

# State Progress Toward a Healthcare Public Option: The State of Washington is the Trailblazer

*\*Update: On May 13, 2019, Governor Jay Inslee [signed](#) SB 5526 into law making Washington the first state public option plan. Washington now takes the first difficult steps toward implementing the law.*

In the current political climate, debate continues at the state and federal level over the role of government in containing health care costs and ensuring coverage for all Americans. Specifically, in a survey done in March 2019 by the Kaiser Family Foundation, a majority of Americans (56%) supported a national health plan.[\[1\]](#) Little consensus, however, exists on how to achieve national healthcare. Congress introduced eight different bills so far in 2019 proposing different plans for universal coverage. The Congressional Budget Office also issued a report on single-payer plans early this month (look for coverage of federal efforts toward universal coverage in future posts).

At the state level, meanwhile, a few state legislatures aren't waiting for Congressional action. In this post, we take a look at nine states that have introduced bills this session to provide universal coverage for their residents. This post compares those efforts, including Washington state's bill, now awaiting the governor's signature, to create a public plan for sale on the state insurance exchanges.

## **Diverse Plans for Universal Coverage: Single Payer vs. Public Option Plans**

One of the most fundamental differences among the state proposed plans is whether the state would create 1) a *single-payer system* to provide coverage for all residents or citizens that eliminates private insurance, or 2) a *public option* that offers coverage through a government plan, but maintains private insurance as an option for employer and individual coverage. See The Source's [prior post](#) for a detailed comparison of single-payer vs. public option plans.

Some states, including Iowa ([HF 96](#)), Hawaii ([HB 1286](#)), and Rhode Island ([S 0290/H5611](#)), introduced single payer plans in 2019, and nine additional states have considered similar legislation in the past two years.[\[2\]](#) All of these bills, however, have died in committee and it appears likely that no state will gather the political support necessary to pass a single-payer plan. Additionally, it remains unclear whether any state will be able to overcome the legal and financial challenges to implement a single payer system.[\[3\]](#) In 2011, Vermont passed a law to adopt a single payer system,[\[4\]](#) but the state could not produce a plan to implement it.[\[5\]](#)

Other states, however, have gathered more support for public option bills. State public option bills generally fall in one of three categories – 1) those that aim to explore the idea of a public option, 2) those that create a buy-in to the state Medicaid program, and 3) those that create a new state health plan with reimbursement rates based on Medicare fee-for-service rates.

## **States Exploring Tailored Public Option Plans: California, Colorado, and Connecticut**

In 2018, California passed [AB 2472](#) to establish “a plan that includes ... a feasibility analysis... of a public health insurance plan option to increase competition and choice for health care consumers...[and] an analysis of the extent to which a new public health insurance plan option could address the underlying factors that limit health plan choices in some regions.”[\[6\]](#) Colorado’s governor [is expected](#) to sign a similar bill passed by the state legislature ([HB 19-1004](#)) on April 22, 2019, requiring the state’s Department of Health Care Policy and Financing, which oversees the state Medicaid program, and the state’s Division of Insurance, which oversees the private insurers in Colorado, “to develop and submit a proposal to... the general assembly concerning the design, costs, benefits, and implementation of a state option for health care coverage.”

While neither California nor Colorado has a timeline for when a public option might be implemented, both states are considering how to tailor a public option to the specific needs of that state. For example, Colorado has fourteen counties where only one insurance option is sold on the state insurance exchange, but 89% of the state’s residents live in counties where at least 3 insurance companies offer plans and 56% live in counties where more than 5 insurance companies offer plans.[\[7\]](#) These figures make Colorado one of the more competitive marketplaces in the U.S., but also demonstrate that a large rural portion of the state has few options. Furthermore, insurers and providers in these regions may face unique challenges when trying to negotiate rates and fulfill network adequacy laws. As a result, Colorado must balance many factors when considering how to implement a public option.

Notably, Colorado’s HB 19-1004 does not specify provider reimbursement rates, but rather requires the task force to “evaluate provider rates necessary to incentivize participation and encourage network adequacy and high-quality health care

delivery.”[\[8\]](#) California’s new law also does not specify how the state will set rates for providers. Provider reimbursement rates will likely be one of the more difficult issues to work out when designing a public option. If provider rates are set too high, premiums and cost-sharing will likely duplicate private insurance plans and individuals will not benefit from the public option. If provider reimbursement rates are set too low, providers may choose not to participate in the plan and residents may lose access to care, especially in rural areas. Furthermore, if the state is able to persuade providers to participate at a low rate (for example, by requiring participation in the public option as a condition for participating in the state Medicaid program), they may unintentionally drive other insurers who cannot match their premiums out of the market. This result, however, can be beneficial to patients, as premiums and cost-sharing for state residents may be lower if the state can demand lower reimbursement rates with providers than private insurers. Nonetheless, states must consider how to fairly set prices to retain needed providers to ensure access for all of their residents.

By contrast, Connecticut’s House Committee on Appropriations is currently considering a bill ([SB 134](#) / [HB 7267](#)) that would require the state to develop a public option, called the ConnectHealth Plan, to be available for sale not later than January 1, 2021. The timeline for implementation, therefore, is much faster than in California or Colorado. In addition, the bill provides a framework for how the public option plan will be constructed. It requires the health insurance plan covering state employees and retirees, or an equivalent plan, be available to individuals and small business purchasing healthcare coverage on the state health insurance exchange.[\[9\]](#) By using a plan developed to serve the employees of the state as

a foundation for the coverage, it presumably takes into account provider rates and network adequacy in that state's specific healthcare markets.

### **States Considering Buy-in to Medicaid: Minnesota and New Mexico**

Rather than have a state agency craft a new insurance plan, Minnesota ([SF 720](#)) and New Mexico ([SB 405](#) / [HB 416](#)) considered bills that would allow individuals to purchase health insurance coverage through the state Medicaid program. Minnesota's bill would have allowed the state to set the premium amounts for the Medicaid buy-in plan at a rate sufficient to pay for the coverage (i.e. the state would not provide additional funds to the program for premium subsidies). Under New Mexico's bill, the state would offer premium subsidies to residents with incomes below 200% of the federal poverty level. Both bills, however, appear to have died in committees.

Furthermore, it remains unclear whether a Medicaid buy-in will be popular with individuals purchasing coverage on state exchanges. No state has offered Medicaid coverage for sale, but the cities of Los Angeles and New York offer Medicaid buy-in options to individuals purchasing coverage on state exchanges. L.A. Care, Los Angeles' Medicaid program, was first offered for sale on the Covered California exchange in 2013, and MetroCare, New York City's Medicaid program, is available in the New York exchange. Enrollment numbers for 2019 show that more than 25% of enrollees living in L.A. County, who purchased coverage on the California state exchange, chose L.A. Care.[\[10\]](#) In January 2019, New York Mayor Bill DeBlasio [announced changes](#) to MetroCare, now renamed MetroPlus, to boost enrollment in the city's public option. The experience of these two city-wide programs suggest that a Medicaid buy-in may appeal to individuals who purchase

individual or small-group insurance plans, but, since these individuals are a small portion of the insurance market, it is unclear if a Medicaid buy-in can appeal to enough individuals to increase competition in the larger insurance market, thereby reducing healthcare costs overall.

## **A Pioneer State in Implementing Public Option Plans: Washington**

The state with the greatest potential to offer a public option to compete with private plans, thereby increasing competition and decreasing costs, is the state of Washington. On April 28, the state legislature passed [SB 5526](#), to increase the availability of quality, affordable health coverage in the individual market. The bill, now only awaiting the Governor's signature, will likely become law since the governor is an [outspoken proponent](#) of the measure and his [proposed budget](#) includes \$500,000 to fund the initial work to set up the public option.

This bill tasks the Washington State Health Care Authority (HCA), a state agency that purchases healthcare for more than 2 million state residents including state Medicaid enrollees and public employees, to contract with one or more health carriers to offer qualified health plans on the Washington health benefit exchange beginning in plan year 2021. Among other requirements, the bill limits the amount the plan "reimburses [to] providers and facilities for all covered benefits, excluding pharmacy benefits,... [to] 160% of the total amount Medicare would have reimbursed... for the same or similar services in the statewide aggregate."[\[11\]](#) The plan also sets a minimum for reimbursement to primary care and pediatric providers of 135% of Medicare rates and to rural or critical access hospitals at 101% of Medicare rates.[\[12\]](#) By December 1, 2022, the HCA, the state

insurance commissioner, and the Washington health benefit exchange must submit a report to the legislature detailing the impact of this public option on qualified health plan choice, affordability, and market stability. Furthermore, this group must develop a plan to implement and fund premium subsidies for individuals with incomes below 500% of the federal poverty line, with the goal of enabling individuals to spend less than 10% of their income on premiums.[\[13\]](#)

The way Washington sets provider rates mirrors Montana's successfully implemented changes to the way it covers state employees. In Montana, the state agreed to pay hospitals 234% of the Medicare rate for services provided to state employees covered by the state plan, if the hospitals accepted that rate as full payment and agreed not to balance bill patients.[\[14\]](#) By 2018, all ten of Montana's largest hospitals and 41 of 48 smaller hospitals agreed to participate in the program,[\[15\]](#) and the state saved an estimated \$32 million in the first 30 months. The setting of rates as a percentage of Medicare rates builds on decades of experience at the Centers for Medicare and Medicaid Services in setting reasonable rates for medical services. As a result, it provides a good foundation for setting prices in a state.

Washington's bill reasonably requires the HCA to consider Medicare rates, but allows the agency some leeway in determining the actual reimbursement rates and encourages value-based reimbursement methods. In addition, the bill allows the caps on reimbursement rates to be lifted if the agency can do so without raising rates or is unable to create a sufficient provider network. While it remains to be seen if Washington is able to implement this law in a way that brings down healthcare expenditures, the state should be applauded for taking the first steps toward designing a plan that can compete with private insurance.

## Conclusion

States are considering a range of options to address the rising costs of healthcare, including single-payer systems that fundamentally change the way health insurance operates. Perhaps one of the most promising reform efforts come from states that seek to sell a public option alongside private insurance. In this effort, one of the more difficult considerations is how to set reimbursement rates for providers. States must balance the goal of appealing to the public and reducing costs with encouraging provider participation in the plan, in order to ensure access for all state residents. In this controversy, Washington has emerged as a state willing to consider the task of balancing these concerns by capping the initial reimbursement rates to 160% of Medicare rates and allowing the plans to adjust them as long as they can do so without increasing premiums. The state legislature has until June 1, 2019 to appropriate funding for this measure, but regardless of the outcome in Washington, other states and the federal government can learn from the discussions about capping provider rates and building networks in public option plans. Furthermore, the diversity of options considered by states can serve as laboratories to experiment with provisions and inform federal efforts to provide universal coverage,

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[1] Ashley Kirzinger, Lunna Lopes, Bryan Wu, and Mollyann Brodie. *KFF Health Tracking Poll – March 2019: Public Opinion on the Domestic HIV Epidemic, Affordable Care Act, and Medicare-for-all*. Kaiser Family Foundation. March 2, 2019. Available from:

<https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-march-2019/>.

[2] The states are: California ([AB 2517](#) – 2018), Florida ([SB 1872](#) – 2018), Illinois ([HB 2436](#) – 2017), Maine ([LD 386](#) – 2017), Maryland ([SB 1002 / HB 1516](#) – 2018), Massachusetts ([S 619](#) – 2018), Michigan ([HB 6285](#) – 2018), New Hampshire ([HB 1793](#) – 2018) and Ohio ([HB 440](#) – 2017). Rhode Island considered legislation in both 2018 ([S 2082 / H 7284](#)) and 2019.

[3] *Single-payer health care systems are no easier in the states.* RollCall. March 29, 2019. <https://www.rollcall.com/news/congress/single-payer-systems-no-easier-states>.

[4] VT H. 202 Act 48 (2011). <https://legislature.vermont.gov/bill/status/2012/H.202>

[5] Amy Goldstein, *Why Vermont's single-payer effort failed and what Democrats can learn from it*, Washington Post, April 29, 2019. Available from: [https://www.washingtonpost.com/national/health-science/why-vermonts-single-payer-effort-failed-and-what-democrats-can-learn-from-it/2019/04/29/c9789018-3ab8-11e9-a2cd-307b06d0257b\\_story.html?\\_hsenc=p2ANqtz-\\_fRb\\_BxpF6Fu\\_k\\_rJ0t0lVmVYNkbov-8sC\\_Pi\\_c\\_XbcdXa0VuQxJjj\\_WCTf0Zb01Yzby36lsSM4JQaZc5gEUwcKQfcm7akEKC3ELMET00D0b9Wc4U&\\_hsmi=72207276&utm\\_campaign=KHN%3A%20First%20Edition&utm\\_content=72207276&utm\\_medium=email&utm\\_source=hs\\_email&utm\\_term=.3bab5fa7fa46](https://www.washingtonpost.com/national/health-science/why-vermonts-single-payer-effort-failed-and-what-democrats-can-learn-from-it/2019/04/29/c9789018-3ab8-11e9-a2cd-307b06d0257b_story.html?hpid=hp_hp-top-table-main-vermont-single-payer%3A%20First%20Edition&utm_campaign=KHN%3A%20First%20Edition&utm_content=72207276&utm_medium=email&utm_source=hs_email&utm_term=.3bab5fa7fa46)

[6] CA AB 2472 (2018).

[7] Connect for Health Colorado Among the Most Competitive State Marketplaces, New Analysis Shows • Connect for Health Colorado, Connect for Health Colorado (2019), <http://connectforhealthco.com/connect-for-health-colorado-among->

[the-most-competitive-state-marketplaces-new-analysis-shows/](#)  
(last visited May 9, 2019).

[8] CO HB 19-1004 (2019).

[9] CT HB 7267 §7(a) (2019).

[10] 2019 Covered California Open Enrollment Plan Selection Profile. Updated 1/18/2019. Available from: <https://hbex.coveredca.com/data-research/>.

[11] WA SB 5526 §3(g)(i).

[12] WA SB 5526 §3(h) and WA SB 5526 §3(i).

[13] WA SB 5526 §6(1).

[14] The 'holy cow' moment that led Montana to save \$15.6M on hospital care. *Advisory Board*. June 27, 2018. Available from: <https://www.advisory.com/daily-briefing/2018/06/27/montana>.

[15] Transparent Pricing. Montana.gov Official State Website. <http://benefits.mt.gov/transparentpricing>. (last visited Feb 15, 2019).