

Washington Universal Health Care Work Group

Meeting #4 Summary

June 24, 2020, 1 pm to 4 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, Office of the State Treasurer
Carrie Glover, Policy Consultant, Dziedzic Public Affairs
Carrie McKenzie, Chief Executive Officer, Goldcore Innovations, LLC
Christine Brewer, Brewer Public Affairs and Association of WA 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. 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
Shirley Prasad, Policy Director, Government Affairs, Washington State Hospital Association
Sybill Hyppolite, Washington State Labor Council
Vicki Lowe, Executive Director, American Indian Health Commission

HCA Staff

Dennis Martin
Gary Swan
Mich'I Needham
Rachelle Alongi
Shawn O'Neill

Consultants

Betsy Jones, HMA
Chris Dickerson, Optumas
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
Sue Birch, Director, Health Care Authority
Dr. Barbara Detering, Medical Director, Washington State Medical Association
Lisa Humes-Schulz, Director of Strategic Initiatives, Planned Parenthood Votes NW and Hawaii

MEETING OBJECTIVES AND AGENDA

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

1. Learn about, discuss, and provide feedback on three draft models of universal health care that the actuaries can model for the Work Group.
2. Review what's next in the process, including plans for the August Work Group meeting.
3. Confirm action items and next steps.
4. Hear public comment on universal health care and draft models.

WELCOME, INTRODUCTIONS, AND CONFIRM AGENDA

Jamie Strausz-Clark (3Si) convened the meeting and introduced Mich'l Needham (standing in for Chair Sue Birch). Mich'l thanked members for their time in reviewing the background materials in advance of the meeting and their patience as we have reconfigured the meeting process. Mich'l also reiterated Sue Birch's comments in the pre-recorded session about the ongoing pandemic and recent events surrounding racial inequities and HCA's commitment to the work ahead.

Jamie Strausz-Clark (3Si) reviewed the agenda for the meeting and 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 explained that today's small group exercise is designed to gather information the actuarial firm needs to develop dynamic models of universal health care for the Work Group to consider and evaluate. The small group discussions will build on the information that was shared with the Work Group in the pre-recorded presentations developed by HMA and Optumas and HCA, 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>.

Jamie Strausz-Clark (3Si) explained that Aren Sparck with the Seattle Indian Health Board is on leave and Vicki Lowe, Executive Director of the American Indian Health Commission for Washington State, will be filling in for him.

PRESENTATION: DRAFT MODELS OF UNIVERSAL HEALTH CARE

Nora Leibowitz from HMA and Shane Mofford from Optumas provided a brief refresher for Work Group members about the three draft approaches for universal health care that were described in the pre-recorded presentation. HMA and Optumas developed these draft approaches based on the Work Group’s prior work to clarify the problem and its root causes and develop assessment criteria for proposed models, as well as the survey that Work Group members completed between February and April. Brief descriptions of each of the three approaches are below:

Option A: Universal Coverage Administered by the State (“Universal 1”)

WHO IS COVERED	All Washington residents are provided health insurance coverage
PLAN STRUCTURE	Single statewide health plan
BENEFITS	Washington Essential Health Benefits, other services TBD
STATE ROLE	<ul style="list-style-type: none"> • Develops and administers the program policy • Designs and manages the delivery system (e.g., value-based payment, promotion of primary care, etc.) • Assumes all financial risk and payer-related functionality
INSURER ROLE	No insurers as state contracts directly with providers
PROVIDERS	Contract directly with state (not employed by state)
PAYMENT RATES	Provider payment is based on service and severity, not type of coverage

Variant – Universal 1.5 would maintain existing coverage for some or all residents with federal coverage (Medicaid, Medicare, Veteran’s and military health care, federal employee coverage)

Option B: Universal Coverage Administered by Multiple Private Plans (“Universal 2”)

WHO IS COVERED	All Washington residents are provided health insurance coverage
PLAN STRUCTURE	Participating health insurers
BENEFITS	Washington Essential Health Benefits, other services TBD
STATE ROLE	<ul style="list-style-type: none"> • Develops and administers the program policy • Designs the delivery system (e.g., value-based payment, promotion of primary care, etc.) • Delegates most financial risk and payer-related functionality, delivery system management
INSURER ROLE	Insurers that meet state standards contract to offer coverage under the program
PROVIDERS	Contract with insurers
PAYMENT RATES	Provider payment is based on service and severity, not type of coverage

Variant – Universal 2.5 would maintain existing coverage for residents with federal coverage (Medicaid, Medicare, Veteran’s and military health care, federal employee coverage)

Option C: “Fill in the Gaps” Coverage for People Without Affordable Access

WHO IS COVERED	Washington residents without access to coverage through Medicare, Medicaid, VA/military or affordable employer-sponsored coverage
PLAN STRUCTURE	Participating health insurers (builds on Cascade Care model)
BENEFITS	Washington Essential Health Benefits, other services TBD
STATE ROLE	<ul style="list-style-type: none"> • Develops the program policy • Designs the delivery system (e.g., value-based payment, promotion of primary care, etc.) • Delegates most financial risk and payer-related functionality, delivery system management
INSURER ROLE	Insurers that meet state standards contract to offer coverage under the program
PROVIDERS	Contract with insurers
PAYMENT RATES	Provider compensation limits (per Cascade Care)

Variant – Fill in the Gaps 1.5 includes premium subsidies for participants

Nora and Shane reinforced a key difference between Model A (Universal 1) and Model B (Universal 2): in Model A, the state contracts directly with providers, whereas with Model B, the state contracts with health plans who contract with providers. Shane explained that although these approaches look similar, there are some significant differences in how each might delivery and cost. Nora and Shane also explained that the variations Universal 1.5 and Universal 2.5 would exclude individuals who are already covered by federal programs including Medicare, Medicaid, Veterans’ Administration (VA) coverage, or are federal employees.¹

BREAKOUT GROUPS: MODELS OF UNIVERSAL HEALTH CARE

Jamie Strausz-Clark (3Si) described the process for breakout groups. Work Group members were divided into three cohorts. A team comprised of a subject matter expert and a representative from the actuarial firm, Optumas, were assigned to each of the three draft models and rotated through each of the three cohorts of Work Group members. Each cohort of Work Group members responded to a series of questions for each specific model. At the end of the third rotation, all of the Work Group members came back together and team summarized key themes from each of the discussions.

REPORT OUT

Option A: Universal Coverage Administered by the State (“Universal 1”)

Jeanene Smith (HMA) and Shane Mofford (Optumas) facilitated the discussions focused on Option A. Many of the questions Jeanene and Shane asked related to both the State and Distributed Administration models (Options A and B). Below is summary of the key themes from across all three cohorts.

¹ Work Group members watched pre-recorded presentations and submitted questions prior to the Work Group meeting, so no time was allocated for questions.

Mandate: In response to the question of whether or not either of the universal health care models (state and distributed administration) should mandate that all residents participate, there was acknowledgement that the program would only work financially if enough healthy people join, which may require a mandate. Some Work Group members shared the perspective that there may not need to be a mandate to ensure full participation if the program is good enough, while others acknowledged that a mandate may be needed early on to get enough Washingtonians to join. An important challenge to implementing a mandate in Washington is that there is no income tax to tie to the potential penalties for not participating.

After discussion, Work Group members seemed to lean towards making all residents automatically eligible, rather than creating a mandate.

Supplemental/Substitute Coverage (Allowing those in the new system to purchase additional benefits): Some Work Group members expressed interest in allowing individuals to buy additional benefit coverage, similar to how the Medicare system allows Medicare supplementals and Medicare Advantage. A Work Group member indicated this would be important to the labor community because they have secured many improvements to coverage offered by labor unions and banning supplemental benefits would threaten these gains. However, Work Group members acknowledged that it would be important to consider the potential unintended consequence of allowing those able to afford other coverage options to opt out of the Universal program, such as increasing the risk in the universal model pool. At the same time, Work Group members suggested that allowing for “opting out” might help generate acceptance of the new model.

As there was not consensus amongst Work Group members about whether supplemental coverage should be allowed, Optumas will build multiple scenarios into their model.

Universal Health Care Variant 1.5: Work Group members understood the challenges involved in including all individuals currently enrolled in the federal programs, such as administrative hurdles and potential delays in securing federal approval to include these populations. One Work Group member suggested that we could consider allowing individuals with other federal coverage to “buy into” the Washington plan.

Benefits: Work Group members generally agreed with using the Essential Health Benefits as the foundation of benefits for the Universal Health Care approach. Many also felt that adult vision and dental should be included in the universal health care models but acknowledged that this would incur higher costs. To better understand the costs, Work Group members would like to see the actuarial outputs with and without vision and dental benefits.

Similarly, Work Group members generally wanted to see actuarial outputs with and without Long Term Care. They also acknowledged that if Long Term Care is included as a benefit, it would have to align with Washington’s new Long-Term Care benefit.²

In general, Work Group members discussed the need for a full benefit package that improves health and is attractive enough to keep participants enrolled without a mandate. Additional benefits mentioned include hearing, chiropractic care, and acupuncture.

Other Comments:

- Many Work Group members felt that maintaining choice of providers would be important to garner participation and support.
- A few acknowledged that Model A will be challenging for the state to implement quickly, since the state does not currently have direct contracts with providers or the responsibility to pay all claims, in comparison to Model B where the state would delegate these functions to health plans.
- A few Work Group members indicated it was important to sort out how employers would financially contribute to the model, while recognizing that employees may expect some adjustment to their wages if employers are no longer contributing financially to their health care.
- A few Work Group members wanted additional clarification on which federal programs would be excluded with the 1.5 and 2.5 variants, as some federal programs—such as the Indian Health Service— fund health care services but are not health insurance coverage. The Washington Health Security Trust model had seven types of federal programs that were excluded.
- One Work Group member pointed out that the Medicare and Medicaid programs tend to lead in innovations to improve care and lower costs, and suggested we look to these programs for ideas.

Option B: Universal Coverage Administered by Multiple Private Plans (“Universal 2”)

Nora Leibowitz (HMA) and Jared Nason (Optumas) facilitated the discussions focused on Option B. Some, but not all questions they asked were specific to both universal health care options, while other questions were specific to just Option B. Below is a summary of the discussion across the three breakout sessions.

Cost sharing (general): Across the three discussions, most Work Group members who spoke supported the two universal health care models including some cost-sharing, but only if premiums and co-payments are based on a participant’s income. Work Group members expressed that this approach has the potential to be more progressive than funding the program solely or mostly with a sales tax. Work Group members generally felt that cost-sharing rates (premiums and/or co-payments) should be standardized and set by the state.

² <https://crosscut.com/2019/05/wa-will-take-care-you-when-youre-old-heres-how>

Co-Payments: Multiple Work Group members noted that co-payments impact health care utilization in ways that can be both negative and positive. Those who spoke in favor of co-payments noted that they can be used to incentivize appropriate care—such as preventive care and minimize or avoid low-value care (one Work Group member shared an observation that some people use the doctor for needs other than medical, and co-payments can help minimize this).

Those Work Group members who supported co-payments generally felt they should be:

- Standardized and set by the state
- Based on evidence of benefit/impact
- Income-based, where lower income people pay less (\$0 for lowest income)

Those who expressed concerns about co-payments worried they could reduce access to needed care. They expressed concerns that under Option B, people will select plan by income, which may result in people with lower incomes having worse access to care. Some Work Group members felt there is a need to eliminate deductibles and co-insurance to get people to seek care when they need it.

As there was no strong consensus on how to handle co-payments, Optumas will build multiple scenarios into their model.

Premiums: Work Group members spent less time discussing premiums, although some people spoke in favor of them.

Universal Health Care Variant 2.5: Some Work Group members indicated that limiting federal involvement by excluding federal programs such as Medicare may be a more expedient option. Furthermore, several Work Group members expressed concern that including Medicare beneficiaries in the program means bringing in a higher risk/cost population.

Providing Administrative Functions: Some Work Group members wanted this model to delegate administrative functions to insurers, such as managing and processing claims and distributing funds. Some hypothesized that by using insurers as administrators, we could reduce inefficiencies of the insurance industry, citing examples from Germany or Japan. Some Work Group members saw insurers as having a role beyond paying claims, suggesting they could help eliminate low value care and fraudulent billing. It was noted that a program that expects value-based payments, capitation, etc. would be a lot of work for the state to implement directly with providers.

Some Work Group members felt that insurers should not have a role in making medical care decisions. Some Work Group members added that insurers having their own networks has led to inequities in access and costs.

Number of Insurers: Some Work Group members supported the idea of fewer insurers, hypothesizing

that fewer insurers would reduce administrative and costs and furthermore, there is no evidence of a benefit to having more insurers. Some Work Group members suggested that reducing the number of insurers may make implementing value-based programs easier, with better opportunities to realize economies of scale. A Work Group member suggested the state could have a competitive process to select a single insurer to run the program. However, other Work Group members pointed out that having no competition can also create issues, such as reduced quality of care. A few Work Group members felt that competition is a strategy, not an end goal, and should be used only if it drives down costs for consumers and the system. Work Group members generally agreed that choice of providers, clinics, and hospitals was more important than plan choice. Finally, Work Group members generally felt that setting strong oversight for insurers was key to the success of this program.

Standardizing Benefits, Coverage Design: A few Work Group members suggested that standardizing the benefit and coverage designs offered would reduce administrative costs and make the plan(s) more user friendly/understandable to consumers. Some Work Group members noted that this approach can be used to support evidence-based care and reduce low-value care but added that this approach is not always transparent. Work Group members asked to what extent the state would be an active purchaser under this model, using its scale to reduce costs and improve quality. Finally, a Work Group member suggested that undoing the profit motive in the system would require setting an annual global budget (or fixed amount of funding per year for a specified population, rather than fixed rates for individual services or cases).³

Generally, Work Group members agreed that the state should have a strong role in standardizing and overseeing plans and insurers, to avoid many of the current pitfalls of the current system, such as limited networks and access.

Option B as a Transitional Program or Final State: Some Work Group members expressed that Option B is more feasible as an end state than Option A. Other Work Group members could see Option B as a transitional program on the way to Option A. Some Work Group members expressed concern that pursuing Option B as a transitional program could reduce momentum to achieve Option A, effectively risking the opportunity to achieve Option A.

Other Comments:

- A Work Group member noted that employers use health benefits for recruiting and retention. As such, some larger employers may resist or want an exemption from participating. This issue would need to be addressed in the model design at some point.

Option C: “Fill in the Gaps” Coverage for People Without Affordable Access

³ The main objective of a global budget is to constrain the amount a hospital can spend to limit the total amount of money spent on health care within the system for large provider groups and hospitals. Maryland’s model includes this approach. (https://www.urban.org/sites/default/files/05_global_budgets_for_hospitals.pdf, accessed 7/2/20)

Jamie Strausz Clark (3SI), Liz Arjun (HMA), and Chris Dickerson (Optumas) facilitated the discussions focused on Option C. Most of the questions asked in this discussion related only to Option C. Below is a summary across the three breakout discussions.

Initial Reactions: Several Work Group members expressed that while Option C seems like the most politically feasible option, it has significant limitations: it would not cover everyone, it is likely to be the most costly of the three options, it would not control costs, and represents the “status quo.” A Work Group member characterized this model as simply “rearranging deck chairs on the Titanic,” and a few other Work Group members echoed this sentiment.

A few Work Group members noted that the underlying financing of the health care system would not change from the current state, and that it would be necessary to require individuals and providers to participate or there would continue to be limited networks and choice for consumers. A Work Group member suggested that it would be difficult to get people to participate.

On the other hand, one Work Group member noted that by pairing this model with Cascade Care, it may be possible to bring up to 700,000 people into coverage.

Many Work Group members agreed that it was important to evaluate this model because it is likely to demonstrate the high cost of the status quo compared to the other two options. One Work Group member stated that it would be better to spend resources evaluating a model that would involve partnering with other states, which is consistent with language in the 2019 budget proviso authorizing this work group.

Incremental/Transition Model: Some Work Group members felt that this model should only be considered as a transitional model on the way to one of the two universal health care options. However, several Work Group members expressed concern that even pursuing this as a transitional approach would take away the momentum for achieving true universal health care. A few Work Group members indicated they would consider this as a transitional option only if it were packaged as an interim step toward universal health care, with legislative benchmarks and assurances that it was a stepping stone to the other models.

Coverage for Immigrants not Eligible for Existing Program: All Work Group members who spoke expressed support for this model covering immigrants not currently eligible for coverage through existing programs. A few Work Group members pointed out that the COVID-19 pandemic has demonstrated the financial and societal costs of not providing affordable and accessible health care to immigrants. Others stated that it is an ethical requirement to cover this population. Some Work Group members added that immigrants are contributing to the state economy and paying taxes, and as such, should be able to receive benefits.

Some Work Group members want to know if it would be possible to see the actuarial outputs for this model with immigrants included and excluded. Chris Dickerson (Optumas) confirmed that this would be

possible. A few Work Group members wanted to know whether the actuarial model would account for cost offsets when comparing costs for including or excluding immigrants, such as uncompensated care in the hospitals and the Medicaid Disproportionate Share Payments. Chris Dickerson confirmed that the model would include these cost offsets.

Unaffordable Employee Coverage Participation: Work Group members felt that if this model sets a better standard for affordability than what one is offered through their employer and an employee's income falls under a specified threshold, they should be allowed to participate in this program. One Work Group members recognized that this could have the unintended consequence of incentivizing some employers to drop health care coverage, but that was not necessarily bad if the coverage and affordability standards were better in this model. Work Group members noted that this is a step in the direction of de-linking employment and health coverage, which could be a challenging transition for some employers.

Other Comments:

- A few Work Group members asked how we would set the affordability standard, as some Work Group members felt current standards are not appropriate or comprehensive enough (e.g., they only include premiums, not other types of cost sharing such as co-payments and deductibles).
- It was noted by some Work Group members that this model could allow us to quickly identify and address the largest gaps, especially given the existing crisis.
- One Work Group member suggested that we could simply enroll everyone in the state employee plan as an interim step.
- One Work Group member suggested that we should talk about “participation” rather than “coverage,” because this is easier to communicate to the public.
- A few Work Group members supported the idea of doing an equity analysis of all three models in the future, to understand how each model would impact different communities and demographic groups across the state.

REPORT OUT

Each facilitator team recapped key themes from their discussion groups. Jamie Strausz-Clark (3Si) synthesized the discussions, highlighting the tension that many Work Group members appeared to be wrestling with: deciding whether to “shoot the moon” and go for a major overhaul of the current system or do something that seems more feasible in the short term. Jamie suggested that the actuarial analyses will provide us with more information to help us better understand the costs, benefits, and tradeoffs of each option.

ACTION ITEMS AND NEXT STEPS

Jamie outlined action items and next steps from the meeting:

- 1) The Work Group will reconvene on August 25 and use the qualitative assessment criteria developed by Work Group members in February to assess the three models. They will also receive an update from Optumas on the actuarial analyses.
- 2) The Project Team is considering options for adding another meeting and will be in touch about this.
- 3) The Consultant Team will compile a meeting summary and share with it with the Work Group.
- 4) 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>.
- 5) HCA will post the videos from this meeting and public comment survey to the UHC website.

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.