April 17, 2024

Dear Members of the Senate Health and Human Services Committee,

On behalf of the Minnesota Chamber of Commerce, representing 6,300 employers and their more than 500,000 employees across the state, I write to share our concerns with SF 4699 (Sen. Wiklund), as amended by the A2 DE amendment.

Public Option

The majority of Minnesotans, roughly 60%, access health insurance coverage through their employer. These and other Minnesotans in the commercial market pay doctors and hospitals *more than twice as much* as the MinnesotaCare program pays these providers today – cross subsidization that occurs because MinnesotaCare and other government programs pay these providers less than what it costs to deliver care.

For better or worse, these higher payments ensure health care providers have the resources needed to pay staff, operate and maintain facilities, expand service offerings, and invest in new treatments, procedures, and devices to improve the health of the Minnesotans they serve.

For better or worse, these higher payments drive the accessible and quality healthcare ecosystem that we all enjoy and prioritize in Minnesota. But the proposal under consideration today raises significant concerns about the impact a public option could have of our health care system.

In its first year, actuarial modeling suggests this public option would cover 107,000 people – 70% of whom are expected to move to it from private coverage in the individual market, which pays doctors and hospitals at the higher commercial rate. The effect of the public option, then, would be to reduce – by half – the amount doctors and hospitals are paid to care for these new public option enrollees.

Already, 67% Minnesota hospitals have negative operating margins. And yet, labor costs are increasing and supply and service costs are rising. Under a public option, with a growing number of patients walking through their doors paying less than what it costs to deliver care, how will they continue to do all the things that they do today?

Will doctors and hospitals be forced to pull back on the services they currently offer? Will they make up the lost revenue by charging those with private insurance even more?

Additionally, what iss the basis for the assumption that none of the roughly 60% of Minnesotans who currently have coverage through their employer will transition to the public option? Why are we considering a plan for a "public option" that assumes those in this majority of the public won't consider this option?

What if they did? With more lives covered, wouldn't the overall cost of the program to the state increase? Especially for this population, since the cost to cover these enrollees wouldn't be subsidized by federal pass-through funds.

And if we did see a shift in coverage like this, wouldn't that exacerbate the access and cross-subsidization issues that we already anticipate could result from doctors' and hospitals' payments being cut in half for an increasing number of their patients?

We agree that the cost of healthcare is too high. **Minnesota families' all-in health care spending is already 3rd highest in the country.** But attempting to address this problem by arbitrarily slashing payments to providers invites a host of serious and unintended consequences.

We have long been concerned that a public option like this could reduce access to critical care and services and increase costs for those who get their insurance through their employer. Unfortunately, this proposal only underscores those concerns and leaves unanswered questions that are fundamental to its operation, funding, and market impact.

Expiration of Reinsurance

While this legislation calls for the creation of a public option to be available beginning January 1, 2028, no provision is made for the fact that the state's individual market reinsurance program is currently set to expire at the end of the 2025 plan year. As such, those who rely on the individual market for health insurance coverage could see as much as a 50% increase in their premiums. Not only would this lead to significant challenges for those in this market, it would mean significant instability, enrollment shifts and changes throughout the state's health insurance market. This is a worrisome outcome of a wholly preventable situation.

Health Insurance Mandates

For our members who offer health insurance to their employees, 70% do so through the fully-insured market, which is the segment of the health insurance market regulated by the state. It should come as no surprise, then, that each year our members rank making health care more affordable as a top concern for state policymakers to address. And yet the cost of health insurance continues to rise.

There are many reasons for year over year increases in health insurance costs, but as the regulator of the state's fully-insured market, decisions made by the Legislature also impact costs.

Minnesota has more than 60 coverage mandates currently in place, more than most other states. Last year alone, the Governor and Legislature added six more, adding an estimated $114 Million to the cost of health insurance in the fully-insured market. As part of this bill, this Committee is considering several additional new health insurance mandates. While all of these health insurance mandates would provide a benefit to someone, they also all come with a cost. At a time when researchers at the University of Minnesota tell us that Minnesota families' all-in health care spending ranks third highest in the country, we have significant concerns about any proposal that would add to that cost burden.

If the Committee decides that there are policy or other public health reasons for adding additional coverage mandates to state statute – above and beyond the long list that is currently in place – we encourage those proposals to be married up with the provisions of SF 1037. This approach would ensure the goals of the new coverage mandates are met without further increasing costs on the Minnesotans and Minnesota families who rely on the coverage provided through the state-regulated fully-insured market.

HMO Licenses

Absent more information about the rationale for doing so, we are concerned about a move to prohibit certain types of HMOs from being licensed in the state. While there are certainly differences between how non-profit and for-profit HMOs are structured and established, there are no regulatory or demonstrated performance differences between the two and how they are required to operate in this state. And yet, this bill would prohibit for-profit HMOs from doing business in here. This despite the fact that the state chose to have one such HMO manage the health care needs of tens of thousands of Minnesotans in the metro areas as part of PMAP enrollees, and despite the fact that work from the Minnesota Department of Health to research this issue is not yet complete. Nevertheless, the interim report from MDH noted, "…minimal data are available to shed light on whether differences exist between nonprofit and for-profit HMOs with regard to day-to-day operations, enrollee satisfaction, and quality of care."

Thank you for the opportunity to provide this input.

Sincerely,

Bentley Graves
Director, Health Care & Transportation Policy