

Policy Levers for Addressing Health Disparities through the Exchange

Minimizing the Disruptive Effects of Churning

As individual or family income changes, whole families or members of families will experience a change in eligibility for public health care programs and for tax credits through the Exchange. Income changes present a special challenge for individuals and families who cross the Medicaid-Exchange threshold, because this may trigger a shift between plans and provider networks as well as a significant increase in cost of coverage. Maintaining continuity of care depends greatly on maintaining covered benefits and services as well as patient/provider relationships during changes in eligibility status.

Recommendations:

1. Navigators should be trained to identify those at risk of churning and assist them with identifying plan options that can provide comparable coverage and similar provider networks.
2. The Exchange should coordinate efforts with Medical Assistance to examine how enrollment procedures could be improved to help reduce churning and to ensure that lack of alignment in eligibility criteria does not create the possibility that individuals or families could get “lost” between Medical Assistance and the Exchange.
3. The Exchange should ensure that children moving off of Medical Assistance, particularly children aging out of foster care, have seamless coverage.
4. To minimize churning, Qualified Health Plans (QHPs) should be required to provide reasonable accommodations to people with disabilities prior to terminating coverage.

Incarceration Status

Individuals in the criminal justice system have disproportionately high rates of chronic disease, mental health issues, and substance abuse. They often have no access to employer-sponsored insurance and have below-average incomes, making unsubsidized insurance on the private market unaffordable. Clarifying when individuals from this population are eligible for tax credits and enrollment through the Exchange can encourage take-up of insurance among this population. The ACA standards are not aligned with Medicaid standards on this issue.

Recommendations:

1. Prior to presenting any questions about incarceration status, the Exchange should allow people to enroll in QHPs if they have not been convicted, even if they are in jail pending the disposition of charges, including charges of parole or probation violations.
2. Within the limits of federal law, the Exchange should work with the Medicaid administration to reconcile eligibility criteria for Medicaid, CHIP, BHP and private insurance on the Exchange according to the least stringent requirements and the narrowest exclusions for persons involved in the criminal justice system. This includes suspending – not terminating – people from MA while incarcerated.
3. The Exchange should allow people who are incarcerated to apply for Medical Assistance while incarcerated but just prior to release, in order to facilitate a smooth transition into the community. This is particularly important for people who live with a serious mental illness, for whom lack of insurance and thus needed medications results in high recidivism rates.
4. The Exchange should allow people who are in a workhouse to access QHPs through the Exchange.

Navigators

A robust Navigator program in the Exchange, focused on serving populations that face barriers to enrollment and to accessing health care and mental health services, could be one of the most powerful tools for mitigating health disparities and reducing the number of uninsured people. Lack of insurance is a leading cause of health disparities, so expanding coverage will contribute to health equity and to improving health outcomes. Community organizations of diverse kinds (ethnic, neighborhood, religious, etc.) are best positioned to fulfill this role, as they can draw on established relationships and trust with the Minnesotans needing assistance determining and weighing their options for health coverage. In designing the Navigator program, much can be learned from existing programs such as the MNCAA (Minnesota Community Application Agent) program and Mental Health Crisis Teams, and from Community Health Workers, certified Peer Specialists, and county workers. In some cases, participants in these established programs will not – if they choose to operate as Navigators – need all the same training required of other groups serving as Navigators, given the overlap with their existing training and certification requirements.

Recommendations:

1. The primary goal of the Navigator program must be to help individuals and communities overcome obstacles to obtaining and maintaining quality health care and appropriate health insurance. Decisions about funding and contracts should reflect this priority.
2. Because of their existing relationships with populations that experience health disparities, Navigator services should be located in community-based organizations such as neighborhood and ethnic organizations, faith-based organizations, community health clinics, community mental health care centers, Indian health care centers, consumer advocacy groups, and culturally-specific human service providers.
3. Outreach (see section below) is a critical function of Navigators, and development of the Navigator program should be undertaken in close concert with planning for outreach and marketing.
4. The Navigator program should be structured to support different Navigator roles designed to address the specific needs of diverse populations, in particular those experiencing the highest levels of uninsurance and the worst health disparities. This set of roles includes – in the small-group market – the role played by agents/brokers in helping both employers and employees understand their options.
5. Funding for the Navigator program, where Medical Assistance does not already reimburse, should be available no later than July 1, 2013.

Outreach and Marketing

A central goal of health reform is to maximize access to health care by encouraging take-up of health insurance by those populations who have remained uninsured due to barriers to enrollment. Traditional market mechanisms have failed to engage these populations, so targeted outreach will be necessary to ensure they have adequate knowledge about their options and assistance in obtaining and maintaining appropriate coverage.

Recommendations:

1. The Exchange must undertake a multi-pronged outreach and education campaign to attract participation from the broadest selection of the population.
2. The Exchange should formally recognize its responsibility to conduct targeted outreach to hard-to-insure populations.
3. The Exchange should conduct a thorough review of insured and uninsured populations to develop possible strategies for reaching the “newly covered” and the “covered-but-not-enrolled”. The Exchange should obtain Minnesota-specific data on the needs of low-income communities of color in order to tailor its outreach to those communities.
4. The Exchange should engage organizations with expertise in culturally-specific outreach in designing micro-targeting strategies.

5. Outreach efforts and the Navigator program (see section above) should be developed in tandem, and implemented in a manner that allows each to strengthen the other.
6. The Exchange should devise measurements and standards for assessing its outreach to target populations.
7. A core component of the outreach program should be partnerships with community organizations that have strong existing relationships with target populations.
8. Ensuring transparency in the Exchange, in terms of benefits, drug formularies, etc. is important for marketing standards, so that people are not misled about, and have access to accurate information on, what is covered.

Network Adequacy

Implementing the ACA will result in an influx of health care consumers that may not be accounted for in current network adequacy considerations. The problems associated with inadequate provider networks disproportionately affect those populations already at risk for health disparities. Adequate provider networks mean that new patients can access all covered services and all patients are protected from undue burdens accessing health care.

Recommendations:

The state should mandate the following network adequacy standards for all health plans in and outside of the Exchange:

1. Provider networks must have sufficient capacity to accept new patients both initially and throughout the plan year.
2. Qualified Health Plans (QHPs) should be required to contract with culturally specific and competent providers, as identified by DHS.
3. Patients must be able to access all covered services at a reasonable distance and in a reasonable timeframe to address their particular health care needs, including mental health.
4. If a patient is not able to access needed services within the network, plans must allow that patient to access services out of network without penalty.
5. Health plans must have the capability to process claims payment for their entire network on a timely and accurate basis.
6. Health plans must cover a broad array of mental health services, contract with Community Mental Health Centers, abide by mental health parity, and support integrated mental health and health care services.
7. The Exchange should establish a method to gather, review, and assess complaints from participants related to access and network adequacy in order to identify the need for and to make improvements.

No Wrong Door

The ACA has established a “No Wrong Door” model: no matter where or with what knowledge a person applies for coverage, she or he must be evaluated for all available public and private health insurance options and enrolled in the one that best suits them. This funded requirement offers the opportunity to align the Exchange’s eligibility-determination and enrollment process with the eligibility-determination and enrollment processes for other public benefit programs, making these programs more accessible to the individuals they are intended to serve. Together, this new infrastructure has the potential to reduce burdens on families, increase access to critical supports, reduce administrative costs, and improve the accuracy of eligibility determination for public and private programs.

Recommendations:

1. The “No Wrong Door” process for enrolling in health insurance through the Exchange should be designed in collaboration with all agencies that oversee the enrollment processes for other public benefit programs, with the goal of aligning and streamlining the eligibility-determination and enrollment processes for all programs.
2. The Exchange should provide a variety of avenues for seeking coverage through the new system, beyond the required hotline and online venues, to ensure that the system is readily available and accessible to everyone.

Data Collection by the Exchange

To effectively address health disparities, we need to be able to measure them. Data collection and reporting methods often make this difficult, or even exacerbate disparities. Having standardized data inclusive of categories relevant to health equity would enable better understanding of the barriers faced by people who experience health disparities. It would also enable the Exchange to hold health care organizations accountable to the public and communities for their performance in eliminating health disparities.

Recommendations:

1. The Exchange should adopt a universal construct for collection of data on race, ethnicity, language and socio-economic status that will be used by both government and the private sector. The Partnership for Data Collection, a robust community advisory group working with the Departments of Health and Human Services, is developing such a construct for data collection. The universal construct should have two major components:
 - a. Data categories of race, ethnicity and language should reflect the ways communities define themselves and allow data to be broken down into additional sub-categories.
 - b. Data collection and reporting methods should be culturally appropriate and available to communities affected by health disparities and the general public.
2. Additionally, the Exchange must be able to disaggregate data to identify disparities between those who enroll in a health plan through the Exchange and those who apply through the Exchange but don't ultimately enroll, and to compare those groups to data on those who enroll in health plans outside the Exchange and those who remain uninsured. This will enable the Exchange to examine how successful its outreach is to targeted populations and to improve services where necessary.

Verification of Citizenship Status

Unnecessary citizenship documentation requirements can create a barrier to enrollment in health insurance plans, even for documented immigrants and U.S. citizens. It also creates an administrative burden for small businesses. Streamlining the process for applying for health insurance through the Exchange by eliminating redundant documentation requirements will improve access to health insurance for many populations.

Recommendations:

1. The Exchange should employ best practices for executing real-time data verification through linkages to other agencies like the Social Security Administration or state agencies in order to minimize the burden on individuals for supplying documentation.
2. The Exchange should not require small businesses to re-verify the identity of their employees in order for them to be eligible to enroll in a QHP through the SHOP Exchange, especially if they already utilize the “e-verify” system.
3. The process for applying for insurance through the Exchange should only require Social Security numbers to be provided for the individuals for which coverage is sought, not for parents who are applying for coverage on behalf of their children or for household members who are not applying for coverage.

Payment Reform and Accountable Care Organization (ACO) Partnerships

ACOs that deliberately aim to mitigate health disparities, with robust community participation in both design/ planning and implementation, have the potential to make significant strides toward health equity. The “Medicaid ACO Demonstration Program” in New Jersey, for example, is a model for how ACOs with carefully structured incentive programs can serve as a powerful tool to reduce health disparities. In this program, participating providers who improve access to care and achieve specific quality standards through better care coordination and information-sharing retain a portion of the savings realized through these improvements, a feature called “gain-sharing.” The program grew out of smaller initiatives that showed that enhanced collaboration, coordination and communication among health care providers significantly improved health outcomes and reduced costs for high-cost and at-risk populations.

Recommendations:

1. The Exchange should study and consider multiple payment reform and cost management schemes for creating ACOs that provide better preventive care and meet other health outcomes and cost goals related to reducing health disparities. Direct contracting by the Exchange with an ACO is one of the payment-reform mechanisms that should be studied and considered. Alternatives to managed care that could offer more cost-effective care and reduce health inequities should be vigorously explored.
2. The Exchange should seek leadership from community organizations in deliberations over how to structure and manage partnerships with ACOs

Active Purchaser Authority

An “active purchaser” model for the Exchange would give the Exchange authority to negotiate with health plans for lower premiums and better benefits, rather than allow any carrier to participate in the Exchange as long as it meets minimum requirements. Active purchasing is commonplace in the insurance industry. It is how large employers keep costs down for their employees and it is how many states negotiate contracts with commercial plans for public health insurance. The Massachusetts Health Connector has active purchasing authority. Because cost is a major barrier for low-income populations seeking health coverage, and uninsurance and underinsurance generate health disparities, the Exchange’s ability to negotiate with health plans is an important mechanism for making coverage affordable and reducing disparities.

Recommendation:

1. The Exchange should have the flexibility to negotiate with health plans and to contract with those that will best serve the interests of the hundreds of thousands of Minnesotans who will get their health coverage through the Exchange.

Quality Rating System

The ACA requires Exchanges to develop a Quality Rating system to display information about health plan quality to consumers. Including information about plan performance on health equity measures in the Quality Rating System would enable consumers to choose a plan that rates high on health equity and would encourage competition among plans for reducing health disparities.

Recommendation:

1. Information about performance on health equity measures should be included in the Exchange’s Quality Rating System. Development of appropriate measures will require careful deliberation and study by the Task Force or a working group reporting to it.

Language Services

Health care consumers whose primary language is not English experience poorer quality patient-provider interactions than do other groups and may have difficulty accessing customer service through venues that lacks interpreter services. Language services can facilitate consumers' understanding of every step in the process of applying for and obtaining health insurance and contribute to better patient-provider interactions, better understanding of instructions for care, and enhanced trust in the health care system.

Recommendations:

1. The Exchange should require that all Qualified Health Plans (QHPs) provide interpreter services in medical settings (where these are not already required by Medical Assistance) and for customer service in, at a minimum, all languages used by the Department of Human Services.
2. All telephone and in-person services offered by the Exchange should provide interpreter services in, at a minimum, all languages used by the Department of Human Services.
3. All Exchange web sites and written materials should be available in, at a minimum, all languages used by the Department of Human Services.

Exchange Board Expertise

Several states have designated seats on their Exchange Board for individuals with expertise in particular areas deemed essential for the efficient and effective governance of the Exchange. Making such a designation for an individual with expertise in the area of public health and health disparities would enable the Exchange Board to incorporate that perspective into their policy deliberations. Additionally, enabling participation on the board by members of community organizations is crucial for ensuring that the Exchange is representative of the people it serves.

Recommendations:

1. Exchanges are intended to support consumers, including small businesses, and as such the majority of the voting members of the Exchange Board should be individuals who represent the interests of individual healthcare consumers and small businesses – as recommended by the Department of Health and Human Services in its guidance to states on Exchange implementation.
2. The membership of the Exchange Board should reflect the diversity of the state's population. In particular, the Board should include representatives from ethnic/racial groups experiencing the most severe health disparities.
3. A provision should be made for paying a stipend to Board members who represent the interests of consumers, including small businesses, who would not be paid by an employer for the time they spend serving on the Board.
4. At least one member of the Exchange Board should have demonstrated expertise in public health and health disparities, and at least one member should have expertise in mental health.