Finance Technical Advisory Committee (FTAC) Meeting Summary

May 11, 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
Ian Doyle
Kai Yeung
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Esther Lucero

Call to order

Pam MacEwan, FTAC Liaison, called the third meeting to order at 3:00 p.m.

Agenda items

Welcoming remarks

Pam MacEwan began with a land acknowledgement, reviewed the agenda, and shared the goals of the meeting.

Meeting Summary review from the previous meeting

Two revisions were submitted and shared onscreen to clarify language in the March 2023 meeting summary. Members present voted by consensus to adopt the meeting summary as amended.

Public comment

Kathryn Lewandowsky, RN, remarked on the political challenges in the current health care system and urged FTAC to focus on designing a non-profit universal health care system (and eventually, a single-payer system).

Cris Currie, retired RN, Health Care for All, recommended that the Commission begin engaging with federal authorities to enact legislation for necessary waivers and put Medicare decisions on hold for the time being.

Roger Collier asked whether a waiver is required for a Medigap option, how a direct reimbursement option would be funded, and asked about the likelihood of waiver approvals by lawmakers and Medicare enrollees.

Maureen Brinck-Lund noted that there has been little to no mention of single-payer design despite provisions in SB 5399 to do so, and urged the Commission to begin planning for waiver(s) submission to include federal funding.

Sarah Weinberg remarked that Medicare enrollees would find a universal system favorable relative to the current system and cautioned against using population-based payments or value-based payment arrangements.

Consuelo Echeverria suggested that the next five months be spent developing a single-payer model rather than considering the Employee Retirement Income Security Act of 1974 (ERISA).

Presentation

FTAC Member Christine Eibner, Senior Economist, RAND Corporation
It is important to include Medicare enrollees in Washington's universal health care system to achieve parity both in terms of cost sharing and benefit design. Six proposed options (and the pros and cons of each) were outlined to include Medicare enrollees in the universal system. Options were ordered from least feasible to most feasible.

Options 1 and 2 are variations on waivers. Option 1, an act of Congress/comprehensive waiver, would enable Washington to redirect federal funding for Medicare into the universal system. However, legal advisors to the state of California on this topic found no clear statutory or regulatory pathway enabling the Centers for Medicare and Medicaid Services (CMS) to redirect Medicare funds to a state, even via waiver.

Option 2 is a demonstration waiver, where Washington could develop a payment-focused reform with CMS to be implemented via a waiver, enabling the capture of federal Medicare funding. However, it is unclear how this could be used to cover premiums and cost-sharing or additional benefits. This option may also be subject to legal challenges and could create administrative burdens for the state.

Members discussed additional pros and cons of Options 1 and 2. FTAC Member Roger Gantz noted that budget neutrality is a key component of 1115a waivers. FTAC Member David DiGiuseppe noted that the Commission's 2022 report explored Medicare as a vehicle to lower commercial fee schedules and extract savings systemwide, and suggested that Option 1, although politically challenging, is the only option to achieve this objective. Christine Eibner remarked that Option 2 may also achieve that objective but would give the state less flexibility and control over the system. Maryland has implemented Option 2 to modify the fee schedule to achieve one rate. Roger Gantz suggested Option 1 as a north star and Option 2 as a potential pathway to a comprehensive waiver. FTAC Member Robert (Bob) Murray asked whether any of the options proposed were mutually exclusive. Christine Eibner responded that in general, some options could be combined. David DiGuiseppe was drawn to pursuing Option 1 or 2 in the long-term and potentially partnering with Oregon and California for leverage with CMS and Congress.

Options 3 and 4 are variations on a state-run Medicare Advantage (MA) plan. In Option 3, the state's MA plan would be the only option for Washington Medicare enrollees. To the extent that MA rules allow, this option could be designed to match the universal system. However, a waiver is needed to allow Medicare enrollees a choice between traditional Medicare and MA, and a mechanism to preclude private MA plans from entering the market. The state would need to apply to become a Medicare Advantage Organization (MAO) or contract with an existing MAO, adding administrative costs. Option 3 could be subject to legal challenges if enrollees were denied access to traditional Medicare.

Option 4 maintains Medicare enrollees' choice and the state could design and offer an MA plan with benefits parity to the universal system with fewer legal challenges. However, the state would still need to design and manage the MA plan in addition to the universal system, and MA pricing and benefit design requirements could limit flexibility. Again, the state would either need to apply to be an MAO, or contract with an existing MAO.

Members discussed additional pros and cons of Options 3 and 4. FTAC Member Eddy Rauser asked how either option would function out of state. Current MA rules would apply and the existing MA delivery system would need to be contended with. Christine Eibner added that it would be difficult for the state to bid competitively enough to achieve benefits parity with the universal system. David DiGiuseppe posed that Option 4 could be a step towards a universal system where the state can gather more experience. Roger Gantz added that there is no existing infrastructure for the state to administer an MA plan. Pam MacEwan noted challenges in restricting consumer choice, though more value can be extracted from a plan when choice is restricted.

Option 5 is a state operated Medigap plan which could be offered by the state to achieve benefits parity between Medicare and the universal system. However, the Medigap plan must have one of 10 specific designs which would not include dental, vision, or drug coverage. Additionally, due to federal rules, this option could not cover the Medicare Part B deductible, nor be available to MA enrollees, nor recoup federal funding.

Under Option 6, the state would reimburse Medicare enrollees directly for Medicare cost-sharing and for services covered in the universal system but not covered by Medicare. However, since enrollees' Part B deductibles couldn't be covered, this option may invite federal scrutiny. This would also be administratively complicated and directly reimbursing enrollees for some services could cause MA carriers to shift rebates to non-reimbursable services.

Members discussed additional pros and cons of Options 5 and 6. Roger Gantz shared that the Medicare Savings Program (MSP) is an existing program that covers out-of-pocket costs for Medicare enrollees up to 100 percent of the federal poverty level (FPL) and could be used as a vehicle to achieve objectives under both Options 5 and 6. For Option 6, eligibility for dual Medicare-Medicaid coverage could be extended. The state could pay the difference for higher income individuals, giving the state flexibility to tailor the income threshold. Kai Yeung noted that Medigap plans would increase fee-for-service (FFS) usage. Roger Gantz stated that the universal system benefit design has not yet been designed which poses a challenge.

Regardless of the approach, it is important to maintain federal funding for low-income enrollees. Dual eligibility is available to low-income Medicare enrollees. The federal government also provides cost-sharing and premium subsidies for low-income Part D enrollees (low-income subsidy (LIS) status). Dual and LIS enrollees could be auto-enrolled and/or reassigned to lower-premium plans.

Introduction to FTAC Member vote

Liz Arjun, HMA

This vote is not about whether Medicare will be included in the universal system, rather it is intended to provide guidance to the Commission on options that allow the design process to advance while ensuring benefits parity for Medicare enrollees now. This vote is not binding forever.

FTAC Member vote: recommendations to the Commission regarding Medicare

Pam MacEwan, FTAC Liaison

Motion to recommend or not recommend Option 1, an act of Congress or comprehensive waiver at this time.

Roger Gantz recommended not pursuing Option 1 at this time due to timing and resources. Though, this is not to suggest that Medicare shouldn't be part of the comprehensive system. Members agreed and recommended that the new system design continue to be developed, recognizing that eventually Medicare will be part of it.

Motion to recommend or not recommend Option 2, a demonstration waiver at this time.
Christine Eibner recommended that Option 2 not be explored as a means to include Medicare enrollees, though this could be explored in the future to reduce costs. Bob Murray agreed, adding that this may be an option for a payment model and Members agreed.

Motion to recommend or not recommend Option 3, a state-operated MA and Part D plan as the only option for Washington Medicare enrollees.
Eddy Rauser questioned the feasibility in the short-term and Kai Yeung noted the significant administrative burden. Pam MacEwan added that this option also restricts Medicare enrollees' choice. Members agreed that the Commission should not pursue Option 3.

Motion to recommend or not recommend Option 4, a state-operated MA and Part D plan that would compete with private MA plans and traditional Medicare.
Kai Yeung noted the administrative burden and questioned the feasibility. Eddy Rauser posed whether this option would be an opportunity for the state learn more, though the state would be competing in a mature market. A majority of Members agreed that though there are several hurdles, this option warrants further examination and should not be taken off the table. Roger Gantz voted no on Option 4 at this time due to a lack of infrastructure/ capacity and potential for exposing the state to downside risks.

Motion to recommend or not recommend Option 5, a state operated Medigap plan.
Bob Murray supported this option, noting the greater political feasibility. Kai Yeung supported this as a short-term option, potentially pairing with Option 1 or 2 in the long-term. However, this option wouldn't apply to MA enrollees which may invite pushback from MA carriers. Eddy Rauser remarked that managed care enrollment has grown significantly, noting several considerations in transitioning to an FFS structure. Roger Gantz voted no on Option 5 at this time, recommending that the Commission continue to endorse the legislature's work to expand the MSP. Pam MacEwan was not supportive of Option 5 at this time, though supported further examination.

Motion to recommend or not recommend Option 6, directly reimbursing or insuring beneficiaries for gaps.
Members generally supported Option 6 with further examination by the Commission. This option could be combined with Option 1 or 2 in the future to support the Commission's long-term goals, however implementation of Option 6 is not dependent on or necessarily related to Option 1 or 2. Roger Gantz recommended getting a second opinion to analyze the politics of these options and that the Commission connect with Oregon to advance this work. There are existing pathways to move towards what Options 5 and 6 could accomplish.

Presentation

Liz Arjun, HMA
FTAC heard updates from the Commission's April meeting. FTAC's next topic after Medicare is ERISA eligibility. FTAC Members with expertise on ERISA and who could present to the Committee at the July meeting were encouraged to reach out to HCA.

Presentation: Creating and sustaining a universal health care system – introduction to system cost containment strategies

Bob Murray, Assoc. Health Services Researcher, University of California College of the Law, San Francisco.
Bob Murray presented several cost containment models in order of intensity from lowest to highest. Cost growth targets (used in Washington) set a maximum target for the rate at which total health care expenditures can increase in a year. This model provides some transparency and identifies cost drivers but is unlikely to be effective in controlling price growth.

As modeled by Rhode Island, affordability standards authorize the Office of the Health Insurance Commissioner to reject premium rate increases exceeding the consumer price index (CPI-Urban). However, there is no control over providers other than hospitals.

Out-of-network (OON) price caps are a maximum payment which applies when a patient obtains care from a provider outside their insurance network. This gives insurers leverage to negotiate lower in-network prices. This is a lower intensity approach because it regulates such a small sector of the market.

Hospital global budgets are a prospectively determined cap on annual revenues. Global budgets can be 100 percent fixed during a performance year (as done in universal systems in Europe and Canada) or semi-variable, e.g., flexible global budgets. Maryland sets fixed global budgets, which may incentivize shifting care to non-hospital providers or may increase wait times for emergency elective procedures as experienced in Europe.

Recently, prominent economists proposed a system of very high price caps. With this approach, it's recommended that limits on price growth (directed at commercial prices) are imposed. However, this is an intensive regulatory approach since price caps are set on all services. This requires significant data collection and compliance, and both regulatory and legislative authority. There is nuance to how this could be implemented.

A population-based payment system (PBP) is a highly integrated finance and delivery system designed to meet population-level cost and quality targets. This requires significant regulatory oversight. Kaiser is an example of a PBP model and may integrate well with a universal system.

Some of the more complex regulatory systems can be prone to regulatory failure, but states have to start somewhere. The Center for Medicare and Medicaid Innovation (CMMI) will soon propose a model for states to implement global budgets. Bob Murray advocated for a flexible approach to global budgets. Roger Gantz asked whether selective contracting has successfully constrained costs in other states. Bob Murray replied that West Virginia's system regulated commercial payers, setting a rate floor (based on providers' reported cost levels) and a rate ceiling. However, the program was not cost-effective because the rate of growth allowed was not restricted over time. This approach also doesn't control health care volumes. Kai Yeung asked why administrative burdens for price caps couldn't be reduced by implementing caps for services with high price variance. Bob Murray replied that this would still require a significant amount of data collection. Bob Murray offered to provide a more in-depth presentation on select cost containment models in the future.

Adjournment

Meeting adjourned at 5:11 p.m.

Next meeting

July 13, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.