Universal Health Care Commission meeting

December 5, 2024

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Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Universal Health Care Commission

Agenda

Thursday, December 5, 2024

2:00 – 5:00 PM

Hybrid Zoom and in-person meeting

Commission members:		
☐ Vicki Lowe, Chair	☐ Senator Emily Randall	☐ Mohamed Shidane
☐ Senator Ann Rivers	☐ Jane Beyer	☐ Nicole Gomez
☐ Bidisha Mandal	☐ Joan Altman	☐ Omar Santana-Gomez
☐ Charles Chima	☐ Representative Joe Schmick	☐ Stella Vasquez
☐ Dave Iseminger	☐ Representative Marcus Riccelli	

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome and call to order	1	Vicki Lowe, Chair
2:05 – 2:08 (3 min)	Roll call		Mary Franzen, HCA
2:08 – 2:10 (2 min)	Approval of 10/10/2024 Meeting Summary	2	Vicki Lowe, Chair
2:10 – 2:30 (20 min)	State agency report outs	3	Commission members
2:30 – 2:45 (15 min)	Public comment	4	Vicki Lowe, Chair
2:45 – 3:00 (15 min)	FTAC update	5	Pam MacEwan, FTAC Liaison
3:00 – 3:30 (30 min)	State approaches to access and affordability • Potential recommendation	6	Evan Klein, HCA Liz Arjun, Health Management Associates
3:30 – 4:00 (30 min)	Cost containment discussion • Potential decision	7	Liz Arjun, Health Management Associates
4:00 – 4:10 (10 min)	BREAK		
4:10 – 5:00 (50 min)	2025 Goals and planning discussion • Potential decisions	8	Mary Franzen, HCA Liz Arjun, Health Management Associates
5:00	Adjournment		Vicki Lowe, Chair

Tab 2

Washington State Health Care Authority

Universal Health Care Commission meeting summary

October 10, 2024

Hybrid meeting held electronically (Zoom) and in-person at the Health Care Authority (HCA)
2–5 p.m.

Note: this meeting was recorded in its entirety. The recording and all materials provided to and considered by the Commission is available on the Universal Health Care Commission webpage.

Members present

Vicki Lowe, Chair
Bidisha Mandal
Charles Chima
Dave Iseminger
Jane Beyer
Joan Altman
Representative Joe Schmick
Representative Marcus Riccelli
Mohamed Shidane
Nicole Gomez

Members absent

Senator Ann Rivers
Senator Emily Randal
Omar Santana-Gomez
Stella Vasquez

Call to order

Vicki Lowe, Commission Chair, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

Chair Vicki Lowe welcomed Commission members to the 20th meeting of the Universal Health Care Commission. Chair Lowe shared comments on beginning meetings with land acknowledgements, as a means of increasing and maintaining awareness of past inequities, and to inform work aimed at reducing and preventing current and future inequities.

Chair Lowe introduced new health policy analysts from the Health Care Authority (HCA), assigned to work with the Commission, Todd Bratton and Ally Power. Chair Lowe shared that Mandy Weeks-Green will be leaving her

position at the HCA as Cost Board and Commissions Director. Chair Lowe thanked Mandy for her great work and support since the Commission was created.

Meeting summary review of the previous meeting

The Commission members voted by consensus to adopt the August 2024 meeting summary.

Public comment

Marcia Stedman, member of Health Care for All - Washington, urged more action from the Commission and asked legislators on the Commission to consider introducing legislation regarding transitional solutions. including Medicaid expansion for undocumented residents, PEBB/SEBB consolidated purchasing, and creation of a Medicaid – Health Benefit Exchange enrollment bridge.

Kathryn Lewandowski, member of Whole Washington, expressed gratitude for volunteers and others working on universal healthcare and frustration regarding the permanence of the current for-profit health care system and its negative impacts on patients and providers.

Maureen Brinck-Lund, affiliated with Health Care is a Human Right and League of Women Voters, noted the work of the Universal Health Care Work Group and urged the Commission to establish a vision around this work, including selecting a single universal health care model, defining detailed operational plans, and establishing policies to ensure health care reform goals are achieved.

Project Status Update

Health Management Associates (HMA) provided an overview of progress within the three workstreams 1. Design of a universal system. 2. Recommending transitional solutions. 3. Evaluation of the Washington Health trust proposed legislation.

The first workstream, focused on system designs, includes three phases. The Commission is currently engaged in Phase 1, which includes work on benefits and services, provider reimbursement and participation, eligibility, financing, and cost containment. In this phase, the Commission has completed its initial work on eligibility and is currently reviewing benefits and services modeling, cost estimates, cost containment, and patient cost sharing.

In the second workstream, focused on transitional solutions, the Commission prioritized three topic areas, including administrative simplification, maximizing and leveraging current programs, and topics being addressed across agencies or in the state legislature. In this workstream, the Commission has been reviewing prior authorization issues and considering support for Apple Health Expansion.

Finance Technical Advisory Committee (FTAC) updates: Cost sharing principles

Pam MacEwan, FTAC Liaison

Pam MacEwan, FTAC Liaison, shared an update. Under workstream 1, FTAC is currently engaged in an analysis and evaluation of benefit design modeling and exploring cost sharing principles. Mary Franzen from HCA shared the population and benefits and services that FTAC will be using to estimate cost scenarios. Pam MacEwan confirmed that the analysis will address consideration of ERISA-restricted populations in the modeling. She also discussed FTAC's work to understand cost sharing through review of available research and approaches. She shared the draft principles of cost sharing developed by FTAC.

Commission discussion on FTAC's cost sharing principles

Commission members verified the benefit and service modeling scenarios and confirmed that some other universal systems utilize a sliding scale in their cost sharing models. Members confirmed that the modeling will allow consideration and opt-in for individuals in self-funded ERISA plans.

Commission members requested that principle 1 and 3 be combined and that principle 4 be revised to include providers.

The revised principles of cost sharing are as follows:

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

Commission members voted to approve the cost sharing principles, as amended, for use in the benefit analysis, and to seek additional resources and information regarding impacts of various approaches.

Approval of 2024 annual report to the legislature

The Commission voted by majority to approve sending the report to the legislature with no additional revisions.

State agency report outs

Department of Health (DOH) - Dr. Charles Chima reported on DOH efforts to address access and health care workforce shortages. Over the summer, DOH finished the rulemaking process for the department's J1 Visa Program. Efforts are currently focused on helping rural communities take advantage of this workforce recruitment program. Dr. Chima noted DOH is currently preparing for the legislative session.

Health Benefit Exchange (HBE) - Joan Altman reported that HBE is preparing for open enrollment from November 1, 2024 through January 15. 2025. HBE recently finalized and certified plan rates and subsidy amounts for 2025. HBE is under legislative directive to study auto-enrollment options for moving individuals to exchange plans when they lose eligibility for Medicaid. HBE is working with other states and reviewing data for the auto-enrollment report. HBE is also reaching out to immigrant communities, specifically targeting individuals who are newly eligible for federal subsidies due to changes in DACA (Deferred Action for Childhood Arrivals).

Health Care Authority (HCA) - Dave Iseminger reported that PEBB/SEBB is currently doing outreach for open enrollment from October 28 through November 25. HCA is also preparing for the upcoming legislative session. HCA has prepared more than 50 decision packages, including policy ideas and potential agency request legislation topics. Items include contracting terms for PEBB/SEBB and providers. More than 40 HCA agency reports are due to the Legislature in November and December, including the PEBB/SEBB consolidated purchasing report. The agency is also addressing network termination and provider contracting issues with legislators and the OIC.

Office of the Insurance Commissioner (OIC) - Jane Beyer reported that the OIC is implementing legislation and rulemaking on bills passed last session, regarding prior authorization, ground ambulance balanced billing, and health care benefit managers. The OIC is monitoring ongoing conversations among carriers and the legislature regarding prior authorization and alignment with federal requirements and timelines. OIC completed its affordability report and the maternity care services report. Staff are currently working with DSHS on studying coverage of essential workers and nursing home workers. OIC is also working on a cost analysis for adding

palliative care to exchange plans. OIC is studying access issues for reproductive services which are required to be covered by plans. Additionally, OIC is conducting outreach and working to simplify processes for reproductive benefit reimbursement.

Representative Riccelli offered thanks to those who participated in the Health Care and Wellness Committee work session. He noted that access to care is front and center and will be in focus during the next legislative session.

Apple Health Expansion

Becky Carrell, Deputy Director, Medicaid Programs Division, Washington State Health Care Authority, presented information on Apple Health Expansion efforts as a refresher for members who missed her presentation at the August meeting. Carrell noted the eligibility and enrollment information for the program since enrollment began in June. The program enrolled more than 12,000 individuals and was closed as funding was depleted. Individuals attempting to enroll going forward are placed on a wait list and may be selected randomly to enroll as funding becomes available. HCA has requested an increase in funding to allow enrollment of an additional 14,000 individuals by 2027.

Commission discussion: Apple Health Expansion

The Apple Health Expansion request is the second highest priority among over 50 decision packages going to the legislature from the Health Care Authority. Several Commissioners shared their support for expansion, while noting support of many other competing budget priorities for addressing access, affordability, and quality of care. Due to budget constraints, several members agreed that support for Apple Health expansion should include context, that other priorities will also need support.

Motion: The Commission continues its support for the Apple Health Expansion program, including recommending additional funding for this program. The Commission voted in favor of the motion. Abstain: Representative Riccelli and Representative Schmick.

OIC Affordability report

Commission Member Jane Beyer presented the OIC health care affordability report, which provides policy options for improving affordability, including establishment of a reinsurance program, increasing the medical loss ratio standard, using reference-based pricing, utilizing hospital global budgeting, and meeting the Health Care Cost Transparency Board targets The aim of the OIC report is to inform the legislature of the policy options available for containing health care costs in Washington. Commission Member Beyer presented the report's analysis for each policy option.

Possible benefits of implementing a reinsurance program include reduction in unsubsidized premiums, potential increase in enrollment, and a large impact on middle-income consumers. Reinsurance programs have been successfully implemented in 17 states. Disadvantages of the programs may include the requirement of significant investment, limited impact on lowest income consumers, and insurers may be more conservative in their assessment of the impact.

Another policy option would include an increase to the Medical Loss Ratio Standard. Current law caps the percentage of collected premiums that insurers may spend on administration. The report noted that nearly all Washington insurers routinely perform better than proposed increases and savings may be limited. This is also the case in most other states.

Other states, including Oregon and Montana, have implemented successful reference-based pricing (RBP) models with buy-in from providers. In Washington, there is a proposal to use RBP for some benefits and services in the PEBB/SEBB plans. Reference based pricing is currently used for the public option program (Cascade Select). Commission members verified that some service providers could be exempted from price caps if access were an issue. Cost savings would depend on how the program is designed. One significant advantage is the ability to cap what providers charge, rather than what insurers pay. Other advantages include incentivizing

certain services (for example primary care) and it may increase price transparency. Disadvantages include the complexities of implementation and possible disruptions in the health care delivery system.

The OIC report also studied the potential impacts of setting global budgets for hospitals. Washington set global budgets for hospitals in the 1970s and 1980s, but that program was repealed in 1989. Maryland is the only state that currently sets global budgets for hospitals. Potential advantages include the possibility of a large effect, and possibility of incentivizing primary care, behavioral health, and other high value services. Disadvantages include the complexity of implementation, rigid budgets could impact hospital financing (flexibility could be built in), and the work required to receive a federal waiver to include Medicare/Medicaid.

The report also addressed the impact of meeting cost growth targets set by the Health Care Cost Transparency Board. If benchmarks were met, there would be between $1-2 billion in savings annually. These savings would continue over time. Advantages include that it is estimated to have the greatest impact on cost, be the least intrusive mechanism, and most flexible approach. Disadvantages include difficulty of enforcement, may protect high-cost providers and insurers, and it is the least targeted approach.

Administrative Simplification - Prior Authorization

Commission members were presented with information on prior authorization policies not currently used in Washington, including gold carding and standardized forms.

Gold carding programs aim to reduce prior authorization requests by exempting providers that have high approval rates over time. Several states have implemented gold carding programs, yet data on effectiveness and benefits is limited and anecdotal. Pros include possible reduction in administrative burden, may improve access and efficiency, and could improve health outcomes. Potential disadvantages include effectiveness if confusion about authorization persists. More data will be needed to understand impact on patients and providers.

New legislation and rulemaking require standardization of prior authorization processes. Washington enacted E2SHB 1357 in 2023 which requires automation and interoperability of prior authorization processes across payers. Washington’s law put the state on schedule to meet new federal requirements for prior authorization. The new rules require standardization of processes but not necessarily a standard form. Several states have adopted standardized form legislation and rules. It may be difficult for a standardized form to meet all the criteria required by payers for the request. Currently the OIC and HCA are working with payers and providers on standardization of prior authorization in substance use disorder (SUD) treatment.

Commission discussion - Prior Authorization

Commission members recalled prior authorization information presented on approval rates, utilization issues, provider frustrations with transparency and decision making, and opportunities for improvement. **Commission members expressed interest in seeing more evidence on the approaches to gold carding and standardized forms in other states, as well as data on approval rates, costs and impacts across payers and providers. They also discussed addressing specific benefits and services which could be targeted due to issues such as high approval rates or access concerns. This topic was forwarded to the FTAC to explore the potential impacts of these programs, to aid in consideration of transitional solutions and the role of prior authorization in a universal system.**

Next steps

Commission members discussed their next steps in designing the universal system and recommending transitional solutions.

Regarding the OIC report on affordability, Commission members requested more information about reference-based pricing and cost containment efforts with the Health Care Cost Transparency (HCCT) Board. Commission members will be sent an email invitation to the next HCCT Board public hearing in December. HCA will add topical information to future agenda planning.

Commission members recommended providing clear status updates to the public, specifically covering progress on the design of a universal health care system.

Commission members requested information on primary care utilization efforts and access, and an interest in transitional solutions for small businesses based on historical efforts and challenges. Staff will work to bring information on these topics forward in future meeting agendas.

Adjournment

Meeting adjourned at 5:08 p.m.

Next meeting

December 5, 2024
Meeting to be held on Zoom and in-person at HCA
2–5 p.m.

Tab 3

State agency report outs

Washington State Health Care Authority

Tab 4

Public comment

Washington State Health Care Authority

Universal Health Care Commission
Written Comments
Received From September 26

Written Comments Submitted by Email

C. Currie, Health Care For All - Washington.......1
J. Shepard, Washington State Medical Association.......2
H. Twitchell.......3
T. Chamberlain.......4

Additional Comments Received at the October Commission Meeting

- The Zoom video recording is available for viewing here: https://www.youtube.com/watch?v=yKuOREyB5c0

From: Cris
To: HCA Universal HCC
Subject: Public Comment
Date: Wednesday, October 23, 2024 12:03:22 PM

External Email

UHCC:

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

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

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

Washington State Medical Association
Physician Driven, Patient Focused

October 31, 2024

Universal Health Care Commission
Washington State Health Care Authority
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Dear Universal Health Care Commission,

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

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

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

Prior authorization

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

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

Gold carding

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

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

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

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

Standardized prior authorization forms

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

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

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

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

Sincerely,

Jeb Shepard
Director of Policy
Washington State Medical Association

From:	Heather Twitchell
To:	HCA Universal HCC
Subject:	Implementation of universal state healthcare
Date:	Thursday, November 7, 2024 9:38:31 PM

External Email

Hello

It's with great concern that I am emailing you. With Trump winning the presidential election, now more than ever our state is going to need this implemented!
Millions of Washington residents will be affected if the ACA is appealed. We won't only be losing healthcare but those who have preexisting conditions are more affected

Thank you.

Heather Twitchell

Get Outlook for iOS

From:	Tyler Chamberlain
To:	HCA Universal HCC
Cc:	Liias, Marko; Cruz-Mendoza, Samantha (LEG)
Subject:	Plans to replace the ACA at the state level?
Date:	Saturday, November 9, 2024 9:08:45 AM

External Email

Hello Universal Health Care Commission,

Given the current political landscape and those set to control the house, senate, and POTUS at the federal level, I am in fear for all of my friends and family that rely on the ACA for health insurance. The Republican party has made it clear that they want to dismantle the ACA and "replace it with something better." Now they will have the power to do exactly that with full control of the legislative, executive, and judicial branches of the Federal government.

I am not typically a political person, so reality is starting to hit me now in understanding the repercussions this recent election has for my loved ones. I was happy to see that our state has *something* in the works for Universal Healthcare. Does the recent power change at the federal level change the urgency for Universal Healthcare initiatives in our state because the its not a matter of if, but when, the ACA will be dismantled?

Also CC'ing my state representatives that I found on leg.wa.gov

Tab 5

Washington State
Health Care Authority

FTAC Update

Pam MacEwan, *FTAC Liaison*

November FTAC meeting topics

- Initial discussion of prior authorization
- Cost modeling and cost containment
  - Update on Milliman work
  - Introduction to reference-based pricing as one possible cost containment mechanism

Prior authorization

- Interest in continuing the discussion about prior authorization
  - Initially considered an interim solution
    - Gold carding
    - Standardized forms
  - FTAC members noted that prior authorization changes could be part of cost containment model, which was also part of the November agenda
- Prior authorization was discussed late in the meeting, so conversation was cut short

Cost modeling and cost containment

- FTAC liaisons continue to guide the cost modeling work undertaken by Milliman
- Slight delay in schedule due to data-sharing requirements
  - Final results expected to be presented to FTAC in March 2025

Cost modeling and cost containment

- Initial topic: reference-based pricing
  - Following direction during the October Commission meeting, FTAC began its examination of reference-based pricing
  - FTAC member Robert Murray presented on cost containment models in general, with a focus on reference-based pricing
  - **FTAC agreed with the following, by consensus:**
    - Recommend UHCC consider supporting transitional efforts which utilize reference-based pricing.
    - Recommend UHCC consider including reference-based pricing and other cost containment strategies for universal design.
    - FTAC will continue exploring cost containment strategies as directed by the Commission.

Additional cost containment mechanisms

- Public utility model
  - Structure health care costs similar to other public utilities, such as electricity and water
  - Typically government entities set standardized prices
- Price caps
  - State/public employee health benefit programs
  - Out-of-network care
  - Hospital global budgeting

Looking ahead: January 2025 FTAC meeting

- Develop recommended prioritization of included benefits and services
- In the Universal Health Care Work Group final report, both Model A (state administered) & Model B (administered by managed care plans) included the same set of benefits:
  - Essential health benefits as defined by ACA
  - Dental for Medicaid-eligible only (dental for others is priced separately)
  - Vision
  - Long-term care for Medicaid-eligible only

Tab 6

PEBB/SEBB
Access & Affordability

Washington State
Health Care Authority

Topics for Discussion

- PEBB & SEBB Access & Affordability
  - Background
  - Reference Pricing Background
  - Summary of Bill
  - Goals & Expected Impacts
- Questions

PEBB & SEBB Access and Affordability

Background

- Recent contract termination notices by large health systems
- Hospital services have largest growth in claims cost & impact on premiums
- PEBB & SEBB rates grew by ~20% from 2021-2024
- WA increased Medicaid payments to hospitals by over $1.3 billion per year starting in 2024
- WA, OR, and other states have found success with reference pricing to contain costs
- Reimbursement for Primary Care and Behavioral Health services lag significantly behind hospital reimbursement, despite benefits of preventive care access

**Rate of growth refers to bid rates, inclusive of fully-insured and UMP plans and averaged across PEBB & SEBB*

Reference Pricing

- Reference pricing is a concept in health care where a standard reimbursement level is established for payment of certain services, such as hospital care. The reference point, or price, is tied to an already defined pricing level, such as Medicare reimbursement rates.
- UMP reimbursement as % of Medicare (2023)
  - Facility IP/OP: ~210%
  - Behavioral Health: ~109%
  - Primary Care: ~150%

State Approaches to Reference Pricing

- Washington's Cascade Select Program
  - Individual Market Public Option
  - Caps payment for all services, in aggregate, at 160% of Medicare
    - Primary Care must be at/above 135% of Medicare
    - CAH/SCH must be at/above 101% of cost
  - Statewide access by 2025 & lowest cost silver plan in 31 counties
- Oregon's PEBB/OEBB Reference Price Law
  - Passed in 2017, took effect in Oct 2019
  - Caps hospitals from charging more than 200% of Medicare
  - Exempts small/rural hospitals
  - Audit found projected savings of $112.7 million in 2021

https://www.oregon.gov/oha/PEBB/MeetingDocuments/PEBB-Board-Agenda-Attachments-20221018.pdf

State Approaches, continued

State	Mechanism	Year Adopted	Covered Program	Number of Covered Facilities	Rates Established (% of Medicare)
CO	Legislation	2021 (effective 1/1/2023)	CO Standardized Health Benefit Plan	n/a	Requires premium reduction targets relative to 2021 plan year. For 2025, premiums must be 15% below 2021 premiums. Sets minimum hospital reimbursement at 155% of Medicare. Certain types of hospitals are eligible for adjustments that increase their baseline rates.
MT	Contract	2014 (eff. 1/1/2016)	State of Montana (Employee) Benefit Plan	11 acute care hospitals	Hospital inpatient range: 220-225% of Medicare; Hospital outpatient range: 230-250% of Medicare
NC	Contract	2020 (eff. 1/1/2021)	State Health Plan for Teachers and State Employees	26,000 providers including 5 hospitals	196% of Medicare for hospital inpatient/outpatient aggregate
NV	Legislation	2021 (eff. 1/1/2026)	Nevada Public Option	n/a	Reimbursements must be comparable to, or “better than,” those paid by Medicare

Washington State Health Care Authority

Summary of Bill

- Applies to all fully-insured & self funded medical plans
- Requires hospitals to participate in-network upon good faith offer to contract from carrier/TPA
- Caps carrier reimbursement for inpatient/outpatient hospital services at 200% of Medicare, beginning in 2027
  - Requires CAH/SCHs to be reimbursed at no less than 101% of allowable costs
  - Sets cap for Children's hospitals at 350% of Medicare
- In 2029, reduces IP/OP hospital cap to 190% of Medicare and reduces Children's hospitals cap to 300% of Medicare

Summary of Bill, cont’d

- Requires Primary Care and non-facility Behavioral Health Services be reimbursed at/above 150% of Medicare
- Requires all carriers take into account changes in reimbursement from this legislation in future rate development cycles
- Requires a report by HCA in 2030 on impacts of legislation

Goals & Expected Outcomes

- Maintain access to critical hospital services
- Increase access to behavioral health and primary care services
- Contain costs for employees & the state

- Initial modelling of 2023 UMP data suggests
  - Net cost avoidance in 2027 of $56 million
  - Net cost avoidance in 2030 of $151 million
  - Increased investment in BH services of over $23 million each year

Questions?

Contact

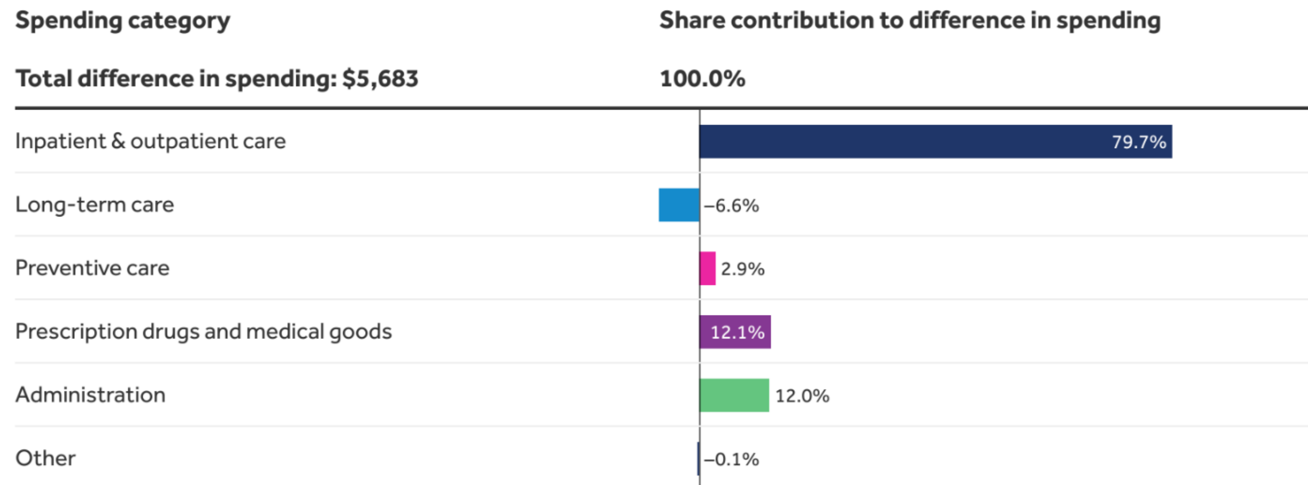
- Evan Klein
  - Special Assistant for Legislative and Policy Affairs
  - Evan.Klein@hca.wa.gov

Discussion

- Does the Commission want to take a position on the bill that was described?
- What additional information would the Commission like to have on this topic?

Appendix

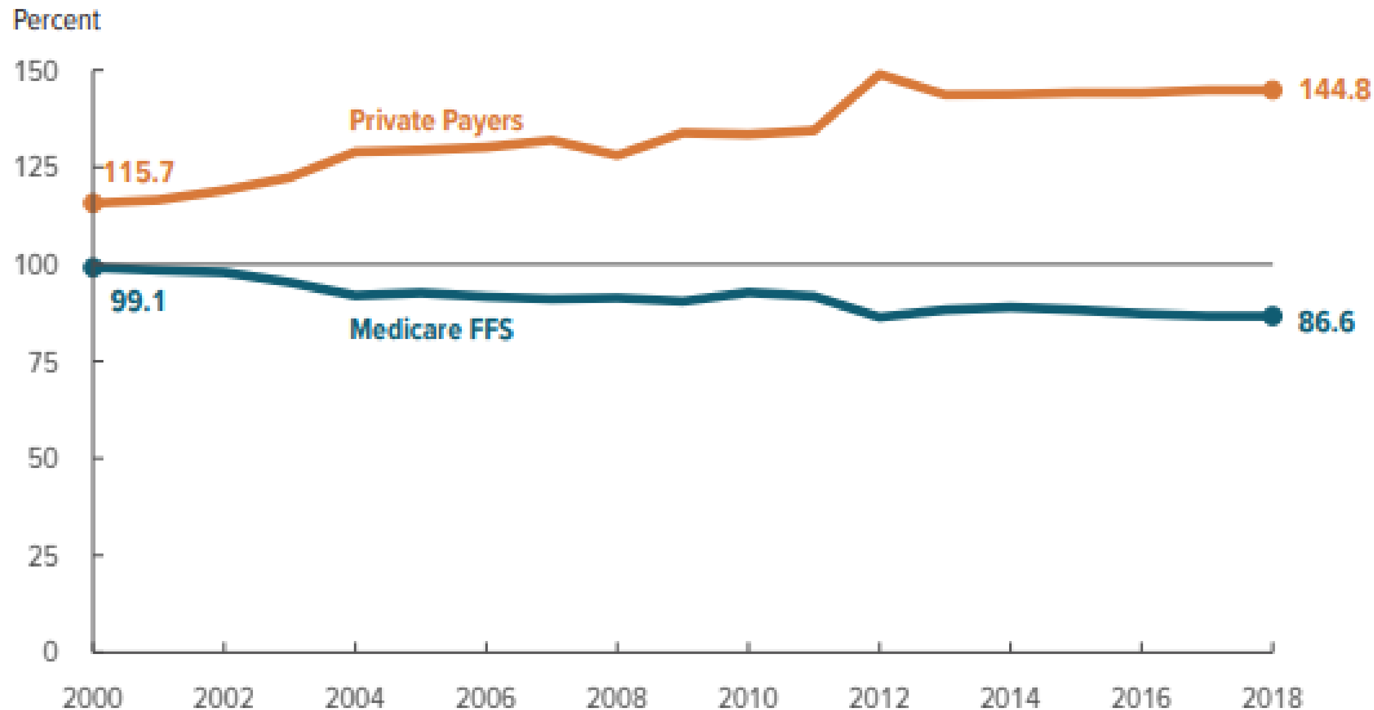
Health Care Spending Relative to Other Nations



From KFF analysis of what drives health spending in U.S. compared to other countries.

https://www.healthsystemtracker.org/brief/what-drives-health-spending-in-the-u-s-compared-to-other-countries/?utm_campaign=KFF-This-Week&utm_medium=email&_hsenc=p2ANqtz-9o0s4btzl4I4Gar3VUINpBWpk2roUBcKzqM2Qohma8TqBM2pUqf3RO25VkWELZi2BOR3qKKQsyB659zwp8chN6BdCvPA&_hsmi=318477004&utm_content=318477004&utm_source=hs_email

Relationship of Price & Cost

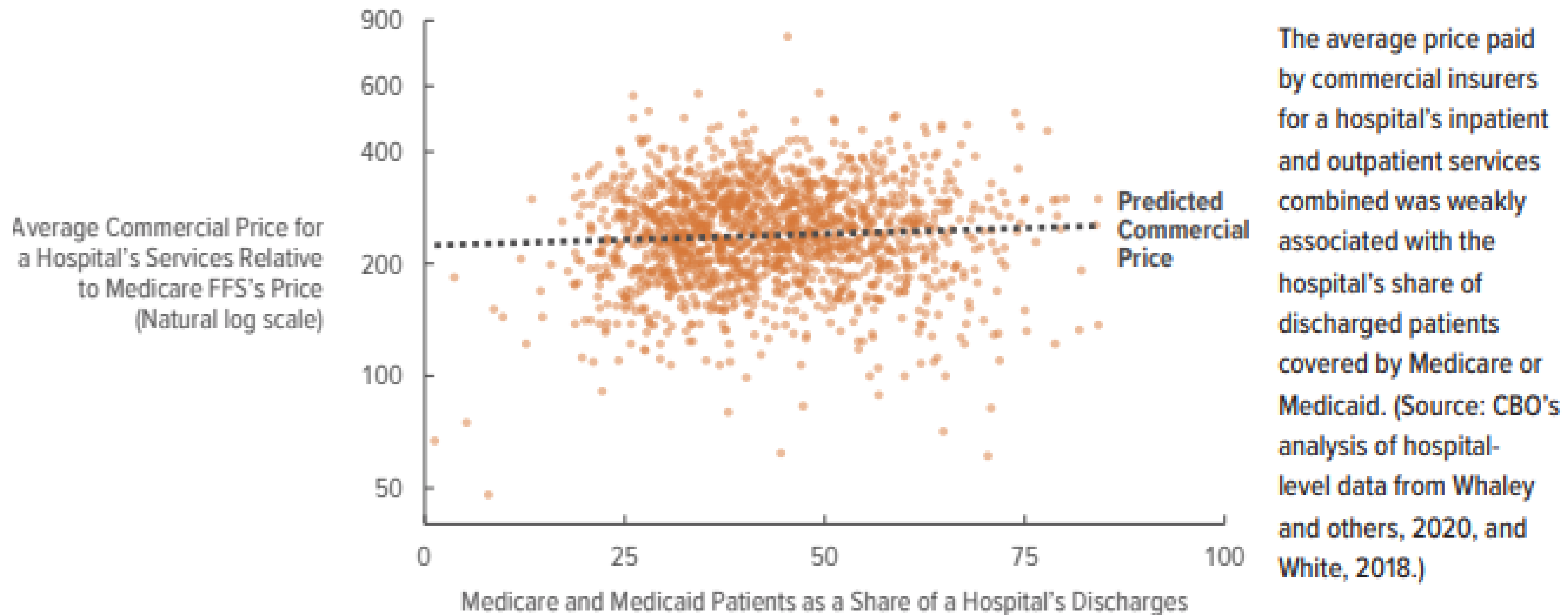


From CBO analysis of the prices commercial insurers and Medicare pay for hospitals and physician services.

"CBO's analysis and a review of the research literature found that commercial insurers pay much higher prices for hospitals' and physicians' services than Medicare FFS does. In addition, **the prices that commercial insurers pay hospitals are much higher than hospitals' costs**."

https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf

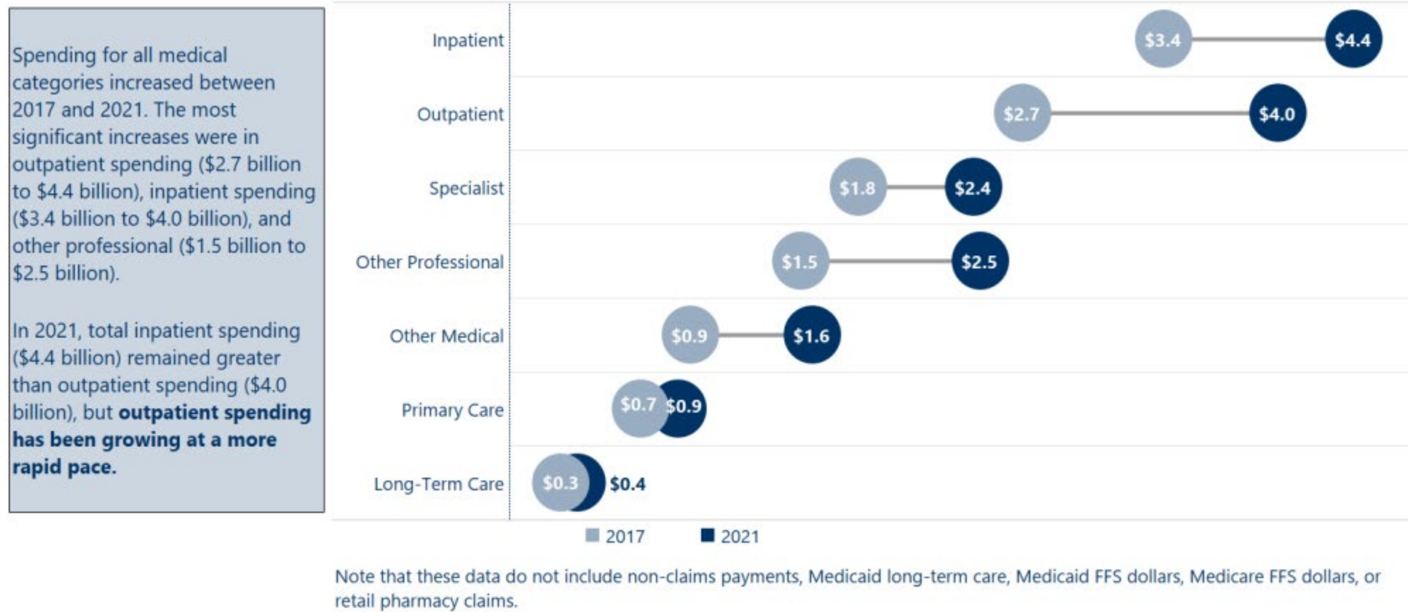
Relationship Between Payer-Mix and Price



The average price paid by commercial insurers for a hospital's inpatient and outpatient services combined was weakly associated with the hospital's share of discharged patients covered by Medicare or Medicaid. (Source: CBO's analysis of hospital-level data from Whaley and others, 2020, and White, 2018.)

Source: CBO Report – The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physician's Services (2022)

Growth in Medical Claims



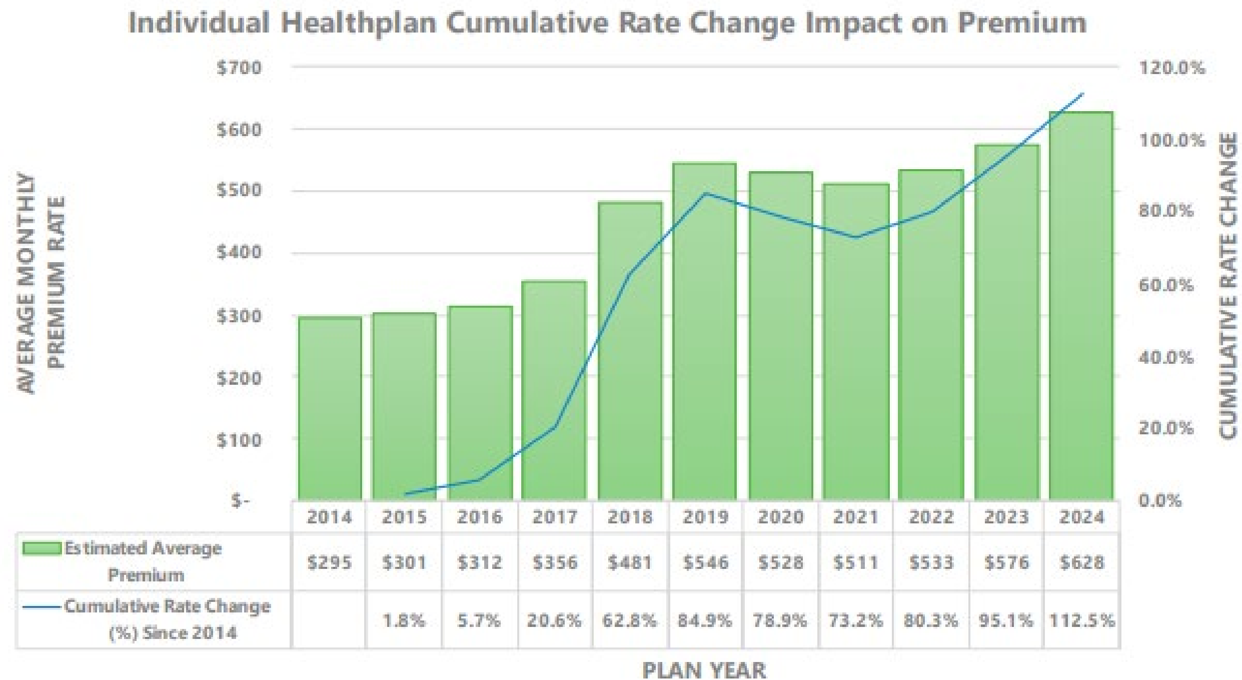
Spending in billions of dollars. Source: Cost Driver Analysis Results. December 2022.

From Cost Board 2023 Annual Report.

Found inpatient and outpatient claims costs, driven by utilization and unit cost increases, outpaced growth in other services from 2017-2021.

https://www.hca.wa.gov/assets/program/leg-report-hcctb-20230905.pdf

OIC Affordability Analysis



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Estimated Average Premium	$295	$301	$312	$356	$481	$546	$528	$511	$533	$576	$628
Cumulative Rate Change (%) Since 2014		1.8%	5.7%	20.6%	62.8%	84.9%	78.9%	73.2%	80.3%	95.1%	112.5%

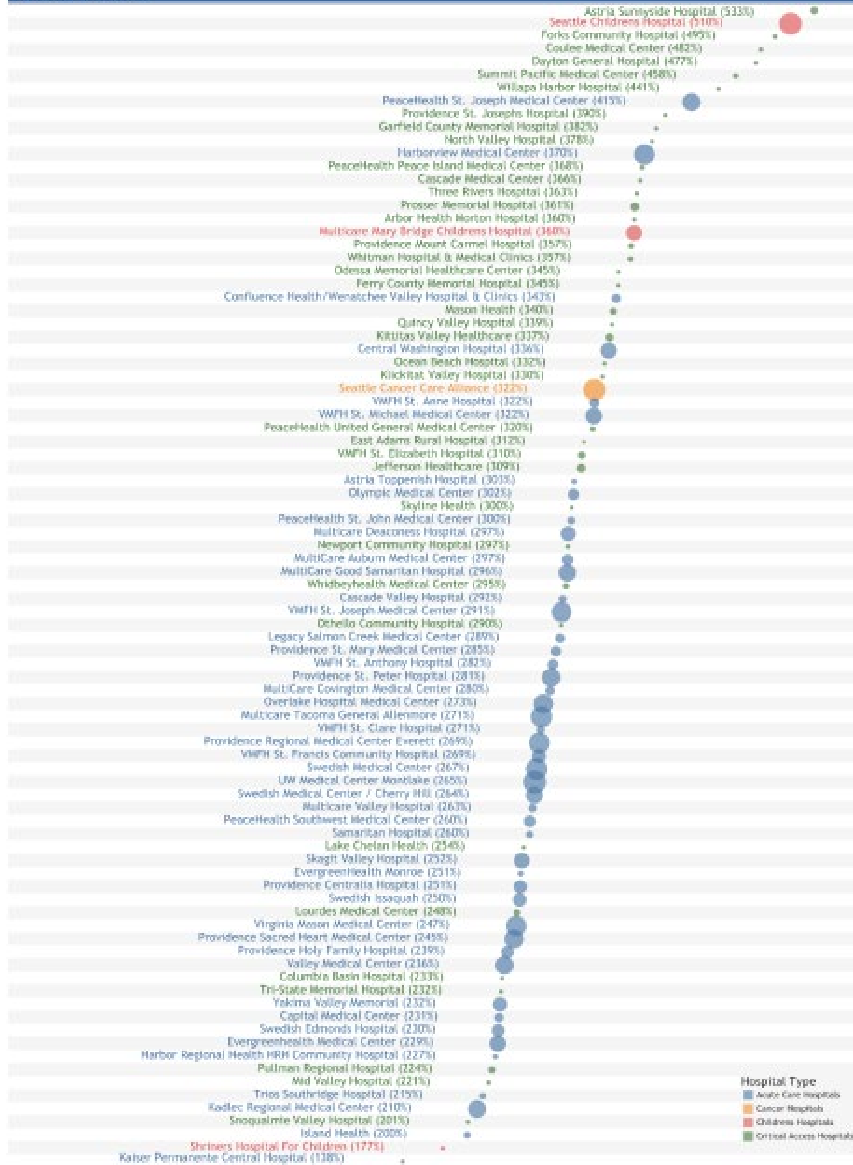
Recent reports by the Office of the Insurance Commissioner explored cost growth and the impacts of various policy interventions across WA's commercial insurance market.

Preliminary Report:

https://www.insurance.wa.gov/sites/default/files/documents/oic-prelim-report-1201123-final_1.pdf

Final Report:

https://www.insurance.wa.gov/sites/default/files/documents/oic-final-health-care-affordability-report-073024_1.pdf



Hospital Reimbursement Variation

2024 WA Health Alliance (WHA) report using 2022 claims data for commercial insurers found hospital reimbursement to vary from 138% to 533% of Medicare across facilities.

https://wahealthalliance.org/wp-content/uploads/2024/05/WashingtonsUnevenHospitalLandscape.pdf

Washington State Health Care Authority

Tab 7

Cost-containment discussion

Liz Arjun, HMA

Cost containment: recap

- Initial FTAC recommendations related to reference-based pricing
- Other cost containment mechanisms (e.g., public utility model)
- State approaches to access and affordability
- Prior authorization as a potential cost containment mechanism, in addition to administrative simplification

Cost containment: discussion

- Does the Commission want to continue consideration of reference-based pricing as a potential cost containment mechanism for a universal system?
- What other cost containment mechanisms should FTAC pursue as part of a universal system? As part of interim solutions?

Break

Tab 8

Universal Health Care Commission 2025 Planning Discussion

Outline

- Objectives
- Legislative directive
- Milestone tracker
- 2025 proposed goals, meeting schedule, and overview
- Discussion

Objectives

- Review legislative directive, current progress, and future directions
- Discuss work plan overview for 2025
- Identify potential opportunities for improvement to our meeting structure

Commission Charge

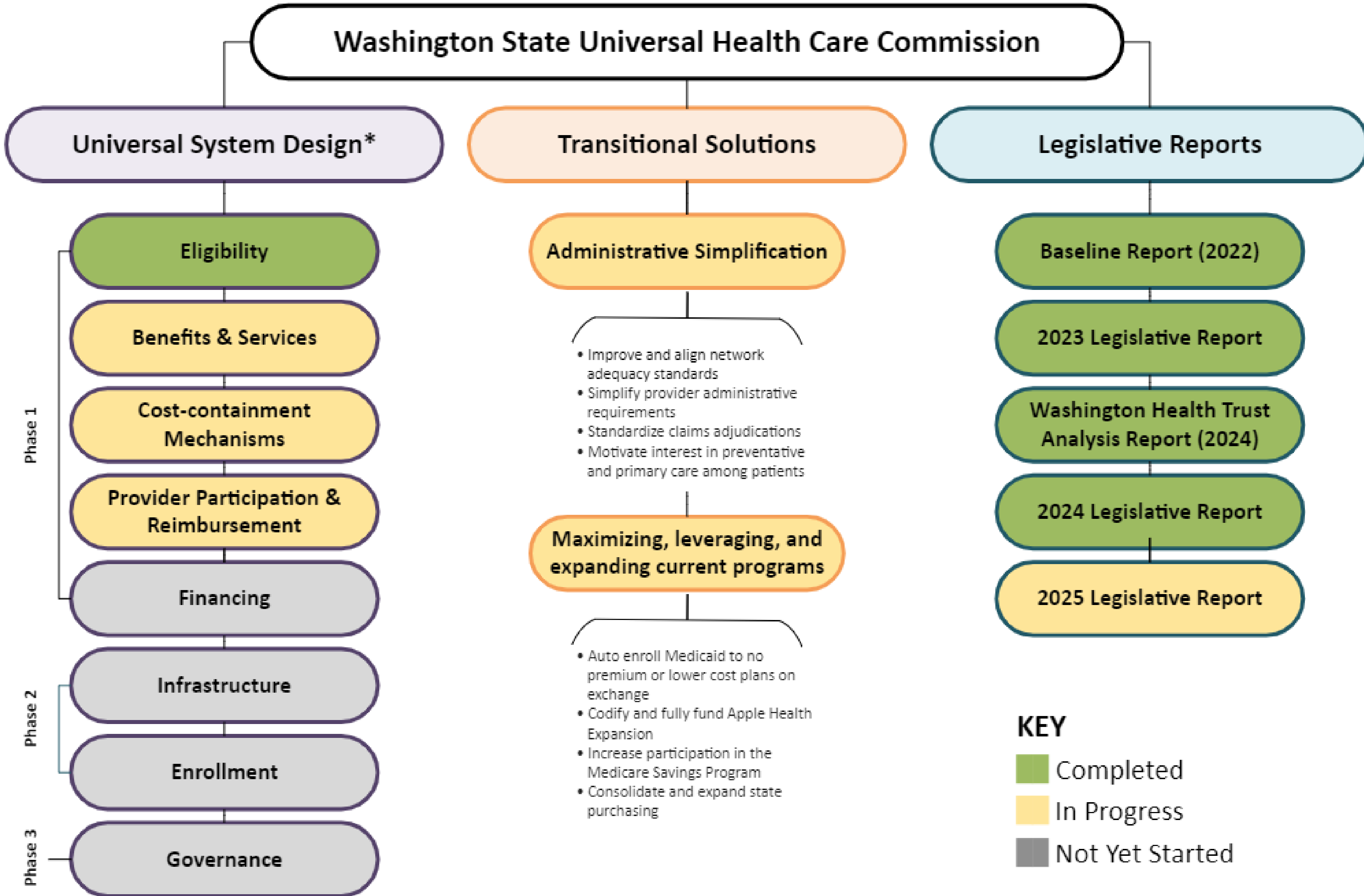
As directed by the Legislature, the Commission must:

Transitional Solutions

"…*create immediate and impactful changes in the health care access and delivery system in Washington* and to *prepare the state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system once the necessary federal authority has become available*." (RCW 41.05.840)

Universal System Design

Milestone Tracker

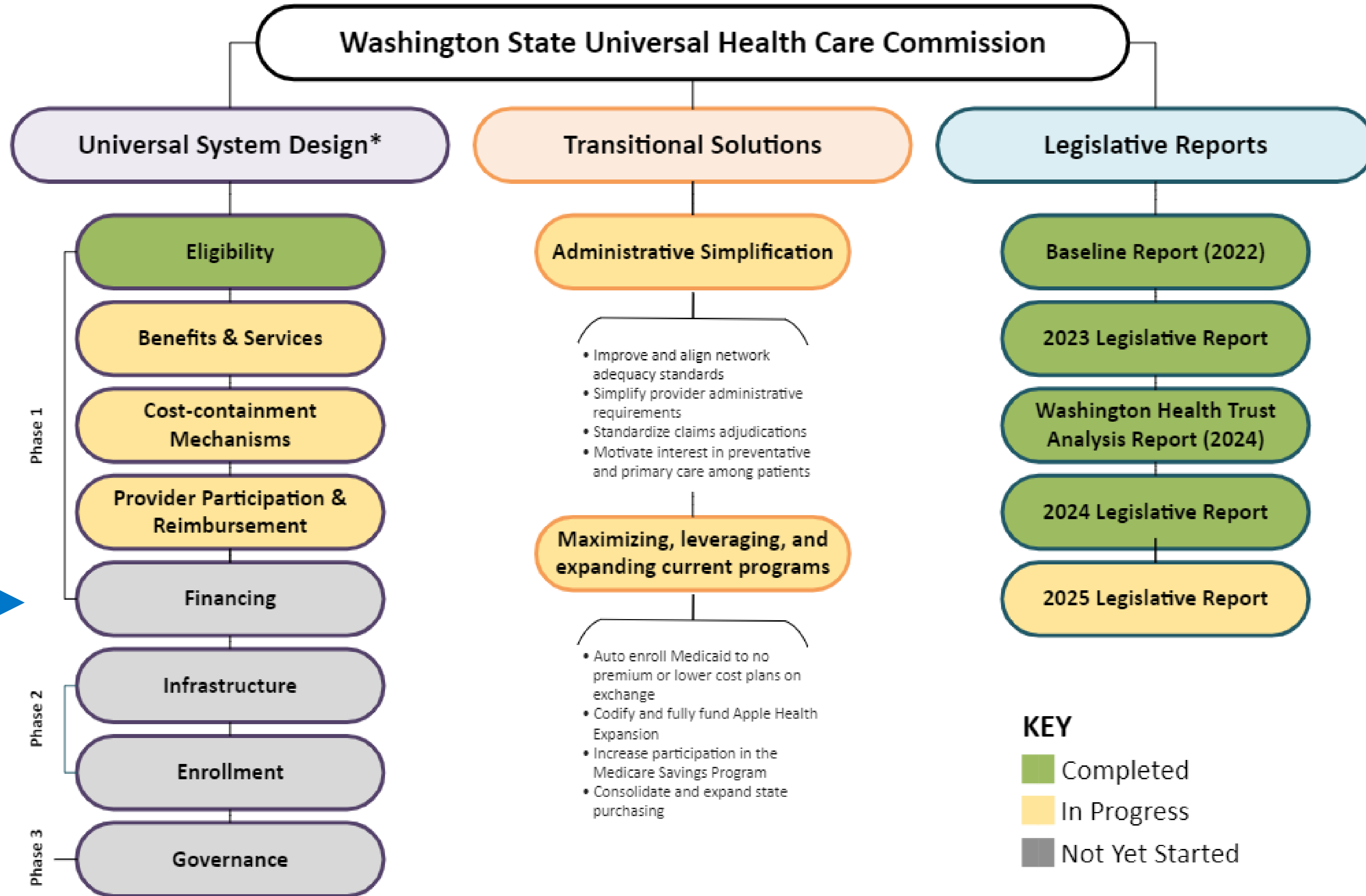


2025 proposed goals: universal design

- Complete analysis of benefits and services and determine prioritization
- Develop set of recommendations for cost containment mechanisms
- Develop set of recommendations for provider reimbursement and participation

Milestone Tracker

early 2026



*Health care quality, health equity, and health disparities will be discussed and considered during each of the core universal system design components.

2025 proposed goals: transitional solutions

- Complete analysis of administrative simplification and develop recommendation(s)
- Continue to maximize, leverage, and expand current programs
- Identify additional transitional solution(s) to explore

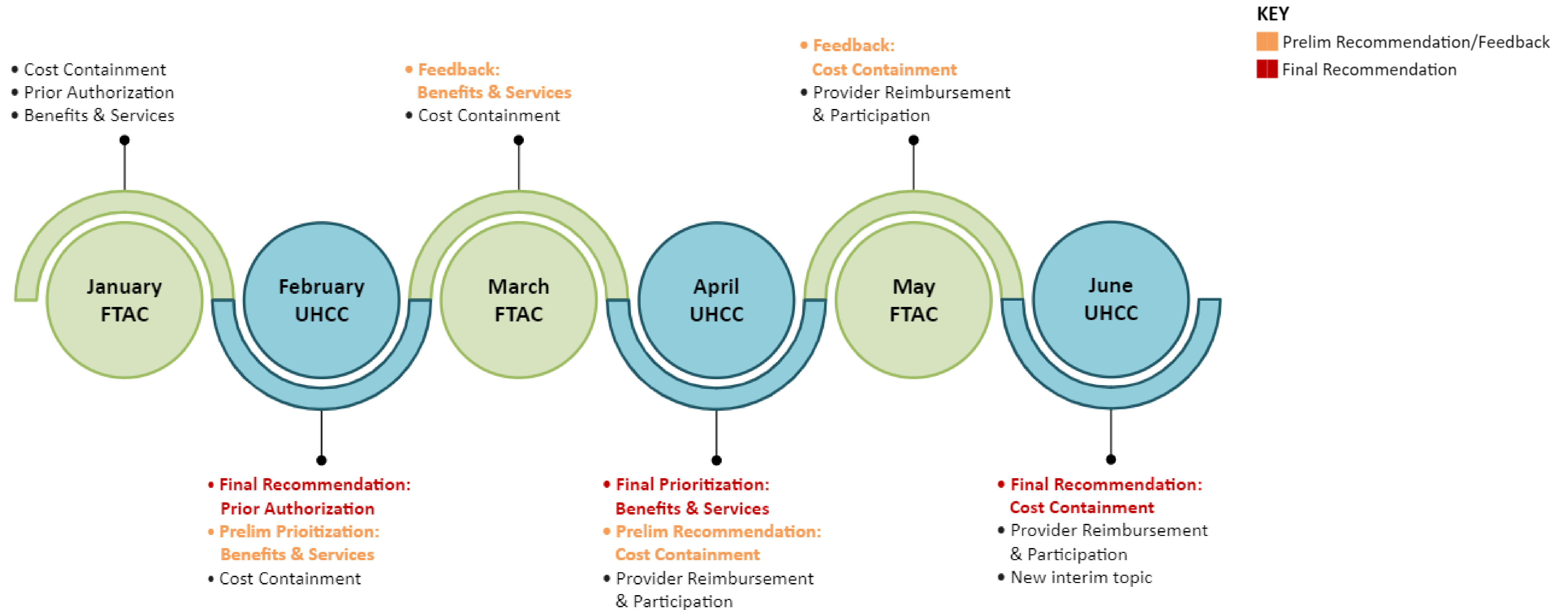
2025 Meeting Schedule

- February 13
- April 17
- June 11
- August 14
- October 9
- December 11

2025 At A Glance

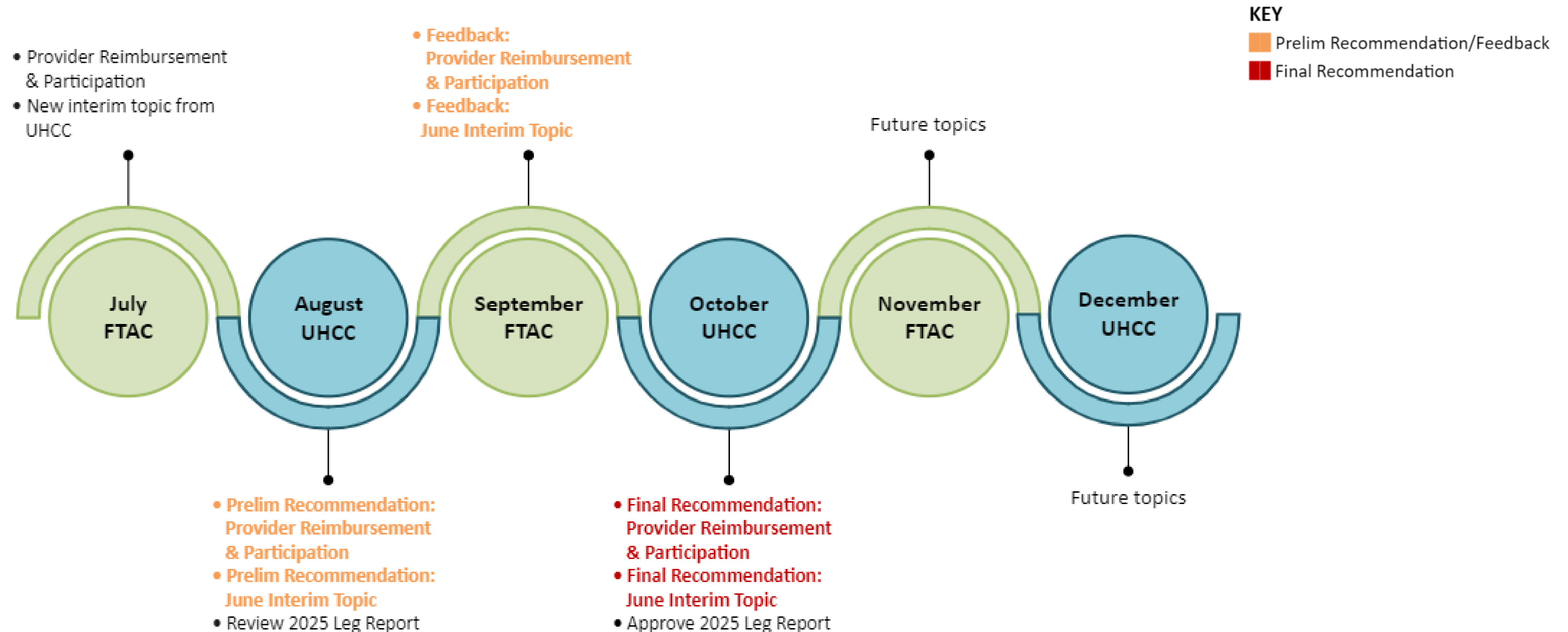
- Universal system design
  - Phase 1:
    - Benefits and services
    - Cost containment mechanisms
    - Provider reimbursement and participation
- Transitional solutions
- FTAC assignments
- Legislative requirements
  - 2025 Legislative Report (due November 1, 2025)
  - Open Public Meetings Act (OPMA) Training (due every 4 years)

2025 workplan



Updated November 2024

2025 workplan



Updated November 2024

Discussion

- Are these the goals and milestones the Commission wants to pursue in 2025?
- To keep the work moving forward, what is a reasonable request for Commission members' time between meetings?
- How does the Commission want to divide its time between **transitional solutions** vs **universal system design** recommendations?

Thank you for attending the Universal Health Care Commission meeting!