AMERICAN EXPERIMENT

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Dear Members of the Senate Commerce and Consumer Protection Committee:

Thank you for the opportunity to provide comments on the Omnibus Commerce and Consumer Protection Finance bill (SF2744). The following comments focus on the health policy provisions included in Article 2.

Minnesota's health care system continues to be challenged by high and rising costs. Minnesotans who earn too much to qualify for publicly subsidized coverage and who don't have access to employer-sponsored coverage depend on the individual health insurance market. Without government or employer support, high health costs present a far more substantial challenge to this population than most.

The policies in the bill clearly recognize the serious problem high health care costs pose to the state and to people who depend on the individual market. Unfortunately, these policies rely on a public utility model which will always hold back the healthcare system from achieving the level of innovation we enjoy and expect from every other major industry. Instead of a public utility model, Minnesotans would be much better served by a competition driven model that finally begins replacing the perverse incentives that pervade the health care system with new incentives that push health plans, providers, and drug companies to compete to deliver more innovative care and treatment models at a lower cost.

The following comments summarize the major problems with the key health care provisions in the bill and briefly points to how competition driven policies can lead to better results.

Price controls reduce access to life-saving drugs

Two provisions would prohibit excessive price increases on certain drugs and to establish a Prescription Drug Affordability Board with the power to set an upper payment limit on the price of drugs. Both policies operate as price controls. Unfortunately, there are always negative consequences when the government steps in to set prices. Time and again price controls lead to shortages, lower quality, less innovation, and fewer new products. In the case of price controls on drugs, there is a clear tradeoff between lower prices and reduced investments in the development of life-enhancing and life-saving new drugs.

This is not a defense for current drug prices. Health care costs are too high across the entire system, including drugs. But the solution to high prices should focus on competition, not price controls. Our system shields health care prices from cost-controlling competition by keeping

them hidden. Several bills are moving through the Minnesota legislature to increase price transparency, including a bill to force drug manufacturers to reveal their list prices. This is where lawmakers should focus.

Cost sharing caps undermine future benefit designs to incentivize value-conscious decisions

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. This bill proposes to limit co-payments to for drugs and related supplies used to treat diabetes, asthma, and allergies requiring the use of epinephrine auto-injectors. These cost sharing caps will raise premiums by adding a new layer of mandated costs. The language of the bill would appear to limit all co-payments for any drug related to treat these conditions. This would severely limit a health plan's ability to use various cost-control measures to incentivize more cost-conscious decisions.

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.

Standard plans reduce incentives to innovate better plan designs

The government is not well suited to designing products and services for consumers in any industry, and health insurance is no exception. Nonetheless, this bill would put the commissioner of commerce in charge of setting parameters for a "standard plan" that all individual market health insurers must offer.

In 2018, the Centers for Medicare & Medicaid Services (CMS) removed similar regulations for plans sold on the HealthCare.gov platform after determining "that not specifying standardized options for the 2019 plan year will remove disincentives for issuers to offer coverage with innovative plan designs" and "that issuers are in the best position to design and offer innovative plan designs."[1] Since then, CMS has added back standardized plan requirements. They now maintain that standard plans will help enhance the consumer experience, increase consumer understanding, simplify the plan selection process, combat discriminatory benefit designs that disproportionately impact disadvantaged populations, and advance health equity. The omnibus bill's standard plan requirement is based on a similar rationale as this current CMS policy applies to HealthCare.gov. Unfortunately, by discouraging issuers from offering and innovating new plans, the standard plan requirement will proposed rule will likely undermine the consumer experience.

Standard plan requirements appear to be primarily driven by concerns about the dangers of choice overload, which could lead consumers to make poorer decisions or no decision and not buy coverage at all. But consumers generally welcome more choices. Grocery stores stock

[1] 83 FR 16930, at 16975.

dozens of types and brands of pasta sauce precisely because consumers buy them. Research tends to show that when stores offer more choices for a product they sell more of the product.[2]

To the extent choice overload might exist for more complex products like health insurance, choice architecture can address those issues without reducing the choices available. For instance, sorting options into smaller subgroups and narrowing choices to selected subgroup has been shown to give consumers the benefits of fewer choices without reducing the number of choices.[3] MNsure already does this in many respects by allowing consumer to sort health plans by metal tier and plan type (e.g., PPO vs. HMO). Agents, brokers, and web brokers also provide decision support tools that help narrow choices when helpful.

While the standard plan requirement in the omnibus bill does not currently limit choices, it does steer choices and it does create a pathway to limit choices in the future. After requiring standard plans for the current benefit year on HealthCare.gov, CMS is currently considering a proposal to limit health plans on the HealthCare.gov to offering just two non-standardized options alongside the standard plan. This proposal would effectively would lock out health plan innovation for the entire market. This is the wrong direction for Minnesota's individual market. Minnesota has already struggled with disruptions in the individual market and needs to take care to retain the insurers and the choices that currently exist in the market. There is no evidence that choice overload presents a problem on MNsure that warrants a move toward standard plans.

Instead of standard plans, lawmakers should create opportunities to give consumers access to purchase subsidized coverage through web brokers, much like CMS has done through their enhanced direct enrollment (EDE) program. Through EDE, web brokers currently compete to provide HealthCare.gov consumers with the latest, most innovative choice architecture tools to give them the best consumer experience without limiting their choices.

Eliminating reinsurance funding will raise premiums and disrupt the health care market

The omnibus bill would eliminate funding for the state's very successful reinsurance program in fiscal year 2026. After individual market premiums spiked from 2015 to 2017, the state responded by implementing the Minnesota Premium Security Plan, a reinsurance program which immediately reduced premiums. By 2019, Minnesota's individual market had the lowest average premiums in the country. Individual market premiums in Minnesota continue to be among the lowest in the country. Despite this success, the omnibus bill would instead facilitate moving toward a MinnesotaCare public option. However, to work, a public option would depend on the sort of government subsidies and price controls that will distort the state's health insurance system and, as a result, undermine the efficient delivery of health care across the state.

There are still affordability and access issues in the individual market. Efforts to address these issues should work to build on the success of reinsurance. Moving in a different direction would

[2] *See* Benjamin Scheibehenne, Peter Todd, and Rainer Greifeneder, "Can there ever be too many options? A meta-analytic review of choice overload," *Journal of Consumer Research*, 2010, vol. 37, no. 3, at 411.
[3] *See* Tibor Besedeš, Cary Deck, Sudipta Sarangi, and Mikhael Shor, "Reducing Choice Overload without Reducing Choices," *The Review of Economics and Statistics* (October 2015).

abandon the effective and efficient cost controls built into reinsurance. Importantly, these cost controls take advantage of competition in the private market which improves the market and does not distort the market.

Conclusion

Minnesotans expect more than a public utility approach to address problems in our health care system. While there are of course tradeoffs to any policy decisions, health care policy approaches that rely on a competition driven model offer the best opportunities to maximize the consumer and patient experience in the health care system. We can have a health care system that simultaneously delivers *broader access* to *higher quality* at a *lower cost.* Other industries achieve all three goals through a competition driven model. A public utility model cannot deliver on all three. Thus, this committee should be pursuing the competition-driven alternatives outlined here.

Sincerely,

/Peter Nelson/

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