THE CENTURY FOUNDATION

REPORT HEALTH CARE

How to Create a Public Health Insurance Plan: Lessons from States

APRIL 21, 2025 — THOMAS WALDROP, JEANNE LAMBREW AND HANNAH RITTMAN

Health coverage rates in the United States have hit a record high, and access to health care has significantly improved since the Affordable Care Act was enacted in 2010.[1] However, high health care costs remain a barrier to care, even when people have health insurance coverage, and tend to disproportionately affect marginalized racial and ethnic groups. A 2022 survey by KFF found that about half of insured adults (47 percent) say it is difficult to afford health care costs.[2] Similarly, a 2024 study by the Commonwealth Fund found that among those with health insurance for the full year, 23 percent were underinsured, meaning that they didn't have affordable access to health care.[3]

To address the struggles and inequities that insured residents face in affording health care, states have taken a variety of actions.[4] One approach that three states—Washington, Nevada, and Colorado—have adopted is creating a public option for health coverage. Building on previous TCF research,[5] this report provides insights from interviews with state officials, policy makers, and advocates on how other states can most effectively develop and pass legislation to successfully implement a public option plan.

State-Level Public Options Laws

States have a variety of ways to respond to high health care prices, including adoption of a public option. The term "public option" has traditionally referred to a health insurance plan offered by a government through which individuals can purchase coverage.[6] In practice, it describes private plans with significant public involvement in reducing the premiums paid by the insured and/or the payment rates to providers.

Three states have passed laws establishing public options in partnership with private insurers: Washington in 2019, Nevada in 2021, and Colorado in 2021. Washington and Colorado have both implemented their programs, and Nevada is set to do so in 2026.[7] The laws all seek to improve premium affordability and lower overall health care costs.[8] Additionally, all three states' laws include the authority for state officials to apply for a Section 1332 state innovation waiver from the federal government, although their use of such waivers varies.[9] These waivers, named after the section of the Affordable Care Act that established them, allow states to waive certain federal policies to test alternative ways to provide health coverage.[10] If Section 1332 waivers are projected to save the federal government money, states may receive those savings as "pass-through" funding for approved health care uses.

The three states with public options take different approaches to cost containment: Washington set aggregate provider reimbursement caps tied to Medicare rates; Nevada set premium reduction targets, without authority over provider rates; and Colorado set premium reduction targets, with the ability to reduce provider rates if those targets are not met.[11] Provider participation rules also differ across the three states.[12] Washington began requiring mandatory participation for some hospitals in 2023 if public option plans were not available statewide in the previous year, whereas Nevada and Colorado require certain providers to participate as a condition of licensure or eligibility for other state programs.[13] Table 1 summarizes these differences, followed by a more detailed description of each state's program.

TABLE 1: KEY DETAILS OF STATE PUBLIC OPTION LAWS

	WASHINGTON	NEVADA	COLORADO
Signed into law	May 13, 2019	June 9, 2021	June 16, 2021
Plan availability dates	Plans first available in 2021; additional changes made in 2023	Individual market plans first available in 2026; small business implementation delayed	Plans first available in 2023
Section 1332 waiver	Authorized; not sought for public option	Authorized; approved January 10, 2025	Authorized; approved June 23, 2022
Primary cost-containment mechanism	Aggregate provider reimbursement caps	Premium reduction targets	Premium reduction targets with authority to reduce provider rates if not met
Provider participation requirements	Hospitals must contract with at least one public option plan	Mandatory participation for providers participating in Medicaid, public employees, and workers' compensation programs	Provider participation may be ordered following a public hearing, with penalties for noncompliant hospitals
Provider reimbursement protections	Payment floors for rural hospitals certified as critical access hospitals or sole community hospitals (101 percent of Medicare rates) and primary care services (135 percent of Medicare rates)	Provider rates in aggregate must be comparable to or better than Medicare rates, inclusive of add-on payments or subsidies; alternative approaches set for certain providers	If carriers do not meet premium reduction targets, state can reduce rates to a minimum of 165 percent of Medicare for hospitals and 135 percent of Medicare for healthcare providers; essential access hospitals, critical access hospitals, and hospitals serving high percentages of Medicaid and Medicare patients have higher floors
Lead agency overseeing public option plans	Health Care Authority that purchases public employee and school coverage and runs Medicaid, in consultation with Health Insurance Marketplace	Medicaid	Division of Insurance
Market(s)	Individual market only	Individual market (on and off marketplace); may also be made	Individual and small-group markets (on and off marketplace)

TABLE 1: KEY DETAILS OF STATE PUBLIC OPTION LAWS

	WASHINGTON	NEVADA	COLORADO
		available in small-group market	
Includes standardized benefits and cost sharing	Yes	No	Yes
Carrier participation	Voluntary; state to contract with one or more private carriers to offer public option plans	Mixed mandatory/voluntary; Medicaid MCOs must submit "good faith" bids to administer public option plans; other carriers may submit bids	Mandatory; all carriers in individual and small-group markets must offer public option plans in each county in which they operate
Geographic scope	Statewide coverage required beginning in 2023	No mandatory statewide coverage requirements or triggers, but may be achieved through the implementation process	State may order carrier(s) to offer coverage in empty counties following public hearing

Sources: Christine Monahan, Kevin Lucia, and Justin Giovanelli, "State Public Option–Style Laws: What Policymakers Need to Know," The Commonwealth Fund, July 23, 2021, https://doi.org/10.26099/acny-0s21; "State Public Health Insurance Options: A Comparison," United States of Care, February 2025, https://unitedstatesofcare.org/wp-content/uploads/2024/02/2024-Comparison-Chart-of-State-Public-Options.pdf.

Washington: Cascade Select

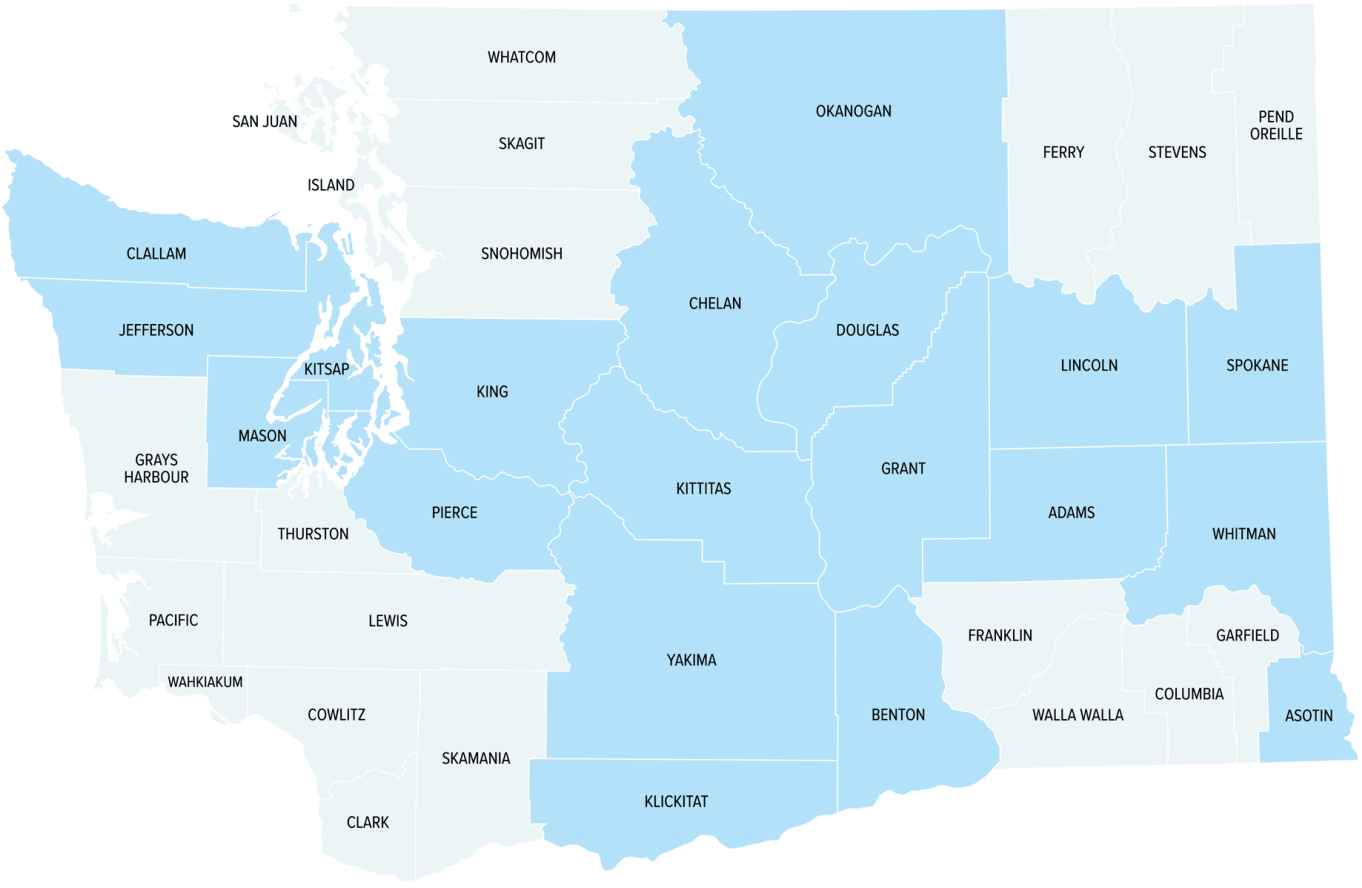
Washington was the first state to pass a public option law with the goal of improving the availability of affordable health coverage in 2019.[14] The law established the state's Cascade Care health care coverage program that includes the Cascade Select public option plan, which began being sold through the state's health insurance marketplace in 2021.[15] Cascade Select plans are designed to lower costs to their enrollees by capping by law on what the private insurers that offer such plans pay for services. Specifically, private insurers choosing to offer a Cascade Select plan must limit their aggregate reimbursement for all covered services (except pharmacy) to no more than 160 percent of what Medicare would pay for the same or similar services.[16] At the same time, to ensure access to care for enrollees, Cascade Select plans must pay at least 135 percent of Medicare rates for primary care and 101 percent of Medicare rates to critical access and sole community hospitals.[17]

In the first two years Cascade Select plans were available, Washington lacked a requirement for providers to contract with the public option plans,[19] Along with a system that automatically re-enrolled marketplace enrollees into their existing plan, this resulted in only 1 percent of enrollees choosing a Cascade Select plan in its first year.[20] The problem of limited availability persisted in 2022; Cascade Select plans were available in only twenty-four counties. Despite their limited availability statewide in this year, Cascade Select plans' premiums decreased by 5 percent and were the lowest premiums for Silver plans in thirteen counties.

MAP 1

CASCADE SELECT AVAILABILITY, BY COUNTY (WA)

2021



Cascade Select plans available

THE CENTURY FOUNDATION **Source:** Washington State Health Care Authority

In response to this challenge, Washington lawmakers passed new legislation nicknamed "Cascade Care 2.0" requiring that hospitals contract with at least one public option plan by 2023.[21] Since this change, the public option has performed significantly better, with plans offered in more counties in each subsequent year with slower premium growth than in other plans. In 2025, Cascade Select plans are available in every county in the state for the first time (see Map 1) and have the lowest premium of all Silver plans in twenty-six counties.[22] As a result of this improved availability and lower premiums, enrollment has increased, as shown in Figure 1, below.[23]

FIGURE 1

Nevada: Battle Born State Plans

Nevada was the second state to enact a public option law, passed in 2021 to improve the affordability of coverage.[24] Nevada's public option plans are scheduled to be available for purchase in 2026.[25] Insurers will be required to submit a bid to offer a public option plan, called Battle Born State Plans, in order to remain eligible for Medicaid managed care contracts.[26] Around 75 percent of the state's Medicaid enrollees receive coverage through managed care, making this a strong incentive for insurers to participate.[27]

Additionally, Nevada's law requires health care providers to be in-network with at least one public option plan to remain eligible for Medicaid, public employee, and workers' compensation payments.[28] Rather than addressing reimbursement rates, Nevada will require public option plans to set premiums at least 5 percent lower than private plan competitors.[29] Nevada applied for a Section 1332 waiver in December 2023, and the federal government approved the waiver on January 10, 2025.[30] The waiver includes a variety of policies, but two are especially relevant: (1) allowing public option plans to calculate their premiums based on public option enrollment and (2) establishing a reinsurance program—a sort of "insurance for insurers," under which the state would help cover very-high-cost claims.[31] Together, these provisions will allow public option plans to achieve the premium reduction goals, lower the root cost of care, and bring in the savings achieved as pass-through funding from the federal government.

Colorado: Colorado Option

Colorado was the third state to enact a public option for health coverage. Governor Jared Polis signed the bill establishing the Colorado Option into law on June 16, 2021, and Colorado Option plans were first available during open enrollment for 2023.[32] Colorado requires individual and small group market insurers in the state to offer a standardized plan for each county in which they operate.[33] Colorado law requires that Colorado Option plans achieve a 15 percent reduction in inflation-adjusted premiums by 2025, compared to premiums in 2021.[34] After 2025, premiums cannot increase more than the Consumer Price Index for medical care each year.[35]

Colorado's law has a strong enforcement method for its cost containment strategy: if insurers fail to meet premium reduction targets or network adequacy requirements, the state's commissioner of insurance is able to hold public hearings with insurers and providers requiring them to justify their prices and networks.[36] The commissioner could then potentially require participation for providers and set insurer reimbursement rates for hospitals within statutory limits of 165 percent of Medicare's rates, so long as the reduction is not more than a 20 percent from the previous year.[37] Similar to Nevada, Colorado has also applied and received approval for a Section 1332 waiver to continue its existing reinsurance program and achieve additional pass-through federal savings from premium reductions.[38] The state is using these savings to fund its reinsurance program and state-level subsidies offered through its state-based marketplace, Connect for Health Colorado, further improving affordability.[39]

The Colorado Option had a stronger start than Cascade Select, with 27,965 people (around 14 percent of the state's marketplace enrollment) choosing a Colorado Option plan in 2023.[40] In 2024, enrollment increased to 80,655 people, more than one-third of the state's marketplace, and in 2025, enrollment increased to 132,791 people, which is just under half of all marketplace enrollment in Colorado.[41] Figure 2 shows this enrollment growth.

FIGURE 2

One analysis found that the Colorado Option was associated with $100 in monthly savings in premiums for the lowest- and second-lowest-cost Silver plan relative to comparison states.[42]

Interview Findings

The Century Foundation conducted interviews with policymakers, advocates, and state officials on the development, passage, and implementation of their public option laws in Washington and Colorado; because Nevada has not yet implemented its plan, it was excluded from this report. The interviewees included:

- In Washington: Representative Nicole Macri, Washington State House of Representatives; Laura Kate Zaichkin, the director of market competition and affordability at the Washington Health Benefit Exchange; Leah Hole-Marshall, the general counsel and chief strategist at the Washington Health Benefit Exchange; Sam Hatzenbeler, a senior policy associate at the Economic Opportunity Institute; and Emily Brice, the co-director of advocacy at Northwest Health Law Advocates.

- In Colorado: Senator Dylan Roberts, Washington State Senate; Michael Conway, the state's insurance commissioner; Kyla Hoskins, the deputy insurance commissioner overseeing the Colorado Option; Rayna Hetlage, the former director of political strategy at the Center for Health Progress; and Adam Fox, the deputy director of the Colorado Consumer Health Initiative.

- Among national experts: Liz Hagan, director of State Policy Solutions, United States of Care; Jason Levitis, senior fellow at the Urban Institute; Dan Meuse, deputy director of the Advancing Coverage in States, and State Health and Value Strategies programs.

Below are observations from these interviews, organized around the public option's development, passage, and implementation.

Developing a Public Option Health Plan

Governors' Leadership. In both Washington and Colorado, interviewees emphasized the impact of having the state's governor involved in the drive toward a public option.[43] Washington Governor Jay Inslee, who has a long history of health care leadership, tasked his staff early to explore possible pathways to make health care and coverage more affordable, including a public option. Governor Inslee continued to advocate for it through the law's passage in 2019, leading a press conference on the proposal with state legislators and calling for the law's passage during his State of the State address.[44]

Colorado Governor Jared Polis also helped spearhead his state's public option effort. Health care affordability was a major priority for Governor Polis who, in one of his first acts in office, established the Office of Saving People Money on Healthcare, led by the state's lieutenant governor. Governor Polis' office helped with both policy development and political strategy around passage. The benefits of leadership from the governor were explained by the legislative sponsor:

> The governor and his administration decided to make a priority which was obviously very helpful. And so we got the expertise and support of the commissioner of insurance and his department, and the Colorado Department of Healthcare Policy and Financing, and others within the state government that wanted to work on this with us.... —Senator Dylan Roberts[45]

Champions in Legislatures. Legislative leaders were also central to advancing public option laws. In Washington, interviewees emphasized the deep health policy expertise of then-Representative Eileen Cody and then-Senator David Frockt. One advocate described them as "really sophisticated operators in [the health policy] space."[46] This included working with other legislators. As one official involved explained:

> [Representative Cody] met with the Health Benefits Exchange and the Office of the Insurance Commissioner, because they understand the private insurance market more broadly, as well as the Health Care Authority. She brought the committee along, and we had a lot of dialogue about it.
> —Representative Nicole Macri[47]

In Colorado, Senator Dylan Roberts was the legislative champion. He sponsored multiple laws aimed at improving the affordability of health care in the state, including the law establishing the Colorado Option. Senator Roberts described the impetus for these laws as the struggles his district faced in affording insurance:

> I represent a lot of the counties in the mountains of Colorado, and for a variety of reasons, those counties had the most expensive health insurance premiums on the individual market—not only in Colorado, but… in the whole country by county. —Senator Dylan Roberts[48]

Studies. Both Washington and Colorado's laws were initially based on legislative studies required in years before passage. Emily Brice, deputy director of Northwest Health Law Advocates, attributed development of the Cascade Care 2.0 law to a study required by the law initially establishing the state's public option:[49]

> The exchange had done a legislative study the previous year. The legislature had asked them to do some modeling and to think about what different options could happen.… So, they did this study that said basically here's what we could do with a pot of money and here are some options for how we might be able to pay for it and made some recommendations. There was discussion of that, and then the legislature ended up being able to push that through with general funds. —Emily Brice[50]

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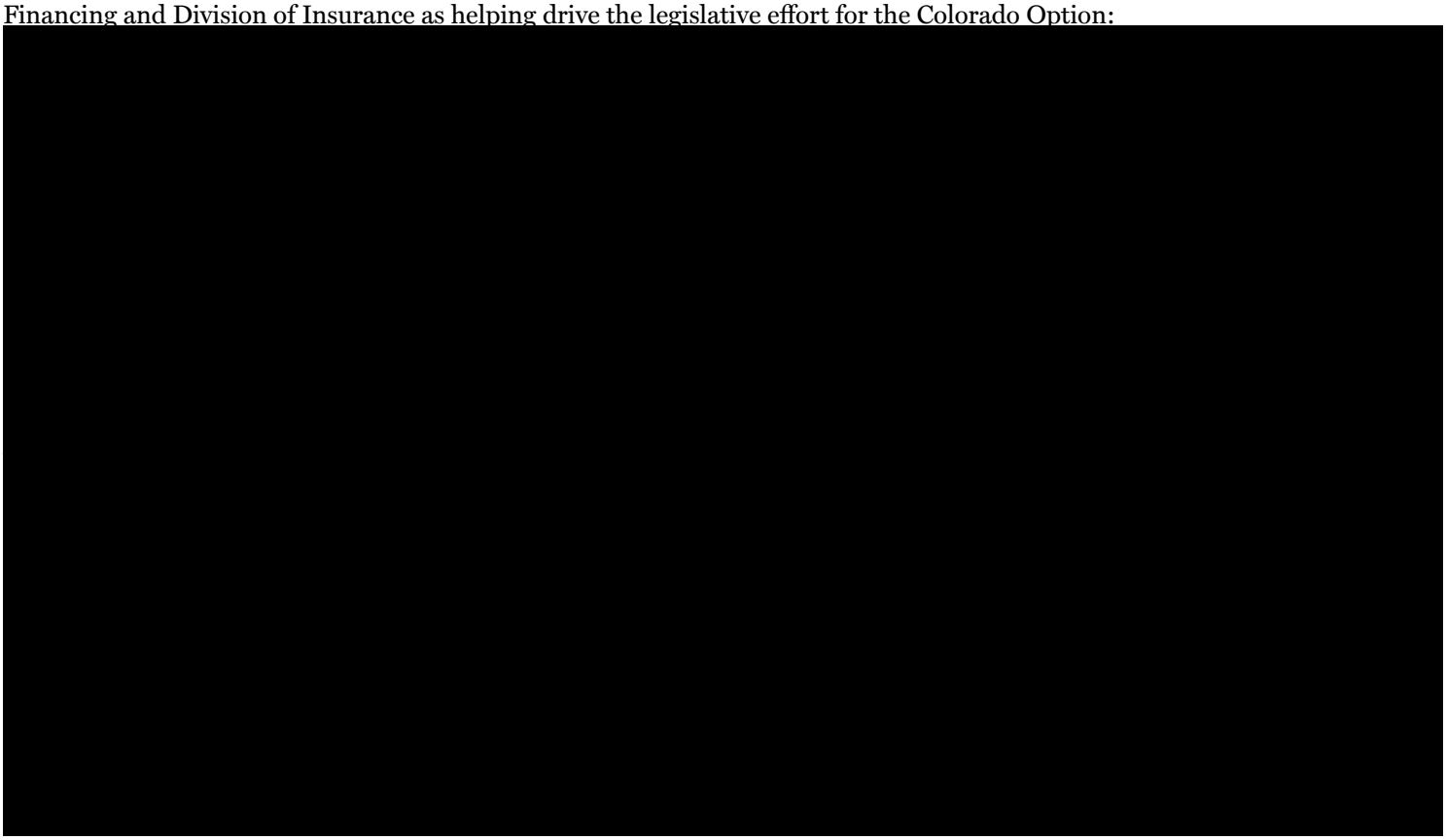
In Colorado, Senator Roberts described a study done in the previous year by the Department of Health Care Policy and Financing and Division of Insurance as helping drive the legislative effort for the Colorado Option:



Exchange, Health Care Authority, and Governor's Office worked with SVHS on whether the public plan was a qualified health plan or not, what the options were to ensure sufficient provider participation, how to design standard plans, and how to communicate about such plans.[53] Modeling work was conducted by consultants as well as state staff. In an interview, Laura Kate Zaichkin, the director of market competition and affordability at the Washington Health Benefit Exchange, discussed how a 2023 report by the consulting firm Milliman outlining policy options to improve the public option informed the Exchange's work with the legislature around options to apply for a Section 1332 waiver to receive pass-through funding.

Goal Clarity. Many conversations regarding public option laws emphasized the importance of goal clarity throughout the development, passage, and implementation of public option laws. In Washington, exchange officials described the goal as highly targeted at ensuring that high-quality, affordability insurance plans were available on the state's marketplace.[54] The law establishing Cascade Select plans did not include any explicitly equity-focused provisions, which has limited the ability of state officials to take as direct action to improve health equity as they may have preferred. Leah Hole-Marshall, general counsel and chief strategist at the Washington Health Benefit Exchange, discussed how early discussions of what the goal of the program is have driven implementation:

> Goal clarity is another key that we've worked on, and the overall goal that we laid out at the beginning, is agreed to by all.... One thing I would humbly advise other states to consider is who you are trying to help. That has shown up in some of the interagency strategy discussions....
>
> I envision the public option to be the lowest cost plan that is high quality according to the other standards that we have in place and that it's an option for individuals, most targeted to those under 250 percent FPL. Looking to low-income individuals, how do we get them the most help possible? Others that want to see maybe a market-wide spread of a public option, which can also be helpful and maybe helpful to numerous different groups, might make different strategy decisions to accomplish that.... [That's] been an important principle that guides some of our policy decisions and strategies. —Leah Hole-Marshall[55]

Additionally, Representative Macri highlighted that while some advocates in Washington were frustrated that the Cascade Care law did not establish a "true" public option, in which the state carries the risk of the insurance plan, clarifying the goal of addressing constituent struggles to afford health care helped achieve passage of the law:

> What we really had going for us was the urgency. The challenge that patients, consumers—our constituents—were feeling about health care affordability. —Representative Nicole Macri[56]


00:00
00:12
57
Nicole Macri

00:00 00:16

Passing Public Option Legislation

Advocates also worked to expand the involvement of other organizations. Rayna Hetlage, the former director of political strategy at the Center for Health Progress (CHP), said that Healthier Colorado and CCHI brought CHP and other groups not focused specifically on health policy into the discussion, allowing them to advocate for more equity-focused provisions of the law (discussed in more detail below).[59]

Education and Engagement. State policymakers worked with these coalitions to educate other legislators as well as develop popular support for public option laws. In Colorado, Michael Conway, the state's insurance commissioner, highlighted the impact of advocates in achieving passage of the law, especially around lobbying members of the legislature:

> We partnered early on with the advocates, and they brought a ton of resources to bear both on general [communications] but also a fair amount of lobbying support too. So we had a coalition of lobbyists at the capital. —Michael Conway[60]

Rayna Hetlage described advocates representing small businesses and undocumented immigrants as a united front, committed to passing the law to improve health care affordability despite industry opposition.[61] Hetlage said that advocates' working with lawmakers to clarify their goals for the proposal and maintaining a united front helped ensure that the law passed with both

groups' policy priorities still in place.[62]

Executive staff were highly involved in the development and passage of the Colorado Option as well. Michael Conway highlighted this, saying:

> "We were heavily involved. There's the standard testifying in committee constantly; lobbying legislators too… We had the governor's office lobbying. We had our internal lobbyists; the [Department of Health Care Policy and Financing]'s lobbyists…" —Michael Conway[63]

Effort and Opposition. Another common theme from interviewees was the level of effort required to pass public option legislation, especially in the face of entrenched opposition. In both states, much of the existing health care industry—insurers, hospitals, and health care provider organizations—opposed the passage of public option laws. In an interview, Emily Brice described hospitals as opposing the law due to the provisions limiting provider reimbursement, but she also highlighted that once the reimbursement limit was made aggregate, hospitals became less vocally opposed to the law.[64] Representative Macri shared this perspective, describing hospitals and medical associations as being especially influential in the state Senate.

Industry opposition was also present in Colorado. Senator Roberts described the entire industry as opposing the law:

> The opponents were basically anybody in the status quo health care industry. Of course, this was directly taking on insurance providers. The original bill actually proposed to create a new health insurance product that would have been managed by the state, so they were certainly some of the first and most vocal opponents. But cost savings in health care requires reductions for all of the payers and providers in health care, so we quickly brought on opposition from the doctors and the medical society and the pharmaceutical industry. —Senator Dylan Roberts[65]

Overcoming this opposition required significant time and energy by proponents of the laws. Senator Roberts highlighted the effort involved and praised the assistance from the Michael Conway's staff:

> There were many days of long heated negotiations with all of the various opponent stakeholders, whether it was insurance providers or hospitals or doctors, and [Division of Insurance staff] were in those rooms helping us with those negotiations. I'm not a healthcare expert. I'm a lawyer and a prosecutor. And so I definitely relied on them for subject matter expertise. —Senator Dylan Roberts[66]

Michael Conway echoed the sentiment that passing a public option law will take significant effort, stating:

> If states want to go down this path, they have to be committed to the fight from the get-go, because it's going to be a hellacious fight.… When we were in the 2021 session, as we were working this bill through, it was easily seventy-, eighty-, ninety-hour weeks simply because of this piece of legislation.… They need to be that committed

> and go into it with the understanding that it very well could be that level of fight if they want to go down this path." —Michael Conway[67]

Ensuring the Final Law Is "Approvable." In addition to other state policymakers, state officials in Colorado worked with the federal government while developing their law. Michael Conway said his staff regularly communicated with the federal government about the policies under consideration, which helped ensure that the law's Section 1332 waiver was generally in line with the policies that the federal officials supported and made for a smoother application process:

> The whole way through we were keeping [federal officials] very closely in the mix on what we were thinking.... They were extremely helpful... as we were drafting the legislation to ensure that we drafted it in a way that would lead to them being able to approve so keeping them in the loop through the process gave basic assurances that we were going in a good direction. —Michael Conway[68]

These conversations, as well as commission staff's existing familiarity with the state's health insurance system, helped legislators craft more-informed policies.

Lessons from Implementation

Governance. In Washington, the task of implementing Cascade Select is split across the state's Health Insurance Marketplace, the Health Care Authority (that is also the state's Medicaid agency), and the state's insurance commissioner. Washington officials discussed the complexities and subsequent level of effort needed to coordinate implementation across these agencies:

> A big learning opportunity for us and what we would pass along to other states is the complexity of having multi-agency implementation roles.... The work that it takes, the collaboration it takes, and resources, frankly, to make sure that all the different authorities and levers are working together from end to end across the agencies is really challenging. —Laura Kate Zaichkin[69]

> We have the deputy [commissioner] for leadership, strategy, [and] vision, in addition to, obviously, the commissioner; the Colorado Option director which is really a project management, program management, [and] policy direction; internal actuarial support.... And then it was really upon the director to make sure that the rates and forms team was able to incorporate any new requirements and that's reviewing the standardized plan. So there are existing people right that the standardized plan in the Colorado Option program already touched, and so there wasn't new staff for rates and forms because yes, there will be more plans for them to review, but they already have systems and tools to be able to do that without additional resources. —Kyla Hoskins[70]

Public Input. Outside experts remained involved in the implementation of Cascade Select. In Washington, the exchange created an implementation work group in 2019, including representatives for public option issuers, health care providers, and patient advocates. This work group was deeply involved in operationalizing the law, with exchange officials describing them as working extensively and meeting monthly. Advocates emphasized their presence in the work group and its input on implementation as being crucial to ensuring patients were centered in the law:

> The Cascade Care work group was convened by the health benefit exchange, and it still is continuing now. Different issues were covered such as designing the different levels of standard plans and data collection, looking at how the subsidies were impacting affordability and enrollment, how we were doing in terms of standard plan and also public option plan availability around the state.... Advocates played a really important role on the work group, because if it weren't for us, it would have been just very industry heavy. We wanted to make sure that we were bringing that consumer voice and advocates for patients. —Sam Hatzenbeler[71]

Federal Approvals and Oversight. The federal government only reviews applications for Section 1332 waivers once a legislation becomes a law. Colorado modified its existing waiver to capture the savings the Colorado Option has achieved as pass-through funding and using these funds to pay for its state-level subsidies. Adam Fox, deputy director of the Colorado Consumer Health Initiative, discussed how this approach helped address budgetary concerns in the legislature about the proposal, as well as funding further affordability measures:

> When the Colorado Option policy was in progress for 2021, it was a huge priority for advocates and, to an extent I think, our Division of Insurance as well: if we're able to maximize the savings on Colorado Option, let's claim those as pass through, because we're saving the feds money, let's add those to our 1332 waiver, and put those into the enterprise. —Adam Fox[72]

> in place that they are hoping to continue…. But don't have any federal dependencies on it so that's maybe a key consideration as you're trying to build out a program like this. There will always be federal administration changes; be thinking about the benefits of those. There are benefits, definitely, to getting it under a waiver and getting some federal pass through, but for right now that is not a concern we have. —Leah Hole-Marshall[74]

Decisions on Timing and Phasing in. Interviewees also emphasized the impact of the timing of public option laws on their implementation. For example, in Washington, Exchange officials discussed the difficulty of addressing issues with the initial Cascade Select law via legislation, saying that giving the Exchange the authority to take additional steps if the goals of the law are not being met would have achieved a smoother implementation:

> I wish we'd built in a phased approach. It's hard to reopen the statute, you get to the compromise you're at, and that's great. We're grateful and thankful that it passed, and it has a lot of promise and is showing its benefit. But it could be even stronger… I wish we would have built in a couple of thresholds, that if they're not met, additional tightening could occur without having to try to renegotiate in the legislature. —Leah Hole-Marshall

> I would also include making sure that the appropriate implementers at the policy level have the appropriate authority at different levels to make sure the goals of a public option are being implemented appropriately. Not just what exact authority does the Health Care Authority have as the purchaser of public options, but what else is needed from an enforcement and consumer protection perspective at the other implementation levels like the Exchange Board and the Office of the Insurance Commissioner.
> —Laura Kate Zaichkin[75]

One area where Washington officials described this lack of phasing as being especially frustrating was in translating any savings on health care spending into savings for consumers via premiums:

> Our public option is very focused on the reference price for health care services, and doesn't, unlike Colorado, have any sort of enforcement or defined expectations about how that transfers to carriers and [premiums]. I would encourage states to consider that kind of phasing and gates, depending on outcomes and process, and what additional levers need to be deployed to meet the goals. —Laura Kate Zaichkin[76]

Provider Participation and Enforcement. Interviewees in both states highlighted the impact that provider participation had on the ability to operate a public option. As discussed earlier in this report, Washington's initial implementation of its public option law resulted in a small proportion of marketplace enrollment choosing Cascade Select plans due to limited provider participation. The state passed additional legislation to address this issue in 2021, and enrollment has since improved. Laura Kate Zaichkin discussed the impact that a lack of provider participation requirement had on implementation:

> [Provider participation] has been one of the greatest challenges that public option has faced. So I think that certainly, some provider participation requirements and enforcement that are tied to outcomes and processes is important. That was built into 2.0; I think maybe we would have built it out a bit further in hindsight. —Laura Kate Zaichkin[77]

In contrast, Colorado included a stronger, phased-in provider participation process. If Colorado Option plans are not able to meet network adequacy and premium reduction standards, the commissioner of insurance is able to hold public hearings with both insurers and providers to determine why. Colorado officials said that the potential for these hearings helped Colorado achieve the savings the state has seen:

> I think reputation is a big thing. No one wants to be called in front of a public hearing where press are going to be there [and] members from the public can comment. It's open to everybody.... I think reputation is a big one, but then it's time and expenses. I mean, this is an adjudicatory process where lawyers need to be involved. —Kyla Hoskins

> It's not just the insurers that are worried about the reputation, it's the hospitals, too. I think the hospitals, maybe even more so, were worried about their reputation in certain instances. —Michael Conway[78]

Following these hearings, the commissioner can require providers to contract with public option networks and reduce rates if plans still cannot meet the requirements. Adam Fox described the impact this tiered approach to provider participation and premium reduction has had:

> I think what is clear is the threat of a public hearing, certainly the carriers and, to an extent, the hospitals want to avoid that… [The Division of Insurance] filed complaints on almost all of the individual market carriers' cases, and essentially pulled a lot of the hospitals into the process in that way.… That helped sort of put the insurance carriers and the hospitals on notice of if you're not filing complaints or you're not coming to the table to try to achieve the cost reductions that could be required of you, then we're going to pull you in,… Ultimately where things have landed in both years on the public hearings is that… the negotiations that sort of happened a little more proactively to avoid DOI filing those complaints. —Adam Fox[79]

Data Ownership, Monitoring, and Changes. Many interviewees discussed how ownership of different datasets—especially data on spending by health insurers and rates charged by health providers—impacted the development of their laws. Washington state officials described data ownership and interpretation as a key aspect of the early development of Cascade Select and the law's payment limits:

> One thing that was hard for us was that we didn't have the level of expertise to understand what we were paying, what the price was. We had access to our state's [all-payer claims database], but that requires sophisticated researchers who understand how to manipulate that data. We took a best estimate approach, so we had access to some data, but it was limited in terms of time and expertise. We then cross referenced that with our insurance carrier filing information to try to get at a range of carrier reimbursement and how that might impact the marketplace. —Leah Hole-Marshall[80]

Colorado officials also pointed to the ability to confidentially access insurer reimbursement rates as important to achieving the premium reduction goals:

> We've already had an existing authority through rate review where we scrutinize premiums to make sure they're adequate and not excessive. We continue to do that for all of our plans, including Colorado Option plans. But in addition to that authority, the commissioner has the ability to look in the books, so to speak, between a health insurance company and a hospital to see about their negotiated reimbursement rate. If a health insurance company is not able to lower premiums to a specified target that we've defined on the standardized plan, then we're able to kick start that hearing process, that public, adjudicatory hearing process that the commissioner oversees." —Kyla Hoskins[81]

Emily Brice praised Washington's inclusion of data the Exchange does have in its implementation process, especially how it has impacted their ability to examine enrollment and health equity.

> If you look at our uninsured rates, there's still pockets of disparities by race in particular. and I think the immigrant coverage expansions, the 1332 waiver and the Apple Health expansion or Medicaid expansion, shows pretty significant differences between baseline demographic data and enrollment data.... Washington state has a pretty significant population of Asian-American Pacific Islander undocumented immigrants that are not showing up in the enrollment data for the immigrant coverage expansions, which are weighted more heavily towards Latinx or Spanish speakers. So you can see that there is some unevenness in how the message is getting out there. —Emily Brice[82]

Effort. Interviewees also highlighted the amount of work that public option programs take to implement. Michael Conway described the state's associated Section 1332 waiver as taking a long time to develop and gain approval, even with conversations with federal officials informing the legislative mandate for the waiver:

> It takes a long time to get [a public option and 1332 waiver] up and running.... So, if you're just starting in this conversation now, you're probably three years away from having a product in play. —Michael Conway[83]

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Advocates are also an important part of this process. Washington and Colorado both included advocacy organizations in the development of public option legislation, which also improved odds of passing the final laws. Including advocates in early policy development, such as in legislatively directed studies, can ensure that many perspectives are included in the development and that advocate priorities essential to securing political support help shape the proposal.

2. Determine precise goals for a public option proposal.

Policymakers should work with advocates and other experts outside of the legislature in their state to determine the goals of a public option proposal. Including advocates in these discussions can create coalitions of support for proposals, making passage more likely, and it can also help ensure that the proposal does not unintentionally entrench existing inequities in the health care system. Similarly, consulting with experts (such as executive branch officials, other states' officials, and academics) can improve the policy's efficacy at meeting these goals and reduce the confusion present if the law ends up being implemented across multiple state agencies, as in Washington.

3. Weigh the value of a federal Section 1332 waiver.

An early decision is whether to pursue a Section 1332, which takes significant time and intention. Washington and Colorado described the tension between accessing federal pass-through funds and maintaining programmatic independence. Including the federal government in a state's public option program via a Section 1332 waiver can represent a meaningful influx of funding for a state that may allow the public plan option to be paired with other priorities, such as expanding affordability programs that could increase support for the law.

That said, such waivers create a federal dependency. Developing programs that advance health equity and bring down the cost of care without reliance on federal resources can ensure the longevity of these programs and avoid the risk of a change in priorities with a change in administrations. President Trump emphasized letting states take different approaches to health policy issues on the campaign trail in 2024, and he directed his administration to lower prices for Americans, including health care prices. Focusing waivers on policies that lower the root cost of health care, as Cascade Select and the Colorado Option do, could potentially continue to secure federal approval.

4. Give the implementing agency the tools they need.

Public plan option legislation should empower the implementing agency (or agencies) to meaningfully implement and enforce the law. Locating the appropriate agency for its management and ensuring strong interagency relationships is key to successful implementation.

Additionally, attention should be paid to the policies regarding participation by health care providers and insurers. Enforcement mechanisms for provider participation may be most useful if they allow implementing officials to dial their actions based on whether the goals of the public option are being met.

In order to maximize savings through a public option, legislation should also ensure meaningful access to data, including how much insurers pay health care providers. Such information allows state officials to determine what aspects of the health care industry are driving high spending, whether parts of the public plan option are more effective than others, and how to sustain and expand meaningful cost-reduction measures.

Progress through a Public Plan Option Is Possible

As the experiences in Washington and Colorado demonstrate, public option laws have the potential to improve the affordability and equity of health coverage, although it is earlier in their experience and more evaluation is needed to draw conclusions. This report captures lessons from leaders in these states on designing, passing, and implementing public plan options. Those

interviewed offered insight such as the importance of identifying policy and advocacy leaders, clarifying goals, balancing the value of a federal waiver, and attending to implementation tools. Lastly, leaders in these states learned from others, building on experience and expertise, which this "playbook" aims to facilitate.

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