COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

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Chairwoman Patty Murray
Committee on Health, Education, Labor and Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

Chairman Frank Pallone
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairwoman Murray and Chairman Pallone,

The Council for Affordable Health Coverage (CAHC) thanks you for the opportunity to provide our comments on the merits of and design considerations for legislation to develop a public health insurance option. CAHC (www.cahc.net) is a broad-based alliance with a primary focus: bringing down the cost of health care for all Americans. Our members include employers, medical providers, patient groups, insurers, agents and brokers, technology companies, pharmaceutical manufacturers, and pharmacy benefit managers who collectively cover millions of lives in the private market.

Universal Coverage

CAHC supports universal coverage. We want all Americans to have access to a health policy they can afford and that meets their individual needs. Fortunately, most Americans (92 percent)[1] do obtain health coverage, which they receive through job-based health benefits, government programs, or charitable care. And most Americans like their health coverage. According to a recent CAHC poll, voters support job-based coverage over government run programs by a 20-point margin.[2]

The "Public Option"

Because each person has different health circumstances, one-size-fits-some solutions like a public option will never work well for many, making it an unappealing approach. That is why we believe the so-called public option is the wrong path, since it would upend the entire market to advance an ideological agenda to expand government run health care. Worse, a public option effectively removes the competitive forces at work in health markets with government prices set by bureaucrats and formulas rather than real world experience. Under a public plan, the government would be responsible for negotiating reimbursement rates for doctors, hospitals, and pharmaceutical companies. The government typically does not "negotiate." The government would likely resort to price-setting based on Medicare or use existing government programs as leverage for negotiations, creating similar effects.

In November 2013, the Congressional Budget Office (CBO) examined a proposal to add a public plan to the health insurance exchanges. The public plan would charge premiums that fully covered its costs, including administrative expenses. At the outset, the plan's payment rates for physicians would be set 5% higher than Medicare's rates in 2013 and increase to reflect costs in later years. In addition, the public plan would pay hospitals and other providers the same amount that would be paid under Medicare, on average, and would set payment rates for prescription drugs through "negotiations" with drug manufacturers. Low reimbursement rates would not likely encourage provider participate in a public exchange, which would likely lead to longer waits for care and inevitably lead to rationed care. These states may be less attractive to specialists who provide critical care to patients with complex medical conditions. States that choose to offer a public option on the exchange may risk losing their health

[1] Health Insurance Coverage in the United States: 2019 (census.gov)
[2] CAHC March 2021 Board Presentation (squarespace.com)

care workforce – or at least some of it – if the arrangements offered by the government health plan are not workable.

Experience

The Affordable Care Act included several attempts at creating "public options" including the creation of co-operative health plans or co-ops, multi-state plans run by the Office of Management and Budget, and finally the creation of the CLASS Act to help with long-term care expenses. Millions of dollars and numerous lawsuits later, most of the federally funded co-ops have either become insolvent or ceased to operate as a co-op. The multi-state plan – intended to interject national competition into local markets – was a failure from the outset. The long-forgotten CLASS Act, which was supposed to be a public option for long-term care, was repealed before it was operationalized due to solvency and serious design flaws.

In short, all the federal public options in the ACA have flopped. The programs cost taxpayer money, destabilized insurance markets, and led to higher overall insurance prices as costs shifted to private payers. The imposition of a new public option scheme would be similarly detrimental to optimal health insurance markets and result in increased costs for both taxpayers and consumers.

State-Based Efforts

Efforts in the states have fared no better. Many state insurance codes included requirements to offer a "basic and standard plan" starting in the late 1980's and early 1990's. Even prior to the passage of the ACA, the plans were not popular with the public and enrollment was anemic, at best. More recently, Washington state (and Colorado and Nevada passed similar laws this year) has passed and implemented their Cascade Care program. The program includes standardized plan designs and a rigid Medicare-based reference price for insurance plans participating in the program. Despite the advantage in set medical costs, Cascade Care plans were more expensive than plans designed and offered by private insurers at commercial reimbursement rates. In response, this year Washington state passed new changes to the program to limit competition with Cascade Care plans.

Characteristics of Coverage

More than 99 percent of the 333 million Americans have access to health coverage, regardless of their income or medical condition. About 30 million people under age 65 are uninsured, but more than two thirds of those lacking insurance could have obtained subsidized coverage in job-based or government programs but did not enroll in those programs.[3] Of the 10 million uninsured, many unsubsidized individuals are present in the U.S. unlawfully, which should be a matter of immigration policy. The remainder of subsidy-ineligible uninsured are in states that did not expand Medicaid, or who have incomes too high to qualify for government programs. In addition, almost three-quarters of those who remain uninsured cite cost as the number one reason.[4]

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[3] 20 million were eligible for subsidized coverage (5.1 million for Medicaid or CHIP, 5.5 million for ACA, and 9.4 million for employer coverage). 9.8 million of the uninsured are not eligible for subsidized coverage, including 4 million who are unlawfully present, 3.2 million in states that did not expand Medicaid and 2.6 million high income people. Who Went Without Health Insurance in 2019, and Why? | Congressional Budget Office (cbo.gov)

[4] In 2019, 73.7% of uninsured nonelderly adults said they were uninsured because coverage is not affordable, making it the most common reason cited for being uninsured. Key Facts about the Uninsured Population | KFF

More targeted policies to address the discrete challenge of the remaining uninsured is a superior approach to the public option. For these reasons, government policy should focus on four key issues:

1. Lowering medical costs relative to income to increase affordability.
2. Expanding currently eligible but unenrolled.
3. Reforming Medicaid to ensure state and individual incentives to maximize program dollars and affordable private coverage; and
4. Expanding private coverage through small business incentives.

Expand Private Coverage

Policymakers should focus on expanding access through the overwhelmingly popular jobs-based insurance market—specifically through small businesses who struggle to provide coverage to their employees and who were hardest hit by government COVID lock downs and capacity limits. Employers, unions, and enrollees place high value on offering and receiving these benefits, giving elected officials of both parties a clear path to success by focusing coverage efforts to increase access where significant gaps in coverage remain.

- Provide a small employer and their employees a tax credit for enrolling in health coverage. The tax credit could be higher for micro groups and slightly lower for larger small groups.
- Provide a shrinking tax credit to assist micro or small employers in offering health insurance to their employees. Micro employers could be provided with a $500 per year, per employee tax credit to provide insurance for the first year, $300 per year, per employee in the second year, and $100 per year, per employee for the 3rd year. The credit could be in addition to the small employer and employee credit.
- Reinsurance has led to direct premium reductions in the individual market and could provide the same advantages in the small group market. Because reinsurance helps address high-cost claims of individuals, they improve market stability and affordability in a virtuous process. Unfortunately, reinsurance programs are not established for small employers, and Congress' focus has been on shoring up ACA markets, not the small business market. Congress should provide states with 50-50 split for the cost of reinsurance up to $200 million per state. Like the Affordable Care Act 1332 waiver program, the federal government would match state dollars 50-50. A roughly $200 million reinsurance program could drop premiums rates up to 10% in some states.
- Congress could allow firms to provide gig worker account-based plans and allow one or more employers to provide contributions to the accounts. A 50% tax credit for each dollar provided by employers subsidizing part-time or gig worker health accounts would incentivize contributions and coverage. Gig worker health accounts would not be treated as an employer subsidy for the purposes of health insurance exchanges.

Instead of turning to a government-run solution, we should also focus on ways to promote greater flexibility in insurance exchanges and insurance design to make coverage more affordable and accessible to all Americans. For example, we should:

- Make subsidies portable so that consumers can buy coverage from any exchange website, public or private – or directly from an insurance carrier.
- Create more flexibility in essential health benefit requirements to reduce premium costs.
- Add a new Copper level of coverage to the insurance exchanges, which would be a lower premium catastrophic plan that would pay 50% of covered expenses; and

- Consider benefit designs that engage consumers and encourage access to high-value and appropriate care. This would include HSA-eligible High-Deductible Health Plans, which would provide first-dollar coverage for targeted preventive services that are clinically proven to lead to good health outcomes and prevent chronic disease progression.

Lowering Medical Costs

A far better approach to universal coverage is ensure health costs, which determine premiums, rise more slowly than family income. Currently the U.S. spends almost $4 trillion annually on health care. Over the next 10 years, the U.S. health sector will take in more than $50 trillion. Currently, three-quarters of health spending goes toward hospitals, professional services, and prescription drugs, which drive premium and out-of-pocket costs. Since 2010, the medical cost trend has grown by 73 percent, about four times faster than the average wage and five times faster than the Consumer Price Index. Because costs are rising faster than wages, health coverage is becoming less and less affordable. If current trends persist, the typical working family will spend more than 40 percent of its income on health care by 2030.

Health Services

Most hospital markets are highly concentrated, leading to higher prices and costs, and fewer choices. For example, during 2012-2016, commercial inpatient spending per person grew 24.3 percent, even as utilization fell 12.9 percent. (In other words, had prices not gone up, inpatient spending per person might have fallen by 37 percent.) Similarly, outpatient spending grew 17.7 percent while utilization fell 0.5 percent. Importantly, these price increases are imposed by non-profits - more than 80 percent of hospitals are nonprofit or state-run, and thus lack the incentives that motivate for-profit institution efficiency. Government policies and programs also fuel much of the problem by stifling competition.

- Pay for Value, Safety and Site of Care. Reforms to taxpayer funded programs should seek to maximize taxpayer value while strengthening incentives to deliver superior patient outcomes. Congress should enact reforms that pay for value, pay for safe care, and seek to pay the same amount for the same services delivered across different sites of care.

- Incentives for Value. Repeal MIPS and establish a new voluntary value program in Medicare in which clinicians can elect to be measured as part of a voluntary group; and clinicians in voluntary groups can qualify for a value payment based on their group's performance on a set of population-based measures. Congress should also deregulate the EHR market by eliminating complex rules for use of EHRs in Medicare and Medicaid and allow direct primary care as an option for Medicare beneficiaries. Finally, consumers should be allowed to share in the savings generated by shared savings models. Currently, Medicare ACOs only share savings with providers and taxpayers. If patients could share in efficiencies, they would be more engaged in their care and have incentives to be well.

- Competition. Outside of Medicare, Medicaid and other public programs, state and federal policies that inhibit market competition should be phased out. New enforcement tools should be employed to ensure competitive markets remain robust. Where competition fails, new rules should be enacted to ensure consumers are protected from monopolies, and incentives are created to encourage new market entrants. The goal is to enact policies that continuously move to more competitive markets.

Prescription Drugs

Medications are only effective if patients can access and afford them. Too many Americans are forced to make difficult choices between medicines and other necessities. Others are unable to access the most effective or innovative treatments because increasing costs throughout the system have led to draconian measures that limit health providers' ability to address the individual needs of each patient. Our current system is not working for too many patients. Rather than rely on government interference in markets, we support common sense solutions that will bring relief to Americans struggling with rising health care costs. Essential provisions that should be part of any legislative package include:

- Establish an annual out-of-pocket limit on costs for Part D enrollees and redesign the standard Part D benefit so that beneficiary initial cost sharing decreases from the current 25 percent, while also restructuring the catastrophic benefit to lower costs
- Reform pricing models that inhibit value-based arrangements. Manufacturers and payers are reluctant to enter value-based arrangements, in part, because of the challenge of squaring such innovative approaches with the inflexible complexities of rebate liabilities under Medicaid's "best price" reporting requirements. The result is that many innovative, lower cost arrangements simply are not pursued. We recommend that clear exceptions to Medicaid best price and Average Manufacturer Price reporting be established for value-based arrangements, coupled with clear guidance to reduce current ambiguity about how to capture value-based pricing for reporting purposes.
- Reform Anti-Kickback and Stark restrictions. Value-based and care coordination arrangements, which should be allowed safe harbors from both laws to allow for greater care coordination and payment, combined with the changes to Medicaid Best Price, would save up to $36 billion annually, and $2.8 billion in federal budgetary savings over the ten-year budget window.
- Enable medication synchronization programs to assist patients in filling their multiple prescriptions. We estimate incentivizing medication synchronization programs in federal health programs will save up to $42 billion in annual healthcare costs.
- Reform Medication Therapy Management programs in Medicare Part D to target resources to at-risk beneficiaries based on data driven insights from EHRs.

Expand Outreach for those Already Eligible

Rather than enact new government programs, Congress should provide incentives to enroll already eligible individuals into current programs. As noted above, this could reduce the number of uninsured by 3 million or more.

Conclusion

Thank you for the opportunity to comment on this important issue, we appreciate your focus and determination in solving these problems. We at CAHC are committed to working with you to solve them, however we do not believe a public option would solve the problem facing Americans, rather it would make matters worse.

Kind Regards,

Joel C. White
President