

Washington Universal Health Care Work Group

Meeting #3 Summary

February 7, 2020, 1 pm to 5 pm

ATTENDEES

Work Group Members

Aaron Katz, Principal Lecturer, UW School of Public Health
Beth Johnson, CEO and President, Coordinated Care Health
Bevin McLeod, Co-Founder, Alliance for a Healthy Washington
Brenda Snyder, Director of Policy and External Relations, Office of the 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
Don Hinman, Founder, Mid-Valley Insurance, Inc.
Dr. Barbara Detering, Medical Director, Washington State Medical Association
Dr. Richard Kovar, Medical Director Emeritus, Country Doctor Community Health Center
Dr. Rod Trytko, Washington State Medical Association
Jane Beyer, Senior Health Policy Advisor, Office of the Insurance Commissioner
Lynnette Vehrs, President, Washington State Nurses Association
Kelly Powers, Healthcare Consumer
Kerstin Powell, Health Center Business Office Manager, Port Gamble S'Klallam Tribe
Lisa Humes-Schulz, Director of Strategic Initiatives, Planned Parenthood Votes NW and Hawaii
Mary Beth Brown for John Wiesman, Secretary, Department of Health
Patrick Connor, NFIB Washington State Director, National Federation of Independent Business
Representative Joe Schmick, House of Representatives
Ronnie Shure, Pharm BS
Senator Emily Randall, Senate
Sue Birch, Director, Health Care Authority (Work Group Chair)
Sybill Hyppolite, Washington State Labor Council

HCA Staff

Dennis Martin
Gary Swan
Michael Arnis
Mich'I Needham
Rachelle Alongi
Tamarra Henshaw

Consultants

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
Aren Sparck, Government Affairs Officer, Seattle Indian Health Board
Dean Carson, Department of Revenue
Dr. Sherry Weinberg, Western Washington Chapter of Physicians for a National Health Care Plan
Dr. Peter McGough, Medical Director, UW Neighborhood Clinics
Jason Brown, Office of Financial Management
Mohamed Shidane, Funds Development and Policy Engagement Manager, Somali Health Board
Representative Nicole Macri, House of Representative
Randy Scott, Consultant, Pacific Health Coalition
Senator John Braun, Senate
Shirley Prasad, Policy Director, Government Affairs, Washington State Hospital Association
Zach Snyder, Director, Premera, Sitting in for Christine Brewer, Association of WA Healthcare Plan

MEETING OBJECTIVES AND AGENDA

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

1. Develop assessment criteria by which we will evaluate and compare models for universal health care.
2. Learn about different models of universal health care so Work Group members provide input on which models the group assesses.
3. Confirm action items and next steps.
4. Hear public comment on universal health care and assessment criteria.

WELCOME, INTRODUCTIONS, AND CONFIRM AGENDA

Chair Sue Birch and Jamie Strausz-Clark (3Si) convened the meeting and confirmed the meeting objectives and agenda with the Work Group. Chair Sue Birch thanked members for their time and input and enthusiasm for the work.

Jamie Strausz-Clark reminded the Work Group of the work from December to evaluate root causes and that they will continue to be refined, so members should continue to share their input. This work was incorporated into draft assessment criteria that the Work Group will discuss during the February meeting. It will also be used to assess the models that the Work Group considers.

A second focus of the February meeting is to establish a common framework for understanding the different universal coverage health care models and their key elements. Between the February and April

meetings, the Work Group will be asked to respond to a survey to get preliminary input into the key elements of potential models for Washington State. The consulting team will use survey responses to develop draft models, which will be further discussed and refined at the upcoming April 2020 Work Group. The April goal is for the Work Group to finalize up to three universal coverage approaches for modeling.

Jamie reminded the Work Group of HCA's commitment to share the public comment and that in the future we plan to send the comments gathered between meetings to Work Group members in advance of the following meeting so that members can review it. Comments collected before the February meeting will be emailed to the group the week of February 10. Jamie recapped the public feedback that had been submitted since the September meeting, noting that many members of the public have commented in support of a single payer system. She also reminded the public about the opportunity for comment at the end of the meeting and in between meetings.

Chair Sue Birch reminded the Work Group about the core things they need to address, including:

- Coverage access and eligibility
- Transparency and the true costs of care
- Service delivery and quality of care
- Innovations that are helping improve care

She expressed confidence that we will get there, but that it is important to think about transition steps and not let ourselves get bogged down in details; we need to keep our eye on the big picture and keep moving forward.

DEVELOPING ASSESSMENT CRITERIA: SMALL GROUP EXERCISE

The Work Group divided into three small groups to discuss the draft assessment criteria. Each group was asked to first envision what the future state would look like if universal coverage were achieved. Work Group members were asked to sort their insights into four categories: Cost; Quality; and Affordability, reflecting the broad categories in the Work Group problem statement and an "Other" category. The small groups then used the information from this exercise to review the proposed assessment criteria and suggest changes and amendments.

REPORT OUT ON ASSESSMENT CRITERIA

Work Group and audience members were invited to review each small group's materials. The full Work Group then reconvened, and Jamie Strausz-Clark asked the group for any general reflections from the group before hearing from each specific group. One Work Group member shared that "evidence-based, culturally attuned and rural health care" was in all of the small groups' materials. Another Work Group

member stated that in order to achieve what was seen in the groups' work, "it would require communications and a strong will."

The facilitators of each small group then reported on areas of agreement and modifications to the proposed assessment criteria:

Populations covered

- Does the model allow for phasing in additional groups over time?
- Does the model cover all residents, without regard to age, geography or immigration status?

Benefits package

- There has been a lot of research and deliberation in Washington and other states to develop benefits packages. Do the benefits build on that existing research?
- Does the model address social determinants of health that may result in cost savings?
- Does the model cover gender-affirming care?
- Does the model cover rare diseases?
- Do the benefits include whole body, holistic care?
- Are the covered benefits culturally attuned (e.g. is traditional medicine covered)?

Access to what

- Does the model allow for or promote culturally-attuned care?
- Does the model allow for or encourage evidence-based care?
- Does the model allow for or encourage psychiatric care in the least-restrictive environment (i.e. outpatient settings whenever possible)?
- Does the model promote preventive health services?

Quality

- Is the model amendable to value-based design?
- Does the model support data sharing at the aggregate and individual patient levels?
- Does the model allow for quality across rural, demographics, etc.?

Costs/Affordability

- How does the model affect different groups (such as individuals, employers, governments, taxpayers, etc.)?
- What is the model's economic impact on the state?
- Does the model include, or support strategies or mechanisms known to control costs and spending?
- Does the model promote evidence-based social programs that have data demonstrating they save money and reduce over-medicalization?

Governance

- Does the model ensure administrative accountability?
- Was the model designed with Tribal partnership?
- Is the governance structure transparent?

Feasibility and Administration

- To what extent is the model politically feasible?
- Does the model's structure reduce administrative complexity?

Other Considerations

- Does the system give the patient a voice/promote self-advocacy?
- One group also reported that it would be good to consider the extent to which the model aligns with recommendations from the Bree Collaborative and Health Technology Commission.

Discussion

Regarding the proposal to replace the benefits section of the criteria with a benefits package that has already been developed through deliberation and research, two Work Group members cautioned that building on existing work is a good idea, but we should be careful that the benefits package we choose does not take us backward in terms of providing comprehensive benefits.

The Work Group discussed a Yellow Group proposal to consider the impact of each model's affordability for each of the following group: families, employers, individuals, the state government, etc. There was some discussion about where to draw the line about the number of parties to include. The consultant team noted that there is limited research on affordability. Information on costs (how much different groups pay) exists, but it is not often crosswalked with the impact of those costs on different populations.

Work Group Members expressed a few concerns about measuring affordability and economic impact:

Issue: If we try to examine affordability for too many groups, it would be difficult and, comparison of affordability across models would not be meaningful.

Response: There was some general agreement that it may not be feasible to measure economic impact if the population subsets are too granular. The Work Group discussed keeping this analysis at a relatively high level. In addition, while a few Work Group members discussed concerns about the economic impact of different health care models on providers, one Work Group member said his priority is on the economic impacts to individuals and families. In discussing the economic impact on employers and employees, Work Group members pointed out that some people will continue to get their coverage through unions.

Issue: How do we avoid using subjective or value-based measures of affordability? Can we use quantitative data to assess affordability and other criteria?

Response: The consultant team will incorporate quantitative data to the extent that the data is available.

Issue: How do we measure affordability?

Response: A Work Group member suggested mining research on affordability thresholds for different groups. The consultant team responded that there is some information on affordability across different groups of consumers, providers and for specific sub-groups that may be of interest.

The Work Group discussed costs and transparency. A few Work Group members wanted assessment criteria that would reflect how a model might promote transparency about the different charges that people receive depending on their coverage. One Work Group member familiar with the Federally Qualified Health Center (FQHC) system pointed out that FQHCs collect data on costs to set their rates. The Work Group member suggested looking into whether these data could be used as a payment framework. Another Work Group member suggested that the same type of data is available through the Indian Health Services and Tribal Health Centers. A Work Group member cautioned against integrating data without first confirming data validity and making sure data from different sources measure the same thing and can be used in the same analysis. The consultant team responded that as new data sources are identified they will work to affirm validity and that data sources are consistently measuring the same things. When the consultant team synthesizes the Work Group's input on the assessment criteria, the actuaries will review the assessment criteria and note which ones are measurable through quantitative data.

A few Work Group members said that costs to individuals and families, employers, and others can vary tremendously depending on the network. Work Group members discussed how the assessment criteria around costs should focus on what the system does to lower costs for these parties and what the system does to promote transparency. A few Work Group members proposed assessment criteria that measure the extent to which the model promotes supports consistency in pricing, so that a service is billed the same without regard to a consumer's type of insurance or lack of insurance. Work Group Members expressed that quality was important and should not be compromised in order to lower costs and increase affordability.

MODELS OF UNIVERSAL HEALTH COVERAGE

Jeanene Smith (HMA) and Nora Leibowitz (HMA) presented models of universal health coverage. The presentation provided information to develop a common understanding of models for universal coverage programs. The international models are referenced in the document "High Level Overview of Major International Models" and the US models are referenced in the document "Identifying Quantifiable Option Elements using Examples of Past, Current Frameworks".

*****Related Attachments: Slide Deck - "Overview of Coverage Models" and Matrix "High Level Overview of Major International Models".***

International Models

Jeanene Smith presented an overview of the four main approaches used by other countries:

- Beveridge Model (Single-Payer National Health Service) – government is the only payer for care and owns and operates the delivery system (employs providers).
- National Health Insurance Model (Single-Payer National Health Insurance) – government is the insurer/payer and contracts with the privately-run delivery system.
- Bismarck Model (Social Health Insurance) – de-centralized, similar to employer-based health plans and some aspects of Medicaid. Employer and employee payroll taxes fund sickness funds and care is delivered through private institutions. Government has strong oversight over what is covered and cost controls.
- Out-of-Pocket Model (Market-Driven) – multiple payers (government, employers, employees, individuals) pay insurance plans to contract with the private delivery system or pay the delivery system directly for care.

Jeanene Smith explained that most of the models have evolved over time and were conceived when the geopolitical circumstances demanded some action. It is important to consider how each model would “translate” to WA state in the current environment. Additionally, most models we see in other countries are combinations of the four general approaches.

The Work Group discussed the distinction between the payer and the delivery system. The payer is the entity from whom providers get reimbursed for services (the national government, regional government, employer, etc.). The delivery system refers to how the providers are organized, such as whether the government employs providers and/or owns hospitals (as in England or the Veterans’ Administration in the U.S.), or whether providers and hospitals are privately-run (as most are in the U.S.).

Work Group members recommended adding additional details on delivery system information to the international models slides and matrix.

There was further discussion about factoring in non-service costs when assessing the impact of any model, such as investments in graduate medical education (GME) and other supports to the workforce. Through several funding streams, the federal government provides GME funding to hospitals to support their costs associated with medical residency training. Workforce training costs are funded differently in the U.S. and other countries. For example, in Cuba the national government funds medical education, while in the U.S. this is not generally the case. In the U.S., medical education is funded by fees paid by students (along with loans or grants) and federal GME and other federal and state funds. The Work Group agreed that it would be ideal if this spending could somehow be factored into the cost of care.

Domestic Models

*****Related Attachments: Slide Deck – “Overview of Coverage Models” and Matrix – “Final Comparison of Universal Model Elements”***

Nora Leibowitz explained that a handful of states have proposed models to achieve universal coverage. However, no state has yet implemented a universal coverage program. Nora Leibowitz noted that for some of the state efforts, the content was based on legislation that was passed, with the development of program details assigned to a specific group or agency to further delineate. Some of the models proposed are still under discussion. The three main domestic approaches are those where:

- Government Directly Administers (sets the rules, pays providers)
- Government Sets Rules, Oversees Private Plans
- Incremental Efforts Build on Existing Programs

The examples of incremental efforts in California and Washington are designed to address gaps in the current system and address affordability and are not intended as universal coverage.

A Work Group member noted that on the slide with recent examples from Washington State, the WA Health Security Trust Bill needs to be clarified. Under the Bill, the state would pay providers directly, without plan involvement.

One Work Group member recommended using the Urban Institute report (“From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs,” October 2019), which provides examples of how we could layer one of these initiatives on top of what Washington State has already in place to achieve universal coverage, noting that Washington has achieved coverage for 98% of children. The same Work Group member recommended that looking at how this was achieved with children could be a model to consider for universal coverage. Some Work Group members were surprised to hear that almost all children in Washington were currently covered. In response, some other Work Group members suggested that we need to better understand our state’s context and starting point.

Work Group members also circled back to the earlier discussion about the need to capture all the system costs that are not necessarily paid by individual consumers. Two Work Group members familiar with FQHC shared information about the work they have to do to report what is factored into their costs as a potential example of how we might approach this. The actuaries on the consultant team responded that they will be able to capture the overall costs to the system. This will be important because it will be necessary for being able to compare to the potential costs of a new system. The Work Group agreed that there was value in trying to have “unified health care financing” of all costs in the system, not just those paid by patients or insurers.

The consultant team will make changes to the matrices and presentation based on Work Group input and will send the revised version to the Work Group. A survey will be developed based on discussions so far and the needed elements to frame up potential models to start to gain initial input from the Work Group members. The survey results will be shared at the April meeting for further small group and overall group discussion on one or two potential universal coverage approaches for modeling.

ACTION ITEMS AND NEXT STEPS

Jamie Strausz-Clark recapped the action items and outlined the next steps from the meeting.

- 1) HCA will send the public comment from the December meeting to the Workgroup.
- 2) The consultant team will revise the assessment criteria based on the February meeting discussion and share it with the Work Group along with meeting summary.
- 3) The consultant team will incorporate the Work Group's clarifications for the meeting materials including the slide deck and the matrices and it will be shared with the Work Group.
- 4) Work Group members will receive a survey in late February/early March to solicit input from the Work Group to identify key elements they would like to see in a universal coverage approach
- 5) The next meeting (Wednesday April 22, 2020, 1-5pm) will focus on the input from the survey and will be spent on further discussions of potential universal coverage approaches

PUBLIC COMMENT

Jamie Strausz-Clark opened the public comment period- two members of the public commented.

ADJOURN

Chair Sue Birch adjourned the meeting and thanked the Work Group members for attending and participating in this important civil discourse.