



July 30, 2021

Hon. Frank Pallone, Jr., Chair  
House Committee on Energy and Commerce  
2107 Rayburn House Office Building  
Washington, DC 20515

Hon. Patty Murray, Chair  
Senate Committee on Health, Education, Labor & Pensions  
154 Russell Senate Office Building  
Washington, DC 20510

Sent via [publicoption@mail.house.gov](mailto:publicoption@mail.house.gov) and [publicoption@help.senate.gov](mailto:publicoption@help.senate.gov)

RE: Request for Information on a Federal Public Health Insurance Option

Dear Chairman Pallone and Chairwoman Murray:

United States of Care is pleased to submit the following comments in response to the [Request for Information \(RFI\) on "a federal public option"](#) from the House Committee on Energy and Commerce and Senate Committee on Health, Education, Labor, and Pensions.

[United States of Care](#) is a non-partisan non-profit founded in 2018 with a mission to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We were established by a diverse [Board of Directors and Founders Council](#) to advance state and federal policies that solve the challenges people face with our health care system. We seek to understand people's unique needs to drive health policy innovation and partner with elected officials and stakeholders to pass and implement those ideas.

At United States of Care, we have a vision of a better, more equitable, accessible, and affordable health care system that is centered on peoples' needs. We recognize that only by putting the needs of people at the forefront of our research and policy solution design work can we ensure that the policies we create and drive work for people.

From our research, we know that when it comes to health care, cost is the primary source of anxiety for people and at the top of their list for desired fixes. It is why approximately [42%](#) of people have foregone health insurance in the past, and [41%](#) of those under 30 have opted not to seek medical treatment in the last year. Affordability is a nationwide crisis as small businesses throughout the United States continue to struggle to provide their employees with affordable health care coverage. At the same time many people during the COVID-19 pandemic have lost both their jobs and their health security, and gig/contract workers remain on their own to find coverage.

The pandemic has shined a light on the critical need to expand access to equitable, quality, affordable health care for more people in the U.S. This is especially true for people who have traditionally been underserved by the U.S. health care system, including Black and Latino people and people with low



incomes, who have been [disproportionately affected](#) by the pandemic. A public option provides an opportunity to address health inequities that have persisted throughout our country by designing a program that minimizes barriers faced by underserved populations. As an organization, United States of Care is committed to making this a reality at the state and federal levels through a public option.

According to our research, [almost 70% of voters](#) nationwide support a public health insurance option, including 54% of Republicans and 68% independents. In just the last month, we have seen critical momentum for policy changes that bring relief to people and provide dependable health coverage throughout life. This momentum reflects how states are leading the way towards building a more affordable and accessible health care system, which is instructive for designing a federal model.

On June 9th, Nevada became the second state in the nation to enact a public health insurance option. Nevada's historic legislation will significantly reduce the cost of health coverage and the number of Nevada residents going without health insurance because they cannot afford it.

Colorado's enactment of the Colorado Option on June 16th likewise marked a significant step towards delivering a far more equitable health care system in the Centennial State. The new law will allow Colorado families to choose from more affordable, standardized, and accessible health care options. The Colorado Option is particularly an improvement for small business owners who will now be able to provide competitive benefits for their employees, which are critical to retaining and recruiting a talented workforce.

By broadening access, driving down costs, and centering health equity, both laws in Nevada and Colorado embody the same principles that guide our work at United States of Care. They also serve as examples for Congress as your committees work to achieve these goals. United States of Care, our staff, and our partners are proud to have been a part of both efforts and look forward to making recommendations and sharing lessons learned for a federal public option.

## **Eligibility**

Through USofCare's [listening work](#) and public opinion surveys, we know people want both the certainty that they can afford their health care as well as the security and freedom that dependable health care coverage provides as life changes. A federally administered public option presents an opportunity to create a coverage choice that can better meet people's needs and minimize the churn and disruptions in coverage that people otherwise experience when changing or losing a job, moving, or experiencing other life changes. Individuals, small businesses, and large employers each currently face issues that could be addressed through a well-designed public option.

## ***Individual Market***

A federal public option should be made available to people purchasing coverage on the Affordable Care Act (ACA) marketplaces, as Colorado, Nevada, and Washington have done. This enables people already shopping for coverage to see the full range of options, including public option plans, so they can make an informed decision and know that the coverage they are buying is comprehensive and quality.

This also provides an opportunity to improve coverage and affordability among communities where health disparities persist. Costs remain a significant barrier to coverage: in 2019, [74% of uninsured nonelderly adults](#) said they were uninsured because coverage is not affordable. With these criteria, populations that would benefit from a public option plan are those in the Medicaid coverage gap and lawfully present immigrants.

*“Before I got the current job, that was prior to the ACA. I didn’t have insurance, and my care costs like medication I take, one dose of it is around \$5,000... It wasn’t that I wanted to. I didn’t have a choice. I could literally have bankrupted myself trying to get treatment. So you, you, you try to go without. You try to avoid needing any kind of care” – Joe, NY*

Source: All pull quotes referenced in this document are taken from United States of Care’s Nationwide Focus Groups conducted in April 2021.

- **People in states that haven’t expanded Medicaid that are in the coverage gap:** A federal public option could also be made available to the [estimated 2.2 million](#) individuals who fall into the coverage gap in states that have not yet expanded Medicaid. This gap disproportionately keeps coverage out of reach for people of color, including [Black and Latino](#) individuals. Specifically, people of color make up 41% of the adult, non-elderly population in non-expansion states but make up [60% of people in the coverage gap](#). Therefore, addressing this coverage gap can help reduce inequities in coverage.
- **Lawfully present immigrants:** Lawfully present immigrants are significantly more likely to be uninsured. Among the nonelderly, [25% of lawfully present immigrants were uninsured](#) compared to 9% of citizens in 2019. Additionally, while [many](#) states implemented an option known as the Immigrant Children’s Health Improvement Act (ICHIA) to use state funds to provide Medicaid coverage to immigrant children and pregnant women who have been lawfully residing in the U.S. for less than five years, many low-income lawfully present immigrants remain ineligible for full Medicaid benefits due to the five-year bar under federal law. Lacking coverage, [immigrants often forgo preventive care and services for major health conditions](#) and chronic diseases and rely on a patchwork of charitable organizations, safety-net clinics, and hospital ERs. A public option can address those issues. These individuals are eligible for marketplace coverage and should also be eligible for public option coverage offered through the marketplace.

### ***Small and Large Group Market***

[Our current health insurance system](#), which connects health coverage to employment, is under [severe strain](#), burdening [both employers and employees](#). In 2019, the Kaiser Family Foundation reported the average annual premium for job-connected health insurance for a family of four crossed \$20,000 for the first time — a 54% increase over the previous ten years. That dwarfs the average inflation-adjusted increase of 4% in wages during the same 10-year period from 2009 to 2019. In fact, studies have shown that increased costs associated with job-connected insurance, such as rising deductibles and copays, lead to [patients seeking less needed preventive care](#), which translates into [worse health outcomes and higher costs](#). By fusing health security to employment, our health care

system stifles innovation, inhibits entrepreneurship, and unhappily [locks people into their jobs](#). Whether individuals want to start their own business or take time off to help care for a loved one, our current system of linking jobs and health security discourages risk-taking and limits individual freedom. As the [COVID-19 pandemic has highlighted](#), it is particularly destabilizing for people to lose their health care at the same time they lose their job, especially during a public health emergency. A federal public option could be an important solution to many of these pain points.

[Employers in the small group market](#) face particular challenges when trying to cover their employees, which a public option could help address. While Washington's approach focused on coverage in the individual market, both Colorado and Nevada crafted public options for those in the small group market as well. In a federal public option, Congress should also include this type of support for small businesses, particularly since the American Rescue Plan premium subsidies do not extend to people purchasing coverage in the small group market. In states that have pursued a public option, small business owners routinely surface [concerns](#) about their ability to pay rising health care costs, ultimately impacting whether they can retain employees and remain competitive in their marketplace. In Connecticut, [USofCare research](#) in 2020 found 72% of small business owners supported a public option, and 41% believed it would result in better health care across the state and for their employees. In Colorado, [HB 1232](#), signed into law in 2021, requires premium reductions and standardized plans for both individual and small group markets. This is directly due to the [support](#) among small business owners who were priced out of affordable options in their state and advocated for the bill's passage.

Additionally, a federal public option could include a phase-in for the large group market based on the lessons learned from initially offering public options in the individual and small group markets. In April 2021, a widely noticed [study](#) organized by respected institutions showed the [vast majority of large employers](#) want the government to play a broader role in controlling health care costs and providing coverage. [One approach](#) is a public option directed at employers, [as developed](#) by law professors [Allison Hoffman](#), [Howell Jackson](#), and [Amy Monahan](#). Just as employers currently select privately run group health insurance plans for their employees, a public option for employers would allow businesses to choose to purchase a public plan - based on Medicare, but adapted to the needs of a working-age population - to cover their workers. This approach would enable employers to free themselves from the financial, administrative, and regulatory challenges of managing their own private health plan while still being able to provide workers high-quality benefits and expansive provider networks. Importantly, if the public option made available to large employers is designed similarly to that available for individuals, people could potentially maintain the same form of coverage when experiencing a life transition that requires them to change insurance.

### **Provider Access**

In designing a federal public option, ensuring people have adequate access to providers is critical, and we appreciate the focus on this important issue. While cost is most consumers' top priority when it comes to their health care, the provider network (both hospitals and clinicians) of a plan is also top of mind, particularly for patients with ongoing or complex medical needs. A robust provider network that reflects the community it serves is also an important policy lever in building health equity within the care delivery system. Provider participation in public option laws is closely tied to provider rates, especially since one of the main mechanisms to reduce people's costs is limiting provider profit. We discuss provider rates in more depth in our response to question three, below.

*“I ruptured my Achilles tendon playing basketball last year, and I’m very fortunate it [my insurance] picked up 80%. But the 20% can be a few \$1,000. And it’s expensive. So if you want the better network and the better doctors, you have to pay more money for it.” – Sharon, IL*

Congress should develop a public option that ties provider participation to participation in other federal health programs like Medicare and Medicaid to better guarantee access to health care services, as states have in their approaches to public options. This is the approach Nevada took: Nevada’s public option law requires providers and facilities that want to continue to participate in the Public Employee’s Benefits Program or Nevada’s Medicaid program to be included in at least one network of the public option. Further, providers are required to accept new patients enrolled in the public option at the same rate as those not enrolled in the public option. Similarly, in learning from their original public option bill, “[Cascade Care](#),” Washington made adjustments in their 2021 bill (referred to as “[Cascade Care 2.0](#)”) to encourage hospital participation. Beginning in 2022, hospitals that provide services and receive reimbursement from Washington public employee benefits or Medicaid must also provide in-network services for at least one public option plan. Nevada and Washington’s approaches are good examples for Congress to consider due to the large number of providers participating in public programs.

Congress should also take steps to ensure *equitable* access to providers. We know from our listening research that people want to get the personalized care they need, when and how they need it. A key piece to this is creating a robust and diverse provider network that reflects the population’s needs. We recommend Congress look to Colorado’s recent [legislation](#) creating new network adequacy requirements for its recently passed public option as one example of how to do this in practice. Colorado’s legislation requires that standardized plans in the individual and small group markets “have a provider network that is culturally responsive and reflects the diversity of its enrollees.” The goal of the network adequacy requirement is to construct networks able to address health equity and reduce disparities. While the implementation rules are still under development, this is a step in the right direction to ensuring people reach a provider that speaks their language and understands their culture and community. This breaks down numerous barriers to getting the personalized care they need, when and how they need it. Other steps to ensuring there is equitable access to providers include:

- **Defining adequate networks as networks where people can get the care they need, when they need it, and in an environment that is accessible to them.** Ways to implement this include using [standards that reflect barriers experienced by certain populations](#); publishing time and distance standards so patients and advocates have transparency into them; setting up a streamlined appeals process for people for whom the provider network fails and that allows them to get the care they need promptly without having to navigate an administratively burdensome system.
- **Ensuring participation of federally qualified health centers (FQHCs), rural health clinics (RHCs), and essential community providers.** These providers serve a diverse population, particularly those who the health care system has marginalised. For

example, racial and/or ethnic minority patients [accounted for](#) about 63% of patients seen by FQHCs in 2019. Participation by these providers in a federal public option will ensure the population groups that typically use these facilities will continue to receive the care they need promptly.

- **Including a range of provider types along the care delivery spectrum in networks, especially for service lines associated with health disparities.** For example, to meet behavioral health, mental health, and substance use disorder needs, consideration should be given for the inclusion of certified peer specialists, certified recovery coaches, and other peer-led interventions. For maternal health disparities, consideration should be made for doulas. Inadequate health care networks are substantive barriers in access to care, especially in access to mental health care where there are already workforce shortages and/or a low volume of providers accepting insurance.
- **Requiring coverage for virtual care services.** Virtual care – including telehealth, remote monitoring, and other digital forms of communication – has emerged as a critical tool for getting people access to health care and has increased significantly due to the COVID-19 pandemic. When clinically appropriate, people must have the flexibility to choose how they would like to receive care, whether in-person or through multiple virtual modalities. For program integrity, the public option should ensure providers are not incentivized to steer patients to certain methods of care based on reimbursement. By putting the patient first, this policy measure has the potential to close gaps in virtual care access.

*“The telehealth that they’re doing now, that shouldn’t change. They should keep that going, even after the pandemic.” – Rachel, D.C.*

### **Determining Prices**

In a federal public option, provider reimbursement rates need to be based on the cost of providing care in order to contain costs and reduce people’s high premiums and out-of-pocket costs. At the same time, it is important to recognize that providers in different communities face varying costs and needs. Striking this balance has been a core component of how the state public options have been debated and enacted to date. However, determining the prices to pay providers has been one of the most contentious debates surrounding public options.

*“Well I think that if they established some affordability standard, it would make it where you know, they wouldn’t be able to raise the prices so high, you wouldn’t be able to charge an arm and a leg for somebody to pay for something that they really need, you know, or to be able to get care for something that could be life-threatening.” – James, GA*

## ***Lessons from Different State Approaches***

A federal public option can incorporate state experiences and lessons learned when establishing provider reimbursement rates.

In Colorado, [the newly-enacted law](#) authorizes the Division of Insurance (DOI) to set payment rates for Colorado Option plans if other market-driven benchmarks, including meeting premium reductions, are unmet. The [new law](#) also includes a framework for DOI to use in setting these rates, should that happen, using the following parameters:

- Hospitals will not receive less than 165% of Medicare, with a base rate of 155% of Medicare with:
  - Critical access and small rural hospitals that are not part of a larger health system receiving a 25% increase;
  - Hospitals with a high case mix of Medicare and/or Medicaid participants receiving a 30% increase;
  - Hospitals efficient at managing the underlying cost of care receiving a 40% increase; and
  - Pediatric trauma 1-designation specialty hospitals receiving a 55% increase
- Physicians will receive rates of at least 135% of Medicare

In landing on this policy approach, Colorado policymakers in 2020 first used self-reported data from its state hospital association to identify each hospital's "break-even point," a percentage of Medicare representing the reimbursement necessary to cover the costs of care. On average in Colorado, this was the equivalent of [143% of Medicare](#). This was factored into the development of the proposed [formula](#) incorporated into the 2020 [legislation](#), with each hospital receiving a [specific reimbursement rate](#). This formula provided the additional payment enhancements mentioned above, including critical access and rural hospitals, carried over to 2021 and ultimately included in the final passed legislation.

In Nevada's public option, participating plans are required to reimburse providers at or beyond Medicare rates, including when reimbursing services at federally qualified health centers (FQHCs) and rural health clinics (RHCs). This reimbursement level is meant to be a starting point and a "floor" for reimbursement rates, not a ceiling.

In Washington, [Cascade Care](#) plans are required to reimburse providers and facilities at or less than 160% of Medicare rates for all covered benefits, except pharmaceuticals. Any rural hospitals CMS has designated "critical care" or "sole community" hospitals must be reimbursed at or beyond 101% of allowable rates. Physicians specializing in family medicine, general internal medicine, or pediatric medicine must be reimbursed at or beyond 135% of Medicare rates for providing primary care services.

The experiences of Colorado, Nevada, and Washington provide a range of options to consider when designing a federal approach.

As was the case in Nevada and Colorado, it will be critical for a federal public option to pay special attention to FQHCs, RHCs, and essential community providers when establishing provider rates. According to 2019 data, [23%](#) of patients seeking care at FQHCs and [15%](#) of patients seeking care at RHCs were uninsured. Upon having access to a public option, uninsured populations will comprise a significant percentage of the patient population at these facilities. States developing public options have kept these sites in mind when determining prices in the following ways:

- **Nevada:** Prioritizes networks that include critical access hospitals, RHCs, and FQHCs when approving an entity to administer the public option. Public option issuers must meet or exceed Medicare rates when reimbursing for services at FQHCs and RHCs.
- **Colorado:** Colorado pursued a payment formula that provided enhanced rates for rural, critical access hospitals. The standardized plan, to be established by the commissioner of insurance, is directed to include most essential services providers in an area.

Further, it will be necessary for a federal public option to adequately reimburse care provided by a range of providers to ensure that people are getting their health care needs met in the way that works best for them. For example, patients trust Community Health Workers (CHWs) and doulas to advocate for their needs and connect them to the services they need, as they are well-positioned to help people access the care they need. CHWs are recognized for improving health outcomes and access to health care services for underserved and underrepresented communities. Doulas play a critical role in supporting mothers to advocate for their health care preferences, helping combat interpersonal and institutional racism in maternal health care, and preventing unwarranted and undesired clinical interventions. Doulas are especially important for communities of color, where significant maternal health disparities persist. The services provided by these types of providers should not replace other health care providers but serve as a necessary complement to provide more comprehensive and supportive care. Covering their services under a federal public option ensures a sufficient number of CHWs and doulas to assist people with their health and social needs.

### ***Limitations with Using Medicare as the Basis for Rates***

Utilizing Medicare as a benchmark or starting point from which to develop provider rates, as states have done, can create efficiencies, but also surfaces significant obstacles worth addressing:

- **Providing Adequate Mental Health and Substance Use Disorder (SUD) Services:** Medicare has limitations on critical mental and behavioral health services and providers that a federal public option based on Medicare would need to address. [Certain providers](#) who play a crucial role in the spectrum of behavioral health and substance use disorder care are not allowed to bill Medicare, including Licensed Professional Counselors (LPCs), Marriage and Family Therapists (MFTs), and Certified Community Behavioral Health Clinics (CCBHCs). Medicare also does not cover mental health crisis services or medical nutrition therapy for eating disorder services. A public option that provides a full range of mental and behavioral health care needs to establish reliable mechanisms to pay these providers.
- **Providing Coverage for Children:** Because Medicare was not designed for children, many pediatric services are not covered. A federal public option based on Medicare rates would need to find a payment benchmark for pediatric services covered by the public option.

Basing payments on Medicaid reimbursements would likely not be sufficient, so a federal public option needs a solution to reimbursing services tailored to children's needs.

### ***Addressing Out-of-Pocket Costs***

The public option should also minimize, or even eliminate, cost-sharing for low-income people, for high-value services, or both, so people are not discouraged from seeking care due to out-of-pocket costs. This can also specifically address some of the disparities people of color face. A federal public option should:

- **Minimize cost-sharing:** Premiums and cost-sharing disproportionately affect low-income populations, who already have worse health outcomes, which can exacerbate existing inequities. Studies have shown that even small cost-sharing levels of (from \$1 to \$5) are associated with [reduced utilization](#), including necessary services. Any federal public option should minimize premiums and cost-sharing to ensure that people can adequately access care and do not face financial barriers that can exacerbate their health conditions and widen health disparities. For example, Colorado established a standardized benefit design framework that prioritizes primary care services and payment by making them available to consumers pre-deductible over other types of ambulatory services.

*“I mean, when you think about some things like surgeries and stuff, they can be well up in the six-figure range, I mean, we’re all living check to check in some cases, even if you tell a person to come up with \$400 or \$500, which should be a very fraction of a major surgery, it’s going to be a lot of money to that person. So you know, 80/20, 90/10, 95/5 would probably be too much for a lot of people.” – Caleb, IA*

### ***Paying for Quality and Value***

A federal public option should be characterized by high-quality care and paid for with value in mind. Understanding where a patient lives, their income, education level, job status, and other social determinants of health (SDOH) can help reduce health care costs and unnecessary utilization while also improving outcomes. Value-based payment (VBP) systems incentivize providers to look beyond the walls of the provider's practice and into people's lives to keep them healthy while incentivizing care at appropriate care settings that result in better health outcomes. A public option with a VBP reimbursement framework can incentivize providers to examine whole-person health, prescribe social interventions, and coordinate care, so people receive the best care for them in the appropriate setting.

State public options have incorporated VBP and can be instructive to a federal model. For example, Nevada lawmakers prioritized in their public option legislation that payment models will enhance value for public option enrollees, reward providers for high-quality service, and encourage value-based care models. Further, the Colorado [payment formula](#) pursued as part of [2020 legislation](#) included hospital payment incentives for value-based care services. These policies are especially important for low-income people and communities of color, who experience many barriers in accessing care and other resources, and receive disconnected (if any) care. Such creative health care

delivery and payment models that emphasize value-based care that rewards providers for providing high-quality and high-value care should be replicated in a federal public option.

### **Benefit Package**

Benefit design in a public option is a significant opportunity to ensure that coverage provides people affordable access to the services that will help them stay healthy. It's also key to helping address longstanding gaps in access to care. The design of benefits for a federal public option should focus on value, making it easy and affordable for people to receive care without worrying about out-of-pocket costs. The protections and framework afforded by the Affordable Care Act's Essential Health Benefits (EHBs) serve as a good starting point. EHBs address many of the limitations of relying on Medicare's benefit design, including pediatric services, maternity and newborn care, mental health, and addiction services.

Within the framework of EHBs, state approaches to standardized plan designs have been a vehicle to offer public option coverage and offer various valuable lessons for a federal public option. For example, the Colorado Option requires the standardized plan to be designed through a stakeholder engagement process to improve access and affordability through defined benefits and cost-sharing, and to provide pre-deductible coverage for primary and behavioral health services. In Washington, the use of standardized plans in each metal level led to coverage of more pre-deductible services, lower deductibles in general, and [reduced out-of-pocket costs](#) for consumers.

A federal public option should incorporate principles of [VBID](#), where high-value services are incentivized in the benefits package. Under VBID, people pay less for high-value services and pay more for low-value services to improve health outcomes. There is [evidence](#) this approach increases the use of high-value services and lowers consumer out-of-pocket costs. Further, plans that incorporate VBID [have seen](#) reductions in health care disparities. A federal public option should include similar policies that align cost-sharing with the value of services, such as what Colorado [pursued in 2020](#).

### ***Meeting the Needs of Diverse Populations***

The benefits package should be structured to meet the health care needs of the diverse populations it serves. This includes:

- **Engaging with the community to understand their needs:** The public option plan should perform regular community assessment surveys to identify what needs are, or are not, being met. Similarly, it should incorporate a public comment or engagement process in which beneficiaries/patients, advocates, and stakeholders can provide feedback regarding how the plan's benefits can best meet the needs of the population. This may include creating a consumer/community advisory board that informs and advises plan policies.
- **Prioritizing coverage for services where the greatest disparities exist:** Mental health, oral health, vision health, and postpartum health each encompass some of the greatest disparities in our health care system. All have been traditionally disconnected from the broader health care system. As a result, the fragmented care delivery and lack of coverage pose problems to accessing this care and achieving good health outcomes. The public option

should develop a benefits package that prioritizes these coverage areas and integrates these services with other health care services.

- **Mental health:** Designing public option benefits also provides an important opportunity to better integrate mental and behavioral health into primary care. Although mental health parity efforts have resulted in better mental health coverage, disparities persist in mental health care. In comparison to their white counterparts, racial and ethnic minorities have less access to mental health services, are less likely to receive needed care, and are more likely to receive poor quality care when treated.

A federal public option should be structured to address these disparities by:

- Integrating mental health care into primary care through appropriate screenings and referrals
- Removing financial barriers to care by lowering or eliminating cost-sharing
- Removing language obstacles by providing interpreter services.
- Strengthening the diversity of its mental health providers, as recommended above, so that people receive culturally appropriate treatment and individualized care tailored to their identity, culture, and experience.

*“And I would love to have mental health at a no-cost benefit. I don’t know why I have to pay so much for it.” – Aaron, D.C.*

- **Oral and vision health:** People are more likely to have poor oral health if they are low-income, uninsured, and members of a racial or ethnic minority, immigrant, or rural population. Similarly, lower socioeconomic status (SES) and visual impairment and eye disease are [correlated](#), and people with less education and lower income are [less likely to have had routine eye care](#). By covering and integrating dental and vision coverage into broader health care coverage, the public option can help address the pervasive disparities in accessing oral and vision health services.

The inclusion of services and benefits, like those outlined above, will need to be weighed and prioritized with other policy goals and assessed needs. States pursuing public options have had to balance the desire for specific services with the impact those services may have in determining actuarial value, which impacts costs to the consumer and the ability to build a sufficient network within a geographic rating area.

## **Premium Assistance**

Keeping affordability front and center is paramount to any effort at creating a new form of health insurance coverage, including a public option. The current framework of Advance Premium Tax Credits (APTCs) created by the Affordable Care Act and enhanced by the American Rescue Plan can serve as a foundation to make federal public option coverage affordable. When considering affordability, it is essential to consider not only premium costs but the full cost of health care that people may encounter, including deductibles, copayments, and coinsurance. Creating a public option does not require building a separate system of premium assistance as it would create

unnecessary complexity. Additionally, providing additional financial aid only to those enrolling in a public option would advantage the public option over other choices in the market. At the same time, savings generated by the public option creates an opportunity to invest in additional premium and cost-sharing assistance across the system, further bringing down out-of-pocket costs.

### **Role of States**

States have long led the way in policy innovation, and public options are no exception. States continue to craft unique policies that address their residents' specific needs. A federal public option should be designed in a way that allows states to continue innovating while also putting safeguards in place. A federal public option should be available to people across states. Those states that have already enacted public options - or are considering doing so - should have the ability to move forward with approaches that build on a federal option. However, any state approach should be at least as comprehensive and affordable as the federally offered public option. This will ensure states do not create a state-level public option that limits coverage.

Congress needs to also consider how a federal public option addresses state-level insurance requirements, rules, and processes. A federal public option of course needs to work in all 50 states, many of which have specific insurance regulations and/or rules related to their state-based exchanges.

### **Interactions with Other Programs**

A federal public option can positively interact with other public programs through the so-called "welcome mat effect," driving increased enrollment in other benefit programs and the potential for lower costs stemming from increased competition.

Following the implementation of the Affordable Care Act (ACA) and the institution of the Marketplaces in 2014, Medicaid and the Children's Health Insurance Program (CHIP) saw [surges of new enrollees](#). From 2013 to 2016, the percentage of children covered by these programs in families with incomes below 100% of the federal poverty level (FPL) increased by 1.9 percentage points; it increased an additional 5.5 percentage points for children in families earning up to 199% of the FPL. These gains are attributed to the "welcome mat" effect," which refers to the surge in families enrolling in subsidized private plans – after the launch of Healthcare Marketplace – only to learn that they and/or their children were already eligible for existing public health insurance programs. The "welcome mat effect" was particularly discernible in Medicaid expansion states and families where the adults became newly eligible for Medicaid coverage. Assuming it's implemented smoothly and advertised effectively, a federal public option would likely come with a "welcome mat" of its own. We could reasonably expect an increased child and adult enrollment in Medicaid and CHIP, marketplace coverage, and dual [eligible](#) enrollment in both Medicare and Medicaid.

Evidence suggests that introducing a public option would increase competition among insurers and lead to lower overall rates for consumers, including those with private coverage. This has been the case in [Massachusetts](#), which requires all health insurance carriers with over 5,000 beneficiaries to make plans available through the Health Connector or the state's Marketplace. That requirement has maximized competition and led to an array of plans with reasonable premiums for consumers to choose from; a similar dynamic is likely to play out at the national level. In fact, the [Urban Institute](#)

calculates that if the public option were introduced in both the employer and nongroup markets, it would cause median premiums for employers to decline by 18 to 25 percent and allow upwards of one million currently uninsured Americans to enroll in affordable health care coverage.

### **Broader Health System Reform Objectives**

A federal public option provides a significant opportunity for the federal government to adopt broader health system changes, including cost containment, reducing disparities, and building a system based on value. Designing a public option that embeds more comprehensive health system reforms, such as the value-based payment provisions outlined above, is critical for the sustainability of the program and will help shape the health care system into one that better meets the needs of people. Each aspect of the design of a public option is an opportunity to further broader goals around value, access and equity. The ultimate goal being to allow more people to access dependable, affordable care and should shape specific policy design decisions.

In any final federal public option legislation, Congress should include evaluation provisions to measure the effectiveness of the policy, including how well it drives overall systems change and if it reduces disparities. Robust data collection is a crucial component of establishing a reliable baseline and enabling future policymakers to measure and evaluate progress, including movement towards health equity. To understand impacts on health disparities, any data collection process should allow for stratifying outcome measures by variables such as race and ethnicity, language preference, age, gender identity, sexuality, disability, and socioeconomic factors. [Minnesota](#), for example, uses an intersectional approach to measuring disparities in its Medicaid population so the state can better understand the association between social risk factors and outcomes and develop interventions that address these barriers to health equity. A similar approach to data collection should be considered in a federal public option.

### **Conclusion**

Thank you again for the opportunity to share our lessons learned and policy recommendations in response to this RFI. We hope that they can serve as a model for Congress as you and your colleagues craft legislation for a federal public option.

As United States of Care embarks on its fourth year, we understand the critical importance of this moment to create a more equitable health care system in the wake of COVID-19 – and our role in making sure that policy solutions focus on meeting people’s needs. United States of Care will continue its research efforts and hone its unique approach to listening to people to better understand shared and different needs and tie them to policy recommendations. We will also leverage our team’s expertise in the existing health care system, working with our vast network to identify solutions that will meet people’s needs, and work with policymakers at the state and federal levels to enact change.

By broadening access, driving down costs, and centering health equity, laws in Washington, Nevada, and Colorado embody the same principles that guide our work at United States of Care. They also serve as examples for Congress as your committees work to achieve these goals. United States of Care, our staff, and our partners are proud to have been a part of both efforts and look forward to being a resource for your Committees both now and in the future.



Thank you for the opportunity to respond to this important RFI. If you have questions or are interested in additional discussion on this or any other health care issue, please contact Liz Hagan, USofCare Director of Policy Solutions at [ehagan@usofcare.org](mailto:ehagan@usofcare.org) or Andrew Schwab, USofCare Director of Policy, Federal Affairs and Partnerships at [aschwab@usofcare.org](mailto:aschwab@usofcare.org).

Sincerely,

A handwritten signature in black ink that reads "Natalie Davis".

Natalie Davis  
Co-Founder and Executive Director  
United States of Care