Evaluation of HF633-1E

Report to the Minnesota Legislature pursuant to Minn. Stat. §62J.26

01/26/2022

Contact Information

Minnesota Department of Commerce
85 7th Place East
St. Paul, MN 55101
651-539-1734
andrew.kleinendorst@state.mn.us
mn.gov/commerce

As requested by Minnesota Statute 3.197: This report cost approximately $2,858 to prepare, including staff time, printing and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

Contents

Executive Summary

House File 633-1E requires that individual and small group health carriers provide a flat-dollar, pre-deductible copayment for all tiers of drugs in at least 25 percent of the plans offered in each geographic rating area in which they operate. The Minnesota Department of Commerce (Commerce) has determined that the bill would not be a new state mandated benefit under the Affordable Care Act (ACA) and would thus not require defrayal of cost from the state. There is no expected fiscal impact to the state overall.

Introduction and Policy Context

Pursuant to Minn. Stat. § 62J.26, subd. 3, Commerce has been requested to perform an evaluation of House File 633-1E. The purpose of the evaluation is to provide the legislature with a detailed analysis of the potential impacts of any mandated health benefit proposal.

House File 633-1E was introduced during the 92nd legislature (2021-2022) and meets the definition of a mandated health benefit proposal under Minn. Stat. §62J.26, which indicates the following criteria regarding the definition of a mandated health benefit proposal:

> A mandated health benefit proposal" or "proposal" means a proposal that would statutorily require a health plan company to do the following:
>
> (i) provide coverage or increase the amount of coverage for the treatment of a particular disease, condition, or other health care need;
> (ii) provide coverage or increase the amount of coverage of a particular type of health care treatment or service or of equipment, supplies, or drugs used in connection with a health care treatment or service;
> (iii) provide coverage for care delivered by a specific type of provider;
> (iv) require a particular benefit design or impose conditions on cost-sharing for:
> (A) the treatment of a particular disease, condition, or other health care need;
> (B) a particular type of health care treatment or service; or
> (C) the provision of medical equipment, supplies, or a prescription drug used in connection with treating a particular disease, condition, or other health care need; or
> (v) impose limits or conditions on a contract between a health plan company and a health care provider.
>
> "Mandated health benefit proposal" does not include health benefit proposals amending the scope of practice of a licensed health care professional.

In producing its analysis, Commerce is required to consult with the Departments of Health (MDH) and Management and Budget (MMB). Per statute, evaluations must focus on the following areas:

- Scientific and medical information regarding the proposal, including potential for benefit and harm
- Overall public health and economic impact
- Background on the extent to which services/items in the proposal are utilized by the population
- Information on the extent to which service/items in the proposal are already covered by health plans, and to which health plans the proposal would impact
- Cost considerations regarding the potential of the proposal to increase cost of care, as well as its potential to increase enrollee premiums in impacted health plans
- The cost to the State if the proposal is determined to be a mandated benefit under the Affordable Care Act (ACA)

The Department's subsequent evaluation addresses all areas noted above, with the caveat that with this particular bill there is a paucity of relevant data.

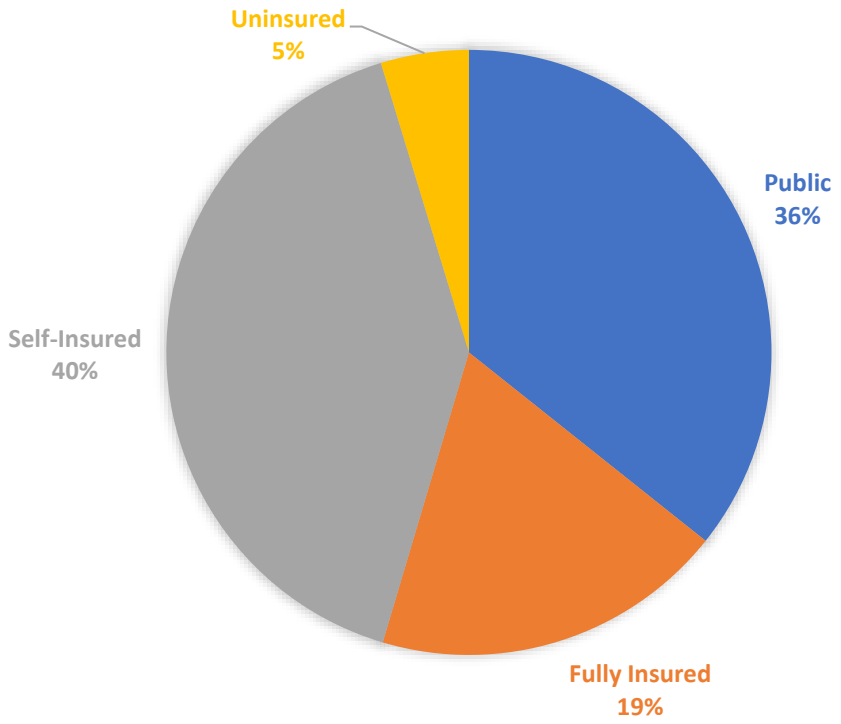
Bill Requirements and Impact

House File 633-1E requires health plans selling individual policies to ensure that no less than 25 percent of their marketed policies in each geographic rating area in which they sell products include a pre-deductible/flat copayment amount for prescription drug services. The flat copayment amount may not exceed one-twelfth (1/12) of the plan's out-of-pocket maximum. House File 633-1E also applies to small group offerings, with the same requirements across all tiers of prescription drugs.

The full text of the bill is available in the Appendix of this document.

The provisions of HF633-1E apply to all fully insured individual and small group health plans regulated in Minnesota. Requirements in the bill would not apply to self-insured employer plans, state public programs, grandfathered plans, and Medicare and Medicare supplemental policies. The bill further indicates that its provisions do not apply to large group plans, health savings accounts (HSA), limited health benefit plans, or short-term limited duration plans. Figure 1 shows a breakdown of health insurance coverage in Minnesota by type (including uninsured).

Figure 1. Minnesota Insurance Coverage 2019



Source: Minnesota Department of Health.[1]

[1] Chartbook Section 2. Trends and Variations in Health Insurance Coverage. Accessed at https://www.health.state.mn.us/data/economics/chartbook/docs/section2.pdf.

State and Federal Law

This evaluation must consider the interaction between state and federal law—specifically as it pertains to the potential for the bill to be considered a state benefit mandate as understood under Section 1311(d)(3) of the ACA (45 CFR § 155.170), which indicates that states must defray the costs of new mandates related to specific care or treatment not offered under the general essential health benefits (EHB) package in the given state's benchmark plan. The state is only required to defray associated costs that would not have been provided by the health carrier without the requirements of the new mandate prior to January 1, 2012. Cost of defrayal applies only to qualified health plans (QHPs), meaning plans on Minnesota's individual, on-exchange market. [2]

Evaluation of Mandated Health Benefit Proposal

This evaluation is based on Commerce's interpretation of the criteria under Minn. Stat. §62J.26, subd. 2, which includes the following:

- Solicitation of feedback from potential stakeholders by publishing a request for information notice in the State Register
- Scoping review of available literature in relevant databases
- Hybrid umbrella/systematic literature review of available resources
- Consultation with the Department of Health and MMB
- Solicitation of comments from health plans, including request for actuarial analysis
- Internal actuarial analysis

In Commerce's evaluation, the requirements of HF633-1E do not constitute a benefit mandate requiring state defrayal of associated costs, as understood under the ACA.[3] The bill does not establish any new benefit related to specific care, treatment or services not already covered by the benchmark plan, and thus does not constitute a new benefit mandate requiring defrayal by the state under federal regulations. Prescription drug services are specifically identified as an EHB and therefore must already be covered under all ACA-compliant plans.

The Department's conclusion is consistent with previous analyses of potential state mandated benefits in previous legislative sessions. While a mandated health benefit proposal may contain language that is related to care and treatment of a specific health condition, it is necessary to consider if the mandated health benefit proposal contains new benefits not already covered under state's benchmark plan. If the services/items are not currently covered or have not been covered by the benchmark plan previously, then there is reason to conclude that the proposal is a new state mandated benefit, requiring defrayal of cost from the state.

Prescription drugs are covered under the benchmark and all other regulated health plans, and requirements in HF633-1E are not explicitly related to any specific care or treatment; therefore, the provisions under HF633-1E would not constitute a benefit mandate as understood under the ACA.

Scientific and Medical Analysis

The bill text of HF633-1E addresses prescription drug costs generally and does not identify any specific health conditions that would allow for analysis on the comparative benefit or harm from alternative forms of

[2] 45 CFR Parts 147, 155, and 156 Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule. Accessed at https://www.govinfo.gov/content/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

[3] 45 CFR § 155.70. Additional required benefits. Accessed at: https://www.law.cornell.edu/cfr/text/45/155.170

treatment. As such, Commerce can only provide general analysis with the data that are available currently regarding utilization and cost of prescription drugs.

Public Health, Economic, and Fiscal Impact

The impact of HF633-1E on general public health is difficult to determine in the absence of an associated disease or condition with the bill. Commerce will focus on general concepts regarding prescription drug coverage, existing statute in Minnesota, and similar proposals in other states (including information regarding their impact when possible) in the subsequent sections.

For the purposes of this and subsequent sections, the following definitions apply:

Public Health: The science and practice of protecting and improving the health and wellbeing of people and their communities. The field of public health includes many disciplines, including medicine, public policy, biology, sociology, psychology and behavioral sciences, and economics and business.

Economic Impact: The general financial impact of a drug, service, or item on the population prescribing or utilizing a particular drug, service or item for a particular health condition.

Fiscal Impact: The quantifiable dollar amount associated with the implementation of the mandated health benefit proposal. The areas of potential fiscal impact that the Department reviews for are for the cost of defrayal of benefit mandates as understood under the ACA, the cost to SEGIP, and the cost to other state public programs. The fiscal impact is expressed in number of dollars required for the state to implement a proposal.

In summary, the public health impact, as understood utilizing the definition above, would likely be favorable if HF633-1E were enacted. In the absence of a specific condition being addressed by HF633-1E, Commerce's public health assessment is based on the principle that increased coverage equals increased utilization. Increased utilization of prescription drugs for any number of chronic health conditions would theoretically have a net positive impact on overall public health.

Commerce assumes that HF633-1E would reduce financial barriers for consumers obtaining prescription medications, and further assumes that a reduction in cost-sharing would increase utilization of services, including prescription drugs.[4][5] The economic impact would be highly variable, depending on uptake of certain prescription drugs for certain conditions.

Finally, Commerce concludes that HF633-1E would have no fiscal impact on the state if enacted. The bill is not a benefit mandate as understood under the ACA, so there is no defrayal cost associated with it. The bill also does not apply to Medical Assistance or MinnesotaCare. According to MMB, implementation of HF633-1E would not incur costs to SEGIP because the provisions of the bill only apply to individual and small group health plan offerings.

---

[4] Goldman DP, Joyce GF, Zheng Y. Prescription drug cost sharing: associations with medication and medical utilization and spending and health. JAMA. 2007 Jul 4;298(1):61-9. doi: 10.1001/jama.298.1.61. PMID: 17609491; PMCID: PMC6375697.

[5] Dickson S, Reynolds I. Estimated Changes in Manufacturer and Health Care Organization Revenue Following List Price Reductions for Hepatitis C Treatments. *JAMA Netw Open.* 2019;2(7):e196541. doi:10.1001/jamanetworkopen.2019.6541

Current Utilization

Given that HF633-1E does not address any specific health condition, this report's evaluation regarding utilization focuses on commonly prescribed prescription medications both locally and nationally.

Healthcare spending continues to increase in the U.S. and accounts for nearly 20 percent of total gross domestic product.[6] Increased spending in the healthcare industry can be in part attributed to prescription drug coverage, which accounts for nearly 10 percent of overall expenditures.

Data regarding local utilization of prescription drugs comes from recently enacted reporting requirements under Minn. Stat. §62K.07, which requires reporting on prescription drug utilization and cost. Each regulated carrier offering prescription drug benefits in its individual or small group health plans must provide Commerce the following data:

1. The 25 most frequently prescribed drugs in the previous calendar year
2. The 25 most costly prescribed drugs as a portion of total annual expenditures in the previous calendar year.
3. The 25 prescription drugs that caused the greatest increase in total spending in previous calendar year.
4. The projected impact of the cost of prescription drugs on next year's premiums
5. Whether any health plan offered requires enrollees to pay cost-sharing on covered prescription drugs in an amount greater than the health plan would pay for the drug absent the applicable cost-sharing and after any rebate amount.
6. Whether third-party payments, such as drug manufacturer discounts or coupons that cover all or a portion of the enrollee's cost-sharing, apply towards the enrollee's cost-sharing obligations.'

The report regarding the above considerations under Minn. Stat. 62K.07 can be found through the Minnesota Legislative Reference Library and at the Commerce website.[7]

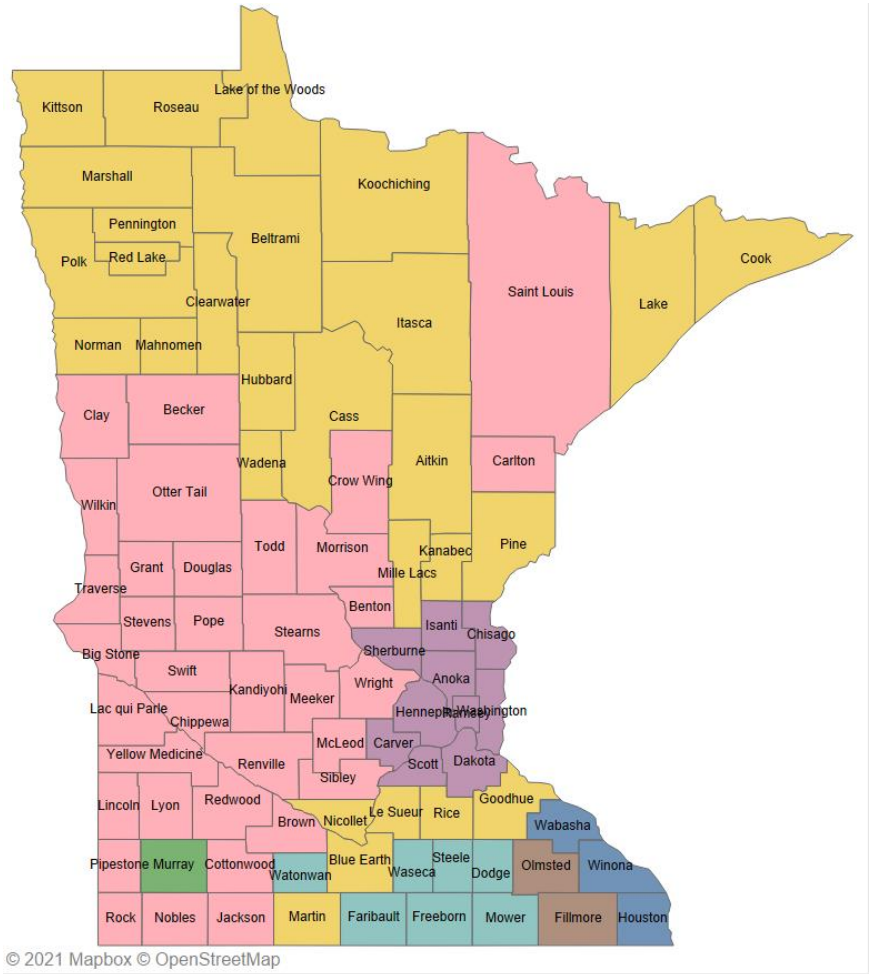
House File 633-1E requires health plans to offer a flat dollar, pre-deductible copayment on at least 25 percent of plan offerings in each geographic rating area in the state. Below are two figures illustrating each geographic rating area.

[6] Micah Hartman et al.; "**National Health Care Spending in 2016: Spending and Enrollment Growth Slow After Initial Coverage Expansions**"; *Health Affairs* 37(1): 150-160; January 2018. Note that the "retail prescription drugs" category excludes drugs purchased directly from physicians or hospitals (e.g., infusion drugs)

[7] https://mn.gov/commerce-stat/pdfs/2022-prescription-drug-cost-summary.pdf

Figure 2 - Map of Rating Areas in Minnesota – 2021

Figure 3 - Actively Marketed Health Plans by County – 2022



Current Health Insurance Coverage

Prescription drugs are specifically identified under the ACA as one of 10 required EHBs. House File 633-1E establishes requirements for health plans to provide a flat copayment or pre-deducible dollar amount to at least 25 percent of their individual and small group offering in each geographic rating area where plans are actively marketed. The requirements under HF633-1E expand upon traditional coverage of prescription drugs under individual and small group plans as a result. A number of existing plans offer coverage for prescription drugs at a pre-deductible/flat dollar amount, but not for all tiers identified under HF633-1E. The following table shows the proportion of existing plans already offering pre-deductible copayments for varying tiers of drugs.

Table 1 – Individual and Small Group Coverage of Prescription Drugs with Pre-deductible Copayments

Drug Tier	Individual/MNSure		Small Group	
	% of plans with pre-deductible copayments	Copayment amount range	% of plans with pre-deductible copayments	Copayment amount range
Generic	64%	$5-30	53%	$10-30
Preferred Brand	43%	$40-200	53%	$30-80
Non-Preferred Brand	0%	N/A	38%	$75-150
Specialty	36%	$550-750	7%	$125-500

Impact on Insurance Coverage

The impact of HF633-1E on insurance coverage is contingent on how prescription drug coverage is already provided by a carrier. Many carriers in Minnesota delegate all pharmacy benefits to PBMs, while others sometimes may meet the definition of a PBM under Minn. Stat. §62W. The top 25 most prescribed and most costly prescription drugs in the individual and small group market should be considered based on the potential that health plans and PBMs could apply additional utilization management techniques to these particular medications.

Based on the provisions of HF633-1E, health plans may include a maximum flat dollar amount of 1/12 of the overall individual out-of-pocket maximum. Per the 2022 Notice of Benefits and Payment Parameters (NBPP) the maximum out-of-pocket amount allowed to be charged by health plans for an individual was $8,700, meaning health plan flat copayment amounts could feasibly be as large as $725 per prescription. While still a significant amount of cost-sharing to the consumer, capping prescription drug costs upfront at $725 per prescription would likely produce an increase in consumer behavior on refills of prescriptions — especially for those on specialty medications.

As the bill requires a reduction in cost-sharing to enrollees, the actuarial value of individual plans would be affected (under the ACA, individual health plans fall under categories of Platinum, Gold, Silver, Bronze, and catastrophic—each with a corresponding minimum/maximum range of actuarial value). Commerce anticipates that health carriers will adjust other cost-sharing in order to continue to meet metal level requirements, though some carriers responding to Commerce's RFI expressed concern about the bill's impact on their ability to meet Bronze standards in particular. Commerce notes that a Milliman study of implementation of a similar law in Colorado indicated that it did not cause a large decrease in plan offerings in that state.[8]

Impact on Health Insurance Premiums

The impact of HF633-1E on health insurance premiums is difficult to quantify. It is unlikely that that the bill would produce a substantive increase in premiums. A Milliman study on Colorado's similar law indicated that

[8] Goss Sawhney, T., Dieguez, G., Mirchandani, H., and Son, M. Impact of prescription drug copay regulatory action on ACA Exchange plans in Colorado and Montana. Millliman, July 2017. Accessed at: https://us.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2017/impact-prescription-drug-copay-guidance-co-mt.ashx

the change likely did not result in increases to enrollee premiums in that state.[9] While there could be some changes in utilization on the margins, Commerce assumes that the bill will not cause a large increase in utilization of high-cost drugs. Additionally, HF633-1E does not prevent utilization management techniques from being employed by health plans. These techniques have an effect of reducing overall health plan expenditures and should be noted in this analysis.

Summary of Comments Received

The Department placed a request for information in the November 22, 2021 publication of the State Register, requesting comments regarding all mandated health benefit proposals, including HF633-1E. The Department received feedback from health plans, other industry stakeholders, and patient advocacy groups.

As noted above, health carriers expressed concern about the bill's impact on their ability to continue to meet Bronze actuarial level requirements. While one carrier anticipated a substantive premium impact from the bill, most did not. Patient advocacy groups generally supported the bill, as it would allow for increased upfront access to medications for chronic, high-cost conditions.

ACA Benefit Mandate Impact and Analysis

House File 633-1E would not be considered a state benefit mandate as understood under the ACA. The ACA stipulates that states mandating requirements from carriers to cover treatment for an illness not previously covered would relate to specific care, treatment, and services. HF633-1E has no such requirement, and also does not appear to fit under the exceptions to the mandated benefits provision of the ACA. A state may enact requirements unrelated to specific care, treatment, or services and not be responsible for defraying the cost, generally falling into the following:

1. ***Provider Types.*** Mandates that require a covered service to be covered by additional health care provider types.
2. ***Cost-Sharing.*** Mandates that require or change cost-sharing amounts for covered services, including deductibles, copayments, and coinsurance.
3. ***Delivery Methods***. Mandates that require health carriers to cover new methods of delivering covered services (telehealth for example).
4. ***Reimbursement Methods.*** Mandates that require health carriers to reimburse health care providers for covered services provided in new ways.
5. ***Dependent-Coverage.*** Mandates that require health carriers to define dependents in a certain way or to cover dependents under specific circumstances.
6. ***ACA Conforming Coverage.*** Mandates required to comply with ACA requirements.

Overall, the impact of HF633-1E on Minnesota consumers, as well as health plans remains somewhat unclear. While there is a likelihood of individuals utilizing higher cost drugs choosing products with this plan design which would increase overall plan utilization, this must be weighed against the fact the bill's measures only apply to a minimum of 25 percent of overall plans marketed in each rating area in Minnesota.

[9] Goss Sawhney, T., Dieguez, G., Mirchandani, H., and Son, M. Impact of prescription drug copay regulatory action on ACA Exchange plans in Colorado and Montana. Millliman, July 2017. Accessed at: https://us.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2017/impact-prescription-drug-copay-guidance-co-mt.ashx

Appendix

Bill Text

A bill for an act
relating to insurance; requiring individual and small group health plan offerings
to include a predeductible, flat co-pay on prescription drug option;amending
Minnesota Statutes 2020, section 62Q.81, by adding a subdivision.
BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2020, section 62Q.81, is amended by adding a subdivision
to read:
Subd. 6.Prescription drug benefits. (a) A health plan company that offers individual
health plans must ensure that no fewer than 25 percent of the individual health plans the
company offers in each geographic area that the health plan company services at each level
of coverage described in subdivision 1, paragraph (b), clause (3), applies a predeductible,
flat-dollar amount co-payment structure to the entire drug benefit, including all tiers.
(b) A health plan company that offers small group health plans must ensure that no fewer
than 25 percent of small group health plans the company offers in each geographic area that
the health plan company services at each level of coverage described in subdivision 1,
paragraph (b), clause (3), applies a predeductible, flat-dollar amount co-payment structure
to the entire drug benefit, including all tiers.
(c) The highest allowable co-payment for the highest cost drug tier for health plans
offered pursuant to this subdivision must be no greater than 1/12 of the plan's out-of-pocket
maximum for an individual.
(d) The flat-dollar amount co-payment tier structure for prescription drugs under this
subdivision must be graduated and proportionate.
(e) All individual and small group health plans offered pursuant to this subdivision must
be:
(1) clearly and appropriately named to aid the purchaser in the selection process;
(2) marketed in the same manner as other health plans offered by the health plan company;
and
(3) offered for purchase to any individual or small group.
(f) This subdivision does not apply to catastrophic plans, grandfathered plans, large
group health plans, health savings accounts (HSAs), qualified high deductible health benefit
plans, limited health benefit plans, or short-term limited-duration health insurance policies.
(g) Health plan companies must meet the requirements in this subdivision separately for
plans offered through MNsure under chapter 62V and plans offered outside of MNsure.

EFFECTIVE DATE. This section is effective January 1, 2022, and applies to individual
and small group health plans offered, issued, or renewed on or after that date.