

# STATE INSURANCE REFORMS AND THE TRADE-OFFS OF A PUBLIC OPTION

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# Executive Summary

Health care consistently ranks among the most important issues to voters. The cost of health care continues to rise faster than wages, and millions of Americans are uninsured or underinsured. While the nation debates large-scale overhauls to the US health care system, such as universal Medicare, there has been a quiet revolution in state health insurance markets. State legislatures are taking steps to enact a diverse array of public option proposals to make health care more affordable for their residents. This report analyzes states' efforts to design public option proposals in relation to the policy trade-offs embedded in the public option as a policy framework. We find that:

- **There are a number of distinct public option proposals.** While many states are contemplating Medicaid buy-ins that could more aggressively compete with private alternatives, some states are considering state public options administered by private insurance plans with less consumer savings but more robust physician participation. The public option, as a policy framework, does not imply any single well-defined set of regulations on cost, access, or eligibility threshold.
- **Public options must balance consumer affordability against market stability.** Public option insurance plans can offer lower premiums through lower physician payments coupled with narrow networks, and potentially through lower administrative rates. Public option plans compete with existing private insurance plans and can slow premium growth while expanding access to coverage and medical care. A low-cost public alternative may capture substantial market share, and existing private plans may face challenges if too many healthier consumers switch to the public option. The challenge of retaining a functional private market acts as a constraint on the extent of consumer savings.
- **Public options can meaningfully lower health care costs for non-group enrollees.** A Medicaid buy-in option could lower plans' medical costs by as much as 13.6 percent relative to the current marketplace, by paying health care providers at lower rates, similarly to the Medicaid program.
- **Many consumers are poised to switch to public option plans.** Consumers who purchase health insurance through their state exchanges are very sensitive to small changes in prices. A public option could induce at least one-third to half of consumers within a given metallic tier of coverage to take up the public option and could draw even more depending on benefit design. Evidence from descriptive and from quasi-experimental studies suggest that marketplace consumers are highly sensitive to nominal premium differences in the tens of dollars.



- **Public options may apply further strain to the health care safety net to achieve greater affordability.** In order to offer lower premiums, public options steer enrollees to narrow networks of physicians reimbursed at low rates, as is typical among many Medicaid-like plans. Current Medicaid beneficiaries are already concentrated among a minority of health care providers who are willing to accept lower payments. Without new participating providers, safety-net providers may become strained by a greater population of patients with lower reimbursements.



# Introduction

The primary objective cited by policymakers and analysts proposing a public health insurance option is the need to improve access to health care and health insurance by making them more affordable.<sup>1</sup> Despite having health insurance coverage, many consumers face high premiums and considerable medical care costs that can impose a significant financial burden.

Public options are designed to address this goal by offering consumers an affordably priced insurance plan that can compete with private insurers. Compared with existing private plans, a public option plan with lower premiums or lower cost-sharing at the point of medical service could offer a more affordable option for consumers. To avoid ceding too much market share to the public option, private insurers would have the incentive to lower premiums and patient costs. As a result, a public option would reduce costs and spending for all consumers, whether they take up the public option or not.

While the public option in health insurance has been proposed on and off for many decades in the United States<sup>2</sup>, its modern iteration emerged during debates in Congress over the legislation that would eventually become the Patient Protection and Affordable Care Act (ACA). In discussion at the time was a concurrent bill for a Medicare public option, which would have allowed individuals not already eligible for Medicare to purchase, or “buy into,” Medicare coverage. The bill was eventually voted down in the Senate and did not appear in the final legislation.

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<sup>1</sup> For example, the Colorado state agency tasked with exploring a state public option writes that the public option responds “first and foremost” to Coloradans’ high financial burdens (page 9). <https://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf>

<sup>2</sup> When Medicare was first introduced, prior to its passage into law, [competing proposals](#) spelled out a similar managed competition model in which seniors could use Medicare dollars as a voucher to purchase a competing private plan (see page 3), referenced by Himmelstein and Woolhandler, quoted in [Gaffney](#).



Since passage of the ACA, there has been a recent resurgence of interest in a public option for health insurance, both at the state and federal levels and among candidates for the Democratic presidential nomination. While the federal policy vision is under debate, states have picked up the legislative momentum with alternative versions of the public option designed to bolster the viability of their state insurance marketplaces and improve consumer affordability. Legislators in Washington, Colorado, and other states are designing public options that would be administered by private insurers under the direction of the state and sold in state marketplaces alongside existing private insurance products. New Mexico is considering a more dramatic proposal for a Medicaid buy-in, in which consumers could elect to purchase coverage similar to Medicaid, with significantly lower premiums and cost-sharing relative to existing private plans. Even without state legislation, some of the private insurers operating Medicaid Managed Care Organizations (MMCO) have successfully introduced Medicaid-like plans into state marketplaces. MMCOs administer state Medicaid programs and maintain networks of health care providers willing to accept low rates of payment. The viability of these low-cost private plans in the private non-group market may encourage states to create similar products potentially designed with a greater emphasis on consumers' interest.

*The more price savings realized, through reduced fees or administrative savings, the more disruptive a public option may be.*

Competition with existing private insurers is the mechanism by which public options are expected to slow, or reverse, premium growth and to affect plan quality for all people in an insurance market. To a lesser extent, public option plans with desirable characteristics—such as low-cost sharing or less complex benefit structures (as is typical of Medicaid coverage), or broad physician networks (available to traditional Medicare beneficiaries but often not to Medicaid enrollees)—may capture significant market share. In order to compete, private insurance plans may need to adopt or improve these elements. The more price savings realized, through reduced fees or administrative savings, the more disruptive a public option may be.

In this report, we assess the feasibility of a public option as a means to provide low-cost, high-quality coverage alongside a functional private insurance market for non-group enrollees. First, we broadly outline the range of state public option proposals. Then, we examine the cost-reduction tools states might employ in their chosen program, including administrative savings and lower provider payments. Third, we assess the potential for diminished physician access, or care quality, under a public option that may rely



on reduced physician payments as its source of consumer savings. Next, we synthesize evidence from existing literature on the potential disruptions that public options may cause to existing private insurance markets depending on how successfully they can pass through plan savings to consumers. Last, we explore a selection of well-developed legislation that states have proposed and analyze their policy trade-offs. We conclude by discussing the capacity for the public option to achieve the broader policy goals of increased affordability and lower health care spending for consumers.

## Types of Public Option Proposals

A public option is a health insurance plan that consumers can elect to purchase. Typically conceived of as government-run health care networks provided by state Medicaid programs or by the federal government through Medicare, public options would compete with private insurance plans in ACA marketplaces. Importantly, the availability of public option insurance plans does not preclude the sale of privately administered health insurance offered by employer groups or even within the non-group market in direct competition with public option coverage. A public option is designed to achieve broader policy goals of increased affordability and lower health care spending for consumers by providing a lower-cost insurance option as an alternative to other forms of coverage.

Current public option proposals generally fall into three broad categories: a federally directed Medicare buy-in, state-directed Medicaid buy-in, and a state-directed private insurance product.

### Medicare Buy-In

A public option operated by the federal government would expand access to the federally administered Medicare program beyond the currently eligible populations of Americans over 65 years old and people with disabilities. The plan is distinct from Medicare-for-all proposals in that consumers would not be endowed with Medicare coverage, but would instead need to elect to take up Medicare. It is not necessary under this proposal for buy-in consumers to face the same premiums or cost-sharing as current Medicare beneficiaries. Instead, competing Medicare buy-in proposals could specify co-payments and deductibles for the buy-in population. This is especially true if a buy-in is implemented through Medicare Advantage, which comprises Medicare plans administered by private insurers.





## Medicaid Buy-In

A state-based public option is more likely to be implemented through Medicaid, the public health care program administered by the states for low-income adults, children, and pregnant women. States' eligibility criteria would be restructured to allow previously ineligible state residents to take up Medicaid coverage. The size and composition of the potential buy-in population varies across states due to the variety of eligibility criteria, and whether a state has opted to expand its Medicaid program under the ACA to include all adults with income under 138 percent of the federal poverty line.<sup>3</sup> Unlike Medicare, cost-sharing in Medicaid is generally low, even for Medicaid enrollees whose coverage is administered by a MMCO.

## Private Insurance Option

A state can alternatively introduce a new plan option that is based neither on Medicare nor Medicaid (managed care or otherwise) and instead independently legislate the plan's design and reimbursement rates. Such a plan would likely be administered by a private insurer and would thus only be a "public" option to the extent that the state would determine certain plan features, such as rates of physician reimbursement or cost-sharing obligations of enrollees. The plan could reimburse providers at rates above Medicare and thus elicit greater provider participation (though the breadth of its provider network would not necessarily be equivalent to that of traditional Medicare, which can command greater physician participation due to the volume of covered patients). Compared with payment reductions under a Medicare-based public option, current state proposals for privately operated public options incorporate only modest reductions in payments relative to private payment rates. While a state-designed public option that pays above Medicare rates may fail to realize maximum savings from reduced medical costs, the plan would also be less disruptive to existing private markets than a Medicare- or Medicaid-based buy-in.

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<sup>3</sup> Under the ACA, states that opted to expand their Medicaid programs received federal funds to cover at least 90 percent of Medicaid claims among the expansion population. As of this writing, 36 states and the District of Columbia have expanded their Medicaid programs, and a number of states are considering expansion.



# Consumer Trade-offs

For consumers, an important difference between a state and federal public option would be the network of providers to which enrollees would gain access. Whereas nearly as many physicians and facilities accept patients with Medicare as with private insurance, far fewer providers accept Medicaid patients. One of the most important reasons explaining physicians' diminished willingness to accept Medicaid patients is the low rates of reimbursement that Medicaid pays. On average, Medicaid pays approximately 72 percent of the rates offered by Medicare (Kaiser Family Foundation 2017). As a result of this low provider reimbursement, individuals with Medicaid coverage may gain access to a highly restricted network of providers whose patient population largely comprises other Medicaid enrollees (Cunningham and May 2006).

Low rates of reimbursement and restricted provider networks highlight a central trade-off: Consumers may be attracted to a public option due to lower premiums or lower cost-sharing, but these savings are likely to be driven by lower provider payments and narrower networks, which can result in restricted patient access to a physician or outpatient facility, or overburdened and under-resourced public providers. To a lesser extent, a federal public option can realize lower consumer costs by reimbursing enrollees' medical care at Medicare rates, which tend to be lower than reimbursements made by private insurance, though not as low as Medicaid payment rates. Consumers who purchase a federal public option would likely have broader access to physicians and facilities that already accept Medicare beneficiaries. State public option proposals differ primarily in how they balance these trade-offs.

## Cost Reduction and Market Competition

Without public option legislation, ACA-established marketplaces for non-group insurance have experienced fluctuations in insurer participation and competition. As many as 26 percent of all marketplace enrollees had only a single insurer offering marketplace plans in their county in 2018, though more recent increases in insurer participation have lowered this number to 10 percent for 2020.<sup>4</sup> Markets with few insurers tend to have

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<sup>4</sup> <https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-aca-marketplaces-2014-2020/>



higher premiums and faster premiums<sup>5</sup> growth,<sup>6</sup> which can translate into higher costs for consumers.

Rural counties tend to be more exposed to the negative consequences of thin insurance markets relative to the rest of the country. In 2017, 42 percent of all urban counties had only one insurer remaining in the market, while 55 percent of rural counties faced one-insurer markets (Barker et al. 2018). Consequently, rural counties faced year-over-year premium increases that exceeded those observed in more urban counties (Griffith, Jones, and Sommers 2018). Rural counties, by definition, have fewer residents and thus have fewer physicians in a given geographic area with whom insurers can negotiate. Furthermore, rural counties also have fewer physicians per capita relative to urban counties, further restricting insurers' ability to negotiate and to selectively include lower-cost providers in their networks.

Increased competition is expected to slow premium growth in these markets in part because private insurers have few other dimensions on which to compete under the ACA's regulations. The ACA carries strict requirements in both the medical and financial terms of coverage. For example, the ACA requires insurance policies to cover all "essential health benefits," including physician office visits, hospital care, prescriptions, and mental health care. Additionally, insurers can offer little product differentiation in terms of the out-of-pocket costs associated with seeking care, such as through co-payments and deductibles. The combination of a maximum on out-of-pocket spending (set at \$8,200 for an individual in 2020) and an actuarial value of 70 percent (requiring that total out-of-pocket costs cover 30 percent of medical services, while the plan pays out the other 70 percent for a "silver tier plan" or more for gold and platinum) substantially constrains insurers' flexibility to offer varying levels of plan generosity. These regulations are designed to prevent insured consumers from incurring potentially catastrophic medical expenses in excess of the out-of-pocket maximum, and to facilitate meaningful communication with consumers on the average level of their plan's generosity. As a consequence, the rules produce highly standardized insurance products.

With plan generosity largely fixed, a public option leverages the primary remaining means of product differentiation to affect price: networks of covered health care providers. The public option enables consumers to buy into public plans and to thereby gain access to care that is reimbursed at lower rates.

In addition to the cost savings from reduced physician fees discussion above, a public option could also reduce costs through administrative efficiency by leveraging the

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<sup>5</sup> <https://www.rwjf.org/en/library/research/2014/08/marketplace-competition—insurance-premiums-in-the-first-year-o.html>

<sup>6</sup> <https://www.kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/>



administrative structures of existing state or federal programs and borrowing from existing administrative capacity. For example, the traditional fee-for-service Medicare program cooperates with the Social Security Administration because both programs are required to maintain lines of communication with the population over the age of 65 and those with disabilities. Additionally, Medicare does not draw profits from the program's operations. Relatedly, the Medicare program spends only 3 percent of its total revenues on administrative expenses such as employee and executive compensation, physician billing, paperwork, and other necessary expenses. By comparison, Medicare also offers a private option, under Medicare Advantage, in which enrollees contract for Medicare coverage through private insurance companies. Medicare Advantage covers approximately one-third of the Medicare population.<sup>7</sup> These plans operate on margins closer to the private market, with approximately 14.2 percent of revenues on average allocated to administrative expenses and compensation (Eibner et al. 2019).

Likewise, in Medicaid, most states contract with private insurers to administer Medicaid Managed Care (MMC). MMCOs tend to pay lower rates to medical providers and, in return, attract narrow networks of participating physicians. States contract with MMCOs to outsource management and administration of enrolling beneficiaries, negotiating payment rates with providers, and paying out medical claims.<sup>8</sup> Furthermore, because MMCOs tend to pay lower rates than traditional fee-for-service Medicaid, states reduce the share of their annual budgets spent on Medicaid claims. States can face challenges sustaining provider participation when shifting to MMC, as cost savings realized through lower provider reimbursements can deter physicians and particularly specialists from joining MMC networks. It is important to note that the evidence is mixed on whether the introduction of managed care is preferable for Medicaid enrollees. Some studies find MMC coverage associated with welfare-reducing declines in medical care utilization and in access to care, which may stem from the narrow networks of available providers found in MMCO coverage (Caswell and Long 2015; Herring and Adams 2011; Toseef, Jensen, and Tarraf 2019).

Still, most states<sup>9</sup> employ MMC for most Medicaid members, with 69 percent of Medicaid beneficiaries nationwide under MMC.<sup>10</sup> Thus, it may be likely that states would continue to employ managed care under a Medicaid buy-in.

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<sup>7</sup> <https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/>

<sup>8</sup> <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2011/05/31/managed-care-explained-why-a-medicare-innovation-is-spreading>

<sup>9</sup> Connecticut is a recent and notable example of a state that has decided to move away from Medicaid Managed Care in part to save money through reduced administrative expenses (Beck 2016).

<sup>10</sup> <https://www.kff.org/other/state-indicator/total-medicare-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22col>



If a state were to use its existing Medicaid physician networks to offer a buy-in, and couple that with another policy that emphasized administrative efficiency similar to the fee-for-service Medicare infrastructure, then a buy-in public option could possibly deliver further savings through reduced administrative overhead. Yet many states appear poised to forgo administrative savings, with proposed buy-in policies that reimburse providers at low rates but that operate through the existing individual market for health insurance. Private insurance plans, particularly those operating in the individual market, spend the greatest share of their revenues on administrative expenses (a share greater than those of nonprofit or for-profit Medicaid Managed Care, or employer-sponsored insurance markets), enabling the highest possible overhead charges atop medical expenditures, but creating the least disruption to the marketplaces.

## Provider Incentives and Slack

While a Medicaid-based public option could potentially generate cost savings sufficient to capture large swaths of marketplace consumers, it could also introduce additional strain to the health care safety net.

The experience of Medicaid expansion under the Affordable Care Act offers some insight into how the health care system may respond to an increase in patients with lower-paying coverage. The ACA's expansion of Medicaid brought a substantial increase in the number of individuals with Medicaid coverage, growing Medicaid rolls by 10 percent, with an additional 13.6 million beneficiaries between 2013 and 2018 across 34 participating states.<sup>11</sup> Because most were uninsured prior to the ACA's passage, the health system had to absorb a considerable increase in the quantity of health care demanded among the new beneficiaries (Collins et al. 2016). Even after Medicaid expansion, Medicaid enrollees were less likely to find a primary care provider willing to accept their coverage and more likely to experience exaggerated wait times to access care relative to individuals with employer-sponsored insurance (Polsky et al. 2017). Additionally, some evidence suggests that Medicaid beneficiaries have greater difficulty obtaining access to physician care (with no difference in the rates of ultimately receiving such care) relative to enrollees in marketplace coverage (Selden, Lipton, and Decker 2017).

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<sup>11</sup> <https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/>



Prior to the ACA, there was wide variation across states in their payments to Medicaid physicians. In states where physicians would receive higher payments for seeing Medicaid patients, more physicians were willing to see them. In an effort to encourage more physicians to treat Medicaid patients, the ACA increased Medicaid payments to physicians by 73 percent on average, with greater increases in lower-paying states (Zuckerman and Goin 2012). However, after the ACA fee increase, there was no evidence of an increase in the number of physicians accepting Medicaid patients, even among those states with the biggest increase (Decker 2018). The fee increase may have been too small to attract physicians, with one earlier study having suggested that only a more substantial change would be an effective incentive (Perloff, Kletke, and Fossett 1995). Alternatively, the temporary nature of the fee bump may have discouraged primary-care physicians from taking on Medicaid patients, whose care could continue past the time at which the fees reverted to their pre-ACA levels. Since that time, 19 states have continued to finance these higher fees through other means.<sup>12</sup>

Nevertheless, previous research generally suggests that the health care system was able to absorb the new Medicaid beneficiaries without detrimental effects on access and utilization (Mazurenko et al. 2018). While there may have been no discernible increase in the number of Medicaid providers (on the extensive margin), there was likely an increase in appointment availability (on the intensive margin), wherein physicians already accepting Medicaid patients saw greater numbers of beneficiaries.

Because low provider reimbursements are a deterrent to increased physician participation, a public option that reimburses physicians at or near Medicaid rates may not see an increase in the number of physicians accepting patients. As with Medicaid expansion, existing Medicaid providers could be expected to absorb increased demand for low-cost care and see a greater number of such patients (though to some extent, it is feasible that the phenomenon would be tempered if physicians are relatively more willing to accept a potentially less medically complex buy-in population relative to Medicaid beneficiaries). Still, as of now, Medicaid networks have the smallest pool of willing providers.

In a recent study, Holgash and Heberlein (2019) estimate that just over 70 percent of office-based physicians are willing to accept new Medicaid patients, significantly lower than the percentage willing to accept those with Medicare (85.3 percent) or private insurance (90.0 percent).<sup>13</sup> Table 1 reproduces estimates from their study that show that general practitioners and family care doctors were even less likely to accept new Medicaid patients

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<sup>12</sup> <https://www.urban.org/research/publication/medicaid-physician-fees-after-aca-primary-care-fee-bump>

<sup>13</sup> <https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf>



(68.2 percent) compared with new Medicare (89.8 percent) or privately insured patients (91.0 percent). They additionally show that Medicaid acceptance rates tend to be lower in states with high managed-care penetration among physicians accepting new patients (penetration above a state median of 69.5 percent) and that these acceptance rates are lower when state Medicaid-to-Medicare payment ratios are smaller.

The existing stock of Medicaid providers may face challenges in continuing to absorb increases in demand for low-paying health care while continuing to provide the quality of care patients require. Under current conditions, some qualitative evidence suggests that Medicaid providers may face difficulty in being able to meet their patients' needs due to underinvestment in the program—through low reimbursements to physicians and care providers, in addition to underpayment for activities such as care coordination across providers, which physicians report as necessary to address the social determinants of their Medicaid patients' health (Gordon et al. 2018).

## Cost Reductions and Potential Migration

### Lower Reimbursement and Administrative Efficiency

States may decide that, rather than competing aggressively on price, simply increasing the number of insurers participating in the marketplace is sufficient to slow premium growth and ensure access to medical care for marketplace enrollees. A private insurer could administer such a public option and reimburse physicians at rates well above Medicare. One study by researchers at the Urban Institute finds evidence that having five marketplace insurers, as opposed to four, in an insurance market area is associated with a nearly \$60 reduction in benchmark premiums on average.<sup>14</sup>

A public option could likely achieve more ambitious reductions in premium growth or average premiums through the use of narrow networks or lower provider reimbursement. A public option that reimburses physicians at Medicaid rates could realize considerable cost savings relative to a public option paying above Medicare rates. For example, Biener and Selden (2017) estimate that, holding constant the composition of the non-elderly population and the complexity of their respective medical needs, primary-care physicians receive an average of \$106 per office-based patient visit (Table 2) for a Medicaid enrollee. By

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<sup>14</sup> [https://www.urban.org/sites/default/files/publication/101221/is\\_there\\_potential\\_for\\_a\\_public\\_option\\_to\\_reduce\\_premiums\\_of\\_competing\\_updated.pdf](https://www.urban.org/sites/default/files/publication/101221/is_there_potential_for_a_public_option_to_reduce_premiums_of_competing_updated.pdf)



comparison, that primary-care physician receives \$176 for a patient covered by a privately administered marketplace plan.<sup>15</sup> Contributing toward that total payment is a \$36 out-of-pocket contribution from the patient at the point of service, either in the form of care received before hitting the deductible or from a patient co-payment.

By contrast, the average Medicaid beneficiary contributes, on average, only \$3 out of pocket for a primary care visit (Table 2).

These estimates suggest that by reimbursing physician care at Medicaid payment rates, a Medicaid public option could lower per-visit medical care expenditures across all types of office-based physician care to almost 64 percent of what private marketplace plans pay on average. Importantly, the premium change would only incorporate the reduction in the portion reimbursed by the plan itself, rather than out-of-pocket spending. After accounting for the difference in out-of-pocket costs, which are far higher in the marketplace than with Medicaid coverage on average (\$51 versus \$4), their estimates imply that by shifting from typical marketplace payment rates to Medicaid payment rates, a public option could reduce plan medical costs for physician services by 13.6 percent.

Public option plans could realize additional savings through increased efficiency: lowering administrative fees associated with paying out a plan's medical costs—including profits, executive and employee compensation, and administrative requirements like billing and other paperwork to maintain records on individual enrollment. A public program could, in theory, have an administrative rate as low as that of traditional fee-for-service Medicare, at only 3 percent of total revenues spent on overhead (Eibner et al. 2019). This low overhead rate is due in part to the lack of profit motive for a public agency and in part to administrative cooperation with other federal agencies such as the Social Security Administration.

Medicaid plans carry an average overhead rate of between 5 and 6 percent (Goldsmith, Mosley, and Jacobs 2018). There is some evidence that for-profit MMCOs carry higher administrative rates, at 12 percent of revenues on average (McCue and Bailit 2011). Because existing Medicaid-like plans sold in the marketplace are primarily sold by for-profit firms,<sup>16</sup> this could represent a source of savings unique to a public option.<sup>17</sup>

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<sup>15</sup> Biener and Selden (2017) use the Medical Expenditure Panel Survey, a nationally representative survey of US medical care utilization and expenditures, to estimate a model of standardized payments for physician visits. Their model controls for patient demographics and health; insurance coverage; physician specialty; and characteristics of the office-based visit, including whether the visit was a checkup, preventive treatment, or other diagnosis or treatment, and if intensive services or use of imaging such as X-ray or CT scan occurred during the visit.

<sup>16</sup> For example, Centene, a publicly traded managed-care corporation that primarily contracts with government agencies for Medicare, Medicaid, and correctional facilities rather than with individuals, now covers approximately 2 million enrollees in the marketplace, making it the single largest marketplace insurer for 2020 (Hempstead 2019).

<sup>17</sup> The profit margins can be considerable. Reporting from the Los Angeles Times finds greater than 7 and 8 percent profit margins for select MMCOs in the state of California in 2014 and 2015, generating more than \$5 billion in profits to investors (Terhune and Gorman 2017).





Currently, MMCOs that offer Medicaid-like plans in the marketplace demonstrate how reduced reimbursements can translate into consumer savings and increased market competition. Medicaid plans offered by MMCOs tend to have premiums that are lower than other private marketplace plans. MMCOs achieve these savings by using the same narrow network of providers and reimbursement rates as their MMC plans. In a recent study from the Urban Institute, researchers found that rating regions with an MMCO participating in the marketplace in 2019 saw slightly lower average premiums compared with similar rating regions without a participating MCO offering their Medicaid plan.<sup>18</sup> They found that among private marketplace plans offering the lowest premium, having an MMCO as a competitor was associated with a \$38 lower premium per month for a 40-year-old, which is 7 percent lower than the average non-Medicaid insurer's lowest-priced plan.

Medicaid Managed Care Organizations report challenges in reducing administrative costs that hinder their more widespread penetration into state marketplaces. In a recent survey of insurers that offer Medicaid plans in the marketplace, Medicaid insurers reported a lack of specialized staff and financial resources to more efficiently administer marketplace plans.<sup>19</sup> Further, MMCOs typically do not compete for their enrollees, who are assigned to coverage by the state Medicaid program, and are unaccustomed to enrollment risk or uncertainty about changing regulation and federal subsidies. By removing the profit margin or even by employing the traditionally lower overhead forms of public coverage like fee-for-service contracting, a Medicaid public option could have lower administrative costs compared with MMCOs offering Medicaid plans on the marketplace. Those lower administrative costs could be passed through to consumers in the form of even lower premiums, suggesting that a Medicaid public option could apply more significant downward pressure on marketplace premiums than current MMCOs.

## Consumer Responsiveness to Price Changes in the Existing Non-Group Market

Evidence from the existing economics literature suggests that consumers in the non-group market are very sensitive to changes in the premium price of enrolling in a particular insurance plan. Marketplaces sell insurance through a standardized portal, where consumers can easily compare plans' premiums when enrolling and select plans

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<sup>18</sup> [https://www.urban.org/sites/default/files/publication/101221/is\\_there\\_potential\\_for\\_a\\_public\\_option\\_to\\_reduce\\_premiums\\_of\\_competing\\_updated.pdf](https://www.urban.org/sites/default/files/publication/101221/is_there_potential_for_a_public_option_to_reduce_premiums_of_competing_updated.pdf)

<sup>19</sup> [https://www.rwjf.org/en/library/research/2019/04/why-dont-more-medicaid-insurers-sell-plans-in-aca-marketplaces.html?cid=xtw\\_rwjfstaff\\_unpd\\_ini:urban%20moni%20medicaid\\_dte:20190429](https://www.rwjf.org/en/library/research/2019/04/why-dont-more-medicaid-insurers-sell-plans-in-aca-marketplaces.html?cid=xtw_rwjfstaff_unpd_ini:urban%20moni%20medicaid_dte:20190429)



within metal tiers denoting the actuarial value. These tiers (bronze, silver, gold, etc.) reflect a composite metric of the plan's average generosity in terms of deductibles and coinsurance due at the point of medical service. Once selecting within a tier, consumers may observe little in the way of differences between plan options other than their premiums.

Observational evidence on marketplace consumers shows frequent comparison shopping. Consumers in the marketplaces are far more likely to switch insurance policies than consumers with employer-sponsored coverage, with 23 percent of all people enrolled in 2014 switching plans versus 2.8 percent of the employer market (DeLeire and Marks 2015). The office of the Assistant Secretary for Planning and Evaluation (ASPE) further reported that consumers who switched saved approximately \$33 per month, suggesting that consumers were sensitive both to prices of their policy and the prices of other policies offered in their area (DeLeire and Marks 2015).

Quasi-experimental studies in economics have attempted to quantify consumer price sensitivity in the marketplace. An ASPE report estimated that a plan whose premium increased by 10 percent saw a 30 percent decline in enrollment.<sup>20</sup> Abraham et al. (2017) examined data from 34 states on plan premiums and benefit generosity to evaluate plan enrollment given a change in premium price, holding all other attributes constant. They found that a 1 percent increase in the premium caused a 4.5 percent reduction in that plan's enrollment.<sup>21</sup> Studying data on California and Washington from the same years, Saltzman (2019) estimates a decline in enrollment of 7 percent and 9 percent, respectively, caused by a 1 percent increase in a plan's premium. A more recent study by Drake (2019) using data from California estimated a 4.7 percent drop in enrollment associated with a 1 percent premium increase. This study accounts for the counteracting force of consumer aversion to narrow networks, which often accompany low premiums, suggesting that consumers may be willing to migrate to lower-premium plans despite the trade-off of having a more restrictive physician network.

## Consumer Migration and Network Size

Compared with the average marketplace plan, state Medicaid programs, with their low rates of reimbursement, exhibit significantly narrower networks of providers. Whereas marketplace policies reimburse their in-network providers at levels similar to employer-sponsored insurance (Table 2), Medicaid (both fee-for-service and MMC) tends to reimburse physicians and hospitals at rates below what Medicare would pay.

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<sup>20</sup> This would suggest a price elasticity, the ratio of the percent change in enrollment to the percent change in price, of -3.

<sup>21</sup> Premium changes in this paper refer to gross premium changes. Premiums that consumers observe are net after receiving tax credits and are 60 percent smaller than gross premiums on average.



Because of the potential restrictiveness of its provider network, a Medicaid public option could be less attractive to consumers than a similarly priced private plan. However, there is evidence that plans employing narrow networks can sustain enrollments in the marketplace. In the first years of the ACA state exchanges, concerns about the long-term viability of marketplace coverage motivated some smaller insurers to design their marketplace plans to more closely resemble Medicaid coverage.<sup>22</sup> Insurers offering Medicaid-like exchange plans captured significant market share and, through the use of narrow networks and low reimbursements, were more profitable than competing marketplace insurers. The Robert Wood Johnson Foundation reports that MMCOs accounted for approximately 20 percent of marketplace entry in 2019 (Hempstead 2019).

Drake (2019) evaluated marketplace enrollees' willingness to trade off between a narrower network and a lower premium when choosing between plans. He found that on average, consumers in the California marketplace were willing to pay \$45 per month in higher premiums in return for a broad-network plan, as opposed to a narrow-network plan, relative to the breadth of plans available in the exchange.<sup>23</sup> Half of consumers were willing to pay \$33, and three-quarters were willing to pay at least \$74, indicating that at least half would switch to the narrow-network plan if they could realize a savings of \$33 or more and that three-quarters would switch for \$74. Younger consumers were consistently the least willing to pay extra for a broader network. For example, three-quarters of single adults under 30 would pay no more than \$27 for a broad-network plan.

In another recent study, the RAND Corporation simulated the impact of a Medicare buy-in offered to non-group enrollees and uninsured adults between the ages of 50 and 64 and projected substantial consumer migration.<sup>24</sup> Assuming a Medicare buy-in could achieve a premium reduction of 24 percent, their simulation suggests that more than 80 percent of consumers enrolled in the non-group market who are eligible for the Medicare buy-in would select the buy-in. A key limitation of this study is that they do not account for the narrowness of physician networks, although a Medicare buy-in may not need to restrict physician networks to offer a substantially lower premium if it maintains the broad

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<sup>22</sup> [https://www.commonwealthfund.org/publications/newsletter-article/2016/may/medicaid-plans-succeed-obamacare-exchange-others-struggle?redirect\\_source=/publications/newsletters/washington-health-policy-in-review/2016/may/may-23-2016/medicaid-plans-succeed-in-obamacare-exchange-as-others-struggle](https://www.commonwealthfund.org/publications/newsletter-article/2016/may/medicaid-plans-succeed-obamacare-exchange-others-struggle?redirect_source=/publications/newsletters/washington-health-policy-in-review/2016/may/may-23-2016/medicaid-plans-succeed-in-obamacare-exchange-as-others-struggle)

<sup>23</sup> The study defines the move from narrow to broad network plan by a two standard-deviation increase in network breadth. Network breadth is measured as the percent of primary care physicians in a 15-mile radius of the individual's zip code covered by the policy.

<sup>24</sup> The study assumes a premium reduction of approximately 24 percent due to the lower reimbursement rates of Medicare (assumed to be 86 percent of the commercial rates), and an assumed reduction in administrative expenses from the 20 percent average in the non-group market to the average Medicare rate of 7.5 percent (Eibner et al. 2019). The assumed administrative rate of 7.5 percent reflects an average across traditional fee-for-service Medicare and Medicare Advantage.



network of traditional Medicare. A Medicaid public option would rely on narrow networks to lower premiums, but may still capture significant market share by attracting the most price-sensitive consumers.

## Migration into a Public Option

States that desire more significant premium reductions and coverage expansions could use a combination of lower reimbursements, narrower networks, and more efficient administration to lower the premium of the public option even further. Recall the MMCOs currently offering Medicaid-like plans in state marketplaces: These plans were associated with a roughly \$38 lower monthly premium for an average 40-year-old enrolled in the lowest-priced marketplace plan in 2019, or 7 percent lower than the same premium in a region without a participating MMCO.<sup>25</sup> Drake (2019) found that nearly half of consumers in California's marketplace were willing to switch into a narrow-network plan to realize savings of just \$33 per month. A Medicaid public option could similarly capture large market share if it could achieve premium reductions similar to current Medicaid plans offered on the marketplace.

If it is able to generate and pass through administrative savings to consumers, a Medicaid public option could potentially compete more aggressively than the standard MMCO operating in the marketplace. This could be enabled by the public option's standing as a state entity, or by operating as a non-profit. A Medicaid public option, through its legislated design and administration, could be more efficiently administered (either by the state Medicaid program or a private insurer) and pass further savings through to the consumer. This lower-priced public option would be more attractive to price-sensitive consumers, but could risk leaving consumers with the greatest health risks in competing private plans while the majority of healthy consumers select into the Medicaid public option. Offering similar price savings as MMCOs through low physician fees, combined with administrative fees closer to the traditional Medicaid rate of 5 percent, could generate a similar level of price savings as that projected by RAND for the near-elderly population, potentially generating a similar level of projected consumer migration (which they estimated at 80 percent for the near-elderly in a Medicare buy-in). Finally, significant enrollments in a Medicaid public option at low physician fees could strain providers who participate in its narrow network if no new providers are willing to accept patients covered by the public option. Public option enrollees would be reimbursed at below-Medicare rates similar to Medicaid, a reality unlikely to encourage new providers to

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<sup>25</sup> [https://www.urban.org/sites/default/files/publication/101221/is\\_there\\_potential\\_for\\_a\\_public\\_option\\_to\\_reduce\\_premiums\\_of\\_competing\\_updated.pdf](https://www.urban.org/sites/default/files/publication/101221/is_there_potential_for_a_public_option_to_reduce_premiums_of_competing_updated.pdf)

participate. However, patients who migrate to the public option will have higher incomes and are likely to be less medically complex than the average Medicaid beneficiary, which may alleviate physicians' concerns of accepting new complex cases.

## State-Level Legislative Initiatives

Given the tradeoffs highlighted throughout this report, what kinds of public option legislation should we expect to see? How would states address the policy trade-offs in practice? Here, we explore the legislative proposals being developed, and in the case of Washington, actually passed into law.

Several states have begun to develop legislatively authorized commissions to study the potential impacts of a state public option.<sup>26</sup> While at least eight states have taken some legislative action, either through study or debate, each state's timeline and particular proposal has unique features. The existing policy proposals across these states illustrate the trade-offs inherent in developing a public option.

State representatives developing these proposals invoke the policy goal of minimizing health care costs for their constituents. Across state proposals, the public option typically realizes lower consumer costs primarily through a reduction in fees paid to physicians who treat patients covered by the public option. However, similar to the expansions of MMC, providers' potential unwillingness to accept patients when reimbursed at low rates (or threats to this effect) can undermine this effort. Lawmakers are considering alternative avenues to generate savings so that public options can be attractive to consumers without severely compromising the breadth of their physician network.

In this section, we highlight three states' policy designs, which have relatively robust proposals to examine the details of the state public option in practice. We examine how state legislation approaches these trade-offs between consumer affordability and health care access, program eligibility, and the degree to which these options compete with existing plans offered in the non-group market.

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<sup>26</sup> <https://www.shvs.org/state-efforts-to-develop-medicaid-buy-in-programs/> Many of the state task forces have contracted with the New York law firm, Manatt Health, to conduct financial feasibility assessments of the various potential specifications of a public option, including New Mexico and Washington.



## Washington

Washington is the only state as of this writing that has passed a public option act into law. Its public option is slated to begin operating insurance policies beginning in the year 2021.<sup>27</sup> Under this law, the state supports competition with the private non-group market by allowing consumers to apply ACA subsidies for insurance toward the public option. The law does not fund any additional subsidies above those allocated under the ACA for either premiums or cost-sharing. The state does instruct its insurance authority to establish policies that limit deductibles, allow more services to be covered without any cost-sharing, and provide “predictable” cost-sharing required of consumers. Yet the state does not impose numerical requirements.

The Washington public option design intends to improve affordability by limiting provider reimbursement rates to 160 percent of Medicare rates in the aggregate. In other words, the public option policy is required to pay out for medical care no more than 160 percent of the amount that Medicare would have paid for the same set of medical services. As a means of protection for care providers, “critical access” hospitals—often operating in rural areas without alternative options for residents—will be able to get reimbursed based on their costs of providing the care (at 101 percent of allowable costs). Additionally, primary care providers are protected by a reimbursement floor at 135 percent of Medicare rates to prevent insurers participating in the public option from squeezing these physicians.

Finally, the services and providers to whom the cap does apply are eligible for the cap to be waived entirely if the insurer is unable to form an adequate network. Network adequacy is defined simply as having enough in-network providers from which to choose but is not otherwise legislatively specified. Additionally, if the insurer is able to realize targeted 10 percent premium savings without limited reimbursement rates, relative to premiums offered in the prior year, then the public option insurer may get the reimbursement constraint lifted altogether.

The state has decided to contract with existing private insurance companies to implement the public option product. Those insurers who are participating in the public option, by issuing such a product, are not prohibited from additionally offering a competing private option. The state does not include legislation to study, clarify, or prevent any potential conflicts of interest that may arise from having private insurers implement a public option that is intended to serve as their own competition. The state will contract with one or more insurance companies to offer policies that will begin operating in 2021.

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<sup>27</sup> <https://app.leg.wa.gov/billssummary?BillNumber=5526&Chamber=Senate&Year=2019>



## Colorado

In Colorado, legislators have made substantial progress toward developing a public option that would impart a degree of price aggression similar to Washington's.<sup>28</sup> Any resident of the state would be eligible to enroll in the plan and would be able to apply for premium subsidies under existing ACA legislation. Reimbursement rates would be limited to a range of 175 percent to 225 percent of Medicare rates. By comparison, the existing average private payment rate in Colorado's individual market is 289 percent of Medicare rates. This represents an expected 20 to 30 percent reduction in reimbursement rates. Colorado's public option, like Washington's, would be implemented in partnership with a private insurer who would develop and implement the plan, largely precluding any expectation of potential administrative savings from public administration. The study does not refer to any targeted reductions to the administrative rate of operating the health care program.

## New Mexico

The New Mexico legislature has commissioned a series of studies on the possible forms a New Mexico public option could take. Additionally, they have commissioned a quantitative evaluation of the economic impacts of a targeted Medicaid buy-in. Proposed bills in New Mexico would enable individual consumers to buy into Medicaid if they are not eligible for coverage through public programs like Medicare or Medicaid, or for ACA private insurance subsidies. The bill would be primarily targeted at consumers with incomes above the threshold for premium subsidies under the ACA—400 percent of the Federal Poverty Level, or approximately \$50,000 for a single adult. Additionally, the ACA does not provide subsidies to undocumented immigrants or to documented immigrants who have resided in the US for less than five years. Individuals ineligible for subsidies due to immigration status would also be eligible to enroll in the state's public option.

Providers who treat consumers enrolled in New Mexico's Medicaid buy-in would face the same low reimbursement rates paid to providers participating in New Mexico's Medicaid program. Concerns that providers may be unwilling to accept more patients at Medicaid payment rates are mitigated by two factors specific to New Mexico: Medicaid in the state of New Mexico offers a higher-than-average rate of reimbursement for medical services relative to Medicare, at 92 percent versus the national average of 72 percent. Additionally, Medicaid in the state covers the highest share of its population—nearly 50 percent—

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<sup>28</sup> The state's report can be found here: <https://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf>



relative to any state in the nation (Conway 2019). Given the higher Medicaid payments and physician participation in the program, the evaluation predicts that lower physician payments among Medicaid buy-in enrollees may translate into premiums between 15 and 21 percent relative to the private insurance exchanges.<sup>29</sup> Further, the high Medicaid enrollment in New Mexico suggests that Medicaid buy-in enrollees will not face severely narrow provider networks, given that Medicaid is the largest payer in the state.<sup>30</sup> The proposals consider administering the public option through a marketplace insurer and possibly an MMCO. In either case, they will operate with the same medical loss ratio as state Medicaid plans. Despite targeting a fairly substantial premium reduction of 15 to 20 percent, the state limits the potential for mass consumer migration through its highly selective eligibility criteria. Most exchange enrollees have ACA subsidies, including 80 percent of New Mexico enrollees, and are thus not eligible for the state's public option. This can serve to protect private insurance markets but may limit the potential for the state's public option to impart competitive pressures on premiums for private insurance policies.

Each of the states examined intends to partner with private insurers to offer a product structured similarly to non-group policies. While state legislatures cite increases in consumer affordability obtained by reducing plan medical costs through lower reimbursement rates, these legislative texts do not explicitly reference cost reductions due to administrative savings. Instead, the plan designs appear to be structured based on the individual market, which carries the highest administrative fees relative to any form of Medicaid, Medicare, or the group-based private insurance market.

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<sup>29</sup> The empirical evaluation was conducted by Manatt Health, a consulting firm based in New York City.

<https://www.manatt.com/Insights/White-Papers/2018/Evaluating-Medicaid-Buy-in-Options-for-New-Mexico>

<sup>30</sup> In 2017, no marketplace plans in New Mexico employed narrow networks, defined as plans that contracted with fewer than 25 percent of physicians in a service area. [https://ldi.upenn.edu/sites/default/files/pdf/2017\\_Narrow\\_Network\\_Issue\\_Brief\\_Vol-21-8.pdf](https://ldi.upenn.edu/sites/default/files/pdf/2017_Narrow_Network_Issue_Brief_Vol-21-8.pdf)





# Conclusion

Ten years after the ACA's passage, remaining gaps in coverage and affordability have shifted the national health policy debate toward broader overhauls of the US health care system; facing continued policy inaction at the federal level, however, states are firing up their policy labs and exploring public options as a means to prop up state exchanges and provide affordable and accessible health care for millions of lower-income Americans. These proposals can offer insights for academics and policymakers on how best to design insurance markets and lessons for states attempting similar reforms.

Our analysis shows that these proposals confront trade-offs central to insurance design. State public options administered by private insurance can enable a state legislature to exhibit a soft influence on the degree of competition in state exchanges. However, with payment rates above those of Medicare, the proposals are limited in their scope to contain costs and make health care more affordable. Medicaid buy-in options that compete more aggressively can risk destabilizing state exchanges and, if implemented at scale as a broadly available public option for all, may have insufficient provider participation to ensure timely access to medical care for all enrollees. Yet an aggressively priced public option risks disrupting the private insurance market for non-group enrollees and potentially for small-group purchasers in small business who may similarly migrate to the new option. In practice, through a cautious approach to price reductions, states are finding compromises between providing consumer savings on the one hand and maintaining private markets on the other.

Finally, states have not shown much ability to leverage existing administrative structures to reduce the administrative expenses of the public option relative to the private non-group market. The federal government would likely face similar challenges in devising a Medicare buy-in that would compete aggressively to meaningfully bring down prices but not so aggressively that it would bring down the private market. Public options for health insurance inherently face a dual challenge: improving consumer welfare while keeping competitors in operation.



# Appendix: Tables

TABLE 1: SHARE OF PHYSICIANS ACCEPTING NEW PATIENTS BY PATIENT COVERAGE TYPE			
Specialty	Medicaid	Medicare	Private Insurance
Total	70.8	85.3	90.0
General/ Family Practice	68.2	89.8	91.0
Pediatrics	78.0	N/A	91.3
Psychiatry	35.7	62.1	62.2

Source: For acceptance rates: SHADAC analysis of the 2014–2015 National Ambulatory Medical Care Survey. <https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf>. Notes: Among physicians accepting payments from new patients.

TABLE 2: AVERAGE PLAN PAYMENTS TO PHYSICIANS BY COVERAGE SOURCE, 2014-2015						
	Primary Care		Specialists		All Visits	
	OOP	Total	OOP	Total	OOP	Total
Employer	\$25	\$168	\$44	\$231	\$35	\$190
Marketplace	36	176	61	243	51	183
Other non-group	40	174	56	239	54	188
Medicare*	11	143	25	198	17	161
Medicaid	3	106	6	120	4	118

Source: Estimates adapted from Biener and Selden (2017) analysis of the Medical Expenditure Panel Survey. Notes: Payment rates are for medical visits to an office-based physician for adults aged 18-64. \* Medicare estimates are predictions for nonelderly visits based on data from visits by seniors.



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