Washington State Health Care Authority

Finance Technical Advisory Committee

May 11, 2023

Washington State Health Care Authority

Finance Technical Advisory Committee (FTAC)

Meeting Materials

May 11, 2023
3:00 p.m. – 5:00 p.m.

(Zoom Attendance Only)

Meeting materials

Meeting agenda 1
Approval of March meeting summary.....2
Public comment.....3
Review 2023 workplan 4
Options to include Medicare in Washington's Universal Health Care Plan .....5 & 6
Updates from the April UHCC meeting 7
Creating and sustaining a Universal Health Care System.....8

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Finance Technical Advisory Committee (FTAC) to the Universal Health Care Commission

May 11, 2023
3:00 p.m. – 5:00 p.m.
Zoom Meeting

AGENDA

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
3:00-3:03 (3 min)	Welcome and call to order	1	Pam MacEwan, FTAC Liaison
3:03-3:06 (3 min)	Roll call	1	Angela Castro, Senior Health Policy Analyst Health Care Authority
3:06-3:08 (2 min)	Approval of Meeting Summary from 03/09/2023	2	Pam MacEwan, FTAC Liaison
3:08-3:23 (15 min)	Public comment	3	Pam MacEwan, FTAC Liaison
3:23-3:25 (2 min)	Review 2023 Workplan	4	Liz Arjun, Senior Consultant Health Management Associates
3:25-4:30 (65 min)	Options to Include Medicare in Washington's Universal Health Care Plan • FTAC Discussion • FTAC Votes on Medicare recommendations to UHCC	5 & 6	Christine Eibner, Senior Economist, RAND Corporation
4:30-4:40 (10 min)	Updates from the April UHCC meeting • Transitional solutions • Preliminary ERISA discussion for next FTAC meeting • Next steps	7	Jon Kromm, Principal Health Management Associates
4:40-5:00 (20 min)	Creating and Sustaining a Universal Health Care System: Introduction to System Cost Containment Strategies	8	Robert Murray, Assoc. Health Services Researcher, University of California College of the Law San Francisco
5:00	Adjournment		Pam MacEwan, FTAC Liaison

Subject to Section 5 of the Laws of 2022, Chapter 115, also known as HB 1329, the Commission has agreed this meeting will be held via Zoom without a physical location.

Tab 2

Finance Technical Advisory Committee (FTAC) Meeting Summary

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

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

Members present

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

Members absent

Esther Lucero
Ian Doyle

Call to order

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

Agenda items

Welcoming remarks

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

Meeting Summary review from the previous meeting

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

Public comment

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

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

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

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

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

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

Presentation: FTAC ideas for transitional solutions

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

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

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

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

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

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

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

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

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

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

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

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

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

Gary Cohen, HMA

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

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

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

Adjournment

Meeting adjourned at 5:04 p.m.

Next meeting

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

Tab 3

Washington State Health Care Authority

Washington State Health Care Authority

FTAC

Written Comments

Received Since February 23

Written Comments Submitted by Email

C. Currie 1
C. Currie 4
R. Collier 8

Additional Comments Received at the March FTAC Meeting

- The Zoom video recording is available for viewing here: https://www.youtube.com/watch?v=QeU79R0kcRQ

Public comments received since (February 23) through the deadline for comments for the May meeting (April 27)

Submitted by Cris Currie

03/29/2023

FTAC:

At the end of the March FTAC meeting, Chair MacEwan noted that there did not seem to be any interest among committee members in immediately applying for a federal waiver. I hope she was joking, since it is not time yet to apply for waivers. Full integration of Medicare into the state system should be the goal, but before that can be accomplished, a waiver application will need to be submitted and negotiations with Health and Human Services will need to take place. That application needs to include a comprehensive UHC program plan that has been approved by the state legislature, along with a 10 year budget, as described in Section 1332 of the ACA. So the top priority for the Commission should be the preparation and passage of a bill that meets the minimum requirements of Section 1332. While parts of the bill would be contingent upon HHS waiver approval it could also include other possible options as alternatives (such as a wraparound). Likewise, the highest priority for the FTAC should be the 10 year budget to accompany the plan. These negotiations need to start soon to take advantage of a favorable administration.

It was Senator Ron Wyden (D-OR) who wrote Section 1332, and it was his intention that it would be sufficient for integrating federal programs into a state universal system. However, there is disagreement about this, which is why the State Based Universal Health Care Act is being reintroduced in Congress this spring and why Washington's SJR 8006 is asking the president and Congress to support it. Nevertheless, a Section 1332 waiver is the place to start in determining how the state will handle Medicare and other federal healthcare programs.

I've attached my summary of the four main options for dealing with Medicare in a single-payer system. I hope you find it useful.

Cris M. Currie RN(ret.) Spokane, WA

The Medicare Problem in Single-Payer

Cris M. Currie, HCFA-WA, with Charlie Swanson, HCFA-OR

There are essentially four options for dealing with Medicare in a single-payer system. How these options would actually play out will only be known after the state passes legislation to authorize a single-payer system and it is then able to apply for Section 1332 waivers to begin

negotiations with the federal government. This paper is meant to serve as a framework for further research and discussion and intended to prompt more questions than it answers.

A. The most cost efficient and equitable option is to **integrate** Medicare into the single-payer system. This option is also likely to be the most difficult to achieve. CMS would essentially give the state a block grant either based on the amounts collected from all Washington residents in Medicare including payroll deductions, premiums, and the percentage of federal income tax dedicated to Medicare, or based on the historical values of what Medicare has paid out to recipients in the state as a whole or per beneficiary. The state would then process beneficiary claims and reimburse providers much like existing Medicare Administrative Contractors (MAC). Additional state funding would be needed to secure additional benefits and adjusted provider reimbursements. In Washington, since there is no income tax, it assumed that this funding (see WHST proposal, Sections 10 and 16) will be raised through a payroll tax and individual premiums. Private Medicare Advantage (MA) plans would be prohibited within the state and participation would be mandatory for Medicare beneficiaries. Since there is no available waiver that could accomplish this, it would likely require Congressional action such as the State Based Universal Health Care Act (SBUHCA).

B. The Balanced Budget Act of 1997 established Medicare Part C, later renamed in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as Medicare Advantage. The BBA authorized CMS to contract with private or public organizations to offer a variety of health plan options for beneficiaries. So the state should be able to offer its own **Medicare Advantage plan** to compete with private insurance companies. If SBUHCA were to pass, the state might be able to secure a waiver that would eliminate private plans, but in that case, Option A would be preferable. It is otherwise unlikely that a state could deny a private company a state license to offer MA plans in the state, since federal standards supersede state law with respect to MA plans other than licensing details and laws relating to plan solvency. So beneficiaries would still have a choice between Traditional Medicare and the private and public MA plans.

As an MA entity, the state would receive capitated payments based on CMS's risk formula for each beneficiary. Calculating risk for each beneficiary will also add to the administrative cost, but these payments would undoubtedly be higher than Traditional Medicare's standard payments, since for at least the last 30 years, overpayments to MA plans have been the norm. Providers would bill the state just like any other patient, but including the patient's Medicare number. The state would then reimburse the provider at the standard single-payer rates that are the same for all classes of providers, and obtain reimbursement from CMS as the secondary payer. Since the state would not have nearly the high administrative costs that private plans have, it could redirect those overpayments toward paying part B premiums and deductibles, adding significant benefits, and adjusting certain reimbursements, making the state plan even more attractive to beneficiaries. For details regarding how physician payments should be adjusted for greatest value go here and here. Go here for hospital payments.

Apparently private MA entities already have the ability to pay providers both above and below standard Medicare rates. Additionally, some providers "not accepting assignment" have the ability to bill the patient an extra "limiting charge," so, while complicated, the state could cover this as well. If necessary, a federal waiver [42 USC 1395b-1] could be sought for changes to payment methods or rates, payments for additional services, or performance or incentive contracts. The problem here is that waivers are only granted for a specified amount of time, and their purpose is to experiment with a policy change at the state level before enacting it nationally. Whether a single state could enact a reimbursement change permanently is doubtful, but CMS could create a rule to allow all states to adjust reimbursements. In any case, private insurers would likely scream unfair competition, and there would be litigation with unpredictable outcomes.

It would, however, be a bit ironic for single-payer advocates to promote the idea of a state offering a MA plan since MA plans and other Medicare privatization efforts are seen as undermining the chances of achieving Medicare for All. However, the main privatization problem stems from the needs of private companies to maximize profits, which can only be done at the expense of the beneficiary. Since the state does not have this requirement, it could run an MA plan much closer to how the plans were originally intended (obviously without the temptation for fraudulent upcoding), benefiting the beneficiary by expanding services and lowering costs, and providing the model for how Improved Medicare for All could operate. But the biggest risk for option B is that the state's plan does not end up being significantly better than the private plans such that it is never able to force the private companies to voluntarily withdraw their plans from the state. However, as with ERISA plans, if Washington Medicare beneficiaries are required to pay the state's health care premiums, they would have no financial incentive to remain in a private plan and continue paying Medicare premiums as well.

C. The third option is for the single-payer to **wrap around** Medicare. The state would obtain a demonstration waiver to serve as a supplemental or Medi-gap plan that would not only cover Medicare deductibles and coinsurance, but also numerous additional benefits, and adjusted reimbursements for certain providers. If the demonstration project is successful, CMS could possibly create a rule that allows all states to offer wraparound plans. However, the Oregon Task Force somehow concluded that provider reimbursements would be outside the state's purview. Beneficiaries could continue paying their Traditional Medicare part B premiums, but more likely the state would pay them in exchange for the beneficiary paying the state's health care premium tax. Beneficiaries would also need to cancel any private supplemental or MA plans. As long as the state's premiums are substantially lower than for private MA and supplemental plans, Option C should be quite popular with beneficiaries. The 2023 Part B premium is $164.90/month and supplemental plans cost around $200/month.

Providers would bill the state, providing the beneficiary's Medicare number, and the state would pay the provider and seek reimbursement from CMS. Presumably the state would receive less funding than in Option B, as standard fee-for-service rates would apply. The state

would also have to bill for every service, instead of receiving capitated lump sums in advance, which could make the administrative costs higher than in Option B. And the state would be in direct competition with private supplemental plans and would likely incur similar charges of unfair competition and litigation. The state would need to negotiate with CMS, but no Congressional approval would likely be necessary. California's AB 1400 advocated Option A and then Option C with "premium support" for Medicare Part D as a backup.

D. The final option is to leave Medicare beneficiaries **completely out** of the single-payer system until Option A can be achieved. This option would minimize the number of residents needing coverage by the state, but would also drastically reduce the revenue for the program. However, it could also lead to a substantial number of providers dropping Medicare beneficiaries as patients because of much lower Medicare reimbursement rates and the added administrative complexity of dealing with two separate systems. So in terms of equity and efficiency, this is the least desirable option, and without both equity and efficiency, the single-payer system will not, and should not, garner legislative approval.

Submitted by Cris Currie

04/19/2023

To the FTAC:

Attached is my summary of Erin Fuse Brown and Elizabeth McCuskey's very influential position on how state based universal healthcare systems should approach the ERISA preemption problem. Because their original 77 page law review article is rather dense and detailed, and their 6 page memorandum to the Oregon UHC Task Force is also somewhat difficult to follow unless one is already familiar with the subject, I have distilled their background information and strategies down to a bit more than 3 pages in order to make their ideas more accessible. I have also shown how HCFA-WA's Washington Health Securities Trust proposal incorporates each of these strategies. Please note that SB 5335 only includes the "Type A" strategy. I hope you find the summary useful.

Cris Currie

ERISA and State Single-Payer Health Care: A Primer
by Cris M. Currie April 2023

The ERISA Problem

According to the authors of Federalism, ERISA, and State Single-Payer Health Care by Erin C. Fuse Brown and Elizabeth Y. McCuskey, as of 2019, employer sponsored health insurance plans covered about 49% of Americans, and the number of employer self-insured plans had grown to about 60% of that number. This represents about 20% of total national health care expenditures, but that percentage continues to grow. The Employee Retirement Income Security Act of 1974 (ERISA) was not originally intended to regulate health care, but it has still managed to derail state-based health care reforms for decades. Essentially it invalidates "any and all" state laws that "relate to" an employee benefit plan, and it arose from the fear that multi-state employers would refuse to provide health care benefits if faced with state variability. Unlike other statutes concerning Medicaid, Medicare, and CHIP, there is no waiver authority with which states might experiment with alternative mechanisms. Plus, employers and third parties can enforce it in court to keep deflecting state regulation. Even though the Affordable Care Act imposed a uniform federal mandate for employer health benefits in 2010, ERISA has yet to be amended to reflect the fact that the original intent is no longer relevant.

In this 2020 article, published in the University of Pennsylvania Law Review, the authors document that between 2010 and 2019, legislators in 21 states have proposed 66 bills attempting to create single-payer universal health care financing systems, and ERISA's preemption of state regulation over employer health benefits has threatened all of them. However, despite its pervasiveness, the authors propose three major types of mechanisms for capturing employer health benefits expenditures and transitioning them to the state single-payer system. For maximum effect, they recommend incorporating all three in a state's single-payer bill.

The A,B,C Strategy

The **Type A** strategy is the most important. It involves adding a payroll tax for employers, an income tax for individuals, or both to fund the system. The payroll tax should be split with the employee, especially in the absence of a state income tax. Since the tax is a percentage of wages paid and not based on the employer's benefits expenditures, it is technically beyond the reach of ERISA. The authors noted 45 bills in 16 states using a Type A provision. Once the state plan is well established, and assuming it is as good or better than any employer plan, it is also assumed that most employers will decide to drop their own plans in order to be relieved of an unnecessary expense and time-consuming administrative matter that is unrelated to their core business interests. The employees will also likely lose interest in the employer plan and will elect to stop paying for it once they are covered by a better state plan. It is of course critical that the state plan be of high quality and that the overall expenses for both the employer and employee drop significantly.

This strategy is particularly important in capturing employer expenditures in self-insured plans. Because of the convoluted "savings" clause, the equally convoluted "deemer" clause, and the "relate to" clause, courts have interpreted ERISA to mean that states can regulate (or save) "fully insured" health insurance plans, but not "self-funded" plans. Employers that buy their insurance from private insurance companies are called *fully insured* and must abide by the state's insurance regulations, but those using their own funds to pay benefits are exempt from

state insurance laws. ERISA does not define insurance, but the courts have not *deemed* self-funding to be the "business of insurance," thus creating a loophole for companies to avoid state regulation.

Here is how the current Washington Health Security Trust (WHST) proposal frames this provision:
Section 16(2) The recommended funding mechanism may contain the following elements:
(a) A health security assessment to be paid by all employers in Washington state; and
(b) a monthly health security premium to be paid by Washington residents with incomes over two hundred percent of the federal poverty level, subject to exemptions such as for Medicare and Medicaid beneficiaries or for persons under the age of eighteen.
(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.

To further encourage employees to drop their employer coverage, **Type B** clauses, involving provider restrictions, have been included in 34 bills across 14 states. These provisions tell healthcare providers that if they participate in the state's single-payer plan, they can only bill the state, and at the state's rates. This should provide an additional incentive for employers to drop their self-funded plans because it will likely shrink the network of participating providers in those plans.

Here is how the current WHST proposal frames this provision: *Section 10(9) A participating provider shall not charge a rate in excess of the payment established through the trust for a health care item or service furnished under the trust and shall not solicit or accept payment from any member or third party for a health care item or service furnished under the trust, except as provided under a federal program.*

For federal programs such as Tricare where waivers are not available, the provider could bill the program directly such that the single-payer would become the secondary payer. If providers are generally unable to be paid by other sources, they will be unable to see patients with other coverage, and if individuals want to see those providers, they will likely drop their employer plan in favor of the state system. Since provider regulation is beyond the scope of ERISA, its state preemption should not apply.

Type C uses subrogation, an assignment of benefits, and secondary payer clauses to pay for services and seek reimbursement from other payers during the transition to a full single-payer system when other payers, such as self-insured employers, might still be operating. In asserting a subrogation claim, the single-payer could pay an individual's medical expenses and then seek reimbursement from the third-party still ultimately responsible for those expenses. Under the assignment of benefits, individuals can transfer their right to reimbursement from another party (the employer) to the single-payer. And secondary payer allows the single-payer to pay for any expenses not covered by the primary/employer payer.

For example, an MRI provider bills an employer plan $800 for the imaging, and the employer agrees to pay up to $1000 for radiology services. Through subrogation, the single-payer could step in and pay the $800 and then bill the employer for an $800 reimbursement through the assignment of benefits provision. Or if the employee plan had a $500 deductible, the employer could pay the $300 and the single-payer could pay the deductible under the secondary payer clause. This arrangement would save the single-payer money, which could reduce the amount needed for the payroll tax. While circuitous and inefficient, Type C does allow for the possibility of establishing a single-payer plan in the presence of employers who want to continue their self-insured plans, possibly preempting a litigation challenge. These are the kind of crazy scenarios that the ERISA presumption forces on states. It would be much easier if the state could just mandate that employers supply coverage under the state's program to eliminate the possibility of dual coverage, but employer mandates are not popular. Type C might also be useful for capturing expenditures from out of state employers who are not subject to the state's payroll taxes.

Here is how the current WHST bill frames this provision: *Section 10(2) If a resident has health insurance coverage for any health services provided in the state, the benefits provided in this act are temporarily secondary to that insurance. During the transition to full implementation of the trust, a resident may transfer their right to reimbursement from a secondary payer to the trust, and the trust may then pay for the resident's healthcare expenses and receive reimbursement from the secondary payer. Nonresidents are covered for emergency services and emergency transportation only.*

The Non-duplication Provision

Many states also add a fourth strategy called a non-duplication provision. These prohibit private insurers from offering plans that duplicate the single-payer benefits. Private insurers can therefore only offer supplemental plans (complementary coverage). Kip Sullivan (attorney member of HCFA-MN and One Payer States) has advised that a non-duplication clause makes it explicitly clear that private health insurance companies are to be cut out on a certain date. He believes that if a court thinks that the legislature was unclear about its intentions, it could rule for the insurance industry. Sullivan also fears that in the absence of a non-duplication provision, insurance companies might continue to sell policies, asserting the defense that they didn't understand the new law (personal email).

Here is how the current WHST proposal frames this provision: *Section 1(4) On and after the day the WHST becomes operational, a health plan, as defined in RCW 48.41.080(11), may not be sold in Washington for services provided by the WHST.*

However, according to Fuse Brown and McCuskey, non-duplication clauses, while they directly target insurers rather than employers and thus should avoid the ERISA preemption, they can only ban the *fully insured* employer plans, leaving self-funded plans untouched, since those plans are not deemed insurance policies. And while the non-duplication clause is seemingly efficient and certainly unambiguous, it also might illicit a strong litigation response from the targeted insurance companies, which are much more likely than employers to sue. This clause

is closer to using a hammer than the more subtle A,B,C approach designed to nudge employers, with either type of health benefit plan, toward choosing the single-payer program. The A,B,C strategy should allow the state to prevail in an ERISA challenge since it preserves a meaningful choice of three employer options: a) continued self-funded duplicative coverage, b) purchasing or self-funding complementary coverage, and c) offering no employer coverage and relying on the state's coverage.

According to the authors, the A,B,C system is somewhat redundant and should survive an ERISA challenge even if parts are shot down. "But the muddle of ERISA jurisprudence renders actual outcomes uncertain. The only certainty in ERISA preemption is that there will be litigation" (p. 440). If, however, a court "erroneously invalidated a payroll tax, a severability provision in the state statute might permit conversion of the state's mandatory single-payer payroll tax into a play or pay option" (p. 442, 423). While this conversion would likely still encourage some continued employer-based coverage by providing an additional option to pay, the B and C strategies could be the key to the state eventually coming out on top.

For additional detail, see the authors' 6 page memorandum to the Oregon UHC Task Force dated July 2022 here pages 59-65.

For the full 77 page law review article go here.

For the chapter in the ERISA that is causing all the problems, go here and then to sections (a) [the *relate to* clause] and (b)(2) (A) [the *savings* clause] and (B) [the *deemer* clause].

Submitted by Roger Collier
04/24/2023

Washington Healthcare Plan public option

Dear FTAC member:

Angela Castro of HCA asked me to send to you the attached revision of a document I submitted several months ago to the UHCC.

The Washington Healthcare Plan public option proposal responds to my concerns about some of the major obstacles facing a single-payer healthcare system in our State:

Medicare *– FTAC members have discussed the regulatory problems of including Medicare beneficiaries in a single State model, but the bigger challenge may be persuading political appointees in DC to grant waivers to allow moving millions of seniors to an untested system.*

Medicaid *– Section 1115 waivers are theoretically available to allow inclusion of Medicaid enrollees in a single State system, but the State could face the same challenge as with Medicare of gaining waivers for the transfer of more than two million—often vulnerable—individuals.*

ERISA *–Washington has no state income tax to share in single-payer funding and an increase in sales or other taxes could be considered regressive and at odds with the UHCC's emphasis on equity. The alternative of relying on a substantial tax on employers could run afoul of a Supreme Court ruling that an "exorbitant" tax would be treated as a mandate and preempted by ERISA.*

State budget impact *– If other obstacles can be overcome, single-payer could mean a doubling of the State budget, an issue that sank similar proposals in Vermont and California.*

The proposed Washington Healthcare Plan would avoid potential delays and dead-ends due to the preceding obstacles. It would cut healthcare costs for millions of Washingtonians through simplified administration and more effective price competition. It would facilitate gaining future waivers by demonstrating an effective system covering more than a million State residents. It would require neither new taxes nor any State budget increase. And it would offer a potential long-term pathway to universal healthcare.

I would be happy to answer any questions from FTAC or UHCC members.

Thank you.

Roger Collier

Cc: UHCC members.

ROGER COLLIER rcollier@rockisland.com

THE WASHINGTON HEALTHCARE PLAN: A PROPOSAL FOR AN EFFECTIVE PUBLIC OPTION

APRIL 2023

Roger Collier (rcollier@rockisland.com)

0

THE WASHINGTON HEALTHCARE PLAN: A PROPOSAL FOR AN EFFECTIVE PUBLIC OPTION

INTRODUCTION

In 2021, the Washington legislature passed Senate Bill 5399 establishing the Universal Health Care Commission "*for the purpose of creating **immediate and impactful changes in Washington's health care access and delivery system** and to prepare the state for creation of a health care system to provide coverage and access through a universal financing system … **once federal authority has been acquired.**"*[1]

The Commission's creation was preceded by the formation of work groups whose efforts were recapped in a consultant report that indicated a strong preference for a new single statewide, State-administered, system covering almost all State residents.

However, current federal law does not allow such a single system and federal waivers to allow the transfer of millions of Medicare and Medicaid enrollees to an untested model may not be readily granted, while the Supreme Court has previously issued a decision[2] that may make infeasible substantial employer levies to help fund the system in a state with no income taxes. Additionally, a single-payer system could require a doubling of the State budget, a significant problem that sank similar proposals in Vermont and California.

Accordingly, an alternative approach to dealing with healthcare costs and access is proposed—a public option plan that responds to the first mandate of SB 5399, to create "immediate and impactful changes in Washington's health care access and delivery system," but which also offers a possible long-term pathway to universal healthcare, the *Washington Healthcare Plan* described in this document.

---

[1] Final Bill Report E2SSB 5399 -- Emphasis added.

[2] N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co, 514 U.S. 664 (1995).

The proposed Washington Healthcare Plan would reduce the premiums of hundreds of thousands of Washington residents by:

- ***Cutting insurer and provider administrative costs through a more efficient streamlined program structure***
- ***Encouraging more effective price competition among insurers.***

The Washington Healthcare Plan would also allow the State to take steps towards a universal healthcare system by:

- ***Facilitating future federal waiver approvals by demonstrating an effective State system covering a million or more State residents***
- ***Offering coverage and costs sufficient to attract current commercial plan enrollees, without the need for mandates that could conflict with federal ERISA law***
- ***Avoiding any new taxes or impacts on State budgets.***

The following pages discuss Washington's current health insurance landscape and describe how it would be changed by the steps involved in implementing the *Washington Healthcare Plan*.

WASHINGTON'S PROBLEMS – AND AN OPPORTUNITY

Health insurance in Washington, as in every state, is extraordinarily complicated. Washington has more than three hundred insurers, some with only a handful of enrollees, others with billions of dollars of business, collectively with a mind-boggling variety of policies. The biggest companies each offer dozens of different benefit packages, with a staggering number of possible choices for consumers.

In turn, healthcare professionals have the problem of determining whether and how much they will be paid for treating patients. Is this in-network or out-of-network? Is there a copay to be collected? How much? Or coinsurance? Has the patient's deductible been satisfied? Is treatment even covered? Does it require authorization? And so on.

The difficulty of comparing costs and benefits means many Washingtonians may be paying for coverage that doesn't match their needs, while ***their premiums are burdened by insurer and provider administrative costs that can consume a third of the healthcare dollar.*** National studies[3][4][5] estimate administrative costs of up to thirty-five percent of premiums, split between insurers and providers, with billing and payment efforts more than half this total[6], in large part because of the numbers of coverage options and related authorization and payment rules.

As administrator of healthcare coverage for State and local government and school district employees, Medicaid beneficiaries, and Exchange marketplace enrollees—a total of close to three million individuals—***the State of Washington is in a unique position to control premium costs.***

To do so would mean consolidating elements of various programs, currently spread over multiple State agencies and more than a dozen insurers offering scores of different benefit packages, ***into a single effective public option. The Washington Healthcare Plan would contract competitively with just a handful of insurers, each offering no more than three or four sets of standard benefits. In this more price-competitive but far less complex environment insurers and providers would each experience lower administrative costs, while trimming profits to keep or grow their business in the face of competitively bid contracts.***

---

[3] "Costs of Health Care Administration in the United States," Steffie Woolhandler et al, *New England Journal of Medicine* (2003)
[4] "Reducing Health Care Costs: Decreasing Administrative Spending," Cutler, David M., *Testimony for Senate Committee on Health, Education, Labor and Pensions* (July 31, 2018)
[5] "Overhead Costs for Private Health Insurance Keep Rising, Even as Costs Fall for Other Types of Insurance," Nick Buffie, *Center for Economic and Policy Research* (February 2017)
[6] "Excess Administrative Costs Burden the US Healthcare System," Emily Gee, *Center for American Progress*, April 8, 2019.

THE *WASHINGTON HEALTHCARE PLAN* PROPOSAL

The *Washington Healthcare Plan* model borrows from European healthcare systems and from a recent proposal by former Oregon Governor Dr. John Kitzhaber[7].

The *Washington Healthcare Plan* would bring together all State-administered programs (except Apple Health, which would be included in a later step) into a single insurance pool with similar coverage options, as shown in Figures 1 and 2 on the following pages.

In contrast to the Cascade Care Select public option, with less than ten thousand[8] enrollees, the Washington Healthcare Plan would offer insurers and providers a potential population of more than one million.

It would comprise four components, each significantly different from today:

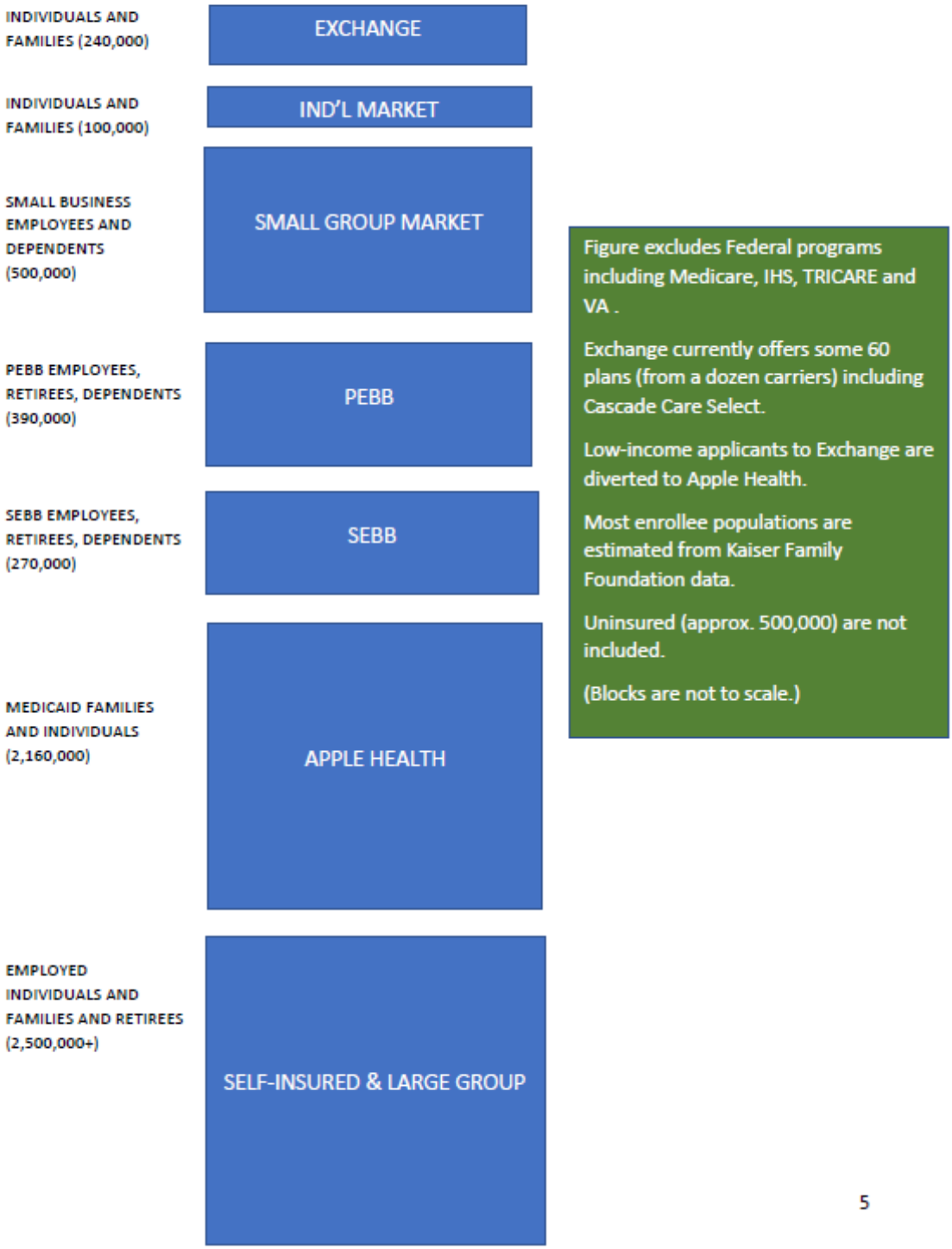
- ***A single enrollment system based on an enhanced version of today's Exchange*** (versus separate enrollment structures for each program)
- ***Limits on the number of insurer networks in each region of the State*** (versus more than a dozen different networks),
- ***Standardized coverage definitions and payment rules*** (approved by the State), and
- ***Competitive selection of insurers to cover all programs in each region*** (versus a variety of approaches to insurer selection).

Single Enrollment System

The Washington Healthcare Plan enrollment system would support Exchange enrollment for individuals, families, and employee groups, plus State and local government and school district employees and dependents. The enrollment system would use an enhanced Exchange for four functions (see Figure 3): determination of program eligibility (including diversion to Apple Health for low-income individuals and families); calculation of State or other sponsor tax credits or premium contributions (one hundred percent for Medicaid beneficiaries, less for others); enrollee selection of insurer (a choice of between no more than three or four); and enrollee selection of benefit level. Once enrollment is complete, enrollees would choose a primary care provider from their selected insurer's list.

[7] "Thoughts on Universal Coverage, Equity and Value," Dr. John Kitzhaber, *State of Reform*, March 2021.
[8] As of December 31, 2022.

FIGURE 1 – CURRENT STRUCTURE

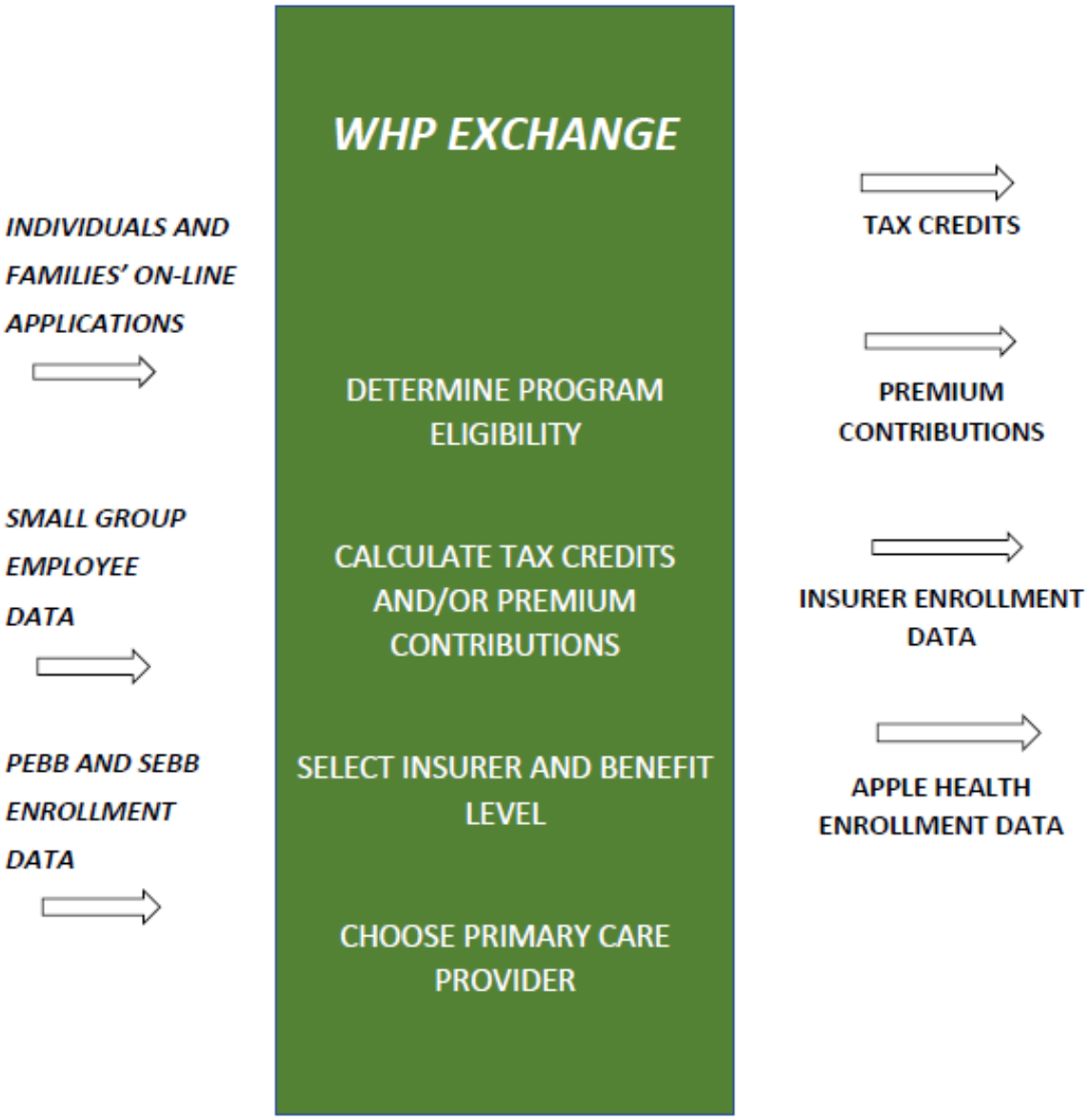


5

FIGURE 2 – WASHINGTON HEALTHCARE PLAN STRUCTURE (INITIAL PHASE)

6

FIGURE 3 – WHP EXCHANGE STRUCTURE



Fewer Insurers per Region

The State would be divided into two or three regions, with sufficiently large populations to attract competitive bids from insurers. A minimum of two insurers per region would be necessary to give enrollees a choice while providing back-up in the event of a possible contract termination. Insurers would be required to offer the same payment rates for all programs (except Apple Health) and a single common network.

Standardized Coverage Definitions

While covered benefits would not necessarily be identical across programs, all services in a "common core" would be required to be defined identically, and approved by the State, with the same prior authorization requirements. Insurers would have some freedom to add services not included in the common core (but not to delete any), while deductibles and copayments would vary depending on the selected benefit level.

Competitive Selection of Insurers

Insurers would be selected via competitive procurements similar to that used currently for Apple Health, with selection based on network capacity, quality, consumer satisfaction, and price. Bids would be specified as "average percent of Medicare" and would cover multiple years.

Employer Group Participation

Members of employer groups not subject to ERISA law would be encouraged to choose the *Washington Healthcare Plan* by requiring that employers offer it as an option to employees (but without mandating its selection), with the expectation that Exchange premiums would be lower—particularly for smaller groups—and federal tax credits may be available. ERISA employer groups would not be subject to any mandates but may find the possible lower costs or more generous coverage of the *Washington Healthcare Plan* more attractive than their own self-funded plans.

Later Inclusion of Apple Health

Low-income individuals and families would be diverted to Apple Health as part of Exchange enrollment (as today), but initially Apple Health would not be part of the *Washington Healthcare Plan*. However, alignment of the two would be possible

with insurers required to cover both with common networks (but with different provider rates). A more complete consolidation of Apple Health and the *Washington Healthcare Plan* (Figure 4) would depend on obtaining federal Section 1115 waivers, but this should be much easier than attempting to obtain waivers to include Medicaid beneficiaries in a totally untested system. It is probable, however, that CMS would insist on its policy of budget neutrality, which could present some challenges if the number of Medicaid eligibles changes significantly over time.

Access and Equity

Access to coverage and to care would be enhanced by simplifying enrollment, reducing costs, and (potentially) requiring insurers to mandate network provider acceptance of Medicaid enrollees.

Equity issues would become fewer as more of those currently uninsured are able to gain coverage, particularly if a possible future employer mandate were to make provision for part-time and seasonal workers.

The Long Run: Universal Healthcare

Universal healthcare may remain an unreachable goal unless federal laws governing Medicare and self-insured plans are changed. However, success in reducing costs could provide opportunities for some ERISA and Medicare beneficiaries to be brought into the *Washington Healthcare Plan*. Specifically, currently self-insured groups may be attracted by lower costs, while the *Washington Healthcare Plan* could be offered as an option within Medicare Advantage. In addition, if universal healthcare does become feasible in Washington, the experience gained with the *Washington Healthcare Plan* will be invaluable.

Implementation

The *Washington Healthcare Plan* would achieve an efficient public option, likely much more attractive than the current Cascade Care Select plan. Because only State-administered and State-sponsored programs would be involved, no ERISA exemption would be needed. However, changes to State regulations would be necessary to establish the new program, and waivers of Title 19 and Affordable Care Act requirements are expected to be required.

Alignment of PEBB, SEBB, and Exchange benefit structures would include recognition of the different premium approaches between the "bulk purchase"

FIGURE 4 – WASHINGTON HEALTHCARE PLAN STRUCTURE (WITH APPLE HEALTH)

rates for PEBB and SEBB versus the individual and family premium rates for the Exchange. (The State is already considering consolidation of PEBB and SEBB programs, but over a five-year timeframe.)

For individuals, families, and employers outside public agencies, the intent of the *Washington Healthcare Plan* proposal is, so far as possible, to avoid mandates. Moving from small group or individual coverage to a large group structure with lower administrative and other overhead costs should result in premium reductions of up to ten percent and fifteen percent respectively, based on national surveys[9][10]. Only if individuals and families are clearly not benefiting because of insurer or employer dissuasion or inaction on the part of insurable individuals would mandates or additional incentives be considered.

Other implementation issues include the necessity for "buy-in" by program sponsors, including state agencies and school districts who may have concerns about the inclusion of their programs in a larger consolidated model, but whose members should see less costly or more generous coverage. Insurers' concerns about loss of business in a more highly competitive environment must also be recognized. In addition, as the State has experienced with Apple Health procurements, unsuccessful bidders might file protests unless the selection process is clear, comprehensive, and transparent.

The *Washington Healthcare Plan* would be implemented in four or five phases:

- **Establish enhanced Exchange as single public option enrollment system for all non-ERISA, non-Medicare coverage**
    a. Enact State legislation
    b. Obtain Section 1332 waiver
    c. Make software changes to Healthplanfinder
    d. Define benefits for each metal level

- **Implement *Washington Healthcare Plan* for PEBB, SEBB, and Exchange individuals and families**
    a. Make software changes to PEBB and SEBB systems
    b. Solicit insurer bids for each region
    c. Prepare and disseminate enrollment materials
    d. Enroll members of each group

[9] Kaiser Family Foundation, 2022 Employer Health Benefits Survey, October 2022
[10] Kaiser Family Foundation, Health Insurer Financial Performance, February 2023

- **Implement *Washington Healthcare Plan* for employee groups**
    a. Reestablish SHOP program to provide federal credits
    b. Implement SHOP for groups up to 50 employees
    c. Allow all employee groups to join *Washington Health Plan*

- **Integrate Apple Health into *Washington Healthcare Plan***
    a. Analyze impacts on access and costs of program integration
    b. Obtain Section 1113 and/or 1115 waivers
    c. Implement full integration of Apple Health

- **Design and implement State employer mandate and individual coverage incentives (if necessary).**
    a. Determine scope of employer mandate
    b. Enact employer mandate legislation
    c. Determine coverage incentive rules and payments
    d. Obtain Section 1113/1115 waiver for incentives
    e. Enact coverage incentive legislation
    f. Implement employer mandate and coverage incentives

What can we expect?

The *Washington Health Plan* should lead to premium reductions for all State-administered and State-sponsored healthcare programs, as a result of:

- Reducing provider and insurer claims submittal and processing efforts, including denials and resubmittals, by cutting the number of participating insurers and benefit options. (A recent study[11] shows that up to forty percent of provider administrative costs could be eliminated with fewer insurers and fewer and simpler coverage options.)
- Further cutting provider and insurer administrative efforts by requiring insurers to adopt common benefit definitions and prior authorization rules.
- Reducing insurer "risk premiums" by spreading risk over more lives by shrinking the number of benefit options.

[11] "Reducing administrative costs in US health care: Assessing single payer and its alternatives," David Scheinker et al, *Health Services Research*, March 2021.

- Causing insurers to squeeze profits and overhead to retain or gain business in a more highly price-competitive environment—especially as the slices of the "premium revenue pie" become larger with fewer payers—while allowing successful bidders to spread fixed costs over more business.
- Reducing the number of uninsured (details below) from the current six percent, whose "charity care" costs may otherwise be passed on to insurers, and thence to premiums.

The *Washington Health Plan* should also facilitate access to coverage and care as a result of:

- Reducing premiums for most benefit options (see above).
- Making enrollment simpler by reducing the number of insurers and benefit options.
- Requiring insurers to mandate provider acceptance of Apple Health (possibly up to ceiling provider enrollment caps).
- Offering coverage incentives (if necessary) to the newly insured, perhaps in the form of gift cards similar to those already provided by one or two insurers.
- Implementing an employer mandate for all non-ERISA groups (if necessary).

The *Washington Healthcare Plan* would directly impact only State-administered programs. Federal programs such as TRICARE and Medicare would be unaffected (unless the *Washington Healthcare Plan* can be offered as a Medicare Advantage Plan). However, reductions in Exchange premium rates should attract more individual enrollees and persuade more small employers to switch from their private market plans, in turn putting pressure on competing commercial plans to reduce their rates. For Apple Health, requiring insurers to offer the same networks as other programs would move enrollees more firmly into mainstream healthcare.

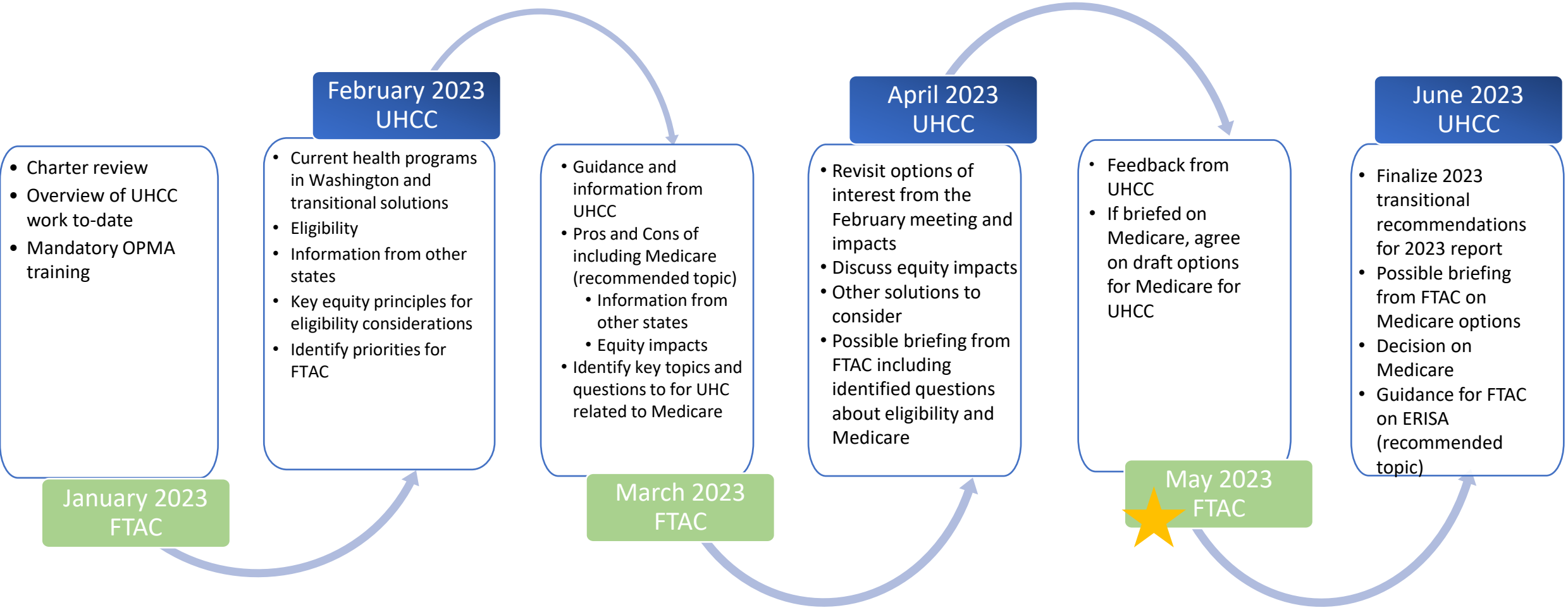
Roger Collier is the retired CEO of a national healthcare consulting firm, where he managed projects for some fifteen state Medicaid agencies, the US Department of Health and Human Services, the US Department of Defense, the national Blue Cross and Blue Shield Association and several individual Blue Cross and Blue Shield Plans, and HMOs including Kaiser and Group Health. He testified on government healthcare issues in Washington DC and before legislative committees in Colorado, Washington and Oregon, and was a panelist for Washington State's 2006 Blue Ribbon Commission on Health Care Costs and Access. He has been quoted in both the regional and national press, including the New York Times.

He can be contacted at rcollier@rockisland.com.

Tab 4

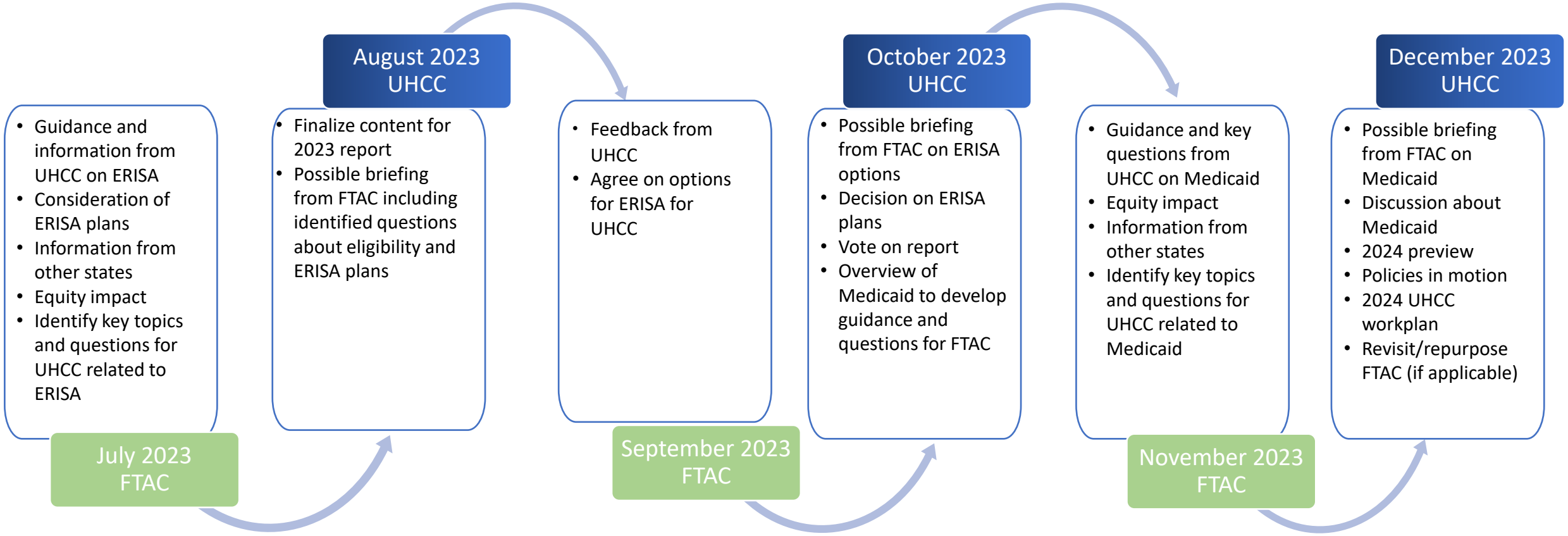
Washington State Health Care Authority

Washington's UHCC 2023 Workplan



Workplan will change depending on progress made in each meeting

Washington's UHCC 2023 Workplan



Workplan will change depending on progress made in each meeting

Tab 5

Washington State Health Care Authority

Options to Include Medicare in Washington's Universal Health Care Plan

Christine Eibner

Overview of presentation

- Provide background on Medicare and UHC
- Discuss a range of options for incorporating Medicare into the universal health care (UHC) plan
- Describe specific issues relevant to low-income beneficiaries
- Summary and discussion

Overview of Medicare

- Federal health insurance program for people ages 65+ and/or qualifying people with disabilities
- Four components -- see table
- Requires premiums for some components
- Traditional Medicare covers ~80 to 84 percent of beneficiaries' health care costs
- MA can have a higher actuarial value, but enrollees can face network restrictions
- Federal government reimburses providers or plans for services

Component	What Does it Cover?	Premium?
Part A	Hospital Care	Not usually*
Part B	Physician Services	Yes
Part C, or Medicare Advantage (MA)	Managed care option combining Parts A and B	Part B premium, and potentially an additional premium
Part D	Prescription drugs	Yes

*Beneficiaries who paid (or had a spouse who paid) hospital insurance taxes for a minimum of 40 calendar quarters don't pay a premium. Requirements can be lower for those with disabilities.

Why might it be important to include Medicare beneficiaries in UHC plan?

UHC Goal	Medicare
No premiums	Premiums required for Parts B and D, and possibly Part C
No cost sharing for UHC options A and B*	Beneficiaries can face significant cost sharing
Would include vision care, and possibly dental and long-term care	Vision, dental, and long-term care not covered

* The Universal Health Care Commission's 2022 report to the state legislature articulated three benefit design options, A, B, and C. Both A and B would eliminate cost sharing.

Overview of presentation

- Provide background on Medicare and UHC
- Discuss a range of options for incorporating Medicare into the universal health care (UHC) plan
- Describe specific issues relevant to low-income beneficiaries
- Summary and discussion

Options for Incorporating Medicare

Less Feasible

More Feasible

1. Act of Congress or comprehensive waiver
2. Demonstration waiver, such as via 1115a
3. State-operated Medicare Advantage & Part D (MA-PD) plan as the only option for WA Medicare beneficiaries (requires a waiver)
4. State-operated MA-PD plan that would compete with private MA plans and traditional Medicare
5. State-operated Medicare supplemental insurance (Medigap) plan
6. Directly reimburse or insure beneficiaries for gaps

1. Act of Congress or Comprehensive Waiver

- If enacted, this option would enable WA to redirect federal funding for Medicare into the UHC plan
- **Advantages:** Would enable the state to capture federal Medicare funding (currently paid to providers or plans) and apply to the UHC plan
- **Disadvantages:**
  - No precedent
  - Legal advisors to the state of California found no clear statutory or regulatory pathway enabling CMS to redirect Medicare funds to a state, even via waiver (Brown, Peisch, and Seidenberg, 2022)
  - Unclear support from either Congress or the Administration. E.g., President Biden has made preserving Medicare a cornerstone of his 2024 campaign
  - Beneficiaries may still owe premiums

2. Demonstration Waiver

- WA could work with CMS to develop a reform that could be implemented via 1115a or 402b (payment-focused) waiver
- **Advantages**: Would enable the state to capture federal Medicare funding to implement a payment focused reform (e.g., statewide ACO)
- **Disadvantages**:
  - Waiver authority focuses on payment reform; unclear how this option could be used to cover premiums, cost-sharing, or additional benefits
  - Must reduce federal spending without reducing quality, or increase quality without increasing spending
    - CMS reported that only 4 out of 50 models tested during the first 10 years after the ACA met this standard (Brooks-LaSure et al., 2021)
  - Subject to monitoring, evaluation, and periodic redetermination, creating administrative costs for the state
  - Potentially subject to legal challenges (for example, no ability to enroll in MA)

Questions and Discussion on Options 1 and 2

1. Act of Congress or comprehensive waiver

- Are there additional pros and cons of these options?
- Should the Commission spend time on this option?

2. Demonstration waiver

- Are there additional pros and cons of these options?
- Should the Commission spend time on this option?

A formal vote on this topic will follow the presentation, as well as voting on:

- 3. State-operated Medicare Advantage & Part D plan as the only option for WA Medicare beneficiaries
- State-operated MA-PD plan that would compete with private MA plans and traditional Medicare
- State-operated Medicare supplemental insurance (Medigap) plan
- Directly reimburse or insure beneficiaries for gaps

3. State-Operated MA-PD Plan, Only Option

- WA would implement an MA-PD plan with comprehensive benefits; this would become the only option for state beneficiaries
- **Advantages**: If MA-PD benefit design rules allow, could provide the same benefits as the rest of the universal system
- **Disadvantages**:
  - Would require waiver of provision that allows choice between traditional Medicare and MA, and a mechanism to preclude private MA plans from entering the market (Brown, Peisch, and Seidenberg, 2022),
  - MA payment is pegged to a FFS benchmark; how would this be resolved?
  - MA pricing and benefit design requirements could limit flexibility
  - State would need to apply to become a Medicare Advantage Organization (MAO), or contract with an existing MAO, creating administrative costs for the state
  - Potentially subject to legal challenges (for example, beneficiaries could be denied access to traditional Medicare)

4. State-Operated MA-PD Plan, Competes with Private Plans

- State would offer an MA-PD plan with comprehensive benefits; residents could opt to enroll or not
- **Advantages**: Enables state to provide comprehensive benefits to Medicare enrollees with fewer legal hurdles than other options
- **Disadvantages**:
  - State would need to design and manage an MA-PD plan, in addition to the UHC plan
  - MA-PD pricing and benefit design requirements could limit flexibility
  - State would need to apply to become an MAO, or contract with an existing MAO, creating administrative costs
  - Some beneficiaries could opt not to enroll

Questions and Discussion on Options 3 and 4

3. State operated MA Plan as the only option

- Are there additional pros and cons of these options?
- Should the Commission spend time on this option?

4. State operated MA plan that competes with private plans

- Are there additional pros and cons of these options?
- Should the Commission spend time on this option?

A formal vote on this topic will follow the presentation, as well as voting on:

- State-operated Medicare supplemental insurance (Medigap) plan
- Directly reimburse or insure beneficiaries for gaps

5. State-Operated Medigap Plan

- State would offer a Medigap plan designed to fill in gaps between Medicare and the UHC plan
- **Advantages**: Enables the state to provide more comprehensive benefits than traditional Medicare
- **Disadvantages**:
  - Must have one of 10 specific designs
  - Do not include dental, vision, or supplementary drug coverage
  - Must offer design A, the least generous option, and either design C or F
  - Cannot cover the Part B deductible (except C and F, which are only available to people who enrolled in Medicare before January 1, 2020)
  - Not available to Medicare Advantage enrollees
  - No opportunity to recoup federal funding

6. Directly Reimburse or Insure Beneficiaries for Gaps

- WA state would reimburse beneficiaries directly for Medicare cost sharing, and for services not covered by Medicare but included in UHC plan
- **Advantages**: Could provide substantial flexibility to fill in gaps and equalize coverage
- **Disadvantages**:
  - Gaps may depend on beneficiary choices (such as enrolling in Part D or not)
  - Approach could be subject to gaming from MA plans
  - Federal rules may limit flexibility to wrap around A & B services
  - No opportunity to recoup federal funding
  - Could be administratively complex for both the state and consumers, due to need to document reimbursable and non-reimbursable expenses

Why is direct reimbursement so complicated?

- If beneficiaries can be directly reimbursed for Parts B and D services, they might opt not to pay premiums
  - Could shift all B and D costs to the state
  - State could provide direct reimbursement *only* as wrap-around approach
    - Would the state pay the premium?
    - What about for higher-income enrollees, who face higher premiums?
- Directly reimbursing beneficiaries for some services could cause MA plans to shift rebate dollars to non-reimbursable services
  - E.g., rather than buying down cost-sharing for basic services, an MA plan might offer supplemental benefits not covered by the UHC plan (e.g., gym memberships)
  - To avoid, reimbursement could be conditioned on enrolling in a specific plan, or limited to FFS only
  - State could also use regulator authority to require certain benefit designs in MA plans

Questions and Discussion on Options 5 and 6

5. State operated Medigap Plan

- Are there additional pros and cons of these options?
- Should the Commission spend time on this option?

6. Direct reimbursement or insuring beneficiaries for gaps

- Are there additional pros and cons of these options?
- Should the Commission spend time on this option?

A formal vote on this topic will follow the presentation.

Overview of presentation

- Provide background on Medicare and UHC
- Discuss a range of options for incorporating Medicare into the universal health care (UHC) plan
- Describe specific issues relevant to low-income beneficiaries
- Summary and discussion

Regardless of approach, important to maintain federal funding for low-income enrollees

	Dual Eligibility	Part D Low Income Subsidy (LIS) Status
What is it?	Medicaid provides wrap around coverage for low-income Medicare beneficiaries	The federal government provides cost-sharing and premium subsidies for low-income Part D enrollees
Who is eligible?	Income<=$914 a month (or $1,371 if married); there is also an asset test	Income<=135% of FPL for full coverage; <=150% of FPL for partial coverage; there is also an asset test
What benefits are covered?	Varies by income	Varies by income

Considerations for dual and LIS beneficiaries

- To retain federal funding, the state may need to operate a “shadow” eligibility system to confirm who is eligible for these benefits
- Dual and LIS beneficiaries can be auto-enrolled and/or reassigned to lower-premium plans
  - Default enrollment: if state allows (WA does not), duals who become Medicare eligible may automatically be placed in plans by an insurer
  - Auto- and facilitated- enrollment: in all states (including WA), LIS eligible individuals can be placed in a low-premium Part D plan
- Autoenrollment presents opportunities and risks for WA state
  - As currently implemented, could move people out of a state-preferred plan
  - Perhaps could be modified to facilitate enrollment in state-preferred option

Overview of presentation

- Provide background on Medicare and UHC
- Discuss a range of options for incorporating Medicare into the universal health care (UHC) plan
- Describe specific issues relevant to low-income beneficiaries
- Summary and discussion

Options that capture federal funding may require waivers and additional oversight

	Captures federal funding	Waiver or law change required	Level of federal oversight	Preserves beneficiary choice	Covers premiums	Covers cost-sharing	Covers non-covered services
1. Act of Congress	Yes	Yes	Unknown	No	Unclear	Possibly	Possibly
2. Demo waiver	Yes	Yes	High	No	Unclear	Unclear	Unclear
3. MA, only option	Yes	Yes	High	No	Possibly, via rebates	Possibly, via rebates	Possibly, via rebates
4. MA, competes	Yes, for enrollees	Probably not	High	Yes	Possibly, via rebates	Possibly, via rebates	Possibly, via rebates
5. State Medigap	No	Probably not	Medium	Yes	No	Yes	No
6. Reimburse directly	No	Probably not	Low to Medium	Yes	Yes, if covered	Yes, if covered	Yes, if covered

Most options would also place an administrative burden on the state

Appendix

MA Premium Components

Premium Component	What is it?	How is it calculated?	How is it paid for?
MA Basic	Covers traditional Medicare services (Parts A and B)	MA bid compared to a benchmark; premium = 0 if bid ≤ benchmark, = (bid – benchmark) otherwise	Beneficiary (if non-zero)
MA Supplemental	Pays for benefits not covered under traditional Medicare (e.g., dental, vision)	Reflects actuarial costs	Beneficiary, but plan can buy down with rebates
Part B	Required contribution for Part B services	Set by CMS; higher income enrollees pay more	Beneficiary, but MA plans can buy down with rebates

Part D Premium Components

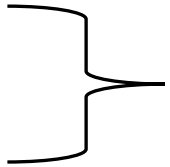
Premium Component	What is it?	How is it calculated?	How is it paid for?
Part D Basic	Premium for basic benefit (includes a deductible and ~25% copay; out of pocket max to be added under IRA)	Base premium is a share (25.5%) of the national average bid. Enrollee pays the difference if plan bid > national average, and pays less of plan bid < national average. Higher income beneficiaries face a surcharge, while low-income beneficiaries pay less.	Beneficiaries pay, but MA-PD plans can buy down with rebates
Part D Supplemental	Premium for additional coverage—such as for drugs not covered by Medicare	Based on the costs of the extra benefits	Beneficiaries pay, but MA-PD plans can buy down with rebates

Rebate Calculation

- If MA bid is below a regional benchmark (based on FFS spending),

  *Rebate = (Benchmark – Bid) * (Quality Adjustor)*

  - 50% for plans with 3 Stars or less
  - 65% for plans with 3.5 – 4 Stars
  - 70% for plans with 5 Stars

  Quality Adjustor

- Rebates can be used to buy-down premiums, fund supplemental benefits, or reduce cost sharing
- Average rebate amount in 2023 was $196 per member per month (PMPM), according to MedPAC
- For reference:
  - Part B Premium: $164.90 PMPM for most beneficiaries in 2023
  - Part D Basic Premium: $31.50 PMPM in 2023

Summary of Medigap Benefit Designs

What does it cover?	A	B	C*	D	F*	G	K	L	M	N
Part A coinsurance and hospital costs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance/copays	✓	✓	✓	✓	✓	✓	50%	75%	✓	**
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A hospice coinsurance/copays	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled nursing facility coinsurance	X	X	✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible	X	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part B deductible	X	X	✓	X	✓	X	X	X	X	X
Part B excess charge	X	X	X	X	✓	✓	X	X	X	X
Foreign travel exchange (up to plan limits)	X	X	80%	80%	80%	80%	X	X	80%	80%
Out of pocket limit?	NA	NA	NA	NA	NA	NA	Yes	Yes	NA	NA

Source: https://www.medicare.gov/supplements-other-insurance/how-to-compare-medigap-policies

* Plans C and F are not available to people who enrolled in Medicare after January 1, 2020

** Plan N replaces Part B coinsurance with more limited cost sharing for some services

Plans E, H, I, J, and K were discontinued and do not appear in the table

MACRA prohibits Medigap insurers from covering the Part B deductible

- MedPAC has repeatedly argued that comprehensive Medigap policies increase costs to the federal government due to overuse of care
- The Medicare and Chip Reauthorization Act of 2015 (MACRA) prohibited coverage of the Part B deductible
- MACRA prohibitions extend to states that had waivers allowing alternative Medigap plans
- State policymakers would need to ensure that direct reimbursement did not run afoul of this provision
- Part B annual deductible is $226 in 2023

Challenges of direct reimbursement depend on which gaps are covered

	Premiums	Cost-Sharing	Non-Covered Services
Rationale for covering	• Beneficiary premiums can exceed $2,000 per year	• Beneficiaries can face substantial cost-sharing • Traditional Medicare has no out-of-pocket limit	• Medicare leaves several key services out of the benefit package
Challenges	• Premiums can be decision dependent • Higher income enrollees face higher premiums • State may end up covering some expenses currently paid with MA rebates	• Federal rules limit flexibility to wrap around A & B services • State may end up covering some expenses currently paid with MA rebates	• State may end up covering some expenses currently paid with MA rebates

Tab 6

Washington State Health Care Authority

Finance Technical Advisory Committee

Liz Arjun, Jon Kromm - HMA

May 11, 2023

Objectives

VOTE on recommendations to the Commission on pursuing a federal waiver at this time.

VOTE on recommendations to the Commission on options to include Medicare in Washington's universal health care system.

FTAC Member Vote
Recommendations to the Commission Regarding Medicare

Motion to recommend or not recommend:

1. **Act of Congress or comprehensive waiver at this time**
2. Demonstration waiver, such as via 1115a at this time
3. State-operated Medicare Advantage & Part D plan as the only option for WA Medicare beneficiaries
4. State-operated MA-PD plan that would compete with private MA plans and traditional Medicare
5. State-operated Medicare supplemental insurance (Medigap) plan
6. Directly reimburse or insure beneficiaries for gaps

Pam MacEwan, FTAC Liaison

FTAC Member Vote
Recommendations to the Commission Regarding Medicare

Motion to recommend or not recommend:

1. Act of Congress or comprehensive waiver at this time
2. **Demonstration waiver, such as via 1115a at this time**
3. State-operated Medicare Advantage & Part D plan as the only option for WA Medicare beneficiaries
4. State-operated MA-PD plan that would compete with private MA plans and traditional Medicare
5. State-operated Medicare supplemental insurance (Medigap) plan
6. Directly reimburse or insure beneficiaries for gaps

Pam MacEwan, FTAC Liaison

FTAC Member Vote
Recommendations to the Commission Regarding Medicare

Motion to recommend or not recommend:

1. Act of Congress or comprehensive waiver at this time
2. Demonstration waiver, such as via 1115a at this time
3. **State-operated Medicare Advantage & Part D plan as the only option for WA Medicare beneficiaries**
4. State-operated MA-PD plan that would compete with private MA plans and traditional Medicare
5. State-operated Medicare supplemental insurance (Medigap) plan
6. Directly reimburse or insure beneficiaries for gaps

Pam MacEwan, FTAC Liaison

FTAC Member Vote
Recommendations to the Commission Regarding Medicare

Motion to recommend or not recommend:

1. Act of Congress or comprehensive waiver at this time
2. Demonstration waiver, such as via 1115a at this time
3. State-operated Medicare Advantage & Part D plan as the only option for WA Medicare beneficiaries
4. **State-operated MA-PD plan that would compete with private MA plans and traditional Medicare**
5. State-operated Medicare supplemental insurance (Medigap) plan
6. Directly reimburse or insure beneficiaries for gaps

Pam MacEwan, FTAC Liaison

FTAC Member Vote
Recommendations to the Commission Regarding Medicare

Motion to recommend or not recommend:

1. Act of Congress or comprehensive waiver at this time
2. Demonstration waiver, such as via 1115a at this time
3. State-operated Medicare Advantage & Part D plan as the only option for WA Medicare beneficiaries
4. State-operated MA-PD plan that would compete with private MA plans and traditional Medicare
5. **State-operated Medicare supplemental insurance (Medigap) plan**
6. Directly reimburse or insure beneficiaries for gaps

Pam MacEwan, FTAC Liaison

FTAC Member Vote
Recommendations to the Commission Regarding Medicare

Motion to recommend or not recommend:

1. Act of Congress or comprehensive waiver at this time
2. Demonstration waiver, such as via 1115a at this time
3. State-operated Medicare Advantage & Part D plan as the only option for WA Medicare beneficiaries
4. State-operated MA-PD plan that would compete with private MA plans and traditional Medicare
5. State-operated Medicare supplemental insurance (Medigap) plan
6. **Directly reimburse or insure beneficiaries for gaps**

Pam MacEwan, FTAC Liaison

Tab 7

Washington State Health Care Authority

Objectives

Share updates from the Commission's April meeting, including transitional solutions and preliminary ERISA discussion

Review next steps

Updates from the Commission's April Meeting

- **Transitional solutions**
  - FTAC's list will be shared with the Commission at their June meeting.
- **FTAC's *next* topic after Medicare is ERISA eligibility. Some preliminary areas for FTAC to examine at its next meeting may be:**
  - "Pay or play" option where employers have a choice to continue providing coverage to employees, and
  - An option where employers pay into the universal system and employees are covered by the universal system
  - How ERISA law has evolved, areas of the law that are unchanged since the last analysis done on the topic, and any new approaches with potential areas of opportunity.
  - Since employer funding contributions may be optional, FTAC could examine how any employer contributions could be captured under the various ERISA eligibility options (and estimated dollar values for each option) to fund the new system.

Next Steps

June (UHCC)

- Pam MacEwan, FTAC Liaison, will share with the Commission FTAC's recommendations for how to include Medicare in Washington's universal health care system.
- Direction from UHCC to FTAC on ERISA.
  - HCA staff to follow up with any FTAC Members with ERISA subject matter expertise to possibly present at July meeting.

July (FTAC)

- ERISA eligibility discussion.
- Last opportunity for FTAC to share recommendations to UHCC to be included in the legislative report.

Tab 8

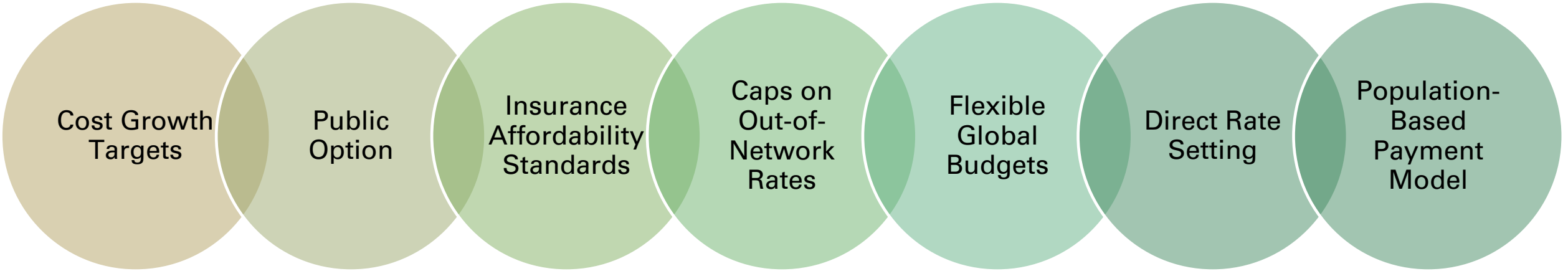
Washington State Health Care Authority

CREATING AND SUSTAINING A UNIVERSAL HEALTH CARE SYSTEM

INTRODUCTION TO SYSTEM COST CONTAINMENT STRATEGIES

MAY 11, 2023

Robert Murray
Associate Health Services Researcher,
University of California College of the Law San Francisco



The Congressional Budget Office (CBO) Recently Issued a Report/Analysis of Potential Cost Savings Initiatives: 1) Improved Price Transparency; 2) Improved Pro-Competitive initiatives and Anti-trust Activity and 3) Regulated Price Setting Models. CBO Concluded that options 1 & 2 had a small potential to control prices and option 3 had the best potential to control high and rising prices and health care expenditures..

Spectrum of Options to Constrain Provider Prices

WHAT IS A COST-GROWTH TARGET?

A maximum target for the rate at which total health care expenditures increase in a year

Typically set based on increases in economic growth and/or wages or median income

May include performance improvement plans or penalties for providers or plans with excessive cost increases

CAN COST-GROWTH TARGETS CONTROL COSTS?

Advantages of cost-growth targets

- Establishes “acceptable” cost increases
- At best, may have a “naming and shaming” effect
- Identify cost-drivers and garner stakeholder support for other policy actions

Fundamental Limitation: Problematic to apply to individual providers or provider groups

- Adjusting for changes in risk profile of patients over time is susceptible to upcoding
- To measure total cost of care, need to attribute patients to provider entities
- Trying to impose penalties commensurate with expenditures over target risks potential methodological and legal challenges
- Unlikely to be effective in controlling price growth

RHODE ISLAND'S AFFORDABILITY STANDARDS

- The Office of the Health Insurance Commissioner (OHIC) may reject premium rate increases that exceed the consumer price index (CPI – Urban)
  - OHIC reviews increases for individual hospital
- Successfully reduced spending on hospital care relatively to a national control cohort
- Limitations
  - % increase limit exacerbates payment disparities
  - Only applies to hospitals, evidence physician prices have increased more significantly

CAN AFFORDABILITY STANDARDS CONTROL COSTS?

Demonstrated success in Rhode Island

Commercial insurers gain negotiating leverage

Need oversight of provider group or hospital rates

Affordability Standards May be relatively easy to pass

Limits on premium increases, so insurers must pass on savings

Interests of the DOI and the industry being regulated – the insurers – are aligned, so regulatory capture is smaller

WHAT ARE OUT-OF-NETWORK (OON) PRICE CAPS?

A maximum payment that applies when a patient obtains care from a provider outside their insurance network

Providers threaten insurers with exorbitant OON Prices to negotiate higher INN rates

Caps on OON prices can truncate very high OON prices AND give insurers move bargaining power to negotiate lower INN rates

State must only regulate prices for OON services, so most services subject to market negotiations

Medicare Advantage has successfully implemented a de facto OON cap set at traditional Medicare rates

CAN OON PRICE CAPS CONTROL COSTS?

Allows insurers to negotiate INN prices that are close to the OON Cap level

In Medicare Advantage, a de facto OON cap appears to have caused INN MA rates to be at or near the cap at TM prices

California's payment standard for OON surprise bills caused anesthesiologist rates to decrease (both OON and INN)

RAND study estimated an OON cap at 200% of Medicare would save $81 billion in lower *in-network* hospital rates (7% of total commercial spending)

WHAT ARE HOSPITAL GLOBAL BUDGETS?

- Are a prospectively determined cap on annual revenues where the total budget is set in advance
- Based on a hospital's historical revenue base and provide predictable revenue flow
- Most easily implemented on an all-payer basis (requiring a Medicare Waiver)
- Can be 100% fixed during a performance year or semi-variable (e.g., "Flexible global budgets")
- 100% Fixed budgets used in Maryland induced hospitals to shift or restrict care leading to increased wait times
- Flexible global budgets cover fixed costs but pay hospitals for changes in their variable costs as volumes change
- Flexible budgets neutralizes FFS incentives to increased volumes but allow for payer "shifts" in care from high-cost to low-cost hospitals
- Can use with P4P Quality incentive programs and by adding physician and other non-hospital services to the budget

COMPARISON OF GLOBAL BUDGET MODELS

Rochester NY

- Applied to all payers
- System regulated at the aggregate budget level and was very "formula-driven"
- Model reduced unnecessary hospital use, significantly constrained hospital total cost growth and improved hospital financial performance

Maryland

- 2014: Maryland moved from a unit rate setting system to hospital global budgets
- 2014-2019 the met its all-payer and Medicare cost growth targets
- In recent years, MD did not meet its Medicare TCOC targets
- Maryland's use of 100% fixed budgets also allowed many hospitals to generate large reserves which were not reinvested in Population-health
- A Flexible budget approach would have avoided this

Pennsylvania

- In 2017, PA obtained CMS waiver implement to implement model for small/rural hospitals
- Wanted to provide improved financial predictability for hospitals and incentivize efforts to improve the health status of community
- WA experienced implementation delays
- The WA model is also a voluntary model

PRICE CAPS AND RATE UPDATES FOR ALL SERVICES

Recently, several prominent economists proposed a system of very high price caps and a cap on the magnitude of annual price updates for health care services

Intended to minimize the level of government intervention, but requires a very elaborate regulatory system

Rate systems that are more complex and interventionist are more challenging to implement and may be vulnerable to regulatory capture/failure

Although the US may one day need to implement more robust rate programs, the use of lower-intensity rate models may be effective and are most feasible presently

HOW COULD A SYSTEM OF PRICE CAPS ON ALL SERVICE PRICES AND CAPPED ANNUAL RATE UPDATES CONTROL COST GROWTH?

Intent is to truncate very high prices with less market intrusion than traditional rate setting

Constraining or tiering price growth could reduce existing provider price disparities

West Virginia operated a system with price caps and floors for commercial insurers and tiered price updates based on the relative costliness of each hospital

A Rate System with both Price Caps and Price Growth Limits would not be a “light-touch” Regulatory model.

WHAT IS A POPULATION-BASED PAYMENT (PBP) SYSTEM?

A highly integrated finance and delivery system to meet population-level cost and quality targets.

Give providers a spending target for the care of a defined patient population so it incentivizes delivery of well-coordinated, high-quality, and person-centered care.

Three features characterize PBP Models:

1) they are prospective -payments to all providers constrained by a budget and providers are at risk for costs that exceed the budget;

2) they require patient attribution to a provider organization; and

3) they allow provider organizations to proactively manage care and costs for the covered population.

Extend budget-based payment incentives to all providers (not just hospitals)

Vermont's all-payer ACO model , Kaiser Permanente, The Massachusetts Blue Cross Alternative Quality Contract and the Israeli Health system are examples of PBP models.

CAN PBP SYSTEMS BE EFFECTIVE IN CONTROLLING COST GROWTH AND MEETING OTHER POLICY GOALS?

Israeli health system helped develop four major health plans with an integrated clinical and financial system. Citizens chose plans , so plans compete on cost effectiveness and outcomes.

Kaiser is an example of a PBP model demonstrating superior results in reducing costs and improving the health of their enrolled member.

Unlike the Israeli PBP, Kaiser does not have similarly structured competitors, Lack of competition may allow “shadow pricing” of other dominant health systems.

APBP system requires a major overhaul of a state’s financing and delivery system and broad legislation to stimulate Kaiser-like entities to operate in the market. Existing MA plan may provide a platform for the development of such entities

Thank you for attending the Finance Technical Advisory Committee meeting!

Washington State Health Care Authority