March 31, 2023

Dear Members of the Senate Health and Human Services 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 views about certain provisions contained on the A-2 DE amendment to SF 2995 (Wiklund).

Article II

Health Insurance Mandates

Employer-sponsored health insurance is an increasingly important benefit, both in terms of retention and attraction of talent and in terms of keeping employees healthy and productive at work. And yet, three-fourths of our members who offer insurance to their employees report that they will be required to make significant changes to their benefit offerings – including dropping coverage altogether – if costs continue to rise at their current rate.

Minnesota requires coverage of roughly 60 benefits as part of fully-insured individual and group health insurance products sold in the state. By some estimates, Minnesota ranks in the top five states with the most mandates. All of these requirements were passed by the Legislature to help Minnesotans access coverage for certain health care procedures or treatments. Like the proposals included here, they all help someone. But it is also true that they all come with a cost.

In January 2022, the Department of Commerce shared with the Legislature its statutorily required cost-benefit evaluation of the proposal contained in Section 5, requiring health plans to provide coverage for all post-screening mammography diagnostic services recommended by a physician at zero cost to the enrollee. In its evaluation, the Department reported that eliminating the barrier of enrollee cost-sharing for follow up services following a mammogram may enable patients to receive earlier diagnoses for cancer. At the same time, however, the report noted that higher utilization of follow up services can result in higher false positive rates. As a result, the evaluation concluded that "the potential for benefit is therefore assessed as moderate."

The evaluation also estimated that the addition of this proposal to state statute as a component of required health insurance coverage in Minnesota's fully-insured market would result in an increase in health insurance premiums.

Similarly, earlier this year, the Department provided its evaluation of the proposal contained in Section 18, Biomarker Testing Requirement. In its evaluation, the Department found "evidence suggests that biomarker testing can optimize treatment by using genetic profiles to assess the risk potentials or efficacy of certain drugs based on individual biomarkers. Biomarker testing may reduce adverse outcomes and improve

provider drug selection." It also noted that "data are limited on whether insurance coverage of biomarker testing itself is linked to reductions in health disparities and improved clinical outcomes" and that "experts acknowledge that additional guidelines and research are needed to aid in further standardizing biomarker testing and integrating it into diagnosis and treatment decisions." Finally, the report found that "other research shows that there is still limited evidence regarding the cost-effectiveness of biomarker testing."

At the same time, the evaluation estimated that the addition of this proposal to state statute as a component of required health insurance coverage in Minnesota's fully-insured market would result in an increase in the health insurance premiums of all Minnesotans in that market. The Department estimates that the cost of implementing the requirement would be up to $2.6 million in the first year alone – and only for the individual market plans sold through MNsure. This is a cost that the federal government requires the state to pay, but it is only for a portion of the health insurance market that will be impacted by this new coverage requirement. There is no requirement that the state cover the increased premiums of those who access coverage through individual market plans purchased outside of MNsure or those who receive coverage through the small group or large group markets.

We would note that, according to the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, policy holders in Minnesota already pay more in total health insurance costs than those in nearly every other state. We are concerned that these proposals will add more costs to what is already an extremely expensive product.

Changes to the All Payer Claims Database (APCD)

We would request that the language in Section 24, related to third party administrator (TPA) outreach to self-insurers about the opportunity of these self-insurers to contribute claims information to the APCD, reflect the language contained in the first engrossment of SF 302. The United States Supreme Court has concluded that self-insurers cannot be required to submit data to state APCDs. As such, it is unclear what purpose there is in the Commissioner maintaining a list of those self-insurers that choose to contribute data to the APCD and those that do not. We know that some self-insureds would be willing to contribute, if notified of the opportunity to do so by their TPA. But that can be accomplished without the commissioner requiring TPAs to compile and submit lists of their clients.

Though a somewhat lesser concern, consideration must also be given to the cost of complying with this requirement, which will likely be passed on to the self-insured entities by the TPAs required to collect and remit the information.

Article III

Nurse Staffing

These provisions would place a significant burden on the Minnesota hospitals and health systems that have been operating for three years under extremely challenging times. They would also set a disturbing precedent in workplace management – establishing a state mandate that the staffing of a work site be set by a committee. This staffing committee is not advisory. It is given the authority to establish the number of employees at work, in this instance the number of Registered Nurses. These are decisions that are made on a daily basis by Chief Medical Officers and Chief Nursing Officers and, at a higher level, with employees through

collective bargaining. The legislature should not upend these decisions about staffing by requiring that they be made by a legislatively mandated committee.

These requirements are also overly punitive and may lead to unintended consequences for Minnesotans across the state. All of us depend on hospitals and health systems for the delivery of health care services. However, these mandates on hospital operations could lead to rising costs, longer wait times, and the reduction of available health care services in a given community. If a hospital is not able to accept and treat a patient while adhering to the required staffing plan, patients would likely be turned away.

There is no industry or community in the state where Minnesota's workforce shortage is not a challenge. Employers are scrambling to retain and hire workers. To do so, they are offering increased wages and salaries, expanded leave benefits, remote working and more flexible work arrangements, customized training, tuition assistance, and childcare support. In much the same way, we know most hospitals and health systems are currently trying to hire more nurses, and wages are escalating. Despite these efforts, however, there are still over 5,000 open nursing positions in the state.

Establishing a rigid, mandated process for staffing hospitals will not help to address the workforce challenges the health care sector is facing. It is our hope that the legislature focuses on licensing and credentialing efforts that help ease this shortage, rather than an approach that further complicates operations and may decrease the availability of care.

Appropriations

Health Care Access Fund Transfer

Various provisions contained in this bill and other bills moving through the legislative process this session have the potential to fundamentally alter the health care landscape in Minnesota. Given the amount of change – and the potential for accompanying challenges – that is ahead, we would urge caution in unnecessarily drawing down the balance of the Health Care Access Fund (HCAF). It is certainly true that, at times in the past, the state has been forced to increase spending from the HCAF during times of budget deficit to ensure Minnesotans' access to critical health care services. However, at a time when the state is enjoying an historic, $17.5 billion surplus, it seems short-sighted to shift more than $1.2 Billion in MA costs from the General Fund to the HCAF simply to allow the Legislature to spend an additional $1.2 Billion from the General Fund.

Thank you for the opportunity to provide this input.

Sincerely,

Bentley Graves
Director, Health Care & Transportation Policy