

Washington Universal Health Care Work Group

Meeting #5 Summary

August 25, 2020, 1 pm to 4 pm

ATTENDEES

Work Group Members

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
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
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
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, Senate
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
Rachelle Alongi
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
Don Hinman, Founder, Mid-Valley Insurance, Inc.
Lisa Humes-Schulz, Director of Strategic Initiatives, Planned Parenthood Votes NW and Hawaii
Senator John Braun, Senate
Shirley Prasad, Policy Director, Government Affairs, Washington State Hospital Association

MEETING OBJECTIVES AND AGENDA

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

1. Hear update on actuarial analyses and provide any final input needed to complete the analyses.
2. Begin assessing three models of health care using qualitative assessment criteria.
3. Confirm action items and next steps.
4. Hear public comment on universal health care.

WELCOME, INTRODUCTIONS, AND CONFIRM AGENDA

Jamie Strausz-Clark (3Si) convened the meeting and reviewed the “Zoom etiquette” protocols for the meeting. She noted that over 40 people signed up for public comment and we would take people in the order that they signed up, adding that because of the high number and limited time for public comment (20 minutes), it was unlikely that everyone who signed up would be able to comment during the meeting. She reminded members of the public that there are other ways to submit comments and all public comments—regardless of format—will be shared with the Work Group. A Work Group member asked if the time period could be extended to allow more time for the public to comment. Jamie responded that we would not change the process for today but would evaluate the approach to public comment for future meetings.

Jamie 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 Strausz-Clark (3Si) reviewed the agenda for the meeting. She explained that today's small group exercises had two purposes:

1. Clarify information needed for the actuarial firm to finish models of universal health care for the Work Group to consider and evaluate.
2. Begin applying the qualitative assessment criteria developed based on outcomes of the December and February Work Group meetings to the three draft models for health care.

The small group discussions will build on the information shared with the Work Group in the pre-recorded presentations, which can be accessed on the HCA Universal Health Care website, <https://www.hca.wa.gov/about-hca/healthier-washington/universal-health-care-work-group>.

Questions from Work Group and responses from staff:

Q: There are various COVID-19 Workgroups. Will there be any dialogue or information sharing between those groups and this Work Group?

A: Sue Birch described a "Uniform Command Group," which meets three times weekly, in addition to a number of Cabinet and sub-Cabinet teams. She described the work of these groups as focused on the details of COVID-19 response—such as sufficient personal protective equipment (PPE) and medical transportation—that may not be relevant to the UHC Work Group. She noted there are efforts to share and leverage information when possible, including scenario planning post-election. Liz Arjun (HMA) added that there is some crossover with the Cascade Care Work Group convened by the Health Benefits Exchange; we are coordinating with them to compile information about how these projects impact one another.

Q: Will the project team be sharing evidence to inform today's deliberations, or will the discussions rest on personal opinion and perception? The Work Group member reiterated concerns about basing the Work Group's discussions on personal opinions, adding that there is evidence available to support these discussions.

A: Jamie Strausz-Clark (3Si) responded that the project team discussed this concern prior to the meeting and explained that the project team will continue to offer pre-recorded presentations and other resources to inform deliberations, as well as staff the breakout discussion groups with subject-matter experts. That said, the project team notes that the availability, quality, and relevance of evidence and research is varied and it may not be possible to provide appropriate resources for each of the 34 separate qualitative criteria identified by the Work Group. Jamie added that the Legislature was intentional in calling for a Work Group comprised of people with a wide range of lived and professional experiences and their perspectives are also important in informing the discussion. Jamie concluded by reminding the Work Group that this is just one step in an ongoing discussion of how any model might be implemented. Another Work Group member suggested that when assessing the three models, we should indicate if we feel there is not enough information to deliberate at this time; the project team agreed to do this.

Q: Can we add another meeting to ensure that the Work Group has enough time to accomplish its task?

A: Jamie Strausz-Clark (3Si) revisited the Work Group decision process/timeline, describing what has been covered in previous meetings, the plan for the current meeting, and what to expect in future meetings. She added that the project team is evaluating adding additional meetings and Work Group members should expect additional updates to the meeting schedule.

BREAKOUT GROUPS: The Work Group divided into two smaller groups to gather specific feedback from Work Group members on how the actuarial modeling should handle cost sharing and provider reimbursement.

COST SHARING

The main theme of the cost sharing discussions focused on the tension between some Work Group members' concerns that cost sharing would deter patients from seeking needed care and the desire of other Work Group members to curb the use of low-value services.

Work Group members who argued against cost sharing pointed to research shared by the project team, including studies in the *New England Journal of Medicine*, the *American Journal of Public Health*, and a RAND study showing the negative impact of cost sharing on access to care, especially for lower-income people. Comments from Work Group members who were not supportive of cost-sharing included:

- Cost sharing is a barrier to seeking needed care.
- It raises administrative costs.
- It doesn't make sense to have a system where people pay thousands of dollars in premiums and then pay additional thousands when using the service they've already paid for.
- There are no copayments in the American Indian health care system and there is no evidence that people overuse it.
- If we focus on quality of care over money, costs will go down.
- We have not seen any evidence from credible studies that cost sharing reduces low-value care.
- Waived cost sharing for COVID testing incentivized people to get tested, which helps everyone.
- Cost sharing puts the burden on the patient to decide whether care is necessary, but the patient should not have that burden.

Comments from Work Group members who supported consideration of modest cost sharing included:

- Modest cost sharing could support key health system goals. For example, high value services would include no cost sharing, in contrast to other services (e.g., elective surgery) that would require cost sharing. Another approach could be to cover an approved network provider (one who meets quality and cost standards established by the system) with no cost sharing, but an individual would have to pay the extra cost for an out of network provider (one who doesn't meet quality and cost standards).
- Group Health information showed \$10 copay kept people from making "social visits." *Work Group members wanted more information about this study.*

- From the Exchange experience, cost sharing with a flat rate has a modest impact on inappropriate use. On the other hand, the Exchange has seen evidence that when cost sharing is high, patients defer care.
- CalPers (CA's public employee benefits) uses cost sharing to drive patients to hospitals for some services (e.g., for knee surgery) where there are more favorable reimbursement terms for the payer.
- Quality suffers if no one is paying (e.g., in socialized medicine).

Although Work Group members disagreed on whether or not the models should include cost sharing, they generally agreed on the following parameters, should cost sharing be included:

- Cost sharing should be structured as a percent of income, which could be very expensive to administer.
- If implemented, cost sharing should be structured to avoid catastrophic financial loss for individuals and families. In addition to limiting out-of-pocket costs, deductibles should be structured so individuals and families are not paying a large amount the first month of year and can spread costs over the year.

Finally, other comments were focused on distinguishing the different impacts of various cost sharing mechanisms such as co-pays, coinsurance and deductibles:

- As a consumer, it is difficult to understand co-insurance. It is not transparent: people are not informed of the actual cost they will pay for the service.
- Chronic disease needs predictability on costs, which means copayments are more desirable than co-insurance.
- Deductibles may influence choices that have little to do with health care outcomes, such as scheduling a service in November because the deductible is paid.

In summary, some argued against including cost sharing in the model because of concern that it discourages needed care. Others expressed support for cost sharing if the goal is to encourage high-value care and discourage low-value care, as long as it is designed with smaller predictable costs such as co-payments at the point of service rather than larger, unpredictable costs such as co-insurance or deductibles. The actuaries will use this information to design the models presented to the group in September.

PROVIDER REIMBURSEMENT

The second breakout discussion focused on gaining more clarity from the Work Group about issues surrounding provider reimbursement. The two main questions posed to Work Group members were:

1. For the universal coverage options, should the model assume lower administrative costs for providers due to a simplified system? Why?
2. Should modeling of the universal coverage options assume that the state will have greater purchasing power that will allow the state to modify provider compensation, as proposed in similar studies?

Work Group members felt that assumptions about the potential for lower administrative costs in the model needed to be specific, realistic, and evidence-based. Additional comments on the model's assumptions about administrative cost savings included:

- There should be one common set of criteria and regulations on billing.
- There should be separate considerations for large systems payment versus payments for smaller practices who have less administrative support.
- We need to consider cost-based payment for smaller practices like those structured for Federally Qualified Health Centers to compensate based on actual costs.

Work Group members recognized that there may be an opportunity to use a greater purchasing power under a universal health care system to improve transparency and lower costs. However, many also acknowledged that this is a complex issue: the amount of potential costs savings would depend on the specifics of the program and developing these parameters will depend on program design and implementation. Additional comments regarding the use of larger purchasing power to bring down costs included:

- Purchasing power can bring costs down, but the model also needs to consider how any potential savings are used (i.e., to bring down overall costs or to invest in other things, such as more benefits).
- Some regulations limit efficiencies and the actual ability to reduce administrative costs and these need to be examined for implementation
- There is work across the state to reduce costs and improve transparency; we should consider how the outcomes of this other work may also help reduce costs and enhance transparency as we consider our recommendations in this area.
- Not all providers are treated equally with respect to reimbursement. For example, Medicare reimbursements to hospitals have steadily increased, while provider reimbursements have stayed at low 1999 levels. This is something to consider in our recommendations.
- We need to design the system to increase primary care relative to other spending: we can start by reducing specialty costs and applying the lessons from "Choosing Wisely" (an initiative of the ABIM Foundation that seeks to advance a national dialogue on avoiding unnecessary medical tests, treatments and procedures).
- We know that Medicare's large purchasing power leads to some savings.
- Need to note that using more units of care is a way to game the current fee-for-service system – need to move the providers/systems to do more value-based care through a payment system that pays based on quality care for populations.
- Also note that with payment adjustments from the current system, there may be impacts of reductions in payments for low-income health workers, such as home health that need to be taken into consideration under new models.
- To estimate the potential cost savings of larger purchasing power, consider looking at the Federal Trade Commission (FTC) score for highly concentrated markets in Washington State.

Overall, Work Group members would like the model to reallocate any potential administrative savings from the new system to lower patient costs or investments in better care. They also want to see a system that is focused on using its power as a purchaser to drive system change, but recognized that this is a complex issue that will take time and more effort to address.

BREAKOUT GROUPS: WORK GROUP MEMBERS BEGIN TO ASSESS HEALTH CARE MODELS USING QUALITATIVE CRITERIA

Work Group members divided into three breakout groups. These groups discussed the qualitative assessment criteria and which—if any—of the three models best supports each criterion. Each breakout group also indicated which—if any—criteria required more evidence to inform the discussion. This is the first of several discussions the Work Group will have on the qualitative criteria, implementation, and policies.

ACCESS: Most Work Group members felt that Model A is more likely to facilitate access than the other Models. That said, some felt Model B—if implemented correctly—could also facilitate access. As one Work Group member pointed out, “CMS (Centers for Medicaid and Medicare Services) delegates administration to carriers—it pays for care for all those enrolled in Medicare- either via traditional Medicare where it directly reimburses providers- or via Medicare Advantage where Medicare reimburses managed care organizations who in turn take on the financial risk for and administer the care for enrolled members. Options A and B are both capable of achieving access; the devil is in the details.” Many Work Group members suggested that Models A and B are more likely to facilitate seamlessness, portability, and choice of provider, but realizing other criteria is dependent on how resources are allocated and policy decisions made during implementation. Work Group members generally felt Model C would be the least capable of facilitating access.

GOVERNANCE: Many Work Group members felt that Model A is more likely to facilitate the criteria for governance, particularly with respect to tribal sovereignty; Models B and C could enable some aspects of governance, but with more entities involved, it would be more challenging. As one Work Group member put it, “It’s likely Model A would have the greatest accountability; it would be a bit more diffuse in Model B, but A and B more than Model C.” One breakout group member pointed out that future work under Governance needed to better define “authentic” consumer engagement, as they felt the engagement they have seen in the Exchange doesn’t seem to meet this standard.

QUALITY AND EQUITY: Some Work Group members felt we should separate equity and quality from one another and switch “culturally attuned care” from access to equity. Many Work Group members asked for more information on how a system might be designed to promote equity. While some Work Group members indicated that Model A has the potential to enable quality and equity more than the other models, many Work Group members felt that realizing these criteria depends on how the selected model is implemented.

FEASIBILITY AND ADMINISTRATION: In general, Work Group members indicated that while Model A is more likely to save the most administrative dollars, Model C is the most politically feasible. Work Group members also indicated that Model A would involve significant administrative challenges to implement but would be the easiest to administer once established. Some Work Group members suggested that these two categories be divided because they are—in many ways—diametrically opposed.

REPORT OUT: There were comments during the large group report out about where the Work Group could benefit from more information, particularly around issues of health equity. One Work Group member pointed out that addressing equity and eliminating disparities will require much more work to design a system that incentivizes proper, culturally-attuned care. Another Work Group member suggested that we need to have “practice-based evidence, in addition to evidence-based practice.”

ACTION ITEMS AND NEXT STEPS

Jamie outlined action items and next steps from the meeting:

- 1) The Work Group will reconvene on September 16 and hear about the outcomes of the actuarial analyses.
- 2) The Consultant Team will compile a meeting summary and share it with the Work Group.
- 3) HCA will post the public comments shared at the meeting on the UHC website, <https://www.hca.wa.gov/about-hca/healthier-washington/universal-health-care-work-group>.
- 4) HCA will post the videos from this meeting and public comment survey to the UHC website.
- 5) The Project Team will update the meeting schedule and topics for the remaining meetings.

PUBLIC COMMENT

Jamie Strausz-Clark (3Si) opened the public comment period. Ten members of the public commented.

ADJOURN

Jamie Strausz-Clark (3Si) adjourned the meeting and thanked the Work Group members for attending and participating in this important civil discourse.