July 30, 2021

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

The Honorable Frank Pallone Jr.
Chair, Committee on Energy and Commerce
United States House of Representatives
Washington, DC 20515

Dear Chair Murray and Chair Pallone:

The Society of General Internal Medicine (SGIM) welcomes the opportunity to respond to the Congressional request for information regarding public option legislation. SGIM is a member-based medical association of more than 3,000 of the world's leading academic general internists, who are dedicated to improving the access to care for all populations, eliminating health care disparities, and enhancing medical education. Our members are committed to delivering high quality care and ensuring patients have access to a well-trained physician workforce. Additionally, our members practice in both inpatient and outpatient settings, serve as the primary internal medicine faculty of every medical school and major teaching hospital in the United States, and are actively involved in all aspects of health services research. SGIM is committed to identifying and addressing system-based disparities of health care delivery. Our efforts are directed toward equitable and affordable access to the highest quality of care possible.

Question 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)?

While a public option can be structured many ways and towards multiple ends, including strengthening insurance markets and providing choice for those already insured, SGIM strongly believes that a primary purpose of a federal public option must be to extend insurance to those who currently are lacking coverage, thus moving the United States closer towards universal coverage. To this end, SGIM recommends unrestricted national offering to those not already under a public plan (e.g., Medicare, Veterans Affairs, Medicaid), including those in Medicaid non-expansion states who would otherwise qualify for coverage were the states to expand, and undocumented immigrants. SGIM also believes eligibility should include those with existing private insurance, including ACA marketplace eligible persons, private employers, and individuals with private insurance. This will increase choice, provide lower cost options, and strengthen

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insurance markets, which is critical given increasing costs and lack of affordability of existing plans[1].

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

While payment rates must be high enough to incentivize meaningful participation as per question 3 below, legislation must include additional policies to guarantee adequate networks. For a federal public option, requiring Medicare providers to accept the public option would be sensible, given the additional benefits of having the public option dovetail as seamlessly as possible with Medicare (see question 7 below). Additionally, requiring all hospitals to accept the public option may be necessary given the experience thus far in Washington state and lessons learned as Nevada and Colorado introduce public options.

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

SGIM believes prices should generally be indexed to Medicare rates. As demonstrated by public options in Washington State, Colorado and Nevada, prices will need to be higher than Medicare rates, but lower than private insurance to both ensure participation but still reduce costs. The public option would also provide an opportunity to reset and revalue existing distortions in Medicare rates have been well described. To this end, high value services such as primary care and preventative services can be reimbursed at higher rates, similar to proposed federal legislation (and existing state laws) increasing Medicaid rates for primary care services due to primary care's importance in improving health outcomes and reducing disparities, and its current undervaluation in existing payment models.

Question 4: How should the public option's benefit package be structured?

SGIM believes a federal public option should follow Washington state and Colorado's examples with a standardized benefit plan to reduce administrative costs and to drive higher value care, for example with lower or no patient cost-sharing on high value services like primary care, preventative care, and certain medications and treatments.

However, unlike state public options, a federal public option should be structured to include a "true" public option without private, for-profit insurance company administration of the plans.

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

[1] Girod C, Hart S, Liner D, et al. 2019 Milliman Medical Index. July 2019. Accessed at http://assets.milliman.com/ektron/2019-milliman-medical-index.pdf on 16 July 2021.

Income based subsidies similar to those in place for the health care exchanges can be applied to ensure affordability of coverage. For those individuals who would have qualified for Medicaid in non-expansion states, cost-sharing should be negligible as per state Medicaid programs.

Cost-sharing should overall be lower for a public option than for comparable private plans, with the overall savings generated from a public option being clearly translated to lower patient cost-sharing. Cost sharing must also be lower than in current traditional Medicare.

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

A federally administered public option would be more impactful and cost-effective than individually-run state plans. As such, states should allow for participation in a federal public option but should not be expected to assume administrative responsibility for the public option. For the three states which have implemented or approved state public options, both can exist to provide consumer choice.

Question 7: How should the public option interact with public programs including Medicaid and Medicare?

While public option proposals have been more popular among Americans than Medicare for All proposals that would replace current plans, Medicare in its current form remains popular with seniors. Thus, administering the public option to mirror Medicare has the benefits of streamlining administrative complexity for providers and health care systems, and effectively expanding a popular plan. Related to question 2 above (requiring providers and systems to accept the public option if they accept Medicare), structuring the public option to be as seamless as possible with Medicare would reduce administrative complexity, burden and cost. Additionally, quality measures and value-based arrangements should be coordinated between Medicare and a public option. Multi-payer alignment is critical to reducing administrative complexity and meaningfully moving the needle on incentivizing improved care, and this will be critical for a new federal public option as well.

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

A fundamental source of health inequity in the United States is the large population of uninsured patients, particularly low-income populations. Medicaid non-expansion states are disproportionately in the South, where a higher share of the Black population resides.[2] Black, indigenous, and other people of color are uninsured at higher rates across the country, and especially in non-expansion states. The vast majority of Americans who would be covered if all states expanded Medicaid are low-income black Americans in southern states. Several studies have assessed the ACA and Medicaid Expansion's effects on health equity outcomes,

[2] Kaiser Family Foundation. Health Coverage by Race and Ethnicity, 2010-2019. https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/

revealing reductions in the uninsured among the poor in addition to increased health care access, affordability, and use of preventative services, with decreases in racial/ethnic disparities and mortality.[3,4,5]

The public option must be structured in a way to meaningfully reduce the uninsured population and associated health inequities. Automatic enrollment will eliminate coverage gaps for individuals who experience job loss or a change in income. Premium assistance and reduced cost-sharing burden for patients will decrease the rates of delayed care, care-seeking in emergency departments, and inability to afford prescription medications.

The public option could also further push the envelope in current efforts to address social determinants of health. Additional incentives and funding can be given to hospitals and providers who meaningfully address community needs and improve equity. Current Medicare policies that inadvertently worsen equity (e.g., inadequate accounting for social risk in value based financial incentives; the undervaluation of primary care) can and should be addressed from the outset in the public option. SGIM has shared detailed comments with the Centers for Medicare & Medicaid Services on these topics and would welcome further opportunity for discussion with Congress as these issues relate to the public option legislation.

SGIM appreciates the opportunity to provide feedback on this important issue. If you have any further questions or concerns, please direct your correspondence to Erika Miller at emiller@dc-crd.com.

Sincerely,

Monica K. Lypson, MD, MHPE
President, SGIM

[3] Lee H, Hodgkin D, Johnson MP, Porell FW. Medicaid Expansion and Racial and Ethnic Disparities in Access to Health Care: Applying the National Academy of Medicine Definition of Health Care Disparities. Inquiry. 2021;58:46958021991293. doi:10.1177/0046958021991293
[4] Kominski GF, Nonzee NJ, Sorensen A. The Affordable Care Act's Impacts on Access to Insurance and Health Care for Low-Income Populations. Annu Rev Public Health. 2017;38:489-505. doi:10.1146/annurev-publhealth-031816-044555
[5] Sommers BD, Baicker K, Epstein AM. Mortality and access to care among adults after state Medicaid expansions. N Engl J Med. 2012;367 (11):1025–1034. https://doi.org/10.1056/NEJMsa1202099.

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