

September 2020 UHC Work Group Meeting

Preliminary Modeling Results

How do you estimate
the cost of moving to
universal health care?



Modeling Approach

Modeling Approaches

Optumas is employing two different approaches for estimating the costs of the different Universal Health Care Models.

Approach 1: Start with current programs and enrollment, make incremental adjustments to account for anticipated UHC program design (enrollment and cost adjustments).

Approach 2: Develop high-level per-capita expenditures for included populations and services by program enrollment.

The two strategies are used together to triangulate a reasonable high-level fiscal impact for each of the three models.

From Status Quo to Fiscal Impact

2018 Base Expenditure

- Construction of 2018 baseline expenditures using available data

2022 Base Expenditure

- Trend and policy adjustments to project 2022 baseline expenditures

UHC Impacts

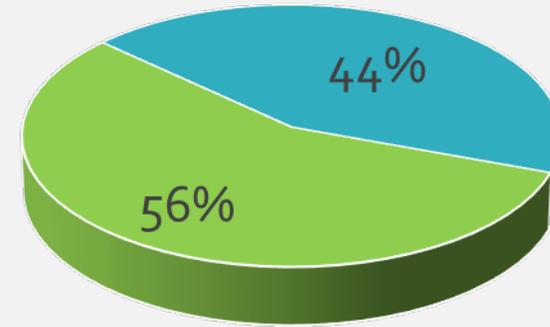
- Incremental adjustments to 2022 baseline expenditures to capture the effects of moving to UHC



Constructing Status Quo Personal Health Care Costs

2018 Data Inputs

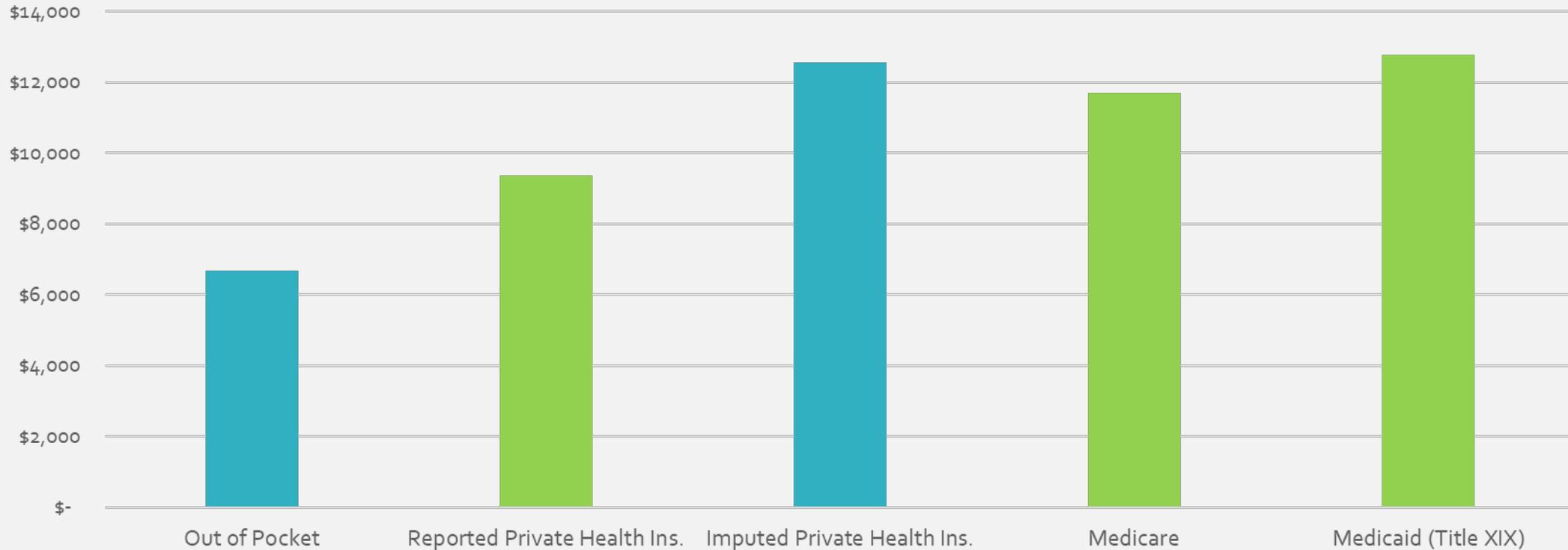
- **Verified expenditures:** Expenditures can be verified with publicly available information (~\$34 Billion)
- **Imputed expenditures** based on state and national statistics for select programs and payer sources (Estimated between \$28 and \$39 Billion depending on which state/federal estimates are used)



■ Verified Data ■ Imputed Data

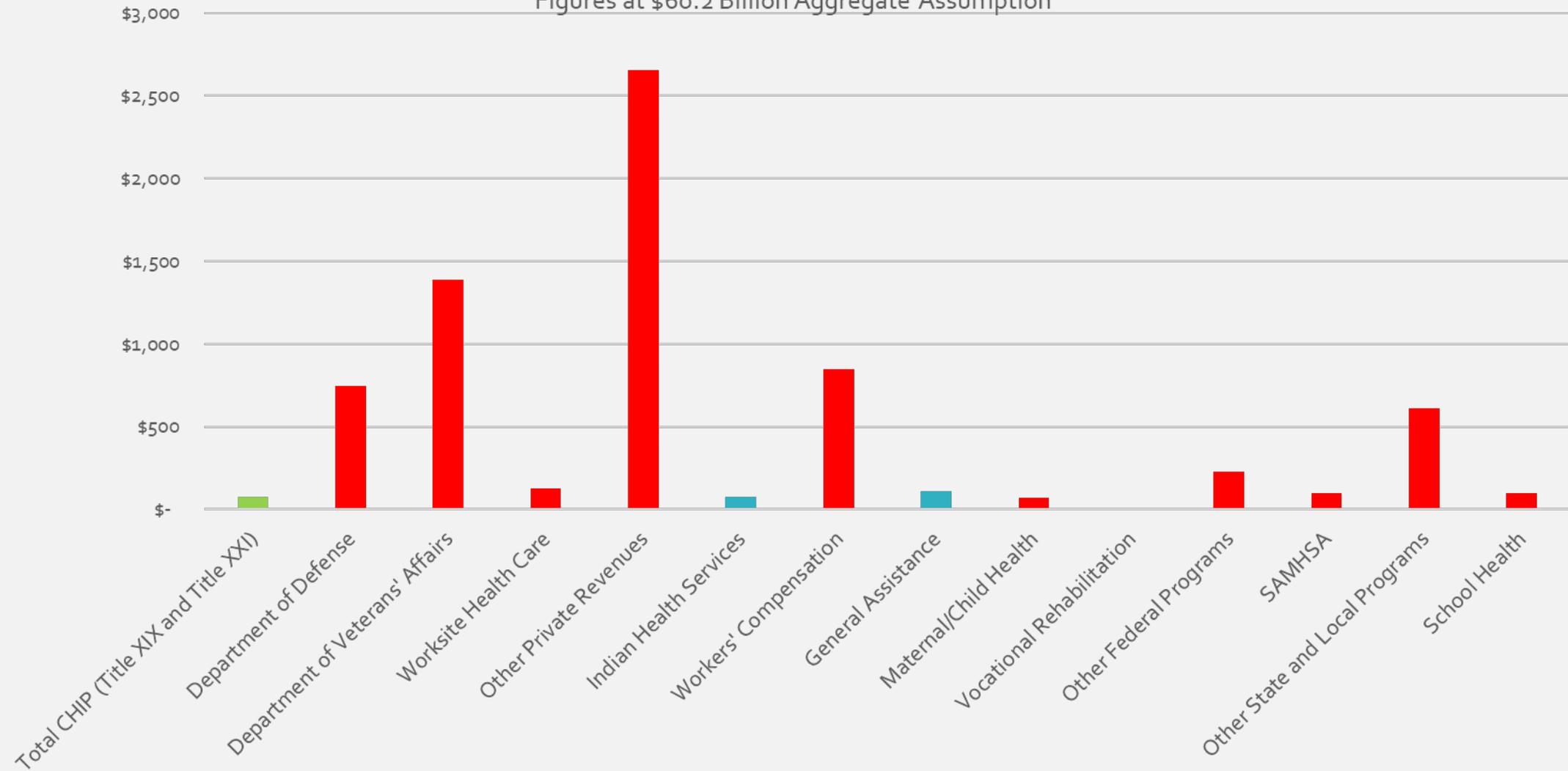
Distribution of Status Quo (2018) Personal Health Expenditures

2018 Estimated Expenditures (in Millions) - Top 5 Payer Sources
Figures at \$60.2 Billion Aggregate Assumption

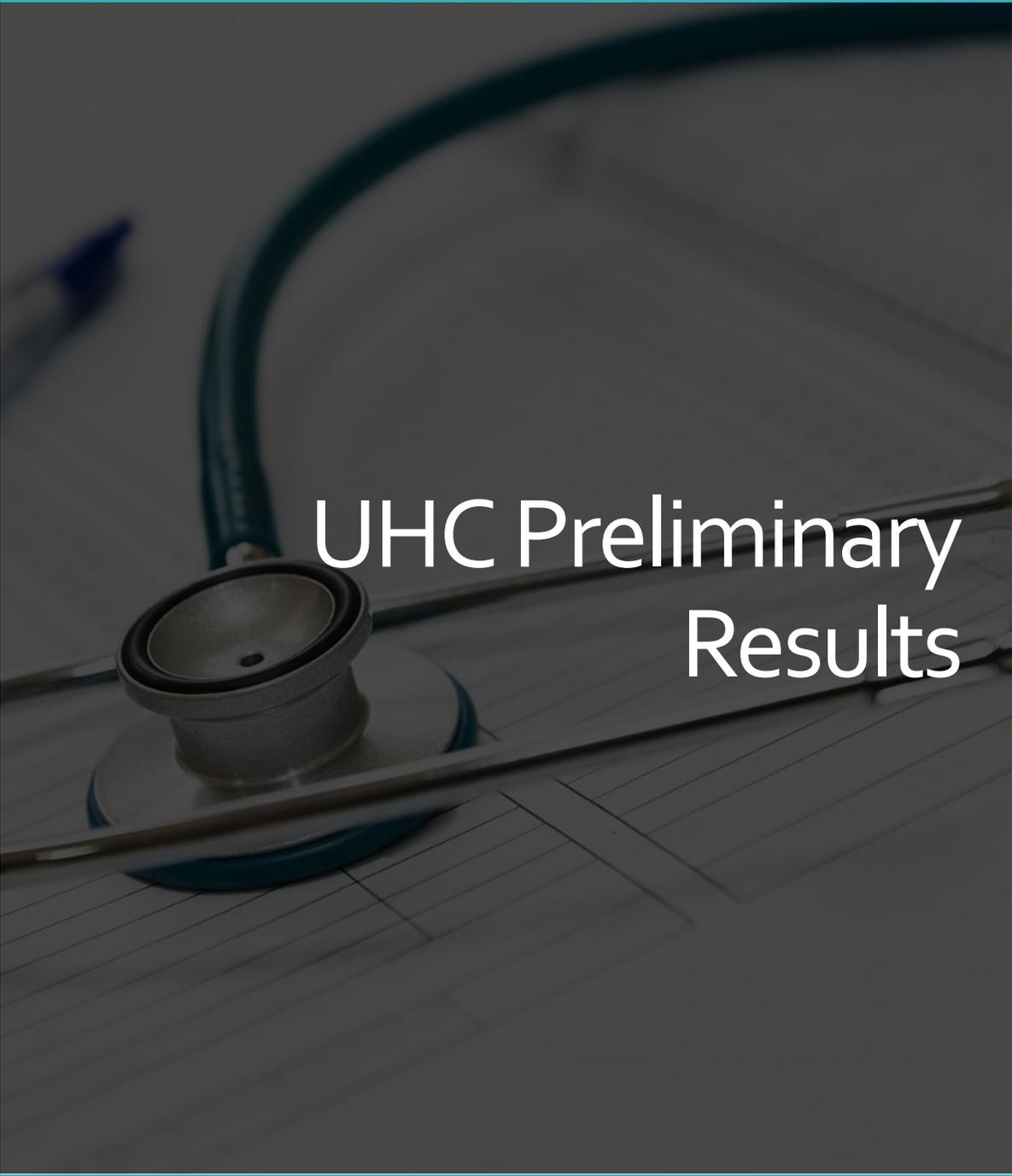


Distribution of Status Quo (2018) Personal Health Expenditures

2018 Estimated Expenditures (in Millions) - All other Payer Sources
 Figures at \$60.2 Billion Aggregate Assumption



Do the cost decreases associated with a Universal Health Care program offset the cost increases?

A close-up photograph of a teal stethoscope resting on a document with a grid pattern. The background is dark and slightly blurred.

UHC Preliminary Results

Deriving a Fiscal Impact

Factors That Increase Short-term Costs to the State

- Covered Populations
- Covered Benefits
- Removal of Cost Sharing



Factors That Decrease Short-term Costs to the State

- Greater Financial Leverage
- Reduced Administrative Costs
- Economies of Scale

Summary of Preliminary Estimates Under Current Assumptions

	Universal - State Administered (2022)	Universal - Delegated Administration (2022)	Close the Gap** (Incremental Only - 2022)
Baseline Expense For Included Populations and Services	\$55.0 B - \$58.0 B		\$0
2022 Incremental Aggregate Impact	Budget Neutral - \$3.0 B Savings	\$461 M Savings - \$2.6 B Costs	\$400 M - \$600 M Costs

**These figures represent the estimated cost of covering undocumented immigrants.

Note: figures include the costs of Dental and Vision benefits for all eligible members. Status quo Long Term Care costs are included, but incremental new costs are not yet included.

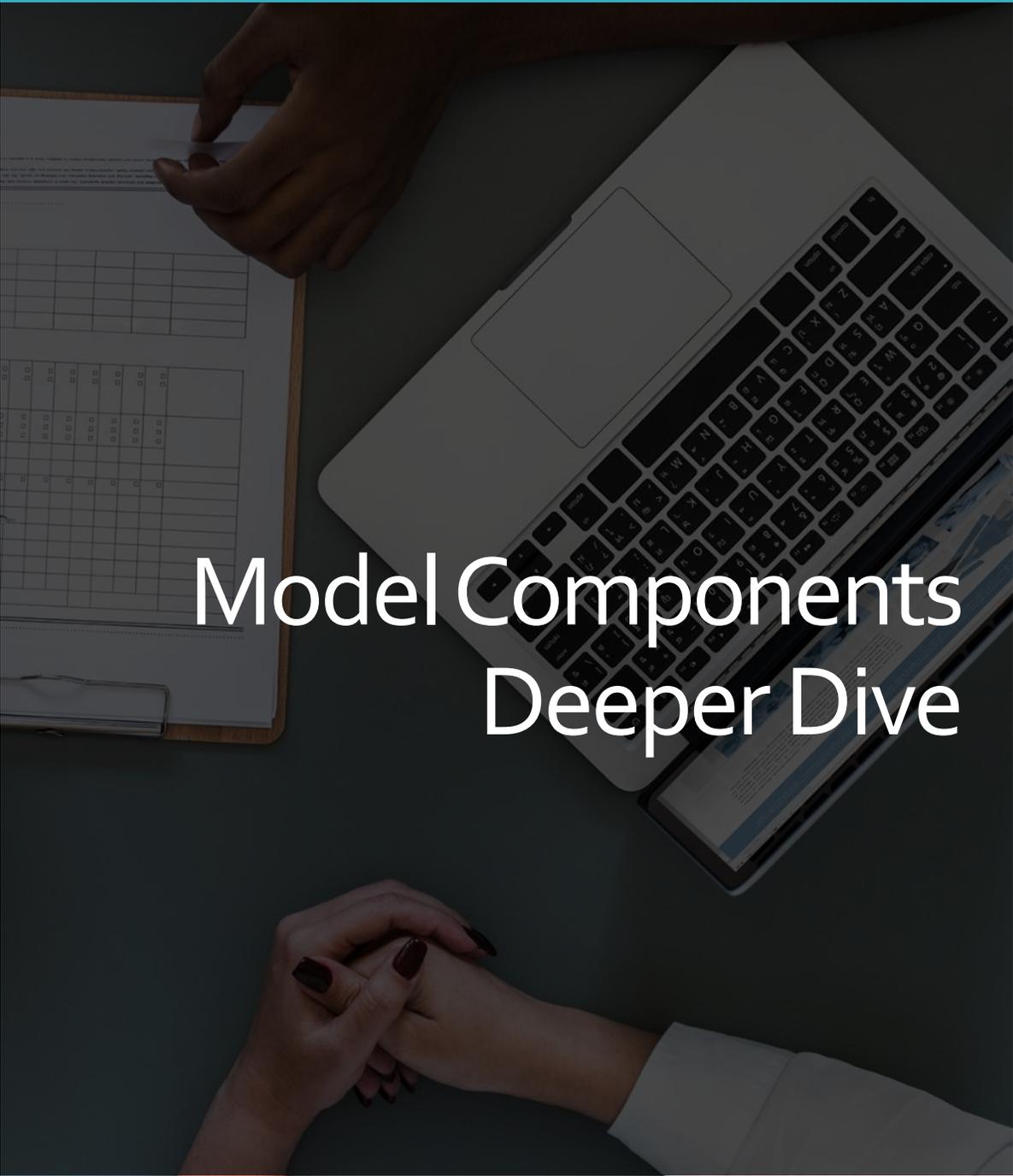
Components of Preliminary Estimate

Highlighted Components	Universal - State Administered (2022)	Universal - Delegated Administration (2022)	Close the Gap** (Incremental Only - 2022)
Populations - Undocumented	\$400 M - \$600 M	\$410 M - \$610 M	\$410 M - \$610 M
Benefits - Dental (Incremental New Dollars)	\$496 M - \$1 B		N/A
Benefits - LTC (Incremental New Dollars)	Pending		N/A
Benefits - Vision (Incremental New Dollars)	\$43 M - \$55 M		N/A
Cost Sharing - Excluding Dental and LTC	\$4.7 B - \$5.5 B		N/A
Administrative Savings (Provider)	(\$350 M - \$600 M)		N/A
Purchasing Power Adjustment	(\$175 M - \$610 M)		N/A
Administrative Savings (Plan)	(\$2.2 B - \$2.7 B)	(\$0.5 B - \$1.0 B)	N/A
Economies of Scale - Program Oversight	(\$125 M - \$175 M)		N/A
**figures will be updated based on future Cascade Care modeling updates			

Note: these figures represent a combination of distributional impacts and incremental system-wide impacts. They cannot be summed to estimate incremental system changes.

Which model assumptions
have the greatest impact?

Do Workgroup members want
to change design elements as a
result?



Model Components Deeper Dive

Included Populations - Assumptions and Considerations

Universal Health Care (Options A and B)

<i>Included</i>	<i>Excluded</i>
<ul style="list-style-type: none"> • Medicaid • CHIP • Private Health Insurance * • Uninsured • Undocumented** • Cascade Care** • Indian Health Services • General Assistance 	<ul style="list-style-type: none"> • Medicare • Worksite Health Care • Other Private Revenues • Workers' Compensation • Maternal/Child Health • Vocational Rehabilitation • Other Federal Programs • School Health • Department of Defense • Veteran's Affairs • Research/Investment • Public Health

The more programs, the greater the impact and progress toward goals.

The more programs, the more resource intensive and the longer implementation will take.

Does the Workgroup agree with our current assumptions for included populations?

*Individual and group plans

**The 'Close the Gap' (Option C) model is limited to public option/subsidy programs and Undocumented Immigrants

Benefits - Assumptions and Considerations

Universal Health Care

Dental

Assumes a standardized commercial-like dental program, which includes prevention and some restorative services, but imposes annual benefit maximums.

Vision

Assumes a standardized commercial-like vision plan that includes coverage of vision related hardware (e.g., frames, lenses, lens enhancements) and eye exams, but imposes annual benefit maximums.

Long-Term Care

Includes nursing home and community-based long-term services and supports. Plan is for the elderly and populations with disabilities.

The more benefits covered, the greater the cost to the UHC plan.

LTC Services eligibility will be need to be defined by the state. The final definitions will impact to the fiscal estimate and will need to be reevaluated.

Based on the estimated costs, which benefits should be included in the final model?

Cost Sharing - Assumptions and Considerations

Universal Health Care

Removing cost sharing **shifts financial accountability** from utilizers of services to everyone that participates in or is impacted by the financing of the plan.

(Estimated to be \$4.7 - \$5.5 Billion with current assumptions)

Removing cost sharing **eliminates potential barriers to access** to care, thereby increasing utilization. Potential short-term access limitations and longer-term savings due to increased access to medically necessary care.

Close the Gap

Cost sharing applies the same as it would under the State's public option.

Eliminating cost sharing is highly impactful - both financially and potentially in terms of political feasibility.

Does the Workgroup remain comfortable with the assumption of absorbing all cost-sharing?

Provider Payment - Assumptions and Considerations

Universal Health Care

Provider-level efficiencies captured through rate reductions reduce the overall cost of the UHC model.

(Estimated \$350 - \$600 Million under current assumptions)

Purchasing power reflected in rate reductions reduce the overall cost of the UHC model. Does not reflect consideration of if or how reimbursement changes may influence provider participation.

(Estimated \$175 - \$610 Million under current assumptions).

Close the Gap

Provider payment rates are assumed to be the same as under the State's public option.

These assumptions are highly sensitive to implementation decisions that would be made in the future. To capture these savings at all, the State must be committed to reducing administrative burden for providers (e.g., prior authorization requirements, billing processes, contracting and enrollment, value-based purchasing, etc.)

Administrative Efficiencies – Assumptions and Considerations

Universal Health Care - State Administered

Reducing plan-level duplication of infrastructure and increasing economies of scale is expected to reduce total system costs.

(Estimated to be \$2.2\$ - \$2.7 Billion with current assumptions)

Universal Health Care - Delegated Administered

This model retains much of the insurance structure. This increases feasibility but reduces savings potential. Savings are limited to economies of scale.

(Estimated to be \$0.5 - \$1.0 Billion with current assumptions)

Economies of Scale - Program Oversight

Savings to the state for consolidating current processes.

(Estimated to be \$125 - \$175 Million with current assumptions)

Close the Gap

Provider payment rates are assumed to be the same as the public option.

Pre 'go-live' implementation costs are not contemplated in the analysis – these costs will likely be high.

The State will need to evaluate build vs. buy claims processing infrastructure, design an entire regulatory framework, a code-level benefit plan, accounting systems, engage in stakeholder process, pursue federal authorities, etc.

Data Gaps and Current State Uncertainty

For a safe and viable transition, Washington will need to conduct in-depth studies in multiple areas.

Implementation Timeline

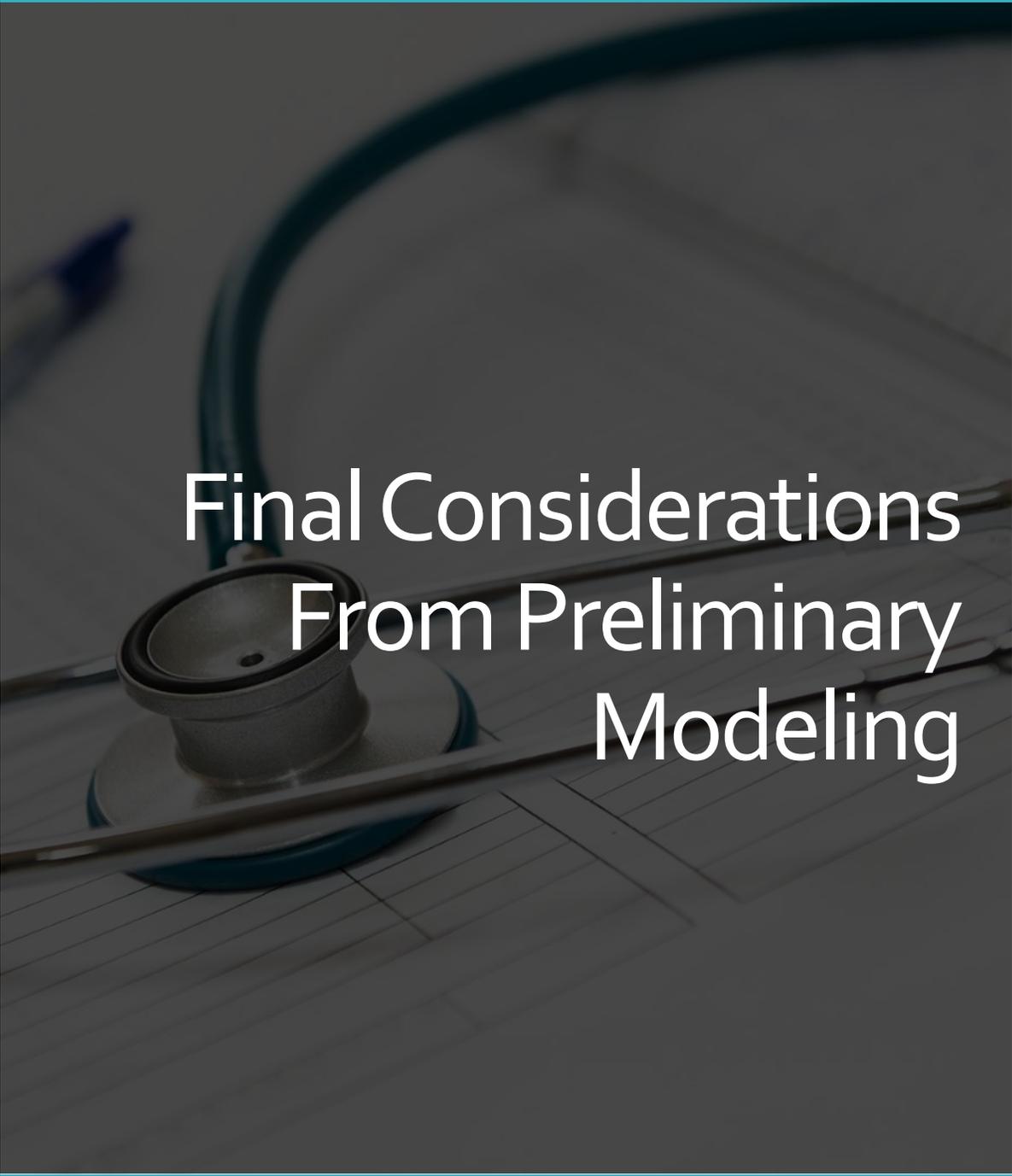
The further out the implementation timeline, the greater the need to refresh the analysis. Health care is changing fast (e.g., high-cost drugs, new technologies, etc.).

Operational Design

Countless nuanced implementation decisions will influence the costs of implementing UHC.

Future Federal Action

Federal action is possible/likely under any future administration. This could either create a more feasible pathway to universal health care or confound it.

A stethoscope with a blue chest piece and black tubing is positioned on a dark grey grid background. The chest piece is in the lower-left quadrant, and the tubing loops across the grid. The overall image is dimly lit, with the grid lines providing a subtle pattern.

Final Considerations From Preliminary Modeling

- Model refinements
- Offsets and new revenues
- Path forward - *identify nuanced decisions that will need consideration by legislative policy makers*

A close-up photograph of a teal stethoscope resting on a white grid surface, likely a piece of paper or a tablet. The stethoscope's chest piece is in the foreground, and the tubing extends towards the top right. The background is slightly blurred, showing a blue pen and more of the grid.

Fiscal Modeling Next Iteration

Summary of Modeling Assumptions (Universal A & B Models)

Included Populations

- Employer (private insured, private self-funded, and public employees)
- Exchange
- Medicaid
- Uninsured
- Undocumented

Covered Health Benefits

- Essential health benefits (*inpatient, outpatient, primary care, specialty physician, mental health & substance abuse, laboratory, radiology, Rx, etc.*)
- Dental - (small / larger group coverage)
- Vision - (small / larger group coverage)
- LTSS (pending)

Out-of-Pocket Cost Sharing

- No deductibles
- No coinsurance
- No copayments

** Annual benefit and coverage limitations apply for dental and vision benefits.*

Health Care Provider Reimbursement

- Adjustments to remove variation in payment for the same service. Providers are kept profit neutral in aggregate, but revenue negative due to reduced provider side costs resulting in reduced rates.
- Strengthens State purchasing power through reimbursement negotiations (e.g. pharmaceuticals).

Role of Insurance Companies

- State Administered = No insurance companies.
- State Delegated = Insurance companies operate state program. As modeled assumes the plans are delegated risk – increases costs due to risk premium.

System Cost Savings / Efficiencies

- Physician administration = Reduced multiple payer requirements for physicians to navigate.
- Program oversight = Reduces costs to employer's health benefits administration, streamlines oversight responsibilities for the Health Care Authority, Department of Insurance etc..).
- Improves fraud, waste, and abuse initiatives.

Questions for the Workgroup

Questions	Slide Reference
Do Workgroup members want to change design elements as a result?	All
Does the Workgroup agree with our current assumptions for included populations?	Slide 13
Does the Workgroup remain comfortable with the assumption of absorbing all cost-sharing?	Slides 11 & 15
Based on the estimated costs, which benefits should be included in the final model?	Slides 11 & 14
What-if any-clarifying questions do you have about the outcomes of the analyses?	All
Based on what you learned from the Sept 16, 2020 actuarial and RAND feasibility/implementation presentations, what-if any-new insights do you have about the three models?	All
Have the modeling outcomes shifted your thinking about which model(s) to recommend? If so, how?	All