Health Systems Digest

NCSL | NATIONAL CONFERENCE of STATE LEGISLATURES

AN NCSL SERVICE TO STATE LEGISLATIVE HEALTH STAFF

VOL. 5, APRIL 2019

ABOUT THIS DIGEST: The NCSL Health Program works in collaboration with professional researchers and writers across the nation. They often publish and post material on current state events that are valuable but may be hard to find for busy legislators and legislative staff. This digest pulls together a concise list that may be of interest or use for your legislative research, hearings, briefings or other events. A special thanks to The Commonwealth Fund for supporting this resource.

States Work to Counteract Surprise Medical Billing

Numerous people have reported receiving extremely high medical bills that they unknowingly incurred while visiting a health care facility or receiving treatment. Surprise medical bills, a practice also known as balance billing, occur when someone seeks care at an in-network facility but receives treatment or services from a provider that is out of network. This brief sheds light on what surprise billing is and what states are doing about it. READ THE NCSL LEGISBRIEF

State Efforts to Protect Consumers from Balance Billing

About one-quarter of insured Americans are considered underinsured because they have significant coverage gaps or high out-of-pocket costs. And all consumers are vulnerable to surprise medical bills, or balance bills, for out-of-network care. In research published by the Commonwealth Fund, as of December 2018, at least 25 states have laws offering some balance-billing protection to their residents, and nine of them offer comprehensive protections. VIEW THE RESEARCH

CMS Issues the 2019 Exchange Open Enrollment Period Final Report

The Centers for Medicare & Medicaid Services (CMS) released the final Health Insurance Exchanges 2019 Open Enrollment Report. Specifically, the report shows approximately 11.4 million consumers selected or were automatically re-enrolled in an Exchange plan during the 2019 open enrollment period in the 50 states, plus D.C. This represents a decline of around 300,000 plan selections from the same time last year. Also, as outlined in the report, average total premiums for plans selected through HealthCare.gov dropped by 1.5% from the prior year. VIEW THE CMS REPORT

Tracking State Innovations in Medicaid: A Two-Part Series

Medicaid now accounts for 17% of total state spending, according to The Pew Charitable Trusts. As states continue to spend a significant portion of their general funds on Medicaid, policymakers continue to explore strategies to improve the efficiency, outcomes and cost-effectiveness of their Medicaid programs. This two-part blog series highlights Medicaid innovations from across the country in 2018—many of which are also being debated in 2019 legislative

sessions—including Medicaid expansion and community engagement and work requirements. READ THE NCSL BLOG PART ONE; PART TWO

The Administration Tried to Make it Easier for States to Waive ACA Rules: Will Any Take the Plunge?

Late last year, the Trump administration issued a pair of regulatory guidance documents that effectively rewrote the Affordable Care Act's (ACA's) Section 1332 innovation waiver program, which authorizes the federal government to permit states to establish programs waiving certain provisions of the ACA. Once recognized as a tool for states to improve health coverage in line with the ACA's goals, the waiver program has been recast to offer states a way to make broader changes to insurance coverage for their residents. Still, it's not yet clear whether any state will take up that offer, according to a blog from the Commonwealth Fund. READ THE ARTICLE

CMS Releases New Info on State Reinsurance Funding

CMS released new information on federal pass-through funding under Section 1332 of the ACA in February. CMS devoted a new section of its website on Section 1332 waivers to pass-through funding resources, an updated methodology, answers to frequently asked questions (FAQs), and state-specific premium data for the seven states with a current state-based reinsurance waiver. The new resources are designed to provide additional clarity as to how CMS and the Treasury Department calculate the amount of federal pass-through funding for each state. These calculations have been a source of concern among policymakers in states such as Minnesota and New Jersey after the federal government determined that certain states would receive less pass-through funding than expected for 2019. The guidance makes clear that states are responsible for fully funding their reinsurance programs even if federal pass-through funding is less than expected. This will likely impact how additional states structure their reinsurance programs going forward, according to author Katie Keith. READ HEALTH AFFAIRS; READ RELATED HEALTH AFFAIRS ARTICLE – Unpacking Lower Federal Funding For Minnesota's Reinsurance Program

What, if Anything, Do the Latest Cost Sharing Reduction (CSR) Court Rulings Mean for 2020 Premiums?

Several recent federal court decisions have held that the federal government owes insurers billions in cost-sharing reduction (CSR) payments. The administration cut off those payments in October 2017, after efforts to repeal the ACA failed in Congress. Insurers promptly sued, arguing that the government had breached its statutory obligation to compensate insurers for offering the mandated low cost-sharing plans. Because this litigation is almost certain to carry over into 2020 or beyond, this brief from researchers at the Georgetown University Center for Health Insurance Reforms suggests that states not change their approach to insurers' rating practices for 2020. However, the researchers argue, states should consider what their approach should be if insurers do prevail in the litigation and states have an opportunity to recoup what otherwise would be a windfall for insurers. SEE THE BRIEF

The Marketing of Short-Term Health Plans

In 2018, a federal rule changed the definition of short-term limited-duration insurance (STLD) so that it could be sold as a full-year substitute coverage for traditional health insurance. This rule change created new marketing opportunities for insurance companies and brokers. It has been suggested that STLD plans are risky for consumers because many people who purchase them mistakenly believe that they are as comprehensive as traditional, ACA-compliant plans. In a study published by the Robert Wood Johnson Foundation, authors assess short-term limited-duration insurers' marketing tactics in the wake of the new federal rules and, through interviews with insurance officials in Colorado, Florida, Idaho, Maine, Minnesota, Missouri, Texas, and Virginia, how regulators have evaluated and prepared for this new market. VIEW THE STUDY

Court Strikes Down a Trump Administration Rule that Circumvents Aspects of the ACA

On March 28, a federal district court in Washington, D.C., invalidated the core of a Trump administration rule designed to alter the federal government's long-standing approach to regulating association health plans (AHPs). Researchers at Georgetown's Center on Health Insurance Reform have written about how the new rule could pose risks to consumers, health care providers, and insurance markets by making it easier for AHPs to offer coverage that is exempt from key ACA provisions. READ THE BLOG

Map: State Efforts to Develop Medicaid Buy-In Programs

In the absence of federal legislation to stabilize the individual market, states are examining strategies to strengthen their marketplaces and maintain coverage gains. In recent months, states have increasingly introduced proposals for individuals above Medicaid eligibility levels to "buy-in" to Medicaid (leverage the Medicaid program in some way) or develop a "public option" to strengthen coverage across the individual market and Medicaid. These Medicaid buy-in or public option programs offer states an opportunity to make coverage more affordable and accessible in their state. The State Health and Value Strategies (SHVS) program has mapped out current legislative state activity and included links to relevant legislation. VIEW THE MAP

The Role of Medicaid Expansion in Care Delivery at Community Health Centers

More than 1,300 Federally Qualified Health Centers (FQHCs) operate across the United States, providing primary care to medically underserved communities, regardless of patients' insurance status or ability to pay. Research shows they save the health system money, in part by reducing the need for people to seek more expensive care in emergency departments, while also boosting the economy through job creation and the purchase of goods and services. This brief uses data from the Commonwealth Fund 2018 National Survey of Federally Qualified Health Centers to compare the experiences of health centers in states that have and have not expanded Medicaid. READ THE BRIEF