Universal Health Care Commission Meeting Summary

February 9, 2023
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
Jane Beyer
Kristin Peterson
Mohamed Shindane
Nicole Gomez

Members absent

Senator Ann Rivers
Senator Emily Randall
Estell Williams
Joan Altman
Representative Joe Schmick
Karen Johnson
Representative Marcus Riccelli
Stella Vasquez

Call to order

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

Agenda items

Welcoming remarks

Chair Lowe welcomed the members of the Commission to the tenth meeting.

Meeting Summary review from the previous meeting

The Commission Members present voted by consensus to adopt the December 2022 Meeting Summary.

Finance Technical Advisory Committee (FTAC) updates

Pam MacEwan, FTAC Liaison, shared with the Commission the agenda, meeting summary, and updates from FTAC's January meeting.

Public comment

Chair Lowe called for comments from the public.

Mike Benefiel, Democratic Precinct Committee Officer (PCO), LD23, shared findings from the Commonwealth Fund's recent report and encouraged the Commission to recommend that the Senate Health Care Committee hold a public hearing on **SB 5335** regarding the Washington Health Trust (WHT).

Kathryn Lewandowsky, Whole Washington, suggested the Commission review Sec. 101 of SB 5335 (WHT) and urged the Commission to recommend that the Senate Health Care Committee hold a public hearing to discuss the bill further and address possible amendments.

Maureen Brinck-Lund thanked the Commission for their work and shared excitement for both Chair Lowe's presentation on the Indian Health Delivery System and further engagement with community members.

Pam Ketzner recognized the federal barriers to including the Medicare-eligible population in a state-based universal system, noting the WHT's plan to transition Medicare into the Trust (Sec. 113 of SB 5335), and urged the Commission to recommend that the Senate Health Care Committee hold a public hearing on the bill.

Paula Lavelle, Whole Washington, recognized the sacrifice of Indigenous peoples and noted that this and other guiding principles of the WHT are outlined in Sec. 1 of the bill.

Andre Stackhouse, Campaign Director, Whole Washington, gathered over 85,000 signatures to get WHT on the ballot to lead the country in establishing health care as a human right for all residents.

Marcia Steadman, Health Care for All Washington, shared that advocates are working with the state Legislature to obtain additional funding to support monthly meetings for the Commission and FTAC, and an FTAC workgroup structure similar to Oregon's Task Force on Universal Health Care.

Cris Currie created a **document** comparing the Washington Health Securities Trust bill with SB 5335 (WHT) as a tool for the Commission. The revised Washington Health Securities Trust bill can be found **here**.

Sarah Weinberg, retired pediatrician, urged that the universal system have universal eligibility – everybody in, nobody out. If initially, parts of Washington's population retain other sources of health coverage, the universal plan can automatically be secondary to that coverage, leaving no one uninsured or underinsured.

Presentation: Lessons for universal health care from the Indian Health Delivery System

Vicki Lowe, Commission Chair, Executive Director, American Indian Health Commission for WA State

The goals of the presentation were as follows: to understand the differences between 1) systems of care and systems of coverage, and 2) direct care and purchase and referred care; to learn about the Jamestown S'Klallam Tribal Health Benefit Program. Chair Lowe noted that this presentation is high-level and may help the Commission think outside of the box of how health care is being done currently.

Indian Health Services (IHS) is a system of care that includes three facility types: IHS, Tribal facilities, and Urban Indian Health Programs. Providers and facilities are funded on an annual basis with funding based and agreed upon services and user population. Like the Veteran's Administration (VA), IHS is a system of care with coverage based on geography. Facility/ provider payments are based on a per person/per year calculation. IHS funding

occurs after services are received. Prior authorizations are needed for referred services which are based on need and availability of funding. Conversely, a system of coverage is based on finding a contracted provider. Here, there are two types of payments: fee-for-service ((FFS) payment *after* providing services), and per member/per month ((PMPM) payments *prior* to providing services). Washington's current health care system focuses on coverage, but the universal system should be more so a system of care. IHS has been chronically underfunded since inception. Purchased and referred care is defined as any care received outside of IHS. Per federal law, hospitals and specialty providers are paid at Medicare rates, or "Medicare Like Rates." Funding for this and other IHS care is appropriated. The Jamestown Tribal Health Benefits Program (Program) is an insurance-based program. Coverage is based on all Tribal Citizens having the same level of coverage regardless of income or eligibility for insurance coverage. Under federal law, IHS programs are required to enroll eligible Tribal users in Medicare or Medicaid before the purchased and referred care dollars can be accessed. The Program wrapped around Medicare, Medicaid, private and employer-sponsored insurance (ESI) to bring each person to the same level of benefits. For example, the Program purchased supplemental benefits for Medicare-eligible individuals and reimbursed members for their Medicare Part B premiums. The Program achieved 100% coverage for Tribal members living in the service area.
Jane Beyer noted that Medicare rates also apply to Medicare Advantage plans.

Bidisha Mandal asked if eligibility was evaluated annually. Chair Lowe replied that members moving out of the Program's service area must notify the Program and Medicare and Medicaid eligible members must update their insurance information annually.

Chair Lowe urged the Commission to think about the level of benefit to provide under the universal system and then decide how to wrap around benefits so that everyone has the same benefits and access to health care. The Jamestown Program could serve as a feasible transition to universal health care. Dave Iseminger asked how often the floor of the Program's benefits was exceeded by another source of coverage, e.g., ESI coverage being richer than the Program's. Chair Lowe clarified that the Program evened out with other sources of coverage in around 2005. Jane Beyer remarked that the Program used braided funding and maximized and combined into one pot revenue from multiple funding sources (IHS, Medicare, Medicaid, ESI) to determine how generous a benefits package could be. Chair Lowe stated that the base fund for the Program was from IHS (funded at 32 cents for every dollar needed) and third-party payments made the Program viable. Dave Iseminger asked if federal policies, e.g., Medicare Like Rates, were connected to Tribes' treaty rights. Chair Lowe confirmed that treaty rights and other advocacy work by Tribal leaders at the federal level helped to secure those rates.

Presentation: Transitional solutions • FTAC guidelines • Goals and measuring success

Liz Arjun, Jon Kromm, and Gary Cohen, Health Management and Associates (HMA)

Jon Kromm, HMA, reviewed the Commission's broad priorities for transitional solutions as determined in 2022. In January 2023, Commission Members provided additional transitional solutions to refine and build upon the 2022 recommendations, including: develop standard benefits across payers; increase the role of consumer/patient engagement; streamline eligibility and enrollment processes; and address workforce shortages to help address system costs. HMA proposed that staff produce a presentation detailing these transitional solutions for the Commission's consideration at their April meeting. Staff would prioritize based on which transitional solutions are high-impact and which are the most feasible for the state to implement. Mohamed Shidane asked whether FTAC's additional suggestions for transitional solutions would come to the Commission for review, and it was decided that that would be the process.

Commission Members voted unanimously to survey FTAC on additional transitional solutions. Commission Members also voted unanimously to adopt the FTAC Charter.

Gary Cohen, HMA, asked what guidance the Commission would like to provide to FTAC for evaluating Medicare eligibility for the new system. Oregon and California examined the Medicare eligibility barriers in a uniform financing system and agree that there is no precedent for a federal waiver that gives a state control over Medicare funds and program administration. This is not to say that a waiver shouldn't be examined, recommended, or pursued. Any pursuit of a waiver should be done soon, as the current administration may be receptive to such a proposal.

Jane Beyer recommended that FTAC look at federal restrictions on a person's ability to shift out of Medicare Advantage (MA) and into Medicare FFS. Additionally, is it better for the state to purchase a Medicare supplemental insurance plan, or to treat the new system like a self-funded plan that wraps around traditional Medicare FFS? Chair Lowe asked what could be done for Medicare beneficiaries living in the state part-time? Dave Iseminger stressed the importance of having coverage for non-Medicare covered services in the retiree community. Can FTAC answer FTAC which, if any, of the Medicare supplemental plans could serve as a starting point, or whether the new system should wrap around Medicare FFS? Dave Iseminger agreed that the federal barriers for shifting out of MA (does not apply for employer-sponsored programs) should be examined by FTAC. HMA added that FTAC could also examine which of the federal MA restrictions are statutory versus regulatory. Dave Iseminger cautioned against taking the path of making the state an MA plan but is interested in FTAC providing any distinctions or flexibilities for the challenges associated with commercial MA. Chair Lowe noted that though the Jamestown S'Klallam program uses funding from multiple sources (IHS, Medicare, Medicaid, etc.), patients view their coverage and experience their care as being under the Tribal program. This should be the same for Medicare beneficiaries, etc. under the new system. Jane Beyer proposed asking FTAC about benefits to having capitated payment per Medicare-eligible persons, versus the state managing wraparound FFS payments.

Pam MacEwan, FTAC Liaison, noted that Medicare is funded via taxes over a person's work life, premiums (Part B once eligible for Medicare), and additional taxes (for certain income levels). Was there consideration of how these might intersect with plans to pull Medicare into the new system? HMA noted that this has not been discussed. Chair Lowe pondered whether the state should purchase for Medicare beneficiaries a Part D plan or create a prescription drug plan. Will this be credible coverage for individuals living in the state part-time? Jane Beyer added potentially exploiting the state's existing relationship with the pharmacy benefits manager (PBM) through PEBB/SEBB. Could FTAC examine the benefits of adding an additional 800,000 people (Medicare beneficiaries) to the state's purchasing power for prescription drugs? Dave Iseminger agreed, noting that Washington and other states leverage this purchasing power through ArrayRx (formerly Northwest Prescription Drug Consortium). Pam MacEwan, FTAC Liaison, encouraged the Commission to provide FTAC specific direction.

Jon Kromm, HMA, proposed that the Commission develop a framework for evaluating transitional solutions and design decisions. Commission agreed on the following broad goals for the universal system: equity; access; affordability; transparency; patient-centeredness; and quality. When asked if goals were missing, Nicole Gomez added ease of use. Mohamed Shidane asked whether the goal of "affordability" referred to consumers or the state. HMA clarified that "affordability" pertained to both. Kristin Peterson added sustainability as a goal, both in terms of consumer affordability and the financing model. The Commission was asked how the list of goals should be prioritized and Chair Lowe suggested moving to the top patient-centeredness and access. Jane Beyer acknowledged there may be conflicting goals, e.g., quality and equity. For example, the new system should cover services that work (based on evidence), but such evidence is based on white, middle-class individuals. When

discussing care that is high-quality or "evidence-based," immediately there are equity implications. Dave Iseminger recommended listing goals in alphabetical order, and Nicole Gomez recommended organizing the goals in a circle (visually).

The Commission voted unanimously for staff to develop a framework for evaluation of design decisions and transitional solutions.

Adjournment

Meeting adjourned at 5:00 p.m.

Next meeting

April 11, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.