Health Care Financing Task Force

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

Barriers to Access Workgroup

Friday, November 13, 2015; 9:00 a.m. – 11:00 a.m.

St. Cloud, MN

Minutes

| **Item** | **Presenter** | **Discussion /Resolution** |
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| **Welcome and Approval of Minutes** | Marilyn Peitso, MD | * The workgroup lead, Dr. Marilyn Peitso opened the Barriers to Access workgroup meeting. Pending two requested amendments, the workgroup approved the minutes from the 11/06/15 meeting for posting to the Task Force website. |
| **Review Workgroup Feedback on Preliminary Recommendations:**   * Consumer Assistance * Benefits * Plan Design | Manatt | * Ms. Patti Boozang reviewed the goal of the meeting: to reach consensus on Barriers to Access workgroup preliminary recommendations on consumer assistance, benefits, and plan design and new recommendations on telehealth and data reporting. Feedback solicited from Barriers Workgroup members via an electronic survey was reflected in the meeting materials. * Ms. Boozang noted that the workgroup has reached near unanimous support of recommendations to enhance community based consumer assistance resources. Ms. Boozang provided an overview of each recommendation including: expand consumer assistance capacity, improve assister training and payment, target consumer assistance resources, and prioritize cultural/linguistic appropriateness. Ms. Boozang noted the only * recommendation reflecting dissent among workgroup members who responded to the electronic survey was the recommendation to prioritize cultural/linguistic appropriateness. The comment associated with this response cautioned against a recommendation that would differentiate and give preference to assistance entities based on these characteristics. Ms. Boozang also noted a comment from a workgroup member to broaden the term community based consumer assistance resources to include agents and brokers, particularly as it relates to building tools that support “warm handoffs” as a person’s status changes.   + One workgroup member stated his belief that the group of recommendations will improve health disparities and that it is appropriate to prioritize certain entities focusing on vulnerable populations.   + The workgroup discussed the tools that can be used to advance a “warm handoff” between types of consumer assistance resources to reduce complications with mixed households or individuals on the threshold of program eligibility. Specific suggestions included: allowing consumers to enter multiple assisters (including agents and brokers) on the MNsure application, sending “push notifications” to assisters when a consumer’s status changes, and encouraging free exchange of information between private and public assistance focused assisters. These ideas would be intended to reduce barriers to remaining in coverage throughout status changes. The concept is the same navigator should be able to help a parent who is enrolled in a MNsure QHP, a child on Medical Assistance, and the parent or child if the household income decreases or increases. MNsure generally agreed with the recommendations and noted the agency is actively working on training and networking to connect agents and brokers with assisters.   + A navigator organization provided public comment agreeing with the recommendations. The organization stated that the recommendation on prioritizing cultural and linguistic appropriateness should be modified to require new consumer assistance tools (such as out-of-pocket calculators) to be developed in multiple languages. The workgroup agreed with the modification to its recommendations.   + The workgroup discussed an additional recommendation to conduct more monitoring and evaluation of consumer assistance resources, including tying the prioritization of consumer assistance resources to population served and evaluation criteria, similar to grantees. * Ms. Boozang provided an overview of the benefit alignment recommendations, which include: add adult dental benefits to QHPs and add non-emergency medical transportation (NEMT) to MinnesotaCare. Of the six respondents to the electronic survey, four agreed with the recommendations and two disagreed. Comments in the electronic survey stated that NEMT should be a separate program (likely because this is an unusual benefit which is found only in Medicaid and not in the private market) and suggested NEMT be provided as a benefit for Exchange products as well. Ms. Boozang noted that the recommendations will be modeled by Milliman.   + The workgroup discussed whether adding NEMT to MinnesotaCare should be advanced as a recommendation. One workgroup member discussed the necessity of NEMT to achieving the “5 As” of access framework as rural Minnesotans may have coverage but may be unable to access care due to transportation issues. A workgroup member raised concern regarding the availability of transportation providers, which could become further strained if more individuals receive the NEMT benefit. The workgroup requested that modeling of this recommendation include, to the extent possible, assumptions related to potential cost savings related to avoiding utilization of higher cost, less appropriate settings and services (i.e. emergency room) due to providing NEMT benefits. The workgroup agreed to advance the recommendation to add NEMT to MinnesotaCare as a benefit and decided not to pursue providing NEMT in QHPs as the income level for QHP eligible individuals is higher and they may have better access to transportation as a result.   + The workgroup discussed whether adding adult dental to QHPs should be advanced as a recommendation. The workgroup discussed implementation of this recommendation through a 1332 waiver to allow consumers to receive APTC for the dental care benefit. Absent a 1332 waiver, consumers would need to pay for the benefit and APTC could not be applied to the new state mandated benefit. The workgroup had a lengthy discussion about the equity of potentially raising medical premiums for all consumers – who may not want to purchase dental insurance – through requiring adult dental as an EHB. The workgroup agreed to advance the recommendation while continuing to pursue paths for providing adult dental care subsidized by APTC and without requiring that all consumers purchase the benefit. * Ms. Boozang provided an overview of plan design recommendations including: standardize cost-sharing design, limit non-standard designs, and exempt services from deductible. For the standardize cost-sharing design recommendation, four respondents agreed with advancing the recommendation and none disagreed. For the limit non-standard design recommendation, two respondents agreed with advancing the recommendation and four disagreed. For the exempt services from deductible recommendation, four respondents agreed with advancing the recommendation and two disagreed.   + The workgroup agreed not to advance the recommendation for limiting non-standard designs. Instead, the workgroup recommended acknowledging in the report the public concern regarding the number of available plans and the recommendations that will enhance consumer assistance resources to assist in navigating plan choices. One workgroup member noted that the State may want to consider the cost of adding consumer assistance resources as compared to the cost of limiting plan designs. The workgroup agreed that the data is too limited on what the ideal number of plans is to balance choice with confusion to recommend a limit.   + The workgroup agreed with advancing the standardize cost-sharing design recommendation.   + The workgroup agreed to advance the exempt services from deductible recommendation with the following modification: “require carriers to offer standard products which exempt certain services from deductibles.” By not requiring issuers to exempt certain services from co-payments in all products, it allows the market to dictate whether consumers prefer to enroll in higher premium or higher cost-sharing plans with services exempt from the deductible or remain in current plan designs. |
| **Review Additional Option on Plan Design and Cost-sharing Reductions** | Manatt | * Ms. Boozang discussed a new option raised by a workgroup member to align QHPs purchased on and off the Marketplace by unbundling cost-sharing reductions (CSR) into a Health Reimbursement Account (HRA). A consumer would first be determined eligible for CSR through the Marketplace then the value would be placed into an HRA for use in paying for health care services in a plan purchased on or off the Marketplace at any metal level (different from today where silver plans on Marketplace plans are required to receive CSR). This proposal would require a 1332 waiver. * MNsure informed the workgroup that 15% of consumers in MNsure currently receive CSR as only those between 200 – 250% FPL are eligible for CSR. * The workgroup discussed the pros and cons including whether the recommendation will increase consumer confusion, what happens when a consumer experiences a mid-year change in circumstance, and whether allowing consumers access to funds will be beneficial or risky to the consumer. * The workgroup agreed that the recommendation should move to the Seamless Workgroup to review how cost-sharing reductions and APTC can best be administered in the state, including the potential for portability. The workgroup discussed the need for modeling the recommendation, including the assumptions of administrative cost and consumer risk. |
| **Review Workgroup Feedback on Potential Additional Preliminary Recommendations:**   * Telehealth Study * Data Collection and Reporting | Manatt | * Ms. Boozang reviewed two other new potential recommendations to address barriers to access that derived from the discussion at last week’s Barriers meeting: conduct a telehealth study and improve data collection to inform development of solutions. * Five respondents agreed with the telehealth recommendation while one respondent disagreed.   + The dissenting workgroup member raised concern with telehealth increasing health disparities citing that individuals experiencing inequities have a huge distrust in the health care system and that trust will not be developed using telehealth. Another workgroup member stated their belief that telehealth could improve disparities, particularly if the service is targeted to underserved populations and uses the appropriate communication vehicle (i.e. mobile applications).   + The workgroup discussed potential changes to the telehealth legislation passed in the last legislative session to address cultural and language barriers to access. One potential addition could be new language on payment to providers, particularly those with capacity limitations today (e.g. mental health and dental.) The workgroup agreed to advance the telehealth recommendation and to specify that the study would focus on the impact of telehealth legislation passed in the last session on payment for and access to telehealth services, including a review of whether and a review of telehealth capacity (including geographic disparity, workforce strategy, and cultural/ethnic disparities). The workgroup agreed that this study would be a longer term initiative, as the legislation only recently passed and is not yet fully implemented. * The workgroup agreed with advancing the data recommendation. |
| **Refine Preliminary Recommendation on Affordability Scale** | Manatt | * Ms. Anne Karl of Manatt provided an overview of the preliminary recommendation to establish a state-tailored health coverage affordability scale that would guide policy, program, and financing decisions on Minnesota’s coverage continuum. Ms. Karl reviewed the premium cliff at 200% FPL in Minnesota. She also discussed how SEGIP premiums, unlike MinnesotaCare and the ACA affordability scales, decrease from 3% to approximately 1% of an individual’s income. * Ms. Karl provided an overview of two options to improve premium affordability. The first option provides additional premium subsidies up to 300% FPL while the second option provides additional premium subsidies up to 275% FPL (the previous MinnesotaCare eligibility threshold). Ms. Karl reviewed the implications of the options. Option 1 covers more people with additional subsidies and costs the state more money. Option 2 is more generous than the current scale, but less than option 1 and thus is less expensive.   + The workgroup discussed potentially making MinnesotaCare less affordable for consumers in an effort to smooth the cliff. The recommendation is that doing so would smooth the cliff while not increasing the cost to the state. Several workgroup members expressed strong points of view that it is critical to maintain current affordability levels, at a minimum. Ms. Karl also informed the workgroup that the Seamless Coverage workgroup is discussing funding issues and is looking at ways to increase federal funding opportunities.   + One workgroup member raised how the curve as presented does not tell the whole story because if it were continued above to 400% FPL the curve would begin to decrease as the consumer would make more money and the maximum premium remains the same. Effectively, this means the middle class is being asked to spend the highest percentage of their income on health insurance premiums.   + One member of the workgroup stated that the cliff in Minnesota is a result of requiring individuals to purchase MinnesotaCare. The workgroup member stated that some individual may want to be between the BHP curve and the ACA affordability scale, especially if they believe their income is subject to change.   + Ms. Karl presented current cost-sharing requirements for SEGIP, the ACA, and MinnesotaCare Ms. Karl presented two options for the state to provide more generous plan AVs to individuals with incomes above 200% FPL.The workgroup agreed that both options should continue to be explored by the Seamless Coverage workgroup. The workgroup agrees that easing the premium and cost-sharing cliffs would address a barrier to access and both options are appropriate. A decision of which option to pursue will be made at the Seamless Coverage workgroup based on modeling of provider, consumer, and fiscal impact. |
| **Public Comment** |  | * No public comment was provided |