Washington State Health Care Authority

# Finance Technical Advisory Committee (FTAC) Meeting Summary

March 9, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
3:00 p.m. – 5:00 p.m.

**Note:** this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the FTAC webpage.

## Members present

Christine Eibner
David DiGiuseppe
Eddy Rauser
Kai Yeung
Pam MacEwan
Robert Murray
Roger Gantz

## Members absent

Esther Lucero
Ian Doyle

## Call to order

called the meeting to order at 3:02 p.m.

## Agenda items

### Welcoming remarks

Pam MacEwan, FTAC Lead and Liaison, began with a land acknowledgement, welcomed FTAC Members to the second meeting, and provided an overview of the agenda.

### Meeting Summary review from the previous meeting

The Members present voted by consensus to adopt the Meeting Summary from FTAC's January 2023 meeting.

### Public comment

Mike Benefiel, Democratic PCO, LD23, remarked that the Washington Health Trust bill has been introduced in the last three legislative sessions but has been ignored in favor of creating the Commission, which has no published mission or timeline for goals leading to legislation.

Kathryn Lewandowsky, RN, Whole Washington, shared a letter from a colleague whose husband suffered

multiple strokes and open-heart surgery over the last 17 years and requires continuous care. Unable to afford health insurance and medical expenses on one salary, her family lost their home and was forced to file bankruptcy.

Ronnie Shure, Health Care for All Washington, commented that since ways for Medicare to be included in a state-based universal system are uncertain, FTAC should study Medicare from the perspective of a model.

Roger Collier noted the following barriers to including Medicare in the universal system: political will for moving 1M voting seniors from a program they're satisfied with to one that is untested; adding wraparound benefits may be feasible for traditional Medicare enrollees, but not for Medicare Advantage (MA) enrollees (half of Washington's Medicare enrollees) due to federal law; the universal system functioning like an MA plan may encounter fewer obstacles but there will still be opposition from insurers.

Jen Nye, Democratic PCO, LD34, proposed that getting more people insured through publicly funded programs will take the state to universal health care, e.g., a legitimate public option, where enrollees could select coverage on the Exchange, employers could offer it to employees, and the system could eventually fully transition.

## Presentation: FTAC ideas for transitional solutions

Liz Arjun and Jon Kromm, Health Management Associates (HMA)

Between their January and March meetings, FTAC Members completed a survey aimed at gathering ideas for transitional solutions to be considered by the Commission. FTAC's survey responses yielded approximately30 ideas. HMA led the committee in a matrix exercise to categorize ideas based on impact and resource intensiveness. Members were asked to discuss and select in which quadrants each idea fit: high impact/less resource intensive; high impact/more resource intensive; low impact/less resource intensive; and low impact/more resource intensive. Discussion began with the ideas proposed by multiple FTAC Members.

The first proposed idea was regulation of hospital global budgets. FTAC Member Roger Gantz asked how global budget models like Maryland's would integrate with a managed care delivery system. FTAC Member Bob Murray replied that a global budget system would be highly complementary with managed care approaches to help control utilization, though it would supplant managed care organizations' (MCOs) ability to set prices, which is not a bad thing. Global budgets create larger purchasing power to achieve cost containment. Maryland's system doesn't need to be duplicated. Global budgets were marked high impact/more resource intensive. FTAC Member Eddy Rauser asked how these fit into managed care capitated amounts. Global budgets govern the amount hospitals charge patients (also applied to managed care) and control the rate of growth of payments over time. The state would set hospitals' rates and pay MCOs a per-member per-month (PMPM) administrative amount. There are major political challenges with this model due to involvement of government regulation. The Centers for Medicare and Medicaid Services (CMS) is proposing a model for global budgets.

The next idea was out-of-network (OON) provider reimbursement caps, which can positively impact insurers' leverage to negotiate lower in-network rates. This requires state oversight to ensure savings pass through to consumers. OON price caps were marked high impact/less resource intensive. Legislation would be required because it would apply to all commercial insurers. OON price caps could range from 170 to200 percent of Medicare, varying by region. The state would need to examine the current level and structure of payment and variances by region. Oregon caps in-network and OON hospital services for state and public employees. FTAC Member Christine Eibner encouraged further study on these ideas before finalizing the matrix. FTAC Member David DiGiuseppe agreed that any of the transitional solutions being proposed would require further study.

The next idea was consolidating state purchasing. Roger Gantz noted that the state controls over 30 percent of the insured market. PEBB and SEBB benefits are not purchased together currently but could be. This idea was marked high impact/more resource intensive. FTAC Member Kai Yeung noted achieving larger goals could be done in phases, e.g., the first step to standardizing benefit design could be standardized measurement of cost and quality.

The next idea was auto-enrollment for Medicaid enrollees to no-premium Exchange plans. Pam MacEwan remarked that this would be less resource intensive and high impact, particularly for uninsured Washingtonians and for individuals whose Medicaid eligibility fluctuates, and Roger Gantz agreed. Eddy Rauser agreed, noting that as the public health emergency unwinds, now is an ideal time to discuss this idea.

## Presentation: Lessons for universal health care from the Indian Health Delivery System

Vicki Lowe, Commission Chair, Executive Director, American Indian Health Commission for WA State

The goals of the presentation were to understand the differences between 1) systems of care and systems of coverage, and 2) direct care and purchase and referred care, and to learn about the Jamestown S'Klallam Tribal Health Benefit Program. This presentation is high-level and describes an existing universal health care system.

Indian Health Services (IHS) is a system of care that includes three facility types: IHS, Tribal facilities, and Urban Indian Health Programs. Providers and facilities are funded on an annual basis with funding based and agreed upon services and user population. IHS is a system of care with coverage based on geography. Facility/ provider payments are based on a per person/per year calculation. IHS funding occurs after services are received. Conversely, a system of coverage is based on finding a contracted provider. Here, there are two types of payments: fee-for-service ((FFS) payment after providing services), and PMPM (payment prior to providing services). IHS has been chronically underfunded since its inception. Purchased and referred care is any care received outside of IHS. Per federal law, hospitals and specialty providers are paid at Medicare rates, or "Medicare Like Rates." Funding for this and other IHS care is appropriated.

The Jamestown Tribal Health Benefits Program (Program) is an insurance-based program. Coverage is based on all Tribal Citizens having the same level of coverage regardless of income or coverage eligibility. Under federal law, IHS programs are required to enroll eligible Tribal users in Medicare or Medicaid before the purchased and referred care dollars can be accessed. The Program wrapped around Medicare, Medicaid, private and employer-sponsored insurance (ESI) to deliver the same level of benefits to each person. For example, the Program purchased supplemental benefits for Medicare-eligible individuals and reimbursed members for their Medicare Part B premiums. The Program achieved 100 percent coverage for Tribal members living in the service area.

Member Roger Gantz asked if the Indian Self-Determination and Education Act of 1975 created structures for tribes to operate their own programs. It was clarified that was the case. Roger Gantz noted the major implications for tribes of Washington's universal system and asked for Chair Lowe's guidance. Chair Lowe agreed to share with Members the American Indian Health Commission's draft language for a universal health care bill (shared at the federal level). Kai Yeung asked how this system of care impacts care quality. Native Americans have provided whole-person care since time immemorial and with chronic underfunding, tribes are accustomed to finding any available resources. There is a high level of attention to quality and innovation since providers are less focused on varying reimbursement from different coverage sources.

## Presentation: Options to include Medicare enrollees in a state-based universal system

Gary Cohen, HMA

Medicare is a federal program and there is no precedent for a waiver that gives a state control over Medicare funds and program administration. Two pathways to include Medicare in Washington's universal system were identified by the Commission for FTAC's guidance: 1) a state-run MA plan to cover Medicare non-covered benefits, and 2) other options to "wrap around" Medicare benefits.

In the MA option, the state could administer an MA plan that would be available to Washington's Medicare enrollees. Roger Gantz noted that Oregon and California's universal health care proposals embraced Medicare as part of a unified purchasing system, however there was no clear path forward. It would be helpful to have trend analyses, e.g., average per capita growth rates of managed care plans in Washington. Christine Eibner remarked that CMS's payment structure is based on the Medicare FFS benchmark. If FFS doesn't exist, how would payment work? More analysis is required. The MA option would not be mandatory for Medicare enrollees - it would be an option that would need to be attractive to appeal to more people. David DiGiuseppe pondered a situation where the state was not precluded from creating an MA plan and was in a competitive environment. It would become increasingly difficult with the new MA star rating and risk adjustment rules. More analysis is required. Roger Gantz posited that the state could build on the UMP retiree plan where the state contracts with Regence, but the state carries the risk. Bob Murray wondered if MA plans could be used to expand coverage to the commercial population by utilizing MA plans' existing infrastructure and arming them with additional capabilities, e.g., OON price caps.

For Medicare wraparound options, Medicare enrollees would receive the same benefits covered under the universal system, regardless of the funding source. Roger Gantz noted that state Medicaid programs do this today for low-income Medicare beneficiaries ("dual-eligibles"). A vision for benefit design would be helpful for this discussion. Roger Gantz suggested not including long-term care in wraparound benefits. There are equity implications of taking away coverage for a service that has been covered previously. David DiGuiseppe suggested an exercise making a theoretical MA plan with supplemental benefits to identify costs. Pam MacEwan noted that the Health Services Act (1993) did not include long-term care, Medicare, or the Aged, Blind, or Disabled program due to high costs. The Commission has not yet decided how or whether to include Medicare in the universal health care system and FTAC's guidance will be key to informing this decision. Pam MacEwan remarked that the pursuit of a waiver is a question of resources, appetite, and feasibility. Currently, the likelihood of succeeding is extremely low. However, there are equity implications of not including Medicare, e.g., enrollees of the universal system potentially having richer benefits than Medicare enrollees. FTAC should provide guidance to the Commission on how to best resolve this, e.g., wraparound benefits. HMA noted the benefit to Washington of demonstrating improved equity, quality and access and reduced costs through consolidating state-run programs, where Congress and/or CMS could be more receptive to granting the state authority of Medicare funding and program administration. Roger Gantz encouraged the Commission to work with Oregon's Universal Health Care Governance Board (once established), so that two states can make the case to CMS and Congress for Medicare authority for state-based universal health care. Pam MacEwan remarked that FTAC's preference not to pursue a waiver at this time will be shared with the Commission, however, the discussion will be revisited at the next FTAC meeting.

### Adjournment

Meeting adjourned at 5:04 p.m.

## Next meeting

May 11, 2023
Meeting to be held on Zoom
3:00 p.m. – 5:00 p.m.