State Public Health Insurance Options: A Comparison

Access to affordable, quality health care is a necessary, yet unmet, component of keeping our nation healthy. Regardless of political affiliation, people believe affordable health care should be a top priority of their elected officials. Despite coverage expansions under the Affordable Care Act and additional action taken by state legislatures across the country, health care remains out of reach for many Americans who don't have it and too expensive for those who do.

Public health insurance options have emerged to fill the gaps that leave people uninsured or underinsured. A public health insurance option provides an affordable and dependable, government-regulated health insurance plan that is often privately run and offers an additional insurance choice for people who do not have coverage through their job, Medicare, or Medicaid. By increasing competition within the market by using the strength of a state's purchasing power, public health insurance options create more affordable options for consumers. With an eye on health equity, these plans can reduce disparities by engaging diverse voices to improve network adequacy standards, provide additional subsidies for those in need, and expand access to safety net and rural providers.

States have been leading the way: Washington, Nevada, Colorado, and Minnesota have each passed a version of a public health insurance option tailored specifically to the needs of their states. Momentum in these states has led state policymakers in other states to look into how a public health insurance option could work for their constituents as well. Unsurprisingly, these efforts are popular: national polling shows that nearly 70% of Americans support a public health insurance option. People desire a system that provides affordable coverage options while giving them the certainty that care is there when they need it.

Commonalities among state public options include using mechanisms to establish provider rates, working within existing markets, prioritizing equity, and seeking pass-through funds from the federal government with 1332 waivers. The table below details the common themes as well as differences between state-level public health insurance option models.

Comparison of State Models

	Colorado (2021, 2023)	Nevada (2021)	Washington (2019, 2021)	Minnesota (2023)
Markets Affected	Individual and small group market	Individual market	Individual market	Individual market
Status	Coverage began January 2023 with plans offered in all 64 counties; public hearings to begin June 2023	Coverage to begin January 2026 on the individual market to align with the next procurement process to select Medicaid managed care organizations (MCOs); small business implementation delayed Addition of Market Stabilization Program announced in October 2023, with the state's proposed 1332 waiver application sent to CMS for approval in December 2023	Coverage began January 2021, with plans offered in 37 out of 39 counties in 2024	Report to the Legislature on the implementation and federal waiver plan for the public option by February 1, 2024. Minnesotans will have the option to enroll in coverage through the public option by January 1, 2027
Overall Approach	★ Creation of a standardized plan called the Colorado Option that includes set benefits and cost-sharing, ways to address racial health disparities, and first-dollar pre-deductible coverage for high-value services ★ Enhanced rate review and additional authority for the Division of Insurance	★ Nevada's Coverage and Market Stabilization Program takes a unique approach to increasing affordability for Nevadans by combining a Public Option with three additional components: a reinsurance program, incentive payment program for issuers, and investment in Nevada's healthcare workforce through a student loan repayment program	★ The state contracts with private issuers to offer standardized "Cascade Select" plans offered on the individual market ★ Cascade Select plans cap aggregate provider reimbursement at 160% of Medicare rates, with payment floors for certain services like primary care and rural hospitals ★ 2021 legislation introduced state subsidies and hospital	★ Minnesota will complete economic and actuarial analysis on the design of several different public option models, including a buy-in to MinnesotaCare (the state's basic health plan), to craft the best proposal for Minnesotans ★ The proposed public option design must take into consideration data on the impact of provider access for enrollees, including the variety and

	and limits on issuers' administrative costs and profits ★ Private issuers are required to offer the Colorado Option with premiums that meet a premium reduction target (5% lower than the previous year's rates; totaling 15% over 3 years) ★ Colorado Option plans are required to be displayed for consumers in a way where they can be "easily identified and compared" ★ Following 2023 public hearings, 80% of issuers offering individual plans, and 66% of insurance companies offering small group plans have decreased initial premium requests ★ In 2024, 25 individual market and 24 small-group market Colorado Option plans will meet state target's of a 10% reduction in premiums (against 2021 levels)	★ The Public Option and Market Stabilization Program together must meet annual premium reduction targets (15% lower over the first four years of waiver implementation) ★ Leverages Nevada's Medicaid MCO infrastructure to create new requirements for issuers who wish to participate in the managed care program to also submit a bid to offer Public Option plans ★ Public Option plans must meet the same standards and provide the same core benefits as private plans under the Affordable Care Act (ACA) ★ Issuers and providers will negotiate their reimbursement rates and network coverage, with a requirement for a minimum reimbursement "floor" that prohibits issuers from providing reimbursement rates below Medicare levels	participation requirements ★ In 2024, public option plan rates increased at just 5%, as compared to an 8% increase in rates for non-public option plans	volume of plan options, and provider reimbursement rates ★ The proposed design must prioritize affordability for enrollees using a household budget approach that considers total costs paid by consumers when calculating enrollee premiums and cost-sharing, minimize premium affordability cliffs, and consider the impact on racial and ethnic disparities in rates of insurance and access to services
Provider and Hospital Participation	If hearings are required due to issuers not meeting the premium reduction targets,	Requires providers and facilities that participate in Medicaid, the Public	Hospitals that provide services and receive reimbursement from Washington's public	Awaiting recommendation from the Commissioner of Commerce by February 1, 2024, as

	the Department of Public Health and Environment can require providers to participate, which are scheduled to be held beginning June 2023. If the provider refuses, warnings and fines can be issued to hospitals and providers	Employees' Benefits Program, or worker's compensation to also participate in at least one public option plan's network	employee benefits program, school employees benefits program, or Medicaid must also participate in at least one public option plan	informed by economic and actuarial analyses. A public option centered on expanding MinnesotaCare would use existing provider networks that exist for current MinnesotaCare beneficiaries
Provider & Hospital Rates	If issuers fail to meet premium reduction targets, DOI is authorized to set hospital and provider rates at no less than 165% and 135% of Medicare rates, respectively. Hospitals will receive a base rate of 155% of Medicare with: ★ Essential access and independent hospitals to receiving a 20% increase; ★ Independent critical access hospitals receiving a 40% increase; ★ Some pediatric specialty hospitals receiving a 55% increase; ★ Hospitals with a high percentage of Medicaid and Medicare patients receiving up to a 30% increase; and ★ Hospitals efficient at managing the underlying cost of care receiving a 40% increase	At least equal to Medicare rates; for FQHCs and rural health clinics, rates must be at least the reimbursement rate established for patient encounters. For community behavioral health clinics, rates must be at least those under the Medicaid state plan	Establishes a provider reimbursement cap of 160% of Medicare rates; includes a 135% of Medicare rate floor for primary care and 101% of Medicare rate floor for rural critical access hospitals and sole community hospitals (allowable costs)	Provider reimbursement rates shall be set at a level that maintains an adequate provider network for enrollees, as determined by the actuarial and economic analyses. A study has been in progress and a report is due back to the legislature next year, on rate adequacy in Medicaid, which would impact a public option centered on expanding MinnesotaCare

Issuer Participation	Requires issuer that offer plans in the individual and/or small group markets to offer the Colorado Option	Any issuers bidding to offer Medicaid managed care plans must also submit competitive bids to offer public option plans. The state may also invite non-Medicaid issuers to submit bids to ensure access for enrollees	Optional; the state is considering whether to require issuers offering public employee plans or Medicaid to also submit bids to offer Cascade Select plans	The state will determine the most appropriate issuers of the public option to maintain adequate availability of providers and health care services for enrollees. A plan expanding a current program, like MinnesotaCare, would likely use existing issuers.
Eligibility	Coloradans who purchase health insurance on the individual market, including undocumented people, and small employers with under 100 employees	All residents of Nevada who qualify for federal premium subsidies under the ACA are eligible for the Public Option. All Nevadans enrolled in a health insurance plan on the Marketplace are eligible to benefit from the reinsurance program components.	All Washingtonians eligible for marketplace coverage, including undocumented people	Legislative proposal included all Minnesotans who are eligible for health insurance on the individual market. Final eligibility to be determined after Commissioner report on February 1, 2024
1332 Waivers	★ Authorized in legislation; pass-through funds will go towards implementation and administration of standardized plan as well as providing additional premium and cost-sharing assistance ★ CMS approved the 1332 waiver in June 2022. This waiver allows Colorado to capture $213.8 million in federal pass-through funding in 2023 to provide people with further affordability	★ Authorized in legislation; enables the state to capture an expected $279 million in federal pass-through funding to subsidize low-income Nevadans and combine the risk pools for the public option and Medicaid if it meets certain parameters ★ Nevada submitted a Section 1332 waiver application to CMS for approval on December 29, 2023 ★ The Section 1332 Waiver is expected to generate an estimated $279 million in federal savings	★ Authorized in legislation; provides premium or cost-sharing assistance, increases access to qualified health plans, and expands exchange programs that increase affordability ★ CMS approved the 1332 waiver in December 2022. This waiver expands access to health and dental plans to undocumented people	★ Authorized in legislation; final program design must minimize impact on the individual market and maximize affordability for public option plan enrollees, as informed by actuarial and economic analysis ★ The Commissioner of Commerce is authorized to submit a Section 1332 waiver for federal approval by June 1, 2024. Earlier action may be taken by the legislature.

	assistance and is expected to increase in future years	in the first five years, and $760 million in the first ten years		
Specific Reference to Addressing Disparities or Health Equity	★ The plan must be designed to improve racial health equity and decrease racial health disparities, including through perinatal health coverage and providing certain high-value services pre-deductible ★ First-in-the-nation approach to ensuring culturally responsive networks that reflect enrollee diversity ★ Issuers are required to take steps to improve health equity and reduce racial health disparities in developing their network access plan ★ Stakeholder engagement process and diverse advisory committee will be set up to aid in implementation ★ Covers all Coloradans, regardless of immigration status	★ Instructs the Agency to prioritize bids from issuers that contract with providers who decrease disparities and support culturally competent care ★ The Coverage and Market Stabilization Program will address geographic disparities in affordability for rural residents of the state ★ The state is considering additional provisions to improve access and outcomes for Nevada's historically marginalized communities	Cascade Care plans must meet requirements for improving health, including adhering to standards on health equity	★ Actuarial and economic analysis conducted ahead of the state's 1332 waiver must include information on the impact of public option models on populations defined by race, ethnicity, geography, and other metrics. ★ Future legislation or regulations prior to implementation may address health disparities or promote health equity, as informed by the actuarial and economic analyses ★ Final public option likely to cover all Minnesotans, regardless of immigration status
Network Adequacy	Plans will be no more narrow than the most restrictive network the carrier is offering for non-standard plans; plans	Requires providers that participate in Medicaid, the state employee health plan, or worker's compensation to be	Hospitals that provide services and receive reimbursement from Washington's public employee benefits program,	As part of its February 1, 2024 report to the legislature, state agencies must report on the adequacy of the public option's

	will include a majority of essential community providers and include certified nurse midwives in plan networks; plans are also required to implement culturally responsive network components listed above	in-network with at least one public option plan; bids will be prioritized that demonstrate alignment between Medicaid and the public option and include access to critical access hospitals, rural health clinics, certified behavioral health clinics, and federally-qualified health centers	school employees benefits program, or Medicaid must also participate in at least one public option plan	expected provider network as informed by the actuarial and economic analyses
Federal/State Funding	State funding: ★ Fiscal Note: $1.5 million for implementation in FY 2021-2022 ★ $1.9 million for ongoing operating costs in FY 2022-23 and beyond Federal funding: ★ Estimated pass-through funding captured through the state's 1332 waiver ($1.618 billion over five years): ○ 2023 - $213.8 million ○ 2024 - $277.3 million ○ 2025 - $341.5 million ○ 2026 - $347.8 million ○ 2027 - $367.6 million	State funding: ★ Fiscal Notes (As Introduced) ★ Appropriations included in final legislation include $1,639,366 to create the Public Option Trust Fund; $600,000 for preparing the states' 1332 waiver application (including actuarial analysis); $1,869,212 for exchange operating costs Federal Funding: ★ Estimated pass-through funding captured through the Section 1332 waiver ($279 million over five years, $760 million over ten years) ○ 2026 - $15 million ○ 2027 - $58 million ○ 2028 - $69 million ○ 2029 - $81	State funding: ★ 2019-2020 Omnibus Budget appropriated the following for implementation: ★ $400,000 to the Health Care Authority ★ $1,048,000 to the exchange The 2021-2022 Omnibus Budget appropriated $289,000 to the Health Care Authority and $8,012,000 to the exchange for implementation, but those costs are largely for implementing the state-level financial assistance components of the legislation Federal funding: ★ Estimated pass-through funding captured through the state's 1332 waiver ($11.99 million over five years, $28.65 million over ten	State funding: ★ 2023 Omnibus Budget appropriated the following: ○ $2.5 million for the actuarial and economic analyses and preparation of the 1332 waiver ○ $22 million for initial implementation, contingent on federal 1332 waiver approval Federal funding: ★ To be determined by the state's 1332 waiver.

		million ○ 2030 - $87 million	years): ○ 2024 - $1.92 million ○ 2025 - $2.22 million ○ 2026 - $2.43 million ○ 2027 - $2.62 million ○ 2028 - $2.80 million	
Enrollment	Approximately 35,000 people in 2023, including 10,000 undocumented people through the state's OmniSalud program; the 25,000 enrolled through the state's exchange represent 13% of the individual market Connect for Health Colorado experienced record enrollment for 2024 with 237,107 enrollees (18% higher than previous year)	The unique design and intent of Nevada's Coverage and Market Stabilization program means approximately 2,100 additional Nevadans will newly enroll in the individual market due to the creation of the Coverage and Market Stabilization Program, also bringing improved affordability to almost 100,000 Nevadans in the individual market	Approximately 27,000 people in 2023; this represents 11% of the individual market 2023 sign-ups for Cascade Select plan increased to 27,000 enrollees (compared to 8,000 in 2022)	Estimates to be reported by February 1, 2024. There are 300,000 uninsured Minnesotans and many more underinsured, such as those with high deductible health plans, who may benefit from the public option
Entities Responsible for Implementation	Colorado Department of Regulatory Agencies Division of Insurance (DOI)	Nevada Department of Health and Human Services Division of Health Care Financing and Policy, in consultation with Nevada Health Link, the state's exchange, and the Division of Insurance	Washington Health Care Authority, in consultation with Washington Healthplanfinder, the state's exchange	Minnesota Department of Commerce, in consultation with the Department of Human Services and MNsure, the state's exchange
Helpful Resources	CO Option landing page CO Option public hearing schedule	Nevada Coverage and Marketplace Stabilization Program landing page 1332 waiver application as	Washington Cascade Select landing page 1332 waiver application submitted	Authorizing legislation – lines 701.5 through 705.20

	1332 waiver amendment request CMS 1332 waiver approval Standardized plan regulation Premium rate reduction methodology	submitted to CMS	CMS 1332 waiver approval Hospital provider participation requirements	