

# Washington Universal Health Care Work Group

Meeting #1 Summary

September 20, 2019, 1 pm to 5 pm

## ATTENDEES

### *Work Group Members*

Aaron Katz, Principal Lecturer, UW School of Public Health  
Aren Sparck, Government Affairs Officer, Seattle Indian Health Board  
Beth Johnson, CEO and President, Coordinated Care Health  
Bevin McLeod, Co-Founder, Alliance for a Healthy Washington  
Brenda Snyder, Director, Policy and External Affairs, Office of the State Treasurer  
Carrie Glover, Policy Consultant, Dziedzic Public Affairs  
Carrie McKenzie, Chief Executive Officer, Goldcore Innovations, LLC  
Christine Gilbert, Sitting in for 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. 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, Western Washington Chapter of Physicians for a National Health Care Plan  
Jane Beyer, Senior Health Policy Advisor, Office of the Insurance Commissioner  
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, Director DOH, Sitting in for John Wiesman, Secretary, Department of Health  
Mohamed Shidane, Funds Development and Policy Engagement Manager, Somali Health Board  
Patrick Connor, NFIB Washington State Director, National Federation of Independent Business  
Randy Scott, Consultant, Pacific Health Coalition  
Representative Nicole Macri, House of Representative  
Robyn Williams, Office of Financial Management  
Ronnie Shure, Pharm BS  
Senator Emily Randall, Senate  
Senator John Braun, Senate  
Shirley Prasad, Policy Director, Government Affairs, Washington State Hospital Association  
Sue Birch, Director, Health Care Authority (Work Group Chair)  
Sybill Hyppolite, Healthcare Policy Specialist, SEIU Healthcare 1199  
Zach Snyder, Director, Premera, Sitting in for Christine Brewer, Association of WA Healthcare Plans

### *HCA Staff*

Rachelle Alongi  
Shawn O'Neill  
Tamarra Henshaw

## **Consultants**

Jamie Strausz-Clark, 3Si  
Jarod Nason, Optumas  
Jeanene Smith, M.D., HMA  
Katie Rogers, HMA  
Liz Arjun, HMA  
Nora Leibowitz, HMA  
Steve Schramm, Optumas

## **NOT ATTENDING**

### **Work Group Members**

Amy Anderson, Government Affairs Director, Association of Washington Business  
Lynnette Vehrs, President, Washington State Nurses Association  
Representative Joe Schmick, House of Representatives

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## **MEETING OBJECTIVES AND AGENDA**

The first meeting of the Washington Universal Health Care Work Group had six objectives:

1. Meet Universal Health Care Work Group (Work Group) members and project team.
2. Review Work Group decision process and approach to engaging stakeholders and the public, including timeline and draft meeting schedule.
3. Affirm Work Group charter.
4. Secure a baseline understanding amongst all Work Group members of:
  - a. The terms we will use throughout this process.
  - b. The history of universal health care in Washington State.
  - c. Alternative models of universal health care delivery that have been implemented in other states and countries, including a comparison of their relative benefits and challenges.
5. Confirm action items and next steps.
6. Hear public comment on universal health care.

## **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. All members introduced themselves and identified the perspectives they bring to the Work Group. HCA Staff and the Consultant Team introduced themselves to the group and their role in supporting the Work Group.

Jamie Strausz-Clark reminded the audience of the public comment period at the end of each meeting and explained the process. She also explained that offering comment at the end of meetings is only one way to offer input on the process; HCA would provide and opportunities to complete online surveys and

submit comment via email. All forms of comment would be considered and reviewed by the project team and work group.

## **REVIEW WORK GROUP DECISION PROCESS**

The project team shared a timeline of future work group meetings and a draft plan for stakeholder engagement with the Work Group.

A Work Group member asked if meeting materials such as slide decks could be posted online in advance of the meeting so members of the public could review them prior to the Work Group Meetings. HCA staff confirmed that meeting materials will be posted to the website two to three days prior to each meeting.

Another Group member raised a concern that two business days for the public to review a video of the Work Group meeting and provide feedback via an online survey did not seem like enough time. They requested that HCA consider adding more time for the public to review and provide feedback. HCA indicated they would take the request under consideration and follow up by the next Work Group meeting.

## **AFFIRM WORK GROUP CHARTER**

Jamie Strausz-Clark (3SI) reviewed the Work group Charter and asked the group for input. There was discussion among the group that the five bullets outlined in the Charter may be too ambitious for this group to tackle given the 14-month time limit and specific expertise comprising the Work Group. One Work Group member recommended the Work Group focus only on the first, fourth and fifth bullets. [The relevant section of the charter is below.]

- *“Ideas for increasing coverage and access for uninsured and underinsured populations.*
- *Transparency measures across major health system players—including insurance carriers, hospitals and other health care facilities, pharmaceutical companies, and health care provider groups—that promote understanding and analyses to best manage and lower health care costs.*
- *Innovations that promote evidence-based practice, health care quality, sustainability, and affordability.*
- *Ways to support transition to a universal health care system for all stakeholders, including but not limited to consumers, businesses, health care providers, and facilities, hospitals, health insurance carriers, state agencies, and entities representing management and labor for these stakeholders.*
- *Options for revenue and financing mechanisms to fund the universal health care system.”*

While a few other members agreed that it would be good to narrow the scope, a few Work Group members indicated it would be important to consider affordability (bullet #3). Others felt it was important to maintain language around innovations and transparency, since addressing affordability

without these would be difficult (bullet #3). A few Work Group members indicated that because the language comes from the legislative budget proviso, it is important to stick with these bullets or the Work Group risks giving the Legislature a different product than they requested. To address these concerns, a Work Group member suggested keeping the language but qualifying it by inserting the term “deliberate on” as a preface to the bullets. Jamie committed to revising the charter language to keep all the bullets but reflect that the Work Group may deliberate on but not have answers for each of the five bullets.

Another Work Group member suggested creating sub-committees to do a deeper dive into some of the topics. Finally, a Work Group member suggested identifying other work groups across the state who may have relevant information or outcomes that can be brought into this Work Group’s deliberations.

Another area of focus during the discussion was about adding language to the third bullet focused on cultural responsiveness or culturally appropriate care. The recommendation was to revise the third bullet (changes underlined): Innovations that promote evidence-based practice, health care quality, sustainability, culturally attuned, community-based health models, and affordability.

A Work Group member requested the following change to the second bullet (change underlined) in recognition of the sovereignty of Tribal governments:

- “Transparency measures across major health system players—including insurance carriers, hospitals and other health care facilities, Indian and Tribal health systems, pharmaceutical companies, and health care provider groups—that promote understanding and analyses to best manage and lower health care costs.”

Within the overall charter, there was a recommendation to call out the Department of Veteran’s Affairs and the Indian Health Services and Tribal Health Systems as models to consider.

A Work Group member suggested clarifying the first bullet, *“Ideas for increasing coverage and access for uninsured and underinsured populations”* with the language, *“with the goal of improving health equity and reducing health disparities.”* The Work Group members supported this change.

Work Group members discussed the terms “Universal Health Care”, “Universal Health Care System”, and “Universal Health Care System(s)”. Specifically, there were concerns that by using the term “Universal Health Care System” in the Charter implies the recommendations coming out of the Work Group would be for a single health care system, rather than a mix of systems. A few Work Group members cautioned against deviating from the legislative language and intent too much. One Work Group member who worked on the legislative language said the “Universal Health Care System” language was important as it broadly encompasses all elements of health care. Another Work Group member pointed to the following language earlier in the Charter: “The legislation specifies that the universal health care system may include publicly funded, publicly administered, and publicly and privately delivered health care.” The Work Group member commented that this language demonstrates the Legislature is not expecting

the recommendation must be for a single system. Jamie confirmed with the Work Group that the language in the Charter regarding a “Universal Health Care System” would remain as is.

Other Work Group members wanted to clarify “coverage” vs. “access” and that “coverage doesn’t necessarily mean access”. It was suggested that the group deliberate on whether Universal Health Care includes universal coverage or universal access to health care and address the distinction in the guiding principles or evaluation criteria the Work Group will discuss and establish.

A few Work Group members asked that the Work Group devote enough time to understanding the specific problems with the current health care system in order to properly consider potential solutions. Another Work Group member asked that the Work Group consider social determinants of health in its deliberations.

## **ORIENTATION TO UNIVERSAL HEALTH CARE IN WASHINGTON**

Nora Leibowitz from HMA presented about the Coverage Landscape in Washington.

Work Group members had questions about the data presented: a few Work Group members indicated the data in the presentation, which came from the Kaiser Family Foundation, did not match currently available data owned by the Washington State Office of the Insurance Commissioner and other agencies. Several Work Group members provided recommendations about how to obtain more accurate Washington State level data. The project team committed to coordinating with HCA and other state agencies to update the data in the presentation with the most current state-level data; the project team also committed to using state-provided data in future presentations whenever possible. A Work Group member recommended coordinating with the American Indian Health Commission (AIHC) to gather more information about coverage for Tribal Members.

A Work Group member asked about self-insured plans and what kind of information might be available about individuals enrolled in these plans. Jane Beyer from the Office of the Insurance Commissioner (OIC) explained that federal law (the Employee Retirement Security Act or ERISA) makes obtaining this information difficult; OIC must “back into” information about this population.

One Work Group member reminded the group of the WA Health Alliance, which has done a lot to gather information from large employers about their coverage may be a good source of data.

Work Group members had questions about specific populations and if/how they are captured in the data presented:

- Individuals on COBRA, since those individuals are typically paying for the coverage themselves.
- Information about people who have purchased health care that is not insurance—such as concierge medicine where a person pays a flat monthly fee for access to a primary care provider but no specialty care or hospital care is included.

- People are left out of coverage all together, such as families caught in the “family glitch”, the ACA rule that bases eligibility for a family's premium subsidies on whether available employer-sponsored insurance is affordable for the employee only, even if it is not actually affordable for the whole family.
- Immigrants who are “qualified non-citizens” must wait five years before they are eligible for Medicaid and CHIP coverage.

Several Work Group members wanted to know more about who is “underinsured” and come up with a definition of “underinsured” to add to the glossary. Nora explained that defining underinsured is very challenging, and there is no agreed upon metric for determining if someone is underinsured. Jamie committed to including a discussion of underinsured on a future Work Group agenda.

Finally, several Work Group Members were very interested in having more information about health care costs: specifically, administrative costs, how much is spent for various procedures, etc. Jamie explained that the next presentation by the Washington Institute of Public Policy (WSIPP) would provide some information on costs.

### **SINGLE PAYER AND UNIVERSAL COVERAGE IN OTHER COUNTRIES**

John Bauer from WSIPP presented information from the study WSIPP conducted for the Legislature about single-payer and universal coverage in other countries.

Work Group members had the following comments:

One Work Group member voiced concerns that the slides presented were so high level, they missed some important nuances. For example, a key advantage of a single payer system is the ability to control health care costs because there is only “one spigot” of funds that can be turned on or off. They added that another advantage of one system is that one payer allows for more transparency about costs. They explained that in a fragmented system with multiple payers, the incentive is to shift costs to another payer rather than controlling costs.

A few Work Group members suggested a major driver of costs in the U.S. is cultural predisposition to new technology.

Work Group members had the following questions:

Q: The rate for administrative costs in the U.S. (8%) seems too low. How did WSIPP derive this rate? Does this rate capture administrative costs for providers? Does this rate capture legal costs, such as malpractice insurance?

A: The rate includes only the administrative costs for insurers. It does not include the administrative cost of health care providers (malpractice insurance).

Q: Do the data capture costs of personal bankruptcies?

A: No, this report does not capture those costs.

Q: If a country such as Canada infused more money into paying providers, would it address the longer wait times for care?

A: Probably not, because it's about how providers are paid, not necessarily how much.

Work Group members had the following data requests. The project team indicated they would consider these requests but cautioned that some of the data requests may be too complicated or costly to provide.

- Costs associated with delayed care, such as the added cost of receiving cancer treatment when it is Stage 4 Cancer rather than Stage 1 Cancer.
- Costs associated with high usage of specialists in the U.S. compared to other countries, which tend to use primary care providers more.
- Costs associated with the high usage of emergency rooms in the U.S. compared to other countries.
- Disaggregating all data by race, ethnicity, and poverty status.
- Look at costs vs. payments in other countries vs. costs and payments in the U.S.

Work Group members asked the project team to consider adding the following topics to future agendas. The project team indicated they would consider these requests, but given time constraints, it may not be possible to cover all topic requests.

- Access to primary care vs. specialty care and how access issues (not enough providers) may contribute to delayed care.
- The doctor/patient ratio, including other countries' investment in workforce development and whether that has a positive impact on access to care and health care costs.
- A comparison of the ratio of national spending on social programs versus health care spending in other countries and the U.S.

## **ACTION ITEMS AND NEXT STEPS**

- The project team will consider the request to revise timelines so presentation materials can be posted and made available to Work Group members in advance of meetings.
- HCA will consider the request to extend the time to complete the public comment survey following Work Group meetings.
- Jamie will revise the Charter to incorporate the recommendations from the Work Group.
- The consultant team will work with HCA to update data in the Health Coverage in Washington State (HMA) presentation with currently available state-level data.