

ARE STATE PUBLIC OPTION HEALTH PLANS WORTH IT?

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ABSTRACT

The COVID-19 pandemic exposed the weaknesses of the U.S. health care system’s reliance on private, employer-based health insurance. The crisis in health care access and affordability has increased support for a public option—the choice to purchase a state-initiated health plan with publicly determined rates. Congressional gridlock, however, may dim the chances for a federal public option. States have stepped into the policy vacuum, proposing forty-nine bills to establish state public options since 2010, including three that became law. This article provides a comprehensive survey and taxonomy of state public option proposals from 2010–2021, identifying three main models: (1) Medicaid Buy-In Public Options; (2) Marketplace-Based Public Options; and (3) Comprehensive Public Options. Though each model serves different policy goals and varies in scope, the defining aim of all public option plans is to improve access to affordable health coverage by applying public payment rates to the private insurance market. We seek to answer whether state public option plans are legally viable and “worth it” for states to pursue. The answer is yes to both, but, surprisingly, the degree of legal difficulty is inversely related to the scope of the plan’s reach—the broadest plans have fewer legal hurdles than narrower plans. Moreover, the policy effects increase with the scope of the plan and the robustness of the controls on provider payment rates. Public options with modest provider rate controls may have too little impact on affordability and costs, falling short of their defining goal of improving affordability. As a result, the legal and political difficulty of enacting such plans may not be worth it. State public option plans may be most effective when they cover a broad swath of the population and pursue robust provider rate controls. In short, for state public option plans to be worth it, bigger is better.

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INTRODUCTION

The COVID-19 pandemic laid bare the inadequacies of the U.S. health-care system for the nation, and the world, to see. One of the most glaring deficiencies was the tether between employment and health insurance.¹ As more than five million Americans watched in disbelief as the pandemic took their jobs,² many of them had the dual realization that they also lost their employer-sponsored health insurance in the midst of the largest pandemic in over a century.³ The need for comprehensive and affordable public health insurance options irrespective of employment has never been more apparent. Yet with the nation embroiled in the continued onslaught of COVID-19, comprehensive action at the federal level remains a distant possibility. Even with the election of Joe Biden, who favors a national public health insurance option,⁴ Congress remains closely divided, so the path to sweeping federal health reform appears difficult. Back in 2010, when the Democrats controlled far more seats in Congress, insurance companies successfully lobbied to strip the public option from the Affordable Care Act (“ACA”).⁵ With a

¹ See generally Jaime S. King, *Covid-19 and the Need for Health Care Reform*, 382 N. ENG. J. MED. e104(1) (2020).

² See GENE FALK, PAUL D. ROMERO, ISAAC A. NICCHITTA & EMMA C. NYHOF, CONG. RSCH. SERV., R46554, UNEMPLOYMENT RATES DURING THE COVID-19 PANDEMIC: IN BRIEF 2 (2021).

³ See Daniel McDermott, Cynthia Cox, Robin Rudowitz & Rachel Garfield, *How Has the Pandemic Affected Health Coverage in the U.S.?*, KAISER FAM. FOUND. (Dec. 9, 2020), <https://www.kff.org/policy-watch/how-has-the-pandemic-affected-health-coverage-in-the-u-s/> [<https://perma.cc/4B3W-RBRM>].

⁴ See *Health Care*, BIDEN HARRIS, <https://joebiden.com/healthcare/> [<https://perma.cc/SYC7-KJZH>].

⁵ See Jacob S. Hacker, *From the ACA to Medicare for All*, in THE TRILLION DOLLAR REVOLUTION 333, 336 (Ezekiel J. Emanuel & Abbe R. Gluck eds., 2020); Richard M. Schefler & Taylor L. Wang, *The Public Option: From Hacker to Biden*, PETRIS CTR. (Sept. 22,

bare Senate majority in 2021, passing a federal public option will prove even more challenging, as such a broad reform would require sixty votes to overcome the Senate filibuster.⁶ Due to federal gridlock, the most likely path to health reform in the near-term is through the states, which have been devising their own policies to provide increased access to affordable health care.

One mechanism for achieving health reform is through the creation of a state-based public health insurance plan or a “public option.” A state public option is a state-initiated health insurance plan created by the state legislature that pays providers publicly determined rates and is offered to a significant share of the private health insurance market. Designed to place competitive pricing pressure on private plans, public options offer coverage to individuals who are privately insured or uninsured.⁷

The concept of a federal public option was launched into the national health policy debate by Barack Obama and health policy scholar Jacob Hacker, who argued for its inclusion in the ACA.⁸ Hacker argued that public option plans could operate more efficiently than private plans by lowering administrative costs, eliminating corporate profits, negotiating and setting prices for health care services and prescription drugs, and providing a competitive benchmark to private plans.⁹ In the political push to pass the ACA, however, the public option was dropped from the legislation, leaving the health insurance Marketplaces, websites where eligible individuals can purchase subsidized, comprehensive health plans that are barred from certain discriminatory practices, to offer only private health plans.¹⁰ Absent competitive pressure from a public option, private plans both on and off the ACA Marketplaces have suffered from dwindling competition and have not substantially controlled costs.¹¹

2020), <https://petris.org/wp-content/uploads/2020/09/The-Public-Option-From-Hacker-to-Biden.pdf> [<https://perma.cc/AGX5-9VCG>].

⁶ See Sarah Kliff & Margot Sanger-Katz, *With New Majority, Here's What Democrats Can (and Can't) Do on Health Care*, N.Y. TIMES (Jan. 7, 2021), <https://www.nytimes.com/2021/01/07/upshot/biden-democrats-health-plans.html> [<https://perma.cc/RP4R-M2RC>].

⁷ See Hacker, *supra* note 5, at 336; Helen A. Halpin & Peter Harbage, *The Origins and Demise of the Public Option*, 29 HEALTH AFF. 1117, 1117–18 (2010) (“The concept was to offer a publicly insured plan in direct competition with other options for private health insurance coverage, in the hope of driving down both premiums and underlying health care costs.”).

⁸ See Halpin & Harbage, *supra* note 7, at 1118–19; JACOB S. HACKER, INST. FOR AM.’S FUTURE & UNIV. OF CAL. BERKELEY L., THE CASE FOR PUBLIC PLAN CHOICE IN NATIONAL HEALTH REFORM: KEY TO COST CONTROL AND QUALITY COVERAGE 1 (2008), https://www.law.berkeley.edu/files/Hacker_final_to_post.pdf [<https://perma.cc/7N42-XQ8V>].

⁹ See Hacker, *supra* note 5, at 6.

¹⁰ See Timothy Stoltzfus Jost & John E. McDonough, *The Path to the Affordable Care Act, in THE TRILLION DOLLAR REVOLUTION*, *supra* note 5, at 35–36; Sheryl Gay Stolberg, ‘Public Option’ in Health Plan May Be Dropped, N.Y. TIMES (Aug. 17, 2009), <https://www.nytimes.com/2009/08/18/health/policy/18talkshows.html> [<https://perma.cc/XNL9-EF3J>].

¹¹ See, e.g., Josh Bivens, *The Unfinished Business of Health Reform*, ECON. POL’Y INST. (Oct. 10, 2018), <https://www.epi.org/publication/health-care-report/> [<https://perma.cc/83ZL-F7HH>]; Lemore Dafny, *Health Care Markets a Decade after the ACA, Bigger, but Probably Not Better*, in THE TRILLION DOLLAR REVOLUTION, *supra* note 5, at 264, 264–66, 272–73;

States have tried to pick up where the ACA fell short by legislating state public option plans to solve their persistent health care coverage and cost problems. Yet state policymakers' hands are tied by federal law, which imposes a variety of requirements and restrictions on state public option proposals, depending on the type of plan. Some requirements ensure minimum levels of coverage and quality. For instance, if a state wants to offer a public option on the Marketplace, the plan must satisfy the ACA's requirements for qualified health plans ("QHPs") and include the essential health benefits ("EHBs") or receive a waiver from the Department of Health and Human Services ("HHS").¹² Other federal laws hinder the development and efficacy of state public option plans by limiting design options, target populations, and the scope of coverage. Federal Medicaid law significantly constrains Medicaid buy-in options by prohibiting states from using federal funds to expand Medicaid coverage beyond those statutorily eligible and from placing public option enrollees in the same risk pool as Medicaid enrollees.¹³ The ACA prohibits undocumented individuals from enrolling in health insurance plans on the Marketplaces. It requires states to ignore one of the largest segments of the uninsured population or offer public option plans off the Marketplaces, diminishing their ability to build on Marketplace investments and potentially destabilizing the Marketplaces. The Employee Retirement and Income Security Act of 1974 ("ERISA"), whose broad preemption provision has long stymied state health regulation,¹⁴ prohibits states from requiring self-insured employers to participate in public option plans, but allows states to nudge employers to adopt the plans.¹⁵ States also have a comparative disadvantage in financing their public option plans, as they must balance their budgets and have limited ability to raise new taxes.¹⁶ In sum, state public option plans have more legal and fiscal constraints than a federal version.

Despite these limitations, states have persisted in proposing public option plans. Yet we lack a comprehensive understanding of how states are designing their public option proposals. This article fills the gap. We define a state public option as a state-initiated health insurance plan that is offered to

Ezekiel J. Emanuel & Amol S. Navathe, *Delivery-System Reforms: Evaluating the Effectiveness of the ACA's Delivery System Reforms at Slowing Cost Growth and Improving Quality and Patient Experience*, in *THE TRILLION DOLLAR REVOLUTION*, *supra* note 5, at 225, 228; Carrie H. Colla & Jonathan Skinner, *Has the ACA Made Health Care More Affordable?*, in *THE TRILLION DOLLAR REVOLUTION*, *supra* note 5, at 250, 251; Joseph R. Antos & James C. Capretta, *The ACA: Trillions? Yes. A Revolution? No.*, *HEALTH AFFS.* (Apr. 10, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200406.93812/full/> [<https://perma.cc/GJ9S-KWNJ>].

¹² See 42 U.S.C. §§ 18021, 18022, 18052.

¹³ See *infra* Section I.B.

¹⁴ See, e.g., Erin C. Fuse Brown & Ameet Sarpatwari, *Removing ERISA's Impediment to State Health Reform*, 378 *N. ENG. J. MED.* 5 (2018).

¹⁵ See *infra* Section III.C.1.

¹⁶ See Lindsay F. Wiley, *Medicaid for All? State-Level Single-Payer Health Care*, 79 *OHIO ST. L.J.* 843, 875 (2018).

a significant share of the private health insurance market—the individual, small group, or large group market—and pays publicly determined rates. State public option plans are state-initiated if they enter the market as a result of a state legislative action and they pay publicly-determined rates by pegging payments to existing public program rates (e.g., Medicare or Medicaid rates) or through administrative rate-setting. Consistent with other health policy and economics experts’ understanding of a public option, states need not administer or finance a plan for it to be “public.”¹⁷ Although some may contest whether a privately administered plan with publicly determined rates is sufficiently “public” to be called a public option, we adopted this broad definition to capture the range of states’ attempts to create—in their words—a public option health plan as an alternative to private coverage.¹⁸

This article provides the first comprehensive analysis of state efforts to create public option plans and offers a roadmap of the legal issues and policy tradeoffs states must navigate to reform their health systems through a public option plan. As each state must analyze its own economic and political environment to determine the viability of a particular health reform, it is impossible to prescribe a single best public option for all states. Instead, the article seeks to answer whether a state public option is legally possible and, if so, when it is worth it.

To answer these questions, we analyzed all public option bills introduced in state legislatures from 2010–2021 and assessed the legal viability of each.¹⁹ We limited our search to bills that could, if passed, implement a public option health plan. We excluded bills that need further legislative action to implement, including those that created a task force to examine the possibility of a public option. We counted a bill in each legislative session it was introduced but did not count a bill twice if it was introduced into both chambers during the same session. Applying this methodology, we identified forty-nine bills introduced by twenty-three states between 2010 and 2021 to create a public health insurance option as shown in the Appendix. To date, three states have enacted a public option: Washington’s 2019 law began offering coverage on January 1, 2021;²⁰ Colorado’s law passed in 2021, begin-

¹⁷ See, e.g., Leemore Dafny, *Health Care Markets a Decade After the ACA*, in THE TRILLION DOLLAR REVOLUTION, *supra* note 5, at 273–74; Allison K. Hoffman, *The Irony of Health Care’s Public Option*, in DEBATING THE PUBLIC OPTION (Anne Alstott & Ganesh Sitaraman eds., Cambridge University Press) (forthcoming) (manuscript at 1) (on file with authors); Lindsay F. Wiley, *Privatized Public Health Insurance and the Goals of Progressive Health Reform*, 54 U.C. DAVIS L. REV. (forthcoming 2021).

¹⁸ This article attempts to categorize and analyze recent state attempts to create what they view as a public option plan, and sidesteps the debate of what should qualify as a “public” option, being held elsewhere in the literature. See, e.g., Wiley, *supra* note 16, at 864–67.

¹⁹ Our original survey focused on state public option bills introduced from 2010 to 2020. Due to the timing of this publication, we added bills that were introduced or passed in the 2021 legislative session as of June 30, 2021, when most, but not all state legislative sessions concluded. The 2021 bills are discussed in Part IV. See *infra* Part IV.

²⁰ WASH. REV. CODE §43.71.095 (2019); see Sara Hansard, *Public Option Experiment Hits Speed Bump as Premiums Don’t Fall*, BLOOMBERG LAW (Aug. 10, 2020, 2:30 AM), <https://www.bloomberglaw.com/news/2020/08/10/public-option-experiment-hits-speed-bump-as-premiums-dont-fall>

ning coverage in 2023;²¹ and Nevada enacted a public option in 2021 to go into effect in 2026.²²

This article provides a taxonomy and detailed analysis of state public option bills to determine whether and how state policymakers can design bills to fit their policy goals. From our survey of state public option bills, we identify three main models for state public options: Medicaid Buy-In Public Options; Marketplace-Based Public Options; and Comprehensive Public Options.²³ Although most bills fall into only one model, a handful of bills straddle models. Five main policy goals motivate state public options: (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. Although these policy goals are not mutually exclusive, some may be contradictory.²⁴ As a result, state policy goals should drive the design of public option plans. The most important considerations include: (1) the target population; (2) plan administration; (3) plan financing and cost control; and (4) the impact on the private health insurance and provider markets.

We conclude that state public option plans are both legally possible and worth it, but, surprisingly, the legal viability and policy effects increase with the scope of the plan. In other words, with state public option plans, bigger is better. The degree of legal difficulty to establish a state public option plan is inversely related to the scope of the plan's reach—the broadest plans have surprisingly fewer legal hurdles than narrower plans, though broad plans may significantly disrupt the existing health care market, creating greater political opposition. A public option plan with modest provider rate controls may have too little impact on affordability and costs to make it worth the legal and political difficulties passing it would entail. This is especially true considering that this type of plan would fall short of its defining goal—improving affordability through the application of public payment rates to the private insurance market. Overall, state public option plans that cover a broader swath of the population and pursue robust provider rate controls are most likely to be effective.

This article proceeds in five parts. Parts I–III provide taxonomies and detailed analyses of the three state public option models. Each Part uses

/news.bloomberglaw.com/health-law-and-business/public-option-experiment-hits-speed-bump-as-premiums-dont-fall [https://perma.cc/ULM6-KCK3].

²¹ H.B. 21-1232, 73rd Gen. Assemb., 1st Reg. Sess. (Colo. 2021).

²² S.B. 420, 2021 Leg., 81st Reg. Sess. (Nev. 2021). Though our survey only covered 2010–2020, we discuss the 2021 bills in Part IV. See *infra* Part IV.

²³ We also identified a couple of states that proposed a buy-in to their State Employee Health Benefit Plan (SEHBP) but dismissed it due to legal and practical constraints. States seeking to create a public option based on their SEHBP should offer a similar plan on the Marketplace. See H.P. 91, 129th Leg., 1st Reg. Sess. (Me. 2019); C.B. 134, Jan. 2019 Sess. § 7 (Conn. 2019); S.B. 1004, Jan. 2019 Sess. § 1(i) (Conn. 2019).

²⁴ For example, covering the remaining uninsured and reducing churn may be mutually compatible, but creating a public option to increase competition on the Marketplaces may work against the goals of administrative simplification. See *infra* Section I.

specific examples from state legislation to analyze each public option model based on its design features, policy goals, target population, administrative requirements, financing options, market impact, and potential legal and political challenges. Part IV provides an update of public option legislation in 2021, including the passage of marketplace-based public option plans in Nevada and Colorado. Though we do not prescribe what any state ought to do or how it should weigh the tradeoffs in the first four Parts, Part V then synthesizes and draws lessons from the last decade of state public option legislation and provides guidance and recommendations to states on the development of a public option plan based on their specific policy goals, resources, and political environment.

Overall, states should design their public option plan with a clear sense of their policy goals and tolerance for administrative burdens, financial risk, and political opposition. Only once they consider their options in light of these factors will they know if it is truly “worth it.”

I. MEDICAID BUY-IN PUBLIC OPTIONS

Since the ACA’s expansion of Medicaid, appreciation for the program has grown due to its comprehensive benefits, low costs, existing infrastructure, and access to federal matching funds, making it an especially attractive framework for states seeking to craft a public option.²⁵ Medicaid provides publicly funded coverage for people living in low-income households and is jointly financed and regulated by the state and federal governments.²⁶ The ACA allowed states to expand Medicaid coverage to include adults under age sixty-five with incomes at or below 138% of the federal poverty level (“FPL”), with the federal government providing ninety percent of the funding for the Medicaid expansion and states funding ten percent.²⁷ Medicaid offers comparatively comprehensive benefits at relatively low costs because of low provider reimbursement rates and administrative costs.²⁸ And, most

²⁵ See Michael Ollove, *The Politics of Medicaid Expansion Have Changed*, PEW: STATELINE (Nov. 13, 2019), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/11/13/the-politics-of-medicaid-expansion-have-changed> [https://perma.cc/3T3Q-MD97].

²⁶ See Wiley, *supra* note 16, at 848 (citing ELICIA J. HERZ, JEAN HEARNE, JULIE STONE-AXELRAD, KAREN TRITZ, EVELYNE BAUMRUCKER, CHRISTINE SCOTT, CHRIS PETERSON, AORIL GRADY & RICHARD RIMKUNAS, CONG. RSCH. SERV., RL 32277, *HOW MEDICAID WORKS: PROGRAM BASICS 1–2* (2006)); *Federal and State Share of Medicaid Spending*, KAISER FAM. FOUND., <https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/> [https://perma.cc/Z22V-US4J].

²⁷ 42 U.S.C. § 1396a(k).

²⁸ See TERESA A. COUGHLIN, SHARON K. LONG, LISA CLEMANS-COPE & DEAN RESNICK, KAISER FAM. FOUND., *WHAT DIFFERENCE DOES MEDICAID MAKE? ASSESSING COST EFFECTIVENESS, ACCESS, AND FINANCIAL PROTECTION UNDER MEDICAID FOR LOW-INCOME ADULTS 1, 7* (2013), <https://www.kff.org/wp-content/uploads/2013/05/8440-what-difference-does-medicaid-make2.pdf> [https://perma.cc/DWV7-YP24].

critically from the perspective of a state, at least half of the costs of Medicaid are funded by the federal medical assistance percentage (“FMAP”).²⁹

But, as we discuss below, the legal constraints of the federal Medicaid statute mean that a pure buy-in is impossible for states to effectuate, belying its intuitive simplicity. Instead, two types of Medicaid buy-ins emerged as viable options. First, states may require their contracted Medicaid managed care organizations to offer a similar plan—in terms of benefits, provider network, and rates—to individuals ineligible for Medicaid.³⁰ Second, states may create a public option, administered by the state Medicaid agency, that targets the uninsured who are ineligible for federal Marketplace subsidies or Medicaid.³¹ To encompass both viable alternatives, our analysis includes any state proposal that builds upon or leverages the Medicaid program to cover residents that are otherwise ineligible for Medicaid.

In the past eleven years, sixteen states introduced twenty-two bills that met our criteria of a Medicaid buy-in.³² The Medicaid buy-in bills typically direct the state agency overseeing the Medicaid program to establish a public option and apply for any necessary federal waivers, many without further detail.³³ These bills tend to be much less specific than the public option plans

²⁹ See ALISON MITCHELL, CONG. RSCH. SERV., R43847, MEDICAID’S FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) 2 (2020).

³⁰ A few states already require contracted Medicaid managed care organizations to offer a plan on the exchange, but we do not consider those public options, as the state does not determine the specifics of these plans or provider rates, except that they must meet the requirements of the state exchange. See Louise Norris, *Nevada Health Insurance Marketplace: History and News of the State’s Exchange*, HEALTHINSURANCE.ORG (Aug. 25, 2021), <https://www.healthinsurance.org/nevada-state-health-insurance-exchange/#MCO> [<https://perma.cc/VP6E-Q9MA>]; Kevin Lucia, Jack Hoadley, Sabrina Corlette, Dania Palanker & Olivia Hoppe, *Stepping into the Breach: How States and Insurers Worked Together to Prevent Bare Counties for 2018*, URB. INST. (Nov. 9, 2017), <https://www.urban.org/research/publication/stepping-breach-how-states-and-insurers-worked-together-prevent-bare-counties-2018> [<https://perma.cc/2RL3-CZQY>]. For an example of a state requiring Medicaid managed care organizations to offer a public option, see, e.g., S.B. 339, 2019 Leg., 155th Gen. Assem. (Ga. 2020) (stating “The department shall be authorized to . . . Make health care coverage available for purchase through the Georgia Reliable Insurance Network. . . Such network shall: (1) Include, at a minimum: (A) The same coverage provided to recipients of Medicaid. . . The department shall: (1) Administer the network through the managed care organizations under contract with the department to provide Medicaid services and benefits”).

³¹ See, e.g., S.B. 405, 54th Leg., Reg. Sess. (N.M. 2019) (stating that “the department shall establish a medicaid buy-in plan and shall offer the buy-in plan for purchase by a resident: (1) who is ineligible for the following: (a) medicaid; (b) medicare; and (c) advance premium tax credits under the federal Patient Protection and Affordable Care Act; and (2) whose employer has not disenrolled or denied the resident enrollment in employer-sponsored health coverage on the basis that the resident would otherwise qualify for enrollment in medicaid buy-in coverage.”).

³² In addition to these bills, Minnesota legislators introduced five state proposals to build on the state’s Basic Health Program (BHP). See S.F. 58, 2017 Leg., 90th Sess. (Minn. 2017); S.F. 684, 2019 Leg., 91st Sess. (Minn. 2019); S.F. 720, 2019 Leg., 91st Sess. (Minn. 2019); S.F. 1080, 2019 Leg., 91st Sess. (Minn. 2019); S.F. 2356, 2019 Leg., 91st Sess. (Minn. 2019). While conceptually similar to Medicaid buy-ins, BHP buy-ins face distinct legal hurdles and are not included here.

³³ See, e.g., S.B. 444, 121st Gen. Assemb., 1st Reg. Sess. (Ind. 2019) (providing that “[t]o the extent allowed by federal law, the office shall establish the Indiana statewide health

discussed in the following sections. The brevity of these bills may reflect uncertainty about the legal constraints that determine the structure of a Medicaid buy-in plan, such as the need for or approval of federal waivers, or it may purposefully grant state Medicaid officials the flexibility to design the plan to fit the specific population and policy goals of the state and permit the legislature to avoid tackling more politically fraught decisions like provider reimbursement.

Of the Medicaid buy-in efforts, bills in Nevada (2017) and New Mexico (2019) advanced the furthest.³⁴ In Nevada, the governor vetoed the 2017 bill passed by the state legislature to offer a Medicaid-based plan on the state Marketplace.³⁵ The New Mexico state legislature passed a study bill in 2018³⁶ that examined four options for a public option based on the state Medicaid program, but bills introduced the following year to implement the recommendations of the study failed to pass.³⁷ To date, no Medicaid buy-in plans have been created, but at least six states have convened task forces to develop state-level Medicaid buy-in plans and assess their impact on state insurance markets.³⁸

Notably, as policymakers grapple with the legal and practical difficulties of crafting Medicaid buy-ins, the policy goals and target populations have diminished, too. What started as a broad idea to provide a public option to anyone who wanted it and increase coverage options for all has become more focused on extending coverage to discrete and difficult-to-cover popu-

plan within the Medicaid program and make coverage available for purchase through the plan to an individual who is not otherwise eligible for Medicaid” and further explaining that “[t]he office shall apply to the United States Department of Health and Human Services for any waiver required to implement or administer this chapter” without providing additional details about how to implement the public option).

³⁴ See Assemb. B. 374, 2017 Leg., 79th Sess. (Nev. 2017); S.B. 405, 54th Leg., Reg. Sess. (N.M. 2019).

³⁵ Letter from Brian Sandoval, Governor of Nev., to Hon. Barbara Cegavske, Secretary of State of Nev. (June 16, 2017) (on file with author) (vetoing Nevada Assembly Bill No. 374 and providing Governor Sandoval’s reasoning vetoing the bill); see also Michelle Hackman, *Nevada’s Governor Vetoes ‘Medicaid for All’ Insurance Plan*, WALL ST. J. (June 17, 2017), <https://www.wsj.com/articles/nevadas-governor-vetoes-medicaid-for-all-insurance-plan-1497701687> [<https://perma.cc/4R9X-GKLT>].

³⁶ S. Memorial 3, 53rd Leg., 2nd Sess. (N.M. 2018); H. Memorial 9, 53rd Leg., 2nd Sess. (N.M. 2018); New Mex. House Meas. 9 (2020).

³⁷ See Michael S. Sparer, *Redefining the “Public Option”: Lessons from Washington State and New Mexico*, MILBANK MEM’L FUND: MILBANK Q. (2020), <https://www.milbank.org/quarterly/articles/redefining-the-public-option-lessons-from-washington-state-and-new-mexico/> [<https://perma.cc/9FWC-UEMG>].

³⁸ The six states are Colorado, Delaware, Massachusetts, Nevada, New Mexico, and Oregon. See, e.g., PATRICIA BOOZANG, CHIQUITA BROOKS-LASURE & ASHLEY TRAUBE, MEDICAID BUY-IN: STATE OPTIONS, DESIGN CONSIDERATIONS AND SECTION 1332 WAIVER IMPLICATIONS (2018) https://www.shvs.org/wp-content/uploads/2018/05/Medicaid_Buyin_-FINAL.pdf [<https://perma.cc/JFH2-DY3Y>]; STATE OF DELAWARE SENATE CONCURRENT RESOLUTION 70 STUDY GROUP, FINAL REPORT (2019), <https://news.choosehealthde.com/wp-content/uploads/2019/01/SCR-70-Medicaid-Buy-In-Study-Group-Final-Report-01.15.19.pdf> [<https://perma.cc/L4WB-54D5>].

lations—undocumented immigrants and those who earn too much to qualify for Medicaid but still find Marketplace coverage unaffordable.

A. Policy Goals

The primary policy goals of Medicaid buy-in plans are: (1) cover the remaining uninsured; (2) reduce churn between Medicaid and other coverage; and (3) control costs so that residents have an affordable insurance option.³⁹ To cover the remaining uninsured, Medicaid buy-ins typically target residents with low incomes.⁴⁰ Fluctuations in household income may alter eligibility for Medicaid and federal Marketplace subsidies, disrupting the continuity of care.⁴¹ Medicaid buy-ins reduce the destabilizing effects when enrollees cycle between private and public insurance by allowing individuals with low incomes to remain in similar plans whether on or off Medicaid.

In addition, Medicaid buy-ins seek to control costs by extending Medicaid's lower provider reimbursement rates and administrative costs to a broader patient population.⁴² These cost-saving measures may make Medicaid buy-ins affordable coverage options for those who cannot currently afford coverage. Consequently, a Medicaid buy-in may be a reasonable choice for states trying to reach universal coverage by targeting affordable coverage and state resources to the remaining uninsured.

B. Legal Issues for Medicaid Buy-In

Conceptually, a Medicaid buy-in public option leverages the Medicaid program to extend coverage to those who are currently ineligible for Medicaid coverage, either by actually enrolling them in the program⁴³ or allowing purchase of a separate health plan modeled on Medicaid.⁴⁴ As we explain, however, statutory constraints make direct enrollment in Medicaid through a buy-in option by otherwise ineligible populations practically infeasible.

³⁹ For example, Iowa's bill declares: "[i]t is the intent of the general assembly to establish a public health care coverage safety net by utilizing a Medicaid program buy-in option to counteract the effects of inadequate private competition and make affordable health care coverage accessible to those Iowans without individual health care coverage." H.F. 2002, 87th Gen. Assemb., Reg. Sess. (Iowa 2018).

⁴⁰ See *infra* Section I.C.

⁴¹ In 2018, twenty-one percent of uninsured adults reported that they lost health coverage when a family member lost or changed jobs, and ten percent of uninsured adults reported they lost Medicaid coverage due to a status change, such as getting married, having a baby, or a wage increase that made them ineligible. See Jennifer Tolbert, Kendal Orgera & Anthony Damico, *Key Facts about the Uninsured Population*, KAISER FAM. FOUND. (Nov. 6, 2020), <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/> [<https://perma.cc/WGN7-U9EB>].

⁴² See BOOZANG ET AL., *supra* note 38, at 11; *infra* Section I.E.2.

⁴³ See, e.g., Assemb. B. 374, 2017 Leg., 79th Sess. (Nev. 2017) (contemplating a new plan to be established "within Medicaid").

⁴⁴ See, e.g., S.B. 405, 54th Leg., Reg. Sess. (N.M. 2019) (contemplating a buy-in plan that "leverages the medicaid coverage structure").

The Medicaid statute does not permit states to use federal matching funds to extend Medicaid eligibility to non-disabled adults or pregnant women with incomes above 138% of the federal poverty limit.⁴⁵ Section 1115 of the Medicaid statute⁴⁶ grants the HHS Secretary authority to waive certain statutory requirements, including group eligibility requirements, through a demonstration or pilot project.⁴⁷ In theory, a state might be able to obtain a Section 1115 waiver to allow non-eligible populations to buy into Medicaid.⁴⁸ However, for both statutory and practical reasons, states are unlikely to receive waivers permitting expansion of these programs that would enable them to draw down federal matching dollars for the buy-in population.

First, federal law bars the use of federal Medicaid funds to pay for non-Medicaid program costs. This prohibition includes using federal Medicaid dollars for administration or to pay providers for non-Medicaid enrollees.⁴⁹ As a result, a risk pool that includes both current Medicaid beneficiaries and those that purchase a Medicaid buy-in would require a Section 1115 waiver covering the entire state population or whomever the state deems eligible for the public option. Otherwise, risk pooling or joint oversight of the Medicaid and public option plans might result in prohibited cross-subsidization between the Medicaid program (and its federal funds) and services for the buy-in enrollees.⁵⁰

Second, CMS policy requires Section 1115 waivers to be budget neutral, meaning federal spending under the waiver cannot exceed what it would have been in absence of the waiver.⁵¹ If the state applies for a Section 1115 waiver to extend Medicaid coverage to a larger portion of state residents previously ineligible for Medicaid benefits, it would almost certainly increase federal spending even when including modest offsetting savings—such as a reduction in Marketplace premium tax credits for individuals that shift from an exchange plan to the Medicaid buy-in option—because the federal government carries an open-ended responsibility to finance program expenditures for each Medicaid-covered life.⁵² Alternatively, a state may

⁴⁵ See 42 U.S.C. §§ 1396a, 1396b(a)(7); 42 C.F.R. § 433.15(b) (2021); see also *Non-Disabled Adults*, MACPAC, <https://www.macpac.gov/subtopic/nondisabled-adults/> [https://perma.cc/SHX4-B4EK] (last visited Oct. 20, 2021). While states may not expand Medicaid to non-disabled adults, states have an option to create a Medicaid buy-in program for persons with disabilities. See 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XV), 1396o(g)(1)(A), (B).

⁴⁶ Social Security Act of 1935 § 1115, 42 U.S.C. § 1315.

⁴⁷ Eligibility requirements set forth at § 1902 of the Social Security Act may be waived under Section 1115. Social Security Act of 1935 § 1902, 42 U.S.C. § 1396a.

⁴⁸ See Wiley, *supra* note 16, at 867–68.

⁴⁹ See 42 U.S.C. §§ 1396a, 1396b(a)(7); 42 C.F.R. § 433.15(b) (2021).

⁵⁰ See Wiley, *supra* note 16, at 868.

⁵¹ See *id.*; Letter from Timothy B. Hill, Acting Director of Ctrs. for Medicaid and CHIP Svcs. on Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects, to State Medicaid Directors (Aug. 22, 2018) (on file with author).

⁵² See Sara Rosenbaum, *Racial and Ethnic Disparities in Healthcare: Issues in the Design, Structure, and Administration of Federal Healthcare Financing Programs Supported Through Direct Public Funding*, in INSTITUTE OF MEDICINE, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 664, 673 (Brian D. Smedley,

choose to create a public option plan that allows residents ineligible for Medicaid to purchase similar coverage using state funds or fully financed by premiums and cost-sharing without obtaining a Section 1115 waiver.

The third Section 1115 hurdle requires that the demonstration project promote the goals of the Medicaid program, which courts have interpreted as providing access to health coverage.⁵³ Presumably, a Medicaid buy-in would expand access to coverage, but a court could read the purpose more narrowly to promote coverage *for those who cannot afford it*, and determine that allowing higher-income populations to buy-in to Medicaid coverage would not promote Medicaid's narrower goals of providing medical coverage to low-income people.⁵⁴

In sum, it is unlikely that any state could allow additional groups to buy into Medicaid coverage directly under current Medicaid requirements. Indeed, none of the Medicaid buy-in public option proposals we examined explicitly contemplates risk-sharing arrangements with the state's Medicaid program. Instead, states may offer a separate, Medicaid-like plan, offering similar benefits, provider networks, and administration for non-Medicaid eligible individuals to purchase on or off the Marketplace.⁵⁵ Offering a Medicaid-like plan that does not pool risk or share funding with the state's existing Medicaid program would not require a Section 1115 waiver.⁵⁶ Furthermore, by not seeking federal matching funds, the buy-in plan would not have to comply with all the requirements for Medicaid beneficiaries, such as strict limits on premiums and cost-sharing and benefits required in Medicaid (such as non-emergency transportation) that are not typically covered elsewhere.⁵⁷ Thus, throughout the remainder of this article, when we refer to a "Medicaid buy-in" plan, we are referring to state proposals that allow non-Medicaid eligible individuals to purchase a plan that is based upon the state's Medicaid benefit plan and overseen by the state's Medicaid agency, rather than to the direct purchase of Medicaid coverage by individuals ineligible for Medicaid.

Adrienne Y. Stith, & Alan R. Nelson eds., 2003) (describing the Medicaid program's structure and open-ended financing).

⁵³ See, e.g., *Gresham v. Azar*, 950 F.3d 93, 99 (D.C. Cir. 2020) (affirming District Court's finding that "the principal objective of Medicaid is providing health care coverage").

⁵⁴ See *Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006) ("The Medicaid program . . . provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs.").

⁵⁵ See, e.g., Nev. Assemb. B. 374, 79th Leg., Reg. Sess. § 3 (2017).

⁵⁶ See Wiley, *supra* note 16, at 869.

⁵⁷ See Jennifer Lav & Héctor Hernández-Delgado, *State Medicaid Buy-Ins: Implications for Low-Income Enrollees*, NAT'L HEALTH L. PROGRAM 4–5 (Feb. 14, 2018), <https://healthlaw.org/wp-content/uploads/2018/02/MedicaidBuyIns-2.14.18.pdf> [<https://perma.cc/JK65-YC8Z>].

C. Target Population

Medicaid buy-in plans typically target uninsured state residents who struggle to find affordable coverage on the Marketplaces and who are ineligible for Medicaid. In states that expanded Medicaid eligibility via the ACA, the remaining uninsured population includes individuals who earn too much to qualify for Medicaid, but for whom Marketplace coverage remains unaffordable due to the “family glitch” or the “subsidy cliff” and undocumented immigrants who are ineligible for coverage through either the Marketplaces or Medicaid.⁵⁸ The family glitch refers to the spouses and children of a covered employee who are ineligible for financial subsidies because the employee’s self-only coverage qualifies as affordable. It affects an estimated six million people.⁵⁹ The subsidy cliff refers to the abrupt end to federal subsidies for purchasing Marketplace coverage for those who earn more than 400% of FPL.⁶⁰ To cover those subject to the family glitch or subsidy cliff, who find existing coverage options unaffordable, states likely need to use state funds and maximize access to federal funds.

The ACA provides two subsidies applicable to individual plans hosted on the state and federal Marketplaces—premium tax credits (“PTCs”) and cost sharing reductions (“CSRs”)—to reduce out-of-pocket health care spending for low to middle income Americans.⁶¹ PTCs reduce premium costs for individuals with incomes between 100% and 400% of FPL, who lack access to public programs and affordable employer sponsored insurance.⁶² In the 2021 American Rescue Plan, Congress increased the generosity of PTCs and expanded availability of PTCs to those earning more than 400% of FPL, limiting premiums to 8.5% of household income, temporarily eliminating the subsidy cliff.⁶³ Although set to expire at the end of the 2022 plan year, the increased PTC subsidies should increase the pot of money states may access through Section 1332 waivers.⁶⁴ CSRs reduce cost-shar-

⁵⁸ More than sixteen percent of the uninsured population in 2019 were ineligible for Medicaid or federal subsidies to purchase coverage on the Marketplaces due to their immigration status. Tolbert et al., *supra* note 41.

⁵⁹ See 26 C.F.R. § 601.105 (2021) (setting affordability standards for coverage); see also TRICIA BROOKS, HEALTH AFFS., THE FAMILY GLITCH (2014), https://www.healthaffairs.org/doi/10.1377/hpb20141110.62257/full/healthpolicybrief_129.pdf [<https://perma.cc/Z2XR-MWVA>].

⁶⁰ See Jodi Liu & Christine Eibner, *Extending Marketplace Tax Credits Would Make Coverage More Affordable for Middle-Income Adults*, COMMONWEALTH FUND (July 2017), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_jul_liu_extending_marketplace_tax_credits_ib.pdf [<https://perma.cc/L7EA-449N>].

⁶¹ See 26 U.S.C. § 36B; 42 U.S.C. § 18071.

⁶² See 26 U.S.C. § 36(b)(3)(A); 42 U.S.C. § 18081–18082.

⁶³ See American Rescue Plan Act of 2021, Pub. L. No. 117–2, § 9661.

⁶⁴ See Jason Levits & Daniel Meuse, *The American Rescue Plan’s Premium Tax Credit Expansion—State Policy Considerations*, BROOKINGS (Apr. 19, 2021), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/04/19/what-does->

ing—deductibles, copays, and coinsurance—for individuals with household incomes between 100% and 250% of FPL that purchase silver-tiered plans.⁶⁵

Most Medicaid buy-in bills tailor the eligible population to avoid jeopardizing existing federal funds flowing into the state, and all attempt to maximize federal PTCs to state residents.⁶⁶ Most Medicaid buy-in bills would authorize state officials to apply for ACA Section 1332 waivers to allow residents to use Marketplace PTCs to purchase the state public option plan.⁶⁷ Some states proposed initially excluding any residents eligible for PTCs from the Medicaid buy-in plan, while contemplating using federal waivers to expand eligibility to these residents.⁶⁸

To cover undocumented immigrants, some bills would specifically allow any resident to purchase the Medicaid buy-in plan and broadly defined “resident” to include undocumented immigrants.⁶⁹ However, the political opposition to the use of state money to subsidize insurance for the state’s undocumented immigrants⁷⁰ may partly explain why these bills have not yet passed and why some state proposals took the opposite approach and specifically excluded undocumented immigrants from the Medicaid buy-in.

The Medicaid buy-in proposals further diverge on whether to permit those with private, employer-based insurance to enroll. To avoid crowding out employer sponsored coverage,⁷¹ New Mexico and West Virginia would not allow residents to purchase the public option if they have been denied or disenrolled from employer-sponsored coverage on the basis that they would qualify for the public option.⁷² Massachusetts, Texas, Wisconsin, and Wyoming take a different approach by allowing employers to purchase public option coverage on behalf of their employees.⁷³

the-american-rescue-plans-premium-tax-credit-expansion-and-the-uncertainty-around-it-mean-for-state-health-policy/ [https://perma.cc/RV6Z-VNBQ].

⁶⁵ See 42 U.S.C. § 18022(d); 42 U.S.C. § 18071(b)–(c).

⁶⁶ For example, Georgia’s bill would have required the department to design the public option “in a manner that prioritizes affordability for enrollees and provides opportunities to maximize federal dollars.” S.B. 339, 155th Gen. Assemb., Reg. Sess. (Ga. 2020).

⁶⁷ See, e.g., H.B. 1132, 191st Gen. Ct., Reg. Sess. (Mass. 2019). For a discussion of the requirements for ACA Section 1332 waivers for plans on the Exchange, see *infra* Section II.B.2.

⁶⁸ See S.B. 405, 54th Leg., Reg. Sess. (N.M. 2019); H.B. 4789, 84th Leg., 2d. Reg. Sess. § 9-4F-2 (W. Va. 2020).

⁶⁹ See, e.g., H.B. 4789, 84th Leg., 2d. Reg. Sess. § 9-4F-2 (W. Va. 2020); Ga. S.B. 339; H.B. 2009, 81st Leg. Assemb., Reg. Sess. (Or. 2019); cf. H.B. 5463, 2018 Gen. Assemb., Reg. Sess. (Conn. 2018).

⁷⁰ See Sparer, *supra* note 37, at 269; see, e.g., Ass. Bill 449, 2017 Leg., Gen. Assemb., (Wis. 2017) (limiting enrollment to individuals with incomes above the maximum limit “who otherwise meet the eligibility requirements” of the Medicaid program).

⁷¹ See Gestur Davidson, Lynn A. Blewett & Kathleen Thiede Call, *Public Program Crowd-Out of Private Coverage: What Are the Issues?*, ROBERT WOOD JOHNSON FOUND. (2004), <https://www.rwjf.org/en/library/research/2004/06/public-program-crowd-out-of-private-coverage.html> [https://perma.cc/5ASQ-5FZ8].

⁷² See H.B. 416, 54th Leg., 1st Sess., (N.M. 2019); W. Va. H.B. 4789.

⁷³ See, e.g., H.B. 1132, 191st Gen. Ct., Reg. Sess. (Mass. 2019) (“[A]ny optional expanded plan offered to an employer shall require the employer to pay not less than 50 per cent of the projected cost of coverage for participating employees.”).

In short, the target populations of the Medicaid buy-in bills resemble a patchwork, driven by design considerations such as minimizing disruption to employer-based coverage or maximizing federal dollars flowing to state residents. Nonetheless, the common target population for all of these plans remains low-income residents who are ineligible for Medicaid and remain unable to find affordable coverage.

D. Administration of Medicaid Buy-In Plans

One of the most appealing features of Medicaid buy-in plans is that they allow states to build on the existing administrative framework of the state Medicaid program to offer comprehensive benefits at a relatively low cost and leverage the program's existing provider network and contractual arrangements. As such, all of the Medicaid buy-in bills task the state Medicaid agency with oversight of the public option. In most states, the Medicaid agency has experience contracting with managed care plans to administer benefits, which makes the Medicaid program an attractive choice for many states when trying to deliver a new state-based plan. Once a state has opted for a Medicaid buy-in, more decisions follow, such as whether to offer the plan on the Marketplace and administer it publicly or privately.

1. On or Off the Marketplace

The decision about whether to offer the plan on the Marketplace is driven by the policy goals and target population that the state seeks to cover with the Medicaid buy-in. All fourteen Medicaid buy-in bills we reviewed would *allow* the state official overseeing the plan to sell it on the Marketplace if all necessary federal waivers were granted.⁷⁴ Offering the Medicaid buy-in on the Marketplace is necessary if a state wants to capture federal Marketplace PTCs and increase options on the Marketplace. In addition, many states use the state-based Marketplace to determine eligibility for Medicaid coverage,⁷⁵ so offering the Medicaid buy-in plan on the Marketplace makes it easier for individuals to enroll in the appropriate plan and reduces the effects of churn.

If a state wants to use a Medicaid buy-in to cover undocumented immigrants, however, then the public option plan cannot be offered *solely* on the Marketplace.⁷⁶ Further, offering a Medicaid buy-in plan on the Marketplace limits design flexibility, as it must receive QHP certification.⁷⁷ Furthermore,

⁷⁴ See, e.g., H.F. 2002, 87th Gen. Assemb., Reg. Sess. 3 §§ 1(a), 2(2) (Iowa 2018).

⁷⁵ See *Medicaid and Health Insurance Marketplace Coordination*, KAISER FAM. FOUND., <https://www.kff.org/health-reform/state-indicator/medicaid-and-health-insurance-marketplace-coordination/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> [https://perma.cc/2AKQ-W8J4] (last updated Jan. 1, 2021).

⁷⁶ See *infra* Section II.B.

⁷⁷ See 42 U.S.C. § 18021 (codifying Section 1301 of the ACA, which sets forth requirements of a QHP); *infra* Section II.B.1.

the guaranteed issue requirements for Marketplace plans⁷⁸ would prevent a state from limiting eligibility for the public option to low-income residents, as contemplated by Oregon.⁷⁹

With the legal and political uncertainties surrounding the choice to offer the Medicaid buy-in on the Marketplace, states may want to preserve flexibility by allowing the plan to be sold both on and off the Marketplace, but also be prepared to change course if unanticipated consequences, such as adverse selection, occur.⁸⁰

2. *Public or Private Administration*

States can contract with private entities to administer Medicaid buy-in plans, or they can do so internally. States that deliver Medicaid benefits through private managed care plans can build on existing infrastructure and procurement processes to contract with Medicaid Managed Care Organizations (“MCOs”) to offer similar plans to non-Medicaid enrollees. In the thirty-eight states that use MCOs to manage Medicaid benefits, the state typically pays a fixed amount per member, and the MCO assumes financial risk for providing health care services for the covered beneficiary.⁸¹ If the MCO kept the Medicaid plans, risk pools, administration, and financing separate from the Medicaid buy-in plans, the state would not need a Section 1115 waiver.⁸²

Conversely, if a state Medicaid agency directly administers the buy-in plan alongside Medicaid coverage, the state may be able to streamline administrative functions and generate cost-savings through economies of scale and bulk purchasing power. However, the Medicaid agency may not use federal Medicaid funds to administer the Medicaid buy-in plan (absent a Section 1115 waiver), rendering truly integrated administration difficult to attain.⁸³ The agency’s ability to use joint purchasing arrangements for pharmaceuticals for the Medicaid buy-in plan by leveraging the combined

⁷⁸ See *infra* Section II.B.1.

⁷⁹ See H.B. 2009, 80th Leg. Assemb., Reg. Sess. § 1(3) (Or. 2019).

⁸⁰ See H.B. 5463, 2018 Gen. Assemb., Reg. Sess. (Conn. 2018) (requiring the Commissioner of Social Services, the Office of Health Strategy, and the Health Care Cabinet to study whether the state should apply for waivers, charge copayments and deductibles, and sell the public option plan on the Marketplace as a QHP).

⁸¹ See Isaac Buck, *Managing Medicaid*, 11 ST. LOUIS U.J. HEALTH L. & POL’Y 107, 110–11 (2017); Wiley, *supra* note 17, at 850; *Medicaid and Managed Care – Policy Brief*, KAISER FAM. FOUND. (May 30, 1995), <https://www.kff.org/medicaid/issue-brief/medicaid-and-managed-care-policy-brief> [<https://perma.cc/FWH9-6X7M>].

⁸² See Wiley, *supra* note 16, at 869–70 (“In states that have largely privatized Medicaid, the most natural approach would be to develop a public option that relies on the state’s infrastructure for Medicaid managed care contracts, but is otherwise separate from Medicaid. . . . [T]he impact on Medicaid could be negligible and a waiver may be unnecessary.”).

⁸³ See U.S.C. §§ 1396a, 1396b(a)(7); 42 C.F.R. 433.15(b) (2021).

populations of the Medicaid buy-in plan and the Medicaid program, however, remains promising.⁸⁴

Of the thirteen states that considered bills to create a Medicaid buy-in, eleven currently use MCOs to manage at least a portion of their Medicaid program.⁸⁵ Administration of a Medicaid buy-in through existing Medicaid MCOs was the predominant approach. Among these, bills in Georgia, Oregon, and Wisconsin would require MCOs to administer the public option in contract with the state Medicaid agency,⁸⁶ while bills in Massachusetts, Nevada, New Mexico, and West Virginia would allow the director to offer the program through MCOs.⁸⁷ However, Medicaid MCOs have mixed performance in cost savings,⁸⁸ which likely explains why Iowa proposed requiring its Medicaid agency to establish and administer the Medicaid buy-in plan in addition to terminating all of its existing MCO contracts.⁸⁹ To avoid violating federal funding restrictions, the Iowa bill would require the Iowa Medicaid agency to obtain any necessary Section 1115 waivers.⁹⁰ In sum, a state's prior experience with Medicaid MCOs will likely determine whether it chooses to administer a Medicaid buy-in internally or via private carriers.

E. Financial Considerations

1. Financing Sources

In addition to administration, policymakers must determine how to pay for Medicaid buy-in plans. Medicaid buy-in plans are primarily funded through enrollee premiums and cost-sharing.⁹¹ For Medicaid buy-ins offered on the Marketplace, federal subsidies, such as PTC and CSR payments, can also help fund the plan.⁹² Relying only on individual and federal funds makes the Medicaid buy-in plan more politically palatable and keeps the plan budget-neutral to the state, allowing it to comply with state balanced-

⁸⁴ See *infra* text accompanying notes 91–92.

⁸⁵ Connecticut and Wyoming do not use Medicaid MCOs.

⁸⁶ See Ga. S.B. 339 (2020); Or. H.B. 2009 (2019); Assemb. B. 449, 2017–2018 Legis. (Wisc. 2017). Oregon uses coordinated care organizations to manage their Medicaid program.

⁸⁷ See Nev. Assemb. B. 374 (2017); N.M. H.B. 416 (2019); W. Va. H.B. 4789 (2020).

⁸⁸ See Michael S. Sparer, *Medicaid Managed Care*, ROBERT WOOD JOHNSON FOUND. (Sept. 4, 2012), <https://www.rwjf.org/en/library/research/2012/09/medicaid-managed-care.html> [<https://perma.cc/FCE4-M7E8>]; see also Jeff C. Goldsmith, David Mosley & Anne Jacobs, *Medicaid Managed Care: Lots of Unanswered Questions (Part 2)*, HEALTH AFFS. (May 4, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180430.510086/full/> [<https://perma.cc/D3C3-JKCH>].

⁸⁹ See H.F. 2002, 87th Gen. Assemb., Reg. Sess. § 3 (Iowa 2018).

⁹⁰ *Id.* § 2-(2)(b).

⁹¹ See, e.g., N.M. S.B. 405 (2019) (“The department shall . . . set the total amount of premiums that should be assessed to [M]edicaid buy-in plan enrollees, after an actuarial analysis, to ensure maximum access to coverage. Premiums imposed may be set at a level sufficient to offset the costs of health benefits under the [M]edicaid buy-in plan and related administrative costs.”).

⁹² See *supra* text accompanying notes 54–56.

budget requirements.⁹³ However, the remaining uninsured population that many states seek to cover through a Medicaid buy-in are uninsured because they are ineligible for Medicaid coverage or sufficient PTCs to afford Marketplace coverage. So, the key financing challenge remains: how to reach low-income residents who aren't eligible for federal subsidies? In particular, states must decide whether to use state funds to subsidize costs for lower income residents.

Of the Medicaid buy-in plans, Connecticut, Massachusetts, Oregon, and Wyoming require the state to set premiums intended to cover the actuarial value of the health services provided,⁹⁴ while New Mexico and West Virginia require the public option to offer financial assistance through discounted premiums and reduced cost-sharing fees to residents with household incomes below 200% of FPL.⁹⁵ To offer this financial assistance, the bills from New Mexico and West Virginia establish non-reverting funds in the state treasury, but do not specify how the states will raise the necessary funds.⁹⁶ As states have few federal funding sources to help cover the remaining uninsured, tensions exist between state coverage goals and financial realities.

2. Cost Control

Expanding the availability of coverage to the uninsured makes cost containment a central concern of any public option plan. States have primarily sought to restrain provider payment rates to limit public option premiums. Medicaid buy-in plans would base provider rates on those paid by the Medicaid program.⁹⁷ Medicaid pays the lowest provider rates of all payers—less than Medicare and far below private insurance plans.⁹⁸ While the tradi-

⁹³ See Nicholas Bagley, *Federalism and the End of Obamacare*, 127 YALE L.J.F. 1, 10 (2017) (noting that the states, unlike the federal government, cannot deficit-spend to cover health care costs in times of revenue contraction); Sparer, *supra* note 37, at 269.

⁹⁴ See, e.g., H.B. 1132, 191st Gen. Ct., Reg. Sess. § 1(b) (Mass. 2019); S.F. 133, 2019 Leg., Reg. Sess. § 42-4-123(b) (Wyo. 2018).

⁹⁵ See H.B. 4789, 84th Leg., 2d. Reg. Sess. § 9-4F-4 (W. Va. 2020) (requiring the department administering the plan to “establish an affordability scale for premiums and other cost-sharing fees . . . based on household income. The department shall offer discounted premiums and cost-sharing fees . . . provided, that the financial assistance is, at a minimum, offered to residents with household incomes below 200% of the federal poverty level.”); N.M. H.B. 416 (offering state-funded premium subsidies to residents earning at or below 200% of FPL).

⁹⁶ See N.M. S.B. 405 (2019) § 6(B); W.Va. H.B. 4789 (2020).

⁹⁷ See W. Va. H.B. 4789 § 9-4F-3(f); N.M. H.B. 416 § 4(F) (“Health care provider reimbursement rates shall be based on the Medicaid fee schedule[.]”); see also Michael Ollove, *Medicaid ‘Buy-In’ Could Be a New Health Care Option for the Uninsured*, PEW: STATELINE (Jan. 10, 2019), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/01/10/medicaid-buy-in-could-be-a-new-health-care-option-for-the-uninsured> [https://perma.cc/GGN8-YSQ9].

⁹⁸ See Thomas M. Selden, Zeynal Karaca, Patricia Keenan, Chapin White & Richard Kronick, *The Growing Difference Between Public and Private Payment Rates for Inpatient Hospital Care*, 34 HEALTH AFFS. 2147, 2147 (2015). While Medicaid rates for specific services rendered overall are about fifty-five percent of Medicaid payments to hospitals, other

tional Medicaid fee schedule is administratively set by each state and not subject to negotiation by providers, Medicaid MCOs typically negotiate payment rates for providers that participate in their network within established state restrictions, including minimum payment rates for providers in some categories.⁹⁹ Most of the Medicaid buy-in bills do not specify reimbursement rates, and even when they reference Medicaid rates, the buy-in plan could conceivably pay a higher multiple of Medicaid rates, such as 150% of current rates. Most states contemplate higher reimbursement rates when possible, but offer few specifics in the bills about how to accomplish that goal.¹⁰⁰

In addition to controlling costs through provider reimbursement rates, some states also consider mechanisms to control prescription drug costs. The New Mexico and West Virginia bills, for example, allow the health services department to contract with other entities or states to combine purchasing power and seek federal authority to create a wholesale drug importation program.¹⁰¹ Georgia's bill requires the state Medicaid agency to "establish a method for procuring prescription drugs consistent with the manner utilized for Medicaid,"¹⁰² but the bill does not specify whether that would include extending the Medicaid best price rule to the state public option.

Medicaid buy-in plans must walk a fine line with cost-control. On the one hand, extending Medicaid provider reimbursement rates to the buy-in population holds the greatest promise for making premiums more affordable. On the other hand, 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.

supplemental payments, including disproportionate share hospital payment, upper payment limit, uncompensated care pool payments, and delivery system reform incentive payments, mean that Medicaid payments to hospitals on par with Medicare. See MEDICAID BASE AND SUPPLEMENTAL PAYMENTS TO HOSPITALS (2020), <https://www.macpac.gov/wp-content/uploads/2020/03/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf> [<https://perma.cc/UYG8-SBFZ>]; *Fact Sheet: Underpayment by Medicare and Medicaid*, AHA (Jan. 2021), <https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid> [<https://perma.cc/R9VG-T86T>]. The public option bills we studied are silent on whether Medicaid buy-in public option payments would be based on an aggregate Medicaid payment rate or on the fee for service schedule.

⁹⁹ See 42 U.S.C. 1396a(a)(13); KATHLEEN GIFFORD, EILEEN ELLIS, AIMEE LASHBROOK & MIKE NARDONE, KAISER FAM. FOUND., *A VIEW FROM THE STATES: KEY MEDICAID POLICY CHANGES: RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY FOR STATE FISCAL YEARS 2019 AND 2020* 70 (2019), <http://files.kff.org/attachment/Report-A-View-from-the-States-Key-Medicaid-Policy-Changes> [<https://perma.cc/MC7E-CFXD>] (noting that nearly half (nineteen) of MCO states reported mandating minimum provider reimbursement rates in their MCO contract).

¹⁰⁰ For instance, Connecticut requires and Massachusetts allows excess funds to be used to increase reimbursement rates for providers. See R.B. 5463, 2018 Gen. Assemb., Reg. Sess. §§ 3, 4 (Conn. 2018); H.B. 1132, 191st Gen. Ct., Reg. Sess. § 1(b) (Mass. 2019).

¹⁰¹ See N.M. S.B. 405 § 5(C)(4) (2019); W. Va. H.B. 4789 (2020).

¹⁰² See Ga. S.B. 339 (2020).

F. Market Effects

One of the most difficult design considerations for policy makers seeking to implement a Medicaid buy-in is identifying and minimizing adverse effects on existing markets. In particular, a public option with payments pegged to Medicaid rates has the potential to destabilize both provider and insurance markets and reduce access. Some federal public option proposals would require providers to accept the public option in order to participate in Medicare and Medicaid,¹⁰³ and a state could require any provider that accepts Medicaid patients or Marketplace plans to accept the public option plan.¹⁰⁴ In many markets, however, Medicaid MCOs already struggle to recruit sufficient providers,¹⁰⁵ and if large portions of state residents are covered by a plan that uses Medicaid rates, providers may leave the state. Not only would this harm enrollment in the Medicaid buy-in, but it could have deleterious effects on access to providers by actual Medicaid enrollees.

Disruptions to the insurance market are more ambiguous. A Medicaid buy-in plan that undercuts premiums for private plans on the Marketplace could slow premium growth—a good disruption—but it could also reduce consumers' choices if private insurance carriers and providers leave the market.¹⁰⁶ Nonetheless, private insurer exit may not be a problem so long as sufficient providers participate—in fact, this may be the goal of a public option.¹⁰⁷ A cheaper, comprehensive Medicaid buy-in could also cause adverse selection between Marketplace plans and the Medicaid buy-in if the public option disproportionately attracts individuals with high health care costs. In this case, the premiums calculated by the state will not be sufficient to cover expenditures. The ACA helps mitigate this risk by applying risk adjustment to Marketplace plans and by requiring insurers to place all indi-

¹⁰³ See Tricia Neuman, Karen Pollitz, Jennifer Tolbert, Robin Rudowitz & Wyatt Koma, *10 Key Questions on Public Option Proposals*, KAISER FAM. FOUND. (Dec. 18, 2019), <https://www.kff.org/health-reform/issue-brief/10-key-questions-on-public-option-proposals/> [<https://perma.cc/ES3Y-2TNS>].

¹⁰⁴ See MATTHEW FIEDLER, USC BROOKINGS-SCHAEFFER INITIATIVE FOR HEALTH POL'Y, CAPPING PRICES OR CREATING A PUBLIC OPTION: HOW WOULD THEY CHANGE WHAT WE PAY FOR HEALTH CARE 10 (2020).

¹⁰⁵ See RACHEL GARFIELD, ELIZABETH HINTON, ELIZABETH CORNACHIONE & CORNELIA HALL, KAISER FAM. FOUND., MEDICAID MANAGED CARE PLANS AND ACCESS TO CARE: RESULTS FROM THE KAISER FAMILY FOUNDATION 2017 SURVEY OF MEDICAID MANAGED CARE PLANS 7 (2018), <http://files.kff.org/attachment/Report-Medicaid-Managed-Care-March-Plans-and-Access-to-Care> [<https://perma.cc/YSG6-BYJT>] (finding eighty percent of Medicaid MCO plans report difficulty in finding adult or pediatric subspecialists and forty percent report difficulty in recruiting primary care physicians).

¹⁰⁶ See CHIQUITA BROOKS-LASURE, APRIL GRADY, ASHLY TRAUBE & PATRICIA BOOZANG, MANATT HEALTH, QUANTITATIVE EVALUATION OF A TARGETED MEDICAID BUY-IN FOR NEW MEXICO 16 (2019), <https://www.manatt.com/Manatt/media/Documents/Articles/Final-New-Mexico-Buy-In-Phase-2-Paper-1-25.pdf> [<https://perma.cc/C6PT-HSS5>] (arguing that offering a Medicaid-like QHP on the Marketplace could decrease competition if private insurers struggle to compete with lower-cost options and exit the market).

¹⁰⁷ See Hoffman, *supra* note 17, at 12.

vidual plan enrollees, both on and off the Marketplace, in one risk pool.¹⁰⁸ Therefore, Medicaid buy-in plans offered on and off the Marketplace would presumably participate in risk-adjustment.¹⁰⁹ A legislatively authorized study analyzing four options for a proposed Medicaid buy-in in New Mexico suggested that offering two plans—one a QHP on the Marketplace and one off the Marketplace targeting those impacted by the family glitch or immigration status—could minimize disruptions to the state Marketplace because they could be implemented in the same ACA risk pool.¹¹⁰

At first glance, Medicaid buy-in plans are an appealing vehicle for a public option because they build on existing infrastructure, offer comprehensive benefits, control costs by importing Medicaid's low provider rates and administrative costs, and come with significant federal funding. The reality, however, is much more constrained and complicated. To comply with the legal constraints of the Medicaid statute and the Affordable Care Act, a state must contort and narrow a Medicaid buy-in, significantly diminishing its resemblance to actual Medicaid. In implementing Medicaid buy-ins, states will likely require Medicaid-managed care plans to offer a separate but similar plan on and off the ACA Marketplaces to allow those eligible for PTCs to use them to purchase the plan, and those who are ineligible (like undocumented immigrants) to purchase a similar plan outside the Marketplace. For legal and practical reasons, the benefits, premiums, cost-sharing, provider reimbursement, and plan design would look more like a Marketplace plan than a Medicaid plan. Thus, the scale of innovation and the scope of increased coverage would probably be modest. Viable Medicaid buy-ins are small-bore public option plans. Perhaps this is why the first states to actually implement a public option follow the next model we review, the Marketplace-based public option plan.

II. MARKETPLACE-BASED PUBLIC OPTIONS

Marketplace-based public options (“MBPOs”) offer states the opportunity to provide affordable, comprehensive coverage to large portions of the population, while generating competition on the ACA Marketplace and bringing federal funds into the state to support health care expenses. MBPOs are health insurance plans that satisfy ACA Marketplace specifications, including state QHP certification, and also conform to coverage, provider payment, and other specifications established by the state for the public option. We examined twenty-one MBPO bills across ten states introduced between

¹⁰⁸ See 42 U.S.C. § 18032.

¹⁰⁹ See CORI E. UCCELLO, AM. ACAD. OF ACTUARIES, EXPANDING ACCESS TO PUBLIC INSURANCE PLANS 9 (2019), <https://www.actuary.org/sites/default/files/files/publications/PublicInsurancePlans.pdf> [<https://perma.cc/3P6V-F9GY>].

¹¹⁰ See BROOKS-LASURE ET AL., *supra* note 107, at 14.

2010 and 2021, including three in Washington, Colorado, and Nevada that were signed into law.¹¹¹ MBPOs' largest advantage in comparison to other public option plans is the opportunity to capitalize on the federal subsidies, in the form of PTCs and CSRs. MBPO plans also face fewer legal constraints than Medicaid buy-ins.

A. *Policy Goals*

As the most flexible public option model, state MBPOs can take a variety of forms depending on the state's policy goals. States can design MBPOs to meet any of the policy goals of a public option, including increasing affordability, reducing churn, providing near-universal coverage untethered to employment (with notable exceptions), increasing competition and market function, and simplifying administration.

Nearly all states contemplating a public option hope to offer comprehensive and affordable coverage, while controlling or reducing health care spending.¹¹² The Colorado legislature stated that the purpose of the public option plan was to "increas[e] the availability of affordable health insurance statewide to any resident seeking coverage in the individual market[.]"¹¹³ States hope MBPOs will control health spending by reducing provider payments to below commercial rates through price caps,¹¹⁴ lowering administrative expenses,¹¹⁵ and generating price competition within the Marketplace to drive down commercial plan rates.¹¹⁶

Beyond affordability, states have proposed MBPOs to achieve additional policy goals. For instance, Massachusetts and Illinois sought to achieve universal coverage and serve as a glide path to a public single payer by offering MBPO coverage to enrollees in the individual, small group, and large group markets.¹¹⁷ As noted above, MBPOs can also reduce the harms of churning on and off Medicaid by ensuring that people can keep their doctors even if their plan technically changes.¹¹⁸ Finally, states seeking to improve market function and enhance patient choice can create an MBPO to

¹¹¹ See Appendix A. Washington enacted its public option in 2019, and Colorado and Nevada enacted theirs in 2021. See S.B. 5526, 66th Leg., 2019 Reg. Sess. (Wash. 2019); H.B. 21-1232, 73rd Gen. Assemb., 1st Reg. Sess. (Colo. 2021); S.B. 420, 2021 Leg., 81st Reg. Sess. (Nev. 2021).

¹¹² See, e.g., Wash. S.B. 5526; Raised B. 346, 2020 Gen. Assemb., Feb. Sess. § 2(a) (Conn. 2020).

¹¹³ Colo. H.B. 20-1349 § 10-16-1202(2)(a).

¹¹⁴ See, e.g., Wash. S.B. 5526 § 3(2)(g)(i) (limiting the total reimbursement amount for all covered benefits to 160% of Medicare reimbursement for the same or similar services in the statewide aggregate).

¹¹⁵ See, e.g., Conn. Raised B. 346 § 2(2) (establishing a medical loss ratio of ninety percent).

¹¹⁶ See, e.g., Colo. H.B. 20-1349 § 10-16-1205(2)(a)(II)(A).

¹¹⁷ See S.B. 697, 191st Gen. Ct., 2019–2020 Sess. § 3 (Mass. 2019); H.B. 5733, 98th Gen. Assemb., Reg. Sess. § 20 (Ill. 2014).

¹¹⁸ See *supra* Section I.A.

provide coverage in “bare counties” without any plan offerings, generate competition in areas with minimal existing offerings, and provide consumers and employers more affordable coverage options.¹¹⁹ The structure of any state MBPO will depend on ACA requirements for all plans offered on the Marketplace as well as the particular needs and policy goals of the state.

B. Legal Issues for Marketplace-Based Public Option Plans

The ACA creates significant financial incentives for states to offer a public option on the Marketplace, but it also imposes requirements on those plans, some of which may be altered via a Section 1332 waiver from HHS.

1. ACA Marketplace Requirements

To access federal Marketplace subsidies, Marketplace-based plans must satisfy the requirements of the ACA. The Marketplaces offer competing health insurance plans with standardized minimum benefits and coverage levels to simplify and facilitate consumer plan selection. Any public option plan offered on the Marketplace must meet the ACA’s guaranteed issue¹²⁰ and modified community rating provisions,¹²¹ which require plans to accept all individuals and charge them the same premium as other similarly-situated individuals, regardless of health status.¹²² Further, all plans offered on the Marketplace must be QHPs,¹²³ which means they must: (1) be offered by a health insurance issuer in the state that is licensed, in good standing, and has agreed to the requirements for offering a plan on the Marketplace; (2) cover all of the Essential Health Benefits (“EHBs”); and (3) be certified for sale on the Marketplace.¹²⁴ The ACA also mandates compliance with federal medical loss ratio (“MLR”) limits, which require Marketplace plans to spend at least eighty percent of individual and small group premium revenue to provide health care to patients, or return the difference to enrollees.¹²⁵ Each of these requirements aims to ensure meaningful access to comprehensive and affordable health care coverage, therefore many of them, such as the EHBs and MLR, a state would likely include in the design of a public option plan even in the absence of the ACA requirements.

¹¹⁹ See, e.g., Colo. H.B. 20-1349 § 10-16-1205(1)(a)–(b) (requiring commercial plans to offer the Colorado Option Plan in the individual market in each county where the carrier offers an individual plan and requiring the commissioner to ensure that there are at least two carriers that offer the Colorado option plan in each county in the state); see also S.B. 5526, 66th Leg., 2019 Reg. Sess. § 1(1)–(2)(a) (Wash. 2019); Mass. S.B. 697 § 3; Ill. H.B. 5733 § 20.

¹²⁰ See 42 U.S.C. § 300gg–1.

¹²¹ See *id.* § 300gg.

¹²² See *id.* The ACA’s modified community rating provision allows health plans to vary premiums based on geographic area, age (up to 3x), and tobacco usage (up to 1.5x). See *id.*

¹²³ See *id.* § 18021; 45 C.F.R. § 155.1000 (2021).

¹²⁴ See 42 U.S.C. § 18021(a)(1).

¹²⁵ See *id.* § 300gg-18.

Yet, the specificity of some requirements can affect a state's design of its MBPO plan. For instance, most states do not have an existing state entity that qualifies as a licensed health insurance issuer. Federal regulations define a health insurance issuer as an "insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance" ¹²⁶ Therefore, to offer a plan on the Marketplace, states will need to have existing commercial carriers offer the public option plans on the Marketplace, ¹²⁷ modify the eligibility requirements for Marketplace certification, ¹²⁸ or grant an existing state agency the authority to offer plans as QHPs on the Marketplace. ¹²⁹ A state agency seeking the authority to issue QHPs must ensure that each QHP complies with federal and state benefit design standards, remain licensed and in good standing with the State, implement quality improvement strategies, and satisfy the necessary reporting requirements established by the ACA. ¹³⁰

Once a state has established a licensed health insurance issuer for the MBPO, the plan must be certified by the Marketplace as a QHP. ¹³¹ Many of the certification requirements involve benefit design, including covering the EHBs. ¹³²

Second, a QHP must also offer coverage of a specific actuarial value, which establishes the percentage of health care costs the plan will cover for a standard population. Plans offered on the Marketplace are divided into four metal tiers based on their actuarial value: ¹³³ Bronze (60%); Silver (70%); Gold (80%); and Platinum (90%). ¹³⁴ Issuers that offer plans on the Marketplace must offer at least one QHP at the silver level and one at the gold level in each service area in which it offers coverage on the Marketplace. ¹³⁵ However, issuers do not have to offer plans in all counties in a state or at all four

¹²⁶ 45 C.F.R. § 144.103 (2021).

¹²⁷ See, e.g., S.B. 5526, 66th Leg., 2019 Reg. Sess. § 3 (Wash. 2019).

¹²⁸ See S.B. 697, 191st Gen. Ct., 2019–2020 Sess. § 4 (Mass. 2019) (modifying Chapter 176Q § 5(a) to read: "Only health insurance plans and stand-alone vision or stand-alone dental plans that have been approved by the commissioner and underwritten by a carrier, as well as the public health insurance option, may be offered through the connector.").

¹²⁹ See S.F. 2302, 91st Leg., 2019 Reg. Sess. § 14(1)(d) (Minn. 2019) (stating that the Dep't of Human Services is deemed to meet and receive certification and authority as a managed care organization).

¹³⁰ See 45 C.F.R. § 156.200(b) (2021).

¹³¹ *Id.* § 156.200(a).

¹³² See 42 U.S.C. § 18022. The ten categories of EHBs include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitation and habilitation services, laboratory services, preventive and wellness services, and pediatric services. *Id.*; 45 C.F.R. § 156.110(a) (2021).

¹³³ See 42 U.S.C. § 18022(d); see also *What the Actuarial Values in the Affordable Care Act Mean*, KAISER FAM. FOUND. (Apr. 1, 2011), <https://www.kff.org/health-reform/issue-brief/what-the-actuarial-values-in-the-affordable/> [<https://perma.cc/Q7US-6EV9>].

¹³⁴ See 45 U.S.C. § 18022(d); 45 C.F.R. § 156.140 (2021).

¹³⁵ See 45 C.F.R. § 156.200(c) (2021).

levels of coverage, which can create significant geographic and financial gaps in coverage that states may want to address through the creation of MBPOs.

Finally, states can impose their own requirements on health plans offered on the Marketplace via state insurance laws and QHP certification requirements. All states have insurance laws that require plans offered in the state to meet criteria for licensure, including mandatory benefits and maintaining and reporting financial reserves. States operating their own Marketplaces can impose conditions on QHP certification, including requiring issuers selling plans on the Marketplace to offer the MBPO.¹³⁶ On the other hand, states with a federally-facilitated Marketplace have less flexibility to impose individual state conditions on issuers because the federal Marketplace has historically certified plans in a unified manner.¹³⁷

Overall, states seeking to create an MBPO will need to design their public option plans to satisfy both federal ACA requirements and state insurance laws. Nevertheless, states may apply for a Section 1332 waiver from HHS to deviate from ACA requirements.

2. *Deviations from ACA Requirements: Section 1332 Waivers*

To offer an MBPO that deviates from ACA requirements, states can apply for a State Innovation Waiver under ACA Section 1332, which allows them to adapt plans offered on the Marketplace to address their specific needs and to try innovative strategies. Section 1332 permits states to waive or modify certain requirements for ACA Marketplace plans, including: the individual and employer mandates, EHB requirements, the definition of a QHP, limits on cost sharing for covered benefits, metal coverage tiers, health insurance Marketplace standards and requirements, PTCs, and CSRs.¹³⁸

For example, the ACA's employer mandate requires large employers to offer "minimum essential coverage" to their employees or pay a penalty.¹³⁹ The penalty is triggered for every full-time employee that receives a PTC to purchase coverage on the Marketplace, instead of using employer coverage.¹⁴⁰ This provision may need to be waived if the MBPO were offered to large employers, to ensure the MBPO counts as minimum essential coverage

¹³⁶ See *id.* § 156.200(d); see, e.g., S.B. 5526, 66th Leg., 2019 Reg. Sess. § 1(2)(a) (Wash. 2019).

¹³⁷ See Waivers for State Innovation, 80 Fed. Reg. 78,131, 78,135 (Dec. 16, 2015) ("Until further guidance is issued, the Federal platform cannot accommodate different rules for different states."). CMS's 2018 guidance notes that technical enhancements may support some variation and flexibility for states using the federal Marketplace to try models through use of Section 1332 waivers. See State Relief and Empowerment Waivers, 83 Fed. Reg. 53,575, 53,581 (Oct. 24, 2018).

¹³⁸ See 42 U.S.C. § 18052(a)(1).

¹³⁹ See 26 U.S.C. § 4980H(a)–(c).

¹⁴⁰ See *id.*

and to prevent employers from being penalized if employees choose the MBPO.

The ACA, however, imposes significant requirements on states seeking a Section 1332 waiver: they must pass legislation permitting the state to seek such a waiver and comply with strict guardrails when proposing changes to ACA requirements.¹⁴¹ For instance, the proposed plan must not reduce the comprehensiveness of benefits, increase cost sharing, or cover fewer residents than would be covered absent the waiver.¹⁴² Furthermore, the proposal must not increase the federal deficit, which means that the projected federal spending with the waiver must be equal to or less than the projected spending without the waiver.¹⁴³ Numerous factors can affect the federal revenue and net federal spending, including changes to federal income, payroll or excise tax revenue, premium tax credits, small business credits, employer shared responsibility payments, Medicaid spending and other forms of federal assistance, and administrative costs.¹⁴⁴

Needless to say, designing a plan modification that can meet these requirements, passing legislation, and submitting a Section 1332 waiver can be onerous for states, and HHS has considerable discretion to deny the waiver, even those that successfully meet these criteria.¹⁴⁵ Faced with these challenges and uncertainties, states wishing to deviate from the ACA requirements may consider offering their public option plan off the Marketplace to avoid the Section 1332 waiver process.

However, Congress created strong incentives for states to innovate within the ACA structure by offering federal pass-through funding to states that receive Section 1332 waivers.¹⁴⁶ If the state reduces the costs of Marketplace plans through Section 1332 innovation, the federal government will pass any savings it incurred from reductions in federal ACA assistance, including PTCs, CSRs, and small business credits, back to the state.¹⁴⁷ States can use the federal pass-through funding to help fund their new state plan. In particular, states may use pass-through funds to increase subsidies for individuals earning above 400% of FPL (the cutoff for federal ACA subsidies) and limit the percentage of income enrollees spend on health care.¹⁴⁸ How-

¹⁴¹ See 42 U.S.C. § 18052(b)(2).

¹⁴² See *id.* § 18052(b)(1)(A)–(C).

¹⁴³ See *id.* § 18052(b)(1)(D) (stating that waivers cannot increase the deficit during the waiver term (up to 5 years) or in total over the ten-year budget plan); State Relief and Empowerment Waivers, 45 C.F.R. §§ 155.1300–155.1328 (2021).

¹⁴⁴ See Waivers for State Innovation, 80 Fed. Reg. 78,131, 78,133 (Dec. 16, 2015) (to be codified at 45 C.F.R. § 155 (2021)); State Relief and Empowerment Waivers, 83 Fed. Reg. 53,575 (Oct. 24, 2018).

¹⁴⁵ See Waivers for State Innovation, 80 Fed. Reg. 78,131, 78,133 (Dec. 16, 2015).

¹⁴⁶ See 42 U.S.C. § 18052 (a)(3).

¹⁴⁷ See *id.* The pass-through savings does not include any savings other than the reductions in federal assistance provided by the ACA. See State Relief and Empowerment Waivers, 45 C.F.R. § 155 (2021).

¹⁴⁸ See, e.g., Raised S.B. 346, 2020 Gen. Assemb., Feb. Sess. § 2(a)(4)(B) (Conn. 2020) (offering cost-sharing subsidies to public option plan enrollees who are ineligible to receive

ever, states must be mindful that the federal government will reduce pass-through savings by losses in federal revenue arising from the waiver to ensure deficit neutrality.¹⁴⁹ The promise of federal money to subsidize health reform may provide powerful motivation for states that must balance their budgets to obtain a Section 1332 waiver for their public option plans.

When designing MBPOs, states must scaffold around ACA requirements as they seek to fulfill their goals for target population, plan administration, financing, and market impact. State goals and priorities can affect the design, legal, and financial implications of offering various MBPO models on the Marketplaces.

C. Target Population

MBPOs primarily target populations that seek individual or small group coverage through the ACA Marketplace, although some MBPOs would also allow large groups to participate. Unlike Medicaid buy-in models, states have less ability to offer MBPO plans directly to a specific target population. Instead, at a minimum, MBPO plans must be offered to any eligible individual in a particular geographic area, which generally includes all lawfully present residents who are not incarcerated.¹⁵⁰ As a result, states cannot limit plan eligibility to individuals that make below certain income levels. They can, however, use financial incentives, such as enhanced subsidies, to encourage certain individuals to enroll in the public option.¹⁵¹ For example, Washington, aiming to prevent individuals from spending more than ten percent of their income on individual coverage, would require state authorities to develop a plan to offer state-sponsored premium subsidies for individuals earning up to 500% of FPL who purchase individual coverage on the exchange.¹⁵² States, in their capacity as employers, can also use automatic enrollment of public employees to expand the plan's risk pool and purchasing power.¹⁵³

States can also target citizens of specific geographic areas by offering or requiring commercial insurers to offer MBPO plans in areas that currently lack coverage or have minimal coverage in the Marketplace. To address the fact that twenty-two counties had only one plan offered on the Marketplace,

CSRs offered by the ACA); S.B. 5526, 66th Leg., 2019 Reg. Sess. § 6(1) (Wash. 2019) (increasing subsidies to those earning up to 500% of FPL and limiting individual premium spending to ten percent of adjusted gross income). Both Connecticut's and Washington's proposals would require Section 1332 waivers to use federal pass-through funds and vary the ACA rules in this way.

¹⁴⁹ For instance, if the Section 1332 waivers result in lower federal tax revenue or higher Medicaid enrollment, the amount of pass-through savings offered back to the state will be offset by those losses. State Relief and Empowerment Waivers, 45 C.F.R. § 155 (2021).

¹⁵⁰ See 42 U.S.C. § 300gg-1; see, e.g., S. 109, Gen. Assemb., 2011-2012 Reg. Sess. §§ 4402, 4403(7) (Vt. 2011).

¹⁵¹ See, e.g., S.B. 5526, 66th Leg., 2019 Reg. Sess. § 6(1) (Wash. 2019).

¹⁵² See *id.*

¹⁵³ See UCCELLO, *supra* note 109, at 13.

the Colorado legislature proposed that at least two carriers offer the Colorado Option Plan in the individual market in every county and granted the Insurance Commissioner the authority to require carriers to offer the Colorado Option Plan in specific counties to fulfill this mandate.¹⁵⁴ Geographic market requirements can help states ensure the availability of individual market coverage throughout the state.

Beyond the individual market, states can also offer MBPO plans to allow small and large employers to enroll their employees. Expanding MBPOs to small employers can ease premium volatility and provide a more affordable choice in this typically dysfunctional market.¹⁵⁵ Broadening MBPO enrollment to include large groups would significantly expand the risk pool and increase its purchasing power, while offering employers and employees an affordable coverage option that reduces administrative burden. As noted above, offering large group plans on the Marketplace may require the state to apply for a Section 1332 waiver of the ACA's employer mandate and other requirements.¹⁵⁶ Over the last decade, Massachusetts proposed a series of nearly identical bills that would offer a state public option in both small and large group markets.¹⁵⁷ Illinois followed suit in 2013 by offering HB 5733, which largely mirrored the Massachusetts bills.¹⁵⁸ These bills proposed allowing a wide array of associations and entities to offer their employees and members insurance through the MBPO.¹⁵⁹ Section 1332 waivers can enable states to cover a very broad target population through MBPOs and move toward removing the tether between employment and health insurance.

In the absence of a Section 1332 waiver, however, the ACA imposes eligibility restrictions that limit states' ability to reach some target populations. For instance, states cannot use MBPO plans to offer insurance options to undocumented immigrants or individuals who have access to employer-sponsored insurance that qualifies as affordable under the ACA without a Section 1332 waiver.¹⁶⁰ Given these limits and the political uncertainty of

¹⁵⁴ See H.B. 20-1349, 72nd Gen. Assemb., 2d Reg. Sess. § 10-16-1205(1) (b) (Colo. 2020); see also S.F. 2302, 91st Leg., 2019 Reg. Sess. art. 9 § 15 subd. 1–2 (Minn. 2019).

¹⁵⁵ See, e.g., COLO. DIV. OF INS. & DEP'T OF HEALTH CARE POL'Y & FIN., FINAL REPORT FOR COLORADO'S PUBLIC OPTION 21 (2019) [hereinafter COLORADO REPORT ON THE PUBLIC OPTION].

¹⁵⁶ See *supra* text accompanying notes 129–30.

¹⁵⁷ See H.B. 1228, 187th Gen. Ct., Reg. Sess. (Mass. 2011); S.B. 514, 188th Gen. Ct., Reg. Sess. (Mass. 2013); H.B. 1033, 189th Gen. Ct., Reg. Sess. (Mass. 2015); S.B. 638, 190th Gen. Ct., Reg. Sess. (Mass. 2017); S.B. 697, 191st Gen. Ct., Reg. Sess. § 3 (Mass. 2019).

¹⁵⁸ See H.B. 5733, 98th Gen. Assemb., Reg. Sess. § 20 (Ill. 2013).

¹⁵⁹ See Mass. S.B. 697 § 3 (including sole proprietors, labor unions, trade associations, and others).

¹⁶⁰ See 42 U.S.C. § 18081(a)(1). In 2016, California applied for a Section 1332 waiver to permit undocumented individuals to purchase plans on the state-based Marketplace, but withdrew the application when the Trump Administration took office. See Letter from Peter V. Lee, Exec. Dir., Covered Cal. Bd. of Dirs., to Sylvia Matthews Burwell, Sec. of Health & Hum. Servs., U.S. Dep't of Health & Hum. Servs. on Covered California 1332 State Innovation Waiver Application – Resubmission (Dec. 16, 2016) (on file with authors); see also Letter

obtaining a Section 1332 waiver, state legislatures aiming to cover currently ineligible populations can provide the implementing agency the flexibility to offer the public option plan on the Marketplace, off the Marketplace, or both.¹⁶¹

Defining the target population for an MBPO often determines the scope of the public option proposal. States should consider whether to specify the target population in implementing legislation or leave the ultimate decision up to the administrative agency implementing the MBPO. That decision will depend on how involved a state wants to be in administering the plan.

D. Administration

One of the most consequential decisions states must make in the development of an MBPO is how involved to be in plan administration. As with Medicaid buy-ins, the choice between a public-private partnership or a state-administered MBPO depends on the amount of control and authority the state wants over the MBPO and the state's willingness to invest time and resources to gain that control. The easiest and least resource-intensive path for states is to contract with commercial carriers to offer the MBPO on the Marketplace—the approach taken by Washington, Colorado, and Virginia.¹⁶² As the least “public” of the models, 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. The trade-off for minimal state burden or investment, however, is that the state cedes control and financial savings. A more traditionally public state-administered model, exemplified by Connecticut, Massachusetts, and Illinois, would give states control over finances and unify administration within one government-run entity. The downsides of the state-administered model include greater financial risk, administrative burden, and resource allocation constraints. As noted above, states with a state-based Marketplace will have more flexibility

from Peter V. Lee, Exec. Dir., Covered Cal. Bd. of Dirs., to Kevin J. Counihan, Dir. & Marketplace Exec. Officer, U.S. Dep't of Health & Hum. Servs. on Covered California 1332 State Innovation Waiver Application Withdrawal Request (Jan. 18, 2017) (on file with authors).

¹⁶¹ Compare S.B. 346, 2020 Gen. Assemb., Feb. Sess. § 2(a)(1), (3) (Conn. 2020) (leaving decisions of how to define enrollment eligibility and whether to offer the ConnectHealth plan, Connecticut's public option, on the Marketplace to the state Comptroller, the entity assigned to administer the plan), with H.B. 20-1349, 72nd Gen. Assemb., 2d Reg. Sess. § 10-16-1205(2)(a)(1) (Colo. 2020) (requiring the Insurance Commissioner to offer the public option plan to all individuals that purchase health insurance in the individual market in plans offered both on and off the Marketplace). See also H.B. 21-1232, 73rd Gen. Assemb., 1st Reg. Sess. § 10-16-1304(1) (Colo. 2021) (requiring the Commissioner to establish a standardized health benefit plan to be offered by carriers in the individual and small group markets both on and off the Marketplace).

¹⁶² See S.B. 5526, 66th Leg., 2019 Reg. Sess. § 3(1)(c) (Wash. 2019); H.B. 20-1349, 72nd Gen. Assemb., 2d Reg. Sess. § 10-16-1205 (Colo. 2020); H.B. 530, 2020 Gen. Assemb., Reg. Sess. § 32.1-329.1(B) (Va. 2020).

to administer their own MBPO than states with federally-run Marketplaces, due to uniformity requirements on the federal Marketplace.¹⁶³

1. Public-Private Partnership with Commercial Plans

The simplest way for states to create an MBPO is to contract with commercial insurance carriers to offer plans with state-specified criteria. These state-specified criteria can range from little more than the ACA requirements for QHPs and some provider reimbursement restrictions¹⁶⁴ to complex benefit design models and cost-saving mechanisms. Two of the three states that have gone farthest in implementing a public option, Washington and Colorado, took the latter approach, requiring commercial carriers to implement state-designed plans with a broad range of specifications.¹⁶⁵

In 2019, Washington created the nation's first public health insurance option, known as CascadeCare.¹⁶⁶ Though not publicly administered, Washington called the plan a "public option" because the state imposed "public-sector reimbursement rates on a commercial insurance market."¹⁶⁷ According to Michael Sparer, Washington's "goal was to derive the benefits of a public option without the political, organizational, and economic tasks of creating a new, state-administered insurer."¹⁶⁸

Washington created a public-private hybrid that required the Health Care Authority, in consultation with the Health Benefit Exchange, to contract with commercial carriers to offer the public option plan on the Marketplace.¹⁶⁹ Carriers, however, are not required to participate.¹⁷⁰ Instead, the Health Care Authority must contract with sufficient carriers to offer the public option in every county.¹⁷¹

Washington imposed several conditions on its public option plans.¹⁷² Significantly, the law limits provider reimbursement in the aggregate to 160% of Medicare reimbursement rates for the same or similar services.¹⁷³ Other requirements include rate review and network adequacy, care coordination, value-based purchasing, and generic drug and utilization review re-

¹⁶³ See *supra* discussion accompanying notes 126–27.

¹⁶⁴ See, e.g., H.B. 530, Gen. Assemb., 2020 Reg. Sess. § 32.1-329.1(D) (Va. 2020).

¹⁶⁵ See Wash. S.B. 5526; Colo. H.B. 20-1349; Colo. H.B. 21-1232.

¹⁶⁶ See Billy Wynne, *Public Option 1.0: Washington State Takes an Important Step Forward*, HEALTH AFFS.: BLOG (May 1, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190430.353036/full/> [<https://perma.cc/VWC8-T477>]; *Cascade Care*, WASH. STATE HEALTH CARE AUTH., <https://www.hca.wa.gov/about-hca/cascade-care> [<https://perma.cc/WYD5-FEVX>].

¹⁶⁷ Sparer, *supra* note 38, at 263.

¹⁶⁸ *Id.*

¹⁶⁹ 2019 Wash. Sess. Laws, enacting Engrossed Substitute S.B. 5526, 66th Leg., 2019 Reg. Sess. § 3(1) (Wash. 2019).

¹⁷⁰ See Sparer, *supra* note 38, at 264.

¹⁷¹ See S.B. 5526, 66th Leg., 2019 Reg. Sess. § 3(1) (Wash. 2019).

¹⁷² See *id.* § 3(2).

¹⁷³ See *id.* § 3(2)(g)(i). For a discussion of Washington's provider rate limits, see *infra* Section II.E.2.

quirements.¹⁷⁴ The authority granted to Washington state agencies gives them significant control over the features and functions of the contracted CascadeCare plans.

Like Washington, Colorado pursued a public-private hybrid that requires commercial insurers to offer a state-regulated “Colorado Option Plan” on the Marketplace. In 2019, the Colorado legislature directed state health authorities to develop a proposal to create an “innovative state option for health insurance coverage.”¹⁷⁵ A bill to implement the ensuing plan appeared poised to pass in 2020, but was tabled due to COVID-19.¹⁷⁶ The bill, H.B. 20-1349, would have required all carriers that offer a health plan in the individual market to also offer the Colorado Option Plan in the same county. Colorado’s H.B. 20-1349 covered the EHBs; provided at least bronze and silver levels of coverage; and offered first-dollar, pre-deductible coverage for certain services, such as primary health care and behavioral health care.¹⁷⁷ Further, the bill granted the Insurance Commissioner the ability to require carriers to offer public option plans in specific counties.¹⁷⁸

Colorado’s 2020 bill was unique because it created a powerful, independent board to oversee public option development.¹⁷⁹ The Board would advise the Commissioner on all aspects of the development, implementation, and operation of the Colorado Option Plan,¹⁸⁰ and has the ability to override any decision made by the Commissioner concerning the Colorado Option Plan.¹⁸¹ The combination of a state official with significant power over plan design, private entities to implement it, and an independent advisory and oversight body with override power would have allowed the state to tailor the public option plan to its specifications while avoiding many of the challenges of self-administering the plan and keeping the risk of agency capture in check.¹⁸² With significant concessions to health care providers and private

¹⁷⁴ See Wash. S.B. 5526 § 3.

¹⁷⁵ H.B. 19-1004, 72nd Gen. Assemb., 1st Reg. Sess. § 25.5-1-129 (1)(a)(VII)(b) (Colo. 2019).

¹⁷⁶ See Ryan Osborne, *Colorado Public Health Insurance Option Put on Hold Due to Covid-19*, DENV. CHANNEL (May 4, 2020), <https://www.thedenverchannel.com/news/local-news/colorado-public-health-insurance-option-bill-put-on-hold-due-to-covid-19> [<https://perma.cc/E2YA-Z7D4>]. The state will likely reintroduce the bill in 2021.

¹⁷⁷ See H.B. 20-1349, 72nd Gen. Assemb., 2d Reg. Sess. § 10-16-1205 (2)(a) (Colo. 2020).

¹⁷⁸ See *id.* § 10-16-1205(1)(b).

¹⁷⁹ See *id.* New Jersey also proposed the creation of the New Jersey Public Option Health Care Board within the Department of Health, but it has less authority, as its power to establish and amend regulations are subject to approval by the Commissioner of Health. See S. 1947, 219th Leg., Reg. Sess. § 5.a. (N.J. 2020).

¹⁸⁰ This includes plan standardization, allocation of federal pass-through funds, the federal waiver application process, value-based payment models, the possibility of offering the Colorado Option Plan in the small group market, and ways to improve quality, access, and affordability of health care. See Colo. H.B. 20-1349 § 10-16-1204(5)(a)–(g).

¹⁸¹ See *id.* § 10-16-1204(6) (allowing override by a vote of seven of nine Board members).

¹⁸² For a detailed description of the membership requirements, appointment proceedings, and powers of the Colorado Option Advisory Board, see *id.* § 10-16-1204.

health carriers, the Colorado legislature passed a scaled-back version of its public option in 2021, described in Part IV below.

By partnering with private commercial carriers to administer and provide MBPO plans, states can dictate certain aspects of the public option, such as provider reimbursement caps and benefit design features, without taking administrative and financial responsibility for the plans themselves. However, this public-private model risks sacrificing much of the potential savings and premium reductions available through a more traditionally public MBPO model.

2. State-Administered MBPOs

Instead of partnering with commercial carriers, several states have proposed a state-administered MBPO.¹⁸³ State-administered MBPOs provide greater control over all aspects of the public option without the constraints of working with commercial carriers, their profit demands, or the concern that carriers may intentionally compromise the public option.

States may authorize the state official in charge of administering the MBPO to contract with third party administrators (“TPAs”), insurance companies that agree to handle only the administrative functions of a plan, to carry-out various tasks including receipt of individual premiums and PTCs.¹⁸⁴ The main difference between this and the hybrid approach taken in Washington is that the state retains the insurance risk, essentially operating like a self-funded plan sponsor with a commercial TPA to administer some portion or all of the plan.¹⁸⁵

While state-administered MBPOs offer states greater autonomy and flexibility to design their public option plan, state administration also creates some challenges. One of the largest challenges is that the ACA requires a state-licensed issuer of insurance to offer QHPs,¹⁸⁶ and PTCs may only be paid to an issuer of a QHP.¹⁸⁷ Without state legislative action, state entities are not generally considered issuers of insurance. Furthermore, the ACA’s risk adjustment program, which stabilizes the individual market by transferring funds from health insurance issuers with lower-risk enrollees to issuers with higher-risk enrollees, is only available to health insurance issuers, so

¹⁸³ See H. 88, 2015 Gen. Assemb., Reg. Sess. (Vt. 2015); H.B. 5733, 98th Gen. Assemb., Reg. Sess. (Ill. 2013); S.B. 697, 191st Gen. Ct., Reg. Sess. (Mass. 2019); S.B. 346, 2020 Gen. Assemb., Feb. Sess. (Conn. 2020); S.F. 2302, 91st Leg., 2019 Reg. Sess. (Minn. 2019).

¹⁸⁴ See, e.g., Conn. S.B. 346 § 2(a)(6); Mass. S.B. 697 § 1 (amending Chapter 176 by adding Chapter 176S which includes Sec. 4 discussing the use of TPAs).

¹⁸⁵ The decision of whether the state retains insurance risk is discussed *infra* Section II.E. 1.

¹⁸⁶ See 42 U.S.C. § 18021(a)(1).

¹⁸⁷ See *id.* § 18082(c)(2)(A) (“The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of [the Internal Revenue Code of 1986] to the issuer of a qualified health plan on a monthly basis”); see also BOOZANG ET AL., *supra* note 38, at 4.

the state would need to qualify as an insurance issuer to participate.¹⁸⁸ The state could have more flexibility to extend risk adjustment to the state-offered MBPO if it runs its own risk adjustment program, but this large undertaking may require the state to operate its own Marketplace.¹⁸⁹

States proposing to administer their MBPOs have tried several approaches. First, Connecticut authorized a state official to contract directly with a TPA to administer the MBPO and receive premiums and premium tax credits.¹⁹⁰ Second, Minnesota passed legislation designating a state entity as an issuer of insurance or a managed care organization capable of offering a QHP and receiving federal PTCs and pass-through funds.¹⁹¹ Third, Massachusetts passed legislation allowing the MBPO to be offered on the Marketplace.¹⁹² Finally, Illinois proposed creating a new state entity authorized by the legislature to stand in the shoes of a carrier for the purposes of administering and funding a QHP offered on the Marketplace.¹⁹³ Each of these options represents a state's attempt to satisfy the ACA's requirement that a QHP be offered by a state-licensed insurance issuer. While none have been implemented or tested, Minnesota's approach appears to the most robust in terms of satisfying the ACA requirements.

In sum, the choice about who administers the public option depends on state agency capacity and political will—the more a state has of both, the more likely it can shoulder MBPO administration. Options that designate a state entity to certify the MBPO for Marketplace eligibility or contract with a TPA to offer the plans on the Marketplace are unlikely to require a Section 1332 waiver because they do not interfere with any of the ACA's specific requirements. However, the creation of an entirely new state entity to design and manage an MBPO on the Marketplace may require a Section 1332 waiver because it would modify the requirements for QHP certification. Whether it does will also depend on the financing features of the new plan.

E. Financial Considerations

Financing for a public option can come from three sources: (1) premiums and cost-sharing; (2) federal funds; and (3) state tax revenues. A public

¹⁸⁸ See 42 U.S.C. § 18063.

¹⁸⁹ See BOOZANG ET AL., *supra* note 38, at 5.

¹⁹⁰ See S.B. 346, 2020 Gen. Assemb., Feb. Sess. § 2(a)(6) (Conn. 2020).

¹⁹¹ See S.F. 2302, 91st Leg., 2019 Reg. Sess. art. 9 § 14 subd. 1(d) (Minn. 2019) (stating that the Dep't of Human Services is deemed to meet and receive certification and authority under Section 62D.03).

¹⁹² See S.B. 697, 191st Gen. Ct., Reg. Sess. § 4 (Mass. 2019) (modifying Chapter 176Q § 5(a) to read: "Only health insurance plans and stand-alone vision or stand-alone dental plans that have been approved by the commissioner and underwritten by a carrier, as well as the public health insurance option, may be offered through the connector.").

¹⁹³ See H.B. 5733, 98th Gen. Assemb., Reg. Sess. § 15 (Ill. 2013) (creating Health Insurance Connector Authority that would operate as independent public entity to develop and administer Illinois public option plan, which must be offered exclusively on Illinois's Marketplace and meet all Marketplace plan requirements).

option that relies only on funding from enrollees may not be affordable, particularly to the remaining uninsured population. Accordingly, many models seek federal funds to offer subsidies to low-income residents, and federal funds from ACA subsidies and pass-through funds for plans sold on the Marketplaces serve as a large well of funding.¹⁹⁴ The ACA provides strong financial incentives for states to offer their public option plans on the Marketplace.¹⁹⁵ At a baseline level, MBPO enrollees are eligible for the federally funded PTCs and CSRs offered through the ACA. Furthermore, if states can qualify for a Section 1332 waiver, the state can also receive pass-through savings from the federal government to help fund the plan.¹⁹⁶ These Marketplace-based financial supports can help bolster states' ability to offer public option plans and drive the decision to offer them on the Marketplace.

All state models we reviewed would finance MBPOs in large part through premiums paid by enrollees. Where states differ is whether the state or commercial carriers bear the financial risk of offering the MBPO plans. A second financial consideration is what cost control mechanisms to implement. There is a relationship between the two—the more financial risk and administrative burden a state can shoulder, the greater the potential savings it can generate.

1. *Financial Risk-Bearing*

As with administration, a state can shift financial risk and the attendant resources to manage the risk (such as maintaining adequate financial reserves) to commercial carriers offering MBPO plans. In this public-private model, commercial carriers bear the insurance risk in exchange for the ability to earn a profit from the public option. Colorado noted the value of this type of model in its Final Report, stating “[t]he public option will not put the State budget at risk. Insurance companies—not the State—will bear the risk for the payment of health claims, as they currently do in the Individual market.”¹⁹⁷ Yet, the reduction in risk comes at the expense of working through profit-driven commercial insurers, which may compromise cost-savings overall.

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;¹⁹⁸ (2) requiring the insurance commissioner to

¹⁹⁴ See 26 U.S.C. § 36B (providing PTCs on Marketplace); 42 U.S.C. § 18071 (providing CSRs); see generally Matthew B. Lawrence, *Fiscal Waivers and State “Innovation” in Health Care*, 62 WM. & MARY L. REV. 1477, 1487–92 (2021) (noting that these funds are “big money”).

¹⁹⁵ See *supra* notes 61–65 and accompanying text.

¹⁹⁶ See *supra* notes 148–51 and accompanying text.

¹⁹⁷ COLO. REP. ON THE PUB. OPTION, *supra* note 155, at 17.

¹⁹⁸ For example, Virginia’s H.B. 530 would require commercial carriers to design MBPO plans to limit increases in premium rates, while the state does not take an active role in setting

regulate how commercial carriers set premiums;¹⁹⁹ (3) requiring the insurance commissioner to review and approve proposed rates; and (4) designating a state agency to establish premiums for the MBPO. States may also combine approaches. Washington requires carriers offering the public option plan to have their rates reviewed and approved by the Insurance Commissioner.²⁰⁰ Granting the Insurance Commissioner the authority to deny premium rates and even provider rate increases, as Rhode Island has done, can restrain premium growth and provide an additional lever to control provider reimbursement rates.²⁰¹ Public-private partnership models shift the state's financial risk to insurers, while allowing the state to retain some oversight over MBPO premiums, particularly if the state grants the Insurance Commissioner prior approval authority.

Other states would retain financial risk and administer the financial aspects of the MBPO, including setting premiums and cost sharing, to control costs.²⁰² By retaining financial risk, the state can keep the MBPO revenues rather than having them go to insurance carrier profits. States typically propose implementing this model by assigning financial responsibility to existing state agencies.²⁰³ For instance, Minnesota's S.F. 2302 would make the Commissioner of Human Services responsible for ensuring the financial sustainability of the MBPO, establishing premiums and provider payment rates, accounting for administrative costs, and creating a reserve account within the state treasury to collect enrollee premiums and pay claims.²⁰⁴ The Commissioner would be able to accept and expend all federal funds available to the state through the MBPO.²⁰⁵ Similarly, Massachusetts' 2019 MBPO proposal would grant the Commonwealth Connector, the state Marketplace, the authority to set premiums for the public health insurance option and estab-

or approving premium rates for the MBPO. *See* H.B. 530, 2020 Gen. Assemb., Reg. Sess. § 32.1-329.1(D) (Va. 2020).

¹⁹⁹ *See, e.g.*, H.B. 20-1349, 72d Gen. Assemb., 2d Reg. Sess. § 10-16-1205 (3)(b) (Colo. 2020) (allowing carriers to establish premium rates for the Colorado Option plan, but requiring the Insurance Commissioner to adopt rules "concerning the premium amounts for silver plans" based on their actuarial value).

²⁰⁰ *See* S.B. 5526, 66th Leg., 2019 Reg. Sess. § 3(1) (Wash. 2019).

²⁰¹ Although none of the state MBPO proposals we reviewed included this authority, Rhode Island has given its Insurance Commissioner broad authority to disapprove of insurance premiums or contracts if they exceed caps on provider reimbursement increases. This authority could be added to premium oversight in an MBPO to enforce provider reimbursement limits in the MBPO plan. *See* Aaron Baum, Zirui Song, Bruce E. Landon, Russell S. Phillips, Asaf Bitton & Sanjay Basu, *Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers*, 38 HEALTH AFFS. 237, 242-43 (2019).

²⁰² *See* S.B. 346, 2020 Gen. Assemb., Feb. Sess. 2020 §§ 2, 4 (Conn. 2020); S.F. 2302, 91st Leg., 2019 Reg. Sess. art. 9 § 14 subd. 1 (Minn. 2019); S.B. 697, 191st Gen. Ct., Reg. Sess. § 6 (Mass. 2019); H.B. 5733, 98th Gen. Assemb., Reg. Sess. § 35 (Ill. 2013).

²⁰³ *But see* Ill. H.B. 5733 § 35 (creating a new public entity, the Health Insurance Connector Authority, to administer the public health option).

²⁰⁴ *See* Minn. S.F. 2302 art. 9 § 14 subd. 1(b), 1(e), 3-4.

²⁰⁵ *See id.* art. 9 §§ 14 subd. 1(b)(2), 15 subd. 3 (specifically noting that the Department of Human Services is not an insurance company).

lish the Public Health Insurance Option Fund to hold funds designated for public option plans.²⁰⁶

In sum, states must determine how much to invest in MBPO plan financing based on their policy goals. Avoiding reliance on commercial carriers will improve affordability and expand coverage, but will also place the state at greater financial risk.

2. *Cost Control*

Regardless of a state's financing strategy, all states considering a public option plan seek to reduce the cost of health care. While MBPO plans employ a range of cost control mechanisms,²⁰⁷ provider payment caps hold the most promise for reducing costs throughout the Marketplace.

Nearly all MBPO bills would limit provider payments to a percentage of Medicare rates or other established payment schedule.²⁰⁸ Medicare-based caps on provider rates ranged from 100% of Medicare rates in Virginia to 160% of Medicare in Washington.²⁰⁹ Establishing provider payment rates is often the most politically contentious aspect of an MBPO. As a result, some state legislatures proposed delegating decisions regarding provider payments and participation to the state agency leading implementation.²¹⁰

In terms of controlling provider rates, the Colorado legislature went through several iterations. Initially, the legislature proposed setting the benchmark for provider payments between 175% and 225% of Medicare rates, but instead its 2020 bill charged the Commissioner of Insurance with establishing “a clear, public, and transparent formula, which may very well fall in that range, but importantly, will be applied on a hospital-by-hospital

²⁰⁶ See Mass. S.B. 697 §§ 1, 3.

²⁰⁷ Aside from provider payment caps, states have increased medical loss ratios and implemented pharmaceutical cost controls. See, e.g., H.B. 20-1349, 72nd Gen. Assemb., 2d Reg. Sess. § 10-16-1205(2)(a)(VI)–(VII) (Colo. 2020) (raising the medical loss ratio to eighty-five percent and requiring all carriers to pass-through pharmaceutical rebates); Conn. S.B. 346 § 2(a)(2)(F) (raising the medical loss ratio to ninety percent); S.B. 5526, 66th Leg., 2019 Reg. Sess. § 3(2)(j) (Wash. 2019) (promoting generic substitution and evidence-based formularies).

²⁰⁸ See Minn. S.F. 2302 art. 9 § 14 subd. 3 (basing provider payments rates for the state's Basic Health Plan); Mass. S.B. 697 § 1 (basing payment rates on Medicare Parts A and B with adjustments); H.B. 5733, 98th Gen. Assemb., Reg. Sess., § 40 (Ill. 2013) (mirroring Massachusetts); Colo. H.B. 20-1349 § 10-16-1206(1)(c) (establishing a base rate of 155% of Medicare rates with adjustments); Wash. S.B. 5526 § 3(2)(g)(i) (stating that total qualified health plan reimbursement cannot exceed 160 % of Medicare rates); H.B. 530, 2020 Gen. Assemb., Reg. Sess. § 32.1-329.1(D) (Va. 2020) (stating rates shall not exceed Medicare rates).

²⁰⁹ See, e.g., Va. H.B. 530 § 32.1-329.1(D); Wash. S.B. 5526 § 3(2)(g)(i).

²¹⁰ See, e.g., Conn. R.B. 346 § 2(c)(1)(B), (D) (Conn. 2020) (charging the Comptroller with developing both “strategies to ensure that health care providers and health care facilities in this state participate in the ConnectHealth Plan;” and “a proposed schedule of the initial payments and reimbursement rates for the ConnectHealth Plan.”); Colo. H.B. 20-1349 § 10-16-1206(1)(a) (requiring the Commissioner to implement a formula that “sets reasonable carrier reimbursement rates” and helps “lower premiums and out-of-pocket costs for consumers and to increase access to health care in rural areas.”).

basis to incentivize efficiency and results.”²¹¹ Colorado recognized not all hospitals were equally able to reduce rates without compromising patient care and access, particularly critical access hospitals and smaller, independent hospitals.²¹² To address this variability, the 2020 bill proposed a reimbursement formula considering a range of factors, including: (1) a hospital’s payer mix; (2) whether the hospital is critical access, rural, urban, independent, or part of a larger system; (3) patient margins, total margins, and accumulated earnings over time; and (4) administrative expenses compared to national norms.²¹³ Under this formula, the base hospital payment rate would be 155% of Medicare rates, with increases for specified providers.²¹⁴ Designed to rein in costs over time, the formula would have evolved in response to analysis of its impact on critical access, rural, and other vulnerable hospitals.²¹⁵ As Washington did initially but later repealed,²¹⁶ Colorado’s 2020 bill would have granted the Commissioner the discretion to exempt hospitals that demonstrated that the prescribed reimbursement rate would have “a significant adverse effect on its financial sustainability.”²¹⁷ Interestingly, Colorado’s 2021 legislation shifted tactics away from provider rate controls to focus on achieving a fifteen percent premium reduction over three years.²¹⁸ The Commissioner can only set rates, for which the hospital base rate remains 155%, if the carriers cannot achieve the required premium reductions.²¹⁹ Furthermore, the Commissioner cannot set the final hospital reimbursement rate less than 165% of Medicare rates.²²⁰

Overall, regulating provider payment rates for MBPOs will be one of the most politically challenging and practically difficult implementation tasks, but it is also one of the most important for controlling costs.

F. Market Effects

In addition to controlling costs, states must account for the effect of MBPOs on Marketplace dynamics. Several state bills require those implementing an MBPO to submit reports to the legislature regarding the impact

²¹¹ *Id.* Colo. H.B. 20-1349 § 10-16-1206(1); COLO. REP. ON THE PUB. OPTION, *supra* note 156, at 13.

²¹² *See* COLO. REP. ON THE PUB. OPTION, *supra* note 156, at 13.

²¹³ *Id.*

²¹⁴ *See* Colo. H.B. 20-1349 § 10-16-1206(1)(c) (adding twenty percentage points to rates for either critical access or independent hospitals among others).

²¹⁵ *See* COLO. REP. ON THE PUB. OPTION, *supra* note 156, at 13–14; Colo. H.B. 20-1349 § 10-16-1206(2) (requiring the Colorado Public Option Board to advise the Commissioner on modifications to the reimbursement formula and the percentage point adjustments after the first two years of the program).

²¹⁶ *See supra* Introduction.

²¹⁷ Colo. H.B. 20-1349 § 10-16-1206(2)(5)(a) (requiring the Commissioner to make this decision in consultation with the Department of Health Care Policy and Financing and the Board).

²¹⁸ *See* Colo. H.B. 21-1232 § 10-16-1304(1); *infra* Part IV.

²¹⁹ *See* Colo. H.B. 21-1232 § 10-16-1306(4)(a)(II).

²²⁰ *See* Colo. H.B. 21-1232 § 10-16-1306(5)(a).

or potential impact of the MBPO on the health care market, including provider and plan participation, federal funding, cost-shifting, and risk adjustment.²²¹

1. *The Potential for the MBPO to Reduce Provider and Plan Participation*

The introduction of an MBPO can disrupt both provider and plan participation in certain markets, especially if the provider rate or premium controls are significant. States designing MBPOs have implemented a range of provisions that either incentivize or require provider and plan participation.

The largest potential market effect from an MBPO is the reduction in provider participation resulting from price controls, which can, in turn, compromise plan participation. In setting provider payment rates, state policy-makers must balance the desire for cost savings against the need to retain sufficient provider participation to satisfy network adequacy requirements.²²² If provider payment rates sink too low, providers will not participate in MBPO plans, threatening their viability. While states have exercised some leverage to require commercial carriers that offer plans on the Exchange to also offer MBPO plans, most MBPO bills do not require provider participation. Instead, to encourage provider participation, state MBPO proposals rely on: (1) commercial carriers;²²³ (2) automatic enrollment of Medicare providers with an opt-out;²²⁴ and (3) payment rates.²²⁵

Washington's experience highlights the difficult balancing act of setting provider rates and ensuring provider participation. State representative Eileen Cody, the architect of S.B. 5526, originally sought a reimbursement cap at 100% of Medicare rates, but the final legislation increased the rate cap to 160% of Medicare, calculated in aggregate. At this level, actuaries estimated that carriers could offer public option premiums five to ten percent cheaper than current Marketplace premiums without destabilizing the insurance markets and alienating providers.²²⁶ However, the 160% of Medicare rate cap may have been too low to attract providers and too high to reduce premi-

²²¹ See S.B. 5526, 66th Leg., 2019 Reg. Sess. § 5 (Wash. 2019); Colo. H.B. 20-1349 § 10-16-1207; R.B. 346, 2020 Gen. Assemb., Feb. Sess. § 2(a)(5)(Conn. 2020); S.F. 2302, 91st Leg., 2019 Reg. Sess. §§ 14 subd. 1(b)(2), 15 subd. 2 (Minn. 2019); S.B. 697, 191st Gen. Ct., 2019–2020 Sess. § 5 (Mass. 2019); H.B. 5733, 98th Gen. Assemb., Reg. Sess. § 30 (Ill. 2013).

²²² See Chapin White, Christine Eibner, Jodi L. Liu, Carter C. Price, Nora Leibowitz, Gretchen Morley, Jeanene Smith, Tina Edlund & Jack Meyer, *A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon*, RAND HEALTH Q., 2017, at 1, 4. Network adequacy laws require health plans to include sufficient numbers of providers within a certain geographic area in their networks to provide care to the patient population.

²²³ See Va. H.B. 530 § 32.1-329.1(A).

²²⁴ See, e.g., Ill. H.B. 5733 § 45; Mass. S.B. 697 § 8.

²²⁵ See Wash. S.B. 5526 § 2(g)–(i) (establishing a payment floor for primary care providers at 135%).

²²⁶ Sparer, *supra* note 38, at 265 (noting that the aggregate cap allows plans to pay some providers more than 160% of Medicare and others less).

ums.²²⁷ At least one carrier found providers, especially hospitals, reluctant to contract even at 160% of Medicare rates.²²⁸ In its first year, 2021, insurers offered public option plans in only twenty of the state's thirty-nine counties.²²⁹ Washington responded by passing S.B. 5377 in 2021, which provides that if a public option plan is not offered in every county, any hospital licensed in the state that provides services to enrollees in the public or school employee benefit programs or Medicaid must contract with at least one public option plan.²³⁰ In addition, the average proposed 2021 premium for plans offered via the CascadeCare public exchange was five percent higher than the 2020 average Marketplace premium and varied among carriers and geographic areas.²³¹ These proposed CascadeCare premiums represent some carriers' first attempt to rate the Washington public option population, and they may stabilize with experience. If not, states may need to incorporate additional tools to improve MBPO affordability.

To address the hydraulic relationship of provider rates and network participation, MBPO legislation often includes exceptions to ensure sufficient provider participation. For instance, Washington's MBPO law initially allowed the Director of the Health Care Authority, in his or her sole discretion, to waive the provider payment cap of 160% of Medicare rates for any carrier that is "unable to form a provider network that meets the network access standards adopted by the insurance commissioner" but remains able "to achieve actuarially sound premiums that are ten percent lower than the previous plan year through other means."²³² In its effort to strengthen the public option in 2021, Washington eliminated this waiver authority with the passage of S.B. 5377, which also requires hospital participation if all counties were not covered by a public option plan by 2022.²³³ To encourage participation, Washington also included a minimum payment threshold of 101% of Medicare rates for rural critical access hospitals and sole community hospitals, as well as 135% of Medicare rates for primary care providers.²³⁴

Policymakers designing Colorado's 2020 public option proposal also stressed the importance of ensuring provider participation for public option viability, noting that "if there are areas where networks are not adequate, the State could implement measures to ensure that health systems participate

²²⁷ See Hansard, *supra* note 20.

²²⁸ See *id.*

²²⁹ See Louise Norris, *Washington's Health Insurance Marketplace: History and News of the State's Exchange*, HEALTHINSURANCE.ORG (Sept. 1, 2021), <https://www.healthinsurance.org/health-insurance-marketplaces/washington/> [<https://perma.cc/YU4A-6J3M>].

²³⁰ See S. 5377, 67th Leg., Reg. Sess. (Wash. 2021).

²³¹ See *id.*; Norris, *supra* note 229. For instance, Community Health Network of Washington, a non-profit carrier that offers Medicaid managed care plans, proposed lower CascadeCare premiums than the benchmark silver plan in certain areas, while United Healthcare of Washington proposed monthly premiums for the CascadeCare plan for a forty-year-old non-smoker that were fifty dollars higher than premiums for a comparable silver tier non-standardized plan.

²³² See S. 5526, 66th Leg., Reg. Sess. (Wash. 2019).

²³³ See Wash. S. 5377.

²³⁴ See *id.*

and provide cost effective, quality care to covered individuals.”²³⁵ Colorado’s 2020 bill took a stronger position than Washington did initially, requiring hospitals licensed by the Department of Health Care Policy and Financing, with some exceptions, to participate in the Colorado Option plan and accept its reimbursement rates.²³⁶ The Department could fine hospitals that refuse to participate up to \$10,000 for the first thirty days and up to \$40,000 a day thereafter, and could suspend, revoke, or impose conditions on the hospital’s license.²³⁷ Yet, the two states ended up switching places—with Washington adding a requirement in 2021 for hospitals to participate in the public option and Colorado limiting its hospital participation and rate-setting requirements to instances where it is established in a series of hearings that a carrier is unable to meet the required premium reductions or network adequacy requirements due to hospital recalcitrance.²³⁸

Unlike Washington, Colorado has consistently required plan participation. The 2020 bill would have required all carriers that offer a health plan in the individual markets to also offer the Colorado Option Plan in the same county.²³⁹ The 2021 legislation maintained this requirement for standardized plans in the individual and small group markets.²⁴⁰ Furthermore, the Commissioner, subject to certain considerations, can compel a carrier to offer the standardized plan in specific counties where no carrier is offering the standardized plan.²⁴¹ By requiring plan participation and minimum premium reductions, the Colorado legislation bolsters insurance companies’ abilities and incentives to wrest price reductions from providers.

Whether through mandated participation or participation requirements only if certain premium and coverage goals are not met, states implementing a public option need a mechanism to monitor and, if needed, require provider and plan participation in the public option.

2. *The Impact of MBPO on Federal Funding*

Introducing an MBPO plan into the Marketplace could also inadvertently increase consumers’ premium costs for commercial Marketplace plans by reducing the amount of premium tax credits, which are calculated based on the second-cheapest silver plan on the Marketplace.²⁴² If the MBPO

²³⁵ COLORADO REPORT ON THE PUBLIC OPTION, *supra* note 155, at 20.

²³⁶ See H.R. 20-1349, 72d Gen. Assemb., 2d Reg. Sess. (Colo. 2020).

²³⁷ See *id.*

²³⁸ See S. 5377, 67th Leg., Reg. Sess. (Wash. 2021); H.R. 21-1232, 73d Gen. Assemb., Reg. Sess. (Colo. 2021).

²³⁹ See Colo. H.R. 20-1349 .

²⁴⁰ See Colo. H.R. 21-1232.

²⁴¹ See *id.*

²⁴² See *Key Facts: Premium Tax Credit*, HEALTH REFORM: BEYOND THE BASICS, (Aug. 2020), <https://www.healthreformbeyondthebasics.org/premium-tax-credits-answers-to-frequently-asked-questions/> [<https://perma.cc/E6W3-7K4B>] (explaining how the benchmark plan premium interacts with the premium tax credit and other plans on the market).

reduces premiums for the second-lowest silver plan, then, absent a Section 1332 waiver, all the premium tax credits would also decline.²⁴³

The Final Report for Colorado's Public Option recommends the state apply for a Section 1332 waiver to enable the state to "draw down federal savings that would otherwise be spent on tax credits for higher-premium QHPs absent the lower-cost public option."²⁴⁴ The state could then use these pass-through funds to provide additional subsidies to improve affordability on the Marketplace, including extending CSRs to individuals earning up to 400% of FPL, funding additional high-value benefits, such as dental care, or increasing premium subsidies available to enrollees.²⁴⁵ Without a Section 1332 waiver, the state would lose access to any federal savings that resulted from its public option plans, and effectively increase the unsubsidized premium costs of non-MBPO plans on the Marketplace.

3. *Cost Shifting*

All states seek to use the MBPO to control health care costs, both directly through caps on provider payments and indirectly through competition. Yet some fear that MBPOs' rate limits may cause providers and insurers to increase their rates and premiums, respectively, in other markets.²⁴⁶ While the empirical literature casts doubt on the extent of cost shifting between public and private payers,²⁴⁷ state public option proposals include mechanisms to monitor for this potential effect. As noted in the Final Report for Colorado's Public Option, "cost shifting only happens if we let it."²⁴⁸ The Final Report also identified several policy tools to prevent the threat of cost shifting, including expanding the public option to the small group market, transitioning provider payment rates gradually, and publishing the public option rates for use in private payers' negotiations with providers.²⁴⁹ Colorado authorized the Commissioner to monitor commercial health insurers for cost-shifting attempts and disapprove the requested rate increase if "the rate filing reflects a cost shift between the standardized plan . . . and the health

²⁴³ See UCCELLO, *supra* note 109, at 14.

²⁴⁴ COLORADO REPORT ON THE PUBLIC OPTION, *supra* note 155, at 23–24 (estimating that Colorado would receive approximately \$89 million per year in federal pass-through savings); see also Colo. H.B. 21-1232 § 10-16-1308(1) (granting the Commissioner the authority to apply for a Section 1332 waiver to capture all applicable savings to the federal government).

²⁴⁵ See COLORADO REPORT ON THE PUBLIC OPTION, *supra* note 155, at 23.

²⁴⁶ See *id.* at 16.

²⁴⁷ See, e.g., Austin B. Frakt, *How Much Do Hospitals Cost Shift? A Review of the Evidence*, 89 MILBANK Q. 90, 123 (2011); Chapin White, *Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates*, 32 HEALTH AFFS. 935, 941 (2013); David Dranove, Craig Garthwaite & Christopher Ody, *How Do Hospitals Respond to Negative Financial Shocks? The Impact of the 2008 Stock Market Crash* 29 (Nat'l Bureau of Econ. Rsch., Working Paper No. 18853, 2013); Chapin White & Tracy Yee, *When Medicare Cuts Hospital Prices, Seniors Use Less Inpatient Care*, 32 HEALTH AFFS. 1789, 1794 (2013).

²⁴⁸ COLORADO REPORT ON THE PUBLIC OPTION, *supra* note 155, at 17.

²⁴⁹ See *id.*

benefit plan” requesting the rate increase.²⁵⁰ The combination of a transparent formula for calculating public option rates and an Insurance Commissioner with the power to review and approve both commercial carrier rates and the negotiated provider rates helps safeguard against any potential cost shifting.

4. Adverse Selection and Risk Adjustment

States might also be wary that the MBPO could attract higher-risk, unhealthier enrollees, which could drive up the cost of the MBPO and threaten its financial viability. States can implement safeguards to minimize these risks, such as risk adjustment or reinsurance, but they may need the additional regulatory flexibility that comes with a state-run Marketplace and a Section 1332 waiver to do so. Offering a public option plan both on and off the Exchange or altering the MBPO’s benefit design or benefits can shift enrollment patterns in ways that affect premiums and challenge risk adjustment methods.²⁵¹ To address this risk, states introducing an MBPO into the individual and small group markets can alleviate fear that the public option plan will destabilize the market by including the MBPO in state risk adjustment programs.²⁵²

Of all MBPO bills, Colorado’s 2020 bill proposed the most extensive market oversight framework. It would have required an annual evaluation and report to the legislature of the public option’s effect on the individual market, cost shifting between markets, the premium tax credits and cost sharing reductions received by individuals, and the adequacy of provider networks.²⁵³ In addition, the bill would require an evaluation of “the impact of the Colorado Option Plan on hospital sustainability, the health care workforce, and health care wages” be reported to the legislature.²⁵⁴

Regardless of policy goals, all states should monitor the MBPO’s impact on the healthcare markets to ensure the plan is having the desired effect and not causing unintended harm. To do so, states need access to data that shows both price and utilization for both providers and insurers, whether from a state’s all-payer claims database (“APCD”) or direct reporting from the Marketplace.²⁵⁵

Overall, MBPOs offer states significant flexibility in achieving their policy goals, access to federal funding, and coverage untethered to employment. States can design MBPOs to accommodate various levels of adminis-

²⁵⁰ Colo. H.B. 21-1232 § 2 (amending Colo. Rev. Stat. § 10-16-107).

²⁵¹ See UCCELLO, *supra* note 109, at 14.

²⁵² See, e.g., S.B. 697, 191st Gen. Ct., 2019–2020 Sess. §§ 2, 8K(a) (Mass. 2019); H.B. 5733, 98th Gen. Assemb., Reg. Sess. § 155.44 (Ill. 2013).

²⁵³ See Colo. H.B. 20-1349 § 10-16-1207(1).

²⁵⁴ *Id.* at § 10-16-1207(2).

²⁵⁵ See, e.g., Conn. R.B. 346 § 2(a)(5); Minn. S.F. 2302 § 15 subd. 2 (permitting the Commissioner to use APCD data to evaluate the impact of OneCare on the individual market, and to require submission of additional information to the state APCD).

trative burden and financial risk by allowing state entities to contract with commercial insurers or administer the MBPO itself. Yet, decisions regarding state administration and financing face tradeoffs between cost control and commitment of state resources. In addition, certain plan designs may require the additional burden of obtaining a Section 1332 waiver.

III. COMPREHENSIVE PUBLIC OPTIONS

Comprehensive public option plans are the broadest category of state-sponsored plans. They are “comprehensive” in terms of whom they target (e.g., any resident), their benefits and provider network, and their anticipated disruption in the health insurance market. The most ambitious Comprehensive public option plans are closest to state single-payer plans, despite their acknowledgement that a multi-payer system will persist. In Comprehensive public option plans, the state is assertively entering the market—either as an insurer itself or through broad regulation of a commercially administered plan—to offer a public source of coverage to all residents. We found fifteen bills proposing Comprehensive public option plans in five states: Massachusetts, Michigan, New Jersey, Vermont, and Washington.²⁵⁶ Some of these models straddle both categories for Marketplace-based plans and Comprehensive plans.

A. Policy Goals

The policy goals of the Comprehensive public option include achieving universal coverage untethered from employment, applying the state’s rate setting-authority to the commercial insurance market to control health care costs, simplifying administrative burdens, reducing fragmentation, and at its most ambitious, providing a glide-path to a state single-payer system.²⁵⁷ These policy goals are more ambitious than those of the Medicaid buy-in or MBPO plans that target a narrower, dysfunctional segment of the individual market or cover the remaining uninsured. Comprehensive plans also try to reduce fragmentation to pursue administrative simplification and unify the risk pools of large, small, and individual markets into one state-sponsored plan.²⁵⁸ The potential cost-savings for Comprehensive public option plans are greater than their narrower counterparts because the rate-controls and reduced administrative costs are implemented across a broader swath of the market, including the large-group market.²⁵⁹

²⁵⁶ See Appendix A.

²⁵⁷ See, e.g., H.B. 1104, 66th Leg., 2019 Reg. Sess. § 1 (Wash. 2019) (declaring the people’s intentions in the preamble).

²⁵⁸ See, e.g., H. 28, Gen. Assemb., 2017–2018 Reg. Sess. § 1852(a)(4) (Vt. 2017) (providing that “[a]ll participants in the Vermont Public Option shall be maintained in a single risk pool”).

²⁵⁹ See, e.g., Wash. H.B. 1104 § 1.

B. Target Population

Comprehensive public option plans are state-sponsored plans available to anyone in the state—a broad combination of different health insurance market segments, including large groups (both public and private employers), small groups, individuals, and possibly those with Medicaid coverage.

In some proposals, the Comprehensive public option plan would be available to any resident of the state.²⁶⁰ For example, New Jersey's S. 1947 provides that "Every resident of the State shall be eligible and entitled to enroll as a member under the program."²⁶¹ Other Comprehensive plans have broad eligibility, but apply different rules or defaults to the different segments of the market. For example, a 2015 Vermont bill proposed a public option plan that would cover all public employees automatically and be offered to all other residents, except those eligible for Medicare or Medicaid.²⁶² Finally, Massachusetts proposed a public option plan that straddles the categories for Marketplace-based and Comprehensive plans. These plans would be offered exclusively on the Marketplace, which traditionally only serves the individual and small group markets, and would be available to large groups in the future.²⁶³

C. Legal Issues for Comprehensive Public Option Plans

The distinguishing feature of Comprehensive plans is that they explicitly include the large group markets—those with employer-based coverage. Reaching those with employer-based coverage means that, in addition to the legal requirements for Marketplace or Medicaid-based plans, Comprehensive plans also must contend with ERISA—the federal law that governs employer-based health benefits—and federal tax laws that subsidize employer spending on health benefits and limit the tax deductibility of state taxes, which may be needed to finance the plan. Because they would also target the individual market and Medicaid, the legal framework for Comprehensive public option plans rests upon the same legal requirements for Medicaid plans and Marketplace-based plans, described above.

Due to the resemblance between Comprehensive public option plans and state single-payer plans, the legal issues of public option plans are comparable to those of single-payer plans.

²⁶⁰ See, e.g., H.B. 6285, 2018 Leg., Reg. Sess. § 202 (Mich. 2018); S.B. 5222, 66th Leg., 2019 Reg. Sess. § 101 (Wash. 2019); Wash. H.B. 1104.

²⁶¹ S. 1947, 219th Leg., Reg. Sess. § 6 (N.J. 2020).

²⁶² See H. 88, 2015 Leg., Reg. Sess. § 1853 (Vt. 2015).

²⁶³ See S.B. 697, 191st Gen. Ct., 2019–2020 Sess. § 1 (Mass. 2019). Lawmakers in Massachusetts have introduced substantially similar public option bills in every legislative session in our search period. See *supra* note 147.

1. ERISA Preemption

One of the biggest legal hurdles states face in comprehensive health reform is ERISA, which generally hampers states' abilities to regulate employer-based health benefits and places self-funded employer plans beyond the reach of state laws. ERISA's preemption provision expressly preempts "any and all" state laws that "relate to" employee benefit plans.²⁶⁴ As comprehensively described elsewhere in the literature on public benefits law, the scope of "relates to" is so indeterminate that it has spawned a convoluted and voluminous jurisprudence struggling to define the bounds of ERISA's sweeping preemption.²⁶⁵

The rule articulated by the courts is that a state law is preempted if it bears an "impermissible connection with" an ERISA plan.²⁶⁶ This occurs when a state law requires sponsors "to structure their plans in particular ways, such as requiring payment of specific benefits," or if it directly or indirectly produces "acute . . . economic effects" which would "force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers."²⁶⁷ In other words, state laws that mandate employers adopt, alter, or administer their employee benefit plans in compliance with state law are preempted because they bear an "impermissible connection with" and thus "relate to" an ERISA plan.²⁶⁸ However, courts have recognized a limit on what it means to "relate to" an ERISA plan. To the extent that the presence of a public option may "merely increase costs or alter incentives for ERISA plans," state laws with such economic effects are not preempted by ERISA.²⁶⁹

The legal question is whether ERISA would preempt a Comprehensive state public option plan offered to employers. ERISA would preempt states from mandating that employers participate in the state plan,²⁷⁰ but state public option proposals that merely nudge, rather than require, employer participation would find surer footing. The ERISA analysis turns on whether the plan's funding mechanisms, such as payroll taxes, cross the line into a "Hob-

²⁶⁴ 29 U.S.C. § 1144(a) (included as Section 514 in the ERISA).

²⁶⁵ See, e.g., Erin C. Fuse Brown & Elizabeth McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. PENN. L. REV. 389, 392–93 (2020); Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, 37 J.L. MED. & ETHICS 88, 89–90 (2009).

²⁶⁶ See *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016). A state law may also be preempted if it makes "reference to" an ERISA plan, but that test is not applicable here. See *Rutledge v. Pharm. Care Mgmt. Ass'n*, 141 S. Ct. 474, 478 (2020).

²⁶⁷ *Rutledge*, 141 S. Ct. at 480; *Gobeille*, 136 S. Ct. at 943; N.Y. State Conf. of B.C.B.S. Plans v. Travelers Ins. Co., 514 U.S. 645, 668 (1995); see *Gobeille*, 136 S. Ct. at 943 (collecting cases); see also *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 146–47 (2001); *Shaw v. Delta Air Lines*, 463 U.S. 85, 97–100 (1983) (finding that laws effectively requiring employers to "pay employees specific benefits" are preempted).

²⁶⁸ This includes data reporting requirements by self-funded employer plans. See *Gobeille*, 136 S. Ct. at 943.

²⁶⁹ *Rutledge*, 141 S. Ct. at 480; see also *Travelers*, 514 U.S. at 668.

²⁷⁰ See Fuse Brown & McCuskey, *supra* note 265, at 393.

son's choice" for the employer, forcing the employer to change or drop its employee health plan in favor of the public option plan.²⁷¹ A state law that imposes such a forced choice on the employer would be preempted.

State public option plans avoid ERISA preemption because they simply offer the state plan as a voluntary option to employers. Compared to a single-payer plan, a public option more clearly and readily preserves for employers the choice of maintaining their employee benefit plans, which should place them on firmer ground under ERISA than single-payer plans. Unlike state single-payer plans, which nearly all rely on payroll taxes either alone or together with income taxes or other individual assessments,²⁷² the Comprehensive public option plans use a more diverse set of funding mechanisms and vary in their reliance on employers to collect, remit, and pay for their employees' enrollment in the state public option plan. After all, neither the employees nor the employers are required to participate in the state public option plan. Yet a more granular examination of the various funding mechanisms employed by particular public option proposals is necessary to determine whether they would avoid ERISA preemption.

For example, a Comprehensive public option like New Jersey's A.B. 1343 would rely on individual premiums.²⁷³ A state-assessed individual premium would not implicate ERISA because it does not target employers, and, unless the employer is required to collect the premium from its employees, does not involve the employer at all.²⁷⁴ The problem with a premium-only model is that the state might not capture all the current employer expenditure on health benefits. Currently, employers pay eighty-three percent of the premiums for individual coverage and seventy-three percent for family coverage.²⁷⁵ Although the employer contribution comes out of the employee's wages, the premium that an employee experiences is only a small fraction of the total cost.²⁷⁶

²⁷¹ See *id.* at 433.

²⁷² See *id.* at Table 2, 413 (finding that 45 of 66 state single-payer proposals contained a funding mechanism including payroll taxes).

²⁷³ A.B. 1343, 218th Leg., 2018–2019 Reg. Sess. § 10.c. (N.J. 2018); see also H.146, 2011 Leg., Reg. Sess. § 1806 (3)(c) (Vt. 2011) (requiring employers to deduct premiums upon request, presumably of the employee).

²⁷⁴ See, e.g., Vt. H. 146 § 1806 (3)(c) (requiring employers to deduct premiums upon request, presumably of the employee).

²⁷⁵ See GARY CLAXTON, MATTHEW RAE, GREGORY YOUNG & DANIEL McDERMOTT, KAISER FAM. FOUND., 2020 EMPLOYER HEALTH BENEFITS SURVEY 81 (2020), <http://files.kff.org/attachment/Report-Employer-Health-Benefits-2020-Annual-Survey.pdf> [perma.cc/9K56-22B9].

²⁷⁶ See generally Jonathan Gruber, *Health Insurance and the Labor Market* (Nat'l Bureau of Econ. Rsch., Working Paper No. 6762, 1998) (reviewing the empirical literature and finding "a fairly uniform result: the costs of health insurance are fully shifted to wages"); Matthew Rae, Rebecca Copeland & Cynthia Cox, *Tracking the Rise in Premium Contributions and Cost-Sharing for Families with Large Employer Coverage*, PETERSON-KFF HEALTH SYS. TRACKER (Aug. 14, 2019), <https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/> [https://perma.cc/S446-AUCG]; *Economic News Release: Table 3 Medical Plans: Share of Premiums Paid by Employer and Employee for Single Coverage*, U.S. BUREAU OF LAB. STAT., <https://>

If a state public option were to rely solely on individual premiums rather than payroll taxes, it would lack a mechanism to capture the employer's share of the cost of coverage. But requiring the employer to pay a percentage of the employee's public option premium or even collect and remit the employee's premium share could potentially amount to an impermissible employer mandate that would be preempted by ERISA.²⁷⁷ Thus, the employer's contribution to or collection of premiums should be voluntary to avoid entanglement with ERISA.

Other Comprehensive public option plans would rely on payroll taxes to fund the public option and capture the employer health benefit expenditures, raising the question of whether these payroll taxes would be preempted by ERISA. Bills in Vermont and Washington²⁷⁸ would rely on a combination of premiums and payroll taxes to fund their public option plans. Vermont would assess a payroll tax on the employer, calculated as a percentage of an employee's gross wages with no exemption for employers that offered employer-based coverage.²⁷⁹ While Vermont's bills do not prohibit employers from offering employer-based coverage, they would not allow individuals to have plans with overlapping coverage, only supplemental.²⁸⁰ The mandatory payroll taxes in Vermont's H.B. 146 and H.B. 88 are unlikely to implicate ERISA (as they do not regulate an ERISA plan),²⁸¹ and the public option plan would provide employers with a meaningful choice between maintaining their own plans or the state plan, thus avoiding a preempted forced choice.²⁸²

Washington's S.B. 5222 would impose a payroll tax of 10.5% of wages. But, the bill would exempt from the payroll tax those employers that maintained a benefit plan at least as comprehensive and affordable as the state plan.²⁸³ ERISA might preempt a bald "maintenance of effort" requirement that imposes a state mandate on the employer's administration of its plan, but here instead the maintenance of effort provision appears as a condition of the

www.bls.gov/news.release/ebs2.t03.htm [<https://perma.cc/S6EX-D7HH>] (last modified Sept. 20, 2019).

²⁷⁷ Compare H. 88, 2015 Leg., Reg. Sess. § 2104 (Vt. 2015) (requiring employers to deduct employee premiums for the state public option plan or other health coverage as prescribed by the state) with S.B. 5222, 66th Leg., 2019 Reg. Sess. § 208 (Wash. 2019) (providing that employers may withhold and remit premiums for employees). See Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255, 292 (1990) (stating that "state level employer mandates" are preempted).

²⁷⁸ Wash. S.B. 5222. Note, this is a different, more comprehensive bill than the public option that ultimately passed in 2019, Wash. S.B. 5526.

²⁷⁹ H. 146 2011 Leg., Reg. Sess. (Vt. 2011) § 2103 (establishing a ten percent payroll tax); Vt. H. 88 § 2103 (establishing an eight percent payroll tax for employers and four percent for employees).

²⁸⁰ Vt. H. 146 § 1808(f); Vt. H. 88, § 1856(f).

²⁸¹ Payroll taxes are calculated on the basis of wages, not on the value of health benefits.

²⁸² See *N.Y. State Conf. of B.C.B.S. Plans v. Travelers Ins. Co.*, 514 U.S. 645, 664 (1995). Some uncertainty remains whether a ten percent payroll tax would be high enough to create a Hobson's choice and force employers to drop or alter their own employer-based plan. *Id.*

²⁸³ Wash. S.B. 5222 § 126.

exemption from the state's payroll tax. Thus, employers have choices; they can: (1) pay the payroll tax and drop their plan; (2) offer a plan at least as generous and affordable as the state plan and qualify for an exemption from the payroll tax; or (3) offer a skimpier or more expensive plan and pay the payroll tax. Because it offers employers at least three viable options, the WA S.B. 5222 bill would likely survive an ERISA challenge.²⁸⁴

Finally, some Comprehensive public option plans do not rely on payroll or income taxes at all. This premium-only financing model is illustrated by Massachusetts' MBPO proposals, under which the state would offer a health plan on its Marketplace to individuals, small groups, and large employers with more than fifty employees.²⁸⁵ An employer could offer employees coverage under the state plan the way it normally would purchase health insurance or it could offer employees a voucher to shop for coverage among the options on the Marketplace. Either way, the state does not dictate the employer's choice of plan or whether or how much of employees' premiums the employer will pay. Because it does not impinge on employers' health benefit choices, a purely premium-financed public option would not implicate ERISA at all. However, a public option financed entirely through premiums may not raise sufficient funds for the state to provide additional subsidies to those who find the plan unaffordable.

To the extent that all state public option plans are more "optional" for employers than a state single-payer plan, they would all be on surer footing under ERISA than their single-payer cousins. Some Comprehensive public option plans that we studied are closer to one end of the spectrum between a mandate and an option. The more a state makes its public option plan, including the financing mechanism, truly optional on the part of employers and preserves a system for the employer to continue to offer its own health plan, the lower the risk of ERISA preemption.

One tradeoff, though, is that improving a state public option plan's resistance to ERISA preemption reduces its momentum toward broad systemic change. Mandatory payroll taxes without exceptions accelerate the glide-path toward single-payer because employers and employees will have significant incentives not to double-pay for both employer- and state-based coverage, and may quickly stop offering and purchasing employer coverage if they are eligible to enroll in public coverage that is at least as comprehensive and affordable.²⁸⁶ The more exceptions and optionality that a state public option presents to employers, the less of a threat ERISA preemption becomes. Yet maintaining options also increases the chance that the market will remain fragmented and stratified by income, wealth, health, employ-

²⁸⁴ See *Golden Gate Rest. Ass'n v. City of San Francisco*, 546 F.3d 639, 646–47 (9th Cir. 2008) (holding a municipal pay-or-play law was not preempted because, by offering a meaningful coverage alternative, it did not force the employers to adopt or change their health plans).

²⁸⁵ H.B. 1228, 187th Gen. Ct., Reg. Sess. § 1 (Mass. 2011).

²⁸⁶ See *Fuse Brown & McCuskey*, *supra* note 265, at 404.

ment status, race, or other socio-economic variables that undermine solidarity and risk spreading.²⁸⁷ Another tradeoff in reducing the threat of ERISA preemption is that the state may fail to fully capture a large and deep source of health expenditures from employers. As a result, the state may lose some of its ability to raise revenues or pool risk in the volumes necessary to extend coverage to those parts of the market that are difficult to reach under current legal and political constraints—namely, undocumented immigrants who are ineligible for coverage on the Marketplace or under Medicaid.²⁸⁸

2. Federal Tax Law

The second legal issue Comprehensive public option plans confront are limitations in their financing mechanisms posed by federal tax law. As described above, to finance a Comprehensive public option plan, state bills propose varying combinations of payroll taxes, personal income taxes, and premium payments. Currently, employers can deduct their spending on employee health benefits as a business expense,²⁸⁹ and health insurance benefits are likewise excluded from employees' taxable income and federal payroll taxes.²⁹⁰ This foregone federal tax revenue is a form of federal spending, subsidizing the cost of employer-provided health coverage to the tune of \$273 billion in 2019.²⁹¹

There are two major tax-related challenges for Comprehensive public option plans. First, states may try to capture not only what employers spend on health benefits, but also the hefty federal tax subsidies for employer-sponsored health benefits. How can states preserve employers' existing tax advantage for health benefit spending under current federal law or draw upon even a fraction of the billions in federal tax expenditures? Second, to the extent that states levy additional individual taxes—such as an employee's share of payroll taxes—to pay for the public option plan, the new state taxes must contend with the cap on state and local tax deductions (SALT) under the 2017 Tax Cuts and Jobs Act. The answers depend on the type of financing mechanism used and who is paying for it: employer-paid payroll taxes; employee-paid payroll taxes; or employer or individual premiums.

State payroll taxes levied on employers to finance Comprehensive public option plans would largely preserve the existing tax benefits for employer-based health spending. The employer-portion of state payroll taxes used to finance a public option plan would be treated like federal payroll taxes or state unemployment taxes, so these employer-paid state payroll

²⁸⁷ See Erin Fuse Brown, Matthew Lawrence, Elizabeth McCuskey & Lindsay Wiley, *Social Solidarity in Health Care, American-Style*, 48 J.L. MED. ETHICS 411, 423 (2020).

²⁸⁸ See Fuse Brown & McCuskey, *supra* note 265, at Section I.B.

²⁸⁹ I.R.C. § 162(a)(1).

²⁹⁰ *Id.* § 162(l)(1) (discussing deductions for self-employed individuals).

²⁹¹ See JOINT COMM. ON TAX'N, ESTIMATES OF FED. TAX EXPENDITURES FOR FISCAL YEARS 2019–2023 (2020), <https://www.jct.gov/publications.html?func=startdown&id=5238> [https://perma.cc/7SHJ-G84G].

taxes would be excluded from employees' taxable income and deductible as business expenses to the employer.²⁹² To the extent the payroll taxes approximate the employer's spending on health benefits, the employer-paid state payroll taxes would roughly retain the existing federal tax advantage for employer health spending.²⁹³

However, if the state levies payroll taxes on employees or income taxes on individuals, the existing tax advantage for employees' health spending would be lost. Currently, employees' share of their health plan premiums are excluded from their taxable income and federal payroll taxes.²⁹⁴ Some states' public option proposals would levy taxes on employees' wages to finance the public plan, perhaps to replicate the current split between employer- and employee-contributions to health insurance premiums.²⁹⁵ Although an employee's share of state payroll taxes would be deductible to the employee, it would be subject to a \$10,000 cap on SALT deductions.²⁹⁶ The SALT cap effectively increases the tax liability for higher income earners in high income-tax states by limiting the amount of SALT deductions the individual may take.²⁹⁷ The employee's portion of payroll taxes used to finance a public option plan would be added to other state and local taxes, such as income or property taxes, for purposes of the SALT cap, limiting the deductibility of these tax obligations for the employee.²⁹⁸ For example, if a single individual paid \$3,000 in local property taxes, \$7,000 in state income taxes, and \$6,000 for the public option plan, the SALT cap would limit the individual's deduction on state and local taxes to the \$10,000 allowed maximum, despite the fact that the individual incurred \$16,000 in state and local taxes (including the cost to the individual for the public option plan).

States also depend on premiums to finance their public option plans. The question is whether premium payments for the state plan would be subject to the SALT cap. In 2020, the average annual premium was \$7,470 for

²⁹² See I.R.C. § 162(a) (allowing employers to deduct payroll taxes as business expenses).

²⁹³ See White et al., *supra* note 222, at xiv (assessing tax impact of a state payroll tax to finance a single-payer plan and noting, "Currently, employer spending on health benefits is excluded from taxable income for federal income and payroll taxes, creating an implicit subsidy for state residents with employer-sponsored coverage. Under the Single Payer option, employers would no longer make tax-advantaged premium payments and would instead pay the new state payroll tax. Those employer-paid payroll taxes would, like employer Federal Insurance Contributions Act (FICA) contributions, be excluded from employees' taxable income, which would roughly preserve the current tax advantage.").

²⁹⁴ See I.R.C. §§ 106, 3121.

²⁹⁵ See, e.g., H. 88, 2015 Leg., Reg. Sess. (Vt. 2015) (assessing a four percent payroll tax on employees in addition to an eight percent payroll tax on employers); S.B. 5222, 66th Leg., 2019 Reg. Sess. § 203 (Wash. 2019) (assessing a two percent payroll tax on employees in addition to a 10.5% payroll tax on employers).

²⁹⁶ See I.R.C. §§ 164(a)(1), (b)(2) (addressing the deductibility of state and local taxes); I.R.C. § 164(b)(6).

²⁹⁷ See Wiley, *supra* note 16, at 884; *How Does the Deduction for State and Local Taxes Work?*, TAX POL'Y CTR. (May 2020), <https://www.taxpolicycenter.org/briefing-book/how-does-deduction-state-and-local-taxes-work> [http://perma.cc/SBD5-QZZA].

²⁹⁸ See I.R.C. § 164(b)(6)(B) (aggregating all state and local taxes for purposes of applying the SALT cap).

individual coverage and \$21,342 for family coverage.²⁹⁹ For taxpayers with significant medical expenses, the tax-deductibility of the health insurance premiums has a significant impact on their finances and their coverage choices. Generally, individuals can deduct their health insurance premium costs if they itemize deductions and if their premium and out-of-pocket medical expenses exceed ten percent of their adjusted gross income in a given year.³⁰⁰ Unlike income or payroll taxes, premium payments may not be considered state or local taxes subject to the SALT cap. Because the public option plan is, in fact, optional, only individuals who elect to enroll in the public plan must pay the premiums. In this way, the premiums are distinguishable from individual income or payroll taxes, which are universally assessed. By contrast, premiums are only remitted by those who are paying to obtain coverage under the public plan.

If employers pay their employees' premiums in order to enroll in the state public option plan, the premium payments would be deductible to the employer as a business expense, no different than premium payments for any insurance plan.³⁰¹

Thus, a state public option financed primarily with an employer payroll tax preserves the tax advantage of the status quo, but raises greater ERISA questions, whereas shifting more of the financing to the individual taxes potentially raises the tax burden particularly for high- or even moderate-income earners. States looking to enact a robust, comprehensive public option that is adopted by private employers and employees and raises revenues for more generous premium subsidies should rely on a combination of employer payroll taxes and individual premiums (rather than individual income or payroll taxes) to finance the public option plan, navigate the maze of ERISA preemption, and preserve the current tax advantages for employer-based health benefits.

D. Administration

Comprehensive public option plans generally call for the creation of a new, publicly administered health plan. State administration is most common, but a state could allow the state agency to contract with a private health insurance company to administer the public option plan.³⁰² Comprehensive

²⁹⁹ Gary Claxton, Matthew Rae, Gregory Young, Daniel McDermott, Heidi Whitmore, Jason Kerns, Jackie Cifuentes, Anthony Damico & Larry Strange, *2020 Employer Health Benefits Survey*, KAISER FAM. FOUND. (Oct. 8, 2020), <https://www.kff.org/report-section/ehbs-2020-section-1-cost-of-health-insurance/> [<https://perma.cc/L3FL-JDCT>].

³⁰⁰ See I.R.C. § 213 (the threshold is 7.5% of adjusted gross income in 2019 and 2020 tax years and increases to ten percent in subsequent years).

³⁰¹ See I.R.C. § 162.

³⁰² See H. 88, 2015 Leg., Reg. Sess. § 1852(a) (Vt. 2015) (“The Agency of Human Services shall establish Vermont Care, a public health care coverage option for all Vermont residents The Agency may establish Vermont Care directly or through a contract with a health insurer to act as the third-party administrator.”).

plans seek bolder disruption and social solidarity—not simply offering a fallback option if a resident becomes uninsured, but rather creating a single plan to cover an increasingly broad swath of the state’s residents.³⁰³ The state sees itself as creating and administering a new public program of health coverage rather than expanding existing programs to patch holes in dysfunctional market segments.

To access federal subsidies, Comprehensive plans would have to be offered on the Marketplace. The broadest versions of these plans conceived of the Marketplace being subsumed into the state plan via a Section 1332 waiver (allowing those eligible for Marketplace subsidies to use them to enroll in the public option plan) rather than attempting to offer the state plan as one of the options on the Marketplace.³⁰⁴ While these broad proposals faced political hurdles under the Trump administration,³⁰⁵ the Biden administration may be more welcoming of such a bold use of Section 1332 waivers.

A more modest variant of the Comprehensive public option plan could be sold on the Marketplaces as an MBPO offered to large group enrollees.³⁰⁶ The state could create and administer a Comprehensive public option plan, essentially entering the market as a public insurer, and design the plan to be offered both on and off the Marketplace.³⁰⁷ However, offering the plan on the Marketplace would inevitably fragment the market and risk pools, sacrificing the administrative simplification and cost savings achieved through a single risk pool and unified state public option plan.³⁰⁸

³⁰³ See, e.g., A.B. 1343, 218th Leg., 2018–2019 Reg. Sess. § 2 (N.J. 2018) (declaring, “It is the intent of the Legislature to create the New Jersey Public Option Health Care Program to provide a universal health plan option available to every New Jerseyan.”).

³⁰⁴ See, e.g., H.B. 6285, 2018 Leg., Reg. Sess. § 402 (Mich. 2018) (“As soon as allowed under federal law, the director shall seek a waiver to allow this state to suspend operation of the exchange and to enable this state to receive the appropriate federal fund contribution in lieu of the federal premium tax credits, cost-sharing subsidies, and small business tax credits provided in the federal act.”); N.J. A.B. 1343 § 9.b.

³⁰⁵ See State Relief and Empowerment Waivers, 83 Fed. Reg. 53,575 (Oct. 24, 2018); Jennifer Tolbert & Karen Pollitz, *New Rules for Section 1332 Waivers: Changes and Implications*, KAISER FAM. FOUND. (Dec. 10, 2018), <https://www.kff.org/health-reform/issue-brief/new-rules-for-section-1332-waivers-changes-and-implications/> [<https://perma.cc/Z7BM-SMGF>] (“By prioritizing private coverage over public programs, the new guidance appears to make it more difficult for states to obtain waivers that would build on Medicaid, adopt a public plan option in the marketplace, or create a single payer plan.”).

³⁰⁶ See, e.g., S.B. 697, 191st Gen. Ct., 2019–2020 Sess. § 2 (Mass. 2019).

³⁰⁷ See S.B. 5222, 66th Leg., 2019 Reg. Sess. §§ 112(6), 115 (Wash. 2019). Washington’s S.B. 5222 (2018) contemplates that the state public option plan could be offered on the Marketplace until a waiver is obtained and the entire Marketplace is folded into the state plan.

³⁰⁸ Fragmentation would persist between separate risk pools for individuals that seek coverage on the Marketplace and those ineligible for Marketplace coverage, like those with employer-based coverage or government-sponsored coverage.

*E. Financial Considerations**1. Financing Sources*

As with all public option plans, there are three main sources of financing for Comprehensive public option plans: (1) premiums and cost-sharing; (2) federal funds, including Marketplace premium tax credits and Medicaid matching funds; and (3) state revenues from payroll and other taxes. The first two sources, premiums and premium tax credits, are the most common, but tax revenues may be necessary for the state to provide additional premium subsidies to individuals or populations who may be underserved by or ineligible for federal premium tax credits on the Marketplaces.

Many of the Comprehensive public option proposals would be financed by individual premiums and cost-sharing established by the administering agency or a contractor, though some populations may be exempt from these requirements.³⁰⁹ Plans offered on the Marketplaces would have to follow the ACA's premium requirements, which include modified community rating.³¹⁰

State bills to establish Comprehensive public option plans generally seek to draw down federal sources of funding and pool these with premiums and state tax revenues to finance the plan. They typically authorize state administrators to seek federal waivers as needed to collect ACA premium tax credits, federal pass-through funds from the Marketplaces, Medicaid matching funds, and other federal funds to enroll these populations in the state plan.³¹¹ In reality, however, the Marketplace premium tax credits and pass-through funds are a more feasible source of federal funding than Medicaid matching funds, due to legal constraints described above.³¹² Like MBPOs, a Comprehensive public option plan can be designed to tap into the extensive federal premium tax credits to finance the plan when offered on the Marketplace.³¹³

Unlike MBPOs, Comprehensive plans can capture employers' and individuals' expenditures to finance large group coverage in the public option plan. To finance large groups' participation, Comprehensive plans (like their single-payer cousins) can draw upon a combination of payroll taxes on employers and premiums or income taxes for employees.³¹⁴ Payroll taxes create incentives for employers and employees to switch to the public option plan

³⁰⁹ See, e.g., S.B. 5222, 66th Leg., 2019 Reg. Sess. §§ 111, 112 (Wash. 2019); S. 1947, 219th Leg., Reg. Sess. § 6.a (N.J. 2020).

³¹⁰ See discussion *supra* Section II.B.1.

³¹¹ See, e.g., A.B. 1343, 218th Leg., 2018–2019 Reg. Sess. § 9.b (N.J. 2018); H.B. 1104, 66th Leg., 2019 Reg. Sess. § 7 (Wash. 2019) (“The board shall . . . seek all necessary waivers so that current federal and state payments for health services to residents will be paid directly to the trust.”).

³¹² See discussion *supra* Section I.B.

³¹³ See, e.g., S.B. 697, 191st Gen. Ct., 2019–2020 Sess. § 2 (Mass. 2019) (offering the public option exclusively on the state Marketplace).

³¹⁴ See, e.g., H.B. 6285, 2018 Leg., Reg. Sess. § 402 (Mich. 2018).

(to avoid double-paying for coverage), but employers may hesitate to pay for employees to obtain public option coverage if they remain subject to the ACA's employer mandate penalties. Thus, if a state includes a payroll tax, obtaining a Section 1332 waiver of employer mandate penalties is advisable.³¹⁵ State tax revenues may also be necessary for the state to finance additional premium subsidies beyond those available on the Marketplaces or cover the remaining uninsured, particularly undocumented immigrants who are not eligible for Medicaid, Medicare, or Marketplace premium tax credits.

Washington and Vermont had bills that called for a combination of all three sources: (1) premiums; (2) federal premium tax credits for Marketplace plans; and (3) tax revenues. Washington's bills called for a funding plan that included a 10.5% payroll tax on employers (called a "health security assessment"), an 8.5% long-term capital gains tax, a 2% personal income tax (called a "personal health assessment"), premiums, cost-sharing, and federal health care funding.³¹⁶

The evolution of Vermont's public option bills from 2011 to 2017 demonstrates the evolution in policymaker thinking on financing possibilities. In 2011, Vermont passed a single-payer plan and also proposed H. 146, a public option to be offered to all residents that combined the state's Medicaid, Marketplace, and large group market into a single public plan with a shared risk pool.³¹⁷ The bill relied on a complex financing formula including a ten percent payroll tax, individual and employer premiums, Medicaid funds (necessitating a Medicaid Section 1115 waiver), federal premium tax credits, an assortment of taxes on sugary foods and cigarettes, and penalties for non-compliance with the state's individual mandate.³¹⁸ Only Medicare beneficiaries were ineligible to participate in the state plan. After the state's single payer plan fell apart in 2014,³¹⁹ a similarly broad public option was re-introduced in 2015.³²⁰ The 2015 bill (H.B. 88) was financed by a 12% payroll tax (8% on employers and 4% on employees), individual premiums, federal Medicaid funds and Marketplace premium tax credits, and penalties for non-compliance with the state's individual mandate.³²¹ By the 2017 legislative session, Vermont's public option bill had been scaled back significantly. It relied primarily on employer and individual premiums, federal premium tax

³¹⁵ See, e.g., H. 88, 2015 Leg., Reg. Sess. § 1811 (Vt. 2015) (requiring the state to apply for a waiver of the employer responsibility requirement of the ACA).

³¹⁶ S.B. 5222, 66th Leg., 2019 Reg. Sess. §§ 117, 202, 203 (Wash. 2019). Another public option bill in Washington in 2019 included a similar set of funding sources, except it did not include a long-term capital gains tax. See Wash. H.B. 1104 §§ 16, 18.

³¹⁷ See H. 146, 2011 Leg., Reg. Sess. (Vt. 2011).

³¹⁸ *Id.* § 1812 (drawing upon revenues from taxes on candy, sugary beverages, and cigarettes).

³¹⁹ See John E. McDonough, *The Demise of Vermont's Single-Payer Plan*, 372 NEW ENG. J. MED. 1584, 1584 (2015).

³²⁰ See H. 88, 2015 Leg., Reg. Sess. § 1860 (Vt. 2015).

³²¹ *Id.* (setting forth financing sources for the Vermont Care Trust Fund); *id.* § 2 (discussing federal waivers under Sections 1115 and 1332); *id.* §§ 2103–04 (setting forth the employer and employee payroll taxes and premium payments).

credits, and, in lieu of an explicit payroll tax, a vague reference to other revenues “generated by a public funding mechanism” to be established by the legislature at a later date.³²² The 2017 bill eliminated the Medicaid population from public option eligibility and as a funding source. By narrowing its scope, the 2017 Vermont public option bill avoided the legal complexities of Medicaid waiver, the political difficulty of imposing new payroll taxes, and a new federal administration hostile to waiver applications to expand public coverage.

Michigan stands out as the only state in our dataset that relied entirely on taxes to finance its public option plan, prohibiting the use of premiums and cost-sharing.³²³ In this regard, the Michigan public option financing most closely resembles state single-payer proposals, which more commonly rely on tax-financing and eschew cost-sharing and even premiums.³²⁴

2. *Cost Control*

As noted above, constraining payments to health care providers is the primary mechanism for public option plans to control costs. Lower costs for health care services translate to lower premiums and exert downward pressure on premiums in the health insurance market. Comprehensive public option plans generally use one of two approaches to control health care payment rates: administrative rate setting or centralized negotiations with providers.

Administrative rate setting typically pegs provider payments to a federal benchmark, such as Medicare rates. Michigan’s H.B. 6285, for example, would set provider payment rates at 110% of Medicare and payment rates for drugs and devices at 100% of the rate paid by the Department of Veterans Affairs.³²⁵ Similarly, Vermont’s H. 88 would pay providers at 110% of Medicare rates.³²⁶ In other instances, Comprehensive public option bills do not set rates or tie them to Medicare, but rather authorize state officials or the governing board to establish payment rates via negotiation with providers.³²⁷ These negotiations potentially offer providers more ability to maintain higher payment rates, closer to private insurance rates, which typically pay providers about double what Medicare pays.³²⁸

³²² H.B. 28, 2017 Leg., Reg. Sess. § 1855 (Vt. 2017).

³²³ H.B. 6285, 2018 Leg., Reg. Sess. § 405(3) (Mich. 2018) (“Micare must not include premiums or cost-sharing requirements.”). H.B. 6285 was introduced and referred to the Committee on Health Policy in August 2018, but the bill never made it out of Committee. *Id.*

³²⁴ See Fuse Brown & McCuskey, *supra* note 265, at 399 (describing how most state single-payer proposals feature low or no cost-sharing).

³²⁵ Mich. H.B. 6285 § 306(5)–(6) (Mich. 2018).

³²⁶ H. 88, 2015 Leg., Reg. Sess. § 1859(b) (Vt. 2015).

³²⁷ See, e.g., A.B. 1343, 218th Leg., 2018–2019 Reg. Sess. §§ 7.c–d (N.J. 2018); S.B. 5222, 66th Leg., 2019 Reg. Sess. §§ 09(2), 110(1) (Wash. 2019).

³²⁸ See Eric Lopez, Tricia Neuman, Gretchen Jacobson & Larry Levitt, *How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature*, KAISER FAM. FOUND.

Provider rate controls are not the only ways public option plans save money. They also promise improvements in administrative efficiency. Comprehensive plans offer greater potential for administrative simplification than the narrower Marketplace-based plans or Buy-In models because Comprehensive plans further reduce fragmentation of the health insurance market and unify administration for many market segments into one body.

F. Market Effects

Comprehensive state public option plans are close cousins of state-based single-payer plans in terms of their aims, scope, and financing.³²⁹ The main difference is that public option plans explicitly contemplate or anticipate that private employer-based coverage will continue to exist alongside the public option plan.³³⁰ To the extent the plans reference employers at all, the state would offer private employers or employees an option to obtain coverage under the state public option plan either in lieu of or in addition to existing employer-based plans.³³¹ Nevertheless, the market for private coverage may be disrupted by the entrance of a public plan that will compete with private plans on the basis of comprehensiveness of benefits, cost, and provider network.³³² The extent of disruption to the private health insurance market depends on several factors, such as the breadth of the provider network, the strength of provider rate controls, ease of enrollment, whether employers or employees must contribute to financing the public plan if employers offer private coverage, and whether it would preserve the same tax advantage as current plans.³³³

(Apr. 15, 2020), <https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/> [<https://perma.cc/JKB9-S9VR>].

³²⁹ For example, Michigan's H.B. 6285 is a public option plan whose policy goals are nearly indistinguishable from a single-payer plan, providing that "all residents of this state are eligible for [the state plan] Medicare, a universal health care program that will provide health care coverage through a single payment system." H.B. 6285, 2018 Leg., Reg. Sess. § 202 (Mich. 2018); see also S.B. 5222, 66th Leg., 2019 Reg. Sess. § 101 (Wash. 2019) (providing that "[a]ll residents of the state of Washington are eligible for coverage through this chapter.").

³³⁰ For example, the Michigan public option bill explicitly permits individuals to maintain alternate sources of coverage: "This chapter does not require an individual with health coverage other than Medicare to terminate that coverage." Mich. H.B. 6285 § 408.

³³¹ See, e.g., *id.* § 202 ("Medicare includes health care coverage provided under Medicaid, under Medicare, under MICHild, by employers that choose to participate, and to state and local government employees including public school employees.") (emphasis added); Vt. H. 88 § 1853 ("An individual may enroll in Vermont Care regardless of whether the individual's employer offers health insurance for which the individual is eligible.").

³³² See, e.g., Margot Sanger-Katz, *Why the Less Disruptive Health Care Option Could Be Plenty Disruptive*, N.Y. TIMES (Dec. 3, 2019), <https://www.nytimes.com/2019/12/03/upshot/public-option-medicare-for-all.html> [<https://perma.cc/VTZ6-YT3L>] (discussing the disruptive effect of a federal public option plan).

³³³ See Fuse Brown et al., *supra* note 287, at 422; see also Sanger-Katz, *supra* note 332; Matthew Yglesias, *Joe Biden's Health Care Plan, Explained*, VOX (July 16, 2019), <https://www.vox.com/2019/7/16/20694598/joe-biden-health-care-plan-public-option> [<https://perma.cc/BAC9-7DD8>].

IV. UPDATE FOR 2021 LEGISLATIVE SESSION

While outside the scope of our original survey, 2021 was an active year for state public option plans. In the 2021 legislative session, twelve bills were introduced in eleven states to implement a public option health plan.³³⁴ All of these bills fit into the taxonomy described in Parts I–III, with six states introducing Medicaid buy-ins,³³⁵ five states introducing MBPOs,³³⁶ and one state introducing a comprehensive public option plan.³³⁷ Most states introducing bills had introduced similar public option bills in previous sessions, but three states—Oklahoma, South Carolina, and Tennessee—introduced public option bills for the first time in 2021, all of which were Medicaid buy-in plans.³³⁸ As with prior years, most bills failed to pass or advance out of committee, but Nevada and Colorado enacted an MBPO in 2021.³³⁹ In addition, the 2021 Washington legislature strengthened its public option plan by authorizing the Insurance Commissioner to require certain hospitals to contract with at least one public option plan³⁴⁰ and eliminating the Commissioner’s ability to waive the cap on provider rates at 160% of Medicare rates.³⁴¹ The successful 2021 bills in Nevada, Colorado, and Washington demonstrate the continuing traction of state public option legislation.

Nevada nearly implemented a Medicaid buy-in public option in 2017,³⁴² but the passage of an MBPO-type public option in 2021, S.B. 420, shows an

³³⁴ See H.B. 21-1232, 73d Gen. Assemb., 1st Reg. Sess. (Colo. 2021); S.B. 842, 2021 Gen. Assemb., Reg. Sess. (Conn. 2021); S.B. 83, 156th Gen. Assemb., Reg. Sess. (Ga. 2021); S.B. 787, 192d Gen. Ct., Reg. Sess. (Mass. 2021); S.B. 420, 2021 Leg., 81st Sess. (Nev. 2021); A.B. 5029, 219th Leg., Reg. Sess. (N.J. 2021); H.B. 1808, 58th Leg., 1st Sess. (Okla. 2021); H.B. 3573, 124th Gen. Assemb., Reg. Sess. (S.C. 2021); S.B. 418, 2021 Leg., 112th Sess. (Tenn. 2021); H.B. 602, 2021 Leg., 112th Sess. (Tenn. 2021); H.B. 4984, 2021 Leg., 87th Sess. (Tex. 2021); H.B. 512, 2021 Leg., 87th Sess. (Tex. 2021); H.B. 3001, 2021 Reg. Sess. (W.V. 2021). Note that West Virginia also introduced H.B. 2241, but because the bill is so similar to H.B. 3001, we count West Virginia as introducing one bill.

³³⁵ S.B. 83, 156th Gen. Assemb., Reg. Sess. (Ga. 2021); H.B. 1808, 58th Leg., 1st Sess. (Okla. 2021); H.B. 3573, 124th Gen. Assemb., Reg. Sess. (S.C. 2021); S.B. 418, 2021 Leg., 112th Sess. (Tenn. 2021); H.B. 602, 2021 Leg., 112th Sess. (Tenn. 2021); H.B. 4984, 2021 Leg., 87th Sess. (Tex. 2021); H.B. 512, 2021 Leg., 87th Sess. (Tex. 2021); H.B. 3001, 2021 Reg. Sess. (W.V. 2021).

³³⁶ H.B. 21-1232, 73d Gen. Assemb., 1st Reg. Sess. (Colo. 2021); S.B. 842, 2021 Gen. Assemb., Reg. Sess. (Conn. 2021); S.B. 787, 192d Gen. Ct., Reg. Sess. (Mass. 2021); S.B. 420, 2021 Leg., 81st Sess. (Nev. 2021).

³³⁷ A.B. 5029, 219th Leg., Reg. Sess. (N.J. 2021).

³³⁸ H.B. 1808, 58th Leg., 1st Sess. (Okla. 2021); H.B. 3573, 124th Gen. Assemb., Reg. Sess. (S.C. 2021); S.B. 418, 2021 Leg., 112th Sess. (Tenn. 2021); H.B. 602, 2021 Leg., 112th Sess. (Tenn. 2021).

³³⁹ H.B. 21-1232, 73d Gen. Assemb., 1st Reg. Sess. (Colo. 2021); S.B. 420, 2021 Leg., 81st Sess. (Nev. 2021).

³⁴⁰ See S.B. 5377, 67th Leg., Reg. Sess. § 5 (Wash. 2021). The requirement applies to hospitals that serve patients from the public employee or school employee benefit plans or Medicaid. This provision was designed to address the poor hospital participation in the public option, which led to only twenty of thirty-nine counties offering a public option plan. See *supra* text accompanying notes 218–19.

³⁴¹ S.B. 5377, 67th Leg., Reg. Sess. § 6(2)(g)(ii) (Wash. 2021).

³⁴² See discussion *supra* Part I.

evolution in public option design. Specifically, S.B. 420 requires the public option to be sold both on and off the marketplace and to be available to all state residents starting on January 1, 2026.³⁴³ The law requires the state Director of Health and Human Services to apply for a waiver from HHS to obtain federal pass-through funds³⁴⁴ and authorizes the Director to apply for a waiver to combine risk pools for the public option and Medicaid, if doing so would lower costs.³⁴⁵ If Nevada is able to combine its Medicaid MCO and public option plans in this way, the public option would be a hybrid MBPO/Medicaid buy-in plan, perhaps reflecting its 2017 origins and aiming to reduce churn on and off Medicaid. S.B. 420 also grants the Director broad discretion about how to implement the public option, including whether to directly administer the plan or to contract with a health carrier to do so and whether to offer it to small employers or their employees.³⁴⁶ Recognizing that there are tradeoffs between a public-private partnership and direct administration of the public option, the Nevada law requires all carriers offering a Medicaid-managed care plan to submit a “good faith proposal” for a public option plan, then allows the Director to choose one of those plans or to implement the public option directly.³⁴⁷ Rather than impose provider rate caps on the public option, the Nevada law requires its premiums be at least five percent cheaper than a reference premium and limits future premium increases to the Medicare Economic Index.³⁴⁸ This premium cap gives the public option plan broad flexibility in how to control costs, but the premium limits appear to end on January 1, 2030, potentially leaving Nevada without mandatory cost controls after 2030.³⁴⁹ The Nevada public option also sets a payment floor commensurate with Medicare rates for most provider reimbursements.³⁵⁰ Finally, to ensure adequate provider participation in the public option, Nevada’s law requires all providers that participate in the Public Employees’ Benefits Program to enroll in at least one public option plan and to accept public option patients equitably compared to other patients.³⁵¹

The strengths of Nevada’s public option legislation are the significant flexibility given to state agencies to design and implement the public option

³⁴³ S.B. 420, 2021 Leg., 81st Sess. § 41 (Nev. 2021).

³⁴⁴ *Id.* § 11.

³⁴⁵ *Id.* § 11(1)(b)(1).

³⁴⁶ *See id.* § 10.

³⁴⁷ *See id.* §§ 12(1), 12(2), 12(5).

³⁴⁸ *Id.* §§ 10(4), 10(6)(d) (defining the “Reference premium” as “for any zip code, the lower of: (1) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the 2024 plan year, adjusted by the percentage change in the Medicare Economic Index between January 1, 2024, and January 1 of the year to which a premium applies; or (2) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the year immediately preceding the year to which a premium applies.”).

³⁴⁹ *See id.* §§ 38, 41 (removing the premium controls for the public option plan effective January 1, 2030).

³⁵⁰ *See id.* § 14(2)–(5).

³⁵¹ *See id.* §§ 13, 21, 29.

plan, including the authority to administer the plan directly, and the provider participation requirements. This strength from flexibility may be undermined, however, by the lack of permanent statutory provider or premium rate controls necessary to achieve the public option's central aim of cost control. Additionally, the long five-year runway to implementation gives the state many opportunities to kill the public option in the face of unfavorable actuarial or budgetary analyses or overwhelming political opposition from industry.

In 2021, the Colorado legislature passed H.B. 21-1232,³⁵² a bill that reflects significant modifications from earlier years' models. The extent of concession and delegation to private insurers and providers begs the question of whether the law can fairly be called a "public option."³⁵³ All mention of public option plans was eliminated from the law.³⁵⁴ Instead, the legislation requires all carriers that offer a health plan in the individual and small-group market to also offer a standardized health benefit plan in the same county both on and off the Marketplace beginning in 2023.³⁵⁵ Its benefit design is similar to earlier years' proposals for the Colorado Public Option Plan.³⁵⁶ Furthermore, the standardized plans are entirely privately administered and lack the defining feature of publicly-determined provider rates except under limited circumstances.³⁵⁷ Instead of imposing state-established provider rate caps, the 2021 bill relies upon premium constraints, leaving private carriers to negotiate health care reimbursement rates with health care providers to achieve the mandated premium savings.³⁵⁸ Beginning in 2023, premiums for the standardized plans must decrease five percent per year compared with inflation-adjusted 2021 rates until they achieve a fifteen percent reduction overall in 2025.³⁵⁹ As a fallback, the Commissioner may set provider reimbursement rates only for hospitals and health systems that prevent a carrier from meeting specified premium rate reductions or meeting network adequacy requirements (by refusing to negotiate their own rate reductions or participate), but state-imposed rates for hospital services cannot be lower than 165% of Medicare rates.³⁶⁰ In addition, the 2021 law eliminated the

³⁵² H.B. 21-1232, 73d Gen. Assemb., 1st Reg. Sess. (Colo. 2021).

³⁵³ See, e.g., Marianne Goodland, *Public Option Bill, Now Just a Health Care Plan with More Oversight, Approved by House Committee's Democrats*, COLO. POLS. (Apr. 27, 2021), https://www.coloradopolitics.com/legislature/public-option-bill-now-just-a-health-care-plan-with-more-oversightapprovedby-house/article_9ceefb20-a78c-11eb-b2d0-fb9e0559f168.html [<https://perma.cc/5LAS-79SD>].

³⁵⁴ See *id.*

³⁵⁵ H.B. 21-1232, 73d Gen. Assemb., 1st Reg. Sess. § 1(10-16-1304(1)(c)) (Colo. 2021).

³⁵⁶ See *id.* §§ 1(10-16-1304-05) (requiring the Colorado Standardized Plans to cover pediatric care and other essential health benefits; offer bronze, silver, and gold levels of coverage; be designed to improve racial health equity; and offer first-dollar, pre-deductible coverage for certain services, such as primary health care and behavioral health care).

³⁵⁷ See *id.* § 10-16-1304(1).

³⁵⁸ *Id.* § 1(10-16-1305).

³⁵⁹ *Id.* § 1(10-16-1305(2)).

³⁶⁰ *Id.* § 1(10-16-1306(5)(a)). But see *id.* § 1(10-16-1306(4)(a)) (establishing a base rate of 155% Medicare rates and allowing add-ons for certain types of hospitals).

override power of the Advisory Board.³⁶¹ Overall, the 2021 version delegates significantly more responsibility to private industry, but if the industry does not achieve the legislature's goals, the state can impose fines,³⁶² reject premium requests,³⁶³ restrict reimbursement rates,³⁶⁴ and suspend the license of any hospital that does not accept the standardized plan.³⁶⁵ Unlike Nevada's model, Colorado's does not authorize the state to administer the plan directly or combine risk pools with Medicaid, but rather imposes increasingly stringent requirements on private plans offered on and off the marketplace as well as mechanisms to compel provider participation. Colorado's new approach appears to more actively regulate insurance rates, akin to Rhode Island's hospital rate caps via insurance rate regulation,³⁶⁶ coupled with standardized plan requirements. The provider rate controls are considerably more modest than even Washington's, setting a floor for hospitals of 165% of Medicare rates versus Washington's ceiling of 160%, and only as a fallback if private negotiations fail. But compared to Nevada's five-year period, implementation in Colorado is a relatively quick two-year time frame.

The 2021 legislative session demonstrated the growth and evolution of state public option bills. Perhaps learning from Washington's struggle with provider rate controls, the new state models lean on premium rate controls and leave the negotiations of how to achieve these premium cuts to the industry players themselves. However, the new models also absorbed Washington's lesson that providers must be made to participate in the public option—carrots will not work as well as sticks. And the biggest stick is the threat of greater state control over the public option plan and provider rates if the private industry players cannot achieve the goals of coverage and cost reduction on their own.

V. ARE STATE PUBLIC OPTION PLANS WORTH IT?

This project surveys and analyzes state legislative proposals since 2010 that aim to establish a public option plan as a health reform tool. Here is

³⁶¹ Compare *id.* § 6 with H.B. 20-1349, 72d Gen. Assemb., 2d Reg. Sess. (10-16-1204 (6)) (Colo. 2020) (stating that “the Board may override a decision of the Commissioner concerning the development, implementation, and operation of the Colorado Option Plan by an affirmative vote of at least seven of the voting members of the board.”).

³⁶² Colo. H.B. 21-1232 § 6.

³⁶³ *Id.* § 2.

³⁶⁴ *Id.* § 1(10-16-1306(4)(I)).

³⁶⁵ *Id.* § 6.

³⁶⁶ See Johanna Butler, *Insurance Rate Review as a Hospital Cost Containment Tool: Rhode Island's Experience*, NAT'L ACAD. STATE HEALTH POL'Y (Feb. 1, 2021), <https://www.nashp.org/insurance-rate-review-as-a-hospital-cost-containment-tool-rhode-islands-experience/> [<https://perma.cc/3L6Z-YYGB>]; ROBERT BERENSON, JAIME KING, KATHERINE GUDIKSEN, ROSLYN MURRAY & ADELE SHARTZER, URB. INST. & U.C. HASTINGS L., ADDRESSING HEALTH CARE MARKET CONSOLIDATION AND HIGH PRICES: THE ROLE OF THE STATES 54–56 (2020), https://www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_3.pdf [<https://perma.cc/JLC7-DPMF>].

what we have learned. First, “public option” means many different things to different people.³⁶⁷ Notably, state public option plans differ from their federal counterparts in that they are not necessarily publicly financed; rather, what makes them “public” is that they are state-initiated and that they impose state-mandated provider rate caps, even if the plan is administered by a private contractor and financed from a variety of public and private sources. Second, there are three main types of state public option plans, listed from narrowest to broadest in scope: (1) Medicaid buy-in public option; (2) Marketplace-based public option; and (3) Comprehensive public option. The type of plan a state should pursue depends on the state’s policy goals. Third, and somewhat ironically, the degree of legal difficulty in establishing a state public option plan is inversely related to the scope of the plan’s reach—the broadest plans have surprisingly fewer legal hurdles than narrower plans, though the broad plans may be more disruptive and politically difficult. This Part assesses these tradeoffs and sets forth a menu of options for states to help answer whether pursuing a public option as a health reform is worth it, and, if so, which kind of public option to pursue.

A. A Public Option Road Map for States

1. Medicaid Buy-In Public Option

A Medicaid buy-in public option is best for states whose primary goal is to provide access to difficult-to-cover, lower-income populations. These groups include undocumented immigrants and those who earn too much for Medicaid but for whom Marketplace coverage is unaffordable due to the family glitch or the subsidy cliff.³⁶⁸ Offering a plan based on a Medicaid-managed care plan would reduce coverage disruptions for those churning on and off Medicaid and keep premiums affordable by reimbursing providers at rates pegged to Medicaid. These populations may be well-served by a Medicaid-like plan because their health and social support needs may resemble those of Medicaid beneficiaries.

Several constraints limit the scope of Medicaid buy-in plans. First, the Medicaid statute does not permit non-eligible individuals to enroll directly in Medicaid, and federal Medicaid matching funds cannot be used to pay for or subsidize non-Medicaid enrollees. Medicaid buy-in thus typically means a state would require its Medicaid-managed care plans to offer parallel plans to the buy-in population, often on the Marketplace.³⁶⁹

³⁶⁷ We are not the first observers of state public option plans to note this. See Sparer, *supra* note 37, at 262.

³⁶⁸ See *supra* Sections I.A, I.C.

³⁶⁹ See *supra* Section I.B.

Second, if the state wants to cover undocumented immigrants, the Medicaid buy-in plan cannot be offered solely on the Marketplace.³⁷⁰ This means that a single Medicaid buy-in plan could not simultaneously create cost competition on the Marketplace and cover undocumented immigrants. A state could offer off- and on-Marketplace versions of the plan, but this bifurcation would sacrifice the plan's administrative simplification.

Another tradeoff is that paying Medicaid rates, which is necessary to maintain the plan's affordability, could also threaten provider participation, limiting the scope of the Medicaid buy-in plan.³⁷¹ Such a plan could never be expanded to large groups, for example, without triggering widespread provider backlash and exit. Further, if offered on the Marketplace, the downward pressure in the market created by a Medicaid buy-in plan could drive down premiums so much as to reduce the available subsidies on the rest of the Marketplace, which would necessitate a Section 1332 waiver to capture federal pass-through funds of amounts saved in lower premium subsidies. Thus, for Medicaid buy-in plans, the state must face all the legal constraints of the Medicaid program and the Marketplaces and thread the needle with provider rates that are low enough to ensure affordability and high enough to maintain sufficient provider participation to serve a larger portion of state residents.

As a result, Medicaid buy-in proposals have not proliferated or progressed very far toward passage. New Mexico has arguably taken the proposal the furthest with its significant Medicaid population, program infrastructure, and a modest goal of expanding access for its remaining uninsured. Nevertheless, the political difficulty of funding coverage for its uninsured, particularly undocumented immigrants, stymied the plan's ultimate passage.³⁷² The legal and practical constraints of the Medicaid buy-in make it the narrowest type of public option; however, it is no less politically difficult than some of the broader types.

2. *Marketplace-Based Public Option*

MBPOs offer states the most flexibility to achieve their specific policy goals, yet states may have to choose between conflicting policy goals from the outset. Some decisions are simple. MBPOs are clearly best for states that aim to cover bare (or nearly bare) counties. For enrollees of individual and small group Marketplace plans, lack of competition in the Marketplace is significant: residents of over seventy percent of counties in the United States—nearly a third of all enrollees in the ACA Marketplaces—had a choice of only one or two insurers in 2021.³⁷³ MBPOs would provide an

³⁷⁰ See *supra* Section I.D.1.

³⁷¹ See *supra* Sections I.E, I.F.

³⁷² See Sparer, *supra* note 37, at 269–70.

³⁷³ See Daniel McDermott & Cynthia Cox, *Insurer Participation on ACA Marketplaces 2014-2020*, KAISER FAM. FOUND. (Nov. 23, 2020), <https://www.kff.org/private-insurance/is->

additional option in these underserved areas, which may drive beneficial price competition.

Yet MBPOs face a surprising tradeoff between the goals of improving competition and reducing premiums. MBPOs' ability to improve affordability hinges on states' willingness to constrain provider payments through ambitious rate caps. States that set timid reimbursement limits may see few, if any, savings or improvements in affordability from the introduction of the MBPO.³⁷⁴ Similarly, states that rely heavily on private insurers to administer and finance the MBPO may lose some of the MBPO's competitive effects or provoke lukewarm efforts by private insurers reluctant to offer MBPO plans that compete with their existing plans.³⁷⁵ On the other hand, a state that administers its own plan, imposes stringent payment caps, retains financial risk and administrative control over the MBPO, and requires (or strongly nudges) provider participation could shift the market with a substantially cheaper more desirable plan option. The downside is that some insurers may exit rather than compete.³⁷⁶ The sweet spot between driving cost savings and maintaining a competitive public-private Marketplace may be as difficult to find as the proverbial needle in the haystack. In sum, the state must decide how willing it is to disrupt the existing market in order to achieve its goals of increased access and affordability.

Despite this challenge, MBPOs remain the most viable form of state public option because they can mobilize federal dollars to achieve state health care coverage goals.³⁷⁷ Most of the public option bills we reviewed, and the plans that have advanced the furthest—in Washington, Nevada, and Colorado—use the Marketplace to access federal financial subsidies.³⁷⁸ States rely on Marketplace federal subsidies to fund their MBPOs in two ways. First, residents who purchase MBPO plans on the Marketplace can use premium tax credits towards purchasing the plan.³⁷⁹ The MBPO directly receives these premium tax credits and, through a more circuitous path, the cost-sharing reduction payments for eligible residents. The federal funds not only offset the cost of the plan to the state, they help pay for the MBPO. Second, if the state obtains a Section 1332 waiver from the federal government, it can access federal pass-through funds of federal savings obtained from the MBPO's provider rate controls or other administrative savings.³⁸⁰ Further, states can use Section 1332 to create shared savings programs, al-

sue-brief/insurer-participation-on-aca-marketplaces-2014-2020/ [https://perma.cc/7WQ4-CLFG].

³⁷⁴ See *supra* Section II.E.2.

³⁷⁵ See *supra* Sections II.D, II.E.

³⁷⁶ See *supra* Section II.F.

³⁷⁷ See *supra* Sections II.B, II.E.

³⁷⁸ See 2019 Wash. Sess. Laws, enacting Engrossed Substitute S.B. 5526, 66th Leg., 2019 Reg. Sess. § 3(1) (Wash. 2019); H.B. 20-1349, 72d Gen. Assemb., 2d Reg. Sess. § 1(10-16-107(3.7)(a)) (Colo. 2020).

³⁷⁹ See *supra* Section II.B.1.

³⁸⁰ See *supra* Section II.B.2.

lowing them to keep any federal savings they generate by the public option plan and potentially use those funds to subsidize additional coverage.

Though there are several ways a state could structure its MBPO, the big choices revolve around scale and disruption. States that are wary of market disruption could create a commercially-administered MBPO with modest provider payment caps, but the results, if any, may likewise be modest, such as creating an extra plan option here or there and slight downward pressure on commercial premiums over time.³⁸¹ Washington and Colorado's public options are examples of modest MBPOs. States that want bigger results must assume a greater role administering, financing, and controlling their MBPOs.³⁸² Nevada's model moves in this direction by authorizing the state to directly administer the public option or award a single contract to a private carrier, requiring providers to participate, and authorizing application for a Section 1332 ACA waiver to capture premium savings and a Section 1115 Medicaid waiver to combine risk pools with the Medicaid program. However, these bolder MBPOs must aggressively cap provider payments or premium rates and consider extending their MBPOs to the large group market to draw in additional covered lives and funds.³⁸³ Like any innovation, Washington's modest first move may facilitate more robust internal iterations and inspire other states to take the reform further, building toward a more transformational vision for a state public option.

3. Comprehensive Public Option

A Comprehensive public option plan is best for states whose goals are to broadly expand access to all residents of the state, pursue administrative simplification through a unified public plan that covers previously segmented markets (individual, small, and large groups), improve affordability and control spending through broadly applicable provider rate caps, and provide a glide-path to single-payer health care.³⁸⁴ Comprehensive plans are distinguishable from other types of state public option plans because they explicitly extend public coverage to the large group market of employer-based coverage.

Adding the large group target population increases the level of administrative and political difficulty to establish a Comprehensive public option compared with MBPOs. A state could develop a Comprehensive public option by offering a broad version of the MBPO and opening it up to large group enrollees, as proposed by Massachusetts, which would require a Section 1332 waiver of the employer mandate and application of federal pass-through funds to new, enlarged subsidies.³⁸⁵ All the lessons for MBPOs

³⁸¹ See *supra* Section II.E.2.

³⁸² See Hansard, *supra* note 20.

³⁸³ See *supra* Section II.E.2.

³⁸⁴ See *supra* Section III.A, III.B.

³⁸⁵ See S.B. 697, 191st Gen. Ct., Reg. Sess. § 2 (Mass. 2019).

would apply, but the scope and stakes would be higher. The administration, risk pool, provider rate limits, benefits, and premium and cost-sharing rates would apply to the entirety of the private insurance market, heightening the tradeoffs between affordability and insurance market disruption. Yet, presumably, Comprehensive plans are designed to disrupt the market, so the tradeoff decision has already been made. In addition, Comprehensive plans offered solely on the Marketplace cannot reach undocumented immigrants, who cannot purchase coverage on the Marketplace.

The most ambitious Comprehensive public option plans would subsume the Marketplace into the new state health plan via an expansive Section 1332 waiver, allowing the state to receive all the federal Marketplace subsidies and pass-through savings and combine these funds and administration into a larger system that includes Marketplace enrollees and off-Marketplace populations, those ineligible for Marketplace coverage or subsidies, public employees, and even potentially Medicaid beneficiaries.³⁸⁶ This ambitious version of the Comprehensive public option would entail creation of a new administrative agency to run the new state health program.

Financing Comprehensive public option plans is also more complex than financing MBPOs, particularly if the plan aims to capture employer health spending. To capture the employer share of health coverage, Comprehensive plans will require payroll taxes or mechanisms to collect an employer premium payment for employees who choose the public plan.³⁸⁷ Although these mechanisms may simply replace existing health spending by large employers and employees, opponents may frame them as new tax increases. Some states, like Massachusetts, have proposed financing narrower Comprehensive plans through premiums and federal Marketplace subsidies, while others, like Vermont, also contemplate raising additional state revenue to provide subsidies to those ineligible for federal subsidies or to supplement federal subsidies where inadequate.³⁸⁸ Ultimately, Comprehensive plans are limited to the same three sources of financing as all state-based public option plans: federal Marketplace subsidies, premiums, and state tax revenue. The broader the plan, the more sources are tapped.

Surprisingly, the level of legal difficulty for Comprehensive public option plans is not significantly higher than for MBPOs. This doesn't mean these plans are easy; a Comprehensive public option plan must still run the gauntlet to satisfy the ACA's requirements and obtain an extremely broad and, to date unheard of, Section 1332 waiver. However, if it can secure the waiver, then a state can structure its Comprehensive plan to avoid further entanglements with ERISA and federal tax law. To avoid ERISA preemption, Comprehensive plans should avoid requiring employers to take any specific action with their health plans, such as including mandating employ-

³⁸⁶ See *supra* Section III.D.

³⁸⁷ See *supra* Section III.E.1.

³⁸⁸ See *supra* Section III.E.1.

ers enroll their employees in public coverage or requiring premium contributions if the employee chooses to do so.³⁸⁹ A payroll tax to encourage participation and capture employer health spending should not raise ERISA concerns, particularly if the payroll tax preserves employers' plan choices. A voluntary, premium-based Comprehensive plan like Massachusetts' proposal would avoid ERISA entirely, but it might also fail to capture employers' health spending. A state payroll tax on employers would roughly preserve employers' current tax advantage for offering employee coverage; structuring individual contributions as premiums rather than individual income or employee payroll taxes would likely avoid the \$10,000 cap on state and local tax deductions.³⁹⁰

B. Universal Advice and Conclusions

To be sure, states have policy alternatives beyond this taxonomy of public option plans. For instance, states seeking to control costs could regulate provider rates across payers rather than establish a public option, which may be more economically efficient but may not create coverage options where they are lacking.³⁹¹ For administrative simplification, states could pursue a single-payer plan to displace the private insurance market more decisively than contemplated even by Comprehensive public options.³⁹² On the narrower end of the spectrum, states could pursue a Basic Health Plan or expand community health centers to provide coverage or services to difficult-to-reach populations.³⁹³ We focused on state public option plans, not because they are the only or even the best health reform model, but rather because states have been actively pursuing them. These are the lessons we gleaned from states' laboratory of public option experimentation.

1. For State Public Option Plans, Bigger Is Better

Narrow plans that target limited slices of the population may not benefit enough people to gain political support or be worth the inevitable political battle. A major goal for many states contemplating public options is to reach populations, such as undocumented immigrants, that have traditionally not

³⁸⁹ See *supra* Section III.C.1.

³⁹⁰ See *supra* Section III.C; Wiley, *supra* note 16, at 884–85.

³⁹¹ See, e.g., MICHAEL E. CHERNEW, LEEMORE S. DAFNY & MAXIMILIAN J. PANY, THE HAMILTON PROJECT, A PROPOSAL TO CAP PROVIDER PRICES AND PRICE GROWTH IN THE COMMERCIAL HEALTH-CARE MARKET (2020), https://www.hamiltonproject.org/assets/files/CDP_PP_WEB_FINAL.pdf [<https://perma.cc/TEZ9-AGQY>]; Fiedler note 104.

³⁹² See, e.g., Fuse Brown & McCuskey, *supra* note 265; Wiley, *supra* note 16.

³⁹³ See, e.g., Lynn A. Blewett & David Anderson, *Examining the New Basic Health Plan Financing Rule*, HEALTH AFFS.: BLOG (Oct. 3, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180927.980559/full> [<https://perma.cc/ULS3-Z5E5>]; Samantha Artiga & Maria Diaz, *Health Coverage and Care of Undocumented Immigrants*, KAISER FAM. FOUND. (July 15, 2019), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants/> [<https://perma.cc/59KT-XSE7>].

been covered by existing public or private plans who will likely require additional state subsidies. This throws some cold water on Medicaid buy-in plans. Not only are they harder to navigate legally, but they do not benefit enough people to secure a broad coalition of defenders or create enough market pressure to meaningfully impact health care spending or private prices.³⁹⁴ While there may be good reasons to try to cover difficult-to-reach populations through an incremental extension of Medicaid, the state should be clear that it is not pursuing systemic reform typically associated with a public option.

Similarly, Marketplace-based plans with a limited target population, minimal state involvement, and timid provider rate caps are less likely than more ambitious plans to achieve the goal of cost containment.³⁹⁵ A weak public option may exert little competitive pressure on private health plans and do little to control costs or expand coverage. Moreover, a neutered public plan may strengthen the idea that the government cannot do better than private markets to provide affordable coverage to the population. Since a weak version of the public option requires nearly as much political capital as a bolder version, it may only be worth the fight to establish a weak public option if the state plans to increase cost control measures over time.³⁹⁶

2. *Affordability Hinges on Strong Provider Reimbursement Controls*

The most common goal of all public option proposals is to improve the affordability of health care coverage for individuals, employers, and the state.³⁹⁷ And the most powerful tool to achieve that goal is a state-mandated cap on provider rates. In fact, a provider rate cap may be all that distinguishes a public option plan that is privately administered and financed from purely private plans.³⁹⁸

Without question, setting provider payment limits in a public option plan is politically contentious. Set the rate too low, and providers may not

³⁹⁴ For a discussion of the dangers of a narrow public option in the national context, see Hacker, *supra* note 5, at 343 (“Small scale is a policy liability, increasing the changes the plan would end up attracting enrollees with disproportionately high costs and decreasing its leverage over the system. It is also a political liability because . . . the lack of a strong constituency or serious stakeholder investment could quell opportunities for expanding the public plan . . .”).

³⁹⁵ See Hoffman, *supra* note 17, at 12 (noting that adding a public option to regions with only one Marketplace plan could hold down premiums and that “[s]uch benefits are laudable, but far short of the transformative vision that the public option’s architects had for it”).

³⁹⁶ See *id.* (“[T]he marginal gains from a competitive public option would have come at a cost. The public option would have further justified preserving the existing system and problems with it. Injecting this option into the existing ACA exchanges would perpetuate, and perhaps even validate, this structure that is causing fundamental problems of inequity and regulatory bloat in health care.”).

³⁹⁷ See *supra* Sections I.A, II.A, III.A.

³⁹⁸ See Dafny, *supra* note 17.

participate or may leave altogether.³⁹⁹ Set the rate too high, and the public option plan will not increase affordability or create competitive pressure for private plans to reduce their provider rates.⁴⁰⁰

To create savings, most public option plans benchmark provider payments to public program rates—either Medicare or Medicaid—which are set by the government and are typically significantly lower than private rates.⁴⁰¹ Because Medicaid rates are the lowest, Medicaid buy-in plans that peg provider payments to Medicaid may keep plans affordable, but risk limiting the plans' viability and reach due to low provider participation. Marketplace-based or Comprehensive plans typically use Medicare rates as the benchmark, but selecting the Medicare multiple (101%, 125%, 160%) is politically fraught and also risks entrenching fee-for-service payment, cost-shifting, and incentives for providers to make up in volume what they lose in price.

Owing to the political challenges of imposing stringent provider rate caps, states are now shifting their cost control efforts to mandated premium cuts for the public option plan paired with stronger provider participation requirements.⁴⁰² It remains to be seen whether this strategy of forcing private payers and providers to the table to negotiate their own cuts will prove effective at controlling costs and fairly distribute payment cuts across providers and services.

3. Not “Buying In”

Due to legal constraints, allowing anyone to simply “buy in” to existing public coverage, such as Medicaid, is not viable.⁴⁰³ Instead, states interested in a buy-in typically lean on their private contractors, such as Medicaid-managed care plans, to create a parallel plan that uses similar provider networks, reimbursement rates, benefit design, and administration. This parallel public plan can then be offered to non-eligible groups and individuals on and off the Marketplace. But these mock “buy ins” do not allow states to capture the efficiencies of a direct buy-in: risk pooling, administrative and communication efficiencies, access to federal funds, and legal pro-

³⁹⁹ See Fiedler, *supra* note 104, at 7–9 (concluding that a public option that pays lower rates than private rates would reduce premiums in the market, but noting that provider exit and negotiating rather than setting prices would diminish impact).

⁴⁰⁰ See ROBERT BERENSON, JOHN HOLAHAN & STEPHEN ZUCKERMAN, URB. INST., GETTING TO A PUBLIC OPTION THAT CONTAINS COSTS: NEGOTIATIONS, OPT-OUTS AND TRIGGERS 2 (2009), <https://www.urban.org/sites/default/files/publication/30756/411984-Getting-to-a-Public-Option-that-Contains-Costs-Negotiations-Opt-Outs-and-Triggers.PDF> [<https://perma.cc/38VX-ERWZ>] (“A strong public option can contribute significantly to reducing subsidy costs and to system wide cost containment. A weak public option would likely not serve that role. A public option that begins with a small market share and would be required to negotiate prices with providers, often from a position of weakness, would do little to contain health care costs.”).

⁴⁰¹ See *supra* Sections I.E.2, II.E.2, III.E.2.

⁴⁰² See *supra* Part IV (discussing 2021 bills).

⁴⁰³ See *supra* Section I.B.

tections that come with participation in actual Medicaid or state employee health plans. Thus, despite its intuitive appeal, a direct buy-in to public coverage is a nonstarter for states.

4. *Finance Through the Marketplaces*

As noted above, a deep well of federal funds runs through the Marketplaces.⁴⁰⁴ Congress deepened the well with a two-year enhancement of Marketplace subsidies in the pandemic response package, the American Rescue Plan.⁴⁰⁵ This makes Marketplace-based public option plans both the most enticing and financially viable option for states. However, for a state to capture the maximum amount of savings possible by adding a public option to the Marketplace, it needs to run its own state-based Marketplace and secure a Section 1332 waiver from the federal government. The wellspring of federal funds flowing through the Marketplace means that in addition to MBPOs, states contemplating Medicaid buy-in plans and Comprehensive plans should consider a version of the plan that could be sold on the Marketplace. So central are the Marketplaces to state public option plans that, if the ACA were to be struck down by the Supreme Court, the entire structure for modern state public options would need reimagining.⁴⁰⁶

Other than federal subsidies available via the Marketplaces, few other sources of federal funding exist to support a state public option. The simplest funding source, both legally and politically, is premiums. States could offer Marketplace plans to large employers to slow the growth of commercial premiums and expand the public option's reach, buying power, and risk pool, but this strategy would require a Section 1332 waiver.⁴⁰⁷ Relying solely on premiums, however, may make the public option plan unaffordable to many (including undocumented immigrants and those affected by the family glitch or subsidy cliff) and may fail to fully capture employers' coverage contributions. The broadest versions of the public option draw on all three available funding sources, including pass-through federal Marketplace funds via a Section 1332 waiver, individual premiums, and new state revenues from payroll taxes to capture the employer contributions.

⁴⁰⁴ See *supra* Sections II.B.2, II.E.

⁴⁰⁵ American Rescue Plan Act of 2021, H.R. 1319, 117th Cong. § 9661 (2021). The Act increased existing premium tax credits for those earning between 100% and 400% of the FPL and extended premium tax credits to those earning more than 400% of the FPL, eliminating the subsidy cliff through the end of plan year 2022.

⁴⁰⁶ The Supreme Court denied the most recent constitutional challenge to the ACA on the grounds that the plaintiffs lacked standing. See *California v. Texas*, 141 S. Ct. 2104, 2120 (2021).

⁴⁰⁷ States seeking a Section 1332 waiver for sweeping changes should also be aware of the deficit neutrality requirement that would reduce pass-through savings by any reduction in federal revenue caused by the plan, including increases in Medicaid enrollment or decreases in federal tax revenue. See *supra* note 139 and accompanying text.

5. Competition and Disruption

All public option plans seek to inject competition into the private health insurance market by adding a public plan that can exert downward pressure on prices and provide additional choices to consumers. Indeed, all the plans we reviewed would initially increase competition. Yet the proposals and their endgames diverge from there. States must decide how much they want the public option to disrupt the private health insurance market. Answers can range from “not at all” (just seeking to cover remaining uninsured) to “maximally” (seeking a glide path to single-payer). A state’s answer to this question will drive the design of its public option.

States that use the full arsenal of regulatory authority to control prices by imposing stringent, market-wide rate caps will achieve the greatest potential cost savings and radically displace the incumbent private health insurance system by outcompeting on price.⁴⁰⁸ To states favoring this approach, the private insurance market has failed to deliver universal coverage or control costs. In this maximalist view, the public plan would eventually cover most state residents—including those with employer-based coverage—harnessing economies of scale from administrative savings, a massive and stable risk pool, and formidable purchasing power. Providers would have no choice but to participate in a public plan this large. This comprehensive version of the public option promises significant market disruption, especially for commercial insurers, but also the greatest potential savings and scope.

Other states may be wary or politically incapable of enacting a public option plan that disrupts providers and drives commercial insurers out of the market. These states can instead preserve a multi-payer system and increase choice and affordability for consumers, particularly in the individual and small group markets. These models embrace a managed competition approach, and if private insurers can compete efficiently within the state’s price constraints, the public option has done its job.⁴⁰⁹ These middle-path states, like Washington, may enlist private insurers to administer and potentially profit from the public option plan and set generous provider rate caps to mollify and encourage their participation, but the plans’ effects on costs, choice, access, and coverage may be accordingly modest.⁴¹⁰

Taken together, the range of state public option plans reveal a fundamental tension between competition and cost control. The more ambitious the provider rate controls, the more likely the public plan will constrain health care prices and premiums, but also the more likely it will disrupt the extant market, perhaps even displacing private insurance options and ulti-

⁴⁰⁸ See Brian J. Miller & Robert E. Moffit, *Choice, Competition, and Flexibility, Part I: Post-ACA Consumer Challenges*, HEALTH AFFS.: BLOG (Aug. 19, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200813.191190/full/> [<https://perma.cc/9WW5-B9LB>]; see also UCCELLO, *supra* note 109, at 12–13.

⁴⁰⁹ See Wiley, *supra* note 16, at 2191.

⁴¹⁰ See *supra* Section I.E.2.

mately reducing choices. On the other hand, a strong commitment to preserving choices and competition among private health plans will require more modest public plan provider rate caps, sacrificing the public option's downward pressure on costs. This paradox means that a public option cannot simultaneously increase choice among competitors and significantly reduce costs. As Allison Hoffman has argued, the paradox results from a misplaced commitment to choice among multiple health plans.⁴¹¹ In health insurance, choice is less important and less valuable than cost-control, and were a state to choose between a public option that increases choices and one that reduces costs for consumers, it should choose the latter.

In the end, the state must identify its goal and its role in the reform effort, and that will answer how much disruption it will tolerate. To take an analogy from education, is the state trying to establish an affordable flagship public university system that will serve as a market leader and benchmark for private competitors, or is the state trying to establish a charter school system to inject a few additional choices that are publicly funded but privately run? The former is more disruptive, more expensive, and more transformative. The latter is much more modest and may hardly be called systemic reform.

C. Federalism Implications

Our comprehensive review of state public option proposals also reveals some lessons for federalism in health reforms. Although this article does not set out to answer whether any state should pursue a public option or whether the federal government is better suited to such reforms, it does show that states have a considerably more difficult path to public option health reform than the federal government. States are faced with legal constraints from federal statutes (e.g., Medicaid, ACA, ERISA, and federal tax law), many of which are intended to protect beneficiaries and the federal budget, which means that states cannot simply extend existing public programs to new populations.⁴¹² To give states a path through the labyrinthine legal requirements to systemic reforms, progressive members of Congress have proposed federal legislation that would modify these statutory constraints to give states greater flexibility to pursue state-level public options or other universal health reforms.⁴¹³ Even if federal reform is on the table, it would be worth enacting these federal pathways to state-based reform so we can learn from the laboratory of the states. However, broad federal waivers and additional state flexibility risk being weaponized to scale back coverage and protec-

⁴¹¹ See Hoffman, *supra* note 17, at 2.

⁴¹² See *supra* Sections I.B, II.B, III.C.

⁴¹³ See State-Based Universal Health Care Act of 2018, H.R. 6097, 115th Cong. (2018); State Public Option Act, H.R. 1277, 116th Cong. (2019).

tions.⁴¹⁴ Thus, any additional state flexibility legislation must contain sufficient guardrails to serve as a one-way ratchet—allowing state experimentation that enhances coverage, access, equity, and consumer protections over federal baselines, while prohibiting state policies that would undermine existing federal coverage.⁴¹⁵ This is no small feat. The guardrails in Section 1115 of Medicaid and Section 1332 of the ACA have been systematically assaulted but have largely held fast. Attempts to promote greater state flexibility must preserve these protective bulwarks.

Given his support for a federal public option while a candidate, President Biden could take concrete steps to advance state public option reforms. In particular, the Biden Administration could enact regulations designed to assist states in obtaining Section 1332 waivers, Section 1115 waivers, or an unprecedented super-waiver combining both, to promote a state public option as a vehicle for systemic reforms.⁴¹⁶ These regulations could streamline access to federal pass-through funds and provide guidance on expanding eligible populations, the limitations on use of federal funds, establishing a state-agency as a QHP, and receiving premiums and premium tax credits.

Equally as important as federal legal constraints are fiscal constraints. States cannot deficit-spend, and most are constitutionally required to balance their budgets every year.⁴¹⁷ Thus, states are inherently more limited in their ability to generate new funding streams to pay for or subsidize coverage for difficult-to-reach populations. States must therefore rely on federal funding and private spending to finance the bulk of their public option proposals. This reliance on federal financing imposes a significant structural limit on state universal health reform.

Although federal reform may be the ultimate answer, states have an essential role to play. They are the engines of federalist innovation. Salutory and failed state experiments provide essential policy design lessons. Even with all their limitations, successful state public option plans will inform and enhance federal health reform. Thus, we all benefit from clearing existing

⁴¹⁴ See Nicole Huberfeld, Sidney Watson & Alison Barkoff, *Struggle for the Soul of Medicaid*, 48 J. L. MED. ETHICS 429, 430–31 (2020); see also Matthew B. Lawrence, *Fiscal Waivers and State “Innovation” in Health Care*, 62 WM. & MARY L. REV. 1477, 1506 (2021); Sara Rosenbaum, *Weakening Medicaid from Within*, AMERICAN PROSPECT (Oct. 19, 2017), <https://prospect.org/power/weakening-medicaid-within/> [<https://perma.cc/A2LK-C93F>].

⁴¹⁵ See Elizabeth Y. McCuskey, *Agency Imprimatur and Health Reform Preemption*, 78 OHIO ST. L. J. 1099, 1146, 1164 (2017) (describing the importance of standards in Section 1332 waivers); see also William W. Buzbee, *Asymmetrical Regulation: Risk, Preemption, and the Floor/Ceiling Distinction*, 82 N.Y.U. L. REV. 1547, 1566 (2007) (describing how federal floor preemption can function as a one-way ratchet, allowing state laws more protective than federal baselines).

⁴¹⁶ See Dylan Scott, *What Biden Could Do to Expand Health Coverage—Without Congress*, Vox (Nov. 17, 2020, 10:30 AM), <https://www.vox.com/policy-and-politics/21562986/president-joe-biden-health-care-plan-obamacare-medicaid> [<https://perma.cc/ZK3M-52WZ>]; see also Lawrence, *supra* note 194.

⁴¹⁷ See Bagley, *supra* note 93, at 10.

legal and fiscal hurdles to state health reforms that move toward universal coverage and effective cost control.

CONCLUSION

Are public option plans worth it? Yes, if the state goes big. The ACA advanced the U.S. health system toward the perennial goals of universal access to affordable, comprehensive coverage. Nevertheless, political and legal setbacks have stymied the full realization of these goals. The next big thing in health reform appears to be a public option, and the states have been actively developing a variety of state-level public option proposals. Three main models of a state public option have emerged that vary in scope and ambition. Though all three models are viable, the degree of legal difficulty is not much greater for the broadest plans than the narrowest ones, while effectiveness increases with the plan's scope. Thus, for state public option plans, bigger is better. Though states have a path forward, they remain constrained by current fiscal and legal federalism. When states can't test models of health reform, we all lose. Thus, for states to function as true laboratories of health reform, they need greater flexibility from Congress and the administration in the forms of broad statutory waivers and new legal pathways to prove whether a public option is indeed worth it.

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APPENDIX: TABLE OF STATE PUBLIC OPTION BILLS 2010-2021

State	Year	Bill Number
Medicaid Buy-ins		
1 Connecticut	2018	H.B. 5463
2 Georgia	2020	S.B. 339
3 Georgia	2021	S.B. 83
4 Indiana	2019	S.B. 444
5 Iowa	2018	H.F. 2002
6 Massachusetts	2017	S.B. 2211
7 Massachusetts	2019	H.B. 1132
8 Minnesota	2015	H.F. 2749 / S.F. 2356
9 Nevada	2017	A.B. 374
10 Nevada	2021	S.B. 420*,**
11 New Mexico	2019	H.B. 416 / S.B. 405
12 Oklahoma	2021	H.B. 1808
13 Oregon	2019	H.B. 2009
14 South Carolina	2021	H.B. 3573
15 Tennessee	2021	S.B. 418 / H.B. 602
16 Texas	2019	H.B. 2313
17 Texas	2021	H.B. 512
18 Texas	2021	H.B. 4084
19 Wisconsin	2017	A.B. 449 / S.B. 363
20 West Virginia	2020	H.B. 4789
21 West Virginia	2021	H.B. 3001
22 Wyoming	2018	S.B. 88
Total	16 states	22 bills

Marketplace-based Public Options		
1 Colorado	2020	H.B. 1349
2 Colorado	2021	H.B. 1232**
3 Connecticut	2019	H.B. 7267 LCO 9710
4 Connecticut	2020	S.B. 346
5 Connecticut	2021	S.B. 842
6 Illinois	2014	H.B. 5733
7 Massachusetts	2011	H.B. 1228*
8 Massachusetts	2013	S.B. 514*
9 Massachusetts	2015	H.B. 1033*
10 Massachusetts	2017	S.B. 618*

	State	Year	Bill Number
	11 Massachusetts	2017	S.B. 638*
	12 Massachusetts	2019	S.B. 697*
	13 Massachuettts	2021	S.B. 787
	14 Minnesota	2019	H.F. 2184 / S.F. 2302
	15 Nevada	2021	S.B. 420*,**
	16 New Jersey	2020	S.B. 1947*
	17 Vermont	2011	S.B. 109
	18 Vermont	2015	H.B. 88*
	18 Vermont	2017	H.B. 28*
	19 Virginia	2020	H.B. 530
	20 Washington	2019	S.B. 5526**
	21 Washington	2017	S.F. 5984
Total	10 states		21 bills

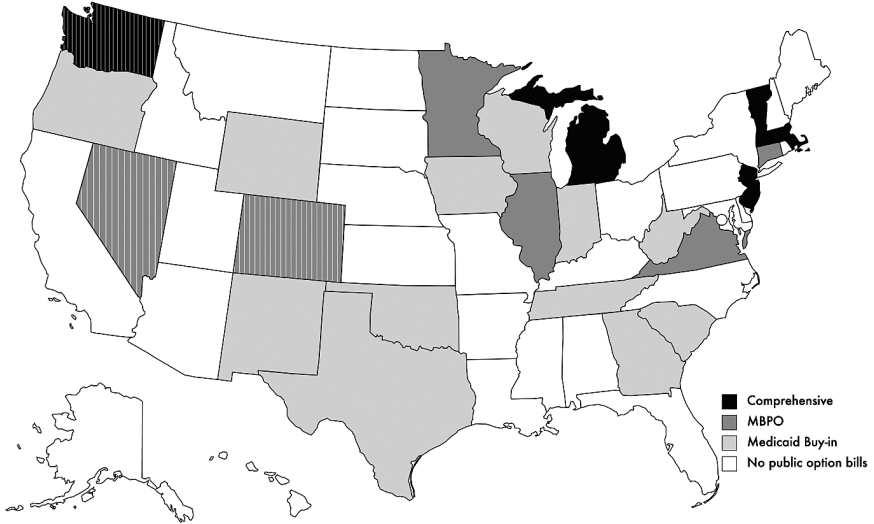
Comprehensive Public Options			
	1 Massachusetts	2011	H.B. 1228*
	2 Massachusetts	2013	S.B. 514*
	3 Massachusetts	2015	H.B. 1033*
	4 Massachusetts	2017	S.B. 638*
	5 Massachusetts	2019	S.B. 697*
	6 Michigan	2018	H.B. 6285
	7 New Jersey	2016	A.B. 4211 / S.B. 3138
	8 New Jersey	2018	A.B. 1343
	9 New Jersey	2020	S.B. 1947*
	10 New Jersey	2021	A.B. 5029
	11 Vermont	2011	H.B. 146
	12 Vermont	2015	H.B. 88*
	13 Vermont	2017	H.B. 28*
	14 Washington	2019	H.B. 1104
	15 Washington	2019	S.B. 5222
Total	5 states		15 bills

Overall Totals	23 states		49 bills
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* Bills counted in more than one category

** Bills signed into law

FIGURE: STATES THAT INTRODUCED PUBLIC OPTION BILLS 2010-2021**



**States are shaded based on the most comprehensive public option introduced. For example, Massachusetts considered all three types of public option plans and is therefore shown in the darkest color.

Vertical lines denote a state that signed a public option bill into law. Note that Washington passed an MBPO but is shown in black because it also considered a comprehensive public option bill in 2019.

