



Charles N. Kahn III
President and CEO

July 30, 2021

The Honorable Patty Murray
154 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Frank Pallone
2107 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairs Murray and Pallone:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, D.C and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH strongly shares your commitment to provide access to affordable coverage for all Americans, and thanks you for your leadership as we work together to make that a reality. The FAH's commitment to universal coverage is long-standing and unwavering. We were among the first health care groups to support and work tirelessly towards the enactment of the Affordable Care Act. And before that, the FAH was the first major health association to roll out a template for universal coverage, Health Coverage Passport, the key elements of which were embodied in the ACA – preserving popular employer-based coverage, reinforcing Medicare and Medicaid, and providing additional coverage options through subsidized private coverage offered on competitive marketplace platforms.

The success of the ACA is evidenced in part by the 31 million Americans who, today, have gained coverage through its provisions. While there is clearly more work to do, the best, if not only approach is to build on the ACA's foundation that balances public and private coverage. That work has begun in earnest following a decade of controversy that is finally subsiding. With your support, Congress recently enacted important ACA coverage enhancements. To further sustain ACA's successes, we need to expand those improvements, make them permanent, and fill the Medicaid coverage gap.

Introducing an untested Medicare-like public option, however, threatens to unwind much of what we have achieved through the ACA, without materially expanding coverage beyond what a strengthened ACA, as originally envisioned by Congress, would attain. This is well documented in the attached comments, which we strongly endorse, filed by the Partnership for America's Health Care Future. The FAH is a founding member of the Partnership, sits on the Executive Committee of its Board, and actively participates in its broad research program. That research details, among other findings, the disruptive impact of a public option, especially how it would undermine the range of coverage options available today and drain resources from hospitals and health systems struggling to emerge from the pandemic. ACA is a proven pathway to expanding coverage and providing all Americans with the health security that they deserve. We should continue to build upon what works.

Thank you for the opportunity to comment. We look forward to continuing this important dialogue and working with you to assure all Americans have comprehensive, affordable, high-quality health care coverage.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Reinhart". The signature is fluid and cursive, with a large initial "A" and "M".

Attachment



PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE

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The Honorable Patty Murray
154 Russell Senate Office Building
Washington, D.C. 20510

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2107 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairs Murray and Pallone:

We are writing on behalf of leaders from throughout the U.S. health care community in response to your Request For Information (RFI) regarding the creation of a public option health insurance program.

The Partnership for America's Health Care Future (PAHCF) – an organization with over 150 members made up of the nation's leading doctors, nurses, clinicians, community hospitals, health insurance providers, biopharmaceutical companies and other stakeholders nationwide – believes every American deserves access to affordable, high-quality health coverage and care regardless of income, age, race, disability or zip code.

We thank you for your leadership and share in your aspiration to ensure that all Americans have access to high quality and affordable health care coverage. However, we believe that strengthening our current health care system – well within reach this Congress by making permanent enhanced Affordable Care Act (ACA) subsidies and closing the Medicaid coverage gap – will achieve our shared objective without creating a new, unfunded health insurance bureaucracy. Moreover, a public option will likely have a minimal impact in terms of achieving its intended goal, while simultaneously threatening access to care for millions of patients.

Americans today have multiple options available to acquire health coverage – including Medicaid, Medicare, employer sponsored insurance, individual markets, and exchanges. We should strive to continue building upon these proven programs, as we have already seen the successes of multi-pronged enhancements made in 2021. In the 11 years since the Affordable Care Act was signed into law, it has driven and achieved substantial coverage gains even as it faced substantial legislative and judicial challenges. Today, it is providing quality health coverage to approximately 31 million Americans.¹

Creating a newly untested and unaffordable government-run health insurance system, like a public option, would have unintended consequences beyond simply creating another coverage plan. Public option and Medicare expansion proposals have been clearly identified as a path towards a single payer, government-run health care system. Advocates of a public option have been clear that the long-term goal is to increase

¹ "New HHS Data Show More Americans than Ever Have Health Coverage through the Affordable Care Act," [HHS](#), 6/5/21



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government-run plan enrollment as a stepping stone towards Medicare for all, as evidenced over the last couple of years:

- “The truth is, if you have a buy-in over a four or five year period, you move us to single payer more quickly,” adding that under such a system, the “step to single payer is so short.”²
- [A public option] proposal would serve as an “on ramp to a single-payer system” and lead to the “slow death of private insurance.”³

Through our research and work, it has also been made abundantly clear that establishing a public option would threaten existing coverage options, which is exemplified in more detail below. There are many potential consequences – beyond the exorbitant cost – that must be taken into account when considering whether to create a new government health insurance system so that we can fully understand the potential impact on our current health care system. Only after full consideration of the many consequences can we fully understand the potential negative impact that a public option would have on our current health care system and most important, our patients.

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)?*

An important question in reviewing potential changes to our current health care system is: what are these proposals trying to fix? In terms of cost and coverage, enhancements to the ACA in the past year have resulted in tremendous progress on both fronts, with millions more Americans now eligible for affordable, high-quality health insurance.

With the American Rescue Plan Act’s (ARPA) expansion of Premium Tax Credit (PTC) subsidies, 63 percent of the entire uninsured population in America is now eligible for financial assistance to obtain coverage through the Health Care Marketplaces, a Basic Health Plan or Medicaid. Four out of 10 uninsured people are already eligible for a free or nearly free health care plan under existing law.⁴

More than one million consumers now have health coverage that costs \$10 or less per month via the federal Health Insurance Marketplace.⁵

² 2019 Democratic presidential debate in Miami, Transcript from [The New York Times](#), 6/27/19.

³ Daniella Altimari, “As Democrats shift left and debate ‘Medicare for All,’ what does that mean for the Insurance Capital?” [Hartford Courant](#), 2/4/19.

⁴ Matthew Rae, Cynthia Cox, Gary Claxton, Daniel McDermott and Anthony Damico, “How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured,” Kaiser Family Foundation, 3/25/21.

⁵ “Four in Ten New Consumers Spend \$10 or Less Per Month for HealthCare.gov Coverage Following Implementation of American Rescue Plan Tax Credits,” [Centers for Medicare and Medicaid Services](#), 6/14/21.



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As of 2021, nearly 31 million Americans have gained coverage under current law.⁶ Just between February 15 and June 30, 2021 during the Special Enrollment Period, more than two million people have signed up for health care coverage through healthcare.gov and state-based exchanges.⁷

The current health care system has lowered adult uninsured rates and reduced racial and ethnic coverage inequities in almost every state over the past decade.⁸

And even prior to passage of ARPA subsidies, individual markets were showing signs of improvement through lower premiums and increased issuer participation. Only four percent of HealthCare.gov enrollees had access to only one issuer, while more than three quarters had access to at least three issuers.⁹ This provided an ideal foundation for new subsidies to help individuals gain coverage.

Altogether, the current health care system has lowered adult uninsured rates and reduced racial and ethnic coverage inequities in almost every state over the past decade.¹⁰

Of course, too many Americans remain uninsured. But it is important to understand the composition of this population before formulating policy solutions to address this need. At present, the bulk of the nation's uninsured are undocumented immigrants (3.9 million people), those who have offers of employer coverage that are deemed unaffordable (3.5 million people) and those in the Medicaid coverage gap (2.2 million people),¹¹ defined as adults whose incomes are above their state's eligibility for Medicaid but below the federal poverty line, the minimum income eligibility for tax credits through the federal marketplace.

We can address eligibility through existing coverage options. To realize the goal of every American having access to affordable, high-quality health coverage and care, we must help these uninsured groups. However, creating a public option or a program like Medicare at 60 would be duplicative of current health care law while simultaneously introducing a range of potential costs and consequences. Rather, we are encouraged that Congress is actively seeking to make the ARPA enhanced ACA subsidies permanent, as well as close the Medicaid coverage gap and continue to incentivize states to expand Medicaid.

At a time when recent enhancements to our health care law are providing millions of Americans with improved access to affordable, high-quality health coverage and care, we encourage you to be building on this progress by coming together to make those enhancements permanent – a proposal which enjoys

⁶ Ricardo Alonso-Zaldivar and Amer Madhani, "Biden turns to Obama to help boost health care enrollment," [Associated Press](#), 6/5/21

⁷ "Health Care Sign Ups Surpass 2 Million During 2021 Special Enrollment Period Ahead of Aug. 15 Deadline", [Centers for Medicare and Medicaid Services](#), 7/14/2021.

⁸ Jesse C. Baumgartner, Sara R. Collins, David C. Radley, "Racial and Ethnic Inequities in Health Care Coverage and Access, 2013–2019," [The Commonwealth Fund](#), 6/9/21

⁹ "Premiums for HealthCare.gov Plans Are Lower for Third Consecutive Year," [CMS](#), 10/19/20

¹⁰ Jesse C. Baumgartner, Sara R. Collins and David C. Radley, "Racial and Ethnic Inequities in Health Care Coverage and Access, 2013–2019," [The Commonwealth Fund](#), 6/9/21

¹¹ Rachel Garfield, Kendal Orgera and Anthony Damico, "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid," [Kaiser Family Foundation](#), 1/21/21



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broad support and would be more effective at getting Americans covered so they can get healthy and stay healthy.

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

To ensure Americans have access to affordable, high-quality health coverage and care, Congress should build on the ACA, including permanently authorizing the enhanced premium tax credits and expanding Medicaid in remaining non-expansion states.

Research indicates that creating a public option could in fact have negative consequences for Americans' access to coverage options and quality care.

While the public option aims to expand health care coverage, the coverage gains under the policy are likely to be limited, reducing the overall national uninsured rate by merely 0.7 percentage points.¹²

At the same time, the public option could cause coverage disruptions and premium increases for currently insured Americans, a reduction in coverage options, and reduced access to care for seniors and low-income families, while also harming care providers and existing health plans.¹³

One report found that, of the hospitals in the sample, approximately half would lose money due to the public option's lower reimbursement rates, totaling \$1.3 billion. More than 500 of these hospitals are already operating at a significant loss and would be at higher risk of financial distress under a public option scenario. These higher risk hospitals could be forced to reduce service lines, shorten appointment times or make staffing changes in order to compensate for lost revenue, thereby diminishing the availability of essential health care services.¹⁴

In this report's analysis, almost one-third of the hospitals at higher risk under the public option serve populations in which racial and ethnic minority patients are overrepresented and for whom barriers such as lack of reliable transportation may limit access to alternative sources of care. One-fourth of the at-risk hospitals serve rural areas, and 90 percent are the only hospital in their county.¹⁵

Another study found the public option could put a \$774 billion financial strain on hospitals over a 10-year period, potentially forcing hospitals to reduce staff and eliminate services as they operate on a negative

¹² "Ripple Effects: Potential Impacts of a National Public Option on Provider Viability and Disparities in Access to Care," [FTI Consulting](#), 7/14/21

¹³ "A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications," [Congressional Budget Office](#), 4/21

¹⁴ "Ripple Effects: Potential Impacts of a National Public Option on Provider Viability and Disparities in Access to Care," [FTI Consulting](#), 7/14/21

¹⁵ "Ripple Effects: Potential Impacts of a National Public Option on Provider Viability and Disparities in Access to Care," [FTI Consulting](#), 7/14/21



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profit margin due to lower reimbursement rates. This could result in reduced access to services for patients, and potential closure of hospitals.¹⁶

Yet another study concurred that dramatic changes in provider reimbursement rates could have profound effects on the health care system and hospitals. It found hospitals most at risk under the public option admitted more children and non-Hispanic Asian or Pacific Islander patients as a share of total admissions than hospitals with lower ratios of private to total charges. Additionally, the report found reductions in private payment rates may make it more difficult for rural hospitals to hire additional physicians, specialists, or other health care professionals in areas already facing shortages of such workers. The report found that hospitals with the greatest exposure to private payers – teaching hospitals, nonprofit nongovernmental hospitals and hospitals in metropolitan regions – would most likely be implicated by lower reimbursement rates under the public option.¹⁷

Overall, the public option could drastically alter the current health care market. It could drive an estimated 60 million people (40 percent of the market) out of employer sponsored insurance which could potentially eliminate the entire private exchange market.¹⁸ A public option could force up to two million Americans off their current coverage and leave eight million Americans without a private coverage option while increasing coverage by less than 1 percent.¹⁹

A narrower version of the public option, such as lowering the Medicare eligibility age to 60, could have similar results. Medicare at 60 could negatively affect hospitals and medical providers that are already financially strained by drastically reducing the reimbursement rates they receive. These potentially unsustainable cuts could mean lower quality and less access to care for the current Medicare-eligible population.²⁰

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

Even if premium assistance is provided alongside introduction of a public option, the cost of that premium assistance would likely be redistributed elsewhere. The public option could have significant impacts on America's future fiscal condition and either increase the federal debt or require higher taxes on American families.²¹

¹⁶ Lane Koenig, Ph.D., Asha Saavoss, Samuel Soltoff, Berna Demiralp, Ph.D. and Jing Xu, Ph.D., "The Impact of Medicare-X Choice on Coverage, Healthcare Use, and Hospitals," [KNG Health Consulting](#), 3/12/19

¹⁷ Anuj Gangopadhyaya and Claire O'Brien, "Which Hospitals Could Be Financially Affected by a Public Option?" [Urban Institute](#), 3/21

¹⁸ Jeremy Nighohossian, Ph.D. and Sabiha Quddus, M.S., "Policy Options to Increase Health Care Coverage and Affordability: Comparing Enhancements to the Affordable Care Act and a Public Option," [FTI Consulting](#), 5/21

¹⁹ Susan H. Manning, Ph.D. and Jeremy Nighohossian, Ph.D., "Assessing the Impact of a Public Option on Market Stability and Consumer Choice," [FTI Consulting](#), 11/19/19

²⁰ Lanhee J. Chen, Ph.D., New Report: "Medicare At 60' Could Come with Large Price Tag, Higher Costs For Americans," [Partnership for America's Health Care Future](#), 6/23/21

²¹ Lanhee J. Chen, Ph.D., Tom Church and Daniel L. Heil, "Economic Shocks and Probable Expansions to a Public Option," [Partnership for America's Health Care Future](#), 2/21



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A public option could add \$700 billion to the federal deficit in its first 10 years and would become the third most expensive government program behind Medicare and Social Security, both of which are already at risk for the seniors who rely on them.²²

A public option could also lead to a new 4.8 percent payroll tax or increases in marginal tax rates for most American families to finance the new program, which exceeds the combined Medicare payroll tax Americans pay today.²³

Similarly, lowering the Medicare eligibility age, such as through Medicare at 60, could result in an increase in taxes for the American people. In fact, Congress could raise the additional Medicare tax rate by 285 percent in 2022, setting it at 3.5 percent in addition to the 2.9 percent for the standard Medicare payroll tax. The plan would also increase the deficit by \$32.2 billion in 2022 and \$393.9 billion over the next 10 years (2022 to 2031).²⁴

At the same time, improvements to current law are already helping lower costs for Americans.

The number of individuals eligible for a subsidy to purchase Marketplace coverage has increased 20 percent from 18.1 million to 21.8 million. The majority of uninsured people (63 percent) are now eligible for financial assistance through the Marketplaces, Medicaid, or Basic Health Plans thanks to ARPA.²⁵

ARPA's expanded Premium Tax Credits have reduced monthly premiums for new enrollees by an average of 25 percent. Americans have been able to sign up for health insurance plans that have lower out-of-pocket maximums with the mean deductible for new consumers falling by nearly 90 percent.²⁶ More issuers have continued to offer coverage on the Exchanges.²⁷

Improving our current health care system with reforms similar to ARPA could reduce net premiums by 24 percent on average and save consumers approximately \$10.6 billion annually.²⁸

²² Lanhee J. Chen, Ph.D., Tom Church and Daniel L. Heil, "The Fiscal Effects Of The Public Option," [Partnership for America's Health Care Future](#), 1/24/20

²³ Lanhee J. Chen, Ph.D., Tom Church and Daniel L. Heil, "The Fiscal Effects Of The Public Option," [Partnership for America's Health Care Future](#), 1/24/20

²⁴ Lanhee J. Chen, Ph.D., New Report: "Medicare At 60' Could Come with Large Price Tag, Higher Costs For Americans," [Partnership for America's Health Care Future](#), 6/23/21

²⁵ Matthew Rae, Cynthia Cox, Gary Claxton, Daniel McDermott and Anthony Damico, "How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured," [Kaiser Family Foundation](#), 3/25/21

²⁶ "2021 Marketplace Special Enrollment Period Report," [Centers for Medicare & Medicaid Services](#), 5/6/21

²⁷ "Premiums for HealthCare.gov Plans Are Lower for Third Consecutive Year," [CMS](#), 10/19/20

²⁸ Jeremy Nighohossian, Ph.D. and Sabiha Quddus, M.S., "Policy Options to Increase Health Care Coverage and Affordability: Comparing Enhancements to the Affordable Care Act and a Public Option," [FTI Consulting](#), 5/21



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If these subsidies were made permanent, an additional 4.5 million individuals could gain health coverage and health care premiums nationally could fall by 15 percent.²⁹

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

While many states have attempted to create a state government-controlled public option in an effort to reduce costs and improve access, none have succeeded in accomplishing their stated objectives.

Washington's public option has failed to lower health insurance premiums for the majority of consumers and actually increased premiums in counties with greater health insurance competition.³⁰ The program has also resulted in higher premiums compared to private-sector plans in many circumstances. Public option plans offered through Washington's exchange cost up to 29 percent more than traditional plans according to the Washington Health Benefit Exchange.³¹

Similar attempts to create government-controlled health insurance systems at the state level have also failed due to unaffordable costs and tax increases. In fact, more than 20 states have tried and failed to create a public option.³² As states have considered creating a public option, doing so may only marginally expand access to coverage.

One previously proposed state public option plan in Colorado would only have increased the insured rate by 0.3 percent, but 78 percent of the state's hospitals would face cuts to reimbursements totaling up to \$112 million in losses annually, and, of the hospitals at risk of closure, forty (40) percent of them serve racial and ethnic minority communities.³³

A proposed public option in Colorado could have caused 23 rural hospitals, of which one-third already operate at a loss, to shut down due to restrictive reimbursement rates from a state government option.³⁴

Lastly, ARPA subsidies could lessen the effect of a public option on coverage rates, as many of those who would otherwise have been uninsured and interested in plans through the public option would already be enrolled through expanded eligibility for marketplace subsidies.³⁵

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

²⁹ Jessica Banthin, Matthew Buettgens, Michael Simpson and Robin Wang, "What if the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022," [Urban Institute](#), 4/14/21

³⁰ "Five Things Lawmakers Should Consider Before the Next Round of the Public Option Debate," [Common Sense Institute](#), 2/11/21

³¹ Sara Hansard, "First Government-Run Health Plan Portends Rocky Start for Biden," [Bloomberg](#), 11/18/20

³² Katie Mahoney, "Washington State Public Option Fails to Deliver Savings to Consumers," [U.S. Chamber of Commerce](#), 9/8/20

³³ "Colorado Government Option: Impact on Racial and Ethnic Minority Groups," [FTI Consulting](#), 5/21

³⁴ Susan Manning, Ph.D. and Jeremy Nighohossian, Ph.D., "Colorado's Government Option: Assessing the Impact of Reforms on Access to Health Care," [FTI Consulting](#), 1/16/20

³⁵ "A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications," [CBO](#), 4/21



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As a starting point, expanding Medicaid in the 12 non-expansion states would be an effective way of improving access to affordable, high-quality health coverage and care.

Closing the Medicaid coverage gap – where individuals have incomes above their state's eligibility for Medicaid but below the federal poverty line – could insure 2.2 million of the uninsured population and an additional 1.8 million uninsured adults in these non-expansion states who are currently eligible for marketplace coverage but would then be eligible for Medicaid.³⁶

Current laws have significantly reduced U.S. racial and ethnic disparities in health insurance coverage. The adult uninsured rates and racial and ethnic coverage inequities declined in nearly every state, particularly in states that built on what's working by expanding Medicaid eligibility.³⁷

The combination of continuing ARPA's enhancements and closing the Medicaid coverage gap could insure 5.0 million people in 2022.³⁸

Implementing ACA enhancements and expanding Medicaid in the 12 non-expansion states could result in significant coverage gains among vulnerable populations without threatening private coverage.³⁹

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?*

Creating the public option could harm access to and quality of care, particularly among already underserved minority and rural communities.

The public option could force health care providers to shorten appointment times, make staffing changes or eliminate services in order to remain financially viable. This could exacerbate healthcare inequality and disproportionately impact vulnerable populations who already face barriers to access to care and experience worse health outcomes.⁴⁰

Reduced reimbursement rates through the public option could harm racial and ethnic minority patients. Many of the hospitals already at risk for closure serve predominantly minority communities who could be left without a health care provider, especially in the southwestern United States.⁴¹

³⁶ Robin Rudowitz, Rachel Garfield and Larry Levitt, "Filling the Coverage Gap: Policy Options and Considerations," [Kaiser Family Foundation](#), 4/22/21

³⁷ Jesse C. Baumgartner, Sara R. Collins and David C. Radley, "Racial and Ethnic Inequities in Health Care Coverage and Access, 2013–2019," [The Commonwealth Fund](#), 6/9/21

³⁸ John Holahan, Matthew Buettgens, Jessica S. Bathin and Michael Simpson, "Filling the Gap in States That Have Not Expanded Medicaid Eligibility," [The Commonwealth Fund](#), 6/30/21

³⁹ Jeremy Nighohossian, Ph.D. and Sabiha Quddus, M.S., "Policy Options to Increase Health Care Coverage and Affordability: Comparing Enhancements to the Affordable Care Act and a Public Option," [FTI Consulting](#), 5/21

⁴⁰ "Ripple Effects: Potential Impacts of a National Public Option on Provider Viability and Disparities in Access to Care," [FTI Consulting](#), 7/14/21

⁴¹ "Ripple Effects: Potential Impacts of a National Public Option on Provider Viability and Disparities in Access to Care," [FTI Consulting](#), 7/14/21



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And, relative to specialized Medicaid managed care plans that prioritize care coordination and address social determinants of health, the public option may not provide the coverage necessary to meet the unique health care needs of at-risk, low-income populations.⁴²

The potential closure of hospitals under the public option could affect rural communities as well. One in four hospitals in rural communities could be at risk of closure and in many of these communities are the only source of health care.⁴³

Fifty-five (55) percent of rural hospitals could be at risk of closure due to the lower reimbursement rates they would be forced to accept, compounding the financial trouble they already face.⁴⁴

Conclusion

74 percent of Americans rate their health care coverage as “excellent” or “good” today.⁴⁵ Any changes to our nation’s health care system should prioritize improving affordability while expanding access to the high-quality health coverage and care most Americans currently can access.

As shown above, a substantial body of research suggests that creating a public option could threaten to increase health care costs, decrease the quality of health care, and harm access to health care options for millions of Americans while only marginally increasing coverage.

Analysis shows paying for the public option could require new taxes on American families and would represent the third largest government program at a cost of \$700 billion. At the same time, health care providers may find it increasingly difficult to deliver quality care sufficient to meet patients’ needs as they are forced to accept lower reimbursement rates, which could disproportionately impact rural communities and communities of color. The public option could also threaten the existing private health care insurance market on which Americans rely, eliminating options for health care outside of the government-controlled health insurance system.

Instead, the evidence shows building on and improving what’s working in health care, where private coverage, Medicare, and Medicaid expand access to coverage and care, while fixing what’s not, such as by permanently extending the ARPA subsidies and closing the Medicaid coverage gap or the non-expansion of Medicaid in states, is the most effective way to improve affordability and access to care while not disrupting the health care coverage Americans are overwhelmingly satisfied with.

⁴² “Ripple Effects: Potential Impacts of a National Public Option on Provider Viability and Disparities in Access to Care,” [FTI Consulting](#), 7/14/21

⁴³ “Ripple Effects: Potential Impacts of a National Public Option on Provider Viability and Disparities in Access to Care,” [FTI Consulting](#), 7/14/21

⁴⁴ Jeff Goldsmith and Jeff Leibach, “The Potential Impact Of A Medicare Public Option On U.S. Rural Hospitals And Communities: A Scenario Analysis,” [Navigant](#), 8/19

⁴⁵ Jeffrey Jones and Megan Brenan, “Americans’ Satisfaction With Health Costs at New High,” [Gallup](#), 12/14/20



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Thank you again for considering the data and rigorous research above as you consider ways to improve coverage options for Americans. The Partnership for America's Health Care Future welcomes a dialogue with Congress and hopes to be a resource as discussions continue. We remain committed to a constructive debate about how best to build on what's working in health care and fix what's broken. To that end, our guiding principles are listed below.

ACCESS: Strengthen the employer provided coverage millions of Americans rely on and defend protections for Americans living with pre-existing conditions, all while ensuring access to care through the health care exchanges, strengthening Medicaid for the uninsured, and protecting Medicare programs for our most vulnerable.

- Encourage employers to maintain employer provided benefits by maintaining or expanding tax preferences for the provision of benefits to a healthy workforce.
- Restore and expand outreach and enrollment funding and re-engage with partner organizations to boost enrollment through the health care exchanges.
- Close the coverage gap and advocate for full state adoption of Medicaid expansion so Americans making below 138 percent of the federal poverty level can receive health coverage and care and provide additional federal support for new states to expand Medicaid.
- Enhance federal funding for Medicaid during economic downturns to ensure the program is affordable for states and allows Medicaid to continue to deliver care for those who need it.
- Eliminate Medicaid changes, such as work requirements and other barriers that would reduce access to coverage and care.

AFFORDABILITY: Promote policies that encourage competition throughout the health care delivery system, which will assure equitable access to affordable, high-quality coverage and care options for all Americans.

- Improve affordability for working families and ensure Americans pay an amount they can afford for their health insurance.
- Increase cost-sharing subsidies for people with incomes up to 300 percent of the federal poverty level.
- Enhance health care spending account (HSA) allowances by enabling employees to use their HSAs to pay for insurance premiums and telehealth services and allow for Americans in high deductible health plans additional flexibility to cover items and services, such as additional medications to treat and prevent chronic conditions.
- Safeguard the future of Medicare and ensure that strong public-private partnerships can work together to deliver care and coverage for our most vulnerable.

QUALITY: Accelerate value-based reimbursement and development of evidence-based guidelines to deliver more personalized and patient-centric care — particularly for those with chronic conditions — while addressing social determinants of health and promoting health equity.



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- Advance preventive care solutions like worksite clinics and wellness programs to improve employee health on a day-to-day basis.
- Support efforts to securely share health record data across systems and advance critical data infrastructure at the local, state, and federal levels to facilitate secure health record data-sharing, enhance the ability to identify critical health needs, and monitor emerging public health emergencies.
- Accelerate the move to value-based payments using consistent, easy to understand measures of quality to improve health care, eliminate health disparities, and deliver value.
- Bolster testing and deployment of innovative solutions such as digital health technologies and telehealth that can improve quality of care and facilitate remote access to medical services where appropriate.

If we can ever be a resource for you, please reach out. Our research can be found online [here](#).

Lauren Crawford Shaver
Executive Director
Partnership for America's Health Care Future