Universal Health Care Commission's
Finance Technical Advisory Committee meeting

May 9, 2024

We want to stay connected with you as we create our community engagement efforts!

Sign up to receive commission announcements, updates, and more at hca.wa.gov/about-hca/who-we-are/universal-health-care-commission.

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

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

Agenda

Thursday, May 9, 2024

Zoom meeting **2:00 – 4:30 PM**

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

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome & call to order	1	Pam MacEwan, FTAC Liaison
2:05-2:08 (3 min)	Roll call	1	Mandy Weeks-Green, Boards and Commissions Dir., Health Care Authority
2:08-2:10 (2 min)	Approval of Meeting Summary from 03/14/2024	2	Pam MacEwan, FTAC Liaison
2:10-2:25 (15 min)	Public comment	3	Pam MacEwan, FTAC Liaison
2:25-2:35 (10 min)	2024 workplan review and Commission updates	4	Liz Arjun, Principal Health Management Associates
2:35-3:55 (80 min)	Framework for Benefit Design and Cost Structure • Actuarial analysis discussion cont'd	5	David DiGiuseppe, Vice President of Healthcare Economics Community Health Plan of Washington
3:55-4:00	5-minute break		
4:00-4:30 (30 min)	Updates from the Health Care Cost Transparency Board • FTAC Q&A	6	Ross McCool, Operations Research Specialist Health Care Authority
4:30	Adjournment		Pam MacEwan, FTAC Liaison

Tab 2

Washington State Health Care Authority

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

March 14, 2024
Virtual meeting held electronically (Zoom)
2–4:30 p.m.

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

Members present

David DiGiuseppe
Eddy Rauser
Ian Doyle
Kai Yeung
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Christine Eibner
Esther Lucero

Call to order

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

Agenda items

Welcoming remarks

Pam MacEwan began with a land acknowledgement, welcomed members to the eighth meeting, and reviewed the agenda.

Meeting summary review from the previous meeting

The Members present **voted by consensus to adopt the January 2024 meeting summary**.

Public comment

Roger Collier suggested that there was a $2B error in the savings calculation projected under the Washington Health Trust on pages 19-20 under Tab 5 of the meeting materials.

Marcia Stedman, Health Care for All Washington, expressed support for the two primary agenda topics and the extra time dedicated for robust committee discussion.

Consuelo Echeverria noted that additional time allotted for meetings is thanks to advocates' efforts and stressed the importance of completing the required report of the Universal Health Care Commission (the Commission) due to the Legislature on June 30.

Kathryn Lewandowsky read an email from Dr. Friedman (author of the economic analyses supporting Whole Washington's SB 5335) who expressed regret for being unable to attend the meeting due to health issues.

Commission updates & goals for today

Liz Arjun, Health Management Associates (HMA)

The Commission directed FTAC to provide guidance on benefits and services for Washington's future universal health care system. The Commission plans to have an actuarial analysis conducted to compare benefits across Medicaid, the essential health benefits (EHB) mandated under the Affordable Care Act (ACA), and the Uniform Medical Plan (UMP) under the Public Employee Benefits Board (PEBB). Today's meeting is focused on understanding what work in this area has already been done, identifying any gaps and additional considerations for designing a benefits package.

Presentation: The Washington Health Trust – Benefits & Services

Andre Stackhouse, Whole Washington

Whole Washington, proponents of Senate Bill 5335 (SB 5335), presented on the benefits and services and financing under their proposed Washington Health Trust (Trust). This is part of the Commission's directive by the Legislature to examine SB 5335.

Professor Gerald Friedman, author of the Trust's economic analyses, anticipates health care costs doubling in the next ten years. Increased health care costs have not resulted in increased life expectancy or increased access to care. The U.S.'s total health care spending is twice that of the Organization for Economic Co-operation and Development (OECD) average without achieving universal coverage.

The Universal Health Care Work Group (Work Group) and Dr. Friedman used different methodologies to project health care costs under the status quo. The greatest cost reductions would be realized under a publicly funded and publicly administered health care system (Model A as proposed by the Work Group). The Trust would begin as Model B (state-designed plan privately administered) and would transition to Model A.

Covered benefits and services are modeled after the EHB mandated under the ACA. Revenue sources to support the proposed Trust include an employer payroll tax, an employee payroll tax (employer may choose to cover employee portion), a sole proprietorship tax, and a capital gains tax (ruled by the 2023 Washington State Supreme Court as constitutional exempting the first $250,000). This would be less burdensome on individuals, families, and employers compared to the status quo.

FTAC members were invited to make comments/ask questions. It was noted that other OECD countries with social insurance systems manage cost and price growth through rate setting systems for all providers (the U.S. does this for public coverage but not for private), which may be more economically and politically feasible. Whole Washington noted the Commission's position to make recommendations without political influence could aid in the political feasibility of either the Trust proposal or an alternative. Additionally, the Trust would incorporate rate setting and may be more politically feasible given the transition period from Model B to Model A.

Members noted that the disparity in health care expenditures in U.S. versus OECD countries is largely due to prices, however Dr. Friedman's analysis names health care administration as the primary source of savings with prices being secondary. Whole Washington welcomed additional cost analysis methodologies and financing model alternatives. Committee members noted that having broader participation and consensus on a cost

analysis will lend credibility to the discussion. Whole Washington agreed that private health carriers are not the sole contributor to higher health care costs in the U.S., nor are they the only opposition to universal health care, e.g., hospitals. Members noted that consolidation drives price increases which drives spending, and taking a broader approach and not focusing only on simplifying health care administration should be the focus of regulatory action.

Whole Washington expressed that while there are challenges with SB 5335, they'd like to hear more reform proposals and solutions from the Committee/Commission. FTAC and Whole Washington agree on the goals for addressing fragmentation, high costs, and inequitable access to care and coverage. It was noted that other OECD countries do not face housing or food insecurity, barriers to education, income inequality, etc., as so many Americans do. These factors, beyond just access to universal health care, are major determinants of health.

There will be more opportunities to reconnect with Whole Washington to further assess SB 5355 as part of the Commission's legislative directive.

Benefits & Services Discussion

In prior meetings, FTAC has outlined the challenges to integrating Medicare and self-insured group health plans (large employers) into Washington's universal health care system. However, there are paths forward for integrating Medicaid, the individual market, and small and large fully insured group health plans.

A grid comparing covered benefits across Medicaid, EHB, and UMP does not exist. However, other states proposing universal health care plans have conducted benefits modeling and chosen EHB (California and Vermont) or the public employee benefits plan (Oregon). Creating a comparison grid of benefits is challenging. Medicaid has benefits that are required by the Centers for Medicare and Medicaid Services (CMS) to obtain federal matching dollars, and fully insured market plans must provide state-mandated benefits not required in the EHB. Members noted that it may be helpful to know how many of the Medicaid unique benefits are related to pediatrics, maternity care, and children with special health care needs.

Wakely's recent comparison of PEBB and Washington's EHB and found PEBB to be approximately 0.24 percent to 0.54 percent more generous (on an allowed cost basis). However, Medicaid is the most generous benefit plan.

There will be a high degree of overlap between Medicaid (keeping Long Term Services and Supports [LTSS] off the table), and general benefit design may not have much impact on the total cost of care, so the issues of interest will be around duration, scope, and cost-sharing. It's important to consider that the benefits for Medicaid, PEBB, and EHB are somewhat tailored to the needs of the respective population demographics, e.g., PEBB - working adults and families, the Exchange - primarily adults, and Medicaid - originally intended for mothers and children.

Benefit generosity between PEBB and EHB is almost negligible from a per-member per-month (PMPM) perspective. It may be helpful to model the most practical benefits package (most socially and politically feasible) and incrementally model out additional benefits, potentially introducing some cost-sharing.

FTAC pondered whether the barriers are too high to make single payer work. There was agreement that it's crucial to address price head on because it is not possible to create a more equitable, accessible, affordable health care system without doing so. Price regulation may be more politically possible than taking on providers, carriers, and the federal government. For example, Oregon recently passed price caps (200 percent of Medicare) on their PEBB/Oregon Educators Benefit Board (OEBB) plans and with evidence of significant savings, Washington should consider pursuing the same. Consolidating and expanding state purchasing is another avenue. Washington did have a hospital commission modeled after Maryland's but failed in implementation.

FTAC agreed that the Commission should consider the following for an actuarial analysis: Begin with PEBB or EHB and layer on additional benefits to be modeled. Cascade Care (standard qualified health plans on the Exchange) could serve as the starting point for EHB to see the cost-sharing impact on premiums across the Bronze, Silver, and Gold metal levels, and then assess whether Medicaid and PEBB cover anything different. Members requested that "PEBB" be updated to "PEBB/School Employee Benefits Board (SEBB)." Other

dimensions of benefit design should be considered in future meetings, including prior authorization, supplemental benefits outside of the universal plan's covered benefits, point of service cost sharing, and a standardized provider reimbursement rate.

Adjournment

Meeting adjourned at 4:32 p.m.

Next meeting

May 9, 2024
Meeting to be held on Zoom
2–4:30 p.m.

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission's

Finance Technical Advisory Committee

Written Comments

Received From March 1

Written Comments Submitted by Email

Additional Comments Received at the March FTAC Meeting

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

Public comments received since (March 1) through the deadline for comments for the May meeting (April 25)

Submitted by Cris Currie

04/02/2024

To the FTAC and the UHCC:

In response to Bob Murray's comment at the March, 2024 FTAC meeting that Whole Washington was "overemphasizing" administrative costs in our current healthcare system, I would like to offer evidence to the contrary. We spend more on healthcare in the U.S. than any other country because our prices are much higher. Numerous studies over the last 40 years, including the PERI economic study, indicate that administrative waste followed by overpriced prescription drugs are the two largest contributors. Certainly the numbers and assumptions vary from study to study, but one recent literature review concluded there is a "high degree of consensus for the fiscal feasibility of the single-payer approach in the U.S."

Gerald Friedman estimated a $476 billion/year savings with administrative simplification, and Uwe Reinhardt, in Priced Out: The Economic and Ethical Costs of American Health Care, published just after he died, accepted a $765 billion/year estimate that included "unnecessary services, inefficiently delivered care, excess administrative costs, excessively high prices, missed prevention opportunities, and fraud." Most of this can be eliminated with a well designed single-payer system. Reinhardt said: "the issue of universal coverage is not a matter of economics. Little more than 1% of GDP assigned to health could cover all. It is a matter of soul."

The recent CBO working paper on healthcare costs also points to excessive administration as one of the two top drivers of high costs, but significant simplification cannot and will not happen until healthcare financing is completely restructured without private insurers. Determining exactly how universal healthcare will be funded in Washington should be the UHCC's top priority now. We can't just rely on transparency and price capping, important as they are as transitional steps. There is no point in wasting even more time on *talk* of administrative simplification as the UHCC work plan indicates. Rather, the UHCC must immediately commit its very limited energies to actual single-payer system design, using SB 5335 as the starting place. The legislator requested June report on SB 5335 should indicate this direction.

So those of us who have been involved with this movement for many years would strongly encourage all members of the UHCC and FTAC to read the studies and the bills that have been produced in other states. The answers to most of your questions are already out there, but you will need to study them on your own time, not in meetings. Please do not waste any more meeting time needed for decision making!

Core documents should include the Washington Health Securities Trust (WHST), the Washington Health Trust SB 5335, Friedman's Washington Study, WA UHC Work Group Report, Oregon Task Force Final Report, Oregon UHC Governance Board SB 1089, California AB 2200, ACA 11, and the Healthy California Commission Report, the Massachusetts Health Care Trust, the Medicare for All Act HR 3421, the SBUHCA HR 6270, the CALTCHA Model, and the Labor Campaign 10 Provisions.

Additional state proposals to review include: Minnesota Health Plan, Michigan MiCare Plan, New York Health Act, Ohio Health Care Plan, Vermont Green Mountain Care and Hsiao Report, Rhode Island Comprehensive Health Insurance Program, New Mexico Health Security Act, and the ColoradoCare Initiative.

Cris M. Currie

Submitted by Cris Currie

04/22/2024

Here is my response to FTAC's critique of SB 5335 as printed in the April 17, 2024 UHCC Meeting Materials. Cris Currie

Price Issue

SB 5335 does address the issue of price. Section 109 requires institutional providers to operate under a negotiated global budget and individuals under negotiated fees for service, presumably using Medicare rates as the baseline, rather than commercial rates. Currently, a primary cause of regular price increases is overbilling by large providers. Insurers generally reward this secret practice by gradually increasing what they will pay, since both entities make more money with higher prices. Insurers can justify higher premiums when prices rise. With higher premiums, the dollar amount of what they are permitted to keep for overhead goes up. Transparency is the key to breaking this corrupt cycle, and it's also the key to establishing global budgets and fair fees for service which SB 5335 requires.

The primary justification for a state-based single-payer system is to eliminate the massive administrative overhead (multi-million dollar salaries, profits, lobbying, advertising, acquisitions, capital projects, preauthorization, appeals, plan management, excessive personnel, etc.) that the multi-payor system demands. This alone will lower costs significantly. Furthermore, Section 116 addresses cost containment in addition to setting a limit on the Trust's administrative expenses. SB 5335 also specifies that standards will be employed to detect excessive utilization, and anonymous reporting of fraud will be incorporated which should cut another major expense. The Board is empowered to institute other cost containment measures, and all of these measures will bring down the total cost of care. It's then up to the Board to establish standardized fair prices.

Implementation and Federal Barriers

Section 113 requires negotiation with federal authorities for waivers, and to apply for federal demonstration projects, and possibly as a state Medicare Advantage Plan. Details are included regarding setting up the governing board for implementation along with a start-up account.

Feasibility

Single-payer is not an economic issue and only a minor legal issue; it's really only a political will issue. If it's needed and the people want it, it's feasible. The regulated rate systems of other OECD countries employ global budgeting as their primary tool to control prices. But this either requires complete cooperation among private companies to all operate in essentially the same way (impossible to imagine here) or a governmental body empowered to establish and enforce regulations, in other words, a single-payer, just as in other countries. Affordability is not the only goal; we also need simplification, universality, higher quality, better case coordination and primary care, a single EMR designed for clinicians and researchers, equity, greater convenience, portability, etc.

What does 5335 propose that the UHCC is not examining?

The UHCC is not talking about a state-based single-payer and how it should be set up! Single-payer is what SB 5335 is all about. The bill also deals with displaced workers, eligibility details, the responsibilities of the Board, the creation of other advisory committees, and how the community is to be engaged. The material in Section 101 (characteristics of the chosen model) is completely absent from the UHCC discussions.

Cost Sharing

Cost sharing contributes directly to high prices because of the huge administrative load it requires. It does nothing to reduce unnecessary utilization, which is not a goal anyway, and therefore has no purpose. It causes harm by encouraging people to delay needed care, and it is prohibited in virtually every other state-based single-payer proposal in the country.

Tab 4

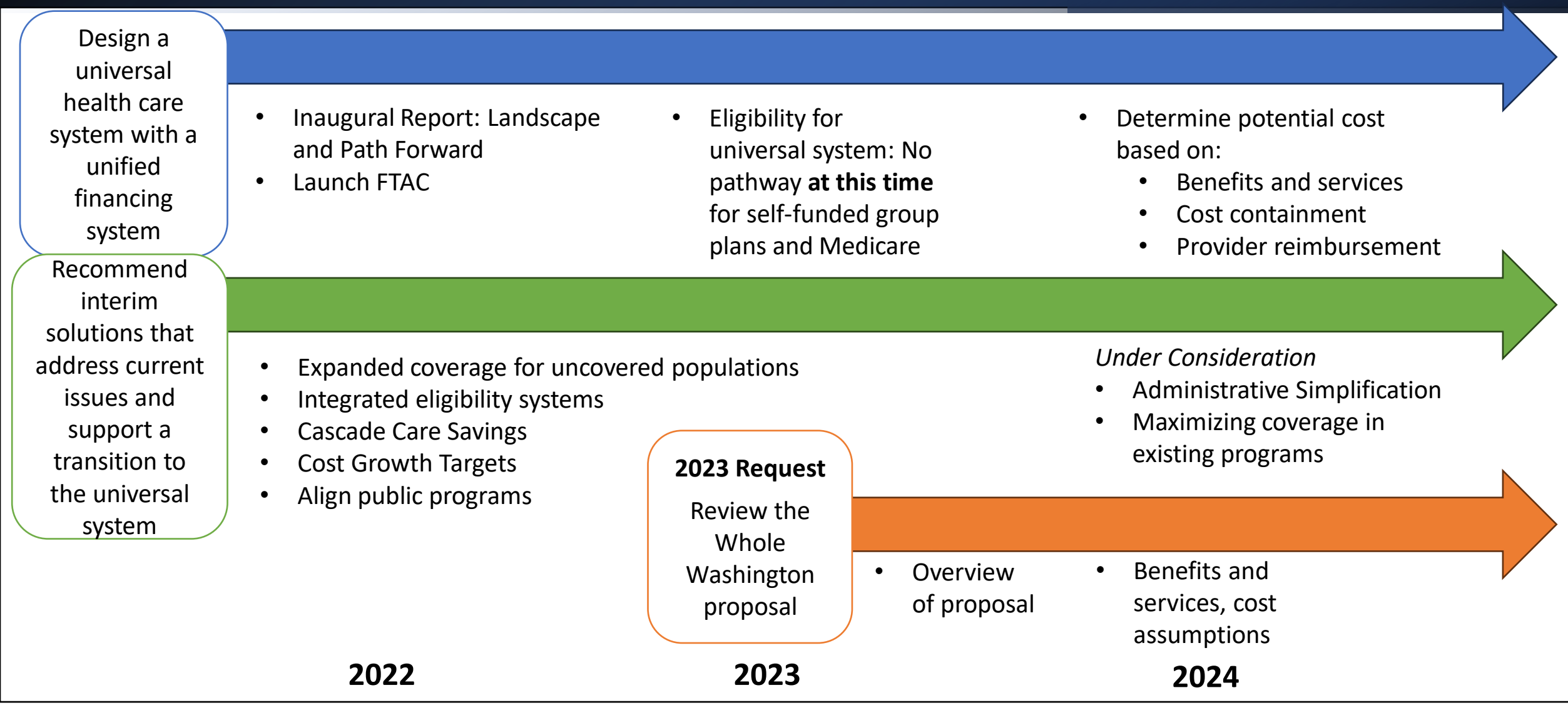
Washington State Health Care Authority

Today's Objectives

- Offer clarity about where the Commission is the process of universal health care system design
- Deep dive into benefits and cost structure
- Learn about Washington efforts to address health care affordability for consumers and overall health care costs and why those efforts are part of the work to design a universal health care system
- Discuss what additional analyses could add value to the Commission's deliberation

Commission Progress and Workplan Update

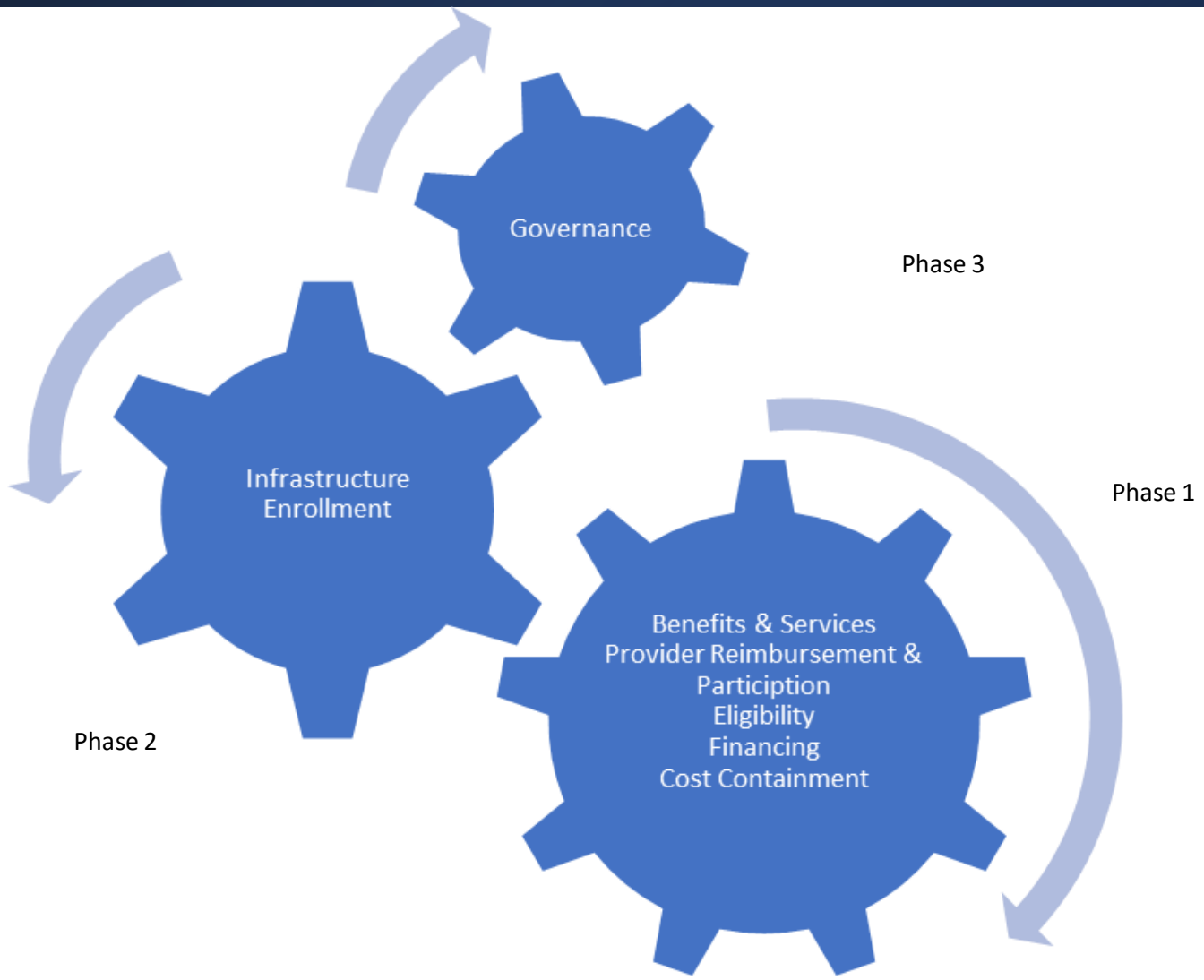
Three Workstreams



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

- ✓ **For now,** the uniform financing system should be designed to include those with coverage under, Medicaid, Exchange, Public Employee Benefits Board/School Employee Benefits Board (PEBB/SEBB), fully-insured employers, and uninsured.
  - Exploring possibilities for self-insured employers (ERISA), including:
    - could offer their employees the option to enroll in the system
    - could be required to offer coverage equivalent to what the system provides or pay a tax to help fund the system
- ✓ Requested an actuarial analysis of the cost of providing benefits that PEBB/SEBB and Medicaid provide to all enrollees in the system
- ✓ Requested an actuarial analysis of the cost of eliminating or reducing enrollees' out of pocket costs
- ✓ Determined that reducing the cost of care is essential if the vision of a uniform financing system is to be achieved

Universal System Design



Phase 3

Phase 1

Phase 2

Phase 1

Eligibility

Benefits & Services

Provider Reimbursement & Participation

Cost Containment

→ Cost Estimates → Financing

2024 Key Decision Points/ Recommendation Areas

- Universal System Design
  - Benefits and Services
  - Provider Reimbursement
  - Cost Containment

- Transitional Solutions
  - Administrative Simplification
  - Maximizing Enrollment in Existing Programs
    - Auto-enroll Medicaid to no-premium or lower-cost plans Exchange
    - Codify and fully fund Apple Health Expansion
    - Increase participation in the Medicare Savings Program
    - Consolidate and expand state purchasing

Commission Update

- Legislative Updates
  - Pathway to coverage for all Washingtonians exists
  - Gaps closed- ground ambulance
  - Issues remain with affordability and underinsurance
- Universal Design: Approach to determining costs

  1. Benefits and services
     - PEBB/SEBB
     - All plans on Exchange
       - Begin with Silver Plan
     - Additional Medicaid benefits (dental long-term care, etc.)

  2. Cost-sharing approaches that could be considered (start with 0)

  ***March FTAC discussion on Whole Washington's proposal focused on cost assumptions, and the Commission expressed interest in learning more.*
- Administrative simplification

2024 Universal Health Care Commission Workplan

- Medicaid Discussion Part 2
- Waivers to expand eligibility
- Federal barriers for asset tests

January 2024 FTAC

February 2024 Commission

- State Agency Updates
- Medicaid Options from FTAC
- Benefits and Services Overview and Approach
- Identify priorities questions for FTAC
- Administrative Simplification and Provider Participation

- Updates from Commission
- Benefits and Services
- Evaluation of Whole WA proposal

March 2024 FTAC

April 2024 Commission

- State Agency Updates
- Report out from FTAC on Benefits and Services
- Administrative Simplification continued

- Updates from Commission
- Benefit design and cost structure
- Cost containment (previously in November)
- Update on actuarial work

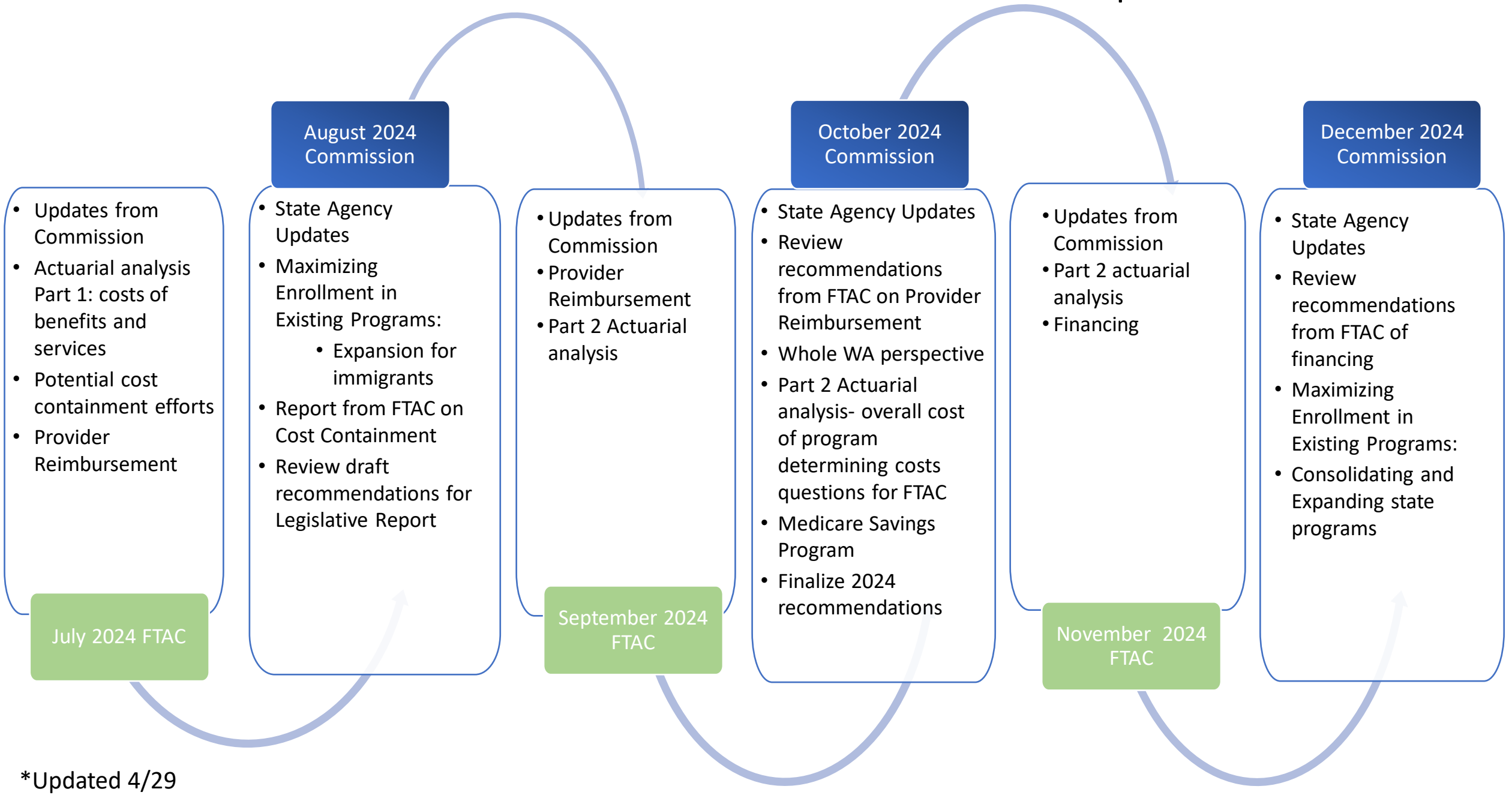
May 2024 FTAC

June 2024 Commission

- State Agency Updates
- Actuarial Analysis Part 1: Costs of benefits and services
- Recommendations on Administrative Simplification and Provider Participation
- Considerations for cost containment from FTAC
- Whole WA perspective
- Questions/guidance for FTAC
- Maximizing Enrollment in Existing Programs:
  - Auto-enrollment

*Updated 4/29/24

2024 Universal Health Care Commission Draft Workplan



*Updated 4/29

Tab 5

Washington State Health Care Authority

Framework for Benefit Design and Cost Structure

FTAC
May 2024

Contents

- Cost build up applicable to health plan (product pricing) or single payer (budgeting)
- Potential conceptual pre-actuarial framework for the Commission (UHCC)
  - Address UHCC questions of FTAC re benefit structure
- Introduce FTAC ideas re cost structure and affordability

Cost Build Up

Cost Build Up – Base Experience

- Identify the population
- Assemble historical experience (claims): inpatient hospital, outpatient hospital, primary care, specialty care, etc.
- Experience represents:
  - Services covered
  - Utilization rate of those services
  - Cost per unit of service at “allowed” amount

Cost Build Up – Projection: Service Expense

- Project enrollment
  - Population growth
  - Individual decision making (price, network, benefits, service)
  - Market dynamics (e.g., premium subsidies)
- Project health care expense
  - New services to be covered
  - Utilization rate trend (health status, selection bias)
  - Cost per unit of service trend (inflation, contract negotiations)

Cost Build Up – Projection: Admin Expense

- Admin activities include:
  - Eligibility and enrollment
  - Network contracting
  - Utilization management (prior authorization)
  - Care management / population health
  - Sales and marketing
  - IT / finance / HR
- Some activities not applicable to single payer
- Tradeoff: No UM associated with higher service expense

Cost Build Up – Projection: Member Share

- Compute 100% total cost of care
  - Regardless of who pays
  - This would be the premium at 0% member cost sharing
  - Depending on market, premium paid by mix of government/employer and individual
- Assign member point-of-service (PoS) cost sharing
  - Includes deductibles, coinsurance, copayments
  - Shifts cost from premium (up front) to individual at PoS

Cost Build Up – Projection: Refinement

- Feedback loop between benefit design and projected enrollment
  - Premium and cost sharing changes impact selection
  - Cost sharing impacts utilization
  - Incentive programs impact utilization

Cost Build Up – UHCC / FTAC Relevance

- Current system
  - Fragmented mix of payers and markets
  - Known total cost of care (TCoC)
- Moving toward unified system, help UHCC visualize what has been addressed vs what is yet to be addressed, in terms of $ impact and who will fund that cost
  - Cost of eliminating PoS cost sharing
  - Covering more people
  - Covering more services
  - Mechanisms to reduce the TCoC

Example: Premium vs. Cost Sharing

https://www.wahealthplanfinder.org/

Browse and Compare Plans

- 98101 (Seattle)
- 04/01/1984 (age 40)
- Male, non-smoker

Coordinated Care Corporation

- Ambetter
- Cascade Select

Metal Level	Premium	Deductible	PCP
Bronze 60% AV	$292	$6,000	$50
Silver 70% AV	$400	$2,500	$30
Gold 80% AV	$417	$600	$15

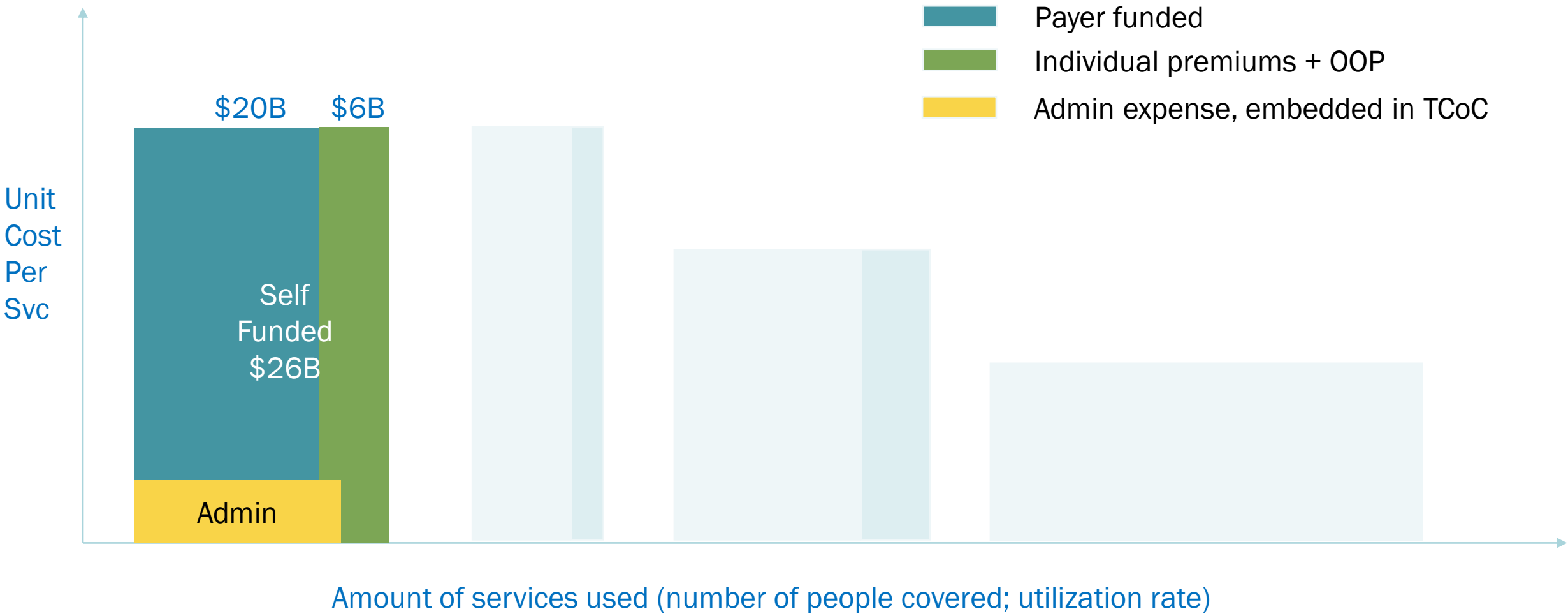
Conceptual Framework

- Illustrative: hypothetical $ amounts for reaction, discussion, refinement
- Real $ amounts available in past reports; excludes LTSS
- Can be enhanced using UHCWG reports, Whole Washington analysis, UHCC/FTAC actuarial study

$ amounts shown are hypothetical, for illustration purposes only

Total Cost of Care In Current System

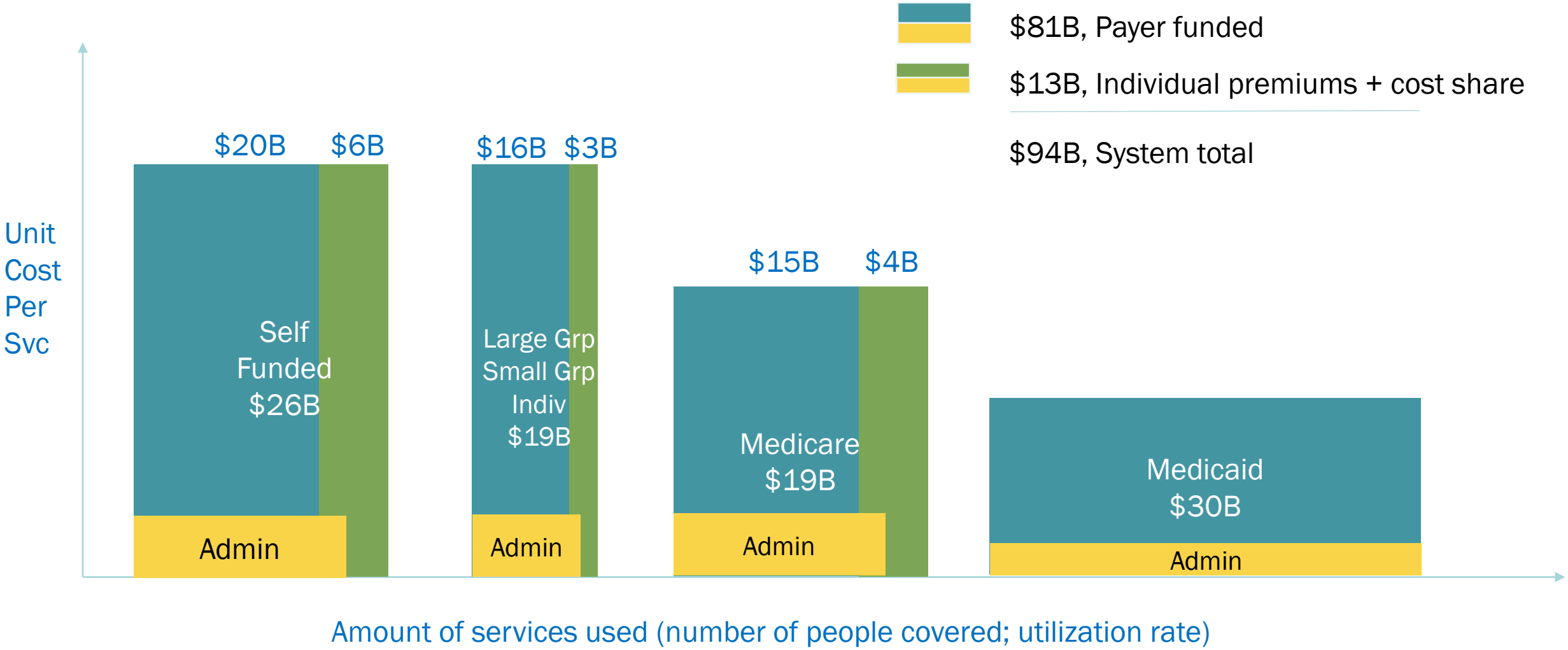
For each market actuarial study could compile component parts from existing data …



$ amounts shown are hypothetical, for illustration purposes only

Total Cost of Care in Current System

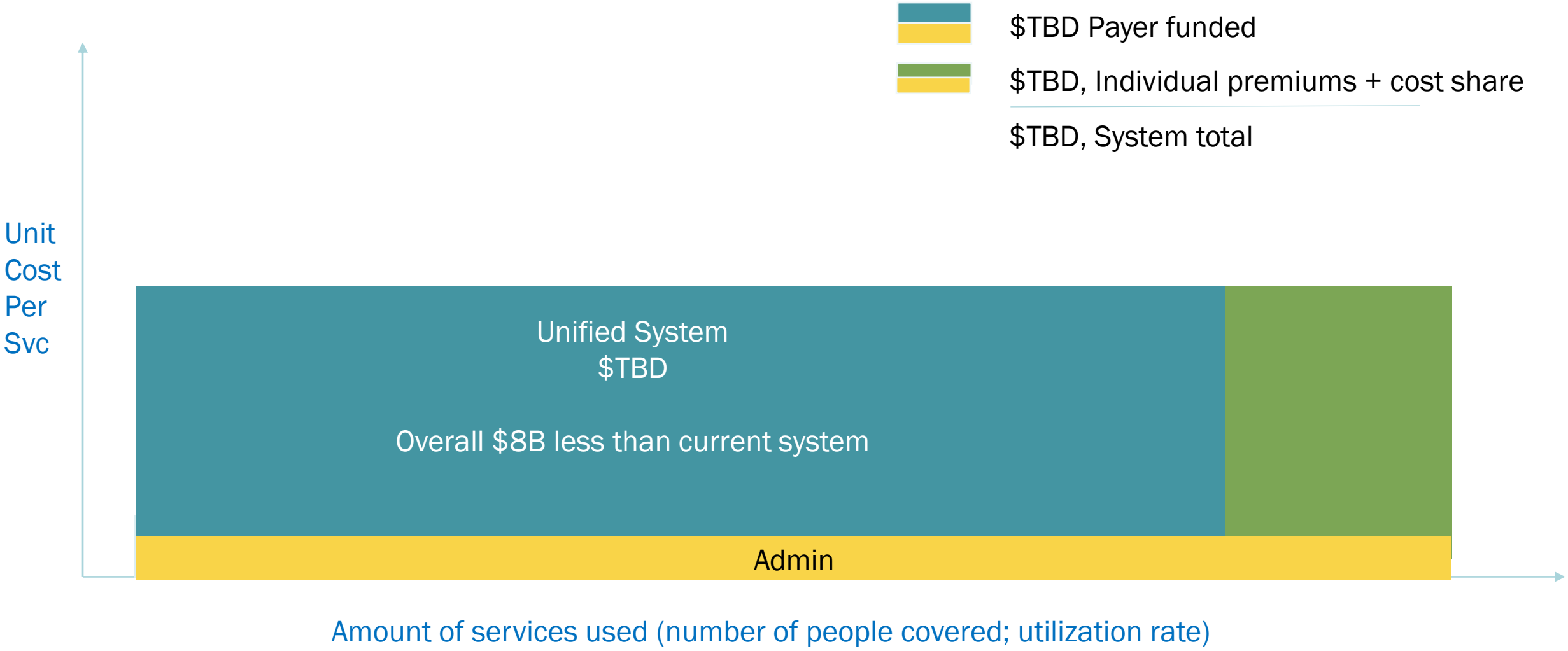
... then assemble for the entire system.



$ amounts shown are hypothetical, for illustration purposes only

UHCWG Model A

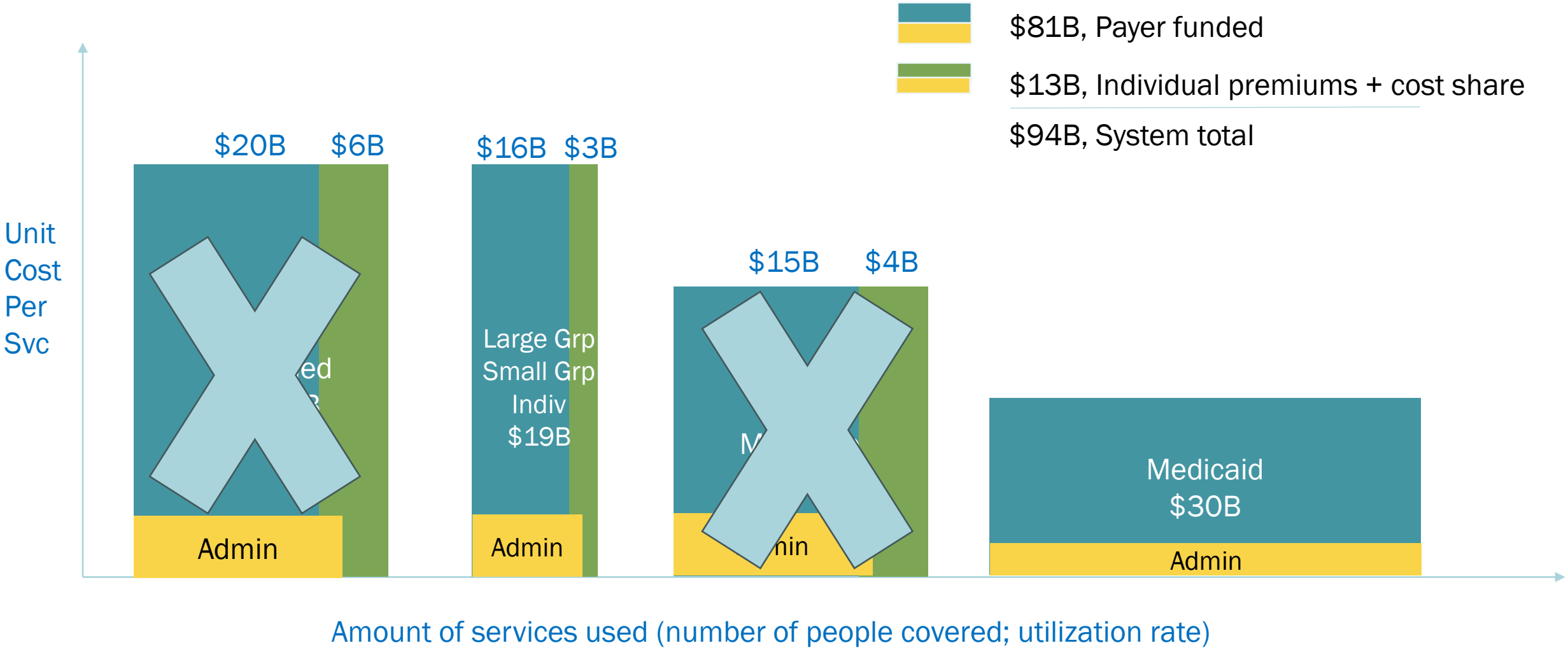
UHCC's ultimate objective is a unified system.



$ amounts shown are hypothetical, for illustration purposes only

FTAC: Significant Barriers to Unify

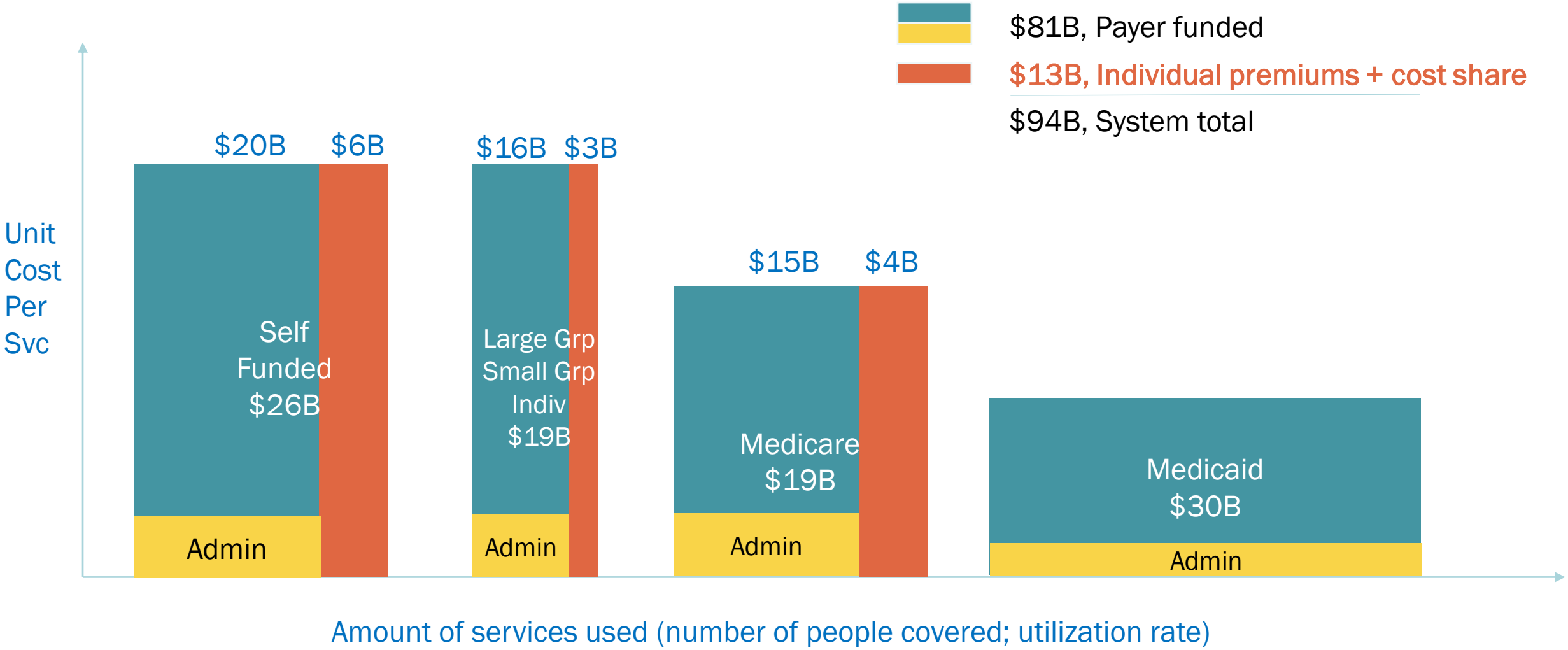
FTAC identified options self-funded groups and Medicare beneficiaries to buy into a pre-unified system.



$ amounts shown are hypothetical, for illustration purposes only

Total Cost of Eliminating OOP Cost

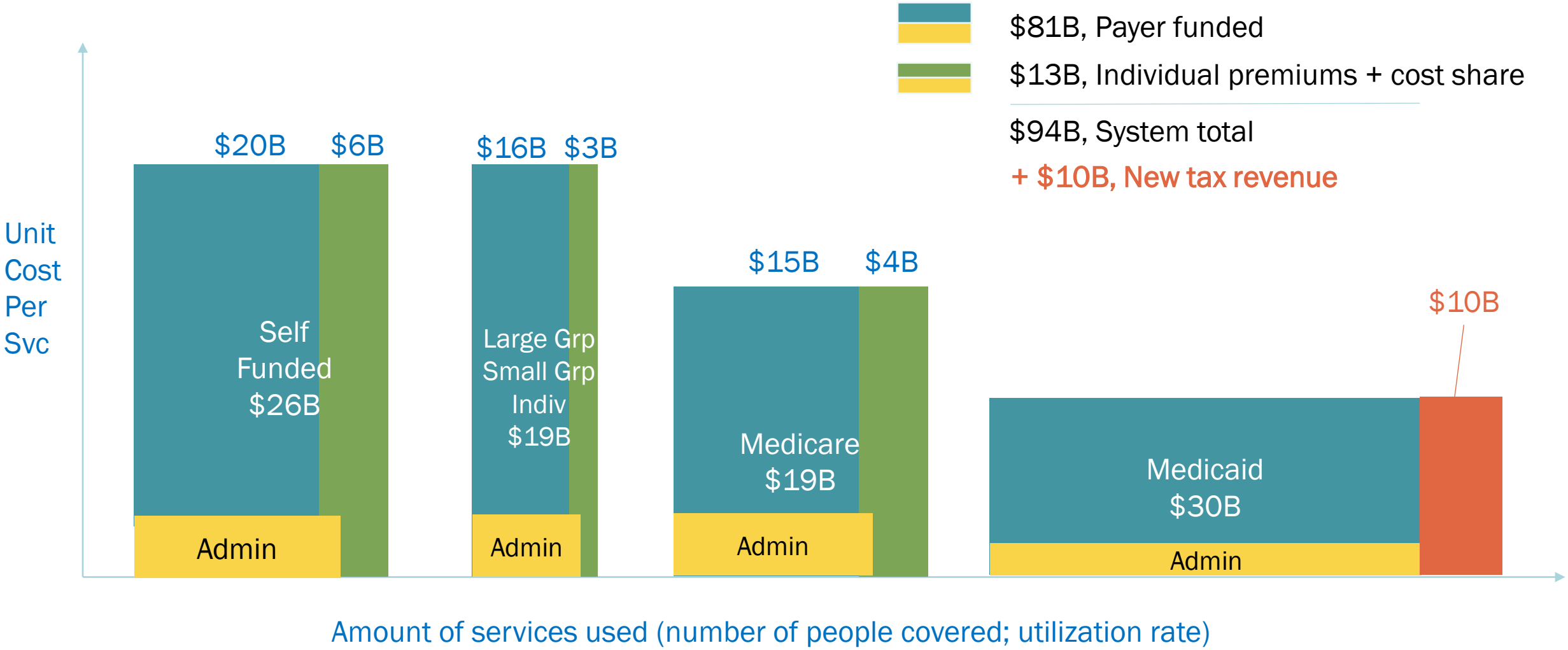
UHCC wants to understand the cost of eliminating individual cost. Doing so would shift cost to payer.



$ amounts shown are hypothetical, for illustration purposes only

Additional Cost to Insure Uninsured

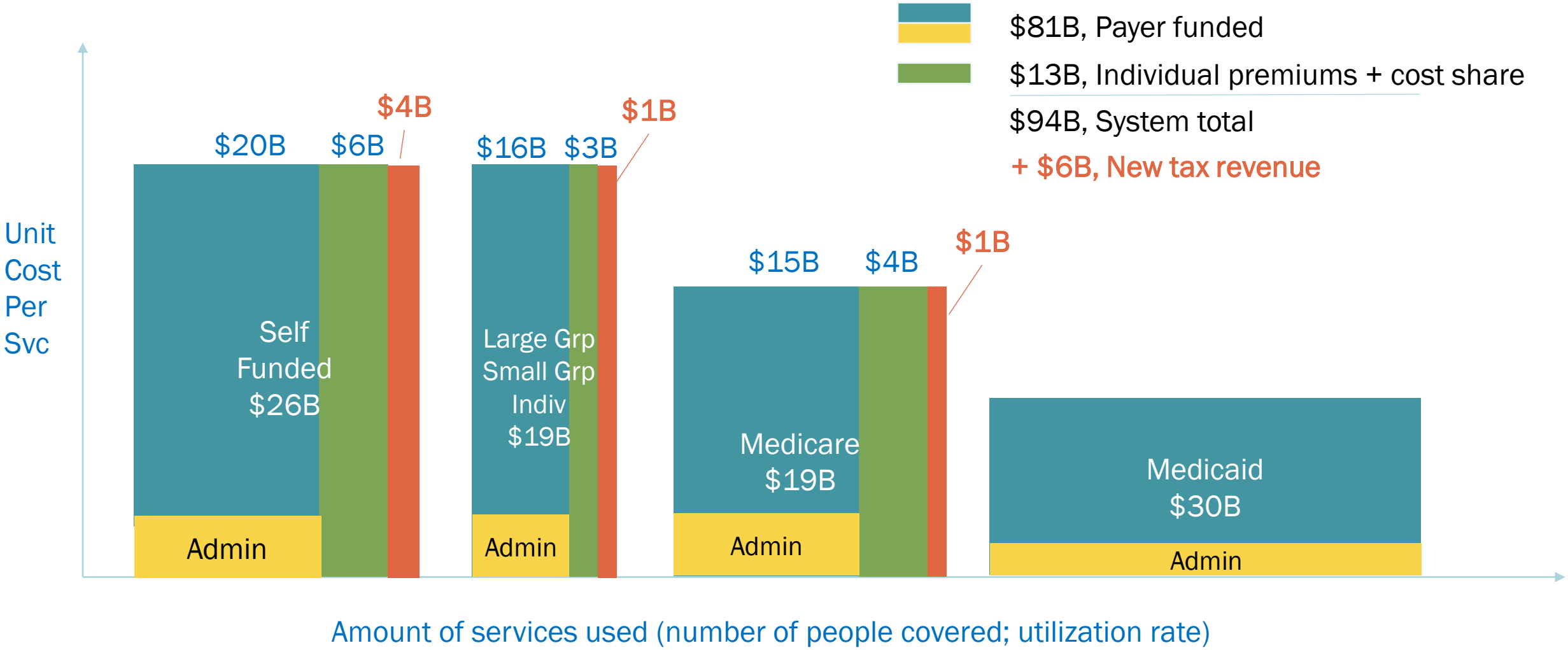
One of UHCC's objectives is universal coverage.



$ amounts shown are hypothetical, for illustration purposes only

Additional Cost to Cover More Services

UHCC has also asked FTAC to look at expanding covered services.



Additional Cost of UHCC Considerations

FTAC / actuary study could itemize the cost of each of UHCC's objectives.

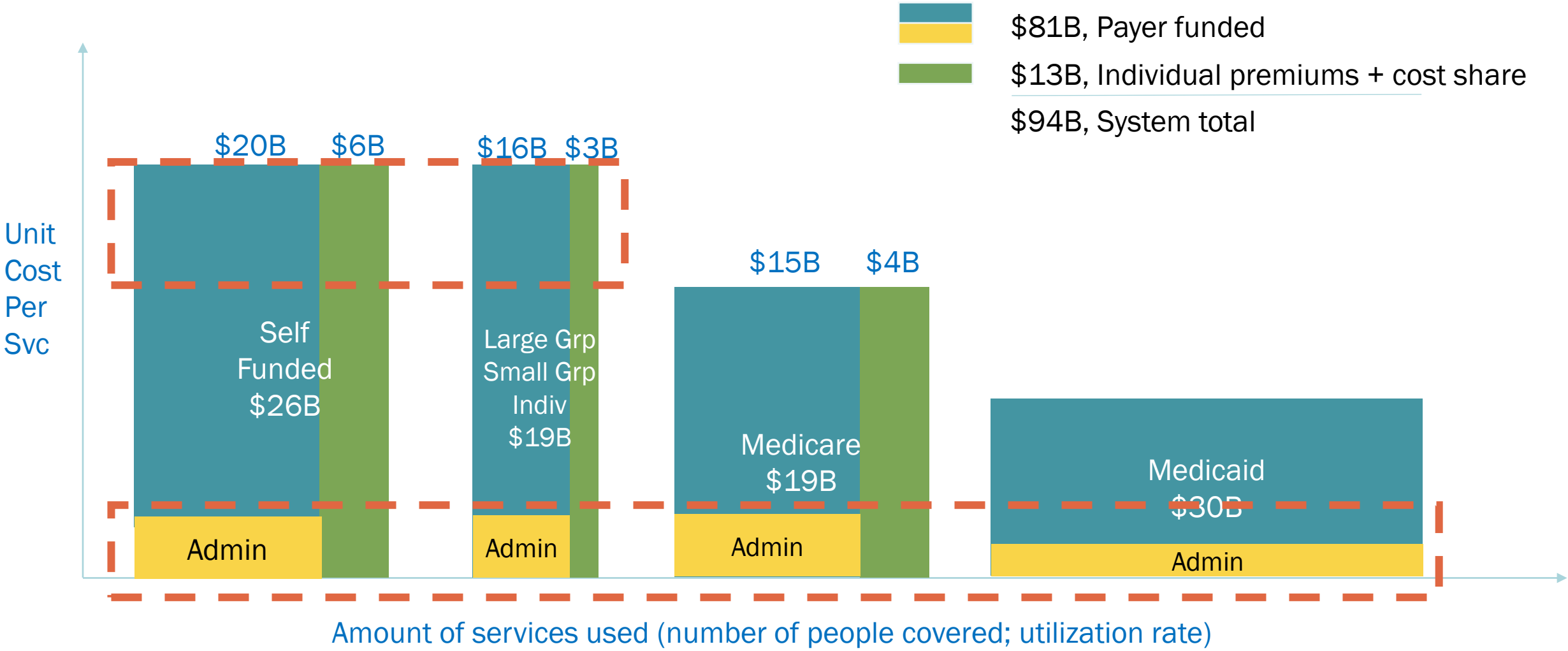
Impact factor	Measurement
Eliminate OOP Cost	$13B
Cover Uninsured	$10B
Cover More Services	$6B
Total	**$29B**

Raises question:
Is there an opportunity to reduce cost to the system?

System Cost & Affordability

Total Cost of Care in Current System

FTAC discussions have touched on reducing the cost of the system via pricing and admin.



Cost Reduction Opportunities

Health Care Expense

- FTAC: Hospital global budgets
- FTAC / HCCTB: Spending caps
- OIC / HMA: Several policy options
- AG: Constrain consolidation

Admin expense

- FTAC: Question raised re role of insurance companies
- Identify essential admin activities, cost, impact on TCoC and who pays

Next Steps

Can actuarial study be helpful to UHCC by illustrating the cost savings potential of each strategy?

Does FTAC have a role in describing the political challenges that come along with pursuit of cost reduction strategies?

Thank you

David DiGiuseppe
david.digiuseppe@chpw.org

April 16, 2024

TO: FTAC Members
Angela Castro, HCA
Liz Arjun, HMA

FROM: Roger Gantz, FTAC

SUBJECT: FTAC Benefit Design Options

The following memorandum is intended to provide the Finance Technical Advisory Committee's (FTAC) members options for consideration in developing benefit design recommendations for the Universal Health Care Commission's (UHCC) deliberations on actuarial analysis of a uniform benefit design (UBD) for the new health care system to "*… provide coverage and access through a universal financing system, including a unified financing system*" (E2SSB 5399).

Three Benefit Design Parameters

The design of a UBD for the E2SSB "universal financing system" encompasses three components:

1. Services – amount, scope, and duration
2. Point-of service cost-sharing.
3. Provider reimbursement

Benefit Design Services

Both federal and state reform efforts have devoted significant time and resources in the development of UBDs for their respective health reform systems. Rather than undertake another effort, I would recommend the UHCC build their UBD upon existing benefit designs that have proven able to meet the general health care needs of enrollees and enjoy general public acceptance. It also should be acknowledged that a UBD is not static. Overtime with the introduction of new evidence-based procedures and changes in medical practices, the UBD will be revised to incorporate such changes.

Washington's Universal Health Care Work Group (UHCWG) built its benefit design on the state's essential health benefits (EHB). They also considered the addition of dental and vision services. Oregon's Joint Task Force on Universal Health Care build their draft design on the state's public employee design. The Healthy California for All Commission agreed that benefit design should include dental, vision and hearing.

I would recommend the UBD actuarily analysis assess six benefits designs (see Chart A).

Chart A

Uniform Benefit Plan - Actuarial Analysis Options			
Plan	**Reference Source**	**Member Enrollment**	**Notes**
Washington Mandatory Essential Health Benefits (EHB) for Health Benefit Exchange (HBE).	WAC 284-43-5622	270,000 (HBE Enrollment)	Washington's mandatory and optional EHB categorices are set forth in WAC 284-43-5622 .
Washington's Mandatory and Optional Essential Health Benefits (EHB) for Individual and Small Group Markets	WAC 284-43-5622		Washington's optional EHB are set forth in WAC 284-43-5622 (1)(b), (3)(b), (4)(b), (5)(b), (6)(b), (7)(c) and (8)(b).
Washington Uniform Benefit Plan (UMP) Classic and Uniform Dental Plan (UDP)	Health Care Authority's "2024 UMP Classic (PEBB) Certificate of Coverage"and 2024 Uniform Dental Plan administered by Delta Dental.	303,000 (UMP Enrollment)	HCA providers health coverage to some 682,000 public (state and local government) and school district active employees, family members and retirees. 45% of SEBB/PEBB members obtain covered through UMP.
Washington Medicaid (Title XIX) Program's Medical, Behavioral Health and Dental Services.	Medicaid (Title XIX) State Plan. The services are defined in Attachment 3, 3.1-L and 3.1-L2.	2,024,000	The Medicaid program's scope of benefits includes medical, hearing, vision, behavioral health, dental and long-term care and support services. The benefits for the actuarial analysis will include medical, hearing, vision, behavioral health and dental.
Washington Medicaid (Title XIX) Program's Long-Term Care and Support ServicesMedical.	Medicaid (Title XIX) State Plan. The services are defined in Attachment 3, 3.1-L and 3.1-L2.		The Medicaid program's scope of benefits includes medical, hearing, vision, behavioral health, dental and long-term care and support services. The benefits for the long-term and support services will be provided by DSHS's Rersearch & Data Analysis Division..
Medicare (Title XVIII) Part A, B and D Benefits	Medicare Benefit Policy Manual, Chapters 1 through 17.	1,503,000	In Washington, 733,000 (49%) of the Medicare beneficiaries are enrolled in Medicare Advantage (Part C) managed care plans.

1. **Mandatory Essential Health Benefit**. As required under the Affordable Care Act (ACA), each state has defined how to operationalize the required ten EHBs prescribed in the Act using existing individual or small group plans in their respective states. Since 2020, Washington's EHB benchmark plan has been the Regence BlueShield Direct Gold+ small group health plan. The benefit categories are prescribed in WAC 284-43-5622. Washington's Health Benefit Exchange (HBE) is using this benefit design to cover some 270,000 persons.

   Of note, beginning in 2020, the Centers for Medicare and Medicaid Services (CMS) gives states three options to define their EHB benchmark plan:

   - **Option 1:** Selecting the EHB-benchmark plan that another State used for the 2017 plan year.
   - **Option 2:** Replacing one or more categories of EHBs under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year.
   - **Option 3:** Otherwise selecting a set of benefits that would become the State's EHB-benchmark plan.

The State legislature (SSB 5338) has directed the Office of Insurance Commission (OIC) to conduct a review of Washington's EHB. As part of this review, OIC is determining the impacts on individual and small group health plan design of including each of the following: (1) fertility services; (2) biomarker testing; (3) contralateral prophylactic mastectomies; (4) donor human milk; (5) treatment for pediatric acute-onset neuropsychiatric syndrome and pediatric autoimmune neuropsychiatric disorders; and (6)resonance imaging for breast cancer screening.

2. **Mandatory & Optional Essential Health Benefits**. In addition to the ACA essential benefits, Washington has prescribed (WAC 284-43-5622) a set of optional benefits the carriers can offer in the individual and small group markets. These optional services include dental care provided by a dentist, hearing care, private duty nursing, personal care, obesity or weight reduction, nutritional counseling, cosmetic or reconstructive services, bariatric surgery.

   It is recommended that the actuarial analysis include a benefit design with both the mandatory and optional EHB that can be offered in the individual and small group market in order to provide the UHCC with a picture of comprehensive benefits. The analysis would include the potential impacts on the actuarial values and premium for each optional benefit. This would provide the UHCC with an analysis of the cost of adding each benefit.

3. **PEBB/SEBB Uniform Medical Plan & Uniform Dental Plan**. Washington's Health Care Authority (HCA) provides healthcare coverage to some 682,000 public employees, state employees, retirees, and their family members. The largest number (304,000 enrollees) of these persons are enrolled in Uniform Medical Plan (UMP) Classic, which is a self-insured plan administered by Regence of Washington with prescription drug coverage from Navitus and dental coverage through Delta Dental of Washington.

   UMP is perhaps the largest ERISA or large group market plan in the state. It representatives a comprehensive benefit health and dental benefit design that would serve as a comprehensive model for the UBD.

4. **Medicaid Medical, Behavioral Health & Dental Benefit**. Washington's Medicaid program's benefit design needs to be part of the actuarial analysis. Medicaid is the largest health program/plan in the state. It covers the broadest array of services and will eventually be incorporated into the state's universal healthcare system.

   For comparison purposes with other benefit designs, the actuarial analysis should include medical and related benefits, behavioral (mental health and substance disorder services) health services and dental services. Medicaid's long-term care and support services will be analyzed separately (see below).

The Medicaid analysis would include per-member-per-month (PMPM) estimates for the cost of bringing the Medicaid benefits to a "standardized fee-schedule rates determined by the UHCC (see below)

5. **Medicaid Long-Term Care and Support Services**. Medicaid is the only program that provides comprehensive long-term care and support services. This ranges from in-home support services such as person care, private duty nursing and family supports, long-term care residential and skilled nursing facility services, long-term residential support for behavioral health treatment, housing support services and employment support services. Most of these services are administered by the Department of Social and Health Services with some long-term behavioral support services contracted through HCA.

   Due to their cost, long-term care services will not be part of an initial universal health care system. However, the UHCC will need a basic understanding of the scope and cost of these services. This would not be an actuarial benefit comparison. Instead, it would be an analysis of services, costs, and users per members. The analysis would be conducted by DSHS' Research & Data Analysis Division (RDA) under contract with HCA.

6. **Medicare Part A, Part B and Part D Benefits**. With some 1,500,000 enrollees, Medicare is the second largest benefit plan after Medicaid. While FTAC has determined there is currently not a path (existing legislation or waivers) to incorporate Medicare in a universal system administered by the State, UHCC's long-term goal is to include Medicare beneficaries into its unified system.

   For these reasons, Medicare Part A (inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery, home health care), Part B (doctor and other health care providers' services and outpatient care, durable medical equipment, home health care, and some preventive services, and Part D (prescription drugs) should be included in the actuarial benefit design comparisons. In addition to an analysis that would include per-member-per-month (PMPM) estimates for the cost of bringing the Medicaid benefits to a "standardized fee-schedule rates" determined by the UHCC (see below), the analysis would provide information on the cost of bringing the Medicare beneficiaries coverage to the UBD actuarial equivalency.

Point-Of Service Cost-Sharing

The second parameter in a benefit design is point-of-services. This includes whether or not to consideration of employing copayments, or deductibles in the UHD.

Point-of-service cost-sharing is considered in benefit designs for three primary reasons. Cost-sharing can reduce the price of premiums to the total ensured enrollee population by shifting medical costs directly to the individual user of a service. Proponents of cost-sharing argue that by assigning out-of-pocket cost to an individual user will make them a more "cost-consensus consumer" of medical services and thus improve market efficiency. The argument goes that since you have to pay part of the bill, it's more likely you'll only seek medical care when you really need it. Reduced utilization would in theory also lead to reduced increases in future premiums. The third argument for cost-sharing, which is more philosophical, is the notion that we should all have "skin in the game." That is, there are no free goods or services.

Much of the understanding of cost-sharing is from the 1971-1986 RAND Health Insurance Experiment (HIE), which attempted to address two key questions in health care financing: (1) How much more medical care will people use if it is provided free of charge? And (2) What are the consequences for their health? Evidence from the RAND HIE showed that patients are not good at distinguishing care that is likely to be effective from care that is likely ineffective, and that cost sharing results in reductions in both types of care. However, the RAND HIE also found that with the exception of low-income patients, cost sharing did not result in measurable reductions in health status. Subsequent research has highlighted that cost sharing is associated with a reduction in the receipt of preventive care services, such as screening mammograms, and the use of necessary medications for chronic conditions including diabetes, and hypertension.

The ACA required that cost-sharing be incorporated into four benefit plans in the state and federal Health Benefit Exchanges (see Chart B). The percent for each plan is its "actuarial value" (AV), which is the percentage of health care expenses a plan would cover on average for a standard population. For example, a plan with an actuarial value of 80% would be expected to cover on average 80% of health care expenses, with enrollees paying the remaining 20% through some combination of deductibles, copays, and coinsurance.

Chart B

Affordable Care Act (ACA) Plan Types		
Plan Type	WA HBE Enrollment	
	Number	Percent
Platinum plan provides the essential health benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits;	0	0%
Gold plan provides the essential health benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits;	56,418	21%
Silver plan provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits;	118,852	44%
Bronze plan represents minimum creditable coverage and provides the essential health benefits, cover 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit);	96,856	36%
NOTE: Provide cost-sharing subsidies to eligible individuals and families. The cost-sharing credits reduce the costsharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income level: 100-150% FPL: 94% 150-200% FPL: 87% 200-250% FPL: 73% 250-400% FPL: 70%		

In Washington, the largest plan selection is the Silver (70/30) plan. However, the impact of the Silver plan's cost-sharing ratio (70/30) can be offset in part by the availability of cost-sharing subsidies (see Chart B). Of note, Washington like 33 other states does not offer the Platinum (90/10) plan benefit design.

I would suggest that FTAC consider recommending four cost-sharing options (see Table C). Given that cost-sharing will damp demand for services, the cost-sharing should not be applied to primary care or preventive care related services. In considering cost-sharing options, it is also criteria to consider existing Medicaid cost-sharing limitations. While CMS would be willing to 1115a demonstration and research waivers to incorporate Medicaid beneficiaries into Washington's unified health care system, they may not be willing to waiver cost-sharing protections for Medicaid beneficiaries.

Chart C

Actuarial Value (AV) Cost-Sharing Options	
	AV Option
No Cost-Sharing	100%
	95%
ACA Platium Plan	90%
ACA Gold Plan	80%

Payment Rates – Standard Fee Schedule

While beyond its immediate charge from UHCC, it is likely that FTAC will be asked for possible recommendations on a standard fee schedule that would be used to reimbursement providers for all member in the E2SSB 5399 universal financing system. These rates would be used regardless of whether the patient was a Medicare or Medicaid beneficiary, or a prior commercially enrolled individual.

There is significant variation in the reimbursement by payer for the same or similar health care service. Medicaid reimbursement is the lowest, followed by Medicare, and commercial insurance reimbursement is highest. For example, the Oregon Joint Task Force on Universal Health Care's "Universal Health Care Financial Modeling report found: (1) Commercial insurance were approximately 170% of Medicare; and (b) Medicaid was approximately 85% of Medicare. A Kaiser Family Foundations' comparison of 2019 "Medicaid-to-Medicare Physician Service Fee Index" found that over all physician services, Medicaid pays at .72 of Medicare. Washington had the 35th lowest rates overall in 2019.

MACPAC found that on average that Medicaid fee-for-service (FFS) base payments were below hospitals' costs of providing services to Medicaid enrollees and are below Medicare payment rates for comparable services . In 2011, FFS base payment rates were 78% of Medicare for the 18 Medicare-severity diagnostic-related groups studied. However, Once supplemental payments were taken into account, MACPA found that Medicaid payment were comparable or higher than Medicare.

To maintain the aggregate level of reimbursement and accounting for the compounding effects with other adjustments, the Oregon Task Force standardized fee schedule was assumed to be 124% of Medicare. Based on this fee schedule, some health care providers could experience increases to their total patient revenues, others will experience decreases, and some will not be impacted significantly.

As FTAC considers possible fee-schedule recommendations, members may want to look at state ACA public option plans where the state as set required FFS rates for payment to providers for plan enrollees. After much deliberation with providers, Washington's legislature enacted E2SSB 5377 requiring its public option plan (Cascade Select plans) to employ index provide payment rates such that they cap aggregate provider reimbursement, excluding pharmacy benefits, to be at 160 percent of Medicare rates, compared with to an estimate average of 174 percent among other Washington exchange plans. .The public option plans are also required to pay not less than 101 percent of allowable costs to CMS defined rural critical access hospitals, and no less than 135 percent of Medicare rates for primary care services.

In developing its UBD, the UHCC will need to adopt a standard fee schedule to ensure uniformity and equitable access. This will entail developing a standard fee indexed against prevailing commercial, Medicare, and Medicaid rates, possibly using a logical similar to the Oregon Task Force, and limit the fee increases at or below true medical inflation.

Break

Tab 6

Washington State Health Care Authority

WA Health Care Cost Transparency Board

WA health care spending growth preliminary results

Washington State Health Care Authority

Washington's Spending Growth Benchmark

- Washington is one of nine states in the nation to adopt a spending growth benchmark
  - Specific rate that carrier and provider expenditure performance will be measured against
    - 2022 and onward
  - Based on a hybrid of median wage and potential gross state product (PGSP)
  - Data sourced from aggregate expenditure data from payers (carriers) and include claims-based and non-claims-based expenditures

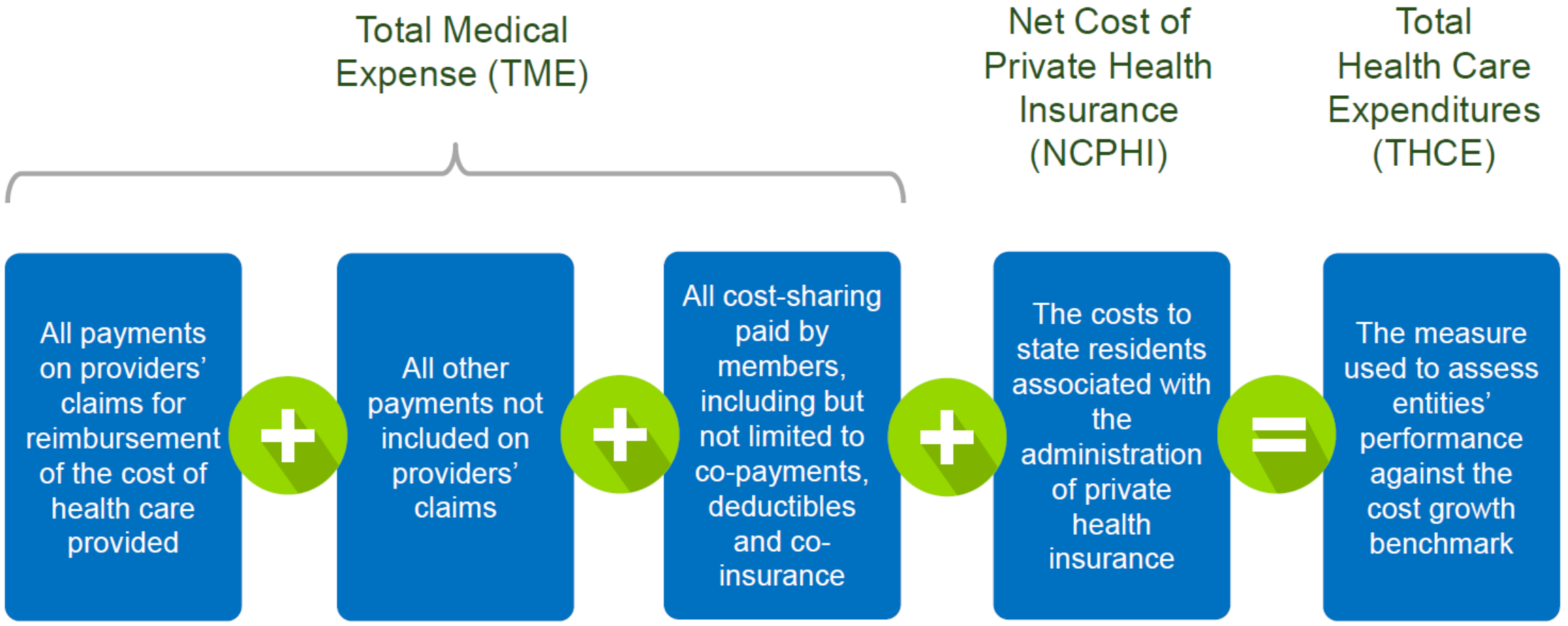
Years	Benchmark
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

Reporting performance against benchmark

Current reporting cycle →

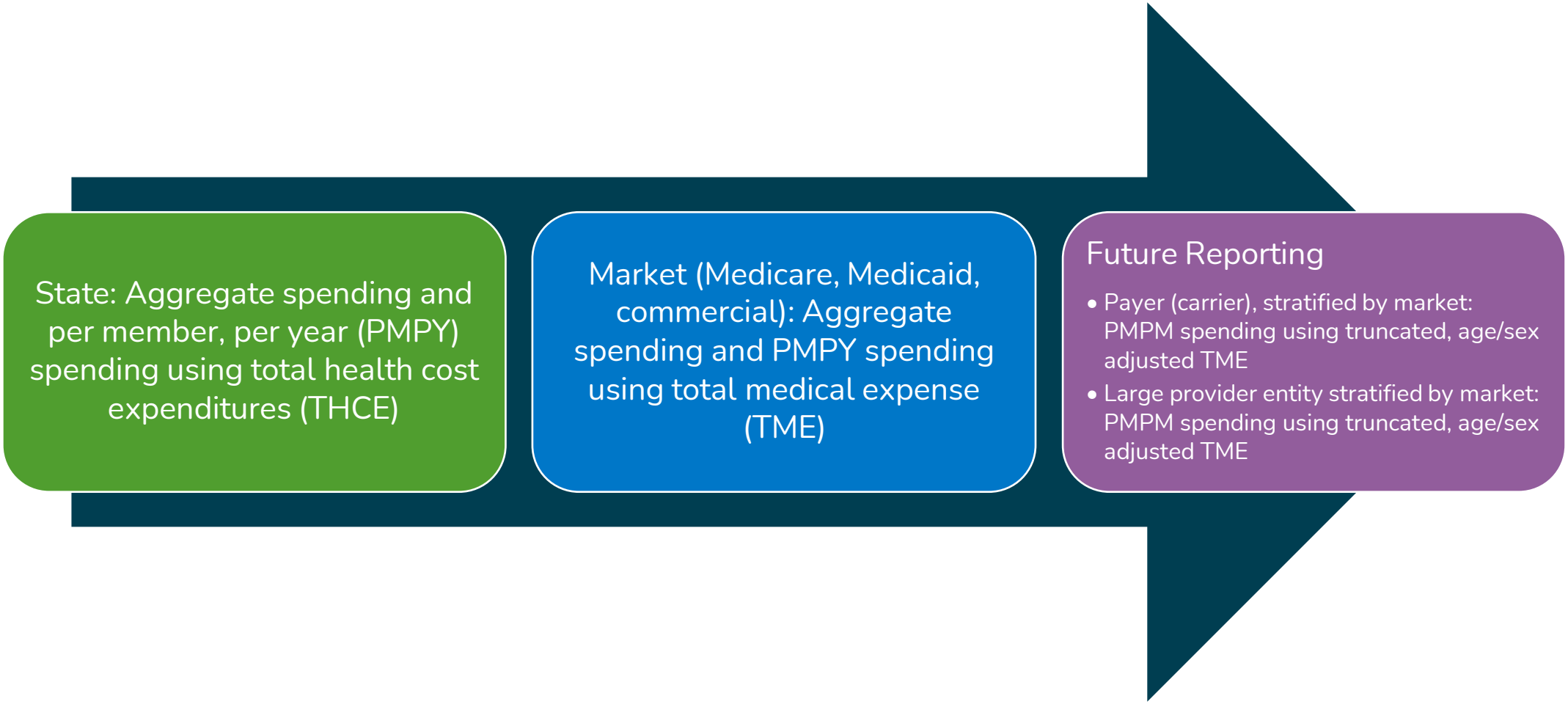
Year of Release	Includes Data from Specified Years	Data Included
Late Fall 2023	2017 – 2019	State and market data only – the board will not publicly report insurance carrier or provider cost growth for this period
Late Fall 2024	2020 – 2022	For large provider entities and carriers – with cost growth target of 3.2%
Late Fall 2025	2022 – 2023	For large provider entities and carriers – with cost growth target of 3.2%
Late Fall 2026	2023 – 2024	For large provider entities and carriers – with cost growth target of 3.0%
Late Fall 2027	2024 – 2025	For large provider entities and carriers – with cost growth target of 3.0%
Late Fall 2028	2025 – 2026	For large provider entities and carriers – with cost growth target of 2.8%

What is being measured?



Washington State Health Care Authority

Performance measurement against the benchmark

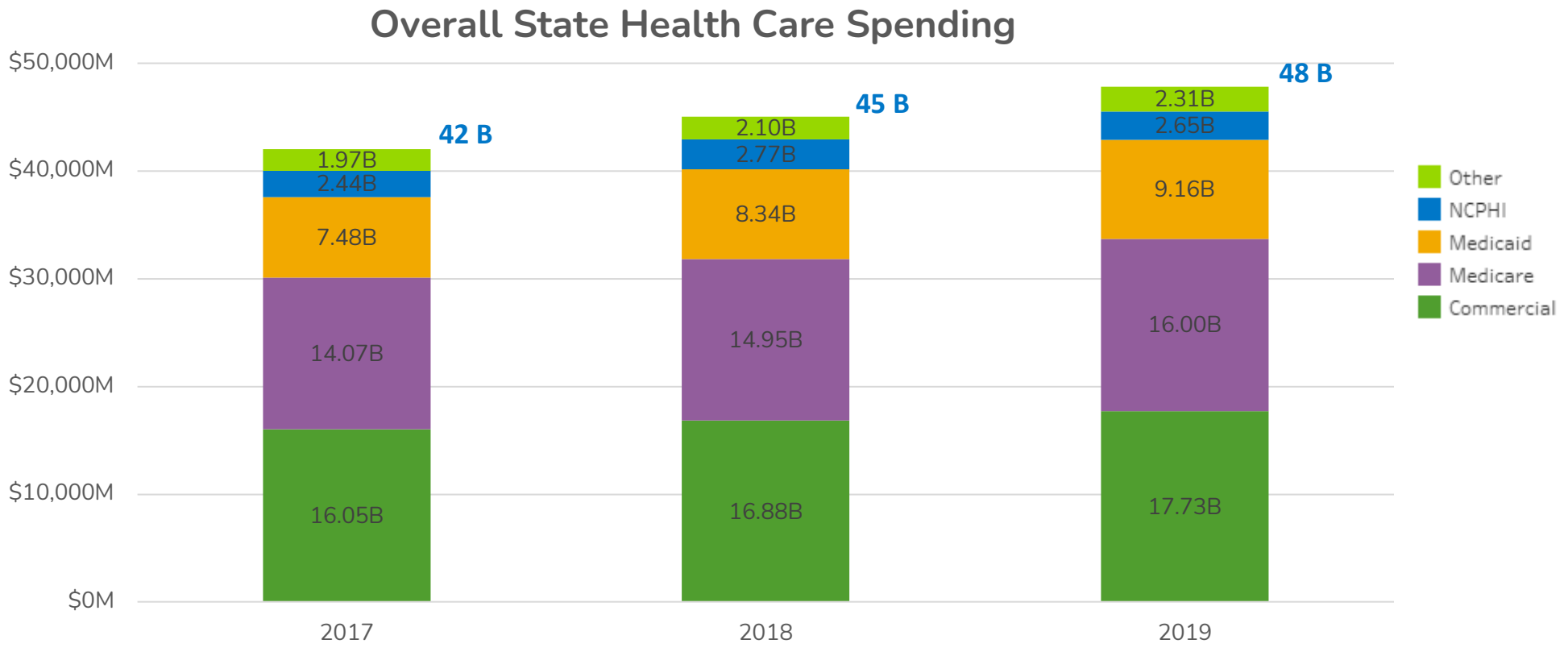


Washington State Health Care Authority

Highlights

- In 2019, total health care expenditures (THCE) was $48 billion
  - Hospital outpatient services are significant and growing
- Growth between 2017-2019
  - Statewide total health care expenditures increased in 2018 (7.15%) and 2019 (5.81%)
  - Medicare PMPY appears to have slower growth than Medicaid or commercial
  - Medicaid seems to be growing faster than other markets but still has a lower PMPY spending than commercial or Medicare

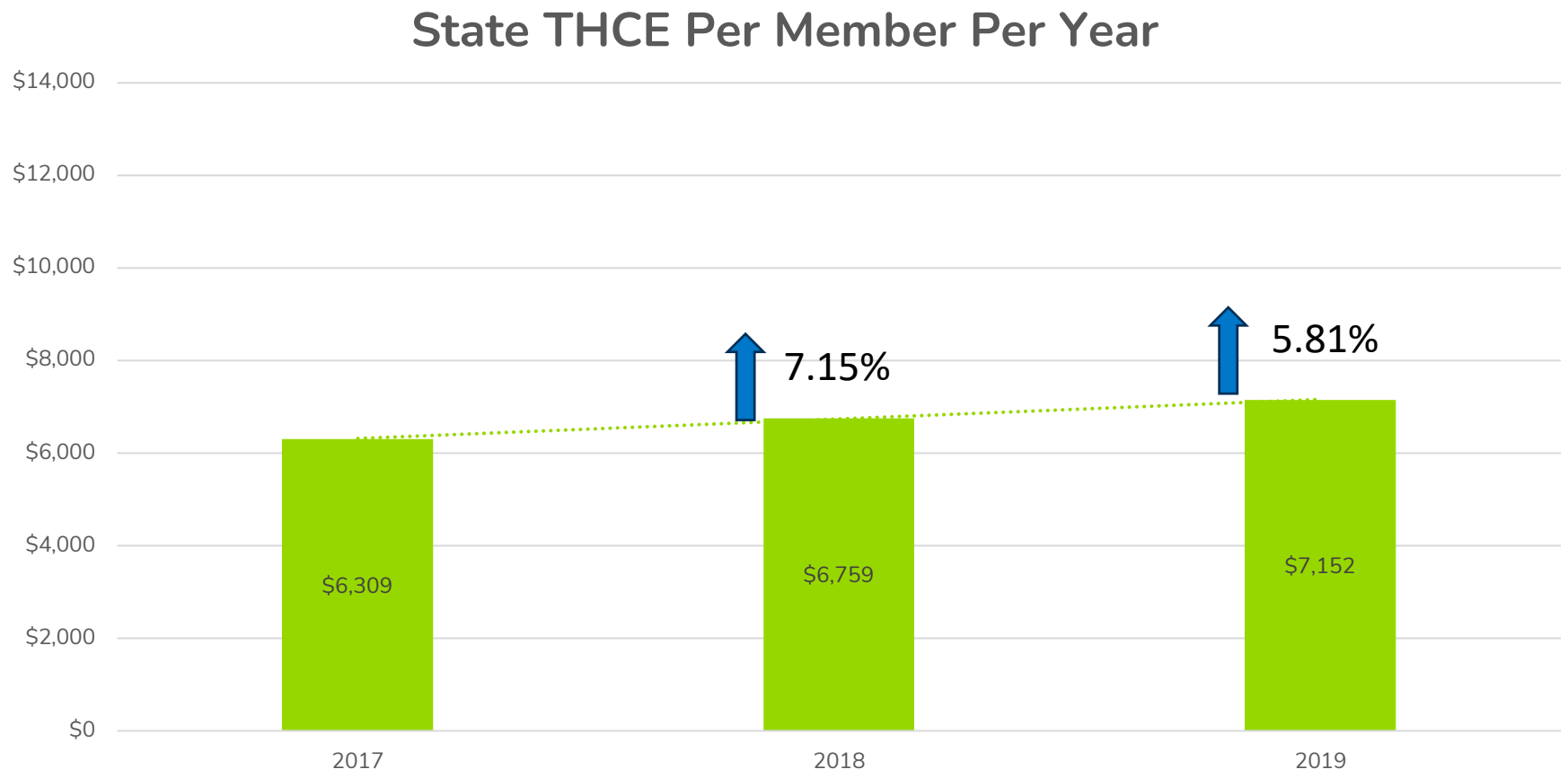
Total health care expenditures (THCE) statewide



NCPHI (Net Cost of Private Health Insurance) are associated with the administration of health insurance.
Other category includes LNI, DoC, & VA health care expenditures.

Washington State Health Care Authority

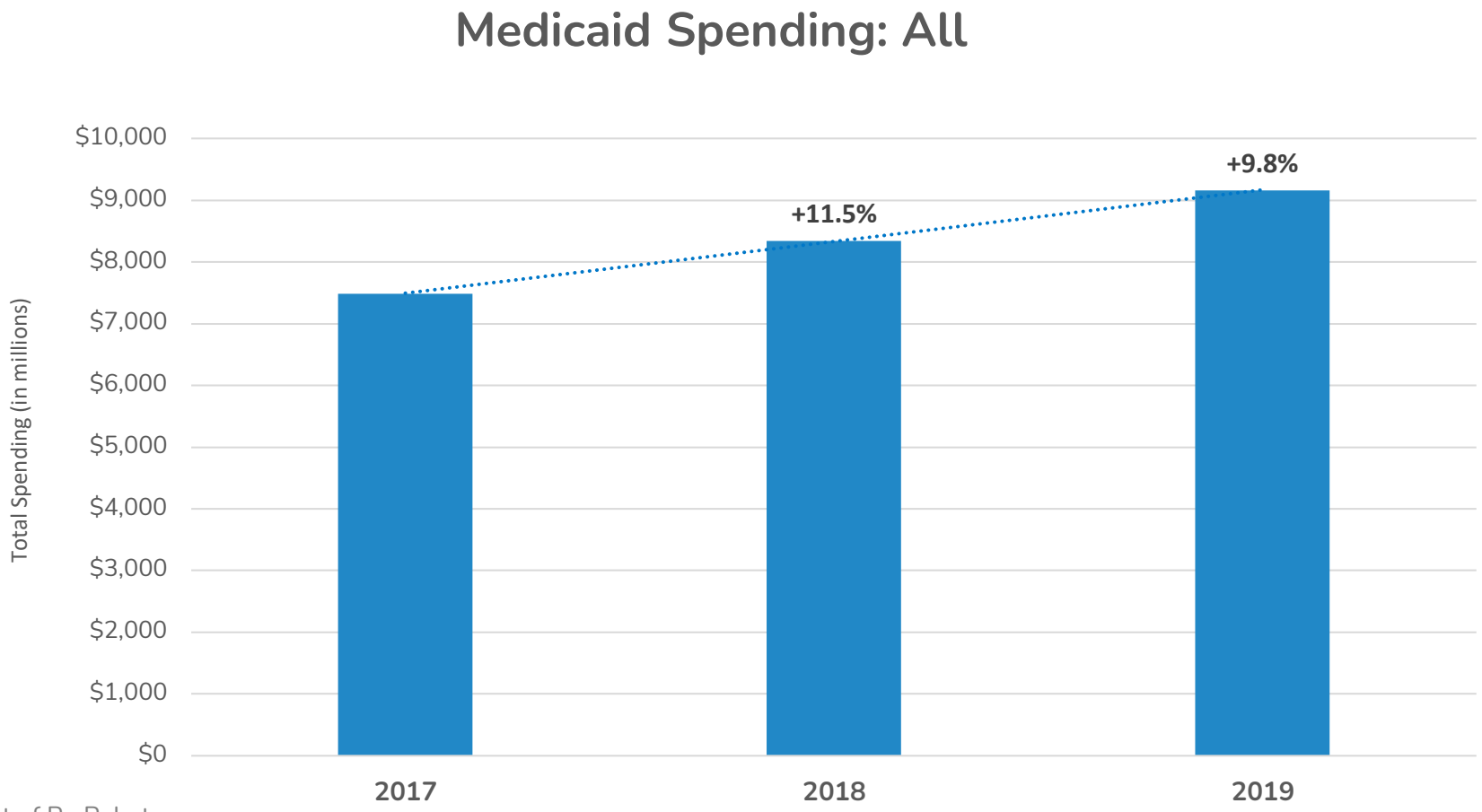
Total health care expenditures for WA



* MA and RI identified 3%-4% annual growth over this period

Washington State Health Care Authority

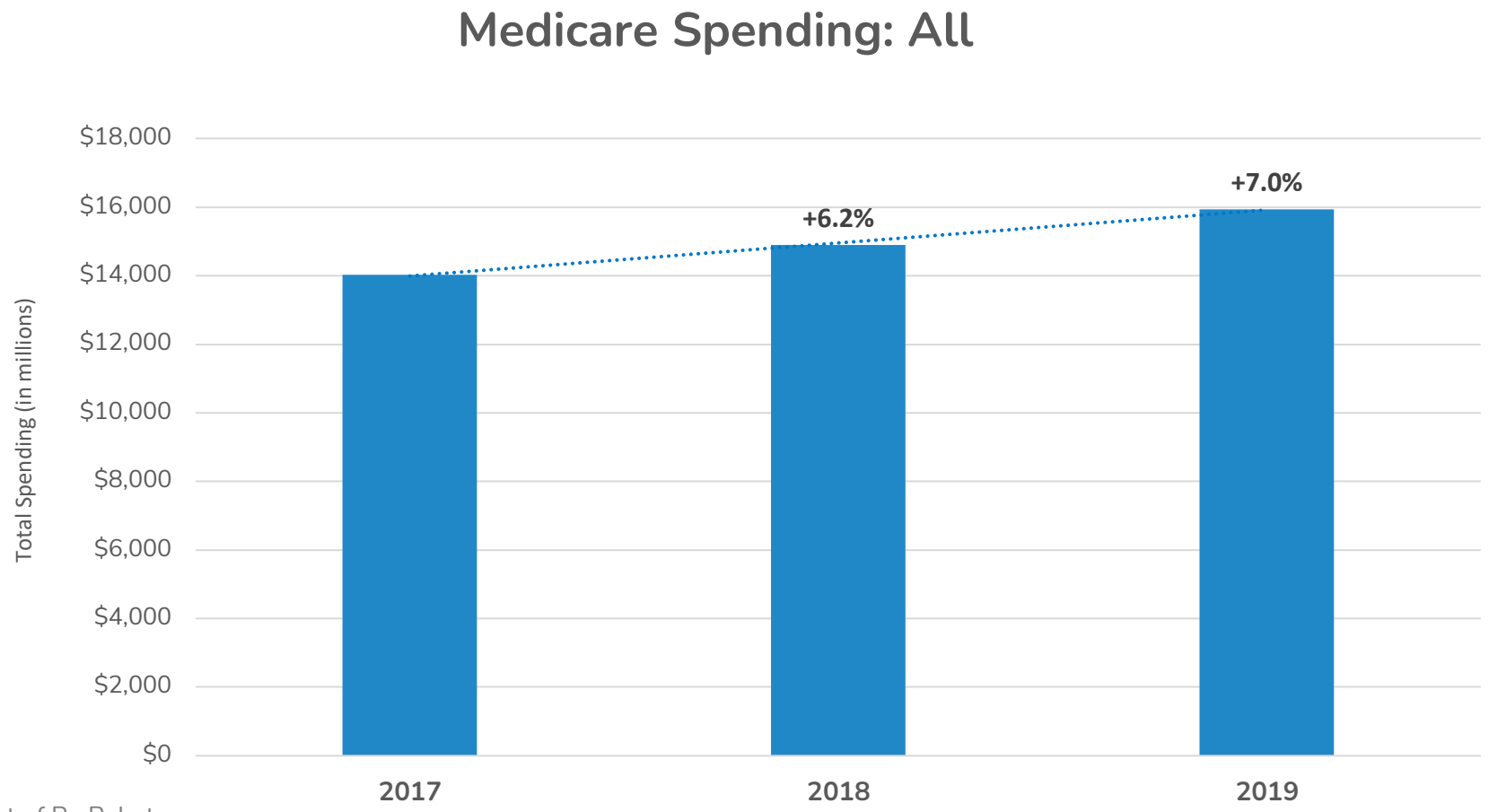
Medicaid growth



* Net of Rx Rebates
Includes Medicaid MC & FFS

Washington State Health Care Authority

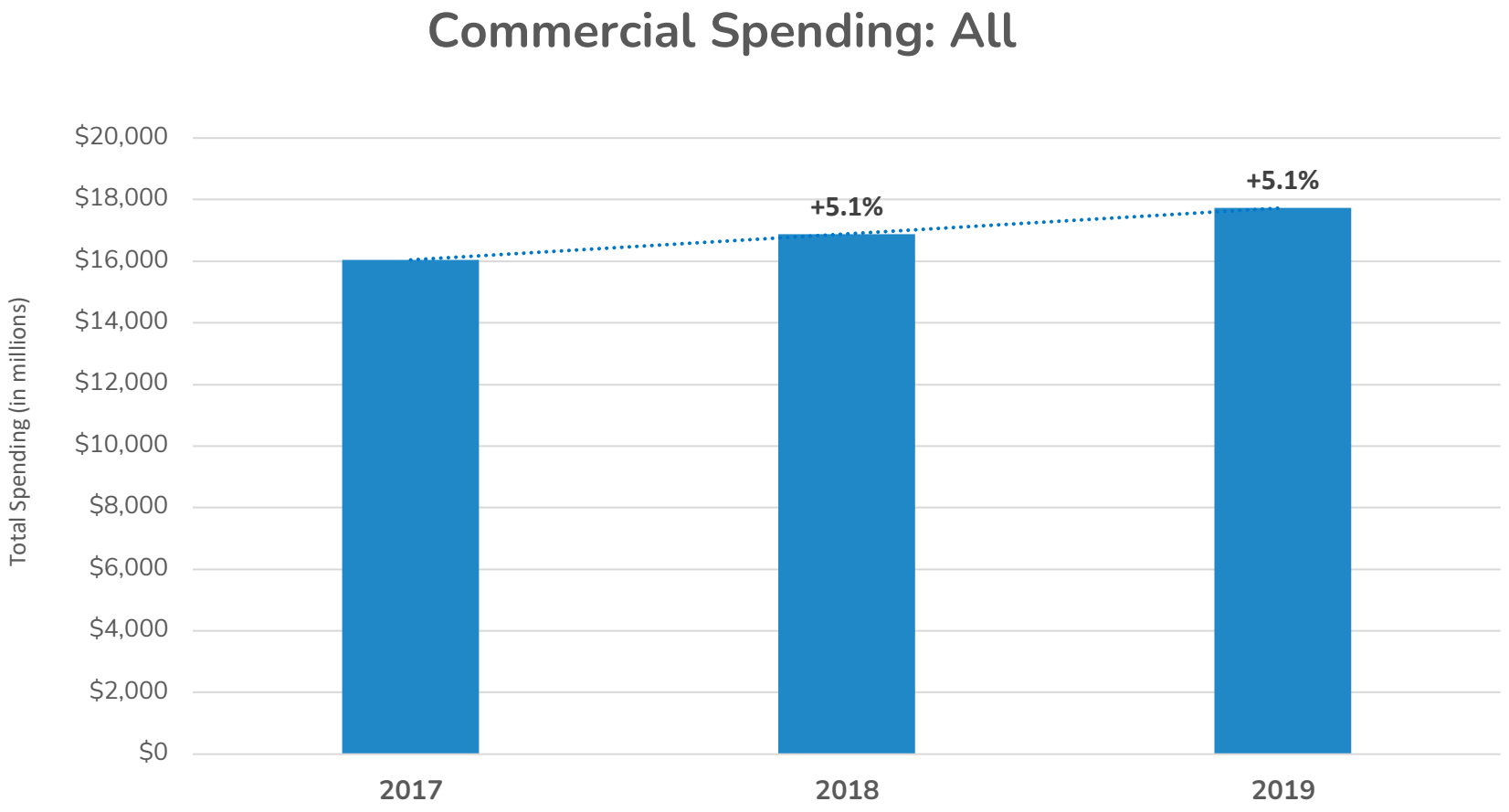
Medicare growth



* Net of Rx Rebates
Included Medicare Adv & FFS

Washington State Health Care Authority

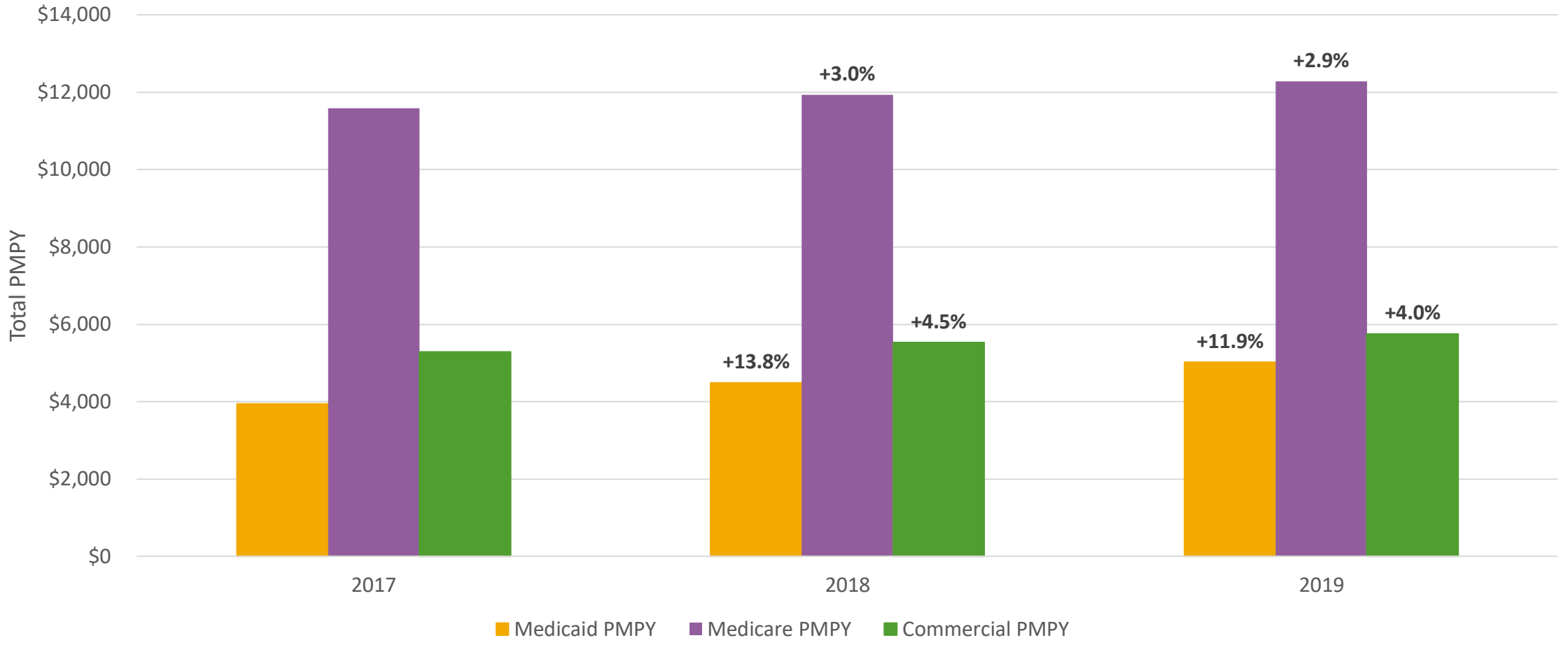
Commercial growth



* Net of Rx Rebates

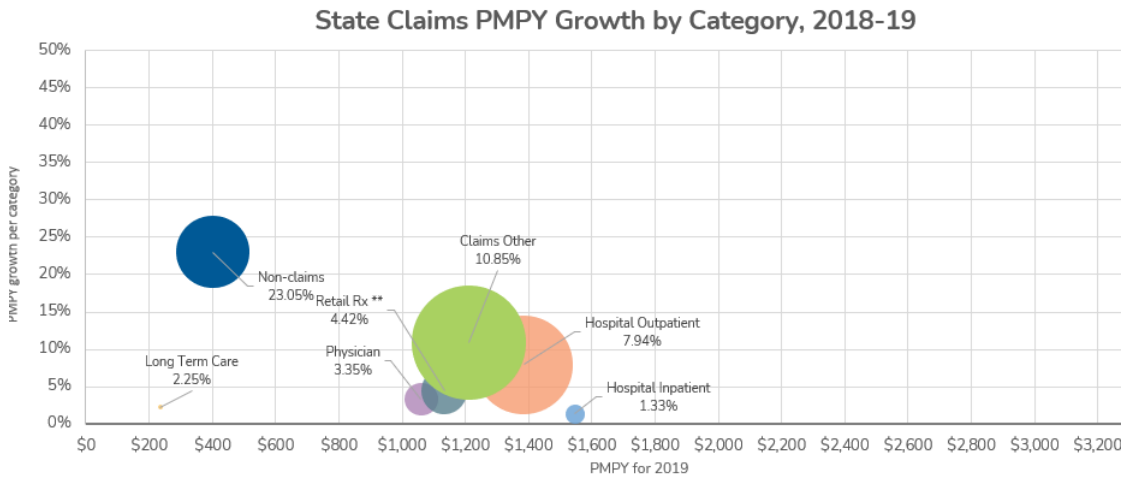
Washington State Health Care Authority

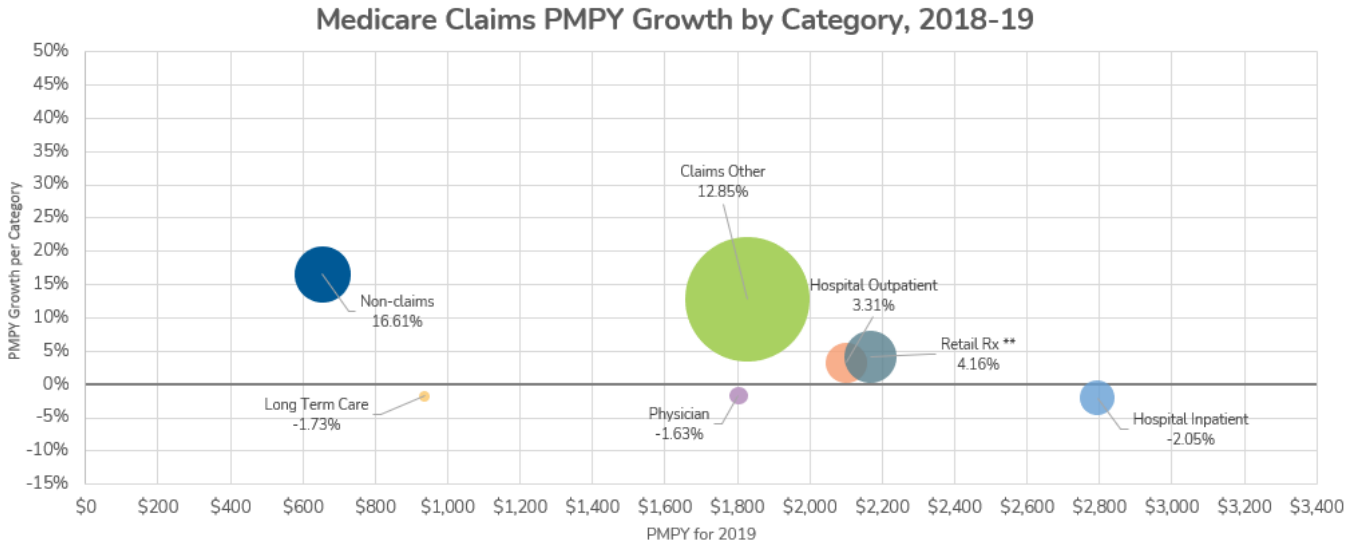
PMPY growth by market – at a glance

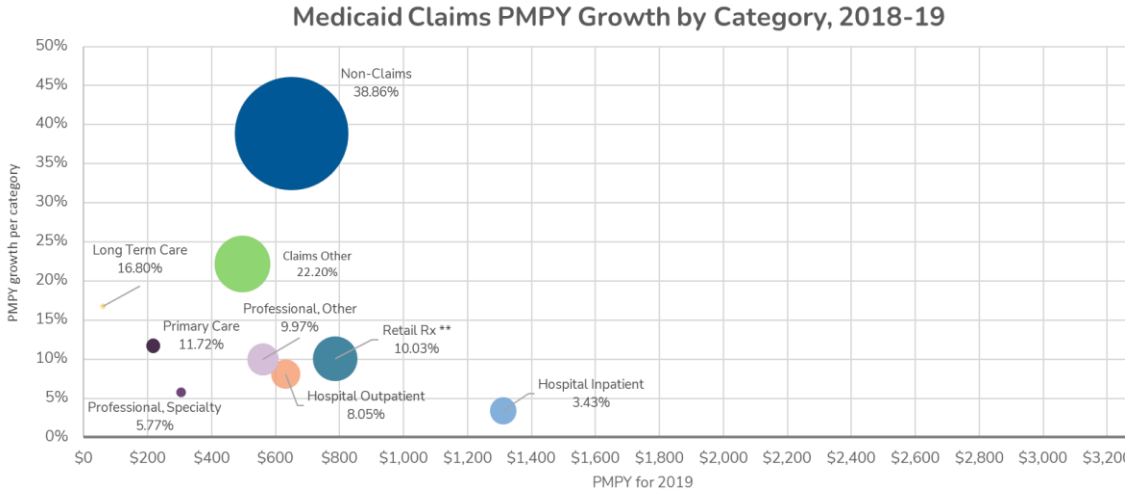


Washington State Health Care Authority

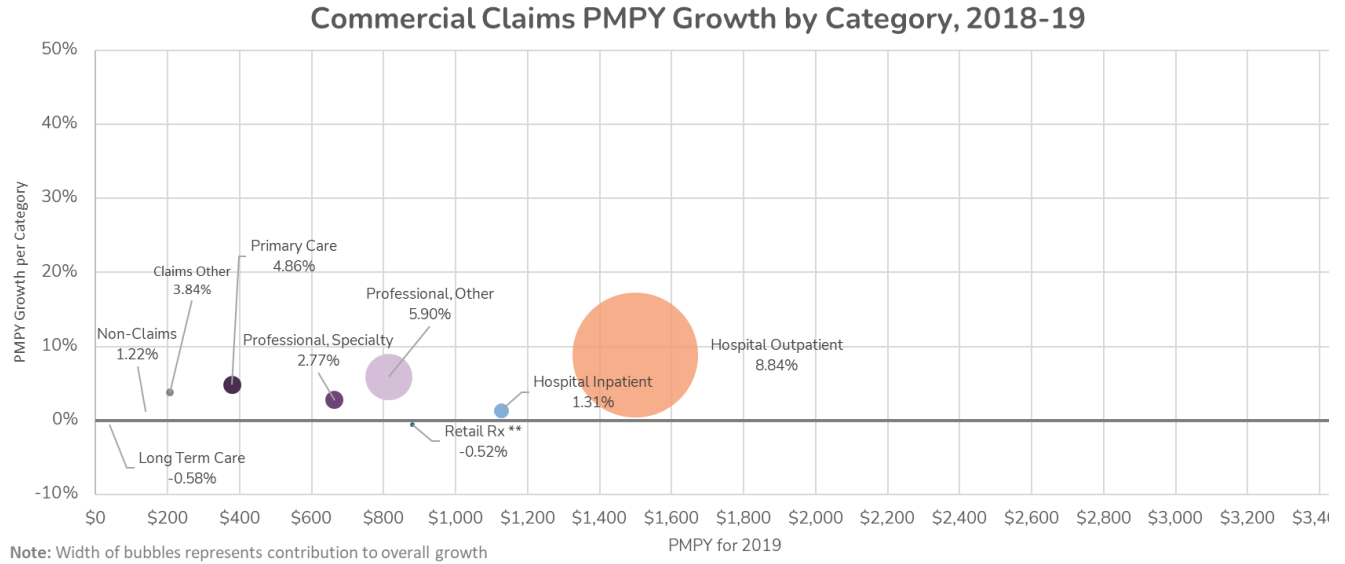
Service category contribution to cost growth – at a glance







Note: Width of bubbles represents contribution to overall growth
Included Medicaid MC & FFS



Note: Width of bubbles represents contribution to overall growth
** Net of Rx Rebates

Washington State Health Care Authority

Policy Options and Voting by the Board at the February Retreat

	Policy	Magnitude of Impact	Complexity for Development & Implementation	Term of Goal	Current Policy Efforts Underway	Final Votes	Selected for Study
	Limiting Facility Fees	Low to overall costs, High to purchases and consumers	Low	Short-term	Covered in OIC report, HB2378	8	**X**
	Balance Billing Protections	Low to overall costs, High to purchases and consumers	Low to Medium	Short-term	SB5986, protecting consumers from out-of-network charges	0	
	Restricting Anti-competitive Clauses in Contracting	Significant impact on costs and spending	Low to Medium	Short-term	AG's report and SB2066, Affordability through Provider contracting	7	**X**
	Increase Hospital Price Transparency	Medium to consumers	Low to Medium	Short- to medium-term	Federal action needed, but CMS is reviewing	4	
	Community Benefit Transparency	Medium to consumers, does not address costs	Low	Short- to medium-term	None	3	
Merged	**Mergers and Acquisition**	Significant	Medium	Medium-term	Covered in OIC report, and SB5241 Keep Our Care Act	7	**X**
Merged	**Private Equity Purchasing of Health Care Providers**	Lower impact, does not address cost	Medium	Medium-term	None		
	Limiting Out-of-Network Charges	Medium to cost, Significant to purchasers and consumers	Medium	Medium-term	Strengthens Balanced Billing efforts	2	
	Strengthening Rate Review Authority	Medium impact on cost, medium to purchasers and consumers	Medium to High	Medium-term	Covered in OIC report	0	

	Administrative Simplification	Medium impact	Medium	Medium-term	Being studied by the Universal Health Care Commission, considered at state and federal level	3	
	Spread Pricing/Pharmacy Benefit Manager Reform	Medium to cost, Significant to purchasers and employers	Medium	Medium-term	SB5213, Studied by Prescription Drug Affordability Board	1	
Merged	**Provider Rate Setting**	Significant impact on costs and spending, potentially significant impact for purchasers and consumers	High	Longer-term	Included in OIC report	2 + 7 **9**	**X**
	Price Growth Caps	Significant impact on costs and spending, significant impact for purchasers and consumers	High	Longer-term	Included in OIC report, Cascade Care uses this mechanism		
	Global Budgets	Significant impact on costs and spending	High	Longer-term	Included in OIC report	0	
	Reference-based Pricing	Significant impact on costs and spending	High	Longer-term	Included in OIC report	2	
	Further Consolidate and Expand State Purchasing	Significant impact on costs and spending	High	Longer-term	None	4	

Next steps

This high-level report sets the stage for the Cost Board's work in 2024

- Next data submission call for carriers
  - Measuring spending against the cost growth benchmark for the first time
    - Explore spending growth from 2021 to 2022, and how that compares to the cost growth benchmark set at 3.2% for 2022
  - Begin reporting on spending at the payer and large health care provider level
- Deeper dives into health care spending
  - Analyze how changes in price and utilization contribute to spending growth
  - Report at the end of 2024 by the Institute for Health Metrics and Evaluation
- Review cost containment strategies to recommend to the legislature

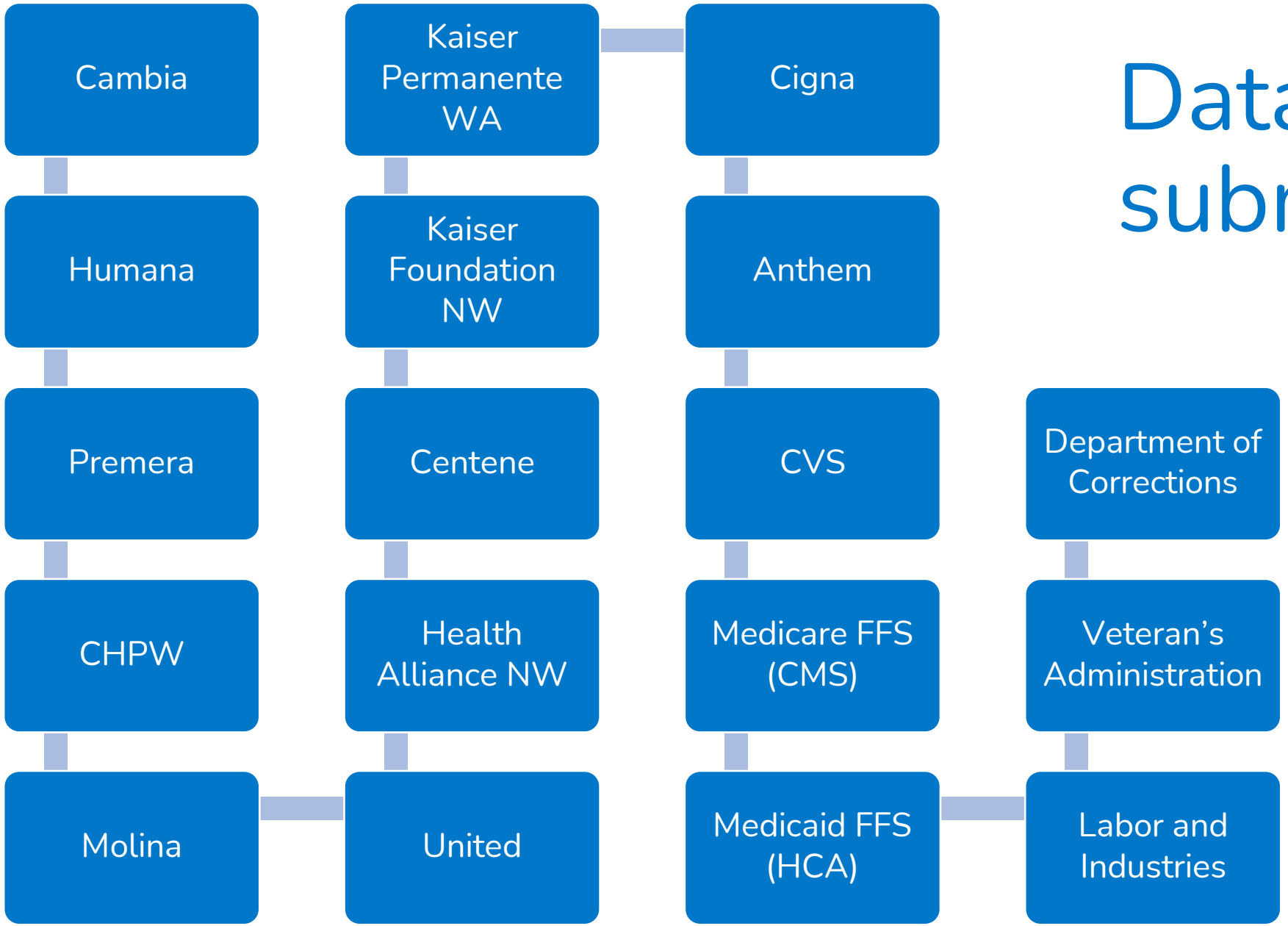
Questions

Appendix

Other spending

Source	2017	2018	2019
DoC	$159,373,434.40	$180,885,549.01	$200,640,533.76
LNI	$400,995,307.95	$397,069,029.47	$445,486,818.21
VA	$1,412,362,918.49	$1,526,068,781.06	$1,665,541,164.18

Data submitters



Washington State Health Care Authority

Service category definitions, continued

- **Professional, other providers:** Includes, but is not limited to licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, chiropractors, and any fees that do not fit other categories, including facilities fees of community health center services and freestanding ambulatory surgical center services
- **Professional, specialty providers:** Includes services provided by a doctor of medicine or osteopathy in clinical areas other than family practice, geriatrics, internal medicine, and pediatrics
- **Professional, primary care:** Includes care management; care planning; counseling; domiciliary, rest home, or custodial care; FQHC visits; health risk and screenings; home health services; immunization administrations; office visits and preventive medicine visits. Determined by taxonomy and/or services types

Note: Due to Medicare FFS reporting capability, grouping of physicians along with Cost Board categories Primary Care & Specialty Professional

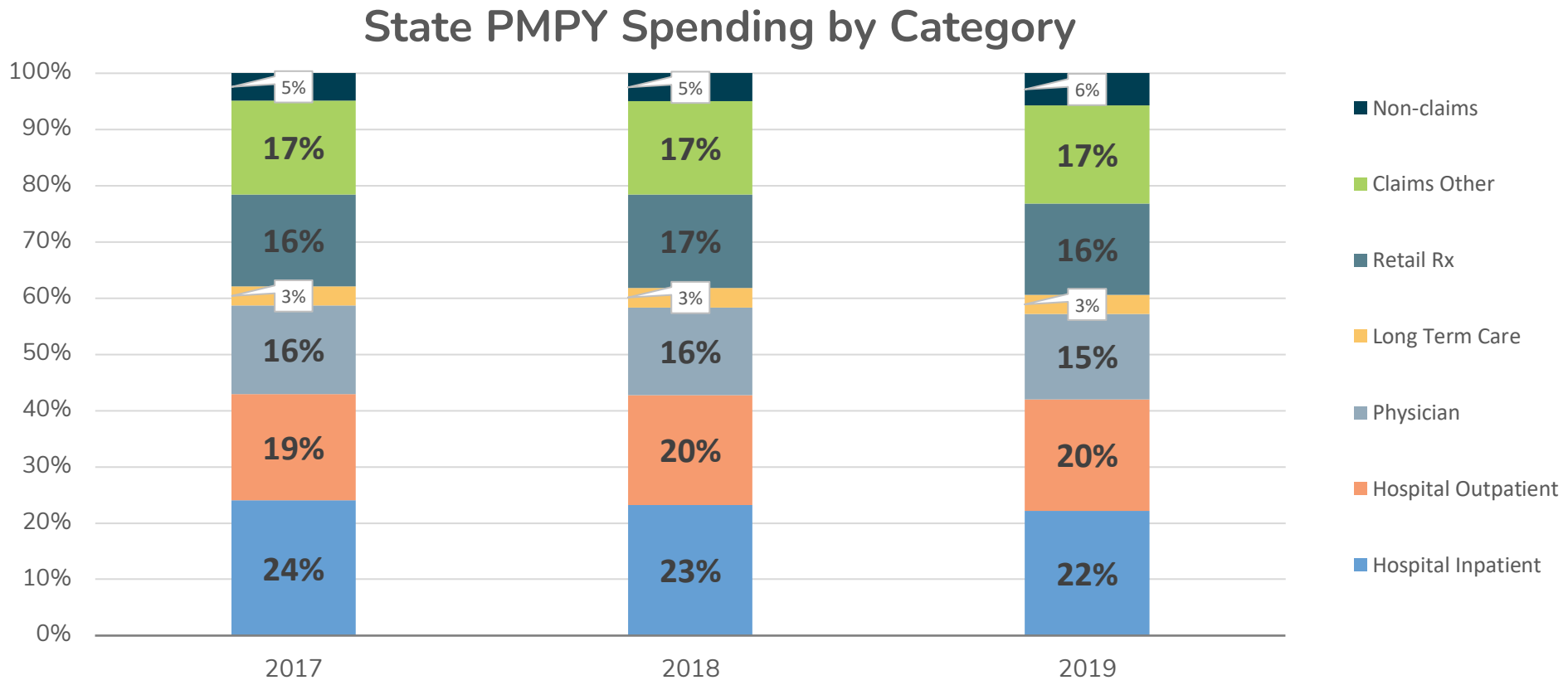
Service category definitions

- **Hospital outpatient:** Includes all hospital types and payments made for hospital-licensed satellite clinics, emergency room services not resulting in admittance; and observation services
- **Hospital inpatient:** Includes all room and board and ancillary payments for all hospital types and payments for emergency room services when the member is admitted to the hospital
- **Retail prescription:** Includes claims paid to retail pharmacies for prescription drugs, biological products or vaccines
- **Non-claims:** Includes incentives, capitation, risk settlements, direct payments or other non-claims-based payments
- **Claims other:** Includes durable medical equipment, freestanding diagnostic facility services, hearing aid services and optical services
- **Long-term care:** Includes skilled nursing facility services, home health service, custodial nursing facility services home- and community-based services including personal care

Caveats & limitations

- **Exclusions**
  - Policies offering limited benefits, such as accident, disability, Medicare supplemental insurance, vision or dental stand-alone policies
  - Health care paid through charity care or by customer cash payment
  - Certain non-claims publicly funded behavioral health services
  - Anthem 2017 data
  - Humana Medicare data
  - Custodial nursing facility services, home- and community-based services, and intermediate care facilities and services for persons with developmental disabilities paid by Washington State Department of Social and Health Services (DSHS)
- **All figures are net of prescription drug rebates**
- **Both Medical and Retail Rx Rebates were collected**
  - All rebates (Medical & Retail) subtracted from the Retail Rx category due to the complexity of medical rebates

TME, per member per year spending

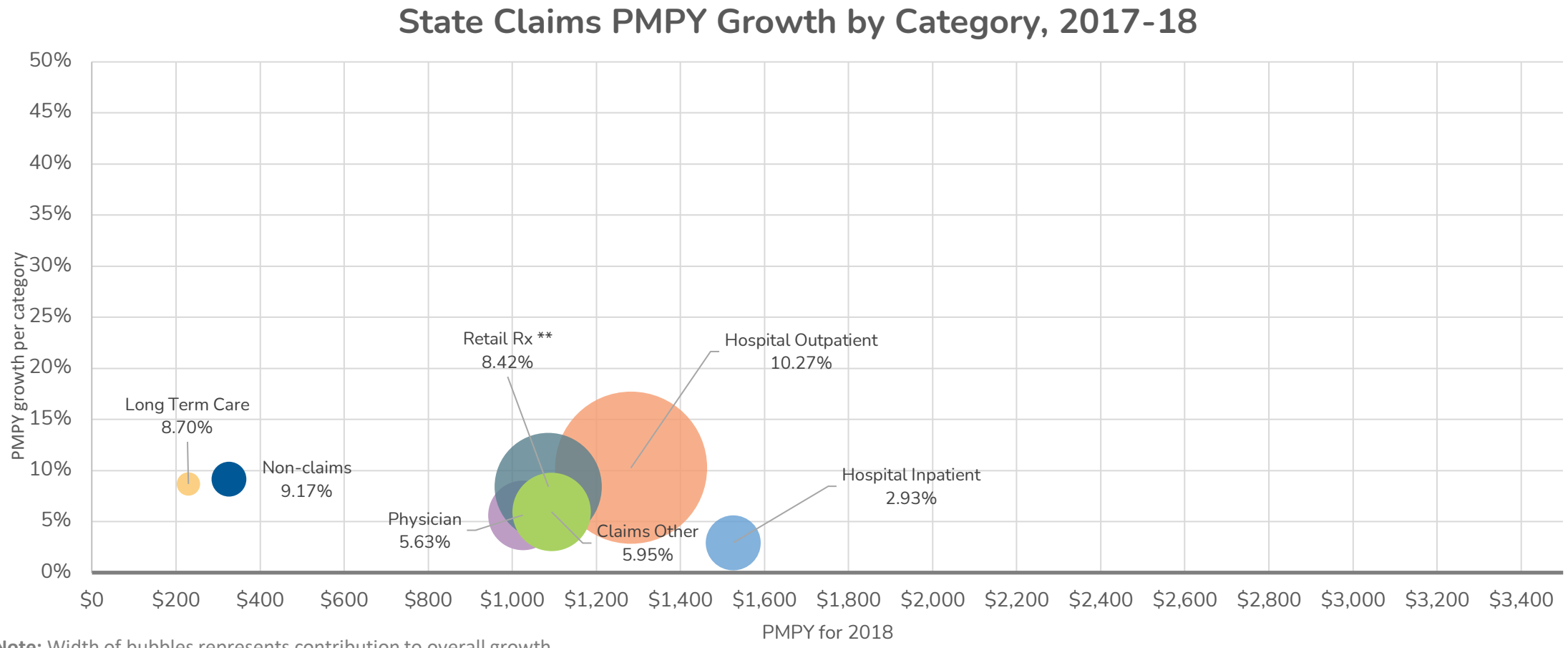


Note: Long term care spending from DSHS is not included

Includes Commercial, Medicaid (MCO & FFS), & Medicare (Adv & FFS).
NCPHI and Other spending is excluded.

Washington State Health Care Authority

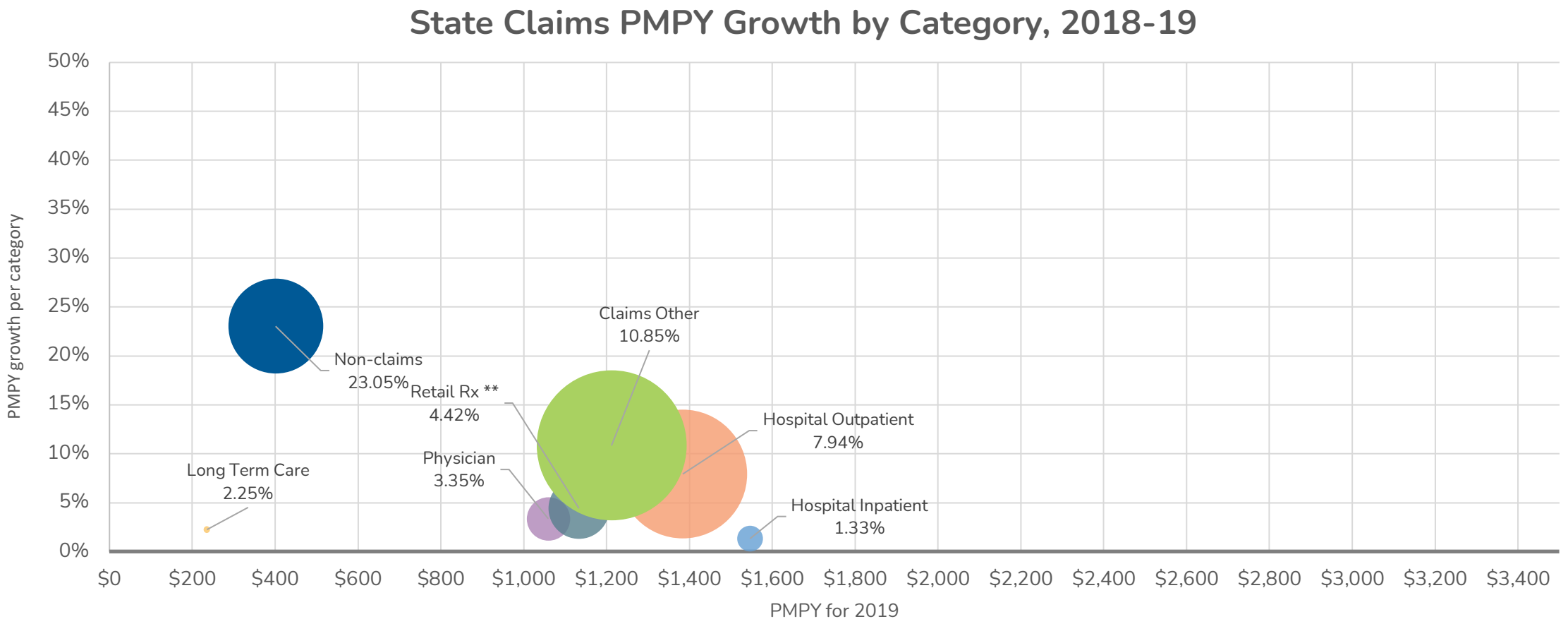
Overall service category contribution to cost growth for 2017 - 2018



Note: Width of bubbles represents contribution to overall growth
Includes Commercial, Medicaid (MCO & FFS), & Medicare (Adv & FFS).
NCPHI and Other spending is excluded.

Washington State Health Care Authority

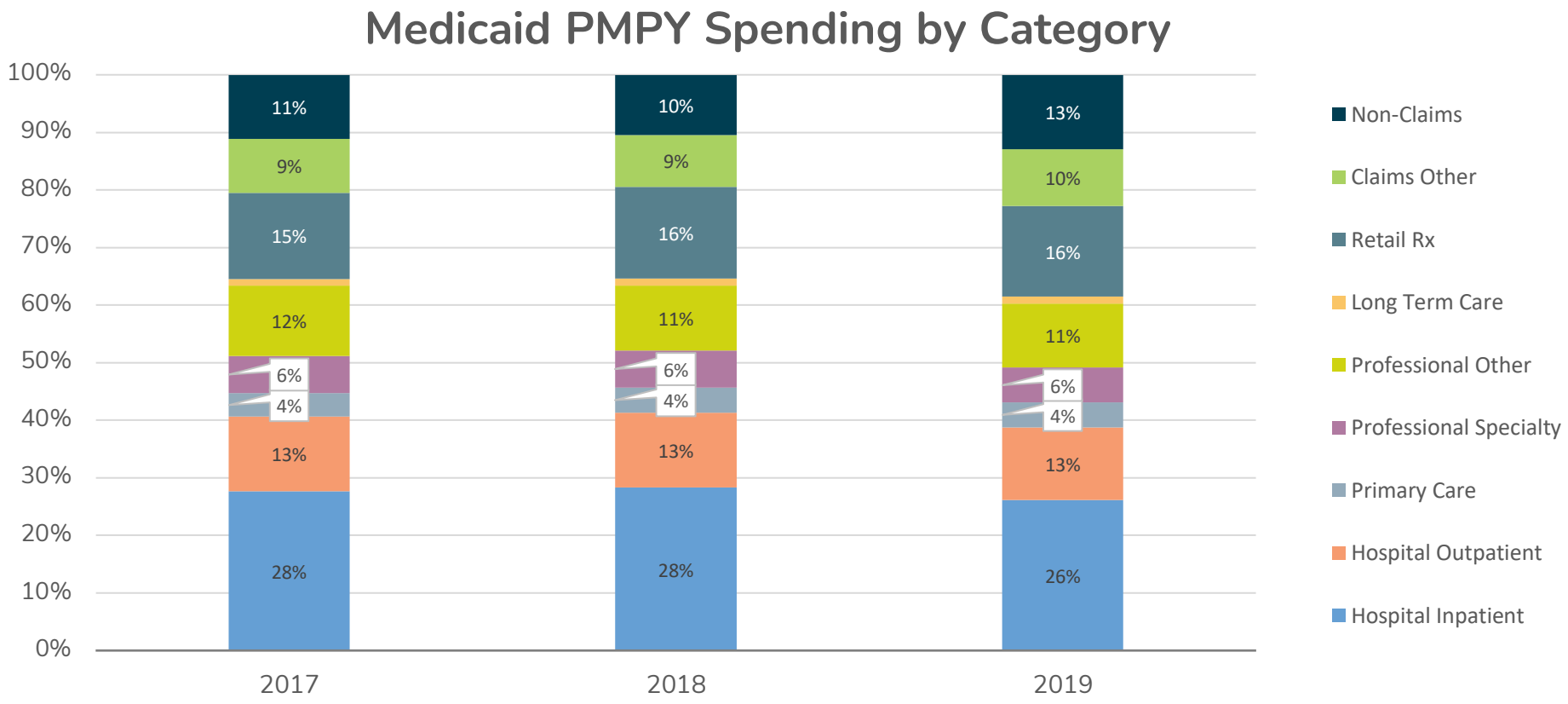
Overall service category contribution to cost growth for 2018 - 2019



Note: Width of bubbles represents contribution to overall growth
Includes Commercial, Medicaid (MCO & FFS), & Medicare (Adv & FFS)
NCPHI and Other spending is excluded.

Washington State Health Care Authority

Medicaid TME category PMPY spending

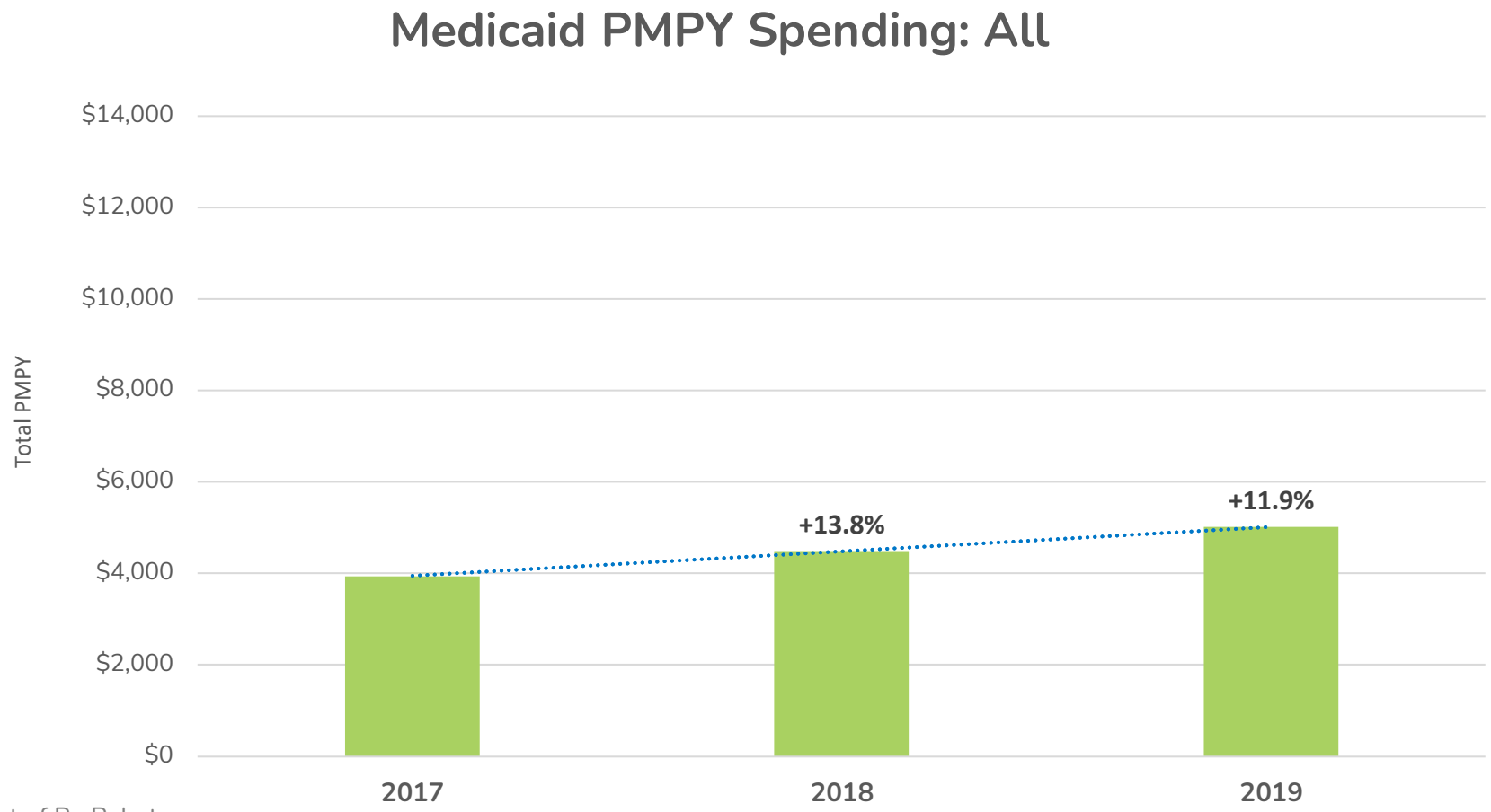


* Net of Rx Rebates
Included Medicaid MC & FFS

Note: Long term care spending from DSHS is not included

Washington State Health Care Authority

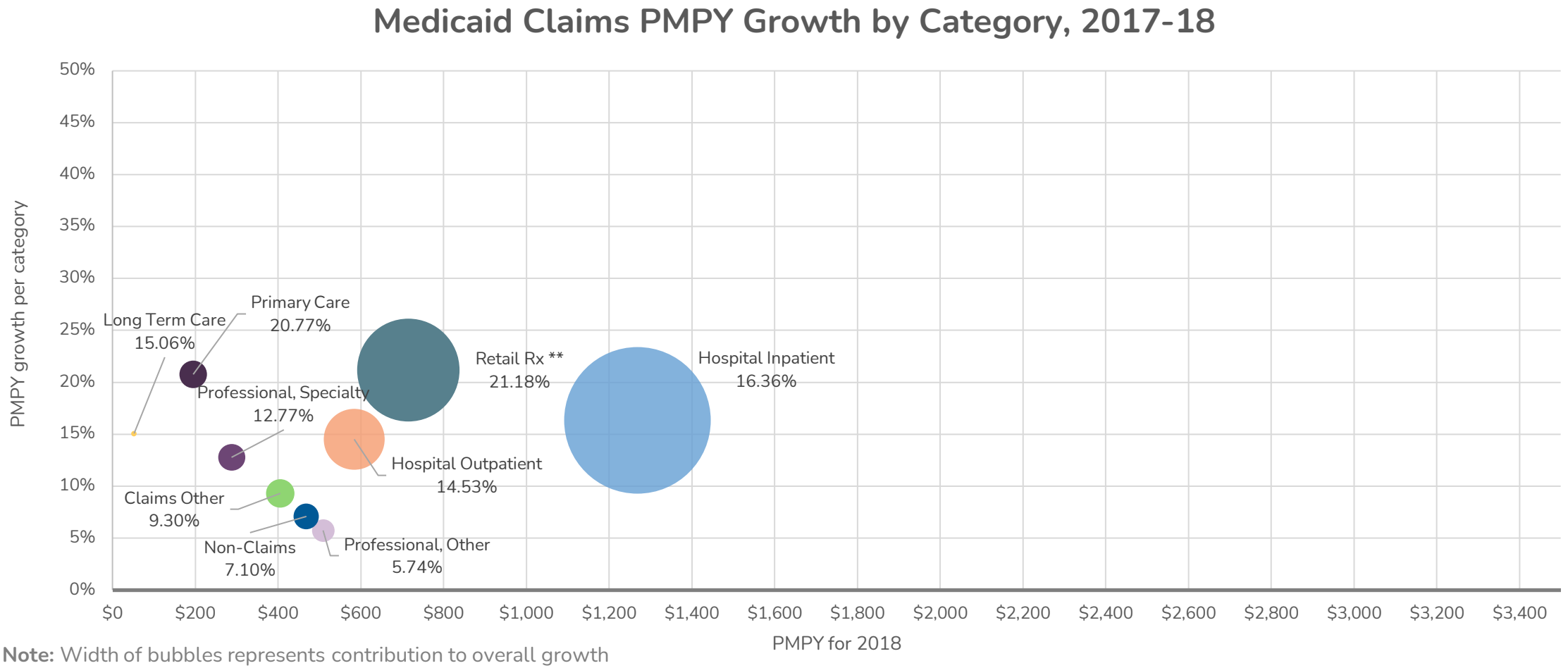
Medicaid PMPY growth



* Net of Rx Rebates
Included Medicaid MC & FFS

Washington State Health Care Authority

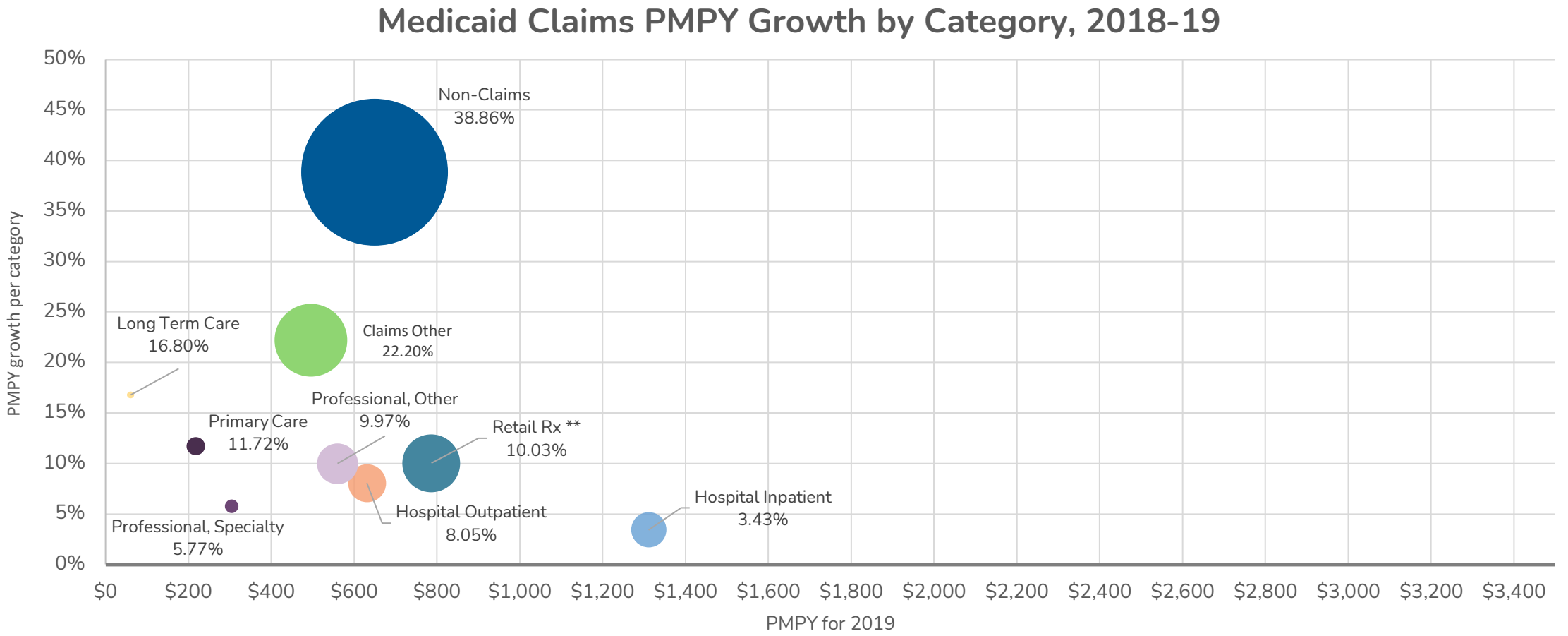
Medicaid service category contribution to cost growth for 2017-2018



Note: Width of bubbles represents contribution to overall growth
Included Medicaid MC & FFS

Washington State Health Care Authority

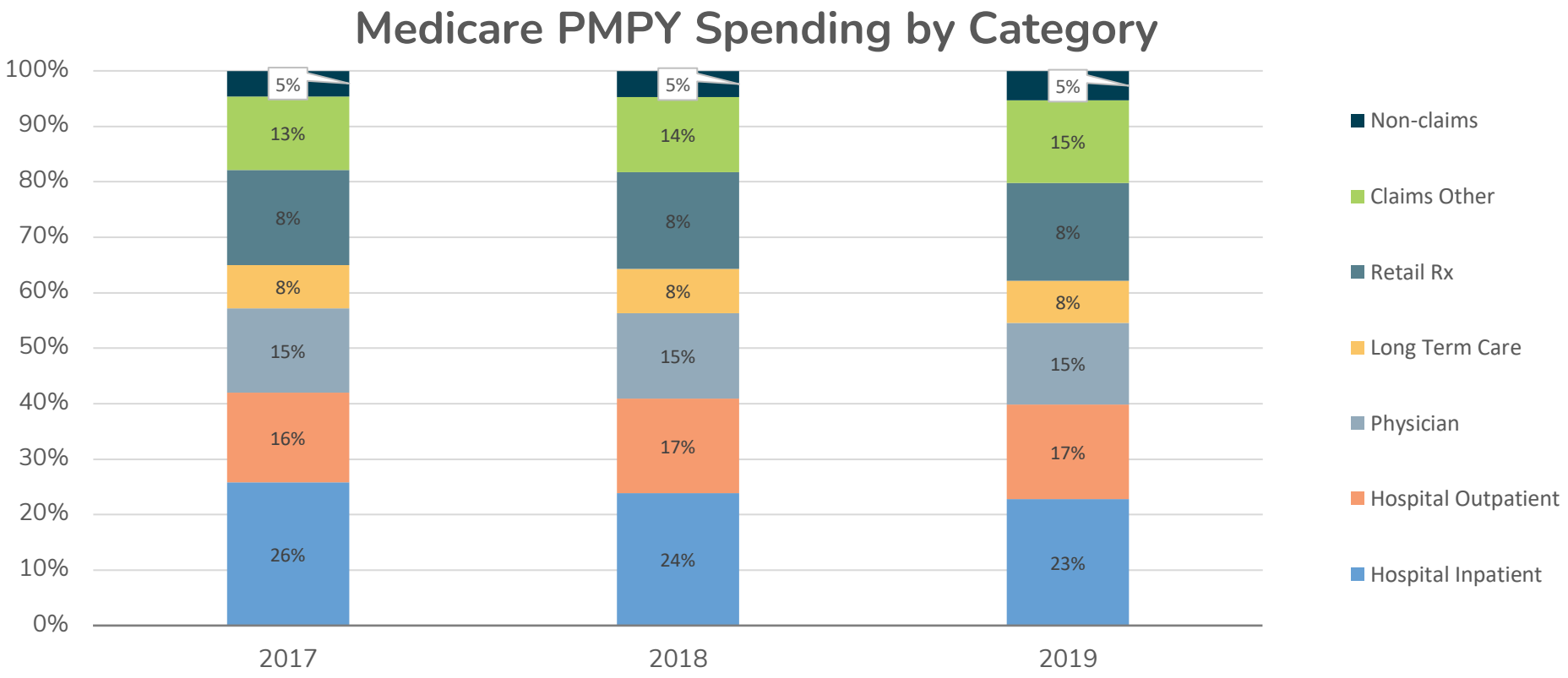
Medicaid service category contribution to cost growth for 2018-2019



Note: Width of bubbles represents contribution to overall growth
Included Medicaid MC & FFS

Washington State Health Care Authority

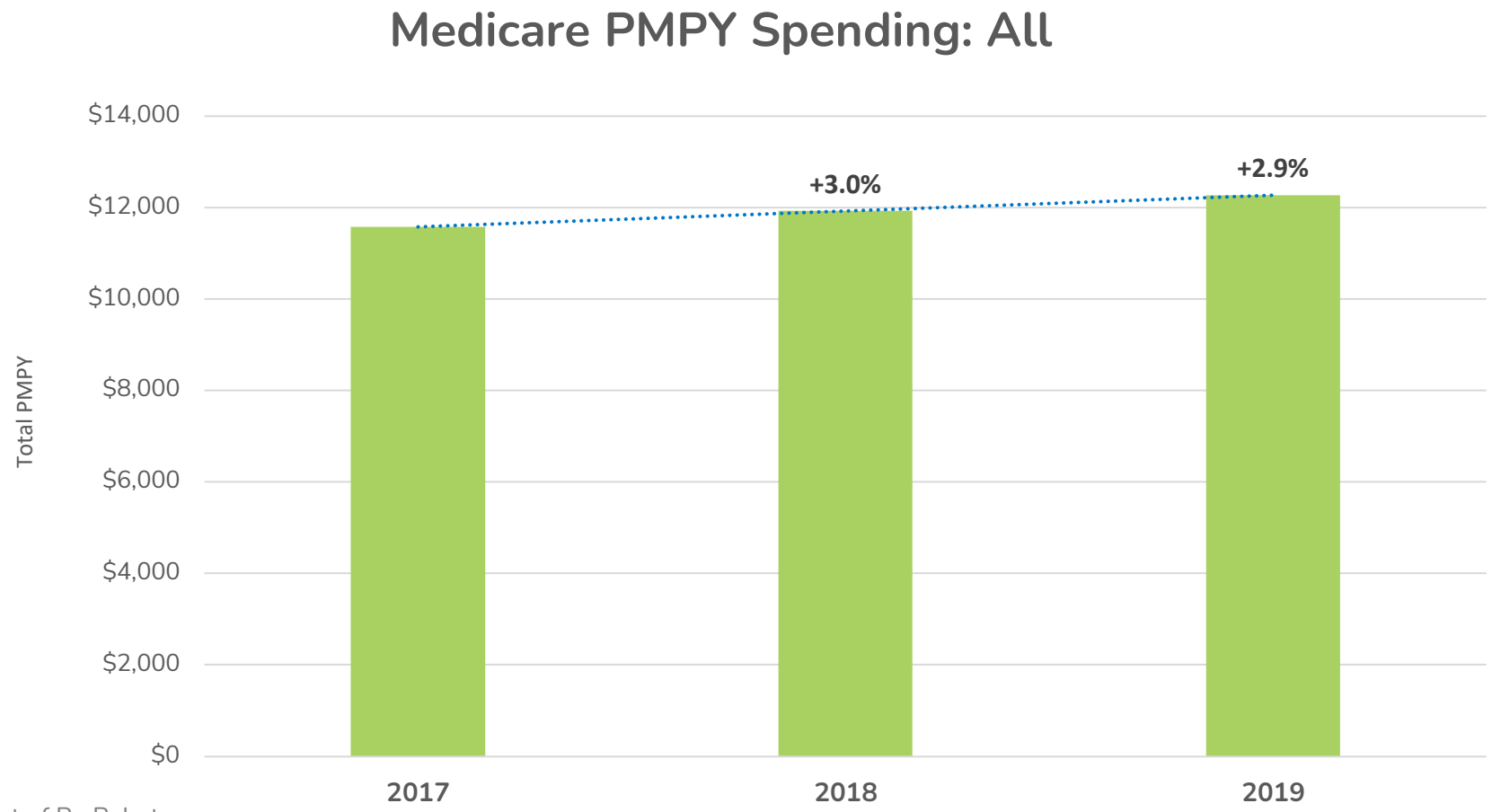
Medicare TME category PMPY spending



* Net of Rx Rebates
Included Medicare Adv & FFS

Washington State Health Care Authority

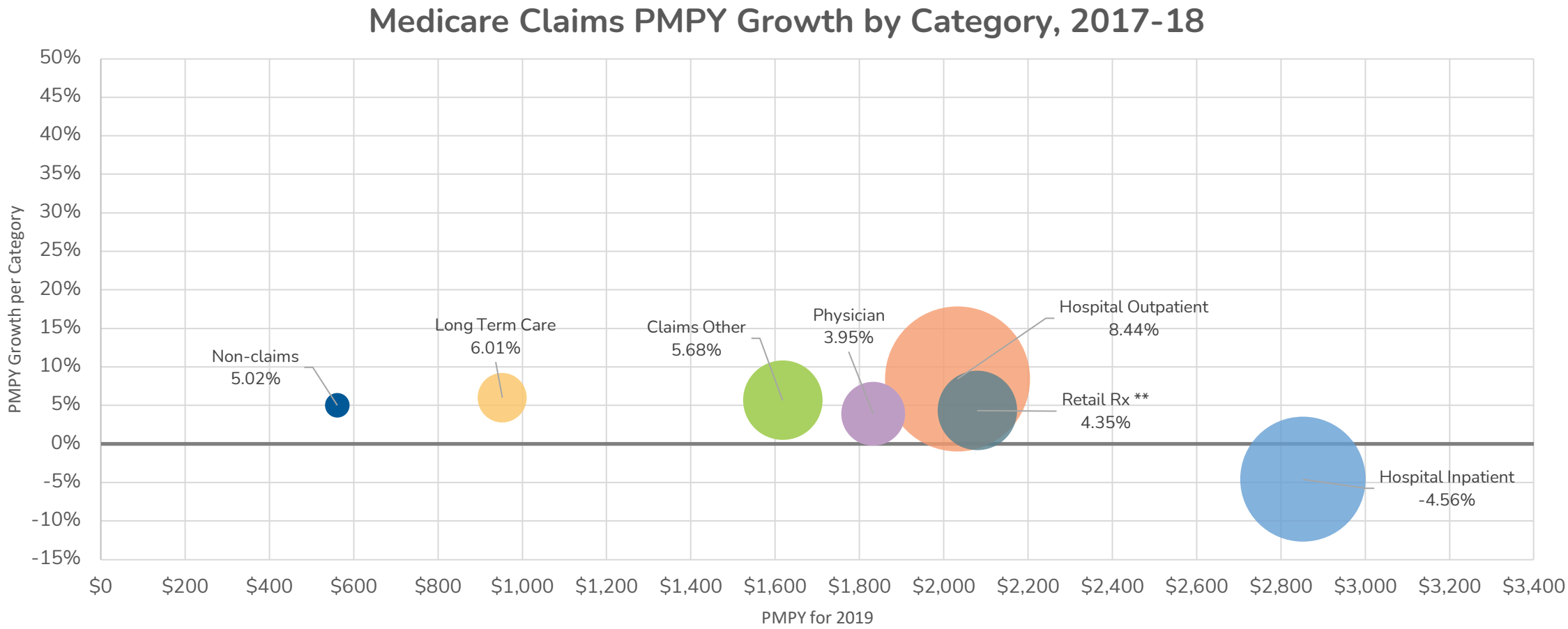
Medicare PMPY growth



* Net of Rx Rebates
Included Medicare Adv & FFS

Washington State Health Care Authority

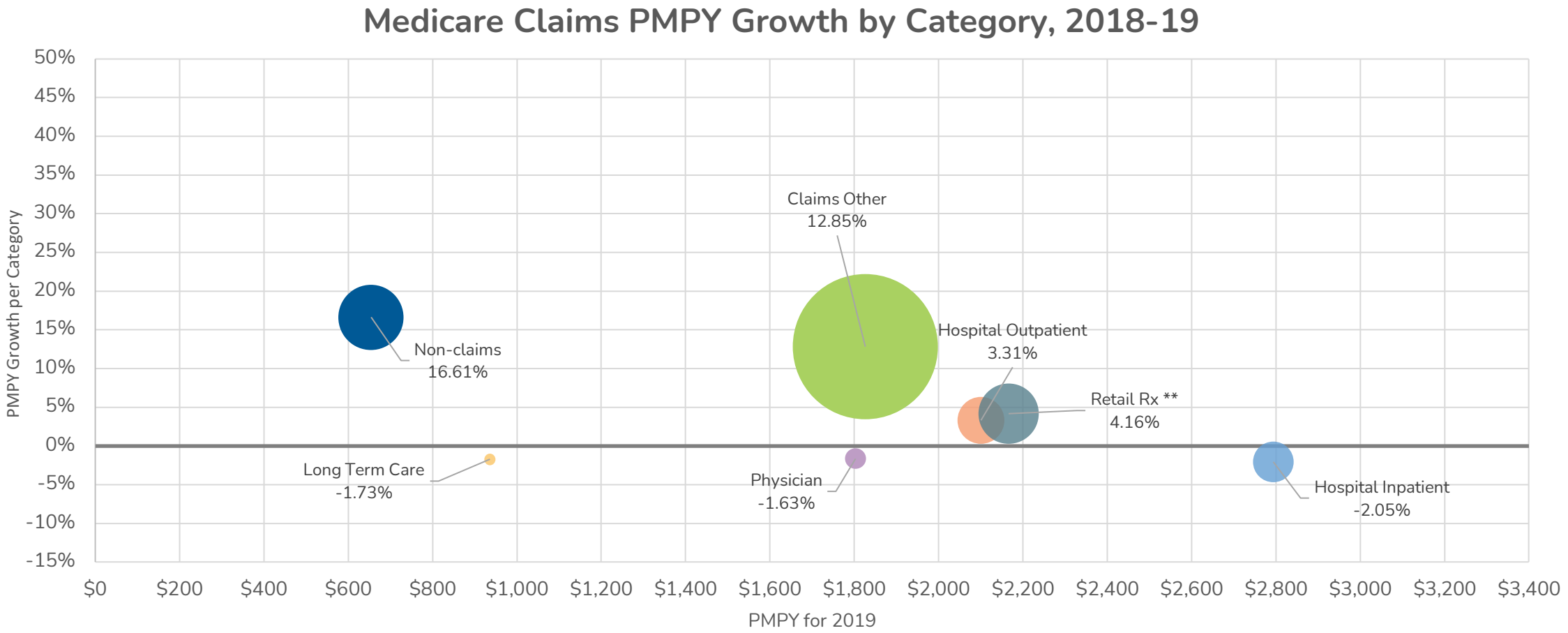
Medicare service category contribution to cost growth for 2017-2018



Note: Width of bubbles represents contribution to overall growth
Includes Medicare Adv & FFS

Washington State Health Care Authority

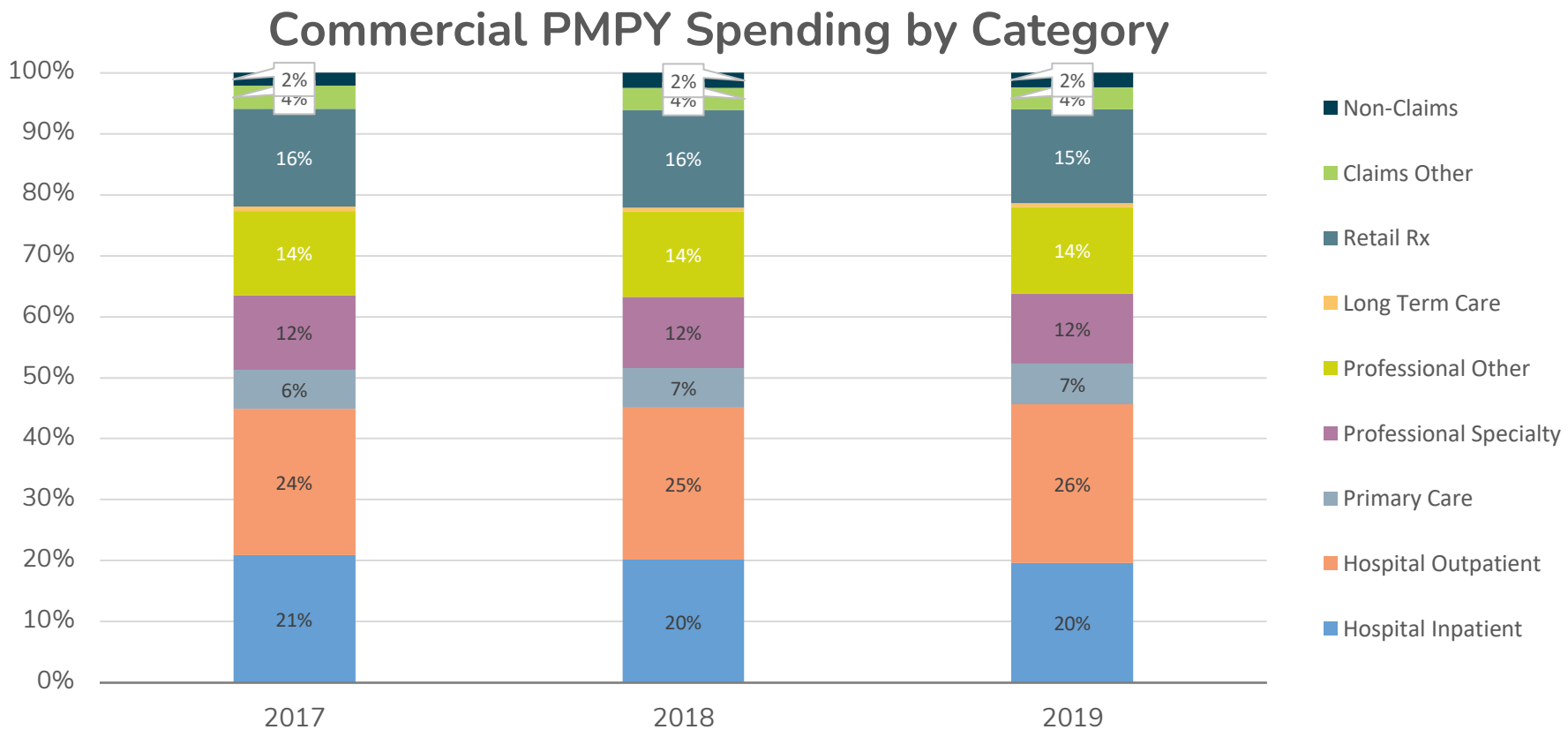
Medicare service category contribution to cost growth for 2018-2019



Note: Width of bubbles represents contribution to overall growth
Includes Medicare Adv & FFS

Washington State Health Care Authority

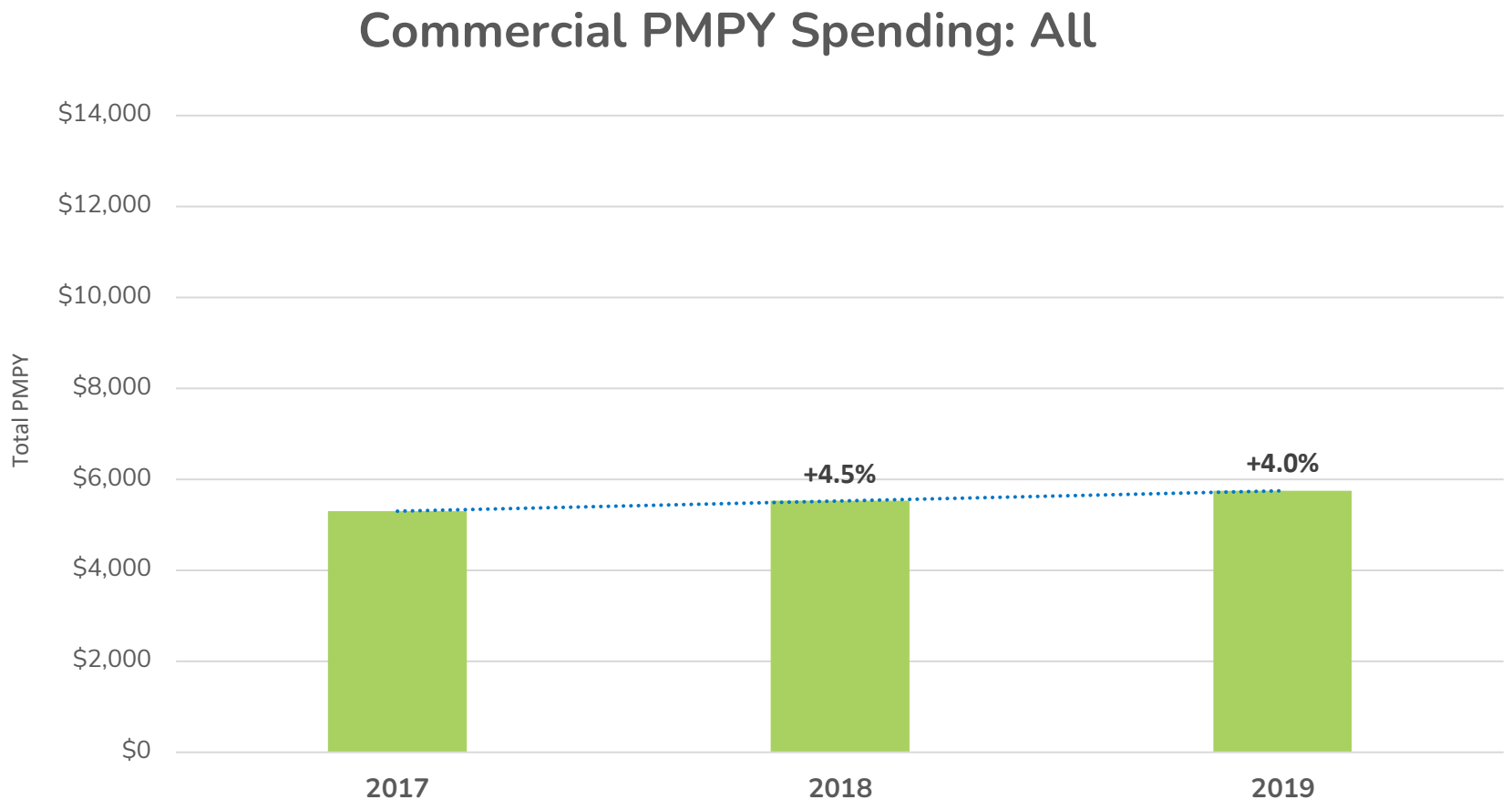
Commercial TME category PMPY spending



* Net of Rx Rebates

Washington State Health Care Authority

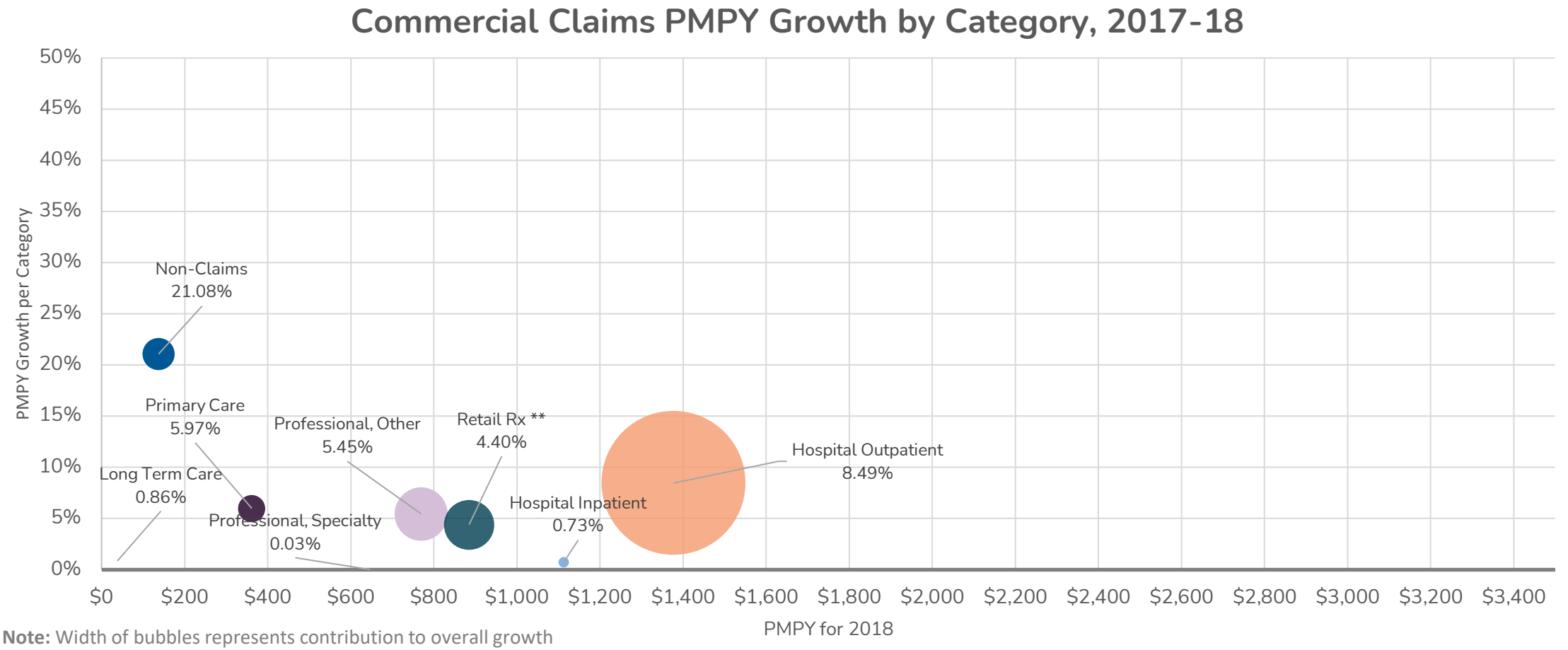
Commercial PMPY growth



* Net of Rx Rebates

Washington State Health Care Authority

Commercial service category contribution to cost growth for 2017-2018

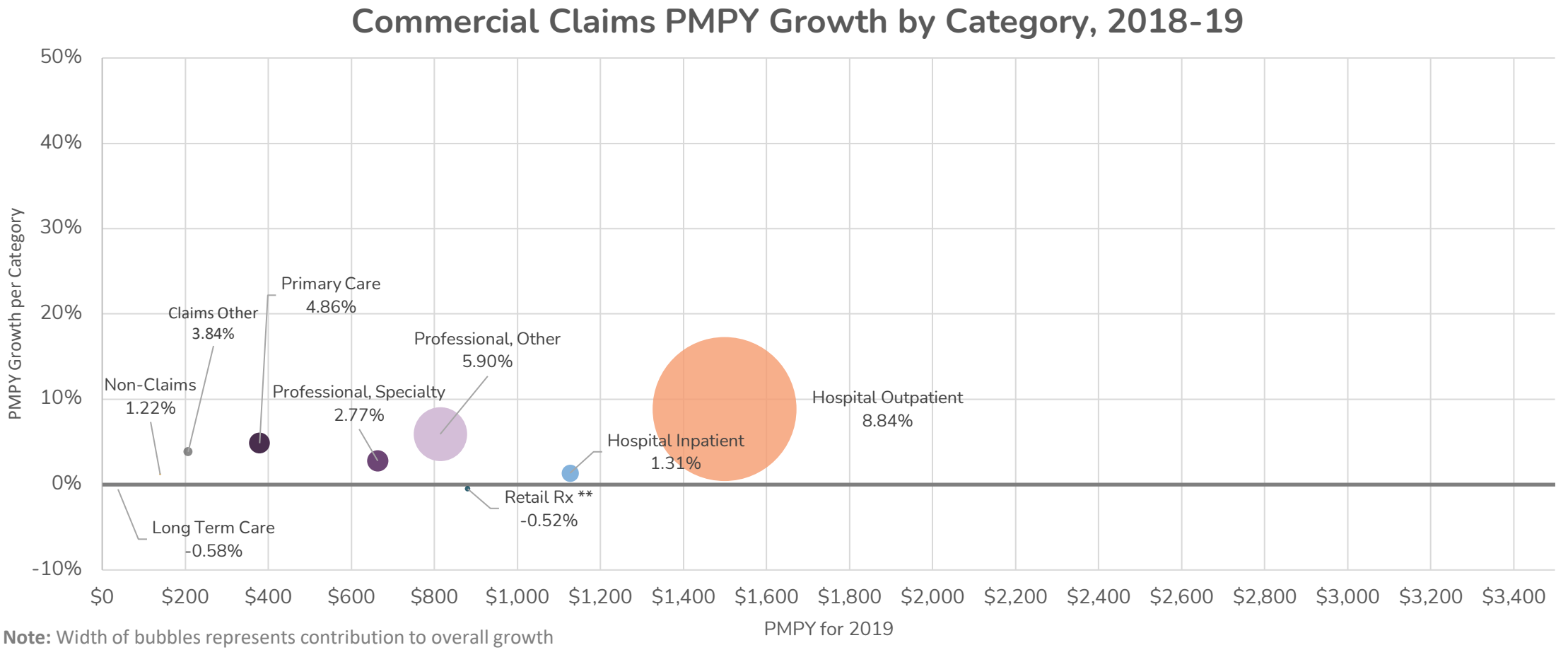


Note: Width of bubbles represents contribution to overall growth

* Net of Rx Rebates

Washington State Health Care Authority

Commercial service category contribution to cost growth for 2018-2019



Note: Width of bubbles represents contribution to overall growth

** Net of Rx Rebates

Washington State Health Care Authority

Thank you for attending the Finance Technical Advisory Committee meeting!

Washington State Health Care Authority