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CHCF Issue Brief

State Public Options:
Comparing Models from Across the Country

States face a wide variety of challenges in their health care markets, starting with the fact that after hitting a historic low in 2016, uninsured rates are beginning to grow again — 8% of Americans, or 26.1 million, were uninsured in 2019 — and communities of color are still more likely to be uninsured compared with White people.[1,2] Other challenges include escalating premiums and even faster growing out-of-pocket costs, wide variations in provider pricing, and less competition in rural areas contributing to high costs. While the full impact of the COVID-19 pandemic on coverage remains unknown, the prepandemic growth in the uninsured rate, as well as the pandemic and associated recession, highlight the need for additional actions to ensure access to affordable health care coverage.

Establishing a federal public option has been identified by some as a way to address some of these challenges. During the campaign, President Joe Biden proposed a federal public option, based on the Medicare program, which would require congressional enactment. Given the Democrats' narrow control of the Senate (50-50 with Vice President Kamala Harris providing the tie-breaking 51st vote), federal enactment of a public option is dependent on eliminating the filibuster or proceeding through budget reconciliation. There are multiple ways to structure a federal public option, many of which would be challenging, but not necessarily impossible, to do under reconciliation. Given this landscape, the design and passage of a federal public option would take time and political will. Further, if passed, a federal public option could take years to implement.

Many states are not waiting for federal action. Nearly a dozen states are exploring the concept of a state-based public option or are actively pursuing some version of this approach through legislation. Driven by state-specific policy goals and coverage and by insurance market dynamics, these initiatives are diverse — including private-public partnerships with existing insurance carriers, allowing residents to buy into an existing government program such as Medicaid or the state employee health plan (SEHP), and other arrangements. This issue brief outlines some of the problems states are seeking to address with their public option proposals, reports the proposals' current status, categorizes the public option proposals into archetypes, and identifies important issues for California policymakers to consider as they explore the use of a state-based public option.

Potential Goals of a Public Option

- Reducing premiums to make purchasing coverage more affordable
- Reducing cost sharing (deductibles, co-insurance, etc.) to make coverage more attractive and access more affordable
- Improving access for uninsured and unsubsidized people
- Stabilizing health insurance offerings statewide (e.g., ensuring coverage in bare or limited-choice counties)
- Strengthening the marketplace by attracting customers and maintaining a balanced risk pool
- Leveraging state purchasing power across programs
- Promoting health care initiatives that improve health outcomes and result in long-term savings

Defining the Problem to Be Solved

Public options come in many flavors, which makes it imperative that states considering a public option start with these questions: What problems are we trying to solve, and how will a public option help us address those problems? The process of selecting a model and tailoring its features should be guided by as much clarity as possible about the problems the state wants to address through a public option, recognizing that answers will be subject to debate and recalibration throughout the process. Some models may be more effective than others in addressing specific goals, such as designing programs to encourage enrollment among the uninsured, addressing high out-of-pocket consumer costs, or containing overall health care costs. Some of these goals can be solved in tandem, while others might be in direct competition; for example, actions to reduce consumer cost sharing could end up raising premiums. The articulated goals could perhaps be met through other policy levers, in which case the public option may be one of several ways to address the key policy goals.

Policies to Meet Access and Affordability Goals

- State subsidies
- Simplified enrollment, or auto-enrollment programs
- Enhanced rate review
- Provider rate setting / global budget initiatives

The target population for the public option will vary depending on the state's goals. For example, if the state is striving toward universal coverage, understanding who remains uninsured and why will inform which public option archetype and design features are most appropriate. If currently uninsured residents are eligible for coverage through Medicaid or the Affordable Care Act (ACA) marketplace, a state may rely on a Medicaid-based public option approach to reduce churn between Medicaid and the marketplace. If the state's goal is providing options for people without insurance who have household incomes over 400% of the federal poverty level (FPL), the state may rely on an off-marketplace commercial or SEHP-based approach to attract those enrollees.

Defining the Continuum of State Public Option Archetypes

Public option terminology is evolving and can be a source of confusion. States and stakeholders use different terms when describing their state initiatives, including public option, Medicaid buy-in, state options, or public health care insurance plans. This brief reviews different state coverage options using the following definitions.[3]

State public option. A health care plan designed by the state to compete with existing health insurance options, with the goals of increasing access and consumer choice and/or lowering overall consumer costs. A state public option can fall under three major archetypes, with model variations within each:

- **Public health care plan / classic public option.** Coverage option established, administered, and managed by a public, governmental entity.[4] The government would have full control, like a self-insured plan, to set premiums, pay claims, establish provider networks, and negotiate rates. This structure would be analogous to fee-for-service arrangements.[5] The state could use a third-party administrator and could seek federal waivers for federal funding support.

- **State program buy-in (or "public program buy-in").** Coverage administered by a state or local government with eligibility, benefits, and provider payment rates established by the state. Under this archetype, the public program contracts with governmental (public) and/or nongovernmental (private) health care plans to assemble the services and deliver them as a benefit plan/product. Medicaid managed care organization plans might be the private entities through which the state contracts to deliver services.

  Variants of this archetype include a buy-in to an existing state program, such as the SEHP or the Medicaid program. A key distinction compared with the public-private partnership approach, described below, is that these programs are offered outside the commercial market — either as part of the existing program risk pool or as a separate, new risk pool — and the state sets eligibility and benefit rules that do not have to conform to ACA or state insurance requirements for

individual market coverage. For example, these plans can be targeted to specific populations, can have different rating rules, or can have a benefit package that does not follow metal-tier requirements.

- **Public-private partnership.** A public option model where the state government takes a lead role in selecting, negotiating, and dictating the participation terms, beyond minimum ACA requirements, for private health plans competing in the commercial market, typically in the ACA marketplace as a qualified health plan (QHP).

  This archetype can entail more or less state control. For example, it includes government-designed products, such as offering a state-sponsored QHP through contracts with insurers (e.g., Washington Cascade Care) as well as models where the state sets the requirements for all carriers operating in the marketplace (e.g., the Covered California active purchaser model and Colorado's proposed plan to require all individual market carriers to offer a state-designed public option plan).

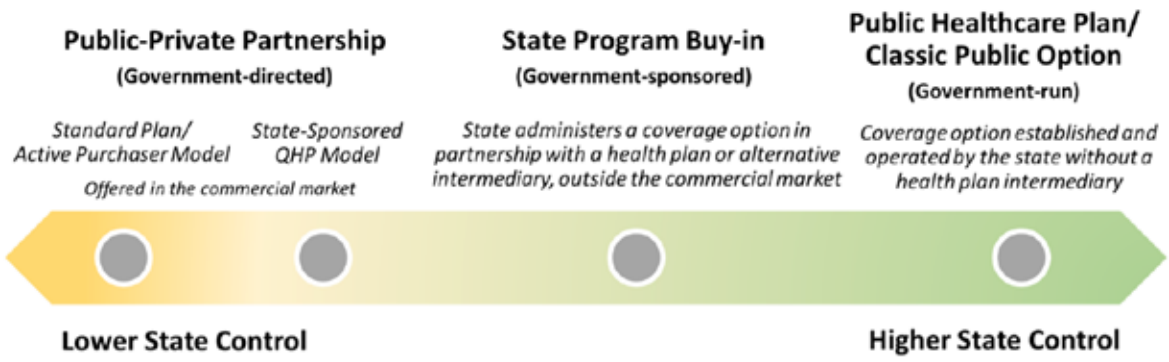
Key Issues Across Public Option Archetypes

Across all states, the following key issues have arisen when designing a public option plan.

Establishing the level of state control. States will have different strategies, capacities, and political dynamics that determine the level of government control in the public option. The one constant in all forms of public option is leveraging government resources and control to distinguish a public option from private health plans. As Figure 1 shows, the level of control can be as limited as adding certain design features to a traditional commercial product or as extensive as a government-run program.

Under a public-private partnership archetype, the state has negotiating power with private plans but does not take on plan operations or provider negotiations. The administering entity has to be paid for providing these functions, which impacts the cost of the public option plan. For example, Washington's Cascade Care public option is a private-public partnership that provides a state-sponsored QHP; the state has set certain parameters while contracting with private health plans to manage and deliver services. A state seeking to take more administrative and financial control of the program could rely on a public health care plan fully utilizing its negotiating and regulating power to create an affordable product. For example, using a state/third-party administrator (TPA) was studied in Oregon, and a Public Employees' Benefits

Figure 1. The Spectrum of State Control Across Public Option Archetypes



Source: Manatt Health.

Program buy-in was studied in Nevada.[6] To date, no state has proposed implementing legislation for a public health care plan.

Choosing the level of control often comes down to state resources, political feasibility, and a decision about the best way to achieve cost savings. Most public option proposals so far have been variants of the public-private partnership archetype, but there is increasing interest in higher levels of government control to improve affordability. However, questions remain about whether states have the financial resources — in a time of budget contraction — to implement a public health care plan. In this regard, states' ability to draw down federal funding may be determinative. Theoretically, some public option designs could qualify for federal funding support via a Section 1332 State Innovation waiver by receiving pass-through funding for cost savings that accrue to the federal government if, for example, the public option becomes the benchmark plan and premium reductions in turn reduce federal tax credits.[7] To date, no such waiver has been sought or approved. The Trump administration was not interested in approving such waivers, and while it appears likely that the Biden administration will change course, it remains to be seen how the Biden administration will view its authority under Section 1332.

States will also consider the potential for adverse selection when selecting an archetype. In particular, states looking at a state program buy-in have been concerned with whether the population attracted to the public option will be less healthy than expected and therefore higher cost. In a state program buy-in, that risk is borne by the state because the state is ultimately responsible for program costs even if using intermediaries. In a public-private partnership, that risk can be shifted to the insurers delivering the product. This difference in who bears the risk of adverse selection is one reason states such as Colorado and Washington have been attracted to public-private partnerships within the existing market that shift the risk of adverse selection to private insurers.

New Mexico. This state was the first to explore a government coverage program, or "Medicaid buy-in," by using the state's Medicaid program — including Medicaid provider rates and network — as a chassis for the public option. The state still intended to use Medicaid managed care organizations to mitigate some risk and operational burden, and therefore this plan was a public option under the government coverage program definition, not a true public health care plan.

The proposal stalled in the 2019 legislative session but may be reconsidered during this legislative session.

Washington. Washington Cascade Care sought to lower premiums via an aggregate provider reimbursement cap of 160% of Medicare. The impact of the cap on plan premiums, however, remains unclear. The program simultaneously introduced standardized plans that covered more services predeductible (while still complying with ACA metal tier requirements), making the impact of the provider payment rate limits hard to delineate from other structural changes. Monthly average premiums for silver-level public option plans range from $392 to $490 (based on geography), compared with $385 and $528 for nonpublic option standard plans, and $376 and $500 for nonstandardized plans.

The results of first-year provider rate negotiations are unknown and will be verified using claims data in the future.

Finding cost savings. The ability of a state public option to reduce underlying costs and increase consumer affordability is central to its ability to compete with existing offerings. States continue to struggle with how to balance cost containment with provider participation. There are three central categories for potential cost reductions for the public option — addressing the underlying cost of claims (e.g., by more aggressively managing care and/or by making changes to provider reimbursement rates), lowering administrative costs, and reducing spending directed to profit. The addition of a public option that increases market competition may also induce wider cost savings that benefit consumers in other plans. Similar to the decision about level of state control, this decision will depend on which policy levers are most feasible in a state. So far, states have proposed a combination of these options.

Considering the market impact. By design, a public option seeks to influence the existing insurance market by offering a new coverage option. How the public option affects the existing ACA individual market, including ACA premiums, depends on the program's design. A public option can be offered inside or outside the individual market, either expanding or segmenting the existing ACA risk pool. The decision to expand or segment the risk pool will depend on the state's strategy — for instance, whether a state endeavors to offer a plan with maximum design flexibility outside the ACA market or to stabilize the existing ACA market. The target population will also influence the potential market impact of these two strategies — attracting healthy people and/or the currently uninsured into the existing ACA market risk pool could decrease costs across the market, whereas attracting healthy people into an off-market plan may degrade the health risk of the existing market and cause a rise in premiums. Additionally, the size of the population migrating or joining, proportional to the current market, will influence the public option's impact.

Understanding stakeholder positioning. Stakeholder positions will influence the outcome of model design and as such, states considering public options are employing different stakeholder engagement approaches. For example, Colorado embarked on a state road show to solicit input for its program design, while Washington formulated its initiative — and engaged stakeholders — through the legislative process. Key stakeholders include:

- **Consumer advocates.** Advocates have mostly been supportive of state efforts to provide a more affordable coverage option but have pushed states to ensure the definition of affordability includes total out-of-pocket costs, to consider health equity and access for marginalized groups, and to ensure transparency and consumer engagement. Single-payer advocates who might view a public option as an incremental step toward structural reform may have mixed reactions, largely driven by the level of state control in the public option and the scope of the program.

- **Insurers.** Insurer reaction depends on the plan design and the insurers' position of providing or competing with the public option plan. Insurers will be concerned with any option that disrupts the "level playing field," particularly if a state product is given benefit or program design flexibilities unavailable to insurers under state or federal regulations. Insurers also favor partnership models, such as Washington's Cascade Care, that allow all insurers to offer the plan (an "any willing insurer" model) rather than models that rely on one or two insurers. Insurers will also prefer programs in which insurer participation is voluntary, though mandatory participation or some form of tying (e.g., requiring insurers to participate in the public option as a condition of participating in one or more other programs) may engender less opposition if provider reimbursement rates are set through a single government-imposed standard that applies to all insurers.

- **Providers.** Provider concerns about a public option will be balanced between the proposed or anticipated provider reimbursement rates and projected enrollment. If the plan mostly attracts the currently uninsured — therefore reducing uncompensated

Connecticut. In 2019, state lawmakers proposed a state program that would allow individuals and small businesses to enroll in the SEHP plan, with the goal of increasing coverage options for small businesses. The 2019 bill — and a subsequent compromise proposal to allow the state to contract with existing insurers (rather than using the SEHP) to provide individual coverage on the marketplace — failed after significant pushback from insurance carriers, including national insurers, many of which are headquartered in the state. A similar bill, Senate Bill 842, offering a public option for small businesses and nonprofit organizations was introduced in the 2021 legislative session and is currently being considered by state lawmakers.

Colorado. The proposed private-public hybrid model that Colorado introduced in March 2020 included a requirement that all carriers and hospitals participate in the program. Hospitals would be required to accept a state-determined benchmark reimbursement rate. The legislation was expected to attract significant attention from state and national provider groups, including public campaigns against the bill. However, the COVID-19 pandemic interrupted consideration of the bill. It is anticipated that Colorado will reintroduce a public option plan during the 2021 session. Depending on the content of the bill, provider groups may mobilize in opposition.

care — providers are more likely to support the plan. However, state and national provider groups are generally opposed to any form of provider rate setting.

Comparing Proposed State Initiatives

Table 1 provides a comparison of how states are tailoring their public option programs across key design parameters.

Notably, Washington is the only state to have implemented a public option program for plan year 2021 coverage. Multiple states will reconsider public option legislation in the 2021 legislative session.

Conclusion

States will continue to explore public option initiatives at the state level. Each state will need to carefully consider the underlying health coverage access and affordability problems policymakers are trying to solve in order to choose a public option model or other policy intervention that will best meet policy needs.

Table 1. Comparison of Key Components in Select State Public Option Programs (as of February 2021)

COLORADO	NEVADA	NEW MEXICO	OREGON	WASHINGTON
Overall Summary				
In March 2020, lawmakers in Colorado introduced legislation to implement the Colorado Health Care Option. The state-sponsored health insurance plans would be offered as a QHP on and off the state marketplace, Connect for Health Colorado. The legislation would also require participation from individual market carriers and hospitals, and sets a hospital payment methodology. The legislation did not proceed due to the COVID-19 pandemic.	During the 2019 legislative session, the Nevada Legislature enacted Senate Concurrent Resolution No. 10 to conduct a study of the feasibility, viability, and design of a "public health care insurance plan" before the 2021 legislative session. The study was published in January 2021.[8] The law specified that the study explore the feasibility of offering a public option health plan allowing any resident of this state to participate in the Public Employees' Benefits Program (PEBP). The published study also evaluated a QHP option on the state marketplace.	In 2018–19, policymakers in New Mexico studied[9] and introduced legislation to introduce a Medicaid buy-in program operated by a managed care organization at Medicaid provider reimbursement rates, outside the individual market.	The Oregon legislature passed S.B. 770 in 2019, calling for Oregon Health Authority to develop a plan for a "Medicaid Buy-in program or public option" to provide an affordable health care option to all Oregon residents. A study was released in December 2020 outlining three public option models:[10] ▶ Coordinated care organization–led model (the CCO is the state's Medicaid managed care infrastructure) ▶ Carrier-led model in partnership with a commercial insurer ▶ State-led model with the state bearing risk and using a third-party administrator to manage the plan State stakeholders will now consider further action and, potentially, legislation in 2021.	Washington State has implemented a first-in-the-nation public option QHP available on the marketplace in select counties. The program was enacted in May 2019. The state contracted with insurers under specific requirements, including a standardized plan design, and negotiated provider reimbursement rates subject to an aggregate cap set at 160% of Medicare rates.

Table 1. Comparison of Key Components in Select State Public Option Programs (as of February 2021), *continued*

COLORADO	NEVADA	NEW MEXICO	OREGON	WASHINGTON
Legislation/Status				
H.B. 1349, 2020 Leg. Legislation stalled in 2019 and 2020; potential for a new proposal in 2021.	S. Con. Res. 10, 2019 Leg. Study released; legislation may be considered.	S.B. 405, 2019 Leg. Legislation stalled in 2019, but may be reconsidered this legislative session.	S.B. 770, 2019 Leg. Study released; legislation may be considered.	S.B. 5526, 2019 Leg. (Wash. 2019) Initiative was implemented.
Policy Objective(s)				
The goal of the legislation is to "create more affordable health benefit plans for health care consumers in the state."	Nevada identified three key goals and priorities in the study and design of a public insurance option: ▶ "Improve stability in the health insurance market in this State." ▶ "Reduce the number of Nevadans without health insurance coverage." ▶ "Increase access to affordable coverage for health care and services to all Nevadans."	The goal of the Medicaid Buy-In Act is to "establish a state public option through Medicaid to provide New Mexico residents with a choice of a high-quality, low-cost health insurance plan."	Legislative goal is to provide an affordable health care option to all Oregon residents that is "equitable, affordable, and comprehensive," with the primary focus being Oregon residents who do not have access to health care.	Cascade Care was intended to increase the availability of "quality, affordable health coverage in the individual market." Standardized plans were designed to offer consumers a plan with reduced out-of-pocket spending within each plan option (bronze, silver, gold).
Archetype				
Public-private partnership	Multiple archetypes considered in the study: ▶ Public health care plan in the PEBP buy-In ▶ Likely public-private partnership for the QHP model	State program buy-in: Medicaid buy-in with managed care organizations	Multiple archetypes considered in the study: ▶ State program buy-in for CCO-led model ▶ Public-private partnership for carrier-led model ▶ State program buy-in or public health care plan, depending on design of the state/TPA model	Public-private partnership
Coverage Dynamics[11]				
2019 uninsured: 8% *Marketplace:* State-based marketplace (SBM) *Medicaid managed care penetration:* 9%	*2019 uninsured:* 11.4% *Marketplace:* SBM *Medicaid managed care penetration:* 69% *SEHP agency:* Nevada Public Employees Benefit Program	*2019 uninsured:* 10% *Marketplace:* SBM-federal platform (SBM-FP) *Medicaid managed care penetration:* 79%	*2019 uninsured:* 7.2% *Marketplace:* SBM-FP *Medicaid managed care penetration:* 80%	*2019 uninsured:* 6.6% *Marketplace:* SBM *Medicaid managed care penetration:* 88%

Table 1. Comparison of Key Components in Select State Public Option Programs (as of February 2021), *continued*

COLORADO	NEVADA	NEW MEXICO	OREGON	WASHINGTON
Administering Agency and Risk-Bearing Entity				
The Department of Insurance would oversee public option rates and plan designs. Insurance companies would bear the risk for payment of health claims.	Dependent on the model chosen for implementation: ▶ The current PEBP program is administered by the state agency, with a third-party administrator and leased provider networks. ▶ A QHP model could be offered with an insurance carrier as the risk-bearing entity, or a state agency.	The Human Services Department will oversee the plan. The department may engage managed care organizations as the risk-bearing entity.	The Oregon Health Authority will likely administer the program. The risk-bearing entity will depend on the chosen model — either CCOs, contracted carriers, or the state with assistance from a TPA for claims processing and other plan management.	The Cascade Care program is administered by the Washington Health Benefit Exchange, in partnership with the Health Care Authority, and the Office of the Insurance Commissioner. Insurance companies bear the risk for payment of health claims.
Eligibility				
All Colorado residents would be eligible to enroll through a marketplace or individual market-based plan; federal tax credits will be available to eligible enrollees.	The law specifies all residents of the state should be eligible, and the final study evaluates model open to all Nevadans.	Residents ineligible for Medicaid, Medicare, and advance premium tax credits under the ACA, and those without access to affordable employer-sponsored insurance (e.g., family glitch populations).	SCR 10 stipulates the plan should be available to all residents, with an option to target the plan to: ▶ Residents with household incomes between 400% and 600% FPL who are unable to afford health insurance offered by the resident's employer ▶ Residents who regularly cycle through medical assistance and employer-sponsored health insurance ▶ Other groups that face significant barriers to accessing affordable, quality health care A targeted CCO-led model for "family glitch*" and undocumented populations was also considered in the study.	Washingtonians eligible for coverage on the marketplace will be eligible to enroll.

*Under the Affordable Care Act, eligibility for marketplace premium subsidies is based on whether there is affordable employer-sponsored coverage. Affordability is based on the consumer's premium cost for individual coverage, not for family coverage, which may be substantially more expensive. This means some families may find themselves ineligible for marketplace subsidies despite having very high-cost employer-sponsored family coverage.

Table 1. Comparison of Key Components in Select State Public Option Programs (as of February 2021), *continued*

COLORADO	NEVADA	NEW MEXICO	OREGON	WASHINGTON
Benefit Design				
Essential health benefits (EHBs) Standardized plan design with increased pre-deductible services.	The models under study included the 2020 PEBP benefit package (excluding dental), and silver- and gold-level QHP benefit packages.	The bill would establish benefits in accordance with federal and state law. The targeted Medicaid buy-in study assumed EHBs.	Comprehensive benefit package, at a minimum, equivalent to QHP benefits, with consideration for additional value-add and equity-centered services that mirror the CCO program. No more than "minimal" cost sharing, deductibles, and copayments within the chosen model structure.	EHBs Under the Cascade Care standardized plan design,[12] the silver-level public option plans have an adjusted actuarial value of 71%, compared with 68% to 72% in nonstandard plans.
Risk Pool				
Individual market	The report recommends the PEBP buy-in be included in the existing state employee risk pool. Offering the buy-in in a new risk pool is also an option. QHP model in the individual market.	Separate risk pool	Individual market for all models, except the CCO-led model, which would be offered in a separate risk pool.	Individual market
Cost-Containment Mechanism				
Carriers are required to reimburse for inpatient and outpatient hospital services at a rate set by the state (155% of Medicare with variations by hospital type). Plans are required to achieve an 85% medical loss ratio (MLR) — up from 80%. Requires all prescription drug rebates and other compensation paid by drug manufacturers to be used to reduce premiums. Value-based payments may be used to incentivize addressing social determinants of health.	PEBP buy-in savings result from administrative efficiencies as a state-run program and a statewide risk pool. QHP model cost-containment mechanisms are undefined, but assumed to be a reduction in provider reimbursement rates; specific rate/cost-containment mechanism to be determined in implementing legislation.	Provider reimbursement rates are based on Medicaid fee schedule, with ability for department to increase reimbursement rates. MLR is the same as applicable Medicaid MLR. Establish a method for procuring prescription drugs, including a wholesale importation program.	Within the study, cost-containment mechanisms differ by model, driven principally by administrative efficiencies/nonprofit status and changes to provider reimbursement. ▶ Under the CCO-led model, providers may be paid Medicaid or Medicaid+ rates. ▶ Under the analyzed carrier-led model, provider reimbursement would be benchmarked to a state-determined blended rate (estimated at 145% of Medicare). Final cost-containment mechanisms to be determined by implementing legislation.	Cascade Care plans will be subject to an aggregate provider reimbursement cap of 160% of Medicare rates, with reimbursement floors for: ▶ Primary care physician at 135% of Medicare ▶ Rural hospitals at 101% of Medicare allowable costs ▶ Exceptions: If the cap will raise premiums, if plans can achieve 10% premium reductions through other means, and/or if plans are unable to form adequate networks given the reimbursement restrictions Contracted insurers are expected to negotiate these rates with provider networks.

Table 1. Comparison of Key Components in Select State Public Option Programs (as of February 2021), *continued*

COLORADO	NEVADA	NEW MEXICO	OREGON	WASHINGTON
Projected Premiums / Savings				
Projected 10% reduction in average premium.	A PEBP buy-in (in the existing employee risk pool) is approximately 9% cheaper than the average ACA gold-level plan; adding buy-in enrollees is expected to raise PEBP premiums for existing enrollees by approximately 2%. A state-sponsored QHP plan was analyzed in a 10% and 20% premium-reduction scenario.	Under the bill, the program would establish an affordability scale for premiums and other cost-sharing fees, based on household income. The targeted Medicaid buy-in study estimated monthly premiums ranging from $377 to $403, a 23% to 28% reduction compared to projected average individual market premiums.	Analysis of an illustrative carrier-led QHP model found projected premium reductions of 10% under a blended provider reimbursement cap. A targeted CCO-led model using Medicaid rates shows significantly lower premiums compared to equivalent metal-tier coverage.[13]	The 2021 monthly average premiums for silver-level public option plans range from $392 to $490 (depending on rating area), compared with $385 and $528 for non-public option standard plans. Nonstandardized plans range from $376 to $500.
Federal Authority				
QHP certification; potential for future Section 1332 waiver for pass-through funding	QHP certification for models on the marketplace; potential for a future Section 1332 waiver	No federal authority required; potential for a future Section 1332 waiver	QHP certification for models on the marketplace; potential for future 1332 waivers for pass-through funding	QHP certification
Financing				
The public option will require minimal state funding and does not require the state of Colorado to cover any costs of care; plans on the marketplace are eligible for federal tax credits for eligible enrollees. Estimated state costs include $750,000 to launch over two fiscal years and then less than $1 million per year for oversight and maintenance.	Premium revenue	Premium revenue and state subsidies would be financed with state funds via a "health care affordability and access improvement fund." Under the proposed program, the state will appropriate $12 million from the general fund annually for implementation and administration of the Medicaid buy-in plan.	The legislation calls for a plan with zero net costs for the state, and a plan that encourages the utilization of federal premium tax credits and other subsidies available under federal law; as well as maximizing the receipt of federal funds to support the costs of the program. A targeted CCO-led model for family glitch and undocumented populations requests state subsidies to ensure affordability; subsidies estimated at $62 to $73 million per year.	Cascade Care plans on the marketplace qualify for federal tax credits for eligible enrollees; no additional state subsidies are provided in year one but are under consideration for future implementation.

Table 1. Comparison of Key Components in Select State Public Option Programs (as of February 2021), *continued*

COLORADO	NEVADA	NEW MEXICO	OREGON	WASHINGTON
State Financial Assistance				
If Colorado seeks federal pass-through funding through a federal Section 1332 waiver submitted as part of this plan, at least 80% of the federal pass-through funding received would be used to increase affordability for unsubsidized individuals and families.[14]	Potential for state subsidization to mitigate the impact of a PEBP buy-in, in the state employee risk pool, on existing state employee premiums. Potential state contribution estimated at $6.5 to $9.6 million annually.	The study proposed the Medicaid buy-in option would provide state-funded premiums and cost-sharing assistance for those with incomes below 200% FPL.	Potential for state subsidies for specified populations.	Cascade Care included a study of potential state-based subsidies. A report outlining the impacts of a flat per-member per-month subsidy or enhanced premium and cost-sharing subsidy structure was released in November 2020.[15] The program could cost between $100 million and $200 million, financed by a health insurance premium tax, a claims-based assessment, or a covered lives assessment.
Outcome / Next Steps				
The legislation was abandoned in May 2020 after the COVID-19 public health emergency restructured the state's health care priorities; lawmakers hope to return to public option legislation in 2021.	Implementing legislation may be considered in the 2021 legislative session.	Additional funding was appropriated for further study in 2019, but legislation was postponed indefinitely. Potential for consideration in the 2021 legislative session as part of a coverage package.	Implementing legislation may be considered in the 2021 legislative session.	Plan coverage will begin January 1, 2021. Oversight of the Cascade Care carriers will continue as the state evaluates implementation of the program. Legislation (Substitute S.B. 5377) has been introduced in the 2021 legislative session to evolve the program, including state subsidies and provider and insurer participation requirements.

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About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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Final Report for Colorado's Public Option (PDF), Colorado Div. of Insurance and Dept. of Health Care Policy & Financing, November 15, 2019.

Endnotes

1. *Health Insurance Coverage in the United States: 2019*, US Census Bureau, September 2020.
2. In 2019, the uninsured rates for nonelderly White populations was 7.5% compared to 21.8% for American Indians / Alaska Natives, 19% for Hispanic populations, and 11.5% for Black populations. For more, see Samantha Artiga, Kendal Orgera, and Anthony Damico, "Changes in Health Coverage by Race and Ethnicity since the ACA, 2010–2018," KFF (Kaiser Family Foundation), March 5, 2020.
3. Adapted from *Public Option in California*, Insure the Uninsured Project (ITUP), March 2020, and the updated brief *Public Option in California*, ITUP, December 2020.
4. Notably, the purest form of this archetype would include full government control over the delivery system, including provider services (e.g., the Department of Veterans Affairs, the United Kingdom National Health Service). This is currently not under consideration at the state level.
5. Use of a third-party administrator to assist with administrative and claims processing would be permitted under this option
6. Chiquita Brooks-LaSure et al., *Senate Concurrent Resolution No. 10 Study: Evaluating Public Health Insurance Plan Options for Nevada Residents*, Manatt Health, January 2021; and Chiquita Brooks-LaSure et al., *Oregon Public Option Report: An Evaluation and Comparison of Proposed Delivery Models*, Manatt Health, December 2020.
7. Subsidized enrollees purchasing the benchmark Silver-level plan are protected from changes in benchmark premiums because the advanced premium tax credit calculation is based on a fixed percentage of income. However, consumers that use their tax credits to purchase Bronze or Gold plans may experience changes in their purchasing power as a result of a lower-premium benchmark plan.
8. Brooks-LaSure et al., *Senate Concurrent Resolution*.
9. Chiquita Brooks-LaSure et al., *Evaluating Medicaid Buy-In Options for New Mexico*, Manatt Health, December 2018; and Chiquita Brooks-LaSure et al., Quantitative Evaluation of a Targeted Medicaid Buy-In for New Mexico, Manatt Health, January 2019.
10. See note 7.
11. For uninsured data, Katherine Keisler-Starkey and Lisa N. Bunch, *Health Insurance Coverage in the United States: 2019* (PDF), US Census Bureau, September 2020; for marketplace type, "State Health Insurance Marketplace Types, 2021," KFF, n.d.; and for Medicaid managed care penetration, "Total Medicaid MCO Enrollment" (2018), KFF, n.d.
12. *2021 Standard Plans – April 2020* (PDF), Washington Health Benefit Exchange, April 29, 2020.
13. The targeted CCO-led coverage analyzed in the report would have benefits equivalent to Medicaid, and therefore above the platinum level. Currently, no platinum plans are available in the Oregon market, so premium comparisons are difficult.
14. *Legislative Report: Plan to Implement and Fund State Premium Subsidies* (PDF), Washington Health Benefits Exchange, November 13, 2020.
15. In 2020, Colorado separately passed SB20-215 to establish the Health Insurance Affordability Enterprise. The enterprise will use a state-based health insurance fee hospital assessment to fund the state's reinsurance program and new state subsidies.