Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Universal Health Care Work Group

Report – May 2020 Update

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

May 15, 2020

Universal Health Care Work Group

This report was created at the request of the State Legislature for public comment. It contains a summary of the work completed since the November 2019 report, including summaries of the December 2019 and February 2020 meetings, the final work group charter, and key documents developed for the work group meetings. All materials provided at work group meetings are also available on the Health Care Authority website.

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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, 36 members serve on the work group. The work group roster is available at the end of this report.

As of May 2020, the work group has met three times. Key activities accomplished to date include:

- The members discussed and affirmed a Charter and a Stakeholder and Public Engagement Plan, and implemented the engagement activities. (November and December 2019 meetings)
- The members reviewed and discussed a proposed decision process, which included a draft outline of the final report. (December 2019 meeting)
- Members proposed root-causes of key challenges a new universal health care system and the delivery system should address. (December 2019 meeting)
- Based on those underlying challenges, members proposed qualitative and quantitative assessment criteria to use in comparing potential models for universal health care. (February 2020 meeting)

- The work group learned about and discussed universal health care system efforts in the United States and models operating internationally, to inform the potential models the Work Group will assess and compare at future meetings. (February 2020 meeting)

Following the February 2020 meeting, HMA surveyed the work group to gather input to develop and finalize up to three models for actuarial analysis. As an actuarial subcontractor to HMA and in partnership with HCA, Optumas has been collecting data to prepare for modeling. For additional details, please see the December 2019 and February 2020 meeting summaries attached to this document.

The attachments at the end of this report also include the schedule of remaining meetings, detailed summaries for the December 2019 and February 2020 meetings, and key documents the work group has developed to date.

Work group members bring diverse perspectives and experience to this process. Overall, there is agreement that our current health care provision creates an inequitable system where not all individuals are covered, is increasingly unaffordable, and requires improvement. 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. Over the course of the year, the work group will continue studying and making recommendations to the Legislature on how to create, implement, maintain, and fund a universal health care system.

Project Team

The project team supporting the Universal Health Care Work Group is comprised of internal HCA staff and leaders, and a team from 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 the organizations and people 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, Insurance Commissioner, and 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, socioeconomic, 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.

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 and finalized by the work group at the December 2019 meeting. The Charter is posted on the HCA's website and attached to this report. The Charter includes the:

- Origins of the work group.
- Charge of the work group.
- Membership of the work group.
- Roles and responsibilities of the work group members, including the chair, facilitator, and project team.
- Work group meeting processes.
- Work group decision-making process.
- Work group meeting summaries communication.

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, informing the Stakeholder Engagement Plan and the ongoing engagement activities:

- 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

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 have been participating 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 Activities

- Created a dedicated webpage to post all work group-related information.
- All work group meetings are open to the public. Meeting dates and times are set in advance and the schedule is posted to the website.
- Public comment periods are provided at the end of each meeting. Guidelines are posted for making public comment on the website.
- Alternate ways to make comments are provided for those who are unable to attend meetings or uncomfortable making a public comment:
    - Following each work group meeting, a video or audio recording of the meeting is posted. The public may review the recording and provide feedback on that meeting. The project team summarizes key themes from this feedback and shares it with the work group at the next meeting.
- A public comment period is offered following each meeting:
    - An online survey collects structured feedback from people, which includes at least one open-ended question to allow for unstructured comments.
    - Public comments are summarized and key themes identified and summarized for work group members.
- Once the work group's initial draft recommendations to the Legislature are drafted, stakeholders and the public will be able to submit input for work group consideration. The

project team will summarize key themes and share it with the work group at the subsequent meeting.

Public Comments

From the December 9 meeting, 24 people provided public comment. From the February 7 meeting, 15 people provided public comment. From submitted comments, there is a strong interest in a recommendation that secures universal health care for Washingtonians. Commenters noted challenges with the complexity of the health care system and encouraged the work group to make recommendations that increase affordability, access, and quality of care of the health care system. Full comments are appended to this report for review.

Public Notifications

- An email subscription through GovDelivery allows people to sign up to receive updates and announcements on work group progress and activities.
- Announcements are sent out through GovDelivery about work group progress and activities, and are available on the Universal Health Care Work Group page.
    - Website visitors and people who attend meetings are invited to subscribe to receive GovDelivery announcements about the work group.
    - Work group members are encouraged to distribute the link to their networks.
    - Legislators are invited to distribute the link to their constituents.

Work Group Meetings: December 9, 2019, and February 7, 2020

December 9 Meeting Topics

The second meeting of the Washington Universal Health Care Work Group had seven objectives:

1. Hear a story about a Washingtonian's experience with health care.
2. Build relationships between work group members that will facilitate productive engagement.
3. Understand the work group decision process, including expectations for the final work product and how we will get there.
4. Review summary of public input since the last work group meeting.
5. Understand and clarify problems (and their root causes) with the current health care system.
6. Confirm action items and next steps.
7. Hear public comment on universal health care.

December 9 Key Accomplishments

- Public feedback and comments from initial meeting were reviewed and integrated into the meeting structure.
- Discussion of a proposed decision process and draft outline of the final report.
- Review, revision, and confirmation of the work group charter.
- Detailed discussions in small breakout groups for a proposed "problem statement" and a "root cause analysis" of the problems with the current health care system.

The results of this last activity were shared electronically, as the meeting was shortened due an emergency evacuation of the building in which the meeting was being held. The findings were used to develop evaluation criteria for consideration by the work group in the next (February 2020) meeting. To view the meeting materials, please follow this link.

February 7 Meeting Topics

The third work group meeting had four objectives:

1. Develop assessment criteria to be used to evaluate and compare universal health care models.
2. Learn about different models of universal health care to inform work group members' understanding of models prior to providing input on which models the group will assesses.
3. Confirm action items and next steps.
4. Hear public comment on universal health care and assessment criteria.

February 7 Key Accomplishments

- Envisioned the universal coverage future state and identified insights in terms of changes to cost, quality, affordability, or other aspects of the system.
- Discussed draft criteria for assessing models and refined based on small-group and large-group discussions.
- Reviewed and discussed international models of universal coverage and models in the United States.

To listen to the meeting, please follow this link.

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. The April 2020 meeting was cancelled due to the stay at home restrictions related to the COVID-19 pandemic and the need for many work group members to focus on their organizations' response. Preliminary input via a survey of work group members occurred during the month of April. This input will help inform potential model drafts for review and will inform the ongoing work group activities. Survey results to be discussed at the upcoming June 2020 public meeting. Alternative formats are being considered for the June 2020 meeting to

accommodate any COVID-19 restrictions the state may be facing at that time, as well as meetings in the summer and fall of 2020.

The Project Staff recognizes the impact the COVID-19 pandemic is having on Washington's health coverage landscape. As such, staff from relevant state agencies including the Health Care Authority, the Office of Financial Management, the Office of the Insurance Commissioner and the Washington Health Benefit Exchange have agreed to provide a special recorded briefing for Work Group members in June 2020 about the impact of the COVID-19 pandemic on the health coverage landscape in Washington. Project Staff anticipate that they will continue to provide brief and timely updates to the Work Group as it continues its work so that it is able to do this work with the most current information about the changing health coverage landscape and the potential impact of their recommendations.

Conclusion

As of May 2020, the work group met three times. Key activities accomplished to date include:

- Adoption of a Charter and a Stakeholder and Public Engagement Plan.
- Implementation of engagement activities.
- Adoption of a proposed decision process, including discussion and review of a draft outline of the final report.
- Discussion of the root-causes of system deficiencies and the key challenges a new universal health care system and the delivery system should address.
- Development of qualitative and quantitative assessment criteria for evaluating potential models.
- Examination of universal health care efforts in the United States and models operating internationally, to inform the potential models.

Overall, there is agreement among work group members that the current health care system is inequitable and can be improved. Given the intentional diversity among the members, there are naturally varying opinions and perspectives on the preferred work group process and outcomes. Members will continue studying the issues and options and will make recommendations to the Legislature on how to create, implement, maintain, and fund a universal health care system.

Attachments

Included in this report as appendices are the Universal Health Care Work Group meeting schedule and public comments. Below are links to the:

- Work group roster
- Work group charter
- Meeting summary – December 9, 2019
- Meeting summary – February 7, 2020
- High-level overview of major international models

- Identifying quantifiable option elements using example of past, current frameworks

Appendix A: Meeting Schedule

Universal Health Care Work Group Meeting 1	September 2019
Universal Health Care Work Group Meeting 2	December 9, 2019
Universal Health Care Work Group Meeting 3	February 7, 2019
Universal Health Care Work Group Meeting 4	April 24, 2020 (Canceled due to COVID 19)
Universal Health Care Work Group Meeting 5	June 24, 2020
Universal Health Care Work Group Meeting 6	August 25, 2020
Universal Health Care Work Group Meeting 7	September 16, 2020
Universal Health Care Work Group Meeting 8	October 7, 2020

Appendix B: Public Comments

December 9 meeting

Below are the public comment questions and responses received from the December 9 Universal Health Care Work Group meeting. Please note this information has not been edited.

What do you think was the most important point made during this work group meeting and why?	Do you have anything else you would like to share?
	Universal Single-Payer health care would have kept my family member alive!!! The U.S. has a screwy health care system that makes most people's health care dependent upon their employment. They might get health care if they have a good job with benefits. But if they get laid off from their jobs, they lose health care. In contrast, all other modern industrial nations recognize health care as a basic human right, and their governments fund efficient, high quality health care for every person regardless of employment status. The U.S.'s failure to have Universal Single-Payer health care caused my cousin's son to DIE!!! My cousin's son had a job with medical benefits. He had a serious medical problem that required an expensive prescription. When he was laid off from his job he lost his medical benefits and could not afford to refill his prescription when it ran out. He found a new job that would start on a Monday, but on Saturday he died because his life-saving medication had run out. If my cousin's son had lived in a civilized nation with Universal Single-Payer health care, he would still be alive. We need to push our state governments and the federal government to adopt Universal Single-Payer. The federal government is currently too cruel and dysfunctional to take positive actions, so we must organize and push at the state level. Indeed, this is how many progressive reforms have occurred throughout our history. State governments are closer to the people, so they can take positive steps. Then after a number of states have succeeded, the federal government can see that it is "politically safe" to make these reforms. Support federal level bills and state level bills for Universal Single-Payer health care — and citizen initiatives at the state level. You and your family members' lives are at stake!!!
Companies profiting from the current lack of effective market or regulatory controls are enjoying soaring profits while the cost of having healthcare insurance and using it is now 25-45% of middle class families' household budgets. Even worse, the cost of using healthcare coverage has climbed even higher, putting millions of WA families at risk of losing employer healthcare coverage and even their homes. One serious illness in a family, can put that family in such financial peril that they lose their housing if a parent is too sick to work. If a parent needs to put all their energy into a sick family member or is ill themselves, they often can't work. Hospital systems are suffering	Other developed countries have a government managed healthcare system that provides healthcare for all and is based on fair taxation. These systems need 1/2 to 1/3 less money than our country spends on healthcare. In Montana, health care costs are now set by limiting the reimbursement rates for hospital systems based on medicare to 220%. It is working because the hospitals are still making money. http://fullmeasure.news/news/cover-story/montanas-solution Other states are following suit. We must legislate straightforward reimbursement rates. Like Montana, all states are facing the inability to pay for their own employee's medical care, run their state hospital systems, fund medicaid programs. Insurance, durable medical devices, other healthcare supplies, and pharmaceuticals costs, based on unregulated profits for the private sector and very complicated reimbursement machinery (that often denies and delays care) are not sustainable and must go. Letting private companies take profits from our medicaid programs is not sustainable. We must have a different model and restore sanity to our healthcare systems. The next economic down turn may very bring this whole house of cards crashing down. Montana moved from a 9 billion dollar deficit in 2015 to a 101 billion surplus in 2019. A good place for all of that savings? Insure

because preventable complications become life threatening ER visit with huge costs for end of life, hopeless care. In Washington the selling of medical debt and the interest rates allowed are creating havoc for those without insurance. Hospital based charity care can not solve this problem, as it extends to those suffering the outrageous costs of their medications, wheel chairs, fracture boots and on and on.	more people! Getting control of medical costs is a good start. Taking the limitless profits out of healthcare and turning the administration of claims and funds with the Healthcare Authority is the right thing to do. A new and robust study, released on how much national Medicare for All could save has just been released. There is a great deal of misinformation and outright lying being broad cast about how we can't afford to insure all. We are already paying enough now to insure everyone with permanent healthcare insurance. We just aren't getting our money's worth. https://jacobinmag.com/2018/12/medicare-for-all-study-peri-sanders?fbclid=IwAR2M0NWuhSY13ZpRpWPqTT8UPFIFBKyrQ0hqcpCmHkR3wNn0_AQQ_OaMivg
The lack of truth! Time to know the FACTS about Medicare for All! FACT: M4A costs $32.6 trillion, doing nothing will cost $50 trillion; FACT: M4A will cost 4.5% of income and investments, even for the rich. FACT: M4A would give workers biggest take home pay increase in a decade. FACT: M4A will cost 7.5% of income for every employee, even for wealthy corporations. FACT: M4A will save businesses trillions of dollars. FACT: M4A will cut poverty 20%. FACT: Sanders strengthens SSDI and M4A services for 25% of Americans with a Disability. FACT: Sanders proposes $81 billion in medical debt relief for 71 million people. FACT: Sanders proposes a cap of $200 a year for pharmaceuticals. FACT: Sanders proposes $20 billion to save 25% rural hospitals from closure. M4A will stop the government from punishing the people for needing help. Bernie Sanders is the lone Democrat fighting for universal mental health care. Insurance companies employ this tactic to discourage patients from obtaining mental health benefits. 43 million Americans join me in the plight against mental illness and we all deserve quality care without having to jump through endless hoops just so rich executives can line their pockets. https://medium.com/@kcmilleredu/sanders-is-lone-democrat-fighting-for-universal-mental-health-care-85ad038faf02	I am extremely disappointed in a full Democratic house and Governorship that will not make the rich and wealthy corporations pay their fair share so we can survive.
I think the most important point that was made was how unaffordable health insurance had become and that more and more costs are shifted to the “insured” and how that cost intersects with American families’ overall financial insecurity	I have had my own small business in Washington for the past 11 years, something i am proud of starting after Microsoft laid me off at the beginning of the recession. I own a home and pay my taxes. I am in the “individual health insurance market” and buy my insurance on the exchange. My daughter is covered by Apple Care. Even with these supports, my healthcare costs more than tripled last year mostly due to high deductibles. My regular medication which used to cost $10 per month switched to $300 per month at the beginning of 2019 because my prescription costs were included in the deductible—i paid $1800 for that prescription last year, a generic. I had no idea until i went to fill my prescription last January that would be the case and was told the two months supply would be $600 dollars. Midway through this year i lost a few clients that i have not yet replaced and so i am facing another new year with a full deductible to meet and for the first time in a long time, i might not HAVE the money for my prescription. So when people talk about

	the percentage of those who can't weather an unexpected $400 bill, I realize that percentage now includes me. The reason the pharmaceutical companies and the health insurance companies continue to have record profits is because every year they are taking in more from people like me and giving out less...this is not healthy for our state and we need to do something about it
Health insurance and care is becoming more unaffordable all the time leaving more people even with good paying jobs unable to afford Health Insurance.	Like so many others my family does not have health insurance. We feel even if we could afford it the outlandish premiums are not justifiable. ACA tried to force very one to purchase health insurance but it did not factor in the companies would "price" themselves out of business for families making a decent living. Currently premiums for my family of 5 would be 25,000 annually . This exceeds the 10% which exempts us from paying the penalty. They didn't really think that through. The more frustrating thing is that if our income went down $30,000 the premium drops to approx. $6000 annually.. At the lower income it would be difficult to afford living expenses etc. I live on Orcas island and Medical is a big concern. The clinics on the island 1 Nonprofit and 1 UW affiliated struggle with the shortfall of Medicare and insurance payments which fall short of actual costs. Recently a Hospital Distric tax was voted in to Ryan to help implement after hours care but so far all that has happened is subsidy payments for "shortfalls" and wage increases. This tax is of no benefit to nonMedicare residents. I really hope that Universal Healthcare becomes a reality soon. I do have concerns with how it will all play it. How will deduction be calculated? I think a flat rate across would be best. So any income variable formula used has been off balance. How would provider payment work. With current Medicare payment rates that seems to be a concern for providers. In the long term there has to be a shield in place that keeps outside private corporations from trying to "manage" the fund . The percent of every dollar medical payment left for medical care is not acceptable. It would be wonderful if ther were some informative public meetings to help get the information out. Thank you for all your efforts.
Before I can answer this, I need to see a written summary of the meeting. I don't have the data allotment, the time or the patience to watch the video.	I decided to retire 3 years before my eligibility for Medicare, because I could no longer tolerate working for the medical industrial complex. This meant I had to find private insurance on the Exchange for myself and my spouse. I wasted many full days just studying the various plans, calculating costs, researching companies, and trying to decide what to do. After 3 months I decided to go with the COBRA plan to continue the reasonably good HMO insurance I had through my employer (and about which I never gave much thought). With just a $200 per individual deductible and 10% co-insurance it was way better than anything I could find on the Exchange. The monthly premium for 2 was $1150/mo but it only lasted 18 months. By comparison at the time, a bronze plan with the same HMO would have been $1002/mo with a $6000/individual deductible and 20% coinsurance. So it was a choice between very expensive insurance where I might get something in return versus very expensive insurance where I was most likely to get nothing in return. My employer told me to apply for the COBRA after getting an application in the mail, which might not arrive until after my employer coverage ended. But I was not to worry about this, because coverage would be "retroactive." Well my coverage terminated and the paperwork had not arrived yet so I called HR. They gave me the COBRA managing company's web address and I was eventually able to submit their application online. Unfortunately while waiting for approval, my spouse got injured and needed immediate medical attention, and all we had was a promise that our insurance was retroactive. We had to self-pay to see the doctor and to make a long story short, it took over 6 months with numerous phone calls and appeals to get the payment mess straightened out, partly because my former employer's COBRA contractor had changed and the HR personnel did not even know about it. This caused even longer delays in getting the insurance restored than it normally would have. When the COBRA ran out, we still had to arrange for 1 month of individual insurance for my spouse and 19 months for me, and we got a Kaiser bronze plan which was $548.41 for me with a $7,150 deductible and no coinsurance in 2017. For 2018, my premium went to $653.15. For 2019, it jumped to $818.06 with a $5,500 deductible and 20% coinsurance. That's when I called it quits and went without insurance until my Medicare started. For 2018 I had some

	doctor and physical therapy visits which I paid for out of pocket, not even coming close to the deductible. I could accept this if the policy was strictly sold as a catastrophic policy with a correspondingly low premium, but this was not the case. As they are, these policies constitute under-insurance such that most people can't afford to use them. These premiums, deductibles, and coinsurance rates are simply outrageous. Nobody, other than our wealthiest 1%, can truly afford them, and even if they could, they are not worth it. If regular people in all other developed countries can receive needed health care for a reasonable tax and with far fewer complications and stress, we should be able to do it too! We need a single-payer system. It's not a matter of economics, as Uve Reinhardt said, it's a matter of soul.
The personal story provided by Kelly Powers was all too relatable. Rising premiums create incredible psychological stress that can only be surpassed by the dilemma of actually needing care. Here, we force families to make gambles and take astounding risks. After having 'Cadillac' insurance for over 20 years, I find myself in that same position. Do I go to the doctor and wipe out our savings to fulfill the deductible or do I hope it goes away? These cost-sharing schemes, these barriers to care, force us to make poor, short-sighted decisions about our health that, in turn, end up making healthcare more expensive for everyone.	Before getting into my interpretation of Dec 9th's meeting, I'd like to propose a couple of metrics that might help the work group compare the final proposals. Human Time Spent. I would like to know how much time an average person spends dealing with bureaucracy related to their healthcare, and I'd like to see that amount quantified in dollars. I'm talking about the phone calls, the emails, the research. How much time is spent reviewing options, picking plans, asking for referrals, looking for subsidies, ensuring authorization, fighting denials, reviewing bills, asking for explanations? This is one of the most damning and infuriating aspects of the current system. Our time on this earth is finite and precious, and no one wants to deal with this manufactured nonsense. (PS. The time spent on bureaucracy with single payer? (Close to zero.) Under the Transparency Category: Profit Details. If we're to say that healthcare is an appropriate arena to make profits, the public should be able to access company data that speaks to how the profit is made. In very clear terms, for each specific company and industry-wide, I would like to see: 1) corporate profits 2) executive salaries 3) denials of care, both in number and dollar amount, and 4) out of pocket costs transferred to consumers. Now, back to 12/9. This session's working activity--to get at the root causes of our most pernicious problems with our current system was critical, and I appreciate the effort to truly get under it. The group I observed didn't have enough time to complete the exercise so I'm not sure how it all shook out. However, I did notice that even though the root cause was clearly offered by a participant, there seemed to be a palpable hesitancy in stating it, so I will state it here. The predominant reason we pay so much more, have such poor outcomes, and have so many citizens without care is simply that health insurance is motivated by profit. We have a behemoth industry planted squarely between doctors and patients, and that industry is permitted to make and is INCENTIVIZED BY PROFIT. That's it. That's the reason. So instead of one giant risk pool funded by all of us based on ability to pay, we have small, fractured risk pools. The oldest and sickest are covered by the government and everyone else is at the mercy of a barely regulated marketplace where decisions are made not by medical professionals, but by business, bureaucracy, and profit-motive. And it's not the insurance industry's fault. They're doing what any for-profit corporation would do. It is our fault that we allow it to continue. This is not complicated, but it is indeed difficult. To identify and admit a moral failing in society takes courage, but we can't fix a problem until we get to that point. And once there, the whole world of possibilities opens up. This work group has the opportunity to make history. You have the ability to change people's lives for the better, to even save lives. You have the chance to advance real social justice and offer a genuine freedom most don't even know is possible. By every conceivable metric, single payer is a better solution. The biggest obstacle we face is the fate of insurance companies. And even here, they could play a huge role in the solution. Just imagine if insurance companies transformed to solve the need we'll have for more doctors and nurses. Yes, we'll certainly be trading old problems for new problems but they'll be problems of operation, not finding ways to mitigate negligence or cruelty. I'm deeply grateful for the opportunity to comment, especially at length, but I must be blunt here. Mankind and all living things are facing a potential mass extinction. More and more reports warn that the impacts of the climate crisis will be so much worse and will touch us far sooner than we ever imagined. The choices we'll have to make will be disruptive, maybe even painful, and they'll require

	everything we have. In comparison, the choice to move to single payer healthcare is a no-brainer. We have a working solution in front of us. I urge everyone to look closely at SB 5222, including its funding and transition plan.People are dying, people are scared, and people are suffering right this very minute. Kindness, justice, and humanity should be what drives us with urgency. Single payer gets us on that path. And for anyone that wants even more info on single payer, I found an excellent book: How Obamacare is Unsustainable - Why We Need a Single Payer Solution for All Americans. It's written by a Washingtonian, Dr. John Geyman, and it is thoroughly documented, sourced, and easy to read. Thank you all for the heart and time you put into this effort, and Happy New Year.
I feel like there was a lot of time missed in the ice breaking session. I was happy to see that there was some dedicated effort in the breakout sessions to outline what type of healthcare program is needed in Washington state to provide comprehensive coverage to all residents.	I would like to hear more about the Single Payer healthcare options. The first day outlined Single Payer Plans but I did not here members addressing the topics from those documents.
	Original public comment: Please find a written statement including supporting articles at this link: https://drive.google.com/open?id=1i2IqwMh8QaCyGaz_YVB49PSRPLhCPbYm Updated public comment: I provided a link to my public comment through the survey monkey but I wanted to update my comments and provide a link to the supporting articles. Unfortunately, I cannot access the survey again because it says I already responded to the survey. Please include these links below for the public comment and the articles. I am trying to make it convenient for the workgroup to access. Thanks again for you time. Public comment link : https://drive.google.com/open?id=1i2IqwMh8QaCyGaz_YVB49PSRPLhCPbYm Supporting articles link: https://drive.google.com/open?id=1XYlbjDKyOE4nLw5yk2d5NXHwQ-NONNNL
Fake bomb scare ended the meeting before public comments. These comments won't be public, will they?	Why is the health care industry allowed to participate? If the Three Pigs had a work group to figure out how to keep the Big Bad Wolf out, they wouldn't let him in the work group. The answer is SINGLE PAYER.
Providing access to care will require much more than simply providing financial coverage for care.	https://www.icsi.org/wp-content/uploads/2019/03/ICSI-AcceleratingHealthCareAffordabilityWhite-PaperBriefFinal021519.pdf I am a physician involved in the Kittitas County Health Network. Our Network receives some financial support from the Greater Columbia Accountable Communities of Health for our cross-sector work for integrated Care Coordination for people in need in our County. The link is to work done in Minnesota that I think speaks to some of the ideas bouncing around in the Universal Health Care Work Group. I feel that the issues of access, cost, and quality are easily bogged down by status quo thinking. Simply doing more of the same will not get us any closer to improving equity or quality or cost. This paper invites other ways of thinking about the problems in order to develop more innovative solutions. Please take a few minutes to read it and share it if you think it can further the collective thinking of the group.
	I am questioning why you spent a whole meeting day trying to get a "shared understanding" of the problems in our healthcare system? Did you not choose people already who understand what the problems are?
I was surprised when one of the gentlemen in the breakout group I attended said that it's very hard to	I have been a nurse in Washington for over 30 years working mostly in acute care hospitals. In my career I have never understood how my employer can possibly make a budget for our hospitals with a "best guess"

compare Washington state residents to the populations of other high income countries that have better health outcomes. I wanted to ask, " What makes Washington residents so different from other people all over the world? Certainly you would want to try and figure out what those differences are that gives the residents of those countries such improved outcomes!"	at who will walk through their ER doors and whether and how much we will be paid for the services we provide. I have long understood that we spend too much money and efforts saving people with long term, untreated diseases that are in a crisis. It is past time to change course and take a hard look at truly reforming our healthcare system. It's time to take the profiteers out of healthcare and just pay to take care of our people. When you look at your 3 models to compare, one of those models needs to be a single payer system such as SB5222. When we accomplish providing a non profit, universal system for everyone we will have another dilemma. What shall we do with all the money we save?
I was able to watch the first meeting in full. I'm very happy it was mentioned that there was already a study done by Dr. Gerald Friedman demonstrating that single payer would save Washingtonians billions annually. It's strange you didn't mention the specific bill that he studied: the Whole Washington health trust.	Sb 5222 (The Whole WA health trust) has been vetted by the DOR/ESD and is already in the legislature. While this group completes its own study, and tries to figure out its own path to universal healthcare, more than 400,000 Washingtonians remain without healthcare coverage. Tens of thousands of people die or go bankrupt because of this. I very much hope you speed up the process for our sake. I ask you recommend the bill that was developed with stakeholder input, is supported by the largest universal healthcare grassroots volunteer group in the state, and is endorsed by dozens of elected officials and organizations.
I am disappointed in how little input you have from proponents of health care for all.	a. Currently the "Charge of the Work Group" in the draft charter states that the Work Group is to deliberate on the following: "Ideas for increasing coverage and access for uninsured and under-insured populations, with the goal of improving health equity and reducing health disparities." This is important but it does nothing for the millions that are paying high premiums, deductibles and co-pays. Employer-based coverage is costing over $20,000 per year plus deductibles and co-payments. 80% of people filing for bankruptcy due to medical bills have insurance and are not included in the statement above. Single payer will provide (not give access) health care for everyone that is affordable and comprehensive. b. Why start from scratch. Whole WA has a bill already written that will work. Rep. Jayapal also has a bill that would be an excellent example. Why not take advantage of systems already developed and vetted?
Providing universal coverage will not ensure universal access to care. The current care model needs a transformation to include other ways of caring for patients, ie community health workers and telemedicine. Perhaps the ACH efforts will produce viable changes that work.	I count 36 members and only one of them is a community member. The community membership should be more vibrant, say 10-15% rather than 3%, in order to truly have community input. And their input should be required for any decision making. Other members may need training in listening. Please consider that.
	Currently in the Charge of the Work Group section of the Draft Charter, states: "This Work Group will study and make recommendations to the Legislature on how to create, implement, maintain, and fund a universal health care system that is sustainable and affordable to all Washington residents." It is essential that we include the word "comprehensive". Good vision, dental and mental health care are badly needed.

February 7 meeting

Below are the public comment questions and responses received from the February 7 Universal Health Care Work Group meeting. Please note this information has not been edited.

What do you think was the most important point made during this work group meeting and why?	Do you have anything else you would like to share?
The system we have is inequitable and unsustainable. Other models around the developed world work for all. No where in the US are all people insured. The insurance and other for- profit medical industries are too expensive, don't allow enough choices or even adequate choices of health care provided. Care is rationed based on profits not on what a health care provider decides should be done.	Workgroup for Universal HealthCare. Dear Pathway to Universal work Group Members, Thank you so much for your admirable work on the matter of the best system to bring universal care to WA State. Our state needs: 1. Equitable affordable coverage for every person in our state. 2. To put an end to the extremely high cost of unregulated for-profit companies that provide healthcare products and services. 3. Hospital systems that won't be closed down by "non-profit" profitable companies and consolidated in only profitable areas. 4. To control the budget for healthcare with efficiencies of administration 5. Stop paying insurance companies to administer Medicaid. 6. Stop allowing pharmaceutical and medical supply industries to gouge people who are ill or hurt. . 7. Stop allowing the system of small care networks with approvals and denials eating up time and funds, and quick proactive care/ I include some links to help you quickly understand why changing the insurance based model of healthcare in WA is so urgent to our people, our hospitals and healthcare workers, and our state financial situation. Functional systems and financial stability will even help our ability to respond to pandemic events such as we are seeing with novel corona virus-19 Consider these instances: 1. In Yakima, a private company's financial decision closed one of the two

	hospitals, the impact on the residents has been immediate and troubling. https://kimatv.com/news/local/astrias-yakima-hospitals-closing-may-be-a-symptom-of-a-bigger-crisis 2. In Montana the state was on the brink of bankruptcy because of the costs of paying for hospital care for their state employees, Medicaid patients needing hospitalization, etc. Montanans were able to control costs by using a model that Montanan hospitals now saying is working well. The hospitals are paid about 234% of Medicare rates. https://www.propublica.org/article/in-montana-a-tough-negotiator-proved-employers-do-not-have-to-pay-so-much-for-health-care And no wonder hospital systems make such terrible consolidation decisions. People who administer these hospitals are used to making millions of dollars. The system we are stuck with now does not help smaller and more rural hospitals financial problems. The American pastime of gobbling up the competition and closing down the unprofitable "business" is making it difficult for the communities to have care anywhere close to home. Please see the healthcare deserts detailed in these maps. https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf Some of the current challenger to hospital survival: 1. Reimbursement rates of 10-20% of the billed amounts paid by insurance companies and poor reimbursement rates by other entities like Medicaid or current Medicare rates. https://www.cnbc.com/2019/02/11/this-is-the-real-reason-most-americans-file-for-bankruptcy.html Therefore, hospitals suffer deep discounts even when insurance companies pay them which of course hurts their ability to stay solvent. 2. The constant negotiations with the myriads of insurance companies are costly. Many of our residents are under-insured or even worse, playing the Russian Roulette of not having insurance. Bankruptcy and homelessness can be the result. https://www.cnbc.com/2019/02/11/this-is-the-real-reason-most-americans-file-for-bankruptcy.html In fact in the U.S. 2/3 of bankruptcy may be due to medical bills. Also three-quarters of the one million American families experiencing medical bankruptcy annually have coverage when they fall sick. This increases the number of people in poverty and homelessness and leads to increasing numbers of people in our state on welfare. A growing number of the homeless have one or more jobs. https://parade.com/643064/beckyhughes/working-homeless-population-grows-in-cities-across-the-u-s/ Health conditions are very rough and stress is very high in these situations, leading to more dependence on the state and hospitals for medical emergencies when their neglect of a manageable health program becomes life

	threatening or too painful to tolerate. This round robin of dysfunction is already disrupting. 1. Individual families 2. Hospitals 3. Local and state governments, Even before the terrible costs occurring with COVID-19, many local jurisdictions suffer from neglected infrastructure maintenance. Rising healthcare costs show no slowing, rising by double digits for the last 5 years. human price that costs the state so much in welfare care! Now with the economy in free fall because of a novel virus that our gutted CDC could not prepare for quickly the 30% of healthcare dollars that go to the medical industries such as insurance, pharmaceutical, manufacturers and middle men had already hamstrung efficient affordable care. Please do not dither about whether we can sustain the current model. No we can't!! We must quickly create a system where the citizens are defended and the private industries are brought under control. In fact, insurance companies are severely regulated or not even used around the world. A simplified payment system through the state health care authority is a must. Doctors and hospital workers and administrations must have adequate budgets. Redistributing the money leaking out of the system in a flood must be done. Hospitals and clinics should not have to make profits, they should be given adequate, guaranteed sure budgets so the energy and money can be spent on health care. We must wake up! Distribute care evenly. All people need adequate care. As it is poor people, people of color, rural people and even the shrinking middle class are faced with the probability they will be unable to afford care and for many find a place to be receive that care.
I did not attend the work group but I read details about the meeting.	When my son graduated with a masters degree he was unable to find a job in the US so he found a job abroad and five years later brought back a wife. They lived with my husband and me because they were unable to afford rent or healthcare. So they went without healthcare until they found jobs. If we had not been willing to take them in, they would have been homeless. Not every family can do this so we need affordable equitable healthcare coverage for every person in our state. We need to end the high cost of for-profit healthcare companies by regulating them and and taking aback the administration of medicaid.
I listened to the first hour of the meeting. The most important point shared was that the criteria for choosing models should include thresholds for affordability. The quality of health care is obviously important, but if it isn't affordable, people will delay in using the care, until their health is greatly compromised. Or alternatively, people will be	I consider these criteria most important in choosing 3 models to study : 1. Access needs to include all residents, including undocumented immigrants. 2.All treatments, procedures, etc. need to be equitably priced 3. The source of the coverage (state government, insurance company should not interfere with clinical decision making. 4.Thresholds for affordability need to be used so that medical

forced into financial ruin.	bankruptcy is avoided. I ask that the WHIST be used as one of the models considered.
It is very important that a single payer option is used in your analysis	Whatever recommendations you end up making, I urge you to very strongly consider MINIMIZING or REMOVING the option of private insurance and profit incentive. This is destroying our health care, driving individuals needing care into bankruptcy (or just skipping care altogether) while making a few very wealthy. This is outrageous, inhumane, and antithetical to the task of providing health care! Removing health insurance companies from the mix leads to big savings. Yes, it is probably challenging to imagine a different system and to understand how to transition to a different system (e.g., how might we help insurance company workers transition to other jobs), but let's be bold, learn from others, and SERVE THE PEOPLE. Thank you for your time and energy, Ed Wayt
The need for Universal Care	Thank you for including the WHST bill in your analysis of the 3 different health care models. It would be an incomplete comparison if that bill was not one of the chosen models to compare. I am sure you would not want your work to be considered incomplete by leaving out this plan which has been presented to our legislatures since 2013 and never received a hearing. Around the world a single payer option has proven to be the most cost effective. We should not try and hide this fact from our citizens.
Study on Major International models. It is clear to me that the members of the UHC Work Group are very knowledgeable. The upcoming meetings and the outcome are invaluable.	We as a state need this
Looks like it's going very slow.	I don't see eliminating the dependence on employers for insurance as one of your goals or charges. The current system is horrible. No one is happy depending on their employer as to which insurance and how much they get.
Establishing the criteria by which to analyze an appropriate healthcare model for the state.	Required reading: "Taking into account both the costs of coverage expansion and the savings that would be achieved through the Medicare for All Act, we calculate that a single-payer, universal health-care system is likely to lead to a 13% savings in national health-care expenditure, equivalent to more than US$450 billion annually. The entire system could be funded with less financial outlay than is incurred by employers and households paying for health-care premiums combined with existing government allocations." from The Lancet Feb. 15, 2020 (sent by Don McCanne on Feb. 17)
There was broad agreement in the "orange" group I sat in on that universal health care means similar things to most of the group: anything you need should be in-network, copays and deductibles are a barrier to access, it's important to share data and have a platform that promotes this, primary care is critical, include social determinants of health as this has cost benefits, coverage should be as broad as possible, portability of care, transparency in health care systems (concern with consolidation of hospitals), important to capture patient input, consider the perspectives of patients as well as doctors. As for	I don't see that you are addressing the following: > Employer-Based coverage is too expensive (upwards of $20,000 per year plus deductibles and copays). Also it's provided at the whim of the employer that can reduce the coverage, eliminate the coverage and/or lay the employee off. Also, you lose your coverage if you lose your job or change jobs, etc. >All private run health care coverage is provided at the whim of the insurance company. They raise premium costs, control treatment options, and deny coverage.

benefits, could begin with the '93-'94 health reform benefits package and move forward. Evidence-based care, sensitivity to cultural differences, and quality across communities also were mentioned as important. Overall, I was very impressed with the general agreement on these attributes of a universal health care system, regardless of profession or politics. I am optimistic, at this point, that the Work Group will most likely be able to fulfill its charge of recommending 2 or 3 universal health care models to the Legislature.	You need to address these issues. Looks like you are only looking to give "access" to those that currently don't have coverage. We all need help. And for some the need is dire.
	People are suffering while we try to reinvent the wheel. Single payer systems have been proven around the world. Seems the health care lobby has too much influence in our government. This is a matter of life and death. Why isn't SB5222 being considered? Why isn't anyone from Whole Washington on the Work Group? They applied.
	The work group charge or mission is very weak. It needs definitions for "increased coverage". Is the goal 100% coverage or something less? And "under-insured" Almost all WA residents are under-insured. Also, What are "health equity" and "health disparities"? The charge should be to seek a system that will PROVIDE COMPREHENSIVE coverage to ALL at an AFFORDABLE cost and not be under control of employers and insurance companies. "Access" isn't definitive enough. People have access to coverage via the ACA but many can't afford it.
	It looks to me like the Work Group is making good progress with the establishment of important criteria and the outlines of other models. The guiding principal for Washington's healthcare model needs to be that every resident will have equal, affordable access to medical care whenever needed. This should include undocumented immigrants, at least with regard to primary care. Providers need to remain private, but private insurers are far too resistant to the kind of change that is necessary to have any significant role, other than for possible supplemental coverage. Because the U.S. has already demonstrated success with its Medicare, single-payer, national health insurance model for those over 65, that model should be the one chosen and improved upon by each state. Once a federal program is approved (along the lines of the Canada Health Act of 1984), each state that has already created a universal system can then be easily integrated. The state should define the benefits package and negotiate transparent prices for all services and products which might vary according to the local costs of living. Benefits could initially be conservatively set (as they were in Canada), but they should eventually include the full gamut of primary care, hospital care, prescription medication, dental, vision, hearing, reproductive, mental health, and long-term care

	(unlike Canada). There should be no point of service costs for consumers. Funding will be established through payroll deductions as a percent of salary, via the state tax system and a merger with the state Medicaid system and possibly the IHS and contributions from the VA. Benefits need to be evidence-based and set by a panel of medical professionals to promote maximum health for all residents. The latest version of my e-book called A Medicare for All Q & A was just published in a variety of formats at https://educationfund-healthcareforallwa.nationbuilder.com/hcfa_ed_fund_ebook_a_medicare_for_all_q_a
	Yes. I was impressed by the variety of coverage models presented by the Economics Group. However, the Washington Health Security Trust (WHST) was described incorrectly. Rather than overseeing private plans, the WHST IS the plan, a public plan that covers all Washington residents for benefits that are deemed medically necessary by the Trustees.

Appendix C: Letter to Jamie Strauz-Clark and Response to UHC Work Group members

May 4, 2020

Jamie Strausz-Clark, Principal at 3Si
Facilitator, Universal Health Care Work Group

Re: Universal Health Care Work Group Requests

Dear Jamie,

Our world has certainly changed since the UHC Work Group last met. We hope all is well with everyone and their loved ones.

UHC Work Group in the Context of COVID-19. While the urgency of the COVID-19 crisis is immediate, we believe the UHC Work Group has a new mission in the context of COVID-19: to help chart the way for the aftermath of COVID-19 given the huge weaknesses in our health care and public health systems the epidemic has illuminated, and the devastation to Washington's economy.

We expect federal actions will affect what we can and should do at the state level. It's important for our state to define the help we need from the federal government to achieve our goal of universality and affordability. We need to be ready for opportunities that arise. We believe that the UHC Work Group's recommendations could play a role in this.

We are concerned with the content of the Work Group process, to date, and that we are not on pace to deliver actionable results to the Legislature as directed in the Budget Proviso. It is now May, so we feel some urgency in offering the following suggestions for how to improve the Work Group process so that our four remaining meetings are as productive as possible.

Meet by Zoom. In case we're not able to meet in person in Spokane, and any future meetings, we hope that the meetings could be structured in a way that would be productive to meet over Zoom.

Extend the deadline. In light of COVID-19, we would request the deadline for the Work Group's recommendations be extended until mid-December, giving the Work Group the needed time to finish its work while still getting its recommendations to the Legislature in time for the 2021 session. Of course, in these uncertain times, even that may have to be reconsidered.

Consult the Experts in the Work Group. We are concerned about the quality of the information presented to the Work Group. Good, reliable information is key to our success, yet presentations made to us at our first and third meetings contained significant errors or mischaracterizations. Not only does this impede the group's discussions, but it also undermines trust in the entire process.

The weaknesses in the information provided to us would have been fairly easily rectified had it been reviewed beforehand by knowledgeable members of the Work Group. We encourage this

review before future presentations and before the corrections to the past presentations are redistributed to the group.

Perform an Actuarial and Financial Analysis of Recommended Options. We have heard that the company hired to handle the analyses is planning to provide *only* an actuarial analysis. We hope this is not the case, because that would be incomplete as specified in the directive for our Work Group in ESHB 1109:

> 57) The health care authority is directed to convene a work group on establishing a universal health care system in Washington. $500,000 of the general fund—state appropriation for fiscal year 2020 is provided solely for the health care authority to contract with one or more consultants to perform any actuarial and financial analyses necessary to develop options under (b)(vi) of this subsection…
>
> …(b)(vi) Options for revenue and financing mechanisms to fund the universal health care system. The work group shall contract with one or more consultants to perform any actuarial and financial analyses necessary to develop options under this subsection.

It is critical that the Work Group's guidance to the Legislature include, as required in the legislation, "financing mechanisms to fund" each alternative model and pathway, including "no change." Actuarial analyses are only part of what we think is needed for such cost estimates and funding mechanisms.

The *Components of the Universal Health Care Models* Survey should be a Straw Poll. We urge you to treat the results of the survey that was due April 3rd as a way to capture *the initial* thoughts of the Work Group participants. We do not think it is appropriate to summarize the results and then send over to the actuarial and financial study consultants without the further Work Group discussion. We need to discuss the survey options and come to agreement about what the choices are, and to explore the priorities with Work Group members and exchange information. For example, the survey asks if Fertility Treatments should be considered. It would be appropriate to hear what reproductive providers think about that in order to make an informed opinion on that topic. Further, it would be good to know how Canada and other countries handle these concerns.

Provide more opportunities for small group work and more fully summarize those discussions. The breakout groups seemed to work better in the February meeting because the discussions relied on participants' own ideas (the post-it notes). In addition to capturing ideas, we request that you capture the frequency with which an idea is brought up and in how many groups.

For example, if a post-it says "Reduce costs by rooting out the over-medicalization of services," the report should show that this was brought up 5 times, in 3 out of 4 groups. This will help us see patterns and understand what is most important to the Work Group, as a whole.

Provide more timely information. Work Group members and their constituents need to have access to important information in a more timely manner. We request that you:

- Provide a copy of the Budget Proviso to every Work Group member (this is summarized in an overview document dated September 5, 2019, provided to the Work Group, but it's important that members have the underlying document and understand our specific charge).

- Provide the meeting location or Zoom link for the June 24th meeting ASAP, so we can help publicize the public meeting.

- Provide all meeting materials at least two weeks prior to each respective meeting. It is important to distribute the agenda and meeting materials - including financial analysis, materials, minutes, online public comments and reports from the previous meeting - at least two weeks prior to the meeting so that we have time to study them.

We believe these requests will help us fulfill the Legislature's directive to recommend a pathway to universal and affordable health care for all Washingtonians. We have cc'd some members of the Work Group with whom we have been sharing our thoughts.

We're looking for a reply as soon as possible but at least by May 15th.

Sincerely,

Universal Health Care Work Group Members:

Aaron Katz
Kelly Powers
Ronald Shure
Sherry Weinberg, MD

cc: Sue Birch, Health Care Authority Director and Chair of the UHC Work Group
Rep. Nicole Macri, Sen. Emily Randall, Dennis Dellwo, Carrie Glover, Don Hinman, Lisa Humes-Schulz, Sybill Hyppolite, Richard Kovar, Peter McGough, Bevin McLeod, Kerstin Powell, Randy Scott, Mohamed Shidane, Aren Sparck, and Lynette Vehrs

May 15, 2020

Dear Kelly, Aaron, Ronnie, Dr. Weinberg, and Universal Health Care Work Group members:

Thank you to Kelly, Aaron, Ronnie, and Dr. Weinberg for your May 4th letter outlining specific concerns about and suggesting improvements to the Universal Health Care Work Group process. HCA and HMA have reviewed and discussed each of your recommendations, some of which were already being discussed by the project team. As you can see, the project team is working to adopt many of your suggestions; however, in some cases, the project team is not able to take your suggestions as originally proposed. In those instances, we have offered some modifications to try to get at the spirit of your proposal. This letter outlines each of your suggestions and how the project team proposes to address them.

Meet by Zoom

There had been a time we had hoped it would be possible to meet in person on June 24 in Spokane, but that is looking less likely given the Governor's restrictions on in-person gatherings and phased reopening of Washington State. Even when restrictions on in-person gatherings are lifted, we are concerned that some work group members and members of the public may have underlying health conditions or other vulnerabilities that make it unsafe or uncomfortable for them to participate in an in-person meeting. As such, we agree with your suggestion to meet remotely and have decided to shift the June 24 meeting to a Zoom meeting. The project team had already been discussing this option given the number of issues to consider (access to technology, managing public comment, breakout rooms, etc.) that need to be worked through to ensure a successful meeting using this technology.

This week, we will send a survey to work group members to confirm whether members have the technical tools needed to fully participate (e.g., a computer, webcam, microphone and/or smart mobile device, and internet broadband service) and to gather information on the length of the meetings. We will explore options to assist work group members who need help to participate.

Extend the deadline

We agree with you that this work is too important to shortchange. HCA believes the Legislature recognizes the impacts of the COVID-19 pandemic on report deadlines and is more interested in the outcome of our work, rather than the deadline. Since we are moving to digital meetings—at least in the near term—we are hoping we can schedule some additional meetings this summer to try to catch up. But, if need be, we believe it will be possible to take additional time later in 2020 to complete this work.

Consult the experts in the group

Aaron Katz and I discussed this earlier in the year, so this is not the first time the project team has heard this feedback.

One of the strengths of this work group is the expertise that each member brings from their own field or lived experience, as well as the diversity of expertise across the work group. The challenge with such breadth and depth of expertise and diversity is how to leverage that expertise in an equitable and appropriate way. The main way in which this is happening is through the work group process and meetings themselves.

You make an excellent point that work group input on the materials that we use for our decision-making is important to ensure that we are working with the best available information. The project team has taken that feedback to heart. Since the September meeting when the presentation used national data instead of local data, HMA has been vetting their presentation materials with state agency work group members who hold relevant data. This includes members representing the Office of the Insurance Commissioner, Health Benefits Exchange, and Office of Financial Management.

Moreover, we are taking the feedback and addressing it in real-time within the work group meeting setting. As you hopefully observed at the February meeting, Nora and Jeanene readily took your input on the meeting materials and made changes to the presentation and handouts to reflect that input. These revised versions are the ones we used as the basis for our small group discussions that are posted on the web and ultimately what will be reflected in the final product we will deliver to the Legislature.

A key goal of the work group meetings is to ensure all members are working with the same set of facts and deliberating together. We welcome work group feedback and will continue to listen to and incorporate that input in presentation materials.

Importantly, we want to recognize that the material outcomes of the work group will be the development of a report that outlines up to three (3) potential models and the preliminary analysis of those models. As we get closer to these work products, the work group will have time and opportunity to provide comments and input.

While we acknowledge this is not the approach you requested, we hope this somewhat addresses your concern about leveraging the work group's expertise to provide the best available information.

Perform an actuarial and financial analysis of recommended options

HCA selected HMA and its subcontractor, Optumas, to perform actuarial and financial analysis of costs of up to three models to achieve universal health care coverage in Washington. These analyses will focus on the models themselves, including their impact on the health coverage landscape, costs, and impacts (to the state, consumers, and others) if adopted in Washington. HMA and Optumas are not scoped to provide information about funding sources: this would require significantly more resources than the amount allocated in the budget proviso. The hope is that by providing the cost information to the work group of the various models, the work group can begin discussions and outline potential funding sources in its final report to the Legislature.

The components of the universal health care models survey should be a straw poll

We agree with your point that results of the survey that was due April 3 should capture the initial thoughts of the work group members, but there should be an opportunity to discuss the survey results and refine the models together, prior to the actuarial analysis. The intention of the survey was to provide some direction to models for further study and refinement in the work group setting. The original plan for the April 22 meeting was to review the survey outcomes, discuss and refine the three models in breakout groups and as a full work group, and only then pass the models to the actuaries to analyze. We have moved these agenda topics to the June 24 meeting and delayed the start of the actuarial analysis to ensure that we are able to have these discussions beforehand.

Provide more opportunities for small group work and more fully summarize those discussions

We also agree that small group discussions have been productive and we intend to continue using this approach at future meetings—including the June 24 meeting.

Regarding your point about more fully summarizing the discussions, we agree it is important to capture the key themes and how many times they come up. We have records of these from the December and February breakout sessions; they will be added to the work group summaries as appendices and re-posted on the website. In the future we will include these as appendices to the work group summaries.

Provide more timely information

In this part of the letter, you asked for three things:

1. A copy of the budget proviso for all work group members.
2. The Zoom link for the June 24 meeting as soon as possible.
3. Meeting materials at least two weeks in advance of work group meetings.

I am attaching the budget proviso to this email (relevant text starts on Line 3) and will also send it out when I send the agenda for the June 24 meeting.

As soon as we have the work group response to the above noted survey, HCA will update the meeting invitation with a Zoom link and provide instructions to sign up for public comment.

We will do our best to send meeting materials as far in advance as possible. Given that we are hoping to schedule some additional meetings this summer to catch up on some of the time we lost due to the COVID-19 pandemic, two weeks may not always be realistic. For context, materials we develop go through multiple rounds of internal review before they go to HCA and other state agencies for their review and feedback. So, in cases where we only have a few weeks between meetings, a two-week advance period may not be possible. That said, we agree that work group members need time to prepare for our meetings, so we will work to provide as much lead time as possible.

Again, thank you for your feedback and your continued commitment to making this a successful work group process. Please continue to share your feedback with me as it comes up.

Best regards,

Jamie