COVERED CALIFORNIA Media Clips

COVERED CALIFORNIA BOARD CLIPS
Sept. 16, 2021 – Nov. 17, 2021

Since our last board meeting, Covered California executive director Peter V. Lee announced he'd be leaving the organization at the end of open enrollment, which began on Nov. 1. HHS Secretary Xavier Becerra kicked of the national open enrollment campaign with an event with Covered California.

PRESS RELEASES

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Articles of Significance

COVERED CALIFORNIA

News Release

Sept. 16, 2021

Peter V. Lee to Leave as Executive Director of Covered California After 10 Years Leading the Nation's Largest State-Based Marketplace

SACRAMENTO, Calif. — Covered California announced on Thursday that executive director Peter V. Lee has informed the board that he will leave the organization in early 2022. Lee has served as Covered California's first and only executive director, helping launch the exchange in 2012 and leading the organization that has provided millions of Californians with access to affordable, quality health coverage.

"I've been privileged to be part of the Covered California team and the broader effort in this state to do everything we can to use the Affordable Care Act to expand coverage and ensure those with coverage get the right care at the right time," Lee said. "I will be stepping down as Covered California's executive director after the upcoming open-enrollment period, with pride and confidence in the team at Covered California, who have taught me so much and who are poised to continue our important work."

Covered California's Board of Directors, chaired by California Health and Human Services secretary Dr. Mark Ghaly, will initiate a national search to find its next executive director.

"The progress we have made improving health care in California and across the nation would not have happened without Peter's dedication, vision and leadership," Ghaly said. "His efforts have improved the lives of millions of Californians, while creating a national model that has been consistently guided by our vision of assuring all Californian can get the right care when they need it. Today, Covered California is an indispensable part of our state's drive toward universal coverage and is in a great position to continue its mission of service and innovation as a state and national leader."

"My passion has always been for starting projects and having the opportunity to return home to California from Washington, D.C. to help launch Covered California and implement the Affordable Care Act has been a wonderful and remarkable experience," Lee said. "I am excited to think about new opportunities and venues I will have to ensure that everyone has access to affordable coverage. I am empowered to do this

because Covered California is in great shape with a strong and dedicated leadership team that can effectively deliver on its consumer-centered mission."

Over Lee's 10 years of service, Covered California has served millions of Californians, become the largest state-based marketplace in the nation, and established itself as a leader in both state and federal health care policies. Among Covered California's accomplishments have been:

- Contributing to California's drop in the uninsured rate, the largest of any state in the nation since the Affordable Care Act exchanges opened, from 17.2 percent in 2013 to 7.7 percent in 2019.

- A record-high 1.6 million enrollees, due to extensive year-over-year investments in marketing and outreach and the recently expanded subsidies available through the State of California and now the American Rescue Plan.

- Holding health plans accountable in addressing quality, equity and delivery system transformation on behalf of the diverse communities served; the percentage of Covered California enrollees in Qualified Health Plans with 3 stars or higher (out of five) increased from 26 percent in 2016 to 88 percent in 2020.

- Developing patient-centered and standard benefits which ensure most outpatient services in Silver, Gold and Platinum plans are not subject to a deductible, including primary care visits, specialist visits, lab tests, X-rays and imaging.

Lee stated that he is not leaving for a particular position and looks forward to continuing his leadership role for the next six months. After his departure, he plans to take time off and consider new opportunities to continue his lifelong work of improving health care.

"There will be time to look for the next mountain to climb," Lee said. "Right now, Covered California and I are wholly committed to doing our job of helping Californians during this pandemic and making sure that as many people as possible have access to the care they need and coverage they can count on."

COVERED CALIFORNIA

News Release

Oct. 12, 2021

- *The 4 percent weighted average rate change for Covered California for Small Business is the second lowest since 2014.*
- *Covered California's small-business marketplace continues to expand, with more than 70,250 members to date and double-digit percentage membership growth for the seventh consecutive year.*
- *Covered California for Small Business also announces an expansion of its four-tier offering as employers can now choose to offer employees the option of selecting from all metal tiers effective Oct. 1.*

SACRAMENTO, Calif. — Covered California for Small Business unveiled the health plan choices and rates for small-business employers and their employees for the upcoming 2022 plan year. The statewide weighted average rate change is 4 percent, which represents the second-lowest annual increase in the program's seven-year history. The rate change is lower than national projected increases for larger employers.

"Covered California for Small Business continues to grow, demonstrating how employers want to provide those who work for them a good choice of coverage options," said Executive Director Peter V. Lee. "While we continue to keep the premiums as low as possible, we will also expand the choice available to employees. We're working to make it easier than ever for both insurance agents and employers to manage the insurance they offer."

Approximately 70,250 individuals have insurance through Covered California for Small Business, representing a growth of approximately 8,250 individuals, or a 13.3 percent gain in membership over this time last year.

Covered California for Small Business has now experienced double-digit percentage growth in membership for seven consecutive years, making it one of the largest small-business health options programs in the nation.

This year's rate increase of 4 percent is lower than the recent projection of 5.8 percent in the large employer market in 2022 (see Table 1: Covered California for Small Business Average Rate Change, by Year).

"The continued growth of Covered California for Small Business highlights again how the Affordable Care Act works in California," Lee said. "With an all-time high of 1.6 million enrolled on the individual exchange and record enrollment for Covered California for Small Business, we're proud to keep meeting the coverage needs of Californians."

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

Year	Rate Increase
2022	**4.0%**
2021	1.5%
2020	4.1%
2019	4.6%
2018	5.6%
2017	5.9%
2016	7.9%
2015	5.2%
Projected Large-Business Rate Change in 2022[1]	**5.8%**

"Premium trends for the small group market often closely resemble the national large employer group market, but our weighted average for 2022 is almost two points lower than what large employers are likely to see in 2022," said Terri Convey, director of Covered California's Outreach and Sales division. "Covered California for Small

[1] National Business Group on Health, "2022 Large Employers' Health Care Strategy and Plan Design Survey."

Business' 1.5 percent change in 2021 and 4 percent in 2022 is a reflection of how hard we are working to keep health care costs as low as possible for Californians."

Covered California for Small Business will offer four statewide plans in 2022, including two preferred provider organization (PPO) plans from Blue Shield of California and Health Net, both offering their broadest provider networks, and two health maintenance organization (HMO) plans — which are provider- and hospital-based — from Kaiser Permanente and Blue Shield.

The 2022 portfolio of health plans also includes Sharp Health Plan in San Diego County and Blue Shield, which is providing HMO plans to residents of Fresno, Kings and Madera counties.

Covered California for Small Business expanded its offerings on Oct. 1, allowing employers to offer their employees the option of selecting from all four metal tiers – Bronze, Silver, Gold or Platinum – rather than the current system where plan selections are limited to two contiguous tiers.

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

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

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

Sep. 30, 2021

Covered California, CalPERS and Purchaser Business Group on Health to Launch Sweeping Quality Improvement Project to Modernize Primary Care for Californians

Covered California, the California Public Employees' Retirement System (CalPERS) and the Purchaser Business Group on Health (PBGH) are partnering to launch a pilot program to promote improvement in primary care which will benefit all Californians.

The partnership includes introducing a set of performance measures that reflect a shared standard of Advanced Primary Care as defined by PBGH's California Quality Collaborative (CQC), a health care improvement program dedicated to helping care teams gain the expertise, infrastructure and tools needed to advance patient-centered care. The measures focused on health outcomes, patient safety and patient experience are designed to encourage high-quality, high-value primary care statewide starting January 2022.

Advanced primary care places patients at the center of every interaction and prioritizes access to high-quality primary care to promote continuity of care and to prevent higher acuity, costlier care which makes for a healthier California.

Purchasers are seeking to transition to an approach that recognizes the outcomes and experience of the care patients receive as a way of identifying high-quality primary care. To support the transition, PBGH's California Quality Collaborative has defined a set of specific measures to improve the delivery of primary care services through a one-of-a kind multi-stakeholder process that includes input from purchasers, health plans, providers and patients.

"Large employers and public health care purchasers want to know they are paying for high-quality health care," said Elizabeth Mitchell, President and CEO of PBGH. "We need an approach to primary care that ensures excellent patient outcomes and quality-of-care. This pilot affords us an opportunity to demonstrate that kind of approach can work."

Covered California provides coverage for 1.6 million Californians and will contract with 12 health plans in 2022. Covered California is piloting the measure set to build on current health plan contract requirements to support advanced primary care, including ensuring all patients have access to a primary care provider and implementing alternative payment models for primary care. Informed by the results of the pilot, Covered California intends to incorporate the measure set into all health plan contracts to increase advanced primary care practices within all health plan networks.

“Raising the bar on the quality of care delivered not only leads to better outcomes for Californians, it also continues our mission to address the underlying costs of care, and making coverage more affordable to everyone,” said Dr. Alice Chen, Covered California’s Chief Medical Officer. “Covered California is committed to going beyond just getting people health care coverage — we want to make sure consumers are getting the quality care they need – and that starts with high-performing primary care.”

CalPERS provides health benefits for 1.5 million California public employees, retirees and their families. CalPERS will pilot the measure set in its 2022 health plan contracts to assess the use of advanced primary care practices by plan networks and providers. This pilot period will inform future requirements for health plans to address the variation in performance of their contracted primary care practices.

“As the largest purchaser of public employee benefits in California, CalPERS has long advocated that patient-centered primary care is vital in the delivery of exceptional health care for our members,” said Dr. Julia Logan, CalPERS Chief Medical Officer. “We look forward to piloting this measure set in our contracts to drive higher quality health care that improves our members’ experience.”

Performance across the suite of measures will allow purchasers and patients to identify practices delivering advanced primary care and strengthen the development and implementation of alternate payment models. Successful incorporation of the measures into Covered California and CalPERS contracts are expected to elevate the standard of primary care in the state of California and provide a model for other large health care purchasers.

Read more about the how CQC defined the standards for advanced primary care here.

COVERED CALIFORNIA

News Release

Nov. 1, 2021

Covered California Launches the National 2022 Open-Enrollment Period From the Golden State With HHS Secretary Xavier Becerra

- *The open-enrollment period for Affordable Care Act marketplaces begins on Nov. 1, and millions of Americans are eligible for more financial help than ever before.*
- *Increased financial help builds on the Affordable Care Act to lower premiums throughout all of 2022, and potentially through 2025 with the proposed Build Back Better plan, helping millions of Americans get and stay covered.*
- *While California has reduced the rate of the uninsured to historic lows, an estimated 1.1 million are still uninsured and eligible for financial help, with the vast majority able to get coverage at no cost through either Covered California or Medi-Cal.*
- *With new subsidies, hundreds of thousands of middle-income people — both uninsured and those who purchase coverage directly from a health insurance company — can now save thousands of dollars a year on their premiums if they sign up through Covered California.*
- *Covered California is also launching a new statewide ad campaign to encourage people to visit CoveredCA.com to check out their options and see how they can benefit from the new financial help now available.*

SACRAMENTO, Calif. — Covered California welcomed Secretary Xavier Becerra of the U.S. Department of Health and Human Services to officially launch open enrollment across the nation for the 2022 coverage year. Open enrollment is a time when Americans can sign up for or renew their coverage through Affordable Care Act marketplaces. This year, they could benefit from more financial help than ever before.

“The Biden-Harris Administration is investing in the most robust open-enrollment

campaign to date — with record-low prices, more choices and 30 more days to pick a plan than last season," said Health and Human Services Secretary Xavier Becerra. "Health care should be a right and in reach for everyone. This open-enrollment season, we will get closer to achieving that goal."

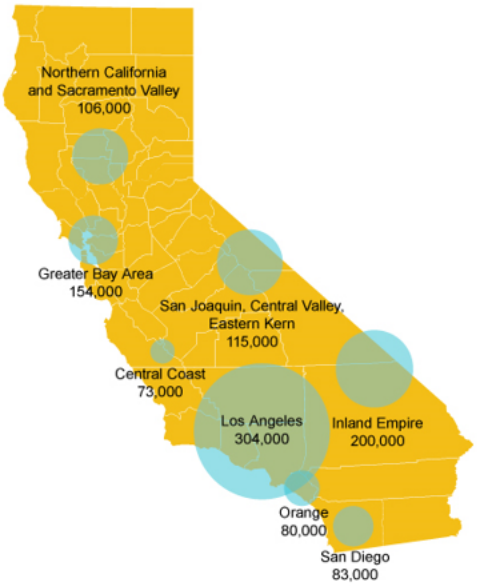
The open-enrollment period begins with a record-high 12.2 million people enrolled in the federal and state marketplaces, including 1.6 million in Covered California. The increased enrollment has been driven by the new and expanded financial help available through the American Rescue Plan, as part of the landmark federal response to the COVID-19 pandemic and the recession it sparked.

"Secretary Becerra and the Biden administration have shown that by building on the Affordable Care Act, we can go a long way toward achieving our goal of true universal coverage," said Dr. Mark Ghaly, California Health and Human Services secretary and chair of the Covered California Board of Directors. "Californians need to see what their coverage options are and find out how affordable insurance can be at CoveredCA.com."

A recent report found that California had reduced the rate of the uninsured to a record-low 6 percent of the population. For those who are still uninsured, the increased financial help is good news for the estimated 1.1 million Californians eligible for financial help. More than 85 percent of that group (about 940,000 people) could get comprehensive quality care with no monthly premium (see Figure 1: Over a Million of California's Uninsured Could Get Quality Coverage for 2022 at a Very Low Cost).

"The Affordable Care Act is working both nationally and here in California, serving as a critical safety net for those who need coverage, and now is the time to sign up," said Peter V. Lee, executive director of Covered California. "The amount of financial help available through 2022, and for many years to come if the Build Back Better plan is enacted into law, will cover the entire cost of many people's monthly premiums."

Figure 1: Over a Million of California's Uninsured Could Get Quality Coverage for 2022 at a Very Low Cost[2]



- An estimated at 1.1 million uninsured could get financial help through Covered California or Medi-Cal.
- Over 85 percent (943,000) could get comprehensive coverage for $0 per month (540,000 through Medi-Cal and 403,000 through Covered California).
- The remaining uninsured eligible for help (172,000) could still receive large subsidies to greatly reduce their monthly premium, while paying a small portion of the total cost of coverage.

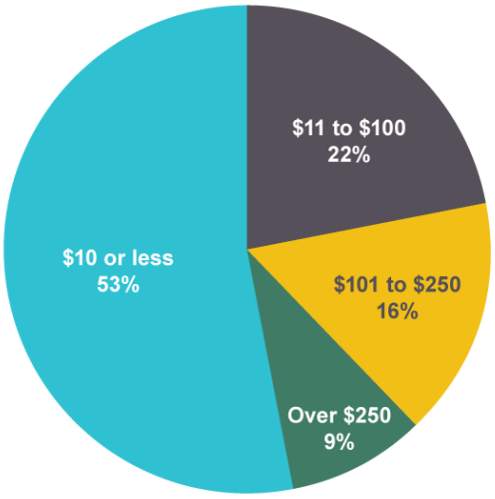
Click here for a chart pack of the data presented in this release.

Californians See Big Savings

In California, more than 70 percent of consumers who get subsidies could choose health coverage for less than $10 per month, which is very similar to the national figure. In 2021, because many consumers chose to get richer benefits that better meet their needs, more than half of subsidized consumers are paying less than $10 per month and 75 percent paying less than $100 for their brand-name health plan (see Figure 2: Covered California's Subsidized Enrollees Are Getting Brand-Name Coverage for Less in 2021).

[2] Estimates derived from 2019 ACS data on overall uninsured under age 65, adjusted for California-specific estimates related to those ineligible for subsidies due to lacking lawful presence, having an available offer of affordable job-based coverage, or foregoing subsidies by enrolling off-exchange. While marketplace enrollment and Medicaid enrollment have both increased since the COVID-19 pandemic and the American Rescue Plan, as of the time of this analysis there remained uncertainty about the uninsured rate in 2021. (For a discussion, see https://aspe.hhs.gov/reports/tracking-health-insurance-coverage.)

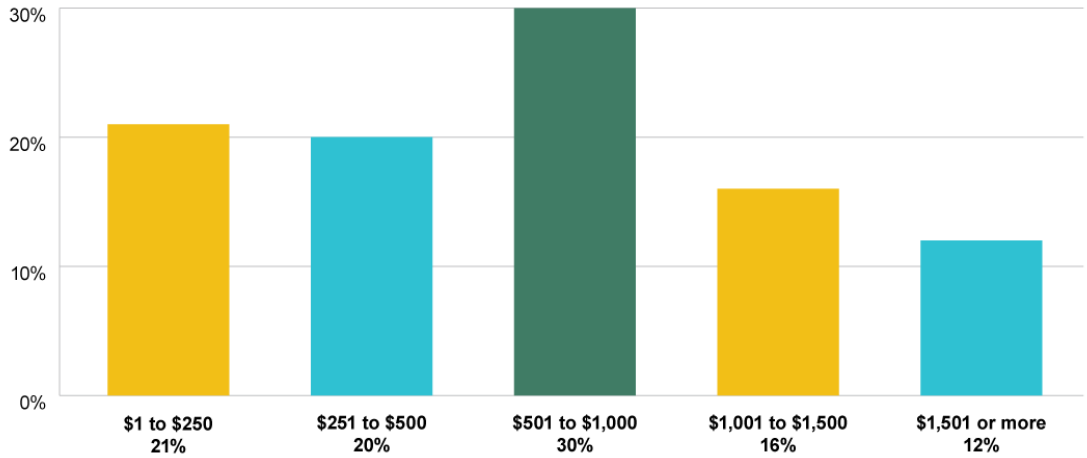
Figure 2: Covered California's Subsidized Enrollees Are Getting Brand-Name Coverage for Less in 2021



- Because of the American Rescue Plan, in 2021, more than half of Covered California enrollees pay $10 or less per month for coverage through brand name health plans.
- Three out of every four enrollees pay less than $100 per month for quality, comprehensive coverage.

In addition, one of the big improvements of the American Rescue Plan is that is makes financial help available for middle-income consumers who were previously ineligible for federal assistance. (Though in 2020, many received the landmark California state subsidies that set the path for the American Rescue Plans' expanded assistance.) Now, families earning more than $100,000 a year can be eligible for financial help. On average, the families who are receiving subsidies are saving nearly $800 a month on their premiums. (See Figure 3: New Financial Help Is Delivering Big Savings to Middle-Income Consumers.)

Figure 3: New Financial Help Is Delivering Big Savings to Middle-Income Consumers



Distribution of monthly subsidies to Covered California's eligible consumers earning more than 400 percent FPL in 2021.

The open-enrollment period is also a time to save for those who are currently insured directly through a health insurance company. An estimated 260,000 Californians have direct coverage — also known as “off-exchange” coverage. They can sign up through Covered California and potentially get the same plan they have off-exchange, or shop for other coverage that best fits their needs, and save hundreds of dollars per month.

“Californians who are paying for health insurance directly can switch to Covered California and get the same level of coverage — likely from the same company — and save thousands of dollars over the course of the year,” Lee said. “These are the last Americans not getting federal financial help to cover their insurance, since even those of us with employer-based coverage get an invisible leg up from the federal tax system to make our coverage more affordable.”

New Television Ad Campaign and Statewide Outreach Target California’s Diversity

For Covered California, open enrollment is also an opportunity to continue its work to address historic disparities in health care by ensuring that Californians of all races, ethnicities, income levels, genders and locales get access to health care coverage.

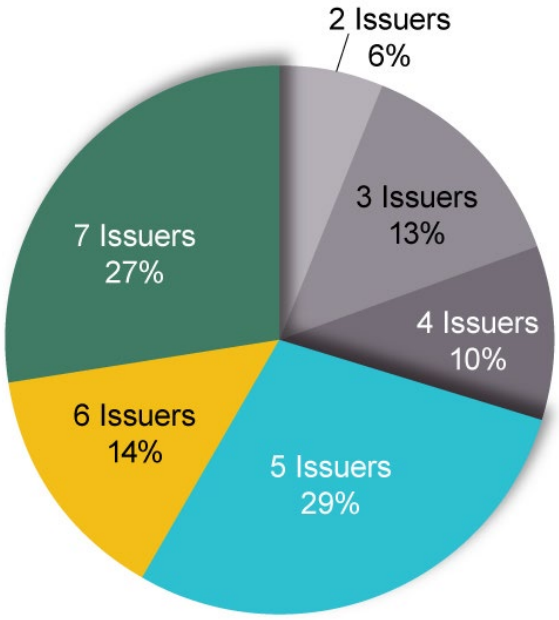
Covered California announced the launch of a new statewide ad campaign to promote open enrollment. The campaign, titled “This Way to Health Insurance,” will be aired in English, Spanish, Mandarin, Cantonese, Korean and Vietnamese. The campaign is directed by award-winning director Luis Peña and seeks to engage California’s diverse population.

The ad “Heart” features the story of a new father, whose love and concern for his children make him realize the importance of having health insurance. “Corazón” features the story of another father, who sees his daughter growing up and reaffirms the importance of taking care of her and himself.

Increased Competition and Consumer Choice

Californians will find they have more health insurance options to choose from this year. Starting in 2022, three of Covered California's health insurance companies will expand their coverage areas, and a new company will join the marketplace. As a result, with 12 carriers providing coverage across the state in 2022, all Californians will have two or more choices, 94 percent will be able to choose from three carriers or more, 81 percent of Californians will have four or more choices, and 70 percent of people will have five or more carriers to choose from (see Figure 4: Robust Competition Means Covered California Consumers Are in the Driver's Seat).

Figure 4: Robust Competition Means Covered California Consumers Are in the Driver's Seat



"Consumers win in a competitive marketplace, and this year most Californians will have four or five insurance companies to choose from," Lee said. "Covered California believes in putting consumers in the driver's seat, so they can choose the option that works best for them."

Consumers can discover their options by visiting CoveredCA.com and quickly and easily find out if they qualify for financial help and see the coverage options in their area. They just need to enter their household income, ZIP code, household size and the number of people who need coverage and their ages into the calculator on Covered California's homepage.

In California, open enrollment runs through Jan. 31, 2022 and it is the one time of the year when eligible people cannot be turned away from coverage.

In addition to visiting CoveredCA.com, those interested in learning more about their coverage options can also:

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

COVERED CALIFORNIA

News Release

Nov. 17, 2021

- *Three of Covered California's biggest health insurance carriers will increase their compensation, by an estimated $22 million annually, for agents who help people sign up for coverage in the individual market.*
- *Agents enroll about half of Covered California's consumers and have directly helped more than 2.3 million people sign up for coverage free of charge since the exchange first opened its doors in 2014.*
- *The move will bolster independent agents across the state, who provide support to consumers free of charge, as more financial help is available than ever before as open enrollment is underway.*
- *The increased payments will go into effect on Jan. 1, 2022, and will benefit the more than 10,000 Licensed Insurance Agents who are certified by Covered California and work in every part of the state.*

SACRAMENTO, Calif. — Covered California announced on Wednesday that three of the biggest health insurance carriers that it contracts with — Anthem Blue Cross, Blue Shield of California and Kaiser Permanente — will be increasing the amount they pay insurance agents who provide independent assistance to consumers signing up for coverage in the individual market.

"Agents play a vital role in helping hundreds of thousands of Californians get affordable coverage every year, serving individuals in every corner of the state," said Peter V. Lee, executive director of Covered California.

"Covered California has been working to be sure that agents are paid fairly for the critical work they do on behalf of consumers for the past two years, and we want to thank Anthem Blue Cross, Blue Shield of California and Kaiser Permanente for doing

the right thing and upping payment to agents, who are on the front lines of expanding health coverage for Californians."

The increased compensation will come at no additional cost to consumers, as Covered California's Licensed Insurance Agents are paid through the monthly premiums that the carriers receive.

The move comes after Covered California studied agent-commission trends and found that while people were continuing to rely on an experienced person to help them understand and choose their coverage options, agent compensation had steadily declined since 2014.

During the study and analysis, three of Covered California's biggest carriers (Anthem Blue Cross, Blue Shield of California and Kaiser Permanente) worked with Covered California to bring their agent compensation up to the average levels in the individual market, which is about 2 percent of premium paid to agents helping consumers enroll. The three carriers account for more than 70 percent of Covered California's enrollees.

The new compensation will increase agent compensation statewide by an estimated $22 million a year, which is a 17 percent increase over current levels. The increase will bring the total compensation provided by carriers to agents to more than $125 million a year, which is nearly equal to Covered California's entire marketing and outreach budget for fiscal year 2021-22.

"The increase in compensation will be money well spent because agents play such a key role in helping Californians get covered and use their health plan benefits," Lee said. "Insuring more people means a healthier consumer pool, which means lower premiums for everyone in the individual market."

In addition, the new payment structure will provide independent agents with a more reliable revenue stream to invest and grow their businesses, which will enable them to provide more services to Californians. For the 6,300 agents who have 10 or more Covered California consumers, the increase will represent an average increase in their annual compensation of about $3,300.

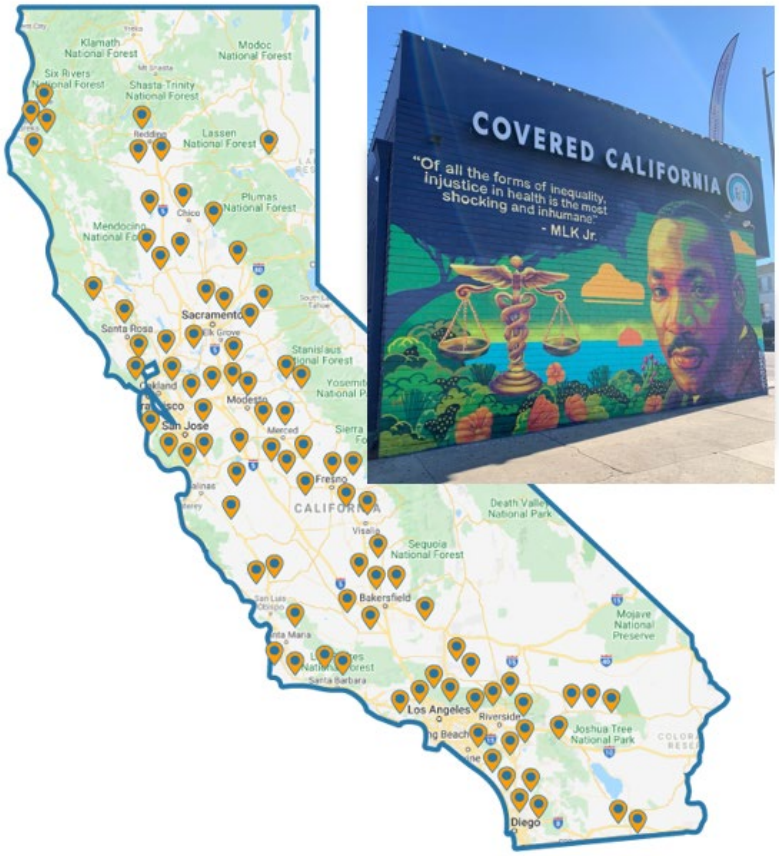
"Bringing compensation up helps keep agents serving the individual market remain actively engaged and supports their dedicated efforts to serve consumers and make sure they are covered," said Terri Convey, director of Covered California's Outreach and Sales division. "Insurance agents have been a key partner since we first opened our doors, and this move goes a long way in making sure they will be there when Californians need them the most."

Free and Confidential Help From Local Agents

Since Covered California opened its doors in 2014, over 4.8 million Californians have benefited from the coverage it provides, which amounts to one in seven of the 33 million California residents under 65 years of age. Licensed Insurance Agents have helped

more than 2.3 million (48 percent) of the people that Covered California has served since it opened for business in 2014. Currently, Covered California has more than 11,000 Licensed Insurance Agents, who have established more than 500 storefronts in communities throughout the state (see Figure 1: Covered California's Over 500 Licensed Insurance Agent Storefront Locations Across the State). These storefronts feature Covered California signs and logos, and they provide consumers with a local point of contact to answer questions and help them enroll in the health insurance plan that best fits their needs.

Figure 1: Covered California's Over 500 Licensed Insurance Agent Storefront Locations Across the State



Consumers can visit https://www.coveredca.com/support/contact-us/ and search for the agent or storefront nearest them.

Covered California's contracted agents truly speak to the diversity of the state. Nearly three out of every five of Covered California's agents (57 percent) speak more than one language, which helps them assist Covered California's diverse population in which two out of every three enrollees represent a community of color (see Figure 2: The Majority of Covered California's Agents Are Multi-Lingual). Overall, Covered California's agents speak more than 40 languages (see Figure 3: Covered California's Agents Serve People in More Than 40 Languages).

Figure 2: The Majority of Covered California's Agents Are Multi-Lingual

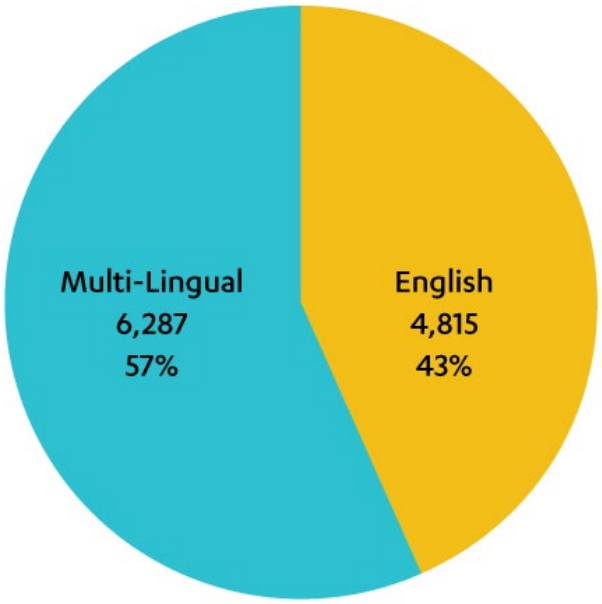
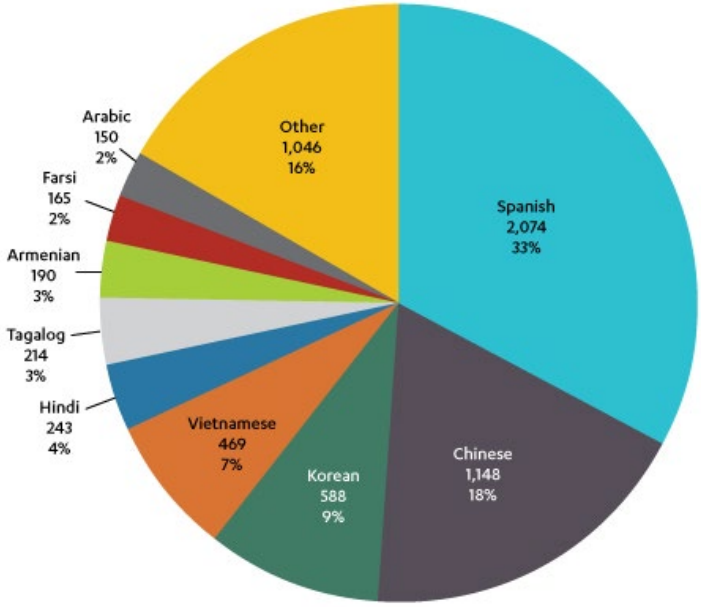


Figure 3: Covered California's Agents Serve People in More Than 40 Languages*



*Other languages include Azerbaijani, Balinese, Balochi, Bengali, Bihari, Bisayan, Bulgarian, Burmese, Cambodian/Khmer, Catalonian, Cham, Croatian, Czech, Danish, Dutch, French, German, Greek, Gujarati, Hebrew, Hmong, Ilocano, Indonesian, Italian, Japanese, Laotian, Persian, Portuguese, Romanian, Russian, Thai and Urdu.

The agents are required to meet stringent certification processes that include the obligation to help consumers find the health plan and coverage that is best for the consumer and commit to serving all Californians, regardless of their age, disability, race, ethnicity sexual orientation or gender identity.

Click here to access the storefront images, along with the agency names and their addresses, contained in this news release.

Open Enrollment and Opportunities to Enroll Now

Open enrollment for the upcoming year started on Nov. 1 and will run through Jan. 31, 2022. Open enrollment is the one time of the year when eligible consumers cannot be turned away from coverage for any reason.

An estimated 1.1 million Californians are uninsured and eligible for financial help through either Covered California or Medi-Cal. More than 85 percent of that group (about 940,000 people) could get comprehensive coverage with no monthly premium.

However, people who need coverage earlier may be able to enroll now. Covered California opened a special-enrollment period to allow the uninsured, and those enrolled directly through a health insurance carrier, to sign up and begin benefiting from the new financial help offered through the American Rescue Plan. People who sign up by Nov. 30 will have coverage that starts Dec. 1.

In addition to visiting CoveredCA.com, those interested in learning more about their coverage options can also:

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

Covered California director to step down in February
Adam Beam

SACRAMENTO, Calif. (AP) — The director of Covered California said Thursday he will step down early next year, prompting a national search for a new leader of the nation's largest state-based health insurance marketplace.

Peter Lee has been Covered California's only executive director in its nine-year history, launching the marketplace in 2012 at a time when the Affordable Care Act was a polarizing force in U.S. politics.

During his tenure, Covered California dramatically expanded the number of people eligible for discounts in their monthly health insurance premiums. A record high 1.6 million people in the state with a population of about 40 million people now buy their health insurance through Covered California. That helped to reduce the state's uninsured rate to 7.7% in 2019 from 18.5% in 2010, according to the U.S. Census Bureau.

Lee, 62, said the recent deaths of his mother and uncle caused him to pause and reflect on what he wants to do with the next phase of his life. He does not have another job lined up.

"Covered California has been in many ways the beacon of showing how the Affordable Care Act can work," Lee told The Associated Press in an interview. "The organization is in great shape and I want to look at something new."

Health insurance marketplaces are a key component of the federal Affordable Care Act, former President Barack Obama's health care law.

The marketplace is for people who don't have — or can't get — health insurance through their jobs and make too much money to qualify for government-funded health care. It was designed to make it easier for those people to get health insurance and offers discounts to some people who make below a certain income level.

Most states chose to let the federal government run their marketplaces for them. But California is one of 15 states that runs its own marketplace. Lee has been the public face of California's marketplace for the past decade, traveling throughout the state to promote it with the fervor of an evangelist.

He insisted on negotiating with health insurance companies on prices and standardizing benefits across plans so consumers could more easily compare plans when deciding which to purchase.

“He’s willing to negotiate and to say no to insurers that were not providing value and to hold the plans accountable for higher standards on quality and equity,” said Anthony Wright, executive director of Health Access California, a consumer advocacy group. “I think it’s a testament to his work that we’ve had less than a 2% average increase in premiums for the last three years.”

When Republican President Donald Trump was in office, the federal government slashed its marketing budget for the federal marketplace. But Lee spent about $100 million per year — money that comes from small fees assessed on premiums — on marketing in California, including TV and radio ads in multiple languages and paying social media influencers to encourage people to buy health insurance.

“He has definitely made his mark in making the point that health insurance doesn’t necessarily sell itself, that you have to market it like any other product,” said Larry Levitt, executive vice president for health policy with the Kaiser Family Foundation, a nonprofit group focusing on health care issues.

Dr. Mark Ghaly, California’s health and human services secretary and chair of Covered California’s Board of Directors, said the agency will launch a national search for Lee’s replacement.

“Today, Covered California is an indispensable part of our state’s drive toward universal coverage and is in a great position to continue its mission of service and innovation as a state and national leader,” Ghaly said.

Covered California's executive director to depart
Victoria Colliver

Peter V. Lee, who’s served as Covered California’s executive director since its inception 10 years ago, will leave the state health insurance exchange in February, the agency announced Thursday.

Lee, 62, has weathered the rollout of former President Barack Obama's signature legislation, the Republican-led effort to dismantle the Affordable Care Act and, now, the Covid-19 pandemic. He said it was a good time to make the move.

"We now have the Affordable Care Act truly woven into the fabric of health care not only in California, but nationally," Lee said.

Lee's story: Lee, a native of Pasadena, said his work as director of programs for the National AIDS Network in Washington D.C. during the AIDS/HIV crisis ignited his passion for health care advocacy. He later served as CEO of the Pacific Business Group on Health in San Francisco before returning to D.C. to serve in the Obama administration, most recently as the deputy director for CMS' Center for Medicare and Medicaid Innovation.

California was the first state to start setting up its exchange after the ACA was signed into law in 2010. Lee became Covered California's executive director in 2011.

"From the very start, California has been a model for how to run an ACA exchange," said Larry Levitt, an executive vice president for the Kaiser Family Foundation, describing Lee as an relentless advocate on a national level for the state-based marketplaces.

Lee has concentrated on increasing enrollment through marketing and outreach, negotiating with plans to keep rate increases as low as possible, and pushing for increased affordability and standardized benefits to make it easier for consumers to choose a plan.

About 1.6 million Californians are enrolled in the exchange, a record high.

"The progress we have made improving health care in California and across the nation would not have happened without Peter's dedication, vision and leadership," said state Health and Human Service Agency Secretary Mark Ghaly, who chairs Covered California's board of directors.

What's next: Lee plans to continue serving in his position until February, after the upcoming open enrollment season which runs through Jan. 3, 2022. He said he is unclear on what he plans to do next, but that he expects to continue working on big-picture health care issues and that he has no plans to leave California.

In the coming months, he said, he will advocate for the Covid-19 stimulus subsidies offered through the federal government to become permanent. And, he said, he plans to assist Covered California's board members with the search for his replacement.

“I’ll absolutely be helping them make sure they cast a wide net, and get a great person to take my place,” he said.

Leader of California’s Muscular Obamacare Exchange to Step Down
Bernard J. Wolfson and Angela Hart

Peter Lee, who has steered California’s Affordable Care Act marketplace since late 2011 and helped mold it into a model of what the federal health care law could achieve, announced Thursday he will leave his post in March.

As executive director of Covered California, Lee has worked closely with the administrations of Democratic presidents Barack Obama and Joe Biden to expand health coverage to millions of people who don’t get it through an employer or government program, most of them aided by income-based financial assistance from the state or federal government. Over 1.6 million people are now enrolled in plans through the exchange, which has covered 5.3 million Californians since it started selling health plans.

Lee lobbied fiercely to fight efforts by the Trump administration and Republicans to repeal the ACA, known popularly as Obamacare. Those efforts appear dead following the U.S. Supreme Court’s decision in June to uphold the law for the third time.

“The really terrific thing, and you can’t say this of every leader, is that Peter is leaving the organization in a position where it is still poised to have the success it has had recently,” said Dr. Mark Ghaly, who chairs the Covered California board and is secretary of the California Health and Human Services Agency.

The board will launch a national search for Lee’s successor. The long runway to his departure “gives us time to cast a wide net and find a leader who understands the history of this organization but also has the vision of where we can go,” Ghaly said.

Lee said he was leaving largely for personal reasons, including the deaths of his mother, Sharon Girdner, and his uncle, Dr. Philip R. Lee. The latter was part of the original Medicare brain trust under President Lyndon Johnson, and the younger Lee described him as a health policy mentor. Lee’s father and grandfather were also deeply involved in health care policy.

The past two years have prodded him to reflect, he said. “Covid reminds you that life’s too short. It’s a good time to say, ‘What else do I want to do?’”

But, at 62, he has no intention of retiring. In his next job, Lee said, he wants to tackle what he believes are flaws in employer-based health insurance that leave many workers, especially low-wage earners, at financial risk if they get sick.

He said he has no idea whether he’ll land in the private sector, a nonprofit or government. First, he plans to take time off to travel and think about his next move.

Covered California’s enrollment is at its highest level since the exchange opened for business — credited partly to longer enrollment periods due to covid and the expansion of federal premium assistance, at least through 2022, under the American Rescue Plan Act.

The expanded federal subsidies were based on California’s first-in-the-nation state-funded financial aid, which — with Lee’s ardent support and implementation — extended subsidized coverage well into the middle class.

The percentage of Californians who don’t have insurance has dropped sharply, from 17% before the ACA began expanding coverage in 2014 to 7% now — mostly due to the expansion of Medicaid rather than the Covered California marketplace.

Those who have worked with Lee credit him for innovations that transcend the provisions of Obamacare and have either set California apart or served as templates for other states.

Covered California, unlike many state exchanges, has standardized health plan designs, so that plans within each coverage level offer the same services with the same deductibles and other out-of-pocket costs.

“Instead of insurers submitting and selling dozens and dozens of plans with differences that just cause consumer confusion, he established standardized benefit packages so you could make apples-to-apples comparisons,” said Anthony Wright, executive director of Health Access California, a consumer advocacy group. Consumers need only compare provider networks and price, Wright said, “but you don’t have to worry that, ‘Oh, in this plan the deductible is $50 less but the copays are $30 more.’ That stuff is crazy-making.”

Paul Markovich, CEO of Blue Shield of California, Covered California’s second-largest insurer, said the health plans didn’t want to standardize benefits at first, but “Peter stuck to his guns.”

As a result, Markovich said, “there was no way to game the system. The only way to compete was to work on your costs and your quality and the access that the members had.”

Another Covered California initiative that was unpopular at first with health plans “but very effective,” Markovich said, is its ambitious advertising and marketing strategy — across racial, ethnic and linguistic communities — which is financed by a surcharge on plans.

Because many people don’t know they are eligible for subsidies, Lee believed no amount of outreach was too much, Markovich said. “And again, he was right.”

Lee has frequently expressed pride in his ability to negotiate relatively low premium increases, noting that over the past three years rate hikes for exchange-based health plans have averaged only about 1%.

Some analysts believe premiums could have been even lower, and that Lee hasn’t pushed the health plans hard enough.

“I think that Covered California has been too eager to see health plans as partners,” said Michael Johnson, a former Blue Shield of California executive turned industry critic.

Lee said he and his team strive to ensure that insurers don’t make excessive profits in the exchange. “Every year we sit down with health plans and look at their books to ask, ‘What profit are you making this year? And what profit are you making next year?’” he said.

Lee has seen health care from the business, consumer and regulatory sides. He held two health care-related jobs in the Obama administration and previously served as CEO of the Pacific Business Group on Health (since renamed the Purchaser Business Group on Health), which represents large employers, and as executive director of the Center for Health Care Rights, a consumer advocacy group.

THE SACRAMENTO BEE

Covered California leader Peter Lee, who steered insurance exchange to prominence, to exit post

Cathie Anderson

After 10 years at the helm of Covered California, Peter V. Lee announced Thursday that he would leave his post in early 2022, having significantly reduced the number of uninsured Californians and steered the health insurance marketplace to national prominence.

“I’ve been privileged to be part of the Covered California team and the broader effort in this state to do everything we can to use the Affordable Care Act to expand ensure those with coverage get the right care at the right time,” Lee said in a prepared news release. “I will be stepping down as Covered California’s executive director after the upcoming open-enrollment period, with pride and confidence in the team at Covered California, who have taught me so much and who are poised to continue our important work.”

The board of Covered California, led by Health and Human Services Secretary Mark Ghaly, plan a national search for Lee’s successor.

Of Lee’s seminal role, Ghaly said: “The progress we have made improving health care in California and across the nation would not have happened without Peter’s dedication, vision and leadership.”

Over the course of Lee’s tenure, California saw its rate of uninsured residents drop by the largest percentage of any state in the nation, to 7.7% in 2019 from 17.2% in 2013. A record 1.6 million Californians are enrolled now as state and federal subsidies substantially dropped premiums.

“Today, Covered California is an indispensable part of our state’s drive toward universal coverage and is in a great position to continue its mission of service and innovation as a state and national leader,” Ghaly said.

Lee emphasized holding health plans accountable for equitable and high-quality insurance plans at affordable prices, and as years passed, the percentage of Covered California enrollees in plans with three to five stars rose to 88% in 2020 from 26% in 2016.

In interviews, Lee often stressed that patients in Covered California's silver, gold and platinum plans could see their primary care doctors and specialists or get lab exams without having to pay a deductible. These out-of-pocket expenses often keep people from seeking care.

Lee said he's not leaving to take another position but rather that he would take some time to consider other opportunities.

"There will be time to look for the next mountain to climb," Lee said. "Right now, Covered California and I are wholly committed to doing our job of helping Californians during this pandemic and making sure that as many people as possible have access to the care they need and coverage they can count on."

BECKER'S HOSPITAL REVIEW

Leader of California's ACA exchange to leave post
Kelly Gooch

Peter V. Lee, executive director of Covered California, will leave the state's health insurance marketplace next year.

Mr. Lee said he will step down after the upcoming open enrollment period and is not leaving for a particular position, according to a Sept. 16 news release. He said he looks forward to continuing his leadership role in the coming months and plans to consider new opportunities.

"There will be time to look for the next mountain to climb," Mr. Lee said in the news release. "Right now, Covered California and I are wholly committed to doing our job of helping Californians during this pandemic and making sure that as many people as possible have access to the care they need and coverage they can count on."

Mr. Lee is Covered California's first executive director. During his decade of service, he helped launch the exchange in 2012 and implement the ACA.

Previously, he was deputy director of the Center for Medicare and Medicaid Innovation at CMS.

Los Angeles Times

Column: How the architect of California's Obamacare success did the impossible
Michael Hiltzik

One could say that service in the name of public health was baked into Peter V. Lee's bones.

His father, also Peter Lee, founded the family medicine department at USC and spoke out in favor of the enactment of Medicare in 1965, a stance that provoked some members of the university alumni association to call for his dismissal.

His uncle, Phillip R. Lee, helped create and implement Medicare as an officer of the U.S. Department of Health, Education and Welfare, then became chancellor of UC San Francisco, and returned to Washington to serve then-President Clinton as an assistant health secretary.

Improving healthcare is an eternal enterprise in America.

Peter V. Lee, executive director, Covered California

So Lee's appointment in 2011 as the first executive director of Covered California, the state's Affordable Care Act marketplace, seemed almost preordained. The Sept. 16 announcement that Lee, 62, would step down from the exchange in February offers a perfect opportunity for taking stock of the state's extraordinary success in healthcare reform over the last decade, as well as looking ahead.

Lee came to the job with more than a family pedigree: A Pasadena native with an undergraduate degree from UC Berkeley and a law degree from USC, he had begun his career in public health running programs at the National AIDS Network in Washington in the 1980s.

Subsequently he served as executive director of the Center for Health Care Rights, a Los Angeles consumer advocacy group, then spent eight years as chief executive of the Pacific Business Group on Health, a coalition of public and private healthcare purchasers, followed by a stint working on healthcare reform in the Obama administration.

Under his leadership, Covered California has been perhaps the most successful ACA marketplace. The exchange's approach to coverage has helped California reduce its population of uninsured adult residents since 2013, the year before the exchange began operating, by about 9.5 percentage points to 7.7% in 2019, the best record in the nation.

Residents of states that have resisted the ACA, such as Texas and Florida, are still saddled with uninsured rates of 15% or higher.

The California exchange's rate increases have consistently been lower than the national average, including a preliminary 1.8% increase expected for 2022 plans and an average annual rate increase of only 1.1% over the last three years. Its offerings have been remarkably stable, with 12 insurers expected to offer plans through the exchange in 2022, including four that are proposing to reduce premiums from 2021 levels — Anthem Blue Cross, L.A. Care, Molina and Sharp.

The advent of the Affordable Care Act marked what Lee calls "a major pivot as a nation" on healthcare. Up to then, in the individual market, "insurers wrote their own rules. They would say, 'I'm going to offer these benefits to some, I'm going to turn these people down but not these people. I'm going to not offer mental health benefits."

The ACA aimed to end these practices. It mandated that carriers spend at least 80% of their premiums on medical claims and improving the quality of care, outlawed refusing or surcharging coverage for people with preexisting medical conditions, and required the carriers to cover a menu of essential benefits, including prescriptions, hospitalization, and maternity and mental health services.

Covered California, however, went further, Lee told me. It established itself as an "active" exchange that set benefit and quality rules for participating insurers to meet, in many cases more stringent than the ACA's rules. ACA plans in California had to be standardized more stringently than the ACA required.

Plans at each metal level — bronze, silver, gold and platinum — had to be identical to one another, reducing consumer choice to two basic factors — the plans' premiums and their provider networks. (Covered California strived to make sure that no matter how narrow a carrier's provider networks, all the required benefits were available.)

The exchange turned the traditional insurer approach of pocketing profits, which was to discourage customers from seeking care, on its head.

"Our design was aimed, as much as possible, to encourage people to get the right care at the right time, not discourage them," Lee says. "We didn't want any financial hurdles to get to a primary care doctor. If you take a silver plan, there's no deductible unless you get admitted to the hospital."

California insurers must disclose every year the steps they've taken to reduce health disparities among ethnic, racial and income groups, to rein in high provider and drug prices and to meet other quality goals.

Insurers may have balked at first, but they also came to understand that on California's level playing field and given the state's efforts to attract the largest coverage pool, they had a better chance to secure profits than in many other states.

Only in 2017-19 did rates increase by more than 4.2% due almost entirely to Trump administration efforts to sabotage the individual market in those years. Even so, customers who shopped around could reduce their rate increase or even find lower rates year to year.

Lee didn't achieve all this entirely on his own, of course. He got a heavy boost from California's political context. That started with the foursquare embrace of the ACA by then-Gov. Arnold Schwarzenegger, who had been trying since 2007 to craft a universal healthcare program for the state.

After Jerry Brown took over as governor in 2011, the state expanded Medi-Cal, its Medicaid program, to take advantage of the ACA's 100% federal subsidy for the expansion. (Twelve states, all of them under the control of Republicans, still haven't expanded Medicaid despite clear signs that the move saves money and improves health.)

California also established its own individual coverage marketplace instead of leaving the task of enrollment and marketing to the federal government, as 35 states did.

California's choice inoculated it from Trump's slashing of marketing and outreach funding to nearly zero; while the Trump cuts were in place, California continued to spend some $100 million a year on marketing to encourage younger and healthier residents to enroll.

The funding came from a 3.25% assessment on health plans. That flowed through to enrollees, but since California's larger member pool kept premiums lower by 20% than they might have been, according to Lee, the assessment paid for itself.

Legislative initiatives further moderated the Trump effect. California outlawed the short-term health plans promoted by the Trump administration, which were outside the ACA's jurisdiction.

Those plans were cheaper than ACA-compliant plans but only superficially. They're allowed to turn away applicants with preexisting medical conditions and to offer only limited benefits. Enrollees diagnosed with costly conditions or serious injuries often discover the coverage gaps too late.

"We weren't going to allow plans that are cheaper because they're crappy," Lee says.

The Trump years were nerve-racking for Lee and Covered California. If Republicans had managed to repeal the ACA, as Trump and the GOP establishment aimed to do, “We had no Plan B,” Lee says. “Healthcare in America requires federal dollars and federal consistency. Absent that, no state can make it up, even California. It would have been a stark new future, and millions of Californians would have been without health insurance.”

California also enacted more generous subsidies than the federal government, covering households with earnings up to 600% of the federal poverty line (or up to $159,000 for a family of four this year) rather than only up to 400% ($106,000 for a family of four); the state’s initiative was supplanted by improved subsidies enacted through the Biden administration’s American Rescue Plan.

The state has progressively extended Medi-Cal coverage to more residents without legal immigration status — starting with children through the age of 18 in 2016, to young adults up to age 26 last year, and to adults up to age 50 starting next May 1.

That reflects the recognition, reinforced by the experience of the pandemic, that “you can’t draw a little island around your next-door neighbor and say, ‘You’re undocumented, so I shouldn’t care about your healthcare.’ If we have people living here and contributing to society and getting sick because they don’t have insurance coverage, we will all foot the bill when they show up at the ER, or when they go to work in a restaurant and get people sick.”

California’s reliance on its own marketplace gives it extraordinary flexibility to offer coverage in crucial situations. In 2019, the Legislature permanently expanded Covered California’s open enrollment period, when all customers can enroll unconditionally for the next year, to Nov. 1-Jan. 31. That protects state residents from the sort of manipulation of open enrollment engaged in by the Trump administration as a way to hold enrollments down.

After the pandemic struck, Covered California was able to extend open enrollment through May 15, 2021. After the American Rescue Plan expanded premium subsidies for the individual market, the state exchange opened a special enrollment period through the end of this year for uninsured residents and those with plans ineligible for subsidies.

After 10 years, healthcare reform is still a work in progress. “Improving healthcare is an eternal enterprise in America,” Lee told me. “We took a giant leap with the Affordable Care Act toward making it more just and more equitable.” He sees Covered California as an exemplar and a proving ground for methods to move toward those goals, though California still struggles with them — although the state’s overall uninsured rate was 7.7% in 2019, among Latino residents it was 12.66%.

Lee hasn’t said what he plans to do in his next act. He says he gave Covered California a six-month lead time to enable its board to launch a nationwide search for his successor and to give him time to negotiate the exchange’s next contract with carriers, to take effect in 2023. He says his thoughts turned to moving on after his mother and his uncle Phillip died in the last year.

“I’ve been involved with healthcare since the AIDS epidemic, and still will be,” he says. “I just don’t know how.”

Losing Federal Unemployment Benefits Or COBRA Health Plan Aid In September? Covered California Can Help
Staff

THIS month millions of Californians are losing federal unemployment benefits made available to them because of the economic downturn caused by the COVID-19 pandemic.

Thousands of others will lose federal aid that helped absorb the high costs of their COBRA (Consolidated Omnibus Budget Reconciliation Act) health coverage after getting laid off or having their hours reduced by their employers.

But Covered California — which administers the Affordable Care Act, aka “Obamacare” — may help take some of the sting out of these lost benefits by offering consumers quality, low-cost health plans from name-brand insurers across the state. Most consumers can now qualify for comprehensive health coverage for just $1 per month.

Here is a quick guide to help those losing benefits

1. **What specific federal unemployment benefits are ending and how can Covered California help?**
2. Four pandemic-related unemployment programs expired earlier in September, which impacted more than 2.2 million Californians. according to the California Employment Development Department (EDD). In addition, another 500,000 Californians will no longer be receiving the weekly $300 federal supplement with their unemployment benefits. Those losing federal unemployment benefits can enroll in low-cost Covered California plans right now, where more financial help is available than ever before thanks to the American Rescue Plan.

Over 1 million Covered California enrollees have already benefitted from the increased financial help, which is dramatically lowering monthly health care costs and has enabled more than 738,000 people to date to get health coverage for as little as $1 per month.

1. **How can Covered California help me, if my federal COBRA health plan subsidies expire at the end of September?**
2. Covered California recently announced it opened a special enrollment period for an estimated 138,000 Californians whose federal subsidies for COBRA health coverage will be ending this month and who face significantly higher monthly health care premiums in October. The subsidies were also part of the American Rescue Plan, and helped many employees and their families continue to receive their group health coverage during the pandemic by covering the full cost of their monthly premiums,

Eligible Californians can qualify for financial help that can save them hundreds of dollars on their monthly health care costs. In addition, many of these consumers will be able to stay with their same brand-name health insurance company when they switch to Covered California.

1. **How long does Covered California's COBRA special enrollment period last?**
2. Covered California's enrollment period for COBRA recipients runs through Nov. 29, 2021. Those who sign up with Covered California before the end of September will have their new coverage begin on Oct. 1. For COBRA recipients who want to keep their existing coverage for the balance of 2021, they can switch during Covered California's open enrollment period starting in November and potentially get significant financial help starting in January 2022.
3. **How do I sign up for these ultra, low-cost Covered California health plans?**
4. Consumers can check their eligibility now for big savings on their monthly health care costs through Covered California by using this quick calculator. They will need to input their household income, ZIP code, household size and the age of each family member and note whether they received unemployment benefits at any time in 2021. Once completed, they will see how affordable a health plan can be in their local area and the cost of their monthly premium.

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

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

1. **Is there other help available for those losing federal assistance in September?**
2. For those whose federal unemployment benefits are ending, California's Employment Development Department (EDD) is encouraging them to apply for other programs expanded by the American Rescue Plan. They include up to $234 per person per month in food assistance via CalFresh, and rental and utility assistance from the Housing is Key program.

Many losing federal unemployment assistance may also qualify for state unemployment benefits. EDD has an online calculator for Californians to estimate any potential benefit amount they can get, which can range from $40 to $450 a week.

State programs are helping shrink racial and ethnic gaps for uninsured in CA, but inequities remain
Anabel Munoz and Grace Manthey

LOS ANGELES (KABC) -- Karla Rodriguez's family moved to Los Angeles five months ago from El Salvador to give her kids a better education and a better life.

Her 8-year-old son has Down syndrome. Someone at his school recommended Rodriguez reach out to non-profit health advocacy group, Community Health Councils, to help with his health care and special needs.

"The truth is that all of this is very new," Rodriguez said in Spanish.

At CHC, community navigators provide much-needed information, support and guidance though the health care system for people like Rodriguez in South Los Angeles and the surrounding areas.

Our America Equity Report: Explore equity data from the 100 largest cities in America

"They don't just do one thing right? Many of them are what we would consider community health workers...they go out and they make sure that people have access to other resources," said Sonya Vasquez, the chief operating officer for CHC.
Rodriguez said she hopes she's not a bother by asking her community navigator, Maribel Rojas, so many questions.

"But she's always been there, very attentive, clarifying things, supporting me," she said.

The organization helped Rodriguez secure Medi-Cal health insurance for her family.

"We are immigrants and perhaps we don't have rights that citizens do, but California embraces immigrants and offers opportunities that perhaps in other states we wouldn't have. In reality, this is a huge privilege, a blessing for our family to be able to count on something so vital, such as health care and to be able to have access to that," Rodriguez said.

But not everyone has the same access to that vital support.

'There's still much more to go'
Latinos across Southern California counties were uninsured at a rate about three times higher than their white neighbors, according to 2019 census data. About 14% of Latinos didn't have insurance, compared to the white rate which was about 4%.

Graph not displaying correctly? Click here to open in a new window.

Uninsured rates have improved in the state since the inception of the Affordable Care Act. For example, estimates from 2013 Census data show nearly 31% of L.A. County Latinos were uninsured, compared to the roughly 14% in 2019.

"Things have gotten better for sure, right? We have a lot of people that are covered. We have a number of new policies and processes that have streamlined the way people enroll, the application process is simpler, we have different procedures for how people can get into the door and to make sure that people don't fall off," said Vasquez.

"However, there's still much more to go," Vasquez continued.

A report from UC Berkeley and UCLA's California Simulation of Insurance Markets, or CalSIM, found that nearly 3.2 million Californians will remain uninsured in 2022, about 9.5% of those under 64. Undocumented Californians make up the largest group of the uninsured, at about 40%.

Graph not displaying correctly? Click here to open in a new window.

The report also projected 16% of Latino Californians aged 0-64 could be uninsured in 2022.

CalSIM researchers modeled these projections before Gov. Gavin Newsom signed a bill expanding access to Medi-Cal services - the state's government-run health care program - to Californians over 50 regardless of their immigration status. That's according to Miranda Dietz, a researcher at the UC Berkeley Labor Center and the project director for the CalSIM team.

"Folks who are under age 26 who are low-income and undocumented can get full scope medical coverage through the state and this expands that to be 50 and above," Dietz explained.

"But, as you can imagine that still leaves a significant number of Californians ages 26 to 49 who are low-income and documented who are without insurance coverage," she continued.

Experts said there are other barriers to accessing health insurance besides just citizenship status, such as language, cost and information.

And Sonya Vasquez from CHC said even the lack of access to health insurance and care creates a barrier itself, "for the rest of the community in terms of it being healthy."

"If we had a stronger...a more streamlined healthcare system, maybe we wouldn't have had the gaps that we did with the pandemic," she said.

Greater accessibility
There are four main ways to enroll in health insurance in California. One, is employer-sponsored insurance. Those who can't get insurance through their job may quality for Medi-Cal, or Medicare if they are 65 or older. For people who don't fall into any of those categories there is Covered California, the state-based health insurance exchange set up under the Affordable Care Act that provides subsidies for people buying private health insurance on a sliding scale based on income.

"Before the Affordable Care Act, it was basically like the wild, wild west," said Rachel Linn Gish, the director of communications for Health Access California, a statewide healthcare consumer advocacy coalition.

If you didn't quality for insurance through your job or for Medi-Cal or Medicare, Gish said you were "left to your own devices."

Insurers could choose their own risk pools, and "only cover the healthy people and stay away from the sick people, which meant that the sick people then didn't have health care coverage," she said.

The ACA made insurance more accessible, but Gish said Covered California is "unique amongst the other state-based exchanges, because of how progressive we made just the consumer-centered design."

She said differences in plans between companies are minimal, which might not be something found in other states.

Sonya Vasquez from CHC highlighted the smoother processes for enrollment in the health insurance system, especially for pregnant women and babies.

"The beauty of California is we've been able to slowly chip away at...only having certain people that are eligible for services, so we have a lot of funding, programming that supports the undocumented children. And now we're going to be having undocumented individuals over the age of 50 that are going to be eligible for Medi-Cal. But again, right now, there's still a lot of challenges and concerns with how people get enrolled," Vasquez said.

Barriers: Information, language and cost
Community Navigators at Community Health Councils, like Larissa Bobadilla help Angelenos through those challenges in navigating the healthcare system.

Bobadilla said a lot of the barriers in the system have to do with a lack of current information.

She said even though the 2019 Public Charge rule is no longer in effect, many in immigrant communities still fear they could become a "public charge" by enrolling in any public benefits, jeopardizing any residency status they might have.

Part of the reason families, especially Latino and immigrant families, don't always have access to the most accurate information on the healthcare system is because of language barriers.

"Some people in the community can cannot read, cannot write in English, only in Spanish or in another language," Bobadilla said.

Another barrier is cost. Premiums can be high for some families, said Bobadilla, even with the subsidies provided by Covered California.

The Biden Administration's American Rescue Plan has brought the cost down for many subsidized plans, experts said. For qualifying families, premiums are capped at 8.5% of income and some can qualify for plans costing as low as $1 per month, though these extra subsidies are set to expire in 2022.

Sonya Vasquez, also from CHC, pointed out that many people became newly eligible for public systems like state-sponsored or state-subsidized health insurance because of pandemic-related job losses.

"They had never had to access public systems before and they didn't know how to do that," she said.

Californians who don't purchase health insurance may be subject to a tax penalty of at least $750 per adult and $375 per child, with exemptions based on income or economic hardships.

Some families might just pay the penalty if they think they can't afford the premiums, but Bobadilla said she spends a lot of time explaining to her clients why health care coverage is important.

She said sometimes her clients don't understand how much hospitals can cost if people get sick. Once she tells them that an emergency room visit could cost $60,000, they often change their minds and enroll instead of paying the tax penalty.

"When you (take) a lot of time to explain to the families, what is the issue...they understand," Bobadilla said.

The work continues

Rachel Linn Gish, from Heath Access California, said one of the biggest goals for the consumer advocacy group is guaranteeing access to all undocumented Californians, including those aged 26 to 49 who are still ineligible for Medi-Cal.

"We believe in universal health care coverage so we're not going to stop until everyone who calls California home can access the care that they need," said Gish.

Heath Access California is also pushing for extensions to the expanded government subsidies, so those that saw huge decreases in their Covered California plans as a result don't see their premiums spike in the future. The group is also working on reforms to lower costs and increase access for prescription drugs.

"Our work with universal coverage, our work to cover the undocumented, our work to lower the cost of care, that's our bread and butter and we'll keep on doing that," said Gish.

Sonya Vasquez from Community Health Councils said the fact that these gaps still exist is "appalling."

"At the end of the day, no one's race or ethnicity should be a reason why they can't get coverage. Their citizenship status shouldn't be a reason why they can't get coverage," Vasquez said.

As someone who helps many families get health insurance coverage, Larissa Bobadilla said her hope is also universal health coverage. But in the meantime, she said her work in the last 15 years as a community health navigator is rewarding not just professionally, but personally.

She said a few families she's helped for years have come to her after losing a family member. One couple even asked Bobadilla's permission to name her daughter after her.

"It's just like a connection between the community and the person who I am," she said. "I am very happy to be working with this role for many years, because I am helping a lot of people."

Karla Rodriguez, who was able to secure health insurance for her family with the help of CHC's community navigators, has been grateful for the help.

"They moved us. We made the decision to look for a better opportunity for them and look for help in every sense," Rodriguez said.

Walnut Creek/Castro Valley/Union City: Special Enrollment Period For Covered California
Bay City News

WALNUT CREEK, CA — Covered California is offering a special enrollment period for Californians at risk of rising insurance premiums once the American Rescue Plan's subsidies end at the end of September.

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, employees who lose health insurance by being fired, having their hours reduced, or other circumstances could extend their coverage by paying the portion of their monthly premium previously paid by their employer.

The American Rescue Plan, the stimulus bill approved by Congress earlier this year, provided subsidies that paid the premiums for individuals seeking COBRA continuation coverage.

Find out what's happening in Walnut Creek with free, real-time updates from Patch. However, those subsidies are set to end on Sept. 30. Covered California estimates that 138,000 people losing their subsidies are still eligible to enroll in a health plan and is offering those Californians the opportunity to switch to Covered California to keep their premiums low.

The special enrollment period for individuals using COBRA continuation coverage lasts from now until Nov. 29, though consumers who wish to switch to Covered California by Oct. 1 must sign up before the end of September.

Covered California is also offering special enrollment through the end of the year for currently uninsured Californians who could still benefit from low premiums under the ARP.

Interested residents can contact Covered California and learn more about their options by visiting the Covered California website or calling Covered California at 800-300-1506.

"As California continues to grapple with the pandemic and its financial fallout, many COBRA recipients will find that financial help is critical to keeping their coverage, and that's what Covered California offers," Peter Lee, executive director of Covered California, said in a statement. "There is more financial help available to Californians than ever before to help them get covered and stay covered."

SACRAMENTO BUSINESS JOURNAL

Covered California for Small Business announces 4% average rate increase for 2022

Emily Hamann

After another year of record enrollment, Covered California for Small Business has released its rates and choices for next year.

The cost of plans on the state's insurance marketplace for employers will go up a weighted average of 4%. That's a jump from last year's increase of 1.5%, but is still the second-lowest annual increase since the program launched in 2014 as part of the Affordable Care Act.

"Premium trends for the small group market often closely resemble the national large employer group market, but our weighted average for 2022 is almost two points lower than what large employers are likely to see in 2022," said Terri Convey, director of Covered California's outreach and sales division, in a statement. "Covered California for Small Business' 1.5% change in 2021 and 4% in 2022 is a reflection of how hard we are working to keep health care costs as low as possible for Californians."

Businesses with 100 or fewer employees are eligible to apply through Covered California for Small Business to get health coverage for their workers.

For the upcoming year, the marketplace will offer four statewide plans, including two PPO plans from Blue Shield of California and Health Net, and two HMO plans from Kaiser Permanente and Blue Shield. This year, the program allows employers to offer their employees the choice to select a plan from any tier, whereas in previous years employees were limited to which tier they could choose based on their employer's contribution.

Over the last year, 8,250 workers were signed up for insurance through the program, for a 13.3% gain in total membership year over year. The program has seen double-digit percentage growth every year for the past seven years.

"Covered California for Small Business continues to grow, demonstrating how employers want to provide those who work for them a good choice of coverage options," said Covered California Executive Director Peter V. Lee, in a statement.

The Covered California individual plan marketplace also saw record enrollment in the last year. Now 1.6 million people are covered under the program, after the program opened up a series of special enrollment periods in response to the Covid-19 pandemic.

Covered California Encourages Members to Re-up for Health Insurance After Record-Setting Year
Staff

During this historic COVID pandemic, more people than ever before signed up for health insurance through Covered California, the state agency that administers the Affordable Care Act (a.k.a. Obamacare).

With a record 1.6 million consumers now enrolled in brand-name health plans through Covered California, the agency recently announced that the renewal process is now underway for its current members for health coverage in 2022. The good news is that he vast majority of Covered California members will receive financial help, from the new American Rescue Plan, that will dramatically lower their monthly health care costs.

This year, Covered California has also seen an uptick in African Americans enrolling in health plans, with quality health care being critical during the pandemic. African American enrollment in Covered California health plans increased more than 30 percent in 2021 over last year.

“Covered California continues to meet the needs of the state’s diverse population during this pandemic and heads into the upcoming open-enrollment period next month with more enrollees than ever,” said Peter V. Lee, executive director of Covered California. “The surge in enrollment is driven by the increased financial help and lower monthly premiums made possible by the American Rescue Plan, which is helping more Californians than ever to get access to quality and affordable health care – no matter their income level.”

New Financial Help and Credits Available to Lower Monthly Health Plan Costs to $0

The American Rescue Plan provides new and expanded financial help that will be available throughout 2022, which will help Californians across all income levels. The financial help covers about 90 percent of a consumer's monthly health insurance premiums, making the cost of health coverage more affordable than ever before. It's important to note that you can only get this financial help through Covered California.

Covered California also estimates that about 1 million of its existing members will be eligible for coverage at no cost because of a new state law called the California Premium Credit. The new law means that some consumers will be able to get the same comprehensive health coverage – with all the benefits and protections of the Affordable Care Act – for free, and the State of California will be providing a credit of $1 per member per month for all Covered California members throughout 2022.

"Getting more people insured, and keeping them insured, not only leads to better health outcomes – it also lowers the cost of health insurance for everyone," Lee said.

Current Covered California enrollees can begin renewing their health coverage now, and they have until Dec. 31 to renew their existing health plan or make changes to their plans for 2022. People who do not actively select a plan for next year will be renewed in their current health plan, so they do not suffer a gap in coverage.

When consumers renew their coverage, many will find that they have more choices to choose from this year. Three of Covered California's health insurance companies will be expanding their coverage areas, and a new company will be joining the marketplace, bringing the total number of health carriers to 12 for 2022. These are brand-name health insurance companies — Anthem Blue Cross, Blue Shield, Bright Health Care, Chinese Community Health Plan, Healthnet, Kaiser, L.A. Care, Molina Healthcare, Oscar, Sharp Health Plan, Valley Health Care, Western Health Advantage — who offer quality care through some of the best doctors and hospitals in the state.

Free Preventive Health Care Always Available with Covered California Plans

Not only will renewing consumers have choice of health plans, but they should be reminded that Covered California health plans are designed to make it easier for someone to get the preventive health care they need for free – including annual physicals, COVID-19 testing and vaccinations, flu shots and all other immunizations, and screenings for diabetes, high blood pressure, and cancer.

As African American disproportionately suffer from chronic health conditions and diseases like hypertension,

diabetes, asthma and cancer, these preventive health care services and screenings can literally be lifesaving.

And with October being Breast Cancer Awareness Month, such preventive health care services are top of mind for many people. Free mammograms are always available to

women with Covered California health plans, and early detection of breast cancer is key – especially among African American women.

According to Breast Cancer Prevention Partners, African American women have a 31 percent breast cancer mortality rate – the highest of any U.S. racial or ethnic group. Among women younger than 45, the breast cancer incidence is much higher among African American women that white women, and the mortality rate for Black women diagnosed with breast cancer is 42 percent higher than the comparable rate for White women.

In addition, Covered California health plans offer free video telehealth visits with primary care physicians, along with free mental health care and substance abuse services, of particular importance during these challenging times.

Easily Renew Your Health Coverage for 2022

Covered California members renewing health insurance for 2022 should go to CoveredCA.com, log in to your account and click on the “RENEW” button. You may also use the Shop and Compare Tool to see your health plan options and cost. It is important to review your health plan during the renewal period because you could receive additional financial help from the American Rescue Plan to lower the monthly cost of health insurance. This means you may now qualify for financial help, even if you didn’t in the past. Or you may receive even more help than you did before! The amount of financial help you may get depends on your income, age, where you live and your family size.

For questions or additional help renewing your Covered California health plan, contact an enrollment expert in your area for free assistance or call Covered California (800) 300-1506.

Covered California, CalPERS team up to make sure your needs are met at your doctor’s office
Cathie Anderson

Three health care industry heavyweights will work together to improve the quality of the day-to-day care that Californians receive at their doctor’s offices as part of a pilot program they announced Thursday.

The goal, they say, is ensuring that patients can get the care that they need from the doctor’s office responsible for their primary care, said Crystal Eubanks, senior director of care redesign at Purchaser Business Group on Health, so that means the primary care doctor’s practice likely will have to expand their teams to meet patient demands.

The nonprofit PBGH represents about 40 private and public employers that purchases $100 billion annually in health care services, and it has joined with two other colossuses — the California Public Employees' Retirement System and Covered California — in funding, developing and steering this pilot.

They are not dictating the types of hires that physicians add to their teams, Eubanks said in a telephone interview. Rather, they are setting benchmarks to assess the value and quality of patient-centered care.

PBGH has invested years of research into helping medical teams determine the type of expertise, infrastructure and tools they need to meeting patient needs through a health care improvement program called California Quality Collaborative. Their process relied upon input from purchasers, health plans, providers and patients.

In this new pilot, set to start in January 2022, PBGH will now take benchmarks derived from that work and use them to assess physician practices that serve PBGH groups but also 1.5 million CalPERS members and Covered California's 1.6 million enrollees.

"Raising the bar on the quality of care delivered not only leads to better outcomes for Californians, it also continues our mission to address the underlying costs of care, and making coverage more affordable to everyone," said Dr. Alice Chen, Covered California's chief medical officer, in a prepared news release. "Covered California is committed to going beyond just getting people health care coverage — we want to make sure consumers are getting the quality care they need – and that starts with high performing primary care."

So, how will you know if the benchmarks are driving change at your primary doctor's office?

Eubanks cited some examples of things patients will notice. Your doctor's office will:

- Offer all the immunizations your family needs and track to ensure you've gotten them on time.
- Ensure you're getting all cancer screenings on schedule.
- Regularly perform checks for diabetes and other chronic illnesses and provide a way to monitor whether you're managing those chronic illnesses.
- Meet needs for services such as dermatology or mild or moderate behavioral health conditions.
- Offer same-day appointments in a manner that meets patient needs.

Small practices may choose to share the cost and services of a behavioral health worker or a community health worker, Eubanks said, because they may not need a particular team member's services on a full-time basis.

Down the road, Eubanks said, this effort will provide more transparency into which practices are offering high-value, low cost care that is meeting the needs of their patients.

Covered California begins open enrollment period for 2022
AP

SACRAMENTO, Calif. (AP) — Open enrollment for the nation's largest state-run health insurance marketplace began Monday and runs through the end of January.

Covered California sells individual health insurance plans to people who can't get coverage through their job. Some people, depending on how much money they make, are eligible for deep discounts on their monthly premiums. Even families making more than $100,000 per year are eligible for discounts.

Covered California says if everyone chose the cheapest plan, more than 70% of consumers would pay less than $10 per month.

Twelve insurance companies will sell plans on Covered California for 2022. How many choices you get depend on where you live. Covered California says everyone will have at least two options.

More than 12.2 million people are enrolled in state and federal marketplaces across the country, including 1.6 million in California.

U.S. Health and Human Services Secretary Xavier Becerra participated in a news conference in Sacramento on Monday to launch the open enrollment period. He said the only thing people should be worried is the quality of their health care, not how much it costs.

"That's where we're heading. That's where President Biden wants to go," he said.

Los Angeles Times

Obamacare open enrollment begins. Find out if you qualify for higher subsidies
Jon Healey

With 2021 winding down, it's time for millions of Americans to sign up for health insurance for 2022. And for Californians who can't get coverage through Medicare, Medi-Cal or an employer's health plan, the good news is that expanded federal subsidies will make next year's policies more affordable for more people than they were a year ago.

Monday marks the first day of open enrollment at Covered California, the insurance marketplace that the 2010 Affordable Care Act created for people who aren't covered by a group health plan. You can sign up online, over the phone or through one of the dozens of offices in Southern California staffed by insurance "navigators." If you'd like to work with a navigator, call that office before visiting — the pandemic has led many of them to limit in-person contact.

Remember, under California law, adults are required to maintain health insurance coverage, with limited exceptions. That's true regardless of whether you have access to a health plan at work. Failing to obtain coverage can result in a tax penalty of hundreds to thousands of dollars.

The process of shopping for policies may seem daunting if you haven't done it before, especially when you don't have an employer narrowing your choices and paying part of the cost. Here are some pointers for enrolling through Covered California.

What am I buying?

The ACA sought to rid the market of junk insurance plans that didn't cover some expensive types of care, leaving customers who needed those treatments crushed by medical bills. So it required every plan sold in state marketplaces such as Covered California to be comprehensive, meaning that it covers all 10 types of care that the federal government deems essential.

But while the policies cover the same services, they aren't all the same. One difference is how much of the total annual medical costs they will pay. That's not your total costs, necessarily; it's based on the average across the broader population. The higher the percentage paid by the policy, the higher the premiums will be.

The offerings are divided into four tiers: Bronze, which covers 60% of the average total; Silver, which covers 70%; Gold, which covers 80%; and Platinum, which covers 90%. And within those tiers, there are two Bronze plans — one conventional, the other a "high

deductible” plan designed to be paired with a health savings account — and four Silver plans, whose deductibles and copays are based on your income level.

To make comparing the plans easier, Covered California has standardized the policies so that within each tier (and sub-tier in Silver and Bronze), the plans all offer the same benefits, copays and deductibles. As a result, shoppers can focus on fewer things to guide their decision: how much they expect to spend on healthcare next year, which doctors they’d like to use, and what prescription drugs they need.

How much will it cost me?

Before choosing among the tiers of plans, you should figure out whether you’re eligible for subsidized premiums and out-of-pocket costs.

For starters, if you have access to a comprehensive health plan from an employer that costs less than 8.25% of your annual income, you can’t get subsidies from Covered California. Nor can you get subsidies if you are living in the country illegally, although you may still be eligible for Medi-Cal if you meet the income limits and you’re 25 or younger, 50 or older, or currently or recently pregnant.

Everyone else is technically eligible, although the amount of subsidy is tied to your income. Those subsidies increased significantly midway through 2021, after Congress passed and President Biden signed the American Rescue Plan. The increase remains in effect for 2022, and Biden’s $1.75-trillion Build Back Better package would keep the higher subsidies in place for three years after that. (The “cost-sharing” subsidies that reduce out-of-pocket costs remain unchanged, however; they are available only to households earning up to two-and-a-half times the poverty level.)

With the expanded aid, anyone earning up to 150% of the federal poverty level — in other words, up to $19,320 for a single individual — can get coverage for $1 a month. And the state will pay that cost starting Jan. 1; the added subsidy will enable an estimated 700,000 people to get Silver- or Bronze-level coverage with no monthly premiums. For households with more means, premiums are set at gradually rising percentages of their incomes — for example, 2% for someone with an income twice the poverty level, 6% for someone at three times the poverty level, and 8.5% for anyone at or above four times the poverty level.

A study by UC Berkeley’s Labor Center projected that the added subsidies will enable 135,000 Californians to obtain insurance in 2022, and would cut the costs faced by an additional 1.5 million enrollees — about 150,000 of whom had not qualified for subsidies before because their incomes were above the previous cutoff.

Bear in mind that the actual subsidy amount you’ll receive is based on the cost of the second-least-expensive plan in the Silver tier that matches your income level. So if you sign up for a different plan, your premiums could be a higher or lower percentage of your

income, depending on whether the plan you chose has lower deductibles or higher out-of-pocket costs than the benchmark.

Which plan is right for me?

Picking a plan is a bit of a dice roll; whether you wind up saving money or spending more depends to a large extent on how much care you'll need in 2022. If you know you're going to need a lot of expensive care, a Gold or Platinum plan could be a better choice than a Bronze or Silver one. If you're healthy and have few medical needs, a plan with low premiums and high out-of-pocket costs makes more sense.

One other possibility is to go with the least expensive Bronze plan, which has a whopping $7,000 deductible for individuals and $14,000 for families, and set up a health savings account to pay for the lab tests, outpatient services or hospital care you may need before the insurance kicks in. (The plan does pay for preventive care and three visits with a primary care physician.)

"The conventional wisdom is that HSA-qualified plans are only good for young, healthy people without kids," said Louise Norris, a licensed health insurance broker and analyst for healthinsurance.org. But if you know that you're going to have high enough medical expenses to hit the out-of-pocket maximum, she said, "the total costs may be lower" on a high-deductible plan with a health savings account.

Still, she said, these plans require you to be able and willing to let savings build up in the health savings account. So you have to be honest with yourself about that. If you're going to be pulling money out of the account constantly, she said, "it might always be a stressful situation."

Once you've figured out which plan best manages your expected out-of-pocket costs, there are two factors you should focus on, Norris said.

The first is this: Which doctors are in a plan's network? Every plan has its own roster of physicians, some larger than others, although there may be some overlap between them. And some HMO plans require you to see your assigned primary care doctor in order to get an appointment with a specialist. Regardless, seeing a doctor outside the plan's network will usually cost you more, so if you want to keep the doctors you're seeing now, make sure they're in network for the plan you choose.

The second question, Norris said, is: What's in the plan's drug formulary? Each insurer assembles its own list of prescription drugs that are fully covered, partially covered and not covered. "If you are taking a particular drug," Norris said, "you do want to see how it's covered on the different plans."

What if I already have coverage?

Covered California automatically renews the policies of current enrollees unless they choose a new one. But many people who renew may see notably higher premiums, even though average premiums will rise only 1.8% in 2022.

Two factors are at work here. Californians who received unemployment benefits qualified for additional premium subsidies in 2021 that will not be available next year. And Covered California provided a year's worth of extra American Rescue Plan dollars in only eight months; once the money is spread over the full year, the discount won't be as large.

Even if you're happy with your current coverage, make sure to alert Covered California to any changes in your income, because that could affect how much aid you're eligible to receive.

When do I have to decide?

For the record:

11:54 a.m. Nov. 5, 2021An earlier version of this story incorrectly stated that the deadline is Dec. 15 for obtaining coverage that goes into effect at the start of the new year. The deadline is Dec. 31.

Open enrollment will continue through Jan. 31, 2022. But if you want your new plan to go into effect right at the start of the year, you have to sign up by Dec. 31.

Covered California enrollment starts with extra federal boost for low and middle-income families
Sammy Caiola

The open enrollment window for the state's health insurance marketplace, Covered California, began Nov. 1. Health officials say purchasing coverage will be more affordable than usual for many people thanks to newly available federal financial help.

The additional subsidies come out of the American Rescue Plan, President Joe Biden's $1.9-trillion post-pandemic stimulus package. The plan includes an estimated $3 billion for the state marketplace through 2022, according to Covered California.

For some Covered California consumers, the new aid will layer on top of existing monthly premium assistance they were receiving from the state. California recently moved to make families earning more than $100,000 a year eligible for financial help.

California health and human services secretary Dr. Mark Ghaly says under the Biden administration, the state has a “tremendous chance to build on the Affordable Care Act and get not just more Californians covered, but more Californians getting help to pay for that coverage.”

Since the implementation of the American Rescue Plan, more than half of marketplace enrollees pay $10 or less per month for name-brand health insurance, according to Covered California’s data.

Covered California estimates that 1.1 million low and middle-income people who are currently uninsured would qualify for these subsidies, and that 85% of them would pay no monthly premium. Of that group, an estimated 106,000 live in Northern California and the Sacramento Valley.

The marketplace has had to increase monthly premiums in some years — a problem that analysts said got worse during Donald Trump’s presidency because of a lack of federal support.

U.S. Secretary of Health and Human Services Xavier Becerra said Monday that those days are over and most Californians can now afford to buy through the exchange without severe financial stress.

“All those horror stories we heard … dismiss that, because the reality is you’re getting more access to better care at a lower price,” Becerra said. “It’s time. We can do this and take advantage.”

The former California Attorney General said the challenge now is finding those who are still uninsured and convincing them to enroll.

Californians must carry health insurance or pay a penalty, which ranges depending on income level and length of time without coverage. The state established its own insurance mandate in 2020 after the federal government removed the penalty established under the Affordable Care Act. For adults who go uninsured for an entire year the penalties begin at $800.

Last year, 94% of Californians had health insurance, the highest number since 2001 according to a new report from the UCLA Center for Health Policy Research. But authors say many people, especially people from marginalized groups, delayed medical treatments during the pandemic despite being insured because they couldn’t easily access care.

“We’ve seen during this pandemic the devastation that individuals without health care coverage have faced, and the fact that sometimes that coverage doesn’t do exactly what

we hope it does," Ghaly said. "Signing up here for Covered California not only might open the gateway to incredible coverage, but you'll have a partner and advocate for improving the coverage over time."

The enrollment window lasts until Jan. 15. Consumers who want their coverage to begin Jan. 1 must sign up by Dec. 1. People can find out more about their health plan options here, or they can contact Covered California for help signing up.

HHS Secretary Becerra visits state as Covered California open enrollment begins
Ashley Zavala, Jonathan Taraya

(KTXL) — U.S. Health and Human Services Secretary Xavier Becerra made his first public appearance back in California since President Joe Biden appointed him to the position.

"Health care in America should be a right, not a privilege," Becerra said Monday while helping launch Covered California's open enrollment period to sign up for health insurance.

The program is the state's insurance marketplace for those without a group plan. Becerra noted with help from Biden's American Rescue Plan, premiums this year are lower.

Covered California was created by the 2010 Affordable Care Act, which Becerra defended in court when he was California's attorney general and is the program he oversees in his new role.

"More Americans are getting health insurance coverage as a result of the Affordable Care Act and here, Covered California," Becerra explained. "Today, we have over 12 million Americans who have medical insurance because of the work done under the affordable care act."

As COVID-19 continues to be a concern for state and federal leaders, many private health insurers are no longer waiving out-of-pocket costs for COVID-19 treatment.

Becerra said the Biden administration will continue to support testing and vaccinations.

“We will not stop our efforts to try to defeat COVID. And as we’ve seen, COVID is a real rascal and the delta variant has made things very difficult. We’re going to be on the watch, we’re going to be working with our partners and doing everything we can,” Becerra said.

Becerra is the first Latino U.S. health and human services secretary. He said his department is boosting outreach in numerous languages and working on expanding access to health services to all, regardless of immigration status.

“The president has also presented a plan to reform our broken immigration system to make sure that we’re treating everyone the right way,” he said. “I hope that what we can continue to say, under President Biden’s watch, that we’ll continue to see more affordable care for more people in this country.”

California’s open enrollment period ends Jan. 1.

ACA, Covered California open enrollment period starts as officials tout low premiums
Eli Walsh

SACRAMENTO, Calif. - State and federal officials launched the nationwide open-enrollment period Monday for health insurance under the Affordable Care Act for 2022.

U.S. Health and Human Services Secretary Xavier Becerra joined state Health and Human Services Secretary Dr. Mark Ghaly and Covered California Executive Director Peter Lee to announce the start of open enrollment and to encourage both insured and uninsured residents to take advantage of new subsidies if they are eligible.

Roughly 12.2 million people are enrolled in state and federal health care exchanges under the ACA, former President Barack Obama's health care law.

Covered California, the state's ACA marketplace, had a record-high 1.6 million state residents enrolled in 2021.

"Looking to 2022, an estimated 575,000 uninsured Californians could enroll now and get remarkably affordable coverage," Lee said Monday during a briefing on open enrollment. "And about 260,000 Californians who pay for their own insurance, directly to their insurance company, could switch to Covered California and likely get the same plan - same doctors, same everything - but save thousands of dollars off what they're paying right now."

While the ACA open enrollment ends Jan. 15, 2022, in most states, California's open-enrollment period runs through Jan. 31.

Lee, Becerra and Ghaly estimated that more than 1 million uninsured state residents would qualify for financial assistance and premium subsidies through Covered California and Medi-Cal, the state's Medicaid program.

Of those 1.1 million residents, more than 85 percent could receive health care coverage while paying no monthly premium, according to Covered California officials.

Uninsured residents who are eligible for subsidies but do not qualify for no-cost coverage are still likely to pay very low premiums per month - more than half of subsidized Covered California enrollees paid monthly premiums of $10 or less in 2021.

The low costs and increased subsidies are partially a result of the federal American Rescue Plan, which expanded financial relief and assistance in light of the ongoing COVID-19 pandemic.

"You're going to save money if you go on the Covered California website and sign up for health insurance," Becerra said. "It's that simple."

Information about enrolling in health care coverage via Covered California can be found at https://www.coveredca.com or by calling (800) 300-1506.

US HHS secretary touts California success as he opens enrollment in federal insurance market

Cathie Anderson

U.S. Health and Human Services Secretary Xavier Becerra praised Californians and outgoing Covered California leader Peter V. Lee on Monday after he took to the podium to invite all Americans to buy an insurance plan through one of the nation’s Affordable Care Act marketplaces.

Open enrollment launched Monday across the country. It will end Jan. 15 in much of the nation but extends until the end of January in California.

“It’s great to be in a state that really launched on the Affordable Care Act, took it seriously and has helped more Americans get covered than any other state in the nation,” said Becerra, who was California’s attorney general prior to accepting the nomination to lead the U.S. Department of Health and Human Services.

“As a former member of Congress from Los Angeles, I can tell you that the rate of uninsured in my congressional district, I believe went down more than any congressional district in the state of California — and I think virtually any congressional district in the nation — as a result of the work that was done by the Affordable Care Act.”

Becerra also saluted Lee, who will be stepping down at the end of March after 10 years as the inaugural leader of Covered California, saying: “There are countless Californians who owe, in many cases their lives, certainly their well-being, the peace of mind that they have today, to the work that you did to make sure Covered California was the most successful state-based marketplace in the nation.”

Lee said that, while it’s a bittersweet time for him, he feels an incredible sense of gratitude to his team and a sense of accomplishment.

“Covered California has been working shoulder-to-shoulder with our Medi-Cal program since Day 1 to be part of reducing the rate of the uninsured more than any state in the nation,” Lee said, “but the other thing I’m grateful for is the work that we’re still doing and the work we still have to do. We are very committed to making sure that everyone eligible for coverage gets covered.”

Becerra said President Biden considers health care to be a right and also wants to ensure that every American can access it.

“If your child gets sick and you have to go to the hospital, the other part of your brain (shouldn’t be) thinking: Am I gonna go bankrupt now if I do this?” Becerra said. “The only thing that you should be thinking about when your child needs to go to an emergency room, to a doctor, to hospital is: Am I getting the best care possible? Not: Can I afford to do this. That’s where we’re heading.”

Four out of five Americans who signed up for 2021 coverage in the Affordable Care Act marketplaces, close to 3 million people, paid $10 or less a month for coverage because of subsidies provided in the American Rescue Plan.

Davis resident Jingjing Cai operated a small business that helps couples achieve their dream of an international adoption. When the pandemic hit and international travel shut down, she said, they had to temporarily close up shop.

“We could no longer afford our for our medical insurance we purchased through our business,” she said, “so we turned to cover California. We are so grateful to Covered California for the financial assistance made possible by the American Rescue Plan. This assistance helped us a lot in a very difficult time. Now, we can afford to keep our health care coverage — and with it, the peace of mind knowing we are protected.”

Becerra said that HHS will be getting the message out about the coverage and subsidies in more languages this year and is hiring four times as many navigators as were employed last year to help educate consumers on their options and how to sign up. Covered California also will invest millions in getting the word out.

Lee said the Cais are among more than 1.4 million people, 90% of Covered California enrollees, who are getting financial help today that has dramatically lowered their health care costs for this year 2021.

“Looking to 2022, an estimated 575,000 uninsured Californians could enroll ... and get remarkably affordable coverage,” Lee said, “and about 260,000 Californians who pay for their own insurance directly to their insurance company could switch to Covered California — and likely get the same plan, same doctors, same everything, but save thousands of dollars off what they’re paying right now.”

In 2013, the year before Covered California began offering policies, 16% of Californians were uninsured, according to the California Health Care Foundation, but Lee said that number now stands at 6% as a result of aggressive marketing by his agency and federal financial assistance.

Still, he said, the Covered California team wants to reach the roughly 1.1 million Californians who don’t have insurance.

Need help with signing up? Call (800) 300-1506 or visit www.coveredca.com for free and confidential assistance.

Vida en el valle

HHS Secretary Xavier Becerra: "Take advantage of what is being offered" during open enrollment

María G. Ortiz-Briones

SACRAMENTO, Calif., November 1, 2021 – U.S. Department of Health and Human Services Secretary Xavier Becerra has a message for eligible, uninsured Latinos who still have not enroll in healthcare coverage: "Take advantage of what is being offered."

"You sign up before Dec. 1. Your coverage will begin Jan. 1. Don't delay. Have that peace of mind if you ultimately need to take your child, your loved one to the hospital," Becerra said.

Becerra was in California Monday (Nov. 1) to kick off open enrollment across the country for the 2022 coverage year and encourage Americans to get covered.

Becerra also highlighted Biden-Harris administration efforts – from an open-enrollment campaign to record-low prices to more choices and 30 more days to pick a plan – to reduce health care costs during a press conference in Sacramento with other state leaders.

"It's great to be in a state that really launched on the Affordable Care Act, took it seriously and has helped more Americans get covered than any other state in the nation," said Becerra, adding that as a former member of congress from Los Ángeles, the rate of uninsured in his former congressional district went down more than any congressional district in the state of California.

The open-enrollment period began with a record-high 12.2 million people enrolled in the federal and state marketplaces, including 1.6 million in Covered California. The increased enrollment has been driven by the new and expanded financial help available through the American Rescue Plan, as part of the landmark federal response to the COVID-19 pandemic and the recession it sparked.

Becerra has played a key role in every aspect of the Affordable Care Act.

"As a member of Congress, he helped establish the law. As California's attorney general, he helped defend the law. Now, as secretary of the United States Department of Health and Human Services, he is leading the charge to get more Americans enrolled and to improve the Affordable Care Act as the nation moves toward true universal

coverage," said Peter V. Lee, executive director of Covered California, the state-based insurance marketplace.

Becerra said parents shouldn't be thinking if they are going to go bankrupt if their child gets sick and have to go to the hospital.

"The only thing that you should be thinking about when your child needs to go to an emergency room, to a doctor, to a hospital is 'Am I getting the best care possible?' Not can I afford to do this," Becerra said of the administration's focus that healthcare in America should be a right and not a privilege. "That's where we are heading."

"The most important thing is I can tell you is, get on the website for Covered California. You want to save money at a time when you keep you see prices going up for other things. Guess what? The price of health care, especially under places like Covered California, is actually going down," Becerra said.

The work is not done

Becerra said the work is not done as there are still too many Americans – including a good number of Californias who still lack a good coverage – who qualify to for the ACA.

An estimated 1.1 million uninsured – including 115,000 people in the San Joaquín Central Valley, Eastern Kern area – are eligible for financial help, with the vast majority able to coverage at no cost through either Covered California or Medi-Cal.

"Our job is to get out there. So, what are we doing? We are quadrupling the number of navigators, the people who help you understand what the plans offer and which one to select four times as many navigators will be out there to help," Becerra said. "We want you to select the right plan."

Bacerra said there are more plans, more options for coverage than ever before with more providers.

"We're going to make sure we reach everyone," Becerra said of the efforts in several other languages besides English and Spanish as well putting additional "trusted voices out there that will help us" including nonprofits, community leaders in California. "We are going to where people are. We're not waiting for them to come to us."

"We are constantly trying to reach out to more and more populations to make sure they understand what opportunities they have," Becerra said.

While open enrollment for the two thirds of the nation served by the federal marketplace healthcare.gov goes until Jan. 15, in California will go through Jan. 31.

“This can confuse consumers a little bit but look to your local state. We’ll be reaching out a lot over the weeks and months to come,” Lee said. “But it is a huge credit to the Biden administration that instead of shortening the enrollment period, they lengthened it, putting more money on the table for navigators, putting more money on the table for outreach that shows a commitment to actually get coverage where it’s needed in low-income people’s hands, in the hands of communities of color.”

Lee said that like the Biden administration, Covered California will be running ads and doing outreach in Chinese, in Korean, in Vietnamese, “in the languages that represent the diversity of California in the nation. And that’s what it takes.”

He said that some of the TV ads from the Biden administration are going to run in California as well.

“They’re going to run the Central Valley, if people go to HealthCare.gov. They will get directly to Covered California, but in many states, healthcare.gov is the endpoint,” Lee said.

National 2022 Covered California Open-Enrollment Period Launched
Staff

Covered California welcomed Secretary Xavier Becerra of the U.S. Department of Health and Human Services to officially launch open enrollment across the nation for the 2022 coverage year. Open enrollment is a time when Americans can sign up for or renew their coverage through Affordable Care Act marketplaces. This year, they could benefit from more financial help than ever before.

“The Biden-Harris Administration is investing in the most robust open-enrollment campaign to date — with record-low prices, more choices and 30 more days to pick a plan than last season,” said Secretary Becerra at the Monday, Nov. 1 launch event. “Health care should be a right and in reach for everyone. This open-enrollment season, we will get closer to achieving that goal.”

The open-enrollment period begins with a record-high 12.2 million people enrolled in the federal and state marketplaces, including 1.6 million in Covered California. The increased enrollment has been driven by the new and expanded financial help available through the American Rescue Plan, as part of the landmark federal response to the COVID-19 pandemic and the recession it sparked.

“Secretary Becerra and the Biden administration have shown that by building on the Affordable Care Act, we can go a long way toward achieving our goal of true universal coverage,” said Dr. Mark Ghaly, California Health and Human Services secretary and chair of the Covered California Board of Directors. “Californians need to see what their coverage options are and find out how affordable insurance can be at CoveredCA.com.”

A recent report found that California had reduced the rate of the uninsured to a record-low 6 percent of the population. For those who are still uninsured, the increased financial help is good news for the estimated 1.1 million Californians eligible for financial help. More than 85 percent of that group (about 940,000 people) could get comprehensive quality care with no monthly premium.

“The Affordable Care Act is working both nationally and here in California, serving as a critical safety net for those who need coverage, and now is the time to sign up,” said Peter V. Lee, executive director of Covered California. “The amount of financial help available through 2022, and for many years to come if the Build Back Better plan is enacted into law, will cover the entire cost of many people’s monthly premiums.”

In California, more than 70 percent of consumers who get subsidies could choose health coverage for less than $10 per month, which is very similar to the national figure. In 2021, because many consumers chose to get richer benefits that better meet their needs, more than half of subsidized consumers are paying less than $10 per month and 75 percent paying less than $100 for their brand-name health plan.

In addition, one of the big improvements of the American Rescue Plan is that it makes financial help available for middle-income consumers who were previously ineligible for federal assistance. (Though in 2020, many received the landmark California state subsidies that set the path for the American Rescue Plans’ expanded assistance.) Now, families earning more than $100,000 a year can be eligible for financial help. On average, the families who are receiving subsidies are saving nearly $800 a month on their premiums.

The open-enrollment period is also a time to save for those who are currently insured directly through a health insurance company. An estimated 260,000 Californians have direct coverage — also known as “off-exchange” coverage. They can sign up through Covered California and potentially get the same plan they have off-exchange, or shop for other coverage that best fits their needs, and save hundreds of dollars per month.

“Californians who are paying for health insurance directly can switch to Covered California and get the same level of coverage — likely from the same company — and save thousands of dollars over the course of the year,” Lee said. “These are the last Americans not getting federal financial help to cover their insurance, since even those of us with employer-based coverage get an invisible leg up from the federal tax system to make our coverage more affordable.”

For Covered California, open enrollment is also an opportunity to continue its work to address historic disparities in health care by ensuring that Californians of all races, ethnicities, income levels, genders and locales get access to health care coverage.

Covered California announced the launch of a new statewide ad campaign to promote open enrollment. The campaign, titled “This Way to Health Insurance,” will be aired in English, Spanish, Mandarin, Cantonese, Korean and Vietnamese. The campaign is directed by award-winning director Luis Peña and seeks to engage California’s diverse population.

The ad “Heart” features the story of a new father, whose love and concern for his children make him realize the importance of having health insurance. “Corazón” features the story of another father, who sees his daughter growing up and reaffirms the importance of taking care of her and himself.

Californians will find they have more health insurance options to choose from this year. Starting in 2022, three of Covered California’s health insurance companies will expand their coverage areas, and a new company will join the marketplace. As a result, with 12 carriers providing coverage across the state in 2022, all Californians will have two or more choices, 94 percent will be able to choose from three carriers or more, 81 percent of Californians will have four or more choices, and 70 percent of people will have five or more carriers to choose from.

“Consumers win in a competitive marketplace, and this year most Californians will have four or five insurance companies to choose from,” Lee said. “Covered California believes in putting consumers in the driver’s seat, so they can choose the option that works best for them.”

Consumers can discover their options by visiting CoveredCA.com and quickly and easily find out if they qualify for financial help and see the coverage options in their area. They just need to enter their household income, ZIP code, household size and the number of

people who need coverage and their ages into the calculator on Covered California's homepage.

In California, open enrollment runs through Jan. 31, 2022 and it is the one time of the year when eligible people cannot be turned away from coverage.

In addition to visiting CoveredCA.com, those interested in learning more about their coverage options can also:

• Get free and confidential assistance over the phone, in a variety of languages, from a certified enroller.

• Have a certified enroller call them and help them for free.

• Call Covered California at (800) 300-1506.

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

Interview: Dr. Ghaly on what California parents should know about vaccines for kids 5- to 11-year-olds
Tiffany Lew and Vicki Gonzalez

California is rolling out thousands of vaccination clinics across the state as eligibility expands to children ages 5 to 11.

The lower dose version of the Pfizer vaccine was approved for emergency use authorization last week, and vaccinations began immediately. This comes as nearly 70% of Californians have received at least one COVID-19 shot.

Now, this latest chapter in the pandemic also comes with questions for the youngest age group. According to the state, around 74,000 kids ages 5 to 11 have already received their first dose of the vaccine since it was approved Nov. 2.

CapRadio's Vicki Gonzalez talked to California's Secretary of Health and Human Services Dr. Mark Ghaly about the vaccine rollout to children 5 and older.

This interview has been edited for clarity and length.

On the unique challenges to scaling up clinics for children 5 to 11

For a lot of young people, it's getting into the provider that they want to administer the vaccine, that they want to get the questions answered from. So I think in the days to come, we're going to see a number of new sites pop up. More pharmacies are able to provide the vaccines, as well as those trusted pediatricians, family practice providers and federally qualified health centers that have been doing it all along. So I think that any challenges that people have experienced, I think, will start to erode and go away in the case.

On whether parents who are interested in vaccinating their child now should go through their pediatrician or an offsite clinic

I think both work. It really depends on what you're comfortable with. I think many people would like to go to their regular provider, which is a completely reasonable thing to do. I know as a primary care pediatrician, I always love to be able to provide all of the care to the patients I had a connection and relationship with. So that might be what works for one family. And another family might say I'm a block away from a Walgreens that's providing it Saturday morning, I'm going to go there. All of that works.

On the kind of clinical trials the vaccine went through for younger children and how or if they differed from other trials for older age groups

They differed in that the age of the young people were 5 to 11. They were very deliberate to try to reach out to all parts of the nation, all races, ethnic groups to make sure that we had a representative sample of 4,000-plus young people in this age group who went through the trial. They saw at the lower dose that it was a highly effective vaccine and that the side effects, even the day of, the day after, side effects were tolerable. A little arm soreness, maybe some low grade temperatures, but overall, the

trial was a very robust one, and it came together because so many eager young people were interested in being part of the trial. It came together just as quickly as some of the adult trials. So I would say a material difference is it was a lower dose. They looked at the 5- to 11-year-olds olds, but they saw the same thing that they saw in the adult trials — highly effective and safe vaccine.

On any more serious side effects that he wants parents to consider or know about when they talk to their pediatrician and make a decision whether to vaccinate their child

I also think it's important to come in with your questions in hand, because as you know, some of those visits go very quickly, and by the time you leave the office, you wish you would ask that one more question. So my advice is always write those down.

But I also remind people with the 5 to 11 [year-olds], we've been so focused on this idea that young people are doing it for older Californians to keep their communities safe. I'll remind you that we've lost more kids to COVID than we have any other vaccine-preventable disease since the beginning of this pandemic. That's the first thing.

The second thing is we are seeing the long term impacts of COVID infection on kids, even though they don't have the worst outcomes, thank God.

Of those significant numbers of hospitalizations and deaths, as we saw in adults, we still see the consequence of long term COVID, respiratory problems, neurologic problems, psychiatric problems that we want to make sure that we avoid [that at] all costs. So this isn't just about the kids doing another great act for adults, this is about protecting the 5- to 11-year-olds first and foremost, and I want to make sure that all parents or guardians, all 5- to 11-year-olds know this is really about protecting and supporting their health, not just the health of all Californians.

On what Ghaly would say to parents who believe children only get mild forms of COVID-19 and don't need to be vaccinated.

The truth is, the side effects of the vaccine, if there are any, are very, very mild as well. And the consequences of actually getting the COVID infection are much greater. For all of the things and the concerns that parents have around the side effects and the concern around inflammation of the heart and other challenges that I think have been well captured in the media, the truth is, getting the disease of COVID can cause those same problems, but much, much worse and more frequently. So it is important to highlight that getting COVID. Sometimes kids and people are lucky to avoid significant

problems, but oftentimes it's not the case.

On whether California's planned vaccine or testing requirement for students or local school district mandates will exacerbate inequity among Latino and African-American residents, where vaccination rates are already low.

When I think about the equity challenges that we've been facing throughout this — and there have been many and California has leaned in in a tremendous way to make sure that we close gaps and really probably to address the inequities that we've seen — having kids and schools vaccinated, to me, is one of the strongest equity equity decisions that we can make. So I support school districts who are making decisions locally. I support what the state has done in looking at having a vaccine requirement in schools once full FDA approval is reached, and I think that we're going to see a number of families see the benefit of the vaccine and moving forward to make the decision for their own young people.

On what he says to parents who are OK with vaccines such as measles and mumps and tetanus, which are required within school districts, but are more uncomfortable with the emergency use authorization piece of vaccinations for children 5 to 15 years old.

First off, it's completely understandable to have questions and concerns. I mean, I have four kids. My wife and I sat down and we talked through the information and the data ourselves, even though I and she live and breathe this. We had a very deliberate conversation and made the decision that it was the safe and effective things to do for our kids, not just our family, but for them. Five, 7, 11-year-old, We've all decided to have them vaccinated, so I think it's important to ask all of the questions that you have, get the answers so that you can make a good and well-informed decision.

On whether masking requirements will go away next summer after the state school vaccine mandate goes into effect.

That's certainly our hope, Vicki. You know, the mask mandate, the mask requirement in schools right now is really in place because we've seen its impact in effect, and it's worked. It's kept California schools open at one of the highest rates since the beginning of this school year. We've had fewer outbreaks than other states have had and we've had, I would say, the school year has been a tremendous success from the perspective of getting kids back in-person education, which we know was something they missed and lost out on in last year. So the assessment of where to go with masking is going to be one that is built around where the transmission rates are and how significant they are across the state. And one of the most effective ways to keep our transmission rates down is to get people vaccinated so they go hand in hand. There's not a direct metric,

there's not a magic number or a threshold of having people vaccinated. But getting vaccinated keeps our rates down. Keeping our rates down is going to help us get not just schools, but everything else back to what we all missed pre-pandemic.

CaliforniaHealthline

Your Out-of-Pocket Health Care Costs Need Not Be a Mystery
Bernard J. Wolfson

If you've ever had a serious illness or cared for someone who has, you know how quickly the medical bills can pile up: from labs, radiology clinics, pharmacies, doctors, different departments within the same hospital — some of them in your insurance network, others not.

It can be extremely confusing, no matter how clever you are, to determine which bills you need to pay. If you're sick, or have technological, cultural or language barriers — not to mention financial difficulties — navigating this maze can be especially intimidating.

A law signed by Gov. Gavin Newsom last month may help you sort through a tangle of medical bills to figure out what your health plan will cover and when the coverage kicks in.

The law, SB 368, requires most state-regulated private-sector health plans to send enrollees updates, for every month in which they received care, showing how much they have paid toward their annual deductible — the amount a person must shell out before insurance begins to cover most of their care — and how close they are to reaching out-of-pocket limits, the amount after which the insurer pays for 100% of care.

The law, which takes effect in July, should help people with costly chronic conditions who need to keep better track of how much they owe, and healthy ones who rarely seek care but might suddenly encounter unexpected medical circumstances.

"It's not that hard to hit those maximums, and it doesn't take a cancer diagnosis to get there," says Dylan Roby, a professor of public health at the University of California-Irvine. "It could be one ER visit with a procedure. A broken leg could get you there pretty easily."

The new law requires health plans to send out-of-pocket updates via mail unless the insured opts for electronic delivery. The information must also be stored in a format that is accessible to customers at any time.

SB 368 “is part of a larger need to provide transparency about individuals’ out-of-pocket risks,” says Roby.

Consumers often are unaware, he notes, of what’s available for free under the Affordable Care Act, including preventive services like screening tests and immunizations. Most health plans offered through Covered California, the state’s ACA marketplace, also must cover outpatient services, including imaging, specialist appointments and physical therapy, before the deductible is met.

One potential pitfall of the new law, Roby observes, is that insurers can crunch numbers based only on the claims they’ve processed, and some doctors and other providers might take six months or more to file claims. That means the information plans send to enrollees could be outdated.

At present, state law imposes no specific requirement on insurers to inform enrollees of their current financial liabilities, but some plans already do so — either in the “explanation of benefits” they send after care is received, or in response to a customer request.

“This law makes an optional practice a requirement,” says state Sen. Monique Limón (D-Santa Barbara), who authored the legislation. “And it’s a good practice.”

The new law should be helpful to a growing number of people, given the increasing prevalence of health plans with ever-larger deductibles.

Between 2012 and 2020, the percentage of California workers with single coverage who had an annual deductible of $1,000 or greater quadrupled, to 54%. And among families enrolled in health plans with deductibles, 70% had deductibles of $2,000 or higher last year, compared with 31% eight years earlier.

For the cheapest Covered California plans, the deductible this year is $6,300 for an individual and $12,600 for a family. And there’s a separate deductible for prescription drugs (the new law requires health plans to inform enrollees where they stand on all their deductibles).

As deductibles rise, health plan members are seeing the financial protection of their insurance kick in later and later in the year. And in many cases, after meeting their deductibles they still need to spend a thousand or more before reaching out-of-pocket spending limits for the year.

People with serious diagnoses such as cancer, HIV, multiple sclerosis or cystic fibrosis frequently make such calculations.

Stacey Armato, a 41-year-old mother of three in Hermosa Beach, has a 6-year-old son with cystic fibrosis, a serious progressive lung disease. Her son, Massimo, takes about a dozen medications, with costs well into the thousands of dollars each month.

Armato and her family are luckier than many: They have good insurance that limits their total spending on Massimo's care to about $6,000 a year. But that is still enough to make them rethink spending plans at times. "I'm always going to prioritize my son's care," Armato says.

She likes the new law. "I think transparency about how much a patient is spending and what their financial obligations are is really important," she says.

Some families coping with cystic fibrosis and other expensive illnesses face much starker trade-offs — choosing between treatment and paying their rent, for example. In those cases, it can be indispensable to know when the financial hemorrhaging will stop, easing pressure on the family budget.

The new law can also be useful if you, like many people, postponed an elective surgery because of the pandemic — a hip replacement or cataract removal, for example — and want to reschedule it now. The best timing, financially speaking, will be when you are close to reaching your deductible and out-of-pocket spending limit — or if you already have reached them. If you know where you stand, you can schedule the procedure for a time when your financial liability will be minimal.

The law might also help people avoid paying money they don't actually owe. "Sometimes when people see any kind of bill, they think they need to pay it," says Jen Flory, a policy advocate at the Western Center on Law & Poverty, which supported the legislation. "So unless they understand that, 'Oh, I reached my deductible, or my out-of-pocket max,' people panic and do whatever they need to do to pay the bill. And it can be hard to get the money back from providers if they pay unnecessarily."

Although your insurer is not required to provide your out-of-pocket status until the law takes effect in July, you can still call the customer help line and ask for it — or for clarification about a bill. If you don't get the answer you want, ask your health plan to tell you who regulates it, and call that agency. It would usually be the Department of Managed Health Care, at 888-466-2219 or HealthHelp.ca.gov, or the California Department of Insurance, reachable at 800-927-4357.

If you need help sorting through heaps of medical bills, you could hire a professional patient advocate, who will typically charge you a percentage of the amount they save you. To find patient advocates in your area, log on to www.advoconnection.com

To see if you qualify for free assistance, try the Patient Advocate Foundation (www.patientadvocate.org or 800-532-5274), which helps people resolve unaffordable health bills and also provides disease-specific, need-based financial aid.

Record-High Marketplace Enrollment, New Census Data, And More
Katie Keith

On September 15, 2021, the U.S. Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) issued new data showing record-high effectuated enrollment through marketplace coverage under the Affordable Care Act (ACA). In total, 12.2 million people were actively enrolled in marketplace coverage as of August 2021. Mid-year enrollment peaked thanks to the more than 2.8 million people who enrolled during the Biden administration's broad six-month COVID-19 special enrollment period (SEP). The new data was released alongside a statement from the White House and a separate report showing continued record-high enrollment in Medicaid and CHIP.

This post also discusses the latest Census data that showed a stable uninsured rate during 2020, new grants to 28 states and the District of Columbia, and a quality rating information bulletin that outlines requirements for marketplaces ahead of the 2022 plan year.

Record-High Marketplace Enrollment

HHS's new report shows that more than 2.8 million people newly enrolled in marketplace coverage during the six-month COVID-19 SEP that ran from February 15 to August 15. The SEP was initially slated to run until May 15 but was extended to August 15, in part due to the enhanced premium tax credits made available under the American Rescue Plan Act (ARPA). Of the 2.8 million people, 2.1 million people enrolled through the 36 states that use HealthCare.gov while an additional 738,000 people enrolled through the 15 state-based marketplaces.

Consistent with the data reported throughout the SEP, enrollment is significantly higher relative to prior years. New HealthCare.gov enrollment for 2021 was nearly three times and nearly four times higher than for 2020 and 2019, respectively. The SEP also increased enrollment among people of color; a higher proportion of SEP enrollees identified as African American or Hispanic/Latino relative to prior years.

HHS emphasized the importance of enhanced ARPA subsidies to new and existing consumers. More than 90 percent of consumers who newly enrolled during the SEP qualified for marketplace subsidies, and 48 percent of new HealthCare.gov consumers paid premiums of $10/month or less. The average premium for new HealthCare.gov consumers fell by 30 percent, from $117 in 2020 to $81 in 2021.

Existing HealthCare.gov consumers also saw savings. Existing consumers had premiums reduced, on average, by $53 per month (i.e., savings of about 49 percent). Many existing consumers—about 2.7 million—actively returned to HealthCare.gov to "claim" and apply their savings while HealthCare.gov automatically reduced premiums for 2.6 million existing consumers. Over 8 million existing consumers saved a total of $537 million.

HHS also reported on the impact of ARPA's special subsidy rule for those who received or were approved to receive unemployment benefits in 2021. Since July 1 (when this benefit was rolled out on HealthCare.gov), nearly 209,000 consumers have qualified. Of these, 34,000 would not have been eligible for marketplace subsidies at all in the absence of ARPA because they would have fallen in the Medicaid coverage gap.

More generous ARPA subsidies also meant that consumers were able to enroll in more generous coverage. The median deductible for new HealthCare.gov enrollees fell by more than 90 percent (from $750 in 2020 and 2019 to $50 in 2021). This is because more low-income consumers qualified for a zero-premium plan with cost-sharing reductions that resulted in platinum-equivalent coverage (i.e., a plan with a 94 percent actuarial value) with the lowest out-of-pocket costs.

The ARPA subsidies also increased the number of higher-income people who enrolled in coverage. Those with an income over 400 percent of the federal poverty level accounted for 7 percent of enrollment compared to less than 2 percent in prior years. This is unsurprising: individuals at this income level were not previously eligible for marketplace subsidies until ARPA eliminated the "subsidy cliff." Enrollment levels were even higher in state-based marketplaces where 12 percent of new SEP consumers had an income over 400 percent of the federal poverty level.

The enrollment report includes even more state-specific statistics and breakdowns by marketplace type. SEP enrollment was significantly higher—about 2.5 times higher—in states without Medicaid expansion. California, Florida, Georgia, North Carolina, and Texas saw six-figure gains in marketplace enrollment during the SEP. The state-based marketplaces in California, Connecticut, the District of Columbia, Nevada, New Jersey, New York, and Vermont are continuing their SEPs through the end of the year.

Effectuated Enrollment Data

When added to existing enrollees, the additional 2.8 million SEP enrollees bring total marketplace enrollment to 12.2 million people as of August 2021. Note that marketplace enrollment has been higher in prior years: nearly 12.7 million people and 12.2 million people enrolled during the 2017 and 2018 open enrollment periods, respectively. But effectuated enrollment during those years dropped following the open enrollment period. As a result, 12.2 million people enrolled as of August 2021 represents record-high effectuated marketplace enrollment.

Report On Medicaid And CHIP Enrollment

Separately, CMS issued a report showing continued historic enrollment through Medicaid and CHIP, with more than 82.3 million people enrolled as of April 2021. This is an increase of nearly 581,000 people relative to March 2021, suggesting that people continue to newly qualify for and rely on Medicaid. Relative to February 2020, enrollment through Medicaid and CHIP has increased by 16.4 percent (11.6 million individuals). Medicaid enrollment increased by 17.8 percent (11.4 million people) while CHIP enrollment increased by 2.9 percent (194,000 people).

Continued enrollment is driven in part by the COVID-19 SEP. While the number of Medicaid/CHIP applications submitted directly to states dropped slightly in April 2021 (compared to March 2021), the number of applications sent to states by HealthCare.gov was up significantly beginning in March 2021, as people visited HealthCare.gov to apply for marketplace coverage but were referred to Medicaid or CHIP. Indeed, the marketplace report discussed above shows that 14 percent of those who applied for coverage through HealthCare.gov (541,000 people) were eligible for Medicaid or CHIP. The is consistent with a similar pattern observed during the annual marketplace open enrollment period: the federal marketplace transferred a high number of applications to states in November and December 2020.

Maintenance of effort requirements included under the Families First Coronavirus Response Act are also contributing to sustained high enrollment. In that legislation, Congress provided a 6.2 percentage point increase in the federal match rate for state Medicaid programs so long as states provide continuous enrollment throughout the declared public health emergency. The public health emergency is expected to be in effect through at least the end of 2021, and federal officials pledged to give states at least 60 days advance notice of any change. The Biden administration has already given some guidance to states about how to process pending eligibility and enrollment actions at the end of the declared public health emergency. CMS also adopted a monthly SEP for low-income individuals to help ensure that those who are churning off of Medicaid coverage can successfully transition to marketplace coverage.

Another Report Shows Stable Uninsured Rate For 2020

On September 14, the Census Bureau issued its report on health insurance coverage for 2020. In 2020, 8.6 percent of people (28 million people) were uninsured. This was not significantly different from the uninsured rate of 8.5 percent (27.5 million people) in 2018, the recommended year of comparison.

(Consistent with other recent analyses, the uninsured rate remained stable despite economic upheaval and job loss from the pandemic. However, this uninsured rate might be artificially low because it does not reflect people who lost coverage during 2020. The survey asks only if someone was uninsured during the entire year (rather than at some point during the year). The pandemic also complicated the fielding of the survey so the data may be less reliable than prior years. For instance, respondents in 2020 and 2021 generally had a higher income and educational level relative to prior years.)

Of those with coverage, most (66.5 percent) had private insurance. More than half of the population had employer-sponsored coverage (54.4 percent), followed by Medicare (18.4 percent), Medicaid (17.8 percent), individual market coverage (10.5 percent), and military coverage (3.7 percent). There was an increase in the percentage of people covered through public programs, but this uptick was observed in Medicare as opposed to Medicaid.

Most of the trends were generally consistent with prior years. Coverage rates among adults increased as age increased. More children (those under age 19) were uninsured in 2020 relative to 2018 (which itself was an increase from prior years). Young adults remained the least likely to be insured in 2020, and those aged 19 to 25 had the highest uninsured rate (14.4 percent) of any age group. Hispanic individuals had the highest uninsured rate (18.3 percent), followed by Blacks (10.4 percent), Asians (5.9 percent), and non-Hispanic Whites (5.4 percent). People of color also had higher rates of enrollment in public coverage while non-Hispanic Whites had higher enrollment in private coverage.

Coverage rates generally increased as income increased. Households with income at or above 400 percent of the federal poverty level had the highest coverage rates while those whose income is below 300 percent of the federal poverty level had double-digit uninsured rates. Uninsured rates for low-income people would be lower if more states expanded their Medicaid program. In 2020, the uninsured rate was 8.9 percent for expansion states versus 17.6 percent for non-expansion states. And non-expansion states saw a 2.6 percentage point increase in the uninsured rate among those living in poverty relative to 2018.

CMS Awards State Flexibility Grants

On September 15, CMS announced $19.6 million in new grant funding for insurance departments in 28 states and the District of Columbia. This two-year funding is to “enhance and support the role of states in the implementation and planning for several of the federal market reforms and consumer protections.” States were able to request funding to evaluate and bolster implementation of only certain market reforms—guaranteed issue, guaranteed renewability, or coverage of the essential health benefits package. Funding awards ranged from $660,000 in Nevada to $698,500 in Pennsylvania.

The announcement does not provide specific detail on each state’s activities except to note which reforms each state will address. Most states will focus on all three market reforms. Grant funds can be used to, for instance, implement or enhance policy form review, hire a clinician to review drug formularies, develop actuarial and economic analyses, perform market scans, and bolster market conduct examinations, market analysis, financial examinations, and consumer complaint investigations.

CMS announced the two-year grant funding in November 2020. This is the second round of funding under this grant opportunity: CMS previously awarded just over $8.6 million in funding to 30 states and D.C. in August 2018. The funding stems from Section

2794 of the Public Health Service Act, which directed the HHS Secretary to administer a five-year grant initiative to support state rate review programs. Congress appropriated $250 million for the rate review program, with four cycles of rate review grants where all but seven states received a grant. Funds that were not obligated by the end of fiscal year 2014 remain available for grants to states for planning and implementing the market reforms and consumer protections under Part A of Title XXVII of the Public Health Service Act.

Quality Rating Information Bulletin For 2022

On August 18, CMS issued a new bulletin with guidance to all marketplaces and direct enrollment entities on the display of quality rating information for the 2022 plan year. Quality ratings—which reflect clinical quality data and enrollee satisfaction data—use a five-star system and have been displayed for most marketplace plans since 2019 (for the 2020 plan year). Before that, quality rating information was only available through five federal marketplace states and some state-based marketplaces.

In light of the pandemic, CMS opted to continue to display quality rating information from plan year 2020 for plan year 2021. In the new bulletin, CMS will extend this policy to plan year 2022, meaning that quality rating information that will be displayed during the upcoming open enrollment period will be the same as in 2021 and 2020 (i.e., the quality rating information calculated during the 2019 rating year). The bulletin also includes marketing guidance for insurers. This guidance appears to be consistent with prior requirements; more technical requirements outlined in September 2020 guidance.

State-based marketplaces should be prepared to display quality rating information for 2022 but will continue to have some display flexibility as outlined here. CMS will provide new ratings data files for the qualified health plans offering coverage in state-based marketplace states. Direct enrollment entities, which had previously had enforcement discretion not to display quality rating information, must do so.

The American Rescue Plan Act (ARPA) passed earlier this year temporarily expanded subsidies available in the Affordable Care Act (ACA) health insurance Marketplaces, building on the ACA's existing subsidies. Through the end of 2022, low-income families who were already eligible for financial assistance under the ACA are eligible for even

more financial help to buy their own health insurance and pay for their copays and deductibles for coverage bought on healthcare.gov or their state's exchange. Additionally, middle income families who were often priced out of ACA coverage before the ARPA, are now eligible for financial help with their monthly insurance premiums for the first time.

These new and additional subsidies were created under the ARPA as part of a larger pandemic relief strategy, but Democrats have long favored similar strategies to reduce the cost of ACA marketplace plans to enrollees. And the state of California, along with a handful of other states, had already implemented its own state-funded subsidies to address premium affordability. One of the key criticisms of the ACA has been the high and rising premiums, particularly for working families with incomes over four times the poverty level (a little more than $50,000 for a single person or just over $103,000 for a family of four), who previously were not eligible for financial assistance. While the relief package did not directly address high cost-sharing for these enrollees, larger premium subsidies can help them afford plans with lower deductibles.

Now, there is a debate in Congress over whether to make these additional premium subsidies permanent, or at least extend them for a longer time period. On the one hand, if Congress extends the ARPA subsidies or makes them permanent, federal costs would increase. On the other hand, if Congress does not extend these subsidies, premium payments will rise sharply for nearly all marketplace enrollees.

If the ARPA subsidies are extended, federal costs will rise

The Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) originally estimated that the additional temporary subsidies provided under the ARPA would increase federal deficits by $34.2 billion. Most of that cost is concentrated in the first couple of years since the additional subsidies expire at the end of 2022, though CBO expected some lingering costs as some subsidized people would remain enrolled for a time, even after the ARPA subsidy enhancements end.

The Department of Health and Human Services (HHS) reports that ARPA subsidies for existing consumers cost $537 million per month. It is likely these costs could rise next year as more people take up coverage during open enrollment.

If subsidies expire, premium payments could double for millions of Marketplace enrollees

According to HHS, the 8 million marketplace enrollees who signed up before the ARPA subsidies were enacted are now paying $68 per month, after accounting for an average monthly premium savings due to the ARPA of $67. Without the ARPA subsidies, premiums would double on average for these enrollees and they would pay an average of $800 per year more if enrolled for the full year.

Premiums or deductibles would increase most steeply for the lowest-income Marketplace enrollees

People with incomes between 1 and 1.5 times the poverty level currently represent 42% of enrollees, and, with the ARPA subsidies, now pay nothing or next to nothing for their monthly premium. Before the ARPA, these individuals had to contribute more than 2% of their income toward the benchmark silver plan premium. These lowest-income enrollees would therefore see the steepest percent increases if ARPA subsidies expire.

Because of these premium increases, some low-income people may move from very generous silver plans with deductibles under $200, to bronze plans with deductibles of about $7,000 – more than 30 times higher. HHS reports that the median deductible in the federal marketplace decreased by more than 90%, from $750 in 2020 to $50 in 2021, because some low-income enrollees moved from bronze to silver plans.

Millions of middle-income people would lose subsidy eligibility

Middle income individuals and families also buy coverage in the marketplace when they don't have access to job-based group plan coverage. These include people who work for small businesses that don't offer group health benefits, gig and other self-employed workers, and people who retire early, before the age of Medicare eligibility. We estimate that 3.7 million people (most with incomes between 4 and 6 times poverty) gained subsidy eligibility with the ARPA.

Under the ARPA, the vast majority of people buying their own health insurance coverage can be sheltered from premium increases by taking advantage of the subsidies offered in the ACA marketplace. If these subsidies expire, though, middle and upper-middle income people who lose subsidy eligibility will not only have to make up the difference in the subsidy; they will also be on the hook for any increase in the "sticker price" of the premium between now and January 1, 2023.

Although these individuals earn a living wage, it is often not enough to afford full-priced insurance. A 48-year-old making $60,000 per year would see their monthly premium payments increase by 36% if they lost subsidy eligibility, and that doesn't account for any additional increase in the sticker price of premiums. Families and older enrollees would see even larger premium increases.

Without a subsidy, a 60-year-old's health insurance premium currently averages more than $11,000 per year. If that 60-year-old has an income just above $51,000 – over four times the poverty level – their ARPA subsidy covers more than half of their monthly costs. Without the ARPA, their premium would increase 165%.

The timing of potential premium increases could have political implications

In the event ARPA subsidies are allowed to expire, the timing of the resulting impact on insurance affordability could become an election issue. The ARPA premium subsidy enhancements are set to expire at the end of 2022. Open enrollment begins on November 1, just one week before the midterm election is held on November 8, 2022.

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Uninsured Adults Remain Unaware of ACA Coverage, Subsidy Options
Kelsey Waddill

September 28, 2021 - Despite the White House's efforts to increase awareness about Affordable Care Act marketplace health plans, uninsured adults are still largely unaware of their coverage options, according to a fact sheet from Urban Institute.

The researchers leveraged Urban Institute's Health Reform Monitoring Survey to analyze whether uninsured individuals were aware of their coverage and financial aid options through the Affordable Care Act.

Nearly half of all uninsured, nonelderly Americans (48.2 percent) had heard of the Affordable Care Act marketplaces. Around seven in ten individuals in the nonelderly, uninsured population reported that they had not heard any information or only a little information about the health insurance subsidies that are available to qualifying uninsured groups.

The researchers noted that there was very little difference between the results from the April 2021 survey and the outcomes from a similar survey that Urban Institute fielded in September 2020.

In the September 2020 survey, 53.9 percent of respondents said that they had heard a lot or some about the Affordable Care Act marketplaces, but almost 65 percent had heard nothing or very little about the subsidies and financial supports available to them.

These problems persisted into April 2021. Most of the uninsured individuals who had heard about the marketplaces but had not enrolled in coverage reported cost as their primary concern and barrier to enrollment.

Younger adults and unemployed individuals were less likely to be aware of the marketplace plans or the subsidy options available.

Of the individuals who had not heard anything or had heard very little about their marketplace and financial assistance options, 27.7 percent spoke Spanish or were bilingual, 15.5 percent did not have internet access, 47.8 percent were not working, and 20.6 percent had a high school degree or less.

To the researchers, these results emphasized the need for improved outreach strategies. In particular, policymakers should focus on refining outreach efforts for the

younger adult populations and should work through unemployment offices to reach the unemployed community with marketplace and subsidy information.

“Without well-targeted outreach and enrollment assistance efforts, uninsured adults’ knowledge gaps could keep some from taking advantage of newly expanded enrollment opportunities and subsidies under the American Rescue Plan,” the researchers explained.

“Outreach will need to be multilingual and accessible for people with different levels of education, be available across various platforms (online and offline), and use trusted community members (e.g., community health centers, community colleges, legal aid workers, and employers).”

Despite the low awareness among currently uninsured individuals, the Affordable Care Act marketplaces received a significant enrollment boost in 2021 due to the special enrollment period.

As part of this effort to increase Affordable Care Act marketplace enrollment, the US Department of Health and Human Services (HHS) dedicated at least $50 million on outreach efforts during the special enrollment period. The funds went toward broadcast and digital advertising as well as email and text communications with consumers.

CMS also offered $2.3 million in grant funding to 30 eligible Navigator organizations in order to provide better support to individuals considering their options on the Affordable Care Act marketplaces.

The agency is already preparing to further escalate consumer support and outreach efforts for the Affordable Care Act’s 2022 open enrollment. CMS announced that it will be offering $80 million to 60 Navigator organizations and estimated that this funding could allow the organizations to hire 1,500 Navigators for plan year 2022.

The grantee organizations must be dedicated to targeting underserved populations with their outreach efforts, CMS specified.

Although the funding starts in 2022, the grants are for a full three-year cycle and CMS will distribute the funds annually. With this regular funding, CMS leaders expressed the hope that Navigator organizations would be able to provide more consistent and efficient support.

California first to let kids add parents to insurance plans
Adam Beam

SACRAMENTO, Calif. (AP) — California is the first state to let some adult children add their parents as dependents on their insurance plans, a move advocates hope will cover the small population of people living in the country illegally who don't qualify for other assistance programs.

The trend nationally has been to let children linger on their parents' health insurance plans. Former President Barack Obama's health care law let children stay on their parents' plans until age 26. Some states have gone further and let kids stay on their parents' plans until at least age 30, including Florida, Illinois, Pennsylvania and New Jersey.

But California is now the first state to go the other direction by letting some adults join their kids' health insurance plans. Gov. Gavin Newsom, a Democrat, signed the law this week, but it won't take effect until 2023.

"The signing of the Parent Healthcare Act will help more families care for their parents the way they cared for us," Insurance Commissioner Ricardo Lara said.

To be eligible, adults must rely on their child for at least 50% of their total support. The law applies only to people who buy their health insurance on the individual market. Those who get insurance through their jobs, which includes most people in the state, aren't eligible.

That makes the law much cheaper. A previous version, which would have applied to more people, could have increased employer premiums between $200 million and $800 million per year, depending on how many people enrolled. That prompted business groups, including the California Chamber of Commerce, to oppose the bill — winning key concessions.

This narrower version of the law ensures far fewer people can enroll. The California Department of Insurance estimates just 15,000 adults will use this law, prompting an annual increase of between $12 million and $48 million per year for individual premiums, according to an analysis by the Senate Appropriations Committee. The change was enough for the Chamber of Commerce to remove its opposition.

The law's author, Democratic Assemblyman Miguel Santiago of Los Angeles, said it targets people who can't get subsidized health insurance because they are living in the country illegally.

Covered California, the state's health insurance marketplace, offers discount insurance plans — but only to citizens. California's Medicaid program offers government-funded insurance to people 50 and over and 25 and younger regardless of their immigration status. But some adults might be ineligible because they make just over the income limits.

The University of California Berkeley Labor Center predicts more than 3 million people won't have health insurance in California next year, 65% of them people who are living in the country illegally.

The law is "a way to close that gap," Santiago said, while also helping other adults who "fall through the cracks."

"We all talk about increasing health care access, and here was a real easy way to do it," he said.

ACA In The States: New State-Based Marketplaces, Section 1332 Updates
Katie Keith

With all eyes have been on Congress in recent weeks, federal and state officials have made several new announcements or requests related to the Affordable Care Act (ACA). This post summarizes those recent developments, including three states transitioning to state-based marketplaces for 2022 and new Section 1332 waiver developments. The latter topic area includes new comment periods on waiver extension requests, evaluation reports for three states, and Colorado's request for a waiver amendment.

State-Based Marketplaces In Kentucky, Maine, New Mexico For 2022
On October 4, 2021, the Centers for Medicare and Medicaid Services (CMS) announced that Kentucky, Maine, and New Mexico were approved to transition from HealthCare.gov to their own state-based marketplaces beginning with the 2022 plan year. The more than 173,000 enrollees who are currently enrolled through

HealthCare.gov in these states will be able to renew their 2022 coverage through kynect in Kentucky, CoverME in Maine, and beWellnm in New Mexico. Consistent with HealthCare.gov, the open enrollment period for these marketplaces will begin on November 1, 2021.

All three states most immediately had a state-based marketplace on the federal platform where the state ran the marketplace but used the HealthCare.gov platform (instead of state technology) for eligibility and enrollment. That said, some of these states' paths to a state-based marketplace were longer than others. Kentucky had a state-based marketplace that was considered highly successful until it was shuttered under Gov. Matt Bevin (R) beginning with the 2017 plan year; Kentucky residents had been using the federal marketplace until current Gov. Andy Beshear (D) recommitted to a Kentucky-specific marketplace. New Mexico was late in establishing its marketplace and relied on the federal platform to ensure an on-time launch in 2013. And Maine's interest in transitioning from HealthCare.gov coincided with the tenure of current Gov. Janet Mills who was elected in 2018. (Louise Norris has even more information on the history of marketplace establishment in Kentucky, Maine, and New Mexico.)

Kentucky, Maine, and New Mexico follow in the footsteps of Nevada, which transitioned for 2020, and New Jersey and Pennsylvania, which both transitioned for 2021. Ahead of the 2022 plan year, there are thus 18 state-based marketplaces and 3 state-based marketplaces on the federal platform, while 30 states will continue to use the federal marketplace.

Other states may transition in the future. Virginia has operated as a state-based marketplace on the federal platform since the 2021 plan year and state officials are working to establish a full state-based marketplace for the 2023 plan year.

Section 1332 Waiver Updates
When we most recently revisited Section 1332 waivers, most states had been notified about additional federal pass-through funding they will receive for 2021; Georgia had rebuffed a request for updated data from CMS; and states had requested waiver extensions or amendments. CMS had also finalized a new marketplace rule that revised Trump-era interpretations of Section 1332 and established a more formal process for states to request extensions of or amendments to approved waivers. The following summarizes even more recent developments.

Hawaii And Other Waiver Extension Requests
Colorado was the first state to be approved for a five-year extension of its current Section 1332 waiver for a state-based reinsurance program, while Alaska, Hawaii, Maine, Oregon, and Wisconsin each submitted letters signaling their intent to apply for five-year waiver extensions or amendments. Except for Maine (whose request is

discussed here), these states asked for a simple extension and would make no changes relative to their existing programs.

Hawaii's request—for a 5-year extension of its current waiver—was submitted in late April 2021. Hawaii is the only state whose waiver does not include a state-based reinsurance program. Instead, Hawaii waived the ACA's small business health options program (SHOP) and related requirements through December 31, 2021. The state's waiver extension request would continue to waive the same requirements—such as the establishment of a SHOP, employee choice, the definition of qualified employer, and certain qualified health plan requirements—through 2026. The extension request was deemed complete on September 14, which marked the beginning of a 30-day federal comment period that ends on October 14. Federal officials will issue a decision within 90 days of September 14.

Colorado's Waiver Amendment Request For Public Option Plans
In July 2021, Colorado submitted a letter of intent to apply for a waiver amendment to incorporate its new standardized public option plans. As discussed here, insurers in the individual and small group markets must, beginning with the 2023 plan year, offer a Colorado Option plan at premiums that are up to 15 percent lower than current premiums. Colorado wants to amend its current waiver to receive additional federal pass-through funding that reflects these new premium savings. The state intends to use the additional federal pass-through funding to help make coverage more affordable for individuals who do not currently qualify for marketplace subsidies.

CMS responded on October 4 to confirm that the application will be reviewed as an amendment request and to encourage Colorado to submit its waiver amendment application by November 30. The response also outlined the information that Colorado must submit as part of its amendment application. In general, it seems that the state must submit much of the same information as would be required if it were filing a brand-new application. The application must include a detailed description of the amendment request, demonstrate compliance with state public notice requirements, identify the state's legal authority for the waiver, provide updated actuarial and economic analysis regarding Section 1332's guardrails, and explain the expected impact on federal pass-through funding.

Section 1332 Evaluation Reports For Alaska, Minnesota, And Oregon
On October 5, CMS issued evaluation reports of Section 1332 waivers in Alaska, Minnesota, and Oregon. These were the first states with approved Section 1332 waivers for state-based reinsurance programs that began in 2018. The analyses were conducted by researchers at RAND Health Care on behalf of CMS and the Office of the Assistant Secretary for Planning and Evaluation; this is the "first set" of federal evaluations of Section 1332 waivers. Each evaluation report addressed the waiver's

impact on 1) enrollee premiums for certain bronze, silver, and gold plans; and 2) individual market enrollment by income and subsidy status (i.e., income). Reinsurance wonks will want to review the reports closely.

Overall, the programs in Alaska and Minnesota led to double-digit premium reductions for the relevant bronze, silver, and gold plans (relative to what premiums would have been in the absence of the waiver). The largest premium savings were realized by unsubsidized enrollees which led to higher enrollment of about 2,800 people in Alaska and about 66,000 people in Minnesota. In Minnesota, the waiver may have increased premiums for subsidized enrollees in the lowest-cost bronze plan, but RAND Health Care found no impact on enrollment across the three income categories that were studied. Overall, the researchers conclude, the Section 1332 waivers helped stabilize each state's individual health insurance market.

The Oregon analysis was less conclusive. The waiver may have helped slow premium growth but did not necessarily reduce premiums or increase enrollment (relative to what would have occurred in the absence of the waiver). There was a decrease in coverage for an estimated 3,000 people with incomes from 351 to 400 percent of the federal poverty level—but no other significant enrollment effects for other subsidized populations. Qualitative interviews could help fill in some gaps in the data to better assess the impact of Oregon's waiver.

Two million poor people were left behind by the ACA. Democrats might finally fix it
Jennifer Haberkorn

WASHINGTON — For most of her adult life, Amy Bielawski has gone without health insurance.

Her small Atlanta-area business, which provides entertainment for parties and events, didn't bring in enough revenue to afford coverage. So she has gotten by on the hope that her high blood pressure doesn't get worse and her small pituitary tumor doesn't grow.

"I try to be as healthy as I possibly can so I'm not needing to run to the doctor, but there's no backup plan when something goes wrong," she said.

Bielawski, 56, is one of the people the 2010 Affordable Care Act, known as Obamacare, was supposed to help. But the Supreme Court in 2012 said the law's Medicaid expansion provision had to be optional, and several Republican-led states refused to embrace it.

That left about 2 million people, mostly in Southern states, caught without any access to health coverage because they are considered too wealthy to qualify for Medicaid, which targets lower-income people, and too poor to qualify for Obamacare subsidies. In states like California, which expanded Medicaid under ACA, the gap is not a problem.

As congressional Democrats consider President Biden's "Build Back Better" plan, a sweeping bill to reshape the nation's social programs, they are debating whether to finally close this Medicaid coverage gap, the most significant piece of unfinished business from the Democrats' health law.

But it faces a mountain of challenges: The social safety net bill's programs will probably be cut or curtailed to reduce the overall costs. Limited healthcare dollars are pitting Medicaid against other proposals to expand Medicare for everyone and ACA subsidies for middle-income people.

Sen. Joe Manchin III (D-W.Va.) says expanding Medicaid would allow for federal funding of abortion, a line he refuses to cross, even though other Democrats say it would not do so. And in the Senate, where Democrats have no margin for error, there are few advocates besides its most junior members.

"There are hundreds of thousands of my constituents who lack basic access to healthcare because my state's Republican leadership refuses to expand Medicaid," said Sen. Jon Ossoff (D-Ga.), whose surprise runoff-election win in January, alongside fellow Democrat Sen. Raphael Warnock, gave Democrats control of the Senate. "It is those voters who delivered the Senate majority."

About 60% of the people in the gap in 2019 were people of color, exacerbating long-held disparities in health access by race.

"Democrats in the House and Senate all realize that solving for the Medicaid expansion gap is the single most important thing we can do for racial equity in healthcare in this bill," said Leslie Dach, founder and chair of the health advocacy group Protect Our Care.

Early drafts of the bill would call for the ACA's subsidies to be expanded to the Medicaid gap population for three years. By 2025, a federal program that mimics a state-run Medicaid program would provide coverage.

Manchin, who as the Senate's most conservative Democrat is among its most closely watched, has two concerns about the Medicaid expansion. He is worried about how to pay for it and he says the Medicaid expansion would allow for the federal funding of abortion.

He insists that the longtime ban on federal funding of abortion, known as the Hyde Amendment, be added. But many other Democrats would oppose such a move. "I do not want to see the Hyde Amendment expanded in this bill, and I don't see any reason why it should be," said Sen. Patty Murray (D-Wash.).

Even if they wanted to, the Senate parliamentarian in 2017 said in an informal ruling that the Senate cannot add Hyde language to a bill passed through the special filibuster-proof procedure Democrats are using to enact their plan.

Democrats are adamant they don't want to see a debate about abortion derail their bill. But federal funding of abortion nearly halted the ACA in 2010 and ended other seemingly bipartisan health initiatives. "There is a supreme irony here. If you're pro-life, then you ought to support a bill that saves lives," Warnock said.

Democrats are considering eliminating the second portion of their plan — the federal Medicaid add-on in 2025, according to several Democrats familiar with the discussions. It would reduce the cost as well as eliminate Manchin's concern. But it would expose Medicaid beneficiaries to losing their coverage in 2025.

Medicaid is also squaring off against two other politically popular health proposals in the bill: expanding either the ACA or Medicare, the healthcare program for seniors.

In recent days, progressives in the Senate and House have made clear that Medicare expansion — to cover vision, dental and hearing — is a non-negotiable for them. And while they haven't proposed cutting Medicaid, Democrats will at some point have to make difficult decisions about what will get axed. That's because their once-$3.5 trillion bill is being narrowed down to about $1.5 to $2 trillion to meet the demands of Manchin and other centrists.

A proposal to require drugmakers to negotiate their prices in Medicare — a money-saving plan designed to fund the expansions in new coverage — is expected to be pared down, too, requiring more belt-tightening.

Expanding Medicare benefits would help about 61 million seniors and provide new benefits that would probably be politically popular with reliable voters.

But the optics will be harsh if Democrats provide more benefits to middle-class people through the ACA expansion or people of all income levels — including the wealthy — through an expansion of Medicare benefits, while leaving people who make less than $12,880 per year exposed in the 12 states coping with the gap.

“I think we’ve got to do everything,” Sen. Bernie Sanders (I-Vt.) said when asked whether Medicaid could be left out. “There is a reason why Medicare is an enormously popular program and that is it is effective. It provides care to all of our people. It is universal.”

Several Democrats, particularly in the Senate, have quietly expressed frustration that they will have to spend their already limited dollars to bail out Republican governors who already have access to other federal dollars if they merely overcome their political opposition to Obamacare and choose to expand Medicaid.

Sen. Tammy Baldwin (D-Wis.), whose state didn’t expand, is pitching to fellow Democrats that the Medicaid expansion should be carved out of the price tag since Congress originally approved the funding back in 2010. “This is something that we have already contemplated and set aside funds for and we should look at it in a unique light because of that,” Baldwin said.

Medicaid is a more significant priority in the House than the Senate.

House Majority Whip James E. Clyburn (D-S.C.), whose state is one of those that did not expand, has made Medicaid a priority. Speaker Nancy Pelosi (D-San Francisco) has prioritized beefing up the ACA subsidies as well as Medicaid. Several House Democrats represent districts in states that didn’t expand coverage and they’re pressing their leadership to make sure it stays in the bill.

But in the Senate, there are only three Democrats who represent states that did not choose to expand the program: Baldwin, Ossoff and Warnock — the latter two are the chamber’s two most junior senators.

A few months ago, Bielawski got health insurance for the first time in years and has already been to the doctor. The Democrats’ COVID-19 relief bill, approved in March, provided heavily subsidized ACA coverage to anyone who collected unemployment benefits this year.

She’s said she’s worried about losing it again and troubled by the inequity that leaves people in some states without coverage.

“That seems wrong, doesn’t it,” she said. “There should be some sort of all-country [program.] Some things should be equal.”

Lower premiums, more choices on Obamacare exchanges for 2022 as Democrats battle to extend generous subsidies
Tami Luhby

(CNN) Consumers shopping for health coverage on the federal Affordable Care Act exchanges can likely find lower premiums and more choices for 2022 -- as well as generous government assistance, according to a Biden administration report released Monday.

The upcoming open enrollment period, which begins November 1 and runs through January 15, is the first for President Joe Biden, who is seeking to restore the landmark health reform law after the Trump administration spent four years trying to undermine it.

It comes as the Obamacare exchanges are seeing increased interest amid the coronavirus pandemic. An additional 2.8 million people signed up for coverage on the federal and state marketplaces during a 6-month special enrollment period that Biden launched in mid-February.

A record 12.2 million Americans were enrolled in Affordable Care Act policies, as of mid-September.

However, Biden and congressional Democrats are also trying to make sure that 2022 isn't the final year the American Rescue Plan's enhanced premium subsidies will be in place. They had hoped to make the beefed-up assistance permanent as part of their $3.5 trillion social spending plan, but it looks like the extension will be pared back to only a few years as the party seeks to shrink the bill's price tag to bring moderate Democrats on board.

Lower premiums

The average premium for the benchmark silver plan in 2022 will decline by 3% a month for the 33 states that are participating in the federal exchange, healthcare.gov, according to the report, issued by the Centers for Medicare & Medicaid Services.

This is the fourth year in a row that premiums have dropped, as insurers are better able to price their policies based on enrollees' health care needs and as the marketplaces become more competitive. The average benchmark plan premium is 10% lower for a 27-year-old and 9% lower for a family of four than in 2018, before subsidies, for example.

"While inflation seems to be increasing prices for a lot of the products that we need and use, the good news is when it comes to health care at the Affordable Care Act exchanges, there's a good chance you'll see a drop in the price of your premiums," Health and Human Services Secretary Xavier Becerra told CNN.

But even fewer people will pay the sticker price for 2022 coverage thanks to the enhanced premium subsidies. The average lowest-priced plan for federal exchange enrollees will cost $41 a month after assistance, compared to $441 without subsidies. Many lower-income enrollees can pick policies with no monthly premium or ones costing just a few dollars.

Four out of five consumers will be able to find coverage for $10 or less, after enhanced subsides, according to the agency.

The Democrats' $1.9 trillion coronavirus relief plan, which Biden signed in March, made two changes to the subsidies to address long-standing complaints that Obamacare plans are not affordable for many people, particularly the middle class.

Enrollees pay no more than 8.5% of their income toward coverage, down from nearly 10%. And lower-income policyholders receive subsidies that eliminate their premiums.

Also, those earning more than 400% of the federal poverty level -- about $51,000 for an individual and $104,800 for a family of four in 2021 -- are now eligible for help for the first time.

The subsidy enhancement, which the Biden administration is heavily touting in hopes of further boosting enrollment, is in effect for this year and next, unless Congress acts.

About 12 million people selected policies or were automatically re-enrolled in coverage during last year's open enrollment period for 2021, the first time sign ups increased during the Trump administration.

Shop around
Still, even with the enhanced subsidies, it's important for people to actively shop for 2022 coverage, rather than let themselves be rolled over into the same plan, said Cynthia Cox, director for the Program on the ACA at the Kaiser Family Foundation.

With so many new insurers offering plans, it's possible that less expensive options are available.

Also, subsidies are tied in part to the premium for the benchmark plan in one's area, which could change every year. If the premium for the 2022 benchmark plan declines, then the subsidy amount could too. Those in more expensive policies could wind up paying even more each month.

"The subsidies can shelter most enrollees from paying any premium increase, but that depends on the enrollee being willing to switch plans," Cox said. "If they are not willing to switch plans or if they just passively re-enroll, then they could be on the hook for a premium increase. It's important to know what you are getting into."

More choices
Some 213 issuers will participate in the federal exchange in 2022, 32 more than this year. Enrollees will have access to between six and seven issuers and more than 107 plans, on average. Both are greater than previous years.

The Centers for Medicare and Medicaid Services is also pouring more money into helping people sign up for coverage -- an effort that was drastically scaled back under the Trump administration.

Some 60 navigator organizations received $80 million in grants for the 2022 plan year. Almost $11.5 million in additional funding is available to these groups to support additional outreach, education and enrollment activities during the expanded sign up period for the federal exchange. The sign up season ended on December 15 under the Trump administration.

"We have also quadrupled the number of navigators available to guide consumers through the sign-up process, and lengthened the open enrollment period," Becerra said.

The agency is also conducting a national broadcast advertising campaign, along with targeted digital efforts. It is working with cultural marketing experts to reach communities with less access to health care, including African Americans and Latinos.

"We're going to make sure that we get the word out," he said, noting that the agency has really beefed up the advertising budget. "We are also targeting communities that have often been left out, that don't get reached."

Three states create their own exchanges
Three states -- Kentucky, Maine and New Mexico -- launched their own exchanges for 2022. Doing so gives them more control over negotiating with insurers on cost, as well as running and marketing their open enrollment periods.

Maine, for instance, is providing $350,000 for a statewide consumer help line and training and technical assistance for 2022, up from $200,000 this year.

The switch to a state-based marketplace will also save residents money since they will no longer have to pay a surcharge on premiums levied by the federal exchange. In Kentucky, for example, enrollees are expected to save at least $15 million a year..

But it faces a mountain of challenges: The social safety net bill's programs will probably be cut or curtailed to reduce the overall costs. Limited healthcare dollars are pitting Medicaid against other proposals to expand Medicare for everyone and ACA subsidies for middle-income people.

ACA Litigation Round-Up (11/9/21): What's Resolved, What's On Hold, And What's Still Moving?
Katie Keith

Much litigation over the Affordable Care Act (ACA) and ACA-related issues remains on hold pending review by the Biden administration. But there has been movement in some ACA cases. This post summarizes the latest developments in pending litigation. The lawsuits discussed here include:

- Cases currently pending before the Supreme Court (on Section 1557, the health insurance tax, and hospital reimbursement policies);
- Lawsuits that are resolved or nearly resolved (on an immigration proclamation, the double billing rule, the SUNSET rule, and unpaid risk corridors payments);

- Challenges that are currently on hold (on association health plans, the provider conscience rule, Georgia's Section 1332 waiver, unpaid cost-sharing reductions, and the contraceptive mandate); and
- Lawsuits that are proceeding or have been newly filed (on the preventive service mandate, Section 1557, the insurer transparency rule, and the Data Marketing Partnership arrangement).

Supreme Court Happenings
The most high-profile ACA-related litigation, California v. Texas, ended in June 2021 when the Supreme Court upheld the law. While there are no similar existential threats to the ACA at this time, the Supreme Court will continue to hear ACA-related litigation.

Section 1557
The Supreme Court will soon hear two challenges related to Section 1557 of the ACA, which is the law's chief nondiscrimination provision and prohibits health programs or facilities that receive federal funds from discriminating based on race, color, national origin, age, disability, or sex. Section 1557 incorporates existing federal civil rights statutes, including Title VI of the Civil Rights Act of 1964 (which bars discrimination based on race, color, and national origin) and Section 504 of the Rehabilitation Act of 1973 (which bars discrimination based on disability). Section 1557 and several of these existing statutes also incorporate Title VI's remedies for victims of discrimination; this includes the right to recover "compensatory damages."

The Supreme Court will hear two separate challenges—Cummings v. Premier Rehab Keller and CVS Pharmacy v. Doe—that address the scope of protections under existing civil rights statutes and, by extension, Section 1557. In Cummings v. Premier Rehab Keller (which will be heard on November 30), a physical therapy provider, Premier Rehab Keller, refused to provide Jane Cummings (who is deaf and legally blind) with an ASL interpreter to help treat her chronic back pain. Cummings sued, alleging that the refusal discriminated based on her disability and violated the Rehabilitation Act and Section 1557. She asked for damages for the emotional distress caused by her experience.

But the district court dismissed her suit after concluding that "compensatory damages" do not include damages for emotional distress. The Fifth Circuit Court of Appeals agreed, and the Supreme Court agreed to hear Cummings' appeal. The Court is being asked to resolve a circuit split since the Eleventh Circuit Court of Appeals has allowed damages for emotional distress. The Justices will consider whether compensatory damages under Title VI (and, by extension, the Rehabilitation Act and Section 1557) include compensation for emotional distress.

The issue is important because, as Cummings argues, those who face discrimination should be able to seek and recover damages related to the humiliation, anguish, and other noneconomic injuries that they might face. Briefs in support of Cummings were filed by the Department of Justice, disability advocates, and civil rights organizations led by the NAACP, among others. Briefs in support of Premier Rehab Keller were filed by a coalition of Republican attorneys general led by Texas, state and local officials led by the National Conference of State Legislatures, and business/insurance entities led by the U.S. Chamber of Commerce, among others.

In CVS Pharmacy v. Doe (which will be heard on December 7), the Supreme Court could resolve a circuit split on a separate question related to Section 504 of the Rehabilitation Act and Section 1557. This lawsuit was filed by patients living with HIV who argue that CVS improperly restricted access to certain HIV medications by requiring patients to use a mail or local CVS retail pharmacy to obtain in-network rates (as opposed to a community pharmacy). These restrictions, they argue, prevent the patients from consulting with their local pharmacist, invade patient privacy by sending HIV medications through the mail, and could result in delayed or lost shipments.

This policy, the plaintiffs argue, adversely and disproportionately affects enrollees with HIV and discriminates on the basis of disability. The Court agreed to hear the appeal but will limit its review to whether Section 504, and by extension Section 1557, provide a disparate impact cause of action for those that allege disability discrimination.

Briefs in support of the patients were filed by the Department of Justice, disability advocates such as the AIDS Healthcare Foundation and The Arc, the NAACP, the Center for Health Law and Policy, and the National Health Law Program, among others. Briefs in support of CVS were filed by America's Health Insurance Plans, state and local officials led by the National Conference of State Legislatures, the U.S. Chamber of Commerce, the Pharmaceutical Care Management Association (PCMA), and a coalition of Republican attorneys general led by Louisiana, among others. A separate brief filed by Democratic attorneys general led by DC supported neither side and urged the Court to resolve the case on other grounds.

Health Insurance Tax

We are waiting to see whether the Court will hear an appeal filed by a coalition of Republican attorneys general, led by Texas, on whether states are entitled to recoup the ACA's health insurance tax as it applies to Medicaid managed care entities. Judge Reed O'Connor, a federal district court judge in Texas, held that six plaintiff states were owed nearly $500 million for the health insurance tax from 2014 to 2016. He concluded that parts of a federal regulation issued in 2002 violated federal nondelegation doctrine by authorizing private entities—the American Academy of Actuaries and the Actuarial Standards Board—to "effectively rewrite the ACA."

A three-judge panel of the Fifth Circuit Court of Appeals disagreed, reversing Judge O'Connor's decision in 2020. Following a request from Texas for en banc review, the Fifth Circuit upheld the panel's conclusion but issued a revised ruling. The request for en banc review was denied over the dissent of four judges who argued that the regulation unconstitutionally subdelegates lawmaking power from an administrative agency (rather than Congress) to a private entity.

Texas filed its cert petition on September 3 and asked the Court to consider whether the regulation violates the nondelegation doctrine. The government's response would have been due on October 8, but federal officials requested, and received, an extension to file their response on November 8. It is unclear if the Court will agree to hear the appeal or not.

Other Health Policy Cases

While not discussed in detail here, the Supreme Court will hear several important health policy-related cases this term. The Court heard oral argument in two cases involving an unprecedented Texas law that has virtually halted abortion access in Texas. Those challenges focus primarily on procedural issues related to Texas' unique law. But the Court will hear a separate challenge, Dobbs v. Jackson Women's Health Organization, on December 1. Dobbs is a challenge to a Mississippi law that would ban nearly all abortion after 15 weeks and could upend long-standing Court precedent on the constitutional right to an abortion in Roe v. Wade and Planned Parenthood v. Casey.

On November 29 and 30, the Court will hear oral argument in Becerra v. Empire Health Foundation and American Hospital Association v Becerra, respectively. Both cases are complicated but involve judicial review of interpretations made by the Department of Health and Human Services (HHS) and thus could be relevant to ACA and other health policy cases.

In Empire Health Foundation, the Court will consider HHS's methodology for calculating the disproportionate share hospital adjustment and whether part of this calculation improperly includes individuals who are "entitled" to benefits under Medicare Part A but for whom the Medicare program does not pay for (such as those who exhausted their inpatient benefits). American Hospital Association focuses on whether HHS can adjust hospital outpatient drug reimbursement rates for Section 340B hospitals without first collecting cost surveys and other data.

In the meantime, the Court has still not resolved litigation over the Trump administration's approval of Medicaid work requirement waivers in Arkansas and New Hampshire. The Biden administration has been revisiting approved waivers, and Arkansas' work requirements waiver expires at the end of 2021.

Resolved (Or Near-Resolved) Cases
The Biden administration has resolved some litigation over Trump-era policies, including the “double billing” rule, an immigration proclamation, one lawsuit over the insurer transparency rule, and the SUNSET rule. Biden officials also previously resolved litigation over the public charge regulations and Title X regulations; however, new lawsuits on those issues have been filed.

The double billing rule required insurers to bill for abortion coverage separately from their billing for other coverage. The rule never went into effect after being set aside by two district courts whose decisions were appealed to the Fourth and Ninth Circuit Courts of Appeals. While the appeals were held in abeyance, the Biden administration repealed these requirements in a regulation finalized in September 2021. The courts voluntarily dismissed the appeals soon thereafter. Separately, litigation over a Trump-era immigration proclamation pending before the Ninth Circuit was vacated as moot after President Biden revoked the proclamation.

There have been two challenges, one by the U.S. Chamber of Commerce and one by PCMA, to the Trump-era transparency rule for health insurers, which is based on legal authority under the ACA. Following an announced delay in some of the rule’s requirements, the Chamber of Commerce voluntarily dismissed its challenge in August. But the PCMA challenge is proceeding.

Lawsuits over how much insurers are owed in unpaid risk corridors have, to my knowledge, now been settled. But some insurers objected to the $185 million in contingency fees that one of the law firms is set to receive for its role in the risk corridors litigation. That issue is now being litigated (go figure).

Litigation over the SUNSET rule is not yet resolved but could be soon. The SUNSET rule would have added global expiration dates to most current HHS rules and could have caused nearly 20,000 rules to expire automatically unless HHS took further action. This rule was challenged in early March and stayed. The lawsuit was cited by HHS in a subsequent rule that delayed the original effective date by one year—to March 22, 2022. On October 28, HHS issued a new proposed rule to repeal the SUNSET rule in its entirety with comments due on December 28. The plaintiffs in the legal challenge praised the move and suggested they will continue to watch the rulemaking process play out

There is continued litigation over the Trump-era public charge rule and new litigation over the Biden administration’s new Title X rule. Challenges to the public charge rule were dismissed from the Supreme Court earlier this year, and the Biden administration swiftly issued a final rule rescinding the Trump-era provisions. Federal officials

subsequently issued an advance notice of proposed rulemaking. But that has not stopped states from trying to keep the Trump-era litigation alive: on October 29, the Supreme Court agreed to consider whether states can intervene to defend a federal regulation—in this case, the prior public charge rule—when the federal government ceases to do so.

Challenges to the Trump-era Title X rule were similarly dismissed from the Supreme Court in 2021, and the Biden administration has since issued a new final rule and funding for the program. On October 25, a coalition of Republican attorneys general, led by Ohio, challenged the latest Title X rule and asked for a preliminary injunction to prevent the rule from going into effect or being enforced. Ohio had previously argued that parts of the Trump-era interpretation are compelled by the text of Title X. There is also a separate lawsuit in Texas that challenges parts of the Title X program for not complying with Texas state laws before providing contraception and family planning services.

Cases On Hold

Many pending ACA-related cases remain on hold. This includes litigation over the association health plan rule (before the Court of Appeals for the District of Columbia Circuit); the provider conscience rule (before the Second and Ninth Circuits); and the approval of part of Georgia's Section 1332 waiver (before district court in DC). In these challenges, the Biden administration asked for the lawsuits to be held in abeyance, citing the need to consult with new agency leadership or follow other processes (such as evaluate Georgia's waiver in light of updated data). These requests have generally been unopposed by the plaintiffs and granted by the courts. The parties are required to submit regular status reports. HHS has consistently indicated that it continues to reconsider or reassess the issues in the litigation.

In a separate slate of challenges, insurers and the federal government are working to resolve disputes over owed unpaid cost-sharing reductions. This activity kicked into high gear after the Supreme Court declined to review a decision from the Federal Circuit that held that insurers were owed unpaid cost-sharing reductions (but that this amount must be reduced by any additional premium tax credits that the insurer received because of premium loading). While the lawsuits are stayed, the parties have filed status reports noting that the insurers and government are "in initial talks regarding potential avenues" to resolve the lawsuits in a way that avoids further litigation.

Litigation over the scope of the ACA's contraceptive mandate—including challenges to the statute itself, an Obama-era rule, and Trump-era rules—is pending before district courts in California, Indiana, Pennsylvania, and Texas as well as the First and Fifth Circuit Courts of Appeals. Most of these cases have been stayed.

Most recently, the Supreme Court issued a decision on the contraceptive mandate in 2020. In Little Sisters of the Poor v. Pennsylvania, the Court held that the federal government had the authority to allow religious and moral exemptions to the contraceptive mandate but did not rule on whether the two Trump-era rules at issue were arbitrary and capricious. A district court in Massachusetts concluded that the rules were neither arbitrary and capricious nor unconstitutional. This ruling was appealed to the First Circuit and then put on hold. Other litigation remains pending before district courts in California, Indiana, and Pennsylvania but those challenges have also been stayed. As discussed here, the Biden administration told the courts that it intends to initiate new rulemaking on the contraceptive mandate within six months.

There is also a pending challenge before the Fifth Circuit. DeOtte v. Becerra, another case decided by Judge O'Connor, was a successful class action challenge to the Obama-era rule on the contraceptive mandate. The Trump administration did not defend the mandate, agreeing with the plaintiffs on the substantive legal issues. The Fifth Circuit heard oral argument in late April, and we are waiting for a decision to be issued. (A prior contraceptive mandate case, Leal v. Becerra, was dismissed as moot by the Fifth Circuit.)

Cases That Are Proceeding

In the meantime, some ACA-related litigation is continuing. These lawsuits focus on the ACA's preventive services mandate, Section 1557, the insurer transparency rule, and the Data Marketing Partnership arrangement.

Preventive Services Mandate

There are continued (and separate) legal challenges to the ACA's preventive service mandate under Section 2713 of the Public Health Service Act and the ACA's contraceptive mandate (which is part of Section 2713). The entire preventive services mandate is being litigated in a case called Kelley v. Becerra, pending before Judge O'Connor.

The plaintiffs in Kelley argues that Section 2713 violates the Appointments Clause, the Vesting Clause, and the nondelegation doctrine. They ask the court to declare that Section 2713 is unconstitutional and unenforceable and that all preventive service mandates under Section 2713 are no longer required to be covered. They further argue that some of the recommendations—to cover contraceptives and pre-exposure prophylaxis (PrEP) to prevent HIV—also violate the Religious Freedom Restoration Act (RFRA).

Judge O'Connor has scheduled discovery to be completed by October 2021, and briefing will begin in mid-November and continue through early 2022. A decision is

expected next year and could significantly impact the coverage of preventive services for millions of people.

Section 1557
In addition to the Section 1557-related challenges pending before the Supreme Court, there are pending and new lawsuits over how Section 1557 has been interpreted by the Trump and Biden administrations. Lawsuits over the Trump-era rule are pending before the DC Circuit, the Second Circuit, and district courts in DC, Massachusetts, and New York, but have been on hold. HHS intends to issue a new proposed rule on Section 1557 no later than April 2022. This has not, however, satisfied all the plaintiffs in these cases, leading some to ask that the stays be lifted (i.e., to allow the litigation to resume). The Biden administration opposed these requests, and the courts have granted the government's request to keep the litigation on hold.

In the meantime, the Eighth Circuit Court of Appeals is considering a recent decision by a district court in North Dakota that held that parts of the Obama-era rule on Section 1557 and interpretation of Title VII violate RFRA. More specifically, the district court prohibited HHS and the EEOC from interpreting or enforcing Section 1557 or Title VII against the Catholic plaintiffs in a way that requires them to cover or perform medical procedures for gender transition. The Biden administration appealed this ruling to the Eight Circuit and proceedings are ongoing.

Other lawsuits are focused on new Biden-era interpretations. A case known as Franciscan Alliance was recently resolved after Judge O'Connor granted a group of religious providers' request for a permanent injunction. This prevents HHS from interpreting or enforcing Section 1557 and implementing regulations in a way that would require those plaintiffs to perform, or provide insurance coverage for, services related to gender transition or abortion. In issuing a permanent injunction, Judge O'Connor cited the Supreme Court's decision in Bostock v. Clayton County and an HHS announcement in May 2021 that it would interpret Section 1557's ban on sex discrimination to include discrimination on the basis of sexual orientation and gender identity. He may soon clarify his order in response to a request from the Department of Justice to do so.

In August 2021, two new class action lawsuits were filed: one in Tennessee by a coalition of medical providers and one in Texas by physicians. Both argue that HHS's interpretation of Bostock is inconsistent with the text of Section 1557 and ask the court to declare it invalid and permanently enjoin HHS from using or enforcing this interpretation. Setting aside the plaintiffs' strained reading of Bostock, it remains unclear how plaintiffs have standing to challenge an interpretive statement where there is no indication that the new interpretation will be applied to or result in enforcement action against them.

Insurer Transparency Rule
As noted above, PCMA's lawsuit over the Trump-era health insurer transparency rule is proceeding before the federal district court in DC. The government has been granted an extension until November 9 to file a response to PCMA's complaint. Briefing will continue from there.

Data Marketing Partnership Arrangement
The Fifth Circuit may soon hear an appeal of a district court decision by Judge O'Connor that blessed another alternative to ACA coverage. Briefing was completed in mid-July. Amicus briefs were filed by the National Association of Insurance Commissioners, individual state insurance commissioners, insurers, state attorneys general, patient advocates, and consumer advocates in support of the federal government's position. One amicus brief was filed in support of Data Marketing Partnership.

CMS Announces 60-Day Comment Period On Georgia's Section 1332 Waiver
Katie Keith
On November 9, 2021, the Centers for Medicare and Medicaid Services (CMS) and Department of the Treasury opened a new 60-day comment period to solicit input on Georgia's waiver under Section 1332 of the Affordable Care Act (ACA). Georgia was notified of the new comment period in a separate letter.

The announcement come after months of negotiation between federal and state officials. CMS and Treasury repeatedly asked Georgia to provide updated actuarial and economic analyses necessary to assess Georgia's waiver, known as the Georgia Access Model, in light of recent federal legal and policy changes. Georgia rebuffed these requests, and federal officials made clear that the state may be violating the conditions of its waiver approval agreement. Comments are due on January 9, 2022.

Brief Background
Under Section 1332, states may be approved to waive certain ACA requirements if a state demonstrates that their waiver proposal meets statutory "guardrails." How to interpret these guardrails has been a point of debate, but most approved waivers have been for noncontroversial state-based reinsurance programs.

Georgia is the only state to have been approved for a broad Section 1332 waiver to restructure its individual market. Georgia's waiver includes two phases: a state-based reinsurance program in 2022 and elimination of HealthCare.gov (without transitioning to a state-based marketplace) in 2023. This second phase of the waiver is known as the Georgia Access Model and would make Georgia the only state without a single one-stop-shop marketplace for consumers in need of private health insurance. Instead of a single marketplace such as HealthCare.gov, consumers would transition to a decentralized enrollment system that uses web-brokers and insurers beginning in 2023. The waiver was approved in November 2020.

Approval of the Georgia Access Model was controversial and challenged in court (although the litigation remains on hold). Prior interpretations of Section 1332 and Georgia's waiver are described in more detail in prior posts.

In June 2021, CMS issued its first request for updated actuarial and economic analyses of the baseline for Georgia's waiver. Federal officials wanted to evaluate the waiver in light of changes under the American Rescue Plan Act (ARPA), the broad COVID-19 special enrollment period, and increased federal funding for outreach and marketing. Georgia's updated analysis would have been posted for a 30-day public comment period. Georgia rejected this request, raising concerns that CMS wanted to "reopen" the waiver approval process.

CMS responded on July 30, noting that federal officials are not trying to reopen approval of the waiver. Rather, CMS is reviewing all approved waivers in light of federal changes and requesting additional information as part of continued monitoring and oversight. The specific terms and conditions (STCs) in Georgia's waiver approval require Georgia to comply with federal data reporting requirements. This includes submission of "data sufficient to show compliance" with Section 1332's guardrails and "other information the Departments determine is necessary … to evaluate the waiver." CMS then extended its deadline, giving Georgia until August 29 to submit the requested data.

On August 26, Georgia again rebuffed CMS's request and declined to provide updated analyses. In a more forceful response, Georgia argued that the cited federal policy changes did not justify a decision to reopen the waiver approval process. ARPA subsidies are irrelevant, state officials argued, because the enhanced subsidies phase out in 2023 and will thus have no effect when the state's waiver goes into effect. (While this is true, ARPA subsidies are expected to have some spillover effect on 2023 coverage.) Georgia also suggested that federal officials could not conduct monitoring and oversight of an approved waiver until after that waiver has actually taken effect and offered only a cursory explanation as to why the waiver continues to satisfy Section 1332's guardrails.

Georgia indicated that it would proceed with implementation of the waiver as approved, leaving CMS and Treasury to decide what to do next.

New Comment Period
On November 9, CMS and Treasury announced a new 60-day comment period and urged Georgia to submit the requested analysis during this period as a way "to demonstrate compliance with the STCs." Federal officials reiterate the need to assess continued compliance with Section 1332 guardrails in light of increased marketplace enrollment (stemming from recent federal changes). CMS and Treasury reviewed all approved Section 1332 waivers in light of these changes and determined that additional information is needed to assess the Georgia Access Model. The letter to Georgia suggested again that the state may not be in compliance with federal rules or STC 6 in its own waiver agreement. Comments are due on January 9, 2022.

Federal officials request supporting data and analysis of how changes in federal law and policy impact Georgia's waiver and baseline. They suggest information that would be helpful for their analysis, provide a list of background documents, and provide additional background on Georgia's waiver. CMS and Treasury will use the comments to inform further evaluation of the Georgia Access Model and whether it continues to meet Section 1332's guardrails.

The documents also highlight some of the changes that have already occurred (thanks to ARPA and the COVID-19 special enrollment period) since Georgia's waiver was approved in November 2020. About 356,500 Georgians benefitted from ARPA subsidies, and Georgia marketplace consumers saw a 54 percent reduction in average monthly premiums. Nearly 150,000 of these Georgians signed up for marketplace coverage during the COVID-19 special enrollment period. This is an increase of more than three times the number of consumers who enrolled during the same period in 2020 (about 41,000 plan selections) and 2019 (nearly 26,000 plan selections).

CMS also expects its investments in marketing ($100 million during the COVID-19 special enrollment period plus $150 million during the 2022 open enrollment period) and outreach ($80 million for the navigator program for 2022) to increase enrollment. Georgia will have three navigator grantees supported through $2.54 million for the 2022 plan year, with the expectation that these investments will continue or even increase over time, leading to higher enrollment.

Each of these changes has or will contribute to higher marketplace enrollment and decrease the number of uninsured people in Georgia relative to the data in Georgia's waiver application. Yet, data on the state's uninsured rate, CMS and Treasury note, was a "core part" of the state's actuarial analysis. Overall, federal officials are concerned that

Georgia's analyses are based on now-outdated assumptions that must be revisited to assess compliance with Section 1332's guardrails.

Why does the uninsured rate matter? With fewer uninsured people relative to when the waiver was approved, private entities may be less motivated to invest in outreach. Indeed, Georgia's waiver assumed that private sector outreach would offset any coverage losses that might occur as Georgia transitioned away from HealthCare.gov. With more people now enrolled in marketplace coverage, there is a smaller base of uninsured consumers (meaning fewer incentives for private sector investments in outreach) and greater potential for coverage disruption during the transition. Both could lead to fewer individuals with coverage under the waiver compared to the number who would have been covered without the waiver, which would violate the coverage guardrail under Section 1332.

While CMS and Treasury do not name the Build Back Better Act, they recognize the possibility of future legislation that impacts the individual health insurance market and invite commenters to note any potential impact to the waiver and statutory guardrails. If Congress were to pass the draft legislation currently under consideration by the U.S. House of Representatives, two of the major ARPA subsidy enhancements would be extended through the 2025 plan year and could significantly impact Georgia's waiver assumptions.