Universal Health Care Commission's
Finance Technical Advisory Committee meeting

July 11, 2024

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Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission's
Finance Technical Advisory Committee
Meeting Materials

July 11, 2024
2:00 p.m. – 4:30 p.m.

(Zoom Attendance Only)

Meeting materials

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

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

Agenda

Thursday, July 11, 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 05/9/2024	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)	Consumer Cost-Sharing in a System of Universal Health Care Coverage • Consideration for Cost-Sharing • Internal Comparisons • Status Quo in Washington	5	Anya Rader Wallack Health Management Associates (previously worked with Vermont's Green Mountain) Hannah Turner Health Management Associates
3:55-4:00	5-minute break		
4:00-4:30 (30 min)	Continued Conversation: Consumer Cost-Sharing in a System of Universal Health Care Coverage • Discussion	6	Anya Rader Wallack Health Management Associates. Principal (previously worked with Vermont's Green Mountain) Hannah Turner, Principal Health Management Associates
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

May 9, 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

Christine Eibner
David DiGiuseppe
Eddy Rauser
Ian Doyle
Pam MacEwan
Roger Gantz

Members absent

Esther Lucero
Kai Yeung
Robert Murray

Call to order

Pam MacEwan, FTAC Liaison, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

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

Meeting summary review from the previous meeting

The Members present **voted by consensus to adopt the March 2024 meeting summary**, following revisions proposed by Roger Gantz (removing "originally intended for mothers and children" in in paragraph four of the Benefits & Services Discussion and revising language in paragraph seven of the Benefits & Services Discussion to say "FTAC considered the following for actuarial analysis" rather than "FTAC agreed that the Commission should consider the following for an actuarial analysis.")

Washington State Health Care Authority

Public comment

Raleigh Watts, volunteer with Whole Washington, noting that the date for deciding on benefits and services had been extended beyond the original June deadline, implored FTAC to continue moving forward on this decision, despite not yet having full information on financing.

Kathryn Lewandowsky, Vice Chair at Whole Washington, wished to stress that Whole Washington is concerned about wealth inequality, seeing the funding of the health trust as a good way to "neutralize" this issue. Regarding SB 5335 revisions, premiums were removed as they were unnecessary, but did not repeal capital gains tax despite not needing the funds. Washington Supreme Court clarified that capital gains tax is not income tax, leaving open the question of what should be done. Wish to have a conversation on what is best to do to ensure sustainability of trust fund and ensure it is funded by and for the benefit of all Washington residents.

Commission updates & goals for today

Liz Arjun, Health Management Associates (HMA)

Liz Arjun provided an update on the workplan, noting that the focus for 2024 is on determining the costs of the unified health care system based on decisions about what benefits and services are covered, cost containment, and provider reimbursement. Also under consideration are administrative simplification and maximizing coverage in existing programs.

Commission updates included 1) additional funding being made available for expanded Medicaid and undocumented residents, which provides a path to covering all Washingtonians, 2) deciding that the decision on cost sharing would be made after deciding on benefits and services, and 3) beginning actuarial analyses with PEBB/SEBB, Silver Plans on the Exchange, and expanded Medicaid (i.e., dental, vision).

Presentation: Framework for Benefit Design and Cost Structure

David DiGiuseppe, Vice President of Healthcare Economics, Community Health Plan of Washington (CHPW)

David's presentation provided a high-level overview of how payers estimate costs in order to price their products. First, payers identify the population and historical experience (i.e., claims), which includes services covered, utilization rates, and cost per unit of service. Payers then project future enrollment—driven by population growth, individual decision marking, and market dynamics—and expenses, which include new services covered, utilization rate trend, and cost per unit of service trend. Finally, they overlay administrative expenses (e.g., network contracting, utilization management, sales and marketing, IT/finance/HR). These factors combined result in a model covering 100% of the total cost of care.

This framework does not address who pays for care (i.e., health plan vs. patient out-of-pocket). Rather, it provides a starting point for FTAC to evaluate the impact of different choices (e.g., removing cost sharing, covering more services, covering broader population(s), raising new tax revenue, etc.). The presentation also offered a few options for evaluating opportunities to reduce costs, including healthcare expenses (e.g., hospital global budgets, spending caps) and administrative expenses (e.g., identifying essential admin costs, role of payers).

Next steps for FTAC include discussing whether an actuarial study will be helpful to the Commission by illustrating the cost savings potential of each strategy and whether FTAC has a role in describing the political challenges associates with each cost reduction opportunity.

Discussion

FTAC members discussed the implications of modeling healthcare costs, including whether to focus first on reducing the total cost of care or on reducing cost sharing for Washingtonians. They also discussed implications of assumptions made in modeling, including the challenges of accurately predicting the impact of changes to cost structure and benefit design. Ultimately, FTAC wants to be able to provide feedback to the Commission

about considerations that might have been overlooked and potential tradeoffs. FTAC members also suggested following up with Milliman actuaries with specific questions as the work progresses.

Presentation & Discussion: Health Care Cost Transparency Board

Ross McCool, Operations Research Specialist, Washinton State Health Care Authority

Washington is one of nine states with a spending growth benchmark, starting at 3.2% in 2022 and going to 2.8% by 2026. The spending data is sourced from aggregate expenditure data from payers that includes both claims-based and non-claims-based expenditures. Spending is measured according to the following formula: **Total Medical Expense** (claims payments + all other payments not included on claims + cost sharing paid by members) + **Net Cost of Private Health Insurance** (administrative costs) = **Total Health Care Expenditures**. The Board is monitoring spending at both the state and market (i.e., Medicare, Medicaid, commercial) levels and plans to expand to evaluate at the payer and large provider levels in the future.

In 2019, total health care expenditures were $48 billion, rising 7.2% between 2017 and 2018 and 5.8% between 2018 and 2019. Medicare spending is growing more slowly than Medicaid or commercial; Medicaid is growing at the fastest rate (11.5% between 2017 and 2018 and 9.8% between 2018 and 2019), but per capita spending is still lower than other markets. Hospital outpatient services were a significant driver of growth overall, especially in the commercial market. Non-claims spending was the largest growth driver in the Medicaid market, though FTAC members pointed out that this could just be reflecting capitated payments and not the underlying spending on other categories like hospital in- and outpatient or primary and specialty care.

The Board has focused on gathering and understanding data. In recent months, conversations have begun to shift to what options are available to address cost issues. From a broader list, the Board selected several options for study, including limiting facility fees, restricting anti-competitive clauses in contracting, mergers and acquisitions/private equity purchasing of health care providers, and provider rate setting/price growth caps. The Washington Office of the insurance Commissioners (OIC) also is researching options to address health care costs. FTAC members expressed interest in collaboration with the OIC and other agencies undertaking similar and complementary work.

No votes were taken.

Adjournment

Meeting adjourned at 4:33 p.m.

Next meeting

July 11, 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 the Last Meeting

Written Comments Submitted by Email

Additional Comments Received at the May FTAC Meeting

- The Zoom video recording is available for viewing here: (https://youtu.be/VoBipljeDqw)

THREE QUESTIONS FOR FTAC ON BENEFITS

The May FTAC meeting focused on costs and benefits, potentially defining the latter for a subsequent actuarial study. A presentation by David DiGiuseppe looked at components of costs, along with a possible actuarial framework. A memo and comments from Roger Gantz discussed possible benefit structures.

The commentaries from DiGiuseppe and Gantz raise three questions.

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1. CAN WE LOWER COSTS, *AND* OFFER BETTER BENEFITS?

Two and a half years after the creation of the UHCC, David DiGiuseppe's presentation provided the first coherent picture of the major components of health care costs in Washington. His discussion covered the contradictory goals of providing more generous benefits to more people *and* reducing total costs.

DiGiuseppe estimated that with no offsetting savings the increased annual cost of providing more services and eliminating out-of-pocket payments for *all* insured Washingtonians plus covering today's uninsured would be *$29 billion*.

Excluding the impact on ERISA plans and Medicare (both of which the UHCC has determined cannot at this time be included in a universal system) the annual cost increase would be *$14 billion*.

DiGiuseppe also identified possible cost reduction areas under the headings of health care expense and administrative expense (but did not provide estimates of possible savings).

As Washington and every other state has discovered, attempts to impose cost controls on payers or providers are likely to be met with immediate push-back. Even apparent successful attempts to cap program costs, as in Medicare and Medicaid, have resulted in increases elsewhere—the "health care waterbed syndrome". All providers try to shift costs to the programs with the least restrictive controls, while hospitals also shift services to outpatient facilities and by acquiring provider practices. (Hospital global budgeting may have the greatest cost control potential—because hospital costs are a large part of total health care costs—but Washington is not eligible to participate in CMS' AHEAD initiative, meaning that a State hospital global budget initiative is unlikely in the foreseeable future.)

Controlling administrative costs may have more potential than controlling health care costs, simply because providers dislike the administrative burden. However, with today's hundreds of combinations of benefit packages, payers, and networks,

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providers and insurers face administrative efforts they can do little to control. (The State of Washington is a major contributor to this burden, with multiple programs with multiple benefit options and multiple networks.)

2. CAN AN ACTUARIAL STUDY HELP?

David DiGiuseppe's presentation posed the question: *Can [an] actuarial study be helpful to UHCC by illustrating the cost savings potential of each strategy?*

The simplistic answer is "yes," but an actuary—whether looking at overall costs or only possible savings—may need much more system definition than FTAC has achieved so far.

Roger Ganz's memo provides a helpful discussion of possible benefits but does not cover some key structural issues. The underlying assumption seems to be that all covered individuals will have the same coverage from the same payer(s), with the same network(s), and with all providers subject to the same payment rules. While this is certainly a possibility, it may not be the most cost-effective approach, nor the most acceptable to the covered population.

The appendix to these comments provides a more comprehensive list of factors influencing benefits, including for example, waiting periods, access to providers, and retroactivity.

3. WHAT ABOUT "THE ELEPHANT IN THE ROOM"?

The UHCC has finally recognized the difficulty of including individuals covered by Medicare or ERISA plans in a universal system, but both the UHCC and FTAC have avoided examining the problems of gaining a federal waiver to allow Medicaid

eligibles to be included.

Theoretically, CMS could grant a waiver, but the application process can be long and uncertain. As Washington and other states have learned, the process of waiver preparation and submittal can take two years or more, with no assurance that CMS will ever make a positive decision[1]. In addition, no waiver application will be accepted that fails to guarantee that federal expenditures will not be increased.

(It might be helpful if FTAC members familiar with the waiver process could address the issues involved, along with their experience.)

FTAC needs to ask how likely is it that CMS would approve a waiver allowing Medicaid eligibles to be included in a universal system which does not yet exist. Specifically, what proof would CMS require that including Medicaid eligibles in a universal system would not disrupt coverage, access to care, or payments to providers?

FTAC also needs to consider the timing implications of the preceding questions, especially if it is clear that no waiver would be possible until the non-Medicaid components of the universal system can be proved to be functioning smoothly.

[1] A recent CMS snapshot of the status of submitted waivers showed eight (out of thirty) still pending after a year. (CMS did not report "worst case" for review time.)

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APPENDIX

HOW DO WE DEFINE "BENEFITS"?

If we define benefits as services that enrollees are entitled to receive (perhaps with limitations), then are each of the following parts of the definition?

- **Covered services**
- **Access to services (e.g. are they reasonably available?)**
- **Restrictions on provider and facility types**
- **Prior authorization requirements**
- **Limitations on services (e.g. frequency)**
- **Deductibles**
- **Copays and coinsurance**
- **Waiting periods (e.g. from date of enrollment)**
- **Retroactivity (e.g. as for Medicaid)**

SHOULD ALL ENROLLEES HAVE THE SAME BENEFITS?

- **Some mandated Medicaid benefits are not typical of most health insurance**
- **Should all Medicaid benefits be extended to all enrollees?**
- **Alternatively, if all Medicaid eligibles are included in the total enrollment, should their long-term-care benefits be segregated and not available to non-Medicaid enrollees?**

SHOULD INSURERS BE ALLOWED TO OFFER SIMILAR BENEFITS? OR ADDITIONAL BENEFITS?

- **In the US currently, MediGap policies are permitted, subject to certain rules, to provide supplemental payments for hospital and other care for Medicare beneficiaries.**

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- **Some nations (e.g. United Kingdom) allow commercial insurers to offer benefits that duplicate the state system, but provide better access to providers, and/or provide additional benefits.**
- **Other countries (e.g. Canada) explicitly ban such duplication, arguing that it undermines the state system.**

SHOULD THE SAME PAYMENT RATES AND RULES (FOR THE SAME SERVICES) BE APPLIED TO ALL PROVIDERS FOR ALL ENROLLEES?

- **There are significant regional variations in providers' costs.**
- **"Universal financing" implies the same payment rules for all providers.**
- **This would likely mean payment increases for providers with many Medicaid eligibles and payment reductions for providers with mostly commercial patients. The risk is that the latter may prefer not to accept patients at the (new) lower rates.**

SHOULD THERE BE A MORE AFFORDABLE "LOWER TIER" OF SERVICES OR PROVIDERS? OR A "HIGHER TIER"?

- **This approach would perpetuate current "metal levels."**
- **Allowing a more affordable "lower tier" would be at odds with a goal of universal coverage**
- **If coverage is financed primarily by income taxes, affordability for the enrollee is no longer an issue.**
- **If State funding is insufficient for very generous coverage, a "base level" for all might be set, with an additional premium for more provider choice (as in the French system) or additional services.**

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Roger Collier was formerly CEO of a national health care consulting firm. His experience includes responsibility for managing the implementation of new state and federal health care programs for millions of enrollees.

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Tab 4

Washington State Health Care Authority

UHCC Status Update and Today’s Topics

3 Workstreams: Key Milestones/Activities

Workstream 1: Design a universal health care system with a unified financing system

- Inaugural Report: Landscape and Path Forward
- Launch FTAC

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

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

Workstream 2: Recommend interim solutions that address issues people face now and contribute to the universal system

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

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

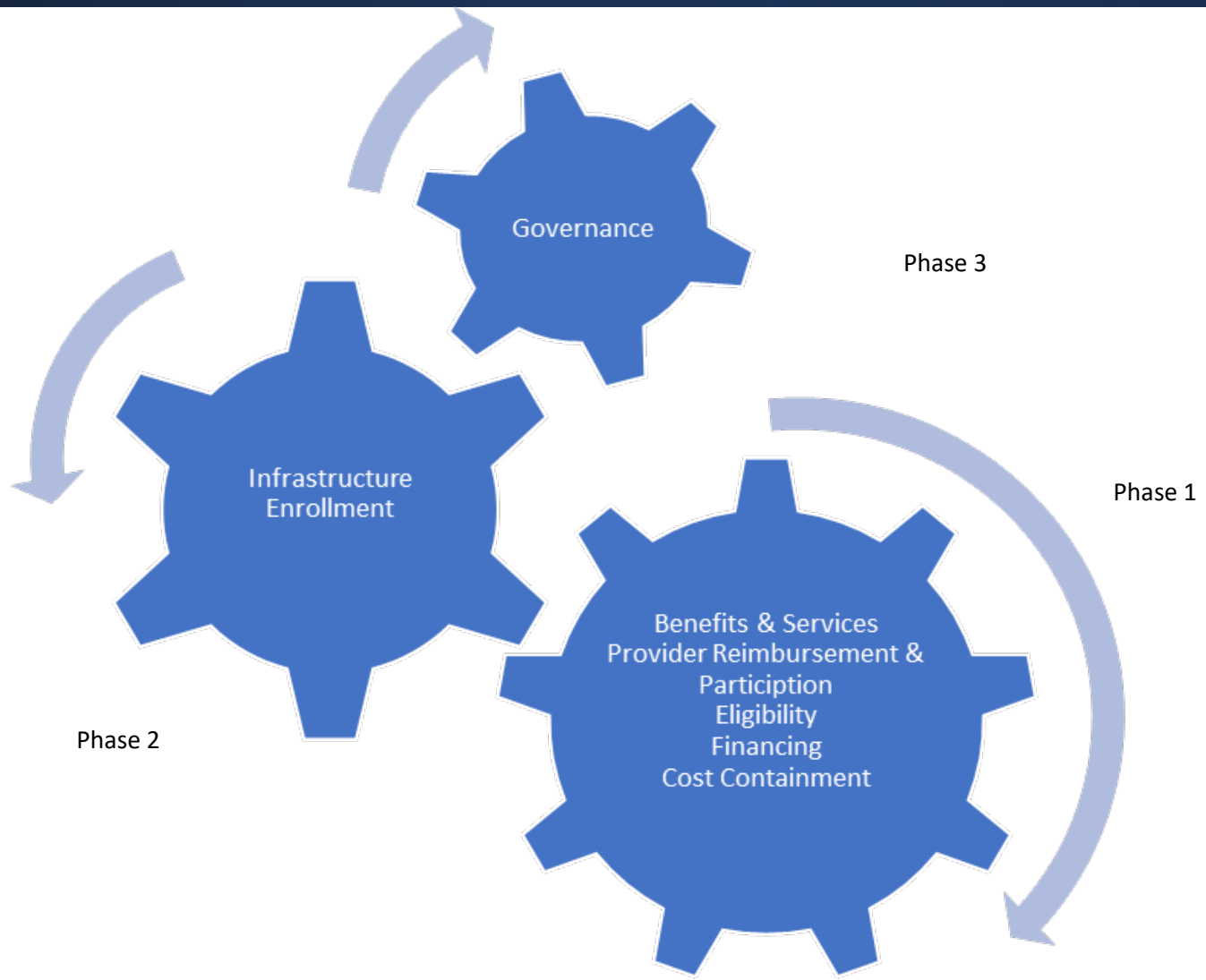
2023 Request Workstream 3: Review the Washington Health Trust proposal

- Overview of proposal

- Benefits and services, cost assumptions

2022 **2023** **2024**

Workstream 1: Universal System Design

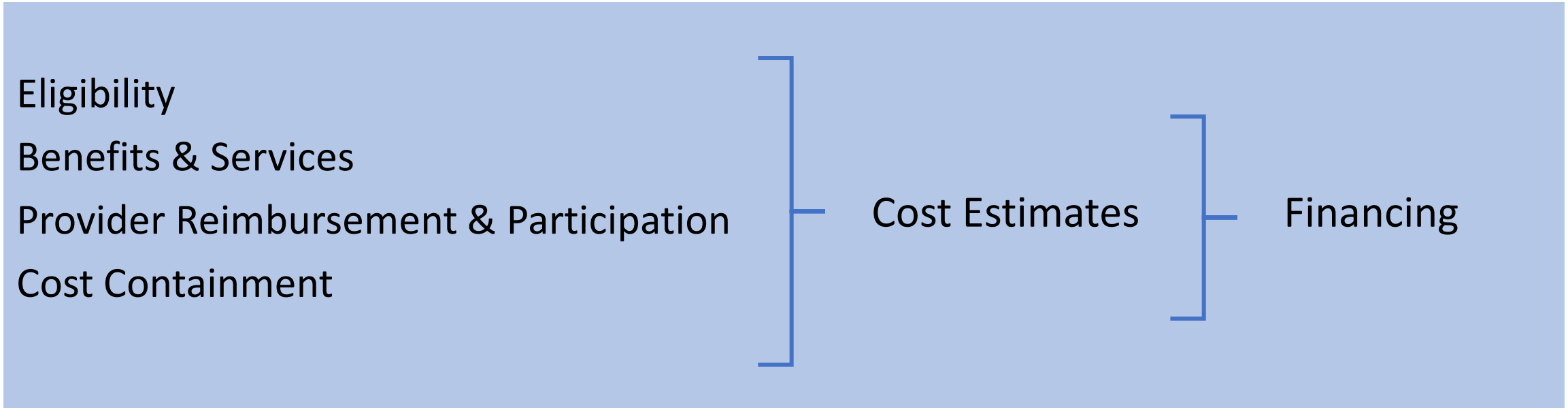


Phase 3

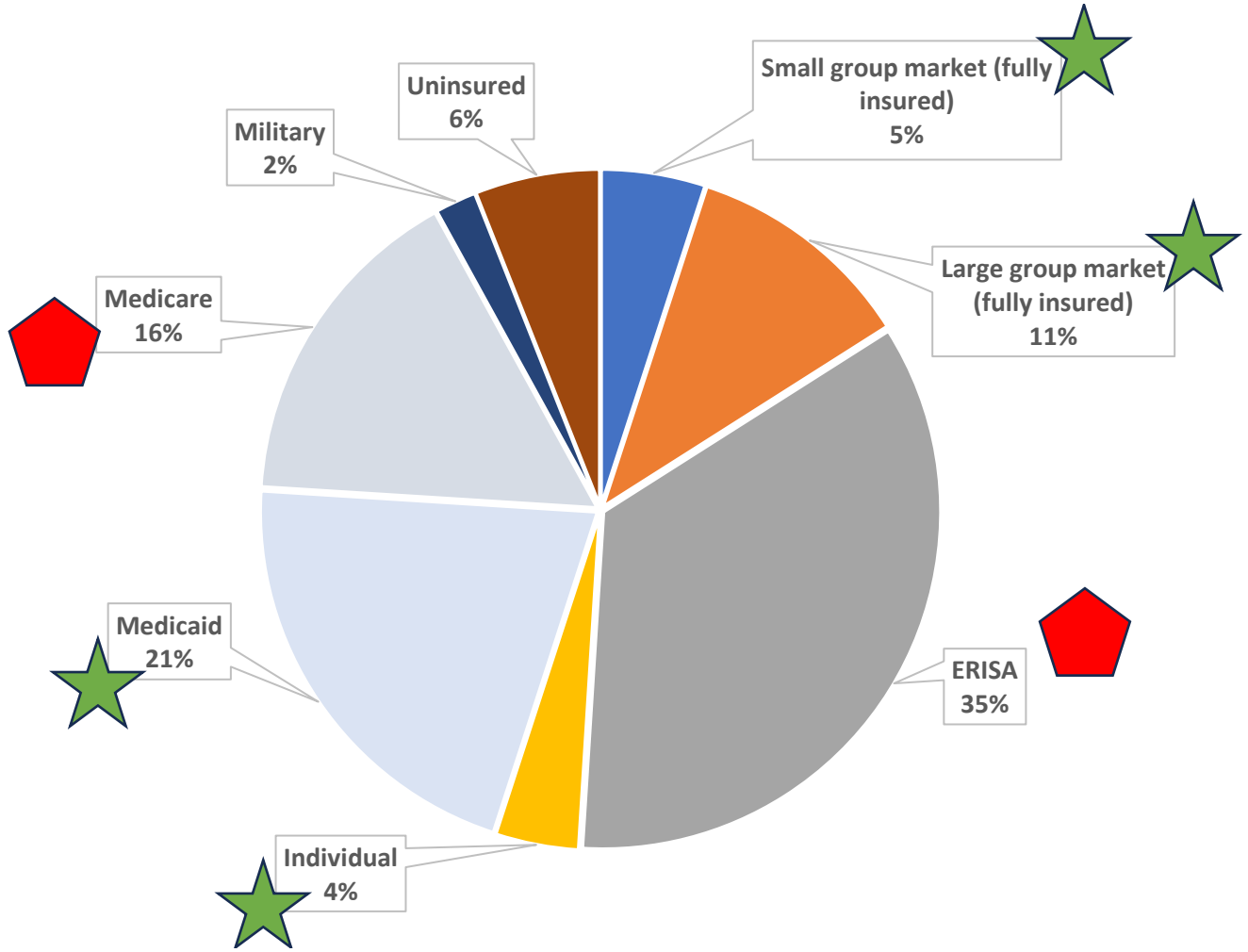
Phase 1

Phase 2

Workstream 1, Phase 1 Sequence: Universal System Design



Eligibility



Benefits and Services

- ✓Commission has given direction to FTAC to provide guidance to develop an actuarial analysis that provides a rough estimate of the cost to provide benefits and services in:
  - ✓PEBB/SEBB Uniform Medical Plan
  - ✓Essential Health Benefits
  - ✓Cascade Care Plan
  - ✓Medicaid dental, vision
- ✓Commission has given direction to FTAC to provide guidance on the actuarial analysis that shows the cost of eliminating or minimizing enrollees' out of pocket costs
- ✓Last FTAC meeting
  - ✓Understand how carriers set rates
  - ✓Ongoing cost containment efforts being led by the Cost Transparency Board

Today

- Universal coverage systems and cost sharing in those systems
- Impacts of different types of cost sharing
- Cost-sharing for the selected benefits and service packages discussed by FTAC
- Discuss different options to provide guidance for actuarial analysis

Tab 5

Washington State Health Care Authority

HMA

Considerations for Consumer Cost Sharing in a System of Universal Health Coverage

July 11, 2024
Washington Universal Health Care Commission
Finance Technical Advisory Committee

PRESENTED BY:
Anya Rader Wallack
Hannah Turner

CONSIDERATIONS FOR CONSUMER COST SHARING IN A SYSTEM OF UNIVERSAL HEALTH COVERAGE

Agenda

- Understanding Consumer Cost Sharing
- Cost Sharing Models in Other Countries with Universal Coverage
- Cost Sharing Examples from Washington State

UNDERSTANDING CONSUMER COST SHARING

- Types of cost sharing
- Impact of cost sharing on total costs
- Cost sharing impact on utilization
- Other sources of financing

TYPES OF COST SHARING

- Cost Sharing for Utilization of Health Care Services
  - **Deductible**: Consumer pays all costs up to the deductible before the plan begins to pay
    - Plans can make certain services not subject to the deductible to ensure it doesn't create a barrier to care, especially high value low-cost care (e.g. preventive, primary care)
  - **Coinsurance**: Consumer pays a percentage of the cost for health care services
    - Ensures the consumer's cost is proportional to the cost of the service, especially for higher cost services (e.g. advanced imaging)
    - Unpredictable cost for consumers, difficult to access cost of service before using service
  - **Copay**: Consumer pays a fixed cost for the health care service
    - Predictable cost for consumers
    - Since consumer cost is not proportional to cost of service, consumer may be paying higher/lower proportion of cost than in a coinsurance model
  - Other utilization management tools:
    - Prior authorization, referrals, Rx step therapy

COST SHARING IS ASSOCIATED WITH REDUCED USE OF CARE

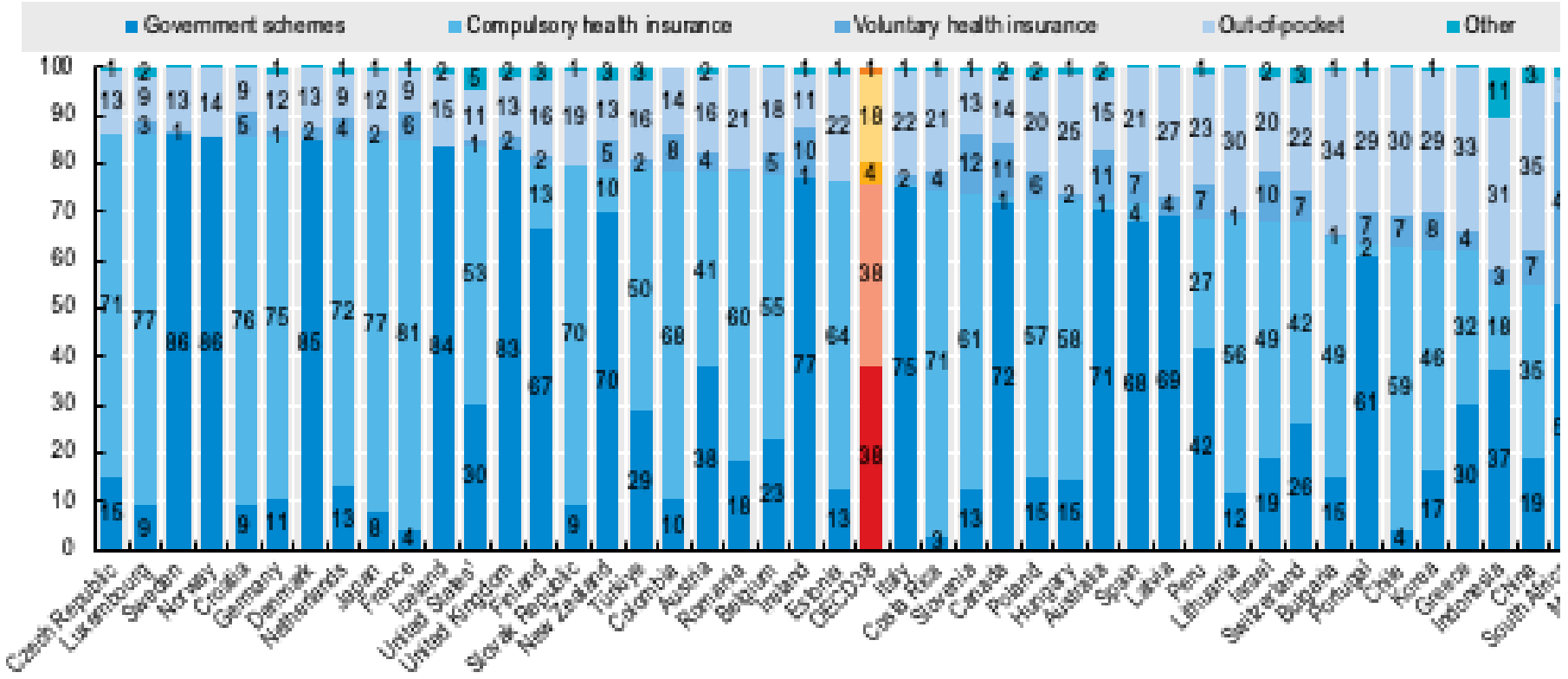
A wide range of studies have found that even relatively small levels of cost sharing, in the range of $1 to $5, are associated with reduced use of care, including necessary services.

- The RAND health insurance experiment (HIE), conducted in the 1970s and still considered the seminal study on the effects of cost sharing on individual behavior, showed a reduction in use of services after cost sharing increased, regardless of income.
- Since then, a growing body of research has found that cost sharing is associated with reduced utilization of services, including vaccinations, prescription drugs, mental health visits, preventive and primary care, and inpatient and outpatient care, and decreased adherence to medications.
- In many of these studies, copayment increases as small as $1-$5 can affect use of care.
- Some studies find that lower-income individuals are more likely to reduce their use of services, including essential services, than higher-income individuals.
- Research also suggests that copayments can result in unintended consequences, such as increased use of other costlier services like the emergency room.

SOURCE: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

DISTRIBUTION OF COSTS IN OTHER COUNTRIES: ALL HAVE SOME DEGREE OF COST SHARING

» Health Expenditure by Type of Financing, 2021 (or nearest year)



Note: Category “Other” refers to financing by NGOs, employers, non-resident

SOURCE: OECD Health Statistics 2023

IMPACT OF COST SHARING ON COSTS

- Cost Sharing for Utilization of Health Care Services (e.g. deductible, coinsurance, copayments)

Advantages	Disadvantages
Costs paid by individuals directly benefiting from program and utilizing health care	Cost sharing can be a barrier for lower income individuals
Having “skin in the game” can result in better decisions about utilization	Individuals who defer care may result in poorer health outcomes and higher costs later
Design of cost sharing can impact utilization to either:	Increased utilization can stress limited health care resources (e.g. provider availability)
Encourage utilization of lower cost / high value services, or	
Discourage utilization of higher cost / lower value services	

- How Cost Sharing Affects the Distribution of Cost
  - Lower cost sharing = higher premiums or taxes
  - Actuarial value (AV) is a rough proxy for the balance between cost sharing and "shared costs"

CONSIDERATIONS REGARDING OTHER SOURCES OF FINANCING

- Just because they are broad source of financing, it doesn't mean that they are "fair"

	Advantages	Disadvantages
Taxes	Lower per-person cost due to costs spread across a larger population (residents or businesses)	Cost paid for by individuals/businesses not directly benefiting from program Potential for additional costs on businesses to be passed along to consumers or employees
Premiums	Cost paid by individuals directly benefiting from program	Higher per person cost due to cost spread across program participants only (i.e. smaller population than taxes) Premiums can be a barrier to entry for lower income individuals

HIGHER COST SHARING – IMPACT ON HEALTH OUTCOMES

A 2023 NIH analysis metanalysis found:

- Increased cost-sharing may be associated with decreased outpatient visits but increased hospitalizations. No association with emergency room visits.
- Cost-sharing had a greater effect on initiation of health care services than it did on the continuation of services
- A paradoxical effect of cost-sharing is that it may ultimately increase health care costs because patients waive essential health care, which in the long-term results in poorer health and therefore necessitates medical treatments, utilization, and procedures that may have been avoided
- Evidence is more limited regarding the impact of cost-sharing on clinical outcomes, resource use, and total health care costs.

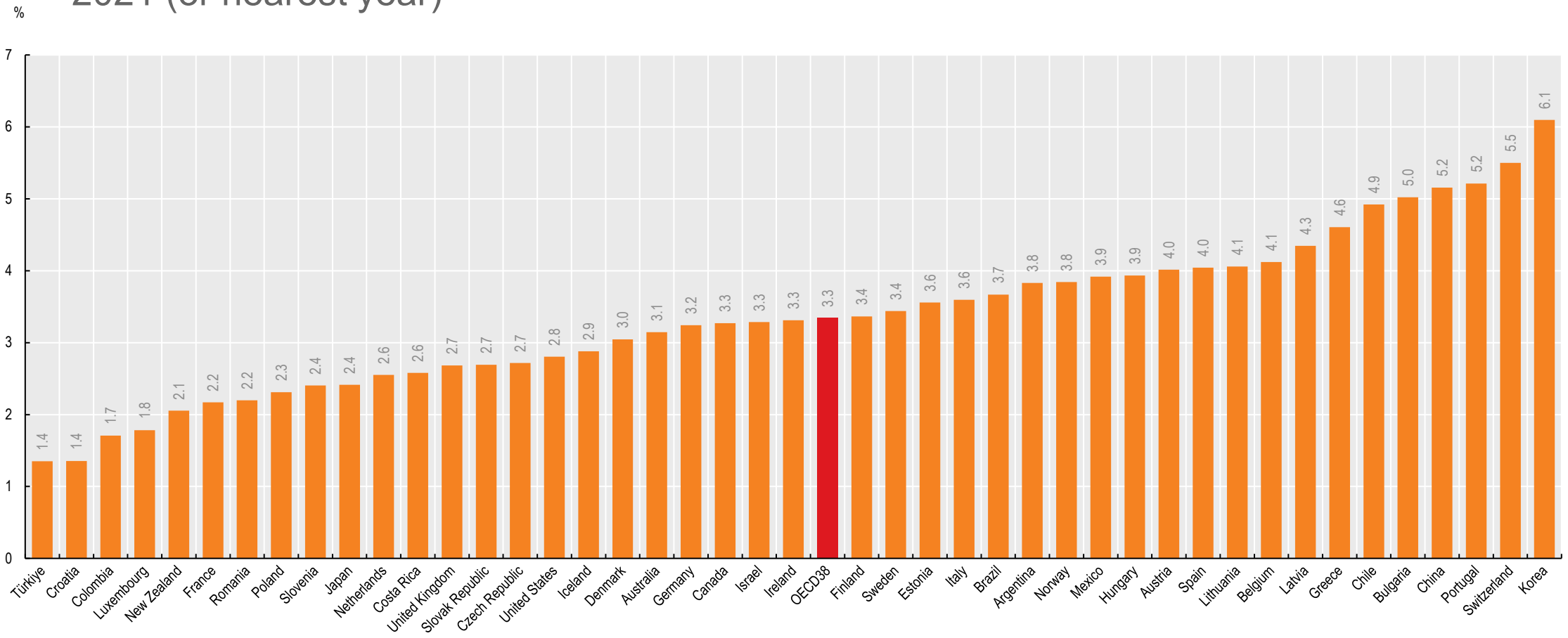
Source: Cost-sharing and adherence, clinical outcomes, health care utilization, and costs: A systematic literature review (2023, NIH) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10394195/#:~:text=In%20terms%20of%20health%20care,no%20association%20with%20ED%20visits.

COST SHARING IN SYSTEMS/ MODELS WITH UNIVERSAL COVERAGE

- Germany
- Canada
- France
- Vermont modeling for a "single payer"

CONSUMERS FACE COST SHARING IN MOST COUNTRIES

Out-of-pocket spending on health as share of final household consumption, 2021 (or nearest year)



SOURCE: OECD Health Statistics 2023, OECD National Accounts Database

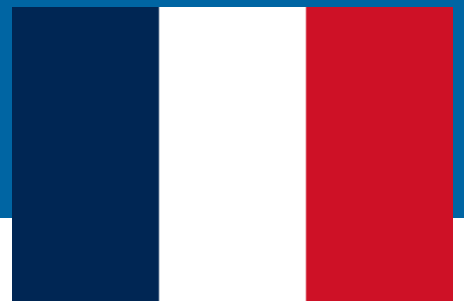
EXAMPLE: GERMANY

- A social insurance system – all individuals are required to have health insurance, and sickness funds (private, not-for-profit insurance companies) collect income-sensitive premiums from employees and employers
- Variation in how people meet their obligation to have coverage, and about 10% of the population buys supplementary coverage
- Consumer copayments and coinsurance are prevalent, but overall cost sharing is capped as a percentage of income

EXAMPLE: CANADA

- A government-run health insurance system covering the entire population for a defined medical benefits package
- Funded through general taxes
- Consumer copayments are negligible
- Private health insurance for services covered by national health insurance is outlawed
- Cost control is achieved primarily through supply constraints – limits on the availability of technology and reduced choice of providers

EXAMPLE: FRANCE



- National health insurance with compulsory coverage
- Copayments, coinsurance
- Balance billing by about 1/3 of physicians
- 88% of the population buys supplemental coverage, which covers cost sharing
- About 8.5% of the population is exempted from cost sharing, mostly due to serious illness or special status (such as disability or veteran)
- Some services are exempted from cost sharing

EXAMPLE: VERMONT MODELING FOR SINGLE PAYER

- Medicare for All? Cost sharing too high
- Teachers' coverage for all? Taxes too high
- Happy medium? Then coverage is not equitable across the entire population – some will have better coverage, some worse
- Other huge issues:
  - Revenue sources don't keep up with cost growth
  - Can a state expect to reduce cost growth below the national market? How?

COST SHARING EXAMPLES FROM WASHINGTON STATE

- Medicare
- Apple Health (Medicaid)
- Cascade Care (Marketplace Public Option)
- Public Employee Benefits

MEDICARE – CONSUMER COST SHARING

- Medicare Overview
  - Eligibility: People age 65+ (or prior to age 65 if have disability or certain diseases)
  - Program Structure:
    - Part A – Hospital Coverage
    - Part B – Provider Coverage
    - Part D – Prescription Drugs
    - Medigap Plans – Private insurance reducing consumer cost sharing on Part A&B

    - **Or** Part C (“Medicare Advantage”) – comprehensive coverage, replaces Part A, B, & D
  - Revenue:
    - Employment taxes – half paid by employer, half by employee
    - Appropriations

MEDICARE – CONSUMER COST SHARING

Premiums for Medicare Enrollees

Part A Hospital

- **$0** for majority of timely enrollees
  - If not timely enrolled, monthly penalty for period of time
  - $278 or $505 per month, if have not paid Medicare taxes long enough
- Income adjusted premiums
  - Lower premium for lower income & limited resources

Part B Medical Provider & Outpatient

- **$174.70 per month** for timely enrollees
  - If not timely enrolled, monthly penalty for period of time
- Income adjusted premiums
  - Higher premium if >$103k single ($206k married)
  - Lower premium for lower income & limited resources

Part D Prescription Drugs

- **Varies by plan**
  - **$42 per month** (2024 average for WA) for timely enrollees
  - If not timely enrolled, monthly penalty for period of time
- Income adjusted premiums
  - Higher premium if >$103k single ($206k married)
  - Lower premium for lower income & limited resources

Medicare Supplement (Medigap)

- **Varies by plan** for timely enrollees
  - If not timely enrolled, monthly penalty for period of time
- Requires enrollment in Part A & Part B

2024 Medicare Costs. Source: https://www.medicare.gov/
2024 Medicare Part D: https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2024-a-first-look-at-prescription-drug-plan-availability-premiums-and-cost-sharing/

MEDICARE – CONSUMER COST SHARING

Consumer Cost Sharing to Utilize Health Care Services

Part A Hospital

- Inpatient Hospital:
  - $1,632 deductible (days 1-60)
  - $408 per day (days 61-90)
  - $816 per day (days 91+ while using lifetime limit days)
- Skilled Nursing Facility:
  - $0 per day (days 1-20)
  - $204 per day (days 21-100)

Part B Medical Provider & Outpatient

- $240 annual deductible
- 20% coinsurance after deductible
- No cost-sharing for certain services (e.g. preventive)

Part D Prescription Drugs

- Varies by plan & pharmacy
  - 21 standalone plans in WA (2024)
- Standard plan design:
  - Deductible: 100% up to $545
  - Initial Coverage: 25%
  - Coverage Gap: 25%
  - Catastrophic Coverage: 0% (new)
  - Out-of-pocket Max: $8,000 (includes manufacturer discounts in the coverage gap)
- 2024 Median Cost Sharing (nationwide)
  - Pref. Generic: $0
  - Generic: $5
  - Pref. Brand: $47 / 21%
  - Non-Preferred: 46%
  - Specialty: 25%

Optional Medigap plan (benefits vary by plan):

- Lower deductibles, copays, and coinsurance
- Additional lifetime reserve hospital days (Part A)
- May cover additional benefits not covered by Medicare (e.g. foreign travel emergency care)

See Appendix for illustration of Part D coverage phases

2024 Medicare Costs. Source: https://www.medicare.gov/
2024 Medicare Part D: https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2024-a-first-look-at-prescription-drug-plan-availability-premiums-and-cost-sharing/

MEDICARE – CONSUMER COST SHARING

Premiums vary by income, and timely enrollment.

Lower income individuals have low cost or free premiums.

Higher income individuals pay higher premiums.

Cost Sharing Trends

- Coinsurance for most services
- Most services are subject to deductible
- Separate prescription drug (Rx) deductibles & OOP Max
  - Note: Rx coverage varies by Part D plan
- Cost sharing can be reduced by purchasing Medigap plan

	Medicare (Part A, B, & D)			
In-Network Cost-sharing	Original Medicare (Part A, B, & D)	Copay (Average)	Coinsur. (Average)	Deductible Applies (% of Plans)
		--	--	--
Deductible (Ind)	$240	$240	--	100%
OOP Max (Ind)	--	--	--	--
Deductible (Fam)	--	--	--	--
OOP Max(Fam)	--	--	--	--
Preventive	$0	--	--	--
Primary Care	20%*	--	20%	100%
Specialist	20%*	--	20%	100%
Urgent Care	20%*	--	20%	100%
Emergency Room	20%*	--	20%	100%
Lab Tests	20%*	--	20%	100%
Diagnostic Imaging (X-rays)	20%*	--	20%	100%
Adv. imaging (CT, MRI, PET)	20%*	--	20%	100%
Rehabilitative Services	20%*	--	20%	100%
Chiropractic Care	20%*	--	20%	100%
Outpatient Surgery (Provider)	20%*	--	20%	100%
Outpatient Surgery (Facility)	20%*	--	20%	100%
Inpatient (Facility & Provider)	$1632****	$1,632	--	--
Behavioral Health (Office Visit)	20%*	--	20%	100%
Rx Separate Deductible	$545	$545	25%	100%
Rx Separate OOP Max	$8,000*****	--	--	--
Rx Value	$0*	$0	--	100%
Rx Generic	$5*	$5	--	100%
Rx Preferred Brand	$47 / 21%*	$47	21%	100%
Rx Non-Preferred Brand	46%*	--	46%	100%
Rx Specialty	25%*	--	25%	100%

* After deductible

**** Additional Per Day costs start on Day 61

***** Medicare Part D Rx OOP Max includes manufacturer discounts in the coverage gap

Medicare Part D Rx benefits illustrated are standard Rx deductible & OOP Max, and 2024 nationwide median cost for each drug tier. Benefits vary by plan.

2024 Medicare Costs. Source: https://www.medicare.gov/

2024 Medicare Part D: https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2024-a-first-look-at-prescription-drug-plan-availability-premiums-and-cost-sharing/

MEDICARE ADVANTAGE – CONSUMER COST SHARING

- Medicare Advantage (Part C) Overview
  - Eligibility: Anyone eligible for Medicare
  - Program Structure:
    - Private insurance plan
    - Comprehensive coverage that replaces Part A, B, D, & Medigap
      - Part A – Hospital Coverage
      - Part B – Provider Coverage
      - Part D – Prescription Drugs
      - Medigap Plans – Private insurance reducing consumer cost sharing on Part A&B
    - Requires enrollment in Part A & B
    - Can offer additional benefits beyond traditional Medicare
  - Premiums: Vary by plan
    - Some Medicare Advantage plans may pay enrollee's Part A/B premiums

2024 Medicare Costs. Source: https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options

CASCADE CARE PLANS

- Cascade Care Plans
  - Eligibility: Washington residents eligible for individual marketplace coverage
  - Program Structure:
    - Private insurance plan, covers ACA essential health benefits
    - Standard benefit design, emphasizes lower deductibles and providing access to many services before having to pay the deductible
    - Only offered on Washington Healthplanfinder
  - Premiums: Vary by plan, location, & age
    - Tax credits (APTC & Cascade Care Savings) can reduce premiums (lower-income individuals)
    - Cost sharing reductions (CSR) can reduce cost-sharing (lower-income individuals)
    - Additional charges for tobacco users

Source: https://www.wahealthplanfinder.org/us/en/my-account/my-coverage/cascade-care-health-plans.html

2024 CASCADE CARE PLANS - 80% AV OR HIGHER PLANS ONLY

Premiums vary by age, location, and plan.

For eligible lower income individuals, low cost or free premiums

Cost Sharing Trends

- Copay for most services
- Coinsurance typically for highest cost services only
- Most services not subject to deductible
- Prescription drugs (Rx) are all copays, not subject to deductible

	Cascade Care - Washington Health Plan Finder					
In-Network Cost-sharing	Silver (CSR 87%)	Silver (CSR 94%)	Gold	Copay (Average)	Coinsur. (Average)	Deductible Applies (% of Plans)
Actuarial Value	87%	94%	80%	87%	--	--
Deductible (Ind)	$750	$0	$600	$675	--	67%
OOP Max (Ind)	$2,500	$1,200	$6,100	$3,267	--	--
Deductible (Fam)	$1,500	$0	$1,200	$1,350	--	67%
OOP Max(Fam)	$5,000	$2,400	$12,200	$6,533	--	--
Preventive	$0	$0	$0	$0	--	--
Primary Care	$10	$5	$15	$10	--	--
Specialist	$30	$15	$40	$28	--	--
Urgent Care	$30	$15	$35	$27	--	--
Emergency Room	$425*	$150	$450*	$342	--	67%
Lab Tests	$20	$5	$20	$15	--	--
Diagnostic Imaging (X-rays)	$40	$15	$30	$28	--	--
Adv. imaging (CT, MRI, PET)	20%*	15%	$300*	$300	18%	67%
Rehabilitative Services	$20	$5	$25	$17	--	--
Chiropractic Care	20%*	15%	$25	$25	18%	33%
Outpatient Surgery (Provider)	$120*	$25	$75*	$73	--	67%
Outpatient Surgery (Facility)	$325*	$100	$350*	$258	--	67%
Inpatient (Facility & Provider)	$425**	$100**	$525**	$350	--	33%
Behavioral Health (Office Visit)	$10	$5	$15	$10	--	--
Rx Generic	$12	$5	$10	$9	--	--
Rx Preferred Brand	$35	$12	$60	$36	--	--
Rx Non-Preferred Brand	$160	$35	$100	$98	--	--
Rx Specialty	$160	$35	$100	$98	--	--

* After deductible

** Per Day (up to 5 days), after deductible

See Appendix for all Cascade Care plans

Annual visit limit may apply for certain rehabilitative and chiropractic care services

Silver Cascade Care plans have lower copays for first 2 PCP visits - $1/visit no deductible.

Source: https://www.wahealthplanfinder.org/

2024 PUBLIC EMPLOYEE BENEFITS BOARD (PEBB)

- Public Employee Benefits (PEBB)
  - Eligibility: Employees of a state agency, higher education institution, or participating employer group
  - Program Structure:
    - Private insurance plan, covers ACA essential health benefits
    - Includes HMO & PPO plans from three insurers
      - Kaiser Foundation of the Northwest (HMO)
      - Kaiser Foundation of Washington (HMO)
      - Uniform Medical Plan (PPO)
  - Monthly Premiums (2024)
    - Self-Only: $26 - $331
    - Self & Spouse: $52 - $662
    - Self & Children: $46 - $579
    - Self & Family: $72 - $910
    - Additional costs for tobacco users
    - Additional costs for spouses eligible for their own employer-sponsored plan

Source: https://www.hca.wa.gov/employee-retiree-benefits

2024 PUBLIC EMPLOYEE BENEFITS BOARD (PEBB)

(excluding Consumer-Directed Health Plans)

Premiums vary by number of covered family members.

Cost Sharing Trends

- Coinsurance for most services
- Most services are subject to deductible
- Most plans have separate prescription drug (Rx) deductibles & OOP Max

	Public Employee Benefits									
In-Network Cost-sharing	Kaiser Foundation NW (Classic)	Kaiser Foundation WA (Classic)	Kaiser Foundation WA (SoundChoice)	Kaiser Foundation WA (Value)	Uniform Medical Plan (Classic)	Uniform Medical Plan (Plus)	Uniform Medical Plan (Select)	Copay (Average)	Coinsur. (Average)	Deductible Applies (% of Plans)
	HMO	HMO	HMO	HMO	PPO	PPO	PPO	--	--	--
Deductible (Ind)	$300	$175	$125	$250	$250	$125	$750	$282	--	100%
OOP Max (Ind)	$2,500	$2,000	$2,000	$3,000	$2,000	$2,000	$3,500	$2,429	--	100%
Deductible (Fam)	$900	$525	$375	$750	$750	$375	$2,250	$846	--	100%
OOP Max(Fam)	$5,000	$4,000	$4,000	$6,000	$4,000	$4,000	$7,000	$4,857	--	100%
Preventive	$0	$0	$0	$0	$0	$0	$0	--	--	--
Primary Care	$25	$15*	$20	$30*	15%*	$0	20%*	$23	18%	57%
Specialist	$35	$30*	15%*	$50*	15%*	15%*	20%*	$38	16%	86%
Urgent Care	$45	$15* / $30*	15%*	$30* / $50*	15%*	15%*	20%*	$36	16%	86%
Emergency Room	15%*	$250*	$75,15%*	$300*	$75, 15%*	$75, 15%*	$75, 20%*	$142	16%	100%
Lab Tests	$10	$0*	15%*	$0*	15%*	15%*	20%*	$10	16%	86%
Diagnostic Imaging (X-rays)	$10	$0*	15%*	$0*	15%*	15%*	20%*	$10	16%	86%
Adv. imaging (CT, MRI, PET)	$10	$30*	15%*	$50*	15%*	15%*	20%*	$30	16%	86%
Rehabilitative Services	$35	$30*	15%*	$50*	15%*	15%*	20%*	$38	16%	86%
Chiropractic Care	$35	$15* / $30*	$20* / 15%*	$30* / $50*	$15*	$15*	$15*	$23	--	86%
Outpatient Surgery (Provider)	15%*	$0	15%*	$0	15%*	15%*	20%*	--	16%	71%
Outpatient Surgery (Facility)	15%*	$150*	15%*	$200*	15%*	15%*	20%*	$175	16%	100%
Inpatient (Facility & Provider)	15%*	$150**	$500*	$250**	$200***	$200***	$200***	$250	15%	100%
Behavioral Health (Office Visit)	$25	$15*	$20*	$30*	15%*	15%*	20%*	$23	17%	86%
Rx Separate Deductible	--	$100 / $300	$100 / $300	$100 / $300	$100 / $300	--	$250 / $750	$138	--	71%
Rx Separate OOP Max	--	$2,000 / $8,000	$2,000 / $8,000	$2,000 / $8,000	$2,000 / $4,000	$2,000 / $4,000	$2,000 / $4,000	$2,000	--	86%
Rx Value	--	$5	$5	$5	5% up to $10	5% up to $10	5% up to $10	$8	5%	--
Rx Generic	$15	$20	$15	$25	10% up to $25	10% up to $25	10% up to $25	$21	10%	--
Rx Preferred Brand	$40	$40	$60*	$50*	30% up to $75*	30% up to $75*	30% up to $75*	$59	30%	71%
Rx Non-Preferred Brand	$75	50% up to $250*	50%*	50%*	--	--	--	$163	50%	43%
Rx Specialty	50% up to $150	--	$150* / 50% up to $400*	$150* / 50% up to $400*	--	--	--	$150	50%	29%
Premium - Self only	$331	$226	$69	$211	$124	$109	$59	$161	--	--
Premium - Self & Spouse	$662	$452	$138	$422	$248	$218	$118	$323	--	--
Premium - Self & Children	$579	$396	$121	$369	$217	$191	$103	$282	--	--
Premium - Family	$910	$622	$190	$580	$341	$300	$162	$444	--	--

* After deductible
** Per Day (up to 5 days), after deductible
*** Per Day (up to 3 days per calendar year)

Annual visit limit may apply for certain rehabilitative and chiropractic care services
If two cost sharing listed in same field, varies by provider/facility type (PCP vs specialist)
Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties and ZIP codes in Oregon.

See Appendix for all PEBB plans

Source: https://www.hca.wa.gov/employee-retiree-benefits

APPLE HEALTH (MEDICAID)

- Apple Health (Medicaid)
  - Eligibility: Lower income individuals, pregnant people, children, and other eligible individuals
  - Program Structure:
    - Comprehensive coverage
    - Covers ACA essential health benefits
      - Benefits may vary for certain eligibility categories
    - Managed Care (MCO) or Fee-for-Service
  - Premiums: $0

Cost Sharing Trends

- No cost sharing for covered services
- Prior authorization and referrals may be required for certain services

	Apple Health
In-Network Cost-sharing	Medicaid
	100%
Deductible (Ind)	$0
OOP Max (Ind)	$0
Deductible (Fam)	$0
OOP Max(Fam)	$0
Preventive	$0
Primary Care	$0
Specialist	$0
Urgent Care	$0
Emergency Room	$0
Lab Tests	$0
Diagnostic Imaging (X-rays)	$0
Adv. imaging (CT, MRI, PET)	$0
Rehabilitative Services	$0
Chiropractic Care	$0
Outpatient Surgery (Provider)	$0
Outpatient Surgery (Facility)	$0
Inpatient (Facility & Provider)	$0
Behavioral Health (Office Visit)	$0
Rx Separate Deductible	--
Rx Separate OOP Max	--
Rx Value	$0
Rx Generic	$0
Rx Preferred Brand	$0
Rx Non-Preferred Brand	$0
Rx Specialty	$0

Source: https://www.hca.wa.gov/billers-providers-partners/program-information-providers/program-benefit-packages-and-scope-services

COMPARISON

Premium trends:

- Lower premiums for lower income individuals
- Higher premiums for high income (Medicare only)
- Age rating (Cascade Care only)
- Additional cost for tobacco use (Cascade Care, PEBB)

Cost Sharing Trends

- Deductible (all)
  - Only higher cost services subject to deductible (Cascade Care)
- Coinsurance for most services (Medicare, PEBB)
  - Coinsurance only higher cost services (Cascade Care)
- Copays for most services (Cascade Care)
- Rx copays for lower cost; coinsurance for higher cost (all)
  - Separate Rx deductible (Medicare, PEBB)
- Reduced cost sharing for lower income individuals (Medicaid, Cascade Care, Medicare)

	Cascade Care			Public Employee Benefits			Medicare (Part A, B, & D)			Apple Health
In-Network Cost-sharing	Copay (Average)	Coinsur. (Average)	Deductible Applies (% of Plans)	Copay (Average)	Coinsur. (Average)	Deductible Applies (% of Plans)	Copay (Average)	Coinsur. (Average)	Deductible Applies (% of Plans)	Medicaid
	87%	--	--	--	--	--	--	--	--	100%
Deductible (Ind)	$675	--	67%	$282	--	100%	$240	--	100%	$0
OOP Max (Ind)	$3,267	--	--	$2,429	--	100%	--	--	--	$0
Deductible (Fam)	$1,350	--	67%	$846	--	100%	--	--	--	$0
OOP Max(Fam)	$6,533	--	--	$4,857	--	100%	--	--	--	$0
Preventive	$0	--	--	--	--	--	--	--	--	$0
Primary Care	$10	--	--	$23	18%	57%	--	20%	100%	$0
Specialist	$28	--	--	$38	16%	86%	--	20%	100%	$0
Urgent Care	$27	--	--	$36	16%	86%	--	20%	100%	$0
Emergency Room	$342	--	67%	$142	16%	100%	--	20%	100%	$0
Lab Tests	$15	--	--	$10	16%	86%	--	20%	100%	$0
Diagnostic Imaging (X-rays)	$28	--	--	$10	16%	86%	--	20%	100%	$0
Adv. imaging (CT, MRI, PET)	$300	18%	67%	$30	16%	86%	--	20%	100%	$0
Rehabilitative Services	$17	--	--	$38	16%	86%	--	20%	100%	$0
Chiropractic Care	$25	18%	33%	$23	--	86%	--	20%	100%	$0
Outpatient Surgery (Provider)	$73	--	67%	--	16%	71%	--	20%	100%	$0
Outpatient Surgery (Facility)	$258	--	67%	$175	16%	100%	--	20%	100%	$0
Inpatient (Facility & Provider)	$350	--	33%	$250	15%	100%	$1,632	--	--	$0
Behavioral Health (Office Visit)	$10	--	--	$23	17%	86%	--	20%	100%	$0
Rx Separate Deductible	--	--	--	$138	--	71%	$545	25%	100%	--
Rx Separate OOP Max	--	--	--	$2,000	--	86%	--	--	--	--
Rx Value	--	--	--	$8	5%	--	$0	--	100%	$0
Rx Generic	$9	--	--	$21	10%	--	$5	--	100%	$0
Rx Preferred Brand	$36	--	--	$59	30%	71%	$47	21%	100%	$0
Rx Non-Preferred Brand	$98	--	--	$163	50%	43%	--	46%	100%	$0
Rx Specialty	$98	--	--	$150	50%	29%	--	25%	100%	$0

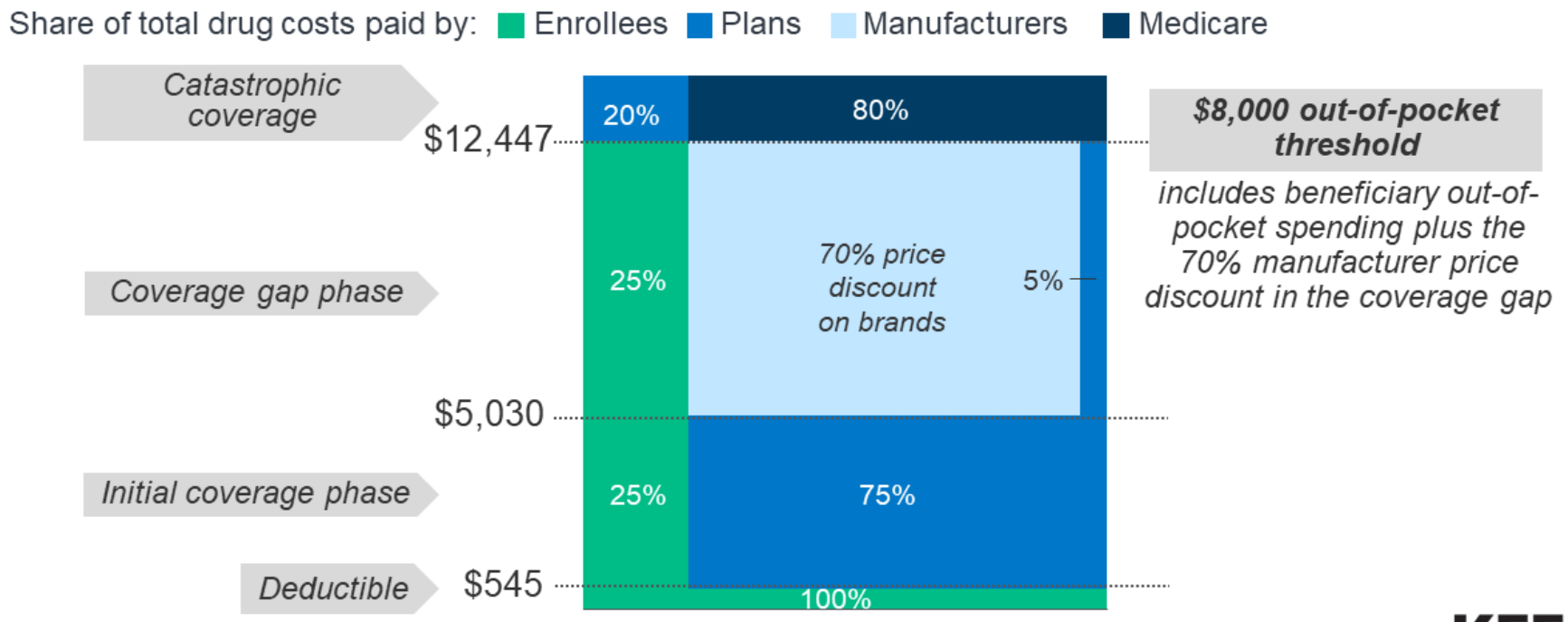
See plan documents for benefit details, limitations, and exclusions.

APPENDIX

MEDICARE PART D – 2024 CONSUMER COST SHARING

Figure 5

Medicare Part D Standard Benefit Parameters Will Increase in 2024, but the 5% Coinsurance Requirement for Catastrophic Coverage Will Be Eliminated, Due to a Provision in the Inflation Reduction Act



NOTE: Some amounts rounded to nearest dollar.
SOURCE: KFF, based on 2024 Part D benefit parameters.

KFF

2024 Medicare Costs. Source: https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/

2024 CASCADE CARE PLANS

	Cascade Care - Washington Health Plan Finder								
In-Network Cost-sharing	Bronze	Silver	Silver (CSR 73%)	Silver (CSR 87%)	Silver (CSR 94%)	Gold	Copay (Average)	Coinsur. (Average)	Deductible Applies (% of Plans)
Actuarial Value	60%	70%	73%	87%	94%	80%	77%	--	--
Deductible (Ind)	$6,000	$2,500	$2,500	$750	$0	$600	$2,470	--	83%
OOP Max (Ind)	$9,200	$9,200	$7,550	$2,500	$1,200	$6,100	$5,958	--	--
Deductible (Fam)	$12,000	$5,000	$5,000	$1,500	$0	$1,200	$4,940	--	83%
OOP Max(Fam)	$18,400	$18,400	$15,100	$5,000	$2,400	$12,200	$11,917	--	--
Preventive	$0	$0	$0	$0	$0	$0	$0	--	--
Primary Care	$50	$30	$30	$10	$5	$15	$23	--	--
Specialist	$100*	$65	$65	$30	$15	$40	$53	--	17%
Urgent Care	$100	$65	$65	$30	$15	$35	$52	--	--
Emergency Room	40%*	$800*	$800*	$425*	$150	$450*	$525	40%	83%
Lab Tests	40%*	$40	$40	$20	$5	$20	$25	40%	17%
Diagnostic Imaging (X-rays)	40%*	$65	$65	$40	$15	$30	$43	40%	17%
Adv. imaging (CT, MRI, PET)	40%*	30%*	30%*	20%*	15%	$300*	$300	27%	83%
Rehabilitative Services	40%*	$40	$40	$20	$5	$25	$26	40%	17%
Chiropractic Care	40%*	30%*	30%*	20%*	15%	$25	$25	27%	67%
Outpatient Surgery (Provider)	40%*	$200*	$200*	$120*	$25	$75*	$124	40%	83%
Outpatient Surgery (Facility)	40%*	$600*	$600*	$325*	$100	$350*	$395	40%	83%
Inpatient (Facility & Provider)	40%*	$800**	$800**	$425**	$100**	$525**	$530	40%	67%
Behavioral Health (Office Visit)	$50	$30	$30	$10	$5	$15	$23	--	--
Rx Generic	$32	$25	$24	$12	$5	$10	$18	--	--
Rx Preferred Brand	40%*	$75	$75	$35	$12	$60	$51	40%	17%
Rx Non-Preferred Brand	40%*	$250*	$250*	$160	$35	$100	$159	40%	50%
Rx Specialty	40%*	$250*	$250*	$160	$35	$100	$159	40%	50%

* After deductible

** Per Day (up to 5 days), after deductible

Annual visit limit may apply for certain rehabilitative and chiropractic care services

Silver Cascade Care plans have lower copays for first 2 PCP visits - $1/visit no deductible.

Source: https://www.wahealthplanfinder.org/

2024 PUBLIC EMPLOYEE BENEFITS BOARD (PEBB)

In-Network Cost-sharing	Public Employee Benefits									
	Kaiser Foundation NW (Classic)	Kaiser Foundation NW (CDHP)	Kaiser Foundation WA (Classic)	Kaiser Foundation WA (SoundChoice)	Kaiser Foundation WA (Value)	Kaiser Foundation WA (CDHP)	Uniform Medical Plan (Classic)	Uniform Medical Plan (Plus)	Uniform Medical Plan (Select)	Uniform Medical Plan (CDHP)
	HMO	HMO	HMO	HMO	HMO	HMO	PPO	PPO	PPO	PPO
Deductible (Ind)	$300	$1,600	$175	$125	$250	$1,600	$250	$125	$750	$1,600
OOP Max (Ind)	$2,500	$5,100	$2,000	$2,000	$3,000	$5,100	$2,000	$2,000	$3,500	$4,200
Deductible (Fam)	$900	$3,200	$525	$375	$750	$3,200	$750	$375	$2,250	$3,200
OOP Max(Fam)	$5,000	$10,200	$4,000	$4,000	$6,000	$10,200	$4,000	$4,000	$7,000	$8,400
Preventive	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care	$25	$20*	$15*	$20	$30*	10%*	15%*	$0	20%*	15%*
Specialist	$35	$30*	$30*	15%*	$50*	10%*	15%*	15%*	20%*	15%*
Urgent Care	$45	$40*	$15* / $30*	15%*	$30* / $50*	10%*	15%*	15%*	20%*	15%*
Emergency Room	15%*	15%*	$250*	$75,15%*	$300*	10%*	$75, 15%*	$75, 15%*	$75, 20%*	15%*
Lab Tests	$10	15%*	$0*	15%*	$0*	10%*	15%*	15%*	20%*	15%*
Diagnostic Imaging (X-rays)	$10	15%*	$0*	15%*	$0*	10%*	15%*	15%*	20%*	15%*
Adv. imaging (CT, MRI, PET)	$10	15%*	$30*	15%*	$50*	10%*	15%*	15%*	20%*	15%*
Rehabilitative Services	$35	$30*	$30*	15%*	$50*	10%*	15%*	15%*	20%*	15%*
Chiropractic Care	$35	$30*	$15* / $30*	$20* / 15%*	$30* / $50*	10%*	$15*	$15*	$15*	$15*
Outpatient Surgery (Provider)	15%*	15%*	$0	15%*	$0	10%*	15%*	15%*	20%*	15%*
Outpatient Surgery (Facility)	15%*	15%*	$150*	15%*	$200*	10%*	15%*	15%*	20%*	15%*
Inpatient (Facility & Provider)	15%*	15%*	$150**	$500*	$250**	10%*	$200***	$200***	$200***	15%*
Behavioral Health (Office Visit)	$25	$20*	$15*	$20*	$30*	10%*	15%*	15%*	20%*	15%*
Rx Separate Deductible	--	--	$100 / $300	$100 / $300	$100 / $300	--	$100 / $300	--	$250 / $750	--
Rx Separate OOP Max	--	--	$2,000 / $8,000	$2,000 / $8,000	$2,000 / $8,000	--	$2,000 / $4,000	$2,000 / $4,000	$2,000 / $4,000	--
Rx Value	--	--	$5	$5	$5	--	5% up to $10	5% up to $10	5% up to $10	15%* (except insulin)
Rx Generic	$15	$15*	$20	$15	$25	$20*	10% up to $25	10% up to $25	10% up to $25	15%* (except insulin)
Rx Preferred Brand	$40	$40*	$40	$60*	$50*	$40*	30% up to $75*	30% up to $75*	30% up to $75*	15%* (except insulin)
Rx Non-Preferred Brand	$75	$75*	50% up to $250*	50%*	50%*	50% up to $250*	--	--	--	--
Rx Specialty	50% up to $150	50% up to $150*	--	$150* / 50% up to $400*	$150* / 50% up to $400*	--	--	--	--	--

* After deductible
** Per Day (up to 5 days), after deductible
*** Per Day (up to 3 days per calendar year)

Annual visit limit may apply for certain rehabilitative and chiropractic care services
If two cost sharing listed in same field, varies by provider/facility type (PCP vs specialist)
Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties and ZIP codes in Oregon.

Source: https://www.hca.wa.gov/employee-retiree-benefits

Tab 6

Washington State Health Care Authority

Discussion Questions for Modeling

Cost Sharing and Benefit Selection:

1. What Cascade Care (i.e., standard plan) benefit design(s) should we price? For example, we could price a cascade bronze, silver, or gold plan. If something off the shelf, like a Cascade Care benefit structure, isn't selected, we will need substantially more information about the cost sharing structure.

2. Define explicitly the coverage of any services not covered by exchange plans or defined under the Cascade Care standard benefit plan designs, that you wish to see added. References to benefits of established plans would be helpful to facilitate modeling. For example, adding a dental benefit and providing a benefit based on the PEBB/SEBB coverage.

3. Would cost sharing be means tested or uniform across the population? If cost sharing would have components that are means tested, would the testing be based on an existing program? For example, like the exchange market, it could include a phased-in reduction:
    a. Up to 150% FPL: CSR Silver Plan of 94% plan coverage of allowed costs,
    b. 151% to 200% FPL: CSR Silver Plan of 87% plan coverage of allowed costs,
    c. 201% to 250% FPL: CSR Silver Plan of 73% plan coverage of allowed costs, and
    d. Greater than 250% FPL – regular cost sharing (70% plan coverage of allowed costs).

Additional questions:

1. Population: What population(s) would the plan expect to cover? For example, we could assume the coverage applies to all individuals ages 0-64 not covered by Medicare or large-group plans.

2. Enrollment: Would we assume that the coverage would be opt-in, or would the coverage be mandatory and replace other coverage options?

3. Reimbursement: Are there expected provider reimbursement targets for the payments to providers, and would these vary by service? For example, Cascade Select plans have historically reimbursed inpatient and outpatient services at approximately 160% of Medicare, and professional services at approximately 130% of Medicare.

4. Medical Management: Are there expectations for the level of medical management in the plan, and how would that be achieved? For example, would the State contract with a private organization, would there be prior authorization required for certain services?

Thank you for attending the Finance Technical Advisory Committee meeting!

Washington State Health Care Authority