

Universal Health Care Work Group

Preliminary Report

Engrossed Substitute House Bill 1109, Section 211, Subsection 57;
Chapter 415, Laws of 2019

November 15, 2019



Universal Health Care Work Group

This preliminary report was created at the request of the State Legislature for public comment. It contains work group composition, a summary of the work completed to date, and an aggregate analysis of individual work group member meetings.



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Executive summary

On behalf of the Universal Health Care Work Group, the Health Care Authority (HCA) is submitting this report for public comment, as required by Engrossed Substitute House Bill 1109(57); Chapter 415, Laws of 2019:

- (a) The health care authority is directed to convene a work group on establishing a universal health care system in Washington.
- (b) The work group must study and make recommendations to the legislature on how to create, implement, maintain, and fund a universal health care system.
- (c) The work group must report its findings and recommendations to the appropriate committees of the legislature by November 15, 2020. Preliminary reports with findings and preliminary recommendations shall be made public and open for public comment by November 15, 2019, and May 15, 2020.

In 2019, the Washington State Legislature directed HCA to convene a work group study. The purpose of the study is to provide recommendations to the Legislature on how to create, implement, maintain, and fund a universal health care system. The Universal Health Care Work Group will meet regularly, for about 15 months, to develop their recommendations.

To help in this work, HCA selected Health Management Associates (HMA) through a competitive request for proposal process. HMA will provide health care policy analysis, financial analysis, and project management for HCA and the work group. The HMA team is comprised of a professional facilitator, actuaries, and subject matter experts.

HCA selected a wide range of people to serve on the work group. Members were selected based on their experiences, perspectives, and role in health care. More than 85 people applied to serve as a member on the work group. At the time of this writing, 35 members serve on the work group, with one vacant spot reserved for Washington State Department of Revenue. The work group roster is available at the end of this report.

The work group convened its first meeting on September 20, 2019, in Olympia, Washington. The work group reviewed a Stakeholder and Public Engagement Plan, its charter, and meeting schedule. Further details may be found in the meeting summary, attached to this document.

This report shares additional information about:

- Work group members.
- The work group charter.
- The Stakeholder and Public Engagement Plan, and a tactical plan for how HCA will share information with the public, partners, and stakeholders about the work group.
- How HCA and the work group will engage with Tribal partners.



- Individual meetings with members, including key themes and takeaways.

Also included at the end of this report is the member roster and meeting schedule.

Project team

The project team supporting the Universal Health Care Work Team is comprised of internal HCA staff and leaders, and a team from Health Management Associates (HMA), including a facilitator, actuaries, and subject matter experts. The project team meets weekly to discuss the project plan, work group and stakeholder feedback, and to plan work group meetings.

Work group composition

House Bill 1109, which authorized the creation of the Universal Health Care Work Group, gave direction to HCA about what organizations and people were to be included in the work group. Specifically, the legislation identified the following as required stakeholder groups:

- Consumers, patients, and the public.
- Patient advocates and community health advocates.
- Large and small businesses with experience with large and small group insurance and self-insured models.
- Labor, including experience with Taft-Hartley coverage.
- Health care providers, including those who are self-employed.
- Health care facilities, such as hospitals and clinics.
- Health insurance carriers.
- The Health Benefit Exchange
- State agencies, including the offices of Financial Management, the Insurance Commissioner, and the State Treasurer, and Department of Revenue.
- Legislators from each caucus of the House of Representatives and the Senate.

HCA underwent a process to identify and select individuals who would fulfill the membership requirements specified in the legislation. HCA also sought to include individuals who:

- Had experience with health care financing and/or health care delivery.
- Demonstrated a willingness and ability to review background materials.

Additionally, HCA staff made a thoughtful and deliberate effort to ensure that membership reflected the geographic, socio-economic, ethnic and racial, and gender diversity of Washington's population. To identify Tribal members, HCA staff consulted with its Office of Tribal Affairs and Analysis Division and several Tribes across Washington.



About the work group charter

To guide the work group, HCA staff and HMA developed a draft charter, which was presented and discussed during the work group's first meeting. The charter includes:

- The origins of the work group.
- The charge of the work group.
- The membership of the work group.
- The roles and responsibilities of the work group members, including the chair, facilitator, and the project team.
- The work group meeting processes.
- The work group decision-making.
- The work group meeting summaries communication.

The work group discussed the draft charter and proposed a number of modifications. The draft charter is being revised to address these modifications; the work group will review and discuss it at the next work group meeting. The final charter will be posted online, once it has been finalized by the work group.

Stakeholders, partners, and public engagement

A critical piece of the work group's legislative charge is stakeholder and public engagement. The following fundamental objectives and ideas were discussed during the first work group meeting and they inform the Stakeholder Engagement Plan:

- Inform stakeholders—including the public—about the purpose of the work group, the process of developing recommendations for the Legislature, the timeline for developing recommendations, and how and when stakeholders and the public can get involved.
- Gather input from stakeholders and the public to inform work group deliberations.
- Demonstrate transparency and trustworthiness.

Key audiences

- Washington State residents, including consumers of health care, patients, and the public, including unserved and underserved populations.
- Patient advocates and community health advocates.
- Large and small businesses.
- Labor unions.
- Health care providers.
- Health care facilities.
- Health insurance carriers.



Partnering with Tribes

In addition to the stakeholders mentioned above, we believe any attempt to achieve universal health care coverage in Washington State must include our Tribal partners. As mentioned above, HCA consulted with its Tribal Affairs and Analysis Division and several tribes across the state. Aren Sparck, Government Affairs Officer, Seattle Indian Health Board and Kerstin Powell, Health Center Business Office Manager, Port Gamble S'Klallam Tribe, were both identified for their expertise and agreed to participate in the work group.

It is important to note that there are twenty-nine federally recognized tribes in Washington State, with different health care delivery systems and levels of funding. Ms. Powell and Mr. Sparck share their unique perspectives, but they do not represent the perspectives of the Tribal nations at large.

Public engagement tactics

- Create a dedicated website to post all work group-related information.
- Make all work group meetings open to the public. Set meeting dates and times in advance and post the schedule to the website.
- Provide public comment period at the end of each meeting. Post guidelines for making public comment on the website.
- Provide alternate ways to make comments for those who are unable to attend meetings or uncomfortable making a public comment:
 - Following each work group meeting, post a video or audio recording of the meeting and provide an opportunity for people to provide feedback on that meeting. The project team will summarize key themes from this feedback and share it with members at the next meeting.
 - Provide an email address where stakeholders and the public can submit input related to the work group's recommendations to the Legislature. The project team will summarize key themes and share it with members at the next meeting.
- Provide a public comment period following release of draft reports, expected November 15, 2019, and May 15, 2020.
 - Create an online survey to collect structured feedback from people. Include at least one open-ended question to allow for unstructured comments.
 - Summarize key themes from public comment and provide summary to members. Post the summary to the website.

Public notifications

- Develop an email subscription through GovDelivery where people can sign up to receive updates and announcements on work group progress and activities.
- Send out announcements through GovDelivery about work group progress and activities, and encourage people to visit the Universal Health Care Work Group website.



- Invite website visitors and people who attend meetings to subscribe to receive GovDelivery announcements about the work group.
- Invite members to distribute the link to their networks.
- Invite legislators to distribute link to their constituents.

Individual work group member meetings

The facilitator and HMA scheduled introductory meetings with each work group member. At the writing of this report, nearly two-thirds of these meetings have been conducted.

The purpose of these meetings is to initiate the relationship between members and the facilitator and HMA team lead. These meetings are also an opportunity to hear member's perspectives on the work group process, what success looks like to them, and their question or concerns. The project team will be using the outcomes of these introductory meetings to inform development of the work group decision process and drive meeting content.

The meetings held so far have been by telephone and lasted 30 minutes to one hour.

Key themes from individual meetings

Below are the questions the facilitator and HMA asked each member. The key themes from these meetings are aggregated in this section.

What are your perspectives and what motivates you to participate on this work group?

A number of work group members indicated they have been working on an aspect of health care reform or universal health care for many years. A few work group members traced their involvement in universal health care back three decades, when then Governor Booth Gardner convened the Washington Health Care Commission to consider and identify options for universal health care in Washington State. Others got involved in health care policy more recently and were part of the effort to pass the budget proviso that impaneled this work group.

A few members from state agencies indicated they are participating because the budget proviso requires their agency to be at the table. Most of these members were selected by their respective agencies because of they have some knowledge of health care policy. That said, a small handful of work group members from state agencies indicated they do not have much universal health care policy experience and are in the process of educating themselves on the topic.

A few of those interviewed have experience as a provider, or are an advocate for health care consumers, particularly for families with low incomes or individuals born outside the U.S. In general, they explained their motivation for participating is to address the problems with the system they see firsthand. One work group member described their motivation as an interest in helping the "left outs".



Some members offer perspectives from constituents who are impacted by the current state of the health care system, as well as constituents who worry about the impacts of a universal health care or single-payer system. For example, there are work group members who have small and independent businesses who said they feel both the sting of rising health care costs and the impacts of taxes to fund government programs, such as single-payer health care.

What does success look like?

Some work group members would like to see clear, concrete, actionable recommendations to the Legislature at the end of this process. Other members expressed that given the relatively large size of the work group, the diverse perspectives around the table, and limited time and resources available to complete this process, consensus around specific recommendations to the Legislature is unlikely.

For some of these members, success would be a thorough exploration of a few different approaches to expanding health care and increasing affordability, including documentation of likely concerns from specific constituencies. For others, it would be documentation of the roadblocks to universal health care and practical solutions to overcoming those roadblocks.

A few work group members expressed that a lot of work has already been done on identifying existing problems with the health care system and articulating solutions, but how to finance these solutions remains an unanswered question. For them, success would be focusing this work group's efforts on identifying viable financing scenarios.

There was a fair degree of divergence amongst members about whether this process should address health care **coverage**, health care **access**, or both.

- Work group members who supported addressing health care **coverage** indicated that tackling the complex problem of health care access would be challenging for this work group, given the time, resources, and expertise. This includes topics like health care workforce and an over-emphasis on specialty care over primary care.
- One member added that addressing affordability and identifying how to pay for health care was a necessary precondition to addressing access to health care.
- Members who supported focusing on health care **access** indicated that health coverage does not matter if people who have coverage cannot access the care they need in a timely manner.
- Members who supported addressing both coverage and access explained that leaving either out would have limited utility for Washington State.

Similarly, there was a high degree of disagreement about whether this work group should try to address the issue of underinsurance. Some members said that defining what it means to be underinsured in Washington, quantifying and describing the populations who tend to be underinsured, and identifying potential solutions would be essential to completing the task outlined in the budget proviso. Others thought defining and addressing “underinsured” was not feasible.



A few members felt that success would be contingent on this work group making an honest assessment of the benefits and impacts of a universal health care system. Specifically, they felt it was important to discuss how different universal health care approaches might affect access to care, wait times, or treatment options for people who currently have comprehensive health care benefits.

A few members indicated success would include exploration of measures to address affordability. Specifically, at least one member expressed a strong interest in addressing the high cost of pharmaceuticals on health care affordability. Another indicated an interest in managing health care to minimize the extent to which the system is paying for high cost procedures with no or negative marginal benefit.

A few members said it would be important to consider what the Legislature needs to take action on universal health care. Additionally, a few work group members expressed interest in coming out of this process with messaging that would help the Legislature address opposition to universal health care and build support for it.

One member indicated that considering health equity and reducing health disparities needed to underpin this group's deliberations.

What are your concerns about the work group?

There was more convergence around concerns. Several work group members expressed concern that some voices around the table may drown out others, specifically members who have been working on health care reform for a longer time.

A few work group members expressed concern that certain constituencies have an outsized influence on the work group's outcomes based on the membership of the work group.

Several members indicated a fear of scope creep and getting mired in topics they felt are too complex for this group to tackle. Work group members cited the issue of underinsurance, foundational public health services, access to health care for undocumented immigrants, and access to health care as potential "rabbit holes". Interestingly, other work group members indicated these topics would be important to discuss.

At least two members expressed skepticism that this process would be able to overcome major obstacles to universal health care, including federal laws, political opposition, and opposition of special interest groups.

Work groups: what works well, what doesn't?

Most of the work group members have served on other work or advisory groups in the past. Based on their experience, they had many ideas for how to make the work group process successful:

- Provide opportunities for members to build relationships and trust amongst each other, as this will allow for real and honest dialogue. For example, start meetings with an icebreaker,



or facilitate opportunities for members to meet in smaller groups and get to know each other.

- Some members—especially those who are not on the front lines of health care—may not understand how the problems with the health care system impact real people. At the beginning of each meeting, share a real-life story of a Washingtonian who has struggled with the current health care system.
- Start by coming to agreement on guiding principles by which the work group can objectively evaluate options or proposals.
- Use the work group’s time effectively. The project team could bring ideas and information the work group can react to, rather than asking the work group to generate these ideas. The project team should synthesize the work group’s input and refine ideas based on that input.
- Consider subcommittees to tackle specific issues and bring recommendations back to the work group.
- Use the resources available, including the Office of the Insurance Commissioner and Health Care Exchange for reliable, accurate data.

The takeaways

There was general agreement across almost all members that the current system has flaws. After that, perspectives on what to do about it and how much this work group will be able to accomplish diverged widely.

To be successful in completing the task before the work group, it is important to articulate a path forward. At this point in the process, the work group is engaging in insightful and thoughtful discussions and studying options together to create a path forward.

The discussions may be lively and dynamic, and we will capture the range of interests and focus areas as we scope the work to fit the interests of the work group with the funding and timing allowed.

Meeting schedule

Work group meetings have been scheduled over the next year. A full listing of those meetings is available at the end of this report.



Conclusion

To date, the work group has formed and met once. The members have discussed a charter and a Stakeholder and Public Engagement Plan, which will be finalized at the next meeting on December 9, 2019. This plan will also reflect work and engagement with our Tribal partners.

Work group members bring forward diverse perspectives and experience to this process. Overall, there is agreement that the current system of health care provision has room for improvement and creates an inequitable system where not all individuals are covered. Given the intentional diversity among the members, there are naturally varying opinions and perspectives on how to carry out the charge of the work group. Members will move forward over the next year in studying and making recommendations to the Legislature on how to create, implement, maintain, and fund a universal health care system.

Additional information

- Appendix A: Universal Health Care Work Group roster
- Appendix B: meeting summary (September 20, 2019)
- Appendix C: meeting schedule



Appendix A: Universal Health Care Work Group roster

Aaron Katz, CPH, Principal Lecturer, UW School of Public Health

Amy Anderson, MHPA, JD, Government Affairs Director, Association of Washington Business

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, BA, MA, Policy Consultant, Dziejdzic Public Affairs

Carrie McKenzie, Chief Executive Officer, Goldcore Innovations, LLC

Christine Brewer, Principal Lobbyist, Brewer Public Affairs and Association of WA Healthcare Plans

Dennis Dellwo, retired attorney and former Chair of the Washington State House of Representatives Health Care Committee

Don Hinman, Founder, Mid-Valley Insurance, Inc.

Dr. Barbara Detering, MD, Family Practice, Kaiser Permanente

Dr. Peter McGough, Medical Director, UW Neighborhood Clinics

Dr. Richard Kovar, MD, FAAFP, Medical Director Emeritus, Country Doctor Community Health Center

Dr. Rod Trytko, MD, MBA, MPH, Anesthesiologist, self-employed

Dr. Sherry Weinberg, retired pediatrician, Western Washington Chapter of Physicians for a National Health Program

Jane Beyer, Senior Health Policy Advisor, Office of the Insurance Commissioner

John Wiesman, Secretary, Department of Health

Kelly Powers, purchases health care for her family from the Exchange

Kerstin Powell, Health Center Business Office Manager, Port Gamble S'Klallam Tribe

Lisa Humes-Schulz, MPA, Director of Strategic Initiatives, Planned Parenthood Votes NW and Hawaii

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Lynnette Vehrs, RN, President, Washington State Nurses Association

Mohamed Shidane, Funds Development and Policy Engagement Manager, Somali Health Board

Pam MacEwan, Chief Executive Officer, Health Benefit Exchange

Patrick Connor, Washington State Director, National Federation of Independent Business (NFIB)

Randy Scott, Consultant, Pacific Health Coalition

Representative Joe Schmick, House of Representatives

Representative Nicole Macri, House of Representative

Robyn Williams, Office of Financial Management

Ronnie Shure, pharmacist, self-employed

Senator Emily Randall, Senate

Senator John Braun, Senate

Shirley Prasad, Policy Director, Government Affairs, Washington State Hospital Association

Sue Birch (Chair), Director, Health Care Authority

Sybill Hyppolite, Legislative and Policy Director, Washington State Labor Council

To be determined, Department of Revenue



Appendix B: meeting summary

September 20, 2019, from 1-5 p.m.

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, Dziejczak 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
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
Lynnette Vehrs, President, Washington State Nurses Association
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 in attendance

Work group members

Amy Anderson, Government Affairs Director, Association of Washington Business
Representative Joe Schmick, House of Representatives
Dr. Sherry Weinberg, Western Washington Chapter of Physicians for a National Health Program

Meeting objectives and agenda

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

1. Meet 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 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 member asked if meeting materials, such as slide decks could be posted online in advance of the meeting so the public could review 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 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 consider the request and follow up by the next meeting.

Affirm work group charter

Jamie 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 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 some members agreed it would be good to narrow the scope, a few other 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

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be difficult (bullet #3). A few 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, one 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 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, which 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.

Another 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.

One 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.” Work group members supported this change.

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 that work group recommendations would be for a single health care system, rather than a mix of systems.

A few members cautioned against deviating from the legislative language and intent too much. One 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 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 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” versus “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 members asked that the work group devote enough time to understanding the specific problems with the current health care system to properly consider potential solutions. Another 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 or comments about the data presented:

- A few 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 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 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. Another 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 Affordable Care Act 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 noncitizens” must wait five years before they are eligible for Medicaid and CHIP coverage.

Several 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 members were very interested in having more information about health care costs. Specifically, there were interested in administrative costs and how much is spent for various procedures. 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 member voiced concerns that the slides presented were so high level that 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 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 percent) 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 like 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 versus payments in other countries versus costs and payments in the U.S.

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 versus 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 are posted and made available to work group members before a meeting.
- 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.



Appendix C: meeting schedule

Date	Time	Location
Monday, December 9, 2019	1-5 p.m.	Legislative Building Columbia Room (119) 416 Sid Snyder Avenue SW Olympia, WA 98501
Friday, February 7, 2020	1-5 p.m.	Legislative Building Columbia Room (119) 416 Sid Snyder Avenue SW Olympia, WA 98501
Wednesday, April 22, 2020	1-5 p.m.	Seattle, TBD
Wednesday, June 24, 2020	1-5 p.m.	Spokane, TBD
Tuesday, August 25, 2020	1-5 p.m.	Capital Event Center Pacific/Grays/Thurston Rooms 6005 Tyee Drive SW Tumwater, WA 98512
Wednesday, September 16, 2020	2-6 p.m.	Capital Event Center Pacific/Grays/Thurston Rooms 6005 Tyee Drive SW Tumwater, WA 98512
Thursday, October 15, 2020	1-5 p.m.	Legislative Building Columbia Room (119) 416 Sid Snyder Avenue SW Olympia, WA 98501

