

## 2019 Agenda for Improving Health Care Coverage, Equity, and Value in the States

State legislative sessions in 2019 bring new opportunities to advance policy that improves health care coverage, value, and equity. With new governors in 17 states, and hundreds of freshman lawmakers, 2019 also brings opportunities for states and advocates to improve health care and health overall through legislative action.

This advocacy agenda offers options for improving health and health care at the state level during the 2019 session. [Bills passed and considered in the 2018 session](#)<sup>1</sup> provide a foundation for health care policymaking in 2019, but there are also new frontiers to explore for health care coverage, equity, and value this year. Here we provide state policy options to consider in 2019 regarding private insurance coverage, Medicaid, oral health coverage, health equity, prescription drugs, surprise medical bills, and health care value.

### Improving Private Insurance Coverage

Efforts to undermine the framework of private health insurance have threatened access to and the affordability of coverage, but states have an opportunity to establish protections that will cover more uninsured people and keep premiums down. Legislative options to improve and expand coverage are spelled out in the Families USA report, [Seven State Options to Reduce the Number of Uninsured \(and Stabilize Insurance Markets\)](#).<sup>2</sup> In addition to the topics discussed here, this report addresses:

1. Medicaid buy-in.
2. state-funded premium and cost-sharing assistance.
3. the Basic Health Program
4. outreach and enrollment assistance
5. streamlining enrollment.

Below we provide examples of legislative initiatives that states can pursue to protect and improve their insurance markets in 2019.

- » **State-based individual mandate.** Starting in 2019, the federal government is no longer enforcing the requirement that all individuals have insurance coverage if they can afford it. States may want to consider implementing their own individual mandates to keep their insurance markets robust and help keep insurance risk pools balanced and premiums reasonable. States may also want to explore policies they can implement that connect efforts to increase enrollment and distribute subsidies to income-eligible individuals with the

enactment of an individual mandate. States can consider the following examples for exploring a state-based individual mandate:

- › [New Jersey](#)<sup>3</sup> and [Vermont](#)<sup>4</sup> enacted state-level individual mandates in 2018 based on the model of the individual mandate included in the Affordable Care Act (ACA).
  - › The District of Columbia [enacted an individual mandate](#)<sup>5</sup> under which revenue from the mandate penalty will support outreach to uninsured District residents, dissemination of information to residents about their health insurance options, and other initiatives to increase insurance availability and affordability.
  - › Maryland is considering implementing a state-based mandate combined with a mechanism to use penalty payments collected from individuals who do not have coverage to assist them in directly paying premiums and purchasing health insurance. For more on this model, see [Health Insurance Down Payments: The Maryland Plan](#),<sup>6</sup> from Families USA.
- » **Reinsurance.** Many states have worked to establish reinsurance programs to lower insurance premiums for consumers who do not receive income-based premium credits. To help advocates and policymakers decide whether this policy is the best use of state resources, Families USA is developing resources on considerations for states seeking to make premiums more affordable. This information will be available in the coming months. Under reinsurance, the costs of very high claims are paid from a pool financed by a wider set of insurers instead of only one insurer, bringing down individual insurance premiums and stabilizing the marketplace. States can pass laws to set up reinsurance programs through

[1332 waivers](#)<sup>7</sup> that they can apply to receive from the federal government. Advocates considering this approach should be aware that 1332 waivers can also be used for harm, and they should consider how to maximize federal resources under a waiver both for beneficiaries of reinsurance (who earn too much to qualify for premium credits) and people who are eligible for income-based premium credits. Information on states that have established or are working to establish reinsurance programs with 1332 waivers is provided through:

- › [Families USA's 1332 Waiver Strategy Center](#).<sup>8</sup> Visit our Waiver Strategy Center to learn about approved and pending reinsurance proposals in states including Alaska, Maine, Maryland, Minnesota, New Jersey, Oregon, and Wisconsin.
  - › [Alaska's Reinsurance 1332 Waiver: An Approach that Can Work](#).<sup>9</sup> This factsheet details how Alaska's reinsurance system works, and the steps required to obtain a 1332 reinsurance waiver.
- » **Protecting against the harms of short-term and association health plans.** States have authority to regulate or prohibit the sale of health plans that are not guaranteed to comply with all standards for comprehensive health coverage. Federal regulations have expanded the sale of short-term plans and association health plans, but states may want to enact policies that limit or prohibit the sale of these plans so consumers do not suffer from inadequate coverage or high costs if they enroll in them, and so these plans do not undermine states' markets for comprehensive coverage. The following resources discuss how states can take action related to short-term and association health plans to protect consumers:

- › [State Strategies to Prevent the Harmful Impact of Short-Term Health Plans](#).<sup>10</sup> This Families USA resource provides a set of strategies that can protect against short-term plans at the state level.
  - › [State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market](#).<sup>11</sup> This Commonwealth Fund study explores how states regulate coverage arrangements that do not comply with the ACA's individual market and includes recommendations for how states can level the playing field.
- » **Upholding consumer protections.** Consumers are guaranteed certain health insurance protections under federal law, but in 2019 states may want to consider enacting these protections under state law if they have not already done so. This will be important to ensure consumers do not lose their current access to coverage or care if federal law changes in the future. Protections that states may want to enact into state law in 2019, if they have not already done so, include the following:
- › **Protections against preexisting condition discrimination.** States may want to pass laws that mirror current federal law in requiring that medical underwriting is prohibited, such that insurers may not deny coverage, increase premiums, or refuse to cover certain services because of preexisting conditions. To find out whether your state already has preexisting condition protections, see [Lawsuit Threatens Affordable Care Act Preexisting Condition Protections But Impact Will Depend on Where You Live](#).<sup>12</sup>

- › **Coverage of essential health benefits.** To ensure consumers have guaranteed access to the 10 essential health benefits currently required under federal law, states can enact essential health benefits requirements into state law. See Connecticut [H.B. 5210](#),<sup>13</sup> passed in 2018, which mandates insurers to cover essential health benefits while simultaneously expanding mandated health benefits for women, children, and adolescents.

## Medicaid

Medicaid expansion and protection of Medicaid benefits will remain on the agenda in many states. Although the federal government funds 90 percent of the costs to provide coverage for low-income adults and families, [14 states still have not expanded](#)<sup>14</sup> Medicaid coverage. In addition, some states are proposing plans to restrict eligibility for the Medicaid program or are increasing bureaucratic red tape for consumers who need coverage. Here are steps that states can take in 2019 to protect and improve their Medicaid programs:

- » **Medicaid expansion.** In 2018, [Virginia adopted Medicaid expansion](#),<sup>15</sup> becoming the first state to adopt an expansion in a state legislature since 2014. Three other states followed the example set by Maine in 2017 and put [Medicaid expansion initiatives](#)<sup>16</sup> on the ballot in 2018. Idaho, Nebraska, and Utah passed ballot initiatives for expansion after state lawmakers and governors repeatedly refused to provide Medicaid coverage for adults and families. State lawmakers will take up [implementation](#)<sup>17</sup> of these expansions in 2019, which will likely be on the legislative agenda in Kansas, North Carolina, and Wisconsin.
- › States anticipating work on Medicaid expansion can [find the Families USA Medicaid Expansion Toolkit here](#).<sup>18</sup>

» **Medicaid restrictions.** After federal officials opened the door to new restrictions on Medicaid coverage, some states chose to increase bureaucratic red tape for the eligibility process. [Families USA's Waiver Strategy Center](#)<sup>19</sup> provides tools and strategies for fighting such proposals, including requirements that people prove they work in order to receive and maintain Medicaid eligibility.

- › California, however, provides a model for states seeking to go in the opposite direction. Learn about California's law that [prohibits work requirements and other restrictions on Medicaid eligibility](#).<sup>20</sup>

## Oral Health Coverage

Millions of Americans suffer the physical and financial consequences of untreated oral health problems, and our health care system pays the price. Poor oral health is linked to diabetes, adverse pregnancy outcomes, heart disease, childhood illnesses, and lost school and work hours. Health coverage for oral health care, particularly in public programs, is often inadequate. However, many states have started to understand that oral health coverage is a wise investment and foundational to other efforts that address oral health access. States have the option to include oral health coverage in their state Medicaid programs for adults; yet many states either do not cover this critical care or offer only limited coverage. Medicare does not cover dental care at all. States can pass legislation that expands eligibility for, or the comprehensiveness of, dental coverage for adults in the Medicaid program. Alternatively, states can call on the federal government to look at Medicare oral health coverage. In 2019, your state can take the first step toward improving adult oral health by:

» **Establishing or restoring comprehensive adult dental coverage.** For example, in 2018, [Illinois](#)<sup>21</sup> and [Massachusetts](#)<sup>22</sup> added coverage of certain dental services for adults to their Medicaid programs, making their benefits fairly robust.

If your state is not ready to pass legislation that provides extensive oral health coverage for all adults, consider:

- › Establishing or restoring limited coverage or specific services. In 2018, [Idaho](#)<sup>23</sup> passed legislation to provide adults receiving Medicaid with coverage for preventive dental services.
- › Covering certain populations, such as pregnant women or people with disabilities. [Virginia](#)<sup>24</sup> passed legislation in 2015 to cover oral health services for pregnant women receiving Medicaid.
- › Starting a pilot program that offers oral health coverage for a certain small population of adults, as was passed in [Maryland](#)<sup>25</sup> in 2018.

» **Calling on the federal government to include dental coverage in Medicare.** Medicare currently excludes dental coverage, and state Medicaid programs may be footing the bill for the health consequences to low-income seniors and people with disabilities who lack dental coverage.

## Health Equity

The U.S. health care system fuels and perpetuates pervasive health inequities based on race, ethnicity, and geography, among many other factors. When working toward health equity, coverage for people who are marginalized is an important part of the work we do for a more equitable health care system. Lack of access to care exacerbates health inequities, and increased coverage for populations can directly

address gaps. Undocumented residents have been barred from coverage under federal policy, but states can take action to close the coverage gap for this population by:

- » **Providing coverage to all children, regardless of immigration status.** Six states—[California](#),<sup>26</sup> [Massachusetts](#),<sup>27</sup> [Washington](#),<sup>28</sup> [Oregon](#),<sup>29</sup> [Illinois](#),<sup>30</sup> and [New York](#)<sup>31</sup>—and the [District of Columbia](#)<sup>32</sup> have enacted Cover All Kids legislation, which ensures children are able to access health care coverage regardless of immigration status.
- » **Covering undocumented adults.** In 2018, the California legislature considered [legislation](#)<sup>33</sup> to expand Medi-Cal coverage to all income-eligible adults regardless of immigration status, and considered alternative approaches to cover young adults. Legislation to cover all income-eligible adults regardless of immigration status in Medi-Cal was [reintroduced](#)<sup>34</sup> for the 2019–2020 session. Governor Newsom’s 2019 [budget proposal](#)<sup>35</sup> includes expanding the Medi-Cal program to cover all income-eligible Californians ages 19–25 regardless of income status.

Health care transformation efforts focus on improving the quality and reducing the cost of health care, while to a great extent not prioritizing achieving equity as a component of transformation. Families USA recently launched the Center on Health Equity Action for System Transformation and published [A National Priority Agenda to Advance Health Equity Through System Transformation](#),<sup>36</sup> which identifies the top 19 recommendations for 2019 and beyond. A few that states looking to improve equity could take on as a priority in 2019 include:

- » **Payment systems that sustain and reward high-quality, equitable health care.** Developing payment systems that specifically support and reward reduction of disparities is essential to achieving equity. Medicaid programs can lead the way by building disparities reductions into pay for performance or other value-based payment programs. Oregon did this through its Medicaid payment transformation effort by requiring its network of health care providers—called coordinated care organizations—to develop plans to reduce identified disparities. This overall initiative has demonstrated [some early success](#)<sup>37</sup> in [reducing](#)<sup>38</sup> white-black and white-American Indian/Alaska Native disparities.
- » **Equity-focused measurement that accelerates reductions in health inequities.** As the foundation for payment transformation, it is vital that measurement be used to identify and monitor health inequities. Advocates should look at legislative and administrative opportunities to require the collection and reporting of stratified data. For example, the quality measures that Oregon uses to evaluate its coordinated care organizations are [stratified by race and ethnicity](#)<sup>39</sup> and reported publicly. It is also important that health data be disaggregated to capture disparities and measure progress for subpopulations that would otherwise be missed. For example, in 2016, California passed legislation to require the collection and reporting of data that are disaggregated to account for additional Asian Pacific Islander groups.
- » **A diverse health care workforce that drives equity and value.** Ultimately, no health care system can work without the appropriate workforce. The U.S. health care workforce needs

to grow to meet burgeoning demand, and it must be more ethnically and racially diverse, better distributed geographically, and inclusive of a broader array of roles—including primary and mid-level care providers, community health workers (CHWs), and peers. Advocates should look for opportunities to build financing streams for CHWs and similar community-based care team members into all payment models, particularly in Medicaid. For example, in 2017, [Connecticut passed legislation](#)<sup>40</sup> that laid the foundation for broader use of CHWs by establishing a common definition and directing the state to study the feasibility of certification.

## Prescription Drug Pricing

High and rising prescription drug prices jeopardize consumers' health and financial well-being. Consumers experience the impact of drug prices through increasing insurance premiums and high out-of-pocket expenses for medicines. While drug companies and other entities in the supply chain continue to contribute to high and rising prices, states are taking action to rein in these excessive costs. Some options for states to consider on the issue in 2019 include:

- » **Establishing a prescription drug affordability board.** States can enact legislation to establish a commission, or affordability board, to set reasonable reimbursement rates that all payers in the state will pay for drugs priced over a certain amount. Maryland [H.B. 1194](#)<sup>41</sup>/[S.B. 1023](#)<sup>42</sup> from 2018 is an example of such legislation.
- » **Penalizing price gouging.** After a prescription drug comes to market, drug makers often increase the price year after year to ensure a significant profit stream. To limit the impact of annual price increases, states can enact legislation that taxes drug price increases that exceed a set threshold. [A Tax on Drug Price Increases Can Offset Costs](#)<sup>43</sup> from The Pew Charitable Trusts provides information about how this could work at the state level.
- » **Requiring prescription drug price transparency.** State legislatures that hesitate to work more directly on drug pricing reforms can consider transparency laws to eliminate some of the mystery around drug pricing and practices that are followed throughout the supply chain. [California](#)<sup>44</sup> and [Oregon](#)<sup>45</sup> led the way recently by passing transparency bills that require manufacturers to disclose when drug prices increase beyond certain thresholds. These bills also add scrutiny of drug prices to existing insurance rate review processes. The laws require information on drug prices, profits, and other practices to be made public and, in some cases, justified to relevant agencies.
- » **Regulating pharmacy benefit managers.** States may also want to consider taking action to address pharmacy benefit manager (PBM) practices that harm consumers and increase drug costs, or building on their existing PBM laws. Health plans hire PBMs to negotiate drug prices, build formularies, and pay pharmacy claims. Plans expect PBMs to drive down drug prices, but their practices can also inflate costs. States interested in changing PBM practices can consider:
  - » Requiring that consumers pay the lowest cost at the pharmacy counter. Some PBM contracts have historically restricted pharmacists from revealing to consumers if it would be less expensive for them to pay for their drugs out of pocket rather than using their insurance coverage. Although Congress enacted a [federal law](#)<sup>46</sup> in 2018 to prohibit these contract terms, states can do more to ensure that consumers

feel the benefits of banning these types of contracts. States can consider:

- Requiring insurers to count cash payments for covered drugs toward a consumer’s in-network deductible and out-of-pocket cap. For example, [AB 315](#),<sup>47</sup> enacted in California in 2018, requires cash payments to count toward a consumer’s deductible and out-of-pocket cap, and [H 463](#),<sup>48</sup> passed in Kentucky in 2018, requires cash payments to count toward an out-of-pocket cap.
  - Requiring pharmacists to disclose the lowest out-of-pocket cost option available to a consumer at the point of sale.
  - Restricting a PBM’s ability to charge a covered consumer more than the cash price of a prescription they fill, as in [FLH 351, enacted in 2018](#).<sup>49</sup>
- › Ensuring PBM transparency. PBMs often operate in a black box with regard to the size of rebates negotiated with manufacturers, including the amount of a rebate kept for compensation and the amount that is passed on to payers and consumers. In 2018, Lawmakers in Louisiana passed [S 283](#)<sup>50</sup> on PBM transparency, which requires PBMs to report aggregated data on rebates to the state’s insurance department. [Connecticut](#)<sup>51</sup> passed a law in 2018 that requires transparency of rebates in the aggregate as they are distributed from manufacturers to PBMs and then to payers and down to the consumer.

## Surprise Billing

Many states have taken action to protect consumers from surprise bills they receive when they expect to see an in-network provider but find that the provider is out of network. Opportunities remain ripe in 2019 for legislation that protects consumers from such surprise bills in both emergency and non-emergency situations, while also holding down health system costs by developing sensible reimbursement structures that determine an insurer’s payments to out-of-network providers in surprise billing situations. The state models below provide ideas if your state is considering legislative action on surprise bills in 2019.

- » [New Jersey’s Assembly Bill 2039, enacted in 2018](#).<sup>52</sup>
- » [New York’s New “Surprise Bill” Law Rolls out New Health Insurance Protections for Consumers](#) (Families USA).<sup>53</sup>
- » California [AB 72: Stop Surprise Medical Bills from Out-of-Network Doctors at In-Network Facilities](#)<sup>54</sup> (Health Access California and California Labor Federation).
- » [Florida House Bill 221](#)<sup>55</sup> (2016).
- » [State Efforts to Protect Consumers from Balance Billing](#)<sup>56</sup> (The Commonwealth Fund).

## Health Care Value

Under our health care system’s current paradigm, the health care industry drives spending without meaningfully improving quality and health outcomes. This unsustainable model fails to provide high-quality, affordable health care to consumers. Health care costs are ever-increasing, quality and health outcomes are suboptimal, and the delivery system is fragmented.

The health care system must transform to meet the needs of consumers, particularly those who are most vulnerable. States can pursue various strategies to transform the health care system to uproot the drivers of high and rising costs and suboptimal quality, and to ensure the health care system provides high-value care to the consumers it serves. Some ways in which states can work to enhance value include:

- » Addressing consolidation in health care industries. For example, in 2018, California enacted [Assembly Bill 595](#).<sup>57</sup> This legislation requires health insurers to obtain approval from state regulators before merging, allows state regulators to reject mergers that will negatively impact competition, and increases transparency and public participation in the merger review process. It also requires regulators to obtain an independent analysis of the impact of proposed mergers on consumers and the stability of the health care delivery system and includes other steps to scrutinize the impact of proposed merges on consumers and the health system.
- » Increase access to and interoperability of health data. For example, in 2018, Virginia launched its [Emergency Department Care Coordination Program](#).<sup>58</sup> This program uses the state's health information exchange to enable health plans, providers, and care teams for patients receiving emergency care to exchange information. It aims to provide emergency providers with critical medical information in a timely manner. Its goal is to increase the effectiveness and efficiency of emergency care by avoiding duplicative tests and dangerous or unnecessary prescribing, thereby improving health outcomes and reducing costs.



## Endnotes

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