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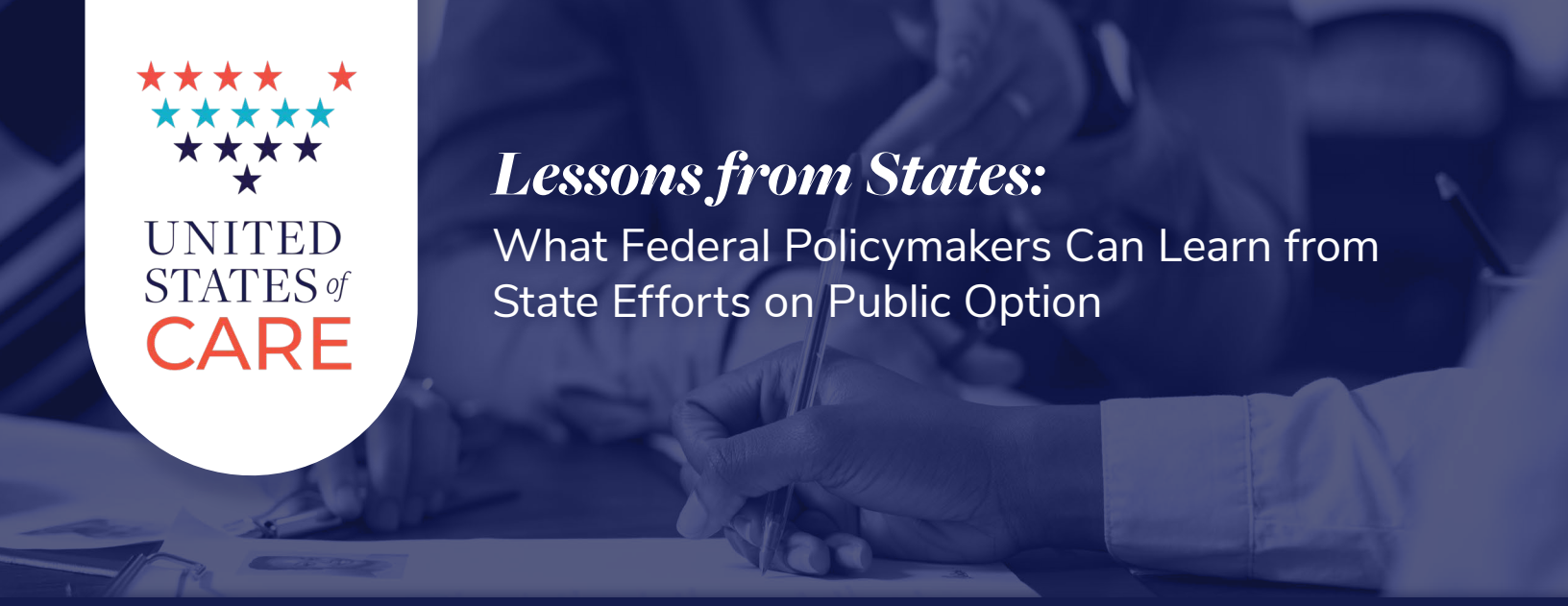
Lessons from States:

What Federal Policymakers Can Learn from State Efforts on Public Option



KEY LESSONS LEARNED

A well-designed federal public option can build on previous health care reform efforts to help address some of the key challenges in our health care system and make it work better for everyday people. Some states have established public options at the state level and these policy designs and experiences provide valuable lessons learned for federal policymakers should they choose to pursue this policy at the federal level.

Determining Prices & Constraining Costs	In order to improve premium affordability for people and ensure stability for critical providers, a federal public option should constrain excessive payments to high-cost outlier providers and bolster payments to certain providers that have lagged.
Benefit Design	A federal public option can be leveraged to standardize plan design, including benefits and cost sharing structures, as well as require coverage of certain high-value services pre-deductible or with zero or reduced out-of-pocket costs. A federal public option should also emphasize predictable cost sharing structures like copays over coinsurance to better help patients budget for care.
Provider Access	A federal public option should tie provider participation to participation in other federal health programs like Medicare and Medicaid to better guarantee access to health care services, as states have in their approaches to public options.
Public Option Administration	States were hamstrung in their ability to operationalize a government-run public option in a way that the federal government is not. When evaluating key outcomes from state public options, Congress should factor in states' use of private insurance carriers in administering these plans and consider that a government-run federal public option may be better equipped to reduce costs and administrative expenses and improve affordability.

INTRODUCTION

Health care is a fundamental part of all people's lives. Yet, too few people in the United States have the health care they want, need, and can afford. Recent polling found that 23 percent of respondents believe the health care system is "in a state of crisis" and another 47 percent believe the system has "major problems." This widespread dissatisfaction, frustration, and mistrust has reached a fever pitch – and it's driving people's desire for policy change. In a recent USofCare/Morning Consult poll, 76 percent of respondents said that a candidate's position on health care costs is important in deciding their vote in the 2026 midterm elections.

There is broad agreement that the current system isn't working for people, and a lot of different ideas about how to fix it. As federal policymakers explore policy options for health care reform, states' efforts to improve health care coverage and affordability can provide valuable insights and blueprints for reforms at the federal level.

States have long led the way in policy innovation, and establishing public health insurance options (referred to as a "public option") are no exception. A public option is a government-regulated health insurance plan that competes alongside privately-run insurance plans to expand health care coverage and address increasing costs in the insurance market.

USofCare and our partners are proud to have been deeply involved in state efforts to establish and implement public options, including in states that have successfully done so – Nevada and Colorado. Through this work on state public options – from inception, study, passage, and through implementation – USofCare has identified key lessons learned from these efforts that can help inform the development of a federal public option.

For federal policymakers considering the concept of a federal public option, this issue brief lays out the key lessons learned from state public option efforts, focusing on **provider payment and access**, **benefit design**, and **public option administration**. We offer our perspective on how these lessons learned can help inform a federal approach to establishing a public option.

STATE EFFORTS TO ESTABLISH A PUBLIC OPTION

	Colorado (2021, 2023)	Nevada (2021)	Washington (2019, 2021)
Market	Individual and small group market	Individual market	Individual market
Status	Colorado Option coverage began January 2023 with plans meeting premium reduction targets and being offered throughout the state.	Battle Born State Plan coverage began January 2026.	Cascade Select Plans coverage began January 2021.
Overall Approach	☞ Provided through the individual and small group issuers, which are required to offer Colorado Option plans. ☞ Colorado Option plans are required to reduce premiums by 15% over 3 years, with the Division of Insurance having authority to hold hearings and set hospital and provider reimbursement rates if premium targets are not met. ☞ Colorado Option plans are standard plans that must provide set benefits and limited cost-sharing, and address racial and ethnic health disparities. ☞ Providers can be required to participate in Colorado Option networks if plans are unable to meet network adequacy requirements or premium reduction targets.	☞ Provided through private plans; Medicaid Managed Care Organizations (MCO) issuers are required to submit a bid to offer the public option. ☞ Battle Born State Plans are required to reduce premiums by 15% over four years. ☞ Provider rates must be at least the Medicare reimbursement rate. ☞ Providers participating in Medicaid, The Public Employee Benefits Program, and worker's compensation must be in at least one Battle Born State plan network.	☞ Cascade Select plans are provided through private plans. ☞ Hospital reimbursement rates are capped at 160% of Medicare; reimbursement floors are also established for primary care and critical access hospitals. ☞ Providers participating in Medicaid and Public Employees' Benefits Program or School Employees' Benefits Program must also be in at least one Cascade Care Select plan network.
Enrollment	In 2026, over 50% of all marketplace enrollees (about 138,000 people) enrolled in a Colorado Option plan.	In 2026, over 10% of marketplace enrollees (about 11,000 people) enrolled in a Battle Born State Plan. Note that 2026 is the first year Battle Born State Plans have been offered.	In 2026, about 40% of marketplace enrollees (about 97,000 people) enrolled in a Cascade Select plan.

WHAT KEY LESSONS CAN BE LEARNED FROM STATE PUBLIC OPTION EFFORTS?

During Congressional health care reform efforts in 2009 and 2010 – which would eventually culminate in the enactment of the Affordable Care Act (ACA) – whether the law would establish a public option was a central component of the debate. The House-passed version of health care reform included a public option, but the policy wasn't included in the final version of the legislation.

After the early years of ACA implementation, a number of states began to pursue legislative efforts to establish a public option in their individual and/or small group markets. States' motivations for pursuing a public option – and the problems they were aiming to solve through this policy – varied. As a result, states prioritized different goals when designing their public options, resulting in differences in approaches and final policies. Many of the problems states sought to solve are issues federal policymakers are also grappling with and these different state approaches provide important insights and possible frameworks from which to draw.

Improving Premium Affordability

Improving premium affordability was top-of-mind for some states. Colorado had some of the highest premiums in the country in the years preceding the consideration of the public option. Relatedly, Colorado also had some of the highest hospital prices in the country, which contributed to these high premiums. In 2026, the average monthly premium savings for Colorado Option plans are $14-$33 per month, depending on plan type. Additionally, Colorado's efforts to standardize Colorado Option plans have made out-of-pocket costs more predictable for consumers and out-of-pocket costs are 15% lower in these plans than non-public option plans in 2026. Washingtonians who purchased Marketplace plans faced an average premium increase of 36% in 2018, which was followed by an average increase of 13.8% in 2019. These year-over-year premium increases resulted in a subsequent drop in enrollment in Washington. Between 2021 and 2023, Cascade Select premium costs in Washington trended down 6%, while non-public option Marketplace plans increased 15%. Additionally, in plan year 2026 (the first plan year in which Nevada's public option was available), the average total (gross) premium for Battle Born State Plans was approximately 4.7% lower and the average out-of-pocket (net) premium for these plans was about 4% lower. Evidence from Nevada also indicates that Battle Born State Plans have created competitive downward pressure on non-public option Marketplace plan premiums – which are about 4.6% lower in 2026 than they would have been without the public option.

Addressing the Uninsured Rate

When the public option was being debated in Nevada, the state had one of the highest uninsured rates in the country and the public option was conceived as a mechanism to extend more affordable coverage to uninsured Nevadans who had been priced out of the individual market.

Addressing Bare Counties and Non-Competitive Markets

Washington and Nevada struggled to prevent "bare counties" (i.e. no participating issuers offering coverage) in the years leading up to their public options. Additionally, in rating areas across Washington, Nevada, and Colorado, choice was limited – or nonexistent – with only one or two insurance companies offering plans on the Marketplaces. This was particularly problematic in certain rural areas. In Colorado, 22 of the state's 64 counties had only one insurance carrier offering plans on the Marketplace in 2019. For the 2018 plan year, 14 of Nevada's 17 counties only had one insurance carrier offering plans on the Marketplace. In the 2026 plan year, three different health insurance carriers offered 11 different Battle Born State Plans across each of Nevada's four rating areas.

In Washington and Colorado, which have offered public option plans across multiple plan years, the share of Marketplace enrollees who have selected public option plans over non-public option plans has grown. In 2023, approximately 13% of Colorado Marketplace enrollment was in Colorado Option plans and in 2026, that share has increased to 50%. In Washington, 40% of Marketplace enrollees selected a Cascade Select plan in 2026 – approximately 22% more people than in 2025.

Improving Benefit Design and Meaningful Difference Standards

States also pursued public options as a mechanism to improve benefit design and meaningful difference standards to help people better understand the scope of benefits plans covered, cost sharing associated with various services, and be able to better differentiate between plans. In rating areas where there was competition and a wide array of plan options, states leveraged their public option to better standardize plans and make the plan selection process more consumer-friendly. The Colorado Option provides the exact same benefits and cost sharing structures (including copays) in each metal tier on the Marketplace, allowing people to more easily compare premiums across plans. This includes pre-deductible coverage of important high-value services, which is also standardized across Colorado Option Plans. Colorado also implemented culturally responsive provider networks as part of its public option to help address health care inequities.

If federal policymakers opt to pursue a federal public option, there are many salient lessons that can be gleaned from state efforts. It is also important to acknowledge that in pursuing a public option at the state level, state policymakers were attempting a policy that was originally envisioned and designed as a federal policy. As a result, some – but certainly not all – of the challenges they faced were inherent challenges for states that may be easier to navigate on the federal level. The federal government has additional levers and tools that are not available to states that may make some aspects of the federal experience less challenging and provide more opportunities for a broader scoped policy.

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MEANINGFULLY ADDRESSING AFFORDABILITY UNDER A PUBLIC OPTION: *Determining Prices and Constraining Costs*

Determining provider payment rates has been one of the most contentious debates surrounding public options – but it is the most important policy to get right if a public option is going to be leveraged to lower premiums and meaningfully address affordability challenges for people. Provider payment rates need to be based on the cost of providing care in order to contain costs in the public option – which is key to reducing high premiums and out-of-pocket costs for people, as well as constraining costs in state and federal budgets. Establishing provider payment rates in a federal public option not only provides an opportunity to constrain payments to providers that have ballooned far beyond the actual cost of providing care, but also provides an important opportunity to bolster payments for certain high-value services or certain hospital or provider-types that have lagged.

Under the current system, hospital and provider market power is more determinative of payment rates than factors that actually impact consumers in a positive way. And the data clearly shows that consolidation – and the resulting market power – drives up prices. There is also significant variation in the financial position of different providers and provider-types. For example, according to an analysis from the Medicare Payment Advisory Committee (MedPAC), in fiscal year 2024, one-quarter of hospitals in the U.S. had an all-payer operating margin below -2%, while another quarter had a margin above 12%. Additionally, federally qualified health centers (FQHCs) – a critical source of care in many communities – had, on average, net margins of -2.1% in 2024. Establishing appropriate payment rates for providers in a federal public option that rein in excessive payments for certain providers and include thoughtfully crafted policies that strategically target higher payments to other providers is an effective way to ensure provider financial stability, while simultaneously preserving access and bringing down costs for people.

With these issues in mind, a federal public option can incorporate state experiences and lessons learned when establishing provider payment rates. In Washington, Cascade Select plans are required to pay providers and facilities at or less than 160% of Medicare rates (i.e. a "ceiling") for all covered benefits, except pharmaceuticals. Any rural hospitals CMS has designated "critical care" or "sole community" hospitals must be paid at or beyond 101% of allowable rates (i.e. a "floor"). Physicians specializing in family medicine, general internal medicine, or pediatric medicine must be paid at or beyond 135% of Medicare rates for providing primary care services.

In Nevada's public option, Battle Born State Plans are required to pay providers at or beyond Medicare rates, including when paying for services at FQHCs and rural health clinics (RHCs). This payment level is meant to be a starting point and a "floor" for payment rates, not a ceiling. Establishing a "floor" for payment rates for certain providers can help preserve access in high-need areas (i.e. rural or provider-shortage areas), and, importantly, support financially strained providers and others who currently lack the market power to negotiate higher payment rates.

An early draft of Colorado's public option legislation mirrored the provider payment "ceiling" and "floor" approach taken up in Washington and Nevada; however subsequent negotiations shifted the approach ultimately taken in the final bill. Colorado's law authorizes the Division of Insurance (DOI) to set payment rates for Colorado Option plans if the premium rate reduction targets established in statute are unmet.

The law also includes a framework for Colorado's DOI to use in setting these rates, should that happen. Under this framework, hospitals will not receive less than 165% of Medicare, with a base rate of 155% of Medicare. There are additional increases for certain types of hospitals and/or if certain conditions are met (i.e. a 25% increase for critical access and small rural hospitals that are not part of a larger health system; a 30% increase for high Medicare and/or Medicaid case mix; a 40% increase for hospitals efficient at managing the underlying cost of care). Additionally, under the framework, physicians will receive rates of at least 135% of Medicare, guaranteeing them at least that payment rate.

In landing on this policy approach, Colorado policymakers in 2020 first used self-reported data from its state hospital association to identify each hospital's "break-even point," a percentage of Medicare representing the payment necessary to cover the costs of care. On average in Colorado, this was the equivalent of 143% of Medicare. This was factored into the development of the proposed formula incorporated into the 2020 legislation, with each hospital receiving a specific payment rate. This formula provided the additional payment enhancements mentioned above, including critical access and rural hospitals, carried over to 2021 and ultimately included in the final passed legislation. To date, the Colorado DOI has never publicly stepped in to establish payment rates in their public option and, in 2026, two-thirds of Colorado hospitals are receiving payment levels for patients with Colorado Option plans that are at the floor set by the program.

Provider Payment and Cost Containment Must Factor Into Consideration for Any Federal Public Option to Succeed

Constraining certain provider rates is critical to establishing a federal public option that actually improves affordability for people and generates savings to the federal government. Federal policymakers should structure the public option in a manner that enables the federal government to set payment rates that are reflective of the costs of delivering care across different types of providers. Highly consolidated provider markets, which are omnipresent across the country, don't allow for negotiation of provider rates on a level playing field and often result in higher payments going to the hospitals and providers that need them least. Establishing a federal public option – whether it's in the individual market, in the employer market or some segment of it, or more broadly across markets – without effective cost containment will only serve the purpose of creating another coverage option without providing one that's substantively more affordable.

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While tying payment rates in a federal public option to Medicare rates or some percentage of Medicare rates has some drawbacks, components of the process by which Medicare sets payment rates can provide an important model for a federal public option. Similar to Medicare, the federal government should have the ability to set payment rates in a federal public option and the process by which those rates are established should take into account differences between different types of hospitals and providers, geographic differences, and labor cost variations.

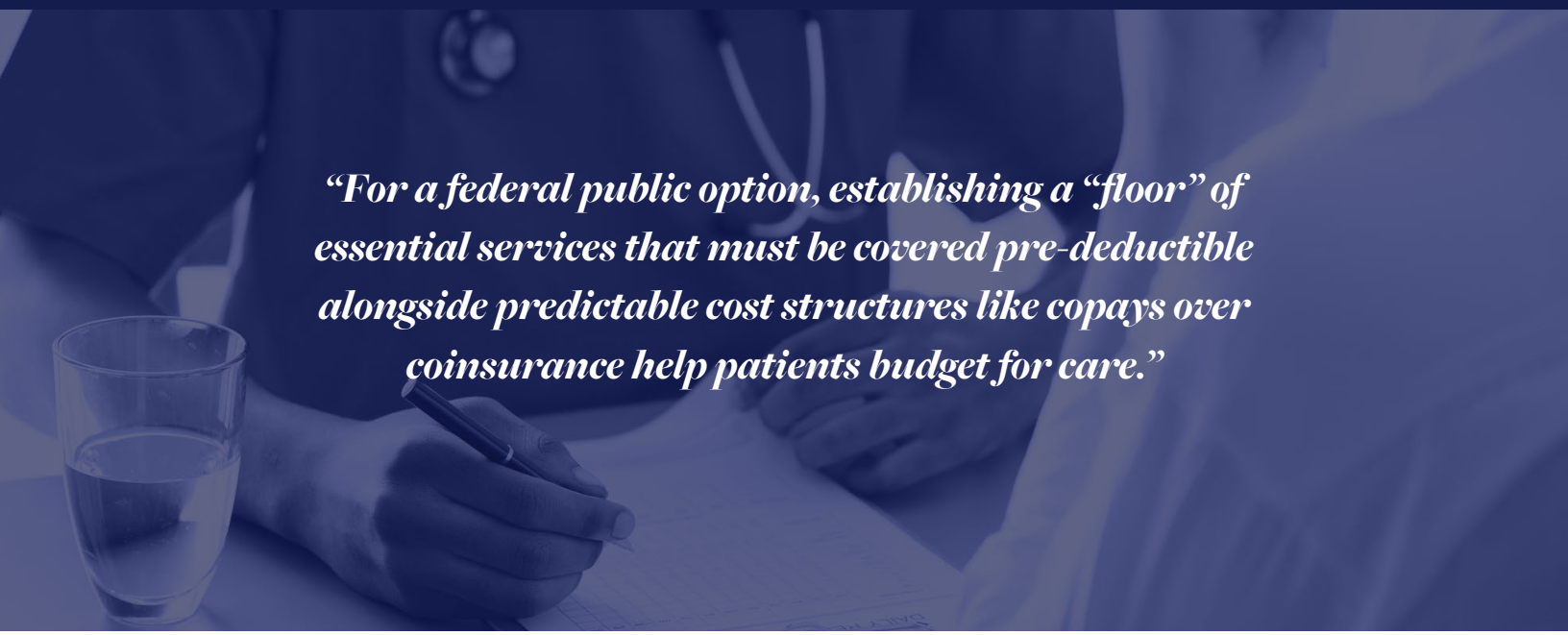
Additionally, the approach of not establishing payment rates in a federal public option or directing insurance companies to drive the required premium reductions and cost savings is not the most effective way to address true cost-drivers in the health care system – and has the potential to drive payment reductions to financially unstable providers, which is not beneficial to patients or the system overall. A federal public option can – and should – drive cost savings for people and the system as a whole including through targeting providers that are high-cost outliers. Federal policymakers should not be agnostic on how those cost-savings are achieved.

STRIKING THE RIGHT BALANCE: *Establishing Benefit Design that Works For Patients*

Benefit design in a public option is a significant opportunity to ensure that coverage provides people affordable access to the services that will help them stay healthy. It's also key to helping address longstanding gaps in access to care. The design of benefits for a federal public option should focus on value, making it easy and affordable for people to receive needed care without worrying about out-of-pocket costs.

The protections and framework afforded by the ACA's Essential Health Benefits (EHBs) serve as the starting point. EHBs address many of the limitations of relying on Medicare's benefit design, such as the inclusion of pediatric services, maternity and newborn care, mental health, and addiction services.

Within the framework of EHBs, state approaches to standardized plan designs have been incorporated into public option coverage and offer various valuable lessons for a federal public option. Standardized plan design in a federal public option can be leveraged to require coverage of certain services with zero or reduced out-of-pocket costs. As part of establishing benefit design requirements in a federal public option, Congress should establish a "floor" of essential services that must be covered pre-deductible and, if allowing cost-sharing, emphasize predictable cost structures like copays over coinsurance to better help patients budget for care. In Washington, Cascade Select plans leverage standardized out-of-pocket costs in each metal level, coverage of more pre-deductible services, lower deductibles in general, and reduced out-of-pocket costs – providing transparent and predictable cost sharing for consumers.



"For a federal public option, establishing a "floor" of essential services that must be covered pre-deductible alongside predictable cost structures like copays over coinsurance help patients budget for care."

Benefit Design Should Account for Value of Services and Predictable Cost-Sharing Under a Federal Public Option

A federal public option should incorporate principles of value-based insurance design (VBID), where high-value services are incentivized in the benefits package. Under VBID, people pay less for high-value services that improve health outcomes, such as primary care, preventive services, and chronic disease management services, and pay more for low-value services. There is evidence that this approach increases the use of high-value services and lowers consumer out-of-pocket costs.

Congress could also follow the lead of some states that have prioritized high-value services that reduce health disparities, including regular primary care visits, mental health visits, care during and after pregnancy, diabetes supplies, smoking cessation programs, prescriptions, and language translation. Colorado's standardized plan option provides enrollees with "first-dollar, predeductible coverage for certain high-value services" including primary care visits and services that disproportionately benefit communities of color, such as low-cost diabetes care.

The inclusion of services and benefits will need to be weighed and prioritized with other policy goals and assessed needs should a federal public option come into focus. States pursuing public options have had to balance the desire for specific services with the impact those services may have in determining actuarial value, which impacts costs to the consumer and the ability to build a sufficient network within a geographic rating area.

COLORADO OPTION BENEFITS

- ***$0 Primary Care, Non-Preventative Visits***
- ***$0 Mental/Behavioral Health/ Substance Use Disorder Visits***
- ***$0 Prenatal and Postnatal Visits***
- ***$0 Diabetic Supplies, Including Continuous Glucose Monitors***
- ***$5 Diabetes Self-Management Education***

PROVIDER ACCESS: *Ensuring Robust Provider Participation & Establishing Culturally Responsive Networks*

In designing a federal public option, ensuring people have adequate access to providers is critical. While cost is most consumers' top priority when it comes to their health care, the provider network (both hospitals and clinicians) of a plan is also top of mind, particularly for patients with ongoing or complex medical needs. A robust provider network that reflects the community it serves is also an important policy lever in building health equity within the care delivery system.

Congress should develop a federal public option that ties provider participation to participation in other federal health programs like Medicare and Medicaid to better guarantee access to health care services, as states have in their approaches to public options. For example, Nevada's public option law requires providers and facilities that want to continue to participate in the State's Public Employee's Benefits Program or Nevada's Medicaid program to be included in at least one network of the public option beginning in the 2027 plan year. Further, providers are required to accept new patients enrolled in Battle Born State Plans at the same rate as those not enrolled in Battle Born State Plans.

Similarly, in learning from their original public option bill, Washington made adjustments in their 2021 bill to encourage hospital participation. Beginning in 2022, hospitals that provide services and receive reimbursement from Washington public employee benefits or Medicaid must also provide in-network services for at least one Cascade Select plan. Nevada and Washington's approaches are good examples for federal policymakers to consider due to the large number of providers participating in public programs.

Congress should also take steps to ensure equitable access to providers, creating a robust and diverse provider network that reflects the population's needs. Congress can look to a 2021 Colorado law creating new network adequacy requirements for its Colorado Option plans as one example of how to do this in practice. Colorado requires that standardized plans in the individual and small group markets "have a provider network that is culturally responsive and reflects the diversity of its enrollees." Culturally responsive networks are one tool in helping to close gaps and improve access to high-quality care and health outcomes for people with varied cultural origins and identities, regardless of their culture, race, ethnicity, language, geography, or ability. It provides an inclusive atmosphere where patients' cultural beliefs are respected and taken into account when providing care.

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Federal Policy Levers may be Particularly Helpful to Expanding Provider Access and Enable Better Care for Various Populations

State approaches to provider networks can help bolster patient access under a federal public option. The federal government has key tools it can leverage to optimize provider access and participation. Tying provider participation to other federal programs like Medicare and Medicaid is one solution for federal consideration. Moreover, a federal public option could weave in elements of Colorado's culturally responsive networks to address disparities in care and ensure patients can receive care by providers who reflect the communities in which they live.

TWO PUBLIC-OPTION PATHWAYS: *Government-Run vs. Administered Through Private Insurance Companies*

All of the state public options in place now are administered by private insurance companies. When states were designing their approaches to establishing a public option, some states explored the possibility of a government-run public option; however, key barriers prevented this approach from being a viable option at the state level. In Colorado, the state ultimately decided to structure their public option as a public-private partnership and have these plans administered by private insurance carriers. While state officials gave meaningful consideration to a state-run public option structure, they were ultimately concerned that in addition to funding the start-up expenses, the State would also need to fund initial and growing reserves associated with a health plan, as well as bear the financial risk associated with the plan. This proves to be especially challenging in annual or biennial state budget cycles.

Federal policymakers should keep this in mind for a few reasons. First, if Congress opts for a policy approach that envisions states taking the lead on establishing public options, consideration should be given to addressing these barriers for states. Second, the involvement of private insurance companies in administering a public option inherently reduces the amount of savings (and premium reductions) that can be generated compared to a government-administered plan. When considering premium savings that have been associated with state public option plans to date, it is important to factor in the use of private insurance carriers in administering these plans, as well as the limited (or non-existent) cost containment tools that state regulators have available in some of these state laws. Third, it is also important to acknowledge the "buying power" that a true government-run federal public option would have and how that could be leveraged to reduce costs for people and the government, as well as embed other valuable reform policies into a federal public option. Nevada established its public option by leveraging its Medicaid managed care program infrastructure, requiring insurers that offer managed care plans in Medicaid to also submit competitive bids to offer Battle Born State Plans. Given how lucrative Medicaid managed care is for insurers, this provided a valuable hook for the state to bolster Battle Born State Plan offerings and align health care coverage strategies across these two markets, including by requiring more value-based payment arrangements and aligning financial incentives for providers and health plans to achieve more efficiencies in the system and to address state priorities – such as increasing affordability and quality of care.

Some of the Challenges Associated with a Government-Run Approach are Mitigated at the Federal Level

While states gave due consideration to the notion of a government-run public option, the prevailing policy choice was to pursue administration of public options through private insurers. Importantly, many of the major limitations states faced in establishing a true government-run public option do not constrain the federal government in the same way, which should assure federal policymakers that such a pursuit is not only possible, but an improvement from state public options to date.

CONCLUSION

As the prospect of a federal public option comes into focus for policymakers, USofCare encourages careful reflection of where state experiences in Nevada, Washington, and Colorado offer essential lessons and considerations for federal action. Critically, those lessons are to:

1. Land on the right policy for provider payment and cost containment to truly deliver affordability in the system and to people, as well as stability for providers
2. Establish benefit design that accounts for value of services and delivers predictable cost-sharing
3. Leverage federal policy levers to expand provider participation and access, while orienting networks to deliver culturally-responsive care
4. Thoroughly explore the notion of a true government-run approach, where federal levers overcome state limits in pursuing such an option

It is past time for Congress to meaningfully address the health care affordability challenges faced by everyday people. There are a number of policies that federal policymakers can pursue to broaden access and drive down costs. State public option efforts in Washington, Nevada, and Colorado can serve as examples for federal policymakers as they work to achieve these goals.