Universal Health Care Commission's
Finance Technical Advisory Committee meeting

September 10, 2024

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Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Universal Health Care Commission's Finance Technical Advisory Committee (FTAC)

Agenda

Tuesday, Sept. 10, 2024

Zoom meeting **2:00 – 4:30 PM**

FTAC members:		
☐ Pam MacEwan, FTAC Liaison	☐ Eddy Rauser	☐ Kai Yeung
☐ Christine Eibner	☐ Esther Lucero	☐ Robert Murray
☐ David DiGiuseppe	☐ Ian Doyle	☐ Roger Gantz

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome & call to order	1	Pam MacEwan, FTAC Liaison
2:05-2:08 (3 min)	Roll call		Mary Franzen, Coverage Strategies Manager, HCA
2:08-2:10 (2 min)	Approval of meeting summary from 07/11/2024	2	Pam MacEwan, FTAC Liaison
2:10-2:25 (15 min)	Public comment	3	Pam MacEwan, FTAC Liaison
2:25-2:35 (10 min)	Update about FTAC procedures	4	Pam MacEwan, FTAC Liaison
2:35 – 2:50 (15 min)	2024 workplan review	5	Liz Arjun, Principal Health Management Associates
2:50 – 3:30 (40 min)	Analysis of cost and cost-sharing for selected population	6	Mary Franzen, Coverage Strategies Manager, HCA Peter Hallum, Milliman
3:30 – 3:55 (25 min)	Principles of cost sharing	7	Liz Arjun, Principal Health Management Associates
3:55 – 4:00	5-minute break		
4:00 - 4:30 (30 min)	Future topics: cost containment, provider reimbursement, reference pricing	8	Liz Arjun, Principal Health Management Associates
4:30	Adjournment		Pam MacEwan, FTAC Liaison

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Tab 2

Washington State Health Care Authority

Universal Health Care Commission's Finance Technical Advisory Committee (FTAC) meeting summary

July 11, 2024
Virtual meeting held electronically (Zoom)
2–4:30 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
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Esther Lucero
Ian Doyle
Kai Yeung

Call to order

David DiGiuseppe, FTAC member, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

Beginning with a land acknowledgement, David DiGiuseppe welcomed members of FTAC to the tenth meeting and provided an overview of the agenda.

Meeting summary review from the previous meeting

The members present **voted by consensus to adopt the May 2024 meeting summary.**

Public comment

Aaron Katz, a retired faculty member from the University of Washington School of Public Health, encouraged FTAC to focus system cost containment considerations on prices, and not on using point-of-service cost sharing as a vehicle to reduce unnecessary utilization. He cited research that suggests cost sharing reduces access to beneficial services at least as often as it impedes the use of wasteful services, particularly for people with lower incomes.

Kathryn Lewandowsky, Vice Chair of Whole Washington, noted that many people across Washington, particularly in rural communities, face dire situations related to their health care. Cost-sharing, such as copays, discourages people from seeking care they need, and can lead to more expensive emergency care later.

Commission updates & goals for today

Liz Arjun, Health Management Associates (HMA)

Liz Arjun provided an update on the workplan, noting that the focus for 2024 is on determining the costs of the unified health care system based on decisions about what benefits and services are covered, cost containment, and provider reimbursement. Also under consideration are administrative simplification and maximizing coverage in existing programs. In addition, FTAC and the Universal Health Care Commission have considered and analyzed the Washington Health Trust proposal and sent a report to the Legislature in early July.

The Commission has directed FTAC to provide guidance on developing an actuarial analysis to estimate: 1) the costs of a range of covered benefits and services; and 2) the costs of varying levels of cost sharing, including eliminating or minimizing enrollees' out-of-pocket costs.

Presentation: Considerations for Consumer Cost Sharing in a System of Universal Health Coverage

Anya Rader Wallack and Hannah Turner, HMA

Both presenters have experience trying to create universal health care coverage systems at the state level, notably in Vermont and Rhode Island. The presenters discussed the different types and impact of cost sharing, cost sharing models in other countries with universal coverage, and cost-sharing examples from systems in place in Washington State.

Different types of cost sharing include deductibles, coinsurance payments, and copays. Utilization management tools, such as referrals and prior authorization, may also impact cost. They noted that cost sharing, even in amounts that could be considered very modest, is associated with reduced use of care, regardless of a person's income.

In many other countries, even those with universal coverage, some form of cost-sharing is in place. There is variation in the percentage of the cost borne by the patient. The presenters noted advantages to cost sharing, including that patients having "skin in the game" can lead to better decisions about utilization (i.e., reduction in unnecessary care). As noted during public comment, disadvantages include creating barriers to care, especially for people with lower incomes, as well as patients' deferring care until they need a higher level of more expensive care.

Detailed examples of cost sharing in other countries included Germany, Canada, and France. Anya Rader Wallack discussed her experience trying to create a system of universal coverage in Vermont. She described drawbacks of various options: "Medicare for all" involved cost sharing that was too high, while matching Vermont's coverage for teachers and other public employees would have resulted in taxes that were too high. Other options did not result in equitable coverage across the entire population, and available revenue sources (premiums and taxes) did not keep pace with cost growth. Ultimately, Vermont did not implement a universal health care coverage system.

Hannah Turner shared examples of cost sharing in systems currently in place in Washington, including Medicare, Apple Health (Medicaid), Cascade Care, and public employee benefits.

Discussion

Panelists and FTAC members had a robust discussion about costs borne by covered individuals in terms of both cost sharing and premiums. Two key points made were that: 1) the lack of cost transparency throughout the US health care system makes it difficult for patients to understand how much cost sharing they will bear; and 2) premium subsidies may assist an individual with obtaining coverage (e.g., limiting premiums to a percentage of income), yet the individual may face point-of-service cost sharing that they cannot afford.

FTAC members then discussed how to structure a request of Milliman for actuarial modeling to generate the cost estimate request by the Universal Health Care Commission. FTAC members described two components of the actuarial analysis: 1) total cost of services covered; and 2) value of cost sharing to be borne by the covered individual. FTAC members discussed options for both of these components and sequencing of these in the Milliman analysis.

Members noted a consideration of potential cost sharing models in a universal system was not an attempt to affect utilization, but rather an effort to uncover ways to distribute costs in a fair and equitable way. Milliman staff were present and indicated that additional assumptions required for the analysis could be provided later.

FTAC members voted to explore engaging Milliman to perform the following analyses:

- **Step 1:** Estimate and compare the annualized total cost of care for three different benefit packages if provided to the entire population that would be covered by a uniform financing system: (1) Cascade Care Silver benefit coverage plus adult dental; (2) PEBB/SEBB benefit coverage plus adult dental and (3) Apple Health Medicaid managed care benefit design plus adult dental (i.e., excluding LTSS and other non-dental Medicaid FFS benefits). FTAC members will work with Milliman to provide further guidance about which PEBB/SEBB plan to model, as well as which benefits to include and exclude from Apple Health plans.

- **Step 2:** Model different cost sharing options, ranging from $0 to higher levels, possibly on a sliding scale based on a person's income. The details of this step will be further refined as the work progresses.

Adjournment

Meeting adjourned at 4:31 p.m.

Next meeting

Sept. 10, 2024
Meeting to be held on Zoom
2–4:30 p.m.

Tab 3

Public comment

From:	Cris
To:	HCA Universal FTAC; HCA Universal HCC
Subject:	public comment
Date:	Thursday, August 29, 2024 5:05:26 PM

External Email

To FTAC and UHCC:

I am proposing several modifications to the Washington Securities Health Trust (HB 1104 from 2019) as previously revised, since it is still a work in progress. Two of these are relevant to recent UHCC and FTAC meetings. The first is to Section 16(c) which currently states: (c) A resident shall not be required to pay a copayment, coinsurance, deductible, or any other form of cost sharing at point of care for all covered benefits under the trust. I want to change it to:

(c) Cost sharing in the form of deductibles and copayments at the time of service shall not be required for any covered benefits under the trust. Coinsurance, not to exceed 10% and with an annual cap, is permitted for treatment procedures, specified prescription drugs and biological products, but not for primary care visits, therapy evaluation visits, preventive procedures or routine diagnostic procedures. Coinsurance for institutional long term care is also permitted. Coinsurance may not be required of residents under the age of 21 or adults whose household income is under 200% of the federal poverty level.

There should be no copay or deductible at the time of service (as in Canada) that discourages doctor visits and evaluations, but the patient will probably still need to contribute directly to the ultimate cost of specific services (up to a cap that could vary with income) in addition to monthly premiums/taxes. This will help keep premiums/taxes affordable and assuage those who think they should not be paying for someone else's health care. Cost sharing should only be done on the back end as with payments for other consumer services. But everyone needs to know the exact, standardized additional cost of treatment up front (as with other consumer services), so they can decide after diagnosis and before treatment begins if the cost and risk are worth it. The French have a great system, except the providers should not have to be involved in accepting payments from patients. That adds too much provider expense and administrative hassle. There is also no need for multiple carriers to run their administrative services through employers. While an employer payroll tax should still help fund the program, all cost sharing, premiums, taxes, and reimbursements should be handled directly by the preferably nonprofit Administrative Service Organization(s) hired and supervised by the single-payer according to pre-established, negotiated fees.

The other change, indicated in bold type, is to Section 11(l): "health care items and services covered under the trust shall not be subject to prior authorization, **beyond what is required by Medicare for a well-defined purpose**, or a limitation applied through the use of step therapy protocols. The determination of medical necessity or appropriateness shall be made by the resident's health care professional who is treating that individual and is authorized to make that determination."

Prior authorization was started by Medicare in the late 1960s and was meant to be used sparingly, as it is still used for a limited set of treatments. The main problem now is that private insurers are using it to extremes in order to deny care and increase profits. Our state-

based system should retain the option to use this tool if needed, but only for very limited purposes.

I would hope that the UHCC could soon begin to agree on parameters such as these so that an overall structure could start to take shape. However for that to happen, background information will need to be presented in advance in written or recorded form, so precious meeting time can be used for discussion of the material and decision making.

Cris M. Currie, RN (ret.)

Tab 4

FTAC decision-making process

Established practices

- All votes require a formal motion and a second by FTAC members, followed by a voice vote.

- Results are recorded in the meeting summary.

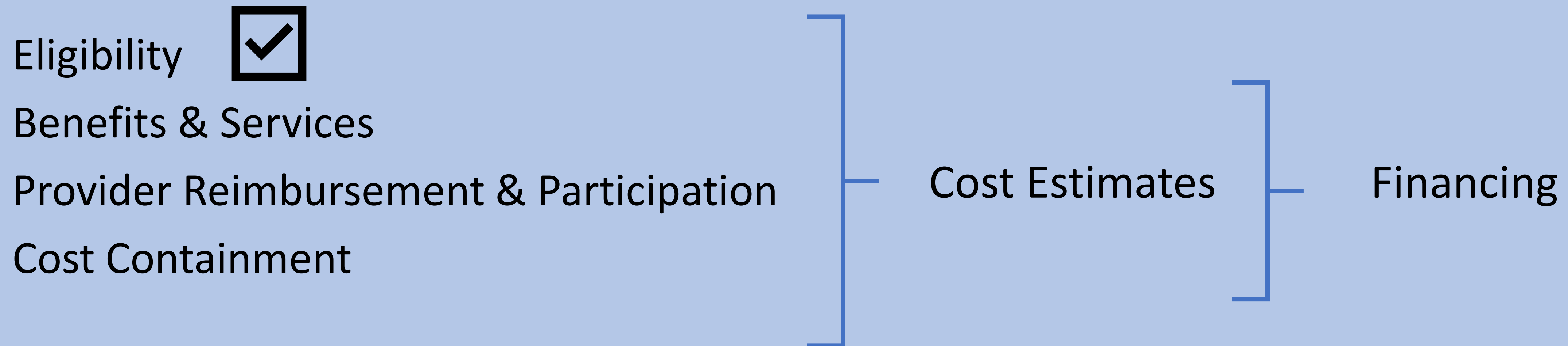
Future refinements

- Whenever possible, items that may need a decision from FTAC members will be noted on the agenda.

- Motions, votes, and results will be more clearly called out in meeting summaries.

Tab 5

Universal System Design: Developing a cost estimate



Workstream 1: Decisions made related to Eligibility

- ✓ **Determined eligibility in order to establish foundation for other Phase 1 decision points**

- ✓ **For now,** the universal health care system with a uniform financing system should be designed to include those enrolled in:
  - ✓ Medicaid
  - ✓ Individual Market plans
  - ✓ Small Group Market plans
  - ✓ Fully Insured large group plans (including PEBB/SEBB)
  - ✓ The uninsured

- ✓ **Self-Funded Plans**
  - ✓ Will explore the possibility that self-insured employers could offer their employees the option to enroll in the system
  - ✓ Will explore the possibility that self-insured employers would be required to offer coverage equivalent to what the system provides or pay a tax to help fund the system

- ✓ **Medicare**
  - ✓ Will consider options to achieve coverage parity for Medicare enrollees

Workstream 1: Developing a cost estimate

Selected Benefit Packages to model including existing assumptions including <u>existing cost-sharing</u>

Refining today

Apply different variables/assumptions

- **Cost-sharing**
- **Provider reimbursement**
- **Cost containment**

Begin discussion today to establish principles

Cost Estimate for the Universal Health Care System

Financing

Tab 6

Cost and cost-sharing analysis

July 11 FTAC discussion

FTAC members voted to explore engaging Milliman to perform the following analyses:

Step 1: Estimate and compare the annualized total cost of care for three different benefit packages if provided to the entire population that would be covered by a uniform financing system: (1) Cascade Care Silver benefit coverage plus adult dental; (2) PEBB/SEBB benefit coverage plus adult dental and (3) Apple Health Medicaid managed care benefit design plus adult dental (i.e., excluding LTSS and other non-dental Medicaid FFS benefits). FTAC members will work with Milliman to provide further guidance about which PEBB/SEBB plan to model, as well as which benefits to include and exclude from Apple Health plans.

Step 2: Model different cost sharing options, ranging from $0 to higher levels, possibly on a sliding scale based on a person's income. The details of this step will be further refined as the work progresses.

Cost and cost-sharing analysis
Benefit Design

Cost sharing scenarios:

Three cost sharing scenarios will be modeled with varying benefits by Medicaid eligibility status (without a sliding-scale cost share structure)

Scenario Title	Non-Medicaid[1] Enrollees	Medicaid Eligibility Status
1. Medicaid	Medicaid cost sharing	Medicaid cost sharing
2. PEBB/SEBB	PEBB/SEBB cost sharing	Medicaid cost sharing
3. Cascade Care Silver	Cascade Care Silver cost sharing	Medicaid cost sharing

Related notes and questions:

- Dental services will be covered for adults and children in all scenarios
- LTSS and other Medicaid benefits not covered by PEBB/SEBB (other than dental) will not be included in any scenario
- PEBB/SEBB model will need to be chosen
- The coverage of additional benefits will not vary by cost sharing scenario (e.g., dental will always be modeled as covered)
- Will vision and hearing be covered? For all enrollees or children only?

(1) For example, this includes those uninsured, individual market coverage, public employees (PEBB), and school employees (SEBB).

Cost and cost-sharing analysis
Provider Reimbursement

Provider Reimbursement:
Provider reimbursement will be modeled at rates that approximate overall payment neutrality to medical providers for individuals enrolled in the program.

Milliman will rely on information from HCA, estimates of commercial and individual market reimbursement rates, and historical enrollment and utilization patterns to estimate these rates. We will not estimate the impact of changing provider reimbursement rates on medical service availability or utilization patterns. We will assume out-of-state providers are reimbursed at the same rate as in-state providers.

Other services may be modeled assuming PEBB/SEBB reimbursement rates, including:

- POS pharmacy services
- Dental services
- Other additional benefits covered (e.g., vision, etc.)

Cost and cost-sharing analysis
Other Modeling and Assumptions

Enrolled population:

- The Uniform Financing System is assumed to enroll all individuals residing within Washington age 64 and under, not enrolled in Medicare, TRICARE, VA health benefits, or an ERISA qualifying plan. This includes the uninsured, individual market coverage, public employees, school employees, and Medicaid. In other words, 100% of this population regardless of current coverage, citizenship, or official resident status.
- Results provided for the entire population (i.e., not broken out by income level or other cohorts)

Additional considerations and limitations:

- Two medical management scenarios will be reported (i.e., assuming PPO-like medical management and fee-for-service-like limited management)
- Program and medical administrative costs will be excluded from the analysis
- Scenario results will be expressed as per member per month costs and ranges
- Consideration of program funding will not be included (e.g., federal match dollars for subpopulations, medical premiums, tax revenue, etc.)

Discussion

- Questions about the analysis and assumptions
- Milliman would like to propose identifying FTAC liaisons who will meet between FTAC meetings to support Milliman's analysis (e.g., to confirm modeling assumptions, report format, etc.).

Tab 7

Establishing principles for cost-sharing

Discussion: Establish principles for cost-sharing in the universal system

- We heard from experts in July, that it is important to be clear about whether cost-sharing is considered a financing mechanism or not.
  - Medicare is an example of a program that has pretty high out-of-pocket expenses to help finance the program. Or is it a tool for something else? For example, incentivizing or disincentivizing certain behaviors.
  - Medicare- realizes a lot from cost sharing (co-insurance) If not Medicare, then what?
  - If there is cost-sharing, should it be the status quo? Or should we limit it by income? What about by service?
  - When and where is cost-sharing charged? (point of service vs. deductible vs. coinsurance)
- Do we mirror what's in the marketplace now or do we want something more aspirational?
  - Medicare Advantage, Exchange, Cascade Care
- Do you want to place limitations?
  - Income sensitive or not
  - Categories of services

Additional Background

- **Other states/WA Health Trust**
  - **Oregon:** no cost-sharing **directed by the Legislature**
  - **Vermont (Green Mountain)**: focused on Actuarial Value and modeled two options 100% AV (no cost sharing) and 87% AV and 80% AV with protections for people eligible for Medicaid and Exchange plans
  - **WA Health Trust**: acknowledges that cost-sharing is a part of most universal health care systems but has a detrimental impact on utilization and counter to prevention and equity and adds administrative complication.

- **WA Packages/Examples**
  - **PEBB/SEBB:** same cost-sharing regardless of income
  - **Cascade Care:** sliding scale cost-sharing- with additional state subsidies to offset
  - **Medicaid:** no cost-sharing

Next Steps

- Develop draft principles about cost-sharing to serve as guidance for the Commission
- Share with FTAC members for approval
- Share with Commission
- Discuss other factors including provider reimbursement and cost containment with FTAC members
- Share with Commission
- Additional modeling that applies these different variables

Finance Technical Advisory Committee meeting

We are currently on a short break

Tab 8

Next Steps - continued

- Develop draft principles about cost-sharing to serve as guidance for the Commission
- Share with FTAC members for approval
- Share with Commission
- Discuss other factors including provider reimbursement and cost containment with FTAC members
- Share with Commission
- Additional modeling that applies these different variables

Thank you for attending the Finance Technical Advisory Committee meeting!