Universal Health Care Work Group Q&A

More Information About the Work Group meeting materials from the September 16th and October 7th meetings

We created this Q&A to answer questions from the presentations at the September 16th Meeting and the October 7th Meeting pre-recorded materials which are available here: https://www.hca.wa.gov/about-hca/healthier-washington/universal-health-care-work-group

The Q&A is organized by topic and updated as we receive new questions. (Updated 10/18/20)

Meeting Process

1. **We would like to accept short video public comments along with written comments because they can be very compelling. 1.5 minutes max. Would encourage younger people to participate, for example.**
   A: HCA is looking into the logistics of providing this option, in addition to submitting comments via email and at the Work Group meetings.

2. **We hope you are continuing to think about how to allow for a couple of public comments during breakout groups. A:** We have discussed this request and determined this is not feasible at this time. Our time for group discussions is already very limited; it is already a challenge to complete necessary deliberations within the limited timeframe the work group has together. The post-meeting survey is an opportunity for members of the public to provide comments on specific topics covered in the meeting and we hope that interested community members continue to take advantage of that opportunity.

3. **Curious how the breakout rooms are formed. Are they random or organized by particular criteria, or?**
   A: Jamie forms them after receiving the final registration list the day before the meeting. She tries to create breakout groups with a balance of perspectives (e.g., placing health care providers in different rooms rather than clustering them in one place). Jamie also attempts to mix up groups so members have an opportunity to work with and hear from different members. Finally, she tries to balance numbers so the breakout groups are roughly the same size.

   One challenge we face is that not all Work Group members register in advance and not everyone who says they will attend shows up. As such, we usually have to do some last-minute rearranging to keep the groups balanced in size. Another challenge is a quirk with Zoom that makes it difficult to move Work Group members from the main room to breakout rooms when we are doing a session with multiple breakouts. As such, breakout discussion groups are not always exactly how we plan them.

4. **How will the final report be drafted and finalized? Every member is bound to have suggestions for the final report. What is the process for the Work Group for to reconcile and incorporate either as a consensus or a separate report? Will there be a voting process? Will minority viewpoints be noted?**
   A: The project team is drafting the report based on feedback received from the Work Group to date and at the October 7 and October 29 Work Group meetings. The draft report will be provided to the Work Group on November 18 to review and provide written feedback. After we have received written feedback, we will catalogue it in a matrix so we can identify feedback that requires further discussion. We will discuss and confirm

feedback from Work Group members at the December Work Group meeting and make revisions to the report to the Legislature.

As this is not a representative group (i.e., an elected body or members selected by their constituents), per our charter we do not seek consensus nor do we use voting. Our objective is to clearly document perspectives as shared with us in Work Group meetings. We recognize that some Work Group members have communicated more in Work Group meetings than others. For Work Group members who have been less vocal in meetings, we are reaching out to individual Work Group members directly to clarify and confirm their viewpoints.

Universal Health Care Modeling Presentation

1. **I find the assumption around cost with the private health insurance and Medicaid being almost the same when you take into account cost sharing odd. My understanding is that the Medicaid population in general is sicker. This brings up a whole host of questions around the modelling. (Added 10/18/20)**
   A: This is an interesting observation. It is coincidental that the per-member costs are the same when you account for cost sharing. You are correct that we should expect client acuity differences between these two populations. In fact, having the same per member costs supports that conclusion. Keep in mind that Medicaid reimbursement levels are far lower than commercial reimbursement rates; consequently, if the per member costs are the same, the Medicaid members must be using significantly more services which is aligned with the assumption that their health burden is greater. Lastly, we would note that all of the cost estimates are actively being refined as we continue to get more information to refine the model.

2. **Are we including Medicaid clients that have limited coverage? (Added 10/18/20)**
   - **Family Planning only**
   - **Medically Needy clients**
   - **Breast and cervical cancer**
   - **Alien Emergent medical**
   - **Medical Savings Plan**
   - **Dual covered individuals**

   A: Yes, the costs for all of these populations are captured in the model. Dually eligible members' Medicaid costs are captured in the Medicaid program cost summary, but the individuals themselves are reported under Medicare to prevent double counting. This does skew the per member costs in the Medicaid program slightly, but allows for an accurate accounting of Title XIX funding that would be preserved under a transition to the new model.

3. **Where are the costs for Medicaid coming from? (Added 10/18/20)**
   A: Medicaid costs are based on CMS 64 reporting found here: https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html. The 2018 expenditures are trended forward to 2022. We anticipate the estimate for 2022 Medicaid expenditures will be reduced in future iterations of the model as the overall target expenditure based on National Health Expenditure forecast tends to overestimate expenditures for Washington.

4. **How do we align benefit packages? We talked about this a little bit but these assumptions need to be plainly documented. Are the following included? (Added 10/18/20)**
   - **Dental?**
   - **Family Planning?**
   - **Behavioral Health?**

- **Substance Abuse**
- **Mental Health**
- **Transportation**
- **Emergent**
- **Non Emergent**

A: We are not assuming the benefits will be the same for all members. For example, the Workgroup is less interested in broad coverage of Long-Term Care but would not want to eliminate it as a benefit for the current Medicaid enrollees. We are assuming Medicaid members will maintain their current benefits, but that services will be repriced to a standard average level across all members. Using different benefit packages will likely be necessary to maintain federal funding under Title XIX. We are assuming that the population not eligible for Medicaid will have access to benefits defined as Essential Health Benefits in Washington. We will provide the incremental costs assumed for covering dental services. Advocates can use that information to make the case for including dental coverage beyond the Medicaid eligible population.

5. **The Optumas report states that cost savings from pharmaceutical purchasing have been obtained through the Medicaid Drug Rebate Program. As Aaron Katz stated today, the mark up is key. This program is based on the average manufacturer's price, which varies widely between purchasers. The overall savings of 50% that Optumas cites is probably based on the higher level of those prices. The law actually specifies 23.1% rebate on brand name drugs and 13% rebate on generic drugs; however, this varies widely. We should probably emphasize it ... it varies widely! (Added 10/18)**

A: To clarify, the model allows for less potential savings for the Medicaid eligible population due to purchasing power as they already have access to steeply discounted drugs.

Medicaid programs generally do have rebates that are 50% or more in aggregate. This statistic refers to rebate revenue as a percentage of total pharmacy expenditures (what the Medicaid agency paid pharmacies for the drugs – many of which use average acquisition cost that reflects the actual cost of pharmacies). You are correct that statute lists a minimum rebate level of 23.1% and 13% on AMP, but this only part of the equation. The Medicaid Prescription Drug Rebate Program uses the greater of the rebate floor you noted and the "Best Price". 42 U.S.C. § 1396r-8 (c) (1)(C) defines Best Price as the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States. States can also negotiate additional rebates on top of the federal program. These two factors result in Medicaid programs having access to better net pricing than private plans typically have access to, which is why the model reflects less opportunity for Medicaid utilization than private plans. The opportunity that remains can be attributed to the type of innovative strategies you mention WHCA has implemented or will be implementing.

6. **Slide 5 Modeled Populations – The slide does not mention either the Indian Health Service or Tribal members who receive health services from Tribal health systems. Where do these groups fit in the model? Also, this slide says we want to exclude Medicare beneficiaries – I don't recall the Work Group making that recommendation; depending on the result of this year's election, federal legislation may provide a pathway for Medicare to be integrated into a state universal health care initiative. I think we should see Medicare included as one alternative. (Added 10/7)**

A: Many IHS eligible individuals have primary insurance such as Medicaid. To avoid double counting, the model treats IHS services as an expenditure category and a related revenue source. The eligible population itself is not isolated. We will provide a scenario where Medicare is included in the model.

7. **Slide 11 – I was surprised about the small estimate for administrative savings for providers (0.5 – 1.0%). I think Shane said in the recording that the team found only "anecdotal" evidence that argued against projecting larger savings. I think the evidence is much stronger that savings among providers will be considerably larger … at least in out-years. I have not conducted a comprehensive literature review, but the attached articles are strongly suggestive that the current multi-payer system, in which billing requirements, payment methods, and utilization management protocols different across the thousands of payers providers much deal with, levies an administrative "penalty" far in excess of 1% (a comparison I did in 1989 between administrative spending in WA and BC estimating that penalty was more like 10 percentage points; I am trying to find a copy of that study, which was probably produced in Word Perfect!). I'd point you, in particular, to the Thorpe article, which provides a good framework for thinking through which administrative activities will likely be reduced or eliminated under Model A. (Added 10/7)**
   A: Thank you for providing additional resources. We will review the materials you provided. We would note that the first year of the model practices will still have a lot to do to "close out" their relationships with the multiple payers and to learn to efficiently navigate the new system. We fully agree that in later years it would be reasonable to account for further reductions.

8. **Slide 11 – I believe Shane said in relation to the "negotiating power adjustment" in this slide that the state's negotiating leverage would be tempered by the considerable consolidation in the provider market. While true, what argues in the other direction is that no provider I know of could survive financially without having access to the >80% of the patient market the state would be controlling. (Added 10/7)**
   A: We agree that providers would not be in a position to walk away from the negotiating table. There are three primary considerations informing our current assumption. High levels of system consolidation largely influence the second factor.

   First, it is common practice in premium development to phase in major financial shifts over time. Even where warranted, systems need time to adjust their business models to reflect new financial realities. This helps mitigate unintended consequences such as reduced access to care, layoffs, or community level economic disruptions. This seems even more important given the current global pandemic and the uncertainty in the future.

   Second, we want to be cognizant of political processes that will likely put upward pressure on rates. It would be valuable to hear from workgroup members regarding this dynamic. Would the rate negotiation process for Cascade Care be informative? This is a particularly challenging aspect of the modeling, but we feel it is important to account for due to the risk of overestimating savings. Because a universal health care program would double the state budget, if tax policy established to cover the projected costs is insufficient due to overstated savings, this could put the State in the position of having to cut critical services outside of the universal health care program.

   Lastly, there are areas of uncertainty in the model where there is a lack of data (ERISA plans, self-pay, charity care, etc.). It will be difficult to precisely target the right level of reimbursement that eliminates overpricing but does not destabilize the system. In the first year of the program, which will generate a utilization data set that can help answer these challenging questions, the State would likely need to take a more conservative approach with provider reimbursement.

9. **Was the team able to think through or assign the distribution of spending (and savings) across different payers in the three models? In order to "sell" Model A or B, it will be important to be able to do so. (Added**

10/7)

A: This is the next phase of our modeling. We plan to do a "revenue side" analysis based on a comparison of estimated status quo expenditures to modeled expenditures by population.

10. **I am unsure why uncoupling insurance from employment is a benefit. Most employees are delighted to have their employer choose, administer, and subsidize health coverage. The problem is when you have few, or no, options when you leave or change jobs. That is why we need an affordable option which does not exist in WA. (Added 10/5)**

    A: This is not the consultants' opinion; this was an opinion expressed by Work Group members during breakout sessions that was captured in the summary documentation. They identified the same challenge as you with individual's labor mobility being constrained by the need to maintain health insurance coverage.

11. **Un-insurance rate in WA is around 8% and according to US Census estimates the population is 7.6 million. According to the attached Rand NY study, most of these individuals have access to subsidized coverage and simply do not enroll. That has been my observation for years with surgeries for uninsured individuals who access the hospital from the ED. (Added 10/5)**

    A: The uninsured estimates are for 2022 and reflect that a portion of that population will sign up for the state's subsidy program under status quo policy. The portion of the uninsured population that consists of undocumented immigrants is carved out and modeled separately. Our modeling is generally aligned with the assumptions you're making here after accounting for the adjustments made to accurately capture policy nuances for subsets of the uninsured population.

12. **Slide 5 the total cost of the status quo adds up to $70.5B yet the following slide it lists $56.5B. (Added 10/5)**

    A: This statistic is referring to two different populations. Slide 5 is a broad overview of all populations. Slide 6 is the subset included in Model A. For example, Medicare is excluded from the statistics in Slide 6. The two statistics should not reconcile. Table 2 in the one-page handout that you received illustrates the value of expenditure excluded from the Model.

13. **Utilization increases for uninsured populations given free coverage are typically much great that 1-2%. The NY Rand study estimated 25%. (Added 10/5)**

    A: The modeling does not assume a 1-2% increase in utilization for this population. The assumptions on Slide 12 related to the two primary uninsured populations are provided below for your reference. Key words are bolded for clarity.

    - Increase in utilization for the undocumented immigrant population **result in per member expenditures equivalent to the expenditure levels for commercially insured populations**.
    - Increase in utilization for uninsured populations bring per member expenditure to the **equivalent 80% of expenditure levels for commercially insured populations.**

14. **There is no question that cost-sharing reduces low and negative value care. If something is free, people will take more. It is not a matter of access but the realization that health care is a scarce resource and too many expensive procedures really are not indicated. (Added 10/5)**

    A: The model does include increases to utilization due to the removal of cost sharing. The comments regarding the evidence base remain accurate.

15. **Slide 11 on negotiating power effects of 0.25% are ridiculous. The Maryland experience, Medicare annual revisions, and the difference in prices between current exchange plans and public employee plans (see attached) is logarithmically greater. Hospital cost inflation and gouging is primarily to blame. (Added 10/5)**

A: Thank you for your feedback. Please keep in mind that the modeling reflects maintaining provider reimbursement in aggregate and redistributes level reimbursement across payers. The modeling includes consideration for operational and political realities that the plan will face in the first year into the first-year assumptions. The plan will include building a network from scratch and will require the consolidated systems to participate in the network to have adequate access for enrollees. With more utilization and experience after the first year, the plan/state should certainly leverage purchasing power to further reduce inappropriate pricing variation where it is identified.

16. **I calculated the cost to WA if we merely made the retired state employee plan available ($654/month, attached) to all 7.6 million Washington residents and the total cost is $59.6 billion – roughly the same as Shane's. Given the fact that WA average age of 37 is decades younger than the retired state employee population, this is a gross over-estimation of costs. (Added 10/5)**
A: We need to be very clear that this is not an appropriate comparison to make. We have provided a few examples below to illustrate this point. Please note it is not a comprehensive list of factors that make the comparison misleading.
    - Inflation – with annual health care inflation of approximately 5%, the $654 monthly premium becomes $721 by 2022. This adjustment increases the total cost included in your estimate by over $6 billion.
    - Out of pocket expense included in the modeling are nearly $8 billion across all covered populations
    - Benefits – the current modeling estimate includes full dental and full vision coverage for everyone and continued coverage of Medicaid long-term care; however, we note additional long-term care costs for non-Medicaid populations will be included in future iterations. Based on PEBB retiree dental premiums (ranging between $39-47 per month). Including dental coverage into your example would further increase the estimate $3.6 to $4.3 billion annually.

      We hope the examples help provide clarity regarding the lack of comparability between the back-of-the-napkin estimate and the modeled results, but please let us know if we can provide further clarification. The draft report will include a detailed methodology writeup that is reviewed by Work Group members and certainly welcome your feedback.

17. **If we offered the 200K currently in the exchange, the 124k undocumented aliens, and the 300k or so uninsured who don't qualify for subsidized coverage or Medicaid the retired state employee health plan as an option based on their ability to pay but not to exceed the current rates that are charged, and the total cost to the state to achieve universal access would be at most $4.9B (assuming nobody can afford it) and likely far less, especially if it was eligible for ACA subsidies. Universal access need not be overly expensive. Let's just create a REAL public option and forget the single payor concept which is not feasible in my lifetime. (Added 10/5)**
A: These assumptions are actually similar to the "Close the Gap" model assumptions. We encourage you to share your recommended revisions to the "Close the Gap" model during the next workgroup meeting. We are can accommodate modeling changes based on feedback from the Work Group.

18. **What is the time basis for the $3 Billion savings for Option A? Is it $3 billion every year, or? (Added 10/5)**
A: The $3 billion represents the estimated first year annual savings from the current status quo total health care expenditures. These are total health care expenditures for all payer sources (including out of pocket). Subsequent years cost program cost would be based on initial year experience and may include both additional

cost savings as well as new costs. The preliminary estimate does not include any estimates beyond the first year, so we can't speak to those estimates yet.

19. **Confirming that the data we're seeing is from Washington state? If not, please indicate.**
    A: Optumas worked with HCA to obtain Washington specific data where available. There are some populations where current state expenditure data is not available such as undocumented immigrants, ERISA plans, etc. Please refer to this week's prerecorded presentation materials for a detailing of data sources used for each population. When the source for a population is listed as "National Health Expenditures", the estimates are imputed based on national statistics.

20. **Based on the August meeting, we are surprised dynamic modeling is not included in the presentation. We think some items merit it -- long-term care, alternative care, and hearing. Will it be added later?**
    A: Optumas built a dynamic model. The populations included/excluded and assumptions can be modified. Results reflected our best understanding of direction from the Work Group to date. We can provide information on different scenarios for any element we included in the model. Hearing services and many of the 'alternative' services are already covered or partially covered as Essential Health Benefits; available here: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-Washington-Benchmark-Summary.pdf.

    Additional modeling on alternative services cannot be performed. Unlike dental, vision, and long-term care, alternative care services are generally substituted for other services. Based on the current data limitations we do not have detailed enough utilization data to identify what portion of status quo utilization could be replaced by alternative care services such that we could create a reasonable estimate of the change in costs relative to status quo. Given what is already covered, it is not likely to significantly impact the $60 B model.

21. **We need details on the spending components. For example, on Slide 7 "Other Private Revenues" is about the same amount as all the other revenue sources combined. We need the explanation and details behind these expenses. We are looking to understand the cost savings.**
    A: The different revenue sources were presented on two slides to prevent the larger scale expenditures of Medicaid, Medicare, and Private Insurance from making the much smaller categories on Slide 7 difficult to see. Other Private Revenues constitute approximately 4% of the total status quo expenditure. This particular category is imputed based on National Health Expenditure (NHE) statistics. It is primarily personal health care costs coved by philanthropy. Some portion of these costs would be covered under the universal health care plan, but not all. Factors such as these are the reason for the range between $55 and $58 B for our estimate of status quo costs. For additional detail regarding specific population definitions represented in the NHE please refer to the following documentation (page 22): https://www.cms.gov/files/document/definitions-sources-and-methods-2

22. **The Initial cost is estimated for the year 2022. What happens if it doesn't start in 2022? We would like to see a graduated pay scale per annum -- "it will cost somewhere between x and z."**

A: When we have come to a final set of assumptions for the model based on Work Group feedback, we can explore trending aggregate results past 2022. We would note that 2022 is already a four-year projection from 2018 data. There is inherent uncertainty in a four-year forecast. That uncertainty increases each additional year beyond the source data period.

23. **When Optumas came up with a total cost of $55-58 billion, what is the state population denominator that that number is based on? Is it the entire population of 7.6 million people or is it a subset? If a subset -- who and how many? We want to see the accounting.**

    A: The total cost excludes Medicare, federal employees, Veterans Affairs, and TRICARE (military). Excluding these populations results in approximately 5.96 million covered lives. Please refer to the prerecorded materials for the 10/7 Work Group meeting for details on specific populations.

24. **Assumptions on MH, BH, hearing**

    A: Mental health, behavioral health, and hearing services are assumed in the model via the inclusion of status quo public and private plan coverage benefits and the out of pocket expenses for those services. Please also refer to the response to question #2 (in this section of the Q/A) above for additional detail for the State of Washington Essential Health Benefits coverage.

25. **School health -- What is this and how much is it? Do you mean school clinics or SEBB or??**

    A: Please refer to page 25 of the attached document for the definition of school health: https://www.cms.gov/files/document/definitions-sources-and-methods-2.

    These expenditures are limited to those that are not otherwise covered by insurance.

26. **Maternal/Child Health - What is this not included? What is it exactly? How much is it?**

    A: Please refer to page 21 of the attached document for the definition: https://www.cms.gov/files/document/definitions-sources-and-methods-2

27. **R&I - What is this? We had some guesses but would like to know.**

    A: Please refer to pages 28 and 29 of the attached document for the definition: https://www.cms.gov/files/document/definitions-sources-and-methods-2

28. **Department of Defense -- Confirming that it means TriCare and the direct health care delivery programs operated by the Dept of Defense such as Bremerton and Madigan Hospitals? Anything else?**

    A: Please refer to page 21: https://www.cms.gov/files/document/definitions-sources-and-methods-2

29. **Public Health - Why is that a separate system? We assume public health would be included as much as possible. The Budget Proviso includes both private and public health care.**

    A: Could you please clarify your questions? What types of public health activities do you believe should be included in the model? Public health is typically focused on community interventions as opposed to publicly-

funded health insurance that is focused on individual interventions. If the UHC model does not capture all populations, it would be highly disruptive to public health activities to exclude a subset of populations in communities based on their insurance coverage type. Any clarification on your intent would be helpful.

30. **Worksite Health Care Workers Compensation -- What is this, and how much is it? Can we cover workers, but if they get an on-the-job injury, federal money would cover that? Washington currently has State L & I and then federal coverage for Longshore and Maritime workers, right?**
A: The UHC model assumes this would work the same way it does now. Workers have personal health insurance, but job-related injuries are covered through a separate program. This maintains the necessary incentives for employers to maintain safe working environments for their employees. Because it is excluded, we have not researched the details of how the program operates in WA and cannot address your final question.

31. **What about Alternative and Complementary medicine? Culturally appropriate care, acupuncture, chiropractic naturopathic care? Would it help if we found a SEBB/PEBB/Medicare/ACA plan with the benefits we'd like to use as assumptions?**
A: Many of these services are already included as Essential Health Benefits. Please refer to the following related to Essential Health Benefits coverage in Washington:
https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-Washington-Benchmark-Summary.pdf

Any incremental specific services cannot be evaluated as noted in the response to question #2 in this section above.

32. **Long Term Care - Include the 2019 legislation. We do not see a robust Long Term Care coverage in the immediate future. If others insist, include it in Dynamic Modeling so that it is easy to see the cost with and without it.**
A: As noted in the preliminary estimate, long-term services and supports estimates will be developed. Please refer to the additional materials presented as part of the pre-record in advance of the October 7, 2020 Work Group meeting. Materials include information related to the Washington LTC Trust, implemented in 2019 with payroll contributions scheduled to begin in 2022.

33. **What are the premium subsidies and cost-sharing enhancements that are assumed for Cascade Care?**
A: The information for Cascade Care has been obtained from the work currently being performed by the Cascade Care Work Group including the subsidy studies. Our modeling reflects information developed by the Cascade Care Work Group. The cost estimate included in the final report will be updated with completed or the most recent Cascade Care information available. Current information for Cascade Care is posted to:
https://www.wahbexchange.org/about-the-exchange/cascade-care-2021-implementation/

34. **In Option C - Undocumented included. Are you assuming a separate Medicaid lookalike public option for the undocumented? Or?**
    A: As currently modeled, we are assuming the separate plan would be an exchange/commercial look alike (subject to the Cascade Care parameters). It could be modeled as a Medicaid lookalike program as well. Work Group feedback would be useful.

35. **At this point, how many Washingtonians receive their health care from the state/federal government? It looks to be hitting or exceeding the 50% mark when considering Medicaid, Medicare, PEBB, SEBB, FEHBP, Military families, VA, and Indian Health Services patients. What is the cost to the state?**
    A: Please see the materials from September 2019. These meeting materials are available in past meeting materials titled "Health Coverage in Washington State": https://www.hca.wa.gov/about-hca/healthier-washington/universal-health-care-work-group

Impact of COVID-19

1. **Related question -- is this assuming what % of Medicaid recipients? Because of job loss due to the COVID economic crisis, Medicaid recipients now make up nearly ¼ of Washington insured.**
    A: Of the 5.96 million, 1.7 million Medicaid eligible individuals are estimated in 2022. We will update this estimate with more recent HCA and OFM assumptions if they are released prior to the finalization of the model. Please note that we are modeling for 2022. Today's may be higher than it will be in 2022 due to the pandemic. There is a high degree of uncertainty that depends on the economic recovery over the next few years.

2. **How many total Exchange enrollees now receive premium subsidies? Before COVID, it was about 60%. What is the total amount of 2020 premium subsidies for Washingtonians?**
    A: Please see the materials from September 2019. These meeting materials are available in past meeting materials titled "Health Coverage in Washington State": https://www.hca.wa.gov/about-hca/healthier-washington/universal-health-care-work-group

    Additionally, information available from the Health Benefit Exchange for COVID can be found at: https://www.wahbexchange.org/

    We would also encourage you to review the COVID briefing that was prepared for Work Group members in June and check the OFM website for any updates to this information.

    - COVID Briefing: https://www.youtube.com/watch?v=E2tdTKbem2Q&feature=youtu.be
    - OFM Website: https://www.ofm.wa.gov/washington-data-research/health-care/health-coverage

3. **How many requests to enroll have we received on the phone, website, or to navigators, since the special enrollment period ended? Are people signing up for short-term options? Is there a trend line pre-COVID through now?**
    A: We do not have updated COVID-related statistics to provide at this time beyond what was shared during the COVID briefing in June and the "Estimated Impact of COVID-19 on Washington State's Health Coverage"

prepared by OFM that is posted on the HCA website with the October 7th materials. We encourage you to regularly check the OFM, HCA and Exchange websites for regular updates.

- OFM Website: https://www.ofm.wa.gov/washington-data-research/health-care/health-coverage
- HCA Eligibility Data: https://www.hca.wa.gov/about-hca/client-eligibility-data-dashboard#overview
- Exchange Website: https://www.wahbexchange.org/

4. **How many people in Washington State are covered by employer-based health insurance? KFF reported in 2018 that only 50% of Americans were covered by employer health insurance— and that is a pre-COVID number. In 2018, 3.8 million Washingtonians were covered by employer-based insurance. It was recently reported that the 2020 population of Washington State has topped 7.6 million.**
   A: 52% of Washingtonians received health coverage through their employer in 2018. This information is from Kaiser Family Foundation (KFF) State Health Facts 2018. Additionally, please refer to data and analysis published by the Washington State Office of Financial Management for additional information: https://www.ofm.wa.gov/washington-data-research/health-care/health-coverage

   Other sources of information about employer sponsored coverage include:

   - September 2019 Work Group meeting presentation materials
   - American Community Survey
   - 2018 Employer Health Benefits Survey published by Kaiser Family Foundation
   - Medical Expenditure Panel Survey

   We do not have any additional COVID-related statistics to provide at this time.

Potential Federal Changes

1. **What if ACA Disappears? - What would the impact be? Figuring OIC probably has someone working on that.**
   A: We are unable to model speculative changes to federal statute. We have no insight into what provisions would be struck down, or what would replace them. Should changes in federal legislation occur, the projection developed as part of the Work Group would need to be revisited and updated.