May 5, 2022

Sen. Jim Abeler Rep. Tina Liebling

Sen. Paul Utke Rep. Jennifer Schultz

Sen. Michelle Benson Rep. Aisha Gomez

Sen. Mark Koran Rep. Dave Pinto

Sen. John Hoffman Rep. Tony Albright

RE: SF 4410 – HHS Omnibus Finance Bill

Chairs Abeler and Liebling and members of the HHS Conference Committee,

The Minnesota Council of Health Plans’ nonprofit members (BlueCross and BlueShield of Minnesota, HealthPartners, Medica, Sanford Health Plan of Minnesota, and UCare) include more than 4.6 million Minnesotans with health care coverage. Throughout this legislative session, the Council has expressed support for policies that maintain stability in the market, lower costs, and increase access to high-quality care. To achieve an outcome that meets these goals, the Council supports inclusion of the proposals on health equity, addressing workforce shortage, and expanding Medical Assistance (MA) coverage for smoking cessation in the final bill. Conversely, the Council urges conferees to oppose inclusion of provisions on white bagging, a managed care opt-out, the MinnesotaCare Buy-In, restrictions on formulary changes, required preference for biosimilar drugs, and new benefit mandates because of the negative impact these will have on health insurance and state public programs. Below are further details on these recommendations.

**Support Health Equity Proposals**

The Council urges support for the five health equity proposals that are included in the House bill. These proposals include tangible ways in which Minnesota can make progress on eliminating the health disparities that exist in our state for Black, Indigenous, and people of color, lower income children, and people living with disabilities:

* Doula Medical Assistance (MA) Reimbursement: Data show that doula care is one of the most effective evidence-based practices for labor and delivery and is also cost-saving and cost-effective. The United States, and Minnesota in particular, is facing a maternal and infant health crisis. Expanding access to community-based doula programs will help improve prenatal care, increase access to culturally-congruent providers for Black and Indigenous birthing people, decrease unnecessary medical interventions, reduce the likelihood of complications and increase the likelihood of a healthy mother and baby.
* Continuous MA Eligibility for Children: Guaranteeing ongoing coverage ensures that children can receive appropriate preventive and primary care as well as treatment for any health issues that arise. Additionally, eliminating the churn of enrollees on and off public programs during the year reduces state time and money wasted on unnecessary paperwork and preventable care needs.
* MA Coverage for Undocumented Children: This expansion is estimated to provide health care access for an average of 1,700 additional children. Health care coverage leads to better health outcomes and is especially important in setting kids up for a long and healthy life.
* Healthy Beginnings, Healthy Families: This proposal aligns with the Council’s Health Equity Committee’s focus on maternal and infant health disparities and the Minnesota Collaborative to Prevent Infant Mortality. This investment will help address the significant disparities for Black, Indigenous and people of color in early childhood outcomes and increase the number of children who are school-ready.
* Disability as a Health Equity Issue: People with disabilities are often and unfortunately left out of the equity conversation. The Council serves a large number of Minnesotans living with disabilities and addressing disparities for these enrollees is a top priority.

**Support Proposals to Address Workforce Shortages**

The shortage of health care workers has impacted patient care and is a stress on providers, especially after three years of working in a pandemic. We appreciate the bipartisan support for investment in expanding and strengthening the health care workforce. The Council supports building on past efforts to update interstate licensing of health professionals by adopting the health professional licensure frameworks included in the Senate bill, including: the Nurse Licensure Compact, the Audiology and Speech Language Pathology Compact, and the Licensed Professional Counselors Compact. The Council also supports investments in existing, successful workforce development programs, particularly the numerous expansions in loan forgiveness eligibility included in the House bill.

**Support MA Coverage for Smoking Cessation**

While MA provides coverage for guidelines-based tobacco cessation treatment, barriers exist and change from year to year, creating confusion for providers and patients. The ACA and federal regulations require quit-smoking medications to be available without cost-sharing and prior authorization requirements, but some enrollees face limited, inconsistent access to these medications. The Council supports the expansion of MA coverage of tobacco and nicotine cessation services included in the House bill. This expansion will reduce tobacco use, improve public health and reduce health care costs. Commercial tobacco use remains the leading cause of preventable death and disease, taking the lives of more than 6,300 Minnesotans each year. Smoking costs the state over $3 billion in excess health care costs, including $563 million in the MA program alone.

**Oppose White Bagging**

The Council is opposed to the provision prohibiting health carriers from requiring providers to use white bagging for specialty drugs. This proposal inserts itself in the middle of contracts that health plans develop with providers and pharmacies to provide patient access to specialty drugs.This bill does nothing to change how these drugs are currently handled, because no plans in the fully insured market (individual and group) require white bagging. This may be occurring in the self-insured market, however the state cannot regulate this market under federal law. Therefore, this law would only apply to health plans who are not using white bagging. Some plans have turned to white bagging because plans can acquire these drugs at a lower cost via a specialty pharmacy when compared to what a hospital and clinic charge to acquire and store. These providers want to maintain the current practice of “buy and bill”, which allows them to get paid to acquire and store drugs rather than just be paid to administer the drug to a patient. There are numerous studies showing that for these drugs, hospital and clinics place a 200-400% mark up on these drugs, which creates a financial burden for patients already struggling to afford their care. Plans should not be prohibited from finding ways to lower the cost of these drugs for enrollees. While proponents have claimed dugs delivered via white bagging may arrive late, damaged, or in the wrong dose, there is no language in the bill creating new regulations on the delivery of drugs. If there are issues with this process, then the Council would support an investigation into where regulations are not being followed.

**Oppose Managed Care Opt-Out**

Managed care organizations (MCOs) are uniquely positioned to offer robust networks and services for the MA program and can quickly adapt to support enrollees because MCO services are interconnected. The Council opposes the language included in the House bill allowing any enrollee to opt out of Prepaid Medical Assistance Program (PMAP), Minnesota’s managed care program, and enroll in fee-for-service (FFS) under DHS. The PMAP program is the best option for the vast majority of MA enrollees because of the care coordination and extra services MCOs provide. Under FFS, enrollees do not have the same access to the coordination of these services and there are fewer providers participating, meaning fewer options for enrollees. The language in the bill provides no assurance that enrollees will be provided with an adequate explanation of this choice to ensure they do not choose an option that is detrimental to their health and wellbeing. Additionally, there is already a mechanism in place that allows adults and children with certain conditions or situations to seek a change from PMAP to FFS by DHS. While the fiscal note for this provision shows savings to the state, the Council is concerned that the fiscal note does not take into account the benefits of care coordination and increased access to care. The preventive care and early interventions promoted by care coordination can address medical issues before they spiral into complex, expensive conditions.

**Oppose MinnesotaCare Buy-in**

The Council opposes the MinnesotaCare buy-in proposal included in the House bill. The Council has several concerns about this proposal, including the negative impact to the MinnesotaCare program – adding more people to the MinnesotaCare program increases program costs and can impact the state’s ability to operate this program. Additionally, the Council is concerned this proposal will have a negative impact on the stability of individual and group markets. Proponents are seeking to have MinnesotaCare compete with commercial plans, even though these are completely different products. MinnesotaCare is a government-funded program managed by DHS which annually contracts with MCOs to provide access to care. Commercial plans are developed by health plans and are subject to regulation and approval by Commerce and MDH. MinnesotaCare does not offer comparable coverage to commercial plans because many of the benefit mandates the legislature has passed in previous sessions have applied to commercial plans, but not MinnesotaCare. Finally, by shifting enrollees out of the commercial market, this proposal would shrink the already relatively small risk pools for these products and increase the cost shift to the commercial as a result of lower provider rates in MinnesotaCare. Drawing enrollees out of the commercial market will destabilize these products, leading to higher premiums and fewer options statewide.

**Oppose Restrictions on Formulary Changes**

The Council opposes the House bill language that would prohibit a plan from making 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 as few changes as possible to a formulary throughout the plan year, but if it occurs it is often in response to a drug manufacturer dramatically increasing their prices. This language will increase the cost of health insurance premiums because the bill does not address the problem of the increasing prices of prescription drugs. This was illustrated in the fiscal notes attached to the house language when SEGIP was included in this provision. The current language, however, does not apply equally to the commercial market and state public programs - DHS is allowed to make formulary changes every three months for the MA and MinnesotaCare programs. Additionally, SEGIP has been exempted from this provision. All state-regulated markets should be treated equally.

**Oppose****Required Preference for Biosimilar Drugs**

The Council opposes the proposal included in the House bill that requires health plans to prefer biosimilar drugs on their formularies. Mandates do not properly contemplate all the various factors that health plans balance to support their members. For example, the biologic and biosimilar markets are new and complex, and the manufacturer rebate system at times results in the biologic being the lowest net cost drug for the enrollee. Council members recommend further discussion on a preference for the lowest net cost drug, to ensure the consumer is paying the lowest cost. Finally, if the legislature chooses to adopt this language, the policy should apply to SEGIP and state public programs, which are currently exempted in the bill. State policy should treat all state-regulated markets equally.

**Oppose New Benefit Mandates**

The House bill contains several new benefit mandates. State mandates apply to the fully insured market, which is currently around 16.3 percent of the state’s health insurance marketplace – the individual, small and large group markets. Everything that is built into health insurance coverage has an underlying cost because insurance is used to pay for health care services. The amount of premiums, copays and other out-of-pocket costs reflects the costs to pay doctors, hospitals, medical equipment and pharmaceuticals needed to provide care. When a new mandate is added to a plan’s benefit, there is going to be an added cost to premiums because there is a health care professional who is being paid to provide that care. The Council is concerned that the additional costs of new coverage mandates will result in health insurance becoming less affordable for Minnesotans. The Council also continues to express concerns about any benefit mandate that does not also apply to Medical Assistance and MinnesotaCare. All state-regulated markets should be treated equally.

We look forward to working with you and all Senate and House 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

CC: Governor Tim Walz

Speaker of the House Melissa Hortman

House Majority Leader Ryan Winkler

House Minority Leader Kurt Daudt

Senate Majority Leader Jeremy Miller

Senate Minority Leader Melisa López Franzen