State Public Health Insurance Options: A Comparison

Access to affordable, quality health care is a necessary, yet unmet, component of keeping our nation healthy. The pandemic has illuminated the severe flaws in our current health care system, where health inequities abound, needs are unmet, and health insurance is not always attainable. As millions lost their jobs during the COVID-19 pandemic, their health insurance and sense of security in the face of a public health emergency were lost as well. People believe affordable health care should be a top priority of their elected officials.

Public health insurance options have emerged to fill the gaps that leave people without access to affordable health care. A public health insurance option provides an affordable and dependable, government-regulated health insurance plan that is often privately run. By increasing competition within the market, public health insurance options can lead to more affordable options for consumers. With an eye on health equity, these plans can reduce disparities by improving network adequacy standards, engaging diverse voices, providing additional subsidies for those in need, and expanding access to safety net and rural providers.

States have been leading the way: Washington, Nevada, and Colorado have each passed a version of a public health insurance option. United States of Care was a foundational partner in the effort in both Nevada and Colorado. 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. Although it did not pass, Connecticut, too, put forth a robust public health insurance option, most recently during the 2021 legislative session. Oregon passed legislation directing state agencies to construct a plan for implementing a public health insurance option, setting the stage for passage of an eventual public option.

This state progress is building momentum for creating a public option at the federal level. Senator Patty Murray of Washington and Congressman Frank Pallone, Jr. of New Jersey issued a Request for Information (RFI) in May 2021 to inform their efforts to build out a public health insurance option at the federal level. United States of Care submitted recommendations informed by our expertise gained through groundbreaking state efforts for affordable and dependable health care. Our suggestions center on people's needs and the lessons we've learned to pass public options and other major affordability laws in states, and aims to build a better system in the wake of the pandemic — one where people have more certainty that they can afford their care.

Commonalities among state public options include leveraging state buying power to encourage participation, establishing provider rates, working within existing markets, addressing equity, and seeking pass-through funds from the federal government with 1332 waivers. The table below details the common themes and differences between state-level public health insurance option bills.

Comparison of State Models

	 COLORADO	 CONNECTICUT	 NEVADA	 WASHINGTON
Legislation	HB 1232	SB 842 (Proposed Legislation)	SB 420	SB 5526 (2019) SB 5377 (2021)
Markets Affected	Individual and small group market	Small businesses and nonprofits	Individual and small group market	Individual market
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 ★ Private issuers will be 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)	★ Leverage the state employee health plan to provide coverage to people working at small businesses and nonprofits	★ Leverages Nevada's Medicaid managed care (MCO) infrastructure to compel MCO plans to also offer public option plans that meet a premium reduction target (5% lower than the previous year's rates) ★ Authorizes the state's Medicaid director to directly administer the public option if necessary	★ The state contracts with private insurers to offer standardized "Cascade Care" plans ★ The state began offering Cascade Care plans in 2020 following initial bill passage in 2019 and made adjustments to the legislation in 2021
Provider & Hospital Participation	★ If hearings are required due to issuers not meeting the premium reduction targets, the Department of Public Health and Environment can require providers to participate. If the provider refuses, warnings and fines can be issued to hospitals and providers	N/A	★ Requires providers and facilities that participate in Medicaid, the Public Employees' Benefits Program, or worker's compensation to also participate in at least one public option plan's network	★ If the public option is not available in each county in 2022, hospitals that provide services and receive reimbursement from Washington's public employee benefits program, school employees benefits program, or Medicaid must also participate in at least one public option plan in future years
Provider & Hospital Rates	★ If issuers fail to meet premium reduction targets, DOI is authorized to set hospital and provider rates at no less than 160% and 135% of Medicare, 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	N/A	★ 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	★ ≤160% of Medicare rates; ≥135% of Medicare rates for primary care; and ≥101% of "allowable costs" for care provided in critical access and sole community hospitals

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Issuer Participation	★ Requires carriers that offer plans in the individual and/or small group markets to provide the Colorado Option in those markets as well	★ Nonprofits and small businesses and their employees would be eligible to opt into the state employee health plan, which is run by the state and administered through a private issuer	★ Any insurers bidding to offer Medicaid managed care plans must also submit competitive bids to offer public option plans	★ Optional; the state contracts with one or more issuers to offer standardized Cascade Care plans; issuers will now have limits on the number of non-standardized plans they can offer
1332 Waivers	★ Authorized in legislation; premium targets are contingent on the waiver's approval; pass-through funds will go towards implementation and administration of standardized plan as well as providing additional premium and cost-sharing assistance	★ Would have authorized the state to apply for two waivers to reduce the cost of health insurance through cost-sharing reductions and premium assistance	★ Authorized in legislation; enables the state to subsidize low-income Nevadans and combine the risk pools for the public option and Medicaid if it meets certain parameters. Also authorizes the state to pursue a waiver that would provide new temporary coverage options as an alternative to COBRA	★ Authorized in legislation to provide premium or cost-sharing assistance, increase access to qualified health plans, and expand exchange programs that increase affordability
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	N/A	★ Instructs implementers to prioritize bids from issuers that contract with providers who decrease disparities and support culturally competent care	★ Cascade Care plans must meet requirements for improving health, including adhering to standards on health equity
Network Adequacy	★ Plans will be no more narrow than the most restrictive network the carrier is offering for non-standard plans; plans will include a majority of essential community providers; DOI to create network adequacy requirements for the standardized plan	★ Enrollees would have access to the issuer's broadest provider network available through the exchange	★ Requires providers that participate in Medicaid, the state employee health plan, or worker's compensation to be 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	★ If the public option is not available in each county in 2022, hospitals that provide services and receive reimbursement from Washington's public employee benefits program, school employees benefits program, or Medicaid must also participate in at least one public option plan in future years

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State Costs	★ Fiscal Note: $1.5 million for implementation in FY 2021-2022 $1.9 for ongoing operating costs in FY 2022-23 and beyond	★ Fiscal Note: $1.3 million for consulting services, administrative and personnel costs in FY 2022 to the Office of the State Comptroller After design and implementation, costs would be completely offset	★ Appropriations included in final legislation: ● $1,639,366 to create the Public Option Trust Fund ● $600,000 for preparing the states' 1332 waiver application (including actuarial analysis) ● Exchange operating costs: $1,869,212 Fiscal Notes (As Introduced)	★ 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
Year Effective	★ Plans available 2023 with changes to network adequacy going into effect in 2024	N/A (Proposed bill would have gone into effect in 2021)	★ 2026, to align with the next Medicaid MCO procurement process	★ 2021, for the most recent legislation
Entities Responsible for Implementation	★ Division of Insurance (DOI)	Office of the State Comptroller (OSC)	★ Division of Health Care Financing and Policy, in consultation with the exchange and the Division of Insurance	★ Washington Health Care Authority, in consultation with the exchange

*Oregon's HB 2010 directs the Oregon Health Authority and the Department of Consumer and Business Services to create a public option implementation plan. The implementation directive necessitates prioritizing the advancement of health equity through a public option and developing a communications strategy to inform Oregonians on the benefits of a public option. The developed implementation plan and complementing analyses will be provided to the Legislative Assembly by January 1st, 2022.

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