

A stethoscope is positioned in the upper left, and a line graph with several data points is in the upper right. The background is a dark green with a white grid pattern. A thick green curved line separates the top image from the title area, and a thick orange curved line is at the bottom of the title area.

# HEALTH POLICY OPPORTUNITIES IN THE SOUTHERN STATES

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## **ABOUT THE SOUTHERN ECONOMIC ADVANCEMENT PROJECT (SEAP)**

**SEAP** is your partner and resource. We amplify the efforts of existing organizations and networks that work towards broadening economic power and building a more equitable future.

Broadening economic power brings attention to how race, class and gender intersect social and economic policy in the South. We explore policy ideas designed to directly address these connections. SEAP focuses on 12 Southern states and marginalized/vulnerable populations within the region and is a fiscally sponsored project of the Roosevelt Institute.

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# EXECUTIVE SUMMARY

Many of the nation's most persistent health policy challenges are not only present but magnified in the Southern states. As a region, the South has the highest uninsured rate in the nation and a higher burden of chronic disease than other parts of the country. Rural hospital closures and health care workforce shortages in rural communities in the South threaten basic access to care. Systemic racism is increasingly recognized as a public health issue and is reflected in the stark racial disparities witnessed in maternal mortality rates, diabetes outcomes, and COVID-19 morbidity and mortality across the country and in the South.

Despite these challenges, the Southern states are well poised to make major advances in health. The Biden Administration has indicated it will focus on shoring up and improving the Affordable Care Act, possibly through greater partnerships and incentives for states to strengthen health coverage for vulnerable populations, among other strategies. Additionally, COVID-19 is front and center and has exposed and exacerbated existing health disparities. Southern states have a range of tools, resources, and best practices to draw upon to strengthen their health infrastructure, including both Medicaid and the public health system, while placing health equity at the heart of these efforts.

As state policymakers simultaneously prepare to respond to the urgent needs facing people and communities in the wake of COVID-19 while also dealing with strained state budgets in 2021, they have the opportunity to draw upon best practices and evidence-based policies from around the country and to innovate in the context of an incoming federal administration that has expressed eagerness to work with states to improve health.

The goals of this report are to inform state and local policymakers, as well as other stakeholders, about the health care policy landscape in the South, provide a primer on state health care and public health financing, and describe promising policy opportunities that Southern states could adopt to increase health care coverage and address health care affordability, improve access to health care services, bolster public health infrastructure to create the conditions for everyone to be healthy, and advance health equity.

The report features six issue modules on the following topics:

- Expanding Medicaid,
- Strengthening the public health infrastructure,
- Addressing social determinants of health,
- Reducing maternal mortality rates by extending post-partum coverage,
- Enforcing mental health parity protections, and
- Addressing health care costs and affordability.

While each issue module can stand on its own, the central role of Medicaid in state health care policy cuts across several issue areas as a lever to advance multiple dimensions of health.

## HIGHLIGHTS FROM THE ISSUE MODULES AND KEY POLICY RECOMMENDATIONS

- 1. Expand Medicaid.** The South has the highest uninsured rate of any region in the nation. Additionally, COVID-19 has increased unemployment, which means people are losing job-based health insurance. State policymakers can dramatically lower the number of people who lack health insurance in their states and strengthen a critical health care safety net by expanding Medicaid.
- 2. Strengthen Public Health Infrastructure.** Strengthening public health systems in the Southern states is central to improving population health in the South. Among the ten lowest ranked states in America's Health Rankings, which ranks states across thirty-five measures of health, eight are Southern states. To create the foundation for a stronger public health infrastructure, state policymakers can encourage lead state public health agencies to pursue accreditation through the Public Health Accreditation Board (PHAB). Local policymakers in the South can also support workers who need COVID-19 prevention measures to be enacted and enforced in their workplaces to stay safe and avoid contracting the virus. Worker-led public health councils can promote awareness, encourage compliance, and allow workers to safeguard the public without fear of retaliation.

- 3. Address Social Determinants of Health.** Factors outside the health care system like safe and stable housing, access to nutritious foods, and transportation play a big role in health. Addressing these needs is particularly urgent in the South: seven of the ten lowest ranking states on a social determinants of health index are Southern states. State policymakers can establish a mechanism for coordination across state agencies and programs to collaboratively meet social determinants of health needs, and incorporate screening and referral for these needs into the care management protocols within Medicaid.
- 4. Reduce Maternal Mortality by Extending Post-Partum Coverage.** Access to care challenges in the South are reflected in the region's shocking statistics on maternal mortality. With high rates of maternal mortality in the Southern states and the majority of births in most Southern states financed by Medicaid, there is an opportunity to fully leverage Medicaid to ensure appropriate perinatal care for women throughout the entire pregnancy and postpartum period by extending Medicaid coverage for 12 months post-partum and covering doula services as an optional benefit in Medicaid.
- 5. Enforce Mental Health Parity Protections.** The Southern states are clustered at the bottom of state rankings on behavioral health access measures such as quality and cost of insurance, access to treatment, access to special education, unmet need for services, and workforce availability. State policymakers can adopt legislation to facilitate implementation and enforcement of the federal parity law and to strengthen parity provisions within state law. State policymakers can also use the Well Being Trust's Framework for Excellence in Mental Health and Wellbeing to identify comprehensive strategies across multiple sectors to address behavioral health challenges in their states.
- 6. Address Health Care Costs and Affordability.** Even with health insurance, out-of-pocket health care costs can create financial challenges for individuals and families. These challenges are particularly acute for uninsured people with multiple chronic health conditions who need ongoing access to health care services and life-sustaining medications. State policymakers can build on the momentum generated by the recent enactment of federal surprise billing protections to further strengthen consumer protections in health insurance. State policymakers can also pursue strategies to reign in prescription drug costs; for example, to specifically address the skyrocketing

cost of insulin (the average price has increased by 64 percent since 2014) impacting people with diabetes, states could cap insulin costs for people regardless of insurance status.

Health care issues impact individuals, families, and communities throughout the Southern states. While this report is by no means exhaustive, it is intended to spotlight some of the most promising policy ideas that state policymakers seeking to improve health coverage, access to care, outcomes, and equity can champion in the Southern states.

## **Examples of Health Policy Leadership in the Southern States**

**Covering the uninsured through Medicaid expansion:** AR, KY, LA, VA, WV

**Enacting state-level mental health parity legislation:** TN

**Addressing Social Determinants of Health:** NC

**Extending post-partum Medicaid coverage to address maternal mortality:** GA

**Protecting consumers through comprehensive surprise billing legislation:** FL, GA, VA

**Receiving public health accreditation:** AL, AR, FL, GA, LA, MS

# INTRODUCTION: THE STATE OF HEALTH POLICY IN THE SOUTHERN STATES

Many of the nation's most persistent health policy challenges are not only present but magnified in the Southern states. As a region, the South has the highest uninsured rate in the nation and a higher burden of chronic disease than other parts of the country. Rural hospital closures and health care workforce shortages in rural communities in the South threaten basic access to care. Systemic racism is increasingly recognized as a public health issue and is reflected in the stark racial disparities witnessed in maternal mortality rates, diabetes outcomes, and COVID-19 morbidity and mortality across the country and in the South.

Table 1 shows the rankings (among all states) of the Southern states on the Commonwealth Fund's 2020 Scorecard on State Health System Performance, a wide-ranging analysis of a number of key health indicators. All but three Southern states are in the bottom quartile among the overall ranks, and of the 12 states in the bottom quartile, nine are in the South. Among the Southern states, only Virginia ranks in the top half (at number 25) of states.



**TABLE 1. STATE HEALTH SYSTEM PERFORMANCE RANKINGS**

State	Overall Ranking	Access & Affordability	Prevention & Treatment	Avoidable Use & Cost	Healthy Lives	Income Disparity
Alabama	40	41	29	27	42	49
Arkansas	42	37	46	36	45	37
Florida	41	48	33	47	27	44
Georgia	46	49	39	32	35	47
Kentucky	39	28	24	45	48	35
Louisiana	44	40	44	48	46	28
Mississippi	51	50	50	50	50	41
North Carolina	36	39	22	18	36	46
South Carolina	37	37	43	16	38	43
Tennessee	44	42	32	24	46	51
Virginia	25	26	8	19	18	45
West Virginia	47	33	25	51	51	27

Source: *The Commonwealth Fund.*

While people in the South face more challenges accessing health care services and have poorer health outcomes, on average, than people in other regions of the United States, these challenges and outcomes are not predetermined or immovable. In fact, when state policymakers have prioritized health policies such as covering the uninsured, reducing tobacco usage, or increasing cancer screenings, they have typically been able to make documented improvements in these areas.

The Southern states are well poised to make major advances in health. The Biden Administration has indicated its focus will be on shoring up and improving the Affordable Care Act, possibly through greater partnerships and incentives for states to strengthen health coverage for vulnerable populations.<sup>1</sup> Additionally,

COVID-19 is front and center and has exposed and exacerbated existing health disparities. Southern states have a range of tools, resources, and best practices to draw upon to strengthen their health infrastructure, including both Medicaid and the public health system, while placing health equity at the heart of these efforts.

The goals of this report are to inform state and local policymakers, as well as other stakeholders, about the health care policy landscape in the South, provide a primer on state health care and public health financing, and describe promising policy opportunities that Southern states could adopt to increase health care coverage and address health care affordability, improve access to health care services, bolster public health infrastructure to create the conditions for everyone to be healthy, and advance health equity. The report is organized in two major sections. The first section of the report provides a State Health Care Financing Primer, which covers Medicaid, the Children’s Health Insurance Program (CHIP), public health, and behavioral health financing. The second section of the report features six issue modules presenting best practices and promising ideas to improve health policy in the Southern states.



# SECTION 1: STATE HEALTH CARE FINANCING PRIMER

States finance a variety of critical health programs and services through a combination of federal and state resources, including health coverage for low-income and vulnerable populations, prevention and public health functions and services, and behavioral health services. While not discussed in the state health care financing primer below due to the temporary nature of this funding source, states also received substantial funding through the 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act, which included a \$150 billion Coronavirus Relief Fund for state, local, and tribal governments, to address the effects of the COVID-19 pandemic.<sup>2</sup>

## MEDICAID FINANCING

Medicaid is a joint state-federal program that provides health coverage to low-income children, parents, seniors, and people with disabilities, and is the primary payer for long term care services and supports.<sup>3</sup> Thirty-nine states (including DC) have also extended coverage to low-income adults through the Medicaid expansion authorized by the Affordable Care Act.<sup>4</sup> There are certain requirements and guidelines states must follow to participate in the Medicaid program and receive federal funds. As long as these requirements and guidelines are met, states have wide latitude to determine their eligibility standards and populations, covered benefits and services, provider reimbursement rates, and payment policies. Federal Medicaid funds are substantial and comprise the largest single source of federal revenues for states.<sup>5</sup>

The amount of federal funds that each state receives is determined annually through a formula known as the Federal Medical Assistance Percentage (FMAP). The FMAP is based on each state's per capita income as compared to the national average. States with lower per capita incomes have higher FMAPs, meaning the federal government pays a higher share of Medicaid costs in these states as compared to its share in states with relatively higher per capita incomes. State FMAPs can range from the statutory minimum of 50 percent to a maximum of 83 percent.<sup>6</sup> There are a handful of exceptions to the FMAP for which the federal share to states is higher, most notably the 90 percent federally financed

share for the Medicaid expansion population in states. Medicaid is also a counter-cyclical program, meaning enrollment tends to increase during economic downturns as people lose job-based coverage. To support states during severe recessions, federal policymakers have historically taken steps to temporarily increase the federal FMAP share. For example, the 2009 Recovery Act included a temporary bump in the FMAP in response to the Great Recession, and the 2020 Families First Act increased the federal FMAP share by 6.2 points through the duration of the public health emergency spurred by the COVID-19 pandemic.<sup>7</sup>

Because many of the Southern states have per capita incomes lower than the national average, they tend to have higher FMAP rates. FMAPs for the Southern states are depicted in Table 2. These are FY 2021 rates; however, through the duration of the public health emergency each state’s FMAP is 6.2 points higher. Because the majority of the Southern states have not expanded Medicaid as authorized and envisioned by the Affordable Care Act, they are leaving a sizeable amount of federal money on the table that could be leveraged to increase health coverage, create jobs, and stimulate the economy.

TABLE 2. FEDERAL MEDICAL ASSISTANCE PERCENTAGES IN THE SOUTHERN STATES		
State	FMAP (FY 2021)	Multiplier (Federal Dollars per State Dollar)
Alabama	72.58	2.65
Arkansas	71.23	2.48
Florida	61.96	1.63
Georgia	67.03	2.03
Kentucky	72.05	2.58
Louisiana	67.42	2.07
Mississippi	77.76	3.50
North Carolina	67.40	2.07
South Carolina	70.63	2.40
Tennessee	66.10	1.95
Virginia	50.00	1.00
West Virginia	74.99	3.00

Source: Kaiser Family Foundation.

## MEDICAID SPENDING

In 2018, total Medicaid spending across all states was approximately \$630 billion, and Medicaid provided health coverage for 97 million low-income Americans. While low-income children and adults make up the majority of people enrolled in Medicaid, seniors and people with disabilities account for most of the Medicaid costs in any given month. Children were 43 percent of Medicaid enrollees in 2018 but accounted for only 20 percent of spending. Seniors or people with disabilities accounted for only 20 percent of Medicaid enrollees in 2018 but 46 percent of spending. This is because these populations need greater and more costly health care services, including not only medical costs but also long-term services and supports.<sup>8</sup> According to the Medicaid and CHIP Payment and Access Commission (MACPAC), Medicaid pays for approximately 42 percent of all long-term services and supports in the United States.<sup>9</sup>

The vast majority of states (including most of the Southern states) deliver Medicaid services through capitated managed care, although not all populations are in managed care (children and adults are most likely to be enrolled in managed care, while some states still “carve out” seniors and people with disabilities from managed care). Nationally, more than two-thirds of Medicaid enrollees receive care through managed care. In 2019, payments to managed care organizations accounted for 46 percent of Medicaid spending.<sup>10</sup> As such, it is increasingly important for state policymakers to think about state managed care contracts as an opportunity to advance health policy goals, particularly around ensuring access to care (through enforcement of provider network adequacy standards, for example) and addressing social determinants of health, among other policy goals.

## CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) FINANCING

The Children’s Health Insurance Program (CHIP) provides health coverage to low-income children in working families who earn too much to qualify for Medicaid but do not have access to job-based coverage. CHIP is also jointly funded by the federal and state governments but, unlike Medicaid, federal funding for CHIP is capped. Federal matching funds for CHIP are currently calculated through a formula that is based on each state’s Medicaid FMAP rate.

CHIP matching rates are higher than Medicaid rates, and the CHIP funding formula is known as E-FMAP (Enhanced FMAP). Each state has an annual federal funding allotment, or cap, for these federal matching funds. There are provisions in place for funds to be redistributed to states with shortfalls.<sup>11</sup> Because CHIP needs to be re-authorized by Congress periodically (unlike Medicaid), the funding formula has been subject to modification over time. In 2018, Congress passed ten years of CHIP funding extensions through the HEALTHY KIDS and ACCESS Acts, which means CHIP is currently funded through Fiscal Year 2027. Precise funding allotments to states will be determined each year. The federal appropriation for the next ten years is expected to be sufficient to cover CHIP costs in all states through this time period.<sup>12</sup> Because the Medicaid FMAP rate is temporarily higher as part of the COVID-19 response, the CHIP E-FMAP rate is also temporarily higher, with states receiving a higher federal match for CHIP as well as Medicaid throughout the public health emergency.

## PUBLIC HEALTH FINANCING

Public health in the United States is funded through a combination of federal, state, and local dollars. Federal agencies, primarily the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA), provide funding to state public health agencies, local health departments, and other public and private entities, such as academic institutions, for a variety of public health programs and activities.<sup>13</sup> Federal funding for state and local public health comes through grants, cooperative agreements, and contracts, many of which can be program specific and competitive. State public health agencies generally combine federal funding with state funding to perform or oversee public health functions in the state, with many states also directing both federal and state funding to local public health departments. There is wide variation across the states in how public health agencies are structured and financed. Some are highly centralized, where local health units are led by state employees, and others are decentralized, where local health units are led by local government employees. Other states have a shared governance structure, and others are mixed.<sup>14</sup> While there are well established public health capabilities and programmatic areas that comprise a foundational public health infrastructure for any state or local public health department, the unique protections and services provided by any given public health department can vary based on community need and funding.<sup>15</sup>

Public health is widely considered to be chronically underfunded in the United States, and the COVID-19 pandemic has strained many public health systems to a near breaking point.<sup>16,17</sup> While federal COVID-19 response funding has provided some immediate help, states are still slashing their budgets in response to lagging state revenue resulting from the pandemic’s economic fallout. To meet the public health challenges and threats of the 21st century, substantial and sustained investment in public health will likely be needed.<sup>18</sup>

<b>TABLE 3. PUBLIC HEALTH FUNDING AND STRUCTURE IN THE SOUTHERN STATES</b>		
<b>State</b>	<b>Per-Person Public Health Funding</b>	<b>Public Health Governance Structure</b>
Alabama	\$115	Largely Centralized
Arkansas	\$108	Centralized
Florida	\$64	Shared
Georgia	\$76	Shared
Kentucky	\$87	Shared
Louisiana	\$89	Largely Centralized
Mississippi	\$85	Centralized
North Carolina	\$59	Decentralized
South Carolina	\$80	Centralized
Tennessee	\$99	Mixed
Virginia	\$77	Largely Centralized
West Virginia	\$140	Decentralized

*Source: Per-Person Financing Figures compiled by America’s Health Rankings from: Trust for America’s Health; U.S. HHS; U.S. Census Bureau, Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018. Governance structures are as reported by CDC, <https://www.cdc.gov/publichealthgateway/sitesgovernance/index.html>, accessed December 2020.*

## BEHAVIORAL HEALTH FINANCING

States finance behavioral health through a combination of federal and state dollars directed to a range of mental health and substance use disorder prevention and treatment services. Medicaid is the single largest payer of mental health services in the United States.<sup>19</sup> Additionally, the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation, provides targeted funding to states, subject to Congressional appropriation, for behavioral health. SAMHSA provides funding to states to implement behavioral health programs and services through a variety of grant programs. Current grant programs include the Community Mental Health Services Block Grant, Substance Abuse Prevention and Treatment Block Grant, Promoting the Integration of Primary and Behavioral Health Care (PIPBHC) Grants, and State Opioid Response (SOR) Grants, among others.<sup>20</sup> States also typically apply some state dollars to behavioral health programs and services, subject to state appropriation.





## SECTION 2: BEST PRACTICES, EMERGING ISSUES, AND PROMISING IDEAS TO IMPROVE HEALTH POLICY IN THE SOUTHERN STATES

As state policymakers simultaneously prepare to respond to the urgent needs facing people and communities in the wake of COVID-19 while also dealing with strained state budgets in 2021, they have the opportunity to draw upon best practices and evidence-based policies from around the country and to innovate in the context of an incoming federal administration that has expressed eagerness to work with states to improve health. This section of the report includes six issue modules that take this context into account. These modules are:

- Expanding Medicaid,
- Strengthening the public health infrastructure in the Southern states
- Addressing social determinants of health,
- Reducing maternal mortality rates by extending post-partum coverage,
- Enforcing mental health parity protections, and
- Addressing health care costs and affordability.

While each issue module can stand on its own, the central role of Medicaid in state health care policy cuts across multiple issue areas as a lever to advance multiple dimensions of health.

### MEDICAID EXPANSION

**The South has the highest uninsured rate of any region in the nation. Additionally, COVID-19 has increased unemployment, which means people are losing job-based health insurance. State policymakers can dramatically lower the number of people who lack health insurance in their states and strengthen a critical health care safety net by expanding Medicaid.**

Under the Affordable Care Act, states have the option to expand Medicaid coverage to nonelderly, low-income adults (with incomes at or below 138 percent of the Federal Poverty Level). The federal government finances 90 percent of the cost of the expansion population, and states are responsible for 10 percent. Thirty-nine states<sup>21</sup> including the District of Columbia have taken up this option, and it has dramatically lowered the uninsured rate in these states.<sup>22</sup> In addition, research on the impact of Medicaid expansion has shown that it improves access to health care<sup>23</sup> and has reduced racial disparities in access to care,<sup>24</sup> facilitates better health outcomes, increases financial security, and results in lower uncompensated care costs.<sup>25</sup>

The experience of many states shows that Medicaid expansion can also generate state budget savings by reducing costs for the state’s traditional Medicaid program, corrections health care costs, and other state-funded health care services.<sup>26</sup>

Of the 12 states that have not yet expanded Medicaid, seven are in the South. Given the high uninsured rates and health care access barriers faced by low-income people in the Southern states, Medicaid expansion holds the potential to be transformative in the “holdout” states. In addition, rural hospitals in non-expansion Southern states have struggled to keep their doors open in recent years, compounding access to care challenges. Among the hospitals most vulnerable to closure, 75 percent are in non-expansion states.<sup>27</sup> Expanding Medicaid would reduce uncompensated care and help stabilize rural hospitals.

**TABLE 4. PERCENT UNINSURED AND MEDICAID EXPANSION STATUS**

State	Percent Uninsured (among non-elderly adults 19-64)	Medicaid Expansion (Y/N)
Alabama	11.6	N
Arkansas	10.9	Y
Florida	16.3	N
Georgia	15.5	N
Kentucky	7.6	Y
Louisiana	10.4	Y
Mississippi	15.4	N
North Carolina	13.6	N
South Carolina	13.1	N
Tennessee	12.1	N
Virginia	9.4	Y
West Virginia	8.2	Y

Source: Kaiser Family Foundation.

Importantly, states are also increasingly turning to Medicaid as a lever not only to encourage health care delivery system improvements and improve access to health care services, but also to screen for and help address social determinants of health like housing instability and food insecurity. Medicaid is also a growing source of reimbursement for substance use disorder prevention and treatment and is the single largest payer for mental health services. Without Medicaid expansion, many of the lowest-income and most vulnerable people in the Southern states will not have the access to a range of services that they need to be healthy and productive.

## PUBLIC HEALTH AND PREVENTION

**Strengthening public health systems in the Southern states is central to improving population health in the South. Among the ten lowest ranked states in America’s Health Rankings, which ranks states across thirty-five measures of health, eight are Southern states. To create the foundation for a stronger public health infrastructure, state policymakers can encourage lead state public health agencies to pursue accreditation through the Public Health Accreditation Board (PHAB).**

**Local policymakers in the South can also support workers who need COVID-19 prevention measures to be enacted and enforced in their workplaces to stay safe and avoid contracting the virus. Worker-led public health councils can promote awareness, encourage compliance, and allow workers to safeguard the public without fear of retaliation.**

Public health, defined as what we do together as a society to ensure the conditions in which everyone can be healthy,<sup>28</sup> is vitally important yet often invisible. State and local health departments, in strategic collaboration with community partners, perform indispensable functions and deliver essential services that promote and protect public health in areas such as communicable disease control, emergency preparedness and response, chronic disease and injury and violence prevention, and environmental health.<sup>29</sup>

The COVID-19 pandemic has thrust public health into the spotlight, elucidating its critical role yet also exposing how underfunded and overlooked our public

health infrastructure has been in recent years.<sup>30</sup> Major national investments will be needed to prepare for and adequately address future pandemics, the environmental health effects of climate change, the rising burden of chronic disease, and other emerging public health threats.<sup>31</sup> In addition, COVID-19's disproportionate impact on communities of color has reinforced the urgent need to focus on structural racism as a public health issue and to place health equity at the center of our nation's public health agenda.<sup>32</sup>

While increased focus on public health at the national level will be crucial, states and localities also play an important role in advancing the public's health. State and local public health departments work together in different ways throughout the country, with some states employing a highly centralized approach, where local health departments operate largely under state authority, others using a decentralized model where local health departments are under the jurisdiction and financing of local governments, and some with shared or mixed authority or governance.<sup>33</sup> Regardless of the model and approach, every state has a lead public health agency that leverages federal and state funding for a variety of public health activities. Throughout the COVID-19 pandemic, these public health agencies have been front and center. This role will continue with vaccine deployment in 2021 and beyond. In addition to the near-term need to strengthen the public health infrastructure for COVID-19 response, strengthening core public health infrastructure at the state level will also allow states to address the long-term health challenges and barriers facing their populations, prepare for emerging health threats, and advance health equity.

Strengthening public health systems in the Southern states is central to improving population health in the South. Among the ten lowest ranked states in America's Health Rankings, which ranks states across thirty-five measures of health to "create widespread awareness of where states stand on important public health measures," eight are Southern states.<sup>34</sup> Only one Southern state, Virginia, ranks in the top half of states.

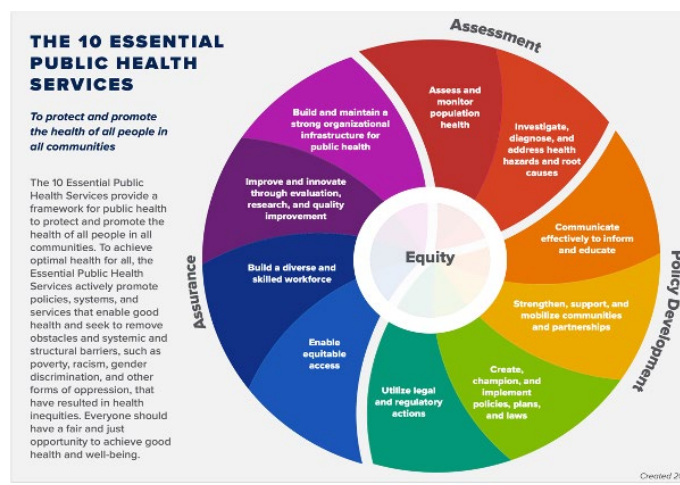
## Encouraging Public Health Accreditation

A promising approach for policymakers in the Southern states is to encourage lead state public health agencies to pursue accreditation through the Public Health Accreditation Board (PHAB). Public health accreditation supports the development and maintenance of high-performing state and local public health departments and is intended to improve quality, performance, and

accountability. Public health accreditation standards are compatible with the 10 Essential Public Health Services depicted in Figure 1 and can establish a foundation for public health departments seeking to modernize, attract federal funding, and incorporate a focus on health equity across all department functions. Research has also found that accredited state public health departments have greater engagement with state policymakers, indicating that the benefits extend beyond improvement of internal functions and can have policy impact as well.<sup>35</sup>

Thirty-six states including the District of Columbia have accredited state public health departments, and many local public health departments are accredited. Notably, of the fifteen non-accredited state public health departments, six are in the South (Kentucky, North Carolina, South Carolina, Tennessee, West Virginia, and Virginia).<sup>36</sup>

State policymakers can pursue laws, regulations, and policies to ensure their state public health departments complete accreditation prerequisites and can work with public health leadership in the state to establish a framework and expectations for undergoing accreditation. While most states do not have legislation requiring accreditation, state policymakers can align legislated public health standards with accreditation standards or make funding available for the pursuit of accreditation. While accreditation will not address the public health and prevention challenges facing Southern states overnight, it lays the groundwork for states to commit to continuous quality improvement in their public health systems and to articulate the value of public health to generate much-needed support and investment.



Source: 10 Essential Public Health Services Futures Initiative Task Force. 10 Essential Public Health Services. September 9, 2020. <https://phnci.org/uploads/resource-files/EPHS-English.pdf>.

## Supporting Worker-led Public Health Councils at the Local Level

Los Angeles (LA) County, in response to concerns raised by essential workers about the need for compliance with COVID-19 prevention and mitigation strategies in the workplace, developed an innovative concept. LA County's approach requires businesses to permit employees to form public safety councils who meet with management to plan and troubleshoot compliance and report regularly to the County Department of Public Health. Workers who participate would be free from retaliation. The Department of Public Health also designates organizations to convene, train, and assist public health councils to spot and report violations.

## SOCIAL DETERMINANTS OF HEALTH

**Factors outside the health care system like safe and stable housing, access to nutritious foods, and transportation play a big role in health. Addressing these needs is particularly urgent in the South: seven of the ten lowest ranking states on a social determinants of health index are Southern states. State policymakers can establish a mechanism for coordination across state agencies and programs to collaboratively meet social determinants of health needs, and incorporate screening and referral for these needs into the care management protocols within Medicaid.**

Social determinants of health are the non-medical factors that influence health outcomes. According to the World Health Organization, they are the “conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.”<sup>37</sup> Examples of social determinants of health include safe and stable housing, food security and access to nutritious foods, air and water quality, education, job opportunities and income, transportation, exposure to violence and toxic stress, racism and discrimination, and other factors outside the health care system that affect the health of individuals, families, and communities.<sup>38</sup>



***Addressing social determinants of health is particularly urgent for the Southern states. According to the social determinants of health index recently published by sharecare and Boston University’s School of Public Health, seven of the ten lowest ranking states in the index are southern states.***

There is a growing recognition among policymakers, the philanthropic community, community-based organizations, and health care stakeholders that addressing social determinants of health is central to improving health and advancing health equity. For example, one of the five overarching goals of Healthy People 2030, the national framework that sets goals and objectives to improve the health and well-being of people in the United States, is to “create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.”<sup>39</sup> The Robert Wood Johnson Foundation, the nation’s largest health philanthropy, includes addressing social determinants of health as part of its Healthy Communities focus area.<sup>40</sup> Through Community Health Needs Assessments and other strategies, hospitals and health systems are increasingly identifying and collaborating with community partners to address social determinants of health. Spurred by innovations in Medicaid policy, many managed care organizations (MCOs) are beginning to connect their members to social determinants of health resources through screening, referral, and case management.

Simultaneously addressing multiple complex factors impacting health and well-being, however, can be challenging. Despite the focus and momentum in this space, substantial barriers remain, including financing, siloed programming, varied regulatory requirements, data collection and sharing, and accurately attributing outcomes to the appropriate intervention. Imagine a patient who misses medical appointments due to lack of transportation or a child who presents frequently in the Emergency Department with asthma because there is mold in the home. By securing a reliable source of transportation to medical appointments for the patient and arranging for mold remediation in the child’s home, these health care problems can be mitigated. These non-medical

interventions to address problems that present in the medical setting require a person-centered, holistic approach. Pursuing non-medical, social service approaches like transportation and mold remediation may require a mechanism for coordination across programs and funding sources. As such, local, state, and federal policy leadership is essential to identifying and overcoming barriers, creating realistic parameters, establishing priorities, and facilitating the cross-sector collaboration required to plan, implement, and evaluate concrete, evidence-based solutions.

***Initial research has found that increased investments in certain social services can result in both health benefits and reductions in health care costs for targeted populations. These investments include housing support for low-income individuals and families; nutritional assistance for high-risk women, infants, and children as well as older adults and people with disabilities; and case management and community outreach for high-need, low-income families and older adults as well as for children with asthma.***

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Source: Lauren A. Taylor et al, [Leveraging the Social Determinants of Health: What Works](#), Yale Global Health Leadership Institute, June 2015.

Two promising approaches that Southern states can pursue to address social determinants of health are 1) establishing a mechanism for coordination, such as a Health in All Policies task force, across state agencies and programs in pursuit of improving health and advancing health equity, and 2) fully leveraging the Medicaid program and the capabilities of contracted managed care organizations (MCOs) to better integrate and address social service and health care needs.



## Mechanism for Coordination

Interventions in the areas of housing, nutritional assistance, transportation, and other domains may fall under the jurisdiction of varying state agencies, each with its own set of funding and programmatic responsibilities and priorities, even though investments in these domains may yield health benefits and even health care savings. Many states and localities have established coordinating bodies or task forces with accountability to state or local leadership. California, for example, has a Health in All Policies Task Force that “assists departments as they integrate health and equity into programs and policies that advance the state’s priorities, including active transportation, access to parks and urban forestry, violence prevention, healthy food systems, education, land use planning, and economic opportunities.”<sup>41</sup> Vermont also maintains a Health in All Policies Task Force, which is a cabinet-level body that was established by Executive Order to “identify how agency policies, programs and budgets can improve the health of Vermonters, especially vulnerable populations.” These types of coordinating entities create a forum for establishing shared goals and metrics, and for assessing the impact of a range of public policies on health.<sup>42</sup>

## Fully Leveraging the Medicaid Program

A number of states have initiated Medicaid payment and delivery reforms that include integration of physical health, behavioral health, social services, and community engagement. States are pursuing these innovations through a range of waivers and grants such as the State Innovation Model (SIM) grant program and the 1115 waiver process.<sup>43</sup> Because the vast majority of states, including most of the Southern states, use capitated managed care to deliver services to Medicaid members, managed care contracting is also an avenue to integrate health care and social services. In 2019, according to the Kaiser Family Foundation, 32 states had at least one MCO social determinants of health policy in place, such as screening for social needs, making referrals for social services, tracking the outcome of the referrals, partnering with community-based organizations or social services providers, and employing Community Health Workers or other Non-Traditional Health Workers.<sup>44</sup> A 2018 study by the Center for Health Care Strategies (CHCS) reviewed MCO contracts for their social determinants of health provisions, and found that, while states often require or encourage MCOs to conduct screening and referral for social needs, they are not taking full advantage

of the flexibility they have in this space. The CHCS analysis also found that state contracts often restated federal authority allowing MCOs to provide additional services but did not provide clarification or detail on how this could be used for social determinants of health interventions specifically and that payment incentives linked to social determinants of health are not yet commonplace.<sup>45</sup>

**North Carolina is pursuing perhaps the most high-profile and ambitious effort to address social determinants of health** through an 1115 Medicaid waiver. This program, known as Healthy Opportunities, focuses on four key domains: housing stability, food security, transportation access, and interpersonal safety. In addition to standardized screening and closed loop referrals through a statewide, electronic coordinated care network known as NCCARE360, North Carolina is pursuing a pilot program to test and evaluate the impact of certain non-medical, health-related interventions in the four key domains to high-needs Medicaid members. These pilots involve the development of Human Service Organization networks, managed by local backbone organizations known as Lead Pilot Entities, to coordinate and deliver services.<sup>46</sup>

As these policy innovations proliferate at the state level, legislation introduced in Congress could further catalyze state-level action to address social determinants of health. For example:

- The Social Determinants Accelerator Act<sup>47</sup>, introduced in 2019, would make grant funding available to state, local, and Tribal governments to develop Social Determinants Accelerator Plans that target a group of high-needs Medicaid patients, identify outcomes that can be achieved through coordinating health and non-medical services, and include a plan for linking data across programs to measure the impact of the interventions.<sup>48</sup>
- The Improving Social Determinants of Health Act, introduced in 2020, would authorize the CDC to create a program to coordinate CDC social determinants of health activities and improve the capacity of public health agencies and community organizations to address social determinants of health. It would authorize research grants for social determinants of health best practices, technical assistance, training and evaluation; authorize grants to state, local, territorial, and Tribal health agencies and organizations to address social determinants of health; and coordinate, support, and align social determinants of health activities at the federal level, among other provisions.<sup>49</sup>

While neither piece of legislation has advanced, Congress appropriated \$3 million in the Consolidated Appropriations Act, 2021 for the CDC to establish a pilot program based on the Social Determinants Accelerator Act. This could create an opportunity for Southern states interested in developing Social Determinants of Health Accelerator Plans to apply for competitive funding. If this approach continues to gain traction and additional federal legislation or funding is authorized beyond the initial pilot, it could open up additional opportunities for state policymakers to access federal funding in the future to implement evidence-based social determinants of health policies at the state level.

It is also worth noting that many of the most promising health policy ideas leverage the Medicaid program in some fashion. **The effect of these health policy approaches is stronger in states that have expanded Medicaid** because the lowest-income and most vulnerable patients are enrolled in Medicaid and can access services that are integrated into Medicaid. In states that haven't expanded Medicaid, many of the people who would most benefit from social determinants of health interventions are uninsured and harder to reach.

## ACCESS TO CARE: ADDRESSING MATERNAL MORTALITY

**Access to care challenges in the South are reflected in the region's shocking statistics on maternal mortality. With high rates of maternal mortality in the Southern states and the majority of births in most Southern states financed by Medicaid, there is an opportunity to fully leverage Medicaid to ensure appropriate perinatal care for women throughout the entire pregnancy and postpartum period by extending Medicaid coverage for 12 months post-partum and covering doula services as an optional benefit in Medicaid.**

Maternal mortality is high and rising, yet substantially preventable, in the U.S. According to the CDC, about 700 women die each year in the U.S. from pregnancy or delivery complications.<sup>50</sup> Maternal mortality, defined as a “death that occurs during pregnancy or within one year postpartum from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy,”<sup>51</sup> is higher in the U.S. than in any other country in the developed world.<sup>52</sup> In fact, maternal mortality is falling around the world but rising here.

In 2018, the maternal mortality rate in the U.S. was 17.4 per 100,000 live births.<sup>53</sup> In addition, there are stark racial disparities in maternal mortality rates, particularly for Black women, for whom the maternal mortality rate was 37.3 per 100,000 live births in 2018, more than double the rate for non-Hispanic white women (14.9 per 100,000). Within the U.S., the Southern states have among the highest maternal mortality rates.<sup>54</sup> For example, the maternal mortality rate per 100,000 live births in 2018 was 45.9 in Arkansas, 40.8 in Kentucky, and 36.4 in Alabama.<sup>55</sup>

These shocking figures have generated attention and focus at the national and state levels. In 2018, the Preventing Maternal Deaths Act was signed into law to establish, support, and provide funding for Maternal Mortality Review Committees (MMRC) in the states to improve data collection and reporting around maternal mortality. State MMRCs analyze data on maternal deaths to identify contributing factors and to make recommendations to address these factors and prevent future maternal deaths. Recognizing that the infrastructure and funding created through this legislation is only a start, a number of bills have been introduced at the federal level to expand access to quality care and perinatal supports, improve cultural competency among the perinatal health care workforce, and facilitate continuous coverage, among a number of other investments and policy changes.

States are also starting to take action to analyze, assess, and address high maternal mortality rates and disparities in perinatal health access, care, and outcomes. In addition to the work happening in the state-level MMRCs, Medicaid is also proving to be a critical lever in this work. Medicaid finances nearly half (43 percent in 2018) of all births.<sup>56</sup> As depicted in Table 5, this percentage is even higher in most Southern states.

**TABLE 5. PERCENT OF BIRTHS FINANCED BY MEDICAID IN THE SOUTHERN STATES**

State	Percent of Births Financed by Medicaid
Alabama	50%
Arkansas	68%
Florida	57%
Georgia	51%
Kentucky	51%
Louisiana	65%
Mississippi	67%
North Carolina	54%
South Carolina	64%
Tennessee	50%
Virginia	37%
West Virginia	54%

*Source: Kaiser Family Foundation.*

State Medicaid programs are required to provide Medicaid coverage to pregnant women with incomes up to 138 percent of the federal poverty level,<sup>57</sup> and most states offer pregnancy Medicaid coverage above that income level. Medicaid covers prenatal care, labor and delivery, and other medically necessary health care services and supports. However, states are only required to provide pregnancy Medicaid for 60 days postpartum, when women are still medically vulnerable<sup>58</sup> and when late maternal deaths can occur. This is a particularly acute challenge for women in states that haven't expanded Medicaid. For example, in Mississippi, pregnant women are eligible for Medicaid with incomes up to 194 percent of the federal poverty level. After the 60-day postpartum period, mothers with incomes only up to 22 percent of the federal poverty level would be eligible for Medicaid as a parent. This means many women lose coverage just 60 days after giving birth. In states that have expanded Medicaid under the Affordable Care Act to all low-income adults with incomes up to 138 percent of the federal poverty level, the decline is less precipitous. In fact, research has found that states that implemented the Medicaid expansion were significantly associated with lower rates of maternal death (by about 7 deaths per 100,000 live births) as compared to non-expansion states.<sup>59</sup> To ensure continuous coverage throughout the critical one-year period following childbirth, some states have extended Medicaid coverage to women for up to 12 months postpartum.

States have also explored other Medicaid policies such as allowing reimbursement for doulas through Medicaid. New Jersey and Georgia both have proposals pending before the federal Centers for Medicare and Medicaid Services (CMS) to extend Medicaid for 6 months postpartum, and Illinois has a pending proposal to CMS to extend Medicaid for 12 months postpartum.<sup>60</sup> Minnesota and Oregon have both chosen to cover doula services as an optional benefit under Medicaid.<sup>61</sup>

With high rates of maternal mortality in the Southern states and, with the exception of Virginia, the majority of births in the Southern states financed by Medicaid, there is an opportunity to fully leverage Medicaid to ensure appropriate perinatal care for women throughout the entire pregnancy and postpartum period.

## MENTAL HEALTH PARITY

**The Southern states are clustered at the bottom of state rankings on behavioral health access measures such as quality and cost of insurance, access to treatment, access to special education, unmet need for services, and workforce availability. State policymakers can adopt legislation to facilitate implementation and enforcement of the federal parity law and to strengthen parity provisions within state law. State policymakers can also use the Well Being Trust’s Framework for Excellence in Mental Health and Wellbeing to identify comprehensive strategies across multiple sectors to address behavioral health challenges in their states.**

As states across the country grapple with the ongoing opioid epidemic, rising suicide rates, and a looming mental health crisis stemming from the effects of COVID-19, there is a heightened need for access to quality, affordable behavioral health services. While the Southern states have a lower prevalence of mental illness and substance use disorder among both adults and children as compared to states in other regions, the Southern states are clustered at the bottom of state rankings on behavioral health access measures such as quality and cost of insurance, access to treatment, access to special education, unmet need for services, and workforce availability.<sup>62</sup>

To address the behavioral health access challenges that are particularly acute in the Southern states, policymakers have two critical tools at their disposal:

- First, expanding Medicaid to low-income adults as envisioned and authorized by the Affordable Care Act (ACA) would help improve insurance coverage for and expand access to mental health and substance use disorder services.

**TABLE 6. STATE MENTAL HEALTH PARITY STATUTE GRADES**

State	Grade
Alabama	C
Arkansas	F
Florida	F
Georgia	D
Kentucky	D
Louisiana	F
Mississippi	F
North Carolina	F
South Carolina	F
Tennessee*	C
Virginia	C
West Virginia	F

*Source: The Kennedy Forum, \*Tennessee has subsequently enacted parity legislation.*



- Second, establishing a state-level framework for enforcing federal mental health and addiction parity laws could transform access to behavioral health services for people with health coverage by requiring transparency and accountability on the part of insurance companies for parity compliance. Because Medicaid expansion has been previously discussed in this report, the remainder of this section will focus on mental health parity.

Mental health parity generally refers to insurance coverage for mental health and substance use disorders that is equal to, or on par with, coverage for medical and surgical care. In 2008, the landmark Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted into law, and in 2010 the ACA amended and expanded its reach. MHPAEA, as amended by the ACA, has become known as “the parity law.” Of importance for state policymakers, federal parity law applies to most individual and small group health plans, which are regulated at the state level by Insurance Commissioners, as well as Medicaid managed care and CHIP plans, which are overseen by state Medicaid agencies.<sup>63</sup> These plans are required to achieve parity with respect to three main areas: 1) financial requirements such as co-payments and deductibles, 2) quantitative treatment limitations such as the number of treatments, annual day or visit limits, and episode day or visit limits, and 3) non-quantitative treatment limitations such as medical necessity determinations, prior authorization, formulary design, and other utilization management techniques. Federal regulations lay out the specific tests and analyses that must be undertaken to ensure plans are compliant, and there are a number of parity compliance tools, including a Parity Self-Compliance Tool developed by the United States Department of Labor.

The promise of the parity law, however, has not yet been fulfilled because of uneven (and in many states, lack of) enforcement, particularly around non-quantitative treatment limitations, which can be complex and opaque in the absence of meaningful oversight. In 2018, the Kennedy Forum and several partner organizations issued state-by-state report cards assessing the strength of state mental health and substance use disorder parity statutes. Thirty-two states received a failing grade, including most Southern states (Table 6).<sup>64</sup>

***The framework for excellence in mental health and wellbeing put forth by the Well Being Trust provides an opportunity for policymakers at all levels to address our nation’s behavioral health crisis comprehensively and makes policy recommendations in five main areas: health systems, the education system, judicial systems, workplace and unemployment, and the whole community.***

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Source: The Well Being Trust.

Following the release of these scorecards and particularly in light of the opioid epidemic and disconcerting increases in suicide rates in recent years, a flurry of activity has taken place in states across the country to improve state parity laws. Illinois, New Jersey, Arizona, California, Colorado, and other states have passed parity laws based at least in part on the Kennedy Forum Model State Parity Legislation in the past three years. **Among the Southern states, only Tennessee has enacted parity legislation.**

Southern states should follow the lead of Tennessee and a growing number of states around the country in adopting legislation based on the Kennedy Forum Model State Parity Legislation, which is intended to facilitate implementation and enforcement of the federal parity law and to strengthen parity provisions within state law.<sup>65</sup>

In addition to expanding coverage through Medicaid and ensuring access to life-saving behavioral health treatments and services through enforcement of parity laws, states should also consider strategies to address behavioral health workforce shortages as part of a longer term, comprehensive approach to address behavioral health challenges. The Well Being Trust has put forth a *Framework for Excellence in Mental Health and Well-being* that can be a resource to state policymakers and help guide the way towards policy change and funding strategies to address people’s unique behavioral health needs.<sup>66</sup>



## HEALTH CARE AFFORDABILITY

**Even with health insurance, out-of-pocket health care costs can create financial challenges for individuals and families. These challenges are particularly acute for uninsured people with multiple chronic health conditions who need ongoing access to health care services and life-sustaining medications. State policymakers can build on the momentum generated by the recent enactment of federal surprise billing protections to further strengthen consumer protections in health insurance. State policymakers can also pursue strategies to reign in prescription drug costs; for example, to specifically address the skyrocketing cost of insulin (the average price has increased by 64 percent since 2014) impacting people with diabetes, states could cap insulin costs for people regardless of insurance status.**

Concern about health care costs is top of mind for many Americans. According to polling from the Kaiser Family Foundation, among the household expenses that people worry about being able to afford, health care is at the top of the list. Additionally, when asked about the health care issues they want elected officials to address, Americans also cited health care costs as the highest priority. Particular challenges include unexpected medical bills and prescription drug costs. About two-thirds of Americans (67%) are somewhat worried or very worried about being able to afford unexpected medical bills, and nearly half (44%) are worried about being able to afford prescription drug costs for themselves and their family.<sup>67</sup>

### Surprise Billing

Surprise out-of-network billing has become an increasing problem for health care consumers and can lead to large, unexpected medical costs. Surprise billing, also known as balance billing, typically occurs when an insured patient is billed for out-of-network services that were provided as part of a patient's care. For example, a patient may have a medical emergency and be transported by ambulance to a hospital that is in the patient's network. While in the hospital, the patient may receive care from emergency physicians, radiologists, anesthesiologists, and/or a range of other specialists, depending on the medical condition and need. Even though these various clinicians may be working together and may be providing care at an in-network facility, they haven't

necessarily all agreed to accept the same insurance. As a result, the patient could get unanticipated bills from the ambulance provider and various specialists and clinicians involved in the patient's care.<sup>68</sup> Among patients admitted to an in-network hospital or having elective surgery at an in-network hospital, about 1 in 5 receives an out-of-network bill.<sup>69</sup> These bills can be substantial (in the thousands of dollars) and can place a large financial burden on patients through no fault of their own, even pushing some into bankruptcy.<sup>70</sup>

As of September 2020, 31 states have enacted legislation to protect consumers from surprise billing. Sixteen of these states have taken a comprehensive approach, while 15 have adopted more limited protections. Among the Southern states, half have enacted consumer protections for surprising billing, although only three Southern states have enacted comprehensive protections (Florida, Georgia, and Virginia).<sup>71</sup> Georgia enacted legislation in 2020 after five years of sustained advocacy from consumer groups that requires insurers to hold enrollees harmless for amounts beyond the in-network level of cost sharing and prohibits out-of-network providers from billing enrollees for any amount beyond the in-network level of cost sharing. These protections apply to consumers enrolled in HMO plans and PPO plans and for both emergency and non-emergency services. The legislation sets up a dispute resolution process between insurers and health care providers that removes the patient from these negotiations. The Georgia law represents a best practice that other Southern states could adopt as well.<sup>72</sup>

In December 2020, as part of an additional COVID-19 stimulus package, Congress passed surprise billing protections for consumers. This legislation has a further reach than state legislation because states lack jurisdiction over certain types of health insurance plans. This action is a welcome sigh of relief for health care consumers and shows how ongoing advocacy resulted in an important policy win at the federal level after multiple states took action.

## Prescription Drug Costs

Consumers are feeling the effects of rising prescription drug costs, and many are making difficult tradeoffs to get the medications they need. According to polling conducted last year by Kaiser Family Foundation, among the 62 percent of adults currently taking prescription drugs, about one-fourth (24%) say that it is difficult to afford their prescription drugs. Nearly three in ten (29%) have not taken medicines as prescribed (for example, they have split pills, used an

over-the-counter drug instead, or left prescriptions unfilled) because of the cost.<sup>73</sup> According to an analysis by Consumer Reports, some Americans are also resorting to postponing paying other bills or spending less on groceries so that they can afford the rising cost of prescription drugs.<sup>74</sup>

Prescription drug prices have also received a flurry of attention at the state and federal levels in recent years. Since 2017, states have enacted 163 laws aimed at addressing prescription drug costs. According to an analysis by the National Academy for State Health Policy, many of these laws focused on regulating pharmacy benefit managers, increasing drug cost transparency, importing drugs from Canada, and limiting cost-sharing by consumers, and are most likely to impact people with health insurance but for whom drug costs are still unaffordable.<sup>75</sup>

While many people with health insurance struggle with drug costs due to high deductibles and out-of-pocket costs that still leave them exposed to unaffordable costs, people who are uninsured face some of the biggest hurdles in affording needed medications because they are not shielded at all from high prices. These affordability challenges are particularly acute for uninsured people with multiple chronic health conditions who need ongoing access to life-sustaining medications. As a region, the South has the highest uninsured rate of any region in the US<sup>76</sup> and a relatively higher prevalence of chronic conditions like diabetes and hypertension,<sup>77, 78</sup> and low income people and communities of color are particularly impacted.<sup>79</sup> To specifically address the skyrocketing cost of insulin (the average price has increased by 64 percent since 2014) impacting people with diabetes, regardless of insurance status, Minnesota recently enacted legislation that caps insulin costs for people with commercial insurance and for the uninsured and underinsured.<sup>80</sup> This legislation creates both an emergency, short-term mechanism for a 30-day supply of insulin as well as a longer-term program. Addressing the high cost of insulin is particularly urgent because people with diabetes are at greater risk of having serious complications from COVID-19.<sup>81</sup> States should continue to explore approaches to making drugs more affordable.<sup>82</sup> Additionally, expanding Medicaid would extend coverage to well over a million people in the South,<sup>83</sup> which would include drug coverage, making Medicaid expansion an important strategy for improving access to prescription drugs for low-income populations in the Southern States.



# CONCLUSION

Health care issues impact individuals, families, and communities throughout the Southern states. While this report is by no means exhaustive, it is intended to spotlight some of the most promising policy ideas that state policymakers seeking to improve health coverage, access to care, outcomes, and equity can champion in the Southern states. **Expanding Medicaid is unquestionably the biggest and most important health-related policy initiative that can be undertaken in the states that haven't yet done so**, not only because of its effect on health coverage and access to care, but because Medicaid is increasingly serving as a linchpin and a lever for state-level health policy improvements. Leaving out large numbers of low-income people and vulnerable populations, particularly in the wake of COVID-19, will continue to have severe consequences for the millions of people in the Southern states who lack the financial protection and access to care that a consistent source of health coverage provides. In addition, it means that state policy efforts to advance health through Medicaid in other ways will have a less powerful impact because they won't reach some of the very people and communities most in need. Nevertheless, all of the policy ideas in this report are intended to be practical, actionable, and worth pursuing, with positive impacts on health for people and communities throughout the Southern states.

## ABOUT THE AUTHOR

This report was prepared by Cindy Zeldin, a Senior Consultant at Health Management Associates (HMA), on behalf of SEAP. She has extensive experience in state level health policy and advocacy, including having led a statewide nonprofit consumer health advocacy organization for eight years in Georgia. She holds an MPH in Health Policy and Management and a BA in Political Science, both from Emory University.

# ENDNOTES

- <sup>1</sup> Michael Ollove, [Biden Likely to Help States Increase Health Care Access](#), Stateline (Pew), November 24, 2020.
- <sup>2</sup> National Conference of State Legislatures, [COVID-19 Stimulus Bill: What it Means for States](#), April 2, 2020.
- <sup>3</sup> Medicaid.gov, [Long Term Services & Supports](#), accessed November 27, 2020.
- <sup>4</sup> Kaiser Family Foundation, [Status of State Action on the Medicaid Expansion Decision](#), November 2, 2020.
- <sup>5</sup> Robin Rudowitz, Kendal Orgera, and Elizabeth Hinton, *Medicaid Financing: The Basics*, Kaiser Family Foundation, March 21, 2019.
- <sup>6</sup> Medicaid and CHIP Payment and Access Commission (MACPAC), [Matching Rates](#), accessed November 2020.
- <sup>7</sup> Paul N. Van de Water, [Increasing Federal Medicaid Assistance Provides Effective Economic Stimulus](#), Center on Budget and Policy Priorities, July 17, 2020.
- <sup>8</sup> Center on Budget and Policy Priorities, [Policy Basics: Introduction to Medicaid](#), April 14, 2020.
- <sup>9</sup> Medicaid and CHIP Payment and Access Commission (MACPAC), [Spending](#), accessed November 2020.
- <sup>10</sup> Elizabeth Hinton, Robin Rudowitz, Lina Stolyar, and Natalie Singer, [10 Things to Know About Medicaid Managed Care](#), Kaiser Family Foundation, October 29, 2020.
- <sup>11</sup> Alison Mitchell, [Federal Financing for the State Children's Health Insurance Program \(CHIP\)](#), Congressional Research Service, May 23, 2018.
- <sup>12</sup> Kelly Whitener, [HEALTHY KIDS and ACCESS Acts: Summary of Key Provisions Impacting Children](#), Georgetown Center for Children and Families, March 2018.
- <sup>13</sup> American Public Health Association, [Public Health Funding: CDC and HRSA Fact Sheet](#), accessed December 2020.
- <sup>14</sup> Centers for Disease Control and Prevention, [Health Department Governance](#), accessed December 2020.
- <sup>15</sup> Public Health National Center for Innovations, [Foundational Public Health Services](#), Fact Sheet, November 2018.
- <sup>16</sup> Lauren Weber and Laura Ungar and Michelle R. Smith, The Associated Press and Hannah Recht and Anna Maria Barry-Jester, [Hollowed Out Public Health System Faces More Cuts Amid Virus](#), The Associated Press and Kaiser Health News, July 1, 2020.
- <sup>17</sup> Trust for America's Health, [The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations 2020](#), April 2020.
- <sup>18</sup> Trust for America's Health, [The Promise of Good Health for All: Transforming Public Health in America. A Blueprint for the 2021 Administration and Congress](#), October 2020.

- <sup>19</sup> Mental Health America, [The Federal and State Role in Mental Health](#), accessed December 2020.
- <sup>20</sup> SAMHSA, [SAMHSA Grants](#), accessed December 2020, National Council for Behavioral Health, [Capitol Connector Blog](#), accessed December 2020.
- <sup>21</sup> Kaiser Family Foundation, [Status of State Action on the Medicaid Expansion Decision](#), November 2, 2020.
- <sup>22</sup> Kaiser Family Foundation, [The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review](#), March 17, 2020.
- <sup>23</sup> Center on Budget and Policy Priorities, [Chart Book: The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion](#), October 21, 2020.
- <sup>24</sup> Jesse C. Baumgartner, Sara R. Collins, David C. Radley, and Susan L. Hayes, [How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care](#), The Commonwealth Fund, January 16, 2020.
- <sup>25</sup> Center on Budget and Policy Priorities, [Chart Book: The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion](#), October 21, 2020.
- <sup>26</sup> Dee Mahan, [The Impact of Medicaid Expansion on State Budgets](#), Families USA, February 2019.
- <sup>27</sup> Dylan Scott, [1 in 4 Rural Hospitals is Vulnerable to Closure, a New Report Finds](#), Vox, February 18, 2020.
- <sup>28</sup> Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services, [Public Health 3.0: A Call to Action to Create a 21st Century Public Health Infrastructure](#), 2016.
- <sup>29</sup> Public Health National Center for Innovations, [Foundational Public Health Services Fact Sheet](#), November 2018.
- <sup>30</sup> Trust for America's Health, [The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations 2020](#), April 2020.
- <sup>31</sup> Trust for America's Health, [The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations 2020](#), April 2020.
- <sup>32</sup> Leonard E. Egede, M.D. and Rebekah J. Walker, PhD, [Structural Racism, Social Risk Factors, and Covid-19—A Dangerous Convergence for Black Americans](#), The New England Journal of Medicine, July 22, 2020.
- <sup>33</sup> Association of State and Territorial Health Officials, [State and Local Health Department Governance Classification System](#), June 2012.
- <sup>34</sup> United Health Foundation and the American Public Health Association, [America's Health Rankings Annual Report 2019](#), December 2019.
- <sup>35</sup> Erwin, Paul Campbell MD, DrPH; Padek, Margaret M. MPH, MSW; Allen, Peg PhD, MPH; Smith, Romario BSW; Brownson, Ross C. PhD [The Association Between Evidence-Based Decision Making and Accreditation of State Health Departments](#), Journal of Public Health Management and Practice: September/October 2020 - Volume 26 - Issue 5 - p 419-427 doi: 10.1097/PHH.0000000000001162
- <sup>36</sup> Public Health Accreditation Board, [Who is Accredited](#), accessed November 2020.



- <sup>37</sup> World Health Organization, [https://www.who.int/health-topics/social-determinants-of-health#tab=tab\\_1](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1), accessed November 2020.
- <sup>38</sup> World Health Organization, [https://www.who.int/health-topics/social-determinants-of-health#tab=tab\\_1](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1), accessed November 2020; Healthy People 2030, *Social Determinants of Health*, Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services, accessed November 2020.
- <sup>39</sup> Healthy People 2030 Framework, [Healthy People 2030 Framework - Healthy People 2030 | health.gov](https://www.health.gov/healthy-people-2030), accessed November 2020.
- <sup>40</sup> Robert Wood Johnson Foundation, [Social Determinants of Health](https://www.rwjf.org/en/about-us/social-determinants-of-health.html), accessed November 2020.
- <sup>41</sup> California Strategic Growth Council, [Health in All Policies \(HiAP\) - Strategic Growth Council \(ca.gov\)](https://www.sgc.ca.gov/health-in-all-policies), accessed November 2020.
- <sup>42</sup> Vermont Department of Health, <https://www.healthvermont.gov/about-us/our-vision-mission/building-culture-health>, accessed November 2020.
- <sup>43</sup> Samantha Artiga and Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, Kaiser Family Foundation, May 10, 2018.
- <sup>44</sup> Kaiser Family Foundation, [States Reporting Social Determinant of Health Related Policies Required in Medicaid Managed Care Contracts](https://www.kff.org/medicaid/policy-issues/states-reporting-social-determinant-of-health-related-policies-required-in-medicaid-managed-care-contracts), accessed November 2020.
- <sup>45</sup> Center for Health Care Strategies, [Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations](https://www.chcs.org/2018/12/12/addressing-social-determinants-of-health-via-medicaid-managed-care-contracts-and-section-1115-demonstrations), December 2018.
- <sup>46</sup> North Carolina Department of Health and Human Services, <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities>, accessed November 2020.
- <sup>47</sup> [Text - H.R.4004 - 116th Congress \(2019-2020\): Social Determinants Accelerator Act of 2019 | Congress.gov | Library of Congress](https://www.congress.gov/116/text/hrg/4004/1-116th-congress-2019-2020/social-determinants-accelerator-act-of-2019), accessed November 2020.
- <sup>48</sup> Aligning for Health, [Social Determinants Accelerator Act – Aligning for Health](https://www.aligningforhealth.org/social-determinants-accelerator-act-aligning-for-health), accessed November 2020.
- <sup>49</sup> Trust for America's Health, [PowerPoint Presentation \(tfah.org\)](https://www.tfah.org/presentation/powerpoint-presentation), accessed November 2020.
- <sup>50</sup> Centers for Disease Control and Prevention, [Maternal Mortality \(cdc.gov\)](https://www.cdc.gov/maternal-mortality/), accessed November 2020.
- <sup>51</sup> Centers for Disease Control and Prevention, [Preventing Pregnancy-Related Deaths | CDC](https://www.cdc.gov/pregnancy/preventing-pregnancy-related-deaths/), accessed November 2020.
- <sup>52</sup> Nina Martin and Renee Montagne, *U.S. Has the Worst Rate of Maternal Deaths in the Developed World*, NPR and ProPublica, May 12, 2017.
- <sup>53</sup> Centers for Disease Control and Prevention, <https://www.cdc.gov/nchs/maternal-mortality/index.htm>, accessed November 2020.



<sup>54</sup> Data is not available for all states; in addition, some of the variability across states may be due to the quality of the data and not underlying differences.

<sup>55</sup> Centers for Disease Control and Prevention, [Maternal Mortality By State 2018](#), accessed November 2020.

<sup>56</sup> Hannah Katch, [State and Federal Policymakers Should Extend Postpartum Medicaid Coverage](#), Center on Budget and Policy Priorities, August 27, 2020.

<sup>57</sup> Kaiser Family Foundation, [Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level](#), January 1, 2020.

<sup>58</sup> Usha Ranji, Ivette Gomez, and Alina Salganicoff, [Expanding Postpartum Medicaid Coverage](#), Kaiser Family Foundation, May 22, 2019.

<sup>59</sup> Jaime Rosenberg, [Medicaid Expansion Linked to Lower Maternal Mortality Rates](#), Research Presented at AcademyHealth National Health Policy Conference, February 6, 2019.

<sup>60</sup> [Illinois Continuity of Care and Administrative Simplification | Medicaid.nj-1115-request-pa.pdf \(medicaid.gov\)](#), accessed November 2020.

<sup>61</sup> Taylor Platt and Neva Kaye, [Four State Strategies to Employ Doulas to Improve Maternal Health and Birth Outcomes in Medicaid](#), National Academy for State Health Policy, July 13, 2020.

<sup>62</sup> Maddy Reinert, Theresa Nguyen, and Danielle Fritze, [The State of Mental Health in America 2020](#), Mental Health America, 2019.

<sup>63</sup> The Mental Health Parity and Addiction Equity Act (MHPAEA) Fact Sheet, CMS, October 25, 2011. [https://www.cms.gov/ccio/programs-and-initiatives/other-insurance-protections/mhpaea\\_factsheet.html#Regulation](https://www.cms.gov/ccio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html#Regulation).

<sup>64</sup> The Kennedy Forum, [32 States Get a Failing Grade on New Report Cards Scoring Statutes for Mental Health and Addiction Treatment 10 Years After Federal Parity Law](#), October 3, 2018.

<sup>65</sup> The Kennedy Forum, [Parity Progress](#), accessed November 2020.

<sup>66</sup> Well Being Trust, [Healing the Nation: Advancing Mental Health and Addiction Policy](#), January 2020.

<sup>67</sup> Ashley Kirzinger, Cailey Muñana, Bryan Wu, and Mollyann Brodie, [Data Note: Americans' Challenges with Health Care Costs](#), Kaiser Family Foundation, June 11, 2019.

<sup>68</sup> Simon F. Haeder, David L. Weimer, and Dana B. Mukamel, Surprise Billing: No Surprise in View of Network Complexity, [Health Affairs](#), June 5, 2019; Chhabra KR, Dimick JB. "Surprise" Out-of-Network Medical Bills. [JAMA](#). 2020;323(9):902. doi:10.1001/jama.2020.0847

<sup>69</sup> Christopher Garmon and Benjamin Chartock, "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills," [Health Affairs](#), January 2017.

<sup>70</sup> Lindsey Bomnin and Stephanie Gosk, “Surprise Medical Bills Lead to Liens on Homes and Crippling Medical Debt,” *NBC News*, March 19, 2019; Laura Ungar, “Heart Disease Bankrupted Him Once. Now He Faces Another \$10,000 Bill,” *NPR*, September 25, 2020.

<sup>71</sup> Maanasa Kona, “State Balance-Billing Protections,” *The Commonwealth Fund*, September 16, 2020.

<sup>72</sup> Georgians for a Healthy Future, “*Five Years in the Making: Consumer Advocates’ Role in Passing Comprehensive Surprise Billing Legislation*,” July 16, 2020; Maanasa Kona, “State Balance-Billing Protections,” *The Commonwealth Fund*, September 16, 2020.

<sup>73</sup> Ashley Kirzinger, Cailey Muñana, Bryan Wu, and Mollyann Brodie, *Data Note: Americans’ Challenges with Health Care Costs*, Kaiser Family Foundation, June 11, 2019.

<sup>74</sup> Lisa Gill, *The Shocking Rise of Prescription Drug Prices*, Consumer Reports, November 26, 2019.

<sup>75</sup> Amanda Attiya and Jennifer Reck, *States Curb Racial Inequities in Rx Drug Affordability with Targeted Legislation*, National Academy for State Health Policy, October 26, 2020.

<sup>76</sup> Dan Witters, *U.S. Uninsured Rate Rises to Four-Year High*, Gallup, January 23, 2019.

<sup>77</sup> Centers for Disease Control and Prevention, *National Diabetes Statistics Report 2020*.

<sup>78</sup> Ward BW, Black LI. State and Regional Prevalence of Diagnosed Multiple Chronic Conditions Among Adults Aged ≥18 Years — United States, 2014. *MMWR Morb Mortal Wkly Rep* 2016;65:735–738. DOI: [http://dx.doi.org/10.15585/mmwr.mm6529a3external\\_icon](http://dx.doi.org/10.15585/mmwr.mm6529a3external_icon).

<sup>79</sup> Amanda Attiya and Jennifer Reck, *States Curb Racial Inequities in Rx Drug Affordability with Targeted Legislation*, National Academy for State Health Policy, October 26, 2020.

<sup>80</sup> Joanna Dornfeld, *Minnesota Lawmakers Establish Emergency Insulin Program — Saving Lives in the Midst of the COVID Pandemic*, United States of Care, April 16, 2020.

<sup>81</sup> Amanda Attiya and Jennifer Reck, *States Curb Racial Inequities in Rx Drug Affordability with Targeted Legislation*, National Academy for State Health Policy, October 26, 2020.

<sup>82</sup> The Minnesota legislation has been legally challenged. See [Legal Resources — The National Academy for State Health Policy \(nashp.org\)](#).

<sup>83</sup> Rachel Garfield, Kendal Orgera, and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid*, Kaiser Family Foundation, January 14, 2020.



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