July 29, 2021

The Honorable Frank Pallone, Jr.
Chairman
House Committee on Energy and Commerce
Washington, DC 20515

The Honorable Patty Murray
Chair
Senate Committee on Health, Education, Labor and Pensions
Washington, DC 20510

Dear Chairman Pallone and Chair Murray:

The American College of Surgeons (ACS) is the largest surgical organization in the U.S., representing more than 82,000 members from all states and surgical specialties. The ACS was founded in 1913 and is dedicated to high-quality, safe surgical care delivered in a compassionate, ethical manner. Surgeons perform approximately 30 million operations annually in the U.S. Although the ACS appreciates the challenges facing the U.S. health care system, the organization also emphasizes that many aspects of surgical health care in the U.S., including surgical education and training, are the best in the world.

The ACS strongly supports efforts to ensure access to timely, patient-centered, affordable, and high-quality health care. We maintain that surgeons are an indispensable and irreplaceable component in the delivery of safe, high-quality health care.

To this end, the ACS believes that continued efforts directed at ensuring access to quality surgical care should be guided by the following core principles:

- Quality and safety
- Timely patient access to surgical care
- Reduction of health care costs

Achieving these goals and building a better health care delivery system will require all stakeholders to work together. If Congress advances legislation developing a public insurance option, it should above all ensure that such an offering meets the needs of enrollees, including surgical patients. This means that a public insurance offering should provide meaningful coverage for an...
inclusive set of health care services, compensation for providing care should take into account the cost of doing so and provide for reasonable profit, and the coverage should be financed through premiums paid by beneficiaries and employers or supported by the government. ACS appreciates the opportunity to respond to your request for information (RFI) and goes into depth on these issues in our responses to the questions below.

**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)?**

The expansion of Medicaid in the Affordable Care Act (ACA) provided coverage for millions of previously uninsured Americans. Further efforts directed to expand coverage must ensure that these vulnerable Americans keep their coverage and that the safety net upon which they depend is preserved until and unless other options become available that enhances their access to care. If developed, a public option should be available to anyone as coverage offered through the individual and employer-based Marketplaces created by the ACA and should compete on efficiency and quality, not simply be benchmarked to current public programs.

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

ACS proposes that the best way to ensure adequate access to providers for enrollees in a public option would be a combination of adequate and appropriate compensation levels, (preferably in the form of value-based contracts for defined episodes of care as described below), and by addressing the underlying causes of the current healthcare workforce shortages.

ACS feels strongly that if a public insurance option is instituted to compete alongside traditional insurance, it should do so on a level playing field. This means that a physician’s participation should not be tied to participation in other federal health programs such as Medicare or Medicaid, or otherwise made mandatory. Making physician participation compulsory for those
wishing to participate in Medicare or other Federal health programs could have the unintended consequence of increasing the number of physicians who instead choose to opt out completely. This would be detrimental to access to care, given recent studies that project current and growing shortages in physicians and general surgeons available to meet our nation’s healthcare needs.¹ ² ³ Shortages in surgery are in fact projected by the Association of American Medical Colleges (AAMC) to grow approximately as fast as those for primary care between now and 2034. Due to these projected shortages, Senators Brian Schatz (D-HI) and John Barrasso (R-WY) recently introduced the Ensuring Access to General Surgery Act (S. 1593)⁴ to conduct research on shortage and grant authority to create a designation for surgical shortage areas.

Any public insurance option should behave more like commercial insurance products and not Medicare. While this might require the development of administrative functions not currently in place at the Centers for Medicare and Medicaid Services (CMS), it would also create exceptional opportunities to increase efficiency and increase value through alternative payment models. Rather than setting broad national payment rates for each individual item and service in a fee-for-service framework, as has been done in the Medicare program, a public insurance option should instead negotiate rates in specific states or markets in much the same way that private insurers currently do, but with a focus on value-based care arrangements. This negotiation should account for the quality of care provided and truly and adequately reward those increasing value to the patient. A public option should avoid proposals to set physician payment rates at Medicare rates (or a set percentage thereof) as this would build on problems inherent to the current Medicare physician payment system by migrating them into the private insurance market.

As with other insurance products, the services provided should be funded through premiums paid (by the patient, employer or subsidized by the government), and payment should be sufficient to cover the costs of providing

¹ The Complexities of Physician Supply and Demand: Projections From 2019 to 2034 (AAMC)
² U.S. Department of Health and Human Services Health Resources and Services Administration Report to the Senate Committee on Appropriations. Prepared in response to Senate Report 115-289, Departments of Labor, Health and Human Services, and Education and related Agencies Appropriation Bill, 2019
³ National and Regional Projections of Supply and Demand for Surgical Specialty Practitioners: 2013-2025 (HRSA)
⁴ S.1593 – Ensuring Access to General Surgery Act (Congress.gov)
care as well as some margin of profit. In a value-based care scenario, where more attention is paid to the cost of providing care, it becomes more feasible to adequately and appropriately compensate physicians and others for the skill they bring to the table in all services they provide. This can obviate the need for cross subsidization of services which are paid below cost with others with a higher margin.

Artificially low payment rates coupled with a growing physician workforce shortage could lead to reduced access to care for patients with such coverage. However, a public insurance option could also be a valuable tool in beginning to address shortages if the proper infrastructure and resources were in place.

In 2017, the ACS published an ACS Policy and Position Paper on GME Reform which included principles and policy proposals intended to ensure access to high quality care in all parts of the country. The proposals hinged upon ongoing accurate collection and analysis of high-quality workforce data through a body such as the National Health Care Workforce Commission (NHCWC) created in the ACA (sec. 5101) but never funded. The NHCWC would be tasked with coordinating and carrying out research on health workforce needs and supply, such as the study included in the previously mentioned *Ensuring Access to General Surgery Act*. The information produced by the proposed NHCWC could be used to inform the creation of incentives and tools to ensure that all Americans have access to the workforce they need from early preventative care to emergency trauma and critical care, to end of life care. The report accompanying the House of Representatives Fiscal Year 2022 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill designated $3 million in funding for the commission and we urge the Senate to similarly support this critical work.

A public insurance option would be a logical opportunity to implement tools to ensure access to a high-quality workforce, including all of the necessary components of a community-based healthcare system, beyond primary care. This could include loan forgiveness programs for physicians who agree to participate and accept patients covered under the public insurance option or those who practice in a geographic shortage area; additional payments such as

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5 ACS Policy and Position Paper on GME Reform (ACS)
the general surgery and primary care incentive programs included in the ACA; and support for additional GME training positions, which could be partially funded through public option premiums, to ensure the nation has the right type of physicians at the right place at the right time to provide whatever care is needed. Such efforts could help to ensure access to enrollees in the public option and facilitate a more robust physician workforce.

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

If properly structured, a public insurance option could serve as an opportunity to foster efficiency and improve the quality of care experienced by patients through implementation of value-based care models.

As noted in the response to the previous question, a public insurance option should not simply be a means to reduce healthcare spending through blunt cost control measures such as setting payment rates steeply below the current level. Such an approach has failed to have the desired effect in Medicare and would likely lead to access problems for enrollees in the public option as well. Yet many proposals hinge upon setting payment rates in the public option at Medicare rates or some percentage thereof.

This would bring several problems with the current Medicare physician payment system directly into the private market. For example, unlike in Medicare Part A where formulas exist to account for inflation and the growth in cost of medical supplies and services, Medicare Part B payment updates have been largely legislated over the past 20 years. This has led to a Medicare Physician Fee Schedule conversion factor roughly equivalent to what it was in 1998 but has not successfully slowed spending growth in certain sectors of health care.

To avoid many of the same pitfalls, payments in a public insurance option should take advantage of this fresh start and, to the extent practical, avoid fee-for-service payments. Instead, the majority of payments should be in the form of value-based contracts built around coherent, patient-centered episodes of care. This approach is team-based, requires and incentivizes care-coordination, and is the most likely to achieve the goal of reigning in unwarranted spending and improving quality.
If implemented, a public insurance option could serve as a model for innovative payment structures more likely to actually achieve the goal of improving quality while maintaining or reducing spending, thereby increasing value. Achieving meaningful control over spending will require novel thinking and innovative payment structures.

One potential way to foster such innovation would be through allowing the Center for Medicare and Medicaid Innovation (the Innovation Center) to pilot or demonstrate stakeholder-developed, physician-focused payment models in the private insurance market through the public option. Additionally, existing models which have been fully vetted by the Physician-Focused Payment Model Technical Advisory Committee (PTAC), could also be tested, improved, and expanded. This would provide access to potentially higher quality, lower cost care to a new cohort of beneficiaries who may be younger and healthier than Medicare enrollees.

Regardless of the payment methodology ultimately selected by the plan or the participants, ACS has learned through ongoing efforts of the importance of understanding both cost and price. Cost and price are two sides of the same coin, but they are not identical. ACS uses “price” to describe how much is ultimately paid for something by the patient and/or insurer and “cost” to refer to the resources used, and personnel required to deliver the goods and services.7 In order for a physician, facility, or other service provider to enter into a value-based contract for a specified price, they must first have an understanding of their cost to provide that service (as well as other risk factors and pertinent information such as patient mix, etc.). For a health care system to remain financially viable, the total price paid for care must exceed the cost. When publicly funded healthcare coverage falls short of meeting the production cost of care, the necessary and predictable result is increased cost in the commercial insurance market to make up the difference. A recent analysis by the Kaiser Family Foundation for example found that private insurance rates were on average 143% of Medicare for physician services and 199% for all hospital services.8

Understanding the cost of an episode, all the steps involved, and the overall price to the patient and insurer, affords many opportunities to surgeons and

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7 Price and cost: Both are important to achieve value-based care (Bulletin of the ACS)
delivery systems and could help achieve buy-in to a value-focused insurance offering. Comparisons across the market will stimulate innovations for exploring efficiencies, removing waste, and increasing value. Understanding the contribution margin of a service line along with overall quality will aid in ensuring adequate payments for services and allow surgeons and delivery systems to modernize and secure the future of their care delivery. A service with a negative contribution margin should address quality, cost overruns, and adequacy of price from insurers. However, obtaining this information has been a difficult and time-consuming prospect.

To address some of the challenges facing physicians and delivery systems entering into value-based care arrangements, the ACS has partnered with the Harvard Business School Institute for Strategy and Competitiveness to develop a value measurement framework. This framework, known as the Transforming Health Resources to Improve Value and Efficiency (ACS THRIVE) is currently being piloted in a limited number of facilities to help hospitals and surgical practices improve patient outcomes while lowering the cost of delivering care. The project is initially focused on measuring the sum of all services which would represent the full cycle of care in a patient’s journey for a particular episode—including its key surgical, medical, behavioral, and social elements—for a limited set of conditions involving surgical care but could be expanded to other areas.

By knowing internal cost and information on price, ACS THRIVE should help participants reduce or at least manage the risk associated with team-based, risk-bearing, negotiated rates for an episode of care. When this price model is coupled with the ACS approach to quality as a program, a clear picture of value emerges, which can be tailored to both payors and patients. This newly designed value measurement process is being piloted at a small number of U.S. hospitals, and ACS THRIVE will look specifically at surgical spending from the different perspectives of price (how much the patient and the payor spend) and cost (the resources used to provide care). The ACS is working with the not-for-profit PACES Center9 to develop price information dashboards for THRIVE participants that will allow them to drill down to the price of care over the prehospital, hospital, and post-discharge stages of care. For information related to the cost of care, the project uses time-driven, activity-

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9 PACES Center for Value in Healthcare
based costing (TDABC) to thoroughly document all the personnel, materials, and other resources used throughout an episode of care for all the services assigned to that episode.

Examining both the actual cost of providing care as well as the price shines a light on hidden opportunities for cost savings. For example, TDABC cost information could improve efficiency by ensuring that clinicians are working at the top of their license and reducing excess capacity in physical resources, allowing the delivery system to function more efficiently. PACES price information will yield other highly actionable knowledge, such as identification of duplicative or potentially unnecessary services that do not add value and can be eliminated safely. PACES also allows for comparison across hospitals or delivery systems looking for areas of variation such as the types of services billed, and the number and types of clinicians involved in care for that episode. This information can be helpful in contracting or in setting price targets in alternative payment models (APMs).

The ACS THRIVE pilot will be used to create a scalable approach that other hospitals can use to measure and improve value. The method will include risk-adjusted benchmarks, so hospitals can compare their value with one another to generate systemwide improvement. It is anticipated that the lessons learned will lead to best practices that can then benefit a wider range of practices and delivery systems. The type of value-based payment arrangements enabled by ACS THRIVE could fit well into a value-driven public insurance option.

**Question 4: How should the public option’s benefit package be structured?**

A public option must provide meaningful and comprehensive benefits to enrollees, including comprehensive surgical benefits and the flexibility to adapt to advancements in technology.

**Another opportunity**

Offering a Public Option would present a renewed opportunity for the federal government to adopt a nationwide minimum and enhanced standard for essential health benefits (EHBs).
Section 1302 (b) of the Affordable Care Act established a minimum federal standard for EHBs. To ensure that the quality of insurance offered to Americans in the individual and small group markets, both inside and outside of the exchanges, the Affordable Care Act mandated plans offered a comprehensive package of items and services, known as “essential health benefits.” Those essential health benefits must, at a minimum, include items and services in the following 10 categories: Ambulatory patient services; Emergency services; Hospitalization; Maternity and newborn care; Mental health and substance use disorder services; including behavioral health treatment; Prescription drugs; Rehabilitative and habilitative services and devices; Laboratory services; Preventive and wellness services, including chronic disease management; and Pediatric services, including oral and vision care.

Although the ACA directed the Secretary to “ensure” that the scope of EHB is equal to the scope of benefits under a typical employer plan as determined by the Secretary,” federal officials ultimately deferred many of these details to state regulators. Specifically, HHS directed each state to select and, if needed, supplement a benchmark plan to reflect the scope of services offered in a typical employer plan in the state. States could choose from 10 plan options, including any of the largest three national Federal Employee Health Benefits Program (FEHBP) plan options. If states chose not to make a benchmark selection, the default was set as the small group plan with the largest enrollment in the state. While all state benchmark plan selections had to reflect the 10 categories specified by statute, this benchmark plan approach resulted in continued state-by-state variation (and thus gaps) in access to many benefits.

Federal officials adopted a similar benchmark plan approach for benefit design for Medicaid expansion beneficiaries. Here too, federal officials gave states the option to select a commercial coverage benchmark plan built on FEHBP coverage and, specifically, the standard Blue Cross/Blue Shield Preferred Provider Option. Accordingly, CMS has long considered the range and scope

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10 Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, (HHS)
11 Essential Health Benefits: HHS Informational Bulletin (CMS)
12 Essential Health Benefits in the Medicaid Program (CMS); Specifically, CMS’ letter provided guidance on the use of Alternative Benefit Plans for the new eligibility group of low-income adults and the relationship between the Alternative Benefit Plans and EHBs. Section 1937 Alternative Benefit Plans provide State Medicaid programs with the option to offer certain
of services provided by the standard Blue Cross/Blue Shield Preferred Provider Option (BC/BS PPO) through the FEHBP appropriate for both commercial coverage and Medicaid expansion coverage under the ACA.

The Federal Employee Health Benefits Program as the Benchmark for the Structure of Benefits
As the standard for benefits provided in the proposed public option, the ACS suggests that Congress look to standards already established by the Office of Personnel Management (OPM) for the Federal Employee Health Benefits Program (FEHBP). As noted above, federal officials have already recognized that these benefits are comprehensive, and insurers have been able to develop efficient national networks to deliver these benefits to federal employees and their dependents. Further, a single benefit standard—rather than the high degree of state-by-state variation—would better ensure consistency, access to care, and ideally better health outcomes.

All FEHBP plans cover hospital, surgical, physician, and emergency care within guidelines set by the OPM. OPM also requires plans to cover prescription drugs; mental health care with parity of coverage for mental health and general medical care coverage; child immunizations; and limits on an enrollee’s total out-of-pocket costs for a year.13 Both fee-for-service plans (FFS) and health maintenance organizations (HMOs) are available in the FEHBP with the FFS plans administered by the Blue Cross and Blue Shield Association on behalf of Blue Cross and Blue Shield Plans nationwide.14

Therefore, ACS believes it would be reasonable to consider the standard BC/BS PPO plan offered through the FEHBP as the benchmark for EHBs under a public option. Providing a benchmark determined to be the standard for federal employee benefits and consistent with CMS’ guidance relative to benefits accorded with Medicaid expansion would also represent a step toward achieving the intended goal of Section 1302(b) of the ACA.

The problem with Medicare as the benchmark
According to a summary document produced by the Kaiser Family Foundation, groups of Medicaid enrollees with “benchmark” or “benchmark-equivalent” coverage based on select commercial insurance coverage.

13 FEHB – Federal Employee Health Benefits (FEDweek)
14 Healthcare & Insurance (OPM)
some of the previous proposals for a public option benchmarked EHBs to Medicare parts A, B, and D.\textsuperscript{15} Consistent with our position elsewhere in this document, the ACS specifically asserts that a public option available in the marketplace exchanges cannot simply mirror the Medicare program for several reasons.

Instead, ACS believes that a public option should build on benefits available through commercial coverage. Building on EHBs and commercial coverage will help ensure that enrollees do not face gaps in coverage for key benefits not currently covered under the Medicare program. Specifically, benchmarking EHBs to Medicare would not provide for maternity and newborn care (including neonatal intensive care services), pediatric primary and specialty care, and pediatric early and periodic screening, diagnostic and treatment services benefits.

**Recommended modifications to the categories of EHBs**
The ACS recommends that a proposed public option refine the ACA’s list of EHBs to ensure inclusion of the following broad and specific categories: Primary care, including preventative health services; In-patient and out-patient hospital services, including emergency services; In-patient and out-patient surgical services, including emergency services; Specialty medical and surgical services; Ambulatory care services; Prescription drugs and medical devices; Diagnostic radiologic services; Diagnostic laboratory services; Maternity and newborn care to include neonatal intensive care services; Pediatric services to include primary care, early and periodic screening, diagnostic and treatment services, and pediatric medical and surgical specialty care; Mental health and substance use disorder services, including behavioral health treatment; Rehabilitative and habilitative services and devices; Dental, vision and hearing services.

**Specific surgery benefits imperative to include**
The ACS also urges Congress to require any public option to cover the full scope of surgical benefits. This clarity is especially important given reports of deficiencies in benefits specific to surgery offered in some plans on the exchanges. Accordingly, the ACS would advocate Congress specifically include the following in the benefit package for a public option:

\textsuperscript{15} Side-by-Side Comparison of Medicare-for-all and Public Plan Proposals Introduced in the 116th Congress (KFF)
1) In-patient surgical services
2) Out-patient surgical services
3) Emergency surgical services
4) Trauma care, including surgical ICU services
5) Burn care, including ICU services and reconstructive surgery
6) Maternity and newborn care
7) Specialty surgical services including bariatric surgery
8) Surgical oncology services

As the practice of medicine is constantly evolving, the construct of benefits for these and all other essential health services should include the flexibility to accommodate future advancements in technology.

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

The American College of Surgeons motto “omnibus per artem fide premisque prodesse” is translated as, “to serve all with skill and fidelity.” Efforts to increase surgical presence and availability are crucial to providing the right care, at the right time, in the right place. Optimal quality of surgical care, the centerpiece of the mission of the ACS, is simply not achievable without optimal access. Therefore, the ACS is committed to optimal access as the key to quality of surgical care.

In broad context, the ACS believes that the cost of a public option should be borne by a combination of the federal government, employers and patient enrollees. Any premium assistance provided by the Federal government should follow the premium assistance principles adopted in other Federal programs.

Though the ACA made great strides in providing access to care for the neediest among us, decisions in twelve states to not take the opportunity to expand Medicaid served to leave too many Americans without access to healthcare. The ACS also believes that the steps taken by Congress and the Biden administration in the American Rescue Plan to build on the ACA were critical for those at both ends of the spectrum of federal poverty level (FPL).
Accordingly, we believe that a public option should be eligible for premium tax credits and cost-sharing reductions that mirror the provisions of the American Rescue Plan including a zero or near zero-dollar premium in the marketplace for all those with an income between 100-150% of FPL. These “means” will assist in accomplishing the “ends” intended by the ACA’s Medicaid expansion provisions by ensuring access to care for more of the neediest among us.  

On the other end of the income spectrum specified as eligible for subsidies by the ACA, we believe that the public option could also mirror the American Rescue plan by capping the amount of premium contribution at 8.5%. This would be particularly beneficial for that segment of our population approaching current Medicare eligibility age who live in rural areas where premiums have been reported to be up to 9% higher compared to urban areas.  

Mirroring the current marketplace provisions of the ACA, assistance for those above 150% FPL should be on par with that provided for the purchase of other Silver Level plans from private companies participating in marketplaces exchanges. Premium contribution from enrollees should continue to be based on income level on a graduated scale beginning at approximately 2% for those at 151% FPL and max out at the 8.5% for those at 400% of FPL and above.  

We again emphasize that competition on the marketplace exchanges between a public option and the products offered by private insurance companies should be based on efficiency and innovation, rather than government subsidization that could encourage consumers to enroll in one plan over another. Again, ACS believes that a public option should exist on a level field with other plans in the marketplace.

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

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16. The American Rescue Plan Expands The ACA, (Health Affairs)  
17. Are Marketplace Premiums Higher in Rural Than in Urban Areas?, (Robert Wood Johnson Foundation)
At this time, it is difficult to answer what role states “should” have with a federally administered public option based on the available information. A federally administered public option cannot ignore the complexity of insurance marketplaces that are operated across the country and the varying state laws and regulations that influence the types of benefit options available in the health plans sold in each of those marketplaces. Even if states do not have a direct role in the public option, the laws and regulations of a state will very likely be influenced by the expectations of the citizens of a state.

If the intended purpose of the federally administered public option is to reduce health care costs and insurance premiums by competing with the private health insurance plans offered through the ACA exchanges operated and regulated by state governments, then it should be expected that the federal public option plans will also be subject to the same state regulations that private plans must comply with to sell policies within the state. To have “fair” competition between private plans and a federal public option plans there should be an expectation of a “level playing field”.

However, the attempt to level the playing field should avoid the mistakes of the ACA’s Multi-State Plan Program operated by the OPM which was discontinued in 2019. As suggested by the authors in the article “For Policy Makers Looking To Expand Coverage, Lessons From The Demise Of The ACA’s Multi-State Plan Program” the complexity of differing state laws and regulations on marketplace health plans was a significant factor leading to the failure of the ACA’s Multi-State Plan Program. The need to conform to the individual state’s regulations was too much for the OPM to manage and private health insurers selling the Multi-State Plans dropped it from their offerings. The federal government will likely need to use the full force of its size and resources to ensure that the public option meets the needs and expectations of the policy holders.

Yet even the Federal Employee Health Benefits plans (FEHB), which benefits from preemption from state laws and regulations, has historically encountered variation in its plan offerings from state to state due to the influence of state

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18 For Policy Makers Looking To Expand Coverage, Lessons From The Demise Of The ACA’s Multi-State Plan Program (Health Affairs)
mandates for coverage of certain medical services. FEHB plans might cover a service in one state that it may not be covered in another state. The variation is not necessarily in response to compete directly with non-FEHB private health plans, but rather is likely influenced by the expectation of benefit coverage options by a state’s population.

As stated above in the answer to question 4, the ACS believes that patients should have access to a broad list of covered EHB services many of which have been added post-ACA by states as mandates to state regulated plans including but not limited to covering access to procedures and screenings such as obesity treatment and bariatric surgery, diagnostic colon and breast cancer screenings as well as prostate cancer screenings. Increasing scientific and technological advancement in disease screening and treatment options requires regular evaluation of health insurance plan coverages.

The ACS, in addition to numerous physician, patient, and other health care provider groups, regularly advocate state legislatures and state insurance regulators to consider these advancements and adjust their laws and regulations to expand access to care to meet the health needs of their residents. The result is a patchwork of varying state health insurance markets across the country that creates a significant challenge to a static federal public option that does not conform to the individualized nature of a state’s health marketplace.

Again, while it is uncertain what role the states will play with a federally administered public option, actions by the states influence the types of health plans offered in the states.

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

At this time, it is difficult to answer this question without first knowing some of the details on how a proposed federal public option would be structured. However, the public option proposal should not use Medicare or Medicaid as a benchmark for payment, nor should a physician’s participation in the public option be tied to participation in other federal health programs such as Medicare or Medicaid, or otherwise made mandatory. The ACS will provide

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19 MWD-76-49 Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employees Health Benefits Carriers (gao.gov)
comments once a proposal is released.

**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?**

As mentioned above, the ACS motto is, “To serve all with skill and fidelity.” One key step to live up to this motto and provide high quality care to all is eliminating racial disparities in access to care as there can be no quality without access.

According to the ACS Committee on Health Care Disparities, access to surgical care is impacted by socioeconomic status, age, gender, level of education, race, ethnicity, health care availability, and geographic distance. Timely access is the key to quality of care. Efforts to increase surgical presence and availability are crucial to providing the right care, at the right time, in the right place.

Optimal quality, the centerpiece of the mission of the American College of Surgeons, is not achievable without optimal access. A new study finds that older cancer patients are less likely to have optimal results following their cancer operation if they live in an area highly affected by social challenges, especially if they are racial-ethnic minorities.\(^{20}\) Another recent study of liver transplant centers confirms that non-Hispanic, white patients get placed on liver transplant waitlists at disproportionately higher rates than non-Hispanic, Black patients.\(^{21}\)

A public option could improve optimal access for those in which private insurance is out of reach due to affordability or those who are not eligible for Medicaid. If implemented, the public option should avoid the pitfalls we have seen with fee-for-service models in the past. As noted in question 3, a public insurance option should not simply be a means to reduce healthcare spending through blunt cost control measures. Such an approach has failed to have the desired effect in Medicare and would likely lead to access problems for

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20. \(^{20}\) *High social vulnerability is associated with a decreased chance to achieve a “textbook outcome” following cancer surgery.* (Journal of the American College of Surgeons)

21. \(^{21}\) *Racial Disparities in Liver Transplantation Listing.* (Journal of the American College of Surgeons)
enrollees in the public option as well. Instead, it should include a value-based health care (VBHC) model which is inclusive and affordable. ACS is hopeful that some health inequities can be addressed through VBHC measures.

Defining value based on what matters to the patient can play a critical role in the system’s ability to transform and become more accessible, affordable, transparent, and equitable. VBHC is designed to achieve outcomes that matter to the patient at a price that the patient and the system overall can afford. The COVID-19 pandemic has demonstrated there is a critical need for better measures of disparities to bring attention and investment to under-resourced areas and populations. The current payment system must also change so that it is accountable for the results of every individual. Patient-centered VBHC provides an opportunity to improve communication with a more diverse set of patients and build trust within communities that have previously been excluded. Redirecting wasted funds under the existing system to improve access and provide adequate resources would encourage delivery systems to come to the aid of underserved patients. ACS has provided additional detail on this in recent comments to CMS and welcomes the opportunity to further discuss this issue with the Committees.

Moving to a system that truly utilizes value-based health care will help to achieve the goals of delivery system reform more broadly. As mentioned previously in question 3, ACS THRIVE could help to address some of the challenges facing physicians and delivery systems entering into value-based care arrangements. ACS THRIVE will aim to help hospitals and surgical practices improve patient outcomes while lowering the cost of delivering care. The project is currently focused on measuring the full cycle of care for a limited set of conditions involving surgical care, and it could be expanded to other areas. The method will include risk-adjusted benchmarks, so hospitals can compare their value with one another to generate systemwide improvement. It is anticipated that the lessons learned will lead to best practices that can then benefit a wider range of practices and delivery systems. The type of value-based payment arrangements enabled by ACS THRIVE could fit well into a value-driven public insurance option.

22 ACS Comment Letter on the CMS FY22 Hospital Inpatient Prospective Payment Systems Proposed Rule (ACS)
In sum, the ACS would reiterate that in developing a public option it is imperative that Congress include meaningful and comprehensive benefits as the OPM has previously provided in the FEHBP and CMS has in its guidance regarding Medicaid expansion. Payment and pricing of services should be based on the cost of actually providing the services plus a reasonable margin for the provider. Lastly, the ACS believes the cost for the program should be borne by the federal government, employers, and enrollees.

The ACS appreciates the opportunity to respond to this RFI and would welcome the opportunity to provide additional information, discuss, or further explain any of the ideas and concepts included in our responses to the committees’ questions.

Sincerely,

David B. Hoyt, MD, FACS
Executive Director