

Universal Health Care Commission meeting summary

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

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

Members present

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

Members absent

Senator Ann Rivers

Call to order

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

Agenda items

Welcoming remarks

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

Public comment

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

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



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

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

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

Sarah Weinberg volunteered to offer verbal comment. (Written)

Marcia Stedman volunteered to offer public comments. (Written)

Roger Collier volunteered to offer public comment. (Written)

Jeff Silverman volunteered to offer public comment. (Written)

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

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

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

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

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

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

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

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

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

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

Kathryn Lewandowsky expressed support for Model A. (Written)



Jeff Silverman added support for Model A. (Written)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

Jeff Silverman commended Stephanie's presentation. (Written)

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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





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

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

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

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

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

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

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

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

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

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

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

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

Jeff Silverman commended the presentation. (Written)

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

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





Meeting summary review from prior meeting

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

Presentation: Single payer and universal coverage health systems

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

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

Single-Payer

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

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

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

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

Multi-Payer

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

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

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Universal Health Care Commission meeting summary

01/04/2022





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

Presentation: Universal Health Care Work Group Report

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

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

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

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

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

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



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

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

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

Commission Comments

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

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

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

Motion to table agenda items until next meeting

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

Adjournment

Meeting adjourned at 4:00 p.m.

Next meeting

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