MINNESOTA
HEALTH CARE
FINANCING
TASK FORCE

Health Care Financing Task Force Vision: Sustainable, quality health care for all Minnesotans

Barriers to Access Workgroup

Recommendations Package

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Health Care Financing Task Force
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Minnesota Department of Human Services

Recommendation 1:

Require standard Qualified Health Plan offerings in the Marketplace to improve consumer choice and experience and ensure availability of no- or low-deductible options. Look to federal standardized designs as a potential model.

- Create standard cost-sharing designs – including low and no deductible plan options – and require carriers to offer standard products in addition to other products they choose to offer.
- Require carriers to offer standard plan designs that exempt certain services from deductibles to incentivize utilization of primary care and other high value preventive services.

JUSTIFICATION: Throughout the Task Force convening's, several stakeholders testified that the absence of low and no deductible product choices is problematic for Minnesota's lower-income consumers: in plan year 2016, there is one silver qualified health plan offered through the Marketplace that has a deductible below $600 and the average deductible for all silver-level plans offered in 2016 is $2,236. S Some consumers enrolled in high-deductible plans forego necessary care to avoid significant out-of-pocket costs. To ensure that consumers have sufficient choice of low and no deductible plans, the Barriers Workgroup recommends that each carrier on MNsure be required to offer two Silver-level products that meet standard cost-sharing design requirements. The first standard product would feature low or no deductible. This product may feature higher co-payments than high-deductible plans with the same actuarial value. As a result, consumers' out-of-pocket costs would be spread across the year, rather than concentrated in the beginning of the year, with negligible, if any, impact on premium. The second standard product would require that certain high-value services, such as primary care visits to treat injury or illness other than the annual check-up, are exempt from the deductible, enabling consumers to receive these services with only a co-payment or co-insurance. Co-payments in these products may be higher than products with deductibles applying to a broader array of services, but there would likely be no meaningful difference in premiums.

Both standard products would increase consumer choice among many insurance carriers, allowing enrollees to select a product most appropriate for both their financial and health situation. The availability of low and no deductible products that allow consumers to spread cost-sharing throughout the year may also reduce disparities in access to care among low-income, minority Minnesotans.

One Barriers Workgroup member highlighted that Minnesota's guaranteed renewability requirements require insurers to maintain all products and expressed concern that standard plan designs would introduce even more products that must remain on the market and create administrative burden for insurers. Despite this concern, the majority of Workgroup members agreed to advance this recommendation.

COST/SAVINGS: Costs/savings were not estimated for this recommendation, but Commerce staff estimate that this proposal would have little impact to State costs or to premiums in the Marketplace.

STATE/FEDERAL AUTHORITY: To implement this recommendation, the State would develop standard cost-sharing designs which would likely require legislation. The Barriers Workgroup discussed potential options for a lead entity that would develop the standard cost-sharing designs – MNsure, Department of Commerce, or a separate Task Force or advisory body – but ultimately did not specify a lead entity. Notably, the U.S. Department of Health and Human Services' (HHS) draft Notice of Benefit and Payment Parameters for 2017 – annual rulemaking in which HHS sets policies for ACA's marketplaces and QHPs – proposes to create standardized bronze, silver and gold cost-sharing designs, as well as standardized designs for silver plan variants available to individuals eligible for CSRs and gives the option for QHP issuers in the federally facilitated Marketplace (FFM, or healthcare.gov) to offer these designs. In its deliberations, the Barriers Workgroup reviewed HHS's proposed designs and agreed to look to federal standardized designs as a potential model for the development of Minnesota's standardized designs.

OTHER OPTIONS CONSIDERED: The Barriers Workgroup considered reducing the total number of non-standard QHPs that a carrier may offer in an effort to reduce the consumer confusion regarding the number of available plan choices. Several Workgroup members were concerned, however, that reducing the number of QHPs offered would reduce consumer choice and carrier flexibility and this recommendation was ultimately not advanced for final consideration by the Workgroup.

Recommendation 2:

Create benefit alignment across the coverage continuum and provide access to high value benefits:

Transportation

- Provide non-emergency medical transportation (NEMT) as a covered benefit in MinnesotaCare.
- Build volunteer transportation provider capacity through a grant program.
- Assess the impact of NEMT legislation on improving access to care and provider capacity.

Dental

- Require that QHP issuers make available dental benefits on par with coverage in Medical Assistance and MinnesotaCare.
- Seek 1332 waiver to allow QHP enrollees to apply Advance Premium Tax Credits/ Cost Sharing Reductions to available dental coverage.
- Raise Medical Assistance dental reimbursement rates.

JUSTIFICATION: While the benefits in Medical Assistance, MinnesotaCare, and QHPs through MNsure significantly overlap, there are some key differences in covered benefits across the continuum – mostly due to underlying federal requirements. The Barriers Workgroup engaged in robust discussion on whether the State should provide identical benefits across its coverage continuum – allowing for continuity in access to benefits when Minnesotans transition across programs as well as ease of consumer understanding their benefits–or to provide broader access to certain critical benefits (i.e., NEMT, dental coverage for adults). Public testimony reinforced the value of covering key benefits such as transportation and dental services, as essential to access; and the Workgroup ultimately concluded that it was a higher priority to ensure access to these benefits rather than aligning benefits overall.

Transportation: The Workgroup heard presentations and testimony regarding access issues in rural areas of the State, where consumers face significant challenges related to provider shortages and travel to available providers. Low-income individuals are likely to experience these challenges most acutely, resulting in barriers to obtaining medical care and adhering to treatment protocols. To mitigate these challenges, the Barriers Workgroup recommends adding NEMT to the MinnesotaCare benefit package. The Barriers Workgroup discussed two options for covering NEMT in MinnesotaCare: (1) coverage of trips through all types of NEMT providers or (2) coverage of trips through personal/volunteer NEMT providers only. The Workgroup will need to agree on its preferred approach in developing its final recommendations to the Task Force. Because the Workgroup believes that expanding coverage of and reimbursement for NEMT will likely only partially address underlying NEMT provider capacity issues, the Workgroup also recommends exploring a grant program to support the development of volunteer NEMT capacity. Finally, the Workgroup recommends evaluating the impact of legislation enacted last session to increase NEMT reimbursement rates in Medical Assistance.[1]

Dental: Today, QHP issuers have the option of including coverage of dental benefits as part of their plan designs or offering stand-alone dental plans. In either instance, individuals who qualify for APTC/CSR are not permitted to

[1] DHS PLEASE ADD CITE

apply their subsidies to dental coverage and thus are responsible for the full cost of the premiums for dental insurance coverage. [x] QHPs on MNsure offer standalone adult dental coverage and 9,578 policies were purchased in 2015. The Barriers Workgroup discussed at length the policy and premium implications of adding adult dental coverage to Minnesota's essential health benefit. Several members expressed concerns about requiring all individual and small group market buyers to pay for dental benefits. Therefore, the Barriers Workgroup recommends that the State require QHP issuers to make available dental benefits to Minnesota consumers, either embedded in QHPs or as a stand-alone plan, but not amend the EHB to include dental services. The Workgroup also recommends that the State pursue federal authority through a 1332 waiver to permit low-income consumers who are eligible for APTC/CSRs to apply their subsidies to dental coverage. Absent such federal permission, the Workgroups recommends that the State subsidize the cost of dental benefits for low-incomes consumers using State-only dollars. Finally, to address dental provider shortages, the Barriers Workgroup recommends that the State raise Medical Assistance rates for dental services. [DHS: Data on MA reimbursement for dental service that can be cited here? E.g. Comparison to Medicare?]

COSTS/SAVINGS: Milliman modeled the annual cost of adding NEMT to MinnesotaCare at $6.6 million, the estimate assumes the vast majority of trips would occur through volunteer providers or personal mileage and applied the same reimbursement rates as Medical Assistance.

DHS modeled the addition of adult dental benefits to QHPs at an estimated $22.55 PMPM for QHPs sold both on and off-Marketplace. For products purchased on Marketplace, the estimate is based on a dental benefit cost of $16.24 ($22.55 PMPM less the enrollee's cost sharing of $6.31 PMPM), which if picked up by the state would be a cost of $11.3 million. This cost may be offset if the State is successful to obtaining 1332 waiver authority for consumer to apply APTC/CSR to the cost of dental benefits. Additionally, to the extent that the State implements the recommendation to expand MinnesotaCare to cover individuals with incomes up to 275% of the FPL who are currently covered through the Marketplace, these individuals will automatically gain access to dental benefits, dramatically reducing the federal and state costs of subsidizing dental benefits for low-income Minnesotans.

DHS did not estimate the cost of increasing Medical Assistance rates for dental services since this recommendation was advanced after they completed modeling.

STATE/FEDERAL AUTHORITY: Adding NEMT to MinnesotaCare would require state legislation and, if the State continues to administer MinnesotaCare as a BHP, an amendment to the State's BHP Blueprint. The State would also require statutory and appropriations authority to implement a grant program for volunteer transportation provider capacity. The State would also evaluate the effectiveness of enacted legislation to increase NEMT provider rate on provider capacity. Such evaluation should be targeted to July 2017 or after to allow sufficient experience with the new legislation to support robust evaluation.

Adding adult dental benefits to QHP coverage through MNsure would require two levels of State action. Through QHP procurement requirements, the State would require QHPs make available dental coverage either embedded in QHP benefits or as standalone products. To permit consumers to apply APTCs to the adult dental benefit, the State could seek a 1332 waiver. In terms of the 1332 "guardrails," which the State would have to meet in advancing this proposal, allowing subsidies to be applied to the adult dental benefit would have a positive impact on affordability and comprehensiveness of coverage. The proposal would have no impact on the scope of coverage but could potentially have an impact on the federal deficit if the added benefit has the effect of increasing premiums overall and increasing available APTC/CSR. The State would then be required to identify savings to offset increased federal costs. As noted above, the State's decision with regard to expanding MinnesotaCare to individuals with incomes up to 275% of the FPL would impact its approach to subsidizing dental services for low-income individuals in the Marketplace. Finally, raising Medical Assistance reimbursement rates for dental would require state legislation as well as an amendment to the state plan.

OTHER OPTIONS CONSIDERED: The Workgroup considered a range of options related to aligning benefits across the coverage continuum including eliminating certain Medical Assistance benefits to align with MinnesotaCare and

QHPs through MNsure (i.e., eliminating non-emergency medical transportation for the new adult group). This idea was ultimately rejected as not meeting the charge of the Barriers Workgroup to make recommendations that would improve access to coverage and care.

Recommendation 3:

Improve and enhance community based consumer assistance resources, including Navigators, consumer assisters and agents/brokers:

- Develop expanded community based, consumer assistance capacity to support consumers in accessing health coverage, understanding how to use their health coverage, and addressing social determinants of health (e.g., food and nutrition, housing);
- Provide adequate and timely payment to, and appropriate training for, community based consumer assisters;
- Utilize currently available race/ethnicity/data to identify type and level of consumer needs and target deployment of consumer assistance resources; and
- Ensure that the State's selection of Navigators prioritizes entities able to provide linguistically and culturally appropriate assistance and that new state-developed consumer assistance tools are culturally and linguistically appropriate.

JUSTIFICATION: Consumer assistance programs provide critical outreach, education, and support to Minnesotan's on the importance of health coverage, their options post-ACA, and enrollment and renewal into coverage. Minnesota's population is becoming more diverse each year – the State's foreign born population is increasing faster than the national average and Minnesotans now hail from countries including Mexico, India, Somalia, Laos, Vietnam, Thailand (including Hmong), China, Korea, Ethiopia, and Canada. The Barriers Workgroup concluded that to serve all Minnesotans, the State must make linguistic and cultural competency and health literacy throughout the coverage continuum a high priority. Testimony from providers and other stakeholders specifically highlighted: the vital role of community-based consumer assistance resources in reaching racial and ethnic minorities, who are also typically underserved populations; the need to build capacity among consumer assisters that have relationships with and successfully support culturally diverse communities; and opportunities to address current barriers to adequate capacity, such as inadequate training and delays in payments for assisters. Overall, the Barriers Workgroup agreed that Minnesota needs additional investment and development of community-based consumer assistance capacity, with a focus on linguistic and cultural competency and integration of services impacting social determinants on health.

COSTS/SAVINGS: Cost estimates were not evaluated for this recommendation, although additional costs to the State and Marketplace are anticipated with respect to expanding the scope of services provided by consumer assisters and enhancing assister training programs.

STATE/FEDERAL AUTHORITY: Minnesota would be able to implement these recommendations either through changes and enhancements to some or all of its current assister programs. The Portico Healthnet model, which features robust training for its care coordinators in health literacy and navigation of the health care system was raised as one potential best practice model. This report also provides specific recommendations for Minnesota to improve race/ethnicity/data collection (see Recommendation 5) which can be utilized for targeting the deployment of consumer assistance resources.

OTHER OPTIONS CONSIDERED: None.

Recommendation 4:

Evaluate the impact of 2015 telemedicine (health) legislation on payment for and access to broad based telehealth/telemedicine (including mobile applications) services and effectiveness in addressing geographic barriers and health disparities.

JUSTIFICATION: Using telemedicine/telehealth (including smart phone mobile applications) to furnish care – through two-way, interactive video, or store-and-forward technology – is one way to address access barriers related to provider shortages and long travel times in rural areas of the State. During the last Legislative session, Minnesota enacted legislation that prohibits carriers from excluding coverage of services provided by certain provider types solely because the service is delivered via telemedicine rather than in-person and requires that carriers reimburse for services delivered via telemedicine on the same basis and at the same rate as services delivered in-person.[2] The Barriers Workgroup recommends evaluating the impact of the legislation, which became effective on January 1, 2016, and whether telehealth capacity is addressing workforce shortages and disparities in geography, culture and ethnicity effectively. The Workgroup also acknowledges that while telemedicine is a tool to increase access, more thinking needs to be done to leverage telemedicine in reaching and building trust with individuals from varying cultural backgrounds including how to most effectively use other forms of electronic communication, including smart phone mobile applications.

COSTS/SAVINGS: Cost estimates were not evaluated with respect to this recommendation.

STATE/FEDERAL AUTHORITY: Sufficient experience with the new legislation – which became effective January 1, 2016 – would be needed before a robust evaluation can be conducted. Therefore, the evaluation would be targeted for 2017 or after.

OTHER OPTIONS CONSIDERED: Initially, the Workgroup considered conducting a broader study on telemedicine capacity in the State. However, the Workgroup refined their recommendation after learning about the recent legislation from MDH staff.

Recommendation 5:

Improve demographic data collection and reporting to inform development of solutions to address disparities in health access and care:

- Ensure that all Minnesota health data collection and reporting systems comply with State Quality Reporting and Measurement System's (SQRMS) standardized best practices for collection and reporting of race, ethnicity, language and country of origin data.
- Charge MDH with development of a standardized set of additional socio-economic measures affecting health and health disparities.
- Develop mechanism for continuous improvement of health data collection and reporting in partnership with racial and ethnic communities disproportionately affected by disparities.

JUSTIFICATION: Detailed race, ethnicity, and language (REL) data by population group are critical to identifying disparities in access to health coverage and care, targeting interventions, and evaluating progress in reducing disparities.[3] Race, ethnicity, preferred language, and country of origin data are requested in the application for Medical Assistance, MinnesotaCare, and MNsure. In 2014, the Legislature directed MDH to develop a plan for collecting, analyzing and reporting measures based on disability, race, ethnicity, language, and other socio-

[2] Minnesota Statutes 2014, Section 62A.672. **DHS please validate.**
[3] Advancing Health Equity in Minnesota. Report to the Legislature February 2014. Accessible at: health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf

demographic factors through the SQRMS. [4] [MDH to validate and expand as necessary.] While Minnesota has made some advances in the collection and analysis of REL data, the Barriers Workgroup affirmed that more work remains to use data to drive improvements to health disparities in the State. The Workgroup recommends the adoption by all Minnesota health data collection and reporting systems of the standardized approach and best practices being developed for SQRMS. Across its discussions, the Barriers Workgroup frequently acknowledged the critical importance of social determinants of health and the relationship between socio-economic factors and health status and health disparities. Therefore, the Barriers Workgroup also recommends that data collection be expanded to include socio-economic measures, and recommends that MDH be charged with developing a standardized socio-economic data set. Finally, the Barriers Workgroup recommends the continuing evaluation and improvement of data collection and reporting, informed by the engagement and perspectives of the racial and ethnic communities affected by disparities.

COSTS/SAVINGS: Costs/savings were not estimated for these recommendations, however, MDH noted that expanding SQRMS to all Minnesota health data collection and reporting systems would generate new State costs.

STATE/FEDERAL AUTHORITY: MDH please provide input here.

OTHER OPTIONS CONSIDERED: None.

Recommendation 6:

Provide access to coverage for uninsured, low-income individuals ineligible for Medical Assistance, MinnesotaCare and QHPs through MNsure due to immigration status by using State funding to provide MinnesotaCare benefits to [children or children and adults] with incomes up to [138 or 200% of the FPL].

Provide coverage for services included in the elderly waiver package and nursing facility benefits to individuals who are eligible for these benefits, but for their immigration status.

In all instances, maintain confidentiality of applicants to ensure information collected is only used for health coverage and maximize available federal funding (i.e., federal funding for EMA and coverage of lawfully present MinnesotaCare individuals 0 – 138% FPL).

JUSTIFICATION: Between 80,000 and 100,000 unauthorized immigrants are estimated to reside in Minnesota today.[5] Unauthorized immigrants represent 22% of the total immigrant population and 2.5% of the Minnesota workforce; over three-fourths of unauthorized immigrants have resided in Minnesota for at least five years and nearly half have resided in Minnesota for more than ten years.[6] Roughly one-third of unauthorized immigrants have a U.S.-

[4] Minnesota Laws 2014, Chapter 312, Article 23, Section 10.

[5] Warren, R. and Warren, J. R. (2013), Unauthorized Immigration to the United States: Annual Estimates and Components of Change, by State, 1990 to 2010. International Migration Review, 47: 296–329. doi: 10.1111/imre.12022. Migration Policy Institute (MPI) analysis of U.S. Census Bureau data from the 2013 American Community Survey (ACS), 2009-2013 ACS pooled, and the 2008 Survey of Income and Program Participation (SIPP) by James Bachmeier of Temple University and Jennifer Van Hook of The Pennsylvania State University, Population Research Institute
Passel, Jeffrey S. and D'Vera Cohn, "Unauthorized Immigrant Totals Rise in 7 States, Fall in 14: Decline in Those From Mexico Fuels Most State Decreases." Washington, D.C. Pew Research Center's Hispanic Trends Project, November.

[6] John Keller, Immigrant Law Center of Minnesota, presentation to the Barriers to Access work group October 16, 2015. Migration Policy Institute, Profile of the Unauthorized Population: Minnesota. Pew Research Center, Unauthorized Immigrants in the U.S., 2012.

born child and 65% have a GED.[7] The Task Force and Barriers Workgroup received considerable testimony directly from consumers as well as from advocacy groups about barriers for unauthorized immigrants in accessing affordable health care. The issue has also been the subject of past legislative action, including most recently a 2012 legislative directive for DHS to develop a plan to provide coordinated and cost-effective care to people eligible for the Emergency Medical Assistance (EMA) program and who are ineligible for other state programs.[8]

The Barriers Workgroup affirmed that providing access to affordable coverage for uninsured, low-income individuals ineligible for Medical Assistance, MinnesotaCare and QHPs through MNsure due to immigration status is a key priority and particularly critical to one of the key goals of the Task Force to address and reduce health disparities. From an equity perspective, the Barriers Workgroup agreed that the eligibility and benefits should not be more expansive for individuals not currently eligible due to immigration status than coverage options currently available for U.S. citizens or lawfully present individuals. The Barriers Workgroup put forward four options for covering individuals without access to health coverage due to their immigration status.

- Providing MinnesotaCare benefits to individuals with incomes up to 200% FPL.
- Providing MinnesotaCare benefits to individuals with incomes up to 138% FPL.
- Providing MinnesotaCare benefits to children ages 0-21 with incomes up to 138% FPL and DACA individuals up to 138% FPL.
- Provide MinnesotaCare benefits to children ages 0-21 with incomes up to 138% FPL.

In addition, the Workgroup recommends providing coverage for services included in the elderly waiver package and nursing facility benefits to individuals who are eligible for these benefits, but for their immigration status.

To mitigate a particular barrier to accessing care by individuals not currently eligible for health coverage based on their immigration status – fear of deportation – the Workgroup recommends an explicit requirement that applicants' confidentiality be maintained and that any information collected is only used for health coverage

COSTS/SAVINGS: DHS modeled the provision of MinnesotaCare benefits, the elderly waiver package of services and nursing facility care services up to 138% FPL and estimated state annual costs of $70.3 million for coverage of all individuals regardless of age and between $10 and 12 million for coverage restricted to children. The estimates assume the State would continue to maximize available federal funding (i.e., federal funding for EMA and coverage of lawfully present MinnesotaCare individuals 0 – 138% FPL) and beneficiaries would face cost-sharing at current MinnesotaCare levels. At this time, DHS was unable to model costs for individuals not currently eligible for health coverage based on their immigration status between 138% and 200% FPL since it is still working to collect necessary data for this population.

STATE/FEDERAL AUTHORITY: Expanding coverage to individuals not currently eligible for health coverage based on their immigration status would require state legislation.

OTHER OPTIONS CONSIDERED: As a starting point for the discussion, the Barriers Workgroup considered options that were derived from the report responding to the 2012 legislative mandate on EMA and emerging models from New York City, San Francisco, and California.[9] The Workgroup considered: (1) creating a Medical Assistance

[7] John Keller, Immigrant Law Center of Minnesota, presentation to the Barriers to Access work group October 16, 2015. Migration Policy Institute, Profile of the Unauthorized Population: Minnesota. Pew Research Center, Unauthorized Immigrants in the U.S., 2012.

[8] Only those unauthorized immigrants with incomes under 138% FPL qualify for EMA coverage, which is limited to treatment of an "emergency medical condition (acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of a bodily organ or part)." Unauthorized immigrants do not otherwise qualify for Medical Assistance, MinnesotaCare, or QHPs through MNsure due to their immigration status.

[9] archive.leg.state.mn.us/docs/2013/mandated/130683.pdf

wraparound coverage program for EMA beneficiaries; (2) expanding the Portico Healthnet Program model to broader areas; (3) creating a pool to support unreimbursed services provided to unauthorized immigrants; (4) creating a grant program to allocate funds to providers who deliver services to significant numbers of unauthorized immigrants; and (5) providing access to care through a defined network of providers similar to the New York City Direct Access or Healthy SF programs. After robust discussion, Workgroup reached consensus that, unlike cities with concentrated urban areas of individuals not currently eligible for health coverage based on their immigration status, Minnesota has a unique statewide distribution of the unauthorized and thus decided to advance a recommendation that would provide more comprehensive coverage and not be limited to certain geographies or delivery systems.