

Universal Health Care Commission

January 4, 2022

Universal Health Care Commission

Meeting materials

January 4, 2022
2:00 p.m. – 4:00 p.m.

(Zoom attendance only)

Meeting materials

Meeting agenda	1
Written and verbal comments	2
Meeting summary.....	3
Presentation: Single payer and universal coverage health systems	4
Presentation: Universal Health Care Work Group report	5
Presentation: WA's coverage and impacts of the public health emergency	6
Public comment on Commission charter.....	7
Discussion and approval of Commission charter	7

Background material

Comments and questions from Zoom chat	8
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Agenda

TAB 1

Universal Health Care Commission

January 4, 2022
2:00 p.m. – 4:00 p.m.
Zoom Meeting

AGENDA

Commission Members:

<input type="checkbox"/>	Vicki Lowe, Chair	<input type="checkbox"/>	Estell Williams	<input type="checkbox"/>	Kristin Peterson
<input type="checkbox"/>	Senator Ann Rivers	<input type="checkbox"/>	Jane Beyer	<input type="checkbox"/>	Representative Marcus Riccelli
<input type="checkbox"/>	Bidisha Mandal	<input type="checkbox"/>	Joan Altman	<input type="checkbox"/>	Mohamed Shidane
<input type="checkbox"/>	Dave Iseminger	<input type="checkbox"/>	Representative Joe Schmick	<input type="checkbox"/>	Nicole Gomez
<input type="checkbox"/>	Senator Emily Randall	<input type="checkbox"/>	Karen Johnson	<input type="checkbox"/>	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
2:05-2:10 (5 min)	Roll call		Mandy Weeks-Green, Manager Health Care Authority
2:10-2:25 (15 min)	Public comment	2	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
2:25-2:30 (5 min)	Approval of meeting summary from November 30, 2021	3	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
2:30-2:55 (25 min)	Single payer and universal coverage health systems	4	Stephanie Lee, Director Washington State Institute for Public Policy
2:55-3:25 (30 min)	Universal Health Care Work Group report	5	Liz Arjun, MPH, MSW, Senior Consultant Health Management Associates and Shane Mofford Public Policy Insights
3:25-3:45 (20 min)	Washington's coverage and impacts of the public health emergency	6	Wei Yen, Senior Forecast and Research Analyst Office of Financial Management
3:45-3:55 (10 min)	Public comment on Commission charter	7	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
3:55-4:00 (5 min)	Discussion and approval of Commission Charter	7	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
4:00	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.

Written and verbal comments

TAB 2

Public comment



Universal Health Care Commission

Written and verbal comments

Received between November 30 and December 18, 2022

Written comments submitted by email

M. Benefiel	3
R. Yrajanson	3

Comments and questions shared by attendees during the November 30 meeting:

Zoom video recording	
Comments and questions from Zoom chat	8
Meeting summary	2

Written comments submitted by email

(Received between November 30 and December 18, 2021.)

Submitted by: Mike Benefiel

Date: December 3, 2021

UHC Committee,

The World Health Organization defines universal health care (UHC) as follows:

"UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course."

The Healthcare Lobby would like us to believe that UHC can include Medicaid, Medicare, Cascade Care and employer-based coverage costing individuals over \$20,000/year. They also promote the idea that providing expensive, un-affordable policies via the Exchange constitutes "access" and can be a part of a UHC system even if people can't afford the policies.

I hope your Commission will heed the definition of the World Health Organization and not the HC Lobby.

I also hope you consider that over 20 studies, including one funded by WA taxpayers ALL agree that a single-payer UHC would provide (not give access to) ALL WA residents comprehensive healthcare and save individuals thousands of dollars (\$5 billion over all).

It is critical to act quickly as many residents are needlessly suffering and dying due to our horrible healthcare system. Also many are facing bankruptcy and the possible loss of their homes.

Whole Washington along with some WA legislators believe that the questions that you've been tasked to answer have already been answered and incorporated into a bill, SB 5204 which is ready to provide the needed healthcare system for WA.

I respectfully request that you review the work that has already been accomplished and vetted as established in SB 5204. I understand that the powerful HC Lobby is putting a lot of pressure to push the implementation of a single-payer healthcare system down the road indefinitely.

I hope you will heed the needs of the people.

Thank you,

Mike Benefiel

Submitted by: Richard E. Yrjanson

Date: December 12, 2021

I am 81 year old health care worker (retired) who has seen the health care system in the United States of America going from good, better, best, to best, better, good, WORST. Wait times, quality of care, concern for the patient, costs, and the whole system of health care is now is in turmoil. Twelve hour wait times is becoming the normal. Dental care is not controlled, follow up appointments in HMO's PPO's and the Advantage Insurance in a drag on the quality of health care.

The introduction of Universal Health Care into this mismanaged health system will only add further confusion and failure to improve the system. The typical cry of "WASHINGTON STATE WILL BE THE FIRST IN THE NATION TO OFFER ????" .. Take a look at the Long Term Care Insurance Fund, which will be taking .58 % out of the salaries of the working people, called a "premium" but it is a income tax, and will only offer benefits for 1 year and only pay \$36,000 max; and you are dropped, you can not take it with you if you leave the state, and it goes on and on shows what a 14 page bill 4 years ago, failed twice, passed 2 years ago has spent millions getting ready for 2022 start date, and they changed the name to Washington Cares Fund {see above file). When you take .58% out of \$180 billion dollars in workers salary it adds up in hurry, The Fund realized or wanted more money they wanted to invest the tax money in the stock market which is unconstitutional in the state

You can see that being first in the Country is costly and Universal Health Care will make the Washington Cares Fund look very small in comparison. It was not approved by the voters and the present system of health care funding has been abused and should be thoroughly examined before any further health care (money bills) are placed on the legislature adjenda

Copies of this email will be forwarded to appropriate members of the House and Senate.

Richard E. Yrjanson

November meeting summary

TAB 3

Universal Health Care Commission meeting summary

November 30, 2021

Health Care Authority

Meeting held electronically (Zoom) and telephonically

1:00 p.m. – 3:00 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

Dave Iseminger

Senator Emily Randall

Estell Williams

Jane Beyer

Joan Altman

Representative Joe Schmick

Kristin Peterson

Representative Marcus Riccelli

Mohamed Shindane

Nicole Gomez

Stella Vasquez

Members absent

Senator Ann Rivers

Bidisha Mandal

Karen Johnson

Call to order

Vicki Lowe, Commission Chair, called the meeting to order at 1:02 p.m.

Agenda items

Welcoming remarks

Ms. Lowe welcomed the members of the Commission to the first meeting. Ms. Lowe provided an overview of the agenda and discussed commission members' roles and responsibilities and the work of the commission.

Presentation: About the Commission: legislation and history

Mich'l Needham, Chief Policy Officer at the Health Care Authority, presented an introduction to the Universal Health Care Commission and its history, including the information on the Universal Health Care Work Group. In 2019, the Washington State Legislature passed House Bill 1109 which created a work group to provide

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Universal Health Care Commission meeting summary

11/30/2021



recommendations on how to create, implement, maintain, and fund a universal health care system. In January 2021, the work group submitted its final report and recommendations to the Legislature.

The Legislature then passed Senate Bill 5399, which established the Universal Health Care Commission based on both the work group's recommendations and advocacy of this work by the public. One of the goals of the Commission is to create immediate and impactful changes in the health care access and delivery system in Washington. Additionally, the Commission must 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.

The legislative charge of SB 5399 was also outlined. By November 1, 2022, the Commission will submit a report and recommendations to the Legislature and the Governor and post them on the Health Care Authority's (HCA) website. After November 1, 2022, the Commission will continue to identify ways to implement recommendations and structural changes to prepare the state for a transition to a universal health care financing system. By November 1, 2023, and annually thereafter, the Commission will submit annual reports and recommendations to the Legislature and the Governor. The Commission's work is ongoing as constituted in legislation and does not have an end date to its work.

The makeup of the Commission was outlined. Members include the Office of the Insurance Commissioner (OIC), Health Care Authority (HCA), Washington State Department of Health (DOH), Washington Health Benefit Exchange (HBE), Office of Equity, Legislative members from each caucus (4), and six members appointed by the Governor with knowledge of health care coverage, access, and financing, including at least one consumer representative and one Tribal government representative.

The following are goals laid out by legislation: 1) meet every other month to review opportunities to increase access to health care services and health coverage, reduce health care costs and health disparities, improve quality, and prepare for transition to a unified health care financing system, and 2) develop a strategy for implementing changes. To achieve these goals, the Commission will summarize past efforts, examine data and reports, assess the state's current preparedness, and develop recommendations for the Legislature.

Presentation: Open public meetings training

Katy Hatfield, an Assistant Attorney General (AAG) with the Office of the Attorney General, Government Enforcement and Compliance Division, provided open public meetings training. After receiving this training today, each member of the Commission must complete refresher training at intervals of no more than four years. The Commission is subject to Washington's Open Public Meetings Act (OPMA) of 1971, requiring the governing body of a public agency to be open to the public to make government affairs more open, accessible, and responsive. The courts interpret the OPMA liberally, except for when there are grounds for maintaining confidentiality, such as executive sessions.

Several terms were defined, including "public agency," "governing body," "action" and "final action," "meeting," "regular meeting," and "special meeting." It was noted that while a meeting occurs when a governing body takes any action, *final action* is not necessary for a meeting to take place. It was also noted that passive receipt of emails does not constitute participation in a meeting. Caution was urged in *replying all* to an email, as replying all to an email could be considered participation in a meeting.



Any member of the public may attend the meetings of the governing body of a public agency and the agency cannot establish conditions of attendance. Cameras and tape recorders are permitted unless disruptive. Though not required, if a governing body allows public comment, they have the authority to limit the time of speakers to a uniform amount and can limit the topics speakers may address. Reasonable rules of conduct can be set. The OPMA provides a procedure for remedying situations where a meeting is being interrupted. There are requirements to record meeting minutes, though no format is specified by law. Minutes of all regular and special public meetings must be promptly recorded and open to public inspection. Violating the OPMA subjects' members to penalties including nullification of actions taken, civil penalties, and an award of costs and attorney fees to the person alleging an OPMA violation.

Some portions of the OPMA have been modified due to COVID-19 and the issuance by the Governor of Proclamation 20-28 which prohibits in-person public meetings and waives and suspends certain OPMA laws. On January 15, 2021, the Legislature passed Senate Concurrent Resolution 8402, extending the emergency proclamation until the termination of the state of emergency, or until rescinded, whichever occurs first. The most significant modification to the OPMA allows agencies to hold open public meetings without requiring a physical location.

Review of draft charter and operating procedures:

Mandy Weeks-Green, Coverage and Market Strategies Manager at the Health Care Authority, reviewed the Commission's draft charter and operating procedures. It was noted that the Commission will possibly vote on the charter at the Commission's next meeting in January 2022. Members with comments or questions regarding the draft charter should email Ms. Weeks-Green by December 17, 2021.

In the draft charter, the *Vision*, *Mission*, and *Commission's Charge* sections, were developed from the legislation (SB 5399) that created the Commission, as was the subsection on *Membership and Terms*. The *Members' Responsibilities* subsection is in part informed by other boards and commissions such as the Health Care Cost Transparency Board, and in part by the legislation. The subsection, *Principles*, utilizes the legislation to create a foundation for adopting and making recommendations. Expectations of Commission members and of their interactions with other Commission members and the public can be found in the *Operations* section.

Review of draft charter and operating procedures:

The 2022 meeting schedule was shared with the Commission. There is only one Commission meeting during Legislative Session, after which the Commission will meet bi-monthly.

Public Comment

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

Jeff Silverman remarked that he enjoyed Ms. Hatfield's presentation on the OPMA. (Written)

Commission member Representative Marcus Riccelli, Washington State House of Representatives, 3rd Legislative District, commented that the February 25 Commission meeting during legislative session may be a conflict for Commission members who are also members of the Legislature. (Verbal)

Paul Oldenkamp asked whether there would be an opportunity to submit written comments. (Written)

DRAFT

Universal Health Care Commission meeting summary

11/30/2021



Commission member Nicole Gomez, Co-founder of Alliance for Health Washington, posted the Commission's website link. (Written)

Tamarra Henshaw, Executive Assistant, Policy Division at the Health Care Authority, posted Mandy Weeks-Green's email contact information. (Written)

Commission member Representative Marcus Riccelli clarified that February 25 is the policy cutoff for the Opposite House during legislative session and though there is no floor action, committees may be busy. (Written)

Marcia Stedman stressed the importance of HCA's applying for federal waivers as part of the Commission's legislative charge. (Verbal)

Jeff Silverman, a computer expert, offered his services to the Commission for technical matters. (Verbal and written)

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)

Jeff Silverman provided his email contact information. (Written)

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)

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

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

Dave Iseminger, Commission member and Director of the Employees and Retirees Benefits Division at HCA, reminded members of the public to use discretion when providing personal or contact information as it will be part of the public record. (Verbal)

Dr. Sarah Weinberg described the work of the Blue-Ribbon Commission on Health Care Costs and Access (2006) and that none of their recommendations (final report, 2007) were implemented. She advised the Commission to read their final report (state of Washington's website) to learn from that Commission's mistakes, and suggested interviewing Representative Eileen Cody who was a member of that Commission. (Verbal)

Commission member Nicole Gomez posted to the chat a link to the final report from the Blue-Ribbon Commission on Health Care Costs and Access. (Written)

Vicki Lowe (Chair) proposed starting Commission meetings with public comment. (Verbal)

Kelly Powers agreed with having public comment at the beginning of a meeting for better participation. (Written)

Commission member Dave Iseminger asked for clarification on whether the Commission will take public comment at the end of meetings unless action is being taken, in which case public comment would precede the action being taken. (Verbal)

Mandy Weeks-Green (HCA), clarified that public comment could precede any action being taken. (Verbal)

Vicki Lowe (Chair) asked for input on whether public comment should be open at the beginning of a meeting and/or precede any action being taken. (Verbal)

Commission member Nicole Gomez agreed that public comment being open at the beginning of a meeting could help members of the public to submit comments if a meeting ended early. (Verbal)

Commission member Representative Marcus Riccelli agreed that if the agenda becomes available ahead of the meeting, it would be okay that public comment precedes action being taken but suggested that it be for a specific period. (Verbal)

Jen Nye inquired as to whether written comments would be part of the public record. (Written)

Vicki Lowe (Chair) and Katie Hatfield confirmed that comments in the chat would be part of the public record. (Verbal)

Mandy Weeks-Green (HCA) confirmed that any comments submitted to the Commission's email address will be distributed to the Commission. (Verbal)

Jeff Silverman asked whether public comments could be given via the Zoom chat during the meeting. (Written)

Paul Oldenkamp asked whether Zoom settings could be changed to allow participants to save the Chat. (Written)

Tamarra Henshaw (HCA) remarked that she captures all comments from the chat and sends them to Mandy for dissemination to the Commission. (Verbal)

Jeff Silverman remarked that he used the USPS to send a letter to Bob Ferguson. (Written)

Bonnie Morris asked that the Commission's email information be posted in the Zoom Chat. (Written)

Hal Stockbridge asked comments posted in the chat after the meeting can be viewed by the public and asked for the URL for the page that will display public comments. (Written)

Kathryn Lewandowsky thanked the Commission for their participation and work and expressed hope that this work will be beneficial to citizens of Washington. (Written)

Jeff Silverman posted a link to the procedure to saving a Chat. (Written)

Leni Skarkin remarked that members of the public cannot save links, etc. in the Chat. (Written)

Mandy-Weeks Green (HCA) posted the Commission's email contact information to the Chat. (Written)



Consuelo Echeverria asked what is being done to ensure outreach to and engagement with rural communities with limited access to broadband, and refugee and immigrant communities with limited digital literacy. (Verbal and written)

Vicki Lowe (Chair) asked for further comment on the vision and mission statements of the draft charter. (Verbal)

Deana Knudsen, Hospital Commissioner, Hospital District No.2, stressed the importance of HCA obtaining 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)

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)

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

Tamarra Henshaw (HCA) posted the Commission's email address and the link to Zoom meeting information and recordings. (Written)

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)

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

Jeff Silverman gave a commendation to everyone for a nice meeting. (Written)

Paul Oldenkamp provided the procedure for enabling participants to save the chat. (Written)

Marcia Stedman urged the Commission to view the Universal Health Care Workgroup's timeline to serve as a guide for their work. (Verbal)

Adjournment

Meeting adjourned at 2:48 p.m.

Next meeting

Tuesday, January 4, 2022

Meeting to be held on Zoom

2:00 p.m. – 4:00 p.m.

Presentation: Single payer and universal coverage health systems

TAB 4

Single-Payer & Universal Coverage Health Systems

WASHINGTON STATE INSTITUTE FOR PUBLIC POLICY

Stephanie Lee, Director

Washington
Universal
Health Care
Commission

January 4, 2022

WASHINGTON STATE INSTITUTE FOR PUBLIC POLICY

Non-partisan research at legislative/board direction

WSIPP Board of Directors

Senator Chris Gildon,
Co-Chair

Senator Andy Billig

Senator Marko Liias

Senator Mark Schoesler

Kim Johnson, Senate Staff Dir.

David Schumacher, OFM

Sarah Norris Hall, UW

John Carmichael, TESC

Representative Larry Springer,
Co-Chair

Representative Larry Hoff

Representative Cyndy Jacobsen

Representative Timm Ormsby

Jill Reinmuth, House Staff Dir.

Keith Phillips, Gov. Policy Dir.

Vacant, WWU

Bidisha Mandal, WSU

STUDY ASSIGNMENT

The 2018 Legislature directed the Washington state institute for public policy to conduct a study of single payer and universal coverage health care systems.

The study shall:

- a) Summarize the parameters used to **define universal coverage, single payer, and other innovative systems**;
- b) Compare the **characteristics** of up to **ten universal or single payer models** available in the United States or elsewhere; and
- c) Summarize any available research literature that examines the effect of these models on outcomes such as **overall cost, quality of care, health outcomes, or the uninsured**.

Engrossed Substitute Senate Bill 6032, Section 606(15), Chapter 299, Laws of 2018.

FOCUS FOR TODAY'S PRESENTATION

- ✓ Single-payer versus multi-payer systems
- ✓ Describe single-payer systems in comparison countries
 - Example: Canada
- ✓ Describe multi-payer universal coverage systems in comparison countries
 - Examples: Germany, Switzerland, the Netherlands
- ✓ Review cost drivers between the US and comparison countries, and the mechanisms to control those costs in other countries

SINGLE-PAYER HEALTH CARE

- ✓ Single public plan would automatically enroll individuals with:
 - ✓ Medicaid,
 - ✓ Medicare,
 - ✓ Employer-sponsored insurance,
 - ✓ Individual coverage, and
 - ✓ Those without insurance.
- ✓ Private insurance would be eliminated or confined to supplemental coverage.
- ✓ Cost sharing would be reduced or eliminated across the board and enrollee premiums would be eliminated.
- ✓ There would be a single set of provider payment rates.

SINGLE-PAYER FINANCING

- ✓ Roughly \$55 billion was spent on medical care in 2018 for Washington residents.
- ✓ About half of the spending is covered by Medicaid and Medicare. Most of the remainder is financed by employer-sponsored insurance.
- ✓ Single-payer funding proposals assume that federal and state health care spending would be pooled to help finance state single-payer plans.
- ✓ Employer and employee premiums, individual premiums, and cost-sharing payments would be replaced by additional tax revenue.
- ✓ Friedman (2018) estimates that \$28 billion in additional revenues would be needed to implement single-payer in Washington.

SINGLE-PAYER PROS AND CONS

Advantages

- More equal and universal access to care;
- Centralized administration; and
- Potential cost savings.

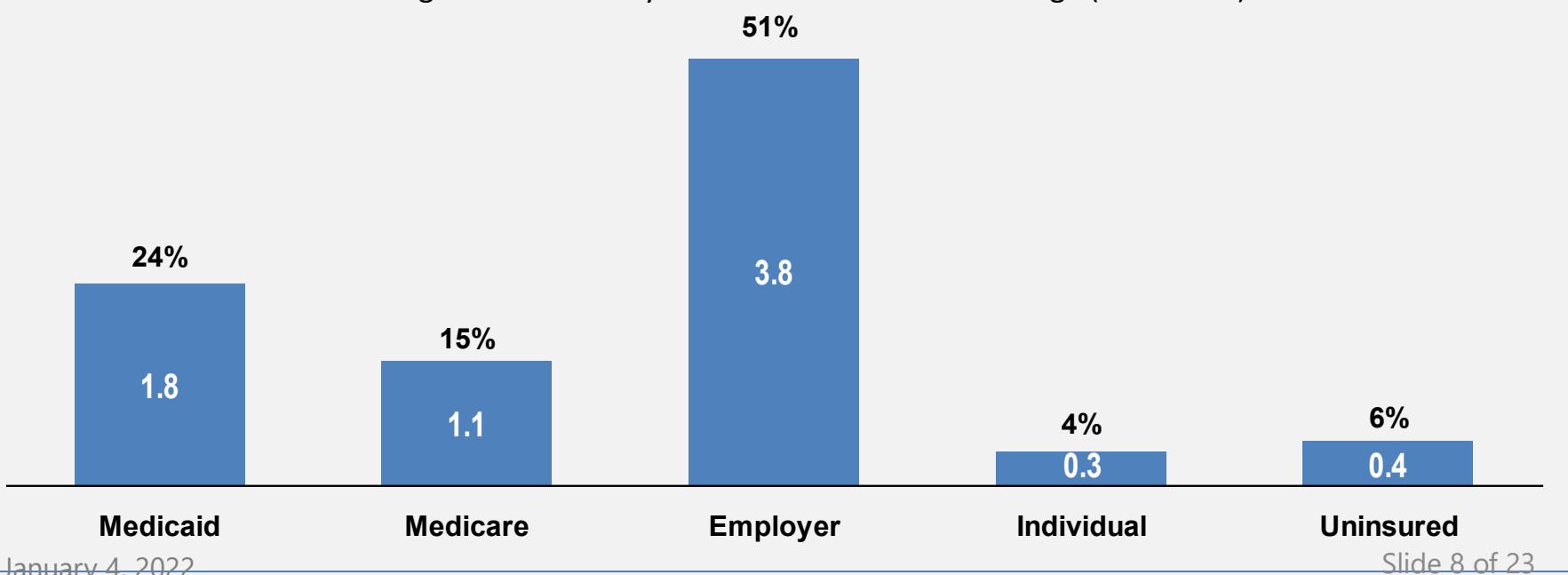
Disadvantages

- Public concerns—higher taxes, government control, excessive rationing of care;
- Possible underfunding;
- Disruption to employment; and
- Implementation challenges.

SINGLE PAYER IMPLEMENTATION CHALLENGES

- ✓ Single-payer funding proposals rely on pooling federal health care spending to help pay for state plans.
- ✓ State single-payer initiatives are limited by the federal law regulating employee benefits, the Employee Retirement Income Security Act of 1974 (ERISA).

Washington Residents by Source of Healthcare Coverage (in millions)



HEALTH CARE SYSTEMS IN COMPARISON COUNTRIES

Single-Payer Countries

- ✓ National health services—many hospitals and clinics are government-owned and many physicians are government employees
 - United Kingdom
 - Scandinavian countries
- ✓ National health insurance systems—providers are typically private and are reimbursed through a tax-financed government plan
 - Canada
 - Australia

HEALTH CARE SYSTEMS IN COMPARISON COUNTRIES

Multi-Payer Countries

- ✓ Mandatory health insurance systems
 - Germany
 - France
 - The Netherlands
 - Switzerland
- ✓ Coverage administered through multiple, mostly nonprofit, insurers
- ✓ People are free to choose among insurers and can change plans – but, required to have coverage
- ✓ Insurers are required to accept all applicants
- ✓ Financing varies across countries (payroll taxes, premiums, out-of-pocket spending)

GOVERNMENT ROLES IN HEALTH CARE MARKETS

- ✓ How governments intervene in health care markets varies across these countries.
- ✓ However, in both the single-payer and multi-payer countries we reviewed **governments play active roles** in health care markets.
 - Regulate insurers (control margins)
 - Subsidize coverage for residents with low incomes
 - Determine standardized benefit packages
 - Control (to varying degrees) prices of medical services and pharmaceuticals

CANADA

Single payer, national health insurance system

- ✓ Financed by provincial and federal tax revenue
- ✓ Benefits vary across provinces
- ✓ All residents covered by universal public insurance
- ✓ Two-thirds also purchase private supplemental coverage
- ✓ No out-of-pocket cost for medically necessary hospital and physician services
- ✓ Relatively long wait times for specialists, elective surgeries
- ✓ Cost controls:
 - ✓ Negotiated physician fee schedules
 - ✓ Health technology assessments
 - ✓ Low administrative costs

GERMANY

Multi-payer system, statutory health insurance

- ✓ Financed through payroll tax (split by employers and employees)
- ✓ Mandatory insurance administered by competing non-profit insurers
 - Federal price list discourages insurers to compete on premiums
- ✓ Insurers cannot deny coverage
- ✓ Standardized benefit package with caps on cost-sharing and protections for unemployed
- ✓ Can purchase substitutive coverage instead (11%)
- ✓ Cost controls:
 - ✓ Fees are negotiated between provider associations and insurers
 - ✓ Pharmaceuticals are reference priced
 - ✓ Health technology assessments

SWITZERLAND

Multi-payer system, mandatory health insurance

- ✓ Financed by premiums, taxes, and out-of-pocket spending
- ✓ Mandatory insurance administered by competing non-profit insurers
 - Insurers compete on price
- ✓ Insurers cannot deny coverage
- ✓ Standardized benefit package; gov't subsidizes premiums for low-income people
- ✓ Can also purchase supplemental coverage
- ✓ Cost controls:
 - ✓ Fees are negotiated between provider and insurer associations at the canton-level;
 - ✓ Gov't sets fees if associations can't agree

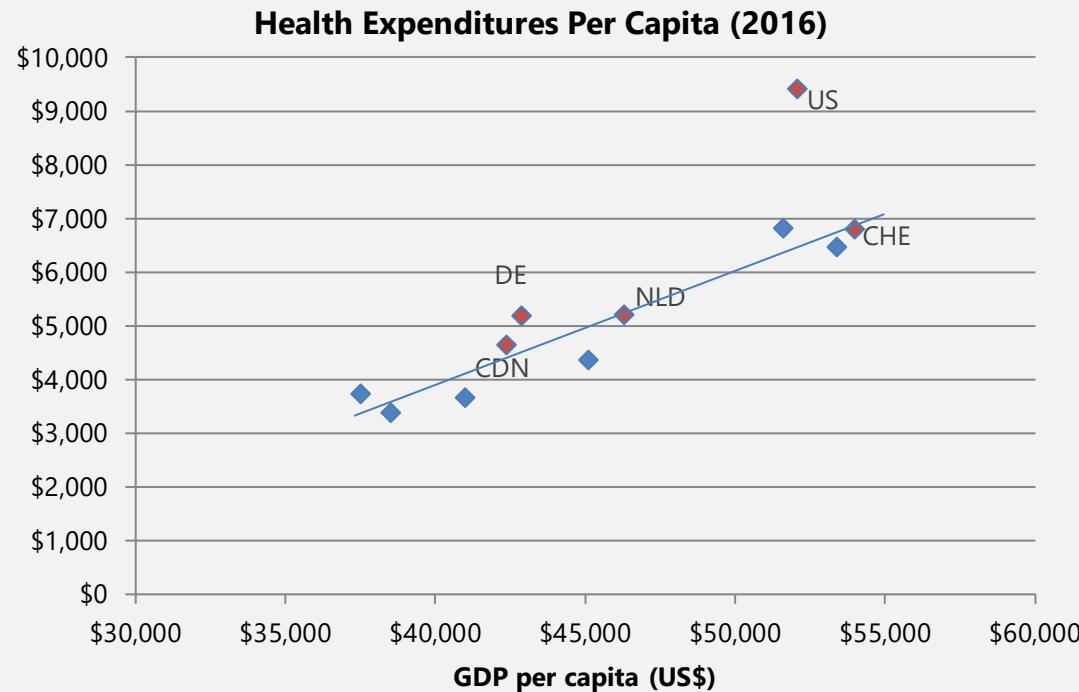
THE NETHERLANDS

Multi-payer system, statutory health insurance

- ✓ Financed through premiums, payroll taxes, general tax revenue
- ✓ Mandatory insurance administered by competing non-profit insurers
 - Insurers compete on price
- ✓ Insurers cannot deny coverage
- ✓ Standardized benefit package; gov't subsidizes premiums for low-income people
- ✓ Can also purchase supplemental coverage
- ✓ Cost controls:
 - ✓ Gov't sets prices for GP, some hospital services, pharmaceuticals
 - ✓ Gov't brokers agreements with insurers and providers on annual expenditure growth targets

HEALTH CARE COST COMPARISONS

- ✓ US spends about 18% of GDP on health care; the other countries 11%
- ✓ US spends \$9,400 per person on health care; the other countries, on average, \$5,000



MAJOR FACTORS DRIVING COST DIFFERENCES

Higher costs in the US are largely due to:

- ✓ Higher prices of medical services and goods (with *pharmaceutical costs* playing an especially important role)
- ✓ Higher utilization of high-margin procedures and advanced imaging (CTs, MRIs)
- ✓ Higher administrative costs, and in the long-term
- ✓ More extensive diffusion of newer medical technologies and drugs with modest or uncertain effectiveness

PHARMACEUTICALS

US spends \$1,440 per person per year on pharmaceuticals versus an average of \$670 for the comparison countries.

The comparison countries have achieved lower spending through:

- ✓ Centralized price negotiations with pharmaceutical companies
- ✓ National drug formularies (i.e. a list of drugs covered by insurance)
- ✓ Cost-effectiveness research to set price ceilings for new and existing drugs
- ✓ Use of reference pricing for pharmaceuticals

HIGH-MARGIN PROCEDURES

The United States has relatively high utilization of some costly procedures and tests; for example:

- ✓ Knee replacements
- ✓ Hysterectomies,
- ✓ Cesarean deliveries,
- ✓ Cataract surgery,
- ✓ Coronary artery bypass,
- ✓ Coronary angioplasty, and
- ✓ Advanced imaging (MRIs and CTs).

In the US, these procedures are more frequent than in other countries, as well as higher cost.

ADMINISTRATIVE COSTS

Insurer Administrative Costs (% of health expenditures)

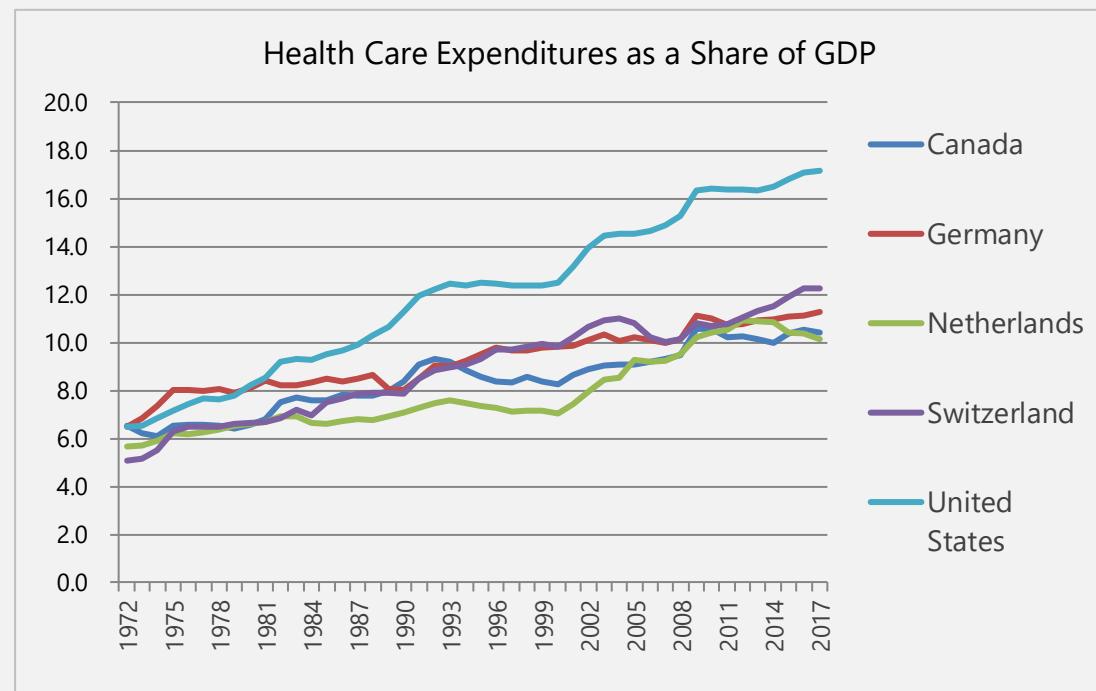
- ✓ Single-payer countries (UK, Canada, Sweden) – 2% to 3%
- ✓ Multi-payer countries (Germany, Netherlands, Switzerland) – 4% to 5%
- ✓ United States – 8%

Provider Administrative Costs

- ✓ Physicians and hospital administrative costs related to billing and insurance-related activities contribute to the higher health care costs in the US.

TECHNOLOGICAL INNOVATION

- ✓ Economists attribute much of the long-term growth in health care costs to technological change (new devices, procedures, drugs)
- ✓ Higher cost escalation in the US attributed to more rapid and less controlled, diffusion of new medical technologies.
- ✓ Washington State
 - HCA's Health Technology Assessment program
 - BREE Collaborative
 - Washington Pharmacy and Therapeutics Committee



CONCLUSION

- ✓ There are multiple examples of universal coverage systems in countries similar to the US. These include single-payer and multi-payer models.
- ✓ Compared to these similar countries:
 - The US spends more per capita and relative to GDP on health care
 - Quality of care and health outcome comparisons are mixed
 - Wait times are relatively shorter than in single-payer countries

It is not clear to what extent other countries' systems and policies, governmental controls, and taxation systems are translatable to the US.

THANK YOU

Questions?

stephanie.lee@wsipp.wa.gov

APPENDIX A

Additional factors driving differences in health care costs between the US and comparison countries

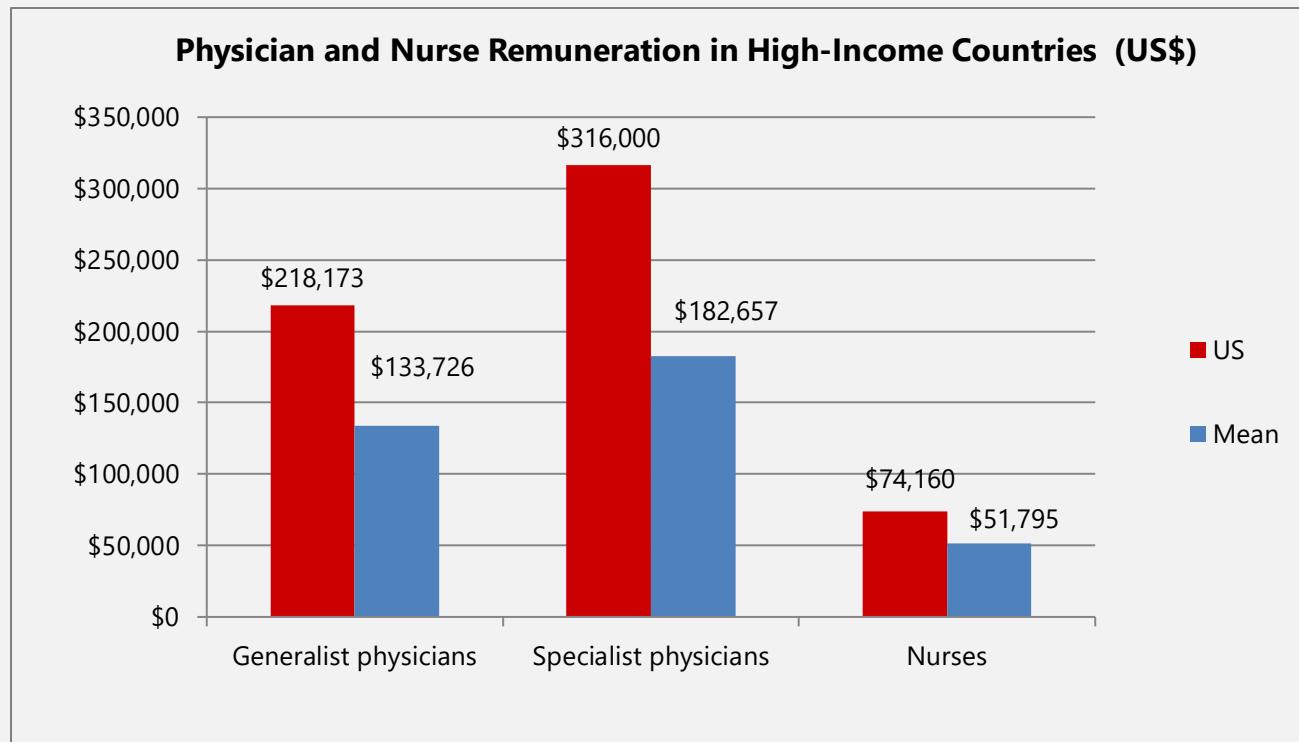
PROVIDER FEES AND BUDGETS

Fee setting and cost control measures vary across countries.

- ✓ Some governments set fees for physician services and hospitals (through negotiations)
- ✓ Some set global budgets to control health expenditures
- ✓ Some broker collective agreements with insurers and providers on cost growth targets
- ✓ Negotiations are often conducted between insurer and provider associations at the national or regional level (rather than individual insurers and providers)

PHYSICIAN COMPENSATION

- ✓ Physicians and nurses earn substantially more on average in the US
- ✓ Variation in physician remuneration accounts for roughly 4% of the difference in overall health care spending between the US and these other countries.

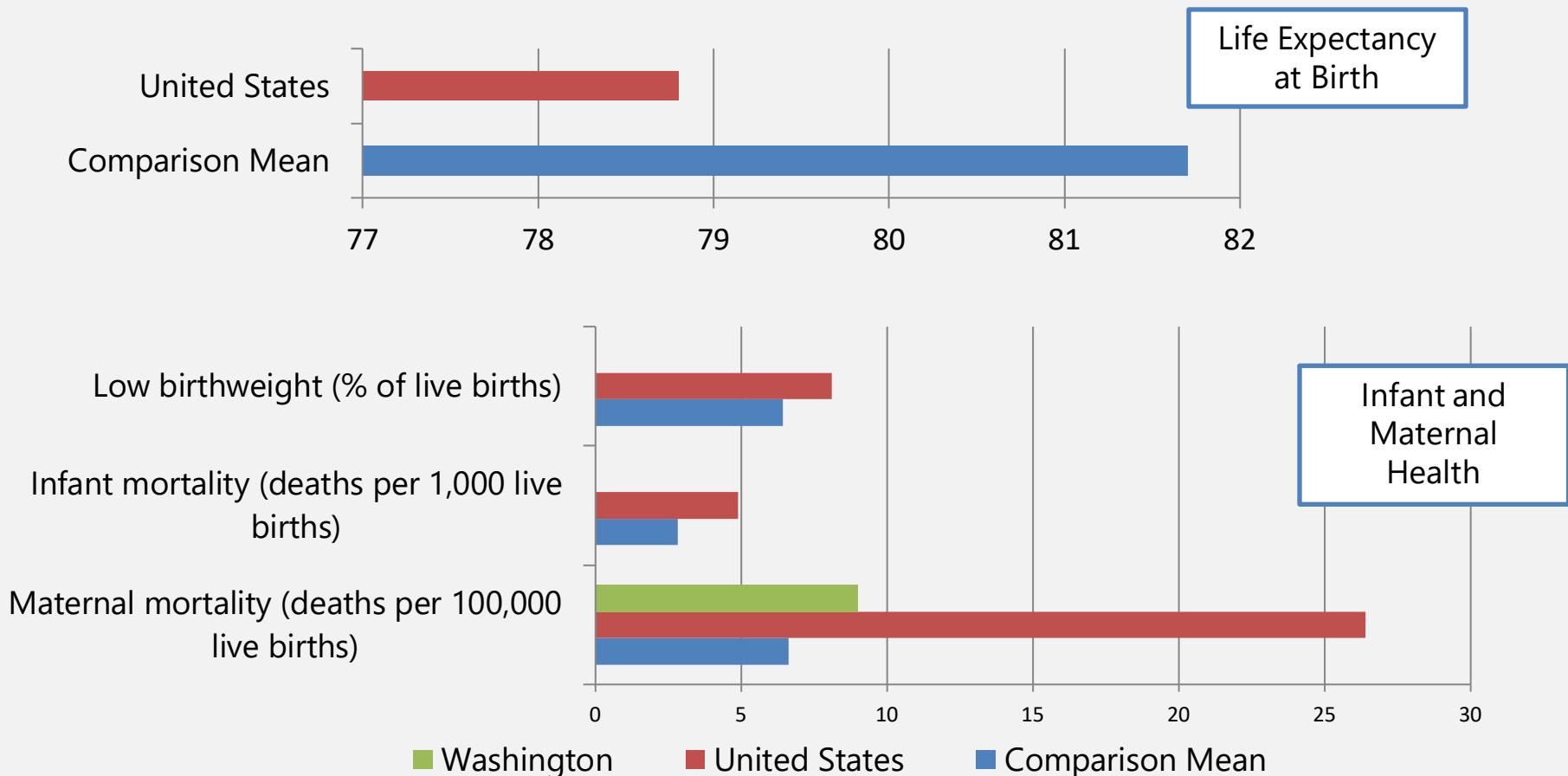


APPENDIX B

Selected indicators of health outcomes
and quality of care

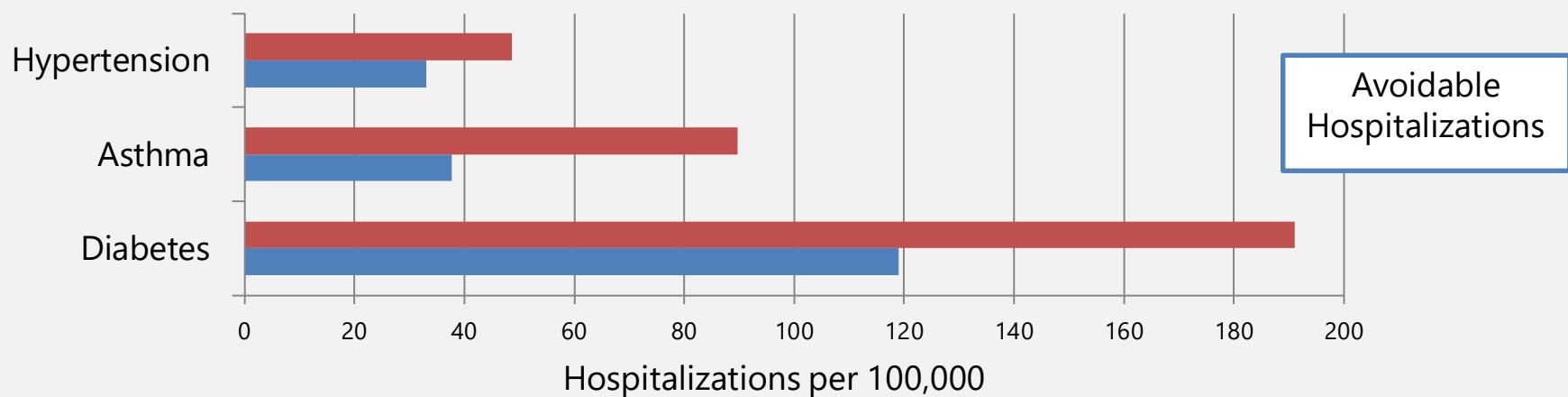
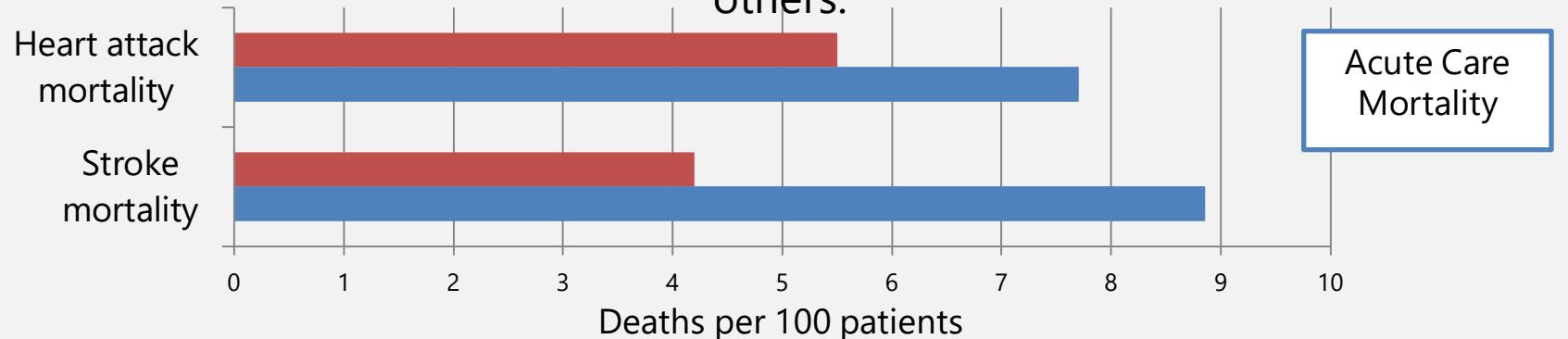
HEALTH OUTCOMES

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.



QUALITY OF CARE

The US performs well on some measures of the quality of its care and poorly on others.

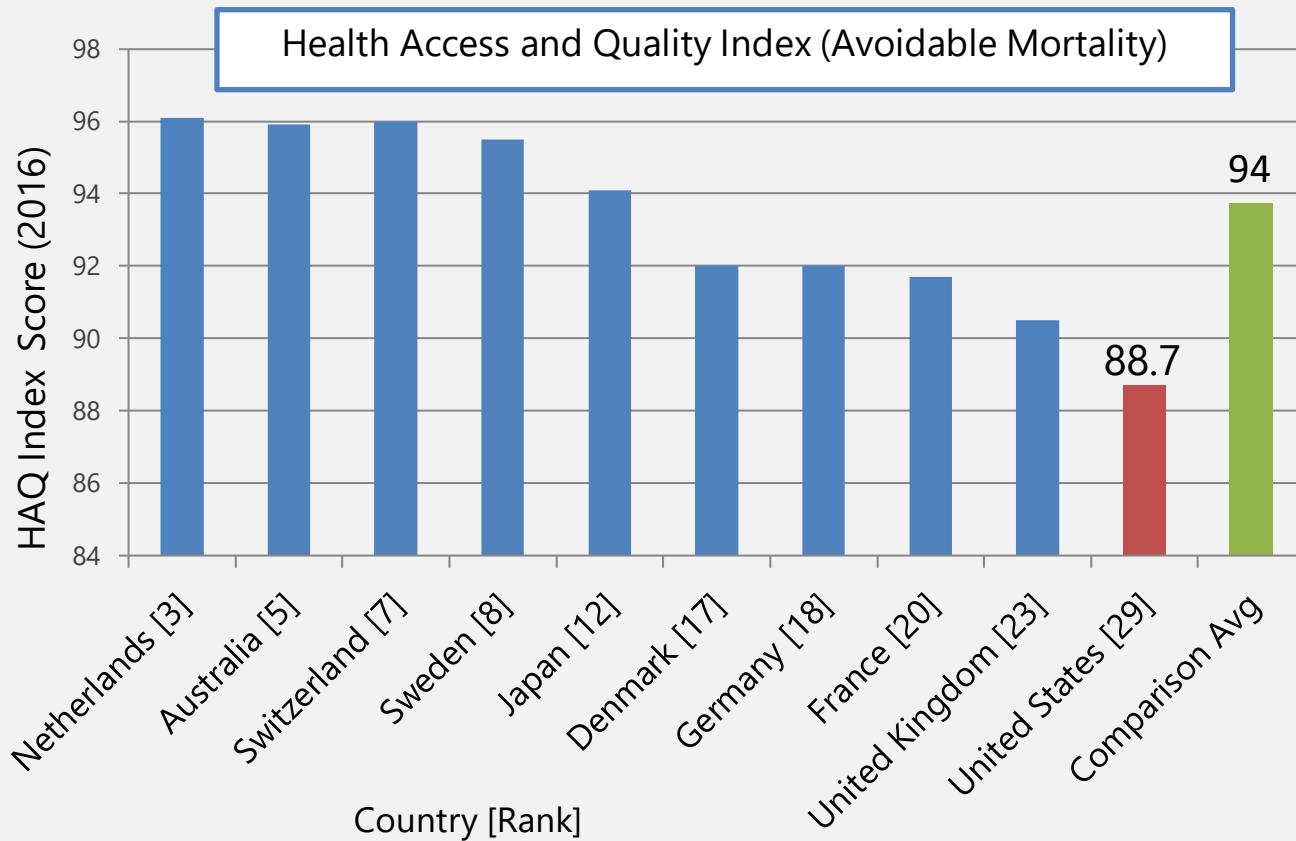


■ United States

■ Comparison country average

QUALITY OF CARE

On an often cited summary measure—avoidable mortality—the US ranks below high-income countries with universal health care.



HAQ index measures:

- ✓ Vaccine-preventable diseases,
- ✓ Infectious diseases,
- ✓ Non-communicable diseases (e.g., cancers, diabetes),
- ✓ Maternal and child health, and
- ✓ Gastrointestinal conditions (e.g., appendicitis)

Presentation: Universal Health Care Work Group report

TAB 5

Washington's Universal Health Care Work Group: Background and Findings

**Washington Universal
Health Care
Commission**

January 4, 2022

Liz Arjun, Senior Consultant,
HMA

Shane Mofford,
Public Policy Insights

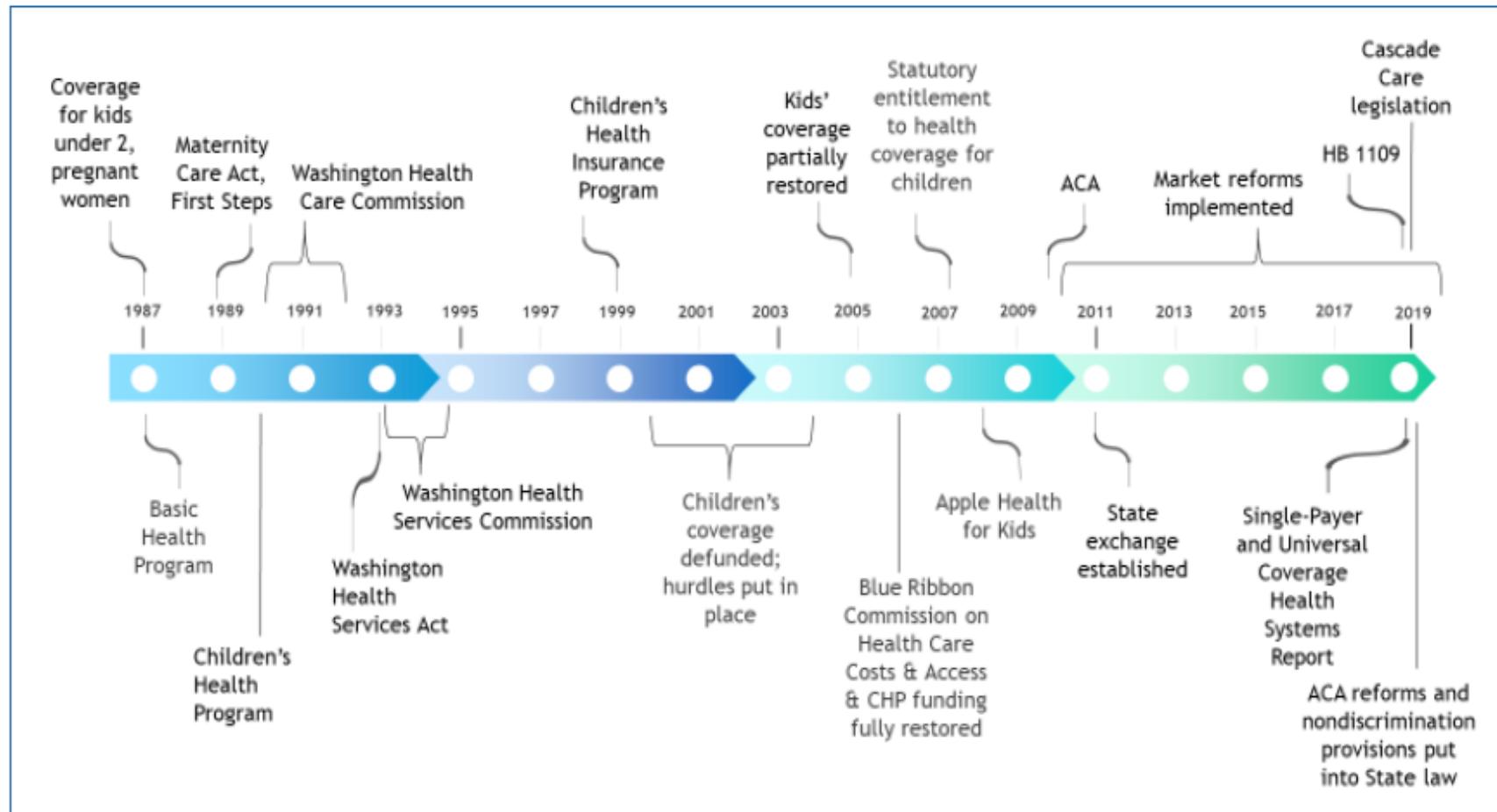
HEALTH MANAGEMENT ASSOCIATES

Work group history

- + Authorized and funded by 2019 Budget Proviso for
 - + *"HCA to convene a work group to study and provide recommendations to the Legislature on how to create, implement, maintain, and fund a universal health care system."*
- + Launched August 2019
- + Interim reports submitted November 2019 and May 2020
- + Final report submitted to the Legislature January 2021

Building on 30 years of progress in Washington

Figure 1: Washington State health reform activities from 1987-2019



Washington health reform: early reforms

- + 1987: Basic Health Plan
- + 1990: Washington Health Care Commission (Gardner Commission)
 - + *The final report, released in 1992, defined universal access as "the right and ability of all Washington residents to receive a comprehensive, uniform, and affordable set of confidential, appropriate, and effective health services" that it called the "uniform set of health services."*
- + 1993: Washington Health Services Act of 1993
 - + Employer and individual mandates.
 - + Guaranteed issue (insurers may not deny coverage due to pre-existing conditions).
 - + Basic set of services
 - + Medicaid & BHP expansions
- + 1995: Repeal of some components of Health Services Act

Washington health reform: children's coverage

- + 1987 – 2014: series of coverage expansions, administrative simplification processes and focused outreach efforts, Washington achieved “universal” coverage for children (98% of children covered)



Washington health reform: costs & access

- + 2006: Washington State Blue Ribbon Commission on Health Care Costs & Access
 - + Using reimbursement to reward quality outcomes
 - + Increasing consumers' access to information and shared decision making
 - + Improving primary care and chronic care
 - + Facilitating secure sharing of health information
 - + Tracking emergency room use
 - + Identifying contributors to health care administrative costs and evaluating ways to reduce them
 - + Designing insurance coverage options that promote prevention and health promotion
 - + Expanding coverage options including dependents up to age 26
 - + Increasing public health activities

Washington health reform: evidence-based medicine

- + 2007 – present: commitment to Evidence Based Medicine in state purchasing
 - + Defining medical necessity in WAC: *"There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service"*
 - + Washington State Health Technology Clinical Committee (HTCC): evidence-based decisions about new technologies for state purchasing
 - + Dr. Robert Bree Collaborative: public and private health care stakeholders to collaborate to improve quality, health outcomes, and cost effectiveness of care in the state

Washington health reform: ACA plus

- + 2010: Affordable Care Act
 - + 2011: Washington Health Benefits Exchange
 - + 2014: Medicaid expansion
- + 2014 – 2017: Additional state provisions to strengthen the market and to state laws to protect the ACA
- + 2017: Medicaid Transformation Project
- + 2018: Single payer and universal coverage report
- + 2019: Cascade Care and Universal Healthcare Work Group
- + 2020: Health Care Cost Transparency Board
- + 2021: Additional premium assistance and cost-sharing support for Exchange plans

Work group members

- + HCA also sought to include individuals who:
 - + Had experience with health care financing and/or health care delivery.
 - + Were affiliated with Tribal health care organizations or knowledgeable about Tribal health care systems and programs.
 - + Had a willingness and ability to review background materials.
- + HCA made a thoughtful and deliberate effort to ensure membership represented the diversity of our state.

Key stakeholders included in the work group

Patient advocates and community health advocates

Large and small businesses with experience with large and small group insurance and self-insured models

Labor, including experience with Taft-Hartley coverage

Health care providers, including the self-employed

Health care facilities, such as hospitals and clinics

Health insurers

The Washington Health Benefit Exchange

State agencies, including the offices of Financial Management Insurance Commissioner, and State Treasurer, and Department of Revenue

Legislators from each caucus of the House of Representatives and the Senate

Overview of the work group process

- Charter & Overview

September 2019



- Problem statement

December 2019



- Vision & goals

February 2020



- Establish common language

June 2020



- Refine model elements

July 2020



- Preliminary models

August 2020



- Understand the models

September 2020



- Evaluate the impacts
 - Transition plan

October 2020



- Finalize report
- Work group Review

December 2020



- Report submitted to the Legislature

January 2021



Work group charter

Role, decision-making, and expectations:

"The Legislature is responsible for making decisions about how to implement universal health care in Washington and is looking to the Work Group for insights and perspectives to inform the Legislature's decision-making. As such, the Work Group is not expected to come to group agreement on all of its recommendations. The meeting summary and reports to the Legislature will document the range of discussions and perspectives."

Common understanding and vision

Current Issues



Unequal access



Poor and
disparate outcomes



Unsustainable
costs

Goals

All Washington residents have access to essential, effective, appropriate, and affordable health care services when and where they need it.

Goals → assessment criteria

- + Access
- + Affordability
- + Equity
- + Governance
- + Administration
- + Feasibility
- + Quality



Health care coverage models

Model A:
Universal Care
(state-administered)

Model B:
Universal Care
(state-delegated)

Model C:
Close the Gap
(populations with
limited access to
traditional coverage)

- + Comprehensive population coverage
- + Standardized benefit package
- + Balanced provider reimbursement
- + Supports ongoing pursuit of health innovation in Washington
- + Administration of model varies between state and insurers

- + Interim step to provide a limited increase in coverage for certain populations:
 - + Currently uninsured
 - + Undocumented immigrants

Cost modeling

- + Work group members “agreed on” these models; however, it was not a universal consensus.
- + Plan design
 - + Covered populations
 - + Cost-sharing (copays, deductibles, coinsurance)
 - + Provider reimbursement adjustments
- + Optional elements
 - + Including/excluding Medicare
 - + Including/excluding dental
- + Not included
 - + Long-term care (except for Medicaid eligible)

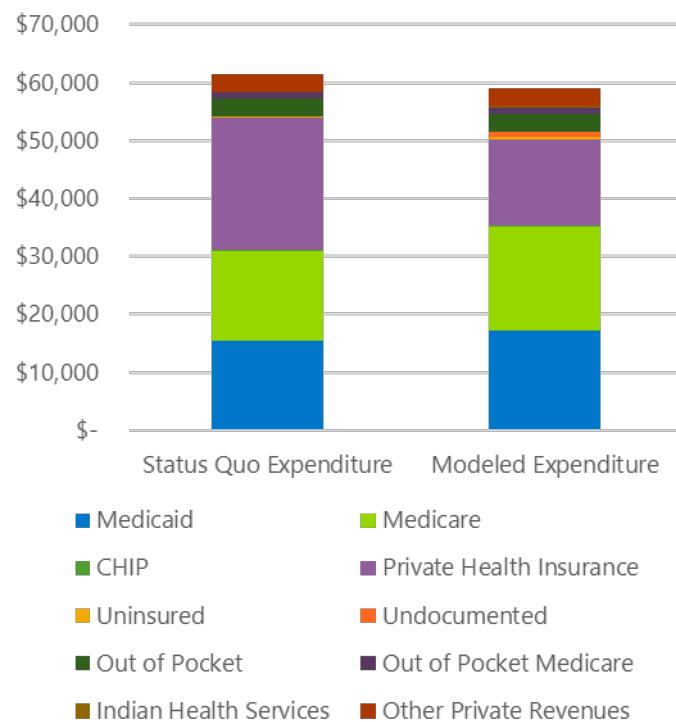
Model A: plan design state-administered

Covered populations	Benefits	Cost-sharing	Provider reimbursement	Population specific impacts	Administration
<ul style="list-style-type: none">• Medicaid• Medicare• CHIP• Private health insurance• Undocumented immigrants• Uninsured	<ul style="list-style-type: none">• Essential health benefits• Dental for Medicaid eligible only• Vision• Long-term care for Medicaid eligible only	<ul style="list-style-type: none">• No cost-sharing• Private insurance utilization changes due to removal of cost sharing	<ul style="list-style-type: none">• Reduced pricing variation between covered populations• Health care provider administrative efficiency• Purchasing power	<ul style="list-style-type: none">• Improved access for the Medicaid eligible population• Reflects increased utilization for uninsured and undocumented immigrant populations	<ul style="list-style-type: none">• State-administered• Premiums are exempt from state premium tax, impacting cost and revenues• Reflects reductions in system-wide administrative costs

Model A: cost and revenue impact state-administered

- + Status quo expenditures: \$61.4 billion
- + Projected expenditures: \$58.9 billion
- + 7,619,000 Washingtonians covered
- + Primary sources of cost savings:
 - + Eliminates private health plan administrative costs
 - + Administrative cost reduction for health care providers
 - + Improved access to care
 - + Greater purchasing power
- + State funds required: \$26.5 billion, plus an additional \$3 billion (total funds) to provide dental services

**CY 2022 implementation
(in millions)**



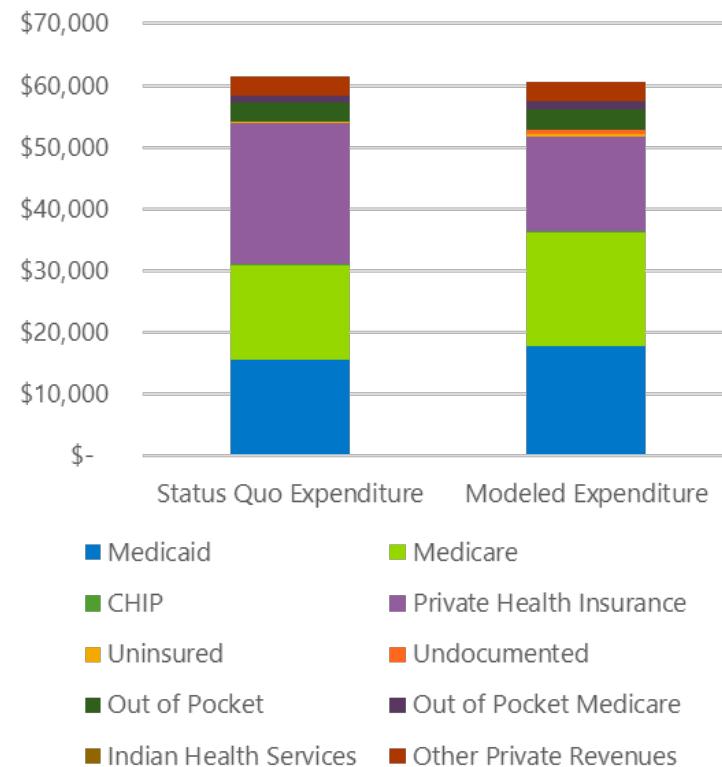
Model B: plan design state-delegated

Covered populations	Benefits	Cost-sharing	Provider reimbursement	Population specific impacts	Administration
<ul style="list-style-type: none">• Medicaid• Medicare• CHIP• Private health insurance• Undocumented immigrants• Uninsured	<ul style="list-style-type: none">• Essential health benefits• Dental for Medicaid eligible only• Vision• Long-term care for Medicaid eligible only	<ul style="list-style-type: none">• No cost-sharing• Private insurance utilization changes due to removal of cost sharing	<ul style="list-style-type: none">• Reduced pricing variation between covered populations• Administrative efficiency• Purchasing power	<ul style="list-style-type: none">• Improved access for the Medicaid eligible population• Reflects increased utilization for uninsured and undocumented immigrant populations	<ul style="list-style-type: none">• Administered by health insurers• Premiums tax applies• Reflects reductions in system-wide administrative costs

Model B: cost and revenue impact state-delegated

- + Status quo expenditures: \$61.4 billion
- + Projected expenditures: \$60.6 billion
- + 7,619,000 Washingtonians covered
- + Primary sources of cost savings:
 - + Reduces private health plan administrative costs
 - + Administrative cost reduction for health care providers
 - + Improved access to care
 - + Greater purchasing power
- + State funds required: \$27.5 billion, plus an additional \$3 billion (total funds) to provide dental services

**CY 2022 implementation
(in millions)**



Model A vs. Model B

Model A: Universal Care (state-administered)

- + Eliminates private health insurers.
- + Establishes a standardized provider reimbursement.
- + Maximizes economies of scale, since the state is the sole purchaser of care, including:
 - + Purchasing power.
 - + Monitoring fraud, waste, and abuse.
- + Employment losses due to eliminating private health insurers.

Model B: Universal Care (state-delegated)

- + Maintains and consolidates the number of private health insurers.
- + Variation in provider reimbursement is reduced.
- + Supports increased economies of scale.
- + Achieved savings is lower than Model A.
- + Maintains premium tax collection.
- + Mitigates employment losses.

Model C: design elements

Close the Gaps

Covered populations	Benefits	Cost-sharing	Provider reimbursement	Population specific impacts	Administration
<ul style="list-style-type: none">Undocumented immigrants	<ul style="list-style-type: none">Essential health benefits	<ul style="list-style-type: none">Standard cost-sharing	<ul style="list-style-type: none">Cascade Care reimbursement standards apply	<ul style="list-style-type: none">Utilization assumed to be similar to the commercially insured population	<ul style="list-style-type: none">Assumes commercial plan levels of administrative costs

- Note:** this model should be considered in conjunction with the Cascade Care subsidy options. While this model creates coverage options for those most likely to lack access to traditional coverage, it does not address affordability for those who do have access to coverage.

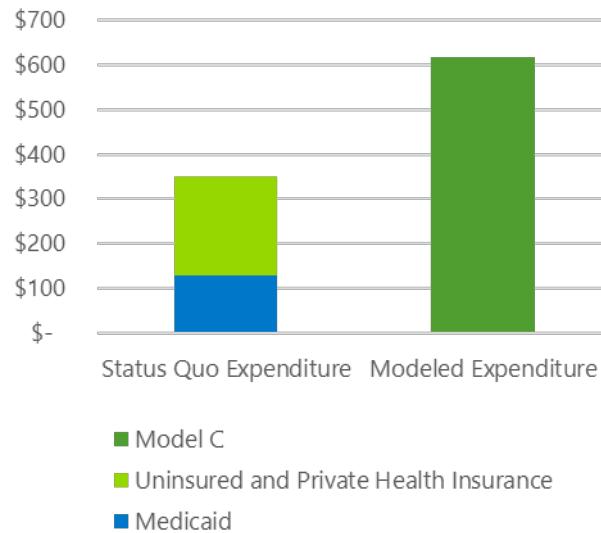
Model C: cost and revenue impact

Close the Gap

- + Represents a very different concept than Models A and B
- + Model C is an incremental step, bridging the gap in the existing health care system
- + Status quo expenditures: \$61.4 billion
- + Increase to status quo expenditures: \$617 million
- + 124,000 incremental increase in covered individuals
- + State funds required: \$617 million for expanding coverage to 124,000 individuals

CY 2022 implementation (in millions)

Status Quo vs. Model C
Expenditures (in millions)



Model impacts and considerations

- + Modeling assumes preserving federal funds for Medicare, Medicaid, and CHIP-eligible populations.
- + Provider reimbursement modeled to be revenue-neutral to providers in aggregate.
 - + Repurposes waste in provider administration.
 - + Supports enhanced purchasing power.
- + Supports current health innovation (e.g., Bree Collaborative and health information technology), but will need continued and future investments to achieve level of efficiency assumed in the model.

Model impacts and considerations continued

- + Additional savings is projected as the program matures.
 - + For example, Model A is projected to increase from \$2.5 billion to \$5.6 billion in annual savings when the program is fully mature.
 - + Savings accrues to the economy and impacts several state and local government agencies.
- + Operational decisions made in the implementation phase will impact the program costs. As decisions are made, the cost estimates will need to be updated accordingly.

Impacts of models: qualitative

Goals	Model A	Model B	Model C
Access			
Governance			
Quality			
Equity			
Administration			
Feasibility			
Affordability			

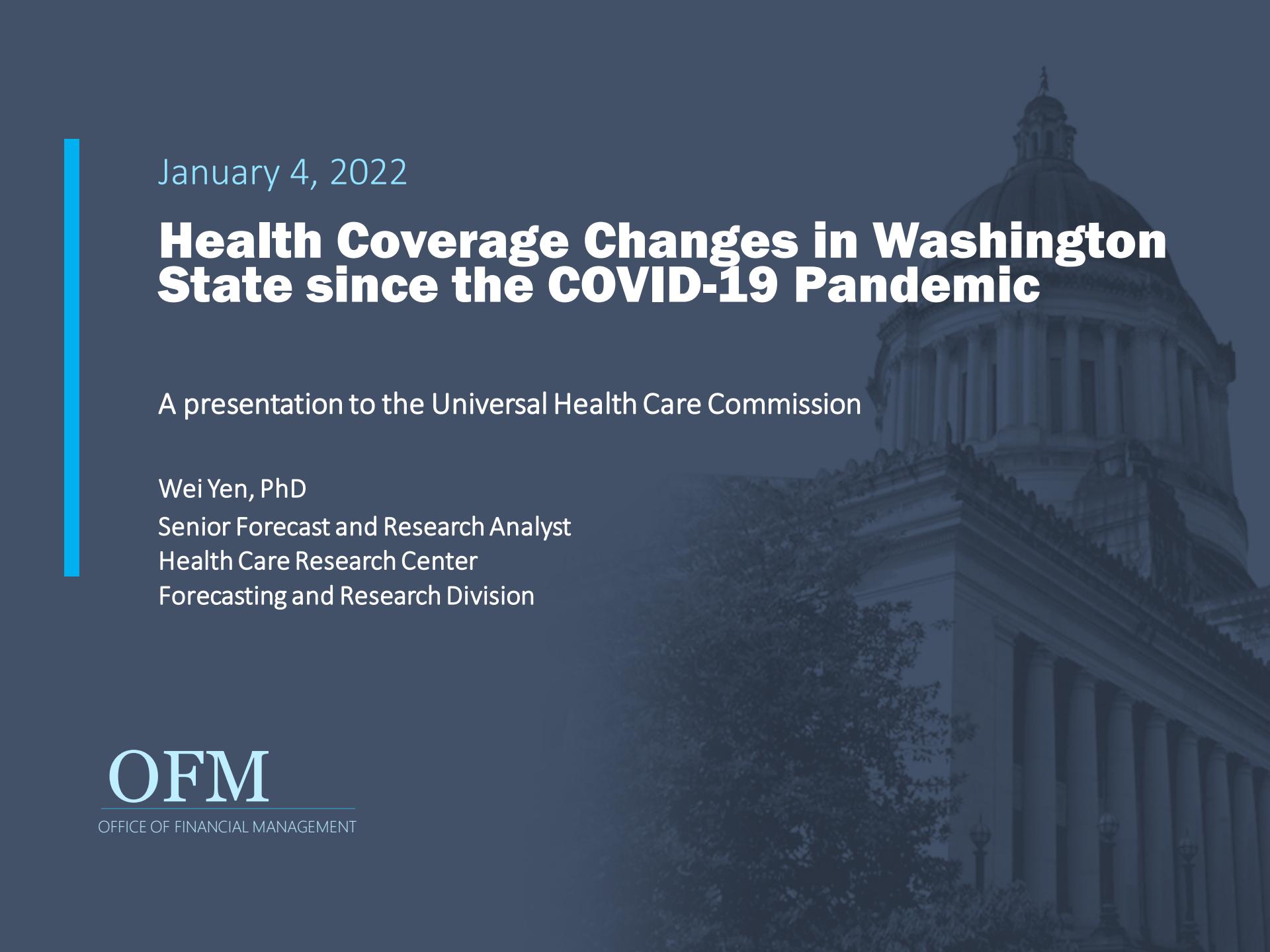
Questions?

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Presentation: Washington's coverage and impacts of the public health emergency

TAB 6



January 4, 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

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

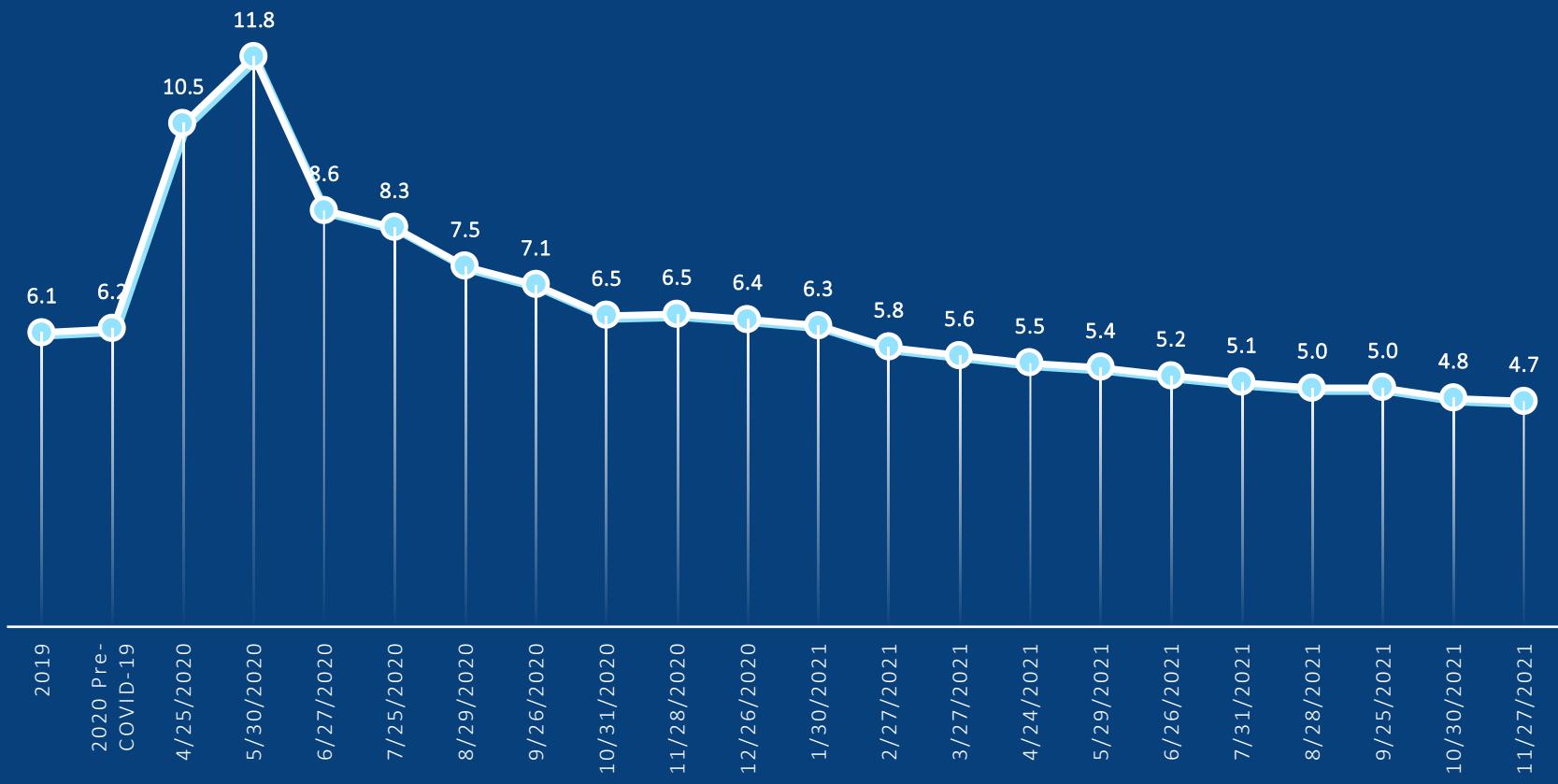
Methodological approach

- 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

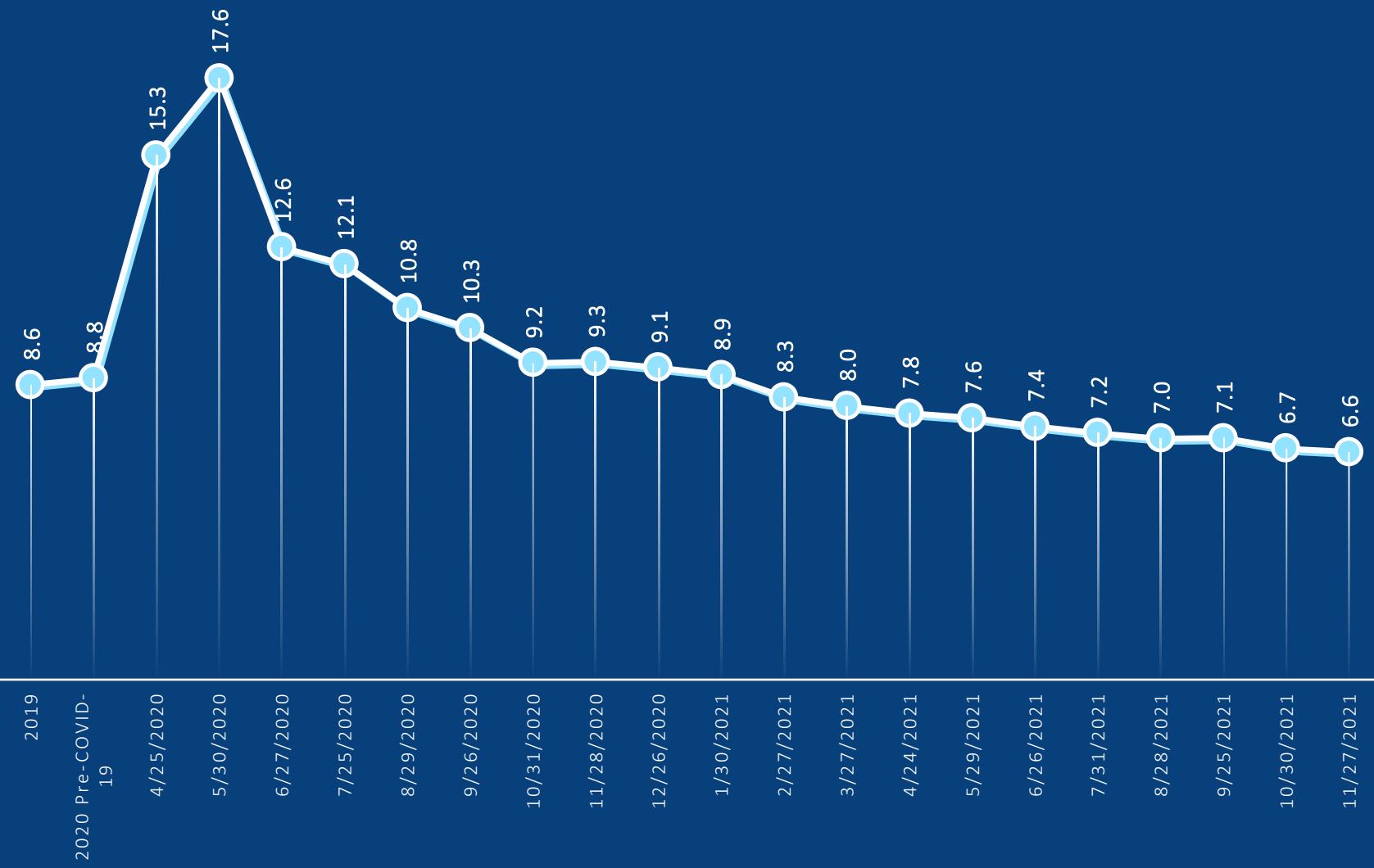
- Weekly report from April to August 2020;
- Monthly report from September 2020 through June 2021 (when COVID-19 restrictions were lifted);
- internal monitoring thereafter.

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

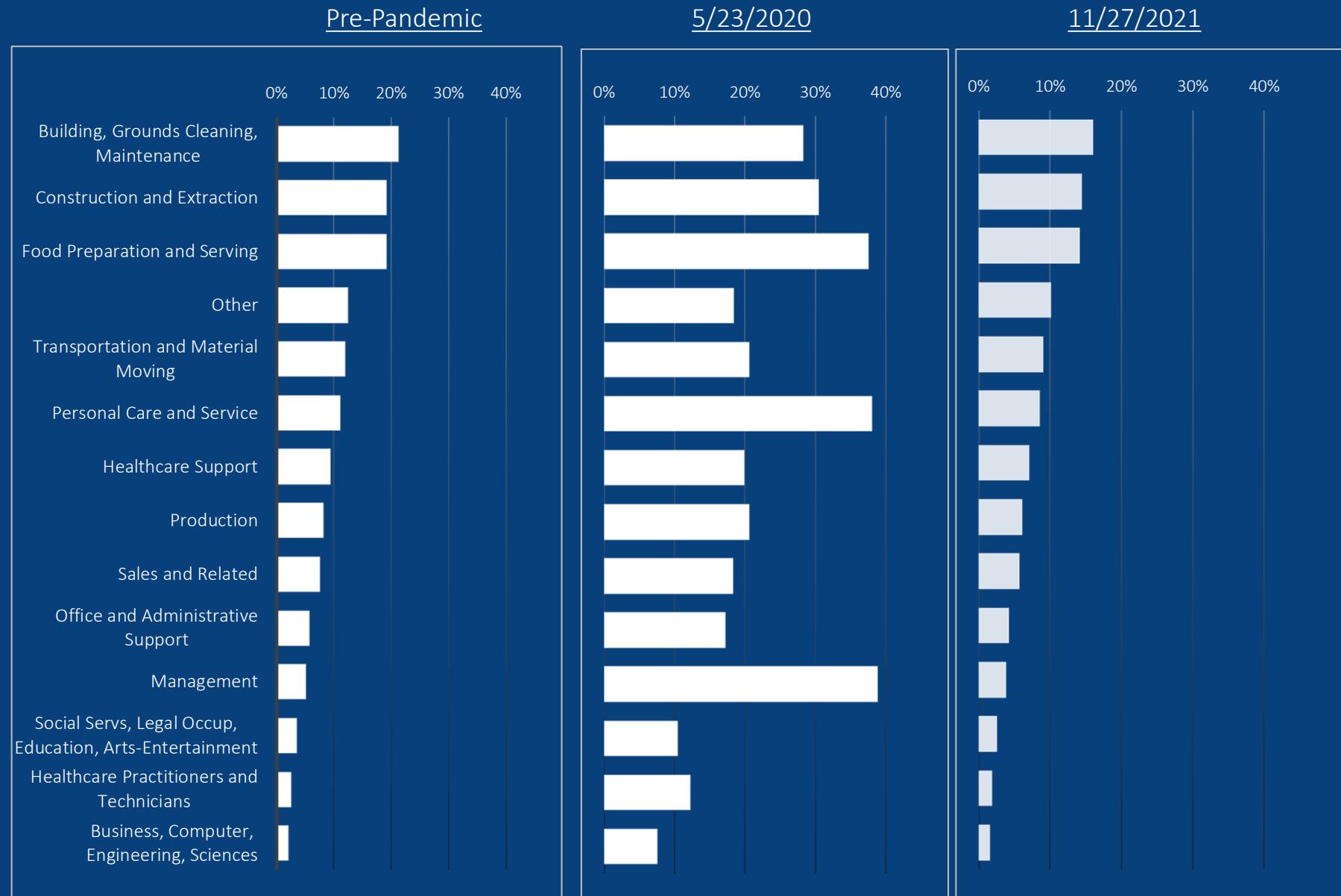


- Rapid increase in uninsured rate during pandemic lockdown in 2020
- Rapid decline when lockdown was lifted
- Gradual decline since October 2020
- Current rate lower than pre-pandemic rate

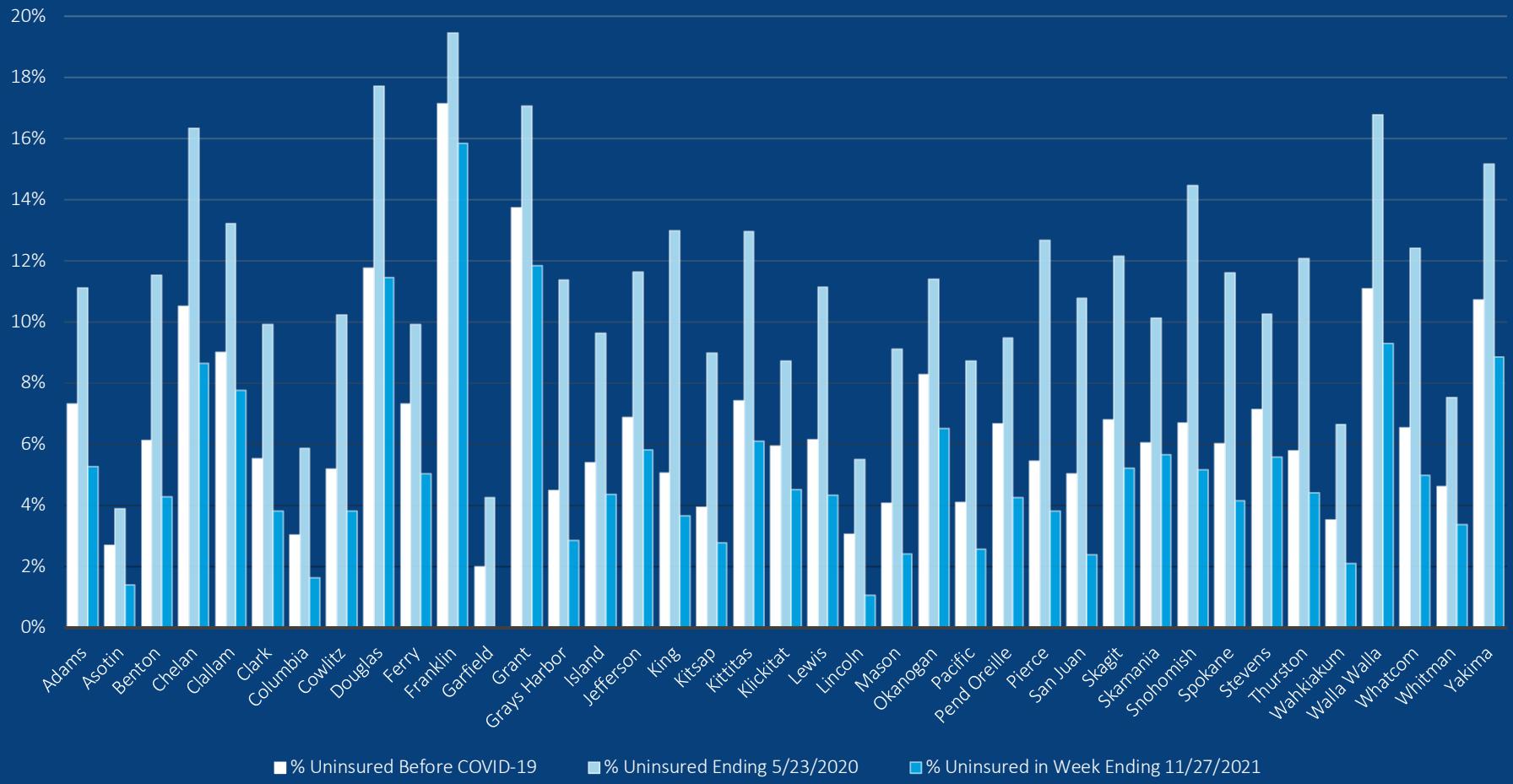
FIGURE 2. ESTIMATED UNINSURED AMONG ADULTS 18-64 IN
WASHINGTON (PERCENTAGE)
2019, PRE-COVID19 2020, AND LAST WEEK OF THE MONTH SINCE APRIL
2020 THROUGH NOVEMBER 2021



**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**



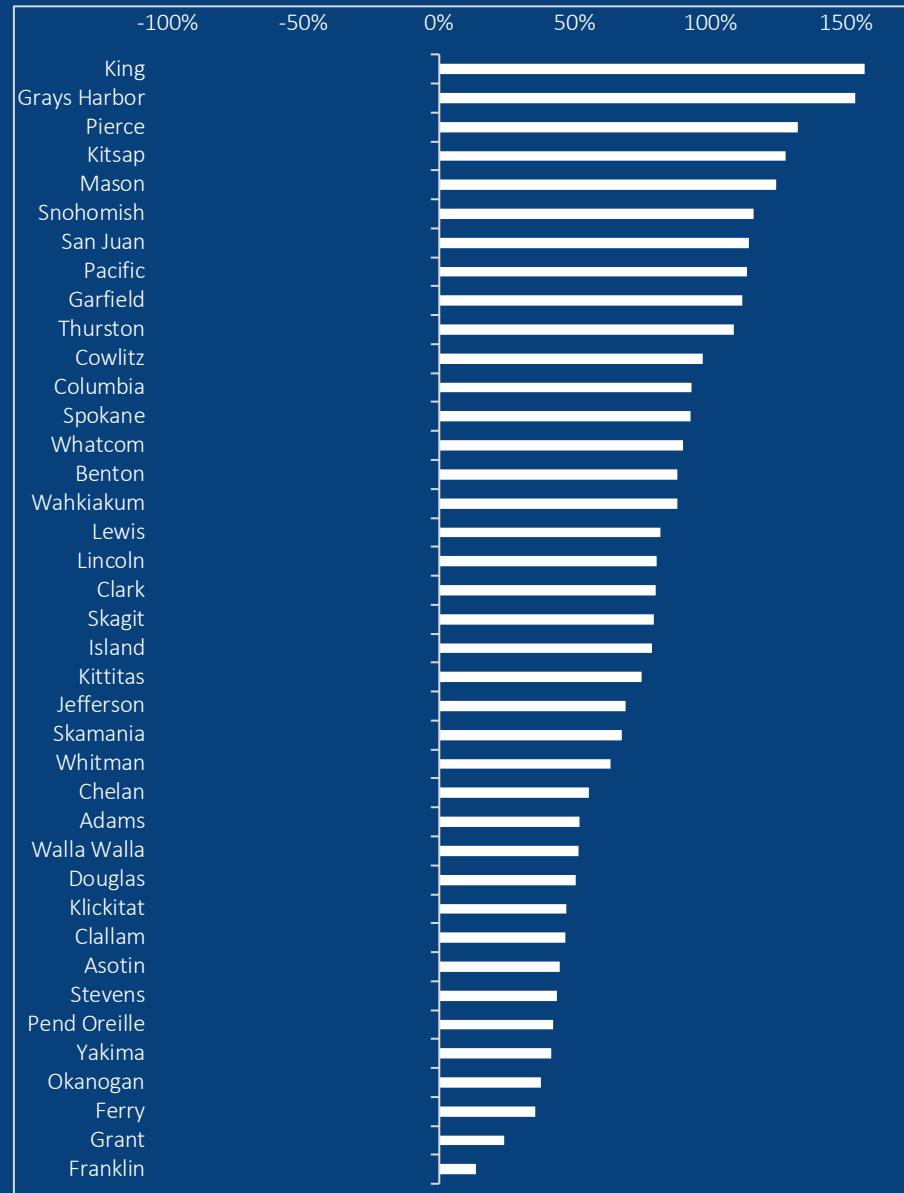
**FIGURE 4. COUNTY UNINSURED RATES (%), WASHINGTON: PRE-COVID19 AND WEEKS
ENDING 5/23/2020 AND 11/27/2021**



- 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**

Pre-pandemic to 5/23/2020



Pre-pandemic to 11/27/2021

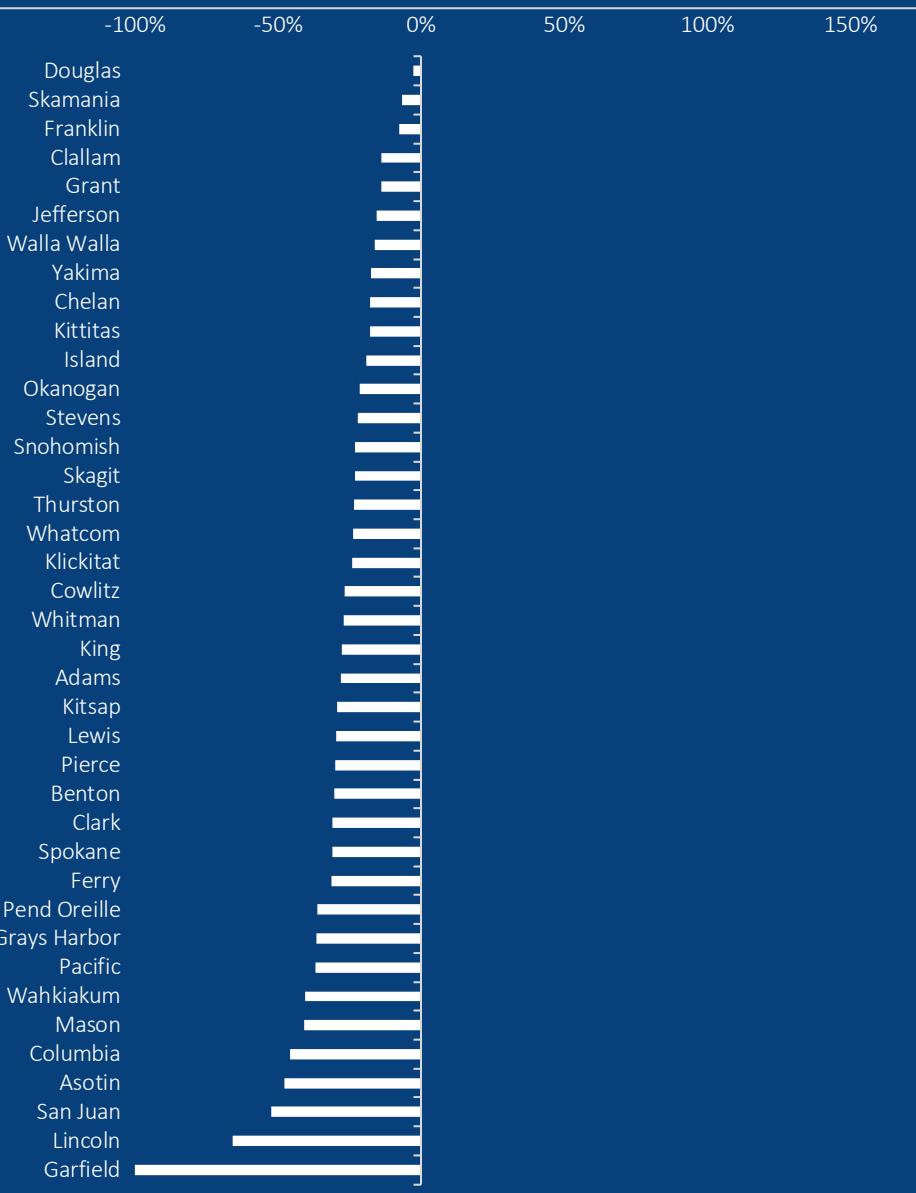
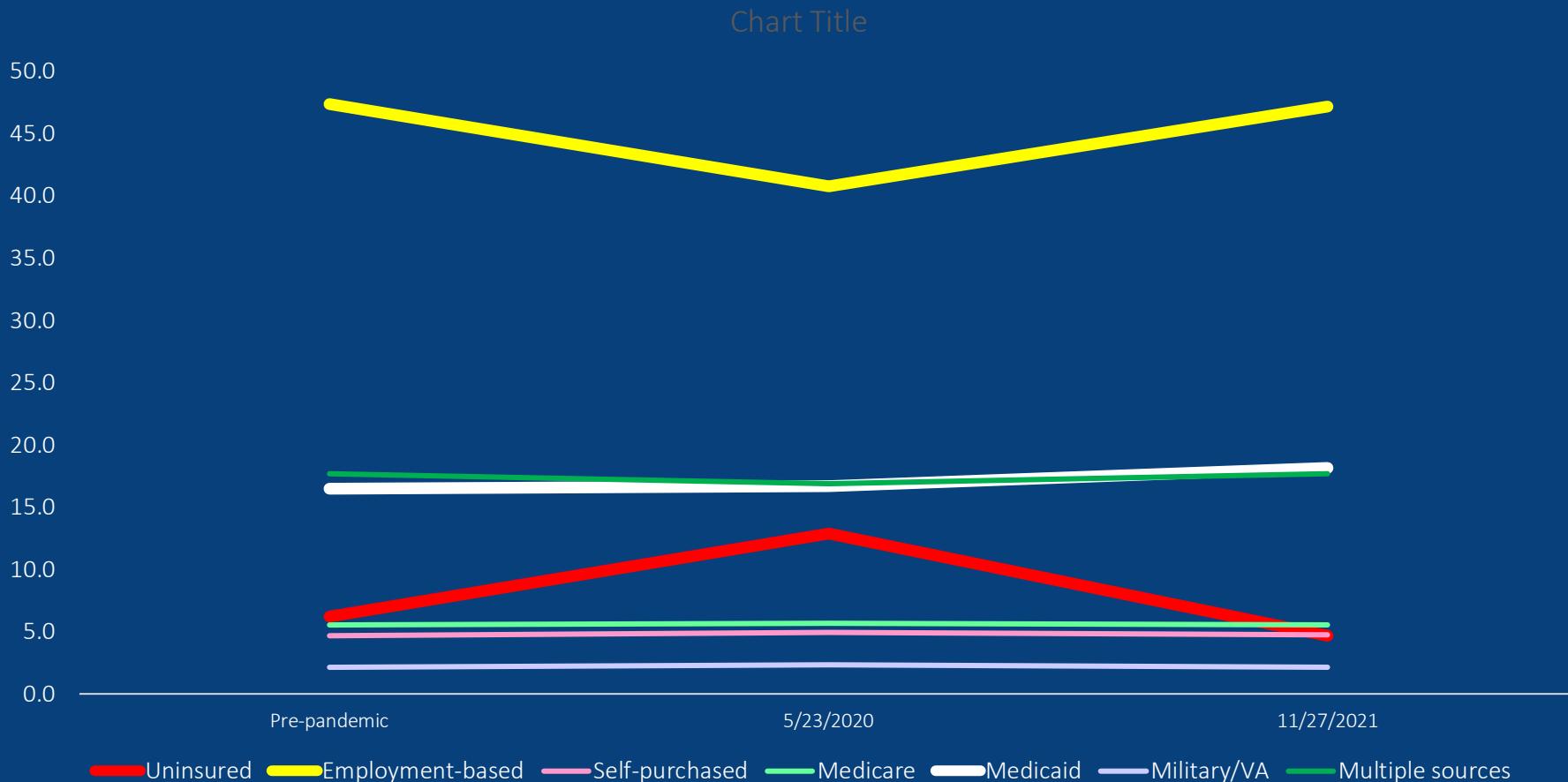
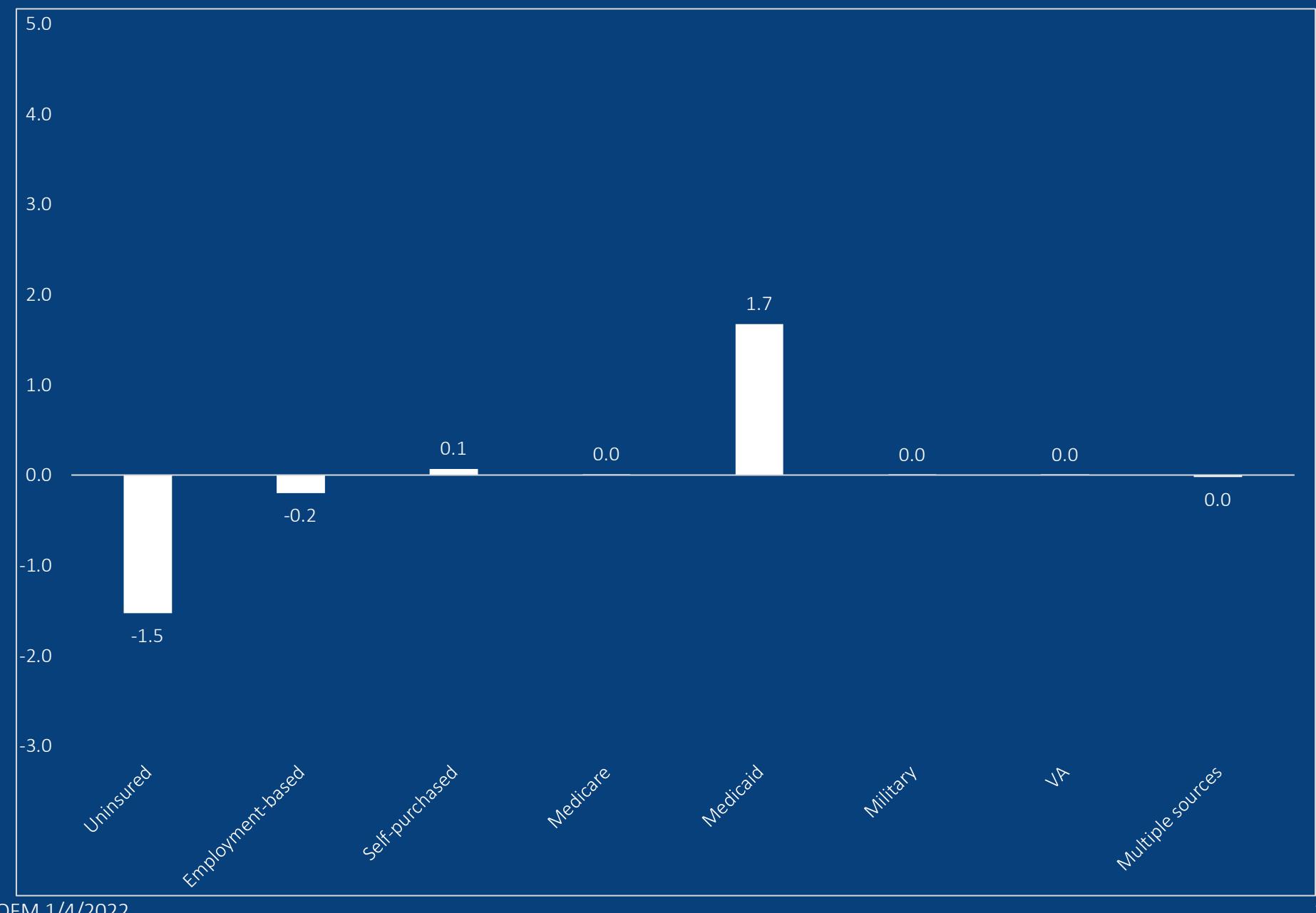


FIGURE 6A. PERCENTS BY COVERAGE SOURCES (MUTUALLY EXCLUSIVE) AT PRE-PANDEMIC, WEEK ENDING 5/23/2020 AND WEEK ENDING 11/27/2021



- During the 2020 lockdown, 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



Summary of Key Findings

- The COVID-19 pandemic caused rapid increases in uninsured rate during the lockdown in 2020.
- With the lockdown 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 lockdown 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.

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

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OFM

OFFICE OF FINANCIAL MANAGEMENT

**Discussion and approval of
Commission charter
and
Public comment on
Commission charter**

TAB 7

**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 prepare for 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 from sources 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 disparities including, 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 to prepare the state for a transition to a unified health care financing system as well continuing to further identify opportunities to implement reforms consistent 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 the Legislature and Governor.
2. Increase access to health care services and universal health coverage, reduce health care costs, 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~~, Be inclusive of all populations and all categories of spending.
4. ~~b~~A Be sensitive to the impact that high health care spending growth has on Washingtonians.
5. ~~A~~llign recommendations with other state health reform initiatives to lower the rate of growth of health care costs, and
6. Be mindful of state financial and staff resources required to implement recommendations.

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 Iseninger, 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.

Background material

TAB 8

Universal Health Care Commission meeting

Notes from Zoom chat

November 30, 2021
1:00 p.m. – 3:00 p.m.

Below are comments and questions shared by attendees with the Universal Health Care Commission during the November 30 meeting. [Learn more about the commission's work](#).

Time	From	Chat
14:04:48	Jeff Silverman	Nice presentation, Ms. Hatfield.
14:10:15	Paul Oldenkamp	Will I have an opportunity to submit written comments?
14:10:54	Nicole Gomez	The Commission website is here: https://www.hca.wa.gov/about-hca/universal-health-care-commission
14:11:12	Tamarra Henshaw	mandy.weeks-green@hca.wa.gov
14:11:51	Rep. Marcus Riccelli	Sorry to clarify, that day is Policy Cutoff for Opposite House day so no floor action likely but committees will likely be scrambling a bit to get things out in a short session.
14:12:09	Jeff Silverman	My name is Jeff Silverman. I am a computer expert, currently studying data science and cyber security. I am interested in the application of computing technology to the delivery of health care, including but not limited to: utility ease-of-use crossing the digital divide security reliability Use of data and statistical measures to measure efficacy. I'm feeling a bit of imposter syndrome. But I would like to make services available to the commission for technical matters and questions.
14:12:38	Kelly Powers	I would like to make some comments, thanks!
14:12:54	Maureen (Mo) Brinck-Lund	I'd like to make a comment too
14:14:02	Jeff Silverman	jeffsilverm@gmail.com
14:18:46	Dave Iseminger	I have something to say but only AFTER the true public comment is done.

14:20:02	Kelly Powers	https://docs.google.com/document/d/1M4xoW7nbnWsoAZL6jdwnEdsQsisE8ZTOupt0dfI8C00/edit?usp= Sharing Suggested language from the bill itself for Vision and Mission statements.
14:20:17	Jeff Silverman	I agree with Kelly and Maureen.
14:20:57	Sarah Weinberg	I agree with Kelly and Maureen and their comments.
14:26:16	Nicole Gomez	Here is the report Dr. Weinberg spoke about: https://leg.wa.gov/JointCommittees/Archive/HCCA/Documents/Final%20Report.pdf
14:27:02	Kelly Powers	Thank you so much! Agree that public comments at the start means better participation.
14:29:02	Consuelo Echeverria	I have a question if I may?
14:29:30	Jen Nye	How will written comments be handled? Will they be part of a public record?
14:30:03	Jeff Silverman	Given the capabilities of chat within zoom, could public comments be given as the meeting goes along?
14:30:32	Consuelo Echeverria	Yes
14:31:47	Paul Oldenkamp	Could you change the Zoom settings so the Chat can be saved by a participant?
14:32:47	Jeff Silverman	I just used the USPS to send a letter to Bob Ferguson.
14:33:17	Bonnie Morris	Please put in the chat the e-mail of the commission. I don't see it.
14:33:25	Hal Stockbridge	How will the public be able to view all public comments (for example, the public comments in today's meeting)? Is there a part of the website where we can view all public comments? What is the URL for the page which will provide all public comments? Thank you very much!
14:34:10	Kathryn Lewandowsky	I would like to say that I thank all of you for your participation and your work and I am very hopeful the work of the Commission will be beneficial to our citizens of Washington's who's physical health and economic health are in your hands.
14:35:20	Jeff Silverman	The procedure to saving a chat may be found at https://support.zoom.us/hc/en-us/articles/115004792763-Saving-In-Meeting-Chat
14:36:05	Leni Skarin	Members of the public cannot save links, etc in the chat.



14:37:00	Mandy Weeks-Green	Email: HCA_UiversalHCC@hca.wa.gov
14:37:42	Consuelo Echeverria	What kind of thoughts are being done to ensure outreach into rural communities where access to broadband can be limited? What can the commission do to ensure rural voices are included?
14:38:26	Consuelo Echeverria	This also stands for many refugee and immigration communities with limited digital literacy. Thanks so much
14:43:51	Kathryn Lewandowsky	Nicole, I don't understand your thoughts about a just transition? Just for who?
14:44:26	Tamarra Henshaw	The Commission's email address HCA_UiversalHCC@hca.wa.gov is provided at the bottom of the agenda, as well as on our webpage where you can also find the meeting materials, Zoom meeting information, meeting recordings, etc. https://www.hca.wa.gov/about-hca/universal-health-care-commission
14:45:35	Jeff Silverman	A commendation to everybody: nice meeting
14:46:06	Paul OldenKamp	The procedure for enabling participants to save the chat is described here: https://support.zoom.us/hc/en-us/articles/115004809306
14:47:04	Kelly Powers	Yes! That UHC Work Group timeline could be very useful.
14:48:40	Kelly Powers	Thank you to the Chair, Staff, and Commission Members.