July 30, 2021

The Honorable Patty Murray
Chair, Health Education and Labor Committee
United States Senate
Washington, DC 20510

The Honorable Frank Pallone
Chair, Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chair Murray and Chair Pallone:

Families USA is pleased to submit these comments in response to your request for information on public option legislation that would extend quality health coverage to those who lack it today, improve affordability of health coverage and care for struggling families, and lower health care costs.

**We support public option policies, and we believe they offer tremendous potential** to achieve these important goals. With careful policy design, a public option could be especially valuable to the historically disadvantaged and marginalized populations that continue to encounter disproportionate barriers to coverage and care.

**Several features of public option legislation will be important** to accomplish these goals, regardless of where and how such an option is deployed. The use of administrative pricing, combined with strong incentives for providers to serve beneficiaries of a public option, is key to a sustainable public option that achieves significant cost savings for families and for the health care system as a whole. Both with prescription drugs and health care services more generally, public opinion research suggests strong support for lowering health care costs by enabling the federal government to negotiate fair and equitable health care prices. Together with stronger oversight over anticompetitive behavior in the health care sector, a public option can be a powerful tool to bring down unaffordable and unsustainable health care costs.

It will also be essential for a public option to cover comprehensive benefits, including but not limited to services classified as essential health benefits under the Affordable Care Act (ACA). Full parity of coverage between mental and physical health care is likewise fundamental, as are limits on consumer premium and out-of-pocket costs. The public option should be a vehicle for solving affordability problems in both private and public coverage, not perpetuating them.

**With these and other relevant design features included, a public option could be deployed effectively in four separate contexts**: the ACA's health insurance Marketplace, employer-sponsored insurance (ESI), coverage for low-income adults denied Medicaid by their states' refusal to expand eligibility, and a state option for experimentation.

**Public option and the Marketplace:** A public option would lower premium costs for Marketplace consumers. Careful policy design will be essential to make sure that low- and moderate-income people benefit, along with more affluent consumers. Most beneficiaries pay premiums with the aid of advance premium tax credits (APTCs), which are based on amounts charged by the second-lowest-cost silver-tier plan. As a result, adding a new, low-premium public option to the health insurance Marketplace has the potential to hurt people who rely on APTCs, while benefiting higher-income consumers who are ineligible for APTCs. This is clearly not the goal of a public option. For a public option in the Marketplace to help rather than harm people at all income levels, it is essential to include guardrails that protect APTCs.

Last year, health researchers at the RAND Corporation, working in collaboration with Families USA and two leading actuarial firms, estimated the impact of offering a public option in health insurance Marketplaces. Without APTC guardrails, almost all affected people with incomes above 400% of the federal poverty level (FPL) were projected to experience cost savings. However, below that income threshold, the overwhelming majority of affected beneficiaries saw their net premium costs rise. Their APTC amounts fell by more than the premiums charged by health plans, so these low- and moderate-income consumers had to spend more to keep the same coverage. By contrast, with guardrails in the form of a policy that disregarded public-option premiums in determining APTC amounts, the vast majority of consumers at all income levels were projected to realize cost savings.[1] Now that, for at least two years, the American Rescue Plan (ARP) has qualified consumers with incomes above 400% of FPL for APTCs, the need for APTC guardrails has become even more important, as such guardrails would protect a broader spectrum of households from an unintended increase in net premium costs that otherwise could result.

Families USA accordingly urges Congress to add a publicly-administered, low-cost plan to existing Marketplace options, accompanied by guardrails that prevent APTC erosion, such as the elimination of public options from consideration in determining benchmark premiums.

**Public option and employer coverage:** In the group market, a public option could be extraordinarily helpful in addressing the problem of ESI underinsurance, which has grown substantially over time. Millions of low-wage workers and chronically ill employees and dependents experience increasingly severe financial burdens and impaired access to essential health care, because a growing proportion of employers offer only coverage that has high out-of-pocket cost-sharing, including high deductibles.[2] Families USA recommends that Congress use one of the following approaches to deploying the public option to strengthen employer-based coverage:

- Give everyone offered group coverage the choice to opt out of the employer plan and instead enroll in a publicly-managed health plan with comprehensive benefits and limited out-of-pocket cost-sharing, including low deductibles. To limit resulting federal costs, such a shift should be accompanied by the employer paying the federal government the same average amount the employer pays for its remaining employees who enroll in ESI, including both worker and firm share of premium.
- As an alternative approach, worth considering if the first approach proves challenging to enact, have the federal government offer low-cost, high-value coverage for purchase by employers, to replace or supplement currently available group options. To prevent this alternative policy from triggering adverse selection and raising premiums by unsustainable amounts, we recommend against putting plans at risk, at least initially. Instead, the public option, under this alternative approach, should pay claims using an approach based on traditional Medicare or a third-party-administrator structure.

These two options would leverage the efficiency gains of publicly-administered coverage to simultaneously achieve three important goals:

1. The nearly three in five (56%) U.S. residents under age 65 who rely on group coverage[3] could experience a significant reduction in financial burdens and improved access to health care by enrolling in a public option with affordable deductibles and limited out-of-pocket cost-sharing. This would be especially important to low-wage workers and people with chronic illnesses, groups of people who are frequently ill-served by high-deductible employer plans.

2. The growth in health insurance costs paid by employers would slow.
3. Despite workers and their families transitioning to publicly-administered plans, cost shifts from employers to the federal government would be limited.

**<u>The public option and poor uninsured adults in the "coverage gap"</u>:** Low-income people in twelve states are now denied access to all insurance affordability programs by their states' continued refusal to expand Medicaid eligibility under the ACA. We urge Congress to consider using a federally-managed coverage option to provide the enrollment-gap population with full, Medicaid-level benefits and cost-sharing protections, including all current legal safeguards. Such an approach would lower federal costs, compared to using private coverage mechanisms to accomplish those same goals.

**<u>The public option and state innovation waivers</u>:** Congress should make it easier for the ACA's State Innovation Waivers to test public option approaches and other innovations that provide health coverage to struggling families who qualify for help today but are not enrolled. Especially if Congress cannot quickly make a public option available nationally, lawmakers should broaden the scope of state experimentation and innovation under ACA section 1332 so states could develop a track record of success that enables later nationwide implementation of a public option. Congress should make two statutory changes:

1. Clarify that section 1332's "federal deficit neutrality" guardrail does not apply to federal spending that results from increased enrollment of people who qualify for APTCs without a waiver. With both Medicaid waivers pursuant to Social Security Act §1115 and state waivers under the Supplemental Nutrition Assistance Program, federal deficit neutrality has been construed to allow policies that increase enrollment of eligible people, with available federal dollars rising proportionately. We believe that §1332 should be construed that way as well, but neither the Obama nor Trump administration took that approach. Congress should eliminate all questions about this issue by simply clarifying the statutory standard to allow for innovation waivers that help achieve the ACA's fundamental goal of covering the uninsured.
2. Amend section 1332 to provide that federal pass-through funding under section 1332 includes, in addition to federal APTC savings, increased federal revenue that results from lower employer spending on health benefits. Most economists believe that, if a state public option lowers ESI costs, federal tax revenue from that state will increase. Both the Congressional Budget Office and the Office of Management and Budget are likely to model employer savings on tax-shielded ESI as raising employee compensation in the form of taxable earnings, thereby increasing federal income tax and payroll tax revenue. Forwarding those savings to states would give them capacity and incentives to develop public-option and other innovative strategies that achieve the critically important policy goal of slowing the growth of employer health benefit costs — for example, by using multi-payer Initiatives to implement payment and delivery-system reforms that facilitate widespread and rapid provider adoption by creating consistent, all-payer metrics and directional incentives.

**The American public strongly supports giving everyone the option to buy a publicly-administered health plan, free from the influence exerted by private insurers**. Families USA looks forward to working with you and your colleagues to help realize this vision in ways that help us become a nation where affordable, high-quality, health care is guaranteed for all.

Sincerely,

Frederick Isasi

Executive Director, Families USA

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[1] Stan Dorn. Public Options and Other Policies to Lower Health Insurance Premiums Need Guardrails to Protect Low- and Moderate-Income Consumers. Families USA, June 2020. https://familiesusa.org/wp-content/uploads/2020/06/COV_COV_Public-Charge-and-Guardrails-Anaylsis.pdf

[2] See, e.g., Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia. U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability. The Commonwealth Fund, August 19, 2020. https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial; Stan Dorn. "The Cadillac Tax: It's Time To Kill This Policy Zombie." *Health Affairs Blog.* June 18, 2019. https://www.healthaffairs.org/do/10.1377/hblog20190617.795057/full/ .

[3] Katherine Keisler-Starkey and Lisa N. Bunch. Health Insurance Coverage in the United States: 2019. U.S. Census Bureau, September 2020. https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf