Promises Unmet:
The Early Experiences of State Public Option Plans

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EXECUTIVE SUMMARY

Since 2019, Washington State, Colorado, and Nevada have enacted public option plans. In 2023, Minnesota passed legislation putting the state on the path to becoming the fourth state with a public option.

In each of these states, the champions of these laws contend their plans will reduce health insurance premiums and expand coverage. However, the early experiences of these state public option plans suggest these promises will go unmet.

This paper evaluates the four state public option plans with a focus on two policy dimensions: provider premiums and reimbursement rates. Policymakers face unavoidable political and economic trade-offs between the two policy dimensions. With particular attention toward Washington State and Colorado, we find that the promise of large premium savings requires setting reimbursement rates for hospitals and providers far below what states appear willing to do. This unwillingness likely reflects both the political challenges of large rate cuts and the potential effects aggressive rate cuts would have on plan quality and access.

Washington State and Colorado have launched their plans, while Nevada and Minnesota are in various design stages. The states have opted for quasi-public option plans where, in lieu of a government-administered plan, private insurers offer the plans with significant state oversight. Despite differences in

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PREMIUMS

Washington State and Colorado have each failed to meet their respective premium target goals:

- Washington State hoped plan premiums would be at least 10 percent lower than non–public option plans. After three years, only four of Washington State's 39 counties have public option plans that have met the state's premium targets for bronze-level plans; only one county has met the target for silver-level plans.
- In its inaugural year, Colorado's public option plans were the cheapest bronze-level offering in only four of 64 counties (10 for silver-level plans and 32 for gold-level plans). Only 15 percent of plans met the state's initial-year premium targets, and even fewer plans met the state's second-year targets.
- In 2022 and 2023, aggregate premiums for Washington State's public option plans were $2 million more than if public option participants had chosen the lowest-cost non–public option. In Colorado, the figure was $13.3 million in 2023.

REIMBURSEMENT RATES

The states have failed to meet their premium targets in part because policymakers have been unwilling or unable to secure sufficiently low reimbursement rates:

- In Washington State, policymakers had initially hoped to set reimbursement rates at Medicare-level rates but ultimately settled on a statewide aggregate ceiling of 160 percent of Medicare-level rates. Even these rate caps proved challenging to meet, forcing policymakers to enact coercive provider participation requirements.
- Colorado policymakers enacted state-mandated floors on hospital reimbursement rates. In some cases, these floors have undermined previous successes by private insurers to secure lower reimbursement rates. The floors have created unintended side effects where some hospitals with previously negotiated rates below the specified floor have demanded rate increases across the insurers' commercial plans.
- While Nevada will not begin public option enrollment until 2026, an analysis of insurers' payments to physicians and other medical providers suggests the state will not be able to significantly reduce provider reimbursement rates. Instead, achieving the state's premium targets will require large cuts to hospital reimbursement rates and aggressive rules on insurers' administrative costs.

ENROLLMENT

Policymakers' unwillingness to accept these inevitable trade-offs has produced plans that have failed to attract consumers. This reality is evident in meager enrollment in the early states:

- In Washington State, less than 10 percent of 2023 exchange participants selected the state's public option plan.
- In Colorado in its first year (2023), over 85 percent of individual exchange enrollees selected a non–public option plan; the take-up was even lower in small-group market plans where only about 100 individuals enrolled.
- Washington State and Colorado public option plans have enrolled less than one percent of their respective state populations.
- State-sponsored actuarial analyses of Nevada's state plan suggest the public option will have little effect on total exchange enrollment, even if insurers meet the state's aggressive premium targets.

The early experiences offer lessons for other states entertaining the idea of a public option. Underpinning the promises of these proposals is the belief that large cost savings are available if payments to providers and hospitals can be cut sufficiently, or administrative costs can be significantly reduced relative to traditional plans. For political and economic reasons, the early state adopters have failed to show this approach will work.

INTRODUCTION

For decades, health care policymakers have debated the merits of a "public option," a government-run health insurance plan that would compete alongside private insurers.

Proponents argue these plans would offer reduced health premiums by cutting payment rates for hospitals and providers, and that further premium savings are promised from expected reductions in administrative costs. Critics, however, argue that the promised public option premium savings could prove illusory. They argue that the steep cuts in reimbursement rates necessary to achieve the savings would be unsustainable, produce political opposition, and discourage provider participation.

Efforts toward a federal public option have stalled. Early legislative versions of the Affordable Care Act (ACA) included a public option, but it was removed before the bill's final passage. Since then, the Congressional Budget Office (CBO) has estimated the budget effects of a nationwide public option.[2] More recently, the Biden administration mentioned the idea in its FY2022 budget proposal.[3]

With little prospect of enacting a federal public option, the debate has shifted to the states. Since 2019, four states have enacted legislation creating quasi-public option plans. Unlike the traditional concept where a government directly runs an insurance plan, these quasi-public option plans rely on private insurers to administer the plans. Washington State and Colorado have begun enrolling individuals in their respective plans. Nevada is developing a public option with the intention of enrolling individuals for the 2026 plan year. In early 2023, Minnesota passed legislation to design a plan. The enacted legislation was silent on nearly all policy questions required to implementing a public option, but Minnesota state policymakers nevertheless hope to launch its plan in 2027.

The early experiences with these state public option plans provide important insights for policymakers in other states that are weighing the merits of public option proposals. To that end, this paper offers an overview of each state's public option plan to better understand the effects on each state's health care system, enrollees, and providers.

We focus on two important dimensions of each public option plan: reimbursement rates for hospitals and providers and plan premiums. The interactions between these dimensions create significant and unavoidable tensions for any public option plan. Without public subsidies, steep cuts in provider reimbursements are necessary to deliver the promised premium savings, but they may impact consumers access to care or engender political opposition.

Medical providers have had some political success in limiting rate cuts. They have made compelling arguments that overly aggressive rate cuts would jeopardize quality or reduce access to care.[4] In Washington State, policymakers had initially hoped to set reimbursement rates at Medicare-level rates but ultimately settled on a statewide aggregate ceiling of 160 percent of Medicare-level rates. Meanwhile, Colorado policymakers enacted state-mandated floors on hospital reimbursement rates that differ by facility and range from 165 percent to 238 percent of Medicare-level rates, depending on the facility. In some cases, these floors have undermined previous successes by private insurers to secure lower reimbursement rates. The floors have created unintended side effects where some hospitals with previously negotiated rates below the specified floor have demanded rate increases across the insurers' commercial plans.

[2] For example, see CBO (2021).
[3] Office of Management and Budget (2021), page 24. A proposed "public option" was notably absent from the President's FY2023 and FY2024 budgets.
[4] See discussion on page 4 in Corlette et al. (2020).

Partially due to the inability to secure significant rate cuts, the premium savings of public option plans have been lower than anticipated by policymakers. In 2022 and 2023, aggregate premiums for Washington State's public option plans were $2 million more than if public option participants had chosen the lowest-cost non–public option plan. After three years, only four of Washington State's 39 counties have public option plans that have met the state's premium targets for bronze-level plans; only one county has met the target for silver-level plans. Colorado has likewise failed to experience significant savings. In its inaugural year, the state's public option plans were the cheapest bronze-level offering in only four of 64 counties (10 for silver-level plans and 32 for gold-level plans). Colorado public option enrollees could have reduced aggregate premiums by $13.3 million by choosing the lowest-cost non–public option plan in lieu of the public option plan. Even worse for its proponents, as we discuss in Section 3, the Colorado insurance commissioner was forced to approve premiums for 2024 well above the premium targets called for under state law.

Nevada and Minnesota are in various stages of designing their plans. On December 29, 2023, Nevada submitted a Section 1332 State Innovation Waiver (1332 waiver) application with a newly proposed reinsurance program added to its public option plan. Minnesota policymakers, meanwhile, are currently studying various proposals with an actuarial analysis due in early 2024. Given the early results in Colorado and Washington State, neither state is likely to deliver the robust savings proponents envision.

Ultimately, our analysis confirms the results of earlier research on the public option. The promise of large premium savings has largely proven illusory due to the inherent trade-offs between the dimensions.

Rate cuts engender political opposition, and policymakers have adjusted rate-setting goals due to concerns that aggressive rate cuts would affect plan quality and access. Premiums could also be lowered by adjusting other dimensions of their plans (i.e., more cost-sharing), but state policymakers have instead demanded insurers include low-deductible provisions. In short, policymakers' unwillingness to accept the inevitable trade-offs has produced plans that are unlikely to attract consumers.

This fact can be readily seen in the relatively low enrollment in these plans. In Washington State, less than 10 percent of 2023 exchange participants selected the state's public option plan, despite the introduction of new state subsidies that led to a large shift in enrollment. In Colorado, over 85 percent of individual exchange enrollees in 2023 selected a non–public option plan. The take-up was even lower in small-group market plans where only about 100 individuals enrolled. Since state exchange enrollment only represents a small share of these states' populations, Washington State and Colorado public option plans enrolled far less than one percent of their respective state populations. Given the significant legislative, regulatory, and budgetary resources needed to implement these plans, these low enrollment figures may give policymakers in other states doubts over whether public option plans merit the effort.

The paper is divided into seven sections. The first reviews existing literature on public option plans with emphasis on the two dimensions mentioned above. In Sections 2–5, we provide case studies on the four states' plans. Each case study includes a legislative history exploring how the legislation evolved under pressure by stakeholders. For Washington State and Colorado, we include analyses on plan premiums, enrollment, and administrative costs. The sixth section provides a scorecard contrasting the states' early experiences with their plans. Section 7 offers a conclusion.

1. AN OVERVIEW OF STATE PUBLIC OPTION PLANS AND RECENT RESEARCH

Traditionally, public option proposals would create a government-administered health insurance plan that would compete directly with other health plans. The four states discussed in this paper, however, are operating, developing, or considering quasi–public option plans that use private health insurance companies to achieve state-mandated goals. Despite the significant differences between bona-fide public option plans and the quasi-public option plans, the proponents of each type share the same primary objectives to reduce health care costs and expand coverage.[5]

In designing a state public option plan, policymakers face several related policy questions that will ultimately affect whether the plan will achieve these goals. Most importantly, policymakers must determine provider payment rules and premium-setting policies. They must also decide who will administer the plan, who will be eligible for the plan, the plan's required benefits and cost-sharing rules, and what costs and financial risks the state is willing to bear. In answering these questions, policymakers face inevitable political and economic trade-offs. In this section, we discuss these issues. Where appropriate, we mention decisions by the four states that have enacted public option plans, but we reserve detailed discussions of each state's policy choices in sections 2–5.

1.1. DESIGNING A STATE PUBLIC OPTION: PLAN ADMINISTRATION

A primary question for policymakers considering a public option is plan administration. Proponents argue that a state-run public option would benefit from lower administrative costs than private insurers. They point to lower administrative costs in Medicare and Medicaid as evidence.[6] Further savings could come from increased scale if a state's public option were broadly available to the public. In addition, unlike most private plans, public option plans would have no need to deliver profits to shareholders.

The potential administrative savings, however, could prove illusory.

First, states would still face significant start-up and ongoing costs of implementing and operating a state-run public option plan.[7] States, for example, would have to meet federal rules for insurers and ACA qualified health plans (QHP).[8] Second, a portion of insurers' administrative costs go to cost containment strategies that may result in lower health expenditures and premiums. Fiedler (2021) finds that the expected administrative savings would "likely be more than offset" by the absence of cost-saving measures employed by commercial insurers such as "utilization management, risk selection, and diagnostic coding." States could contract with insurers for some of these processes. This would be akin to large employers who self-insure but contract with insurance providers to administer their plans. States would still bear the financial risks of the public option plans, while avoiding the legal hurdles in creating a QHP and the outlays associated with developing their own cost-containment measures. Nevertheless, doing so would sacrifice at least a portion of the administrative cost savings as well as leave states open to the financial risk of setting inadequate premiums (we discuss premium-setting issues further in Section 1.3).

States could also enlist private insurers to operate their public option plans. Sparer (2020) refers to these arrangements as quasi- or redefined public option plans. While there are questions about whether this approach should count as a bona fide public option plan, Washington State, Colorado, and Nevada have opted for this route in designing their plans.[9] Minnesota may follow this route as well if it allows buy-in to its current MinnesotaCare program. The implementation costs of this approach are likely to be far lower than a government-administered plan. Further, the quasi-public option plan avoids exposing the state

[5] *King et al. (2022) offer five similar policy goals: "(1) controlling health insurance costs; (2) covering the uninsured; (3) reducing the effects of cycling on and off public coverage (i.e., churn); (4) improving competition; and (5) simplifying plan administration" (Page 151).*
[6] *For example, see https://www.brown.senate.gov/imo/media/doc/public_option_fy23_budget_letter_3-4-22.pdf.*
[7] *An advisor to the Washington State governor explained that the state opted for private insurers to administer the plans because "it would have cost the state hundreds of millions of dollars just to operate the plan" (Kliff, June 27, 2019).*
[8] *For a discussion on the legal issues facing states, see page 177 in King et al. (2022).*
[9] *Fiedler (2020) argues that despite the "public option" label, proposals that rely on private insurers to operate the plans are more consistent with price regulation policies rather than genuine public option plans.*

to the financial risks of directly insuring enrollees.[10] Depending on premium and rate rules, it may also mitigate (although certainly not eliminate) the political opposition to enacting these plans by leaving contentious policy and plan design questions to insurers. Sparer (2020), for example, notes that in the case of the Washington State public option, policymakers' "goal was to derive the benefits of a public option without the political, organizational, and economic tasks of creating a new, state-administered insurer."

1.2. DESIGNING A STATE PUBLIC OPTION: REIMBURSEMENT RATE POLICIES

Proponents contend that increased government oversight would yield significant premium savings through lower reimbursement rates for hospitals and providers. The government could mandate or use its market power to negotiate lower payment rates. Most often, public option proposals link reimbursement rates for the new plans to rates paid by Medicare or Medicaid, which tend to pay providers and hospitals at rates below those paid by private insurers.[11]

Securing meaningful reductions in reimbursements rates, however, comes with significant political and economic trade-offs. Payments must be set sufficiently low to secure meaningful premium reductions, but as explained in King et al. (2022), "if states set provider reimbursement rates too low, providers may drop out of the public option or Medicaid programs, creating unintended effects on the private insurance market." This is not a mere hypothetical. Low Medicaid payment rates, for example, have resulted in limited access to physicians. Survey evidence suggests that significantly fewer doctors are willing to accept Medicaid patients than those with private insurance.[12] The result is longer reported wait times for Medicaid, particularly in places with the lowest relative reimbursement rates.[13] Narrow provider networks could thus make the state's public option plans less attractive to consumers.

Limited participation by providers could also make it difficult for public option plans to meet the essential community provider and network adequacy rules required for QHPs. This concern is pronounced for rural areas that already face significant provider shortages.[14]

To overcome these issues, states could adopt rules requiring provider participation. Fiedler (2020) finds that, absent a requirement that providers participate, it is unlikely that a public option plan would negotiate lower rates than those secured by private insurers.[15] Blumberg (2021) argues that a public option that relies on "voluntary provider participation will most likely lead to a trade-off between network breadth and premium savings." Thus, several public option proposals have suggested methods to persuade providers into participating. For a federal public option, this could include requiring Medicare providers also accept public option recipients. States could opt for similar approaches for providers in Medicaid or other state-sponsored insurance programs. Washington State's public option, for example, contains a rule that ties a hospital's public option participation with access to state employees' and retirees' health care systems.

Participation requirements will engender significant political opposition, particularly if the proposal relies on significant payment cuts to providers to deliver premiums savings. Blumberg (2021) notes that, while hospitals would likely accept the lower rates rather than forego Medicare and Medicaid payments, "physician participation is difficult to enforce." If the government cannot "enforce consequences for physicians declining to participate with the public option, it could lead to a significantly narrower provider network than envisioned."

Even if policymakers are successful in initially delivering reimbursement rates below the rates paid by private insurers, it is unclear whether the rates would be sustainable over the long term. In Chen, Church, and Heil (2023), we highlighted several examples where federal health programs were unable to sustain aggressive provider

[10] King et al. (2022) note that "this public-private model allows the state to specify certain terms of the MBPO, but places the majority of the administrative burden and financial risk on commercial carriers" (page 174).
[11] In a review of recent literature, CBO (2022) estimates that from 2010 to 2020, commercial providers paid 240 percent more for outpatient services and 182 percent for inpatient services than Medicare's fee-for-service prices.
[12] Shadac (2022), for example, reports that, between 2014 and 2017, 95 percent of physicians accepted new privately insured patients, while only 74 percent accepted new Medicaid patients.
[13] Oostrom, Einav, and Finkelstein (2017) find Medicaid patients were more likely to experience a wait time longer than 20 minutes, and that longer wait times were correlated with lower Medicaid reimbursement rates. Similarly, Gotlieb, Rhodes, and Candon (2020) find that, compared to individuals with private coverage, mean waiting times for primary care doctors are one day longer for Medicaid recipients.
[14] In a nod to this issue, Colorado and Washington State both adopted reimbursement regulations to limit their plans' effects on provider payments in rural settings.
[15] Fiedler (2020) draws an important distinction between administratively determined rates and negotiated rates. In the case of administratively determined rates, the effects of allowing providers to opt out would depend on how responsive providers are to the falling rates.

payment schedules. Most notably, for nearly two decades Congress repeatedly enacted "doc fix" legislation to shield providers from scheduled cuts under Medicare's sustainable growth rate (SGR) formula. In 2015, Congress replaced the SGR with a new system in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Since 2020, however, Congress has repeatedly increased Medicare provider payments above what was called for in MACRA. A similar example was seen in Medicaid in 2013 and 2014 when Congress temporarily increased payments to primary care physicians (i.e., the "Medicaid primary care fee bump").[16]

Failing to sustain low reimbursement rates could be more disruptive for enrollees and policymakers than beginning with less aggressive payment cuts from the outset. If reimbursement rates rose considerably, public option enrollees would face significant increases in premiums, well above what was hoped for by public option proponents. This could produce significant year-over-year "churn" in enrollment. Meanwhile, state policymakers could find they have invested significant money in implementing a plan that fails to achieve its goals of lower health costs and expanded coverage.

1.3. DESIGNING A STATE PUBLIC OPTION: PREMIUM SETTING

Policymakers must also consider how public option premiums will be determined. The decision depends on who will administer the plans. For government-run plans, policymakers must determine directly how premiums will be set. This includes decisions about the medical loss ratios that plans will target and how the plans will maintain financial reserves. As highlighted in Church, Heil, and Chen (2020) political considerations are likely to influence the plan's premium setting rules.[17] In particular, requirements to maintain actuarially fair premiums may be waived if it would yield large year-over-year increases in premiums or during economic shocks.

In the case of states who opt to use private insurers, King et al. (2022) summarizes four approaches state public proposals have taken in regulating premiums:

> *States choosing the public-private model have taken varied roles in setting premiums to control costs. These models include: (1) allowing commercial carriers to set rates; (2) requiring the insurance commissioner to regulate how commercial carriers set premiums; (3) requiring the insurance commissioner to review and approve proposed rates; and (4) designating a state agency to establish premiums... (pages 179–180)*

Some states have considered premium reduction targets. Colorado and Nevada have both enacted rules requiring insurers to reduce their public option premiums year-over-year after accounting for health inflation. As we discuss below, despite the mandates, Colorado regulators approved plan premiums in 2023 and 2024 that failed to meet the state's premium targets. Setting premium targets may require policymakers to specify an appropriate inflation metric. Most health inflation metrics, however, do not account for changes in utilization or the intensity of services provided; instead, inflation metrics tend to measure the change in the per-unit-price of health care services.[18] This problem could be more pronounced if policymakers discourage insurers from including utilization management or other cost-containment strategies in public option plans.

1.4. DESIGNING A STATE PUBLIC OPTION: PLAN DESIGN

Political oversight in plan design could have large ramifications for the costs of the plan. Policymakers may be inclined to create plans that the public perceives as relatively generous or higher quality. For example, they may be leery about creating public option plans with aggressive cost-management strategies. This is true regardless of whether the plans are administered directly by the government or if states enlist private insurers to operate the plans. For example, Washington State and Colorado have both insisted that their state's public option plans offer zero-cost sharing for more

[16] *We discussed the Medicaid fee bump in Church, Heil, and Chen (2020).*
[17] *That paper was focused on a federally public option, but the political demands would likely be similar for a state-run public option.*
[18] *See Hovakimyan (2021) for an overview of different medical price indices.*

services than private plans tend to offer. Similarly, policymakers may insist that public option plans offer robust provider networks that are broader than required by the ACA's network adequacy requirements. Washington State's law features network adequacy requirements. Colorado's law goes even further, requiring that insurers create public option plan networks that are "no more narrow than the most restrictive nonstandardized plan offered by the carrier."[19]

All else constant, decisions by policymakers to insist on relatively generous public option plans will result in higher premiums. These could also produce significant side effects for utilization and create the risk of adverse selection. As Blumberg (2021) explains in discussing a federal public option:

> *Offering a public option plan (or plans) that differs from the other plans offered in the markets where the public option is sold carries significant risks. Benefit variations can make it more difficult for consumers to compare their options, but more importantly, they can lead to adverse selection either into the public option or private plans. (page 11)*

Using a comparison of traditional Medicare to Medicare Advantage plans, Fiedler (2020) expects that a government-run public option plan would face some adverse selection even after risk adjustment. The public option plans could also produce higher utilization rates. Again, using Medicare as an example, Fiedler assumes that utilization would be 10 percent higher in public option plans than private individual market plans for similar enrollees, in part because the public option plans are unlikely to adopt aggressive utilization management methods.

1.5. DESIGNING A STATE PUBLIC OPTION: TRADE-OFFS

As highlighted above, policymakers face unavoidable trade-offs in designing a state public option. Some of these trade-offs are political. Aggressive reimbursements cuts, for example, will engender opposition from providers. Mandates obligating insurance companies to participate are likewise subject to disputes. Policymakers will also face political issues in designing plans. Cost-containment measures like utilization management may be necessary to deliver substantially lower premiums, particularly if a state is unwilling to set sufficiently low reimbursement rates. Yet, policymakers may experience political pushback if cost-containment measures are perceived as limiting consumer choice or discouraging certain kinds of care.

Other trade-offs are economic. Significant disruptions to payment structures or the insurance market could destabilize the health care market, resulting in fewer providers or insurers. Since the ACA, the individual market has already experienced significant consolidation among insurers. States that require insurers to operate public option plans may drive additional insurers from the market or discourage new entrants.

There are also complicated interactions with other government policies. For example, a low-cost public option plan may reduce federal subsidies to all ACA enrollees.

ACA premium subsidies are based on the second-cheapest silver-level plan in a rating area. Thus, a public option plan that is the cheapest or second cheapest silver-level offering on a state's exchange will lower federal premium subsidies. This is true regardless of whether enrollees opt for the plan. For example, Cadwell, Rocha, and Novak (2023) find that the state's public option plans may have increased required premium contributions in four Colorado counties by as much as $1,128 for a family of four who selected a non–public option plan. Thus, a public option plan that fails to garner many enrollees could nonetheless have significant effects on the state's marketplace population. This outcome has led states to apply for waivers to use additional federal funds. Colorado, for example, received a 1332 waiver to receive federal pass-through funding from the reductions in the federal premium tax credits. Nevada applied for its 1332 waiver in December 2023. It expects its new public option plans will produce pass-through funding to help fund the state's new reinsurance program

[19] *See https://leg.colorado.gov/bills/hb21-1232.*

and other health priorities. If Minnesota's actuarial analysis of its public option comes back favorably, it is also expected to apply for similar pass-through funding.

The litany of choices—and trade-offs—that states face in designing a state public option means no two states will have identical plans. In the next sections, we review the decisions made by the four states that have adopted public option plans. We provide an analysis of each state's public option.

For each state we begin with a short legislative and regulatory history to highlight the political and economic constraints the states face when establishing rules for reimbursement rates and premiums. We then explain the current or planned major rules for each state's plan. In the case of Washington State and Colorado, we offer an overview of the early experience of each state's plan. The analysis includes data on reimbursement rates, premiums, and enrollment. Importantly, the analysis is not intended to be an exhaustive exercise for each plan. Instead, it illustrates how policymakers have weighed the trade-offs between the two dimensions and the effect these decisions have had on the states' health care systems.

2. THE WASHINGTON STATE PUBLIC OPTION

In 2019, the Washington State Legislature enacted a law adding public option plans to the state's health insurance exchange.[20]

The aim of the law was "to improve access to affordable health care coverage in the individual market."[21] The public option plans, called Cascade Select plans, were to be administered by private insurers who were required to negotiate with hospitals and providers to meet legislatively determined aggregate reimbursement rates. Cascade Select plans began offering coverage to enrollees in 2021.

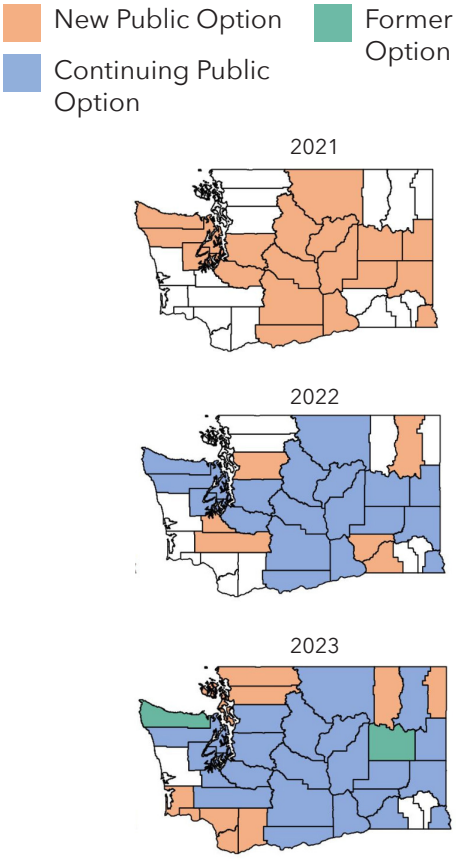
2.1. WASHINGTON STATE LEGISLATIVE AND REGULATORY HISTORY

The legislative history of the Washington State public option illustrates the trade-offs policymakers face in enacting a state public option. Seeking to reduce premiums, the initial version of the legislation proposed in the state senate in January 2019 required Cascade Select plans pay Medicare-level rates to providers and facilities.[22] By the time of its passage, policymakers had increased the cap on reimbursement rates to 160 percent of Medicare-level rates.[23] In addition, the legislation established floors on reimbursements for rural hospitals and primary care services.[24]

The increase in the reimbursement rates reflected significant opposition from stakeholders. State senator David Frokt, a sponsor of the bill, stated: "The whole debate was about the rate mechanism. With the original bill, with Medicare rates, there was strong opposition from all quarters. The insurers, the hospitals, the doctors, everybody." [25] The 2019 law did not require providers to participate in the public option, and thus if rates were too low, insurers would not be able to field adequate networks.

Even with the modified reimbursement cap, insurers initially faced significant opposition from providers who argued that the rates were insufficient to cover their costs. The Washington State Health Care Authority (HCA) noted that "voluntary provider participation was a significant barrier to reaching statewide availability in the first two years of Cascade Select."[26] As a consequence, the public option plans had particularly narrow provider networks and covered few counties. As shown in Figure 1, only 19 of the state's 39 counties offered at least one Cascade Select plan in 2021. Meanwhile, as discussed below, in the initial year monthly premiums remained high, often above the rates of non–public option plans.

Figure 1. Counties with Cascade Select Plan (Public Option) by Year



[20] *Senate Bill 5526. Individual Health Insurance Market--Standardized and State-Procured Plans. https://Lawfilesext.Leg.Wa.Gov/Biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5526- S.SL.Pdf?Q=20220203164635.*
[21] *HCA (2022), page 8.*
[22] *See Senate Bill 5526 Sec. 3(1)(d). https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Senate%20Bills/5526.pdf.*
[23] *Specifically, the law requires that a plan's total reimbursements to facilities and providers "may not exceed one hundred sixty percent of the total amount Medicare would have reimbursed providers and facilities for the same or similar services in the statewide aggregate" (Senate Bill 5526. Sec. 3(g)(i)).*
[24] *Cascade Select plans must pay at least 101 percent of allowable costs to rural hospitals and at least 135 percent of Medicare-level rates to primary care providers.*
[25] *Kliff (June 27, 2019).*
[26] *HCA (2022), page 14.*

The 2019 law specified that all public option plans conform to standardized cost-sharing rules. It required plans to have zero-cost sharing for certain preventive services, lower deductibles than non-Cascade plans, and primarily use copays rather than coinsurance for most cost sharing. These rules are in addition to federal QHP requirements. While the actuarial values of the public option plans are like non–public option plans of the same metal tier (e.g., bronze, silver), the standardization requirements limit insurers' ability to differentiate their plan offerings. Carlton, Kahn, and Lee (2021) attributed the initially higher premiums among Cascade Select plans to the mandated lower deductibles.

The cost-sharing rules were also applied to the law's Cascade Standard plans. The Cascade Standard plans are traditional plans (i.e., non–public option plans) offered on the exchanges. Non-Cascade plans, a third type of plan, are still available on the exchanges.

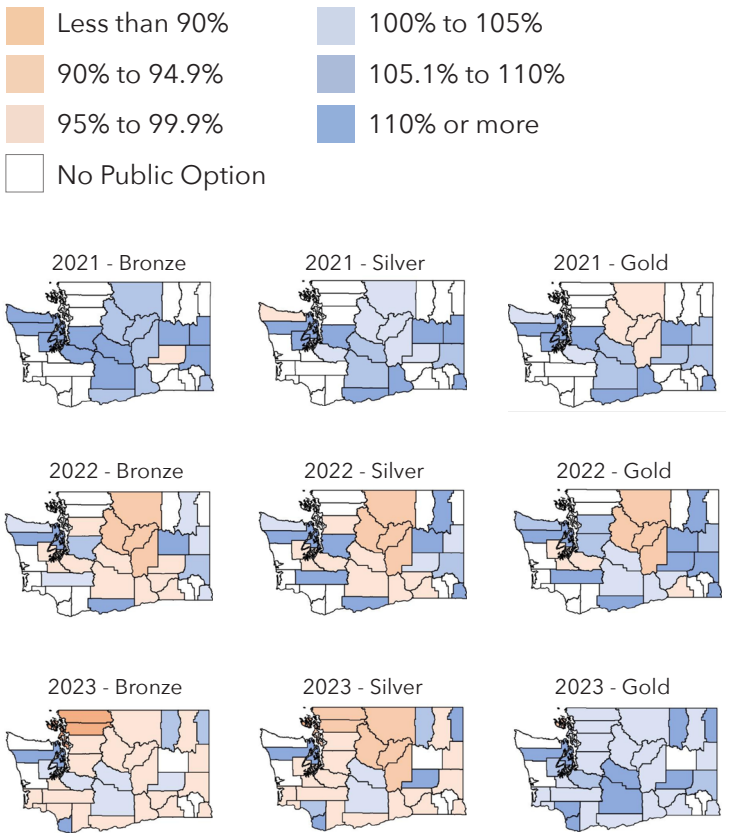
In response to the slow uptake among providers, the legislature passed Senate Bill 5377 in 2021, which reformed several parts of the 2019 law.[27] Among the changes, the law included language requiring that, under certain circumstances, hospitals that receive payments from the state's public employees' benefits program or that school employees' benefits program must contract with one or more public option plan.[28] Subsequent rulemaking established fines and other enforcement actions for non-compliance. The 2021 law also created a new program for low-income enrollees, the Cascade Care Savings program, which offers state-provided subsidies to low-income enrollees who choose a Cascade Select plan or Cascade Standard plan.

Since 2021, more counties have had access to Cascade Select plans. As shown in Figure 1, six additional counties were added in 2022. In 2023, 11 counties gained access to at least one Cascade Select plan, but two counties lost access.[29]

2.2. WASHINGTON STATE PREMIUMS

An explicit goal of Washington State's public option was to have "meaningfully lower premiums compared to non-Cascade Select Exchange plans." Specifically, the state aimed to have the premiums of Cascade Select plans at least 10 percent lower than traditional plans.[30] As of 2023, the state has failed to meet this goal in nearly all counties.[31]

Figure 2. Public Option Premiums as a Share of Cheapest Non-Public Option Plan



Notes: Premiums are for 40-year-old participant

[27] *Senate Bill 5377. Health Insurance Individual Market—Premium Assistance—Standardized Plans. https://Lawfilesext.Leg.Wa.Gov/Biennium/2021-22/Pdf/Bills/Session%20LawsSenate/5377-S2.SL.Pdf?Q=20210615170717.*
[28] *This provision only applies to hospitals that have an offer from a public option. The provision would also only be in effect if public option plans were not offered in every county.*
[29] *United Healthcare had offered Cascade Select plans for Clallam and Lincoln counties in 2022, but the insurer was not "Re-Awarded" a contract for 2023 (See HCA, 2022).*
[30] *See HCA (2022), page 15.*
[31] *Unless otherwise noted, premium data are from CMS's Health Insurance Exchange Public Use Files and are limited to individual plans on a state's marketplace exchange. Data are available at: https://www.cms.gov/marketplace/resources/data/public-use-files.*

In 2021, the Cascade Select bronze-level plan was only the cheapest option in one county (out of 39). This was also true for silver-level plans, while Cascade Select plans were the cheapest gold-level plan in four counties. By 2022, the public option plans were the cheapest bronze-level plans in 14 counties, the cheapest silver-level plans in 13 counties, and the cheapest gold-level plans in eight counties.

With the enactment of Senate Bill 5377 insurers appear to have more, albeit still limited, success in reducing premiums.

In 2023, four counties had bronze-level Cascade Select plans with premiums that were more than 10 percent below the cheapest non-public option plan.[32] In total, these counties accounted for 8.5 percent of total 2023 enrollment in the Washington State exchange. And even in these counties, only 22 percent of enrollees opted for the public option plan (with only a subset of that cohort choosing bronze-level plans). No other county had a bronze-level Cascade Select plan with premiums at 95 percent or less of traditional bronze-level plans.

Even though Cascade Select plans were the lowest-premium silver-level plan in 25 counties, the difference between the Cascade Select and the non-public option plans in most of these counties was less than five percent. In 2023, one county (San Juan) met the state's goal for "meaningfully lower premiums" for silver-level plans, but this county accounted for less than one percent of total enrollment. Seven counties had Cascade Select silver premiums between five to 10 percent lower than the cheapest non-public option.[33] Among gold-level plans, San Juan was the only county where premiums were lower than non-public option plans.

Rate filing increases for 2024 suggest that premium growth for Cascade Select plans will be lower than for non-Cascade Select plans. Table 1 shows the rate increases for plans remaining on the exchanges weighted by reported enrollment.[34] Bronze-level Cascade Select plan premiums will rise by 6.8 percent, while Cascade Standard plan premiums will rise by 8.4 percent and non-Cascade plan premiums will rise by 12.4 percent. Premiums for silver-level Cascade Select plans will rise by 5.9 percent compared to 8.5 and 6.3 percent for Cascade Standard plans and non-Cascade plans, respectively. The biggest differences in rate increase are among gold-level plans where Cascade Select premiums will grow half as fast as non-Cascade plan premiums.

Table 1. Washington State 2024 rate increases by metal level and plan type

	Cascade Select Plans	Cascade Standard Plans	Non-Cascade Plans
Gold	4.5%	9.4%	10.8%
Silver	5.9%	8.5%	6.3%
Bronze	6.8%	8.4%	12.4%

Notes: Weighted by 2023 plan enrollment. Finalized rate filing increases are from the Office of the Insurance Commissioner's rate request decisions. Enrollment figures are from the insurers' initial rate filings.

It is unclear, however, whether this trend reflects underlying cost savings of the public option plans rather than issuer-specific rate experiences. Because Table 1 reflects the rate changes among all insurers, it confounds the effects of the public option with premium growth differences among insurers. To avoid this issue, in Table 2 we limit the analysis to insurers who offer a Cascade Select plan. Three insurers offer Cascade Select plans: Community Health Plans of Washington, Coordinated Care Corporation by Ambetter, and LifeWise Health Plan of Washington. Table 2 shows the rate increases for the three insurers by metal level and plan type. Community Health Plans of Washington only offer Cascade Select Plans; the others also offer traditional plans. As shown in the table, the rate increases for their non-Cascade Standard offerings are consistently lower than their Cascade Select plans. The results show that insurers offering public option plans are increasing premiums for their public option plans by more than their non-public option plans.

[32] *The counties were San Juan, Whatcom, Island, and Skagit.*
[33] *The included counties were Chelan, Douglas, Okanogan, Grant, Skagit, Island, and Whatcom.*
[34] *Finalized rate filing increases are from the Office of the Insurance Commissioner's rate request decisions. Enrollment figures are from the insurers' initial rate filings. The data do not include plans that are new for the 2024 plan year or plans that were terminated.*

Table 2. Washington State 2024 rate increases among Cascade Select insurers by metal level, issuer, and plan type

	Cascade Select	Other Plans	Cascade Select	Other Plans	Cascade Select	Other Plans
Community Health	-1.2%	--	-1.0%	--	-1.7%	--
Coordinated Care	9.0%	3.2%	9.3%	4.6%	6.3%	1.9%
LifeWise Health	8.4%	7.5%	7.1%	7.9%	8.6%	8.8%
All Cascade Select Insurers	6.8%	5.3%	5.9%	5.1%	4.5%	3.9%

Notes: Weighted by 2023 plan enrollment. Finalized rate filing increases are from the Office of the Insurance Commissioner's rate request decisions. Enrollment figures are from the insurers' initial rate filings.

2.3. WASHINGTON STATE ENROLLMENT

Initial enrollment in the public option was low. Likely due in part to the high premiums in 2021, total enrollment in Cascade Select plans in Spring 2021 was 779.[35] This rose to 6,335 in 2022 and to 23,032 in 2023. The Washington State Health Care Authority has touted the rapid rise in enrollment as an indication of the popularity of the public option plan.[36] It is unclear, however, whether the enrollment increases reflect a growing popularity of the public option plans or were driven by the introduction of expanded ACA subsidies and the Cascade Care Savings program. The period analyzed coincides with expanded federal premium subsidies, which reduced required premium contributions for all ACA enrollees and expanded eligibility to individuals with incomes above 400 percent of the federal poverty line. Meanwhile, as mentioned above, the Cascade Care Savings program provides subsidies to exchange participants who enroll in a Cascade Select or Cascade Standard plan; those with non-Cascade plans are not eligible.

Unsurprisingly, the introduction of the new subsidies coincided with a shift in enrollment from non-Cascade plans to Cascade plans (Standard or Select). Table 3 shows the change in enrollment from 2022 to 2023 across these three types of plans. Overall enrollment declined slightly from 2022 to 2023. Non-Cascade plans, however, lost nearly half of their enrollees. It appears most of these individuals chose a Cascade Standard plan rather than a Cascade Select plan, despite the lower average premiums of the latter. This can be seen by the share of enrollment by plan type: the share of exchange enrollees in Cascade Select plans rose eight percentage points while the share choosing Standard plans rose 24 percentage points.

Table 3. Washington State Individual Market Enrollment

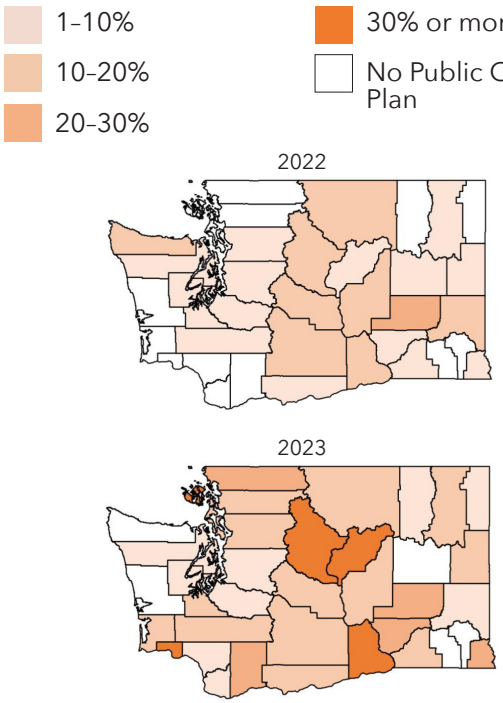
	2021	2022	2023	Change (2022 to 2023)
Cascade Select (Public Option)	779	6,335	23,032	16,697
Cascade Standard	22,047	58,993	108,916	49,923
Non-Cascade Plan	168,700	147,290	78,432	-68,858
Total Enrollment	191,526	212,618	210,380	-2,238

Notes: Enrollment is based on Spring enrollment reports from the Washington State Health Benefit Exchange.

Figure 3 shows public option enrollment as a share of total enrollment within each county for 2022 and 2023. Among counties with a Cascade Select plan, the plans account for less than 20 percent of enrollment in 24 counties; in 10 counties public option enrollment accounted for more than 20 percent of enrollment.[37]

[35] *Unless otherwise noted, enrollment data is from the Spring enrollment and data reports from the Washington Health Benefit Exchange (https://www.wahbexchange.org/about-the-exchange/reports-data/enrollment-reports-data/). To ensure continuity, we use Spring enrollment estimates across all years.*
[36] *For example, see https://content.govdelivery.com/accounts/WAHCA/bulletins/3482512.*
[37] *This includes Wahkiakum County where 72 of the 118 exchange enrollees (61 percent) select a public option plan.*

Figure 3. Public Option Share of Exchange Enrollment



It is difficult to disaggregate the effects of Washington State's public option from the 2021 expansion of ACA premium subsidies. Nevertheless, a comparison to other states suggests that the introduction of Cascade Select plans does not appear to have substantially increased participation in the state's exchange. From 2020 to 2023, the Washington State exchange population rose 8.6 percent. Meanwhile, the total US exchange population rose by 43.4 percent. During that period, Washington State's enrollment growth ranked 38 among all states.[38]

2.4. WASHINGTON STATE PLAN COSTS

Using enrollment and premium data, we estimate how much total premiums have fallen due to the presence of the Cascade Select plans. In 2022, if public option enrollees chose the lowest-premium non–public option plan, average premiums would have fallen by $400.[39] With over 6,000 enrollees, aggregate 2022 premiums would have been $2.75 million lower if Cascade Select enrollees had opted for the lowest-cost non–public option plan. In 2023, enrollment in Cascade Select plans did reduce total premiums by an estimated $710,000 or about $31 per Cascade Select enrollee. Thus, in total, over the last two years, Cascade Select enrollees would have reduced total premium spending by $2 million if they had opted for the lowest-cost traditional plan.

The increased premium spending is not the only cost of the Cascade Select plans. Implementation and ongoing administrative costs likely exceed $1 million for the state thus far. Governor Inslee's 2019-2021 proposed budget included $558,000 for the "Public Option."[40] The 2021 legislation included a biannual funding request from the Health Care Authority of $289,000 for a program manager.[41]

[38] To ensure consistency across all states when comparing enrollment, we use enrollment estimates from CMS Marketplace Open Enrollment Period Public Use Files (https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products/2023-marketplace-open-enrollment-period-public-use-files). These estimates are based on data from the open enrollment period, which will differ from Washington State's Spring enrollment estimates.

[39] See the Data Appendix for an overview of how we model the demographics and plan selection of enrollees.

[40] See page 97 in https://ofm.wa.gov/sites/default/files/public/budget/statebudget/20supp/2020SuppRecSumsCLvNL.pdf.

[41] The Fiscal Note also included $8.3 million in expenditures that were largely related to the state's new Cascade Care Savings program. A portion of these expenditures, however, may be related to the Cascade Select plans. See Multiple Agency Fiscal Note Summary for SB 5377, https://fnspublic.ofm.wa.gov/FNSPublicSearch/GetPDF?packageID=62670.

3. THE COLORADO ONLY PUBLIC OPTION

On June 16, 2021, Colorado followed Washington State and Nevada as the third state to pass legislation creating a public option.

In 2023, it became the second state to begin enrolling residents in public option plans.[42] The state's plan, the Colorado Option, differs from the Washington State public option plan in several ways. In particular, Colorado policymakers opted for different rules concerning reimbursement rates and premiums. Initial results, however, have been similar to Washington State's experience. State regulators implementing the program have been unwilling or unable to secure sufficiently low reimbursement rates to deliver significant premium reductions. The result has been public option plans that fail to deliver the law's promised premium reductions.

3.1. COLORADO LEGISLATIVE AND REGULATORY HISTORY

In 2019, Colorado policymakers asked the Division of Insurance and the Department of Health Care Policy and Financing to develop a proposal to implement a public option within the state.[43] Following the submitted report, Colorado policymakers proposed legislation in 2020 to create a public option.[44] The bill, HB20-1349, would have required hospitals and insurers to participate in the public option. Like the Washington State plan, it specified a reimbursement rate formula that would have linked hospital reimbursement rates to Medicare-level rates. The base rate would have been 155 percent of the Medicare-level rate with adjustments for hospitals that meet certain characteristics (e.g., those with a disproportionately large Medicare and Medicare population). The bill failed in committee after facing significant opposition from providers, who objected to the bill's hospital reimbursement rate structure and the participation requirements.[45]

The next attempt was introduced in March 2021. The bill, HB21-1232, passed after several iterations.[46] The initial version of the bill called for insurers to cut premiums by 20 percent over 2021 levels by the year 2024, with premiums then only allowed to grow at the rate of the consumer price index plus one percentage point.[47] If insurers failed to meet the premium reduction targets, the state would then create a quasi-government entity, the Colorado Option Authority, to administer the public option plan. Policymakers enacted a revised version of the bill that removed state authority to create its plan, lowered premium reductions targets to 15 percent relative to 2021 levels by 2025, and tied the allowable rate of premium increases after 2025 to the medical component of the Consumer Price Index (CPI-M).[48]

The Colorado Option went into effect in 2023. Like the Washington State public option, it is not a government-run insurance plan; instead, the state requires that private insurers offer a standardized public option plan on the individual and small group markets in each county that they offer traditional health plans. Insurers must offer plans meeting the ACA's bronze-, silver-, and gold-levels of coverage with standardized deductibles and cost-sharing requirements. Plans must also meet certain network adequacy requirements.

While Washington State focused on reducing provider payments through an aggregate cap on insurers' reimbursement rates, Colorado opted for a different approach. Insurers are tasked with negotiating rates that meet the state's premium and network adequacy targets. If an insurer finds it cannot meet these targets due to a "reimbursement rate dispute," it may request non-binding arbitration with providers. If the arbitration fails, the insurer must notify the state's insurance commissioner. After holding a public hearing on the matter, the commissioner "may establish carrier reimbursement rates for hospitals and health-care providers and require the hospitals and health-care providers to accept patients and the established reimbursement rates." The legislation specified a reimbursement rate floor that the insurance commissioner may impose on hospitals. The floor is set at 165 percent of the Medicare-level rate

[42] *In 2023, it became the second state to begin enrolling individuals in a state public option.*
[43] *See https://leg.colorado.gov/bills/hb19-1004.*
[44] *See https://leg.colorado.gov/bills/hb20-1349.*
[45] *See Paul (May 4, 2020). Supporters also pointed to the COVID-19 pandemic as a reason to abandon the legislation.*
[46] *See https://leg.colorado.gov/bills/hb21-1232.*
[47] *See bill version introduced on March 18, 2021.*
[48] *We discuss the state's calculation for medical inflation and its effect on the premium targets in Section 3.2 and in the appendix.*

with higher floors for certain types of hospitals (e.g., independent hospitals and hospitals with a level one pediatric trauma center).[49] Specifically, Colorado hospital floors range from 165 percent to 238 percent of Medicare-level rates, depending on the facility.[50]

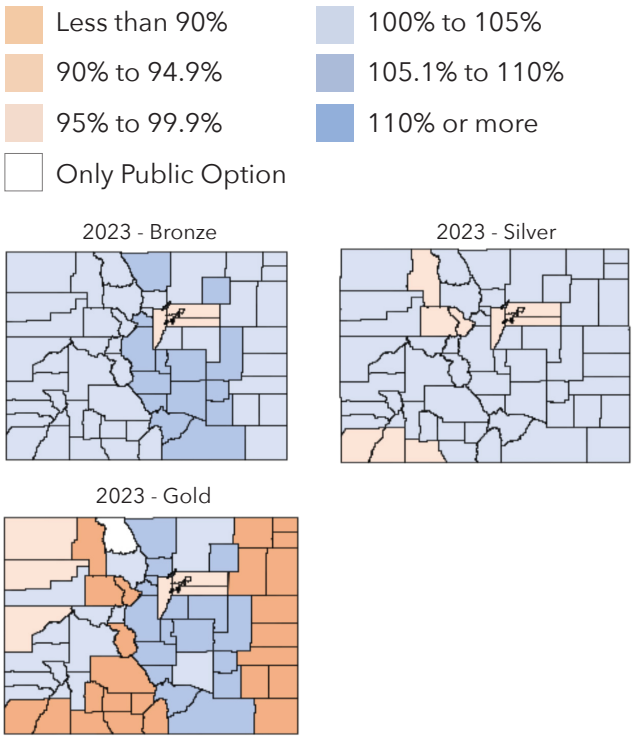
3.2. COLORADO PREMIUMS

In its inaugural year (2023), existing insurers were tasked with delivering Colorado Option premiums that were five percent below the level the insurer charged in 2021 for the same county and metal level, adjusted for CPI-M and before accounting for the effects of the state's reinsurance program. The premium reduction targets rise to 10 percent in 2024 and 15 percent in 2025. Beginning in 2026, premiums are only allowed to rise by the rate of medical inflation.

In 2023, six insurers offered plans on the individual exchange, although one of the six insurers' plans was terminated prior to the end of the plan year.[51] Most insurers were unable to meet the 2023 targeted rates.[52] Cadwell, Rocha, and Novak (2023) find that 85 percent of the Colorado Option plans offered in the individual market failed to meet the five percent reduction target. Only one insurer, Elevate by Denver Health Plan, Inc., met the targeted reductions for all of its plans. Cadwell, Rocha, and Novak, however, note that Denver Health priced "their Colorado Option Plans at an unsustainable loss." This prediction appears to have proved prescient as Denver Health Plan raised its Colorado Option premiums by nearly 21 percent for the 2024 plan year after the Colorado Division of Insurance stated that their initial rate proposals were inadequate.[53]

In addition to not meeting the initial premium targets, Colorado Option plans were rarely the cheapest plan in any county. Figure 4 compares the lowest-cost Colorado Option plan to the lowest-cost non-Colorado Option plan. As shown in Figure 4, there were only four counties (out of 64) where the lowest-cost bronze-level plan was a Colorado Option plan. If we exclude Denver Health's "unsustainably" low premiums, Colorado Option bronze-level plans would have been more expensive than the cheapest non–public option plan in every county. Among silver-level plans, Colorado Option plans were the cheapest in 10 counties (out of 64). Colorado Option plans were the cheapest gold-level plan in half of the state's counties.[54] The relatively high number for gold-level plans reflects the fact that HMO Colorado (Anthem)—the only insurer offering plans in every county—did not offer any non-Colorado Option gold-level plans in 2023.

Figure 4. Public Option Premiums as a Share of Cheapest Non-Public Option Plan



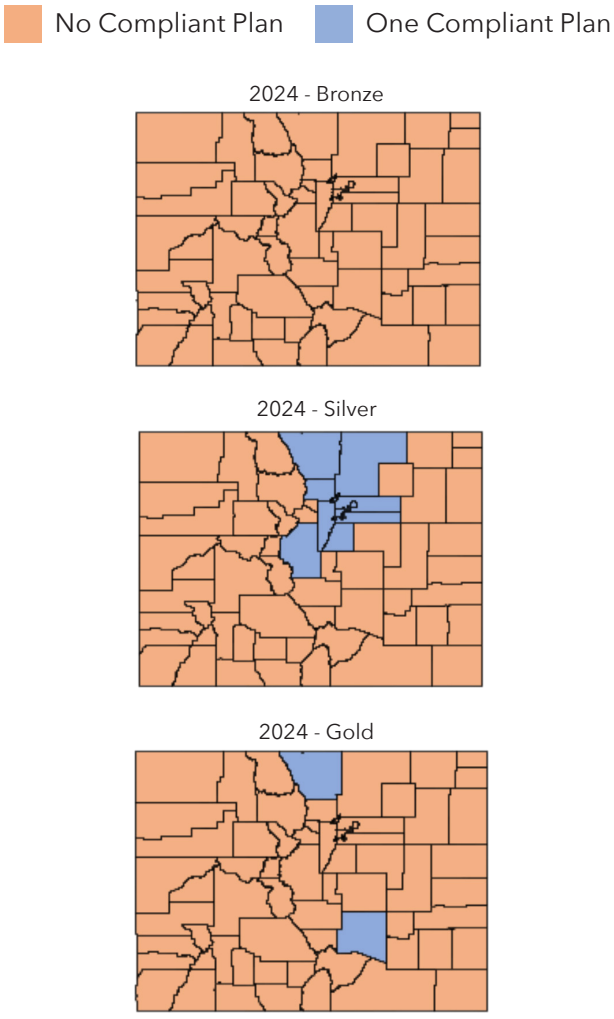
Notes: Premiums are for 40-year-old participant with an on-exchange plan.

The failure of insurers to meet the 2023 premium targets casts significant doubt on whether the long-term premium targets can be met. Insurers' 2024 finalized rates cast further doubt on this prospect. For the 2024 plan year, there were 468

[49] *The state set a base rate of 155 percent with upward adjustments up to 40 percentage points depending on hospital characteristics. The insurance commissioner is also prevented from reducing rates by more than 20 percentage points below the level negotiated between the insurer and provider in the previous year.*
[50] *See page 7 of https://www.cms.gov/files/document/1332-federal-questions-co-responses-waiver-amendment-application.pdf.*
[51] *On August 31, 2023, the Colorado Division of Insurance terminated the health plans of Friday Health of Colorado. It had offered plans in 47 counties. A seventh insurer, Rocky Mountain Hospital and Medical Service, Inc., D.B.A. Anthem Blue Cross and Blue Shield, offered a single catastrophic plan.*
[52] *Unless otherwise noted, our analysis focuses on the Colorado Option's effect on the individual market rather than the small group market.*
[53] *Initially, Denver Health had asked for an average rate increase of nine percent. In an August 3, 2023, objection letter the state "expressed concern of the prior rate levels potentially being inadequate." See "Colorado Actuarial memorandum 2023-08-14.pdf" in Denver Health's annual rate filings on SERFF (https://filingaccess.serff.com/sfa/home/CO).*
[54] *The figure includes the Friday Health Plans, which were terminated on August 31, 2023. Excluding Friday Health Plans does not affect the counts of counties where the lowest-cost plan was a Colorado Option plan.*

plan-county combinations for the Colorado Option. Of these combinations, only 12 met the state's 2024 premium targets. As shown in Figure 5, no bronze-level plans met the 2024 targets, while only 10 silver-level plans and two gold-level plans met their targets out of the total 468 plan-county combinations.

Figure 5. Number of Colorado Option Plans Meeting 2024 Rate Targets



Notes: Data from issuers' finalized rate filings. No country had more than one compliant plan.

In March of each year, insurers are required to "notify the [Insurance] Commissioner of the reasons why the carrier is unable to meet the requirements." One purpose of the notification is to identify hospitals whose unwillingness to negotiate lower rates contribute to an insurer's inability to meet a premium target. Despite this requirement, only one insurer (Cigna) stated that they failed to meet the targeted rates due in part to providers' unwillingness "to negotiate better contracting rates." While Cigna identified three hospitals that had failed to negotiate better rates, the insurer noted that even if the hospitals' rates were set at their statutory floor, most of the insurers' plans would still not have met the state's premium targets.[55]

Anthem Blue Cross and Blue Shield, meanwhile, noted that 82 percent of hospitals in their networks had already agreed to reimbursement rates "at or below" the floors specified by the public option law. Further, the insurer noted that in some cases the rate floors specified in the law were above previously agreed to rates, which meant many providers had no incentive to negotiate further rate reductions. This may have larger effects on the state's insurance market. For example, in at least one case, an Anthem provider demanded "a raise in reimbursement on all commercial plans."[56]

The failure to reduce reimbursements rates sufficiently to meet the premium targets is consistent with earlier actuarial analyses.

Milliman (2021) found "that the minimum hospital reimbursement levels established in the bill may be higher than the contracted arrangements that certain insurers…currently have in place with at least some of their providers." In a follow-up analysis, Novak et al. (2022) echoed these findings, arguing that "the reimbursement reduction floors and limitations combined with actuarial issues in the allowed adjustments will make it difficult to achieve the premium reductions throughout the State."

Insurers argued that they could not meet the targets because of significant issues with the state's method for setting the premium targets. Specifically, the state's method does not account for potential selection issues or changes in

[55] *See Cigna's Actuarial Analysis for CO Public Option, https://drive.google.com/drive/folders/1x20Q8jn946bXb17-1sU_yNJEgaH2tm3a.*
[56] *Anthem noted that negotiations continued among the remaining hospitals, but even if all providers agreed to the lower reimbursement available under the law, the insurers "might be able to meet the premium reduction in one or two metal level individual plans offered in just one county." See Anthem's March 1, 2023, Notice of Noncompliance, https://drive.google.com/drive/folders/1jCPGPClzE3_9tAYdl_KYjVEkLKLAY0wr.*

utilization and intensity; instead, the state's targets only grow with per unit health inflation. The insurers also noted that the health inflation measurement specified by the public option law fails to anticipate future increases in prices that will affect the adequacy of insurer premiums. Instead, for the 2023 plan year the state's medical inflation measurement relied on the historic 10-year average change in the medical care index component of the CPI-U. Health inflation, however, can vary widely year-to-year with greater variations experienced in recent years. During 2022, for example, health prices rose 4.1 percent, but the 10-year rolling average was only 2.8 percent.[57] This issue could compound over time. Since the benchmark premiums are only permitted to grow at a rolling average of price growth, extended periods of above-average health inflation will result in a growing discrepancy between premium benchmarks and premiums adjusted for current health inflation.[58]

The Commissioner held a public hearing in July 2023 regarding the general inability of insurers to meet the 2024 premium targets. The Commissioner, however, cancelled and did not hold the insurer- and hospital-specific adjudicatory hearings that were envisioned in the regulations and statute. These cancelled adjudicatory hearings are a necessary precursor before the Commissioner could set any hospital reimbursement rates.

Table 4 shows the approved rate increases for Colorado Option plans by insurer and metal level. Most insurers submitted year-over-year rate increases for their Colorado Option plans. Weighted by total current enrollment, premiums for Colorado Option bronze-level plans will rise an average of 9.4 percent from 2023 to 2024, silver-level plans by 11.7 percent, and gold-level plans by 4.1 percent.

Table 4. 2024 Colorado Option Approved Rate Increases by Metal Level and Insurer

	Bronze	Silver	Gold
Cigna Health and Life Insurance Company	2.8%	-0.4%	1.2%
Elevate by Denver Health Medical Plan	19.9%	22.1%	18.2%
HMO Colorado, Inc (Anthem)	7.9%	13.7%	4.0%
Kaiser Foundation Health Plan of Colorado	5.7%	15.4%	5.5%
Rocky Mountain HMO, Inc.	-0.4%	6.8%	-4.1%
All Plans	**9.4%**	**11.7%**	**4.1%**

Notes: Data are from Insurers' Uniformed Rate Review Templates. Rate increases are weighted by current enrollment.

As the Colorado Option enters its second year, there is little evidence that the Colorado Option is putting downward pressure on individual premiums across the individual market.

Table 5 shows the average annual change in premiums for the lowest-cost plan by metal tier. The premium increases experienced for the 2023 and 2024 plan years stand in sharp contrast to the premium reductions experienced in the years prior to the introduction of the Colorado Option. The steep decline in 2020 has been attributed to the state's reinsurance program.[59] The trends do not appear to be simply a consequence of COVID or other nation-wide trends. From 2019 to 2022, the state's lowest-cost silver plan premium fell by 27 percent while the national average fell by only six percent. From 2022 to 2024, however, Colorado's rose by 26 percent while the national average only grew by nine percent.

[57] *The appendix includes a figure showing single-year and 10-year trends of the MCPI.*
[58] *In September 2023, the state revised its inflation metric for subsequent years to be the rolling three-year average of the MCPI "for the Denver-Aurora-Lakewood area." See Colo. Rev. Stat.Section 10-16-1303.*
[59] *For example, see Ingold (October 11, 2019).*

Table 5. Colorado Individual Exchange Historical Premium Growth by Metal Tier

	Lowest-Cost Bronze Plan	Low-Cost Silver Plan	Lowest-Cost Gold Plan
2019	-6.7%	6.5%	-8.3%
2020	-22.9%	-25.7%	-22.2%
2021	-2.9%	-2.0%	-0.5%
2022	-1.1%	-0.3%	-7.8%
2023	8.2%	9.0%	2.8%
2024	12.4%	15.2%	12.1%

Notes: Data from Kaiser Family Foundation (see https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier).

3.3. COLORADO ENROLLMENT

The initial enrollment goal for the state's public option was 10,000 Coloradans.[60] As of January 31, 2023, nearly 40,000 had enrolled in the plans, or about 19 percent of the total enrollment in individual plans. In comparison, the state's population was 5.87 million in 2023, meaning less than one percent of Colorado residents enrolled in a Colorado Option plan.[61]

The aggregate enrollment estimates, however, include approximately 10,000 enrollees in the state's OmniSalud program, which "allows undocumented Coloradans and DACA recipients to safely apply for a Colorado Option plan through the secure Colorado Connect platform."[62]

Importantly, OmniSalud enrollees could only select Colorado Option plans. Among exchange participants—who had a choice between a Colorado Option and non-Colorado Option plan—only 14 percent opted for a Colorado Option plan.[63] Initial enrollment estimates by insurer are shown in Table 6.

Table 6. Colorado Option Enrollment by Insurer (As of 1/31/2023)

Insurer	On-Exchange	Off-Exchange	Total
HMO Colorado, Inc (Anthem)	15,047	4,076	19,123
Elevate by Denver Health Medical Plan	3,979	1,009	4,988
Rocky Mountain HMO, Inc.	2,707	2,226	4,933
Cigna Health and Life Insurance Company	2,387	1,910	4,297
Kaiser Foundation Health Plan	2,324	1,534	3,858
Friday Health Plans	1,583	1,039	2,622
All Plans	**27,965**	**11,764**	**39,729**

Notes: Individual market only. Data are from the February 22, 2023 Colorado Option Advisory Board Meeting presentation. All plan totals may not match due to multiple enrollments. Off-exchange plans include enrollment through Colorado Connect and direct purchases from insurers.

One aim of the Colorado Option was to increase the number of Coloradans with individual insurance.[65] Colorado policymakers highlighted the first-year enrollment figures as evidence of the law's success. They compared the enrollment to Washington State's, which had enrolled less than one percent of those with individual insurance in its inaugural year.[64] The comparison, however, may not be apt because Colorado's requirement that all insurers participate in the Colorado Option means that the plans were available in every county in 2023. In contrast, in their inaugural year (2021), Washington State's Cascade Select plans were only available in 19 of the state's 39 counties. A more apt comparison is likely with 2023 enrollment.

In that year, the share enrolled in Cascade Select plans was 11 percent, still slightly lower than Colorado's public option enrollment.

[60] *See https://www.hhs.gov/about/news/2022/06/23/hhs-announces-historic-first-in-the-nation-program-that-seeks-to-expand-coverage-to-nearly-10000-coloradans.html.*
[61] *Population estimates are from the U.S. Census Bureau, https://www.census.gov/data/tables/time-series/demo/popest/2020s-national-total.html.*
[62] *See https://doi.colorado.gov/omnisalud.*
[63] *See the February 22, 2023, Colorado Option Advisory Board Meeting presentation, https://drive.google.com/drive/folders/1qjRxvwcokDK3uzUzcG8Xv_j-GHs7IkC-. The estimates include the now-defunct Friday Health Plans, which had enrolled 2,600 Coloradans.*
[64] *See https://doi.colorado.gov/news-releases-consumer-advisories/approximately-35000-coloradans-chose-the-colorado-option-during.*

Even then, Cascade Select plans were only available in 34 of Washington State's 39 counties.

The state's year-over-year enrollment growth, however, was much lower than the nationwide average. The state's open enrollment for the 2023 plan year reported 212,000 enrolled in an individual plan, an increase of seven percent relative to the 2022 plan year (198,000).[66] Meanwhile, the nationwide exchange population grew by nearly twice as much (12.7 percent from 2022 to 2023).[67]

While our analysis is focused on plans on the individual exchange, enrollment for small group Colorado Option plans merit inspection. As of February 15, 2023, fewer than 100 Coloradans were enrolled in a small group Colorado Option plan.[68] As shown in Table 7, only two insurers had enrollment greater than 10 people. There are significant development and compliance costs with offering these plans that are unlikely to be recouped with such limited uptake.

Table 7. Enrollment in Small-Group Colorado Option plans by Insurer

HMO Colorado, Inc. (Anthem)	27
Kaiser Foundation Health Plan of Colorado	51
Kaiser Permanente Insurance Company	2
Rocky Mountain Hospital & Medical Service	10
UnitedHealthcare Insurance Company	0
UnitedHealthcare of Colorado, Inc.	0

Notes: Data from Colorado Option Rate Reduction Notices filed in March 2023 (retrieved from SERFF).

3.4. COLORADO PLAN COSTS

Enrollment in the Colorado Option may not have reduced aggregate premiums. We estimate that if Colorado Option enrollees had opted for the lowest-cost traditional plan within their county and selected metal level, aggregate premiums for on-exchange individual policies would have fallen by $13.3 million.[69]

Meanwhile, the state has devoted at least $3.7 million to implement the Colorado Option. The state's Legislative Council staff estimated that the 2021 law would add $1.7 million in expenses for the FY2021-22 budget year and $2 million annually from FY2022–23 to FY2025–26.[70]

The costs of the public option are in addition to costs borne by insurers as they develop their public option plans. These costs may be passed on to consumers in the form of higher premiums. Given the requirements that insurers offer Colorado Option plans in all counties where they offer a public option plan, a portion of these costs may be borne by exchange enrollees that opt for non-Colorado Option plans. These costs could be seen through higher insurance premiums or potentially fewer plan offerings if the public option rules lead insurers to exit particular counties or potentially the entire state.

[65] *In approving the state's Section 1332 waiver, HHS touted Colorado's projection that by 2027 32,000 additional Coloradans would be insured due to the Colorado option. See https://www.hhs.gov/about/news/2022/06/23/hhs-announces-historic-first-in-the-nation-program-that-seeks-to-expand-coverage-to-nearly-10000-coloradans.html.*
[66] *See https://c4-media.s3.amazonaws.com/wp-content/uploads/2023/03/31121205/By-the-Numbers-final-OE10.pdf.*
[67] *Nationwide enrollment estimates are from CMS Marketplace Open Enrollment Period Public Use Files, https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products/2023-marketplace-open-enrollment-period-public-use-files.*
[68] *Six insurers offered Colorado Option's in the small group market: Anthem's HMO Colorado, Kaiser Foundation Health Plan of Colorado, Kaiser Permanente Insurance Company, Rocky Mountain Hospital & Medical Service, Inc, UnitedHealthcare Insurance Company, and UnitedHealthcare of Colorado, Inc.*
[69] *This includes data from the now-defunct Friday Health Plans. See the appendix for an overview of the calculation.*
[70] *See Final Fiscal Note for HBV 21-1232, https://leg.colorado.gov/sites/default/files/documents/2021A/bills/fn/2021a_hb1232_f1.pdf.*

4. THE NEVADA PUBLIC OPTION

Nevada's public option legislation was signed into law on June 9, 2021.[71]

It expects to begin offering plans to enrollees in 2026. The legislation's specific goals were to lower health insurance premiums and out-of-pocket costs for consumers, improve access to health care, and reduce disparities in access and outcomes.

4.1. NEVADA LEGISLATIVE AND REGULATORY HISTORY

Since at least 2017, Nevada policymakers have considered various reforms to expand the state's role in the individual market. In 2017, the legislature passed AB374, legislation that would allow Nevadans to "buy-in" to the state's Medicaid program. The bill was vetoed by then-Governor Brian Sandoval who argued that the legislation needed "further study and analysis" to ensure it did not "introduce more uncertainty to an already fragile healthcare market."[72] In 2019, after failing to pass a new version of a Medicaid buy-in proposal, the Nevada Senate commissioned an analysis "to study the feasibility, viability and design of a public healthcare insurance plan that may be offered to all residents of this State."[73] The report estimated that a statewide plan offered on the marketplace exchange would enroll 9,000 to 32,000 individuals, including 1,500 to 4,900 who would otherwise be uninsured. The enrollment estimates assumed premium reductions of 10 percent to 20 percent. The report cautioned that "to achieve such a [premium] reduction, the state will need to determine how to contain costs, such as setting a provider reimbursement cap or a premium reduction target for contracting insurers."[74] Following the report, the Nevada Legislature passed, and then-governor Steve Sisolak signed, SB420 in June 2021.[75] Despite passing legislation to create a public option plan the same year that Colorado policymakers did, Nevada policymakers set the plan's start date three years later than Colorado's, on January 1, 2026.

Like Washington State and Colorado, Nevada's plan requires private insurers to administer the public option plans rather than create a state-administered QHP.[76]

Similar to Washington State (but unlike Colorado), not all carriers are required to offer a public option plan on Nevada's Silver State Health Insurance Exchange. Instead, the state will contract with health carriers through a competitive procurement process. The law requires any Nevada health insurers that participate in the State's Medicaid managed care program to submit "good faith" bids to offer a public option plan. Insurers who do not participate in the state's Medicaid program may also submit bids but are not required to do so.[77]

The carriers' public option plans must satisfy all QHP requirements under the ACA and offer at least one silver-level plan and one gold-level plan. The plans will be offered on the state's exchange and for direct purchase to any "natural persons" who reside in the state (i.e., non-citizens are eligible to participate). The plans are expected to be available only to those in the individual market.[78] Like the Colorado plan, the state is required to seek a 1332 waiver to receive pass-through funds for any federal premium tax credit reductions.

The state opted against explicit provider reimbursement rates targets. Nevada plans to rely on premium reduction targets to achieve savings. We discuss these targets in the next section. With limited exceptions, the law requires that reimbursement rates for participating health providers in public option plans must be, "in the aggregate, comparable to or better than reimbursement rates available under Medicare."[79]

[71] *See https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8151/Overview.*
[72] *See Sandoval's veto message on June 16, 2017, https://gov.nv.gov/uploadedFiles/govnvgov/Content/News_and_Media/Press/2017_Images_and_Files/AB374VETO.pdf.*
[73] *See 2019 Senate Concurrent Resolution No. 10, https://www.leg.state.nv.us/Session/80th2019/Bills/SCR/SCR10_EN.pdf.*
[74] *Brooks-LaSure et al. (2021), page 24.*
[75] *See https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8151/Overview.*
[76] *The law does include a provision allowing the state to "directly administer the Public Option if necessary to carry out [its] provisions." See Sec. 12 of SB420.*
[77] *As discussed in King et al. (2022), the Nevada law contains providers that could eventually make the law closer to a "hybrid" public option/Medicaid buy-in plan. For example, the law gives the state's director of HHS authority to seek a federal waiver combining the risk pools of the public option and the state's Medicaid plan.*
[78] *Milliman (2023) notes that, while small employers could not directly purchase the plans, they could use Individual Coverage Health Reimbursement Arrangements (ICHRA) to provide employees with pre-tax employer contributions to an individual plan. Milliman expects "some incremental number of employers" would consider offering ICHRA in response to the public option's assumed premium savings (page 26).*
[79] *See Sec. 14 of SB420.*

Rates for federally qualified health centers or rural health clinics must be comparable or better than those in the Prospective Payment System under Medicare. In addition, reimbursements to community behavioral health clinics must be comparable or better than state Medicaid rates.[80] Providers and hospitals that participate in other state health programs including Medicaid and the state employee health plan are required to contract with at least one public option plan.

One difference in implementation has been a change in partisan control of the governor's office, unlike the implementation of Washington State's and Colorado's public option programs where the governor who signed the legislation also led its implementation. In 2022, Republican Joe Lombardo defeated then-Democratic Governor Steve Sisolak. In his 2023 State of the State Address, Governor Lombardo stated that "questions remain about the rushed implementation of the public option, agency amendments to the statute, and lack of transparency" and "at a minimum this law needs to be substantially revised."[81] On October 11, 2023, Governor Lombardo's office announced it would seek a 1332 waiver to operate a reinsurance program alongside the state's public option reforms.[82]

In December 2023, the state submitted its 1332 waiver application.[83] Under the application, the implementation of the public option plans, now referred to as "Battle Born State Plans" (BBSPs), will be paired with a reinsurance program as part of a larger "Market Stabilization Program." The state plans to use any pass-through funds generated through the waiver, to fund three priorities:

1. The State-Based Reinsurance Program, which is intended to reduce "any unexpected financial risk to participating carriers and their provider networks with the introduction of the BBSPs that meet premium reduction targets."[84]

2. A Quality Incentive Payment Program "to reward high-performing insurers that offer BBSPs and meet certain metrics or quality indicators."[85]

3. A "Practice in Nevada" Incentive Program that will provide loan repayment for "providers willing to live and work for at least four years in a region of Nevada that qualifies as a federal Health Professional Shortage Area."[86]

Pass-through funds would be prioritized for the reinsurance program, with the remaining available funds available for the Quality Incentive Payment Program and then the "Practice in Nevada" Incentive Program. The state plans to launch its reinsurance program in 2027, one year after the introduction of the public option plans. The staggered start will allow the state to accumulate "sufficient [pass-through funds] to cover the State of Nevada's portion of the reinsurance program costs."[87]

4.2. NEVADA PREMIUMS

Like the Colorado Option, Nevada's law relies on mandated targets to reduce health insurance premiums. The law requires premiums to be lower than a "reference premium" by a specified amount and that premiums must not rise faster than the increase in medical inflation. The law defines the "reference premium" as the lesser of the second-lowest priced silver-level plan sold on the exchange in that zip code in 2024 (adjusted for medical inflation between the reference year and the year of the premium) or the second-lowest silver-level plan available in the previous year. The Director of Nevada's Department of Health and Human Services (DHHS), in consultation with the Nevada Insurance Commissioner and Health Exchange Director, has the discretion to revise public option premium reduction requirements, as long as the average public option premium over the first four years is at least 15 percent lower than the average reference premium over the same period.

[80] *See Sec. 14 of SB420.*
[81] *See https://gov.nv.gov/uploadedFiles/gov2022nvgov/content/Newsroom/PRs/2023/GovernorJoeLombardo_2023_StateOfTheStateAddress.pdf.*
[82] *See Nevada DHHS (2023) for more details.*
[83] *The finalized waiver application is available at https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/MarketStabilization/FinalRemediatedNevada1332WaiverNarrative.pdf.*
[84] *See page 5 of the waiver application.*
[85] *See page 12 of the waiver application.*
[86] *See page 12 of the waiver application.*
[87] *Milliman (2023), page 1.*
[88] *See Nevada DHHS, General Guidance Letter 23-003, available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/MarketStabilization/General%20Guidance%20Letter%20 23-003%20-%20NRS%20695K%20Programs.pdf. This guidance replaced an October 2022 guidance, where DHHS specified that the plans in each county must be four percent lower than the 2024 reference premium in 2026, falling by a total of 16 percent by 2029. See Nevada DHHS, General Guidance Letter 22-001, available at https://dhcfp.nv.gov/ uploadedFiles/dhcfpnvgov/content/Public/AdminSupport/MeetingArchive/PublicHearings/2022/MSM_PH_12_27_22_General_Guidance_Letter-Signed_ADA.pdf.*

In November 2023, DHHS issued a guidance bulletin to set the 2026 targeted reduction to three percent lower than the 2024 reference premium; the total 2029 targeted reduction was set at 15 percent.[88]

In 2027 and 2028, the targeted premium reductions will be determined during the insurers' procurement and contracting negotiations with the state. Importantly, the new guidance's target rate reductions are inclusive of premium reductions from the reinsurance program.

In addition, while SB420 called for the state to use the Medicare Economic Index for its inflation metric, DHHS has instead opted for the Medical Care Index of the CPI-U (Medical CPI) "plus any adjustments necessary to reflect local changes in utilization and morbidity."[89] Although Nevada has yet to describe how it will adjust for utilization and morbidity, the adjustments could prove important. As discussed in Section 3, Colorado's inflation metric fails to account for changes in utilization, which has made it more challenging for Colorado insurers to meet the state's premium targets.

The most recent state-sponsored actuarial analysis (Milliman, 2023) assumed the state could meet the 15 percent reduction by 2029. Excluding savings from the reinsurance program, the analysis pointed to three sources of cost savings the state would rely on to achieve premium savings: 1) reductions in reimbursement rates, 2) reductions in administrative costs through the law's mandated reductions in expense loads, and 3) cost-savings through value-based purchasing.[90] The analysis included the caveat that "if any one of the sources of savings does not materialize or materializes less than expected, the remaining savings from other sources must increase for the BBSPs to achieve their premium reduction goals."[91]

Similar to the Washington State and Colorado public option plans, the promised reductions in reimbursement rates are key to expected premium reductions for the state's public option.

Milliman (2023) ranked "[r]eductions in provider reimbursement unit costs" as the most important source of savings from the introduction of the public option plan. Significant rate reductions, however, may prove challenging for Nevada as the difference in reimbursement rates between commercial providers and Medicare is smaller than the national average. This is particularly true for physician services. CBO (2022) estimated that in 2017 commercial insurers in Nevada paid eight percent more for physician services than Medicare, well below the 27 percent average for all states.[92]

In a recent actuarial analysis, Wakely Consulting Group (2023) finds that insurers in Nevada's individual market pay 105 percent of Medicare-level rates for "professional services." Since the law prohibits insurers from reimbursing at rates below Medicare, insurers are thus unlikely to secure significant savings from payment cuts for physician services. As a consequence, the report finds that hospital reimbursement rates would need to be cut by 25 percent to 30 percent to achieve a 16 percent reduction in premiums.[93]

The newly proposed reinsurance program may reduce the necessary cuts to hospitals providers. Milliman (2023) estimates that the reinsurance program could account for more than half of the expected decline in premium reductions. They assume the state's public option plans will thus only reduce premiums by eight percent by 2029, half as large as the earlier actuarial reports that were based on 2022 guidance.[94] Importantly, the rate reduction targets would remain the same regardless of whether the reinsurance program achieves its rate reduction goals, thus the public option plans may be forced to find larger premium savings if Milliman's estimates prove overly optimistic. The reinsurance program is also expected to produce different premiums effects across the state's rating areas.[95] Consequently, the public option premium targets in certain rating areas may be even more difficult to meet.

[89] See https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8151/Overview.
[90] See Appendix C in Milliman (2023).
[91] Milliman (2023), page 14.
[92] CBO (2022) also found Nevada had relatively lower commercial reimbursement rates for inpatient hospital services. CBO estimates that in 2018 Nevada's commercial insurers reimbursed at 200 percent Medicare-level rates for inpatient hospital care. The average across all states 245 percent.
[93] The report also found that the necessary reductions in insurers' medical loss ratios were unlikely to materialize, and thus the administrative cost savings needed to meet the premium targets would also be less than projected.
[94] See Table 2 in Milliman (2023).
[95] See Table 10 in Milliman (2023).

4.3. NEVADA PROVIDER PARTICIPATION REQUIREMENTS

SB420 requires that any health care provider that participates in Nevada's Public Employees' Benefits Program, the Medicaid managed care program, or the state's workers' compensation program to contract with at least one public option plan and to accept public option enrollees to the same extent that they accept non–public option enrollees. This provision is similar to Washington State's SB5377, which, as discussed above, was enacted in response to evidence that Washington State providers were unwilling to contract with Cascade Select plans.

Since the law requires only that providers contract with "at least one" public option plan, they may prove unwilling to contract with multiple insurers if reimbursement rates are too low to justify offering plans across many networks. As noted in Wakely Consulting (2023), this could result in no insurers meeting the network adequacy requirements if the contracts "are sufficiently distributed across insurers." Importantly, the law includes a provision waiving the provider participation requirement "when necessary to ensure that recipients of Medicaid and officers, employees, and retirees of this State who receive benefits under the Public Employees' Benefits Program have sufficient access to covered services."[96] Thus, the provider participation requirement may not be as compulsory as policymakers expect.

Milliman (2022) found that the provider participation requirements are unlikely to have a material impact on provider participation. Milliman's 2023 report relied on a similar assumption.[97] The 2022 report projected the annual revenue loss to providers and hospitals from lower rates for public option plans would have a small effect on providers' total revenue and thus they expected, regardless of the participation requirements, "providers would be likely to contract with the PO at the required rates to achieve premium targets."[98] The small revenue estimates assumed the introduction in the public option has no effect on reimbursement rates paid by any other type of insurance.[99] This assumption requires providers and insurers to enter into separate rate negotiations for public option and traditional plans. Providers, however, may be leery about offering discounts to the public option plans as insurers may insist non–public option plans receive similar discounts.

4.4. NEVADA ENROLLMENT

Enrollment in the Nevada public option will depend on whether the state can deliver the premium reductions outlined in the law and the characteristics of the plan.

The most recent state-sponsored actuarial analysis (Milliman 2023) expects little increase in total exchange enrollment after the introduction of the public option plans. The introduction of BBSPs is expected to raise total enrollment by less than one percent during the first 10 years.[100] For most subsidized enrollees, the net premium (the premium less federal premium subsidies) will not change after the introduction of the public option plans. Consequently, only a small group of Nevadans who would otherwise not purchase an individual plan are expected to enroll due to the BBSP.

While total enrollment is not expected to change dramatically, the introduction of the public option plan is expected to lead to a large shift in plan selection.

The initial state-sponsored actuarial analysis (Milliman 2022) found that, depending on the specific assumptions, the state's public option plans would account for 39 to 40 percent of total enrollment in individual plans in 2026. This would rise to 59 to 60 percent by 2030.[101] The revised actuarial analysis (Milliman 2023) was slightly less optimistic. It assumed that half of the on-exchange population would enroll in a BBSP.[102] They note, however, that the take-up rate would depend on whether insurers offered bronze-level BBSPs, which, as noted above, is not required under the public option law.

[96] *See Section 13 of SB420.*
[97] *See page 9 in Milliman (2023).*
[98] *See Appendix D in Milliman (2022).*
[99] *See Appendix D, Table 7 (page 149) in Milliman (2022).*
[100] *The reinsurance program would lead to slightly larger enrollment gains. Combined, the BBSP and the reinsurance program is expected to raise total enrollment by just over one percent from 2026 to 2035. See Table 3 in Milliman (2023).*
[101] *See Tables 22, 29, 40, and 47 in Milliman (2022).*
[102] *See page 24 and 25 of Milliman (2023) for a discussion of the take-up assumptions.*

These assumed take-up rates are far higher than those experienced by Washington State or Colorado. Crucially, the estimates assume that insurers meet the mandated percent premium reductions by 2029. Since Milliman's (2023) take-up rate assumption is based on the "price advantage" of the new plans, failure to achieve the premium reductions would reduce the expected take-up. As discussed, in Sections 2 and 3, Colorado and Washington State have both failed to meet their states' respective premium goals. If Nevada is similarly unsuccessful, Milliman's enrollment projection will likely prove illusory.

4.5. NEVADA PLAN COSTS

Funding for implementing and administering the public option is expected to come primarily from the federal government pass-through funds related to their 1332 waiver. Nevertheless, the state projected that SB420 would increase annual state expenditures due to implementing and administering the public option. The state's Department of Health and Human Services, Health Care Financing and Policy estimated that implementing the public option would cost $1.6 million during the 2022-23 biennium budget and $2.4 million during the 2024-25 biennium budget.[103] Beginning in 2026, the state expects total costs from administering the public option will be $3 million annually. The state expects these costs will be paid through federal pass-through funds.[104]

[103] *See https://www.leg.state.nv.us/Session/81st2021/FiscalNotes/10523.pdf.*
[104] *See Appendix A in finalized waiver, https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/MarketStabilization/FinalRemediatedNevada1332WaiverNarrative.pdf.*

5. THE MINNESOTA PUBLIC OPTION

Minnesota's path to a public option was different than Washington State's, Colorado's, or Nevada's path.

Since 1992, Minnesota has been operating its own supplemental health insurance coverage for individuals who are ineligible for Medicaid but have incomes below 200 percent of the federal poverty line (FPL) as part of its MinnesotaCare program. While the design of the public option is still pending further study, the current public option legislation seems likely to expand on the state's existing health infrastructure and extend coverage to individuals up to 400 percent of FPL, and possibly to small employers.

5.1. MINNESOTA LEGISLATIVE AND REGULATORY HISTORY

At the beginning of 2023, the Minnesota legislature introduced legislation to enact a public option through an expansion of the existing MinnesotaCare program, beginning in 2026.[105] Concerns about the legislation's effect on providers and insurers slowed its progress. Policymakers ultimately enacted provisions of the legislation in its omnibus Health and Human Services Bill (SF2995).[106] Signed into law in May 2023, the law sets the state up to begin offering public option plans in 2027, if additional criteria are met and additional legislation enabling it to move forward is enacted. Notably, it requires an actuarial and economic report for implementing the public option as well as a 1332 waiver granted by the federal government. The actuarial analysis is due in early 2024.

The Commissioner of Commerce, in consultation with the Commissioners of Human Services and Health, and the Board of Directors of MNsure, "must report the final recommendation for a public option" as part of the actuarial analysis. That recommendation will include the health care benefit set to be provided to enrollees, estimated premiums, and cost-sharing for enrollees across the income range after accounting for state or federal subsidies, the type of plan issuers, health care reimbursement rates, adequacy of the expected provider network, and any additional information the state requires to request a 1332 waiver. If policymakers do not enact a related public option law by June 1, 2024, the Commissioner of Commerce may still submit a 1332 waiver application based on the report's recommendations.

While the omnibus legislation offers regulators significant flexibility in designing the state's public option, the law requires the report include an analysis of "a MinnesotaCare public option." We focus our discussion on the earlier MinnesotaCare public option legislation as it has attracted the most attention among the state's public option proposals and was explicitly mentioned in the omnibus legislation.

MinnesotaCare currently provides low-cost health insurance to Minnesotans with incomes between 133 percent to 200 percent of the FPL.

The program is administered by private insurers who receive capitated payments for enrollees. Enrollees pay premiums ranging from $0 to $80 a month, although the enhanced premium tax credits from the Inflation Reduction Act of 2022 have reduced premiums to a maximum of $28 per person per month through 2025. Until 2015, MinnesotaCare was funded wholly by the state. Following the passage of the ACA, however, it was converted into a Basic Health Program (BHP) to receive federal funding. In 2022, MinnesotaCare covered 106,000 individuals and spent $637 million, with about 90 percent financed by the federal government.[107]

A MinnesotaCare public option would extend eligibility in the program above the 200 percent threshold and potentially make it available for employees of small businesses. Eligible individuals

[105] *See Minnesota House Bill HF 96, https://www.revisor.mn.gov/bills/bill.php?b=House&f=HF96&ssn=0&y=2023).*
[106] *See Article 17, Sections 20-20 of SF2995, https://www.revisor.mn.gov/bills/text.php?number=SF2995&version=latest&session=ls93&session_year=2023&session_number=0.*
[107] *See slides 35 and 41 in Chartbook Section 5: Public Health Insurance Programs, https://www.health.state.mn.us/data/economics/chartbook/docs/section5.pdf.*

5.2. MINNESOTA PREMIUM AND ENROLLMENT PROJECTIONS

Like other public option plans, premium savings would largely come from lower reimbursement rates paid to providers. Estimates suggest that MinnesotaCare's reimbursement rates are significantly below commercial providers.[108] As a consequence, any significant shift in exchange enrollment to a MinnesotaCare public option would result in significant cuts to providers. The large difference in reimbursement rates could result in premium savings for those with private coverage, but with significant effects on providers. Nighohossian (2023) estimates that premiums could be 28 percent lower than exchange plans. As such, 62 percent of the estimated 80,000 enrollees in the public option would switch from private plans. This could reduce payments to Minnesotan hospitals by $2.3 billion over 10 years, with large risks for critical access hospitals and hospitals in rural areas.

5.3. MINNESOTA PLAN COSTS

Like other state public option plans, implementing the plan would come with significant costs. The omnibus legislation included a $2.5 million appropriation for the actuarial and economic analysis and for the preparation of the 1332 waiver. A contingent appropriation of $22 million was included for FY2025 to implement "to implement a Minnesota public option health care plan." The appropriation was subject to the approval of the state's 1332 waiver.[109]

[108] *Milliman (2016) estimated that on-exchange plans offered reimbursement rates 50 percent higher than MinnesotaCare plans.*
[109] *See Minnesota SF 2995, Article 20, Sec. 2, Subd. 5(d) and Minnesota SF 2995, Article 20S, Sec 2, Subd. 5(e).*

6. STATE PUBLIC OPTION SCORECARD

In this section, we evaluate the early experiences of the Colorado and Washington State public option plans. We focus on whether the states have met the objectives they have set for their plans. We include the two dimensions: premiums and reimbursement rates. We also discuss enrollment and the estimated costs of the public option plans thus far.

Table 9. Public Option Score Card

Washington State		
Policy Dimension	**Success?**	**Explanation**
Reimbursement Rates	Mixed	Initial proposal called for Medicare-level rates Hospital rates set at 160% of Medicare-level rates Hospitals were reluctant to contract at capped rate State then revised rules to require hospital participation, which increase participation
Premiums	No	Goal: Public option premiums 10% lower than other plans In 2023, only one county reached target for silver plan (four for bronze plans)
Enrollment	Mixed	Initial enrollment less than 1% of exchange population In 2023, enrollment rose to 11%, but the increase may be due to new subsidies rather than public option design Enrollment remains less than 1% of the state's population
Cost Reductions	No	In 2022–23, total premiums would have been $2 million lower if public option enrollees chose lowest-cost non-public option plans State has spent at least $1 million on implementation

Colorado		
Policy Dimension	**Success?**	**Explanation**
Reimbursement Rates	No	Hospital-specific floors with premium targets Insurers did not attribute missed premiums targets to providers' unwillingness to contract Floors may increase rates in some cases
Premiums	No	2023 target was 5% less than insurers' 2021 rate 85% of public option plans failed to meet target Rate filings show fewer will meet 2024 target
Enrollment	Mixed	Initial enrollment four times larger than projections But total enrollment growth less than U.S. average Enrollment accounts for less than 1% of the state's population
Cost Reductions	No	In 2022–23, total premiums would have been $13.3 million lower if public option enrollees chose lowest-cost non-public option plan State has spent at least $3.7 million on implementation

7. CONCLUSION

Policymakers in Washington State, Colorado, Nevada, and Minnesota have championed their state public option plans as a vehicle for delivering lower costs and better coverage to residents. The plans share many common features. Unlike traditional public option proposals that would have the government run an insurance plan, the states have opted to rely principally on private insurers. Regulators have been given significant oversight powers regarding the plans' premiums, provider payment rules, and plan design.

While each state has adopted a unique approach to delivering premium reductions, they expect the lion's share of premium savings to come from reduced reimbursement rates to providers and hospitals. This has proven more challenging than hoped for in Washington State and Colorado.

Moreover, the states' rules have upset complicated rate negotiations in unintended ways. For example, Colorado's reimbursement floors have given providers leverage to demand rate increases.

The provider payment cuts that have occurred have not resulted in meaningful premium reductions that meet the states' goals. The 2024 premium increases for both Colorado and Washington State suggest neither state will meet its stated goals. The premium targets in Colorado are particularly aggressive, and over the long term, premium increases will be limited to a general metric of inflation that will fail to capture changes in utilization or even expected changes in prices.

These early experiences offer lessons to Nevada and Minnesota, as well as other states entertaining the idea of public option or Medicaid buy-in experiment. Underpinning these proposals is the belief that large cost savings are available if payments to providers and hospitals can be cut sufficiently, or administrative costs can be significantly reduced relative to traditional plans. For political and economic reasons, Washington State and Colorado have thus far failed to show this approach can work. Instead, the states have spent more on their public option plans than they have saved.

In comparison, recent actions by states to enact reinsurance programs have delivered premium savings to exchange enrollees and cost savings to states through federal pass-through funds.

Minnesota enacted a reinsurance program in 2017. Colorado followed in 2019. The reinsurance programs have been credited with significant declines in premiums.[110] Unlike public option laws, the premium reductions explicitly benefit all exchange participants rather than being limited to those enrolling in specific state-sponsored plans.[111] State policymakers may thus find it worthwhile to use their limited legislative time and state resources to consider the merits of reinsurance programs or other health reforms rather than state public option plans.

[110] See Oyeka and Wehby (2023).

[111] Nevada's recent decision to seek a 1332 waiver for a reinsurance program reflects a similar aim. And, indeed, Nevada's state-sponsored actuarial report finds that even with aggressive premium reduction assumptions, the state's reinsurance program would deliver larger premium reductions than the public option plans (see Table 2 in Milliman (2023). Whether Nevada's reinsurance program can deliver the savings of other state reinsurance program is unclear, as the state as opted to tie it closely with the far-more controversial public option.

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DATA APPENDIX

WASHINGTON STATE AGGREGATE PREMIUM SAVINGS: ENROLLEE DEMOGRAPHICS AND PLAN SELECTION

We make several simplifying calculations to calculate aggregate premium savings for the Cascade Select Plans. Because premiums differ by rating area and the age of recipients, we must determine the number and demographics of enrollees by plan type and by county.

Publicly available enrollment data allows us to determine the number of Cascade Select enrollees by county and insurer. We do not, however, know the number of enrollees by age and county. Similarly, we are unable to determine which metal level enrollees selected with public option plans by county. Given these data restrictions, we make the following simplifying assumptions:

- **Age Adjustments:** The enrollment data provides statewide enrollment by age group (under 18, 18 to 34, 35 to 54, and 55 and above) for each type of health plan (Cascade Select, Cascade Standard, Non-Cascade). We thus assume the statewide age composition within Cascade Select plan for each county enrollment. The difference in premiums by each age group and metal level is then equal to the basic arithmetic mean of the difference in individual (non-smoking) premiums between the cheapest Cascade Select plan and the cheapest non–public option plan for each age group and metal level.
- **Metal Adjustments:** The state enrollment data does not include breakdown enrollment by metal level enrollment in the Cascade Select plans. Instead, we use reported enrollment estimates found in the annual rate requests made by insurers.[112] These enrollment estimates are not county-specific and thus we assume the metal-level breakdown by insurer is constant across the state.

COLORADO STATE AGGREGATE PREMIUM SAVINGS

We use enrollment estimates from insurers' Colorado Option Rate Reduction Notice filings.[113] These forms provide enrollment by county and plan ID as of February 15, 2023. We then use the reported enrollment by age for all exchange plans from Colorado's annual enrollment report.[114] The report divides enrollment into the following age groups: 0–25, 26–34, 35–44, 45–54, and 55–64. Using the premium levels at the midpoint of each age group (using age 14 for the 0–25 age group), we calculate the difference in annual premiums from the public option plan to the lowest-cost non–public option plan in the county. We then multiply this difference by the product of the county level enrollment in the plan and the share of total enrollment by age group to calculate the aggregate change in premiums.

These estimates are sensitive to the relative size of each age group. If Colorado Option plan enrollment is younger than the state average, our estimate will overstate the aggregate premium change. Conversely if the enrollment trends older, we will understate the aggregate premium change.

[112] *Typically, we use the initial rate requests for the following year to find enrollment by metal level. The one exception is the 2022 enrollment for the Community Health Network of Washington Cascade Select plan where the data are unavailable. In that case, we use their projected estimates from their 2022 rate requests. Rate requests are available from the Washington State Office of Insurance Commissioner (https://fortress.wa.gov/oic/consumertoolkitrt/Search.aspx.)*

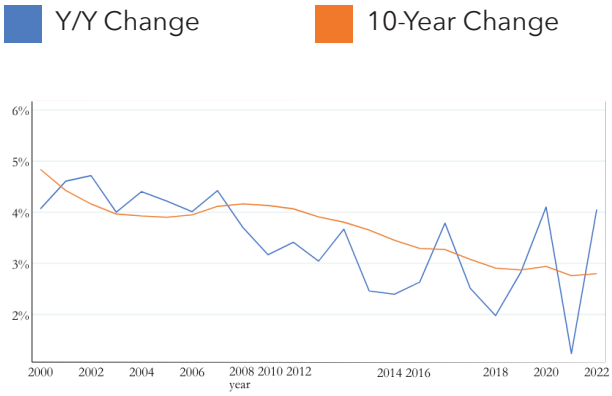
[113] *The filings are available on SERFF (https://filingaccess.serff.com/sfa/home/CO).*
See page 11 in https://c4-media.s3.amazonaws.com/wp-content/uploads/2023/03/31121205/By-the-Numbers-final-OE10.pdf.

[114] *See page 11 in https://c4-media.s3.amazonaws.com/wp-content/uploads/2023/03/31121205/By-the-Numbers-final-OE10.pdf.*

MEDICAL INFLATION: ROLLING AVERAGE AND SINGLE-YEAR AVERAGE

The graph shows the single-year and 10-year rolling average of the medical component of the CPI-U (i.e. Medical CPI). See Section 3.4 for the related discussion.

Medical CPI: Annual Rate Compared to 10-Year Rolling Average



Notes: Using the CPI-U for all medical care (includes commodities and services).