

# USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POLICY

Economic Studies  
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1775 Massachusetts Ave NW  
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Dear Chairman Pallone and Chair Murray:

Thank you for the opportunity to offer comments on the design of a public option. Most of this letter responds in detail to each of the questions you have posed.<sup>1</sup> To begin, however, we comment briefly on the policy rationale for introducing a public option and how a public option compares to other potential policy approaches.

In our view, the principal rationale for introducing a public option is that it could pay health care providers lower prices than existing private plans while still ensuring adequate access to care. Indeed, the Medicare program pays far less than existing private plans for most health care items and services, likely reflecting the fact that many health care markets (particularly hospital markets) are highly concentrated, which gives providers considerable leverage in negotiations with insurers.<sup>2</sup> Yet, despite this large price differential, Medicare beneficiaries' access to care is comparable to the access enjoyed by people with private insurance.<sup>3</sup> Availability of a plan that paid lower prices could generate savings for consumers and the federal government, both directly and by placing competitive pressure on private plans that would allow them to negotiate lower prices with providers.

Reducing provider prices is not the only possible rationale for introducing a public option, but it is, in our view, the most compelling one. In principle, a public option could offer lower premiums without paying providers less by having lower administrative costs or setting premiums that do not incorporate a profit margin. In practice, however, these cost advantages would likely be more than offset by a public option's disadvantages in utilization management, risk selection, and risk adjustment diagnosis coding.<sup>4</sup> Alternatively, a public option's lack of a profit motive might lead it to offer better coverage than existing private plans, but it is unclear whether consumers would be willing to pay the higher premiums required to finance that more robust coverage.

Reducing provider prices would, of course, involve tradeoffs. Lower prices would mean lower revenue for providers. The changed pricing environment could also cause providers to reduce investments in quality (although introduction of a public option could also drive a shift into broader network plans, which could shift volume toward higher-quality providers). The mere existence of a tradeoff is not, in itself, an argument for preserving the

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<sup>1</sup> Much of the analysis in this letter is adapted from prior work on this topic by one of us. See Matthew Fiedler, "Capping Prices or Creating a Public Option: How Would They Change What We Pay for Health Care?" (Brookings Institution, November 2020), <https://www.brookings.edu/research/capping-prices-or-creating-a-public-option-how-would-they-change-what-we-pay-for-health-care/>; Matthew Fiedler, "Designing a Public Option That Would Reduce Health Care Provider Prices" (Brookings Institution, May 2021), <https://www.brookings.edu/essay/designing-a-public-option-that-would-reduce-health-care-provider-prices/>.

<sup>2</sup> For a review of research comparing Medicare and private prices, see Fiedler, "Designing a Public Option That Would Reduce Health Care Provider Prices." For evidence on market concentration, see Brent D. Fulton, "Health Care Market Concentration Trends In The United States: Evidence And Policy Responses," *Health Affairs* 36, no. 9 (September 1, 2017): 1530–38, <https://doi.org/10.1377/hlthaff.2017.0556>; Zack Cooper et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *The Quarterly Journal of Economics* 134, no. 1 (February 1, 2019): 51–107, <https://doi.org/10.1093/qje/qjy020>.

<sup>3</sup> See, for example, Medicare Payment Advisory Commission (MedPAC), "Medicare Payment Policy," March 2021, [http://www.medpac.gov/docs/default-source/reports/mar21\\_medpac\\_report\\_to\\_the\\_congress\\_sec.pdf](http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf).

<sup>4</sup> For a review of relevant evidence, see Fiedler, "Designing a Public Option That Would Reduce Health Care Provider Prices."

status quo. Indeed, the fact that current prices are the product of imperfectly competitive markets leads us to suspect that there is scope to reduce prices without harming quality to an extent that would outweigh the resulting cost savings, and we proceed under that assumption in what follows. Nevertheless, there is room for legitimate debate on this question, and policymakers should be mindful of these tradeoffs in crafting policy.

Finally, we note that introducing a public option is not the only potential strategy for reducing health care provider prices. One closely related alternative would be to cap the prices that providers could collect for delivering services. This type of policy would be simpler to implement than a public option in some respects, although it would have design and implementation challenges of its own, and it would not directly address objectives of a public option other than reducing provider prices.<sup>5</sup> Another approach would be to take steps to increase competition in health care markets, such as strengthening antitrust enforcement; there are clear opportunities to improve policy in this area, although there are also reasons to doubt whether steps to improve competition would, on their own, be adequate to reduce health care prices to an appropriate level.<sup>6</sup>

We now turn to answering your specific questions.

### **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)?**

In our view, there is likely scope to reduce provider prices in both the individual and group insurance markets. There is clear evidence that group plans pay providers far more than Medicare, and while individual market plans likely pay less than group plans, they likely still pay more than Medicare.<sup>7</sup> This suggests that a public option should be made available both to individuals and to employers to purchase on behalf of their employees.

While the scope to reduce prices is, if anything, larger in the group market, there are arguments for starting with the individual market.<sup>8</sup> Because the individual market is far smaller than the group market, introducing a public option solely in the individual market could give policymakers the opportunity to learn about the effects of a public option before deploying it more broadly. The federal government also bears a particularly large fraction of the cost of individual market coverage via the premium tax credit—71% of the marginal premium dollar in 2020

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<sup>5</sup> For a detailed discussion of the relative strengths and weaknesses of a public option and caps on provider prices, see Fiedler, “Capping Prices or Creating a Public Option.”

<sup>6</sup> Martin Gaynor, “What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work” (Brookings Institution, March 2020), [https://www.hamiltonproject.org/assets/files/Gaynor\\_PP\\_FINAL.pdf](https://www.hamiltonproject.org/assets/files/Gaynor_PP_FINAL.pdf); Michael E. Chernew, Leemore S. Dafny, and Maximilian J. Pany, “A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market” (Brookings Institution, March 2020), [https://www.hamiltonproject.org/assets/files/CDP\\_PP\\_WEB\\_FINAL.pdf](https://www.hamiltonproject.org/assets/files/CDP_PP_WEB_FINAL.pdf).

<sup>7</sup> See, for example, Congressional Budget Office, “A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications,” April 2021, <https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf>.

<sup>8</sup> Even if a public option was not directly offered to employers, employers might be able to pay employee premiums for an individual market public option via an individual coverage health reimbursement arrangement (ICHRAs). That could be an attractive option for employers if the public option paid providers substantially lower prices than existing private plans. Thus, if policymakers wished to limit a public option to the individual market, they would likely need to restrict the use of ICHRAs.

Policymakers might conclude they needed to eliminate ICHRAs entirely. If policymakers merely barred the use of ICHRAs to pay public option premiums, this could have the paradoxical effect of making it difficult for private insurers to compete effectively in the individual market. This is because providers might come to realize that offering price concessions to private plans in the individual market that allowed private plans to remain competitive with the public option (something that might otherwise be in providers’ interest) would have the effect of siphoning enrollment out of the group market, compromising providers’ high margins in that market.

and more in future years following the tax credit expansions included in the American Rescue Plan Act—which may make reducing individual market premiums a particularly high priority for policymakers.<sup>9</sup>

Whether policymakers elect to offer a public option solely to individuals or make it available to employers as well, we generally suggest that it be offered through the channels currently used to sell private health insurance plans. For example, a public option offered to individuals could be offered as a qualified health plan through the Health Insurance Marketplace and a public option offered to small employers could be offered as a health plan in the small group market. Marketing a public option through existing channels would reduce administrative costs and facilitate take-up. Closely related, it would maximize the competitive pressure the public option placed on existing private plans, maximizing the potential to achieve cost savings in those plans.

Offering a public option to large employers would involve some special considerations. As background, large employers currently obtain coverage in two ways. Some purchase insured coverage on the large group market; premiums for this type of coverage are typically experience-rated, meaning that premiums vary based on the claims risk of an employer’s enrollee pool. Other employers operate self-insured plans under which the employer pays enrollees’ claims itself and (typically) contracts with a third-party administrator to run the plan.

In our view, the best way to make a public option available to large employers would be to allow employers to contract with the public option as a third-party administrator for a self-insured plan. While a public option could, in principle, offer insured coverage on the large group market, doing so successfully would require the public option to set experience-rated premiums. Otherwise, it would disproportionately attract employers with sicker enrollees and have to set very high premiums. Setting experience-rated premiums would be both administratively and politically challenging for a public option, so we do not view this as a viable option in practice. Importantly, employers that hired the public option as a third-party administrator could purchase stop-loss coverage from a private insurer, so they could still benefit from much of the predictability available under a fully-insured plan.

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

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

These two questions are tightly intertwined, so we answer them jointly.

Broadly speaking, there are two ways that a public option could determine the prices it pays for health care items and services, each of which has different implications for provider participation. First, it could set prices administratively, as the Medicare program does for most items and services. Second, it could determine prices through negotiations with providers, as private insurers do. We discuss each in turn.

#### Setting Prices Administratively

We view administered pricing as the most plausible path to achieving the objective of reducing provider prices. By setting prices administratively, a public option could directly ensure that the prices it paid were less than the prices paid by existing private plans. The challenge for this type of public option would be ensuring adequate provider participation. Indeed, a provider would likely be reluctant to participate in a public option at prices much below the prices it received from existing private plans. This is because the public option could then offer an alternative, cheaper way to access the provider’s services. This would, in turn, reduce how much consumers were

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<sup>9</sup> The federal government bears the full cost of premium increases at the margin for people receiving the premium tax credit. CMS data indicate that 71% of people with ACA-compliant individual market coverage received the advance premium tax credit in 2020.

willing to pay for a private plan that included that provider, thereby reducing how much private plans were willing to pay the provider and undermining the provider's ability to continue negotiating high prices.<sup>10</sup>

Policymakers could overcome this participation problem in a couple of ways:

- *Make participating in the public option a condition of Medicare and Medicaid participation:* One commonly discussed approach is to make participation in the public option a condition of participation in other federal coverage programs, like Medicare and Medicaid. This approach is straightforward but does have the downside that it could cause some providers to opt out of Medicare and Medicaid to avoid participating in the public option. This would probably not be a major problem for an individual market public option since providers are unlikely to be willing to sacrifice the considerable volume they receive under Medicare and Medicaid to protect their ability to receive high prices in the relatively small individual market, but it could be a larger problem for a group market public option.
- *Require providers to make an “all or nothing” choice about serving a given insurance market:* Another approach would be to require a provider to serve the public option's patients if the provider wanted to serve patients covered by the public option's private competitors (with exceptions for emergency care and certain other defined circumstances). For example, a provider that refused to serve patients in an individual market public option might be barred from private Marketplace plans. Similarly, a provider that refused to participate in a group market public option might be barred from participating in private health plans that benefit from the tax exclusion for employer-provided coverage. (In practice, this type of requirement might be most naturally imposed on *insurers* rather than providers. That is, *insurers* could be barred from covering services delivered by providers that did not serve public option patients.)

This approach would eliminate the main benefit a provider obtains by opting out of the public option—the ability to extract higher prices from competing private plans—and thus strongly encourage providers to participate. This approach has precedent in the Medicare program. Notably, Medicare's conditions of participation bar institutional providers from placing restrictions on Medicare beneficiaries' ability to access their services that differ from those that apply to “all other persons seeking care.”<sup>11</sup> This has the effect of making it impossible for providers to serve beneficiaries enrolled in Medicare Advantage plans without also serving beneficiaries enrolled in traditional Medicare, which may be an important reason that provider participation in traditional Medicare is so broad despite the presence of Medicare Advantage.

We note that, under either of these two approaches, it would be necessary to require providers to offer public option enrollees real access to their services, not just nominally “participate” in the public option. This type of requirement could be structured in a few different ways. One option would be to require a provider to accept public option patients on the same terms as it accepts patients covered by private plans in that market, similar to the Medicare condition of participation described above. Another option would be to set substantive minimum standards for patient access, although this could be a complex undertaking in practice.<sup>12</sup>

The actual prices under an administered pricing regime could be set in several different ways, but the two most commonly discussed approaches are to set prices as a multiple of Medicare's prices (perhaps with some adjustments for services not commonly provided by Medicare, such as pediatric and obstetric services) or as a

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<sup>10</sup> For additional discussion of these competitive dynamics, see Fiedler, “Designing a Public Option That Would Reduce Health Care Provider Prices.” and Fiedler, “Capping Prices or Creating a Public Option.”

<sup>11</sup> See 42 CFR § 489.539(a)(2).

<sup>12</sup> For additional discussion of policy options to address this problem, see Fiedler, “Capping Prices or Creating a Public Option.”

percentage discount off of the average prices paid by private plans. While either approach is potentially workable, we see a few advantages to setting prices as a multiple of Medicare's prices:

- *Reduces administrative burden:* Basing the public option's payment systems directly on Medicare's would allow the agency administering the public option to rely on processes and systems that already exist for Medicare and allow providers to do the same with respect to billing. By contrast, basing the public option's prices on the prices currently paid by private plans would require the federal government to undertake an extensive data collection process (since comprehensive national data on the prices paid by private plans do not currently exist). It would also require providers to adapt to a set of payment rules that would not precisely align with the payment rules in use by any currently existing payer.
- *Eases updating prices over time:* Basing the public option's payment systems on Medicare's would also make it easy to update prices over time since Medicare has well-established (albeit imperfect) processes for doing so. By contrast, updating prices derived from the prices paid by private plans would be difficult.

Notably, policymakers likely could not simply recalculate prices periodically using updated data on the prices paid by private plans because this would create complex and unpredictable feedback effects. Under this approach, providers would likely come to recognize that agreeing to a lower price with a private insurer would reduce what they were paid by the public option, which would cause providers to demand higher prices from private plans, leading to higher prices in the public option in future years.<sup>13</sup> On the other hand, competition from the public option would likely enable private plans to negotiate lower prices with providers, which would then result in lower prices in the public option.<sup>14</sup> The net effect of these factors would be unpredictable and would likely vary across service lines and geographic areas, so it is likely these factors would result in prices that are much lower than intended in some cases, while resulting in prices that are much higher than intended in other cases.

Policymakers could seek to avoid these problems by using historical data on private prices to set the public option's prices in its early years and then formulaically trending those prices forward over time. However, this approach would make it difficult to account for the introduction of new items and services and would cause prices for existing items and services to become "stale" over time.

- *Ensures prices exceed marginal cost:* Basing the public option's prices on Medicare would also likely ensure that its prices exceeded providers' marginal cost of delivering care. Importantly, if the public option's prices were lower than providers' marginal cost, serving the marginal public option patient would not be profitable for the provider, and the approaches to ensuring adequate provider participation in the public option that were described above would either fail or be much harder to enforce.

As noted above, evidence indicates that Medicare's prices are adequate to ensure robust provider participation in Medicare, which is a strong indication that those prices do typically exceed providers' marginal cost. (This is likely by design since policymakers have a strong interest in ensuring broad provider participation in Medicare.) It follows that setting prices as a multiple of Medicare's would ensure

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<sup>13</sup> A similar problem exists today in the context of the Medicaid drug rebate program. See Mark Duggan and Fiona M. Scott Morton, "The Distortionary Effects of Government Procurement: Evidence from Medicaid Prescription Drug Purchasing," *The Quarterly Journal of Economics* 121, no. 1 (February 1, 2006): 1–30, <https://doi.org/10.1093/qje/121.1.1>.

<sup>14</sup> For a public option available solely in the individual market, policymakers could seek to mitigate these competitive feedback effects by calculating the public option's prices based on prices in the group market. However, this approach would still put upward pressure on the prices negotiated by group plans. It could also forfeit some of the perceived advantages of using private prices to set the public option's prices since the public option's prices would no longer reflect the status quo in the individual market. Regardless, this approach would not be available to policymakers interested in creating a group market public option.

that prices typically exceed providers' marginal cost (as long as that multiple is greater than or equal to one, as seems likely in practice). By contrast, if prices were set at a discount off of average private prices, there is no guarantee that prices would consistently exceed marginal cost.

The main potential downside of relying on Medicare's prices is that Medicare's payment systems have a range of well-documented shortcomings.<sup>15</sup> These include fee schedules with miscalibrated relative prices and underuse of non-fee-for-service payment methods. Private payers sometimes avoid these problems; for example, there is evidence that private payers sometimes set lower relative prices for services for which Medicare overpays.<sup>16</sup> On the other hand, there are also cases where the structure of private payments is worse than Medicare's; for example, around one-quarter of hospital-insurer contracts are based on the hospital's chargemaster, and non-fee-for-service payment models appear to be more widespread in Medicare than in private plans.<sup>17</sup> Moreover, to the extent that private plans do use non-fee-for-service payment methods, it might be difficult to carry those over to a public option given the wide variation in payment arrangements across private plans. On balance, therefore, we see no reason to presume that payment structures derived from private plans would be better designed.

We note that policymakers could consider hybrid approaches to setting the public option's prices. For example, the public option's prices could be a multiple of Medicare's prices, but that multiple could be based on the average ratio of private prices to Medicare prices in a historical period, perhaps disaggregated by service line. This approach to using private price information would retain most of the advantages of using Medicare's prices.

#### Setting Prices Via Negotiation with Providers

The other way that a public option could determine provider prices is through bilateral negotiations with providers. However, we do not see determining prices through negotiations as a viable pathway to achieving the objective of reducing provider prices. Ultimately, an insurer's only source of negotiating leverage is the threat to exclude a provider from its network. There is no clear reason to expect a public option to be better at wielding that threat than private plans and some reason to believe that it would be worse since it might face political pressure to maintain a broad network. (Setting prices through negotiation would, however, ensure adequate provider participation since the public option could continue raising its price until a provider accepted.)

A public option might be able to negotiate better prices if it had a source of leverage that private insurers lack. For example, if a provider that failed to reach agreement with the public option was also barred from serving patients covered by the public option's private competitors (as suggested above in the discussion of ways to ensure provider participation in the context of administered pricing) that could allow the public option to negotiate much lower prices. But for that leverage to be useful to the public option, it would need to be willing to use it. And there is reason to believe that a public option would be reluctant to use that leverage in practice. In particular, the same political pressures that would tend to make a public option leery of excluding a provider from its own network would likely make it even more leery of excluding a provider from an insurance market entirely.

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<sup>15</sup> See, for example, Medicare Payment Advisory Commission (MedPAC), "Medicare Payment Policy."

<sup>16</sup> Jeffrey Clemens, Joshua D. Gottlieb, and Tímea Laura Molnár, "Do Health Insurers Innovate? Evidence from the Anatomy of Physician Payments," *Journal of Health Economics* 55 (September 2017): 153–67, <https://doi.org/10.1016/j.jhealeco.2017.07.001>.

<sup>17</sup> Cooper et al., "The Price Ain't Right?"; Health Care Payment Learning & Action Network (HCP-LAN), "Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Traditional Medicare Programs" (Health Care Payment Learning & Action Network, October 24, 2019), <http://hcp-lan.org/workproducts/apm-methodology-2019.pdf>.

Negotiating prices with providers would also be administratively complex. There are about 6,000 hospitals in the United States and hundreds of thousands of physician practices.<sup>18</sup> Managing negotiations with all of those providers would be difficult and would cause the public option to incur meaningful administrative costs, forfeiting at least part of the administrative cost advantages a public option might otherwise hold. In practice, the agency responsible for administering a public option would likely delegate that responsibility to a contractor, but creating appropriate incentives for a contractor could be challenging in practice.

#### Special Considerations Related to Pharmaceuticals

Setting prices for pharmaceuticals would raise a somewhat different set of considerations. For retail prescription drugs, a public option could not simply rely on Medicare's payment systems since Medicare does not pay for retail prescription drugs directly. The public option's prices could, in principle, be based on the prices paid by private plans, but the challenges that arise when trying to update prices set that way would be particularly severe in this context, particularly for a public option that was available in the group market. For similar reasons, simply carrying over Medicare's existing payment policies for physician-administered drugs (for which Medicare's payment rates are based on the average prices paid by other payers) could also prove problematic—and outright unworkable in the context of a public option that was offered in the group market.

Policymakers would, thus, have two main options in relation to prescription drugs. First, they could direct the public option to establish a new administered pricing system to set pharmaceutical prices. This approach is feasible in concept and could allow the public option to pay less than existing private plans, but it would require the public option to build a fundamentally new administrative infrastructure and would represent a notable departure from past policy practice. Second, they could direct the public option to contract with a pharmacy benefit manager that would negotiate prices on behalf of the public option. This approach would be straightforward to implement, but consistent with the earlier discussion of negotiated prices, likely result in the public option paying pharmaceutical prices that are comparable to or higher than those paid by private plans.

Finally, we note that the tradeoffs involved in deciding whether and how far to reduce pharmaceutical prices are somewhat different than those that arise in the context of other medical items and services. The marginal cost of producing a pharmaceutical is often only a small fraction of its price, so there is potentially greater scope to reduce these prices while preserving patient access to existing drugs. On the other hand, changes in pharmaceutical prices may affect decisions about whether to invest in development of new drugs, a consideration that is typically not present (or present in much weaker form) for other items and services.

#### Special Considerations for an Individual Market Public Option

In considering the effects of an individual market public option, policymakers should be mindful of the fact that most research to date on the prices paid by commercial insurance plans pertains to group market plans.<sup>19</sup> While reliable estimates of the prices paid by individual market plans are not currently available, the prices paid by individual market plans are generally believed to be lower than the prices paid by group plans.<sup>20</sup> This implies that prices would typically need to be set at a lower level under an individual market public option to reduce prices

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<sup>18</sup> American Hospital Association, "Fast Facts on U.S. Hospitals, 2021," 2021, <https://www.aha.org/statistics/fast-facts-us-hospitals>; Aaron Young et al., "FSMB Census of Licensed Physicians in the United States, 2018," *Journal of Medical Regulation* 105, no. 2 (July 2019): 7–23, <https://doi.org/10.30770/2572-1852-105.2.7>; Carol K Kane, "Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians Are Owners Than Employees" (American Medical Association, 2019), <https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf>.

<sup>19</sup> For a brief review of that evidence, see Fiedler, "Designing a Public Option That Would Reduce Health Care Provider Prices." For a longer review that discusses this issue in particular, see Fiedler, "Capping Prices or Creating a Public Option."

<sup>20</sup> See, for example, Congressional Budget Office, "A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications."

relative to the status quo (and that, in this respect at least, the rationale for creating an individual market public option may be weaker than the rationale for creating a group market public option).

#### **4. How should the public option's benefit package be structured?**

In choosing among alternative benefit designs for the public option, policymakers would need to consider two types of effects. The first is how different benefit designs would directly affect the financial protection and access to care provided by the public option, as well as the premium the public option charged, holding enrollment patterns fixed. The second is how different benefit designs would affect the public option's overall attractiveness to enrollees. This would determine how much competitive pressure the public option placed on private plans and, thus, how effective the public option was in constraining costs in private plans. To the extent that the public option had a benefit design that policymakers viewed as superior to private plans', these effects on the public option's competitive position would also determine how many people benefited from that superior benefit design.

These two perspectives on benefit design would often align, but not always. For example, focusing just on the first set of effects would suggest that a public option should always offer a particular plan feature if the benefits of that coverage in terms of improved financial protection and access to care exceeded the direct cost of offering that coverage. However, if that plan feature particularly appealed to sicker enrollees and forced the public option to charge a higher premium, adding that feature might reduce the public option's market share and undermine its overall ability to achieve its goals, in which case offering that plan feature might not be appropriate. Similarly, these two perspectives could diverge if enrollees undervalued a particular plan feature.

Appropriately balancing these considerations will be difficult and will likely require the public option to make case-by-case determinations about coverage of specific services, determinations that should likely evolve over time as medical technology and market conditions change. For this reason, we believe that it would be wise for legislation creating a public option to define a general framework governing the public option's benefit design but leave the executive branch substantial discretion to determine the details of that design.

Statutory guidance governing the public option's benefit design could include two main components. First, it could lay out a set of minimum requirements. The public option could be required to cover essential health benefits as defined in the Affordable Care Act (including in the case of a public option offered outside of the individual or small group markets) and abide by all other federal regulatory requirements that apply to insurance plans offered in the relevant market. Additionally, to help ensure that the public option's benefit package adapts to changes in market conditions over time, the public option could be required to cover any services that are typically being covered by private plans offered in the same market.

Second, the statute could offer general guidance on how to craft the public option's benefit package within those minimum standards. Specifically, the public option's administrator could be directed to consider how alternative benefit packages would affect the financial protection and access to care enjoyed by people *throughout* the relevant insurance market, as well as the premiums that *all* plans in that market charged. This approach would require the administrator to account for both how alternative benefit designs would directly affect public option enrollees and any indirect effects that might arise through changes in the public option's competitive position.

The discussion above shows that introducing a public option is an imperfect tool for addressing shortcomings in the benefit designs of existing private plans. To the extent that policymakers wish to improve benefit designs, other tools are likely more appropriate. For example, to the extent that the deficiencies of existing plans result from adverse selection, strengthening risk adjustment or imposing stronger minimum benefit standards on *all plans* would be a better approach to addressing those problems. Stronger minimum standards could also help address benefit design shortcomings that arise because consumers undervalue a particular plan feature.



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

Consistent with our recommendation that a public option should be made available through the same channels as existing private plans, we recommend that a public option be eligible for federal subsidies on the same terms as private plans. In particular, Marketplace enrollees who enroll in the public option should be eligible for the premium tax credit on the same terms as if they enrolled in a private Marketplace plan, and the public option should be required to offer cost-sharing reductions (and, if applicable, be eligible to receive cost-sharing reduction payments). Similarly, public option coverage purchased by an employer on behalf of its employees should qualify for the tax exclusion for employer-sponsored coverage just like private group plans.

There are surely respects in which the federal government's existing mechanisms for subsidizing coverage could be improved. However, subsidy improvements should be implemented broadly so that they benefit both people who elect to enroll in the public option and those who remain in private plans.

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

Giving states an expansive role in a federal public option would carry some risks. First, it could allow states to undermine the public option, frustrating the goals of federal policymakers; experience with the Affordable Care Act's Medicaid expansion shows this is a serious concern. Second, state involvement could add administrative costs by necessitating the design and implementation of state-specific systems. Third, to the extent that state involvement caused the public option to function differently in different parts of the country, this might make the public option less attractive to large national employers with employees in many different jurisdictions (in scenarios where a federal public option was available in the group market).<sup>21</sup>

On the other hand, state involvement may also have benefits. Perhaps most importantly, states may be able to improve on the design of a public option, particularly if the political constraints faced by state policymakers are looser than those faced by federal policymakers. (In principle, states could also better tailor policies to local conditions, although we question how large this benefit would be in practice, particularly since the payment rates under a federal public option would presumably incorporate geographic adjustments.)

One approach to balancing these competing considerations would be to adopt a framework similar to the one that exists under the Affordable Care Act's Section 1332 waiver process. Under this approach, the federal government would specify a default set of policies that would go into effect absent any state action. However, states could seek a waiver to deviate from the federal default if they presented an alternative approach that would perform at least as well with respect to criteria specified in statute; those criteria should include, at a minimum, that the alternative approach would not increase federal or consumer costs. In light of the concerns related to large national employers noted above, policymakers might wish to limit any waivers solely to the individual and small group markets. Additionally, to limit administrative costs, federal policymakers might consider allowing states to make certain modifications to the public option while leaving most administrative functions at the federal level; for example, states could be allowed to reduce the public option's payment rates by a fixed percentage.

Finally, we note that states often levy taxes and assessments on insured health plans. Policymakers might wish to allow states to collect similar amounts from the public option to avoid eroding state revenue bases and to place the public option on a level footing with private plans. Giving states unfettered authority to tax the public option would give states the power to undermine the public option. However, federal policymakers could direct the

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<sup>21</sup> Similar concerns could arise in the individual and small group markets to the extent that greater cross-state variation in the policy environment made it harder for private insurers operating in one state to enter a new market in a different state.

public option to make a payment to each state equivalent to what the public option would owe the state if it were a private plan. This could address states' revenue concerns without threatening the public option's viability.

### **7. How should the public option interact with public programs including Medicaid and Medicare?**

As described above, we envision that, where possible, the public option would make use of Medicare's programmatic infrastructure, particularly in setting payment rates and processing claims. A public option might also use Medicare and Medicaid to encourage provider participation. Beyond that, however, we envision that interactions between the public option and these programs would be limited, akin to existing private plans.

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

Introducing a public option that set lower premiums than existing plans could generate substantial federal savings by reducing the federal government's cost of providing Marketplace subsidies and the tax exclusion for employer-provided coverage. Those savings could be used to finance investments aimed at a variety of objectives.

Notably, those savings could be used to finance policies aimed at expanding or improving insurance coverage, such as closing the Medicaid coverage gap or making permanent the expansion of the premium tax credit included in the American Rescue Plan Act. Steps like these could substantially improve health equity in light of the large disparities in insurance coverage across population groups.<sup>22</sup> By reducing premiums, a public option could also directly increase insurance coverage by inducing more individuals or employers to take up coverage.

We hope that this letter is helpful to you. If we can provide additional information, please do not hesitate to ask.

Sincerely,

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<sup>22</sup> Robin Cohen et al., "Demographic Variation in Health Insurance Coverage: United States, 2019" (National Center for Health Statistics, June 2021), <https://doi.org/10.15620/cdc:106462>.