Universal Health Care Commission's
Finance Technical Advisory Committee meeting

November 14, 2024

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Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

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

Agenda

Thursday, November 14, 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	1	Mary Franzen, HCA
2:08-2:10 (2 min)	Approval of Meeting Summary from 09/10/2024	2	Pam MacEwan, FTAC Liaison
2:10-2:25 (15 min)	Public comment	3	Pam MacEwan, FTAC Liaison
2:25 –2:30 (5 min)	Progress Update	4	Liz Arjun, HMA
2:30-2:40 (10 min)	Universal Health Care Commission update	5	Pam MacEwan, FTAC Liaison
2:40-2:50 (10 min)	Milliman Analysis Update	6	Peter Hallum, Milliman
2:50-3:35 (45 min)	Reference-based pricing presentation and Q&A	7	Liz Arjun, HMA Robert Murray, FTAC Member
3:35-3:55 (20 min)	Discussion about FTAC direction ***Potential decision regarding direction**	8	Liz Arjun, HMA
3:55 – 4:00 (5 min)	BREAK		
4:00 – 4:30 (30 min)	Prior authorization overview and discussion *** Potential decision regarding recommendations**	9	Mary Franzen, HCA

4:30	Adjournment	10	Pam MacEwan, FTAC Liaison

Tab 2

Washington State Health Care Authority

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

September 10, 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 are available on the **FTAC webpage**.

Members present

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

Members absent

Ian Doyle
Esther Lucero

Call to order

Pam MacEwan, FTAC Liaison, called the meeting to order at 2:01 p.m.

Agenda items

Welcoming remarks

Beginning with a land acknowledgement, Pam MacEwan welcomed members of FTAC to the eleventh meeting and provided an overview of the agenda.

Meeting summary review from the previous meeting

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

Public comment

Andre Stackhouse, Whole Washington, thanked members for the **analysis report on SB 5335**. Stackhouse referred to Whole Washington's draft response and requested the analysis report be included in the appendix of the Commission's 2024 Legislative Report.

Katherine Lewandowsky, Whole Washington, encouraged the committee not to recommend any additional cost sharing at point of care.

Marcia Stedman, Health Care for All – Washington, referred to the actuarial work done for the Universal Health Care Work Group and noted the need for updated data. Stedman recommended that future analyses should model the impact of the presence and absence of cost sharing in each plan.

John Godfrey, Washington Community Action Network (Washington CAN) and Health Care is a Human Right, echoed the concerns of previous public comments regarding cost sharing. Godfrey commented that the benefits of cost sharing are canceled out by the barriers they present and discussed the need for cost-sharing transparency.

Ronnie Shure, Health Care for All – Washington, encouraged the committee to clarify actions that occur during meetings. Shure urged the Committee to adopt policy that clarify these actions.

Update about FTAC procedures

Pam MacEwan, FTAC Liaison

Pam MacEwan reminded members of the established agreed-upon consensus process, in which all votes require a formal motion and second by FTAC members, followed by a voice vote. Results are then recorded in the meeting summary. In response to previous questions about the process, the following future refinements were shared: Whenever possible, items that may need a decision from FTAC members will be noted on the agenda; Motions, votes, and results will also be more clearly called out in meeting summaries.

Committee member Roger Gantz encouraged the committee to identify decision points in forthcoming agendas so that stakeholders can weigh in on specific items and decisions before the committee or the Commission. MacEwan concurred and pointed to the public comment received today as testimony for this. It was determined that more of an effort will be made to point out the intention and goals of meetings moving forward.

2024 workplan review

Liz Arjun, Health Management Associates (HMA)

Liz Arjun updated the committee on the 2024 work plan and the decisions that have been made related to Phase 1: Eligibility. These decisions included:

- 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 Public Employees Benefits Board and State Employee Benefits Board, or PEBB/SEBB), and the uninsured.
- The Commission will explore the possibility that self-insured employers could offer their employees the option to enroll in the system.
- The Commission 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.
- The Commission will consider options to achieve coverage parity for Medicare enrollees.

Arjun reviewed the different steps the committee has taken to develop a cost estimate, including selecting benefit packages to model and beginning to consider various assumptions for cost-sharing, provider reimbursement, and cost containment.

Committee member Roger Gantz commented that he would like the Commission to be able to see the implications of the different variables and assumptions on a per member per month (PMPM) basis. He noted that benefit packages could be distorted due to reference pricing. He further commented that excluding features that may distort the model could simplify financing decisions.

Discussion: Analysis of cost and cost sharing for selected population

Mary Franzen, Health Care Authority (HCA)

Mary Franzen briefly reviewed the proposed steps of the Milliman analyses, which were determined by committee members during the July 11 FTAC meeting. She then presented the three scenarios for cost sharing that will be modeled with varying benefits by Medicaid eligibility status (without a sliding-scale cost share structure):

Scenario Title	Non-Medicaid 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

There was robust discussion on the proposed analyses. Committee member Roger Gantz expressed concern about the scenarios, commenting that using the existing cost-sharing structures will not provide an accurate actuarial value of each of the service packages. Peter Hallam, Associate Actuary at Milliman, responded that both the allowed costs (total costs for services) and the cost sharing reduced cost (payer-paid amount for services) will be provided, which should remove the direct impact of cost sharing from the results. He noted, however, that there will still be impacts associated with different cost-sharing scenarios, even across the same population.

Committee member Christine Eibner noted that small group and fully insured markets were not included in the list of non-Medicaid enrollees. Hallam responded that this was an example list, that they should be included, and that the list is non-ERISA (Employee Retirement Income Security Act of 1974), essentially.

Committee member Kai Yeung commented that it would be helpful to know the incremental changes to cost sharing for different populations. Following this, committee member David DiGiuseppe requested that the analysis include, at first, the total cost of care for each scenario for the entire population with no cost sharing before splitting the analyses into columns one and two to isolate the difference from total cost of care before overlaying cost sharing. Hallam commented that there will be different utilization patterns across the three scenarios due to user response to cost sharing. He also indicated that historical reimbursement rates will be blended, and that no assumptions about how the shifting of payment neutrality would be skewed across providers will be included in the model.

Committee member Roger Gantz asked how prior authorization will be handled in the model. Hallam responded that two medical management scenarios will be reported (i.e., assuming preferred provider organization-like medical management and fee-for-service-like limited management), which will include prior authorization considerations. Committee member David DiGiuseppe asked how excluding program and medical administrative costs from the model will impact the absolute dollar impact, which he noted the Commission will

likely want to know. Hallam responded that there are many unknowns, including any reasonable estimate of administrative costs. Hallam noted these are limitations to the model.

Finally, committee members interested in being FTAC liaisons to support Milliman's analysis were encouraged to express interest by emailing **HCAUniversalFTAC@hca.wa.gov**. Hallam indicated the time commitment would be about 1 hour per week for meetings, as well as additional time for research and preparation of those meetings.

Discussion: Principles of cost sharing

Liz Arjun, Health Management Associates (HMA)

Liz Arjun reminded the committee that the Commission requested FTAC develop cost-sharing principles. Arjun opened up the discussion by sharing a list of questions for members to consider as they work to establish principles for cost sharing. Arjun then shared cost-sharing examples in Oregon, Vermont, Washington Health Trust, and current Washington packages (i.e., PEBB/SEBB, Cascade Care, Medicaid).

Committee members began their discussion with statements about cost sharing to frame the guiding principles that will be shared with the Commission. Many committee members shared results of past research, including examples that indicate cost sharing can affect utilization, hospitalization rates, and health outcomes. Members recognized that the body of literature has produced conflicting results and noted that having health insurance can have benefits beyond physical health, such as increased financial security.

Following this discussion, it was determined that project staff would draft and circulate a "Principles for cost sharing" document for committee members to review and provide feedback before bringing to the Commission.

Future topics: cost containment, provider reimbursement, reference pricing

Liz Arjun, Health Management Associates (HMA)

Liz Arjun briefly discussed topics for the next meeting of FTAC including provider reimbursement and cost containment principles. She noted that the goal would be to share these additional principles with the Commission ahead of the findings from the cost and cost-sharing analyses.

Adjournment

Meeting adjourned at 4:27 p.m.

Next meeting

Thursday, November 14, 2024
Meeting to be held on Zoom
2–4:30 p.m.

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission's

Finance Technical Advisory Committee

Written Comments

Received From August 22

Written Comments Submitted by Email

C. Currie, Health Care For All - Washington 1
A. Stackhouse, Whole Washington 2
J. Shepard, Washington State Medical Association 3

Additional Comments Received at the September FTAC Meeting

- The Zoom video recording is available for viewing here: https://youtu.be/dQ9Djr-7V4E?si=spNzUZWw_qjAAN96

From: Cris
To: HCA Universal FTAC
Subject: Public Comment
Date: Wednesday, October 23, 2024 12:04:14 PM

External Email

FTAC:

I have two comments about the October 10, 2024 UHCC meeting. The first concerns Pam's FTAC report. FTAC members tossed around several ideas related to cost sharing at their September 10 meeting but drew no conclusions. Liz actually tried to get the group to draw some definite conclusions by asking: "If cost sharing is needed, what should be the parameters?" A few other ideas were mentioned but nobody attempted to answer Liz's question, and then of course they ran out of time. So she said she would be in touch by email to produce something for the UHCC's next meeting. Then presto, six recommendations appeared in the materials for the next meeting. I think the public deserves to know exactly how these recommendations were reached, and in the future, the recommendations need to be reached in the public meeting and not behind a closed door.

Then there was Gary's comment during the prior authorization discussion that he was not aware of any examples of lists of services requiring prior authorization. I'm wondering why he is not aware of CMS's traditional Medicare prior authorization lists that it has compiled for many years. For example, the current list for outpatient services can be found here. Additionally, a DME prior authorization program was started in 2016 and an outpatient surgical program this year. Information can be found here, and here. Traditional Medicare requires very little prior authorization and it is generally only for rather obscure, risky or very expensive procedures, and for a specific reason. So rather than trying to force carriers to explain their arbitrary prior authorization chaos that maximizes profits, or study the equally complicated gold card idea, why not simply say that prior authorization will not be required in our UHC system beyond what is required by traditional Medicare?

Cris M. Currie, RN (ret.) Spokane, WA HCFA-WA policy committee member

Whole Washington

Response to Washington Health Trust (SB.5335) analysis report

August 2024

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Acknowledgements

Whole Washington (Whole WA) thanks the Universal Health Care Commission (Commission) for their analysis of the Washington Health Trust (SB.5335) and the publication of this report (WHT Analysis Report).

We also thank Senator Annette Cleveland for taking the initiative of requesting that the Commission do this work.

Last, we make special thanks to Senator Bob Hasegawa for doing the incredible work of introducing universal public healthcare in the form of The Washington Health Trust into the last six legislative sessions first as SB.5222 in 2018, then as SB.5204 in 2020, and last as SB.5335 in 2022 - all of which created the legislative language that is under review in this report.

The public of Washington is both more involved and better informed because of this report having been made. We look forward to our ongoing collaboration on making universal public healthcare a reality in Washington and we are hopeful for significant progress in the upcoming legislative biennium.

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Executive Summary

This is a detailed response to the Washington Health Trust (SB 5335) Analysis Report conducted by the Commission's Financial Technical Advisory Committee (FTAC) and approved by the Commission. The report is available at www.wholewashington.org/commission and the Reports section of the Commission website.

The report came at the request from members of the Legislature. This response is written by Whole Washington executive director Andre Stackhouse and may be cosigned by other organizations and individuals. This response is intended to summarize what Whole WA sees as the key takeaways that we hope are emphasized in your upcoming annual Report to the Legislature (November Report). We also suggest what we see as the most appropriate follow up work to progress our goals forward.

This response is currently a draft. It also makes reference to a draft of the November Report. As such, there is still considerable room for the contents of this response to change as additional feedback is collected from our community as well as our conversation with the Commission develops. Where we reference the opinions, decisions, and perspective of the Commission we hope to characterize them accurately - if at any point we misunderstand or misrepresent the work of the Commission please let us know and we are happy to amend and clarify.

For the latest version of this response go to:
https://docs.google.com/document/d/1Ht3GB__L6N0MUbrdGCmNU8Ca1aFvOwNAE8-fKKamC_4/edit?usp=sharing

The response is also be linked at:
www.wholewashington.org/commission

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Key takeaways

Our reading of this report is that there is considerable alignment between the goals and analysis of the Commission and the design of the Washington Health Trust and its supporting analysis. While the Washington Health Trust compiles a comprehensive health care system design including transition and financing into a single piece of legislation, we consider many of the Commission's findings and recommendations to effectively be recommending different components of the Washington Heath Trust's transition and implementation. Whether passed in a single piece of comprehensive legislation or across multiple pieces of incremental legislation, universal health care must be implemented one step at a time and it appears there are many steps we agree on.

Eligibility

- The Legislature, Commission, and WHT understand universal eligibility to include all residents of Washington state.
- The WHT additionally includes some eligible nonresidents including in-state workers who reside in a different state, and in-state students from out of state. It is unclear if the Commission has determined which if any nonstate residents would be included in their eligibility criteria.
- While Whole WA imagines that it will be either necessary or ideal to include some nonresidents, we consider state residency to be a reasonable baseline eligibility requirement.
- Whole WA suggests that on eligibility questions that relate to out-of-state residents who work in Washington that design and collaboration with the Universal Health Plan Governance Board of Oregon is important.
- Whole WA recommends the Commission emphasize a firm commitment to state residency as the basis for eligibility in its November Report with room for expansion to other populations as additional design and analysis is completed.

Medicaid integration

- The Legislature, Commission, and Whole WA are aligned on the goal of incorporating Medicaid enrollees and all state and federal Medicaid dollars into our state's universal health care system (UHCS).
- Whole WA and the Commission both identify federal waivers as pathways to integration while the Commission's report also discusses the use of State Plan Amendments (SPAs) as a potential long-term integration strategy.
    - "Compared to a waiver, a SPA would require a state to put up additional matching dollars and provide mandatory or optional benefits depending on the population. In addition, a SPA would be a relatively permanent change to a state's Medicaid program that wouldn't have to be renewed every five years (as a waiver does) and it creates an entitlement where all those who apply and enroll must be served all the benefits for that program." (Analysis Report page 14).

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    - Based on the Commission's analysis, Whole WA believes that SPAs may offer the best long-term solution to Medicaid integration as the more permanent transition and uniform benefits both match Whole WA and WHT's intention to create a stable, permanent, and fair UHCS.
- Whole WA recommends Medicaid as the ideal public health system to begin the establishment of a unified financing system, public trust, and public option as its lack of any premiums or point-of-use cost sharing makes it most closely resemble the intended design of the WHT.
- Current Medicaid reimbursement rates are considered a potential challenge of integrating Medicaid into a state UHCS.

Medicare integration

- The Legislature, Commission, and Whole WA are aligned on the goal of incorporating Medicare enrollees and federal Medicare dollars into our state's universal health care system (UHCS).
- The Commission and Whole WA agree that federal waivers are the ideal long-term solution to Medicare integration but may take time to acquire.
- WHT aims to introduce a public Medicare Advantage option to allow for voluntary enrollment into the state's UHCS, the Commission believes this is possible but may face significant challenges.
- The Commission believes that direct reimbursement is the most feasible short-term solution to Medicare integration which would not require a federal waiver and would be unlikely to face legal challenges. Whole WA agrees with this assessment and is open to this pathway as the initial transition step to Medicare integration.
- The Commission believes that the three pathways outlined above (direct reimbursement, federal waiver, public Medicare Advantage option) may exist alongside each other, Whole WA agrees with this assessment and considers each option to present advantages. We recommend advancing work on all three paths and beginning with direct reimbursement.
- Whole WA recommends that the Commission include in its November Report that Medicare integration is not understood as a significant barrier to the establishment of a unified financing system, public trust, and public option while Medicare continues to operate in its current form.

Self-funded employer plans

- The Legislature, Commission, and Whole WA are aligned on the goal of incorporating employers and employees into our state's UHCS.
- The Legislature, Commission, and Whole WA agree on the importance and challenge of navigating federal ERISA regulations but agree that there may be paths forward. However, it is also likely that a legal challenge will be pushed regardless, necessitating careful legal review and a design resistant to litigation on these grounds.

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- Unlike with Medicare, there are currently no established federal waivers to be exempted from ERISA limitations, though they could be established in the future possibly through federal legislation like the State-Based Universal Health Care Act (SBUHCA).
- The Commission does not at this time recommend incorporating self-funded employer plans that are protected under ERISA without further review while the WHT establishes voluntary enrollment combined with an employer mandate to provide coverage of the employers choosing to all employees up to a minimum spending requirement.
- While Whole WA maintains confidence and optimism in the legality and durability of its universal health care system design, we and the Commission agree that there is fundamental ambiguity in the rules and how courts would decide given a case.
- For this reason, we understand the Commission does not recommend any changes at all to self-funded employer plans protected by ERISA. While the WHT articulates its transition for these plans, Whole WA does not believe integration of these plans is necessary for the establishment of the WHT or similar publicly funded and/or administered trust open for enrollment to the public.
- For additional information and strategies regarding navigating ERISA in the design of a statewide universal health care system, we suggest the Commission consult A Road Map to 'Single-Payer' published by Public Citizen.
- Whole WA recommends that the Commission include in its November Report a firm commitment to the intention to integrate self-funded employer plans into the state UHCS.
- Whole WA recommends that the Commission include in its November Report that ERISA not be treated as a barrier to the establishment of a unified financing system, public trust, and public option open to individuals and employers to enroll and that all requirements and incentives to integrate ERISA-protected plans be considered after additional analysis.

Benefits & services

- "The Commission aims to design a benefits package for the new system that prioritizes prevention, comprehensive coverage, and equitable access to appropriate care"
- Whole WA has oriented its benefits around the general concept of "comprehensive coverage" of medically-necessary care across the entire state's population.
- While Whole WA has articulated a fairly specific benefits package, the Commission has yet to make clear decisions about what a benefits package for their recommended state UHCS would include.
- The WHT covers long term services & supports (LTSS) including hospice and end-of-life care, and long-term care benefits at least at the standards of Medicaid coverage, but these benefits would not be offered at the outset. Rather, these benefits are intended to be phased in within four years of the Trust's implementation. The Commission has not yet made a decision regarding coverage of LTSS.
- Whole WA recommends that the Commision include in its November Report a clear recommendation ACA mandated EHBs be set as the absolute minimum benefits package for the state UHCS with room for expansion as additional analysis and decisions are completed.

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Costs, administrative waste, and prices

- Whole WA has run two economic studies analyzing the costs of a statewide UHCS in the form of the WHT.
- While the Commission has not run its own cost-analysis, it has based much of its work off of prior work including the Universal Health Care Work Group Report.
- Prior to the UHC Work Group Report the Legislature commissioned a report from the Washington State Institute for Public Policy which conducted a meta-analysis of economic studies across US states and global health care systems.
- While the systems and the methodologies of the studies all differ, there is consensus between them all that universal health care provides a net savings on total health care spending compared to the status quo.
- The WHT Analysis Report articulates some skepticism of Whole WA's projections on savings through administrative efficiency and emphasizes the role that high prices play on total cost.
- Whole Washington's economic analysis was conducted without assumption of significant price adjustment and therefore does not find significant savings in price adjustments. However, this assumption was made not to assume that prices do not contribute to high total costs or that significant savings could not be found through price controls but instead an attempt to find enough savings through administrative efficiency such that prices would not need to be significantly adjusted. It is a means of conducting a more conservative analysis. The Washington Health Trust gives the Washington Health Trust Board the ability to enact price controls where necessary and to negotiate on drug prices. In this sense, both Whole WA and the WHT recognize the role of price inflation has played in the inflation of health care costs and are open to mechanisms to address and bring down prices.

Cost sharing

- Whole WA understands cost sharing to be a part of virtually any/every UHC system in the world and would be in Washington as well.
- Whole WA identifies excessively complicated cost sharing as contributing to administrative waste and less cost transparency resulting in higher prices, vectors for waste, fraud, and abuse, and an overall more expensive health care system.
- We understand point-of-service cost sharing to have negative impacts including
    - Complicating billing by splitting the bill more ways and necessitating more collection infrastructure including on providers.
    - Reducing health care utilization much of which is likely medically and financially advisable and should not be skipped/delayed.
    - In this way, Whole WA understands point-of-service cost sharing to be especially counter to the goals of prevention and equity.
- Whole WA views hospital and insurance networks and "out of network" cost sharing as primarily a barrier to patients seeking care from the provider of their choosing and are therefore undesirable.

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- Whole WA recognizes that some providers appreciate prior authorization, case management, care coordination, and denials of insurance claims when they filter out health care utilization that they would not medically recommend - however Whole WA believes this is an inappropriate role for an insurer to play and that it is a responsibility to providers to make their medical recommendations clear to clients rather than leaning on bureaucracy to avoid the conversation.
- WHT is designed and intended to eliminate all point-of-service cost sharing.
- Whole WA seeks to be evidence-based in our system design and therefore is open to forms of cost sharing in which there exists evidence that they improve affordability or outcomes at either the individual or public health level.

Requests for the November Report to the Legislature

Whole WA has not yet had the capacity to do a detailed reading and analysis of the draft of the November Report included on pages 111-147 of the meeting materials of the August Commission meeting. However, we offer the following initial feedback on the sections that make reference to the WHT and the Analysis Report.

- A more detailed summary of the Washington Health Trust Analysis Report and its findings especially on points of alignment, decisions, and pathways forward.
- Points of alignment, decisions, and pathways forward identified in this report should be articulated in the form of clear policy recommendations to the legislature to be advanced in the next legislative biennium.
- In particular, Whole WA believes the Commission should make the following specific recommendations to the Legislature in its November Report.
    - The establishment of a public trust to consolidate funding for state health plans including PEBB, SEBB, and Medicaid.
    - The consolidation of PEBB and SEBB and Medicaid into a single benefits package administered by one board while covering all current enrollees.
- An outline of future planned analysis and decisions including a general timeline should be included to set expectations on what further questions will be answered at a future date.
- The full Analysis Report should be included in the November Report in the Appendix.

Requests for next steps, future work, and further decisions

- Synthesizing a 10-year cost analysis with some affordances for transition, uncertainty, and variations in potential system design.
- Identification of potential sources of revenue to finance a universal public health care system including overprovision for the development of a healthy surplus, changes in economic conditions, and other potentially unknown or hidden costs.
- An actuarial analysis which reconciles the differences in methodology and findings between the UHC Work Group Report and the analyses run by Dr. Friedman on behalf of Whole WA.

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- A review and report on the Fiscal Note conducted by the Washington Office of Financial Management on SB.5222 (the original Washington Health Trust bill introduced in 2019).
- Clear definition, decisions, and recommendations on which benefits & services the Commission believes the state UHCS should include as essential health benefits available to all enrollees.

Cosigners

Organizations

- Whole Washington

Individuals

- Andre Stackhouse *Whole Washington Executive Director*

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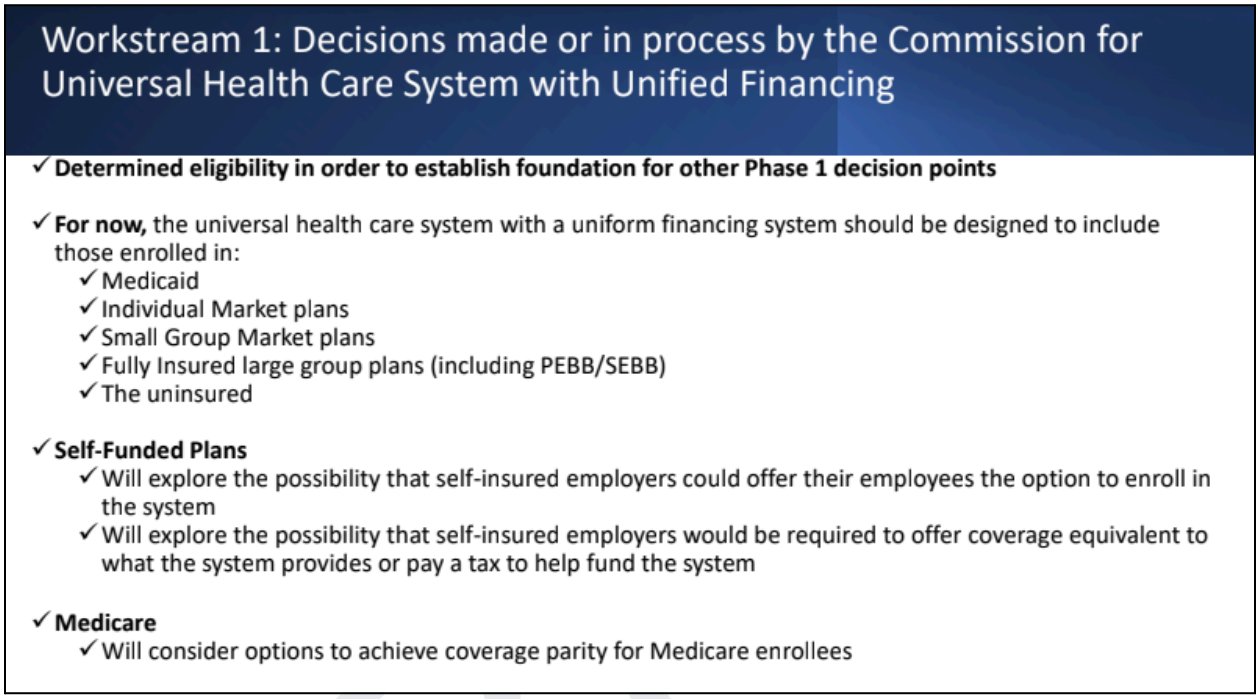
Appendix A

Below is a slide which summarizes key decisions made by the Commission as discussed in the August Commission meeting and published in the meeting materials. This is the last slide within Tab 7 of the August meeting materials.



Workstream 1: Decisions made or in process by the Commission for Universal Health Care System with Unified Financing

- ✓ **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

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Appendix B

Fiscal note conducted by the office of Financial Management for SB.5222, the original Washington Health Trust bill introduced in 2018: https://fnspublic.ofm.wa.gov/FNSPublicSearch/GetPDF?packageID=56734

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Washington State Medical Association
Physician Driven, Patient Focused

October 31, 2024

Universal Health Care Commission
Washington State Health Care Authority
628 8th Ave SE
Olympia, WA 98501

John Bramhall, MD, PhD
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Vice President

Bindu Nayak, MD
Secretary-Treasurer

Jennifer Hanscom
Chief Executive Officer

Dear Universal Health Care Commission,

On behalf of the Washington State Medical Association (WSMA), we are thankful to the Universal Health Care Commission (UHCC) for exploring wasteful administrative burden and its impact on healthcare workforce, costs to the system and patients, and access to care.

At its October meeting, the UHCC explored two strategies for mitigating the challenges posed by insurance carrier prior authorization programs – "gold carding" and standardized prior authorization forms.

In this letter, the WSMA shares feedback on these topics and urges the UHCC, in its report to the legislature, to broadly recommend prioritizing ways to reduce the administrative burden and barriers to patients' access to care associated with prior authorization. WSMA supports approaches like gold carding (when implemented appropriately) and offers caution regarding standardized forms.

Prior authorization

Prior authorization delays patients' access to care and worsens health outcomes. A recent survey by the AMA of over 1,000 physicians found that one in three physicians have seen prior authorizations lead to a serious adverse event—including hospitalization, permanent impairment, or death—for their patients. Moreover, 94% of physician respondents indicated that prior authorization led to delays in patients accessing care; 89% reported it had a negative impact on patient clinical outcomes; and 80% shared that it caused patients to abandon treatment.

Prior authorization constitutes a significant administrative burden for physicians and practice staff. Spending more time on administrative duties that do not improve patient care is associated with decreased career satisfaction and higher rates of career fatigue among physicians. Prior authorization also diverts significant practice resources from patient care – which increases healthcare costs. On average, medical practices report spending approximately two business days per week completing prior authorizations. In the same AMA survey, 35% of physician respondents reported hiring staff whose sole responsibility is working on tasks associated with prior authorization. Eliminating administrative expenses that do not add value enjoys broad support as it has the benefit of lowering healthcare costs without affecting patient care.

Gold carding

Gold carding is an area of interest for WSMA members.
At the last meeting of our House of Delegates in September, the following resolution related to gold carding and
generally lowering the

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volume of prior authorizations impacting physician practices and patient care was adopted:

> *The WSMA will advocate for state legislation, regulation and/or policy changes to reduce the total volume of prior authorization demands on physicians and other prescribers.*
>
> *The WSMA supports efforts to exempt frequently approved medical services and prescription drugs from the prior authorization process.*

Several states have implemented gold carding programs and we are monitoring implementation, including challenges in the state of Texas. The Centers for Medicare and Medicaid Services (CMS) has taken an interest and have asked for feedback in a recent related rule on prior authorization. Finally, some carriers have implemented their own programs.

Standardized prior authorization forms

A challenge with prior authorization is that each insurance carrier has a unique process, and physician practices that contract with many insurance carriers are required to understand and navigate varying programs. Standardizing forms that physicians submit to authorize medications and services has been a topic of policy discussion for many years and largely predate industry-wide implementation of electronic health records (EHR).

Anecdotally, we hear from colleagues in states that have implemented standardized forms that insurance carriers will routinely ask for additional information that is not provided for on the form, which does not eliminate variability and back-and-forth with payers. At the state level, these kinds of form requirements would not apply to ERISA plans – are large segment of the market in Washington state.

Our larger concern with this approach is, in an era of widespread EHR adoption, initiatives to reduce the impact of prior authorization on physicians and patients should focus on requiring impacted payers to automate the process for physicians via industry data exchange standards to determine whether a prior authorization is required, identify prior authorization information and documentation requirements, as well as facilitate the exchange of prior authorization requests and decisions from their EHRs or practice management system. This is the way the industry is moving – automated through the EHR – as evidenced by CMS rulemaking and HB 1357, which WSMA brought forward and advocated for during the 2023 session. We urge the UHCC to not recommend an approach that maintains fax machines, for example, as the technology utilized to facilitate these transactions.

We are thankful to the UHCC for exploring challenges posed by prior authorization and again, we request that the UHCC include a recommendation in its report to the Legislature continue to explore ways to reduce administrative burden and barriers to care imposed through inappropriate uses of prior authorization. Please consider WSMA a resource as you consider this important work, including your report to the legislature.

Sincerely,

Jeb Shepard
Director of Policy
Washington State Medical Association

Tab 4

Washington State Health Care Authority

Project Status Update

Liz Arjun, *HMA*

3 Workstreams

Design a universal health care system with a unified financing system

2022
- ✓ Inaugural Report: Landscape and Path Forward
- ✓ Launch FTAC

2023
- ✓ Eligibility
  - ✓ Medicaid, Individual, Small Group, Fully-Insured Large Group (includes PEBB/SEBB)
  - ✓ **No pathway at this time** for self-funded plans and Medicare

2024
- Determine potential costs based on:
  - Benefits and services
  - Cost containment
  - Provider reimbursement

Recommend interim solutions that address issues people face now and contribute to the universal system

2022
- ✓ Expanded coverage for uncovered populations
- ✓ Integrated eligibility systems
- ✓ Cascade Care Savings
- ✓ Cost Growth Targets
- ✓ Align public programs

2024
- ***Under Consideration***
  - Administrative Simplification
  - Maximizing coverage in existing programs

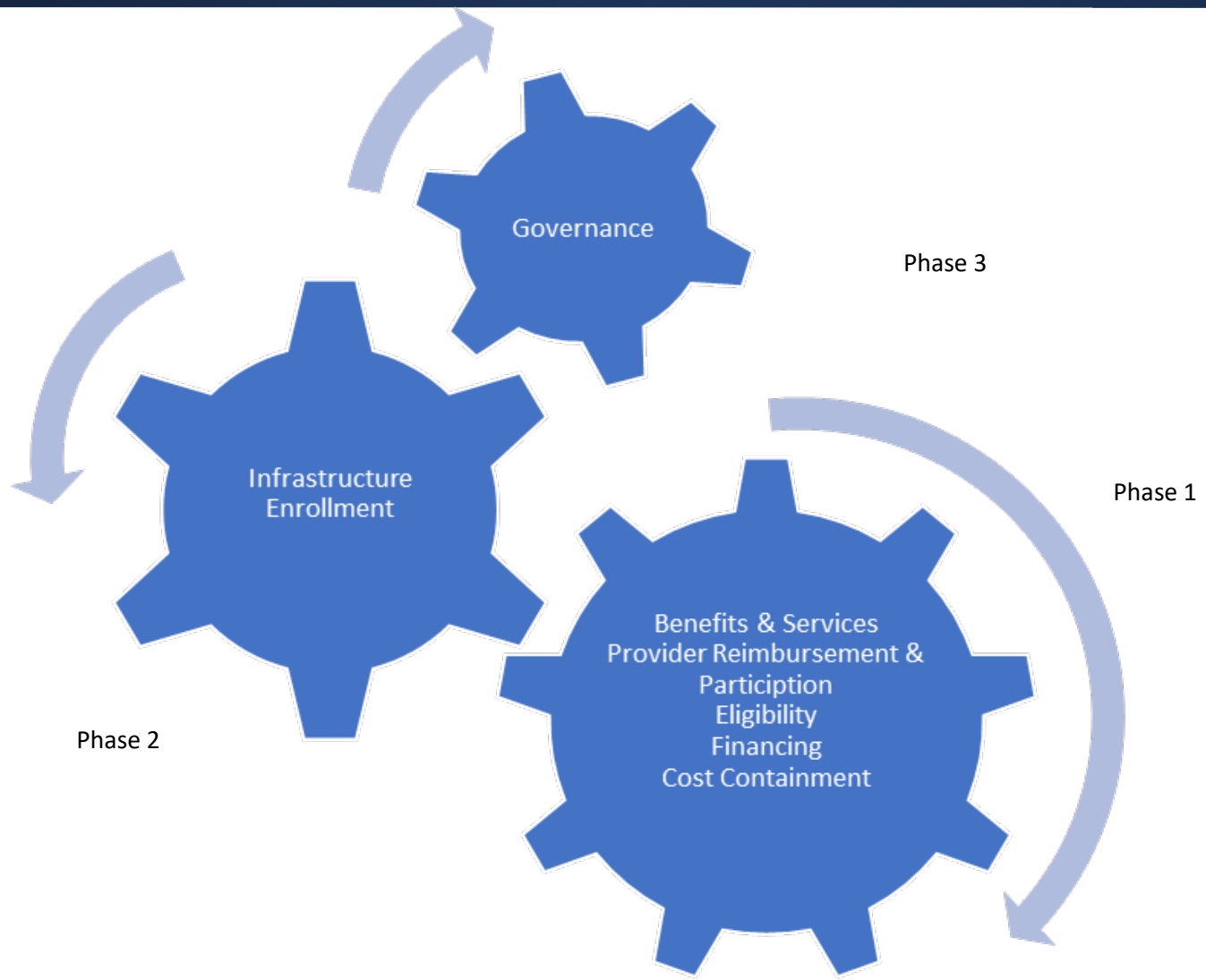
2023 Request

Review the Washington Health Trust proposal

2023
- Overview of proposal

2024
- Benefits and services, cost assumptions

Workstream 1 (Universal System Design)

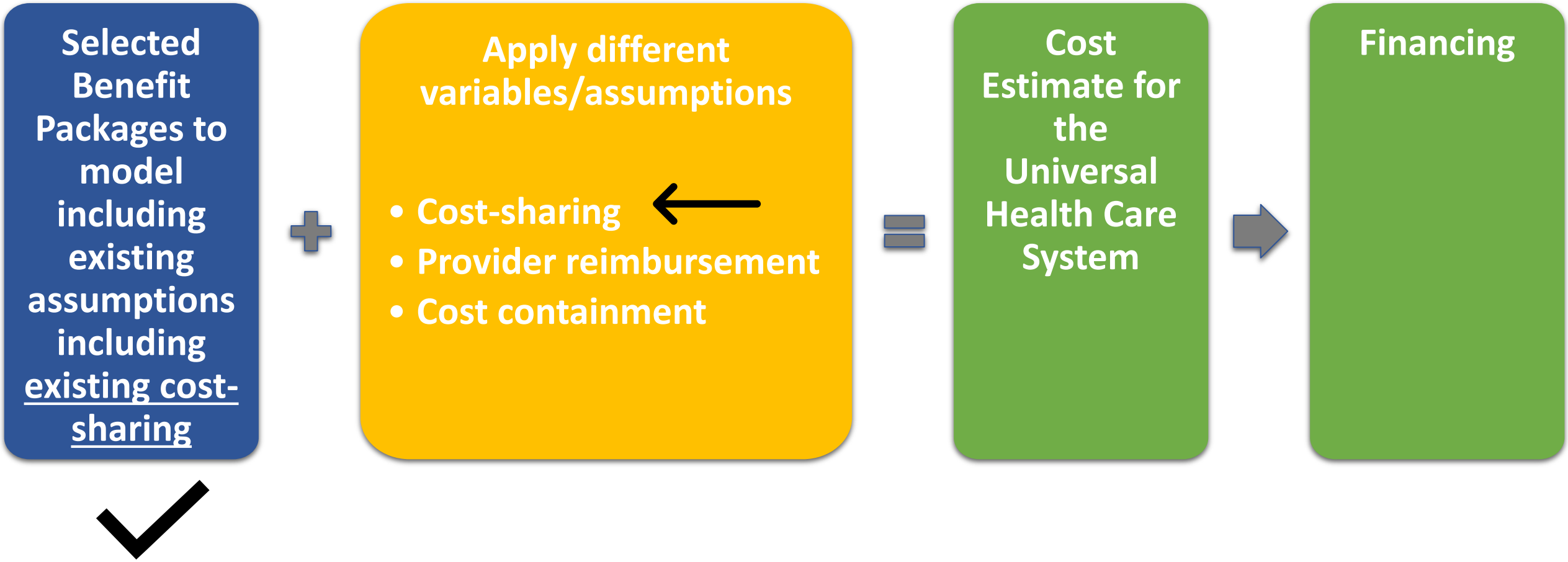


Phase 3

Phase 1

Phase 2

Workstream 1 (Universal System Design): Status



Workstream 2 (Transitional Solutions)

February

- Overview of administrative simplification
- Overview of HCA efforts related to administrative simplification

April

- OneHealthPort and efforts to support administrative simplification in Washington

June

- Provider perspectives on administrative simplification

August

- Focus on Prior Authorization
- Prior Auth Recs

October

- Expanded coverage for immigrants (maximize current enrollment)
- Revisit Prior Authorization Recs

Tab 5

Washington State Health Care Authority

Status Update – Commission action

Commission Update

During their October meeting, Commission activity included:

1. Review and discussion on administrative simplification/prior authorization information and engaging FTAC to consider transitional solutions, benefits, impacts and future design options.

2. Voted to continue support for Apple Health Expansion efforts, as a transitional solution, with context that other programs will need support in a difficult budget environment.

3. 2024 report to Legislature approved.

4. Cost-sharing principles reviewed and amended – Milliman update.

5. OIC affordability report presentation – interest in policy recommendations on reference-based pricing, cost growth targets

Commission Update on Cost Sharing

During their October meeting, the Commission adopted the principles of cost sharing as amended:

1. Avoid creating barriers to care by considering, among other things, income thresholds and exemptions for cost sharing.
2. Identify selected services (e.g., preventive care or diagnostic screening) that would not be subject to cost sharing.
3. Create cost-sharing structures that are simple, predictable, transparent, and easily understood for providers and individuals seeking care.
4. Review the Commission's final policy decision on cost sharing through the health equity toolkit as adopted by the Commission.
5. Review and revise cost-sharing designs as medical technology and services evolve.

UHCC horizon

Commission will address its 2025 agenda in December.

Continue addressing phase 1 design topics which may include:

- Continue benefit design
- Cost-containment
  - Reference-based pricing (PEBB/SEBB presentation)
  - Health Care Cost Transparency Board growth benchmarks
  - Primary care spend
- Transitional solutions – small business affordability
- Provider reimbursement
  - Primary care
  - Access

Tab 6

Washington State Health Care Authority

Affordability analysis

Milliman Affordability Analysis – Timeline

Progress to date

- Data collection progress
  - Publicly and internally sourced data is complete (subject to review). This includes:
    - Publicly available information related to plan designs, demographics, etc.,
    - NAIC Supplemental Health Care Exhibits and US DOL's Form 5500 Series for 2023 commercial and individual plan costs and enrollment rates,
    - Publicly available enrollment, utilization, and cost research from the RAND Corporation, KFF (FKA Kaiser Family Foundation), among others, and
    - Detailed cost and utilization estimates from Milliman proprietary datasets.
  - We are still waiting on access to HCA Medicaid and PEBB/SEBB summary data (as of the time of drafting of this deck on November 7th).
- Methodology/approach is complete (subject to revision as the analyses progress). We intend to use detailed historical utilization and cost information from HCA data sources for the Medicaid, PEBB, and SEBB populations, and the Milliman Managed Care Rating Model for other populations.
- Analysis models/framework drafts are complete (waiting for some data).

Milliman Affordability Analysis – Liaison Meetings

Liaison meeting background [FTAC 7/11 meeting notes]

Milliman is estimating the cost of care under the several benefit packages discussed during the FTAC meetings. This includes the range of cost sharing options defined by the associated benefit packages.

Topics covered in FTAC liaison meetings

- FTAC liaisons and Milliman have met three times since the September 10 FTAC meeting
- Key direction from the liaisons includes
  - Confirmation of various scenario parameters (e.g., dental benefit parameters, CSR applicability, other/new EHBs, etc.)
  - Payment neutral reimbursement rate assumptions for Medicare fee-for-service (FFS) priced services and for non-Medicare FFS priced services (e.g., pharmacy, dental, etc.)
  - Exclusion of ERISA-covered plans' population (including both ERISA-covered fully- and self-insured plans)
  - Provider network assumption (no "out of network" services or cost sharing, and limited out-of-state utilization)
- Continued refinement of analysis scoping and focus

Milliman Affordability Analysis – Background

Cost sharing scenarios

Three benefit and cost sharing scenarios will be modeled, varying by Medicaid eligibility status and without a sliding-scale cost share structure.

Scenario Title	Non-Medicaid[1] Enrollees	Medicaid Eligibility Status
1. Medicaid	Medicaid-like (No Cost Sharing)	Medicaid-like (No Cost Sharing)
2. PEBB/SEBB	PEBB/SEBB-like (Classic/Achieve 2 CS)	Medicaid-like (No Cost Sharing)
3. Cascade Silver	Silver Plan Benefits (approx. 70% AV)	Medicaid-like (No 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
- Vision, hearing, and other benefits covered under one structure (e.g., Medicaid) but not another (e.g., Cascade Care Silver) will reflect those coverage differences in our modeling

(1) This includes non-Medicaid eligible uninsured, individual market coverage, public employees (PEBB), and school employees (SEBB), and non-ERISA commercial group enrolled.

Milliman Affordability Analysis – Background

Population and cost sharing detail

Additional detail of by-population cost sharing assumptions are included in the table below.

This includes the following scenarios (and associated sensitivity tests[1]):

Enrollee Market Populations	Scenario 1 – Medicaid	Scenario 2 – PEBB/SEBB (Classic/Achieve2)	Scenario 3 – Cascade Silver
State & School District Employees	Medicaid-like (No Cost Sharing)	PEBB/SEBB-like Classic/Achieve 2 CS	Silver Plan Benefits (approx. 70% AV)
Non-ERISA: Large & Small Group	Medicaid-like (No Cost Sharing)	PEBB/SEBB-like Classic/Achieve 2 CS	Silver Plan Benefits (approx. 70% AV)
Individual Market (on & off HBE)	Medicaid-like (No Cost Sharing)	PEBB/SEBB-like Classic/Achieve 2 CS	Silver Plan Benefits (approx. 70% AV)
Uninsured above 138% FPL	Medicaid-like (No Cost Sharing)	PEBB/SEBB-like Classic/Achieve 2 CS	Silver Plan Benefits (approx. 70% AV)
Uninsured below 138% FPL	Medicaid-like (No Cost Sharing)	Medicaid-like (No Cost Sharing)	Medicaid-like (No Cost Sharing)
Medicaid (all sub-populations)	Medicaid-like (No Cost Sharing)	Medicaid-like (No Cost Sharing)	Medicaid-like (No Cost Sharing)
ERISA-covered health plans (incl. fully- and self-insured)	EXCLUDED		
Federal Employees	EXCLUDED		
Veterans Admin & TRICARE	EXCLUDED		
Medicare	EXCLUDED		

(1) For example, testing the impacts associated with increasing or decreasing assumed provider reimbursement rates by 5-10%.

Milliman Affordability Analysis – Analysis Plan and Results

EXAMPLE ONLY – Values do not reflect modeling results

Example summary results

Assumptions / Population or Total Results	CY 2023 Population	CY 2023 Baseline[1]	Scenario 1 – Medicaid	Scenario 2 – PEBB/SEBB (Classic/Achieve2)	Scenario 3 – Cascade Silver
Scenario Benefit Details					
Scenario Actuarial Value			100%	88% AV (100% AV for Medicaid)	73% AV (100% AV for Medicaid)
Maximum Out-of-Pocket (individual)			$0	$2,000 (+$2,000 Rx)	$9,200
Average Provider Reimbursement			120% Medicare (60% AWP Rx)		
Assumed medical management			Loose (FFS-like)	Moderate (PPO-like)	Moderate (PPO-like)
Population and Total Results					
State & School District Employees	550,000	$700 PMPM	$650 - $700 PMPM	$625 - $675 PMPM	$575 - $625 PMPM
Non-ERISA: Large & Small Group	400,000	$650 PMPM	$600 - $650 PMPM	$575 - $625 PMPM	$550 - $600 PMPM
Individual Market (on & off HBE)	250,000	$500 PMPM	$500 - $550 PMPM	$475 - $525 PMPM	$450 - $500 PMPM
Uninsured	475,000	$200 PMPM	(note separately modeled – blended into other modeled populations)		
Medicaid (all sub-populations)	1,750,000	$600 PMPM	$675 - $725 PMPM	$675 - $725 PMPM	$675 - $725 PMPM
Total Medical[2] Costs PMPM		$550 PMPM	**$625 - $675 PMPM**	**$625 - $675 PMPM**	**$600 - $650 PMPM**
Patient Pay PMPM (non-Medicaid pop.)		$50 - $75 PMPM	$0 PMPM	$40 - $50 PMPM	$75 - $100 PMPM
Total Medical Costs (based on CY 23 pop.)	3,425,000		$21.92 B – $23.65 B	$21.55 B – $23.27 B	$21.00 B – $22.76 B

EXAMPLE ONLY – VALUES DO NOT REPRESENT ACTUAL HISTORICAL VALUES OR ESTIMATES

(1) CY 2023 total medical costs PMPM by population and in aggregate (based on CY 2023 population reported in the first column).
(2) Inclusive of drugs, dental, and all other modeled benefits (e.g., excludes Medicaid LTC). Range reflects a blend of sensitivity test results including varying reimbursement rates, population assumptions, and other assumptions subject to significant variability.

Milliman Affordability Analysis – Next Steps

Next steps

- Past due: complete data collection (internal)
- End of November: complete first-pass of report and results (internal)
- December 13: complete internal review and provide draft report to HCA (HCA only)
- January 9: present final report to FTAC (FTAC, public)

Tab 7

Washington State Health Care Authority

Cost containment

Liz Arjun, *HMA*

3 Workstreams

Design a universal health care system with a unified financing system

2022
- ✓ Inaugural Report: Landscape and Path Forward
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- Determine potential costs based on:
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  - Cost containment
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Recommend interim solutions that address issues people face now and contribute to the universal system

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- ✓ Expanded coverage for uncovered populations
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2023 Request

Review the Washington Health Trust proposal

2023
- Overview of proposal

2024
- ***Under Consideration***
  - Administrative Simplification
  - Maximizing coverage in existing programs
- Benefits and services, cost assumptions

Costs and cost containment

- As Milliman cost and cost-sharing analysis progresses, the Universal Health Care Commission is beginning to consider other components of a universal system
  - How to pay providers
  - How to contain costs

- During their October meeting, the Commission reviewed information from OIC's health care affordability report.
  - Out of this report, the Commission showed interest in exploring the topics of cost-growth benchmarks and reference-based pricing.

Low-Intensity Rate Setting Models

Presentation to:
The Finance Technical Advisory Committee

Robert Murray
November 14th, 2024

Components of a Politically Feasible Rate Setting Strategy

- Oregon's current strategy is an example of a potentially successful entrée into Rate Setting
  - Link implementation of rate model to requirement to balance the state budget
    - Oregon's strategy connects a spending limit on Medicaid and its overall state health care growth target to mandated growth in State/Public employee benefit program
  - Start out gradually, imposing price relatively generous (or reflecting existing) rate levels
    - Oregon's price caps on its State/Public employee benefit program generated substantial savings without any deleterious impact on the hospital industry
  - Expand program and level of constraint gradually by reducing price cap limits and extending the scope of coverage to other local governments and potentially non-governmental self-funded plans
    - Enlist support by Taft-Hartley plans and other private self-funded entities (Labor and Small Businesses are key sources of political support)
  - Gradually impose tighter constraints and/or expand state rate setting initiatives to Out-of-Network hospital services for Private Payers and eventually an All-Payer Hospital Global Budget Model
- Note other factor that will drive a move to hospital rate setting: impending US budgetary Issues

Setting the Context & the Need for State-Based Rate Setting

- States in a better position to craft rate models to meet their needs and unique issues
- Federal action won't occur because of this is not a Federal Policy priority (yet)!
- Focus on hospitals because of Massive Market Failures in U.S. Hospital Market
  - Non-competitive Hospital Markets due to Consolidation
  - Moral Hazard
- Attempt to Quantify the "Massive Transfer of Wealth" from workers and their families to Hospitals
  - Brot-Goldberg and other researchers note that hospital price increases due to mergers results in nearly a dollar-for-dollar transfer of wealth (higher premiums, lower wages, etc.) from employees and their families to hospitals
- We make the case that Insurers haven't done a good job of constraining price and spending
- Antitrust can at BEST freeze the existing level of hospital consolidation
- State-based systems were successful in controlling price and spending growth previously
- All OECD countries have some form of mandatory rate setting
- RAND, CBO and Urban – all project rate setting has the best potential to generate savings

Recommend States Implement Lower-Intensity Rate Models

- Of all the possible initiatives that might rein in hospital prices and spending, government-administered rate setting models have the best potential

- This conclusion is corroborated by analyses from RAND and CBO
  - See RAND research report: "Impact of Policy Options for Reducing Hospital prices Paid by Private Plans" J. Liu et. al. https://www.rand.org/pubs/research_reports/RRA805-1.html
  - Also see Congressional Budget Office report: Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services. https://www.cbo.gov/publication/58222

- Past state rate setting models were successful, but became too complex and were vulnerable to Regulatory Failure and Capture

- Accordingly, we suggest states pursue one or all of the aforementioned "lower-intensity" (and less complex) rate setting models
  1. Price Caps for State/Public Employee Health Benefit Programs
  2. Price Caps on "Out-of-Network" (OON) Prices
  3. All-Payer Hospital Global Budgets
- We recommend that states consider creating a Public Utility-style and independent regulatory Commission to administer an all-payer hospital global budgets to help avoid regulatory capture

Characteristics of Successful Rate Setting Models

- Based on this previous discussion – we believe that States should aggressively pursue the development of provider rate regulation for the Private Insurance Sector

- There are several key Characteristics of Successful Government Rate setting Models:
  - Less complex Models have a better potential to be successful over the long-term
  - Rate Models should be Administered/Regulated by the State (not by a provider or insurer entity)
  - Models should be "mandatory" (backed by legislation) with required participation by applicable providers and payers

    Voluntary Models, such as those promoted by the CMMI, have been far less successful
  - Price Cap models can be implemented by existing State regulatory capacity
  - Hospital Global Budget Models require the participation of all hospitals and payers in a state or a specific region of the state
  - An all-payer HGB model best overseen by an Independent Regulatory Commission – following a Public Utility Model
  - A Public Service Commission regulatory approach is a more effective governance model and can help avoid issues of Regulatory Failure & Capture

Key Observations re: Oregon's SPEHBP Price Cap Model

- What the Model Does
  - State passed legislation requiring hospital payments to be at or below 200% of what Medicare pays
  - Used Claims data on existing price levels, along with Oregon's "targeted" savings requirements to set caps
  - OR Picked 200% of what Medicare pays hospitals for both IP and OP services

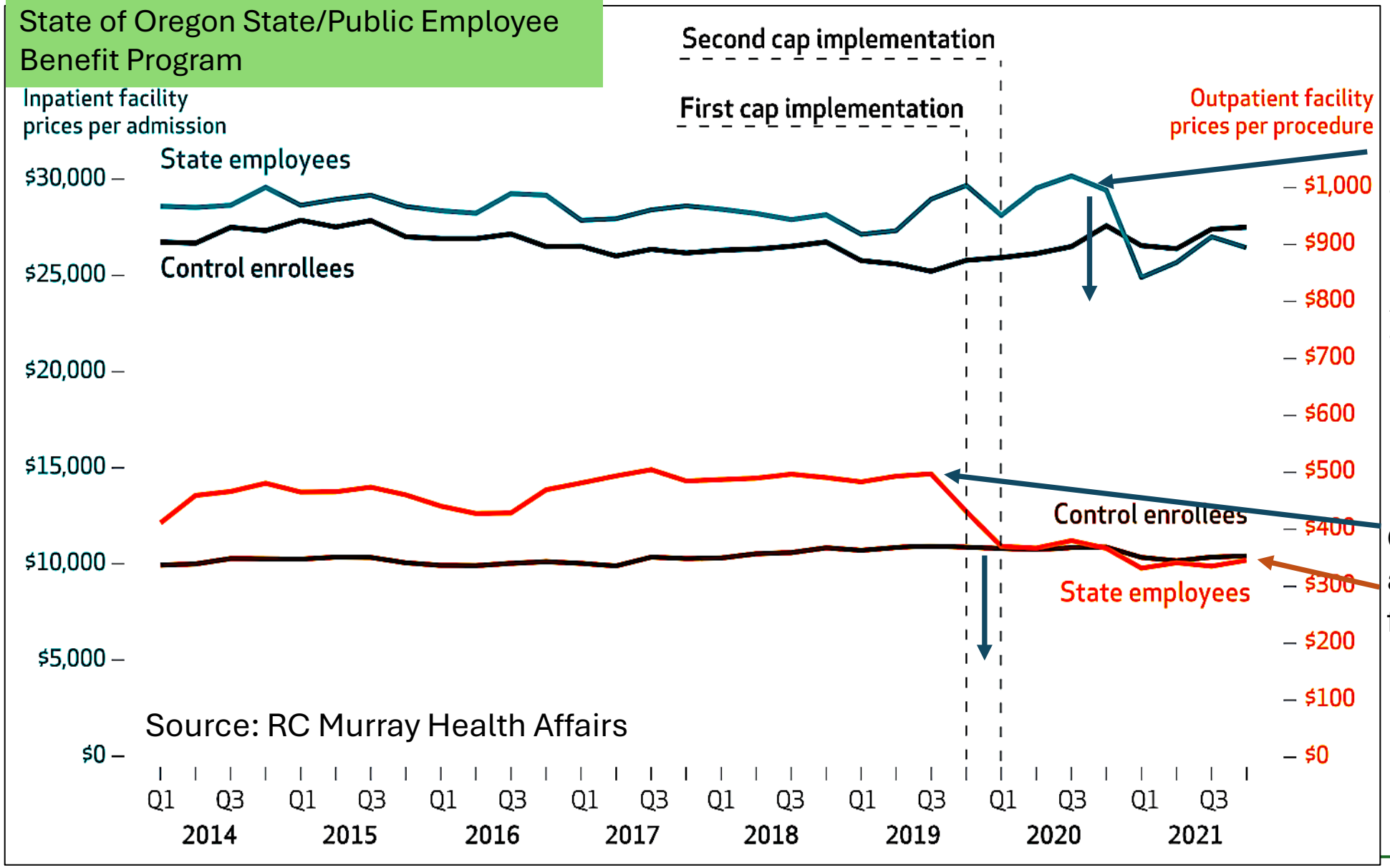
- Earlier Oregon Policy Work laid the groundwork for this Price Cap model
  - 3.4% price cap on Medicaid Growth & 3.4% growth cap for State Cost Growth Benchmark model
  - These earlier "targets" helped frame rationale for imposing a price caps on SPEHBP hospital prices

- Key Factors in Passing the Price Cap Legislation
  - Linking the Legislation to State Budget requirements **This was a key favor in passage of the Price Cap Bill**
  - State also focused the Price Cap program on Oregon's larger "IPPS" hospitals
  - Exempting CAHs and other Specialty hospitals key in passage
  - Even with support of the Speaker of the House and President of the Senate SB 1067 passed narrowly

- Results
  - Initial issues with prices increasing to 200% but OR later clarified policy was the "lower of"…..
  - Over $107 million in savings (~4%) over first 27 months (primarily on OP) and reduced cost-sharing
  - No evidence of "cost-shifting" (preliminarily) but evidence of reduced cost-sharing for Beneficiaries
  - No evidence of restricted access for beneficiaries

Results: Inpatient and Outpatient Prices Pre-and Post-Caps

State of Oregon State/Public Employee Benefit Program



Source: RC Murray Health Affairs

About 50% of the hospitals had IP price below the 200% Of Medicare Cap

Initially, state audits found that hospitals raised prices below 200% to the limit

After the rule was clarified to be the "lower of past negotiated price level, billed charges or the 200% Cap, Inpatient prices declined

Outpatient prices were above the 200% price limit for all the hospitals pre-Caps

But declined to around 200% post Cap implementation – generating most of the Saving for the Program

Key Observations re: Oregon's SPEHBP

- Benefits
  - Program covers State Employees and Public Employees & Educators (University, Community College K-12)
  - Easy to administer by State Program (price caps are "benchmarked" to what Medicare pays hospitals)
  - Met State Budget requirements and avoided increasing employee premiums

About 15% of total Commercial Market

- Weaknesses
  - Hospitals & TPAs initially interpreted the 200% of Medicare Limit, as the "Price" to be paid for each service
  - This is a FFS payment model – so hospitals may attempt to increase volumes of care
  - Medicare may not be the best reference point for certain services
  - Hospitals may refuse to treat State/Public Employees

OR later clarified it was the lower of billed charges, the previously negotiated rate and the 200% Cap

- Potential for Expansion
  - Some Local Governments are part of the Oregon Plan & more can be added
  - Recommend OR look into legislation to expand this program to Taft-Hartley Plans & Self-insured employers
  - Model not vulnerable to ERISA Challenge because it sets the rate paid to the hospitals

- Model Can Be Easily Implemented/Administered by DOH/State Benefit Program

Other Price Cap Program States May Wish to Consider: Price Caps on Commercial Insurer Hospital Out-of-Network Services

- Earlier Oregon Policy Work may lay the groundwork for OON Price Cap model
  - Also a Low-Intensity Rate Model – only affects 4-9% of hospital services
  - Can easily be Benchmarked to Medicare Price Levels
- This strategy corrects what is a significant market failure– where hospitals can augment their already strong negotiating leverage vs. private plans by threatening to terminate a health plan contract, go OON, and bill the plan much higher prices (approaching their charges)
- Our Theory: Caps on OON prices can remove this leverage, restore negotiating power back to commercial plans and result in lower In-Network Negotiated (INN) rates. This has been discussed in the literature: Murray 2013, Melnick 2019, Duffy et al. RAND 2020
- The Medicare Advantage (MA) program, which has an effective cap on OON payments by MA plans may provide evidence of what might happen in commercial markets with such a Cap.
- The MA statutory Cap may be largely responsible for creating a high degree of negotiation "discipline" on in-Network Negotiated (INN) rates MA paid to hospitals
  - Berenson 2015, Baker 2016 & others show MA INN rates are close to Traditional Medicare prices
- Caps on OON hospital prices could be a straightforward and low intensity regulatory strategy to improve plan negotiating leverage vs. hospitals which might result in reductions in INN rates

Price Caps on Commercial Insurer Hospital Out-of-Network Services (continued)

- OON Caps Benchmarked to Medicare with restrictions on balance billing solves the OON pricing problem
  - Federal No Surprises Act was flawed because it benchmarked local In-Network Negotiated (INN Prices)
  - Bakes in existing pricing distortions in the Private Market
  - Arbitration process is a nightmare – completely undermines this program
  - Benchmarking to Medicare along with balance billing prohibitions solves most of the problems associated with the NSA
- Similar administrative/logistical issues as with Price Caps for State/Public Employees
  - Where to set the cap?
  - Potential to set regional caps if price vary significantly on a regional basis (e.g., California)
  - Whether to exempt certain types of hospitals
  - How to address issues with certain services that are not well-represented by Medicare weights/price?
  - Again – can be implemented using existing State regulatory Capacity
- Other Issue is How to Make Sure Savings Realized by Private Plans Flows back to Beneficiaries
- Savings Estimates
  - Duffy et al. Savings Estimates & Jerry Anderson State Savings Estimates following Duffy et al. methodology

Modeling of OON Price Cap Strategy– Potential Reduction in In-Network Rates

This means WA state Private Prices are 316% of Medicare Currently

Potential reduction in In-Network Negotiated rates (INN) from price caps at 300% Medicare

Washington State Aggregated Result

	Effective OON Rate	INN Rate	Private to Medicare Ratio	# of Hospitals Affected	Operating Margin	Overall Margin	Savings
Status Quo	3.16	1.70	1.73	0	-2.57%	4.20%	0%
Cap at 300% Medicare	3.00	1.64	1.67	32	-4.83%	2.24%	2.16%
Cap at 275% Medicare	2.75	1.56	1.59	39	-8.66%	-0.87%	5.60%
Cap at 250% Medicare	2.50	1.48	1.50	44	-12.77%	-4.19%	9.04%

Savings for limits on High priced Hospital

Tacoma General Allenmore Hospital (Highest "PMR")

	Effective OON Rate	INN Rate	Private to Medicare Ratio	Operating Margin	Overall Margin	Savings
Status Quo	4.73	2.99	3.03	23.33%	24.57%	0%
Cap at 325% Medicare	3.25	2.20	2.22	4.03%	6.34%	20.11%
Cap at 300% Medicare	3.00	2.07	2.09	-0.21%	2.37%	23.49%
Cap at 275% Medicare	2.75	1.93	1.95	-4.86%	-1.96%	26.88%

"PMR" = Private to Medicare Price Ratio

Potential reduction in In-Network Negotiated rates (INN) from price caps at 250% of Medicare = approximately $900 million savings/year

More Comprehensive Rate Model: "Flexible" All-Payer Hospital Global Budgets

Hospital Global Budgets (HGBs) PROS:

- Create very strong incentives for Comprehensive Cost Control – both price and quantity
- Can be enforced by the authority of a Rate Agency thereby providing a cap on expenditures but also providing the hospital with "guaranteed" revenue
- Improve the affordability of the system: growth of expenditures can be tied to affordability benchmarks

  Such as the growth in Gross State Product over time
- Solve a fundamental problem with current Shared Savings Programs – Global Budgets incentivize hospitals to cooperate with ACOs & other Care Management initiatives
- Promote the financial stability and sustainability of efficient hospitals (removing inefficiency under a Global Budget can be a source of financial sustainability for the hospital)
- Are structured with the use of a Volume Adjustment system to Neutralize FFS incentives to unnecessarily increase hospital service volumes and to support payment of hospitals fixed costs if volumes decline
- Provide increased flexibility for a hospital to invest in new ways to meet the unique health care needs of their PSA residents

  This model provides effective but less severe incentives than fixed Global Budget model used in Maryland
- Can reduce administrative complexity and cost over time

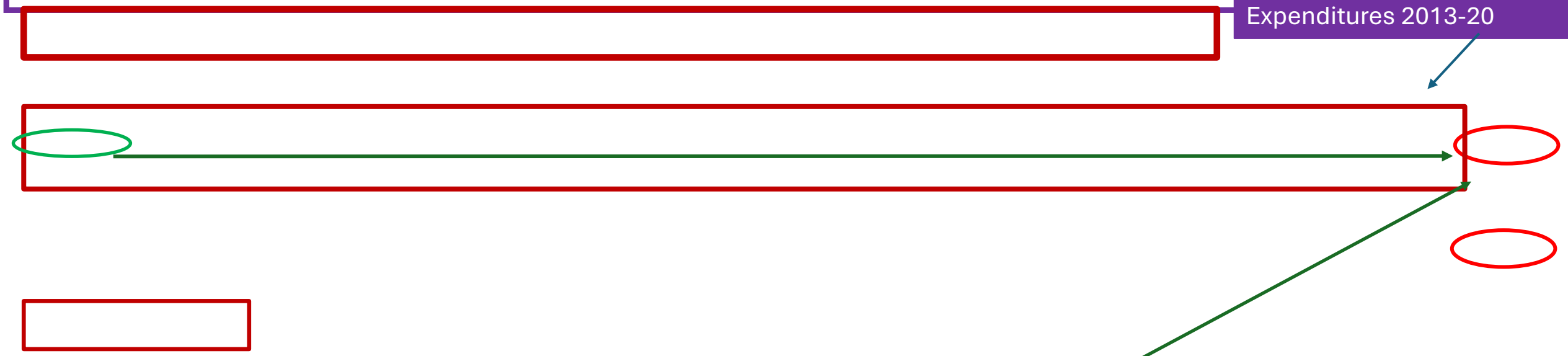
Other Price Cap Program States May Wish to Consider: All-Payer "Flexible" Hospital Global Budgets (continued)

Hospital Global Budgets (HGBs) CONS:

- Apply only to Hospital care (and perhaps additional services such as Home Health, Subacute and Hospital Physician owned Practices
- Fixed Global Budgets impart Extremely Strong incentives to reduce hospital volumes of care and may cause hospitals to "Stint" on care
- This occurred in Canada and Europe when Fixed HGBs were first implemented
- Increased wait times for ED services and Elective Services
- Maryland – which uses largely Fixed HGBs has extremely long ED wait times (no studies performed on elective wait times I am aware of)
- France and Germany eventually moved to a system called "pay for activity" to counter the stinting of care under fixed HGBs
- Hospitals under Fixed HGBs also incentivized to "Shift" care to non-hospital services
- Some suburban hospitals also generated huge surpluses under their HGB by shifting care to non-hospital providers

Our proposed "Flexible Hospital Global Budget" model designed to address both of these issues

Modeling of a Flexible HGB Model for Washington – Based



Key Points:

(1) Washington CAGR 2013 – 2020 for hospital expenditures = 2.93%
(2) Washington CAGR 2013 – 2020 for non-hospital expenditures = 4.20%
(3) Modeled Per capita (all-payer) hospital expenditure growth = 2.5% per year under Flexible HGB model
(4) Flexible HGB model **will not induce shifts to non-hospital sector** as is the case in Maryland currently
(5) Washington Gross State Product (GSP) i.e., "income" growth has been **nearly 4.5%** in recent years
(6) Washington projected hospital savings from implementing an All Payer Flexible HGB model 7 years 2014-2020 = $1.7 billion

Data source: US National Health Spending Account Data

Advantages and Characteristics of a Public Utility Model of Governance

- Extensive case law and strong regulatory authority (i.e., a mandatory system) to collect necessary data, establish rates and perform key regulatory functions
- History of transparent, effective decision-making and due process protections
- Flexibility in application of different rate setting approaches
- State-based as opposed to federal implementation (more responsive to state needs)
- Governance by a board or Commission of appointed individuals with an interest in health care and backgrounds salient to the operation and governance of the regulatory system
  - Best if Commissioners are prominent "volunteers" with key expertise and backgrounds (e.g., 7 Commissioners)
  - Labor, Business, Consumer, Academic, Insurance and Hospital representatives
  - Important to limit Hospital Representation to one of seven because of conflict of interest and asymmetry of information problems
- Commission conducts most of its operations in public during monthly meetings inviting participation and testimony by interested and affected parties
- Commission employes a full-time professional staff that serves at the pleasure of the Commission

Note: based on a literature review & interviews– past Washington HRC may have been "out-gunned" by Hospital Representatives

QUESTIONS ?

Low-Intensity Rate Setting Models

Presentation to:
The Finance Technical Advisory Committee

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November 14th, 2024

Tab 8

Washington State Health Care Authority

Discussion Questions

1) Should FTAC explore potential impacts, benefits, and trade-offs of pursuing reference-based pricing as a transitional solution?
2) Should reference-based pricing be a part of the universal design?
3) What other cost-containment strategies should FTAC evaluate?

Break

Tab 9

Washington State Health Care Authority

Universal Health Care Commission Prior Authorization Update

Washington State Health Care Authority

Administrative simplification

- Prior authorization emerged from the Commission's administrative simplification work for transitional solutions

Administrative simplification and increase provider participation in public programs	Maximizing, leveraging, and expanding current programs	Being addressed elsewhere (reported in Commission meetings)
Improve and align network adequacy standards	Auto enroll Medicaid to no premium or lower cost plans on exchange	Services not covered by the Balanced Billing Protection Act
Simplify provider administrative requirements	Codify and fully fund Apple Health Expansion	Uncovered ambulance services
Standardize claims adjudications	Increase participation in the Medicare Savings Program	Provider rate regulation
Motivate interest in preventative and primary care among patients	Consolidate and expand state purchasing	N/A

How did we get here?

- June 2024 Commission Meeting
  - Panel on provider perspectives for administrative simplification
    - Three of the four panelists named prior authorization as their top administrative simplification issue
- August 2024 Commission Meeting
  - KFF presented an overview of prior authorization and state initiatives
  - OIC presented on prior authorization modernization in Washington
- October 2024 Commission Meeting
  - Commission discussed potential recommendations for the legislature on prior authorization, but ultimately felt they needed more information

Prior authorization

- Pre-approval from a health plan for services and drugs to be covered
  - Used by commercial and public plans to promote safe, evidence-based, cost-effective care
- Perspectives differ
  - Health plans: prevents unnecessary or inappropriate care or drugs
  - Providers: overly burdensome
  - Patients: delayed or forgone care

Information adapted from KFF slide deck, Tab 4, Aug. 15, 2024 Universal Health Care Commission meeting. Recordings and materials from past Commission meetings are available here.

Differing perceptions

- A recent Health Affairs article (Perceptions of Prior Authorization (PA) Burden and Solutions, 2024) found:
  - Among private payer employee respondents:
    - **79%** of private payer employee respondents reported experiencing a growth in PA volumes over the last three years
    - **94%** answered "yes" when asked if PAs were necessary
  - Among provider respondents:
    - **65%** of provider respondents reported experiencing a growth in PA volumes over the last three years
    - **46%** answered "yes" when asked if PAs were necessary
  - Among patient respondents:
    - Most likely group to report "no burden" from prior authorization (**34%**)
    - **51%** reported spending no time on prior authorization, and **39%** reported spending less than one hour

Washington prior authorization data

- Health plan prior authorization data report, prepared by OIC and submitted to the Legislature January 2024
  - The 10 codes with the highest number of requests and the percent of approved requests.
  - The 10 codes with the highest percentage of approved requests and the total number of requests.
  - The 10 codes with the highest percentage of requests that were initially denied and then approved on appeal and the total number of such requests.
  - Average response times for standard, expedited, and extenuating circumstance requests

Sample Washington data

Figure 5: Highest number of requests by code table

Code Description	Total Prior Authorization Requests	Number of Approved Requests	Approval Percentage	Number of Carriers that Reported Code
Office visit e&m est pt	118,739	115,415	97.2%	4
TTE (echocardiography)	40,108	38,718	96.5%	7
CPAP device	37,731	36,358	96.4%	9
MRI any joint	28,786	26,556	92.3%	5
CT abdomen & pelvis	27,257	26,092	95.7%	4
Physical therapy	21,069	14,538	69.0%	1
MRI of lumbar spine	20,447	18,902	92.4%	5
Therapeutic procedure	19,969	17,461	87.4%	4
MRI of brain and further sequences	18,297	17,545	95.9%	6
Room and board	15,694	15,546	99.1%	2

p. 14, Health plan prior authorization data 2023 annual report to the Legislature Jan. 1, 2024

Sample Washington data

Figure 6: Highest prior authorization approval rate by code table, PY 2022

Code Description	Total Requests	Number of Approved Requests	Approval Rate	Number of Carriers that Reported Code
CPAP device	4,171	3,996	95.8%	3
Room & Board - Psychiatric	961	947	98.5%	9
Chiropractic Care	626	618	98.7%	1
Room & Board - Rehabilitation	551	532	96.5%	5
Other therapy services	476	471	99.0%	2
Genetics counseling	391	391	100.0%	2
Shoulder orthosis	371	371	100.0%	1
Residential treatment, SUD	354	349	98.6%	5
Ostomy pouch, drainable	311	311	100.0%	2
Bone density study	272	272	100.0%	1

p. 15, Health plan prior authorization data 2023 annual report to the Legislature Jan. 1, 2024

Discussion

- Should prior authorization reform be included as a transitional solution?
- How, if at all, should prior authorization be included in a universal system?
- Should FTAC make recommendations to the Universal Health Care Commission?

Appendix

- August Universal Health Care Commission meeting:
  - KFF presentation about prior authorization
  - OIC presentation on prior authorization modernization in Washington
- October Universal Health Care Commission meeting:
  - Commission considered three proposed reforms:
    - Gold carding
    - Standardized forms
    - Eliminating prior auth requirements for frequently approved procedures and code
- Commission questions about the three proposed focus areas:
  - How would carriers, providers, and patients be impacted by each of these prior authorization proposals?
  - What would the impact be if we implemented all three at once?
  - What are the costs associated with these proposals (e.g., IT-related costs, personnel infrastructure costs)?
  - What should the Commission do with prior authorization in the larger plan?

Appendix

- Perceptions of Prior Authorization (PA) Burden and Solutions, *Health Affairs* (2024)
- Health plan prior authorization data report, prepared by OIC and submitted to the Legislature January 2024
- The Good, The Bad, The Costly: State Efforts to Reform Prior Authorization Practices, Georgetown University Center on Health Insurance Reforms (2024)
- Final Prior Authorization Rules Look to Streamline the Process, but Issues Remain, KFF (2024)

Thank you for attending the Finance Technical Advisory Committee meeting!

Washington State Health Care Authority