State Public Options: Evidence From the Field

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STATE Health & Value STRATEGIES

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About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

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What Is a State Public Option? Framework Overview

- A state public option is a broad category of health insurance policy in which state government uses its regulatory and purchasing power to lower costs and expand access, without necessarily creating a government-run insurer.
- ***Pathway 1 — Reimbursement Limits***: State law caps what private carriers can pay providers (e.g., tied to Medicare rates), reducing insurer costs and enabling lower premiums. Delivered through private plans.
- ***Pathway 2 — Premium Savings Targets***: State mandates that carriers must offer a plan meeting a specific premium reduction target (e.g., 10% to 15% below baseline). Carriers determine how to meet the target.
- ***Pathway 3 — Public Program Buy-Ins***: Individuals purchase into an existing public program (Medicaid, state employee plan). The state, not a private insurer, bears insurance risk. Requires a federal waiver.

What All Models Share:

All are targeted primarily at the individual market, the segment most affected by high premiums and coverage gaps.

Additional Tools:

Standardized Plans: State-designed benefit templates that create apples-to-apples comparison and improve consumer decision-making.

Basic Health Program (BHP): Affordable Care Act (ACA) Section 1331 option for 138% to 200% of the federal poverty level (FPL) populations. No waiver required. Operated by DC, MN, OR.

Pathway 1: Reimbursement Limits

- State law requires that private carriers offering a designated public option plan reimburse hospitals and clinicians at rates no higher than a specified percentage of Medicare - for example, 100% to 135% of Medicare rates for primary care, or 235% for hospital services.
- The private insurer still administers the plan, processes claims, and manages networks. The state does not pay providers. But the state sets an effective ceiling on what the insurer can pay, and therefore how much the insurer must charge in premiums.
- Washington (Cascade Select): Carriers are procured by the state with an agreement to limit provider rates using percentages of Medicare as the benchmark, set through statute.

Key Tradeoffs:

Potential Benefits:
Reduces insurer cost structure, enabling meaningful premium reductions without direct state subsidy.

Potential Risks:
Provider resistance is significant. Hospitals and health systems, particularly in rural markets, may refuse to accept lower reimbursement, leading to narrower networks or reduced access.

Target Population:
Individual market enrollees purchasing through the state exchange. Most directly beneficial to unsubsidized buyers (over 400% FPL) who see full premium savings. Washington targets state-subsides to enrollees in these plans (<250% FPL).

Pathway 2: Premium Savings Targets

- The state mandates that carriers must offer a designated plan at a specified percentage below a market benchmark, requiring a price outcome without dictating the means of achieving it. Carriers may use reimbursement renegotiation, benefit management, network design, or administrative efficiency to reach the target.
- The Colorado Option required carriers to reduce premiums by 5% (2023), 10% (2024), and 15% (2025) below 2021 baseline rates. If a carrier cannot meet the target, the state can engage in more oversight.
- Nevada Battle Born State Plans (BBSPs) launched on 1/1/2026, with a 15% reduction target by 2029. Just over 10,000 enrolled in BBSPs in the first year.

Key Tradeoffs:

Potential Benefits:
Mandatory targets create real consumer savings if achievable. Colorado Option was among the lowest-cost Silver plans in most counties in 2024–2025. The competitive effect moderated premium growth across the market.

Potential Risks:
Insurer financial sustainability is a genuine concern. If premium targets are set too aggressively, carriers may not be able to remain profitable, particularly in high-cost rural markets.

Companion programs (reinsurance, risk corridors) are generally necessary to make mandatory premium savings targets financially viable for insurers.

Target Population:
Individual market enrollees purchasing through the state exchange. Most directly beneficial to unsubsidized buyers (over 400% FPL) who see full premium savings.

Pathway 3: Public Program Buy-Ins

- Rather than regulating private insurers, this pathway enables individuals to purchase into an existing public program - such as Medicaid managed care or a state employee health plan. The state (or its Medicaid managed care organization contractors) effectively becomes the insurer for this population.
- Requires significant study to understand the implication on the remaining market and the program that people would buy into.
- Requires at least one federal waiver so the state does not lose premium tax credit (PTC) funding.

Key Tradeoffs:

Potential Benefits:
Can reach populations that private carriers won't serve competitively (very low-income unsubsidized individuals, certain immigrant populations).

Uses existing Medicaid network infrastructure, which may be better suited to underserved communities than commercial networks.

Potential Risks:
Most complex to implement. Requires a federal Section 1332 waiver (individual market) or Section 1115 waiver (Medicaid). CMS/Treasury approval typically takes 2–4 years.

Requires a State-Based Marketplace (SBM) to access pass-through funding. States using HealthCare.gov cannot use 1332 pass-through funds for subsidies or non-qualified health plan offerings.

Target Population: Primarily unsubsidized individuals, but potentially lower income marketplace enrollees; potentially small employers.

Additional Tools: Standardized Plans & the Basic Health Program

Standardized Plans

States can require all Marketplace carriers to offer plans built to a standard template - specifying deductibles, cost-sharing, and covered services in uniform terms. This is not itself a public option, but it is a critical enabler of meaningful comparison shopping and can amplify the consumer benefit of a public option.

With standardized plans, consumers can compare plans on premium alone - network, quality, and service attributes - rather than trying to decode benefit structure differences. Several states require standardized plan offerings alongside their public option products.

Does not require a federal waiver. Can be implemented through state insurance regulation or Marketplace operating rules. Can be enacted quickly relative to other pathways.

Basic Health Program (BHP) — ACA Section 1331

The BHP is an ACA option, not a waiver, that allows states to create a coverage program for individuals at 138% to 200% FPL who would otherwise access Marketplace coverage with PTCs.

Federal funding: States receive 95% of what the federal government would have spent on PTCs and Cost-Sharing Reduction (CSR) subsidies for these enrollees. States use this funding to offer near-free or very low-cost coverage.

Active Examples:
DC, Minnesota, and Oregon. New York previously operated a BHP.

Key Policy Consideration: PTCs & the Benchmark Effect

How ACA Subsidies Are Calculated

- The ACA's PTCs are calculated as the difference between the benchmark plan premium (the second-lowest cost Silver plan (SLCSP) available in each county) and the enrollee's statutory contribution amount (a percentage of household income).
- This means the benchmark plan's premium determines how much subsidy every subsidized enrollee in that county receives, regardless of which plan they actually choose.

The Benchmark Problem

- If a public option plans lower premiums, the subsidy amount for all subsidized enrollees in that county will be reduced. Enrollees who stay in non-option plans will effectively receive smaller subsidies.

Design Implications:

States considering a public option must decide whether it will be allowed to compete as a benchmark-eligible plan.

The benchmark effect is strongest when the public option achieves significant savings and depresses premiums. Ultimately, affordability is the goal, but it creates the subsidy compression problem.

Enrollee Dynamics:

Research from CO and WA suggests that public option enrollment comes substantially from existing Marketplace enrollees switching plans, rather than from newly insured individuals. Net coverage gains may be smaller than gross enrollment figures suggest.

Enabling Policy: Section 1332 Waivers & the SBM Requirement

Section 1332 State Innovation Waivers

- Section 1332 of the ACA allows states to waive certain ACA requirements and design alternative coverage approaches.
- **Pass-Through Funding:** The key financial tool. When a state receives a 1332 waiver, the federal government passes through the value of PTCs and CSR subsidies that would otherwise be paid to individuals as a lump sum to the state. States can use this funding to design their own subsidy structures.
- **Alaska's Current Reinsurance Waiver:** Alaska already operates a 1332 waiver for its reinsurance program, which has reduced premiums significantly in the individual market. This existing waiver infrastructure is directly relevant to any public option discussion.
- **Timeline:** New 1332 waiver development, public comment, and CMS/Treasury review typically takes 2 to 3 years from legislative authorization to implementation.

State-Based Marketplace (SBM) Requirement:

To access 1332 pass-through funding for subsidy enhancements (beyond the base reinsurance model), states must operate a State-Based Marketplace rather than using HealthCare.gov.

Alaska currently uses HealthCare.gov. Transitioning to an SBM requires state investment in technology, staffing, and regulatory infrastructure and typically takes 2 to 3 years. Several states have made this transition successfully.

Key Distinction:
For Pathways 1 and 2 (reimbursement limits, premium savings targets), a 1332 waiver is not required. These are achieved through state insurance regulation. A waiver is primarily needed if Alaska wants to (a) offer additional state-funded subsidies, or (b) implement a buy-in model (Pathway 3).

State Experience at a Glance: Washington, Colorado & Nevada

Washington
Cascade Select
(since 2021)

Model: Selective procurement / reimbursement limits. 7 carriers bid; 3 selected.

Enrollment: ~84,000 enrollees (2025 est.)

Premiums: Lowest-cost Silver in 26 of 39 counties. No statutory reduction mandate; mandated reimbursement drives savings.

Key lesson: Selective, voluntary model created competition without regulatory confrontation. Cascade Care Savings subsidy supports enrollment.

Colorado
Colorado Option
(since 2023)

Model: Mandatory participation for all individual market carriers; premium savings targets (5%/10%/15%).

Enrollment: 47% of individual market (2025) - highest public option market share of any state.

Premiums: +4.6% in 2025 vs. +6.1% for non-Option plans. Reinsurance program prevented ~24% higher premiums ($477M savings).

Key lesson: Mandatory model drives high uptake, made easier with reinsurance.

Nevada
Battle Born State Plans
(since Jan. 2026)

Model: Premium reduction program.

Enrollment: Still early - launched January 2026. 10,000 estimated enrollments, full enrollment data not yet available.

Premiums: ~4.6% overall reduction from benchmark. Capped at Medicare Economic Index annually.

Key lesson: Still learning!

Thank You

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