Universal Health Care Commission Meeting Summary

December 15, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
3:00 p.m. – 5:00 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
Jane Beyer
Joan Altman
Representative Joe Schmick
Karen Johnson
Kristin Peterson
Representative Marcus Riccelli
Mohamed Shindane
Nicole Gomez
Stella Vasquez

Members absent

Senator Ann Rivers
Estell Williams

Call to order

Vicki Lowe, Commission Chair, called the meeting to order at 3:01 p.m.

Agenda items

Welcoming remarks

Chair Lowe began with a land acknowledgement and welcomed Commission Members to the ninth meeting.

Meeting Summary review from the previous meeting

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

Public comment

Chair Lowe called for comments from the public.

Consuelo Echeverria spoke on behalf of Noah White. Noah's health diagnosis and the increasing cost of health care resulted in bankruptcy. Noah supports the immediate implementation of a state-based, single-payer universal health care system in Washington.

Kathryn Lewandowsky, RN, Whole Washington, noted that the Commission supported implementation of the Cascade Care Savings program, promoting Model C (Universal Health Care Workgroup) which was not as favored by Work Group members compared to Model A.

Sarah Weinberg noted that the FTAC applicant recommendations did not include an individual to represent patients, preferably an individual with a chronic disease. It is important to understand the difference between *consumer* and *patient* and to focus on creating a patient-centered health care system.

Liz Murphy, Washington Community Action Network, was diagnosed with Type I diabetes followed by 30+ hospitalizations and a double-organ transplant. Even with employer sponsored health insurance, Liz suffered financial ruin due to medical debt. Liz stressed that Washingtonians are counting on the Commission.

Kelly Powers, Health Care is a Human Right, shared experience with family members encountering gaps in health care coverage due to the structure of the current system and urged that the design and implementation of the universal health care system be patient-centered.

Elizabeth Hovde, Washington Policy Center, stated that a single-payer universal health care system is not the solution to achieving affordable and accessible health care and that competition, innovation, and educated consumers are necessary to lower health care costs in Washington.

Presentation: Oregon's universal health plan design

Bruce Goldberg, MD, Chair, Oregon Joint Task Force on Universal Health Care
John Santa, MD, MPH, Member, Oregon Joint Task Force on Universal Health Care
Daniel Dietz, JD, Policy Analyst, Oregon Legislature

Oregon's Joint Task Force on Universal Health Care (Task Force) worked over two years (plus a one-year extension due to COVID) and were charged with developing a state-based single-payer health care system, known as *the Plan*. The Task Force's final report to the Oregon Legislature, submitted in September 2022, can be found **here**.

Bruce Goldberg shared that the Plan would cover all Oregon residents regardless of job, income, or immigration status. There would be no payment at the point of care and no co-pays or deductibles. The benefit package is based on Oregon's Public Benefits Employee Board (PEBB) benefits and would include a dental and vision benefit. The Plan would eliminate structural inequities and be less expensive than the current system with savings generated from more efficient administration. Providers would be paid directly, eliminating the current system of different reimbursement rates by payer. Private health carriers may offer insurance to cover benefits not covered by the Plan, e.g., long-term care. Long-term care would remain a separate benefit (paid by Medicaid and private payment), though the Task Force recommended this be studied for future inclusion. Social determinants of health (SDOH) would not be a covered benefit. Tribal members could choose to enroll in the Plan.

Mohamed Shidane asked whether the Task Force looked into covering behavioral health. The Task Force did not have the time or expertise to recommend how to change Oregon's fragmented and underfunded mental health

system. However, the Task Force recommended restructuring and enhancing the state's behavioral health benefit and revamping the state's mental health system.

John Santa shared six health equity concepts from the Task Force's recommendations: 1) all Oregon residents are eligible, 2) no payment at the time of service, 3) utilize one benefit plan, 4) normalization of reimbursement, 5) uncouple coverage from employment, and 6) address SDOH with delivery system savings. The Task Force compared the impact/cost of the Plan in 2026 to the status quo. Administrative savings, about 6% of total health expenditures, was a key factor in developing expenditure estimates. The Task Force recommended creating a robust and well-funded non-profit corporation for governance of the Plan. Jane Beyer asked if the status quo commercial conversion rate was based on commercial rates in the aggregate, and it was clarified that it was. Jane Beyer noted that vertical and horizontal consolidation among health care systems presents challenges for rates and asked if the Task Force looked at how reimbursement would be redistributed among providers. The Task Force did examine the redistribution of commercial revenue streams to Medicare and Medicaid. With administrative savings at the provider level, more can be invested in care delivery. The Plan would not reduce funding for provider rates, rather these dollars would be redistributed, e.g., investing in primary care.

Daniel Dietz reviewed the Task Force statute which provided a deadline, framework, and boundaries, and defined a staffing structure, public engagement activities, and inspiration for the Plan. Both Task Force and technical advisory group (TAG) meetings were held at least monthly. TAGs included: Eligibility, Benefits, & Affordability; Provider Reimbursement; Finance & Revenue; Governance; Intermediate Strategies; Expenditure & Revenue Analysis; Communications; Public Engagement; and Consumer Advisory. Jane Beyer asked about the member make-up of the TAGs, and it was clarified that TAGs were comprised mostly of Task Force members with outside expertise as needed. Jane Beyer asked if the Task Force's funding was enough, and it was clarified that the Task Force ran out of resources at the end of their work. Bidisha Mandal asked about provider recruitment and retainment (particularly specialists) and competing with health systems outside of Oregon. The Task Force discussed workforce challenges but there is more work to do. Bidisha Mandal asked whether providers could accept privately insured patients. Self-pay patients could not be charged more for a service covered under the Plan, and private insurers could not sell individual or group policies. There is an assumption that the Plan's payroll tax would disincentivize self-insured businesses from providing their own coverage to employees. Dave Iseminger asked if the Task Force defined the payroll tax. This requires more work, but the Task Force recommended a graduated personal income tax (0-7%) and payroll tax (7-10%). In the aggregate, and compared to the status quo, consumers would pay ~10% less, and businesses would pay ~12% less (small businesses not currently providing coverage for employees would pay more due to the payroll tax).

Bruce Goldberg reviewed the outside consultants and expertise utilized for design choices, including actuarial modeling, revenue estimates, ERISA, and financial analysis. Oregon's Task Force determined that certain decisions should be made now, and some decisions are more operationally focused and can be made by a governing board. Bruce Goldberg suggested that when the Commission reads Oregon's report, focus particularly the executive summary and the section on ERISA. Kristin Peterson asked about next steps. In their report, the Task Force recommended that the Oregon Legislature establish and fund a founding governing board to develop an implementation and financing plan over two years. It's now up to the Legislature to decide on whether to accept this recommendation. Joan Altman asked in what ways the Task Force engaged with stakeholders. Bruce Goldberg noted the discreet listening sessions with consumers and different sectors of the health care marketplace were highlights of this work conducted after completion of the report and that for these efforts was included in the Task Force's budget. Jane Beyer asked if it was helpful to separate the listening sessions from the TAGs, versus including consumer and marketplace stakeholders in the TAGs. Time constraints precluded the Task Force from combining

the TAGs and stakeholders, and the Task Force relied on public input at their meetings to guide their work. Nicole Gomez asked if Oregon had similar efforts in place prior the Task Force, and it was clarified that the Task Force statute was their primary guide.

Presentation:

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

The Commission voted to extend this meeting past 5:00 p.m. to attend to all business. HMA reviewed the proposed 2023 Legislative report approach: an update to the baseline (2022) report with recommendations for transitional solutions and design decisions. HMA shared the 2023 proposed workplan. Jane Beyer proposed discussing at a future meeting how the Commission can bring public input into the report and workplan processes, and Chair Lowe and Joan Altman agreed. The Commission voted to adopt the 2023 report development approach as amended to incorporate community and stakeholder engagement. The Commission then voted to adopt the 2023 workplan approach as amended to incorporate community and stakeholder engagement (subject to resources). The Commission agreed to move the adoption of the FTAC charter to their February meeting business.

The Commission received over 50 FTAC applicants. Per the Commission's request, HCA and HMA reviewed each applicant's qualifications (resume and application) and provided recommendations of the nine most qualified applicants. Kristin Peterson thanked HMA and HCA for vetting the applications. Jane Beyer proposed that the Commission keep in mind that outside expertise may be necessary to help guide FTAC's work. Chair Lowe reviewed each of the applicants and suggested keeping in mind the applicants not chosen for FTAC appointment for future engagement and expertise. The Commission voted to select the FTAC applicants as recommended.

When asked who should serve as FTAC liaison to the Commission, Joan Altman recommended Pam MacEwan (approved as the FTAC consumer representative) to create an intentional connection between patients, consumers, FTAC, and the Commission. Mohamed Shidane noted the difference between consumers and patient advocacy. Chair Lowe and Nicole Gomez rescinded the motion to allow FTAC to self-nominate the FTAC liaison, and the Commission moved for Chair Lowe to ask Pam MacEwan to consider serving as FTAC liaison.

Adjournment

Meeting adjourned at 5:25 p.m.

Next meeting

February 9, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.