United Solutions for Care: Progress and Opportunities

United States of Care is building a better future for the health care system. We champion fair and commonsense policy changes to meet people's urgent needs: the certainty that their health care will be affordable, that their coverage will be dependable and there when they need it, that their health care is personalized, and that the system is easy to understand and navigate.

In a system that people feel is unfair and profit-driven, our goal is simple. We believe all people deserve to have access to quality affordable health care regardless of their health status, ability, social need, race, ethnicity, sexual orientation, income, or where they live. People of all backgrounds and political beliefs share this goal. United States of Care knows that because we listen and learn from thousands of people living in every state.

United States of Care drives change at the state and federal level, in partnership with everyday people, business leaders, health care innovators, fellow advocates, and policymakers. Together, we build and advocate for new solutions to our shared health care challenges — solutions which people of every demographic tell us will bring them peace of mind and make a positive impact on their lives.

Based on years of research to understand what people need and want from their care, we have created a one-of-a-kind roadmap of a dozen smart and targeted solutions to the most pressing and urgent challenges people face with the health care system. *United Solutions for Care* is a set of twelve concrete and achievable aims to help us build a fairer system — one that doesn't leave anyone bankrupt when they need care.

United Solutions for Care includes targeted solutions for our health care system, which have strong public support across a wide range of demographics and ideologies. The agenda includes twelve solution across four key areas:

GOAL 1: Affordability
Solution 1: Lowering prescription costs
Solution 2: Eliminating out-of-pocket costs for basic health care services

GOAL 2: Dependability
Solution 3: Providing new, low-cost coverage options that increase competition
Solution 4: Allowing people to use tax credits for people to get coverage outside of their employer
Solution 5: Expand eligibility for public programs including Medicare, Medicaid, Medicare, or the Children's Health Insurance Program (CHIP)

GOAL 3: Personalized Care
Solution 6: Providing support to caregivers
Solution 7: Improving mental health coverage
Solution 8: Provide better maternal and newborn care
Solution 9: Making care more convenient
Solution 10: Ensure that people can equitably get care virtually

GOAL 4: Understandable Care
Solution 11: Making prescription costs more transparent
Solution 12: Increasing availability of patient navigators

These solutions will address people's pain points with the health care system, and bring more fairness and financial peace of mind. The list includes suggestions at all ends of the policy spectrum – from ready-to-implement recommendations to areas needing research, outreach, innovation, and policy design.

USofCare is pursuing and monitoring policies all over the country that work toward meeting people's health care needs. We actively work in states and at the federal level to find and advocate for the solutions that we all need. The following memo outlines where progress has been made and where there are future opportunities to make people's care and lives better.

Goal 1: Affordability: People have the certainty that they can afford their health care.

Across the country, people's most urgent need is the certainty that they can afford their care when they need it, without fearing debt or bankruptcy. When it comes to making care more affordable, we believe policymakers should focus on solutions that can reduce direct costs to people, while being intentional about costs to the overall system and making coverage more dependable. Bringing down the cost of prescription drugs and out-of-pocket costs for basic health services are critical places to relieve people of the fear of financial ruin.

Lowering prescription drug costs by allowing the government to negotiate prices and increasing competition among drugmakers to make it easier and faster to get generics.

At the federal level, Congress is considering a number of proposals to address the high costs of prescription drugs. The House has passed many key provisions that would would allow the federal government to negotiate prices for high-cost drugs covered in Medicare Part B and Part D, cap out-of-pocket spending for Medicare Part D enrollees, limit cost-sharing for insulin for people with Medicare and those with private insurance, and create a rebate system similar to Medicaid's, which requires drug manufacturers to provide refunds if prices grow faster than inflation. The Congressional Budget Office estimates that these drug pricing provisions would reduce the federal deficit by $297 billion between 2022 and 2031 and Congress has an opportunity to enact these provisions this year.

This momentum builds on years of bicameral work, with multiple hearings and proposals to curb the high price of prescription drugs, including a focus on anti-competitive practices, government price negotiation, and antitrust issues. Between March and July 2021, the House Education and Labor Committee, House Energy and Commerce Subcommittee on Health, Senate Health, Education, Labor, and Pensions Committee, and the Senate Judiciary Subcommittee on Competition Policy all invited academics, consumer advocates, and health care policy experts to share their perspectives and ideas.

In 2019, the Democratic caucus released H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act, which would have allowed the Department of Health and Human Services (HHS) to negotiate some drug prices for Medicare and private insurance, and the Senate Finance Committee proposed a bipartisan drug pricing package, both aimed at restraining prescription drug prices.

States have also pursued several policy fixes to help relieve consumers of the prescription drug price burden, including: regulating pharmacy benefit managers, importing drugs from other

countries, addressing price gouging or unjustified price increases, and creating Prescription Drug Affordability Review Boards.

In 2017, Maryland became the first state in the nation to enact a law protecting consumers who rely on essential generic drugs by prohibiting manufacturers or wholesale distributors from price gouging for off-patent or generic drugs. The Maryland law, however, was struck down by a federal appeals court in 2018 because it would have violated the "dormant commerce clause" by regulating sales outside the state. In 2019, the Supreme Court declined to take up the case, further underscoring how important it is for federal lawmakers to address prescription drug pricing.

Eliminating out-of-pocket costs for basic health care services, like mental health and primary care visits.

Access to services with low or no out-of-pocket costs can help ensure people get the primary and behavioral health care they need.

One step that states have taken to reduce out-of-pocket costs is to evaluate the current landscape of primary care spending with an aim of investing more in primary care over time. Several states have pursued legislative or regulatory measures that benchmark, monitor, and seek to increase the levels of health system spending in primary care. These states have typically done so through the creation of working groups or commissions charged with assessing the overall health care system and making policy recommendations.

States are also increasingly exploring Value-based Insurance Design (VBID) that promotes access to preventive and other high-value services at little or no cost-sharing. These VBID approaches aim to increase utilization of high-value services and to prevent severe illness. At the federal level, the Medicare Advantage and TRICARE programs have tested VBID pilot programs and states continue to explore and identify opportunities to incorporate VBID into plan design. Additionally, in the 2023 budget, the Biden Administration has proposed requiring health insurance companies to cover three behavioral health visits and three primary care visits without charging a copayment, coinsurance, or deductible-related fee.

Finally, some states are using standardized plans as another tool to help consumers select their health insurance plans and improve plan competition. Standardizing coverage can include consistent out-of-pocket costs across plans, including for primary care and behavioral health services. For example, the Colorado Option's standardized health insurance plans must include

certain high-value services — such as primary care and behavioral health care — that are first-dollar, pre-deductible coverage. This helps advance equity and means people can seek this important care without incurring any cost.

For plan year 2022, nine states require marketplace insurers to offer standardized plans on the exchange, and two additional states require marketplace issuers to offer plans with limits on deductibles. (Colorado's standardized plans will begin in plan year 2023.)

All nine of these states require copays only for primary care, mental health and substance use disorder, and specialist visits. Most often, these visits are offered as pre-deductible coverage, encouraging utilization of these high-value services because people can seek care without having to worry about paying their deductible or coinsurance, which can be a significant burden.

The federal government also proposed that standardized plans be offered in states using the federally facilitated marketplace, starting in the 2023 plan year. These plans would provide services — including primary care, urgent care, specialists, and mental health care — outside of the plan's deductible (with copays only), providing people with more affordable care that is also more predictable and transparent.

Goal 2: Dependability: People have the security and freedom that dependable health care coverage provides as life changes.

Far too many people cannot count on their coverage. People are concerned that changes in their job, age, or health status, among other things, could cause them to lose health coverage. We need to ensure that people can depend on their health insurance to be there when they need it.

Establishing new, low-cost coverage options, allowing people to use tax credits to get coverage outside of their employer, and expanding eligibility for programs like Medicaid put us on the path to achieving this goal.

Providing new, low-cost coverage options that also increase competition, including allowing individuals and small businesses to access high-quality, dependable, more affordable, and government-regulated options for health insurance.

Allowing individuals and small businesses to access high-quality, dependable, and more affordable coverage, such as through public health insurance options, can help to increase competition and make coverage more accessible to all. In 2021, Colorado and Nevada passed state-level public options, and 22 more states introduced legislation to implement or study how public options could be designed to meet the needs of their states. Further, Congressional leaders have begun exploring what a public option could look like at the federal level, seeking input from stakeholders on how a federal public option could be designed and implemented.

Colorado and Nevada's passage of public option legislation followed Washington state's 2019 passage of Cascade Care. Colorado and Nevada's laws include requirements for private issuers that offer public option coverage to meet premium reduction targets established by the state. Reaching these targets will ensure people have choices of more affordable plans. State public option policies continue to improve over time, particularly as many of the early lessons learned from Cascade Care were incorporated into Colorado's and Nevada's policy approaches. Other states' leaders should continue to watch and learn from the implementation of Cascade Care's updates and the plans in Colorado and Nevada.

Allowing people to use tax credits to get coverage outside of their employer — if their employer coverage is too expensive, doesn't meet their needs, or doesn't extend to family members.

The health care system needs to do a better job of meeting the needs of those that have historically sought coverage through their employer. Approximately 5.1 million people fall into the "family glitch," a barrier to dependable coverage brought on by a federal rule interpreting the financial assistance provisions of the Affordable Care Act (ACA). The family glitch occurs when a worker receives an offer of affordable coverage from their employer, but the offer is not affordable for their dependents. That offer alone, even if it's unaffordable, makes them ineligible for financial assistance when seeking marketplace coverage. In early April 2022, the Biden Administration released a proposed rule to fix the family glitch and estimates that the fix would provide coverage to 200,000 uninsured people and improve affordability for nearly 1 million others.

This move follows efforts made in states that have already moved to provide state-funded subsidies to people who are ineligible for federal financial assistance. Those states include Colorado, Minnesota, New Mexico, and Washington. State subsidies can attract healthier consumers to the market, improving the risk pool and lowering base-rate (list) premiums. This, in turn, creates savings for unsubsidized individuals as well. States with longstanding

state-funded subsidy programs are among those with the nation's lowest uninsured rates and have some of the lowest premiums.

In addition, employers themselves face increasingly unaffordable options. Small businesses, in particular, have found it challenging to keep up with the health care cost demands and therefore struggle to retain and recruit a talented workforce. Public health insurance options are a promising way to create a more affordable option for businesses and/or a pathway for employees to seek financial assistance and lower-cost options in the marketplace.

Expanding eligibility for public programs so that more people qualify for coverage through Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

For many people, expanded eligibility for public programs such as Medicaid, Medicare, and CHIP would ensure their coverage is more dependable and affordable. Many states are pursuing approaches that strategically expand these programs to different populations, such as those without proper documentation, pregnant individuals, or additional children. Black people, Latinos, and American Indians/Alaska Natives are significantly less likely to have health insurance than White people. Expanding coverage is critical for advancing equitable access to health care and improving outcomes.

Currently, 38 states and the District of Columbia have expanded or are currently expanding Medicaid under the ACA. This includes Missouri and Oklahoma, which both expanded their Medicaid programs in 2021. Promoting additional opportunities to expand Medicaid coverage has also been proposed by Congressional leaders as a meaningful step toward closing coverage gaps, particularly amid the COVID-19 pandemic. Black and Latino adults in Medicaid expansion states have had greater coverage gains and larger reductions in disparities than those in non-expansion states. Advocating for Medicaid expansion across the country supports efforts to close the coverage gap and address racial disparities.

Additionally, 35 states have either expanded or are taking action to expand Medicaid postpartum coverage to 12 months, which can improve maternal health outcomes and coverage stability. A number of states are utilizing a state plan option to expand postpartum coverage included in the American Rescue Plan Act (ARPA), which went into effect on April 1, 2022.

Progress is also being made to expand Medicaid dental benefits and extend Medicaid eligibility to people who are pregnant and people who are undocumented. Oral health coverage is an important benefit that improves health outcomes and can reduce overall health spending. Opportunities to expand access to oral health care can also help address existing disparities in access for those underserved by the current health care system.

Nearly half of the states and the District of Columbia have addressed the dental coverage gap by expanding Medicaid to cover dental health, and an additional 24 states provide limited and emergency dental coverage. Regarding pregnancy coverage, 24 states and the District of Columbia have raised income eligibility for people who are pregnant to at least 200% of the federal poverty level (FPL). Additionally, 18 states have utilized the CHIP Unborn Child Option pathway to provide coverage for people who are pregnant, regardless of their immigration status. Sixteen states have also utilized the Immigrant Children's Health Improvement Act to use federal funds to provide prenatal care for people who are undocumented and pregnant. Meanwhile, six states have expanded Medicaid coverage to low-income, undocumented children using state-only funds. And Colorado has created a state-funded subsidy program for individuals who are undocumented buying individual market plans. These expansions are allowing more people to access the care they need.

Medicare expansion is another policy topic that has been reignited during the COVID-19 pandemic. President Biden originally included language on lowering the eligibility age from 65 to 60 in his 2022 budget proposal, and 150 House Democrats called for ARPA to include language that lowered the Medicare eligibility age from 65 to 60 (or even 55). This eligibility expansion could allow individuals to qualify for both Medicaid and Medicare, depending on the policy provisions. Additional discussions at the federal level regarding the expansion of Medicare dental benefits continue, and a proposal to do so has been included in several recent legislative packages.

Goal 3: Personalized Care: People can get the personalized care they need, when and how they need it.

People need care that meets their unique needs and treats them as a whole person, while maintaining the quality and choice they appreciate about the U.S. health care system. Unfortunately, many don't feel that they are receiving this type of personalized care. United States of Care believes that to improve personalized care, the health care system should better provide support to caregivers, seek parity between mental and physical health, provide better

maternal health support, and make it more convenient for people to get care–both in-person and virtually.

Supporting caregivers with sick family members at home by making it easier for people to continue to live independently while receiving care rather than moving into long-term care facilities.

Currently, there are 53 million caregivers in the U.S, with sixty-four percent of them being Baby Boomers or from Generation X. Among caregivers, 61% have another job and 23% say that their own health has suffered as a result of caregiving, demonstrating the impact caregiving has on caregivers themselves. Not only are there more caregivers now than five years ago, the general well-being of caregivers is deteriorating as well.

One of the biggest strains on caregivers is the financial burden they bear. Caregivers are expected to cover general care and health care costs for the individual(s) in their care, but they may also be unable to work another job, forced to work fewer hours, or have to take valuable paid or unpaid time off from their other job.

States have been able to help ease this burden, including by reimbursing caregivers through self-directed Medicaid home and community-based services (HCBS), which are authorized through 1915 waivers or state plan options. These programs allow individuals to develop plans based on their unique needs and allow for payment directly to caregivers if the individual who needs care qualifies for Medicaid. States also have the opportunity to further explore innovative ways to help caregivers navigate and get connected to the many public resources available to them. For example, Idaho is leading a pilot program with this focus, which is called the Idaho Caregiver Alliance navigator program. Federal policymakers also continue to discuss additional investments in Medicaid HCBS in recognition of the importance of meeting people where they are – in their homes and communities – to provide care.

Requiring coverage of mental and physical health to be the same and expanding the ability to get mental health care.

There has been a noticeable shift in the policy conversation over the past few years that has elevated the importance of mental health care and the value of care integration. Reports show that at least one in five U.S. adults has some mental health condition, with many more reporting feelings of anxiety and depression. Going without necessary mental health care can

result in a crisis situation, and the number of individuals experiencing mental health challenges continues to rise as COVID-19 persists.

In 2018, The Kennedy-Satcher Center for Mental Health Equity produced a scorecard for each state's adherence to the Mental Health Parity and Addiction Equity Act (MHPAEA), which is meant to ensure parity between mental and physical health. In their analysis, 32 states received a failing grade. More recently, the National Association of Insurance Commissioners (NAIC) created a working group among 32 states and the District of Columbia that will monitor, facilitate, and coordinate best practices for states seeking to enforce MHPAEA. The actions of the NAIC to create this working group and broad group membership highlight the interest of states to refine the regulatory framework to better serve people.

Additionally, Inseparable, a nonprofit coalition of people working to fundamentally improve mental health care policy, released a February 2022 state report card on Youth Mental Health, which shows all states face challenges in providing adequate access to youth mental health care services. For example, only Idaho and District of Columbia exceed the minimum recommended ratio of school psychologists to students while onlyVermont and New Hampshire exceed the minimum recommended ratio of school counselors to students. Meanwhile, no states exceed the minimum recommended ratio of social workers to students.

Recently, there has been greater investment and focus on mental health, including provisions in federal COVID-19 relief packages to boost funding for existing grant programs. There has also been increased recognition of the need for greater enforcement of the federal mental health parity laws. Specifically, there has been more attention paid to monitoring non-quantitative treatment limitations (NQTLs) — which place limits on the scope or duration of benefits for treatment, such as preauthorization requirements — and emphasis on the requirements included in the Consolidated Appropriations Act, 2021, which directs health insurance plans to perform and share comparative analyses of NQTLs.

The Biden Administration recently released the President's Fiscal Year 2023 budget, which reaffirms the Administration's commitment to advancing access to mental health care, including enforcing parity requirements and investing in the mental health workforce.

Providing better maternal and newborn care by expanding in-home visits by nurses who can connect families with additional help after the baby comes home and increasing insurance coverage for the

different ways people want to give birth — like doula services, birthing centers, and home births.

Compared to other high-income countries, the United States has the highest rate of avoidable deaths among women: a Commonwealth Fund report found that 198 in 100,000 deaths could have been prevented with the right care. In particular, many women in the United States experience adverse health effects regarding their reproductive health. 700 people die each year from pregnancy or pregnancy-related complications in the U.S., and significant disparities exist in these outcomes by race and ethnicity, with Black and American Indian and Alaska Native (AIAN) people experiencing disproportionately worse outcomes than White and Hispanic people. It is critical to invest in services that support better maternal and newborn care and improve long-term health outcomes, including by increasing coverage for births that happen outside of the hospital.

Currently, only four states are actively reimbursing doulas through Medicaid, despite research demonstrating the important role they can play in closing racial and ethnic gaps in maternal health outcomes. Fortunately, eight states and the District of Columbia have passed legislation relating to Medicaid coverage of doulas, which will take effect in the next few years. Despite this progress, a majority of states do not extend Medicaid coverage to doulas, and low reimbursement rates remain an issue in all 50 states.

The number of individuals seeking home births and using alternative birth centers (ABCs) in the United States is on the rise. To increase options for pregnant people, 21 states now cover at-home births through Medicaid and 32 states cover ABCs. In addition to increasing the options for labor and birth, 40 states have implemented Maternal Mortality Review Committees (MMRCs) to better understand the cause of death in each case of maternal mortality. The MMRCs will provide valuable information about policy and actions states can take to address the growing maternal mortality rate in the United States, as well as its disproportionate impact on people of color.

Twenty-seven states have expanded Medicaid to cover postpartum in-home visits for infants and new parents, and a total of 30 states have expanded Medicaid to cover prenatal at-home visits in addition to postpartum visits. This evidence-based approach is meeting families where they are to help them navigate their new normal, while ensuring parents and babies are healthy and able to thrive.

Making it more convenient to get care by expanding the ability to get physical and mental health care where it's most convenient, like at workplaces, local schools, or clinics.

Providing access to physical and mental health care through school-based health clinics (SBHCs) in public schools helps to address health disparities among youth by ensuring all students have access to high-quality care when they need it. While total funding for SBHCs has increased over the past two decades, the number of state public health or education departments providing that funding has decreased. States looking to expand SBHCs have an opportunity to leverage capital and start-up incentives from the federal Health Resources and Services Administration. States can also take action to implement policies that encourage the expansion of SBHCs through partnerships with community-based partners and others, while also recognizing SBHCs are a unique provider type to streamline reimbursement under Medicaid.

In addition to expanding school-based health centers, there are additional opportunities for states to explore broadening where and how people can get more-convenient care. For one, states can develop partnerships with businesses, which could have clinics in areas where providers are not otherwise easily found.

Ensure that people can equitably get care virtually by requiring insurance companies to cover appointments that happen by computer or phone.

Over the past few years, state and federal policies related to virtual care have continued to adapt, particularly due to new flexibilities permitted under the federal public health emergency (PHE). Many states made broad, temporary authorizations of virtual care since the beginning of COVID and 37 states have enacted legislation to make flexibilities permitted under the PHE permanent. 2020 and 2021 were both landmark years for virtual care legislation, and 2022 looks to continue this trend with hundreds of virtual care-focused bills in state legislatures. Those policies include the permanent removal of reimbursement restrictions on where patients and providers are located to receive and give care, coverage reimbursement and parity between virtual and in-person services, prioritization of improving the diversity of the provider workforce available to provide care via virtual care, and increased utilization of audio-only technology, among others.

Twenty-nine states have fully engaged in Interstate Licensure Compacts, which enable

providers to provide virtual care across state lines. Several states and the federal government have removed reimbursement restrictions on where patients and providers are located (also called “originating sites”), to enable greater access to some virtual care services, particularly in rural areas. Forty states have made virtual care reimbursable via private insurance, with 27 enabling permanent reimbursement for both Medicaid and private insurance. At least 29 states have made audio-only care permanently reimbursable, where no state considered audio-only consultation a reimbursable service prior to COVID, improving access to care for those without access to the internet. In addition, at least 19 states passed bills ensuring reimbursement parity between virtual and in-person services.

USofCare believes that a well-designed approach to virtual care has the potential to break down long-standing barriers for people accessing care. Without deliberate effort, however, a rapid move to virtual care could worsen gaps, making care more convenient for those who already had access while continuing to leave behind those who need it most. Policies that expand access to virtual care services should take into account barriers to access that impact already underserved communities.

Goal 4: Navigable System: People experience a health care system that’s understandable and easy to navigate.

The sheer complexity of our system can prevent people from getting the care they need. Too many people feel they are on a solo journey to understand the system and are forced to create hacks that help them make their way through it. Providing more transparency for how costs are set and increasing the availability of trained people who can help others walk through their health care needs are important first steps.

Making prescription costs more transparent by creating clarity about how prices are set and creating prescription affordability review boards that can evaluate pricing and set maximums.

Promoting increased transparency in drug prices can improve competitive pricing, leading to increased affordability across the prescription drug industry. There has been momentum at both the federal and state levels to promote accountability and transparency in setting prescription drug prices. Federal policymakers continue to support the inclusion of transparency provisions in various legislative packages, including one that would require manufacturers to report certain information to federal regulators.

Over the past five years, states across the nation have taken action to limit rising drug costs and promote price transparency, enacting over 163 laws. As noted above, these efforts include regulating pharmacy benefit managers, increasing drug price transparency, importing drugs from Canada, and limiting cost-sharing. Eighteen states have also passed legislation requiring prescription drug manufacturers to disclose certain drug price information, intending to discourage high prescription drug prices and, in turn, save the health system and people money. Six of these states have specifically enacted legislation to establish Prescription Drug Affordability Review Boards (PDABs), which typically have some data collection, reporting, and transparency components. In 2021, at least five states pursued legislation that would allow them to set upper payment limits for prescription drugs.

People who are Black or Latino could see more equitable health outcomes as a result of increased prescription drug transparency and the resulting downward pressure on prices. Inequitable access and high prices have significant implications, as those groups tend to use fewer prescription drugs while experiencing more severe chronic illnesses than people who are White, highlighting affordability barriers. Reforms, such as increased transparency and the implementation of PDABs that lower prices, improve disparate health outcomes.

Increasing availability of trained people, sometimes called "navigators" or "care coordinators," who can help people walk through their health care needs — from picking the right insurance plan to selecting treatment options, and identifying how much it would cost.

Some states are increasing Medicaid beneficiaries' access to community health workers, or similar types of public health workers, who are trusted members of a community or have a close understanding of it. These workers–similar to navigators and care coordinators–serve as a liaison between health care, social services, and the community, facilitating better access to services and improving both the quality and cultural competence of service delivery.

While community health workers are a valuable resource in many communities, this is not the only solution to improve the availability of navigators or care coordinators. USofCare believes there are opportunities for state policymakers and policy experts to develop additional innovative solutions to address the concerns people have raised about making the health care system easier to navigate.

Conclusion

The health care system is complex and includes deeply entrenched interests on many sides. However, when you focus on issues that matter to people and tangible fixes, progress is possible. In fact, there has already been significant state and federal movement in the 12 areas identified in *United Solutions for Care*.

United Solutions for Care includes suggestions at all ends of the policy spectrum – from ready-to-implement recommendations to areas needing research, outreach, innovation, and policy design. These issues cannot be solved by a single person or organization.

USofCare knows we can make the biggest impact for people by bringing together organizations and experts to elevate existing efforts and filling gaps as needed. Progress is possible, and it's happening. Please join us in putting people back in the center of health care.