July 30, 2021

Chairman Frank Pallone  
House Committee on Energy & Commerce

Chairwoman Patty Murray  
Senate Committee on Health, Education, Labor & Pensions

Sent via email:

Dear Chairman Pallone and Chairwoman Murray:

The Association for Community Affiliated Plans (ACAP) respectfully submits comments in response to your request for information on a public health insurance option.

ACAP is an association of 78 not-for-profit and community-based Safety Net Health Plans (SNHPs). Our member plans provide coverage to more than 20 million individuals enrolled in Medicaid, the Children’s Health Insurance Program (CHIP) and Medicare Special Needs Plans for dually-eligible individuals, including over 765,000 Marketplace enrollees in 2020. Nationally, Safety Net Health Plans serve almost half of all Medicaid managed care enrollees. Seventeen of ACAP’s Safety Net Health Plan members and Partner Plans, including the remaining health care Consumer Operated and Oriented Plans (Co-Ops) established under the ACA, offer qualified health plans (QHPs) or basic health plans (BHPs) in the Marketplaces, and two additional ACAP plans will be entering the Marketplaces for 2022. Accordingly, our comments are focused on ensuring stability for SNHPs and access to affordable, high-quality, comprehensive coverage for the consumers they serve. ACAP member plan enrollees are generally low-income populations and we would like to emphasize that the comments herein support SNHPs in their efforts to serve their communities.

We appreciate and strongly support efforts to make the cost of coverage more affordable for consumers and we find ourselves in full agreement with your desire to ensure that every American has quality, affordable coverage, regardless of income, age, race, disability, or zip code. It makes sense that the committees of jurisdiction have reinvigorated the discussion on a public option as part of this effort. Since the early days of the Affordable Care Act, when public option legislation was considered under the House health reform bill, ACAP has been open to the idea of a public option, depending on its design and structure.

In the absence of a federal public option to date, however, ACAP’s SNHPs have in fact been part of the solution to providing affordable, comprehensive coverage options through the ACA Marketplaces. Millions of Americans finally have gained access to high quality, affordable coverage in the decade since the ACA was enacted, however, we know that there are still affordability changes that remain for many. We desire to continue to be part of the solution as
Congress and the Administration build on the ACA and what has been proven to work. We also believe, as we have since the idea of a federal public option was considered by Congress during the ACA debate over a decade ago, that a public option could most effectively be operated by a not-for-profit, mission-driven entity, such as a community-focused health plan. This is currently the case in Washington state, where ACAP member Community Health Plan of Washington (CHPW) operates one of the CascadeCare public option plans, and as is essentially the case in California, where ACAP Member L.A. Care Health Plan, an independently-operated public plan offers Marketplace coverage to approximately 100,000 consumers in the Los Angeles area alone. Data show that SNHPs, the ACA-established Co-Ops, as well as other Medicaid-focused plans offer some of the lowest premiums in the Marketplace—helping fill the role of a public option: a competitive entity that places downward pressure on premiums to improve affordability. L.A. Care, for example, had the lowest premiums available for a number of years, however, in other years its competitors lowered their rates to match theirs—arguably exactly what the initial House-passed public option was intended to do: create downward, competitive pressure on the Marketplace. SNHPs’ mission, as well as their background in the Medicaid program, in particular, has enabled them to keep rates low due to their care management programs and their ability to build off their Medicaid-focused provider networks and reimbursement rates.

However, outside of such a structure in which managed care entities like SNHPs serve as the public option, especially in the context of a federally-administered, fee-for-service type public option proposals, we wish to impress upon you the importance of having any such public option operate on a level playing field so that market dynamics can continue to benefit the consumer and provide meaningful choice. While we recognize that the goal of a public option is first and foremost to drive down premiums, we believe that any public option must, at the same time, not operate in a manner in which other issuers will be at a competitive disadvantage. In fact, in a 2009 letter to the House Tri-Committees, we stated that “ACAP applauds the Committees’ effort to make the public health insurance option operate on a level playing field with other health plans in the Health Insurance Exchange with respect to benefits, provider networks, notices, consumer protections and cost sharing.” It is safe to say that we continue to feel similarly.

Accordingly, given the structure of the individual market, as established by the ACA, it is vitally important that any offering through the Marketplaces meet essential health benefit requirements and cost sharing, be part of the single risk pool, and otherwise operate under the same rules when it comes to provider contracting and payment. Without the same operational rules, no private entity will be able to compete over the long run, thereby providing choice to the consumer; we are operating under the assumption that Congress is not looking to, under the guise of a public option, eliminate private coverage altogether and move toward a single-payer system. There is a significant difference between a plan that is structured to provide additional value for consumers while putting downward pressure on the market, as opposed to one that is structured to ultimately become the only choice in the Marketplace. In other words, plans with lower profit margins and increased value for consumers can help drive down costs without competing at an unfair advantage.
To elaborate more, it is vitally important that any public option retain the same benefit package structure as other plans on the individual market; more specifically, one that is based on a benchmark plan and meeting all EHB requirements, although a standardized plan, for example, could still fit in such a structure. Any significant changes to the benefit structure, however—such as offering more robust Medicaid-level benefits—would make a fair risk adjustment process impossible under the single risk pool established by the ACA, as it would effectively segment the market. Similarly, it is vitally important that a public option plan operate no differently as far as setting premiums or developing provider networks. If the public option is able to both mandate provider participation and mandate rates, rather than negotiate rates with providers like all its competitors, such a plan will necessarily have the upper hand to such an extent that premiums will be drastically lower—to the point that private plans will simply be unable to compete for any real market share. However, we recognize the importance of structuring a public option plan to be an affordable coverage option for individuals who currently struggle with premiums and out of pocket costs, in order to pull more currently uninsured individuals into the marketplace and improving the risk pool and that there may be middle-ground ways to do so without putting QHP issuers at such a competitive disadvantage that they cannot compete on the Marketplace.

It is worth noting that some states have begun to experiment with state-run public options with slight variations on the above, which are worth watching. For example, Washington state permits an aggregate rate cap of 160% Medicare without mandating provider participation, which has had moderate success and some challenges. These challenges include provider negotiation issues and providers’ unwillingness to accept at or below 160% of Medicare, as they desire to be on the top side of the aggregate. Without significant provider participation requirements, the public option plans have not been able to meet network adequacy requirements that would enable them to be offered statewide. However, they still provide an additional choice for consumers and another level of market competition.

Colorado, meanwhile, would require a standardized benefit package and require that issuers reduce premiums. If issuers are unable to adequately reduce premiums, the state will step in to arbitrate provider contracting and rates for certain plans in order to ensure lower premiums for consumers. In a previous iteration of Colorado’s draft legislation, however, if issuers were unable to reduce premiums the state would have stepped in to offer a state-run public option plan with mandated provider participation and lower rates. This concept was ultimately abandoned, as other plans on the Marketplace would have had extreme difficulty competing with this form of public option, with no ability to mandate the providers accept lower rates from them as well.

We urge Congress to watch these experiments closely and consider the unintended consequences that may arise from providing a public option plan with different flexibilities than the issuers it would be competing against. Accordingly, we would be pleased to schedule a call or meeting for you and your staffs with our health plans that currently serve as the public option plans in their respective states, so that you can hear their experiences directly.
Regardless, we appreciate your willingness to engage in a thoughtful discussion on whether and how best to structure a public option. We thank you for your focus on improving access to affordable coverage for the millions of remaining uninsured or underinsured Americans. Please contact ACAP Vice President for Marketplace Policy at hfoster@communityplans.net with any questions or to discuss further.

Sincerely,

/s/

Margaret A. Murray
CEO, ACAP