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Perspective

Redefining the "Public Option": Lessons from Washington State and New Mexico

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Policy Points:

- States are enacting a host of policy initiatives designed to reduce the number of Americans without health insurance. Policymakers and policy analysts need to examine whether this "laboratory of federalism" is producing ideas that can and should be replicated on a national scale.
- This article evaluates reform efforts in two states: Washington state, which enacted what its policymakers call a "public option" and New Mexico, which failed in its effort to enact a Medicaid buy-in. Some common themes emerge. First, without federal funding, state efforts to aid the uninsured remain limited. Second, the gap between commercial and public insurance reimbursement rates poses an additional significant obstacle.
- Washington state was able to overcome these obstacles by enacting a law (called Cascade Care) which imposes public sector reimbursement rates in a commercial insurance market (the state's ACA Marketplace). This quasi- or redefined public option could become a politically viable model for federal policymakers.

The bitter and partisan debate over the future of the US health care system will play an important role in the 2020 presidential campaign, with Democratic candidates proposing an array of public insurance expansions (primarily building off Medicare) and President Donald Trump assailing the proposals as "socialist" and continuing his effort to scale back (or even eliminate) the Affordable Care Act (ACA). In the meantime, however, several states are considering or enacting a host of public insurance expansions that could provide a

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model for national policymakers. This article looks at two states that are part of this "laboratory of federalism": Washington State, which recently enacted what its policymakers call the nation's first state-based "public option," and New Mexico, which failed in its effort to enact the nation's first "Medicaid buy-in."

Despite the small "sample size" of this qualitative comparative case study, the opportunities and challenges facing policymakers in these two states are quite similar to those experienced by their peers. Indeed, three themes emerge from this review that are relevant to both state and federal policymakers. First, federal funding remains central to public-sector efforts to encourage more affordable health coverage because the states themselves cannot be expected to finance significant public insurance expansions. Second, while the distinction between "public" and "commercial" coverage continues to blur, there still is a significant difference between these two markets' provider reimbursement rates, and this difference poses a serious and ongoing challenge to insurance expansion initiatives. Third, despite growing calls for "comprehensive" health reform, the most plausible path to an American version of affordable universal coverage is likely through a more "incremental" approach. The "quasi-" or "redefined" public options enacted in Washington State and under consideration in New Mexico offer useful models for federal policymakers.

Expanding Coverage in Washington State

Imposing Public-Sector Reimbursement Rates on the Commercial Market

In May 2019, Washington State Governor Jay Inslee signed legislation creating Cascade Care, under which buyers on the state's insurance exchange will soon be able to purchase a lower-cost private health plan in which premiums (and deductibles) will be kept low in accordance with state-mandated caps on providers' reimbursement. Although it is not referred to as such in the legislation, Governor Inslee and others are calling this initiative the nation's first "public option," largely because it is the first time the government (in this case, a state) has imposed public-sector reimbursement rates on a commercial insurance market.[1]

To be sure, the term public option means different things to different people, a topic we will discuss at greater length later in this article. Nonetheless, with or without the public option label, the more pressing question is whether Cascade Care will eventually be seen as a modest expansion of state regulatory authority that has little impact on affordability or coverage, or as a politically viable model for comprehensive health reform that could and should be replicated nationally.

The Cascade Care story began after the 2016 presidential campaign when a small cadre of Washington State legislators and regulators started discussing ways to protect and stabilize the state's ACA Insurance Exchange during an era in which the Trump administration was seeking to repeal the entire law. At the time, the focus was on how best to stop the erosion of the individual insurance market, especially in the 14 counties with only one health plan then participating in the state's insurance exchange (the so-called bare counties). Washington State's legislative solution, enacted in 2018, was to require health plans that participated in the more lucrative school (K through 12) employee health plans to also participate in the Exchange.[2] Even though this provision would not take effect until 2020, it was expected to fully resolve the "bare county" issue.

Following the November 2018 election, the state's Democratic leadership became increasingly emboldened as a "blue wave" gave the Democrats a commanding majority in both houses of the state legislature, and the state's governor, Jay Inslee, announced his candidacy for the presidency. The goal now was to both expand coverage and reduce costs, with a particular focus on the high cost of both premiums and deductibles for those purchasing coverage on the Exchange. Nonetheless, despite the political momentum, there were significant obstacles to a reform agenda: the state's fiscal woes minimized the likelihood of significant state spending (especially given other legislative priorities); the Trump administration was unlikely to approve any Medicaid expansions or experiments that would be funded largely with federal dollars; and the state senate, while controlled by the Democrats (27 to 21), included several moderate to conservative Democrats who would be suspicious of any significant public-sector expansion.

In this context, a variety of reform initiatives were considered and rejected. There was little interest, for example, in pursuing a "Medicaid buy-in," both because federal officials were unlikely to contribute financially and because hospitals and other providers would fiercely complain about the low Medicaid reimbursement rates. Nor was there enthusiasm

for the idea of a "reinsurance" program, under which the state would protect health plans against the high costs of catastrophic illnesses, thereby enabling the plans to lower premiums for other buyers. Even though the federal government would likely contribute to the cost of such a reinsurance program, state officials decided that the cost to the state was still too high. State officials also rejected the idea of a state-based individual mandate. Instead, they decided to develop an innovative program that would reduce costs, increase coverage, and do so without needing federal permission and without contributing significant state dollars.

Led by State Representative Eileen Cody, long considered the legislature's most knowledgeable (and liberal) health policy expert, a handful of legislative and executive branch leaders developed the core idea of what would become Cascade Care. The heart of the original proposal was to have a health plan on the state's Exchange that would offer significantly reduced premiums and deductibles because it capped providers' reimbursement at 100% of Medicare rates, an amount well below the average rates (estimated to be 175%) that Exchange insurers were then paying. Even though the idea differed from the long-standing definition of a public option, since it did not create a new, publicly administered plan, the drafters called it a "public option," partly for marketing purposes but also because it was the first time a state had imposed public-sector reimbursement rates on a commercial insurance market. Their goal was to derive the benefits of a public option without the political, organizational, and economic tasks of creating a new, state-administered insurer.

The proposed legislation also contained two other core components. First, the state would develop a "standardized benefit design" that each Exchange insurer would have to offer on the Exchange (regardless of whether it participated in the "public option" initiative). Second, the state would develop a "plan" to offer premium subsidies to low-wage persons. Neither of these proposals drew significant opposition from stakeholders, especially since carriers could still offer "nonstandardized" plans on the Exchange and since the request for a "report" on premium subsidies meant that no such subsidies (and thus no such state funding) would be included in the legislation being considered.

There was, however, fierce pushback against the "redefined public option" proposal led by those insurers and providers who objected to both the concept of public rate-setting for a commercial product and the actual rates proposed. These arguments were rooted in a core underpinning of the American health care system under which providers rely on the

relatively high reimbursement in the "commercial" markets to subsidize the relatively low reimbursement in the "public insurance" markets (such as Medicare and Medicaid). Indeed, recognizing this distinction, the ACA had divided its effort to aid the nation's uninsured into two categories, the public insurance (Medicaid) expansion and the federal support and subsidies for the commercial market (the Exchanges). The unusual and particularly important aspect of the Cody proposal was that it bridged these two worlds by introducing public rate-setting into the commercial market.

In this context, the stakeholders suggested that the Cody proposal would cause both short-term and longer-term distortions in the state's insurance markets. For starters, since the Cody plan did not require insurers or providers to participate in the "public option," it was unclear which carriers (if any) would offer such a plan, and if they did, whether they would be able to develop a high-quality provider network. There was no backup plan if carriers and providers refused to participate, other than the threat that inadequate participation could lead to a subsequent mandate to participate. Some providers also suggested that they might compensate for the reduced "commercial" revenue by seeing fewer public-insurance (especially Medicaid) patients.

Perhaps ironic were the quite different concerns raised by some that the proposed "public option" could be too successful and could undermine the stability of the rest of the state's individual and small-group markets. For example, the state's "small-group" market currently offers those businesses with fewer than 50 employees less expensive health coverage than is now available on the individual insurance markets. According to actuarial estimates, however, a "public option" plan paying Medicare rates would likely offer premiums significantly lower than those currently available in the small-group market. Under such a scenario, small-business owners would likely drop their employee coverage and urge their employees to purchase the "public option" plan instead. While such a result might please those who saw the "public option" as a path to a state-based "single-payer," the state's more pragmatic liberals (including Representative Cody) were anxious to avoid the complete destabilization of the individual and small-group markets.

Opposition to the "public option" resonated particularly strongly in the state senate, where Senator David Frockt had become the leading voice in the health reform debate. Frockt shared Cody's reform agenda (he had even previously cosponsored a state-based, single-payer

proposal). But in this debate, his task was to be the voice of moderation that could fashion a workable compromise. He performed that mission quite strategically. First, he actually stripped the "public option" provision from the senate's version of Cascade Care, substituting in its stead language authorizing state regulators to more closely regulate the products offered on the Exchange (a so-called active purchaser approach). The stakeholders supported this alternative approach, and Frockt's senate colleagues passed such a bill, which meant that a conference committee (led by Cody and Frockt) was charged with negotiating a compromise that could make it through both chambers.

Over the next two weeks, Cody, Frockt, and Jason McGill (representing Governor Inslee) negotiated with one another and with the key stakeholders. By all accounts, the pressure to reach a compromise that included a "public option" was intense. Governor Inslee wanted a health reform program he could feature in his presidential campaign, and Cody, Frockt, and McGill were determined to take advantage of this window of opportunity. By this time, most lobbyists and legislators realized that this was a "no kill bill" and that the "public option" "cake was baked." One way or another, the state's leaders were determined to make it happen.

Cody, Frockt, and McGill then floated the idea of a "public option" plan that would determine premiums based on the actuarial assumption that total costs would not exceed an aggregate cap of 160% of Medicare for the services rendered. The actuaries estimated that the 160% cap, combined with the new standardized plan rules, would enable the "public option" to offer premiums 5% to 10% lower than they otherwise would be. The hope was that the lower enrollee cost-sharing (copays and deductibles) in the standard benefit design would provide needed assistance to those buying on the Exchange without destabilizing the rest of the individual and small-group markets. The compromise also would allow carriers to retain the flexibility to pay some providers more than 160% and others less (as opposed to the original Cody bill, which required 100% of Medicare to all providers). If it turned out that high-cost providers (say surgeons) had a higher volume than expected and the costs thus exceeded the 160% cap, the carrier would need to absorb that loss (just as they would keep the surplus if the total costs came in under the cap).

The compromise proposal created a division among the state's insurance carriers, with the two Blue Cross plans (Premera and Regence) agreeing to support the 160% cap, and the insurance industry trade

association opposing it, partly because the rates were presumably still too low, but also because of fears of a "slippery slope" of rate regulation, both in Washington State and the rest of the country. Soon the provider community split as well, first when Cody added a provision requiring the "public option" to pay primary care physicians at least 135% of Medicare, (prompting the family practice physicians to offer their support) and then when Frockt added a provision requiring the "public option" to pay rural hospitals at least 101% of Medicare. Frockt gained yet another vote with a provision that authorized state regulators to waive the 160% cap if a health plan demonstrated that it could still lower premiums by the required amount (though Governor Inslee later declared that no waiver requests would be accepted in the program's first year).

The state legislature approved the compromise legislation in late May 2019, and Governor Inslee signed the bill into law soon thereafter. Staff in the state's insurance exchange are now developing the standardized benefit plans to be offered directly to the Exchange purchasers (and as part of the "public option)." Staff in the Health Care Authority (the state's Medicaid agency) are now preparing the request for insurers' proposals to offer a "public option" in 2021. And staff in both the Exchange and the Health Care Authority are together drafting a plan for how best to offer state-funded subsidies to certain Exchange purchasers, with a recommendation due to the legislature in November 2020.

The "Public Option" Proposed in New Mexico

Offering a Medicaid-like Plan to Those Without Other Options

When Michelle Lujan Grisham was elected governor in November 2018, New Mexico seemed poised to become the first state to permit persons (other than the working disabled[3]) to buy into the Medicaid program. More than a year earlier, the state had authorized a study of buy-in options; consultants offered options and recommendations; key stakeholders (including hospitals, insurers, and consumer advocates) voiced their general support, as had candidate Grisham while on the campaign trail; and policy analysts from around the country were viewing New

Mexico as a leader in the laboratory of federalism. As it turned out, however, the buy-in proposal never received serious legislative consideration (although the state did authorize funding for another round of studies and reports). Interestingly, while the obstacles to passage (largely) resembled those in Washington State, the political dynamics in the two states were quite different, leading to the very different outcomes.

New Mexico, of course, is not the first or the only state to consider legislation that would rely on Medicaid as a "public option." In 2017, for example, the Nevada legislature approved a proposal to offer a "Medicaid option" to buyers on that state's insurance Exchange,[4] which Governor Brian Sandoval vetoed just hours before the law would have taken effect. In his veto message, Sandoval expressed general support for the buy-in idea and a willingness to explore the option again once there was a greater evidentiary base on how such a proposal might work.[5] Several other states (including Colorado, Minnesota, and Oregon) have also explored different Medicaid buy-in options,[6] but only New Mexico seemed on the verge of moving ahead.

The idea of a Medicaid buy-in looked to be a particularly good fit in the New Mexico insurance market. The state's Medicaid enrollment has grown dramatically under the ACA, up 66% from 2013 to 2016,[7] so much so that 42% of the state's population is now on the program, the highest percentage in the nation. Given its market penetration, most of the state's providers treat Medicaid enrollees, and the program is generally well regarded by state residents. The state also is home to several influential consumer advocacy organizations, and it was a staffer at one of those groups, Colin Baillo of Health Action New Mexico, who in late 2017 became the earliest and the most vigorous supporter of the Medicaid buy-in strategy.

There were mixed views on the merits of the Medicaid buy-in approach as the January 2018 legislative session began. Key legislators, particularly Representative Deborah Armstrong (D) and Senator Jerry Ortiz y Pino (D), who chaired the health and human services committees in their respective chambers, offered strong support. But the health industry trade associations were ambivalent, as was the state's Republican governor, Susana Martinez. The result was an unusual compromise: the legislature would enact a so-called legislative memorial authorizing a study of the pros and cons of the buy-in approach, but the advocates would need to find private funding for the study. Baillo and his colleagues at the New Mexico Center for Law and Poverty then raised

the needed funding from the Laura and John Arnold Foundation, and Manatt Health was hired to conduct the study, with actuarial help from Wakely Consulting.

The momentum for a Medicaid buy-in strategy increased during the November 2018 elections, largely because of the election of a liberal Democratic governor, Michelle Lujan Grisham. As a congresswoman, Grisham in 2017 had proposed federal legislation that would have permitted states to create a Medicaid buy-in plan in counties with fewer than two competitors on their ACA Exchange.[8] Interestingly, while the problem of so-called bare counties received much national attention during the period when President Trump and his Republican colleagues sought to "repeal and replace" the ACA, it was not an issue in New Mexico, which was the only state in the nation that required statewide coverage by all Exchange carriers. Nonetheless, the newly elected governor was both familiar with and supportive of the concept of a Medicaid buy-in.

As the buy-in debate evolved over the course of 2018, its proponents needed to focus more closely on the political and programmatic implications of different options. Was it feasible to consider a Medicaid buy-in without seeking federal permission or funding, neither of which would likely be offered? How should the state deal with hospitals and other providers who would surely complain about the low Medicaid reimbursement rates? Would a Medicaid buy-in "crowd out" (ie, undermine) the remaining individual and small group commercial markets? Should the state itself administer the buy-in program, or should it contract with private carriers to do so? Where did the buy-in proposal rank on the list of priorities competing for the support of the new governor?

In its review, Manatt Health considered these various issues and, in its December 2018 report, recommended a relatively modest and incremental approach under which the state would offer Medicaid-like coverage, off the Exchange, to persons otherwise without access to publicly funded coverage.[9] The advantages of this approach were clear: the state could proceed without seeking federal approval. It would have relatively little impact on the remaining individual or small-group markets, at least when compared with the other options under review. Hospitals and other providers would gain reimbursement for previously uninsured persons, which, one hoped, would exceed any revenue lost if persons with commercial coverage transitioned to a lower-paying Medicaid product. Moderate Democrats would be more likely to support an incremental

expansion that focused on the currently uninsured than on a more ambitious proposal that would more directly undermine the state's already fragile commercial insurance markets.

Representative Armstrong (supported by other key buy-in proponents) agreed with the Manatt recommendation. In early 2019, she introduced HB 416, which would establish a "state public option through Medicaid" to be offered to those currently ineligible for Medicaid, Medicare, or ACA premium subsidies and to those who had not disenrolled from employer-sponsored coverage in order to enroll in the buy-in program. The buy-in plan would offer benefits similar to those covered on the ACA Exchange, be delivered via a contract with a private insurance carrier, and pay reimbursement rates based on the Medicaid fee schedule. The state would subsidize premiums for persons with an income at or below 200% of the federal poverty level, seek federal dollars when possible, and conduct a study of the feasibility of offering the buy-in to a more expansive group of residents.[10]

As the legislative session proceeded, however, it became clear that Armstrong's proposal faced serious political hurdles. The most immediate red flag was the lack of federal funding, as state legislators (especially those on the key finance committees) questioned the wisdom of an ongoing, state-funded Medicaid expansion. The new Grisham administration shared this concern. Moreover, the new governor's top priority, during both the campaign and the early days of her term, was reforming expensive (and court-mandated) school funding. And without an Executive branch push, the chair of the senate's finance committee, John Arthur Smith, never even held a hearing on Armstrong's proposal.

Another obstacle to the buy-in idea was the confusion and concern over the composition of the state's uninsured population, the target audience for the proposal. It was unclear, for example, how many of the state's nearly 200,000 uninsured persons already were eligible for publicly financed coverage (through either Medicaid or the Exchange), how many fell into the so-called family glitch (a category complicated to define and hard to identify), and how many were currently excluded from coverage because of their immigration status. The immigration issue was especially sensitive as many stakeholders and politicians were concerned about the optics of an initiative that would cover large numbers of the undocumented, especially given the state's ongoing battle with the Trump administration over immigration and border policy. Added to that were concerns that some higher-income (and often healthier) residents now

buying on the Exchange would shift to the less costly buy-in program, potentially destabilizing the Exchange (and perhaps the individual and small-group markets more generally). Indeed, it also was not clear how the ban on coverage for those with access to employer-sponsored coverage would be enforced, other than by requiring an attestation by applicants, which raised concerns as well.

Complicating the politics even further was the unfortunate fact that Representative Armstrong was faced with a difficult personal crisis (an illness in her family), which meant that the most important legislator in the policy debate was unavailable at key points during the session. In the end, the combination of programmatic and political concerns won over the prior momentum in favor of reform, and the buy-in legislation never proceeded to a vote. As an alternative, however, Governor Grisham signed legislation appropriating $142,000 to the state's Human Services Agency for additional reports on the pros and cons of alternative Medicaid buy-in options. The goal is to reconsider options that would provide affordable coverage while leveraging every possible federal dollar, minimizing state expenditures, and avoiding harm to the individual and small-group markets.

The New Mexico legislature will convene again for a 30-day session in early 2020. Before then, the state hopes to vet more carefully a range of alternative options. At the top of the current wish list is a proposal to create a Medicaid-connected "Basic Health Plan (BHP)," which would replace individual market coverage for citizens between 139% and 200% of the Federal Poverty Level (FPL) and lawfully present noncitizens between 0% and 200% of the FPL, and which also could be the path through which to create a buy-in program for other populations. If New Mexico adopted a BHP, the federal government would contribute an amount equal to 95% of the federal marketplace funding that would otherwise be paid to cover premium subsidies and cost-sharing assistance for the enrollees. Furthermore, the enrollees would get access to a low-cost health plan without deductibles. (Minnesota and New York have both implemented this option under the ACA). The downside for the state is that more than 45% of those now buying on the Exchange likely would shift to the BHP (since their coverage would cost less and be more comprehensive than that available on the exchange), leaving behind an older and sicker population and a significantly destabilized market. Accordingly, the BHP option is viable only if state officials have a strategy to protect the individual market, perhaps by combining it

with the small-group market or by increasing the subsidies to those who stay in the Exchange.

Expanding Coverage via a Redefined "Public Option"

Lessons from Washington State and New Mexico

Different states adopt different strategies in their effort to encourage affordable and high-quality health care coverage.[11] Several states have adopted reinsurance programs to limit premium increases by covering some portion of high-cost claims. Others have imposed state-based individual mandate laws to incentivize young healthy adults to buy coverage. Still others are enacting (or considering) public plan options under which the state itself would offer a lower-cost coverage alternative, either by regulating prices on the commercial exchange market or by permitting uninsured individuals to buy into Medicaid (and its managed care delivery system).

This article examines two of these recent state initiatives: "Cascade Care," Washington State's program designed to provide more affordable coverage by regulating reimbursement rates on the individual commercial market, and New Mexico's investigation into the possibility of permitting individuals otherwise without coverage to buy into the state's Medicaid program. The small "sample size" of this qualitative comparative case study raises important questions about the generalizability of findings and lessons learned. That said, the opportunities and challenges facing policymakers in these two states are quite similar to those experienced in their peer jurisdictions, and the outcomes generated in this laboratory of federalism should resonate with their peers at both the state and the federal level.

Federal Funding Remains Central to Expanded Coverage

Over the past 30 years, Medicaid has evolved from its welfare roots to become the nation's primary program for expanding medical coverage to the uninsured. Among the many reasons for the programs' growth and resilience is the support of interest groups (eg, hospitals, nursing homes, community health centers, consumer advocates), America's

political culture (which generally prefers state-based programs for the poor), and the fact that Medicaid has become a leader in innovative care management efforts. But perhaps the most important factor in its growth is the shared funding formula, under which the federal government contributes between 50% and 80% of the cost of the traditional (pre-ACA) Medicaid program (the poorer the state, the higher the federal match). This funding formula encourages states to expand in good economic times and discourages contraction during economic downturns. It also has led states to become quite reliant on federal Medicaid funding, thereby creating a culture in which states hesitate to finance insurance expansions without federal fiscal support.

The ACA also relies on fiscal federalism to encourage states' participation, offering an even more generous federal match for states that adopt its Medicaid expansion, providing federal subsidies for low-wage persons who buy coverage on the Exchanges, and permitting states to seek special permission (via a Section 1332 waiver) to use federal funds to experiment with new coverage and delivery reform initiatives.

Over the past few years, however, the Trump administration has made it more difficult for states to access federal funds for programs designed to increase access to publicly funded insurance. As a result, policymakers in both Washington State and New Mexico based their initiatives on the assumption that federal officials would not approve any "public option"–related waiver request. Instead, Washington State developed a regulatory model that lowered costs by cutting reimbursements and put off at least for now any proposal to offer additional premium subsidies. Similarly, New Mexico's Medicaid buy-in proposal did not succeed largely because it would create a recurring cost for the state, without the federal funding that policymakers had come to expect from a public insurance expansion. The result is that states cannot be expected to finance significant public insurance expansions by themselves, partly owing to limited capacity (and states' constitutional balanced budget requirements) and partly owing to a growing expectation of federal fiscal help with any such efforts.

High "Commercial" Reimbursement Rates Are a Core Challenge for Policymakers

The ACA offers two separate paths toward its goal of reducing the number of Americans without health insurance: expanded access to

public insurance (via Medicaid) and more affordable private insurance (through the Exchanges and the accompanying subsidies for premiums). These dual paths reflect the long-standing (but fraying) assumption that public coverage should be a safety net only for those without access to private coverage. Equally important is the recognition that hospitals and other health care providers have, whenever possible, offset relatively low reimbursements for public insurance with far more lucrative commercial payments. The drafters of the ACA thus split the difference, proposing that half the newly insured (the lower-income half) would receive public coverage and the other (higher-income) half would receive commercial coverage.

Over the last decade, however, the line between the ACA public insurance expansion and the commercial Exchanges has begun to blur. Most states, for example, rely on commercial managed care plans to administer benefits to Medicaid enrollees, and many of those same carriers also participate on the state's ACA Exchange. Most states also offer a single eligibility pipeline for Medicaid and the Exchanges, recognizing that beneficiaries often move back and forth between the two programs. Some states combine the two programs even more directly. Arkansas, for example, implements its ACA Medicaid expansion program by purchasing private Exchange coverage for enrollees. Nonetheless, certain key distinctions between these two ACA initiatives remain, the most important of which is the reimbursement rates paid to medical providers: the commercial carriers in the individual and small-group markets both on and off the Exchange pay a significantly higher rate than does their public insurance counterpart.

The "public options" enacted in Washington State and proposed in New Mexico are intended to encourage more affordable coverage by closing the gap between public and commercial providers' reimbursements. Washington State's strategy is to regulate the overall reimbursement paid by a "public option" health plan competing in a commercial market (ie, the ACA Exchange). While the regulatory cap is relatively modest (160% of Medicare), it poses a significant "slippery slope" threat to the status quo: providers worry about lower reimbursements; insurers worry about unfair competition; and policymakers worry about the possible destabilization of the individual and small-group markets.

The "public option" proposed by Representative Armstrong in New Mexico seeks a similar result using a different strategy: creating a Medicaid-connected "public option" that would pay far lower rates

(based on Medicaid's fee schedule) than its Washington State counterpart. But by limiting eligibility to persons otherwise ineligible for insurance coverage, it presumably would have a smaller impact on the commercial markets. That proposal failed and the state now is considering a more ambitious approach, such as the creation of a basic health plan, which would have a far more dramatic impact on many people now receiving commercial coverage. Whether policymakers can balance the desire to offer a more affordable public insurance product while also maintaining a stable individual and small-group commercial market remains to be seen.

Incrementalism and the Redefined Public Option

Several of the Democratic candidates running for president in the 2020 election have proposed a comprehensive overhaul of the nation's health care system, greatly reducing (or perhaps completely eliminating) the multipayer private insurance health insurance industry and replacing it with comprehensive, publicly funded coverage for all, referred to generally as a "single-payer" insurance model. The progressives' hope is that if the Democratic Party gained control of both the White House and Congress in the 2020 election, they would have a window of opportunity for a dramatic (indeed path-breaking) legislative act.

The political obstacles to the national single-payer movement are obvious[12] and include the fierce and influential opposition of interest groups, the antigovernment ethos that resonates strongly with much of the population, and the need to dramatically raise taxes to fund such a program (even though the tax increases would be counteracted by the elimination of insurance premiums). There also is the obvious challenge of winning both the presidency and a filibuster-proof Senate.

Not surprisingly, the call for comprehensive reform is heard as well in many states, including New Mexico and Washington State. Both states have active and engaged organizations promoting a "single-payer" agenda; both recently had a "blue wave" ushering in liberal Democratic control of both the executive and legislative branches; and both recently appropriated funds for a study of the pros and cons of single-payer legislation. Neither state, however, has a single influential policymaker (or policy analyst) who considers the enactment of single-payer legislation to be even remotely possible.

Liberal democrats are deeply divided on how to respond to the sharp political opposition to single-payer proposals. Those led by Senator Bernie Sanders (D-VT) are encouraged by public polling showing general support for the single-payer concept and are more convinced than ever that "Medicare-for-all" is both good policy and good politics. Others, however, are far more cautious and propose instead a more incremental approach. Former Vice President Joe Biden and Pete Buttigieg (among other Democratic presidential candidates) have suggested creating a new, federally administered "public option" that would be available to anyone who chose to join. Alternatively, Congressman Ben Ray Lujan (D-NM) has proposed a state-based "public option" under which persons could buy into Medicaid, with the care delivered through private managed care plans.[13]

Those in favor of one or more of these public option strategies emphasize the "incremental" nature of their proposals, particularly in contrast to the far more comprehensive and radical single-payer initiatives. But the political path for all of these proposals is filled with difficult obstacles. In 2009, for example, liberal Democrats proposed that the ACA include a Medicare-like public option available to anyone purchasing coverage on the newly created insurance exchanges. The assumption was that this newly created and publicly administered plan would compete with the commercial plans that participated on the exchange. The hope was that the idea would appeal to moderates interested in infusing more competition and cost control into the insurance markets. The House of Representatives even included such a provision in its version of the law.

Perhaps not surprisingly, however, there was fierce opposition to the idea from insurers who were worried about publicly subsidized competition, providers who were worried about lower rates, and conservatives who were worried about "creeping socialism." President Barack Obama was not interested in using his political chips to press for the idea, especially since Senator Joe Lieberman (I-CT) promised to join a Republican filibuster of any bill that contained such a proposal. Accordingly, the Senate did not include a public option in the bill it passed and sent to the joint conference committee. The proposal officially died with the passage of the ACA.[14]

A decade later, the idea of the public option is back on the political agenda, this time with more support of the mainstream Democrats. That said, Biden's and Buttigieg's proposals are far more comprehensive in

reach than that passed by the House of Representatives in 2009, and they are far more likely to generate significant opposition from stakeholders, mainly because they pose a greater threat to the long-term stability of the employer-sponsored insurance system. Biden's and Buttigieg's proposals also assume that it will be relatively simple to create a new federally administered (Medicare-like) health plan, even though the likelihood of such straightforward implementation is unclear, especially in a world in which more and more Medicare beneficiaries are enrolled in private Medicare Advantage plans.

The complicated politics of the public option idea are nicely illustrated in Washington State (with its more modest and redefined public option) and New Mexico (with its so far unsuccessful effort to enact a Medicaid buy-in). Despite the unified Democratic political control in both states, the stakeholders' opposition to these incremental public option proposals remains fierce, largely because of their potential impact on commercial reimbursement rates. Indeed, enactment clearly requires a window of opportunity, unified public-sector leadership, and artful negotiation of obstacles from interest and ideological groups and institutions. For example, Washington State's policy elites formed a consensus to move forward with a "public option" rooted in a rather modest regulation of commercial rates. In contrast, New Mexico's policy elites were unable to reach (at least so far) a similar consensus on how to move forward.

The single-payer debate on both the national and the state levels may ultimately generate a liberal consensus regarding a "public option" proposal, such as Biden's and Buttigieg's ideas of a Medicare-like program, federally administered, and available to everybody who wants it. Such an initiative could be an important step toward a more equitable and more affordable health insurance system. At the same time, however, reformers should also consider more modest ideas, such as the quasi- or redefined public option enacted in Washington State, and the Medicaid buy-in being considered in New Mexico. To be sure, even these more incremental proposals will be opposed, especially if they explicitly threaten the viability of the traditional commercial insurance markets and the reimbursement rates paid to influential health care providers. But now a laboratory of federalism is generating evidence and lessons.

The implementation of the Cascade Care model in Washington State thus will be particularly important to follow: will it become a modest

expansion of state regulatory authority with little impact, or will it emerge as a politically viable model for health reform that becomes a welcome step on the path toward an American version of affordable universal coverage? This is an important question for the laboratory of American federalism and for American politics more generally.

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