Response to Request for Information
From the American College of Physicians
To the United States House of Representatives Committee on Energy and Commerce and
To the United States Senate Committee on Health, Education, Labor and Pensions
On
Design Considerations for Legislation to Develop a Public Health Insurance Option
July 22, 2021

The American College of Physicians (ACP) is pleased to offer our views regarding improvements to the coverage, quality, and access to care for everyone in the United States. We greatly appreciate that Chairman Frank Pallone of the House Committee on Energy and Commerce and Chair Patty Murray of the Senate Committee on Health, Education, Labor & Pensions have issued the May 26, 2021, request for information (RFI) about a federally administered public option's key design considerations, including how it can lower the cost of health care for American families and dramatically expand coverage. Thank you for your commitment to crafting legislation with the priority of establishing a federally-administered public option that provides quality, affordable health coverage throughout the United States.

ACP believes that the U.S. health care system requires systematic reform and envisions a health care system where everyone has coverage for and access to the care they need, at a cost they and the country can afford.[1] Unfortunately, 30 million Americans lack health care coverage[2] and many insured people struggle to pay for the care they need. Accordingly, ACP strongly recommends transitioning to a system of universal coverage through either a single-payer system or a public insurance plan to be offered along with regulated private insurance.[3] We are pleased to share our recommendations on how such a public choice—or public option—model might be designed to achieve our policy objective of ensuring that all Americans have coverage for essential benefits that are not dependent on their income, health status, place of residence, or employment.

ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 163,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Executive Summary

ACP believes that fundamental reforms are needed to make affordable coverage available to all Americans. Specifically, we call on Congress to enact legislation to create a public option, consistent with the following recommendations as explained in more detail later in this letter:

1. Make a public option broadly available so that all Americans have a choice of enrolling in a public option plan or in a qualified private employer-based or non-group plan, provided that the benefits and cost-sharing in the private insurance options are comparable to those available from the public option.
2. Under a public option, payment rates to physicians and other clinicians, as well as to hospitals and other facilities that offer health care services, must be sufficient to ensure access to needed care and should not perpetuate disparities in current payment methods. Innovative alternative payment models to support primary care should be adopted by the public plan. Physicians should be allowed to choose to participate in the public option. Participation in Medicare, Medicaid, other public coverage program should not be contingent on whether a physician participates in the public option.
3. Under a public option model, coverage must include an essential health care benefit package that emphasizes high-value care.
4. Cost sharing that creates barriers to evidence-based, high-value, and essential care should be eliminated, particularly for low-income patients and patients with certain defined chronic diseases and catastrophic illnesses.
5. The public option should include income-adjusted premium and cost-sharing subsidies especially for persons at or below 138% of the Federal Poverty Level (FPL).
6. In a public option system, employers should be required to offer comprehensive coverage to their employees (and families) that is at least as generous as the public insurance option or pay a portion of the cost of their employees' public insurance plan coverage (that is, "pay or play").

We provide more detailed explanations and rationale below for the above recommendations, on why expanded public coverage is needed, and our responses to the questions asked by the committees.

Why Expanded Public Coverage is Needed

Millions of Americans are uninsured

The United States remains the only wealthy industrialized nation without universal health coverage, a crucial component to ensuring quality health care for all without financial burden that causes delay or avoidance of necessary medical care. The Patient Protection and Affordable Care Act of 2010 (ACA) led to historic reductions in the number of uninsured persons, yet millions remain uninsured or underinsured and even before the public health emergency caused by COVID-19, the number of uninsured persons was expected to grow.[4] [5]

In part, this was the result of congressional policy decisions, including limiting eligibility for premium tax credits and cost-sharing reduction assistance to those with incomes under 400 percent of the federal poverty level (FPL); a Supreme Court decision making Medicaid expansion eligibility voluntary, and decisions by some states' decisions not to broaden Medicaid eligibility. Accordingly, ACP strongly supported the American Rescue Plan (ARPA), H.R. 1319, provisions that provided incentives for states to expand Medicaid by temporarily increasing the state's base federal medical assistance percentage

by five percentage points for two years for states that newly expand Medicaid. This provision will hopefully promote adoption of Medicaid expansion by all states, providing coverage to tens of millions of low-income persons who currently are not eligible in states that have declined so far to expand Medicaid, although more needs to be done to close the Medicaid coverage gap in states that continue to decline to participate in Medicaid expansion. A public option could be one approach to closing this coverage gap.

The US spends more on health care, and on health care administration

The United States spends far more per capita on health care than other wealthy countries, and spending is increasing at an unsustainable rate.[6] [7] In 2019, nearly 18% of the nation's gross domestic product— nearly $3.8 trillion—was directed to health care.[8] Hospital services accounted for about 31% of spending, physician and clinical services for 20%, and prescription drugs for 10%. National health expenditures are projected to equal nearly 20% of gross domestic product by 2028. Available evidence suggests that health care prices are an important driver of U.S. spending.[9] However, it is important to recognize that utilization is growing and represents a larger share of spending, with more people being insured in the wake of the ACA and state Medicaid expansion.[10]

In large part owing to its pluralistic financing system, the United States spends more on administration of health care than peer countries. One study estimated that in 2012, the United States spent $471 billion on billing and insurance-related costs—$375 billion (80 percent) more than in a "simplified financing system," such as Canada's single-payer model.[11] Another study concluded that administrative costs were 31 percent of total U.S. health care expenditures, nearly double those of Canada.[12] In 2010–2012, administrative costs varied with type of insurance market: 20 percent in nongroup and 11 percent in large-group markets.[13] Average administrative costs for private insurers are around 12.4 percent, substantially higher than Medicare administrative spending, which accounts for around 2 percent of total program costs.[14] [15]

Many Americans cannot afford coverage and health care

Affordability of coverage is a common reason for remaining uninsured.[16] Factors that contribute to the affordability of health care include prices of goods and services, premiums, copayments, deductibles, coinsurance, type of health care coverage (employer-based, third party, or government), and benefits included with the plan. Premiums vary with enrollee mix, insurer administrative costs and profits, generosity of coverage, and prices of goods and services.[17] The share of workers with employer-sponsored insurance dropped from 67.3% in 1999 to 55.9% in 2014, with a slight increase to 58.4% in 2017, possibly due to the ACA and improved economy.[18] Family premiums for employer-sponsored insurance have increased 54% since 2009, outpacing inflation.[19] In 2019, the average annual premium for employer-sponsored coverage was $20 576 for a family and $7188 for an individual and had risen over the previous year.[20] [21] The 2019 Milliman Medical Index found that total health care costs (including employer subsidy, employee contribution, and employee out-of-pocket cost at time of service) for a typical American family of 4 with an employer-sponsored preferred provider organization insurance plan exceeded $28 000.[22] The Congressional Budget Office predicts that over the next decade, premiums will continue to outpace wages, decreasing the prevalence of employee-based

coverage.[23] Evidence suggests that more low-income families, who generally spend a larger proportion of income on employer-based insurance than wealthier counterparts, enrolled their children in public insurance plans to relieve the burden of employer-sponsored insurance costs.[24] [25]

As insurance costs rise, many employers offer insurance with high cost sharing.[26] The Kaiser Family Foundation reports that 82% of workers have an annual deductible, and since 2009, the deductible burden has increased 162%.[27] Since 2006, total cost sharing has grown at a higher rate than wages.[28] Of employer-sponsored insurance enrollees who were continuously insured throughout the year, 28% were underinsured in 2018, compared with 10% in 2003.[29]

A Public Option Could Make Care More Affordable and Available, Depending on How It Is Designed

In January 2020, ACP In 2020, ACP offered its views about how to achieve universal coverage in its new vision for U.S. health care, "Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care". In that paper, ACP made the following recommendations:

1. *The American College of Physicians recommends that the United States transition to a system that achieves universal coverage with essential benefits and lower administrative costs.*
    a. *Coverage should not be dependent on a person's place of residence, employment, health status, or income.*
    b. *Coverage should ensure sufficient access to clinicians, hospitals, and other sources of care.*

2. *Two options could achieve these objectives: a single-payer financing approach, or a publicly financed coverage option to be offered along with regulated private insurance.*

While we continue to believe that a single payer model merits consideration, we will focus only on the public option in our comments, although consideration should be given to transitioning to a single payer system if a substantial and growing number of Americans choose to get coverage through a public plan.

We strongly believe that a public option concept could broaden access to affordable coverage choices, rein in excessive hospital and prescription drug costs, promote preventive and primary care, reduce health inequities, relieve administrative burdens, and embrace innovative payment and delivery systems designed to improve patient care and enhance value, helping to achieve universal coverage. Yet designing a coverage option from scratch is an incredibly complicated endeavor that could trigger unintended consequences or amplify existing problems, including health system fragmentation, undervaluation of primary care and other physician services, and lack of viability in rural and other underserved areas. The following comments provide ACP's recommendations on how a public option can serve as a means to test innovative delivery system and payment reforms, preserve the patient-physician relationship, and expand access to comprehensive, affordable coverage.

Specifically, ACP recommends that the Energy and Commerce and HELP Committees develop legislation that would:

1. Make a public option broadly available so that all Americans have a choice of enrolling in a public option plan or in a qualified private employer-based or non-group plan, provided that the benefits and cost-sharing in the private insurance options are comparable to those available from the public option.
    a. If the public option is to be made initially available only in the nongroup market and to the Medicaid coverage gap population, it should subsequently be expanded to offer a choice to people with employer-sponsored insurance and other populations.

2. Under a public option, payment rates to physicians and other clinicians, as well as to hospitals and other facilities that offer health care services, must be sufficient to ensure access to needed care and should not perpetuate disparities in current payment methods.
    a. Current Medicare payment rates generally are insufficient to achieve the objectives of universal coverage.
3. Physician payment policies must ensure robust participation and not undervalue primary care and cognitive services, including the primary, preventive, and comprehensive care provided by internal medicine physician specialists.

4. Physicians are more likely to be able to afford to participate in, and see a significant number of patients, in a public plan that offers high-quality service to patients, limits administrative burdens for physicians, and provides fair and sufficient reimbursement rates.
    a. It is particularly important that payments to physicians under a public option support an increased investment in undervalued primary and comprehensive care, consistent with the consensus report of the National Academies of Sciences, Engineering and Medicine (NASEM), *Implementing High Value Primary Care: Rebuilding the Foundation of Health Care*, which notes that primary care is the foundation of a high-functioning health care system.[30]
    b. Innovative alternative payment models to support primary care should be adopted by the public plan. Specifically, health care delivery and payment under a public plan should be redesigned to support physician-led, team-based care delivery models in providing effective, patient- and family-centered care as stated in, "Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms."
    c. Policies and necessary oversight to support broad and sufficient networks of physicians and other clinicians should be included.
    d. Physicians should be allowed to choose to participate in the public option. Participation in Medicare, Medicaid, other public coverage program should not be contingent on whether a physician participates in the public option.

5. Under a public option model, coverage must include an essential health care benefit package that emphasizes high-value care, preferably based on recommendations from

an independent expert panel that includes the public, physicians, economists, health services researchers, and others with expertise.
   a. Cost sharing that creates barriers to evidence-based, high-value, and essential care should be eliminated, particularly for low-income patients and patients with certain defined chronic diseases and catastrophic illnesses.

6. The public option should include income-adjusted premium and cost-sharing subsidies especially for persons at or below 138% of the Federal Poverty Level (FPL).
   a. The ACP has recommended extending the ACA marketplace's premium tax credits to people with incomes over 400% of the FPL and enhancing their generosity to make insurance more affordable, as the American Rescue Plan Act has authorized, albeit on a temporary basis through CY 2022. These improvements should be made permanent.
   b. Similar premium subsidies and eligibility could be applied to persons choosing the public option.

7. In a public option system, employers should be required to offer comprehensive coverage to their employees (and families) that is at least as generous as the public insurance option or pay a portion of the cost of their employees' public insurance plan coverage (that is, “pay or play”).

The ACP has also offered recommendations for a public option that would be available alongside private insurance in the ACA marketplaces to inject competition into areas underserved by private insurers and reduce premiums. The ACP also supports a Medicare buy-in option for persons aged 55 through 64 years.[31] Evidence shows that areas with a single insurer have faster premium growth than those with multiple insurance options.[32] ACP also supported the ARPA full subsidization of the health coverage of people earning up to 150 percent of the FPL under the ACA and those on unemployment insurance for a period of two years. Lastly ACP supported the ARPA making enrollees who earn over 400 percent FPL eligible for subsidies and have their premium costs capped at 8.5 percent of income for two years. ACP fully supports policies to eliminate the 400 percent FPL premium tax credit eligibility cap and to enhance the premium tax credit for all levels. The two-year extension will help many of these uninsured and underinsured low- to middle- class Americans achieve health care coverage. **We believe further that these premium tax credit reforms should be extended permanently by Congress.** In addition, ACP has offered recommendations for improving the ACA's coverage provisions.[33]

ACP’s Responses to the Committee’s RFI

1. **Who should be eligible for the public option? Should a federally administered plan be available to all individuals or be limited to certain categories of individuals (e.g., ACA Marketplace eligible individuals, private employers and individuals offered employer coverage)?**

ACP believes that a public option should be made broadly available so that all Americans have a choice of enrolling in a public option plan or in a qualified private employer-based or non-group plan, provided

that the benefits and cost-sharing in the private insurance options are comparable to those available from the public option.

Persons with employer-based coverage should be able to choose to enroll in a federally-operated public insurance plan or remain in their employer based coverage if it offers comparable benefits. The public plan would be available nationwide, ensuring portability from state to state. We acknowledge that opening up the public option plan to those with employer-sponsored insurance may create additional regulatory and implementation challenges and require the public option to take on insurance risk; however, we believe doing so will increase the ability of the public option to take the lead on making lasting, necessary changes to the nation's health care system.

Alternatively, a public option could be designed to transition from initially offering it in the non-group and Medicaid gap population to making it available to all Americans. This gradual approach of implementing a public option in the nongroup market and expanding eligibility over time would broaden coverage choices for millions of Americans. Insurer participation in the Health Insurance Marketplaces has fluctuated over the past few years. Although competition is currently robust and stable, 26% of people had only one insurer to choose from in 2018.[34] Similarly, workers with an offer of employer coverage usually have limited options. In 2019, 75% of employers offering coverage offered only 1 plan type, although nearly 64% of workers who had employer-based insurance had more than 1 plan available to them.[35] Employers that offer a single plan generally provided a preferred provider organization plan, but 27% of workers only had an offer of a high-deductible health plan. Additionally, people with affordable, comprehensive employer-sponsored insurance are ineligible for subsidized marketplace-based coverage under the ACA. This means most nonelderly Americans are restricted to the health insurance plan offered by their employer, or unsubsidized individual coverage inside or outside of the health insurance marketplace. A public option approach would provide choice to those with few or undesirable private options. A nationwide public plan would be portable and people would not need to remain in a job solely to maintain health insurance coverage.

The public option plan's benefits may be greatest for low-income uninsured and underinsured persons. As of April 2021, roughly 2.2 million people are eligible for expanded Medicaid but live in a non-expansion state and earn too little to qualify for subsidized marketplace-based insurance.[36] A public option approach would ensure access to coverage for such individuals.

Transitioning to Universal Coverage

Major health care system transformation is not without precedent. Medicare benefits were available less than 1 year after the program was signed into law,[37] despite the necessity of compromises with hospitals, physicians, and other stakeholders.[38] Stop-gap coverage options, such as broadening eligibility to the Medicare, Medicaid, and ACA marketplace plans, should be established during the transition to the new system. The ACP supports establishing a public option in the ACA marketplace,[39] and more generous financial subsidies for ACA marketplace plans.[40] A Medicare buy-in option for persons aged 55 to 64 years should also be created. In addition, a major public education campaign will need to raise awareness about the new plan.

The ACP envisions that transition might occur as follows:

First, close gaps and stabilize the markets created by the ACA, including creating a public option in all individual insurance marketplaces, expanding Medicaid to lower-income persons in all states, and ending the income eligibility cap for premium subsidies and creating a Medicare buy-in for persons aged 55 to 64 years, as ACP has previously recommended as a way to improve the ACA.[41] [42]

Next, transition to a publicly financed option for all who want it while allowing individuals to keep private coverage that meets federal requirements, with mechanisms to ensure that everyone is enrolled in a qualified plan.

Over time, if most Americans choose the public option plan, the United States could transition entirely to a single-payer system.

2. **How should Congress ensure adequate access to providers for enrollees in a public option?**

Physicians are more likely to participate in a health plan that offers high-quality service to patients, limits administrative burdens for physicians, and provides fair and sufficient reimbursement rates. The public option should adopt policies and necessary oversight to support a broad selection of physicians and other health care professionals.

Physician Participation Should Be Voluntary

ACP believes that **physician participation in a public option should be voluntar**y as it is in the Medicare and Medicaid programs. Physicians that participate in Medicare, Medicaid or other public programs should not be required to participate in the public option. ACP also opposes clauses in commercial insurer contracts that obligate the physician to participate in any plan offered by an insurer. Voluntary participation maintains physician autonomy and ensures physicians can continue to deliver high-quality care. It also prevents practices with large patient panels from being overwhelmed.

Eliminate Administrative Burdens that Discourage Physician Participation

Evidence shows that administrative burdens and billing problems dissuade physicians from participating in insurance networks and coverage programs like Medicaid.[43] Excessive administrative tasks contribute to physician burnout, which is costly to the health care system and associated with negative clinical outcomes.[44] ACP recommends that the public option be developed with the intent of excluding and eliminating unnecessary, inefficient, and ineffective billing and reporting requirements for all health care services, as well as reducing administrative barriers to appropriately paying for and valuing non-face-to-face-based care, such as care management and telemedicine. Doing so will help to ensure the continued strength of the patient-physician relationship and physician participation in the public option. The public option should be designed to reflect the recommendations in ACP's position paper "Putting Patients First by Reducing Administrative Tasks in Health Care."

Increase Investment in Primary Care

Ensuring access to clinicians in a public option program would require a greater allocation of resources to primary care. For example, Medicare's fee-for-service model rewards high-volume, procedure-oriented specialties over complex cognitive care delivered by primary care physicians. Medicare has long undervalued primary care. In 2017, MedPAC found that median primary care compensation was much lower than specialty care, raising concerns about fee schedule mispricing primary care.[45] The U.S. shortage of primary care physicians impedes access to high-quality care.[46] Medicare beneficiaries are more likely to have trouble finding a primary care physician than a specialist.[47] Racial and ethnic minority Medicare beneficiaries report longer wait times and higher rates of forgoing care than non-Hispanic white beneficiaries. As part of a strategy to lower health care costs and increase patient access, the American College of Physicians supports greater investment in primary care and preventive health services, including support for the unique role played by internal medicine specialists in providing high-value primary, preventive, and comprehensive care of adult patients.

Primary care is essential in the prevention and early detection and treatment of disease, which can help to avoid costlier future care. Only between 6% and 8% of health care dollars are spent on primary care,[48] but greater use of primary care is associated with decreased health expenditures, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality.[49] Recent state-level analyses show an association between investment in primary care and reductions in emergency department visits, total hospitalizations, and hospitalizations for ambulatory care–sensitive conditions.[50] United States markets with larger numbers of primary care physicians have lower costs and higher quality of care.[51] Data suggest that investments in primary care physicians in Medicare would result in an overall drop in total Medicare costs.[52] Small increases in the number of primary care physicians (1 primary care physician per 10 000 individuals) have been associated with lower all-cause, stroke-associated, and infant mortality.[53] Furthermore, primary care is integral in caring for people with chronic disease, a demand that will become increasingly critical as the U.S. population ages.[54]

Initiatives to increase investment in primary care should align with the Primary Care Collaborative's recommendations, including standardized metrics, broad stakeholder participation, targeted strategies, aligning payment incentives, and evidence-based outcome evaluation.[55]

3. **How should prices for health care items and services be determined? What criteria should be considered in determining prices?**

The public option offers an opportunity to implement policies that reinvigorate primary care, incentivize care coordination, reward positive health outcomes, and tamp down on excessive health care prices, particularly for prescription drugs and certain hospital services.

Public option premiums depend on a variety of factors, including prescription drug costs; reimbursement rates for hospitals, physicians, and other health care professionals; utilization policies; benefit package; and enrollee health status.[56] ACP policy offers the following recommendations on several key health care cost drivers, including on physician payment and strengthening primary care as recommending in "Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care"

and "Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms."

Physician Payments Should Be Sufficient and Not Based on Medicare Rates or Payment Structure

ACP recommends that that in a public option model, payment rates to physicians and other clinicians, as well as to hospitals and other facilities that offer health care services, must be sufficient to encourage physician participation, ensure access to needed care and should not perpetuate disparities in current payment methods. **Current Medicare payment rates generally are insufficient to achieve the objectives of universal coverage.** Similarly, Medicaid rates are often lower than Medicare's, and inadequate to attract physician participation.[57] [58] In a public option program, the continued existence of commercial employer plans, which typically pay physicians more than Medicare, may help to offset lower public plan pay rates, but this is not guaranteed. Medicare Advantage rates closely track Medicare fee-for-service rates.[59] Proponents of public option proposals, including Medicare Part E developer Jacob Hacker, believe that adopting Medicare rates will cause commercial rates to drop. The public option approach could reduce access if payments are cut to an extent that continued physician participation is unsustainable.

Building the Bridge to More Complete Value-Based Transformation

The American College of Physicians recommends that health care delivery and payment be redesigned to support physician-led, team-based care delivery models in providing effective, patient- and family-centered care as stated in, "Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms."

In 2013, ACP published a set of principles for supporting dynamic clinical care teams[60] that reaffirmed the importance of patients having access to a personal physician who is trained in the care of the "whole person" and has leadership responsibilities for a team of health professionals.[61] A unique strength of multidisciplinary teams is that clinicians from different disciplines and specialties bring distinct training, skills, knowledge bases, competencies, and patient care experiences to the team, enabling the team to better respond to the needs of each patient and the population it serves. Payment systems should encourage and support the organization of clinical care teams, both within a practice and across the medical neighborhood.[62]

In the report, "Investment in Health as the New Paradigm for Financing Primary Care as Public Good", ACP—along with six other primary care medical organizations—advanced several payment principles for primary care. These principles focused on making payments to physicians more relationship-centered and placing increased value on the cognitive treatment of the patient. This new paradigm would result in clinicians serving the patient, with the driver being the overall health of the patient rather than reactive, sick care. Payment would be connected to social drivers and preventative care where possible. Predictability would be achieved through a baseline stream of revenue through payment models that satisfy patient needs, individual life circumstances, and overall population health needs. Payments would increase both access and usage of high value, community based care.[63]

NASEM offers different options for reforming payment for primary care services. Four options are proposed: 1) Updating the existing fee schedule for Medicare to value primary care services in a more accurate fashion; 2) combining traditional fee-for-service (FFS) with lump payments or prospective payment per person for a hybrid approach; 3) using risk sharing organizations, such as accountable care organizations (ACOs), to administer global payment models; and 4) allocate more spending resources to primary care by requiring payers to increase the proportion of health care spending directed to primary care.[64]

ACP supports moving towards prospective population-based payment model for primary care, similar to the second option proposed by NASEM. This hybrid approach would be offered as an option for primary care physicians as an alternative to the traditional Medicare Physician Fee Schedule under Medicare Part B and could serve as a template for a payment for a public option. This option would offer a hybrid model under the public option plan, similar what NASEM recommends, that would pay primary care teams a prospective payment per patient, adjusted for health status, risk, demographics and social drivers, combined with FFS for discreet services like vaccines, at a level that is sufficient to promote high value care and support health equity.

A public option creates an opportunity to move to such innovative and value-based payment models for physicians who participate in the program, and for patients who receive care under it, rather than perpetuating the flaws in the current Medicare payment system for physician services.

4. **How should the public option's benefit package be structured?**

The American College of Physicians recommends that under a public option model, coverage must include an essential health care benefit package that emphasizes high-value care, preferably based on recommendations from an independent expert panel that includes the public, physicians, economists, health services researchers, and others with expertise.

The public option must guarantee coverage of essential health care services for a diverse population. In general, **ACP supports maintaining the ACA's essential health benefit package, which requires certain insurance plans to cover 10 service categories, ranging from such foundational services as hospitalizations and ambulatory care to more specialized areas, such as rehabilitative or habilitative benefits.** However, the public option's benefit package should reflect the health care needs of the covered population and emphasize high-value care. For example, a public option program that includes Medicaid-eligible individuals may need to cover services like nonemergency transportation services, Early and Periodic Screening, Diagnostic, and Treatment benefits, and other services covered by Medicaid.

Overtreatment, Low-Value Care, and Preventable Diseases

ACP supports greater efforts to reduce low-value care and reduce costs associated with preventable disease. The public option's benefit package should emphasize high-value care. Overutilization of low-value care contributes to the high cost of U.S. health care. It is estimated that $760 to $935 billion is wasted annually in the health care system, with overutilization or low-value care accounting for $75.7 to $101.2 billion annually.[65] Although the United States is not alone in overutilization, particularly

overuse of antibiotics, it leads in overutilization of many services, including imaging services, repeated colonoscopy or chest computed tomography, and diagnostic allergy testing.[66] In 2012, the ACP was one of the first 9 specialty partners in the American Board of Internal Medicine's Choosing Wisely campaign to promote high-value care, an effort that has generally been considered a success. However, additional efforts are needed to reduce the overuse of low-value services that are frequently performed and may represent a large share of revenue.[67]

Although the public option's benefit package should largely mirror the ACA's essential health benefit package, it should reflect recommendations from an independent expert panel that includes the public, physicians, economists, health services researchers, and others with expertise to ensure that high-value services are included and emphasized. In 2011, at the Department of Health and Human Services' (HHS) request, the Institute of Medicine (IOM) (now the National Academies of Medicine, Engineering, and Science) developed criteria and methods to determine benefits to include in the ACA's essential health care benefits package while balancing coverage and cost. The IOM encouraged the government to consider population health needs, be evidence-based, emphasize the judicious use of resources, and improve value and performance.[68] To achieve this, IOM recommended that benefits be based on an annually updated premium target and be continuously updated by using a public process and considering costs to be fully evidence-based and promote value.[69] A national benefits advisory council and the public would provide input. Ultimately, HHS took a different approach, basing essential health benefits on a private sector or government employee benchmark plan, which led to some variation among states.

ACP believes that the public option's benefit package should embrace and promote high-value care and discourage low-value care. According to MedPAC, "[L]ow-value care has the potential to harm patients by exposing them to the risks of injury from inappropriate tests or procedures and may lead to a cascade of additional services that contain risks but provide little or no benefit".[70]

Under the public option, employers could opt to subsidize their employees' public insurance or offer their own coverage. This may require new regulations for employer-sponsored insurance plans, including benefit package and actuarial value requirements. For example, Congress could mandate that insurance offered by large employers at a minimum reflect the public option benefit package, actuarial value, and other characteristics. Without these important safeguards, the more generous public insurance plan may attract a disproportionate share of sicker people, which would increase claims and premiums. Employers would be required to provide information on the public option insurance program to employees during open enrollment.

5. **What type of premium assistance should the Federal government provide for individuals enrolled in the public option?**

The ACP recommends that a public option model include income-adjusted premium and cost-sharing subsidies. The ACP has recommended extending the ACA marketplace's premium tax credits to people with incomes over 400% of the FPL and enhancing their generosity to make insurance more affordable. In a public option system, large employers should be required to offer comprehensive coverage to their employees (and families) that is at least as generous as the public insurance option or pay a portion of the cost of their employees' public insurance plan coverage (that is, "pay or play").

ACP supports expanding the eligibility and generosity of premium tax credits for marketplace-based plans. In a public option system, financial subsidies and regulations to make the public plan affordable would need to be made available to a wider array of people than in the ACA marketplace. Premiums should be income adjusted and capped at a percentage of annual income. Large employers would need to financially contribute to the public plan when employees choose it over the employer-sponsored plan. Alternatively, employers could choose to pay to enroll their employees in the public plan rather than offering a private plan. Employer-sponsored insurance would need to meet new benefit and regulatory standards to prevent adverse selection, ensure a level playing field, and promote equitable coverage. Robust risk adjustment mechanisms would need to be adopted.

Eliminate Cost Sharing for High Value Care

ACP believes cost sharing that creates barriers to evidence-based, high-value, and essential care should be eliminated, particularly for low-income patients and patients with certain defined chronic diseases and catastrophic illnesses. In general, when cost sharing is required for some services, it should be income-adjusted through a subsidy mechanism and subject to annual and lifetime out-of-pocket limits.

Cost sharing can temper utilization and reduce costs by steering enrollees to high-value services. Over the past decade, enrollment in low-deductible health plans has decreased while enrollment in high-deductible health plans has grown for adults in employer-based plans.[71] In the RAND Health Insurance Experiment, cost sharing reduced utilization of both effective and ineffective services.[72] Low-income, sick patients in plans with zero cost sharing had better hypertension and vision outcomes than those with cost sharing, but those with cost sharing had fewer restricted-activity days and worried less about their health.[73] Despite the potential benefits of cost sharing, the RAND study suggests that cost sharing should be minimal or nonexistent for low-income individuals. Evidence shows that even very low Medicaid copayments are associated with decreased use of necessary care.[74] High deductibles may serve as a barrier to receiving high-value, preventive care and treatment after diagnosis. One study found that switching from a low-deductible to a high-deductible employer-based plan was associated with delays in breast cancer diagnosis and chemotherapy initiation among women, regardless of income.[75]

These observations lead ACP to recommend zero cost sharing for essential services, particularly for low-income individuals (at a minimum, 138% of the FPL) as well as those with special health care needs, serious illnesses, and chronic conditions. Taiwan, Germany, and Switzerland are examples of countries that cap or eliminate cost sharing on the basis of income, service category, or health condition.[76] For higher-income enrollees, cost sharing should be structured to direct patients to effective, patient-centered, high-value care. Value-based insurance design proposals, supported in concept by ACP, reduce or eliminate cost sharing for high-value services and have been shown to increase use of mammography [77] and adherence to medications.[78] [79] [80]

6. **What should be the role of states in a federally-administered public option?**

A federal public option plan made available along with regulated insurance, must be designed to protect and ensure that patients can get, and physicians are able to provide, the care they need consistent with evidence-based guidelines, essential guaranteed benefits determined with patient and physician input, and overall available resources. Although states have primary regulatory responsibility overseeing health insurance, the Affordable Care Act laid a regulatory "floor" for nongroup and group plans, preempting state insurance laws with less robust consumer protections. It is likely that the federal government would have primary regulatory responsibility of a federally-operated public option plan, similar to traditional Medicare.

Medicare Advantage provides a cautionary experience of what can happen in a system where private and public entities compete, underscoring the need for strong regulatory oversight and a level playing field. The U.S. Government Accountability Office and MedPAC have called for improvements in the program, where private insurers are contracted to provide Medicare benefits as an alternative to the Medicare fee-for-service program, after finding questionable risk coding practices,[81] [82] narrowing "provider" networks and inaccurate directories,[83] and evidence that beneficiaries in poor health were more likely than beneficiaries in better health to disenroll because of problems related to getting needed care and accessing their preferred doctor or hospital.[84]

7. **How should the public option interact with public programs including Medicaid and Medicare?**

In the near term, other public programs would largely be unaffected by the public option. Health care programs that serve special populations, including the Veterans Health Administration, Medicaid long-term services and supports, and Indian Health Service, should continue to operate alongside the new public option plan. Over the long-term, if the public option is viable and achieves the goals of better care at a cost that enrollees and the country can afford, eligibility, benefit structure, and other plan characteristics may be amended to include certain populations currently covered by public programs such as Medicaid "new adult" expansion population.

8. **What role can the public option play in addressing broader health system reform objectives, such as delivery system reform and addressing health inequities?**

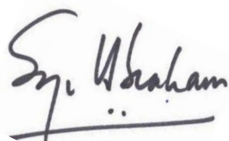
In 2021, ACP released the position paper, "Understanding and Addressing Disparities and Discrimination Affecting the Health and Health Care of Persons and Populations at Highest Risk," which offered specific recommendations to address health issues that disproportionately impact racial and ethnic minorities, including during a pandemic. ACP believes that public policy must strive to make improvements to coverage, quality, and access to care for everyone, while addressing the disproportionate effect on those at greatest risk because of their personal characteristics. Universal health coverage, such as a public option model as recommended in "Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care"[85] is fundamental in addressing the underlying racial and ethnic disparities in comorbidities that increase risk of negative health outcomes. Having adequate

health coverage is closely associated with one's access to care and well-being. Compared to those who are insured, uninsured individuals are three times less likely to visit a doctor or health professional regarding their health.[86] While the ACA greatly decreased the coverage gap, additional measures are needed to achieve universal coverage and eliminate persistent disparities in coverage. As the overall population has seen a decrease in the uninsured rate since the ACA was implemented, racial and ethnic minorities have experienced some of the largest gains but still have higher uninsured rates compared to White persons.[87]

Conclusion
We commend you and your colleagues for working to develop a legislative proposal to create a federal public option. We also appreciate your effort to solicit recommendations from the medical stakeholder community. We wish to assist in the Energy and Commerce and HELP Committees' efforts in this area by offering our input and suggestions about ways that Congress and can create a public option through evidence-based policies. The United States is the only wealthy industrialized country without universal health coverage. It spends more on health care than its peers, and spending is growing at an unsustainable rate, care is unaffordable for many Americans (including insured persons), and health outcomes lag behind those of countries with universal coverage. ACP believes that achieving universal coverage and access is an ethical obligation. The positions recommended above will help achieve ACP's vision of a better health care system, as described in "Envisioning a Better U.S. Health Care System for All: A Call to Action from the American College of Physicians",[88] including a system where everyone will have coverage for and access to the care they need, at a cost they and the country can afford.

Thank you for your consideration of our recommendations that are offered in the spirit of providing the necessary support to physicians and their patients. Please contact Jonni McCrann, Senior Manager, Legislative Affairs, by phone at (202) 261-4541 or via email at jmccrann@acponline.org and Jared Frost, Senior Associate, Legislative Affairs, by phone at (202) 261-4526 or via email at jfrost@acponline.org with any further questions or if you need additional information.

Sincerely,



George M. Abraham, MD, MPH, FACP, FIDSA
President

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