Washington State Health Care Authority

# Universal Health Care Commission

**February 25, 2022**

Washington State Health Care Authority

# Universal Health Care Commission
# Meeting Materials

**February 25, 2022**
**2:00 p.m. – 4:00 p.m.**

**(Zoom Attendance Only)**

## Meeting materials — Tab

Washington State Health Care Authority

# Agenda

# TAB 1

Washington State Health Care Authority

# Universal Health Care Commission

**February 25, 2022**
**2:00 p.m. – 4:00 p.m.**
**Zoom Meeting**

## AGENDA

| Commission Members: | | | | | |
|---|---|---|---|---|---|
| ☐ | Vicki Lowe, Chair | ☐ | Estell Williams | ☐ | Kristin Peterson |
| ☐ | Senator Ann Rivers | ☐ | Jane Beyer | ☐ | Representative Marcus Riccelli |
| ☐ | Bidisha Mandal | ☐ | Joan Altman | ☐ | Mohamed Shidane |
| ☐ | Dave Iseminger | ☐ | Representative Joe Schmick | ☐ | Nicole Gomez |
| ☐ | Senator Emily Randall | ☐ | Karen Johnson | ☐ | Stella Vasquez |

| Time | Agenda Items | Tab | Lead |
|---|---|---|---|
| 2:00-2:05 (5 min) | Welcome and call to order | | Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State |
| 2:05-2:15 (10 min) | Roll call & schedule update | 1 | Mandy Weeks-Green, Manager Health Care Authority |
| 2:15-2:30 (15 min) | Public comment | 2 | Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State |
| 2:30-2:35 (5 min) | Approval of Meeting Summary from 1/4/22 | 3 | Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State |
| 2:35-3:05 (30 min) | Health Coverage Changes in Washington State since the COVID-19 Pandemic | 4 | Wei Yen, Senior Forecast and Research Analyst Office of Financial Management |
| 3:05-3:15 (10 min) | Public comment on Commission Charter | 5 | Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State |
| 3:15-3:35 (20 min) | Discussion and approval of Commission Charter | 6 | Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State |
| 3:35-3:55 (20 min) | Introduction to the Health Care Cost Transparency Board | 7 | AnnaLisa Gellermann, Manager Health Care Cost Transparency Board, Health Care Authority |
| 3:55-4:00 (5 min) | Adjournment | | Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State |

*During the COVID-19 public health emergency, and out of an abundance of caution for the health and welfare of the Commission and the public, this meeting of the Universal Health Care Commission will be conducted virtually.*

Washington State Health Care Authority

# Updated Universal Health Care Commission Meeting Schedule

## Additional Meeting added in July to Enable the Commission to Begin Discussions of all Required Legislative Report Topics

## Upcoming Meetings and Topics

| Month | Topic |
|---|---|
| **April** | • Initial synthesis of analyses done on Washington's existing health care finance and delivery system<br>• Key design elements of universal health care |
| **June** | • Preliminary assessment of preparedness for universal health care<br>• Potential strategies for change |
| **July* Added Meeting** | • Strategies for change (continued)<br>• Considerations for coverage expansion |
| **August** | • Financing models for universal health care<br>• Costs of increasing reimbursement rates for medical assistance providers |
| **October** | • Report Review |

**This schedule will enable to Commission to fulfill the legislative report requirements and is designed to ensure that the Commission will be able to begin discussions on each of the topics to be included in the report.**

Washington State Health Care Authority

# Public Comment

# TAB 2

# Public Comment

Washington State Health Care Authority

Washington State Health Care Authority

# Universal Health Care Commission
# Written Comments

Received from December 28th, 2021, through
February 10, 2022

## Written Comments Submitted by Email



## Additional Comments Received at the January 4th Commission Meeting

- The Zoom video recording is available for viewing here: https://youtu.be/y_vSZEn7SNo
- The Zoom comments and questions from the captured chat are available here: https://www.hca.wa.gov/assets/program/uhcc-meeting-chat-20220104.pdf
- The Meeting Summary is available here: https://www.hca.wa.gov/assets/program/uhcc-meeting-materials-20220104.pdf

# Public comments received since December 28th through the deadline for comments for the February meeting (February 10th)[1]

**Submitted by Roger Collier**

**12/29/2021**

ROGER COLLIER
303 MOREY AVENUE, BELLINGHAM, WA 98225
rcollier@rockisland.com

Dear Universal Health Care Commission members:

I am interested in working with the Commission on a pro bono basis.

Before my retirement I was CEO of a national healthcare consulting firm, where I managed projects for some fifteen state Medicaid agencies, the US Department of Health and Human Services, the US Department of Defense, the national Blue Cross and Blue Shield Association and several individual Blue Cross and Blue Shield Plans, and HMOs including Kaiser and Group Health. I also testified on government healthcare issues in Washington DC and before legislative committees in Colorado, Washington and Oregon, and was quoted in both the regional and national press, including the *New York Times*.

In 2006, I was an invited panelist for Washington State's Blue Ribbon Commission on Health Care Costs and Access. As a panelist, I tried to make two points: first, the State should recognize it has little leverage in terms of influencing federal legislation; second, the State should instead seek ways to capitalize on the extent to which it administers healthcare coverage for a substantial percentage of Washington's residents.

As noted in the first 2021 Commission meeting, none of the major recommendations of the 2006 effort – my own or anyone else's -- were implemented. While the Affordable Care Act has led to some changes to our State's healthcare landscape, the major issues remain much the same. Healthcare coverage is still too costly for too many, while subsidy efforts eat up an increasing amount of the State's budget; State-administered programs now cover close to three million State residents but with an ever more complex patchwork of program options; and partisan gridlock in the Congress makes changes to Federal healthcare legislation even less likely than in 2006.

The January 2021 Work Group report offered an enormously ambitious path to universal coverage, with preferred options comparable to systems in the UK (Model A) and in Germany and Holland and elsewhere (Model B). The report's history of earlier reform efforts in the State – and especially that of the 1993 legislation, which underestimated both the stumbling block of ERISA and the opposition of employers -- gives some idea of the challenges facing implementation of either option.

[1] Public comments that requested confirmation of delivery received an acknowledgement of receipt have been addressed.

On the other hand, perhaps the State could retain universal healthcare as a goal but accept an intermediate objective that still would create a program serving three million people and that could be a model for every other state in the Union – and which would have the potential for expansion to even more of the State's population, starting with those targeted by the Work Group's Model C. With that achieved, the more ambitious goal could begin to be possible.

No rational person would have designed from scratch the patchwork quilt of State-administered healthcare programs that has built up over the past fifty years. Better coordination, consolidation, standardization, and more effective price competition could reduce costs by billions of dollars and better serve individuals, employers, and providers.

It's not going to be easy to achieve even a less ambitious program than the Work Group's Models A and B. Waivers of Title XIX and the Affordable Care Act will be required; employers, providers, employee organizations, and various interest groups will have to be persuaded to accept compromises; and – maybe most critically – acceptable funding mechanisms will have to be found.

Having thought a lot about healthcare reform issues over the past several years, I believe I can be a useful contributor to the Commission's efforts. In particular, my unique experience in implementing new healthcare programs – including Washington's original Basic Health, the Department of Defense's TRICARE, and Orange County's CalOPTIMA Medicaid managed care plan – should be of especial value.

I look forward to your comments.

Sincerely

Roger Collier

**Submitted by Roger Collier**

**1/3/2022**

ROGER COLLIER
303 MOREY AVENUE, BELLINGHAM, WA 98225
rcollier@rockisland.com

Dear Universal Health Care Commission members:

Before I retired I was CEO of a national healthcare consulting firm, where I managed projects for some fifteen state Medicaid agencies, the US Department of Health and Human Services, the US Department of Defense, the national Blue Cross and Blue Shield Association and several individual Blue Cross and Blue Shield Plans, and HMOs including Kaiser and Group Health.

I am not in any way a lobbyist for the health insurance industry. However, I do have some questions and comments about details of the Work Group recommendations which underly much of the Commission's agenda. **Please consider the following as public testimony.**

**Feasibility of the recommended Models A and B -- Questions**

1. Did the Work Group or its consultants talk with key players in Vermont about the reasons for the failure of the Green Mountain Healthcare Plan – in particular, the opposition of smaller employers?
2. Did the Work Group or its consultants review the ERISA legal opinions prepared as part of Washington's 1993 reform effort?
3. Did the Work Group or its consultants review the 2016 Supreme Court opinion on the supremacy of ERISA?
4. Did the Work Group or its consultants discuss with US Senator Murray's office the possibility of obtaining an ERISA waiver?
5. Did the Work Group or its consultants evaluate the likelihood of CMS abandoning its policy of federal budget neutrality for 1115 waivers?

**Expenditure estimates for Models A and B -- Comments**

The consultant analysis of the impact of moving to either Model A or Model B is comprehensive and well-argued. However, the exact dollar estimates imply more confidence in the assumptions than may be warranted. In particular:

1. A recent Stanford University research paper suggests that more substantial reductions in administrative costs may be possible for either Model A or Model B.
2. The analysis does not adequately consider the effect of at-risk insurers' efforts to control provider costs. While Medicare Advantage is a long way from an ideal program, it does provide a useful cost comparison with the loose controls and high levels of fraud and abuse of traditional Medicare.
3. Estimates of increased service utilization by former Medicaid beneficiaries may be understated. A recent JAMA paper implies close to a 10 percent increase, not the report's 1 percent.

**Model A versus Model B – Question**

Given that the State has chosen to have insurers administer its current healthcare programs, did the Work Group or its consultants analyze the reasons for the present arrangements? Was any estimate made of the savings (or costs) which might result from switching current programs to a Model A type structure?

**Submitted by 34th District Democrats Health Care Caucus, Jennifer Nye, Jennifer Robertson, Roxanne Thayer**
**1/4/2022**

Dear Commission Members,

We are writing to you in our capacity as members of the 34th District Democrats Health Care Caucus. We share with you the recognition that health care is a primary concern both for voters and all

residents. We are also aware that health care is a complex and challenging issue involving many interested and invested parties.

We have studied the Commission's charter and suggest that your "vision" and "mission"

statements could—and, in our view, should—be further clarified and strengthened. Therefore, we have composed a new version of these statements and ask that you consider our version in your deliberations.

**Commission's version:**

A. Vision: To increase access to quality, affordable health care by streamlining access to coverage.
B. Mission: The Commission's primary objective is to develop a strategy for implementable changes to the state's health care financing and delivery system to increase access to health care services and health coverage, reduce health care costs, reduce health disparities, improve quality, and prepare for the transition to a unified health care financing system. The Commission aims to achieve this objective by: (1) examining data and reports from sources that are monitoring the health care system; (2) assessing the state's current preparedness for a unified health care financing system; (3) developing recommendations to increase access to health care services and health coverage, reduce health care costs, reduce health disparities, improve quality, and (4) preparing for the transition to a unified health care financing system.

**Our proposed version:**

A. Vision: To make universal health care available to every Washington State resident.
B. Mission: The Commission's primary objective is to develop a strategy for implementable changes to the state's health care financing and delivery system with the goal of achieving universal health care services. This goal is contingent upon the reduction of health care costs, especially administrative costs; the elimination of health care disparities; improvements in health care quality; and a transition to a single-payer, unified health care financing system and universal health care that is free at the point of service. The Commission aims to achieve this objective by: (1) examining data and reports from sources that are monitoring the health care system; (2) assessing the state's current preparedness for a single-payer unified health care financing system; (3) developing recommendations for a) the goal of achieving universal health care services that are free at the point of service, b) the reduction of health care costs, c) the elimination of health care disparities, and d) the improvement of health care quality, and (4) implementing preparations for a transition to a single payer unified health care financing system and universal health care for every Washington State resident.

Thank you in advance for taking our proposed version of the "vision" and "mission" statements into consideration. We appreciate the efforts of the Universal Health Care Commission in working to ensure the health and well-being of all Washington residents. We recognize the challenges ahead and urge you to set a universal health care precedent in our state that will provide other states with an effective and implementable model. The interminable Covid pandemic and associated pathologies have highlighted

the urgent need to transition to universal health care in Washington and beyond. Thank you very much for your attention.

Sincerely yours,
34th District Democrats Health Care Caucus
Jennifer Nye
Jennifer Robertson
Roxanne Thayer

**Submitted by David Grembowski, PhD**
**1/4/2022**

For your information, the Commission may be interested in Thomas Rice's new book, published in 2021, comparing health insurance systems across countries. Here is some information from the publisher's website:

# Health Insurance Systems

### An International Comparison

1st Edition - May 6, 2021

- Author: Thomas Rice
- eBook ISBN: 9780128162941
- Paperback ISBN: 9780128160725

## Description

Health Insurance Systems: An International Comparison offers united and synthesized information currently available only in scattered locations - if at all - to students, researchers, and policymakers. The book provides helpful contexts, so people worldwide can understand various healthcare systems. By using it as a guide to the mechanics of different healthcare systems, readers can examine existing systems as frameworks for developing their own. Case examples of countries adopting insurance characteristics from other countries enhance the critical insights offered in the book. If more information about health insurance alternatives can lead to better decisions, this guide can provide an essential service.

### Key Features

- Delivers fundamental insights into the different ways that countries organize their health insurance systems
- Presents ten prominent health insurance systems in one book, facilitating comparisons and contrasts, to help draw policy lessons
- Countries included are Australia, Canada, France, Germany, Japan, the Netherlands, Sweden, Switzerland, the United Kingdom, and the United States
- Helps students, researchers, and policymakers searching for innovative designs by providing cases describing what countries have learned from each other

**David Grembowski, PhD**
Professor Emeritus & Interim Director
Center for Health Innovation & Policy Science
Department of Health Systems & Population Health
Hans Rosling Center
School of Public Health
University of Washington
UW Box 351621
3980 15th Avenue NE
Seattle, WA 98195

**Submitted by Cris Currie**

**1/4/22**

UHC Commission:

Here is my comment from today for the written record. Thanks for the opportunity

My name is Cris Currie. I'm a retired RN in Spokane and author of *A Medicare for All Q & A,* a free eBook available at the Healthcare for All website (healthcareforallwa.org/resources).

As Dr. Stephen Kemble of the Hawaii Health Care Authority who is in charge of devising Hawaii's universal health care plan says: The simple truth is that contracting healthcare to private insurance companies has dramatically increased administrative burdens, greatly restricted access to care for those who desperately need it, drastically restricted one's choice of providers, and has raised costs well beyond the reach of the average person.

It is well known that about 1/3 of every healthcare dollar spent in our commercial system is wasted on useless administrative overhead like preauthorizations, claim denials, and appeals, as well as high pressure profit motivated lobbying, misleading aggressive advertising, inappropriate share-holder dividends and profits, and outlandish executive compensation. Universal healthcare will never be affordable and will not work as long as commercial insurance companies remain involved, because they add nothing of actual value to the system. Please, this commission needs to focus its very limited resources on UHC Work Group recommended Option A. Thank you.

**Submitted by Kathryn Lewandowsky**

**1/4/22**

Hello members of our Universal Healthcare Commission,

My name is Kathryn Lewandowsky and I have been a Registered Nurse here in Washington for over 30 years. I am also the Vice Chair of Whole Washington, Inc. and the Treasurer for One Payer States, Inc. I am very excited to see that you have started your work as it is so extremely

necessary. Over my career I have seen so much waste and cruelty within our healthcare system and I feel that we really are all morally obligated to not allow it to continue. Our families and our communities are too important.

I first wanted to say thank you for your commitment to the health and economic well being of our state's residents. It is a huge job, but it is not insurmountable. There are many other countries of comparable or even smaller size to our state who have been able to accomplish this for far less cost and with much improved outcomes for their people. We just must be willing to objectively look at our failures with a commitment to learn from them and not go down the same paths of history expecting different results.

With the death of my parents, I really got to experience the problems within our healthcare system from the family's perspective. Our goal really needs to be to keep our communities healthy and productive. The best way to do that is to allow our people to easily go see their doctor when they need to. They need to be able to have easy access to their doctors prescribed therapies and necessary medications with no financial barriers. Their families need to be protected from loss of their homes and savings just because of a medical emergency.

I'm sure you are aware that Whole Washington testified "other" in the creation of your commission. We did this because of the efforts that we put into doing the work of creating such a system and we understand how time intensive that can be. This work has now been placed in your competent hands. We want to publicly give you permission to please use the information pulled together from dedicated volunteers and experts in the creation of SB5204 to make your work go quickly and more easily. These times call for speed and efficiency as people's lives and livelihoods are dependent on your completion of the task at hand. Our work was completed through the dedication of committed volunteers and through serious consultation with agencies within our state government in order to design a plan that can quickly and most easily be realized with or without federal approval. We would not even be offended in the slightest if you chose to rename the trust as you see fit. Because we understand that the most important goal is to quickly make the needed changes to our healthcare system. There was a time when maybe we could have accepted incrementalism. These are not those times.

As your meetings continue we will be watching attentively and will continue offer needed language changes to SB 5204 that we feel will make the plan even more improved from what we originally envisioned and we hope that you will take those suggestions without offense but with an understanding that we have shared goals and our only hope is for your success in creating and getting credit for developing the first state based, universal, single payer healthcare system in the United States. If you are successful, we all win!

Kathryn Lewandowsky, BSN, RN
Whole Washington- Board member
One Payer States, Treasurer

Together we can all have healthcare free at the point of service; that is comprehensive with no copays or deductibles. Healthcare that will take care of all of our people from Cradle to Grave! We must do it for the people that we love. Please donate today!

https://secure.actblue.com/donate/whole-washington-1

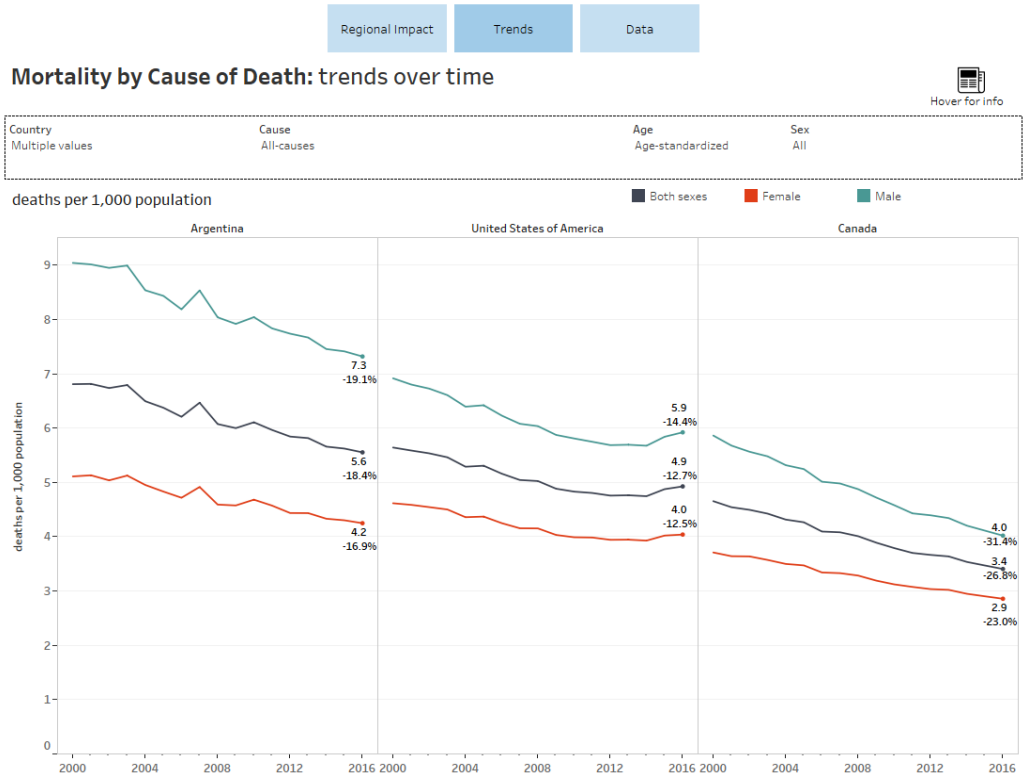
"Never believe that a few caring people can't change the world, For indeed that's all who ever have" Margaret Mead

**Submitted by Kathryn Lewandowsky**

**1/4/22**

Dear UHC Commission,

As promised, here is some of the data I was able to researched from WHO in regards to comparing US multi-payer states to Canadian stats. (I'm not sure why Argentina came up. I thought I only checked USA and Canada)




**Sources of data:**
**Death estimates by cause, sex and country: WHO Global Mortality Estimates (2018).** Methods are available from: Global Health Estimates: Website | PDF

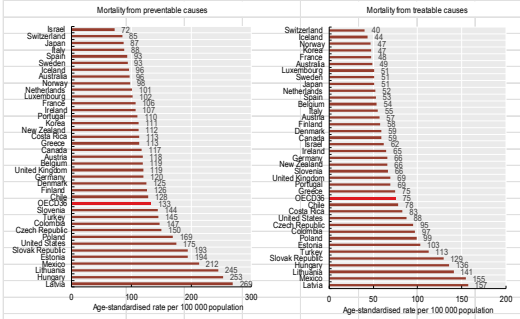
**Population: United Nations, Department of Economic and Social Affairs, Population Division.** World Population Prospects: The 2017 Revision. New York. Publication.

**Details**

Last Updated: 01 October 2020

Health at a Glance 2019 - © OECD 2019
Chapter 3 Figure 3.9. Mortality rates from avoidable causes, 2017 (or nearest year)
Version 1 - Last updated: 03-Nov-2019
Disclaimer: http://oe.cd/disclaimer

**3.9 Mortality rates from avoidable causes, 2017 (or nearest year)**




Source: OECD calculations, based on WHO Mortality Database.

| | Preventable | | | Treatable | |
|---|---|---|---|---|---|
| Latvia | 269 | *2015* | Latvia | 157 | *2015* |
| Hungary | 253 | | Mexico | 155 | *2016* |
| Lithuania | 245 | | Lithuania | 141 | |
| Mexico | 212 | *2016* | Hungary | 136 | |
| Estonia | 194 | *2016* | Slovak Rep | 129 | *2014* |
| Slovak Republic | 193 | *2014* | Turkey | 113 | *2016* |
| United States | 175 | *2016* | Estonia | 103 | *2016* |
| Poland | 169 | *2016* | Poland | 99 | *2016* |
| Czech Republic | 150 | | Colombia | 97 | *2015* |
| Colombia | 147 | *2015* | Czech Rep | 95 | |
| Turkey | 145 | *2016* | United Sta | 88 | *2016* |
| Slovenia | 144 | *2015* | Costa Rica | 83 | *2014* |
| **OECD36** | **133** | | Chile | 78 | *2016* |
| Chile | 128 | *2016* | **OECD36** | **75** | |
| Finland | 126 | *2016* | Greece | 75 | *2016* |
| Denmark | 125 | *2015* | Portugal | 69 | *2016* |
| Germany | 120 | *2016* | United Kin | 69 | *2016* |
| United Kingdom | 119 | *2016* | Slovenia | 66 | *2015* |
| Belgium | 119 | *2016* | New Zeala | 66 | *2014* |
| Austria | 118 | | Germany | 66 | *2016* |
| Canada | 117 | *2015* | Ireland | 65 | *2015* |
| Greece | 113 | *2016* | Israel | 62 | *2016* |
| Costa Rica | 113 | *2014* | Canada | 59 | *2015* |
| New Zealand | 112 | *2014* | Denmark | 59 | *2015* |
| Korea | 111 | *2016* | Finland | 58 | *2016* |
| Portugal | 110 | *2016* | Austria | 57 | |
| Ireland | 107 | *2015* | Italy | 55 | *2015* |
| France | 106 | *2015* | Belgium | 54 | *2016* |
| Luxembourg | 102 | *2016* | Spain | 53 | *2016* |
| Netherlands | 101 | *2016* | Netherlan | 52 | *2016* |
| Norway | 98 | *2016* | Japan | 51 | *2016* |
| Australia | 96 | *2016* | Sweden | 51 | *2016* |
| Iceland | 96 | | Luxembou | 51 | *2016* |
| Sweden | 93 | *2016* | Australia | 49 | *2016* |
| Spain | 93 | *2016* | France | 48 | *2015* |
| Italy | 88 | *2015* | Korea | 47 | *2016* |
| Japan | 87 | *2016* | Norway | 47 | *2016* |
| Switzerland | 85 | *2016* | Iceland | 44 | |
| Israel | 72 | *2016* | Switzerlan | 40 | *2016* |



**Submitted by Kathryn Lewandowsky**

**1/4/22**

Dear UHC Commission members.

First I want to mention that myself and several others from Whole Washington had several written comments that were sent after the last meeting that did not appear in today's meeting materials and even in my request last night to speak today my first request was returned as undeliverable and I had to resend it to another address. So maybe the links for sending written comments can be checked going forward.

While reviewing the materials for the meeting for today (1/4/2022) I was curious where some of your data was coming from and I was confused that in your comparison of countries in regards to avoidable mortality you did not include Canada which seemed odd as usually in research comparing single payer and multi-payer healthcare plans the USA is usually compared against our closest single payer neighbor. So I took the liberty of looking up data from the WHO website where unfortunately we again have results than worse than not only Canada but also then average the OECD 36 countries and I will send that data to you in my written comments.

And I am not sure where the information was received regarding Canada's supposedly long wait times for elective surgeries. I could not easily find that information late last night and so I wonder if that information can be provided. But if Canadians do have to wait an exceptionally long time it must be a good thing because their mortality rates for both preventable and for treatable diseases seem far better than ours. I cannot argue that often my horses sometimes heal much faster on their own than when I try and interfere in the process, but I digress.

I was also very interested to know where I could find the sources of the information in the upcoming slide presentation as I was not able to find it from the meeting materials. And so, late last night, I did find the paper from the WSIPP page and so I will send it to you in written comments to make it easy for you to review in greater detail. It really does contain a lot of great information and I'm sure represents many hours of dedicated work by that office.

I also was interested in their statement that , "The US performs poorly on measures of population health often cited in rankings. However, the usefulness of these and other crude measures of health is questionable." I am curious as to what they would see as an improved measure of health outcomes. Here is the link to the entire report.

http://www.wsipp.wa.gov/ReportFile/1705/Wsipp_Single-Payer-and-Universal-Coverage-Health-Systems-Final-Report_Report.pdf

Again, I want to thank you for all your work and your commitment to the goals of this commission. Too many Americans are suffering due to this pandemic and the failings of our for-profit healthcare system here in the United States. No amount of losses or disruption to the current system will ever adequately replace the economic losses and loss of life and productivity that have been sustained by our Washington Citizens both preceding and during this pandemic.

In appreciation,

Kathryn Lewandowsky, BSN, RN

Whole Washington, Inc., Vice-Chair,
One Payer States, Inc., Treasurer

**Submitted by Jennifer Robertson**

**1/4/22**

Dear Members of the UHCC,
I attended today's UHCC Zoom meeting . Thank you for your dedication to working on the realization of universal healthcare in Washington. Today's meeting was both ambitious (lots to cover!) and well orchestrated. The caliber of public participation (85 participants!) was impressive and attests to the vital importance of your Commission.

I would like to suggest the addition of an angle (or a factor or variable) that was, in my view, not explored or taken into account in your proposals and model-making, and that is the ramifications on universal healthcare of the inordinately high cost of medical education and training in the US.

Healthcare costs are, understandably, a/the primary focus of UHCC deliberations; the matter of the actual availability and quality of healthcare (physician, nurse, therapist) services, however, is left self-evident. A (much) bigger picture is needed if universal healthcare can be achieved. The shockingly (and internationally singular) high cost of medical education in the US, which leaves new MDs in debt by an average of over $250K, results in a much higher proportion of narrow specialists (much more lucrative) and a low and falling lower proportion of general practitioners and pediatricians (much less lucrative). A truly universal healthcare system mainly depends on general practitioners, but the cost of becoming an MD in the US pushes new doctors into more lucrative specialties with higher salaries/fees.

Thus, what also needs to be factored into universal healthcare deliberations and model-making is the way in which the high cost of medical school/training results in the outrageous cost of healthcare and a ballooning of healthcare disparities in the US. New models of doctor/nurse training programs along with models that include a dedicated focus on the availability (in all communities, urban and rural alike) of general practitioners, together with the promotion of preventive medicine and actual health-focused initiatives, are needed. I've attached an excellent overview of the connection between the price of a medical education and healthcare disparities.

Thank you for your attention, and for your dedicated work.

Sincerely yours,

Jennifer Robertson (West Seattle)

_____

Jennifer Robertson, Professor Emerita
https://professorjenniferrobertson.com/
My art website: http://www.biwahamistudio.com
Departments of Anthropology and History of Art,

Penny W. Stamps School of Art & Design, and Michigan Robotics
University of Michigan, Ann Arbor, MI 48109 USA
Affiliate Professor
Departments of Anthropology and Japan Studies
University of Washington, Seattle, WA 98195 USA

I acknowledge and respect the Coast Salish, Duwamish, Muckleshoot, Stillaguamish, and Suquamish peoples on whose traditional territory the community of West Seattle now stands, and whose historical relationships with the land continue to this day.

**Submitted by Jennifer Robertson**
**1/4/2022**

## Health Policy Musings

A place where you can discuss health policy issues that matter most to you!

### The Price We Pay: How the Cost of Medical School Contributes to US Healthcare Disparities and Spending

Posted on **April 9, 2017** by **Caroline Claire Elbaum**

From 1998 to 2008, the average level of debt for medical students increased by more than 50%.[1] The cost of medical education has been rising double the rate of inflation.[1] The average tuition cost to attend medical school per year in the United States is approximately $55,629, which amounts to $222,516 in tuition debt for four years of school.[2] This calculation does not include fees, health insurance, housing and living expenses, which vary widely by location and the individual. There are also costs that are difficult to anticipate before medical school, but become apparent quickly. Students must pay to take national licensing exams that total approximately $2,500, but can vary due to travel costsas one exam is only offered in five cities in the country (Step 2 CS). Finally, during their final year, students must apply and interview at residency programs to continue their training as physicians which can amount to many thousands of dollars. With accruing interest, which canbe as high as approximately 7% depending on the year, a medical student, like me, with no financial aid or parental help can expect to graduate with a *quarter of a million dollars or more* in federal loans. For someone like me, this number could be higher because of the high costs of my school, the expensie of living in Boston, and earning a second degree. These loans continue to accumulate interest during the following years of training when new physicians, also called residents, make a salary that, per hour worked, approaches what hospital cleaningstaff earn.[3] In the end, some physicians may pay two to three times their original amount with interest over multiple decades.[4]

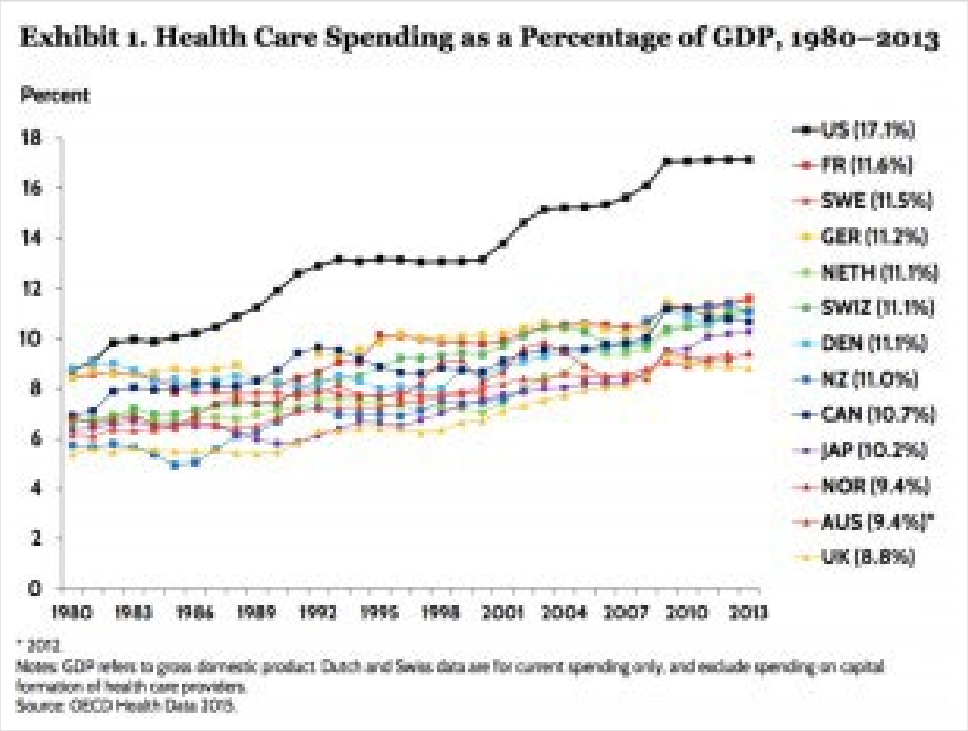
Why does this matter? This is not a problem of bankrupting physicians, as the majority, even those in

primary care will successfully pay off their loans.[5–7] The problem is four-fold. First, increased debt is associated with increased risk of mental illness and substance use disorders amongstudents as well as decreased performance on examinations.[8,9] Second, increased debt affects professionalism of future physicians such thatstudents feel their debt limits altruism and engenders a sense of entitlement for high salaries.[10] Third, the cost of medical school can be

prohibitive, especially for students from underrepresented minorities which limits the diversity of the physician workforce.[1,4] Fourth, many students feel pressure to enter more lucrative fields that our fee-for-service billing system rewards, not primary care, which has resulted in ahealthcare system with significantly more specialists and a lack of primary care physicians.[11] The two primary issues affecting healthcaredisparities and costs in the US, that are a result of increased student debt, are the lack of diversity of physicians combined with excessive specialization.

In the US, specialists outnumber primary care physicians.[12] Despite this level of expertise, the US spends more money on healthcare than any other developed nation and has worse health outcomes.[13] Two factors that contribute to increased costs are the salaries of physicians, which compared to other countries are higher in the US, and the fee-for-service model that encourages specialization and thus, costly interventions. Increased emphasis on primary care has been shown to decrease healthcare costs by increasing preventative services and decreasing

interventions and procedures that are costly as well as improving health outcomes.[11,13] Students with increased debt are more likely to give more value to future salary when picking a specialty and are more likely to switch away from a primary care specialty.[14,15] This causes a shift away from primary care specialties such as Pediatrics and Family Medicine which have the lowest average salary. There is a gap in primary care physicians in the US which will continue to widen if more medical students do not choose to enter the field.[4] The inability of the United States to meet the needs of the population with primary care physicians everywhere will contribute to excessive and rising healthcare costs.[11]

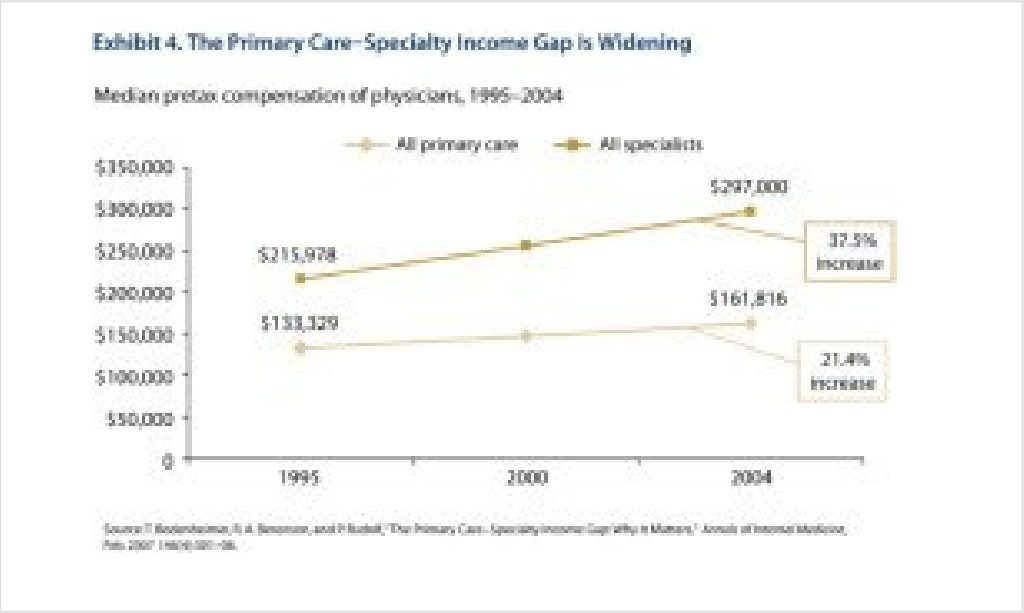


Debt can be prohibitive to minorities which decreases diversity. Concordance of race, ethnicity, and language between physicians and patients has been linked to better health outcomes.[16] Currently, our physician workforce lacks diversity and does not mirror the composition of the US population.[4] Health outcomes are poorer for racial and ethnic minorities and these disparities increase healthcare costs.[17] Decreasing the cost of medical education could diminish barriers that inhibit underrepresented minority students from attending medical school. An increase in diversity has the potential limit healthcare disparities and decrease healthcare costs.

The steady increase in medical student debt is unsustainable and could cause debt burdens to climb to catastrophic levels such that by 2030 approximately 50% of physicians' after-tax income could be shunted to loan payments for projected average debt burdens of close to a million dollars.[4] There are various proposed solutions including shortening medical education to three years, placing a limit on institutional tuition and fees, fundraising from alumni, and expanding state and federal loan forgiveness programs in exchange for public service. However, altering medical school length to three years does not address the increasing cost of attendance. Placing a limit on tuition and fees does not address current debt burdens placed on students that de-incentivize primary care. Fundraising from alumni is not a feasible option to cover the cost of attendance for all students, especially as many alumni have substantial debt burdens of their own. Finally, although expanding public service loan forgiveness programs is a noble option, it fails to address the rising attendance costs and currently, proposed federal budgets will limit funding of these programs.[18] Many countries, such as Canada and the United Kingdom, have federally funded medical education. In those countries, more than half of physicians are primary care doctors, and physician salaries, healthcare costs and spending are lower, and health outcomes are better.[13]

I propose that we can address health outcomes, disparities, and the cost of healthcare in the United States by making medical school free for students funded by federal and state governments. Currently, it is unclear how much it costs to educate a medical student and for what proportion of that cost the student should be responsible.[4] Governmental funding of medical education would cause increased transparency and more fairly distribute cost burden between students, institutions and the government. This would allow the US to pay physicians less and encourage medical students to enter primary care.

Critics of this solution will argue that physicians are overpaid already and may not agree with their tax dollars funding medical education. However, many financial models have shown that primary care physicians have expenses more than their income for the first three to five years after residency[19] and other models leave the physicians with only $200-$600 per month in flexible income.[5] Further, the government (and tax payers) already fund medical education through Medicare funding of residency programs.[20] Some contend that it is too costly for the government. However, free medical education will increase the primary care workforce and diversity of physicians. Decreased spending on physician salaries and specialist-driven interventions and improved health outcomes will lead to healthcare cost savings that will outweigh the cost of funding medical education.




(13: Squires et al, 2015)

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Departments of Anthropology and Japan Studies
University of Washington, Seattle, WA 98195 USA

I acknowledge and respect the Coast Salish, Duwamish, Muckleshoot, Stillaguamish, and Suquamish peoples on whose traditional territory the community of West Seattle now stands, and whose historical relationships with the land continue to this day.

**Submitted by Kelly Powers**

**1/7/22**

Good morning Mandy, UHCC Commission staff, and Chair Vicki Lowe,

Thank you for the informative UHC Meeting last Tuesday. I appreciate all the work that must have gone into that over the holidays. That Work Group really did cover a lot of ground!

Now that the Commission has a couple of meetings under its belt. and in the spirit of good governance and giving the Commission members enough time to prepare, I am wondering if it is possible to have the goal of publishing meeting materials 5 business days before a meeting? I have been a staff member so I know how challenging this can be. If we are to make the best use of the meeting time it would be so helpful.

With great understanding and appreciation,

Kelly

Kelly Powers (She/Her)

Everyone deserves quality, affordable health care.

**Submitted by Roger Collier**

**1/7/2022**

Dear Universal Health Care Commission members:
Attached in pdf form is my 5-page critique of the Work Group final report. As you will see, I believe the report has very serious deficiencies which should be addressed as soon as possible.

I welcome your comments.

Thank you

Roger Collier

**Submitted by Roger Collier**

**1/7/2022**

**STATE OF WASHINGTON**

**UNIVERSAL HEALTH CARE COMMISSION**

**COMMENTS ON WORK GROUP FINAL REPORT**

**JANUARY 2022**

**Roger Collier (rcollier@rockisland.com)**

**STATE OF WASHINGTON**

**UNIVERSAL HEALTH CARE COMMISSION**

**COMMENTS ON WORK GROUP FINAL REPORT**

## INTRODUCTION

Compared with health care systems in other industrial nations, that of the United States is more costly, provides less access, results too often in inferior outcomes, and is far less equitable.

The Universal Health Care Work Group final report recognizes these problems and indicates the Work Group's strong preference for a single statewide, State-administered, health care system covering almost all State residents (Model A in the report).

Unfortunately, the report has serious weaknesses. Some of these are noted in the report but only as problems to be considered at some future time. However, each of the following are issues that are fundamental to the Commission's mission and need to be considered now.

*(Note: the comments below apply equally to the Work Group's Models A and B unless otherwise stated. Generally, the comments do not apply to Model C since this is assumed to be entirely State-funded and will not replace any existing program.)*

## FEASIBILITY

The proposed new system would replace Medicare, Medicaid, CHIP, Exchange-based insurance, and all non-federal employer-sponsored and individual coverage.

Is this feasible?

### Medicare

Medicare is a federal program, established by Title XVIII of the Social Security Act. **There is NO existing waiver process or other mechanism for replacing Medicare by a state program.**

The Work Group report suggests that the Biden administration might be sympathetic to including Medicare in a state's single-payer program. However, this would require federal legislation and no such administration proposal has been made.

The State-Based Universal Care bill (HR 3775) would, if enacted, allow Medicare waivers. However, this bill has been introduced in multiple House sessions without action and would be unlikely to pass in the closely-divided Senate.

Even if a Medicare waiver process existed, there are other obstacles. Many seniors will be concerned about replacement of a familiar trusted federal program by an unfamiliar State one, while insurers with Medicare Advantage contracts may be expected to amplify such concerns (as they did successfully with the Harry and Louise campaign against the Clinton reform effort).

### Employer-Sponsored Insurance

Large and medium-sized employers typically self-insure their health care coverage. One result is that the **coverage is protected by the Employee Retirement Income Security Act (ERISA) which, among other provisions, effectively prevents states from imposing their own insurance rules.**

As for Medicare, HR 3775 would allow ERISA waivers, but as noted above, the likelihood of enactment seems slim. Also as in the case of Medicare, it must be assumed that insurers would mount a considerable lobbying effort against any weakening of ERISA.

The State might try to avoid the ERISA conflict by requiring *all* employers to contribute to funding the new system (so that self-insured employers would effectively be paying twice). However, a 2016 Supreme Court ruling emphasizing the primacy of ERISA even where employer coverage is *not* directly affected seems to preclude this option.

While larger employers may self-insure, there are many smaller employers who choose traditional insurance. As with the State's 1993 "play or pay" reform approach, the State could require these employers to contribute to the State-administered plan. However, the result could be simply to encourage switching to self-insurance.

### Medicaid and CHIP

Sections 1113 and 1115 of Title XIX allow states to request waivers of Medicaid and CHIP regulations. Some five hundred waivers have been granted, typically focused on adding subgroups to those eligible or with moving to managed care. **NONE has been so extensive as would be required to merge Apple Health into a larger statewide system, and the potential outcome of such a waiver request is unknown.**

The Work Group report suggests that increasing Medicaid payment rates might result in increased federal match funding. However, **the federal websites describing the waiver process state clearly that waivers must NOT result in increases in net federal expenditures.**

### Exchange-Based (Healthplanfinder) Insurance

Section 1332 of the Affordable Care Act allows states to request waivers of federal exchange provisions, and a number of states have been granted such waivers. A review of these waivers suggests some flexibility on the part of the government, but as for Sections 1113 and 1115, **the federal website language is clear: waivers may NOT increase net federal expenditures.**

## COSTS AND REVENUES

The Work Group report provides implementation year and ongoing cost estimates for both the State-administered Model A and the health plan-administered Model B, as well as for the less ambitious Model C. *(Note: It is assumed that the report intends "Implementation Year" to mean the first year of operations.)*

**The report fails to address costs for developing and implementing the new system.** While not necessarily comparable, the multi-million-dollar costs for setting up the Exchange (for a much smaller population) provide a clue to the implementation costs for the new system, with Model A being more costly than Model B because of the need to create a State administration. Also, **unlike the Exchange which received substantial federal funding, almost all costs of implementing the new system would be borne by the State.**

### Ongoing Operations Costs

The report's tables and bar charts indicate that the new system would cost less than the status quo, but fail to consider a major issue: providers whose current payment rates are above the projected homogenized levels may refuse to participate if they have to accept much lower payments. As the State experienced with the Cascade Care public option, it may be necessary to pay higher rates than hoped. **The result would be a significant increase in costs, potentially pushing costs above the status quo numbers.**

With benefits guaranteed to all residents, costs may be further increased if Medicaid-eligible individuals sidestep components of managed care that help manage their utilization of services.

### Ongoing Operations Revenues

The report estimates ongoing revenues from various sources including Medicare, Medicaid, and State funds. However, in a system in which *all* State residents are guaranteed coverage, eligible individuals may fail to apply for Medicare or Medicaid. **If the State cannot substantiate their eligibility, federal funding may be reduced, leaving the State with a large gap between costs and revenues.** A similar problem could occur in the event of a major economic slump, with large numbers of potential Medicaid eligibles still paid with State-only funds. **Similarly, there would be little incentive for people to apply for Exchange ACA subsidies, potentially eliminating another source of federal funding.**

An even larger problem results from the Work Group report's assumption on page 21 that "*a single provider fee schedule… increases the rates paid by current public sector programs [and so] the model increases the amount of federal funds used compared to the current Medicare and Medicaid programs.*" As commented previously, **there is NO reason to believe that federal payments will be increased as a result of waivers. Assuming this continues to be true, the new system faces a substantial revenue shortfall.**

## FUNDING

**The report provides minimal discussion of funding for the new system**, and as noted earlier, federal funding for Medicare, Medicaid, and Exchange benefits could be vulnerable to beneficiaries' failure to apply for specific federal program benefits.

The single largest potential source of funding is the State, presumably via new taxes on employers and/or individuals, but as the report states "*The Work Group did not address how the state would fund costs needed to replace current individual and employer contributions to coverage. However, the Work Group did discuss that this is an issue requiring specific focus…*"

Whether the State could design an acceptable funding structure is a matter of conjecture, but **the report's revenue projection shows State funding of some $33 billion annually, implying a doubling of State taxes from the current approximately $30 billion.**

## MODEL A versus MODEL B

The Work Group report expresses a strong preference for a State-administered system rather than a health plan-administered one. However, **the report does not consider the enormous effort necessary to establish and manage the new system, presumably including the hiring or contracting of hundreds of skilled staff and building complex IT systems. In particular, the report provides no indication that the Work Group or its consultants discussed with State officials their reasons for choosing health plan administration for every current program.**

## TRANSITION

**The report devotes several pages to transition to the new system but provides little specific planning information.**

As the report says in introducing several pages of generic task charts, "*The following is an example transition plan that outlines the steps and work needed to reach a state-level universal health care system. This process example is not tied to a specific coverage proposal…"*

What is certain is that transition to either Model A or Model B would be an immense multi-year project. **By way of comparison, the much smaller state of Vermont spent close to five years between establishing its single-payer commission and abandoning the effort.** Closer to home, Washington's Exchange project was initiated in 2011, with start-up in 2014, but with implementation efforts continuing after that. The State's Medicaid Transformation Project provides an example of a single complex waiver effort, with more than two years required between the State starting to prepare the waiver application and federal approval.

## CONCLUSIONS AND RECOMMENDATIONS

For all the desirability of finding a new approach that will lead to affordable, high-quality health care coverage for all Washington residents, **the Work Group report is very seriously deficient.**

**The Commission should:**

- **• Contact US Senator Murray's office to confirm the improbability of gaining Medicare and ERISA waivers (or other mechanism) in the foreseeable future; and, assuming this is so,**
- **• Re-evaluate the costs and revenues of Models A and B without Medicare and self-insured employer enrollees; and,**
- **• Estimate implementation costs for Model A and Model B; and,**
- **• Consider other options to improving affordability and access, including Model C and also an enhanced Exchange-based model that would replace all current State-administered programs and be available to all State residents**

**<u>Submitted by Calvin Snow</u>**

**1/17/2022**

Thank you for working on this important issue.

I would like to know how many people are currently enrolled in Cascade Care policies. Also how many of them are in the Public Option plans.

I apologize if you've already discussed this and I missed it.

Thank You,

Calvin Snow

**Submitted by Mike Benefiel**

1/17/2022

UHC Commission,

With respect your “purpose” to increase access” is a step in the wrong direction. The UHC Work Group recommended that a single-payer health care system be implemented. Your purpose should be to seek how to implement such a system that will **provide coverage**, not provide access to coverage. There is a huge difference. Access means it's there whether it's affordable or not.

Sen Cleveland and Rep Cody indicated that the passage of Cascade Care (CC) would mean that all WA residents would have ACCESS to coverage. Now we have 500,000 WA residents with “access” but no coverage because it's too expensive even with subsidies. We need more than than access, we need UHC. Words are important.

Definitions as well as words are important. Universal Health Care is part of the Commission's title and should be part of it's purpose, so it's very important to know the Commission's definition of UHC.

The health care lobby would have us believe that WA currently has achieved UHC because with employer-based, Medicare, Medicaid, and CC, everyone has ACCESS to something even if it's too expensive and/or non-comprehensive.

I request the Commission use the definition of UHC from the World Health Organization (WHO) and not the health care lobby.

To achieve the coverage we need, deserve and can afford, we need a single-payer system as recommended by the UHC Work Group and over 20 national studies including the Congressional Business Office (CBO). That's the only way to get true UHC as defined by WHO. I request that the Commission acknowledge the work of the UHC Work Group and include the term “single-payer” in your purpose. Again, words are important.

When the bill was passed that set up the UHCC we were told that the Commission was to identify and make recommendations on how to remedy the obstacles standing in the way of implementation of a single-payer, UHC system. I hope we get to see what obstacles you have identified as well as your remedies.

I recommend that the Commission review the work done by Whole Washington which has evaluate the obstacles and has provided remedies in SB5204. Please don't ignore the work that has already been done.

I hope we all recognize that the longer we take to provide UHC, the more WA residents that will needlessly go bankrupt, suffer and die. Insurance corps should not get to make decisions of life and death.

Mike Benefiel

**Submitted by Pamela Dalan**

**1/25/2022**

1. Thank you so much to our WA legislators, the UHC Workgroup members, and the Health Care Authority for making the Universal Health Care Commission a reality!

2. Model A from the Work Group Study Report was shown by the professional actuaries to save almost 3 Billion dollars the first year and 6 billion in each of the next years.

This savings would come in large part from having the Healthcare Authority be administrator of healthcare coverage instead of for-profit Insurance companies, and regulation and bargaining power over pharmaceuticals

Reinvesting the billions now paid to for-profit companies into actual healthcare for people is a very good way to get quality and affordable healthcare for all of us.

3. Equitable and affordable quality healthcare must be the main outcomes of this commission's work.

Sincerely,

Pamela Dalan RN

206 718 6691

**Submitted by Oolaa Kaplan**

**1/25/2022**

Hello Wa legislators & Health Care Authority

I very much appreciate that you made the Universal Health Care Commission a reality

Model A from the Work Group Study was shown to save almost 3 Billion dollars the first year and 6 billion in each of the following years. Some of the savings would be having the Healthcare Authority as administrator of healthcare coverage instead of for profit Insurance companies.

Equitable and affordable quality healthcare for every resident of WA should be the main outcomes of the commission's work

sincerely

Oolaa kaplan

Bellevue Wa

98008

**Submitted by Sandra Ingalls**

**1/26/2022**

External Email

Dear Universal Health Care Commission,

1. Thank you so much to our WA legislators and the Health Care Authority for making the Universal Health Care Commission a reality!

2. Model A from the Work Group Study was shown by the professional actuaries to save almost 3 Billion dollars the first year and 6 billion in each of the next years. This savings would be partly from having the Healthcare Authority be administrator of healthcare coverage instead of for profit Insurance companies.

3. Equitable and affordable quality healthcare for every resident of WA must be the main outcomes of this commission's work.

Thank you,

Sandra Ingalls

**Submitted by David Loud**

**1/27/2022**

Dear UHC Commission:

Thanks for the opportunities you are providing for public comment. Here is the comment I offer for the record of your January 4 meeting.

I wish to join the many others who have voiced support for Model A in the report of the UHC Work Group due to its huge advantage in cost-savings – more than three times the savings of a universal state plan administered by private, risk-bearing entities.

I also believe Model A would maximize our ability to achieve greater EQUITY in access to care. A state-administered plan could negotiate budgets for institutional providers of care and would have the power to invest resources to address the greatest needs. Continuing to rely on risk-bearing plans and providers

will only perpetuate the injustice that poorer, marginalized and rural communities will continue to have less access to care.

Finally, I am disappointed that the UHC Work Group consultants once again highlighted “feasibility” as a problem particular to Model A. I believe this is primarily a political issue. If the Commission prioritizes equity, cost savings and a comprehensive benefits package, this will help us generate the political will required to achieve the goal of affordable and equitable care for all Washingtonians.

Thank you,
David Loud
Puget Sound Advocates for Retirement Action Executive Board
Co-Chair, Health Care Is a Human Right WA Steering Committee

**Submitted by Jennifer Robertson**

**1/28/2022**

Dear Members of the Universal Health Care Commission,

I am a member of the Health Care Caucus, 34 LD Democrats (West Seattle). Attached please find a letter that Jen Nye (of the Caucus) had sent to you before the deadline for public comments at the last UHCC session but that was not acknowledged. We understand that members of the Commission are multitasking as much as the rest of us, and are very busy, however we would appreciate confirmation of receipt (to this email address).

Thank you very much in advance for your consideration, and for the work you are doing on behalf of the health and welfare of Washington residents.

Sincerely yours,

Jennifer Robertson (for the 34 LD Democrats, Health Care Caucus)

_____

Jennifer Robertson, Professor Emerita
https://professorjenniferrobertson.com/
My art website: http://www.biwahamistudio.com
Departments of Anthropology and History of Art,
Penny W. Stamps School of Art & Design, and Michigan Robotics
University of Michigan, Ann Arbor, MI 48109 USA
Affiliate Professor
Departments of Anthropology and Japan Studies
University of Washington, Seattle, WA 98195 USA
I acknowledge and respect the Coast Salish, Duwamish, Muckleshoot, Stillaguamish, and Suquamish peoples on whose traditional territory the community of West Seattle now stands, and whose historical relationships with the land continue to this day.

**Submitted by Jennifer Robertson**

**1/28/2022**

34th District Democrats, Health Care Caucus
6523 California Avenue SW
Box 183
Seattle, WA 98136-1879

28 January 2022

Universal Health Care Commission
Washington State Health Care Authority
Cherry Street Plaza/626 8th Avenue SE
Olympia, WA 98501
Subject: Universal Health Care Commission Charter

Dear Commission Members,

We are writing to you in our capacity as members of the 34th District Democrats Health Care Caucus. We share with you the recognition that health care is a primary concern both for voters and all residents. We are also aware that health care is a complex and challenging issue involving many interested and invested parties.

We have studied the Commission's charter and suggest that your "vision" and "mission" statements could—and, in our view, should—be further clarified and strengthened. Therefore, we have composed a new version of these statements and ask that you consider our version in your deliberations.

Commission's version:
A. **Vision:** To increase access to quality, affordable health care by streamlining access to coverage.

B. **Mission:** The Commission's primary objective is to develop a strategy for implementable changes to the state's health care financing and delivery system to increase access to health care services and health coverage, reduce health care costs, reduce health disparities, improve quality, and prepare for the transition to a unified health care financing system. The Commission aims to achieve this objective by: (1) examining data and reports from sources that are monitoring the health care system; (2) assessing the state's current preparedness for a unified health care financing system; (3) developing recommendations to increase access to health care services and health coverage, reduce health care costs, reduce health disparities, improve quality, and (4) preparing for the transition to a unified health care financing system.

Our proposed version:
A. **Vision:** To make universal health care available to every Washington State resident.

B. **Mission:** The Commission's primary objective is to develop a strategy for implementable changes to the state's health care financing and delivery system with the goal of achieving universal health care services. This goal is contingent upon the reduction of health care costs, especially administrative costs; the elimination of health

care disparities; improvements in health care quality; and a transition to a single-payer, unified health care financing system and universal health care that is free at the point of service. The Commission aims to achieve this objective by: (1) examining data and reports from sources that are monitoring the health care system; (2) assessing the state's current preparedness for a single-payer unified health care financing system; (3) developing recommendations for a) the goal of achieving universal health care services that are free at the point of service, b) the reduction of health care costs, c) the elimination of health care disparities, and d) the improvement of health care quality, and (4) implementing preparations for a transition to a single payer unified health care financing system and universal health care for every Washington State resident.

Thank you in advance for taking our proposed version of the "vision" and "mission" statements into consideration. We appreciate the efforts of the Universal Health Care Commission in working to ensure the health and well-being of all Washington residents. We recognize the challenges ahead and urge you to set a universal health care precedent in our state that will provide other states with an effective and implementable model. The interminable Covid pandemic and associated pathologies have highlighted the urgent need to transition to universal health care in Washington and beyond. Thank you very much for your attention.

Sincerely yours,
Jen Nye
Jennifer Robertson
Roxanne Thayer
34th District Democrats Health Care Caucus

**Submitted by John Kim**

**1/30/2022**

Dear Ms. Lowe and HCA Staff,

On behalf of our community, I would like to express gratitude to you and your fellow commissioners for investing your time and talents to the effort of making quality healthcare available to all Washingtonians through the Universal Health Care Commission.

I am the Executive Director of the Pacific Hospital Preservation & Development Authority where we seek to eliminate disparities in health outcomes and access to healthcare. In reading the proposed charter for the UHC Commission, we noted that there was an opportunity to add a Value Statement to ground the whole of the work of the UHC Commission. This type of statement is common and would describe the "why" that underlies the vision and mission statements.

We humbly submit for your consideration a proposed value statement for inclusion in the UHC Commission Charter:

**We believe every person in WA deserves equitable access to affordable, quality, health care services, regardless of their identity, zip code, or medical needs.**

Thank you and the rest of the Commission for considering this proposal. We eagerly look forward to progress you will be making soon!

Sincerely,
John Kim

**Submitted by Roxanne Thayer**

**1/30/2022**

Please read this attached document in the open meeting, as you have other letters to your Commission.
Thank you,
Dr. Roxanne Thayer

Submitted by Roxanne Thayer
1/30/2022

Health Care Disparities and Slides from 4 January 2022 UHCC Meeting

To: Universal Health Care Commission HCAUniversalHCC@hca.wa.gov

From: Dr. Roxanne Thayer

Date: 5 January 2022

To begin, a little history of the work the Health Care Authority commissioned to begin Universal Health Care (UHC). Following this, a critique of your January 4th UHCC meeting PowerPoint.

In 2019, the Washington State Legislature directed Health Care Authority to convene a work group study. The purpose of the study was to provide recommendations to the Legislature on a best health care model. [The Working Group identified Model A, the top ranked model]:

Model A: state-governed and administered program for all state residents. Estimated implementation year savings: $2.5 billion Estimated annual steady state savings: $5.6 billion/year

[In what other scenario would our State move away from billions of dollars of savings? Who is keeping our State from embracing Model A, immediately? Who is keeping the UHCC from working to implement these savings? These savings could be applied to medical school scholarships and medical employment compensation to fulfill the desperate need for medical staff in our State] (https://www.hca.wa.gov/assets/program/final-universal-health-care-work-group-legislative-report.pdf)

After the Work Group presented its findings to the Washington State Legislature in 2021, yet another group was formed to study the work of the first group and plan implementation:

The Washington State seeks to establish a universal system of health care for all residents. Senate Bill 5399 passed during the 2021 legislative session creating a Universal Health Care Commission to aid in this effort.

You already have your answer, instead of yet another commission to study, let's acknowledge the truth of the issue, including the fact that anything less than universal single payer health care is an attack on health care equity, a most despicable form of racism/sexism, and immediately move to implement universal single payer health care now. SB 5204, creating the Whole Washington Health Trust, does just that.

HEALTH CARE DISPARITIES AND SLIDES FROM THE 4 January UHCC Meeting

The PowerPoint presented Jan. 4th was deficit and incorrect. The slides were not parallel in their coverage of countries, nor did they adequately cover comparisons with the U.S. for-profit-health system. In fact, you made one evaluative statement on slide #25, showing Canada has longer wait times than the U.S. This is false. Note: "I sold Americans a lie about Canadian medicine. Now we're paying the price." - Wendell Potter, Health Insurance CEO and Whistleblower. (https://www.washingtonpost.com/outlook/2020/08/06/health-insurance-canada-lie/ ).

Then you did not cover other countries with UHC that have shorter wait times than the U.S. Why cover an inaccurate negative in one UHC country and no positives in other UHC countries?

On wait times, please note: "On average, residents of Germany, France, UK, Australia, and the Netherlands reported shorter wait times relative to the U.S." (https://health.usnews.com/health-care/for-better/articles/the-case-for-universal-health-care).

The public would also like to know why you didn't cover the quality of care differences, with the U.S. being the lowest in developed nations, all others having UHC: U.S. News and World Report: "The Case for Universal Health Care" (https://health.usnews.com/health-care/for-better/articles/the-case-for-universal-health-care ).

If you are going to compare countries, you, or your consultant, should also cover:

The OECD's* international comparison study of health care system clearly shows that the U.S. spends more money on health care than any other developed nation in the world. Yet, the U.S. has the worst health outcomes, particularly within BIPOC populations. "Multinational Comparisons of Health Systems Data, 2019" ( file:///C:/Users/roxan/OneDrive/Desktop/Dems%20State%20&%2034th/OECD%202%20Chartpack%20(pdf).pdf ).

*(The Organization for Economic Co-operation and Development is an intergovernmental economic organization with 38 member countries, founded in 1961 to stimulate economic progress and world trade. Their goal is to shape policies that foster prosperity, equality, opportunity and well-being for all.)

It appears that this commission, or its consultants, are presenting inaccurate information and leaving out facts that support UHC. Could you please explain, during your next public meeting, and in writing, why that would be? Also, inform the public, at your next meeting and in writing, who developed the January 4th meeting's PowerPoint and, if it is a consultant, who that consultant is and how much you paid for this ill-informed piece of work.

FACTS OF THE FAILED FOR-PROFIT HEALTH INSURANCE PROGRAMS

People who own their own businesses, who are not insured by their employer, or who are unemployed, in Washington State must rely on the "health care" marketplace or exchange. That exchange is trafficking in subpar health plans that are increasingly cheating the provider, doctor or pharmacy, and the patient. The for-profit health insurance corporations are then donating to our State legislators, particularly those serving on the Health Care and Wellness Committees (followthemoney.org) .

The last administration opened the door to these "junk" health/pharmaceutical insurance plans, which are now flooding the market:

• Expanded subpar health plans. In October 2018, the Trump Administration finalized a regulation expanding the availability of so-called short-term health plans, … and let insurers extend them for longer. The Administration also changed rules to expand the availability of association health plans, which are also exempt from many ACA standards. Expanded availability of these subpar plans exposes consumers to new risks and raises premiums for those seeking comprehensive coverage — especially middle-income consumers with pre-existing conditions.

(https://www.cbpp.org/research/health/the-trump-administrations-health-care-sabotage).

THE RESULTS OF SUBPAR INSURANCE PLANS

1. My daughter has psoriatic arthritis and her dermatologist, ophthalmologist, and pharmacist all told her, in the middle of an "insurance year", that they could no longer accept her insurance. The reason: the "junk" insurance programs, are taking more money from providers and patients—to increase their already bloated profits.

She thought if she changed to Premera Health Insurance that all would accept that. But no, her primary rheumatologist won't take Premera, the other preferred doctors do. What is she to do?

2. A co-worker's daughter, was diagnosed with MS. Her pharmacy no longer accepts her insurance and then, she lost her job. Together, the family cannot afford the prescriptions for her MS medications. She's been 6 months without it.

How long shall you wait? How many lives will you be comfortable with losing or families bankrupted due to lack of medication or health care?

Each of you, members of the UHCC, personally hold a lot of responsibility and the hope for single payer, free at the point of service, universal health care in Washington State. Yet, even in the face of billions of dollars of savings, you continue to look for ways to "fix" a completely broken system. Why? That is not a rhetorical question, citizens would like an answer.

Again, you already have your answer, instead of yet another commission to study, let's acknowledge the truth of the issue, including the fact that anything less than universal single payer health care is an attack on health care equity, a most despicable form of racism/sexism, and immediately move to implement universal single payer health care now. SB 5204, creating the Whole Washington Health Trust, does just that.

**Submitted by Sarah Weinberg**

**1/31/2022**

Dear Vicki:

Forgive me for sending this email to you individually. I have been unable to contact the UHCC through either of the two email addresses on the website. I keep getting error messages from Outlook claiming that those email addresses don't exist, even though others of my friends have been able to get through.

I have written an essay that is a critique both of the WSIPP Report and of the way that Report was presented to the UHCC on Jan. 4. I have attached it to this email. Assuming that you get it OK, would you

please make sure that it gets into the packet of information the UHCC members will get before the Feb. 25 meeting?

As a member of the Universal Health Care Work Group, I am most pleased that the UHCC is getting underway, and that you are not only on it, but also are the Chair. That, along with getting Sequim back on track will keep you very busy – never mind your day job!

My best to you and your fellow Commission members.

Sarah K. Weinberg, MD
weinbergsk@msn.com
206-236-0668

**WSIPP Report: Single-Payer and Universal Coverage Health Systems**
**1/4/22 Presentation Concerns**

The slide presentation is straightforward, but there is a significant failure on the part of WSIPP to take into account that a substantial portion of our state's employees are employed by public entities: federal employees, state employees (including teachers) and local government employees. Part of the reason that $28 billion in additional revenues would be needed for a state single-payer health plan would be shifting both the public employers' and public employees' health care costs to a different revenue-raising scheme. Since overall costs are predicted to go down by 5% or more, this $28 billion should be a substitution of increased taxes for drastically lowered premiums and cost-sharing expenses by Washingtonians.

The Report mentions the administrative burden on both physicians and hospitals, but makes no attempt to quantify that burden other than stating this burden contributes "substantially to the higher health care costs in the U.S."

Regarding assumed resistance by employers citing ERISA protections, no attempt has been made in this report to explore how real this resistance is. Especially as the costs of private insurance go up and the quality of plans goes down (both are documented trends), employers may not be as resistant as is assumed to trading the hassles and expense of dealing with private insurers for some sort of payroll tax. The presentation's "Conclusion" slide misstates the quality of care and health outcomes comparisons in the Report. The Report states in its summary: "Finally, the United States' higher health expenditures do not translate to better health outcomes and quality of care for the entire US population." This is not a "mixed" result.

The "Conclusion" slide also mentions longer wait times for elective procedures in single-payer countries, but makes no mention of MUCH lower pharmaceutical prices and administrative costs. Also not mentioned are the uninsured in the U.S. who can't even get on a wait list.
The disadvantages listed are all political, and have nothing to do with whether the systems examined work – and work better than the U.S. non-system. Aside from political concerns, there are no inherent barriers to a national universal health care coverage system.

The “disadvantages” should be viewed as problems that should be addressed in order to get the benefits of a unified system that costs less overall. The main issue that has caused problems in the other wealthy countries profiled in the Report is underfunding. When the austerity politicians are in charge, as under Margaret Thatcher in the UK, serious damage can result. The UK’s National Health Service is still recovering, 30+ years later. What is saving the NHS is the solid public support for (and pride in) their system. The lesson? Develop that public support for a national system in the U.S. that would be “our system”.

Canada had a similar underfunding problem, also 30+ years ago. It took the form of decreasing the number of physicians trained in Canada (or at least not increasing the physician training system as population increased). Their system is still short of physicians – a likely cause of the longer wait times for elective procedures.

As the Universal Health Care Commission looks at systems that actually deliver health care for their entire population for ideas for the State of Washington the conclusions from the WSIPP study should be:

- Single -payer systems work, and keep overall costs lower, while providing high quality health care to their populations.
- Single-payer systems are dependent on widespread popular support and pride in “our” system.
- Single-payer systems are dependent on adequate public funding through some sort of taxation.
- In the U.S., federal cooperation is essential for a state to establish a single-payer system for the state’s residents.

**Submitted by Marcia Steadman**

**1/31/2022**

Comments to the Universal Health Care Commission

Jan. 31, 2022

When the lost lives and economic disruption of the pandemic are taken into account, the bill will be astronomical, according to this Oct. 12, 2020, online JAMA Network article: The COVID-19 Pandemic and the $16 Trillion Virus. The article notes that in environmental and health policy a statistical life is assumed to be worth $10 million. With a more conservative value of $7 million per life, the economic cost of premature deaths expected through the next year is estimated at $4.4 trillion. The article goes on to mention that the Congressional Budget Office projects a total of $7.6 trillion in lost output during the next decade.

The findings presented on pp. 87-101 of the 2021 Final Report of the UHC Work Group document that billions of dollars ($2.4 billion the 1st year, and $5.6 billion in subsequent years) would be saved under a publicly funded and publicly administered health care system (Model A) while at the same time ensuring universal health care for all Washington residents. Model B, publicly funded healthcare administered by private insurers, would save a modest $7.8 million the first year; subsequent years were not modelled. Model C, covering the currently uninsured under the existing healthcare system would actually cost the

state an additional $617 million in the first year; again, future years were not modelled. Is it any wonder that nearly ¾ of the Work Group members who participated in the straw poll selected Model A as their preferred choice?

Time and again, states that have attempted to enact their own state-based universal health care systems have foundered on the shoals of feasibility, fear, and unaffordability. The Timeline presented on pages 105-113 of the 2021 Final Report of the UHC Work Group anticipated that the financing strategies would be completed by Nov. 2022, a goal that will be delayed by at least another year. Now is the time for UHC Commission to immediately appoint the financial advisory group so that Washington can begin to achieve the savings projected for the UHC Work Group. It's not so much a question of "can we afford" to provide health care to all our residents as it is a question of "how can we NOT afford" to make the transformation in our health care system that is so sorely need right now, and that is projected to actually save billions of dollars in health care spending statewide each and every year.

--respectfully submitted by Marcia Stedman

Immediate Past President, Health Care for All-Washington

www.healthcareforallwa.org

**Submitted by Michael Mulroy**

**2/9/2022**

Madam Chair, Members of the Commission

First, thank you for the opportunity to speak, and for your service.
I am a retired anesthesiologist strongly supporting affordable accessible universal health care for our fellow Washington residents. I am concerned about the feasibility of several proposals that have been made and urge you to strongly consider the practical features of other functioning healthcare systems identified in the excellent presentation by Stephanie Lee of the Washington State Institute for Public Policy at your last meeting.
I am concerned about three specific areas. First, prescription drug pricing is an egregious inequity in our current system and negotiating power should be included in any proposal. Second, several proponents of "Model A" from the previous Work Group have identified health insurance companies as a component of our out-of-control health costs and advocated their elimination. In contrast, the WSIPP report showed that many countries have maintained health insurers as virtual non-profit (3-5% margin) conduits of premiums and payments, which are established by the government single payor directive (as our current Medicare does). I urge you to include this model, using the existing structures with constraints rather than creating a new bureaucracy,
Third, in the same vein, several commenters have advocated the elimination of employer-based insurance. The European experiences demonstrate that employer premiums work well as long as those unfortunate to lose employment are enrolled immediately in the government-subsidized health plan. Keeping employer payments will avoid the need for waivers and reduce the visible cost of the program and elicit the support of those businesses and workers who see advantages to the current system.

In summary, I urge you to consider the features of the programs outlined in the WSIPP report in making your final recommendations, in the hopes of promoting feasibility and support from the multiple strongly vested parties.
Thank you again for your attention.

Respectfully,
Michael F. Mulroy, MD
Redmond, WA
206-200-8282

**Submitted by Kelly Powers**
**2/10/2022**

Dear Chair Vicki Lowe, UHC Commission, and HCA Staff,

We thank you for your dedication to designing a universal health care system for Washington state. You could have a historic impact on the health and prosperity of millions of people in our state.

We are writing to recommend the early creation of some Advisory Committees to assist the Commission in completing important goals for 2022. Please see the attached proposal.

We're looking forward to working together to achieve universal health care for Washingtonians!
Sincerely,

Kelly Powers & Maureen Brinck-Lund, Co-Chairs

Health Care is a Human Right-WA UHC Commission Subcommittee (HUHCCS)

## Advisory Committees: Breaking the Elephant into Bites

Email Subject: Recommendation for the Early Creation of the Advisory Committees

Dear Chair Vicki Lowe, UHC Commission and HCA Staff,

We thank you for your dedication to designing a universal health care system for Washington state. You could have an historic impact on the health and prosperity of millions of people in our state.
**We are writing to recommend the early creation of some Advisory Committees to assist the Commission in completing important goals for 2022.**

The Legislature established the UHC Commission to:

1. **CREATE immediate and impactful changes i**n the health care access and delivery system in Washington - and -

2. **PREPARE the state for the creation of a health care system** that provides coverage and access for all Washington residents through **a unified financing system** once the necessary federal authority has

become available

SB 5399 also directs the UHC Commission to submit its **first report to the legislature due November 2022.**

Given these directives, we propose the Commission's 2022 work should focus on:
- **Insuring Uninsured and Underinsured Washingtonians**
- **The November 2022 Report**

**Insuring the Un- and Under - insured** fulfills the directive to create immediate and impactful changes for the most vulnerable Washingtonians. It is a practical goal in step with the Legislature's and agency objectives.
It allows the Commission to work on a smaller, less expensive problem and put it through the paces1, while strengthening the Commission's expertise in preparation for creating a unified financing system for all Washingtonians. There are a number of ways it could be designed – it could be based on already existing systems, and might be able to be partially implemented before WA applies for additional federal waivers. If the Commission can work on this in 2022, it could propose legislation in time for the 2023 Regular Session. It could also begin working with state agencies, as provided for in SB 5399.

**The November 2022 Report.** SB 5399 specifies that the November 2022 report should include:
- A **synthesis of research** done on existing healthcare finance and delivery systems, including cost, quality, workforce, and consolidation trends

1 As of November 2021, the overall uninsured rate was 4.7% and for adults age 18-64 it was 6.6% according to OFM Meeting Materials in UHC Commission meeting materials for Jan. 4, 2022 meeting. That would be nearly 400,000 18+ uninsured Washingtonians assuming 2020 census.gov figure of 6,024,689 people 18+ in WA state.

- A **strategy for developing implementable changes** to the state's health care financing and delivery system
- An **inventory of design elements** needed for a universal health care system
- Recommendations for the creation of a **finance committee**
- An **assessment of the state's current level preparedness** to meet the elements of a universal health care system
- Recommendations for implementing **reimbursement rates**
- Recommendations for **coverage expansions** prior to and consistent with a uhc system

All of these elements are important to understanding the current picture of health care coverage in WA – what's been tried, what's been studied, what's needed and the pros and cons.

Additionally, we recommend **adding criteria for evaluating health equity** to the November 2022 Report. Health Equity criteria should permeate the design, implementation, maintenance, evaluation and improvements to the UHC system. It is vital that our health care system is designed with the input from people with lived experience and community champions.

**We propose that Advisory Committees could begin to address these directives right away.**
Several of the UHC Commission members have mentioned that the Commission needs to approach

these tasks by breaking the elephant into bite sized pieces and in a phased approach. One way to do that is to form *some* Advisory Committees now to begin working on these goals.

Advisory Committees provide structure for the Commission's work. They help people focus on a bite of the elephant because they know there is a structure and timeline in place to handle other important bites. For example, when asked how the proposal will handle worker transitions the Commission can put people at ease by explaining that the Transitions Planning Advisory Committee is expected to begin working on that issue on a specific date.

## ADVISORY COMMITTEE RECOMMENDATIONS

The following chart contains Advisory Committees proposed by Universal Health Care Work Group in a timeline on page 101 of the Final UHC Work Group report.
In addition, we propose adding a Health Equity Committee and a Healthcare Workforce Advisory Committee. The following chart shows all of the Advisory Committees grouped by those that we think should be launched right away to fulfill 2022 goals, and those that can be phased in after 2022.

| 2022 Advisory Committees | Suggested Description |
|---|---|
| 1. Health Equity | Helps participants reach a common understanding of Health Equity, recommends Health Equity criteria that willpermeate the design, implementation, maintenance, evaluation and improvements to the UHC system. Drivesthe discussion "How can UHCC advance health equity goals for our state?" |
| 2. Insuring the Uninsured & Underinsured | Fulfills the directive to create immediate and impactful changes for the most vulnerable Washingtonians. |
| 3. Financing, Waivers, Law and Regulatory Change[2] | Price tag for covering the uninsured-only would help far fewer people (up to 400,000). The Advisory Committee would define what we can do with current laws in place and what laws are needed. It would map out a strategy forapplying for existing federal waivers and any new waivers that become available. This Advisory Group would begin working on the question How will we pay for it?. Pros/Consof different options.. |
| 4. Health Care Workforce | Addresses how to protect, strengthen and build the workforce required to pave the way for resources we neednow and for UHC. |

On down the road, the Commission could phase in the remaining Advisory Committees as recommended in the UHC Work Group's Final Report:

| PHASE 2 ADVISORY COMMITTEES (after Nov 2022) | Suggested Description |
|---|---|
| Benefits and Coverage Structure | Mission: What will UHC cover? For Report - Comparescurrent health plan coverage including: Indian Health Care, TRICARE, PEBB, SEBB coverage, Medicaid, Medicare, Cascade, ACA, best/least employer plans. |
| Cost Containment | Would make recommendations for bolstering existing efforts and devise new ways to contain costs. |
| Administration & Operations | Designs the processes, activities, tools, and standards involved with operating, administering, managing and maintaining Washngiton's universal health care system. |
| Quality Goals and Reporting Process (Data) | Data such as Health Care quality measures - evaluating outcomes and service |
| Transition Planning | Including Healthcare Workforce issues |

For an idea of how the 2022 Advisory Committees could tackle the work, see this spreadsheet.

We're looking forward to working together to achieve universal health care for Washingtonians! Sincerely,

Kelly Powers and Maureen Brinck-Lund, HUHCCS Co-Chairs
(Health Care is a Human Right - WA Universal Health Care Commission Subcommittee)

[2] For 2022, we suggest combining two Advisory Committees recommended in the UHC Work Group Report: 1) Financing Strategies & Cost Modeling, and 2) Waivers, Law and Regulatory Change into aFinancing, Waivers, Law and Regulatory Change Advisory Committee. As the capacity of the Commission and the workload of the Advisory Committee increases, they could be separated into twostand-alone Advisory Committees.

Washington State Health Care Authority

# Meeting Summary

# TAB 3

# Universal Health Care Commission meeting summary

January 4, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

**Note:** this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the commission is available on the Universal Health Care Commission webpage.

## Members present

Vicki Lowe, Chair
Bidisha Mandal
Dave Iseminger
Senator Emily Randall
Estell Williams
Jane Beyer
Joan Altman
Representative Joe Schmick
Karen Johnson
Kristin Peterson
Representative Marcus Riccelli
Mohamed Shidane
Nicole Gomez
Stella Vasquez

## Members absent

Senator Ann Rivers

## Call to order

Vicki Lowe, Commission Chair, called the meeting to order at 2:04 p.m.

## Agenda items

### Welcoming remarks

Ms. Lowe began with a land acknowledgement and welcomed the members of the Commission to the second meeting. Ms. Lowe provided an overview of the agenda and shared the goals of the meeting.

### Public comment

Ms. Lowe called for verbal and written (via the Zoom chat) comments from the public.

Kathryn Lewandowsky remarked that she is here from the land originally cared for by the Sauk-Suiattle and the Salish tribes. (Written)

Sydney Zvara stated that she is here from the land of the Snoqualmie, "Valley of the Moon". (Written)

Bevin Mcleod acknowledge that they were here from the land of the Duwamish. (Written)

Carolyn Cole wished a speedy recovery to Mohamed Shidane. (Written)

Sarah Weinberg volunteered to offer verbal comment. (Written)

Marcia Stedman volunteered to offer public comments. (Written)

Roger Collier volunteered to offer public comment. (Written)

Jeff Silverman volunteered to offer public comment. (Written)

Kathryn Lewandowsky suggested that the links for sending written comments be checked going forward to ensure that the public has the correct email contact and that their requests to provide public comment are received. (Written)

Kathryn Lewandosky was interested in to learn about the sources of the data from the presentations. She mentioned that Canada was not compared to the U.S. regarding avoidable mortality and inquired about Canada's long wait times. (Verbal)

Maureen Brinck-Lund reminded the Commission of the strong preference for Model A as reviewed by the Universal Health Care Work Group, particularly due to significant cost savings, and the model's fulfilling the needs of universality, accessibility, and affordability. (Verbal)

Cris Currie urged the Commission to focus its limited resources on the UHC Work Group Model A, stating that private insurance add nothing of value to the system. (Verbal)

Aaron Katz stressed that "feasibility" is a matter of political will and suggested that part of the Commission's work will be to build political will to make feasible what may not be considered feasible today. (Verbal)

Kathryn Lewandowsky provided a link to the WSSIP report. (Written)

Kathryn Lewandowsky posed whether cost sharing encourages folks not to go to the doctor until it is an emergency. (Written)

Jen NyeCan asked that the email for public comment be confirmed. (Written)

Dr. Rice expressed his support of Model A. (Written)

Devī Bhaktānanda expressed her appreciation of the Commission's hard work, and added her support of Model A. (Written)

Kathryn Lewandowsky expressed support for Model A. (Written)

Jeff Silverman added support for Model A. (Written)

Sarah Weinberg reminded the Commission of the strong support of Model A by the UHC Work Group (16 out of 21 voting members), and by the public. She also stated the difference between being insured and having access, and being able to afford care. (Verbal)

Roger Collier requested that the process and cut off times for submitting public comment via email be restated. He also offered his experience and assistance to the Commission pro bono. (Verbal)

Mandy Weeks-Green, Health Care Authority, posted the Commission's email address to the chat. (Written)

Jeff Silverman volunteered his assistance for data or technical issues. (Verbal)

Marcia Stedman stated that regarding feasibility and our state's priorities for health care reform, the Commission should consider the cost of a human life, and the large support of Model A as reviewed by the UHC Work Group. (Verbal)

Aruna Bhuta shared that most public comments during UHC Work Group meetings were in favor of Model A. (Verbal)

Stephanie Lee, WSIPP, posted the WSIPP report to the chat. (Written)

Mandy Weeks-Green, Health Care Authority, offered her email contact if attendees have issues submitting public comments and shared the Commission's webpage. (Written)

Kathryn Lewandowsky remarked that in Dr. Friedman's recent review of SB 5204, the assumed tax rates bring in $12B more per year than is necessary. (Written)

Kelly Powers remarked on the rationing of care now. (Written)

Kathryn Lewandowsky agreed that care is currently rationed by for profit corporations whose alliance falls to their shareholders. (Written)

Kathryn Lewandowsky asked whether reimbursement in Canada is done Nationally or Provincially. (Written)

Aaron B Katz stated that provider fees are determined in each province. (Written)

Kathryn Lewandowsky supports establishing a National M4A plan and having it be administered at the state level. (Written)

Aaron B Katz stated that universal systems provide "outs" for residents: the ability to purchase insurance for benefits not covered by the universal system (e.g., Canada) or the ability to "buy out of" the universal system (e.g., UK). (Written)

Jeff Silverman asked whether there are comparisons of health care outcomes vs expenditures, infant mortality, or life span? (Written)

Kathleen Randall asked whether Taiwan was studied in the WSIPP study. (Written)

Jennifer E Robertson posted a resource, stated that physician training is expensive in the USA compared to Europe where 6-year undergrad-level training is still the norm, and that this burden must be addressed in developing a system of universal healthcare. (Written)

Jen Nye asked for more detail in what's included in Healthcare Costs, and asked whether the U.S. amount includes cost sharing? (Written)

Aaron B Katz responded to another public comment question, suggesting that the best international comparisons of outcomes and expenditures is by the Commonwealth Fund, CWF.org. (Written)

Aaron B Katz responded to another public comment and confirmed that the health expenditure data include all spending regardless of source, so are comparable across countries. (Written)

Bonnie Morris asked about the cost of insurance companies advertising and marketing. (Written)

Aaron B Katz stated that health care spending data include all the costs of so-called insurance overhead (including for public insurance programs). (Written)

Kathryn Lewandowsky expressed her appreciation of the many public attendees sharing their healthcare expertise. (Written)

Vicki Lowe, Chair, confirmed that the rich conversation in the chat would be captured. (Written)

Jeff Silverman commended Stephanie's presentation. (Written)

Aaron B Katz remarked that in Germany the insurers and providers know what the resource limitations are under which they are negotiating. (Written)

Kelly Powers asked whether Germany has a robust small business sector. (Written)

Maureen (Mo) Brinck-Lund stressed the higher healthcare costs and worse outcomes in the U.S. (Written)

Aaron B Katz remarked his understanding that in Germany, all plans are private., that all residents with incomes below a certain amount must enroll in one of the regulated "sickness plans," and that those with higher incomes must enroll in an alternative insurance plan that meets certain standards. (Written)

Kelly Powers stated that many workers are not provided employer-based insurance. (Written)

Jen Nye commented that medical debt is a detriment to our system that isn't accounted for in the presentation. (Written)

Jeff Silverman replied that he is not provided insurance by his employer. (Written)

Maureen (Mo) Brinck-Lund thanked the presenter for the presentation. (Written)

Dr. Rice asked how health technology assessment and approval decisions are made in current U.S. for-profit insurers. (Written)

Sarah Weinberg remarked that she thought that in Germany, to buy private insurance instead of enrolling in a sickness fund, a citizen must show adequate wealth to pay for it. (Written)

Kathryn Lewandowsky commented that a gentleman she'd met told her that a company in Germany for which he worked, was able to choose to provide private coverage. (Written)

Alan Unell and Vokouhi Hovagimian remarked that the 2020 Dec. CBO report identified $400B yearly in overhead that would be removed in any of the 5 single payer systems evaluated. (Written)

Kathryn Lewandowsky stated that in her research on Germany's healthcare system, she found that the insurance companies are restricted to a 3% profit margin and that additional profits must be used to reduce next year's premiums. (Written)

Aaron B Katz remarked that WA state's actions on cost control often aren't or can't be applied to the entire health care system, whereas, for example, when Germany decided to get aggressive on disease management payment years ago, it applied to the entire system. (Written)

Kelly Powers expressed pride for Washington's history of health care reform. (Written)

Bevin Mcleod commented that SB 5399 was written to include standing up of advisory committees, a significant opportunity for deep diving into categories that need research to support the commissioners and the overall mandate of the Commission. (Written)

Jennifer E Robertson posted a resource and shared that the cost of medical school contributes to U.S. healthcare disparities and spending. (Written)

Hal Stockbridge MD agreed that the standing up of advisory committees is a good opportunity to help support the Commission. (Written)

Bevin Mcleod contributed that with limited time and resources, the allocation of statewide savings could not be assessed, and that it would be nice to be able to dig into where the savings are allocated across sectors. (Written)

Kathryn Lewandowsky expressed her fear that there may be a bit of sticker shock at the cost of treating sick COVID patients. (Written)

Commission Member Nicole Gomez shared the link to the full Universal Health Care Work Group's Final Report. https://www.hca.wa.gov/assets/program/final-universal-health-care-work-group-legislative-report.pdf (Written)

Jeff Silverman asked whether there were topics of research interest that did not have adequate time/resources. (Written)

Kathryn Lewandowsky asked whether Cascade Care reimbursement is 40% of Medicare reimbursement? (Written)

Dr. Rice stated that European multi-payer systems all used non-profit private health insurers, which he did not see mentioned in the Work Group's Model B, and that the first insurer in the U.S., Blue Cross, was initially non-profit. (Written)

Kathryn Lewandowsky stated that the hospital where she works does not accept Cascade Care as the hospital cannot afford to provide care at that reimbursement level. (Written)

Commission Member Joan Altman stated the possible interest to members that last session the legislature directed the Exchange, in collaboration with HCA and OIC, to look at coverage solutions for folks without a federally recognized immigration status – with the goal of providing coverage to that group by 2024. (Written)

Michele Ritala shared, European countries may use non-profit health insurers to provide administrative services, but provider rates are determined at a national level, and that there are no proprietary networks that differ by health plan. (Written)

Aaron B Katz stated that the largest three health insurers in WA (Kaiser, Premera/Blue Cross, and Regence/Blue Shield) are not-for-profit entities, and the "rules" of the marketplace are more important than the tax code status of the competitors. (Written)

Commission Member Jane Beyer shared an evaluation of the Maryland all payer model for hospitals for an example of an all-payer model that applies to Medicare. (Written)

Bevin Mcleod stated that he could work on creating a list to share if folks think that would be helpful. (Written)

Mich'l Needham, Health Care Authority, shared that Cascade Care reimbursement requirements aim at 160% of Medicare as an aggregate measure across all payments. (Written)

Commission Member Joan Altman shared additional information on Cascade Cade care with a link. (Written)

Kelly Powers stated that it was more challenging this year to find one Cascade Care plan that covered the hospital, providers, etc. (Written)

Aruna Bhuta shared that the Bree Collaborative's work on healthcare technology effectiveness and government cost control strategies info will be helpful. (Written)

Jeff Silverman commended the presentation. (Written)

Kathryn Lewandowsky thanked the Commission and presenters for their time and efforts in fulfilling the goals of this Commission. (Written)

Consuelo Echeverria agreed that feasibility is a matter of political will, stressing that at one point in the history of the U.S., slavery was legal, and women were not allowed to vote. (Written)

## Meeting summary review from prior meeting

All Commission members voted by consensus to adopt the Meeting Summary from the November 2021 meeting.

## Presentation: Single payer and universal coverage health systems

Stephanie Lee, Director, Washington State Institute for Public Policy (WSIPP) shared the WSIPP study of single-payer and universal coverage health systems.

In 2018, the state legislature assigned WSIPP to study international single payer and universal coverage health systems. WSIPP produced an interim and final report to the legislature. Today's presentation shared key findings from the final report, including a broad overview and examples of single-payer and multi-payer systems in the scope of universal health care provision, and a review of cost drivers between the U.S. and comparison countries.

*Single-Payer*

Single-payer models that have been put forth in the U.S. on a state level have assumed that a single-payer public plan would automatically enroll individuals currently under Medicaid, Medicare, employer-sponsored insurance, individual coverage, and those without insurance. These models have also assumed 1) that private insurance would be eliminated or confined to supplemental coverage, 2) cost sharing would be reduced or eliminated, and enrollee premiums eliminated, and 3) there would be a single set of provider rates.

Estimates presented in the single payer financing portion of WSIPP's presentation predated the COVID-19 pandemic. Of the roughly $55B spent on medical care in 2018 for Washington residents, about half was covered by Medicaid and Medicare, the remainder being financed by employer-sponsored insurance. Single-payer funding proposals assumed that federal and state health care spending would be pooled to help finance state single-payer plans. Employer sponsored premiums, individual premiums, and cost-sharing payments would be replaced by additional tax revenue. Economists estimate that $28B in additional annual revenues would be needed to implement a single-payer system in Washington.

Two implementation challenges of single-payer plans include 1) reliance on pooling of federal health care spending to help pay for state plans, and 2) limitations by the federal law regulating employee benefits, the Employee Retirement Income Security Act of 1974 (ERISA).

There are two types of single payer models; 1) national health services, where hospitals and clinics are government-owned and many physicians are government employees (United Kingdom, Scandinavian countries), and 2) national health insurance systems, where providers are typically private and are reimburse through a tax-financed government plan (Canada, Australia). A national health insurance system at a state level is most like Model A as proposed by the Universal Health Care Work Group.

*Multi-Payer*

Purchasing health insurance is mandatory in countries with multi-payer plans. Individuals are free to choose among competitive, mostly non-profit, insurers. Insurers are required to accept all applicants. Multi-payer systems are typically financed by payroll taxes, premiums, or out-of-pocket spending.

In both single-payer and multi-payer countries reviewed by WSIPP, governments play active roles in health care markets. Governments regulate insurers, subsidize coverage for low-income residents, determine standardize benefit packages, and control prices of medical services and pharmaceuticals.

The U.S. spends about 18% of GDP on healthcare, compared to 11% in other countries. The U.S. spends $9,400 per person on health care, compared to other countries' average of $5,000 per person. Major factors driving cost differences between the U.S. and other countries are driven by 1) higher expenditures on medical services and goods, 2) higher utilization of high-cost, high-margin procedures and advanced imaging, and 3) higher administrative costs. The U.S. spends about $1,440 per person per year on pharmaceuticals versus and average of $670 for the comparison countries. In single-payer and multi-payer countries, administrative costs account for roughly 2%-5% of health expenditures, compared to 8% in the U.S. It is not clear to what extent other countries' systems, policies, governmental controls, and taxation systems are translatable to the U.S.

## Presentation: Universal Health Care Work Group Report

Liz Arjun, MPH, MSW, Senior Consultant, Health Management Associates (HMA) and Shane Mofford, Senior Consultant, Optumas, shared the Universal Health Care Work Group's final report to the Legislature.

The Universal Health Care Work Group was provided by a 2019 Budget Proviso. The Work Group launched in August 2019 and submitted their final report to the legislature in January 2021. The Work Group included more than 30 individuals, including those who had experience with health care financing and/or health care delivery, and those with affiliation with or knowledge of Tribal health care organizations or Tribal health care systems. Key stakeholders included legislators, health insurers, patient advocates, health care providers, and various state agencies.

The Work Group was created by the legislature for insights and perspectives to inform their decision-making. Three of the issues reviewed by the Work Group were unequal access, poor and disparate outcomes, and unstable costs. The goals identified by the Work Group were to ensure that all Washington residents have access to essential, effective, appropriate, and affordable health care services when and where they need it. Health Management Associates (HMA) worked with the Work Group to establish the following assessment criteria based on the goals identified by the Work Group: access, affordability, equity, governance, administration, feasibility, and quality. These criteria were used to measure and evaluate the health care coverage models that were put forward.

HMA came up with three models of universal health care for cost modeling and evaluation: Model A (state-administered), Model B (state-delegated), and Model C (populations with limited access to traditional coverage). Work Group members agreed on the plan design, optional elements, and elements that would not be included for each of these models.

Model A was generally favored by the Work Group. It would be directly administered by the state and would cover all populations, including undocumented immigrants. Under this model, there would be no cost-sharing, pricing variations between covered populations would be reduced, and premiums would be exempt from state premium tax. Where status quo expenditures are $61.4B, Model A had predicted expenditures of $58.9B for the first year of implementation. Model A is projected to increase annual savings from $2.5B to $5.6B once the program is fully mature. The primary sources of cost savings in this model were the elimination of private health plan administrative costs, administrative cost reduction for providers, improved access to care, and greater purchasing power. The state funds required for this model are $26.5B, plus an additional $3B to provide dental for Medicaid eligible populations.

Model B covered the same populations as Model A, though it would be administered by health insurers. Projected expenditures in the first year of implementation were $60.6B. In this model, both the efficiencies assumed and the

magnitude in cost savings were better compared to the status quo, though they were lower compared to Model A. This model maintains and consolidates the number of private health insurers, supports increased economies of scale, and mitigates employment losses.

Model C focuses on covering undocumented immigrants. It was noted that this model should be considered in conjunction with the Cascade Care subsidy options, as this model does not address affordability for those who do not have access to coverage. This model would increase expenditures by $617M.

Operational decisions made in the implementation phase of any model will impact program costs. As decisions are made, costs estimates will need to be updated accordingly.

### Commission Comments

Ms. Lowe called for verbal and written (via the Zoom chat) comments from Commission Members.

Kristin Peterson, Commission Member, had no questions but expressed that the information was helpful. (Written)

Nicole Gomez, Commission Member, reminded the Commission of their ability to form advisory committees. (Verbal)

### Motion to table agenda items until next meeting

Commission members voted unanimously to table the remainder of the agenda to the next meeting.

### Adjournment

Meeting adjourned at 4:00 p.m.

## Next meeting

Friday, February 25, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Washington State Health Care Authority

# Health Coverage Changes in Washington State since the COVID-19 Pandemic by Wei Yen, Office of Financial Management

# TAB 4

February 25, 2022

# Health Coverage Changes in Washington State since the COVID-19 Pandemic

A presentation to the Universal Health Care Commission

Wei Yen, PhD
Senior Forecast and Research Analyst
Health Care Research Center
Forecasting and Research Division

OFM
OFFICE OF FINANCIAL MANAGEMENT

# Contents for Today's Presentation

- The OFM microsimulation model of Washington's unemployment claims during the COVID-19 pandemic and associated health coverage changes
- Estimates from the OFM model

# Project on COVID-19's Impact on Health Coverage

## Why this project

- COVID-19 pandemic – anticipated scale unparalleled in recent history
- Evolving fast
- Impact on health care coverage was certain, but needed to be quantified

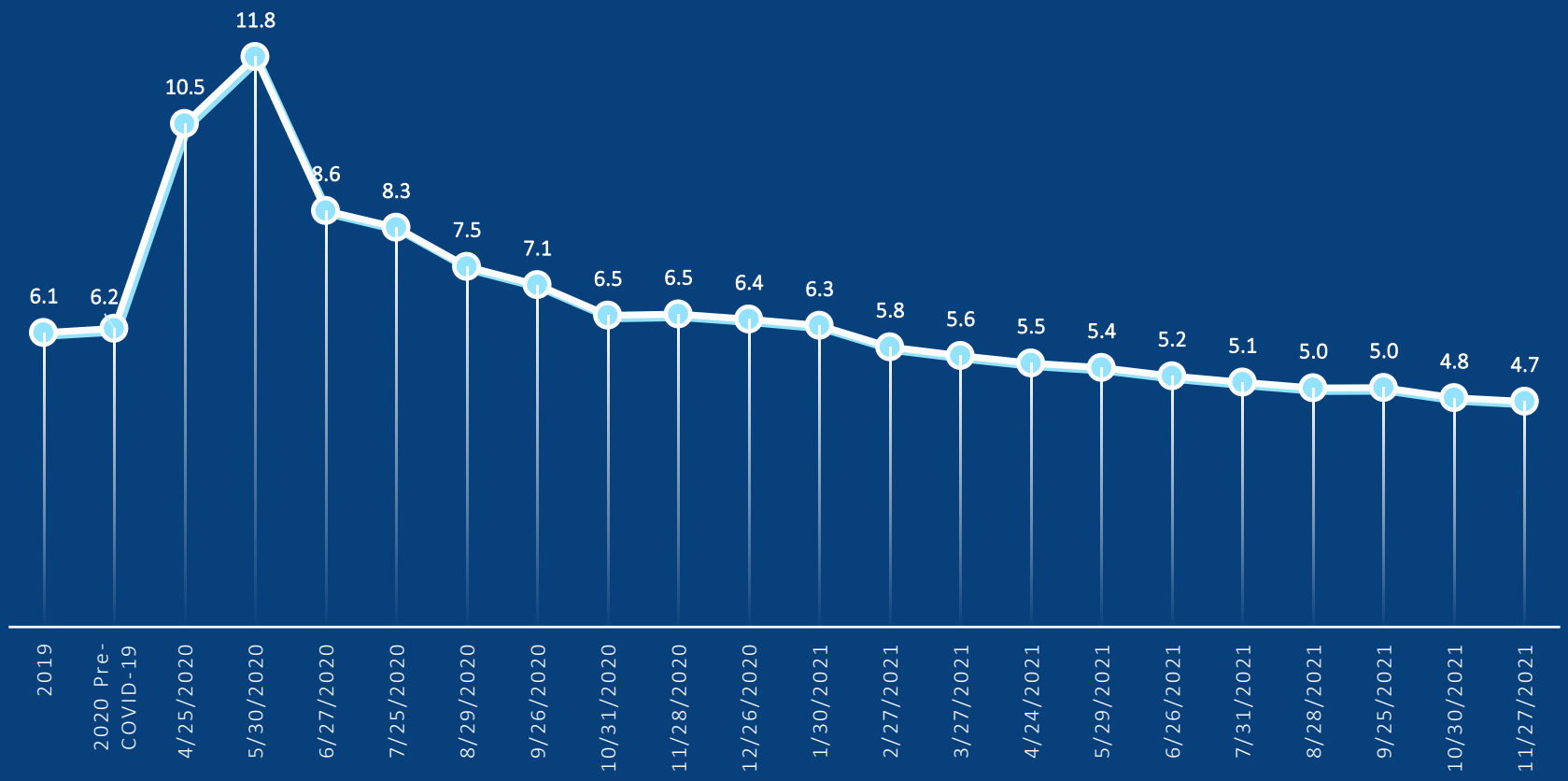
## Methodological approach

- Microsimulation model on real-time changes in employment on health coverage
  - Simulation on job loss by occupation by county;
  - Simulation on changes in employment-based health insurance (EBI);
  - Simulation on family members' coverage changes related to the worker's EBI change
  - Simulation on Medicaid and Exchange enrollment changes
- Model base data – Census Bureau's 2019 American Community Survey for Washington (early model used 2018 ACS)
- Other data - weekly data reports from ESD's unemployment claims (by county by occupation), HCA's Medicaid enrollment and HBE's Exchange enrollment

## Project product

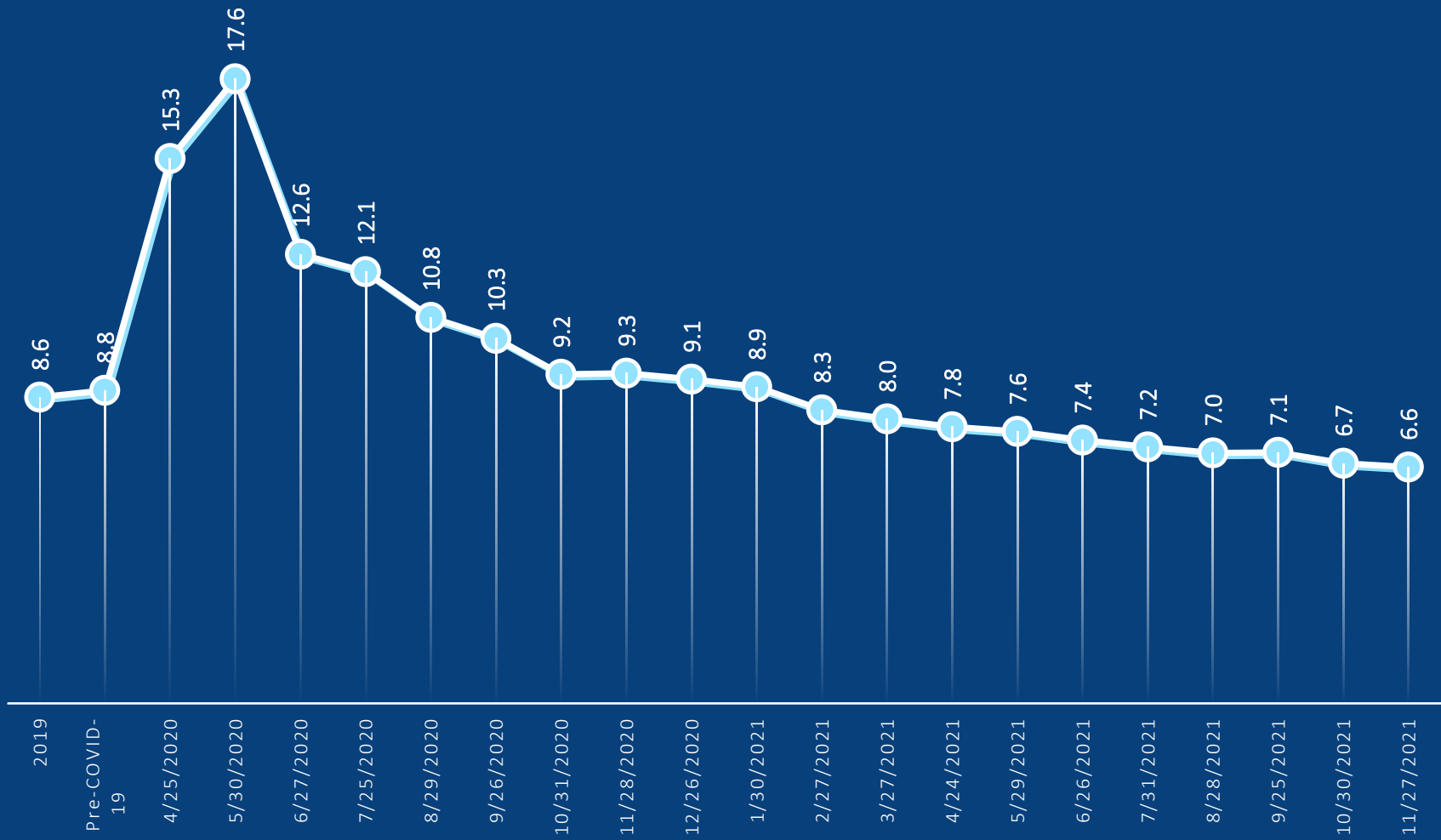
- Weekly report from April to August 2020;
- Monthly report from September 2020 through June 2021 (when COVID-19 restrictions were lifted);
- internal monitoring thereafter.

## FIGURE 1. ESTIMATED UNINSURED IN WASHINGTON (PERCENTAGE) 2019, PRE-COVID19 2020, LAST WEEK OF THE MONTH SINCE APRIL 2020 THROUGH NOVEMBER 2021

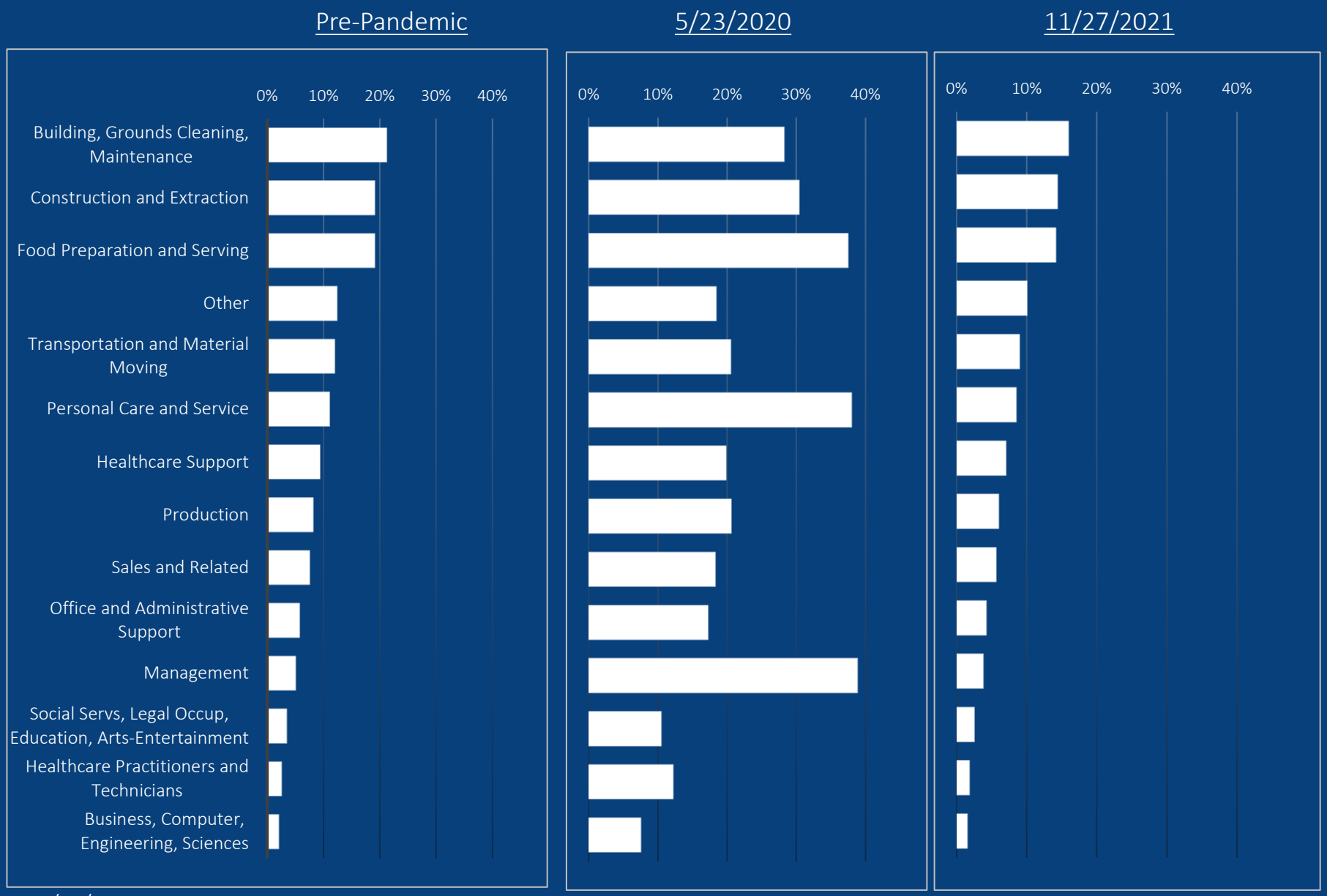



- Rapid increase in uninsured rate during pandemic shutdown in 2020
- Rapid decline when shutdown was lifted
- Gradual decline since October 2020
- Current rate lower than pre-pandemic rate

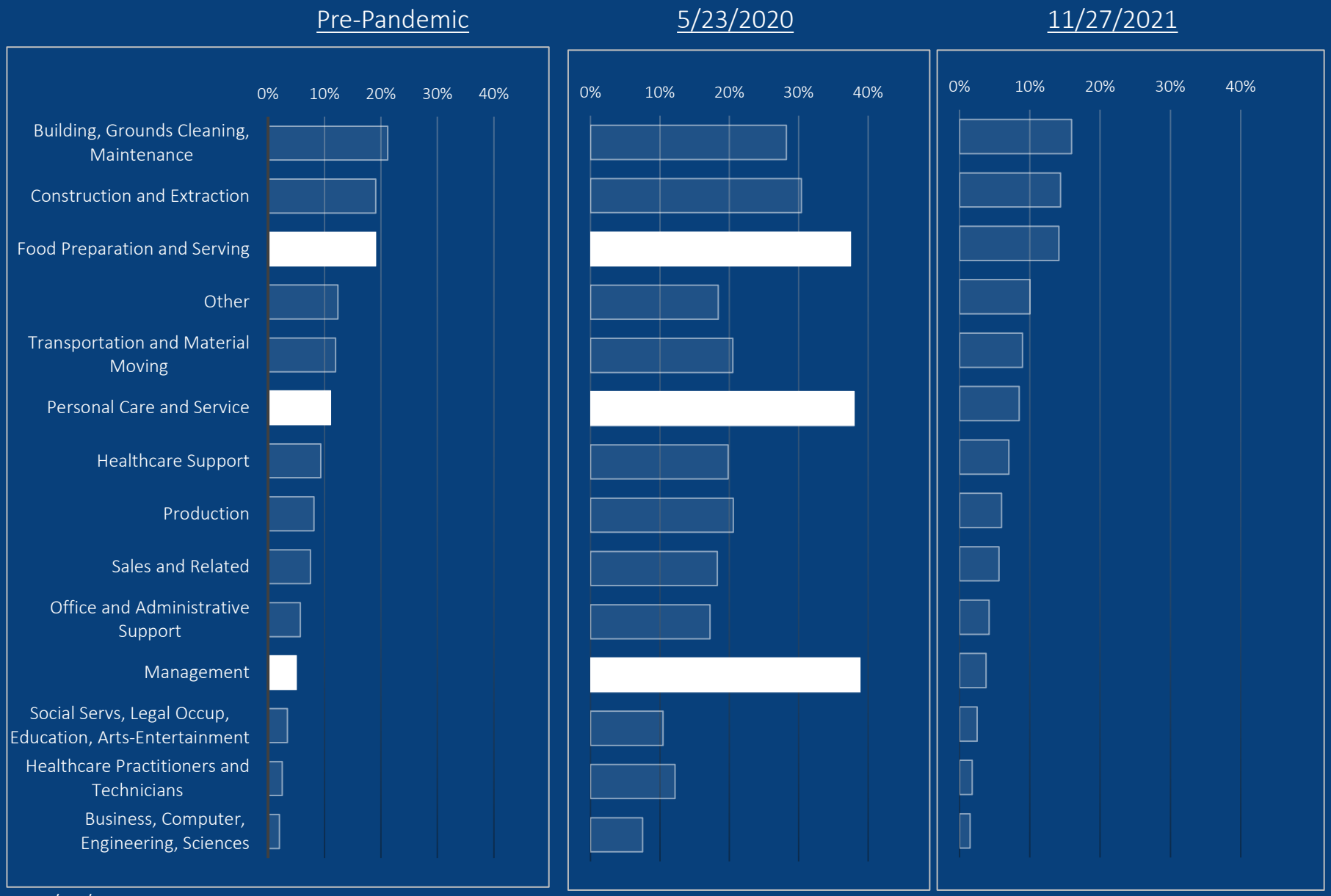
# FIGURE 2. ESTIMATED UNINSURED AMONG ADULTS 18-64 IN WASHINGTON (PERCENTAGE) 2019, PRE-COVID19 2020, AND LAST WEEK OF THE MONTH SINCE APRIL 2020 THROUGH NOVEMBER 2021



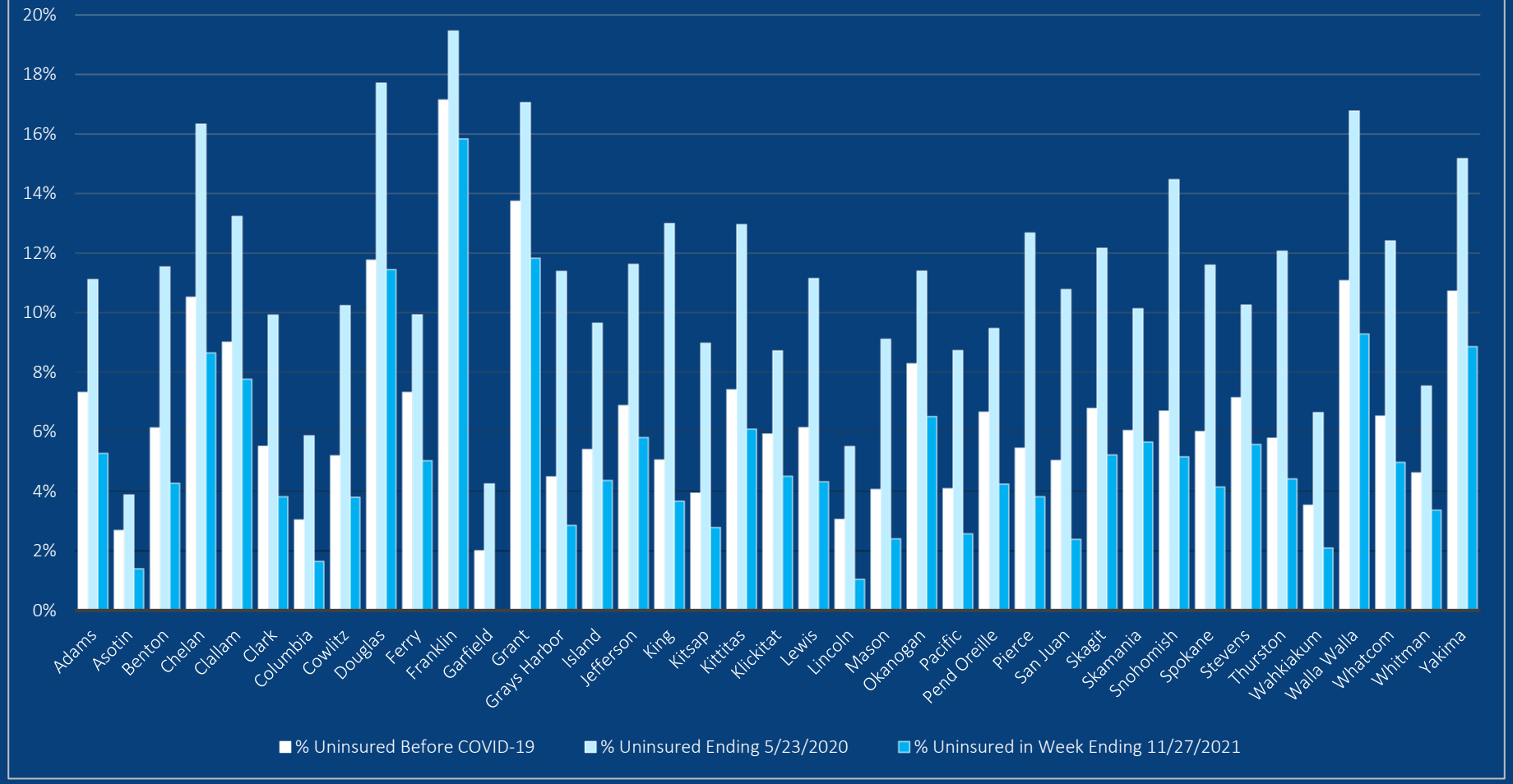
# FIGURE 3. UNINSURED RATES (%) BY OCCUPATION, ADULTS 18-64 EMPLOYED PRE-COVID19, WASHINGTON: PRE-COVID19 AND WEEKS ENDING 5/23/2020 AND 11/27/2021



# FIGURE 3. UNINSURED RATES (%) BY OCCUPATION, ADULTS 18-64 EMPLOYED PRE-COVID19, WASHINGTON: PRE-COVID19 AND WEEKS ENDING 5/23/2020 AND 11/27/2021

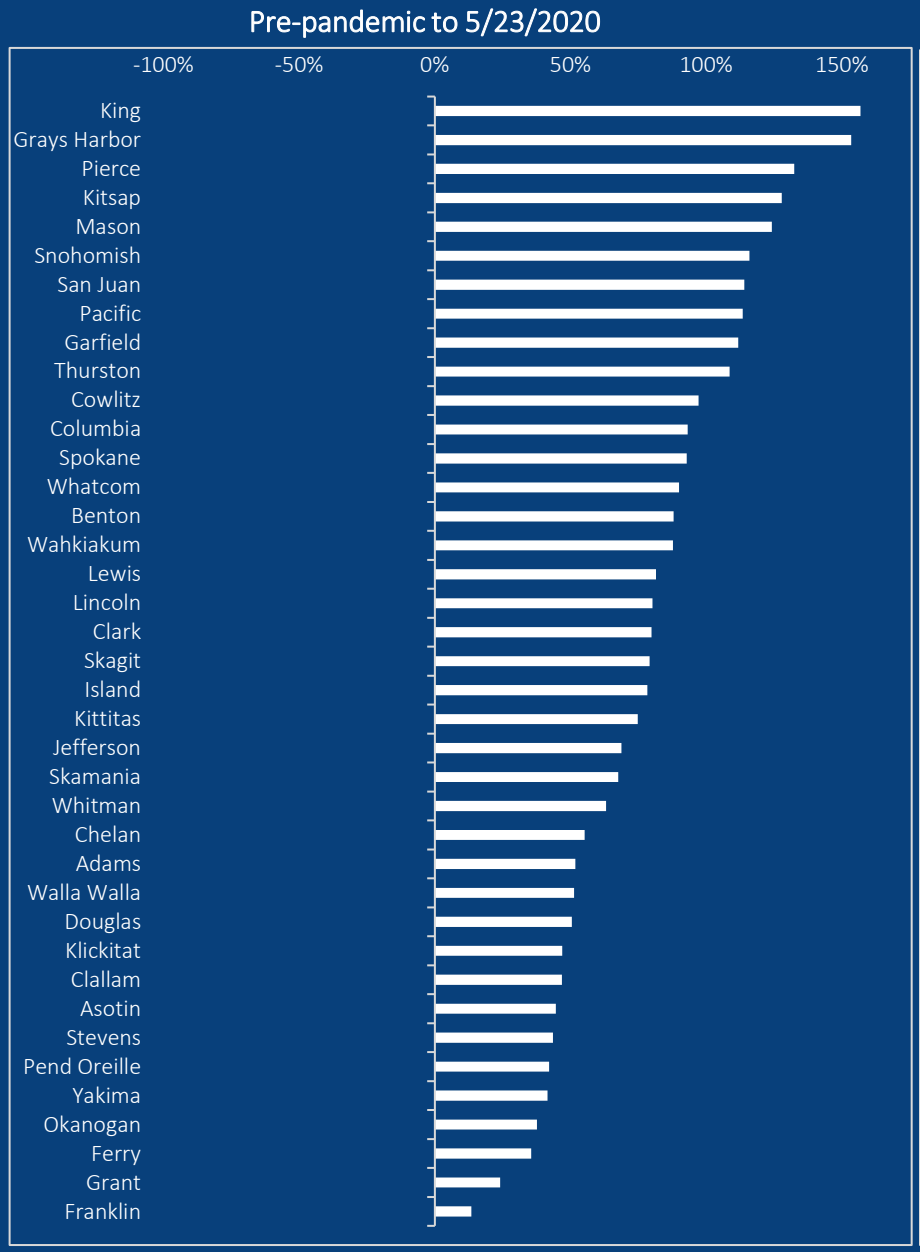


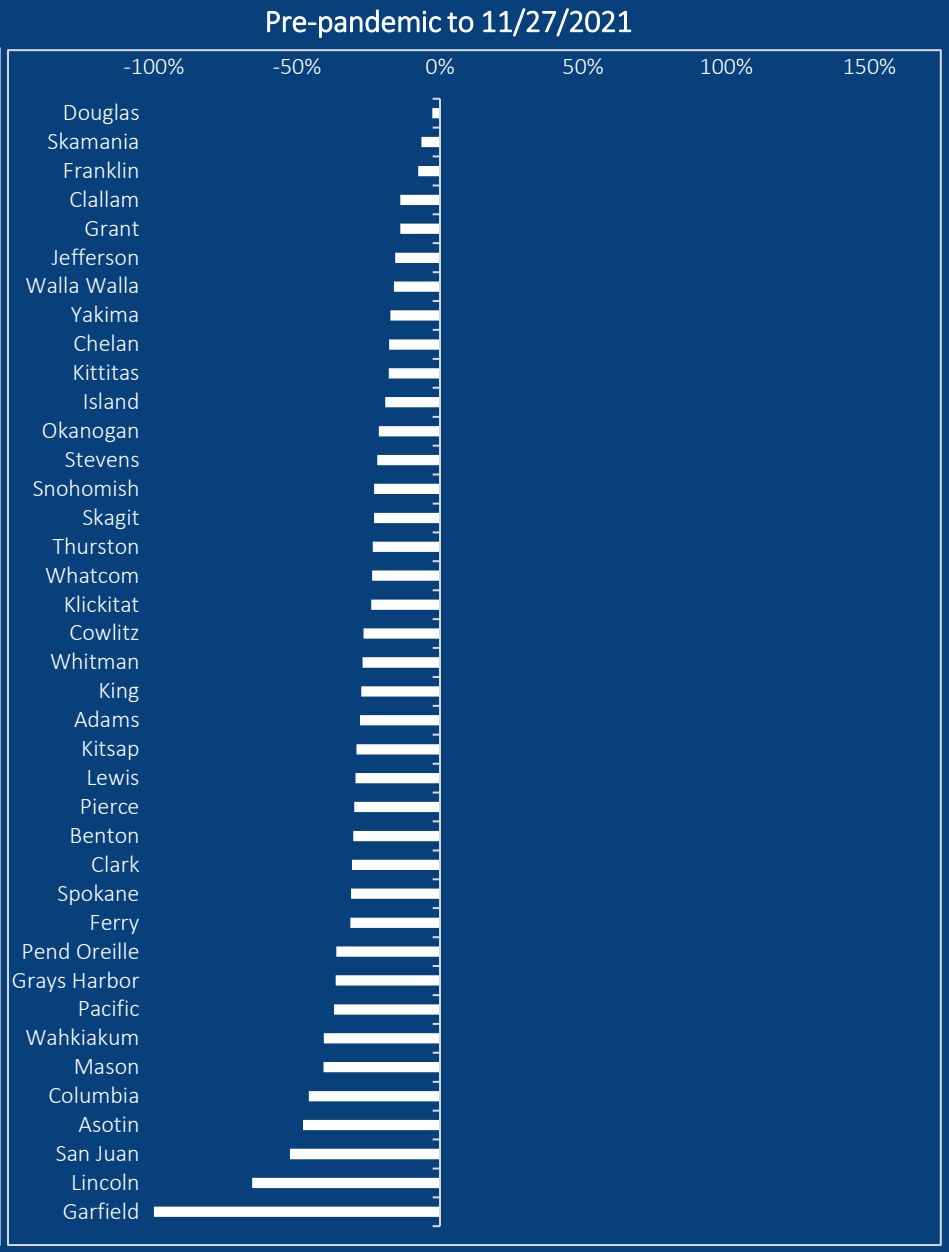
## FIGURE 4. COUNTY UNINSURED RATES (%), WASHINGTON: PRE-COVID19 AND WEEKS ENDING 5/23/2020 AND 11/27/2021



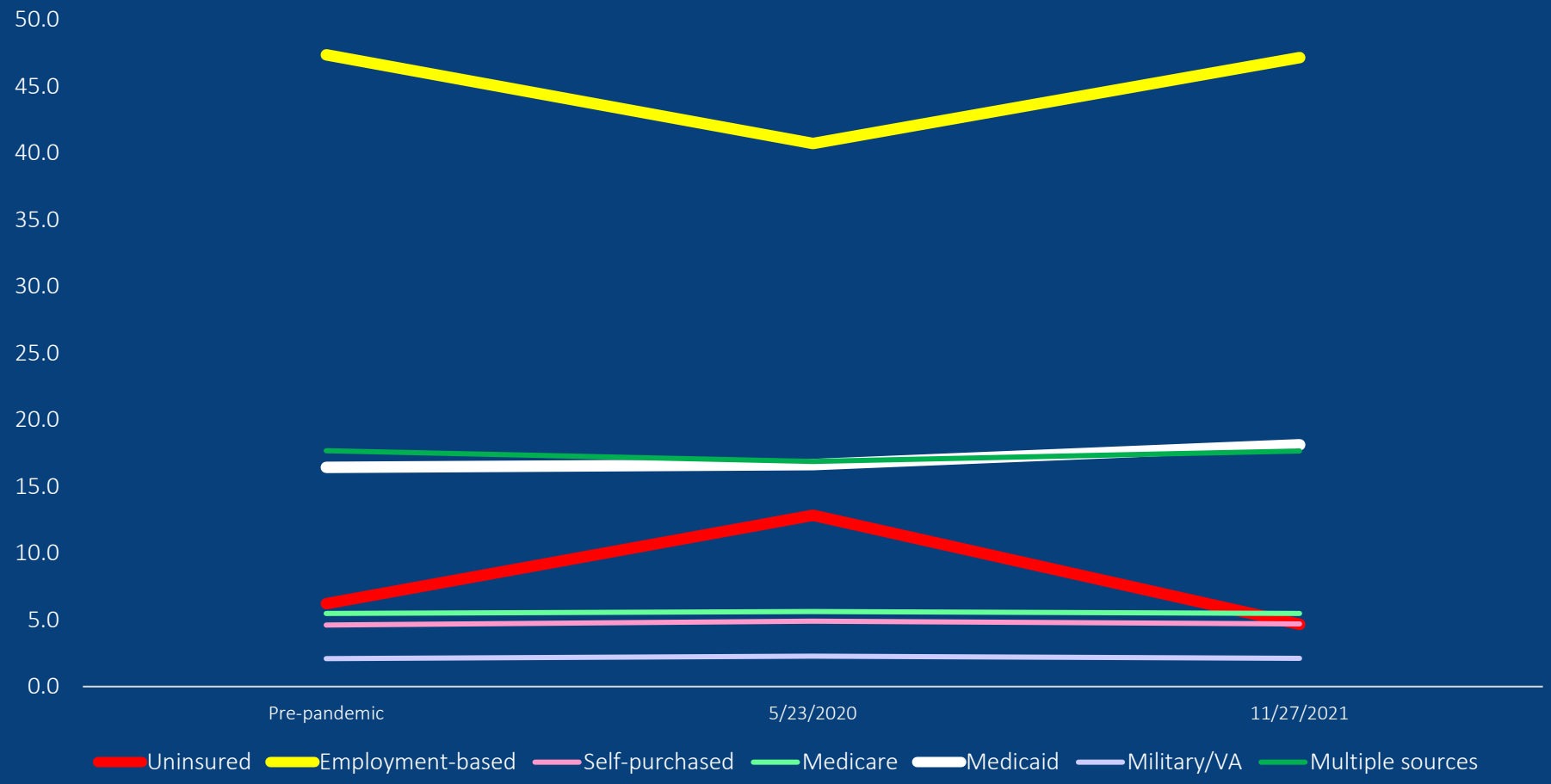

- Uninsured rates increased significantly in all counties in May 2020 but have declined since.
- Current rates are lower in all counties than their pre-pandemic rates.
- Franklin County has the highest rate.

# FIGURE 5. PERCENT CHANGE OF COUNTY UNINSURED RATES, WASHINGTON: FROM PRE-COVID19 TO WEEKS ENDING 5/23/2020 AND 11/27/2021



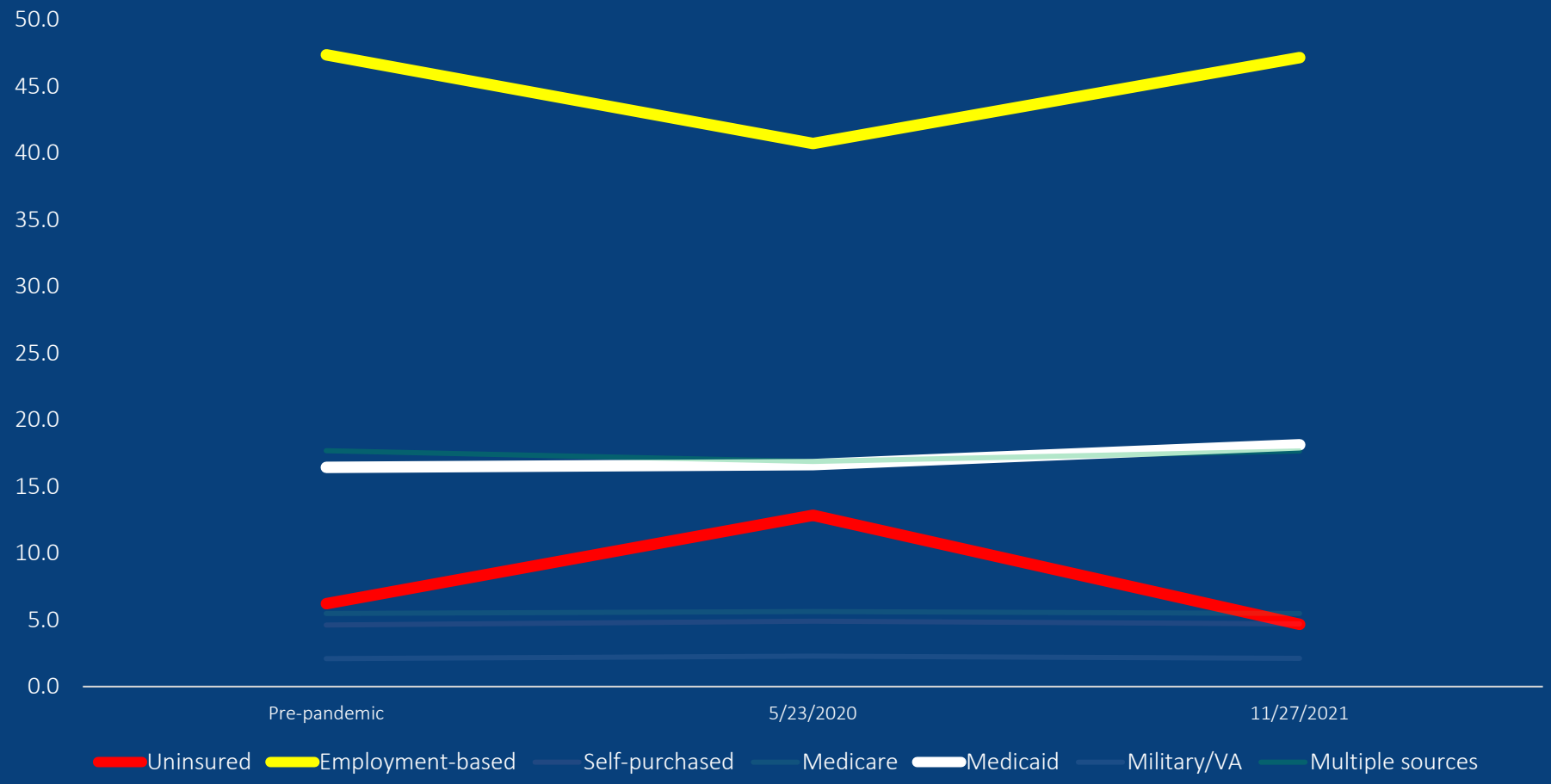



# FIGURE 6A. PERCENTS BY COVERAGE SOURCES (MUTUALLY EXCLUSIVE) AT PRE-PANDEMIC, WEEK ENDING 5/23/2020 AND WEEK ENDING 11/27/2021



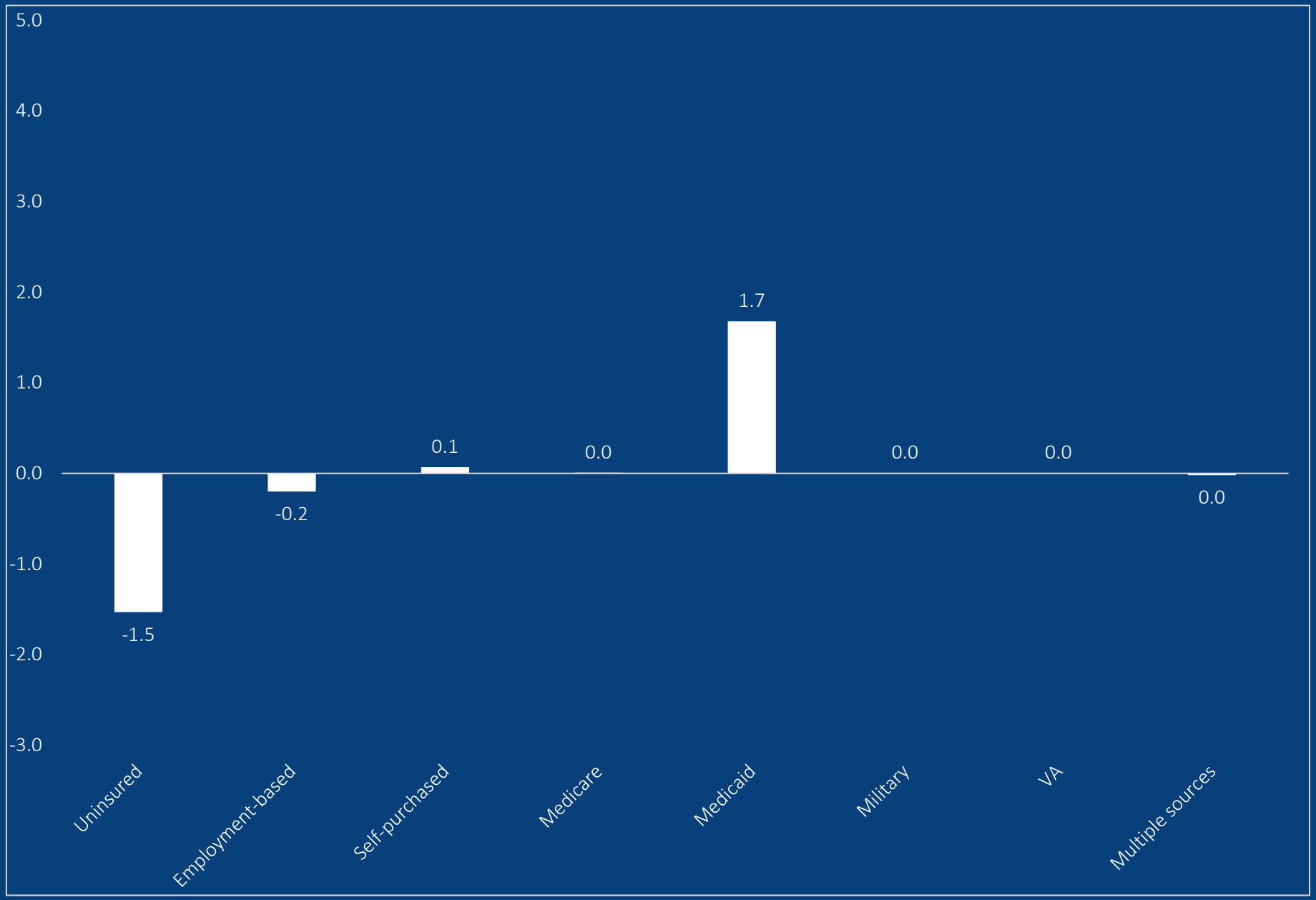

- During the 2020 shutdown, decrease in employment-base coverage is the sole driver in the increase of the uninsured.
- Currently, the temporary suspension of Medicaid eligibility redetermination under the Public Health Emergency is the main driver in the uninsured rate that is lower than the rate before the pandemic

## FIGURE 6A. PERCENTS BY COVERAGE SOURCES (MUTUALLY EXCLUSIVE) AT PRE-PANDEMIC, WEEK ENDING 5/23/2020 AND WEEK ENDING 11/27/2021




- During the 2020 shutdown, decrease in employment-base coverage is the sole driver in the increase of the uninsured.
- Currently, the temporary suspension of Medicaid eligibility redetermination under the Public Health Emergency is the main driver in the uninsured rate that is lower than the rate before the pandemic

# FIGURE 6B. PERCENTAGE POINT CHANGE IN COVERAGE FROM PRE-PANDEMIC TO WEEK ENDING 11/27/2021



# Estimated Impact on the Uninsured When PHE Ends (preliminary draft for information purposes only)

| Medicaid | 2019 | Pre-pandemic 2020 | October 2021 | When PHE ends | Estimated change |
|---|---|---|---|---|---|
| % (of state total pop) | 21.2 | 21.1 | 24.9 | 20.7 | -4.3 |
| N | 1,616,000 | 1,630,000 | 1,945,000 | 1,611,000 | -334,000 |
| **State Total Population** | **7,615,000** | **7,731,000** | **7,796,000** | | |

| Uninsured | 2019 | Pre-pandemic 2020 | October 2021 | When PHE ends Assuming 40% of Medicaid exits to become uninsured when PHE ends | Assumption Range (30%-60%) | |
|---|---|---|---|---|---|---|
| | | | | | Low | High |
| % (of state total pop) | 6.1 | 6.2 | 4.7 | 6.5 | 6.0 | 7.3 |
| N | 465,000 | 479,000 | 370,000 | 503,000 | 470,000 | 570,000 |
| | | Change from Oct 2021 | | | | |
| | | % (percentage points) | | 1.7 | 1.3 | 2.6 |
| | | N | | 133,000 | 100,000 | 200,000 |

# Summary of Key Findings

- The COVID-19 pandemic caused rapid increases in uninsured rate during the shutdown in 2020.
- With the shutdown lifted, the uninsured rate had a rapid decline, followed by a more gradual decline. The current rate is lower than even the pre-pandemic rate.
- Adults 18-64 accounted for most of the changes in the uninsured rates.
- Uninsured rates in all occupations were affected in the first few months of the pandemic, but food services, personal care and service, and management had the highest rates close to 40%.
- County variations:
  - All counties had higher uninsured rates at the height of unemployment in 2020 with King and Grays Harbor having the largest changes proportionately.
  - All counties currently have rates lower than their pre-pandemic rates with San Juan, Lincoln and Garfield's rates more than 50% lower.
  - Franklin has the highest uninsured rate.
- Medicaid and Exchange helped prevent the uninsured rates from increasing further during the shutdown in 2020. Thanks to the temporary Medicaid rule change under the federal Public Health Emergency declaration for COVID-19, Washington's current uninsured rate is lower than the rate before the pandemic. An end to the PHE could increase the state's uninsured to possibly the pre-pandemic level.

# Disclaimers and Limitations

- Estimates here are intended as interim until official estimates become available; however, the key data source for official 2020 estimates won't be available due to data collection challenges the US Census Bureau encountered during the spring and summer of 2020. The official 2021 estimates are expected to become available in late 2022.
- Changes in assumptions used in the model would result in different estimates.
- The microsimulation model did not account for those who lost their jobs during the pandemic but could not file for unemployment claims.
- The model also did not account for those whose unemployment claims stopped while remaining unemployed.

# Questions & Answers

# FOR MORE INFORMATION:

Wei Yen
wei.yen@ofm.wa.gov

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OFFICE OF FINANCIAL MANAGEMENT

Washington State Health Care Authority

# Public Comment on Commission Charter

# TAB 5

# Public Comment on Commission Charter

Washington State Health Care Authority

Washington State Health Care Authority

# Universal Health Care Commission

## Public Comment on Draft Charter provided during November 30, 2021 meeting

Below are comments and questions shared by attendees with the Universal Health Care Commission regarding the Commission's draft charter during the November 30, 2021, Universal Health Care Commission meeting. Learn more about this work.

**Comment #1**

Kelly Powers remarked that the vision and mission statement outlined in the Commission's draft charter did not align with the original bill. She suggested that during the January Commission meeting, those concepts of universality and affordability be stressed, as well as making clear the difference between access to coverage and access to care. (Verbal and written)

**Comment #2**

Maureen Brinck-Lund noted the importance of differentiating between access to coverage and access to health care, and the importance of including health care workforce in the access and coverage discussions. (Verbal)

**Comment #3**

Jeff Silverman stressed the importance of differentiating between access to coverage and access to health care. (Written)

**Comment #4**

Sarah Weinberg stressed the importance of differentiating between access to coverage and access to health care. (Written)

**Comment #5**

Deana Knudsen, Hospital Commissioner, Hospital District No.2, stressed the importance of HCA's getting federal waivers for the Commission's work, as the 1993 Health Coalition was discontinued due to inability of getting ERISA waivers. She stressed that the Commission's mission should be carefully worded so that it does not limit changes to being incremental. (Verbal)

**Comment #6**

Commission member Kristen Peterson, Deputy Secretary for Policy and Planning, Washington State Department of Health, agreed that the vision statement could be written to be more aspirational to include the idea of wellbeing, and to reflect the intent of the bill to address health disparities and provide access to all Washingtonians. (Verbal)

**Comment #7**

Commission member Nicole Gomez wants to ensure that the mission statement includes the health care workforce. (Verbal)

**Comment #8**

Commission member Jane Beyer, Senior Health Policy Officer, Office of the Insurance Commissioner, asked for the Commission Principles to be revised to include the development of each annual report, rather than just the report due on November 1, 2022. Ms. Beyer also suggested that the term "practical" be revised, especially given the focus of the Commission on equity. (Verbal)

**Comment #9**

Commission member Dave Iseminger suggested using numbers instead of bullets in the charter. (Verbal)

Washington State Health Care Authority

# Discussion and Approval of Commission Charter

# TAB 6

# Universal Health Care Commission
## Charter and Operating Procedures
## Draft with Comments Incorporated
## 12.20.2021

The purpose of this charter is to clarify the charge and responsibilities of, and expectations for the Universal Health Care Commission (Commission).

### I. Vision and Mission

#### A. Vision

To increase access to quality, affordable health care by streamlining access ~~to~~ universal health ~~to~~ coverage.

Commented [UHCC1]: Concerning comments #1-4, comments from the public.

#### B. Mission

The Commission's primary objective is to develop a strategy for implementable changes to the state's health care financing and delivery system to increase access to health care ~~services~~ and universal ~~health~~ coverage, reduce health care costs, reduce health disparities, improve the health and well-being of patients and the health workforce, improve quality, and prepare for the transition to a unified health care financing system. The Commission aims to achieve this objective by: (1) examining data and reports from sources that are monitoring the health care system; (2) assessing the state's current preparedness for a unified health care financing system; (3) developing recommendations to increase access to health care services and health coverage, reduce health care costs, reduce health disparities, improve quality, and (4) preparing for the transition to a unified health care financing system.

Commented [UHCC2]: Concerning comment #6 by Commission Member Kristen Peterson, Washington State Department of Health, and comment #7 by Member Nicole Gomez, Alliance for a Healthy Washington

### II. Universal Health Care Commission Charge

Engrossed Second Substitute Senate Bill 5399, which passed during the 2021 Washington State Legislative Session, established the Universal Health Care Commission (Commission) to develop a strategy for implementable changes to the state's health care financing and delivery system to increase access to health care services and universal health coverage, reduce health care costs, reduce health disparities, improve quality, and preparefor the transition to a unified health care financing system. The Commission's work is primarily broken into two stages:

1. **By November 1, 2022**, the Commission must submit a baseline report to the Legislature, the Governor, and post the report on the Health Care Authority's website. The report must include:
    a. A complete synthesis of analyses done on Washington's existing health care finance and delivery system, including cost, quality, workforce, and provider consolidation trends and how they impact the state's ability to provide all Washingtonians with timely access to high quality, affordable health care.
    b. A strategy for developing implementable changes to the state's health care financing and delivery system to increase access to health care services and universal health coverage, reduce health care costs,

reduce health disparities, improve quality, and prepare for the transition to a unified health care financing system by actively examining data and reports fromsources that are monitoring the health care system.

c. An inventory of the key design elements of a universal health care system including: (i) a unified financing system including, but not limited to, a single-payer financing system; (ii) eligibility and enrollment processes and requirements; (iii) covered benefits and services; (iv) provider participation; (v) effective and efficient provider payments, including consideration of global budgets and health plan payments; (vi)cost containment and savings strategies that are designed to assure that total health care expenditures do not exceed the health care cost growth benchmark established under chapter 70.390 RCW; (vii) quality improvement strategies; (viii) participant cost sharing, if appropriate; (ix) quality monitoring and disparities reduction; (x) initiatives for improving culturally appropriate health services within public and private health-related agencies; (xi) strategies to reduce health disparitiesincluding, but not limited to, mitigating structural racism and other determinants of health as set forth by the office of equity; (xii) information technology systems and financial management systems;
(xiii) data sharing and transparency; and (xiv) governance and administration structure, including integration of federal funding sources.

d. An assessment of the state's current level of preparedness to meet the key design elements of a universal health care system (immediately above) and steps Washington should take to prepare for a just transition to a unified health care financing system, including a single-payer financing system. Recommendations must include, but are not limited to, administrative changes, reorganization of state programs, retraining programs for displaced workers, federal waivers, and statutory and constitutional changes.

e. Recommendations for implementing reimbursement rates for health care providers serving medical assistance clients who are enrolled in programs under chapter 74.09 RCW at a rate that is no less than 80 percent of the rate paid by Medicare for similar services.

f. Recommendations for coverage expansions to be implemented prior to and consistent with a universal health care system, including potential funding sources; and

g. Recommendations for the creation of a finance committee to develop a financially feasible model to implement universal health care coverage using state and federal funds.

2. **Following the submission of the baseline report on November 1, 2022,** the Commission will submit annual reports to the Legislature and Governor reviewing the work of the Commission, continue strategy development regarding a unified health care financing system, and begin implementation, if possible.

a. The Commission will continue developing implementable changes to the state's health care financing and delivery system to increase access to health care services and universal health coverage, reduce health care costs, reduce health disparities, improve quality, and prepare for the transition to a unified health care financing system and implement structural changes toprepare the state for a transition to a unified health care financing systemas well continuing to further identify opportunities to implement reformsconsistent with these goals.

b. Subsequent annual reports beginning on November 1, 2023. The report will detail the work of the Commission, the opportunities identified to advance the Commission's goals, which, if any, of the opportunities a state agency is implementing, which, if any, opportunities should be pursued with legislative policy or fiscal authority, and which opportunities have been identified as beneficial, but lack federal authority to implement.

## III. Commission Duties and Responsibilities

### A. Membership and Term

There are a total of fifteen commission members. Six members are appointed by the Governor, using an equity lens, with knowledge and experience regarding health care coverage, access, and financing, or other relevant expertise, including at least one consumer representative and at least one invitation to an individual representing tribal governments with knowledge of the Indian health care delivery in the state. One member from each of the two largest caucuses of the House of Representatives, appointed by the Speaker of the House of Representatives. One member from each of the two largest caucuses of the Senate, appointed by the President of the Senate. Additional members include the Secretary of the Department of Health, Administrator of the Health Care Authority, the Chief Executive Officer of the Washington Health Benefit Exchange, Insurance Commissioner, and the Director of the Office of Equity, or their designee. The Governor shall also appoint a chairperson from the members for a term of no more than three years.

The Commission will convene beginning in 2021.

### B. Commission Member Responsibilities

Members of the Commission agree to fulfill their responsibilities by attending and participating in Commission meetings, studying the available information, directing the work of advisory committees if any are created, and participating in the development of the required reports, including the November 1, 2022, report to the Legislature and Governor as well as the annual reports thereafter.

Members agree to participate in good faith and to act in the best interests of the Commission and its charge. To this end, members agree to place the interests of the state above any political or organizational affiliations or other interests. Members accept the responsibility to collaborate in developing potential recommendations

that are fair and constructive for the state. Members are expected to consider a range of issues and options to address them, discuss the pros and cons of the issues or options presented, and deliver a set of recommendations with key conclusions. The Commission should include the rationale behind each recommendation adopted.

Specific Commission member responsibilities include:

1. Reviewing background materials and analysis to understand the issues to be addressed in the review and recommendation processes.
2. Working collaboratively with one another to explore issues and develop recommendations.
3. Attending Commission meetings; and
4. Considering and integrating advisory committee recommendations, if any advisory committees are established, and public input into Commission recommendations as appropriate.

C. **Vacancies Among Governor-appointed Commission Members**
Vacancies among Governor-appointed Commission members for any cause will be filled by an appointment of the Governor. Upon the expiration of a member's term, the member shall continue to serve until a successor has been appointed and has assumed office. If the member to be replaced is the chairperson, the Governor shall appoint a new chair within thirty days after the vacancy occurs.

D. **Role of the Washington Health Care Authority (HCA)**
HCA shall assist the Commission and, if created, any advisory committees by facilitating meetings, conducting research, distributing information, draft the reports, and advising the members.

E. **Chairperson's Role**
The chair will encourage full and safe participation by members in all aspects of the process, assist in the process of building consensus, and ensure all participants abide by the expectations for the decision-making process and behavior defined herein. The chair will develop meeting agendas, establish subcommittees if needed, and otherwise ensure an efficient decision-making process. The chair will also serve as the liaison between the Commission and the Legislature, including presenting the report and recommendations of the Commission to legislative committees.

F. **Commission Principles**
The principles, listed below, are to guide decision-making during the development and adoption of recommendations by the Commission. The principles can be revised if proposed by the chairperson or by majority of members. The Commission's recommendations will:

1. Support the development of the report due by November 1, 2022, and all subsequent reports, to theLegislature and Governor.
2. Increase access to health care services and universal health coverage, reduce health carecosts, reduce health disparities, and improve quality.

**Commented [UHCC3]:** Concerning comment #8 by Commission Member Jane Beyer, Office of the Insurance Commissioner

**Commented [UHCC4]:** Concerning comment #8 by Commission Member Jane Beyer, Office of the Insurance Commissioner

3. ~~to the extent practical,~~ Bbe inclusive of all populations and all categories ofspending.
4. ~~b~~Be sensitive to the impact that high health care spending growth has onWashingtonians.
5. A~~a~~lign recommendations with other state health reform initiatives to lower therate of growth of health care costs, and
6. B~~b~~e mindful of state financial and staff resources required to implementrecommendations.

## IV. Operating Procedures

### A. Protocols

All participants agree to act in good faith in all aspects of the Commission's deliberations. This includes being honest and refraining from undertaking any actions that will undermine or threaten the deliberative process. It also includes behavior outside of meetings. Expectations include the following:

1. Members should try to attend and participate actively in all meetings. If members cannot attend a meeting, they are requested to advise HCA staff. After missing a meeting, the member should contact staff for a recording of the meeting, or if not available, then a meeting summary and any available notes from the meeting.
2. Members agree to be respectful at all times of other Commission members, staff, and audience members. They will listen to each other and seek to understand the other's perspectives, even if they disagree.
3. Members agree to make every effort to bring all aspects of their concerns about these issues into this process to be addressed.
4. Members agree to refrain from personal attacks, undermining the process or Commission, and publicly criticizing or misstating the positions taken by any other participants during the process.
5. Any written communications, including emails, blogs, and other social networking media, will be mindful of these procedural ground rules and will maintain a respectful tone even if highlighting different perspectives.
6. Members are advised that email, blogs, and other social networking media related to the business of the Commission are considered public documents. Emails and social networking messages meant for the entire group must be distributed via a Commission facilitator.
7. Requests for information made outside of meetings will be directed to HCA staff. Responses to such requests will be limited to items that can be provided within a reasonable amount of time.

**Commented [UHCC5]:** Concerning comment #9 by Commission Member Dave Iseminger, Health Care Authority

## B. Communications

### 1) Written Communications

Members agree that transparency is essential to the Commission's deliberations. In that regard, members are requested to include both the chair and Commission staff in written communications commenting on the Commission's deliberations from/to interest groups (other than a group specifically represented by a member); these communications will be included in the public record as detailed below and copied to the full Commission as appropriate.

Written comments to the Commission, from both individual Commission members and from agency representatives and the public, should be directed to HCA staff. Written comments will be distributed by HCA staff to the full Commission in conjunction with distribution of meeting materials or at other times at the chair's discretion. Written comments will be posted to the Commission webpage.

### 2) Media

While not precluded from communicating with the media, Commission members agree to generally defer to the chair for all media communications related to the Commission process and its recommendations. Commission members agree not to negotiate through the media, nor use the media to undermine the Commission's work.

Commission members agree to raise all their concerns, especially those being raised for the first time, at a Commission meeting and not in or through the media.

## C. Conduct of Commission Meetings

### 1) Conduct of Commission Meetings

The Commission will meet by videoconference or in person at times proposed by the chair or by most voting members.

Most voting members constitutes a quorum for the transaction of Commission business. A Commission member may participate by telephone, videoconference, or in person for purposes of a quorum.

Meetings will be conducted in a manner deemed appropriate by the chair to foster collaborative decision-making and consensus building. Robert's Rules of Order will be applied when deemed appropriate.

### 2) Establishment of Advisory Committees

The Commission may establish advisory committees that include members of the public with knowledge and experience in health care, to support stakeholder engagement and an analytical process by which key design

options are developed. A member of an advisory committee need not be a member of the commission.

Meetings of advisory committees will be conducted in accordance with the operating procedures in Section V.

3) **Consensus Process/Voting**
A consensus decision-making model will be used to facilitate the Commission's deliberations and to ensure the Commission receives the collective benefit of the individual views, experience, background, training, and expertise of its members. Consensus is a participatory process whereby, on matters of substance, the representatives strive for agreements that they can accept, support, live with, or agree not to oppose.

Members agree that consensus has a high value and that the Commission should strive to achieve it. As such, decisions on Commission recommendations will be made by consensus of all present members unless voting is requested by a Commission member. Voting shall be by roll call. Final action on Commission recommendations requires an affirmative vote of most of the Commission members. A Commission member may vote by videoconference, telephone, or in person.

Members will honor decisions made and avoid re-opening issues once resolved.

4) **Documentation**
All meetings of the Commission shall be recorded, and written summaries prepared. The audio records shall be posted on the Commission's public webpage in accordance with Washington law. Meeting agendas, summaries, and supporting materials will also be posted to the Commission's webpage.

Interested parties may receive notice of the Commission meetings and access Commission materials on the website, or via GovDelivery.

At the end of the process, HCA staff will draft recommendations for which there is consensus and any remaining issues on which the Commission did not reach consensus.

D. **Public Status of Commission and Advisory Committee Meetings and Records**
The Commission and any advisory committee meetings are open to the public and will be conducted under the provisions of Washington's Open Public Meetings Act (Chapter 42.30). Members of the public and legislators may testify before the Commission upon the invitation of the chair or at the invitation of most of the members of the Commission. In the absence of a quorum, the Commission may still receive public testimony.

Any meeting held outside the Capitol or by videoconference shall adhere to the notice provisions of a regular meeting. Recordings will be made in the same manner as a regular meeting and posted on the Commission webpage. Written summaries will be prepared noting attendance and any subject matter discussed.

Committee records, including formal documents, discussion drafts, meeting summaries and exhibits, are public records. Communications of Commission members are not confidential because the meetings and records of the Commission are open to the public. "Communications" refers to all statements and votes made during the meetings, memoranda, work products, records, documents, or materials developed to fulfill the charge, including electronic mail correspondence. The personal notes of individual members will be public to the extent they relate to the business of the Commission.

E. **Amendment of Operating Procedures**

These procedures may be changed by an affirmative vote of most of the Commission members, but at least one day's notice of any proposed change shall be given in writing, which can be by electronic communication, to each Commission member.

Washington State Health Care Authority

# Introduction to the Health Care Cost Transparency Board by AnnaLisa Gellermann

# TAB 7

# Washington's Health Care Cost Transparency Board

AnnaLisa Gellermann, Board Manager, HCA

Washington State Health Care Authority

# Agenda

- Basics of the Health Care Cost Transparency Board (HCCTB)
- The problem we are solving
- Decisions made and next steps

# What is a Cost Growth Benchmark?

**What is a cost growth benchmark?**

- A health care cost growth benchmark is a per annum rate-of-growth benchmark for health care costs for a given state.

**Why pursue a cost growth benchmark?**

- To curb health care spending growth.

# Cost Benchmark Purpose

- Increase affordability for the people of Washington through lowering the growth of health care costs to a sustainable rate.
- Board identified considerations include:
  - Quality
  - Access
  - Spending on health-related social needs

# Board Structure

- The HCCTB is made up of 14 members
  - Representation from purchasers, large and small businesses, local and state government, University of Washington, and others
    - List of board members and their bios: hca.wa.gov/about-hca/board-members
- Two advisory committees support the HCCTB:
  - Health Care Providers and Carriers
  - Data Issues
    - List of advisory committee members: hca.wa.gov/about-hca/advisory-committee-members

# Health Care Cost Transparency Board Members

Sue Birch, Director, HCA (chair)
Lois Cook, owner/operator, America's Phone Guys
John Doyle, CFO, Starr Ranch Growers
Bianca Frogner PhD, Director of Center for Health Workforce Studies, UW
Sonja Kellen, Sr. Dir. Global Health and Wellness, Microsoft
Pam MacEwan, CEO WAHBE
Molly Nollette, Deputy Commissioner for Rates and Forms, OIC
Mark Siegel, Director of Employee Benefits, Costco
Margaret Stanley
Kim Wallace, Medical Administrator, L&I
Carol Wilmes, Director of Member Pooling Programs, Assoc. of WA Cities
Edwin Wong PhD, Research Associate Professor, UW
Laura Kate Zaichkin, Dir. of Health Plan Performance, SEIU 775 Benefits Group

Jody Joyce, CEO, Unity Care NW (Advisory Committee Representative, non-voting member)

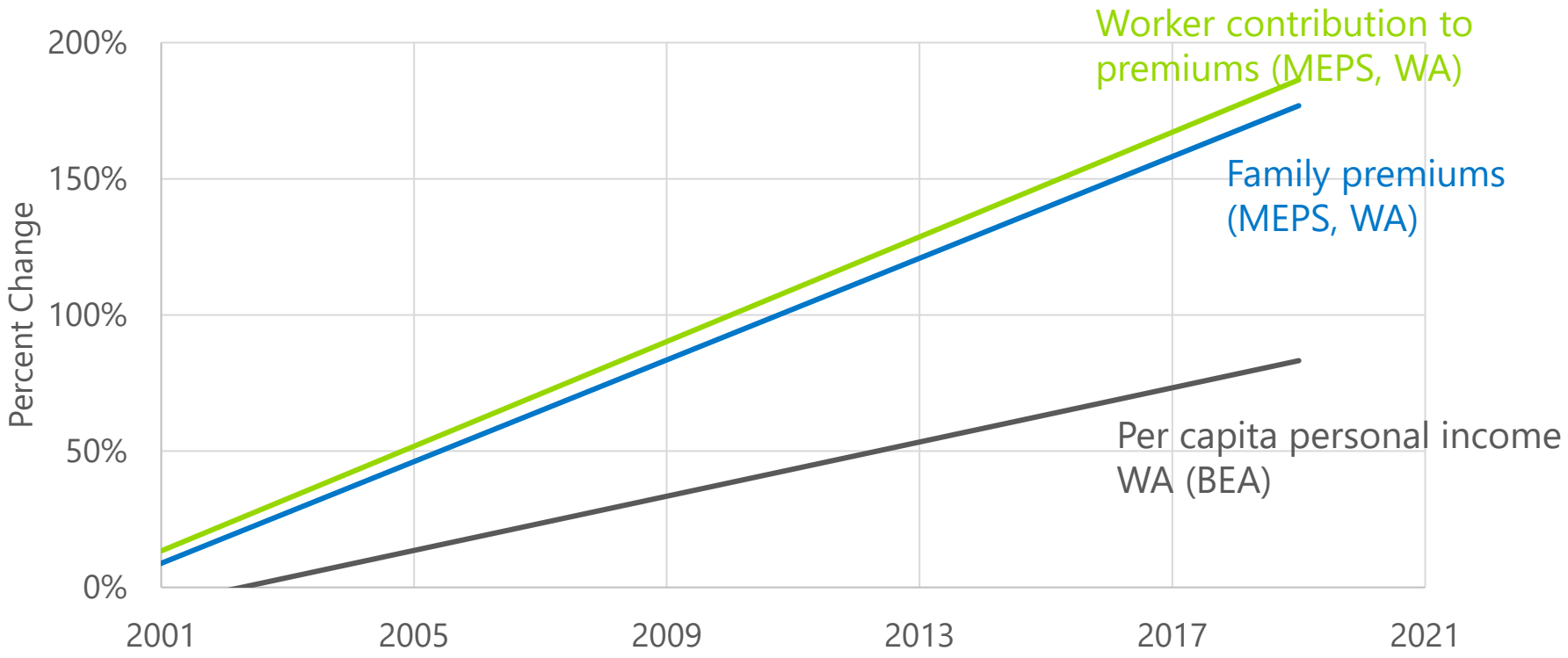
# The problem of high cost

- We spend too much
  - In 2017, the U.S. spent 17.9% of gross domestic product (GDP) on health care services. Switzerland, the country with the second highest share, spent only 12%.
  - Nationally in 2019, total health spending was $1.4 trillion.
  - Government (federal, state, and local) represents roughly 45% of total spending.

# The problem of growing cost

| Percentage growth | Economic indicator | Time period |
|---|---|---|
| 4.0% | Per capita cost | 2017-2018 |
| 2.6% | GDP | Quarter 4 of 2018 |
| 3.38% | Nominal wage growth | Dec. 2018 |
| **6.2%** | **Health services spending** | **2019** |

# The problem of growing cost




Graphs are linear trendlines of the data
Sources: AHRG's Medical Expenditure Survey, Tables D.1 and D.2 for 2001-2019 and Bureau of Economic Analysis



Washington State Health Care Authority

# The problem of growing cost

- The average share of U.S. household budgets devoted to health care increased from 5.2% to 8.2% **over 30 years**.
- Middle class families' spending on health care **increased 25%** since 2007.
- In 2017, roughly 7% of insured adults and 28% of uninsured adults said they delayed or did not receive medical care **due to cost.**

# Legislative charge for the HCCTB: House Bill 2457 (2020)

- Establish a **health care cost growth benchmark**/target percentage to limit growth.
- **Annually collect payer spending data.**
- determine **total health care expenditures annually**, and trends in growth.
- **Analyze Washington-specific cost drivers.**
- Provide **annual reports and recommendations** to Legislature.

# Cost Benchmarks in participating states

| | 5-Year Average (2010-2014) | 10-Year Average (2005-2014) | 20-Year Average (1995-2014) | Cost Growth Benchmark |
|---|---|---|---|---|
| Massachusetts | 3.0% | 4.7% | 5.1% | 3.6% for 2013-2017<br>3.1% for 2018-2022 |
| Delaware | 5.1% | 5.7% | 5.6% | 3.8% for 2019<br>3.5% for 2020<br>3.25% for 2021<br>3.0% for 2022-2023 |
| Rhode Island | 2.6% | 3.7% | 5.3% | 3.2% for 2019-2022 |
| Oregon | 5.3% | 5.9% | 5.7% | 3.4% for 2021-2025<br>3.0% for 2026-2030 |
| Connecticut | 2.4% | 3.9% | 4.8% | 3.4% for 2021<br>3.2% for 2020<br>2.9% for 2023-2025 |
| **Washington** | **4.1%** | **5.8%** | **6.7%** | **3.2% for 2022-2023**<br>**3.0% for 2023-2025**<br>**2.8% for 2026** |

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group
National Health Expenditure Data: National Health Expenditures by State of Residence, June 2017

Washington State Health Care Authority

# Peterson-Milbank Program for Sustainable Health Care Costs

- Goal to advance state-based efforts to make health care more affordable
- States selected for participation are Connecticut, Nevada, New Jersey, Oregon, and Washington
- Grant includes:
  - Technical assistance on benchmark and cost-driver analysis through Bailit Health
  - Assistance for IT/data development
  - Organized interstate cooperation and education

# HCCTB decision: sources for total health care expenditures

- Medicare
- Medicaid
- Medicare and Medicaid “duals”
- Commercial (fully insured and self-insured)
- L&I’s worker’s compensation (state fund)
- Department of Corrections

# HCCTB decision: cost benchmark

- 70% historic median wage and 30% potential gross state product (PGSP)
- Initial period of 5 years
- Assess impacts annually
- Consider change under "extraordinary circumstances"

| Years | Target |
|---|---|
| 2022 | 3.2% |
| 2023 | 3.2% |
| 2024 | 3.0% |
| 2025 | 3.0% |
| 2026 | 2.8% |

# Upcoming board/advisory activities

- Annual data collection design and implementation
- Report to the Legislature
  - Benchmark baseline: 2022
  - Performance against the benchmark: 2023
- Board review of current cost-related initiatives
- Policy recommendations on general cost mitigation strategies
- Analysis of specific cost drivers

# How could this data be used?

- Highlight variance for purchasers and policymakers
- Create a common expectation
- Access data insights that can help purchasers shape their benefits and sourcing strategies
  - Identify high-performing providers
  - Identify opportunities for improvement
  - Strategically structure network and benefit design to encourage high-value care

# Questions?

# Thank You!

Contact: AnnaLisa Gellermann, HCCT Board Manager
annalisa.gellermann@hca.wa.gov

Board Website:
https://www.hca.wa.gov/about-hca/health-care-cost-transparency-board

# Advisory Committee of Health Care Providers and Carriers

| Name | Title | Place of Business |
|---|---|---|
| Patricia Auerbach | Market Chief Medical Officer | United Healthcare |
| Mark Barnhart | Chief Executive Officer | Proliance Surgeons, Inc., P.S. |
| Bob Crittenden | Physician and Consultant | Empire Health Foundation |
| Bill Ely | Vice President of Actuarial Services | Kaiser Permanente |
| Paul Fishman | Professor, Dept. of Health Services | University of Washington |
| Jodi Joyce | Chief Executive Officer | Unity Care NW |
| Louise Kaplan | Associate Professor, Vancouver | WSU College of Nursing |
| Stacy Kessel | Chief Finance and Strategy Officer | Community Health Plan of Washington |
| Ross Laursen | Vice President of Healthcare Economics | Premera Blue Cross |
| Todd Lovshin | Vice President and WA State Executive | PacificSource Health Plans |
| Vicki Lowe | Executive Director | American Indian Health Commission |
| Mike Marsh | President and Chief Executive Officer | Overlake Hospital and Medical Center |
| Natalia Martinez-Kohler | Vice President of Finance and CFO | MultiCare Behavioral Health |
| Megan McIntyre | Pharmacy Director, Business Services | Virginia Mason |
| | | |
| Mika Sinanan | Surgeon and Medical Director | UW Medical Center |
| Dorothy Teeter | Consultant | Teeter Health Strategies |
| Wes Waters | Chief Financial Officer | Molina HealthCare of Washington |

# Advisory Committee on Data Issues

| Name | Title | Place of Business |
|---|---|---|
| Megan Atkinson | Chief Financial Officer | Health Care Authority |
| Amanda Avalos | Deputy, Enterprise Analytics, Research, and Reporting | Health Care Authority |
| Allison Bailey | Executive Director, Revenue Strategy and Analysis | MultiCare Health System |
| Jonathan Bennett | Vice President, Data Analytics, and IT Services | Washington State Hospital Association |
| Purav Bhatt | Regional VP Operations, Management, and Innovation | OptumCare Washington |
| Bruce Brazier | Administrative Services Director | Peninsula Community Health Services |
| Jason Brown | Budget Assistant | Office of Financial Management |
| Jerome Dugan | Assistant Professor, Department of Health Services | University of Washington |
| Leah Hole-Marshall | General Counsel and Chief Strategist | Health Benefit Exchange |
| | | |
| Scott Juergens | Division Director, Payer Analytics and Economics | Virginia Mason Franciscan Health |
| Lichiou Lee | Chief Actuary | Office of the Insurance Commissioner |
| Josh Liao | Medical Director of Payment Strategy | University of Washington |
| Dave Mancuso | Director, Research and Data Analysis Division | DSHS, Research and Data Analysis |
| Ana Morales | National Director, APM Program | United Healthcare |
| Thea Mounts | Senior Forecast Coordinator | Office of Financial Management |
| Hunter Plumer | Senior Consultant | HealthTrends |
| Mark Pregler | Director, Data Management and Analytics | Washington Health Alliance |
| Julie Sylvester | Senior Consultant, Contracting and Payer Relations | University of Washington Medicine |