

Universal
Health Care
Workgroup

9/30/20

Preliminary Model Results and Assumptions Supplement

Introduction

- Level Setting
- Population Overview
- Review of Models and Key Assumptions
- Models
 - Model “A” Universal Care – State Administered
 - Model “B” Universal Care – State Delegated
 - Model “C” Status Quo + Fill the Gap (uninsured and undocumented)

Level Setting

Modeling Status Update

- Results shared during the September meeting were preliminary and intended to provide the workgroup a starting point, subject to additional refinement.
- There is ongoing model refinement, particularly for areas of the model that required imputing results. Adjustments based on workgroup feedback will be incorporated throughout October/November as appropriate.

Approach

- While there is evidence and research that supports many assumptions in the model, the direct applicability, quality, and consistency of the evidence (or comparison systems) is typically low.
- Evidence is used to inform assumptions, but assumptions also reflect operational realities or major systemic differences that would make achieving the level of results found in other systems difficult to achieve in the short-term.

Data Limitations

- As noted in prior discussion, some components of the model are limited by the availability of reliable data. Charity care, out of pocket expenditures, and self-funded employer plan data is predominantly imputed based on national statistics.

Model and Assumption Review

Populations

Covered Benefits

Cost Sharing

Provider Reimbursement

Population Specific Impacts

Administration

Program Oversight

Modeled Population Overviews

Populations ⁽¹⁾	Model Impacted	Estimated 2022 Population	Estimated Status Quo Expenditure	Potential Benefits of Inclusion	Challenges of Inclusion	Source for Population / Expenditure Estimates
Medicaid	A, B	1.7 Million	\$17 Billion	<ul style="list-style-type: none"> Economies of Scale Potential Improved Access Reduced pricing variation 	<ul style="list-style-type: none"> Federal authority Ongoing regulatory compliance 	<ul style="list-style-type: none"> Washington Medicaid data (<i>CMS 64 reports</i>) HCA provided data
Medicare	Excluded	1.7 Million	\$16 Billion	<ul style="list-style-type: none"> Economies of Scale Cost sharing relief 	<ul style="list-style-type: none"> Federal authority Ongoing regulatory compliance 	<ul style="list-style-type: none"> National Health Expenditures (NHE) Medicare Annual Trustees Reports Medicare Current Beneficiary Survey
CHIP	A, B	62 Thousand	\$101 Million	<ul style="list-style-type: none"> Economies of Scale 	<ul style="list-style-type: none"> Federal authority Ongoing regulatory compliance 	<ul style="list-style-type: none"> CMS 21 Reporting HCA documentation
Private Insurance	A, B	3.7 Million	\$31 Billion	<ul style="list-style-type: none"> Economies of Scale Decouple insurance from employment Opportunity to reduce pricing variation 	<ul style="list-style-type: none"> Federal authority (ERISA) Potential stakeholder challenges 	<ul style="list-style-type: none"> PEBB / SEBB data Large and Small Group Insured KFF Employer Health Benefits Survey Health Benefit Exchange NHE Medical Expenditure Panel Survey (MEPS)
Undocumented Immigrants	A, B, C	124 Thousand	\$98 Million	<ul style="list-style-type: none"> Access to affordable care for this population Public Health Benefits 	<ul style="list-style-type: none"> Administrative structure needed to support separate financing 	<ul style="list-style-type: none"> OFM population estimates
Uninsured ⁽²⁾	A, B	371 Thousand	\$291 Million	<ul style="list-style-type: none"> Access to affordable care for this population Public Health Benefits 		<ul style="list-style-type: none"> OFM population estimates Status quo cost, based on research, suggests current uninsured spend 1/10th of the insured population.
Other Expenses ⁽³⁾	A, B	N/A	\$6 Billion	<ul style="list-style-type: none"> Improved transparency and accountability 	<ul style="list-style-type: none"> Difficult to estimate costs accurately 	<ul style="list-style-type: none"> Extrapolated from NHE estimates

(1) Does not include: Federal Employees, Department of Defense, Veteran Affairs, School Based Health, Worksite Health Care, Workers' Compensation, Maternal/Child Health programs, Vocational Rehabilitation.

(2) Uninsured estimates exclude the portion that are anticipated to enroll in existing state programs by 2022.

(3) 'Other Expenses' includes estimates for expenditures that would be captured under a universal model including, charitable care, Indian Health Services, and out of pocket expenditures.

Model A: Universal Coverage – State Administered

Overview of Key Assumptions

Covered Populations	Benefits	Cost Sharing	Provider Reimbursement	Population Specific Impacts	Administration
<ul style="list-style-type: none"> Medicaid CHIP Private Health Insurance (<i>employer, state employee, exchange</i>) Undocumented Immigrants Uninsured 	<ul style="list-style-type: none"> Essential health benefits Dental Vision Long Term Care (incremental new system costs pending) 	<ul style="list-style-type: none"> No cost sharing Private Insurance utilization changes due to removal of cost sharing 	<ul style="list-style-type: none"> Reduced pricing variation Administrative efficiency Purchasing power 	<ul style="list-style-type: none"> Medicaid population access change Uninsured utilization changes Undocumented immigrant utilization changes 	<ul style="list-style-type: none"> State administered program Exempt from premium tax Reductions in system-wide administrative costs

Financial Highlights:

- **Status Quo Expenditure for Covered Populations:** \$55.0 B to \$58.0 B
- **Preliminary Model Cost Estimate:** \$52.0 B to \$58.0 B
- **Difference:** Projected \$3.0 B decrease in aggregate expenditure and no change in aggregate spending
- **Estimated Enrollment:** 5.96 M

Model “A” and “B”: Universal Coverage State Administered

Additional Benefits Assumptions – Dental

Preliminary Model Assumptions

- Based on standard commercial-like dental programs covering preventative, minor and major restorative services
- Annual benefit maximums
- Eliminates out-of-pocket cost sharing
- Reimbursement based on commercial dental coverage
- Excludes dental insurer administration and premium tax
- Variation in dental estimates are driven by dental managed care organization vs. preferred provider organization coverage and out-of-pocket costs

Considerations

- Dental is a unique service because NHE includes a separate dental service category by payer (e.g, Medicaid, commercial, etc.).
- The NHE expenditures were removed from Model “A” and Model “B” and replaced with the dental coverage estimates and included uninsured and undocumented populations.
- Covered benefits vary across populations, for example Medicaid children are entitled to coverage that Medicaid adults do not receive (crowns, bridges, implants).
- Benefit package structures including annual maximums and cost-sharing vary in status quo data.

Key Notes

- \$496 M - \$1.0 B estimated for dental coverage.
- Includes annual benefit maximums (\$1,500 - \$2,000).
- Lifetime limit for orthodontia coverage typical in commercial coverage.
- Establishes standardized reimbursement consistent with commercial coverage.
- Will require reimbursement increases for Medicaid as well as consideration for dental provided in Federally Qualified Health Centers.
- Impact on dental access due to 100% availability.

Model “A” and “B”: Universal Coverage State Administered

Additional Benefits Assumptions – Vision

Preliminary Model Assumptions

- Based on standard commercial-like vision coverage and includes annual eye exams, eyeglass frames, lenses, lens enhancements, and contact lenses.
- Includes cost limits like commercial or private vision coverage (e.g., maximum frame reimbursement)
- Eliminates out-of-pocket cost sharing up to coverage limits.
- Reimbursement based on commercial vision coverage
- Coverage estimates include two generalized groups of individuals:
 - Those currently with vision coverage who will receive out-of-pocket cost sharing relief.
 - Those without coverage but have a need for vision coverage

Considerations

- Vision is not a unique service in National Health Expenditure categories.
- The cost of commercial vision reflects the fact that most participants enroll because they have a need for vision.
- Estimates are focused on costs for individuals between 40-64 years old.

Key Notes

- \$43 M - \$55 M increase cost due to cost sharing and coverage for populations with a vision need.
- Estimates are limited because vision data is limited or unavailable.
- National vision survey information is dated (e.g., CDC Behavioral Risk Factor Surveillance System Surveys 2009).
- Need for vision coverage and estimates informed by more recent National Eye Institute survey and vision council surveys.
- Majority of literature is focused on adults 40-64 years old with a need for vision coverage.

Model “A” and “B”: Universal Coverage State Administered Additional Benefits Discussion – Long-Term Services and Supports (LTSS)

Modeling Considerations

- Washington Medicaid spent approximately \$2.2 billion in providing LTSS 66,000 individuals with disabilities.
 - 57,000 individuals at an average annual cost of \$27,000 for community based LTSS only.
 - 9,600 individuals at an average annual cost of \$70,000 for nursing home services only – after reducing cost of care for an individual’s contribution based on monthly income.
- LTSS need is based on assessment of an individual's functional ability to perform activities of daily living.
- HHS ASPE Issue Brief identified that 52% Americans turning 65 today will develop a disability serious enough to require LTSS, although most will need assistance for less than two years and 14% would need more than five years LTSS care¹

Considerations

- Based on 2018 ACS there were 1.1 million Washingtonians 65+ years old.
- Medicaid coverage is based on low reimbursement relative to other long-term care insurance or private pay reimbursement.
- How a universal care model would integrate with or compliment the LTC Trust Act model.

Key Notes

- The LTC Trust Act addresses an aging population in which the vast majority lack the financial resources to pay for the care they need as they age.
- Beginning in 2020, Washingtonians will contribute \$0.58 per \$100 through payroll deduction.
- To be eligible, a person must have paid premiums either (1) for 3 years within the past 6 years, or (2) for a total of 10 years, with at least 5 of those years paid without interruption. For a year to count, a person must have worked at least 500 hours during that year to be able to access the benefit.
- Provides for a \$36,500 lifetime benefit in 2019 dollars if vesting requirements met.

Model “A” and “B”: Universal Coverage State Administered Cost Sharing Assumptions

Preliminary Model Assumptions

- No cost sharing: Approximately \$6.4 B in projected current (status quo) out-of-pocket costs are included as costs in Models A and B.
- Includes utilization increases for the private insurance population. The aggregate adjustment across all service categories (e.g. inpatient, outpatient, physician etc.) categories of services for this population is between 1.00% and 1.75%.

Rationale

- Medicaid and CHIP populations are not impacted.
- Undocumented and currently uninsured populations are addressed separately.
- Private insurance population would be impacted.
- Utilization increases for professional/clinic services, pharmacy, and hospital services are assumed based on removal of the barrier to access to care.
- Offsetting decreases to hospital services are expected to be nominal in the first year. It will take time for individuals to first access services they were not previously accessing due to cost barriers, and to reap the longer-term benefits of prevention and early intervention and greater access to health maintaining medications.

Key Notes

- The \$6.4 B included in the model is a distributional impact, not a change in overall system spending. The costs currently born by utilizers of services would be shifted to taxpayers.
- Estimated cost of additional benefits (dental, vision) includes the impact of removing cost sharing.
- Evidence for the efficacy of cost sharing in driving **efficient** utilization is scant. There are some studies that have found that copays for nonemergent emergency room utilization is effective after a certain price point.
- There is ample evidence that cost sharing can be a barrier to access to care.

Model “A” and “B”: Universal Coverage State Administered Provider Reimbursement

Preliminary Model Assumptions

- Administrative efficiency of a universal system reduces costs 0.5% to 1.0% for providers across all services categories. Provider rates are reduced accordingly.
- Negotiating power adjustment of 0.25% for hospital services, adjustment between 1% and 4% to the pharmacy and durable medical equipment categories.

Rationale

- A single, streamlined billing process with a single payer should reduce administrative costs for providers; however, the first year of implementation, the full magnitude of the efficiency gain cannot be realized.
- With consolidation of members into a single plan, the State will have bulk purchasing power and greater negotiating leverage.
- First year savings opportunities are dampened. The State will not have the full utilization data needed to negotiate bulk purchasing agreements. It will also take time to get agreements in place.
- Medicaid already receives steep pharmacy discounts through the federal rebate program. This dampens additional savings opportunity.
- Market consolidation creates financially and politically powerful organizations. It is unclear if the state will be successful in fully leveraging purchasing power.

Key Notes

- How the Universal Health Care plan is implemented will have a direct impact on how much provider-side efficiency is generated. If the program is built to be highly administratively burdensome, there will be no efficiencies.
- While there is research on differences in provider administrative costs in different countries, the evidence does not support large adjustments due to interacting with fewer payers. There are many differences (regulatory requirements, prior authorization requirements, value-based purchasing requirements, etc.).

Model “A” and “B”: Universal Coverage State Administered Population Specific Impact Assumptions

Preliminary Model Assumptions

- Increase in utilization of primary care services for the Medicaid population of 0.5% to 1.0% with a corresponding decrease of hospital services of 0.1%.
- 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.

Rationale

- With pricing variation by population eliminated, providers will not cap Medicaid empanelment. Primary care access is expected to increase but would be constrained by system capacity. A small corresponding reduction in hospital services due to prevention and early detection is expected with longer-term gains possible.
- The remaining uninsured population (not including undocumented immigrants) in the state that would be captured under the model is expected to have low utilization. Between subsidy program and safety net programs, if these individuals had moderate or high needs, they likely would have sought coverage through one of the existing mechanisms in place.

Key Notes

- There is limited data available to inform utilization assumptions for the undocumented and uninsured populations.

Model A: Universal Coverage State Administered Plan Administrative Cost Assumptions

Preliminary Model Assumptions

- Aggregate Administrative Rate of ~4.5%

Rationale

- This represents an approximate reduction of 4.1 percentage points relative to the projected status quo administrative rate of 8.6% (for the populations included in the model). The reduction is attributable to removing plan profit, marketing and other costs that would not be incurred under a single payer, state administered system.
- There are administrative activities in the first year associated with a major transition and plan operational stability that reduce the immediate savings potential.
- The state will have to maintain certain administrative responsibilities associated with federal programs/financing.
- The reduction also reflects the elimination of premium tax currently that would no longer be applicable under the state administered universal health care plan.

Key Notes

- How the administrative system is structured and implemented will heavily influence how much it costs. A future body of work should include detailed administrative design and associated pricing.
- Loss of premium tax revenue may need to be backfilled when contemplating future tax policy.
- Some research identifies Medicare as an appropriate benchmark for achievable administrative efficiency. Medicare is not comparable in scale or scope of administrative responsibility, and the cost per member is not comparable. All these factors make the Medicare administrative rate informative, but not directly applicable.

Model A: Universal Coverage State Administered Plan Oversight Assumptions

Preliminary Model Assumptions

- Aggregate reduction of 0.25% to account for greater Program Integrity efficacy.

Rationale

- The ability for the State to identify and prevent fraud is increased when all utilization is consolidated under the universal health care plan. Statistical patterns that identify fraud will be more easily detected than in the current fragmented system where each payer is looking at only their own data.
- It will take time to accumulate utilization data to analyze and pursue identified fraud. First year savings are expected to be smaller than future year potential.

Key Notes

- Future year savings could be significantly larger.
- Greater first year savings could be achieved if there is a pre implementation public awareness campaign that creates a 'sentinel effect'. This could reduce the actual incidence of fraud, not just increase the rate at which it is identified.

Model B: Universal Coverage – Delegated Administration

Overview of Key Assumptions

Covered Populations	Benefits	Cost Sharing	Provider Reimbursement	Population Specific Impacts	Administration
<ul style="list-style-type: none"> Medicaid CHIP Private Health Insurance (<i>employer, state employee, exchange</i>) Undocumented Immigrants Uninsured 	<ul style="list-style-type: none"> Essential health benefits Dental Vision Long Term Care (incremental new system costs pending) 	<ul style="list-style-type: none"> No cost sharing Private Insurance utilization changes due to removal of cost sharing 	<ul style="list-style-type: none"> Reduced pricing variation Administrative efficiency Purchasing power 	<ul style="list-style-type: none"> Medicaid population access change Uninsured utilization changes Undocumented immigrant utilization changes 	<ul style="list-style-type: none"> State provided insurance, administered by managed care plans Not exempt from premium tax Reductions in system-wide administrative costs

Financial Highlights:

- Status Quo Expenditure for Covered Populations: \$55.0 B to \$58.0 B
- Preliminary Model Cost Estimate: \$54.5 B to \$60.6 B
- Difference: Projected between a \$0.5 B decrease and an increase of \$2.6 B in aggregate expenditure
- Estimated Enrollment: 5.96 M

Model B: Universal Coverage - Delegated Administered Plan Administrative Cost Assumptions

Preliminary Model Assumptions

- Aggregate Administrative Rate of ~7.5%

Rationale

- This represents an approximate reduction of 1.1 percentage points relative to the projected status quo administrative rate of 8.6% (for the populations included in the model).
- There are administrative activities in the first year associated with a major transition and plan operational stability that reduce the immediate savings potential. We may increase the administrative rate relative to the current assumption as a result.
- The state will have to maintain certain administrative responsibilities associated with federal programs/financing.
- The State's premium tax is assumed to be applicable to the plans.
- The plans are assumed to be 'at risk'. Risk premium is assumed in the administrative rate.

Key Notes

- How the administrative system is structured and implemented will heavily influence how much it costs. A future body of work should include detailed administrative design and associated pricing.
- Rather than leveraging managed care entities, the plan could leverage administrative service organizations that are not 'at risk' for utilization. This would reduce costs due to the removal of risk premium, but it also reduces the incentive for the managed care entities to manage plan utilization.

Model C: Close the Gap (Status Quo + Program for the Uninsured)

Model Component	Key Assumption
Covered Populations	<ul style="list-style-type: none"> Undocumented Immigrants
Benefits	<ul style="list-style-type: none"> Essential Health Benefits
Cost Sharing	<ul style="list-style-type: none"> Standard allowable cost sharing
Provider Reimbursement	<ul style="list-style-type: none"> Consistent with Cascade Care parameters
Population Specific Impacts	<ul style="list-style-type: none"> Utilization assumptions reflect this population having similar utilization patterns to the commercially insured population
Administration	<ul style="list-style-type: none"> Standard exchange plan administrative costs

Status Quo Expenditure for Covered Populations: Expenditure information unavailable.

Preliminary Model Cost Estimate: \$400 M - \$600 M

Difference: N/A

Estimated Enrollment: 124,428

Summary

- There are countless financial intricacies associated with unraveling deeply institutionalized programs and replacing them with a single comprehensive system; consequently, there are many assumptions in the model. We've provided more detail for those that seem to be most relevant for workgroup discussion, but please let us know if you want more information on other specific aspects of the model.
- Assumptions are designed to recognize that not all efficiencies are achievable from day one of the program.
- Rationale for the assumptions is provided. Workgroup members have a great deal of expertise in the Washington delivery system. To the extent we are not capturing all the relevant considerations that inform the assumptions, we welcome your feedback.

Glossary

- **CHIP** – Children’s Health Insurance Program, a state administered, state/federally funded program for eligible children and pregnant women
- **CMS** – Centers for Medicare & Medicaid Services, the federal oversight agency for Medicare and Medicaid
- **CMS 64** – Form used to report official Medicaid expenditure totals to CMS
- **ERISA** – Employee Retirement Income Security Act, an act that governs certain aspects of self-funded employer plans.
- **HCA** – (Washington) Health Care Authority
- **HHS** – Health and Human Services
- **LTC** – Long Term Care
- **LTSS** – Long Term Services and Supports
- **MEPS** – Medical Expenditure Panel Survey, a large-scale, national survey of families, medical providers, and employers
- **NHE** – National Health Expenditures, estimates of national health expenditure developed by the Office of the Actuary within CMS.
- **OFM** – (Washington) Office of Financial Management
- **PEBB** – Public Employee Benefits Board, program for public employee insurance coverage
- **SEBB** – School Employee Benefits Board, program for school employee insurance coverage