WEEKLY SESSION UPDATE

March 22, 2019

It was an eventful week at the capitol as House and Senate committees work toward second deadline next Friday, hearing bills or companion bills that met the first deadline in the other body. High-profile pieces of legislation continued their journey through the legislative process, with the House passing the following bills:

- Hands-Free cell phone legislation (HF 50 – Hornstein) that would ban holding cell phones while driving passed the House Floor 106-21 (additional reading at the Star Tribune and the Pioneer Press)
- Rep. Liz Olson's bill, HF 400 to establish an opioid stewardship advisory council passed 94-34 (see the opioid section further down for more details)
- Rep. Kelly Moller's bill clarifying the definition of sexual harassment (HF 10, same bill as former Majority Leader Joyce Peppin authored last year) passed 113-10 (additional reading via Session Daily)

The Senate was also busy, approving $13 million to reimburse deputy registrars for costs incurred as a result of MNLARS issues (SF 621 – Jasinski) on a vote of 60-6, as well as unanimously approving transferring $10 million from the General Fund to the disaster contingency account to address flooding across the state (SF 307 – Limmer).

The House will also be welcoming a new member in the coming weeks, with Republican Nathan Nelson handily defeating Democrat Tim Burkhardt 68% to 32% in the special election in House District 11B after Rep. Jason Rarick was elected to the Senate seat vacated by HHS Commissioner Tony Lourey. For more details, check out this article from the Star Tribune.

The date and time of Gov. Walz's inaugural State of the State address was announced this week – the event will take place on Wednesday, April 3rd at 7:00 PM. We will be tracking it and will keep you updated.

The excitement lasted through the end of the week, with Gov. Walz announcing his revised budget proposal just this morning, required after the February budget forecast came in worse than the November forecast. The revised budget totals $49.35 billion for the coming biennium, which is $121 million less than the original proposal. At a press conference held in the Governor's Reception Room, Walz said:

> *While we had to take a hard look and scale back some proposals, the core tenets of our budget – education, health care and community prosperity – remain strong. This budget tackles the great challenges facing our state and promotes opportunity for everyday Minnesotans while protecting our fiscal stability.*

The revised budget includes (via MPR News) :

- *Claiming $142 million in unspent money targeted for a reinsurance plan to reduce risk for health insurers in the individual market and returning it to the state's general fund. Republican legislative leaders had planned to use the money to extend the reinsurance program. Walz instead has a plan to subsidize insurance premiums by 20 percent.*
- *Reducing spending increases by $131 million from his original budget proposal across a variety of areas. Those savings are slightly offset by $37 million in spending for a number of items not in the governor's original proposal.*
- *Tax changes for businesses that add $65 million to the two-year budget.*
- *Instead of leaving $789 million unspent as his original plan did, Walz now leaves $562 million on the bottom line.*

Additional documents from the budget press release are attached.

Opioids

Opioid Stewardship Bill Passed off the House Floor

"We are in the midst of an opioid addiction crisis," Olson said. "Parents have lost children. Teachers have lost students … no other family deserves to go through this."

Several legislators shared their own personal experiences of losing children, friends, and constituents during the four hour floor debate that preceded the passage of HF400, the Opioid Stewardship bill authored by Rep. Liz Olson (DFL-Duluth). The bill builds off the last two years of work by Sen. Julie Rosen and Rep. Dave Baker, with a multitude of new provisions including support for alternative pain management, various pilots and demonstration projects, and funding increases for children protection services which are overwhelmed with the increase in need. While the bill passed 94-34, there is currently no direct companion in the Senate.

In the Senate, however, Sen. Julie Rosen continues to work through her own opioid proposal that she has spent years putting together. She faces a tough climb in the Republican-controlled Senate that is not completely on board with the legislation to charge opioid manufacturers a registration fee that would then go to a fund to support prevention and treatment efforts.

The Governor has made clear that he will sign these opioid bills into law, and even included funding in his budget proposal for addiction services and opioid overdose-reversing medication.

The "Third Wave" of the Epidemic

Via Martha Bebinger, *WBUR-Radio (listen/read)*

A report published Thursday by the CDC suggests that the third wave of the US opioid epidemic has begun. The analysis looks into the specific causes of death of for those who die of drug overdoses. While the first two waves included prescription pain medications, such as OxyContin, and heroin, respectively, the most recent trend shows a massive surge in fentanyl-related deaths and is continuing to rise.

The report also looks into geographical differences and other demographic variations in the data. According to the research, the highest number of fentanyl-linked deaths came from New England, the Mid-Atlantic, and the Upper Midwest, while the West (including Hawaii and Alaska) showed only slight increases. In addition, Bebinger writes, "men are dying after opioid overdoses at nearly three times the

rate of women in the United States. Overdose deaths are increasing faster among black and Latino Americans than among whites. And there's an especially steep rise in the number of young adults ages 25 to 34 whose death certificates include some version of the drug fentanyl."

These findings represent a slice of the research taking place nationwide to find insight into the opioid epidemic and ways to combat it.

Opioid Treatment
Via *Associated Press,* in the *New York Times*
A report by the National Academies of Sciences, Engineering and Medicine highlights the barriers that many experience opioid addiction face when seeking treatment, including government regulations, the training gap medicine for addiction services, and the stigma that accompanies anything other than "abstinence –only" treatment approaches.

Verbatim: *Only a fraction of the estimated 2 million people addicted to opioids are getting the medications, according to a report by the National Academies of Sciences, Engineering and Medicine. Government-approved medications, which include methadone, buprenorphine and naltrexone, help control cravings and withdrawal symptoms like nausea, muscle aches and pain… The report concludes that patients taking the medicines fare better over the long term and are 50 percent less likely to die than if they weren't on them. An "all hands on deck" response is needed — including doctors, law enforcement and family members — to expand access to treatment, it said.*

For further reading, check out these articles from the Associated Press and Session Daily.

PBM Licensure

The regulation of PBMs has been a keen focus in the House and Senate this session and legislators on both sides of the aisle are working through the complex pharmaceutical supply chain. S.F. 278 (Jensen) *Minnesota Pharmacy Benefit Manager Licensure and Regulation Act* went in front of the Senate Commerce committee on Wednesday and, with a few tweaks and brief discussion, passed on to the Finance committee. This bill would require PBMs to register for a license with the state and includes language with expansive definitions for pharmacies and regulation of PBMs' practice. The bill has brought together stakeholders from all sectors of the industry and has cracked open discussion about rebate practices, transparency, and quality measures in health care delivery. While this committee hearing was brief, the next stop in the Finance committee will likely be much longer as the terms and conditions of the fees collected through licensure will need to all be accounted for and discussed.

3D Mammograms

Yesterday, the Senate HHS Finance and Policy committee heard Sen. Michelle Benson's **SF 1038**, requiring coverage for 3D mammograms for individuals with a family history of breast cancer (first or second degree relative), testing positive for BRCA1 or BRCA2, having dense breast tissue, or having a previous diagnosis of breast cancer. Sen. Benson stated that the bill does not apply to public programs, and does not limit coverage of breast tomosynthesis in any plan certificate or contract in effect prior to January 2020. She sees the bill as an efficiency for the health care system, and figures the Commerce Department will see it as a mandate, but because it is becoming more common, hopes that the mandate won't be so expensive as to impact health care rates.

Lisa Hills, Executive Director of the MN Newspaper Association but speaking on her own behalf, was the lone testifier on the bill. She shared her experience with breast cancer and that her doctors believe that her cancer could have been caught at a much earlier stage with a 3D mammogram.

The only member discussion was a question from Sen. Klein around concerns that the bill only applies to private plans, creating a dual-level of healthcare in Minnesota. Sen. Benson shared that the bill also does not include SEGIP because they want to get the language moving forward because if it becomes normalized in the industry faster, then it will move into public plans. The bill passed and re-referred to the State Government Finance committee, where it is scheduled for a hearing on Tuesday, March 26th. We will keep you updated as the bill continues to move.

Quality Care Measures

Via MN Department of Health News Release

Verbatim: Whether you are talking about product development, professional sports or health care, it's hard to make progress on big challenges in the 21st century if you don't start with a good foundation of data. Recognizing that, the Minnesota Department of Health (MDH) is releasing, for the first time, a set of clinical quality-of-care measures broken down by zip code as well as a number of demographic factors. The goal is to provide advocates, researchers, community groups, health care providers and other stakeholders accurate and reliable information they can use to develop new policies and projects that improve health and limit the impacts of chronic disease. The data can also help communities identify differences in health care quality and develop community health profiles.

Reinsurance

Via Steve Karnowski, Associated Press

Verbatim: A bitter, partisan debate erupted on the Minnesota House floor when Republicans tried to bring up a health care reinsurance bill that House Democrats oppose as a giveaway to the insurance industry. Republicans passed a $549 million reinsurance plan to hold down individual marketplace premiums when they controlled the Legislature in 2017. A bill the Senate approved last week would re-extend it three years. Republican Rep. Greg Davids tried a procedural maneuver Wednesday to pull the Senate bill out of committee so it could get a floor vote, saying the program works. His motion failed 45-79 after nearly two hours of debate.

Health Care Access Fund

One of the biggest question marks of the session came up on Wednesday evening with Commissioners from MDH and DHS and a representative from MMB providing a status update and overview on the Health Care Access Fund. During this two-hour-long hearing, the committee discussed the sunset of the provider tax, the programs funded through the HCAF, and the short and long term budget outlook.

Ahna Minge, the Senior Executive Budget Officer at MMB, outlined the health of the fund noting the stability of its revenue from the provider tax. This funding stream, she mentioned, increases proportionally with healthcare funding making it a safe way to fund vital MinnesotaCare and Medical Assistance programs.

MDH Commissioner Jan Malcom focused her presentation on the statewide benefits that stem from programs funded by the HCAF, including the Statewide Health Improvement Partnership (SHIP), the Office of Rural Health, and grants to support culturally competent care and loan forgiveness for rural providers.

DHS Commissioner Tony Lourey, on the other hand, spent a great deal of his presentation discussing the dire need to repeal the sunset from the provider tax, calling upon legislators to look at the HHS line item budget and strike $1 billion dollars from it. He mentioned that this loss of revenue would likely mean cuts to TEFRA, MA-EPD, and other "optional" healthcare programs that Minnesotans rely upon.

Following the three presentations, two health directors from Carver and Hennepin counties relayed how lost revenue to the HCAF would impact their communities. Both testifiers agreed that their counties could not absorb the cuts to their funding and would be forced to turn away low income and vulnerable populations from getting much needed care, like addition treatment and access to mental health services.

The discussion, included below, highlighted the broader debate taking place at the Capitol surrounding healthcare. No resolution was found or even discussed during the committee hearing, but this conversation will without a doubt continue through the final moments of the legislative session—and possibly beyond.

House Health and Human Services Finance
Wednesday, March 21 – 6:45 p.m.

Discussion

Munson: Taxing people who are sick only raises the overall cost of healthcare and I will vote against that. Have you thought about incorporating the state's sin taxes to go to the HCAF—it's just under $50M for the liquor tax, $335M for tobacco, $150M for tobacco lawsuit, so around $534M/year that could offset the provider tax. We could direct opioid settlement money there, too.
Lourey: Sin taxes is a source of revenue—that would create a GF hole. This doesn't really solve our problem here. A philosophical disfavor of the provider tax as a mechanism. I think this is very real criticism. In an ideal world we would have a broader based tax system that could sustain this program, but we don't live in an ideal world. This is better than any other state could come up with—it floats with the costs and consumption of healthcare and it's worked very well. It's continued and reliable.

Gruenhagen: Two states in the nation that have a BHS or MinnesotaCare plan?
Lourey: Yes, MN and NY.
Gruenhagen: What do other states do at population?
Lourey: They would be shopping on their state's respective exchange for qualified health plans.
Gruenhagen: When we passed the ACA, we expanded Medicaid. What was the degree of expansion in 2010 and how many people fell into that expansion?
Lourey: That happened in 2011, and during session we raised it to ~138% of the poverty level and impacted around 200,000 people.

Hamilton: *Shared an example that one of his constituents emails him about frequently. The constituent works in a grocery store and a person comes in, uses their EBT card to withdraw cash, then uses the cash for junk food and cigarettes. The constituent is made because that is taxpayer money.* Can we help people signing up for SHIP benefits to address their tobacco use, their obesity, and inadequate exercise?

Malcom: I don't really have an answer to that question. It's very frustrating, and it's something that we are continuing to work on.
Halverson: We are seeing the science behind this as less about the individual and their choices and more about the community behind them. We are doing the right thing by funding these community programs.
Liebling: This is an area that we should continue to work on. We want people to make their own choices, but sometimes it's hard to watch people make choices that we don't think are right.

Cantrell: 1 in 5 Minnesotans are enrolled in MinnesotaCare or MA and if the provider tax sunsets, we are looking at a pretty dire budget deficit. What is going to happen to those people on MA and MinnesotaCare?
Lourey: We don't know. It's going to have to be something we work on with the legislature to make those cuts.
Cantrell: We currently have people who need more services than we can even offer. If we get past that 2021 deficit, we are going to have to start making cuts to people's lives.

Schomacker: Has SHIP ever been in the GF?
Malcom: It has only ever been in the HCAF
Schomacker: Do nursing homes pay the provider tax?
Lourey: No, I don't believe they pay the provider tax
Schomacker: Anything funded in the HCAF that would be prohibited from being funded through the GF?
Lourey: No
Schomacker: The HCAF grows larger than the state's economy?
Minge: I don't have the precise growth rates, but the provider tax as grown about 4% and general fund revenues have grown at a slightly slower rate
Schomacker: We know that the provider tax is a regressive tax—it impacts people with less means more than people with means.

Schultz: I don't want to be here if the provider tax isn't here. I don't want to make $1.4 billion in cuts when almost everyone in MN agrees that all people should have access to healthcare.

Haley: Of course we want to provide quality healthcare. This bill was bipartisan when it passed, as was the sunset. This sunset is a chance for us to evaluate this program. I have to stand up for the tax payer. The farmers, the electricians, and the retirees who aren't yet 65. My district is 75% public programs—these people are paying higher rates because of these taxes. They're paying higher county taxes. We keep adding onto these people, we forget people who pay these taxes, can't afford their own care, but we have people on these MA and MinnesotaCare who have much better coverage. I don't want to take away services, but we need to consider these people in the conversation. These people can't keep paying these taxes when they can't afford care, just so that other people can have care.
Lourey: We need to look at this problem and an opportunity to make life better on the upside of the cliff instead of just making life worse on the down side of the cliff.

Noor: How many people will be uninsured if we take away the HCAF?
Lourey: This is a huge cliff. It will mean loss of coverage, lower benefits, lower provider reimbursement. We would need to work with the legislature on that to

Liebling: The flexibility that this fund allows us is more than just the public programs—it's about all of MN. When we stop funding these programs, people don't stop getting healthcare and we don't stop paying for those costs. We would be a very different state if this went away. It's doesn't raise healthcare costs, it saves healthcare costs.

Provider tax debate heats up at the Capitol

Via MPR News: The debate over a tax on health care providers in Minnesota took center stage at the Capitol this week, with both sides making their case for what should happen when the tax is set to expire next year. But disagreements between Republicans in control of the Senate and Democrats in control of the rest of government could become one of the major sticking points in budget negotiations this session. What's called the provider tax is a 2 percent assessment on licensed health care professionals, including physicians, dentists, nurses and physical therapists. It was started 27 years ago by a bipartisan group of legislators trying to find a funding source to help cover health care costs for working Minnesotans who earn too much to qualify for Medical Assistance, the state's version of Medicaid, but not enough to buy health insurance.

Via MN Senate Republican Caucus memo, ***Verbatim*****:** "With the support of Gov. **Mark Dayton**, the 2011 Minnesota legislature voted to end the provider tax in 2019. There is a common misperception among policymakers and the media about what the provider tax actually funds. When it was created, the provider tax funded MinnesotaCare, the state's healthcare program for the working poor. When Obamacare expanded Medicaid to cover more people, Minnesota began using federal funds to pay for 95% of MinnesotaCare. Since 2013 the Health Care Access Fund, funded by the provider tax, has been raided to pay for things that used to be covered in the general fund. By the way, Senator **Tony Lourey** (now Commissioner of the Department of Human Services) was the architect of several raids on the HCAF . . . When policymakers such as Gov. **Tim Walz** advocate for re-instating the provider tax, they are not doing it to help poor people pay for health insurance. They are doing it to support out of control general fund spending."

MORE: Via *Minnesota Management and Budget,* a provider tax forecast update published last month. **READ:** http://bit.ly/2YbfYKY

Additional articles of interest

Star Tribune: To rebuild backs, synthetic replacements and living cells hold promise

Bill introductions of interest

HF 2589 (Bernardy) – Opioid Addiction Advisory Council established; opioid stewardship fund established; opiate product registration fee established; opioid addiction prevention, education, intervention, treatment, and recovery provisions modified; reports required; and money appropriated
HF 2613 (Haley) – Southeastern Minnesota pilot program requiring health plan companies to develop and implement shared savings incentive program established
SF 2524 (Abeler) – Nonprofit health maintenance organizations net earnings use requirements establishment
SF 2616 (Abeler) – Health insurance claims assessment establishment
SF 2627 (Newton) – Health insurance providers to charge enrollees the negotiated provider payment plus 20 percent for denied services
SF 2632 (Benson) – Direct primary care service agreements establishment; short term health insurance sale and purchase authorization