Washington State Health Care Authority

Universal Health Care Commission's Finance Technical Advisory Committee (FTAC) meeting summary

March 14, 2024
Virtual meeting held electronically (Zoom)
2–4:30 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the **FTAC webpage**.

Members present

David DiGiuseppe
Eddy Rauser
Ian Doyle
Kai Yeung
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Christine Eibner
Esther Lucero

Call to order

Pam MacEwan, FTAC Liaison, called the meeting to order at 2:01 p.m.

Agenda items

Welcoming remarks

Pam MacEwan began with a land acknowledgement, welcomed members to the eighth meeting, and reviewed the agenda.

Meeting summary review from the previous meeting

The Members present **voted by consensus to adopt the January 2024 meeting summary**.

Public comment

Roger Collier suggested that there was a $2B error in the savings calculation projected under the Washington Health Trust on pages 19-20 under Tab 5 of the meeting materials.

Marcia Stedman, Health Care for All Washington, expressed support for the two primary agenda topics and the extra time dedicated for robust committee discussion.

Consuelo Echeverria noted that additional time allotted for meetings is thanks to advocates' efforts and stressed the importance of completing the required report of the Universal Health Care Commission (the Commission) due to the Legislature on June 30.

Kathryn Lewandowsky read an email from Dr. Friedman (author of the economic analyses supporting Whole Washington's SB 5335) who expressed regret for being unable to attend the meeting due to health issues.

Commission updates & goals for today

Liz Arjun, Health Management Associates (HMA)

The Commission directed FTAC to provide guidance on benefits and services for Washington's future universal health care system. The Commission plans to have an actuarial analysis conducted to compare benefits across Medicaid, the essential health benefits (EHB) mandated under the Affordable Care Act (ACA), and the Uniform Medical Plan (UMP) under the Public Employee Benefits Board (PEBB). Today's meeting is focused on understanding what work in this area has already been done, identifying any gaps and additional considerations for designing a benefits package.

Presentation: The Washington Health Trust – Benefits & Services

Andre Stackhouse, Whole Washington

Whole Washington, proponents of Senate Bill 5335 (SB 5335), presented on the benefits and services and financing under their proposed Washington Health Trust (Trust). This is part of the Commission's directive by the Legislature to examine SB 5335.

Professor Gerald Friedman, author of the Trust's economic analyses, anticipates health care costs doubling in the next ten years. Increased health care costs have not resulted in increased life expectancy or increased access to care. The U.S.'s total health care spending is twice that of the Organization for Economic Co-operation and Development (OECD) average without achieving universal coverage.

The Universal Health Care Work Group (Work Group) and Dr. Friedman used different methodologies to project health care costs under the status quo. The greatest cost reductions would be realized under a publicly funded and publicly administered health care system (Model A as proposed by the Work Group). The Trust would begin as Model B (state-designed plan privately administered) and would transition to Model A.

Covered benefits and services are modeled after the EHB mandated under the ACA. Revenue sources to support the proposed Trust include an employer payroll tax, an employee payroll tax (employer may choose to cover employee portion), a sole proprietorship tax, and a capital gains tax (ruled by the 2023 Washington State Supreme Court as constitutional exempting the first $250,000). This would be less burdensome on individuals, families, and employers compared to the status quo.

FTAC members were invited to make comments/ask questions. It was noted that other OECD countries with social insurance systems manage cost and price growth through rate setting systems for all providers (the U.S. does this for public coverage but not for private), which may be more economically and politically feasible. Whole Washington noted the Commission's position to make recommendations without political influence could aid in the political feasibility of either the Trust proposal or an alternative. Additionally, the Trust would incorporate rate setting and may be more politically feasible given the transition period from Model B to Model A.

Members noted that the disparity in health care expenditures in U.S. versus OECD countries is largely due to prices, however Dr. Friedman's analysis names health care administration as the primary source of savings with prices being secondary. Whole Washington welcomed additional cost analysis methodologies and financing model alternatives. Committee members noted that having broader participation and consensus on a cost

analysis will lend credibility to the discussion. Whole Washington agreed that private health carriers are not the sole contributor to higher health care costs in the U.S., nor are they the only opposition to universal health care, e.g., hospitals. Members noted that consolidation drives price increases which drives spending, and taking a broader approach and not focusing only on simplifying health care administration should be the focus of regulatory action.

Whole Washington expressed that while there are challenges with SB 5335, they'd like to hear more reform proposals and solutions from the Committee/Commission. FTAC and Whole Washington agree on the goals for addressing fragmentation, high costs, and inequitable access to care and coverage. It was noted that other OECD countries do not face housing or food insecurity, barriers to education, income inequality, etc., as so many Americans do. These factors, beyond just access to universal health care, are major determinants of health.

There will be more opportunities to reconnect with Whole Washington to further assess SB 5355 as part of the Commission's legislative directive.

Benefits & Services Discussion

In prior meetings, FTAC has outlined the challenges to integrating Medicare and self-insured group health plans (large employers) into Washington's universal health care system. However, there are paths forward for integrating Medicaid, the individual market, and small and large fully insured group health plans.

A grid comparing covered benefits across Medicaid, EHB, and UMP does not exist. However, other states proposing universal health care plans have conducted benefits modeling and chosen EHB (California and Vermont) or the public employee benefits plan (Oregon). Creating a comparison grid of benefits is challenging. Medicaid has benefits that are required by the Centers for Medicare and Medicaid Services (CMS) to obtain federal matching dollars, and fully insured market plans must provide state-mandated benefits not required in the EHB. Members noted that it may be helpful to know how many of the Medicaid unique benefits are related to pediatrics, maternity care, and children with special health care needs.

Wakely's recent comparison of PEBB and Washington's EHB and found PEBB to be approximately 0.24 percent to 0.54 percent more generous (on an allowed cost basis). However, Medicaid is the most generous benefit plan.

There will be a high degree of overlap between Medicaid (keeping Long Term Services and Supports [LTSS] off the table), and general benefit design may not have much impact on the total cost of care, so the issues of interest will be around duration, scope, and cost-sharing. It's important to consider that the benefits for Medicaid, PEBB, and EHB are somewhat tailored to the needs of the respective population demographics, e.g., PEBB - working adults and families, the Exchange - primarily adults, and Medicaid.

Benefit generosity between PEBB and EHB is almost negligible from a per-member per-month (PMPM) perspective. It may be helpful to model the most practical benefits package (most socially and politically feasible) and incrementally model out additional benefits, potentially introducing some cost-sharing.

FTAC pondered whether the barriers are too high to make single payer work. There was agreement that it's crucial to address price head on because it is not possible to create a more equitable, accessible, affordable health care system without doing so. Price regulation may be more politically possible than taking on providers, carriers, and the federal government. For example, Oregon recently passed price caps (200 percent of Medicare) on their PEBB/Oregon Educators Benefit Board (OEBB) plans and with evidence of significant savings, Washington should consider pursuing the same. Consolidating and expanding state purchasing is another avenue. Washington did have a hospital commission modeled after Maryland's but failed in implementation.

FTAC considered the following for actuarial analysis: Begin with PEBB or EHB and layer on additional benefits to be modeled. Cascade Care (standard qualified health plans on the Exchange) could serve as the starting point for EHB to see the cost-sharing impact on premiums across the Bronze, Silver, and Gold metal levels, and then assess whether Medicaid and PEBB cover anything different. Members requested that "PEBB" be updated to "PEBB/School Employee Benefits Board (SEBB)." Other dimensions of benefit design should be considered in

future meetings, including prior authorization, supplemental benefits outside of the universal plan's covered benefits, point of service cost sharing, and a standardized provider reimbursement rate.

Adjournment

Meeting adjourned at 4:32 p.m.

Next meeting

May 9, 2024
Meeting to be held on Zoom
2–4:30 p.m.