Universal Health Care Work Group report

Senate Health & Long Term Care Committee

December 1, 2020

HMA Optumas

Washington State Health Care Authority

Work group history

- Authorized and funded by 2019 Budget Proviso for

  "**HCA to convene a work group to study and provide recommendations to the Legislature on how to create, implement, maintain, and fund a universal health care system.**"

- Identified key stakeholders to be included in the work group.

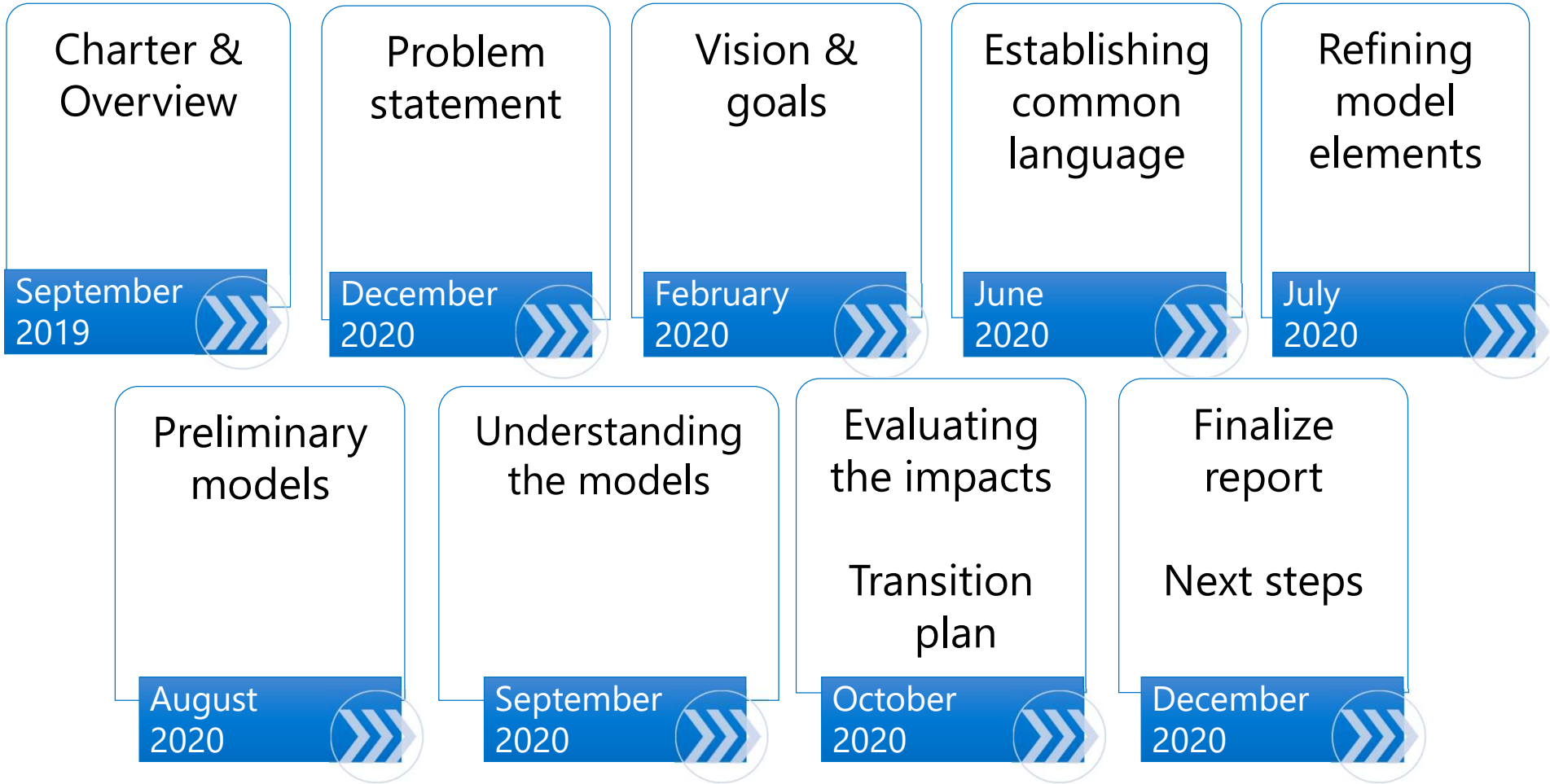
Key stakeholders

- Patient advocates and community health advocates
- Large and small businesses with experience with large and small group insurance and self-insured models
- Labor, including experience with Taft-Hartley coverage
- Health care providers, including the self-employed
- Health care facilities, such as hospitals and clinics
- Health insurers
- The Washington Health Benefit Exchange
- State agencies, including the offices of Financial Management Insurance Commissioner, and State Treasurer, and Department of Revenue
- Legislators from each caucus of the House of Representatives and the Senate

Work group history continued

- HCA also sought to include individuals who:
  - Have experience with health care financing and/or health care delivery.
  - Are affiliated with Tribal health care organizations or knowledgeable about Tribal health care systems and programs.
  - Have a willingness and ability to review background materials.
- HCA made a thoughtful and deliberate effort to ensure membership represents the diversity of our state.
- HCA selected Health Management Associates (HMA), in partnership with 3Si and Optumas, to support and facilitate the work group.

Overview of the work group timeline and process



Work group charter

Role, decision-making, and expectations:

"The Legislature is responsible for making decisions about how to implement universal health care in Washington and is **looking to the Work Group for insights and perspectives to inform the Legislature's decision-making.** As such, the Work Group **is not expected to come to group agreement on all of its recommendations.** The meeting summary and reports to the Legislature will document the range of discussions and perspectives."

Problem and vision

PROBLEM

Unequal access 

Poor and disparate outcomes 

Unsustainable costs 

VISION

All Washington residents have access to essential, effective, appropriate, and affordable health care services when and where they need it.

Goals → assessment criteria

- Access
- Affordability
- Equity
- Governance
- Administration
- Feasibility
- Quality

Health care coverage models

Model A: Universal Care (state-administered)

Model B: Universal Care (state-delegated)

- Comprehensive population coverage
- Standardized benefit package
- Balanced provider reimbursement
- Supports ongoing pursuit of health innovation in Washington
- Administration of model varies between state and insurers

Model C: Close the Gap (populations with limited access to traditional coverage)

- Interim step to provide a limited increase in coverage for certain populations:
  - Currently uninsured
  - Undocumented immigrants

Cost modeling

- Work group members "agreed on" these models; however, it was not a universal consensus.
- Plan design
  - Covered populations
  - Cost-sharing (copays, deductibles, coinsurance)
  - Provider reimbursement adjustments
- Optional elements
  - Including/excluding Medicare
  - Including/excluding dental
- Not included
  - Long-term care (except for Medicaid eligible)

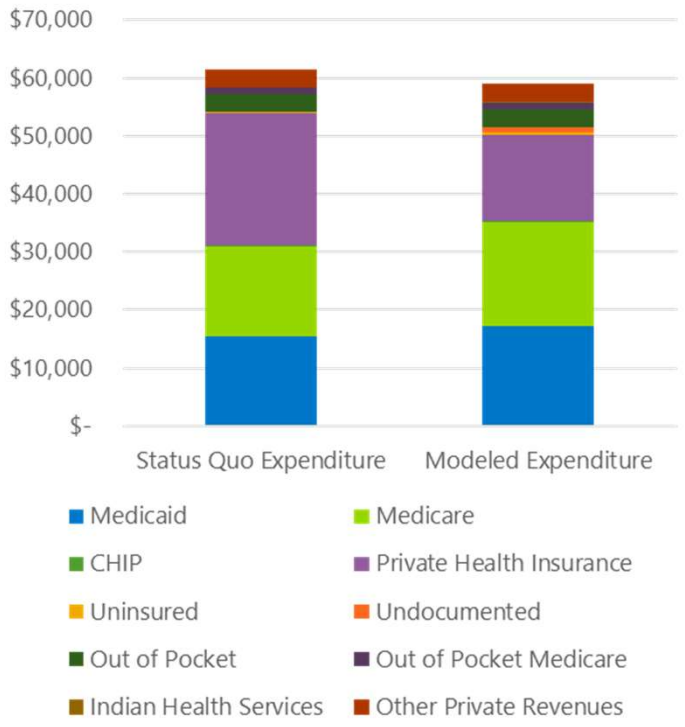
Model A: plan design
state-administered

Covered populations	Benefits	Cost-sharing	Provider reimbursement	Population specific impacts	Administration
• Medicaid • Medicare • CHIP • Private health insurance • Undocumented immigrants • Uninsured	• Essential health benefits • Dental for Medicaid eligible only • Vision • Long-term care for Medicaid eligible only	• No cost-sharing • Private insurance utilization changes due to removal of cost sharing	• Reduced pricing variation between covered populations • Health care provider administrative efficiency • Purchasing power	• Improved access for the Medicaid eligible population • Reflects increased utilization for uninsured and undocumented immigrant populations	• State-administered • Premiums are exempt from state premium tax, impacting cost and revenues • Reflects reductions in system-wide administrative costs

Model A: cost and revenue impact
state-administered

- Status quo expenditures: $61.4 billion
- Projected expenditures: $58.9 billion
- 7,619,000 Washingtonians covered
- Primary sources of cost savings:
  - **Eliminates** private health plan administrative costs
  - Administrative cost reduction for health care providers
  - Improved access to care
  - Greater purchasing power
- **State funds required: $26.5 billion, plus an additional $3 billion (total funds) to provide dental services**

CY 2022 implementation (in millions)



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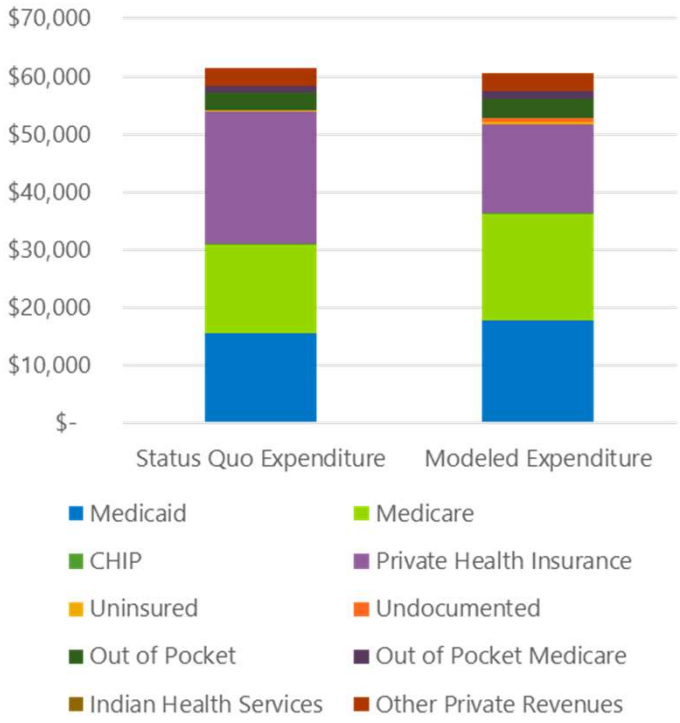
Model B: plan design
state-delegated

Covered populations	Benefits	Cost-sharing	Provider reimbursement	Population specific impacts	Administration
• Medicaid • Medicare • CHIP • Private health insurance • Undocumented immigrants • Uninsured	• Essential health benefits • Dental for Medicaid eligible only • Vision • Long-term care for Medicaid eligible only	• No cost-sharing • Private insurance utilization changes due to removal of cost sharing	• Reduced pricing variation between covered populations • Administrative efficiency • Purchasing power	• Improved access for the Medicaid eligible population • Reflects increased utilization for uninsured and undocumented immigrant populations	• **Administered by health insurers** • **Premiums tax applies** • Reflects reductions in system-wide administrative costs

Model B: cost and revenue impact
state-delegated

- Status quo expenditures: $61.4 billion
- Projected expenditures: $60.6 billion
- 7,619,000 Washingtonians covered
- Primary sources of cost savings:
  - **Reduces** private health plan administrative costs
  - Administrative cost reduction for health care providers
  - Improved access to care
  - Greater purchasing power
- **State funds required: $27.5 billion, plus an additional $3 billion (total funds) to provide dental services**

CY 2022 implementation (in millions)



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Models A and B: key differences

Model A:
Universal Care
(state-administered)

- Eliminates private health insurers.
- Establishes a standardized provider reimbursement.
- **Maximizes** economies of scale, since the state is the sole purchaser of care, including:
  - Purchasing power.
  - Monitoring fraud, waste, and abuse.
- Employment losses due to eliminating private health insurers.

Model B:
Universal Care
(state-delegated)

- Maintains and consolidates the number of private health insurers.
- Variation in provider reimbursement is reduced.
- Supports **increased** economies of scale.
- Achieved savings is lower than Model A.
- Maintains premium tax collection.
- Mitigates employment losses.

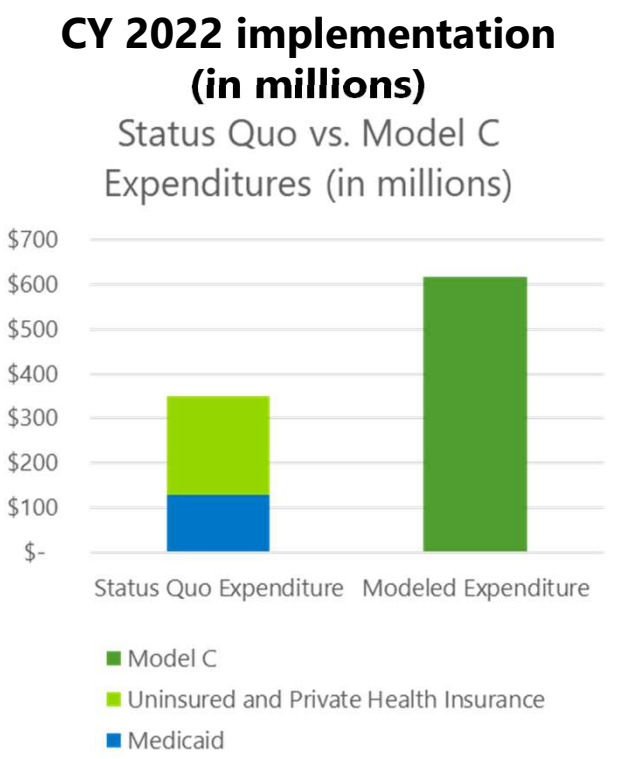
Model C: design elements
Close the Gap

Covered populations	Benefits	Cost-sharing	Provider reimbursement	Population specific impacts	Administration
• Undocumented immigrants	• Essential health benefits	• Standard cost-sharing	• Cascade Care reimbursement standards apply	• Utilization assumed to be similar to the commercially insured population	• Assumes commercial plan levels of administrative costs

Note: this model should be considered in conjunction with the Cascade Care subsidy options. While this model creates coverage options for those most likely to lack access to traditional coverage, it does not address affordability for those who **do** have access to coverage.

Model C: cost and revenue impact
Close the Gap

- Represents a very different concept than Models A and B
- Model C is an incremental step, bridging the gap in the existing health care system
- Status quo expenditures: $61.4 billion
- Increase to status quo expenditures: $617 million
- 124,000 incremental increase in covered individuals
- **State funds required: $617 million for expanding coverage to 124,000 individuals**



Model impacts and considerations

- Modeling assumes preserving federal funds for Medicare, Medicaid, and CHIP-eligible populations.
- Provider reimbursement modeled to be revenue-neutral to providers in aggregate.
  - Repurposes waste in provider administration.
  - Supports enhanced purchasing power.
- Supports current health innovation (e.g., Bree Collaborative and health information technology), but will need continued and future investments to achieve level of efficiency assumed in the model.

Model impacts and considerations
continued

- Additional savings is projected as the program matures.
  - For example, Model A is projected to **increase from $2.5 billion to $5.6 billion in annual savings** when the program is fully mature.
  - Savings accrues to the economy and impacts several state and local government agencies.
- Operational decisions made in the implementation phase will impact the program costs. As decisions are made, the cost estimates will need to be updated accordingly.

Impacts of models: qualitative

Goals	Model A	Model B	Model C
Access			
Governance			
Quality			
Equity			
Administration			
Feasibility			
Affordability			

Wrapping up

- For final legislative report:
  - Currently incorporating work group feedback
  - Includes a robust transition plan, applicable to all models
- Final meeting is December 9:
  - Spending more time on Model C
  - Discussing what's next

Questions?

Contact HCA at:
HCAUniversalHealthCare WorkGroup@hca.wa.gov

Visit **Universal Health Care Work Group page** at:
hca.wa.gov/about-hca/healthier-washington/universal-health-care-work-group

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