POLICIES TO HELP PATIENTS PAY LESS FOR THEIR MEDICINES

PhRMA
RESEARCH • PROGRESS • HOPE

America's biopharmaceutical companies agree that, for too many Americans, the health care system is not working and needs to change. While medical innovation has made the United States a world leader in the discovery of new medicines, these treatments won't benefit patients who can't get them.

There are no easy solutions, but patients need real leadership from everyone involved in our health care system to make it work better. That's why our companies are calling for everyone in the health care system to join us in supporting common-sense reforms to make insurance work like insurance and ensure that patients can access and afford the medicines their doctors prescribe.

We believe the following policies are the best way to achieve these goals and make sure that *patients pay less* for their medicines.

1 Share the Savings

On average, nearly half of spending on brand medicines goes to health insurers, PBMs, the government and others, not the manufacturer that researched and developed the medicine. However, patients often do not benefit from these significant discounts in the form of lower out-of-pocket costs for their medicines. That's not right, and it needs to change. If insurance companies and middlemen don't pay the full price for medicines, patients shouldn't have to either. These rebates and discounts must be directly shared with patients at the pharmacy counter.

2 Make Coupons Count

In some cases, health insurance companies are not allowing the coupons manufacturers provide to patients to count towards deductibles or other cost sharing requirements, meaning patients could be paying thousands more at the pharmacy than they should be. We need to end this practice so that patients are getting the full benefit of programs meant to help them access their medicines.

3 Offer Lower, More Predictable Cost Sharing Options

Actual spending on medicines is growing at the slowest rate in years. Unfortunately, it doesn't feel that way for patients. Insurers are increasingly using high deductibles and coinsurance that result in patients paying more for certain medicines out of pocket. Patients should have more choices when it comes to their medicine coverage. Every state should require health insurers to offer at least some health plan options that exclude medicines from the deductible and offer set copay amounts instead of forcing patients to pay an amount based on the full list price of their medicines.

4 Cover Medicines from Day One

Insurers increasingly require patients to pay high deductibles before receiving coverage of their medicines. This can lead to patients rationing or not taking their medicines, which can result in devastating consequences to their health. Policymakers can help patients from day one by requiring all plans to cover certain medications used to treat chronic conditions with no deductible. Additionally, insurers should be mandated to offer some plans that cover all medicines from day one.

5 Cap Patient Cost Sharing

Many commercially insured patients are being exposed to high out-of-pocket costs due to increasing use of deductibles and coinsurance. High cost sharing is a barrier to prescription medicine access, especially for patients with chronic, disabling or life-threatening conditions, who shoulder the largest share of the burden. Cost sharing should not be so burdensome that it prevents patients with insurance from accessing necessary prescription medicines.

March 31, 2023

Minnesota Safety Net Oral Health Alliance

The Honorable Sen. Melissa Wiklund, Chair
Senate Health & Human Services Committee
95 University Avenue W.
St. Paul, MN 55155

Dear Chair Wiklund and Committee Members:

We, the undersigned dental providers, make up the Minnesota Safety Net Oral Health Alliance (the "Oral Health Alliance"), a coalition of safety net dental providers who provide oral health care to underserved communities across the state. We are writing you today to offer our support for three currently included in the omnibus health finance bill (S.F. 2995).

Clinical Dental Education Innovation Grants: The Oral Health Alliance is very supportive of the language which would dedicate roughly $1.2 million per year towards grants to educational institutions and clinical training sites that are working to expand access to dental care. The Oral Health Alliance is very supportive of any support for the development of the next generation of dental professionals.

Rebasing the Medical Assistance Rate Schedule: The Oral Health Alliance strongly supports the language in S.F. 2995 that would bring the underlying fee schedule into the 21st Century by using 2022 claims data to support a more accurate understanding of the cost-of-service delivery going forward. The proposal also calls for subsequent rebasing of the rate schedule every three years to support a more economically responsive approach to dental reimbursement.

Restoring MA Coverage for Adult Dental Services: The Oral Health Alliance believes strongly that access to quality dental care is fundamental to public health and supports the language in S.F. 2995 that restores a full adult dental benefit set for individuals on Medical Assistance.

As S.F. 2995 moves through the committee process, the Oral Health Alliance respectfully requests that the committee consider funding the Critical Access Dental ("CAD") Infrastructure Program contained in S.F. 1008 (Boldon). That program would support the construction of new clinics, the expansion or renovation of existing clinics, or the acquisition of dental equipment (including that used for mobile and/or tele-dentistry). CAD providers are uniquely suited to serve the communities enrolled in MA. Without additional service delivery equipment and space, CAD providers lack the resources to meet the 2024 target of 55%. This lack of oral care delivery infrastructure is acute. Please see our white paper attached and current service levels by county.

The Minnesota Oral Health Alliance looks forward to continuing to work with Sen. Wiklund and the members of this committee the legislative session progresses. Please do not hesitate to reach out if we can be of any assistance.

Sincerely,

The Minnesota Safety Net Oral Health Alliance

March 31, 2023

RE: Support for Shelter Capital, Emergency Services Program Homelessness Provisions and Children and Families in SF 2995

Dear Chair Wiklund and members of the Senate Health & Human Services Committee,

People Serving People is the region's largest and most comprehensive shelter for families experiencing homelessness. We write today to express gratitude and support for many of the provisions in SF 2995 and to urge you to consider additional critical investments. Since January of last year, we have seen a fast increase in the number of families requesting flexible prevention support and shelter. Over the summer, we reached capacity – all 99 shelter rooms were full. And by the end of 2022, there were nearly 3x the number of families in need of shelter than there was capacity to serve county wide – that's nearly 500 children and 300 caregivers in Hennepin County alone.

While all included in this bill is critical to supporting people experiencing homelessness, children and families, we want to lift the **need for $40M this biennium and $70M in the following biennium for the Emergency Services Program and $150M for shelter capital to create and maintain our shelter spaces and capacity.** While this letter is focused on critical crisis responses, **we also support innovations like the Community Solutions Grant Program, investment in childcare and providers, and changes to MFIP. All of this will help prevent the experience of family homelessness.**

For People Serving People, we also saw inflationary increases to food, utilities, insurance, contracts, and staffing – without corresponding increases in contract and other funding. This means People Serving People has a significant operating gap that jeopardizes our ability to provide dignified and holistic shelter this year.

Investment in Emergency Shelter facilities would help providers like People Serving People meet increased demand for when people need shelter, ensure our shelter spaces provide for a dignified experience, and make needed infrastructure improvements. Over the last month, one of our two guest elevators has been inoperable multiple times and days. Replacing it is over $1M, more costly than we can afford. While the experience of homelessness exists in this state, we must make sure there are dignified and safe places for people to shelter.

As an organization, we also saw inflationary increases for food, utilities, insurance, contracts, and staffing – without corresponding increases in contracts and other funding. This means People Serving People has a significant operating gap that jeopardizes our ability to provide dignified and holistic shelter this year. **Dollars for the Emergency Services Program (ESP) will allow organizations and local communities to meet the needs of people experiencing homelessness.** This increase will be key to supporting both new and existing shelters in providing services to people experiencing homelessness; these services help people get on the path to stability and keep the doors of the shelter open.

Sincerely,

Rinal Ray
CEO

rray@peopleservingpeople.org
612.277.0249

614 3rd Street South
Minneapolis, MN 55415

DID YOU KNOW?

PBMs, Plans and Wholesalers Continually Rank Higher on Fortune 500 Lists than Biopharmaceutical Companies

THE TOP 10

2022
Fortune 500 Rankings

1. Walmart
2. Amazon
3. Apple
4. CVS Health
5. UnitedHealth Group
6. Exxon Mobil
7. Berkshire Hathaway
8. Alphabet
9. McKesson
10. AmerisourceBergen

Health Plan, PBM, Pharmacy
Health Plan, PBM
Wholesale Distributor

FORTUNE

https://fortune.com/ranking/fortune500/2022/search/

PBMs, Plans and Wholesalers Continually Rank Higher on Fortune 500 Lists than Biopharmaceutical Companies

TOP RANKED PBMS AND PLANS

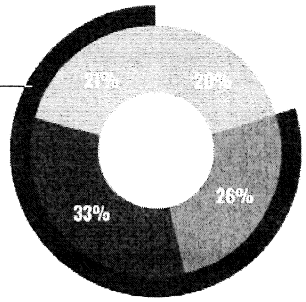
4. CVS Health (Caremark and Aetna)
5. UnitedHealth Group (OptumRx)
12. Cigna (Express Scripts)

TOP RANKED BIOPHARMA COMPANIES

37. Johnson & Johnson
43. Pfizer
63. AbbVie

Insurers and PBMs Control Access to Pharmacies and Leverage for Medicine Costs

TOP 3 MARKET SHARE:
80%



All Other
OptumRx (UnitedHealth Group)
Express Scripts
CVS Health (Caremark)

INSURERS DETERMINE:

FORMULARY
if a medicine is covered

TIER PLACEMENT
patient cost sharing

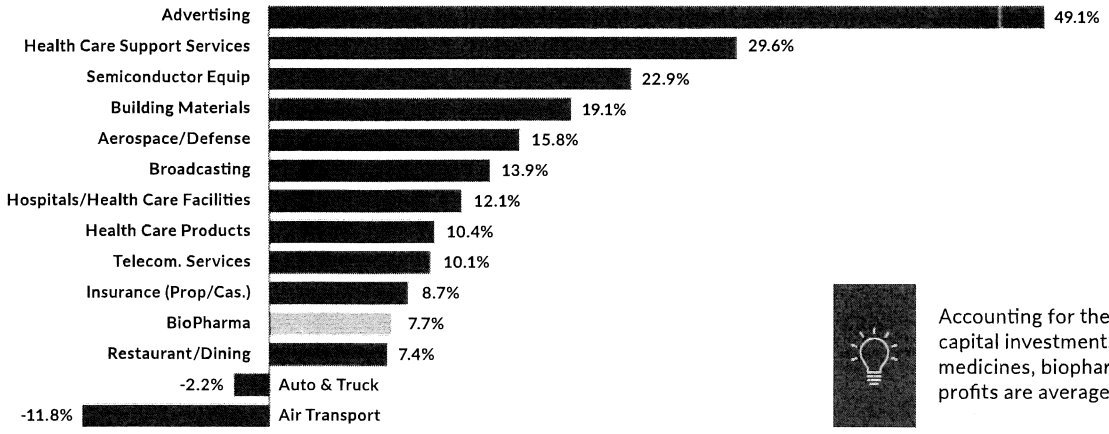
ACCESSIBILITY
utilization management through prior authorization or fail first

PROVIDER INCENTIVES
preferred treatment guidelines and pathways

HOW DOES THE BIOPHARMACEUTICAL INDUSTRY COMPARE TO OTHER INDUSTRIES?

Biopharmaceutical Profits Are in Line With Those of Other Industries

AVERAGE ECONOMIC PROFIT FOR SELECTED INDUSTRIES, 2019-2021*



Accounting for the significant risk and capital investments required to develop medicines, biopharmaceutical industry profits are average among industries.

*Economic profits are accounting profits minus capital expenses.

†Represents the weighted average of pharmaceuticals (8.2%) and biotechnology (2.2%), which are listed as separate industries in the source data.

Source: Adapted from R. Manning and A. Subramaniam, Intensity, LLC. Economic Profitability of the Biopharmaceutical Industry, 2022. https://intensity.com/news/economic-profitability-of-the-biopharmaceutical-industry-2022

STATEMENT

PhRMA
RESEARCH · PROGRESS · HOPE

In Opposition to Advance Price Notification in
Minnesota Senate File 2995, Senate Health and Human Services Omnibus Bill

March 30, 2023

Position: The Pharmaceutical Research and Manufacturers of America (PhRMA) opposes the advance price notification provisions (Article 2, Section 17) in the Senate Health and Human Services Omnibus Bill, Senate File 2995 (SF 2995), legislation that would require reporting of confidential trade secret information by biopharmaceutical manufacturers. The provisions of this legislation could be harmful to the market and to future innovation and raise constitutional concerns.

SF 2995 amends the Prescription Drug Price Transparency Act to require drug manufacturers to report pricing information for prescription medicines with a wholesale acquisition cost (WAC) of $100 or more for a 30-day supply annually and give the insurance commissioner 90 days' written notice prior to increasing the WAC of a prescription medicine.

Requiring advance notice of price increases could harm consumers, interfere with market competition, and raises constitutional concerns.

SF 2995 would require manufacturers to provide 90 days advance notification of WAC price increases. The WAC price does not account for rebates, discounts, and other price concessions provided for prescription medicines and therefore, does not accurately reflect the true cost to an insurer or pharmacy benefit manager. According to the IQVIA Institute, in 2021, net prices for brand medicines were, on average, 49% lower than WAC prices.[1] Such notification could also result in voluminous reporting that will in no way assist in making thoughtful changes to formulary design or budgeting decisions.

The Federal Trade Commission has acknowledged that disclosure of competitively sensitive information could undermine beneficial market forces within the industry,[2] so advance notice and other disclosure requirements could have the opposite of their intended effect and undermine competitive bidding in the market.[3] In addition, advance notification of WAC price increases creates financial incentives for secondary distributors to enter the pharmaceutical supply chain, thus creating a "gray" market. Gray market distribution networks consist of a number of different companies – some doing business as pharmacies and some as distributors – that buy and resell medicines to each other before one of them finally sells the drugs to a hospital or other health care facility. As the medicines are sold from one

[1] IQVIA. "Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2026." May 2022

[2] FTC's comment to the Honorable James L. Seward concerning the competitive effects of the pharmacy benefit manager provisions of NY SB 58, March 31, 2009, available at: https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-honorable-james-l.seward-concerning-new-york-senate-bill-58-pharmacy-benefit-managers-pbms/v090006newyorkpbm.pdf.

[3] FTC Letter to Terry G. Kilgore, Member, Virginia House of Delegates, re: H.B. 945 (Oct. 2, 2006); FTC Letter to Representative Patrick McHenry, re: North Carolina Bill 1374 (July 15, 2005); FTC Letter to California Assembly Member Greg Aghazarian, re: AB 1960 (Sept. 7, 2004). FTC Letter to The Honorable Mark Formby, Mississippi House of Representatives, re: SB 2445 (March 22, 2011).

secondary distributor to another, the possibility of counterfeit medicines infiltrating the supply of legitimate medicines increases, thereby threatening patient safety.

PhRMA has challenged the constitutionality of a law requiring advance notification of price increases in Oregon on a number of grounds, including under the First Amendment and the Dormant Commerce Clause. The litigation is pending. If the law is invalidated, a similar analysis would apply to similar legislation in other states. The U.S. Court of Appeals for the Fourth Circuit overturned a Maryland drug pricing law in 2019 on Dormant Commerce Clause grounds because it regulated the price of transactions that occurred outside of the state.[4]

It is unclear how advance price notification would work when notice is based on the "for the next calendar year."

Our understanding is that the advance price notification language is meant to align with the language in the bill which describes what changes a health plan may make during the health plan contract term. It is important to note that drug price increases do not always align with the health plan contract term because 1) drug manufacturers contract with many health plans who have varying start and end dates of their contracts with plan sponsors and 2) drug manufacturer price increases may occur at various points during the calendar year.

Because of this potential misalignment, PhRMA is concerned that it is unclear what the language in requires of drug manufacturers. We request the language be changed so that a drug manufacturer gives 90 days notice prior to the effective date of a price increase. We believe this change makes clear and does not change the intent of the bill.

This legislation does not account for insurance benefit design issues that prevent discounts from flowing to patients, and SF 2995 assumes incorrectly that the price a patient pays is determined solely by drug manufacturers.

This legislation singles out the biopharmaceutical industry and ignores the variety of stakeholders involved in determining what consumers ultimately pay for a medicine, including insurers, pharmacy benefit managers (PBMs), wholesalers, and the government. The important role that these entities play in determining drug coverage and patient out-of-pocket costs is overlooked by the requirements of this legislation. For example, PBMs and payers—which dictate the terms of coverage for medicines and the amount a patient ultimately pays—negotiate substantial rebates and discounts.

According to research from the Berkeley Research Group (BRG), rebates, discounts, and fees account for an increasing share of spending for brand medicines each year, while the share received by manufacturers has decreased over time. In 2020 manufacturers retained only 49.5% of brand medicine spending while members of the supply chain retained 50.5%.[5]Increased rebates and discounts have largely offset the modest increases in list prices and reflect the competitive market for brand medicines.

This, of course, does not necessarily reconcile with what patients are feeling at the pharmacy counter, which is why looking at the whole system is so important. For example, despite manufacturers' rebates and discounts negotiated by health plans, nearly half of commercially insured patients' out-of-pocket spending for brand medicines is based on the medicine's list price rather than the negotiated price that health plans receive.[6]

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[4] *Ass'n for Accessible Medicines v. Frosh* ("*AAM*"), 887 F.3d 664 (4th Cir. 2018), *cert. denied*, 139 S. Ct. 1168 (2019).
[5] BRG: The Pharmaceutical Supply Chain 2013-2020. January 2022.
[6] IQVIA Institute for Human Data Science. Medicine spending and affordability in the United States. Published August 2020. Accessed August 2020. https://www.iqvia.com/insights/theiqvia-institute/reports/medicine-spending-and-affordabilityin-the-us

PhRMA is increasingly concerned that the substantial rebates and discounts paid by pharmaceutical manufacturers, approximately $236 billion in 2021,[7] do not make their way to offsetting patient costs at the pharmacy counter. Patients need concrete reforms that will help lower the price they pay for medicines at the pharmacy, such as making monthly costs more predictable, making cost-sharing assistance count toward a plan's out-of-pocket spending requirements, and sharing negotiated savings on medicines with patients.

Innovative therapies provide unique value in the health care system.

It is important to remember that advances in medicine help control health care spending. Greater patient access to prescription medicines means fewer doctor visits and hospital stays and a decrease in costly medical procedures, all of which translate into lower health care costs overall. For example, in 2014, a new drug came to the market that provided a cure for more than 90% of patients with hepatitis C, eliminating a lifetime of hospitalizations, debilitating symptoms, and treatments with harsh side effects and replacing it with a complete cure in just 12 weeks. Often, patients with hepatitis C needed liver transplants, which could cost almost $500,000. Since 2014, several new treatments have come to the market, further driving down the price of the medicine and recent research indicates that these medications have saved Medicaid $15 billion, with the cost of a cure now lower than a single year of disease burden.[8] Innovation and progress in the pharmaceutical industry means better outcomes and quality of life for patients and their families as well as reduced health care costs to patients and the system.

PhRMA opposes SF 2995 for the above stated reasons and respectfully urges it not be enacted.

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The Pharmaceutical Research and Manufacturers of America (PhRMA) represents the country's leading innovative biopharmaceutical research companies, which are devoted to discovering and developing medicines that enable patients to live longer, healthier and more productive lives. Since 2000, PhRMA member companies have invested more than $1.1 trillion in the search for new treatments and cures, including $102.3 billion in 2021 alone.

In Minnesota the biopharmaceutical industry employs over 11,000 individuals and the industry generates a total economic output of over $16.9 billion per year while contributing over $1.1 billion in state and federal taxes annually. Additionally, according to the Minnesota State Medicaid Program, the industry rebates more than $632 million back to the federal and State governments through Medicaid prescription drug rebates, which is 55% of the total Medicaid drug spend in the State.

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[7] Drug Channels Institute. The 2021 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers. March 2022

[8] Roebuck, M. Christopher "Impact of Direct-Acting antiviral use for chronic Hepatitis C on health care costs in Medicaid: Economic Model Update." The American Journal of Managed Care December 2022, Vol. 28 Issue 12.

March 30, 2023

Senator Melissa Wiklund
Chair, Health & Human Services Committee
Room 1100, Minnesota Senate Building
Saint Paul, MN 55155

Dear Chair Wiklund and Members of the Committee:

Minnesota's Prenatal to Three Coalition (PN-3) is excited to support SF 2995 A2 Amendment, to invest in Minnesota's children and families. Families are struggling to meet daily expenses and challenges, many of the investments in SF 2995 A2 will help families with young children have a great start, regardless of race, zip code or income level. The PN-3 Coalition would like to highlight key provisions that are necessary to improve the health and wellbeing of young children, birthing people, and families.

Family, Friend, and Neighbor Grant Program A.13. 1. Sec. 12 & Line 428.4
Funding for family Friend and Neighbor (FFN) care grants will allow federally funded programs to continue statewide and complement the care provided by licensed homes and centers. FFN providers often serve families who need care for 2nd and 3rd shifts, want culturally specific care, and/or provide care to children with disabilities.

Community Solutions for Health Child Development A.13 Sec.18 & Line 433.18
Allowing communities of color and communities experiencing geographic inequities to identify their needs and challenges related to maternal and child health provides opportunities to develop locally driven solutions to help address maternal and child inequities. We are pleased to see this program continue to receive support.

Maternal and Child Health Equity
We are pleased to see funding for the **Supporting Healthy Development of Babies Grant Program** in (Article 4 Sec. 39) and the **Equitable Health Care Task Force** (Article 4 Sec. 81) work to reduce health inequities for birthing persons and children.

Doula Services A.1. Sec. 33 & Line 49.10 & Sec. 17 Subd. 28b & Line 20.15
Doulas are proven to lower racial disparities in healthcare by improving health outcomes, increasing breastfeeding rates, reducing childbirth complications, and reestablishing the relationship between historically marginalized communities and the medical establishment. Both provisions help reduce barriers to serving families on Medicaid and improve birth outcomes.

Healthy Beginnings, Healthy Families Act A. 4 Sec. 53 & Line 182.12
Expanding the Healthy Start Act to county jails improves the health outcomes of justice involved families and helps stabilize and improves parent-child attachment.

Early Childhood Care, Education & Workforce A. 13 Sec. 25 & Line 442.5; Article 14
These historic investments in early care and learning is critical to maintaining the field and supporting families who need access to care. The entire community benefits when parents can work, and businesses have workers.

988 Suicide and Crisis Lifeline A. 4 Sec. 47 & Line 174.1
Expanding the capacity of Minnesota's crisis response is critical to meet the mental health needs of our communities and will increase factors that promote resilience by increasing access to immediate care and mental health support.

Children's Mental Health Supports A. 9 Section 3 & Beginning on Line 358.28
We support increased access to infant and early childhood consultation services. These programs and resources help families mitigate mental health challenges for our youngest children and provide those working with families and young children with the skills and tools to provide ongoing supports. Please consider adding policies changes that would allow for increased access in currently funded programs and consider funding to keep families intact.

Home Visiting for Priority Populations Line 1204, Budget Spreadsheet
Expanding funding for family home visiting programs will help improve maternal and child outcomes, address the mental health needs of both parents and their children whilst providing housing, food, and employment support. We are particularly pleased to see funding will target priority populations that aren't currently served through family home visiting programs.

Funding for Help Me Connect Line 1200, Budget Spreadsheet
Much work has been done over the past several years to educate families and providers about this important tool. Investing in this resource will help families across the state and we encourage the committee to add this to your final bill.

Department of Children, Youth, and Families A. 13 Sec. 14 & Line 429.18
The PN-3 Coalition believes that quality investment in young children and families includes establishing the infrastructure and system needed to support public services and programs. This will not only ease the burden on other state agencies facing capacity issues but provide families in Minnesota with a holistic opportunity to create a full-service care continuum that supports families and their children from birth through their most critical developmental years.

Thank you,

Deb Fitzpatrick,
Children's Defense Funds-MN,
Co-Chair

Nancy Jost,
West Central Initiative,
Co-Chair

Laura LaCroix-Dalluhn,
MN Prenatal to Three (PN-3) Coalition,
Coalition Coordinator

resolve
THE NATIONAL INFERTILITY ASSOCIATION

March 30, 2023

Senator Melissa Wiklund
Chair, Health and Human Services Committee
2105 Minnesota Senate Bldg.
St. Paul, MN 55155

RE: IVF Budget Provision - SUPPORT

Dear Chair Wiklund:

RESOLVE: The National Infertility Association represents the millions of women and men in the U.S. with infertility and the more than 163,000 Minnesota residents struggling with this disease, plus thousands more who require medical intervention to build their families. Thank you for supporting adding the provisions of SF 1704 for in vitro fertilization (IVF) and fertility preservation insurance coverage in your HHS omnibus finance bill for large fully insured groups. This is an important and significant first step to assuring all Minnesotans have access to infertility care.

This pro-family provision will significantly improve access to the standard of care for patients with infertility and those diagnosed with cancer or other conditions that may cause infertility. According to the CDC, one in eight people have trouble getting pregnant or sustaining a pregnancy. Infertility cuts across socioeconomic levels, and all racial, ethnic and religious lines. Medical conditions such as endometriosis, ovulation disorders, premature ovarian failure and male factor are some causes of infertility. The American Medical Association, the American Congress of Obstetricians and Gynecologists, and the World Health Organization all recognize infertility as a disease. As such, infertility should be covered by health insurance like other diseases.

Family building options for this population are costly; the average cost of an IVF cycle in the U.S. is approximately $15,000. A recent survey found that women (25-34 years old) accrued $30,000 of debt on average after undergoing fertility treatment. Such costs put fertility treatment out of reach for many. In fact, only one in four people get the treatment they need to overcome infertility.

Minnesota should join the growing list of states that require fertility coverage. As proven in these states, insurance covering IVF decreases the chance of multiple births, and lowering multiple births decreases overall health care costs and results in healthier babies and healthier moms.

On behalf of all Minnesotans struggling to build their families, we thank you for your support and leadership in supporting this important pro-family-building provision..

Sincerely,

Barbara Collura

Barbara Collura
President and CEO

7918 JONES BRANCH DRIVE, SUITE 300, MCLEAN, VA 22102 I PHONE 703.556.7172 I FAX 703.506.3266 I WWW.RESOLVE.ORG

March 31, 2023

Dear Chairs Wiklund and Mann and Committee Members,

I am writing to ask for your support for the Senate Health Finance & Policy budget omnibus bill and school-based health centers in Minnesota. This written testimony is for the Health Finance & Policy Committee hearing on Friday March 31, 2023 at 3:00 pm

I have worked as a Pediatric Nurse Practitioner in school- based health care for the past 15 years at Plymouth Youth Center, a contract alternative high school for students on the North Side of Minneapolis. Our clinic provides essential primary care needs including annual physical exams, sports physicals, immunizations, sexual health needs, acute minor illness evaluation/ treatment, and ongoing monitoring/treatment of chronic health issues. The PYC School Clinic has been able to fill a gap over this COVID time when health care access has so negatively impacted adolescents.

School based health care is needed in schools all over Minnesota. The time is now to expand and open this model to all children and teens across our state.

Thank you for your support,

Mary E. Jordan, APRN, CPNP

Coordinator, PYC/NTC Satellite Clinics

NorthPoint Health and Wellness Center

RICHFIELD
PUBLIC SCHOOLS

Enriching and accelerating learning

Enriqueciendo y acelerando el aprendizaje

Dear MN Legislators,

In my role as a Superintendent of Richfield Public Schools I am writing to support school-based health initiative language in for SF2995, specifically Article 4, Section 49. School-based clinics have been strongholds of accessible, equitable and comprehensive preventative care for students in Minnesota for 50 years. If passed, this legislation would be the first state policy and dedicated funding to support school-based health centers in that time. As the only part of the health care safety net dedicated entirely to children, your vote for this bill at this pivotal time will be historic.

The gold-standard model for school-based clinics had its genesis here in St Paul, Minnesota, and is now codified in federal statute. Today, over 2,200 school-based clinics operate across the United States. Until 2022, our local School Based Health Alliance was a voluntarily coalition of the leaders who operate school-based clinics in Minnesota. There are now 27 in existence and at least 10 in development in our state. The Alliance represents and supports each of the health care providers and districts partnering in school-based health care. I see the impact of their efforts daily in my work managing partnerships with four school districts operating our school based health centers in Brooklyn Park, St Louis park, Richfield and Burnsville.

Richfield Public Schools opened our Health Resource Center in partnership with the Park Nicollet Foundation and have been serving children in the City of Richfield from birth through age 21 for a number of years now. Since that time we have seen improvements in attendance and student achievement. Our Richfield Health Resource Center is a vital part of our district serving children and our community and has been directly supportive of greatly improved student outcomes. Passage of this bill would support providing more opportunities to a wider range of children.

Growth in school basic health supports has been slow in Minnesota compared to most other states. This is a critical time to change that, particularly in rural areas where one school-based clinic can offset care shortages for an entire community. This language allows school-based clinics to be here for kids as they recover from the pandemic, a time when their needs are critically underserved and increasingly acute.

The ROI on school-based care is irrefutable. The care is not a replacement for the allied health professionals in schools such as school counselors and social workers, or licensed school nurses. Simply said, their co-existence creates ease for families and optimizes learning. Expanding this to more children is a key lever for reducing disparities in education and health outcomes for children in Minnesota.

Thank you,

Steve Unowsky, Superintendent

401 70th Street W, Richfield, MN 55423 (P) 612-798-6000 (F) 612-798-6057 (W) richfieldschools.org

Local Public Health Association of Minnesota

Association of Minnesota Counties

March 31, 2023

RE: SF 2995 – DE Amendment

Chair Wiklund and Members of the Committee:

The Local Public Health Association of Minnesota (LPHA) and the Association of Minnesota Counties (AMC) appreciate your continued support of local public health departments throughout our state who are fulfilling state-mandated services that protect and promote the health of all Minnesotans. We would like to highlight several critical items in the Health and Human Services omnibus budget bill proposal that would impact the ability of local health departments to serve their communities and address local public health priorities:

- **Public Health System Transformation**
  Thank you for your ongoing support to increase the capacity of our local and tribal public health departments. We appreciate the inclusion of funds for these health departments to fulfill foundational public health responsibilities. Specifically, the bill includes $22,600,000 per biennium to support Minnesota's public health system. While it is challenging to estimate the cost needed to fully fund the system, national estimates indicate there is a $32 per person gap between what local health departments spend now and what they would need to spend to fully meet public health responsibilities. In Minnesota, this translates to a funding gap of $180 million. We hope you will consider expanding investments in public health system transformation to meet the great needs across the state. Consistent and ongoing funding is crucial to building a strong statewide foundation for our public health system. We know the capacity of our local health departments vary throughout the state and we look forward to working with you to continue strengthening and rebuilding that capacity into the future.

- **Public Health Emergency Preparedness Response**
  Responding to disasters and emergencies—whether health focused or not—is a core responsibility of Minnesota's local public health departments. Thank you for the investment in our statewide public health system, including $8.4 million per year in local and tribal public health emergency preparedness and response. This funding will be crucial to rebuild the capacity of Minnesota's local health departments and in ensuring strong future response to emergencies. Our system does best when all parts are functioning at the most optimal level.

- **Addressing Workforce Challenges in Public Health Careers**
  We appreciate the inclusion of provisions that address workforce challenges in local public health. Minnesota's local health departments have seen significant turnover in leadership and staff since the start of the COVID-19 pandemic. Thank you for inclusion of funding to support the Public Health AmeriCorps program and for expanding the role of Community Health Workers in Minnesota. Both programs will be valuable in building public health capacity and recruiting a new, diverse, governmental public health workforce.

- **Supporting Children and Families**
  We appreciate the inclusion of numerous provisions that support the healthy development of children and families. Prenatal to age three are particularly crucial years for a child's development, with 85% of a child's brain growth occurring during that time. Focusing resources on our youngest Minnesotans set them on a path for a stable and healthy future.

Thank you for the inclusion of $20 million per biennium to increase access to prevention-focused family home visiting services. This will ensure Minnesota children get a healthy start.

- **Additional Provisions that Support Community Health**
  LPHA and AMC support the inclusion of various prevention-related provisions in the bill including those that create MDH offices focused on American Indian and African American health; dedicate potential JUUL lawsuit funds to youth commercial tobacco prevention activities; fund planning for and addressing extreme weather events; fund family planning special project grants; address lead exposure in school and childcare settings; reinstate fetal and infant mortality case review; address long COVID; focus on HIV prevention; and, provide grants to expand school-based health clinics. We also hope that you will consider funding to support the MN Uninsured and Underinsured Adult Vaccine (UUAV) Program to ensure all Minnesotans have access to vaccinations that prevent the spread of disease. Further, we hope you will consider mirroring the Governor's budget proposal for peer led adolescent mental health promotion to equip community members to deliver mental health support and programming.

Local public health agencies are on the front lines every day to protect and promote the health of our communities. To do so successfully requires stable and reliable funding. Thank you for your continued support of these critical sources of public health funding and other programs that will improve the health of our state. We look forward to continuing to work with you as this bill moves forward to advance prevention strategies that promote the public's health.

Sincerely,

Kari Oldfield-Tabbert
Director, Local Public Health Association of Minnesota
Public Health Policy Analyst, Association of Minnesota Counties
koldfield@mncounties.org | (651) 789-4354

Angela Thies
Child Wellbeing Policy Analyst, Association of Minnesota Counties
athies@mncounties.org | (651) 789-4321

PR%F
Alliance

March 31, 2023

To: Health and Human Services Committee Members

Re: Minnesota SF2995 Healthy Beginnings, Healthy Families Act

Dear Members of the Committee,

On behalf of Proof Alliance, please accept this letter of support for provision modifications and appropriations for the Department of Health- Healthy Beginnings, Healthy Families Act (Article 4 Section 53; Subd 6. Act). I write to you as the Executive Director at Proof Alliance, the Minnesota-based nonprofit organization dedicated to preventing fetal alcohol spectrum disorder [FASD] and caring for all impacted.

13% of babies in Minnesota are born with prenatal alcohol exposure each year. Prenatal alcohol exposure is the leading cause of preventable birth defects in the U.S. Prenatal alcohol exposure causes FASD. **FASD is a disability with lifelong implications** that can impact brain function, development, learning, behavior, and social skills. One in 20 children in the U.S. has an FASD. That means it's likely to be in every classroom across this state.

This bill would improve early identification of developmental delays, thus helping to identify prenatal alcohol exposure and provide effective interventions for children with an FASD. For example, developmental and social-emotional screening and referrals to community-based resources and support are critical to supporting people with an FASD. People living with an FASD are more likely to need foster care, PCA services, waivers, medical care, mental health care, case management and special education. The physical, mental, and emotional cost of FASD to families is devastating, and the financial cost to our state is shocking. But, if a child is screened and diagnosed early, and connected to the right interventions, resources and supports 1) the child has an opportunity to reach their full potential, and 2) the child is more likely to experience better outcomes, better quality of life, and less healthcare and other resource utilization.

We urge the committee to support this vital legislation and thank you in advance for supporting budget proposals related to children with special/specific health needs and disabilities in SF2995.

Sincerely,

Mollie O'Brien
Executive Director
Proof Alliance

1876 Minnehaha Avenue West
St. Paul, MN 55104

proofalliance.org
651-917-2370

the Aliveness project

612.822.7946 phone
612.822.9668 fax

info@aliveness.org
aliveness.org

3808 Nicollet Avenue
Minneapolis, MN 55409

March 31, 2023

To: The Honorable Senator Melissa Wiklund,
Members of the Senate Health and Human Services Committee

Re: Support for SF2995 – Addressing the HIV Epidemic in Minnesota

Dear Members of the Senate Human Services Committee,

We write to applaud your investment in HIV prevention and care programs that directly address the health inequities of communities experiencing the greatest rates of HIV. The funding level of $10,000,000 over the biennium for HIV Care and $4,500,000 for HIV Prevention is a strong and necessary first step. Unfortunately, this number falls below the Governor's recommendation and far below the House Human Services Omnibus bill of $12,100,000 in fiscal year 2024 and $12,100,000 in fiscal year 2025 in appropriations to the Commissioner of Human Services for grants to community-based HIV/AIDS support services.

Minnesota is experiencing three unprecedented HIV outbreaks. We would expect to see the overall number of new cases decrease because there are medications to treat people with HIV and prevent people who are negative from becoming infected. People who identify as American Indian/Alaskan Native (AI/AN), Black, and Latin o/Latinx are disproportionally impacted by HIV due to a combination of historical, current, and intergenerational trauma; structural and individual racism; and discrimination that all influence the social determinants of health. These trends are reflected in HIV infections, with BIPOC people comprising 17% of Minnesota's population but accounting for 60% of new HIV diagnoses

DHS currently receives both state and federal funding for HIV programmatic activities and external grants. Since 2002, MDH has also received HIV rebate revenue generated through the federal 340B rebate program via an interagency agreement with DHS. However, MDH learned in October 2022 that the amount of rebate revenue we will receive from DHS would decrease by nearly 60% beginning January 1, 2023, which subsequently results in a decrease of grants being awarded to community-based organizations and clinics to implement HIV prevention interventions.

Even before the loss of rebate funds, the level of state and federal funding has been insufficient to support the staff and interventions required to end the current outbreaks, prevent future outbreaks, address ongoing HIV health inequities, and achieve and maintain the legislatively mandated outcomes. This request replaces the lost rebate revenue.

Given the overwhelming data, we strongly recommend that Minnesota include increased investment to support HIV prevention programs that directly address the health inequities of communities experiencing the greatest rates of HIV. We have the tools to end HIV in Minnesota. This bill is a transformative step forward in preventing new infections, and ensuring that all people living with HIV,

the Aliveness project

612.822.7946 phone
612.822.9668 fax

info@aliveness.org
aliveness.org

3808 Nicollet Avenue
Minneapolis, MN 55409

can live long and healthy lives! We ask that you continue aligning these proposed funding levels at the House Human Services Omnibus amount.

Sincerely,

Matt Toburen, Executive Director, **Aliveness Project**

Jeremy Hanson Willis, CEO, **Rainbow Health**

Charlene Leach, Executive Director, **African American AIDS Task Force**

Val Smith, Executive Director, **Youth and AIDS Project**

Sharon Day, Executive Director, **Indigenous Peoples Task Force**

Phoebe Trepp, Executive Director, **Clare Housing**

Mary McCarthy, Executive Director, **Rural AIDS Action Network**

Sue Purchase, Executive Director, **Harm Reduction Sisters**

Audrey Harrell, Executive Director, **Hope House**

INSTITUTE FOR COMMUNITY ALLIANCES
2550 UNIVERSITY AVENUE W, SUITE 250-S, ST. PAUL, MN 55114
E: MNHMIS@ICALLIANCES.ORG
W: WWW.ICALLIANCES.ORG

Institute for Community Alliances

ALASKA | BOISE CITY / ADA COUNTY | IOWA | MINNESOTA | MISSOURI | NEW HAMPSHIRE | NORTH DAKOTA | OMAHA/COUNCIL BLUFFS | ROCK RIVER COALITION SOUTH CAROLINA LOW COUNTRY | VERMONT | WISCONSIN | WYOMING

MARCH 30, 2023
CHAIR WIKLUND
MEMBERS OF THE HEALTH & HUMAN SERVICES COMMITTEE

Dear Members of the Health & Human Services Committee,

I am concerned that investment in **Minnesota's Homeless Management Information System (HMIS)** was dropped from the House omnibus bill (HF238) this week and am asking that you ensure it remains in your Health and Human Services omnibus bill (SF2995).

Comprehensive, reliable data is crucial to understanding our state's progress toward its goal of ending homelessness, and that requires ongoing investment in data infrastructure. Minnesota's HMIS enables planners and policy makers to evaluate programs' effectiveness, provides an accountability mechanism for those who oversee their funding, and researchers to understand the needs of the most vulnerable in our communities (like the recent Minnesota Department of Health Homeless Mortality Report). It enables service providers to refer individuals and families to available housing units and, in Minnesota's largest county, allows clients in need of a shelter bed to reserve one in a dignified way.

Minnesota recognizes the criticality of HMIS as its use is mandated by ten (10) state programs, including the Department of Human Services (DHS) Homeless Youth Act, and Minnesota Housing Finance Agency (MHFA) Family Homeless Prevention and Assistance Program (FHPAP). **However, in 17 years of using the HMIS, Minnesota does not yet guarantee HMIS funding from year to year. Investing in these programs in historic ways and not bringing the HMIS infrastructure alongside makes it hard to support those programs in the way they need.**

HMIS funding as originally proposed in SF388 reads:

$250,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are appropriated from the general fund to the commissioner of human services to assist with the ongoing maintenance and improvement of the Homeless Management Information System (HMIS). The base appropriation for this purpose is $1,140,000 in fiscal year 2026 and $1,140,000 in fiscal year 2027.

Please permanently invest in HMIS by including it in the SF2995 omnibus bill and help get it to the Governor's desk for his signature.

Reverently,

BRITT HEINZ-AMBORN, MPP
HMIS DIRECTOR

Start Early

Senator Melissa Wiklund
Chair, Health and Human Services
95 University Ave W
Minnesota Senate Building
St. Paul, MN 55155

March 31, 2023

Madame Chair and Members of the Committee,

On behalf of the Start Early Funders Coalition, we would like to share our appreciation and support for SF 2995 before your committee. Our vision as a Coalition is that every child in Minnesota is physically, socially, emotionally and cognitively prepared for school and lifelong success. Our coalition is committed to supporting policies that will benefit low-income, rural and Black, Indigenous and children of color and their families; and the programs that serve them.

The early childhood omnibus bill shares many of our priorities that all children in Minnesota have a strong and healthy start and are prepared to contribute to our state's vitality. In particular we were pleased to see priorities that will enable more children to access programs and efforts that make child care and early learning more accessible including increasing the CCAP reimbursement rates to the 75th percentile (section 11). The establishment of the Department of Children, Youth and Families is an important systemic fixes to provide support and resources that meet family's needs. We also were pleased to see resources for Family, Friend and Neighbor childcare providers through the inclusion of the FFN grant program (section 12) and the inclusion of the Community Solutions Fund grant program (section 18). The inclusion of the elements that will directly benefit the early childhood workforce will have a significant impact broadly on the early childhood system and we were particularly pleased to see the establishment of the wage scale through the Children's Cabinet Working Group (section 22). Our early childhood system requires significant investment after decades of underinvestment to ensure all families have access to affordable programs that will meet their needs, with a fairly compensated and supported early childhood workforce, and these investments move us in the right direction.

We support a robust early childhood system that gives children and families access to a continuum of high-quality child care and early learning programs. We must maintain and continue to grow equitable investments in critical early childhood programs based on ongoing community feedback and guidance.

Sincerely,

Carrie Zelin Johnson
Start Early Funder
Coalition Coordinator

Allison Corrado
Public Policy
Committee

Denise Mayotte
Public Policy
Committee

Nancy Jost
Public Policy Committee

The Use of Medicines in the U.S. 2022: Usage and Spending Trends and Outlook to 2026

IQIVA • April 21, 2022

Key Findings

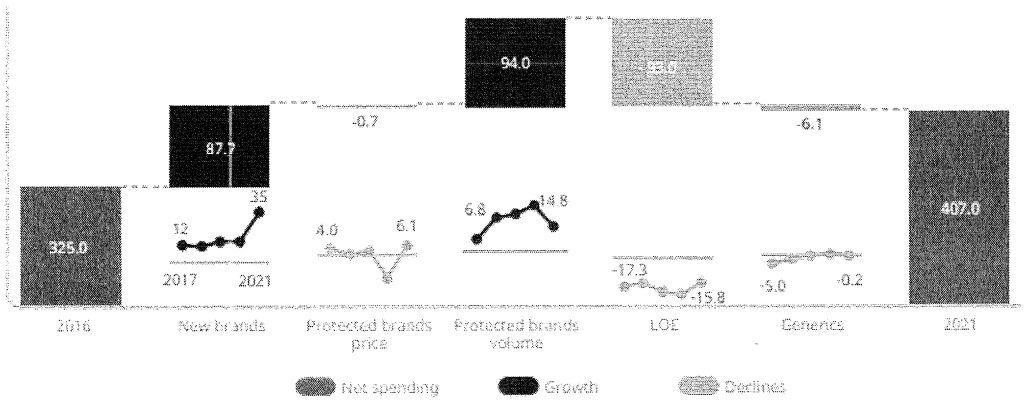
- Net prices for brand medicines increased 1.0% in 2021, below the rate of inflation for the fifth year in a row. Looking ahead, net price growth is projected to be 0% to -3% per year through 2026.
- Overall net spending on medicines (net manufacturer revenue) increased 12.1% in 2021, driven by the "unprecedented contribution" of the COVID-19 vaccine and treatments. Excluding spending on COVID-19 vaccines and treatment, spending on medicines increased just 4.9% in 2021.
- Excluding spending on COVID-19 vaccines and treatment, net per capita spending on medicines *declined* by 1% in 2021.
- Looking ahead, net spending growth is projected to return to pre-pandemic trends, increasing 1% to 4% per year, on average, through 2026.
- Brand medicine net prices are, on average, 49% lower than their list price.
- Savings from loss of exclusivity (LOE) totaled $93 billion between 2016 and 2021, more than offsetting the $87 billion spent on newly launched brand medicines over this period.

Full Summary

Medicine Spending

- Total net manufacturer revenue on medicines increased 12.1% in 2021, driven by the "unprecedented contribution" of the COVID-19 vaccine and treatments, reaching $407 billion.
    - Excluding spending on COVID-19 vaccines and treatment, spending on medicines increased 4.9% in 2021.
- Total net manufacturer revenue on medicines is projected to increase 1-4% per year, on average, through 2026.
- Real per capita net medicine spending (net manufacturer revenue) grew by 5.8% in 2021 when factoring in COVID-19 spending.
    - Excluding spending on COVID-19 vaccines and treatment, real per capital net medicine spending would have *declined* by 1% in 2021.
    - Medicine spending per capita has increased just $204 since 2011, a 1.8% compound annual growth rate, from $1,028 to $1,232.
- Total net spending on medicines increased by $82 billion from 2016 to 2021, driven by new products and increased utilization
    - COVID-19 vaccines and treatments accounted for $29 billion of this growth
    - Savings from loss of exclusivity (LOE) totaled $93 billion between 2016 and 2021, more than offsetting the $87 billion spent on newly launched brand medicines
    - Between 2016 and 2021, changes in brand medicine prices *reduced* total spending on medicines by $700 million.

Exhibit 22: Spending and growth at estimated net manufacturer prices 2015-2020, all channels, US$Bn



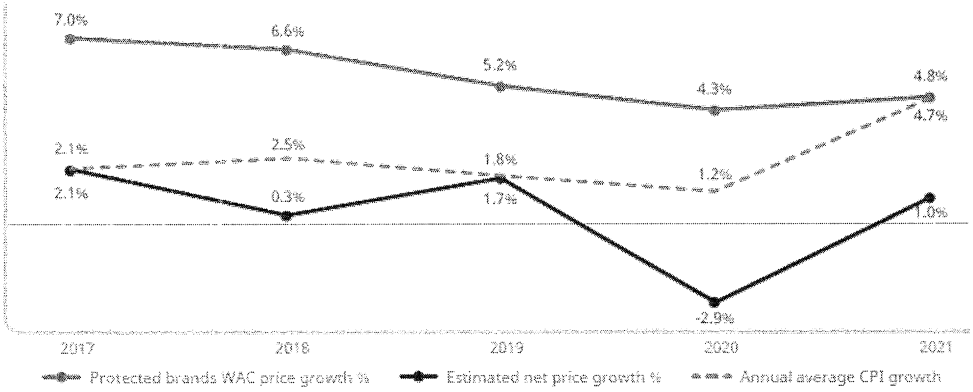
Source: IQVIA Institute, Mar 2022.

- Specialty medicines accounted for 55% of total medicine spending in 2021 but accounted for 3% of total prescription volume.

Medicine Prices

- Net prices for brand medicines increased 1.0% in 2021, below the rate of inflation for the fifth year in a row. Looking ahead, net price growth is projected to be 0% to -3% per year through 2026.
- Brand medicine net prices are, on average, 49% lower than their list price.
- List prices for brand medicines increased 4.8% in 2021, below the rate of inflation.

Exhibit 24: Wholesaler Acquisition Cost (WAC) growth and net price growth for protected brands

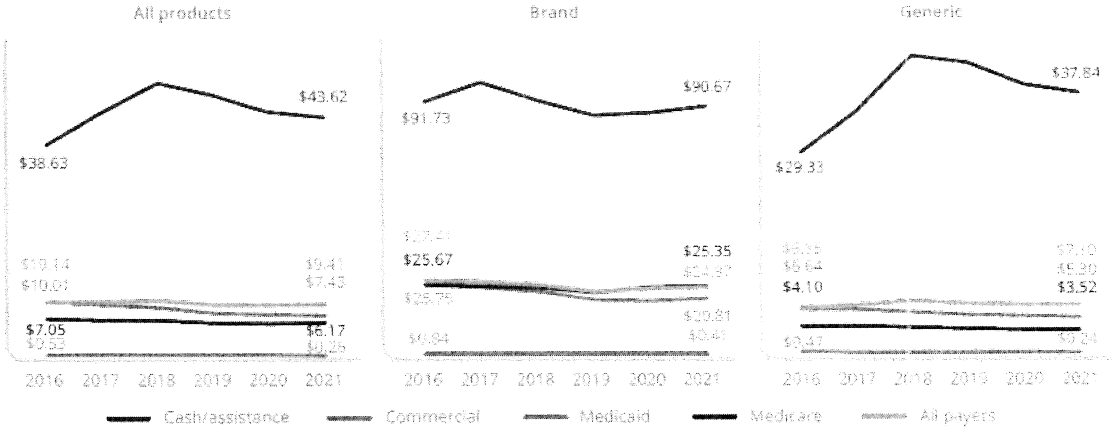


Source: IQVIA Institute, National Sales Perspectives. Dec 2021; Bureau of Labor Statistics, Annual Average Monthly CPI Growth, Dec 2021.

Patient Out-of-pocket (OOP) Spending

- The average OOP cost per retail prescription was $9.41 in 2021 (down from $10.14 in 2016)
- The average OOP cost per brand retail prescription was $24.87 in 2021 (down from $27.41 in 2016)

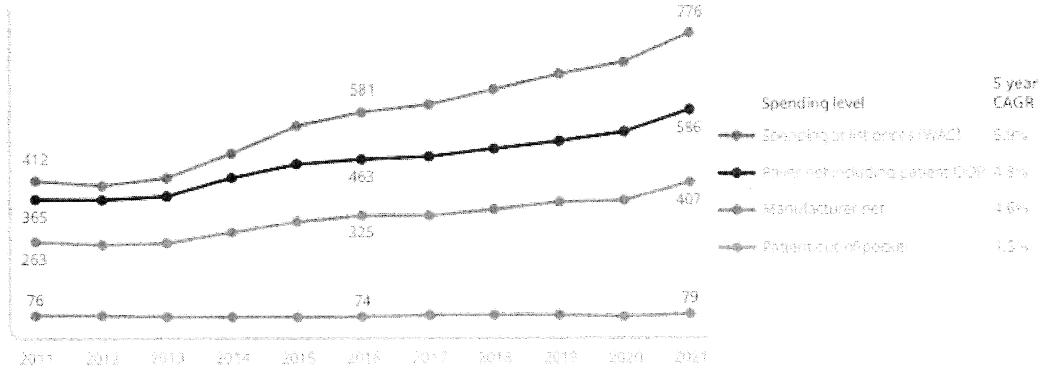
Exhibit 31: Average final out-of-pocket cost per retail prescription by product type and method of payment, 2016–2021



Source: IQVIA LAAD Sample Claims Data, Dec 2021.

- Across all patients, 29% had no annual medicine OOP costs, 8% reached annual OOP costs above $500, and 2.1% paid more than $1,500 OOP in 2021.
    - Among Medicare beneficiaries, 22% had no annual medicine OOP costs, 16% reached annual OOP costs above $500, and 4% paid more than $1,500 OOP.
    - Among commercially insured patients, 23% had no annual medicine OOP costs, 7.3% reached annual OOP costs above $500, and 1.6% paid more than $1,500 OOP.
- Over 92% of total prescriptions (brand and generic) had a final OOP cost below $20 in 2021, while 0.9% (totaling 64 million prescriptions) had a final OOP cost above $125.
- 73% of brand prescriptions had a final OOP cost below $20 in 2021, while 4% had a final OOP cost above $125.
- Coupons and debit cards provided by brand manufacturers totaled $12 billion in 2021.
- Total patient OOP spending increased by an average of 1.5% per year over the past five years, slower than the growth rate of payer spending on medicines, manufacturer net revenue growth, and spending at list price.

Exhibit 17: Medicine spending at selected reporting levels, US$Bn



Source: IQVIA Institute, Mar 2022; CMS National Health Expenditures (NHE), Dec 2020.

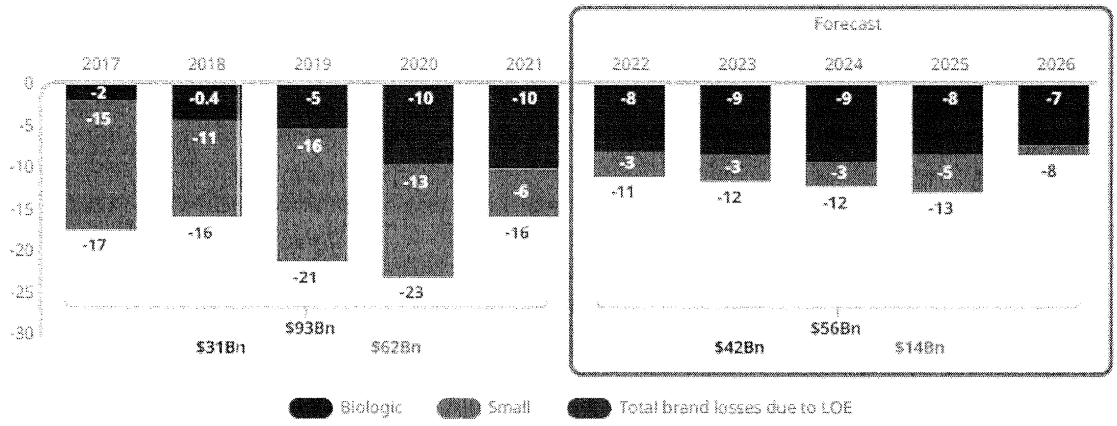
Abandonment

- Patients starting a new therapy abandoned 81 million prescriptions in total at the pharmacy in 2021.
- 61% of patients did not fill their new prescription when OOP costs exceeded $250, while just 7% of patients abandoned their prescriptions when OOP costs were less than $10.
- Abandonment of medicines to treat chronic conditions resulted in 5.3 billion fewer patient days of therapy in 2021.

Market Dynamics

- There were 72 novel active substances (NAS) launched in 2021, including emergency use authorizations (EUA) for COVID-19.
- Over the next five years, a projected 250–275 NAS will enter the market but are anticipated to represent an average 6–7% of brand spending compared to 11% in the past five years.
- LOE reduced net spending on brand medicines by $93 billion over the past five years, with a $62 billion savings from small molecules and $31 billion savings from biologics
- LOE is expected to lower brand spending by $56 billion from 2022 to 2026, with $41.6 billion from reduced spending on biologics.

Exhibit 42: U.S. impact of brand losses of exclusivity 2017–2026, US$Bn



Source: IQVIA Market Prognosis, Sep 2021; IQVIA Institute, Mar 2022.

Medicine Use

- Medicine utilization, measured by days of therapy, grew by 3.3% in 2021
- In total, dispensed prescriptions increased by an average of 2.1% per year over the past five years, driven mainly by the aging population.
- Retail drugs currently represent 86% of medicine use (by days of therapy), with non-retail accounting for the remaining 14%.

Condition Specific Findings

- Oncology
  - Oncology spending is projected to exceed $113 billion by 2026, with annual growth slowing to 9% due to competitive pressure from biosimilars
  - Net prices for brand oncology products are, on average, 7% lower than the list price.
- Cell, Gene, or RNA Therapies
  - There are currently 33 cell, gene or RNA-based therapies launched globally to-date, with 18 currently marketed in the U.S.
  - An additional 55–65 new therapies are expected to launch globally by 2026
  - "Even considering the large numbers of these products, they will not be more than 20% of all new drugs expected to be launched in the next five years and less than 10% of the spending on new drugs in the same period."
  - Spending on these treatments is projected to reach $11 billion by 2026, estimates range under different assumptions ($7 to $20 billion).
- Diabetes
  - Net prices for brand diabetes products are, on average, 78% lower than the list price.
  - Total OOP costs paid by patients with insulin prescriptions amounted to $1.27 billion in 2021
    - 44% of this total is from the 20% of prescriptions that cost patients more than $35
  - Insulin OOP costs have declined by $500 million since 2018

        - If insulin OOP costs were capped at $35, patient spending would have been further decline by $555 million.
    - Net spending (manufacturer revenue) on diabetes medicines is projected to decline 12% through 2026, while list prices are estimated to grow 10-13% annually
- Autoimmune
    - Net prices for brand autoimmune products are, on average, 49% lower than the list price.
    - Net spending on autoimmune disorder treatments is expected to exceed $70 billion by 2026, slowing after 2022 due to key biosimilars

Distribution and Financial Flow

FOR RETAIL BRAND DRUGS

PhRMA

Source: Adapted from Pembroke Consulting

CornerHouse

First Witness
CHILD ADVOCACY CENTER

March 30, 2023

Senator Melissa Wiklund
Chair, Health and Human Services
95 University Avenue W
St. Paul, MN 55155

Dear Chair Wiklund,

We would like to express our sincere appreciation to you and the Health and Human Services Committee SF 1852 - CornerHouse and First Witness for Safety Training and Child Abuse Prevention - in the committee's Omnibus bill. Access to body safety trainings and engaging adults, professionals, and children to normalize body safety concepts, recognize potential threats, and to use safety strategies is vital if we're going to help keep more kids safe. SF 1852 provides an incredible constellation of trainings along with tools to integrate and monitor ongoing safety with a diverse lens for 20,000 people in rural, Tribal, suburban and urban communities in Minnesota. And it gives direct access to community call lines for anyone seeking help.

Thank you so much for supporting such an important and impactful project. Many thanks to the committee members and staff as well. If you have any additional questions or need any further information about CornerHouse and First Witness and SF 1852, please contact us any time.

With gratitude,

Mitzi Hobot

Mitzi Hobot, Executive Director
CornerHouse
Minneapolis, MN
mitzi@cornerhousemn.org
651-403-0778

Tracie Clanaugh

Tracie Clanaugh, Executive Director
First Witness
Duluth, MN
tclanaugh@firstwitness.org
218-727-8353

cc: Senator Fateh
Anna Burke
Chris Meyer