MINNESOTA COUNCIL of HEALTH PLANS

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Health and Human Services Committee
95 University Avenue W.
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Chair Wiklund and Members of the Committee:

The Minnesota Council of Health Plans' nonprofit members (Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica, Sanford Health Plan of Minnesota, and UCare) provide 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 outcomes that meet these goals, the Council appreciates the opportunity to provide feedback on several items included in the Senate Health and Human Services Omnibus Bill.

**Public Option and Market Impacts**

*MinnesotaCare Public Option Implementation*

The Council has significant concerns regarding the public option implementation language included in the omnibus bill. With reinsurance slated to run out of funding at the end of 2025 and the proposed public option not beginning until 2028, Minnesotans in the Individual market face significant affordability and access challenges in plan years 2026 and 2027. Keeping the Individual market stable is vital to continued stability across all markets. We urge continued support for the bipartisan reinsurance program, which has proven to consistently lower premiums since its inception in 2018.

Last year, the Council identified several items that would be essential to study prior to implementation of a public option, including:

- An examination of broader market impacts, including market stability, adverse selection, and cost shifting to other markets.
- Consideration of impacts to providers including reimbursement, if participation would be required, and the impacts to enrollee access to care if providers refused to take patients enrolled in MinnesotaCare.
- The coverage and utilization differences between commercial plans and MinnesotaCare.
- Any negative impacts to the MinnesotaCare program because of increased costs to the state and any state budget impacts, including the impact of the state taking on a greater share of the financial risk for coverage.

Unfortunately, the Milliman report produced this winter did not include in-depth analysis of any of these considerations. Without a full understanding of these broader impacts, submission of a waiver and implementation of a public option is premature.

The Council urges caution when considering implementing this type of significant disruption to the individual market and health care system. We would like to direct your attention to New York, the only other state that has attempted to expand their Basic Health Plan (BHP). New York received approval on March 1, 2024, to suspend their BHP and replicate the program for up to 250% FPL, beginning April 1, 2024. In their 1332 waiver application, New York explains the reason for this approach is "in the interest of reducing coverage disruptions to as many consumers as possible" and cites a heightened administrative burden from running two separate programs. They also included funding to ensure removing the 200-250% FPL population from the individual market risk pool would not result in instability or premium increases for those remaining on the individual market.

Given the only other state contemplating such a move decided separate programs would result in coverage disruptions, heightened administrative burden, and higher costs for the remaining market, the Council urges considerations of additional approaches than what is currently included in the Minnesota Public Option Proposal. We encourage legislators to review the results of the RAND study commissioned by the Council that provides enrollment and cost analysis on alternative options.

*Premium Security Plan Account Transfer*

The Council opposes transferring out the remaining funding in the Premium Security Account. Reinsurance is a proven program that has provided stability in the individual market and reduced premiums on average by 20% since 2018. The defunding of this program will result in several thousand Minnesotans becoming uninsured starting in 2026. Ending this successful program will jeopardize access to affordable insurance for Minnesotans who purchase health insurance on their own, including farmers, day care providers, contractors and entrepreneurs. We strongly urge the Committee to reassess this position and to reinstate the previously transferred out funding in order to continue reinsurance and our state's high rates of coverage and access to needed care.

**Benefit Mandates**

*Apply Mandates Equally*

The Council has a long-standing position that any coverage requirements enacted by the legislature must apply equally to all state regulated markets, which includes the fully-insured market (individual and group commercial markets), state public programs (Medical Assistance and MinnesotaCare) and the state employee health insurance program (SEGIP). We appreciate the consistency with which most of the benefit mandates are applied across markets.

The Council would like to better understand the need for the fee-for-service exemption included for the maternity care cost sharing prohibition. We would like to ensure the remaining 15% of Minnesotans enrolled in fee-for-service Medical Assistance would receive the same benefits as those enrolled in managed care.

Pharmacy services payment requirements similarly does not extend the requirement to fee-for service or MinnesotaCare because it does not include market application language as heard in committee. We strongly encourage reinstating the requirement to apply to all markets if the policy moves forward.

*Adjust Effective Dates of Benefit Mandates*

Finally, the Council requests the new coverage mandates to have effective dates of January 1, 2026. All health carriers in the fully-insured market must submit their insurance products proposed for sale in these markets to the Department of Commerce for their approval. Submission of these plans for an upcoming plan year occurs in April of the year prior. Health carriers are already in the process of submitting their plans for the 2025 plan year and will have done so before this bill is enacted.

**Level Playing Field**

*County-Administered Rural Medical Assistance Model (CARMA)*

The Council supports competition that occurs on a level playing field. However, we hold concern that the CARMA model may limit options for those on medical assistance, by creating a system in which a county could restrict their options of coverage to a single option. We encourage the bill author and committee to examine this language further in order to ensure that the existing federal requirement of at least two plan options is preserved.

*Minnesota Health Records Act (HRA)*

We respectfully oppose the HRA language included in the bill, because it would lead to delayed access to care, duplication of services, patient frustration, and increased costs. Access to health records is already a highly regulated process under federal and state law. Federal regulations, including HIPAA, the HITECH Act and the Omnibus Privacy Rule strictly govern when, where, and to whom health information can be shared. This language would put Minnesota at odds with 48 other states who do not deem these extra regulations necessary to sufficiently protect private health information. We understand the author's intent may be to return to a pre-Supreme Court ruling landscape in Minnesota. However, we are concerned this language is open to even stricter interpretations, which could hinder Minnesotans' ability to access timely care.

We look forward to continuing working with you as this bill progresses to ensure its impact is to lower health care costs, maintain stability in the market, and help Minnesotans gain access to needed care.

Sincerely,

Lucas Nesse President
and CEO