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April 7, 2021

Health Finance and Policy Committee
Minnesota House
75 Rev Dr Martin Luther King Jr Boulevard
St Paul, MN 55155

Chair Liebling and Members of the Committee,

Minnesota's seven non-profit health plans, who together make up the Minnesota Council of Health Plans, help 4.7 million Minnesotans access the health care they need. Throughout this legislative session, the Council has expressed support for policies which can lower health care costs, maintain stability in the individual market, and help Minnesotans gain access to needed care.

We would like to thank you for including the language of HF 521 to extend MA postpartum coverage to 180 days. This initiative will improve the quality of life for the mother and her child's early development and increase much needed health equity by protecting mothers from preventable postpartum complications. We are, however, opposed to several other provisions in the bill which will have a negative consequence of increasing health care costs and impacting access to health care. Those provisions are as follows:

ARTICLE 1

Nonemergency Medical Transportation (Sections 6, 14, 15, 27-28, 30)
Carving out Nonemergency Medical Transportation (NEMT) from managed care organizations' (MCOs) offerings will have a negative impact on the patient care coordination chain. MCOs are strategically positioned to be able to offer robust networks for NEMT and can respond more nimbly to enrollee needs because our services are interconnected, specifically developed for member and family-centered programs based on critical input from members and providers.

MCOs have recognized that each member has their own medical and behavioral health conditions and social circumstances that require an individualized approach to effectively support their needs. In the case of NEMT services, when these special situations arise, MCOs are prepared to respond promptly and consult with other departments such as behavioral health, disease and case management, dental, and member services to assist their members and meet their needs wherever they are.

Single Administration of MA Dental (Sections 13, 23, 47, 48, 49, 58, 59)
Switching to a single MA Dental Administrator impacts a patient's ability to receive integrated holistic care through a MCO. This proposal also reduces reimbursement to safety net providers who provide the vast amount of care to MA enrollees. With less than a 30% increase in overall payment for children's services, this seems counterintuitive. The most recently published DHS Access Monitoring Review Plan shows that MCOs have consistently delivered better access to care than the fee-for-service system administered by DHS. While the MCOs acknowledge the need to increase patient utilization rates, especially among the child population, carving out this service will not make the positive impact that the legislature seeks.

Several bills heard during this session in this committee have the potential to be a start to a better alternative. HF 1918 (Reyer) establishes an advisory committee to develop recommendations for a dental home pilot project and HF 620 (Demuth) offers a loan forgiveness pathway for general dentists. SF 1371 (Koran) includes a dental home pilot project and establishes access benchmarks and access improvement goals. While these ideas need refinement, they can help set the stage for an open collaboration between DHS and MCOs to increase the rates of dental visits and improve patients' wellbeing.

Prescription Drug MA Carve Out (Sections 10, 42, 46, 64)
The Council is opposed to carving out pharmacy benefits in MN Health Care Programs. Managed care is most effective when care and utilization management extend across all health care services. Prescription drugs are a central component of these services and carving them out will remove vital opportunities to coordinate care. We are also concerned about the likely increased cost of this approach given the experience of pharmaceutical carve-outs. The use of lower-cost generic drugs leads to lower overall costs, but it also tends to lead to lower rebates per prescription to the purchaser. Generic drugs have much lower percentage statutory rebates than do brand drugs and additional supplemental rebates are negotiated for these drugs less frequently. Under a carve-out approach, we have seen states use a lower percentage of generic medications and instead negotiate for more rebates per prescription on brand drugs. This rebate maximization strategy typically leads to a higher average net cost per prescription. An April 2019 report from the Menges Group found that administrative savings were significantly less than promised and Medicaid costs per prescription rose 12.6% compared to the US average of 4.1% when a similar carve out was used in West Virginia.

Most important, we are concerned about the impact of this proposal to MSHP enrollee based on the impact to enrollees since DHS adopted their Preferred Drug List (PDL) in July 2019. Minnesotans on MA are those who have the lowest incomes, who are elderly, and those living with disabilities and chronic conditions. They are the most vulnerable Minnesotans. Since this change, consumer choice has been reduced, going from a program where MA enrollees could choose from multiple MCOs with multiple formularies to now just one governed by DHS. The new system has created confusion as

MA enrollees have faced multiple switches between medications as they must now adhere to a new formulary. In 2020, prior authorization appeals nearly doubled from the previous year as enrollees sought to maintain access to existing medications not preferred under the PDL. The Council urges an evaluation of the 2019 changes and evaluate the real-world impact of the current program on MA enrollees before proceeding with an expansion.

ARTICLE 5

Flat Dollar Copay Plans (Section 7)

The price of prescription drugs continues to be the costliest item of all health care spending, making up about a fifth of the total cost of every premium dollar today. However, this proposal doesn't address the root of the problem: pharmaceutical manufacturers relentlessly increasing the prices of high-demand, lifesaving drugs. This proposal as written encourages egregious increases in drug prices that will fall on the backs of Minnesotans.

If drug copays are kept flat the entire year, other plan benefits would need to change because the bill does not include language to lower drug prices. Additionally, dividing a deductible across a year will become a challenge for our health plans as our enrollees' health care needs change throughout the year and fluctuations in drug prices need to be accounted for. It is our belief that this bill is unintentionally creating a platinum level product, which is no longer found in the marketplace because of historical higher premiums and copays for office visits and generic drugs. This may create the unintended consequence of pushing healthier people out of the individual market who do not want to pay more to self-insure. We urge the legislature to consider a more thorough actuarial analysis of the effects that this this type of plan will have on the healthy individuals the market depends on to balance out the costs for those who need more care.

Formularies Changes (Section 8)

The Council opposes language that would prohibit a plan from being able to make changes to a drug formulary, thereby restricting a plan's ability to manage the ever-increasing cost of prescription drugs. Our plans strive to make few changes to a formulary throughout the plan year. For our plans in the fully insured market, these changes are rare, but if they do happen it is because a drug manufacturer has decided to increase their prices in the middle of the year. As written, the bill will likely increase the cost of health insurance premiums because the bill does not address the problem of the increasing cost of care. The Council also has concerns this language is not applied equally to state public programs. The language in the bill allows DHS to make formulary changes four times a year. We understand the goal of the bill is to protect patients but having a different standard for those on public programs compared to those in the commercial market does not uniformly accomplish that objective. The language in this bill should apply to everyone equally.

Biologic Products (Sections 9, 12, 13, 22)
This proposal prohibits health insurers from applying lower member cost-sharing to incentivize the use of lower cost biologics, biosimilars, and interchangeable biosimilars. More than 20 years ago, efforts were made in Minnesota and across the country to drive higher utilization of generic medications to achieve cost savings for the state, businesses, and consumers. The passing of theses sections would move Minnesota away from this focus and ultimately force Minnesota businesses and consumers to pay more for biological products.

As an alternative, the Council recommends establishing a study where stakeholders can look for an effective means of replicating the success that resulted from driving higher utilization of generic pharmaceuticals and recommend a similar approach with the continued introduction of biosimilars to the market, including SEGIP, Medicaid and MinnesotaCare, the state public programs serving the elderly and Minnesotans living with disability or with low-incomes.

ARTICLE 6

Affordable Care Act Provisions (Sections 1-9, 11, 15, 16, 19)
The Council is currently complying with all provisions in the ACA and is concerned this language does not match up to that in federal law and therefore will creates a conflict between state and federal law. For instance, we there is a discrepancy in the language on premium grace periods (lines 278.3-278.19) Under the ACA, those receiving APTCs through the exchange have a 90-day grace period while those not receiving tax credits have a 30-day period. Language in the DE extends this 90-day grace period for everyone in the exchange and also to the entire small group market and those purchasing off the exchange. We would also recommend changing the effective date of these changes and to a point if or when the ACA is repealed.

ARTICLE 7

Telehealth (Art. 7, Sec. 1)
The delivery of health care has changed since the legislature last debated telehealth policy 6 years ago. Technology has advanced, providers have adopted the technology, and patients have access to care at a time and place that works for them. The Council fully supports the ongoing use and expansion of telehealth for all Minnesotans but is opposed to language which mandates payment parity (lines 296.19-296.29) and places restrictions on virtual networks (lines 295.11-295.13).

Just like care delivered through an ER visit is reimbursed at a different rate than a clinic visit, an in-person visit should be reimbursed at a different rate than a telehealth visit because of the varying levels of care. Language in Article 7 would require medical care be reimbursed at the same level no matter the method or care provided. This means patients will be charged the same amount for medical care, whether the care is provided in the office or over the phone. Patients should only have to pay medical bills that reflect the true cost of the care being provided. The Council urges consideration for payment flexibility so that telehealth may be a tool to address increasing health care costs and link payments to the value and outcomes provided to a patient, not patient volume.

We look forward to working with you and all committee members on advancing issues that will lower health care costs, maintain stability in the market and help Minnesotans gain access to needed care.

Sincerely,

Lucas Nesse
President and CEO