



To: Interested Parties
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Subject: Constructing a study: public health insurance option policy development

Executive Summary

Several states have proposed legislation in recent years to implement a public insurance option and Nevada recently enacted a public option. As a precursor to proposing new legislation, state legislatures and governors sometimes create committees to study the feasibility of a public option and the impact such a policy would have on the state's health care system. While frequently these studies focus solely on public option legislation, others also include an analysis of Medicaid buy-in, single and multi payer systems, and other changes to the state Medicaid program or marketplace. Studies are an important way to advance policy development and stakeholder engagement on the path to public option legislation.

Key Findings

- ★ Seven of the states that completed studies went on to propose public option legislation, showing that for many states, a study is an early first step in the process.
- ★ Most states required committees to study specific policies, such as single or multi-payer systems, public option or Medicaid buy-in, and increasing marketplace subsidies and tax credits. Nearly all states included requirements to maximize the use of federal funds.
- ★ Study length and cost varied widely, with longer and more expensive studies tending to include a thorough examination of financing options and actuarial analysis.
- ★ Most states included language allowing for gifts, grants, and donations from public and private sources to be contributed towards the cost of the study to help stretch limited budgets.
- ★ Committees were typically required to have health policy experts, providers, and insurance carriers, but some states included additional requirements for members with diverse voices (i.e. race, gender, economic status, experience accessing public services). States that delegated studies to state agencies required consultation with these groups.
- ★ States that have passed or are actively pursuing public option legislation also use studies to refine programs or plan for implementation.

Other Considerations

- ★ While not a part of the examined legislation, states should also include requirements for the study to consider how implementation of a public option,

Medicaid buy-in, or similar program can be used to advance health equity or close gaps in health disparities.

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Public Option Proposals

A public health insurance option, often called a “public option,” is a government-regulated insurance plan that is often privately-run. It can be made available to individuals, small businesses, and/or other entities, like nonprofit organizations, and can be chosen as an alternative to a traditional private insurance plan, typically at a lower cost. Public option plans are an improvement to the health care system that lower costs and make quality health care more accessible by adding more competition for the health care industry.

Seven of the states that completed studies on public option, Medicaid-buy-in, or similar policies either proposed or passed public option legislation between 2018-2021. Studies can serve as a useful tool to develop policy before pursuing public option legislation.

- ★ Legislation was signed into law in [Washington](#) in 2019 creating a public option. Washington completed a study in [2019](#) on steps to increase access to health insurance, including a universal system and other available financing mechanisms (i.e., public option, Medicaid-buy-in, state compacts) Washington also pursued a [study](#) after passing public option legislation to further increase affordability.
- ★ A public option was proposed in [New Jersey](#) in 2020 following the [2019 study](#) on different options to improve affordability, including subsidies, premium assistance, implementing a Basic Health Program, and Medicaid-buy-in.
- ★ Several Medicaid-buy-in bills were proposed in 2019 in Oregon and a [public option bill](#) has been introduced in 2021. Oregon passed legislation creating studies in [2018](#) and [2019](#) that examined a public option and Medicaid-buy-in among other policy proposals.
- ★ A [public option bill](#) was initially introduced in Colorado in 2020, and [another bill](#) has been introduced in 2021. Colorado’s previous studies in 2019 included an analysis of [implementation of a public option](#) and a broader [study](#) of multi and single payer systems.
- ★ Nevada’s legislature passed public option legislation in [2017](#), but it was not signed into law. A public option bill has also been [introduced in 2021](#). Nevada completed two studies on Medicaid-buy-in and public option implementation in the intervening years.
- ★ [Legislation](#) was introduced in Maine in 2019 to create a public option following the 2017-2018 [study](#) analyzing public option and single payer policies.

Research Focus

All studies included a broad goal of achieving universal coverage for their populations. Most states required committees to study specific policy options, including creating a single-payer or multi-payer system, implementing a public option or Medicaid buy-in, and increasing Marketplace subsidies and tax credits. A few states did not include requirements for committees to study specific policy options, and instead requested committees analyze the current state health care landscape, including examining what other states have done, and provide recommendations. Nearly all states included requirements to maximize federal funds. Several states included federal policy

implications such as 1332 waivers, 1115 waivers, and implementing a Basic Health Program under section 1331 of the ACA.

State examples

- ★ California's [2018](#) and [2019](#) bills included a broad directive to study options to create a single-payer financing system, but noted that the committees should consider public option and Medicaid-buy-in policies as well.
- ★ Colorado commissioned two studies in 2019, a [5-month study](#) requiring analysis of a public option and a [2 year study](#) analyzing the current healthcare system, a multi-payer universal system, and a single-payer universal system. The second bill required the committee to present any necessary federal waivers or state plan amendments needed to implement the proposal.
- ★ [Delaware](#) established a Medicaid-Buy-In Study Group to examine the impact of using a 1332 waiver to establish a program that would allow individuals with incomes above 138% of the Federal Poverty Level to purchase insurance coverage through Medicaid.
- ★ [Maine](#)'s bill required the committee to study implementing a public option and a single payer system with multiple financing methods. The committee also examined waiving requirements under the Affordable Care Act in order to maximize federal funds for implementation of the option.
- ★ Nevada's [2017](#) and [2019](#) bills required the Legislative Committee on Health Care to examine the feasibility of a Medicaid-buy-in program if the ACA was repealed and to later study the design and viability of a public option.
- ★ [New Jersey](#)'s study required an analysis of implementing additional state subsidies to the marketplace, lifting caps on premium assistance in the marketplace, implementing the ACA's Basic Health Program, and creating a Medicaid-Buy-In option.
- ★ New Mexico commissioned an initial [2018 study](#) to examine the impact of a Medicaid-buy-in program and a longer study in [2019](#) to study the administration of such a program under sections 1331 and 1332 of the ACA.
- ★ Oregon's [2018 bill](#) required an analysis of a Medicaid-buy-in program, increased flexibility for consumers eligible for premium tax credits, and aligning networks in Medicaid and the Marketplace. The [task force](#) created in the following year was required to develop a plan for a Medicaid-buy-in program or public option, including drafting any federal approvals required to implement the plan.
- ★ Washington's [2019 bill](#) provided recommendations to the legislature on steps to implement, maintain, and fund a universal healthcare system, but also recommended studying alternate financing mechanisms (i.e. public option).

**See appendix A for a side by side comparison of the research focus of all studies*

Timeline

On average, committees met for approximately 13 months before delivering their final reports. However, the timelines ranged from 4 months to 2 years. Reporting requirements

throughout this timeline also varied. States committees that met for about a year ([New Jersey](#), [Nevada](#)) delivered a final report to the legislature at the specified deadline with no other updates. Committees with longer timelines ranging from 16-24 months ([Washington](#), [Maine](#), [Colorado](#), [California](#), [New Mexico](#)) were required to provide at least one update before the final report was due, and sometimes once every six months. In contrast, groups that met for 6 months or less ([Colorado](#), [Delaware](#), [New Mexico](#)) provided a final report that focused on a specific topic rather than analyzing the impact of proposed changes on the state's entire health care system.

State examples

- ★ [California](#) passed legislation in 2019 updating its original 2-year study with goals focused on examining single-payer and other universal access systems.
- ★ Colorado and New Mexico completed shorter 4-5 month studies before launching 12-24 month studies on more in depth topics or examining different financing mechanisms.
- ★ Nevada, Oregon, and Washington completed multiple 13-18 months studies consecutively.

Cost of the Study

The cost of studies on potential health reforms varied widely: less expensive studies used existing state resources whereas more expensive studies included actuarial assessment. Several states ([California](#), [Delaware](#), [Maine](#), [Nevada](#), [New Mexico](#), [Oregon](#)) listed no fiscal impact, sometimes because committee members served without compensation aside from reimbursement for travel expenses. Other states ([New Jersey](#), [Washington](#)) granted authority to state agencies or ongoing committees, but did not include a specified dollar amount. In studies that included a fiscal impact, the total cost ranged from \$92,649 ([Colorado](#)) to \$1,174,816 ([Oregon](#)), with an average of \$479,336. These costs were not dependent on study length.

State examples

- ★ Most states included language specifying that gifts, grants, and donations from public and private sources were allowed ([Colorado](#), [Maine](#), [Oregon](#)), which can be a helpful way to fund studies when states have limited budgets.
 - [Colorado](#) created an exemption to the Taxpayer Bill of Rights (TABOR), a law restricting the use of state revenue, in order for gifts, grants, and donations to be allowed to go towards funding their 2019 study.
- ★ Costlier studies (those over \$500,000) specified that the study should include an actuarial analysis ([Colorado](#), [New Jersey](#), [Oregon](#), [Washington](#)).
- ★ [Delaware](#) noted that the general assembly would appropriate general funds for the study, while other states ([Maine](#)) specifically disallowed general fund appropriations.

Committee Composition

Most legislation authorizing studies included specifications for committee size and membership. Committee size ranged from 9 to 20 members and included appointments by state legislators and the governor. Appointments varied, some states ([California](#), [Oregon](#)) included a broad directive to choose health experts in business, academia, labor, and philanthropy while other states used fixed criteria. These criteria included naming specific positions, such as the insurance commissioner or the director of the state Medicaid program, and basing requirements on experience or qualifications. For example, some states ([Maine](#), [Delaware](#)) required a certain number of legislators, providers, hospital representatives, and people with expertise in insurance, small and large businesses, and health policy. A few states ([Colorado](#), [Oregon](#)) highlighted the need for diverse perspectives. [Oregon](#) required inclusion of advocates, diverse social identities (such as race and economic status), and consumers with experience using public programs or seeking care for mental and chronic disease. Other states did not appoint any members and instead tasked an existing agency ([Colorado](#), [New Jersey](#), [Washington](#)) or legislative committee ([Nevada](#), [New Mexico](#)) to complete the study, often by hiring a consultant.

State examples

- ★ [Oregon](#)'s 2019 bill contained the most requirements for committee members from diverse backgrounds, including geography, race, ethnicity, sex, gender, sexual orientation, economic status, and disability or health status. The bill also required committee members with experience accessing rural healthcare, alternative therapy, and social services. [Oregon](#)'s 2018 bill did not include these specific requirements, but a broad directive for experts in health policy.
- ★ [Colorado](#)' 2019 bill authorizing a 5 months study granted authority to the Department of Public Health & Environment and the Division of Insurance to carry out the study in consultation with other state agencies and external experts.
- ★ [Nevada](#)'s [2017](#) and [2019](#) bills were both conducted by the Legislative Committee on Health Care. In 2017 legislators and staff conducted the study in consultation with state agencies. In 2019 the legislature contracted with several consultants to conduct the analysis.
- ★ [Delaware](#)'s 2018 Medicaid Buy-In study included the directors of state health agencies, members appointed by the legislature and the governor, and a contractor hired to complete the fiscal analysis.

Stakeholder & Committee Engagement

Nearly half of states required committees to consult with certain groups throughout the study. This was particularly common among states that used an existing agency ([Colorado](#), [New Jersey](#), [Washington](#)) or legislative committee ([Nevada](#), [New Mexico](#)) and did not appoint specific members. States most frequently included the state health benefit exchange, but also cited other state agencies such as the department of health, office of insurance, department of revenue, and the department of business or commerce. While it is unclear to what extent these organizations were involved in studies, they are some of the

same groups that were explicitly included as members of committees in states that did not require any external consultation.










State examples

- ★ [New Jersey](#) and [New Mexico](#) required committees to consult external groups, such as advocates, insurers, providers, and the general public.
- ★ [Washington](#)'s bill included the legislature as a stakeholder, in addition to consumers, businesses, labor groups, healthcare providers, health carriers, and state agencies. This state's study was carried out by the state health department with no legislative involvement otherwise.

Conclusions

- ★ States frequently conduct multiple studies, but may focus on different topics or vary in thoroughness. For example, Colorado's [5-month study in 2019](#) included a general analysis of implementing a public option while the [2 year study](#) required the committee to present any necessary federal waivers or state plan amendments needed to implement the proposal.
- ★ Costs varied widely. While they were not associated with study length, studies that included more in depth analysis (i.e. actuarial analysis) were more likely to cost over \$500,000.
- ★ Most states included language allowing for gifts, grants, and donations from public and private sources to be contributed toward the study.
- ★ States varied between including a general directive for committee members to have experience in healthcare, listing specific criteria members had to meet, and delegating responsibility for the study to an external agency or legislative committee. In the latter instance, agencies and legislative committees were frequently required to consult with certain groups.
- ★ While some states only required members from the healthcare or health policy industries, others included requirements for diverse voices in their studies. This includes race, gender, economic status, and experience accessing public services like Medicaid or CHIP.
- ★ All studies contained the broad goal to achieve universal coverage, but varied from specifying a policy proposal (i.e. public option, Medicaid buy-in, Marketplace subsidies) to requesting a general analysis of the healthcare landscape.
- ★ Nearly every study recommended using federal funding to the fullest extent possible. Some states required committees to analyze how funding would change using 1332 waivers, 1115 waivers, and implementing a Basic Health Program under section 1331 of the ACA.
- ★ Public option legislation proposals frequently followed studies. Occasionally legislation authorizing studies was passed after a public option proposal failed to advance.

Appendix A: Research Focus Summary Table

State	Year	General Analysis*	Public Option	Medicaid Buy-In	Single or multi payer	Marketplace Changes	Federal Funding**	1115 Waiver	1332 Waiver	1331: Basic Health Program
 California	2018		✓		✓					
	2019	✓			✓					
 Colorado	2019		✓				✓			
	2019	✓			✓		✓			
 Delaware	2018			✓					✓	
 Maine	2017	✓	✓		✓		✓			
 Nevada	2017			✓		✓				
	2019		✓							
 New Jersey	2019			✓		✓	✓			✓
 New Mexico	2018			✓			✓		✓	
	2019			✓			✓		✓	✓
 Oregon	2018			✓		✓	✓	✓	✓	
	2019	✓			✓		✓	✓	✓	
 Washington	2019	✓			✓		✓			
	2019		✓							

* General analysis means that the state asked for broad recommendations, but study results may include public option, Medicaid buy-in, etc.

**Federal funding means that states included requirements to maximize federal funding, study results might specify 1115 waiver, 1332 waivers, etc.

Appendix B: Study Checklist

- ✓ Determine focus for study. Options include: general recommendations to increase coverage, public option, Medicaid buy-in, Marketplace subsidies, or some combination.
- ✓ Include requirements for the study to consider how implementation of a public option, Medicaid buy-in, or similar program can be used to advance health equity or close gaps in health disparities.
- ✓ Set a timeline for the study. Typically studies averaged 13 months, with a range of 4 months to 2 years.
- ✓ Decide how thorough the study should be. More expensive studies tended to include an actuarial analysis.
- ✓ Allow for gifts, grants, and donations from public and private sources to contribute to the cost of the study. Exempt these funds from state revenue restrictions if applicable.
- ✓ In addition to members with health policy experience, include requirements for diverse voices in the committee, including criteria based on race, gender, economic status, and experience accessing public services.
- ✓ If the study will be delegated to a state agency or legislative committee, include requirements to consult with key healthcare groups (providers, insurers, health advocates) and community members with diverse and lived experiences.
- ✓ Utilize federal funding to the fullest extent possible. Consider asking committees to analyze specific policies like 1332 waivers, 1115 waivers, and implementing a Basic Health Program under section 1331 of the ACA.
- ✓ Consider the impact of pending or recently enacted federal policies on the state's health policy landscape.