Health Industry Advisory Committee Meeting Minutes

March 25, 2021, 2 – 4 p.m.

Virtual meeting via Cisco Webex

Members in attendance: Matthew Schafer – Chair, Hodan Guled – Vice Chair, Matthew Aiken, Jenifer Ivanca, Maria Lima-Leite, La Sheenlaruba Tyacke, Joel Ulland, Brian Vamstad, Richard Wallace

Members not in attendance: Danielle Paciulli

Staff in attendance: Christina Wessel, Joel Ingersoll, Eva Groebner

Meeting Topics

Welcome and Attendance

Matt Schafer, HIAC Chair

Matt Schafer, chair, called the meeting to order at 2:02 p.m. Christina Wessel, MNsure staff, took attendance.

Review and Approval of Prior Meeting Minutes

Motion: Matt Schafer moved to approve the draft February 25 meeting minutes. Joel Ulland seconded. All were in favor and the minutes were approved.

Public Comment and Operational Feedback

No public comments.

No operational feedback.

MNsure Update

Christina Wessel, Senior Director of Partner and Board Relations

Christina shared several updates from the March 10 MNsure board meeting. The board approved MNsure's preliminary budget for the next two fiscal years. The agency will continue with a conservative budget, but Christina noted there are a couple of uncertainties that could impact the budget at the state and federal levels. First, the Minnesota legislature is debating an extension to reinsurance or offering MinnesotaCare buy-in options. Secondly, health care provisions from the federal American Rescue Plan will have impacts on MNsure's IT costs and

premium withhold income. Neither level of legislation should prevent MNsure from remaining a self-sustaining entity; MNsure will continue to receive reimbursements from the Department of Human Services (DHS) for costs incurred that benefit public program enrollees as well as plan premium withhold revenue.

MNsure projects $21.6 million in premium withhold revenues, $11.3 million in DHS reimbursements, and a bit of interest income, totaling about $35.9 million to fund operations. Expenditure increases in next year's budget are mainly due to statutorily mandated wage increases and associated benefit costs for staff. Approximately 18% of the budget is for technology operations.

Further adjustments to the budget will likely be needed as MNsure anticipates additional funds to support implementation of the American Rescue Plan from either from the state or federal government. The final budget will be approved at the July board meeting.

Christina shared a slide show with the committee while she discussed further MNsure updates. As of March 10, nearly 2,300 Minnesotans had enrolled in coverage since the COVID-19 special enrollment period started on February 16. MNsure anticipates that the American Rescue Plan will result in even more interest before the special enrollment period ends on May 17.

Joel Ulland asked whether the total enrollments for MNsure are consistent with the same time last year, at around 160,000. Christina confirmed that enrollments were similar in the 2020 calendar year, but the retention rate was higher. Joel asked whether economic or other factors have decreased retention that the committee should consider. Christina replied that among other things, a greater number of consumers are on public program and will not return to the individual market until the public program emergency continuation ends.

Christina continued that MNsure has added life event change data to the board slides to provide additional transparency. She stated that MNsure's goal is to process these changes within 10 days of a consumer reporting them, but MNsure is essentially caught up with reported changes and exceeding its goal.

Next, Christina discussed the expansion of the Affordable Care Act under the American Rescue Plan Act (ARPA.) For two years, premium tax credits will increase for those purchasing insurance through MNsure. Enrollees that earn more than 400% of the federal poverty level will newly become eligible for premium tax credits, and monthly premiums will be capped at 8.5% of an enrollee's income. Individuals that have already enrolled in 2021 coverage through MNsure are eligible for tax rebates when they file their federal taxes for premium payments that they have already made this year. Also, anyone that is enrolled through the individual health insurance market and not through the exchange can move to the exchange and potentially become eligible for tax credits.

Joel Ulland asked how MNsure will apply the 8.5% maximum of applicants' income. Christina explained that MNsure is working on the calculation within its application system. She stated this will be automatically calculated for anyone with an active application once system updates can be implemented.

Matt Schafer asked whether MNsure was aware of specific federal funding for state exchanges, and whether guidance has come out surrounding how those funds are to be spent. Christina replied there are about $2 billion allocated for implementation of the ARPA, but no clear determinations of how that will be divided yet. She noted that other employees at MNsure are working to sort through the uncertainty. Matt then asked whether MNsure intends to extend its special enrollment period as the federal exchange has. Christina replied that it may be a consideration, but MNsure had not yet decided.

Christina shared a couple of examples of how this could impact Minnesotans. There will be an average premium decrease of 19% in Minnesota. That number could be greater if households that are currently enrolled through MNsure without financial assistance have their applications closed so that they can apply for premium tax credits.

Finally, Christina acknowledged technical changes that will need to occur before MNsure can implement these changes. MNsure will need to recalculate the tax credits for all the active financial applications, removing the 400% federal poverty level cap that is currently in place. MNsure will also need to implement the changes to all the new applications moving forward. She noted that communications and outreach efforts are being made to ensure that Minnesotans know about these changes.

Jenifer Ivanca asked how MNsure will announce the changes in areas where inequities exist. Christina said that simply because of the timing of the ARPA passing, MNsure is in the end of the budget year and so limited funds are left for advertising, so Christina explained that MNsure is prioritizing broader audiences immediately and will be able to focus messaging in the next budget cycle. Matt Schafer added that Medica is funding marketing to encourage consumers to learn about how the ARPA has impacted their eligibility for subsidies while special enrollment periods are still running. He noted this has been a big lift operationally, but Medica is sensitive to consumers' race against time.

Advancing Health Equity in Minnesota

Sara Chute, Assistant Director at Minnesota Department of Health

Hodan Guled introduced Sara Chute to the committee, thanking her for taking time away from her valuable COVID-19 work at the Minnesota Department of Health (MDH.)

Sara greeted the committee and thanked them for inviting her to present. Sara began by explaining that equality could be represented by giving people with different needs the same thing; whereas equity would be giving them each something that accommodates their need and leaves them at similar advantages. The Minnesota Department of Health defines "Health equity is a state where all persons, regardless of race, creed, income, sexual orientation, gender identification, or age have the opportunity to reach their fullest health potential."

Sara explained that health is not just about genetics or behaviors, but largely determined by social, economic and environmental factors. Minnesota is ranked fourth in overall health in the nation but is one of the worst states as far as being inequitable. Infant mortality in American Indian and black communities are far worse than in white communities. Wealth gaps are drastic and show that white Minnesotans are nearly three times as likely to own their home. Sara

described redlining, which is a systematic denial of services or goods through selective price raises to services or goods, as a problem that still exists in the housing market.

Sara explained that structures and systems can be changed to be more equitable, and that is why it is important that committees and organizations that analyze the gaps are so important in addressing change. This was capitalized by a quote from Dr. Rachel Hardeman that acts on an MDH advisory board: “Structural racism is normative, sometimes legalized, and often manifests as inherited disadvantage.”

Next, Sara showed a graphic that noted the susceptibility of people with lower education levels to diabetes, smoking and inadequate prenatal care. She explained that higher education levels commonly correlate with better health outcomes.

Sara explained that something like infant mortality rate is not tied inherently to racism but can be associated with the disadvantages that communities face. An individual that is supported in a healthy pregnancy, delivery and after the birth will have healthier outcomes regardless of education level or race.

MDH has a mission statement to protect, maintain and improve the health of all Minnesotans but also has a vision statement for health equity in Minnesota, where all communities are thriving, and all people have what they need to be healthy. In 2013 MDH prepared a report on advancing health equity on Minnesota to identify health disparities and inequities that produce disparities in Minnesota. Of the recommendations to advance health equity, the commissioner created a Center for Health Equity (CHE) at MDH that established a mission to connect, strengthen and amplify health equity efforts within MDH and across the state of Minnesota. Sara shared visuals that represented the value that these ambitions carry.

Finally, Sara explained various projects, training, teams, councils and grants that MDH employs to further equity in Minnesota. Due to COVID-19, some projects have had to be put on hold, but additional response has been created to address inequities the pandemic has highlighted.

Jenifer asked whether MDH will track data about equity impacts following decreased premiums under ARPA. Sara replied that MDH evaluates data regarding improvements toward equity, but there are not necessarily baseline statistics in each area. She emphasized that testing and vaccines are not being limited by insurance, which eliminates some barriers across the country.

Brian Vamstad asked how COVID-19 testing outreach informed strategies for vaccine outreach. Sara replied that lessons are still being learned in each area, but as more people become eligible for the vaccination it is becoming a higher priority to build trust and reach into certain populations to ensure that distribution is equitable. She explained that testing was rolled out in a very different way than vaccines have been, so there is room for each outreach to improve.

Hodan thanked Sara for her presentation and for her work through MDH. She noted that MNsure is a first stop for consumers to access health care, and asked Sara what more the committee prioritize to ensure that MNsure provides health access equity. Sara suggested having MNsure consider a health and racial equity assessment within its policies and practices to see where there are opportunities.

Matt Schafer mentioned there are representatives within the committee from different private organizations. He asked whether Sara would recommend different advice for the different private sectors. Sara reiterated the value in assessments, adding that anti-racism and historical trauma training can help businesses understand their impact on communities. She also recommended that businesses make the efforts to have an on-ground connection to their community.

Dick Wallace mentioned that health care plan providers have sizeable foundations. He asked whether MDH reaches out to health care providers for grant funding. Sara said that MDH's director frequently works to obtain more funding. She mentioned how disappointing it is to be unable to fund every grant that is proposed, and how there is always need for philanthropy. Sara concluded that investments need to outweigh the inequities that exist.

Legislative Update

Matt Schafer, Chair

Matt Schafer noted the rollout of ARPA being the most impactful federal update. Next, he explained some considerations at the state level. The Minnesota Senate is expected to make recommendations on reinsurance for a fifth year. There have also been discussions for additional 1332 waivers through the Department of Commerce for the Department of Human Services and even MNsure. Although subsidies lower premiums for enrollees, more action has been discussed to reduce co-pays and other out-of-pocket expenses. Matt explained that the House and Senate will work more on their budgets for the next biennium, after their Easter break.

Role of Federally Qualified Health Centers in Vaccination

Jonathan Watson, Minnesota Association of Community Health Centers

Matt Schafer introduced Jonathan Watson, who began working for Minnesota Association of Community Health Centers (MNACHC) in 1996 and became the executive director in 2017. Jonathan's background includes public policy analysis, managed care, fiscal analysis, written and oral presentations. Prior to joining MNACHC, Jonathan served as a budget and policy analyst for the Wisconsin Department of Health and Family Services where he provided fiscal and policy analysis for the managed care expansion and Wisconsin welfare reform project. Joel Ulland added that Jonathan previously served on HIAC.

Jonathan shared an overview of MNACHC. There are 17 organizations delivering "one-stop" care at 83 sites to serve nearly 200,000 low income Minnesotans on an annual basis. The sites provide medical, dental and behavioral services and are working to expand into vision and chiropractic services, regardless of patients' ability to pay.

Jonathan explained that 70% of their patients are in black, indigenous and people of color (BIPOC) communities, and in lower-income communities throughout urban and rural locations. He highlighted social disparities that determine health outcomes: economic stability, neighborhood and physical environment, education, food, community and social context, and

health care system. He noted that on average patients face an average of seven of the disparities under these categories.

Regarding COVID-19, Jonathan explained the waves that MNACHC prepared for. Understanding that shutdowns and losses of income would have lasting impacts on the needs across patient communities, MNACHC was able to focus its efforts in different ways. To centralize sliding scale policies, explain services and further direct patients, MNACHC created MNhealthcenters.org.

Since the beginning of the pandemic, MNACHC has tested over 50,000 low-income Minnesotans for COVID-19. Jonathan stated that about 50% of those tests are from BIPOC communities, but he again pointed out that they serve about 70% of the BIPOC population, so he would like to see those numbers more closely align. He noted the positivity rate has decreased from 15.6% to 7.6% overall, and the BIPOC positivity rate has decreased from 23.7% to 4.2% which means that BIPOC communities are improving mitigation efforts at a higher rate.

Jonathan explained there is a close relationship between MDH and MNACHC regarding COVID-19 vaccinations. In late 2020, Governor Walz acknowledged MNACHC's role in reaching BIPOC communities. Federally, the supply of COVID-19 vaccinations is targeted more in the Twin Cities, whereas MDH supplies are spread throughout Minnesota. MDH releases rates at which vaccinations are administered, and MNACHC consistently averages over 80%.

Jonathan shared vaccine hesitancy data that was compiled by National Public Radio. He noted that because MNACHC works so largely with BIPOC communities, it was encouraging to see that the largest groups of vaccine hesitancy were within white communities, not groups that MNACHC generally works with. He said that more recent data indicates that hesitancy is decreasing with better messaging about COVID-19 vaccines. Other ways that MNACHC promotes vaccine confidence are trust, a workforce that reflects the patients they serve, outreach to respected community leaders, selective media outreach, community health worker roles and community base organizations.

Jonathan explained that early demand for the vaccination could not be met with the supply that existed. Expanded vaccine eligibility, funding to support administration of vaccines and funding to support community-based partnerships would contribute to keeping the supply and demand matched.

To summarize, Jonathan explained that COVID-19 has once again laid bare the health care disparities that exist. He gave credit to MNACHC's 50+ years of an established relationship with disenfranchised populations, and their ability to offer audio-only visits in internet-scarce areas to maintain patient relationships. He suggested that MNsure should take on more messaging to promote no-cost vaccines, and proactively anticipate the "pent-up" demand and cost increases as health care utilization upticks at the tail end of the pandemic.

Matt Schafer agreed that Medica has been seeing that more recent claims are higher because people had to put off care for so long that they are now sicker than they would have been with preventive care.

Jenifer asked whether there is any indication that COVID-19 vaccines will require annual booster shots. She commended MNACHC's work and asked what sort of methods they use to keep underrepresented patients at the forefront. Jonathan replied that their existing relationships with patients and surrounding communities has made their work simpler, but MNACHC will need more funding to expand their outreach and to prepare for having more patients on the heels of the pandemic.

Brian asked whether specific messaging would be a good effort for MNsure to help combat vaccine hesitancy. Jonathan responded that any messaging is helpful, as are the optics of public vaccine events to show vaccine safety. He shared that people have different aversions to the vaccines, so there need to be a variety of responses to increase vaccine acceptance.

Hodan commended MNACHC's work, and specifically complimented them for alleviating transportation issues. She asked what challenges the clinics have had with getting people back for the second vaccine. Jonathan said that staffing is always the biggest barrier to support community engagement. He continued that pop-up vaccination sites that are government run instead of community led add an element of distrust in many communities.

Brian noted that he had the privilege of volunteering at a pop-up Allina site recently, an experience which he really enjoyed. He asked, regarding staffing needs, whether regulations have been issued to include more people to administer vaccines. Jonathan replied that although shot administration is an important staffing factor, there also need to be security, data entry and general staff to direct lines and sit with shot recipients before they leave the site. He welcomed any recommendations from the committee to fill each staffing need.

Adjourn

Motion: Brian moved to adjourn. Maria Lima-Leite seconded. All were in favor and the meeting adjourned at 4:02 p.m.