Health Care Financing Task Force

Barriers to Access Workgroup

Friday, October 2, 2015; 8:30 a.m. – 11:00 a.m.

Minnesota State Office Building, Room 200

Minutes

| **Item** | **Presenter** | **Discussion /Resolution** |
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| **Introductions** | Marilyn Pietso, MD | * The Barriers to Access Workgroup lead opened the meeting. |
| **Barriers to Access Workgroup Workplan** | Manatt | * *See Manatt presentation* * Patricia Boozang of Manatt presented on the workplan for the barriers to access workgroup including key meeting dates and upcoming topics. * Workgroup members expressed concern regarding the ability for members of the public to comment if the meetings are conducting by webinar. The member suggested that the webinar be set up in a place where the public can access it. * Dr. Pietso reminded the workgroup that the timeframe is short and recommendations which can be analyzed in the limited window available should be prioritized. The workgroup agreed that focusing on a limited number of recommendations will be important for reaching consensus on recommendations and using the resources available for modeling most efficiently. |
| **What are Structural Barriers** | Manatt | * Alice Lam of Manatt presented on structural barriers to access to care and coverage, noting they may arise from potential misalignment in coverage program features including: benefit design, health plans, and provider networks. |
| **Options and Considerations for Reducing Structural Barriers, Part 1** | Manatt | * Ms. Lam presented on the potential options and considerations for reducing structural barriers and disparities. She presented three categories for reducing structural barriers including: (1) aligning benefits across the coverage continuum, (2) aligning plans and providers across the coverage continuum, and (3) mitigating disruptions in care during coverage transitions. * The workgroup discussed whether the goal of benefit alignment is to ensure access to the same benefits across the coverage continuum and allow for continuity as well as ease of understanding, or to provide access to certain high value benefits (e.g., adult dental). No clear consensus emerged. * The workgroup considered several potential options to bring alignment to benefits in Medical Assistance, MinnesotaCare, and QHP coverage through MNsure:   + *Use same benchmark plan to define EHB categories across programs:* Certain states, including New Hampshire, have elected to use the EHB benchmark plan for Medicaid ABP and QHP to make essential health benefits nearly identical. The workgroup discussed the impact of selecting a more comprehensive benchmark in the pricing of products and the interrelatedness of benefit, network, and product design. Unless the product design or provider network changes, increasing benefits will likely result in higher product costs. The workgroup also discussed motivation for states to default to the small group benchmark. One workgroup member posited that using the small group benchmark reduces the distortion for individuals transitioning between those coverage types. The workgroup agreed that aligning benefits will simplify administration and reduce consumer confusion but may do so at the cost of reducing consumer choice.   + *Add a new EHB category to cover a highly valued service*: Minnesota could elect to add a new category, such as dental coverage for adults, to ensure access to a highly valued service. As currently provided in law, adult dental and vision are prohibited from being considered an EHB even if the benchmark plan covers those services. The workgroup discussed considerations for adding an EHB category. Since EHBs apply to the broader individual and small group coverage, adding an EHB category will have broader ramifications. The workgroup agreed that if an EHB category were added through a 1332 waiver the state would need to consider offsetting the cost to the federal government. * Due to time constraints, the remaining discussion was tabled to the next meeting. |

**Health Care Financing Task Force**

**Vision:** Sustainable, quality health care for all Minnesotans

**Guiding Principles:**

***Realistic:*** The task force will make recommendations that can realistically be implemented.

***High Value Impact:*** The task force will seek recommendations that have high value and are meaningful to Minnesota’s health care reform efforts.

***Holistic Perspective:*** The task force understands that health care finance and our recommendations do not exist in a vacuum, and are components of the health care and population health systems

***Focus:*** The task force recognizes that health care financing and system reform is extremely complex and it will contribute to the broader policy debates by focusing its time and attention on the issues it is charged with addressing.

***Innovation:*** The task force is encouraged to identify opportunities for innovation in Minnesota’s health care financing and delivery systems which show promise for lowering costs, improving population health and improving the patient experience.