AARP Testimony in Support of HF 1652
House of Representatives Health Finance and Policy Committee
March 19, 2025

Chairs Bierman, Backer, and Committee Members,

My name is Thomas Elness and I serve as the State Advocacy Director with AARP Minnesota. On behalf of our more than 620,000 members across the state, please accept this written testimony in support of H.F. 1652.

AARP supports consumer protections, such as those included in this bill, that limit mid-year changes to drug formularies that are not clinically appropriate. Prohibiting mid-year formulary changes provides a measure of fairness to consumers who often choose a health plan based on its coverage of services and medications that best suit their medical needs. Since most consumers can only switch health plans during their annual open enrollment period, mid-year formulary changes can trap consumers in a plan that, while suitable at the beginning of the year, is no longer a good fit for their health needs.

Mid-year formulary changes can force consumers to choose between paying more out-of-pocket or switching to a different, possibly less-effective drug to reduce the strain on their finances. Such choices can lead to adverse health outcomes, including less effective treatment and negative side effects.

If enacted, this bill would protect consumers from sudden increases in their out-of-pocket costs for prescription drugs or the loss of access to a needed drug entirely. It would ensure that prescription drug formularies maintain greater continuity over the course of a health benefit plan year, providing fairness and increased certainty to consumers.

Thank you for the opportunity to testify in support of H.F. 1652.

Thomas Elness
State Advocacy Director
AARP Minnesota

March 19, 2025

Dear Members of the House 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 several bills on the Committee agenda today.

HF 1652

This bill 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. Due to the fact that formularies are one of the few tools available to plan sponsors to help control prescription drug costs, fiscal notes have provided varying cost estimates for similar proposals over the years when applied to state public programs.

However, it is important to note that that the provision included in this bill is not applied to state public programs like Medical Assistance and MinnesotaCare. 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 public programs. If there is an interest in moving forward legislation to change the way formularies are used in Minnesota, we believe the same standard should be applied both to commercial plans and state public programs.

HF 1075

This bill requires a health plan's prescription drug rebates to be passed along to consumers at the point of sale, to reduce out of pocket costs. Here again, while the goal of this proposal has merit, the impact of such a change would lead to increased premiums for covered by the health plan. In May 2019, the Congressional Budget Office (CBO) analyzed a similar proposal being considered in the federal Medicare program. In its analysis, the CBO noted that rebates are currently used to reduce premiums for all beneficiaries in a given health plan. "If those rebates were no longer paid directly to plans," CBO said, "premiums would rise."

Minnesota has the 9th highest family premiums and the 13th highest individual premiums in the country for employer sponsored insurance. According to the Minnesota Department of Health, since 2017, Minnesota families have reported among the highest median health care spending in the country. We ask the Legislature to carefully consider the impact of bills, like these, that have the potential to add to the health insurance affordability burden that many Minnesotans are already struggling with.

Thank you for the opportunity to provide this input.

Sincerely,

Bentley Graves
Director, Health Care & Transportation Policy

Minnesota Chapter

INCORPORATED IN MINNESOTA

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Minnesota Chapter of the American Academy of Pediatrics
1609 County Road 42 W #305,
Burnsville, MN 55306

March 18, 2025

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

Dear Members of the Health Finance and Policy Committee,

On behalf of the over 1,000 members of the Minnesota Chapter of the American Academy of Pediatrics, I am writing in strong support of HF1652.

Insurance companies and pharmacy benefit managers (PBMs) can currently change drug coverage at any point in the insurance contract year. This can lead to delays in care, unexpected and increased expenses, and overall worse health outcomes for patients. These mid-year formulary changes must be prohibited.

While formularies and preferred drug lists can have a role in reducing costs, this must be balanced with patient's access to care. Families will often choose their health insurance plan based on whether the plan covers needed medications. HF1652 is a balanced approach because it only applies to a patient who is currently receiving a drug therapy. This is not a standard "frozen formulary" proposal as seen in some other states. Nothing in the bill would prohibit PBMs and insurers from changing formularies for all other enrollees.

Thank you for the opportunity to weigh in on this important piece of legislation. HF1652 will help our patients – Minnesota's children – receive the care they need. I strongly urge your support.

Sincerely,

Katie Smentek, MD
President, Minnesota Chapter American Academy of Pediatrics

March 18, 2025

Representative Jeff Backer, Co-Chair
Representative Robert Bierman, Co-Chair
House Committee on Health Finance and Policy
Capitol Room 120
75 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

Dear Co-Chair Backer, Co-Chair Bierman, and Members of the House Committee on Health Finance and Policy,

The Minnesota Society of Clinical Oncology Society (MSCO) and the Association for Clinical Oncology (ASCO) are pleased to strongly support **HF 1652**, a bill that would protect Minnesota patients from non-medical switching of medications during the same plan year. We thank you for your consideration and encourage the Committee to vote this bill forward.

MSCO is a professional organization whose mission is to facilitate improvements for Minnesota physician specialties in both hematology and oncology. MSCO members are a community of hematologists, oncologists, and other physicians who specialize in cancer care. ASCO is an organization representing physicians who care for people with cancer. With over 50,000 members, our core mission is to ensure that cancer patients have meaningful access to high-quality cancer care.

MSCO and ASCO are committed to supporting policies that reduce cost while preserving quality of cancer care; however**,** such policies should be developed and implemented in a way that does not undermine patient access. Payer utilization management approaches like non-medical switching are of particular concern because they undermine patient access to the most appropriate treatment for their disease as well as erode patient confidence in their provider's ability to construct an effective care plan.

Non-medical switching of medication, whereby a patient's treatment regimen is changed for reasons other than efficacy, side effects, or adherence, is often done without prior notification of the prescribing physician and is primarily focused on reducing drug costs. MSCO and ASCO understand health plans need strategies for controlling costs; however, payers and providers must share the primary goal of delivering high-quality care that is most appropriate for the patient.

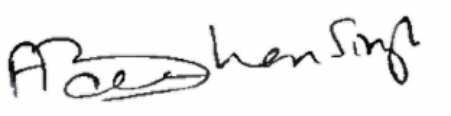
While many treatments preferred by payers cost less, they may not be the best treatment available for the patient. Oncologists take great care to construct highly individualized treatment plans specifically designed to be most effective for each patient with cancer under their care. If a patient is re-directed to take a drug that is not in their treatment plan or known to be less effective for their disease, and they experience progression in the meantime, this could result in increased costs to the payer over the course of the patient's care since even more specialized treatments would be required. This can ultimately increase costs, as savings by insurers are cancelled out by higher costs to the overall health care system as a result of poorer patient outcomes.

With the welfare of Minnesota cancer patients in mind, we are pleased HF 1652 places safeguards around potentially harmful practices like non-medical switching by:

- **Protecting patients who are already stable** on a medication from potential physical and financial toxicity caused by tiering, coverage, and formulary restrictions that often coincide with payer decisions to engage in non-medical switching;
- **Preventing payers from imposing higher cost sharing** on patients who are stable on their current regimen. To limit or discourage use, payers are increasingly placing cancer therapies on the "specialty tier" of their formularies. Placing a drug on a specialty tier shifts a large portion of the cost of care from the payer to the patient. As such, high coinsurance rates related to specialty tier designation undermine the primary purpose of health insurance, causing cancer patients to face significant financial burdens or to forgo access to life-extending and life-saving drugs; and
- **Limiting the use of restrictive formularies,** which are particularly problematic in oncology because cancer drug therapies often are not clinically interchangeable. Restrictive formularies may preclude a patient's best option for a successful outcome and should not be a cost containment strategy for cancer drug therapies. Prescription drugs have different indications, different mechanisms of action, and different side effects, depending on the diagnosis and comorbidities of an individual patient. Even if the threat of non-medical switching is mitigated, plans restricting drug benefits would limit the ability of providers to make the best medical decisions for the care of their patients.

MSCO and ASCO are encouraged by the steps that HF 1652 takes toward improving continuity of care and preventing non-medical switching of medications during a plan year for patients with cancer in Minnesota. For a more detailed understanding of our policy recommendations on this issue, we invite you to read the ASCO Position Statement: Utilization Management by our affiliate, the American Society of Clinical Oncology. Please contact Nick Telesco at ASCO at Nicholas.Telesco@asco.org if you have any questions or if we can be of assistance.

Sincerely,



Amrit Singh, MD
President
Minnesota Society of Clinical Oncology

Eric P. Winer, MD, FASCO
Chair of the Board
Association for Clinical Oncology

Members of the House Health and Commerce Committees,

Senator Mann and I are running a set of three drug marketplace reform bills, this session. They were first heard in the Senate Commerce Committee last week, and they'll be heard in the House Health Committee, this week (and re-referred to Commerce, knock-on-wood). Understanding the objective of these bills requires a somewhat deeper understanding of the role that PBMs play in the value chain and their relationship with both manufacturers and health plans. To get the gist of what's going on, here, you'll first want to read this Wall Street Journal article:

https://www.wsj.com/health/healthcare/same-drug-two-prices-why-the-higher-price-prevails-d24038c8?st=oPcv2U&reflink=desktopwebshare_permalink

It's about a five-minute read and your initial reaction will be: **WTF?**

So, how did we get here?

Once upon a time Pharmacy Benefit Management (PBM) was a boring business specializing in processing drug claims for health insurance companies. Then in 1990, Congress carved out a safe harbor exemption from the federal anti-kickback statute that allowed drug manufacturers to offer rebates to the purchasers of their drugs in hopes that this would inject more price competition in the drug marketplace. There were some unintended consequences.

The PBM companies saw a business opportunity and approached the health plans with a business proposition: "Since we understand this side of the business much better than you do, we can negotiate much better deals with the manufacturers than you can and, in fact, we're so confident of this that we're willing to be compensated by taking a share of the savings that we win for you." In the beginning, the concessions were modest. The PBM might win a 10% rebate and pass 8% on to the health plan. Except that every January, right after the health plan year began and the drug formularies were locked in for the year, the drug manufacturers would raise their prices by 12% to assure themselves of a net price increase. The next year, the rebate would be 15%, 12% was passed along the health plan and, in January the manufacturers would raise their prices by 17%. This went on for years and every year the manufacturers got a net increase in price and the PBMs got a bigger slice of rebate dollars but the health plans and their members were actually worse off.

Eventually, the health plans caught on and demanded basic changes in the relationship. From then on, the health plans received substantially all the rebate revenues and the PBMs were instead paid transaction fees for conducting the negotiations and processing the claims. (They've since invented new revenue streams – we'll leave that for part 3.) Henceforth, the PBMs were compelled to negotiate exemptions from the manufacturer's January price increases on behalf of their health plans. However, by the time the cycle was broken, the average drug price had doubled and the average rebate had reached about 50%. (Dr Adam Fein refers to this as the "Gross to Net Bubble".) (Note: When I first hypothesized

that this is what had happened, each of the major PBMs personally confirmed to me that this was *exactly* what had happened.)

So now you're thinking that, surely, these huge rebates must be finding their way back to the patients taking these drugs in the form of lower prices at the pharmacy, right? If you're thinking this, you would be wrong! Instead of passing the rebate savings along to patients in the form of lower drug prices, the plans decided to pocket the savings for themselves and use them to buy down the cost of premiums for their memberships at-large. In the case of employer-sponsored ERISA plans, a Milliman study found that employers were pocketing 70% of the rebates to buy down their share of plan contributions. What was worse, the PBMs and plans didn't exempt *their members* from the manufacturers' January surprise price increases. So, if you're a patient taking one of these expensive drugs with an inflated list price you might be paying a co-insurance payment of 25% of the inflated full list price of the drug – you might even be paying more than your health plan is paying for the drug (net of the rebate).

Now, go back and re-read the Wall Street Journal Article, again, and connect the dots, because something else that's really pernicious has crept into the equation: The health plans have become so addicted to the rebates that, when offered the choice between a high-price/high-rebate drug and a low-price/low-rebate drug, *they're choosing PBM formularies with the high price drugs instead of PBM formularies with the low-price drugs*. The PBMs are taking most of the blame for this sad state of affairs, but it's really the plans that are driving this behavior. The result is that sick patients who need lifesaving drugs are paying higher prices so that the healthy can pay lower premiums. In many cases the sick patients who need the drugs can't afford to take them, so "drug regimen adherence" and patient health suffer.

And then there's this: *there is no longer any incentive for competitive manufacturers to enter the market with cheaper generic and biosimilar drugs*. If formulary placement is based solely on the size of the rebate, the incentive is to ***raise*** the price to that you can pay a larger rebate to buy your way onto the formulary. Why spend millions to develop a new low-price generic drug if the PBMs and plans are going to prevent you from selling it? This is why you see manufacturers offering the same drug in a high-price/high-rebate version and a low-price/low-rebate version and why we're seeing the high price version being the one that the PBMs and plans usually choose.

The three bills that will be before the House Health Committee on Wednesday attack this in different ways.

HF1652/SF1806 says that a health plan can't force you to switch drugs in the middle of a plan year because they're now getting a bigger rebate from the manufacturer of a competitive drug. If you chose your health plan because the drug that works for you was on that plan's formulary during open enrollment, then the health plan should be required to allow you to keep taking that drug though the end of the plan year. It's already illegal for a health plan to take away a medical benefit during the plan year. Why is it legal for lifesaving drugs?

HF1075/SF1877 says that your health plan and PBM must use the rebates that they received when you bought your drug to buy down your price at the pharmacy counter in the form of a “Point of Sale Rebate”. This is now done in several states. Minnesota-based OptumRx is a PBM that pioneered POS Rebates and promoted them to its health plan clients (who said “no thanks, we’d rather keep the rebates for ourselves”). All the big PBMs have confirmed to me that they already have the capability to implement POS rebates seamlessly (most of them use the Optum RxClaim drug claim processing system). This is all done automatically and invisibly in the system – the patient and pharmacist don’t have to do anything special. When POS rebates were implemented in Arkansas, a follow-up study by Milliman found no perceptible increase in health insurance premiums. This bill has been through the Mandate Review process. Commerce determined that it did not constitute a mandate subject to defrayal.

HF1076/SF1876 is a novel approach not yet adopted by any other state. It says that, when there are high-price and low-price drug equivalents in the market, the PBMs and plans have to include the low-price drugs in their formularies and construct their formularies so that the drugs with the lowest prices *to the patient* receive the best placement in their formularies. One of the objectives with this approach is to redirect competition away from rebates towards lower prices.

Both HF1075 and HF1076 will exempt plans where patients pay modest copays for their drugs (instead of percentage co-insurance payments based upon high list prices).

I’m still looking for co-authors on these three bills.

Finally, if the Wall Street Journal article wasn’t sickening enough for you, this New York Times article will surely put you over the top:

“Drugmakers including Purdue Pharma paid pharmacy benefit managers not to restrict painkiller prescriptions, a New York Times investigation found.”

https://www.nytimes.com/2024/12/17/business/pharmacy-benefit-managers-opioids.html?unlocked_article_code=1.4k4.HTZt.Lj0ENodLMTlB&smid=em-share

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