A public option for Oregon: Health care policy lessons from other states

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Standing Up To Powerful Interests

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ABSTRACT

Health care costs too much. Insurance premiums on the health insurance exchange in Oregon have risen 77% since 2014, and consumers in the state pay the third-highest average deductible in the nation.[1] These costs lead to negative effects on Oregonians, including medical debt and other financial and emotional burdens. Whether they are stressing about choosing and paying for the right insurance plan, or worrying about paying for services, Oregonians deserve better when it comes to health care and insurance.

Oregon is pursuing various methods to lower the cost of care, from monitoring provider consolidation to banning surprise medical bills. One of the more recent considerations is a public health insurance option. Other states have adopted public option programs, and Oregon can learn from those states' policies in shaping its own. This paper will explore three case studies of public option designs from Washington, Colorado, and Nevada and make recommendations as to how Oregon's public option should be structured.

INTRODUCTION

The high cost of health care in Oregon

Health care costs too much. The United States spends nearly a fifth of its gross domestic product on health care, at approximately $11,500 per capita.[2] Often, these expenditures are coming directly from consumers' pockets. In 2019, households accounted for the second-largest share of health care spending at 28.4%, just over half a percentage point behind the federal government.[3]

The U.S. outpaces many other well-developed countries' health care spending, as well as in the increase in its spending.[4] Data from the Organisation for Economic Co-operation and Development (OECD) demonstrate that the United States spends more in total spending,

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[1] Rate change calculated by determining the difference between the average approved individual market rates 2014-2022 found at DFR rate filings, archived at https://web.archive.org//web/20211028214226/https://dfr.oregon.gov/healthrates/Pages/find-filing.aspx; Oregon Health Authority, "Charting a Sustainable Path for Health Care Spending," p. 1, archived at https://web.archive.org/web/20211028214037/https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost-Growth-Target-Overview.pdf.

[2] Centers for Medicare and Medicaid Services, "Historical National Health Expenditure Data," available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.

[3] Centers for Medicare and Medicaid Services, "NHE Fact Sheet," 2019, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.

[4] Roosa Tikkanen, "Multinational Comparisons of Health Systems Data, 2019," *The Commonwealth Fund*, p. 2, archived at https://web.archive.org/web/20211028215504/https://www.commonwealthfund.org/sites/default/files/2020-01/Tikkanen_multinational_comparisons_hlt_sys_data_2019_01-30-2020.pdf.

including out-of-pocket payments and government expenditures.[5] Norway, with the next-highest government spending, is $3,000 per capita behind the United States, and U.S. consumers have the third-highest out-of-pocket spending per capita after Switzerland and Malta.[6]

Despite the amount of money poured into health care in the United States, other nations have significantly better health outcomes.[7] Compared to 10 other high-income, developed nations, the United States has the lowest life expectancy and the highest rate of chronic disease.[8] One area in which the U.S. excels is preventative measures like flu vaccinations for seniors and breast cancer screenings, but the country still has the second-highest rate of hospitalizations from preventable causes like diabetes and hypertension.[9]

The costs aren't just at the national level. Looking at Oregon, health insurance premiums have risen 77% since 2014.[10] On top of the rising premiums, Oregon has the third-highest average deductible in the nation, leaving even insured consumers financially exposed as they still have to pay through the nose before coverage kicks in to cover costs.[11] Insurance companies in Oregon also pay more than those in nearly any other state, which certainly contributes to the high consumer costs as well as overall health care spending.[12] This growth in health care spending has been increasing across the industry in recent years. On average, Oregon's spending per capita has risen 6.5% every year from 2013-2017, faster than the national average and outpacing wages.[13]

The high cost of health care has real effects on Oregonians. Pre-pandemic, approximately 94% of Oregonians had health insurance, but high costs are making it harder for individuals and families to purchase insurance and get the health care they need.[14]

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[5] Organisation for Economic Co-operation and Development, "Health Spending," available at https://data.oecd.org/healthres/health-spending.htm.
[6] Id.
[7] Roosa Tikkanen and Melinda K. Abrams, "U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?" *The Commonwealth Fund*, 30 January 2020, available at https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019.
[8] Id.
[9] Id.
[10] Rate change calculated by determining the difference between the average approved individual market rates 2014-2022 found at DFR rate filings, archived at https://web.archive.org//web/20211028214226/https://dfr.oregon.gov/healthrates/Pages/find-filing.aspx.
[11] Oregon Health Authority, "Charting a Sustainable Path for Health Care Spending," p. 1.
[12] Bill Johnson, Kevin Kennedy, et al., "Comparing Commercial and Medicare Professional Service Prices," Figure 2, *The Health Care Cost Growth Institute*, 13 August 2020, archived at https://web.archive.org/web/20211028220734/https://healthcostinstitute.org/hcci-research/comparing-commercial-and-medicare-professional-service-prices.
[13] Oregon Health Authority (OHA), "Sustainable Health Care Cost Growth Target Implementation Committee Recommendations Final Report to the Oregon Legislature," January 2021, p. 10, archived at https://web.archive.org/web/20211015225342/https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost%20Growth%20Target%20Committee%20Recommendations%20Report%20FINAL%2001.25.21.pdf. The national average was 4.5% from 2016-2019. Anne B. Martin, Micah Hartman, et al., "National Health Care Spending In 2019: Steady Growth For The Fourth Consecutive Year," *Health Affairs* 40(1): 14–24, p. 14 https://doi.org/10.1377/hlthaff.2020.02022, 16 December 2020.
[14] Oregon Health Authority (OHA), "Overview," *2019 Oregon Health Insurance Survey*, October 2020, available at

OREGON VOICES

One woman, Abby G., told OSPIRG's Voices for Better Care that her monthly premium increased from $561 to $678 over the course of two years — and this was after she downgraded her plan because she couldn't afford the higher premiums of a higher value plan. On the flip side, she now faces out-of-pocket expenses she can't afford. "If I really had to, I could cover the deductible, but it would take a chunk out of my savings, and I'm not sure I could do it more than once or twice."[15]

With high insurance prices and coverage that doesn't actually offset many costs for consumers, it is no wonder that 60% of the people who filed for Chapter 7 or Chapter 13 bankruptcy in Oregon in 2019 reported some amount of medical debt as part of their filing.[16]

Oregon has adopted some policies to reduce health care costs

States have various avenues to pursue lower health care costs, and Oregon has made this a priority in the last decade. The state's premium rate review process ensures transparency in insurance rates in an attempt to prevent costs from rising out of control.[17] With the rate review process, consumer groups and Oregonians are able to bring "public pressure to bear on unjustified rate increases."[18] This saved consumers $179 million dollars from 2010-2015, and more since then.[19] Since 2017, Oregon has moved its attention to cost controls, creating a Primary Care Payment Reform Collaborative (PCPRC) to "direct greater health care resources

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https://visual-data.dhsoha.state.or.us/t/OHA/views/OregonHealthInsuranceCoverageRates/Overview?%3Aiid=1&%3AisGuestRedirectFromVizportal=y&%3Aembed=y.

[15] Abby G., Voices for Better Care, Oregon State Public Interest Research Group, available at https://voicesforbettercare.org/post/643406972002189312/abby-g-says-my-alimony-plus-retirement-account.

[16] Jamie Friedman, Elizabeth Ridlington, et al. "Unhealthy Debt:Medical costs and bankruptcies in Oregon," p. 4, *Frontier Group* and *Oregon State Public Interest Research Group*, Fall 2021, archived at https://web.archive.org/web/20210909214531/https://ospirg.org/sites/pirg/files/reports/OSPIRG_Unhealthy-Debt%20FINAL%20(1).pdf.

[17] Oregon Department of Financial Regulation (DFR), "Understanding health insurance rate review," archived at https://web.archive.org/web/20201016184157/https://dfr.oregon.gov/healthrates/Pages/understanding-rate-review.aspx.

[18] Oregon State Public Interest Research Group (OSPIRG), "Health Insurance Rate Watch Program," archived at https://web.archive.org/web/20211028225351/https://ospirg.org/issues/orp/health-insurance-rate-watch-project.

[19] OSPIRG Foundation, "Accountability in Action: Rate Review Cuts over $24 Million in Waste from 2015 Health Insurance Premiums," 11 September 2014, archived at https://web.archive.org/web/20210411035047/https://ospirgfoundation.org/reports/orf/accountability-action-rate-review-cuts-over-24-million-waste-2015-health-insurance; OSPIRG Foundation, "Accountability in Action: Rate Review Cuts More Than $100 Million from 2018 Health Insurance Premiums," 20 July 2017, archived at https://web.archive.org/web/20211117192353/https://ospirgfoundation.org/blogs/blog/orf/accountability-action-rate-review-cuts-more-100-million-2018-health-insurance.

and investments toward supporting and facilitating health care innovation and care improvement in primary care" and a Sustainable Health Care Cost Growth Target Program to limit the increases in annual health care spending and report on cost drivers.[20] Increasing consumer protections around balance billing and surprise medical bills in 2018 reduced some of the outrageous burden on consumers, and efforts to increase transparency and lower the costs of prescription drugs have also been important parts of Oregon's cost control efforts.[21]

These steps are pieces of the larger push to contain health care spending and costs. In lowering costs, Oregon can make insurance less of a burden, and thereby also make it easier for the uninsured to get coverage. The steps Oregon has taken already make it easier to reach those goals, but there are still significant challenges.

Lately in Oregon, there has been interest in a single-payer system to lower costs, but that proposal faces several obstacles that make it a lengthy and expensive process, from reconciliation with federal laws to implementation.[22] Another, more incremental, approach would be to create a public health insurance option.

Policy decisions necessary for a public option

A public option can take one of two basic forms. It may be a health plan run by the government and offered in competition with private plans in order to bring down costs throughout the market.[23] Alternatively, it may be less strictly "public," and function as more of a

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[20] Oregon Health Authority, Primary Care Payment Reform Collaborative, archived at https://web.archive.org/web/20211029200805/https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx; Oregon Health Authority, Sustainable Health Care Cost Growth Target, archived at https://web.archive.org/web/20211029201117/https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx.

[21] Oregon Division of Financial Regulation, "New law protects consumers from surprise medical bills," 2 March 2018, archived at https://web.archive.org/web/20211029201619/https://dfr.oregon.gov/news/2018/Pages/20180301-balance-billing.aspx. Surprise billing often leads to higher bills than a consumer was expecting due to the use of providers the consumer didn't choose who aren't covered by insurance, usually without the consumer's knowledge. Prescription drug transparency: HB 4005 (2018), archived at https://web.archive.org/web/20211029202919/https://olis.oregonlegislature.gov/liz/2018R1/Measures/Overview/HB4005; SB 763 (2021), archived at https://web.archive.org/web/20211029203143/https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/SB763. Lower drug costs: SB 844 (2021) https://web.archive.org/web/20211012163253/https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/SB844.

[22] Bend Editorial Board, "Editorial: Single-payer plan in the works for Oregon," 5 January 2021, archived at https://web.archive.org/web/20210128104649/https://www.bendbulletin.com/opinion/editorial-single-payer-plan-in-the-works-for-oregon/article_8c28e6f8-4ebc-11eb-9e01-13a72e0e6288.html.

[23] Nicole Rapfogel and Emily Gee, "4 Myths About the Public Option," Center for American Progress, 20 November 2020, archived at https://web.archive.org/web/20211029204537/https://www.americanprogress.org/issues/healthcare/news/2020/11/20/493105/4-myths-public-option/.

public-private partnership wherein the government regulates the design and cost of the plan but private insurance companies or other non-government entities are the ones offering it.[24]

A public option can seek both to lower costs for consumers and to reduce overall health care spending. Capping provider reimbursement rates (in other words, what insurers can pay for services) and requiring participation is one policy lever, for example, that can help lower premiums and what consumers pay for coverage; using value-based payments also reduces wasteful spending.[25] Changing the plan benefits and covered services affects consumers' cost-sharing.[26] Increased competition in the market also lowers costs as insurers strive to bring a more attractive product (insurance plan) to market.[27] Government input can also lower overhead and administrative costs by streamlining plan design and administration.[28] In terms of overall health care spending, when consumers are able to use their insurance effectively to cover health care costs, they can seek care immediately instead of delaying or avoiding it.[29] Instead of worsening conditions, health care outcomes will improve and the need for higher-cost treatments and care will decrease, lowering overall health care expenditures.

However, creating a successful public option also requires answering other questions: how or will a public option expand coverage to more people, what other ability does the government have to alleviate cost through subsidies or other aid, who will be eligible for the public option, and how can participation in the plan — from providers to insurers and other risk-bearing entities to consumers — be sufficiently broad?

Some states have begun to answer these questions as they design, pass, and implement their own public option plans. In 2019, Washington was the first state to adopt a public option program, called Cascade Care. Two years later, both Nevada and Colorado

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[24] Christine Monahan, Kevin Lucia, and Justin Giovannelli, "State Public Option–Style Laws: What Policymakers Need to Know," *The Commonwealth Fund*, 23 July 2021, archived at https://web.archive.org/web/20211029205125/https://www.commonwealthfund.org/blog/2021/state-public-option-style-laws-what-policymakers-need-know.

[25] Matthew Fiedler, "Capping prices or creating a public option: How would they change what we pay for health care?" *Brookings Institution*, 19 November 2020, archived at https://web.archive.org/web/20210730053319/https://www.brookings.edu/research/capping-prices-or-creating-a-public-option-how-would-they-change-what-we-pay-for-health-care/; Oregon Health Authority, "Value-Based Payments," available at https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx.

[26] Chiquita Brooks LaSure, Kyla Ellis, et al. "Oregon Public Option Report: An Evaluation and Comparison of Proposed Delivery Models," p. 7, *Manatt Health*, December 2020, archived at https://web.archive.org/web/20211029210500/https://www.oregon.gov/oha/HPA/HP/docs/Manatt-Health-Oregon-Public-Option-Report-An-Evaluation-of-Proposed-Delivery-Models-December-16-2020.pdf.

[27] Rapfogel and Gee, "4 Myths About the Public Option."

[28] Matthew Fiedler, "Designing a public option that would reduce health care provider prices," *Brookings Institution*, 5 May 2021, archived at https://web.archive.org/web/20210618131159/https://www.brookings.edu/essay/designing-a-public-option-that-would-reduce-health-care-provider-prices/.

[29] Ashley Kirzinger, Cailey Muñana, et. al, "Data Note: Americans' Challenges with Health Care Costs," *Kaiser Family Foundation*, 11 June 2019, archived at https://web.archive.org/web/20211029211144/https://www.kff.org/health-costs/issue-brief/data-note-americans-challenges-health-care-costs/.

passed public option bills. Though all are called 'public options,' there are variations in each state's policy.

As Oregon considers its own public option as the next step to lower health care costs, design questions are at the forefront of the policy discussion. Comparing what other states have done in creating their public option programs can help illuminate the policy decisions that Oregon will face in designing its own public option health plan to lower costs and health care spending.

CASE STUDIES

Three states have passed public option bills into law: Washington, Colorado, and Nevada. All of the states that have passed or are looking to implement a public option are motivated by the need to lower health care costs. Another major driver is increasing access to care for individuals, families, and small businesses.

Each case study will provide an overview of trends in the state's health care costs and other policy efforts it has undertaken to lower these costs. For each state, the case study will provide a breakdown of the public option bill or bills that created the public option program and will review the policy decisions that each state made in creating its program. Finally, the case studies provide a brief consideration of each policy and its success.

WASHINGTON

Washington's public option was the first to be passed and implemented, with passage in 2019 for coverage beginning in 2020. It set provider reimbursement rates to lower costs, but ran into initial problems ensuring provider participation and availability of the plan. Later iterations of the program, passed by the legislature in 2021, addressed these issues by requiring participation in the program. Oregon can avoid the need for multiple iterations of the program by requiring participation in and procurement of public option plans from the beginning.

Background

Washington's health care costs have been rising to the detriment of consumers. Washington has operated a state-based exchange since 2014, and expanded Medicaid prior to that, which helped slow the rising cost of premiums and reduce the uninsurance rate.[30]

[30] Louise Norris, "Washington and the ACA's Medicaid expansion," *Health Insurance.org*, 6 October 2020, archived at https://web.archive.org/web/20211117201457/https://www.healthinsurance.org/medicaid/washington/; Louise Norris, "Washington health insurance marketplace: history and news of the state's exchange," 1 September 2021, archived at https://web.archive.org/web/20211117201617/https://www.healthinsurance.org/health-insurance-marketplaces/washington/.

However, problems began to arise after a few years: 2017 saw a marked increase in deductibles.[31] Though the market had been relatively competitive, in 2018 there was a significant decline in plans offered through the exchange and an increase in both premiums and deductibles.[32] The exchange serves approximately 220,000 Washingtonians who were affected by these cost increases, but the impact of the cost increases was especially severe for those ineligible for subsidies or near the income cutoff for eligibility.[33] The state-based exchange reported that Washingtonians were paying up to 30% of their household income on premiums, and nearly half of exchange purchasers had $6,000 or higher deductibles.[34] The cost is even higher for the uninsured; consumer advocates from Northwest Health Law Advocates (NoHLA) highlighted the crisis that medical expenses often place on Washingtonians, noting that half of uninsured adults said they had $100 or less after bills every month, and less than $100 in savings.[35]

Unexpected medical expenses on top of other daily needs put undue financial pressure on Washington families, and the public option would lower those costs. Washington consumers made this clear when they came out in support of a public option and shared their experiences of routinely delaying treatment and prioritizing budgeting for expensive diseases and related necessary services.[36]

Washington's public option developed with the support of a governor looking to run for president after other options to address affordability failed.[37] Despite the cost problems described above, the legislature was not able to pass either surprise billing protections or a reinsurance program that could have helped reduce costs for consumers.[38] However, Governor

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[31] Pam McEwan, "Senate Health Care Committee Presentation," p. 12, *Washington Health Benefit Exchange*, 16 January 2017, available at https://www.wahbexchange.org/content/dam/wahbe/2013/05/HBE_LEG_170116_Exchange_Overview_SHC.pdf.

[32] Pam McEwan, "Senate Health & LTC Committee Presentation," p. 9 and 11, *Washington Health Benefit Exchange*, 18 January 2018, available at https://www.wahbexchange.org/content/dam/wahbe/2018/01/HBE_EB_Leg_180108_HCC-Presentation.pdf.

[33] Pam McEwan and Joan Altman, "Senate Health & Long-Term Care Committee Presentation," p. 3, 9-10, *Washington Health Benefit Exchange*, January 2019, available at https://www.wahbexchange.org/content/dam/wahbe/2019/01/WAHBE_SHC_011619_Final_submitted.pdf.

[34] Id.

[35] Washington House Health Care & Wellness Committee Public Hearing, 30 January 2019, 01:27:13, available at https://www.tvw.org/watch/?eventID=2019011319.

[36] Id. at 00:43:10, 00:47:10, and 01:41:14.

[37] Paul Roberts, "The One State Taking a Big Run at Health Reform," 25 November 2019, archived at https://web.archive.org/web/20211029220844/https://www.politico.com/news/agenda/2019/11/25/is-medicare-for-all-right-answer-wrong-idea-072462.

[38] Washington Office of the Insurance Commissioner, "Kreidler's reinsurance and surprise billing proposals fail to pass this session," 9 March 2018, archived at https://web.archive.org/web/20210124225436/https://www.insurance.wa.gov/news/kreidlers-reinsurance-and-surprise-billing-proposals-fail-pass-session. Reinsurance programs lower premiums on the exchange by giving assurances to insurance companies that the government will insure them from extremely high-cost consumers they may cover. Sara Lueck, "Reinsurance Basics: Considerations as States Look to Reduce Private Market Premiums," *Center on Budget and Policy Priorities*, 3 April 2019, archived at https://web.archive.org/web/20211013184408/https://www.cbpp.org/research/health/reinsurance-basics-considerations-as-states-look-to-reduce-private-market-premiums.

Jay Inslee was planning a presidential campaign for 2020, and health care was one of the key issues in the election cycle.[39] After the other efforts failed, long-time health care champion Representative Eileen Cody joined the governor's push to lower health care costs and to improve coverage, introducing Washington's public option bill in 2019.[40]

Policy

- Requires silver and gold level standardized plans be offered on-exchange
- Sets provider reimbursement rates for standardized public option plans (separate from other standard plans) to an aggregate of 160% of Medicare, with a minimum of 135% for primary care
- Waives reimbursement rate requirements if the carrier otherwise reached premium reduction standards
- Requires hospital participation in at least one public option plan
- Authorizes a 1332 waiver for further subsidies

The initial public option that Washington adopted came through SB 5526 (2019), or Cascade Care. That version includes three main things: 1) the state requires insurers to offer silver and gold level plans designed by the state with standardized benefits; 2) it establishes provider reimbursement rates for standardized public option plans, limited to an aggregate 160% of Medicare rates; and 3) it orders the Washington Health Benefit Exchange (the state-based exchange) to develop a subsidy plan to be sent back to the legislature.[41]

The standard plan design is intended to "reduce deductibles, make more services available before the deductible, provide predictable cost sharing, maximize subsidies, limit adverse premium impacts, reduce barriers to maintaining and improving health, and encourage choice based on value, while limiting increases in health plan premium rates."[42] The public option plans go a little further, explicitly setting provider reimbursement rates in order to guide lower premium rates. In order to ensure the availability of preventative services, the public option sets a minimum reimbursement rate of 135% of Medicare for primary care. The minimum rate also protects critical access hospitals designated at the federal level for financially vulnerable rural facilities and other rural providers by making their rates higher than the typical

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[39] Dan Goldberg, "The 2020 Dem who may actually know how to fix health care," *Politico*, 28 July 2019, archived at https://web.archive.org/web/20201127020240/https://www.politico.com/story/2019/07/28/jay-inslee-2020-climate-change-health-care-1437877.

[40] HB 1523 (2019-20), Washington Legislature, available at https://app.leg.wa.gov/billsummary?Year=2019&BillNumber=1523. Eileen Cody, "Biography," Washington Legislature, available at https://housedemocrats.wa.gov/cody/.

[41] SB 5526 (2019), Washington Legislature, p. 1, 3-5 sec. 1, 3, archived at https://web.archive.org/web/20211029222500/https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5526-S.SL.pdf.

[42] Id. at p. 1 sec. 1, archived at https://web.archive.org/web/20211029222500/https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5526-S.SL.pdf.

Medicare reimbursement.[43] Legislators had initially considered setting the maximum aggregate rate at Medicare, but raised it to 160% of Medicare after committee hearings.[44] Opponents warned that low rates would not be sustainable. Doctors were also concerned that lower physician reimbursement would reduce capacity to serve Medicaid patients and other populations, and shift costs to other groups in the market.[45]

However, Washington did not experience these problems opponents had warned about, and doesn't foresee that changing as the 2021 amendments (detailed below) are implemented in 2022. Both the governor's office and the state-based exchange supported the practicality of the public option and rate-setting, pointing out that other nations reach lower spending through similar processes, and that this is something the state can do without federal money or high costs to the state to lower costs and create affordable, usable coverage for Washingtonians.[46]

Still, insurance companies worried they would not have enough providers accepting the public option plan to make it usable. To alleviate those concerns, Cascade Care allowed for a waiver of the reimbursement rate caps in the case of inadequate provider networks, so long as the plan reduces premiums by 10% compared to the previous year.[47] Unofficial estimates for the public option said it could lower premiums by 5-10%, so this waiver is in keeping with that goal.[48] The bill also allows public option reimbursement to be exempt from the state's business and occupation tax (Washington's version of income tax), to "help dull the impact of the reimbursement cap" and incentivize providers to accept public option plans despite lower reimbursement rates.[49]

Finally, the 2019 Washington public option bill explores the possibility of further subsidies, with a goal of expanding eligibility.[50]

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[43] Id. at p. 3-5 sec. 3, archived at https://web.archive.org/web/20211029222500/https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5526-S.SL.pdf.
[44] SB 5526 (introduced), p. 3 sec. 3(1)(d), archived at https://web.archive.org/web/20201023032721/http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Senate%20Bills/5526.pdf.
[45] Austin Jenkins, "Will Washington State's New 'Public Option' Plan Reduce Health Care Costs?", *NPR*, 16 May 2019, archived at https://web.archive.org/web/20201221214001/https://www.npr.org/sections/health-shots/2019/05/16/723843559/will-washington-states-new-public-option-plan-reduce-heath-care-costs; Washington House Health Care & Wellness Committee Public Hearing, 30 January 2019, available at https://www.tvw.org/watch/?eventID=2019011319.
[46] Washington House Health Care & Wellness Committee Public Hearing, 36:55 and 1:15:57.
[47] SB 5526 (2019), p. 5 sec. 4.
[48] Sarah Kliff, "The Lessons of Washington State's Watered Down 'Public Option,'" *The New York Times*, 27 June 2019, archived at https://web.archive.org/web/20211101173524/https://www.nytimes.com/2019/06/27/upshot/washington-state-weakened-public-option-.html.
[49] The Public Option Institute, "Summary of Washington's Request for Applications for Public Option Procurement," 2 March, 2020, archived at https://web.archive.org/web/20211101173812/https://www.publicoptioninstitute.org/feed-wa-implementation-materials/summary-of-washingtons-request-for-applications-for-public-option-procurement.
[50] SB 5526 (2019), p. 6 sec. 6.

The program experienced some challenges in its first year, with few offerings, low enrollment, and only some cost-savings in the form of lower deductibles.[51] Because of the higher reimbursement rate and the uncertainty of testing this new product on the market, Washington did not see the premium reductions it had expected.[52] In addition, participation from carriers and providers was limited due to that same market uncertainty and lack of participation requirements.[53]

In 2021, the legislature modified the public option law, passing amendments aimed at increasing participation from providers and requiring them to accept appropriate rates to lower premiums.[54] Oregon has the benefit of being able to observe and learn from these changes to Washington's program. SB 5377, "Cascade Care 2.0," requires all hospitals that participate in the state's Medicaid or state employee plan to accept at least one public option plan if one is not available in that county by 2022.[55] The state must study the effect of the public option on consumers' costs, as well as hospital finances once there is significant enrollment in the public option.[56]

The amendments also establish a new state subsidy program that will start in 2023 with an initial $50M budget appropriation for premium subsidies, limit insurance companies' ability to offer plans without standardized benefits on the exchange, and direct Washington to pursue a section 1332 innovation waiver under the ACA.[57] This waiver allows the state to capture money that its changes to the exchange saves from federal funding and reinvest it in other programs such as state subsidies or projects to improve access.

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[51] Stephanie Carlton, Jessica Kahn, Mike Lee, "Cascade Select: Insights From Washington's Public Option," *Health Affairs*, 30 August 2021, DOI: 10.1377/hblog20210819.347789, available at https://www.healthaffairs.org/do/10.1377/hblog20210819.347789/full/.

[52] Melissa Santos, "Despite law, 20 WA counties don't offer public-option health plans," Crosscut, 26 July 2021, archived at https://web.archive.org/web/20211130210924/https://crosscut.com/politics/2021/07/despite-law-20-wa-counties-dont-offer-public-option-health-plans.

[53] Id.

[54] Id.

[55] SB 5377 (2021), p. 6 sec. 5(1)(a), available at https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Passed%20Legislature/5377-S2.PL.pdf?q=20211011125411. This requirement will be triggered in 2023 since only 25 of Washington's 39 counties will have public option plans available. Amy Lotven, "Washington's Cascade Care Public Plans To See 5% Premium Drop In 2022," *InsideHealthPolicy*, 24 September 2021, available at https://insidehealthpolicy.com/daily-news/washington%E2%80%99s-cascade-care-public-plans-see-5-premium-drop-2022. There is some controversy over the number of public option plans a hospital has to contract with. Washington State Hospital Association, Letter to the Governor, 27 April 2021, available at https://stateofreform.com/wp-content/uploads/2021/04/5377-WSHA-Partial-Veto-Request-Public-Option-04-27-21.pdf.

[56] SB 5377 (2021), p. 5-6 sec. 5(3).

[57] Rachel Schwab, "A Fixer Upper: Washington State Enacts Legislation to Boost its Public Option," *Georgetown University Center on Health Insurance Reforms*, 24 June 2021, archived at https://web.archive.org/web/20210826145508/http://chirblog.org/fixer-upper-washington-state-enacts-legislation-boost-public-option/.

Evaluation

The first year of Washington's public option faced challenges which pointed out some of the program's limitations. The legislature tried to address these in the 2021 bill. Because the public option had more generous benefits than many of the other plans and the provider reimbursement cap was more generous than initially proposed, there were no premium savings in the first year. Though no public option plan was the most expensive plan in any county, public option plans' premiums were an average of 4% higher than commercial rates from the year before.[58] In contrast, the average rates for marketplace plans decreased by an average 3.2%.[59] The silver public option plans had lower deductibles than non-public option plans, but many other costs such as out-of-pocket maximums and copays were the same as or similar to non-public option plans.[60] In terms of availability, insurance carriers offered public option plans in only 19 of Washington's 39 counties.[61] On the other hand, the public option program may have contributed to the re-entrance of at least one insurance carrier that had previously exited the individual market, as it fit within the company's community-driven mission.[62] In addition, 15% of enrollees chose standard plans, and about 1% chose public option plans that are held to the reimbursement rate created by statute.[63] Enrollment was higher among new enrollees, with nearly 40% choosing a plan from this new program, including 2.5% who selected public option plans.[64] The overall low enrollment is in part due to the costs remaining high.[65]

The first public option program in the U.S. had some mixed results for its first year (2021), not achieving the cost-savings it aimed for but still potentially setting the stage for the state to lower costs through future evaluations of the program and reinvestment of pass-through savings. The incentives and requirements added in 2021 are changes that Oregon can learn from in adopting its own program. The Washington public option is still viewed by most advocates and legislators as an experimental, incremental, and good first step rather than the be-all, end-all solution to health care costs, and Oregon benefits from seeing this program in action.[66] The amendments and continued implementation for 2022 will provide more for evaluation, but it does appear as though more counties will have a public option available at

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[58] The Public Option Institute, "Washington Certifies Plan Offerings for the 2021 Marketplace," 30 September 2020, archived at https://web.archive.org/web/20211101180524/https://www.publicoptioninstitute.org/feed-wa-implementation-materials/washington-certifies-plan-offerings-for-the-2021-marketplace; Schwab, "A Fixer Upper: Washington State Enacts Legislation to Boost its Public Option."

[59] Washington Office of the Insurance Commissioner, "Kreidler approves average rate decrease of 3.2% for Washington's 2021 Exchange health insurers," 24 September 2020, archived at https://web.archive.org/web/20211101181630/https://www.insurance.wa.gov/news/kreidler-approves-average-rate-decrease-32-washingtons-2021-exchange-health-insurers.

[60] Carlton, Kahn, and Lee, "Cascade Select: Insights From Washington's Public Option."

[61] Id.

[62] Id.; Community Health Plan of Washington, https://www.chpw.org/about-chpw/.

[63] Carlton, Kahn, and Lee, "Cascade Select: Insights From Washington's Public Option."

[64] Id.

[65] Id.

[66] Roberts, "The One State Taking a Big Run at Health Reform."

rates that are lower than the year before, and lower than comparable non-public option standard plans.[67]

COLORADO

Colorado's legislature considered a public option for several sessions, debating how to reduce costs and where to set provider reimbursement rates, before finally adopting a law in 2021. Ultimately, the bill reflected negotiations with industry, instituting a two-phase approach: requiring specific premium reductions over the course of three years (phase 1), with the condition that failure to meet those reductions would result in rate-setting levels based on provider type by the state's Department of Insurance (phase 2). The law also required insurers to offer a standardized public option plan on the exchange for the small group and individual markets. Beneficial parts of Colorado's program that Oregon might want to adopt include specific premium reduction targets and Colorado's original rate-setting criteria to ensure reimbursement rates reflect the needs of a range of providers.

Background

Colorado has been working to bring down health care costs for a while. In 2016, voters had a chance to adopt a state single-payer system through a ballot measure.[68] Though it failed by a wide margin, the state has pursued other policy solutions to address the high cost of health care since then.

In 2019, health care costs became a priority for the state when a new governor entered office.[69] Governor Jared Polis created the Office of Saving People Money on Health Care — intended to serve Coloradans and do just what the name says.[70] The legislature passed surprise billing protections and instated a reinsurance program to help lower individual market insurance costs.[71] However, there is still an access problem in various rural counties. Colorado has a highly consolidated hospital system, which leads to higher prices, and many rural counties have

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[67] Washington Health Benefit Exchange, "Special Exchange Board Meeting," p. 17, 15 September 2021, available at https://www.wahbexchange.org/content/dam/wahbe/2021/02/SEB_Presentation_091520211.pdf.

[68] Megan Houston, "Heavily Modified, Colorado Public Option Appears to have Neutralized Industry Opposition," *Georgetown University Center on Health Insurance Reforms*, 1 June 2021, archived at https://web.archive.org/web/20211101184100/http://chirblog.org/heavily-modified-colorado-public-option-appears-neutralized-industry-opposition/.

[69] Office of the Governor of Colorado, "Gov. Polis Signs Executive Order Establishing the Office of Saving People Money on Health Care," archived at https://web.archive.org/web/20211101185609/http://coloradogovernor.migrate.acquia.com/governor/news/gov-polis-signs-executive-order-establishing-office-saving-people-money-health-care.

[70] Colorado State, "Office of Saving People Money on Health Care," archived at https://web.archive.org/web/20211101185932/https://ltgovernor.colorado.gov/programs/office-of-saving-people-money-on-health-care.

[71] Markian Hawryluk, "Colorado Forges Ahead On A New Model For Health Care While Nation Waits," *Kaiser Health News*, 28 February 2020, archived at https://web.archive.org/web/20211101190022/https://khn.org/news/colorado-health-care-reform-state-model-national-blueprint/.

only one company offering plans on the market, meaning there is no competition to help drive down costs.[72] A 2021 report indicated that hospital prices in Colorado were more than 20% higher than the national average, and another study showed rates were increasing rapidly, moving from 254% of Medicare in 2015 to 269% in 2017.[73]

In response to this cost crisis, the Colorado legislature authorized state agencies to develop an implementation plan, which included an actuarial analysis of a public option which then required legislation to enact, similar to Oregon's path.[74] The actuarial study from Wakely, a health care actuarial consulting firm, was published in 2020 and found that their public option proposal had the potential to reduce the average premium for exchange plans by 12%, cover about 18,000 more people, and save nearly $43 million that Colorado could use to to increase subsidies if it is able to obtain a section 1332 innovation waiver from the federal government.[75] That waiver application is currently in process.[76]

Policy

- Mandates premium reductions (15% over three years)
- Requires bronze, silver, and gold level standardized public option ("Colorado Option") plans be offered on-exchange in the individual and small group markets
- Expands pre-deductible coverage of high-value services such as primary and behavioral health care
- Authorizes state rate-setting based on hospitals' location, payer mix, and independent ability to lower costs if premium reductions are not met, with waivers available if providers are able to lower their rates from previous years
- Authorizes a 1332 waiver to invest in reducing health disparities by providing additional premium and cost-sharing assistance to certain populations

After the Wakely study, Colorado's Division of Insurance and the Department of Health Care Policy & Financing drafted a report providing recommendations as to the structure,

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[72] Health Care Cost Institute, "Healthy Marketplace Index," available at https://healthcostinstitute.org/research/hmi-interactive; Jared Gaby-Biegel, "The Effects of Hospital Consolidation in Colorado," *Center for Economic and Policy Research*, 5 March 2020, archived at https://web.archive.org/web/20211101190539/https://cepr.net/report/the-effects-of-hospital-consolidation-in-colorado/.

[73] Colorado Department of Health Care Policy and Financing, "Hospital Cost, Price and Profit Review," p. 4, August 2021, archived at https://web.archive.org/web/20210818225351/https://hcpf.colorado.gov/sites/hcpf/files/Hospital%20Cost%20Price%20and%20Profit%20Review%20Full%20Report_withAppendices-0810ac.pdf; Chapin White and Christopher M. Whaley, "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative," 2019, DOI: 10.7249/RR3033, available at https://www.rand.org/pubs/research_reports/RR3033.html.

[74] Aree Bly and Brittney Phillips, "State of Colorado: Actuarial Analysis of a Colorado Health Insurance Option in 2022," *Wakely Consulting Group*, 21 February 2020, available at https://hcpf.colorado.gov/sites/hcpf/files/Wakely%20Colorado%20Public%20Option%20Report.pdf.

[75] Id.

[76] Colorado Division of Insurance, "Colorado Section 1332 Innovation Waiver, Waiver Amendment Request, Colorado Option," 15 October 2021, available at https://drive.google.com/file/d/1mi54sMTLJySObIMm1JmMGEWLJwG5M8rQ/view.

administration, and design of a public option program in Colorado.[77] This was introduced as legislation in 2020, but did not pass.[78]

COLORADO'S 2020 PUBLIC OPTION

The bill would have established a state-designed public option both on and off the health insurance exchange. To ensure a sufficient network, the bill would have required hospitals and insurance carriers to participate. To control costs, the bill would have set hospitals' reimbursement rates at a base rate of 155% of Medicare rates.[79] However, that rate could increase if they met certain criteria: whether they were rural or critical access hospitals, if they provided care to a sufficiently high enough percentage of patients with non-commercial insurance coverage, and their ability to lower health care costs on their own.[80] It also would have limited insurance carriers to spending 15% or less of earnings from premiums for administrative costs and profits, and would have required drug rebates between manufacturers, insurance companies, and pharmacy benefit managers, which typically don't directly affect consumers' payments, be used to lower costs for consumers.[81]

However, the 2020 bill stalled when the COVID-19 pandemic hit. The realities of adjusting to the pandemic and the expected shortfall in the state budget made it challenging to move the bill forward, and the bill sponsors ultimately withdrew the bill.[82]

In 2021, HB21-1232 was introduced and passed, slightly different from the 2020 policy.[83] As introduced, it focused on offerings through the exchange, creating a state-designed health plan which carriers would offer in the first year at a 10% lower premium than they offered in 2021..[84] It also would have created a state agency to act as an insurer, in the vein of a 'true' public option, if insurance companies failed to participate and did not offer public option plans with the required cost reductions (20% over the course of two years).[85]

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[77] Colorado Division of Insurance, "Final Report for Colorado's Public Option," 15 November 2019, available at https://hcpf.colorado.gov/sites/hcpf/files/Final%20Report%20for%20Colorados%20Public%20Option.pdf.
[78] HB20-1349 (2020), Colorado Affordable Health Care Option, Colorado Legislature, available at https://leg.colorado.gov/bills/hb20-1349.
[79] HB20-1349, p. 15 sec. 10-16-1206(1)(c), available at https://leg.colorado.gov/sites/default/files/documents/2020A/bills/2020a_1349_01.pdf.
[80] Id.
[81] Id. at p. 13 sec. 10-16-1205(2)(a)(VII); Kaiser Family Foundation, "Prescription Drug Rebates, Explained," 26 July 2019, archived at https://web.archive.org/web/20211108222743/https://www.kff.org/medicare/video/prescription-drug-rebates-explained/.
[82] Jesse Paul, "Colorado Democrats abandon 2020 effort to pass public health insurance option," *The Colorado Sun*, 4 May 2020, archived at https://web.archive.org/web/20211108222951/https://coloradosun.com/2020/05/04/colorado-public-health-insurance-option-2/.
[83] HB 21-1232, Colorado Legislature, available at https://leg.colorado.gov/bills/hb21-1232.
[84] Id. at p. 6 sec. 10-16-1304(1)(c), 10-16-1305(2)(a)(I); Colorado Department of Regulatory Agencies and Department of Health Care Policy & Financing, "Summary of the Public Option Proposal," https://web.archive.org/web/20211108223336/https://hcpf.colorado.gov/sites/hcpf/files/Summary%20of%20the%20Public%20Option%20Proposal.pdf.
[85] HB 21-1232, p. 10 sec. 10-16-1306(1)(b)(I).

However, industry lobbyists, including a high-spending national coalition of insurance, hospital, and pharmaceutical industry groups called Partnership for America's Health Care Future, managed to secure modifications to the bill.[86] Legislators adjusted the bill in response to arguments that ranged from opposing government control to assurances that insurance companies can lower costs without interference.[87] They created a two-phase approach to the public option, drafted with industry and other stakeholder feedback, so that Coloradans would see lower costs while the bill would provide industry an opportunity to pursue lower costs independently.[88] It also reduced the premium targets to 15% over three years as part of those negotiations.[89]

The amended, passed version of the bill creates a standardized public option insurance plan with premium reduction requirements over the course of three years.[90] The bill requires the insurance commissioner to create a plan with standardized benefits at the bronze, silver, and gold levels, and requires carriers offering plans in the individual and small group markets to offer them on the exchange.[91] The plan design will prioritize high-value services such as primary care and behavioral health before the deductible.[92] In the first year that new public option plans will be offered, expected in 2023, the premiums must be 5% less than each carrier's commercial premiums from 2021 in the same geographic area; in the subsequent two years, the premiums must be 10% and 15% less, respectively, and beyond that the premiums cannot increase by more than medical inflation, an annual increase in cost to support medical trends and developments determined by the U.S. Department of Labor.[93] The bill prohibits cost-shifting between standard and non-standard plans during rate filing, so commercial prices will not suddenly increase to compensate for lower-cost non-standard plans.[94]

If insurers or providers anticipate they cannot meet those premium reductions or provide network adequacy, they may enter nonbinding arbitration with providers to determine rates prior

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[86] House Committee on Health and Insurance Hearing Summary on HB 21-1232, 9 April 2021, available at https://leg.colorado.gov/content/e76891c8f367b181872586b2006391e9-hearing-summary; Sandra Fish and Jesse Paul, "Nonprofit launches $1 million TV ad buy against Colorado Democrats' public health insurance option proposal," *Colorado Sun*, 3 March 2021, archived at https://web.archive.org/web/20211130223436/https://coloradosun.com/2021/03/03/partnership-for-americas-health-care-future-ad-colorado/.

[87] Amanda Massey, Testimony at House Committee on Health and Insurance Hearing on HB 21-1232, 03:03:00, 9 April 2021, available at https://sg001-harmony.sliq.net/00327/Harmony/en/PowerBrowser/PowerBrowserV2/20210909/-1/11395#agenda_; Zach Zaslow, Testimony at House Committee on Health and Insurance Hearing on HB 21-1232, 03:38:13, 9 April 2021, available at https://sg001-harmony.sliq.net/00327/Harmony/en/PowerBrowser/PowerBrowserV2/20210909/-1/11395#agenda_.

[88] Jesse Paul and Thy Vo, "Colorado Democrats drop public health insurance option to pursue state-regulated plan instead after industry pushback," *Colorado Sun*, 26 April 2021, archived at https://web.archive.org/web/20211130224541/https://coloradosun.com/2021/04/26/colorado-public-option-health-care-bill-update/.

[89] HB 21-1232, p. 8-10, sec. 10-16-1305(2)(a)-(c), available at https://leg.colorado.gov/bills/hb21-1232.

[90] Id. at p. 8-10 sec. 10-16-1305.

[91] Id. at p. 5 sec. 10-16-1304(1) and p. 7-8 sec. 10-16-1305(1).

[92] Id. at p. 6 sec. 10-16-1304(1)(d)(III)(B).

[93] Id. at p. 8-10 sec. 10-16-1305(2)(a)(I), (2)(b)(I), (2)(c)(I), and (2)(d).

[94] Id. at p. 20 sec. 2.

to filing their annual premium rate proposals with the state.[95] If carriers file plans that do not meet the rate reduction requirements, the insurance commissioner is empowered to set their rates through a public hearing to achieve the premium rate reductions.[96] However, the insurance commissioner cannot use this rate-setting power against hospitals that have already negotiated rates lower than 20% less than their rates in the previous year or are at 165% of Medicare rates.[97]

Finally, the bill authorizes an application for a 1332 federal waiver to implement the standard plans and "to increase the value, affordability, quality, and equity of health-care coverage for all Coloradans, with a focus on [...] Coloradans historically and systematically disadvantaged by health and economic systems."[98]

Evaluation

Although the bill passed, its provisions do not take effect until 2023 and thus its success cannot yet be evaluated. The success of Colorado's public option law will likely be measured by its ability to meet the premium reduction standards, whether through action by insurers or through rate-setting by regulators. However, that doesn't mean there aren't lessons to learn from that program. Colorado has begun the waiver process, with a draft available for public comment in November.[99] The waiver addresses expanding plan benefit designs and expanding subsidies to target populations.[100] This will be one of the first public option 1332 waivers submitted by any state, so it will be one to watch.

NEVADA

Nevada passed its public option bill in 2021, following Washington and Colorado. Like the other two states, Nevada sets provider reimbursement rates and has premium reduction standards like Colorado. However, the state also takes a strong stance on carrier and provider requirements by tying participation in the public option to participation in other public programs and using the state's medicaid managed care infrastructure. Oregon can follow Nevada's example in leveraging public programs to ensure carriers and providers participate in the public option program as well.

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[95] Id. at p. 11 sec. 10-16-1306(1)(b).
[96] Id. at p. 13 sec. 10-16-1306(3).
[97] Id. at p. 12, 15 sec. 10-16-1306(3)(a), (4) and (5).
[98] Id. at p. 19 sec. 10-16-1308.
[99] Colorado Division of Insurance, "Colorado Section 1332 Innovation Waiver, Waiver Amendment Request, Colorado Option," 15 October 2021, available at https://drive.google.com/file/d/1mi54sMTLJySObIMm1JmMGEWLJwG5M8rQ/view.
[100] Id.

Background

Nevada has a high uninsurance rate.[101] At over 11%, it has one of the highest rates of uninsurance in the country.[102] This means that improving health care access, coverage, and affordability has been a priority.

There has been a push for a public option in Nevada for the last four years.[103] In 2017, the state very nearly adopted a Medicaid buy-in program, but it was vetoed by the governor.[104] In 2019, another public option bill died after its chief sponsor left the legislature.[105] That bill was revived by state Senator Nicole Cannizzaro as a study bill on a buy-in to public benefits programs.[106] The study, completed by Manatt Health, explored models for public option programs, including a public program buy-in and an on-exchange public option, which formed the policy backbone of the 2021 bill.[107]

Policy

- Requires silver and gold level public option plans to be offered on- and off-exchange
- Requires carriers that bid to submit Medicaid managed care plans to also bid to provide public option coverage
- Requires providers that accept public program plans (such as Medicaid and public employees' benefit plans) to also be in at least one public option plan network
- Mandates premium reduction standards (15% in the first 4 years of the program)
- Offers exemptions from rate-setting for plans that use payment models that increase value for consumers other than fee-for-service, and Includes minimum rates for primary care, FQHC, and similar safety net providers
- Authorizes a section 1115 Medicaid innovation waiver to combine the Medicaid risk pool as well as a 1332 waiver application to reduce health disparities and costs
- Delays implementation until 2026

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[101] Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," 2019, archived at https://web.archive.org/web/20211111015421/https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Uninsured%22%2C%22sort%22%3A%22desc%22%7D.
[102] Id.
[103] Megan Messerly and Sean Golonka, "Sisolak signs bill making Nevada the second state to adopt a public health insurance option," *The Nevada Independent*, 9 June 2021, archived at https://web.archive.org/web/20211111015834/https://thenevadaindependent.com/article/sisolak-signs-bill-making-nevada-the-second-state-to-adopt-a-public-health-insurance-option.
[104] Louis Norris, "Nevada and the ACA's Medicaid expansion," *HealthInsurance.org*, 1 August 2021, available at https://www.healthinsurance.org/medicaid/nevada/. .
[105] Messerly and Golonka, "Sisolak signs bill making Nevada the second state to adopt a public health insurance option."
[106] Id.
[107] Chiquita Brooks-LaSure, Kyla Ellis, et al., "Senate Concurrent Resolution No. 10 Study: Evaluating Public Health Insurance Plan Options for Nevada Residents," *Manatt Health*, January 2021, archived at https://web.archive.org/web/20211105144538/https://www.manatt.com/Manatt/media/Documents/Articles/Manatt-Health_Nevada-Concurrent-Resolution-No-10-Public-Option-Study_January-17-2021.pdf.

The 2021 public option bill, SB 420 (2021), directs that carriers offer the public option health insurance plan on and off the state-based exchange at the silver and gold levels by 2026.[108] Since it is offered off the exchange as well, the public option will be available to any resident of Nevada, not just those eligible to purchase on the exchange. Health plans participating in the state's Medicaid managed care program will need to offer a good faith bid to also offer a public option plan.[109] Because the state spends nearly $2 billion on Medicaid each year, lawmakers anticipate health insurance providers will want to continue to participate in the program rather than withdraw over the public option requirement.[110]

The premium for these plans must be 5% lower than the reference premium, defined as the second-lowest cost silver plan (the benchmark plan) in the coverage area in 2024 or the previous year, and cannot rise more than the Medicare Economic Index, a measure of medical cost inflation.[111] That rate can be revised if the average public option premium drops at least 15% compared to the average reference premium over the first four years of the program.[112] Carriers' bids for the public option will help reach lower premiums, but the bill also establishes other criteria for consideration: non-fee-for-service payment models with the best value for the people covered under the plan (which may be exempt from reimbursement rate-setting), whether critical access and rural hospitals are included in the network, and whether the insurer has a plan to decrease racial health disparities, support the provision of culturally competent care, or support the health care workforce.[113] It uses additional levers to help reach the premium reduction goals as well, such as leveraging state purchasing tools and incentivizing attractive bids through Medicaid procurement.[114]

Because Nevada is such a rural state, both consumer advocates and providers were concerned about network adequacy and access to care.[115] To ensure enough providers accept public option plans, Nevada's program requires providers that accept public programs such as Medicaid and public employees' benefits to also accept at least one public option plan.[116] The bill allows providers to apply for a waiver if accepting the public option plan would risk access to services for those already enrolled in public programs.[117] The bill also sets a floor for providers' reimbursement rates to ensure they are not underpaid. Specifically, it requires health plans participating in the public option to pay providers in their network an aggregate of at least Medicare rates.[118] For certain safety-net providers, such as federally qualified health centers

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[108] SB420 (2021), Nevada Legislature, p. 5 sec. 10(2)-(3), available at https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8151/Text.
[109] Id. at p. 7-8 sec. 12(2).
[110] Stacie Weeks, Marie Zimmerman, et. al., "The Public Option Finds An Uncommon Ally In Medicaid In Nevada," *Health Affairs*, 26 August 2021, DOI: 10.1377/hblog20210823.604663, available at https://www.healthaffairs.org/do/10.1377/hblog20210823.604663/full/.
[111] SB420 (2021), p. 5-6 sec. 10(4)-(6).
[112] Id. at p. 5 sec. 10(4)-(5).
[113] Id. at p. 5-6 sec. 12 and p. 11 sec. 14(6).
[114] Id. at p. 7 sec. 12(1).
[115] Testimony from Senate Health and Human Services, 4 May 2021, https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8151/Meetings.
[116] SB420 (2021), p. 9 sec. 13.
[117] Id..
[118] Id. at p. 10 sec. 14(2).

(FQHCs) and rural health clinics, health plans participating in the public option cannot pay less than the rates set for those providers by the federal government.[119]

The bill also authorizes federal waivers: both a 1332 waiver to seek pass-through funding to implement the program and further subsidize the plan, as well as a new 1115 Medicaid innovation waiver to combine the Medicaid risk pool to achieve lower health care costs.[120] Finally, it requires an actuarial analysis as part of the 1332 waiver application, including 10-year projections for the reform in the market and its impact on the consumers and various providers. The legislature plans to use this analysis to understand the public option's impact on the market and consider changes to address any issues.[121]

With a united legislative and gubernatorial agenda, Nevada passed this public option bill very quickly, despite some of the same national industry pushback that Colorado experienced.[122]

Evaluation

Similarly to Colorado,evaluation of the public option policy in Nevada cannot yet occur because it has not taken effect. Until it does in 2026, it will be important to monitor the parameters of the program and its implementation over the next few years to ensure it is executed in a manner that strives towards its goals of lowering health care costs and increasing choice and access for consumers.

KEY OBSERVATIONS AND TAKEAWAYS FROM PUBLIC OPTION CASE STUDIES

Because Washington is the only state that has implemented its public option thus far, it is the only program that can be fully evaluated. Due to Colorado and Nevada's bills not being in effect yet, there is no easy way to robustly compare the success or effectiveness of the different policies. However, there are significant design differences and similarities that are worth exploring, both for their political feasibility and for their potential improvements to the program.

To start, there are some pre-legislative similarities. For example, both Colorado and Nevada first passed a study bill on the effect of a public option — Colorado's Wakely study and Nevada's Manatt report.[123] These studies provided information on public option models and their impacts, the effect of premium subsidies, and federal pass-through savings, which helped shape the introduced policies and guided some of the compromises that were made in the amendment

[119] Id. at p. 10 sec. 14(3)-(5).
[120] Id. at p. 9 sec. 11.
[121] Id. at p. 6-7 sec. 11(2).
[122] Meetings on SB420 (2021), available at https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8151/Meetings; Votes on SB420 (2021), available at https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8151/Votes; Messerly and Golonka, "Sisolak signs bill making Nevada the second state to adopt a public health insurance option.".
[123] Bly and Phillips, "State of Colorado: Actuarial Analysis of a Colorado Health Insurance Option in 2022."; Chiquita Brooks-LaSure, Kyla Ellis, et al., "Senate Concurrent Resolution No. 10 Study: Evaluating Public Health Insurance Plan Options for Nevada Residents."

process. Another attribute shared by all three states is that they all have state-based exchanges for their health insurance market.[124] This gives the states more control over exchange functions, including how to make a public option available; though a public option can be offered on non-state-based exchanges, there are some limitations on the state's jurisdiction and power to tailor the plan to the state's population.[125]

In all three cases, the goal of a public option is to lower costs. Colorado and Nevada are more specific than Washington in laying out specific premium reductions. However, from Washington's experience, we can see that premium reductions are difficult to achieve, while cost-sharing reductions are easier through standardizing some health plans. Colorado also uses a standardized plan design for its public option.

Each state varies in its methods to incentivize cost reductions.[126] In Washington, the bill establishes a rate cap. In Colorado, rate caps are a last resort, after insurers' and providers voluntarily try to meet set reduction standards. Nevada uses bid criteria to reach lower premiums. In terms of incentives, both Nevada and Colorado created statutory premium reductions. Washington had no such standards, only a non-statutory estimate, and in the first year of the program, its rate-setting policy did not meet the 5-10% goal. That could be in part due to the reimbursement rate that passed —- a much higher one than the original bill instituted. It could also be because Washington's law put little pressure on insurers to meet a requirement — insurers could simply not offer the public option, so long as they offered another standardized plan. In contrast, Colorado uses its two-phase approach to encourage industry to reach lower rates.

There are some non-cost-related goals for the public option as well. Uniquely, Colorado lays out equity standards and goals in its public option bill, including reporting requirements on efforts to increase diversity and culturally responsive networks as well as decrease disparities.[127]

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[124] Kaiser Family Foundation, "State Health Insurance Marketplace Types, 2022," 2022, archived at https://web.archive.org/web/20211111024620/https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&selectedRows=%7B%22states%22%3A%7B%22colorado%22%3A%7B%7D%2C%22nevada%22%3A%7B%7D%2C%22oregon%22%3A%7B%7D%2C%22washington%22%3A%7B%7D%7D%7D&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D.

[125] Softheon, "States are Choosing to Switch to State-Based Exchange," archived at https://web.archive.org/web/20211111024919/https://www.softheon.com/blog/states-are-choosing-to-switch-to-state-based-exchanges/.

[126] Dylan Scott, "The public option is now a reality in 3 states," *Vox*, 17 June 2021, archived at https://web.archive.org/web/20210823183729/https://www.vox.com/policy-and-politics/22535267/public-option-health-insurance-nevada-colorado-washington. Often state health care programs are not truly public programs because of the cost; Medicare and Medicaid are good examples of 'public' programs that in reality are public-private partnerships. Many state and local infrastructure programs - road maintenance, transportation, utilities, etc. - do the same thing. National Conference of State Legislatures, "Building-Up: How States Utilize Public-Private Partnerships for Social & Vertical Infrastructure," 16 February 2017, archived at https://web.archive.org/web/20211111025944/https://www.ncsl.org/research/transportation/building-up-how-states-utilize-public-private-partnerships-for-public-multi-sector-vertical-infrastructure.aspx.

[127] HB 21-1232, p. 6 sec. 10-16-1304(1)(g), available at https://leg.colorado.gov/sites/default/files/2021a_1232_signed.pdf.

Both Colorado and Nevada also specifically include the aim of increasing access in their respective bills.[128]

All three states have designed their public options with a participation requirement to ensure there are insurers on whom to impose the cost-reduction goal and providers to ensure network adequacy. In Nevada, participation in the public option is tied to participation in other public programs; in exchange, there are some provisions to protect doctors' minimum rates. Colorado also requires participation in the public option by certain parties, and provides minimum rates for primary care services and criteria that could earn hospitals higher rates. Washington didn't impose participation requirements until the second year of its program, and now it requires all hospitals that participate in the state's Medicaid or state employee plan to accept at least one public option plan.

To gain funding and increase flexibility, all three states will seek waivers from the federal government. Washington, Colorado and Nevada all have authorized a 1332 waiver, though only Nevada's bill includes expanding the 1115 Medicaid waiver as well. These waivers will give the states more flexibility in implementing their public options, as well as more funding as they capture the pass-through savings from the waiver and reinvest them in the public option program — encouraging enrollment, funding implementation, etc. Though not strictly necessary for a fully functional, successful public option, the waiver eases the financial burden on states to implement this program at the state level.

Washington was the only state of the three that had little national input on the policy in support or opposition. Given the recent attention given to public option programs, Oregon is more likely to have a similar experience to Nevada and Colorado with some national attention brought to bear.

OTHER STATES CONSIDERING A PUBLIC OPTION

Several other states have considered or attempted to establish a public option in recent years.[129] Connecticut has made two prior attempts in 2019 and 2020, and a third in the most recent legislative session.[130] The most recent attempt, SB 842 (2021), failed as well. It constituted a significantly different design than the bills in the previous case studies, putting

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[128] Id. at p. 6 sec. 10-16-1304(1)(d)(2); SB420 (2021), p. 4 sec. 2(2), available at https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8151/Text.

[129] This is not including states that attempted single-payer systems, like Vermont (see Avik Roy, "Six Reasons Why Vermont's Single-Payer Health Plan Was Doomed From The Start," *Forbes*, 21 December 2014, available at https://www.forbes.com/sites/theapothecary/2014/12/21/6-reasons-why-vermonts-single-payer-health-plan-was-doomed-from-the-start/?sh=4b80c52c4850).

[130] Maanasa Kona, "Third Time's Not the Charm: Connecticut's Public Option Bill Fails Once Again," *Georgetown University Center on Health Insurance Reform*, 8 June 2021, archived at https://web.archive.org/web/20211112010902/http://chirblog.org/third-times-not-charm-connecticuts-public-option-bill-fails/.

more emphasis on providing a public option to small businesses and their employees.[131] Several insurers spent approximately half a million dollars opposing the bill.[132]

New Mexico has been exploring a public option. In 2018, Manatt Health completed a report which led to a bill in the next session. HB 416 (2019) began as a Medicaid buy-in program where individuals can purchase Medicaid health plans with premiums and cost-sharing; however, concerns about the cost of the plan, interest in other policy priorities, and overall uncertainty about the proposal stalled the bill. Instead, the state funded further studies.[133] Like Oregon, New Mexico does not have a fully state-based exchange, but rather a hybrid exchange that uses the federal technology platform.

Minnesota had a bill in 2021 as well: HF 11, a Medicaid buy-in intended to benefit undocumented immigrants and the family glitch population (those who are ineligible for subsidy assistance because they are eligible for 'affordable' employer-based insurance coverage only as an individual rather than in the context of family needs and costs).[134] Despite some support from the governor, patient advocacy groups, and the Minnesota Medical Association, the bill did not pass the legislature.[135]

Two recent attempts were made in Massachusetts. S697 (2019), which would have established a public option health plan on the state-based exchange available to individuals, small groups and, eventually, large groups, did not pass.[136] A similar attempt was made in 2021 wherein the public option's premiums would be set by the exchange administrator and the plan would be accepted at all Medicaid and Medicare providers. However, Medicare providers would be able to opt-out during an annual enrollment period for providers, and could opt back in. There were also measures in place to prevent the public option risk pool from varying too greatly from

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[131] Id.
[132] Alexandra Ellerbeck, "The Health 202: States are eyeing public option health plans. Many obstacles stand in the way," *The Washington Post*, 22 March 2021, available at https://www.washingtonpost.com/politics/2021/03/22/health-202-states-are-eyeing-public-option-health-plans-many-obstacles-stand-way/.
[133] Michael S. Sparer, "Redefining the "Public Option": Lessons from Washington State and New Mexico," *The Milbank Quarterly* 98, June 2020, available at ps://www.milbank.org/quarterly/articles/redefining-the-public-option-lessons-from-washington-state-and-new-mexico/.
[134] HF 11, Minnesota Legislature 2021, available at https://trackbill.com/bill/minnesota-house-file-11-minnesotacare-eligibility-expanded-and-public-option-established-enrollee-premiums-modified-affordability-definition-modified-for-families-and-alternative-delivery-and-payment-system-implementation-plan-and-recommendations-required/1966755/; Minnesota House of Representatives, "RELEASE: Rep. Schultz announces MinnesotaCare Public Option to help Minnesotans struggling with high health care costs," 27 January 2021, archived at https://web.archive.org/web/20211112015032/https://www.house.leg.state.mn.us/members/profile/news/15446/31035; Take Action Minnesota, "2021 State Healthcare Priorities," archived at https://web.archive.org/web/20211112015254/https://takeactionminnesota.org/health-care-for-all/.
[135] Minnesota Medical Association, ""Public Option" Bill Gets First House Hearing," 28 January 2021, archived at https://web.archive.org/web/20211112015514/https://www.mnmed.org/news-and-publications/News/Public-Option%E2%80%9D-Bill-Gets-First-House-Hearing.
[136] S.697 (2019), Massachusetts Legislature, available at https://malegislature.gov/Bills/191/SD40

that of other plans and maintaining stability and consistency in overall costs.[137] As of November 2021, this bill had not moved out of its first committee.

New Jersey has also taken steps to pass a public option bill. In 2018, the bill would have created a universal health plan available to every New Jerseyan and required the state to pursue all appropriate waivers.[138] However, the bill language was vague, indicating that the premium for the public option "shall be determined in a manner to make the program viable, but at the lowest possible cost to members" without any further elaboration.[139] It also deferred regulation of payment rates for the program to later rulemaking.[140] The legislature returned in 2020 with the same bill, introduced in both houses, but as of November 2021 it had not moved out of its first committee.[141]

Although these are the only states that have introduced legislation for a public option, the policy has drawn attention in other states. There has been some non-legislative action in other states around the public option, such as the governor of Wisconsin putting a Medicaid buy-in and transition to state-based exchange in his budget plan.[142]

A PUBLIC OPTION FOR OREGON

Background

As indicated in the beginning of this paper, Oregon has been working to lower health care costs for over a decade, from transforming the Medicaid system with coordinated care organizations (CCOs) to banning balance billing. Continuing the state's efforts of health care transformation, the House Committee on Health Care convened a workgroup on universal access to care in 2018.[143] Consisting of stakeholders from across the health care industry, including insurance carriers, hospitals and other provider groups, and consumer advocates, the workgroup concluded that their goal was "better access to care for more people at a lower

[137] S.787 (2021), Massachusetts Legislature, available at https://malegislature.gov/Bills/192/S787
[138] S 561 (2018), New Jersey Legislature, available at https://www.njleg.state.nj.us/2018/Bills/S1000/561_I1.PDF
[139] Id.
[140] Id. at p. 6 sec 7(c).
[141] A 5029 (2020), New Jersey Legislature, available at https://www.njleg.state.nj.us/2020/Bills/A9999/5029_I1.PDF.
[142] Wisconsin Office of the Insurance Commissioner, "Commissioner Afable Statement on Governor Evers' Budget Announcement," 16 February 2021, archived at https://web.archive.org/web/20210730210400/https://oci.wi.gov/Pages/PressReleases/20210216BudgetAnnouncement.aspx.
[143] Oregon Universal Access to Health Care Workgroup, "Report on Barriers and Incremental Steps to Universal Access," December 2018, archived at https://web.archive.org/web/20211112021032/https://www.oregonlegislature.gov/committees/hhc/Reports/Report%20on%20Barriers%20and%20Incremental%20Steps%20to%20Universal%20Access.pdf.

cost."[144] The group explored many options which remain important considerations in Oregon's cost containment strategy, two of which were acted on in 2019.

In 2019, the legislature passed SB 770, which did two things in pursuit of universal coverage: it created the Joint Task Force on Universal Health Care and authorized a report on public option models in Oregon.[145] The Task Force was "charged with recommending a universal health care system that offers equitable, affordable, comprehensive, high quality, publicly funded health care to all Oregon residents."[146] As of January 2021, when the group published an interim report, the Task Force was committed to a single-payer system, finding that

> "health care is a fundamental right and only a single payer system will be able to address the health disparities and disfunction [sic] within the current health care system by ensuring all individuals are provided health care on an equitable basis. The goal is a publicly funded single payer system that is equitable, affordable and comprehensive, provides high quality health care and is available to all Oregonians".[147]

The report on public option models was released in December 2020.[148] Completed by Manatt Health, the study reviewed three possible formats for a public option: a 'true' public option administered by the state, an insurance-led private-public partnership, and a CCO-led model.[149] The report indicated that depending on the design, a public option could lower premiums by 10% and be utilized by "7,000 to 11,000 [people], including between 3,400 and 4,600 uninsured Oregonians who would gain coverage."[150] The first model was expensive, requiring further infrastructure to support the administration of the program.[151] The CCO model faced restrictions that would have limited its availability on the exchange; still using the federal platform for its exchange further limits Oregon's flexibility in being able to address that challenge.[152] The 2021 bill that resulted from this study proposed a public option using the public-private partnership in the second model.

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[144] Oregon Universal Access to Health Care Workgroup, "Report on Barriers and Incremental Steps to Universal Access," December 2018, archived at https://web.archive.org/web/20211112021032/https://www.oregonlegislature.gov/committees/hhc/Reports/Report%20on%20Barriers%20and%20Incremental%20Steps%20to%20Universal%20Access.pdf.
[145] SB 770 (2019), Oregon Legislature, available at https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB770/Enrolled
[146] Oregon Health Authority, "Task Force on Universal Health Care," available at https://www.oregon.gov/oha/HPA/HP/Pages/Task-Force-Universal-Health-Care.aspx
[147] Joint Task Force on Universal Health Care, "Interim Status Report," June 2021, archived at https://web.archive.org/web/20211112021227/https://olis.oregonlegislature.gov/liz/2019I1/Downloads/CommitteeMeetingDocument/246518.
[148] Chiquita Brooks-LaSure, Kyla Ellis, et al, "Oregon Public Option Report: An Evaluation and Comparison of Proposed Delivery Models," *Manatt Health*, December 2020, archived at https://web.archive.org/web/20211029210500/https://www.oregon.gov/oha/HPA/HP/docs/Manatt-Health-Oregon-Public-Option-Report-An-Evaluation-of-Proposed-Delivery-Models-December-16-2020.pdf.
[149] Id. at p. 6.
[150] Id. at p. 8.
[151] Id. at p. 6.
[152] Id.

Some parties find that the public option and the work of the Task Force are in contradiction or opposition to each other, but in 2021 the Task Force considered a public option and similar strategies as an incremental step to reaching a single-payer system.[153]

Policy

HB 2010 (2021), a public option for Oregon, was originally proposed to help the family glitch population, small business owners, those churning in and out of public programs' eligibility, and those who could not afford health plans because of premiums, deductibles, or other cost-sharing.[154] The plan was also supposed to align with the state's other health care goals (e.g. equity, integration of primary and behavioral health, etc.).[155]

To ensure availability of public option plans, the bill required insurance companies that contract with public programs (e.g. the public employees' benefits program, Medicaid, and Medicare) to offer public option plans on the health insurance exchange for individuals and small groups at the silver and gold levels.[156] It also required providers that accept those programs to accept public option plans.[157]

In order to achieve lower premiums, the bill set the maximum provider reimbursement rates for public option plans at 100% of Medicare.[158] It also aimed to leverage state purchasing power to lower the cost of prescription drugs for public option plans.[159] Finally, the bill authorized pursuit of waivers to secure pass-through funding to support the public option program with the goal of having public option plans on the marketplace in 2022.[160]

However, the bill received some opposition, described below, including a competing public option bill.[161] HB 2010 was ultimately amended to declare the legislature's intent to create a public option "designed to support and advance other state efforts to improve value and contain costs" by directing state agencies to create an implementation plan for the next legislative session.[162] In doing so, the state agencies are required to make recommendations for the administration and operation of the program, how to lower costs and stay within the state's cost growth target (e.g. through leveraging state and other public programs or transitioning to a state-based exchange), and other opportunities to further the state's health care goals.[163] These recommendations will be based on an analysis of target populations that can benefit from a

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[153] See Joint Task Force on Universal Health Care, "Interim Status Report," at p. 28.
[154] HB 2010 (introduced, 2021), Oregon Legislature, p. 1 sec 1(2), available at https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2010/Introduced.
[155] Id. at p. 2 sec 1(4)(c).
[156] Id. at p. 1-2 sec 1(3).
[157] Id. at p. 2 sec 1(6).
[158] Id. at p. 2 sec 1(4)(b).
[159] Id. at p. 2 sec 1(7).
[160] Id. at p. 2 sec 1(10).
[161] HB 3381 (2021), available at https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB3381.
[162] HB 2010 (2021), p. 1, available at https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2010/Enrolled.
[163] Id. at p. 2 sec. 1(3).

public option, the effect of the American Rescue Plan Act and further subsidies, the effect of federal waivers, and strategies being developed by the Joint Task Force on Universal Health Care.[164] The implementation plan and recommendations are to be presented to the legislature in early 2022 in time for the next legislative session, but pursuit of federal waivers is authorized in the meantime to expedite the timeframe.[165]

Politics

Given all the work being done around health care in Oregon, it is no surprise that there are competing ideas. Representative Andrea Salinas, a former chair and current vice-chair of the House Health Care Committee, chair of the Universal Access to Care workgroup, and sponsor of the section of SB 770 that led to the public option study, championed HB 2010 in 2021.[166] She was a steadfast proponent of the public option. Representative Cedric Hayden was also interested in a public option and introduced his own bill that functioned as a public employees' benefits program buy-in.[167] He later co-sponsored the amended version of HB 2010 and was instrumental in passing the bill unanimously in the House and with strong bipartisan support in the Senate. The bill passed 56:0 and 23:5, respectively.[168]

Similar to the case study states, proponent testimony focused on consumer stories and the need for low-cost options for individuals who can't afford full-price premiums, are ineligible for subsidies, are uninsured, or are otherwise unable to afford health care. The bill had support from consumer advocates, including OSPIRG, the Oregon Center for Public Policy, and AARP.[169] Labor groups like SEIU and small business organizations came out to support the bill, as well as several consumers. Businesses shared their stories of trying to maintain coverage for their employees through the pandemic, and individuals shared their struggles in affording insurance and subsequent care.[170] There was also support from federally qualified health clinics, who recognized the benefits a public option could provide to the people who need it the most.[171]

The strongest opposition came prior to the amendment to the bill from hospitals, who were specifically concerned about the reimbursement rate, and integrated hospital systems,

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[164] Id. at p. 1-2 sec. 1(1)-(2).
[165] Id. at p. 2 sec. 1(6)-(7).
[166] Representative Andrea Salinas, "Biography," Oregon Legislature, archived at https://web.archive.org/web/20211112234827/https://www.oregonlegislature.gov/salinas/Pages/biography.aspx; SB 770 (2019), Oregon Legislature, available at https://olis.oregonlegislature.gov/liz/2019R1/Measures/Overview/SB770; HB 2010 (2021).
[167] HB 3381 (2021).
[168] HB 2010 (2021), Overview, Oregon Legislature, available at https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB2010.
[169] HB 2010 (2021), Testimony, Oregon Legislature, available at https://olis.oregonlegislature.gov/liz/2021R1/Measures/Testimony/HB2010.
[170] Lindsey Grayzel, Testimony in Support of HB 2010, available at https://olis.oregonlegislature.gov/liz/2021R1/Measures/Testimony/HB2010; Abigail Giedd, Testimony in Support of HB 2010, available at https://olis.oregonlegislature.gov/liz/2021R1/Measures/Testimony/HB2010.
[171] Oregon Primary Care Association, Support HB 2010 with -1 amendment, available at https://olis.oregonlegislature.gov/liz/2021R1/Downloads/PublicTestimonyDocument/22832.

who disliked the reinforcement of fee-for-service payments. There was also some concern about rural hospitals and how the payment rates would affect access in those areas.[172] In addition, one nonprofit testified against the bill in an all-or-nothing stance in favor of a single-payer system.[173]

However, there were some groups missing from the testimony in comparison to the other case studies. No other physician groups or advocates, such as the Oregon Medical Society, chose to testify on either side of the bill. Neither did any health insurance carriers. There were some consumers who believed that a public option would be ineffective, waste government resources, or detract from the state's ability to get to a single-payer system, as well as concern expressed about the public option's effect on the second-lowest cost silver plan and the benchmark premium.[174]

Moving into 2022, the legislature will be considering a public option bill once again. One of the reasons HB 2010 was reduced to an implementation plan instead of establishing a public option program was to address the concerns posed by the opposition: to ensure that payment rates would not harm access and to evaluate a public option in the context of the Joint Task Force on Universal Health Care's work. That implementation plan will be the basis for the 2022 bill, and Oregon should take other states' public option designs into consideration for its own public option policy.

POLICY RECOMMENDATIONS

Recommendations that come out of HB 2010 will reconcile many of the questions and concerns expressed in the last legislative session, but that doesn't mean that there aren't policy choices that are preferable, especially given our ability to compare Oregon's work to the public option programs in other states. Oregon can learn from those states to shape its policy to make an effective public option program.

1. **A public option should be offered at least on the health insurance marketplace to individuals and small businesses.**

The health insurance marketplace provides a level playing field for health insurance plans, with minimum coverage benefits. It allows consumers to easily compare plans' prices and benefits. Small businesses and their employees often face the same struggles as individuals in paying for health insurance, and should be able to benefit from the public option as well. Offering the public option off the exchange in addition would make it more widely available, but should at least be made available on the exchange, as that is one of the more common places for consumers without employer-sponsored coverage to look for insurance.

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[172] HB 2010 (2021), Testimony.
[173] Health Care for All Oregon, Testimony in Opposition to HB 2010, available at https://olis.oregonlegislature.gov/liz/2021R1/Measures/Testimony/HB2010.
[174] HB 2010 (2021), Testimony; Rick Hangartner, Testimony in Opposition to HB 2010, available at https://olis.oregonlegislature.gov/liz/2021R1/Downloads/PublicTestimonyDocument/22809.

2. **A public option should regulate reimbursement rates as the most straightforward way to lower costs for consumers.**

Other states have used reimbursement rate-setting in their public option designs. Washington and Nevada's public option programs control reimbursement rates for providers. Colorado's program can set reimbursement rates as a last resort if insurers and providers can't reach an agreement that meets the state's cost reduction standards.

In all three states, hospitals, physicians, and other providers have expressed fear that setting rates will reduce their capacity to care for patients, the quality of care, and/or patients' access to care. Oregon providers have expressed similar concerns. This fear is based on the presumption that the rate offered in the public option will be too low. One of the problems in addressing this fear is that it is difficult to pinpoint how much providers are currently paid — it varies based on geographic area, contracts with insurance carriers, the treatment or procedure being reimbursed, and other factors that are onerous to calculate. Some estimates show that the commercial reimbursement rate in Oregon metropolitan areas ranges from 161% to 185% of Medicare.[175] Another state-wide study indicated that inpatient procedures averaged at 274% of Medicare, while outpatient treatment averaged 259%.[176] The difference between these estimates demonstrates how hard it is to determine the cost of health care, but finding and reducing these rates could significantly lower the cost for consumers.

There are three ways to strike a balance in setting reimbursement rates, based on other states' policies. Oregon could adopt Colorado's initial policy of making adjustments to reimbursement rates depending on need-based criteria, such as serving safety-net or critical access populations. It could also follow Nevada's examples in making exceptions for non-fee-for-service payment models. Finally, using floors in setting reimbursement rates like Washington and Nevada can protect the providers who need it most. Regulating reimbursement rates does not have to be a one-size-fits-all; that would, in fact, do more harm than good. Instead, reimbursement rates should be calculated to lower costs while balancing the needs of providers and enable them to serve Oregonians.

This should not be the only avenue that the state pursues in lowering costs. Using payment reforms such as the transition to value-based payments and state efforts to lower costs like the health care cost growth program are also important tools in lowering costs through a public option plan.

3. **A public option program should require participation from insurance carriers and providers.**

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[175] Johnson, Kennedy, et al., "Comparing Commercial and Medicare Professional Service Prices," Figure 4, Variation in Commercial Service Prices within States.

[176] Michael Chernew, Andrew Hicks, and Shivani Shah, "Wide state-level variation in commercial health care prices suggests uneven impact of price regulation," *Health Affairs,* 39(5), 2020, DOI: 10.1377/hlthaff.2019.01377, available at https://www.healthaffairs.org/doi/suppl/10.1377/hlthaff.2019.01377/suppl_file/2019-01377_suppl_appendix.pdf

As seen in Washington, it can be difficult to develop a successful program without sufficient participation from both providers and insurers. Otherwise, there is a barrier to making the public option widely available and usable throughout the state. Oregon should include provisions to ensure adequate participation, as Nevada has done.

HB 2010 (2021) in Oregon started along that track by requiring carriers that offered plans for public programs, including Medicaid, Medicare, and public employees' benefits, to also offer public option plans. It also required providers that accepted those plans to accept public option programs.

Nevada's policy varies a little because its Medicaid program operates differently, but the state makes insurers' eligibility to participate in Medicaid contingent upon engaging with the public option. In Oregon, some legislators and advocates feared that requiring participation would result in those providers or carriers pulling out of those public programs. This is unlikely because the government spends more than $10.7 billion annually and serves about a quarter of Oregonians through the Medicaid program, and neither insurers nor providers are likely to withdraw from such a large portion of the health care market.[177] In addition, the rates under the public option would likely be higher than Medicaid rates, making public option patients attractive to providers that serve Medicaid patients.

Washington amended its public option to require participation by hospitals. Colorado required all carriers on the exchange to offer the standard public option plan. Some tying provisions in Oregon will provide a level playing field for providers and carriers that participate in the program and enable the state to leverage existing infrastructure.

4. **A public option should set specific premium reduction targets.**

In order to measure and ensure the success of the public option in lowering costs for consumers and overall health care spending, there have to be clear standards for premium reductions. Both Nevada and Colorado set reductions with specific percentages over time. Oregon can follow a similar pattern. Being vague about those targets increases the risk of not actually lowering costs and being unable to measure the success of the public option program.

5. **A public option should prioritize integrated primary care and other essential services.**

Prioritizing high-value care and preventative services such as primary care serves multiple functions. It can improve health outcomes as patients are able to get needed care before a condition worsens. It can also lower costs as health outcomes improve and the need for expensive treatments and procedures decreases. Both Washington and Colorado

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[177] Kaiser Family Foundation, "Total Medicaid Spending," 2020, archived at https://web.archive.org/web/20211113000419/https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/?currentTimeframe=0&selectedRows=%7B%22states%22%3A%7B%22oregon%22%3A%7B%7D%7D%7D&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D; Oregon Health Authority, "Oregon Health Insurance Survey Early Release Results," 2019, archived at https://web.archive.org/web/20211113000616/https://www.oregon.gov/oha/HPA/ANALYTICS/InsuranceData/2019-OHIS-Early-Release-Results.pdf.

emphasized the need for pre-deductible coverage of these high-value services, and Oregon should follow their lead.

CONCLUSION

A public option health insurance plan can provide a lower-cost alternative for Oregonians who need it. Oregon is in a unique position to learn from other states' policies and programs. Moving into the 2022 legislative session, state agencies responsible for making policy recommendations on Oregon's public option should account for the progress other states have made and use the thorough analysis resulting from HB 2010 to find the best balance among these policies. Their recommendations will be the next incremental step Oregon can take to reduce health care costs.