April 7, 2022

Dear Members of the Health Finance and Policy Committee,

On behalf of the Minnesota Chamber of Commerce, representing 6,300 employers and their more than 500,000 employees across the state, I am writing to share our concerns with the A22-0419 DE amendment to HF 4706 (Liebling), the Health Finance Omnibus Supplemental bill.

Article I

Hospital Nurse Staffing

This proposal would place a significant burden on Minnesota's hospitals and health systems that have been operating for two years under extremely challenging times. It would also set a disturbing precedent in workplace management – establishing a state mandate that the staffing of a work site be set by a committee. Under the proposal, this staffing committee is not advisory. It is given the authority to establish the number of employees at work, in this instance the number of Registered Nurses. These are decisions that should be made by management or in collaboration with employees through collective bargaining.

There is no industry or community in the state where Minnesota's workforce shortage is not a challenge. The Department of Employment and Economic Development recently reported that in the health care sector alone, Minnesota has 40,000 open positions. Employers are scrambling to retain and hire workers. To do so, they are offering increased wages and salaries, expanded leave benefits, remote working and more flexible work arrangements, customized training, tuition assistance, and childcare support. In much the same way, we know most hospitals and health systems are currently trying to hire more nurses, and wages are escalating.

Mandating a process for staffing hospitals will not help to address the workforce challenges the health care sector is facing. It is our hope that the legislature focuses on licensing and credentialing efforts that help ease this shortage, rather than an approach that further complicates operations and efforts to deliver quality care.

Article III

Health Care Affordability Board

We agree that there is value in bringing the experience and knowledge of various subject matter experts to bear on the state's efforts to lower health care costs. But rather than empowering this group of individuals to unilaterally set and enforce statewide health care spending growth targets, we believe the state, the industry, policymakers and stakeholders would be better served by a different approach, like the one contemplated in HF 1612 (Schomacker). To provide input and recommendations about how we as a state can better achieve improved care and health outcomes at lower costs through our commercial market and public programs, HF 1612 establishes an independent Health Policy Commission. This independent Commission will work to understand why Minnesota ranks so high in health care costs and spending, identify what the drivers

are of escalating health care costs and spending in Minnesota, and offer recommendations about policy, legislative, and market reforms that can be undertaken to bend the cost curve and improve care and quality for all Minnesotans.

Public Option

We appreciate the extent to which this proposal attempts to highlight and address the issues that many small employers have in providing health insurance coverage to their employees. But we have significant concerns about the bill's solution to the problem of rising health care costs: a government-sponsored public health insurance option.

Government healthcare programs like Medicare, Medicaid, and MinnesotaCare pay doctors and hospitals much less than commercial health insurance plans do for medical services and procedures. As a result, health care providers' operations are subsidized by higher prices paid by those with private insurance, who pay more to offset this differential. Changing programs like MinnesotaCare, which pays health care providers significantly less than the commercial rate, into an expanded government-sponsored health insurance option that is available to any Minnesotan, regardless of income, will lead to significant financial impact on providers and hospitals – especially practices that operate on already narrow margins in rural areas and underserved communities. This, in turn, may further reduce access to critical care and services in some parts of the state. It will also lead to increased costs for those with private coverage – whether fully-insured or self-funded – because health care providers will likely shift even more costs to these Minnesotans. These changes will only lead to increased instability in the commercial health insurance market in the state and would threaten the continued viability of the individual and small group markets in particular.

One state, Washington, has led the nation in the creation of a public option. To date, its experience in doing so has been an offering that first had to dramatically raise payment rates for providers to entice participation in the plan and, more recently, has moved to compel participation by health care providers in order to ensure sufficient access to the health care providers and services prospective enrollees would rely on. It is also an offering whose premiums well exceed those of comparable commercial plans.

Article VI

Prescription Drug Affordability Board

We share the goal of lowering health care costs by curbing the cost of prescription drugs. However, we do not agree with the approach taken in this proposal. In particular, we are concerned with the fact that the proposal would allow the newly established Prescription Drug Affordability Commission to unilaterally set the price for certain prescription drugs for all non-exempt public and private purchasers in the state.

In handing an unelected, independent commission the authority to set prices for privately produced products that are sold in a competitive, private market, the state of Minnesota would be setting a very concerning precedent for government. We must find solutions to the pressing issue of high and continually rising prescription drug costs without setting dangerous precedents for state intervention in the marketplace and inviting harmful, unintended consequences.

Restrictions on Prescription Drug Formularies

This proposal limits the extent to which the prescription drug formularies associated with private, fully insured health insurance plans can be changed during the plan year. While the goal of such proposals has merit, the real-world impact of these types of proposals is often increased costs associated with prescription drug benefits. Fiscal notes have provided varying cost estimates for similar proposals over the years. This is due to the fact that formularies are one of the few tools available to plan sponsors to help control prescription drug costs.

It is important to note that the provision included in this bill has no impact on the cost of the State Employee Group Insurance (SEGIP) plan or state public health care programs like Medical Assistance and MinnesotaCare because it sets a different standard for these state public programs than what is required in the commercial market. Under this proposal, SEGIP is explicitly exempted. Similarly, four times a year, state public programs would still be able to make the kinds of formulary changes to limit program costs that would no longer be allowed in the commercial market. This is a basic fairness consideration.

Too often, cost increasing health insurance coverage and regulatory mandates, like this one, are applied legislatively to the fully insured commercial market without applying those same standards to taxpayer funded benefits and public health care programs. If there is an interest in moving forward legislation to change the way formularies are used in Minnesota, we would ask that the commercial plans be granted the same flexibility to manage prescription drug costs that is being granted to state programs.

Alternative Sourcing of Specialty Drugs ("White Bagging")

This proposal is similar in nature to legislation that has been debated in legislatures across the country. As a result, there is much information to draw on when analyzing the tradeoffs associated with proposals like it to prohibit or limit payers' use of "white bagging"/alternative sourcing options for expensive specialty drugs. The Massachusetts Health Policy Commission, for example, completed an analysis of the issue in 2019 using Massachusetts commercial claims data. In it, the Commission found that white bagging led to lower costs with little difference in out of pocket costs between it and a buy and bill approach. Similarly, it noted that utilization of white bagging to reduce costs did not require sacrificing quality of care.

While this report and its findings from Massachusetts are helpful, it is nevertheless important to note that it was a study conducted using data and market analysis from Massachusetts. The only way to know if the same conditions exist here in Minnesota is to ensure a similar review is undertaken here. The new mandated health benefit proposal review process is intended to provide this kind of review, and it should be utilized to help educate all of us about the proposal's real world impact.

Articles VI & VII

Various Mandated Health Benefit Proposals

Employer-sponsored health insurance is an increasingly important benefit, both in terms of retention and attraction of talent and in terms of keeping employees healthy and productive at work. Three-fourths of our members who offer insurance to their employees report that they will be required to make significant changes to their benefit offerings – including dropping coverage altogether – if costs continue to rise at their current rate.

Minnesota requires coverage of roughly 60 benefits as part of fully-insured individual and group health insurance products sold in the state. By some estimates, Minnesota ranks in the top five states with the most mandates. All of these coverage mandates were passed by the Legislature to help Minnesotans access coverage for certain health care procedures or treatments. Like the proposals included in the bills under consideration by the committee today, they all help someone. But it is also true that they all come with a cost. Research has indicated that:

- the average mandate increases premiums between 0.44-1.11% annually
- mandates tend to have a larger impact on the premiums of small employers who do not have the advantage of self-insuring, which provides greater flexibility around plan design and benefit offerings

Seventy percent of our members who offer health insurance coverage to their employees purchase coverage in the fully-insured market. It is these small and mid-sized employers and their employees who bear the full cost of Minnesota's extensive coverage mandates.

It is often difficult, however, for legislators to weigh concerns about cost against the impact that coverage of a specific treatment or procedure could have on those who seek it. We are pleased that several of the mandated health benefit proposals included in this bill were recently reviewed by the Department of Commerce as part of a new mandated health benefit proposal process, which was signed into law last year. And while we would note the Department's findings that each of these proposals would lead to some increase in premium costs for those in the fully insured market – and would urge continued caution in adding more costs to what is already an extremely expensive product – it is reassuring to see the law working. These reports allow legislators and stakeholders to draw their own conclusions about the value of each proposal.

We are concerned, however, that no such review has been completed for a number of the other proposals included in the bill. We believe all of these proposals should be reviewed by the Department of Commerce as part of the mandated health benefit proposal process. As was noted above, this will ensure legislators have access to reliable data and information about the cost/benefit tradeoffs associated with the proposal.

Thank you for the opportunity to provide this input.

Sincerely,

Bentley Graves
Director, Health Care & Transportation Policy