Joint Task Force on Affordable, Accessible Health Care
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Policy Option: Public Option

Description

This option is an insurance coverage program that is designed to leverage the state's position as a purchaser/regulator to create coverage options for Vermonters. A public option is generally offered alongside commercial, individually purchased (e.g., through the marketplace) and other public insurance plans as a means to either broaden coverage options or enhance competition among carriers.

Approaches to a public option typically vary along a continuum of government intervention:

- At one end would be a program where government intervention and control would be maximized, e.g., creating a new government administered insurance offering.
- At the other end would be a program implemented in partnership with private plans, where private plans administered and delivered benefits subject to oversight and guidance by the state.
- In the middle would be a program by which existing state programs were offered or made generally available to a broader section of state's residents, e.g., a Medicaid or state employee benefits buy-in program.

Who Will It Affect, and How?

Consideration of a public option is typically made to advance one or several public policy goals:

- Reducing Costs. By reducing premiums or cost sharing either through regulation or some combination of regulation and market competition.
- Increasing Access. To the extent that existing commercial, marketplace or public programs are leaving certain populations uncovered.
- Addressing Market Weaknesses. To the extent that there are limited coverage options geographically or risk pools statewide or in particular counties are weak.

In achieving these policy goals, a public option would affect all stakeholders in the health care system, although the structure and approach to implementation will determine stakeholder reaction:

- **Consumers.** In general, consumers are likely to support public option initiatives, particularly if the benefit of reduced cost and increased access are felt broadly. At the same time, some advocates may leverage consideration of a public option to drive resolution of equity and access issues for otherwise marginalized populations or to press for greater government control of health care generally (e.g., as a substitute for a single payer).
    - The combined small group and individual market in Vermont has roughly 69,000 consumers (or about 11 percent of all Vermonters, per GMCB). The market is split roughly evenly between small group and individual enrollees -- according to CMS

data, in 2020 there were roughly 34,000 individual market plans purchased on the marketplace, of which about 24,000 were subsidized. When combined with the roughly 3.9 percent of Vermonters who are uninsured, the potential consumer impact of an affordable, accessible public option plan is potentially significant.

- From a consumer cost perspective, according to GMCB, since 2015 weighted average small and individual market premium increases have hovered right around 8 percent, ranging from a low of 3.5 percent in 2021 to a high of 11.5 percent in in 2020. Holding premium increases from 2021 (where the unsubsidized family silver plan premiums is $2,171, according to Vermont Health Connect), to even 95 percent of historic increases would save Vermonters hundreds of dollars per year. ***Moreover, if a public option could successfully reduce premiums year over year (as is required in Nevada and contemplated in other states), the savings for families could be as much as $1,300 per year.***

- **Insurers**. Where the public option lands on the "government intervention" continuum will generally determine insurer support. A strictly government run plan designed to compete with insurers in existing markets is likely to run into opposition. On the other hand, a partnership where insurers are given the opportunity to compete for new customers in a lightly regulated market will be more welcome.

- **Providers.** To the extent that the goal of a public option is increasing access – providing coverage to patients who might currently be driving provider uncompensated care and bad debt – providers are generally going to be supportive. On the other hand, using a public option to decrease costs, either via premium reductions or out of pocket limits, necessarily requires a source of funding. To the extent that provider payment limitations are considered as a source of funding, provider support may be limited.

Financing Considerations. If reducing costs is a consideration, some infusion of funding will be needed to drive reductions to consumers, for example:

- Provider reductions. Recouping state expenditures through provider rate limitations would generate an estimable level of savings, although at the risk of provider participation and potential access issues
- Competition. It is theoretically possible, although hard to estimate, that through benefit design and by stabilizing the risk pool (by increasing consumer participation) it is possible that increase competition alone could reduce costs.
- New appropriations/State only dollars.
- Federal dollars. It is possible to craft a public option initiative leveraging federal 1332 demonstration waiver authority that could allow the state to re-capture Advanced Premium Tax Credits (APTC) and cost sharing subsidy savings accruing to the federal government as the result of the program in the form of federal pass-through payments.

The Role of the State. Another key policy consideration is the state's appetite for government intervention, i.e., where on the continuum of options should a public option proposal land? As

noted, there will be tension in stakeholder reaction, with consumer advocates likely to favor more aggressive state intervention in a public option while providers and insurers will view government intervention through a different lens.

The Role of the Federal Governmen*t*. Under the Affordable Care Act (ACA) HHS has the authority to approve demonstration waivers ("1332 Waivers") to experiment with market-place coverage if doing so provides equivalent coverage at the same or lower cost. Notably, states could use this authority to recapture savings that would otherwise accrue to the federal government if the changes they are proposing reduce federal payments for APTC and cost sharing subsidies (i.e., "pass-through funding"). This pass-through funding creates an opportunity for states to advance a public option and use federal dollars to help pay for it, assuming the demonstration is structured appropriately.

To date, states have only requested 1332 demonstration waivers to finance reinsurance waivers: no state has made a request for pass-through funding to finance a public option. Further, the Biden administration has not articulated any priority or strategy related to 1332 authority (as they have for similar authority for Medicare and Medicaid demonstrations). On the other hand, it is likely that the Administration would look favorably on a public option given the President's campaign position on a federal public option.

What have other states done?

Washington State:

- Description: Enacted a public private partnership, "Cascade Care," (July, 2019) designed to increase access to affordable coverage in the individual market by requiring standardized public option plans. Largely financed with provider rate reductions. There is currently not a federally financed (i.e., 1332 waiver) component to the program.
- Status: Public option went live in 2021 with five carriers, but only in 19 of 39 counties, requiring enactment of provider participation requirements for future years.

Nevada:

- Description: Enacted a public/private public option (June 9, 2021) requiring issuers offering Medicaid managed care to make good faith bids for a standardized set of benefits. Financed by premium rate regulation with provider payment floors (and other protections) to ensure provider participation. Statute requires appropriate marketplace (1332) and Medicaid (1115) waiver proposals to secure additional federal funding.
- Status: Currently in stakeholder engagement to design plans to offer in the 2026 plan year.

Colorado:

- Description: Enacted a watered-down version of 2020 public option legislation (June, 2021). Instead of a proposed public private partnership offering QHPs on and off the exchange with the goal of making coverage affordable (from the 2020 bill), the final law requires issuers to offer standard benefits at all metal levels in counties where they currently offer coverage. Financed by regulated premium reductions and backstop provider rate limitations. Statute requires request for federal (1332 waiver) passthrough funding (but to finance other state initiatives).

- Status: In public process to design the standard benefit plan in anticipation of offering for the 2023 plan year.

Oregon:

- Description: Enacted a second public option study bill (2021) directing the Oregon Health Authority to create an implementation plan for a public health plan for individuals and families in the individual health insurance market and small employers.
- Status: The implementation plan, associated analyses, and recommendations for the structure and design of the public health plan are due to the Legislative Assembly by January 1, 2022.

New Mexico:

- Description: Medicaid buy-in with the goal of providing a low-cost health insurance choice for New Mexico residents. Financed with state dollars.
- Status: Legislation stalled since 2019.

Connecticut

- Description: Proposals to allow small businesses and individuals to enroll in state employees program (failed in 2019) and create a public option for small businesses and non-profits (2021).
- Status: Legislation under consideration.

Health Equity Impact

The United States Centers for Disease Control and Prevention (CDC) describes Health Equity as "…action to ensure all population groups living within an area have access to the resources that promote and protect health". This Public Option can positively impact health equity by setting cost sharing or network requirements to address economic, racial, or geographic disparities or access issues, or to add benefits on top of essential benefits to compliment other programs.

Alignment with other proposed Options

Savings identified in Cost Growth Target performance improvement plans, Moderate Needs Group, and Blueprint Expansion Options can be used to reduce the Public Option premiums.

Policy Implementation and Considerations for Further Study

State experience across the country indicate that leveraging a public option (defined broadly) is viewed as a viable means to expand coverage options, increasing access and addressing affordability issues for consumers—even as data on outcomes related to early implementers are still uncertain. It is also the case that introducing a new coverage option is complex and multifaceted, with disparate and interconnected impacts on consumers, issuers, providers, employers, and the state.

States which have implemented some form of public option (Nevada, Colorado and Washington), as well as states that are still considering the appropriateness of a public option for their market, have rested their decision-making upon some level of detailed study and analysis to understand policy

design and implementation considerations before moving forward (or as a guide to deciding whether or not to move forward).

Given the size of the market and the potential for affordability gains related to a public option, a prudent, forward looking next step would be to authorize/direct further study and analysis on this issue to refine and make more precise the viability of a public option to address affordability and access in Vermont.

There are a number of policy levers and implementation considerations to take into account in analyzing the viability of a public option. The analysis should illuminate pros and cons associated with implementation options based on actuarial and policy analysis, as well as examining what has or has not worked in other states (such state comparisons provide an advantage not available to early adopting states).

In this case, the study should also examine those levers with a particular focus on the uniqueness of the Vermont marketplace, including:

1. **What Type of Public Option?**

   As noted, a public option generally is considered along a continuum of state intervention – ranging from creating a new state sponsored insurance program, to a state plan "buy in", to a public private partnership.

   Based on the experience and stakeholder reaction in other states, notably Nevada and Washington, where public option legislation has been enacted, a public private partnership where the state sponsors a plan (either through bidding or regulation) on the marketplace would be most likely to meet dual goals of increasing access and affordability for Vermonters.

   There are two approaches to administering a public private partnership—via contracting with an existing issuer or administered by the state with the help of a TPA.

   Using an issuer requires significantly fewer administrative state resources, since it only requires contracting and oversight and not full implementation and operational support. Using TPA to operationalize the program reduces the need for new agency resources, including hiring new expertise and investing in technology to review and pay claims – however, the state holds the risk of premiums covering all medical and administrative expenses.

   State Approaches to Type*s*: Both Nevada and Washington are leveraging commercial issuers as the delivery mechanism. In Nevada, issuers who wish to participate in Medicaid managed care must submit a good faith bid (and they have the option to open competition to other issuers). In Washington the Health Care Authority has procured five carriers that will offer the newly created Cascade Care public option plans in 19 counties.

   Opportunities for Vermont-Specific Analysis*:* Both Washington and Nevada opted for a public private partnership to advance the public option in their state. Given Vermont's market dynamics (discussed below), it might be worth considering further examination of a public program buy in, either via Medicaid or the public employee program, as a potential option for

the state (given recent history and policy considerations in the state, the third type of public option -- a new state-run plan -- is likely not viable for Vermont).

2. **What is the Most Appropriate Plan Benefit Design?**

In order to operate on the Marketplace, a state-sponsored public option must meet the requirements of a QHP, including offering the ten essential health benefits, community rating and participating in risk mitigation programs (i.e., risk adjustment and reinsurance). In addition. A public option plan will need to compete among plans to draw consumers, and plan design – benefit levels and cost sharing protections – will be key to generating enrollment in a competitive marketplace.

The public option could be offered in all the metal tiers of marketplace insurance plans (bronze, silver, gold, and platinum) or in only a subset. Moreover, multiple public plans could be offered within a metal tier or just a single plan (allowing varying combinations of cost sharing and deductibles and provide different benefits, such as coverage of dental and vision care).

Plan design can also be a lever to drive other important policy considerations or savings for the state. For example:

- Setting cost sharing or network requirements to address economic, racial, or geographic disparities or access issues.
- Adding benefits on top of essential benefits to compliment other programs, such as services tied to ADL supports and perhaps some other non-traditional supports focused on improving and maintaining function in populations at risk for needs in the LTSS area.
- Creating value or performance based contracting opportunities with providers, or networks of providers, to drive clinical improvement and cost savings via shared risk arrangements, for example.

State Approaches to Plan Benefit Design: Washington requires carriers to offer at least one gold and one silver standard plan and incents other key outcomes in benefit design as part of the procurement including: lower deductibles, access to more services before the deductible, and copays to provide transparency and predictability of costs for consumers. In addition, there are quality and value participation requirements specific to the Cascade Care public option plans.

Nevada requires carriers to meet QHP requirements at the silver and gold level and aims to prioritize insurer applicants with networks that: align the providers across the public option and state Medicaid program, include rural and safety-net providers, strengthen the primary care and behavioral health workforce (particularly in rural areas), accept value-based payment models, and decrease disparities in access and outcomes and provide culturally competent care.

Opportunities for Vermont-Specific Analysis: The study can examine whether the benefit designs in the public option can be used to drive desirable policy outcomes in the state. For example, using the plan to set cost sharing or network requirements to address economic, racial, or geographic disparities or access issues, or to add benefits on top of essential benefits to compliment other programs. Further, the all-payer model in Vermont provides

an opportunity to examine how provider contracting, networking and payment arrangements can be used to drive savings and quality improvements.

3. **How Will Premium Savings and Financing be Established?**

A public option will need to compete on premium, not just to draw enrollees but also if federal passthrough savings are to be considered. The effect that establishing a public option would have on premium tax credits would depend on how the public option's premiums compared with those of private plans. Notably, a lower benchmark premium also lowers federal costs due to reduced federal tax credits.

As noted, the state could seek a Section 1332 waiver to recoup the difference in costs in the form of pass-through funding if the state-sponsored plan is the new benchmark or becomes the lowest-cost plan.

Generally, there will be two levers available to the state to drive premium savings: provider rate limitations or premium regulation.

Using provider rate limitations, the state would set a benchmark provider reimbursement rate to be used by the contracted carrier, or in direct state negotiations with providers. In order to reduce premiums, this reimbursement rate would need to be set below the current commercial rates but would have to be balanced against the need to attract providers and pay a reasonable amount for clinical services. The state may consider incenting provider participation in order to maintain lower-than-Marketplace rates, such as tying participation in the public option to participation in other state-procured health coverage programs (e.g., Medicaid).

Premium regulation would entail authorizing requirements for bidders to reach a premium reduction target and leave the mechanisms of the reduction to the carrier. Existing carriers may have more flexibility to negotiate rates for a state-sponsored product than for a traditional commercial offering with the backing of the state.

State Approaches to Premiums and Financing: Washington caps rates at 160 percent of Medicare with floors for primary care and rural hospitals. Of note, because in the first year of operation, plans were only offered in 19 of 39 counties, Washington is amending their program to add hospital tie-in requirements to ensure access and participation.

Nevada is taking a hybrid approach to ensure premium savings. First, the state ties participation in the Medicaid managed care plan to offering public option plans. Second, they set a payment floor to Medicare provider rates. Finally, to ensure premium savings for Nevadans, public option plans must submit rates that are at least 5 percent lower than the previous year's rates for a benchmark Marketplace plan; annual premium increases must be no higher than the Medicare Economic Index for that year. The state may revise these requirements if it ensures at least a 15 percent reduction in premiums over the first four years.

Opportunities for Vermont-Specific Analysis: In general, we know that a public option can theoretically help drive premium down for intended populations. An actuarial study will help determine specifically for Vermont, given its market and risk profile, if a public option premium can be meaningfully set to drive enrollment, and hopefully capture savings for consumers.

The study should also examine the role of premium savings on potential passthrough funding available to Vermont via a 1332 demonstration waiver, and how those savings might be applied to offsetting any state costs for the program.

The study should also be used to understand the impact of extended ARPA premium subsidies on the current marketplace and as well as the impact of their extension or expiration on the viability of a public option. Such analysis will be helpful in discussions with the Administration over continuation/expiration of the enhanced subsidies.

The premium analysis should also, to the extent practicable, illuminate impacts on small employers of premium reductions and enrollment changes.

To the extent that Vermont moves forward with cost growth or affordability targets, is there an opportunity to tie premium growth or reduction targets for a public option to a broader scheme of growth limitations?

4. What Market/Resident Eligibility is Most Appropriate?

The state will also need to consider resident eligibility and market segment for the public option: in particular, will the target population include both subsidized and unsubsidized populations who may benefit from a lower-premium product? Further, given that the small and individual group markets in the state share a risk pool, it makes sense to open the option to both segments.

Eligibility can also be a tool to drive access and affordability efforts at targeted populations. For example, leveraging a public option to assist small group market in meeting the cost and coverage demands for their employees. Setting up a plan on the exchange with lower premiums, or where individuals could receive subsidies, might be more attractive option for employers. Alternatively, either as a stop gap or as part of a public option implementation plan, the state could set up navigator or other assister programs to help small employers understand the financial considerations associated with offering coverage versus allowing employees to seek subsidized coverage on the marketplace. Of course, the federal guardrails (particularly limitations on increases to federal spending of 1332 waivers) need to be considered when targeting previously covered small group members – waivers that increase federal spending (e.g., by increasing the # of state residents receiving subsidies when previously covered by employers) will not lead to passthrough funding.

State Approaches to Eligibilit*y*: Washington and Nevada make coverage open to those eligible to enroll on the exchange; Nevada is studying opening coverage to small employers and their employees.

Opportunities for Vermont-Specific Analysis: Unlike Washington and Nevada, the small group and individual markets in Vermont are combined, requiring unique technical actuarial and policy analysis to understand the premium and uptake parameters of a public option in Vermont.

Also unlike other states, insurance coverage and offerings in Vermont are fairly stable; the study should examine whether or not a public option would further promote uniformity across the state, or not.

The presence of only two issuers in the state makes analysis of a public option somewhat unique relative to what other states have undertaken. The analysis should specifically consider the impact of limited issuers and how the # of issuers might inhibit or promote the goals of a public option.

The study could also be useful in understanding the role of information and comparison tools for small employers seeking to understand the value of providing coverage or having employees seek coverage in the marketplace

5. State Administration

Enacting a public option will also require consideration of the locus of administrative accountability in the state. Under any scenario, the interplay of marketplace oversight, provider rate setting, access and beneficiary protections will require consultation across all relevant state agencies.

State Approaches to Administration: Cascade Care, in Washington, is administered by the state exchange in partnership with the Medicaid agency and the insurance commission. In Nevada, the plan is administered by the Human Services agency, in consultation with the marketplace and insurance commission.

6. Study Timing and Execution

Executing Agency: States have taken varying approaches to assigning further responsibility for additional analysis. In Nevada, the study was authorized by the state legislature to be conducted by a legislative committee. In Washington and Colorado, the state executive branch was directed to do the study by the legislature. With appropriate resources, the Department of Vermont Health Access, as a locus of both Medicaid and marketplace operations and policy would likely be an appropriate locus of responsibility, in coordination with the Green Mountain Health Board and the Department of Financial Regulation.

Timing: Ideally given the timing of plan design and implementation, any study would need to be complete in time for the state and issuers to operationalize any recommended changes. Anticipating a 12-18 month plan implementation window, a study would need to be complete sometime in the summer of 2022 in time for the 2024 plan year.