



Preparing for the August 2020 UHC Work Group Meeting

Background Materials
and Information

Preparing for the August UHC Work Group Meeting

August Meeting Goal: Further refining the draft “straw” models, assessing models on qualitative elements and preparing to develop the final report

August Meeting Plan:

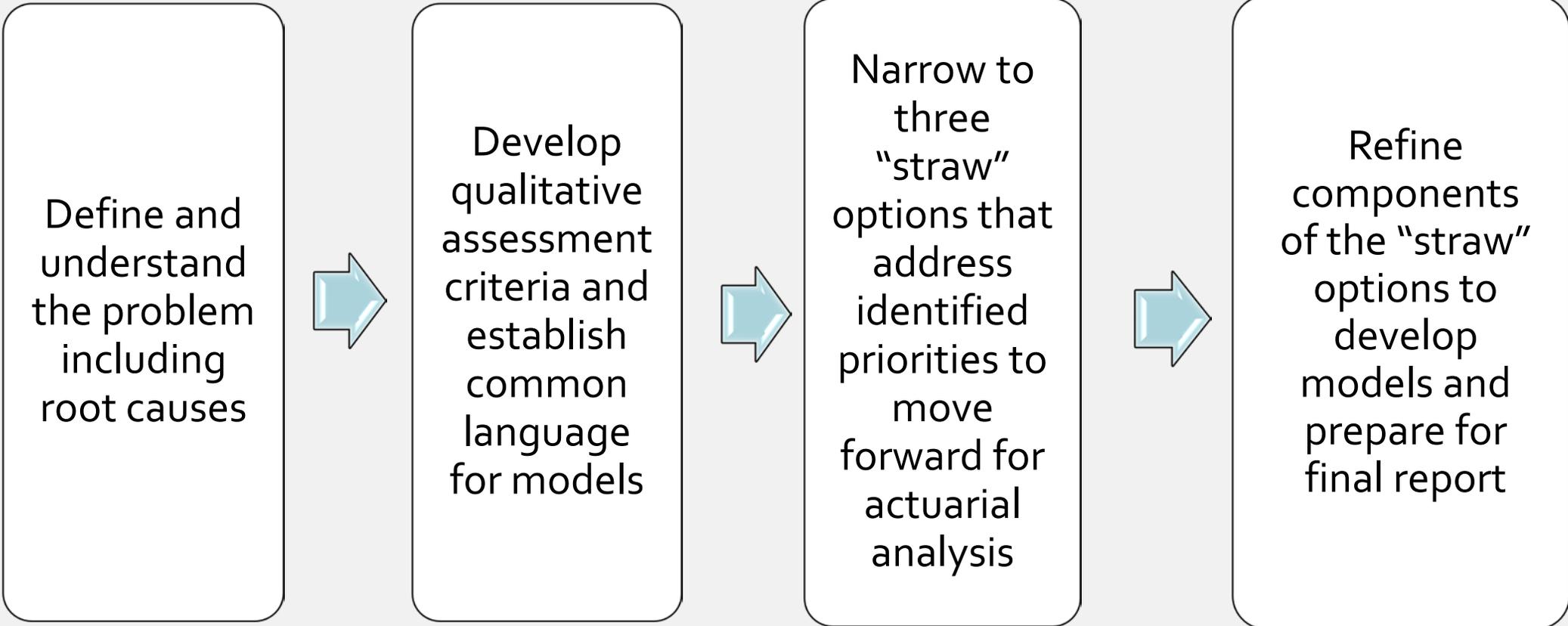
- Review progress modeling the three draft “straw” options
- Discuss key elements: member cost sharing and provider reimbursement
- Qualitative assessment criteria discussion
- Confirm action items
- Hear public comment



Today’s Presentation: background to prepare for August discussions

- Cost Sharing and Provider Reimbursement
- Initial Qualitative Assessment Criteria Review

Work Group Efforts To Date



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graph LR; A[Define and understand the problem including root causes] --> B[Develop qualitative assessment criteria and establish common language for models]; B --> C[Narrow to three "straw" options that address identified priorities to move forward for actuarial analysis]; C --> D[Refine components of the "straw" options to develop models and prepare for final report];
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Define and understand the problem including root causes

Develop qualitative assessment criteria and establish common language for models

Narrow to three "straw" options that address identified priorities to move forward for actuarial analysis

Refine components of the "straw" options to develop models and prepare for final report

August UHC Work Group Meeting Aims: Refine Elements of the Universal Health Care Coverage Options

Build on the Discussions at Prior Work Group Meetings

Prior meeting discussions including:

- Definition of Universal Health Care
- Root causes of issues with the current health care system
- International and national universal health care models – frameworks and key components
- Input from work group members in the recent survey on components of universal coverage models
- June work group meeting discussions of 3 “straw” options to consider as starting point for framing options for the actuaries to model

Refinement of the “Straw” Options at August Virtual Work Group Meeting

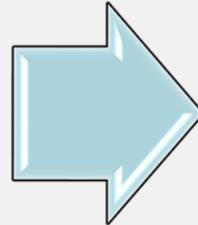
At August work group meeting:

- Workgroup members will join virtual breakout “rooms” to consider cost sharing and provider reimbursement components of the models
- The whole work group will come back together to share themes of key components and any refinements
- Review qualitative assessment criteria and have initial discussions in breakout rooms

After the August Meeting

Actuaries will further refine models and will present at September meeting

Between meetings, workgroup members will consider the three models on qualitative criteria



Develop recommendations

Identify outstanding issues that have not been addressed but still need attention; where possible, potential solutions

Identify near-term transition and other strategies for moving universal health care forward

For the August 2020 UHC Meeting

A composite image with a teal overlay. On the left, a doctor's hand holds a patient's arm while using a stethoscope. In the background, there is a blood pressure monitor and a clipboard with a stethoscope resting on it.

Model Components – Cost Sharing and Provider Reimbursement

Model Components: Cost Sharing and Provider Reimbursement

Two major model components for members to consider are:

- **Cost Sharing**
- **Provider Reimbursement**

This section provides basic context and questions to consider leading up to the discussions in the August work group meeting.

- This includes an explanation of the difference between cost sharing and premiums.

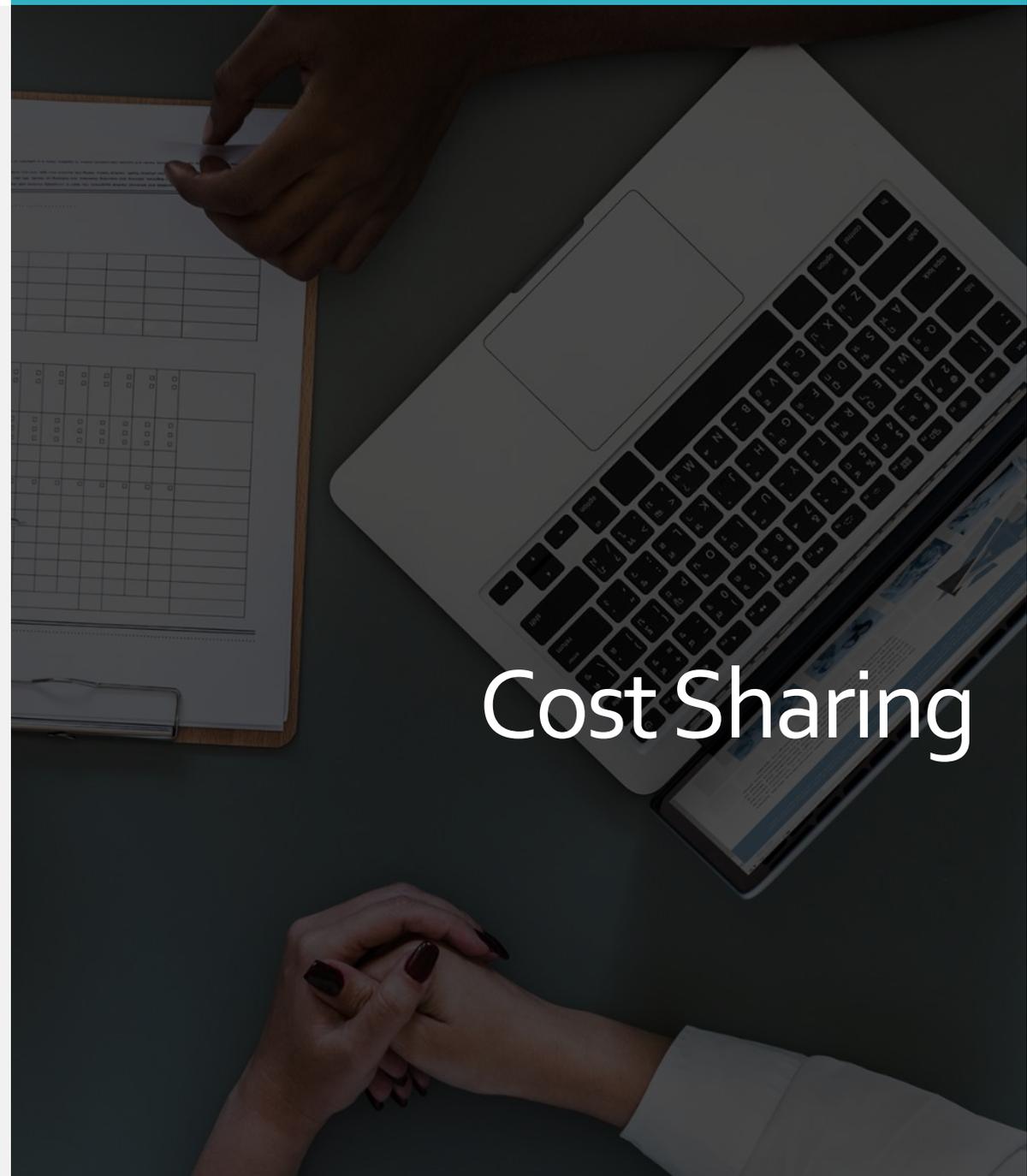
Work group members will be provided documents that explore these issues in greater depth.



Typical cost sharing mechanisms:

- Copay
- Deductible
- Coinsurance
- Out-of-Pocket Maximum

Seeking work group guidance for cost sharing parameters included in modeling



Cost Sharing Mechanisms: Copays

- A **copay** is an amount set by the insurer and due from the beneficiary to the health care provider at the time a service is rendered.
- **Copays may vary based on type of service** (e.g. specialist visits, hospitalization, pharmacy, therapy, etc.)
- **Copays reduce the total cost to the insurer and increase the cost to the member.**
- **Copays can have the effect of discouraging utilization** due to the financial burden on the insured member.

Example: \$30 Office Visit Copay, \$25 per Rx

Date	Service	Amt. Due	You Pay	Ins. Pays
1/20/21	Office Visit	\$250	\$30	\$220
2/25/21	2 Rx	\$250	\$50	\$200
3/1/21	Office Visit	\$300	\$30	\$270
4/5/21	1 Rx	\$150	\$25	\$125
Total		\$950	\$135	\$815

Cost Sharing Mechanisms: Deductible

- A **deductible** is an amount due from the insured before insurance coverage begins to pay.
- **Deductibles reduce the total cost to the insurer** by shifting initial cost of care to the insured member and impacting consumer behavior.
- **Deductibles can reduce both appropriate and inappropriate utilization** by creating a financial disincentive for a member to seek care.

Example: \$500 Deductible

Date	Amt. Due	You Pay	Ins. Pays
1/20/21	\$250	\$250	\$0
2/25/21	\$250	\$250	\$0
3/1/21	\$300	\$0	\$300
4/5/21	\$150	\$0	\$150
Total	\$950	\$500	\$450

Cost Sharing Mechanisms: Coinsurance

- **Coinsurance** is an amount due after the deductible is met based on a percentage of the insured allowed amount.
- Like deductibles and copays, **coinsurance reduces the cost to the insurer and increases the cost to the member.**
- **Coinsurance can be a strong disincentive to utilize higher cost services** and can drive consumers to more actively scrutinize costs and explore care options.

Example: 10% Coinsurance

Date	Amt. Due	You Pay	Ins. Pays
1/20/21	\$250	\$25	\$225
2/25/21	\$250	\$25	\$225
3/1/21	\$300	\$30	\$270
4/5/21	\$150	\$15	\$135
Total	\$950	\$95	\$855

Financial Safeguards Currently in Place for Consumers

- Plans that include these cost sharing mechanisms are also required to **include member safeguards**.
- The primary safeguard is the **out-of-pocket maximum** – after an insured member contributes a certain amount towards their own care through copays, coinsurance, and deductibles, the payer assumes 100% of costs.
- This safeguard **limits an individual's total financial risk**.
- Example: Under the Affordable Care Act, 2020 high-deductible plans have out-of-pocket limits of \$6,900 for an individual and \$13,800 for a family.



Additional Points to Consider

Do you believe the health care model should include cost sharing (i.e., co-payments, coinsurance, and deductibles)? Why or why not?

If you are in favor of cost sharing mechanisms, which ones do you support and are there any specific parameters that you think are important to include (low income excluded, etc.)

Note: To help frame your thinking regarding potential cost sharing structures, and example of one potential cost sharing design is provided on the next slide.

Cost Sharing Considerations

- Administrative complexity
- Compliance with federal regulations for different populations

Simple Example of Cost Sharing Design to Support Discussion

Note: this is not a recommendation

Income Level	Premiums	Copays	Deductible	Coinsurance	Out Of Pocket Max
Medicaid Eligible	No	No	No	No	N/A
Medicaid Ineligible up to 300% FPL	No	For low-value services and pharmacy	No	No	0 - 5% of household income
301% FPL and Higher	No	For low-value services and pharmacy	No	5 - 15%	0 - 5% of household income

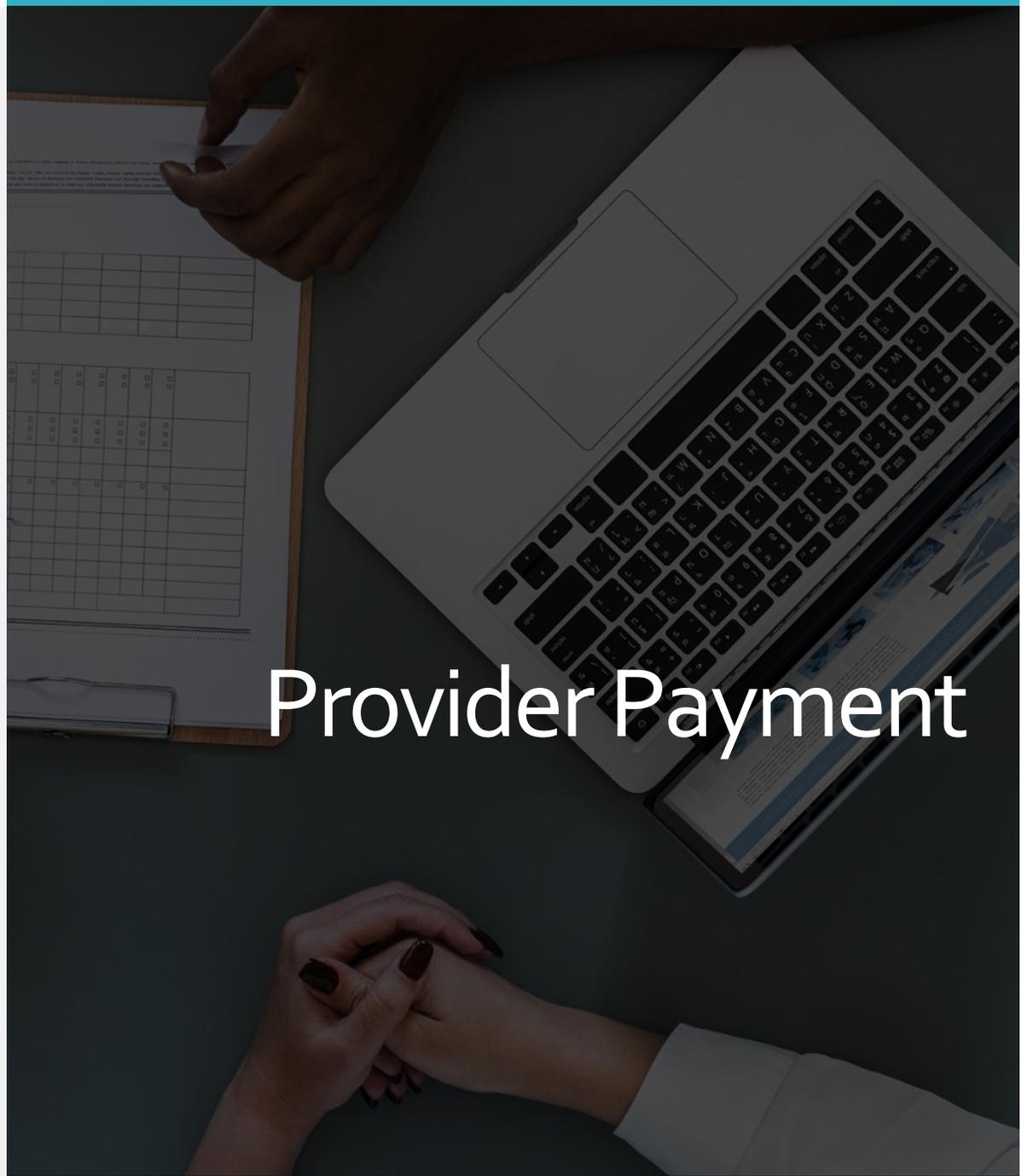


Important Concepts:

- Purchasing power and market shares
- Provider impacts
 - Efficiencies
 - Normalized fees

Will the workgroup recommend capturing provider efficiencies?

What transition strategies will the workgroup recommend?



Provider Payment

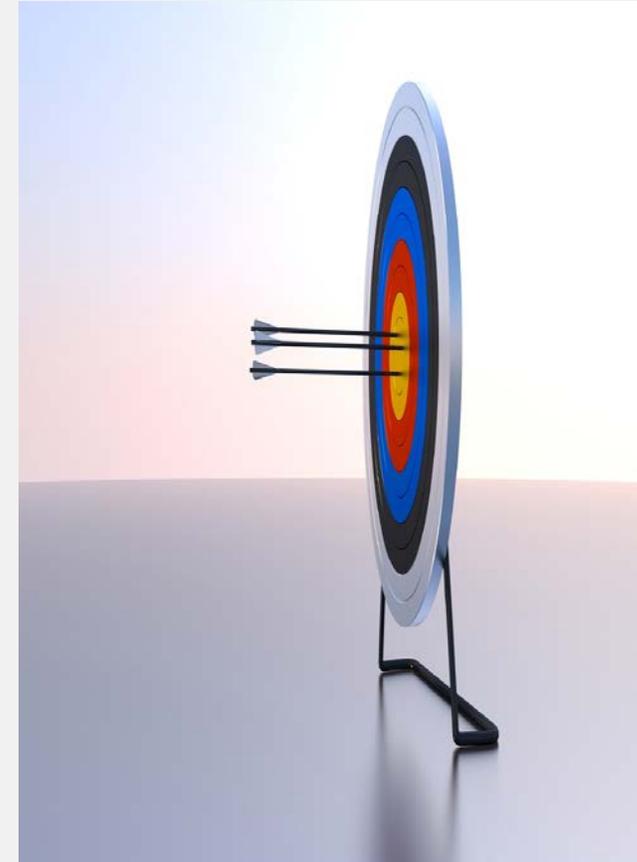
Provider Payment: Purchasing Power and Market Shares

- A single-payer would have greater purchasing power.
- The payer could use its purchasing power to put downward pressure on provider reimbursement and negotiate better deals with pharmaceutical and medical suppliers.
- Can the plan's increased purchasing power overcome monopolistic pricing?



Provider Payment: Provider Impacts - Efficiency

- It costs providers more to deal with many different payers.
- This is due to **duplicative contracting, billing processes, and reporting.**
- Administrative **costs are passed on to consumers.**
- A single-payer system **reduces some of this duplication.**



Provider Payment: Provider Impacts – Single Set of Standardized Fees

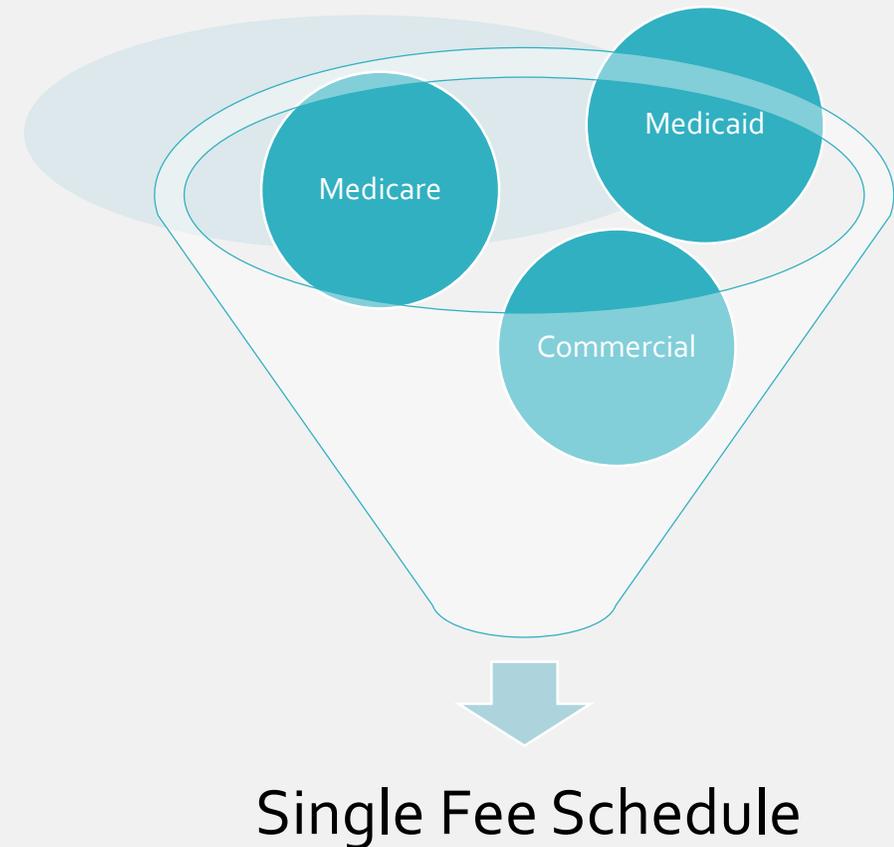
Each payer offers different reimbursement rates for services.

- Medicaid tends to be the lowest
- Medicare is somewhere in the middle
- Private/commercial insurance tends to be highest

A single fee schedule will either decrease or increase revenue for providers, depending on the insurance mix of a provider's panel. In some cases, this change in revenue could be significant for the provider.

Need to consider:

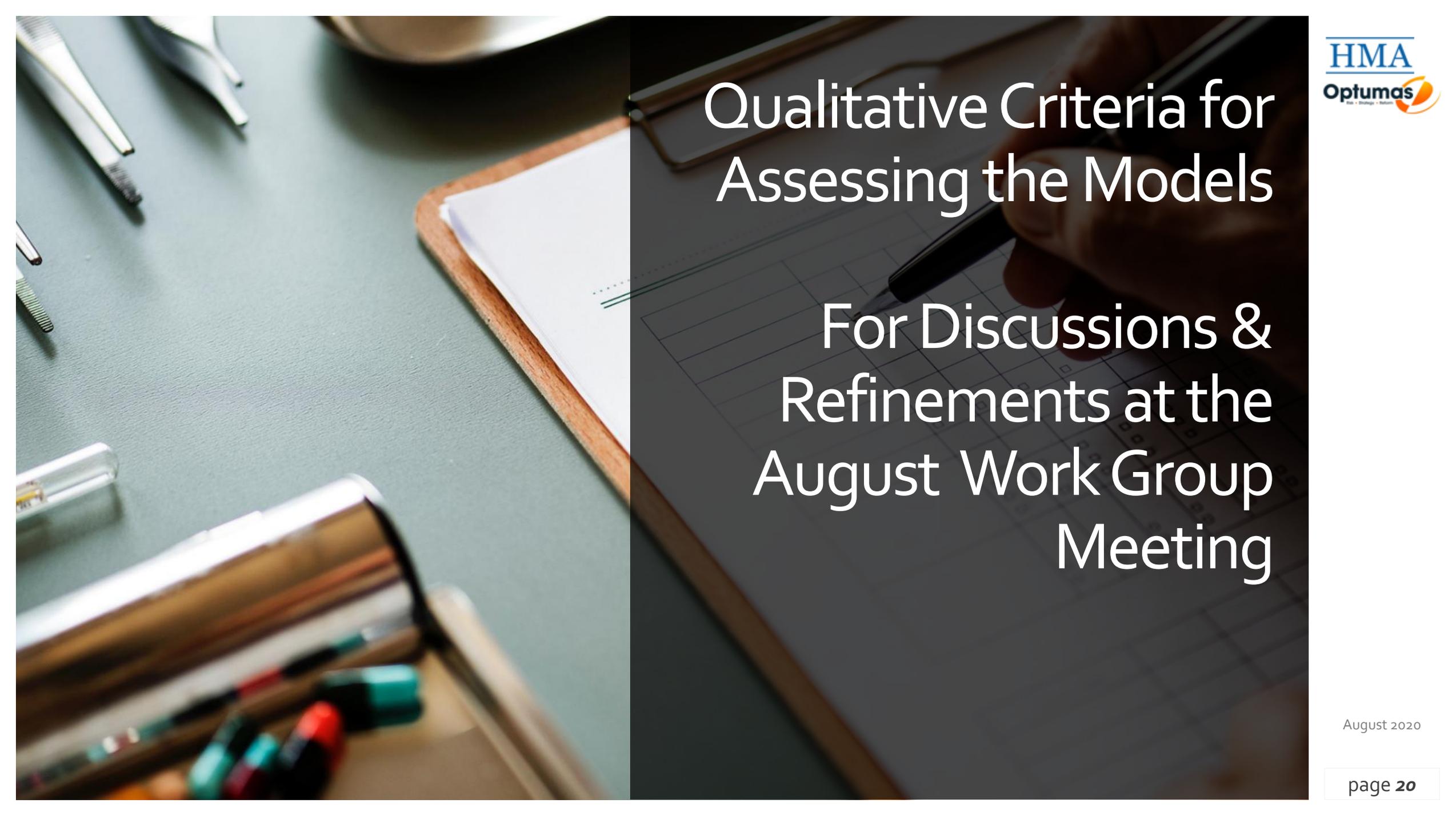
- What reimbursement should be established?
- Recommendations to mitigate detrimental impacts on providers?



Additional Points to Consider

For the universal coverage options, should the model assume lower administrative costs for providers due to a simplified system? Why?

Should modeling of the universal coverage options assume that the state will have greater purchasing power that will allow the state to reduce provider compensation as proposed in similar studies?

The background of the slide is a photograph of a desk. On the left, there are several pens and pencils in a holder. In the center, a wooden clipboard holds a white sheet of paper. On the right, a hand is holding a black pen over a calculator. The text is overlaid on the right side of the image.

Qualitative Criteria for Assessing the Models

For Discussions & Refinements at the August Work Group Meeting

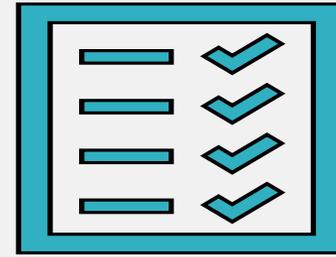
- The assessment criteria were first developed through discussions at earlier work group meetings; came out of
 - The work group's root cause analysis
 - System improvements work group members would like a new model to incorporate
- The work group discussed assessment criteria at the February meeting. The discussions and later feedback from work group members shaped the assessment criteria
- Criteria fell into two categories:
 - **Quantitative**
 - **Qualitative or Policy-related**
- At the August meeting we will discuss the qualitative criteria as they relate to the structure of the 3 models
- We will examine the models at a later meeting using quantitative criteria once the actuaries complete their modeling



About the Assessment Criteria

Aim of the Assessment Criteria: To Help the Work Group to Evaluate the Models

Assessing the Models: Quantitative and Qualitative Assessment Criteria



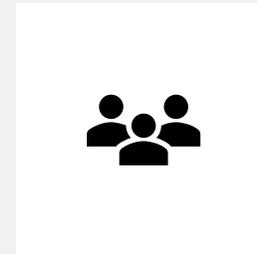
Quantitative (Measurable) Criteria, including:

WHO?

How many people will be covered under the model?

WHAT?

What healthcare benefits will be offered under the model?



Qualitative (Policy-Dependent) Criteria, including:

EQUITY?

Does the model support fair and appropriate access to quality care across cultural, ethnic, language, geography and other communities?

ACCESS?

Does the model facilitate the right care at the right time in the right setting?

Qualitative Assessment Criteria

- The qualitative assessment criteria fall under the following topics:
 - Access
 - Governance
 - Quality
 - Equity
 - Administration
 - Feasibility



- The next several slides go through some of the questions in each category

Qualitative Assessment Criteria: ACCESS

To what extent does the coverage:

- Allow seamless coverage from birth to death?
- Allow the choice of health care provider?
- Allow for easy navigation of the health care system for patients and providers?

How well does the model:

- Provide access to comprehensive, essential, effective and appropriate health services?
- Provide a full range of services? (whole body/holistic)
- Provide access to culturally-attuned care?
- Provide equitable access to quality care based on a person's need and regardless of income, geography, age, gender, etc.?
- Provide coverage for experimental treatments for rare diseases?

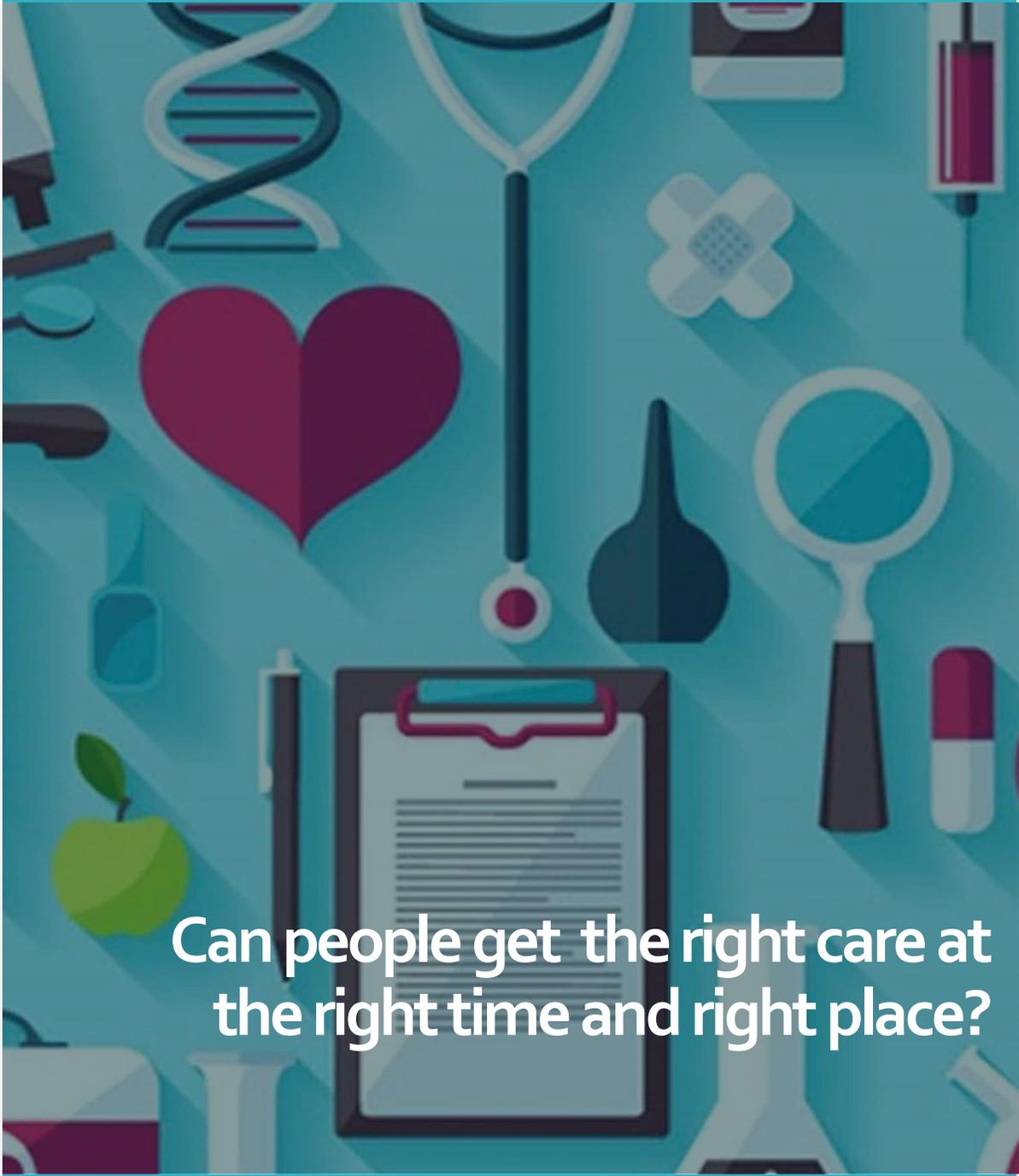


Who and what are covered?

Qualitative Assessment Criteria: ACCESS continued

To what extent does the model:

- Provide access to affordable care?
- Promote preventive health care and utilization of primary care?
- Encourage preventive health care and utilization of primary care?
- Promote workforce capacity building?
- Facilitate the right care at the right time in the right setting?
- Provide psychiatric care in the least restrictive environment necessary?



Can people get the right care at
the right time and right place?

Qualitative Assessment Criteria: Governance

To what extent does the model:

- Ensure transparency and accountability in how the model is governed?
- Include participation by community-based systems/organizations in its governance?
- Respect the primacy of the patient-provider relationship?
- Ensure administrative accountability?
- Have governance that maintains Tribal sovereignty and voice?
- Makes sure the patient has a voice in how the health care system works?



**Who is involved and how
decisions will be made?**

Qualitative Assessment Criteria: Quality and Equity

How well does the model:

- Encourage consistency in health care delivery in rural areas and across different cultural, ethnic, language, and other types of communities? (does this model reduce variance in care)
- Incentivize or enhance the delivery of quality health care?
- Include efforts to improve health care safety and minimize medical errors?
- Encourage transparency about health care quality, including reporting of adverse events (e.g. deaths, infections)?



**Does the model promote
better health outcomes for
everyone?**

Qualitative Assessment Criteria: Administration and Feasibility

How well does the model:

- Reduce administrative costs
- Include mechanisms to reduce duplication of services?
- Include effective cost controls for all services, including prescription drugs, without compromising access and quality?
- Support value-based payments to providers and health systems?
- Respond to implementation challenges due to federal regulations?
- Respond to challenges related to political buy-in, implementation, or administration?

**Does the model focus
resources on value?**

Qualitative Assessment Criteria: Administration and Feasibility (continued)

How well does the model address:

- Impacts of program implementation and administration on key delivery system stakeholders, such as:
 - Commercial health insurance plans
 - Medicaid managed care plans
 - Employers who currently do purchase insurance for their employees?
 - Employers who currently do NOT purchase insurance for their employees?
 - Health care providers/hospitals?
 - Tribal health?
 - Others?

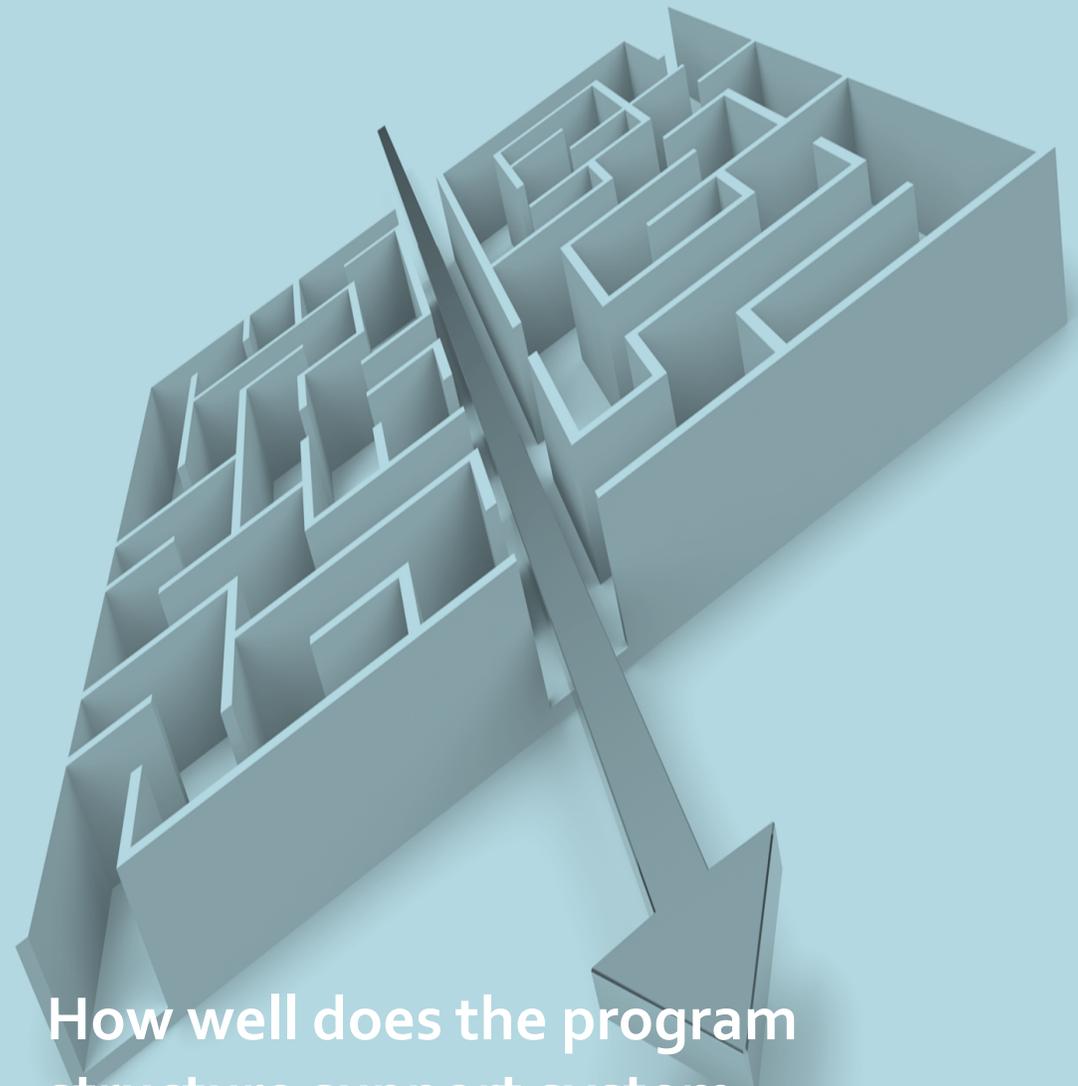


How will the program work
for various people and
organizations?

Qualitative Assessment Criteria: Administration and Feasibility (continued)

How well does the model:

- Support administrative simplification
- Allow for phasing/incremental advances toward universal health care
- Facilitate data sharing and data portability
- Utilize open enrollment periods or allow residents to enroll in coverage at any time



How well does the program
structure support system
improvements?

The 3 draft “straw” options for modeling

A

Universal Coverage- State Administered

WHO: All state residents

WHAT: State defines benefit package for all

HOW:

- State sets delivery system rules (e.g., promotion of primary care, use of value-based payment, etc.)
- No health insurers, state contracts directly with providers

B

Universal Coverage- Delegated Administration

WHO: All state residents

WHAT: State defines benefit package for all

HOW:

- State sets delivery system rules (primary care promotion, use of value-based payment, etc.)
- Health insurers that meet requirements provide coverage, contract with providers

C

“Fill in the Gaps” Coverage for People without Coverage

WHO: State residents with limited access to quality, comprehensive coverage

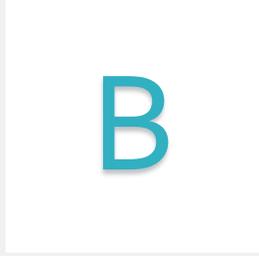
WHAT: State defines benefit package

HOW:

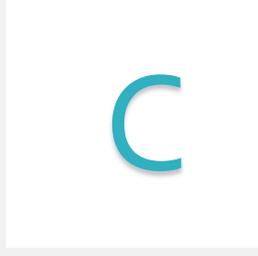
- State sets delivery system rules (primary care promotion, use of value-based payment, etc.)
- Similar to Cascade Care
- Insurers that meet requirements offer coverage, contract with providers



Universal
Coverage-State
Administered



Universal
Coverage-
Delegated
Administration



“Fill in the
Gaps”

Consider each model’s framework and assess how well it might support or facilitate the qualitative criteria in each of the following areas:

- Access
- Governance
- Quality
- Equity
- Administration
- Feasibility

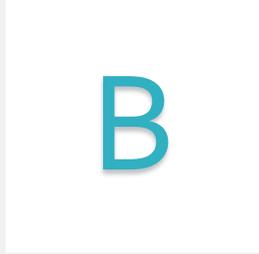
Exercise: How well does each model drive desired qualitative changes?

The work group may recommend that ANY model implemented must include some of these criteria

Example: Access



Universal
Coverage-State
Administered



Universal
Coverage-
Delegated
Administration



“Fill in the
Gaps”

For each model, how well does it support access?

- Very Much
- Somewhat
- Very Little or Not at All

Does one model stand out as best suited to support access? Why?

Access includes:

- Seamless coverage
- Choice of provider
- Comprehensive, effective, appropriate services
- Culturally-attuned care
- Equitable access
- Affordable care
- The right care at the right time & setting



- 
- Optimus update on modeling progress will lead off the meeting
 - Breakout group discussions – consideration of the models and:
 - Cost sharing
 - Provider reimbursement
 - Results of breakout discussions will be shared and discussed by whole work group at the August meeting
 - All breakout discussions will be summarized and shared
 - **Qualitative** assessment criteria will be discussed as the members think about the models' frameworks and how best to further key policy or implementation issues
 - Will review and discuss the **Quantitative** assessment criteria as the actuaries bring back their modeling to the next meeting in September



Summary

Join the virtual August meeting ready to provide more input on the straw models and begin discussing qualitative impacts and implementation issues

More discussions to come in the fall as well

Thank You

Please submit your questions by August 22nd to:
HCAUniversalHealthCareWorkGroup@hca.wa.gov

Visit the [Universal Health Care Work Group webpage](#) for more information