

July 31, 2021

Chairwoman Patty Murray
Senate Committee on Health, Education, Labor,
and Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

Chairman Frank Pallone
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

RE: Request for Information – Design Considerations for Legislation to Develop a Public Health Insurance Option

Dear Senator Murray and Representative Pallone,

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. Our work within the health care sector is driven by a recognition that the current system costs too much, leading to access issues for patients and affordability challenges for families, businesses, and the government.

We thank you and the Committees for making this important commitment to developing a new affordable coverage option that can help to lower health care costs. We at Arnold Ventures share this commitment to improving health care affordability. The status quo is both unfair and unaffordable. A lack of competition and the excessive prices dominant providers often charge the privately insured has led to higher premiums, higher deductibles and cost-sharing, access issues, and lower wages. Beyond these impacts on consumers, high health care prices are also an increasing burden for employers and the federal budget.

Reducing the underlying price of care is critical to improve access and affordability, including for people with health insurance coverage who often still face problems of underinsurance. The savings generated by addressing excessive prices can also make coverage expansions easier to finance and sustain. A well-designed public option is one option to lower prices and health care costs. Other policies could also achieve similar goals.

In this response letter, we outline options for developing a public health insurance option that directly addresses health care prices, as well as other design considerations that respond to the questions included in the Committees' Request for Information. In addition, we outline alternative policies, particularly a cap on provider payment rates, which would limit the maximum price providers can charge. A rate cap could be applied alone or in combination with a public option to accomplish similar goals. **Several principles provide a foundation for our more specific feedback in this letter, including:**

- A primary goal should be containing costs and making coverage more affordable. Reforms that do not lower costs will likely have little effect on spending and coverage.
- To effectively lower costs and result in savings for consumers, employers, and the government, policymakers must limit the prices hospitals and physicians can charge the privately insured and include a strong enforcement mechanism. For example, a public option should combine administratively set rates with a provider participation requirement to ensure an adequate provider network at the lower rates.
- Reforms to lower provider prices should be extended throughout the private insurance market, including to people with employer-sponsored insurance. Excessive prices and affordability challenges exist across the entire private market. The employer market also covers many more people than the

individual market. Extending reforms to the employer market generates larger effects on spending and coverage. It would have higher potential benefits for consumers and employers, as well as a larger positive impact on the federal deficit.

Either a public option or a cap on provider payment rates can improve affordability and lower health care costs for consumers, businesses, and the federal government if they are well-designed with appropriate limits on provider reimbursement rates. The approaches have different advantages (summarized in Figure 1). A public option has the advantage of offering a publicly administered plan to consumers that could provide an alternative to private plans and be a lower cost option, particularly in markets with little insurer and/or hospital competition. A public option could be offered in the nongroup market on the ACA exchanges, as well as offered as an option in the employer market.

A cap on provider prices in the private insurance market would be more direct way to address high provider prices and is likely simpler to design and implement since it would not require creating and operating a new insurance entity. This is particularly true in the employer market, where offering a public option is more complex. Additionally, the savings to consumers, employers, and the government from capping provider prices across the group market are likely much larger than those that would arise from allowing employers to buy-in to the public option since all employers and workers would benefit from a price cap.¹ Finally, a price cap would allow consumers to benefit from lower prices while maintaining their current coverage.

A public option and rate cap could work together to provide more affordable coverage. For example, a price cap that applies across the private insurance market (in both the group and nongroup markets) could be implemented alongside a public option offered in the nongroup market. Doing so would allow private insurers to benefit from the lower prices paid by the public option and would likely increase insurer competition, while still offering individuals the choice of a publicly-backed plan.

Figure 1: Policy Options for Addressing High Prices in the Commercial Insurance Market
Reforms Should Directly Limit Provider Prices and Extend to the Employer Market

Public Option Plan in the Nongroup and Employer Markets	Public Option Plan in the Nongroup Market alongside a Market-Wide Rate Cap	Rate Cap Applied Across the Commercial Market (No Public Option)
<ul style="list-style-type: none"> • Should include administratively set rates & provider participation requirements. • Creates a new publicly-run coverage option but is more complex to design and implement. • Can help address cost issues arising from a lack of hospital and/or insurer competition. • To mitigate design challenges and adverse selection, public option in employer market should function as a TPA. Employer contributions and the tax subsidy for employer insurance would continue to apply. • Main benefits accrue to individuals who buy the public option in the nongroup market and employees whose employers buy-in, resulting in lower system-wide savings for consumers and employers. 	<ul style="list-style-type: none"> • Includes administratively set rates & provider participation requirements in public option (offered in the nongroup market), and applies a mandatory rate cap across the entire commercial market. • Creates a new public coverage option in the nongroup market, while also directly lowering prices for employees and employers. • Helps ensure robust insurer competition in the nongroup market by allowing private plans to benefit from lower rates. • Rate cap in employer market is simpler to operationalize and allows those with employer coverage to keep their current insurance plan and structure. • Results in broader benefits and more substantial savings than a public option. 	<ul style="list-style-type: none"> • Includes mandatory rate caps on provider prices – a more direct way to address high provider prices. • Providers and plans would continue to negotiate prices below the cap, which establishes a maximum price. • Administratively simpler than creating a public option but does not offer a new publicly-run coverage option as an alternative to private plans. • Maintains the market structure and allows individuals to continue enrolling in their preferred plan, while broadly increasing health care affordability. • Results in broader benefits and more substantial savings than a public option.

In the sections below, we discuss the following: 1) the rationale for making limits on provider reimbursement rates a central part of any reform, 2) considerations for limiting provider rates that apply

to both a public option and a rate cap, 3) design considerations specific to a public option, and 4) design considerations specific to a rate cap.

High Provider Prices are the Primary Driver of High Health Care Costs

In the private insurance market, the underlying price of care is the primary driver of high costs. There is clear evidence that provider consolidation has led to higher prices for the privately insured while the quality of care has remained relatively constant or, in some cases, worsened. Dominant health systems use their market power to negotiate excessive prices with insurers, on average charging more than 2.5 times what Medicare pays for the same service.ⁱⁱ These high prices flow through the system to consumers and employers in the form of rising premiums and out-of-pocket costs, including high deductibles.

The average family employee premium increased by 55% over the last ten years, at least twice as fast as wages (27%) and inflation (19%), and now exceeds \$20,000 per year. Further, deductibles continue to rise as purchasers have dealt with these increases by shifting more of the cost onto workers. Deductibles increased about 79% over the last ten years; more than one in every four workers with single coverage now have a deductible of at least \$2,000.ⁱⁱⁱ Many patients (about 35% of Americans in 2020) report problems accessing medical care due to costs. Further, a quarter of adults with insurance reported problems paying medical bills.^{iv}

Rising prices also have a negative impact on labor market outcomes and the federal budget. Economists connect rising health care costs to stagnant wages, finding that hospital mergers lead to a reduction in wages for workers who receive employer-sponsored insurance.^v Money that employers could have put toward higher wages has instead gone toward the cost of providing health benefits. High health care prices affect the federal budget – and as a result, taxpayers – in two ways: directly through changes in ACA subsidies and indirectly through tax preferences tied to the provision of employer-sponsored insurance.^{vi} Failing to address the underlying cost of care makes it more expensive to finance coverage expansions in the private insurance market, including enhancements that could lower out-of-pocket costs for people purchasing coverage on the ACA exchanges among other priorities.

Considerations for Limiting the Prices Charged by Providers, Which Should be a Primary Policy Goal

Any private market reform, whether a public option or alternative policy, should lower costs for consumers in the private market, as well as employers and the federal government. The most important step policymakers can take to lower costs is to limit provider prices. Limiting provider prices can be done through administratively set rates (e.g., as part of a public option plan) or a cap on the maximum price hospitals and physicians can charge the privately insured (e.g., limiting rates to Medicare plus a certain percentage). This section discusses design choices that apply to limiting provider prices in either approach.

There is room to reduce provider payment rates without compromising access to or quality of care – and in fact, reducing rates may increase access to care as coverage becomes more affordable. Commercial payment rates far exceed the cost of providing care. On average, hospital prices in the private insurance market are about 150% of hospital costs.^{vii} Prices for the same services also vary widely within the same market, suggesting the highest priced providers in the market could operate more efficiently and be paid lower rates without compromising access.^{viii}

Determining Provider Reimbursement Rates. Using Medicare rates (likely Medicare plus some percentage) as the basis for setting or capping rates for hospitals and physicians is likely the most straightforward approach. There are several benefits to using Medicare as the baseline for determining provider reimbursements, including administrative simplicity and transparency. Medicare rates are

readily available, whereas developing or limiting rates based on commercial rates would likely require a significant data collection effort.¹

The Medicare program also has a transparent and widely accepted process for determining rates. To be sure, there are places where the Medicare fee schedule could be improved, such as the relative prices paid to primary care physicians and certain specialists. However, in addition to the advantages mentioned above, the Medicare fee schedule already accounts for factors such as geographic adjustments and does not reflect the market distortions (e.g., those arising from consolidation) that affect commercial rates.

Rates must be set or capped at an appropriate level to ensure lower prices and savings. Currently, hospitals charge privately insured patients on average 231% of Medicare for inpatient services and 267% for outpatient services. Some states have average rates as high as 350%.^{ix} In general, policymakers may want to consider lower provider payment rates and a faster implementation timeline when pursuing policies limited to the nongroup market than when pursuing policies for the larger group market. This is because current payment rates in the nongroup market are lower on average than rates in the employer market, so limiting rates to a smaller percentage above Medicare rates will be needed to generate savings in the individual market vs. the employer market.^x In addition, policies that apply to both the nongroup and group markets would benefit a larger share of enrollees and as a result, potentially affect a larger share of providers' revenue. This may argue for a higher payment rate and a slower phase-in of the reform.

A key difference between a public option that uses administratively set rates and a cap on provider payment rates is that a provider rate cap only affects those providers whose rates exceed the cap. If rates are not set sufficiently low in a public option, costs could increase when certain provider rates currently below the new administratively set rate increase to meet it. Setting a rate cap at an excessively high level would substantially reduce the potential savings and benefit to consumers, employers, and the government. However, there is less risk of offsetting any savings by increasing what providers currently below the cap are paid.

Estimated Savings. To give you a sense of the range of the savings that could result from setting or capping rates at various levels, we have provided several estimates below. Some of these options are focused solely on the nongroup market, while others include estimated savings for options that apply to the employer market as well. The Urban Institute has modeled² the effects of both a public option and rate cap at various payment levels.^{xi} The Committee for a Responsible Federal Budget has also estimated rate cap policies.^{xii} The estimates included below represent ten-year savings assuming immediate implementation.

- A **public option solely introduced in the nongroup market**, with physician rates set at 115% of Medicare and 160% of Medicare for hospitals would reduce premiums by 12% and the federal deficit by \$60 billion over ten years. Household spending would decrease by \$30 billion.^{xiii}
- A **public option introduced in the nongroup and group market** (employers opt in) with the same payment rates (115% of Medicare for physicians and 160% of Medicare for hospitals) reduces employer premiums by 18% and nongroup premiums by 13%, and reduces the federal deficit by \$130

¹ In any case, legislation creating a public option or establishing rate caps could include requirements for improving commercial market data and price transparency, such as establishing a federal All Payer Claims Database.

² Note, Urban Institute estimates also assume federal implementation of prescription drug reforms, which would reduce average prescription drug prices in the commercial market by about 30%. Drugs account for about 23% of premium dollars. The estimated savings would be lower absent this effect.

billion over ten years. Household spending would decrease by \$270 billion, while employer spending would decrease by \$320 billion.^{xiv}

- **A rate cap applied across the full commercial market with physician rates capped at 115% of Medicare and hospitals capped at 160% of Medicare** would reduce employer premiums by 18% and nongroup premiums by 13%, and reduce the federal deficit by \$380 billion over ten years. Household spending would decrease by \$870 billion, while employer spending would decrease by \$1.45 trillion.^{xv}
- **A rate cap applied in the commercial market that limits the prices charged by hospitals in urban areas (rural and critical access hospitals exempted) to 200% of Medicare** would reduce commercial premiums by \$899 billion (savings which accrue directly to consumers and employers) and the federal deficit by \$216 billion over ten years.^{xvi}

Additional Rate Considerations. Under either a public option or a rate cap, policymakers could consider only introducing the reforms in certain markets or targeting certain providers. These considerations could help make reforms aimed at addressing prices more politically palatable and account for different market conditions. These choices will have an impact on the scope of any potential benefits that could be generated through a public option or rate caps, including the system-wide savings.

Rural Markets. Policymakers may be interested in approaching rural markets differently than urban areas, given the financial challenges some rural providers may face. Policymakers could consider two primary variations when determining rates for rural areas: either entirely exempting rural providers (or types of providers, such as Critical Access Hospitals) or establishing a separate, higher rate for rural providers. Estimates from the Urban Institute find that exempting rural providers would not have a substantial impact on the potential overall savings.^{xvii} However, it would mean that consumers and employers in high-priced rural areas would not benefit from the reforms.

Consolidated Markets. Alternatively, policymakers might choose to implement reforms only in highly consolidated areas as a mechanism to target high-priced providers or markets with little insurer competition.^{xviii,xix} This approach would be better than the status quo. However, it would not address the problem of high prices in areas that are relatively competitive based on measures of provider or insurer competition but that still have providers able to extract prices far above what would be expected in a well-functioning market. Estimates suggest that if a hospital rate cap at 200% of Medicare across the commercial market was limited to highly concentrated markets, the savings would decrease by about 30 percent.^{xx}

Considerations for Designing a Public Option That Effectively Reduces Prices

In this section, we outline considerations that are particular to designing a public health insurance option that provides more affordable coverage. Policymakers may have policy objectives other than cost containment for a public option, such as providing a stable, publicly-run alternative to private plans. However, a public option designed without a mechanism to lower provider prices is unlikely to have much impact on spending (for consumers or the government) and coverage.

Cost containment in a public option includes two primary components: setting a reimbursement rate for hospital and physician services (discussed in the section above) and requiring provider participation. Other design considerations, such as eligibility, plan offering, and benefit structure, are also discussed in this section.

Provider Participation Requirements. Establishing lower, administratively set rates without an accompanying provider participation requirement will likely result in providers threatening to leave networks or refusing to participate in the public option, prohibiting the development of an adequate

provider network. Further, the providers who would be willing to participate absent a requirement would likely do so because their current payment rates are lower than what they would be paid by the public option.^{xxi} The increase in their rates would offset the potential cost savings associated with a public option.

One approach is requiring provider participation in the public option as a Medicare Condition of Participation (CoP). Alternatively, participation in the public option could be tied to a condition of participation in the ACA exchanges or to the market in which the public option is being offered.^{xxii} The Congressional Budget Office does not expect that requiring participation in the public option as a CoP would have a significant effect on provider participation in the Medicare program.^{xxiii}

Enforcement. Policymakers should consider ways to enforce a provider participation requirement and ensure the public option plan provides meaningful access to the providers participating in the plan network. This could include imposing maximum wait times for appointments, requiring participating providers to accept new patients except in limited circumstances, and establishing a robust patient feedback and monitoring process.

Eligibility for the Public Option. The public option should at a minimum be available to beneficiaries in the nongroup market and offered on the exchange with ACA premium and cost-sharing subsidies. Offering the public option in the nongroup market can provide a more affordable coverage option if effectively designed by addressing cost issues arising from hospital and insurer consolidation. It would also reduce the cost to the federal government of providing subsidies to eligible individuals enrolled in exchange coverage.

Policymakers could consider offering a public option in the employer market, as several existing proposals have done. While we recommend policymakers extend reforms to the employer market given the considerable affordability challenges that still exist there, applying a rate cap to the employer market would be more straightforward than offering a public option in that market. However, below we provide recommendations for how policymakers could design a public option that is available to the employer market if that is the preferred direction.

Offering a Public Option in the Employer Market. Extending the public option into the group market is more complex for several reasons, including the need to deal with differences in how premiums are set in the nongroup market versus the employer market. It would also add administrative complexity since a public option offered in the employer market would likely require a separate administrative structure. However, these design challenges can be overcome.

We recommend allowing employers to buy-in to the public option and structuring the public option as a third-party administrator (TPA). This buy-in framework should also include an administratively set rate and provider participation requirement, as outlined above.

Structure Public Option as TPA. A public option offered in the employer market should be structured as a TPA. The TPA would set payment rates, develop a provider network, and handle the administrative side of paying claims. Employers buying to the public option would self-insure (meaning that the employer assumes the financial risk and pays the cost of enrollees' claims) and determine premium rates as currently occurs in the group market. This is comparable to how much of the employer market functions today.

Designing the public option as a TPA would make it simpler to continue experience rating premiums in the group market. Experience rated premiums are important to mitigate adverse selection. (Note that premiums in the nongroup market are community rated and cannot vary based on health status.) Allowing employers to buy into the public option without experience-rated premiums could make the public option more appealing to employers with sicker, higher risk workers who currently pay a higher premium for private insurance. If these employers buy in at disproportionately high rates, this could result in adverse selection and higher costs for the public plan.

Allow Employers to Choose. The choice of whether to opt into the public option should rest with employers, rather than individual employees. This employer buy-in approach aligns with the recommendation to structure the public option as a TPA in the employer market. If individual employees were able to opt into a fully-insured public option, employees in firms with less healthy, higher risk workers that pay higher premiums would have an incentive to enroll in the public option. Similarly, employers would have an incentive to steer less healthy workers toward the public option, potentially by using certain benefit designs, to lower their costs. Having employers opt-in on behalf of their employees to a public option functioning as a TPA mitigates the risk of adverse selection against the public plan.

Employer Contributions toward Coverage. Under this approach, employers would continue paying a portion of the premium (with employees paying the remainder) as the system currently works. Employers should also be allowed to continue to exclude premium contributions from taxable income as occurs today.

Coverage Gap Population. The public option could also be used to fill in the coverage gap in non-Medicaid expansion states if policymakers wanted to go in that direction. This option is likely to cost less than expanding ACA subsidies below 100% FPL without the existence of a public option.^{xxiv} A public option could also serve as a default plan that auto-enrolls individuals with incomes below 100% FPL who are not Medicaid-eligible. The plan could offer wraparound benefits to this population and provide subsidies to cover the premium cost and lower cost-sharing. Other considerations include benefit design and how to approach states who have expanded Medicaid.^{xxv}

Plan Offerings and Market Rules. The public option should generally follow federal and state requirements for qualified health plans offered on the exchange. This is important to ensure a level playing field and limit adverse selection. For example, the public option should follow the premium rating standards – which include requirements around age rating, tobacco use, and geographical rating standards – as well as network adequacy standards, which states are responsible for establishing and enforcing under the ACA. The public option should also be subject to risk adjustment.

Metal Tiers and Subsidy Structure. The public option should, at a minimum, offer silver tier coverage at all the cost-sharing variations. Policymakers should also consider allowing or requiring the public option to offer bronze and gold tier coverage as well. The existing ACA subsidies should apply to enrollees in the public option offered in the nongroup market as they do currently.

We do not recommend that policymakers make the public option plan the default benchmark plan for the purposes of determining enrollee subsidies. Subsidies should continue to be tied to the second lowest-cost silver plan, regardless of whether it is the public option or another plan being offered. In areas where the public option is more expensive than the second lowest-cost silver plan, making the public option the benchmark plan would increase federal spending. We do not think that ensuring enrollees can purchase

the public option at a specific cost is a sufficient justification for increasing federal spending on subsidies in those areas.

Benefit Design. The public option should cover Essential Health Benefits (EHBs) as required by the ACA and vary based on state EHB requirements. Benefit design could disincentivize the use of low-value services, when possible, and could be used to address health inequities by offering certain services at zero-dollar copay/coinsurance or pre-deductible. Such services could include primary care services or mental and behavioral health services. It is worth noting that some of these design choices could potentially increase spending all else equal, but increases could be offset by savings from lower provider payment rates among other things.

Other Considerations for Designing a Public Option. Policymakers could consider including components that advance population health and health equity. Congress could permit or require the public option plan to participate in certain alternative payment models or pursue multi-payer models that have been tested or deployed by CMS, including through the Center for Medicare and Medicaid Innovation. However, there should be a high degree of confidence that the payment reform will lower costs and maintain or improve quality if it is implemented in the public option. Policymakers should also be cautious about subjecting the public option plan to additional requirements beyond those applied to private plans, as this could make the public plan less competitive in terms of costs. Policymakers should work closely with stakeholders that have lived experiences related to designing an affordable coverage option and that represent communities of color and communities with varying economic challenges.

Considerations for Designing a Rate Cap that Effectively Lowers Prices

This section outlines design considerations that pertain to implementing a cap on provider payment rates. Capping provider payment rates in the private insurance market is an alternative approach to improve the affordability of coverage. It could be implemented as a standalone policy or implemented alongside a public option, either across the entire commercial market or limited to the nongroup market.

Two key advantages of a rate cap are that it is simpler to operationalize than a public option, particularly in the employer market, and it allows all consumers to benefit while still enrolling in the plan of their choice. It is relatively consistent with the current framework and design of the private insurance market.

Many of the design choices associated with a cap on provider payment rates, such as where to set the payment rate, are discussed in section two above. Below we discuss design choices and recommendations specific to the rate cap approach.

Markets. Any rate cap on provider payment rates should be mandatory. Consistent with our recommendation that reforms should benefit the employer market as well, we recommend a rate cap be applied broadly across the private insurance market (both nongroup and group markets). A rate cap applied across the private insurance market would substantially increase the potential savings for consumers, employers, and the federal government since all privately insured consumers would benefit.

An alternative would be to limit the rate cap to the nongroup market and implement it alongside a public option offered only in that market. Capping rates alongside a public option could ensure more robust participation and competition among private insurers by giving them an effective tool to secure lower rates commensurate with the public option. However, a rate cap limited to the nongroup market would greatly limit its reach and potential benefits.

Setting a Rate Cap. A key consideration for establishing a rate cap in the commercial market is where to set the rate and how to implement such a cap. As noted, most of these considerations are outlined in an above section. One issue specific to a rate cap is how to define the set of services that the rate cap would apply to. We suggest a rate cap that applies to all medical services provided in and out of network. The rate cap would place a limit on the maximum price providers can charge for services. Insurers would continue to determine payment rates through negotiations with providers (subject to the rate cap) and could negotiate prices beneath the cap. Only the highest-priced providers would be affected.

Enforcement. The enforcement challenges of a rate cap differ from those associated with a public option. One major difference is that there would be no way for a provider treating the privately insured to opt out of a rate cap applied across the private insurance market. Thus, it is not necessary to implement a provider participation requirement if the rate cap is applied in a broad manner. A market-wide rate cap should not have a negative effect on insurers' ability to form an adequate provider network.

However, a rate cap has its own enforcement challenges. Policymakers could consider implementing a robust financial penalty for providers violating the rate cap to discourage noncompliance. But they would still need an effective way to monitor and enforce compliance. For example, certain providers would continue to have substantial market power under a rate cap. Those providers may be able to continue to use their market power to extract higher payments that circumvent the rate cap (e.g., an insurer could employ weaker utilization management against certain providers).^{xxvi} Policymakers would need to contemplate effective oversight and enforcement mechanisms. Possible options could include establishing a method for tracking overall payments exchanged between insurers and providers or requiring insurers to report certain contract terms to state regulators for oversight purposes.

Thank you for your work on this important issue, which could meaningfully improve consumers' access to affordable coverage and reduce health care costs for families, employers, and the federal government. We appreciate your review of these comments. We would be glad to have further discussions on considerations for designing a public health insurance option or related policies at your convenience. Please contact Erica Socker (ESocker@arnoldventures.org) and Mark Miller (MMiller@arnoldventures.org) with any questions.

Sincerely,

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