ing support. Even with unified Democratic control of the White House and Congress, enactment of a public option and expansion of Medicare eligibility are far from certain.

Another uncertainty is the ACA's legal fate, which became more precarious after the death of Justice Ruth Bader Ginsburg. The Supreme Court will hear oral arguments November 10 in *California v. Texas*, a challenge brought by Republican states and supported by the Trump administration that seeks to invalidate the entire ACA.[1] The Court will probably issue a decision in 2021. A decision to strike down the ACA or major components of it would destabilize both the insurance market and health politics, transforming the possibilities for reform.

An audio interview with Dr. Oberlander is available at NEJM.org

Barring such breathtaking disruption, the 2020 elections will shape the ACA's future. A decade ago, ambitious health care reform passed largely because Democrats had sizable congressional majorities, reached a consensus on a plan, and secured broad support for the ACA from health system stakeholders. In 2021, even if one party has unified control of government, it may not be able to reproduce all these favorable conditions. So a breakthrough in health policy is not inevitable during the next administration. Still, the profound political and economic instability wrought by Covid-19, frustrations with the ACA's limitations, the legal uncertainty, and a polarized environment in which parties are willing to legislate without bipartisan support mean that major change is possible. Stalemates, after all, can be broken.

Disclosure forms provided by the authors are available at NEJM.org.

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Insurance Coverage after Job Loss — The Importance of the ACA during the Covid-Associated Recession

Sumit D. Agarwal, M.D., M.P.H., and Benjamin D. Sommers, M.D., Ph.D.

During the coronavirus pandemic, the U.S. unemployment rate reached 14.7%, the highest level since the Great Depression. More than 40 million people filed for unemployment insurance between March and May 2020, and official statistics may understate the true extent of job disruptions. Widespread layoffs amid the pandemic threaten to cut off millions of people from their employer-sponsored health insurance plans. Concurrently, health insurance has increased in importance because of the need for coverage of Covid-19 diagnostic testing and treatment. As restrictions are lifted and the economy begins its slow recovery, some people who had been laid off will be able to reclaim their jobs and health benefits. But the economy is unlikely to recover to prepandemic levels in the near future, meaning that the Covid-associated recession will leave many people without jobs and without their usual source of health insurance.

Before the Affordable Care Act (ACA) was implemented, people who lost their jobs had limited choices for health insurance. Newly disabled people could apply for Medicaid if their savings and assets were low enough for them to qualify for Supplemental Security Income, or they could enroll in Medicare after receiving 2 years of benefits from Social Security Disability Insurance. For adults without a disability, many states' income cutoffs for Medicaid were well below the poverty line, and only people with dependent children could apply. An individual private-insurance market

existed, but without insurer regulations — such as guaranteed issue, community rating, actuarial-value standards, and coverage of essential health benefits — plans were skimpy, excluded people with preexisting conditions, and were often unaffordable. Married people who lost their jobs could potentially switch to their partner's employer-sponsored insurance (ESI) plan. Finally, the Consolidated Omnibus Budget Reconciliation Act of 1985, known as COBRA, allowed former employees and their dependents to temporarily continue their enrollment in employer-based insurance. Former employees who opt for COBRA coverage must pay 102% of the full premium cost (the employee plus employer shares), however, which has led to very low levels of take-up.

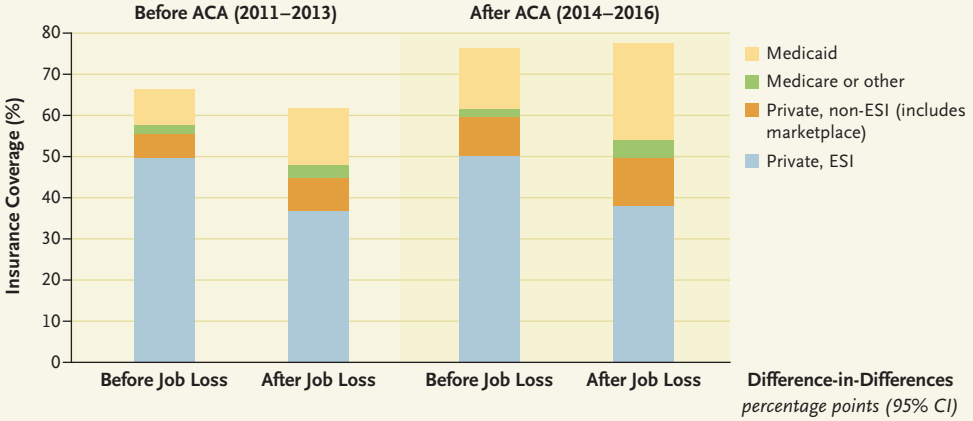
The ACA, having created several new options for health insurance unrelated to employment, will protect many recently unemployed people and their families from losing coverage. In the 36 states that opted to expand their Medicaid programs, expansion removed asset tests and categorical eligibility requirements (for example, policies that required enrollees to be disabled, pregnant, or parents of dependent children) and extended eligibility to all U.S. citizens and qualifying documented immigrants with incomes below 138% of the federal poverty level. Many newly displaced workers will therefore be able to apply for Medicaid. Under another ACA provision, young adults can stay or go back on their parents' plans as dependents through 26 years of age. And by establishing health insurance marketplaces supported by consumer protections and premium tax credits, the law has allowed people to shop directly for subsidized, comprehensive coverage.

To quantify the ACA's effect on changes in health insurance coverage after job loss, we used national data from the Medical Expenditure Panel Survey to compare the trajectories of nonelderly adults who lost their jobs before 2014 — the year the law's Medicaid and marketplace provisions went into full effect — with the trajectories of those who lost their jobs in 2014 or later. The sample included adults 19 to 64 years of age who were employed at the beginning of the 2-year longitudinal survey but had left or lost their jobs by the end of it. We examined the insurance status of these participants during the first 3 months and the last 3 months that they were surveyed.

Between 2011 and 2013, job loss was associated with an average coverage loss of 4.6 percentage points; the proportion of participants with any coverage decreased from 66.3% to 61.7% (see figure). This overall reduction in coverage was caused by a 12.8 percentage point reduction in ESI that was only partially offset by higher rates of Medicaid and nongroup coverage after losing a job. In the post-ACA period, the overall coverage rate in this population was much higher to begin with (76.2%) — reflecting the additional coverage options available through Medicaid and the marketplaces established under the ACA — and job loss was no longer linked to an increase in the uninsured rate. Large gains in Medicaid (8.9 percentage points) and marketplace coverage (2.6 percentage points) nearly fully offset the reduction in ESI for people who left or lost their jobs. Overall, there was a 6.0 percentage point net reduction in loss of coverage after a job loss in the post-ACA period as compared with the pre-ACA period (see the Supplementary Appendix, available at NEJM.org). These results indicate the critical role that the ACA will play in alleviating coverage losses related to the Covid-associated recession, in keeping with findings from other recent reports.[1,2] Data from early 2020 show that enrollment in marketplace plans and Medicaid is already rising.[3] The ACA's effects would most likely dwarf the emergency measures that are under consideration in Congress to protect people who are laid off from losing their health insurance, such as subsidizing COBRA coverage.

In the context of increased attention to structural racism, it's important to acknowledge the key role that the ACA has played in reducing racial disparities in health insurance coverage.

During the pandemic, job loss has been concentrated among Hispanic and Black workers and workers in service industries. The country's attention to structural racism has intensified in the aftermath of George Floyd's murder and subsequent protests. In this context, it's important to acknowledge the key role that the ACA has played in reducing ra-



	Before Job Loss	After Job Loss	Before Job Loss	After Job Loss	Difference-in-Differences *percentage points (95% CI)*
Any Coverage (%)	66.3	61.7	76.2	77.6	**6.0 (0.9 to 11.1)**
Private, ESI (%)	49.7	36.9	50.3	37.9	0.5 (–4.0 to 5.0)
Private, Non-ESI (%)	5.8	8.0	9.4	11.9	0.3 (–2.6 to 3.2)
Marketplace (%)	—	—	2.2	4.8	**2.6 (1.0 to 4.1)**
Medicaid (%)	8.6	13.8	14.6	23.5	**3.7 (0.1 to 7.3)**
Medicare or Other (%)	2.2	3.1	1.9	4.2	1.4 (0.0 to 2.9)
Uninsured (%)	33.7	38.3	23.8	22.4	**–6.0 (–11.1 to –0.9)**

Pre- and Post-ACA Health Insurance Coverage among Nonelderly Adults with Job Loss.

Bold type indicates a differences-in-differences estimate that is significant at P<0.05 (see the Supplementary Appendix for details). Data are from the Medical Expenditure Panel Survey for 2011–2016. The sample included all adults 19 to 64 years of age who had any employment in the first round of the survey but had become unemployed by the final round (pre-ACA, N=1350; post-ACA, N=1103). Participants were interviewed in five rounds over 2 years. The mean age of the full population-weighted cohort was 39.7 years, and 57.5% of participants were female, 13.5% were Black, and 17.7% were Hispanic. Insurance types were mutually exclusive and were defined according to the following hierarchy: (1) employer-sponsored insurance (ESI), (2) Medicaid, (3) marketplace or nongroup insurance, (4) Medicare or other, and (5) uninsured. Percentages may not total 100 because of rounding. CI denotes confidence interval.

cial disparities in health insurance coverage. In our analysis, the ACA's protective effects against becoming uninsured after a job loss were largest for Black people (a 7.0 percentage point reduction in loss of coverage) and Hispanic people (a 13.9 percentage point reduction).

Even with the ACA, gaps in insurance coverage remain. Fourteen states have not yet expanded their Medicaid programs, despite evidence of the economic and public health benefits of expansion.[4] Several states have approval from the Centers for Medicare and Medicaid Services to add work requirements to their programs, even though the current recession undercuts a key argument commonly made in favor of work requirements: that reliance on public welfare programs is the major barrier to employment. Other persistent gaps include a lack of coverage options for undocumented immigrants, who are ineligible for public programs or marketplace subsidies. Finally, for people in many occupations — especially blue-collar, seasonal, and part-time workers — employment was hardly a guarantee of coverage to begin with, though these groups have benefited the most from the ACA's coverage expansion.[5]

The Families First Coronavirus Response Act increased the federal government's share of Medicaid costs for the duration of the Covid-19 emergency, and it prevents states from cutting eligibility. Additional policies that could help people who lose their jobs include boosting incentives offered to states that haven't expanded their Medicaid programs, authorizing a special enrollment period related to the Covid-associated recession to permit people to purchase marketplace coverage outside standard enrollment periods, and using unemployment insurance itself as a mechanism for auto-enrolling people in Medicaid.[2,3]

While policymakers work to close these remaining gaps, it's imperative that other gaps not be reopened. The ACA's fate will again hang in the balance when

the U.S. Supreme Court considers the law's constitutionality in *California v. Texas*. This newest challenge comes from a contingent of 18 Republican state attorneys general who argue that the individual mandate, which was ruled unconstitutional in the lower courts after the associated tax penalty was zeroed out, is not severable from the rest of the law, and therefore the entire law is unconstitutional. The Trump administration filed a brief in support of striking down the law, and President Donald Trump recently reiterated his desire to "terminate" the ACA.

In the current context of millions of Americans losing their jobs and an ongoing pandemic, overturning the ACA would most likely be devastating to patients, clinicians, hospitals, and state economies. The very virus that has brought about record unemployment levels is the same agent that makes health insurance — and the new options created under the ACA — more important than ever.

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Redoubling Efforts to Help Americans Quit Smoking — Federal Initiatives to Tackle the Country's Longest-Running Epidemic

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The 2020 U.S. Surgeon General's report on smoking cessation[1] is the first such report to focus on this topic since 1990. Its release came as the Department of Health and Human Services was investigating an outbreak of deadly lung injuries linked to the use of e-cigarette, or vaping, products. Although these products pose a new public health challenge, we cannot lose sight of the fact that the burden of death and disease associated with tobacco use in the United States is still overwhelmingly caused by combusted tobacco products, especially conventional cigarettes.[2] The rate of cigarette smoking among U.S. adults is 13.7%, its lowest point since monitoring of smoking rates began in 1965,[1] yet smoking remains the country's leading preventable cause of death and disease, and it costs the United States more than $300 billion annually.[2,3] Increasing smoking-cessation rates among adults is the fastest way to reduce this health and economic burden.[1] As leaders of three of the federal agencies responsible for reducing tobacco-product use, we are committed to intensifying our efforts to help Americans quit smoking.

Most adult smokers want to quit.[1] Less than 10% successfully quit each year,[1] however, largely because cigarettes are designed to create and sustain nicotine addiction.[2] The popualtion-wide cessation rate is driven by two factors: the number of quit attempts and their success rate.[1] Each year, just over half of smokers attempt to quit, but most try to quit multiple times before succeeding. More needs to be done to increase the number of quit attempts and the likelihood of success of each attempt. Tobacco dependence is a chronic, relapsing condition and should be treated accordingly. Clinicians should encourage patients to keep trying to quit and offer support and assistance until and even after they succeed.

Effective cessation treatments are available. Individual, group, and telephone-based counseling increase success rates, as does each of the seven smoking-cessation medications approved by the Food and Drug Administration