A PUBLIC OPTION FOR MAINE: CONSIDERATIONS FOR POLICYMAKERS

PREPARED BY THE OFFICE OF AFFORDABLE HEALTH CARE

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INTRODUCTION AND BACKGROUND

This report has been produced by the Office of Affordable Health Care in response to two legislative directives. The first, Public Law 2021 Ch. 518, directs the office to "study the effects of policies aimed at improving health care affordability and coverage, including effects on the affordability of premiums and cost-sharing in the individual and small group health insurance markets, and the effects of the policies on enrollment in comprehensive health coverage." The law specified that the policies considered should include creating a public option health benefit plan, creating a Medicaid buy-in program, increasing enrollment in Medicaid, and providing state-level premium subsidies to populations that do not currently qualify for federal Advance Premium Tax Credits. In 2023, the Legislature passed an additional resolve (P.L. 2023 Ch. 87) directing the office to prioritize the study of a public option plan that takes the form of either a buy-in to the MaineCare program, or a fully publicly administered plan offered through the Health Insurance Marketplace, CoverME.gov.

This report builds on prior work in Maine to develop public option models. In the early 2000s as part of Dirigo Health, the state administered a public-private collaborative health plan for individuals and small businesses.[1] That program was discontinued in 2013, following the implementation of the federal Patient Protection and Affordable Care Act (ACA),[2] but interest in a state-level public option has continued. Notably, the Task Force on Health Care Coverage for All of Maine included a public option as one of three topics to be studied by small workgroups.[3] That group developed a set of guiding principles for a new health care model, but no specific recommendations on the development of a public option were included in the Task Force's 2018 final report. Since that time, a handful of bills have been considered in the legislature with scopes ranging from mandating studies or establishing commissions to outlining high-level program design elements and requiring implementation. This report seeks to advance the conversation about the design of public option for Maine by reviewing the potential policy goals of a public option, discussing design considerations, and describing three high-level models for operation of a publicly administered plan.

CURRENT LANDSCAPE OF HEALTH COVERAGE IN MAINE

Over the last 10 years, the state of Maine has made significant progress in expanding quality health insurance to more residents. Following implementation of the ACA, Maine was a leader in enrolling eligible people in health coverage through the HealthCare.gov Marketplace.[4] Those efforts, along with

[1] Governor's Office of Health Policy and Finance, "Dirigo Health Reform – An Overview and Progress Report," Issue Brief prepared for the Legislative Policy Forum on Health Care, January 2007. http://muskie.usm.maine.edu/Publications/PLA/Dirigo.pdf

[2] Maine State Legislature Legislative History Collection, "Dirigo Health," updated August 2023, accessed January 2024. https://www.maine.gov/legis/lawlib/lldl/dirigo/index.html

[3] Maine State Legislature, "Task Force on Health Care Coverage For All of Maine" accessed January 2024. https://legislature.maine.gov/task-force-on-health-care-coverage

[4] Daniel Polsky, Janet Weiner, Christopher Colameco, and Nora Becker, "Deciphering the Data: Final Enrollment Rates Show Federally Run Marketplaces Make Up Lost Ground at End of Open Enrollment," University of Pennsylvania Leonard Davis Institute of Health Economics In-Brief, May 2014. https://ldi.upenn.edu/wp-content/uploads/archive/pdf/final%20enrollment%20rates%20federal%20marketplaces%20make%20up%20lost%20ground.pdf

other reforms including the elimination of coverage exclusions for people with pre-existing conditions, resulted in a 30% decline in the uninsured population in Maine between 2013 and 2018. Following the expansion of MaineCare to eliminate the coverage gap for low-income adults, as well as state and federal actions to bolster the fully-insured commercial market, the uninsured rate declined a further 14%. The uninsured rate in Maine now stands at about 6.5%, or roughly 88,000 people.[5] Despite these successes, Maine people continue to struggle to afford needed health care. In a recent survey, nearly 60% of respondents expressed concern that they would experience a gap in coverage due to the cost of health insurance, and one in three reported skipping or delaying care when they were sick because of costs.[6]

A recently published report by the Urban Institute helps to illustrate how cost and coverage are impacting Maine people by projecting enrollment and costs in 2025.[7] The report projects that 5.8% of non-elderly adults, or roughly 59,000 people, will remain uninsured.

Health Insurance Coverage of the Nonelderly in Maine, 2025

	People	Percent of total
Insured	966,000	94.2%
Employer	562,000	54.8%
Private nongroup	81,000	7.9%
Marketplace with PTC	64,000	6.2%
Full-pay Marketplace	8,000	0.8%
Other nongroup	10,000	0.9%
Medicaid/CHIP	284,000	27.7%
Disabled	55,000	5.3%
Medicaid expansion	57,000	5.6%
Traditional nondisabled adult	59,000	5.8%
Nondisabled Medicaid/CHIP child	113,000	11.0%
Other public	38,000	3.8%
Uninsured	59,000	5.8%
Total	**1,025,000**	**100.0%**

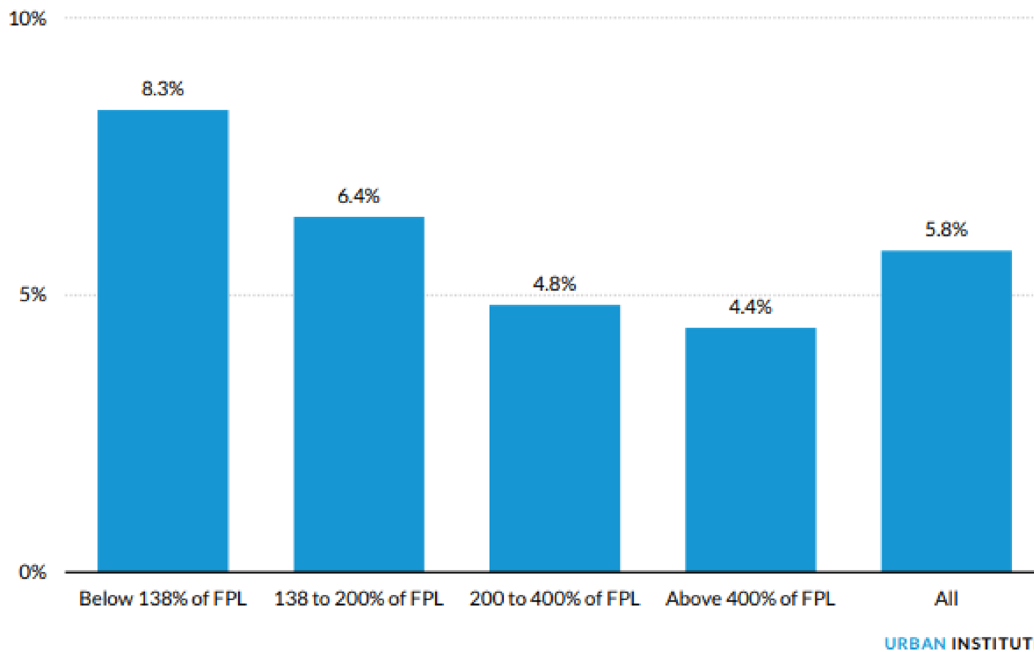
Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.
Notes: PTC = premium tax credit; CHIP = Children's Health Insurance Program.

The rate of uninsurance declines as household incomes increase, with the highest rate of 8.3% among people below 138% of the Federal Poverty Level (FPL). This translates to roughly 23,000 individuals, most of whom are likely eligible for MaineCare but unenrolled. Another 7,000 people with incomes between 138-200% of FPL are estimated to be uninsured, although many likely qualify for Premium Tax Credits through the Marketplace.

[5] KFF, "Health Insurance Coverage of the Total Population," State Health Facts, accessed January 2024. https://www.kff.org/2fdbf6d/

[6] "Views of Maine Voters on Health Care Affordability," Consumers for Affordable Health Care, May 2023. https://mainecahc.org/advocacy/expanding-access-affordability.html

[7] Matthew Buettgens, Jessica Banthin, Mohammed Akel, and Michael Simpson, "An Overview of Health Coverage and Costs in Maine for 2025," Urban Institute, February 2024. https://www.urban.org/sites/default/files/2024-02/An%20Overview%20of%20Health%20Coverage%20and%20Costs%20in%20Maine%20for%202025.pdf

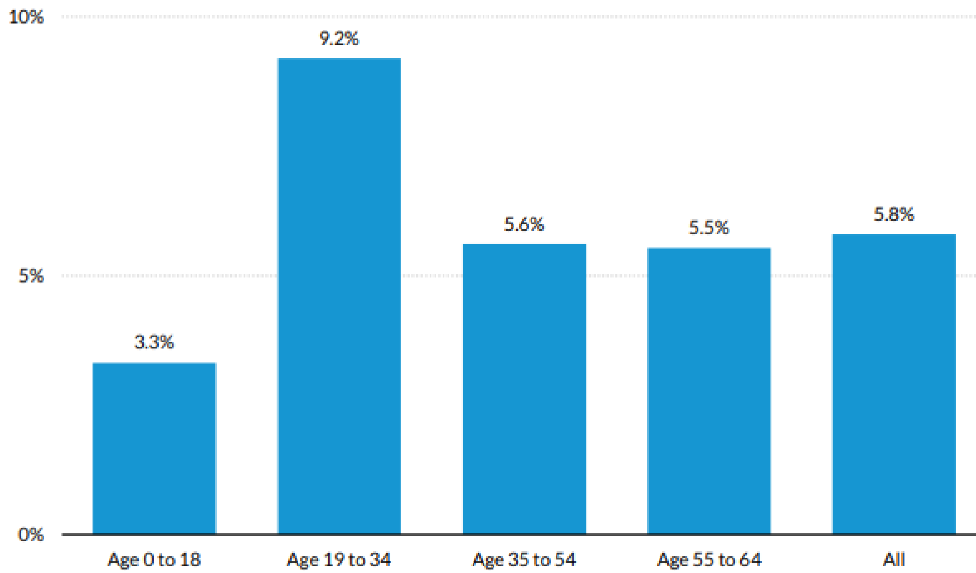


Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.
Notes: FPL = federal poverty level.

Children are the least likely age group to be uninsured with 3.3%, or roughly 9,000 children, projected to be without coverage in 2025. Medicaid income eligibility limits for children are significantly higher than for adults, and 45% are projected to have coverage through the MaineCare program, roughly equal to the percentage with coverage through a parent or guardian's employer. The age group most likely to be uninsured are young adults ages 19 to 35, a group that national surveys suggest are more likely to go without coverage because they believe they do not need it.[8] In survey data specific to Maine, adults between the ages of 25 and 34 were the most likely to report skipping needed medical care because of concern about cost.[9]

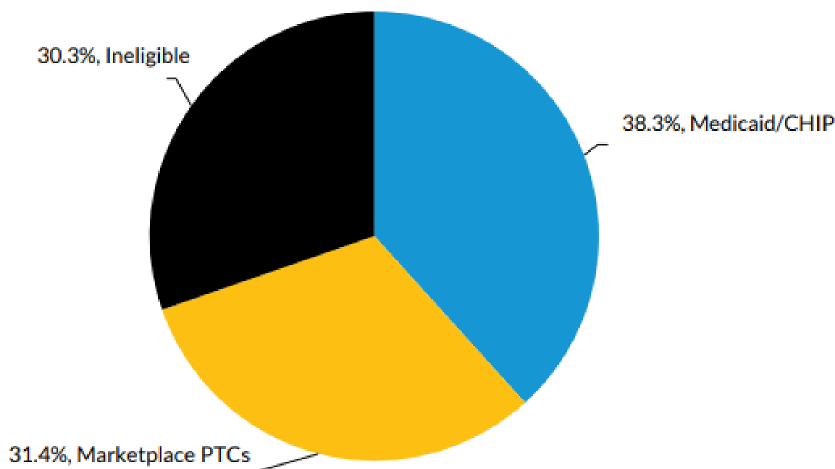
[8] Amy E. Cha and Robin A. Cohen, "Reasons for Being Uninsured Among Adults Aged 18–64 in the United States, 2019," Centers for Disease Control National Center for Health Statistics Data Brief, September 2020. https://www.cdc.gov/nchs/data/databriefs/db382-H.pdf

[9] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS 2022 Prevalence & Trends Data, accessed February 2024. https://www.cdc.gov/brfss/brfssprevalence/



Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.

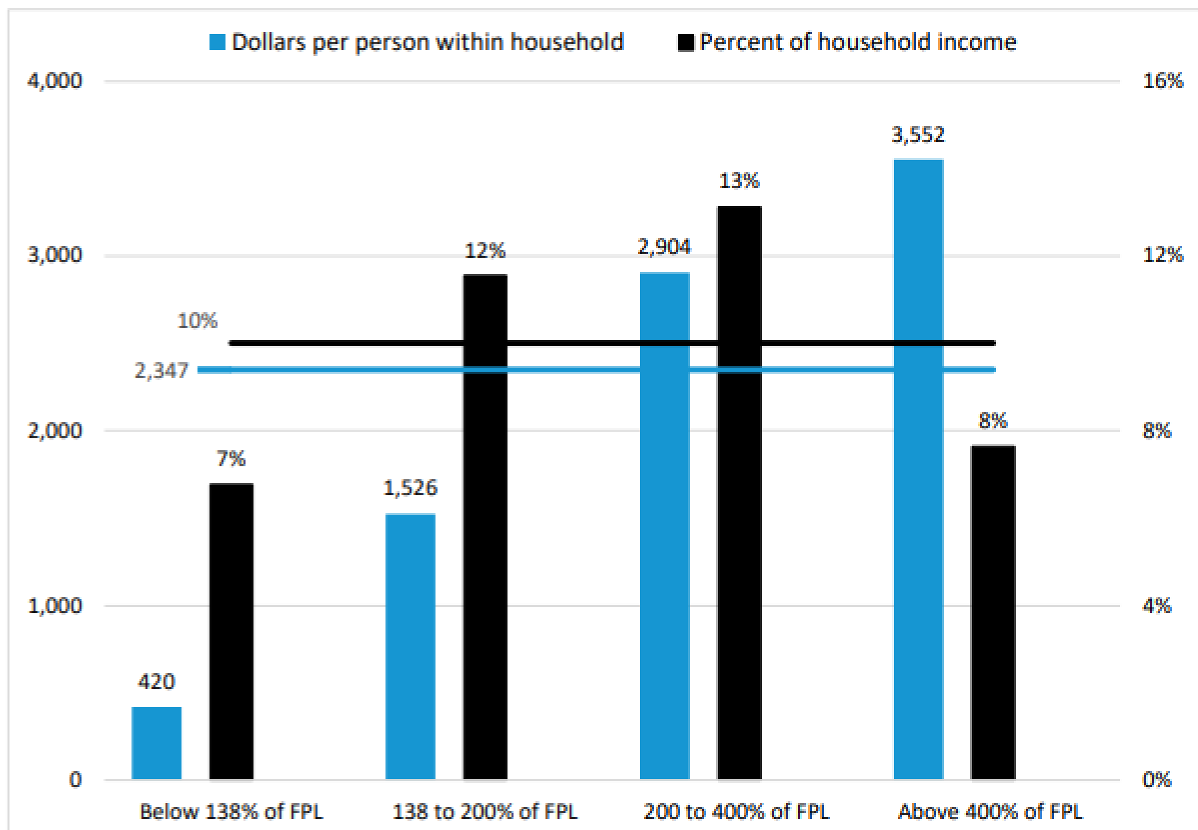
Of the remaining residents of Maine who are projected to be uninsured in 2025, roughly 70% are eligible for either MaineCare or Marketplace Premium Tax Credits. The remaining 30%, or 18,000 people, are ineligible, likely because income or an offer of affordable employer coverage disqualifies them from eligibility for tax credits, or because their immigration status makes them ineligible for public coverage programs.



Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.
Notes: PTC = premium tax credit, CHIP = Children's Health Insurance Program.

Lack of insurance is not the only affordability-related barrier to care. Many individuals with insurance struggle to afford care, and a recent survey found that 40% of insured Mainers had difficulty affording premiums or out-of-pocket costs. The burden of cost varies significantly based on the health care needs of a household, but on average, the Urban Institute report found that non-elderly Mainers will spend 10% of household income on health care in 2025, roughly in line with national estimates.[10] This spending includes the cost of premiums, any out-of-pocket costs (e.g. deductibles, co-insurance, and co-pays), as well as direct spending on services not covered by insurance. Households with incomes between 138% and 400% of FPL have the greatest cost burden as a percentage of income.

Household Health Spending of the Nonelderly in Maine, by Income Group, 2025



URBAN INSTITUTE

Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.
Notes: FPL = federal poverty level. Spending includes premiums paid by households, adjusted for taxes, and other out-of-pocket health spending.

OVERVIEW OF COMMERCIAL INSURANCE OPERATIONS

In order to consider how a public option may improve affordability, it is important to acknowledge how premiums and out-of-pocket costs for insurance are currently developed. Health insurance companies

[10] Peterson-KFF Health System Tracker, Household Health Spending Calculator, accessed February 2024. https://www.healthsystemtracker.org/household-health-spending-calculator/?_sft_hhsc_insurance=average&_sft_hhsc_size=average&_sft_hhsc_income=average&_sft_hhsc_health=average -health

develop premiums by using prior-year experience to project expenses for the coming plan year. In the individual and small group markets, premiums must be developed using "community rating," which considers the experience of the entire risk pool of the combined individual and small group markets. In the fully-insured large group market (covering businesses with 51 or more employees), insurers may use the specific utilization and cost data associated with the group of employees covered by the employer's plan. In their projections of costs for the coming year, insurers consider a variety of factors, including trends in utilization, the price of medical services and prescription drugs, and expected shifts in enrollment.[11]

Under rules established in the ACA, the majority of premium dollars collected by health insurance companies must be spent on payment for medical and prescription drug claims.[12] The reimbursement rates insurance carriers pay to in-network providers are negotiated in contracting processes, and there can be significant variation in the prices carriers pay.[13] Variation in these prices is largely a function of the relative market power of the insurance company and provider involved in the negotiation.[14]

In addition to projecting claims costs for the coming year, insurers also include administrative expenses, including operational functions, marketing of plans, as well as return on investment for for-profit insurance companies or a contribution to reserves for non-profit insurers. The ACA established a minimum "Medical Loss Ratio" (MLR) for different market segments, which limits the percent of total premiums collected that can be spent on administrative expenses. In the individual and small group markets, the MLR is 80%, meaning that no more than 20% of premiums may be spent on administrative costs and profits.[15] If insurance carriers fail to meet MLR, they are required to issue rebates to their members.

Overall, health insurers' profit margins are low relative to other industries. Nationally, the industry profit margin was reported at 3.3% in the National Association of Insurance Commissioner's 2023 Mid-Year Report.[16] In Maine, overall underwriting gain for 2022 was 2%, although individual company performance ranged from a 9% loss to a 23% gain.[17] Due to the enormous amount of spending on

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[11] National Association of Insurance Commissioners, "Product Filing Review Handbook," August 2016. https://content.naic.org/sites/default/files/inline-files/Product-Filing-Review-Handbook.pdf

[12] Uwe Reinhardt, "Where Does the Health Insurance Premium Dollar Go?" JAMA Forum, April 25, 2017. https://jamanetwork.com/channels/health-forum/fullarticle/2760129

[13] Nisha Kurani, Matthew Rae, Karen Pollitz, Krutika Amin, and Cynthia Cox, "Price transparency and variation in U.S. health services," Peterson-KFF Health System Tracker, January 13, 2021. https://www.healthsystemtracker.org/brief/price-transparency-and-variation-in-u-s-health-services/#Average%20allowed%20charges%20for%20an%20outpatient%20lipid%20panel%20(i.e.,%20cholesterol%20test)%20in%20large%20employer%20plans,%20by%20MSA,%202018

[14] Congressional Budget Office, "The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services," January 2022. https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf

[15] National Association of Insurance Commissioners, "Medical Loss Ratio," Update October 2023, accessed January 2024. https://content.naic.org/cipr-topics/medical-loss-ratio#:~:text=The%20medical%20loss%20ratio%20(MLR,as%20well%20as%20profits%20earned.

[16] National Association of Insurance Commissioners, "U.S. Health Insurance Industry Analysis Report, 2023 Mid-Year Results," 2023. https://content.naic.org/sites/default/files/inline-files/Health%202023%20Mid-Year%20Industry%20Report.pdf

[17] Maine Department of Professional and Financial Regulation, Bureau of Insurance, "2022 Financial Results for Health Insurance Companies in Maine," accessed January 2024. https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/Rule945_Report_Charts_Graphs.pdf

health care, even narrow margins can translate to significant dollar amounts. Maine's insurance carriers reported underwriting margins ranging from a gain of over $34 million to a loss of more than $18 million in 2022.

Notably, Maine's insurance market includes one of the last operating Consumer Operated and Oriented Plans (CO-OPs) in the country, Community Health Options. CO-OPs, authorized under the ACA, are non-profit plans that are required under federal law to reinvest any profits earned to lower premiums, enhance benefits, or improve care. The creation of CO-OPs was supported by federal funds in the form of loans to qualifying organizations. Community Health Options was awarded a total of more than $132 million in start-up and solvency loans by the program.[18]

OVERVIEW OF MAINECARE OPERATIONS

When considering a Medicaid-based public option model, it is important to note some of the ways in which the Medicaid program differs from commercial insurance. MaineCare is Maine's Medicaid program, a joint federal-state program providing coverage for children and adults who qualify based on age, disability, or family income. The Medicaid program was enacted in the Social Security Amendments of 1965, and MaineCare, like all state Medicaid programs, operates within a complex set of federal guidelines that significantly differentiates it from commercial health insurance. Most significantly, MaineCare is a publicly funded entitlement program, with very limited costs to enrollees which do not vary based on the cost of providing care or operating the program. The benefit package for MaineCare also includes services not covered by commercial health insurance, including long-term services and supports like nursing facility care and home and community-based services.

Medicaid programs are jointly financed by the state and federal governments. The federal government reimburses states for a share of their total costs based on the state's federal medical assistance percentage (FMAP), a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average. Maine's FMAP for federal fiscal year 2024 is 62.65%[19] meaning that the federal government pays 62.65% of the costs of care for most enrollees. The federal matching rate is higher for some populations including adults newly eligible following the expansion of MaineCare under the ACA, and certain children. The federal government also pays 50% of eligible expenses to administer the program, and higher matching rates for technology improvements and other program enhancement initiatives. Total combined federal and state expenditures for the MaineCare program in federal fiscal year 2022 were $3.87 billion.[20]

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[18] Congressional Research Service, "Consumer Operated and Oriented Plan (CO-OP) Program: Frequently Asked Questions," July 13, 2016. https://crsreports.congress.gov/product/pdf/R/R44414/7

[19] Medicaid and CHIP Payment and Access Commission, "Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPs (E-FMAPs) by State," December, 2023. https://www.macpac.gov/wp-content/uploads/2023/12/EXHIBIT-6.-Federal-Medical-Assistance-Percentages-and-Enhanced-FMAPs-by-State-FYs-2021%E2%80%932024.pdf

[20] KFF, "Total Medicaid Spending FY 2022," State Health Facts, accessed January 2024. https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22maine%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Many states have partially commercialized their Medicaid programs by contracting with insurance companies to administer coverage for some, or all, covered populations. In this model, known as managed care, the state pays a fixed or "capitated" per enrollee fee to the insurance company, which in turn negotiates rates with providers and handles other administrative functions for enrolled members. If the company is able to provide the required level of care for less than the capitated rate paid by the state, it retains the difference as profit, subject to a federal minimum MLR of 85%. Maine, however, does not utilize these types of contracts, and the MaineCare program is administered by the Office of MaineCare services within the Department of Health and Human Services.

Unlike commercial insurers, the MaineCare program does not negotiate reimbursement rates with providers. Instead, rates are set through legislative and administrative processes, and are often lower than commercial and Medicare payment rates. The Office of MaineCare Services is currently in the midst of a multi-year initiative to reform MaineCare reimbursement and institute a transparent, data driven approach to establishing payment rates to promote high-value and equitable care, and to ensure the sustainability of the program.[21]

THE ROLE OF WAIVERS

Some public option models require the waiver of certain provisions of federal law in order to meet the goals of program design. In particular, two waivers are frequently referenced in discussions of public option models.

I. **ACA Section 1332 Waivers.** The Affordable Care Act included a provision authorizing "State Innovation Waivers" that allow states to request the waiver of specific provisions of the ACA related to the individual and small group markets in order to test different approaches to accomplish the law's goals. 1332 waivers are required to be deficit-neutral and to ensure that coverage is at least as affordable and comprehensive as it would be without the waiver, and that the same or a greater number of people will be covered with the waiver as would be without it. If an approved waiver has the effect of reducing federal expenditures by lowering the amount of money the federal government would spend on Advanced Premium Tax Credits in the state's Marketplace, the state may request that those savings be passed-through to the state and used to implement the program authorized in the waiver.[22]

II. **Medicaid 1115 Waivers.** The Social Security Act also includes a section granting the Secretary of Health and Human Services the authority to approve innovative state projects with the potential to promote the objectives of the Medicaid program and better serve enrollees. 1115

[21] Maine Department of Health and Human Services, "MaineCare Rate System Reform," accessed January 2024. https://www.maine.gov/dhhs/oms/about-us/projects-initiatives/mainecare-rate-system-reform

[22] Sarah Lueck and Jessica Schubel, "Understanding the Affordable Care Act's State Innovation ("1332") Waivers," Center on Budget and Policy Priorities, September 5, 2017. https://www.cbpp.org/research/understanding-the-affordable-care-acts-state-innovation-1332-waivers

waivers must be budget neutral, meaning that the waiver will not be approved if it is projected to increase federal Medicaid spending.[23]

Federal law does include other waiver programs, though they are more narrow in scope. These include Medicaid Section 1915 waivers which allow for the provision of services in home and community-based settings, as well as waivers of certain Medicare laws to facilitate demonstration projects administered by the Center for Medicare and Medicaid Innovation. Federal law and regulations do not provide a pathway for states to seek the waiver of federal laws beyond the scope of these specifically authorized programs. Importantly, available waivers all have deficit or budget neutrality provisions specific to the federal programs they are associated with, and are evaluated independently.[24] This means that savings under one program (e.g., Medicaid) can not be used to offset higher spending in another (e.g., Marketplace Advance Premium Tax Credits). While waiver programs operate within the authority of federal law and regulation, there are also elements of the programs that have been subject to varying interpretations under different presidential administrations, so an additional consideration in designing a waiver-dependent program is the degree to which it aligns with priorities of the current or future administration overseeing it.

Maine currently operates programs authorized under 1332 and 1115 waivers. The federal government used 1332 authority to waive provisions related to rate review to allow for the merger of the small group and individual markets, and operation of a reinsurance program in the combined market. Both actions reduce premiums in the individual market, and consequently Maine receives pass-through funding from the federal government which is combined with an assessment on health carriers to fund the reinsurance program.[25] Maine also currently operates two approved 1115 waiver demonstrations. One provides defined benefits to individuals with HIV who would not otherwise qualify for MaineCare, while the other allows the state to receive federal matching funds for individuals receiving substance use disorder treatment in certain mental health facilities.[26]

PURPOSE AND UTILITY OF A PUBLIC OPTION

Public option plans have been proposed nationally and in other states to address specific market failures or promote desired outcomes. In order to provide value to consumers, a public option plan

[23] Catherine McKee and Jane Perkins, "Primer: State Plan Amendments v Section 1115 Waivers," National Health Law Program, May 20, 2021. https://healthlaw.org/wp-content/uploads/2021/06/Primer-on-SPA-v.-1115-FINAL.pdf

[24] United States Department of Treasury and Department of Health and Human Services, "Waivers for State Innovation," Federal Register Vol. 80 No. 241, December 16, 2015. https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation

[25] Maine Department of Professional and Financial Regulation, Bureau of Insurance, "State of Maine 1332 Waiver Amendment Application," February 10, 2022. https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/maine-section-1332%20waiver-complete-application-02-10-2022.pdf

[26] Maine Department of Health and Human Services, Office of MaineCare Services "Policy Waivers," accessed January 2024. https://www.maine.gov/dhhs/oms/about-us/policies-rules/policy-waivers

must be differentiated from existing available insurance options. The following is a discussion of possible justifications for a public option plan and the applicability of each in Maine.

INCREASING COMPETITION

Since the creation of the Health Insurance Marketplace in 2013, some states have struggled to ensure adequate carrier participation, particularly in certain low-population and/or low-income counties. In response, some states have considered establishing a public option plan – either to serve as a backstop to ensure at least one plan is available, or to provide a level of competition to prevent an effective monopoly by one commercial health insurance carrier.[27]

Like many states, Maine's individual market experienced some volatility in the early years of ACA implementation, but has largely stabilized in the past several years. Three insurance carriers currently offer Marketplace plans in all counties of the state, and a fourth entrant in 2023 also offers plans in the southern coastal region. Since 2022, the three largest Marketplace insurers have each had a market share ranging from 25%-40%, with shifts in market share each year.[28] Given existing carrier participation and the overall size of the market, it seems unlikely that the introduction of an additional public plan following commercial practices would exert any significant downward pressure on premiums.

CONTROLLING COSTS BY CONSTRAINING PROVIDER PRICES

Analysis of national claims data has demonstrated significant correlation between higher prices and hospital market power across geographies with varying insurer market structure, even after adjusting for input costs and quality of care.[29] Since insurance companies often must include certain hospitals or provider groups in their networks in order to meet network adequacy requirements and attract members, their ability to effectively negotiate lower prices in a consolidated provider market can be limited. Given the high level of consolidation in Maine's most populous region[30] a public option plan would likely face similar challenges, unless the model includes authority to set rates for some or all services or providers.

All of the public option models currently implemented or authorized in other states include constraints on reimbursement rates paid to providers as a means to deliver lower premiums and reduced out-of-

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[27] Nevada Department of Business and Industry, Division of Insurance, "Market Options Study – Discussion Paper," January 2018. https://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/News_and_Notices/Market%20Options%20Study%20-%20Discussion%20Paper%20-%201-3-18.pdf

[28] Maine Department of Health and Human Services, Office of the Health Insurance Marketplace, "2024 Open Enrollment Overview," February 2024. https://www.coverme.gov/sites/default/files/inline-files/2023%20Open%20Enrollment%20Overview%20CoverME.gov%282%29.pdf

[29] Zack Cooper, Stuart Craig, Martin Gaynor, and John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," National Bureau of Economic Research Working Paper, December, 2015 (Revised May, 2018). https://isps.yale.edu/sites/default/files/publication/2015/12/cooper_2015_pricing_variation_manuscript_0.pdf

[30] Health Care Cost Institute, "Hospital Concentration Index," updated June 2023, accessed January 2024. https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Concentration-Index

pocket costs to consumers. In Washington State, Cascade Select plans are subject to an aggregate provider reimbursement cap of 160% of Medicare rates. In Nevada and Colorado's models, insurance carriers are required to achieve premium reduction targets. In Colorado, if issuers fail to meet targets, the state is authorized to cap reimbursement for certain providers at a multiplier of Medicare rates, and to compel provider participation in issuer networks. In Nevada, there is no explicit cap on reimbursement, but providers participating in the public employee plan and/or Medicaid must also participate in at least one public option plan network, giving participating carriers greater leverage to deliver premium savings through lower reimbursement rates while ensuring that people have access to providers . Minnesota's legislation would allow the state to establish reimbursement rates in the public option plan through a regulatory process, and a recently released study assumes reimbursement in the public option would be equal to or less than Medicare rates.[31]

While lower provider reimbursement rates can yield lower costs for consumers, it is critical to assess provider's capacity to absorb lower rates in order to avoid harming access to care or increasing the prices charged to non-public payers. In addition to assessing the overall impact of rate setting within the public option plan, policymakers can also consider targeted initiatives to support certain provider types or locations. In Washington and Nevada, for example, the public option plans are subject to a "floor" on reimbursement for critical access hospitals and primary care providers.

ENROLLING MORE ELIGIBLE INDIVIDUALS, IMPROVING THE RISK POOL

Some public option models are designed to attract new consumers to the individual market, strengthening the risk pool and lowering premiums overall. To accomplish this, the public option must have features to attract new consumers who are either ineligible or eligible but uninsured. For example, Washington's Cascade Select utilizes a 1332 waiver to allow undocumented residents to enroll through the Marketplace, and provides a state-funded subsidy to those new enrollees as well as additional premium reductions for households with income up to 250% of the federal poverty level. Together, these initiatives are projected by the state to increase enrollment while slightly lowering premiums due to the newly eligible population having relatively low health care needs.[32] Annual federal savings of roughly $2 million projected in the waiver application, however, are a fraction of total state funding for the subsidy program, which is $55 million in 2024.[33]

The share of Maine's population with an undocumented immigration status is relatively low, making it unlikely that an expansion of eligibility or extension of subsidies to that group would meaningfully

[31] Fritz Bush, Michael Cook, Peter Fielek, and Alisa Gordon, "Milliman Report: State of Minnesota Department of Human Services Public Option Study," January 30, 2024. https://mn.gov/commerce-stat/insurance/industry/policy-data-reports/2024_public_option_report.pdf

[32] Washington Health Benefit Exchange, "Washington Section 1332 Waiver Application," August 3, 2022. https://www.wahbexchange.org/content/dam/wahbe-assets/materials/state-legislation/WA%20Section%201332%20Waiver%20Application-updated%208-3.pdf

[33] Ibid.

impact the individual and small group market risk pool.[34] Given the relatively high share of uninsurance among young adults in Maine, however, and their lower than average utilization of care,[35] a public option that effectively attracts more enrollment from that demographic could potentially improve the risk pool and modestly lower premiums.

SIMPLIFYING CHOICES AND LOWERING OUT-OF-POCKET COSTS

While premiums are an important element of insurance affordability for consumers, out-of-pocket costs can also be a major barrier to care. Individuals enrolled in insurance must generally meet a deducible before most services are covered by their plan and after meeting the deductible, most services are subject to a copay (a flat fee) or co-insurance (a percentage of the negotiated rate) until the plan's maximum out-of-pocket amount is reached.

Plans sold in the fully-insured small group and individual market are grouped into metal levels of bronze, silver, gold, and platinum, which reflect the proportion of an average enrollee's health needs that are paid by the health insurance carrier, as opposed to the member. This measure is known as "actuarial value" (AV) of the plan. Bronze plans cover 60% of average expenses, silver cover 70%, gold cover 80%, and platinum cover 90%. Although metal levels can be helpful in understanding the varying value of plans in a general sense, they still allow for considerable variation because carriers can use almost limitless variations in cost sharing structure to meet AV requirements, and they are also granted some flexibility to vary AV within a "de minimis" threshold established by the federal Centers for Medicare and Medicaid Services (CMS). Additionally, AV is not particularly helpful as a predictor of a particular individual or family's total health care spending, since it does not account for variation in utilization or the types of services used.[36]

While the presence of a variety of plans may have some utility to consumers in terms of providing choices and allowing plans to prioritize the design of low premium plans, a considerable body of evidence suggests that a large variety of plan choices results in poor consumer decision-making and foregone savings.[37] To counteract that effect, regulators can require standardization of plans, limiting the variation of cost-sharing structures, deductibles, and out-of-pocket costs to foster competition

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[34] Pew Research Center, "What we know about unauthorized immigrants living in the U.S.," November 16, 2023. https://www.pewresearch.org/short-reads/2023/11/16/what-we-know-about-unauthorized-immigrants-living-in-the-us/

[35] Matthew McGough, Gary Claxton, Krutika Amin, and Cynthia Cox, "How do health expenditures vary across the population?" KFF-Peterson Health Tracker, January 4, 2024. https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/#Share%20of%20overall%20out-of-pocket%20spending,%20by%20percentile,%202021

[36] Ryan Lore, Jon R. Gable, Roland McDevitt, and Michael Slover, "Choosing the "Best" Plan in a Health Insurance Exchange: Actuarial Value Tells Only Part of the Story," The Commonwealth Fund Issue Brief, August 2012. https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2012_aug_1626_lore_choosing_best_plan_hie_actuarial_ib_v2.pdf

[37] Jason Abaluck and Jonathan Gruber, "Improving the Quality of Choices in Health Insurance Markets," National Bureau of Economic Research Working Paper, December 2016. https://www.nber.org/system/files/working_papers/w22917/w22917.pdf

among plans based on network and premium.[38] Most states implementing standard plans have also sought to increase the value of plans for consumers by including more services before the deductible and utilizing co-pays, rather than co-insurance, as much as possible to make health expenses more predictable.[39] While these goals can be advanced without a public option, Washington and Colorado's public plans have been designed to build on the states' existing standardization requirements by ensuring that the public plans offer clearly delineated and consumer-oriented cost-sharing structures.

The Made for Maine Health Coverage Act, passed in 2020, included a provision requiring the standardization of most plan offerings in Maine's regulated health insurance markets. Since plan year 2023, most plans must conform to one of the "Clear Choice" designs established annually by the Bureau of Insurance, although the Superintendent may approve up to three alternative designs per carrier if they are determined to benefit consumers. During the annual Clear Choice design process, consumer advocates have generally encouraged greater adoption of co-pay structures and a reduction in available designs to simplify options, while carrier representatives have generally prioritized continuity for members and premium considerations.[40]

If a public option plan were introduced and permitted to deviate from Clear Choice Designs and offer an even more simplified benefit design, it could present an opportunity to allow for consumer choice between more typical Marketplace plan offerings and a highly simplified design. Given the strong price sensitivity of health insurance consumers,[41] however, as well as choice inertia that contributes to high rates of passive re-enrollment,[42] it would likely require significant effort to educate consumers about the public option plans and encourage comparison shopping.

REDUCING COSTS VIA ADMINISTRATIVE SIMPLIFICATION

Some proponents of a public option have suggested that lower premiums can be achieved through efficiency and administrative simplification in a public plan. Both traditional Medicare and Medicaid have lower billing and insurance related expenses than commercial health plans.[43] While a lack of profit motive and lower per capita administrative costs are likely contributors, some of this difference

[38] Rose C. Chu, Jacquelyn Rudich, Aiden Lee, Christie Peters, Nancy De Lew, and Benjamin D. Sommers, "Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, December 28, 2021. https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf

[39] Ibid

[40] Maine Department of Professional and Financial Regulation, Bureau of Insurance, "Clear Choice Plans," accessed February 2024. https://www1.maine.gov/pfr/insurance/news-public-notices/other-news-and-updates/clear-choice-plans

[41] John Holahan, Linda J. Blumberg, and Erik Wengle, "Marketplace Plan Choice: How Important is Price? An Analysis of Experience in Five States," Robert Wood Johnson Foundation and Urban Institute, March 2016. https://www.urban.org/sites/default/files/publication/78761/2000660-Marketplace-Plan-Choice-How-Important-Is-Price-An-Analysis-Of-Experiences-in-Five-States.pdf

[42] Coleman Drake, Bryan Dowd, and Conor Ryan, "Sources of Consumer Inertia in the Individual Health Insurance Market," The Center for Growth and Opportunity at Utah State University, November 18, 2019. https://www.thecgo.org/research/sources-of-consumer-inertia-in-the-individual-health-insurance-market/

[43] Emily Gee and Topher Spiro, "Excess Administrative Costs Burden the U.S. Health Care System," Center for American Progress, April 8, 2019. https://www.americanprogress.org/article/excess-administrative-costs-burden-u-s-health-care-system/

may also be attributable to operational differences including administratively set prices, the exclusion of prescription drug benefit administration from the traditional Medicare program, and less need to market coverage to enrollees. To the extent that meaningful savings are possible from reduced administrative costs and lack of profit motive in a public option plan, they may also be offset if program design choices result in higher costs from increased utilization and adverse selection.[44] Since even the most expansive state public option would not eliminate the presence of Medicare and national employer sponsored plans in Maine, it also would not create an opportunity to overhaul administrative processes for health care providers, limiting any potential savings or burden relief. Consequently, while administrative efficiency may be a benefit of a public option plan, it seems unlikely that significant consumer cost relief could be funded through administrative savings alone.

DESIGN CONSIDERATIONS

Assessing the impact of a public option plan requires that the model specify several key design elements. Many of these decision points interact and cannot be considered in isolation. If policymakers have a strong perspective on a given design element, though, it may help to narrow the range of feasible models.

ELIGIBILITY & TARGETED POPULATIONS

Core to the design of a public option is identifying the population to be eligible for the plan. Generally broader eligibility for a public option is likely to cause more significant market disruption than a narrower approach.

Marketplace consumers – subsidized or unsubsidized. To date, most authorized public option programs in other states have focused on using the Marketplace to reach individual market consumers. One major advantage of offering a public option through the Marketplace is that qualifying consumers can benefit from available federal APTC, ensuring that federal dollars can be leveraged to reduce premiums for most enrollees. There are Marketplace consumers purchasing coverage at full price, with roughly 17% of enrollees in Maine's Marketplace enrolling without APTC.[45] While some may qualify and decline to receive APTC because of tax concerns, the majority of these are likely to be ineligible either because their income is too high or because they already receive an offer of affordable insurance through their job. When considering the introduction of a public option in the Marketplace, it is important to consider whether the plan primarily aims to reduce premiums for unsubsidized consumers or those who receive APTC. Depending on the model structure and pricing strategy the impact may not be consistent across these populations, and lower base premiums may even increase

[44] https://www.brookings.edu/articles/designing-a-public-option-that-would-reduce-health-care-provider-prices/

[45] Maine Department of Health and Human Services, Office of the Health Insurance Marketplace, "2024 Open Enrollment Overview," February 2024.

actual costs for subsidized consumers, a dynamic discussed in more detail in the Pricing and Market Dynamics section below.

Undocumented residents. Individuals who do not have a documented immigration status are among the most likely to be uninsured,[46] and are ineligible under federal law to enroll in health insurance coverage through the Marketplace, even at full cost. Recently, however, the federal government has approved waivers in Colorado, Washington, and New York to provide pathways to enrollment for this population, although they continue to be ineligible for APTC.

Employers. While the individual market has been the focus of most states' public option models, a public option could also be offered to employers, either in addition to an individual market public option or an alternative to it. One consideration in an employer-inclusive model would be the potential shifting of cost from employers to the government. New Mexico's Medicaid Forward concept accounts for the role of employers in providing coverage by requiring large businesses whose employees enroll in the plan to contribute the average monthly premium cost for an enrollee.[47] When considering an employer public option, policymakers should also consider whether all, or just a subset of businesses would be eligible. Small employers generally face higher premiums than large employers, and a model targeting them may be less disruptive, but including larger employers would likely ensure a more stable risk pool for the plan.[48]

Medicare enrollees. All public option plans considered in other state have, directly or indirectly, excluded Medicare-eligible populations from enrolling in the plan. Allowing enrollment by Medicare-eligible individuals presents a significant financing challenge, since it would shift costs currently subsidized by the Medicare Trust Fund onto enrollees or the state. If policymakers are contemplating a very low cost and/or generous benefit plan as a public option, however, it may be politically difficult to exclude Medicare eligible populations.

BENEFIT AND COST-SHARING STRUCTURE

The design of a public option plan must contemplate the benefit structure of the plan or plans available. This includes decisions about whether services not usually covered by commercial health insurance should be included (e.g., dental coverage) as well as how much the enrollee will pay out of pocket. Generally, unless the plan includes either subsidies or mechanisms to constrain prices, the greater the generosity of a plan, the higher the premium will be. There are opportunities, however, to

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[46] Justin Giovanelli and Rachel Swab, "States Expand Access to Affordable Private Coverage for Immigrant Populations," The Commonwealth Fund, February 8, 2024. https://www.commonwealthfund.org/blog/2024/states-expand-access-affordable-private-coverage-immigrant-populations

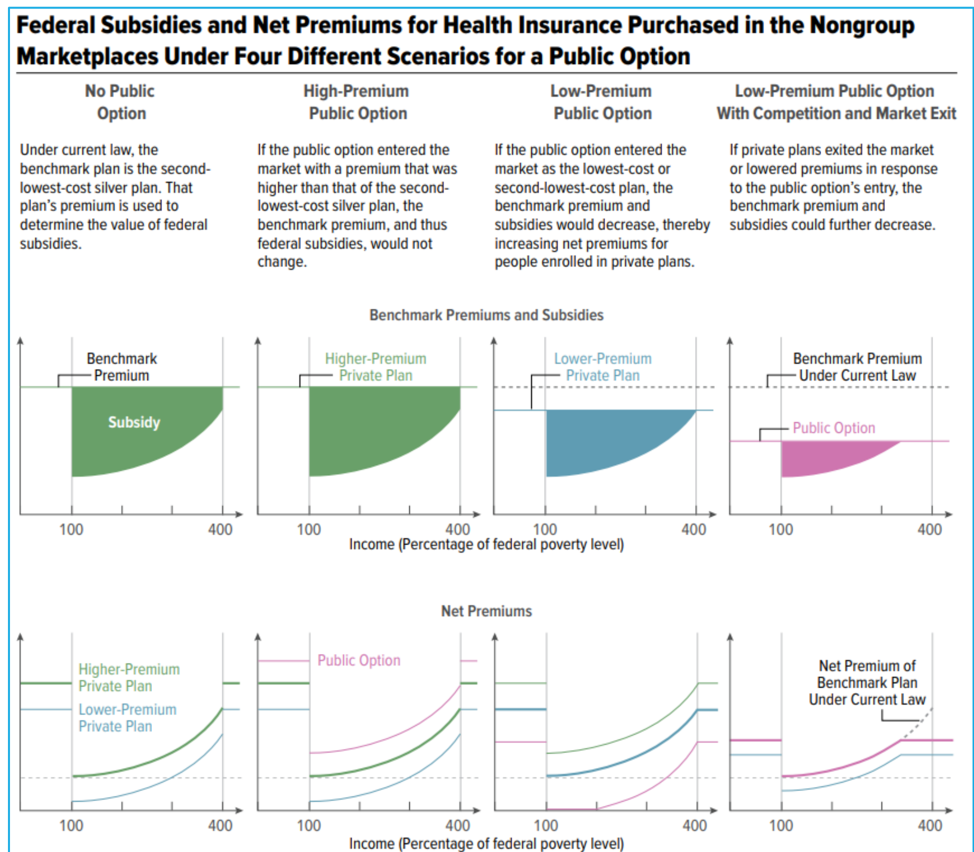
[47] Matthew Buettgens, Jason Levitis, Jessica Banthin, Urmi Ramchandani, and Michael Simpson, "Medicaid Forward in New Mexico: Health Coverage, Health Care Spending, and Government Costs," August 2023 (updated September 2023). https://www.urban.org/research/publication/medicaid-forward-new-mexico

[48] Natasha Murphy, Sam Hughes, and Nicole Rapfogel, "The Employer Public Option: A Tool for Improving Affordability via Alternative Health Coverage," Center for American Progress, January 25, 2024. https://www.americanprogress.org/article/the-employer-public-option-a-tool-for-improving-affordability-via-alternative-health-coverage/

maintain premiums while lowering the out-of-pocket costs associated with certain high-value or high priority services by increasing cost sharing on other service categories.[49] When considering the benefit design of a public option plan, policymakers should consider how design may impact the utilization of care, as well as the consumers attracted by the plan. A public option with higher premiums but lower cost-sharing may be more likely to attract consumers in need of higher than average amounts of care, a situation known as adverse selection.

PRICING AND MARKET DYNAMICS

Decisions about product pricing will depend heavily on choices about the benefit structure of the plan and provider reimbursement, but also can have implications for the state's health insurance market more broadly. In particular, the amount of APTC provided by the federal government is tied to the cost of the specific Marketplace's "benchmark" plan – the second lowest-cost silver plan offered to consumers. This can cause a tension between the effect of lowering total premiums and lowering actual premiums for subsidized consumers. If the public option is the lowest, or second-lowest, silver plan offered on the Marketplace, and is offered at a lower premium than existing options, it will reduce the amount of federal subsidy available to all enrollees. The accompanying figure from the Congressional Budget Office demonstrates this effect under three different public option scenarios.[50]



Federal Subsidies and Net Premiums for Health Insurance Purchased in the Nongroup Marketplaces Under Four Different Scenarios for a Public Option

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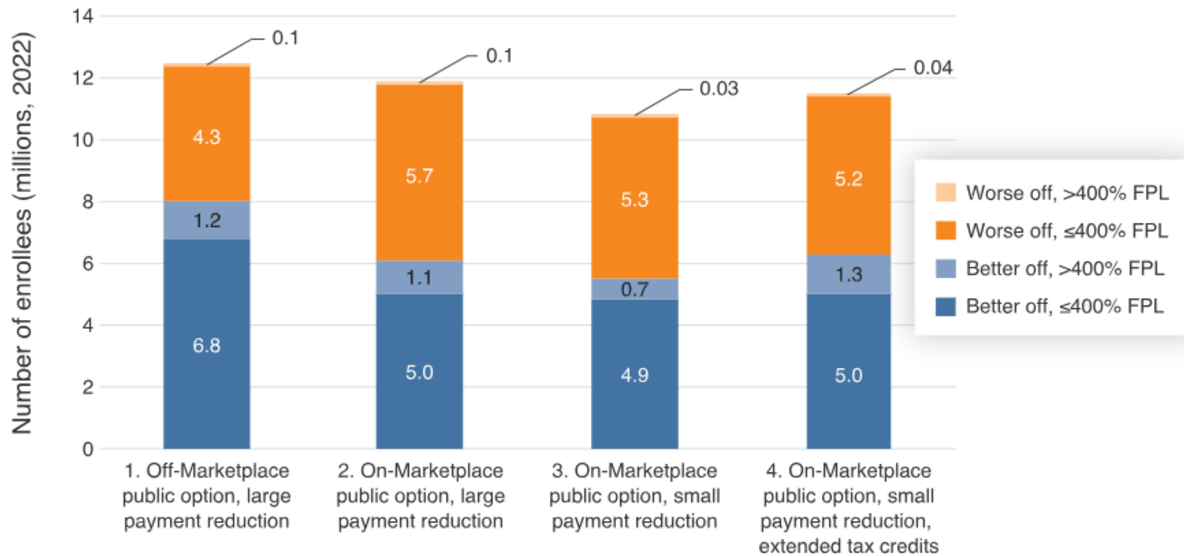
[49] Rose C. Chu, Jacquelyn Rudich, Aiden Lee, Christie Peters, Nancy De Lew, and Benjamin D. Sommers, "Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, December 28, 2021. https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf

[50] Congressional Budget Office, "A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications," April 2021. https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf

The impact of a low-premium public option varies based on both the income and the plan choice of an individual or family. In 2020, the Rand Corporation modeled the impact of four different versions of a federal public option, and found that few unsubsidized consumers would be negatively impacted by a public option plan, but that the impact on lower-income consumers was split, particularly in public option plans offered on the Marketplace.[51]



It may be possible to mitigate the impact of this reduction in available APTC by combining a public option plan with a 1332 waiver, in order to capture and re-invest any savings to the federal government from a reduction in premiums. This may not be workable, however, if the public option results in greater enrollment because of the deficit neutrality requirement of section 1332.

Another consideration is how a public option plan in the individual market may impact employer-sponsored insurance. If a comprehensive and low-cost plan is available to consumers in the individual market, the value of insurance as a benefit to employment may decline, and small businesses may forgo offering coverage. In this scenario, state government may see increased revenue in the form of higher income and payroll taxes associated with wage increases, but if there is a significant shift in the cost of coverage from employers to the government, it may also be necessary to capture some funding from those employers in the form of additional taxes or fees.

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[51] Jodi L. Liu, Asa Wilks, Sarah A. Nowak, Preethi Rao, Christine Eibner, "Effects of a Public Option on Health Insurance Costs and Coverage," RAND Research Brief, May 28, 2020. https://www.rand.org/pubs/research_briefs/RB10120.html

PROVIDER REIMBURSEMENT AND PARTICIPATION

Key to the success of a public option plan is ensuring robust provider participation in the plan. As discussed above, other state public option plans have achieved premium savings in the public option in part by constraining the prices paid to providers in the plan. Washington has done so directly by implementing a requirement that insurers offering public option plans limit their aggregate provider reimbursement levels to 160% of Medicare rates, and Minnesota's study contemplates reimbursement rates either consistent with the state's existing Basic Health Program, which are estimated to be roughly 83% of Medicare reimbursement, or at 100% of Medicare rates.[52] A public option plan that targets primarily uninsured populations is better positioned to implement lower rates since it would cover a group that currently utilized uncompensated care resources. If the public option would attract enrollment from individuals currently covered by commercial plans, policymakers would need to assess and balance any potential impact on providers and access to care with the cost savings resulting from the established reimbursement rates.

Providers may be incentivized to join through competitive reimbursement rates, or their participation may be mandated directly or indirectly (e.g. by tying public option participation to eligibility for MaineCare reimbursement or inclusion in the public employee health plan network). If a mandate approach is used, policymakers may need to consider whether it provides sufficient incentive to ensure an adequate network across services and geographic regions. The State Employee Health Plan, for example, may have relatively low enrollment in some counties, and some sub-sets of services (e.g., dental care) may have lower rates of provider participation in MaineCare. The design will also need to consider whether and how coverage will extend to out-of-state providers, who would not be subject to Maine law.

ADMINISTRATION

In establishing a public option program, a state must determine what division of state government will be responsible for implementing the program. This decision will be heavily influenced by the model selected. For example, if the state elects to administer a Medicaid buy-in, it's likely that the Medicaid agency would take primary responsibility for the program. An advantage of utilizing a Medicaid agency to administer any public option plan would be to leverage the existing plan administration functions that the agency already conducts. This kind of hybrid model may also introduce complexity, however, since the Medicaid agency would need to carefully allocate and track expenditures on different

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[52] United States of Care, "State Public Health Insurance Options: A Comparison," September 17, 2021, (updated February 1, 2024). https://unitedstatesofcare.org/state-public-health-insurance-options-a-comparison/

programs to ensure that federal Medicaid administrative matching funds are not being inappropriately used.

As an alternative to the Medicaid agency, the insurance regulatory agency, State Employee Health Plan, or the state health insurance Marketplace could oversee the plan, leveraging the health insurance policy experience within those agencies. If the state is administering the plan, these agencies would likely need significant appropriations in order to establish all the necessary functions of an insurance carrier, before premium revenue becomes available. An additional consideration, particularly for the Bureau of Insurance and Office of the Health Insurance Marketplace, would be how the entities would balance their regulatory and oversight duties with the operation of the plan.

To date, all enacted public option models in other states have utilized a hybrid public-private model for plan administration. In Colorado, all carriers offering plans in the Marketplace are required to offer the Colorado Option plan, and meet specific benefit, cost reduction, and health equity requirements. In Washington, the state enters into contracts with carriers to offer the Cascade Select public option plans. Nevada's plans for implementation of the public option includes leveraging the state's Medicaid infrastructure and providing coverage partially through carriers that also participate in the state's managed care program.

ENSURING QUALITY CARE

A public option plan will generally be subject to minimum requirements related to the quality and accessibility of care based on the structure of the plan. For example, if the plan is offered as a Qualified Health Plan on the Marketplace, it must meet network adequacy and essential community provider requirements, and participate in CMS quality reporting and quality improvement initiatives. Increasingly, Medicaid programs that utilize managed care organizations are being directed to implement similar oversight structures, and CMS has also released a proposed rule creating a program to evaluate access to providers in state-managed programs.[53]

Many states implementing a public option have aimed to exceed these minimum standards, and utilize the public plan as a tool to address identified health inequities. Laws establishing public option plans in both Colorado and Nevada included explicit requirements to promote health equity.[54] Colorado implemented this requirement by instituting a first-of-its-kind requirement that plan networks be "culturally responsive" and set higher standards for participation by Federally Qualified Health Centers and certified nurse midwives.[55]

[53] Centers for Medicare Medicaid Services, "Fact Sheet: Summary of CMS's Access-Related Notices of Proposed Rulemaking," April 27, 2023. https://www.cms.gov/newsroom/fact-sheets/summary-cmss-access-related-notices-proposed-rulemaking-ensuring-access-medicaid-services-cms-2442-p

[54] Jamila Taylor and Thomas Waldrop, "States Must Prioritize Health Equity as They Expand Coverage through Public Options," The Century Foundation, September 8, 2022. https://tcf.org/content/report/states-must-prioritize-health-equity-as-they-expand-coverage-through-public-options/

[55] Ibid.

PUBLICLY ADMINISTERED PUBLIC OPTION MODELS

The legislature specifically directed that the Office of Affordable Health Care study models for a public option that is fully publicly administered. The following section describes three possible models for administering a plan, with a discussion of potential pros and cons. Each of these models would require further refinement and some elements could be adjusted based on program goals.

MAINECARE BUY-IN

A MaineCare Buy-in model would operate a plan based on the benefit package and provider rates established in the MaineCare program. Such a plan could take one of two forms:

I. Expanded MaineCare eligibility. Under section 1902(a)(10)(A)(ii)(XX) of the Social Security Act, state Medicaid programs may expand eligibility to adults under age 65, up to an income threshold established by the state.[56] The plan would need to meet all federal requirements for Medicaid programs, and the combined cost of premiums and out-of-pocket costs would be limited to no more than 5% of household income. The federal government would pay for a portion of program expenditures at the state's established FMAP.

II. A separate program established and operated using MaineCare infrastructure. The state could establish a separate plan based on the benefit, reimbursement, and cost-sharing structure of MaineCare, and require provider participation in the plan as a condition of MaineCare participation. This model would provide more flexibility to adjust the benefit structure, charge higher premiums and cost-sharing for participants, and adjust reimbursement rates to providers. Importantly, however, no federal matching funds would be available, and the program would need to be fully supported by a combination of general fund revenue and premiums.

An advantage of offering a MaineCare-based public option plan would be the relative administrative simplicity of utilizing existing MaineCare infrastructure for some aspects of plan operations. While increased enrollment would likely require additional resources to scale up variable expenses, there are existing structures that could be leveraged for rate setting, claims processing, provider relations, and appeals. There would also be new functions associated with the expansion of MaineCare to higher income ranges, in particular the calculation and collection of premiums for coverage, given their very limited use in the existing program.

A major challenge of the model would be financing, in light of the significant cost associated with providing a broad set of benefits with very limited cost-sharing and low premiums. The state of New Mexico has studied a model using the first option, expansion of Medicaid eligibility, and found that the

[56] Medicaid and CHIP Payment and Access Commission, "Medicaid Buy-In: Program Options and Considerations," April 2020. https://www.macpac.gov/wp-content/uploads/2020/04/Medicaid-Buy-In-Program-Options-and-Considerations.pdf

state share of funding would total several hundred million dollars.[57] Maine could likely expect higher funding to be necessary, given the state's lower FMAP rate and comparable eligible population.[58] Additionally, New Mexico has existing sources of significant funding that would be repurposed to cover program costs, including a high-risk pool and a premium tax on all fully-insured plans.

Depending on where the income limit for eligibility is set under a MaineCare buy-in plan, this option would also be likely to significantly impact the individual and group markets in Maine. If a significant portion of individuals currently enrolled in Marketplace coverage were to become eligible for the MaineCare plan, they would no longer be eligible for federal APTC, and there may no longer be sufficient participation to sustain carrier participation in the health insurance Marketplace. Since a Medicaid expansion model would not exclude individuals with employer-sponsored insurance, it would also be likely to cause some employers to cease offering health insurance to employees. This would shift some costs from employers and enrollees onto the state, although some revenue could be recaptured through income and payroll taxes if reduced health insurance costs result in increased wages.

Another important consideration in the plan is the rate of reimbursement to providers. MaineCare rates (like Medicaid rates nationally) are generally lower than other payers. Relying on rates at, or close to, MaineCare would be certain to raise major concerns about impacts on providers in the state, particularly if the plan enrolled a significant proportion of individuals previously covered in commercial plans. New Mexico's study addresses this concern by contemplating the possibility of increased reimbursement rates across the entire Medicaid program, a particularly impactful proposal given the state's high enrollment in Medicaid currently,[59] but which increases the state cost to operate the program.

PUBLICLY ADMINISTERED COMMERCIAL PLAN

An alternative model to a Medicaid buy-in would be to offer a public option modeled more closely on the structure of existing commercial health plans. Under this model, the plan would be designed to be supported primarily by member premiums, although those premiums could be further subsidized using state funds. In order to ensure that members could benefit from federal APTC, the plan would need to meet federal requirements to be deemed a Qualified Health Plan (QHP) including offering all essential health benefits, following limits on cost-sharing and complying with metal tier AV requirement, and participating in quality improvement initiatives.

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[57] Matthew Buettgens, Jason Levitis, Jessica Banthin, Urmi Ramchandani, and Michael Simpson, "Medicaid Forward in New Mexico: Health Coverage, Health Care Spending, and Government Costs," August 2023 (updated September 2023).

[58] KFF, "Health Insurance Coverage of the Total Population, 2022," State Health Facts, accessed January 2024. https://www.kff.org/other/state-indicator/total-population/?dataView=1¤tTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-mexico%22:%7B%7D,%22maine%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[59] Matthew Buettgens, Jason Levitis, Jessica Banthin, Urmi Ramchandani, and Michael Simpson, "Medicaid Forward in New Mexico: Health Coverage, Health Care Spending, and Government Costs," August 2023 (updated September 2023).

Depending on program goals, a public option under this model can be designed to compete alongside commercial insurers. A major advantage of this approach would be minimizing disruption and preserving choice for consumers. While choice for choice's sake is not necessarily to consumer's benefit, health care coverage is not always one-size fits all, especially when tradeoffs are necessary. Some consumers may highly value the breadth of the network of their plan, for example, while others would gladly accept a narrower network in order to have a lower premium.

In considering a market-focused public option, policymakers should consider whether there are specific populations who are not well-served by the current system, or aspects of commercial insurance that they believe are causing particular friction for a large number of consumers. In Washington, for example, there was a strong desire to provide coverage for undocumented residents who were previously excluded from any coverage, and to lower out-of-pocket costs for the lowest-income enrollees. In Colorado, the state focused on exerting greater pressure on commercial insurers to lower premium increases over time by creating efficiencies and negotiating lower payment rates to providers if needed. A public option does not need to replace commercial insurance in order to be successful if it is designed to fill a gap or better meet the needs of a subset of residents, while existing alongside private plans.

Depending on the goals and scope of the model, it would likely be the lowest-cost to operate since premiums could be set based on actuarial analyses and beneficiaries. It would not be without cost though. One challenge of the model would be developing the necessary infrastructure to operate a new health plan within state government. While state government has insurance purchasing experience outside of MaineCare as the sponsor of the State Employee Health Plan, that model utilizes a contracted insurance company for administrative functions. To operate a public plan would require building both staff and technology systems to manage enrollment, claims, premium processing, marketing, and other functions. The program would also need to be sufficiently capitalized to ensure that it could cover claims from members in a variety of enrollment and utilization scenarios. While Maine state law requires new entrants to the major medical market to have a minimum of $2 million in capital and surplus, the Superintendent of Insurance is also responsible for ensuring that the company's initial surplus is sufficient to support its obligations.[60] The amount of funding necessary to meet this requirement would vary based on the projected enrollment of the plan, and other factors, but would be significant particularly if the envisioned public option model was likely to attract high enrollment.

BASIC HEALTH PROGRAM

The Basic Health Program (BHP) was created in the ACA as an option for states that wish to directly cover individuals above 138% of FPL. Under the program, the federal government will provide the state

[60] Maine Department of Professional and Financial Regulation, Bureau of Insurance, Rule Chapter 231: Certificates of Authority for Insurance Companies. 02-031 C.M.R Ch. 231 § 4(D)(2) (2005).

with 95% of the funds it would have otherwise expended on APTC for individuals with incomes up to 200% of FPL. The state can use those funds to offer a plan that is at least as affordable as the "benchmark" silver plan offered through the Marketplace. To-date, two states have elected to operate a BHP: New York and Minnesota. Both states utilized the option to continue the operation of state programs that pre-dated the enactment of the ACA, and both utilized the state's Medicaid program as the basis for coverage under the BHP. New York recently expanded access to its BHP to include individuals with incomes up to 250% FPL and submitted a recently-approved 1332 waiver enabling the state to receive federal pass-through to fund the expansion.[61] Oregon is in the process of implementing a BHP, with coverage beginning July 2025.[62] Other states, including Kentucky, have been considering the impact of establishing a BHP as well.

An advantage of the BHP model is the opportunity to create a hybrid plan that can leverage Medicaid operations and payment rates, while offering flexibility to adjust benefits and cost-sharing. States that have considered a BHP often approach the plan as a way to create a "bridge" between Medicaid and the individual commercial health insurance market. BHPs have also been attractive to states because while it is by no means fully insulated from politics, the structure of the program offers a defined pathway to federal approval and pass-through of funding.

There are also several challenges associated with the BHP model, however. First, enrollees under 200% of FPL enrolled in the Marketplace currently benefit from Cost-Sharing Reductions (CSRs) which lower deductibles, co-pays, co-insurance, and maximum out-of-pocket costs for silver level plans. These CSRs were originally funded by the federal government through payments to insurers, but in 2017 that practice was discontinued following a re-interpretation of the authorizing statute. In order to sustain the program, insurance regulators in most states, including Maine, implemented a strategy known as "silver loading," in which the cost of providing CSRs is built into the silver level premiums of on-Marketplace plans. This strategy results in the federal government paying a higher level of APTCs for Marketplace enrollees, largely replacing the funding necessary to offer CSRs to qualifying Marketplace enrollees. An additional benefit is that it increases the level of subsidization of all APTC eligible consumers by increasing the benchmark premium. If a state implements a BHP, however, CSR enrollment (and therefore the required rate of silver-loading) will dramatically decrease. That may lead to higher net premium costs for APTC-eligible consumers earning more than 200% of FPL.[63] An additional consideration of the BHP option is that it removes BHP enrollees from the individual risk

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[61] New York State Department of Health, "New York Section 1332 Innovation Waiver Essential Plan Expansion," May 12, 2023. https://info.nystateofhealth.ny.gov/sites/default/files/NY%201332%20Waiver%20Application_5.12.2023.pdf

[62] Oregon Health Authority, press release: "Oregon receives state approval for Basic Health Program," September 12, 2023. https://content.govdelivery.com/accounts/ORHA/bulletins/36ffef4

[63] Sabrina Corlette, Jason Levitis, Erik Wengle, and Rachel Swindle, " The Basic Health Program: Considerations for States and Lessons from New York and Minnesota," April 2023. https://www.urban.org/sites/default/files/2023-04/The%20Basic%20Health%20Program%20Considerations%20for%20States%20and%20Lessons%20from%20New%20York%20and%20Minnesota.pdf

pool. Depending on the risk profile of the population, that segmentation could impact the risk pool positively or negatively.[64]

CONCLUSION

The development and implementation of a public option plan is a significant undertaking that involves careful consideration of varying impacts and cost-benefit analysis. In considering a public option for Maine, policymakers should focus on three areas to clearly define the goals of the program and lay the groundwork for a successful proposal.

First, it is essential to articulate specific priorities for a public option in terms of their policy impact. This should include both the desired outcome of the policy and the populations of focus. Clarity of purpose is essential to navigating the multitude of design decisions required to develop a public option, and to making the case for the impact of the initiative.

Second, as discussed above, a successful public option must be differentiated from options already available to consumers, generally by providing value in the form of lower premiums or better benefits at a similar cost. The efforts of other states have demonstrated that it is necessary to include some elements of state-funded consumer cost-relief or place constraints on margins for system participants including health insurance carriers and health care providers in order to deliver meaningful relief to consumers. This means that creation of a public option program requires significant political will and often faces opposition from industry and other stakeholders.

Finally, public option models should be assessed alongside other potential policy initiatives that have the potential to increase consumer affordability. A variety of other policy interventions have been considered or implemented in other states including state-funded subsidy programs, integration of affordability standards in insurance rate review, promoting value-based benefit designs and payment models, and implementation of a cost growth target.[65] Depending on the outcome policymakers are looking to achieve, other policy interventions may be either more effective or more efficient than creating a public option.

The Office of Affordable Health Care welcomes engagement with policymakers on the considerations outlined in this report, and stands ready to assist with the continued consideration of a public option plan, pending further direction.

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[64] Ibid.

[65] Ann Hwang, Amy M. Lischko, Tom Betlach, Michael H. Bailit, "State Strategies for Slowing Health Care Cost Growth in the Commercial Market," Commonwealth Fund Issue Brief, February 24, 2022. https://www.commonwealthfund.org/publications/issue-briefs/2022/feb/state-strategies-slowing-health-care-cost-growth-commercial-market

APPENDIX

P.L. 2021 CH. 518

https://legislature.maine.gov/legis/bills/getPDF.asp?paper=HP1329&item=3&snum=130

APPROVED	CHAPTER
MARCH 29, 2022	518
BY GOVERNOR	PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-TWO

H.P. 1329 - L.D. 1778

An Act To Improve Health Care Affordability and Increase Options for Comprehensive Coverage for Individuals and Small Businesses in Maine

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 5 MRSA §3122, sub-§3, as enacted by PL 2021, c. 459, §3, is amended by enacting a new first blocked paragraph to read:

Beginning in 2023, the office shall analyze barriers to affordable health care and coverage and develop for consideration by the legislative oversight committee proposals on potential methods to improve health care affordability and coverage for individuals and small businesses in the State.

Sec. 2. 5 MRSA §3124, as enacted by PL 2021, c. 459, §3, is amended to read:

§3124. Annual public hearing

~~Beginning in~~ In 2022, the office shall convene ~~an annual~~ a public hearing on cost trends no later than October 1st. Beginning in 2023, the office shall convene an annual public hearing no later than October 1st on cost trends and barriers to health care affordability. The hearing must provide an opportunity for public comment on health care cost trends and, beginning in 2023, on barriers to health care affordability. The executive director shall preside over the hearing.

Sec. 3. Health care and coverage study. The Office of Affordable Health Care, established under the Maine Revised Statutes, Title 5, section 3122, shall study the effects of policies aimed at improving health care affordability and coverage, including effects on the affordability of premiums and cost-sharing in the individual and small group health insurance markets, and the effects of the policies on enrollment in comprehensive health coverage. The office shall consider, but is not limited to considering:

1. Creating a public option health benefit plan;

2. Creating a Medicaid buy-in program;

3. Increasing enrollment in Medicaid and the federal Children's Health Insurance Program, including by increasing income eligibility levels;

4. Providing state-level subsidies to populations that do not qualify for federal subsidies through the Maine Health Insurance Marketplace, established under Title 22, section 5403; and

5. Other policies as identified by the office and the Advisory Council on Affordable Health Care, established in Title 5, section 12004-I, subsection 31-B.

The office shall provide a report of its findings to the joint standing committee of the Legislature having jurisdiction over health coverage and insurance matters no later than January 1, 2024.

P.L. 2023 CH. 87

https://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP1186&item=3&snum=131

LAW WITHOUT GOVERNOR'S SIGNATURE

JUNE 28, 2023

CHAPTER

87

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

H.P. 1186 - L.D. 1856

Resolve, to Study the Establishment of a Public Option Health Benefit Plan

Sec. 1. Office of Affordable Health Care study of health care and coverage. Resolved: That, when conducting the study required by Public Law 2021, chapter 518, the Office of Affordable Health Care shall prioritize consideration of the creation of a public option health benefit plan that takes the form of either a buy-in to the MaineCare program or a fully publicly administered plan that may be eligible for advanced premium tax credits through the Maine Health Insurance Marketplace established under the Maine Revised Statutes, Title 22, section 5403. The office shall also consider other models to address the availability and affordability of health coverage in the State and ways that the State may leverage available federal-state innovation waivers to improve affordability for consumers. Notwithstanding Public Law 2021, chapter 518, the office shall submit a report that prioritizes the consideration of a public option health benefit plan and other models as described in this resolve to the Joint Standing Committee on Health Coverage, Insurance and Financial Services no later than January 31, 2024. The committee may submit legislation in response to the report to the Second Regular Session of the 131st Legislature. The office shall submit a report fulfilling the remaining requirements in Public Law 2021, chapter 518 no later than January 31, 2025.

AN OVERVIEW OF HEALTH COVERAGE AND COSTS FOR MAINE IN 2025

https://www.urban.org/sites/default/files/2024-02/An%20Overview%20of%20Health%20Coverage%20and%20Costs%20in%20Maine%20for%202025.pdf

An Overview of Health Coverage and Costs in Maine for 2025

Matthew Buettgens, Jessica Banthin, Mohammed Akel, and Michael Simpson

February 2024

Introduction

Health coverage in Maine has experienced major changes in the past few years as Medicaid enrollment increased and the number of people without coverage shrank. More change is expected in the coming year. In 2019, the state expanded Medicaid eligibility to 138 percent of the federal poverty level (FPL). The following year saw the COVID-19 pandemic, with substantial disruptions in employment and availability of health care. In response, Congress passed the Families First Coronavirus Relief Act, which imposed a continuous coverage requirement on Medicaid and the Children's Health Insurance Program (CHIP): enrollees could not be disenrolled unless they requested it. This requirement was in effect through March 2023, leading to record-high Medicaid enrollment and record-low uninsurance (Buettgens and Green 2022). Also, during this time, Marketplace premium tax credits (PTCs) were enhanced, leading to record-high Marketplace enrollment (Buettgens, Banthin, and Green, 2022). These enhanced PTCs will be in effect through at least 2025, after which they will expire unless Congress renews them.

Like all other states, Maine is now resuming normal Medicaid and CHIP eligibility determination, often called the "unwinding." Enrollment in Medicaid and CHIP is declining, affecting enrollment in the Marketplaces, employer-sponsored health insurance, and the number of uninsured people.[1] The

unwinding was intended to take about 14 months, but CMS recently announced that temporary waivers to reduce disenrollment would be continued through at least the end of 2024.[2]

Health coverage in Maine after the unwinding will not look like any recent survey data, so we prepared this summary of health care coverage and costs in 2025 when these transitions are expected to have stabilized. We used a detailed simulation model that incorporates real-world data from Maine, both before and after the COVID-19 pandemic. We show the distribution of all types of health coverage by income and age and provide additional details on the uninsured. We then provide estimates of average household health care spending by income.

Methods

We estimated health coverage and costs in Maine for 2025 after Medicaid enrollment has stabilized following the unwinding (Buettgens and Green 2022) using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options (Buettgens and Banthin 2020). The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. HIPSM can analyze various new scenarios—from novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several years. Results from HIPSM simulations have been favorably compared with actual policy outcomes and other respected microsimulation models (Glied, Arora, and Solís-Román 2015).

For this work, we incorporated publicly available data on Medicaid and Marketplace enrollment in Maine from two time periods: as of December 2023, and before the COVID-19 pandemic. Health coverage in 2025 will differ from both, so we had to estimate the impact of the continuous coverage requirement and its subsequent unwinding on all types of health coverage (Buettgens and Banthin 2022; Buettgens and Green 2022). Nongroup health care costs are based on 2024 Marketplace premiums in Maine, inflated to 2025. Details of our methodology are available in Buettgens and Banthin 2020.

Results

In table 1, we estimate the health coverage of the almost 1.03 million nonelderly Mainers in 2025, after the completion of the Medicaid unwinding and associated transitions to other sources of coverage. About 94.2 percent of nonelderly Mainers would have health coverage. The majority, 54.8 percent or 562,000 people, would be covered through an employer. We show only one type of coverage for each person, so the small number of people who report both Medicaid/CHIP and employer coverage are counted as Medicaid/CHIP.

TABLE 1

Health Insurance Coverage of the Nonelderly in Maine, 2025

	People	Percent of total
Insured	966,000	94.2%
Employer	562,000	54.8%
Private nongroup	81,000	7.9%
Marketplace with PTC	64,000	6.2%
Full-pay Marketplace	8,000	0.8%
Other nongroup	10,000	0.9%
Medicaid/CHIP	284,000	27.7%
Disabled	55,000	5.3%
Medicaid expansion	57,000	5.6%
Traditional nondisabled adult	59,000	5.8%
Nondisabled Medicaid/CHIP child	113,000	11.0%
Other public	38,000	3.8%
Uninsured	59,000	5.8%
Total	**1,025,000**	**100.0%**

Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.

Notes: PTC = premium tax credit; CHIP = Children's Health Insurance Program.

We estimate just under 8 percent of nonelderly Mainers would have private nongroup coverage:

- 6.2 percent, or 64,000 people, get PTCs in the Marketplace
- 0.8 percent, or 8,000 people, are enrolled in Marketplace coverage without PTCs
- 0.9 percent, or 10,000 people, are enrolled in nongroup coverage outside the Marketplace

We estimate that 27.7 percent of nonelderly Mainers would be enrolled in Medicaid or CHIP:

- 11.0 percent, or 113,000 children, would be enrolled in Medicaid or CHIP.
- 5.3 percent, or 55,000 adults, would have coverage because of disability.
- 5.6 percent, or 57,000 adults, would be enrolled through the Affordable Care Act's (ACA) Medicaid expansion. This is larger than Medicaid expansion enrollment at the beginning of the pandemic.[3] Expansion was still relatively new then, and enrollment most likely had not reached its full level.
- 5.8 percent, or 59,000 adults, would be other nondisabled adults enrolled in Medicaid through non-ACA pathways, particularly parents.

The remaining 5.8 percent of nonelderly Mainers, or 59,000 people, would be uninsured. We will take a closer look at the uninsured below.

Health Coverage by Income

In table 2, we show how health coverage varies by income. The share of uninsured nonelderly Mainers falls with rising income, ranging from 8.3 percent for those with family incomes below 138 percent of FPL to 4.4 percent for those with incomes above 400 percent of FPL (figure 1).

TABLE 2

Health Insurance Coverage of the Nonelderly in Maine, by Income Group, 2025

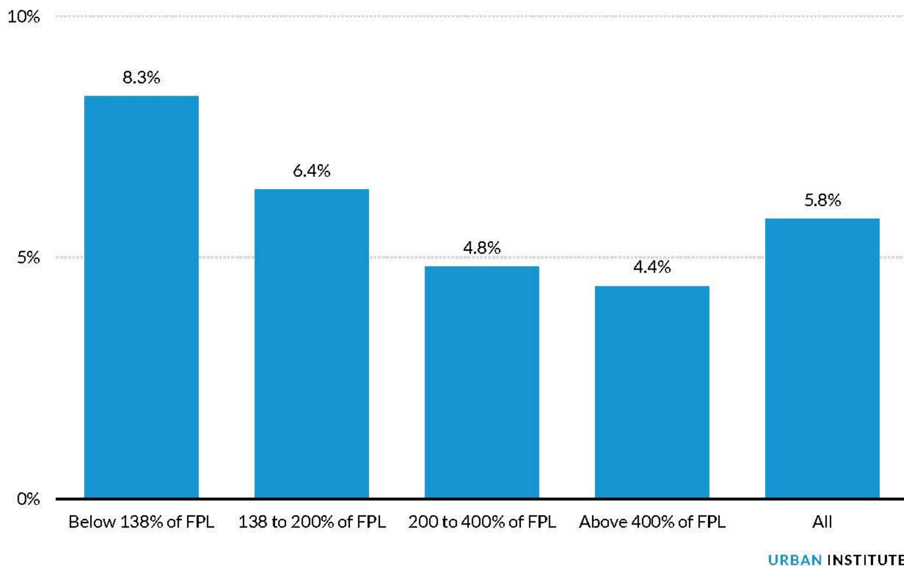
	People	Percent of total
Below 138% of FPL		
Insured	252,000	91.7%
Employer	28,000	10.0%
Private nongroup	1,000	0.3%
Marketplace with PTC	*	0.1%
Full-pay Marketplace	*	0.1%
Other nongroup	*	0.1%
Medicaid/CHIP	214,000	77.8%
Other public	10,000	3.5%
Uninsured	23,000	8.3%
Total	**275,000**	**100.0%**
Between 138 and 200% of FPL		
Insured	107,000	93.6%
Employer	38,000	33.3%
Private nongroup	21,000	18.4%
Marketplace with PTC	20,000	17.3%
Full-pay Marketplace	1,000	0.5%
Other nongroup	1,000	0.6%
Medicaid/CHIP	43,000	37.9%
Other public	5,000	4.0%
Uninsured	7,000	6.4%
Total	**114,000**	**100.0%**
Between 200 and 400% of FPL		
Insured	265,000	95.2%
Employer	196,000	70.1%
Private nongroup	38,000	13.5%
Marketplace with PTC	34,000	12.4%
Full-pay Marketplace	1,000	0.5%
Other nongroup	2,000	0.6%
Medicaid/CHIP	21,000	7.6%
Other public	11,000	4.0%
Uninsured	13,000	4.8%
Total	**279,000**	**100.0%**
Above 400% of FPL		
Insured	342,000	95.6%
Employer	300,000	84.0%
Private nongroup	22,000	6.2%
Marketplace with PTC	9,000	2.5%
Full-pay Marketplace	6,000	1.7%
Other nongroup	7,000	2.0%
Medicaid/CHIP	6,000	1.7%
Other public	13,000	3.7%
Uninsured	16,000	4.4%
Total	**358,000**	**100.0%**

Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.

Notes: * = less than 500 people; FPL = federal poverty level; PTC = premium tax credit; CHIP = Children's Health Insurance Program.

FIGURE 1

Uninsurance Rate in Maine, by Income Group, 2025



Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.
Notes: FPL = federal poverty level.

Nearly 78 percent of nonelderly Mainers with incomes below 138 percent of FPL would be enrolled in Medicaid, and only 10 percent would be enrolled in employer-sponsored insurance.[4] About 3.5 percent would have other public coverage, and a small fraction would be enrolled in nongroup coverage. That leaves 8.3 percent of Mainers with incomes below 138 percent of FPL uninsured.

The next income group, those with incomes between 138 and 200 percent of FPL, would have notably different health coverage. About 37.9 percent—generally children—would be covered by Medicaid or CHIP. One-third would have coverage through an employer. About 18.4 percent would have private nongroup coverage, with the large majority receiving PTCs. About 4.0 percent would have other public coverage, leaving 6.4 percent uninsured.

The large majority (70.1 percent) of Mainers with incomes between 200 and 400 percent of FPL would have health coverage through an employer. About 13.5 percent would have private nongroup coverage, mainly with PTCs. About 7.6 percent would have Medicaid or CHIP, and 4.0 percent would have other public coverage, leaving 4.8 percent of Mainers in this income group uninsured.

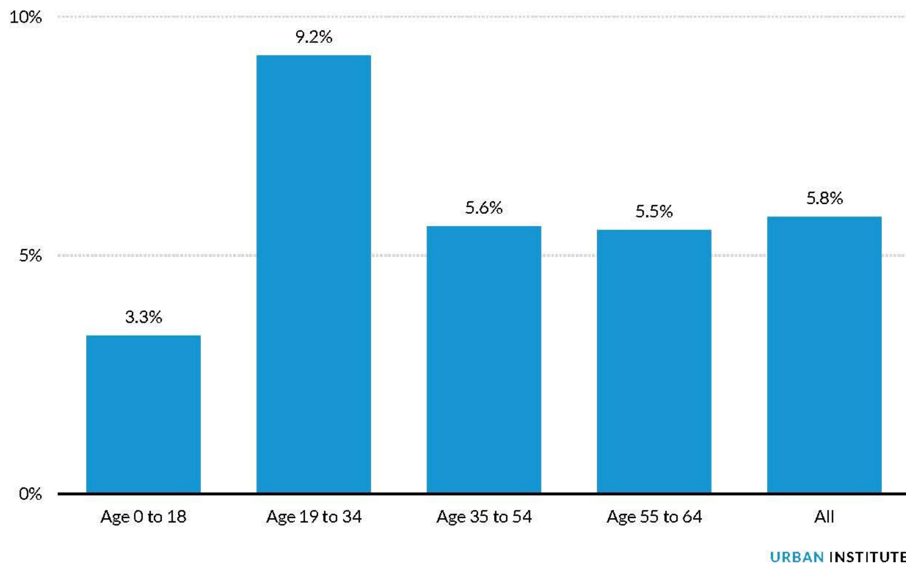
Employer-sponsored insurance covers an even larger share of Mainers with incomes above 400 percent of FPL (84 percent). Just over 6 percent would have nongroup coverage, with 2.5 percent getting PTCs. About 5.4 percent would have public coverage,[5] leaving 4.4 percent uninsured.

Health Coverage by Age

Table 3 shows the distribution of health coverage for nonelderly Mainers by age group. Uninsured rates vary considerably by age (figure 2). Children have the lowest uninsured rate, 3.3 percent, mainly because of higher Medicaid/CHIP eligibility thresholds. Young adults aged 19 to 34 have a dramatically higher uninsured rate of 9.2 percent. Older adults would have an uninsured rate of 5.5 to 5.6 percent.

FIGURE 2

Uninsurance Rate in Maine, by Age Group, 2025



Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.

Table 3 shows that there would be roughly equal shares of children enrolled in Medicaid/CHIP and employer coverage, 45.3 and 46.7 percent, respectively. About 3 percent would be enrolled in nongroup coverage, mostly with PTCs, and 1.6 percent have other public coverage.

Over half of adults aged 19 to 34 would have employer-sponsored insurance (51.2 percent). About 31.3 percent would be enrolled in Medicaid, 6.1 percent in nongroup, and 2.3 percent in other public coverage.

Among adults aged 35 to 54, 61.5 percent would be covered through an employer, just under 20 percent have Medicaid, just under 10 percent have private nongroup coverage, and 3.5 percent have other public coverage. Adults aged 55 to 64 have a roughly similar pattern, with just under 60 percent covered through an employer, just under 13 percent with Medicaid, just over 14 percent with nongroup coverage, and 9.4 percent with other public coverage.

TABLE 3

Health Insurance Coverage of the Nonelderly in Maine, by Age Group, 2025

	People	% of Total
Children (Age 0 to 18)		
Insured	259,000	96.7%
Employer	125,000	46.7%
Private nongroup	8,000	3.0%
Marketplace with PTC	5,000	2.0%
Full-pay Marketplace	1,000	0.4%
Other nongroup	2,000	0.6%
Medicaid/CHIP	121,000	45.3%
Other public	4,000	1.6%
Uninsured	9,000	3.3%
Total	**268,000**	**100.0%**
Age 19 to 34		
Insured	208,000	90.8%
Employer	117,000	51.2%
Private nongroup	14,000	6.1%
Marketplace with PTC	12,000	5.1%
Full-pay Marketplace	1,000	0.5%
Other nongroup	1,000	0.5%
Medicaid/CHIP	72,000	31.3%
Other public	5,000	2.3%
Uninsured	21,000	9.2%
Total	**229,000**	**100.0%**
Age 35 to 54		
Insured	329,000	94.4%
Employer	215,000	61.5%
Private nongroup	34,000	9.7%
Marketplace with PTC	27,000	7.8%
Full-pay Marketplace	3,000	0.8%
Other nongroup	4,000	1.1%
Medicaid/CHIP	69,000	19.7%
Other public	12,000	3.5%
Uninsured	20,000	5.6%
Total	**349,000**	**100.0%**
Age 55 to 64		
Insured	170,000	94.5%
Employer	105,000	58.3%
Private nongroup	26,000	14.2%
Marketplace with PTC	19,000	10.8%
Full-pay Marketplace	3,000	1.8%
Other nongroup	3,000	1.7%
Medicaid/CHIP	23,000	12.6%
Other public	17,000	9.4%
Uninsured	10,000	5.5%
Total	**180,000**	**100.0%**

Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.

Notes: FPL = federal poverty level; PTC = premium tax credit; CHIP = Children's Health Insurance Program.

Characteristics of the Uninsured

In table 4, we show selected characteristics of uninsured Mainers, besides income and age, which we have already seen. Uninsured rates fall dramatically with educational attainment (figure 3). More than 12 percent of adult Mainers with less than a high school education would be uninsured, compared with 4.8 percent of college graduates. Uninsured rates also vary geographically within the state (figure 4), ranging from 4.8 to 5.0 percent in Androscoggin and Kennebec counties to 6.6 and 6.7 percent in Northeast and Coastal Maine.

TABLE 4

Composition of the Nonelderly Uninsured in Maine, 2025

	Uninsured	Percent of uninsured	Population	Uninsurance rate
Geography				
Northeast Maine	5,000	8.1%	72,000	6.6%
Northwest Maine	6,000	10.7%	114,000	5.6%
Penobscot County	7,000	11.5%	121,000	5.6%
Kennebec County	5,000	7.9%	93,000	5.0%
Coastal Maine Region	8,000	13.7%	123,000	6.7%
Androscoggin County	4,000	6.9%	85,000	4.8%
Cumberland, Sagadahoc, and York Counties	25,000	41.2%	416,000	5.9%
Total	**59,000**	**100.0%**	**1,025,000**	**5.8%**
Educational attainment (age 19 to 64)				
Less than high school	2,000	4.6%	19,000	12.3%
High school	21,000	41.0%	234,000	8.9%
Some college	14,000	28.1%	226,000	6.3%
College graduate	13,000	26.3%	278,000	4.8%
Total	**51,000**	**100.0%**	**758,000**	**6.7%**
Family work status				
No worker in family	13,000	21.5%	153,000	8.9%
Only part-time worker in family	5,000	9.1%	66,000	8.1%
One full-time worker in family	31,000	51.6%	490,000	6.2%
> One full-time worker in family	11,000	17.7%	316,000	3.3%
Total	**59,000**	**100.0%**	**1,025,000**	**5.8%**
Eligibility				
Medicaid/CHIP	23,000	38.3%	352,000	6.5%
Marketplace PTCs	19,000	31.4%	175,000	10.6%
Ineligible	18,000	30.3%	498,000	3.6%
Total	**59,000**	**100.0%**	**1,025,000**	**5.8%**

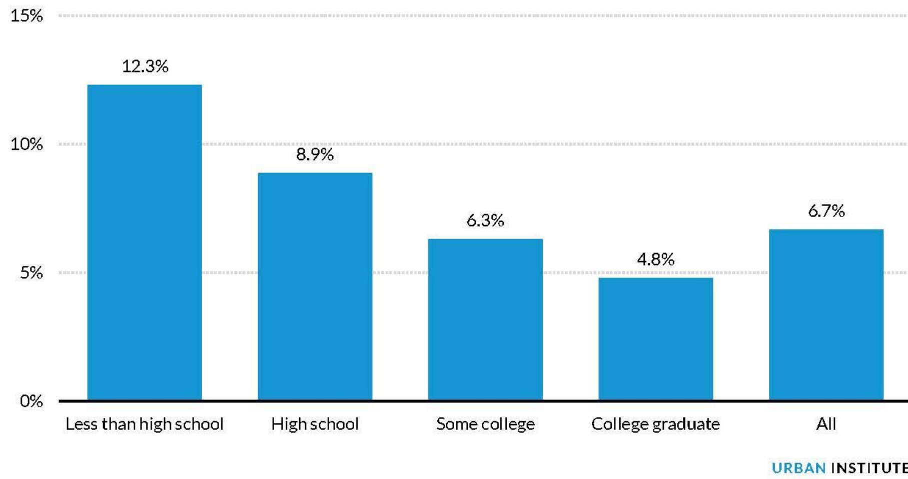
Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.

Notes: FPL = federal poverty level; PTC = premium tax credit; CHIP = Children's Health Insurance Program.

FIGURE 3

Uninsurance Rate in Maine, by Educational Attainment, 2025

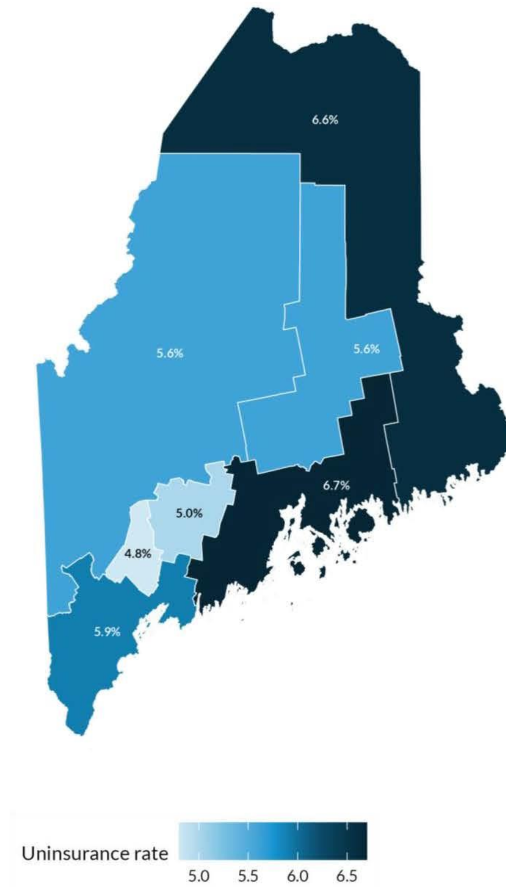
Ages 19 to 64 only



Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.

FIGURE 4

Uninsurance Rate in Maine, by Geographical Area, 2025



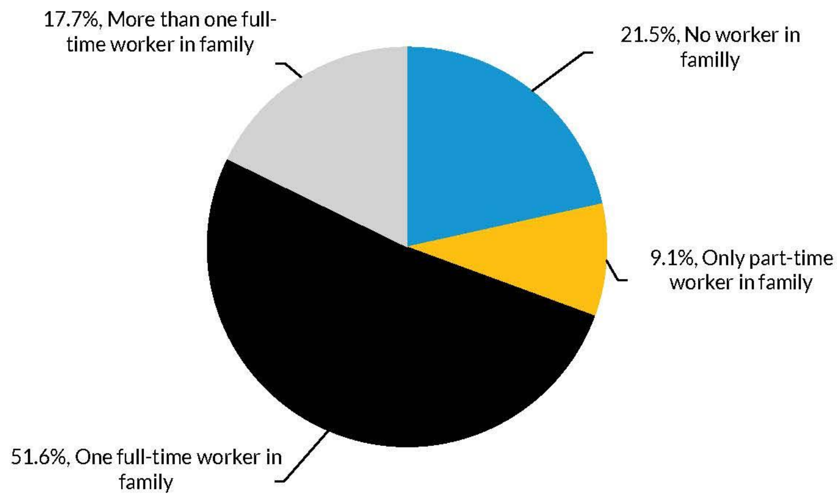
URBAN INSTITUTE

Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.

The overwhelming majority of uninsured Mainers would be in working families; only 21.5 percent would be in families without a worker (figure 5). Further, just under 70 percent of the uninsured would be in families with at least one full-time worker. While most nonelderly Mainers get their health coverage through an employer (table 1), employment does not provide access to coverage for many workers.

FIGURE 5

Percent of Uninsured People in Maine, by Family Work Status, 2025



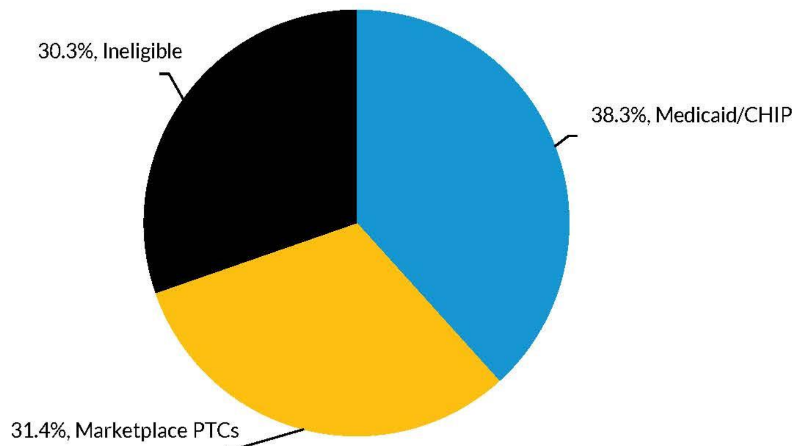
URBAN INSTITUTE

Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.

We estimate that 70 percent of uninsured Mainers would be eligible for assistance in affording health coverage but would not be enrolled (figure 6). About 38 percent would be eligible for Medicaid or CHIP but not enrolled. Higher enrollment in Medicaid expansion could make a particularly large difference in the uninsured. Medicaid expansion was still relatively new at the beginning of the COVID-19 pandemic, and enrollment was below what we would expect based on take-up in other states. Since then, the Medicaid continuous coverage requirement has led to notably larger Medicaid expansion enrollment. There is considerable uncertainty about how enrollment will change during the unwinding as the state resumes normal eligibility redetermination. We estimate that Medicaid expansion enrollment will be higher in 2025 than in 2020. It could end up higher than we estimate.

FIGURE 6

Percent of Uninsured People in Maine, by Eligibility for Public Benefits, 2025



URBAN INSTITUTE

Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.
Notes: PTC = premium tax credit, CHIP = Children's Health Insurance Program.

We estimate that 32 percent of uninsured Mainers would be eligible for Marketplace PTCs but not enrolled. The Medicaid unwinding will also affect Marketplace enrollment, so the eventual level may differ from our estimate. Also, unlike Medicaid, Marketplace coverage requires nontrivial premiums and cost sharing, which can be a barrier to enrollment. See the cost estimates in the next section.

The remaining 30 percent of uninsured Mainers would be ineligible for Medicaid and CHIP because of high income or immigration status and are ineligible for PTCs because of offers of coverage deemed affordable under the ACA or immigration status.

Household Health Care Spending of the Nonelderly

In table 5, we estimate the average household health spending of Mainers with private health coverage. Those with coverage through an employer would spend an average of $3,904 per person, $2,077 on premiums, and $1,828 on other out-of-pocket (OOP) health spending. This excludes employer premium contributions. Those covered through large firms would spend less on average than those covered through small firms, $3,821 versus $4,612 per person.

TABLE 5

Average Household Health Spending of the Nonelderly in Maine, by Private Coverage, 2025

Dollars per person within household

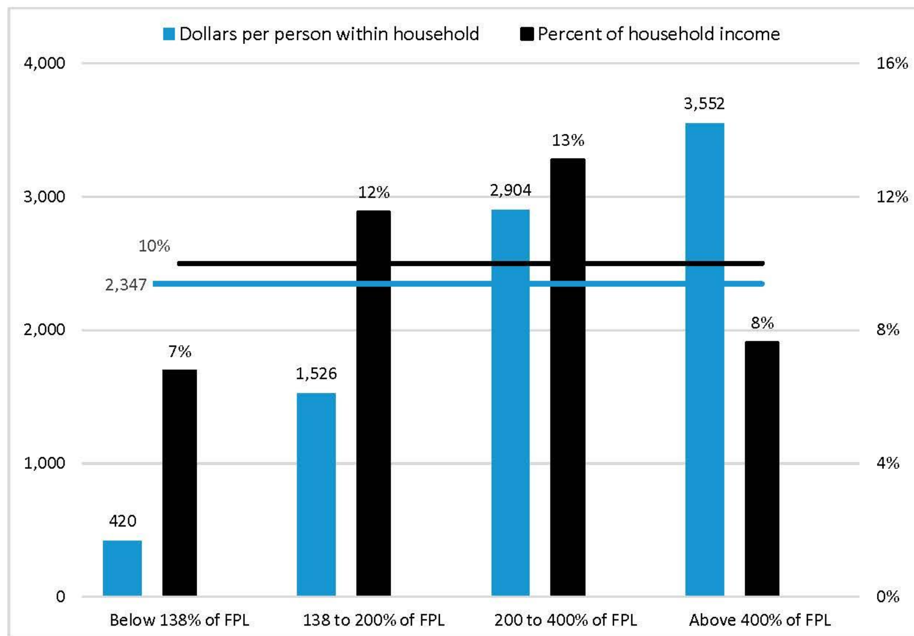
	Total spending	Premiums	Out-of-pocket
Employer-sponsored insurance			
Small group	4,612	2,704	1,908
Large group	3,821	2,003	1,818
All	**3,904**	**2,077**	**1,828**
Nongroup Insurance			
Marketplace with PTC, <200% of FPL	1,458	249	1,209
Marketplace with PTC, >200% of FPL	4,715	1,654	3,061
Full-pay nongroup	9,906	7,238	2,668
All	**4,224**	**1,865**	**2,359**

Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.

Notes: FPL = federal poverty level; PTC = premium tax credit.

FIGURE 7

Household Health Spending of the Nonelderly in Maine, by Income Group, 2025



URBAN INSTITUTE

Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.

Notes: FPL = federal poverty level. Spending includes premiums paid by households, adjusted for taxes, and other out-of-pocket health spending.

Household spending for those with nongroup coverage can differ dramatically, depending on their income and whether they receive Marketplace PTCs and cost-sharing reductions (CSRs). Those with incomes below 200 percent of FPL receiving Marketplace PTCs would pay $1,458 per person on average, $249 in premiums, and $1,209 in OOP spending. This group would see the most generous PTCs and CSRs. If enhanced PTCs expire after 2025, this will increase substantially (Buettgens, Banthin, and Green 2022). Those with incomes above 200 percent of FPL receiving Marketplace PTCs would pay $4,715 per person on average, $1,654 in premiums, and $3,061 in OOP costs. The few Mainers purchasing nongroup coverage without PTCs would pay substantially more: $7,238 in premiums and $2,668 in OOP spending per person on average.

Average Health Care Spending of the Nonelderly

In table 6 and figure 7, we estimate average household health spending by income group, including those with all types of health coverage and the uninsured. In 2025, Mainers would spend an average of $2,347 per person on health care. Health care spending would increase with income. Those with incomes below 138 percent of FPL would spend $420 per person. People enrolled in Medicaid would have minimal health spending, but the uninsured and the few people with incomes this low enrolled in private coverage would spend considerably more.

TABLE 6

Average Household Health Spending of the Nonelderly in Maine, by Income Group, 2025

	Total spending	Premiums	Out-of-pocket
Dollars per person within household			
Below 138% of FPL	420	156	265
Between 138 and 200% of FPL	1,526	662	863
Between 200 and 400% of FPL	2,904	1,282	1,622
Above 400% of FPL	3,552	1,766	1,787
All	**2,347**	**1,097**	**1,250**
Percent of household income			
Below 138% of FPL	7%	3%	4%
Between 138 and 200% of FPL	12%	5%	6%
Between 200 and 400% of FPL	13%	6%	7%
Above 400% of FPL	8%	4%	4%
All	**10%**	**4%**	**5%**

Source: The Urban Institute Health Insurance Policy Simulation Model, 2023.

Notes: FPL = federal poverty level.

Those with incomes above the adult Medicaid eligibility threshold, between 138 and 200 percent of FPL, would spend $1,526 per person. These costs would be moderated by more generous PTCs and CSRs, as shown in table 5. Health care spending rises steeply at higher incomes as PTCs phase down and most people have employer coverage (table 2). It is important to note that Medicaid and Marketplace policies are not the only reason average spending increases with income. Those with higher incomes

may choose more generous coverage because they are better able to afford it. Also, higher income is associated with older ages, and average health care costs vary considerably by age.

Considering only dollar amounts of health care spending does not consider that households with higher incomes are more able to pay for health care. Thus, we also show household health care spending as a percentage of household income. We estimate that Maine households would pay an average of 10 percent of their income in health care costs in 2025.

Those with the lowest and highest incomes would pay a similar share of their income (7 to 8 percent) but for different reasons. Those with incomes below 138 percent of FPL are a mix of Medicaid enrollees with very little health care spending and those with no or private coverage who would face substantial spending. Their incomes are so low that even relatively small dollar amounts could be a high percentage of income. By contrast, those with incomes above 400 percent of FPL would have relatively low spending as a percent of income primarily because their income is so high.

Those with incomes between 138 and 400 percent of FPL would spend between 12 and 13 percent of their income on health care on average. As we saw in table 5, PTCs and CSRs make a considerable difference for those who enroll, but not all are eligible and not all of those who are eligible enroll in the Marketplace.

Discussion

We estimate that 59,000 Mainers—5.8 percent of the nonelderly population—would be uninsured in 2025 after the Medicaid unwinding has finished. About 70 percent of uninsured Mainers would be eligible for Medicaid, CHIP, or Marketplace PTCs but not enrolled. Thus, additional outreach and improving enrollment processes could increase health coverage significantly.

Groups with the highest rates of uninsurance include those with the lowest incomes, those with the lowest educational attainment, and young adults. Children have the lowest uninsured rates because of high-income eligibility for Medicaid and CHIP. About 78.5 percent of the uninsured are in working families, and most have a full-time worker.

We estimate that Mainers would spend an average of 10 percent of household income on health care. Those with incomes too high to qualify for adult Medicaid (138 percent of FPL) but below 400 percent of FPL would pay a higher share on average (12 to 13 percent). While Marketplace PTCs and CSRs reduce health care costs substantially, costs are still notably higher than Medicaid, so affordability may still be an issue. Also, not all are eligible for PTCs and CSRs.

Notes

[1] The following paper is forthcoming in 2024: Buettgens, Matthew, Jameson Carter, Jessica Banthin, and Jason Levitis. 2024. "State Variation in Unwinding Rates and Correspondence with Key Policy Choices." Washington, DC: Urban Institute.

[2] "Biden-Harris Administration Releases New Medicaid and CHIP Renewal Data Showing the Role State Policy Choices Play in Keeping Kids Covered," HHS.gov, December 18, 2023, https://www.hhs.gov/about/news/2023/12/18/biden-harris-administration-releases-new-medicaid-chip-renewal-data-showing-role-statepolicychoices-play-keeping-kids-covered.html.

[3] "MaineCare (Medicaid) Update: March 2, 2020," State of Maine Department of Health and Human Services, accessed February 8, 2024, https://www.maine.gov/tools/whatsnew/index.php.

[4] Rules for counting family income differ for Medicaid and Marketplace PTCs, with Medicaid Modified Adjusted Gross Income as a percent of FPL lower for a small number of people. We classify anyone with income below 138 percent of FPL according to Medicaid rules in this group.

[5] Although Medicaid and CHIP income eligibility does not extend above 400 percent of FPL, nearly all household survey data show a small number of people with incomes apparently too high to qualify reporting Medicaid or CHIP coverage. We leave these people with their reported coverage. They may be eligible through a special pathway, such as the medically needy, that we cannot model, their circumstances may have changed since their last eligibility determination, or there may be errors in their survey responses.

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Matthew Buettgens is a senior fellow in the Health Policy Center at the Urban Institute, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington, as well as to the federal government. His recent work includes several research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers;

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UNITED STATES OF CARE COMPARISON TABLE

https://unitedstatesofcare.org/state-public-health-insurance-options-a-comparison/

State Public Health Insurance Options: A Comparison

Access to affordable, quality health care is a necessary, yet unmet, component of keeping our nation healthy. Regardless of political affiliation, people believe affordable health care should be a top priority of their elected officials. Despite coverage expansions under the Affordable Care Act and additional action taken by state legislatures across the country, health care remains out of reach for many Americans who don't have it and too expensive for those who do.

Public health insurance options have emerged to fill the gaps that leave people uninsured or underinsured. A public health insurance option provides an affordable and dependable, government-regulated health insurance plan that is often privately run and offers an additional insurance choice for people who do not have coverage through their job, Medicare, or Medicaid. By increasing competition within the market by using the strength of a state's purchasing power, public health insurance options create more affordable options for consumers. With an eye on health equity, these plans can reduce disparities by engaging diverse voices to improve network adequacy standards, provide additional subsidies for those in need, and expand access to safety net and rural providers.

States have been leading the way: Washington, Nevada, Colorado, and Minnesota have each passed a version of a public health insurance option tailored specifically to the needs of their states. Momentum in these states has led state policymakers in other states to look into how a public health insurance option could work for their constituents as well. Unsurprisingly, these efforts are popular: national polling shows that nearly 70% of Americans support a public health insurance option. People desire a system that provides affordable coverage options while giving them the certainty that care is there when they need it.

Commonalities among state public options include using mechanisms to establish provider rates, working within existing markets, prioritizing equity, and seeking pass-through funds from the federal government with 1332 waivers. The table below details the common themes as well as differences between state-level public health insurance option models.

Comparison of State Models

	Colorado (2021, 2023)	Nevada (2021)	Washington (2019, 2021)	Minnesota (2023)
Markets Affected	Individual and small group market	Individual market	Individual market	Individual market
Status	Coverage began January 2023 with plans offered in all 64 counties; public hearings to begin June 2023	Coverage to begin January 2026 on the individual market to align with the next procurement process to select Medicaid managed care organizations (MCOs); small business implementation delayed Addition of Market Stabilization Program announced in October 2023, with the state's proposed 1332 waiver application sent to CMS for approval in December 2023	Coverage began January 2021, with plans offered in 37 out of 39 counties in 2024	Report to the Legislature on the implementation and federal waiver plan for the public option by February 1, 2024. Minnesotans will have the option to enroll in coverage through the public option by January 1, 2027
Overall Approach	★ Creation of a standardized plan called the Colorado Option that includes set benefits and cost-sharing, ways to address racial health disparities, and first-dollar pre-deductible coverage for high-value services ★ Enhanced rate review and additional authority for the Division of Insurance	★ Nevada's Coverage and Market Stabilization Program takes a unique approach to increasing affordability for Nevadans by combining a Public Option with three additional components: a reinsurance program, incentive payment program for issuers, and investment in Nevada's healthcare workforce through a student loan repayment program	★ The state contracts with private issuers to offer standardized "Cascade Select" plans offered on the individual market ★ Cascade Select plans cap aggregate provider reimbursement at 160% of Medicare rates, with payment floors for certain services like primary care and rural hospitals ★ 2021 legislation introduced state subsidies and hospital	★ Minnesota will complete economic and actuarial analysis on the design of several different public option models, including a buy-in to MinnesotaCare (the state's basic health plan), to craft the best proposal for Minnesotans ★ The proposed public option design must take into consideration data on the impact of provider access for enrollees, including the variety and

	and limits on issuers' administrative costs and profits ★ Private issuers are required to offer the Colorado Option with premiums that meet a premium reduction target (5% lower than the previous year's rates; totaling 15% over 3 years) ★ Colorado Option plans are required to be displayed for consumers in a way where they can be "easily identified and compared" ★ Following 2023 public hearings, 80% of issuers offering individual plans, and 66% of insurance companies offering small group plans have decreased initial premium requests ★ In 2024, 25 individual market and 24 small-group market Colorado Option plans will meet state target's of a 10% reduction in premiums (against 2021 levels)	★ The Public Option and Market Stabilization Program together must meet annual premium reduction targets (15% lower over the first four years of waiver implementation) ★ Leverages Nevada's Medicaid MCO infrastructure to create new requirements for issuers who wish to participate in the managed care program to also submit a bid to offer Public Option plans ★ Public Option plans must meet the same standards and provide the same core benefits as private plans under the Affordable Care Act (ACA) ★ Issuers and providers will negotiate their reimbursement rates and network coverage, with a requirement for a minimum reimbursement "floor" that prohibits issuers from providing reimbursement rates below Medicare levels	participation requirements ★ In 2024, public option plan rates increased at just 5%, as compared to an 8% increase in rates for non-public option plans	volume of plan options, and provider reimbursement rates ★ The proposed design must prioritize affordability for enrollees using a household budget approach that considers total costs paid by consumers when calculating enrollee premiums and cost-sharing, minimize premium affordability cliffs, and consider the impact on racial and ethnic disparities in rates of insurance and access to services
Provider and Hospital Participation	If hearings are required due to issuers not meeting the premium reduction targets, the Department of Public Health and Environment can require providers to participate, which are scheduled to be held beginning June 2023. If the provider refuses, warnings and fines can be issued to hospitals and providers	Requires providers and facilities that participate in Medicaid, the Public Employees' Benefits Program, or worker's compensation to also participate in at least one public option plan's network	Hospitals that provide services and receive reimbursement from Washington's public employee benefits program, school employees benefits program, or Medicaid must also participate in at least one public option plan	Awaiting recommendation from the Commissioner of Commerce by February 1, 2024, as informed by economic and actuarial analyses. A public option centered on expanding MinnesotaCare would use existing provider networks that exist for current MinnesotaCare beneficiaries
Provider & Hospital Rates	If issuers fail to meet premium reduction targets, DOI is authorized to set hospital and provider rates at no less than 165% and 135% of Medicare rates, respectively. Hospitals will receive a base rate of 155% of Medicare with: ★ Essential access and independent hospitals to receiving a 20% increase; ★ Independent critical access hospitals receiving a 40% increase; ★ Some pediatric specialty hospitals receiving a 55% increase; ★ Hospitals with a high percentage of Medicaid and Medicare patients receiving up to a 30% increase; and ★ Hospitals efficient at managing the underlying cost of care receiving a 40% increase	At least equal to Medicare rates; for FQHCs and rural health clinics, rates must be at least the reimbursement rate established for patient encounters. For community behavioral health clinics, rates must be at least those under the Medicaid state plan	Establishes a provider reimbursement cap of 160% of Medicare rates; includes a 135% of Medicare rate floor for primary care and 101% of Medicare rate floor for rural critical access hospitals and sole community hospitals (allowable costs)	Provider reimbursement rates shall be set at a level that maintains an adequate provider network for enrollees, as determined by the actuarial and economic analyses. A study has been in progress and a report is due back to the legislature next year, on rate adequacy in Medicaid, which would impact a public option centered on expanding MinnesotaCare

Issuer Participation	Requires issuer that offer plans in the individual and/or small group markets to offer the Colorado Option	Any issuers bidding to offer Medicaid managed care plans must also submit competitive bids to offer public option plans. The state may also invite non-Medicaid issuers to submit bids to ensure access for enrollees	Optional; the state is considering whether to require issuers offering public employee plans or Medicaid to also submit bids to offer Cascade Select plans	The state will determine the most appropriate issuers of the public option to maintain adequate availability of providers and health care services for enrollees. A plan expanding a current program, like MinnesotaCare, would likely use existing issuers.
Eligibility	Coloradans who purchase health insurance on the individual market, including undocumented people, and small employers with under 100 employees	All residents of Nevada who qualify for federal premium subsidies under the ACA are eligible for the Public Option. All Nevadans enrolled in a health insurance plan on the Marketplace are eligible to benefit from the reinsurance program components.	All Washingtonians eligible for marketplace coverage, including undocumented people	Legislative proposal included all Minnesotans who are eligible for health insurance on the individual market. Final eligibility to be determined after Commissioner report on February 1, 2024
1332 Waivers	★ Authorized in legislation; pass-through funds will go towards implementation and administration of standardized plan as well as providing additional premium and cost-sharing assistance ★ CMS approved the 1332 waiver in June 2022. This waiver allows Colorado to capture $213.8 million in federal pass-through funding in 2023 to provide people with further affordability assistance and is expected to increase in future years	★ Authorized in legislation; enables the state to capture an expected $279 million in federal pass-through funding to subsidize low-income Nevadans and combine the risk pools for the public option and Medicaid if it meets certain parameters ★ Nevada submitted a Section 1332 waiver application to CMS for approval on December 29, 2023 ★ The Section 1332 Waiver is expected to generate an estimated $279 million in federal savings in the first five years, and $760 million in the first ten years	★ Authorized in legislation; provides premium or cost-sharing assistance, increases access to qualified health plans, and expands exchange programs that increase affordability ★ CMS approved the 1332 waiver in December 2022. This waiver expands access to health and dental plans to undocumented people	★ Authorized in legislation; final program design must minimize impact on the individual market and maximize affordability for public option plan enrollees, as informed by actuarial and economic analysis ★ The Commissioner of Commerce is authorized to submit a Section 1332 waiver for federal approval by June 1, 2024. Earlier action may be taken by the legislature.
Specific Reference to Addressing Disparities or Health Equity	★ The plan must be designed to improve racial health equity and decrease racial health disparities, including through perinatal health coverage and providing certain high-value services pre-deductible ★ First-in-the-nation approach to ensuring culturally responsive networks that reflect enrollee diversity ★ Issuers are required to take steps to improve health equity and reduce racial health disparities in developing their network access plan ★ Stakeholder engagement process and diverse advisory committee will be set up to aid in implementation ★ Covers all Coloradans, regardless of immigration status	★ Instructs the Agency to prioritize bids from issuers that contract with providers who decrease disparities and support culturally competent care ★ The Coverage and Market Stabilization Program will address geographic disparities in affordability for rural residents of the state ★ The state is considering additional provisions to improve access and outcomes for Nevada's historically marginalized communities	Cascade Care plans must meet requirements for improving health, including adhering to standards on health equity	★ Actuarial and economic analysis conducted ahead of the state's 1332 waiver must include information on the impact of public option models on populations defined by race, ethnicity, geography, and other metrics. ★ Future legislation or regulations prior to implementation may address health disparities or promote health equity, as informed by the actuarial and economic analyses ★ Final public option likely to cover all Minnesotans, regardless of immigration status
Network Adequacy	Plans will be no more narrow than the most restrictive network the carrier is offering for non-standard plans; plans	Requires providers that participate in Medicaid, the state employee health plan, or worker's compensation to be	Hospitals that provide services and receive reimbursement from Washington's public employee benefits program,	As part of its February 1, 2024 report to the legislature, state agencies must report on the adequacy of the public option's

	will include a majority of essential community providers and include certified nurse midwives in plan networks; plans are also required to implement culturally responsive network components listed above	in-network with at least one public option plan; bids will be prioritized that demonstrate alignment between Medicaid and the public option and include access to critical access hospitals, rural health clinics, certified behavioral health clinics, and federally-qualified health centers	school employees benefits program, or Medicaid must also participate in at least one public option plan	expected provider network as informed by the actuarial and economic analyses
Federal/State Funding	State funding: ★ Fiscal Note: $1.5 million for implementation in FY 2021-2022 ★ $1.9 million for ongoing operating costs in FY 2022-23 and beyond Federal funding: ★ Estimated pass-through funding captured through the state's 1332 waiver ($1.618 billion over five years): ○ 2023 - $213.8 million ○ 2024 - $277.3 million ○ 2025 - $341.5 million ○ 2026 - $347.8 million ○ 2027 - $367.6 million	State funding: ★ Fiscal Notes (As Introduced) ★ Appropriations included in final legislation include $1,639,366 to create the Public Option Trust Fund; $600,000 for preparing the states' 1332 waiver application (including actuarial analysis); $1,869,212 for exchange operating costs Federal Funding: ★ Estimated pass-through funding captured through the Section 1332 waiver ($279 million over five years, $760 million over ten years) ○ 2026 - $15 million ○ 2027 - $58 million ○ 2028 - $69 million ○ 2029 - $81 million ○ 2030 - $87 million	State funding: ★ 2019-2020 Omnibus Budget appropriated the following for implementation: ★ $400,000 to the Health Care Authority ★ $1,048,000 to the exchange The 2021-2022 Omnibus Budget appropriated $289,000 to the Health Care Authority and $8,012,000 to the exchange for implementation, but those costs are largely for implementing the state-level financial assistance components of the legislation Federal funding: ★ Estimated pass-through funding captured through the state's 1332 waiver ($11.99 million over five years, $28.65 million over ten years): ○ 2024 - $1.92 million ○ 2025 - $2.22 million ○ 2026 - $2.43 million ○ 2027 - $2.62 million ○ 2028 - $2.80 million	State funding: ★ 2023 Omnibus Budget appropriated the following: ○ $2.5 million for the actuarial and economic analyses and preparation of the 1332 waiver ○ $22 million for initial implementation, contingent on federal 1332 waiver approval Federal funding: ★ To be determined by the state's 1332 waiver.
Enrollment	Approximately 35,000 people in 2023, including 10,000 undocumented people through the state's OmniSalud program; the 25,000 enrolled through the state's exchange represent 13% of the individual market Connect for Health Colorado experienced record enrollment for 2024 with 237,107 enrollees (18% higher than previous year)	The unique design and intent of Nevada's Coverage and Market Stabilization program means approximately 2,100 additional Nevadans will newly enroll in the individual market due to the creation of the Coverage and Market Stabilization Program, also bringing improved affordability to almost 100,000 Nevadans in the individual market	Approximately 27,000 people in 2023; this represents 11% of the individual market 2023 sign-ups for Cascade Select plan increased to 27,000 enrollees (compared to 8,000 in 2022)	Estimates to be reported by February 1, 2024. There are 300,000 uninsured Minnesotans and many more underinsured, such as those with high deductible health plans, who may benefit from the public option
Entities Responsible for Implementation	Colorado Department of Regulatory Agencies Division of Insurance (DOI)	Nevada Department of Health and Human Services Division of Health Care Financing and Policy, in consultation with Nevada Health Link, the state's exchange, and the Division of Insurance	Washington Health Care Authority, in consultation with Washington Healthplanfinder, the state's exchange	Minnesota Department of Commerce, in consultation with the Department of Human Services and MNsure, the state's exchange
Helpful Resources	CO Option landing page CO Option public hearing schedule 1332 waiver amendment request CMS 1332 waiver approval Standardized plan regulation Premium rate reduction methodology	Nevada Coverage and Marketplace Stabilization Program landing page 1332 waiver application as submitted to CMS	Washington Cascade Select landing page 1332 waiver application submitted CMS 1332 waiver approval Hospital provider participation requirements	Authorizing legislation – lines 701.5 through 705.20