AMERICAN EXPERIMENT

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Dear Members of the Senate Health and Human Services Committee:

My name is Peter Nelson and I am a Senior Policy Fellow at Center of the American Experiment. Thank you for the opportunity to provide comments today on SF 49. This bill would establish the MinnesotaCare public option and includes several transitional provisions to lower cost sharing and premiums while the state implements the public option. Establishing a public option would move the state's health affordability programs in the wrong direction. To address ongoing affordability and access issues, Minnesota should build off the success of the state's reinsurance program.

The Affordable Care Act's affordability problems

The public option appears to be aimed at addressing several severe problems that the Affordable Care Act (ACA) imposed on Minnesota's health care system. The ACA increased premiums, reduced the comprehensiveness of health insurance, narrowed health insurance provider networks, and adopted a subsidy structure that subjects people to a dramatic premium cliff when their income rises above the income eligibility threshold. From 2014 to 2017, average premiums in Minnesota's individual health insurance market skyrocketed by 119 percent. This was the largest percentage increase in the nation and it dropped Minnesota's individual premium affordability rank to 37th in the country.

Reinsurance successfully lowered ACA premiums and increased coverage

The state responded by implementing a reinsurance program which immediately reduced premiums and, by 2019, Minnesota's individual market had the lowest average premiums in the country. Individual market premiums in Minnesota continue to be among the lowest in the country.

On top of directly reducing premiums with a reinsurance subsidy, Minnesota's reinsurance program did so in way that mitigates a severe structural problem with the ACA's subsidy structure that inflates premiums. The ACA's premium subsidy structure creates inflationary pressure because the value of the ACA's premium tax credit is tightly linked to the price of insurance premiums. This means the government generally pays the full cost of any premium increase. As a result, there's little pressure on insurance companies to keep premiums down for subsidized people. The reinsurance program replaces a portion of the ACA's inflationary premium subsidy with a reinsurance subsidy that adds incentives to control costs.

The dramatic success that Minnesota's reinsurance program achieved is documented in a recent report I wrote to help inform these discussions. The report draws heavily on an independent evaluation of the program by the RAND Corporation, which was commissioned by the Centers

for Medicare & Medicaid Services. This report finds that the reinsurance program reduced premiums for a benchmark plan by up to 36 percent and increased unsubsidized enrollment by 82,000 when compared to what would be expected without the reinsurance program. As noted, reinsurance adds cost control incentives, which is likely why the RAND Corporation finds a larger premium impact than the amount the reinsurance subsidy alone would provide.

Public option abandons effective subsidy and adopts inefficient market distorting policies
Despite the dramatic success of the reinsurance program, there are still affordability and access issues. Efforts to address these issues should work to build on the success of reinsurance. Moving in a different direction would abandon the effective and efficient cost controls built into reinsurance. Importantly, these cost controls take advantage of competition in the private market which improves the market and does not distort the market.

A MinnesotaCare public option would abandon this success and move Minnesota in a completely different direction. To work, a public option would depend on the sort of government subsidies and price controls that will distort the state's health insurance system and, as a result, undermine the efficient delivery of health care across the state. The public option subsidy structure relies on the same inflationary premium linked subsidy structure of the ACA. In addition, the only way a public option can compete is by setting provider reimbursements below the actual cost of delivering care. This distorts how providers must price services for private payers to fully cover the cost of their operations. This distortion will disproportionately impact providers in lower-income communities that rely more on state health program reimbursements.

Building off reinsurance offers a more stable long-term federal partnership
Many of the policies offered here will depend on a federal waiver which will put the long-term success of the program at risk. Unfortunately, the Biden administration has recently set a precedent for undoing waivers implemented under a prior administration. Biden revoked several Medicaid waivers and reopened the 1332 waiver application that was already approved in Georgia. A future administration may do the same if Minnesota pursues a highly controversial approach like a public option. By contrast, reinsurance has been implemented with bipartisan support in fifteen states. Therefore, we can expect the federal government to be a good faith partner in any efforts that build off this bipartisan approach.

The timing of this public option is also problematic considering Congress will need to address the expiration of the temporary expansion of the ACA's premium subsidies at the end of 2024. How Congress responds will directly impact the federal framework which a public option would operate under. Reinsurance would likely adapt to any changes more easily.

Considering the success and long-term stability of reinsurance, I urge the committee to build off reinsurance versus pursuing the public option proposed in SF 49.

Sincerely,
Peter Nelson
Senior Policy Fellow
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