Joint Advisory Committee Meeting Minutes

Thursday, February 27, 2020, 2 – 4 p.m.
UCare, 500 NE Stinson Blvd, Minneapolis, MN 55413

Consumer and Small Employer Advisory Committee Members in attendance: Grace Aysta – Chair, Denise Robertson – Vice-Chair, El'gin Avila (via phone), Lana Barskiy, J.P. Little (via phone), Madison Nelson, Olga Sheveleva

Health Insurance Advisory Committee Members in attendance: Joel Ulland **–** Chair, Hodan Guled – Vice Chair**,** Matthew Aiken, Hillary Hume, Todd Hurst (via phone), Jenifer Ivanca (via phone), Matthew Schafer

Members not in attendance: Leigh Grauman, Thomas Hoffman, Maria Lima-Leite, Daniel Miesle, Steven Narowetz, Danielle Paciulli, Kathleen Saari

Staff in attendance: Christina Wessel – Senior Director of Partner and Board Relations, Aaron Sinner – Board and Federal Relations Director, Eva Groebner – Legal Analyst

Meeting Topics

Welcome & Introductions

Grace Aysta, CSEAC Chair & Joel Ulland, HIAC Chair

Joel Ulland, HIAC chair, called the meeting to order at 2:03 p.m. Members introduced themselves.

Review & Approval of Prior Meeting Minutes

CSEAC MOTION: Denise Robertson moved to approve the draft January 28 meeting minutes. Madie Nelson seconded. All were in favor and the minutes were approved.

Denise added commentary that the minutes accurately reflect that the committee intended to drop Life Event Changes as a priority (meeting minutes page 5), however she was not present during that part of the meeting and has requested that the issue remain open for discussion. Grace Aysta, CSEAC chair, confirmed it will be added back to their next meeting's agenda.

HIAC MOTION: Matt Schafer moved to approve the draft January 30 meeting minutes. Hodan Guled seconded. All were in favor and the minutes were approved.

Legislative and MNsure Staff Updates

Aaron Sinner, Board and Federal Relations Director

Aaron provided three updates to committee members.

He reported that the public charge rule is in effect as of Monday, February 24, 2020. The U.S. Department of Homeland Security published a regulation last August that was set to take effect on October 15, 2019. Five federal judges imposed injunctions temporarily preventing implementation; however, the U.S. Supreme Court has now lifted the stay. Aaron explained that the rule has the largest impact on immigrants living in Minnesota in receipt of Medicaid (referred to as Medical Assistance or "MA" in Minnesota) who will need to evaluate the possible effect of receiving Medicaid benefits upon their long-term immigration status. He noted applying through MNsure for financial assistance runs health care eligibility checks sequentially: eligibility for MA is determined first; if the applicant does not meet requirements then eligibility requirements for MinnesotaCare are applied; if the applicant is not found eligible for MinnesotaCare, eligibility for a qualified health plan (QHP) with or without an advanced premium tax credit (APTC) is determined. Aaron explained that Department of Homeland Security caseworkers may use this routine MA eligibility check in public charge evaluations, but there is no precedent to foresee the impact the public charge rule may have on immigrants who apply for APTC. MNsure has posted frequently asked questions surrounding the public charge rule on its website. This information was compiled by Minnesota state agencies, and is available in English, Hmong, Karen, Somali and Spanish. MNsure will continue to monitor developments to the regulation but encourages all concerned parties to consult an immigration attorney for guidance.

Grace and Hodan asked whether MNsure will inform applicants, either by written notice or on the application, about potential repercussions of the public charge rule. Aaron noted that an applicant's health care eligibility is not impacted by this rule, so MNsure's intent is to offer support and not to discourage any Minnesotans from seeking health coverage.

Lana Barskiy inquired whether an applicant can bypass the MA check and apply solely for MinnesotaCare coverage. Aaron stated it was not a change MNsure intends to make to its eligibility system.

Olga Sheveleva followed up, inquiring whether a person can change their health care program after the eligibility check is run. Aaron clarified that because MA is funded by federal programs, and MinnesotaCare is funded by state programs there is no way for MNsure to change eligibility, this would require intervention by legislation.

Hodan noted that many people impacted by the public charge rule are not eligible for MA, but rather for MinnesotaCare. She explained that immigrants are typically sponsored, which makes them ineligible for MA. Lana noted that she sees the same trend.

Joel added that the rule is very narrow, impacting a small number of individuals, but it has incited a great deal of panic and confusion. He affirmed that accurate information needs to be sought out on every level. Hodan and Denise added that there is not a lot of media coverage on it, and even lawyers that have spoken out tend not to have absolute answers yet, making it increasingly difficult for assisters to work with households.

Aaron next updated the committee members that MNsure is reserving funds to pursue year-round marketing. He mentioned that this should be especially good news to the HIAC, after they

made the recommendation to the MNsure board in July of 2018 and again in July of 2019. He elaborated that the initiative will be online only – digital, paid search and paid social media based on an individual's online activity – and this will be a pilot in order to determine long-term marketing approach.

Hillary Hume asked how soon the marketing will begin. Aaron said he was unable to give a precise date, but that it would launch within a month or two, lasting into the summer.

Joel stated year-round marketing is an opportunity to increase understanding surrounding life event changes outside of open enrollment.

Denise mentioned that CSEAC had discussed something similar and asked whether it will be aimed toward the QHP market. Aaron stated that the initiative would be funded by premium withhold dollars, the messaging would be broader in an attempt to understand who is driven to enroll and whether there is a return on investment on the QHP side compared to the public programs side. Hillary suggested that the Minnesota Department of Human Services (DHS) assist in the funding if they see an uptick in enrollments.

Finally, Aaron provided statistics since the 2020 open enrollment period. He noted a 2% increase in QHPs, and even greater for public program sign ups. Cumulative QHP enrollments are now over 123,000, which is similar to the year over year figure from this time in 2019. Aaron noted that it took longer to get to this number because of the shortened open enrollment period, and the more extensive process that an individual must go through for the special enrollment process. He mentioned that an individual not in immediate need of health coverage may drop out during the special enrollment process because it is a more cumbersome process than enrolling during open enrollment. Aaron closed with the note that effectuation data is not yet available but should be soon.

Review Overview of CSEAC Focus Areas for 2020

Grace Aysta, CSEAC Chair

CSEAC Members

Joel suggested that all committee members add to the conversation as point struck them, and not wait for the "Discussion" portion of the meeting. Grace agreed and added that the purpose of the joint advisory committee meeting was both to align committee goals for strength in numbers and divide and conquer in a way that supports both committees.

Grace began with an overview of the committee's projects from the past months' meetings. She explained that health care literacy has been important to CSEAC, but without a clear suggestion for the board, they've moved this initiative to the back burner. Madie added clarification why CSEAC has moved on from the topic temporarily: health literacy tends to be tied up in the language used on mandatory notices, making action unclear to consumers. Madie stated that a resolution to understand these notices is not one absolute or easy fix, which is why CSEAC is tabling for a later discussion when more tangible resolutions may present themselves.

Joel mentioned that health care literacy comes up in HIAC discussions frequently, not necessarily as a “top three” item, but more so as an undercurrent running through other issues. He suggested that CSEAC keep literacy in mind as a sub-topic for all headlining topics.

Hodan added that health care literacy does not need to be specific to reading MNsure documents but rather to understand all aspects of health care. She introduced some concepts HIAC has discussed, such as having MNsure as a resource to define what a deductible is, or to offer links for mental health resources in the community. She added that HIAC would like to see MNsure embrace a more one-stop approach to health care, MNsure-specific and otherwise.

Denise mentioned an ongoing issue she sees as a navigator: each year the carriers send out a notice citing the next year’s tax credit and premium amount. She said the notices contain outdated information, which confuses and frustrates consumers. She asked committee members what the purpose of these letters is, and whether MNsure can implore them to stop. Joel replied, as a representative of UCare, that Centers for Medicare & Medicaid Services (CMS) requires carriers to send the letters out, and Matt Schafer agreed that is his understanding as well, as a representative of Medica. Denise asked if the carriers could agree to call more attention to state that the information is based on previous data and is not necessarily accurate. Matt Aiken added that in his experience as a health insurance broker, HealthPartners has the most accurate notice that directs consumers to MNsure for the most up-to-date tax credit information. He stated that HealthPartners’ notice specifically states right next to the premium that the calculated tax credit is from a previous year, and to call MNsure for current eligibility. He added that his understanding is that CMS and the Department of Commerce heavily regulate notices. Aaron suggested that because Minnesota is one of the last states to release final rates each year, there may be a federal deadline that carriers need to conform to that perpetuates inaccurate rates before they have the full picture for the upcoming year. Joel and Matt Schafer confirmed that was their understanding as well.

Next, Grace informed the committee members that CSEAC has been discussing the role of an ombudsperson or office of ombudspersons to clarify information for consumers between the departments. She explained that because MA, MinnesotaCare and QHP are handled by different agencies, there are a great number of consumers that get lost between the departments. She suggested that the assisters within the committees find specific examples of the confusion caused by changing programs and present the cases to the board to illustrate problems that need resolution. Madie added that in her experience as a navigator, there are households that need to contact multiple agencies to resolve any issues. She confirmed that it can be frustrating as an assister and must be difficult for a consumer to navigate without guidance. Olga added that an inexpensive suggestion to the board could be to host an online forum for assisters to provide one another with resolution they’ve found throughout their experiences.

Christina Wessel, MNsure staff, clarified for committee members that DHS makes use of two health care systems that MNsure does not have access to, necessitating a call to DHS for MA or MinnesotaCare questions. Denise added that health insurance carriers are another agency that can add to agency ping-ponging when QHP households are involved; it isn’t an issue exclusive to MNsure and DHS. Joel explained that the carriers can only be as good as the

information they have access to. He elaborated that MNsure is providing cleaner data following the GetInsured updates, which positively impacts the carriers.

Jenifer Ivanca stated that as a broker she sees a greater discrepancy between public programs and MNsure rather than from MNsure to the carriers. She referred to households that receive a request to verify income to DHS but go to a broker out of confusion with that process. Brokers are specifically licensed to help consumers select a health plan to enroll into. Jenifer stated that her broker enrollment center is not equipped to help with public programs, but her agents find themselves attempting to help mixed-eligibility households contact MNsure and DHS frequently. Denise added that she has seen numerous households that should be eligible for MA or MinnesotaCare, but failed to comply to certain standards, so their eligibility was changed to an unassisted QHP as a default. These households would be best directed by DHS but may not be savvy enough to know where to direct their questions.

Grace segued into CSEAC's next focus area for 2020, the processing time for life event changes (LECs). Grace noted recent improvements, with MNsure's Resolution Review Team (RRT) resolving higher numbers of consumer issues than before its implementation. Madie added that MNsure now informs assisters when LECs are resolved. MNsure's operations team processes LECs in the order received and has updated its process to inform assisters on which date they are working.

Denise noted that the minor improvements made by MNsure do not negate the impact of delayed processing. She mentioned that some of her clients reported LECs in December that have yet to be resolved. Christina explained that LECs that prevent enrollment, such as adding a new family member to a household take precedence to ensure that new enrollees can gain coverage quickly. She sympathized that an income LEC is of lowest priority and therefore can see substantial delays in processing. Denise stated that income changes are the most common household change and deemed it unacceptable that any reported change take months to rise to the front of a queue. She proposed that prioritization methods be scrapped to make room for an inclusive process. She added that navigators take the brunt of this issue.

Hodan agreed that the committees find suggestions surrounding LECs to take to the MNsure board. Jenifer suggested that MinnesotaCare premiums be taken out of a consumer's taxes to effectuate the coverage without delay for a premium payment. Matt Aiken asked if Jenifer was suggesting a type of tax reconciliation like tax credits, which Jenifer confirmed, stating it could prevent gaps in health coverage. Hodan explained to the committee members that MinnesotaCare coverage cannot effectuate without premium payment, and even in cases of retroactive MA, DHS needs to create identification numbers for recipients to get service at most clinics.

Review Overview of HIAC Focus Areas for 2020

Joel Ulland, Chair and *Aaron Sinner, Board and Federal Relations Director*

HIAC Members

Joel presented the committee members with HIAC's research process from 2019, adapted for a summer 2020 presentation to the board. He began with HIAC's first step, a survey between

meetings so that the committee members could rank their top interests. An additional step in the survey was to rank MNsure's potential influence over each suggested subject matter. The result showed three front-running topics the committee found interest and potential sway over: mental and behavioral health (including addiction education), individual market affordability, and underserved populations. Joel explained the vital resource that the SHADAC (State Health Access Data Assistance Center) report had been for HIAC to research uninsured sub-groups. He elaborated that basic education efforts, marketing and additional opportunities can be designed once the committee understands what continues to prevent these populations to miss out on MNsure. He also commented that MNsure affordability is largely regulated by law, so the committee intends to explore deeper discussions on initiatives that will not require legislative change.

Joel then mentioned HIAC's ongoing conversations around health literacy as a deficit for common health care terms such as "co-pay" and "deductible." Jenifer added that HIAC has interest in exploring the active selector process that is within MNsure's authority. She recommended that behavioral health initiatives should be better explained in the Summary of Benefits and Coverage (SBC) specifically with better explanation of co-pays. She posed situations such as loss of a child or spouse and bullying as times that consumers should have immediate access to cogent information.

Matt Aiken emphasized HIAC's initiative to offer common-good suggestions to the MNsure board with focus on profit and loss analysis and no requirement for legislation.

Matt Schafer initiated a discussion about the insulin bill, HF 3100 (also known as the Alec Smith Insulin Affordability Act), passed by the Minnesota House of Representatives on February 26, 2020. He recognized that a similar bill is in the Minnesota Senate, but has not been voted on yet. He indicated that one difference between the bills is the recommended supply of emergency insulin. The House endorses a 90-day supply, whereas the Senate has proposed up to a year. Aaron explained that MNsure's role in emergency insulin distribution would potentially be upon receipt of a consumer's application through their pharmacy. Recipients would need to be under the 400% federal poverty level threshold, and after verified would be given a form for the insulin manufacturer. He added that navigators would have a role in helping with long-term programs for these households.

Discussion: Opportunities for Collaboration

Grace Aysta, CSEAC Chair, Joel Ulland, HIAC Chair and *Aaron Sinner, Board and Federal Relations Director*

CSEAC and HIAC Members

Grace directed the committee members to suggestions that the MNsure board made to both committees at the beginning of their latest session in November 2019.

Reinsurance and Individual Market Affordability

"How can Minnesota best address affordability in the individual market? If a reinsurance program is the solution, how can it best be funded in a sustainable way? Does Minnesota's

Workers' Compensation Reinsurance Association offer any insights that could inform Minnesota's current reinsurance program?"

Grace stated this suggestion didn't spark a great deal of interest in CSEAC members.

Plan Affordability Across the State

"The reinsurance program has lowered premiums overall and done a little to narrow the gap between premiums in rating areas 1 and 3 vs. the rest of the state, but the cost of premiums in those two regions is still well above the statewide average. This in turn is due to a significantly higher risk-adjusted cost of care in those regions, driven by Mayo in particular. With no evidence market forces are changing this dynamic, is there some role for MNsure here? If not MNsure, then a role for whom?"

Grace mentioned that Madie and Denise are from areas with the greatest disparity in health care prices, so CSEAC intends to put effort into some solid recommendations to the board. She said that their initial discussion generated an idea for local rates like lowered college tuition for state residents. Madie acknowledged that MNsure cannot persuade Mayo Clinic to change their rates but could publish quality and cost ratings to help southern Minnesotan residents make better informed decisions about their local clinic preferences.

Joel recommended that CSEAC look at MN Community Measurement HealthScores for some of the tools to achieve a MNsure rating system.

Denise added that age plays a significant factor in southeastern Minnesota. She observed a trend for residents to abandon the individual market and hold out for Medicare (at age 65) without preventive or emergency care in the months or years leading up to it.

Matt Schafer asked whether Denise knew of individuals crossing the state border into Iowa for less expensive health care. Denise confirmed that Rochester residents and even Austin residents cross into Iowa frequently for diagnostic care rather than pay Mayo Clinic prices. She stated that individuals with high deductibles have limited incentive to stay in-network for care. Hillary and Denise mentioned that Sanford and Mercy are alternatives to Mayo Clinic, but that they cannot be considered "competition" to the destination medical center. Denise added that the Twin Cities are a reasonable drive from Rochester but is considered out of network. She stated that Rochester is the third-largest Minnesota city, so there are significant numbers of people impacted by the larger premium costs.

Joel weighed in that UCare is a young company that has stuck to its service area without a lot of expansion. He explained that from a health insurance carrier's point of view, Mayo Clinic limits premium negotiations. He added that there have been legislative proposals to modify rating areas, but the concept of raising rates in the metro area to offset southeast Minnesota premiums prevents the proposals from passing.

Denise asked whether the MNsure board could hold discussions with the intent to circulate knowledge despite having no power to force changes. Aaron said that educating the public would be an attainable goal but cautioned against creating false hope.

Hillary noted higher entertainment taxes in Minneapolis and asked if southeastern Minnesota had anything like that to create bigger city funds.

Grace thanked the committee members for some inspired input. She asked if any members knew of other states that have overcome similar disparities. Matt Schafer replied that there is a district in Texas with a similar situation, but he couldn't recall specifics. He noted that rating areas are part of the Affordable Care Act, adding Governor Tim Walz once observed that southeast Minnesota has the greatest discrepancy. Joel added that there's a formula to create rating areas.

QSEHRA/ICHRA

"Federal rules and regulations allow for use of certain kinds of health reimbursement arrangements toward the purchase of individual market health insurance. This includes qualifying small employer health reimbursement arrangements (QSEHRAs) and individual coverage health reimbursement arrangements (ICHRAs). How should MNsure respond to these opportunities? Should MNsure promote or pursue enrollees via these mechanisms? What level and kinds of support should MNsure offer to these types of enrollees?"

Grace mentioned that Leigh Grauman was not present, but previously provided CSEAC with compelling information about reimbursement arrangements that undermine employees' eligibility for tax credits. Leigh had suggested that MNsure's role should be supporting consumers that are cornered into the position of having an HRA rather than supporting the policies for employers.

Joel mentioned that UCare does not offer small group coverage, so he was unable to address any operational information to the committees.

Matt Schafer noted HRA plans are regulated differently than group coverage and appeal to different businesses. The biggest difference between individual and commercial policies would be that the employer administers either funding or the actual health coverage. Matt mentioned that Medica's role as a third-party administrator (TPA) cannot address commercial policy specifics. Often, large employers' Human Resources department needs to inform the employees if certain coverage is exempt because there are employees in multiple states.

Grace asked if there is a minimum contribution that employers need to make. Matt Aiken stated that the employee must be enrolled in an individual plan without tax credits and the employer establishes parameters, then contributes funding to the HRA. He continued that his broker agency serves as TPA to many accounts, and his experience is that employers contribute at least $200 a month so that their administrative fees are not negating the tax benefits for the employer.

Active Selector and "Co-Pay-Only" Plans

"MNsure was approached by a collection of outside groups about mechanisms MNsure could use to promote 'co-pay-only' plan offerings in Minnesota's individual market in order to smooth the costs of prescription drugs for high-cost enrollees. Should MNsure explore using its active selector authority? Does promotion of co-pay-only plans merit use of active selector? If so, what is the best way to structure an active selector regulation to promote these plans? If MNsure

were to explore using active selector, are there other potential uses that should be done instead of or in conjunction with promotion of 'co-pay-only' plans?"

Grace mentioned that CSEAC's biggest question with active selector has been how the MNsure board can negotiate with carriers and incentivize participation rather than trigger abandonment from the exchange. Aaron said that carrier participation on the exchange gives access to an exclusive market, as the only place Minnesotans can enroll and receive tax credits.

Joel added a carrier perspective, noting certain standards can inadvertently limit the market in other ways. If there are counties that don't have specific service providers, the carrier cannot expand their network to meet active selector guidelines, thus forcing them to leave that county or the exchange entirely. Joel stated that health coverage and network benefits are far more complex than compliance versus non-compliance. He recommended committee members consider incentives rather than punishments under this topic.

Joel noted IRS guidance in 2019 allowing co-pays focused on six preventive categories in HSA-compliant plans. Insulin has been the first category to near implementation.

Denise asked whether there's a list of preventive medications available. She inquired whether EpiPens or inhalers might be next on carriers' lists of medications to tackle. Joel noted these were difficult conversations for carriers to have publicly due to the competitive nature of their products. He stated that carriers prefer maximum flexibility to provide the best options to their consumers.

Grace suggested that MNsure look to the Amazon favored products model. She recommended that if a product meets criteria it could become a "choice" plan with boosted reputation on MNsure. Joel replied that Medicare policies follow a similar star model that compare quality to value. He mentioned that could carry over to the individual market. Hodan summarized that MNsure should ensure that the carriers compete for consumer loyalty rather than force consumers to fight for adequate coverage.

Public Comment

No public comment.

Next Steps

Joel stated that HIAC will devote one meeting per topic so they can develop recommendations by their June meeting, and present to the board in July. He said that HIAC will focus on mental health, market affordability and underserved populations. He offered to keep CSEAC apprised and suggested that each committee could present to the other as a practice run before presenting to the board.

Grace mentioned that CSEAC was unable to present to the board in 2019 and is working on a shorter timeline. She stated they intend to focus on communication failures, LECs and possibly HRA discussions.

Committee members discussed the value of presenting to the board separately so that each issue gets due focus.

Hodan, Joel and Grace mentioned collaboration opportunities with health literacy. Grace suggested creating a lesson plan together because each committee offers valuable resources. Denise added that a clearinghouse functionality between the committees could vet existing resources to minimize confusion. Hillary added that a filter of “What do I know? Why do I care?” can help focus on consumer priorities. Matt Aiken offered CSEAC an HRA resource to diversify their research.

Aaron informed committee members that the board meets on March 11, June 17 and July 15.

Adjourn

MOTION: Matt Schafer moved to adjourn. Denise seconded. All were in favor and the meeting adjourned at 4 p.m.