ITUP
Insure the Uninsured Project

» Health Policy Essentials

Public Option in California

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INTRODUCTION

During Congressional deliberations on the federal Affordable Care Act (ACA), one final sticking point was whether to include a "public option," a new government-sponsored coverage choice for individuals eligible for the newly forming ACA exchanges.[1]

Since passage of the ACA, several public option proposals have been introduced in Congress and multiple 2020 Presidential candidates proposed versions of a public option. President-elect Joe Biden proposes, among other features of his health care plan, to build on the ACA by adding a public option "like Medicare," that "will negotiate prices with providers," and offer "a more affordable option."[2] The Biden Plan would make the public option available to individuals eligible for ACA exchanges (e.g., Covered California) and Medicaid, people with employer-sponsored coverage, and low-income individuals in states that did not expand Medicaid under the ACA. States that did expand Medicaid (like California) could choose to move the Medicaid expansion population into the public option. States have also been exploring ways to introduce state-level competitive coverage choices, building on elements of the federal proposals, and modifying the public option concept based on specific state circumstances.[3]

PURPOSE OF THIS REPORT

This report updates previous ITUP publications from 2018 and 2020 to inform policy discussions on what a public option might look like in California. To that end, this report builds on the earlier reports by illustrating how three distinct public option "approaches" might be applied in California, identifies relevant characteristics of the California health care landscape, and highlights key considerations for policymakers.

What is a Public Option?

The public option debate has been characterized by differing views of what a public option needs to look like and what it would mean for the U.S. health care system.[4] As the discussions unfold, it is important to clearly identify the policy problem(s) the public option is meant to solve and in what ways the public option addresses the problem(s).

Federal Public Option. In the federal context, a public option is most often defined as ***"****a government-run (or publicly insured) health insurance option in direct competition with other options for private health insurance coverage."* The public option generally differs from a Medicare for All approach, which would establish one national health insurance program for all Americans, because the public option is not meant to replace current sources of coverage.[5]

The 2009 federal public option proposals would have tasked the U.S. Health and Human Services Secretary with contracting directly (or through an administrator) with providers. Most federal public option proposals would be offered to consumers in the individual health insurance market, typically through ACA exchanges, but some, like the Biden plan, propose to offer the public option more broadly.[6]

One central feature of most federal public option proposals is provider rate negotiation, rate caps, or other benchmarks linked to Medicare reimbursement levels, or to a percentage of commercial provider rates. Importantly, the emphasis on lower provider payment rates is in part the basis for the contention that the public option will be more affordable for consumers than competing commercial options. Some would take it a step further and define the public option as *"an insurance plan [for the individual insurance market] with access to publicly-determined provider payment rates."*[7]

The "Public" in Public Option

The classic public option proposed at the federal level is a health insurance option publicly administered by the federal government. The public option concept is, however, evolving in state-level discussions to emphasize publicly defined provider reimbursement rates and increased government oversight as the distinguishing features of a public option, whether the coverage is publicly or commercially administered.

This shifting landscape raises questions of definition and purpose.

- What level of additional government oversight would define a public option?
- Would publicly administered health plans like California's public county-based plans (local public plans) be considered public options because they are government-run?
- What, if anything, would a publicly-sponsored option add, or need to add, in contrast to commercial insurance, beyond the payment of lower provider rates, to be within the meaning of a public option?

Proponents of a public option note that it offers any number of potential benefits, including: (1) improved affordability for consumers because of competition between the public option and commercial health plans, (2) greater transparency on cost and quality, (3) reduced administrative costs through direct provider contracts and no profit in the public option, and (4) increased accountability because of the expanded role of government. Additionally, some advocates, implicitly or explicitly, see the public option as an incremental or glide-path approach to Medicare for All.

Nationally, the health insurance industry and many provider organizations have opposed a public option. Health plans raise concerns that they would have difficulty competing on a level playing field with a public option, and ultimately would be put out of business. Hospitals and other health care providers raise concerns about the adequacy of payment rates in a public option, potential impacts on quality of care, and the potential loss of revenues.[8]

State-Level Public Option. Multiple states continue to explore how they might develop and implement state-level public options, drawing on the concepts underlying the federal proposals. Some states have also considered expanding their state Medicaid programs by allowing individual consumers, and possibly employers and employees, to purchase Medicaid coverage as an alternative to other coverage. Some federal public option proposals would allow states to build a Medicaid-based public option.

Some states are exploring or implementing a coverage choice, labeled as a public option, that is not administered directly by government, but is more of a public-private partnership. This approach relies on commercial health plans, who would be subject to greater government oversight and pay providers based on publicly-determined rates.[9] For example, the recently implemented Washington State Cascade Care "public option" adds health plan choices in the Washington Health Benefit Exchange (WBHE).[10] The "Cascade Select" public option plans offer standardized benefits and also meet additional requirements above those imposed on other health plans in WHBE, including following specified technology assessment guidelines and offering bronze-level products in addition to silver and gold.[11] Cascade Select plans must also apply provider reimbursement caps at 160 percent of Medicare, subject to a floor for primary care and rural hospitals.[12]

Table 1 illustrates how three emerging approaches to the public option might be applied in California: a classic public option similar to what has been proposed federally, a public-private partnership similar to Cascade Care in Washington State, and a Medicaid buy-in. There are many nuances to consider and implementation choices that would need to be made within each approach. While the approaches and individual features might vary in a California public option (e.g., different administering agencies), ***the illustrations in Table 1 are intended to help make concrete the differences between the approaches***.

Table 1. STATE PUBLIC OPTION APPROACHES Applied to California (*For Illustration Purposes)*

	Classic Public Option (Government-Run)	Public-Private Partnership (Government-Sponsored)	Medi-Cal Buy-In
Description	State or local government organizes and administers a coverage choice that would compete with existing health plans across the state in specified market(s) (e.g., small group, individual, excluding Medicare and Medi-Cal for this purpose)	Covered CA would selectively contract with licensed health plans by region (existing structure) AND some or all health plans would meet additional criteria as "public option" plans (Cascade Care model)	State would offer Medi-Cal as a coverage choice for purchase by individuals or groups not otherwise eligible
Administering Agency	Could be: a) A State agency with relevant expertise (e.g. could be modeled after the California Public Employees' Retirement System's (CalPERS), self-funded plan[13] or after County Medical Services Program (CMSP) and its third party administrator structure[14]), or; b) County option could be administered by existing local health plans, a like model(s), or a consortium of those plans	Covered CA	Department of Health Care Services (DHCS) or a contracted administrator
Delivery System	State or county would directly contract with/certify providers; could use a contract administrator(s)	Participating public and commercial health plans would contract with and pay providers (existing structure)	DHCS would contract with Medi-Cal managed care plans, or other health plans which, in turn, would contract with and pay providers; could also pay some providers FFS (existing structure)
Health Plan Payments	Set by the state or county consistent with costs and market conditions	Covered CA would negotiate with participating health plans to set monthly premiums (existing structure)	DHCS would negotiate or set health plan monthly premiums
Participating Provider Rates	Provider rates would be set through negotiations, or a fee schedule/ benchmark to Medicare or commercial rates	Public option health plans would implement provider rate caps or benchmarks in negotiating contracts with providers	Provider rates would be negotiated by health plans and / or a fee schedule as in Medi-Cal FFS
Markets/Eligibility	Individual consumers or group purchasers; could be offered in Covered CA or outside market	Individual consumers and small group purchasers buying through Covered CA	Individual consumers or group purchasers as specified
Benefits	▪ ACA essential health benefits? ▪ Modified benefits?	▪ ACA essential health benefits (existing structure) ▪ Health plans must offer only standardized benefits (existing structure)	▪ Medi-Cal benefits? ▪ ACA essential health benefits? ▪ Modified benefits?
Financing	State and federal premium assistance in the exchange; no other federal funds without federal waiver or authorization	State and federal premium assistance; Covered CA is financially self-sustaining through health plan assessments	State only; and purchaser funds absent federal waiver or authorization; health plan assessments possible

Source: Insure the Uninsured Project

The California Landscape for a Public Option

Deciding if California should adopt a version of the public option will necessarily require a comprehensive analysis of the problem to be solved and policy goals of a public option, relative risks, costs, benefits, consumer perspective, and any unintended consequences, in addition to whether provider rate setting might reduce premiums. There could be significant impacts for health insurance markets, existing public programs, consumer access to care, health system quality, and many other variables, depending on the scope and structure of a public option.

A California public option approach would need to consider or be adapted to specific, unique characteristics of California's existing health coverage, care delivery, and payment arrangements. These include:

- ***Covered CA as an active purchaser.*** From the start, California implemented and empowered a strong active purchaser ACA exchange that selectively contracts with health plans and actively negotiates with them on premiums, networks, geographic coverage, and quality. Covered CA standardizes benefits for all products and imposes by contract additional quality measures and reporting, beyond the ACA and state licensing standards. To establish its public option, Cascade Care added features that already exist in the Covered CA model, except that Covered CA does not have the authority to set provider rates. (See ITUP's brief Covered California and Individual Health Insurance).

  - *How would Covered California's existing structure affect consideration of a California public option?*
  - *What would the state need to add or revise to accomplish potential policy goals of a public option?*
  - *Can the goals be accomplished in other ways without a public option framework?*

- ***Network of local public health plans.*** Over the past several decades, California invested in an extensive network of local public health plans to serve primarily Medi-Cal enrollees. California's local public health plans are public entities organized through one or more counties to ensure that Medi-Cal enrollees, and in some cases county employees and Covered California enrollees, receive comprehensive care. (See ITUP's brief Mapping the Future of Medi-Cal and Exploring Public Options in California for more information on local public health plans.)

  - *What is the role of California's local public health plans in the state's consideration of the public option?*
  - *What lessons can be learned from the local public health plans participating in Covered CA, or other non-Medi-Cal markets, as well as from the local public health plans that choose not to, especially around the differences between operating a health insurance product in a commercial market versus the safety net?*

- ***Provider shortages and lack of competition.*** In many areas of California, particularly remote and rural areas, there are severe provider shortages and often fewer health plan choices than other regions. Geographic inaccessibility, provider shortages, and provider concentration within markets can make it challenging for health plans, public or commercial, to develop adequate networks. Lack of competition can lead to higher provider prices and higher premiums. To address the issue of whether providers would accept lower payments, some policymakers propose requiring providers to participate in the federal public option as a condition of participating in Medicare. It could be more difficult to ensure provider participation at the state level.

  - *How would a public option overcome the barriers in underserved areas to offer greater choice at lower prices?*
  - *Will providers in California, particularly in areas of provider shortage or concentration, accept lower rates than commercial rates and participate in a public option?*

- ***High managed care penetration rates.*** California has one of the highest proportions of the population enrolled in managed care in the country. Some form of managed care (HMO, PPO, etc.) is nearly universal in public and commercial health care coverage. The prominence of managed care in the state over more than four decades has led to sweeping changes in health care, including hospital and medical group consolidation, integrated delivery systems, and complicated provider reimbursement arrangements. Provider payments include the widespread use of capitation, fixed monthly payments per enrolled individual, as an alternative to traditional fee-for-service (FFS).

- *How would the dominance of managed care affect consideration of a public option in California?*
- *What might be the impact of introducing a FFS direct care coverage environment?*
- *What benefits or shortcomings of managed care would be lost or improved, respectively?*

- ***Strong consumer protections.*** California has some of the strongest consumer protection laws and health plan regulations in the country. Qualified health plans (QHPs) in Covered CA and most Medi-Cal managed care plans must meet extensive state licensing requirements affecting benefits, financial solvency and capacity, network adequacy, consumer disclosure, consumer right of appeal, and review of quality and utilization management systems. It is not clear whether a public option would necessarily be subject to the same rules and requirements as existing public and commercial health plans.

- *How can California preserve the protections it has developed over decades in the public option approach it adopts?*
- *Are there cost-effective opportunities to improve or enhance quality and system accountability through a public option?*

- ***Continuing health disparities.*** As has been profoundly illustrated in the wake of the COVID-19 pandemic, Californians continue to experience significant disparities in health status and in access to health care. To address these inequities requires reducing disparities not only in health, but in the social determinants that affect historically excluded or marginalized groups. Disparities occur across many dimensions, including race/ethnicity, socioeconomic status, age, place of residence, gender, disability status, and sexual orientation.[16]

- *How would adoption of a public option impact the ability of the state to identify and address the factors that contribute to health disparities?*
- *What are the potential challenges and opportunities to advance state progress in addressing disparities and systemic racism in health care through a public option?*

Considerations for Policymakers

Fundamentally, there are two threshold issues in considering implementation of public plan choice:

What is the problem that policymakers are trying to solve?

In what ways is a specific public plan model a workable and effective solution to the problem?

The advisability of a public option in California, and the best model for the state to adopt, will depend on embracing a common definition of public option, setting clear goals, and conducting a comprehensive and honest evaluation of the risks and benefits of any proposal. This process might include focusing on the following core issues:

- Does California confront a particular policy problem for which one of the public option approaches might be a viable remedy? For example, would a public option:
  1. Expand access to those who are currently uninsured?
  2. Improve affordability for consumers?
  3. Increase coverage options in underserved communities which currently have limited health plan choice?
  4. Improve continuity for individuals moving between eligibility for public and commercial coverage?
  5. Increase quality of services?
  6. Contribute to reducing health disparities and achieving health equity?

- Consistent with the goals and problem(s) to be solved, who would be the target population(s) for the public option in California? People without current coverage, those currently enrolled in individual coverage in Covered CA or the outside market, individuals with job-based coverage, or other groups?

- Which state or local entity(ies) would be most appropriate to administer a public option? Would they have experience administering health insurance products and negotiating/setting health plan/administrator and/or provider rates? Would they be able to offer products regionally or statewide?

- Would implementing the public option approach in California yield benefits commensurate with the investment of financial resources and attention? What are the risks or negative spillover effects, and how could those be mitigated?
- How does consideration of a public option in California present different issues than federally or in other states, and potentially require different solutions, because of the unique history and characteristics of health care in California?
- Does an incoming federal Administration open new windows of opportunity to maximize funding and flexibility for a state public option in California? How much of a priority would a state public option be in contrast to other federal policy choices and flexibilities that might emerge under a new federal administration?

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Notes

1. See ITUP Exploring Public Options in California (2018) for more on the public option proposals under consideration during deliberations on the ACA.
2. The Biden Plan to Protect and Build on the Affordable Care Act.
3. Michael S. Sparer, "Redefining the Public Option: Lessons from Washington State and New Mexico," The Millbank Quarterly, Volume 98, June 2020
4. Helen A. Halpin and Peter Harbage, "The Origins and Demise of the Public Option," *Health Affairs* 29, No. 6 (2010): 117-1124,
5. Neuman, Tricia, Karen Pollitz, Jennifer Tolbert, and Robin Rudowitz, 10 Key Questions on Public Option Proposals, Kaiser Family Foundation, December 18, 2019.
6. Ibid.
7. Liu, Jodi L., Asa Wilks, Sarah A. Nowak, Preethi Rao, and Christine Eibner, Public Options for Individual Health Insurance: Assessing the Effects of Four Public Option Alternatives, Wakely Consulting Group, 2020.
8. Neuman, Tricia, Karen Pollitz, Jennifer Tolbert, and Robin Rudowitz, 10 Key Questions on Public Option Proposals, Kaiser Family Foundation, December 18, 2019.
9. Liu, Jodi L., Asa Wilks, Sarah A. Nowak, Preethi Rao, and Christine Eibner, Public Options for Individual Health Insurance: Assessing the Effects of Four Public Option Alternatives, Wakely Consulting Group, 2020.
10. Washington State Health Benefit Exchange, Cascade Care Implementation 2021.
11. Standardized benefits share common cost-sharing features, such as copayments, deductibles and covered services not subject to the deductible. Under the ACA, products offered in the individual market are categorized based on relative plan value, or actuarial value, the percentage of covered benefits paid for by the health plan. ACA coverage levels (tiers) and actuarial values are bronze (60%), silver (70%), gold (80%) and platinum (90%), plus a catastrophic plan. Under the ACA, health plans in the exchange must offer at least one silver and one gold level product. California law goes beyond the ACA and requires health plans to offer products in all five coverage levels both inside and outside of Covered CA. In addition, Covered CA requires all health plans to offer only standardized products in each coverage tier.
12. Liu, Jodi L., Asa Wilks, Sarah A. Nowak, Preethi Rao, and Christine Eibner, Public Options for Individual Health Insurance: Assessing the Effects of Four Public Option Alternatives, Wakely Consulting Group, 2020.
13. CalPERS manages pension and health benefits for employees and retirees of the State of California and some local public agencies (cities, counties, schools and special districts). For 2021 coverage, CalPERS offers seven state-licensed health plans and three self-funded Preferred Provider Organization (PPO) options (PERSCare, PERS Choice and PERS Select). The coverage choices available for individual enrollees vary by region. The three PPO options are considered self-funded because CalPERS accepts the financial risk to cover claims costs. Anthem Blue Cross serves as a contract administrator for the three self-funded PPOs, which includes negotiating and contracting with participating providers.
14. CMSP provides health coverage for uninsured low-income, indigent adults that are not otherwise eligible for other publicly funded health care programs. CMSP partners with 35 primarily smaller, rural California counties to help the counties meet their indigent health care responsibilities under California law. Advanced Medical Management (AMM) currently administers CMSP medical and dental benefits on behalf of the CMSP Governing Board. Health care providers interested in providing services to CMSP members must contract with the CMSP Board to become participating providers.
15. Medi-Cal enrollees in 36 of the state's 58 counties are able to be served by at least one local public health plan—either a local initiative in Two-Plan counties or a county-organized health system (COHS). https://www.dhcs.ca.gov/services/Documents/MMCD_County_Map.pdf
16. Gaines, Robbin, 2019 Edition — Health Disparities by Race and Ethnicity. California Health Care Foundation.

About ITUP

Insure the Uninsured Project (ITUP) is a Sacramento-based nonprofit health policy institute that for more than two decades has provided expert analysis and facilitated convenings for California policymakers and decisionmakers focused on health reform.

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