Washington Universal Health Care Work Group

Meeting #7 Summary

October 7, 2020, 1 pm to 4 pm

ATTENDEES

Work Group Member

Aaron Katz, Principal Lecturer Emeritus, UW School of Public Health
Beth Johnson, CEO and President, Coordinated Care Health
Bevin McLeod, Co-Founder, Alliance for a Healthy Washington
Brenda Snyder, Office of the State Treasurer
Carrie Glover, Policy Consultant, Dziedzic Public Affairs
Carrie McKenzie, Chief Executive Officer, Goldcore Innovations, LLC
Chris Bandoli, Executive Director, Association of Washington Healthcare Plans
Pam MacEwan, Chief Executive Officer, Health Benefit Exchange
Dennis Dellwo, Retired attorney, former State Representative, Health Care Committee Chair
Dean Carlson, Washington State Department of Revenue
Don Hinman, Founder, Mid-Valley Insurance, Inc.
Dr. Richard Kovar, Medical Director Emeritus, Country Doctor Community Health Center
Dr. Rod Trytko, Washington State Medical Association
Dr. Sherry Weinberg, Physicians for a National Health Care Plan
Jane Beyer, Senior Health Policy Advisor, Office of the Insurance Commissioner
Jason Brown, Washington State Office of Financial Management
Lynnette Vehrs, President, Washington State Nurses Association
Kelly Powers, Healthcare Consumer
Kerstin Powell, Health Center Business Office Manager, Port Gamble S'Klallam Tribe
Mary Beth Brown for John Wiesman, Secretary, Department of Health
Mohamed Shidane, Somali Health Board
Patrick Connor, NFIB Washington State Director, National Federation of Independent Business
Randy Scott, Pacific Health Coalition
Representative Nicole Macri, House of Representatives
Representative Joe Schmick, House of Representatives
Ronnie Shure, Pharm BS
Senator Emily Randall, Washington State Senate
Shirley Prasad, Policy Director, Government Affairs, Washington State Hospital Association
Sue Birch, Director, Health Care Authority
Sybill Hyppolite, Washington State Labor Council
Vicki Lowe, Executive Director, American Indian Health Commission

HCA Staff

Tamarra Henshaw
Dennis Martin
Mia Nafziger
Mich'l Needham
Shawn O'Neill

Consultants
Betsy Jones, HMA
Jamie Strausz-Clark, 3Si
Jared Nason, Optumas
Jeanene Smith, HMA
Liz Arjun, HMA
Nora Leibowitz, HMA
Shane Mofford, Optumas

NOT ATTENDING

Work Group Members
Amy Anderson, Government Affairs Director, Association of Washington Business
Dr. Barbara Detering, Medical Director, Washington State Medical Association
Dr. Peter McGough, Medical Director, UW Neighborhood Clinics
Lisa Humes-Schulz, Director of Strategic Initiatives, Planned Parenthood Votes NW and Hawaii

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MEETING OBJECTIVES AND AGENDA

The seventh meeting of the Washington Universal Health Care Work Group had seven objectives:

1. Hear public comment on universal health care.
2. Understand and right-size expectations for the final product from this Work Group process and what will need to be addressed in future work.
3. Continue reviewing, discussing, and understanding the outcomes of the actuarial analyses and answer Optumas' questions so they can finalize the models and the data can be used in Work Group decision-making.
4. Consider lessons learned from examples of previous universal health care efforts that have been implemented (e.g., universal coverage of children in WA), to inform how the Work Group articulates proposed next steps in the report.
5. Discuss and confirm the end state (goals) we are trying to achieve with universal health care.
6. Discuss and confirm Work Group feedback on report outline.

WELCOME, INTRODUCTIONS, AND CONFIRM AGENDA

Jamie Strausz-Clark (3Si) convened the meeting and reviewed the "Zoom etiquette" protocols for the meeting. She reviewed the meeting agenda and announced that this would be the first of two three-hour October meetings. Meetings will include facilitated small discussion groups.

PUBLIC COMMENT

Jamie Strausz-Clark (3Si) opened the public comment period. Twelve people signed up for public comment; seven members of the public commented.

Jamie introduced Chris Bandoli, Executive Director of the Association of Washington Health Care Plans, who joined the Work Group in June 2020.

UNIVERSAL HEALTH COVERAGE FOR EXAMPLE

To help Work Group members consider potential transition steps and challenges in securing universal health care, Jane Beyer (Office of the Insurance Commissioner), shared a case study with the Work Group about how Washington achieved universal coverage for children in 2015 (the uninsured rate for children is less than 3%). Jane walked through a timeline outlining the incremental policies adopted over time that led to universal coverage of children, including the transition steps and challenges/opportunities. She pointed out that the Legislature built on prior steps to incrementally expand services for kids, simplify administrative processes, and expand which populations were covered. Key contributions to success included establishing an explicit goal of universal coverage and securing legislative leadership and a broad coalition of supporters to get behind that goal.

The timeline is available here: https://www.hca.wa.gov/assets/program/uhcwg-example-of-a-four-year-path-oct-2020.pdf

Jane pointed out the similarities between how the Legislature worked through each of these incremental steps it tackled in this effort and many of the issues before the Work Group today.

DISCUSSION

In reviewing the timeline, Work Group members acknowledged the accomplishment but raised concerns about the long timeline (27 years). Jane explained that the most important developments occurred between 2005 and 2009 when an explicit legislative goal was established to cover all children. A Work Group member added that the Health Services Act of 1993 was achieved in a similar fashion and the commission that put together the proposal set an implementation schedule of five years from enactment to universal coverage.

Work Group members felt it would be important to understand who is still falling through the cracks (i.e., who are the 3% of WA children who are still uninsured and why). Addressing this gap would be an important consideration for achieving the goal of equity and provide the Legislature with a way to strengthen the program.

COMMENTS FROM WORK GROUP CHAIR

Jamie Strausz-Clark (3Si) introduced Work Group Chair Sue Birch (HCA), who thanked members for their time, voiced support for the efforts of the Work Group, and reiterated HCA's commitment to the purpose of the Work Group given current circumstances. She reminded the Work Group that this was designed as a robust engagement process to reflect the diversity of perspectives. She added that the project team may not be able to answer all Work Group questions and requests for information, but they project team are working hard to provide as much information as possible to inform the Work Group. She also anticipates that there will be a significant advocacy effort by many Work Group members to advance universal health care after the Work Group concludes. Work Group members

reiterated a request that the Work Group hear more from Cascade Care Work Group. The project team will provide a pre-recorded update on the Cascade Care subsidy study in advance of the next meeting.

Note: The Facilitator and Project Manager revised the meeting agenda during the meeting and opted to extend the actuarial analysis discussion in the large group rather than divide into breakout sessions to discuss goals.

OUTCOMES OF ACTUARIAL ANALYSES: DISCUSSION

Jamie Strausz-Clark (3Si) kicked off a discussion with the full Work Group about the pre-recorded presentations developed by Shane Mofford and Jared Nason (Optumas). Jamie asked the Work Group members if they had any clarifying questions or feedback on the presentations. We have summarized this discussion topically below.

Model C

Some Work Group members commented that most of the discussion has been about Models A and B and requested that we devote equal time to Model C. Work Group members briefly discussed the merits of considering Model C as a pathway to universal coverage rather than an end state. Some felt Model C was the best solution in the short term, while others expressed concern that Model C does not address the problem of lack of access to affordable coverage for individuals and small businesses. Work Group members also discussed a need to lack cover undocumented immigrants quickly, especially given what we've learned from the COVID pandemic, and requested more information on the costs of covering undocumented immigrants. Optumas responded that they are aligning assumptions in the actuarial model with the Cascade Care subsidy program, which is still in development. The development timeline for the Cascade Cares subsidy program is not aligned perfectly with the Work Group timeline; as such, some assumptions in the model will need to be updated after the Universal Health Care Work Group concludes.

Medicare

Work Group members discussed whether Models A and B should include the Medicare population. It was noted that depending on the outcome of the upcoming election, there may be more opportunity to partner with the federal government in implementing a universal health care system in Washington State. Optumas responded that the Models were built to include and exclude populations easily and they can show Models A and B with and without the Medicare program.

Administrative Costs

There was a robust discussion about the model's assumptions about the potential savings from administrative changes at the systems and provider levels. Optumas explained that the administrative savings in the first year may seem low to some Work Group members, but this is because providers would still have a higher administrative burden in the first year as they transition into new system with fewer payers. Opportunities to become more efficient would not manifest until later years. Optumas added that it can be difficult to measure the administrative savings on the provider side because every situation is different

Work Groups discussed system design elements to reduce administrative costs, such as simplifying administration and eliminating the fee for service system in favor of global and value-based payment models.[1] Work Group members also wanted to consider the potential effects of bargaining power on driving down administrative costs.

A Work Group member indicated that tribal health systems may be able to provide information about government purchasing to contain costs on things like hearing aids. Another Work Group member suggested looking to Maryland for cost-containment innovations: they have an active exchange, their own state reinsurance program, mechanisms to bring people with low incomes into low-cost coverage with no cost sharing, and a cost control mechanism for hospital costs.

The Work Group also discussed the importance of increased transparency, noting that the state has a cost transparency board that was passed in 2020. There is also model legislation from the National Academy for State Health Policy (NASHP) focused on more transparency with hospitals.

Cost Sharing

Work Group members discussed the whether cost sharing should be included in the modeling. As with earlier Work Group discussions, some Work Group members wondered whether strategically-applied cost sharing strategies could minimize low-value care or over-utilization of care, sharing anecdotal examples from their own experience to support this premise. Other Work Group members expressed concern that cost sharing dissuades people—especially people with lower incomes—from seeking the care they need. A few Work Group members expressed that eliminating cost sharing was important to equity. These Work Group members asked if there are any credible studies that demonstrate cost sharing minimizes utilization of low value care. They also asked if it is possible to quantify the cost of delaying needed care because of an inability to pay required cost sharing.

Work Group members expressed—and Optumas echoed—that there may be other ways besides cost sharing to achieve more efficient utilization.

Optumas concluded that because there is no consensus on whether or not to include cost sharing, the actuarial models will show outcomes if cost sharing is included and excluded.

Understanding Projected Savings

Optumas explained that the cost estimates are only for the first year of implementation, plus 12 different iterations based on the variances in population, benefits, inclusion of cost sharing, etc. The

[1] Global and value-based payments are cost containment strategies. A global payment is a fixed prepayment made to a group of providers or a health care system that covers most or all of a patient's care during a specified time period. This is different from fee-for service, which pays separately for each service. Value-based payment models hold providers financially accountable for the cost and the quality of care they deliver, rewarding providers financially for delivering better, more cost-effective care, and penalizing them for failing to do so.

report will using 2018 data for the projections. Optumas explained that there are too many uncertainties to accurately project beyond year one.

Work Group members expressed concern about not having projections beyond the first year and wondered how to communicate about out-year costs without those projections. They also requested a visual of where savings are allocated (state, Medicaid program, individuals), which Optumas agreed to provide.

Funding

Work Group members wondered when we would know more about how much it would cost to fund these models; Optumas indicated that the next step of the modeling is the revenue side.

Benefits and Utilization

Work Group members want the models to include mental and behavioral health care benefits but recognized that a robust long-term care benefit would too costly. Optumas explained that most mental and behavioral health services are already covered through the Essential Health Benefits or Washington's mental health parity laws, but there are some limitations and elements that lack detail. Optumas will provide an estimate for including long-term care, but noted that there Washington has a recently-established Long Term Care trust to provide Long Term Care benefits up to $36,500 over a lifetime.

Work Group members wanted to know how changes in utilization are reflected in the models, adding that there may be many people who will have access to needed care—such as hearing aids and dental care—for the first time under a universal health care system. Optumas used dental benefits as an example, explaining that the model assumes a standard benefit across all populations and extends that benefit to previously uncovered populations.

Process

A Work Group member expressed concern that the assumptions in the models seem to reflect the perspectives of the people who talk the most, and worried that the final report will reflect only those perspectives. Jamie Strausz-Clark (3Si) said that she is proactively reaching out to Work Group members to encourage those quieter voices to share their opinions.

NEXT STEPS

Jamie Strausz-Clark (3Si) thanked the Work Group for sharing their perspectives and encouraged members to send additional questions about the models. She expressed appreciation for the Work Group's flexibility in adjusting the agenda to focus on the actuarial modeling; since we did not get to the draft goals of the universal health care system, she requested that Work Group members submit written comments about the draft goals. She also asked Work Group members to submit feedback on the draft report outline.

Optumas will be refining the models and sharing additional materials before the October 29th meeting; the October 29 meeting will be used to discuss and confirm the recommendations to include in the report.

The slides to the actuarial analyses can be accessed on the HCA Universal Health Care website, https://www.hca.wa.gov/about-hca/healthier-washington/universal-health-care-work-group and the timeline of children's coverage in Washington can be accessed here: https://www.hca.wa.gov/assets/program/uhcwg-example-of-a-four-year-path-oct-2020.pdf