Policymakers have long debated the concept of a public option, a government-run health insurance plan that competes with private insurers. Although proponents argue these plans reduce health costs for both consumers and the government, critics claim that these savings are illusory because the required cuts in reimbursement rates to hospitals, physicians, and other clinicians necessary to produce savings are unsustainable. Efforts to enact a federal public option have generally stalled. Thus, the conversation has largely shifted to the states.

Since 2019, four states have started the process of creating public option-style plans. Colorado and Washington State have begun enrolling individuals, whereas Nevada and Minnesota plan to launch their own public option plans in 2026 and 2027, respectively. In both Colorado and Washington, private insurers offer and operate public option plans. Washington's public option plans, called Cascade Select plans, were inaugurated in 2021. Colorado, for its part, began offering the Colorado Option to state residents in 2023. In both states, individuals and families can get access to public option plans on their health insurance marketplaces. Colorado also allows small businesses with fewer than 100 employees to get access to the Colorado Option through a broker associated with the state's marketplace. An early look at how both Colorado and Washington have fared on metrics ranging from reimbursement rates to premiums and plan quality will provide crucial insights for policymakers in other states considering public option proposals.

In Washington, Cascade Select plans were designed to be administered by private insurers with legislated reimbursement rates set for hospitals, physicians, and other health care clinicians. Hospitals and clinicians have had success asserting that aggressive reimbursement reductions would lead to less clinician participation in Cascade Select plans, thereby impacting quality or reducing access to care. This argument has been particularly compelling to elected officials.

The initial version of public option legislation introduced in the Washington Senate in January 2019 required Cascade Select plans to pay Medicare-level rates to clinicians and facilities. However, legislators ultimately settled on a cap that a plan's total reimbursements “may not exceed 160 percent of the total amount Medicare would have reimbursed providers and facilities for the same or similar services in the statewide aggregate,” and established floors on reimbursements for rural hospitals and primary care services to ensure adequate availability of health care in both categories. Cascade Select plans must pay at least 101% of allowable costs to rural hospitals and at least 135% of Medicare-level rates to primary care clinicians.

Public option premium reductions are, in no small part, dependent on favorable reimbursement rates to clinicians and facilities across a variety of care settings. However, because advocates for public option plans in Washington State have been unsuccessful at securing meaningful rate cuts, premium savings for patients have not materialized in many cases. The state's goal was to offer “meaningfully lower premiums,” defined as at least 10% lower than non-Cascade plans. A state-sponsored actuarial analysis, however, concluded “that the reimbursement targets may not be low enough to meaningfully reduce premiums across Cascade Select plans.”

Moreover, the participation of health care clinicians for public option enrollees has fallen short of expectations. This is to be expected given research suggesting that lawmakers need to impose clinician participation requirements in public option plans so consumers have access to a sufficient network with reasonable premiums.
The data from Washington State demonstrate that clinician networks of public option plans are consistently narrower than those of other plans. The Washington State Health Care Authority (HCA) report to the legislature noted that “[v]oluntary provider participation was a significant barrier to reaching statewide availability in the first two years” the public option plans were offered. In its third year of enrollment, the Cascade Select networks were still narrower than traditional health plans. The HCA noted that many insurers have had trouble offering “low-cost provider networks because of the required reimbursement targets.”

Securing participation of clinicians is not just an issue for Washington State. Colorado’s early experiences with its public option program reflect similar challenges despite a different approach. Rather than directly mandate reimbursements rates, the state set aggressive premium reduction targets for insurers with the expectation that they would negotiate lower reimbursements rates. If the negotiations fail, the state’s insurance commissioner may require clinicians and hospitals to accept lower payments, but crucially the law specified hospital-specific floors on reimbursement rates.

Despite the premium reduction targets, only 15% of Colorado Option plans met these targets in 2023. In their 2024 plan rate filings, most insurers again failed to reach the targets, but the insurers generally did not attribute the missing targets to excessive reimbursement rates. In fact, one of Colorado’s largest insurers, Anthem Blue Cross and Blue Shield, in a letter written to the state’s insurance commissioner, noted that most hospitals had already agreed to reimbursement rates “at or below” the floors specified by the public option law.

As policymakers in other states finalize rules governing public option plans, the early returns from these plans in Colorado and Washington suggest they have experienced substantial challenges in meeting many of the goals originally set out for them. Most notably, both states look unlikely, for the foreseeable future, to achieve the meaningful savings that proponents of the public option had hoped for.

Existing analysis of public option plans confirm that the promise of meaningful savings from the public option—for taxpayers and plan participants—have not been realized because they require an unacceptable set of trade-offs. Most notably, policymakers in Colorado and Washington have been unwilling to cap reimbursement rates for hospitals and clinicians at the levels that would be required to generate savings.

Large cuts to health care reimbursement rates create substantial political challenges (which have also been seen on the federal level for many years in the recurring debates over physician rate cuts in Medicare), but the cuts also have implications for both plan quality and access to care. Premiums could be reduced for example, by narrowing clinician and hospital networks or imposing more cost sharing on patients, but that would make the plans less attractive to potential enrollees. Instead, policymakers have restricted insurer flexibility to take such steps.

Early experiences with public options in Colorado and Washington offer cautionary tales to Minnesota and Nevada, as well as other states entertaining public option proposals. Although it may be tempting to believe that public option plans can be a panacea to the vexing problem of rising health care costs, the early returns have thus far failed to reveal this approach as an effective one.
REFERENCES

