

Universal Health Care Work Group Q&A

About the videos for the work group meeting on June 24, 2020

We created this Q&A to answer questions from two videos that were created for Universal Health Care Work Group members: the [COVID-19 briefing](#) and [Background materials and information](#). The Q&A is organized by topic and updated as we receive new questions.

Stakeholders

1. There are frequent mentions of the term "stakeholders" without defining who they are. In these three models, is HMA considering health insurers as stakeholders?

The legislation that established this work group (HB 1109) specifically included health insurance carriers as a category of stakeholder to be included in the work group, along with a range of other stakeholders. Beyond the legislation's requirements for work group participants, stakeholders for this process include all interested persons, without regard to their organization or other affiliation.

2. Slide 22 appears to "highlight" four key stakeholder impact areas. Why were these four chosen? Also, it looks like "provider compensation" refers mostly to medical care practices. What about hospitals (rural and urban), pharmacies, community health centers, etc.?

The topics were not intended to be comprehensive, but instead illustrative of important topics that have different types of impacts on different stakeholder groups. The intent was to promote dialogue that considers a variety of perspectives as members participate in the breakout groups. Work group members can and should discuss other key stakeholder impact areas during the breakout sessions, including those members feel are most important from their perspective, or for which they have expertise to contribute.

Sustainability is a function of how the models are designed and implemented, and not an attribute inherent to each of the models themselves. Work group members should consider which elements of the model designs will most likely negatively or positively impact sustainability (benefit design, reimbursement levels, cost sharing, etc.) as part of model recommendations.

The term "provider" is comprehensive of all health care providers. Work group members can and should expand on the limited set of examples provided in the webinar.

Model options

3. If a state-run and funded health coverage system is adopted (straw #1), there will be a need to upgrade the state's ability to process claims and payments to providers. Is the need for increased administrative personnel by the state's agency running the system being taken into account in the models?

Yes, changes in administrative structure are considered.

4. The presentation uses various words to characterize how many respondents said what, from a rather precise 30 percent to "most," "many," "fewer," and "some." It's really impossible to understand the meaning of each of these characterizations (is "many" a majority? is "fewer" more than 30 percent?) as they relate to building models.



This was not a scientific process, and the survey was not the sole determiner of the three options presented here. These options were selected following work group discussion and they are not final. The goal of this was to give the work group "straw options" to optimize the discussion on June 24. The goal is to refine these options through discussion so the actuaries are able to create dynamic models.

5. Where did the 1.5/2.5/3.5 model variants come from? At least for 1.5 and 2.5, these options seem to ignore the benefits provided; that is, they allow for some to be left out of coverage by the main model but with substantially less comprehensive benefits. Is that what's intended?

These variants are presented for the work group to consider and are offered based on the experiences and significant hurdles to efforts in Maryland, Maine, Oregon, and others to fold existing federal programs, such as Medicare or redirecting the federal share of Medicaid into a statewide population initiative. The variants could be an initial approach but recognize the reality of implementation challenges that could take considerable months or years to achieve and delay initiation of the overall universal approach, if the federal administration is even willing to consider allowing a state to direct federal funding investments. Benefit alignment will be key in any discussions with the federal government for the use of the federal dollars.

6. Option C, slide 18, says that the "state defines benefits package for all," but the model doesn't contemplate the state governing all forms of coverage. So, for example, how would the state define benefits for those with employer coverage or Medicare or VA?

The wording in slide 18 was intended to note that the state defines the benefit package for the Cascade Care (or similar) program – "all" meaning "all program participants." It is not intended to imply that the state defines the benefit for any other type of coverage. If this program were to replace employer or individual coverage, residents previously in such coverage would enter coverage with the state-defined benefit package. If the program was established but the state maintained employer and other forms of individual coverage, residents with other individual or group coverage types would not have their benefit defined by the state.

7. Could any of the models be implemented quickly enough or phased-in to help address the newly uninsured? How long it could feasibly take to implement these models?

It is important to note that individuals who have lost access to health insurance due to job loss or reduced income can currently get coverage through two existing programs: [Apple Health \(Medicaid\)](#) and [Washington Health Benefit Exchange](#). Depending on their current income, many Washington residents can get coverage through these programs right away. Apple Health covers individuals and families with income up to \$1,468/month for a single person and up to \$3,013/month for a family of four. The Exchange offers coverage for people with income above Apple Health limits, with financial support for premiums based on household income.

Implementing significant changes to the state's health care system, whether to implement universal coverage or another program, will take significant concerted effort and start-up funding. The process is multi-step, and will include:

- Legislative approval of a reform concept.
- Program design work.
- Legislative approval of a specific program and authorization of financing (including for start-up costs and ongoing administration and/or consumer financial assistance).
- Regulatory changes.
- Depending on the changes, federal approval for use of federal funds or changes to federally administered programs.

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- Implementation of the program, including detailed design and implementation phases, administrative changes, technology implementation, contracts, etc.
 - Stakeholder engagement and feedback at each stage of the process.

For any of the potential reform options, this process is anticipated to be at least 18 months and can take three years or more.

8. Can the actuarial analyses shed light on which models could address the uninsured and/or prevent a similar catastrophe in the future?

The actuarial and other financial analyses are intended to provide information on the costs associated with operating each program option, and will not address the options' ability to avoid coverage losses in a catastrophe. From a policy standpoint, universal coverage models would continue to provide coverage in the event of a catastrophe as well as when individuals change jobs or have other life changes. For this to be the case, the state must maintain program funding in the face of catastrophic economic events that reduce state tax collection. Similarly, any state-funded premium program that is part of a fill-the-gap scenario will face the same funding issue as would funding for universal health coverage. At the same time more people require assistance, state revenue is likely to be down to fund the program.

Washington now faces a significant budget shortfall, and state agencies identified potential cuts that will reduce costs by 15 percent. While no cuts have been made official, based on past economic downturns, proposed changes could reduce Medicaid services or end eligibility for some currently covered populations. Legislators and state agencies will be focused on maintaining current services prior to addressing potential future program changes.

9. Please clarify that the state would be administering the insurance or coverage – not the health care. Some people hear “state-administered” and assume the British NHS system.

In both Options A and B, the state would design the system (determine the operating rules, including the use of value-based payment). In Option A, the state would also administer the coverage, which means set payment rates, contract with providers, pay claims, and otherwise do the things that insurers do now. As noted in the slides, the state would not be providing the care through state employees, but would contact with providers across the state.

10. Are undocumented immigrants covered in this plan and its variation? Later in the documentation, “permanent residents” are mentioned. How does that work with a pandemic that does not check papers? Does it exclude undocumented who don't yet have papers?

From feedback we have received during work group meetings and from survey responses, Option A would cover undocumented Washingtonians. The details of how residency is determined, whether it is self-attested or otherwise, would need to be developed for implementation of the model. “Permanent resident” is meant to imply that visitors to the state (vacationers, say) are not covered.

11. Would COBRA still exist under either of these options?

If employer-sponsored coverage is replaced by state coverage, Washingtonians would not need or be eligible for COBRA. If the program allowed some employer coverage to be maintained, this question would have to be further developed for implementation.

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12. Not ideal, but was wondering about other options—pre-Medicare? (Especially with people working for health care—if we took that off that table, it might ease unemployment. Or just handle COVID-19 health care until there is a readily available vaccine? Or something else?)

The straw models were primarily based on the discussions at the work group meetings. The survey was developed based on those work group discussions as well. Other options or variations could be designed. The straw models were an attempt to get at a limited number of proposals for discussion at the June meeting in order to allow in-depth financial analysis of associated costs and to further discussions on other program elements.

Option 1.5

13. Would a federal waiver still be required for Option 1.5?

The state might need a waiver if federal funds are being used and the state wants to do something different than the federal government has given Washington the authority to do under existing Medicaid and Medicare law. Option 1.5 is intended to get at the federal program issue, particularly related to the federal government's historic unwillingness to allow states to control Medicare rules or dollars.

If the program impacts employers impacted by Employee Retirement Income Security Act (ERISA) law, it would need a federal exemption from that law to proceed.

Options 2 & 2.5 – universal coverage—delegated administration

14. What are the possibilities for private/public partnerships? Perhaps as little as claims processing?

The specific details of what the state would take on versus contract out would need to be further defined to prepare for implementation of this model. This level of detail would be defined in the implementation process once a model was selected by the state.

15. Does this mean we still have narrow provider networks and bare counties?

The work group has indicated that increased access is a key value that would drive its recommendations for a proposed program.

16. Are there actually cost savings by doing this with Medicaid?

The answer depends on the reimbursement rate selected. Currently, public and commercial provider rates differ significantly. The total cost to provide care for all Washingtonians under a given model (and savings compared to the current system) would depend on the reimbursement rate selected.

Options 3 & 3.5 – fill in the gaps and subsidies

17. Would you consider this to be the current system?

This model adds to the current system by including subsidies to support individuals purchasing coverage in the individual market.



18. Confirming that we could use data already developed about Cascade Care. The Universal Health Care Work Group's \$500,000 wouldn't be going toward analyzing that system?

We are not re-creating any work already done for Cascade Care's development.

19. Do we have to include the current system as one of the models to be analyzed, or is it automatically included?

All three models will be compared to the current system, which allows the work group to understand the financial, coverage, and other impacts between today and modeled options.