

SUBJECT: Design considerations for a public health insurance option

Dear Chairman Pallone and Chairwoman Murray:

As children's health insurance researchers and policy experts at PolicyLab at Children's Hospital of Philadelphia (CHOP), we welcome this opportunity to respond to the House Energy and Commerce and Senate HELP Committees' request for information on design considerations for a public health insurance option.ⁱ

We share your commitment to ensuring that all people living in the United States, including children, have access to comprehensive, affordable health coverage, and appreciate your leadership on this critical issue. We also welcome your recognition of the rising cost burden of health coverage for many families and that this needs to be addressed. Our researchⁱⁱ shows that working families have been seeking alternatives to employer-based insurance for their children for years, likely in response to the rising cost to families, fewer employers providing family coverage, and the desire for the comprehensive benefits offered by Medicaid and the Children's Health Insurance Program (CHIP).

While a public health insurance option may be a useful mechanism for addressing this problem, we strongly urge you to ensure that child and dependent coverage is considered in its design. In doing this, it is essential to address the unfortunate "family glitch" within the Affordable Care Act that has left millions of people without access to marketplace premium subsidies. It has also reinforced the persistent issue of underinsurance for families, defined by high out-of-pocket costs that discourage seeking care and limited benefit packages and/or provider networks, which means that families do not have meaningful, comprehensive coverage.

As we laid out in a recent *Health Affairs* blog post,ⁱⁱⁱ reforms through the American Rescue Plan Act, while critical, do little to address the fundamental issues of underinsurance for working families that are becoming the norm in the employer-based insurance and health insurance marketplaces. We urge that further reforms, including this exploration of a federally administered public option, work to address these shortcomings, and do not neglect the specific needs of children and families seeking dependent coverage in their design and implementation.

Below are more detailed responses to a subset of the questions in your request for information. We would welcome the opportunity to further discuss this feedback—please contact Rebecka Rosenquist at rosenquisr@chop.edu.

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)?

While we will not offer feedback on specific eligibility categories for a federally administered public health insurance option, we instead urge consideration of how eligibility decisions may impact families and also intersect with current gaps in health coverage. Considering eligibility for a public option provides the perfect opportunity to reexamine affordability for families,

including how subsidies have been calculated on the marketplace, creating the so-called “family glitch” referenced above. Since their inception as part of the Affordable Care Act, the health insurance marketplaces have been inaccessible to as many as 5.1 million people.^{iv} Due to the “glitch,” many working families are unable to receive premium subsidies for family coverage on the exchanges because the employer-based coverage offered to them for an individual plan, no matter the cost of family coverage, is deemed to be within defined thresholds of affordability.

Separately, in recognition of the often limited benefits of pediatric coverage through health insurance marketplace plans, many state health insurance marketplaces already direct eligible children toward Medicaid and CHIP, or to CHIP buy-in programs in the limited states in which they exist, as these are the only programs that guarantee comprehensive benefits to children. This precedent of splitting off children into public insurance programs, which are specifically designed to meet their needs, should be considered in the structural design of any public option on the marketplace.

The option of employer buy-in to a public health insurance option could potentially reduce costs for employers, aid economic recovery and more quickly get beneficiaries enrolled in a public option in greater numbers. This is something that has been explored related to children’s health insurance coverage through authorization of employer buy-in to CHIP in the 2009 CHIP Reauthorization Act, and there may be some potential to learn from this. To date, no states have exercised this option, and to do so would require addressing issues related to both risk pooling and consumer awareness that stand in the way of implementing this policy.

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

It is essential that any federally administered public health insurance option include comprehensive pediatric benefits and adequate pediatric provider networks, including specialty care and behavioral health providers. We would particularly want to see a comprehensive pediatric policy added if a public option were to build off of Medicare. Even in the current landscape, Medicare, which by design does not serve children, often determines benefit and network structures to the detriment of children’s health.

Again, we would urge consideration of how well Medicaid and CHIP serve the children enrolled in them. While Medicaid has suffered from historically low provider payment rates, and this urgently needs to be addressed, in research that compares access and quality across different pediatric insurance products, children on Medicaid had similar success with finding a specialist as those with private insurance coverage,^v and, in behavioral health, the options, while dismally limited, are often better than in commercial coverage. To ensure it reaches families, any effort on establishing a public option should set aside funding to raise awareness of coverage availability as well as assistance with enrollment.

Even in Medicaid and CHIP, access needs to be protected and continually improved upon, and coverage alone does not equate to access. Recognizing inadequate pediatric access to specialty care for children on Medicaid, the New Jersey legislature just passed a pediatric network adequacy bill that requires the full range of pediatric services be available in-network to families and that the care be within certain time and distance requirements of their homes.^{vi} While implementation and enforcement of these requirements will ultimately define the success of this effort, taking a similar approach at the federal level would greatly improve access to pediatric

care, especially for underserved communities for whom barriers to out-of-network services, not to mention the burden associated with traveling far from home, can make care unattainable.

How should the public option’s benefit package be structured?

Consideration of the public option’s benefit package should be done hand-in-hand with strengthening the essential health benefit standard to improve children’s coverage on the health insurance marketplaces. Any legislation on a federally administered public option should spell out that the full spectrum of pediatric care be readily available. Without this national standard, many current marketplace plans fail to fully address children’s health needs. Moreover, there has been a state-by-state patchwork of coverage with exclusions, resulting in particularly limited coverage for behavioral health, dental or vision services for children.^{vii}

Here again, Medicaid, with its Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement, or even standalone CHIP plans, have historically provided a broad spectrum of pediatric benefits with limited cost-sharing that serve children well. To best serve children enrolling in a public option, we would urge looking to Medicaid EPSDT benefits as a model and benchmark.

We would additionally draw attention to the importance of designing a benefit package that is not only robust, but that has minimal cost-sharing for children and families. Between 2010 and 2020, the average deductible for employer-based family health insurance increased by a staggering 111%.^{viii} Such high direct costs to families are, however, not limited to employer-based plans; as of 2021, the out-of-pocket limit for a family plan on the marketplace was \$17,100. These out-of-pocket maximums place substantial financial strain on families and functionally limit their access to necessary services. A public health insurance option on the marketplace would provide the most utility with a low deductible that allows families to access the care that they need without high financial burden.

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

We again would reiterate the importance of addressing “the family glitch” in order to allow more families facing high costs for family coverage through their employers to access subsidies on the health insurance marketplaces—see above for additional detail. Premium assistance on the health insurance marketplace, including for the public option, should be pegged to family premiums, not just individual.

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

There is a strong body of evidence on the positive impact of Medicaid and CHIP in childhood, including that children with Medicaid coverage are more likely than low-income, uninsured children to report a usual source of care and receive the periodic well-child care appointments recommended by the American Academy of Pediatrics. They have also been less likely to report having unmet or delayed needs for medical care, dental care and prescription drugs because of cost.^{ix} We include these findings to highlight the importance of Medicaid and CHIP, which together insured nearly 40% of all children before the COVID-19 pandemic, and likely now an even higher proportion due to increased enrollment during the pandemic.

PolicyLab research has highlighted that working families have increasingly turned to Medicaid and CHIP for dependent coverage, even as the parents may have stayed on their employer-based insurance. Furthermore, there is precedent of state-based marketplaces facilitating this “splitting off” of dependent coverage into Medicaid or CHIP for children who are eligible when their parents seek coverage on the marketplaces, given the track record of these programs in serving children, their comprehensive benefits packages and limited cost-sharing. The proposed public option may be the best fit for parents, but we would recommend further exploration of the tradeoffs—including cost and benefit structure—of enrolling a family in a public option’s family plan versus solidifying or formalizing the practice of splitting off children into Medicaid or CHIP.

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

With innovation in its benefit structure and payment models, a public option could go a long way in supporting a focus on population health and improving health equity. You could consider higher capitation or value-based payment models to support care management and initiatives to manage health—behavioral and physical—and address the social determinants of health in community and primary care settings.

Thank you for taking the time to consider our feedback. We welcome opportunities to continue to engage with you.

Sincerely,

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ⁱ House Energy and Commerce and Senate HELP Committee. https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Public%20Option.2021.5.26_FINAL.pdf Accessed July 15, 2021

ⁱⁱ Strane D, French B, Eder J, Wong CA, Noonan KG, Rubin DM. Low-Income Working Families With Employer-Sponsored Insurance Turn To Public Insurance For Their Children. *Health Affairs*. 2016; 35(12). doi:10.1377/hlthaff.2016.0381

ⁱⁱⁱ Strane D, Rosenquist R, Rubin DM. Leveraging Health Care Reform To Address Underinsurance In Working Families. *Health Affairs Blog*. <https://www.healthaffairs.org/doi/10.1377/hblog20210611.153918/full/>. Published June 15, 2021. Accessed July 15, 2021

^{iv} Cox C, Amin K, Klaxton G, McDermott D. The ACA Family Glitch and Affordability of Employer Coverage. Kaiser Family Foundation. <https://www.kff.org/health-reform/issue-brief/the-aca-family-glitch-and-affordability-of-employer-coverage>. Published April 7, 2021. Accessed July 15, 2021

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- ^v Kreider AR, French B, Aysola J, Saloner B, Noonan KG, Rubin DM. Quality of Health Insurance Coverage and Access to Care for Children in Low-Income Families. *JAMA Pediatr.* 2016;170(1):43-51. doi: 10.1001/jamapediatrics.2015.3028
- ^{vi} New Jersey State Senate Bill #3000. https://www.njleg.state.nj.us/2020/Bills/S3000/3000_R4.PDF. Accessed July 15, 2021
- ^{vii} Grace AM, Noonan KG, Cheng TL, Miller D, Verga B, Rubin D, Rosenbaum S. The ACA's Pediatric Essential Health Benefit Has Resulted In A State-By-State Patchwork Of Coverage With Exclusions. *Health Affairs.* 2014; 33(12). doi: 10.1377/hlthaff.2014.0743
- ^{viii} Kaiser Family Foundation. 2020 Employer Health Benefits Survey. <https://www.kff.org/health-costs/press-release/average-family-premiums-rose-4-to-21342-in-2020-benchmark-kff-employer-health-benefit-survey-finds/> Published October 8, 2020. Accessed July 15, 2021
- ^{ix} Paradise J, Garfield R. What Is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence. Kaiser Family Foundation. <https://www.kff.org/report-section/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief/> Published August 2013. Accessed July 15, 2021