



July 22, 2021

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

The Honorable Frank Pallone  
Chairman  
Committee on Energy and Commerce  
U.S. House of Representatives  
Washington, D.C. 20515

Dear Chairs Murray and Pallone:

On behalf of the American Academy of Family Physicians (AAFP), which represents 133,500 family physicians and medical students across the country, I write in response to your [request for information](#) published on May 26<sup>th</sup> regarding public option legislation.

As the largest medical society devoted solely to primary care, the AAFP advocates for federal policies and programs to advance health equity and ensure family physicians can provide comprehensive, continuous primary care to all patients, including those who are historically underserved and systematically disadvantaged. To this end, the AAFP has outlined a framework to achieve [Healthcare for All](#), which includes a public option for healthcare coverage. In our view, a public option approach could encompass a federally administered or state-based plan directly competing for customers with private insurance plans. It could be national or regional in scope, and physicians and other clinicians would continue to operate independently. A public option would increase competition in the insurance marketplace and has potential to increase insurance coverage and improve population health. However, if such legislation only addresses the uninsured and fails to fundamentally restructure the system to promote and pay differently and better for family medicine and primary care, any solution will not reach its full potential to achieve the Quadruple Aim of better care, better health, smarter spending, and a more efficient and satisfied physician workforce. Additional responses to the committees' questions are outlined below.

**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)?**

Federally administered plans under a public option should **maximize eligibility for as many individuals as possible** to encourage larger negotiating power. Regional or local public options would have fewer customers and a weaker negotiating position with hospitals, health systems, pharmaceutical companies, and other major drivers of health care costs and an inability to effectively compete with other payers. Conversely, a robust singular public option would have a large or national market share and be able to operate and compete nationally with private plans. This would introduce effective competition and ensure savings for consumers. Additionally, physician willingness to participate in the public option could depend upon the number of

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individuals the plan covers. The greater the share of physicians' patients the public option covers, the more likely physicians would want to accept the plan.<sup>i, ii</sup>

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

The Health Resources Services Administration (HRSA) estimates a current shortage of [15,444 primary care physicians](#) across all primary care health professional shortage areas, so investments in primary care are necessary regardless of implementation of a public option. Yet any successful health system reform designed to achieve health care coverage for all must re-emphasize the centrality of primary care, reinvigorate the primary care infrastructure in the United States, and support a redesign of primary care delivery and payment. To achieve centrality of primary care and ensure adequate access to primary care physicians, especially for traditionally underserved populations, it is critical to ensure appropriate payment rates for those physicians. **Rates should be set at or above Medicare rates to ensure adequate access to primary care physicians.** If public option rates are too low, those physicians may not be able to accept the plan and keep their practices financially viable, absent other incentives, diminishing the size of the plan's network and limiting access.

The AAFP has advocated for adequate payment for primary care outside of a public option plan. Recently, the Academy and others [called](#) on Congress to raise Medicaid payment rates for primary care and pediatric services to at least Medicare levels by passing the Kids Access to Primary Care Act (H.R. 1025). Physician practices already operating on thin or negative margins are still working to make up revenue losses from the pandemic, and many simply cannot afford to accept additional Medicaid patients.

**To further improve physician participation in public option plans, significant effort should be made to ensure administration of a public option does not add to administrative burden for physicians.** This also serves to reduce overall health care spending as a significant share of the overall costs of health care in United States is due to high administrative costs. Much of these high administrative costs is due to complexities in billing, which is exacerbated by the multiple payers involved. Countries with lump-sum budgets and fewer health care payers have seen lower costs in administrative spending.<sup>iii</sup> Of all hospital spending in the United States, 25% is dedicated to administrative costs--- nearly \$200 billion. In comparison, Canada dedicates only 12% of hospital spending to administrative costs, while England spends 16%. Additionally, no link has been found between higher administrative costs and higher quality care. Reducing administrative burden across all payers, including a public option plan, would encourage physician participation and help ensure adequate and timely access to care.

Furthermore, adequate payment for primary care under the public option could have an expansionary effect on the healthcare workforce. More family physicians may want to enter markets with a public option that provides for enhanced investment in primary care services. Family physicians could, in turn, use the additional funding to expand their practices and hire additional clinical staff, like those that enable and support advance primary care, such as care managers, behavioral health staff, and others. However, if payment rates are inadequate for the services provided and primary care physicians still face increasing workloads for newly covered individuals, it is likely that levels of physician burnout and patient wait times would increase. Without adequate payment, patient access to primary care physicians and primary care services would not improve under a public option.

**Any legislation to implement a public option should preserve the ability of patients and physicians to voluntarily enter into direct contracts for a defined or negotiated set of services.** Physicians should not be compelled to accept the public option plan as a condition of participation in other federal programs.

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

The AAFP remains concerned that rising healthcare costs and consolidation-driven price increases will continue to make healthcare unattainable for many individuals and families. The AAFP is part of Consumers First, a multi-stakeholder group committed to reforming our healthcare system to better serve patients, and reiterates the details of their [recent report](#) on preventing consolidation and unaffordable pricing. The AAFP supports payment policies that are site-neutral, transparent, and value preventative services.

*Site Neutral Payment Policies* - For many health care services, current payment policies often are highly variable depending on the site of service (e.g., higher payment for the same service performed in a hospital versus an ambulatory surgery center versus a physician's office) despite no significant differences in quality or outcomes of care. Such payment policies contribute to excessive spending in our current system, incentivize consolidation, decrease competition between providers of care, and facilitate over-utilization of high-cost health care services. **Site-neutral payments generate significant health care savings that directly and positively impact patients and payers, in addition to enhancing transparency.** The AAFP has [strongly supported](#) Medicare's move toward site neutral payments in recent years. Any public option should pay consistently for services regardless of care setting (i.e. hospital outpatient departments, ambulatory surgery centers, emergency departments and physician offices) and create incentives for services to be performed in the most cost-effective location, such as a physician's office.

*Transparency* - Price [transparency](#) is critical to ensure investments and savings are passed on to consumers. Requiring hospitals and payers to disclose negotiated rates is a significant step toward price transparency and ultimately toward cost containment. The AAFP recommends detailed reporting that includes the full range of prices for hospital services. All transparency efforts should focus on refining a value-based health care system by ensuring that cost is reported together with quality data.

*Value Preventative Services* - Payment for preventive services should incentivize physicians to administer those services, specifically evidence-based preventive services that are proven to reduce the prevalence of preventable diseases (e.g., access to free ACIP-recommended vaccines and screening programs recommended by the USPSTF). The AAFP [lauded](#) CMS' recent increase to COVID-19 vaccine administration payments to more accurately reflect the unique costs associated with storing and administering vaccine products, as well as the time primary care physicians spend counseling patients and answering their questions about the vaccine. **Appropriate payment for preventive services expands access and helps ensure primary care physicians have financially viable practices.** The AAFP has a number of resources on [value-based insurance design](#), [value-based payment](#), and [physician payment](#) that should be incorporated into payment design to help practices shift to a value-based care design. These services should be made available without cost-sharing for enrollees, consistent with the ACA.

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

Ensuring access to affordable health care coverage that provides a defined set of essential health benefits is necessary to move towards a healthier and more productive society. Coverage under a public option should, at a minimum, include items and services in the following benefit categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment and medication assisted treatment (MAT)
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

In addition to requiring coverage for essential health benefits, **the public option should ensure primary care is provided through the patient's primary care medical home**. We have repeatedly seen financial barriers cause patients to delay or forego health care services, which may result in costlier care down the road.<sup>iv</sup> To foster a longitudinal relationship with a primary care physician, **the following services should be independent of financial barriers (i.e., deductibles and co-pays) if the services are provided by the patient's attributed primary care physician:**

- Evaluation and management services
- Evidence-based preventive services
- Population-based management
- Well-child care
- Immunizations
- Basic mental health care

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

Affordability should be a priority in the implementation of a public option plan. Financial barriers to care compound access problems and ultimately lead to worse health outcomes, especially for low-income Americans and those with chronic conditions.<sup>v</sup> Premium assistance should be made available and preventative services and a defined set of high-value primary care services should have no cost-sharing across any public option plans. The AAFP [lauded](#) the premium assistance and tax credits included in the American Rescue Plan and hopes Congress will continue to prioritize affordability with implementation of any new legislation.

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

States with established public options should be involved as part of an advisory committee to support the development of the federal option, along with individuals who have purchased these plans, those who administer the plans, and physicians who participate in the plans. A federally administered public option should accommodate or embed existing state public option plans where possible to maintain state flexibility and lower health care costs. States could be given the option to emulate the “state-based marketplace-federal platform” model introduced by some states’ health insurance marketplaces, where states are responsible for most day-to-day operational functions while using the federal platform for eligibility and enrollment. States should have the ability to allow for direct primary care arrangement exemptions and encourage the use of alternative payment models as part of a public option plan.

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

Payment rates under any public option should equal or exceed those of Medicare to enable physician and other clinician participation. Individuals who qualify for a public option plan and Medicaid or Medicare coverage should be allowed the option to remain enrolled in those public programs should they so choose. Additionally, a public option could utilize many of the eligibility determination mechanisms found in other public health insurance programs and related elements to save costs, maximize beneficiary choice, streamline enrollment, and reduce administrative burden. The “no wrong door” approach implemented as part of the Affordable Care Act streamlined health care enrollment and should be included in any public option legislation.

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

The AAFP believes a health care system that places comprehensive, continuous primary care at the center is best positioned to successfully improve health care quality and lower costs. **Any public option plan should incentivize value-based care over fee-for-service.** Although many primary care practices continue to experience financial strain from the pandemic, those that participate in Alternative Payment Models (APMs) have been more financially stable and have used prospective payments to support innovative capabilities to safely care for patients amid the pandemic. **To support the transition to value-based care, Congress should expand the Center for Medicare & Medicaid Innovation’s (CMMI’s) authority to include testing alternative payment models for public option populations.** Further, clinicians’ participation in public option APMs should count toward meeting the thresholds to qualify for the advanced APM bonus under the Medicare Quality Payment Program (QPP). Additionally, definitions of success within CMMI demonstrations and under the QPP should be adjusted to better reflect quality, access, and equity, particularly for small, solo, or rural providers that face barriers to participating given lower patient volumes. These measures should be harmonized across the public option and other CMS programs to reduce administrative burden related to reporting. More broadly, a public option that expands health insurance and health care access could ultimately have a beneficial impact on public health and health outcomes. The structure and administration of a public option should prioritize value-based care to ensure health care costs are more accessible and overall spending is reduced.

The AAFP appreciates your interest in developing legislation to achieve our shared goals of universal health care coverage and lower health care costs, and we look forward to working with legislators to advance policies that achieve health care for all and re-emphasize the centrality of primary care in our

health care system. For questions, please reach out to Erica Cischke, Senior Manager, Legislative and Regulatory Affairs at [ecischke@aafp.org](mailto:ecischke@aafp.org).

Sincerely,



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Board Chair, American Academy of Family Physicians

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<sup>i</sup> Halpin HA, Harbage P. The Origins And Demise Of The Public Option. Health Affairs. 2010;29(6):1117-1124.

<sup>ii</sup> Holahan J, Clemans-Cope L, Buettgens M, Favreault M, Blumberg LJ, Ndwandwe S. The Sanders single-payer health care plan. 2016; <http://www.urban.org/sites/default/files/publication/80486/200785-The-Sanders-Single-Payer-Health-Care-Plan.pdf>. Accessed Apr. 19, 2017

<sup>iii</sup> Himmelstein, D. [A comparison of hospital administrative costs in eight nations: U.S. costs exceed others by far](#). Accessed July 3, 2018

<sup>iv</sup> Gallup Poll: Cost Still a Barrier Between Americans and Medical Care. November 2014. <https://www.cdc.gov/nchs/data/databriefs/db317.pdf>

<sup>v</sup> Collins SR, Gunja MZ, Blumenthal D, et al. What are Americans' views on the coronavirus pandemic? NBC News/Commonwealth Fund health care poll. Published March 20, 2020. Accessed January 22, 2021. <https://www.commonwealthfund.org/publications/surveys/2020/mar/what-are-americans-views-on-coronavirus-pandemic>