

States Seek to Improve Affordability, Expand Coverage with “Public Option” and Medicaid Buy-in Proposals



Georgetown University Health Policy Institute

CENTER ON HEALTH
INSURANCE REFORMS

January 2020

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Abstract

Issue: The 2018 election brought with it new energy in statehouses and state legislatures to improve access to insurance coverage and fill gaps in current law. During the 2019 legislative sessions, at least ten states debated “public option” or “Medicaid buy-in” programs as mechanisms to expand coverage, lower premiums, and increase the number of plan options for consumers.

Goal: Assess states’ goals in pursuing public option or Medicaid buy-in programs, the variety of mechanisms proposed, and critical issues for state consideration, such as the impact of such programs on state finances, providers, and consumers of other sources of coverage, including ACA-compliant individual market and employer-group plans.

Methods: Analysis of state legislation, laws, and published reports about public option or Medicaid-buy in proposals and structured interviews with state officials, legislators, and advocates in nine states.

Findings and Conclusions: Only one state – Washington – ultimately enacted a public option bill during the 2019 state legislative session. Five other states—Colorado, Maryland, Nevada, New Mexico, and Oregon—tasked agency officials or independent commissions to study and/or develop a Medicaid buy-in or public option program. These states share common goals, such as improving the affordability of insurance, reducing the uninsured, and offering consumers more plan choices. The states also share similar political and practical challenges to enacting and implementing a public option or buy-in proposal. These include stakeholder concerns and fiscal constraints, and considerations regarding the downstream impact on ACA marketplace and employer-sponsored coverage.

Background

The Affordable Care Act (ACA) has achieved remarkable success expanding insurance coverage to more people, reducing the uninsured rate from 16.3 percent in 2010 to 8.8 percent in 2017.¹ However, in the last two years there is some evidence that those coverage gains have eroded, and approximately 27.5 million people nationwide lacked coverage throughout 2018.² The primary reason cited for being uninsured is the lack of an affordable coverage option.³

Deep ideological differences in the U.S. Congress have inhibited federal action to expand coverage beyond current levels, but the 2018 election brought with it new energy in statehouses and state legislatures to improve access to insurance and fill gaps in current law. During the 2019 legislative sessions, this energy manifested itself in several ways, including five new states with reinsurance programs, two states with a new individual mandate penalty, and state-funded premium subsidies in California.⁴ Additionally, at least ten states debated “public option” or “Medicaid buy-in” programs as mechanisms to expand coverage and improve affordability.

Medicaid buy-in and public option proposals can vary widely in their design and impact. Conceptually the Medicaid buy-in would allow individuals with incomes too high to qualify for Medicaid under current eligibility rules to “buy in” to the program.⁵ Some states are also considering leveraging the purchasing power of the Medicaid program to reduce provider prices and thus improve coverage affordability for people enrolled in commercial insurance. One version of this is the ACA-authorized Basic Health Plan (BHP) program. The BHP is an option for states to leverage federal premium subsidy dollars to cover low-income residents (up to 200 percent of the federal poverty level) through state-contracted plans outside the ACA marketplaces. Years before the 2019 state legislatures were considering public option or Medicaid buy-in proposals, New York and Minnesota adopted the BHP. New York and Minnesota’s BHPs have been able to offer enrollees comprehensive benefits at a lower cost than private marketplace plans, largely because they pay lower rates to providers.⁶ The BHP can also be a platform for states to subsidize the enrollment of certain residents who are ineligible for marketplace coverage, such as undocumented immigrants.

The public option concept envisions a state-backed health plan that would compete in the individual market with private plans.⁷ However, the amount of state backing can vary. At one end of the spectrum, the state would design the benefits, set the premium rate, build the network, conduct the marketing and consumer support, and bear the full financial risk of paying claims. In other proposals, such as in

Washington, the government's involvement is less, with the responsibility for plan network design, operation, and risk delegated to private insurers. While state officials are charged with developing a plan to provide additional subsidies for marketplace coverage, Washington has not committed any additional funds to subsidize plan costs for public option enrollees.

Findings

Enacting a Public Option or Medicaid Buy-in: States Share Similar Goals as well as Political, Policy Challenges

Although legislatures in at least ten states considered Medicaid buy-in or public option proposals in 2019, only six states ultimately enacted legislation to advance or study the concept. Of these, only one (Washington) authorized a program.⁸ The remaining five authorized feasibility studies or recommendations to implement either a Medicaid buy-in or public option plan (see Exhibit 1).

Several other state legislatures, including in Connecticut and Minnesota, seriously considered, but ultimately did not enact public option legislation. In pursuing public option or Medicaid buy-in programs, state goals included improving affordability, increasing competition, and

reducing the number of uninsured. Different goals may dictate different policy choices for the public option or buy-in plan. For example, both Washington and Colorado focus in part on reducing premiums in the individual market. Reducing premiums can help individuals who are ineligible for Medicaid or the ACA's premium subsidies find more affordable coverage. However, critics have noted that it can have the perverse effect of reducing the buying power of subsidized marketplace enrollees because the ACA's premium tax credits are pegged to premiums.⁹ In another state where the primary goal is to increase competition, a "fallback" public plan solely for areas that have only one or two insurers might become an attractive policy option.

Exhibit 1. State Public Option/Medicaid Buy-in: Enacted Legislation, 2019

State	Policy Goal(s)*	Program Type	Legislative Result	Timeline
Washington	<ul style="list-style-type: none"> Improve affordability Increase competition 	Public Option	State to contract with insurers to offer a plan with a network of providers paid at a government-set rate; insurers would be allowed to also offer plans at commercially negotiated rates.	Public option to be available by January, 2021
Colorado	<ul style="list-style-type: none"> Improve affordability, access Increase competition 	Public Option	Recommendations	Due to legislature by November 15, 2019; Public option to be available by January, 2022
Maryland	<ul style="list-style-type: none"> Improve affordability Market stability 	Medicaid buy-in	Study	Due to legislature via annual report
Nevada	<ul style="list-style-type: none"> Reduce uninsured Improve affordability Increase competition, particularly in high-premium areas 	Public Option	Study	Due to legislature in 2020
New Mexico	<ul style="list-style-type: none"> Improve affordability Reduce uninsured 	Medicaid buy-in	Study	To be conducted in 2019-2020 (no deadline provided)
Oregon	<ul style="list-style-type: none"> Reduce uninsured 	Medicaid buy-in Public Option	Study	Due to legislature by May 1, 2020

*As described in legislative text and in interviews with state officials, legislators and stakeholders.

State Approaches

Under Washington’s “Cascade Care” program, all insurers participating in the individual market will have to offer some plans with standardized benefits that, among other things, provide more pre-deductible coverage of high-value services. Private insurers that choose to offer a public option health plan must also limit the amount they pay providers and adhere to additional quality and value requirements. These insurers will operate and market their public option plans and will ultimately bear the financial risk of enrollees’ health care costs. They are also permitted to continue to market plans in which they pay commercially negotiated rates to providers, which would have to compete alongside the public option plan.

Colorado’s legislature gave its Medicaid and insurance agencies broad latitude to develop policy recommendations for a public option plan. Their proposal, released in November 2019, is similar to Washington’s program in that it relies on private insurers to deliver the benefits and cover claims, but sets limits on their payments to hospital providers.¹⁰ While it also would require insurers to offer standardized benefit designs, it differs from Washington’s approach in key areas (see Exhibit 2).

Exhibit 2. The Washington and Colorado State Public Option Plans

Key Features	Washington	Colorado
How will the plan be offered?	The plan will be marketed through the state’s health insurance marketplace and sold by private insurers that contract with the state.	Private insurers in the individual market will be required to offer the public option plan on and off-marketplace to ensure at least two insurers per county.
Who’s eligible?	Those seeking individual market insurance, whether or not eligible for premium tax credits.	Those seeking individual market insurance, whether or not eligible for premium tax credits. In future years, the plans may be available to small employers. Self-funded employer plans may “opt in.”
How will premiums be reduced?	Providers will be reimbursed at a maximum of 160% of Medicare rates ^a Standardized benefit design ^b State officials must study how to support state premium subsidies for people with incomes below 500 percent of the federal poverty level	Hospitals reimbursement will be capped based on a fee schedule (in development) ^c Plans must spend 85 percent of premiums on patient care Rebates from drug manufacturers or benefit managers must be passed onto policyholders Standardized benefit design ^d
When will the plans be available?	January, 2021	January, 2022

Source: 66th Legislature of Washington State, 2019 Regular Session, Ch. 364, Laws of 2019; Colorado Department of Regulatory Agencies and Department of Health Care Policy & Financing, “Final Report for Colorado’s Public Option,” Nov. 15, 2019.

^a Excludes pharmacy benefits and rural hospitals. Reference pricing based on Medicare rates for “the same or similar services in the statewide aggregate.” Primary care services (defined by the Washington Health Care Authority) must be reimbursed at least 135 percent of Medicare. Beginning in 2023, the Washington Health Care Authority may waive this contracting requirement if rates for the public option plan are determined to be no greater than the prior year’s rates (adjusted for inflation), or if the Director of the Health Care Authority determines that the requirement prevents the insurer offering the public option plan from meeting network adequacy standards, and the carrier can attain actuarially sound premiums at least 10 percent lower than the prior plan year through different means.

^b Public option plans will offer state-prescribed benefits and cost-sharing amounts. In addition, all insurers offering exchange plans will be required to offer at least one standard silver plan and at least one standard gold plan through the exchange beginning in January, 2021. Insurers offering any bronze exchange plans will also be required to offer at least one standard bronze plan.

^c Colorado’s public option plans would be required to reimburse hospitals based on a state-established, hospital-specific formula designed to “improve efficiency” and reduce “exorbitant prices.” The draft report proposed capping hospital reimbursement at between 175 and 225 percent of the Medicare payment rate.

^d Colorado’s public option plans would be required to cover more primary and preventive care services that enrollees can access without having to meet their deductible.

Colorado's legislature will need to approve key elements of the plan, including provisions limiting the amount that participating insurers would pay hospitals and requiring that two insurers in every county offer a public option plan.¹¹

New Mexico sought to adopt a Medicaid buy-in for residents who do not have access to Medicaid or Medicare, employer-sponsored insurance, or federal premium tax credits. According to a state official, the state's goal was to assist consumers who do not qualify for marketplace subsidies, including spouses and dependents deemed ineligible because of access to employer-sponsored coverage (often referred to as the "family glitch"),¹² and undocumented immigrants. Efforts foundered in the wake of a fiscal analysis projecting an annual state cost of up to \$81 million per year, and advocates settled for a \$132,000 appropriation to study the issue.^{13,14}

Nevada is studying three possible approaches: (1) allowing individuals to buy in to its state employee health benefit plan, (2) offering a public option solely in those regions that currently lack private insurance choices and where consumers face high premiums, or (3) offering a statewide plan through a public-private partnership.¹⁵ Maryland's study of the Medicaid buy-in is part of a broader state market stabilization strategy, and the commission's mandate includes a review of other policy proposals, including merging the individual and small-group markets, adopting a BHP, standardizing benefit designs, and supplementing federal subsidies with state dollars.¹⁶ In Oregon, a newly created Task Force on Universal Health Care is charged with recommending the design of a "well-functioning single payer health care financing system," and the Oregon Health Authority will separately develop a plan for a Medicaid buy-in or public option program that can cover Oregon residents without current access to health care, at no net cost to the state.¹⁷

Easier Said Than Done: Political and Policy Challenges

• Stakeholder concerns

Ultimately, to meet their goals of expanding affordable coverage to more people, states have two primary but not mutually exclusive choices. One is to tackle the primary source of high insurance costs by limiting

provider reimbursement.¹⁸ This can ignite strong opposition from politically powerful providers. For example, Colorado's proposal for a public option plan, which reduces premiums by constraints on provider prices, has drawn a strong critical reaction from the state's hospital lobby.¹⁹ Washington's public option proposal initially proposed paying providers at 100 percent of Medicare rates, but legislators increased that limit to 160 percent of Medicare in the final bill, reducing premium savings for consumers. Policymakers cited opposition from providers who feared a cut in revenue. However, providers may still be reluctant to join the public option's network at even 160 percent of Medicare rates.²⁰

States must also grapple with resistance from insurance companies. Washington legislators, for example, reported surprise at how strong initial insurer opposition was to their bill, with one noting: "I thought that they would welcome the idea of putting some limits on the providers." Officials and media in Connecticut reported that even though insurers were "at the table" during negotiations over their public option proposal, last minute threats from Cigna to move its Hartford headquarters to a different state effectively killed the bill.²¹ "That threat has a lot of power in Connecticut," said one official. "...[I]t scared off too many important or key members [of the legislature]."

However, insurers' views do not appear to be monolithic. While some seem prepared to battle any additional amount of government involvement in health plan development or administration, state officials reported that other insurers were more flexible. For example, Washington legislators found that several insurers ultimately either supported their bill or committed not to oppose it, in part because they recognized the cost-saving potential of reduced provider rates.

• Fiscal concerns

A second option is to use state money to supplement federal financial assistance under the ACA or to expand access to state public programs. However, proposals that could require state resources or put the state at financial risk face significant hurdles. For

example, a participant in Colorado’s development of a public option proposal noted that the state was unable to raise any general funds due to its “Taxpayer Bill of Rights” law, which prevents the state from raising taxes without voter approval. The law effectively eliminates the ability to take on any insurance risk or improve affordability through state-funded subsidies. Similarly, Nevada collects no income tax, leaving the legislature with “very constrained revenue options” for any buy-in program. Oregon’s legislature has charged the Task Force on Universal Health Care with devising a Medicaid buy-in or public option program that has “no net cost” to the state. In New Mexico, policymakers expressed an initial willingness to consider state financial support for a Medicaid buy-in, but ultimately could not agree to the price tag for covering thousands of uninsured residents including undocumented immigrants. California’s new program using state funds to significantly expand premium and cost-sharing subsidies for marketplace coverage, and Massachusetts’ and Vermont’s supplementation of federal premium tax credits, are notable exceptions.²²

- **Interaction with federal policy**

Reducing the overall cost of coverage—through Medicare reference pricing or some other means—can enable the state to apply for an ACA “Section 1332” waiver from the federal government. The 1332 waiver allows a state to modify provisions of the law in order to pursue state health reform goals. If those changes result in lower premiums (and thus lower costs for the federal government due to reduced premium tax credits), the state can seek “pass through” funding and capture those savings to support coverage expansion.²³ Although Washington did not seek a 1332 waiver to support its public option plan, Colorado officials have signaled an intent to do so. However, the prospects for such a waiver being approved are uncertain. The current administration has made clear it will not look favorably upon a waiver that seeks to improve access to public coverage and rejected a prior Colorado plan to use Medicare reference pricing to help fund an individual market reinsurance program.^{24, 25}

Implications of Buy-in, Public Option Plans for the Individual and Employer Plan Markets

- **The Individual Market**

Depending on their structure, public option and Medicaid buy-in programs may have a significant impact on the stability of the ACA-compliant individual market. Key design questions include:

- **Who is eligible for the plan? Is the goal primarily to help consumers above 400 percent of the federal poverty line (and ineligible for federal premium subsidies), or lower-income enrollees?** Will the plan be an alternative to marketplace coverage (as with the BHP and potentially a Medicaid buy-in)? States may have more leeway under federal rules to design off-marketplace programs and to target them to certain populations. However, plans available only outside the marketplace, if offered as an alternative to marketplace coverage, could negatively affect the marketplace’s financial stability and reduce incentives for private insurers to participate, particularly in lower-population areas. A program designed to improve affordability for unsubsidized individuals by reducing individual market premiums (an aim of Washington’s Cascade Care and Colorado’s public option proposal, as well as most other public option concepts) might broaden the risk pool and promote market stability. At the same time, it could lower premium tax credits for the subsidized population, raising the risk that some lower-income enrollees might drop their coverage.
- **How will risk be shared?** Will the plan participate in the ACA’s risk adjustment program or a state reinsurance program? If a public option or Medicaid buy-in plan draws healthier individuals away from the ACA-compliant individual market, it could drive up premiums. Alternatively, it could attract individuals who are sicker on average than those in the ACA market. In both cases, the state may need to institute a risk-sharing program.

- **How will the program affect choice of private plans?** Under the ACA, private insurers' participation in the marketplace is optional. Will competition from a lower-cost, publicly backed plan discourage private insurers from offering marketplace plans? On the other hand, will a state's commitment to its market and partnership with carriers lead to greater stability and a more attractive market in which to participate?

Notably, Washington and Colorado, which have the two most developed public option plans to date, will preserve the role of private insurers to offer plans, build provider networks, and bear the risk of paying medical claims. Indeed, stakeholders reported that a BHP option was off the table, given the risk that it would siphon enrollees away from the ACA marketplace. Washington's role (and Colorado's proposed role) are largely limited to capping provider payment rates and prescribing a standard benefit design. These states have also thus far chosen to have the public option offered through the ACA marketplace, keeping enrollees in the individual market risk pool and enabling those eligible to qualify for federal premium and cost-sharing assistance.

- **The Employer Group Market**

Less intuitively, states will also need to think about the impact of a public option or buy-in plan on their employer group market. For example, in Washington, policymakers received projections from insurers suggesting their proposal would undermine the insurance market for small businesses. Insurers in that market opposed setting provider rates at 100 percent of the Medicare rate, arguing that the availability of a low-cost individual market option would encourage more small employers to drop their group plans and send employees to the public option plan. This would also have the effect of reducing provider revenues further. Increasing the limit to 160 percent of the Medicare rate ensured that premiums for the public option plan would be closer to those available in the small-group market, enabling these insurers to drop their initial opposition. Using Medicare as a reference price for a public option plan has also raised complaints among some employers who claim that providers will demand higher prices from employer group plan payers to make up for any lost revenue from the public option, although there is little empirical evidence to support such concerns.

Conclusion

Public option and Medicaid buy-in plans promise to leverage the power of state government to offer residents a lower-cost option for comprehensive coverage. Depending on their design, these programs have the potential to reduce a state's uninsurance rate, promote competition, and address, at least modestly, underlying health care costs. To achieve these goals, however, states face real challenges. Though payments to providers represent the biggest driver of health care costs,²⁶ a program that works by constraining provider prices will face strong provider opposition. Insurers have also made clear their concerns about competing with a public plan, even one designed as a public-private partnership, as in Washington and Colorado. Meanwhile, efforts that rely on state dollars to subsidize coverage may be fiscally

infeasible for many states. States must also consider whether to apply for a 1332 waiver and how a public option or Medicaid buy-in plan will affect premiums and plan choices for consumers in the ACA's marketplaces, which have only recently begun to stabilize, as well as potential impacts on the employer group market. Further, continued state-level debates over these proposals must take place in the context of a 2020 presidential debate during which candidates are proposing sweeping national reforms. However, should Washington and Colorado successfully implement programs that constrain provider prices to improve affordability and preserve enrollees' access to services, they may serve as models for other states and for those contemplating national reforms.

Acknowledgments

The authors thank the Commonwealth Fund for supporting the research underlying this issue brief. We are also grateful to Sara Collins, Linda Blumberg, and John Holahan for their thoughtful review and comments on the draft.

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