COVERED CALIFORNIA Media Clips

COVERED CALIFORNIA BOARD CLIPS

May 1, 2025 – May 15, 2025

Since our last board meeting, the media coverage includes:

- Covered California's push to improve health care as federal cuts loom.
- Google and LinkedIn facing class action lawsuit following Covered California data incident.
- State-based Marketplaces make a push for enhanced premium tax credits.
- Rep. Kiley requests investigation into Covered California data incident.
- Debate and discussion around the effects of Medicaid cuts.
- A look at the impact of Trump's first 100 days on health care.
- Gov. Newsom pivots on policy of providing Medi-Cal coverage for undocumented residents

PRESS RELEASES

None to report

PRINT

Articles of Significance

Covered California Pushes for Better Health Care as Federal Spending Cuts Loom
KFF Health News.....May 2, 2025

Also in Los Angeles Times, CALÓ News, CapRadio, Times of San Diego, California Healthline, The Business Journal, Stocktonia, and LAist

After CalMatters investigation, LinkedIn and Google face lawsuit alleging improper access to health data
CalMatters.....May 2, 2025

Also in The Markup, KQED, Bloomberg Law, LAist, Local News Matters, Times of San Diego, and Sing Tao Daily

House bill could eliminate ACA employer health coverage mandate

The bill would keep some other Affordable Care Act coverage rules and add a Roth health savings account program.

By Allison Bell | May 01, 2025 at 02:28 PM

U.S. Capitol building in Washington. Photo: Diego M. Radzinschi/ALM

A new House bill could eliminate the Affordable Care Act employer health coverage mandate and also make many other changes in federal health insurance rules.

Rep. Pete Sessions, R-Texas, introduced a new version of the Health Care Fairness for All Act bill Tuesday.

The new bill is identical to a bill Sessions introduced in May 2023.

Like the earlier version, the new version would adopt many changes that have been popular with Republicans without repealing either the entire Affordable Care Act or the ACA provisions that apply to major medical insurance.

One section confirms that many of the most popular ACA rules, such as the current ban on medical underwriting, would stay in effect. But the bill would discourage people from waiting until they get sick to pay for coverage by letting plans charge a 20% late-enrollment

penalty for people who enroll in new coverage without having had other coverage in place for at least 12 months.

Other provisions would support state efforts to create association health plans and endorse state use of high-risk pools to provide health coverage for high-risk individuals, according to a bill summary.

Roth HSAs: Another Sessions bill provision could replace the current health savings account system.

Today, taxpayers can deduct HSA contributions from taxable income. Taxpayers must use HSAs together with high-deductible health plans.

Sessions' bill would replace today's HSAs with "Roth HSAs," or HSAs that resemble Roth individual retirement accounts. Roth IRAs let people put after-tax income in their retirement accounts, and then pull cash out later in life without paying taxes on the distributions.

In Sessions' Roth HSA system, taxpayers would contribute after-tax income to their HSAs. In exchange for using after-tax income to fund the HSAs, they could combine the HSAs with ordinary, low-deductible health coverage.

Bill mechanics: Sessions serves on the House Oversight and Accountability Committee and the House Financial Services Committee.

His bill is under the jurisdiction of the House Energy and Commerce Committee, House Ways and Means Committee and House Education and the Workforce Committee.

The earlier version of Sessions' bill had six Republican cosponsors and died in committee.

The new version may have a chance to go farther, because Republicans sympathetic to Sessions' goals now control the House, the Senate and the White House.

One question will be how the administration of President Donald Trump would see an effort to change the current ACA framework.

Trump implied during a debate in September that he would like to replace the ACA major medical insurance rules.

But, at least for now, Trump's administration appears to be assuming that most ACA major medical insurance coverage rules and programs will continue to be in place for at least the next few years.

The ACA employer exchange data gap: Feds want enrollment numbers

The freshest numbers that lawmakers' research office could get are from 2017.

By Allison Bell| May 09, 2025 at 02:16 PM

Researchers who help members of Congress understand federal programs still can't find out how many employers use the Affordable Care Act public health insurance exchange program to cover their workers.

Vanessa Forsberg, an analyst at the Congressional Research Service, revealed the ACA public exchange data gap earlier this week when she published an updated guide to the ACA exchange program.

The 63-page guide provides detailed information about how HealthCare.gov works and how state-based exchanges like Covered California work.

The ACA public exchange system has helped 24 million people get individual or family coverage, but, originally, the system was also supposed to provide a way for small employers to use federal tax credits to buy small-group health insurance through the "small business health options program," or SHOP exchange system.

Some jurisdictions — including California, Colorado, Massachusetts, Vermont and the District of Columbia — do have active SHOP exchange programs, but half have no health

plans available through a SHOP exchange, or no SHP coverage access at all, according to Forsberg.

Forsberg also tried to answer a nagging question: How many employers have SHOP coverage and how many participants participate in SHOP plans?

The Centers for Medicare and Medicaid Services, the arm of the U.S. Department of Health and Human Services, has published detailed individual exchange enrollment data.

CMS has rarely released SHOP usage data, possibly because usage in many states was low.

Republicans now control both the House and the Senate, and a Republican is president and in charge of CMS. But Forsberg still was unable to get any SHOP usage figures compiled for coverage years after 2017.

CMS reported that 27,000 employers were using SHOP plans to cover 233,000 people in 2017, according to Forsberg.

That was up from 10,700 employers using the plans to cover 85,000 people in 2015.

The U.S. Government Accountability Office reported in 2019 that Rhode Island, Vermont and the District of Columbia were the only jurisdictions where the SHOP exchange accounted for more than 3% of enrollment in the small-group market, according to Forsberg.

Telemarketers Are Using a Weird Trick to Sell Bare-Bones Health Plans

How a former TV comedy writer's fake-job loophole could blow up Obamacare.

By Zachary R Mider and Zeke Faux

May 5, 2025 at 9:00 PM UTC

Joe Strohmenger, a self-employed contractor in Rocky Point, New York, had never shopped for health insurance before. So last year, when he needed to, he did what a lot of people do: He Googled it.

The internet search led him to a website that offered free quotes. He typed in his number, and his phone rang immediately. It rang hundreds of times over the next few days as telemarketers vied to reach him.

The plan Strohmenger and his wife, Sarah, ended up buying from one of those salesmen sounded like normal health insurance, they say. They got the impression that it covered all the basics, including hospitalization and emergency-room visits. The telemarketer even promised, they say, that it would cover the pricey specialist monitoring Joe's benign brain tumor.

But after paying $8,734 for a year's coverage, the Strohmengers learned the plan didn't include those things. In fact, it was so bare-bones that selling it in the US would normally be illegal.

Only months later did the Strohmengers learn how the salesman pulled it off. At the time he enrolled them in the health plan, he also signed up Joe for a fake job at a tech company in Georgia. Joe says was never told about the job, never got paid and never did any work. But the bogus relationship opened a loophole that the salesman used to sidestep most insurance laws.

Without meaningful coverage, the Strohmengers started avoiding medical care. Joe, who's 40, skipped visits to the tumor doctor. Sarah, 39, tried and failed to get a refund. When they contacted the New York state insurance regulators, they said they were unable to help.

"How can someone take this much money from us and no one do anything about it?" says Sarah Strohmenger, who runs a skin-care boutique near her home on the north shore of Long Island. "Why is no one regulating this?"

Joe and Sarah Strohmenger and their health plan ID cards. The photograph at right has been altered to conceal numbers associated with personal information. Photographer: Lila Barth/Bloomberg

The Strohmengers are among more than 100,000 US households that have bought plans tied to fake jobs in recent years, data compiled by Bloomberg News show. And their experience echoes complaints from hundreds of consumers across the country, according to a review of government records and interviews with customers, salespeople and regulators. But because the plans are backed by obscure companies with names like Socios Buenos and Vitamin Patch, not by insurance carriers, it's unclear who, if anyone, has the authority to regulate them.

Some Republican officials have endorsed the legal theory behind the plans, seeing it as a way to deregulate the US health-insurance system without congressional action. That theory is the subject of a long-running dispute in a federal court in Texas that may be resolved in the coming months. Favorable action by the Trump administration or a judge could bring the plans to millions more customers and reshape health insurance in America. It might also make a fortune for the former TV comedy writer behind it all.

"We thought we could just contact someone and buy insurance"

The flurry of calls bombarding Joe's phone was the first sign the Strohmengers had stumbled into a sketchy corner of the health-care industry. They hadn't expected it to be this way. Joe was looking for insurance after he gave up his union plan to start a small business installing tile and renovating bathrooms. "This was all new," Joe says. "We thought we could just contact someone and buy insurance."

But if you look for health insurance on the internet, you might end up talking to a telemarketer offering a cheap product that, in the end, doesn't provide much coverage. Policy experts call it "junk insurance."

The heart of the industry is South Florida, where hundreds of call centers clutter the boulevards and office parks around Fort Lauderdale. Even though junk policies are cheaper than plans sold under the Affordable Care Act, the 2010 law known as Obamacare, they pay bigger commissions, making them more profitable to sell and leaving less money to fund claims. Fast-talking salespeople have been known to use fake names, pose as government workers and pretend plans are backed by Aetna Inc. or Blue Cross & Blue Shield. Top earners flaunt gold chains and Lamborghinis on Instagram. The products they sell are varied. Fake-job plans are the newest addition to the lineup.

Not long after the calls started coming in, Joe heard a pitch that sounded promising, so he set the phone on the kitchen table, allowing Sarah to join in. On speaker was a 24-year-old salesman named Tylor Trego. His agency, Quick Health, was located near Reading, Pennsylvania, but the setup wouldn't have been out of place in Florida: a noisy room

crammed with about 40 desks and phones, with salespeople pushing cheap, low-benefit plans.

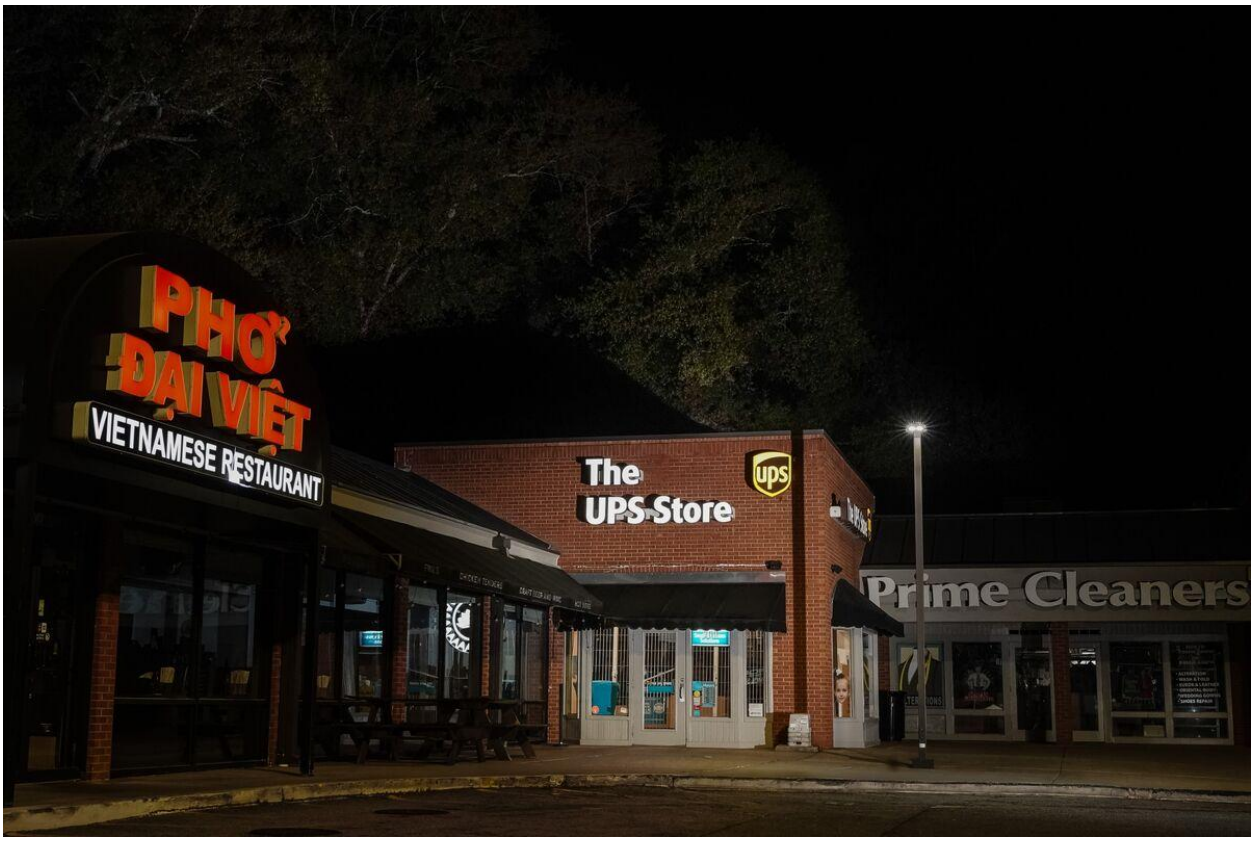
Although Quick Health had been in business only a few years, it had already been banned in four states for using deceptive sales scripts, selling without a license, lying about coverage and committing other offenses. It had even attracted the attention of the Federal Bureau of Investigation, which searched the place in 2022 alongside state insurance officials, seizing computers and questioning employees. No criminal charges have been publicly filed, and the FBI declined to comment.

The Strohmengers weren't aware of any of that. On the phone, the salesman sounded friendly. He told them he'd researched a wide range of options and identified the best plan, Joe recalls. He assured them it would pay for visits to the specialist monitoring Joe's tumor, as well as his $1,500-a-month prescription for a drug to lower his blood sugar, Joe says. The plan wasn't as expensive as they had feared, and the agent told them they could save more by paying for a full year up front.

"It covered everything we needed, and we're like, OK, this isn't that bad," Sarah says, cradling a cup of coffee in her two-bedroom home. "It's embarrassing how stupid we were."

Soon, a pair of white plastic ID cards arrived in the mail. The cards didn't show the name of any insurance company, but they indicated Joe was a "member" of something called Outreach Data Partners LP.

If the Strohmengers had tried to check out their new insurance provider, they probably wouldn't have learned much. Outreach didn't have a public-facing website. It reported 4,800 employees in a government filing, but LinkedIn didn't list a single one. Its headquarters was Box 371 at a UPS store in a strip mall in Atlanta, sandwiched between a dry cleaner and a Vietnamese restaurant.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More than a dozen data companies, "employing" 30,000 people, have shared an address in a single mailbox at a UPS store in Atlanta. Photographer: Elijah Nouvelage/Bloomberg

The Strohmengers didn't examine the cards too closely. The salesman said the coverage was good, so what did it matter?

It mattered. Under Obamacare, health insurance plans sold on the market must cover 10 "essential health benefits," including prescription drugs, emergency-room visits and hospitalization. Employee plans provided by large companies don't have to meet those standards, although most do voluntarily.

Outreach is one of a new breed of companies set up to exploit that gap. By conjuring an employment relationship, however tenuous, with strangers on the telephone, it can sell them plans with far skimpier coverage than required in the Obamacare marketplace.

Here's how it works: At the same time they buy a health plan from a company like Outreach, customers sign papers agreeing to become limited partners and contribute some work. That's enough, these companies contend, to establish an employee relationship under the federal benefits law known as the Employee Retirement Income Security Act, or Erisa. (Joe says he signed some documents electronically without fully reading them during the phone call with the salesman. He says he wasn't provided with a copy afterward.)

The "work" typically involves installing an app on their phones, such as a web browser alternative to Apple's Safari or Google Chrome. The data company harvests information from the app and, theoretically, sells it to advertisers looking for insights on consumer habits. Promoters of the scheme argue that the setup creates an employee relationship, even if the data generates little or no profit.

Not long after the ID cards arrived, the Strohmengers' pharmacy said the plan wouldn't pay for Joe's medication after all. Then his doctor's office said visits weren't covered, either.

So Joe called Quick Health. This time, he got routed to a different salesman, who told him a more expensive version of the plan would cover everything, he says. After a bewildering series of transactions — including a refund that was deposited in their bank account and then retracted — the couple ended up having paid for two policies, plus an extra $1,500 whose purpose was never explained, he says. Now they were out about $20,000, and the new plan didn't meet their needs any better than the old one.

Sarah spent hours last summer trying to get at least something back. Text messages and emails show Quick Health employees promising that as much as $12,000 was on the way, but some technical glitch always cropped up. "This is our hard earned saved money," she texted one employee. "It's disgusting what you are doing to us."

The Quick Health call center near Reading, Pennsylvania. Photographer: Joe Lamberti/Bloomberg

Quick Health Chief Executive Officer Arthur Walsh and two of his lieutenants blame Outreach for some of the Strohmengers' problems. In an interview at the call center, in a commercial building next to a freeway, they say that the data company failed to pay some valid claims. They say the salesmen never misled anyone about coverage, and that one of the refund mix-ups was the Strohmengers' fault. Trego and the other salesman didn't reply to phone calls and emails.

By late July, Sarah had had enough. She filed a complaint with her state insurance department. "New York State will start an investigation," Strohmenger texted a Quick Health executive. "I will be the one that speaks for all of the people that have been scammed by this company."

Normally, state regulators are the first line of defense against insurance companies that don't pay claims or agencies that lie to customers. But the companies that back the fake-job plans aren't insurance companies, and they contend that states have no jurisdiction over them. A few states have tried to ban the plans, with uneven success. Others, including

Maine and Connecticut, merely advised the public to beware. When customers in Texas and Indiana complained about rip-offs, regulators there told them they were unable to help.

Plan sponsors contend the US Labor Department should oversee the plans, but that department doesn't consider them real employers. That leaves the industry in a legal black hole where no one is responsible.

It took just one day for the New York Department of Financial Services to respond to the Strohmengers. "We apologize," a representative wrote, "we are unable to resolve your complaint."

"We apologize we are unable to resolve your complaint"

The Strohmengers' experience parallels dozens of complaints filed across the country with the Better Business Bureau and state and federal regulators. Customers would buy plans from Quick Health thinking they provided comprehensive insurance. When they found out weeks or months later that the plans didn't, they couldn't get a refund.

"They positioned this plan as health insurance and it's NOT," a customer in Birmingham, Alabama, wrote to the Federal Trade Commission. From Dayton, Washington, another complained, "I gave this company MULTIPLE opportunities to make this right before I wrote this letter. I believe they are scamming people."

Others were alarmed to receive papers showing they had become partners in a data-collecting operation, or were required to download an unfamiliar app. "I would have NEVER agreed to be part of a Consumer Data Partner Agreement," wrote a customer in Cleveland. "All I wanted was health insurance."

Still others, like the Strohmengers, didn't recall ever hearing about an app, let alone an employment relationship.

Quick Health didn't misrepresent the plans, doesn't tolerate deceptive practices and has "refunded tens of thousands of dollars in good faith," Walsh says. He faults the health plans themselves for sometimes failing to pay valid claims, leading customers to point the finger at Quick Health. He says he switched to selling Obamacare plans last year. Bill Rush, a Quick Health lawyer, says the company's regulatory scrapes are the result of misplaced blame and mistakes by previous counsel. As for the FBI search, Walsh said in a written statement that it "was part of a broad inquiry involving multiple entities" and that "we cooperated fully."

"We try very hard — maybe because we are a rural, small agency, more a mom-and-pop type situation — to be very customer-centric," says Walsh, who has since left the CEO job. "We want happy, repeat customers."

But Quick Health salespeople were trained to exaggerate the plans' benefits, says Brionna Myers, who worked in sales there for four years, until last spring. She showed Bloomberg a sales script that describes a fake-job plan as an "A-rate provider," comparable to Blue Cross and Aetna but less expensive. "How I would pitch it, and what it actually was, is completely different," she says.

Customers were constantly calling about expected refunds that never arrived, Myers says. The employee responsible for handling them was so notoriously stingy that a co-worker gave her a gag Christmas gift, Myers says — a license plate that said "NO REFUNDS."

Consumers Complain

Hundreds of people have filed complaints with the US Federal Trade Commission, state regulators, the Better Business Bureau and Apple's App Store about health plans tied to fake jobs and the insurance agencies that sold them. Here are a few.

My daughter broke her arm and had to go to the emergency room to have it reset and taken care of. The insurance statements declined all services as items not covered. Now I have over $14,000 in medical bills.My husband had emergency gall bladder surgery. They haven't covered anything from the surgery. I contacted the Washington State Insurance Commissioner and was informed that this company was a self-funded insurance company that they weren't able to regulate.I'm being forced to use this app to have health insurance. If I don't use this app they will cancel my health insurance. How pathetic is that. This app is a joke just like my insurance. Pure subhuman gutter trash.

Outreach isn't the only company to occupy Box 371 in that strip mall in Atlanta. More than a dozen other entities have set up shop there, including Consumer Data Partners, American Partnership Group and Socios Buenos ("Good Partners" in Spanish). In all, these companies boast about 30,000 employees, which would make them one of the largest employers in the metro area. But Google them, and instead you'll find complaints from all over the country about meager health plans and misleading sales pitches.

Not long after Bloomberg started calling people connected with the Box 371 operation last year, a public relations representative got in touch. Soon he was at Bloomberg's office in New York with a wealthy Californian named Bill Bryan — the man behind the plans.

For a guy who wants to transform the US health-insurance system, Bryan, 66, has an unlikely résumé. For most of the 1980s and 1990s, he wrote for television sitcoms including Night Court and Coach. Later came a satirical novel about the reality-TV business.

Bryan says he parlayed his comedy earnings into savvy real estate deals and later ran a senior-living company and started an investment fund. By 2018, a regulatory filing shows, he'd amassed more than $20 million in investments.

During a three-hour interview, Bryan laid out his vision for providing affordable health care to the millions of Americans he sees as "left behind" by Obamacare, especially gig workers and other self-employed people. More than 20 million don't have health insurance, and many who do complain about the price. Why buy an expensive plan, Bryan said, if you could never afford to pay the $9,000 deductible? The solution, he said, is to use the looser rules that apply to employer plans. "The goal is to level the playing field," Bryan said. "We think everybody should be able to get their health insurance that way."

Federal law forbids employers from turning a profit on benefits, so even though Bryan had the idea for the data companies, he can't control or profit from them directly. Instead, he and his business partner, Arjan Zieger, who declined to comment, run a pair of Puerto Rican companies, Suffolk Administrative Services LLC and Providence Insurance Co. These firms handle almost every aspect of the data companies' health plans, charging for plan design, administration and reinsurance.

In 2018, Bryan began distribution of the plans through a network of telemarketers, many in South Florida. The complaints to regulators and the Better Business Bureau started right away. (In a statement, Bryan said he has thousands of satisfied customers and that only a "very small fraction" have complained.)

"Long story short, it turns out that the coverage that i thought i had purchased is for all intents and purposes non existent," wrote a Kentucky woman who'd been hit with medical

bills after signing up for one of Bryan's plans through a call center in Florida. "Nothing seems to be covered at all," a Wisconsin man wrote to his state regulator. "I've never delt with anything this shady in my whole life." The man said that after buying the plan from a Florida salesman, he called the number on the back of his ID card and was told he'd reached a Honda dealership. "Lady that answered the phone says she gets about 25 calls a day, even from doctors."

In Indiana, a nurse practitioner named Brandy Dantzer says she bought a health plan from a salesman after he assured her it would cover her daughter's pregnancy and delivery. It didn't, sticking the family with $30,000 in bills. Bryan says plan documents made clear that maternity wasn't covered.

The Indiana Department of Insurance told Dantzer it couldn't help because she had an employee plan, she says — the first time she heard anything about being an employee. "For two years I was on the phone arguing," she says. "It was all a fraud."

Typical plans cost $200 to $400 a month, with some topping $900. In some cases, documents obtained through public-records requests to Wisconsin and Washington regulators show, the actual value of the plans' medical coverage was as little as 26% of the cost, with the rest of the money going to sales commissions and other fees. By contrast, Obamacare plans are required by law to spend at least 80% on care.

Last year, in New York, Bryan was vague about who was selling the plans or how they got paid. He suggested some agents might be working for free. "There are things that we cannot control," he said. "The truth is, and I will say this much, we don't really have visibility into all that."

Bill Bryan at an event in Los Angeles. Photographer: Araya Doheny/Getty Images

In a more recent interview, Bryan allowed that some agents might be earning big commissions. He said he would prefer to rely less on telemarketers, but a long-running court dispute with the Labor Department has kept traditional brokers away. He added that he'll soon be offering plans with no commissions, sold by an in-house marketing team.

Bryan dismissed the notion that his plans ever denied valid claims, which are processed by licensed, independent administrators, and said he monitors agencies and terminates those with shady practices. Quick Health, he said, had been cut off years ago, after reports of misleading customers.

Told that Quick Health resumed selling his plans after that and was pitching people like the Strohmengers as recently as last year, Bryan said he was shocked. "That is absolutely news to me," he said, his voice rising. "I just don't have anything more to say about any of these motherf---ers."

He later added, in written statements, that his health plans shouldn't be blamed for the actions of third-party marketers and that privacy laws prevented him from fully commenting on customers' experiences. Quick Health, he wrote, "victimized many people, including the Strohmengers — and us."

When Bryan first asked the Labor Department to sign off on his health plans, in 2018, congressional Republicans had just failed to repeal the Affordable Care Act, and the Trump administration was exploring other ways to permit cheaper, less comprehensive coverage. Bryan quickly found allies. Jeff Landry, then Louisiana's attorney general and now its governor, rounded up six other Republican attorneys general to endorse Bryan's plan. Landry didn't respond to a request for comment.

Trump appointees at the Labor Department initially praised the idea, too. One urged Bryan's group not to bother with formal approval, according to a court filing, but to "just do it." So he did.

But then, in 2020, the department issued a six-page opinion concluding that web-surfing work wasn't enough to turn health plan buyers into employees under the law. A Bryan-allied data company sued, persuading a federal judge in Fort Worth, Texas, to rule that the Labor Department got it wrong. An appeals court mostly affirmed that ruling but sent it back to the judge for further review.

In the latest twist, the Labor Department sued Bryan, Zieger and two of their companies in November, accusing them of improperly pocketing millions of dollars in an employee-benefits business separate from the fake-job plans. Bryan says the allegations are false and concocted to pressure him to drop his suit.

Meanwhile, the favorable court rulings attracted copycats. Using government filings and marketing materials, Bloomberg identified other so-called "employee" plans being pushed by South Florida telemarketers. Disclosures to the Labor Department suggest these competing plans now boast more participants than Bryan's.

One, with more than 17,000 participants, enlists people in a multilevel marketing business to sell a nutritional supplement called the Vitamin Patch. "Our innovative, time-released topical patches are designed to deliver supplements directly through your skin and into your bloodstream," the company's website says. An investigation by Maryland regulators last year found that health-plan buyers "are not performing any work."

Vitamin Patch LLC acknowledged in a statement that some enrollees claimed to be unaware of work requirements, adding that in recent months it took a "harder look" at its sales network, terminated bad agencies, strengthened vetting for new ones and "scaled back recruiting dramatically."

Buyer Beware

Insurance regulators in Maine and Connecticut warned consumers last year to beware of "employee" health plans sold by telemarketers.

Bryan and his imitators are awaiting decisions that could bring their health plans to a broader market. The question of whether people like Joe Strohmenger are employees under federal law is back before the Fort Worth judge who previously said they were. He's expected to rule in the coming months. But President Donald Trump, who promised to shake up Obamacare with vague "concepts of a plan" during his latest campaign, could order the Labor Department to stop contesting the case. The department referred questions to the Justice Department, which declined to comment.

A Bryan victory would at least make someone — the Labor Department — responsible for overseeing the plans. It would also encourage more salespeople to market them and keep state regulators at bay.

If the plans become popular enough, Obamacare's defenders warn, they could blow up the private health insurance market. The idea behind the Affordable Care Act is to gather both sick and healthy people into the same insurance pool. If fake-job plans lured significant numbers of healthy people out of the pool, prices for those remaining could skyrocket, leaving the sickest uninsured. It's what the Leukemia & Lymphoma Society, in a court brief opposing the fake-job idea, calls a "classic insurance 'death spiral.'" (In his statement, Bryan said he's serving people who can't afford or don't want Obamacare and called the death-spiral scenario "absurd.")

The ranks of uninsured Americans are likely to grow. Extra subsidies approved in 2021 helped millions sign up for Affordable Care Act plans for the first time. Those subsidies are scheduled to expire at the end of this year. Unless Congress acts, the number of uninsured may rise by almost 4 million, according to the Congressional Budget Office. Many might be tempted by telemarketers offering cheap alternatives.

Since taking the financial hit, the Strohmengers haven't tried shopping for insurance again. Their second, more expensive Outreach plan has paid a few claims but rejected others for reasons they don't understand. They say they never got any paperwork outlining their benefits.

Joe has stopped taking the blood-sugar medication and skipped almost a year's worth of visits to the tumor specialist. "Hopefully, the universe is going to just keep us healthy and out of the hospital for a couple years," Sarah says. "The universe could put this right somehow."

As Trump Cuts Health, More May Exit Obamacare Like CVS Health's Aetna

By Bruce Japsen,

May 04, 2025, 08:00am EDT

News that CVS Health's Aetna is pulling out of the individual health insurance business, also known as Obamacare, could mean more insurers will follow if President Trump and his fellow Republicans in Congress cut health benefits.

CVS' decision, announced last week, leaves about 1 million people in 17 states looking for new coverage in 2026. That's a fraction of the more than 24 million Americans who signed up for such coverage on the Affordable Care Act (ACA) exchanges last fall.

But Republicans and the Trump White House are making moves to make it difficult on health insurers to sell Obamacare. The Trump administration, via the Centers for Medicare & Medicaid Services, earlier this year slashed what the federal government spends on navigators that help people sign up for Obamacare coverage.

If the cuts to navigators lead to fewer signing up for coverage, that hurts health insurers. Some of the biggest players in Obamacare, including Centene and Oscar Health, UnitedHealth Group's UnitedHealthcare and many operators of Blue Cross and Blue Shield plans such as Elevance Health have seen record growth in their individual coverage business in recent years.

Obamacare has come a long way with millions of Americans gaining such coverage in part due to expanding subsidies that allow more people to afford health insurance. The subsidies were enhanced thanks to moves by the Biden administration and the Democratic-controlled Congress, which passed the Inflation Reduction Act of 2022, allowing more Americans to buy coverage.

Earlier this year, before Trump took office, then CMS Administrator Chiquita Brooks-LaSure attributed the record-breaking enrollment "to the importance of the enhanced financial assistance available through 2025."

"This additional help has made all the difference for people seeking affordable insurance," Brooks-LaSure said in January. "For example, a young professional just starting out making $30,000 a year would have previously been expected to contribute around $165 per month but can now pay no more than $50 per month, with even cheaper plans available. Just a little extra help can mean less financial stress for millions of enrollees across the country."

Whether such momentum and growth continues after this year is uncertain. When Trump was in office from 2017 to 2021, he and Republicans in Congress tried and failed several

times to repeal the ACA, the signature legislative achievement of former President Barack Obama.

So when the enhanced subsidies expire at the end of this year, Trump and Republicans in Congress may be unwilling to spend the money if they need the revenue to make up for tax cuts.

"Much of the enrollment growth stems from the enhanced premium aid first made available in 2021 that helped to make marketplace coverage more affordable for many people," a KFF report earlier this year said. "The extra assistance is set to expire at the end of this year unless Congress acts to extend it."

So far, none of Aetna's rivals have hinted at plans to exit Obamacare or pull back from markets where the currently sell plans.

But industry analysts say they are watching and they expect – at the very least – that more insurers will retreat to fewer states and counties.

"Don't be surprised if this isn't the last announcement by an ACA carrier that they're bailing on the exchange market entirely (or at least reducing their footprint of where they offer coverage) over the next few months," Charles Gaba who founded ACASignups.net, a website that tracks Affordable Care Act data and other health topics wrote on his site last week after the CVS announcement. "Their actuaries are crunching the numbers right now to figure out what plans they plan on offering next year at what premium levels, and the likely expiration of the (Inflation Reduction Act) subsidies on New Year's Eve is likely going to lead to millions of enrollees being priced out of the market."

CVS Plans To Exit Obamacare In 2026, Impacting 1 Million Aetna Members

By Bruce Japsen,

Senior Contributor.

Bruce Japsen writes about healthcare business and policy.

CVS Health plans to exit the individual health insurance business also known as Obamacare next year, … More

Associated Press

CVS Health plans to exit the individual health insurance business also known as Obamacare next year, leaving about 1 million Aetna members in 17 states looking for new coverage in 2026.

The decision, disclosed Thursday on a day when CVS reported nearly $1.8 billion in net income amid a financial turnaround, comes as a relatively new management team works to get rising healthcare costs in its Aetna brand health insurance plans under control.

"The company decided to exit the individual exchange business where Aetna independently operates ACA plans for 2026," CVS said in a statement Thursday accompanying its first quarter earnings report regarding coverage its Aetna health insurance unit sells under the Affordable Care Act known as Obamacare.

"This decision is consistent with others taken this year to focus the company's portfolio," CVS said. "The company is best able to serve members through its other health benefit solutions, which offer access to quality care, affordable health benefits and exceptional service. The company will continue delivering superior service and support to its individual exchange members through 2025 and residual activities in 2026."

CVS' move to exit the individual insurance market comes as the Donald Trump White House and Republicans in Congress ponder cuts to health insurance benefits to pay for tax cuts for wealthy Americans. Trump has never been a fan of Obamacare, which he tried and failed several times to repeal in his first term, and his administration has already made moves to cut spending on such health benefits, already slashing what the federal government spends on navigators that help people sign up for Obamacare coverage.

Meanwhile, it remains unclear whether subsidies Americans use to buy individual coverage will remain once Congress has passed its budget.

Enhanced tax credits to buy Obamacare that were signed into law by former President Joe Biden run out at the end of this year and it remains unclear whether a Congress led by

Republicans will extend them. Such tax credits contributed to record Obamacare enrollment for this year of 24 million.

CVS has about 1 million people in its Aetna brand individual health insurance plans spread across 17 states. Those Aetna health plan members will have to purchase new coverage on the ACA's exchanges this fall when insurers unveil their benefits for 2026.

CVS' Aetna health insurance unit is not a big player in Obamacare like some its rivals and individual coverage is a fraction of the total medical membership CVS reported as of March 31, 2025 of 27.1 million, which the company said "remained relatively consistent compared with December 31, 2024, reflecting membership declines in the individual exchange and Medicare product lines."

CVS and rival operators of health insurance plans, particularly Medicare Advantage benefits for seniors, have been hit hard in the last year with higher costs.

Medicare Advantage plans contract with the federal government to provide extra benefits and services to seniors, such as disease management and nurse help hotlines with some also offering vision, dental care and wellness programs.

But CVS said it is getting a better handle on cost trends. In the first quarter, the company's medical benefit ratio, which is the percentage of premium revenue that goes toward medical costs, decreased in the first quarter to 87.3% from 90.4% in the prior year. The company attributed the better performance in part due to "improved underlying performance in Medicare, including the impact of improved Medicare Advantage star ratings for the 2025 payment year."

CVS, which also operates the nation's largest retail drugstore chain and one of the nation's largest pharmacy benefit management companies known as Caremark, said total revenues rose 7% to $94.6 billion in the first quarter compared to $88.4 billion in the year-ago period. First quarter net income was up to $1.77 billion, or $1.41 per share, compared to $1.11 billion, or 88 cents in the year ago quarter.

"As we aim to be the most trusted health care company in America, we are driving greater care, value, and service from our integrated, industry-leading businesses," said CVS president and chief executive officer David Joyner, who was promoted to the CEO's job last fall. "Thanks to a resolute focus on customers, our colleagues across CVS Health delivered positive results across our health care benefits, health services and pharmacy and consumer wellness segments, as we continue to build a world of better health around the 185 million consumers we are privileged to serve."

CVS lowered its full year 2025 diluted earnings per share guidance to a range of "$4.23 to $4.43 from $4.58 to $4.83 and raised its 2025 adjusted EPS guidance range to $6.00 to $6.20 from $5.75 to $6.00," the company said. "The company also raised its full-year 2025 cash flow from operations guidance to approximately $7.0 billion from approximately $6.5 billion."

The adjustments include "amortization of intangible assets, net realized capital losses, acquisition-related integration costs, the loss on the wind down and sale of accountable care assets, the Omnicare litigation charge, office real estate optimization charges and the corresponding income tax benefit or expense related to the items excluded from adjusted income attributable to CVS Health."

How Congress can help millions of Californians who can't afford health care | Opinion

By Devon Mathis *Special to The Fresno Bee*

May 7, 2025 11:08 AM

"Despite record insurance coverage, about half of all residents — and 63% of Central Valley residents — admit to postponing medical care due to cost." *Bigstock*

As a former member of the California Assembly and a ranking member of the Budget Subcommittee on Health and Human Services, as well as a proud combat veteran, I've witnessed firsthand the struggles many Americans face in accessing affordable health care. The national health care affordability crisis is at an all-time high, impacting people and their employers alike: An estimated 91 million people report that they can't currently access the care or prescription medicine they need.

Even those with insurance are increasingly drowning in medical bills, as tax-advantaged health care savings tools remain out of reach and unknown for many.

This issue is particularly pressing for the millions of "working-class" Americans who shaped the outcome of the 2024 election. A recent poll showed that a shocking 78% of voters feel they need a better option to deal with runaway health-care costs.

That hits close to home here in California: Despite record insurance coverage, about half of all residents — and 63% of Central Valley residents — admit to postponing medical care

due to high costs. Too often, people are forced to choose between their health and affording other basic needs like bills, credit cards and food for their families. More than one in three Californians report having medical debt.

It's especially tough for those from middle- or lower-income backgrounds, who are disproportionately affected by out-of-pocket expenses. This financial strain not only impacts people on an individual level, it also contributes to increasing health-care costs for employers who are experiencing a rise in absenteeism and presenteeism — being unfit for work due to illness or injury — due to chronic illnesses and injuries, leading to productivity losses that cost U.S. employers upwards of $2,500 per employee per year. Small businesses, the lifeblood of our economy, feel these effects even more acutely.

Thankfully, members of Congress from both sides of the aisle, including California Reps. Jimmy Panetta (D-Carmel) Raul Ruiz (D-Palm Desert) and David Valadao (R-Hanford) are working to bridge the affordability gap and help hardworking Americans receive the care they need and deserve. The Health Out-of-Pocket Expense Act, or HOPE Act, would give over 100 million people the chance to better manage their health care expenses.

This legislation would create HOPE Accounts, a savings tool designed to help those who need it most plan for out-of-pocket medical costs, including co-pays, prescriptions, mental health and long-term care. Individuals can contribute to their personal account, and they may also leverage employer and state contributions. The money stays with them, regardless of their employment or type of insurance, giving millions of Americans a pathway to save money.

It's time middle-class Americans benefit from the opportunities to save for health care that higher-income people enjoy, and employers are ready to do their part: With new tools to incentivize and help more employees take control of their health care expenses in a financially responsible way, we all gain. When people can afford to take their medications as prescribed, deal with pressing medical issues promptly and engage in preventative care, everyone benefits.

The HOPE Act is a straightforward, common-sense solution that empowers individuals and families to take control of their health care dollars. And it turns out that good policy is also good politics: more than seven in 10 Trump and Harris voters and 63% of swing voters support the HOPE Act.

As health care costs rise, Congress must identify solutions that both address the immediate need for affordable care and equip people from all walks of life with tools that prepare them for future challenges. The HOPE Act, while not a complete fix to the health care affordability crisis, is a critical bridge that's needed now.

In these divisive and uncertain times, the HOPE Act is an opportunity for Congress to provide a lifeline that working families need to take their health, security and futures back into their own hands.

State-Based Exchange Officials Push For Enhanced APTCs

By Sigi Ris / May 7, 2025 at 7:31 PM

Executives from the nation's state-based marketplaces (SBMs) are in DC this week urging Congress to quickly extend the enhanced Affordable Care Act premium tax credits (APTCs) to avoid marketplace and consumer uncertainty in the coming months.

Even though the credits are set to expire at the end of December if Congress doesn't act, marketplaces will start feeling impacts of a lack of renewal as early as the summer, the SBM officials say.

The lack of clarity is also leading some states, including Washington, to ask their carriers to submit two sets of rates -- one with and one without the APTC -- when they file next week, Washington Health Benefit Exchange CEO Ingrid Ulrey said during a State Marketplace Network media briefing Tuesday (May 6).

According to Ulrey, if there's no news by September or October, things will become difficult as consumers will be starting to shop for coverage.

"The longer [Congress takes]," Ulrey said, "the more chaos and market instability we will experience."

Covered California Executive Director Jessica Altman said some SBMs will have two open enrollment strategies that depend on the status of the EPTC , as well as a massive retention and outreach plan, "We are going to do that work, but at some point we have to be able to hit button A or B," Altman said.

The enhanced tax credits initially enacted in the American Rescue Plan further reduced the monthly costs for people earning less than 400% of poverty, making $0 plans available to many low-income consumers. The policy also capped premiums at 8.5% of income for enrollees earning more than 400% of poverty who were previously ineligible for assistance.

The state officials emphasized how the credits benefited state residents -- and contributed to record enrollment.

Small business owners, older Americans who are not yet retired and residents who live in rural areas with high-cost coverage are among the largest beneficiaries of the credits, and will see significant rate increases if they expire, officials said.

The comments at the meeting echo a letter that 19 exchange officials sent to congressional leadership in March explaining how the enhanced credits spurred enrollment growth and that their expiration would leave Americans with higher premiums, even as they continue to grapple with inflation.

Failure to renew APTCs would mean an average family of four earning $65,000 per year will see their premiums more than double, and costs for a 60-year-old couple earning $82,000 will increase by more than $18,000 per year, the letter said. -- *Sigi Ris* (sris@iwpnews.com)

Exchange enrollment hits a new high

Nona Tepper

Bloomberg

A record 24.3 million people signed up for health insurance on federal and state-based marketplaces during the exchange open enrollment period for 2025.

Fueled by enhanced subsidies enacted in 2021 and extended in 2022, the number blew past the record set a year ago by nearly 2.9 million — a 13% increase, the Centers for Medicare and Medicaid Services reported Monday. The more sizable tax credits will expire at the end of this year, barring a congressional renewal.

In the 28 states where the federal government manages the exchanges and the three states that operate marketplaces but use the federal Healthcare.gov enrollment platform, 17.1 million people enrolled in coverage. An additional 7.2 million people signed up through one of the 20 state-based marketplaces, according to CMS.

The data released by the CMS on Monday is part of a comprehensive report detailing exchange enrollment and premiums in all states. It follows a report from January that included data from Healthcare.gov states and preliminary data from the state-based exchanges.

Consumers can switch plans as frequently as desired during the annual Healthcare.gov sign-up period, which ended January 15. They can switch plans once between January 15 and the end of the open enrollment period March 31. Most state-based exchange sign-up periods vary.

Exchange enrollment breaks another record for 2025

Nearly 2.9 million more people bought exchange policies on the federal and state-based marketplaces for 2025 compared with the previous year.

Most people retained the same plan for 2025 in which they were enrolled for 2024. The number of people whose coverage was automatically renewed increased about 65% to 10.8 million, from 6.6 million the previous year, CMS reported.

At the same time, the number of new customers buying coverage dropped 21% to 4.1 million from 5.2 million in 2024, CMS said.

Nationwide, average monthly premiums increased 2.3% to $619 before premium tax credits. People with incomes too high to qualify for federal assistance must pay the full cost

of the premium. For the 92% of customers who received a subsidy, the average monthly premium was $113.

If Congress does not extend the enhanced subsidies, 3.8 million people would go uninsured and benchmark premiums would rise an average 7.6% over the next decade, the Congressional Budget Office reported in December.

Total Healthcare.gov enrollment grew despite CMS implementing new rules on how sales agents can use the federal exchanges, the report noted. Last year, CMS received at least 200,000 complaints from consumers who had unknowingly enrolled in coverage or switched to another plan. In response, regulators required marketers to contact Healthcare.gov by phone to sign a consumer up for a new plan for 2025, among other requirements.

State exchange officials plead for ACA subsidy extension

Bridget Early

Congress has less time than lawmakers may think to renew enhanced subsidies for health insurance exchange customers before the market is disrupted, state officials are warning federal policymakers.

Executives from 12 state-based marketplaces including Covered California, Connect for Health Colorado and the Massachusetts Health Connector traveled to Washington to exhort Congress to extend the more generous tax credits that drove exchange enrollment to record highs before they expire at the end of the year.

“This is not some 'inside-the-beltway' budget exercise or a political football,” Audrey Gasteier, executive director of the Massachusetts Health Connector, said during a news conference Tuesday. “This is real people's lives. This is people's financial stability. This is people's access to healthcare that keeps them and their families safe and well.”

The looming end of these subsidies complicates planning for the exchanges and the health insurance sector, which need to anticipate what the customer base will look like next year and calculate premiums. And this market already faces headwinds from President Donald Trump's administration, which has taken steps to shorten the open enrollment period and slash enrollment assistance funding.

Health insurance exchange officials met with lawmakers and officials at the Centers for Medicare and Medicaid Services on Monday and Tuesday to press their case, they said.

Health insurers are readying rate change requests for 2026, which have to be finalized this summer to give companies time to notify customers and plan market strategies before open enrollment, said Jessica Altman, executive director of Covered California. The sign-up period begins Nov. 1 in most states.

That means insurers and states may have to game out two scenarios: one with the enhanced subsidies and another with the tax credits as originally written in the ACA, Altman said.

A definitive answer to whether Trump and the GOP-led Congress will let the beefed up tax credits lapse would at least resolve those logistical issues. But the exchange executives were clear that their preference is to reauthorize them.

“We could be looking at an open enrollment where people see record drops in the affordability of the coverage,” Gasteier said.

Though Republicans have long sought to eliminate the Affordable Care Act of 2010, they may be reluctant to let the subsidies expire because of the consequences for their constituents. Yet the issue has not been part of the fraught intraparty discussions about a sweeping tax-and-spending-cuts package the GOP is assembling, which is likely to feature significant Medicaid cuts.

If Congress chooses not to extend the subsidies, premiums will rise, the risk pool will worsen and enrollment will fall, said Kevin Patterson, executive director of Connect for Health Colorado. Younger, healthier customers and rural residents are most likely to flee the exchanges in large numbers under those circumstances, he said.

In Colorado, premiums could jump as much as 76% in rural areas and 50% in urban areas if the subsidies aren't renewed, Patterson said.

Uncertainty about financial assistance in the meantime may depress enrollment, Altman said. “From our experience, people leave for sticker shock. And even if the tax credits do get extended, if they get that letter, they may not come back,” she said.

Why health systems are caring for more ACA exchange patients

Caroline Hudson

Big for-profit health systems are seeing double-digit growth in exchange volumes, signaling a larger industry trend as the number of enrollees balloons to record highs.

At least 24.2 million people purchased insurance on the Affordable Care Act exchange marketplaces during open enrollment for 2025, beating the record 21.3 million people in 2024, according to the Centers for Medicare and Medicaid Services. The increase is showing up in health systems' latest financial reports and catching interest from analysts on first-quarter earnings calls, largely due to continued uncertainty surrounding ACA subsidies.

The marketplace may also be shifting. CVS Health said Thursday morning it plans to exit the individual exchange business next year.

Nonprofit health systems are also likely to report strong exchange volumes as they roll out earnings reports over the next few weeks. Industry observers say the effect of higher exchange volumes on health systems' balance sheets depends on their payer mixes and patients' previous coverage.

Here's a look at how exchange volumes are growing what that means for health system finances.

What health systems are saying

The four large for-profit systems — HCA Healthcare, Tenet Healthcare, Community Health Systems and Universal Health Services — reported growth in their exchange volumes on their first-quarter earnings calls this month.

HCA Chief Financial Officer Mike Marks said the system's same-facility exchange admissions increased 22.4% from the year-ago period. UHS CFO Steve Filton reported a similar increase. Tenet CFO Sun Park told analysts the system saw a 35% increase in exchange admissions in the first quarter.

"We figured it would be relatively strong," Park said on Tenet's first-quarter earnings call. "I think that's reflective of not only the coverage and payer environment, but also of our continued networking strategy of [offering] broad access to these exchange populations."

CHS President and CFO Kevin Hammons also said he is seeing growth in the exchange business.

Why exchange volumes are growing

Subsidies that help lower premiums and out-of-pocket costs for exchange programs are a big driver. Patients could be eligible for premium tax credits, which reduces their monthly payments, or cost-sharing reductions, which reduce deductibles and out-of-pocket costs.

Exchange volumes have been increasing for a few years, thanks to enhanced tax credits. Congress enacted enhanced advance premium tax credits in 2021 as part of the American Rescue Plan Act, a $1.9 trillion COVID-19 relief package. In 2022, the Inflation Reduction Act extended those credits for another three years.

Medicaid redeterminations, which restarted in 2023 after a pause during the COVID-19 pandemic, are also driving up exchange volumes. Many patients disenrolled from Medicaid plans are turning to the exchanges as a coverage option.

What the trend means for provider finances

There are pros and cons to health systems having higher exchange volumes.

Exchange volume growth is bringing in revenue to the for-profit systems, though the percentage of total revenue remains relatively small.

UHS' Filton said the number of exchange patients went from about 5% to 6% of the system's acute care adjusted admissions.

Tenet's Park said exchange patients were tied to about 7% of the system's total revenue. At CHS, it is less than 6%, Hammons said.

In some cases, patients may turn to exchange coverage as a last option to avoid becoming uninsured. Insured patients are generally going to bring in more revenue for health systems than uninsured patients.

But the impact also depends on patients' previous coverage. Reimbursement rates for exchange plans are typically not as favorable as other types of coverage, such as commercial or employer-sponsored plans.

Why the trend could change

The Congressional Budget Office projects exchange volumes will plummet by millions if the enhanced tax credits are not renewed at the end of the year. The enhanced credits have made exchange plans more affordable for many enrollees.

Still, reverting the subsidies back to their original levels is a possibility, industry observers say.

President Donald Trump and Republicans have often expressed their disdain for the Affordable Care Act of 2010. Ending enhanced subsidies is a way to cut into the

program and government spending overall, which is a big push under the new Trump administration.

Supplemental Post-Argument Briefs in Obamacare Appointments Clause Case

By Ed Whelan

May 5, 2025 5:54 PM

Two weeks ago, the Supreme Court heard oral argument in Kennedy v. Braidwood Management, Inc., a very interesting case that presents the complicated question whether the members of the United States Preventive Service Task Force have not been constitutionally appointed to their positions. Two lawyers I hold in very high regard—principal deputy solicitor general Hashim Mooppan for HHS Secretary Robert F. Kennedy Jr. and Jonathan Mitchell for Braidwood Management—argued the case.

One set of questions in the case is whether the Task Force has the plenary authority to mandate the items and services that health insurers must cover as preventive health services under Obamacare and whether its members are therefore principal officers who under the Appointments Clause of the Constitution must be appointed by the president after confirmation by the Senate. Another set of questions arises if its members are inferior officers: has Congress "by Law vest[ed]" the authority to appoint them in the Secretary of Health and Human Services?

Three days after oral argument, the Court invited supplemental briefs on this latter question by 2 p.m. today. The Office of the Solicitor General and Mitchell have filed their competing briefs.

There is a lot to digest here, and I'm still ruminating, so I will limit myself to a few observations:

1. Braidwood points out in Part III of its brief (pp. 13-14) that even if the Court were to rule that Congress has "by law" vested appointment authority in the HHS Secretary, it would still have to affirm that portion of the Fifth Circuit's decision that enjoins the coverage mandates made by the Task Force between March 23, 2010 (the date on which Obamacare was enacted) and June 28, 2023. That's because it was only on June 28, 2023 that the HHS Secretary (Xavier Becerra) first appointed members of the Task Force—and only because Braidwood's lawsuit, filed in 2020, exposed that the members of the Task Force had not been constitutionally appointed even if they were inferior officers.

Indeed, the Department of Justice in the Biden administration expressly conceded to the Fifth Circuit in the brief that it filed on June 20, 2023 that "the existing Task Force members have not yet received an appointment consistent with the Appointments Clause." (DOJ Brief at 30.) Nor were any previous Task Force members appointed by the HHS Secretary.

OSG does not contest or withdraw DOJ's previous concession, so it is difficult to see how it has any basis to oppose the invalidation of the coverage mandates that the Task Force made before June 28, 2023.

2. OSG invokes the canon of constitutional avoidance, which calls for courts to avoid an interpretation of a statute that would raise "grave and doubtful constitutional questions" when an alternative interpretation that doesn't raise such questions is available. (OSG Brief at 8-10.) It argues that any ambiguity about who has the power to appoint Task Force members should be resolved in favor of the HHS Secretary. But Braidwood points out that its interpretation would leave the president free to appoint Task Force members with the consent of the Senate, so it could not possibly conflict with the Appointments Clause. (Braidwood Brief at 5-6.)

3. Consistent with a principle that Justice Gorsuch voiced at oral argument ("we're a court of review, not first view"), Braidwood argues (in Part IV) that the Court should not weigh in at this stage on whether Congress has vested appointment authority in the HHS Secretary, as it "is exceedingly unusual for this Court to resolve a contested issue of law that no court in the country has previously addressed, and it almost always declines requests to do so."

Government ACA ads make the health insurance market bigger, economists report

The researchers also found insurers' own ads simply help them capture share from rivals.

By Allison Bell| May 07, 2025 at 12:46 PM

Do health insurance TV ads really increase sales?

Two economists handled the question by looking at TV advertising data and sales data for Affordable Care Act exchanges and exchange plans.

The federal government ran general, educational ads that made consumers aware of the HealthCare.gov exchange program and states' own state-based exchange programs. Health insurers focused on running ads that promoted their own health insurance policies.

The federal government's general awareness-building ads increased overall ACA exchange plan enrollment, and eliminating the ads entirely might cut enrollment by up to 6.7% in some markets, the economists found.

The TV ads appeared to be about 40% as effective at increasing enrollment as exchange deadline reminder letters that the Internal Revenue Service mailed to taxpayers who appeared to be uninsured.

The economists are more skeptical about the power of insurers' own ads.

Overall, "it is not very clear that private advertising is effective in increasing enrollment at the market level or at the insurer level," the economists write.

When the economists analyzed the data one way, they found that an insurer's own ads could help it take some business away from competitors without expanding the market.

When the economists analyzed the impact of health insurers' TV advertising another way, the ad impact was "very small and not statistically different from zero."

"We do not rule out the possibility that private advertising is not effective at all," the economists write.

Naoki Aizawa, an economist at the University of Wisconsin-Madison, and You Suk Kim, an economist at the Federal Reserve Board, have published the paper in the American Economic Journal: Economic Policy.

Study details: The economists looked at plan enrollment data for 2014 through 2018 from HealthCare.gov, which provides ACA exchange services in more than 30 states, along with plan enrollment data for the same period from the ACA exchange programs in California and New York.

The analysis also included TV ad spending data for the period from Kantar Media.

What it means: The economists who wrote the paper said they hope to apply their analytical approach to determining the value of different types of advertising for other insurance products and other types of services, such as electricity and mortgage loans.

For brokers who are still in the retail insurance market, the study demonstrates the power of institutional, awareness-building advertising.

For benefits brokers and employers, the study could have a bearing on enrollment in voluntary group plans and efforts to sell individual products at the worksite through payroll-deduction payment arrangements.

If Aizawa and Kim are correct, educational materials from sources that employees think of as neutral parties might work better than materials that highlight the features of specific insurers' or distributors' benefits products.

Josh Hawley: Don't Cut Medicaid

May 12, 2025, 5:01 a.m. ET

By Josh Hawley

Mr. Hawley is a Republican senator from Missouri.

Polls show Democrats down in the dumps at their lowest approval level in decades, but we Republicans are having an identity crisis of our own, and you can see it in the tug of war over President Trump's "one big, beautiful bill." The nub of the conflict: Will Republicans be a majority party of working people, or a permanent minority speaking only for the C suite?

Mr. Trump has promised working-class tax cuts and protection for working-class social insurance, such as Medicaid. But now a noisy contingent of corporatist Republicans — call it the party's Wall Street wing — is urging Congress to ignore all that and get back to the old-time religion: corporate giveaways, preferences for capital and deep cuts to social insurance.

This wing of the party wants Republicans to build our big, beautiful bill around slashing health insurance for the working poor. But that argument is both morally wrong and politically suicidal.

Let's begin with the facts of the matter. Medicaid is a federal program that provides health care to low-income Americans in partnership with state governments. Today it serves over 70 million Americans, including well over one million residents of Missouri, the state I represent.

As for Missouri, it is one of 40 Medicaid expansion states — because our voters wanted it that way. In 2020, the same year Mr. Trump carried the Missouri popular vote by a decisive margin, voters mandated that the state expand Medicaid coverage to working-class individuals unable to afford health care elsewhere. Voters went so far as to inscribe that expansion in our state constitution. Now some 21 percent of Missourians benefit from Medicaid or CHIP, the companion insurance program for lower-income children. And many of our rural hospitals and health providers depend on the funding from these programs to keep their doors open.

All of which means this: If Congress cuts funding for Medicaid benefits, Missouri workers and their children will lose their health care. And hospitals will close. It's that simple. And that pattern will replicate in states across the country.

One of my constituents, a married mother of five, contacted me to explain why Medicaid is vital to her 8-year-old daughter, who depends on a feeding tube to survive. Formula, pump

rentals, feeding extensions and other treatments cost $1,500 a month; prescriptions nearly double that cost. These expenses aren't covered by private insurance. The mother wrote to me, "Without Medicaid, we would lose everything — our home, our vehicles, and eventually, our daughter."

Congress should be doing everything possible to aid these working families, to make their health care better and more affordable. We should cap prescription drug costs, as I have recently proposed. We should give every family in America with children a hefty tax cut. What we should not do is eliminate their health care.

Mr. Trump himself has been crystal clear on this point. Since taking office he has repeatedly rejected calls for Medicaid benefit cuts. Just the other week, he said, "We are doing absolutely nothing to hurt Medicare, Medicaid or Social Security. Nothing at all."

And for good reason. The president understands who his voters are. Recent polling shows that 64 percent of Republicans hold a favorable view of Medicaid. About one in six have personally been on the program. Meanwhile, more than 80 percent of Americans oppose significant cuts to Medicaid and over half — half — have a personal or family connection to the Medicaid program.

It's safe to say the Trump coalition was not pulling the lever for Medicaid cuts in November. Mike Johnson, the House speaker, finally woke up to this fact last week, when he withdrew his support from one of the most aggressive reductions to Medicaid on the table. But many of my House and Senate colleagues keep pushing for substantial cuts, and the House will begin to hash out its differences in negotiations this week.

My colleagues have cited the editorial board of The Wall Street Journal, which has been pushing that line for months, including in a recent editorial that inveighed against my opposition to Medicaid benefit cuts. But following The Journal's prescriptions would represent the end of any chance of us becoming a working-class party.

Republicans need to open their eyes: Our voters support social insurance programs. More than that, our voters depend on those programs. And there's a reason for this that Republicans would do well to ponder. Our economy is increasingly unfriendly to working people and their families.

For the better part of 50 years, working wages have been flat in real terms. Working people cannot afford to get married when they want to, have the number of children they want to or raise those children as they would like. These days, they can barely afford to put a roof over their kids' heads, to say nothing of health care.

Both Democrats and Republicans share the blame for this state of affairs, which is one big reason Mr. Trump got elected. He promised to shake up the status quo. Republicans in Congress should pay attention. Our voters not only want us to protect the social insurance they need to get by; they also want us to fight for a better life — for a better economy with the kinds of jobs and wages that allow working people to get married and start families, to buy homes and have a stake in their towns and neighborhoods.

That's the promise of American life. If Republicans want to be a working-class party — if we want to be a majority party — we must ignore calls to cut Medicaid and start delivering on America's promise for America's working people.

Josh Hawley is a Republican senator from Missouri.

U.S. Prosecutors Accuse Large Insurers of Paying Kickbacks for Private Medicare Plans

The Justice Department accused large insurers of colluding with national brokers to steer older people and those with disabilities toward coverage that might not offer the best medical care.

By Reed Abelson and Margot Sanger-Katz

May 1, 2025Updated 6:51 p.m. ET

The Justice Department on Thursday accused three of the nation's largest health insurers of paying hundreds of millions of dollars in illegal kickbacks over several years to insurance brokers that steered people into private Medicare plans.

Federal prosecutors also accused two of the insurers of colluding with brokers to discriminate against people with disabilities, by discouraging enrollment in the private Medicare plans because the insurers believed coverage would be more costly.

About 12 percent of Medicare beneficiaries are younger than 65, covered by the federal insurance program because they are disabled. Their care can be expensive given complex health needs.

According to the complaint, originally brought by a whistle-blower and joined by the Justice Department, three of the nation's largest health insurance companies — Aetna; Elevance Health, formerly known as Anthem; and Humana — are accused of paying kickbacks to three large brokers, eHealth, GoHealth and SelectQuote, to increase enrollment in their Medicare Advantage plans. Those brokerage firms are also charged with misconduct.

The complaint, filed in a federal court in Boston, asserted that the kickbacks occurred from at least 2016 through 2021, and it accused Aetna and Humana of discriminating against people with disabilities.

Aetna, Elevance, GoHealth and Humana denied the allegations, while the others did not immediately respond to requests for comment.

The lawsuit is one of the first indications by the Trump administration that some Medicare Advantage plans will continue to be subject to federal scrutiny. Critics of these plans, including congressional lawmakers, have faulted the incredibly popular policies for using overly aggressive marketing tactics and overcharging the federal government. Medicare Advantage plans now cover more than half of all individuals enrolled in the federal program.

During the Senate confirmation hearing for Dr. Mehmet Oz, now the administrator of the Centers for Medicare and Medicaid Services, he replied to senators concerned about excess in the private plans that there was a "new sheriff" in town.

Brokers often play a pivotal role in helping older and disabled Americans eligible for Medicare to decide which private plan to choose. In the complaint, the brokers are accused of steering an individual into the plan that paid them the most rather than the one best suited to that person's needs.

In recent years, small local brokerages have given way to large national organizations employing many agents and using call centers and websites, like the companies named in the suit. They now tend to rely on computer programs to help brokers identify the best plan for each caller, a technology that could make the kind of steering described in the lawsuit easier.

Last year, the Biden administration finalized a regulation designed to lower the fees insurers could pay these companies to enroll patients, after congressional testimony and consumer complaints that insurers were awarding bonuses for enrolling more people in particular plans, regardless of their individual needs. But a lawsuit has put the rule on hold.

In referring to cases involving people with disabilities, federal prosecutors were blunt: "The alleged efforts to drive beneficiaries away specifically because their disabilities might make them less profitable to health insurance companies are even more unconscionable," U.S. Attorney Leah B. Foley said. "Profit and greed over beneficiary interest is something we will continue to investigate and prosecute aggressively."

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The GOP's Medicaid Moment of Truth

Do Republicans want to help pregnant women or able-bodied men?

By The Editorial Board

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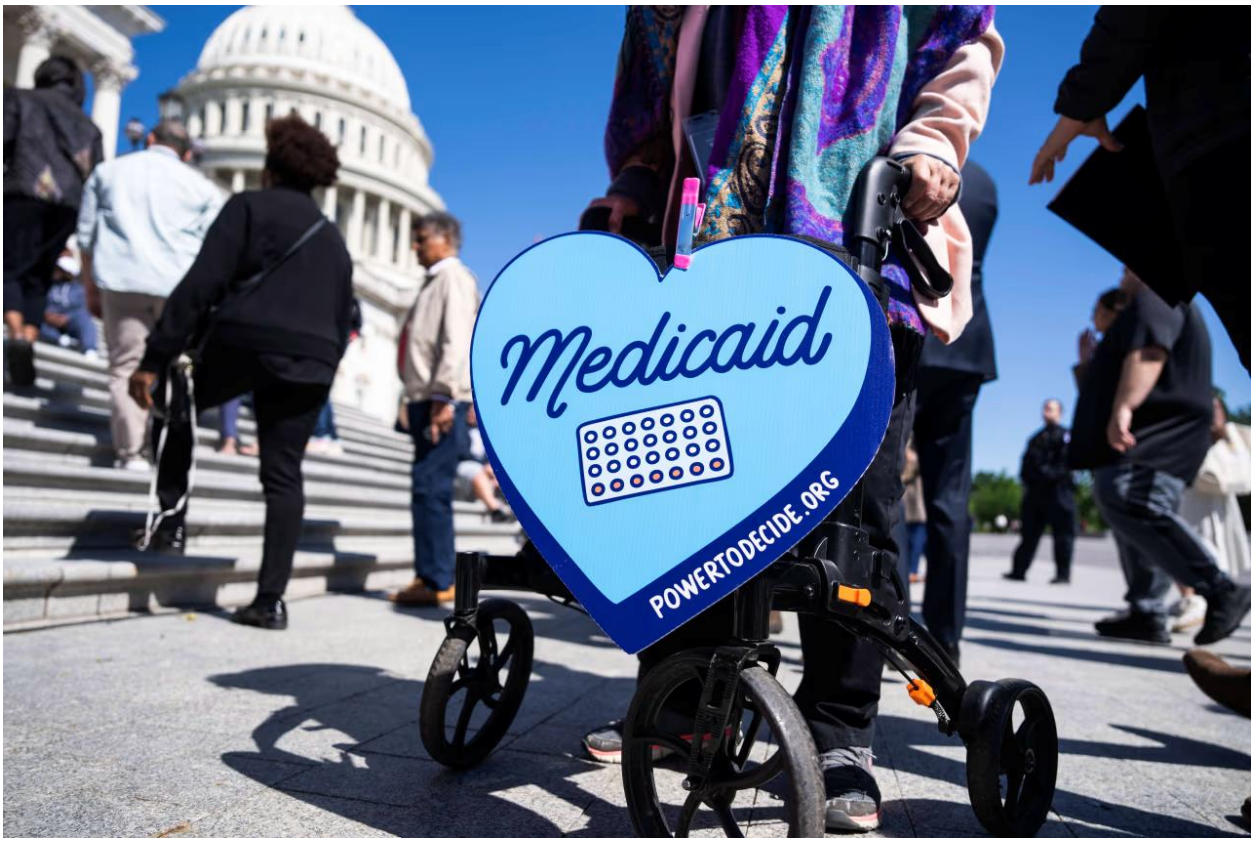

Photo: Tom Williams/Zuma Press

The GOP hasn't yet rolled out a draft Medicaid bill, but Democrats and their media allies are already pounding Republicans for snatching healthcare from millions. Republicans would be making a terrible blunder to let that intimidate them from fixing the program—especially winding down "free" federal money for able-bodied men on Medicaid.

The House's reconciliation bill outline instructed the Energy and Commerce Committee to come up with $880 billion in savings over a decade, and the GOP is now filling in the policy specifics. One worthy idea is imposing sanity on the way federal Medicaid money flows to the states.

Here is the core dysfunction. The feds pick up roughly 50% to 77% of the tab (depending on the state) for pregnant women, the disabled and other low-income populations. But the

feds pay 90% for prime-age adults eligible under the Affordable Care Act's Medicaid expansion. The enhanced funding was a Democratic bribe to bait states into expanding their programs under ObamaCare. It also contradicted the founding purpose of Medicaid, which was to help the poor.

You won't find many voters who think the federal government should focus scarce health resources on working-age men over poor children and pregnant women. Yet that is what the perverse financing formula encourages, as states can grab more federal dollars if they sign up more prime-age adults.

A 2022 study from the Mercatus Center looked at spending growth patterns in states that took the expansion money compared with those that didn't. It found "strong evidence" in Medicaid expansion states "of a shift of financial resources away from certain vulnerable enrollee populations, the most notable being from low-income children."

The GOP can make the strong and accurate argument that fixing this bias in federal payments is shoring up the program to better serve the vulnerable. Paragon Health Institute, a think tank, has done the intellectual leg work for the GOP and rolled out proposals to rationalize the payment treatment over time.

But some Republicans are nervous about the politics and they're airing their anxieties (or courting accolades) in the press. Some may prefer to impose a part-time work requirement on Medicaid, go after improper payments—and call it good. Both reforms would be improvements, but Republicans may not get another opening for decades to fix the core problems in Medicaid.

Ten states—including Florida and Texas—have declined the federal government's Medicaid expansion bait. These states wisely haven't wanted to absorb the big cost and enrollment overruns that have bedeviled those that took the expansion money. More important, the holdouts have bet that the 90% federal match is a teaser rate and that the "free" cash would eventually run dry.

But if Republicans in Congress ratify the status quo, expect all states to cave and take the money, and even GOP states might use a work requirement as a political excuse to justify doing so. Medicaid enrollments and costs would continue to grow. This result would defy the GOP's hope to use this bill to contain runaway spending.

Many Republicans bear the wounds of failing to repeal the Affordable Care Act in 2017 and don't want to revisit the scene of their political trauma. President Trump—not known for poring over Medicaid policy documents—wants to avoid anything that can be construed as cutting benefits. But on this so-called match rate, Republicans would merely be fixing a bad incentive and spurring states to spend their resources better and on those most in need.

One lesson of the failure to repeal ObamaCare is that Democrats and the media will attack GOP proposals no matter what the details are. The press coverage won't improve a whit if the GOP retreats on Medicaid, but Republicans will have wasted a generational opportunity to improve the social safety net and U.S. finances.