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House File 96 (Long), House File 1843 (Reyer)

Dear Chair Liebling and House Health Finance and Policy Committee Members,

The National Federation of Independent Business (NFIB) represents over 10,000 small businesses in every corner of our state. NFIB's mission is to advocate for the best interests of Main Street.

Respectfully, NFIB Minnesota opposes HF 96 and HF 1843. We agree there is a choice and affordability problem in health insurance and health care in our state, but we do not believe a public option or single payer system is the solution.

Higher Commercial Plan Costs. Health insurance costs are a top concern for small employers. In fact, the cost of health insurance was the number one small business problem in NFIB's most recent edition of *Small Business Problems & Priorities* – as it's been for the previous 29 years.

A public option is likely to shift costs onto the already overburdened small group and individual markets due to government-level healthcare provider reimbursements.

In 2017, the Minnesota Hospital Association cited low reimbursements in its opposition to the creation of a public option[1]:

> *State public health care programs currently pay providers about half of what a commercial plan pays. … Minnesota's hospitals have a payer mix comprised of 63 percent government payer and only 37 percent commercial payer. With public program payments below costs, maintaining a private insurance market is important for all hospitals and health systems.*

More enrollees in government-level reimbursement plans means higher prices for remaining commercial employer-based plans when Minnesota's small businesses are already struggling to maintain this important employee benefit.

According to the Minnesota Department of Health (MDH), the share of Minnesotans insured through small groups declined from 11% to 8% between 2010 and 2019. Meanwhile, from 2014 to 2020, small group premiums increased by a total of over 41% on average.[2]

In addition, lower reimbursement rates may make it even harder to access care in rural areas, where there is already a "severe shortage of all provider types," according to MDH.[3]

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[1] Minnesota Hospital Assc., "Minnesota hospital and health system priorities for the 2017 legislative session," March 2017.
[2] MDH Health Economics Program, Minnesota Health Care Markets Chartbook Summaries," https://www.health.state.mn.us/data/economics/chartbook/summaries, updated 10/3/2022.
[3] MDH Division of Health Policy, "Rural Health Care in Minnesota: Data Highlights," 11/18/2021, https://www.health.state.mn.us/facilities/ruralhealth/docs/ruralhealthcb2021.pdf.

Other State Public Options. In 2018, the Dayton Administration estimated a public option would cover 100,000 people. Removing that number of lives from the fully insured market as envisioned would mean significant cost shifting and disruption for remaining commercial policyholders.

Despite those lofty projections, other states that have recently enacted public options have struggled to attract enrollees for much the same reason that commercial plans also struggle: healthcare is expensive.[4] Finding a balance between affordable premiums, benefit sets, and attractive provider reimbursement rates is a challenging proposition.

Washington's public option has struggled to attract enrollees since its inception in 2021:

> *Proponents estimated the cap would result in public option plans having premiums 5% to 10% lower than traditional plans on the exchange. But public option premiums were, on average, 11% higher than the lowest silver plan premium available in each county on the marketplace in 2021, and a silver public option plan had the lowest premium in just nine counties.*[5]

In an effort to boost public option enrollment, Washington lawmakers earmarked $50 million in additional subsidies for 2022. Enrollment increased to just 3% of the individual market.

Other Single Payer Proposals. In 2011, Vermont enacted legislation to create a single payer system. Despite an already high insured rate, the state would have had to more than double its annual tax revenue collections to fund the system.[6] Vermont abandoned the plan in 2014.

Former Governor Peter Shumlin explained: *"These are simply not tax rates that I can responsibly support or urge the Legislature to pass… In my judgment, the potential economic disruption and risks would be too great to small businesses, working families and the state's economy."*[7]

California pegged the cost of a state-run single payer plan at $400 billion per year in 2017. The staggering price tag led then-Gov. Jerry Brown to dismiss it entirely, saying: *"This is called 'the unknown by means of the more unknown.' In other words, you take a problem, and say 'I am going to solve it by something that's … a bigger problem,' which makes no sense."*[8]

We encourage lawmakers to focus on market reforms that give small employers more tools to manage healthcare costs and make it easier for them to provide a sustainable array of employer-sponsored coverage options.

Sincerely,

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[4] Messerly, Megan, "These states tried an Obamacare public option. It hasn't worked as planned," Politico.com, 12/27/2022.
[5] Hawryluk, Markian, "The 1st public option health plan in the U.S. struggles to gain traction," NPR.org, 2/21/2022.
[6] Fitzgerald, Jay, "Costs derail Vermont's dream of single payer health plan," Boston Globe, 1/25/2015
[7] Wheaton, Sarah, "Vermont bails on single-payer health care," Politico.com, 12/17/2014
[8] Cadelago, Christopher, "Jerry Brown sounds skeptical note on single-payer health care for California," Sacramento Bee, 3/23/2017