

Washington Universal Health Care Work Group

Meeting #6 Summary

September 16, 2020, 1 pm to 4 pm

ATTENDEES

Work Group Member

Aaron Katz, Principal Lecturer Emeritus, UW School of Public 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, Association of Washington Health Care Plans
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. Barbara Detering, Medical Director, Washington State Medical Association
Dr. Peter McGough, Medical Director, UW Neighborhood Clinics
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
Lisa Humes-Schulz, Director of Strategic Initiatives, Planned Parenthood Votes NW and Hawaii
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
Pam MacEwan, Chief Executive Officer, Health Benefit Exchange
Randy Scott, Pacific Health Coalition
Representative Nicole Macri, House of Representatives
Representative Joe Schmick, House of Representatives
Ronnie Shure, Pharm BS
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

Dennis Martin
Mia Nafziger
Shawn O'Neill

Consultants

Betsy Jones, HMA
Jamie Strausz-Clark, 3Si
Jarod 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
Beth Johnson, CEO and President, Coordinated Care Health
Christine Brewer, Brewer Public Affairs and Association of WA Healthcare Plans
Senator Emily Randall
Senator John Braun

MEETING OBJECTIVES AND AGENDA

The sixth meeting of the Washington Universal Health Care Work Group had four objectives:

1. Hear public comment on universal health care.
2. Review and understand outcomes of actuarial analyses so the data can be considered in decision-making.
3. Understand the work that remains to design a system of universal health care, including policies, legal and administrative hurdles, financing, etc., to inform both deliberations about which model(s) to recommend and articulate proposed next steps in the report.
4. Confirm action items and next steps.

WELCOME, INTRODUCTIONS, AND CONFIRM AGENDA

Jamie Strausz-Clark (3Si) convened the meeting and reviewed the “Zoom etiquette” protocols for the meeting. She introduced 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.

Jamie noted we would start with public comment for two reasons: 1) to create an opportunity for Work Group members to consider public comments as they deliberate and 2) make it more convenient for members of the public and minimize the number of people who signed up but were not able to stay for the entire meeting.

Jamie Strausz-Clark (3Si) reviewed the agenda for the meeting.

PUBLIC COMMENT

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

OUTCOMES OF ACTUARIAL ANALYSES PRESENTATION: OPTUMAS

Jamie introduced Shane Mofford and Jared Nason (Optumas) for a preliminary presentation on the modeling they prepared for the Options for Universal Coverage. The presentation included the current state, an explanation of the data limitations, and the model outputs to design a system of universal health care in Washington. Optumas employed a two-part strategy to arrive at the proposed models:

1. Starting with current programs and enrollment, make incremental adjustments to account for the anticipated UHC program design.

Ex: to reduce the expenses associated with hospital utilization for the Medicaid population due the increase access to primary care as a result of the price difference between Medicaid and commercial insurance going away.

- 2: Build system from the bottom up: Develop a high-level, per capita expenditures for included populations and services by program enrollment.

Shane (Optumas) reported preliminary cost estimates for the proposed health care models. Findings showed an anticipated aggregate savings for the State Administered Model (A) of \$3 billion in the first year. The Universal Delegated Administration Model (B) could result in savings of up to \$461 million. In the Close the Gap Model (C), Optumas calculated \$400-\$600 million in increased costs—just to cover the undocumented immigrant population.

Jared (Optumas) disclosed some of the assumptions and considerations that were made in the preliminary estimates in benefits, cost sharing, provider payments, and administrative efficiencies. (Please see the meeting materials and follow-up FAQ for more information about these assumptions). Washington would need to conduct in-depth studies in multiple areas due to data gaps and state budget uncertainty. He detailed future steps that would need to be undertaken after the Work Group has concluded; these include identifying revenue offsets and new revenues needs, and nuanced decisions that will need consideration by legislative policy makers. Jared presented two questions to WG members:

1. Which assumptions have the greatest impact?
2. Do WG members want to change design elements as a result?

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>.

DISCUSSION

Work Group members had a number of clarifying questions, and a few Work Group members expressed concern that they need more time to ask these questions and digest the material before they can discuss it and provide feedback. As such, Jamie Strausz-Clark (3Si) proposed an adjustment to the agenda: forgo the breakout discussion groups and spend the time allocated for this discussion asking and answering clarifying question about the model. Work Group members will have an opportunity to submit additional questions after the meeting and receive answer. We will also provide a list of questions for the Work Group to consider in preparation for our meeting October 7. We will save the discussion of the models for the October 7 meeting.

What—if any—clarifying questions do you have about the outcomes of the analyses?

Baseline of Analysis

Q: Why is the baseline for Models A and B different than Model C?

A: We defined the baseline as all included programs that would be replaced by the model, such as Medicaid expenditures and commercial expenditures. Since Model C would not replace these programs, it is current subsidy policy plus undocumented people.

Assumptions

Q: Even though you shared your assumptions verbally, it was difficult to track. It would be helpful to have a slide that delineates your underlying assumptions.

A: Optumas will provide a slide that delineates the assumptions. There is a complicating factor that is important to acknowledge; everything interacts and compounds. So, for example, if we add a new population it has a domino effect on other assumptions.

COMMENT: The Work Group may want to discuss the underlying assumptions around which programs were excluded from the model (e.g., Medicare) and whether or not we agree with these assumptions.

Costs and Savings

Q: The offsets shown included Indian Health Service (IHS) resources. Is it feasible to include Indian Health Services as a population?

A: It is important to keep magnitude in mind: IHS populations represent a fraction of one percent in the total model. There is likely some overlap with Medicaid population, and we will need to refine our assumptions to reflect this overlap.

Comment: IHS is care of last resort based on federal law, and that is why it should be included in the model.

Q: How do we estimate offsets associated with changes in utilization patterns (e.g., cost reductions associated with currently uninsured people using the emergency room less once they have insurance)?

A: We have adjustments for changes in utilization, including increases in use of primary care and decreases in use of health care associated with exacerbation of untreated illness.

Q: Most health plans have an underwriting expense of approximately 5%. That is why ERISA plans—which assume the underwriting risk—tend to be much cheaper. Do the models assume underwriting expenses?

A: Under Model A (State Administered System), the State administers the program and all functions within it. There are no insurance carriers involved, so there would be no underwriting expense. Under Model B (Delegated Administration), underwriting expenses vary depending on the level of risk assumed by insurance carriers. The current model assumes that insurance carriers are taking on some risk; therefore, there is some underwriting expense. Alternatively, insurance carriers could provide administrative functions only; in that scenario, there would be no risk and therefore no underwriting expense, resulting in greater cost savings. The Work Group may want to discuss which approach to take.

Comment: Under Model A, the system is going to need to build in some reserve capacity because the state will not know what its claims experience is going to be. The model would need to build in some level of reserves.

Comment: Assumptions about cost savings and risk are based on a number of unknowns at this point, which leads to wide ranges in costs for each model.

Q: The cost estimate is for the first year (2022). Are we assuming those costs will be the same for every subsequent year?

A: No, the cost assumptions look different over time. Some of the efficiencies of universal health care won't be realized until later years, but it is really difficult to estimate what those efficiencies will be until we have data from the early years of implementation. Additionally, there are big data gaps (e.g., we don't know precisely how much people are currently paying out of pocket or the total costs of uncompensated care). And, finally, the actual cost savings is entirely dependent on how this program is implemented; until we have those details, it is not possible to estimate costs beyond the implementation year.

Q: In terms of distributing savings, could we break down where these would be allocated? How much savings would there be to the state, individuals, businesses, etc.?

A: This is difficult, because the sources of revenue have to be factored in and we need a breakdown of current and future revenue sources. An example of why this matters is that even if decisions made at the state level save dollars for a population whose care is jointly funded by both state and federal dollars, a certain percentage of those savings has to be allocated to the federal government.

Q: I am wondering about the assumption on slide 9 that elimination of cost sharing would increase short term costs for the state? Is there any research we can access that sheds light on how cost sharing affects costs? I believe that people having early access to care may prevent more costly emergency room and/or hospitalization later.

A: By eliminating cost sharing, we are transferring costs (approximately \$6 billion) that are currently born by the individual to the universal health care plan. That is one reason why this appears as a cost increase for the state. We also assume that changes to utilization will affect costs. You made the point

that early intervention could stave off more costly emergency room and hospitalization, but there may also be increases costs associated with removing all financial barriers to accessing care.

COMMENT: When trying to understand what would happen to utilization if we took away cost sharing, we have two kinds of contradictory evidence. In the U.S., we've observed that when people don't have insurance, their short-term utilization of some services go up. However, when comparing the U.S. to other industrialized health care systems, we see that without point-of-service cost sharing, there is lower overall spending. The model may need to take this into account.

Q: Can we use the all payers claims database to help us understand costs?

A: The all payers claims database (APCD) is missing some key utilization data. For example, by federal law, states are not permitted to require that self-funded (ERISA) plans contribute data to the APCD. Self-funded plans can contribute data voluntarily, but it isn't clear how many do so.

Q: Slide 6 shows imputed and reported private health insurance. Which one is the model using?

A: We include both. Commercial plans have robust reporting. The bar that is imputed is trying to capture all of the unreported expenditures, such as ERISA plans.

Implementation

Q: Can we take a phased approach to bringing different populations into the program?

A: Work Group members are likely to have feedback on this idea. Phasing in populations would create some challenges. One of the things we are learning through the model is that there are different implementation challenges for each population and program. Furthermore, there are some operational considerations that would increase the complexity of a phased approach. For example, when you introduce new populations into a universal health care program, you have to rebalance provider reimbursement. This would get very complicated under a phased approach.

Provider Reimbursements

Q: WG would like more information around the assumptions made about provider reimbursements.

A: We can provide that.

Not-for-profit Managed Care Organizations (MCOs)

Q: Can you provide us with more information about the efficiency of nonprofit vs. for-profit Managed Care Organizations (MCOs) and whether nonprofits would yield higher savings over for-profit carriers? And, if so, what is the magnitude of that difference.

A: If that data is available, we will provide it. Anecdotally, we did a comparison between for-profit and nonprofit hospitals in Colorado, we found the opposite: nonprofits were less efficient than for-profits.

WORK AHEAD TO IMPLEMENT THE MODELS

Jamie Strausz-Clark (3Si) welcomed back everyone from their break. She introduced Jeanene Smith (HMA) who presented on how the UHC model could be implemented in Washington state and discussed administration and feasibility for implementation. Below were the objectives of the presentation:

1. Learn about and compare the complexities of implementing these models that need to be considered in implementation.
2. Learn about an example of how implementation issues were assessed in a similar universal coverage project in Oregon.
3. Consider the relative feasibility of each model in decision-making about which model(s) to recommend to the legislature.
4. Draw conclusions about the work that remains to identify and address these complexities in implementation and how that work might need to be carried out (e.g., different entities such as the Indian Health Board, Medicare administration, etc. will need to form work groups/task forces to develop implementation plans)

BREAKOUT GROUPS: WORK GROUP MEMBERS BEGIN TO ASSESS THE ADMINISTRATION AND FEASIBILITY OF IMPLEMENTATION

Work Group members divided into three breakout groups. These groups discussed takeaways from Nora and Jeanene's pre-recorded presentation and presentation regarding the work ahead to implement universal health care. Below is a summary of the themes that emerged from the breakout group discussions and the report out.

Implementation Obstacles and an Incremental Approach

- The obstacles to implementing universal health care seem overwhelming. Of particular concern are the hurdles associated securing an ERISA waiver, and the potential reluctance of groups—such as unions—who already have high quality plans.
- Health care reform efforts in the 1990s faced many of the same challenges. Back then, the long-term intention was to cover everyone, but the best path forward was to create a system in which everyone would eventually want to participate. The Balanced Billing Law, which was enacted in 2020 and prevents insurance carriers from billing individuals for emergency services or medical care the patient reasonably could have expected to be in-network, and from charging patients more than the in-network cost-sharing amount, offers an example for how this approach could work. Even though they were not required to participate in this law, over 225 self-funded plans have opted in in order to ensure the protections for their members.
- Such an incremental approach offered encouragement for some; others expressed concern that the actuarial analyses may be indicating that an incremental approach would be more costly. They asked for more information to better understand and compare the costs of each option.

- The current environment may be optimal for engaging potentially reluctant people/organizations because employers' costs associated with offering health insurance for employees is so high and many people have lost coverage as a result of COVID.
- Another incremental approach would be to pass universal healthcare legislation and negotiate the implementation details afterwards.
- Given the current environment, which has been impacted by the pandemic and people losing their health insurance, a third way would be to start with focusing on the areas where the need is greatest.
- Regardless of which incremental approach we choose, it is important to clarify a universal health care goal; the lower we set our sights, the less that will be accomplished.
- While in the past many labor unions might have opposed a universal health care approach, some may see the value in such a system. Unions would be strong allies in the effort to secure Universal Health Care.

Medicare: In or Out?

- Work Group members grappled with the challenges and time involved in securing agreement from the federal government to allow Medicare to be included in a state universal health care plan. They weighed these issues against the desire for a comprehensive universal health care plan.
- Suggestions for addressing this tension included creating a state-based Medicare Gap plan (e.g., a plan administered by the state to fill gaps in Medicare coverage), and/or designing a universal health care system that could incorporate Medicare in the future.

Paying for Initial Start-Up and Funding

- The Legislature may be unwilling to take on the financial risk of implementing a universal health care system, even if it means cost savings later, particularly when the state anticipating a budget shortfall in the coming session.
- Perhaps we could look at examples of social investment models or other models that mitigate initial risks by taking on risks and costs of high needs populations incrementally.
- The Oregon RAND study identified an 8.4% sales tax (in a state without a sales tax) to fund universal health care. Since we already have a state sales tax in Washington, would we need to charge 8.4% on top of the existing 6% state sales tax?
- Work Group members wrestled with whether to start with tackling the delivery system or the finance system. One Work Group member felt that because changing funding mechanisms will take a long time, perhaps it makes sense to start by changing the delivery of care, which could be done faster and may lead to additional funding. Another Work Group member challenged this, suggesting that unless we first "de-fragment" the health care finance system, which impacts how health care is delivered, we will not be able to improve health care delivery.
- Option B may present a opportunity to balance feasibility and financial risk with achieving a comprehensive universal health care system. That said, the level of risk to the state would depend on how Option B is designed and the role of insurance carriers (i.e., administrative functions only or taking on more of the financial risk.)

Where Savings Accrue

- Work Group members wanted more information about where the savings from each Model would accrue (i.e., what would be the savings for individuals, taxpayers, etc.), so they can better explain to Legislators and others.
- They also wanted to know when the state could expect a return on investment from the initial start-up costs.

Quality

- Work Group members wanted to understand how improved quality would lower costs and make the program more appealing to additional people and organizations.
- Addressing quality would be critical, regardless of the selected Model. Some of the areas that Work Group members suggested that should be factored in under “quality” included:
 - a. Quality performance and patient satisfaction.
 - b. Cost-based care considerations and accommodations for providers in rural areas.
 - c. Ensuring that independent providers can survive under a move to a Value Based Payment model.¹
 - d. Measuring and promoting the use of strategies such as telemedicine (particularly important for addressing rural access).
- One Work Group member said that it may be possible to achieve similar quality outcomes between Model A and Model B by considering Model B similar to a self-insured plan where you (the state) sets quality metrics through contracting.

Transition/Implementation Plan and Building on Current Infrastructure

- It would be helpful to have an example implementation plan from other states or systems to discuss and refine.
- Washington has some existing infrastructure that could facilitate or inform a transition, including the Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) programs.
- There are concerns about the State’s current capacity to manage a transition or implementation at a statewide scale.
- The transition plan needs to address job losses equitably (e.g., avoid disproportionately impacting certain geographic areas. It also needs to be structured so rural and independent providers can participate.

Stakeholder Engagement

- The Work Group did not come to consensus about ideal end-state for universal health care, and it is reasonable to assume that external stakeholders will have similarly divergent opinions.

¹ A Value Based Payment model offers financial incentives to healthcare providers for meeting certain performance measures, and penalizes health care providers for poor outcomes, medical errors, or increased costs. Professional societies have given qualified approval to incentive programs, but express concern with the validity of quality indicators, patient and physician autonomy and privacy, and increased administrative burdens.

- Advocates for universal health care will need to build trust with external stakeholders to gain traction. They will also need to make sure we are framing the information from the actuarial analyses in terms of tradeoffs (i.e., these are the costs) and benefits (i.e., this what you get out of it).

Process Concerns and Next Steps

- Some Work Group members expressed concerns that the Work Group has more to discuss and there is not enough time with the remaining meetings to do what needs to be done. They asked if there was work that could be done between meetings to accelerate decisions and discussions.
- Some Work Group members perceived that the discussions and analyses are focusing on Model A more than Models B and C, expressed concern that this is in response to the loudest voices in the room, and indicated it will be important to reflect the range of perspectives on the models in the report. For example, some Work Group members may want to solve some of the key challenges in the system without going for full universal coverage.

NEXT STEPS

Jamie Strausz-Clark (3Si) recapped the next steps:

- The slides will be sent to the Work Group and will be notified when they are added to the website.
- The Project Team will consider how we can add more time at the next meeting for discussion of the models and how we can potentially do more work between meetings to meet the Work Group's objectives.
- A revised draft outline will be sent to the Work Group next week.