MINNESOTA COUNCIL of HEALTH PLANS

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Senate Health and Human Services Committee
95 University Avenue W.
St. Paul, MN 55155

Dear Chair Wiklund and Members of the Committee:

The Minnesota Council of Health Plans ("Council"), the trade association for Minnesota's nonprofit health plans (Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica, Sanford Health Plan of Minnesota, and UCare) works every day to support access to high-quality affordable health care. We are writing to express concern that several proposals contained in the omnibus proposal will increase costs and thereby increase premiums and make coverage less affordable for Minnesotans.

MA Rates/ Health Plans Assessment / Directed MCO Payments

The Council shares the concern over low Medical Assistance ("MA") payment rates and the impact this has on patient access to care and cost shifting into commercial markets. However, we have several concerns regarding the funding mechanism requiring the managed care organizations serving MA enrollees to provide the State a zero-interest loan and pay a new tax on commercial insurance to fund an across the board increase to providers.

The higher costs in this proposal would impact the individual market, which has already required the reinsurance program to support affordability for Minnesotans. Increasing costs for a market that is broadly recognized as needing subsidization to be viable undermines the goal of making coverage more affordable. The higher costs also impact the small to mid-size employer group market, which has become less stable year after year as employers have left due to higher state costs and sought relief in the federally regulated self-insured market.

Finally, this proposal does not contemplate offsetting increased MA rates with policies to support lower commercial rates, which are significantly higher to account for existing MA rates being below the actual cost of care. We urge any increase, especially those reliant on new taxes or fees applied to commercial plans, be paired with policies that can help Minnesotans benefit from proportionately lower commercial rates.

Again, we sympathize with low MA rates but do not support the financing mechanism proposed in this bill to increase those rates. Health plans already pay significant taxes into the Health Care

Access Fund and the General Fund, totaling more than $800 million annually. These existing, broad-based taxes could be used to draw down federal funds without creating a new tax. We recommend the legislature consider exploring this option rather than create a new tax.

The approach is stark contrast to the MA rate increase as proposed for hospitals. There are many low to negative margin hospitals, especially in rural areas, that are in critical need of this increase. That proposal relies on existing funding to leverage increased federal funding without any detrimental impact on commercial rates. We are generally supportive of the funding mechanism while noting that timelines for payment need to be logistically possible and that less financial pressure and therefore lower commercial rates should not be prohibited in the language.

There are proposed license and filing fee increases for health plans as well as tax increases in the omnibus bill. The most significant is the provider tax increase to 2%. Last biennium we opposed this committee transferring over $1.2 billion out of the health care access fund to support general fund obligations, which withdrew a strong structural balance from the fund that could have otherwise been used to support access to care. Health plans and ultimately consumers, indirectly in the form of higher premiums and often directly out of pocket as well, pay this tax as part of utilizing provider services. Increasing this tax will increase costs for Minnesotans.

95% of the lives covered in the state regulated fully-insured commercial markets are through nonprofit health plans products, and their historically slim 1-3% operating margins that are needed to sustain coverage options. Health plans are also subject to payment delays and withholds exceeding $1 billion annually. Any new tax on our nonprofit plan members will need to be passed along in the form of increased premiums for Minnesotans.

Reduction in MA Capitation Payments

The omnibus bill proposes to authorize limiting trend increase in rates paid to MCOs by an amount equal to the value of a .1% reduction in trend in MA and mandates a forecast adjustment to trend growth over the next three state fiscal years. Rates already must meet actuarial soundness and rate development requirements under federal regulation and review. An arbitrary reduction or cut expressly less than actual or forecasted trend does not properly adhere to those requirements.

Replace Reinsurance with Premiums Subsidies and Health Plan Tax

We appreciate the author's recognition that the individual market requires a subsidy to support affordability. The state used subsidies for one year in 2017 and learned significant lessons before transitioning into operating the successful reinsurance program.

While reinsurance is effectively a subsidy program, a state premium subsidy program has several operational shortcomings. The two most significant are that the subsidies are considered taxable income and the program fails to reallocate, and therefore forfeits, the state subsidies' impact on federal APTC subsidies. The reinsurance program was purposefully designed to avoid both of those major pitfalls.

The financial mechanism for reinsurance has historically been health care access fund and general fund appropriations combined with roughly 50% federal funding. As noted above, health plans pay significant taxes to both funds already. The proposed new tax on health plans to fund the state subsidy is counterproductive and will result in a much less effective program should it be enacted.

If the legislature wants to go the state subsidy route rather than the state and federally funded reinsurance program, major changes need to be made, and federal waiver approval should be sought to maximize federal funding and avoid federal funding loses. Furthermore, among several administrative uncertainties noted by MNsure that need to be addressed, they also recommended, and the Council agrees, that actuarial modeling should be conducted prior to any implementation of such a significant policy change.

Finally, and perhaps most importantly, MNsure highlights in the fiscal notes that a subsidy program cannot be implemented until 2027. This means there will be a gap in premium assistance for this market in 2026 unless reinsurance is extended. Tens of thousands of Minnesotans can otherwise be expected to become uninsured. We urge funding the existing proven reinsurance program to effectively mitigate the looming affordability challenge.

Health Plan Formulary Requirements

Prescription drugs are life-changing and often lifesaving. However, the cost of prescription drugs now exceeds even the cost of inpatient hospitalization. Health plans are tasked with trying to manage these extremely high costs so all enrollees have access to needed and cost-effective medications. The Council opposes this language because it places restrictive regulations on health plans when the root cause of concern is the enormous price of prescription drugs as set by the drug manufacturers.

Our nonprofit plans strive to make as few changes as possible to a formulary throughout a plan year because we want consistency for those enrolled in our coverage. While some exceptions in the bill generally reflect current health plan practices, there are also times when a drug manufacturer arbitrarily and exponentially increases their prices. Health plans only have a few mechanisms to shield our enrollees from even higher costs and this proposal would inhibit our effort to keep coverage more affordable. A similar bill on this topic was debated in the last biennium and included language requiring drug manufacturers to freeze their prices over a 12-month period, thus eliminating the need for a health plan to make formulary changes because of price increases. This is not included in the bill and we urge it be included.

State Pharmacy Benefit Manager

Minnesota implemented Managed Care almost 40 years ago to provide better access to care for Minnesotans served by public programs and financial certainty for the state. Through care coordination, enrollees receive optimal care, providers are better informed and compensated, and there is less wasteful spending on unnecessary testing or duplicative procedures. Care coordination means serving the whole person and managed care is most effective when care management extends across all health care services.

Prescription drugs are a central component of these services and separating this benefit from the Managed Care Organizations and moving them to a separate PBM will have a number of downstream impacts for enrollees. We should look to the other states who have implemented similar policies and learn from the many challenges they have experienced.

Data: After moving to a single PBM, it has been difficult for MCOs to get clean data from the state's selected PBM. This makes it challenging for MCOs to understand which enrollees may have a new diagnosis as evidenced by new prescriptions, to do medication therapy management, to stratify for clinical program enrollment, to identify enrollees that may have medication adherence issues, and to manage the pharmacy lock-in program to assist enrollees with high potential for medication misuse. The lack of clean data has also caused concern for Medicaid risk adjustment purposes.

Administrative Burden: Under a single state PBM, MCOs have no flexibility nor ability to negotiate a contract with the state-selected PBM. This has resulted in contracts requiring convoluted processes for MCOs to pay the PBM for services and validate invoices. In other states, it took over six months to implement the new vendor to include file exchanges and to operationalize.

Member Experience: In other states, moving to a single PBM has created unnecessary challenges for enrollees. Enrollees have been faced with excessive call center wait times with the single PBM. When they eventually hang up and call their MCO, the MCOs have limited ability to answer questions related to their prescriptions or to help facilitate solutions. Despite the other states having established portals to assist with data access for MCOs, the data was not always current, and plans were not always receiving the data.

We urge the committee to consider the data challenges, administrative burden, and poor member experience that implementing the language would create and to oppose this provision.

We look forward to working with the committee on amendments to this proposal that will support lower costs and broad access to needed care for Minnesotans.

Sincerely,

Lucas Nesse
President and CEO