YEAR-END REPORT - 2019

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I. Introduction

This year continues the tension between expanding health insurance for individuals, protecting coverage and controlling the costs of insurance and care.

II. MEDICAID EXPANSION

Arkansas

2019 AR H.B. 1929 (NS), introduced March 26, to create the Medicaid Expansion Efficiency Act of 2019 and to declare an emergency.

California Offers Medicaid Eligibility to Undocumented Immigrants

California is the first state to offer Medicaid benefits to young adults living in the United States illegally. [FN1] Governor Gavin Newsom (D) signed a bill into law that makes low-income adults aged 25 and younger eligible for Medicaid regardless of immigration status. The state already covers children under age 18 regardless of immigration status.

Some state Democrats pushed to expand coverage to even more immigrant adults, but Newsom rejected the plan since it would cost $3.4 billion to cover all persons living in the state illegally. However, Newsom said he hopes to expand coverage to more immigrant adults in the years to come.

Around 90,000 people are expected to be covered under this plan at a projected cost of $98 million.

Connecticut

2019 CT S.B. 1052 (NS), enrolled June 18, to require the Commissioner of Social Services to expand Medicaid coverage of telehealth services state wide whenever such coverage meets federal Medicaid requirements for efficiency, economy and quality of care.

Florida

2019 FL H.B. 1311 (NS), filed March 3, expands Medicaid coverage for certain individuals by specified date; requires AHCA to submit request for amendment of state Medicaid plan to implement such expansion; requires implementation of Florida COMPASS demonstration project and TEEOP for participation by certain eligible individuals; provides eligibility and participation criteria; creates Medicaid Access and Coverage Council within AHCA; provides appropriations and authorizes FTE positions.

Georgia Plans for Limited Medicaid Expansion

Governor Brian Kemp (R) is set to detail a waiver proposal that could lead to limited Medicaid expansion in Georgia. [FN2] The governor has long ruled out full expansion, which he sees as too costly, but has been open to a more scaled-back program.

The Kemp administration's Medicaid policy seeks to harmonize separate proposals that would lower insurance premiums and undercut the ACA. Premiums would be lowered by setting aside more than $300 million in public money to pay insurance firms to cover high-cost claims. Another $2.7 billion in federal subsidies would be shifted to state control to reduce costs for lower-income policyholders.

The waiver needs to withstand federal scrutiny and any money needed to run the waiver program would have to come through the state legislature. A legislator opposing the waiver argues that it “costs more person, covers fewer people and takes longer to get started than a straightforward expansion of Medicaid.” Kemp has also been open to adopting elements of other waivers, such as tying eligibility to jobs, school enrollment or community service, which have recently met strong opposition in federal court.

Feds Partially Reject Idaho Medicaid Expansion Waiver Request

A part of Idaho's Medicaid expansion waiver request, which would allow newly-eligible residents to buy private insurance using federal tax credits, has been rejected by CMS because the plan would be too costly for the federal government. [FN3]

Following voter-approval of expansion last November, a state law was passed this year requiring that waiver applications be submitted for various proposals, including work requirements. There is disappointment and surprise amongst Idaho Republican officials. They worked closely with federal agencies throughout the process and claim that at no point was an indication made that the state's cost neutrality guardrail would be insufficient.

While supporters believe the plan would save the state money, critics argue that significant differences between Medicaid and private insurance would create problems, such as disparate covered services and out-of-pocket costs.

The Department of Health and Welfare is also now taking public comment on a second possible waiver regarding work requirements. [FN4]

Idaho

• 2019 ID H.B. 290 (NS), introduced March 22, amends and adds to existing law to provide funds for Medicaid expansion and other services and to provide exclusions from eligibility for the county medically indigent program and the catastrophic health care cost program.

• 2019 ID S.B. 1204 (NS), engrossed April 1, amends existing law to review provisions regarding Medicaid eligibility expansion.

Kansas Medicaid Expansion Stalled

After Governor Laura Kelly (D) was elected last November largely on the issue of Medicaid expansion, along with a newly empowered coalition of liked-minded Democratic and moderate Republican legislators, expansion seemed inevitable. [FN5] However, a bill that would have enacted expansion never reached the senate floor since a handful of Republican leaders blocked its progress by linking it to the welfare state and “the abomination of Obamacare.”

As a result, Kansas remains as one of the fourteen states yet to expand their Medicaid program. Despite the fact that a Kaiser poll from last November showed a 77% support of Medicaid expansion, holdout politicians are deploying a new playbook like that used here to prevent the adoption of the measure: slow-walking bills, undermining grassroots ballot measures or utilizing procedural roadblocks, then adding provisions with a conservative twist that make passage unlikely.

Advocates say they will try expansion again next year.

Kansas

2019 KS H.B. 2030 (NS), introduced January 14, to expand eligibility for Medicaid benefits to the extent permitted by the Affordable Care Act.

Mississippi

• 2019 MS H.B. 290 (NS), introduced January 14, to expand eligibility under federal healthcare law and under CHIP.

• 2019 MS S.B. 2323 (NS), introduced January 21, to expand eligibility to include individuals entitled to benefits under federal Patient Protection and Affordable Care Act.

• 2019 MS H.B. 928 (NS), introduced January 21, to require Governor and Division of Medicaid to negotiate to obtain federal waiver to expand Medicaid coverage.

• 2019 MS H.B. 290 (NS), introduced January 14, would expand eligibility under the ACA and CHIP.

• 2019 MS H.B. 257 (NS), introduced January 14, would require the Governor and Division of Medicaid to negotiate to obtain a federal waiver to expand Medicaid coverage.

• 2019 MS H.B. 316 (NS), introduced January 14, would expand Medicaid for adults under 65 years old whose income is at or below 133% FPL.

Missouri Groups Advocate for Medicaid Expansion Ballot Measure

Hospital groups, physicians, patients and business executives are launching a campaign in Missouri to put Medicaid expansion on the 2020 ballot. [FN6] At least 172,000 signatures will be needed for the measure to qualify for the ballot.

So far, the campaign has received significant financial backing from the Fairness Project, a D.C.-based nonprofit. The Fairness Project hopes that the movement can build off success from the pro-health wave 2018 election. The Missouri Hospital Association, another supporting organization, said rural hospitals particularly need Medicaid expansion to stay open. Nine rural hospitals have closed in the state since 2014.

Even if the measure qualifies and is approved by voters, it will not be a done deal. Other states, such as Maine, Utah and Idaho have approved expansion but later balked at implementation or tried to slim-down the program.

Montana

• 2019 MT H.B. 425 (NS), introduced February 7, to revise and make permanent Medicaid expansion.

• 2019 MT H.B. 658 (NS), adopted May 9, to generally revise healthcare laws and permanently expand Medicaid.

Lawsuit Challenges Nebraska Medicaid Expansion Delay

Advocacy group Nebraska Appleseed has filed a lawsuit seeking court action that would require the state to implement Medicaid expansion this year, instead of a delayed date as planned by Governor Pete Ricketts' (R) administration. [FN7] This suit is on behalf of two individual who are eligible for coverage under expansion, which was approved by voters last November.

The Nebraska Department of Health and Human Services announced in April that expansion for some 90,000 uninsured residents would not be implemented until October 1, 2020. Administration officials defend the decision, citing that federal approval is still pending and that other steps must be completed first, such as technology buildouts, contract negotiations and regulatory changes.

Appleseed argues that the state is ignoring voter intent by the long delay with complex tiered benefit plans and work requirements. It is also concerned that delayed implementation would mean a failure to capture around $149 million in federal funds for the program, since reimbursement rates will drop from 93% to 90% on January 1, 2020.

The lawsuit seeks to require state officials to open enrollment on or before November 17, 2019.

North Carolina Medicaid Expansion Bill Expected to Move Forward

North Carolina House Speaker Tim Moore (R) anticipates that a Republican Medicaid expansion proposal will get another look soon. [FN8] It would provide for expansion, but with small premiums and work requirements. Governor Roy Cooper's (D) budget did not include these expansion criteria and was recently vetoed by the house.

Group Seeks to Put Medicaid Expansion Issue Before Oklahoma Voters

A coalition of medical professionals, patients, business leaders, nonprofits and health care advocates are launching a campaign to put the issue of Medicaid expansion to voters in Oklahoma. [FN9] The group supports a plan for the state to obtain around $1 billion annually in federal dollars for expanding the program to some 200,000 residents. About 90% of the expansion would be funded with federal money, but Republican leaders are concerned that state's share would cost too much.

178,000 signatures must be collected by the coalition before the issue can be put on the November 2020 ballot. A conservative think tank challenged the initiative, arguing it unconstitutionally cedes state power to the federal government. However, the Oklahoma Supreme Court has rejected the challenge allowing signature gathering to continue. [FN10]

Tennessee

• 2019 TN S.B. 464 (NS), introduced February 4, authorizes the governor to expand Medicaid pursuant to the Affordable Care Act; authorizes the governor to negotiate with the Centers for Medicare and Medicaid Services to determine the terms of the expansion.

• 2019 TN S.B. 983 (NS), introduced February 7, authorizes the governor to expand Medicaid pursuant to the Affordable Care Act; authorizes the governor to negotiate with the Centers for Medicare and Medicaid Services to determine the terms of the expansion.

• 2019 TN S.B. 1029 (NS), introduced February 7, to authorize the governor to expand Medicaid eligibility in accordance with Patient Protection and Affordable Care Act.

• 2019 TN S.B. 974 (NS), introduced February 7, directs the commissioner of finance and administration to seek a federal waiver to establish VolunteerCare and permits persons who are 55 years of age or older to purchase healthcare coverage through the TennCare program.

• 2019 TN H.B. 1259 (NS), filed February 6, requires the bureau to submit to the federal department of health and human services a Section 1115 waiver that would expand Medicaid eligibility to Tennessee residents who suffer from an opioid addiction and earn less than 138 percent of the federal poverty level as long as the eligibility only lasts for the duration of the person's involvement in a substance abuse treatment program approved by the bureau.

• 2019 TN S.J.R. 170 (NS), introduced February 7, to authorize the governor to expand Medicaid eligibility in accordance with the Patient Protection and Affordable Care Act to fully combat the opioid crisis in Tennessee.

Texas

• 2019 TX S.B. 327 (NS), introduced January 10, relating to the expansion of eligibility for Medicaid in certain counties under the federal Patient Protection and Affordable Care Act.

• 2019 TX H.B. 816, introduced January 15, relating to the expansion of eligibility for Medicaid in certain counties under the federal Patient Protection and Affordable Care Act.

• 2019 TX H.J.R. 46 (NS), introduced January 16, proposing a constitutional amendment requiring the state to expand eligibility for Medicaid to certain persons under the federal Patient Protection and Affordable Care Act.

• 2019 TX H.B. 840 (NS), introduced January 16, relating to expansion of eligibility for Medicaid to certain persons under the federal Patient Protection and Affordable Care Act.

• 2019 TX S.J.R. 34 (NS), introduced January 30, proposing a constitutional amendment requiring the state to expand eligibility for Medicaid to certain persons under the federal Patient Protection and Affordable Care Act.

• 2019 TX S.B. 524 (NS), introduced January 30, relating to the expansion of eligibility for Medicaid to certain persons under the federal Patient Protection and Affordable Care Act.

• 2019 TX H.J.R. 92 (NS), introduced February 28, proposing a constitutional amendment requiring the state to expand eligibility for Medicaid to certain persons under the federal Patient Protection and Affordable Care Act.

• 2019 TX S.B. 1752 (NS), introduced March 6, relating to the expansion of eligibility for Medicaid to all persons for whom federal matching money is available.

• 2019 TX H.B. 3698 (NS), introduced March 7, relating to the expansion of eligibility for Medicaid in certain counties.

Utah Medicaid Expansion Could Be Delayed, Altered

Medicaid expansion was approved by Utah voters in November via Proposition 3, which provided for $800 million in funding, combined with about $90 million in new state sales tax revenue to provide healthcare for 150,00 low-income residents. [FN11] However, the April launch date could be moved back and benefits could be available to fewer people than previously thought.

According to legislation sponsored by Sen. Allen Christensen (R), “We are going to implement Medicaid expansion. We are going to implement the sales tax increase to help pay for it…but we have to put some bumpers or guardrails around it so that it isn't going to break the bank.” Guardrails would include a cap on Medicaid enrollment and work requirements. Critics of expansion argue that the voter approved Proposition 3 did not provide enough money to accomplish what it claimed to do.

Supporters disagree, saying that Proposition 3 provided enough money to address increased healthcare costs. AARP Utah Director Alan Ormsby said a “cushion” of roughly $15 million was built into the initiative's sales tax hike, an increase of 0.15 percent on nonfood items, and that a combination of state and federal funding is sufficient for the initial expansion and future years. Ormsby also criticized imposing work requirements on beneficiaries, saying that it does little to incentivize productivity, causes patients to lose access to health care and imposes costly complications to the administration of Medicaid.

A scaled-down expansion plan was approved by lawmakers last year but was superseded by Proposition 3's passage. That plan would have also imposed work requirements on a smaller pool of beneficiaries with no additional state investment. It had yet to be approved or denied by federal administrators. Christensen's current plan would also require a federal waiver.

Feds Reject Enhanced Funding for Utah Partial Medicaid Expansion

The Trump administration has rejected Utah's waiver request for enhanced federal funding for a partial Medicaid expansion. [FN12] State officials say that the move will not change the April expansion to additional low-income residents.

In its waiver, Utah asked the federal government to cover a larger share of costs, even though the partial expansion would not extend eligibility to as many people as a general overhaul would have. Earlier this year, state lawmakers scaled back the expansion approved by voters by reducing coverage numbers and adding spending caps. CMS explained that it supports states' efforts “to design innovative Medicaid demonstrations that improve outcomes and promote fiscal sustainability” but that providing enhanced federal funding “would invite continued reliance on a broken and unsustainable ‘Obamacare’ system.”

No other state has received federal approval for increased federal money without fully expanding Medicaid.

Utah

2019 UT S.B. 97 (NS), introduced January 28, to repeal the expansion of the state Medicaid program under the Affordable Care Act and change the sales tax rate.

Wyoming

• 2019 WY S.F. 146 (NS), introduced January 24, relating to a possible expansion of the Medicaid program; requiring a study of the benefits and costs of expanding the Medicaid program; assigning duties to the insurance department, the department of family services, the department of health and the state library; providing for actuarial and other studies; providing exceptions to state contracting rules and regulations; setting reporting dates; providing definitions; authorizing an additional at-will position; providing appropriations; and providing for an effective date.

• 2019 WY H.B. 244 (NS), introduced January 25, relating to medical assistance; requiring the department of health to enter into negotiations with the federal government to expand Medicaid; authorizing the department of health to seek work requirements and certain mental health services as part of an expansion of Medicaid; requiring specified notice relating to expansion activities; repealing expansion authority under certain circumstances; and providing for an effective date.

Medicaid Buy-In

Selected Legislation

Hawaii

• 2019 HI H.B. 1454 (NS), introduced January 24, requires the department of human services to implement an earned income disregard program as an intermediate step to implementing a Medicaid buy-in program. Requires reports to the legislature. Takes effect upon approval by the governor and Centers for Medicare and Medicaid Services.

• 2019 HI S.B. 330 (NS), adopted June 26, requires the Department of Human Services to implement an earned income disregard program as an intermediate step to implementing a Medicaid buy-in program; requires reports to the legislature; and takes effect upon approval by the Centers for Medicare and Medicaid Services.

Minnesota

2019 MN H.F. 3 (NS), engrossed March 11, to require human services and commerce commissioners to seek federal waivers to permit individuals whose income is greater than the income limit to purchase coverage through a MinnesotaCare purchase option, and legislative proposal required.

Montana

2019 MT H.B. 251 (NS), introduced January 21, to expand the Medicaid buy-in program to children with disabilities.

New Mexico

2019 NM S.B. 405 (NS), introduced January 29, enacting the Medicaid Buy-In Act to provide health coverage to certain uninsured individuals; creating the health care affordability and access improvement fund; creating an advisory board and making appropriations.

Wyoming

2019 WY S.F. 133 (NS), introduced January 24, creating a medical assistance buy in program; creating a medical assistance prescription drug program for insurers; requiring the department of health to conduct outreach to specified persons regarding contraceptive services and supplies; requiring the submission of a federal waiver application relating to a medical assistance buy in program; requiring specified actions relating to the expansion of medical assistance and the child health insurance program; requiring studies and reports; requiring specified actions to promote telemedicine; and other provisions.

III. OTHER LEGISLATION

2019 State Legislation in Review

A. Cost Controls

New Mexico

2019 NM S.B. 346 (NS), introduced January 25, relating to health insurance limiting patient liability to nonparticipating providers for a balance bill; establishing a framework for reimbursement of nonparticipating providers of emergency care; prohibiting balance billing without written agreement of the patient; increasing the rate of interest due for late payment of clean claims and requiring reporting on network adequacy.

Oregon

• 2019 OR H.B. 2701 (NS), prefiled January 14, relating to charges billed for services provided by an out-of-network health care provider in an in-network health care facility; declaring an emergency.

• 2019 OR S.B. 889 (NS), enrolled June 25, relating to containing the cost of health care; and declaring an emergency.

Virginia

• 2018 VA S.B. 1763 (NS), amended/substituted January 31, directs health carriers that provide individual or group health insurance that provides any benefits with respect to services rendered in an emergency department of a hospital to pay directly to an out-of-network health care provider an amount equal to the greatest of (i) the amount negotiated with in-network providers for the emergency service or, if more than one amount is negotiated, the median of these amounts; (ii) the regional average for commercial payments for emergency services as of the date of treatment; and (iii) the amount that would be paid under Medicare for an emergency service. The measure defines “regional average for commercial payments” as that fixed price that is determined and reported to the State Corporation Commission's Bureau of Insurance (the Bureau) by Virginia Health Information and adjusted annually by the Bureau in accordance with the United States Average Consumer Price Index (CPI) for medical care for the South region by considering the amounts paid to and accepted from health carriers or managed care plans in 2017 by similar providers for comparable out-of-network emergency services, as identified by Current Procedural Terminology codes, Health Care Common Procedure Coding System codes, diagnosis related group classifications, or revenue codes, in the community where the services were rendered, with the exclusion of amounts accepted by providers for patients covered by Medicare, TRICARE, or Medicaid. The bill removes from the determination of whether a medical condition is an “emergency medical condition” the final diagnosis rendered to the covered person. The measure provides that the State Corporation Commission shall resolve disputes between health care providers and health carriers regarding the appropriate reimbursement amount for such services rendered. The bill directs Virginia Health Information to submit a report to the Bureau establishing the regional average for commercial payments for emergency services based on 2017 data from the All-Payer Claims Database.

• 2018 VA H.B. 1714 (NS), amended/substituted January 31, directs health carriers that provide individual or group health insurance that provide any benefits with respect to services rendered in an emergency department of a hospital to pay directly to an out-of-network health care provider the fair market value for the emergency services, less applicable cost-sharing requirements. The bill provides that direct payment from the health carrier to the out-of-network health care provider precludes the out-of-network health care provider from billing or seeking payment from the covered person for any other amount other than the applicable cost-sharing requirements. The measure defines fair market value as that price that is determined by considering the amounts billed to and accepted from health carriers or managed care plans by similar providers for comparable out-of-network emergency services in the community where the services were rendered, with the exclusion of amounts accepted by providers for patients covered by Medicare or Medicaid. The bill removes from the determination of whether a medical condition is an emergency medical condition the final diagnosis rendered to the covered person.

Washington

• 2019 WA H.B. 1065 (NS), introduced January 14, relating to protecting consumers from charges for out-of-network health care services; amending RCW 48.43.005, 48.43.093, and 41.05.017; reenacting and amending RCW 18.130.180; adding a new section to chapter 48.30 RCW; adding a new section to chapter 70.41 RCW; adding a new section to chapter 70.230 RCW; adding a new section to chapter 70.42 RCW; adding a new section to chapter 43.371 RCW; adding a new chapter to Title 48 RCW; creating new sections; prescribing penalties; providing an effective date; and providing an expiration date.

• 2019 WA S.B. 5031 (NS), introduced January 14, relating to protecting consumers from charges for out-of-network health care services; amending RCW 48.43.005, 48.43.093, and 41.05.017; reenacting and amending RCW 18.130.180; adding a new section to chapter 48.30 RCW; adding a new section to chapter 70.41 RCW; adding a new section to chapter 70.230 RCW; adding a new section to chapter 70.42 RCW; adding a new section to chapter 43.371 RCW; adding a new chapter to Title 48 RCW; creating new sections; prescribing penalties; providing an effective date; and providing an expiration date.

• 2019 WA S.B. 5699 (NS), introduced January 28, relating to protecting consumers from charges for out-of-network health care services.

B. Cost Transparency

Selected Legislation

Illinois

2019 IL H.B. 156 (NS), engrossed April 12, creates the Prescription Drug Pricing Transparency Act. Requires health insurers to disclose certain rate and spending information concerning prescription drugs and certain prescription drug pricing information to the Department of Public Health. Requires the Department and health insurers to create annual lists of prescription drugs on which the State spends significant health care dollars and for which costs have increased at a certain rate over time and other related provisions.

Nevada

2019 NV A.B. 469 (NS), enrolled May 15, relating to health care; limiting the amount a provider of health care may charge a person who has health insurance for certain medically necessary emergency services provided when the provider is out-of-network; requiring an insurer to arrange for the transfer of a person who has health insurance to an in-network facility under certain circumstances; prescribing procedures for determining the amount that an insurer is required to pay a provider of health care which is out-of-network for certain medically necessary emergency services provided to an insured; and other related provisions.

Rhode Island

2019 RI S.R. 580 (NS), adopted June 26, would develop a common summary of payments forms, to be used by all health insurance carriers and to be provided to health care consumers, providing the consumer with their responsibility for payment, of any portion of a health care provider claim.

Virginia

• 2018 VA H.B. 2798 (N)S, introduced January 18, requires the Commissioner of Health, in cooperation with the Bureau of Insurance, to collect health claims data from certain insurers, corporations, managed care organizations, third-party administrators, and employee welfare benefit plans whose employer has opted-in to the All-Payer Claims Database, the Department of Medical Assistance Services, state government health insurance plans, local government health insurance plans, and federal health insurance plans.

• 2018 VA S.B. 1216 (NS), adopted March 21, Requires the Commissioner of Health, in cooperation with the Bureau of Insurance, to collect health claims data from certain insurers, corporations, managed care organizations, third-party administrators, and any self-funded employee welfare benefit plans (ERISA plans) whose employer has opted-in to the All-Payer Claims Database, the Department of Medical Assistance Services, state government health insurance plans, local government health insurance plans, and federal health insurance plans. The bill provides that employers that maintain an ERISA plan may opt-in to participate in the All-Payer Claims Database and provides a process for such agreement.

Washington

2019 WA S.B. 5741 (NS), enrolled April 27, making changes to support future operations of the state all payer claims database by transferring the responsibility to the health care authority, partnering with a lead organization with broad data experience, including with self-insured employers, and other changes to improve and ensure successful and sustainable database operations for access to and use of the data to improve health care, providing consumers useful and consistent quality and cost measures, and assess total cost of care in Washington state.

C. Direct Care Agreements

Alaska

2019 AK H.B. 92 (NS), introduced March 13, exempting direct health care agreements from regulation as insurance; establishing a direct care payment program for medical assistance recipients; and providing for an effective date.

Florida

2019 FL S.B. 1520 (NS), introduced March 13, expanding the applicability of provisions relating to direct primary care agreements exempt from the Florida Insurance Code to direct health care agreements, etc.

D. High-Risk Pools

Selected Legislation

Minnesota

2019 MN H.F. 2639 (NS), introduced March 21, health insurance underwriting, renewability, and benefit requirements modified; Minnesota health risk pool program created; unified personal health premium account creation allowed; Minnesota health contribution program created; health plan market rules eliminated; and waivers requested.

North Dakota

2019 ND H.B. 1106 (NS), enrolled April 16, relating to the establishment of an invisible reinsurance pool for the individual health insurance market; to amend and reenact subsection 2 of section 26.1-03-17 of the North Dakota Century Code, relating to premium taxes and credits for insurance companies; to provide for a legislative management study; to provide an expiration date; and to declare an emergency.

Texas

2019 TX H.B. 3325 (NS), introduced March 6, relating to the administration of a temporary health insurance risk pool.

E. Individual Mandates

Rhode Island

2019 RI S.B. 683 (NS), introduced March 21, to establish a reinsurance program in order to provide stability in the individual insurance market and imposes a shared responsibility payment penalty for individuals who do not have health insurance coverage with certain exceptions.

Vermont

2019 VT H.B. 524 (NS), adopted June 17, proposes to implement Vermont's individual mandate to maintain health insurance coverage. It would also codify in State law certain health insurance consumer protections, including a ban on preexisting condition exclusions and a requirement to provide coverage for dependents up to 26 years of age. The bill would require looking through the structure of an association to provide health insurance plans based on the size of each underlying employer. It would prohibit licensed brokers from accepting payment for enrolling Vermont residents in certain health expense-sharing arrangements and would require the Green Mountain Care Board to quantify the impact of the Medicaid and Medicare cost shifts and uncompensated care on health insurance premiums. The bill would also direct the Agency of Human Services to develop strategies for increasing the affordability of health insurance and to evaluate options for the future of Vermont's health insurance markets.

F. Insurance Exchanges/Marketplaces

Selected Legislation

Delaware

• 2019 DE H.B. 176 (NS), introduced June 3, to amend Titles 16 and 18 of the Delaware Code relating to the Delaware Health Insurance Individual Market Stabilization Reinsurance Program.

• 2019 H.B. 193 (NS), introduced June 10, to amend Titles 16 and 18 of the Delaware Code relating to the Delaware Health Insurance Individual Market Stabilization Reinsurance Program.

Minnesota

2019 MN H.F. 1006 (NS), introduced February 11, relating to the state transition from MNsure to a federally facilitated marketplace and appropriating money.

New York

2019 NY A.B. 6791 (NS), amended/substituted May 20, authorizes individuals to participate in the NY State of health marketplace without providing information regarding citizenship or lawful residency or receiving or requesting a subsidy.

Rhode Island

2019 RI S.B. 738 (NS), amended/substituted May 16, establishes the Rhode Island health insurance market stability and consumer protection act in order to update state law to reflect current insurance standards, practice and regulation to maintain market stability.

Washington

2019 WA S.B. 5526 (NS), enrolled April 28, relating to increasing the availability of quality, affordable health coverage in the individual market; adding a new section to chapter 43.71 RCW; adding a new section to chapter 42.56 RCW; adding new sections to chapter 41.05 RCW; adding new sections to chapter 48.43 RCW; adding a new section to chapter 82.04 RCW; creating new sections; and providing expiration dates.

G. Insurance Premium Assistance and Tax Credits

Selected Legislation

Georgia

2019 GA S.B. 3 (NS), filed January 14, to provide a program of premium assistance to enable eligible individuals to obtain health care coverage.

Minnesota

2019 MN S.F. 2765 (NS), introduced April 1, relating to health coverage premium subsidy program modification and appropriation.

New York

2019 NY A.B. 5203 (NS), introduced February 7, establishes a personal income tax credit for health insurance premiums paid by a taxpayer.

Texas

2019 TX S.B. 742 (NS), introduced February 11, relating to premium and maintenance tax credits related to certain fees paid under the Patient Protection and Affordable Care Act.

Washington

The Health Care Authority is amending these rules to clarify and update eligibility criteria for clients receiving premium assistance subsidies for comprehensive health insurance. See 2019 WA REG TEXT 486694 (NS).

H. Medicaid Work Requirements

Medicaid Work Requirements Face Political, Court Resistance

(Thomson Reuters Regulatory Intelligence) - As the number of Americans eligible for the Medicaid low-income health insurance program grows through expansion under the Affordable Care Act (ACA), some states are aiming to trim the rolls by requiring recipients to work or satisfy related criteria. However, these rules have recently met significant legal opposition in multiple states. [FN13]

MEDICAID WORK REQUIREMENTS

States are allowed to experiment with their Medicaid plans using pilot programs or demonstration waivers. Before doing so, states must request approval from the Centers of Medicare and Medicaid Services (CMS), which is a part of the Department of Health and Human Services (HHS). Before granting such waiver requests, HHS must find that the programs are “likely to assist in promoting the objectives” of Medicaid.

One example of a Medicaid waiver involves work rules, which require able-bodied adults to work a minimum number of hours each month or participate in an equivalent activity as a condition for continued Medicaid eligibility. Equivalent activities include skills training, education, job searching, volunteering or caregiving.

While advocates argue the rules will increase employment among low-income people, critics point to a study with several findings that would undermine the efficacy of work requirements. First, most Medicaid recipients already work. Second, a majority of recipients work full-time in low-wage industries with low rates of employer-sponsored insurance. Third, of those who do not work, a majority would be exempt anyway. Lastly, persons who remain eligible could lose coverage by failing to meet reporting requirements.

COURT CHALLENGES SLOW WAIVER EXPANSION

President Donald Trump's administration in early 2018 announced that work requirement waivers would be permitted by the federal government. The Obama administration previously rejected all such proposals.

CMS issued guidance on how states should design their waiver proposals to increase the likelihood of approval. Under the guidance, certain recipients must be exempt from work requirements, such as those with disabilities, the elderly, children and pregnant women. States must also make “reasonable modifications” for those with opioid addictions and other substance-use disorders.

So far, nine states have received approval{here} from the Trump administration to impose work requirements. Of those nine, the programs of three states -- Arkansas, Kentucky and New Hampshire -- have been temporarily halted by challenges in federal court. The other six states' programs have not yet been implemented. Another nine states currently have waiver applications pending.

n a pair of March 2019 decisions, Judge James Boasberg of the U.S. District Court of the District of Columbia rejected Kentucky's waiver approval and blocked a similar Arkansas rule already in effect where more than 18,000 people have lost coverage.

The approval of Arkansas and Kentucky's work rules by HHS were deemed “arbitrary and capricious” by the court since their impact on Medicaid coverage loss was not considered adequately. Boasberg also took an unusual step in halting Arkansas' work requirement, instead of putting a stay on the ruling, stating that any disruption “must be balanced against the harms that plaintiffs and persons like them will experience if the program remains in effect.”

In July 2019, Boasberg also rejected New Hampshire's waiver since HHS had not considered the possibility that the proposal might cause a significant number of recipients to lose coverage. “In short, we have all seen this movie before,” wrote Boasberg.

The Trump administration in May appealed Boasberg's March decisions on the Kentucky and Arkansas work requirements to a three-judge panel of the U.S. Court of Appeals for the D.C. circuit.

The government defended its work rules, arguing that: 1) requiring able-bodied adults to work a certain a certain amount of time each month is essential for maintaining quality coverage; 2) keeping borderline populations out of Medicaid frees up for funds for others; 3) Medicaid recipients who start working could gain private insurance through their employers; and 4) work requirements save money for states struggling to make sure their expansion programs stay financially solvent.

Plaintiffs opposing work rules argued that: 1) work requirements would not necessarily result in Medicaid recipients transitioning to private insurance; 2) massive coverage losses will likely result; 3) the objective of the ACA is to provide coverage for more people, not financial independence; and 4) coverage should not be conditioned on someone's physical well-being or job status.

Prospects for overturning the District Court decision in the appeals court appear slim. Two of the appeals panel's three judges sharply criticized the government's arguments defending work rules. One seemed to agree with the plaintiffs that financial independence is not an objective of Medicaid and the ACA, critiquing the government by saying it was “looking for objectives that are not in the statute.” Another judge undercut the government's position by saying that Congress would have passed work rules for Medicaid, as it did for some other welfare programs in 2010, if they had deemed it appropriate.

A date has not been set for the appeals judges' decision.

POLITICAL BATTLEGROUND

Regardless of the appeals court decision, Kentucky's work rule could be in jeopardy. In November 2019, Governor-elect Andy Beshear vowed to rescind it after the Democrat takes office in early 2020{here}. During the election, Beshear ran on defending Medicaid expansion.

Although he only won by a slim 0.4% margin, Beshear's victory could signal that tides are turning against the popularity of Medicaid work requirements. Their future remains to be seen depending on whether a similar trend emerges in other states and the outcome of the 2020 presidential election.

Arizona First State to Exempt Native Americans from Work Requirement

Recent federal approval of Arizona's request to impose work requirements means that 120,000 of the state's 1.8 million residents on Medicaid, ages 19 to 49, must work or volunteer at least 80 hours a month. [FN14] However, recipients belonging to federally recognized Native American tribes will be exempt. Arizona is now the only state to recognize such an exemption.

Arizona initially wanted to exempt all Native Americans. CMS pushed back, citing equal protection concerns. Tribes disagreed with CMS, arguing that it ignored Supreme Court precedent allowing different treatment, disregarded the Constitution and violated treaties. After negotiations, Arizona limited its request to federally recognized tribes, which was granted. CMS explained that the current exemption request is consistent with tribes' status as political entities.

Arizona has 21 federally recognized tribes whose reservations take up about a quarter of the state. Now that the Trump administration has granted Arizona's request and set a precedent, it is expected to grant the same exemption for other states that seek one.

Arizona Suspends Medicaid Work Requirement

The Arizona Health Care Cost Containment System, the state's Medicaid program, said it is temporarily delaying implementation of its work requirement “to avoid disruptions and protect Arizona's most vulnerable members.” [FN15]

This decision comes as federal courts have taken a dim view of similar mandates in other states, such as Arkansas and Kentucky, where work requirements were blocked. Some states have taken their own initiative, including New Hampshire, which suspended its work requirement, and Maine, whose new Democratic governor dropped its plan.

Arizona officials said their decision was not made in response to specific developments and that they are still committed to eventually implementing work requirements.

Arkansas Medicaid Work Requirement Backfired

The Arkansas Medicaid work requirement has been described as backfiring by a new study from the New England Journal of Medicine, which found that the requirement caused thousands of poor adults to lose coverage without evidence that the target population gained jobs. [FN16] The requirement had little chance of succeeding since about 97% of eligible residents aged 30-49 were already employed or should have been exempt.

The state mandate resulted in 18,000 of the 100,000-targeted people to fall off Medicaid rolls. Despite officials' statements that many of those individuals may have found jobs, the study found no evidence they secured jobs or coverage. In fact, a noticeable dip in the employment rate was found among those eligible for Medicaid. Additionally, the uninsured rate increased among those aged 30-49 years old from 10.5% in 2016 to 14.5% in 2018, while the employment rate fell from 42% to 39%.

The study is the first to provide direct evidence that Arkansas' work requirement left people uninsured and did not promote employment as intended. It also found that a “lack of awareness and confusion about the reporting requirements were common, which may explain why thousands of individuals lost coverage.” At a minimum, researchers think that the state should “pump the brakes” on the program.

Judge Blocks Work Requirements in Arkansas and Kentucky

U.S. District Judge James Boasberg overturned the Trump administration's approval of Medicaid work requirement plans in Kentucky and Arkansas, ruling that HHS failed to adequately consider the extent to which the plans would cause people to lose coverage. [FN17] The ruling is considered a setback to the Trump administration's efforts to scale back Medicaid.

The plaintiffs' lawyer, Sam Brooke, praised the decision: “the court reaffirmed the rights of financially insecure individuals to access health care.” Adam Meier of the Kentucky Cabinet for Health and Family Services criticized the ruling as “illogical” because it did not consider how the program was helping state enrollees. Meier said Kentucky is currently considering next steps, including appeal. Arkansas Governor Asa Hutchinson (R) said he was disappointed by the ruling.

This marks the second time that Boasberg has vacated the approval of an HHS waiver for Kentucky's work requirements. The previous occurrence was in June 2018. HHS sought to address the coverage issue by arguing that the initial loss figure of 100,000 people would be dwarfed by 450,000 people if the state repealed its expansion. This argument did not sway Boasberg, who said it would justify approval of any plan “as long as it is accompanied by a threat that the state will de-expand.”

Idaho Introduces Work Requirement Bill

A Medicaid work requirement bill has been introduced in the Idaho House Health and Welfare Committee. [FN18] It would require a 20-hour work week minimum, while also mandating that those between 100 percent and 138 percent of the federal poverty level continue paying for private insurance on the state-run health exchange.

This is one of many proposals by state Republicans to add sideboards to the voter-approved initiative expanding Medicaid coverage to those who previously earned too much to qualify but too little to afford private insurance on the state health care exchange. Previous versions gave enrollees the choice to move to Medicaid, but supporters of the current version felt that compelling them to stay on the exchange would be better for the state financially.

Critics of the measure are concerned about whether barring those people from Medicaid would create a secondary coverage gap and push the burden of covering emergency health care costs to the counties, via the state's catastrophic health care fund.

Last year a grass-roots effort put Proposition 2 on the ballot to expand Medicaid, and it passed overwhelmingly, with 61% in favor.

Iowa Work Requirement Bill Passes in Senate

The Republican-controlled Iowa Senate voted 32-17 along party lines to advance a bill that would require some Medicaid patients to work to receive benefits. [FN19] The bill will now move to the Republican-controlled House, where its future is unclear.

The measure, if it becomes law, would require weekly work hours for Medicaid recipients but carves out people with physical and mental conditions. Of the 166,000 enrolled in Medicaid expansion in the state, it is estimated that more than 70,000 may require review and be subject to work requirements.

An Iowan enrolled in Medicaid would have one of several options:

• Work 20 hours or more per week, averaged over a six-month period

• Comply with a work program for 20 hours or more per week, average on a monthly basis

• Volunteer 20 hours or more per week, average on a monthly basis

• Meet a combination of work and work program participation requirements

• Participate in other eligible program activities.

Those who do not meet the requirements during an initial 6-month period of eligibility would be terminated for rest of the benefit year. There are multiple exemptions, which include: a woman who is pregnant; a parent or caretaker responsible for a child under six years old, a child with a disability, an elderly person or someone with a medical condition; someone in a drug or alcohol treatment and rehabilitation program or involved in other exempt activities.

Implementation would cost nearly $5 million in its first year and nearly $12 million in the second, with the federal government picking up additional expenses.

Federal Court to Hear Case on Kentucky Medicaid Work Requirement

A federal appeals court is set to decide if Kentucky and other states are allowed to enact work requirements for some low-income adults added to the Medicaid rolls via expansion. [FN20] Under the new requirement, enrollees must report work or volunteer hours, pay premiums and meet other new rules. Kentucky was the first state to win federal approval for such a Medicaid overhaul.

The appeals court's panel of judges will determine whether or not it agrees with a lower court ruling that the plan proposed by Kentucky Governor Matt Bevin (R) violates federal Medicaid law. The appeals court will also hear arguments from Arkansas, whose Medicaid work requirement proposal was overturned in March by a federal judge because the state failed to show that the changes would advance the central goal of Medicaid: ensuring coverage to the most vulnerable citizens.

This decision could have far-reaching implications. 15 other states have either won approval to enact work requirements or are currently seeking permission to do so. Lawyers for the U.S. DOJ and Governor Bevin are asking the appeals judges to reinstate Kentucky's plan.

Health law advocates argue that the plan violates federal Medicaid law, which includes no provision for work requirements and would cause thousands to lose coverage. Critics also point to data showing that 97% of Kentucky adults covered by Medicaid already meet the proposed requirements or qualify for an exemption. They argue that they policy will compel few beneficiaries to work.

Maine Governor Rejects Medicaid Work Requirements

Governor Janet Mills (D) has rejected new Medicaid work requirements that were requested by former Governor Paul LePage (R) and approved by the Trump administration just days before LePage left office. [FN21] Mills informed CMS that Maine would not accept the terms of the pending 1115 Medicaid waiver, which she had wide latitude to accept or reject as the new governor.

Instead, according to a news release, the governor has “directed Acting Commissioner of Labor Laura Fortman and Acting Commissioner of Health and Human Services Jeanne Lambrew to make available vocational training and workforce supports to MaineCare participants at every opportunity while increasing access to needed services that keep people in the workforce.”

Mills was concerned that the likely result of the waiver would be to leave more residents uninsured without improving workforce participation. Instead of work requirements, Mills plan to expand job training programs for Medicaid recipients.

Missouri

2019 MO S.B. 76 (NS), introduced January 9, requires certain MO HealthNet participants to comply with work and community engagement requirements.

New Hampshire Medicaid Work Plan Approved

The federal government has approved a plan that requires some Medicaid expansion recipients to complete at least 100 hours of community engagement work each month to keep their coverage. [FN22] State officials are hard at work nailing down the final rules.

It is estimated that between 15,000 and 20,000 people will be subject to the new requirement. However, there will be numerous statutory exemptions, including those participating in drug treatment programs and pregnant women. It is unclear when the work requirement will put into effect.

New Hampshire Senate Advances Bill Attacking Medicaid Work Requirement

The New Hampshire Senate approved a bill that would weaken, and possibly eliminate, a work requirement for Medicaid expansion enrollees. [FN23] This move angered Senate Republicans, who see it as a betrayal of compromise reached last session to expand only if a work requirement was attached.

The work requirement would be terminated if more than 500 people are removed from Medicaid as a result. In addition, restrictions would be eased on who will be exempted from the work requirement.

The bill will now advance to the Finance Committee. An amendment may be offered to protect the work requirement when it returns to the full Senate. Senate Democrats said they are open to further compromises. Other provisions in the original bill, such as eliminating the work requirement for enrollees over age 50, were scrapped to win more support.

New Hampshire House Passes Bill Easing Medicaid Work Requirement

A bill that would weaken work requirements for New Hampshire's Medicaid expansion program passed the state house in a party-line vote. [FN24] It had already been approved by the state senate. However, Governor Chris Sununu (R) will likely veto it.

The work requirement would be ended entirely if it resulted in more than 500 people losing their benefits out of 50,000 expansion enrollees. Other restraints include applying it only to people 19 to 49 years of age, reducing required hours worked from 100 to 80 and basing it on an average of 20 hours per week instead of 25. Self-employment and participation in mental illness recovery programs are also added as activities that would satisfy the work requirement.

Exemptions would be provided for custodial parents or caretakers has been changed to apply in households with children up to the age of 16, as opposed to under the age of 6 in the existing statute. Any beneficiary who is homeless, the caretaker of a grandchild, a full-time college or university student and anyone 50 or older would also be exempted.

The work requirement took effect on June 1, with reporting deadlines in July.

New Hampshire Delays Medicaid Work Requirement

New Hampshire Governor Chris Sununu (R) is delaying penalties related to the state's Medicaid work requirement after nearly 17,000 recipients were found to be out of compliance in the first month of the program. [FN25] Of the 24,895 Medicaid recipients enrolled in June without a qualifying exemption, 16,874 people failed to provide proof to the state that they met the new Medicaid work rules. Recipients are required to work 100 hours each month, or prove some other type of qualifying community engagement.

Despite months of outreach by the state, including radio ads, public information sessions, direct mailings and text messages, the work requirement will be delayed for 120 days before being implemented again. Sununu announced that some of the program requirements would be loosened and that a door-to-door effort will be made by state employees to notify recipients of the new rules.

New Hampshire Work Requirement Blocked by Federal Judge

A federal judge has ruled in favor of a class action lawsuit alleging that the Trump administration exceeded its authority by allowing New Hampshire to implement its work requirement. [FN26] U.S. District Judge James E. Boasberg reasoned that the Trump administration did not adequately address potential coverage loss for low-income residents and that "we have all seen this movie before."

Specifically, plaintiffs argued that the requirement does not further Medicaid's original goals because implementation failures will lead to many losing coverage unnecessarily. [FN27] Officials from the state and Trump administration disagreed, arguing that the work requirement encourages upward mobility and makes the program more fiscally sustainable.

The federal judge hearing this case also recently struck down similar requirements in Arkansas and Kentucky, which are being appealed by the Trump administration.

Ohio Work Requirement Request Granted

CMS has granted the Ohio Department of Medicaid's request to create a work requirement for Medicaid expansion enrollees. [FN28] Participants would need to have a job or perform community services for at least 20 hours per week, unless given an exemption.

Some of the people who will be exempt include those 50 years of age or older; those "physically or mentally unfit for employment"; participants in alcohol or drug addiction treatment; caregivers for a disabled household member; pregnant women; parents or guardians of minor children; those who applied for or receiving unemployment compensation and students who go to school at least half time.

The state has estimated that about 95% of those covered by expansion would already either meet the work requirement or be exempt. The Center for Community Solutions, a Cleveland think tank, has questioned the math of how many people will lose coverage. While the state estimated 134,000 recipients would be affected, nearly 400,000 Ohioans no longer receive SNAP benefits.

Ohio will need to develop and publish a comprehensive implementation plan that is due within 90 days of federal approval. Within 150 days of federal approval, the state needs to develop and publish monitoring protocols and within 150 days the state needs to develop and publish its monitoring protocol.

Ohio Medicaid Work Requirement Calls for Case Worker Contact

Ohio Medicaid recipients will not be required to meet work criteria (80 hours per month) to receive coverage until a case worker speaks with them first. [FN29] According to the state's latest implementation plan filing to CMS:

"Prior to initiating Medicaid termination, a caseworker must speak directly with the beneficiary over the phone or in person…If, after speaking with the beneficiary, the caseworker determines that the beneficiary should have Medicaid eligibility terminated for non-compliance with the (work) requirement, a pre-termination review will be completed to determine if the beneficiary qualifies for Medicaid under a different eligibility category."

Ohio's Medicaid work requirement plan, which received federal approval in March, is expected to begin January 1, 2021. The state's implementation plan, which spells out how the work requirement will be carried out, also needs federal approval. Ohio Department of Medicaid Director Maureen Corcoran said, "One of the things that the governor [DeWine] was very specific about was making this kind of more individualized – contact with a person, not just cutting people off."

South Carolina Seeks Medicaid Work Requirement

Despite ongoing court battles in other states, South Carolina is seeking waiver permission from CMS to impose work requirements on Medicaid recipients, who would need to work, be enrolled in job training or attend school for an average of 80 hours a month. [FN30]

Unlike other states that have tried to impose work requirements, South Carolina will not completely end Medicaid benefits for those who do not comply or force beneficiaries to re-enroll in the program if they lose their benefits. Instead, people who cannot meet the requirements for three consecutive months will have their benefits suspended for three months, or until the work requirements are met, whichever comes first. Exemptions would be provided to disabled adults, full-time caregivers, pregnant women, anyone over age 65 and others.

A state analysis estimated that 11,000 recipients would lose coverage over the course of the five-year demonstration period. If approved, the requirements would not take effect until at least July 1, 2020.

Medicaid Work Bill Moves Closer to Passage in Wyoming

A bill that would require able-bodied Wyoming residents to work 20 hours per week to qualify for Medicaid has passed its first reading in the house. [FN31] A similar bill died in the house last year after passing the Senate.

Proponents say that only 2-3,000 of the state's 60,000 Medicaid recipients would be impacted. Critics fear that a 6-month lockout provision in the bill could lead to some recipients slipping through the cracks and not getting needed healthcare services.

The Medicaid work bill must survive two more votes in the House before heading to Governor Mark Gordon (R), who previously opposed expansion.

I. Preserving PPACA Coverage

Selected Legislation

Connecticut

2019 CT S.B. 984 (NS), introduced February 28, to: (1) Establish a minimum essential health coverage requirement; (2) require the Commissioner of Revenue Services to develop methods to enforce such requirement and design a tax credit to offset the cost of health insurance; (3) impose a tax on certain health carriers for net direct premiums; (4) establish the "Connecticut Health Insurance Exchange Fund"; (5) require certain insurers, health care centers, fraternal benefit societies, hospital service corporations, medical service corporations and other entities that transact health insurance business in this state or administer state health plans to offer not fewer than one qualified health plan through the Connecticut Health Insurance Exchange; and (6) require the Office of Health Strategy to study the possible implementation of state-financed health insurance premium and cost-sharing subsidies and a reinsurance program.

Florida

• 2019 FL S.B. 418 (NS), filed January 22, specifying conditions under which health insurers and health maintenance organizations may comply with requirements under the federal Patient Protection and Affordable Care Act to provide essential health benefits, etc.

• 2019 FL S.B. 418 (NS), introduced March 5, specifying conditions under which health insurers and health maintenance organizations may comply with requirements under the federal Patient Protection and Affordable Care Act to provide essential health benefits, etc.

• 2019 FL S.B. 322 (NS), engrossed April 24, revising eligibility requirements for multiple-employer welfare arrangements; authorizing health insurers and health maintenance organizations to create new health insurance policies and health maintenance contracts meeting certain criteria for essential health benefits under the federal Patient Protection and Affordable Care Act (PPACA); revising applicability of requirements relating to preexisting conditions, etc.

Hawaii

2019 HI S.B. 1043 (NS), introduced January 18, requires health insurers, mutual benefit societies, and health maintenance organizations to provide coverage for a comprehensive category of reproductive health services, drugs, devices, products, and procedures. Prohibits discrimination in the provision of reproductive health care services.

Indiana

• 2019 IN H.B. 1653 (NS), introduced January 24, prohibits preexisting condition exclusions in individual and small group policies of accident and sickness insurance and health maintenance organization contracts; Specifies benefits that must be included in individual and small group policies of accident and sickness insurance and health maintenance organization contracts; repeals provisions providing for preexisting condition exclusions in small group policies of accident and sickness insurance and other related provisions.

• 2019 IN H.B. 1655 (NS), introduced January 24, prohibits preexisting condition exclusions in, and use of a preexisting condition to determine a premium for, individual policies of accident and sickness insurance, small employer group health insurance plans, and health maintenance organization contracts. Specifies benefits that must be included in individual and small group policies of accident and sickness insurance and health maintenance organization contracts. Repeals provisions providing for individual and association group accident and sickness insurance policy waivers of coverage.

• 2019 IN S.B. 392 (NS), engrossed April 12, specifies that the preexisting condition requirements of the federal Patient Protection and Affordable Care Act (ACA) as in effect on January 1, 2019, are in effect in Indiana, regardless of the legal status of the ACA. Prohibits preexisting condition exclusions in state employee health plans, policies of accident and sickness insurance, and health maintenance organization contracts. Permits premium rate variation based on certain factors.

Louisiana

• 2019 LA S.B. 219 (NS), engrossed May 9, relative to health insurance; to provide relative to coverage; to require coverage for dependent children; to prohibit preexisting condition exclusions and annual and lifetime limits; to provide for an effective date; and to provide for related matters.

• 2019 LA H.B. 308 (NS), enrolled June 2, relative to health insurance benefits; to provide for certain guarantees; to prohibit lifetime limits; to prohibit annual limits; to provide for applicability; to establish exceptions; to provide for interpretation; to define key terms; and to provide for related matters.

Michigan

2019 MI H.R. 78 (NS), introduced April 25, a resolution to urge the United States Department of Justice to reverse its position affirming the federal court decision to strike down the entire Affordable Care Act as unconstitutional.

New Jersey

2018 NJ A.B. 5501 (NS), amended/substituted June 13, requires continuation of health benefits dependent coverage until child turns 26 years of age.

New York

• 2019 NY S.B. 659 (NS), introduced January 9, enacts the “comprehensive contraception coverage act.”

• 2019 NY A.B. 585 (NS), introduced January 9, enacts the “comprehensive contraception coverage act.”

Ohio

2019 OH S.R. 303 (NS), introduced July 11, to reaffirm the Ohio Senate's support of the Patient Protection and Affordable Care Act of 2010.

Pennsylvania

2019 PA S.B. 50 (NS), introduced March 4, providing for health care insurance coverage protections, for duties of the Insurance Department and the Insurance Commissioner, for regulations, for enforcement and for penalties.

Virginia

• 2018 VA S.B. 1344 (NS), introduced January 9, requires a health carrier offering or providing a health benefit plan, including (i) short-term and catastrophic health insurance policies, and policies that pay on a cost-incurred basis; (ii) association health plans; (iii) plans provided by a multiple-employer welfare arrangement; (iv) plans provided pursuant to a benefits consortium, the members of which are banks and employers that provide products and services to banks; and (v) plans provided pursuant to a not-for-profit benefits consortium consisting of five or more private educational institutions, to provide, as an essential health benefit, coverage that includes preventive care. Essential health benefits include items and services covered in accordance with regulations issued pursuant to the Patient Protection and Affordable Care Act in effect as of January 1, 2019.

• 2018 VA S.B. 1132 (NS), amended/substituted January 31, requires health benefit plans to cover the costs of specified health care services, drugs, devices, products, and procedures related to reproductive health, including (i) contraception and women's preventive health services identified by the Health Resources and Services Administration of the U.S. Department of Health and Human Services or the women's preventive services initiative as of January 1, 2017; (ii) screening to determine whether counseling and testing related to the BRCA1 or BRCA2 genetic mutations is indicated and testing and genetic counseling related to the BRCA1 or BRCA2 genetic mutations if indicated; (iii) abortion to the extent permitted by applicable law; and (d) voluntary sterilization. The health benefit plan requirements become effective when a plan is delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2020, or at any time thereafter when any term of the health benefit plan is changed or any premium adjustment is made. The measure also requires the Board of Medical Assistance Services to include in the state plan for medical assistance services a provision for the payment of the costs of a reproductive health care program providing reimbursement for medically necessary reproductive health care services, drugs, devices, products, and procedures for eligible individuals.

J. Right to Shop

Oklahoma

2019 OK H.B. 2780 (NS), prefiled December 10, an act relating to health insurance; creating the Oklahoma Right to Shop Act; defining terms; requiring insurance carriers to create certain program; establishing requirements of program; construing certain provision as not an expense; requiring certain filing with Insurance Department; requiring carriers to establish certain online program; establishing requirements of program; authorizing exemption to requirements of act; requiring certain notification; requiring certain enrollees to receive out-of-network treatment under certain conditions; requiring certain payment method; and other related provisions.

K. Short-Term and Catastrophic Plans

Selected Legislation

Arizona

• 2019 AZ H.B. 2375 (NS), introduced January 30, relating to short-term limited duration insurance; notice.

• 2019 AZ S.B. 1109 (NS), engrossed February 13, relating to short-term limited duration insurance.

Arkansas

2019 AR H.B. 1742 (NS), introduced March 7, to establish the short-term, limited duration insurance act; to regulate short-term, limited duration insurance; and for other purposes.

Kansas

• 2019 KS H.B. 2053 (NS), introduced January 22, providing for short-term, limited-duration health plans.

• 2019 KS S.B. 35 (NS), introduced January 22, providing for short-term, limited-duration health plans.

Maryland

2019 MD S.B. 28 (NS), introduced January 9, altering the definition of “health benefit plan” as it applies to certain provisions of law related to coverage requirements for the diagnosis and treatment of mental illness and emotional, drug use, and alcohol use disorders to include short-term limited duration health insurance.

Missouri

• 2019 MO S.B. 48 (NS), introduced January 9, modifies provisions relating to short-term major medical insurance policies.

• 2019 MO H.B. 83 (NS), introduced January 9, changes the law relating to short term medical policies sold in the state of Missouri.

Virginia

• 2018 VA H.B. 2260 (NS), introduced January 7, authorizes health carriers to offer catastrophic plans on the individual market and to offer such plans to all individuals. The measure provides that a catastrophic plan is deemed to provide an essential health benefits package and to meet certain requirements of federal law. A catastrophic plan is a high-deductible health care plan that provides essential health benefits and coverage for at least three primary care visits per policy year.

• 2018 VA S.B. 1027 (NS), introduced January 9, authorizes health carriers to offer catastrophic plans on the individual market and to offer such plans to all individuals. The measure provides that a catastrophic plan is deemed to provide an essential health benefits package and to meet certain requirements of federal law. A catastrophic plan is a high-deductible health care plan that provides essential health benefits and coverage for at least three primary care visits per policy year. Under the federal Affordable Care Act, catastrophic plans satisfy requirements that health benefit plans provide minimum levels of coverage only if they cover individuals who are under 30 years of age or who qualify for a hardship exemption or affordability exemption. The measure requires the Commissioner of Insurance to apply to the federal government for a state innovation waiver allowing the implementation of the provision. The provision will become effective 30 days after the Commissioner notifies certain persons that the request has been approved.

• 2018 VA S.B. 1240, introduced January 9, authorizes health insurance carriers in the Commonwealth to offer short-term, limited-duration health plans. Short-term, limited-duration health plans are defined as plans that have an expiration date that is less than 12 months after the original effective date of the contract, policy, or plan and, taking into account renewals or extensions, have a duration that does not exceed 36 months. Short-term health plans are required to include a specified disclaimer.

L. Universal Insurance

Selected Legislation

Colorado Releases Draft of Public Option

Officials in Colorado released a draft report on the proposed state public health insurance option.

Health care providers were critical of the plan for including lower reimbursements for health care services.

In May, Colorado Gov. Jared Polis (D) signed a bill requiring state officials to create a public health insurance option. The bill called for the development of a plan to create a public health insurance option by the Colorado Department of Health Care Policy and Financing (HCPF) and the Department of Regulatory Agencies.

The public health insurance option is meant to compete with private health insurance plans offered for sale by insurers in Colorado on and off the state's health insurance exchange that was created by the ACA.

The departments have until November to submit a plan. The plan must “assess costs, funding sources, necessary federal permissions and funding, consumer eligibility, and who in government would run the program.”

The proposal is 196 pages and includes a plan for a public health insurance option. The option is designed by the state and would be administered by private insurance companies by January 2022.

Under the plan, private health insurers over a specified size would have to sell the state option health plan. The plans would be available both on and off the state's health insurance exchange. According to the report, the plans would be accessible to “all Colorado residents who buy their own individual health insurance.”

Colorado residents who qualify for federal tax subsidies to purchase private health insurance plans would be permitted to use those subsidies toward purchasing the public option plans.

The proposal enables private insurers to create the structure of premiums and deductibles. However, they would be constrained by a set of requirements. These requirements include a new medical loss ratio (MLR).

Currently, the ACA has an MLR of 80%. Insurers are required to spend 80% of premiums for individual and small group plans on medical care and quality improvements or refund customers. The proposal would change the MLR threshold in Colorado to 85% for insurers administering the plans.

Additionally, plans would need to include coverage for all ACA essential health benefits. Many services would be covered pre-deductible, including behavioral, preventive, and primary care.

Private insurers would also be responsible to applying for prescription drug rebates to help lower the cost of medications for state option health plans.

The private health insurers administering the state option health plans would contract with health care providers. State officials, however, would set the rates of payment for those providers' services. The plan calls for rates of 175% to 225% of Medicare charges for the same services.

Currently, Colorado providers charge an average of 269% of Medicare's charges for services through private health insurance.

According to state officials, these lower rates would make up the bulk of the savings from the state option plans. Lower payment rates would translate to savings of 9% to 18% on monthly premiums.

The state officials also indicated that these lower premiums should result in savings for the government on the cost of subsidies for people who purchase health insurance through the exchange.

The public comment period for the draft proposal will be open until October 25, 2019. The proposal will be submitted to the Colorado legislature by November 15.

Colorado officials are also planning to apply for a “state innovation waiver” request from CMS. This waiver would allow the state to keep some of the savings the federal government would gain from the lowered costs if the proposal goes forward.

State officials planned on using premium tax credit pass through funding to lower out-of-pocket costs for consumers choosing the public option. Costs would decrease from $133.6 million to $69.7 million.

Officials are planning on applying for the waiver by the summer of 2020.

An actuarial analysis from the firm Wakely predicted that the proposal would increase enrollment in the individual market in Colorado by 4,600 to 9,200 in the first year. The state's limited involvement in managing the plan would help to offset any medical claims that exceeded the cost of premiums preventing a tax increase for Colorado residents. [FN32]

Colorado

2019 CO H.B. 1004 (NS), engrossed March 4, concerning a proposal for implementing a competitive state option for more affordable health care coverage in Colorado, and, in connection therewith, requesting authorization to sue existing federal money for the proposed state option and taking other actions toward the implementation of the state option.

Connecticut

2019 CT H.B. 7267 (NS), introduced February 28, to: (1) Establish the ConnectHealth Program, the ConnectHealth Trust Account and the ConnectHealth Advisory Board; (2) require the Comptroller, in consultation with the ConnectHealth Advisory Board and the Office of Health Strategy, to establish the ConnectHealth Plan; (3) modify requirements concerning nonstate public employer enrollment in the state employee plan; (4) expand the variety of plans offered by the Comptroller to nonstate public employers; and (5) authorize the Comptroller to offer coverage to small employers.

Florida

2019 FL S.B. 1486 (NS), introduced March 13, designating the “Healthy Florida Act”; creating the Healthy Florida program, to be administered by the Healthy Florida Board; creating the Healthy Florida Board; specifying powers and duties of the board in establishing and implementing comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of state residents; prohibiting law enforcement agencies from using Healthy Florida moneys, facilities, property, equipment, or personnel for certain purposes; providing that every resident of this state is eligible and entitled to enroll.

Indiana

2019 IN S.B. 444 (NS), introduced January 14, establishes the Indiana statewide health plan within the Medicaid program. Sets forth requirements of the plan. Requires the office of the secretary of the family and social services administration to apply for any federal waivers required for the plan.

Maryland

• 2019 MD S.B. 871 (NS), introduced February 7, finding that all State residents have a right to health care; providing it is the intent of the General Assembly to establish a comprehensive universal single-payer health care coverage program and a health care cost control system; establishing Healthy Maryland as a public corporation and a unit of State government to provide comprehensive universal health coverage for every State resident; requiring Healthy Maryland to provide certain services for residents of the State by January 1, 2021; etc.

• 2019 MD S.B. 802 (NS), engrossed March 19, establishing the Maryland Health Insurance Option and the purpose of the Option; requiring certain individuals who are under a certain age to maintain certain minimum essential coverage for the individual and certain household members; requiring a certain individual to pay a certain amount if certain coverage is not maintained for a certain period of time of a certain taxable year; etc.

Maine

2019 ME H.P. 1163 (NS), introduced April 23, establishes the Maine Health Plan to provide universal health care coverage to all residents of this State. The bill is modeled on proposed legislation considered in Minnesota.

New Hampshire

2019 NH H.B. 697 (NS), introduced January 3, establishes a single payer healthcare system to provide healthcare for the citizens of New Hampshire.

New York

2019 NY A.B. 5248 (NS), introduced February 8, provides for establishment of the New York Health plan.

Ohio

2019 OH H.B. 292 (NS), introduced June 19, to establish and operate the Ohio Health Care Plan to provide universal health care coverage to all Ohio residents.

Rhode Island

2019 RI H.B. 5611 (NS), introduced February 27, would repeal the “Rhode Island Health Care Reform Act of 2004; Health Insurance Oversight” as well as the “Rhode Island Health Benefit Exchange.” The act would establish a universal, comprehensive, affordable single-payer health care insurance program and help control health care costs, which shall be referred to as, “the Rhode Island Comprehensive Health Insurance Program” (RICHIP). The program will be paid for by consolidating government and private payments to multiple insurance carriers into a more economical and efficient improved Medicare-for-all style single payer program and substituting lower progressive taxes for higher health insurance premiums, co-pays, deductibles and costs due to caps. This program will save Rhode Islanders from the current overly expensive, inefficient and unsustainable multi- payer health insurance system that unnecessarily prevents access to medically necessary health care.

Washington

• 2019 WA H.B. 1104 (NS), introduced January 14, requiring the submission of a waiver to the federal government to create the Washington health security trust; adding a new chapter to Title 43 RCW; creating new sections; repealing RCW 82.04.260 and 48.14.0201; providing contingent effective dates; and providing an expiration date.

• 2019 WA S.B. 5222 (NS), introduced January 19, relating to health care financing and development of the whole Washington health trust to ensure all Washington residents can enroll in nonprofit health insurance coverage providing an essential set of health benefits; adding new sections to chapter 82.02 RCW; adding a new section to chapter 82.32 RCW; adding a new section to chapter 82.04 RCW; adding a new chapter to Title 43 RCW; adding a new chapter to Title 82 RCW; adding a new title to the Revised Code of Washington to be codified as Title 50B RCW; prescribing penalties; providing effective dates; and other related provisions.

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