MINNESOTA COUNCIL of HEALTH PLANS

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Senate Commerce and Consumer Protection Committee
95 University Avenue W.
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Chair Klein and Members of the Committee:

The Minnesota Council of Health Plans, the trade association for Minnesota's nonprofit health plans (Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica, and Sanford Health Plan) works every day to support access to high-quality affordable health care. We are writing to respectfully express concerns with the mandate proposals being debated by the committee today.

Minnesota already has some of the most generous benefit requirements in the country, with over 60 additional mandates beyond what was required to be included under the ACA's 10 Essential Health Benefits. Over the last three years, the Legislature has added 13 new coverage mandates and their associated costs to the fully-insured market.

The individual market already has an affordability challenge, exacerbated by increased health care costs, higher utilization, and the sunsetting of Federal enhanced premium tax credits. According to the Department of Commerce, premiums this year significantly increased in both the individual market (ranging from 7.40% to 30.76%) and small group market (ranging from 6.95% to 17.50%).[1] This resulted in an 8% reduction in MNsure enrollments[2] and a 112% increase in consumers "buying down" looking for a lower-cost option in a lower metal tier.[3] Without continued funding of the state's reinsurance program, premiums would have been 47% higher.

Adding coverage mandates adds costs to health insurance. While each of these mandates on their own might not seem like a significant additional cost to be passed along to premium payers, the cumulative impact of these mandates certainly present real affordability challenges for Minnesotans.

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[1] Individual Market Final Average Rate Changes for Plan Year 2026. Minnesota Department of Commerce. https://mn.gov/commerce/insurance/health/consumer-protections/rates/approved/2026/
[2] MNsure Press Release. https://www.mnsure.org/news-room/news/index.jsp#/detail/appId/1/id/724507
[3] MNsure January Board Meeting, January 28, 2026.

Federal law requires certain mandate costs to be reimbursed by state appropriation. Therefore, if adopted, some, but not all, of the new mandate costs would be defrayed by the state and not added to premiums. We urge support for SF 565 (Frentz), a proposal that expands the scope of future defrayals to ensure premiums never increase from new mandates.

Currently, the state defrays millions in coverage mandate costs per year. The Walz Administration, however, has proposed a process that effectively resets the defrayal baseline, passing on all the currently defrayed costs to rate payers, as well all the costs of any mandate that are passed prior to the reset. Absent any defrayal, the costs of the mandates being considered today total: **$35/month individual; $140/month for a family of four**[4]

Mandates become less and less effective if families cannot afford coverage in the first place.

It is also concerning to see the trend of mandates being backed by private equity groups and pharmaceutical companies. These groups often target specific services or treatments, consolidate and create monopolies, to ensure they can charge unchecked prices. Mandate proposals often take the extra step to hide their high costs in premiums by limiting a health plan's ability to utilize cost sharing. We oppose limitations on our ability to support Minnesotans with access to high quality care at the most affordable price.

Below are specific comments on each proposal.

SF 3768 (Oumou Verbeten) - Doula services coverage
Health plans currently provide coverage for prenatal, maternity, and postnatal care. Prenatal care is already exempt from cost sharing, while labor, delivery, and postpartum services are not. The level of cost sharing may vary depending on the plan an enrollee chooses.

Further clarification is needed on the specific services and claims that would be required by this mandate given the definition of doula services is broad. While most consider doula services to be used during the prenatal and postnatal periods, accompanied by support during labor and delivery, some doulas offer extended packages for weeks or even months of postpartum support. In addition, some doulas offer additional services such as private or small group childbirth education classes, sleep consultation, overnight postpartum services, sibling preparation, and more. This lack of a firm definition and language to prohibit utilization review opens the door to misuse and fraud under this mandate.

SF 1946 (Kupec) - Nonopioid and nonpharmacologic pain management coverage
We share concerns about opioid use, encourage nonopioid alternatives when appropriate, and already cover some of these drugs. However, this bill removes prior authorization and step therapy

[4] Note that some of the costs cannot be determined and that some of these costs could be defrayed by the state if Commerce determines the benefit goes beyond the ACA's Essential Health Benefit set.

requirements and requires plans to favor nonopioid treatments. This limits a plan's ability to steer an enrollee to a less expensive alternative.

There are significant variations in costs among nonopioid medications. Some can be as low as $4.42 for acetaminophen (500 mg). Newer, brand name-only nonopioid prescription medications, such as Journavx, can be more expensive at $15 per tablet. This proposal would require a health plan to favor this more expensive brand-name drug (which only earned FDA approval in January 2025) over a cheaper alternative.

The bill also requires health plans to distribute educational materials on pain management to providers. This is a role for providers, not health plans. It also seems unlikely providers would use these materials, thus it would be an unutilized cost requirement.

SF 1961 (Maye Quade) - Infertility treatment

Most health plans currently cover initial infertility diagnosis, but coverage for infertility treatments could be limited. Intrauterine insemination (IUI) may be covered with cost sharing. IVF is not covered due to its significant cost.

This proposal is more expansive than what any other state has enacted into law regarding infertility coverage. The bill requires almost no limitations on IVF coverage. It allows plans to limit completed oocyte retrievals to four, but prohibits restrictions on the number of embryo transfers or length of preservation services. Most states who have enacted mandates limit coverage to non-IVF services, limit the number of IVF transfers, or do not cover preservation services.

Cost sharing is limited to be no greater than maternity coverage under a plan. Some services under the maternity benefit do not have cost-sharing, so it is unknown if coverage under this mandate would need to delivered with no cost sharing.

The bill is also silent on if this benefit extends to surrogates or how surrogacy would be handled under this mandate.

SF 3716 (Mann) - Pap test coverage & subsequent diagnostic services

All health plans cover routine pap tests at no cost. Our concern is with the language that extends coverage requirements to all "*additional diagnostic services after a pap test, if a health care provider determines the additional services are medically necessary based on the pap test's result.*" It is likely these additional services are already covered by health plans, but some services may have cost sharing because of the level of cost sharing in that plan design. It is also unknown what services this may include – whether it is only a second pap test or would extend to imaging or biopsies.

This bill also prohibits health plans from using utilization management for these services, which limits a plan's ability to intervene when services are overprescribed to maximize reimbursement or

in cases of fraud. The bill also prohibits a plan from placing quantity limits for pap tests, which could lead to overuse of services, with detrimental impacts on member health and wellbeing in addition to costs. There is no language in the bill requiring providers to follow clinical practice guidelines on frequency of ordering a pap test (such as those published by the National Cancer Institute[5]) and the bill prohibits plans from enforcing delay periods or quantity limitations.

Cervical screening recommendations are developed by several organizations, including the United States Preventive Services Task Force (USPSTF) and the American Cancer Society:

Age 21-29 years: pap testing every 3 years.
Age 30-65 years: pap testing every 3 years; HPV/Pap co-test every 5 years.
Older than 65 years: no longer need screening unless recent test results were abnormal.

Given a health plan is prohibited from placing quantity limits, there is nothing to stop an unscrupulous provider from ordering tests more often than is recommended.

SF 2071 (Mann) - Step therapy use protocol for insulin prohibition
None of our member health plans utilize a step therapy protocol for insulin. But plans do prefer certain products over others due to cost and it is unknown if the language in the bill extends to formulary placement.

Additionally, there is already language in statute that requires health plans to have a process to allow a provider to override a step therapy protocol - *Minnesota Statute 62Q.184, Step Therapy Override*. Even if a health plan started using step therapy for insulin, a provider already has a mechanism in place to go around a step therapy protocol.

SF 1302 (Mann) - Cancer imaging and genetic testing coverage
Most health plans cover imaging and genetic testing, but some patients are required to pay cost sharing depending on the plan they choose. Prohibiting cost sharing will result in these costs being shifted to premiums or cost sharing for other services.

SF 970 (Mann) - Bowel and bladder management coverage in spinal cord injury cases
Most health plans provide some coverage of these services, but some patients are required to pay cost sharing depending on the plan they choose. Removing this from cost sharing will result in these costs being shifted to premiums or cost sharing for other services. The definition of the services covered under this mandate is broad. If this mandate includes surgery or implants, this cost shift to premiums or cost sharing for other services will be greater.

[5]https://www.cancer.gov/types/cervical/screening#:~:text=Older%20than%2065%20years%20If%20you%20are,need%20to%20continue%20screening%20beyond%20age%2065.

Health plans are also prohibited from using utilization management for these services, which limits a health plan's ability to intervene when services are overprescribed to maximize reimbursement or detect fraud.

SF 1101 (Wiklund) - Augmentative and alternative communication systems coverage
The definition of an augmentative and alternative communication (AAC) device is broad in this bill and therefore it is difficult to know what devices require coverage and the cost of this mandate. Health plans currently cover some AAC devices, such as cochlear implants, but do not cover every device that could be considered an AAC device under the definition in this bill. Given that some of these devices are very expensive, such as neuroprosthetics, and coverage would extend to repair and replacement, this proposal could significantly add to premium costs.

SF 3859 (Klein) - Immunizations coverage, Vaccine Advisory Council
Health plans currently cover vaccines with no out-of-pocket costs and have no intentions to change this policy.

We look forward to working with the committee and authors on these proposals in an effort to lower costs and maintain broad access to needed care for Minnesotans.

Sincerely,



Lucas Nesse
President and CEO