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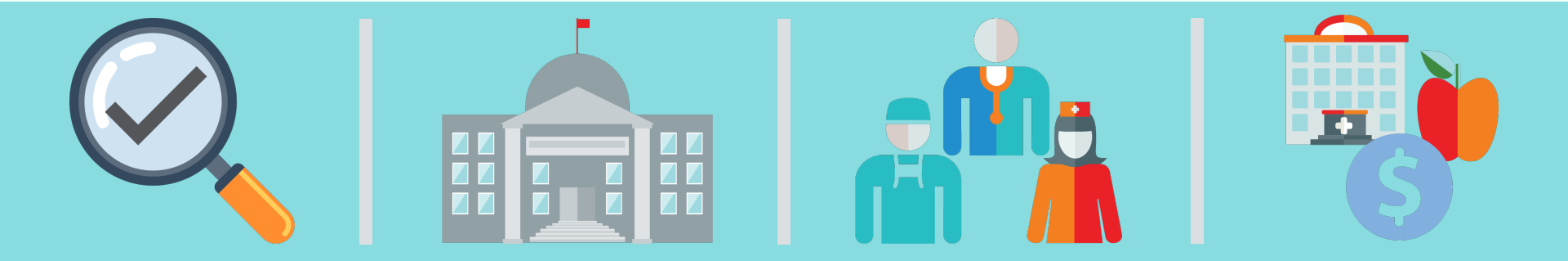
Affordable for Whom? Steps for States to Include Equity in Affordability Policies

@HealthValueHub

July 13, 2022

www.healthcarevaluehub.org



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Welcome and Introduction

Elise Lowry
Policy Analyst
Healthcare Value Hub

Housekeeping

- Thank you for joining us today!
- All lines are muted until Q&A
- Webinar is being recorded
- Technical problems? Contact Tad Lee at Tad.Lee@altarum.org

Agenda

- Welcome & Introduction
- Curbing Excess Prices
  - Josh Wojcik, Connecticut Office of Comptroller
- Reducing Low-Value Care
  - Beth Beaudin-Seiler, PhD, Altarum
- Extending Coverage to All Residents
  - Stephani Becker, MPP, Shriver Center on Poverty Law
- Making Out-of-Pocket Costs Affordable
  - Audrey Gasteier, MS, Massachusetts Health Connector
- Q&A

Healthcare Affordability Domains

Curbing excess prices

Reducing low-value care

Expanding Coverage to All Residents

Reducing Out-of-Pocket Costs

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Curbing Excess Prices: Connecticut's Healthcare Affordability Index

Joshua Wojcik
Director of Health Policy and Benefits Division,
Connecticut Office of the State Comptroller

Connecticut Healthcare Affordability Index

EVALUATION OF THE STATE HEALTHCARE COST GROWTH BENCHMARK

JULY 2022

Joshua Wojcik
Director of Health Policy and Benefits Division
Connecticut Office of the State Comptroller

Connecticut Healthcare Affordability Index CHAI

The CHAI sets a maximum percentage of income a household can spend on healthcare* while leaving room to cover other expenses required to meet basic needs.

The measure is described as an index because it varies based upon a number of factors including:

- **Household type;**
- **Geographic region;**
- **Health risk factors;**
- **Market through which a household can access health coverage;**

Depending on the above factors Connecticut households can generally afford between 7% and 11%

*healthcare costs include both premiums and out-of-pocket costs

Analyzing the Connecticut Healthcare Cost Growth Benchmark using the CHAI affordability standards

Impact on Commercial Hospital Spend by 2025

-$1.1 billion or -14.2%

Impact on Commercial Insurance Premiums

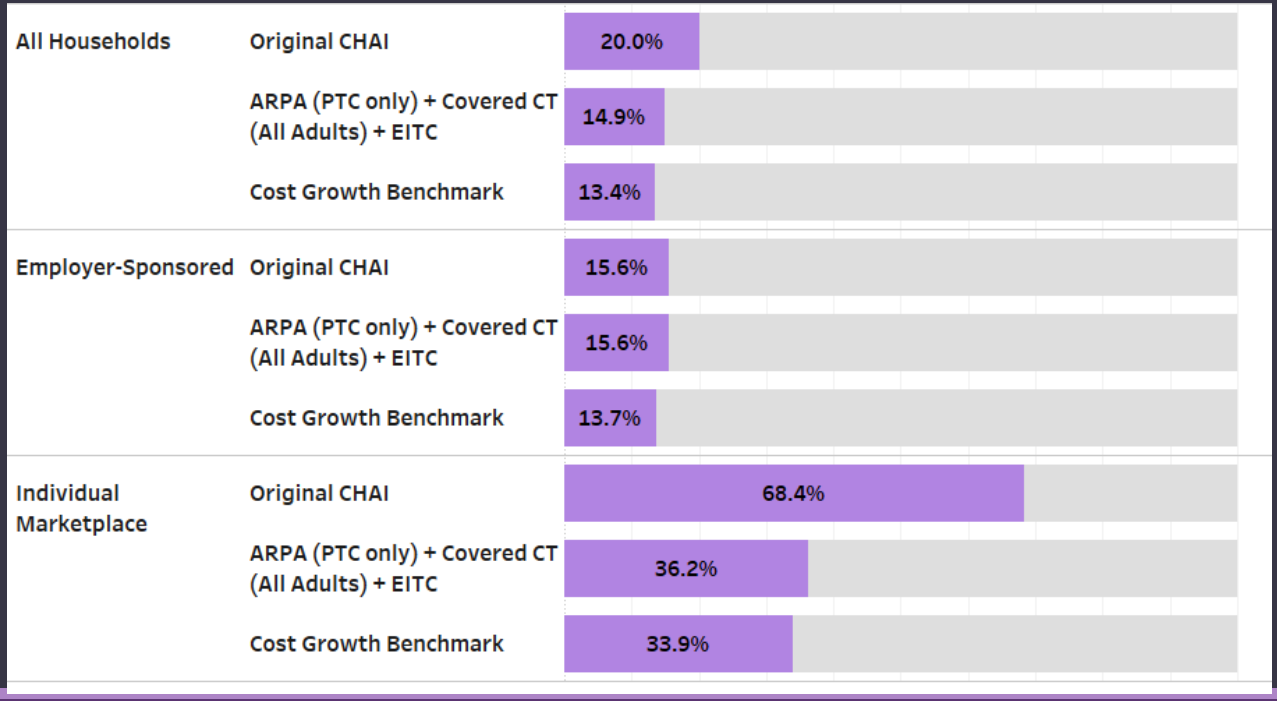
-5.2% individual market

-5.5% employer market

	Hospital Growth Rates			
	Actual 2018-2019 growth continues into the future		Growth meets annual cost growth benchmark	
Year	Outpatient	In-Patient	Outpatient	In-Patient
2021	6.3%	4.7%	3.4%	3.4%
2022	6.3%	4.7%	3.2%	3.2%
2023	6.3%	4.7%	2.9%	2.9%
2024	6.3%	4.7%	2.9%	2.9%
2025	6.3%	4.7%	2.9%	2.9%

Connecticut Cost growth Benchmark: Gross State Product (20%), Median Income (80%)

Percentage of Households with Healthcare Expenses Exceeding the *Connecticut Household Healthcare Spending Target*



Source: U.S. Census Bureau, 2019 ACS 1-Year Public Use Microdata Sample.

Policy Impact

- ***Reducing healthcare costs to the cost growth benchmark results in over 14,000* additional households with affordable healthcare according to the Connecticut Household Healthcare Spending Target.***

*Householders that are over 65 or with a work-limiting disability are not included in the analysis. Results would be even **higher** with these groups included.

	Original CHAI	Combined impact of all policy models*	Difference
Age of householder			
18-34	18.7%	12.7%	6.0%
35-49	19.3%	13.4%	6.0%
50-64	21.4%	13.7%	7.7%
Age of youngest child			
Age of youngest child less than 6	23.2%	18.7%	4.5%
Age of youngest child more than 6	23.5%	17.5%	6.0%
No children	18.0%	10.5%	7.5%
County			
Fairfield County	24.5%	16.4%	8.0%
Hartford County	15.0%	10.3%	4.7%
Litchfield County	17.9%	13.4%	4.5%
Middlesex County	18.4%	13.5%	4.9%
New Haven County	21.3%	13.2%	8.1%
New London County	20.5%	14.3%	6.2%
Tolland County	20.7%	12.2%	8.5%
Windham County	20.4%	13.5%	6.9%
Family type			
No children	18.0%	10.5%	7.5%
Married with children	19.3%	14.9%	4.3%
Single father	39.4%	31.2%	8.2%
Single mother	28.5%	21.3%	7.3%
Race/ethnicity of householder			
American Indian or Alaska Native	9.0%	4.4%	4.6%
Asian, Native Hawaiian, and Pacific Islander	19.9%	11.5%	8.4%
Black or African American	24.6%	18.7%	5.9%
Latinx	29.1%	21.5%	7.6%
White	17.1%	10.7%	6.4%

*ARPA Premium Tax Credit changes, expanded State EITC, Covered CT program, and the Cost Growth Benchmark model

Source: U.S. Census Bureau, 2019 ACS 1-Year Public Use Microdata Sample.

Detailed Impact Analysis

- **Estimating impacts across various demographics to better target interventions**

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Reducing Low-Value Care: Incorporating Health Equity Considerations

Beth Beaudin-Seiler, PhD
Senior Analyst,
Altarum

RESEARCH CONSORTIUM
for Health Care Value Assessment

REDUCING LOW-VALUE CARE: INCORPORATING HEALTH EQUITY CONSIDERATIONS

Beth M. Beaudin-Seiler, PhD
Senior Analyst, Applied Research and Analytics, Altarum

What is Low-Value Care

- Health care services that:
  - Provide little to no benefit to patients
  - Have the potential to cause harm to patients
  - Incur unnecessary costs to patients
  - Waste limited health care resources

Sources: Concept_Paper_No._10_-_Advancing_Health_Equity.pdf (hcvalueassessment.org) and https://www.hcvalueassessment.org/application/files/8416/2325/9472/Concept_Paper_No._10_-_Advancing_Health_Equity.pdf

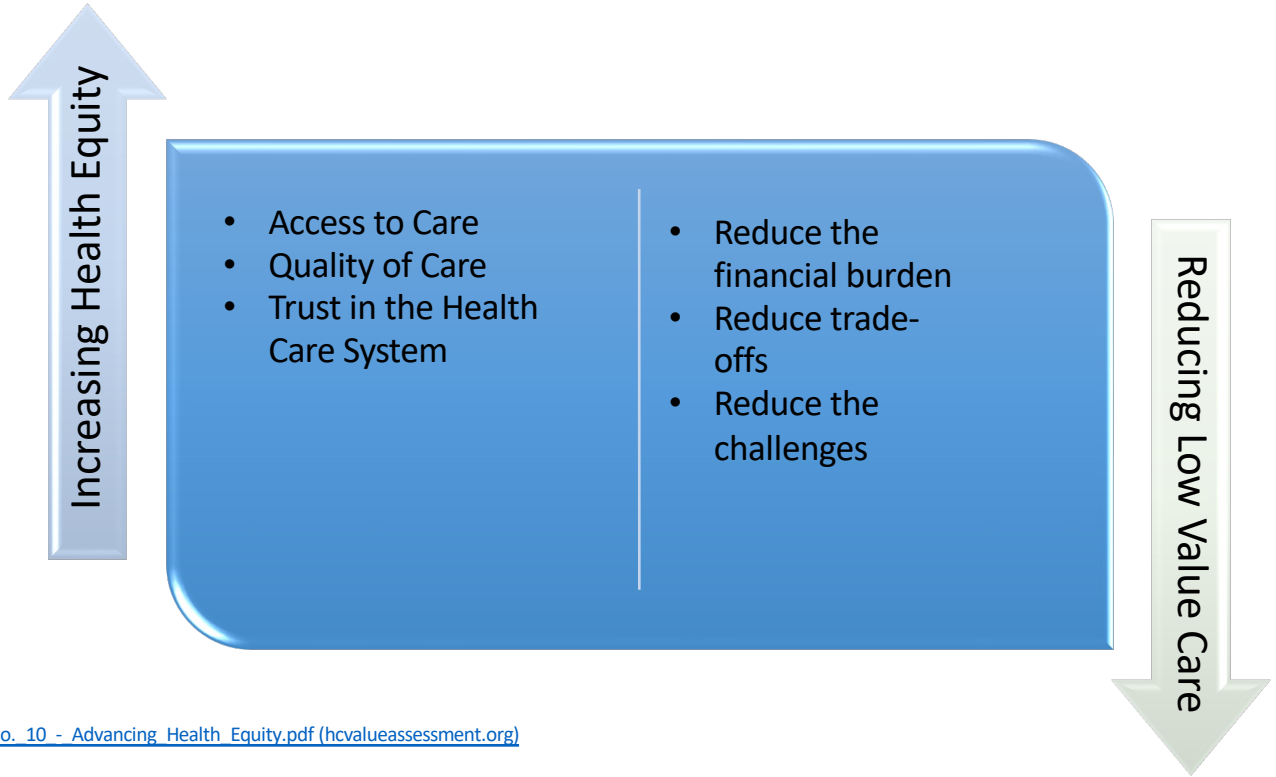
Rate of Low-Value Care in Disadvantaged Communities

Research suggests Black and Hispanic Medicare beneficiaries are more likely to receive certain low-value services than Whites

Research suggests low-value care spending was lower among non-Whites and lower-income patients among commercially insured

Sources: For Selected Services, Blacks And Hispanics More Likely To Receive Low-Value Care Than Whites - PubMed (nih.gov) and Low-Value Health Care Services in a Commercially Insured Population | Headache | JAMA Internal Medicine | JAMA Network

Factors to Consider



Source: Concept_Paper_No._10_-_Advancing_Health_Equity.pdf (hcvalueassessment.org)

How Do We Increase Health Equity Considerations

- Devote resources to examine how low-value care impacts equity in underserved communities
  - What are the financial burdens, the trade-offs and unintentional consequences
- Increase engagement with underserved communities to identify services that are low-value
  - Stop the erosion of trust
- Generate research that incorporates the unique perspectives and needs of underserved communities
  - Listen to the voice of the patient
- Promote policy change to remove incentives to provide low-value care
  - Value-based payment models

Source: https://www.hcvalueassessment.org/application/files/8416/2325/9472/Concept_Paper_No._10_-_Advancing_Health_Equity.pdf

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for Health Care Value Assessment

Thank you!!

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Extending Coverage to All Residents: Medicaid-like Coverage for Immigrants in IL

Stephani Becker, MPP
Associate Director of Healthcare Justice,
Shriver Center on Poverty Law

Affordable for Who? Steps for States to Include Equity in Affordability Policies:

Medicaid-like Coverage for Immigrants in IL

July 2022

Shriver Center on Poverty Law

ABOUT US

The Shriver Center on Poverty Law fights for economic and racial justice. Over our 50-year history, we have secured hundreds of victories with and for people living in poverty in Illinois and across the country. Today, we litigate, shape policy, and train and convene multi-state networks of lawyers, community leaders, and activists nationwide. Together, we are building a future where all people have equal dignity, respect, and power under the law. Join the fight at **povertylaw.org**.

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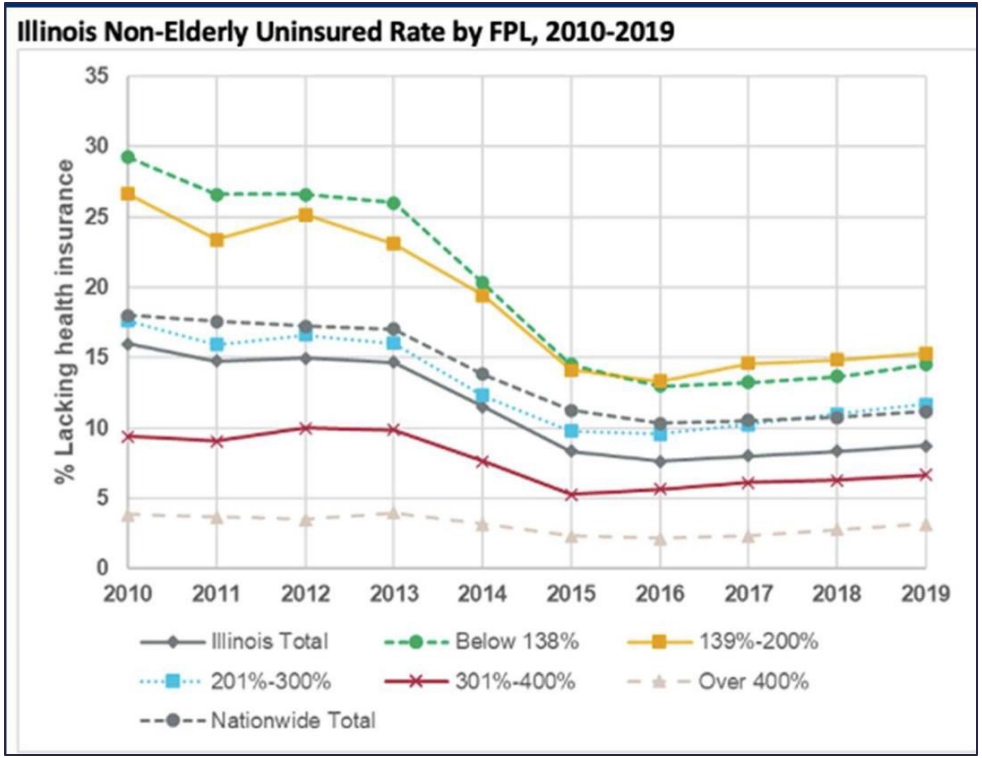
Uninsurance Rates Reveal Significant Health Disparities in IL

- Despite progress under the Affordable Care Act (ACA), coverage gains started to erode in 2016.
- The lowest income Illinois residents have the highest uninsured rates
- Black and Hispanic or Latino Illinoisans are more likely to be uninsured, with 10.6% of Black residents uninsured and 16.3% of Hispanic or Latino residents uninsured in 2019.



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Source: HFS/DOI Study

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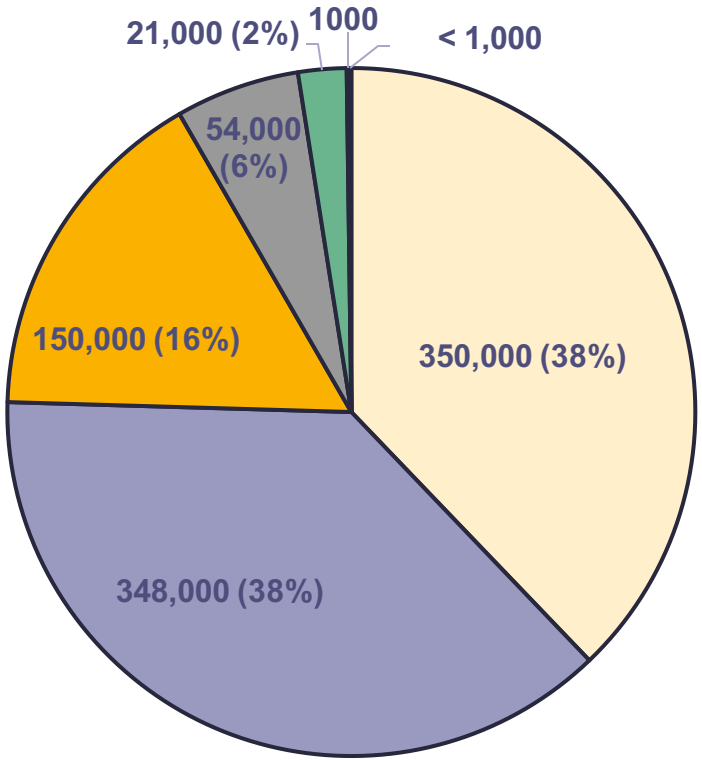
People of Color Comprise a Disproportionate Share of the 925,000 Uninsured in Illinois Estimated for 2022



- White
- Hispanic
- Black or African American
- Asian
- Other
- American Indian and Alaskan Native
- Native Hawaiian

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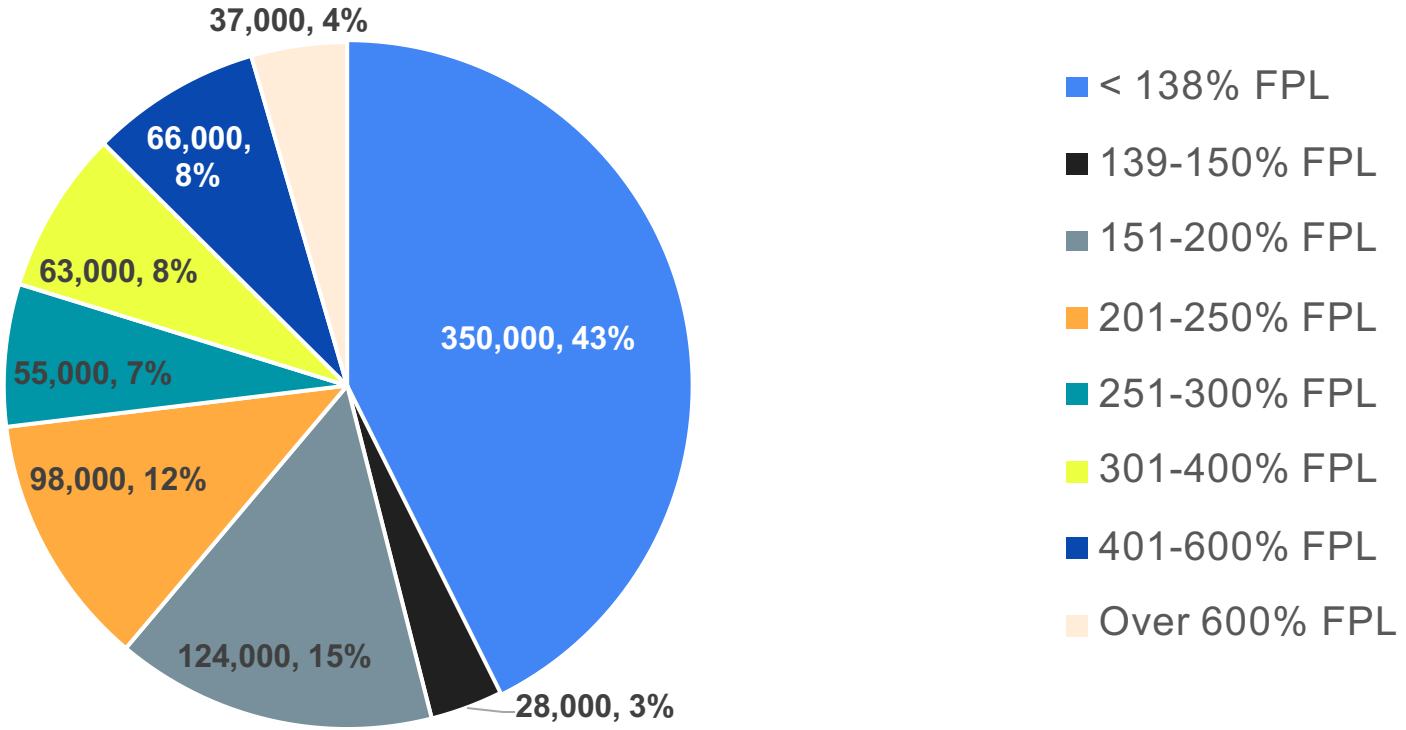
Source: HFS/DOI Study, Appendix A-3 (7.1% Unemployment)

Low Income People Comprise More than Six out of Ten Uninsured



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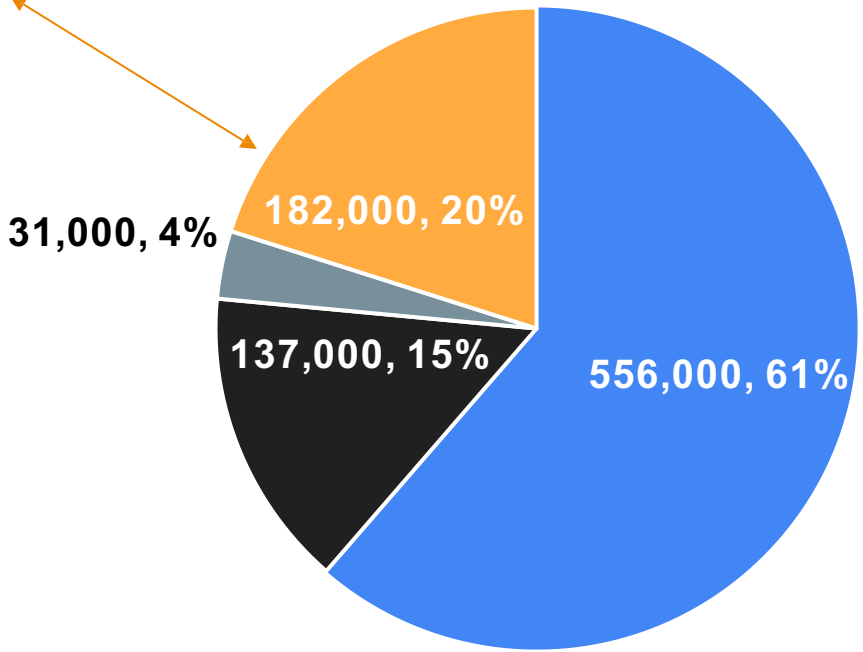
Source: HFS/DOI Study, Appendix A-1b (7.1% Unemployment)

For economic and racial justice

Almost 4 out of 10 Uninsured are Non-Citizens

Undocumented immigrants are excluded from Federal Medicaid (unless pregnant) and ACA coverage pathways



- Citizen
- Immigrant 5+ years
- Immigrant < 5 years
- Undocumented Immigrants

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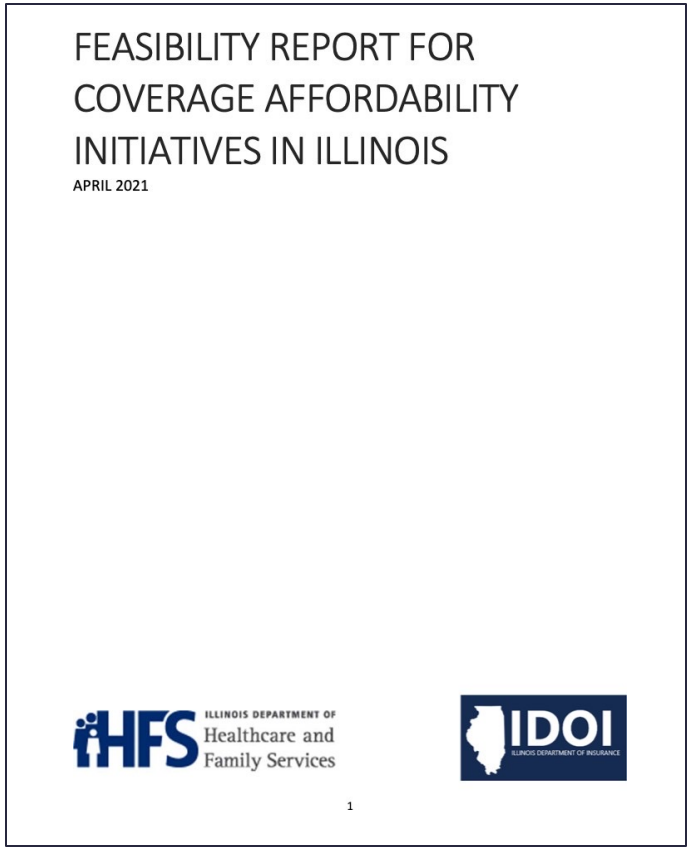
Source: HFS/DOI Study, Appendix A-5 (7.1% Unemployment)



The April 2021 ***Feasibility Report for Coverage Affordability Initiatives in Illinois*** serves as a foundational blueprint for the state's next Steps in Future Changes to Illinois Healthcare Landscape

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Six Policy Options Discussed in the *HFS/DOI Affordability/ Feasibility Study*

1. **Basic Health Program**, creates (with Federal permission and funding) a Medicaid-like plan for residents up to 200% FPL; undocumented are not eligible.
2. **State-Funded Premium and Cost-Sharing Subsidies** make plans more affordable; can be offered on and/or off the ACA marketplace.
3. **Public Option** is a government-designed plan offered on a State Based Marketplace and/or off-marketplace to increase competition and lower unsubsidized premium costs.
4. **Medicaid buy-in (MBI)** creates an on-ramp to add people to existing Medicaid program; various designs: 1) targeted to individuals locked out of Marketplace due to immigration status or ACA employer coverage "family glitch" or 2) available to any Illinois residents;
5. **Transition to a State-Based Marketplace (SBM)** would create a state-run eligibility and enrollment, consumer outreach and assistance and plan management functions (instead of using the current federal platform).
6. **State Supported Marketing and Outreach** would create a robust investment in community-based and centered ***enrollment*** assistance for ACA coverage and Medicaid.

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Centering Illinois Residents Who Have Been Historically and Systemically Excluded from Coverage Pathways

- We focus on the policy options that yield the **largest reduction in uninsured for low-income populations who identify as Black, Hispanic, and/or have an undocumented immigration status.**
- Given the urgency of the needs of these systemically-excluded populations, we also prioritize policy options that could be implemented:
  - in the relative short-term,
  - leveraging existing state resources (relative to the other policy options) and
  - which have the largest impact on reducing the uninsured.

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Our Top Three Policy Recommendations:

1. State-Funded Marketing/ Outreach (and Enrollment Assistance)
2. Medicaid buy-in
3. State-Funded Tax Credits and Cost Sharing Subsidies

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Medicaid Buy-in Has Largest Impact on *Uninsured Hispanic/Latino Population*

Policy Options	% Reduction in Uninsured for Hispanic/Latino Population	Estimated Enrollees Previously Uninsured
Medicaid buy-in (Enhanced)	23.4%	80,000
Medicaid buy-in (Basic)	13.5%	46,000
Medicaid buy-in (Targeted)	12.8%	44,000
State Funded Premium Tax Credits/Cost Sharing Reductions (HEC Proposal)	8.6%	29,000
Basic Health Program (Zero Premium Model)	6.7%	23,000
State Funded Premium Tax Credits/Cost Sharing Reductions (MA Proposal)	4.7%	16,000

Reminder: The Policy Option That Shows *Most Potential* for Reducing Largest Number of Uninsured Hispanic/Latino residents is **State-Funded Outreach & Marketing (and Enrollment)**: 187,000 are eligible but unenrolled

Medicaid Buy-in Has Largest Impact for *Undocumented Immigrants*

Policy Options	% Reduction in Uninsured for Uncocumented Immigrants	Estimated Enrollees Previously Uninsured
Medicaid buy-in (Broad-Enhanced)	39.2%	83,000
Medicaid buy-in (Broad-Basic)	31.8%	60,000
Medicaid buy-in (Targeted)	29.3%	53,000

Reminder of the Total Number: 182,000 Illinois residents are undocumented and uninsured.

Reminder of the Exclusion of Major Health Coverage Pathways: Currently, people who are undocumented are ineligible for ACA marketplace coverage and from Federal Medicaid coverage (unless pregnant). Undocumented people are eligible for specific exclusively-state-funded Medicaid-like coverage pathways, such as All Kids (at or < 318% FPL) (for ages 0 through age 18), Moms & Babies (at or < 210% FPL) (if pregnant or post-partum for 60 days after pregnancy ends, or age 65 and older (at or < 100% FPL)).

By May of 2022: state-funded Medicaid-like coverage (essentially a MBI) will be available to people aged 55 through age 64 who are undocumented.

Source: HFS/DOI Report Appendix B-4

Targeted Medicaid Buy-in: Cover the adults included in the Healthy Illinois Campaign Proposal

- The Healthy Illinois Campaign is a coalition dedicated to creating a pathway to affordable, comprehensive health coverage for low-income immigrants who have been excluded from traditional federal Medicaid: LPRs < 5 years and undocumented adults.
- An estimated 182,000 Illinois residents are undocumented and uninsured.
- We recommend that Illinois create a Medicaid Buy-In program for people currently without a meaningful path to coverage, starting with a phased-in coverage plan to cover the most critical population--undocumented adults at the < 138% FPL

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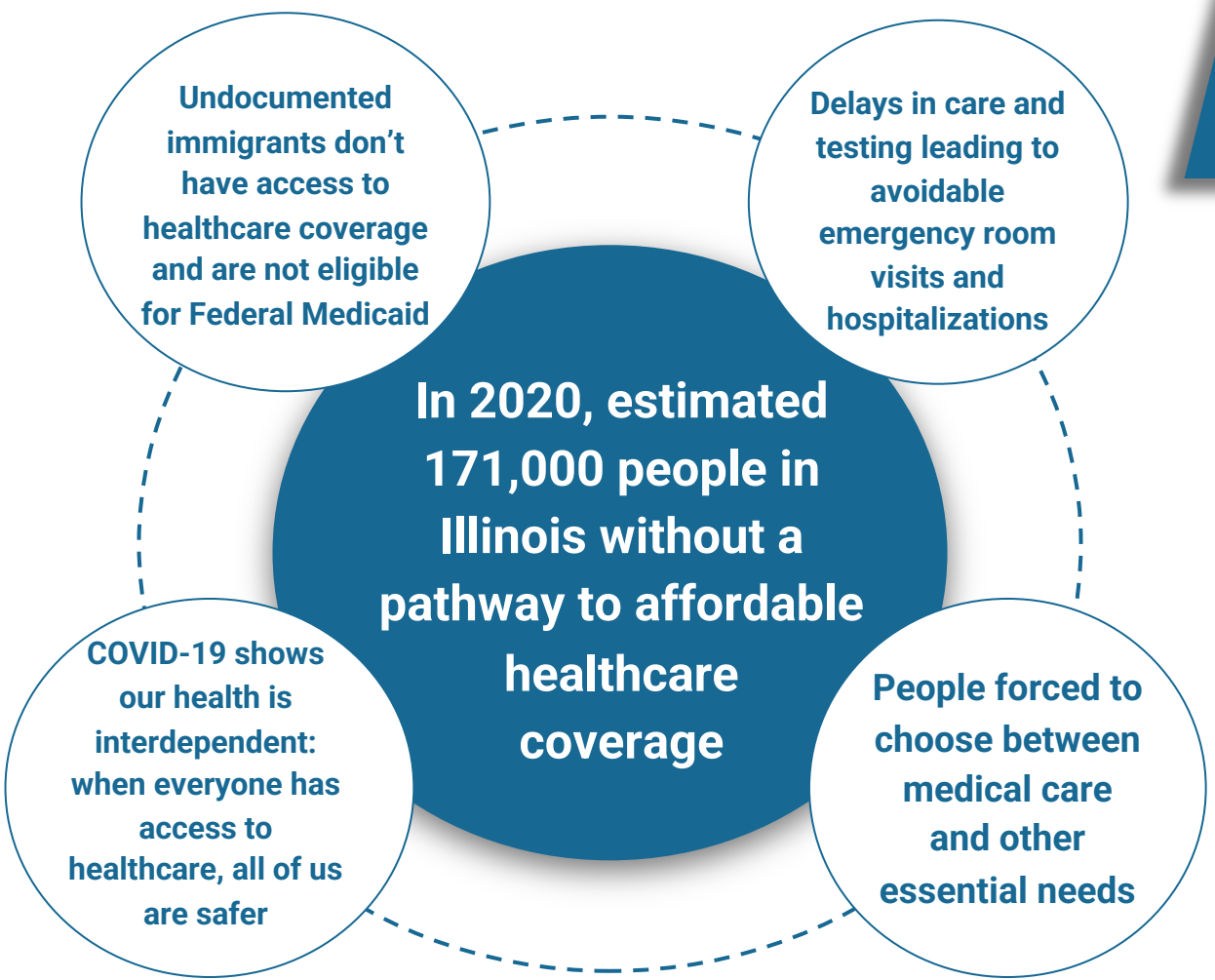
For economic and racial justice

Campaign for Healthcare Coverage for All


SALUD MEDICA
PARA TODXS
¡COBERTURA DE SALUD PARA TODXS! HEALTHY ILLINOIS
HEALTHCARE FOR ALL! HEALTHY ILLINOIS
Acceso a Salud Medica Para Todxs! #LSNA
Healthcare for ALL! #LSNA

The Issue



HEALTHY ILLINOIS

Healthy Illinois Campaign

➔ Founded in 2014

➔ Statewide coalition of 70+ organizations
- ◆ Community-based organizations
- ◆ Healthcare providers and associations
- ◆ County government

➔ Decided to campaign for state-funded health insurance (like Medicaid)

HEALTHY ILLINOIS

Campaign Strategy

- ➔ Build a strong coalition (grassroots, policy advocates, healthcare leaders)
- ➔ Build power through grassroots organizing
- ➔ Build strong relationships with legislators
- ➔ Work with legislative champions to file bill for Health Coverage for All
- ➔ Advocate to cover as many people as possible starting with the most vulnerable by moving from oldest to youngest

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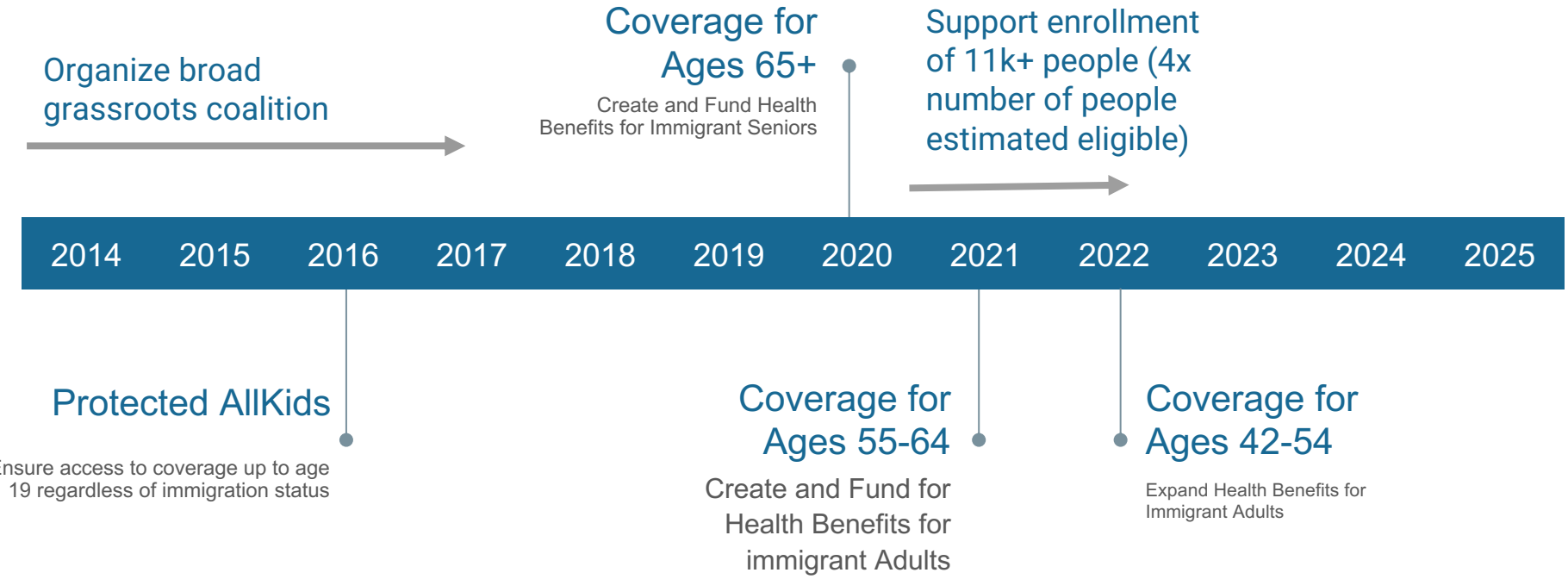
Campaign Tactics

Victories



HEALTHY ILLINOIS

Healthcare Coverage for Immigrants Age 42+

- ➔ Open NOW
- ➔ To qualify you must:
  - Live in Illinois
  - Be 42 years old or older, AND
    - An undocumented immigrant OR
    - A green card holder or legal permanent resident in the U.S. who has had that immigration status for less than five years OR
    - Have another immigration status that makes you ineligible for federal Medicaid; AND
  - For ages 65+: Have income under 100% Federal Poverty Level (FPL) which is $1,133 per month for one person
  - For ages 42-64: Have Income under 138% Federal Poverty Level (FPL) which is $1,563 per month for one person.

HEALTHY ILLINOIS

2022 Federal Poverty Guidelines

Household Size	Monthly Income - 100% Ages 65+	Monthly Income - 138% Ages 42-64
1	$1,133	$1,563
2	$1,526	$2,106
3	$1,919	$2,648
4	$2,313	$3,191
5	$2,706	$3,734
6	$3,099	$4,277
7	$3,493	$4,820
8	$3,886	$5,362

Note: For people ages 65+ with incomes over the 100% FPL, they may still qualify through spend-down

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Healthcare Coverage for Immigrants Age 42+

- ➔ Provides comprehensive healthcare coverage with $0 premiums and $0 co-payments
- ➔ Covered services include:
  - ◆ doctor and hospital care,
  - ◆ lab tests,
  - ◆ rehabilitative services such as physical and occupational therapy,
  - ◆ mental health and substance use disorder services,
  - ◆ dental and vision services, and
  - ◆ prescription drugs.
- ➔ Nursing facility services and home and community-based services are not covered.
- ➔ Program includes 3 months backdated coverage from application date.

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How To Apply

- ➔ Apply online at www.abe.illinois.gov OR
- ➔ Call (800) 843-6154, Fax, Mail or In Person at DHS FCRC Office
- ➔ If you need help applying:
  - ◆ Find a local health center: www.findahealthcenter.hrsa.gov OR
  - ◆ Call the ICIRR Family Support Hotline: 1-855-HELP-MY-FAMILY / 1-855-435-7693 OR
  - ◆ Make an appointment with a free enrollment assister, visit www.widget.getcoveredamerica.org/get-covered-illinois

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Common Questions

- ➔ Enrolling in Health Coverage does NOT put someone at risk of a public charge finding.
- ➔ If an application is denied, there is an appeal process. You can do this yourself or a navigator can help you.
- ➔ After a person receives this coverage, many providers accept it! You can find a provider at a local health center: www.findahealthcenter.hrsa.gov OR if you need help finding a doctor that accepts Medicaid, you can call the numbers on your medical card DHS 1-800-843-6154 or HFS 1-800-226-0768

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Examples

1. A 67-year-old undocumented woman has no income. Her children support her financially. Does she qualify?
2. A 44-year-old undocumented woman has 3 U.S. Citizen children. She earns $1,600/month. Does she qualify?
3. A 27-year-old man has DACA. He is not working currently and does not have a source of income. Does he qualify?
4. A 56-year-old man has had a green card for the last 10 years. Does he qualify?

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Examples

	Eligible for Health Benefits for Immigrants Coverage?	More information
Undocumented 67-year-old	Yes, eligible for Health Benefits for Immigrant Seniors	She does not need information about her children's income or taxes. She is considered a household of 1 and only her income counts towards eligibility
Undocumented 44-year-old	Yes, eligible for Health Benefits for Immigrant Adults	She will qualify for Health Benefits for Immigrant Adults, should start gathering documents now and make an appointment
DACAmented 27-year-old	No	No, because of his age but could qualify for emergency medicaid if he has an urgent medical need
56-year-old lawful permanent resident	No because eligible for ACA Adult federal Medicaid program (if otherwise eligible)	No, he would quality for federal Medicaid (assuming income eligibility)

What's Next

Expansion

- Expand Health Benefits for Immigrant Adults for 19-41 year olds
- Include long term care and home and community based services in coverage package

Full Implementation

- Make sure everyone eligible has the information they need to apply

Healthy Illinois Resources for Enrollment Assisters

Resources for outreach are in this shared folder and below:

- Social media posts to announce program - in English, Spanish
- Eligibility one-pager flyers - in English, Spanish, Chinese, Arabic
- Public charge one-pager flyers - in English, Spanish
- Detailed FAQs (aimed at advocates more than general public) -in English, Spanish
- Train-the-trainer presentations - in English, Spanish

Enrollment So Far

Health Benefits for Immigrant Seniors – Age 65+

- 12,000 enrolled since December 2020

Health Benefits for Immigrant Adults – Age 42-64

- 3,500 enrolled since February 2022 (Age 55 – 64)
- Adults, age 42-54 have begun to enroll as of July 1!

申请方法：

1. 访问 https://abe.illinois.gov/
2. 拨打电话： (800) 843-6154
3. 如需注册帮助，请拨打 ICIRR 家庭支持热线：1-855-HELP-MY-FAMILY / 1-855-435-7693

HEALTHY ILLINOIS

- 更新于 2022 年 4 月 22 日

Get in touch!

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Shriver Center on Poverty Law

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Reducing Out-of-Pocket Costs: Affordability and Health Equity Initiatives in the Massachusetts Marketplace

Audrey Gasteier, MS
Deputy Executive Director,
Chief of Policy & Strategy,
Massachusetts Health Connector

MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

Affordability and Health Equity Initiatives in the Massachusetts Marketplace

AUDREY MORSE GASTEIER
Deputy Executive Director
Chief of Policy & Strategy

Wednesday, July 13, 2022

Health Connector Overview

The Health Connector is the state's official ACA health insurance marketplace, offering Massachusetts residents and small businesses a way to compare, understand, and enroll in high-value health coverage options and access financial assistance to lower the cost of coverage.

- The Health Connector was created in 2006 as part of a set of bipartisan state health reforms aimed at increasing access to health insurance in Massachusetts, and later adapted to incorporate the federal health reforms of the Affordable Care Act (ACA)
- The Health Connector serves three primary populations:
  - Low-to-moderate income residents via its ConnectorCare Program (<300% FPL)
  - Middle and higher-income federally subsidized unsubsidized nongroup enrollees (>300% FPL)
  - Small employers (<50 employees)
- The Health Connector also plays an active policy role in continued implementation of the Affordable Care Act in Massachusetts, as well as our enduring state-level health reform framework, working with the Massachusetts Division of Insurance to support a robust "merged market" for individuals and small groups, setting policy for the state's individual mandate, and conducting broad outreach and public engagement about health coverage

Health Connector's Role in Massachusetts Reform

Massachusetts' success in promoting coverage and affordability for residents rests in part on unique programs and policies administered by the Health Connector:

- Our unique "wrap program," ConnectorCare, which uses state-financed subsidies on top of federal ACA subsidies
- Active market engagement for unsubsidized individuals and small groups
- Our state individual mandate
- Substantial outreach to the general population and targeted communities about health coverage and how to get and stay insured

Centering Health Equity in Seal of Approval 2023

Health Connector staff continue to take steps to center health equity and racial equity in its work, including the Seal of Approval process (our plan certification process for on-exchange plans).

Health equity problem	Targeted Seal of Approval response
• **Health disparities in health status and chronic conditions** by race and ethnic group	• **Zeroing out cost sharing** in ConnectorCare for high-value medications needed for treatment of four select chronic conditions disproportionately affecting communities of color: ➢ Diabetes ➢ Asthma ➢ Coronary artery disease ➢ Hypertension
• Disparities in **foregone care due to cost** reported by communities of color	
• **Inequities in medical debt** by race and ethnic groups	• **Eliminating cost sharing for PCP sick visits** in ConnectorCare program to ease access to care setting where many chronic conditions are managed
• Inequities among CCA enrollees in ability to access **full range of carrier and provider choices based on income/subsidy eligibility**	• Steps in 2023 Seal of Approval to **require full carrier participation** in ConnectorCare starting in 2024
• Disparities by race and ethnic group and LGBTQ+ status in **mental health disorder incidence** and/or **access to behavioral health care**	• Encouragement of carriers **to incorporate recovery coaches and certified peer specialists** into members' treatment • Will require carriers **to contract with Community Behavioral Health Centers** for earliest plan year in which they are implemented
• Inconsistent or **unclear access to gender affirming care** and/or **care for transgender residents**	• Requiring carriers to **enhance gender-affirming care case management expertise** and work toward **establishment of gender-affirming care advisory councils**

New Member Benefits to Promote Value, Equity, and Access

As a primary component of the Health Connector's equity work, the 2023 SOA proposes to alleviate cost-sharing burdens with Value-based Insurance Design (VBID) initiatives particularly in the ConnectorCare program, with a focus on disparate health outcomes experienced by people of color.

	VBID Area of Focus	Description
All CCA members	Recovery Coaches and Certified Peer Specialists	Encourage coverage for these EHS BH Roadmap services, with $0 cost sharing where covered
ConnectorCare members	Reduced Cost Sharing for Tier 1 Insulin	Provide $0 cost sharing for Tier 1 insulin in ConnectorCare
	Reductions in ConnectorCare Cost Sharing for PCP Sick Visits and Mental Health Outpatient Visits	Reduce PCP sick visit copays to $0, which helps reduce care management access barriers for members with chronic conditions; mirror $0 for mental health outpatient visits for parity
	Reductions in ConnectorCare Cost Sharing for Certain Conditions	Provide $0 cost sharing for commonly used medications for diabetes (non-insulin), coronary artery disease, hypertension, and asthma

Additional Coverage Priorities

The Health Connector proposes to use the 2023 SOA, informed by SOA RFI responses, to take steps to improve coverage in other areas of priority such as maternal health and gender-affirming care.

- Health Connector staff plan to continue to engage in statewide doula coverage efforts and plan to ask carriers to report efforts to close maternal health outcomes disparities based on race in their SOA responses
- The Health Connector received robust and thoughtful RFI responses from the transgender health advocacy community that informed 2023 Seal of Approval recommendations
  - The Health Connector recommends requiring carriers to enhance gender-affirming care case management expertise and work toward establishment of gender-affirming care advisory councils
  - The Health Connector plans to ask carriers information regarding how they ensure members are treated in a respectful, nondiscriminatory manner in their SOA responses
- Behavioral health advocacy groups and providers suggested the Health Connector review QHPs for mental health parity
  - Health Connector staff will explore ways to enhance oversight of insurance plan design regarding mental health parity
- The Health Connector will engage with these communities and organizations and the Division of Insurance to identify ways the Seal of Approval can support ongoing policy efforts in the future

ConnectorCare Participation

Given the equity issues and program fragility caused by partial carrier participation, the proposed 2023 SOA will lay the groundwork for required ConnectorCare program participation from all carriers in Plan Year 2024.

- Staff concluded that partial carrier participation in ConnectorCare is an approach that no longer serves in the best interests of the program and Health Connector members
- ConnectorCare comprises roughly 60 percent of the individual market, yet members do not currently have access to the full range of market choices (carriers and providers), contravening the spirit of the exchange model and the ACA

- Addressing this dynamic is important to the Health Connector from an equity perspective in light of the fact that the ConnectorCare program has a greater share of enrollees of color and immigrants than the rest of the individual market

- Expanded participation will:
  - **Make the program more equitable for members** and better reflect the Health Connector's commitment to **connecting the public it serves to the full market**, and avoid operating a "two tier system" based on income
  - **Increase statewide access, competition, and stability** in the program by **protecting against the risk of members having minimal carrier options** or "bare counties." (Thousands of ConnectorCare members currently have a choice of only 1 or 2 carriers in their region, leaving members with limited choices, and the program vulnerable to market shifts.)

Focus on Reducing Administrative Burdens as a Health Equity Issue

Administrative burdens for entering and remaining in coverage have emerged as a key policy and equity focus for the Health Connector in our work to keep people in coverage.

Key initiatives underway:

1. Marketplace & state tax filing partnership to ease access to Marketplace enrollment ("Simple Sign Up")

2. Functionality being added to our state's Marketplace/Medicaid integrated eligibility and enrollment system to facilitate automatic enrollment for people eligible for $0 Marketplace coverage

3. Planning an equity-oriented "sludge audit" to surface administrative burdens and member "pain points" that can interfere with the onramp to Marketplace coverage or the ability to stay covered

Questions?

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Appendix

Value Initiatives: Mental Health and Substance Use Disorder (SUD)

Health Connector staff, in support of EHS's Behavioral Health Roadmap and in line with RFI respondents' suggestions, recommend coverage and cost-sharing improvements for behavioral health and SUD.

- National data indicate that racial and ethnic minorities have less access to behavioral health care and medication than other groups, and when they are able to access care, it is of lower quality. National data also indicate a greater incidence of mental health and substance use disorders among LGBTQ+ populations
- The Massachusetts Department of Public Health (DPH) reported that opioid-related overdose deaths increased for Hispanic and Black non-Hispanic communities between 2018 and 2020, a trend expected to continue in 2021
- A 2021 NIH study found that Non-Hispanic Black individuals in four U.S. states experienced a 38 percent increase in the rate of opioid overdose deaths from 2018 to 2019, while the rates for other race and ethnicity groups held steady or decreased
- The 2023 SOA will encourage carriers to incorporate recovery coaches and certified peer specialists into members' treatment, ensuring they are included in all instances in which they are part of an organization or program providing recovery services
- Health Connector staff recommend requiring carriers to contract with Community Behavioral Health Centers (CBHCs), in line with the EHS BH Roadmap, for the earliest plan year in which they are implemented
- Additionally, the Health Connector will continue to require ConnectorCare carriers to provide key treatments for opioid use disorder at zero-dollar cost sharing for ConnectorCare enrollees, first introduced in Plan Year 2017

Sources: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5895177/; https://www.nih.gov/news-events/news-releases/disparities-opioid-overdose-deaths-continue-worsen-black-people-study-suggests; https://www.mass.gov/lists/current-opioid-statistics; https://www.jaacap.org/article/S0890-8567(12)00287-0/fulltext; LGBTQ+ Behavioral Health Equity Center of Excellence | SAMHSA

Value Initiatives: Diabetes and Hypertension

Health Connector staff intend to reduce cost-sharing in the ConnectorCare program for commonly used medications for diabetes, hypertension, coronary artery disease, and asthma, as well as PCP 'sick visits' as diabetes, for example, is chiefly managed in a primary care setting with occasional specialist support.

- Diabetes
  - In 2015, it was estimated that 8.9 percent of Massachusetts residents had diabetes, with higher proportions of disease among Black and Hispanic residents
  - Black residents also have twice the rate of diabetes-related mortality and four times as many diabetes-related emergency room visits compared to White non-Hispanic residents
  - Building on the Health Connector's existing initiative requiring insulins at Tier 1 cost-sharing, staff propose providing Tier 1 insulin at $0 cost sharing in ConnectorCare
  - In addition, Health Connector staff propose $0 cost-sharing in ConnectorCare for two highly effective non-insulin medications for patients with Type 2 Diabetes
- Hypertension
  - By age 55, 75 percent of both Black men and women have already developed hypertension, compared to 55 percent of white men and 40 percent of white women
  - Health Connector staff propose $0 cost-sharing for ConnectorCare members for three first-line generic medications used for treating hypertension

Sources: https://www.mass.gov/service-details/massachusetts-diabetes-data#:~:text=Diabetes%20prevalence%20in%20Massachusetts%20has%20been%20steadily%20increasing.,than%20double%20the%20amount%20in%20just%2022%20years; https://www.diabetes.org/diabetes/complications; https://www.ahajournals.org/doi/10.1161/JAHA.117.007988

Value Initiatives: Coronary Artery Disease and Asthma

- Coronary Artery Disease
  - Coronary Artery Disease and cardiovascular disease in general account for nearly 40 percent of the disparity in life expectancy between blacks and whites
  - Health Connector staff propose $0 cost-sharing for ConnectorCare members for two generic medications, one of which is one of the most widely prescribed medications in the United States
- Asthma
  - Black, Hispanic, and American Indian/Alaska Native communities have the highest rates of asthma-related disease, death, and hospitalizations
  - Health Connector staff propose $0 cost-sharing for ConnectorCare members for two generic inhaled medications, one brand inhaler, and one generic oral medication, to treat mild to severe asthma

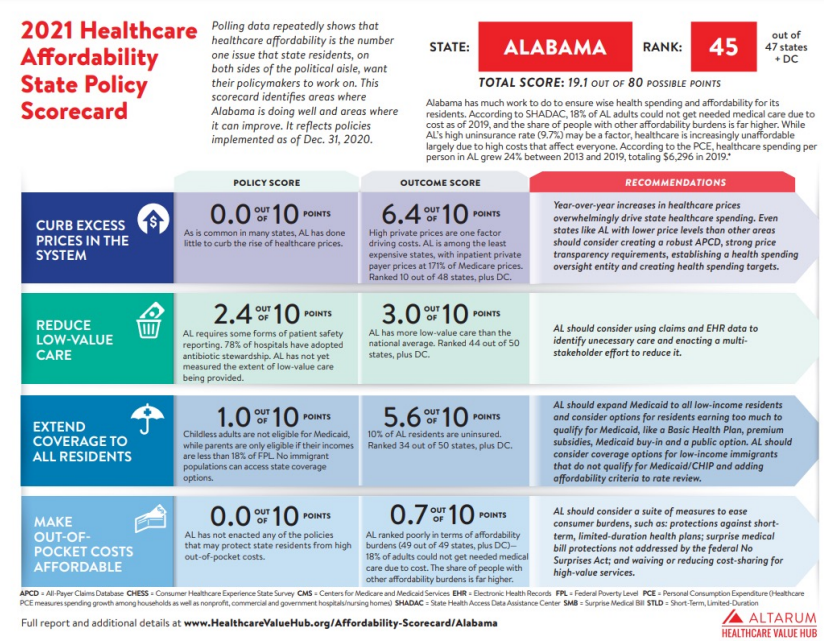
Sources: https://www.heart.org/-/media/Files/About-Us/Policy-Research/Fact-Sheets/FACTS-CVD-and-Health-Equity.pdf; https://www.aafa.org/media/2743/asthma-disparities-in-america-burden-on-racial-ethnic-minorities.pdf

Questions for our Speakers?

- Use the chat box or to unmute, press *6
- Please do not put us on hold!

Resources from the Hub

Healthcare Affordability State Policy Scorecard



2021 Healthcare Affordability State Policy Scorecard

Polling data repeatedly shows that healthcare affordability is the number one issue that state residents, on both sides of the political aisle, want their policymakers to work on. This scorecard identifies areas where Alabama is doing well and areas where it can improve. It reflects policies implemented as of Dec. 31, 2020.

STATE: **ALABAMA** RANK: **45** out of 47 states + DC

TOTAL SCORE: 19.1 OUT OF 80 POSSIBLE POINTS

Alabama has much work to do to ensure wise health spending and affordability for its residents. According to SHADAC, 18% of AL adults could not get needed medical care due to cost as of 2019, and the share of people with other affordability burdens is far higher. While AL's high uninsurance rate (9.7%) may be a factor, healthcare is increasingly unaffordable largely due to high costs that affect everyone. According to the PCE, healthcare spending per person in AL grew 24% between 2013 and 2019, totaling $6,296 in 2019.*

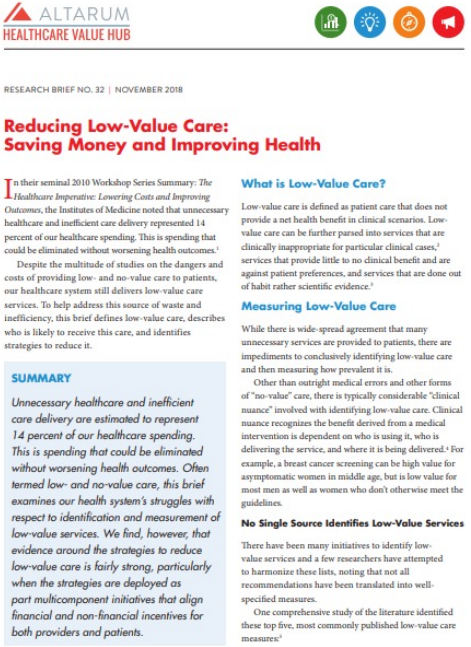
	POLICY SCORE	OUTCOME SCORE	RECOMMENDATIONS
CURB EXCESS PRICES IN THE SYSTEM	0.0 OUT OF 10 POINTS As is common in many states, AL has done little to curb the rise of healthcare prices.	6.4 OUT OF 10 POINTS High private prices are one factor driving costs. AL is among the least expensive states, with inpatient private payer prices at 171% of Medicare prices. Ranked 10 out of 48 states, plus DC.	*Year-over-year increases in healthcare prices overwhelmingly drive state healthcare spending. Even states like AL with lower price levels than other areas should consider creating a robust APCD, strong price transparency requirements, establishing a health spending oversight entity and creating health spending targets.*
REDUCE LOW-VALUE CARE	2.4 OUT OF 10 POINTS AL requires some forms of patient safety reporting. 78% of hospitals have adopted antibiotic stewardship. AL has not yet measured the extent of low-value care being provided.	3.0 OUT OF 10 POINTS AL has more low-value care than the national average. Ranked 44 out of 50 states, plus DC.	*AL should consider using claims and EHR data to identify unecessary care and enacting a multi-stakeholder effort to reduce it.*
EXTEND COVERAGE TO ALL RESIDENTS	1.0 OUT OF 10 POINTS Childless adults are not eligible for Medicaid, while parents are only eligible if their incomes are less than 18% of FPL. No immigrant populations can access state coverage options.	5.6 OUT OF 10 POINTS 10% of AL residents are uninsured. Ranked 34 out of 50 states, plus DC.	*AL should expand Medicaid to all low-income residents and consider options for residents earning too much to qualify for Medicaid, like a Basic Health Plan, premium subsidies, Medicaid buy-in and a public option. AL should consider coverage options for low-income immigrants that do not qualify for Medicaid/CHIP and adding affordability criteria to rate review.*
MAKE OUT-OF-POCKET COSTS AFFORDABLE	0.0 OUT OF 10 POINTS AL has not enacted any of the policies that may protect state residents from high out-of-pocket costs.	0.7 OUT OF 10 POINTS AL ranked poorly in terms of affordability burdens (49 out of 49 states, plus DC)—18% of adults could not get needed medical care due to cost. The share of people with other affordability burdens is far higher.	*AL should consider a suite of measures to ease consumer burdens, such as: protections against short-term, limited-duration health plans; surprise medical bill protections not addressed by the federal No Surprises Act; and waiving or reducing cost-sharing for high-value services.*

APCD = All-Payer Claims Database **CHESS** = Consumer Healthcare Experience State Survey **CMS** = Centers for Medicare and Medicaid Services **EHR** = Electronic Health Records **FPL** = Federal Poverty Level **PCE** = Personal Consumption Expenditure (Healthcare PCE measures spending growth among households as well as nonprofit, commercial and government hospitals/nursing homes) **SHADAC** = State Health Access Data Assistance Center **SMB** = Surprise Medical Bill **STLD** = Short-Term, Limited-Duration

Full report and additional details at **www.HealthcareValueHub.org/Affordability-Scorecard/Alabama**

ALTARUM HEALTHCARE VALUE HUB

Reports and other resources on many topics within the affordability domains!



ALTARUM HEALTHCARE VALUE HUB

RESEARCH BRIEF NO. 32 | NOVEMBER 2018

Reducing Low-Value Care: Saving Money and Improving Health

In their seminal 2010 Workshop Series Summary: *The Healthcare Imperative: Lowering Costs and Improving Outcomes*, the Institutes of Medicine noted that unnecessary healthcare and inefficient care delivery represented 14 percent of our healthcare spending. This is spending that could be eliminated without worsening health outcomes.[1]

Despite the multitude of studies on the dangers and costs of providing low- and no-value care to patients, our healthcare system still delivers low-value care services. To help address this source of waste and inefficiency, this brief defines low-value care, describes who is likely to receive this care, and identifies strategies to reduce it.

SUMMARY

Unnecessary healthcare and inefficient care delivery are estimated to represent 14 percent of our healthcare spending. This is spending that could be eliminated without worsening health outcomes. Often termed low- and no-value care, this brief examines our health system's struggles with respect to identification and measurement of low-value services. We find, however, that evidence around the strategies to reduce low-value care is fairly strong, particularly when the strategies are deployed as part multicomponent initiatives that align financial and non-financial incentives for both providers and patients.

What is Low-Value Care?

Low-value care is defined as patient care that does not provide a net health benefit in clinical scenarios. Low-value care can be further parsed into services that are clinically inappropriate for particular clinical cases,[2] services that provide little to no clinical benefit and are against patient preferences, and services that are done out of habit rather scientific evidence.[3]

Measuring Low-Value Care

While there is wide-spread agreement that many unnecessary services are provided to patients, there are impediments to conclusively identifying low-value care and then measuring how prevalent it is.

Other than outright medical errors and other forms of "no-value" care, there is typically considerable "clinical nuance" involved with identifying low-value care. Clinical nuance recognizes the benefit derived from a medical intervention is dependent on who is using it, who is delivering the service, and where it is being delivered.[4] For example, a breast cancer screening can be high value for asymptomatic women in middle age, but is low value for most men as well as women who don't otherwise meet the guidelines.

No Single Source Identifies Low-Value Services

There have been many initiatives to identify low-value services and a few researchers have attempted to harmonize these lists, noting that not all recommendations have been translated into well-specified measures.

One comprehensive study of the literature identified these top five, most commonly published low-value care measures:[5]

Thank you!

Robert Wood Johnson Foundation

- To our Speakers: Josh Wojcik, Beth Beaudin-Seiler, Stephani Becker and Audrey Gasteier
- To the Robert Wood Johnson Foundation

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