Universal Health Care Commission Meeting Summary

August 10, 2023
Health Care Authority
Hybrid meeting held electronically (Zoom) and in-person at the Health Care Authority
2:00 p.m. – 4:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the commission is available on the Universal Health Care Commission webpage.

Members present

Vicki Lowe, Chair
Bidisha Mandal
Jane Beyer
Representative Joe Schmick
Representative Marcus Riccelli
Mohamed Shidane
Nicole Gomez

Members absent

Senator Ann Rivers
Dave Iseminger
Senator Emily Randall
Estell Williams
Joan Altman
Kristin Peterson
Stella Vasquez

Call to order

Vicki Lowe, Commission Chair, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

Chair Lowe began with a land acknowledgement and welcomed Commission members to the thirteenth meeting.

Meeting summary review from the previous meeting

The Commission members present voted by consensus to adopt the June meeting summary.

Public comment

Chair Lowe called for comments from the public.

Meike Weyrauch shared that people in Cowlitz county are increasingly facing barriers to accessing care and

encouraged the Commission to financially incentivize providers to practice in small and rural counties.

Madeline Bishop, retired state worker, supported Washington's universal health care (UHC) plan being based on the existing Uniform Medical Plan. The Commission should also identify the following: legislators to champion the UHC; a communications strategy to get legislation passed; and who will defend and fund any court challenges.

Lisa Gaynor, a widow and constituent of Cowlitz county, does not work for an employer that provides health care coverage. It has been challenging to find affordable health care coverage, let alone in-network providers who are taking new patients. People in Washington need easy, affordable health care coverage.

Ronnie Shure, President, Health Care for All – Washington (HCFA-WA), remarked on the difficulty of transitioning Medicaid enrollees into the new system due to potential differing levels of benefits. The Commission should build upon their work to address issues for low-income Medicare beneficiaries.

Cris Currie, (HCFA-WA), noted that a suggested draft vision for Washington's UHC is included in this meeting's written public comments. The Commission's agreement on an overall direction would facilitate the task of prioritizing transitional solutions and will give the Legislature and the public a clearer picture of the future UHC.

Warren George, former member of Oregon's Joint Task Force on Universal Health Care, announced that Senate Bill 1089 passed and was recently signed by the governor. The bill establishes a governing board for UHC in Oregon. The Commission was encouraged to refer to this meeting's written public comments for more information on nuances of single-payer systems.

Michael Hubbart, retired actuary, lived in the United Kingdom for several years and had a positive experience with their National Health Services (NHS). The greatest issue with the current U.S. health care system is the complexity. A single-payer system is simpler and may lead to improved health outcomes.

Emily Brice, Deputy Dir., Northwest Health Law Advocates, suggested the following transitional solutions for prioritization: continue to address undocumented immigrant health; fill gaps in benefits and affordability for Medicare enrollees; support efforts to unify health coverage to eligibility and enrollment systems; explore universal enrollment screening at key life transitions; work towards consolidation in state health care purchasing where doing so could expand access; study the state's prevalence of underinsurance across all markets; and explore opportunities to make care more affordable by pegging to the Medicare benchmark.

Mason Chittick shared that growing up, his family could barely afford the cost of medicine and treatment for his health conditions, and universal health care would have been very beneficial.

Commission member Mohamed Shidane thanked members of the public for their comments and shared his experience with health care costs. Though his employer provides health care coverage for employees, half of his paycheck is still spent on the cost of health care coverage for he and his family.

Robin Thayer remarked that the Kitsap County Board of Health declared a health care crisis in Kitsap County due

to shutdowns and takeovers of medical facilities by large, faith-based health systems, and health care plans not providing patients access to providers in the county in which they live.

FTAC updates: First discussion on Employee Retirement Income Security Act of 1974 (ERISA)

Pam MacEwan, FTAC Liaison

The Commission directed FTAC to examine pathways to include ERISA in Washington's universal health care system. FTAC's July meeting was focused on information gathering on ERISA issues both in Washington and at the national level. FTAC heard from two presenters. The first was Professor Carmel Shachar from the Harvard School of Law who provided an overview of ERISA, including the evolution of Courts' interpretation of ERISA preemption, ERISA preemption impacts on state innovation (including universal health care initiatives), and potential areas of opportunity. FTAC also heard from Commission member Jane Beyer, Senior Health Policy Advisor at the Office of the Insurance Commissioner on ERISA issues specific to Washington. This included an overview of segments of the health care market for which ERISA preemption does not apply and Washington health policies that have and have not brought ERISA challenges and why. In September, FTAC will dive deeper into options to include ERISA, assess the pros and cons of each option, and develop recommendations to the Commission.

Presentation: Guidance to FTAC on Medicaid

Liz Arjun, Health Management and Associates (HMA)

The Commission was asked what preliminary questions they'd like FTAC to answer and evaluate regarding Medicaid eligibility for the universal health care system. Commission member Jane Beyer suggested getting a sense of what other states have done with 1115 waivers to expand eligibility. Chair Lowe added exploring federal barriers with regards to asset limitations for enrollees of classic Medicaid. Does a comparison of benefits exist for Medicare, Medicaid, and Public Employee Benefits (PEB)? Commission member Bidisha Mandal asked whether there is a map of providers in Washington who are not accepting Medicaid (often due to low Medicaid reimbursement rates). Mandy Weeks-Green, Dir., Health Care Cost Transparency Board, Health Care Authority (HCA), remarked that provider directories are unreliable because they're constantly changing. Jane Beyer added that state agencies work to ensure network access but it's difficult to identify which providers have room in their practice and/or are willing to participate in Medicaid. FTAC should surface reasons for Medicaid enrollees' access issues in addition to low reimbursement rates. Chair Lowe remarked that without a federal waiver to include Medicaid, even if the universal health care system can wrap around Medicaid benefits, there will still be provider reimbursement issues. FTAC should examine federal boundaries in terms of Medicaid provider reimbursement. Chair Lowe also noted examining the connection between the primary care certification work group and Medicaid.

Presentation: Understanding the Washington Health Trust

Andre Stackhouse and Erin Georgen, Whole Washington

Whole Washington is a 501(c)4 nonprofit organization founded in 2017 to advance the passage of universal public health care at the state, regional, and federal level. Whole Washington is the organization behind the Washington Health Trust (WHT) in multiple iterations both as legislation (most recently, Senate Bill 5335) and ballot initiatives. Whole Washington's goals are to establish an ongoing and collaborative relationship with the Commission and to co-develop universal health care policy for recommendation to the Washington Legislature. Whole Washington's definition of universal health care aligns with that of the World Health Organization, where "…all people have access to the full range of quality health services they need, when and where they need them, without financial hardship."

The WHT, a hybrid of Model A and Model B (as defined by the Universal Health Care Work Group that preceded the Commission), would begin as Model B and transition over time to Model A. The WHT would be an all-payer model

with public options for all Washington residents, public health funding for participating community health providers, and the financing and transition plans necessary to achieve universal coverage.

The WHT would create the Washington Health Trust Board (WHTB) for which Commission members could be appointed. WHTB's committees would include a citizen committee, a provider committee, and a finance committee. HCA would lead all direct integration efforts for state-managed and publicly funded health benefits programs, facilitate enrollment for all residents prior to integration, and acquire federal waivers.

All Washington residents would be eligible, but so would some nonresidents including students attending college, workers employed in Washington, and spouses and dependents of eligible nonresidents.

The WHT would offer an essential health benefits (EHB) package defined by the WHTB. HCA would need to align the benefits for all state-managed publicly funded benefits towards the WHT.

Provider participation would be optional. Providers and health systems giving care to a WHT enrollee could not be denied reimbursement for any service covered under the EHB. Provider rates would be negotiated by the WHTB in coordination with HCA on an annual basis with providers' input and participation. Washington providers and health systems could participate in annual collective negotiations to set rates.

The WHTB would be responsible for enacting cost controls without limiting access to or reducing quality of care. Cost containment approaches outlined in SB 5335 include the single EHB and aligning benefits and reimbursement rates for publicly funded benefits programs.

Co-pays, deductibles, and premiums would be eliminated. Instead, the WHT would be funded through public financing. All employers would be required to pay the same percentage of each employee's payroll toward the employee's health care regardless of whether an employer continues to offer health care coverage other than the WHT. Employers would contribute 10.5 percent of wages and could deduct up to two percent from employee payroll. Employees could contribute up to two percent of their wages via a payroll deduction, of which employers could cover all or a portion. The up to two percent employee contribution would count towards the 10.5 percent employer contribution. Sole proprietors would contribute two percent of earnings (the first $15,000 would not be taxed). Investors would contribute 8.5 percent of capital gains (the first $15,000 would not be taxed). The WHT would use a quarterly graduated exemption for required employer expenditures.

ERISA laws prevent Washington from requiring employers who provide health benefits to participate directly in the WHT. However, Whole Washington suggested that the state could require employers to provide coverage for minimum essential coverage and require employers to spend a certain amount on each employee's health care and could define the spending amount. The WHT's ERISA workaround was modeled after Healthy San Francisco's city-option which has survived ERISA legal challenges.

SB 5335 instructs HCA to pursue a demonstration waiver to integrate Medicare into WHT. During the transition to WHT, the WHT would be a Medicare Advantage plan with Part D for those who voluntarily enroll. The Health Options Program (managed by HCA) would reimburse for any gaps for those who don't enroll. Washington must pass state law and create a universal health care infrastructure before a federal waiver for integration can be approved. Whole Washington recommends that federal funds currently providing cost assistance through the Health Benefit Exchange be folded into the WHT which would be the only plan with cost assistance. WHT's

transition plan would occur over five years. The first two years would be focused on enrollment (with emphasis on enrolling lower income Washingtonians) and contracts. WHT coverage would begin in January of the third year.

Jane Beyer asked for clarification on the employers pay-or-play component. It was clarified that the amount employers are required to pay is per-employee. Initially, employers could meet the required expenditure by continuing to provide non-WHT coverage. Commission Member Rep. Joe Schmick asked how to address any reluctance to enroll due to mistrust in the government. It was clarified that the WHT is a voluntary model and that some people don't trust health insurance companies to manage their current coverage. It will be important to provide people with a better experience compared to the current system and it will take time to build trust. Mohamed Shidane asked how soon the transition plan could begin. It was clarified that while it could take two years to begin enrollment, it may be achieved sooner if the WHTB and HCA can transition things more quickly. Immediate policy action is necessary to get universal health care established in Washington as soon as possible.

Presentation: Continuing transitional solutions discussion

Liz Arjun, HMA

The Commission is charged with identifying transitional solutions. Both the Commission and FTAC were surveyed about potential transitional solutions. The next step is to prioritize transitional solutions for further study. Transitional solutions have been grouped into the following categories: affordability/cost containment/pricing; capacity/infrastructure; coverage/enrollment; providers; purchasing; and subsidies. The Commission was asked whether any ideas or categories were missing.

Commission member Rep. Marcus Riccelli suggested adding "strengthen the work of the Health Care Cost Transparency Board" to the affordability/cost containment/pricing category. Jane Beyer suggested adding "anti-competitive contracting," e.g., between an insurer and a physician's group, to either the providers category or the affordability category. Chair Lowe suggested modifying "consolidate state purchasing" to "consolidate and expand state purchasing" under the purchasing category.

Presentation: Draft 2023 legislative report

Liz Arjun, HMA

Commission members' review of the draft 2023 legislative report is underway. The report describes five highlights of the Commission's work this year, including the launch of FTAC, the adoption of a health equity framework, Medicare and ERISA eligibility considerations for the new system, identification of areas to consider for transitional policy solutions, and incorporating the work to evaluate the Washington Health Trust. The Commission will vote to adopt the report at their October meeting.

Adjournment

Meeting adjourned at 4:00 p.m.

Next meeting

October 12, 2023
Meeting to be held on Zoom and in-person at the Health Care Authority
2:00 p.m. – 4:00 p.m.