Health Care Financing Task Force

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

Barriers to Access Workgroup

Friday, October 16, 2015, 8:30 am – 11:00 am

Minnesota State Office Building-Room 200

Minutes

| **Item** | **Presenter** | **Discussion /Resolution** |
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| **Welcome** | Marilyn Peitso, MD | * The Barriers to Access Workgroup lead, Dr. Marilyn Peitso, opened the meeting. |
| **Preliminary Recommendations on Reducing Financial barriers** | Manatt | * *See Manatt presentation*   *Affordability Scale*   * Ms. Anne Karl of Manatt provided an overview of the premiums and maximum out-of-pocket expenses for consumers at various income ranges across the ACA, MinnesotaCare, and Medical Assistance. She noted the increase in premium as a percentage of income when a consumer reaches 201% FPL increases from 4% to 7%. Ms. Karl reviewed an option to increase premiums gradually between 201 – 300% FPL to smooth the cliff for that income range. Ms. Karl discussed two components of affordability: cost-sharing and monthly premiums which both need to considered when deciding if a consumer can purchase and use their coverage.   *High Deductible Health Plans*   * Ms. Karl provided an overview of the current plan offerings through MNsure. She noted that only one of the 33 available silver plans for 2015 had no deductible while the average deductible was $2,236. The silver plan with the highest number of enrollees has a deductible of $3,000. She noted that none of the recommendations would reduce total cost-sharing – since the actuarial value of the plan remains the same – but would rather spread that cost-sharing over time.   + A workgroup member noted that high deductible plans could be paired with a health savings account (HSA), which some consumers may prefer. The workgroup discussed whether consumers purchasing plans through public programs are able to afford the HSA option. The workgroup was reminded that this option will not remove high deductible options but add a new low deductible plan that is not currently available to consumers. * Ms. Karl reviewed two additional options for addressing high deductible QHP products: (1) require that carriers offer products with low or no deductible options, and (2) exempt services from deductibles to incentivize utilization of primary care and generic prescription drugs.   + The workgroup discussed how plans may offer a low deductible option while keeping the 70% actuarial value of a silver plan through spreading cost-sharing over the entire year instead of requiring an early deductible. It was noted that changing deductibles will always require changes to co-insurance, if premium is to remain constant. The workgroup was reminded that issuers cover certain services at zero deductible, as required by the ACA. The workgroup agreed that it would be helpful to review New York’s standard plan design at 70% AV, which requires $0 deductible. * Ms. Karl provided an overview of two other options for addressing high deductible QHP products including creating standard cost-sharing products across all types of cost-sharing (co-insurance, co-payments, and deductibles) and limiting the number of non-standard plans a carrier may offer to reduce consumer confusion.   + A workgroup member raised concern over the number of plans being offered and consumer and provider confusion in understanding the services each plan covers. There was discussion regarding the benefits and drawbacks of more plan offerings. It was agreed that for individual consumers without assistance, the volume of plan offerings can be confusing. However, the state spent significant time and money in developing an infrastructure of in-person assisters to help consumers choose the best plan for them, which requires choice. The impact of choosing the best plan on downstream access to care was discussed, with an emphasis on low-income and underserved individuals.   + The workgroup discussed benefit design, including an evaluation of the alternative benchmark plans to better understand cost-sharing in other programs. It was mentioned that standard benefit design could apply only to MNsure products or to the entire individual market, if the state has the regulatory authority for the market generally. Even if the state is unable to regulate off-Marketplace, any plans available through MNsure must be available off-Marketplace which would help to standardize all plans. |
| **Options and Considerations for Reducing Structural Barriers and Disparities, Part 1** | Manatt | * Ms. Alice Lam of Manatt provided an overview of last week’s discussion on aligning benefits across the coverage continuum. She discussed the ten essential health benefits (EHBs) which apply to both Medicaid expansion and individual and small group coverage. Ms. Lam noted the EHB requirement allows for a base of alignment but benefit differences do remain between coverage programs. Ms. Lam noted that Minnesota generally has more robust benefits in its coverage programs and that while chiropractor services may be included in individual and small group coverage but not in Medicaid in some states, Minnesota does in fact cover chiropractor services in Medical Assistance. She reminded the workgroup that choosing the same EHB benchmark plan across programs would allow for greater alignment.   + The workgroup’s discussion focused on the history and importance of the EHB benchmark plan. Specifically, a workgroup member provided an overview of the Institute of Medicine’s (IOM) role in determining the benchmark for coverage would be deferred to the states to choose a plan which encompasses the ten EHBs. The benchmark is used to further define EHB and the state may choose to go above and beyond the EHBs, if it so desires. Minnesota defaulted to a small employer group plan which defined 62 EHBs, far exceed the ten federal EHBs.   + The workgroup member provided an overview of the implications of changing the benchmark plan noting that the details of coverage would change for each plan in the State. It was mentioned that earlier this year the state was given the opportunity to change to a different EHB benchmark plan but ultimately defaulted to the same plan due to a question of which agency had the authority to make the change. If the state were to decide to change the benchmark for 2018, the state would need to determine the agency with the authority to do so.   + The workgroup discussed the state reasons for pursuing a change in the benchmark. One member mentioned that the motivations could be different depending on whether stakeholders wanted to expand or decrease covered benefits. Ultimately, changing the benchmark plan could bring greater alignment between the private market and public programs. * Ms. Lam discussed benefits which are specifically excluded from EHB including: adult vision, adult dental, long-term nursing home care, and non-medically necessary orthodontia. She noted that a state may choose to mandate these benefits as EHB but APTC may not be used towards those benefits. In addition, the state must directly pay for any new state mandated non-EHBs. She also discussed the differences in benefits provided through Medical Assistance, Minnesota Care, and MNsure QHPs. Most notably, dental and vision are offered in both Medical Assistance and MinnesotaCare and are not offered through QHPs. Medical Assistance offers the most comprehensive set of benefits including nursing facility care and non-emergency medical transportation (NEMT). * Ms. Lam reviewed four options for addressing differences in benefits: (1) use the same benchmark plan to define EHB categories across Medical Assistance, MinnesotaCare, and QHPs through MNsure; (2) add a new EHB category to cover a highly valued service; (3) require all or some unique Medicaid benefits as EHBs in MinnesotaCare including NEMT; (4) waiving certain Medicaid benefits to align more with the private market. Ms. Lam mentioned that select states who are providing Medicaid to beneficiaries through QHPs have received federal authority to waive NEMT for adult Medical coverage. |
| **Preliminary Recommendations for Reducing Structural Barriers, Part 1** | Manatt | * Discussion tabled to subsequent meeting due to time constraints. |
| **Barriers Relating to Immigrant Access to Care** | John Keller, Immigrant Law Center | * Mr. John Keller of the Immigrant Law Center introduced an advocate to discuss the importance of health insurance coverage for immigrants in Minnesota. The advocate’s written testimony was submitted to the workgroup. * Mr. Keller provided an overview of the Immigrant Law Center’s mission to serve as the intersection between health care and immigration policy. He provided testimony from an individual who is an immigrant with health conditions that have limited his ability to work. The individual’s written testimony was submitted to the workgroup. * Mr. Keller stated that the largest barrier to access for immigrants is being undocumented without a legal status or having a status that restricts them from eligibility for public programs. Mr. Keller reminded the workgroup that individuals who are undocumented and uninsured often forego primary care and instead seek expensive emergency care. Approximately 95,000 undocumented immigrants reside in Minnesota. Of this population, approximately 1/3 have a U.S.-born child, 65% have a GED, and approximately 1/3 have purchased their homes. Undocumented immigrants tend to live in the country for approximately 15 years. * Mr. Keller recommended Minnesota address the issues surrounding undocumented immigrants and health care.   + The workgroup requested more information on the uninsured rate of undocumented immigrants.   + The workgroup discussed the impact of paying for coverage of undocumented immigrants through the emergency room uncompensated care pool. One member mentioned that patients without insurance may stay in expensive emergent care and not be admitted to a more appropriate in-patient facility because the hospital will only be reimbursed for emergent care. The workgroup was reminded that limited coverage is available for undocumented immigrants including pregnant women and emergency medical assistance.   + A workgroup member raised that it is possible for undocumented individuals to get coverage through the individual market. However, often times individuals who are undocumented are also low-income and would be unable to afford unsubsidized coverage.   + The workgroup also discussed mixed status families, where some individuals have legal status and others do not. Often children may be able to obtain coverage but their parents will be uninsured impacting the care the entire family receives. |
| **Options and Considerations for Reducing Structural barriers and Disparities, Part 2** | Mark Schoenbaum, Minnesota DOH  Rosemond Sarpong Owens, Health Literacy/Cultural Competency Specialist for CentraCare Health | * Ms. Rosemand Sarpong of CentraCare Health provided an overview of the state’s geographic barriers to accessing coverage. Specifically, she mentioned that primary care and specialty services are often located in cities and not rural areas making it difficult for residents of rural areas to access coverage.   + The workgroup discussed the importance of NEMT as a benefit to reduce geographic barriers to accessing coverage. In addition, transportation of individuals between hospitals often contributes to high hospital cost as individuals are not able to obtain the appropriate level of care. The workgroup recommended further analysis on the upstream cost of patients not being transported to the appropriate facility. * Ms. Sarpong discussed the current disparity in Minnesota between the racial/ethnic composition of the health care workforce and the communities which they serve. * Ms. Sarpong discussed the disparity between consumers health literacy understanding, which is at the fifth grade reading level, and materials that are often drafted in the medical community at the college reading level. * Ms. Sarpong raised that the languages spoken in the state are often not reflected in the health care that is delivered in the state, specifically providing Sudanese as a prominent example.   + The workgroup requested more information on languages spoken in the state, or specific communities, and an understanding of whether those languages are reflected in the medical community. * Mr. Schoenbaum’s presentation was tabled for discussion due to time constraints. He will present at an upcoming meeting. |
| **Public Comment and Next Steps** |  | * None |