a subsidy for COBRA premiums in its next coronavirus bill. The House-passed Heroes Act would provide a 100% subsidy for laid-off workers through Jan. 31. Republicans are expected to unveil their stimulus plan Monday.

For more information on Cal-COBRA, see bit.ly/calcobrahelp.

California: @CoveredCA confirms over 231K have enrolled via #COVID19 SEP to date; extends deadline thru 8/31
Charles Gaba

The extension isn't surprising at this point. Frankly, I won't be surprised if a couple of the state-based exchanges don't just say "screw it" and keep the 2020 enrollment period open year-round until the COVID-19 pandemic is under control.

The 231,000 figure is up from 210K as of July 11th, 175K as of June 20th, 155K as of June 5th, 124K as of May 19th, 84,000 as of April 28th and 58,000 as of April 14th.

While the increase varies depending on the state and the exact conditions of the "open" COVID-19 SEP, it's safe to say that doing so via HealthCare.Gov would result in at least twice as many people getting covered via the federal exchange via SEPs during the off-season as normally would. This completely nullifies CMS's "look, we increased SEP enrollment by 27% anyway!" excuse for not offering one. It basically suggests that they'd have enrolled a good 500,000+ additional people in coverage across the 38 states hosted by the federal exchange if they'd opened one up.

There's a bunch of Californians enrolled in off-exchange ACA healthcare policies who are leaving up to thousands of dollars in federal and/or state subsidies lying on the table. They have another month to rectify that.

Recordnet.com
News worth sharing *online*

Covered California extends enrollment to uninsured through end of August
Joe Goldeen

People who are uninsured and eligible to enroll in health care coverage through Covered California are now able to sign up through the end of August.

The extension of the special-enrollment deadline comes during ongoing uncertainty in the lives and livelihoods of Californians as public health officials fight against the spread of COVID-19. It also applies to people who enroll in off-exchange plans, outside of Covered California, to ensure that people enrolling in the entire individual market in California will have access to coverage during the pandemic.

“Health insurance is just a phone call away, and our agents and staff stand ready to help people get the coverage they need,” Covered California’s Peter Lee said. Get free and confidential assistance over the phone, in a variety of languages, from a certified enroller at (800) 300-1506, or go to CoveredCA.com.

Covered California initially responded to the COVID-19 emergency by opening the health insurance exchange to any eligible uninsured individuals who needed health care coverage from March 20 to June 30, which was then extended to July 31.

The latest extension runs through Aug. 30.

The most recent data shows that 231,040 people have signed up through Covered California for health care coverage between March 20 and July 25, which is more than twice the number who signed up during the same time last year.

Those who sign up through CoveredCA.com may find out that they are eligible for no-cost or low-cost coverage through Medi-Cal, which they can enroll in online. Those eligible for Medi-Cal can have coverage that is immediately effective.

California has halted Medi-Cal renewal reviews and discontinuances through the end of the public health emergency, ensuring that those already enrolled can continue their coverage. The decision will free up county resources to process new enrollments.

The Department of Health Care Services also received expanded authority to expedite enrollment for seniors and other vulnerable populations through Hospital Presumptive Eligibility; expand the use of telehealth; and to provide COVID-19 testing, testing-related services and treatment to the uninsured, among other steps to make it easier to access care.

Go to CoveredCA.com to learn more and enroll or call (800) 300-1506.

Medi-Cal Agency's New Head Wants to Tackle Disparities and Racism
Samantha Young

When Will Lightbourne looked at the statistics behind California's coronavirus cases, the disparities were "blindingly clear": Blacks and Latinos are dying at higher rates than most other Californians.

As of Monday, Latinos account for 45.6% of coronavirus deaths in a state where they make up 38.9% of the population, according to data collected by the California Department of Public Health. Blacks account for 8.5% of the deaths but make up 6% of the population.

Lightbourne, who led California's Department of Social Services under Gov. Jerry Brown, describes this pandemic as one that "rips the bandage off" a health care system long riddled with inequity.

So, when Gov. Gavin Newsom asked Lightbourne, 70, to come out of retirement in June to lead the Department of Health Care Services, he said, he couldn't say no.

"He has committed his whole professional life to public service," said Mike Herald, director of policy advocacy at the Western Center on Law & Poverty. "He's not joking when he talks about the importance of these issues and the important role that government plays in addressing societal inequities."

The Department of Health Care Services oversees the state's Medicaid program for low-income people, called Medi-Cal, which provides health care to some 12.5 million Californians.

Lightbourne said he sees the job as a chance to refocus Medi-Cal on reducing disparities — improving people's health not only by providing better access to doctors, but also by linking them with behavioral health programs and using health care dollars to get them into housing.

He said the department also plans to amend contracts with health providers and use routine performance reviews to make sure providers are addressing disparities.

Health care advocates say Lightbourne has a track record of getting things done.

At the Department of Social Services, he persuaded Brown, a known penny pincher, to increase cash assistance to low-income families, restoring cuts lawmakers had made in the Great Recession. And he was instrumental behind the scenes in the repeal of the contentious policy that had prohibited Californians from receiving increased welfare income if they had more children while receiving public assistance, Herald said.

"Will is very purpose-driven and has made substantive changes in every role he has ever had," said Graham Knaus, executive director of the California State Association of Counties.

Before embarking on state service, Lightbourne served as director of the Santa Clara County Social Services Agency, the Human Services Agency of the City & County of San Francisco and the Santa Cruz County Human Services Agency.

Lightbourne's local and state experience give him a valuable skill set as state and county officials grapple with providing health care to some of California's most vulnerable residents during a pandemic, Knaus and other advocates said.

The task won't be easy. The previous director of the Department of Health Care Services, Brad Gilbert, left the job after less than four months.

Lightbourne talked to California Healthline about why he returned to state government, how the department is responding to COVID-19 and how he hopes to improve access to health care for those who need it. The interview has been edited for length and clarity.

Q: Why did you come out of retirement to take a job that's difficult under normal circumstances — and even tougher during a pandemic?

Events of the past six months have made it blindingly clear that we've got structural inequities that are not just immoral but are, at an existential level, unsurvivable. It's a pandemic that landed on top of a pandemic of inequalities, opportunity and income that's been raging since the 1980s. And that pandemic has been enabled by a pandemic of racism that has rotted in our society for generations.

I think we have to use the moment to insist that our publicly financed health care system really partners up with our public health network and with our social safety-net system to address community and population health with a laser focus on reducing disparities.

Q: How has the department responded to COVID-19 to address the most vulnerable Californians?

The growth in telehealth is something that would not have occurred without this experience. There's work still underway to look at how we can come up with some approaches to reduce the number of people in skilled nursing facilities, where the rate of spread is so much more severe and with really mortal results.

I have the suspicion that we're never really going to get to a point where we say the effect of COVID is over. The mere fact that so much health care utilization is down now, particularly down in the places where people who start at a disadvantage normally seek care, we're going to find long-term health consequences into the future, even post-vaccine.

Q: In January, Gov. Newsom outlined a proposal to broaden a Medi-Cal program known as CalAIM that addresses physical and behavioral health needs in patients' care, and even pays for their housing with health care money. Can your department still move forward with those goals even though there isn't money in the budget for it?

We may be delayed to some extent. It was never intended initially as a big-bang system change. It was always going to be a degree of iterative development, and that remains true — whether some things have to go a little slower because of money reasons.

Q: You have talked about access to health care and how COVID-19 has really highlighted systemic disparities. In Medi-Cal, lack of access to care has long been a

problem, especially in rural areas. So has inadequate care for children. Are those issues you intend to address?

One of the things we need is an adequate network of providers that really covers the medically underserved areas of the state. We need to work effectively with our rural health clinics, as well as our urban Federally Qualified Health Centers to expand access, particularly to the populations that historically haven't had that access.

In terms of services for children, that's a big part of that agenda both in physical and behavioral health and also the dental health system. There's a big focus on how to improve access and preventive services for children.

Q: In the Great Recession, California lawmakers made many deep cuts to safety-net programs, some of which have been restored only recently. The governor proposed a number of health care-related cuts this year that were ultimately rejected by the legislature. How will you ensure that Medi-Cal enrollees won't see their benefits scaled back in the future?

It's going to be my job to make the case not to reduce services that poor people rely on. That said, we live in the real world and if we ever have to reduce things, my approach would be to try to say, "How can we reduce things we can readily rebuild rather than destroy things that are foundational?"

Goal No. 1 at this point is to work very closely with our congressional delegation to really encourage the federal government to support the core services and activities so that we can meet the needs of the people of the state.

California, 20 other states push back against attempts to undo Affordable Care Act
Ashely Zavala

SACRAMENTO, Calif. (KTXL) — California's attorney general and 20 other states are pushing back against the Trump administration's attempt to undo the Affordable Care Act.

In a brief to the U.S. Supreme Court filed Wednesday, states in favor of the ACA pointed to the pandemic to keep the policy in place.

“There is never a good time to take people’s health care away but to do so in the middle of a pandemic, well, that’s another level of heartlessness,” said California Attorney General Xavier Becerra.

The U.S. Supreme Court will decide whether to overturn the health care law and also review a recent lower-court decision that ruled the individual mandate unconstitutional.

That was the rule requiring Americans to have health insurance or else pay a fine.

Opponents of the ACA have said without the rule, the rest of the policy shouldn’t stand.

But experts estimate with the rise in unemployment, about 5 million Americans have lost their health insurance coverage since March.

If the ACA is undone, supporters warn 133 million people with preexisting conditions could lose protections and another 20 million could lose coverage altogether.

Critical funding for community health centers on the front lines of COVID-19 could also be lost.

“Good, affordable healthcare has become more and more important for every American,” Becerra said.

The Supreme Court has not yet scheduled oral arguments on the issue. Officials say the issue likely won’t be heard until after the November presidential election.

San Francisco Chronicle

Covered California extends enrollment deadline through August due to coronavirus
Anna Kramer

California has extended the special enrollment period for health insurance through the end of August on the state’s Covered California insurance marketplace.

The state’s recent surge in coronavirus cases drove the decision to extend the enrollment period, officials wrote in a statement. The California Department of Health Care Services, which manages the state’s Medi-Cal program, and the California

Department of Insurance also extended special enrollment deadlines to August 31, “which applies to all health plans on the individual market.”

While official open enrollment for health insurance on Covered California ended January 31, the state opened a special enrollment period on March 20 for eligible uninsured Californians in response to the pandemic. The special enrollment period was originally scheduled to end June 30 and was later extended through July 31. More than 230,000 people signed up for health coverage on the marketplace from March 20 through the end of July, officials said.

“As the battle against the pandemic continues, we want to give people every possible opportunity to get health care coverage, whether it is through Covered California or Medi-Cal,” Peter Lee, executive director of Covered California, said in a statement.

Almost 9 million unemployment claims have been processed by the state since the pandemic began, and the Covered California marketplace should allow unemployed Californians to set up plans that will ensure they do not face a gap in health coverage even if they lost job-based coverage, officials said.

People who sign up for Covered California may also be eligible for coverage through Medi-Cal, which would become effective immediately. Some who sign up for coverage may also be eligible for new state subsidies that can lower monthly premiums for lower-income households.

Covered California Announces Record-Low Rate Hike for 2021
Bernard J. Wolfson

Premiums for health plans sold through Covered California, the state’s Affordable Care Act insurance exchange, will rise an average of 0.6% next year — the smallest hike since it started providing coverage in 2014, the agency announced Tuesday.

The modest increase follows an average statewide increase of 0.8% on coverage that started in January of this year, which was the previous record low.

The rate changes will vary across regions, ranging from an average increase of 5.6% in Santa Clara County to reductions of 2.1% in southwestern Los Angeles County and 2.6% in Mono, Inyo and Imperial counties.

Before the announcement, some industry observers had called for rate cuts, given the windfall health plans have reaped so far this year from lower spending on care. The COVID-19 pandemic shut down elective surgeries in the spring and has continued to sharply reduce patient visits to doctors, emergency rooms and outpatient clinics.

But Peter Lee, Covered California's executive director, told California Healthline that lower spending by insurers due to the pandemic had "very, very little" impact on 2021 premiums.

Covered California's insurance carriers "are seeing their health care costs rebound and are projecting that for the balance of the year they will catch up on the health expenses they thought they were going to spend for 2020," Lee said. Health plans in the exchange projected increases in non-COVID medical costs of 4% to 8% next year and did not think they needed to budget extra for the pandemic, he said.

The rate increase was modest mainly because of a surge of new, "healthier" enrollees both during the regular enrollment period for 2020 coverage and the current "special" enrollment period — recently extended to Aug. 31 — for people whose coverage has been affected by the pandemic, Lee said. Covered California said an analysis of the medical risk and demographics of these newcomers showed "they are healthier on average than the equivalent cohorts from 2019."

But Kaiser Permanente said in a regulatory filing that it saw no change in the overall health of enrollees, and Anthem Blue Cross expected a less healthy patient mix, pushing costs up about 2.2%.

Covered California said that other factors keeping the average rate hike low include the repeal of a federal tax on health plans, which reduced 2021 premiums by an average of 1.7%, and a cut next year in the "participation" fee health plans pay Covered California, from 3.5% of premiums to 3.25%.

The exchange provides coverage for about 1.5 million Californians who buy their own insurance. About 90% of them receive financial assistance from the federal or state government, or both, to help them pay for their premiums. Another 800,000 Californians buy coverage in the open market, where financial assistance is not available. About 600,000 of that group are in plans that mirror the ones available on the exchange and will see the same rate increase.

Glenn Melnick, a professor of public finance at the University of Southern California's Sol Price School of Public Policy, differed with Lee's view of the medical spending trend, saying health plans will likely continue to benefit from depressed patient volume

next year, which will more than offset their assumed 4% to 8% increase in non-Covid costs.

Emergency room visits are lagging pre-pandemic levels by about 20% and outpatient volume is about 5% to 10% down, Melnick said. “I don’t see those people coming back unless there’s a vaccine – and when there’s a spike, more people will stay home.”

Michael Johnson, a health insurance industry observer and critic who worked as an executive at Blue Shield of California from 2003 to 2015, said next year’s premiums should be lower. “Preliminary indications are that rates for 2020 are way too high, so for 2021 they should be going down, not up,” he said.

The average statewide increase among Covered California carriers is smaller than what’s been proposed in many other states.

A KFF analysis last month of proposed 2021 rates in the exchanges of 10 states and the District of Columbia showed a median increase of 2.4%, with changes ranging from a hike of 31.8% by a health plan in New Mexico to a cut of 12% by one in Maryland. (Kaiser Health News, which produces California Healthline, is an editorially independent program of KFF.)

This year’s rate announcements come as the Affordable Care Act remains under threat from a federal lawsuit by Republican officials in 18 states, joined by the Trump administration, who want to repeal it. If they prevail, more than 20 million people could lose their health coverage and popular consumer protections afforded by the ACA, including the ban on health plan discrimination against people with preexisting medical conditions, could be eliminated.

The Supreme Court plans to hear the case in the fall.

All 11 insurance companies operating in Covered California this year will remain in 2021, and no new ones will enter the marketplace. But Anthem Blue Cross and Oscar Health Insurance will expand their offerings geographically, the exchange said. Anthem will enter Inyo, Kern, Mono and Orange counties. Oscar will join the competition in San Mateo County. Many of the Covered California health plans are available only in certain regions of the state.

Kaiser Permanente is the largest carrier in the exchange, with about 526,000 enrollees this year, more than one-third of the total. Kaiser is followed by Blue Shield of California, with 392,000, and Health Net, with 232,000.

Kaiser is seeking an average increase of 0.9% in its individual market plans, including those sold in the exchange and outside of it, according to a filing with the state's Department of Managed Health Care. Last year, Kaiser raised its rates by an average of 0.7%.

Blue Shield of California plans to cut rates by an average of 2.4% statewide, following a hike of 3.6% this year, according to its regulatory filings. One of the main factors in next year's rate cut, it said, is that it set current premiums with a projection of medical costs that was too high.

Rates differ not only from carrier to carrier and region to region, but also by the covered person's age. Premiums also differ by benefit level, from the cheaper "bronze" coverage tier up to the highest, known as "platinum." The lower the premium, the higher the deductibles and coinsurance payments for care.

The individual deductible for the bronze tier in 2021 is set at $6,300, unchanged from this year. For the silver tier, the second-cheapest level of coverage, the full individual deductible in 2021 will be $4,000, also unchanged from this year. But many silver enrollees are in plans that offer financial aid to reduce their share of medical costs, and that can push the 2021 silver deductible as low as $75.

Moreover, numerous medical services are not subject to the deductible in silver plans, including primary care and specialist visits, lab tests, X-rays and other imaging. In bronze plans, the first three primary care visits are not subject to the deductible.

Covered California said that, on average, exchange enrollees who plan to renew for 2021 can save 7.3% on premiums by switching to the least expensive plan in the same tier of coverage.

The 2021 rates are subject to final review by the Department of Managed Health Care and the Department of Insurance, but significant changes are unlikely.
The enrollment period for 2021 coverage starts Nov. 1 and runs through Jan. 31.

Covered California Announces Record-Low Rate Hike for 2021
Adam Beam

SACRAMENTO, Calif. (AP) — Health insurance premiums for the 1.5 million Californians who purchase coverage through the state marketplace will go up an average of 0.6% next year, officials announced Tuesday. It's the smallest increase yet and is attributed to a surge of new signups coupled with a decline in health care use during the coronavirus pandemic.

More than 230,000 people have signed up for coverage since March 20, the day after Gov. Gavin Newsom issued a statewide stay-at-home order. Meanwhile, fewer people are using their health insurance as hospitals delayed elective procedures and some people chose to stay away from doctor's offices.

"Insurers are really rolling in money right now because so many fewer people are using health care," said Larry Levitt, executive vice president of health policy for the Kaiser Family Foundation.

Charles Bacchi, president and CEO of the California Association of Health Plans, said insurers can offer smaller increases because of new laws aimed at getting more healthier people to buy insurance.

"Californians can rest assured that health plans are dedicated to providing the affordable high quality healthcare they expect and deserve," Bacchi said.

In general, the cost of health insurance premiums depends on who pays them. If only sick people buy them, they cost more. But the more healthy people who buy them brings down the cost for everyone.

From 2015 through 2019, monthly premiums in California's marketplace increased an average of 8.5 percentage points per year. But since then, the Democratic-controlled Legislature and governor have passed laws aimed at getting more healthier people to buy coverage — including taxing people who refuse to buy health insurance and offering new subsidies to people who earn as much as six times the federal poverty level.

The result was an average premium increase of 0.8% in 2020. Next year's increase is even lower, in part because of an increase in new people buying insurance during the coronavirus pandemic. Covered California Executive Director Peter Lee says the new people who signed up were healthier, making them on average about 5% cheaper to cover.

"We don't want a vicious cycle. We want a virtuous cycle of more people enrolling, broadening the pool and making it cheaper for everybody," said Anthony Wright, executive director of Health Access California, a health care consumer advocacy group.

Covered California premiums average about $587 a month for an individual. But about 90% of the people who buy coverage through Covered California receive state and federal subsidies of about $450 per month, lowering their premium to about $137 per month.

The state also spends more on marketing and outreach than any other state, including the federal government, buying TV ads and paying social media influencers to persuade people to buy coverage. This year, amid a coronavirus-induced recession, Covered California plans to spend $150 million in marketing, up from $121 million last year.

"People that are losing their jobs, that are financially insecure, do not need to be health-care insecure," Covered California Executive Director Peter Lee said. "We're making the largest investment for this year and thinking next year we're going to dial it back."

The health insurance rates announced Tuesday still must be approved by state regulators. The overall rate increase is a statewide average. How much people will actually pay depends on where they live and which insurance company they decide to purchase coverage from.

In Southern California, Lee said rates in general decreased up to 3% in some places. But in Northern California, including the counties surrounding the San Francisco Bay, rates increased an average of 1.4% because there is less competition from insurance companies.

The biggest projected increase is Valley Health Plan, whose rates will jump an average of 9% next year. The biggest projected drop is the LA Care Health Plan with an average decrease of 4.6%.

LA Care Health Plan CEO John Baackes said the biggest factor for their lower rates was an influx of younger people who purchased coverage to avoid paying a state tax. Most of those people purchased the cheapest plan and have rarely used their insurance, he said.

THE SACRAMENTO BEE

Pay for your own health insurance? Expect the average Sacramento rate to rise 2.3% in 2021

Cathie Anderson

Residents of El Dorado, Placer, Sacramento and Yolo counties who buy their health insurance through Covered California or on the individual market will see their premiums increase an average of 2.3% in 2021, according to state data released Tuesday.

If those consumers shop around and compare plans, they should be able to save an average of 2.4%, according to Covered California officials.

On a statewide level, Californians will enjoy a record-low rate increase of 0.6% in 2021, on average, said Peter V. Lee, the executive director of Covered California, and this follows what now becomes the second-lowest premium increase, an average of 0.8%, this year.

“California continues to show the nation what can be done when you build on and strengthen the Affordable Care Act,” Lee said. “California’s bold policies to provide additional state financial help, to reinstate the penalty to encourage consumers to enroll in health care, and to make significant marketing investments in Covered California are providing stability and lower costs in the face of national uncertainty.”

Passed in 2010, the Affordable Care Act — known as Obamacare or the ACA — created a federal health care insurance marketplace and allowed states to create their own. California Gov. Arnold Schwarzenegger laid the groundwork for the creation of Covered California. The state exchange negotiates for health insurance plans that now cover about 2.3 million state residents, roughly 87,000 of them in the four-county Sacramento region.

California leaders introduced new state subsidies this year and passed an individual mandate that requires Californians to have health insurance or face a tax penalty, Lee said. Those measures, along with Covered California’s annual multimillion-dollar awareness campaign, have led to increased enrollment and one of the healthiest consumer pools in the nation.

For the sixth year in a row, he noted, the U.S. Centers for Medicare and Medicaid Services reported that California is among the top five healthiest states in the nation.

“Access to affordable health care coverage is more critical than ever as our nation and state navigate the COVID-19 pandemic,” said Gov. Gavin Newsom. “Covered California is leading the nation by eliminating barriers to access and providing Californians real opportunities to get the care and coverage they need.”

Health plan costs have been lower than expected for 2020 because, out of fear of a potential COVID-19 infection, many people have deferred care and avoided health care services, Lee said. Although that trend now appears to be reversing, he added, it looks as though the pandemic won’t have much of an impact on the total cost of care in California’s individual market.

Covered California officials said that, absent the impact of the new coronavirus, actuaries had predicted that health care costs would rise 4 to 8% statewide for its 11 contracted health insurers.

Rates will increase an average of 2.6% for the 56,000-plus residents of 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 who buy their own health coverage. They will be able to save 0.4%, on average, if they are willing to change plans or benefits.

In San Joaquin, Stanislaus, Merced, Mariposa and Tulare counties, rates will increase an average of 4.2%, but shopping around could generate average savings of 1.4%.

Many of the 36,200 residents of Fresno, Kings and Madera counties who buy their own insurance will see an average decline in their premiums of 0.1%, even if they don’t shop around. If they do, they could get savings that average 3%.

Lee also noted that all 11 insurance carriers will continue offering plans in the state, and two carriers — Anthem Blue Cross and Oscar Health Insurance — will expand their coverage areas. Consequently, in the coming year, 99.8% of Californians will have two or more choices, 88% will have three or more, and 77% will have four or more choices.

“A competitive market means virtually everyone across California will have a choice in coverage and is further proof that the Affordable Care Act is working in California for both consumers and health plans.”

Since Covered California began signing up state residents for health insurance, the percentage of uninsured Californians has dropped to 7.2 percent from 17.2 percent.

KSBW 8
Coverage You Can Count On

Covered California announces 0.6% premium increase in 2021
Alani Letang

Covered California, the health insurance marketplace for people uninsured, said they are crediting the pandemic with their 2021 statewide coverage increase of 0.6%.

The announcement follows 230,000 new signups since March 20, a day after Gov. Gavin Newsom enacted a stay at home order.

Peter Lee, the Covered California executive director, said: "Not a surprise when you encourage people to enroll. You give them that nudge through the penalty and you encourage them to step up. Healthier people say, 'yeah, I'll get covered.'"

What a person pays will depend on where they live and the plan they chose from.

"This is a factor of competition. This is a factor of giving consumers the tools to drive plans to be accountable to them and to the market," Lee said.

The marketplace said they are going to spend $40 million more on marketing and consumer support for 2021.

To learn more about Covered California, click here.

Desert Sun.
PART OF THE USA TODAY NETWORK

Covered California announces record-low rate hike for 2021
Nicole Hayden

Premiums for health plans sold through Covered California, the state's Affordable Care Act insurance exchange, will rise an average of 0.6% next year — the smallest hike since the exchange started providing coverage in 2014, the agency announced Tuesday.

The modest increase follows an average statewide increase of 0.8% on coverage that started in January of this year, which was the previous record low.

The rate changes will vary across regions, ranging from an average increase of 5.6% in Santa Clara County to reductions of 2.1% in southwestern Los Angeles County and 2.6% in Mono, Inyo and Imperial counties.

Before the announcement, some industry observers had called for rate cuts, given the windfall health plans have reaped so far this year from lower spending on care. The COVID-19 pandemic shut down elective surgeries in the spring and has continued to sharply reduce patient visits to doctors, emergency rooms and outpatient clinics.

But Peter Lee, Covered California's executive director, told California Healthline that lower spending by insurers due to the pandemic had "very, very little" impact on 2021 premiums.

Covered California's insurance carriers "are seeing their health care costs rebound and are projecting that for the balance of the year they will catch up on the health expenses they thought they were going to spend for 2020," Lee said. Health plans in the exchange projected increases in non-COVID medical costs of 4% to 8% next year and did not think they needed to budget extra for the pandemic, he said.

The rate increase was modest mainly because of a surge of new, "healthier" enrollees both during the regular enrollment period for 2020 coverage and the current "special" enrollment period — recently extended to Aug. 31 — for people whose coverage has been affected by the pandemic, Lee said. Covered California said an analysis of the medical risk and demographics of these newcomers showed "they are healthier on average than the equivalent cohorts from 2019."

Other factors, it said, include the repeal of a federal tax on health plans, which reduced 2021 premiums by an average of 1.7%, and a cut next year in the "participation" fee health plans pay Covered California, from 3.5% of premiums to 3.25%.

Covered California provides coverage for about 1.5 million Californians who buy their own insurance. About 90% of them receive financial assistance from the federal or state government, or both, to help them pay for their premiums. The plans on the exchange are mirrored on the open market, where individuals buy insurance without financial assistance.

Some health system experts believe insurers will continue to spend less on patient medical care next year. Glenn Melnick, a professor of public finance at the University of Southern California's Sol Price School of Public Policy, said last week that hospital

volumes — especially emergency room and outpatient visits — still lag pre-COVID levels and could continue to do so until an effective vaccine is available.

Michael Johnson, a health insurance industry observer and critic who worked as an executive at Blue Shield of California from 2003 to 2015, said the modesty of 2021 premium rises seen in other states so far didn't go far enough.

"Regulators should be forcing these plans to justify why they are not reducing rates, given the effect we've seen the pandemic is having so far," Johnson said last week.

The average statewide increase among Covered California carriers is smaller than what's been proposed in many other states.

A KFF analysis last month of proposed 2021 rates in the exchanges of 10 states and the District of Columbia showed a median increase of 2.4%, with changes ranging from a hike of 31.8% by a health plan in New Mexico to a cut of 12% by one in Maryland. (Kaiser Health News, which produces California Healthline, is an editorially independent program of KFF.)

This year's rate announcements come as the Affordable Care Act remains under threat from a federal lawsuit by Republican officials in 18 states, joined by the Trump administration, who want to repeal it. If they prevail, more than 20 million people could lose their health coverage and popular consumer protections afforded by the ACA, including the ban on health plan discrimination against people with preexisting medical conditions, could be eliminated.

The Supreme Court plans to hear the case in the fall.

All 11 insurance companies operating in Covered California this year will remain in 2021, and no new ones will enter the marketplace. But Anthem Blue Cross and Oscar Health Insurance will expand their offerings geographically, the exchange said. Anthem will enter Inyo, Kern, Mono and Orange counties. Oscar will join the competition in San Mateo County. Many of the Covered California health plans are available only in certain regions of the state.

Kaiser Permanente is the largest carrier in the exchange, with about 526,000 enrollees this year, more than one-third of the total. Kaiser is followed by Blue Shield of California, with 392,000, and Health Net, with 232,000. Information on rate changes by individual carriers was not immediately available.

Rates differ not only from carrier to carrier and region to region, but also by the covered person's age. Premiums also differ by benefit level, from the cheaper "bronze" coverage

tier up to the highest, known as “platinum.” The lower the premium, the higher the deductibles and coinsurance payments for care.

The individual deductible for the bronze tier in 2021 is set at $6,300, unchanged from this year. For the silver tier, the second-cheapest level of coverage, the full individual deductible in 2021 will be $4,000, also unchanged from this year. But many silver enrollees are in plans that offer financial aid to reduce their share of medical costs, and that can push the 2021 silver deductible as low as $75.

Moreover, numerous medical services are not subject to the deductible in silver plans, including primary care and specialist visits, lab tests, X-rays and other imaging. In bronze plans, the first three primary care visits are not subject to the deductible.

Covered California said that, on average, exchange enrollees who plan to renew for 2021 can save 7.3% on premiums by switching to the least expensive plan in the same tier of coverage.

The 2021 rates are subject to final review by the state’s Department of Managed Health Care and Department of Insurance, but significant changes are unlikely.

The enrollment period for 2021 coverage starts Nov. 1 and runs through Jan. 31.

Covered California reports record-low premium increases for 2021
Victoria Colliver

Covered California premiums will increase by an average of 0.6 percent next year — the lowest rate increase in the health marketplace’s history, according to preliminary figures reported Tuesday. This follows an increase of 0.8 percent this year.

The Covid-19 effect: The possibility of health insurance rate hikes have loomed large in the wake of the outbreak, with Covered California in March releasing estimates projecting 2021 premium increases of up to 40 percent.

But hospitals and doctors, in general, didn’t get overwhelmed as the state flattened the curve. They delayed or canceled nonurgent appointments and procedures, which decreased claims and increased the bottom line for insurers.

The exchange gave its 11 health insurers more time this year to adjust their rates. It has extended open enrollment through August and continued marketing, allowing more than

231,000 Californians to enroll. Analysis on these new consumers shows they tend to be healthier on average, creating a stronger risk pool for insurers.

“The good news is we and other experts looked at how bad Covid could be. As bad as it is — and it’s not good — it could have been far worse,” said Peter Lee, Covered California’s executive director.

The backstory: Covered California, which covers about 1.5 million residents, was already experiencing a resurgence this year, reporting a 41 percent increase in new enrollments during the regular 2021 open enrollment period compared with the previous year.

Exchange officials attributed the rebound — new signups had plummeted nearly 24 percent the previous year — to state policies that included the reinstatement of a mandate to buy health insurance in California and enhanced subsidies to help middle-income residents afford coverage.

The repeal of the federal health insurance tax beginning in 2021 also helped lower rates, along with a slight reduction in the amount Covered California assesses insurers.

The results: The preliminary rates average by geography and other factors such as provider competition, ranging from an average increase in Santa Clara County of 5.6 percent to a decrease averaging 2.6 percent in Mono, Inyo and Imperial counties.

What’s next: State regulators will review the rates over the next two months, and the rates are expected to be finalized in October. Open enrollment for 2021 begins Nov. 1.

Column: California is still showing how to make Obamacare work, even with COVID-19
Michael Hiltzik

Amid the patchwork of state-level approaches to healthcare reform, California has always stood out for its all-in embrace of the Affordable Care Act.

The state expanded Medicaid, taking full advantage of a federal government subsidy of the expanded program’s costs — starting at 100% from 2014 to 2016 and settling at 90% this year and beyond.

It established its own individual insurance exchange, Covered California, and managed it actively so that coverage options and expenses would be understandable for applicants and benefits would be consistent.

When the Trump administration and Congressional Republicans pursued a strategy of undermining the ACA by cutting marketing budgets and allowing cheap junk insurance plans to flood the market, California resisted.

The state banned junk plans, instituted an individual mandate penalty as a substitute for the penalty the GOP Congress repealed in 2017 and extended premium subsidies further into the middle class than the federal subsidies did.

The result has been continued strong enrollments and comparatively moderate premium increases. More than 418,000 Californians enrolled in Covered California during open enrollment for the first time for 2020, a 41% increase from the year before. The state exchange covers about 1.5 million members.

As I reported a few months ago, during that halcyon era before COVID-19 became the nation's No. 1 concern, since the inauguration of the individual insurance exchanges in 2013, California's uninsured rate has fallen by 10 percentage points, to 7.2%.

That's the largest drop in the nation. Among "eligible uninsured" people — that is, excluding those barred from participating because of their immigration status, such as adult undocumented residents — the rate is even lower, 3%.

The question this spring was whether the coronavirus would upend the system Covered California created. The answer appears to be no. Covered California on Tuesday announced that average premiums for 2021 will rise by 0.6% — even lower than the 0.8% increase charged for coverage this year over last.

Customers willing to shop for new 2021 plans, the exchange says, can do even better — reducing their rates by an average of 7.3% statewide and as much as 13.4% in parts of Los Angeles County, without changing their benefits. The figures don't reflect state and federal subsidies, which can reduce premiums even further.

"This is a story about what it means to be a counterpoint to three years of an administration seeking to undercut the Affordable Care Act, versus a state that says, 'No, that's not the track we're going to take,'" Peter V. Lee, executive director of Covered California, told me. "We're seeing in California a multiyear payoff of building on the Affordable Care Act."

The exchange's experience with COVID-19 costs may well be replicated across the country, for aggregate healthcare costs due to the disease haven't soared, as many feared when the pandemic emerged in the spring.

Those fears seemed eminently plausible only a few months ago. Covered California issued an analysis in March projecting that the one-year costs in the national commercial insurance market could "range from $34 billion to $251 billion for testing, treatment and care specifically related to COVID-19."

If insurers had to "recoup 2020 costs, price for the same level of costs next year and protect their solvency," the exchange warned, premium increases for 2021 for COVID alone "could range from 4% to more than 40%."

The 11 insurers that sell plans through Covered California initially projected that they might have to bump up premiums by 2% to 5% to cover costs associated with the coronavirus, Lee says.

The exchange gave them an extra month, through mid-July, to submit final premium proposals so they would have a better handle on the potential costs. By then the smoke had cleared, and the projections ranged from zero to about 3%.

All 11 carriers will stay in the exchange next year. Two will expand within the state: Anthem Blue Cross will add five counties, and Oscar will add one.

Several factors contributed to moderating the insurers' calculations.

One was that efforts such as shelter-at-home policies to limit the spread of COVID-19 in California worked, especially through the spring.

"The scope and scale of hospital admissions is far less than they might have been if California had sat on its hands and let the pandemic run its course," Lee says. Covered California's initial estimates were for at least 400,000 COVID-related hospital admissions this year; there have been fewer than half that many.

Although infections are rebounding in California, the overall cost of treatment is declining as medical professionals learn best practices. "Far fewer of the people who are infected are hospitalized, and of those who are hospitalized, fewer end up in intensive care," Lee says.

Meanwhile, deferrals of non-emergency surgery by patients wary of entering hospitals during the pandemic have exceeded any added costs of COVID for commercial

insurers. (The impact on hospitals is another story — some are facing red ink from the dearth of profitable procedures.)

Indications are that elective procedures will rebound through the end of this year, Lee says, but they'll fall within the insurers' non-COVID expectations. The exchange was careful to warn, however, that "there continues to be considerable uncertainty about the progress of the pandemic and resulting healthcare service costs."

Another factor is Covered California's expansion of its special enrollment period — leaving enrollment open through the end of this month for uninsured Californians.

The exchange's open enrollment period traditionally ends on Jan. 31 for coverage in a calendar year, after which one must have experienced a designated life change — such as loss of job-related coverage, marriage or the birth of a child — to sign up. This year, the pandemic prompted the exchange effectively to extend open enrollment to June 30, then July 31 and, currently, to Aug. 31.

More than 230,000 people have signed up since March 20, the exchange says, more than twice as many as took advantage of the special enrollment period in the same period a year ago. More to the point, those signing up this year have been much healthier on average than those who signed up during the special enrollment period in previous years.

Typically, the exchange says, the special enrollment pool is less healthy than the traditional open enrollment cohort, possibly because many of those who make a point of signing up after they've lost job-related coverage or have other life-changing events are relatively more motivated to avoid a lapse of coverage, presumably because they suffer from medical conditions or know their prospects are riskier.

This year, the special enrollment pool resembles the open enrollment group in terms of health risks. That's good for insurers, because healthier enrollees effectively subsidize sicker members.

Some non-COVID factors contributed to the moderate premium increase for next year, Covered California says. One is the Congressional repeal last December of the ACA's health insurer tax, which goes into effect Jan. 1.

This tax, which ranged as high as 3.3% of collected premiums, was thoroughly detested by the insurance industry, which finally got its way on a permanent repeal after goading Congress to suspend it in 2017-2019. The repeal lowered premiums for 2021 by about 1.7% on average, the exchange says.

Still, the most important lesson from Covered California's experience with rates is that expanding the pool of insured individuals and families by making sure that coverage is indeed affordable is the key to making the ACA work.

Trump continually asserts that the ACA has been a "disaster" and promises that he'll sign a replacement reform that always seems to be two weeks over the horizon. But he doesn't have any ideas for doing so, and no answer for the reality that California has made the ACA work.

CAPITOL WEEKLY
COVERING CALIFORNIA GOVERNMENT AND POLITICS

Capitol Weekly's Top 100: Tales from the pandemic
Staff

44 Peter Lee
Peter Lee is the executive director of Covered California, the landmark entity set up via the federal Affordable Care Act to expand health insurance coverage for people through a competitive market place. About 1.6 million people currently are covered, according to its own figures. Covered California is working the way it's supposed to and Lee is a survivor, but it hasn't been easy: Since its inception nearly a decade ago, Covered California has come under near constant criticism from, mostly, Republicans and business interests, over the concept of the "individual mandate." The "individual mandate" penalty, the fine for uninsured people who refused to get coverage, went into effect for the first time in January. Lee has been executive director for nine years, and before that he served in the Obama administration as ranking Medicare and Medicaid official, and he also worked under former Health Secretary Kathleen Sibelius.

CAL MATTERS

Here are five elements to help transform California's health care system for all
Dr. Robert K. Ross

The COVID-19 pandemic has laid bare racial inequities, health inequalities and health injustices for all to see, and challenges the very structure and delivery of our health care system.

As president and CEO of California's largest health foundation, the California Endowment, we have championed universal coverage since our founding nearly 25 years ago. At the same time, we understand that "coverage" is insufficient to improve the health of all Californians.

We know from research that the most significant contributors to health are largely found outside of the medical system and are the conditions within which people are born, grow, live, work and play. Further, these conditions are shaped by issues of money, power, resources and race. And we've known this for decades – that social determinants drive health status.

Having the privilege to serve on Gov. Gavin Newsom's Healthy California For All Commission, and in light of the COVID-19 pandemic, it is timely and appropriate to share my – and the California Endowment's – perspective on the health system we need for our state and nation.

The California Endowment's vision includes five essential elements for a transformed system that:

1. Provides 100% coverage, everybody all in, regardless of immigration status;
2. Embodies a unified financing mechanism with appropriate incentives to achieve other essential elements and ensure affordability;
3. Advances health equity by addressing racial equity;
4. Optimizes prevention by linking to and supporting the social determinants of health;
5. Possesses a health workforce that is culturally representative and proficient in serving California's diverse landscape.

There is more than one policy option that can embrace all of these elements. For example, a single-payer system and Medicare for All offer unified financing approaches that cover all Californians, which would be terrific. However, even an all-in, government-sponsored health insurance system is simply not enough.

The prize is not insurance coverage – the prize, as our commission is aptly named and tasked to present to the governor, is to create a Healthy California For All, which should include all of the above elements.

California, along with other states, offers innovations to bridge health care, public health and social services, such as coordinated care organizations and accountable communities for health. These are promising intermediaries that also focus on equity and root causes of poor health. Such innovations are especially critical at this moment in our state and nation's history. As colleagues have noted, without fundamentally

transforming the delivery system, we are merely moving dollars around in a broken system.

In addition to the “what” of reform, there is an important set of “how” questions as we make decisions for our large and diverse state. Specifically, how do we assure that, in the course of our deliberations, we are hearing from communities and families most directly impacted by the inequalities and inequities of our current system? We need that input, and we need to be excellent listeners. This was well done under Peter Lee’s leadership in the formative stages of Covered California, where I served as one of the founding board members.

Further, we need to develop a winnable roadmap to a transformed system. Do we lay out a roadmap for the governor that involves one bold stroke? Or, rather, should we put forth a series of “boldly incremental” steps? What implications will the outcome of the November presidential election have for the needed roadmap? Finally, what can we learn from other states, like Vermont’s valiant but failed attempt to enact a single-payer system?

For sure, whatever our commission agrees upon as the roadmap to system transformation will have the support of The California Endowment. While achieving the momentous task of implementation is daunting, I remain optimistic that with the input of my colleagues, and the leadership of our governor and secretary of Health and Human Services agency, California can once again be in the lead on health reform.

THE MENDOCINO VOICE

Covered California extends special enrollment period again, now open through August 31
Miguel Gracia-Zhang

MENDOCINO Co., 8/14/20 — The special enrollment period for Covered California, the state’s Obamacare exchange, has been extended again through August 31 in response to the many hardships caused by the COVID pandemic. If you are uninsured and eligible, you can sign up at CoveredCA.com, where you can also see if you are eligible for Medi-Cal.

The special enrollment period began at the beginning of the pandemic on March 20 so that increasing numbers of uninsured people in need of healthcare could get coverage during the Coronavirus pandemic. It was originally set to end on June 30, but was extended once to July 31 and now again through the end of August.

If you sign up through CoveredCA.com, you can also find out if you are eligible for no-cost or low-cost Medi-Cal coverage and sign up online. Medi-Cal coverage would be effective immediately. You may also qualify for new government subsidies that could cover as much as 70% of premiums, depending on income level.

According to a press release, 231,040 people signed up for health care coverage through Covered California between March 20 and July 25 — more than twice the number who signed up during the same time last year.

You can go to www.CoveredCA.com and get assistance from a certified enroller in a variety of languages. You can also call Covered California at (800) 300-1506 for more information.

Covered California Opens Special Enrollment for Those Affected by Wildfires, Pandemic, Job Loss
Heather Navarro

As Californians deal with more than 500 raging wildfires amid the pandemic, Covered California has opened a special enrollment period.

Those who've lost their jobs due to the recession or have become victim to wildfires can sign up for coverage.

"Right now, many Californians face a triple threat, with hundreds of wildfires burning during a pandemic and recession, and Covered California wants to make sure they have access to the health care they need," said Peter V. Lee, executive director of Covered California.

While the open enrollment period typically ends Jan. 31, Covered California re-opened enrollment for those affected by the "triple threat" of fires, the pandemic, and the recession.

Covered California Offers Special Enrollment Period for Those Affected by CA Wildfires, COVID-19
Ameera Butt

Covered California is offering those Californians, who have been impacted by the wildfires, COVID-19 or lost their jobs during the recession, eligibility to sign up for coverage in a special enrollment period.

"In an effort to help Californians who have been impacted by the wildfires burning across the state, and to build on the help provided to those affected by the COVID-19 pandemic and the ensuing recession, Covered California announced the establishment of new paths to coverage during the current special-enrollment period," the organization announced Monday.

Earlier this month. Gov. Gavin Newsom announced a state of emergency due to the wildfires.

California is reporting that on Aug. 22, there were 6,777 newly recorded confirmed cases. The state now has a total of 663,669 positive cases. There have been a total of 12,134 deaths in the state.

"Right now, many Californians face a triple threat, with hundreds of wildfires burning during a pandemic and recession, and Covered California wants to make sure they have access to the health care they need," said Peter V. Lee, executive director of Covered California, in a press release. "Providing these paths to coverage will ensure that those who have lost jobs, suffered a loss of income, or have been affected by wildfires have an opportunity to get health care coverage, whether it is through Covered California or Medi-Cal."

There are more than a dozen major wildfires burning across the state and two major fires burning in the Bay Area.

"California over the last week has been hit by 650 wildfires across the state, many sparked by more than 12,000 lighting strikes recorded since Aug., 15. There are 14,000 firefighters. 2,400 engines and 95 aircraft battling the fires," an Associated Press story from Monday reports.

Covered California said in a press release:

"Covered California initially responded to the COVID-19 emergency by opening the health insurance exchange from March 20 to Aug. 31 to any eligible uninsured individuals who needed health care coverage. With that special-enrollment period expiring at the end of the month, the new qualifying life events will continue to help consumers sign up for health care coverage during this turbulent time.

The most recent data shows that 271,820 people signed up through Covered California for health care coverage between March 20 and Aug. 20, which is more than twice the number who signed up during the same time last year."

Covered California Opens Up Enrollment Due To Wildfires And Pandemic!
Valerie Hernandez

Californians are dealing with one thing after the other, first the pandemic and then the raging wildfires on top of that, it seems like no one can catch a breaks. Well, Covered California has opened a special enrollment period for those who have lost their jobs due to the recession or have become victim to wildfires. According to executive director of Covered California, Peter V. Lee, "Right now, many Californians face a triple threat, with hundreds of wildfires burning during a pandemic and recession, and Covered California wants to make sure they have access to the health care they need."

The open enrollment period normally ends on January 31st, but Covered California re-opened enrollment for those affected by the fires, the pandemic, and the recession. Now, Covered California is allowing people to sign up until August 31st. You can find out if you're eligible for Medi-Cal or other forms of financial help with the website's Shop and Compare Tool. You just have to entire your zip code, household income and the ages of those who need coverage. You can find more information at www.CoveredCA.com.

Escalon Times

Covered California Introduces New Special Enrollment Period
Staff

In an effort to help Californians who have been impacted by the wildfires burning across the state, and to build on the help provided to those affected by the COVID-19 pandemic and the ensuing recession, Covered California announced the establishment of new paths to coverage during the current special-enrollment period. Consumers who are victims of the wildfires, or who lose their jobs — even if they do not receive health care coverage through their employer — and those who suffer a loss of income, could be eligible to sign up for coverage.

“Right now, many Californians face a triple threat, with hundreds of wildfires burning during a pandemic and recession, and Covered California wants to make sure they have access to the health care they need,” said Peter V. Lee, executive director of Covered California. “Providing these paths to coverage will ensure that those who have lost jobs, suffered a loss of income, or have been affected by wildfires have an opportunity to get health care coverage, whether it is through Covered California or Medi-Cal.”

Covered California’s regulations allow it to establish a special-enrollment period for people affected by the current statewide state of emergency.

“The emergencies facing our state right now will continue to have a long-lasting impact on Californians, and Covered California is doing what it can to meet people’s health care needs, so they have one less thing to worry about,” Lee said. “If you have been affected by the wildfires, or lost your job or income because of the pandemic and recession, we’re opening our doors for eligible individuals to get health coverage through Covered California or Medi-Cal.”

Covered California initially responded to the COVID-19 emergency by opening the health insurance exchange from March 20 to Aug. 31 to any eligible uninsured individuals who needed health care coverage.

With that special-enrollment period expiring at the end of the month, the new qualifying life events will continue to help consumers sign up for health care coverage during this turbulent time. The most recent data shows that 271,820 people signed up through

Covered California for health care coverage between March 20 and Aug. 20, which is more than twice the number who signed up during the same time last year.

Every year, Covered California provides eligible consumers the opportunity to sign up for health care coverage outside of the traditional open-enrollment period if they experience a qualifying life event. These can include events like losing your health insurance, moving, getting married or having a baby.

Overall, 339,530 people have signed up for coverage since Covered California ended its open-enrollment period on Jan. 31, which is nearly twice as many as seen during the same time period last year.

People who sign up through Covered California will have access to private health insurance plans with monthly premiums that may be lowered due to federal and new state financial help that became effective in 2020.

After selecting a plan, their coverage would begin on the first day of the following month — meaning individuals losing job-based coverage would not face a gap in coverage.

Medi-Cal Coverage Consumers who sign up through CoveredCA.com may find out that they are eligible for no-cost or low-cost coverage through Medi-Cal, which they can enroll in online. Those eligible for Medi-Cal can have coverage that is immediately effective. California has halted Medi-Cal renewal reviews and discontinuances through the end of the public health emergency, ensuring that those already enrolled can continue their coverage.

The decision will free up county resources to process new enrollments. The Department of Health Care Services also received expanded authority to expedite enrollment for seniors and other vulnerable populations through Hospital Presumptive Eligibility; expand the use of telehealth; and to provide COVID-19 testing, testing-related services and treatment to the uninsured, among other steps to make it easier to access care.

All Covered California and Medi-Cal Plans Offer Telehealth Options All health plans available through Covered California and Medi-Cal provide telehealth options for enrollees, giving individuals the ability to connect with a health care professional by phone or video without having to personally visit a doctor’s office or hospital.

All medically needed screening and testing for COVID-19 is free of charge.

This includes telehealth or doctor’s office visits, as well as network emergency room or urgent care visits for the purpose of screening and testing for COVID-19.

In addition, Medi-Cal covers costs associated with COVID-19 in both its managed care plans and with fee-for-service providers. Covered California health plans will help cover costs that arise from any required treatment or hospitalization.

Californians who sign up for coverage may be able to benefit from a new state subsidy program that expanded the amount of financial help available to many people.

The subsidies are already benefiting about 625,000 Covered California consumers. Roughly 576,000 lower-income consumers, who earn between 200 and 400 percent of the federal poverty level (FPL), are receiving an average of $608 per month, per household in federal tax credits and new state subsidies (which averages $23 per household).

The financial help lowers the average household monthly premium from $881 to $272, a decrease of 70 percent.

In addition, nearly 32,000 middle-income consumers have qualified for new state subsidies, with an average state subsidy to eligible households of $504 per month, lowering their monthly premium by nearly half.

Many of those eligible for the new middle-income state subsidies are an estimated 280,000 Californians who are likely eligible for new state or existing federal subsidies but kept their “off-exchange” coverage.

They are also eligible to switch to Covered California and benefit from the financial help. Covered California is working with the more than 10,000 Certified Insurance Agents who help Californians sign up and understand their coverage options through phone-based service models.

“Over the past several months, our staff and insurance agents across the state have been working to help thousands of people over the phone or through virtual meetings to help people get the coverage they need,” Lee said. “Health care coverage through Covered California of Medi-Cal can be just a phone call away.”

Consumers can easily find out if they are eligible Medi-Cal or other forms of financial help and see 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.

For more information about Covered California, visit www.CoveredCA.com.

Covered California Introduces New Special Enrollment Period
Robert Sheen

Covered California, the state health insurance marketplace established by the Affordable Care Act, has introduced a new special enrollment period to benefit victims of the 500+ wildfires raging across California.

The executive director of Covered California, Peter V. Lee, called the wildfires, pandemic, and recession a “triple threat” to Californians. As a result, Covered California is reopening enrollment to offer affordable healthcare options to those who have been affected by the wildfires, or have lost their job or income due to the pandemic and recession.

Covered California initially allowed people to continue signing up due to the pandemic from March 20 through August 31. As of August 20, more than 271,000 people had taken advantage of the opportunity. Typically, only certain individuals who experience a “qualifying life event”, such as the birth of a child, can enroll outside of the open enrollment period. Now that this period has expired, Covered California is allowing certain individuals affected by the fires, the pandemic, and the recession to qualify for special enrollment based on new definitions of qualifying life events.

Those who sign up through Covered California have access to private health insurance plans, with coverage beginning on the first day of the following month. Or, they may be eligible for no-cost or low-cost coverage through Medi-Cal, which is effective immediately.

Covered California and Medi-Cal plans offer tele-health options, so individuals can connect with a health care professional by phone or video without having to visit a medical office in person.

To learn more about how California employers can achieve ACA compliance in 2020, click here.

To learn more about ACA compliance in 2020, click here.

With a jab at Trump, Pelosi unveils new 'Obamacare' bill
Ricardo Alonso-Zaldivar

WASHINGTON (AP) — Flicking a dismissive jab at President Donald Trump, House Speaker Nancy Pelosi unveiled a plan Wednesday to expand "Obamacare," even as Trump's administration is about to file arguments in a Supreme Court case to strike it down.

Pelosi announced an upcoming floor vote on her measure, setting up a debate that will juxtapose the Democrats' top policy issue, Trump's unrelenting efforts to dismantle Obama's legacy, and the untamed coronavirus pandemic.

On Thursday, the Trump administration is expected to file papers with the Supreme Court arguing that the Affordable Care Act is unconstitutional. Pelosi wants her bill on the House floor Monday.

Trying to overturn a health insurance expansion providing coverage to about 20 million people "was wrong any time," Pelosi said.

"Now, it is beyond stupid," she added. "Beyond stupid."

COVID-19 cases are rising in major states like Texas, Florida and California, and millions of workers who have lost coverage in the economic shutdown to contain the virus can rely on the health law as a backup.

The White House said Pelosi is just playing politics. "Instead of diving back into partisan games, Democrats should continue to work with the president on these important

issues and ensuring our country emerges from this pandemic stronger than ever," spokesman Judd Deere said Wednesday in a statement.

Pelosi's legislation has no chance in the Republican-controlled Senate.

Her bill would expand subsidies, allowing more people to qualify for coverage under the ACA. It would financially squeeze some states that have refused to expand Medicaid under the health law. And it would empower Medicare to negotiate prescription drug prices — a position Trump once favored but later abandoned.

It would also undo the Trump administration's expansion of short-term insurance plans that don't have to cover preexisting medical conditions, something Democrats say will undermine a central achievement of the ACA.

Democrats won control of the House in 2018 on their defense of the health care law. Since then, that chamber has voted on most of the measures in Pelosi's plan in one form or another.

But, as underscored in a memo last month led by Democratic Congressional Campaign Committee Chair Cheri Bustos, D-Ill., the broader goal is to make Republicans squirm.

"Republicans at all levels own this lawsuit's attack on Americans' health care," said the memo. "They will be held responsible for their party-wide obsession with throwing our health care system into chaos and stripping health care from 20 million Americans during a global pandemic."

Obama's law has grown more popular since Trump's unsuccessful effort to repeal it in 2017, when Republicans controlled both the House and Senate. In May, a poll from the nonpartisan Kaiser Family Foundation found that 51% of Americans view "Obamacare" favorably while 41% have unfavorable views.

An earlier Kaiser poll found also found that nearly 6 in 10 are worried they or someone in their family will lose coverage if the Supreme Court overturns either the entire law or its protections for people with preexisting medical conditions.

In the case before the court, Texas and other conservative-led states argue that the ACA was essentially rendered unconstitutional after Congress passed tax legislation in 2017 that eliminated the law's unpopular fines for not having health insurance, but left in place its requirement that virtually all Americans have coverage.

The conservative states argued that elimination of the fines made the law's so-called individual mandate unconstitutional. U.S. District Judge Reed O'Connor in Texas

agreed, adding that the mandate was so central to the law that without it the rest must also fall.

The Trump administration's views on the law have shifted over time, but it has always supported getting rid of provisions that prohibit insurance companies from discriminating against people on account of their medical history. Nonetheless, Trump has repeatedly assured Americans that people with preexisting conditions would still be protected. Neither the White House nor congressional Republicans have specified how.

A federal appeals court in New Orleans found the health law's insurance requirement to be unconstitutional, but made no decision on such popular provisions as protections for people with preexisting conditions, Medicaid expansion and coverage for young adults up to age 26 on their parents' policies. It sent the case back to O'Connor to determine whether other parts of the law can be separated from the insurance requirement, and remain in place.

Democratic-led states supporting the ACA appealed to the Supreme Court. It's unclear if the court will hear oral arguments before the November election. A decision is unlikely until next year.

The court has twice upheld the law, with Chief Justice John Roberts memorably siding with the court's liberals in 2012, amid Obama's reelection campaign. The majority that upheld the law twice remains on the court.

Bloomberg LAW

Obamacare Coverage Spikes After Covid-Related Job Losses
Sara Hansard

Nearly a half million people signed up for Obamacare after losing health-care coverage from their employer, the Department of Health and Human Services said Thursday.

The 487,000 consumers who got coverage from the federal HealthCare.gov exchanges marks an increase of 46% from the same time period last year, the HHS said in a report.

The increased enrollment through May came as millions of people became unemployed and lost job-related coverage due to the Covid-19 pandemic. The increase in sign-ups outside of the normal open enrollment period was higher than during any other year, the HHS said.

The Trump administration has refused to reopen HealthCare.gov to let uninsured people get coverage. It instead has argued that under the Affordable Care Act, people who lose health-care coverage due to job loss can enroll during a special enrollment period. People can sign up for coverage outside of normal open enrollment if they have a life-changing event, such as the birth of a child, marriage, divorce, or job loss.

“As a result of the economic disruption that followed COVID-19 outbreaks, many consumers experienced life changes—particularly related to employment—that allowed them to enroll in health coverage through the Exchange,” the HHS said in a statement. “Enrollment data for April and May of this year show that thousands of Americans who lost job-based coverage due to COVID-19 are successfully taking advantage of existing SEPs to enroll in coverage.”

Democrats and the health insurance industry maintain that reopening HealthCare.gov is vital to getting as many people covered as possible during the health-care emergency.

The HHS doesn’t normally release special enrollment data, and it has declined to do so when queried in prior months by Bloomberg Law.

Enrollment Rises
The largest monthly gain was in April, when enrollment increased 139% compared to April 2019, the HHS said.

Bureau of Labor Statistics data show that non-farm employment dropped by 20.7 million from March to April, as states issued stay-at-home orders to prevent the virus from spreading, according to the report. The unemployment rate hit a high of 14.7% in April.

It’s unclear how many people will ultimately look to the Obamacare exchanges to replace job-based coverage due to a number of factors, including expectations that people will return to work within six months and employers continuing to provide coverage to laid-off and furloughed employees, according to the report.

In total, 892,141 people have signed up for special enrollment coverage in the states that use HealthCare.gov.

About 8.3 million people enrolled in plans using the HealthCare.gov platform during the normal 2020 open enrollment period that ended in December 2019.

As of Nov. 1, 2019, 13 states have been operating their own exchanges, and all of them except Idaho have reopened their exchanges to let more people get enrolled.

The New York Times

Trump Administration Asks Supreme Court to Strike Down Affordable Care Act
Sheryl Gay Stolberg

WASHINGTON — The Trump administration asked the Supreme Court late Thursday to overturn the Affordable Care Act — a move that, if successful, would bring a permanent end to the health insurance program popularly known as Obamacare and wipe out coverage for as many as 23 million Americans.

In an 82-page brief submitted an hour before a midnight deadline, the administration joined Republican officials in Texas and 17 other states in arguing that in 2017, Congress, then controlled by Republicans, had rendered the law unconstitutional when it zeroed out the tax penalty for not buying insurance — the so-called individual mandate.

The administration's argument, coming in the thick of an election season — as well as a pandemic that has devastated the economy and left millions of unemployed Americans without health coverage — is sure to reignite Washington's bitter political debate over health care.

In his brief, Solicitor General Noel J. Francisco argued that the health law's two remaining central provisions are now invalid because Congress intended that all three work together.

"Nothing the 2017 Congress did demonstrates it would have intended the rest of the A.C.A. to continue to operate in the absence of these three integral provisions," the brief said, using the abbreviation for the name of the health care law. "The entire A.C.A. thus must fall with the individual mandate."

The Texas case is by far the most serious challenge to date for the 10-year-old health care law, President Barack Obama's signature domestic achievement. The Supreme Court has already ruled on two legal challenges to the act, and both times it has left most of the law in place.

The court has not said when it will hear oral arguments, but they are most likely to take place in the fall, just as Americans are preparing to go to the polls in November.

Republicans have long said their goal is to “repeal and replace” the Affordable Care Act but have yet to agree on an alternative. They are bracing for the possibility that the effort to overturn the health law will cost them. Joel White, a Republican strategist, said in a recent interview that he considered it “pretty dumb to be talking about how we need to repeal Obamacare in the middle of a pandemic.”

Democrats, who view health care a winning issue and who reclaimed the House majority in 2018 on their promise to expand access and bring down costs, are trying to use the Supreme Court case to press their advantage. Speaker Nancy Pelosi has scheduled a vote for Monday on a measure to expand the health care law, in an effort to draw a sharp contrast between Democrats and Republicans.

“President Trump and the Republicans’ campaign to rip away the protections and benefits of the Affordable Care Act in the middle of the coronavirus crisis is an act of unfathomable cruelty,” Ms. Pelosi said in a statement late Thursday night, after the administration’s brief was filed.

“If President Trump gets his way,” she added, “130 million Americans with pre-existing conditions will lose the A.C.A.’s lifesaving protections and 23 million Americans will lose their health coverage entirely.”

The case the court will hear grows out of a lawsuit that Republican officials in 20 states, led by Texas, filed against the Department of Health and Human Services in February 2018, seeking to have the health law struck down. After Democratic victories in the 2018 midterm elections, two states, Wisconsin and Maine, withdrew.

When the case was argued in the trial court, the Trump administration, though a defendant, did not defend the law, siding instead with the plaintiffs. But unlike Texas and the other states, the administration argued at the time that only the law’s protections for people with pre-existing conditions should be struck down, but that the rest of the law, including its expansion of Medicaid, should survive.

Last year, however, the administration expanded its opposition, telling a federal appeals court that the entire law should be invalidated. In the meantime, another 17 states, led by California, intervened to defend the law, as did the House, now controlled by Democrats.

“Now is not the time to rip away our best tool to address very real and very deadly health disparities in our communities,” Attorney General Xavier Becerra of California said in a statement on Thursday, adding: “This fight comes at the most crucial time. The death toll from the coronavirus today is greater than the death toll of the Vietnam War.”

The Supreme Court has agreed to consider three legal questions in the case: whether Texas and two individual plaintiffs who have joined the suit have standing; whether Congress rendered the individual mandate unconstitutional; and, if it did, whether the rest of the law must fall with it.

If the court strikes down only the mandate, not much will change, according to an analysis by the Kaiser Family Foundation, which wrote that the “practical result will be essentially the same as the A.C.A. exists today, without an enforceable mandate.” But if the court decides that all or part of the law must be overturned, it would affect “nearly every American in some way,” the foundation wrote.

The Texas suit has created great uncertainty for the roughly 20 million people covered by the law, as well as for millions of others who have lost their jobs and health coverage during the coronavirus pandemic. A recent analysis by the liberal-leaning Center for American Progress estimated that 23 million people would lose coverage if the Affordable Care Act is abolished — including nearly two million in Texas and more than four million in California.

The lawsuit has also drawn opposition from hospitals and doctors, including the American Medical Association. In a friend of the court brief filed last month, it wrote that striking down the law “at a time when the system is struggling to respond to a pandemic that has infected nearly 1.4 million Americans and killed more than 80,000 at the time of this writing would be a self-inflicted wound that could take decades to heal.”

Column: Incredibly, amid COVID-19 pandemic, Trump moves to take away your healthcare
Michael Hiltzik

Over the years, there have been many reasons to fear the reckless, heedless policies emanating from the Trump White House, like a miasma. Thursday brought us a reminder of what may be the scariest of all: The administration’s determination to overthrow the Affordable Care Act.

We’re talking about the government brief in a case brought by Texas and a score of other red states seeking to have the ACA declared unconstitutional. The brief is based

on a theory that has been ridiculed by legal experts from one end of the political spectrum to the other.

Its impact would be almost indescribably profound, ripping health coverage from some 23 million Americans in the teeth of a pandemic that already has claimed more than 120,000 American lives and condemned untold others to years, possibly decades, of chronic disease.

The brief “manages to be both mind-numbingly dumb and completely terrifying,” veteran healthcare expert Christen Linke Young of the Brookings Institution judges. That’s putting it mildly.

We’ve written before about the crackpot legal theory underlying the plaintiffs’ case and its endorsement by Trump. Before revisiting its arguments, let’s examine its consequences, should a majority of at least five Supreme Court justices buy in.

Generally speaking, the lawsuit and the White House endorsement reflect the Republican Party’s approach to healthcare and health coverage in the U.S., which is essentially vandalism. The GOP in Congress treat healthcare as a privilege, not a right.

The party doesn’t see health as a communal good, but merely something to be endowed upon those who can afford it; all others be damned.

That’s why 100% of its healthcare policy since the ACA was enacted in 2010 has been devoted to tearing down the law, and 0% to crafting an effective replacement. The Republican mantra has been “repeal and replace,” yet they’ve aimed for the first but never even tried to achieve the second.

Although most people think of the ACA chiefly in terms of the individual insurance exchanges that provide otherwise uninsured low- and middle-income households with subsidized health coverage, and of the Medicaid expansion that has brought no-cost coverage to the lowest-income households in the District of Columbia and 33 states that have accepted it, the law is much broader.

Overturning the ACA as unconstitutional would eliminate subsidized coverage for 10 million Americans and Medicaid coverage for 17 million more.

Protection for an estimated 133 million Americans whose preexisting medical conditions would freeze them out of the insurance market or condemn them to coverage exclusions or heavy premium surcharges — the obstacles they faced before the ACA — would be gone.

So too would the ACA's ban on annual and lifetime limits on health benefits, limits on out-of-pocket expenses, a guarantee that every health plan cover 10 "essential benefits," including prescriptions, hospitalization, maternity and newborn services, and mental health services.

The closing of the infamous Medicare prescription "donut hole," which raised prescription prices for seniors, would end. The right of children to remain on their parents' insurance until age 26 would be eliminated.

The ACA has been crucial in bringing healthcare services to Americans during the COVID-19 pandemic, in part because it has spurred demand for testing and treatment, and because the economic crisis caused by the pandemic has forced millions off their employer-based plans and into the individual or Medicaid market.

Overturning the ACA would increase the number of uninsured Americans by more than 65%, raising it to 50.3 million from 30.4 million, the Urban Institute projects. Ethnic minorities and low-income Americans would be most severely affected.

More than 10.5 million people would lose their coverage in coronavirus hot spots such as Arizona, Texas, Florida, California, Georgia and the Carolinas, according to an estimate by the Center for American Progress.

Quite obviously, this spells disaster. Trump and his minions in the GOP evidently don't know how to read.

That brings us to the legal argument, which has made its way through the federal courts since 2018. The plaintiffs' case is based on the tax cut passed by a Republican Congress and signed by Trump in December 2017.

Unable to muster the votes to repeal the ACA outright, the Republicans chose in the tax cut measure to reduce the ACA's penalty on Americans who failed to acquire health coverage to zero from about $700 per adult per year, with a maximum of about $2,000 per household. That effectively suspended the individual mandate, since there was no longer any cost from flouting it.

Texas and the other red states argued that this invalidated the entire ACA. Their reasoning was that the Supreme Court, in a 2012 decision written by Chief Justice John Roberts, had upheld the ACA by terming the penalty a "tax," which Congress had an unchallengeable right to impose.

Reducing the “tax” to zero meant there was no tax, and therefore no mandate, and therefore no constitutional protection; because the ACA had to survive or fall as a whole, the plaintiffs asserted, the entire law must fall.

This argument came before a right-wing federal judge in Texas, Reed O’Connor, who bought it. His ruling invalidating the law was appealed to the conservative 5th Circuit Court of Appeals in New Orleans.

A three-judge appellate panel punted in a decision that legal scholar Nicholas Bagley of the University of Michigan derides as “blending arrogance and cowardice in equal measure” — arrogant because it ignored the essence of Roberts’ ruling, cowardly because it sent the case back to O’Connor without ruling itself on whether the whole law, or only parts of it, had to go.

Meanwhile the Trump administration threw in its lot with the plaintiffs by refusing to defend the law in court. The defense has been taken up by the now-Democratic House and a coalition of blue states led by California.

Instead of leaving things to O’Connor, the Supreme Court accepted the case. It’s not expected to rule until after the November election.

Whether one expects the court to uphold the law or kill it, or find a middle ground, this is arguably a big problem for Trump and the GOP. That’s because they can be blamed for leaving a crucial healthcare reform in limbo as the need for a functioning healthcare system grows more urgent by the hour.

The administration waited to file its legal brief with the Supreme Court on Thursday night to beat the filing deadline by minutes, so it might not be too proud of its handiwork — with good reason.

Legal experts see the government brief as replicating all the flaws of the underlying argument. The government argues that by reducing the individual mandate penalty to zero, Congress eliminated the “tax” because a tax that raises no revenue isn’t a tax.

But as Bagley notes, that’s not true — many taxes raise no revenue or have been suspended temporarily, but still remain in effect. That’s the case here.

Even if the Supreme Court holds that the individual mandate is invalid, there are no grounds to hold that the entire ACA must stand or fall as a whole — that its provisions are inseverable, in legal parlance.

“The ACA’s interlocking web of provisions cannot function as Congress intended” without the individual mandate, the government brief maintains. That’s absurd.

Numerous provisions of the law are unrelated to the individual insurance market the ACA established. Many relate to Medicare or to general healthcare policy and practice. Others set standards for health policies outside the individual market, such as employer plans.

As for whether Congress intended the zeroing out of the penalty to invalidate the entire law, there’s no evidence for that. Congress didn’t say so when it passed the tax cut bill.

The government brief weasels its way around this issue. It acknowledges that “Congress did not speak in general terms about ... severability,” when it passed the tax cut, but addressed only the “specific issue” of the penalty.

But it says that even if overturning the ACA was “not what its Members expected in 2017 when they amended the ACA,” that doesn’t matter (“there were likely Members on both sides” of the issue, the brief admits) — the penalty is “directly relevant to severability” and the court should consider the whole law inseverable.

Bagley observes: “This case has had nothing to do with law as we conventionally understand it. It’s an exercise of raw political power.” By asking the court to invalidate the Affordable Care Act, “the Trump administration is begging the court to give it an excuse to stop enforcing the entire law altogether.”

He’s right. This is an expression of Trump’s method of injecting chaos into everything he touches, as though the purpose of government is to make human existence harsher, crueler and more stupefying and terrifying than anyone could have imagined.

Throwing the healthcare system into anarchy at the very moment when millions of Americans face sickness and death from an implacable pathogen? So much the better. Welcome to Trump’s vision of America.

San Francisco Chronicle

Editorial: Trump’s ill-advised legal attack on Obamacare
Editorial Board

House Speaker Nancy Pelosi called it “an act of unfathomable cruelty.” The Trump administration’s move to persuade the U.S. Supreme Court to repeal the Affordable

Care Act in the midst of the worst pandemic in a century simply makes no sense as a matter of politics or public health.

In doing so, the Trump White House has just assured that the landmark health law that is providing coverage to 130 million Americans with pre-existing conditions will be a significant issue in the November election.

Why the president would pick such a battle — especially in the absence of a plausible alternative to replace it — is inexplicable. Did he and his strategists somehow miss the message of the 2018 midterms, when the law was in the thick of the debate, and Democrats won big?

It's doubly puzzling because the Trump administration is taking a more aggressive stance when the lawsuit brought by 20 Republican attorneys general was in trial court. At that point, the administration was focused on eliminating pre-existing conditions rather than the entirety of the law. The case now going to the Supreme Court with the administration's support argues that the law became void when Congress eliminated a tax penalty for Americans who fail to buy insurance, commonly known as the individual mandate.

Did someone forget to remind President Trump that, despite his opposition to the individual mandate, he has repeatedly said he would defend a requirement for coverage of pre-existing conditions?

Most important of all is the absurdity of peeling back access to health care during the coronavirus pandemic in which more than 125,000 Americans have died — and infections continue to surge in many states with neither a vaccine nor effective treatments in sight. It is notable that the American Medical Association, along with many doctors and hospitals, opposes the lawsuit.

California has taken the lead among the 17 states that have come forward to defend the law.

"Now is not the time to rip away our best tool to address very real and very deadly health disparities in our communities," state Attorney General Xavier Becerra said in a statement last week. "This fight comes at the most critical time. The death toll from the coronavirus today is greater than the death toll of the Vietnam War."

The job losses from the shutdown-induced economic shock also must be considered. In fact, a new report from the Centers for Medicare and Medicaid Services showed 487,000 Americans enrolled on Healthcare.gov in April and May — a 46% increase from the previous year.

In his brief on behalf of the Trump administration, Solicitor General Noel Francisco argued that the absence of a tax penalty —upheld by the Supreme Court — unraveled the core of the law. He suggested the individual mandate was “inseverable” from the requirement on covering pre-existing conditions.

His logic would be laughable if the stakes were not so serious.

“Nothing the 2017 Congress did demonstrates it would have intended the rest of the ACA to continue to operate in the absence of these ... integral provisions,” Francisco wrote.

Pure nonsense. If the then-Republican-controlled Congress had intended to repeal the Affordable Care Act, it would have done so. It lacked the votes. One vote, to be precise. Many will recall Sen. John McCain’s pivotal thumbs-down vote in the early morning hours of July 28, 2017, to preserve the law commonly known as Obamacare.

Former Vice President Joe Biden, the presumptive Democratic nominee, instantly signaled that he would be pressing the issue. He should. Americans need the law more than ever.

Obamacare Versus the G.O.P. Zombies
Paul Krugman

Covid-19 cases are surging in states that took Donald Trump’s advice and reopened for business too soon. This new surge — is it OK now to call it a second wave? — is, on average, hitting people younger than the initial surge in the Northeast did. Perhaps as a result, rising infections haven’t been reflected in a comparable rise in deaths, although that may be only a matter of time.

There is, however, growing evidence that even those who survive Covid-19 can suffer long-term adverse effects: scarred lungs, damaged hearts and perhaps neurological disorders.

And if the Trump administration gets its way, there may be another source of long-term damage: permanent inability to get health insurance.

Remarkably, last week the administration reaffirmed its support for a lawsuit seeking to overturn the Affordable Care Act, which would, among other things, eliminate protection for Americans with pre-existing medical conditions. If the suit were to succeed, having had Covid-19 would surely be one of the pre-existing conditions making health insurance hard, perhaps impossible, to get.

Now, the legal argument behind the case is beyond flimsy: The lawsuit claims that the 2017 tax cut effectively invalidated the act, even though that was no part of Congress's intention. But with a conservative majority on the Supreme Court, nobody knows what will happen. And Trump's support for the suit makes it clear that if re-elected he will do all he can to destroy Obamacare.

Not to worry, says the president. In tweets over the weekend he insisted that he would come up with an alternative to Obamacare that would be "FAR BETTER AND MUCH LESS EXPENSIVE" while protecting Americans with pre-existing conditions.

But he's been claiming to have a much better alternative to Obamacare since he took office. Republicans in Congress, who voted to repeal Obamacare 70 times during the Obama years, have been making the same claim for more than a decade.

Yet somehow the great alternative to the Affordable Care Act has never materialized. In 2017, when the G.O.P. finally came close to repealing the act — failing thanks only to a last-minute change of heart on the part of Senator John McCain — the plan on offer would have stripped away protection for pre-existing conditions and added 23 million Americans to the ranks of the uninsured.

In other words, Republicans' insistence that they have a superior alternative to Obamacare is a zombie lie — a claim that should be dead after having been proved false again and again, but it is still shambling along, eating people's brains.

But why can't Republicans come up with a better alternative to Obamacare? Are they just incompetent? Possibly — but even if they did know what they were doing, they couldn't produce a superior plan, because no such plan is possible. In particular, unless you're willing to move left instead of right, by going for single payer, the only way to guarantee coverage for Americans with pre-existing conditions is a system that looks a lot like Obamacare.

The logic here has been clear from the beginning. To ensure coverage of people with pre-existing conditions, you have to prohibit insurers from discriminating based on medical history. But that's not enough: To provide a decent risk pool, you also have to induce healthy people to sign up, preferably with both subsidies and a penalty for being uninsured. In other words, you need a system that is basically Obamacare.

The 2017 tax cut, which did away with the individual mandate — the penalty for noninsurance — weakened the system; you can see this by the fact that states, like New Jersey, that imposed their own mandates saw a drop in insurance premiums. But the design of the subsidies, which insulated most people from rising premiums, contained the damage: The percentage of Americans without health insurance, which fell sharply as a result of Obamacare, remains near record lows.

So is there any alternative to Obamacare? Of course there is. We could go back to being a country in which people with pre-existing conditions and/or low incomes can't get health insurance, where for a large fraction of the population illness either goes untreated or leads to bankruptcy. That would, in part, mean becoming a country in which Americans who caught Covid-19 during the pandemic would be uninsurable for the rest of their lives.

Indeed, turning us back into that kind of country is the G.O.P.'s true goal, and is what will happen if the party gets its way either as a result of the current lawsuit or through legislation during a second Trump term.

But Republicans can't admit that this is their goal. The public overwhelmingly supports protection for Americans with pre-existing conditions, so right-wing politicians have to pretend they can provide that while dismantling the regulations and subsidies such protection requires. And they have to hope that voters won't remember that they have been promising a plan, but never delivering, for more than a decade.

Let's hope voters are smarter than that. Fool me once, shame on you. Fool me 70 times and counting, shame on me.

Republican Leaders Want to End Obamacare. Their Voters Are Expanding It.
Sarah Kliff

Deeply conservative Oklahoma narrowly approved a ballot initiative Tuesday to expand Medicaid to nearly 200,000 low-income adults, the first state to do so in the midst of the coronavirus pandemic.

The vote to expand the Affordable Care Act's reach once again put voters, many of them conservative, at odds with Republican leaders, who have worked to block it or invalidate it. Five states — Maine, Utah, Idaho, Nebraska, and now Oklahoma — have

used ballot initiatives to expand Medicaid after their Republican governors refused to do so.

Oklahoma pushed the G.O.P. over a notable threshold: Most congressional Republicans now represent Medicaid-expansion states. The vote also came at a striking moment, less than a week after the Trump administration asked the Supreme Court to overturn the entirety of Obamacare — including Medicaid expansion.

“What we saw last night was Medicaid expansion triumph over party and ideology,” said Jonathan Schleifer, executive director of the Fairness Project, which has helped organize all the Medicaid votes. “Oklahoma voted for Medicaid expansion even as Trump is doubling down on repeal.”

Medicaid expansion could spread further into Republican-controlled states this year, as they weigh how to cover the many unemployed Americans expected to lose health insurance along with their jobs. Missouri voters will decide on a ballot initiative at the state’s August primary. If it passes, it will expand Obamacare coverage to 217,000 low-income people.

Some Wyoming legislators recently took a fresh look at the program, too, as they watched job losses mount. “I’ve voted against it about 10 times, never voted for it,” said the state’s House speaker, Steve Harshman, a Republican. “Now I’m thinking of our work force. We’re a mineral and oil kind of state. That’s a lot of able-bodied adults in a lot of industries who will probably need some coverage.”

Mr. Harshman voted in May to have a legislative committee study the topic, but he does not expect any action until the body’s next session begins in January.

Medicaid expansion has proved an especially resilient part of the health care law, despite early challenges. The program, which provides coverage to Americans earning less than 133 percent of the federal poverty line (about $16,970 for an individual), was initially meant to serve all 50 states.

But in a 2012 ruling, the Supreme Court declared that states could decline to participate. The program began in 2014 with about half of the states, mostly run by Democratic governors.

That figure has grown to 37 states and the District of Columbia, as more Republican-controlled states have signed on. Many academic studies have found that the program increases enrollees’ access to medical care. A more limited body of research shows that the program also reduces mortality rates.

The program still faces threats, most significantly the Trump administration lawsuit to overturn the health law. The Department of Justice, alongside a coalition of 20 Republican-controlled states, submitted briefs to the Supreme Court last week arguing that the recent repeal of the individual mandate, which required all Americans to carry health coverage or pay a fine, made the entire law unconstitutional.

President Trump has found strong support in Oklahoma; he took 65 percent of the vote there in 2016 in a 36-point victory, and recently held a campaign rally in Tulsa, his first since the start of the pandemic.

Still, voters there broke with him on this issue, albeit by the margin of one percentage point. The ballot initiative drew 30,000 more voters than the state's Senate primaries, suggesting that some Oklahomans came out specifically to support the insurance expansion.

"Oklahoma is an awfully red state," said Adam Searing, an associate professor at Georgetown University who has tracked the state's ballot effort. "It's very conservative, very rural. To have it pass there is quite significant."

Oklahoma's Republican leadership had opposed Medicaid expansion and initially offered more limited alternatives. Gov. Kevin Stitt outlined a program in January in which new low-income enrollees would pay modest premiums and be required to work to gain coverage.

He went on to veto that program, after the legislature secured its funding.

Oklahoma was also the first state to ask the Trump administration for permission to convert its Medicaid program to "block grant" funding, an idea strongly pushed by Mr. Trump's health appointees. The state would receive a lump-sum payment from the federal government to run the program with additional flexibility. Opponents of that proposal worry that such a funding formula could struggle to keep up with increased enrollment in an economic downturn.

Oklahoma submitted its application in April, and the Trump administration had not issued a decision before the Tuesday vote.

Oklahoma's ballot initiative is notable in being the first to add the Medicaid expansion to the state's Constitution. That will make it hard for Governor Stitt and the Republican-controlled legislature to tinker with or block the program, as other governors have sought to do in the wake of successful ballot initiatives. Most notably, when Paul LePage was governor of Maine, he declared he would go to jail before implementing the

state's Medicaid ballot initiative. The situation was resolved when a Democratic governor was elected and set up the coverage expansion.

In Oklahoma, ballot organizers can pursue either statutory or constitutional initiatives. The latter have more staying power but also require gathering twice as many signatures. Amber England, who led the ballot effort, felt the additional work was worth it.

"If we're going to ask people to get clipboards and pens, and gather signatures, we want to make the policy as strong as possible," she said. "It was important that we protect Oklahomans' access to health with the Constitution. We didn't want politicians to be able to take that right away."

Missouri will be the next state to vote on Medicaid expansion, in its Aug. 4 primary. The state is a party to the Trump administration's case against Obamacare. Gov. Michael Parson, a Republican, has publicly opposed that ballot initiative, which he argues is too costly in the midst of an economic downturn. Missouri would need to cover 10 percent of new Medicaid enrollees' bills, with the federal government paying the other 90 percent.

"I don't think it's the time to be expanding anything in the state of Missouri right now," Mr. Parson told a local television station in early May. "There's absolutely not going to be any extra money whatsoever."

Trump's trying to end Obamacare but there's emerging evidence it could undo him
Sahil Kapur

WASHINGTON — Six days after President Donald Trump's administration asked the Supreme Court to overturn Obamacare, voters in deeply red Oklahoma effectively voted to embrace the law by adopting its Medicaid expansion.

The narrow victory for Obamacare came in a state that Trump won by 36 points in 2016, highlighting a growing gap between the president and his own base on health care as he asks Americans to give him four more years. The tension comes as anxieties are rising amid a coronavirus resurgence that has forced some states to pause or roll back the reopening.

Oklahomans joined voters in other red states like Utah, Nebraska and Idaho in expanding Medicaid under the 2010 law, which the Supreme Court made optional. Trump does not appear in any danger of losing these states on Nov. 3, but Democrats intend to weaponize the issue elsewhere — in battleground states.

For Trump, health care could go from being a vulnerability to a fatal political wound. It was the top issue for voters in the 2018 elections and those who cited it preferred Democratic candidates by 52 points in House races, according to exit polls.

Joe Biden is hoping to replicate that this fall by criticizing Trump's attempts to undo Obamacare's protections for pre-existing conditions and expansion of Medicaid coverage for low-income people.

"He just keeps giving us more ammunition," said Guy Cecil, the chair of the Democratic super PAC Priorities USA.

Obamacare enrollment surged by 46 percent in June, compared to the same time last year, according to a report by the Department of Health and Human Services. Nearly half a million consumers gained coverage through the law, which is one of the few options for people who lost their employer-based health care plans during the coronavirus pandemic.

The other option is COBRA, which allows Americans who lost their job to keep their employer-based plan by paying 102 percent of the cost. That is an unaffordable sum for many.

A Fox News poll taken mid-June found that 39 percent of Americans approve of Trump's handling of health care, while 53 percent disapprove. A recent Quinnipiac poll found that Biden has a 14-point lead over Trump among respondents asked which candidate would better handle health care.

The issue also could have implications for Republicans in competitive congressional races.

Sen. Susan Collins, R-Maine, who faces a difficult re-election battle this fall, said the Trump administration's attempt to eliminate the ACA in court was wrong on the law and the policy.

"Congress maintained important consumer protections in the ACA for people with pre-existing conditions such as asthma, arthritis, cancer, diabetes and heart disease," she said. "The administration's decision to submit this new brief is the wrong policy at the

worst possible time as our nation is in the midst of a pandemic. The Affordable Care Act remains the law of the land, and it is the Department of Justice's duty to defend it."

Collins was a rare Republican who voted against the repeal of Obamacare in 2017. Other vulnerable GOP lawmakers like Sen. Cory Gardner, R-Colo., and Sen. Martha McSally, R-Ariz., supported it.

Republicans have successfully fought to eliminate several unpopular provisions in the law, such as the individual requirement for most people to buy coverage and taxes on medical devices and the so-called Cadillac tax on high-cost plans.

Trump's ongoing determination to eliminate the 2010 law is consistent with two driving forces in his presidency: Fight for his most passionate supporters and undo President Barack Obama's initiatives. But while "Obamacare" continues to be viewed negatively by Republicans, the law's remaining provisions are popular. Medicaid expansion proponents in red states have notably refrained from using the nickname for the Affordable Care Act.

The White House defended its attempts to roll back the ACA.

"A global pandemic does not change what Americans know: Obamacare has been an unlawful failure and further illustrates the need to focus on patient care," White House spokesman Judd Deere said, arguing that the law has limited consumer choice of plans and providers and that Trump has fought to improve those issues. "The American people deserve for Congress to work on a bipartisan basis with the President to provide quality, affordable care."

But the White House has not offered an alternative plan.

The replacement proposals that Trump endorsed in 2017, which fell short of passing the Republican-controlled Congress, would have rolled back Medicaid coverage and weakened protections for pre-existing conditions due to state waivers allowing insurers to charge people more for coverage on the basis of factors like health status.

"People, even Trump voters, want their Medicaid. Trump just wants applause from right-wing Twitter for taking it away," said Democratic consultant Jesse Ferguson, who worked on Hillary Clinton's 2016 campaign. "The 2020 election will be pretty simple: if you want more sick people without health care coughing on you, vote Trump."

Obamacare Helps Poorer Americans Spot Cancer Earlier: Study
Amy Norton

MONDAY, July 6, 2020 (HealthDay News) -- Medicaid expansion under Obamacare may have decreased the number of poorer Americans diagnosed with advanced cancer, a new study suggests.

The study focused on Ohio, which was among the first states to expand its Medicaid program under the Affordable Care Act (ACA) in 2014.

The researchers found that in the three years after expansion, low-income residents saw a 15% drop in their odds of being diagnosed with metastatic cancer.

That refers to cancers that have spread from the original site to other parts of the body. While metastatic cancer can be treated, it is most often incurable, according to the U.S. National Cancer Institute.

Medicaid is the publicly funded insurance program for the poor. The new findings suggest that its expansion helped prevent some of those late diagnoses.

And it's "quite likely" that better access to cancer screenings was one reason, said senior researcher Dr. Johnie Rose, of Case Western Reserve University School of Medicine in Cleveland.

"There also might have been a 'hmm' factor," he said. That is, if more people were able to see a primary care doctor, that might have caught some red-flag symptoms that led to timelier cancer diagnoses.

Starting in 2014, the ACA allowed U.S. states to expand their Medicaid programs, making more poor residents eligible for coverage. It's known that those expanded programs reduced the ranks of the uninsured -- and, at least in some cases, improved access to health care.

More recently, studies have been linking expansion to clear health benefits -- including declines in deaths from heart disease, stroke and opioid overdose.

The new study, published online July 6 in the journal Cancer, points to another benefit.

"I think for policymakers and for voters, this shows there's a concrete, demonstrable, life-saving benefit from expanding access to care," said Rose, an assistant professor at the Case Western Reserve Center for Community Health Integration.

For the study, his team analyzed information on nearly 12,800 Ohio residents, aged 30 to 64, who were diagnosed with breast, cervical, lung or colon cancer between 2011 and 2016. All either had Medicaid or were uninsured.

On average, the study found, people diagnosed after Medicaid expansion were 15% less likely to be diagnosed with metastatic cancer, versus those diagnosed before.

That does not prove Medicaid expansion directly led to the reduction. But, Rose said, there was no similar decrease in metastatic cancer among people who remained uninsured.

And to create a "control" group, the researchers did a separate analysis of privately insured people living in higher-income Ohio communities. Again, there was no change in the odds of being diagnosed with metastatic cancer after 2014.

A decline of 15% might not sound large. But in this context, Rose said, it is.

"Bringing it down that much in three years is really remarkable," he said.

When it comes to catching cancer at earlier stages, "the gaps between the rich and the poor have been so stubborn for so long," Rose said.

"This is a rare bit of progress," he said.

It is a "major finding," agreed Dr. Hala Borno, an oncologist and assistant clinical professor at the University of California, San Francisco.

Borno, who wrote an editorial published with the study, said the results are "compelling." But she also pointed out that access to Medicaid -- or health insurance in general -- does not guarantee that people can afford needed care.

Health insurance, including some states' Medicaid programs, can come with hefty "cost-sharing" -- such as monthly premiums, deductibles and co-pays.

According to Borno, Ohio is one of only 21 states where Medicaid does not charge monthly premiums or enrollment fees. She said the current findings are relevant to those states where cost-sharing is not an issue, but that may not be true in other states.

Besides making sure all Americans have access to health care, Borno said, it's critical to ensure they have comprehensive coverage.

"Coverage for all is when people can actually obtain the health services they need with necessary financial risk protection," she said.

As of July 1, 38 states (including Washington, D.C.) have expanded their Medicaid programs under the ACA, according to the Kaiser Family Foundation.

The Washington Post
Democracy Dies in Darkness

Supreme Court says employers may opt out of Affordable Care Act's birth control mandate over religious, moral objections
Robert Barnes

The Supreme Court ruled Wednesday that the Trump administration may allow employers and universities to opt out of the Affordable Care Act requirement to provide contraceptive care because of religious or moral objections.

The issue has been at the heart of an intense legal battle for nine years — first with the Obama administration sparring with religious organizations who said offering contraceptive care to their employees violated their beliefs, and then with the Trump administration broadening an exemption, angering women's groups, health organizations and Democratic-led states.

Wednesday's decision greatly expands the ability of employers to claim the exception, and the government estimates that between 70,000 and 126,000 women could lose access to cost-free birth control as a result.

The decision was one of several that has made the Supreme Court's term strikingly successful for religious interests. By the same 7-to-2 vote as in the contraceptive cases, the court on Wednesday also ruled for the ability of religious organizations to hire and fire without offending some anti-discrimination laws.

And last week religious groups achieved a longtime goal when the court ruled that states that provide support to private education must allow religious schools to participate.

“It’s a big term,” said Mark Rienzi, president of the Becket Fund for Religious Liberty. And Wednesday’s decisions showed that “broad agreement for religious interests and religious diversity.”

The Supreme Court’s decisions will conclude Thursday with what could be a blockbuster decision abut whether President Trump may shield his private financial records and tax returns from congressional committees and a New York prosecutor.

It will be a fitting finale to a term in which the court has left few politically controversial topics untouched: It said federal law protects LGBTQ workers from discrimination, disappointed antiabortion activists and gun rights supporters, and stopped the Trump administration from ending the program that protects undocumented immigrants brought to the United States as children.

Supreme Court ruling on Trump’s tax returns, financial records to come next

The contraceptive case involves a long-running dispute over Obamacare, as the ACA is known, and a requirement that employers provide cost-free birth control for female employees. The law itself doesn’t specify the rules, leaving it to federal agencies to determine how contraceptives fit into the mandate for cost-free “preventive care and screenings.”

The Obama administration required contraceptives and had narrower exceptions for churches and other houses of worship. It created a system of “accommodations,” or workarounds, for religiously affiliated organizations such as hospitals and universities. Those accommodations would provide the contraceptive care but avoid having the objecting organizations directly cover the cost.

The Trump administration moved in 2018 to expand the types of organizations that could opt out to include religious groups and nonreligious employers with moral and religious objections.

Under the rules, the employers able to opt out include essentially all nongovernmental workplaces, from small businesses to Fortune 500 companies. And the employer has the choice of whether to permit the workaround. (Most companies are happy to provide birth control.)

The U.S. Court of Appeals for the 3rd Circuit had put the Trump administration exemptions on hold, and said the agencies didn’t have the broad authority to grant them.

Justice Clarence Thomas, who wrote the majority opinion, said that was wrong.

“We hold that the [administration] had the authority to provide exemptions from the regulatory contraceptive requirements for employers with religious and conscientious objections,” wrote Thomas, who was joined by Chief Justice John G. Roberts Jr. and Justices Samuel A. Alito Jr., Neil M. Gorsuch and Brett M. Kavanaugh.

Thomas reasoned that if an administration’s agencies have “virtually unbridled discretion to decide what counts as preventive care and screenings, he said, they must also have “the ability to identify and create exemptions” from those guidelines.

Liberal Justices Elena Kagan and Stephen G. Breyer agreed with the court’s conservatives that the administration had the right to create an exemption, but they said lower courts should examine whether the administration’s rules were “consistent with reasoned judgment.”

[Past coverage: Supreme Court struggles with Trump administration’s limits on birth control coverage]

Justice Ruth Bader Ginsburg issued a blistering dissent, in which she said her colleagues had gone too far to appease religious conservatives.

Until now, “this Court has taken a balanced approach, one that does not allow the religious beliefs of some to overwhelm the rights and interests of others who do not share those beliefs,” Ginsburg wrote in a brief joined by Justice Sonia Sotomayor.

“Today, for the first time, the Court casts totally aside countervailing rights and interests in its zeal to secure religious rights to the nth degree.”

Ginsburg said Congress meant to provide “gainfully employed women comprehensive, seamless, no-cost insurance coverage for preventive care protective of their health and wellbeing.”

The court’s action, she wrote, “leaves women workers to fend for themselves, to seek contraceptive coverage from sources other than their employer’s insurer, and, absent another available source of funding, to pay for contraceptive services out of their own pockets.”

Thomas countered that it was Congress that left the decisions up to federal agencies. “Contrary to the dissent’s protestations, it was Congress, not the departments, that declined to expressly require contraceptive coverage in the ACA itself.”

Reproductive rights groups were alarmed by the decision.

“The Supreme Court’s decision to allow the Trump administration to put control over people’s birth control in the hands of the whims of their bosses and employers is deplorable,” NARAL Pro-Choice America President Ilyse Hogue said in a statement. “This decision just further exposes that ultimately, the Radical Right is really about controlling women and our lives with no eye towards equality or public health and well being.”

Religious groups said the legal battles should stop.

In addition to the Trump administration, the Little Sisters of the Poor defended the rules. The order of nuns, which runs homes for the elderly and employs about 2,700 people, pointed out that the government provided exemptions from the beginning for religious organizations such as churches. It said the accommodation provision violates the 1993 Religious Freedom Restoration Act, the law that says the government must have a compelling reason for programs that substantially burden religious beliefs.

“We are overjoyed that, once again, the Supreme Court has protected our right to serve the elderly without violating our faith,” said Mother Loraine Marie Maguire of the Little Sisters of the Poor, whose employees work in the group’s facilities. “Our life’s work and great joy is serving the elderly poor and we are so grateful that the contraceptive mandate will no longer steal our attention from our calling.”

White House press secretary Kayleigh McEnany said in a statement that the decision was “a big win for religious freedom and freedom of conscience.”

“Since Day One, the Trump Administration has sought to lift burdens on religious exercise for people of all faiths,” she said, adding the administration would work to allow “women who lack access to contraceptive coverage because of their employer’s religious beliefs or moral convictions to more easily access such care” through federal programs.

The states of Pennsylvania and New Jersey initially challenged the rules, noting that when women lose coverage from their employers, they seek state-funded programs and services.

[Past coverage: Supreme Court sides with employers over birth control mandate]

While Thomas’s opinion leaned more heavily on administrative law than religious liberty, he praised the nuns who have been involved in challenging the mandate from the beginning.

“For over 150 years, the Little Sisters have engaged in faithful service and sacrifice, motivated by a religious calling to surrender all for the sake of their brother,” he wrote.

“. . . After two decisions from this court and multiple failed regulatory attempts, the federal government has arrived at a solution that exempts the Little Sisters from the source of their complicity-based concerns — the administratively imposed contraceptive mandate.”

But the legal fight might not be over.

In a concurring opinion, Alito and Gorsuch said the court had not gone far enough to settle the issue for good.

“We now send these cases back to the lower courts, where the Commonwealth of Pennsylvania and the State of New Jersey are all but certain to pursue their argument that the current rule is flawed on yet another ground,” Alito wrote.

He would have found that the religious exemption was not just authorized, but also required under the Religious Freedom Restoration Act.

“I would bring the Little Sisters’ legal odyssey to an end,” Alito wrote.

The cases are Little Sisters of the Poor v. Pennsylvania and Trump v. Pennsylvania.

Imagine a world with a COVID-19 pandemic and without the Affordable Care Act. Trump does.
Dr. David Blumenthal

If the Trump administration has its way, the Affordable Care Act will be gone long before COVID-19. Late last month, the Justice Department laid out its case for declaring the law unconstitutional and striking it down.

That raises the question, what would the COVID-19 pandemic look like in a post-ACA world?

To start, over 20 million Americans who are getting insurance through provisions in the ACA would lose their coverage. Uninsured Americans avoid getting care when they are

sick. In the age of COVID, that means their disease doesn’t get diagnosed, and they keep spreading it.

They suffer, and we suffer.

Imagine also that without the ACA, the newly uninsured would include more than 1.1 million people in Texas, 1.9 million in Florida and nearly 600,000 in Arizona — states experiencing record numbers of COVID-19 cases at this very moment. Clearly, some of those who lose coverage would be infected. Some might end up in intensive care units that are filling to bursting. Many of these will receive bills in the hundreds of thousands or millions of dollars that will drive them to bankruptcy, or burden them and their families with debt for decades to come.

Health and finances unprotected
People with health insurance would be in danger, too. Annual and lifetime limits on what insurers will pay would return. And for the many millions who have been infected and survived, any downstream complication of COVID-19 may become a preexisting condition that renders them uninsurable in the future. Why?

Because in the absence of ACA protections, insurance companies will be free, like they were before the law, to refuse to cover conditions that existed before individuals sought coverage.

There's more.

In the midst of the greatest economic crisis in a generation, hospitals and providers already suffering huge revenue losses will go back to providing care to the uninsured and knowing they will not be paid for it. Their uncompensated care burden could skyrocket 82%. This will further undermine the brave and nimble institutions and professionals who have been incurring huge additional expenses — more ICU beds, more personal protective equipment — and sacrificing lucrative elective procedures to cope with the pandemic.

More health care workers will be laid off, adding to the ranks of the unemployed.

A way forward:We can't wait for a COVID-19 vaccine. Test everyone now to help end the pandemic.

Rural hospitals will suffer disproportionately, as will those serving the poor and persons of color everywhere. Primary care providers, underpaid and scarce before the pandemic, will face further economic pressure. It will become harder for anyone — regardless of income or insurance status — to find a primary care clinician willing to

include them in their practice. This at a time when millions of Americans are eager for advice on what to do when they fear they have been exposed or have COVID-like symptoms, and don't want to take the risk of going to emergency departments buckling under the burden of the pandemic.

Why not strengthen care instead?
The ACA also made important investments in our public health system, one of our greatest weapons in fighting the pandemic, by increasing vital disease prevention efforts, supporting community health workers and shoring up local public health departments. Even so, public health officials are struggling to get ahead of the pandemic. Now is not the time to reconsider investments in public health.

What would be better for everyone in this country, and our health care system, would be for the administration to drop its support for this lawsuit and work with Congress to make American health care stronger — assuring everyone affordable coverage, protecting our vital hospitals and providers, and ensuring our public health system has everything it needs to combat COVID-19.

However, if the Trump administration wants to cripple the nation's ability to fight COVID-19, add to the suffering of the infected and undermine our health care system over the long term, it could hardly pick a better strategy than repealing the Affordable Care Act in the throes of the worst health care crisis the nation has faced since 1918.

Avalere: ACA's exchange enrollment could increase by 1M due to COVID-19 job losses
Robert King

The Affordable Care Act's (ACA's) insurance exchanges could add more than 1 million new members because of the COVID-19 pandemic.

The analysis, released Thursday by Avalere, attributes the spike to special enrollment due to massive job losses caused by COVID-19. The boost in customers could cause more insurers to return to a market they have left after financial losses over the past few years.

“With unemployment rates at or near 10% in almost all states, many consumers have been separated from their previous employer-sponsored plans,” the analysis said. “The economics of Medicaid eligibility in many states and the recent boost to unemployment assistance indicate that many are turning to the exchanges for coverage.”

RELATED: Biden-Sanders task force health platform pushes public option, a free COVID-19 vaccine

Currently, there are more than 750,000 new exchange enrollees that have signed up since the end of open enrollment.

A new report from federally run HealthCare.gov found 487,000 enrollees bought coverage since the close of open enrollment last December. The increase is 47% higher than the use of special enrollment periods at the same time in 2019.

A majority of state-run exchanges such as Colorado reopened enrollment as the pandemic caused businesses across the country to close.

Nearly 263,000 people signed up for coverage since March in the 12 states and Washington, D.C., that run their own exchanges.

Enrollment numbers have only been released for eight of the 12 exchanges so the total could be higher, Avalere said.

Avalere’s proprietary COVID-19 enrollment model also predicts the enrollment in the exchanges is going to last due to the availability of premium subsidies.

RELATED: House Dems unveil plan to bolster ACA

But Avalere cautioned that consumers should be aware that the most popular types of plans on the exchanges have fewer covered benefits and more limited drug formularies than employer-sponsored insurance.

“Even for individuals who are able to enroll in exchange coverage, the transition from employer-sponsored coverage to the exchanges is not seamless, and can have implications for access and affordability,” the analysis said.

The ACA exchanges have started to recover in terms of premium hikes and plan participation. Major insurers such as UnitedHealth who left the exchanges have announced they are expanding their presence again.

Bloomberg
NEWS

Obamacare Is All the More Essential During a Pandemic
Editorial Board

Obamacare is cushioning the fall for many Americans who have lost their health insurance, along with their jobs, in the coronavirus pandemic. Millions of the newly unemployed are eligible for premium subsidies if they buy individual policies on the marketplaces created under the Affordable Care Act. Millions more are eligible for Medicaid, which was expanded in most states under the ACA.

Thus, the law, now 10 years old, is demonstrating its ability to protect families during an economic crisis. Americans have grown fond of some of its other virtues as well — including provisions that require insurers to cover people with pre-existing health problems, not limit the amount of coverage they provide over a lifetime and allow young adults to remain on their parents' policies until they turn 26.

Add in that the law has shrunk the uninsured population by some 20 million, two-thirds of whom are now covered by Medicaid, and it's clear that the House of Representatives was right to pass legislation last month to reinforce the system.

Unfortunately, President Donald Trump is taking the opposite tack. His administration is urging the Supreme Court to strike down the law altogether over a dubious technicality having to do with Congress's action, in 2017, to eliminate a tax penalty for going without health insurance. If Trump were to succeed, Americans without employer health insurance would be left with few options, millions of Medicaid recipients would lose coverage and people with pre-existing conditions — now including Covid-19 — might not be able to find affordable alternatives. Nor has the administration proposed any replacement for the law; its plan is to wait and see what the court decides and then, if necessary, throw together something new — a challenge that has perpetually eluded Republicans.

Heading into an election at a time of such extraordinary insecurity, the Republican-led Senate would be wise to reconsider its intention to ignore the House bill.

The legislation would address a number of weaknesses in Obamacare that have become obvious over its first 10 years — including excessive premiums for individual insurance policies sold on its exchanges. Monthly payments have proved unaffordable for many families whose household incomes exceed the threshold for premium tax

credits. The House bill would do away with that ceiling — currently set at 400% of the federal poverty line — and instead subsidize all families and individuals so that no one spends more than 8.5% of their income on premiums.

The bill would also fix the so-called family glitch, a provision that prevents families from receiving subsidies if any member can get individual insurance from his or her employer costing no more than 9.5% of household income. The new rule would measure affordability by the employee's cost for family coverage, making some 6 million more people eligible for premium tax credits.

Experience has shown, too, that states with their own exchanges enroll more people than do those that rely on HealthCare.gov, the federal marketplace. The legislation would provide $200 million a year to create new state exchanges, plus another $100 million annually to assist the uninsured in signing up. It also offers $10 billion a year to help states either create reinsurance programs to protect insurers from the most expensive claims, or to further subsidize people who buy individual or family policies.

Crucially, the bill would reverse or prevent various bits of Trump administration mischief that stand to weaken the ACA: It would, for instance, block a rule that would allow "short-term" insurance policies (which don't meet ACA guidelines) to last three years rather than just three months, and prevent another change that would permit states to provide tax credits for plans that don't comply with the law's standards.

The legislation now goes to the Senate, where Republican leaders are prepared to ignore it. They've been entirely consistent in their refusal to the support the ACA — and in their unwillingness to offer a good alternative. It would be smarter, during a pandemic, to finally recognize how vital a safety net Obamacare has become.

THE WALL STREET JOURNAL.
WSJ

Taxpayers Race to File Refund Claims if Obamacare Is Struck Down
Laura Saunders

Taxpayers and their advisers are rushing to file claims for refunds of 2016 taxes in case the Affordable Care Act, often known as Obamacare, is struck down. For many higher earners who could benefit, the deadline to file such claims is Wednesday.

The rush is occurring because the Supreme Court will consider whether to invalidate the ACA in its next term. The decision probably won't come before Election Day.

"These refunds are a long shot. But you never know what will happen, and putting in the request is worth a small amount of time and postage," says David Lifson, a certified public accountant with Crowe who advises high-net-worth clients. He expects the firm to file hundreds of refund claims for its clients.

If the court does strike down the ACA, the decision could also invalidate two taxes on higher-income people that were enacted as part of the law to help fund it. One is the net investment income tax, a 3.8% surtax on capital gains, dividends and similar income. The other is a 0.9% increase in their Medicare tax rate. The threshold for both levies is income of $200,000 for most single filers and $250,000 for most married filers.

If these two taxes are struck down along with the ACA, then filers who paid them could ask the Internal Revenue Service for refunds, as long as a three-year statute of limitations hasn't expired. In 2016, nearly four million tax filers owed $15.8 billion due to the 3.8% surtax.

For most taxpayers who filed tax year 2016 returns by the April 18, 2017, due date, the statute of limitations for requesting refunds expires July 15, 2020, because of the three-month pandemic extension.

For those who got six-month filing extensions for 2016, the deadline is normally three years from the date they filed. So if a taxpayer with an extension for 2016 filed a return by Aug. 15, 2017, the deadline for a refund request would be Aug. 15, 2020.

However, taxpayers can file a "protective" refund claim that extends the statute if it is about to expire and a law is in question—as is the case with the ACA. This enables them to request refunds after a statute has expired, if they have filed a protective claim by the deadline.

While some tax advisers are filing protective claims for clients, others are providing clients with a template form they can file themselves. Andrew C. Levine, a tax attorney in Poughkeepsie, N.Y., says he has sent such forms to more than 100 clients.

The Taxpayer Advocate Service's website lists the requirements for a valid protective claim.

The request doesn't have to give a dollar amount or ask for an immediate refund. But it must be signed, and it must include the taxpayer's name and address, Social Security

number or taxpayer ID number and the specific year for which the refund may be sought. It must also explain why the taxpayer is making the claim.

Mr. Levine notes that the protective claim must be postmarked by the deadline, although the IRS doesn't have to receive it by that date, and recommends getting and saving a proof of mailing.

Los Angeles Times

As millions lose health insurance, Trump administration offers little help
Noam N. Levey

WASHINGTON — As millions of people lose jobs in the coronavirus outbreak, jeopardizing their health benefits, the Trump administration and many states are doing little if anything to connect Americans with other insurance coverage.
The U.S. Health and Human Services Department hasn't launched any special effort to publicize the availability of Medicaid, the Children's Health Insurance Program or health plans being sold on marketplaces created by the Affordable Care Act.

And federal officials haven't made any substantial new commitment of money for outreach or to help people enroll in coverage.

In California and 11 other states that operate their own insurance marketplaces, state governments have created special enrollment periods to give people more time to enroll in health coverage during the pandemic.

But patient advocates around the country say many state governments have been largely silent, as well, leaving nonprofit groups, health clinics that serve poor patients and others scrambling to get the word out to people losing health insurance in the outbreak.

"People are really struggling, but there is virtually no communication," said Jodi Ray, project director of Florida Covering Kids & Families, which works to expand health coverage in the state.

In Texas, which already has the nation's highest uninsured rate and is now suffering one of the worst outbreaks, advocates are becoming increasingly concerned that growing numbers of people are falling through the cracks.

“There is a desperate need for strong, consistent consumer information,” said Anne Dunkelberg, associate director of Every Texan, a longtime advocate for strengthening the state’s safety net.

The Assn. for Community Affiliated Plans, a trade group representing health insurers, was so concerned about inaction by the Trump administration that it launched its own advertising campaign last month to direct people to online marketplaces.

“Tens of millions of people have lost employer-based coverage, but federal agencies aren’t helping to lead people to the best resources available: the state and federal insurance marketplaces,” said Margaret A. Murray, the group’s chief executive.

A spokesman for the federal Centers for Medicare and Medicaid Services, or CMS, which oversees government health plans, noted that the federal HealthCare.gov marketplace allows people to enroll in coverage if they lose their job-based benefits, but the spokesman did not identify any significant new initiatives to help people affected by the coronavirus pandemic. .

The full count of how many people have lost coverage isn’t yet known, though some estimates put the number in the millions.

The weak federal effort to confront those coverage losses marks a notable departure from the last economic downturn in 2009. At that point, the Obama administration backed nationwide efforts to help states stem the loss of health coverage.

The Trump administration has taken a different approach to the safety net, calling repeatedly in White House budgets for large cuts to Medicaid and backing legal and legislative efforts to eliminate the Affordable Care Act, commonly called Obamacare.

The latest legal challenge to the health law is to be considered by the Supreme Court this fall. The administration has asked the court for a ruling that would eliminate coverage for tens of millions of Americans.

Shortly after Trump took office, the administration cut funds to help people enroll in marketplace coverage through the law.

Administration officials, led by CMS administrator Seema Verma, have strongly backed efforts by conservative states to restrict access to Medicaid, including by imposing work requirements. Federal courts have blocked work requirements, deeming them inconsistent with Medicaid’s purpose of providing health coverage, but Tuesday, the administration asked the Supreme Court to reverse that.

“CMS’ political agenda over the last few years has been to create barriers to Medicaid coverage,” said Joan Alker, director of the Georgetown Center for Children and Families. “It comes as no surprise that we see no national effort to inform families of their public coverage options.”

Under different circumstances, a national emergency like the pandemic might have caused federal officials to reconsider, said Larry Levitt, executive vice president of the nonprofit Kaiser Family Foundation, which studies U.S. health policy.

“You would have expected big outreach campaigns, public service ads and efforts to help people sign up,” Levitt said. “But because the Affordable Care Act remains such a political football, what you’d normally think would be good government simply isn’t happening.”

The number of people who have lost coverage is uncertain in part because many who are out of work likely have found ways to retain coverage. Some may have switched onto a spouse’s health plan. Others may have found their own way to Medicaid or a subsidized health plan on an insurance marketplace created by the 2010 health law.

Fred Ammons, executive director of Community Health Works, which helps uninsured Georgians find coverage, said many people who have called during the pandemic are already familiar with government health insurance options, perhaps because employers are sharing the information.

But Ammons warned that limited resources to educate the newly unemployed will likely hamper efforts to reach the newly uninsured, many of whom may not realize that government assistance may be available.

“Whenever you have a major downturn in the economy, you have people who don’t have prior experience with public programs,” said Cindy Mann, who oversaw Medicaid and the Children’s Health Insurance Program, or CHIP, in the Obama administration.

That is one reason why Congress and the Obama administration in 2009 provided states with additional funding to do outreach for CHIP, a government health plan for the children of working parents who make too much to qualify for Medicaid but not enough to afford commercial insurance.

“There was an understanding that even if you build it, they may not come,” said Donna Cohen Ross, who oversaw the 2009 outreach effort.

Today, some states with Democratic governors are following the same playbook, stepping up efforts to ensure that residents who lose job-based coverage can find other options.

Covered California, in addition to creating a special enrollment period during the coronavirus outbreak, has also boosted advertising by $3 million a month and is working with the state employment agency so every unemployment check sent to an out-of-work Californian includes information about enrolling in Covered California or in Medi-Cal, the state Medicaid program.

“People need to be encouraged and nudged and informed about how to take care of themselves,” said Covered California director Peter Lee, noting that this strategy not only helps protect people but also brings in younger, healthier customers who, in turn, help keep premiums in check.

The state’s marketplace is planning even more marketing and outreach next year, Lee said.

REUTERS

Obamacare bars discrimination through health benefits design - 9th Circuit
Nate Raymond

A federal appeals court on Tuesday ruled that the Affordable Care Act’s anti-discrimination clause prohibits disability discrimination in how insurers such as Kaiser Permanente design the health benefits they include in their plans.

The 9th U.S. Circuit Court of Appeals revived a proposed class action alleging that Kaiser violated the ACA’s anti-discrimination clause by excluding all hearing loss treatment except for cochlear implants.

Court backs Trump expansion of cheap health insurance plans
Nate Raymond

WASHINGTON (AP) — A divided federal appeals court on Friday upheld the Trump administration's expansion of cheaper short-term health insurance plans, derided by critics as "junk insurance," as an alternative to the Affordable Care Act's costlier comprehensive insurance.

The U.S. Court of Appeals for the District of Columbia Circuit said in a 2-1 decision that the administration had the legal authority to increase the duration of the health plans from three to 12 months, with the option of renewing them for 36 months. The plans do not have to cover people with preexisting conditions or provide basic benefits like prescription drugs.

President Donald Trump, who wants to get rid of the entire health care law but failed to repeal it in Congress, has praised the plans as "much less expensive health care at a much lower price."

House Speaker Nancy Pelosi said the decision would allow the administration to "keep railroading vulnerable families into shoddy junk health insurance plans."

Judge Thomas Griffith wrote for the court that the administration lifted the three-month cap put in place by the Obama administration because "premiums for ACA-compliant plans continued to soar while enrollment dropped off."

The goal was to increase "the availability of more affordable insurance," Griffith wrote, in an opinion that was joined by Judge Greg Katsas. Griffith is a George H.W. Bush appointee, and Katsas was put on the court by Trump.

In dissent, Judge Judith Rogers wrote that insurers offering the short-term plans "can cut costs by denying basic benefits, price discriminating based on age and health status, and refusing coverage to older individuals and those with preexisting conditions." The plans "leave enrollees without benefits that Congress deemed essential and disproportionately draw young, healthy individuals," making ACA plans more expensive, wrote Rogers, an appointee of President Bill Clinton.

The Association for Community and Affiliated Plans, an insurer group that sued the administration, said it would appeal to the full appeals court.

“Junk insurance is an inferior and hazardous substitute for comprehensive coverage. The court’s decision today protects these plans and their harmful practices, placing patients, families, and providers at increased risk amidst a global health emergency,” the group’s CEO, Margaret A. Murray, said in a statement.

Premiums in the short-term plans are one-third the cost of comprehensive coverage, and the option is geared to people who want an individual health insurance policy but make too much money to qualify for subsidies under Obamacare.

Short-term plans have been a niche product for people in life transitions: those switching jobs, retiring before Medicare eligibility or aging out of parental coverage.

Obama, in discussion with Biden, says he 'couldn't be prouder' of ObamaCare
Tyler Olson, Madeleine Rivera

Former President Barack Obama, in a clip from a discussion with his former Vice President Joe Biden released Thursday morning by Biden's presidential campaign, says that he "couldn't be prouder" of the Affordable Care Act and that "20 million people have health insurance that didn't because of what we did."

The campaign had previously released other segments from the discussion between the former Democratic president and the current presumptive Democratic nominee for president. The entire video will be released later Thursday morning.

"I mean, you and I both know what it's like to have somebody you love get really sick. And in some cases to lose somebody, but that loss is compounded when you see the stress on their faces, because they're worried that they're being a burden on their families," Obama said while talking about his signature health care legislation known as ObamaCare, which Biden has run on and promised to expand, including a public option.

Obama added: "They're worried about whether the insurance is gonna cover the treatments that they need. I couldn't be prouder of what we got done, 20 million people have health insurance that didn't have it because of what we did."

Biden, in the clip, also talks about the death of his son and says it made him reflect on the importance of some of the protections in the law.

"I used to sit there and watch him in the bed and in pain and dying of glioblastoma, I thought to myself, what would happen if his insurance company was able to come in, which they could have done before we passed ObamaCare and said, you have outrun your insurance, you've outlived it?" Biden said. "Suffer the last five months in peace, you're on your own... It was so profound an impact on people."

The Trump campaign ripped into Biden over the video.

“Even the former president’s half-hearted, scripted praise can’t cover-up Joe Biden’s nearly 50-year long legacy of failure," said Hogan Gidley, a Trump campaign spokesman. "Biden’s half-century in Washington has been mired in controversy and failed socialist policies that don’t reflect our values, while in just three years, President Trump has provided every day, hard-working Americans with real success and more opportunities to reach their American Dream.”

The Biden campaign, in a statement on the video, called "passing the Affordable Care Act and expanding health care to more than 23 million Americans" one of Obama and Biden's "greatest accomplishments."

The ACA is currently facing a legal challenge over its constitutionality by a coalition of Republican-leaning states, which is backed by the Trump administration. The Supreme Court will hear the challenge in its upcoming term. The Trump administration has said that whatever the outcome of the challenge, it will ensure that people with preexisting conditions are protected when buying health insurance. But the Biden campaign has nevertheless attacked Trump for ostensibly trying to overturn the law, which provides those protections now.

"I think it’s cruel, it’s heartless, it’s callous,” Biden said of Trump’s attempts to dismantle ObamaCare at a campaign event in June, just hours before the Trump administration filed a brief with the Supreme Court arguing that it should be overturned. "It’s all because in my view he can’t abide the thought of letting stand one of President Obama’s great achievements."

That brief, however, argued that because there is no longer a financial penalty for not having insurance, the individual mandate incorporated in the law can no longer be read as a tax, which saved the law from being struck down in a previous Supreme Court challenge. The Trump administration further said that because of how integral the individual mandate was to the law's design, the rest of it cannot be allowed to stand if the current form is declared unconstitutional.

"The individual mandate cannot be severed from the remainder of the ACA. Congressional findings incorporated into the ACA’s text clearly indicate that Congress would not have adopted the guaranteed-issue and community-rating provisions absent the individual mandate’s requirement to purchase insurance," the June brief said.

Modern Healthcare

Feds ordered to pay $3.7B in ACA funds following Supreme Court ruling
Shelby Livingston

The U.S. Court of Federal Claims has issued judgments of $3.7 billion for health insurers involved in two class actions over the federal government's failure to pay funds owed under a now-expired Affordable Care Act program.

The judgments issued late Thursday come after the U.S. Supreme Court ruled in April that insurers were owed more than $12 billion in ACA risk-corridor payments. After that ruling, the lower courts worked on resolving the dozens of pending lawsuits, including the two class actions.

Now, more than four years since the first risk-corridor lawsuits were filed, lower court judgments and agreements between the insurers and the U.S. Department of Justice have accounted for $9.6 billion of the $12.2 billion in unpaid risk-corridor funds, according to Katie Keith, a Georgetown University law professor who tracks ACA litigation.

Once an insurer obtains a judgment, the HHS can ask the U.S. Treasury Department for payment from the Judgment Fund, she said. It is unclear how long that process will take.

The ACA risk-corridor program was created to keep insurance premiums stable by protecting insurers from significant financial losses during the first three years of the public insurance exchanges. The government would collect payments from insurers that did well and distribute payments to those with high losses.

But the government did not pay the full amount, arguing that Congress erased its obligation by passing appropriations riders that effectively made the program budget neutral. It also argued that funds were not appropriated for the risk-corridor program beyond what it collected from profitable health plans. The Supreme Court disagreed and found that the federal government was obligated to pay up.

The government subsequently asked for a delay in some cases, prompting speculation that it might try to recoup some of the risk corridor payments owed. But in large part, the cases have been resolved quickly without much dispute over the amounts.

On Thursday, the Court of Federal Claims ordered the U.S. government to fork over about $1.9 billion in unpaid risk corridor funds for 2014 and 2015, largely settling a class action led by Health Republic Insurance. It also ordered the government to pay $1.8 billion in unpaid funds for 2016 to resolve the class action led by Common Ground Health Cooperative. In each class action, a handful of insurers' payments are still in dispute.

Earlier this month, the court also entered judgments in the lawsuits of four other insurers that were the subject of the Supreme Court litigation— Blue Cross and Blue Shield of North Carolina, Land of Lincoln, Maine Community Health Options, and Moda Health Plan. Beyond those, dozens of other lawsuits have been resolved, though some are still pending. New cases are also being filed.

Legal and insurance experts have said the payments are unlikely to benefit health plan members in the form of lower premiums or rebates under the ACA medical loss ratio rule, which requires insurers to spend a specific portion of premium revenue on medical care and quality improvement.

Moreover, some of the insurers, including most of the health insurance cooperatives created under the ACA, that sued to recover the payments have shuttered. In at least two cases, litigation funding firms and other investors bought insurers' recoveries from the lawsuits.

KFF
HENRY J KAISER
FAMILY FOUNDATION

KFF Health Tracking Poll – July 2020 – Politics
Liz Hamel, Audrey Kearney, Ashley Kirzinger, Lunna Lopes, Cailey Muñana, and Mollyann Brodie

- Less than four months before the 2020 presidential election, the latest KFF Health Tracking Poll finds President Trump receiving his lowest ratings ever from voters on his handling of the coronavirus outbreak. President Trump still garners majority support from Republican voters on all key issues.
- With the number of coronavirus cases in the U.S. now exceeding 4 million people, nearly twice as many voters give President Trump negative marks on his handling of this issue as give him positive marks (61% v. 35%).
- The July poll also explores how two key groups of voters for the 2020 election (swing voters and Electoral College battleground voters) view the job President Trump is doing. About half of these voters approve of President Trump’s handling of the U.S. economy, but similar to overall voters, they disapprove of his handling of other issues.

- President Trump also receives low marks on his handling of health care and the Affordable Care Act, the 2010 health care law which the Trump administration is currently challenging in court. About one-third of voters say they approve of the president's handling of health care generally (35%) and the Affordable Care Act specifically (33%). Partisans have very different views on President Trump's handling on both of these issues with most Democrats disapproving while majorities of Republicans approving.
- The public's views of the Affordable Care Act have largely remained unchanged over the course of the coronavirus pandemic, with half of the public continuing to view the law favorably. There are strong partisan differences in how the public views both the ACA and the pending Supreme Court case challenging the legality of the 2010 law, with Republicans overwhelmingly wanting to see the law overturned while most Democrats want to see the ACA remain in place and largely disapprove of recent Trump administration actions challenging the law.

The 2020 Election

Four months out from 2020 election, voters give President Trump negative ratings on his overall job approval as well as his handling of key issues that will likely decide the election President Trump also now garners his lowest net approval on the handling of the coronavirus outbreak in the U.S. since KFF began polling on the topic. One-third (35%) of voters approve of his handling of the coronavirus outbreak in the U.S. while six in ten (61%) voters disapprove (net approval of -26 percentage points). President Trump also receives negative ratings on his handling of health care more broadly (net approval of -21 percentage points) as well as his handling of the Affordable Care Act (net approval of -21 percentage points). While President Trump had previously received positive marks on his handling of the economy, voters are now split with 47% approving of his handling of the nation's economy, and 50% disapproving (resulting in a negative net approval—approval minus disapproval—of -3 percentage points). Overall, four in ten voters (41%) approve of how President Trump is handling his job as president while a majority disapprove (56%).

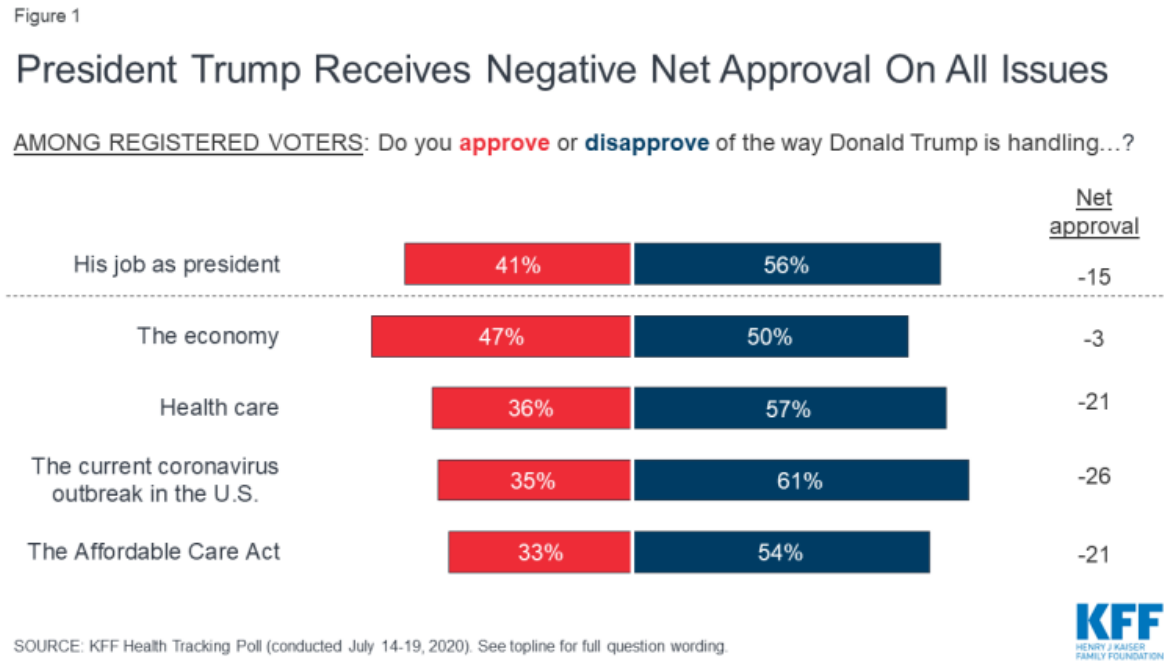


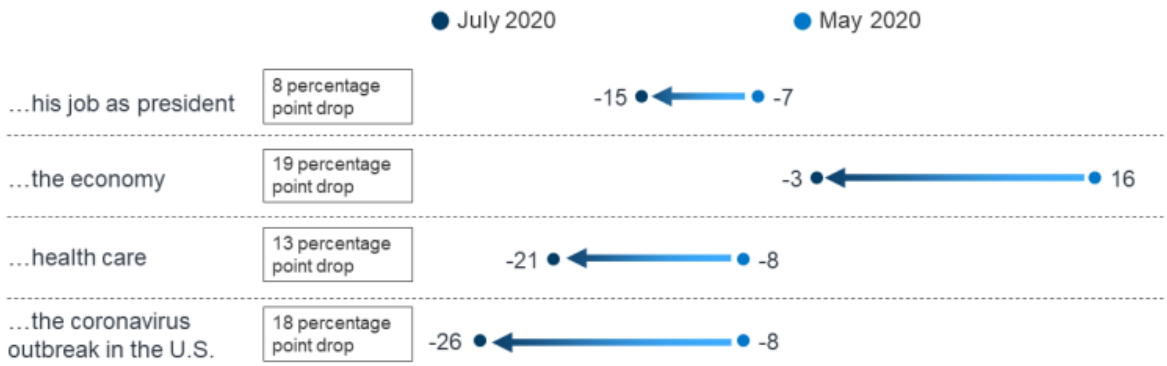
Figure 1: President Trump Receives Negative Net Approval On All Issues

Voters' attitudes on President Trump's handling of both the economy and the coronavirus outbreak have dropped sharply since May 2020. The latest KFF Health Tracking Poll finds President Trump's overall net approval on these two key issues has dropped nearly 20 percentage points over the course of the summer (economy: 19 percentage point drop in net approval; coronavirus: 18 percentage point drop in net approval).

Figure 2

President Trump's Job Approval Drops Across Key 2020 Issues

AMONG REGISTERED VOTERS: President Trump **net approval** on his handling of…



SOURCE: KFF Health Tracking Polls. See topline for full question wording.

KFF
HENRY J KAISER FAMILY FOUNDATION

2020 Voters to Watch: Swing Voters

Swing voters, a crucial group of voters who have not yet decided which candidate they will vote for in November, are also negative in their assessments of President Trump's presidency and his handling of most national issues – but remain positive in their assessment of his handling of the economy. Swing voters (who comprise 29% of all voters) largely disapprove (57%) of the way President Trump is handling his job overall and are also negative in Trump's handling of both the coronavirus outbreak (66% disapprove) and health care (58% disapprove).

Defining Swing Voters

When asked about their intentions for the upcoming election, voters say they are either "definitely going to vote for President Trump" (30%), or "definitely going to vote for Joe Biden" (36%), while about three in ten voters either say they are undecided in their 2020 vote choice (8%), don't know yet who they will vote for (2%), or are probably going to vote for President Trump (8%) or Democratic nominee Joe Biden (11%) but have not made up their minds yet.

Swing voters are more positive in views of how President Trump is handling the economy, but at a smaller margin than their assessments in May, with a net approval of +5 percentage points compared to +19 percentage point net approval in May. Swing voters' assessments of Trump's handling of health care and the coronavirus outbreak have also become more negative, with the assessments of the president's handling of

health care down 8 net percentage points, and the current coronavirus outbreak down 14 net percentage points.

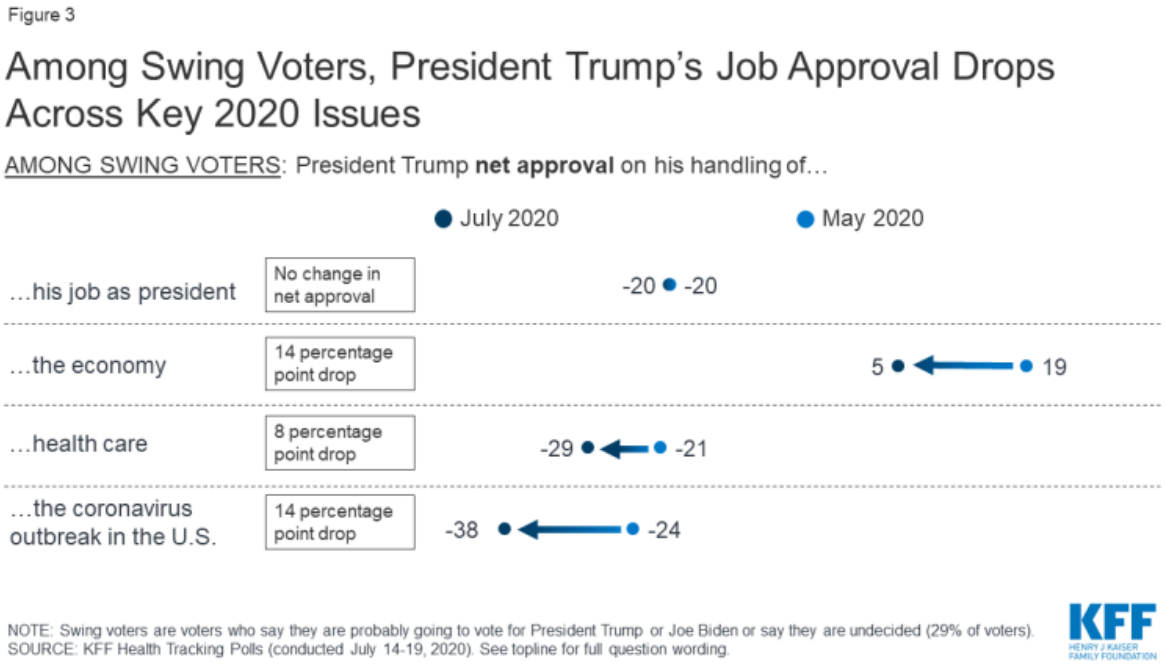


Figure 3: Among Swing Voters, President Trump's Job Approval Drops Across Key 2020 Issues

2020 Voters to Watch: Electoral College Battleground Voters

Another important group of voters to watch in 2020 are voters living in states where the election outcome is less predictable. The attitudes of these Electoral College battleground voters will be important in the upcoming election, as their states and districts are likely to swing the Electoral College towards President Trump or Joe Biden.[1] This group of voters, representing 38% of all voters, are evenly split in their party preferences, with three in ten saying they are Democrats, Republicans and Independents (31%, 30% and 31% respectively).

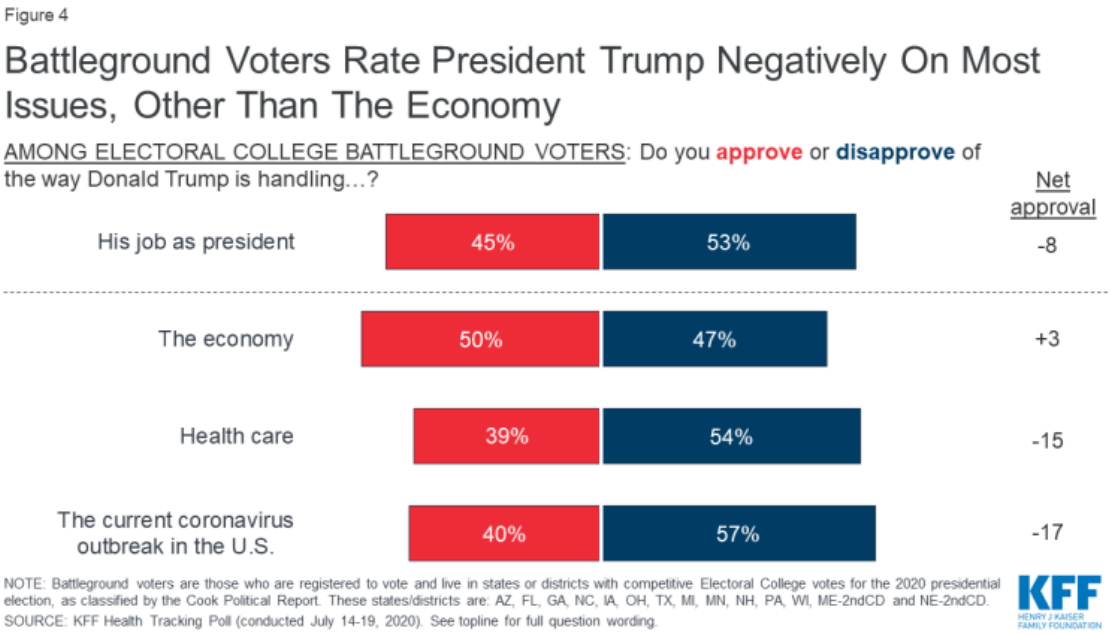


Figure 4: Battleground Voters Rate President Trump Negatively On Most Issues, Other Than The Economy

President Trump fares slightly better with these battleground voters on all key issues. Half of these voters approve of President Trump's handling of the economy and 45% say they approve of his handling of his job as president. But similar to the views of all voters and swing voters, President Trump fares slightly worse on his handling of health care and the coronavirus outbreak in the U.S.. Partisan voters in these battleground states and districts fall largely along the same party lines in their evaluations of President Trump, as partisan voters overall.

The Affordable Care Act

The public's attitudes towards the 2010 Affordable Care Act (ACA) have remained relatively unchanged over the past 5 months, with half (51%) now saying they hold a favorable opinion of the law, while 36% hold an unfavorable view.

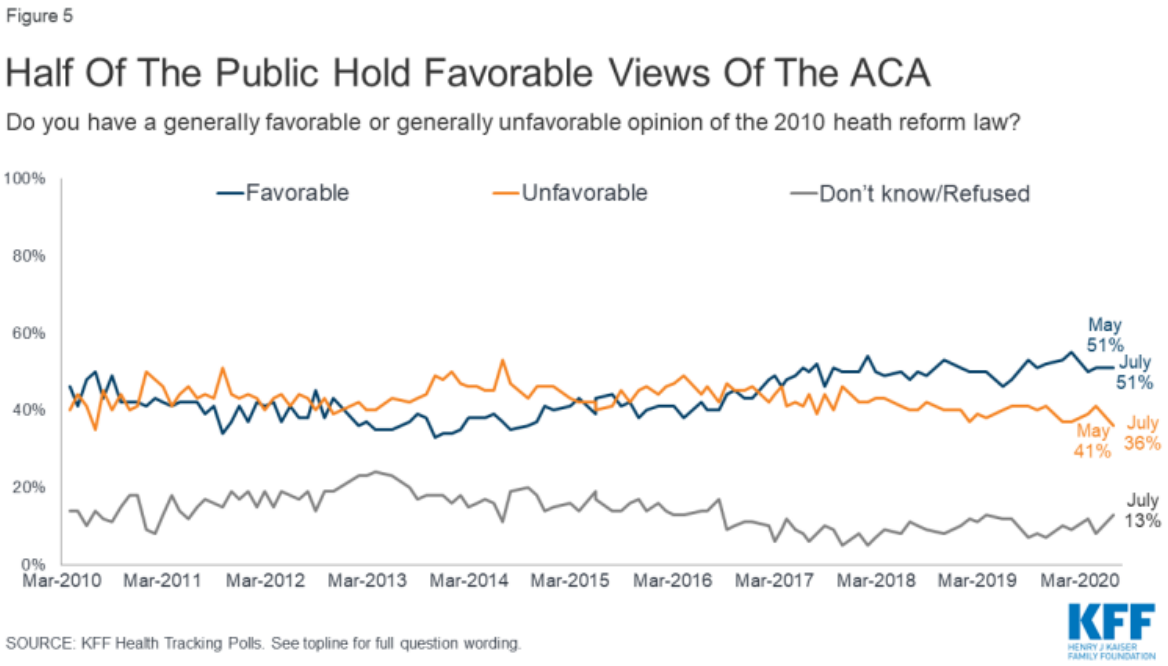


Figure 5: Half Of The Public Hold Favorable Views Of The ACA

Partisans continue to hold different views of the ACA, with about eight in ten Democrats (79%) holding favorable views while seven in ten Republicans (72%) view the law unfavorably. Half of independents hold favorable views (51%) while a smaller share (35%) say they view the law unfavorably.

On June 25th, 2020, the Trump administration issued a brief asking the U.S. Supreme Court to overturn the entire Affordable Care Act. The brief was filed in support of an ongoing challenge to the ACA by a group of Republican attorneys general in California v. Texas, a case that challenges the legality of the ACA in light of the zeroing out of the individual mandate penalty in the 2017 Tax Cuts and Job Acts. While there is a possibility that the case may be heard in the days leading up to the 2020 election, no opinion is expected to be issued until 2021.

Republicans largely approve (77%) of the Trump administration's actions, while the vast majority of Democrats (91%) as well as more than half of independents (55%) disapprove of the Trump administration asking the Supreme Court to overturn the ACA.

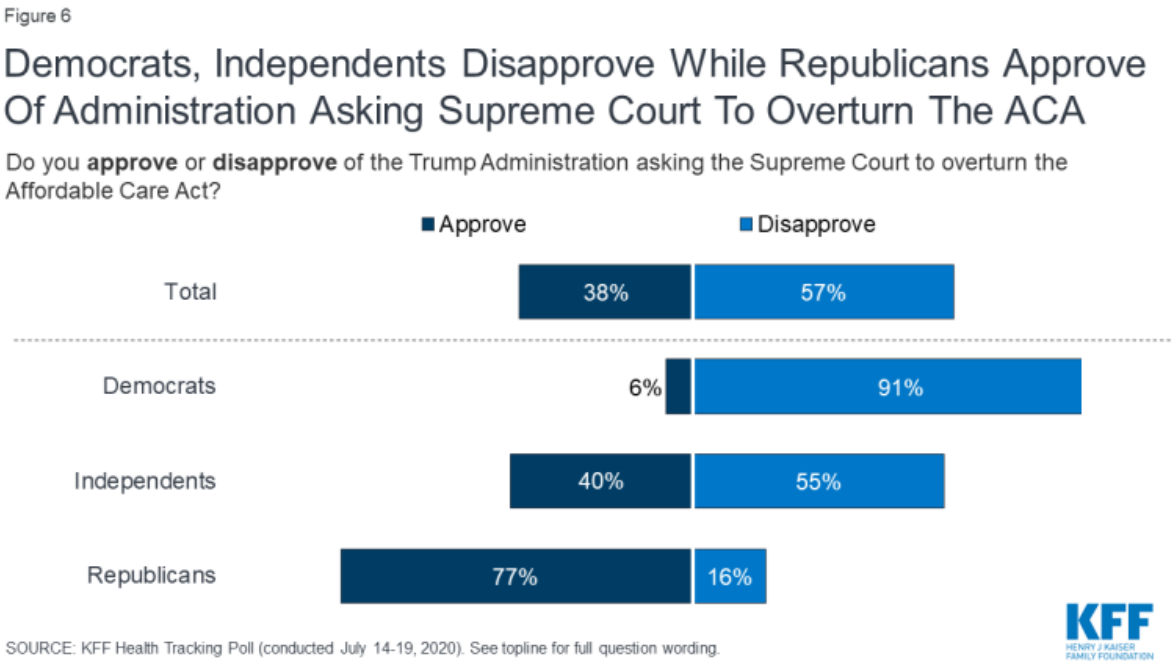


Figure 6: Democrats, Independents Disapprove While Republicans Approve Of Administration Asking Supreme Court To Overturn The ACA

If the Supreme Court sides with the Trump administration and the coalition of Republican attorneys general, all or parts of the 2010 Affordable Care Act would no longer be the law of the land. About half (53%) of the public *do not want* to see the ACA overturned by the Supreme Court while four in ten (38%) say they want to see the law overturned. Once again, attitudes are largely partisan with eight in ten Democrats (82%) and half of independents (51%) not wanting the law overturned, while seven in ten Republicans say the Supreme Court should overturn the 2010 health care law. Previous KFF polling has found that majorities across partisans want many of the ACA's protections to remain in place.

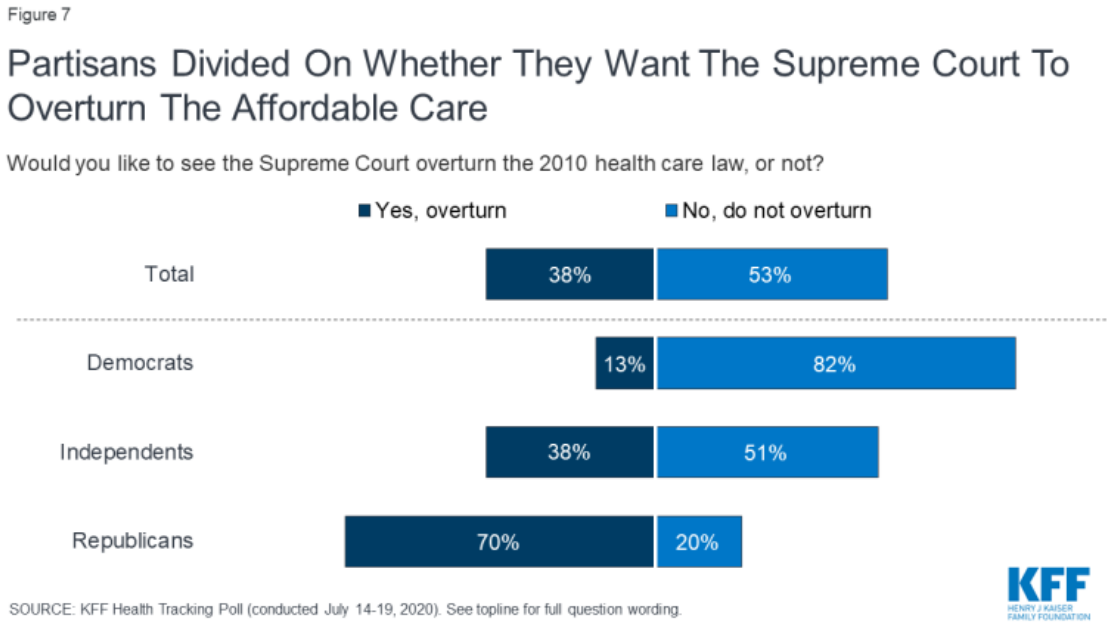


Figure 7: Partisans Divided On Whether They Want The Supreme Court To Overturn The Affordable Care Act

Bloomberg LAW

HHS Refusal to Reopen Exchanges for Covid Irrational, City Says
Mary Anne Pazanowski

The Health and Human Services Department's refusal to open a special enrollment period for people to buy health insurance on federally operated Obamacare exchanges during the Covid-19 pandemic must be set aside, Chicago told a federal court in Washington.

HHS's administrative record reveals that it didn't try to estimate how many people might benefit from reopening the enrollment period or determine how an SEP could help them, health-care providers, or the general public, the city said Monday in a brief urging the U.S. District Court for the District of Columbia to enter a pretrial judgment declaring HHS acted arbitrarily and irrationally.

Instead, the agency offered an after-the-fact explanation from a federal official who said HHS reasonably concluded the Covid-19 pandemic doesn't present "exceptional

circumstances" justifying an SEP. That explanation relied on documents and evidence produced long after the agency reached its decision, Chicago said.

HHS's determination, moreover, adds words to the ACA, the city said. It's also unreasonable, given how many Americans have contracted and died from the disease, it said.

The agency's argument that it hasn't yet reached a final decision on whether to open an SEP also must be rejected, the city said. HHS's March decision "definitively rejected" an SEP, it said. The idea that HHS might revisit the question in the future is "legally irrelevant," it added.

Chicago also disputed HHS's argument that it lacks standing to bring the case. The city has shown it has and will continue to suffer injury by having to cover the cost of health care for residents unable to access health insurance through the exchange, it said.

Chicago's brief argues against HHS's attempt to dismiss a June complaint in which it claimed the agency should have used an Affordable Care Act provision that allows it to reopen the period for buying health insurance on federally operated exchanges when there are extraordinary circumstances.

An SEP would allow people to buy insurance that will pay for coronavirus testing and treatment, thus alleviating fears of high medical bills, Chicago said. State exchanges already have offered SEPs, it pointed out.

Chicago alleged the agency's decision is purely political and stems from President Donald Trump's fear of "propping up the ACA."

Democracy Forward Foundation and the Chicago Law Department represent the city. The U.S. Department of Justice represents HHS.

Forbes

Oscar Health To Expand Obamacare To 19 New Markets In 2021
Bruce Japsen

Oscar Health is expanding its health insurance products into four new states and 19 new markets to sell coverage for individuals and families in 2021.

The move announced Thursday into new cities and states marks the fourth consecutive year Oscar is expanding into new markets and comes as health insurance companies in the individual business brace for an influx of new customers losing their employer coverage during the Covid-19 pandemic. Oscar's niche has long been the individual

market of Americans signing up for Obamacare coverage sold under the Affordable Care Act, which is expected to become more attractive for 2021 amid the recession and the surge of cases of the Coronavirus strain Covid-19.

“The pandemic in different ways has made this more meaningful for us,” Oscar Health chief executive officer and co-founder Mario Schlosser said in an interview. “There are a lot of ways we can help members.”

For the first time, Oscar said it will offer “individual & family plans” in the Arkansas markets of Little Rock and Fayetteville; the North Carolina market of Asheville; Oklahoma City; and five markets in Iowa that include Des Moines, Sioux City, Cedar Rapids, Waterloo and Dubuque.

Oscar currently sells individual Obamacare coverage in 29 markets in 15 states. Oscar now has about 420,000 health plan enrollees across the country that includes about 400,000 in individual plans, about 18,700 in small group plans and another 1,600 in Medicare Advantage plans, a business the company entered in the last year.

As Americans have lost their jobs or health benefits from employers that has helped health plans like Oscar that sell individual coverage. “By the end of this year, we will be up 3% to 5% in members (over expectations),” Schlosser said, referring to people who signed up for coverage during “special enrollment” periods after they lost their employer or other health benefits.

With budget-conscious Americans in mind, Oscar is also rolling out its new “$0 Virtual Primary Care product” to a total of 10 markets in 2021 in five states: Texas, Florida, California, New York and Colorado where about 75% of Oscar’s total health plan members live.

The new offering means these Oscar health plan members will get “unlimited, free primary care visits with their virtual doctors,” the company said. The no-cost coverage will also include certain prescriptions, durable medical equipment, lab tests, diagnostic imaging orders and initial specialist referrals prescribed by an Oscar primary care provider, executives said.

“You can pick a primary care physician in the cloud and the care that that physician triggers . . . that downstream care will also be free,” Schlosser said of the New $0 Virtual Primary Care product.

The Washington Post
Democracy Dies in Darkness

Trump keeps promising an overhaul of the nation's health-care system that never arrives

Anne Gearan, Amy Goldstein and Seung Min Kim

It was a bold claim when President Trump said that he was about to produce an overhaul of the nation's health-care system, at last doing away with the Affordable Care Act, which he has long promised to abolish.

"We're signing a health-care plan within two weeks, a full and complete health-care plan," Trump pledged in a July 19 interview with "Fox News Sunday" anchor Chris Wallace.

Now, with the two weeks expiring Sunday, there is no evidence that the administration has designed a replacement for the 2010 health-care law. Instead, there is a sense of familiarity.

Repeatedly and starting before he took office, Trump has vowed that he is on the cusp of delivering a full-fledged plan to reshape the health-care system along conservative lines and replace the central domestic achievement of Barack Obama's presidency.

No total revamp has ever emerged.

Trump's latest promise comes amid the outbreak of the novel coronavirus, which has infected millions, caused more than 150,000 deaths and cost Americans their work and the health benefits that often come with jobs. His vow comes three months before the presidential election and at a time when Trump's Republican allies in Congress may least want to revisit an issue that was a political loser for the party in the 2018 midterm elections.

Yet Trump has returned to the theme in recent days.

"We're going to be doing a health-care plan. We're going to be doing a very inclusive health-care plan. I'll be signing it sometime very soon," Trump said during an exchange with reporters at an event in Belleair, Fla., on Friday. When a reporter noted that he told Fox's Wallace that he would sign it in two weeks, Trump added: "Might be Sunday. But it's going to be very soon."

Trump's decision to revive a health-care promise that he has failed to deliver on — this time with less than 100 days before Election Day — carries political risks. Although it

may appeal to voters who don't like the ACA, it also highlights his party's inability to come up with an alternative, despite spending almost a decade promising one.

It also raises questions about what exactly his plan would look like and whether it would cover fewer Americans than the current system as the pandemic ravages the country.

Nonetheless, some of Trump's allies said floating health-care ideas is a smart move by the president.

Sen. Lindsey O. Graham (R-S.C.), who regularly meets and golfs with the president, said the health-care plan that Trump has referred to would come in the form of an executive order that Graham called "fairly comprehensive." However broad, an executive order would fall short of a full legislative overhaul.

Graham said what Trump has in mind now would ensure that consumers do not risk losing their health plans if they get sick, but he did not give details.

"He's pretty excited about it," Graham said of the president. The ACA's consumer protections for people with preexisting medical conditions is one its most popular facets with the public, and it is the one part of the law Trump consistently says he would preserve if he could get rid of the rest. How he could do that while containing costs after he and congressional Republicans remove the law's requirement that everyone has to purchase health insurance remains the question.

Graham said it is politically astute for the White House to present an alternative to Democratic proposals close to the election, including the idea of Joe Biden, the party's presumptive nominee, to build on the ACA so that more people could get coverage.

Still, senior Republican aides on Capitol Hill who are steeped in health care said they had little knowledge of any White House planning for a comprehensive replacement of the ACA.

The White House did not offer details or parse the president's terminology, which has included saying that the forthcoming plan would be a bill. That implied legislation rather than an executive order.

"President Trump continues to act in delivering better and cheaper health care, protecting Americans with preexisting conditions, lowering prescription drug costs, and defending the right of Americans to keep their doctors and plans of their choice," White House press secretary Kayleigh McEnany said in a statement to The Washington Post.

McEnany pointed out that Trump issued four executive orders in late July intended to lower prescription drug prices. "There will be more action to come in the coming weeks," she said without identifying any.

Trump signs executive orders aimed at lowering drug prices in largely symbolic move

On Capitol Hill, the president's promises of health plans and legal efforts by the administration to scrap the ACA have created dilemmas for some Republicans. Of the GOP senators facing competitive races this fall, only Susan Collins (Maine) has said that she opposes the Justice Department's decision to back an effort to gut the law in the courts. Other Republicans have struggled to answer directly, walking a tightrope between embracing a position that would go against popular provisions in the health-care law and risking the wrath of conservatives who want Obamacare repealed.

And the pandemic has also only sharpened the relevance of health care in the eyes of voters — increasing Republican anxiety about doing anything that could limit coverage ahead of the election. Republican Sens. John Cornyn (Tex.), Dan Sullivan (Alaska), Steve Daines (Mont.) and Martha McSally (Ariz.) — all on the ballot this November — this past week drafted legislation that would provide assistance through COBRA for people who lose their employer-sponsored health care as jobs continue to vanish during the pandemic.

"I think there's definitely things we need to do," Cornyn said. "But I think our focus ought to be on giving people more choices."

The ACA — politically polarizing throughout the decade it has existed — is favored by a slim majority of Americans. A Kaiser Family Foundation survey in July found that 51 percent support the law while 36 percent oppose it. A Fox News survey in June showed 56 percent support and 38 percent opposition.

For Trump, saying that he is about to produce a health-care plan to replace the ACA has become a recurrent mantra of his presidency.

During his 2016 campaign, condemning the law was central to Trump's candidacy. During that campaign's final days, Trump said he was so eager to repeal and replace the 2010 law that he might ask Congress to convene a special session to do it.

"It will be such an honor for me, for you and for everybody in this country," the then-Republican nominee said, "because Obamacare has to be replaced. And we will do it, and we will do it very, very quickly."

The ACA was a significant theme of the president's joint address to Congress just over a month into his tenure. "Tonight I am calling on this Congress to repeal and replace Obamacare," he said, calling for measures that would "expand choice, increase access, lower costs and, at the same time, provide better health care."

With GOP majorities in both the House and the Senate, Congress devoted much of 2017 to trying to get rid of substantial parts of the law. But a succession of repeal bills ultimately faltered in the Senate. When the last one did, Trump said nothing.

Near the end of the year, Congress took one big whack at the health law. As part of a major change in tax law, it eliminated the penalty the ACA levied on most Americans if they failed to carry health insurance. The penalty's end neutralized the law's insurance mandate.

With little appetite after that among Senate Republicans to continue trying to gut the law, and a Democratic House majority a year later, the momentum for replacing the ACA fell back to the Trump administration. Cabinet departments have, by turns, undercut specific parts of the law and tried to have it invalidated in the courts, while emphasizing that their concern for the nation's health-care system and America's patients reaches beyond the ACA.

And the president? He has continued to periodically vow that he would come up with a better health plan.

In the fall of 2017, Trump took a major swipe at the law by ending payments to insurance companies that had helped them afford to offer lower-income customers discounts on their deductibles and other out-of-pocket costs, as the ACA requires.

During 2018, health officials sought to shrink the law in several other ways. They wrote rules that gave states greater latitude in defining a set of 10 "essential health benefits" that the ACA requires many health plans to cover. They widened the availability of short-term health plans — originally intended as bridge coverage when someone was, say, between jobs — that do not meet consumer protections or benefits that the law otherwise requires.

The administration has joined with a group of Republican attorneys general who are pursuing a lawsuit, now before the Supreme Court, that contends the entire ACA is unconstitutional. At first, the Justice Department argued that only part of the law is invalid, but the administration hardened its position to argue that the entire law should be thrown out.

As these and other administration health-care actions have played out, the drumbeat has continued that the president was about to reveal an ACA replacement plan.

In June 2019, Trump said in an interview with ABC News that he would announce a "phenomenal" new health-care plan "in about two months, maybe less."

Two months later, White House counselor Kellyanne Conway told reporters that the president was preparing to introduce an elaborate plan to redesign the nation's health-care system in a speech the following month. "We're working every single day here," Conway said last August. "I've already been in meetings this morning on the president's health-care plan. It's pretty impressive."

No speech or plan came.

In June, Health and Human Services Secretary Alex Azar suggested that the administration would develop a health-care plan only if the nation's highest court, which has upheld the law in two earlier cases over the past eight years, overturns it this time. "We'll work with Congress on a plan if the ACA is struck down," Azar said on NBC's "Meet the Press." "We'll see what the Supreme Court rules."

That was three weeks before the president told Fox that he was about to issue a plan.

The administration's antipathy toward the law has not produced much real-world change for the approximately 20 million people who have coverage through the insurance marketplaces the ACA created for those who cannot get affordable health benefits through a job and those insured through Medicaid expansions.

Early on, HHS slashed federal funding for advertising and other outreach efforts to encourage people to buy ACA health plans during the annual enrollment period. Critics of the administration predicted that sign-ups would ebb. They have not.

The most recent enrollment figures document the number of people choosing an ACA health plan who had followed up by paying insurance premiums last winter so their coverage was in place as of February. The figures, released last week, show that 10.7 million consumers have such plans, slightly more than the 10.6 million a year earlier.

Despite the administration's steps to undercut parts of the law, and the elimination of the penalty for not having insurance, some of the ACA's main features remain in place. They include federal subsidies for more than 8 in 10 people who buy health plans in the marketplaces created under the law, the expansion of Medicaid in most states, many consumer insurance protections, and a rule that young adults can stay on their parents' insurance until they turn 26.

Against existing evidence, Trump says that will soon change.

"We're getting rid of it because we're going to replace it with something much better," Trump told Wallace two weeks ago.

Major U.S. Health Insurers Report Big Profits, Benefiting From the Pandemic
Reed Abelson

The nation's leading health insurers are experiencing an embarrassment of profits.

Some of the largest companies, including Anthem, Humana and UnitedHealth Group, are reporting second-quarter earnings that are double what they were a year ago. And

while insurance profits are capped under the Affordable Care Act, with the requirement that consumers should benefit from such excesses in the form of rebates, no one should expect an immediate windfall.

But the amounts that insurers are retaining have caught the attention of the Trump administration. The Health and Human Services Department advised companies to consider speeding up rebates, and on Tuesday suggested that they reduce premiums to help consumers through the economic downturn caused by the pandemic.

Just this Wednesday, CVS Health, which owns Aetna, the big insurer, posted much higher earnings. CVS, which also owns a large pharmacy benefit manager and a drugstore chain, said net income for the second quarter reached $3 billion, about $1 billion more than it reported for the same period of 2019, on revenues of $65 billion.

Others had already trumpeted blockbuster results, ensuring that their stocks weathered swings in the markets. Anthem's net income soared to $2.3 billion for the second quarter, from $1.1 billion in 2019, while UnitedHealth reported net earnings of $6.7 billion, compared to $3.4 billion for the same three months last year.

Although many hospitals have been overwhelmed by the coronavirus outbreaks raging from state to state, insurers have shelled out billions of dollars less in medical claims in the last three months because expensive, elective surgeries have been postponed in many places. Moreover, people have steered clear of doctors' offices and emergency rooms in fear of contagion.

The companies' staggering pandemic profits stand in stark contrast to the scores of small medical practices and rural hospitals that are struggling to stay open. And the earnings are putting a spotlight on the big insurance companies at a time when government officials in many states are facing massive budget shortfalls as businesses collapse, unemployment rises and tax revenues plummet. Some states are discussing cutting payments to insurers that offer Medicaid plans to their residents.

"This could tilt the politics against insurers on a whole number of fronts," said Larry Levitt, the executive vice president for health policy for the Kaiser Family Foundation, a nonpartisan research group.

And in this presidential election year, the companies' overly buoyant position could also reignite a discussion among Democrats about "Medicare for all," a proposal that would replace the current private health care system with a government one that guarantees coverage for all U.S. residents.

"We're looking at the fact that health care can't be regulated by the marketplace," said Representative Pramila Jayapal, the Washington State Democrat who is a strong proponent of Medicare for all.

"Who knows what's going to happen by January?" Ms. Jayapal asked. "It's entirely possible that everything shifts on health care, within weeks or months after the election."

Some lawmakers may also try to revive proposals to cap insurers' profits even more, like one that Senator Elizabeth Warren, the Massachusetts Democrat, has suggested.

"There is that money sitting there," said Dan Mendelson, the founder of Avalere Health, a consulting firm.

Among the companies with robust earnings is Humana, which reported Wednesday that its net income rose to $1.8 billion for the second-quarter, compared to $940 million for the same three months of 2019. The profits for Cigna, which also owns a large pharmacy benefit manager, were also higher.

Under the federal health care law, insurers are required to use a fixed percentage of the money they take in from premiums for their customers' medical expenses. The companies must spend at least 80 cents of every dollar they collect in premiums from small businesses and individuals on health care, and 85 cents per dollar for large employers. The remaining 15 to 20 percent is all they are allowed under the Affordable Care Act to spend on administrative costs like overhead and marketing and to keep as profit. Any additional revenues are to be returned to consumers in the form of rebates.

Insurers are currently spending a far lower portion of premium revenue on their customers' health care costs. CVS said its medical-benefits ratio was 70 percent for the quarter, compared to 84 percent in the same period of 2019.

That translates into millions of dollars that some lawmakers in Congress and advocates say should wind up in the pockets of consumers.

In recent years, insurers have paid out billions of dollars in rebates, said Cynthia Cox, one of the authors of a recent Kaiser Family Foundation analysis that estimated employers and individuals would receive $2.7 billion this year in rebates required under Obamacare. That figure does not include 2020 amounts.

People who had health insurance through the A.C.A. last year could receive an average of $420 a person, she said.

"For any given customer, it's not going to be a lot of money," said Mr. Mendelson of Avalere. "It will always feel underwhelming."

Eventually consumers should get some of this year's money back. The insurers "are not just able to profiteer," said Katherine Hempstead, a senior policy adviser for the Robert Wood Johnson Foundation who studies health insurance markets.

Even though the federal government is now encouraging insurers to turn over excess funds to consumers more quickly this year, the Obamacare law gives companies a three-year window to calculate how much to return as a way to offset any mistakes they made in setting rates or if they experienced unexpected expenses.

“There’s a cushioning effect for swings,” said Mark Hall, the director of the health law and policy program at Wake Forest University.

So no one should count on getting money from this year’s burgeoning insurance profits anytime soon.

And the financial outlook for the year is still uncertain, given the rising number of Covid-19 cases shifting from state to state and the longer term costs of caring for Covid-19 patients, with potentially expensive new vaccines or treatments around the corner. Conversely, the many people who postponed getting medical attention could flock back to doctors’ offices and submit more bills for coverage.

“They don’t actually know what’s coming around the corner,” said Dr. Sanjay Saxena, a managing director for the Boston Consulting Group. “They can’t just write checks and give away the money.”

Insurers say that they are using their financial strength to help customers as well as hospitals and doctors. “From the very beginning, health insurance providers have focused on being part of the solution,” said Matt Eyles, the chief executive of America’s Health Insurance Plans, a trade group. As examples, he cited waiving co-payments for testing and treatment for coronavirus and paying for telemedicine visits, some of which the government has mandated be covered.

The companies also say they are spending billions of dollars on efforts that range from giving small businesses a break on their monthly premiums to paying physicians in advance to help keep practices afloat.

On conference calls with Wall Street analysts, executives were quick to point out steps they have taken to assuage the worries of Americans overwhelmed by the virus outbreaks.

“We took action to commit $2.5 billion in financial assistance to ease the burden of Covid-19 among our members, employer customers, care providers and nonprofit partners,” said Gail K. Boudreaux, the chief executive of Anthem. She listed several initiatives, including giving customers a premium credit and donations to a food charity. “The needs are ongoing, and I’m proud of the way Anthem has responded quickly to provide needed support,” she said.

Nonprofit insurers, including most of the Blue Cross plans offered in individual states, are also experiencing much higher profit margins. While they too are subject to the A.C.A. rules and must pay out required rebates, they can plow any additional surplus into their capital reserves, Mr. Hall said. “They never feel that they have enough reserves, and the regulators don’t really require insurers to spend down their reserves,” he said.

But the companies may have even higher profits than is apparent. Some, like UnitedHealth, have large networks of doctors and other health care businesses, in addition to owning giant pharmacy benefit managers. There are no limits on how much these units can make, and many of the units sell their services directly to the insurer.

The profits being reported don't "give an accurate picture of how much money they are making for the insurers," said Michael Turpin, a former insurance executive and an executive vice president at USI, an insurance brokerage. "You're not going to negotiate with your sister company very robustly."

Some hospital executives and doctors say that the insurers should do much more. "Everyone should be playing a part as it relates to the pandemic, and insurers are no exception," said Colleen M. Blye, the chief financial officer for the Montefiore Health System, a large hospital group in the Bronx that has treated more than 10,000 Covid patients.

"The government has been funding the providers significantly," she said, referring to the $175 billion in funds Congress has allocated to date for hospitals and doctors. "The insurers should be sharing that burden, and they haven't been."

Insurers say they have been strong advocates for providers like the hospital systems. "We've consistently supported their efforts," said Mr. Eyles.

So far, investors are not concerned about the political risks of the insurers' high profits, said Les Funtleyder, who is a health care portfolio manager for E Squared Capital Management, which owns shares of UnitedHealth.

Even if former Vice President Joseph R. Biden Jr., the Democratic presidential candidate, wins in November, he would probably be unlikely to push for anything close to Medicare for all. Mr. Biden favors revamping Obamacare and offering a public option, a government-run alternative to private insurance.

But the calculation could change, depending on his choice of vice president, Mr. Funtleyder said. Senator Warren, who has called for a sweeping health care overhaul, is one of several names on a long list of potential female running mates for Mr. Biden.

"If Warren was vice president, it would definitely spook Wall Street," Mr. Funtleyder said.

UPI.com
100 YEARS OF JOURNALISTIC EXCELLENCE

Study: U.S. healthcare costs nearly double of other wealthy countries
Brian P. Dunleavy

Aug. 6 (UPI) -- Americans spend roughly twice as much annually on healthcare as those living in seven other high-income countries, according to an analysis published Thursday.

Researchers, writing in JAMA Network Open, analyzed U.S. health expenditures in 2015 -- the year after the Affordable Care Act was fully implemented -- and pegged spending at $9,524 per person.

Switzerland was next in per capita health spending at $6,730 annually, with Germany -- at $5,277 -- the only other country above $5,000 per person, the researchers said.

The biggest differences were seen in adults age 20 to 64, who spent an average of $8,161 for healthcare in the United States. That is more than twice the mean of spending -- $3,603 -- for all of the countries included in the analysis.

Adults in Switzerland that age group had the second-highest per capita figure, at $5,166, the researchers found.

And while healthcare spending increased for all adults 65 and older in all the countries, it more than tripled in the United States -- to $24,655 per person -- they said.

"Compared to other high-income countries, U.S. healthcare spending is considerably higher at all ages," study co-author Irene Papanicolas, associate professor of health economics at the London School of Economics, told UPI.

"Our work shows that the U.S. healthcare system for individuals aged 65 and up remains considerably more costly than in other countries," she said.

The average health expenditures of seniors in the United States was more than twice the mean -- $12,309 -- for all eight countries included in the analysis, according to Papanicolas.

For the analysis, the researchers used data from the Organization for Economic Co-operation and Development to examine variations in 2015 total healthcare spending per capita, by age, for the United States and seven other high-income countries: Australia, Canada, Germany, Japan, the Netherlands, Switzerland and the United Kingdom.

They also compiled spending data from the "Health Expenditures by Diseases and Conditions" report and from the 2013 Institute for Health Metrics and Evaluation project in the United States.

In addition to increased spending on care for seniors, expenditures on healthcare for children from birth to age 4 in the United States outpaced that of the other countries in the analysis by $3,899 per child, the researchers found.

"I believe this to likely be driven by higher spending in the first year of life, particularly [during] the neonatal period, where we know from other studies that large inpatient spending occurs," Papanicolas said.

Trump Vows Coverage For Preexisting Conditions — As He Fights To Kill It In Court
Mary Papenfuss

President Donald Trump’s promised breakthrough in health care coverage looks like it could be insurance protection for preexisting conditions. One sticking point: It’s already guaranteed by the Affordable Care Act — which his administration is fighting to kill in the Supreme Court.

“Over the next two weeks I’ll be pursuing a major executive order requiring health insurance companies to cover all preexisting conditions for all customers,” Trump crowed at a news conference Friday at his Bedminster golf resort in New Jersey. “That’s a big thing. I’ve always been very strongly in favor. We have to cover preexisting conditions.”

The news was so “major” that it was touted in an official White House tweet.

Trump claimed it’s “never been done before.”

But it has been done before. Health insurance companies have been required to cover people with preexisting conditions ever since the Affordable Care Act, also known as Obamacare, was enacted 10 years ago.

To put an extra head spin on the whole incident, Trump’s Department of Justice argued before the Supreme Court in June to shut down the ACA with its guaranteed coverage

for preexisting conditions. It even specifically singled out coverage for preexisting conditions as something that's got to go.

If the action against Obamacare by Trump's DOJ succeeds, some 20 million Americans would lose their health insurance amid the COVID-19 crisis.

CNN's Chris Cuomo slammed Trump's vow as a "dangerous lie."

Coverage for preexisting conditions is "already the law of the land," he said. Now, "not only is he lying to you about giving you something you already have, he's actively trying to take it away," Cuomo added.

Twitter went bonkers over Trump's announcement.

Bloomberg LAW

Insurers Entitled to Obamacare Cost-Sharing Pay, Court Says
Mary Anne Pazanowski

The Trump administration must make it up to health insurers for refusing to honor an Obamacare program that required it to pay them for reducing low-income members' deductibles, copayments, and coinsurance costs, the Federal Circuit said Friday.

Up to $2.5 billion is at stake in the long-standing litigation over whether the Affordable Care Act's cost-sharing reduction provision requires the government to reimburse insurers for foregoing costs normally passed on to members, given that Congress never set aside the money for it to do so.

The result was foreshadowed by the insurers' April win in a U.S. Supreme Court case presenting substantially the same question, but involving Obamacare's "risk corridor" provision—Maine Community Health Options v. United States.

The Supreme Court determined that the "risk corridor" section obligated the government to pay insurers in exchange for selling plans at affordable premiums to a group of people who previously would have been denied coverage or charged more.

The cost-sharing provision contains the same "shall pay" language found in the risk corridor section, and the U.S. Court of Appeals for the Federal Circuit found no "persuasive basis" for distinguishing the cases.

“Our clients have provided cost-sharing as required by law, and the court’s decision makes clear that the government was required to provide CSR payments in accordance with the law, Stephen J. McBrady, who represented Sanford Health Plan, Montana Health Co-Op, and Maine Community Health Options, told Bloomberg Law.

“We look forward to continuing to pursue CSR amounts owed by statute, he said. McBrady is a partner at Crowell & Moring LLP in Washington.

Maine Community Health Options was the fourth insurer involved in the appeals, which covered cost-sharing payments due to insurers in 2017 and 2018. Insurers also may be entitled to damages for 2019 and 2020, because the cost-sharing program is ongoing.

The government didn’t respond to Bloomberg Law’s request for comment. It potentially could file a petition for rehearing, a petition for rehearing en banc, or a request for Supreme Court review.

Limiting Damages

The Federal Circuit specifically rejected the government’s argument that the insurers shouldn’t be entitled to any damages because their losses were made up through a practice called “silver loading.”

As part of this practice, the insurers received states’ permission to raise premiums on mid-level, or silver, plans. Tax credits available under Obamacare to subsidize low-income members’ purchases of those plans rose accordingly.

The government’s appeal from a judgment for Sanford Health and Montana Co-op involved only the 2017 payments. Because neither took advantage of silver loading that year, they were entitled to the full amount of the cost-sharing payments the administration owed them, the court said. The lower court set those amounts at just over $360,000 for Sanford Health and $1.2 million for Montana, it said in an opinion written by Judge Richard G. Taranto.

But the damages for Community Health and Maine Community claimed for 2018 must be reduced, the court said in a second opinion—this one written by Judge Timothy B. Dyk—that resolved appeals from judgments for them. The panel’s third member was Judge William C. Bryson.

The ACA didn’t set out any express remedies for the government’s failure to honor its obligations, so the court drew one out by analogy to contract law.

Damages are compensatory in nature under contract law, meaning that the winning party is entitled only to the amount of damages necessary to put it into the position it would have been in had the contract not been breached, the court said. A winning party can’t recover an “unwarranted windfall,” it said.

The mitigation doctrine applies in this instance, the court said. The doctrine requires parties to take steps to mitigate their damages, and courts to reduce damages to reflect the benefit realized through the mitigation efforts, it said.

There was a direct relationship between the cost-sharing reductions and the premiums, as Community Health and Maine Community received additional tax credits due to the silver loading, the court said. The government thus was entitled to set off those payments against the insurers' damages.

The court sent those insurers' cases back to the trial court to determine the amount of damages. The same fate likely awaits other insurers seeking damages for 2018 and beyond that increased silver plan premiums.

Column: Trump promotes shoddy faith-based health plans in new attack on Obamacare
Michael Hiltzik

Never let it be said that President Trump doesn't know how to take advantage of a crisis. For our latest example, let's look at how he has exploited the distractions caused by the COVID-19 pandemic to quietly launch yet another attack on the Affordable Care Act.

This attack involves promoting "healthcare sharing ministries," which are typically associated with religious faiths, to siphon enrollment from legitimate health insurance plans, thus weakening the latter in a way that is likely to drive up their costs.

A new regulation proposed by the Treasury Department would define healthcare sharing ministries as health insurance and for the first time allow some members to take a tax deduction for their monthly contributions.

That could encourage more people to sign up for what many healthcare experts consider substandard coverage.

The Trump administration's redefinition of sharing ministries as insurance contradicts the ministries' own self-description. They typically warn enrollees that they're not health insurance companies and don't guarantee that they'll pay any enrollee claims, even for ostensibly covered services.

Those formal disclaimers have enabled the ministries to avoid regulation by state insurance agencies. The plans are “largely unregulated,” in the words of the Commonwealth Fund.

Thirty states exempt healthcare sharing ministries from insurance laws as long as they issue a written disclaimer that they’re not insurance, and Congress granted them an exemption from Affordable Care Act rules.

The sharing ministries, however, are often marketed in ways that could confuse customers into believing they’re buying real health insurance.

The Treasury Department slipped its proposed rule into the regulatory hopper on June 10, giving critics until Aug. 10 to file comments.

California Atty. Gen. Xavier Becerra and the attorneys general of 19 other states have weighed in. In their official comment, they say that “incentivizing payments to HSMs will only accelerate medical debt and poor health outcomes during an international health crisis” and give sharing plans greater incentive “to ramp up fraudulent marketing practices.”

They maintain that the change is illegal because it was proposed without any analysis of the potential to cause consumer confusion or to erode existing health insurance markets.

In other words, they say Trump is offering a trifecta of dumb and dishonest healthcare policy.

The Treasury’s proposed rule reflects the Trump administration’s policy of promoting low-quality health plans that are generally noncompliant with the Affordable Care Act such as short-term health plans, that lack the ACA’s consumer safeguards. These plans can appear to be cheaper than compliant plans because they offer poorer benefits.

In an October 2017 executive order cited in the Treasury’s rule proposal, Trump called for expanding access to noncompliant plans to give Americans “meaningful choice” in healthcare. In a follow-up order in June 2019, Trump directed the Treasury to craft regulations allowing healthcare sharing ministry expenses to be tax-deductible.

The concept of sharing healthcare costs originated with Amish and Mennonite communities more than 100 years ago, but spread to other religious groups in the 1980s. The monthly contributions can be applied to the needs of specific members, but typically they’re placed in a pool from which members’ bills are paid according to the ministries’ coverage terms.

The Affordable Care Act exempted healthcare sharing ministries from consumer protection rules, such as the requirement that health plans cover 10 “essential services” such as immunizations, hospitalization, maternity care and mental health services.

Customers who signed up with sharing plans aimed at members who shared “a common set of ethical or religious beliefs” were also exempted from the ACA’s penalty for not carrying insurance. (Congress reduced that penalty to zero as of this year as part of the 2017 tax-cut bill.)

Those exemptions allow healthcare sharing ministries to offer their members junk. The plans typically place benefit limits on member claims. The ACA doesn’t allow legitimate health plans to do so.

The sharing plans can exclude coverage of preexisting conditions. They usually don’t cover prescription drugs or preventive services such as immunizations and mammograms.

According to a 2018 report for the National Assn. of Insurance Commissioners, they often refuse to cover any claim putatively resulting from immoral activities such as drug use or — in the words of Christian Healthcare Ministries, one of the largest sharing plans — “adultery, fornication, homosexual behavior [and] bisexual conduct.”

Christian Healthcare Ministries won’t grant maternity coverage to unwed mothers. Adopted children can be covered unless they’re disabled, in which case CHM reserves the right to refuse coverage.

Members of sharing ministries are sometimes instructed to attempt on their own to negotiate with their healthcare providers for discounts, a task that traditional insurers generally perform for their enrollees.

The members are instructed to pay providers up front, then submit bills to the ministries for reimbursement if they exceed a given threshold — anywhere from $500 to several thousand dollars per “incident,” defined as a single injury or brief period of coverage for a chronic condition.

Despite these shortcomings, sharing ministries have expanded in recent years, with enrollment rising to about 1 million in 2018 from 100,000 in 2010, according to the state attorneys general. Revenues of Christian Healthcare Ministries soared to $510 million in 2019 from $220 million in 2016, according to its tax filings.

Consumers may find the ministries attractive because their monthly fees can appear modest compared to premiums charged by conventional insurance plans. That can be misleading, since the ministry contributions aren’t eligible for Affordable Care Act subsidies and the plans don’t offer the same consumer protections or minimum services required of ACA plans.

The plans also attract customers by appealing to their spiritual impulses. Christian Healthcare Ministries describes itself as “a healthcare cost solution that’s biblical,” citing the command Jesus issued to his disciples at the Last Supper to “love one another.”

Some ministries have adopted features that mimic those of traditional insurance in ways that could confuse consumers. Monthly contributions resemble insurance premiums, and the threshold exclusions look like deductibles.

Shared healthcare ministries have been thorns in the side of state consumer regulators, who have been fielding complaints from members whose claims have been denied even though they thought they were covered.

The ministries “often employ deceptive marketing tactics,” the attorneys general assert. Members have filed complaints or lawsuits asserting that they’ve been left holding the bag for six-figure medical bills they assumed would be covered.

That could lead to “long-term economic deprivation, bankruptcy, housing instability, and even homelessness,” the attorneys general say. “The confusion HSMs cause by mimicking traditional health insurance is not without a human toll.”

Authorities in Texas, Colorado, Washington, Maryland, New York and New Hampshire have opened investigations or sought cease-and-desist orders against one company, Atlanta-based Aliera Healthcare, and its affiliates, generally charging that it deceptively marketed sharing plans to consumers.

In its defense, Aliera has invoked a dodge common in the healthcare sharing ministry world — that its products aren’t insurance and therefore can’t be regulated by insurance authorities. Aliera “is neither an insurance company nor a Health Care Sharing Ministry, the firm told me by email. Through “multiple wholly owned subsidiaries,” however, “we do provide services to HCSM clients.”

In a response earlier this month to a lawsuit filed by several customers in federal court, however, Aliera said that its affiliates never “assumed any contractual obligation (and took no responsibility) to pay for any member’s medical expenses from their own funds. ... Nor is there any guarantee that any specific member’s requests for sharing will be paid out of other members’ health sharing contributions.”

The affiliates “act merely as clearinghouses for their members to share each other’s medical expenses,” the company said.

Texas alleged last year that although Aliera claimed to administer a “health care sharing ministry,” the company is actually “a multimillion dollar for-profit business that admittedly siphons off over 70% of every dollar collected from its members to ‘administrative costs.’” The action is pending, with a trial tentatively set for next year.

The company denied allegations by Connecticut authorities that it was illegally selling insurance by asserting that its products were not insurance. The state allowed Aliera to continue serving existing customers but barred it from soliciting new business. In February, Maryland authorities moved to revoke Aliera's insurance license; Aliera told me it is "strongly contesting" Maryland's allegations. Aliera has also agreed to cease marketing healthcare sharing ministries in Colorado.

Put this all together, and it becomes clear that the Trump administration has merely concocted another tactic to erode the Affordable Care Act and saddle Americans with more healthcare risk. The proposed rule would define as insurance the health plans that they themselves admit are not insurance. It will entice more Americans into wasting their money on coverage that won't give them protection when they need it.

It's not "free choice," as the rule proposal says, but like every one of Trump's supposed healthcare reforms, it's a poisoned chalice. It will leave many Americans sicker and poorer, in the teeth of the worst public health crisis in our lifetimes.

KHN
KAISER HEALTH NEWS

'Pennie'-Pinching States Take Over Obamacare Exchanges From Feds
Phil Galewitz

Pennsylvania is rolling out its new "Pennie" this fall: a state-run insurance exchange that officials say will save residents collectively millions of dollars on next year's health plan premiums.

Since the Affordable Care Act's marketplaces opened for enrollment in fall 2013, Pennsylvania, like most states, has used the federal www.healthcare.gov website for people buying coverage on their own.

But in a move defying the usual political polarization, state lawmakers from both parties last year agreed the cost of using the federal marketplace had grown too high and the state could do it for much less. They set up the Pennsylvania insurance exchange (nicknamed "Pennie"), designed to pass on expected savings to policyholders. Although the final rates for 2021 are not yet set, insurers have requested about a 3% average drop in premiums.

Pennsylvania is one of six states shifting in the next several years from the federal insurance exchange to run their own online marketplaces, which determine eligibility,

assist with enrollment and connect buyers with insurance companies. They will join 12 states and the District of Columbia with self-contained exchanges.

The transitions come amid mounting evidence that state marketplaces attract more consumers, especially young adults, and hold down prices better than the federal exchange. They've also been gaining appeal since the Trump administration has cut the enrollment period on healthcare.gov and slashed funds for advertising and helping consumers.

State policymakers say they can run their own exchanges more cheaply and efficiently, and can better respond to residents' and insurers' needs.

"It comes down to getting more bang for your buck," said Rachel Schwab, a researcher at Georgetown University's Center on Health Insurance Reforms in Washington, D.C.

The importance of state-run exchanges was highlighted this year as all but one of them held special enrollment periods to sign up hundreds of thousands of people hurt financially by COVID-caused economic turmoil. The federal exchange, run by the Trump administration, refused to do so, although anyone who has lost workplace insurance is able to buy coverage anytime on either the state or federal exchange.

Like Pennsylvania, New Jersey expects to have its state-run exchange operational for the start of open enrollment on Nov. 1.

In fall 2021, New Mexico plans to launch its own marketplace and Kentucky is scheduled to fully revive its state-run exchange, which was dismantled by its Republican governor in 2015. Maine has also announced it will move to set up its own exchange, possibly in fall 2021.

Virginia's legislature passed an exchange bill this year and hopes to start it in 2022 or 2023.

Nationwide, about 11 million people get coverage through the state and federal exchanges, with more than 80% receiving federal subsidies to lower their insurance costs.

"Almost across the board, states with their own exchanges have achieved higher enrollment rates than their federal peers, along with lower premiums and better consumer education and protection," according to a study published this month in the Journal of Health Politics, Policy and Law.

Controlling 'Their Own Destiny'

Since 2014, states using the federal marketplaces have had a rise in premiums of 87% while state exchanges saw 47% growth, the study found.

In one key metric, from 2016 to 2019 the number of young enrollees in state exchanges rose 11.5%, while states using the federal marketplace recorded an 11.3% drop, a study by the National Academy for State Health Policy found.

Attracting younger enrollees, who tend to be healthy, is vital to helping the marketplaces spread the insurance risk to help keep premiums down, experts say.

When the Affordable Care Act was debated, Republicans and some Democrats in Congress were cautious about a one-size-fits-all approach to insurance and accusations about a federal takeover of health care. So the law's advocates gave states more control over selling private health coverage. The law's framers included a provision that allowed states to use millions in federal dollars to launch their own insurance exchanges.

Initially, 49 states took the money. But in 2011, conservative groups convinced Republican-controlled states that forgoing state-run exchanges would help undermine Obamacare.

As a result, most GOP-controlled states defaulted to the federal marketplace.

In the ensuing years, several states that had started their own marketplaces, such as Oregon, Nevada and Hawaii, reverted to the federal exchange because of technological problems. Nevada relaunched its exchange last fall.

"States want to control their own destiny, and the instability of healthcare.gov in the Trump administration has frustrated states," said Joel Ario, managing director for the consulting firm Manatt Health Solutions and a former Obama administration official, who helped set up the exchanges. States running their own platform can use data to target enrollment efforts, he said.

An Effort to Hold Down Premium Increases

Marlene Caride, New Jersey commissioner of Banking and Insurance, said that "the beauty of [a state-based exchange] is we can tailor it to New Jersey residents and have the ability to help [them] when they are in dire need."

About 210,000 New Jersey residents enrolled in marketplace health plans for this year.

New Jersey has been spending $50 million a year in user fees for the federal exchange. After startup costs, the state estimates, it will cost about $7.6 million a year to run its own exchange enrollment platform and $7 million a year for a customer service center.

Open enrollment on the New Jersey exchange — called Get Covered NJ — will run from Nov. 1 to Jan. 31.

New Jersey plans to provide additional government subsidies for lower-income enrollees. Those would supplement federal subsidies.

Kentucky officials said insurers there were paying $15 million a year in user fees for healthcare.gov, a cost passed on to policyholders. When the state switches to its own operation, it plans to collect $5 million in its first year to cover the startup costs to revive its Kynect exchange and another $1 million to $2 million in annual administrative costs. So insurers will pay lower fees and those savings will help cut premium costs, said Eric Friedlander, secretary of the Kentucky Cabinet for Health and Family Services.

States using the federal marketplace this year paid either a 2.5% or 3% surcharge to the federal government on premiums collected.

In Pennsylvania, where about 330,000 residents buy coverage through an exchange plan, those fees accounted for $90 million a year. State officials estimate they can run their own exchange for about $40 million and will use the savings for a reinsurance program that pays insurers to help cover the cost of extremely expensive health care needed by some customers. Removing those costs from the insurers' responsibility allows them to drop premiums by 5% to 10%, the state projects.

"When we talk about bringing something back to state control, that is a real narrative that can appeal to both sides of the aisle," said Jessica Altman, the state's insurance commissioner. "There is nothing political about making health insurance more affordable." (Altman is the daughter of Drew Altman, CEO of KFF. KHN is an editorially independent program of KFF.)

Without the savings from running its own exchange, Pennsylvania would not have been able to come up with the more than $40 million needed for the reinsurance program, state officials said.

In addition, Pennsylvania has extended its enrollment period to run an extra month, until Jan. 15 (federal marketplace enrollment ends Dec. 15). Pennie also plans to spend three to four times the $400,000 that the federal government allocated to the state for navigators to help with enrollment, said Zachary Sherman, who heads Pennie.

"We think increased outreach and marketing will bring in a healthier population and broaden enrollment," he said.

Federal judge blocks Trump administration's rollback of Obama-era transgender health care protections
Devan Cole

Washington (CNN) A federal judge on Monday blocked the Trump administration's rollback of an Obama-era regulation prohibiting discrimination in health care against patients who are transgender, a day before it was set to go into effect.

US District Court Judge Frederic Block found that the planned rollback, which was announced in June, violates the Supreme Court's landmark ruling that extended federal civil rights law to gay, lesbian and transgender workers.

"In this case, the Court is tasked with having to decide if a proposed set of rules by the Department of Health and Human Services ... is contrary to the Supreme Court's pronouncement in Bostock or if the agency acted arbitrarily or capriciously in enacting the rules," Block wrote in the preliminary injunction.

"(The) Court concludes that the proposed rules are, indeed, contrary to Bostock and, in addition, that HHS did act arbitrarily and capriciously in enacting them. Therefore, it grants plaintiffs' application for a stay and preliminary injunction to preclude the rules from becoming operative."

An HHS spokesperson said in a statement that the department is "disappointed in the court's decision." CNN has reached out to the Department of Justice for comment.

The department was planning to nix some provisions of a 2016 rule that interpreted the Affordable Care Act's ban on sex discrimination to include discrimination on the basis of gender identity, saying it would enforce the ban "according to the plain meaning of the word 'sex' as male or female and as determined by biology."

A number of LGBTQ groups had strongly criticized HHS' plan, saying it would allow health care providers to openly discriminate against transgender patients. Monday's decision came in response to a case brought in June by the Human Rights Campaign, which represented two transgender women of color who "experienced discrimination based on their transgender status," according to the ruling.

The group's president, Alphonso David, called the ruling a "crucial early victory" for the plaintiffs.

"We are pleased the Court recognized this irrational rule for what it is: discrimination, plain and simple. LGBTQ Americans deserve the health care that they need without fear of mistreatment, harassment, or humiliation," he said in a statement.

Block leaned heavily on the Supreme Court's June ruling, which related to discrimination in the workplace and extended protection for LGBTQ workers but opened the door to other challenges to discrimination on the basis of sexual orientation or transgender status. The department published the rule change in the Federal Register four days after the justices passed down the historic ruling.

"Had the agency correctly predicted the outcome in Bostock, it may well have taken a different path. Instead, it continued on the same path even after Bostock was decided. This satisfies the Court that the premise of the repeal was a disagreement with a concept of sex discrimination later embraced by the Supreme Court. Therefore, the repeal was contrary to law," he wrote.

"The Court reiterates the same practical concern it raised at oral argument: When the Supreme Court announces a major decision, it seems a sensible thing to pause and reflect on the decision's impact," the ruling read. "Since HHS has been unwilling to take that path voluntarily, the Court now imposes it."

Lambda Legal, another LGBTQ group that sued this summer to block the rollback, also welcomed the court's decision on Monday.

"LGBTQ people, particularly transgender people, have been under constant attack by the Trump administration," said Carl Charles, an attorney with the group. "We applaud today's decision and look forward to continuing our fight against this rule that unlawfully targets and singles out LGBTQ people for discrimination during their most critical time of need, when seeking health care. Our communities deserve better."

The state of Washington had also sued in July to block the rollback, arguing in its suit that it violates patients' constitutional rights and the purpose of the ACA to increase access to health care and insurance, by "allowing broad discrimination to interfere with important medical care."

The Supreme Court will hear a suit seeking to overturn Obamacare a week after the election.
Abby Goodnough

The Supreme Court announced Wednesday that it would hear arguments in the latest case seeking to invalidate the Affordable Care Act — one backed by President Trump — on Nov. 10, a week after the presidential election.

Democrats have seized on Mr. Trump's support of the case, brought in 2018 by Republican state officials, as an election issue and have repeatedly mentioned it at their convention this week.

Joseph R. Biden Jr., the Democratic nominee and former vice president under Barack Obama, has campaigned on protecting and improving the Affordable Care Act. The law was the signature domestic achievement of the Obama presidency and has led to millions more Americans having health coverage even as the cost remains out of reach for others.

The suit awaiting the Supreme Court argues that when Congress in 2017 zeroed out the law's penalty for failing to obtain health insurance, it rendered the entire law unconstitutional.

The Trump administration sided with the state officials, arguing that the rest of the 2010 law could not survive without the penalty, also called the individual mandate. A federal judge in Texas agreed late in 2018 but postponed the effects of his ruling pending an appeal.

An appeals court late last year agreed that the mandate had become unconstitutional but declined to rule on the rest of the health law, asking the lower court to reconsider the question in more detail.

That led the defendants — Democratic states and the House of Representatives, which intervened in the case — to ask the Supreme Court to hear the appeal.

Bloomberg LAW

HHS Quietly Makes It Easier to Sign Up for Obamacare
Sara Hansard

People who have lost their health coverage since the beginning of the year now have a streamlined pathway to sign up for Obamacare.

The Department of Health and Human Services recently changed a question on the application for Affordable Care Act insurance to indicate that losing coverage since the start of the year allows people to sign up outside of the normal open enrollment period, according to people following ACA coverage.

Previously, the application for such coverage on the federal HealthCare.gov website used in 38 states asked if people had lost their coverage in the last 60 days—and the agency hasn't made any announcement of the change.

The change reopens the door to Obamacare to many people who didn't sign up within 60 days because they thought they would be back at work before then. It also eliminates some of the hoops people have to jump through in signing up for coverage.

"It's a really important step for people who have lost job-based coverage," Tara Straw, senior health policy analyst for the Center on Budget and Policy Priorities, said in an interview. "Many more people will be able to get it automatically."

However, it doesn't allow people who were uninsured before the pandemic to get coverage—as congressional Democrats have called for and as 12 of the exchanges run by states have done.

The Urban Institute estimates that on an average monthly basis during the pandemic period, 3.5 million people will have lost employer-sponsored insurance coverage and become uninsured.

Nearly 500,000 people had signed up for coverage on HealthCare.gov due to job loss through June.

The HHS didn't have an immediate response to a request for comment.

2018 Guidance

The HHS's Center for Consumer Information and Insurance Oversight, which operates HealthCare.gov, based its change on regulatory guidance the Trump administration issued in 2018, allowing for special enrollment periods when the Federal Emergency Management Agency declares a disaster, Straw said.

FEMA declared a nationwide disaster due to the Covid-19 pandemic in January. The provision extends until 60 days after the end of the FEMA incident period, Straw said.

The FEMA special enrollment period, or SEP, isn't specific to Covid, Straw said. "If there's a FEMA-declared disaster, then there's an extension on your ability to enroll" as long as enrollees qualify due to life changes such as loss of coverage, moving, or having a baby, she said.

However, the administration hasn't publicized it, and Affordable Care Act advocates only recently noticed the change on HealthCare.gov.

Easier Enrollment

The FEMA special enrollment period will allow people who have lost coverage in 2020 to enroll more easily, but they still have to provide documentation that they lost coverage, Straw said.

Previously, “no one knew about it, and it was a very complicated process to get it,” requiring contacting offices of the Centers for Medicare & Medicaid Services, she said.

“This is a really big deal,” Shelli Quenga, director of programs for the Palmetto Project, a nonprofit health insurance broker that serves South Carolina, said in an interview.

“We are talking to people now who are saying, I thought I was going to get called back on my job, I thought I was going to start working again, and I haven’t been called back. I don’t have health insurance. It’s been more than 60 days,” Quenga said.

An estimated 20% of South Carolinians, about 1 million people, are uninsured as a result of the pandemic, Quenga said. “We should be able to get a lot more people enrolled in coverage,” she said.

But, she added, “The challenge now is to get the word out because HealthCare.gov isn’t doing that.”

New Victory Shows ACA’s Staying Power In Court
Nicholas Starkman

In another court victory for the Affordable Care Act (ACA), a federal appellate court ruled in Texas v. Rettig that a provision of the ACA that imposes a federal health insurance provider fee is constitutional. Section 9010 of the ACA contains a provision known as the “Provider Fee,” which is one of the funding mechanisms which allowed Congress to expand healthcare access to 20 million more Americans. According to the IRS, the Provider Fee is broadly required from “each covered entity engaged in the business of providing health insurance for United States health risks.” Opponents of the ACA have tried through legal and political means to diminish the ACA’s efficacy by gutting the federal government’s ability to collect fees and penalties associated with ACA compliance. (In fact, the Provider Fee is set to expire after 2020 anyway.) More often than not, however, courts have upheld the ACA against challengers.

Texas v. Rettig is another data point in this trend. In this case, the states of Texas, Kansas, Louisiana, Indiana, Wisconsin, and Nebraska sued the federal government and its agencies by claiming that Section 9010 violated the constitution. You may be wondering why states sued the government and not the insurance providers

themselves, who are responsible for payment of the Provider Fee. Central to the states' argument that the Provider Fee is unconstitutional was that if the health insurance providers failed to pay the Provider Fee, it would be the states that would suffer, such as by losing Medicaid funding from the federal government. In tax terms, this concept is known as "incidence" and it describes who has the burden to pay the tax. The court quickly dismissed this idea by pointing out that the wording of the statute precludes states from picking up the tab if insurers fail to pay the Provider Fee: "The States misunderstand the meaning of legal incidence… the legal incidence of the Provider Fee does not fall on the states because Congress expressly excluded states from paying the fee."

Ultimately, Texas v. Rettig reinforces the staying power of the ACA, which has taken on more importance than ever in light of the global COVID-19 pandemic. As of the date of this article, the CDC notes that there are more than 170,000 deaths from COVID-19 in the US alone. Another case challenging the ACA is set to go before the United States Supreme Court this fall. In a brief, the American Medical Association and 20 leading physicians pleaded with the Court that now is the worst time to undue coverage gains associated with the ACA. Stay tuned to the ACA Times as we continue to update coverage of the ACA, the courts, and the pandemic.

Opponents of the ACA have tried through legal and political means to diminish the ACA's efficacy by gutting the federal government's ability to collect fees and penalties associated with ACA compliance. More often than not courts have upheld the ACA against challengers.

How Obamacare helped millions who lost their jobs during Covid-19, in 3 charts
Dylan Scott

The Covid-19 pandemic has been the first serious test for the Affordable Care Act as a new social safety net — and the law's provisions have proven adept, if imperfect, in protecting Americans from losing health insurance in the middle of an infectious disease outbreak and an economic crisis.

Two new analyses published in the last week explain concisely (as will I, aided by their charts) the depth of coverage losses resulting from the job losses of the last six months and the ACA's success in catching many of those people to give them a new health insurance plan.

This piece by Harvard researchers Sumit Agarwal and Benjamin Sommers, published in the New England Journal of Medicine, lays out how the ACA has made it easier for people who lose their job and their employer-sponsored health insurance to find coverage. The law created private insurance markets, with federal subsidies to help people afford a plan, and encouraged states to expand Medicaid for people in or near

poverty. Those provisions, especially Medicaid expansion, led to a meaningful reduction in the number of people who end up becoming uninsured after losing their job.

The Harvard researchers summarized their key finding like this:

In the post-ACA period ... job loss was no longer linked to an increase in the uninsured rate. Large gains in Medicaid (8.9 percentage points) and marketplace coverage (2.6 percentage points) nearly fully offset the reduction in ESI for people who left or lost their jobs. Overall, there was a 6.0 percentage point net reduction in loss of coverage after a job loss in the post-ACA period as compared with the pre-ACA period.

This data notably does not cover the coronavirus crisis itself, but it demonstrates Obamacare's general capacity to function as a safeguard against coverage losses resulting from unemployment.

As Agarwal and Sommers wrote: "These results indicate the critical role that the ACA will play in alleviating coverage losses related to the Covid-associated recession."

Still, no coverage losses during the Obama administration, when unemployment was on a consistent downward trajectory, can compare to what the US is enduring in the Covid-19 pandemic, when the jobless rate reached nearly 15 percent over the summer, though it has since recovered some.

New estimates from the Economic Policy Institute put the number of people who have lost the health insurance they or a family member previously got through their employer at about 12 million. There has been a significant churn in coverage since the spring.

The Harvard researchers summarized their key finding like this:

In the post-ACA period ... job loss was no longer linked to an increase in the uninsured rate. Large gains in Medicaid (8.9 percentage points) and marketplace coverage (2.6 percentage points) nearly fully offset the reduction in ESI for people who left or lost their jobs. Overall, there was a 6.0 percentage point net reduction in loss of coverage after a job loss in the post-ACA period as compared with the pre-ACA period.

This data notably does not cover the coronavirus crisis itself, but it demonstrates Obamacare's general capacity to function as a safeguard against coverage losses resulting from unemployment.

As Agarwal and Sommers wrote: "These results indicate the critical role that the ACA will play in alleviating coverage losses related to the Covid-associated recession."

Still, no coverage losses during the Obama administration, when unemployment was on a consistent downward trajectory, can compare to what the US is enduring in the Covid-19 pandemic, when the jobless rate reached nearly 15 percent over the summer, though it has since recovered some.

New estimates from the Economic Policy Institute put the number of people who have lost the health insurance they or a family member previously got through their employer at about 12 million. There has been a significant churn in coverage since the spring.

“These data indicate strongly that it is Medicaid, not the ACA marketplace exchanges, that does the heavy lifting of providing a health insurance safety net for those workers who lose ESI,” Bivens and Zipperer wrote.

Medicaid expansion has often been underappreciated for its role in Obamacare’s success, accounting for more than half of the coverage gains since the law took effect. In the time of Covid-19, it has continued to prove its worth.

But as I covered last week ahead of Joe Biden’s DNC speech, until the dozen Republican-led holdout states come around on Medicaid expansion, or until Democrats pass a plan to extend coverage to the people left in the Medicaid expansion gap, the work of Obamacare will remain unfinished.

ACA Reporting To Grow In Complexity Due To State Individual Mandates
Robert Sheen

Employers with operations in states that have additional state level ACA reporting as a requirement of the state’s Individual Mandate know that it’s no easy undertaking, but what exactly is required of them? Let’s find out.

The Individual Mandate requires individuals to purchase qualifying health coverage or pay a tax penalty, unless they qualify for an exemption. The Mandate encourages residents who might otherwise not buy health insurance to do so in order for health insurance to be more evenly spread amongst the pool of covered individuals, and not just the sick. Employers too have a part to play under the statewide Individual Mandate.

Currently California, Massachusetts, New Jersey, Rhode Island, Vermont, and the District of Columbia have Individual Mandates in place and require employers to report their ACA information on a state level.

Below is a breakdown of the statewide ACA reporting requirements and deadlines for employers by state:

New Jersey

The state of New Jersey requires Applicable Large Employers – companies with 50 or more employees – to use IRS forms 1094-C and 1095-C, (1095-B, and 1094-B if self-

insured) to communicate health insurance information to the state, in addition to their federal responsibilities for annually furnishing these forms to full-time employees and to the IRS. The deadline is March 31 of the following reporting year.

California
California has adopted a similar approach to New Jersey. Additionally, for the 2020 tax year, self-funded employers in California will need to report on the employees that had health coverage throughout the year. The information must be furnished to employees by January 31, 2021 and filed with California's Franchise Tax Board by March 31, 2021.

Washington DC
The DC law requires every "applicable entity that provides Minimum Essential Coverage to an individual during a calendar year" to submit an information return regarding such coverage to the Office of Tax and Revenue (OTR). It also requires the applicable entity to submit a statement about the individual's type of coverage. These filing requirements, while similar to Federal filing requirements under the ACA, are not the same. All information returns are required by OTR to be filed electronically through MyTaxDC, as paper filings will not be accepted. The new tax guidance requirements for annual reports are due beginning June 30, 2020. For future reporting years, the deadline for employers to file is 30 days after the federal IRS filing deadline.

Massachusetts
Employers with operations should note that their filings on the state level do not need to contain employee-level details like they do in annual ACA submissions to the IRS and are generally done by insurance carriers on behalf of individual employers. Massachusetts's mandate has been in place since 2006. Employers must file by December 15th of the reporting year, much earlier than the federal filing deadline.

Vermont
Currently in Vermont, there are no additional ACA reporting requirements for employers. Employers will have new coverage reporting obligations to the state only if the federal ACA reporting requirements are eliminated. And with the ACA's recent victories, that does not appear to be happening any time soon.

Rhode Island
Rhode Island's individual penalty went into effect in January 2020. At this time, the only additional reporting requirements employers will need to comply with are the furnishing of healthcare receipts to employees beginning January 2021. The state has not disclosed whether the furnishing of health statements will be on the standard 1095-C or through a similar document. Employers with operations in Rhode Island should watch closely for updates.

Ultimately, the patchwork of state-level ACA reporting could create a myriad of complexities for employers handling their ACA compliance in-house. This is especially true for employers who have operations in multiple states. These state-level ACA reporting requirements are in addition to the annual ACA reporting filed with the IRS as required under the Employer Mandate.

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

With the IRS now resuming the issuance of IRS penalties, employers should ensure they are complying to avoid penalty assessments from the federal agency and their state governments. For employers struggling to comply with all of the statewide reporting requirements in addition to the federal filing, contact us to learn how our ACA Compliance Services can benefit your organization.

To learn more about ACA compliance in 2020, click here.

Fortune

Only three of 26 Obamacare-era nonprofit health insurance co-ops will soon remain
Phil Galewitz

New Mexico Health Connections' decision to close at year's end will leave just three of the 23 nonprofit health insurance co-ops that sprung from the Affordable Care Act.

One co-op serves customers in Maine, another in Wisconsin, and the third operates in Idaho and Montana and will move into Wyoming next year. All made money in 2019 after having survived several rocky years, according to data filed with the National Association of Insurance Commissioners.

They are also all in line to receive tens of millions of dollars from the federal government under an April Supreme Court ruling that said the government inappropriately withheld

billions from insurers meant to help cushion losses from 2014 through 2016, the first three years of the ACA marketplaces. While those payments were intended to help any insurers losing money, it was vitally important to the co-ops because they had the least financial backing.

Lauded as a way to boost competition among insurers and hold down prices on the Obamacare exchanges, the co-ops had more than 1 million people enrolled in 26 states at their peak in 2015. Today, they cover about 128,000 people, just 1% of the 11 million Obamacare enrollees who get coverage through the exchanges.

The nonprofit organizations were a last-minute addition to the 2010 health law to satisfy Democratic lawmakers who had failed to secure a public option health plan — one set up and run by the government — on the marketplaces. Congress provided $2 billion in startup loans. But nearly all the co-ops struggled to compete with established carriers, which already had more money and recognized brands.

State insurance officials and health experts are hopeful the last three co-ops will survive.

“These are the three little miracles,” said Sabrina Corlette, a research professor and co-director of the Center on Health Insurance Reforms at Georgetown University, in Washington, D.C.

Maine aided in Supreme Court victory
The Maine co-op, Community Health Options, helped bring competition to the state’s market, which has had trouble at times attracting insurance carriers, said Eric Cioppa, who heads the state’s bureau of insurance.

“The plan has added a level of stability and has been a positive for Maine,” he said.

The co-op has about 28,000 members — down from about 75,000 in 2015 — and is building up its financial reserves, Cioppa said. Community Health Options is one of three insurers in the Obamacare marketplace in Maine, the minimum number experts say is needed to ensure vibrant competition.

Kevin Lewis, CEO of the plan, attributed its survival to several factors, including an initial profit in 2014, the year the ACA marketplaces opened, that put the plan on a secure footing before several years of losses. He also credited bringing most functions of the health plan in-house rather than contracting out, diversifying to sell plans to small and large employers, and securing lower rates from two health systems during a couple of difficult years.

Jay Gould, 60, a member who offers the plan to workers at his small grocery in Clinton, has been happy with the plan. “They have great customer service, and it’s good to know when I am talking to someone that they are from Maine,” he said.

Central Aroostook Association, a Presque Isle nonprofit that helps children with intellectual disabilities, switched to the co-op last year to save 20% on its health premiums, said administrator Tammi Easler. Having a Maine insurer means any issues can be dealt with quickly, she said. “They are readily available, and I never have to wait on hold for an hour.”

The co-op, which made a $25 million profit each of the past two years, has proposed dropping its average premiums by about 14% in 2021, Lewis said.

Community Health was one of the lead plaintiffs in the case before the Supreme Court and expects to get $59 million in back payments from the settlement.

The federal decision to suspend those so-called risk corridor payments — designed to help health plans recover some of their losses — was one of the factors that caused many of the co-ops to fail, Corlette said. Republican critics of the ACA, however, blame poor management by the plans and lack of oversight by the Obama administration.

Insurers are in talks with the Trump administration about whether the $13 billion due the carriers must be added to their 2020 balance sheet or could be counted toward operations from prior years. This year, insurers are generally banking large profits since many people have delayed non-urgent care because of the COVID-19 pandemic. Since the ACA limits insurers’ profit margins, adding that federal windfall to this year’s ledger might mean many insurers would have to pay out most of the money to their consumers. If the money is applied to earlier years, the insurers could likely keep more of it to add to their reserves.

Too much competition in New Mexico

The Supreme Court ruling came too late for New Mexico Health Connections, which lost nearly $60 million from 2015 to 2017. The co-op would have received $43 million in overdue payments, but, in an effort to raise needed cash, it sold that debt to another insurer in 2017 for a much smaller amount.

Marlene Baca, CEO of the co-op, which made a $439,000 profit in 2019, said its goal of bringing competition into the market was achieved, since five other companies will be enrolling customers this fall for 2021. Yet, that competition eventually led to the plan’s decision to end operations, announced last month.

With only 14,000 members, it made no sense to continue operating due to high fixed administrative costs, she said. Her plan was also hurt by the slumping economy this year, which pushed many state residents out of work and made more than 3,000 members eligible for Medicaid, the state-federal health program for the poor.

“We did our very best,” Baca said, noting that her company is closing with enough money to pay its outstanding health claims. Many other co-ops that shuttered were closed out by their states and unable to meet all their debts to health providers, she said.

Montana’s Co-Op Is Expanding

The Mountain Health Co-Op, with about 32,000 members, has just two competitors in its home state of Montana and four in Idaho.

A big factor behind its survival was that the plan received a $15 million loan in 2016 from St. Luke’s Health System, Idaho’s largest hospital provider, said CEO Richard Miltenberger. Although he wasn’t working for the co-op at that time, Miltenberger said, it is his understanding that the hospital wanted to help keep competition in that marketplace.

The co-op is expecting $57 million from the Supreme Court victory.

“We are in excellent shape,” Miltenberger said. The plan, which paid back the St. Luke’s loan and made a $15 million profit in 2019, added vision benefits this year and is offering a dental exam benefit for next year. It’s also providing most insulin and medications for asthma and chronic obstructive pulmonary disease to members without any copayment to help ensure compliance.

The insurer is moving into Wyoming for 2021, which will end the Blue Cross plan monopoly in that state’s Obamacare marketplace, he said.

Wisconsin’s mystery donor
Wisconsin’s Common Ground Healthcare Cooperative was on the verge of ending operations in 2016 when itreceived a lifesaving $30 million loan, said CEO Cathy Mahaffey. The insurer has refused to identify the benefactor other than to say it was not a person or company doing business with the plan.

In 2018, Common Ground was the only health plan in seven northeastern Wisconsin counties, she said. Today, the co-op has about 54,000 members and faces competition from two to five carriers in the 20 counties where it operates.

Common Ground, which recorded a $73 million profit last year, expects to receive about $95 million from the Supreme Court case victory.

Wisconsin's decision not to expand Medicaid under the health law has benefited the co-op because people with incomes from 100% to 138% of the federal poverty level ($12,760 to $17,609 for an individual) are ineligible for Medicaid and must stay with marketplace plans for coverage. In states that expanded Medicaid, everyone with incomes under 138% of the poverty level is eligible.

Another factor was its decision in 2016 to eliminate the broad provider network offering and sell a plan offering only a narrow network of doctors and hospitals, allowing it to benefit from lower rates from its providers, according to Mahaffey.

"We are very strong financially," she said.