COVERED CALIFORNIA Media Clips

COVERED CALIFORNIA BOARD CLIPS

May 13, 2021 – June 7, 2021

Since the May board meeting, Covered California saw a surge in enrollment with its American Rescue Plan special enrollment period, as did the HealthCare.gov, which announced that it now has 31 million Americans are receiving health care coverage through the Affordable Care Act.

PRESS RELEASES

PRINT

Articles of Significance

COVERED CALIFORNIA

News Release

May 20, 2021

Covered California's Enrollment Surges as People Sign Up to Benefit From the New Financial Help and Lower Premiums Now Available Through the American Rescue Plan

- *More than 76,000 people signed up for health insurance during Covered California's special-enrollment period between April 12 and May 15.*
- *The surge is more than 2.5 times higher than a traditional special-enrollment period, reflecting an increase of more than 46,000 people, compared to the same time period in 2019.*
- *Covered California launched a special-enrollment period to allow the uninsured and those enrolled directly through a health insurance carrier to enroll and benefit from lower premiums due to the American Rescue Plan.*
- *More than half of the Covered California households which are benefiting from the new and expanded financial help provided by the American Rescue Plan are getting high-quality coverage for $1 per month.*
- In order to start saving, Californians need to enroll by May 31 so they can begin benefiting from the new law on June 1.

SACRAMENTO, Calif. — New data from Covered California shows a surge in enrollment as tens of thousands of consumers signed up for health care coverage to benefit from the lower premiums now available through the American Rescue Plan. More than 76,000 people have signed up for coverage since Covered California launched a special-enrollment period, which is more than 2.5 times as many as those that enrolled during the same time period in 2019.

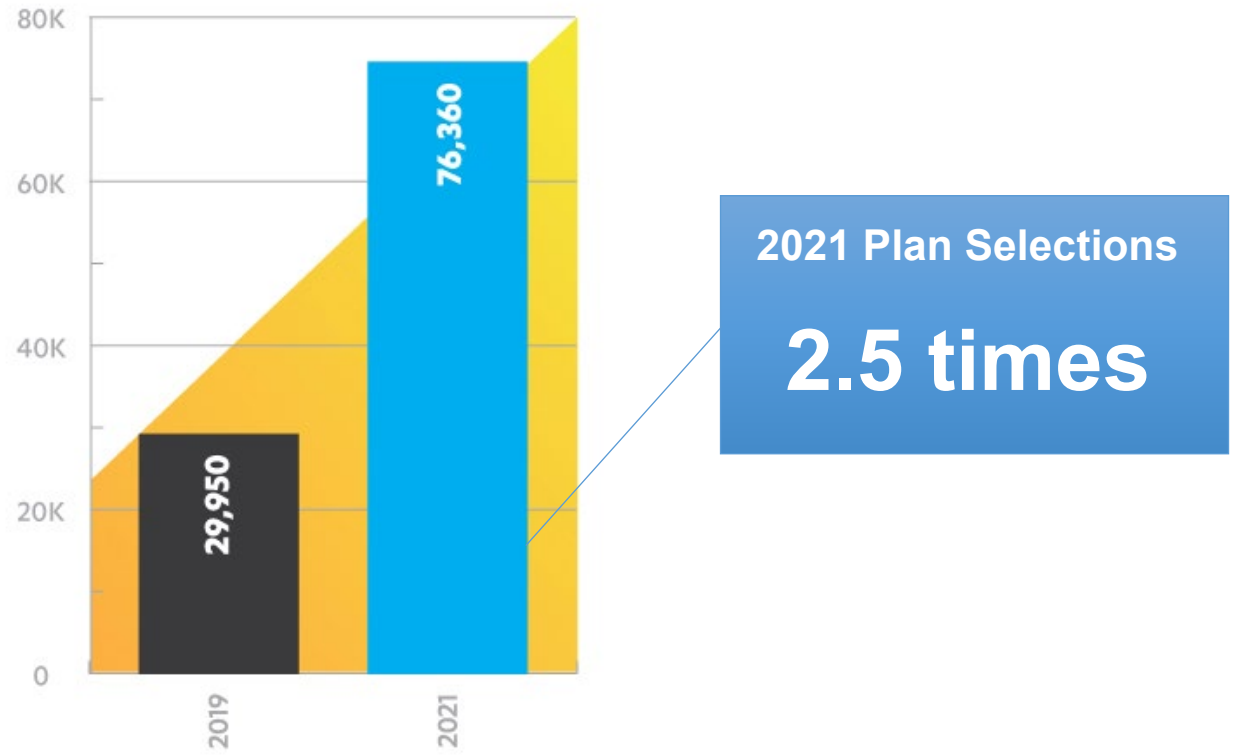
"The new and expanded financial help provided by the American Rescue Plan is lowering premiums for thousands of Californians, making it easier for them to get covered and stay covered," said Peter V. Lee, executive director of Covered California.

“The good news is that Californians still have time to sign up, but they need to act quickly, because every month that goes by is a month without coverage and money lost.”

The American Rescue Plan provides new and expanded financial help to people who receive their health insurance through an Affordable Care Act Marketplace, like Covered California. The law ensures that everyone eligible will pay no more than 8.5 percent of their household income on their health care premiums. Covered California launched a special-enrollment period on April 12 to allow Californians to sign up for coverage, or switch their coverage to the exchange, in order to begin benefiting from the new law.

The data shows that a total of 76,360 people signed up between April 12 and May 15, which is 46,000 more — or 2.5 times higher — than the same time period in 2019, when a traditional special-enrollment period was last held.[1] (See Table 1: Consumer Plan Selections During Special Enrollment.)

Table 1: Consumer Plan Selections During Special Enrollment (April 12 – May 15)



“Quality health care coverage through Covered California is more affordable than ever, and the sooner people sign up, the sooner they can start saving and be covered,” Lee

[1] In 2020, Covered California had 64,430 plan selections during the same period. The increase was due to a special-enrollment period established to respond to the COVID-19 pandemic and recession, which was supported by a major outreach campaign. Today’s announcement is almost 20 percent higher than the results of 2020.

said. “We have seen consumers save hundreds of dollars a month by switching to Covered California, while others are able to get covered for $1 a month.

In addition to providing lower costs to those who are uninsured or currently purchase coverage directly, the American Rescue Plan reduced the costs for 1.3 million of Covered California’s 1.55 million consumers. Prior to the American Rescue Plan, only 11 percent of those households, which had their eligibility redetermined to benefit from the new law, were able to get a quality plan for $1 a month. The new data shows that more than four times as many households, or 51 percent of the redetermined group, are now covered for $1 per month through the new and expanded financial help of the American Rescue Plan.

“For less than the price of a bus ride, or a soda, many Californians are able to get high-quality coverage from some of the best doctors and hospitals in the country,” Lee said. “Do not miss out on this historic opportunity, you owe it to yourself to check it out and see what this new financial help can mean for you and your family.”

Overall, about 680,000 of Covered California’s 1.55 million enrollees are now enrolled in plans that cost $1 per month. Of those, nearly 400,000 people signed up for enhanced Silver plans that include cost-sharing benefits such as lower co-pays, lower deductibles and lower out-of-pocket expenses which make it easier for them to access the health care they need.

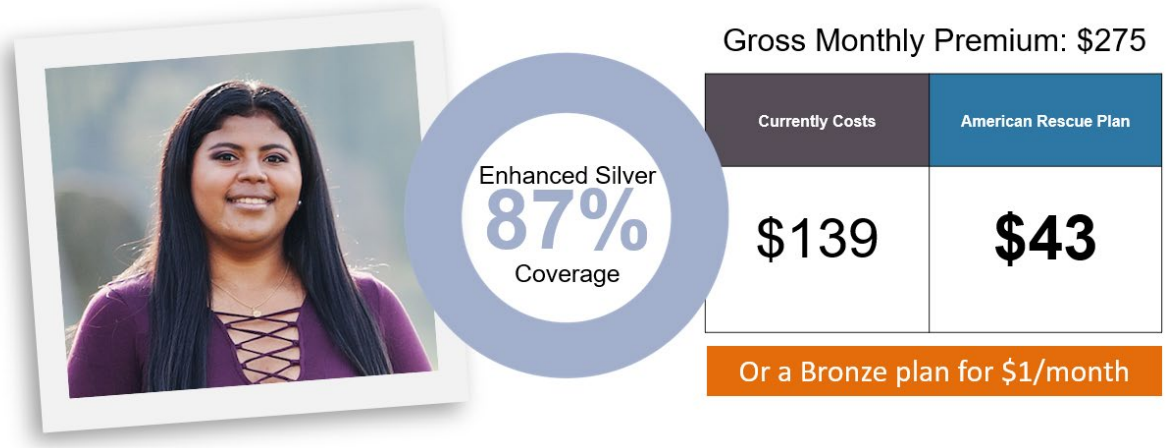
“Lowering the cost of coverage and care helps people stay covered and it allows them to put that money back into our economy, which helps their communities,” Lee said.

Which Californians Need to Act Now to Benefit From the American Rescue Plan?

The new financial assistance can directly help Californians by lowering their monthly premium to levels never seen before. However, in order to maximize their savings, the following groups of people need to act now by May 31 in order to have coverage that starts on June 1:

- **Uninsured Californians**: New data shows that an estimated 810,000 Californians in the state are uninsured and eligible for health insurance through Covered California, with an additional 1 million people eligible for no-cost Medi-Cal. Under the American Rescue Plan, most of those eligible for Covered California would be able to get a high-quality health plan from one of 11 trusted name-brand companies for as little as $1 per month, or a plan that offers richer benefits for less than $100 per month (see Figure 1: Premiums Are Lower Than Ever for the Uninsured).

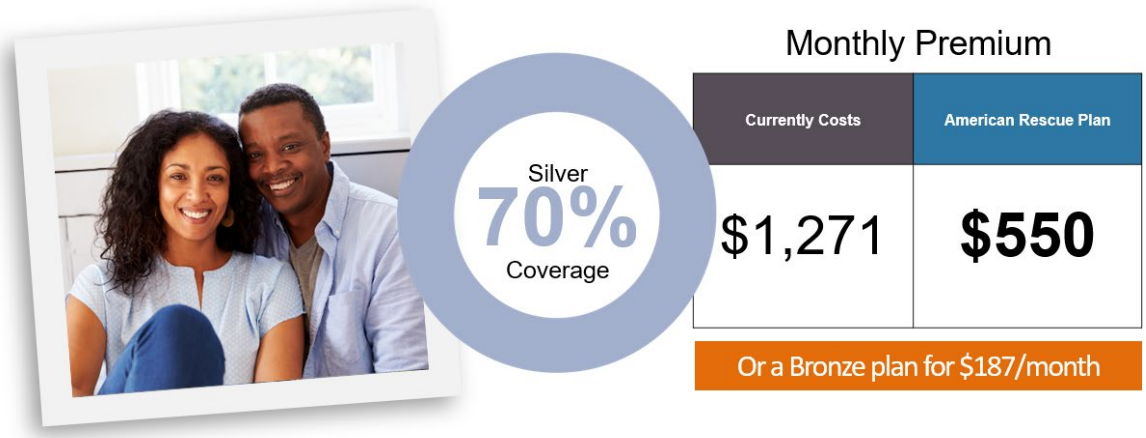
Figure 1: Premiums Are Lower Than Ever for the Uninsured



Sofia in Los Angeles | Age: 21 | Income: $25,520/year

- **Californians insured directly through a health insurance company**: Nearly 270,000 Californians are insured directly through a health insurance company in what is referred to as "off-exchange coverage" and do not receive any financial help. The new and expanded subsidies mean that many consumers will be able save hundreds of dollars per month if they switch and get their insurance through Covered California (see Figure 2: Off-Exchange Consumers Save by Switching to Covered California).

Figure 2: Off-Exchange Consumers Save by Switching to Covered California



Vanessa and Mike in Oakland | Ages: 45 | Income: $77,580/year

Covered California's special-enrollment period will run through the end of the year, but Lee encouraged consumers to act now in order to start saving.

"Do not miss out on this opportunity," Lee said. "We don't want any eligible person to be uninsured or leave money on the table."

Consumers Can Find Out in Minutes How Much They Can Save

Covered California is encouraging people to check if they are eligible for lower premiums due to the American Rescue Plan. Consumers can easily see exactly how they can benefit from the new law at CoveredCA.com by entering their ZIP code, household income and the ages of the people in the household to see how low their premiums can be and the health insurance options in their area.

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

- Visit www.CoveredCA.com.
- Use the website to find local insurance agents or certified enrollers in community organizations who provide free and confidential assistance over the phone or in person, in a variety of languages.
- Have a certified enroller call them for free help.
- Call Covered California at (800) 300-1506.

COVERED CALIFORNIA

News Release

May 25, 2021

Covered California Urges Central Valley Residents to Enroll by May 31 to Save Money With Lower Health Insurance Premiums Now Available Through the American Rescue Plan

- *The American Rescue Plan provides new and expanded financial help that dramatically lowers health insurance premiums for people who purchase health insurance through Covered California.*
- *More than 136,000 people in the Central Valley, including the uninsured and people currently enrolled directly through a health insurance carrier, stand to benefit from the new financial help that is now available.*
- *In order to maximize their savings, consumers need to enroll by May 31 so they can begin saving and benefiting from the new law on June 1.*
- *Many people will be able to get a high-quality plan for as little as $1 per month, and currently insured consumers could save hundreds of dollars per month on their coverage if they switch to Covered California.*

SACRAMENTO, Calif. — Covered California announced that an estimated 136,000 people throughout the Central Valley can benefit from lower health insurance premiums provided by the American Rescue Plan. The landmark law provides new and expanded financial help that is making health care coverage more affordable than ever before. However, people in the Central Valley need to act now in order to realize those savings. Those who sign up by May 31 will have coverage starting June 1.

“The new and expanded financial help provided by the American Rescue Plan can help people throughout the Central Valley get covered and stay covered by lowering their premiums and putting money back into their pockets,” said Peter V. Lee, executive director of Covered California.

“The American Rescue Plan provides the most significant savings for consumers since the Affordable Care Act began, but in order for many people to make the most of those savings, they need to act before the month ends.”

State lawmakers Assemblyman Dr. Joaquin Arambula (Fresno) and Sen. Melissa Hurtado (Sanger) joined Covered California to encourage people in the Central Valley to take a moment to check out their options and find out how affordable quality coverage can be. The lawmakers also recognized the importance of health insurance in addressing the disproportionate impacts of the pandemic and recession in the Central Valley’s diverse communities.

Data from prior to the pandemic showed that California faced significant and persistent racial and ethnic health disparities, particularly among its Latino and Black populations. The pandemic widened these gaps, with disproportionately higher infection and death rates among California’s Latino, Black and Pacific Islander communities.

“The COVID-19 pandemic has shown us just how crucial it is to have health care coverage — especially for our communities of color, for those who work in our fields and in other essential jobs that power our state,” Arambula said. “This crisis has made it clear that everyone in California must have access to quality health care. With the American Rescue Plan in place, the cost of quality coverage through Covered California is an affordable option.”

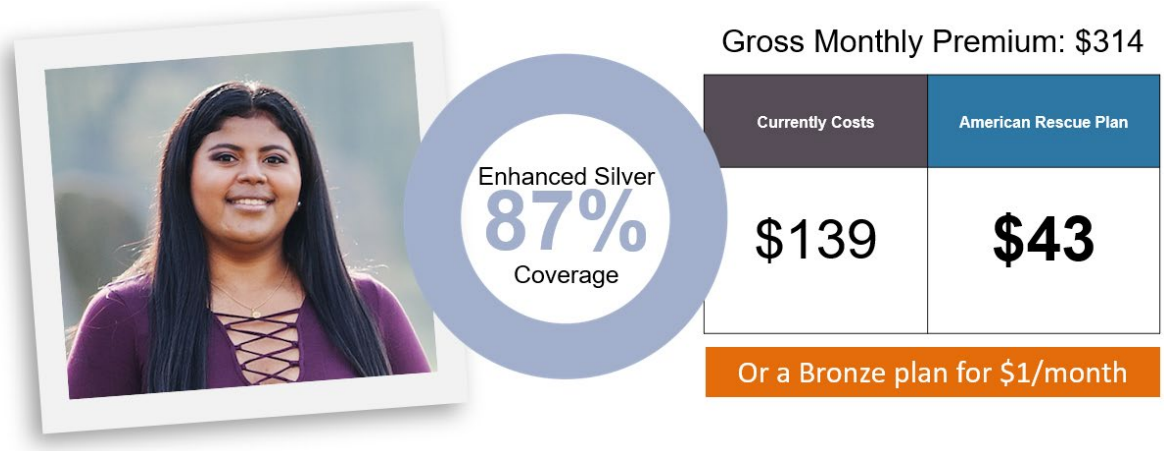
“The Central Valley has limited access to health care and faces great inequities regarding health care quality,” said Sen. Hurtado. “Many people lack adequate health insurance — which in some areas can be such a high cost that people only elect to get minimum coverage. The American Rescue Plan will extend the opportunity for millions in California to receive affordable health insurance through Covered California. I encourage people who are seeking health insurance to enroll through Covered California, to save money and receive comprehensive coverage.”

Which Californians benefit from the American Rescue Plan?

Covered California estimates the new financial assistance can directly help 2.5 million Californians — including more than 136,000 people in the Central Valley — by lowering their monthly health insurance premiums. The new law stands to benefit the following groups of people:

- **Uninsured Central Valley residents:** New data shows that nearly 65,000 people in the Central Valley are uninsured and eligible for health insurance coverage through Covered California. Under the American Rescue Plan, most of those consumers would be able to get a high-quality health plan from one of 11 trusted name-brand companies for as little as $1 per month, or a plan that offers richer benefits for less than $100 per month (see Figure 1: Premiums Are Lower Than Ever for the Uninsured).

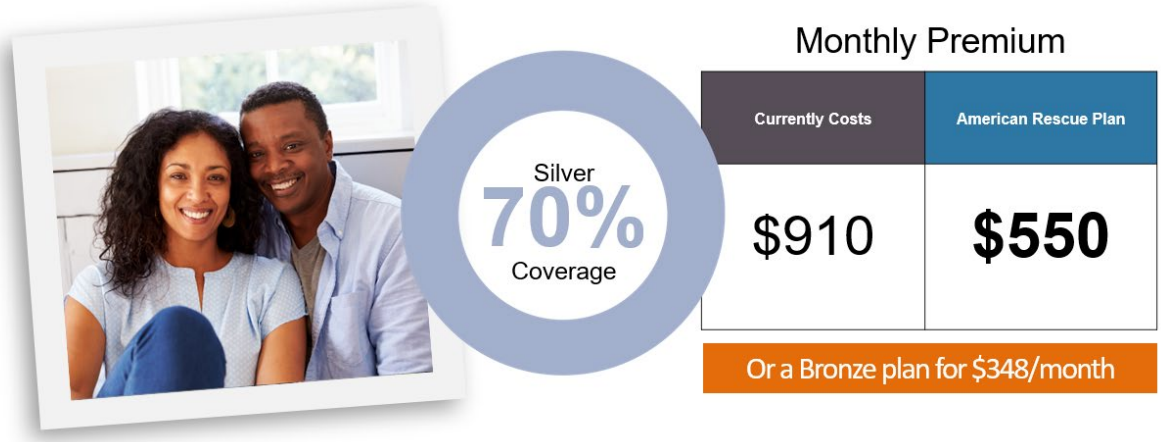
Figure 1: Premiums Are Lower than Ever for the Uninsured



Sofia in Fresno | Age: 21 | Income: $25,520/year

- **Central Valley residents insured "off-exchange":** Nearly 10,000 people in the Central Valley are insured "off-exchange," or directly through a health insurance carrier, and do not receive any financial help. The American Rescue Plan ensures that everyone eligible will pay no more than 8.5 percent of their household income on their health care premiums if they are enrolled in an Affordable Care Act marketplace like Covered California. The new and expanded subsidies mean that many consumers will be able to save hundreds of dollars per month if they switch and get their insurance through Covered California (see Figure 2: Off-Exchange Consumers Save by Switching to Covered California).

Figure 2: Off-Exchange Consumers Save by Switching to Covered California



Vanessa and Mike in Bakersfield | Ages: 45 | Income: $77,580/year

Finally, more than 76,000 Central Valley residents already enrolled through Covered California have begun benefiting from the new law, when their monthly premiums were automatically reduced in May.

Covered California's special-enrollment period will run through the end of the year, but Lee encouraged consumers to act now in order to start saving.

"Do not miss out: the sooner you sign up, the sooner you can start saving and be covered," Lee said. "We don't want anyone, from Fresno to Bakersfield and everywhere in between, to be uninsured or leave money on the table."

Lee also noted that even if people are not eligible for the new financial help through Covered California, they may still have insurance options. An estimated 138,000 people in the Central Valley are uninsured and eligible for no-cost coverage through Medi-Cal.

Quality Coverage for $1 a Month

Covered California announced last week that roughly 680,000 of its 1.55 million enrollees, or 44 percent, are signed up in quality coverage plans that cost $1 per month. Of those, nearly 400,000 people are in Enhanced Silver plans that include cost-sharing benefits in the form of lower copays, lower deductibles and lower out-of-pocket expenses, which make it easier for them to access the health care they need.

"You owe it to yourself to check it out and see what this new financial help can mean for you and your family," Lee said. "For less than the price of a bus ride or a soda, many Californians are getting the protection and peace of mind that comes with being covered for just $1 a month."

Consumers in the Central Valley are even more likely to get a quality health insurance plan for just $1 per month. Data shows that nearly three out of every five households (57 percent) in Fresno, Kern, Kings and Madera Counties are paying $1 a month.

In addition, the American Rescue Plan provides generous help to those who received unemployment insurance benefits in 2021. Under the new law, Californians who received unemployment insurance benefits in 2021 — *regardless of their actual income in 2021* — will be eligible for quality coverage that will cost only $1 per month.

Covered California is currently working to implement this benefit into its enrollment and consumer cost-comparison systems. While those changes are expected to be implemented next month, consumers who are enrolled or who sign up before that time will receive the lower premium retroactive to when their coverage commenced. An estimated 10 percent of current Covered California enrollees would be eligible for this added benefit, further reducing their costs and putting even more money back into their pockets.

Consumers Can Find Out in Minutes How Much They Can Save

Covered California is encouraging people to check if they are eligible for lower premiums due to the American Rescue Plan. Consumers can easily see exactly how they can benefit from the new law on CoveredCA.com by entering their ZIP code, household income and the ages of the people in the household to see how low their premiums can be and the health insurance options in their area.

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

- Visit www.CoveredCA.com.
- Use the website to find local insurance agents or certified enrollers in community organizations who provide free and confidential assistance over the phone or in person, in a variety of languages.
- Have a certified enroller call them for free help.
- Call Covered California at (800) 300-1506.

COVERED CALIFORNIA

News Release

May 25, 2021

Covered California Urges Inland Empire Residents to Enroll by May 31 to Save Money With Lower Health Insurance Premiums Now Available Through the American Rescue Plan

- *The American Rescue Plan provides new and expanded financial help that dramatically lowers health insurance premiums for people who purchase health insurance through Covered California.*
- *Hundreds of thousands of people in the Inland Empire, including the uninsured and people currently enrolled directly through a health insurance carrier, stand to benefit from the new financial help that is now available.*
- *In order to maximize their savings, consumers need to enroll by May 31 so they can begin saving and benefiting from the new law on June 1.*
- *Many people will be able to get a high-quality plan for as little as $1 per month, and currently insured consumers could save hundreds of dollars per month on their coverage if they switch to Covered California.*

SACRAMENTO, Calif. — Covered California announced that hundreds of thousands of people, including an estimated 140,000 people throughout Riverside County alone, can benefit from lower health insurance premiums provided by the American Rescue Plan. The landmark law provides new and expanded financial help that is making health care coverage more affordable than ever before. However, people in the Inland Empire need to act now in order to realize those savings. Those who sign up by May 31 will have coverage starting June 1.

“The new and expanded financial help provided by the American Rescue Plan can help people throughout the Inland Empire get covered and stay covered by lowering their premiums and putting money back into their pockets,” said Peter V. Lee, executive director of Covered California.

“The American Rescue Plan provides the most significant savings for consumers since the Affordable Care Act began, but in order for many people to make the most of those savings, they need to act before the month ends.”

Congressman Dr. Raul Ruiz (36th Congressional District) joined Covered California to encourage people throughout the county to take a moment to check out their options and find out how affordable quality health care coverage can be. Rep. Ruiz, who serves as Chair of the Congressional Hispanic Caucus and who has championed the American Rescue Plan, is an emergency room doctor who provided care Eisenhower Medical Center in Rancho Mirage, and helped open a free clinic for underserved communities in the region to ensure that they get the health care they need.

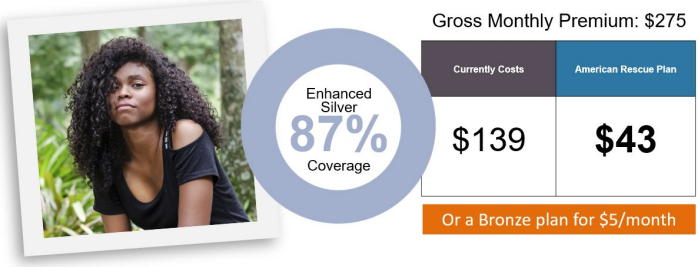
“The COVID-19 pandemic has underscored how crucial it is for Californians to have access to quality, affordable health care,” said Dr. Ruiz. “I am thrilled to have partnered with Covered California today to help all Californians access the care they need at a time when they need it most. Now is the time to get covered and access affordable, quality health care thanks to the American Rescue Plan’s reduced premiums through expanded subsidies. I encourage Californian families to enroll for health care coverage through Covered California before the May 31st deadline so that they can get the care they need starting on June 1st.”

Which Californians benefit from the American Rescue Plan?

Covered California estimates the new financial assistance can directly help 2.5 million Californians — including more than 140,000 people in Riverside County alone[2] — by lowering their monthly health insurance premiums. The new law stands to benefit the following groups of people:

- **Uninsured Inland Empire residents:** Under the American Rescue Plan, many uninsured consumers would be able to get a high-quality health plan from one of 11 trusted name-brand companies for as little as $1 per month, or a plan that offers richer benefits for less than $100 per month (see Figure 1: Premiums Are Lower Than Ever for the Uninsured). An estimated 62,000 people in Riverside County are uninsured and eligible for health insurance coverage through Covered California.

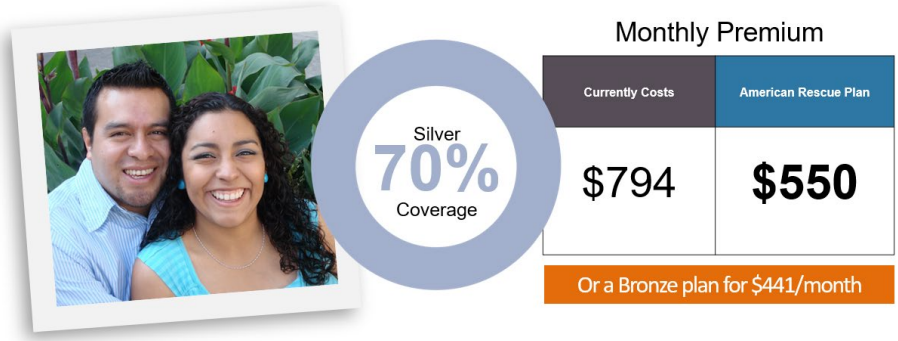
Figure 1: Premiums Are Lower Than Ever for the Uninsured



[2] Specific estimates for San Bernardino County are not available.

- **Inland Empire residents insured "off-exchange":** Thousands of people in the Inland Empire – including 10,000 in Riverside County - are insured "off-exchange," or directly through a health insurance carrier, and do not receive any financial help. The American Rescue Plan ensures that everyone eligible will pay no more than 8.5 percent of their household income on their health care premiums if they are enrolled in an Affordable Care Act marketplace like Covered California. The new and expanded subsidies mean that many consumers will be able to save hundreds of dollars per month if they switch and get their insurance through Covered California (see Figure 2: Off-Exchange Consumers Save by Switching to Covered California).

Figure 2: Off-Exchange Consumers Save by Switching to Covered California



Fran and Jesse in Palm Springs | Ages: 45 | Income: $77,580 /year

Finally, existing Covered California have already begun benefiting from the new law, when their monthly premiums were automatically reduced in May.

Covered California's special-enrollment period will run through the end of the year, but Lee encouraged consumers to act now in order to start saving.

"Do not miss out: the sooner you sign up, the sooner you can start saving and be covered," Lee said. "We don't want anyone in the Inland Empire, or across the state, to be uninsured or leave money on the table."

Lee also noted that even if people are not eligible for the new financial help through Covered California, they may still be eligible for no-cost coverage through Medi-Cal.

Quality Coverage for $1 a Month

Covered California announced last week that roughly 680,000 of its 1.55 million enrollees, or 44 percent, are signed up in quality coverage plans that cost $1 per month.

Of those, nearly 400,000 people are in Enhanced Silver plans that include cost-sharing benefits in the form of lower copays, lower deductibles and lower out-of-pocket expenses that make it easier for them to access the health care they need.

"You owe it to yourself to check it out and see what this new financial help can mean for you and your family," Lee said. "For less than the price of a bus ride or a soda, many

Californians are getting the protection and peace of mind that comes with being covered for just $1 a month."

In addition, the American Rescue Plan provides generous help to those who received unemployment insurance benefits in 2021. Under the new law, Californians who received unemployment insurance benefits in 2021 — *regardless of their actual income in 2021* — will be eligible for quality coverage that will cost only $1 per month.

Covered California is currently working to implement this benefit into its enrollment and consumer cost-comparison systems. While those changes are expected to be implemented next month, consumers who are enrolled or who sign up before that time will receive the lower premium retroactive to when their coverage commenced. An estimated 10 percent of current Covered California enrollees would be eligible for this added benefit, further reducing their costs and putting even more money back into their pockets.

Consumers Can Find Out in Minutes How Much They Can Save

Covered California is encouraging people to check if they are eligible for lower premiums due to the American Rescue Plan. Consumers can easily see exactly how they can benefit from the new law on CoveredCA.com by entering their ZIP code, household income and the ages of the people in the household to see how low their premiums can be and the health insurance options in their area.

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

- Visit www.CoveredCA.com.
- Use the website to find local insurance agents or certified enrollers in community organizations who provide free and confidential assistance over the phone or in person, in a variety of languages.
- Have a certified enroller call them for free help.
- Call Covered California at (800) 300-1506.

COVERED CALIFORNIA

News Release

May 26, 2021

Covered California Urges Sacramento, Stockton and Modesto Residents to Enroll by May 31 to Save Money With Lower Health Insurance Premiums Now Available Through the American Rescue Plan

- *The American Rescue Plan provides new and expanded financial help that dramatically lowers health insurance premiums for people who purchase health insurance through Covered California.*
- *An estimated 272,000 people in the Sacramento, Stockton and Modesto region – including the uninsured and people currently enrolled directly through a health insurance carrier – stand to benefit from the new financial help that is now available.*
- *In order to maximize their savings, consumers need to enroll by May 31 so they can begin saving and benefiting from the new law on June 1.*
- *Many people will be able to get a high-quality plan for as little as $1 per month, and currently insured consumers could save hundreds of dollars per month on their coverage if they switch to Covered California.*

SACRAMENTO, Calif. — Covered California announced that an estimated 272,000 people throughout Sacramento, Stockton and Modesto can benefit from lower health insurance premiums provided by the American Rescue Plan. The landmark law provides new and expanded financial help that is making health care coverage more affordable than ever before. However, people in the region need to act now in order to realize those savings. Those who sign up by May 31 will have coverage starting June 1.

“The new and expanded financial help provided by the American Rescue Plan can help people throughout the Sacramento, Stockton and Modesto region get covered and stay covered by lowering their premiums and putting money back into their pockets,” said Peter V. Lee, executive director of Covered California.

“The American Rescue Plan provides the most significant savings for consumers since

the Affordable Care Act began, but in order for many people to make the most of those savings, they need to act before the month ends."

Congressman Dr. Ami Bera (7th Congressional District) joined Covered California to encourage people throughout the region to take a moment to check out their options and find out how affordable quality health care coverage can be. Bera not only voted in support of the American Rescue Plan, he's served as a doctor throughout the Sacramento region and has worked to improve the availability, quality, and affordability of healthcare.

"The American Rescue Plan provides critical financial help to people throughout Sacramento, and across the state, and makes quality health care coverage more affordable than ever before," Bera said. "The new financial help that is now available gives us all a tremendous opportunity to make sure our family and friends have the protection and peace of mind that comes with coverage, and now is the time to sign up."

California State Senator Dr. Richard Pan (6th Senate District) also voiced his support for the effort. Dr. Pan is a pediatrician who chairs the Senate Committee on Health, and he encouraged everyone who needs coverage to check out their options and find out how affordable quality health insurance can be.

"The American Rescue Plan is making health care coverage even more affordable for more Californians. Being uninsured may be more expensive than getting insured," Pan said. "The COVID-19 pandemic is a reminder that people often need health care coverage when they don't expect it. If you have not checked recently, go to Covered California to learn about new opportunities to save on your health coverage."

Which Californians benefit from the American Rescue Plan?

Covered California estimates the new financial assistance can directly help 2.5 million Californians — including more than 272,000 people in the Sacramento, Stockton and Modesto region — by lowering their monthly health insurance premiums. The new law stands to benefit the following groups of people:

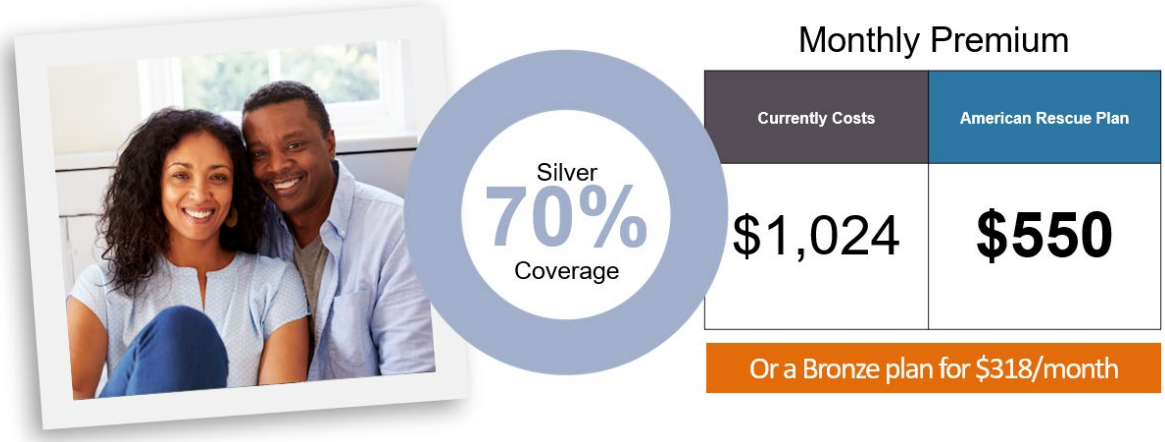
- **Uninsured residents:** Under the American Rescue Plan, many uninsured consumers would be able to get a high-quality health plan from one of 11 trusted name-brand companies for as little as $1 per month, or a plan that offers richer benefits for less than $100 per month (see Figure 1: Premiums Are Lower Than Ever for the Uninsured). More than 85,000 people in the region are estimated to be uninsured and eligible for health insurance coverage through Covered California. An additional 112,000 are estimated to be uninsured and eligible for no-cost coverage through Medi-Cal.

Figure 1: Premiums Are Lower Than Ever for the Uninsured

Sofia in Sacramento | Age: 21 | Income: $25,520/year

- **Residents insured "off-exchange":** More than 20,000 people in the Sacramento region are estimated to be insured "off-exchange," or directly through a health insurance carrier, and do not receive any financial help. The American Rescue Plan ensures that everyone eligible will pay no more than 8.5 percent of their household income on their health care premiums if they are enrolled in an Affordable Care Act marketplace like Covered California. The new and expanded subsidies mean that many consumers will be able to save hundreds of dollars per month if they switch and get their insurance through Covered California (see Figure 2: Off-Exchange Consumers Save by Switching to Covered California).

Figure 2: Off-Exchange Consumers Save by Switching to Covered California



Vanessa and Mike in Stockton | Ages: 45 | Income: $77,580/year

Finally, more than 165,000 people in the region enrolled in Covered California have already begun benefiting from the new law, when their monthly premiums were automatically reduced in May.

Covered California's special-enrollment period will run through the end of the year, but Lee encouraged consumers to act now in order to start saving.

"Do not miss out: the sooner you sign up, the sooner you can start saving and be covered," Lee said. "We don't want anyone in Sacramento, Stockton or Modesto – or across the state – to be uninsured or leave money on the table."

Lee also noted that even if people are not eligible for the new financial help through Covered California, they may still be eligible for no-cost coverage through Medi-Cal.

Quality Coverage for $1 a Month

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Of those, nearly 400,000 people are in Enhanced Silver plans that include cost-sharing benefits in the form of lower copays, lower deductibles and lower out-of-pocket expenses that make it easier for them to access the health care they need.

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In addition, the American Rescue Plan provides generous help to those who received unemployment insurance benefits in 2021. Under the new law, Californians who received unemployment insurance benefits in 2021 — *regardless of their actual income in 2021* — will be eligible for quality coverage that will cost only $1 per month.

Covered California is currently working to implement this benefit into its enrollment and consumer cost-comparison systems. While those changes are expected to be implemented next month, consumers who are enrolled or who sign up before that time will receive the lower premium retroactive to when their coverage commenced. An estimated 10 percent of current Covered California enrollees would be eligible for this added benefit, further reducing their costs and putting even more money back into their pockets.

Consumers Can Find Out in Minutes How Much They Can Save

Covered California is encouraging people to check if they are eligible for lower premiums due to the American Rescue Plan. Consumers can easily see exactly how they can benefit from the new law on CoveredCA.com by entering their ZIP code, household income and the ages of the people in the household to see how low their premiums can be, and the health insurance options in their area.

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

- Visit www.CoveredCA.com.

- Use the website to find local insurance agents or certified enrollers in community organizations who provide free and confidential assistance over the phone or in person, in a variety of languages.
- Have a certified enroller call them for free help.
- Call Covered California at (800) 300-1506.

COVERED CALIFORNIA

News Release

June 7, 2021

Covered California Urges Eureka Residents to Sign Up for Health Insurance to Benefit from Lower Premiums Now Available Through the American Rescue Plan

- *The American Rescue Plan provides new and expanded financial help that dramatically lowers health insurance premiums for people who purchase a plan through Covered California.*
- *More than 11,000 people in the Eureka region — including the uninsured and people currently enrolled directly through a health insurance carrier — stand to benefit from the new financial help that is now available.*
- *In order to maximize their savings, consumers need to enroll by June 30 so they can begin saving and benefiting from the new law on July 1.*
- *Many people will be able to get a high-quality plan for as little as $1 per month, and currently insured consumers could save hundreds of dollars per month on their coverage if they switch to Covered California.*

SACRAMENTO, Calif. — Covered California announced that an estimated 11,000 people throughout the Eureka region can benefit from lower health insurance premiums provided by the American Rescue Plan. The landmark law provides new and expanded financial help that is making health care coverage more affordable than ever before. However, people in the region need to act now in order to realize those savings. Those who sign up by June 30 will have coverage starting July 1.

“The new and expanded financial help provided by the American Rescue Plan can help people throughout the North Coast get covered and stay covered by lowering their premiums and putting money back into their pockets,” said Peter V. Lee, executive director of Covered California.

“The American Rescue Plan provides the most significant savings for consumers since the Affordable Care Act began, but in order for many people to make the most of those savings, they need to act before the month ends.”

California State Assemblyman Jim Wood (2nd Assembly District) joined Covered California to encourage people throughout Northern California to take a moment to check out their options and find out how affordable quality health care coverage can be. Wood chairs the Assembly Health Committee and has worked to expand access to health care in rural areas.

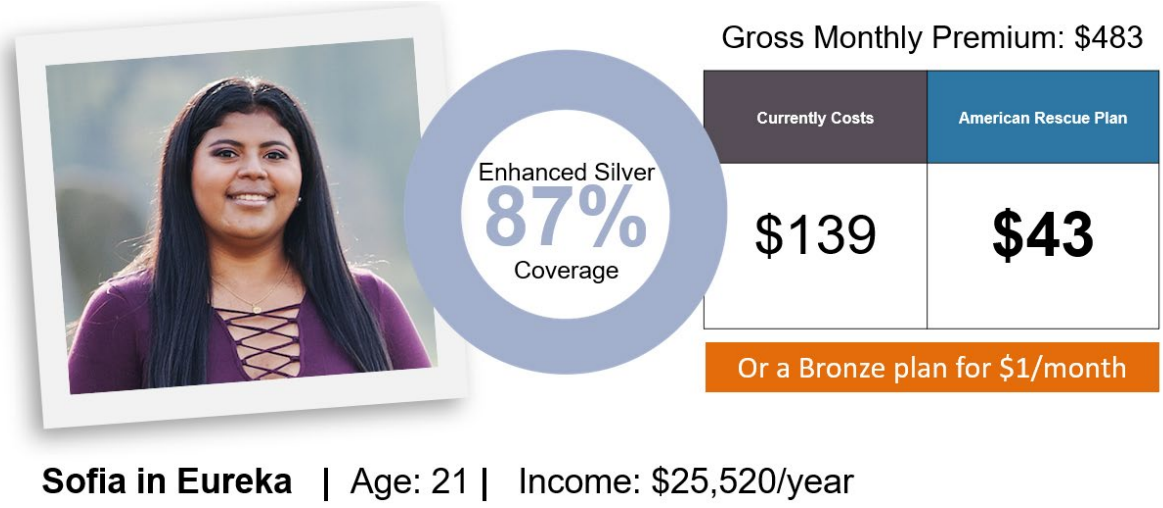
"The American Rescue Plan builds on what we have done in California to expand health care coverage by making it more affordable and more attainable for more people," Wood said. "The pandemic highlighted the importance of quality care, and I encourage everyone in Northern California to take a moment and find out just how affordable coverage can be with this new and expanded financial help."

Which Californians benefit from the American Rescue Plan?

Covered California estimates the new financial assistance can directly help 2.5 million Californians by lowering their monthly health insurance premiums. The new law stands to benefit the following groups of people:

- **Uninsured residents:** More than 3,500 people in the region are estimated to be uninsured and eligible for health insurance coverage through Covered California Under the American Rescue Plan, many would be able to get a high-quality health plan from one of 11 trusted name-brand companies for as little as $1 per month, or a plan that offers richer benefits for less than $100 per month (see Figure 1: Premiums Are Lower Than Ever for the Uninsured).

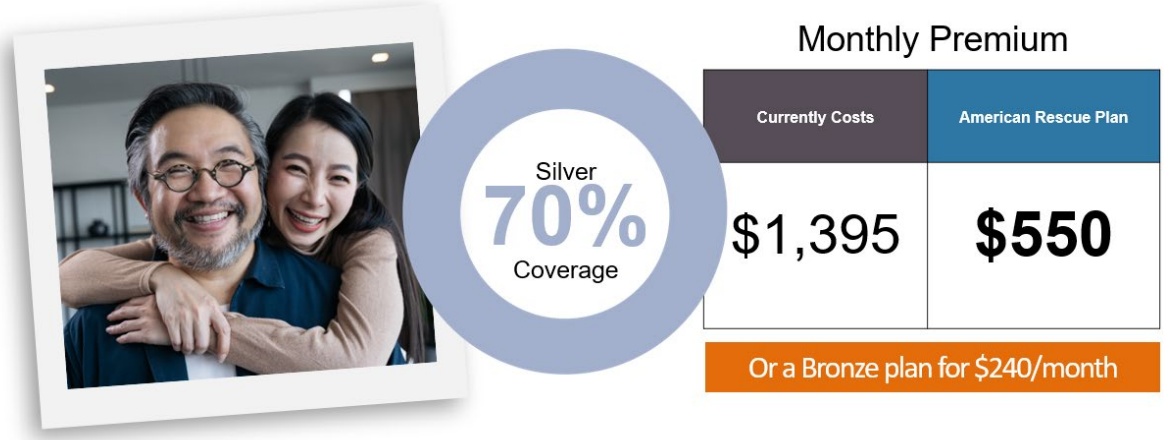
  Figure 1: Premiums Are Lower Than Ever for the Uninsured



- **Residents insured "off-exchange":** More than 1,000 people in the Eureka area are estimated to be insured "off-exchange," or directly through a health insurance carrier, and do not receive any financial help. The American Rescue Plan ensures that everyone eligible will pay no more than 8.5 percent of their household income on

their health plan premiums if they enroll through an Affordable Care Act marketplace like Covered California. The new law means that many off-exchange consumers are now eligible for financial help, and could save hundreds of dollars per month if they switch and get their insurance through Covered California (see Figure 2: Off-Exchange Consumers Save by Switching to Covered California).

Figure 2: Off-Exchange Consumers Save by Switching to Covered California



Shao and Amy in McKinleyville | Ages: 45 | Income: $ 77,580/year

Finally, more than 6,000 people in the Eureka region enrolled in Covered California have already begun benefiting from the new law, when their monthly premiums were automatically reduced in May.

Covered California's special-enrollment period will run through the end of the year, but Lee encouraged consumers to act now in order to start saving.

"Do not miss out: the sooner you sign up, the sooner you can start saving and be covered," Lee said. "We don't want anyone in Eureka, McKinleyville or Fortuna — or anywhere across the state — to be uninsured or leave money on the table."

Lee also noted that even if people are not eligible for the new financial help through Covered California, they may still have health care options.

Quality Coverage for $1 a Month

The new and expanded financial help available through the American Rescue Plan is dramatically lowering health care premiums for many Californians. The most recent data from Covered California shows that 680,000 of its 1.55 million enrollees are signed up in quality plans that cost $1 per month.

Of those, nearly 400,000 people are in Enhanced Silver plans that include cost-sharing benefits in the form of lower copays, lower deductibles and lower out-of-pocket expenses that make it easier for them to access the health care they need.

“You owe it to yourself to check it out and see what this new financial help can mean for you and your family,” Lee said. “For less than the price of a bus ride or a soda, many Californians are getting the protection and peace of mind that comes with being covered for just $1 a month.”

In addition, the American Rescue Plan provides generous help to those who received unemployment insurance benefits in 2021. Under the new law, Californians who received unemployment insurance benefits in 2021 — *regardless of their actual income in 2021* — will be eligible for quality coverage that will cost only $1 per month.

Covered California is currently working to implement this benefit into its enrollment and consumer cost-comparison systems. While those changes are expected to be implemented later this month, consumers who are enrolled or who sign up before that time will receive the lower premium retroactive to when their coverage commenced. An estimated 10 percent of current Covered California enrollees would be eligible for this added benefit, further reducing their costs and putting even more money back into their pockets.

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Biden's relief plan boosts Covered California enrollment
Victoria Colliver

More than 76,000 Californians took advantage of the cost savings offered through President Joe Biden’s stimulus plan by signing up for health insurance through Covered California between April 12 and May 15, exchange officials said Thursday.

The context: Covered California on April 12 opened a special enrollment period to allow Californians to sign up or switch coverage based on increased subsidies offered through the American Rescue Plan. The federal plan directed about $3 billion to California to help the economy and reduce health costs.

At that time, California exchange officials estimated that as many as 2.5 million Californians could see lower premiums, in some cases for as little as $1 a month. So far, the stimulus plan has lowered costs for 1.3 million of the 1.55 million Californians covered by the exchange.

The details: The American Rescue Plan expanded the federal tax credits created by Obamacare, but it’s only available to consumers who buy through the exchange.

The credit will automatically be applied for existing customers, and their savings from the benefits will be retroactive to the beginning of the year. But those who are uninsured or who had purchased coverage outside the exchange have to enroll. The savings for new enrollees will start at the first of the month.

Covered California launched a $20 million advertising campaign through June to let people know about these changes. Its executive director, Peter Lee, said he was pleased with the state's progress, noting that people typically think of health care enrollment in the fall.

What’s next: The federal help is set to expire at the end of 2022, but Lee said states cannot shoulder the burden of making health coverage affordable.

“We need to get the federal government to make the American Rescue Plan subsidies permanent,” he said.

Covered California sees surge in sign-ups during special enrollment period
Staff

Newly released numbers show there was a surge in sign-ups for Covered California during a recent special enrollment period.

Covered California Executive Director Peter Lee said 76,000 new people registered from April 12 through May 15, which is 2.5 times more than during the same time period in 2019.

Lee told KCBS Radio that he credits the American Rescue Plan, which Congress passed in March, for the surge.

“What we’re seeing, though, is not only that it’s getting financial help in the hands of people who were previously uninsured, we’re also seeing the financial help go to the 1.3 million Covered California enrollees, who were already getting some financial help, but are now getting more financial help,” the executive noted.

Lee said the average premium dropped from $215 to $110 once the American Rescue Plan was passed.

He added that almost 45% of those enrolled are covered by plans that cost only $1 a month.

Will the American Rescue Plan Make California Health insurance affordable?
Logan B.

Covered California is urging state residents to take a second look at prices, as many have fallen.

The California health insurance exchange is asking uninsured state residents to take a second look at what is available to them, as the new American Rescue Plan has reduced the price of some options.

The federal law could make it notably cheaper to purchase a health plan on Covered California.
According to a new report by Californiahealthline.org, the American Rescue Plan (ARP) has the potential to bring California health insurance into the hands of residents who had not been able to afford it before. This applies to individuals who must purchase their own health plan because it isn't provided by an employer or by any of the government insurance programs such as Medicaid or Medicare.

The report explained that ARP is providing billions in federal dollars for the reduction of California insurance premiums for people who much buy their own coverage through the Affordable Care Act (ACA). In essence, it is an expansion on the federal tax credit already provided by the ACA. It can be used either up front as a premium discount, or it can be claimed when that year's taxes are filed.

The ARP assistance is available only through the California health insurance exchange. It does not apply to people who purchase their individual or family health plans on the open market off the official ACA exchanges. Therefore, Covered California encourages people who have purchased their health plans off the exchange also to have a look at what is available there, as additional savings may now be available even if it wasn't there before.

Covered California opened a special enrollment period on April 12. This was meant to provide the opportunity for people seeking to take advantage of the new ARP aid to do so. This special enrollment period will continue right through until December, which

offers an additional four and a half months over the traditional special enrollment end date of August 15, which is the case on the federally run insurance exchanges.

According to Covered California estimates, the new funds from ARP will create an average monthly California health insurance premiums savings of $180 household for those enrolled though the exchange. Almost 90 percent of those enrolled through the exchange are already receiving financial assistance and will now be receiving an additional amount through the new law.

After Enrollment Deadline, Some Californians Can Still Save on Health Insurance
Quinci LeGardye

December 31, 2021, is the deadline for Californians to sign up for health insurance coverage. But people who already have health insurance through Covered California will still get a sizeable federal tax credit. Others seeking affordable plans can still save and enroll.

The $1.9 trillion American Rescue Plan Act (ARPA) the COVID-19 relief package signed into law last March, includes significant aid for millions of people nationwide who either are either uninsured, have marketplace coverage or have lost their employer coverage.

This aid for affording health insurance comes after a pandemic that filled hospitals and took away jobs, leaving many without employer-sponsored health insurance.

"As we continue to battle the COVID-19 pandemic and its recession, this will help more people get covered, lower health care costs and put money back into people's pockets when they sign up for health insurance through the Affordable Care Act (ACA)," Covered California's executive director Peter V. Lee said in March.

"Millions of Californians stand to benefit, including those who do not have any insurance in the midst of this health crisis, those who are struggling to pay their premiums, and those who currently do not receive any financial help," he said.

The healthcare aid included in the ARPA offers increased premium subsidies for plans available through ACA marketplaces for the 2021 and 2022 plan years. With these

subsidies provided through tax credits, premiums are reduced at every income level and are capped at 8.5 percent of a person's income.

An analysis by the Center on Budget and Policy Priorities found that a single person who makes $30,000 annually will pay $85 per month in premiums on average under the new law for a silver plan instead of $195. The analysis also found that a family of four making $75,000 will pay $340 on average rather than $588 per month for similar coverage.

Covered California has also announced that people who are currently enrolled will automatically have their premiums updated to include the new aid.

ARPA also includes a rule that says people are not required to pay back premium tax credits if they earned more income that year than what they estimated on their 2020 Marketplace or Covered CA application. This applies to people who have already filed their tax return as well as those who haven't. The IRS is reviewing the law, so people should not file an amended tax return at this time.

ARPA also provides aid for people who lose their employer-sponsored insurance in 2021. Under the new law, anyone who receives unemployment insurance (UI) benefits in 2021 will receive premium-free marketplace health insurance. UI recipients will be considered to have income at 133 % of the federal poverty level (about $17,000), which allows them to get a zero-premium plan. UI recipients who buy silver-level plans can also be eligible for cost-sharing reductions that lower their deductible and other out-of-pocket costs.

The federal government says it will provide more information about how to receive the additional premium tax credits this summer. In the meantime, UI recipients can still receive the overall increased subsidies.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) recipients are also set to receive aid. Under typical conditions, people who are laid off can keep their employer coverage for 18 months, but they have to pay the entire premium. Under ARPA, the federal government will pay the entire COBRA premium through September 2021. People who missed the original 60-day enrollment window for COBRA now have 60 more days to enroll after they're notified of the new provisions. These people can also review coverage to determine whether COBRA or marketplace coverage with lower premiums is the best option.

Need Health Care? Covered California Prices at All-Time Low
April Dembosky

If you shopped around for health insurance last year and decided you just couldn't afford it, state officials say it's time to check again.

Funds from President Biden's American Rescue Plan are bringing the monthly cost of health plans to new lows as long as those plans are purchased through Covered California, the state's Affordable Care Act marketplace.

President Donald Trump did all he could to undermine the Affordable Care Act, and Biden is trying to repair that damage. The new infusion of federal cash has lowered the average cost of a health plan purchased through Covered California by close to 50%, from $215 a month to $110.

"Health insurance premiums have truly never been lower," said Peter Lee, executive director of Covered California, noting that more half of its customers are now getting coverage for about $1 per month.

"Affordable, high-quality coverage with the best doctors, hospitals, in the country for the price of a bus ride, the price of a cup of coffee," he said.

In light of these new savings, enrollment in the state's marketplace plans more than doubled in the past month, with more than 76,000 new sign ups between mid-April and mid-May 2021, compared to just under 30,000 during the same time period in 2019.

Covered California is open from now until the end of the year for a special enrollment period when anyone can sign up or switch health plans.

sac cultural hub
urban entertainment

GROUP NEWSPAPERS
Observer
OF SOUTHERN CALIFORNIA

Covered California Health Plans: The Best Deal in Health Care
Staff

The base fare for a bus ride on Los Angeles Metro is $1.75. A ride from Oakland to San Francisco on BART, the San Francisco-Bay Area rapid transit system can cost upwards of $3.70 one way.

Not bad, right? But the best bang for your buck out there may be the deal that hundreds of thousands of Californians are getting for comprehensive health insurance coverage through Covered California. Thanks to new and expanded financial help from the American Rescue Plan, they are paying just $1 per month for quality coverage.

“For less than the price of a bus ride, a cup of coffee, or a soda, many Californians are able to get high-quality coverage from some of the best doctors and hospitals in the country,” said Peter V. Lee, executive director of Covered California. “Do not miss out on this historic opportunity, you owe it to yourself to check it out and see what this new financial help can mean for you and your family.”

The landmark American Rescue Plan not only increased the amount of financial help that is now available for Californians, it also increased the number of Californians who are eligible for the lower monthly premiums, but consumers can only get this deal on health plans purchased through Covered California.

In order to help more people get covered and stay covered, Covered California recently launched a special-enrollment period that runs through the end of 2021, so people can benefit from premiums that are more affordable than ever before. Right now, 680,000 Covered California enrollees are paying monthly health insurance premiums of just $1.

“Quality health care coverage through Covered California is more affordable than ever, and the sooner people sign up, the sooner they can start saving and be covered,” Lee said.

These major financial savings aren’t the only benefits consumers may be unaware of with Covered California health plans, which are provided by brand-name insurance carriers like Kaiser Permanente, Anthem Blue Cross, Blue Shield of California and

Health Net and others. Here are five hidden health insurance gems offered through Covered California:

- COVID-19 Care: The good news is that all health plans cover COVID-19 vaccinations and testing – at no charge. In addition, health insurance provides financial protection if you need to be hospitalized or require extensive treatment due to COVID-19.
- Preventive Health Care: All Covered California health plans offer 10 essential benefits that range from maternity care and hospitalizations to preventive health care. This free preventive health care includes annual check-ups with your doctor, all immunizations, mammograms, and screenings for diabetes, cancer, and high blood pressure.
- Mental Health and Substance Use Disorder:Counseling and treatment are fully covered by all health plans. Given the emotional impact of the COVID-19 pandemic, professional help is more critical than ever.
- Dental and Vision Coverage: Children's preventive dental benefits are automatically included in the health plans Covered California offers, and these services are provided for free. Adults, for additional costs, can add dental and vision coverage once they've selected health plans.
- Health Plans for Those With Lower Incomes:It's important to note that Californians with lower incomes can enroll in no-cost or low-cost Medi-Cal health plans, and these plans also offer the same 10 essential benefits that Covered California does. Medi-Cal enrollment is year-round.

You can use services offered by your health insurance plan on the first of the month after you sign up through Covered California, even before your membership ID card has arrived, as long as you make your first payment.

Those interested in learning more about their health coverage options for Covered California and Medi-Cal plans can also:

Visit www.CoveredCA.com.

- Find local help with certified enrollers who provide free and confidential assistance over the phone, virtually or in person, in a variety of languages.
- Have a certified enroller call them for free help with our "help on demand" feature.
- Call Covered California at (800) 300-1506.

Los Angeles Times

Editorial: Want single-payer? California needs a public option first
Jon Healey

You couldn't design a better stress test for the healthcare system than the COVID-19 pandemic. And on some fundamental levels, the system failed — witness, for example, the racial and ethnic disparities in outcomes that the virus laid bare.

Most fundamentally, the disease and the resulting shutdowns caused millions of Californians to lose their jobs, and in many cases, their employer-sponsored health insurance. And there couldn't have been a worse time to lose one's coverage than in the midst of a deadly pandemic.

Solving the insurance problem won't fix everything that's wrong with the healthcare system, but it's a prerequisite to almost every other needed improvement. That's because for all but the wealthiest Americans, insurance is key to care in this country. It's simply too expensive otherwise. Unfortunately, insurance itself is rapidly becoming unaffordable too.

The solution seems clear to many progressives: Replace the hodgepodge of public and private insurance coverage with one government-provided plan that covers everyone, financed by taxpayers. This "single-payer" approach would guarantee that everyone could afford the care they needed. It also would slash the billing, collection and paperwork costs that are an albatross in the current system, while also giving the government the power to cap overall healthcare spending as it strives to match resources to needs. And it would prevent private insurers from acting as gatekeepers to care and siphoning profits out of the system.

Converting to a single-payer system would cause enormous upheaval, however, and the Legislature has balked at bills to mandate it. Instead, in 2019 it created the Healthy California for All Commission to study its feasibility. That work is starting to bear fruit.

A recent analysis for the commission by Rick Kronick of UC San Diego concluded, as many other researchers have found, that a single-payer system would cost less overall than the current system. That's not to say that the transition would be painless; having the government pick up the tab for all the costs now borne by individuals and employers would require an enormous increase in taxes, even as premiums and out-of-pocket costs would evaporate.

The same report by Kronick, however, identified an insurmountable hurdle: A single-payer system in California would almost certainly require an act of Congress to let the state funnel Medicare and Medicaid dollars, veterans' health benefits and other federal and corporate health insurance contributions into a new, unified insurance system. And single-payer advocates don't have enough votes among Democrats to overcome unified Republican opposition.

The division among congressional Democrats reflects the tradeoffs a single, government-run insurance plan would create, such as how hard it may be to address the biggest factor behind high and growing healthcare costs: not the profits made by insurers, but the prices charged by doctors and hospitals for care, which are far higher here than in other countries. When politicians take steps to rein in those costs — for example, as in the Medicare "cuts" in the Affordable Care Act that slowed the growth of payments to providers — they take a pounding from the voters. That helps explain why Medicare spending per enrollee is projected to grow more than 50% this decade.

As countries around the world have shown, however, there are ways to make a single-payer plan work, and we need to keep exploring how to do that. In the meantime, though, California should focus on the steps it can take to close the insurance gaps that COVID-19 revealed.

In the year before the pandemic, a little less than half of Americans and Californians were covered by employer-sponsored insurance, according to a Kaiser Family Foundation report. One benefit of this kind of coverage, particularly when it's from a large employer, is that it groups individual consumers into pools, with risks and costs spread out among people of varying ages and conditions. That holds down premiums for people who need expensive care, which at some point in our lives is pretty much all of us. And under federal law, people covered by employer plans can't lose their coverage or be charged higher premiums because of their health problems.

But this coverage is fragile because it's tied to your job, not to you. The Affordable Care Act — which created state marketplaces where people without employer-sponsored insurance could shop for policies, aided by federal subsidies for low- and moderate-income households — was a big step forward. Crucially, it requires insurers to treat these markets the same way they treat large employer plans: No one can be turned away, all major health conditions have to be covered and no one's premiums can be affected by their preexisting conditions. Instead, enrollees are pooled by geographic area, with risks and costs spread across everyone in the market.

Coverage has been expensive, however, in part because the policies are comprehensive; for many moderate-income Americans, especially families, the combination of premiums, deductibles and out-of-pocket costs has rendered care

unaffordable. The response by state and federal lawmakers has been to provide more premium subsidies, but the boost is temporary at this point and doesn't help with the increase in deductibles, which have risen to $4,000 for the benchmark "silver 70" plan in California's marketplace, Covered California.

Beyond that, subsidies treat the symptoms of high healthcare costs instead of the problem itself. A better, more sustainable answer is to confront the forces pushing up healthcare spending, most notably the lack of competition. Consolidation among hospitals and some medical groups and a shortage of healthcare professionals has given too many providers the power to set high prices in too many regions. The state needs tools to counter that excessive power.

One possibility is for the state to compete with private insurers by providing a public option: opening Medi-Cal, the state's version of Medicaid, to all state residents. The state pays doctors and hospitals much less to care for Medi-Cal patients than private insurers and even Medicare does, so expanding Medi-Cal could pressure insurers and healthcare professions to lower prices, improve services and innovate.

It would also take some doing — and no small amount of dollars — to make Medi-Cal an attractive alternative to employer-sponsored insurance and the private plans offered through Covered California. For starters, the state may have to bump up the rock-bottom fees it pays for care in order to attract more doctors, while also finding a way to let workers shift their employer's financial contribution from the company's group policy into the state's plan. But the enormous amount of money the state spends on healthcare — including about $120 billion per year on Medi-Cal — gives it leverage when trying to persuade providers to get on board.

Opening Medi-Cal to all could be enormously disruptive, which is why much of the healthcare industry opposes a public option. But if ever a system needed disrupting, it's this one.

Another possibility is for the state to use its regulatory power to try to make insurance and care more affordable. Gov. Gavin Newsom has called for a new state Office of Healthcare Affordability that would set healthcare spending goals for regions across the state, then apply increasing amounts of pressure to insurers and providers to meet those goals. Less draconian than simply dictating what prices doctors, hospitals and insurers could charge, this approach would encourage the industry to attack wasteful and unnecessary treatments, tests and procedures.

The catch, however, is that political leaders would need to show the courage of the office's convictions. And historically, elected officials have wilted in the face of

opposition from the hospitals, drugmakers and healthcare companies that are major employers in their districts.

There's at least one other difficulty that California lawmakers have to confront. The biggest group of uninsured Californians — by one estimate, nearly 40% of the state's roughly 3.2 million uninsured — are unauthorized immigrants, who are ineligible for Medi-Cal and Covered California subsidies.

Although there is a powerful moral argument for insuring all Californians regardless of immigration status, doing so would be expensive for state taxpayers — the Legislative Analyst's Office recently put the cost at $2.1 billion annually. But failing to insure these Californians is costly in its own way. They're left to rely on expensive, inefficient treatment at emergency rooms, whose costs are borne by taxpayers and people with insurance. And their untreated illnesses take a toll on public health and productivity.

A public option, spending goals and expanded eligibility for subsidies aren't perfect substitutes for a well-designed single-payer system, but they have one clear advantage: They're doable. With the pandemic exposing deep flaws in how Californians are insured, it's time not just for bold steps, but achievable ones.

Why Cash Is Better Than Expanded Health Insurance for the Poor
Amy Finkelstein

The Biden administration is moving in a new direction. It is trying to help low-income Americans by pushing for direct cash assistance in addition to expanding health insurance.

Each is a laudable goal. But doing both at once may not be feasible, as lawmakers raise concerns about the total price tag of Biden's plans.

If the administration has to make hard choices, it can do more to help the poor by prioritizing cash transfers over expanded health insurance. That's because cash helps recipients directly, while health insurance would pay mainly for care that many uninsured people were already receiving at low or no cost.

For over a decade, health insurance expansions have dominated the budget and politics of legislation directed toward the poor. In 2019, the government spent more than

$600 billion on Medicaid — the major health insurance program for low-income Americans. This was more than 10 times the amount spent on the largest cash transfer program, the earned-income tax credit.

By contrast, the $1.9 trillion rescue legislation enacted in March brought a welcome shift in focus toward cash benefits. Among its temporary provisions were about $100 billion in increased payments to low-income families with children and $15 billion in stepped-up wage subsidies for low-income workers, overshadowing the approximately $35 billion in new spending for health insurance.

The evidence indicates that for the low-income recipients of these programs, cash transfers will provide a greater bang for the government's buck. Two separate studies that my collaborators and I conducted found that, on average, low-income adults would benefit more from a dollar in cash than a dollar of government spending on health insurance.

These kinds of comparisons are inherently difficult. One approach we took to measuring the value of health insurance to recipients was to see how much they were willing to pay for it. Another was to estimate the effects of such insurance on their lives, like improved health and increased economic security. Neither approach is airtight.

But they gave very similar answers: The benefit of Medicaid coverage received by a newly insured adult is less than half what that coverage costs taxpayers, which is about $5,500 a year.

The reason is simple: The uninsured already receive a substantial amount of health care, but pay for only a very small portion of it, especially when their medical bills are high.

We have estimated that 60 percent of government spending to expand Medicaid to new recipients ends up paying for care that the nominally uninsured already receive, courtesy of taxpayer dollars and hospital resources. In other words, from the recipient's perspective the alternatives are $5,500 in cash or only about 40 percent of that — $2,200 — in health insurance benefits, on top of the care they were already receiving.

The United States has a longstanding tradition of providing free medical services to the indigent. Hospitals emerged in the 18th century largely to care for those with no other sources of help. In modern times, federal and state governments have enacted a grab bag of policies to help defray some of the costs incurred by hospitals and clinics in providing humanitarian care.

The result is today's health care safety net for the uninsured. It is grossly inadequate and inefficient. It needs a radical overhaul.

But in the meantime, the direct benefits from expanding insurance to the low-income uninsured are, paradoxically, limited by the imperfect patches currently in place. Hospitals are major beneficiaries of health insurance expansions, which reduce their financial burdens and increase their profit margins.

Health insurance has always been an important financial tool for hospitals. During the Great Depression, they pioneered the first widespread health insurance in the United States to help ensure payment for provided care.

More recently, in 2006, when Senator Mitt Romney was the Republican governor of Massachusetts, he embraced the state's health insurance expansion — which became the blueprint for Obamacare — as a way to reduce the costs that uninsured patients imposed on hospitals and taxpayers. Hospitals later used similar logic in lobbying for Medicaid expansions under Obamacare and against their repeal.

Of course, the newly insured have also benefited greatly from health insurance expansions. On this point, the evidence from Obamacare is in, and the research results are clear: Medicaid coverage is better than the safety-net care available to the uninsured.

Studies have shown that the health insurance expansions under Obamacare saved lives. They also increased access to medical care and reduced medical debt, which can impose substantial financial and emotional pain on patients and their families, even though most of it is never repaid. Covering some of the remaining 30 million Americans who are still uninsured would most likely produce similar benefits.

But people in need also benefit greatly from cash. And there is evidence that cash transfers can also save lives.

In addition, a large body of work shows that wage subsidies to low-income workers with children help lift their families out of poverty, increase economic self-sufficiency, and improve their health and well-being. A recent experiment found that wage subsidies very similar to the ones that were temporarily expanded in March also increase employment and earnings for low-income adults without dependent children. Likewise, direct cash transfers provide important benefits to families and their children, whose academic achievement and physical and mental health can improve as a result.

In an ideal world, everyone would have health insurance and sufficient income. But in the real world, budgetary and political constraints often force wrenching trade-offs.

There are powerful moral imperatives for making sure that everyone has adequate medical care, as well as sufficient income for their nonmedical needs. It's hard for economists to weigh competing moral imperatives.

But we can, at least, stack dollars on scales. And the good done by cash transfers tips the scale in their favor.

The Biden administration is now trying to make permanent its temporary expansions of both cash subsidies and health insurance. If forced to prioritize how best to help those who are struggling economically — either because of the coronavirus pandemic or from longer-term, structural obstacles — it's time to recognize that cash is more effective than insurance.

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How Extending ACA Premium Tax Credits May Fix the Family Glitch
Kelsey Waddill

May 13, 2021 - By making all family members eligible for marketplace premium tax credits with the exception of those who have access to affordable coverage individual health insurance marketplace premiums may decline and access to coverage would increase, a recent Urban Institute study found.

According to current regulations, there are certain restrictions on who can receive premium tax credits. Among those qualifications, the law stipulates that members of the family must not have access to an affordable employer-sponsored health plan.

"Under current rules, employer-sponsored insurance is deemed affordable if the cost of employee-only coverage is no more than 9.83 percent of family income in 2021," the brief summarized.

"All family members are ineligible for PTCs to purchase Marketplace coverage if just one family member has an affordable offer of coverage (and family coverage is available) from an employer. This is the case even if the cost of coverage for the whole family is greater than 9.83 percent of family income."

The researchers used the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to model the impact of extending premium tax credits to all family members that do not have access to affordable coverage.

The results showed that newly eligible families who were formerly on employer-sponsored health plans would spend approximately $1,028 less per eligible family member in premium dollars.

These savings would be offset in part by the loss of their tax advantage through their employer-sponsored health plans, resulting in a net savings of around $403 per family member.

The savings would be most significant for low-income families, with those at 200 percent of the federal poverty level saving on average $580 per person.

“Those gaining eligibility for PTCs would not necessarily be better off taking them. That depends on the amount of PTCs available at their income level, the cost of single coverage for the worker with an affordable offer, the tax advantage of financing the family’s health coverage through an employer, and the difference in out-of-pocket health costs for the family,” the researchers acknowledged.

Approximately 4.8 million individuals would become eligible for premium tax credits.

READ MORE: Rectifying the ACA Family Glitch Could Drive ACA Premiums Down

Slightly more than 84 percent of the dependents who would receive premium tax credits would have the opportunity to switch to the individual health insurance marketplace from an unaffordable employer-sponsored health plan. This data syncs with similar reports on the subject.

Almost 10 percent of the dependents who became eligible (9.6 percent) would otherwise be uninsured. Similar reports have suggested that solidifying financial support for the Affordable Care Act might cause uninsurance to drop as much as 14 percent.

Slightly more than three percent would be switching from short-term limited-duration health plans. A small portion would already be in a nongroup health plan that was less affordable than the plan with premium tax credits.

Most of the dependents who would gain more affordable coverage through premium tax credits would be minors. Slightly more than 45 percent of the newly eligible dependents would be between 0 and 18 years old.

One in five of the dependents who gained eligibility would be between 35 and 54 years of age. Nearly a quarter of them (23.6 percent) would be between the ages of 19 and 34 years old.

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Around 3.6 million people who are connected to these eligible individuals would not qualify for premium tax credits due to other affordable coverage opportunities.

Still, enough eligible individuals might switch to produce minor shifts in premium costs in the marketplace, with on average a one percent decrease in premiums for nongroup premiums nationwide.

Private nongroup enrollment would increase by 0.2 percentage points, insured employer-sponsored coverage would decline by 0.2 percentage points. Medicaid and Children's Health Insurance Program (CHIP) enrollment would increase by 93,000 beneficiaries and the uninsured population might shrink by 0.1 percentage point.

This policy would boost federal spending by $3.0 billion in premium tax credits alone and heightened Medicaid enrollment would boost federal spending by another $349 million.

A number of funding streams could offset some of that spending. Uncompensated care would drop by $192 million. Federal tax revenue would get a boost from the drop in employer-sponsored coverage.

Ultimately, balancing the spending and savings, federal spending would increase by 0.6 percent

"In summary, changing the family glitch would lower health care premiums for hundreds of thousands of affected families without undermining employer coverage," the study concluded.

"There would be a modest increase in health coverage, but the biggest effect would be to improve affordability. There would be a small increase in federal government spending and a tiny increase in state spending that would be at least partially offset by additional tax revenue."

NBC NEWS

'A sea change': Subsidies and White House push leads to surge in Obamacare sign-ups

Phil McCausland

Sheryl Hagen was earning $13.25 an hour after working more than five years at a Missouri grocery store. But even working full time, she couldn't afford the $300 premium for her employer's health insurance plan — so she went without.

Earlier this year, Hagen, 51, broke her ribs and the resulting hospital stay led to a $1,300 bill. She didn't have enough to pay it, and taking time off to recover only put her further behind.

“I couldn't move and couldn't work and couldn't really do anything,” she said. “And then I knew I was going to have these giant bills coming at me. It was terrifying.”

That experience, an arthritic knee and a later doctor’s visit had her looking into the special enrollment period for health care coverage under the Affordable Care Act, or Obamacare. With help, she was able to sign up for a marketplace plan for $73 per month. When President Joe Biden then signed the American Rescue Plan into law, which carries huge health care subsidies for the next two years, she reapplied and her premium was reduced to $0.

“It’s like a light at the end of the tunnel,” said Hagen, who hasn’t had health insurance in 12 years. “I’m blown away.”

Hagen is one of more than a million people who have signed up for Obamacare plans since the Biden administration opened up the special enrollment period, which began Feb. 15 and ends on Aug. 15. With the new subsidies and the limits the Covid-19 relief bill placed on health care costs, many are also paying much less for Obamacare plans than they have in the past.

NBC News spoke to 16 people, eight of whom have signed up for Obamacare coverage or changed their plans since April 1 for greater savings, as well as advocates, doctors, insurance brokers and officials about the recent changes to the landmark health care regulation.

Those who signed up, especially older people who did not yet qualify for Medicare, said they felt as though Obamacare was finally living up to their expectations.

Jodi Smith, 62, paid $400 to $600 in monthly premiums for her Obamacare plans since she retired from a county government job in Tucson, Arizona, about 10 years ago. With the new subsidies, she now pays $175 per month, which she says has freed up her and her husband's household income.

"It's what I kind of envisioned the ACA being when it was conceived," she said. "The first bunch of years, it ended up being more expensive. We finally have evolved to a point where it's working much better than it had been."

The new subsidies provide tax credits to a larger number of enrollees and helps address the sudden ballooning costs some saw when their annual incomes varied.

Experts and advocates said the uncertainty of the pandemic, in which many were laid off and lost their employee-provided health insurance and the resulting need for affordable health care has driven people to sign up. But the biggest reason that more than 1 million people have signed up, they said, is likely because of the promise of further savings.

"The reality is that the Affordable Care Act priced too many people out of coverage," said Emily Stewart, the executive director of Community Catalyst, a left-leaning consumer health advocacy group. "And so when Congress and the Biden administration passed this policy to address that, I think that is the biggest driver of this surge that you're seeing."

The number of those who have signed up for coverage also could be higher than 1 million, as the latest figures from the Department of Health and Human Services only covers the 36 states that use Healthcare.gov, the federal website. It does not account for those enrolling in the 14 states and Washington, D.C., that oversee their own markets — they are also able to take advantage of the new subsidies and many opened their own special enrollment period in response to the pandemic.

"These 36 states have had, in essence, four years of drought, neglect and active efforts to, in essence, discourage enrollment," said Peter V. Lee, the executive director of California's health benefit exchange. "And now we've had a Biden administration that did marketing, that actually got the word out and affirmatively said, 'If people are uninsured, they should know they've got options.' They've also added what I would call fertilizer, which is the new subsidies from the American Rescue Plan."

The Biden administration has invested $100 million into Affordable Care Act marketing and $80 million into nonprofit navigator programs that help individuals sign up for health care coverage. Much of that funding was stripped away under President Donald Trump.

Lee said that California has also seen a bump in enrollment, although it’s not as sizable as the federal spike because the state consistently put high levels of funding into marketing and navigation programs.

But Lee noted that the subsidies have been a huge boon in helping low-income workers who don’t qualify for Medicaid to afford health care coverage. It’s also been an aid to others by capping the amount people pay at 8.5 percent of their income.

“It really is a sea change,” he said.

The White House agrees, though they face a fair amount of work to make those subsidies permanent. As it stands, they expire within two years.

Christen Linke Young, the deputy director of the White House Domestic Policy Council for Health and Veterans Affairs, said the Biden administration remains committed to ensuring the subsidies become permanent.

“The subsidies in the American Rescue Plan are a meaningful victory for American families,” she said. “The president's been clear he wants to see that continue, and we very much look forward to working with Congress to get that done.”

They do have more political capital to work with these days.

Opinions of the Affordable Care Act have changed significantly since the law’s passage and implementation. At the height of its unpopularity, according to a Kaiser Family Foundation tracking poll, 53 percent of people viewed Obamacare unfavorably and 37 percent held a favorable view. That number has practically flipped with 54 percent now favorable of the health care law and 39 percent unfavorable.

“You don't need to like President Biden or like President Obama or like Obamacare to find it attractive to buy an affordable health insurance product,” Young said.

Overcoming skepticism
Many said they were shocked by how much they were saving after they re-enrolled in their Obamacare plan.

April Henry, an Oregon-based mystery writer who formerly worked in the health care industry, said she and her husband are saving $700 a month on their premiums after they signed back up after April 1. She said the two of them could now save more for retirement and help their 25-year-old daughter with upcoming dental surgery.

“It's huge. It's so much money,” she said. “I was really shocked at how much it was going to be.”

To reach more people, however, Obamacare still has a difficult history it must overcome: Many still remember it as overpriced and limiting.

“One of the big issues with the ACA was that people who earned more than 400 percent of the federal poverty level would immediately lose their tax credit,” said Carolyn McClanahan, a doctor and financial planner in Jacksonville, Florida. “People were owing back thousands and thousands of dollars, and that gave the ACA a really bad rap. But now the tax credits are phased out instead of all of a sudden just being gone.”

Kenneth Smith, 62, lives outside of Pittsburgh and works construction and occasionally as a truck driver. He said he decided to sign up for the Affordable Care Act at the hospital when he was rushed there for diabetic shock this year.

Smith is still waiting for those hospital bills, but he admitted that he long had a skeptical view of the coverage provided through Obamacare.

“From what I heard, it was garbage, it was unaffordable, and it was dumped down your throat — you had to take it or you paid a fine,” he said.

Before he was hospitalized, Smith said he had maxed out his credit card on a short-term “junk insurance plan” that did not cover any of his hospital bills. After his hospitalization, because of the subsidies, he said he was able to obtain a plan that he could afford and cost half as much as the one offered by his employer.

“The insurance is fantastic,” he said. “The two medications I’m on were 100 percent covered.”

I’ve definitely gotten a couple of comments of, ‘Well in two years, this is going to go right back up.’

While many appear to be enjoying the new affordability of Obamacare, the White House still faces many questions and challenges. Chief among them is the current expiration date on subsidies.

“The most important thing to remember is that these new affordability policies are temporary,” Stewart said. “They are only put in place for two years. It's really essential that they are made permanent.”

The White House intends to do just that and has attached the subsidies to the president's proposed American Families Plan, a $1.8 trillion investment in education, child care and paid family leave. But with a razor-thin majority in Congress, the Biden administration will face a challenge to get that package, as well as a massive infrastructure bill, through either chamber.

There is also a feeling of whiplash on health care for some — especially between the Republican and Democratic administrations.

Jenny Chumbley Hogue, who runs an insurance agency north of Dallas, said she has signed up a number of people, some who have never had coverage before. She said many are deeply conservative and critical of Obamacare.

"There's a lot of, in general, people not believing it's going to be around," said Hogue. "I've definitely gotten a couple of comments of, 'Well in two years, this is going to go right back up.'"

Medicare for 60-year-olds not guaranteed to be a better deal
Ricardo Alonso-Zaldivar

WASHINGTON (AP) — President Joe Biden and progressive Democrats have proposed to lower Medicare's eligibility age to 60, to help older adults get affordable coverage. But a new study finds that Medicare can be more expensive than other options, particularly for many people of modest means.

There are two reasons: Traditional Medicare has gaps in coverage that most people fill by purchasing supplemental plans, which means they pay added premiums. And premiums for the Obama-era Affordable Care Act have come way down recently due to Biden's COVID relief bill. That's made the ACA more attractive for older adults who haven't reached Medicare's eligibility age of 65.

"Simply expanding Medicare eligibility does not guarantee premium affordability," concluded the study by Avalere Health for The Associated Press.

It found that many older adults with low to modest incomes can already find cheaper premiums in Obamacare's markets, while those in the solid middle class would be more likely to benefit if they could get into Medicare.

Lowering the Medicare eligibility age to 60 is politically popular, with nearly 2 in 3 Americans backing the idea in a Kaiser Family Foundation poll late last year. That included about half of Republicans. But in Congress the proposal has little support from Republicans, meaning that it would be up to Democrats to try to advance it. Liberals are enthusiastic, but moderates worry that tinkering with Medicare's complex financing could have unintended political consequences.

The Avalere analysis did find that traditional Medicare has an important advantage over Obamacare because hospitals and doctors nationwide accept it, whereas coverage through private insurers generally relies on restrictive networks. Another potential plus: the combination of traditional Medicare and a supplemental "Medigap" policy provides more generous coverage than the ACA's midlevel plans.

Avalere, a market analysis and consulting firm, compared Obamacare premiums to premiums for Medicare coverage in Houston, Miami, Los Angeles, and Chicago for a hypothetical 60-year-old nonsmoker and a 65-year-old enrolled in Medicare. Because the ACA's financial assistance is keyed to income, the study looked at individuals making about $18,000 a year, those making about $32,000, and those around $52,000. It also took into account Medicare Advantage, the private insurance option that nearly 4 in 10 Medicare enrollees pick.

Medicare was generally the better deal for those in the solid middle class, those around $52,000.

In Houston, a 60-year-old making $32,000 can get a midlevel ACA "silver" plan for $88 a month, compared with either $284 for traditional Medicare plus a Medigap supplement and a prescription plan, or a Medicare Advantage plan starting at $149. For a resident of the same city making $52,000, the Obamacare plan would cost $344, making Medicare the better deal.

A hypothetical 60-year-old in Los Angeles making $18,000 can now get a silver plan for a monthly premium of $1, compared with $277 for traditional Medicare and its added wrap-around coverage. But for an Angeleno making $52,000, traditional Medicare would work out to about $70 less per month than the ACA plan.

"Simply expanding Medicare as it is to younger people does not always mean those patients are getting a better deal," said Chris Sloan, an industry analyst at Avalere. "The things that the Biden administration has done to increase the Obamacare subsidies thru 2022 have made it really affordable."

Biden is asking Congress to permanently extend the more generous financial assistance that has brought down the cost Obamacare premiums.

The Avalere analysis also found that uninsured people make up only 8% of the 24.5 million adults ages 60-64 who would qualify for Medicare by lowering the eligibility age. Of the total, about 6 in 10 currently have employer coverage.

The Biden administration, through the Department of Health and Human Services, had no comment.

Economist John Holahan of the Urban Institute think thank said the new research "illustrates an important point."

"Medicare as it stands right now is a sort of complicated beast with a separate drug plan and no out-of-pocket caps," he said. "The nation has that in the ACA, and at a pretty heavily subsidized amount."

Without other changes, lowering the Medicare eligibility age may not really solve coverage or affordability problems, said health policy expert Katherine Hempstead of the Robert Wood Johnson Foundation.

"It's hard to see a lot of obvious situations where 'Wow, this is a great deal' for someone, or a big improvement over the status quo," she said.

But Rep. Ro Khanna, D-Calif., a progressive advocating a "Medicare for All" national health insurance plan, said the study framed the question too narrowly. A new tax-financed plan modeled on Medicare and offering comprehensive coverage with no premiums or deductibles would be better for consumers, he said. And the U.S. would reduce health care spending because Medicare pays doctors and hospitals less than private insurance.

"The ACA is still basically a subsidy for private insurance," said Khanna. "What we don't want to be doing is entrenching private insurance companies that are a drain on American competitiveness and have failed to deliver comprehensive coverage to Americans."

In other findings, the study showed that in Miami, the ACA could offer slightly lower premiums than traditional Medicare even for a solid middle-class individual making $52,000, a potential savings of about $40 a month.

And in Chicago, the traditional Medicare combination would cost a lower-income person $268 a month. But they could find ACA coverage starting at $1.

Fixing The ACA's Family Glitch
Katie Keith

Enrollment through HealthCare.gov continues to climb during the COVID-19 special enrollment period, bolstered by enhanced marketplace subsidies under the American Rescue Plan Act (ARP) through 2022. Millions of lower- and middle-income Americans are eligible for financial help under the ARP, including many who did not previously qualify based on income. The ARP did not, however, change other subsidy eligibility rules, or federal interpretations of those rules. As a result, gaps remain in who can access subsidized marketplace coverage, leaving some without relief even with the changes made by the ARP.

This post focuses on one of those long-standing gaps known as the "family glitch"; this renders not only an employee but also his or her family members ineligible for subsidized marketplace coverage if self-only coverage for the employee is affordable as defined by the ACA, even if family coverage is not. An estimated 5.1 million people—mostly children of low-income workers—fall into the family glitch and are thus barred from enrolling in subsidized marketplace coverage. Many of these families go on to purchase health insurance (either through a family member's job or the marketplace) but pay high portions of their income towards premiums. Personal stories of those affected by the family glitch can be found in media outlets, Reddit threads, and even comments from readers on prior Health Affairs Blog posts.

Critics have argued that the family glitch is inconsistent with the goals of the Affordable Care Act (ACA) and unfairly penalizes family members of lower-income workers. There is also broad support among a range of health care stakeholders to fix the family glitch. An analysis for The Commonwealth Fund of recommendations from diverse health care stakeholders to the Biden-Harris presidential transition team showed that a majority recommended fixing the family glitch. And legal experts such as Tim Jost have argued that the Biden administration should fix this Obama-era mistake. Indeed, President Biden hinted at the possibility of fixing the family glitch in an executive order on the ACA and Medicaid that directed federal officials to examine "policies or practices that may reduce the affordability of coverage or financial assistance for coverage, including for dependents."

This post discusses the history of the family glitch, recent data on its impact, and why a new interpretation based on the affordability of family coverage would be legally sound. An alternate interpretation that would “fix” the family glitch is supported by the ACA’s text and legislative intent. The Biden administration would have more than sufficient grounds to adopt a reasonable alternative interpretation of the ACA, as the Trump administration did in numerous instances.

What is the Family Glitch?
Under Section 36B of the Internal Revenue Code, individuals generally do not qualify for premium tax credits if they are eligible for another source of minimum essential coverage, including employer-sponsored plans. There is an exception, however, if an employer-sponsored plan is not “affordable” or of “minimum value.” An employer’s plan is not “affordable,” as defined under the ACA, if the employee must contribute more than 9.83 percent of household income towards premiums. (This percentage was initially set at 9.5 percent and is adjusted annually.) If an employer’s plan is not “affordable,” an employee may qualify for premium tax credits through the marketplace, and the employer may face penalties under the employer mandate.

The so-called “family glitch” stems from a 2013 interpretation by the Treasury Department and Internal Revenue Service (IRS) that an employer’s offer of coverage is “affordable” based on the cost of employee-only (rather than family) coverage. This means that an employee and their family members are ineligible for premium tax credits when the employee is offered affordable employee-only coverage. This is true even if the cost of employer-sponsored family coverage would otherwise be unaffordable (i.e., the employee’s contribution towards premiums for family coverage would exceed 9.83% of household income).

This situation—where employee-only coverage is affordable, but family coverage is not—is not uncommon. Most employers offer family coverage, but data from the Kaiser Family Foundation’s 2020 Employer Health Benefits Survey shows that average premiums and employee contributions have increased significantly over time.

In 2020, average premiums for employee-only coverage were $7,470 compared to $21,342 for family coverage. On average, employees contribute 17 percent of the premium for employee-only coverage compared to 27 percent of the premium for family coverage. The average employee contribution for self-only coverage was $1,243, while the average contribution for family coverage was $5,588 (an increase of 22 percent from 2015). The average employee contribution rate is even higher at employers with a large share of lower-wage workers: employees in these firms contribute 38 percent of the premium for family coverage. Six percent of covered employees, including 17 percent of those in small firms, are in a plan with an employee contribution of at least $12,000 for family coverage.

The interpretation of the ACA that created the family glitch was proposed in broader rulemaking from 2011. In the preamble to the proposed rule, the IRS justified this reading of the statute by noting that Section 36B(c)(2)(C)(i) referenced Section 5000A(e)(1)(B), which refers to an employee's premium contribution for self-only coverage. This reference to Section 5000A(e)(1)(B), the IRS reasoned, meant that the affordability test for both employees and family members is based on the employee's contribution for self-only (not family) coverage. The IRS also cited a 2011 analysis from the Joint Committee on Taxation (JCT) that interpreted the affordability test to be based on self-only coverage.

The family glitch policy was not finalized alongside other related provisions in a final 2012 rule. Instead, the IRS noted only that commenters opposed the proposed interpretation and that the policy would be finalized in future regulations. It was ultimately finalized as proposed in a short 2-page rule from 2013 that reiterated the prior rationale regarding the cross-reference to Section 5000A(e)(1)(B).

As Tim Jost notes, many comments on both the 2011 proposed rule and the 2012 final rule—found here and here, respectively—urged the IRS to adopt an affordability test for family members based on the cost of family coverage. That interpretation was supported by members of Congress, consumer advocates, labor unions, and others including the National Health Law Program, First Focus, and SEIU who argued that the interpretation was contrary to or, at a minimum, inconsistent with the ACA.

Who Is Affected By The Family Glitch?
The IRS's interpretation has barred millions of Americans—largely the children of low-income workers—from receiving premium tax credits for marketplace coverage even when they would otherwise qualify based on household income. Two recent studies shed some light on who is affected by the policy and build on prior analyses from the Urban Institute, RAND, and the Agency for Healthcare Research and Quality, among others. The Commonwealth Fund also provided a recent illustrative example of how the family glitch results in higher premiums for families.

In April 2021, the Kaiser Family Foundation estimated that 5.1 million people currently fall into the family glitch, most of whom (2.8 million) are children and nearly half of whom (46 percent) are low-income, earning between 100 and 250 percent of the federal poverty level. Most of these individuals (85 percent) are enrolled in family coverage through an employer-sponsored plan, while about 9 percent are uninsured and 6 percent purchase unsubsidized individual coverage. The vast majority (94 percent) of those in the family glitch reported that they are in good health. Fixing the family glitch would thus increase marketplace enrollment among younger and healthier enrollees,

which would improve the health of the overall risk pool and help lower marketplace premiums for all enrollees.

In May 2021, the Urban Institute found that 4.8 million people would be newly eligible for premium tax credits if the family glitch were fixed in the manner described below. Consistent with the Kaiser Family Foundation analysis, the Urban Institute found that nearly half of those affected by the family glitch are children. About 90 percent are insured but paying more than 9.83 percent of their family income towards that coverage. Although many more would be eligible, about 710,000 people would enroll in subsidized marketplace coverage, leading to 190,000 fewer uninsured people. Because these new enrollees would be younger and healthier, individual market premiums would be, on average, about 1 percent lower, according to the Urban Institute analysis.

The Urban Institute further quantified the impact of fixing the family glitch on affordability. Families that switched from employer-sponsored plans would save about $400 per person in premiums on average, with even greater gains ($580 per person) for those with incomes under 200 percent of the federal poverty level. (The Urban Institute had previously estimated that those who fell in the family glitch were spending, on average, nearly 16 percent of their income on premiums alone.) Increased premium tax credits and cost-sharing reductions to cover those who newly enrolled in subsidized marketplace coverage would cost about $2.6 billion annually. There would be no disruptions to the employer market even as hundreds of thousands of families gained access to affordable marketplace coverage.

Fixing The Family Glitch

There are several policy options to fix the family glitch. The most comprehensive approaches would address the family glitch as part of a broader effort to eliminate or reduce the ACA's current "firewall." As discussed above, the firewall bars workers with an offer of employer-sponsored coverage from accessing subsidized marketplace coverage. Eliminating the firewall would allow workers to choose to enroll in subsidized marketplace coverage over an employer's plan, thereby eliminating the restriction that resulted in the family glitch in the first place.

Alternatively, policymakers could focus more narrowly on the family glitch and allow family members (or the employee and family members) to enroll in subsidized marketplace coverage if an employer fails to offer affordable family coverage.

Congress has considered, but not yet adopted, these types of fixes before. Bills to fix the family glitch were introduced as early as 2014, passed by the U.S. House of Representatives in 2020, and included in public option proposals and ACA enhancement bills in 2021. As noted above, the ARP extended subsidies to millions more Americans but did not address the family glitch.

Although Congress has not yet acted, the IRS could adopt an alternative interpretation relative to the 2013 rule and revise the family glitch policy. Members of Congress have acknowledged as much. The 2014 legislation, sponsored by former Sen. Al Franken (D-MN), included a “sense of Congress” that the Secretaries of the Department of Health and Human Services (HHS) and the Treasury “have the administrative authority necessary to apply the affordability provision … to expand access to affordable health insurance coverage for working families without further legislation.”

The Legal Rationale

Although this would not be the most comprehensive “fix” to the family glitch, the Biden administration could revise the affordability test to account for the cost of coverage for family members. This would separate the affordability determination for employee-only and family coverage and enable family members to access subsidized marketplace coverage if an employer offered family coverage that was not “affordable.” Under this policy, employees with an offer of affordable employee-only coverage would still be barred from receiving subsidies, but their family members would not be. Because employees would not be newly eligible for premium tax credits, there would be no impact on liability under the employer mandate (which is only triggered by statute if an employee receives subsidies).

Fixing the family glitch in this manner would be a permissible interpretation of the ACA. Indeed, it would arguably be more faithful to the statute and consistent with the text, structure, and goals of the ACA than the current interpretation that has resulted in the family glitch. This section highlights just some of the legal arguments in support of a revised interpretation.

First, by concluding that the affordability test is the same for family members as for employees, the current interpretation ignores the ACA’s special rules for family coverage in Sections 36B(c)(2)(C)(i) and 5000A(e)(1)(C). In adopting the family glitch policy, the IRS emphasized the cross-reference to Section 5000A(e)(1)(B) but ignored an adjacent provision, Section 5000A(e)(1)(C), which lays out special rules for individuals related to employees. Notably, the IRS reached a different conclusion regarding these special rules when it came to the individual mandate. In interpreting Section 5000A(e)(1)(C), the IRS concluded that an employee’s required contribution towards family coverage, not employee-only coverage, dictated affordability for purposes of an exemption to the individual mandate.

The IRS thus adopted inconsistent interpretations for adjacent statutory provisions, by considering the cost of employee-only coverage for subsidy eligibility but the cost of family coverage for exemptions to the individual mandate. The IRS noted this inconsistency but never reconciled its interpretation with the fact that Congress, had it

intended the family glitch, would not have included special rules in the ACA for related individuals. Had Congress intended the special rules for dependents to use the same measure as for employees, it could have used similar language—or it could have omitted the special rules altogether. Instead, in requiring the use of the same test for affordability as for the individual mandate, Congress intended that the entire provision be applied, including the special rule in (e)(1)(C) that qualifies the application of the affordability test for employees in (e)(1)(B).

This alternative reading—that the reference to Section 5000A(e)(1)(B) in Section 36B(c)(2)(C)(i) is a reference to Section 5000A(e)(1)(B) as clarified by the special rule in Section 5000A(e)(1)(C)—is a more than reasonable (and arguably better) construction of the statute that the IRS already adopted in rules regarding the individual mandate. Some commenters suggested as much at the time, noting that a "more cohesive and logical reading" is that Congress referenced Section 5000A(e)(1)(B) because it intended for the entire rule (including the special rule for related individuals) in Section 5000A(e)(1) to be applied to PTC eligibility.

Second, a revised interpretation is more consistent with other parts of the ACA. The Secretary of HHS must, for instance, determine whether an individual's coverage (rather than an employee's coverage) under an employer-sponsored plan is unaffordable. Under the ACA, marketplace enrollees who qualify for premium tax credits because "the enrollee's (or related individual's) employer" fails to offer affordable coverage must report certain information to HHS. This information includes "the lowest cost option for the enrollee's or individual's enrollment status and the enrollee's or individual's required contribution" towards the employer-sponsored plan. There would be no reason for the statute to repeatedly distinguish between required contributions for an "enrollee" and an "individual," or for HHS to require a related individual to report their required contribution for a plan, if the only relevant factor for the affordability test is the cost of employee-only coverage.

Third, the IRS's reliance on the JCT analysis from 2011 is misplaced. Indeed, JCT reached the opposite conclusion while the ACA was being debated in Congress. A JCT analysis released on March 21, 2010 (the day the bill was passed by the U.S. House of Representatives) noted that the affordability test would be based on the type of coverage applicable (e.g., individual or family coverage). While the JCT adopted a different interpretation later in 2010 and 2011, commenters such as Avik Roy noted that "the JCT's narrow point of view wasn't apparent at the time that PPACA was being voted upon, because on the day the final vote took place in the House, the JCT told Congress something different." An early Senate Finance Committee report also suggested that the affordability test would be based on family coverage.

Finally, eliminating the family glitch is more consistent with the ACA's goal of expanding access to affordable health insurance than the current interpretation, which unfairly penalizes low-income workers and their families and creates barriers to affordable coverage. Observers and commenters have long raised these concerns, noting that the current interpretation "excludes people Congress intended to cover" and is "simply incongruent" with Congress's intent. A review of the publicly available comments on the prior rule showed little support for the current interpretation. Indeed, the IRS's interpretation was attributed more to policy and political concerns that existed in the early years of ACA implementation, such as a desire to avoid higher federal outlays.

Policy (But Not Legal) Criticisms

These are certainly some valid policy criticisms of such an administrative fix. Some will argue that the policy would have little impact on the overall uninsured rate or point to the policy's price tag of about $2.6 billion annually, as estimated by the Urban Institute. Others will argue that the policy would not go far enough: If the worker cannot join the family members in subsidized marketplace coverage, families will be split between two plans—job-based coverage for the worker and marketplace coverage for the rest of the family—thus paying separate premiums, deductibles, and out-of-pocket maximums. The cost of coverage in this "premium stacking" scenario may still be too high for some families.

These are valid policy criticisms but not legal criticisms. Despite suggestions that agencies cannot change their minds, the Supreme Court has made clear that policy changes are permissible and expected, and agencies can reconsider prior interpretations to reflect new circumstances or a change in policy preferences. As discussed above, the IRS may ultimately read the statute differently or take the position that the ACA is ambiguous on the question of how an offer of employer-sponsored family coverage should be treated for purposes of premium tax credit eligibility. This view, that the statute is ambiguous, is supported by many diverse observers who have long noted that the statute is unclear on the question of the affordability test as it relates to family coverage.

In considering whether to reinterpret the family glitch, the Biden administration will surely weigh these factors as well as the need to expand access to affordable coverage, promote financial security, and respond to the COVID-19 crisis. The fix described above could bring significant financial relief to many working families who are currently paying more than 10 percent of their income towards premiums alone. Indeed, the disproportionate impact of the family glitch on low-income children, in particular, is among the reasons why the U.S. Government Accountability Office previously recommended that the IRS explore an alternative interpretation. The change would also be beneficial for the ACA risk pool, reducing overall marketplace premiums by, on average, 1 percent as new younger, healthier people enroll.

POLITICO

The Tortured Saga of America's Least-Loved Policy Idea
John E. McDonough

As a health care advocate in Massachusetts and later as an aide to Sen. Ted Kennedy, I first opposed and later embraced the "individual mandate" as a pathway to increase health insurance coverage for millions of people. At the time of my switch in 2004, the mandate was considered a conservative idea and seemed like a way to achieve one of liberalism's most cherished goals, universal coverage. It succeeded and has helped to make Americans healthier. But it proved to be a flashpoint, and has outlived its usefulness as a policy tool.

Now, I find myself in the uncomfortable position of hoping that the Supreme Court will kill it rather than use it to kill the Affordable Care Act.

By the end of June, the U.S. Supreme Court will rule on a lawsuit seeking to overturn the entirety of the ACA. For the second time, the core legal argument confronting the Court involves the ACA's "individual responsibility requirement," better known as the "individual mandate" that requires most Americans to obtain health insurance. For 33 years, and especially since President Barack Obama signed the ACA into law in 2010, the mandate has been a prize and a booby trap for Republicans and Democrats, conservatives and progressives alike, rarely at the same time. Initially a policy favored by many Republicans and conservatives and reviled by most Democrats, both sides swapped roles during the ACA's creation between 2008 and 2010. Since then, the mandate has been the least favored part of the now popular health law, and the most disputed feature of one of U.S. history's most contested laws.

The mandate has always been a case of tough love. First introduced into the Washington conversation in 1989 by the conservative Heritage Foundation, the concept was written and promoted then by its chief domestic policy expert, Stuart Butler. It became law in the U.S. for the first time in 2006 in Massachusetts. In 2012, after the mandate had become part of the ACA, USA Today published an op-ed by Butler titled: "Don't Blame Heritage for the Obamacare Mandate." In 2020, he signed onto an amicus brief to the Supreme Court in opposition to the now-pending lawsuit seeking to take down the mandate and the whole ACA. For Butler, for me and for many others, the mandate has been a journey of twists and turns.

Stuart Butler's personal journey is also noteworthy. A British ex-pat who emigrated to the States in 1979 to advance the free-market revolution envisioned by Nobel

economist Milton Friedman and others, he is an unfailingly polite and amiable man of conservative instincts and ideas who obliterates the stereotype of a right-wing firebrand. His intellectual and policy journey reflects the rise and fall of President Ronald Reagan's conservative revolution that shaped U.S. public policy for 40 years between 1980 and 2020. Butler's leasehold on the individual mandate came to haunt his final years at Heritage which he left in 2014 for the more genteel and ecumenical Brookings Institution. Butler agreed to participate in interviews in the crafting of this article.

Stories about public policies are also stories about persons, the creators and destroyers, and those in between. Policy ideas that hatch in people's minds are products of time and context. As eras shift, so do the policies that define them, and so do the persons who gave birth to the ideas. The story of the ACA's individual mandate involves many ideas and persons and, in particular, the ideas of one person who provoked it, a revealing anecdote for an epoch in American history now coming to a close.

Following the path of Thatcher
Butler was born in 1947 in Shrewsbury, England, located between Birmingham and Liverpool, to working class parents, both traditional and non-active Conservative Party loyalists. His father left school at age 13 to work at the post office until he started his own auto business. His mother, from Scotland, won a full scholarship to Oxford and then couldn't go because her father thought young women should look after the home and gain "practical" skills.

Stuart was the middle child of three brothers and the first to obtain higher education, which he did at the University of St. Andrews on the southeast coast of Scotland. He obtained bachelors, masters and doctoral degrees there, the last concentrating on American economic history. After a bachelors focused on physics and math, he switched to economics and philosophy after experiencing an intellectual epiphany that led him toward free market, conservative, neoliberal thinking in an otherwise leftist, Labor Party-dominated environment.

"Milton Friedman was the counter-culture in British universities in the 1960s," he recalls. "If you were radical on the right, you absorbed Friedrich Hayek for theory and Friedman for practical steps forward."

Butler's younger brother, Eamonn, followed Stuart's passion and led the charge to erect a statue to 18th century classical liberal economist Adam Smith in downtown Edinburgh, still standing today. In the late 1970s, Stuart and Eamonn helped found the Adam Smith Institute in London which continues today with Eamonn as director. The term "neoliberal" or "classical liberal" refers to Hayek and Friedman's updating of 18th century Smithian liberalism, brought into the 20th century context, they maintained.

Butler was an early supporter of Margaret Thatcher well before she won her first election as British prime minister in 1979. Like Butler, she experienced an epiphany influenced by Hayek and Friedman. At a Conservative Party policy conference in the mid-1970s, as recounted by historian John Ranelagh, Thatcher stood to confront her colleagues who suggested that the party pursue a moderate course. As the new party leader, she pulled Hayek's book The Constitution of Liberty from her briefcase and slammed it on the table, saying, "This is what we believe!"

In 1973, both Stuart and Eamonn Butler began traveling back and forth between the U.K. and the U.S., doing teaching stints at the conservative Hillsdale College in rural Michigan, looking for opportunities to advance their cause and to make a difference. In 1974, the Heritage Foundation published a book, co-written by both of them, comparing the British National Health Service and the U.S. Medicare and Medicaid programs, finding all three wanting. Of the two, Stuart became more discouraged by the state of British society and politics. He obtained permanent U.S. residency, and left the U.K. for good in 1979 just as Thatcher won her first election as prime minister.

He had a job offer from the Heritage Foundation in Washington that was too tempting to resist.

Reinventing public policy

The late 1970s and 1980s were bold and invigorating times for conservatives and Republicans in America and especially in Washington. Since 1933, Democrats, Keynesians and other progressives owned the policy ideas ranch named the New Deal. That era didn't end with President Franklin D. Roosevelt's death in 1945. Yale historian Steven Skowronek writes that the New Deal was the dominant "regime" in America from 1933 to 1980 until Ronald Reagan's election. In that 48 year epoch, Democrats controlled the D.C. "Trifecta" (holding White House, Senate and House simultaneously) for 30 years, with 18 years of divided government, and a mere two held by Republicans.

In that era in 1947, in the Swiss Hotel du Parc in a town called Mont Pelerin sur Vevey, Austrian economist Friedrich Hayek assembled a global group of like-minded intellectuals and businessmen to forge a new political and economic philosophy inspired by Adam Smith's ideas. The assembled participants opposed what they saw as a slippery slope to totalitarianism in the New Deal and its progressive elite along with their global allies. Hayek's first popular book, The Road to Serfdom, attacked central government planning as a threat to liberty, preferring an updated version of unbridled 19th and early 20th century capitalism grounded in a reinterpretation of Smith. Joining Hayek at that first global meeting of the Mt. Pelerin Society was his future fellow Nobel economics laureate, Milton Friedman. They knew that their journey would take decades,

not years, and that their prime audience would be subsequent generations, not those then in power.

By the time Stuart Butler settled in America, he and many like him viewed Milton Friedman “like a god,” in his words. Friedman used his fast and voluminous writing skills to produce a large body of work, including his 1962 book, Capitalism and Freedom. His technical work on economics is highly regarded, even today, including by economists such as Paul Krugman. His political writings and advocacy were, however, sharply contested.

Friedman’s bottom lines were many, articulated in books, articles, Newsweek columns, a 1980 PBS series called Free to Choose and more. Freedom is society’s watchword, he maintains, and economic freedom is the gateway to political freedom and general prosperity. Competition between economic freedom and equality in outcomes is zero sum, and the former must win. Preceding Reagan’s inaugural address by nine years, Friedman wrote in Newsweek in 1972 that “government is the problem, not the solution.” Taxes are bad, ditto for regulations, and both should always be reduced. Budget deficits are never an excuse to raise taxes. Unions interfere with economic freedom. Global free trade, governed by clear rules, is the boss, even when partners manipulate their own markets. Though monopolies are bad, government intervention is a cure worse than the disease—so free markets should prevail. An influential proposition in his September 1970 op-ed in the New York Times Magazine asserted that the only legitimate purpose of for-profit corporations is return on equity to shareholders. Obligations to workers, customers, communities, the environment? Just say no. Just stay within the boundaries of law, he cautioned.

In 1979, Margaret Thatcher in Great Britain and Deng Xiaoping in China each assumed power with the Hayek-Friedman doctrine as a key influence. In 1981, Ronald Reagan joined them, declaring in his inaugural address that “in the current crisis, government is not the solution, government is the problem.” A new era—political, cultural and economic—had dawned in America and around the world and Stuart Butler had arrived just in time.

Camping with the Heritage Foundation
In 1973, a rising generation of conservative thinkers and activists formed the Heritage Foundation, intended as a “think and do” tank, a conservative force to counter the influence of the imposing Brookings Institution, the think tank of the liberal establishment. Unlike conservative fellow travelers at the American Enterprise Institute and the Hoover Institution, Heritage founders wanted their experts and writers of reports, books and white papers to get in the face of members of Congress, offering free and timely advice, anytime, anywhere. They rejected only talking with conservative media, preferring relationships with anyone and everyone.

“Heritage was a bridge between the academic and the policy-making communities,” Butler remembers. “It was set up to combine the research functions of a Brookings with the activist approach of a [Ralph] Nader-type group.”

As a young, politically-oriented PhD, Butler fit Heritage’s profile well. And Heritage fit his. As an IRS 501(c)(3) tax exempt organization, Heritage responded to requests for consultations without endorsing legislation or candidates. Their experts circulated accessible research on key issues rapidly to get analyses to mostly Republican members of Congress before votes, not after. In the 1970s, this was unprecedented help for congressional conservatives who noticed Heritage, as did the media and a significant part of the public. Though heavily funded in its early years by deep pockets such as Joseph Coors, Richard Scaife and other wealthy conservatives, Heritage rapidly developed a sizable paying membership base.

In 1980, shortly before Reagan’s inauguration, Heritage produced a 1,100 page “Mandate for Leadership” blueprint for the incoming administration, with 2,000 actionable recommendations to help them to hit the ground running in disassembling the New Deal state. Butler was a contributor, and when the project was repeated for the start of Reagan’s second term in 1985, he was lead author. He made a name fashioning and refashioning ideas for ambitious conservatives. In the early 1980s, he developed a U.S. version of the “urban enterprise zone” concept that offered tax advantages to corporations locating in distressed inner cities, an idea he borrowed from England and sold to policy entrepreneurs including Rep. Jack Kemp (R-NY).

Later in the decade Butler advanced “privatization” of government services including public housing, education and transportation. Many government services should be privatized, he argued, to save money and improve quality. In his 1985 book, Privatizing Federal Spending: A Strategy to Eliminate the Deficit, he wrote: “I see privatization as a very powerful device to change the rules of the game. It allows us to accept that society has an obligation to provide certain services, but gets you out of the trap of saying that they must be provided by government.” During the Reagan administration, Butler made the National Journal’s list of the 150 non-government officials with the greatest influence on decisions in Washington.

The health insurance conundrum

When Butler arrived in the U.S. in 1979 as a permanent resident, he remembers being shocked to learn that he had to sign up for health insurance. In England, access to health care had been a right since 1947 thanks to its National Health Service—no premiums, cost sharing, enrollment, narrow networks or the like that bedevil American consumers. This experience made an impression. “I went to the Blue Cross office in

D.C. to sign up," he remembers. "They asked, 'who's your employer?' I said: 'What's that got to do with anything? This is odd.'"

Joe Antos of the American Enterprise Institute sees the U.K. connection as important to the evolution of Butler's thinking: "Though he was no big fan of the NHS and had lived under it, he could ask questions that average smart Americans wouldn't think of."

In 1982, Butler became director of Heritage's Domestic Policy Studies, a job spanning multiple policy domains. For the first time, health policy was his responsibility, and he managed a team that included health specialists such as Ed Haislmaier, who had strong analytical skills, and Bob Moffit with wide connections.

In the second half of the 1980s, U.S. health policy involving universal health insurance went from sleepy to hyperactive. In 1987, activists led by Boston physicians Steffie Woolhandler and David Himmelstein started Physicians for a National Health Program that reinvigorated activism for a Canadian-style "single payer" health system. In Congress, the Pepper Commission chaired by Sen. Jay Rockefeller (D-WV) proposed national reform built on a mandate for most employers to provide health insurance for their workers. This approach gained traction with passage in 1988 of a universal health care law in Massachusetts, signed by Democratic Governor (and presidential candidate) Michael Dukakis, that included an aggressive employer mandate, a law never implemented and repealed by 1996.

In a 1991 U.S. Senate special election in Pennsylvania, little-known Democrat Harris Wofford defeated former U.S. Attorney General Richard Thornburgh by declaring: "If criminals have a right to a lawyer, I think working Americans should have the right to a doctor." An energetic debate had begun between single payer versus employer mandates, and the public was starting to pay attention.

During President George H.W. Bush's term, Republican interest in health reform was evident and less noticed as an alternative to single payer and employer mandates. Health economists Mark Pauly and Martin Feldstein had published articles back in the 1970s for universal coverage built on tax credits to help lower-income households buy health insurance, and including a mandate for individuals to purchase insurance so that younger, healthier people wouldn't opt out. In 1989, Pauly and colleagues started working with Bush administration officials. Their proposal to mandate coverage got dropped from the plan President Bush announced in February 1992, in the midst of his re-election campaign. Pauly and colleagues wrote up their ideas in 1991 in the journal Health Affairs: "[A]ll citizens should be required to obtain a basic level of health insurance," they proposed. In 1991, Milton Friedman endorsed the concept in his Newsweek column.

Butler first spoke publicly about his new plan for universal coverage in a talk on October 2, 1989, at Meharry Medical College in Nashville at a conference titled “Health Care for the Poor and Underserved.” His address was accompanied by a monograph, Assuring Affordable Health Care for All Americans, identified as “The Heritage Plan,” with the first objective asserting: “All citizens should be guaranteed universal access to affordable health care.” Key components sought to change the tax treatment of employer provided insurance, give tax credits to those who could not afford coverage, reform programs for the elderly and, on page 6: “Mandate all households to obtain adequate insurance …

“This mandate is based on two important principles,” Butler wrote. “First, that health care protection is a responsibility of individuals, not businesses … Second, it assumes that there is an implicit contract between households and society … A mandate on individuals recognizes this implicit contract.”

This was not a one-shot deal. Earlier in 1989, Butler and Haislmaier wrote a Heritage-published book, titled A National Health System for America. Butler now was deeply into health policy. Before 1989, he had written three health-related articles; by late 1992, he had 12 more, most expanding on his plan. Heritage, too, was all in, as seen in the “The Heritage Consumer Choice Health Plan,” dated March 5, 1992: “All heads of households would be required by law to obtain at least a basic health plan specified by Congress.”

Other conservatives, and their think tanks and advocacy groups, expressed alarm at the Butler/Heritage framework, particularly the individual mandate, regarded by them as a violation of liberty. Conservative groups such as the Cato Institute, Consumers for Affordable Health Insurance and the National Center for Policy Analysis objected, while few outsiders paid attention.

At the time, Butler defended his position: “If a proposal moves policy in a conservative direction, go for it.” He argued that conservatives were losing at health reform “a yard at a time. We could keep on losing ground or put forward a real alternative that contained real risk.” Today, Butler recalls: “If you look at the state of the knowledge in the ’80s for how to construct a stable health system in a competitive private model, if you didn’t have everyone in, it wouldn’t be stable. Conservatives and Republicans would always have to play defense against Ted Kennedy unless they embraced the notion that everyone should get health care.”

The Clinton fiasco

The drama over President Bill Clinton’s national health insurance plan became the first moment of opportunity for the Butler/Heritage plan, especially the mandate, to get noticed as a legitimate Republican and conservative alternative. After his January 1993 inauguration, Clinton put First Lady Hillary Clinton in charge of a 500-person task force

to devise health reform legislation based on the concept of “managed competition” and managed care. Early on, prospects for passage were bright, especially in September when the president introduced the plan to a joint session of Congress and in October when the First Lady winningly testified before multiple Congressional Committees.

Senate Republicans, then in the minority, had recognized in 1992 that universal coverage bills would be introduced by either presidential campaign winner and began formulating proposals, especially Senators Bob Dole (R-KS), John Chafee (R-RI) and Don Nickles (R-Okla.), all seeing value in an individual mandate for policy and political reasons. Butler, following the Heritage playbook of meeting with anyone, offered research and analysis assistance, engaging all comers from both parties, including the Clinton White House, and especially Nickles.

Then things began to unwind. In December 1993, conservative writer Bill Kristol circulated an electrifying strategy memo to Republicans urging them to abandon cooperation with Democrats on health reform. “There is no health care crisis,” he wrote, a line Dole began using publicly within one month, challenging Clinton’s core rationale. The memo encouraged Senate and House Republicans to follow their instincts and harden their position against any reform bill. The tide had turned and quickly. Chafee and Dole had collaborated on legislation resembling the Heritage plan with tax credits and an individual mandate. After Kristol’s memo, Dole retreated. More conservative Sen. Don Nickles (R-OK) advanced his own bill including a mandate. Hearing from conservative critics, he deleted that provision in his bill’s final version.

Butler and Heritage collaborators, Moffit and Haislmaier, kept pressing, hiring the prestigious Lewin Group consulting firm to produce financial and coverage estimates on Nickles’ plan, sharing numbers with both parties and with the Clinton White House. In January 1994, Health Affairs published a Moffit article, “Personal Freedom, Responsibility, and Mandates.” He wrote: “An individual mandate for insurance, then, is not simply to assure other people protection from the ravages of a serious illness … it is also to protect ourselves. Such self-protection is justified within the context of individual freedom.”

During this time, Heritage’s critics became more outspoken. The libertarian Cato Institute’s Tom Miller wrote in June 1994, “Nickles-Stearns Is Not the Market Choice for Health Care Reform.” (Rep. Cliff Stearns of Florida was Nickles’ House partner on this issue.) “By endorsing the concept of compulsory universal insurance coverage, Nickles-Stearns undermines the traditional principles of personal liberty and individual responsibility that provide essential bulwarks against all intrusive governmental control of health care." Leaders including Phyllis Schlafly of the American Eagle Forum, Grover Norquist of Americans for Tax Reform and John Goodman of the National Center for Policy Analysis, signed a petition with 37 movement leaders against the Heritage plan.

In spring, the Cato Institute's President Ed Crane complained that "our friends at the Heritage Foundation have endorsed a mandated, compulsory, universal national health plan which flies in the face of the American heritage of individual liberty and individual responsibility." Butler shot back: "Attacking Heritage for its alleged political incorrectness seems to have become a cottage industry at Cato and at NCPA."

In late September 1994, Senate Majority Leader George Mitchell (D-Maine) officially threw in the towel on any effort to achieve health reform that year in Congress, awaiting the judgment of the American people in upcoming mid-term elections. The verdict: Democrats lost control of both branches of Congress for the first time since 1954.

The states take center stage

The Clinton failure offered bushels of lessons that future reformers remembered in crafting the ACA in 2009 and 2010, mostly concerning what not to do, such as setting up a 500-person task force to invent a plan. Unexpectedly, the Clinton process also legitimized the individual mandate as an emerging policy idea. It provided Republicans such as new House Speaker Newt Gingrich (R-GA) with a rationale to oppose Democrats on employer mandates and single payer while endorsing universal health insurance via an alternative pathway.

American society and even most Democrats abandoned universal coverage as an issue after 1994, focusing on incremental efforts that led to passage of the 1996 Health Insurance Portability and Accountability Act (HIPAA) and the 1997 Children's Health Insurance Program. When Republicans reclaimed the White House in 2001 under President George W. Bush, their major health policy achievement was the 2003 Medicare Modernization Act that created outpatient drug coverage for Medicare enrollees. Universal coverage got occasional public hearings and little more.

Starting in the late 1980s and expanding after the 1994 Clinton failure, state governments began trying to improve and expand coverage using their available authorities. A prime reform target for governors and state legislators was a policy called "guaranteed issue" that prohibited insurance companies from considering an applicant's current or prior medical history in issuing or pricing health insurance. States including New Hampshire, Massachusetts, New York, New Jersey, Kentucky, Vermont and Washington State proudly passed guaranteed issue laws to protect consumers from being turned down for having pre-existing conditions.

In each state that implemented guaranteed issue, premiums skyrocketed and markets collapsed. New Hampshire, Kentucky and Washington quickly repealed or watered down their laws, while the others stuck with the policy.

New York saw its number of people with private coverage outside of employer plans plummet from 752,000 people in 1994 to around 30,000 by 2009. The message was clear: guaranteed issue and pre-existing condition exclusion bans were unsustainable without an individual mandate or expensive premium subsidies, or both. The reason was that, with insurers required to offer plans to sick people, many customers would wait until they got sick to enroll. For policy makers the question became: how robust a mandate and/or how deep the subsidies? No one knew.

Butler and the Heritage health policy team deepened their policy in this period, incorporating the idea that states and/or the federal government should authorize or establish “health insurance exchanges” to provide a consumer-friendly marketplace for individuals to shop for private insurance policies.

Massachusetts steps up
In 2003, moderate Democratic Senator John Breaux (D-LA) decided that Democrats were ready to embrace an individual mandate as a “radically centrist” path to universal coverage, filing legislation to that end. His bill went nowhere and convinced observers that Democrats were unmovably against the idea. He was just a little bit ahead of his time.

On April 12, 2006, after decades of political stalemate on universal coverage, a bipartisan breakthrough happened in Massachusetts in historic Faneuil Hall in downtown Boston at the signing of the Massachusetts Universal Coverage Law. Republican Governor Mitt Romney successfully teamed with President George W. Bush and Democratic U.S. Senator Edward Kennedy along with the overwhelmingly Democratic State Senate and House of Representatives.

The Romney-backed system included a “three-legged stool” of insurance market reforms that later would be embedded in the ACA, including guaranteed issue, generous public subsidies for income-eligible consumers, and an individual mandate with a tax penalty on those who could afford to buy insurance and failed to do so. After years of talk about individual mandates, plus great uncertainty whether Republicans really meant it, Mitt Romney did it. On January 1, 2007, Massachusetts became the first state in America to mandate that most residents must have health insurance or pay a tax penalty.

Months before the signing, Romney had announced he would not run for re-election that year. The national press came to Boston to witness the signing by a prospective presidential candidate. Sharing the stage with Romney and public officials was one non-government person, Robert Moffit, senior fellow at the Heritage Foundation. At the ceremony, Moffit and Heritage were saluted by Romney for their contributions to the law’s individual mandate and new Health Insurance Connector, a version of Heritage’s

exchange model. Butler was not part of the ceremony or the prior consultations with Romney or his team.

“I want to begin by saying thank you to Bob Moffit and Ed Haislmaier,” said Romney at a 2006 Heritage event. “Bob and Ed worked extensively with our team as we were developing our plan for health care.” Replied Moffit, “We’ve been honored by your request—myself and my colleague Ed Haislmaier, who’s done a lot of the work on this bill—to participate in giving our best advice and our technical assistance in designing a new and different kind of health insurance market.” As the duo wrote articles explaining the Massachusetts model, Stuart Butler held back, writing a paper in 2007—for Brookings—suggesting that the individual mandate would not be a suitable model for every state, even if it inspired action by some. Butler recalled the flak from Faneuil Hall: “Lots of people felt it would have been better if we had not been on the stage. It was done and we couldn’t back away.”

Romney left as governor before the law’s full implementation, which happened smoothly on the watch of new Governor Deval Patrick, a Democrat. After 17 years, the 1989 policy idea had become real and judged workable as Massachusetts’ rates of uninsured dropped to unprecedented levels of 2-3 percent. Even conservative firebrands such as Sen. James DeMint (R-SC), who became Heritage’s president in 2013, praised Romney and the law as a national model. Gingrich wrote that year: “The health bill that Governor Romney signed into law this month has tremendous potential to effect major change in the American health system.”

On the conservative/libertarian right, organizations such as Cato, the Council for Affordable Health Insurance, the Galen Institute and others issued stern condemnations of the Massachusetts model as an assault on conservative values. Though they got noticed by some, Republicans appeared on the verge of major policy success, achieving a universal coverage scheme to their liking. What could go wrong?

The birth of Obamacare

In the 2008 Democratic presidential nominating process, Senators Hillary Clinton (D-NY) and John Edwards (D-NC) publicly embraced the Massachusetts path in their respective platforms, including an individual mandate. The rising star, Sen. Barack Obama (D-Ill.) publicly rejected it, arguing that sufficient subsidies would obviate need for a mandate. Obama won the nomination and the general election against Sen. John McCain (R-AZ), castigating his opponent’s proposal to slash federal tax deductions for those with employer-sponsored insurance.

President Obama maintained public opposition even as his experts and Congressional leaders began working on reform legislation with a mandate. They all knew that the Congressional Budget Office would issue deal-killing financial and coverage projections

for their bill absent such a requirement. Obama publicly shifted his position to support for a mandate in June 2009 just as five Congressional committees began marking up their health reform bills, all including a mandate. “I am open to your ideas on shared responsibility,” he wrote Senators Ted Kennedy and Max Baucus (D-Mont.), referencing the go-to euphemism for the mandate.

In spring 2009, a resurgent conservative opposition movement, the Tea Party, stopped focusing on the federal deficit and shifted toward defeating Democrats’ health reform aspirations, embracing the term “ObamaCare” as an epithet. They focused fire on the mandate as an assault on freedom. For the first time since 1989, a grass-roots movement, amply funded by conservative deep pockets, made the mandate a combustible grassroots issue.

While the Tea Party’s impact on Democrats was negligible, it scared remaining Republican office holders who were toying with health reform collaboration. Sen. Charles Grassley (R-Iowa), who had co-sponsored the Chafee-Dole and Nickles bills in 1993-94, as well as the 2007 Healthy Americans Act, all of which included individual mandates, stands out. On June 14, 2009, on Fox News, he stated, “when it comes to states requiring it for automobile insurance, the principle ought to lie the same way for health insurance … I think individual mandates are more apt to be accepted by a vast majority of people in Congress.” Three months later in September, also on Fox, he reversed: “Individuals should maintain the freedom to choose whether to purchase health insurance coverage or not.” In August, Tea Party activists had confronted him in all his 40 town halls across Iowa, some with signs saying, “You’re fired!”

Though America’s right was consolidating opposition, Heritage did not back down. On March 17, 2009, Haislmaier testified publicly before the health subcommittee of the House Energy and Commerce Committee, “if lawmakers are going to reform health insurance markets to make coverage portable and accessible for all, further provide all individuals with a wide choice of coverage options, and finally, ensure that those with lower incomes have sufficient financial help to buy coverage, then citizens have no excuses left for not obtaining coverage, or otherwise paying for the medical treatments that they and their dependents receive.”

The ACA’s treacherous path to passage involved multiple cliffhangers. The final bill reached President Obama’s desk for signing on March 23, 2010, with the individual mandate intact, scheduled for full implementation, along with Medicaid expansion, guaranteed issue and tax subsidies for income-eligible purchasers of private coverage, on January 1, 2014.

The Supreme Court makes health-policy history

Democrats mistakenly assumed that, post-passage, animus toward the ACA would diminish as both sides focused on an unprecedented, complex implementation of the law's 10 titles and 487 sections. Over time, though, intense and substantial Obamacare opposition persisted. Federal courts got involved in multiple lawsuits. Republican members of Congress grabbed every opportunity to vote to repeal or undermine the new law, emboldened by recapturing the House in the November 2010 elections and the Senate in November 2014.

According to the National Conference of State Legislatures, between 2010 and 2013, 18 states passed laws or constitutional amendments to prohibit agents of the state from implementing or enforcing mandates related to individual or employer health insurance. Since the ACA was a federal law, states could not block implementation inside their borders, though these efforts made clear the opposition's intensity. In August 2010, Missouri voters approved a ballot initiative, 71-29 percent, declaring the individual mandate to be null and void inside the state.

Most important, the individual mandate became the primary target of anti-ACA lawsuits that reached the U.S. Supreme Court in 2012. Oral arguments were set for late March with a rare three days of court hearings, and a final ruling by late June. Obama administration officials used two tried-and-true rationales to defend the mandate. First, they relied on the U.S. Constitution's Interstate Commerce Clause to justify the ACA—because the interstate and commercial nature of American medical care is undeniable. The second rationale relied on Congress' constitutional authority to levy taxes because enforcement of the individual mandate penalty was assigned to the Internal Revenue Service. But in 2008, candidate Obama had promised not to raise taxes on the middle class, so that second argument created discomfort for a president seeking re-election. Congress had used the Commerce Clause rationale often since the 1930s. Conservative and Republican legal scholars and activists had wanted to limit this power since the 1980s. This was their chance.

ACA opponents asserted that the Commerce Clause permits regulation of economic activity, not economic inactivity such as not buying health insurance. If permissible, mulled late Supreme Court Justice Antonin Scalia, what could prevent the federal government from mandating that citizens must purchase broccoli? In a pirouette mirroring Republican and Democrat position-swaps on the mandate itself, both pro- and anti-ACA advocates switched positions before the court. During the ACA legislative process, Democrats relied on the Commerce Clause and denied that the mandate was a tax, while Republicans always called the mandate a tax. Before the court, with justices noticeably leaning against the Commerce Clause justification, Democrats hastily agreed that the mandate was a tax while Republicans opposed that explanation.

On June 28, 2012, the Justices by a 5-4 vote upheld the ACA's constitutionality, in particular, the individual mandate, by relying on the Constitution's taxation powers, ruling against Commerce Clause applicability. As a result, the Supreme Court put Congress on notice that future legislation justified by the Commerce Clause is under suspicion, an important win for conservatives who were distracted by their intense antipathy at Chief Justice John Roberts for providing the fifth vote upholding the ACA.

In the midst of this judicial drama, on February 6, 2012, seven weeks before the Court's public hearings, USA Today published an op-ed by Butler titled "Don't Blame Heritage for the Obamacare Mandate." In it, Butler declared his opposition to the ACA's individual mandate, casting his earlier support as a "technical matter." The column appeared at an intense point for the Right, facing health reform armageddon and the opportunity to cancel Obama's signature accomplishment. A ruling against the ACA might have been the stuff needed to win the 2012 presidential election for GOP nominee Mitt Romney. Instead, journalists never stopped asking Romney about the individual mandate he had signed as governor.

Obama and journalists taunted conservatives, noting Heritage's role in promoting the mandate. Butler commented on this in his column:

"Nevertheless, the myth persists. ObamaCare 'adopts the 'individual mandate' concept from the conservative Heritage Foundation,' Jonathan Alter wrote recently in The Washington Post. MSNBC's Chris Matthews makes the same claim, asserting that Republican support of a mandate 'has its roots in a proposal by the conservative Heritage Foundation.' Former House speaker Nancy Pelosi and others have made similar claims."

A tight spot it was, even for a seasoned policy hand such as Butler used to rough-and-tumble political action. Who better for him to summon in such a fix than the ghost of Milton Friedman, who had died in 2006:

"My view was shared at the time by many conservative experts, including American Enterprise Institute (AEI) scholars, as well as most non-conservative analysts. Even libertarian-conservative icon Milton Friedman, in a 1991 Wall Street Journal article, advocated replacing Medicare and Medicaid 'with a requirement that every U.S. family unit have a major medical insurance policy.'"

Butler's ending was candid and revealing:

"Changing one's mind about the best policy to pursue—but not one's principles—is part of being a researcher at a major think tank such as Heritage or the Brookings Institution. Serious professional analysts actually take part in a continuous bipartisan and collegial

discussion about major policy questions. We read each other's research. We look at the facts. We talk through ideas with those who agree or disagree with us. And we change our policy views over time based on new facts, new research or good counterarguments. Thanks to this good process, I've altered my views on many things. The individual mandate in health care is one of them."

It wasn't just Butler who had changed. It also was Heritage, which formerly took pride in its hands-on interactions with public officials without endorsing bills or rating politicians. In 2010, Heritage set up its own IRS 501(c)(4) organization called Heritage Action for America to do direct advocacy and lobbying.

"They were going down a road that I don't care for and I'm not good at," recalls Butler. In 2013, long-time Heritage President Ed Feulner stepped down and his successor was DeMint, among the Senate's most hardline conservatives. In a 2009 conference call with conservative activists, he said, "If we're able to stop Obama on this, it will be his Waterloo. It will break him."

In 2014, Alice Rivlin, the first director of the CBO in the 1970s, and then Brookings Institution president, invited Butler to join Brookings, where he could write whatever he wanted. He said yes, and bid Heritage goodbye after 35 years.

To repeal or not to repeal

When Republicans took control of both houses of Congress in 2015, they finally could advance legislation to Obama's desk to repeal the ACA. Knowing that the president would veto their bills and block defunding, they sought to assure conservatives that they would not surrender, especially if they held Congress and won the White House in 2016. All Congressional Republicans united in 2015 and 2016 to fight Obamacare, never needing to specify a replacement.

Much of President Donald Trump's first year in office in 2017 was focused on keeping the Republican promise to repeal and replace the ACA. By October, Republicans admitted failure and switched to another priority, major tax cuts for corporations and individuals. To accomplish this, as they had intended to do in their unsuccessful ACA repeal efforts, they used the "budget reconciliation process." The upside to reconciliation is that such bills cannot be filibustered or blocked by a minority in the Senate, and can pass with 51 votes instead of 60 needed for regular legislation. The downside: Only matters directly relating to the federal budget, up or down, are game.

Sen. Tom Cotton (R-Ark.) began advocating in November to insert repeal of the individual mandate into the tax cut bill. Unfortunately for him, the Senate parliamentarian ruled that full mandate repeal was impermissible under reconciliation rules. However, zeroing out the mandate's financial penalty was permissible and got

included. While not as exciting for conservatives as full repeal, it was de facto repeal, and Republicans could boast a victory.

Though the CBO and other experts predicted disaster from young and healthy adults dropping coverage because of the penalty defenestration, it didn't happen. Turns out, the ACA's individual mandate mattered less than most had imagined because of the premium subsidies. Drew Altman, president of the Kaiser Family Foundation, wrote last year that the ACA's "insurance market has not been materially affected by the elimination of the individual mandate penalty … Healthy enrollees have not left the market in droves, premiums have not spiked and there has been no market death spiral."

Since its 2014 implementation, the mandate had been real. That year, 8.1 million households, or 5.4 percent of the U.S. population, paid the $395 penalty, while 13.3 million filed for an exemption. In 2017, 4.6 million paid the fully phased in penalty of $695, and 12.9 million claimed exemptions, for a total of $3.56 billion in penalties, according to IRS data.

With the tax law's signing, some journalists wrote obituaries and eulogies for the much-maligned mandate. Reports of its death were premature. Like the villain in a James Bond movie who reappears in the final scene for one last fight, the mandate again claims center stage in a national command performance.

Shortly after the 2017 tax cut law was signed, Texas Attorney General Ken Paxton convinced 19 other Republican state attorneys general to join him in suing in federal court to repeal the entire ACA because the penalty elimination made the defanged individual mandate unconstitutional since it was no longer a tax. They filed suit (now California v. Texas) in a conservative federal district court and won a full-repeal judgment in December 2018. The conservative Fifth Circuit Court of Appeals upheld the lower court in December 2019, sending the suit back to the lower court for additional review. In March 2020, the Supreme Court agreed to hear the case, and oral arguments were held on November 10, 2020. At the hearing, Chief Justice John Roberts and Justice Brett Kavanaugh made statements that have been interpreted as indications they would not vote to repeal the entire law, which would presumably create at least a 5-4 majority against complete ACA repeal. But no one knows how the case will come out.

The elegant and merciful solution would be for the Court to invalidate the now-comatose mandate, delete it from the ACA and do nothing else. No one will mind. In so doing, the Hippocratic Oath, "First do no harm," would be followed to a T.

A decision is expected between now and the end of June.

Saving lives

In the first decade of the 2000s, Butler concluded that the benefit of the individual mandate was worth less than the price of unending political and legal warfare. Obama sensed that as a presidential candidate in 2008. Princeton's Paul Starr, author of The Social Transformation of American Medicine, repeatedly offered this advice in 2009 and 2010. Yet scorching memories from the 1990s, when states implemented guaranteed issue without mandates or premium subsidies, had spooked experts, especially at the CBO, whose estimates often mean life or death for legislation. CBO's opinions made clear how vital they viewed the mandate in the Obama era. Political aid and comfort also came from Massachusetts, where 2007 implementation had gone smoothly. The mandate and the subsidies were seen as belts and suspenders, and few could predict whether one or the other was unnecessary.

"Unnecessary" refers only to political and insurance market stability. While the mandate helped keep markets stable, did it induce anyone to buy health insurance who otherwise would not have done so, and did that coverage matter for their health and wellbeing? These questions were not factors in Congress' consideration of the ACA because there was no valid answer then beyond limited evidence from Massachusetts. Today, in 2021, we have an answer.

In 2019, Jacob Goldin of Stanford Law School plus two U.S. Treasury Department officials produced a study for the National Bureau of Economic Research, titled "Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach":

"We evaluate a randomized pilot study in which the IRS sent informational letters to 3.9 million taxpayers who paid a tax penalty for lacking health insurance coverage under the Affordable Care Act. Drawing on administrative data, we study the effect of the intervention on taxpayers' subsequent health insurance enrollment and mortality. We find the intervention led to increased coverage in the two years following treatment and that this additional coverage reduced mortality among middle-aged adults over the same time period. Our results provide the first experimental evidence that health insurance reduces mortality."

The report has been published in the Quarterly Journal of Economics, among the most respected economics research journals.

In 2021, because of President Joe Biden's American Rescue Plan Act signed on March 11, the ACA's premium subsidies have been substantially increased and expanded for the next two years. Because of these changes, insurance levels nationally will likely increase in the next several years. But unless Congress and the president extend the

added subsidies into 2023 and beyond, an affordability cliff will reoccur. Meanwhile, reinstating the ACA individual mandate penalty is not under consideration.

Another surprising outcome from the 2017 penalty repeal is that some states beyond Massachusetts have enacted their own enforceable individual mandates, including California, New Jersey, Rhode Island and the District of Columbia. All solid blue in political terms, the mandates come from a Democratic Party that does not view them as assaults on liberty. No citizen revolts are apparent in these states. Regardless of the ACA mandate's fate before the U.S. Supreme Court, the individual mandate as state policy may persist. If other states face pressures on individual health insurance affordability, it may reemerge as a legitimate tool.

It is interesting to recall how Butler in 2007 wrote that the individual mandate might work better as a state prerogative rather than as a federal tool. Once again, he was ahead of the curve. At 73, Butler remains engaged and active. He chairs the board of a community health center in Washington. He moderates challenging multi-stakeholder policy negotiations through the Convergence Center for Policy Resolution. His home base remains Brookings, where he writes about his current passion, how the U.S. health system needs to better address "social determinants of health," such as housing, nutrition and environmental quality, bringing a conservative perspective to the table.

Earlier last year, he signed onto a friend of the court brief in California v. Texas in support of not repealing the ACA. And, he says, he is still a card-carrying member of the Mt. Pelerin Society.

Forbes

Why Healthcare Needs A Civil Rights-Style Movement
Sachin H. Jain

There will come a time in the not too distant future when we look back at the healthcare system as it is today with shame and embarrassment. We'll wonder how anyone got the right kind of care and rue the policy and clinical decisions that have made oursystem unaffordable, inaccessible, wasteful, and inferior to our peer nations.

To hear some people discuss healthcare these days, the Affordable Care Act (ACA) fixed the healthcare system. But that's not really true. The ACA broadened the tent and made health insurance coverage available to more people. But the tent poles now need to be replaced.

More than a decade since the ACA's major provisions became law, America still spends twice as much on healthcare as other high-income countries, and yet when compared to those other countries, we have poorer health outcomes, including the highest rates of preventable deaths. Quality remains variable at best.

This is the 35,000-foot view of the economics of the U.S. healthcare system. It may be more instructive to come down to the human level, where 21 million Americans holding $46 billion of medical debt as of April 2021 face collections and half of all U.S. adults are concerned that a major health event in their household could lead to bankruptcy. Aggressive debt collecting behavior is not limited to for-profit organizations—but has extended also to non-profits whose actions have left recovering patients and families in endless litigation over their medical bills.

Not surprisingly, wealth plays a big role in one's experience of the American healthcare system. Dr. Atul Nakhasi is a primary care physician at Martin Luther King, Jr. Outpatient Center in South Los Angeles. Atul trained to be a physician at UCLA, which is located in the 90095 ZIP code, and then went to work across town at MLK, which is in 90059. That's not insignificant. Reversing those two numbers reveals what Nakhasi calls "two vastly different Los Angeleses" and makes the difference between "whether you live to see your grandchild come into this world and take his or her first footsteps." Eighty percent of the patients Nakhasi sees in South Los Angeles make less than $18,000 a year—what Nakhasi calls "an unlivable income in the 21st century." Differences in outcomes across these two Los Angeleses were particularly pronounced in the pandemic—where infection rates and income maps seemed to work in inverse proportion.

This is not to say that the current system serves even the wealthiest Americans very well. A recent study published in JAMA found that while "the health outcomes of White US citizens living in the 1% and 5% richest counties are better than those of average US citizens," those wealthy people are nevertheless more likely to die from a heart attack or cancer, during childbirth, or to lose an infant than people in 12 other industrialized countries.

Let's be honest. Our healthcare system is stupidly broken.

One of the sources of that brokenness is our propensity to aggressively intervene when chronic diseases become complicated—but do little to prevent or treat those chronic diseases in the first place. As I've written before, the American system—in contrast to those of our peers—funnels endless streams of money into expensive specialist visits while at least 25 percent of people don't even have a primary care physician. We easily send end-state diabetic patients for costly dialysis and retina surgeries—but pay minimally for primary care physicians and programs to prevent the development of

diabetes in the first place. Pundits like to say we have a sick care system, not a health care system. I prefer to say we have a sick system.

Some heavy hitters in American business have tried to heal our sick system—notably Amazon, Berkshire Hathaway and JP Morgan with their much trumpeted Haven Healthcare venture. Haven collapsed earlier this year, but many of us suspected from the start that it never had a chance. No matter what its brilliant minds put together, patients still had to get care in dysfunctional clinics and hospitals, take outrageously expensive medications, and wait for clunky labs to process tests. Haven sought to disrupt a system it simultaneously relied on. Without wholesale revolution, it's hard to disrupt an existing model of care.

As for government regulators, having been one myself, I have great faith in their ability to, once a generation, create policy—like the ACA—that can enable innovation. But as of late policymakers are suffering from the same lack of bold ideas as the leaders of our major health systems. Even when they do create the right policy instruments, such as demonstrations from the Centers for Medicare and Medicaid Innovation (CMMI), uptake and adoption is often low. We need more courage and imagination in the field.

What will it take to produce genuine reform in our system? I think of the Civil Rights movement that blossomed in America after World War II. Looking at the horrors of Jim Crow, bold leaders saw a system that was a national embarrassment and demanded reform. And so a movement was born and carried by a brave aggregation of ordinary people who were not about to rest until they saw concrete change in front of their eyes.

We need a similar movement in healthcare. We need bold leaders who will admit that our current system is an embarrassment. We need clinicians like Atul Nakhasi who understand that a little more common sense can heal people. We need employers to stand up and say they're no longer willing to fork health benefits into the furnace of lackluster outcomes. We need insurers to focus their efforts on covering low-income Americans and communities of color, and to go to bat for their members by demanding quality care at a fair cost.

Now is the time for leaders to emerge and for us to engage as a nation in the same way that past generations engaged in the Civil Rights Movement. Now is the time for us to work together to demand and find fundamental solutions to these issues.

Or we can ignore them, and wait for our children to look back on us with embarrassment and shame.

Why Healthcare Needs A Civil Rights-Style Movement
Daniel McDermott and Cynthia Cox

The American Rescue Plan Act (ARPA) was passed by Congress and signed into law by President Biden in March 2021. The ARPA includes provisions that increase subsidies for Marketplace shoppers who were already eligible for financial assistance and removes the upper income cap on subsidy eligibility, eliminating what was known as the "subsidy cliff." As a result, KFF estimated that roughly 3.7 million more Americans, more than a third of whom are uninsured, are newly eligible for financial assistance to buy their own coverage on the exchanges, and millions more are eligible for increased financial assistance.

As of April 30, nearly 1 million people had enrolled in a HealthCare.gov plan during the ongoing special enrollment period, which lasts through August 15. The Centers for Medicare and Medicaid Services (CMS) announced an outreach campaign to inform people about Marketplace enrollment opportunities and the enhanced financial assistance. For 2021 and 2022, CMS released over $80 million in grants to Navigators and related organizations that help consumers enroll in coverage and provide outreach and educational services. The Trump administration had made substantial cuts to ACA marketing activities and Navigator programs, which received just $10 million in grants in both 2018 and 2019.

In this analysis, we examine key demographic characteristics of the 10.9 million uninsured people who are eligible for Marketplace subsidies, including 6 million uninsured individuals eligible for tax credits that cover the full cost of a Marketplace plan. We exclude people who are eligible for Medicaid, Medicare, or affordable employer coverage, as well as those who are undocumented immigrants. We also exclude people who fall into the Medicaid coverage gap, since Marketplace coverage is generally unaffordable to people with incomes below poverty.

We find that relatively large shares of uninsured people eligible for significant assistance to buy Marketplace coverage are young adults without college educations, Hispanic, non-native English speakers, and working in the fields of entertainment, recreation, and construction. Most people eligible for free Marketplace coverage are concentrated in a handful of states (Texas, Florida, North Carolina, and Georgia). These findings can

inform marketing, outreach, and enrollment assistance activities as the 2021 special enrollment period continues and consumers begin shopping for 2022 coverage later this year.

Findings

We estimate there are approximately 12.1 million[1] uninsured potential Marketplace shoppers, of whom the vast majority (10.9 million) are eligible for subsidies under the ACA and ARPA to help lower the cost of coverage.

Nationally, certain groups are overrepresented among the uninsured who are eligible for Marketplace subsidies following the enactment of the ARPA. We find that 30% of uninsured people eligible for Marketplace subsidies are Hispanic (compared to 20% of non-elderly people in the U.S.), 59% have a high school diploma or less (compared to 36% of non-elderly adults in the U.S.), and 42% are young adults ages 19 to 34 (compared to 25% of non-elderly people in the U.S.). In total:

- 10.9 million uninsured people could purchase Marketplace coverage for a reduced premium. Although subsidies for this group may not cover the full premium, they can significantly lower the premium and/or out-of-pocket liability. Even so, some people in this group may still find Marketplace coverage unaffordable or unattractive due to high deductibles.
- At least 6.0 million uninsured people could get a free Marketplace plan (with a $0 premium payment, after accounting for subsidies). As explained in our earlier brief and in some detail below, people in this group would clearly benefit from getting Marketplace coverage rather than continuing to go without coverage.
- Of uninsured people who are eligible for $0 premium plans, 1.3 million have incomes below 150% of poverty, which makes them eligible for a free benchmark silver plan and substantial cost-sharing reductions (CSRs) that would make their plan more similar to platinum level coverage (which an average deductible of $177 in 2021). Some people with incomes just above 150% of poverty may also qualify for zero-premium silver plans depending on the gap in price between the benchmark (second-lowest cost) silver plan and the lowest-cost silver plan in their area.
- In addition, under the ARPA, any person who qualifies to purchase a Marketplace plan and receives unemployment compensation in 2021 is similarly eligible for a benchmark silver plan with a $0 premium and cost-sharing assistance. Therefore, our estimate of the number of uninsured people eligible for zero-premium plans is likely an undercount.

Subsidy ELigible uninsured: key characteristics

We estimate that 10.9 million non-elderly uninsured people in the U.S. are eligible for some level of subsidy to help purchase a Marketplace plan. Relative to the general non-

elderly population in the U.S., uninsured people eligible for Marketplace subsidies are more likely to be:

- **High school educated:** 59% of subsidy eligible adults have a high school education or less, compared to 36% of non-elderly adults in the U.S.
- **Young Adults**: 42% of subsidy eligible uninsured people are ages 19-34, compared to 25% of the non-elderly U.S. population.
- **Hispanic:** 30% of subsidy eligible uninsured people are Hispanic, compared to 20% of the non-elderly U.S. population.
- **Living in rural areas:** 16% of subsidy eligible uninsured people live in non-metro areas, compared to 13% of the non-elderly U.S. population.
- **Lacking internet access**: 11% of subsidy eligible uninsured people do not have internet access at home, compared to 6% of the non-elderly U.S. population.

Table 1: Characteristics of the Uninsured Marketplace Eligible Population, by Subsidy Eligibility in 2021

	Uninsured Eligible Marketplace Subsidies	Uninsured Eligible for Free Plan*	Uninsured Eligible for Free Platinum-Like Silver Plan	Nationwide Non-Elderly Total (%)
Total	**10,933,600**	**6,034,300**	**1,297,600**	**–**
Hispanic	3,344,600 (30%)	1,937,800 (32%)	525,800 (41%)	20%
Young Adults (Age 19-34)	4,618,200 (42%)	2,536,300 (42%)	645,900 (49%)	25%
High School Education or Less	6,507,200 (59%)	3,736,300 (62%)	846,100 (65%)	36%

Non-Metro Resident	1,755,700 (16%)	1,073,300 (18%)	188,200 (15%)	13%
Work in Arts / Entertainment / Construction	3,326,100 (30%)	1,872,900 (32%)	425,000 (33%)	22%
No Internet Access at Home	1,223,600 (11%)	788,300 (13%)	200,100 (15%)	6%
Language Other Than English Spoken at Home	3,670,570 (33%)	2,119,000 (35%)	602,300 (46%)	23%
Income				
< 200% FPL**	4,589,700 (42%)	4,307,600 (71%)	1,297,600 (100%)	29%
200% – 400% FPL	5,055,100 (46%)	1,681,200 (28%)	-***	29%
> 400% FPL	1,244,346 (11%)	45,700 (1%)	-***	41%

NOTES: *The Uninsured Eligible for Free Plan category includes people who would also qualify for a Free Platinum-Like Silver Plan. **FPL stands for Federal Poverty Level ($12,760 for individual in 2020). ***Estimates do not account for unemployment insurance received in 2021, which would qualify Marketplace eligible individuals for free benchmark silver plans.

Uninsured Marketplace eligible population does not include people with incomes below poverty who fall into the Medicaid coverage gap. People age 65 and over are excluded from this analysis. Estimates may not add to 100% due to rounding.
SOURCE: KFF analysis of 2019 American Community Survey.

uninsured eligible for Zero premium plans: key characteristics

We estimate that at least 6.0 million uninsured people in the U.S. could get a bronze or silver plan on the ACA Marketplace with a $0 premium contribution, after accounting for their subsidy. Compared to the total subsidy-eligible uninsured population and the general U.S. population, uninsured people eligible for free Marketplace plans are more likely to be:

- **High school educated:** 62% of free bronze eligible uninsured adults and 65% of the free silver eligible uninsured people have a high school education or less, compared to 59% of all subsidy-eligible uninsured people and 36% of all non-elderly adults in the U.S.
- **Hispanic:** 32% of free bronze eligible uninsured people and 41% of the free silver eligible uninsured people are Hispanic, compared to 30% of all subsidy eligible uninsured people and 20% of the total non-elderly population.
- **Lacking internet access**: 13% of the free bronze eligible uninsured people and 15% of free silver eligible uninsured people do not have internet access at home, compared to 11% of all subsidy eligible uninsured people and 6% of the total non-elderly population.
- **Non-English speaker at home:** 35% of free bronze eligible uninsured people and 46% of free silver eligible uninsured people speak a language other than English at home, compared to 23% of the U.S. non-elderly population.

In addition to the 1.3 million uninsured people who qualify for zero-premium benchmark silver plans because their income is less than 150% of poverty, there are likely many more uninsured people who qualify for free silver plans because the ARPA ensures that any enrollee receiving unemployment insurance at some point in 2021 is eligible for zero-premium platinum-like coverage. As noted above, there are also some uninsured people with incomes just above 150% of poverty who would have to pay a small premium for a benchmark silver plan, but may receive enough in subsidies to cover the full cost of the lowest-cost silver plan in their area. Further, there are many counties in the U.S. where the lowest-cost gold plan is cheaper than the lowest-cost silver plan. Lower-income Marketplace shoppers in these areas could potentially purchase a free gold plan with lower cost-sharing and more financial protection than plans in lower metal levels.

As we have explained in earlier analyses, many people who are eligible for a free bronze plan are also eligible for a low-cost silver plan with a substantially lower deductible due to CSRs. The average annual deductible for people with incomes between 150-200% of poverty who choose to enroll in a silver plan with a CSR is $800. Many people in this group, therefore, could be better off buying a silver plan with a small premium than a zero-premium bronze plan.

Even so, *all* of the uninsured eligible for a free bronze or a free silver plan would be better off taking advantage of that $0 premium coverage instead of remaining uninsured. People in this group may need help understanding the tradeoff between silver and bronze coverage (i.e. affordability of the premium and deductible), as well as help understanding the benefits that even a high-deductible bronze plan offers over being uninsured (i.e. free preventive care, limited out-of-pocket liability, lower negotiated payment rates to providers, and often at least some covered benefits before having to meet the deductible).

Almost half of the uninsured who could get a free bronze plan live in Texas, Florida, North Carolina, or (Figure 1). A detailed table in the appendix provides demographic characteristics of people eligible for free Marketplace coverage in each state.

Discussion

The findings of this analysis can inform government agencies, insurers, or Navigators tasked with outreach and marketing responsibilities, helping them to target specific groups that are more likely to be uninsured but eligible for significant financial assistance. The Department of Health and Human Services has announced concerted efforts to reach historically uninsured communities during the ongoing special enrollment period. Relatively large shares of uninsured people eligible for significant assistance to buy Marketplace coverage are young adults without college educations, Hispanic, non-native English speakers, and working in the fields of entertainment, recreation, and construction. Most people eligible for free bronze or silver coverage are concentrated in a handful of states (including Texas, Florida, Georgia, and North Carolina).

In addition to the findings highlighted above, the appendix of this brief provides detailed demographics about the uninsured population eligible for fully-subsidized coverage in each state.

Democrats plot Medicaid expansion backdoor in red states refusing program
Rachel Roubein and Susannah Luthi

Democratic lawmakers are rallying around an effort to extend health insurance in states that have refused to expand Medicaid, believing they have a limited window to help millions who've been unable to get coverage because of intractable GOP opposition to the Obamacare program.

Democrats had hoped that President Joe Biden's election, along with the promise of new federal cash from the recent Covid relief package for states to expand Medicaid, would move at least some of the dozen remaining holdout states. But there's little indication those states are budging, which is energizing a push among Democratic lawmakers for a new federal program guaranteeing coverage for low-income adults long shut out of Medicaid expansion.

"I think in most of them, like Texas, it's not a question of dollars, it's a question of wanting to be ideologically opposed to any additional role for government in helping impoverished people," said Rep. Lloyd Doggett (D-Texas), the House Ways and Means health subcommittee chairman, who's working on a coverage proposal. "The only way we overcome that is through a federal initiative."

Expanding coverage to the estimated 2.2 million people lacking affordable health insurance options in the Medicaid expansion holdout states would fulfill a Biden campaign pledge while his other key health care promises, like government drug price negotiations and a public option, face tough odds in Congress. Democrats also believe it would deliver a major win for their party heading into tightly contested midterm elections next year, given that Medicaid expansion has polled well — including in states where Republican leaders have blocked it for years.

However, the new effort carries risks that Democratic lawmakers, White House officials and health care advocates have been struggling to resolve in behind-the-scenes discussions over the past few months, say people involved in those talks. One challenge is designing a program that won't invite backlash from a health care industry ready to battle Democrats on other sweeping changes. Another concern is inadvertently rewarding states that blocked Medicaid expansion for years. Any plan would also come with a steep price tag.

"There is pretty universal acknowledgment that action is needed to address the population," said Henry Connelly, spokesperson for House Speaker Nancy Pelosi. "Everyone is exploring ways to get it done."

Democratic lawmakers are weighing a few options that could potentially get wrapped into a major economic package they hope to pass along party lines this year. But they haven't yet agreed on an approach, and Democratic leaders are facing competing demands to use upcoming infrastructure legislation to expand Medicare eligibility and benefits, mandate drug price negotiations and bolster Obamacare subsidies.

Health care advocates caution that Democrats have limited time to address stalled progress on Medicaid expansion — seen as the biggest unfinished piece of the Affordable Care Act — while the party controls Washington for the first time since the law's passage a decade ago.

"This is the moment," said Judy Solomon, a senior fellow at the left-leaning Center for Budget and Policy Priorities. "This is probably the only moment that we'll have for years."

The White House has taken a largely hands-off approach in talks over a Medicaid expansion alternative, as it has with other major health care proposals Biden campaigned on. While Biden's budget proposal on Friday reiterated his support for those ideas, including closing the Medicaid coverage gap, it was short on specifics. The only major health promise Biden proposed including in major economic legislation is the one seen as the least politically divisive: making permanent the recent Covid relief package's temporary expansion of financial help for people buying Obamacare health plans.

"The President has consistently supported providing coverage for this population," an administration official said when asked about the administration's plans in Medicaid expansion holdout states.

Congressional panels with jurisdiction over Medicaid, the House Energy and Commerce Committee and the Senate Finance Committee, have been leading work on the issue. The committee chairs and Pelosi haven't spoken publicly about their plans as staff work through the details.

Support for a federal workaround got a big boost this week when Georgia Sens. Raphael Warnock and Jon Ossoff, whose elections delivered Democrats control of Washington, urged leadership to include the policy in infrastructure legislation. This week's Senate confirmation of Chiquita Brooks-LaSure to run the federal Medicare and

Medicaid agency is also expected to accelerate the Biden administration's work on health coverage policies.

The renewed push to insure people in the expansion holdouts comes after those states largely ignored new financial incentives to expand Medicaid that were included in the Democrats' stimulus. The law provides a two-year boost in federal Medicaid payments to states that expand, on top of the generous federal match they would already receive for covering the expansion population.

Of the holdout states, only Wyoming's legislature seriously considered an expansion bill this year, but it died in the Senate after passing the House. And recent moves in other states showed expansion still faces tough hurdles across the country.

In Wisconsin, Republican lawmakers this week quickly shut down a special session Democratic Gov. Tony Evers convened to consider expansion. In Missouri, the state is facing a lawsuit after Gov. Mike Parson refused to implement an expansion that voters approved last summer. And in Mississippi, advocates halted a campaign to put Medicaid expansion on the ballot next year after a state Supreme Court ruling made such initiatives impossible.

"What just happened in Wisconsin and Missouri is giving some momentum to the effort because it's clear that where Republicans can stop this in holdout states, they will," said Brad Woodhouse, president of the liberal group Protect Our Care that's closely allied with Democratic leaders in Congress.

Crafting the policy remains difficult, however. And while congressional Republicans have given up on trying to repeal Obamacare, they're not expected to lend any support to the effort.

Biden's budget calls for creating a federal public-run health insurance option in the holdout states that would offer free coverage modeled after Medicaid benefits. States that already expanded – and fund 10 percent of the program's costs – would receive unspecified "financial incentives" to discourage them from dropping coverage.

That idea would likely draw swift opposition from hospitals and health insurers, who support expanding Medicaid but oppose a public option that would eat into their profits.

Chip Kahn, president of the Federation of American Hospitals, said it would be difficult to set up a new coverage system without creating a financial imbalance between states that expanded Medicaid and those that haven't.

“The fact that all the states have not implemented the ACA Medicaid expansion means there’s inequity among eligible Americans,” said Kahn, whose group represents for-profit hospitals. “But the problem is that to try to jury-rig a solution for the states that have stayed out of ACA Medicaid would then create inequities in financing and rules between the states that have the expansion and those that don’t.”

Another idea is expanding Obamacare subsidies to allow low-income people in the non-expansion states to receive free private coverage in the law’s insurance marketplaces. Currently, people earning below the federal poverty line, or about $13,000 per year, are ineligible for Obamacare subsidies. Expanding those subsidies would be expensive since private plans cost the government much more per person than Medicaid or Medicare.

A third idea from Doggett, the Ways and Means health subcommittee chairman, would seek to circumvent state opposition by allowing counties and other local governments to expand Medicaid in a hyperlocal fashion. That would still leave large gaps in coverage and could be difficult to implement.

On Thursday, nearly 60 civil rights and advocacy groups — including the NAACP, The Arc, Planned Parenthood and the Whitman-Walker Institute — in a letter urged lawmakers to expand coverage in the holdout states “as part of recovery legislation this year.”

“Congress has a responsibility – which it has exercised in the past, in some of its proudest moments – to step in with national policies to ensure that everyone is treated equally, no matter what state or territory they live in,” they wrote.

REUTERS®

Major rulings including Obamacare loom for U.S. Supreme Court
Lawrence Hurley

The U.S. Supreme Court heads into the last month of its current term with several major cases yet to be decided including a Republican bid to invalidate the Obamacare healthcare law, a dispute involving LGBT and religious rights and another focused on voting restrictions.

The court, which has a 6-3 conservative majority, now has 24 cases in total left to decide after issuing two rulings on Tuesday. There also is speculation about the potential retirement of its oldest justice, Stephen Breyer. Some liberal activists have urged Breyer, who is 82 and has served on the court since 1994, to step down so President Joe Biden can appoint a younger liberal jurist to a lifetime post on the court.

In the most notable of Tuesday's decisions, the court unanimously endorsed the authority of Native American tribal police to stop and detain non-Native Americans on tribal land.

The court's nine-month term starts in October and generally concludes by the end of June, though last year it continued into July because of delays caused by the COVID-19 pandemic.

Speaking during an online event for students on Friday, Breyer hinted at the court's complex deliberations that go into deciding high-stakes cases at this time of year.

"It's complicated by the fact that you are dealing with eight other colleagues. ... You'd better be willing to compromise," Breyer said.

Republican-governed states have asked the court to strike down the Affordable Care Act, a law signed in 2010 by Democratic former President Barack Obama that has helped expand healthcare access in the United States even as Republicans call it a government overreach.

It appears unlikely based on November's oral arguments that the court would take such a drastic step. But if the Obamacare law were to be struck down, up to 20 million Americans could lose their medical insurance and insurers could once again refuse to cover people with pre-existing medical conditions. Obamacare expanded public healthcare programs and created marketplaces for private insurance.

Another major case yet to be decided is one that pits religious rights against LGBT rights as the justices weigh Philadelphia's refusal to let a Catholic Church-affiliated group participate in the city's foster care program because it would not accept same-sex couples as prospective foster parents.

The conservative justices appeared during the November arguments in the case to be sympathetic toward the Catholic group's claim that its religious rights under the U.S. Constitution's First Amendment had been violated. The court's conservative majority has taken an expansive view of religious rights and has spearheaded several rulings backing churches in challenges to COVID-19 pandemic-related restrictions.

With various states enacting new Republican-backed voting restrictions in the aftermath of former President Donald Trump's false claims that the 2020 election was stolen from him through widespread voting fraud, the court is preparing to rule in a case concerning Arizona voting limits.

Republican proponents of Arizona's restrictions cite the need to combat voting fraud. A ruling upholding the restrictions could further undermine the Voting Rights Act, a landmark 1965 federal law that prohibits racial discrimination in voting.

The court also is getting ready to decide a closely watched case involving the free speech rights of public school students. It involves whether a high school that punished a cheerleader for a foul-mouthed social media post made off campus on a weekend violated her free speech rights under the First Amendment.

The court has taken up major cases on gun and abortion rights for its next term, which begins in October.

Obamacare Prices Continue to Fall
Michael Ollove

The cost of the health insurance plans sold on Obamacare marketplaces has declined for the third year in a row, according to a new analysis.

In addition to the decrease in premiums since costs spiked in 2018, more insurance carriers are now participating in the marketplaces, according to a report published by the Urban Institute, a left-leaning think tank based in Washington, D.C.

The authors examined policies offering similar benefits in the 15 states that run their own marketplaces and the 36 states that rely at least in part on the federal marketplace. Premiums fell by an average of 1.2% from 2018 to 2019, 3.2% from 2019 to 2018 and 1.7% from 2020 to 2021, they found. That contrasts with a huge increase from 2017 to 2018 of nearly 32%, which the authors attributed largely to policies of the Trump administration intended to undercut the Affordable Care Act.

Prices dropped on the Obamacare marketplaces even as health insurance premiums rose overall.

“This decline is remarkable because it contrasts with premium increases in the employer-sponsored insurance market over the same period,” the report said. Premiums in employer-sponsored plans rose 3.9% in 2019 and 4.3% in 2020. (Data on rates in 2021 is not out yet, the authors say.)

Obamacare premiums varied considerably by state, because states have different insurance laws, demographics and numbers of competing insurance companies. Marketplace premiums fell by 31% in Iowa in 2021, the largest drop in a state this year. They rose by nearly 6% in Arkansas, representing the largest increase.

The number of insurance carriers participating in the marketplaces increased by 50% between 2018 and 2021, creating more competition and better prices, the authors said.

The authors attribute the big increase in premiums that occurred in 2018 to the Trump administration’s decision to stop paying insurance carriers for reducing certain out-of-pocket costs for lower income policyholders. Insurers reacted to the loss of those payments by raising premiums.

Another reason for the big premium increase that year, according to the authors, was insurers’ uncertainty over the impact of Congress’ elimination in 2019 of the penalty for people who failed to sign up for health insurance.

Harvard Business Review

The Fastest-Growing U.S. States Have the Worst Health Care
David Blumenthal and David C. Radley

The 2020 census revealed trends in the geographic distribution of Americans that may be bad news for their health unless policymakers and private sector leaders act to correct marked deficiencies in the health and health systems where more and more Americans are dwelling.

The fastest-growing states in terms of population over the last decade, including Texas, Florida, and Georgia, consistently rank last when it comes to health and health care. This is because these states have large numbers of uninsured adults, high levels of premature death from treatable conditions, less investment in public health, too many people with mental illness unable to get the care they need, and residents facing

mounting insurance costs that make health care less affordable than in many other parts of the country, according to the Commonwealth Fund.

Take Texas, which added 4 million people, the most of any state, over the past decade. Texas ranked 42nd overall in our measure of health system performance — in large part because of how hard it is for people in the state to get and afford the health care they need. It has the highest uninsured rate in the country, and fewer of its residents report having a regular source of health care — an important marker of how well the health system is working. Texas also has the largest number of residents who said they skipped health care they needed because of cost, and health insurance costs take a bigger share of people's incomes in Texas than in almost any other state. Texas is also one of 14 states that still have not expanded Medicaid under provisions of the Affordable Care Act, leaving millions of working people uninsured.

Florida, which grew by nearly 3 million people, has a similar story. It ranks 41st overall and its residents face many of the same health care access and affordability challenges as people living in Texas, with many uninsured and high insurance costs. Another fast-growing state, Georgia, ranks 46th overall. Georgians face similar health care access problems as Texans and Floridians, but what stands out is its preventable mortality: Georgia has one of the highest rates of premature (before age 75) death from treatable conditions and one of the highest rates of infant mortality — ranking 42nd on both measures. All three of these states rank poorly in other areas of health care too.

Overall, the states that rank at the bottom of the scorecard accounted for half of the aggregate population growth in the United States from 2010 to 2020.

So, what does all of this mean for Americans' health? Geography does not have to be destiny. There are things state and federal policymakers and private sector leaders can do to significantly improve health at the state level.

Recently, the Biden administration and Congress made more people eligible for assistance with their Affordable Care Act marketplace health insurance premiums. Right now, these more generous subsidies will last for two years. Making them permanent would make health insurance more affordable for millions, including the 3.7 million people in Texas and Florida, who have enrolled in insurance plans through ACA marketplaces. States could also expand their Medicaid programs under the Affordable Care Act. Doing so in Texas, Florida, and Georgia would extend health insurance coverage to 2.7 million people.

Health insurance coverage has a ripple effect. It is the most important determinant of access to health care, and assuring more people have it is also likely to lead to improvements in other health measures.

Similarly, investments in public health made possible by the $350 billion allocated to states and local governments under the American Rescue Plan, which President Biden signed into law in March, could improve the capacity of low-performing states to address preventable causes of illness and death such as excess maternal mortality, heart attack, stroke, cancer and more.

Finally, it is possible that people from healthier states may bring their better health and commitment to collective health improvement with them to less healthy states. Migrants from states with more robust governmental health programs, included expanded Medicaid, may support such investments at the voting booth in their new home states. This could mean that states that have been reluctant to invest in health care coverage and improvements may be more likely to do so in the future. Business leaders, who depend on a healthy workforce, can assist by letting state and local officials know how important it is prioritize public health and coverage expansion.

Of course, in an ideal world, our health system would be good enough that people in every state would have affordable, high quality health care. Getting there will require investing in state and federal policies that we know work to get people the health care they need, no matter where they live.

How To Improve Consumer Plan Selection In ACA Marketplaces—Part 1
David Anderson, Coleman Drake and Petra W. Rasmussen

There is currently an opportunity for the Centers for Medicare and Medicaid Services (CMS) to help consumers enroll in better Marketplace coverage in 2022. By adjusting how returning Marketplace enrollees are automatically re-enrolled in coverage, CMS can nudge more enrollees into plans that offer them both lower premiums and reduced cost sharing. We outline here the steps to improve consumer plan selection that CMS should make, placing this in the context of the American Rescue Act (ARA).

COVID-19 Relief And The Marketplaces
As a candidate, President Joe Biden's health care platform focused on strengthening the insurance coverage expansions of the Affordable Care Act (ACA). His proposals included creating a public option and increasing the size of and eligibility for premium tax credits for health plans sold on the ACA's health insurance Marketplaces. With a

narrow Democratic margin in the Senate, the administration faces an uphill climb to pass a public option. However, far more generous premium tax credits than the baseline assistance in the ACA has already passed Congress and been signed into law by the president. The president has also signed an executive order that seeks to minimize administrative burdens and barriers of enrollment and maximize affordability of coverage. The executive order in Section 3 Paragraph IV requires agency heads to review rules that may "present unnecessary barriers to individuals and families," while Paragraph V requires a review of rules that "reduce the affordability of coverage or financial assistance for coverage." Current Marketplace rules and procedures that place people into inferior plans with lower actuarial value and the same or higher premium would likely run afoul of these presidential directives.

Premium tax credits fill the gap between what a Marketplace enrollee is expected to pay for a designated benchmark plan and the full, gross premium of that plan. Under the four metal-level system (bronze, silver, gold, platinum), the benchmark plan is the second least-expensive silver plan. Under the current ACA, individuals with incomes at 150 percent of the federal poverty level pay 4.14 percent of their income ($66.03/month) for the benchmark silver plan.

Additional cost-sharing reduction (CSR) subsidies for individuals below 250 percent of poverty make silver plans the most frequently chosen option for relatively lower-income households, as CSR subsidies significantly reduce silver plans' deductibles and copayments. Under the ARA, all eligible households earning less than 150 percent of poverty have access to a zero-premium, CSR silver plan with a 94 percent actuarial value. Zero-premium plans are available when a buyer chooses a plan that is priced below the benchmark premium and where the difference in monthly premiums is greater than the individual's expected payment for the benchmark plan. The law also reduces out-of-pocket premiums for the benchmark plan for households earning 200 percent of poverty by more than half.

The law's increase to premium tax credits will lead to a major premium decrease for enrollees who currently pay premiums (exhibit 1). Unfortunately, the subsidized market is characterized by significant inertia where people stay in their initial plan without re-examining their options in subsequent years. People will stay in their initial plan until there is a strong incentive to pay attention, such as a large change in monthly premiums. For example, subsidized buyers saw a major premium reduction in 2018 due to a change in federal policy on the funding of CSR benefits. Plan switching behavior increased, although not drastically. Those who did not switch often remained in "strictly dominated plans," defined as plans where premiums and cost sharing are worse than comparable alternatives offered by the same insurer on the same network.

Source: Authors' calculations of 2021 Landscape Public Use File for the availability of a zero-premium, 100 percent essential health benefit silver plan for a single, non-smoking 40-year-old for states using the federally facilitated Marketplace, Healthcare.gov. Note: Several states mandate non-Hyde abortion benefits, which precludes the availability of a zero-premium plan

Automatic Re-Enrollment And Dominated Plan Choice
The increased premium tax credits will interact with current automatic re-enrollment rules to default many low-income Marketplace enrollees into these dominated plans in 2022. Unless these rules are changed, the default option for these enrollees will be less generous plans with higher premiums than other available plans.

The current automatic re-enrollment rules prioritize placing consumers in a plan with the same metal level with the same insurer if possible. These rules, as we saw in 2018, will place hundreds of thousands of people into dominated plans for the 2022 plan year. Individuals earning less than 150 percent of poverty who purchase bronze or gold plans will have less generous coverage and higher premiums than if they enrolled in a CSR silver plan.

Those with incomes between 150 percent and 200percent of poverty could face a similar issue as households in this income range could have access to a more generous plan from their current insurer with the same or lower net premium.

CMS's Role In Improving Consumer Choice
Fortunately, CMS has the power to address this problem by changing the automatic re-enrollment rules. We describe how CMS could do so below.

Our proposed change would default individuals and households into the highest metal-level plan that is offered in their insurer's network and that is priced no higher than the net premium of any other available option, including their current plan. If there is no plan that meets this criterion, CMS could continue using its current rules that default households into the same plan that they purchased for 2021. Our proposed change would move many households earning less than 150 percent of poverty out of bronze plans into silver plans with CSR benefits. Households with higher incomes would experience similar changes to their defaults, although the increases to coverage generosity and decreases to premiums would be less drastic, albeit still meaningful. These changes will improve returning enrollees' coverage affordability, financial protection from health care expenditures, and access to health care.

CMS could further improve the experience and the choice environment for new Marketplace consumers by changing the Marketplace's choice architecture. Healthcare.gov could automatically exclude the display of strictly dominated plans or

include alerts and require decision confirmation when a buyer is making an explicitly inferior choice. Connecticut's state-based Marketplace has implemented these steps, which led to a notable decrease in the number of individuals earning less than 200 percent of poverty from choosing non-CSR plans. These, and other steps, could lead to lower premiums and less cost sharing for more people.

Purchasing insurance is a challenging experience. In 2021, on Healthcare.gov, more than 70 percent of potential enrollees had 25 or more plans to choose between; 50 percent had 50 or more plans available to choose from. Improving defaults has been shown to lead to meaningful improvements in beneficiary outcomes in Medicare Part D. Modifying automatic enrollment logic for the ACA's Marketplaces to notably reduce the probability of consumers selecting significantly inferior plans will improve the usability of insurance and the functionality of the Marketplaces and help consumers best capitalize on the enhanced premium tax credits.

Bloomberg LAW

Fate of Obamacare in Limbo: Fight at Supreme Court Explained
Lydia Wheeler

The global Covid-19 pandemic has highlighted the need for health insurance and pushed hundreds of thousands of Americans to the Obamacare exchanges, but it's unclear if those enrolled will be able to count on keeping that coverage.

The Supreme Court is expected to release a decision any day now on the constitutionality of the signature health-care law. It's a ruling that could create chaos if the law is invalidated and make 29.8 million people lose their insurance, according to an estimate from the Economic Policy Institute.

But legal scholars on both sides of the ideological line doubt the court will go that far.

1. What are they fighting about?

The short answer: a change Congress made to the Affordable Care Act in 2017. In the Tax Cuts and Jobs Act, Congress dropped the tax penalty for those who fail to buy insurance to $0.

A group of states led by Texas and two individuals brought a lawsuit challenging the law after that change, arguing the ACA provision that requires everyone to buy insurance is no longer a valid exercise of Congress's taxing power. And because the individual mandate is essential to how the law operates, the entire thing must be struck down as unconstitutional, they argued.

A group of states led by California intervened to defend the law after the Department of Justice under the Trump administration refused. The DOJ urged the court to strike down the ACA in its entirety but has since changed its position under the Biden administration.

2. What could the justices decide?

It all depends on whether the court rules the individual mandate is constitutional or not. If it is, the fight ends there with the law left intact. If it isn't, the justices have to decide if it can be cut from the rest of the law and if the remaining provisions can survive without it.

If the justices decide the mandate is unconstitutional but severable from the rest of the law, it's possible they could send the case back to the district court to decide what other provisions are tied to the mandate and have to be tossed out, too.

The court could also rule the mandate is not severable and strike down the law entirely.

But the justices could sidestep those questions altogether if they decide neither the states led by Texas nor the individuals that sued suffered the necessary injury for the district court to hear the dispute to begin with.

3. Didn't they already decide the constitutionality of the law?

Yes. This is the second time a broad constitutional challenge to the Affordable Care Act has reached the high court. In a 2012 case, known as National Federation of Independent Business v. Sebelius, the justices upheld the individual mandate as a constitutional exercise of Congress's taxing power in a 5-4 decision.

The court said it was unconstitutional to threaten to withhold federal funding to force states to expand Medicaid, but said that constitutional defect was remedied by prohibiting the Health and Human Services secretary from the pulling the purse strings on states that refuse. The other provisions of the ACA are not affected, the court said.

4. How likely is the court to strike down Obamacare?

Court watchers think it's pretty likely the Affordable Care Act will remain, but they anticipate there being disagreements among the justices about why one provision can't take down an entire statute.

Based on the oral arguments, the 2012 precedent in NFIB v. Sebelius, and the intervening cases challenging the ACA, legal scholars say it's unlikely the court would find the individual mandate both unconstitutional and inseverable from the remaining provisions.

During arguments in November, at least five justices on the court indicated there's a strong argument for cutting that one provision from the rest of the law.

Justice Brett Kavanaugh even said then he thinks this is a "very straightforward case for severability" under the court's precedents.

5. Why is it taking so long?

The court heard arguments in the case on Nov. 10, about a month into the court's 2020-2021 term. Supreme Court terms run from October through June, and it's common for decisions in some of the biggest cases to come at the bitter end.

But the delay could signal the court is divided on one or more issues in the case. Legal scholars say Chief Justice John Roberts isn't a fan of splintered 5-4 decisions and may be working to reach a greater consensus on the court's majority opinion.

The court is scheduled to release more opinions on Thursday starting at 10 a.m.

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CMS Raises Awareness of ACA Marketplace Coverage for Gig Workers
Victoria Bailey

June 02, 2021 - The Centers for Medicare and Medicaid Services (CMS) is asking online platform companies to bring awareness to their gig workers' ability to obtain Affordable Care Act marketplace coverage during the marketplace special enrollment period (SEP).

Companies such as Delivery Drivers, Inc., DoorDash, Lyft, Postmates, StyleSeat, Uber, and Wanolo saw a boost in employees, many of whom were previously unemployed

due to the coronavirus pandemic. These platforms are participating in “Gig Workers’ Week of Action” to promote marketplace healthcare plans to their workers, according to the press release.

Affordable Care Act marketplace health plan enrollment is available through August 15, 2021.

The Biden administration’s American Rescue Plan Act (ARP) increased Affordable Care Act subsidies which lowered consumers’ average monthly premiums and out-of-pocket costs. The ARP aimed to make better-quality plans more affordable for those eligible for the increased tax credits.

During the SEP, monthly premium amounts decreased by over 25 percent for new enrollees. The median deductible’s cost dropped significantly, going from $450 to $50.

Gig workers have the opportunity to take advantage of the benefits that Affordable Care Act marketplace health plans have to offer, and CMS wanted to make sure they are aware of it.

“As millions of Americans have relied on gig economy work to sustain their incomes and support their families during the pandemic, we want these hardworking men and women to know they can purchase quality, affordable health coverage through HealthCare.gov,” said Xavier Becerra, secretary of the US Department of Health and Human Services (HHS).

“And thanks to the American Rescue Plan, these gig workers may be eligible for increased financial help to reduce the cost of their monthly premiums, making the health insurance plans on the marketplace more affordable than ever before. I encourage everyone to go to HealthCare.gov to see if they are eligible for lower costs coverage today.”

As a part of Gig Workers’ Week of Action, gig companies are informing drivers and couriers about the availability of marketplace coverage, sharing stories of how past gig workers have benefitted from marketplace coverage, and offering communication about enrollment in English and Spanish, according to the press release.

Other companies, with help from CMS-approved direct enrollment partners, have made it possible for workers to enroll in coverage and receive financial assistance through apps on their smartphones. Workers can also use their companies’ apps to find out if they qualify for plans and to check their coverage options.

New consumers can apply to check their enrollment eligibility at HealthCare.gov. Current enrollees can review their coverage, make any necessary changes, and resubmit the application to receive the American Rescue Plan savings, the CMS press release informed.

Gig workers can be an essential part of everyday life, especially when it comes to ridesharing companies like Uber and Lyft. For example, Blue Cross Blue Shield of Massachusetts (Blue Cross) and Blue Cross Blue Shield of North Carolina (Blue Cross NC) partnered with Lyft to improve coronavirus vaccine access.

The payers coordinated with Lyft and other local organizations to arrange and finance Lyft rides to vaccine appointments for their members.

Although gig workers for rideshare companies may participate in and support local access to care through these partnerships, this population of workers often has trouble accessing healthcare coverage themselves.

For example, an article published in the Spring Nature journal analyzed healthcare coverage of freelancers, full-time temporary workers, and part-time workers from 2010 to 2012 and 2015 to 2017 using Medical Expenditure Panel Survey (MEPS) data.

The researchers found that uninsurance had dropped since the implementation of the Affordable Care Act. Nevertheless, nearly three in ten freelancers, a quarter of full-time temporary workers, and almost 18 percent of part-time workers were uninsured a couple of years into healthcare reform. Meanwhile, standard workers saw only 12 percent uninsurance.

Thus, CMS targeted gig workers in its efforts to boost Affordable Care Act enrollment during the SEP.

The encouragement from CMS directed toward online companies followed the launch of a CMS educational campaign to inform and provide resources for uninsured and financially eligible individuals about the SEP.

As of April 2021, the Affordable Care Act marketplace health plans had gained 500,000 new enrollees from the special enrollment period.

How to Improve Consumer Plan Selection In ACA Marketplaces—Part 2
David Anderson and Patrick O'Mahen

A cornerstone of the Affordable Care Act (ACA) is individual insurance market reform. The law created managed competitive Marketplaces to ensure equal access to plans for those with preexisting health conditions. Before the recent passage of the American Rescue Plan Act (ARPA), the ACA subsidized premiums for households earning less than 400 percent of the federal poverty level and out-of-pocket costs for households earning less than 250 percent of poverty. Subsidies lower consumer net costs and encourage healthy people to buy a plan, which lowers average total costs. The ARPA has eliminated the income threshold for 2021 and 2022 while also enriching the value of subsidies for all eligible buyers.

About 12 million people are insured through these Marketplaces in 2021, and more will likely enroll as they see lower premiums due to enhanced subsidies, increased outreach, and supportive messaging from political elites such as the president. Despite offering consumer choice, however, many of the exchanges, including the federally facilitated Marketplace on Healthcare.gov and some state-based Marketplaces, create complex choice environments where consumers are likely to make suboptimal choices and end up with a plan that either costs too much in premiums or cost sharing, or does not meet their health needs.

Individuals who receive subsidies must estimate their future income, likely health expenditures, and ability to manage catastrophic health expenses. They then must sort through complicated provider networks and cost-sharing designs, attempting to pick an optimal plan for their estimated personal situation. The difficulty of selecting an appropriate plan for the individual buyer increases in counties offering many plans. In Medicare Advantage, choice quality declined with consumers becoming indifferent to benefit richness when more than 15 plans were available. The cost of complexity heavily falls on individuals with low cognitive capabilities and low socioeconomic status. Exhibit 1 illustrates the ongoing choice challenges individuals face on Healthcare.gov, where 73 percent of enrollees must choose from at least 25 plans for 2021.

Exhibit 1: Proportion of individuals on Healthcare.gov exposed to various length choice menus

Source: Authors' calculations. Notes: Proportion of individuals younger than age 65, earning between 138 percent to 400 percent federal poverty level in 2013 exposed to different sized choice menus on Healthcare.gov from 2014 to 2021. County population estimates from 2013 Small Area Health Insurance Estimates for individuals younger than age 65 and earning between 138 percent to 400 percent federal poverty level were categorized by the number of unique plans available and then summed for each category. Unique plans categorized from Landscape Public Use Files where standard plan component HIOS ID for all on-exchange, subsidy eligible plans are counted as a single, unique plan choice.

Some states have implemented policies that simplify consumer choice. California restricts insurers to standardized benefit designs; buyers need to only evaluate metal levels, networks, and insurer-specific features such as customer service and brand reputation. For example, California consumers do not need to consider variations in cost-sharing designs and trade-offs between actuarially equivalent plans in which one plan's cost sharing is mostly deductible while another plan's cost sharing is mostly co-insurance and co-payments on high-cost services and drugs. Washington State offers a public option in which private insurers offer plans with standard cost sharing. Maryland decreases search costs by allowing residents to opt into a data-matching program in which the state uses tax return data to suggest plans that have low net-of-subsidy premiums and high actuarial value compared to other zero-premium plans.

Although these examples help to ease cognitive overload, state-based Marketplaces should do more. Borrowing innovations from the retirement savings industry is a useful path forward. State Marketplaces and retirement plans face similar challenges: Choosing retirement plans and selecting health policies are important decisions for consumers who possess scant expertise in the arcane arts of investing or insurance design. To limit complexity while matching consumers' life situations, many retirement accounts default to target-date savings funds. These funds are automatically managed collections of mutual funds appropriate for people who intend to retire on a certain date. As a person ages, fund compositions automatically shift from growth-focused equities to safer income-producing investments, which provide cash flow during retirement. Target-date funds reduce cognitive complexity and administrative burdens from individuals who have little investing expertise and trust dispassionate experts to manage the money. Investors who want more choice can opt out of target-date funds into other mixes. States that run their own health insurance exchanges can use this logic to create targeted defaults similar to target-date funds to optimize enrollment policies.

We propose that states link health insurance eligibility and enrollment systems to tax and social service databases such as the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and

Children (WIC) eligibility systems to minimize cognitive and administrative burdens. The system would automatically notify individuals of their eligibility for ACA Marketplace subsidies. Qualified individuals would receive a letter displaying a short list of recommended plans and premiums. If an individual has not signed up for insurance within 30 days of the letter and they were eligible for a zero-premium plan, the state would auto-enroll the individual in a zero-premium plan that minimizes cost sharing.

This plan has several potential alternatives depending on how individual states manage trade-offs between simplicity and individual choice. For example, one variant might allow individuals to opt into automatic enrollment into plans up to a set premium level (for example, an individual might say they would pay up to $50 a month for a plan). Plan selection and enrollment would be determined by an algorithm with input from an optional questionnaire to determine broad individual preferences. Such a questionnaire might, for example, broadly account for preferences of provider networks or drug coverage. Payment could be automatically handled through a person's federal income taxes, similar to how the Internal Revenue Service reconciles ACA premium subsidies each tax year. This proposed reform would improve the process of choosing a plan in the same manner that target-date funds improve retirement savings choice; individuals can choose trusted experts who may be using automated decision supports to make dispassionate decisions in a complex, specialized, and changing choice environment.

These policy changes have the potential for several important improved outcomes. First, these reforms will reduce the stress of the process of choosing a plan. Second, our recommendations will on average place people in plans better tailored to individual needs. Third, the increased availability of zero-premium plans will lead to more young, and relatively healthy individuals in the Marketplace. Healthier risk pools lead to lower gross premium costs, which in turn decreases federal subsidy payments and costs to customers who do not qualify for subsidy support. Decreased net premium costs, lower-stress enrollment, and better-matched plans should increase overall satisfaction with the market, which should help stabilize the state Marketplaces both financially and politically. These are helpful outcomes for both a health care system and a populace recovering from the shock of a deadly global pandemic.

Biden turns to Obama to help boost health care enrollment
Ricardo Alonso-Zaldivar and Aamer and Madhani

WASHINGTON (AP) — President Joe Biden turned to his old boss, former President Barack Obama, on Saturday to help him encourage Americans to sign up for "Obamacare" health care coverage during an expanded special enrollment period in the pandemic.

Biden used his weekly address for a brief Zoom chat with Obama to draw attention to the six-month expanded enrollment period that closes Aug. 15. Meanwhile the government released a report that claims that nearly 31 million Americans — a record — now have health coverage through the Affordable Care Act.

"We did this together," said Obama, whose administration established the health insurance marketplace. "We always talked about how, if we could get the principle of universal coverage established, we could then build on it."

The White House effort to spotlight the expanded enrollment and claim strong numbers for the health law comes as the political world and the health care system await a Supreme Court ruling on the law's constitutionality. The Zoom call was recorded on Friday afternoon and released Saturday as Biden's weekly address.

The Health and Human Services Department said in a report that nearly 31 million have obtained coverage in 2021 as a result of the law. That's considerably higher than the more than 20 million estimate that's commonly cited.

The Biden administration has launched a special sign-up period during the pandemic, and Congress passed a big boost in subsidies for private health plans sold under the law. But that alone doesn't explain the increased coverage.

The report says 11.3 million people are covered through the health law's marketplaces, where subsidized private plans are offered. An additional 14.8 million are covered through expanded Medicaid, the report adds. All but a dozen states have accepted the law's Medicaid expansion, which mainly serves low-income working adults. And 1 million are covered by so-called basic health plans, an option created by the law and offered in a limited number of states.

That accounts for enrollment of about 27 million people. But the Biden administration is also claiming credit for four million people who would have been eligible for Medicaid without Obama's law.

Larry Levitt, executive vice president for health policy at the Kaiser Family Foundation, said the law broke down barriers to enrollment among those who were already eligible by simplifying applications and increasing awareness. He also pointed to the establishment of community-based navigators tasked with helping newly eligible people find coverage and conducting outreach to those who were already eligible but didn't necessarily know it.

"It didn't require a sweeping law like the ACA to get people who were already eligible for Medicaid enrolled, but the provisions of the ACA did help to get these millions of people covered," Levitt said

The Supreme Court is soon expected to rule on a challenge to the health law from Texas and other GOP-led states. They argue that because Congress has eliminated the law's penalty for being uninsured, a now-toothless ACA requirement that almost all Americans must have health insurance is unconstitutional and therefore the law should fail.

Those defending the law say that even if the Supreme Court strikes down the coverage requirement there's no reason to tamper with the rest of the law.

The White House says 1.2 million people have now signed up for health insurance through the government marketplace during the special enrollment period that began in February. That number includes people who would have qualified for a sign-up opportunity even without Biden's special enrollment period.

A life change such as losing workplace coverage or getting married is considered a "qualifying life event" that allows people to sign up any time during the year. Last year about 390,000 people signed up because of life changes from Feb. 15 to April 30, the government said.

Biden, in the conversation with Obama, spoke about the 2015 death of his son Beau Biden from cancer.

"I literally remember sitting on the bed with him within a week or so him passing away," Biden said, "and thinking, what in God's name would I do if I got a notice from the insurance company saying you've outlived your coverage?"

The Washington Post
Democracy Dies in Darkness

Record 31 million Americans have health-care coverage through Affordable Care Act, White House says
Amy B Wang

About 31 million Americans now have health-care coverage through the Affordable Care Act, the White House announced Saturday, setting a record since the law, colloquially known as “Obamacare,” was enacted in 2010 under President Barack Obama.

According to a report from the Health and Human Services Department, about 11.3 million Americans were enrolled in health-care plans through the Affordable Care Act’s federal marketplaces as of February, with 14.8 million people newly enrolled in Medicaid through the law’s expansion of eligibility as of December. The report also counted an additional 3.9 million Medicaid-enrolled adults who would have been eligible even before the Affordable Care Act but credited “enhanced outreach, streamlined applications, and increased federal funding” from the law for the numbers.

The report also said 1 million people were enrolled in the Affordable Care Act’s Basic Health Program option, which covers people whose incomes are just slightly too high to qualify them for Medicaid, as well as for some immigrants.

In addition, this year, because of the coronavirus pandemic, President Biden ordered an extended three-month enrollment period for people to buy health insurance through the Affordable Care Act’s federal marketplaces at HealthCare.gov. More than 1.2 million additional Americans enrolled in health-care plans through Obamacare during that special enrollment period, the report said.

To commemorate the milestone, Biden spoke with Obama in a taped Zoom conversation that was released by the White House on Saturday.

“Really good news, folks. Great news: 31 million people are now covered by the Affordable Care Act,” Biden said. “And I know someone who’s going to really want to know that number is up as high as it is. I got to call this fella.”

Obama credited Biden for continuing to build on the health-care law they had established during their administration and also praised him for extending the special enrollment period at HealthCare.gov because of the pandemic.

“Joe Biden, we did this together. We always talked about how if we could get the principle of universal coverage established, we could then build on it,” Obama said.

“The effort was worth it. The families that have been able to care for their loved ones, be cured, have access to care, that all makes it worthwhile,” Obama said.