

July 30, 2021

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

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

Dear Chairman Pallone and Chair Murray:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments on the request for information (RFI) on design considerations for legislation to develop a public health insurance option. The AMA shares your goals of improving access to health insurance coverage and lowering health care costs. Covering the uninsured and improving health insurance affordability have been long-standing goals of the AMA. Since the enactment of the Affordable Care Act (ACA), the AMA's proposal for reform has continued to evolve to ensure that AMA policy is able to address how to best cover the remaining uninsured in the current coverage environment. Earlier this year we put forward an [updated series of proposals to cover the uninsured](#) that also considers the impact of the COVID-19 pandemic on health insurance coverage, as well as the enactment of the American Rescue Plan Act (ARPA) into law.

The AMA believes that, with guardrails in place to protect patients and physicians, any public option legislation must have the goal of maximizing patient choice of health plan, as well as health plan marketplace competition. AMA policy offers meaningful criteria that, in our view, would ensure that that a public option is designed to respond to the unique needs of patients, and physicians and their practices; these criteria are discussed further in the responses below to the specific questions posed in the RFI.¹

¹ Options to Maximize Coverage under the AMA Proposal for Reform H-165.823:

Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:

- a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
- b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
- c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
- d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
- e. The public option is financially self-sustaining and has uniform solvency requirements.
- f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.

However, there are significant limitations of public option proposals as stand-alone reforms to cover the uninsured. The enactment of the ARPA into law--the largest coverage expansion since the ACA--showed how much more we can accomplish under the ACA, without turning to proposals that have a real potential to cause significant health system disruptions. The nation has witnessed record enrollment in ACA coverage, via coverage offered on ACA marketplaces and under the Medicaid expansion. The AMA has long been in support of the improvements to the ACA included in the ARPA that made premium tax credits more generous and eliminated ACA's "subsidy cliff," and we urge Congress to take steps to make these changes permanent to ensure our patients have access to affordable health insurance coverage. Beyond these improvements, it will be essential for Congress to target future policy proposals on the populations that remain uninsured despite the ARPA improvements. For example, millions of uninsured individuals in the U.S. are now eligible for zero-premium marketplace coverage or Medicaid. As such, the AMA believes that Congress should explore pathways to auto-enroll these individuals in health insurance coverage at no cost to them, which would have a significant impact on the number of uninsured in the U.S.

More affordable premiums that are now available thanks to the American Rescue Plan are only one piece of the puzzle. A segment of the uninsured still cannot receive the premium help they need, including some families of workers offered unaffordable employer coverage--which is why the AMA supports Congress or the Administration taking the necessary steps to fix the ACA's "family glitch." Also, uninsured young adults may need more of a financial incentive to get covered. In addition, some of the uninsured may not see the benefit in getting covered if they cannot afford their deductibles, copayments, and other cost-sharing responsibilities. Individuals need more help in affording their cost-sharing responsibilities, which is why the AMA urges Congress to make ACA's cost-sharing reductions more generous and available to more people. And, solutions must be found for individuals who fall in the "coverage gap" in states that have not expanded Medicaid.

Considering the potential significant, positive impacts of the aforementioned ACA improvements on health insurance coverage rates and affordability, the AMA is extremely concerned about expansive public option proposals that rely heavily on Medicare payment rates, mandatory physician participation, and expansion of Medicare or Medicare-like benefits to achieve near-universal coverage. We are deeply alarmed about the growing financial instability of the Medicare physician payment system, due to the confluence of fiscal uncertainties confronting physician practices at the end of this year and legislative proposals to extend the current Medicare sequester that, in effect, will require physicians and health systems to pay for hard infrastructure. Medicare payments have been under pressure from the Centers for Medicare & Medicaid Services' (CMS) anti-inflationary payment policies for more than 20 years. While physician and non-physician provider services represent a very modest portion of the overall growth in health care costs, they are perennial targets for cuts when policymakers seek to limit spending. Medicare provider payments have remained constrained by a budget-neutral financing system.

On January 1, 2022, physician practices face the following Medicare financial hits:

1. Expiration of the current reprieve from the repeatedly extended 2 percent sequester stemming from the Budget Control Act of 2011, continuing into 2030.

g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

- Congress originally scheduled this policy to sunset in 2021 but it will now continue into 2031 or beyond.
2. Imposition of a 4 percent Statutory PAYGO sequester resulting from passage of ARPA, presumably for at least another 10 years.
 3. Expiration of the Congressionally enacted 3.75 percent temporary increase in the Medicare physician fee schedule (PFS) conversion factor to avoid payment cuts associated with budget neutrality adjustments tied to PFS policy changes.
 4. A statutory freeze in annual Medicare PFS updates under the Medicare Access and CHIP Reauthorization Act (MACRA) that is scheduled to last until 2026, when updates resume at a rate of 0.25 percent a year indefinitely, a figure well below the rate of medical or consumer price index inflation. Combined, physician practices face a 9.75 percent cut on January 1; and
 5. Additionally, potential penalties under the Merit-Based Incentive Payment System (MIPS), which apply to Medicare PFS services, will increase to 9 percent in 2022.
- In a [study](#) published this year in the *JAMA Health Forum*, physician practice leaders reported that the mean per-physician cost of participating in MIPS was over \$12,000 per year, consuming more than 200 hours of physician and administrator time each year.

This financial uncertainty comes at a time when physician practices are still recovering from the financial impact of the COVID-19 public health emergency, including continued infection control protocols that, while necessary, have increased the costs of providing care. Physician practices continue to be stretched to their limits clinically, emotionally, and financially as the pandemic persists well beyond 15 months and the delta variant is surging across the country. The enactment of further Medicare payment cuts will undoubtedly threaten patient access to care, especially considering the stark reality that, adjusted for inflation in practice costs, Medicare physician payment declined 22 percent from 2001 to 2020, or by 1.3 percent per year on average. At the same time, the cost of running a medical practice increased by 37 percent between 2001 and 2020, which equates to 1.7 percent per year, when measured by the Medicare Economic Index (MEI). Given these realities and the need for long-term reform to the PFS, an expansive public option that relies on Medicare rates and requires physician participation would only exacerbate this situation by further disrupting physician practices, patient access to care, and health care delivery. You should not build additional floors on top of a foundering foundation.

Responses to Request for Information

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

Congress cannot ignore the complexity of running a physician practice and the balance involved in determining the capacity and ability of a practice to serve a mix of patients. There are many reasons why a practice may not participate with a plan, including payment levels as well as factors such as a history of unfair contracting and business practices of a payer, burdensome administrative requirements, saturation of practice resources and physician time, engagement in alternative payment models, pending retirement, and so on. It is critical that physicians be able to weigh their contract options and make decisions that are best for their practice, patients, and employees. Establishing a provider network that meets the needs of enrollees is one of the most basic and fundamental responsibilities of health insurance plans, as they collect premium payments from patients in exchange for timely access to health care. Knowing the importance of networks that meet the needs of patients, the AMA has long fought for improved network adequacy requirements that are based on objective and meaningful standards at the state and federal levels. Unfortunately, a public option that requires physician participation shifts that network adequacy responsibility onto physicians and other providers, allowing plans to simply turn to regulators, rather than negotiate.

Recognizing that provider networks are critical to the success of a public option and any product, there are ways to incentivize physician contracting as alternatives to requiring participation. For example, legislation could require that payers administering a plan reduce prior authorization and other costly and administratively burdensome programs that require physicians to hire extra staff and spend hours on paperwork and interaction with health plans. Additionally, guarantees of transparent payer business practices, reduced denials of medically necessary services, decreased paperwork, rapid credentialing, and streamlined appeals processes would make plan participation an attractive choice for many physicians, negating the need for government mandates. We urge Congress to consider such alternative paths to establishing provider networks.

Physicians must have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.

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

Medicare rates will not cover the costs of providing care in the commercial market. In fact, according to data from the Medicare Trustees, Medicare physician pay has barely changed for nearly two decades, increasing only 7 percent from 2001 to 2020, or just 0.3 percent per year on average. At the same time, the cost of running a medical practice increased 37 percent between 2001 and 2020, or 1.7 percent per year. Economy-wide inflation, as measured by the Consumer Price Index, increased 46 percent over this period (or 2.0 percent per year). As a result, Medicare physician pay does not go nearly as far as it used to. Specifically, when adjusted for inflation in practice costs, Medicare physician pay declined 22 percent from 2001 to 2020, or by 1.3 percent per year on average.

Given the financial risk of setting the public option rates at a Medicare baseline for physician practices, the AMA urges Congress to consider the impact of such a policy on the long-term sustainability of physician practices and, ultimately, access to care. As such, regardless of the public option design,

physician payments under the public option need to be established through meaningful negotiations and contracts and must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.

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

A public option must compete on a level playing field with other health plans offering coverage options for individuals, including providing coverage for essential health benefits (EHBs). Under current law, the requirement that all qualified health plans offer at least the EHBs in the EHB package, has helped ensure that individuals have had access to meaningful coverage. On the ACA marketplaces, it has also helped facilitate patient choice of health plan, as all qualified health plans competing on the marketplace are operating from the same health benefits baseline. Therefore, if a public option were to be added as a health plan option on the ACA marketplaces, that consistency and clarity in the benefits baseline would have to be upheld. Importantly, the prohibition on annual and lifetime limits, as well as the cap on out-of-pocket expenses, is only required for care that is considered to be under the umbrella of essential health benefits.

The AMA believes that using the current benchmark approach to EHBs, while requiring 10 categories of EHBs, strikes a balance between offering meaningful coverage and maintaining patient choice in health plans and their respective benefits packages. The benchmark approach to EHBs recognizes that there is not a "one size fits all" approach to health insurance benefits, and that some variability is needed.

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

As an additional offering available on ACA marketplaces, the public option must be financially self-sustaining and have uniform solvency requirements. In addition, the public option must not receive advantageous government subsidies in comparison to those provided to other health plans. The premium assistance provided to individuals and families enrolling in coverage must be the same as that provided for other health plans offered on the marketplaces. As such, following current law concerning eligibility for ACA financial assistance to purchase marketplace coverage, eligibility for premium tax credit and cost-sharing assistance to purchase the public option needs to be restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits. Otherwise, opening up the public option to individuals who are offered affordable employer-sponsored coverage would be expected to cause crowd-out from employer-sponsored coverage, as well as higher enrollment in the public option, which would impact the payer mix of physician practices. In addition, as employer-sponsored health plans tend to have higher provider payment rates than nongroup health plans, opening up a public option to individuals with employer-sponsored coverage has the potential to significantly reduce provider revenues and cause disruptions in the health care delivery system.

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

Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners in ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices. In addition, as is the case under the ACA for marketplace plans, there must be a federal floor for patient protections, network adequacy, etc.

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

The public option should be available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits--at no or nominal cost. It should not be available to Medicare-enrolled or eligible individuals.

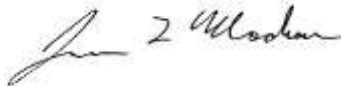
7. What role can the public option play in addressing broader health system reform objectives, such as delivery system reform and addressing health inequities?

The AMA believes that building upon the ACA to extend coverage to the uninsured--by permanently expanding eligibility for and increasing the generosity of premium tax credits and cost-sharing reductions, exploring mechanisms to auto-enroll individuals eligible for zero-premium marketplace coverage and Medicaid and other policy interventions previously highlighted--takes essential steps to dismantle longstanding inequities in our health care system that have directly harmed Black, Latino and Indigenous communities and other historically marginalized groups. The coverage gains under the ACA have helped to narrow--but have not eliminated--disparities in health insurance coverage. Many racial and ethnic groups still remain more likely to be uninsured compared to Whites. How the federal government, Congress, and the states decide to move forward with coverage will determine how equitable coverage opportunities are advanced. For example, uninsured Blacks are more likely than Whites to fall into the coverage gap in states that have not expanded Medicaid. Finally, eligibility for premium tax credits to purchase marketplace coverage differs by racial and ethnic group.

Conclusion

The AMA appreciates the opportunity to provide these comments and looks forward to working with you as you develop legislation to improve coverage rates and make health insurance coverage more affordable.

Sincerely,



James L. Madara, MD