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Dear Members of the House State and Local Government Finance and Policy Committee:

My name is Peter Nelson and I am a Senior Policy Fellow at Center of the American Experiment. Thank you for the opportunity to provide comments on HF 348. This bill would limit a health plan's co-payments to $25 per one-month for drugs and related supplies used to treat diabetes, asthma, and allergies requiring the use of epinephrine auto-injectors. If adopted, HF 348 would add another unnecessary benefit mandate that will add a new layer of mandated costs and undermine future benefit designs aimed at incentivizing more value-conscious health care decisions.

The state should not micromanage plan designs

Co-payments are an important tool in health plan designs used to encourage enrollees to consider the cost of care when making health care decisions. While co-payments can be quite high in some health plans, historically most people have been in plans with low co-payments. These simple plan designs with low co-payments have been a large contributor to the high and rising cost of health care in America. To address costs, health plans are moving more and more to offer plans with smarter co-payment structures to encourage more value-conscious and appropriate use of care.

In the health care system, research shows there can be a substantial level of both underuse and overuse of heath care items and services. Aligning the incentives in a health plan to encourage the appropriate use of care by avoiding overuse and discouraging underuse can be challenging but health plans are constantly working to meet this challenge. Moreover, they are the best equipped to meet this challenge. State lawmaker should be working to ensure health plans have the flexibility to fully meet this challenge. They should not be micromanaging plan designs.

Drug prices are not exploding

Contrary to what we often hear, drug prices have not been exploding in recent years. In fact, the main data source used to compare health care spending trends in America shows drug prices are one of the few areas in our health care system which has risen slower the rate of inflation in recent years. According the Centers for Medicare & Medicaid Services (CMS) National Health Expenditure (NHE) data, retail drug prices dropped for the fourth consecutive year in 2021. Over the most recent five-year period from 2016 to 2021, drug prices *dropped* by a compound average annual rate of 0.5 percent. By comparison, hospital prices *increased* by 2.0 percent annually.

Co-payments keep drug prices lower

Co-payments are likely a substantial reason why drug prices have *not* been exploding in recent years. NHE data shows there is a higher proportion of out-of-pocket spending on retail prescription drugs than other spending categories. In 2021, out-of-pocket funds accounted for

13.2 percent of retail prescription drug spending. By comparison, out-of-pocket funds accounted for 2.6 percent of hospital care spending and 7.6 percent of physician and clinical services spending. This higher out-of-pocket responsibility for drugs likely contributes to more price-conscious health care decisions, which has helped keep drug prices lower.

Little evidence to justify singling out the co-payments targeted in the bill

There is certainly the possibility that some out-of-pocket drug costs can be too high for some people and lead them to underuse certain drugs. However, there is little evidence that high co-payment costs are posing a substantial obstacle to the appropriate use of the drugs HF 348 proposes for co-payment limits, especially considering recent developments in the market.

The Department of Commerce Evaluation of a similar bill from last session appears to show that the average commercial health plan co-payment is $24.59 for diabetes drugs, $15.34 for asthma drugs, and $7.04 for allergy drugs. Nearly every Minnesota health insurer already caps insulin costs at $25 or less. These are very affordable co-payments.

It's worth noting here that the federal government recently gave health plans flexibility to offer certain drugs and supplies for diabetes and asthma without cost-sharing for preventive services before the deductible is met for health savings account qualified high deductible health plans.[1] This has helped mitigate cost issues for higher-income people without adding any mandates. The notice recognized the value in providing certain drugs at no or low-cost sharing to promote the appropriate use of the drugs. However, it left health plans in charge of deciding how to best establish co-payments. Many health plans are already taking advantage of this flexibility. One survey found three in four employers were already taking up this flexibility in 2021.[2]

Bill would block reasonable cost-control incentives

The language of the bill would appear to limit all co-payments for any drug related to treat these conditions to $25. This would severely limit a health plans ability to use various cost control measures to incentivize more cost-conscious decisions. Because the bill refers to “any co-payment,” the bill appears to prohibit the use of tiering and other formulary designs to steer people to lower cost drugs. It would also restrict health plans from requiring higher co-payments for drugs and supplies purchased out-of-network. Moreover, it would inhibit the development and adoption of other health plan designs that might reward value-conscious health care decisions, such as reference pricing plans and plans that provide shared savings.

Bill may violate federal EHB requirements

The Department of Commerce evaluation of a similar bill from last session concludes that this proposed mandate on health plans would not constitute a benefit mandate that requires defrayal under the ACA’s essential health benefit (EHB) requirements. However, this is not the only EHB requirement that is relevant to assessing a state mandate. Section 1302(b)(4)(B) of the ACA restricts an EHB from benefit designs that discriminate against individuals because of age,

[1] IRS Notice 2019-45, Additional Preventive Care Benefits Permitted to be Provided by a High Deductible Health Plan Under § 223 (July 17, 2019), available at https://www.irs.gov/pub/irs-drop/n-19-45.pdf

[2] Paul Fronstin, “Employer Uptake of Pre-Deductible Coverage for Preventive Services in HSA-Eligible Health Plans,” *EBRI Issue Brief*, October 14, 2021, available at https://www.ebri.org/docs/default-source/ebri-issue-brief/ebri_ib_542_hsaemployersur-14oct21.pdf?sfvrsn=73563b2f_6

disability, or expected length of life. This would appear to require health plans to put diabetes, asthma, and allergy drugs in a preferred drug tier, which would adversely tier all other drugs.

In the 2023 Payment Notice—the annual CMS rule on Exchanges and the insurance market—CMS provided an extensive discussion on the ACA's EHB requirements. In regards to adverse tiering, the preamble to the rule states that CMS "will look at the totality of the circumstances, including whether the issuer demonstrated that neutral principles were used in assigning tiers to drugs."[3] In this case, there does not appear to be any neutral principles guiding this legislation.

While CMS may not take action to stop enforcement of this bill as it focuses on favorable tiering versus adverse tiering, the CMS point on applying neutral principles remains an important consideration. Unfortunately, the bill appears to be driven by non-neutral factors tied to the politics and elevation of these particular classes of drugs in the public discussion. These are not appropriate factors for giving out advantages to some people that necessarily come at the expense of other people.

Committee should focus on ensuring flexibility for health plans to innovate

Alongside HF 348, this committee is also hearing bills to increase price transparency across Minnesota's health care system. These bills create the potential to produce pricing information that can be used to design health plans that give patients better tools to make value-conscious health care decisions without discouraging appropriate and necessary care. Shared savings approaches that provide cash incentives for choosing lower cost health care are one merging tool. The federal government recently updated insurance rules to ensure that health plans that offer shared savings are not dinged by medical loss ratio requirements.

Similarly, this committee should be focused on ensuring that health plans have the flexibility to pursue new plan designs. Considering health plan designs already recognize the value in ensuring that patients with chronic conditions take the medications they need to manage their condition, this bill can only serve to block reasonable plan designs aimed at ensuring access while also managing the cost.

Sincerely,

/Peter Nelson/

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[33] 87 FR 27208, at 27303.