Health Care Financing Task Force

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

Barriers to Access Workgroup

Friday, October 23, 2015; 9:00 a.m. – 12:00 p.m.

Rochester, MN

Minutes

| **Item** | **Presenter** | **Discussion /Resolution**  |
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| **Introductions** | Marilyn Peitso, MD | * The workgroup lead, Dr. Marilyn Peitso opened the barriers to access workgroup meeting. Dr. Peitso approved the minutes for posting to the Task Force website from 10/16/15.
* Dr. Peitso discussed the “five As” of access as the framework for considering options for addressing barriers to access. The “five As” represent the dimension of access to care including: availability, accessibility, accommodation, affordability, and acceptability.
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| **Review Joint Preliminary Recommendations on Financial Barriers to be Presented to Task Force** | Marilyn Peitso, MDManatt | * Patti Boozang of Manatt provided an overview of the preliminary recommendations developed by the barriers to access and seamless coverage workgroups to be delivered to the Task Force.
	+ *Reduce Financial Cliffs at 200% FPL:* Recommendation is to explore options for reducing the cliff in premiums, cost sharing and deductibles for individuals at 200% FPL. Three options are being considered further by the seamless workgroup: (1) establish voluntary HSA-like accounts for Medical Assistance and MinnesotaCare, (2) expand eligibility for enhanced subsidies to consumers with incomes between 200 – 275% FPL, (3) redistribute federal subsidies (APTC and CSR) to improve affordability for consumers with incomes 200 – 300% FPL.
	+ *Rationalize Affordability Definition:* Recommendation is to change the definition of affordability for families with employer sponsored insurance to be based on a family rather than an individual basis.
	+ *Align Insurance Affordability Programs:* Recommendation is to align insurance affordability programs including eligibility and enrollment rules, benefits, and plan requirements. Options to be considered include: (1) consolidate MinnesotaCare with the private marketplace, (2) consolidate Medical Assistance and MinnesotaCare, and (3) maintain the status quo on MinnesotaCare. Ms. Boozang raised two additional options which are outside of the scope of the current Task Force: (1) transition to a single payer model, (2) consolidate all programs in the private marketplace.
* The workgroup discussed the process of moving forward preliminary recommendations. Specifically, a member of the workgroup recommended the Task Force’s next step be to conduct modeling to drive recommendations. The workgroup agreed with this recommendation.
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| **Discuss Preliminary Recommendations on:*** Minnesota Affordability Scale
* High Deductible QHP Products
* Alignment of Benefits Across the Coverage Continuum
 | Manatt | * Alice Lam of Manatt stated the goal of the session is to reach consensus on preliminary recommendations for improving affordability, addressing high deductible plans, and aligning benefits to create a seamless coverage continuum and reduce barriers to care.
* Ms. Lam reviewed the affordability scale for programs across the coverage continuum in Minnesota. She noted the cliff as consumers move from 200% to 201% FPL. Ms. Lam discussed the options available for helping smooth the cliff to ensure a gradual transition as a consumer’s income increases.
* The workgroup agreed that smoothing the cliff should be a priority and discussed what affordability scale would be most appropriate for Minnesota. A few potential solutions were offered: (1) compare the current EHB benchmark to the Minnesota employee plan, (2) compare the current EHB benchmark to states which have transitioned their EHB benchmark to their state employee plan (including New Mexico, Arizona, and Colorado), and (3) analyze other state plans as a model which have high actuarial level silver plans (instead of MinnesotaCare).
* The workgroup discussed the cliff being a function of plan design, premium, and covered benefits. A workgroup member recommended comparing benefits in addition to premium for the three options presented above. The workgroup was specifically interested to see the difference between SEGIP and the small group EHB plan. The workgroup’s assumption is the difference primarily lies in cost-sharing and plan design and not in benefits, potentially as a result of EHB requirements. The workgroup discussed whether it was equitable for any difference in benefits to exist between programs. The workgroup was also reminded that changing cost-sharing will have an impact on budgeting, which is particularly important if considering a 1332 waiver.
* The workgroup was reminded that the state does not have clearly defined authority for selecting the EHB benchmark. As a result, any initial recommendation for changing the EHB benchmark will need to include first defining the authority through the state’s legislature.
* One workgroup member recommended using cost-sharing to gradually improve affordability from 0 – 400% FPL, including increasing cost-sharing for those below 200% FPL. The workgroup discussed this recommendation and raised that doing so may smooth the line of the curve but will have a substantial impact on individuals. The workgroup was reminded that the affordability chart only shows premium and does not include benefits or other cost-sharing. The workgroup agreed that further discussion is needed including more information on the total cost of care (premiums and cost-sharing) across all programs and SEGIP.
* One workgroup member recommended providing CSR upfront in an HSA-like account instead of providing CSR to issuers on the back end.
* Ms. Lam provided an overview of options to address high deductible QHP Products in the Marketplace including: (1) require that carriers offer products with standard cost sharing designs featuring low or no deductible options, (2) exempt certain high-value services from deductibles, (3) create standard cost-sharing products that address all types of cost-sharing, and (4) limit the number of non-standard plans a carrier may offer. Ms. Lam reminded the workgroup of a few basic assumptions. First, that addressing high deductible plans does not change the actuarial value but instead distributes cost-sharing through the year rather than requiring an upfront deductible. Second, that all products sold on the Marketplace are also offered outside the Marketplace which will create more low or no deductible options off Marketplace as well.
	+ One workgroup member commented that the recommendation should be more specific and state “explore options to create more low and non-deductible options in the Marketplace.” The rationale for this comment is in 2016 Minnesota is offering several low or non-deductible options. In addition, individuals currently enrolled in high deductible plans may have intentionally enrolled in the plan as the best fit for them or their family.
	+ The workgroup agreed with the recommendation as high deductible plans do often present a barrier to accessing care for individuals. The workgroup recommended that the option not limit other available products but rather add a new option for consumers. One workgroup member also recommended incorporating value-based design to help plans establish low or no-deductible plans without changing premium or cost-sharing.
* Alignment of benefits was tabled to a subsequent discussion.
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| **Begin to Discuss Options and Considerations for:*** Improving language access in eligibility and enrollment process
* Enhancing cultural and linguistic competency in consumer assistance
* Improving health literacy to support access to care
 | Manatt | * Ms. Lam opened the session which will include an overview of Minnesota’s racial and ethnic composition, identification of language access practices to improve eligibility and enrollment processes, a review of Minnesota’s consumer assistance network to enroll the remaining uninsured, and identification of health literacy best practices to improve access to care.
* Ms. Lam provided an overview of the racial and ethnic composition of Minnesota. She noted that Minnesota’s foreign born population is increasing faster than the national average, and over a quarter of foreign born residents are without health insurance. Ms. Lam stated that approximately 20% of the remaining uninsured in Minnesota are undocumented immigrants. She also reviewed the top five languages spoken in Minnesota other than English.
* Ms. Lam reviewed the ACA requirements for eligibility and enrollment in public programs and customer service requirements. She stated that the ACA requires all applications, notices, and renewal forms to be in plain language and accessible to Limited English Proficient (LEP) individuals. The requirements on the Marketplace are more stringent requirements including all website material must be translated into languages that reach 10% or more of the LEP population and taglines must be provided in the top 15 languages spoken in the state indicating the availability of language services. She noted that DHS and MNsure must provide a call center which includes interpreter services in 150 languages.
* Ms. Lam discussed Minnesota’s progress in ACA language access practices. In Minnesota, the single streamlined application is available in six languages and both the Medical Assistance and MNsure call center provides a language line that can translate into 150 languages. The online application is only available in English. DHS and MNsure notices are sent in English with taglines indicating availability of language services in 10 languages. Ms. Lam noted that DHS reviews consumer communications for plain language and LEP access.
* The workgroup discussed eligibility and enrollment language access practices including the following topics: improvements that can be made to the application and renewal process, strategies that can be implemented to further enhance cultural and linguistic competency, and improvements that can be made to help undocumented immigrants understand their coverage options (which are limited to emergency Medical Assistance).
* Ms. Lam provided an overview of the ACA requirements for consumer assistance including: the state must provide in person Medicaid/CHIP application assistance in a manner that is accessible to individuals who are LEP, navigators must provide information in a culturally and linguistically appropriate manner, navigator grantees must develop training programs on underserved and vulnerable populations, and agents/brokers must make all materials language accessible for LEPs.
	+ The workgroup discussed potential improvements for the navigator program to address cultural and linguistic barriers. It was agreed that building capacity for individuals who may have the skill set to address culturally diverse populations (e.g., tax preparers) but have not been trained as health insurance assisters will be important for reaching the remaining uninsured.
* Representatives from MNsure discussed the current state of the navigator program and improvements that have been made in the second and third years of the program to extend coverage throughout the state. Specifically, MNsure has worked with the Blue Cross Blue Shield Foundation, navigator entities, and other community stakeholders to capacity build. MNsure has also held networking events with agents and brokers and navigators to help facilitate the “one-door” concept. In addition, navigator grants are specifically given to community centers that facilitate enrollment for targeted underserved populations. MNsure discussed their priorities for addressing language barriers is to: (1) develop an online version of the application in top spoken languages, and (2) train other entities in providing enrollment assistance as a wraparound service.
	+ MNsure has a broker stakeholder group, navigator group, and an in-person assistance group which meet regularly to provide MNsure with feedback on training, advertisements, and understanding of how better to reach underserved populations.
	+ One workgroup member suggested developing a mechanism to alert in-person assisters when a consumer reports a change to the Marketplace. While MNsure is not working on that system, they are developing an internal referral system where consumers can be formally directed if they contact MNsure and would be better served by an in-person assister.
	+ The workgroup recommended increasing compensation for navigators and other in-person assisters who target the hard to reach remaining uninsured. It was suggested that Medicaid and other federal funding sources be explored as options, although any non-state dollars are likely limited. The workgroup agreed that the decision to allocate state dollars to new programs will need to be carefully considered with ensuring the sustainability of existing programs.
	+ The workgroup discussed the reasoning behind why agents and brokers have stopped selling coverage through MNsure. One workgroup member suggested that the agents were not able to sell policies, possibly because subsidies were so low and premiums were too high. The representatives from MNsure suggested that the agents and brokers may have decided to stop selling policies because the total QHP eligible population is low in the state.
	+ MNsure discussed their efforts for addressing the transportation barrier for accessing enrollment events. One of MNSure’s navigator grantees has a mobile health clinic which conducts medical screening and health insurance enrollment simultaneously to reach those unable to drive. In addition, MNsure has developed an advertising campaign in public transit locations with maps to the nearest walkable in-person assistance site.
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| **Public Comment** | Marilyn Peitso, MD | * No public comment was provided
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| **Wrap Up and Next Steps** | Marilyn Peitso, MDManatt | * Dr. Peitso reminded the workgroup that there is no meeting on October 30th and the next meeting will be on November 6th.
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