Washington State Health Care Authority

Universal Health Care Commission

June 16, 2022

Washington State Health Care Authority

Universal Health Care Commission
Meeting Materials

June 16, 2022
3:00 p.m. – 5:00 p.m.

(Zoom Attendance Only)

Meeting materials — Tab

Washington State Health Care Authority

Agenda

Tab 1

Washington State Health Care Authority

Universal Health Care Commission

June 16, 2022
3:00 p.m. – 5:00 p.m.
Zoom Meeting

AGENDA

Commission Members:					
☐	Vicki Lowe, Chair	☐	Estell Williams	☐	Kristin Peterson
☐	Senator Ann Rivers	☐	Jane Beyer	☐	Representative Marcus Riccelli
☐	Bidisha Mandal	☐	Joan Altman	☐	Mohamed Shidane
☐	Dave Iseminger	☐	Representative Joe Schmick	☐	Nicole Gomez
☐	Senator Emily Randall	☐	Karen Johnson	☐	Stella Vasquez

Time	Agenda Items	Tab	Lead
3:00-3:10 (10 min)	Welcome and call to order	1	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
3:10-3:20 (10 min)	Roll call	1	Mandy Weeks-Green, Manager Health Care Authority
3:20-3:25 (5 min)	Approval of meeting summary from April 14	2	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
3:25-3:40 (15 min)	Public comment	3	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
3:40-5:00 (80 min)	Report to the Legislature draft sections 2 and 4 with Commission member feedback and discussion • For reference, Section 2 can be found under Tab 5, and Section 4 can be found under Tab 6	4	Liz Arjun, Senior Consultant, Gary Cohen, Principal, and Jon Kromm, Principal Health Management Associates
5:00	Adjournment • For reference, updated Section 1 can be found under Tab 7, and updated Section 3 can be found under Tab 8		Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State

During the COVID-19 public health emergency, and out of an abundance of caution for the health and welfare of the Commission and the public, this meeting of the Universal Health Care Commission will be conducted virtually.

Washington State Health Care Authority

Meeting summary

Tab 2

Universal Health Care Commission Meeting Summary

April 14, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
3:00 p.m. – 5:00 p.m.

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

Members present

Vicki Lowe, chair
Bidisha Mandal
Dave Iseminger
Senator Emily Randall
Jane Beyer
Joan Altman
Representative Joe Schmick
Karen Johnson
Representative Marcus Riccelli
Mohamed Shidane
Nicole Gomez
Stella Vasquez

Members absent

Senator Ann Rivers
Estell Williams
Kristin Peterson

Call to order

Vicki Lowe, Commission Chair, called the meeting to order at 3:03 p.m.

Agenda items

Welcoming remarks

Ms. Lowe welcomed the members of the Commission and the public to the fourth meeting of the Universal Health Care Commission.

Meeting Summary review from the previous meeting

The Commission Members present voted by consensus to adopt the Meeting Summary from the Commission's February 2022 meeting.

Public comment

Ms. Lowe called for verbal and written (via the Zoom chat) comments from the public.

Kelly Powers, a Cascade Care enrollee, urged that the Commission's report to the Legislature (due November 2022) should include the Universal Health Care (UHC) Work Group's financial analysis of Model A (state-governed, state-administered), particularly the $5.6B in estimated annual savings. She also noted that though uninsured rates have decreased, the number of underinsured Washingtonians has increased. (Verbal)

Lynette Vehrs, Registered Nurse and President of the Washington State Nurses Association remarked that nurses want universal health care. She shared that in her nursing practice, it was emotionally painful to care for patients who were denied medication or procedures due to lack of health care coverage. (Verbal)

Cris Currie, retired Registered Nurse, encouraged the Commission to work promptly with Health and Human Services (HHS) to the develop a 1332 waiver. He suggested that waiver authority can be granted prior to finalizing a single-payer funding plan, and that the Commission should determine the projected amount of passthrough funding from the 1332 waiver, as this information may it easier to pass the necessary legislation. (Verbal)

Roger Collier urged the Commission to read his written proposal for the Washington health care plan which combines two of the goals of the Commission; 1) to make immediate and impactful changes to the current health care system, and 2) to take the first steps toward a universal financing system. He asked Commission Members to consider letting him read his full proposal at a future Commission meeting. (Verbal)

Pam Dalan, Registered Nurse, remarked that 25-30% of the current health care budget is dedicated to administration. She called on the Commission to work on creating a finance committee and consider the formation of an ad hoc committee to make recommendations on the finance committee formation. She also asked for further transparency regarding consultants engaged to work with the Commission. (Verbal)

Marcia Stedman, Board Member for Health Care for All Washington, remarked that it is impossible for the costs of universal health care under a publicly administered system to be more costly than our current system. She recommended that the Commission move quickly to form an ad hoc committee to make recommendations for the creation of a finance committee. (Verbal)

Maureen Brinck-Lund commented that the chart on page 69 (of the meeting materials) describing Models A-C only displayed the estimated savings for the implementation year. She noted that Model A generates $5.6B in savings annually past the implementation year. (Verbal)

Kathryn Lewandowsky, Registered Nurse and Vice-Chair of Whole Washington, stated that true health care reform has been a topic of discussion for decades in each election cycle and has never been achieved. She remarked that the COVID-19 pandemic has exposed the disadvantages and shortcomings of the current for-profit health care system. (Verbal)

Presentation: Evan Klein, Special Assistant for Policy and Legislative Affairs, Health Care Authority (HCA), and Jane Beyer, Commission Member and Senior Health Policy Advisor with the Office of the Insurance Commissioner (OIC), shared updates from the 2022 legislative session.

Mr. Klein shared that 2022 was a short legislative session and a supplemental budget year. The state's revenue increased by over $5B, and the Health Care Authority's budget increased by over $1.5B. HCA's increased funding is designated for various HCA programs as well as the creation of new programs, which also includes provider rate increases. HCA analyzed over 200 pieces of policy legislation and received over 55 new legislative reporting requirements.

At least two bills will have a significant impact on HCA and may be relevant to the work of the Commission. The first, Senate Bill 5589 (primary care expenditures), directs the Health Care Cost Transparency Board to analyzing progress towards spending 12% of total statewide health care expenditures on primary care. The second, Senate Bill 5532 requires the Prescription Drug Affordability Board to identify and conduct affordability reviews of drugs that have been on the market for 7 years and meet certain criteria. The Board is also authorized to set upper payment limits for up to 12 drugs beginning in January 2027. Other directives for HCA in the budget proviso include the following: standing up a new coverage program for individuals earning under 138% of the Federal Poverty Level (FPL); funding for continuous enrollment for children up to age 6; and a suite of provider reimbursement rate increases.

Ms. Beyer shared three bills, of which the first two were high priorities for consumer advocates regarding commercial health insurance. The first, House Bill 1688 (balance billing), passed with bipartisan support and broadens the scope of services protected from balance, or "surprise" billing. This bill also prohibits hospitals and providers from requiring patients to waive their balance billing protections. A provision of this legislation allows individuals with a behavioral health emergency to receive services regardless of whether the provider issuing services is in-network of the individual's health care coverage/plan.

Senate Bill 5610 (specialty medications/"co-pay accumulator bill") is the second high priority bill for consumer advocates regarding commercial health insurance. This bill directs private health plans to count the value of third-party payments, including manufacturers' coupons, toward a consumer's health plan deductible and their maximum out-of-pocket if, 1) a drug doesn't have a generic equivalent or a therapeutic equivalent that's a preferred drug on their health plan's formulary, or 2) if a consumer has been able to have a drug covered as an exception process.

The third bill updated coverage of audio-only telemedicine (House Bill 1821). This legislation revised the requirement that the patient have an established relationship with the provider issuing audio-only telemedicine services before the audio-only telemedicine will be covered by insurance.

Presentation: Dan Meuse, Deputy Director of State Health and Value Strategies at Princeton University, shared Federal Coverage Structures and Hurdles for State-Run Financing Systems.

Mr. Meuse outlined the various methods of coverage for individuals post-Affordable Care Act (ACA):

- Medicare – 65 and over, some disabled
- Medicaid – Available to individuals under 138% of FPL (except undocumented individuals)
- CHIP (Children's Health Insurance Program) – Available to lower-income children
- Self-Marketplace coverage (except undocumented individuals)

- Employer – Most, though not all employers offer coverage to full-time employees

Mr. Meuse shared that Medicare is likely the largest hurdle for a state-run health system. Medicare represents the single largest revenue line for most hospitals and functions the same across the country. Additionally, funding decisions for Medicare are completely under federal control. However, if Washington can find savings in Medicare, then this savings could fund coverage for other population groups. Maryland and Pennsylvania have some level of control over Medicare payments for hospitals through a CMMI (Center for Medicare and Medicaid Innovation) waiver.

- For over 40 years, Maryland has had an agreement with the federal government to set rates for hospital reimbursement in the state's health care system. In 2014, Maryland engaged with CMMI to implement a statewide waiver allowing the state to set rates for Medicare payments (in the ACA context) and leverage savings from the rate setting under the waiver into other population health opportunities.
- Pennsylvania allows rural hospitals to opt into a waiver-based payment program that transitions payment away from fee-for-service to a global budget.

Medicaid and CHIP are a federal/state partnership where funding decisions are generally under state control subject to some federal constraints. Eligibility for these programs is often income-based, though states can apply for "demonstration waivers" to add populations and change funding and payment models. However, the federal government must approve changes to Medicaid programs which may impact the state's ability to innovate depending on the current administration. While Medicaid has some flexibilities, the program pays providers less than Medicare and commercial insurance.

The individual market is a federal, state, and private market partnership, where states can regulate coverage, but federal dollars are critical for affordability. There are limits on how states can innovate in their individual market and the individual market relies on the current insurance system.

The employer market is protected by a federal law called ERISA (Employee Retirement Income Security Act, 1974) and is likely impenetrable without some level of legislative change. The two models for employer-sponsored coverage include the fully insured model and the self-insured model. A large multi-state employer is usually self-insured so they can contract with a large, national carrier to provide coverage to their employees. The employer market represents the largest pool of portable dollars because employers overpay for services as compared to public programs.

Federal authority lives in three departments including Health and Human Services, the Treasury, and the Department of Labor. The agencies under these respective departments have varying levels of flexibility for transitioning to a unified funding model. Flexibility is most generous for Medicaid, the marketplace, and premium tax credits. There is moderate flexibility in Medicare and COBRA. The areas with limited flexibility are ERISA, employer health insurance exclusion, Federally Qualified Health Centers, and hospital payments.

Even programs with ongoing flexibility have constraints and the model of flexibility looks different to federal officials than to state officials. Crafting a payment model will be the greatest challenge. There is no single payment structure that can be used for all services. Additionally, managing a budget will likely require payment model innovations, including global budgeting which requires provider system participation.

Mr. Meuse noted that the current system was built and designed with structural racism at its root. For example, Medicaid was limited to certain income levels and pays providers less than other providers. In its pursuit of a new health care delivery and financing system, Washington must ensure that it is equity centered to create a model in which the remnants of racism are eliminated.

Presentation: Liz Arjun and Gary Cohen, Health Management and Associates, shared section 1 and section 3 of the draft report to the Legislature, due November 2022. Section 1 covers a synthesis of analyses done on Washington's existing health care finance and delivery system and section 3 addresses the legislative requirement to create an inventory of the key design elements of a universal health care system.

Section 1 of the draft report focused on the issues in Washington's current health care system, as well as many of the policy responses developed to address them. According to the Washington State Office of Financial Management, the current uninsured rate is the lowest ever as a result of the ACA and work by the state to maintain and increase coverage for Washingtonians. However, the uninsured rate for some populations has increased, specifically for American Indian/Alaskan Native, Hawaiian and Pacific Islander, and Hispanic populations.

Health care costs have increased over time and are exceeding inflation and wage growth. Some of the policy responses to rising costs include the establishment of value-based payments, the Health Care Cost Transparency Board, the Prescription Drug Price Transparency Program, and the Prescription Drug Affordability Board.

In terms of health care workforce, the number of physicians in the state increased. However, physicians are disproportionally allocated throughout the state and are particularly concentrated in Chelan County. There are significant shortages in behavioral health and nurses. Hospital consolidation has also increased significantly.

The Universal Health Care proposed three models (Models A, B, and C) for universal health coverage in Washington. Ms. Arjun remarked that Washington is moving forward with implementation of Model C (access to coverage for undocumented immigrants) through a 1332 federal waiver.

Section 3 of the draft report focused on the design elements of a universal health care system. Eligibility and enrollment in the unified health care financing system is a consideration with a goal to cover every Washingtonian under a universal system. The covered benefits and services under the unified health care financing system will also need to be considered. Mr. Cohen raised considerations regarding whether essential health benefits, dentals, vision, and benefits mandated by Medicaid would be covered under the new system.

In terms of financing, it will be key to identify an approach to align or pool all funding sources to finance the benefits and services covered under the new system. One approach for consideration is the unified health care financing system could move away from a fee-for-service model and toward value-based payment models in order to encourage provider participation, as well as to improve quality and reduce health care costs. Mr. Cohen noted the importance of investing in administrative and operational capabilities to implement a cohesive model.

Mr. Cohen highlighted that in terms of governance, it will be important to ensure transparency and accountability for planning and implementing the new system. Additionally, the voice of consumers must be part of decision making.

Adjournment

Meeting adjourned at 5:00 p.m.

Next meeting

Thursday, June 16, 2022
Meeting to be held on Zoom
3:00 p.m. – 5:00 p.m.

Washington State Health Care Authority

Public comment

Tab 3

Washington State Health Care Authority

Universal Health Care Commission
Written Comments
Received From April 1

Written Comments Submitted by Email

Additional Comments Received at the April 14 Commission Meeting

- The Zoom video recording is available for viewing here: https://www.youtube.com/watch?v=KiO3wVVKpmg
- The Meeting Summary is available here: https://www.hca.wa.gov/assets/program/uhcc-meeting-summary-20220414.pdf

Public comments received since April 1 through the deadline for comments for the June meeting (May 31)

Submitted by Aaron Katz
4/14/2022

Dear Commissioners,

Please accept these few comments on the materials you will discuss today. Note that I'm commenting on the slides, not the draft report to the Legislature, as I have not yet had time to read that draft:

* Governance (HMA slide #26) - The large text on the left seems to define, appropriately, "governance" as comprising the critical components of accountability and consumer voices. The "Key Considerations" box, however, largely ignores these critical components, focusing instead on administration and regulation. Although these latter topics are important, the report should discuss how consumers will or should be involved in oversight (e.g., majority of a governing board?) and to whom the governing and administering body is accountable (e.g., who has the authority to elect/appoint governing members and redress failures).

* Draft of Section 1 of the UHCC Report to the Legislature - On page 93, the draft report summarizes an OFM report on hospital mergers, which demonstrates the considerable market consolidation between 1986 and 2017. The OFM report appears to ignore an important characteristic of this trend, that the result has been a very large proportion of available hospital beds - 100% in some communities - are in hospital systems run by Catholic organizations. This had greatly reduced access to abortion, reproductive health, and humane dying services for Washingtonians. Access to these are priorities for our state as demonstrated by various actions taken by voters and legislators.

* The description of the 1993 Washington Health Services Act (p. 11) fails to note that a key part and innovation of this Act was setting public health as a co-equal part of comprehensive health system reform. Our experience with the Covid pandemic has clearly shown why this is important and emphases that the UHCC should strive to integrate public health into its thinking about and recommendations for a pathway to a unified, integrated universal health system for the people of Washington.

Thank you.
Aaron

Aaron Katz, Principal Lecturer Emeritus
School of Public Health
University of Washington
Skype: aaronatuw

We acknowledge the people – past, present, and future – of the Dkhw'Duw'Absh, the Duwamish Tribe, the Muckleshoot Tribe, and other tribes on whose traditional lands we study and work.

Submitted by Pamela Dalan

4/14/2022

This is the transcript of my public comment for the April 14 2022 UHC Commission,

My name is Pamela Dalan. I am a registered nurse and a member of SNOW, School Nurses of WA.

While studying the meeting materials, I was struck by the numbers. $64.1 Billions per annum is our state Healthcare Budget. According to the data put forth by Roger Collier in the meeting materials,(although I do not agree with his conclusions), the administrative costs of our current system are 25- 30% or up to $20 billion! The Universal Healthcare Work Group Determination by the Optimus Consultants stated that by the second year of the existence of Model A we would $5.5 Billion for other important needs such as subsidizing the education and graduation of the needed new healthcare professionals to give the care.

As to current issues for the Commission, there are urgent matters that a Finance Committee should begin to work on. I would like to call for the Commission to begin now to form the finance committee called for by SB 5399. I support the formation of an ad hoc committee with expertise to make recommendations on the Finance Committee Formation to build step by step toward a truly effective universal health care for all Washington people.

Also I want to ask for further transparency regarding consultants.engaged to work with the Commission. I would like to see this process published on the website, including the "Request for Quotes and Qualifications."

Thank you so much for your diligent work thus far. You understand that it is WA healthcare solvency that you are fighting for$!

Thank you for understanding the human tragedy of our dysfunctional addiction to allowing Industry to "handle" healthcare.

Far more costly in human terms than even these numbers highlight, is the ruining of people's ability to work, care, contribute and even live when their healthcare is delayed and denied for profit.

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Sincerely,

Pamela Dalan RN

206 718 6691

Submitted by Cris Currie

4/14/2022

Public Comment for 4/14/22 UHC Commission Meeting

I'm Cris Currie, a retired RN from Spokane. I want to encourage the commission to begin working with Health and Human Services soon regarding negotiating a Section 1332 Medicare/Medicaid waiver. When California State Representative Karla met with HHS staff last October, he was pleasantly surprised at how receptive they were to his single-payer bill, AB 1400, and he was told that while health policy legislation must be passed, waiver authority can be granted prior to finalizing the single-payer funding plan. This is despite the 1332 requirement that a 10-year budget be included in the application. See Karla's testimony here at 3:38:05.

In previous CMS guidance (page 4), states have been encouraged to "reach out to the Departments promptly for assistance in formulating an approach that meets the requirements of section 1332." With the sympathetic Department that we have now, it might even be possible to use SB 5399 with some minor amendments added during the next legislative session as the basis for our waiver application. If there is any way we could obtain a 1332 waiver or at least determine the amount of the projected pass-through funding before the full UHC plan is enacted, it could make passing that legislation much easier.

As soon as the Commission's Finance Committee (or perhaps even an ad hoc committee) is set up, I would encourage it to immediately open a dialogue with HHS, inform them of our unique legislative situation with 5399 and UHC plan, find out exactly what additional legislative language is required for the waiver application, and begin to explore various ideas for using existing waiver processes and other federal statutes (including those governing Medicare Advantage Plans and Medicare Administrative Contractors) to meet the state's goals for unified financing. We've never had an administration this open to single-payer before, and we should take full advantage of their willingness to help while they are in office. Thank you so much for your work thus far.

Cris M. Currie, Member Health Care for All-WA Mead, WA

Submitted by Roger Collier

6/1/2022

UHCC MEETING – JUNE 16, 2022

PUBLIC COMMENT FROM ROGER COLLIER

Seven months into this Commission's deliberations, one thing should be apparent: **the single-payer system proposed in the January 2021 Work Group consultant report is infeasible for the foreseeable future.**

Why?

Look at the three biggest population groups in today's system (approximately 70 percent of the State's total population).

- **Employees of Self-Insured employers** – **Federal law DOES NOT allow states to impose their own insurance rules on ERISA employers.** A waiver would require new Federal legislation -- highly unlikely in today's Congress.
- **Medicare beneficiaries** – **Federal law DOES NOT allow for replacing Medicare by a state program.** A waiver would require new Federal legislation -- also currently highly unlikely. (The CMMI process allows "innovative programs", but their scope is far narrower than would be necessary to fold Medicare into a single-payer system.)
- **Medicaid beneficiaries** — **Federal law DOES allow waivers of Medicaid regulations but DOES NOT allow waivers to increase net Federal costs.** To include Medicaid beneficiaries in a single-payer system would require the State to find around ***one billion dollars a year*** in new tax revenue.

That's bad news for single-payer advocates. However, the Commission does have a unique opportunity to propose changes to State laws and regulations that could reduce healthcare costs for the two million Washingtonians outside the three big groups, as well as improving access to care, *and* perhaps providing the first steps on a pathway to universal healthcare.

One approach could be that outlined in my Washington Healthcare Plan proposal (included in the Public Comment materials for this meeting), which borrows concepts from European healthcare systems and from a recent proposal by former Oregon Governor Dr. John Kitzhaber. It focuses particularly on two areas that the State *can* influence: enhancing price competition and reducing

administrative costs. **It could cut per capita costs by up to 10 percent or more for Plan enrollees, help the uninsured gain coverage, and move Medicaid beneficiaries more firmly into the mainstream.**

Obviously, there are other possible approaches, but *any* significant changes are likely to involve waivers of either Title 19 or the Affordable Care Act or both. **Here lies the danger of losing the opportunity to do more than just tinker with Washington's healthcare system.** The Biden administration has signaled some support for innovations that could reduce costs and expand access, but the process of waiver submittal and approval can take two years or more, and there is no certainty whatsoever that this support will carry over to an incoming January 2025 administration.

One possible conclusion: unless the Commission can provide both timely and implementable recommendations for real change, there is a risk that its efforts could be as unsuccessful as those of the two predecessor Commissions.

BIO NOTE

Roger Collier is the retired CEO of a national healthcare consulting firm, where he managed projects for some fifteen state Medicaid agencies, the US Department of Health and Human Services, the US Department of Defense, the national Blue Cross and Blue Shield Association and several individual Blue Cross and Blue Shield Plans, and HMOs including Kaiser and Group Health. He testified on government healthcare issues in Washington DC and before legislative committees in Colorado, Washington, and Oregon, and was a panelist for Washington State's 2006 Blue Ribbon Commission on Health Care Costs and Access. He has been quoted in both the regional and national press, including the New York Times.

THE WASHINGTON HEALTHCARE PLAN: A PROPOSAL

REVISED JUNE 2022

Roger Collier (rcollier@rockisland.com)

THE WASHINGTON HEALTHCARE PLAN: A PROPOSAL

INTRODUCTION

American healthcare expenditures are the highest in the world, with per capita costs close to twice those of other industrialized nations. The gap continues to widen, with United States' costs growing faster than wages, faster than corporate revenues, and faster than GDP. The State of Washington is a long way from bucking the national trend. Even though Washington's population is younger (and presumably healthier) than most other states', **per capita healthcare costs are above the national average** and continue to rise more rapidly than incomes.

In partial response, in 2021, the State legislature passed Senate Bill 5399 establishing the Universal Health Care Commission "*for the purpose of creating* ***immediate and impactful changes in Washington's health care access and delivery system*** *and to prepare the state for the creation of a health care system to provide coverage and access through a universal financing system …* ***once federal authority has been acquired.***"[1]

The Commission's creation was preceded by the formation of work groups whose efforts were recapped in a consultant report that indicated a strong preference for a single statewide, State-administered, system covering almost all State residents.

However, current federal law does not allow such a single system, the State has no existing capability to administer a program of such size, and the consultant report made multiple dubious financial assumptions.

[1] Final Bill Report E2SSB 5399 -- Emphasis added

Accordingly, an alternative approach to dealing with healthcare costs and access is proposed—one that responds to the first mandate of SB 5399, to create "immediate and impactful changes in Washington's health care access and delivery system," but which, if federal law is changed, also offers a possible pathway to universal healthcare: the Washington Healthcare Plan described in this document.

WASHINGTON'S PROBLEMS – AND AN OPPORTUNITY

Health insurance in Washington, as in every state, is extraordinarily complicated. Washington has more than three hundred insurers, some with only a handful of enrollees, others with billions of dollars of business, collectively with a mindboggling variety of policies. The biggest companies each offer dozens of different benefit packages, resulting in a staggering number of potential choices for consumers.

In turn, healthcare professionals must determine whether and how much they will be paid for treating patients. Is this in-network or out-of-network? Is there a copay to be collected? How much? Or coinsurance? Has the patient's deductible been satisfied? Is this treatment even covered? Does it require prior authorization? And on and on.

The difficulty of comparing costs and benefits means that many Washingtonians may be paying too much for coverage that doesn't match their needs, while **the premiums paid are burdened by insurer and provider administrative costs that can consume a third of the healthcare dollar**. Various national studies[2][3][4] estimate typical administrative costs of up to thirty-five percent of premiums, split between insurers and providers, with billing and payment efforts

[2] "Costs of Health Care Administration in the United States and Canada," Steffie Woolhandler et al, *New England Journal of Medicine* 349 (2003)
[3] "Reducing Health Care Costs: Decreasing Administrative Spending," Cutler, David M., *Testimony for Senate Committee on Health, Education, Labor and Pensions* (July 31, 2018)
[4] "Overhead Costs for Private Health Insurance Keep Rising, Even as Costs Fall for Other Types of Insurance," Nick Buffie, *Center for Economic and Policy Research* (February 2017)

representing more than half the total[5], in large part because of the numbers of coverage options and related authorization and payment rules.

As administrator of healthcare coverage for State and local government and school district employees, Medicaid beneficiaries, and Exchange marketplace enrollees – a total of close to three million individuals – **the State of Washington government is in a unique position to control premium costs.**

To do so would mean consolidating elements of various programs, currently spread over multiple State agencies and more than a dozen insurers offering scores of different benefit packages, into a simplified public option. The proposed *Washington Healthcare Plan* would contract competitively with just a handful of insurers, each offering no more than three or four sets of standard benefits. In this more price-competitive but far less complex environment insurers and providers would each experience lower administrative costs (and should pass the savings onto consumers), while trimming profits to keep or grow their business in the face of competitively bid contracts and greater transparency of benefit costs and coverage.

THE *WASHINGTON HEALTHCARE PLAN* PROPOSAL

The *Washington Healthcare Plan* borrows concepts from European healthcare systems and from a recent proposal by former Oregon Governor Dr. John Kitzhaber[6]. It would comprise four components, each significantly different from today:

- A single enrollment system (versus separate enrollment structures for each program),

[5] "Excess Administrative Costs Burden the US Healthcare System," Emily Gee, *Center for American Progress*, April 8, 2019.

[6] "Thoughts on Universal Coverage, Equity and Value," Dr. John Kitzhaber, *State of Reform*, March 2021.

- Limits on the number of insurer networks in each region of the State (versus more than a dozen different networks),
- Standardized coverage definitions and payment rules (approved by the State), and
- Competitive selection of insurers to cover all programs in each region (versus a variety of approaches to insurer selection).

Single enrollment system

The *Washington Healthcare Plan* enrollment system would support enrollment in the Exchange marketplace for individuals and groups, in the State and local government and school district employee programs, and in Apple Health (except for dual eligible Medicaid enrollees, who could be added later).

The enrollment system would be based on the present Exchange Healthplanfinder system, and would support four functions: determination of program eligibility, including possible diversion to Apple Health for low-income individuals and families; calculation of program-dependent State (or other sponsor) premium subsidy amounts (generally one hundred percent for Medicaid beneficiaries, less for others); enrollee selection of insurer (expected to be a choice between no more than three or four in each region); and enrollee selection of benefit level (with gold, silver, and bronze choices available for all programs except Apple Health). Once enrollment is complete, enrollees would choose a primary care provider from their selected insurer's lists.

Fewer Insurers per Region

The State would be divided into regions, as is currently the case for most other healthcare programs, but the number of regions and their geographic definitions would likely vary from today's structure. The goal would be to have sufficiently large populations in each region to attract competitive bids from insurers while minimizing the State's

contract administration costs. A minimum of two insurers per region would be necessary to give enrollees a choice while providing a back-up in the event of an insurer's possible contract termination. Insurers would be required to offer the same payment rates for all programs except Apple Health and a single common network (but could add providers to meet State or federal mandates for Medicaid benefits; for example, EPSDT screening and non-health social services).

Standardized Coverage Definitions

While covered benefits would not be the same across programs, all services in a "common core" would be required to be defined identically, with the same prior authorization requirements, and subject to State approval. Insurers would have some freedom to add services not included in the common core, while deductibles and copayments would vary depending on the benefit level (Gold, Silver, etc.).

Competitive Selection of Insurers

Insurers would be selected in each region using a competitive procurement approach similar to that currently used for Apple Health. Insurers would be allowed to bid in any number of regions, with selection based on factors including network and individual provider capacity, quality and consumer satisfaction, and price. Bidders would be required to propose a single "package price" covering all programs in each region they bid in order to simplify proposal evaluation, maximize price competition, and encourage Apple Health participation.

Access and Equity

Access to coverage and to care would be enhanced by facilitating enrollment, reducing costs, and requiring insurers to mandate provider acceptance of Medicaid (up to ceiling provider enrollment caps).

In later implementation phases, an employer mandate would be imposed, along with individual coverage incentives, in order to further maximize access to coverage.

Equity issues would become significantly fewer as more of those currently uninsured are able to gain coverage, particularly if the proposed employer mandate makes provision for part-time and seasonal workers.

The Long Run: Universal Healthcare

Universal healthcare will remain an unreachable goal unless federal law is changed. However, success in reducing costs could provide opportunities for some ERISA and Medicare beneficiaries to be brought into the *Washington Healthcare Plan*. Specifically, currently self-insured groups may be attracted by lower costs, while the *Washington Healthcare Plan* might be offered as an option within Medicare Advantage. In addition, in the event that federal law is eventually changed and universal healthcare becomes feasible in Washington, the experience gained with the *Washington Healthcare Plan* will be invaluable.

Implementation

The *Washington Healthcare Plan* would achieve an efficient public option, likely much more attractive than the current Cascade Care Select plan. Because only State-administered and State-sponsored programs would be involved, no ERISA exemption would be needed. However, changes to State regulations would be necessary to establish the new program, and waivers of Title 19 and Affordable Care Act requirements are expected to be required.

Alignment of PEBB, SEBB, and Exchange benefit structures would include recognition of the different premium approaches between the "bulk purchase" rates for PEBB and SEBB versus the individual and family premium rates for the Exchange. (The State is already

considering consolidation of PEBB and SEBB programs, but over a five-year timeframe.)

Other implementation issues include the necessity for "buy-in" by program sponsors, including state agencies and school districts who may have concerns about the inclusion of their programs in a larger consolidated model, but whose members should see less costly coverage. Insurers' concerns about loss of business in a highly competitive environment must also be recognized. In addition, as the State has experienced with Apple Health procurements, unsuccessful bidders might file protests unless the selection process is clear, comprehensive, and transparent.

The *Washington Healthcare Plan* would be implemented in five phases:

- **Establish Exchange marketplace as public option single enrollment system for all non-ERISA, non-Medicare coverage**
    a. Enact State legislation
    b. Obtain Section 1332 waiver (if necessary)
    c. Make software changes to Healthplanfinder
    d. Define benefits for each metal level

- **Implement *Washington Healthcare Plan* for PEBB, SEBB, and Exchange individuals and families**
    a. Make software changes to PEBB and SEBB systems
    b. Solicit insurer bids for each region
    c. Prepare and disseminate enrollment materials
    d. Enroll members of each group

- **Integrate Apple Health into *Washington Healthcare Plan***
    a. Obtain Section 1113 and/or 1115 waivers
    b. Implement full integration of Apple Health

- **Implement *Washington Healthcare Plan* for employee groups**

a. Reestablish SHOP program to provide federal credits
b. Implement SHOP for groups up to 50 employees
c. Allow all employee groups to join *Washington Health Plan*

- **Design and implement State employer mandate and individual coverage incentives.**
  a. Determine scope of employer mandate
  b. Enact employer mandate legislation
  c. Determine coverage incentive rules and payments
  d. Obtain Section 1113/1115 waiver for incentives
  e. Enact coverage incentive legislation
  f. Implement employer mandate and coverage incentives

What can we expect?

The *Washington Health Plan* should result in premium reductions for all State-administered and State-sponsored healthcare programs, by:

- Reducing provider and insurer claims submittal and processing efforts, including denials and resubmittals, as a result of cutting the number of participating insurers and benefit options. (A recent study[7] shows that up to forty percent of provider administrative costs could be eliminated with fewer insurers and fewer and simpler coverage options.)
- Further cutting provider and insurer administrative efforts by requiring insurers to adopt common benefit definitions and prior authorization rules.
- Reducing insurer "risk premiums" by spreading risk over more lives by shrinking the number of benefit options.

[7] "Reducing administrative costs in US health care: Assessing single payer and its alternatives," David Scheinker et al, *Health Services Research*, March 2021.

- Causing insurers to squeeze profits and overhead to retain or gain business in a highly price-competitive environment—especially as the slices of the "premium revenue pie" become larger with fewer payers—while allowing successful bidders to spread fixed costs over more business.
- Reducing the number of uninsured (details below) from the current six percent, whose "charity care" costs may otherwise be passed on to insurers, and thence to premiums.

The *Washington Health Plan* should also facilitate access to coverage and care as a result of:

- Reducing premiums for most benefit options (see above).
- Making enrollment simpler by reducing the number of insurers and benefit options.
- Requiring insurers to mandate provider acceptance of Apple Health (up to ceiling provider enrollment caps).
- Offering coverage incentives to the newly insured (perhaps in the form of gift cards similar to those already provided by one or two insurers).
- Implementing an employer mandate for all non-ERISA groups.

The *Washington Healthcare Plan* would directly impact only State-administered programs. Federal programs such as TRICARE and VA would be unaffected. However, reductions in Exchange premium rates should attract more individual enrollees and persuade more small employers to switch from their private market plans, in turn putting pressure on competing commercial plans to reduce their rates. For Apple Health, requiring insurers to offer the same networks as other programs would move enrollees more firmly into mainstream healthcare.

Roger Collier is the retired CEO of a national healthcare consulting firm, where he managed projects for some fifteen state Medicaid agencies, the US Department of Health and Human Services, the US Department of Defense, the national Blue Cross and Blue Shield Association and several individual Blue Cross and Blue Shield Plans, and HMOs including Kaiser and Group Health. He testified on government healthcare issues in Washington DC and before legislative committees in Colorado, Washington and Oregon, and was a panelist for Washington State's 2006 Blue Ribbon Commission on Health Care Costs and Access. He has been quoted in both the regional and national press, including the New York Times.

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Washington State Health Care Authority

Readiness and strategies

Tab 4

Washington Universal Health Care Commission Report to the Legislature: Sections 4 & 2

Liz Arjun, Senior Consultant - HMA
Gary Cohen, Principal - HMA
Jon Kromm, Principal - HMA

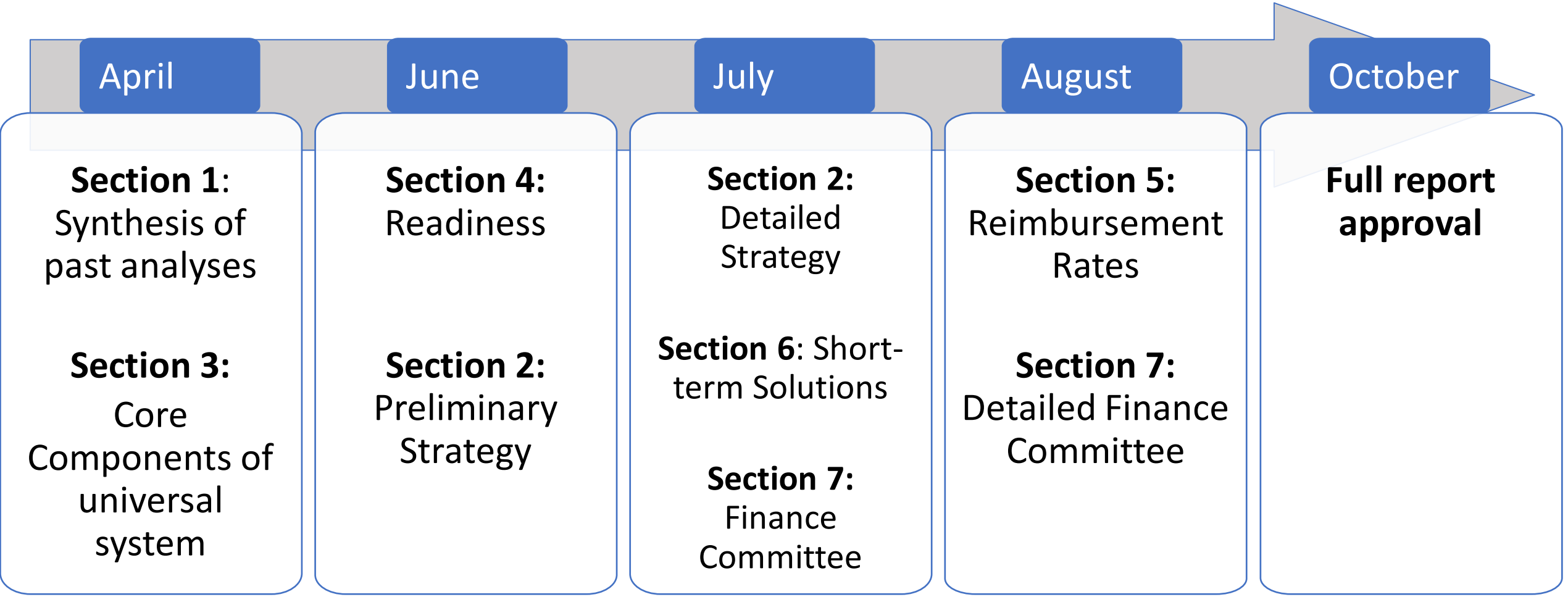
Presentation to the Universal Health Care Commission

June 16, 2022

Agenda

- Timeline of Report Development
- Goals for Today
- Section 4: Readiness
  - Discussion
- Section 2: Proposed Strategy
  - Discussion
- Next Steps

Report Development Timeline



Today's Goals

1) Establish a common understanding about the State's readiness to implement key design elements of a universal health care system

2) Gather additional information from the Commission about key design elements to:

- Refine the proposed strategy
- Develop interim solutions

3) Prepare the Commission for approving recommendations in upcoming meeting:

- Establishing guardrails for the work ahead
- Create a process to get the work completed
- Generate interim solutions
- Model of focus

Section 4: Understanding the State's Readiness to Implement Key Design Components

Green, Yellow, and Red Assessments

Green signifies that Washington is ready to implement a particular design element without major additional resources and IT systems or disruption to existing State programs.

Yellow signifies that Washington has some resources, IT systems, and programs that could be modified and expanded to implement the design element.

Red signifies that Washington lacks the resources, IT systems, and programs needed to implement the design element or has no history of implementing a similar function.

Eligibility and Enrollment

Washington's eligibility and enrollment readiness for a universal health care system is assessed as yellow:

- No centralized system with information about existing coverage
- Existing systems are not interoperable
- Robust systems in place for Apple Health and Qualified Health Plans via Healthplanfinder – modifications would be costly
- Enrolling uninsured and transitioning individuals from existing coverage require significant and ongoing resources

Benefits and Services

Washington's benefits and services readiness for a universal health care system is assessed as yellow:

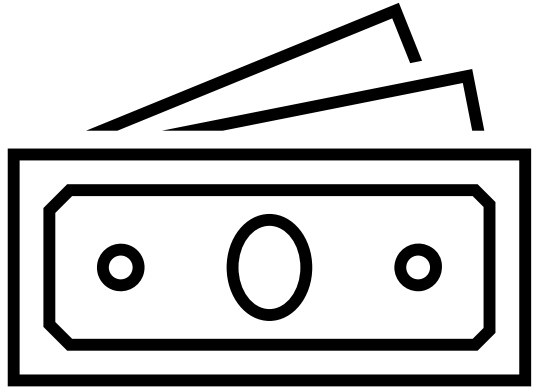
- Varied Benefit Packages
  - Essential Health Benefits
  - Apple Health
  - School Employees Benefits Board & Public Employees Benefits Board

- Washington has experience managing benefits under Apple Health, PEBB and SEBB, but largely through managed care plans and commercial insurers providing administrative functions.

Discussion

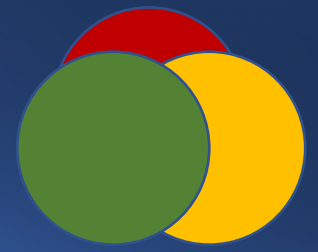
Financing

Washington's financing readiness for a universal health care system is assessed as red:



- Unclear what federal funds would be available
- Limited state revenue options

Provider Reimbursement and Participation



Washington has experience paying fee-for-service

- Not aligned with the efforts to pay for improved quality, improved equity and lowered costs through coordinated and/or managed care
- Does not promote value-based care to promote these outcomes

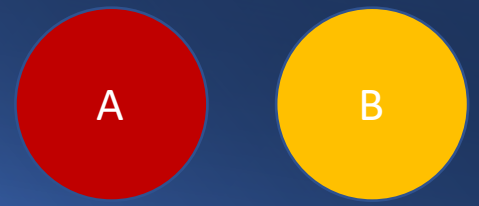
Washington has experience contracting with managed care and third-party administrators that provide alternative payment models and incentives for higher value care for specific programs

- Scalability for a large population

Washington has no experience using a direct provider employer model (United Kingdom or Veteran's Health Administration)

Discussion

Cost Containment Elements



Washington has many initiatives underway to manage costs

A

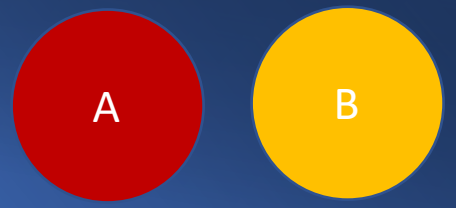
The current efforts of cost and care management are tailored to the respective programs that provide health coverage and are not unified among the different entities implementing them.

B

Could align contracted carriers' actions to provide consistent, effective cost containment and care management measures to everyone

- a common list of clinical guidelines
- benefit exclusions
- one standardized appeal process across coverages
- common prescription medication formularies

Infrastructure



The new system will need robust data and IT systems to support the universal health care system and many existing systems are not compatible with other systems.

A

- State has no direct experience with some functions of the system
  - Member portals and call centers are not tied together
- Significant workforce changes
  - Functions like care management that would need to be integrated across programs and/or delivered by the state

B

- Some staffing and workforce changes

Governance

Washington's governance readiness for a universal health care system is assessed as red:

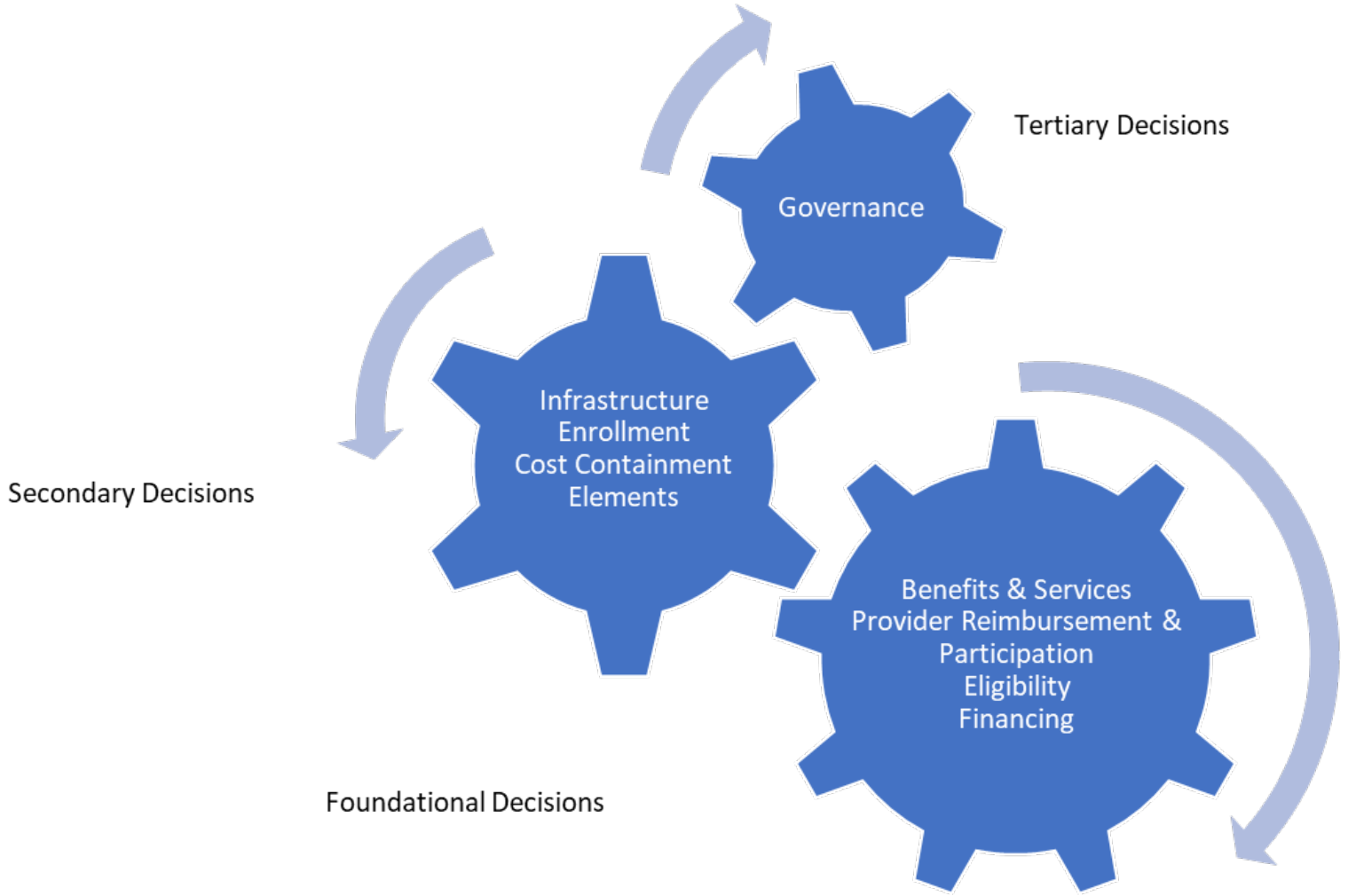
- No single agency or entity performs all the functions necessary for operating a universal financing system or serves all populations and stakeholders that would be served by the system.

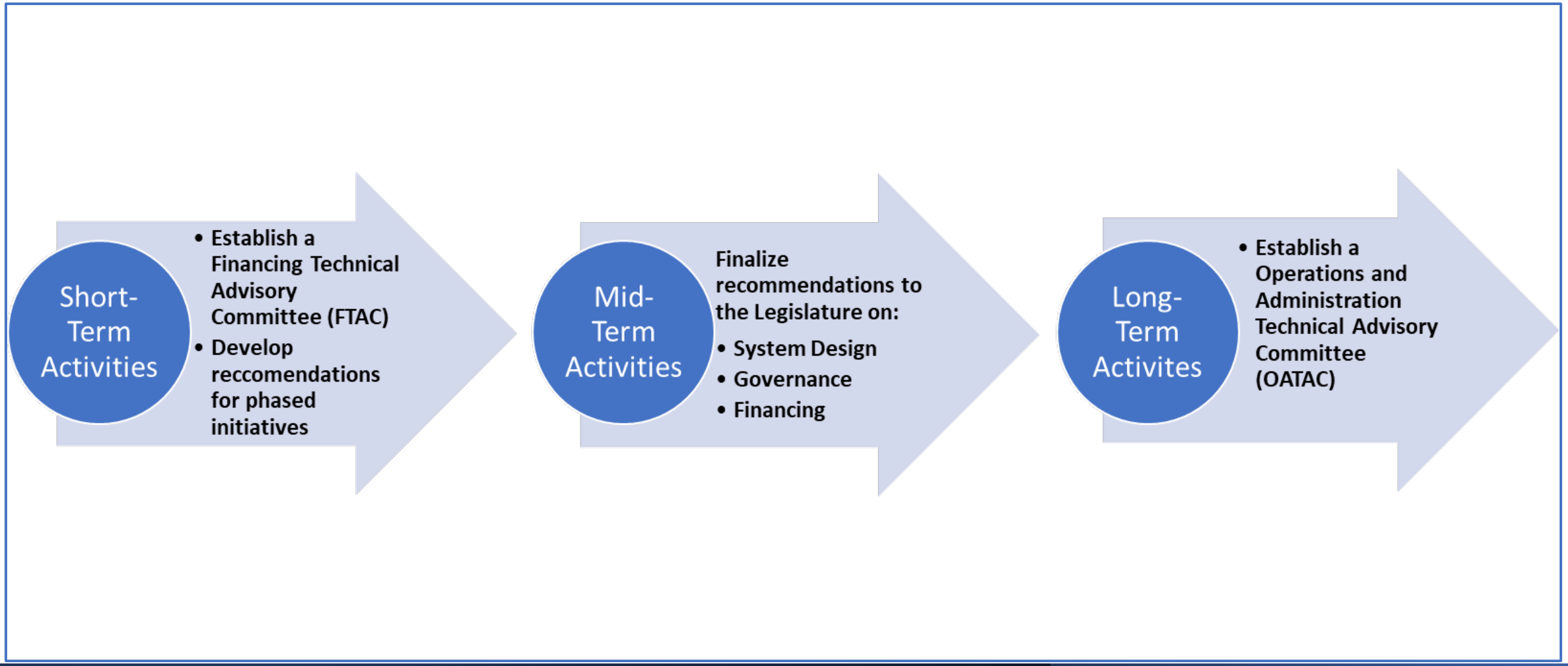
- No agency or entity has the authority to operate, oversee, or regulate across the entire healthcare landscape.

Discussion

Section 2: Proposed Strategy

Proposed Sequencing





Proposed Strategy

Discussion

What's Next

- Refining Sections 4 and 2
- Developing interim steps (Section 6)
- Consider which model(s) the Commission should focus on exploring further

Washington State Health Care Authority

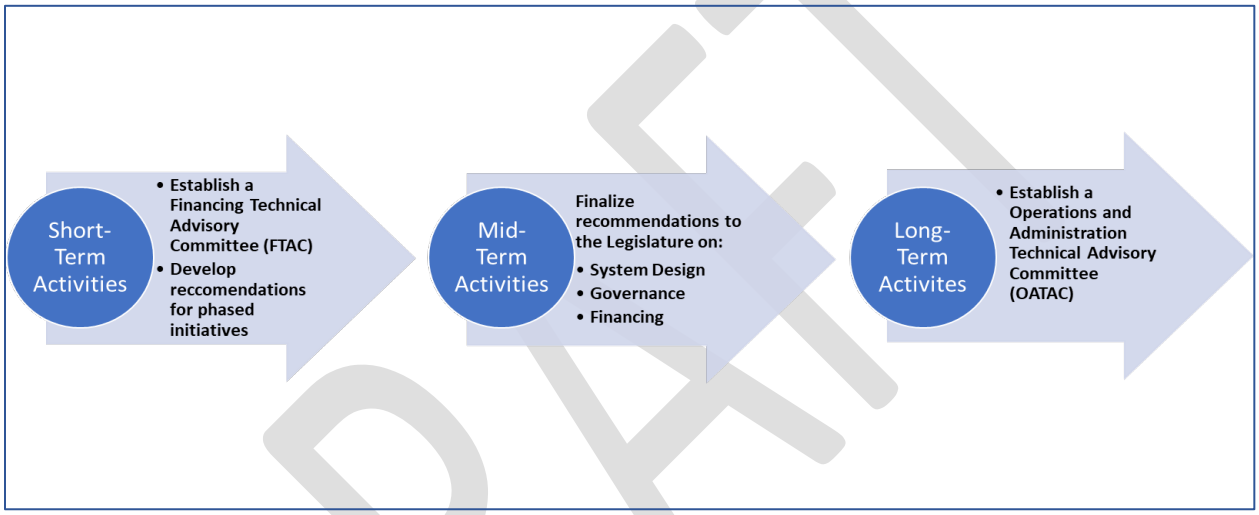
Report to the Legislature: Draft of section 2

Tab 5

Section 2: Strategies to Move Toward a Universal Health Care System

Introduction

Section 1 of this report describes Washington's long history of innovation and continued efforts to expand access and improve the quality and equity of affordable health care coverage. Later sections of this report outline the key design elements of a universal health care system, options for developing and implementing approaches to these foundational elements, and Washington's readiness to implement those approaches. This section offers a set of strategies, analyses, and planning activities to move toward a universal health care system, which are summarized in Figure 1.



Short-Term Activities

Establishing a Financing Technical Advisory Committee (FTAC)

Establishing a Financing Technical Advisory Committee (FTAC) will provide additional insights and technical guidance to the Commission, as directed by the authorizing legislation.[1] This approach is similar to Oregon's Task Force on Universal Health Care and other Washington boards and commissions that utilize advisory committees.

In general, the first set of activities FTAC is tasked with will be to understand and provide guidance to the Commission concerning the functions required to achieve the cost, equity and quality goals envisioned and required by a universal financing system. A more thorough description of the process to establish FTAC is described in *Section 7* of this report.

Develop Recommendations for Phased Initiatives

As described in *Section 1*, Washington has submitted a Section 1332 waiver to CMS to make it possible for all residents to purchase coverage on the Exchange which will remove federal barriers for certain groups.[2] Once these new initiatives are in place, the principal barrier to universal coverage for Washingtonians will be cost. Therefore, many of the intermediate steps toward a universal health care

[1] Engrossed Second Substitute Senate Bill 5399 Chapter 309, Laws of 2021. Retrieved from: https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5399-S2.SL.pdf?q=20220530104327

[2] Washington has also provided state funding for this group to utilize subsidies in the place of federal subsidies that cannot be utilized for this purpose.

system will focus on decreasing underlying costs of health care while improving health care quality and reducing inequities in the access and delivery of care.

The Commission will continue its work to enhance, expand, or modify the existing coverage programs informed by the ongoing work of the state agencies responsible for existing coverage programs, the broader private payer and provider community, and FTAC. The Commission's future work will lay a foundation for the universal health care system as well as advance cost, quality, and equity goals.

Mid-Range Activities

Mid-range activities addressed by the Commission is likely to focus on developing functions to advance cost, quality, and equity goals through changes to the existing health care system. The Commission also may focus on critical strategies for establishing a framework for a unified financing system including the following:

- *Governance:* The Commission will examine a governance structure that places oversight of the universal health care system under an existing agency, new agency, or a multi-agency structure. The Commission may provide a framework for establishing authority for this governing structure and ensuring that resources are allocated to implement and maintain the universal health care system.

- *Financing Strategies:* In the mid-term, the Commission will further assess and finalize decisions about appropriate financing strategies that leverage federal and state funding sources. An examination of potential revenue sources would be needed particularly if it is determined that state funding will largely replace premiums and out-of-pocket costs that currently finance the health care system. This examination would include an assessment of the impact of shifting away from the currently existing coverage programs on citizens, employers, and on Washington. Mid-term work of the Commission will also focus on developing strategies for including federal Medicaid state plan and waiver authority requests.

- *State and Federal Authorities and Revenue:* After the core functions of a unified health care financial system have been developed, and how those functions should be administered, Washington's Legislature may need to make statutory changes to establish a new state entity or expand the authority of an existing entity to administer the universal system. Additionally, federal approval may be needed to access any dollars associated with federal programs such as Medicaid, Affordable Care Act subsidies, and Medicare.

Long-Term Activities

Operations and Administration Technical Advisory Committee

Once planning and authorizing the universal health care system is complete, the Commission can work to refine the operational and administrative vision for the model that will shape implementation. When FTAC sunsets as it completes its design and planning work, a new Operations and Administrative Technical Advisory Committee (OATAC), focused on operations and administration, may need to be established. OATAC could be responsible for providing technical guidance and support as the new system is operationalized and implemented. A description of potential activities for OATAC could include:

- Working with the designated accountable agency or agencies, OATAC could help to guide the business and implementation planning, advising on key next steps to align or build the needed functionality of the new system.
- OATAC could develop a process for establishing annual performance targets (including those for cost, quality, and equity), a measurement and evaluation strategy, and a reporting process to continuously assess measurements.
- OATAC may also provide guidance on improving care management for chronic illnesses. Implementing universal access and better management of chronic disease would be expected to reduce annual per member costs over time based on findings in Rand's analysis of Oregon universal coverage options.[3]
- OATAC could provide guidance on how to leverage the purchasing power of a unified health care financing system such as achieving prescription drug discounts or instituting a hard cap on system spending with clear measures to reduce costs when needed.
- OATAC may assist the Commission with developing a communication approach for awareness and a stakeholder input process for refining the design concepts of the new system and to initiate an educational and engagement process in preparation of implementation. It will be important to communicate decisions and timelines to providers, insurers, and consumers.
- OATAC may assist the Commission with planning the transition from current programs and populations, including mediating impacts of potential job losses. For example, OATAC could consider distinct aspects, including:
    - *Roles and Jobs:* Regardless of the model, restructuring the health care system will impact staff in policy, management, actuarial, analytics, eligibility, claims payment, and technology functions.
    - *Provider Contracting:* Regardless of the model, there will be transitions to new contracting arrangements between the accountable entity and those providing services. In Model A, this would require the accountable entity to directly contract with providers and health systems. In one version of Model B, plans may need to alter their current contracts with providers and health systems to meet the new unified health system requirements and expectations.
    - *Transitions of Care:* State agency and health carrier staff from the previously utilized programs will need to ensure smooth transitions of care into the new system. This may necessitate maintenance of previously utilized programs as they are closed out to ensure that Washingtonians can complete treatment courses that may be in progress.

Summary

As outlined here in Section 2, there are short-term, mid-term, and long-term activities for transitioning Washington to a universal health care system. The proposed approach calls for additional subject matter expertise to support the Commission by establishing two consecutive technical advisory committees.

[3] White, C et al. "A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon Research Report". RAND/HMA. Retrieved from: https://www.rand.org/pubs/research_reports/RR1662.html

These advisory committees could provide guidance and support to the Commission as it considers key design and implementation decisions.

Washington State Health Care Authority

Report to the Legislature: Draft of section 4

Tab 6

Section 4: Readiness

Introduction

The Legislature directed the UHC Commission to provide an assessment of Washington's current level of preparedness to meet the elements of universal health care with a unified financing system, including, but not limited to a single-payer financing system. *Section 4* provides a preliminary readiness assessment of the State's current level of preparedness to implement a unified health care financing system as described in Model A and Model B of the UHC Work Group. It outlines the functions state agencies are currently performing and potential resources available to perform those functions under a unified health care financing system.[1] Additionally, *Section 4* compares the current health care system with a potential unified health care financing system and identifies the steps and considerations necessary to move from the current system to universal health care supported by a unified financing system.

Washington's readiness to transition will likely evolve as the Commission continues its work, as a complete readiness assessment is dependent on finalizing various design elements, including which model of universal health care is chosen to pursue. This preliminary assessment will, however, provide initial considerations that will help to inform the Commission's work and potential next steps. Throughout the course of the Commission's work, this initial assessment will be revisited and expanded upon to provide for continual assessment of the unified health care financing system in development.

A readiness assessment survey tool was developed and provided to Commission Members to gather information and evaluate Washington's readiness.[2] Individual interviews were also conducted with state agency representatives participating on the Commission. The survey and interviews demonstrated that while Washington has significant resources that could be adapted and expanded to implement a unified health care financing system, major gaps exist. The assessment revealed important information for consideration, including identifying that state agencies have limited to no experience in directly performing important functions of the health care system. For example, state agencies have not historically performed utilization management functions whereas managed care organizations, private payers, providers, and others typically employ utilization management strategies to coordinate and manage care, to reduce wasteful, unnecessary care, and to contain costs. In some cases, this is done by private entities such as Medicaid Managed Care Organizations and commercial health plans on behalf of state agencies in public programs which the state agency administers (e.g., Apple Health, School Employees Benefits Board (SEBB), Public Employees Benefits Board (PEBB)).

The assessment of the seven core components of a universal health care system is summarized in Table 1 (*see below*). This table describes the State's readiness to move from the current system to the potential new model(s). For purposes of assessing Washington's level of preparedness in this Report, Green signifies that the State is ready to implement a particular design element without major

[1] Washington is currently adopting policies and making budget allocations to achieve Model C.
[2] The survey and interview guide are included in Appendix X.

additional resources and IT systems or disruption to existing State programs; Yellow signifies that the State has some resources, IT systems, and programs that could be modified and expanded to implement the design element; and Red signifies that the State lacks the resources, IT systems, and programs needed to implement the design element or has no history of implementing a similar function.

Preliminary Readiness Assessment Findings	
Core Component	**Readiness Level**
1. Eligibility and Enrollment	**Yellow**
2. Benefits and Services	**Yellow**
3. Financing	**Red**
4. Provider Reimbursement and Participation	**Dependent upon Model Design**
5. Cost Containment Elements	**Model A: Red** **Model B: Yellow**
6. Infrastructure	**Model A: Red** **Model B: Yellow**
7. Governance	**Red**

Table 1: Summary of Readiness to Implement Core Components of a Universal Health Care System with a Unified Financing System

Core Component 1: Eligibility and Enrollment

The goal of universal health care is to enroll all eligible Washington residents to ensure that they will have the best possible access to essential, effective, appropriate, and affordable health care services when and where they need it. In the current system, determinations about coverage eligibility and enrollment vary depending on the coverage source: public programs, employer-sponsored coverage, or the individual market.

There are several challenges to establishing universal eligibility and enrollment processes. Washington lacks a centralized source of information about individuals' existing coverage because the various information technology systems currently in use are not capable of interacting with one another. Similarly, there is no centralized source of information for uninsured individuals and families. As a result, systems will need to be developed to effectively transition individuals enrolled in any current systems and the uninsured into the new health care system. This will ensure continuous care and will help determine whether an individual or family is eligible to enroll in a unified health care financing system.

This work will vary depending on current coverage: people who have existing coverage will transition into the new system, and people who are uninsured will need to be enrolled into the system. Each of these coverage scenarios presents its own challenges.

Eligibility Readiness = Yellow

Under any universal health care system, certain information will need to be obtained to determine eligibility. The nature and extent of the information needed depends to some extent on the design of the new system. Under any model, residency status would need to be determined and verified. Residency requirements could include a waiting period or a minimum residency duration to establish eligibility.

Additional information will be needed to determine eligibility criteria. For example, more information would be needed to determine eligibility for non-residents such as those eligible for health insurance offered by their Washington-based employer. Similarly, further work may be needed to identify the impacts on specific populations (e.g., tribal members or persons who are incarcerated) and to ensure comprehensive collaboration with all partners.

Washington's robust system to determine eligibility for Apple Health and Qualified Health Plans (QHPs) could be modified to serve as the eligibility system for any universal health care system. However, depending on the model chosen for the unified health care financing system, these modifications could be significant and costly. For example, if multiple coverage programs are maintained under the system (e.g., Apple Health, QHPs, PEBB, and SEBB), a unified eligibility platform would need to reconcile multiple sets of eligibility criteria to determine the program and subsidies for which an individual is eligible.

Modifications may be more straightforward if all participants have the same eligibility criteria and receive the same benefits under the universal health care system. For example, under Model A, eligibility may presumably be determined based on state residency, with subsidy eligibility determined based on income. This is similar to the eligibility criteria employed by the Exchange in determining eligibility for QHPs and subsidies. Clear criteria and required documentation would need to be identified in the program design and operational implementation phases.

The current eligibility systems would need to be expanded to determine eligibility for the entire population, which will require planning and funding, including some lead time prior to enrollment for system builds and testing. Readiness for eligibility processes will require coordination with Medicare (if Medicare enrollees can be included in the universal health care system). It will also be important to consult with tribal leaders regarding the relationship between the tribal health system and the unified financing system. Finally, additional resources would be needed for consumer outreach, education, and support during the eligibility application process.

Enrollment Readiness = Yellow

Once an individual or family is determined to be eligible for coverage under the new system, enrollment processes will be needed to place eligible individuals and families in coverage. The methods for enrollment and the complexity of the processes depend on the design of the universal system.

Currently, Washingtonians often have a choice among health carriers or health plans for their coverage. For public programs and most employer-based coverage, selections are made after reviewing the available options. Occasionally, people are assigned or auto-enrolled into a plan.[3] Under Model A,

[3] This would occur in Apple Health when a person does not make a plan selection and employer-sponsored coverage when only one plan is offered.

enrollment could be relatively streamlined since everyone who is eligible would be enrolled in the state-administered program. While there may be various approaches to Model B, the enrollment processes currently utilized for Apple Health and the Exchange could be expanded upon to enroll the entire eligible population which may streamline enrollment.

Core Component 2: Benefits and Services = Yellow

Benefits and services will be a critical component of the universal health care system. As discussed in *Section 3* of this report, two of the potential coverage models (A or B) will require the state to develop, administer, and assess the performance of covered benefits and services. The UHC Work Group recommended, as a starting point, that the ACA-mandated Essential Health Benefits (EHB) would be provided, with the possibility of additional benefits, including vision and hearing. Among the outstanding considerations is whether other benefits not included in EHB, such as long-term care and disability services, will be provided by the universal health care system.

Through its existing coverage programs, Washington manages distinct benefits and services packages for Apple Health, PEBB, SEBB, and Cascade Care. As a result, Washington is well positioned to engage stakeholders, develop options, and make decisions regarding the standard benefits and services covered under the unified financing system. However, in many cases, programs including Apple Health, PEBB, SEBB, and other programs offer benefits that are not mandated under EHB. Using the EHB may be a helpful starting point for a standard benefit package, though the difference in benefits between what currently exists under these programs will need to be reconciled.

Once the benefit package is developed, the benefits must be administered. Depending on the coverage model, the state could administer benefits directly, through third-party administrators, or through contracted health plans. Currently, benefits under Apple Health, PEBB, SEBB, and Cascade Care are currently administered through all three methods. More investigation is needed to understand the scalability of each program's benefit administration capabilities. Further, to support the affordability, quality, and equity goals of the unified financing system, administration must be configured to accommodate any complex eligibility rules and value-based payment models as they currently exist and in the future. As such, Washington's readiness to administer benefits is critically tied to decisions regarding the benefits package as well as provider reimbursement, consumer cost-sharing, and financing.

It will also be necessary to assess the performance of the standard benefits and services in advancing affordability, quality, and equity goals. Currently, several coverage programs and agency-housed programs such as the Health Care Cost Transparency Board (HCCTB) and the All-Payer Claims Database (APCD) collect and analyze claims, encounter data, and other data. However, more assessment will be needed to determine readiness to support value-based benefit design within the universal health care system. This will be critical to ensuring that incentives are provided and financial barriers are removed for greater utilization of high value services such as recommended preventive care.

Core Component 3: Financing = Red

Health care is currently financed through several different sources and in a variety of ways. Financing sources include direct payments by the federal and state governments for public programs, subsidies for the purchase of health coverage on the Exchange, premiums paid by employers and consumers, and out-of-pocket costs paid by consumers such as copays and coinsurance. The complexity and cost of the

current system make financing one of the most challenging aspects of establishing a universal health care system. Consolidating and simplifying this system is one of the outcomes that supports establishment of a universal health care system. Another likely outcome is reduced financial burden on consumers and increased access to care.

Under either Model A or B, numerous, complex decisions will determine how the system would be financed, as described more fully in *Section 3* of this report. *This section of the report may be further revised or developed pending Commission discussions.*

Perhaps the most challenging and time-consuming task will be to obtain the federal waivers needed to utilize federal funds to help finance the unified financing system. This work cannot begin until the universal health care system design has been further explored. Significant time will then be needed for waiver drafting and the federal approval process. The federal government may not agree to approve the entire request, which would require alternative sources of funding to be identified. In addition, further exploration is needed to determine how to raise state funds to replace the amounts currently paid by businesses and families in the form of premiums and copays. These decisions are likely to be controversial, and this work will be more efficiently conducted once the design of the universal health care system is further developed.

Core Component 4: Provider Reimbursement and Participation = Readiness Assessment Dependent on Model Variables

Provider reimbursement is a critical element of any health care system. It must ensure financial solvency for providers, advance equitable access to affordable health care services, and drive value-based health care delivery. Implementation requires both the operational functions to administer payment and the analytic functions to assess provider performance against quality, cost, and equity targets. Washington's readiness to implement a provider reimbursement model in a unified financing system is greatly dependent on the overall universal health care system, and the methods of provider reimbursement selected for the model.

Depending on the provider reimbursement methods, the assessment reveals varying levels of readiness (green, yellow, or red). For example, if Washington chose to implement a direct provider employment model such as the National Health Service in the United Kingdom or the Veterans' Health Administration in the U.S., its readiness assessment would be red. Washington has little experience with such a system and the challenges of contracting directly with all the health care providers in the state would be considerably more involved.

However, Washington's readiness to reimburse providers entirely on a fee-for-service (FFS) basis with a uniform rate structure, as suggested in the UHC Work Group Report, is assessed as green. HCA has experience in paying claims in FFS Medicaid. Until 2011, HCA also contracted directly with providers to establish the Uniform Medical Plan network for PEBB and SEBB. While the scale and scope of these capabilities would need to be greatly expanded, Washington has demonstrated its capacity for provider contracting and FFS claims payment. Moving to an entirely FFS method of paying providers may be inconsistent with the many efforts Washington, along with other states and the federal government, has made to reduce costs and improve the quality of care using managed, coordinated care models. This may mean moving away from use of value-based provider reimbursement, which may disrupt advances made in quality, equity, and cost containment under value-based provider reimbursement.

Washington's readiness to transition to a system that makes greater use of alternative payment models and provides incentives for higher value care is assessed as yellow. While Washington does not have a history of administering global budgets, it does contract with managed care organizations and third-party administrators to provide these functions for specific programs. This is similar to what could be done under a variation of Model B. However, the extent to which these capabilities can be scaled to support a universal system requires further assessment and is likely dependent on the specific reimbursement models selected for the financing system. For example, while a third-party administrator under Model B may be able to administer quality bonuses, capitated payments, or value-based contracts in the commercial insurance market, the third-party administer may not be able to easily implement a global budget for an attributed population.

In addition to these analytic and operational considerations, provider reimbursement under Model A or B would require an agency to have authority to set and pay provider rates. While that authority exists today in limited programmatic contexts (e.g., Apple Health), a unified financing system would require significant expansions of authority for a governing agency to support provider reimbursement models.

Core Component 5: Cost Containment Elements = Readiness Assessment Red or Yellow, Depending on Model Variables

Improved cost containment is one goal of a unified health care financing system. Washington's readiness to implement cost containment in a unified financing system is assessed as red for Model A and yellow for Model B. One of the more problematic features of the current health care system is that incentives for payers and providers are not aligned to control costs. Though changes have been made to improve health care financing and cost control, much of the system relies primarily on fee-for-service payments that focuses and pays based on volume rather than value. Further, due to the different delivery models and markets, the current health care system is fragmented making it difficult to apply cost containment measures at scale.

Many different efforts to contain costs are underway in Washington, as more fully described in *Section 1* of this report. Various entities are currently responsible for managing costs and coordinating care, with various state or federal agencies regulating their activities. For example, HCA oversees Apple Health managed care plans, OIC regulates commercial insurers, and the federal Department of Labor regulates self-funded employers. The state and federal governments have not directly engaged in managing costs and coordinating care to a large extent, with the Veterans' Health Administration being a notable exception.

Under Model A, Washington would need to develop new processes and obtain additional resources to carry out the functions of directly managing costs and coordinating care. The current efforts of cost and care management are tailored to the respective programs that provide health coverage and are not unified among the different entities implementing them. Under one version of Model B that uses carriers to provide health care insurance, the accountable agency administering the new system would need to align the contracted carriers' actions to provide consistent, effective cost containment measures to everyone covered by the system. This could include myriad uniform cost containment and care

management approaches such as a common list of clinical guidelines and benefit exclusions, one standardized appeal process, and common prescription medication formularies.[4]

Reducing fraud, waste, and abuse is another strategy for cost containment that should be considered in the universal health care system.[5] Currently, Washington agencies employ strategies to reduce fraud, waste, and abuse in public health care programs. Further, as part of their regulatory and consumer protection mission, state agencies identify and prevent fraud, waste, and abuse in the provider and private payer markets. As the design of the universal health care system is developed, further assessment will be necessary to identify the readiness of these current functions and programs to support a fraud, waste, and abuse program, particularly if the financing system includes complex, value-based provider reimbursement models.

Core Component 6: Infrastructure = Readiness Assessment Red or Yellow, Depending on Model Variables

The capacity of the State's existing administrative infrastructure to scale and adapt to the new system is a key determinant of Washington's readiness to implement a unified financing system. The overall readiness of Washington's infrastructure supporting a universal health care system is assessed as red for Model A and yellow for Model B.

Technology and data platforms are some of the more important infrastructure considerations necessary to execute the universal health care system.[6] In administering existing coverage programs, Washington utilizes multiple call center and data management platforms for assessing claims, eligibility, and enrollment. However, most of the platforms currently in use are not compatible with other systems, making program integration a challenge. Further, given that platforms serving different programs have been developed to widely varying requirements, existing systems may not be well suited to support the unified financing system. However, there may be eligibility and enrollment platforms, such as the Apple Health and HBE's eligibility platforms, that could be repurposed for eligibility determination with modifications. Or, if utilizing work hours is a key determinant of eligibility, the PEBB and SEBB eligibility platforms could be modified and repurposed. As key design elements of the universal health care system are developed, each of the IT systems utilized in Washington will need to be evaluated for appropriateness and scalability to support the model selected.

Human resources and staffing are also critical areas of infrastructure readiness. Certain functions needed to implement a universal health care system are currently being performed by the private sector. For example, health insurance carriers currently contract with providers who care for their members. Carriers also help to coordinate and manage care delivered by providers in the community who may not be part of the same health care system. Carriers also perform utilization management to ensure that care is medically necessary and appropriate. Under Model A, additional state workers may be needed to perform these functions, or in the alternative, enter into contracts with private entities with state workers managing those contracts. While each agency has a complement of staff to support existing programs, significant planning efforts must be invested to assess needs pertaining to training, change management, and integration, particularly for Model A. For example, many of the programs

[4] Many existing state initiatives would establish a foundation to support such approaches to better manage cost while improving quality as discussed in *Section 1*.
[5] Efforts to reduce fraud, waste and abuse were previously discussed in *Section 3.*
[6] As discussed in *Section 3.*

operate call centers to support clients with eligibility determinations, enrollment, and other services. However, call center staff are typically highly trained and expert in the rules and processes for one coverage program and may require additional training to support a unified financing system, even if many of the rules and processes are retained in the new model.

Another consideration for readiness is Washington's ability to support the transition for employees whose service may not be required if agencies and programs can be consolidated to support the unified financing system. Training programs can help transition these employees to new employment opportunities, possibly within the universal health care system. Further assessment will be needed to determine whether an existing employment program could fulfill this need.

Finally, assessing human resource needs may also identify needs for new personnel and skill sets that do not currently exist in the State's workforce. For example, provider rate setting in Washington has never been done comprehensively across all payers. Supporting that function under the unified financing system will require combining technical expertise from across all markets. While this may be a challenge for implementation, identifying these needs and developing training programs for employees in the current health care system wherever possible may help mitigate implementation risk and ease employment concerns through the transition.

Core Component 7: Governance = Red

In this report, governance has been identified as a critical design element of the universal financing system. The primary consideration for establishing the governance structure is whether a single agency or multi-agency governance structure should be accountable for overseeing the operation of the universal financing system.

Currently, no single agency or entity performs all the functions necessary for operating a universal financing system or serves all populations and stakeholders that would be served by the system. Additionally, no agency or entity has the authority to operate, oversee, or regulate across the entire healthcare landscape. However, Washington does have a history of shared authorities and collaboration across agencies. For example, HCA, OIC, and WAHBE collaborate to implement Cascade Care as designated by the Legislature.

Once the accountable agency or agencies are decided, the governing entity is likely to need significant resources and expanded or new authority to oversee and operate the universal financing system. When this critical design element is established, a governance structure and needed resources will need to be reassessed.

Summary

The preliminary readiness assessment reveals several opportunities to build on existing functions, but also identifies some initial areas that will require greater resources and/or new authorities to be able to design and develop a universal health care system. It also helps to clarify a potential sequencing for how the Commission might approach the system design for these key elements according to those that are foundational, secondary, or tertiary as seen in Figure 1.

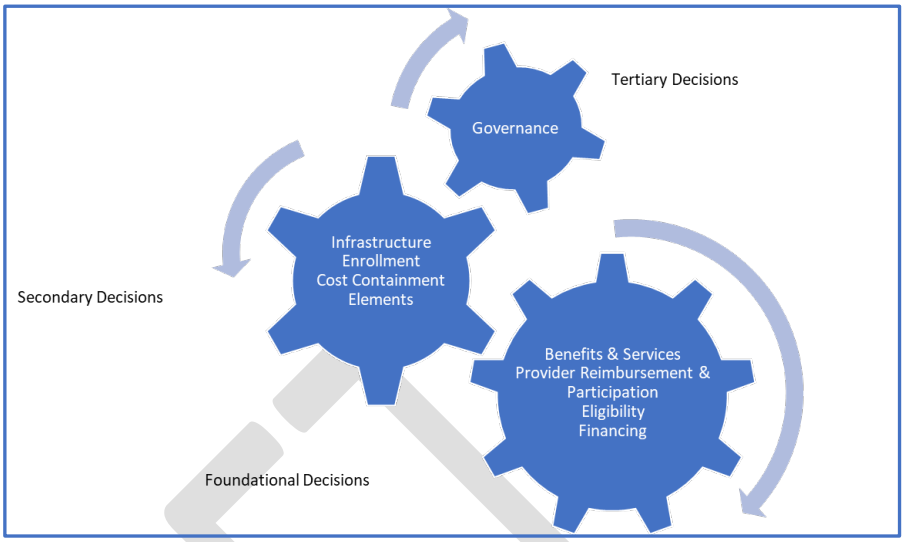


Figure 1: Potential Sequencing for Universal Health Care System Design

Washington State Health Care Authority

Report to the Legislature: Updated section 1

Tab 7

Section 1

Introduction

Washington State is a recognized national leader on innovative health policy efforts granting residents access to affordable and quality health care. For more than thirty years, these innovative health policy efforts have transformed Washington's health care system. The first section of this report provides a summary of analyses of Washington's health care finance and delivery system in key areas including coverage trends, costs, quality, provider consolidation trends, and key policy interventions that Washington has implemented to make improvements to access, affordability, quality and equity of the health care system. This section also summarizes recent efforts focused on evaluating the impacts of a unified health care financing system/universal health system (hereafter "universal health care system") in Washington.

The goal of this section is to provide a common understanding of the current state of health care trends and past and recent policy efforts. This overview may help inform future decisions regarding a universal health care system in Washington.

Washington Health Care Coverage Analyses and Trends

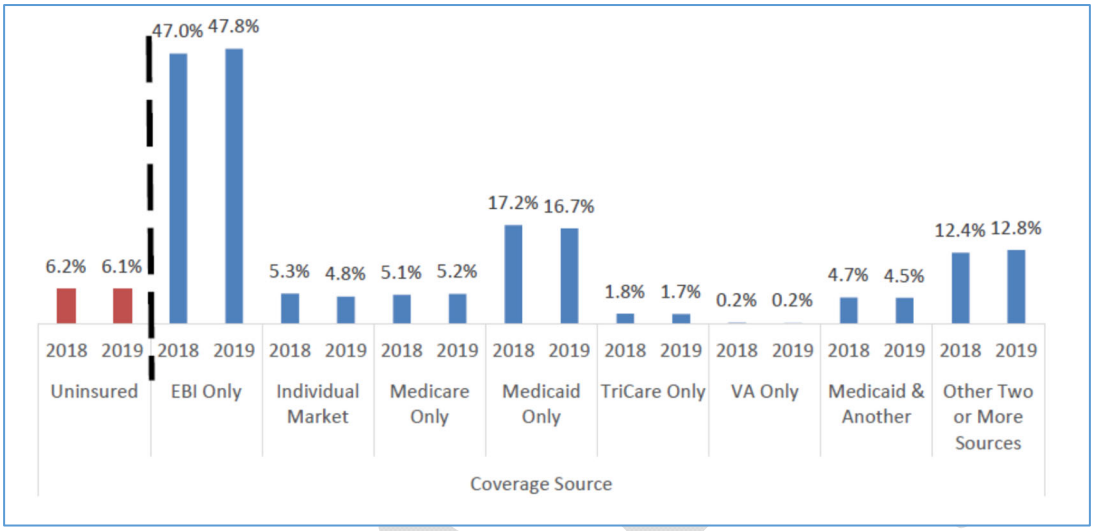
Washington is a national leader in health care system innovation, seeking policy solutions to address coverage gaps well before the Affordable Care Act (ACA). These efforts are detailed in a timeline provided in *Appendix X (*to be added from the UHC Workgroup report)* and described in this section. Following passage of the ACA, Washington fully embraced the opportunity to expand Medicaid and offered new subsidized coverage through the Health Benefits Exchange (HBE) which extended health care coverage to more Washington residents.

The Office of Financial Management (OFM) produces an annual report on the rate of uninsured. The reports indicate the uninsured rate declined from 14.1% in 2013, to five point four percent (5.4%) in 2016, then slightly increased to six point one percent (6.1%) in 2019 before the start of the COVID-19 pandemic.[1,2] The OFM report also details information about the sources of health coverage for Washingtonians. According to the 2020 report and as shown in Figure 1, 47.8% of Washingtonians relied on employment-based insurance, sixteen point seven percent (16.7%) on Apple Health (Medicaid), four point eight (4.8%) on individual market coverage, five point two percent (5.2%) on Medicare, one point seven percent (1.7%) on TriCare, point two percent (0.2%) on Veteran's Affairs, four point five percent (4.5%) on Medicaid and another ~~S~~source of ~~C~~coverage and 12.8% on ~~O~~other or ~~T~~two or ~~M~~more ~~S~~sources of ~~C~~coverage.

[1] Statewide Uninsured Rate Remained Unchanged from 2018 to 2019. Office of Financial Management, December 2020. https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief098.pdf

[2] The most recent data utilized in this report is from 2019. The Office of Financial Management anticipates an update will be available late in 2022.

Figure 1: Percentage by Source of Coverage, 2018 and 2019, Washington[3]



The Office of the Insurance Commissioner (OIC) Uninsured Report released in December 2021 provides additional specificity about which populations remain uninsured by age, geography, race, and gender and ~~what~~ the uninsured trends ~~were~~ over time across geography and sociodemographic groups. ~~The OIC Report examined trends in the rate of the uninsured b~~Between 2014 and 2019,~~.~~ t~~T~~he OIC Uninsured Report found that across all counties there were declines in the number of Washingtonians without health insurance, but that the declines were more significant in rural compared ~~with~~ to urban counties, due in large part to the fact that more individuals in urban counties already had a source of coverage compared with individuals in rural counties in 2014. The OIC also found that residents ages eighteen (18) to forty-four (44) years had the highest uninsured rate over time with an average of 10%, while those sixty-five (65) years and older had the lowest uninsured rate over time with an average of point five percent (0.5%), most likely due to Medicare enrollment. ~~When looking at income, t~~The OIC report noted that individuals with household incomes below $49,999 saw the greatest decrease in the uninsured rate, with a more significant decrease ~~for~~among those with incomes below $25,000, declining from 14.1% to eight point nine (8.9%).[4]

The OIC Uninsured Report also provides important insights into ~~who is~~ uninsurance~~ed~~ by race. People who identify as white, Asian, and multiracial have the lowest uninsured rates statewide at a little over five percent (5%). Individuals who identify in these racial categories as well as individuals who identify as African American/Black, had substantially lower uninsured rates in 2019 than 2014, demonstrating the impact of the ACA's coverage expansions. ~~However, the uninsured rate in 2019 for the remaining race categories including American Indian/Alaskan Native, Hawaiian and Pacific Islander and individuals not identifying a race exceeded the uninsured rates in 2014.~~

[3] Reprinted with permission from Statewide Uninsured Rate Remained Unchanged from 2018 to 2019. Office of Financial Management, December 2020. https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief098.pdf

[4] Report on the number of uninsured people in Washington state 2014-2020. Office of the Insurance Commissioner, December 30, 2021. https://www.insurance.wa.gov/sites/default/files/documents/2021-uninsured-report.pdf#:~:text=Washington%20state's%20uninsured%20rate%20was,2014%20and%205.5%25%20in%202017

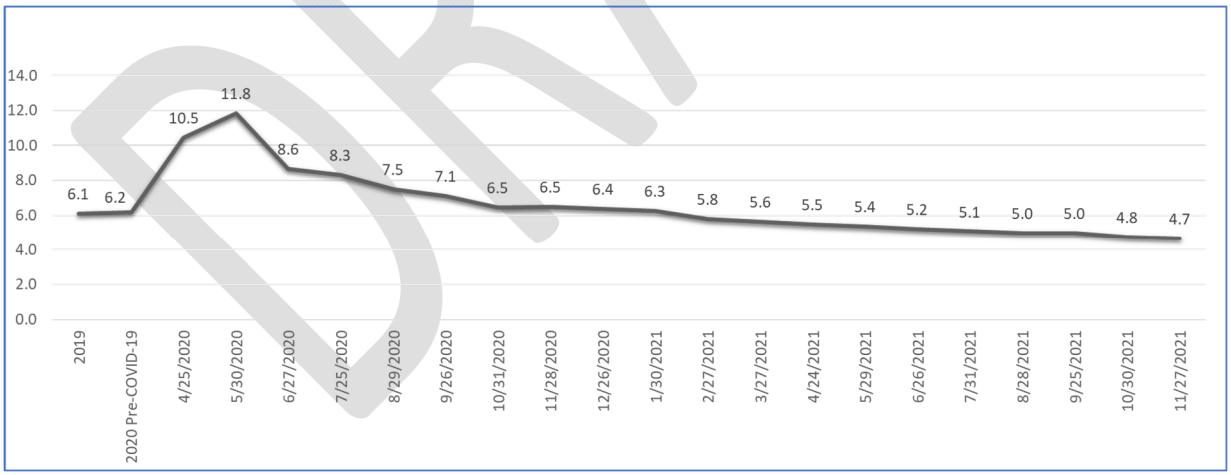
OFM's 2020 analysis reports that before the implementation of the Affordable Care Act in 2013, the uninsured rate for the Hispanic population was two and half times the rate of non-Hispanic population ~~(29.8% for the Hispanic population compared with 12% for the non-Hispanic population)~~. Both populations have seen significant declines in their uninsured rate since 2013, but the disparities persist and are expanding when comparing the uninsured rate for the Hispanic population with that of the non-Hispanic population. In 2019, the uninsured rate for the Hispanic population was ~~16.8% compared with 4.5% for the non-Hispanic population, an~~ nearly four ~~almost fourfold difference~~times greater than the non-Hispanic population as seen in Table 1.[5]

Table 1: Washington Uninsured Rate for Hispanic vs. Non-Hispanic Populations 2013-2019

Uninsured Rate	2013	2019
Hispanic	29.8%	16.8%
Non-Hispanic	12.0%	4.5%

The impact of the pandemic on the overall uninsured rate in Washington was significant, resulting in a spike in the uninsured rate to 11.9% in May 2020, which steadily declined thereafter as seen in Figure 2. The most recent monthly data from OFM (November 2021) indicates an uninsured rate of four point seven percent (4.7%), which is the lowest uninsured rate since the implementation of the Affordable Care Act.[6]

Figure 2: Estimated Uninsured in Washington 2019, Pre-COVID-19 2020, last Week of the month Since April 2020 through November 2021[7]



The lower uninsured rate is reflective of a number of key policy changes undertaken to mitigate coverage losses during the pandemic. These key policy changes include continuous Medicaid coverage,

[5] Statewide Uninsured Rate Remained Unchanged from 2018 to 2019. Office of Financial Management, December 2020. https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief098.pdf

[6] Health Coverage Changes in Washington State since the COVID-19 Pandemic: Office of Financial Management presentation to the Universal Health Care Commission, February 25, 2022. https://www.hca.wa.gov/assets/program/uhcc-meeting-materials-20220225.pdf

[7] Ibid. Reprinted with permission from OFM.

expanded eligibility for premium subsidies to purchase coverage through the Exchange, enhanced premium subsidies to improve the affordability of Exchange coverage, and increased outreach and enrollment opportunities to obtain coverage.[8] OFM has monitored the impact of these policies closely and is developing projections about the effect of the end of the Public Health Emergency on the state's uninsured rate.

During the February 2022 Universal Health Care Commission (UHC Commission) meeting, OFM shared a preliminary analysis about these potential impacts, projecting a significant bump in the rate of the uninsured, mostly due to the return of temporary disenrollment and re-enrollment in Apple Health. However, work is underway at the Health Care Authority (HCA) and HBE to minimize projected coverage losses. Tracking this data and the impact of these efforts to minimize coverage losses will be important information in developing strategies for the transition to universal health coverage.

Cost Analyses and Trends

A large part of Washington's efforts to address problems in the health care system has focused on addressing rising health care costs. These efforts are likely to remain in the forefront of Washington health policy as health care costs continue to increase yearly nationwide.

In recent years, Washington health care costs increased each year at a pace that exceeds the rate of inflation. In the commercial market, OIC reported a 13% increase in costs in 2021, nearly double the rate of inflation at seven percent (7%).[9] Cost growth in Washington also generally exceeds national trends. From 2014-2018, Washington's average annual growth in per person spending on employer-sponsored insurance was four point nine percent (4.9%), which is higher than the national average of four point three percent (4.3%). Similarly, in the Medicare market, Washington's average annual growth in per capita health care costs was two point four percent (2.4%) between 2007-2018, exceeding the national average of two point one percent (2.1%).[10]

To better understand cost drivers and to address rising health care costs, Washington engaged in a number of initiatives over the last several years. These include the Health Care Cost Transparency Board, the Prescription Drug Price Transparency Program, the Prescription Drug Affordability Board, Value-Based Purchasing, and the OIC's Report on Prior Authorization.

Health Care Cost Transparency Board

In 2020, the Washington State Legislature created the Health Care Cost Transparency Board (HCCTB) to identify health care cost trends, set a cost-growth benchmark, and develop recommendations to reduce health care costs.[11] As of September 2021, the Board has approved a cost growth benchmark of three percent (3.2%) for 2022-23, three percent (3.0%) for 2024-25, and two point eight percent (2.8%) by 2026.[12] Washington's benchmark aligns with other states' cost-growth benchmarks, such as in Oregon,

[8] "COVID Relief Provisions Stabilized Health Coverage, Improved Access and Affordability." Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/covid-relief-provisions-stabilized-health-coverage-improved-access-and

[9] Health Care Cost Trends. Office of the Insurance Commissioner. https://www.insurance.wa.gov/health-care-cost-trends

[10] Health Care Cost Transparency Board slides, June 2021. *https://www.hca.wa.gov/assets/program/hcctb-board-book-20210616.pdf*

[11] Second Substitute House Bill 2457 Chapter 340, Laws of 2020. https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/2457-S2.SL.pdf?q=20220405153723

[12] Health Care Cost Transparency Board. September 14, 2021, Meeting Minutes. https://www.hca.wa.gov/assets/program/board-meeting-summary-20210914.pdf

Connecticut, Delaware, Massachusetts, and Rhode Island.[13] The HCCTB will be responsible for identifying providers and payers whose cost growth exceeds the benchmark. Data collected in 2022 will help set the baseline for tracking spending growth in future years, which will be measured against the benchmark. Legislation approved in 2022 (SB 5589) will incorporate primary care into the work of the HCCTB. Beginning in 2022, the HCCTB will annually report on the progress toward primary care expenditures increasing to 12% of total health care expenditures.

Prescription Drug Price Transparency Program

In 2019, the Washington State Legislature enacted legislation establishing the Prescription Drug Price Transparency Program to develop a better understanding of the drivers and impacts of drug costs.[14] Under this program, HCA gathers prescription drug cost information from health insurers, pharmacy benefit managers (PBMs), manufacturers, and other entities to create an annual report on how prescription drugs affect health care costs. In the first annual report (based on data from 2020 that was reported in 2021), HCA identified that ~~while~~ drug price increases may have an impact on health care premiums; however, the extent of the impact could not be identified~~, it is unable to describe the specific extent in this first report~~. This is in some part due to the agency's limitations in its ability to analyze this relationship without a comprehensive set of claims data for all health plans in the state.[15] The report included several suggested statutory changes to improve the program's ability to understand the impact of prescription drugs on rising health care premiums including requiring health insurers, Pharmacy Benefit Managers (PBMs), manufacturers, and other entities to provide additional data to the HCA. Many of these recommendations, including these additional reporting requirements were included in legislation that passed in 2022 which created the Prescription Drug Affordability Board (PDAB).[16]

Prescription Drug Affordability Board

Beginning in 2023, the PDAB is empowered to conduct up to twenty-four (24) affordability reviews of drugs that have been on the market for at least seven years, including drugs dispensed at a retail, specialty, or mail-order pharmacy, but does not include drugs designated by the United States Food and Drug Administration as a drug solely for the treatment of a rare disease or condition. These drugs must also meet the following benchmarks to be considered for an affordability review:

- Brand name prescription drugs:
    - Have~~ing~~ a wholesale acquisition cost of $60,000 or more per year or for course of treatment lasting less than one year,
    - ~~Or in the alternative or~~ Have~~have~~ a price increase of fifteen (15) ~~percent~~% or more in any twelve (12)-month period or for a course of treatment lasting less than twelve (12) months, or
    - ~~Or~~Have a 50 ~~percent~~ % cumulative increase over three years,
- Biosimilar products with an initial wholesale acquisition cost that is not at least 15 ~~percent~~% lower than the referenced biological product, and

[13] Block, R. & Lane, K. (2021). *Supporting States to Improve Cost Growth Targets to Improve Affordability.* Health Affairs. https://www.healthaffairs.org/do/10.1377/forefront.20210526.658347/full/

[14] Engrossed Second Substitute House Bill 1224 Chapter 334, Laws of 2019. https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1224-S2.SL.pdf?q=20220404145622

[15] Health Care Authority. (2022). Prescription Drug Price Transparency – Annual Report. https://www.hca.wa.gov/assets/program/hca-dpt-annual-report-2022.pdf

[16] Second Substitute Senate Bill 5532 Chapter 153, Laws of 2022. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5532-S2.SL.pdf#page=1

- Generic drugs with a wholesale acquisition cost of $100 or more for a thirty (30)-day supply or less that has increased in price by 200% ~~percent~~ or more in the previous twelve (12) months.

The legislation includes ~~the~~ additional parameters for the affordability reviews including establishment of advisory panels which include stakeholders such as patients, patient advocates and a representative from the pharmaceutical industry. Affordability reviews will be focused on determining if the drug led to or will lead to excess costs, or are not sustainable to the health care system over a ten-year period. Beginning January 1, 2027, PDAB will have the authority to set an upper payment limit for up to twelve prescription drugs each year.[17]

Value-Based Purchasing

As the largest purchaser of health care in Washington, HCA is leading value-based purchasing (VBP) strategies to contain health care costs while improving outcomes. HCA set a target to achieve 90% ~~percent~~ of state-financed health care payments to be under VBP contracts and is making progress toward this goal. HCA's *Value Based Purchasing Roadmap for 2022-2025* sets forth VBP priorities, successes, challenges, and progress to date in implementing VBP arrangements in Washington.[18]

Office of the Insurance Commissioner Report on Prior Authorization

In 2020, the Legislature passed Engrossed Substitute Senate Bill 6404 that requires health carriers with at least one percent (1%) market share in Washington to report certain data regarding prior authorization to OIC.[19] Prior authorization is a tool used by carriers to control cost and access to certain benefits. This reporting may offer insightful information that will be helpful in making decisions concerning design elements of a universal system, particularly regarding the appropriate use of prior authorization as a tool to control costs. Carriers are required to report data annually for the following specified categories of health care services:

- Inpatient medical/surgical.
- Outpatient medical/surgical.
- Inpatient mental health and substance-use disorder.
- Outpatient mental health and substance-use disorder.
- Diabetes supplies and equipment.
- Durable medical equipment.

Within these categories of health care services, carriers report:

- Ten codes with the highest number of prior authorization requests and the percentage of approved requests.
- The ten codes with the highest percentage of approved prior authorization requests and the total number of approved requests.
- Ten codes with the highest percentage of prior authorization requests that were initially denied and then approved on appeal.
- The total number of requests.

[17] Ibid.
[18] VBP Roadmap https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf
[19] Engrossed Substitute Senate Bill 6404 Chapter 316, Laws of 2020. https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/6404-S.SL.pdf?q=20220405154910

- The average response time in hours for requests in each of the above categories for expedited decisions, standard decisions, and extenuating circumstances decisions.

The OIC issued the 2021 report on January 1, 2022 and stated that the average approval rate across all carriers was 84.4%. For the codes with the highest number of prior approval rates, the average approval rates were as follows:

- Outpatient Medical/Surgical: 98.3%Inpatient Medical/Surgical: 97.8%
- Durable Medical Equipment: 96.1%
- Inpatient Mental Health/Substance Abuse: 94.5%
- Outpatient Mental Health/Substance Abuse: 91.8%
- Diabetes Supplies and Equipment: 84.1%

The OIC also reported the average response times for the codes with the most requests, which were as follows:

- Inpatient Mental Health/Substance Abuse: 14.4 days
- Diabetes Supplies and Equipment: 12.4 days
- Inpatient Medical/Surgical: 10.7 days
- Outpatient Mental Health/Substance Abuse: 6.7 days.[20]

Balance Billing Protection Act

Beginning in January 2020, Washington residents were protected from surprise (or balance) billing when receiving emergency care at a medical facility or when treated at an in-network hospital or outpatient surgical facility by an out-of-network provider. The Balance Billing Protection Act (BBPA), passed in 2019, applies to all state-regulated health plans and state and school employee benefit plans. Self-funded group plans are not required to comply.[21] In 2022, Washington's BBPA was updated to comply with the federal No Surprises Act passed in 2020. Emergency services and post-stabilization services are now covered, including behavioral health emergency settings. Consumers cannot be asked to waive these balance billing protections, which protects them from surprise bills for covered services.[22]

Quality Analyses and Trends

Improving health care quality has been and remains a policy priority for Washington's health care delivery system. Washington policymakers have made several investments and enacted key policies in recent years to monitor and support quality improvements. These include the Washington State Health Technology Clinical Committee, the Dr. Robert Bree Collaborative, the Washington Statewide Common Measure Set, the All-Payer Health Care Claims Database (APCD) and Washington's Medicaid Transformation Project. These efforts focus on promoting transparency and systematic processes to

[20] Health Plan Prior-Authorization Data 2021 Report. Office of the Insurance Commissioner. https://www.insurance.wa.gov/sites/default/files/documents/health-plan-prior-authorization-data-2021-report.pdf

[21] Second Substitute House Bill 1065 Chapter 427, Laws Of 2019. https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1065-S2.SL.pdf#page=1.

[22] Engrossed Second Substitute House Bill 1688 Chapter 263, Laws of 2022. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1688-S2.SL.pdf#page=1

evaluate and support improved quality in the health care system and are important building blocks to consider in the future design of a universal health care system.

The Washington State Health Technology Clinical Committee (HTCC)

The HTCC was established in 2006 to make evidence-based coverage determinations for health technologies.[23] The HTCC is supported by HCA's Health Technology Assessment program, which develops and publishes systematic health technology assessment reports on the strength of the evidence for medical devices, procedures, and tests.

The HTCC considers Health Technology Assessment reports and other information, including state utilization and public comments. HTCC's determinations ~~guide~~ apply to coverage decisions for state health care purchasers, including Medicaid, Uniform Medical Plan, and the Department of Labor and Industries.

The Dr. Robert Bree Collaborative (Bree Collaborative)

The Legislature established the Bree Collaborative in 2011 as a forum for public and private health care stakeholder collaboration to improve quality, health outcomes, and cost effectiveness of care in Washington.[24] Participating experts are nominated by community stakeholders and appointed by the Governor. Each year, the Bree Collaborative identifies up to three health care service areas with high variation in the delivery of care that do not lead to better care or patient health, or that have demonstrated patient safety issues. The selected service areas are addressed by a work group of experts on the topic who are Bree Collaborative members and other experts in the community. The work group analyzes evidence on best practices for improving quality and reducing practice pattern variation. The Bree Collaborative recommendations consider existing quality improvement programs and organizations currently working to improve care. HCA incorporates Bree Collaborative recommendations into state-purchased coverage rules.

Washington Statewide Common Measure Set

In 2014, the Legislature established the Washington Statewide Common Measure Set as part of a larger bill focused on "improving the effectiveness of health care purchasing and transforming the health care delivery system."[25] Specifically, the intent of the Statewide Common Measure Set is to minimize variation about how the health care delivery system is measured and monitored. This legislation established a statewide performance measures committee, known as the Performance Measures Coordinating Committee (PMCC) which is supported by the HCA. The PMCC identifies and recommends a standard set of health performance measures that are utilized to develop benchmarks to inform health care purchasers. The PMCC includes diverse representation such as state agencies, large and small employers, health plans, federally recognized tribes, patient groups, academics, hospitals, physicians, and consumers. In 2014, a set of measures were introduced and are continually updated by the PMCC as new health care measures are developed and priorities for improvement are identified. The most recent set of measures was updated in 2022.[26] The Statewide Common Measure Set is used by ~~the~~ HCA ~~Health Care Authority~~ to promote quality improvement efforts in Apple Health, PEBB and SEBB through the use of such tactics as value-based purchasing.

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[23] Health Care Authority. Health Technology Clinical Committee and Health Technology Assessment.
[24] Bree Collaborative website.
[25] Engrossed Second Substitute House Bill 2572 Chapter 223, Laws of 2014. https://lawfilesext.leg.wa.gov/biennium/2013-14/Pdf/Bills/Session%20Laws/House/2572-S2.SL.pdf?q=20220405155431
[26] Washington Statewide Common Measure Set. https://www.hca.wa.gov/about-hca/washington-statewide-common-measure-set#what-is-statewide-common-measure-set

All-Payer Health Care Claims Database

The same legislation that established the PMCC and the Statewide Common Measure Set also allocated resources to OFM to establish the Washington All-Payer Health Care Claims Database (WA-APCD) to support transparent public reporting of health care information.[27] The WA-APCD contains eligibility, medical, pharmacy and dental claims representing about 75% of the statewide health care claims , including Medicaid, Medicare, public employees benefits, and workers' compensation and more than 50 commercial payers.[28] In 2019, the Legislature transferred the responsibility for the WA-APCD to HCA to partner with a lead organization with experience collecting and analyzing claims data.[29] The WA-APCD Data is displayed on the Washington HealthCareCompare website-, allowing consumers to compare the cost and quality of medical care and services. Consumers can find local prices of a treatment or visit by zip code. The WA-APCD data is also used to inform and support other work in Washington ~~State~~ examining costs of health care, including the BBPA, ~~and~~ the OIC study of health care cost trends and the HCCTB.

Medicaid Transformation Project (MTP)

Washington is currently in its final year of an 1115 Medicaid wavier that includes five key initiatives to transform the Medicaid program including:

- **Initiative 1:** transformation through Accountable Communities of Health (ACHs) and Indian Health Care Providers (IHCPs): implements projects that change the way people receive health care in their region. HCA is in the process of developing a waiver renewal proposal that will be submitted to the Centers for Medicare and Medicaid Services in Summer 2022. Efforts to improve quality through value-based payments will continue to be a focus of ongoing transformation efforts.[30]
- **Initiative 2:** supporting older adults and family caregivers: provides~~ing~~ support for Washington's aging population and family caregivers who provide care for their loved ones.
- **Initiative 3:** Foundational Community Supports (FCS): provides supportive housing and supported employment services to vulnerable Medicaid enrollees.
- **Initiative 4:** substance use disorder (SUD) institution for mental diseases (IMD): provides ~~for~~ greater access to SUD treatment by allowing Washington State to use federal funds to pay for SUD treatment in a mental health or SUD facility that qualifies as an IMD. IMDs are large facilities dedicated to psychiatric care (more than sixteen (16) beds where more than 50% ~~percent~~ of the residents are admitted for psychiatric care).[31]
- **Initiative 5:** mental health IMD: provides ~~for~~ greater access to in-patient care by allowing Washington State to purchase ~~(~~an average of thirty (30) days~~)~~ of acute inpatient services for Medicaid clients between the ages of twenty-one (21) and sixty-five (65) who reside in an (IMD).[32]

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[27] Engrossed Second Substitute House Bill 2572 Chapter 223, Laws of 2014. https://lawfilesext.leg.wa.gov/biennium/2013-14/Pdf/Bills/Session%20Laws/House/2572-S2.SL.pdf?q=20220405155431

[28] Washington All-Payer Health Care Claims Database newsletter. https://www.hca.wa.gov/washington-all-payer-health-care-claims-database-wa-apcd-newsletter

[29] Engrossed Substitute Senate Bill 5741 Chapter 319, Laws of 2019. https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5741-S.SL.pdf?q=20220320080426

[30] Medicaid Transformation Project Renewal https://www.hca.wa.gov/about-hca/medicaid-transformation-project-mtp/mtp-renewal

[31] Amendment to Washington's Medicaid Transformation Project (MTP): The substance use disorder (SUD) IMD initiative. https://www.hca.wa.gov/assets/program/sud-imd-faq.pdf

[32] Amendment to Washington's Medicaid Transformation Project: Introducing the mental health IMD initiative. https://www.hca.wa.gov/assets/program/mental-health-imd-faq.pdf

Through these initiatives, HCA is implementing and overseeing projects that are designed to improve the way people access the health and social supports they need. By further integrating these services and supporting providers in the transition to value-based payments, Washington will improve the quality-of-care people receive.

Health Care Workforce Analyses and Trends

Developing and maintaining an adequate health care workforce will be critical to any effort to move toward a universal health care system focused on improving access and quality and reducing costs. Workforce trends will be particularly important considerations when developing a provider reimbursement model.

OFM's Forecasting and Health Care Research Division produces an annual report on Washington's physician supply using data collected from the Network Adequacy Reports Network (NAR) that health insurance carriers submit monthly to the OIC. The 2021 report found that the number of licensed physicians (including Medical Doctors and Doctors of Osteopathy) increased by 769 from 2020 to 2021 for a total of 20,563 licensed physicians. This growth in the number of licensed physicians outpaced the general population increase, resulting in an increase in the physician-to-population ratio from 269 physicians per 100,000 in 2020 to 275 physicians per 100,000 population in 2021. The report also found that the ratio of physicians practicing primary care in comparison to specialty care remained relatively unchanged (declining from 34% to 33% for primary care and rising to 67% from 66% for specialty care).

Similar to past annual reports, the physician supply is disproportionately distributed across the state, with more than 40% of all physicians located in King County. This is not surprising given that King County accounts for the bulk of the state's population. However, Chelan County, not King County, has the highest ratio of physician-to-population ratio by a significant margin: 532 physicians per 100,000 people versus 383 physicians per 100,000 people. Overall, significant disparities in Washingtonians' access to physicians remains across the state.[33]

The Washington Health Workforce Council was created by the Legislature in 2003 to investigate and support initiatives to address health care workforce shortages. The Council is responsible for producing an annual report outlining these trends and making recommendations to the Legislature about possible improvements. One of the initiatives of the Council has been the Washington Health Workforce Sentinel Network (the Network), created in 2016. The Network is a collaboration of the Council and the University of Washington Center for Health Workforce Studies (UW CHWS). The Network links the health care industry with partners in education and training, policymakers, and other workforce planners to identify and respond to emerging demand changes in the health workforce. The information captured by the Network seeks to provide more insights into the "why" of changes in occupations, roles, and skills needed to deliver quality care.

Since its inception, the Network has tracked health disciplines with exceptionally long vacancies across a number of health care settings.[34] According to the Health Workforce Council Annual Report for 2021, employers in Long-Term Care settings, including skilled nursing facilities, nursing homes, and assisted living facilities, reported significant challenges in hiring enough registered nurses (RNs), nursing assistants, and licensed practical nurses (LPNs). Notably, these workforce challenges are not new, but

[33] Office of Financial Management: 2020-21 Physician Supply: Estimates for Washington. https://ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/workforce/physician_supply_2020-21.pdf
[34] Health Workforce Council. https://www.wtb.wa.gov/planning-programs/health-workforce-council/

have become more acute since the COVID-19 pandemic.[35] There are various causes for these shortages such as the lack of adequate training slots for many of these professions, lower salaries in Long-Term Care settings when compared ~~with~~to other settings, and administrative challenges with licensure when moving from other states.

Another area where there are significant and ongoing healthcare workforce shortages is in behavioral health. According to the 2017 Washington State Behavioral Health Workforce Assessment, "the demand for behavioral health care, including mental health and substance use disorder treatment, exceeds the availability of services throughout the state."[36] This is consistently echoed in the data collected by the Network. Long-term vacancies ~~were~~are commonplace and have become more acute over the last two years due to the pandemic, during which the demand for behavioral health services has skyrocketed.[37]

In response to the significant and enduring gaps in the behavioral health workforce, in 2021 the Legislature formalized an existing stakeholder workgroup that became known as the Behavioral Health Workforce Advisory Committee (BHWAC). BHWAC issued an interim report in December 2021 with updated policy recommendations to improve hiring and retention. Key recommendations included in the interim report focused on increasing Medicaid reimbursement rates for behavioral health providers, increasing the ability of behavioral health agencies to accept students/trainees and enhancing training programs to support individuals pursuing careers in behavioral health. A final report from the BHWAC is expected in December 2022.[38] ~~Recognizing and understanding~~ Addressing the existing healthcare workforce shortage~~s~~ will be a prerequisite~~n important factor that will need to be addressed~~ in the transition to a universal health care system.

Market Consolidation Analyses and Trends

Over the last thirty-five (35) years in Washington, there has been an increase in hospital consolidation because of mergers and acquisitions. This trend is not unique to Washington and is identified in many studies as a contributing factor to higher costs and poorer outcomes in the health care delivery system. Understanding these trends is an important factor when making design and policy decisions about a universal health care system in Washington.

OFM released a comprehensive report, "Hospital Mergers in Washington 1986-2017" which describes the increased concentration of hospital resources and care as more hospitals in Washington became part of larger hospital systems over the 1986-2017 period.[39] While it does not provide specific data comparing quality and costs of care before and after hospital mergers and acquisitions, it does provide information about how many hospital beds, ICUs, and hospital admissions are concentrated to a few health care systems compared with independent hospitals. The concentration of these resources provides insights into the lack of competition that may contribute to reduced access and higher costs.

[35] Health Workforce Council Annual Report 2021 Annual Report. https://www.wtb.wa.gov/wp-content/uploads/2022/01/Health-Workforce-Council-Annual-Report-2021.pdf
[36] 2017 Washington State Behavioral Health Workforce Assessment. https://www.wtb.wa.gov/wp-content/uploads/2019/05/WA-Behavioral- Health-Workforce-Assessment-2016-17.pdf
[37] Health Workforce Council Annual Report 2021 Annual Report. https://www.wtb.wa.gov/wp-content/uploads/2022/01/Health-Workforce-Council-Annual-Report-2021.pdf
[38] Behavioral Health Workforce Advisory Committee Preliminary Report and Recommendations. https://www.wtb.wa.gov/wp-content/uploads/2021/12/BHWAC-Preliminary-Report-Final-Draft.pdf
[39] Office of Financial Management. Hospital Mergers in Washington 1986-2017. https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief105.pdf

The report found that the percentage of hospitals in systems grew from 10% in 1986 to almost ~~half~~50% in 2017. This trend was not consistent over the entire time of the study and most of the changes happened between 2006 and 2017. With this shift to larger systems, hospital resources became more concentrated. ~~as indicated by the following:~~

The number of available hospital beds per 100,000 population decreased from 298 to 170. Meanwhile, the percentage of hospital beds in systems, patient admissions to systems, and ICU beds in systems all increased dramatically as indicated in Table 2.

- ~~The percentage of beds in hospital systems increased from 19% to 73% between 1986-2017~~
- ~~The percentage of patient admissions to system hospitals compared to independent hospitals rose from 20% to 79% from 1986-2017~~
- ~~The percentage of ICU beds found in system hospitals rose from 19% to 73% between 1986 and 2017~~

Table 2: Change in Percentage of Hospital Beds, Patient Admissions and ICU Beds in Systems 1986-2017

Percentage of Hospital Beds in Systems	
1986	19%
2017	73%
Percentage of Patient Admissions to Systems	
1986	20%
2017	79%
Percentage of ICU Beds in Systems	
1986	19%
2017	73%

OFM's Hospital Mergers Report also provided data about consolidation at the county level across the state. In 1986, hospitals in systems operated in six (6) counties that accounted for 60% of the state population. Each of these six (6) counties also had at least one (1) independent hospital. In total, twenty-nine (29) counties accounting for 39% of the state's population were served only by independent hospitals and four (4) counties had no hospitals. In 2017, systems operated hospitals in seventeen (17) counties. Eight (8) of those counties were served only by system-operated hospitals. Close to 90% of the population lived in a county with at least one (1) system hospital, compared to 60% in 1986.

The increased consolidation and concentration of health care resources may have an unforeseen impact on the community. One concern articulated in this report was the significant amount of consolidation into Catholic hospital systems which could impact access to women's reproductive health services which has been a long-standing priority for Washington policymakers. This will be an important factor to consider when designing a universal health care system to achieve better outcomes and lower costs.

Seeking Comprehensive Solutions in Washington: A 35-year Journey

Exploring comprehensive solutions to improve quality, lower costs, and improve access to affordable coverage are not new endeavors in Washington. Over the last thirty years, Washington's wide-ranging efforts aimed to provide a comprehensive solution to these pervasive problems, including establishing the Basic Health Plan, the Washington Healthcare Commission (often called the Gardner Commission),

the Washington State Blue Ribbon Commission on Health Care Costs & Access, and the more recent Universal Health Care Work Group. These efforts, in addition to the targeted efforts described earlier, are foundational steppingstones in Washington's current deliberations and decision-making to develop a universal health care system that will provide affordable and quality health care to all Washingtonians.

Basic Health Plan

Washington began extending coverage to qualified low-income adults and children in 1987 using a state- funded effort called the Washington State Basic Health Program (BHP). The initial pilot program was expanded statewide in 1993, eventually enrolling over 100,000 low-income, Medicaid-ineligible working adults with incomes under 200% ~~percent~~ of the federal poverty level (FPL).

Enrollment into Washington's BHP continued to grow through the mid-90s and in 2003 reached a peak of 130,000 (the program's enrollment cap at the time).[40] Due to state budget pressures, BHP funding was cut by 43% ~~percent~~ in the 2009-2011 state budget, greatly reducing the number of enrollees and stopping new enrollment. Many BHP enrollees transitioned to Medicaid with the state's Section 1115 waiver and ACA Medicaid ~~eligibility~~ expansion. The ACA's Basic Health Program was modeled on Washington's BHP.

Washington Health Care Commission

In 1990, the Washington State Legislature passed Legislative Resolution 4443, which established the Washington Health Care Commission to recommend plans for ensuring access to health care for Washingtonians.[41] The Washington Health Care Commission's final report, released in 1992, defined universal access as "the right and ability of all Washington residents to receive a comprehensive, uniform, and affordable set of confidential, appropriate, and effective health services" which was called the "uniform set of health services."[42]

The proposed uniform set of health services was to be delivered by competing certified health plans to cover preventive, primary, and acute care. The uniform set of health services also included prescription drugs, dental care, mental health and substance use disorder services. Long-term care services were planned to be to be phased in. The Commission stressed that services must be timely and not tied to ability to pay or pre-existing health conditions. Consideration of geographic, demographic, and cultural differences would also be taken into account in providing services.

A majority of Commission members wanted a single organization to sponsor coverage for all residents, while others believed employers should be a part of a "pay or play" system that allows the employer to offer coverage or pay into the system. Approved health carriers would compete on price within a maximum allowed premium and under rules set by an independent state commission. Financing would be shared by individuals, employers, and Washington state. Carriers would be encouraged to implement capitation and increase provider risk for managing care. The Commission also recommended seventeen strategies for making the health care liability system less costly, time consuming, and emotionally burdensome for consumers and providers.

Recognizing that implementation would take time, the Commission recommended immediate action to reauthorize~~ing~~ the Basic Health Plan and increase~~ing~~ funding for public health programs.

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[40] Revised Code of Washington (RCW) 70.47.060 permitted the program to temporarily close enrollment to avoid over-expenditures.

[41] This Commission is often referred to as the Gardner Commission after then-Governor Booth Gardner.

[42] Washington Health Care Commission: Final Report to Governor Booth Gardner and the Washington State Legislature. November 30, 1992.

The group recommended that the Legislature should also pursue insurance reforms, including implementing guaranteed issue and renewability, a prohibition or limit on pre-existing condition exclusions, implementation of modified or strict community rating, and the development and implementation of small group market reforms.

The Washington Health Services Act of 1993

Based on the recommendations of the Washington Health Care Commission, in 1993 the Washington Legislature passed a comprehensive health law that included many of the recommended elements. Many of these elements would be included in the ACA fifteen (15) years later:

- Employer and individual mandates
- Guaranteed issue (insurers may not deny coverage due to pre-existing conditions)
- Required coverage of a basic set of benefits
- Expanded Medicaid eligibility

However, the law was not fully implemented because portions of it were~~as~~ repealed by the 1995 Legislature. These repealed provisions included the individual and employer mandates, the use of certified health plans to deliver coverage based on a uniform set of benefits, and caps on insurance premiums.[43] The law retained expansion of the Basic Health Program and Medicaid for children in families with income up to 200% ~~percent~~ FPL. The guaranteed issue and required coverage of a basic set of benefits provisions of the law were also maintained.

Washington State Blue Ribbon Commission on Health Care Costs & Access

In 2006, the Legislature established the Blue Ribbon Commission on Health Care Costs and Access, which was supported by OFM, and charged with delivering a five (5)-year plan for substantially improving access to affordable health care for all Washingtonians. The Commission included then-Governor Christine Gregoire, eight (8) legislators, and leaders from OIC, HCA, Department of Health (DOH), Department of Social and Health Services (DSHS), and Department of Labor and Industries (L&I).

Based on the vision of a system that allows every Washingtonian to get needed health care at an affordable price, the group identified four (4) overarching strategies:

- Build a high-quality, high-performing health care system
- Provide affordable health insurance options for individuals and small businesses
- Ensure the health of the next generation
- Promote prevention and healthy lifestyles

The Commission made sixteen (16) recommendations tied to one (1) or more of the above strategies and included proposed actions. Many of the Commission's recommendations were implemented by the state Legislature in 2007, including:

- Using reimbursement to reward quality outcomes
- Increasing consumers' access to information and shared decision making
- Improving primary care and chronic care
- Facilitating secure sharing of health information
- Tracking emergency room use
- Identifying contributors to health care administrative costs and evaluating ways to reduce

[43] Certified health plans were defined by the law as organized delivery systems with financial risk for delivering the uniform benefit package.

them

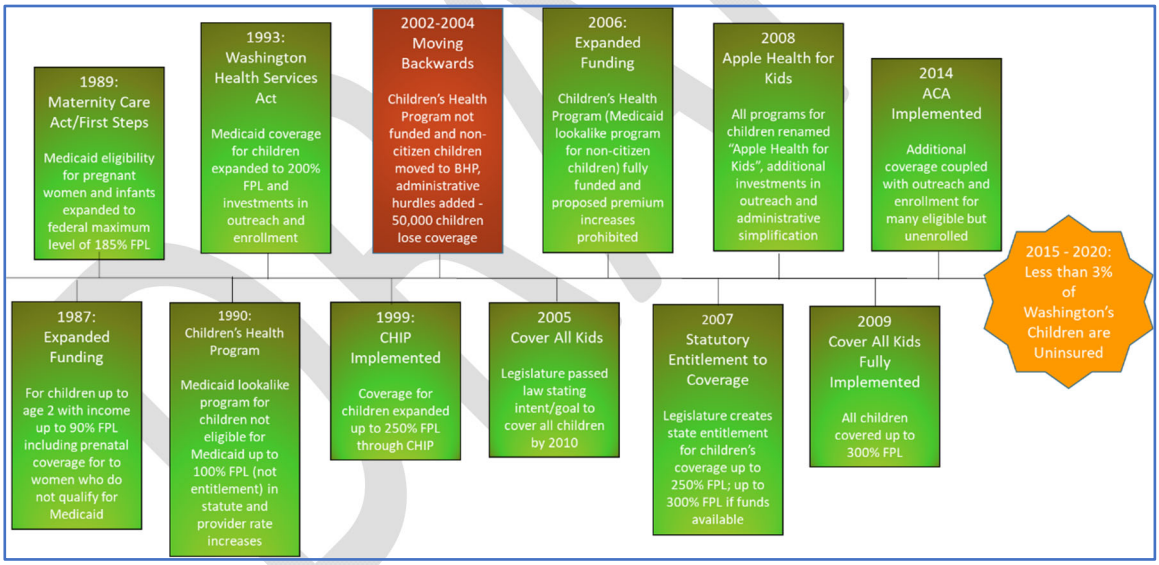
- Designing insurance coverage options that promote prevention and health promotion.
- Expanding coverage options
- Increasing public health activities[44]

Years ahead of the ACA, the same legislation that created the Commission in 2007 also included the requirement to allow purchasers of individual or group coverage the option to cover their unmarried dependents until they reach age twenty-five (25). This requirement was also implemented for disability insurance. Additionally, the legislation directed the DSHS to develop coverage expansion options that could utilize Medicaid, CHIP and/or the Basic Health Program.

Universal coverage for children

Over 98% ~~percent~~ of Washington children are covered by health insurance, meaning that the state is now considered to have universal child coverage. The process of reaching universal coverage for children took over a decade and involved multiple steps by the Legislature as seen in Figure 3.

Figure 3: The Pathway to Universal Coverage for Children in Washington



Investigating Single Payer Models

In 2018, Washington policymakers allocated resources to investigate the impact of moving to a universal health care system.[45] The first study, conducted by the Washington State Institute for Public Policy (WSIPP), examined various models of universal health care from other countries to gain insights about

[44] Engrossed Second Substitute Senate Bill 5930 Chapter 259, Laws of 2007. https://lawfilesext.leg.wa.gov/biennium/2007-08/Pdf/Bills/Session%20Laws/Senate/5930-S2.SL.pdf#page=1

[45] Engrossed Substitute Senate Bill 6032, Section 606(15), Chapter 299, Laws of 2018. https://app.leg.wa.gov/billsummary?BillNumber=6032&Initiative=false&Year=2017

how these models were constructed and their effectiveness in comparison with the current US system.[46] This study compared the healthcare systems of the US to ten (10) comparable "high-income" countries including Japan, Germany, the United Kingdom, France, Canada, Australia, the Netherlands, Sweden, Switzerland, and Denmark. In general, the health care systems of the comparable countries are considered "universal" models to varying degrees. These models included:

- Single payer systems in which the government is the payer and provider (e.g., the United Kingdom).
- Single payer systems in which the government is the payer, but providers are generally private (e.g., Canada).
- Multi-payer systems that combine the governmental oversight and benefit design with private health insurance (e.g., Germany or Japan).

WSIPP's analysis found that the US spends more on health care on a per capita basis when compared with countries with universal health coverage models. Specifically, the US spent $9,400 per person on health care in 2016, whereas the selected universal models spent on average $5,000 per person on health care in 2016. This difference in spending was attributed to several factors: higher administrative costs, higher prices, higher utilization of more expensive services,[47] and higher prevalence of newer technology or drugs with "modest or uncertain" effectiveness. However, wait times for certain procedures were lower in the US systems and the availability of newer technology was generally higher. Overall, the outcomes of the US systems as compared to the universal systems are mixed. For example, the utilization of preventative care (screenings, immunizations) is higher in the US, but deaths due to diabetes and other manageable chronic diseases or "avoidable mortality" is also higher.

The WSIPP report concluded that countries providing universal health care systems generally were more successful in limiting health care spending and patients' financial barriers to care while achieving comparable health outcomes to the US. However, the report noted that comparing these systems to the US and judging the feasibility of implementing a universal health care system in the US was difficult due to the large differences in population, lifestyle, and general differences in the nature of the comparison countries to the US, such as governmental policies and taxation systems.

The Universal Health Care Work Group

Following the WSIPP study, in 2019, Washington policymakers secured funding to support the Universal Health Care (UHC) Work Group, which was charged with evaluating the potential impacts of moving to universal health care system in Washington.[48] The Work Group produced a comprehensive report of their work and findings that was submitted to the Washington State Legislature in early 2021.[49]

Membership of the UHC Work Group reflected the geographic, socio-economic, ethnic, racial, and gender diversity of Washington's population. The Work Group consisted of thirty-seven (37)

[46] Washington State Institute for Public Policy: Single-Payer and Universal Coverage Health Systems Final Report, May 2019. https://www.wsipp.wa.gov/ReportFile/1705/Wsipp_Single-Payer-and-Universal-Coverage-Health-Systems-Final-Report_Report.pdf

[47] This is likely due to the general lower threshold of utilization management rules present in private insurance as compared to universal systems.

[48] Engrossed Substitute House Bill 1109, Section 211, Subsection 57;
Chapter 415, Laws of 2019. Retrieved from: https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1109-S.SL.pdf?q=20220321001807

[49] Universal Health Care Work Group – Report to Legislature, January 2021. Retrieved from: https://www.hca.wa.gov/assets/program/final-universal-health-care-work-group-legislative-report.pdf

stakeholders representing relevant state agencies, legislative leaders from the two (2) largest political parties from both the State House and Senate, health care provider groups, health care associations and health care consumers. The Work Group initially focused on determining and providing guidance on essential elements in a universal health care coverage model for Washington. These elements helped design straw models that were then analyzed to understand the costs and savings associated with each. The three (3) models proposed and evaluated by the Work Group to achieve universal coverage included:

- **Model A:** State-governed and administered program for all state residents.
- **Model B:** State-governed and health plan administered program for all state residents.
- **Model C:** Access to coverage for undocumented residents unable to buy coverage, which was termed "fill in the gaps coverage." This model could be expanded to other uninsured or underinsured populations.

The following table provides an overview of some of the key characteristics featured in each model including the populations covered, minimum benefits offered, cost sharing requirements, and provider reimbursement levels. Notably, all three (3) models would continue to have care delivered by private and public providers, clinics, and hospitals.[50]

Table 1: Overview of the Characteristics of the UHC Work Group's Three Models [51]

	Model A	Model B	Model C
Populations	All state residents, including Medicaid, Children's Health Insurance Program (CHIP), Medicare, privately insured, undocumented, uninsured		Undocumented immigrants
Covered benefits	• Essential health benefits, plus vision for all participants • Dental and long-term care for Medicaid[1]		Essential health benefits
Cost sharing	• No cost sharing • Associated utilization changes		Standard cost sharing
Provider reimbursement	• Reduced pricing variation between populations • Administrative efficiency • Increased purchasing power		Cascade Care reimbursement levels

Using the key characteristics identified by the Work Group, an actuarial analysis was conducted to compare the impacts of each of the three models to the status quo including the number of individuals covered, the cost to implement the model and the potential savings (if applicable) of each model. The key findings are highlighted in Table 2 and summarized further below.

Table 2: UHC Work Group Overview of each model's impacts, including potential savings

	Model A	Model B	Model C
Population impacts	• Improved access for the Medicaid population • Improved access for uninsured, undocumented		Assumes commercial utilization

[50] Ibid.
[51] Ibid.

Administration	• State administers • Premiums are exempt from state premium tax • Lower system-wide administrative costs	• Health plans administer • Premium tax applies • Lower system-wide administrative costs	Assumes commercial plan administrative costs
Expenditures and potential savings for covered populations			
Status quo expenditure	$61.4 billion	$61.4 billion	Not available
Model cost estimate	$58.9 billion	$60.6 billion	$617 million
Implementation year savings	$2.4 billion	$738 million	N/A

Work Group members were asked to respond to a survey regarding their preference ranking of Models A, B, and C. [52]Twenty-nine (29) of the thirty-seven Work Group Members participated. Seven (7) of the

[52] Under Model B, there are potentially several paths to universal coverage, including utilizing Model B as a transition to Model A. However, due to modeling restrictions, Model B was proposed with a fixed method of providing universal coverage.

twenty-nine (29) respondents indicated they abstained from stating a preference. The majority of the Work Group Members who stated a preference ranked Model A as their most preferred Model of the three options.

There was a diversity of perspectives about the impacts of each model among the members of the UHC Work Group in achieving the stated goals. Many Work Group members recognized that Models A or B were most likely to achieve the coverage, access, and equity goals of a universal health care system while generating health care savings in the long-term when compared with Model C. ~~Like Models A and B,~~ Model C requires additional state dollars, but does not generate savings to the state, and was not as likely to achieve the goals of a universal system. At the same time, many Work Group members ~~did~~ acknowledged that Model C could potentially provide a pathway to moving to a more universal system envisioned in Model A or B.

Recognizing that moving to a universal system would be a multi-year effort, the Work Group included an outline of a transition plan in the report to the Legislature. This multi-year outline incorporated a plan for a short-term focus on coverage that would fill in the gaps. The state is in the process of implementing Model C as evidenced by the additional policies that have been undertaken since 2020.[53]

SUMMARIZING THE MODELS

Model A (state-governed and administered program for all state residents) was projected to cost $58.9 billion and to save $2.5 billion in health care spending in the first year of implementation. These estimates are based on actuarial modeling using current utilization and reimbursement trends and assumptions around the development of such a program, such as the elimination of cost sharing and introduction of a single payor. Savings were estimated to come from the reduced administrative costs of a single payer, increased state purchasing power over reimbursement rates, and reductions in extraneous spending such as fraud, waste, and abuse expected from the streamlining of the health system. The model would provide coverage to all Washingtonians.

Model B (state-governed and health plan administered program for all state residents) was projected to cost $60.6 billion and save $783 million in the first year of implementation. These estimates are based on actuarial modeling. Similar in structure to Model A, the State would remain the single payer and overseer of the system, but coverage is administered by insurance companies that contract with the State. Coverage follows Model A, with some modifications to utilization rules due to lack of cost sharing. The lower savings for Model B when compared with Model A are attributed to the increased costs of outsourcing the burden of plan administration to third-party insurers. The model assumes coverage for all Washingtonians.

Model C (access to coverage for undocumented residents unable to buy coverage now or "fill in the gaps") was projected to increase state costs by about $617 million based on actuarial modeling. Model C is structurally different from Models A & B, focused on adding and enhancing the current system to improve coverage for undocumented individuals who are currently uninsured through increased subsidies or the creation of additional health plan options with a potential to expand to include additional uninsured populations. The model assumes coverage for an additional 124,000 residents.

Implementing Model C

~~The American Rescue Plan Act of 2021 temporarily increased subsidies provided to individuals at lower incomes, and newly extended eligibility to people above 400% FPL. These provisions have led to increased enrollment and affordability, but are scheduled to expire at the end of 2022.~~ Model C is structurally different from Models A & B. Model C is focused on adding and enhancing the current system to improve coverage for undocumented individuals who are currently uninsured through increased subsidies or the creation of additional health plan options with a potential to expand to include additional uninsured populations. The Cascade Care Program, which

[53] Engrossed Substitute Senate Bill 5693. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Passed%20Legislature/5693-S.PL.pdf?q=20220405170049

includes Cascade Care, Cascade Select (Public Option), and Cascade Care Savings, will provide coverage to individuals who are currently uninsured through increased state subsidies.

Cascade Care

In 2021, Washington State offered standard benefit plans through Cascade Care. These plans have the same benefits, which allows consumers to better compare insurance carriers. Cascade Care plans emphasize lower deductibles and provide access to services before having to pay the deductible. Cascade Care is a multi-agency effort involving HBE, Health Care Authority (HCA), and Office of the Insurance Commissioner (OIC).

Cascade Select

The public option, Cascade Select, was not yet fully implemented at the time of the UHC Workgroup discussions and was made available to Washingtonians beginning in 2021. Cascade Select offers health insurance coverage options on the individual market through Washington's Healthplanfinder (operated by the Health Benefit Exchange). ~~Cascade Care is a multi-agency effort involving HBE, Health Care Authority (HCA), and Office of the Insurance Commissioner (OIC).~~ The goals of Cascade Select are to increase the availability of quality, affordable health care coverage in the individual market, and ensure residents in every Washington county have a choice of qualified health plans. As of 2021, only two point five percent (2.5%) of all new enrollees selected this plan and it is not yet offered in all counties of the State. [54] However, this program can be used to gauge the effectiveness and feasibility of a larger-scale public program.

Cascade Care Savings Plan

Recognizing that affordability continues to impact uptake of Exchange plans, appropriations were allocated to HBE during the 2021 legislative session to implement a state-funded subsidy plan that will supplement federal health care subsidies for certain income levels in Washington.[55] This program is very similar to the expanded Model C envisioned by the UHC Work Group and can be studied to understand the effects of increasing the amount or eligibility of such subsidies. The subsidies will be available to individuals up to 250% FPL who enroll in Cascade Care gold or silver plans.

Creating More Coverage Opportunities for those Not Currently Eligible

Also during the 2021 session, the Legislature authorized HBE to seek a federal 1332 waiver to allow more Washingtonians to shop and buy coverage on the Exchange.[56] Additional funding was allocated during the 2022 legislative session to develop new coverage options for undocumented individuals who are currently prohibited from being able to shop, buy or enroll in many coverage options.

Summary

While the UHC Work Group identified a number of barriers to designing a universal a health care system and developed models to implement a universal health care system, it falls to this Commission to make specific decisions and recommendations about how to address these challenges in the coming years. *Section 1's* objectives were to 1) to provide an overview to the Legislature of the current health care system trends that the UHC Commission is considering in its efforts to design a universal health care

[54] Health Affairs. https://www.healthaffairs.org/do/10.1377/forefront.20210819.347789#:~:text=Enrollment%3A%20In%20the%20first%20year,chose%20a%20Cascade%20Select%20plan.

[55] https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5377-S2.SL.pdf?q=20220224145451

[56] Ibid.

system with a uniform financing structure required by the authorizing statute; 2) to provide an overview of many of the past efforts that have been made to improve Washington's health care system so that the Commission and the Legislature have a common understanding of the starting place for their efforts; and 3) to recognize and highlight Washington's rich history of innovation in addressing pervasive problems in the health care system that can be drawn upon to best leverage the existing tools and interventions in future design decisions. The next sections of the report will:

- Describe the design components of a universal health care system
- Provide an assessment of Washington's readiness to implement those components
- Recommend a strategy to implement the components of a universal health care system
- Recommend options for increasing reimbursement rates for Medicaid
- Recommend policy solutions to address existing coverage gaps
- Recommend options for the development of a finance committee to develop a feasible model to implement universal health coverage.

Washington State Health Care Authority

Report to the Legislature: Updated section 3

Tab 8

Section 3

Introduction

The Universal Health Care (UHC) Commission is charged with preparing Washington state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system once the necessary federal authority becomes available. This section of the report addresses the Legislature's requirement for the Commission to inventory the key design elements of a universal health care system. The key design elements are organized into seven (7) core design components to form a framework for the implementation and operation of a universal health care system:

1. **Eligibility and Enrollment**—identify how to cover currently uninsured populations; determine which, if any, existing coverage options will remain; and which segments of the existing insured population will be included in the Commission's universal coverage considerations.
2. **Benefits and Services**—create an approach to develop standards that ensure equal access to a minimum set of benefits and services.
3. **Financing**—define an approach to align or aggregate public funding sources, private sector funding sources; and individual cost-sharing, if any.
4. **Provider Reimbursement and Participation**—select a method for paying providers, encouraging their participation, and aligning provider behavior to quality and equity goals.
5. **Cost Containment Mechanisms**—establish global budgeting and utilization management functions to control total cost of care.
6. **Infrastructure**—invest in administrative and operational capabilities necessary to implement a cohesive model.
7. **Governance**—ensure transparency and accountability for planning and implementing the model ~~and~~ that ~~the~~ includes the voice of consumers in decision-making.

These core components align with the framework proposed by the Congressional Budget Office in their 2019 report on single-payer systems.[1] It is important to note that the other ~~the~~ key design elements, including health care quality, equity, and health disparities, identified by the Legislature for the Commission to address in its report are considered strategic goals of the universal health care system. These goals can be achieved through any design, but some design choices have a greater impact than others. As such, quality, equity, and health disparities are discussed within each of the core design components and will be taken into account at every stage by the Commission in making its final recommendations. The Legislature also set specific goals to implement impactful changes in the current health care system and incorporate into the design of a universal health care system including:

- Supporting quality improvement strategies.
- Allowing for quality monitoring and disparities reduction.
- Promoting initiatives for improving culturally appropriate health services within public and private health-related agencies.
- Supporting strategies to reduce health disparities including, but not limited to, mitigating structural racism and other determinants of health as set forth by the Office of Equity.

[1] Congressional Budget Office. (2019). Key Design Components and Considerations for Establishing a Single-Payer Health Care System. https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf

In *Section 3*, we describe and identify key considerations for developing the seven (7) core health system components based on the different approaches to achieving universal health care coverage outlined by UHC Work Group's Models A, B, and C. We then describe Washington's current level of preparedness to meet these core components.[2]

The UHC Workgroup Models: A Starting Place

In January 2021, the UHC Work Group released its final report identifying three (3) potential models for Washington to pursue universal health care coverage, as described in *Section 1*. Throughout this *Section 3*, and in each discussion of a core design component, the three (3) potential models are used as a starting point to frame the considerations for each design component. As shared in *Section 1*, the three (3) models proposed and evaluated by the UHC Work Group to achieve universal coverage included:

- **Model A:** State-governed and administered program for all state residents.
- **Model B:** State-governed and health plan administered program for all state residents.
- **Model C:** Access to coverage for undocumented residents unable to buy coverage, or "fill in the gaps coverage." This model could be expanded to include other uninsured or underinsured populations.

Table 1: Overview of Universal Health Care Work Group Models[3]

Model A	Model B	Model C
• Establishes a single, state-designed coverage plan available to everyone in Washington State. • The state develops the delivery system rules. • There is a standard benefits package. • No insurance companies participate as the state contracts directly with providers and administers all functions currently provided by insurers, including claims payment, utilization management, care coordination, and member and provider services.[4]	• Establishes a single, state-designed coverage plan available to everyone in Washington State. • The state develops the delivery system rules. • There is a standards benefits package. • Unlike Model A, in Model B insurance companies contract with the state to offer plans to Washington residents. As they do today, insurers may develop and maintain provider networks and administer some or all of the functions they currently provide, such as claims payment, utilization management, care coordination, and member and provider services.	• Designed to provide coverage to Washingtonians who are now uninsured. • Keeps the varied plans and coverage sources that exist presently. As in Models A and B, the state sets the program and delivery system rules, but carriers meeting participation requirements will provide coverage to eligible individuals. • The model is similar to Cascade Select, with insurers developing and maintaining their own networks and administering the functions they currently provide, such as claims payment, utilization management, care coordination, and member and provider services.

[2] ***Section 4* to be populated in a later draft for the Commission.**

[3] Each of these models, their costs estimates and impacts, and savings (if applicable) are described in *Section 1* of this report.

[4] In some universal health care systems, such as Canada, supplemental insurance could cover services not included in the standard benefit package.

It is important to recognize that under Model B, there are a range of options for which functions could continue to be performed by health plans and which could be performed by the state. For example, Washington could contract with health carriers to provide coverage to residents. Alternatively, Washington could directly contract with providers rather than delegating that responsibility to health carriers, while leaving carriers responsible for more administrative processes such as utilization management and claims payment. In addition, the state could choose to manage more of these responsibilities over time. In this way, Model B could provide a transition to Model A.

Core Component 1: Eligibility & Enrollment

Under any model to achieve universal coverage, it will be necessary to determine who will be eligible for the program and develop a process for enrollment. A primary goal of adopting a universal health care system is to extend coverage to those who are currently uninsured such as individuals who cannot afford commercial coverage or individuals ineligible for Medicaid or federal subsidies due to their immigration status. Under either universal health care model, state-administered or multi-plan, state-governed models (Model A or B), all Washington residents could potentially be determined eligible for the program. It would be necessary to determine several eligibility considerations, including:

Key Considerations – Eligibility & Enrollment

- Eligibility for certain populations such as the following:
  - Washington residents
  - Out-of-state residents working for Washington employers
  - Opt-in options for people covered by Employer-Sponsored Insurance, self-funded plans, Federal Employees Health Benefits, Veterans Health Administration
- Data and information needed to determine eligibility
- Eligibility and enrollment processes

- Would out-of-state residents who work for Washington employers be eligible?
- Would employees who work for national companies and live in Washington be allowed to keep their coverage or be required to enroll in the universal system?
- Would federal employees be covered by federal programs such as Federal Employees Health Benefits and the Veterans Health Administration be eligible to opt into the system?
- Would individuals with fully-insured employer-sponsored coverage be eligible to opt in?
- Would individuals with self-funded employer-sponsored coverage be eligible to opt in?
- Would Medicare beneficiaries be included in the program?
- Would the definition of meeting residency requirements for health insurance coverage differ from the current standard of residency determination for the state?[5]

Under Model C, eligibility could be expanded through new programs to populations who are currently uninsured due to a variety of factors, such as income levels, immigration status, lack of eligibility for subsidies, lack of ability to afford employer sponsored insurance, and other factors that pose barriers to

[5] Washington Department of Revenue. State residency definition. https://dor.wa.gov/contact/washington-state-residency-definition#:~:text=Persons%20are%20considered%20residents%20of,a%20temporary%20or%20transient%20basis.

coverage under the current system. In this model, minimal changes would occur to the current system of coverage.

Information for Determining Eligibility

To maximize coverage and make eligibility determinations as simple and seamless as possible, it will be important to consider options to minimize the amount of information needed to determine eligibility. Under Model A or B, the best approach may be a streamlined process that collects the minimum information necessary to verify eligibility for health coverage while simultaneously collecting the data needed to maintain compliance with federal regulations for the Medicaid, Medicare, Exchange subsidies and other federal programs to ensure ongoing contribution of federal funds. Similarly, setting up processes to validate continued eligibility will reduce costs for maintaining coverage when individuals are no longer eligible for federal programs. Under Model C, the process for determining and redetermining eligibility for the expanded populations would likely be comparable to processes that exist today for determining eligibility for public health care programs and Exchange subsidies.

Eligibility and Enrollment Process

Under each of the models (A, B or C), once a person is determined eligible, they would be enrolled into coverage. Under state-administered universal health care (Model A), enrollment could be relatively simple, and auto-enrollment could be used to streamline and maximize enrollments. For example, anyone who currently has coverage under private insurance, or a government program could be auto enrolled into the program. Individuals without coverage could be auto enrolled when they seek health care services, file tax returns, or apply for other government programs such as the Supplemental Nutrition Assistance Program (SNAP). In other countries that have adopted single-payer models such as the United Kingdom, individuals are automatically determined eligible at birth, when residency is established, or when a resident registers with a primary care provider.[6]

Under Model B, (the version that involves insurance companies contracting with the state to offer plans to Washington residents), individuals transitioning from private insurance to the state program could be auto enrolled into a comparable plan, with the option to change coverage. This would be similar to current Exchange re-enrollment processes when an individuals' plan is cancelled, and the Exchange auto enrolls consumers into the most similar version of a plan available.

Under Model C, individuals could choose a plan by a process similar to what currently exists today through Washington Healthplanfinder. Once an individual is determined eligible for either Apple Health (Medicaid) or subsidies, they are prompted to select a plan from the available options.

[6] National Health Service. (2022). What is an NHS Number? https://www.nhs.uk/using-the-nhs/about-the-nhs/what-is-an-nhs-number/.

Core Component 2: Covered Benefits & Services

Key Considerations – Covered Benefits & Services

- Covered benefits and services
  - Essential Health Benefits
  - Adult Dental to be determined
  - Vision to be determined
  - Benefits mandated by Medicaid
- Cost-sharing for services including premiums, co-pays, and coinsurance
- Development of a single drug formulary or standard drug formularies and how they would impact current programs and the Washington Prescription Drug Program
- Benefit package oversight
- Utilization management and prior authorization requirements

Each of the coverage models (A, B, and C) will involve examining what benefits and services will be covered by the model. The UHC Work Group report assumed that the benefits provided under Models A and B will be equivalent to Washington State's Essential Health Benefits (EHB) mandated by the ACA, which includes behavioral health services. In general, UHC Work Group members discussed the need for a benefit package that improves health and is attractive enough to keep participants enrolled without a mandate to participate in the universal health system. Additional benefits mentioned include dental and hearing, for both adults and children. Model C is the least burdensome approach; the benefits provided would vary depending on the program and plan a person is enrolled in but would be similar to plans offered on the exchange and/or Cascade Care today. For all three (3) models, it is important to consider whether additional benefits may be required to advance quality and equity goals such as social support services and culturally responsive care and services. For example, Apple Health (Medicaid) provides some benefits that are not included in EHB such as Long-term Services and Supports and transportation to non-urgent medical appointments. Some of these services are required by federal Medicaid law, while others are required by state law.[7] These additional services could be provided to all Washingtonians (paid for by the state for those who are not Medicaid-eligible) or there could be a mechanism to make sure that everyone who would otherwise be eligible for Medicaid will receive these additional services.

Washington has a long history of transparent, evidence-based decision processes to inform what benefits/services are covered in state-purchased health care programs. For example, health technology assessments are conducted by the independent Health Technology Clinical Committee and serve Washingtonians by ensuring that certain medical devices, procedures, and tests paid for with state dollars are safe and proven to work.

Administration of the benefit package will also be a critical area of consideration. Establishing who will govern how the benefit package would be regularly updated and adjusted based on new evidence to ensure the required benefits adapt over time to improve the quality and lower the cost of care within

[7] Another state program that may need to be considered is the Washington CARES Program. Washington CARES is the state's new long-term care benefit, created and signed into law by the Governor in 2019. The program is funded by a payroll tax of up to $0.58 per $100 and has a lifetime benefit of up to $36,500. Premium collections (via the payroll tax) have been delayed until July 2023 and there continue to be ongoing legal challenges to the tax.

the universal health care system. This is particularly important for Models A and B, because once established these benefit packages would need to regularly be examined and updated.

Pharmacy Benefits

Under Models A and B, there could be a single drug formulary that would apply to all individuals in the program. The drug formulary developed under this program will need to align with any federal Medicaid and Medicare requirements. The Washington Prescription Drug Program provides prescription information and assistance for the residents of Washington. As a part of this program, Washington State has partnered with Oregon since 2006 to create the Northwest Prescription Drug Consortium which allows state agencies, local governments, businesses, labor organizations, and uninsured individuals to pool their purchasing power to gain bigger discounts on prescription drugs. This and the work of the Prescription Drug Cost Transparency Board and the Prescription Drug Affordability Board will both need to be included in the consideration of single drug formulary.

Currently, individuals who are enrolled in Apple Health managed care or in commercial coverage are subject to the utilization management and prior authorization policies and procedures of their carrier. Under ~~Models B and~~ C, this is not likely to change. Under Model B, the state could focus on efforts to align these processes and requirements across payers and programs. Model A will require examining utilization management and prior authorization processes and determining how the state-administered plan would conduct these activities.[8]

Core Component 3: Financing

Under Washington's current health care system, there are multiple sources of funding that pay for health care. The funding sources that pay for an individual's health care will govern the specific benefits individuals receive, the providers they can see, and how much they ~~must~~ pay out of pocket. A primary goal of the Universal Health Care Commission is to develop a plan for a unified financing system that will simplify or minimize these differences and lead to greater access, higher quality, and increased equity for all Washington residents.

Key Considerations – Financing

- Role of federal funding sources such as Medicaid, ACA subsidies, and Medicare
- Role of state funds such as general funds and taxes
- Role and appropriateness of consumer cost-sharing

To achieve this goal, the different sources of funding must be combined to the greatest extent possible. This begins with assessing which sources will be continued or potentially eliminated due to the structure of the unified health care financing system and identifying potential new sources of funding to ensure coverage can be extended to all Washington residents. This financing subsection outlines the complex issues and decisions related to different financing sources to consider in designing a universal health care system. *Section 7* of this report details specific considerations and processes for the Commission to establish a finance committee specifically tasked with addressing these financing questions and considerations.[9]

[8] ***Section 4* to be populated in a later draft for the Commission.**
[9] **Section 7 to be developed in a later draft for the Commission.**

Federal Funding Sources

The federal government is responsible for the greatest share of health care spending, at 36.3% in 2020.[10] This estimate includes all federal sources including Medicaid, Medicare, coverage for federal employees, and active and retired military. As described in the UHC Work Group Report, the three (3) models assume that all sources of federal funding, such as the federal funding of the Medicaid program and Medicare funding would be preserved to pay for health care costs and administration.
Model C presents the least challenges with respect to retaining federal funding, since the existing federal programs including Medicare, Medicaid, ACA subsidies, tax deduction for employers' contribution to health care, either insured or self-funded remain the same. However, making changes to the current financing system are considerably more complex for Models A and B. Notably, each of the models will require additional state funds to implement. Possible sources to fund these models are described in the following subsections including Medicare funding, Medicaid funding, ACA subsidies, employers, taxes, other sources of insurance, and other revenue sources.

Medicare Funding

There are a number of legal challenges that need to be analyzed and considered to include Medicare funding under either Model A or Model B. The decision to pursue or not pursue inclusion of Medicare into the unified health care financing system development is complex and requires a thorough examination of the regulatory and legal issues and understanding of the Medicare program. The Medicare program consists of several primary components:[11]

- **Medicare Part A** is financed primarily by a payroll tax that employers and employees pay into the Medicare Hospital Insurance Trust Fund. Part A covers inpatient hospital stays, skilled nursing facility stays, some home health visits, and hospice care.
- **Medicare Part B** is financed primarily through a combination of general revenues and beneficiary premiums, deductibles and copays. Part B covers physician visits, outpatient services, preventive services, and some home health visits.
- **Medicare Part C** (Medicare Advantage) is Medicare's managed care program delivered through contracted health plans.[12] Medicare Advantage plans are financed by monthly payments from the federal government based on bids submitted by the plans and monthly premiums.
- **Medicare Part D** is financed primarily by general revenues, beneficiary premiums and state payments for beneficiaries dually eligible for Medicare and Medicaid. Part D covers outpatient prescription drugs.

A key to maintaining a large portion of federal funding is determining if and how Medicare dollars can be used. An important threshold topic for consideration under either Model A or Model B is whether Medicare funding can be used to pay for health care costs for people not eligible for the Medicare

[10] Centers for Medicare and Medicaid. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet Note: This figure does not take into account the federal income tax deductions for employer and individual's health care spending.
[11] For more information on Medicare programs, see Kaiser Family Foundation. (2019). *An overview of Medicare*. https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/?msclkid=c46e7ab3b3bd11ecb53ed918624357e3
[12] For more information on Medicare Advantage, see Kaiser Family Foundation. (2019). *Medicare Advantage.* https://www.kff.org/medicare/fact-sheet/medicare-advantage/

program. While this may be considered in more detail in the future, it may be likely that Congress will need to pass legislation for these changes to be possible.

The Medicare Part A Trust Fund is projected to be fully depleted in 2026, which raises the question of whether it would be practically and politically viable to provide for the use of this fund to pay for non-Medicare beneficiaries. One other significant consideration under Model A or Model B is whether beneficiaries would continue to have the option to choose "traditional" Medicare, which is administered by the federal government, or to enroll in a Medicare Advantage plan under Medicare Part C. Some states, such as Oregon, have discussed that a single payer entity could function like a single Medicare Advantage plan that would be offered only to Medicare eligible individuals.[13] This would likely keep the Medicare funding sequestered out of other pooled funding which may make it easier to use Medicare funding, because the funding would not be used to fund non-Medicare eligible people.

Medicare Part D, the prescription drug benefit administered by private plans, is another potential source of funding for consideration. This program is financed primarily by general revenues, beneficiary premiums and copays, and state payments for beneficiaries dually eligible for Medicare and Medicaid. To utilize funds from this program, Medicare's integrated funding would need to be examined in great detail, especially if the new unified financing system offers a single drug formulary.

The UHC Work Group report assumes that under Model A or Model B there would be a single provider fee schedule for all care and that the rates would be higher than currently paid by Medicaid and Medicare, but that the rates would be lower than what is currently paid by commercial insurers. There are significant legal and regulatory issues around whether the federal government would be willing and able to contribute to the additional costs that would be incurred for care provided to those currently in the Medicaid and Medicare programs, including the higher reimbursement rate. There are also similar questions as to whether or not if rates were lower and potential federal savings incurred, the federal government would be willing to share the savings.[14]

The UHC Work Group report acknowledged the challenges in including Medicare funding and suggested that it might be possible to keep Medicare enrollees in their current coverage under Models A and B. The goals of universal coverage could still be met if the Commission followed this approach for two reasons. First, most providers currently accept Medicare patients and are accustomed to billing under the program. Second, the costs of administering the program are borne entirely by the federal government, so the state may not realize any savings by including it. Finally, as discussed in the UHC Work Group Report, it may be a more financially viable approach to implement because health care needs generally increase with age, resulting in higher per capita costs. Keeping Medicare enrollees in their current coverage rather than including them in the universal health care program would mean that the universal health care program would cost less on a per capita basis.

Utilizing an approach with Medicare distinct from the unified financing system would greatly simplify the legal and administrative obstacles to achieve universal coverage under Models A or B. In addition, as the UHC Work Group report notes, if Medicare reimbursement rates are left as they are, the rates

[13] Rand Corporation. A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon. https://www.rand.org/pubs/research_reports/RR1662.html

[14] These questions are best answered by seeking ~~obtaining a~~ legal guidance ~~opinion~~ and through conversations with the federal government about what is possible via waivers and what might ~~be~~ require federal legislation.

payable by the rest of the program could be higher as a percentage of Medicare rates because of the unrealized per capita savings of not including this population. See Table 2 below (from the UHC Work Group analysis) for more information about the financial impacts as seen through provider reimbursement rates of including or excluding Medicare in rate development.

Table 2: reimbursement level target before efficiency adjustments[15]

Service category	Reimbursement as a % of Medicare when Medicare is included in Model A	Reimbursement as a % of Medicare when Medicare is excluded in Model A
Hospital services	125%	150%
Physician and clinical services	111%	114%

Medicaid Funding

Washington's Medicaid program, Apple Health, which currently serves nearly 2,000,000~~two million~~ Washington residents, is funded by the state general fund and federal matching funds. Eligibility for Apple Health is primarily based on income and most beneficiaries have managed care, where the state pays managed care organizations a monthly premium which pays for all health services provided by the program. Both federal and state law mandate what services must be provided under the program.[16]

Including Medicaid funding as a revenue source for a unified financing system is complex, but less complicated than Medicare because there is an established process and experience with states seeking and obtaining Medicaid flexibilities, which is not the case with the Medicare program. To use existing federal Medicaid funds as a revenue source for the unified financing system, it would be necessary to obtain a waiver from the Centers for Medicare and Medicaid Services (CMS) under Section 1115 of the Social Security Act. Section 1115 gives the Secretary of the Department of Health and Human Services authority to approve experimental, pilot, or demonstration projects by states that are found to be likely to assist in promoting the objectives of the Medicaid program. This authority has been used frequently by states, including Washington. Washington's current 1115 waiver, the Medicaid Transformation Project, is in effect until December 31, 2022, unless CMS authorizes further renewals or extensions.

The two (2) primary ways that a unified health care financing system would promote the objectives of the Medicaid program, which could be included in support of a potential waiver application are: 1) this change is likely to increase the number of individuals with continuous access to health care, and 2) this is likely to increase the number of providers willing to serve Medicaid enrollees. If the process for enrollment and determining eligibility is simplified, then more Medicaid-eligible individuals should be covered. In addition, some individuals inevitably fail to obtain new coverage as individuals gain and lose eligibility for Apple Health due to changes in income or employment status more. A unified health care financing system could eliminate or greatly reduce this on/off program cycle, which would result in more people having continuous health care coverage~~.~~

Secondly, the UHC Work Group Report assumed that under Model A or Model B there would be a single fee schedule for provider reimbursement with rates higher than what Medicaid currently pays. This

[15] Universal Health Care Work Group Report, January 2021

[16] For more information on Medicaid funding, see Snyder, L., Rudowitz. R., (2015). *Medicaid Financing: How Does It Work and What Are the Implications?* Kaiser Family Foundation issue brief. https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/

should result in more providers being willing to serve people who would otherwise be eligible for Medicaid, which in turn is likely to reduce the disparities and inequities in access to care.

ACA Subsidies

Under the ACA, the federal government provides subsidies in the form of tax credits to help individuals and families pay premiums for health care coverage provided by health plans. Eligibility is determined by income. As with federal Medicaid funding, Washington would need an ACA Section 1332 waiver from CMS to enable the unified health care financing system to include people who otherwise would receive subsidies under the ACA in the new program. This would also shift ACA tax credit funding that is currently provided to individuals and families to the unified health care financing system.

The ACA contains certain "guardrails" that must be satisfied for a Section 1332 waiver to be granted. The changes requested by a state must result in health care coverage that is as comprehensive, affordable, and covers as many individuals as under the current system. In addition, the changes must not increase the federal contributions. It is possible to demonstrate that these guardrails would be met under either Model A or Model B. Additionally, coverage would include all of the Essential Health Benefits mandated by the ACA, and therefore would be as comprehensive. Coverage could be more affordable, although the state would have to demonstrate that any additional taxes on individuals and families would be lower than what they currently pay for health care. As discussed above, more people would be covered by the new program, primarily because people would not lose coverage as they move from one source of coverage to another. In addition, Section 1332 of the ACA authorizes waiver of certain provisions and provides that requests for waivers under Sections 1115 and 1332 may be combined in a single application. Both 1115 and 1332 waivers must be "budget neutral" to the federal government, which means that during the course of the waiver period, federal expenditures must not be more than it would have been without the waiver.

Other Revenue Sources

To address any gaps in funding because of the transition to a unified financing system, additional funding could be raised through a combination of taxes on businesses and individuals. However, it is important to acknowledge that any discussion about additional taxes and how that tax is collected should take into account the equity impact of the proposed tax on different populations. Under Model C, most sources of funding would remain the same.

Other Revenue Sources: Business Taxes

There are two (2) types of business taxes that are generally considered as potential sources of revenue for funding a universal health care system. The first, is a tax on business activity, such as Washington's Business and Occupations tax, which is a gross receipts tax measured on the value of products, gross proceeds of sale, or gross income of the business. The second is a tax on payroll (either based on the number of employees or the amount of wages paid), such as the federal taxes that currently fund the Medicare program and the state taxes that currently fund state unemployment, the workers' compensation system, and the ~~recently enacted~~ tax that will fund Washington's new long-term care program, Washington CARES.[17]~~.~~

[17] The implementation of this tax has been delayed until July 2023. https://wacaresfund.wa.gov/about-the-wa-cares-fund/.

It is important to note that under current law, employer contributions to employees' health care premiums are deductible from federal income tax. This represents a significant subsidy from the federal government toward the cost of health care. To maintain the benefit of the current tax deduction for employer health care expenditures, the best approach would be to ensure that either type of tax imposed could be deducted from federal taxes.

Individual Taxes

There are two (2) types of taxes that could be considered as sources of revenue for this type of program. The first is a payroll tax. The second is a sales tax (including taxes on certain types of products that are deemed harmful to individuals or society, such as cigarettes and alcohol).[18]

Sales taxes could be a source of revenue for the program. However, sales tax is complex and if not applied to prevent regressive taxation, it could have a burdensome impact on low-income populations. Sales taxes could be regressive if the taxes take a larger percentage of income from low-income taxpayers than from high-income taxpayers. One way to avoid the disparate impact of these taxes is to exempt necessities such as food from the sales tax, as Washington currently does.

A payroll tax, which currently funds the Medicare program, may be more feasible to implement because it involves less administration. A payroll tax could be imposed only on wages over a certain level which would reduce the possibility of a disparate impact. This would also ensure that those who currently receive subsidies or Medicare do not experience an increase in their cost of health care services. ~~It would also be necessary to consider the impacts of a progressive tax which would fall more heavily on those earning higher incomes.~~

Employee Retirement Security Act (ERISA)

The federal Employee Retirement Security Act (ERISA) sets minimum standards for health plans established and funded by employers to provide health care to their employees. These "self-funded" or "self-insured" plans place the obligation of paying for health care costs directly on the employer and the employer bears the financial risks associated with that obligation rather than an insurance company. The ERISA statute exempts these plans from most state regulations.[19]

~~I~~If the federal government makes changes to ERISA that would enable states to wrap employer coverage into a state-based unified health care financing system, it will be necessary to consider whether employers would be able to continue to provide coverage to their employees through self-insurance. It is possible that if a tax is imposed on employers to pay for the program, employers would be discouraged from remaining self-insured. An alternative approach would be to allow employers to ~~continue to be~~remain self-insured, while giving employees the option of enrolling in the state coverage rather than in the employer-sponsored coverage.

[18] Because Washington state does not have an income tax on individuals, this method of taxation has not been considered. However, an income tax is typically easier to administer.

[19] For more information on ERISA, see National Association of Insurance Commissioners. (2019). Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation. https://content.naic.org/sites/default/files/publication-ers-om-health-welfare-erisa.pdf?msclkid=93e40b08b3c111eca359435da84df82c

Other Sources of Insurance

It may be beneficial to examine whether health services that are currently paid for by other sources of insurance, such as liability insurance and by the workers' compensation system, would continue to be covered by those programs. In the alternative, the amounts paid into those systems could instead be paid into the unified health care financing system.[20]

[20] ***Section 4*** **to be populated in a later draft for the Commission.**

Core Component 4: Provider Reimbursement and Participation

One of the more challenging elements in designing a universal health care system is developing an approach to provider reimbursement that will ensure providers want to participate in delivering care and services to Washingtonians through this system. This will involve considering how reimbursement rates will be set and how to encourage alternative payment models that may provide incentives for higher quality care and lower costs. Rate setting processes could be applied broadly in a unified financing system or more narrowly for specific programs and providers. Rate setting affords the state the opportunity to ensure that providers are adequately reimbursed to encourage provider participation in the universal health care system, control costs within the system; drive improvements in the quality of care delivered within the system; and ensure equitable access to providers and services.

Key Considerations – Provider Reimbursement and Participation

- Provider reimbursement methods
  - Centralized rate-setting and single fee schedule
  - Negotiated rates
  - Value-based payment
- Provider participation requirements and incentives

~~This~~ A range of rate-setting approaches could~~an~~ be considered depending on the overall universal health care model. For example, ~~for countries like~~ the United Kingdom, and, for certain components of Canada's health system, providers are contracted with or directly employed ~~or contract with providers~~. ~~Other countries~~On the other hand, ~~such as~~ France, Germany, Switzerland, Netherlands, and Japan, have established centralized rate-setting for provider reimbursement.[21] This approach is intended to control total health care costs across sectors of the health care system that may be financed by private payers or different government programs.

It is possible that a more phased-in approach that preserves existing frameworks for rate setting, or provider contracting could be appropriate for advancing goals of universal health care. The approach may be easier to initiate and could enable adoption of a universal care model sooner than a non-phased in approach.

Both Models A and B ~~provide for~~include a single fee schedule that would establish rates for all health care services. One method for accomplishing this would be to set rates at a percentage above the Medicare fee schedule. The UHC Work Group report discussed a single fee schedule which would establish rates that are lower than current commercial rates, but higher than what Medicaid and Medicare pay. The report notes that approval from CMS would be needed for these federal programs to pay different rates than what they pay currently.[22]

Under Models A and B, rates would be set by Washington through an administrative process similar to Apple Health's fee-for-service provider payments today. Under Models A and B, it may be possible to set rates for individual health care services, rather than setting rates at a percentage above Medicare for all

[21] Commonwealth Fund. (2017). *International Profiles of Health Care Systems*. https://www.commonwealthfund.org/publications/fund-reports/2017/may/international-profiles-health-care-systems

[22] This could have implications for meeting budget neutrality under Sections 1115 and 1332 of the Social Security Act. Assuming that these provisions could not be changed, and no additional federal funds could be obtained in order to pay the higher rates provided for by Washington's single fee schedule, the state may have to provide additional revenue in order to pay the higher rates.

services. A range of possible options exist under Model C which would not necessarily require changes to the current system of rates, ~~and~~ provider reimbursement, or provider participations. ~~In this model, providers would continue to have the choice whether to participate in each of these systems.~~ However, the State could also choose to more actively regulate provider reimbursement and provider participation for existing programs.

~~However, t~~The state of Maryland provides an example of how centralized rate-setting could be applied under a multi-payer system. Maryland, through its Health Services Cost Review Commission, sets rates for all hospitals in the state across all payers, allowing the state to slow the growth of hospital costs across the state.[23]

There are additional considerations when evaluating provider reimbursements such as whether reimbursement will be provided directly from the state or through carriers. Cost reduction and transparency measures are additional considerations, such as the newly established Health Care Cost Transparency Board, and how these measures will assist in the future approach to provider reimbursement.

Value-based Reimbursement

Universal health care delivered through a single payer model or incremental model can create opportunities to shift away from fee-for-service to more value-based methodologies of reimbursement. Under these arrangements, providers can receive additional payments or accept down-side risk to provide care and services to certain standards. It may be helpful to establish a process to identify and prioritize target metrics for which providers will be accountable and establish a methodology for collecting data and assessing whether providers have met the target thresholds.

Through value-based reimbursement, Washington can incentivize a range of provider behaviors. For example, this may include reducing disparities for vulnerable populations or improving the treatment for individuals with high priority conditions such as diabetes and substance use disorders. This may also manage costs by reducing ~~preventable~~unnecessary utilization of health care services. Model A could utilize alternative payment models, similar to what the Centers for Medicare and Medicaid Innovation currently employs. Washington already applies value-based reimbursement strategies through multiple initiatives and programs. For example, currently offering a Cascade Public Option plan must confirm that at least 30% ~~percent~~ of provider contracts include value-based payment arrangements.[24] The HCA's Value Based Purchasing Roadmap for 2022-2025 sets forth priorities and goals for value-based purchasing to contain health care costs while improving health care outcomes, including having 90% ~~percent~~ of state-financed health care (Apple Health, PEBB and SEBB) payments in VBP arrangements by the of 2021.[25] To monitor progress towards this goal, HCA conducts an annual survey of providers and payers to gather information about participation in VBP. The results of the 2021 survey (using 2020 data) found that 77% ~~percent~~ of state-financed health care is in VBP arrangements. While short of the 85% ~~percent~~ benchmark for 2020, this was an increase from 2019 when only 62% ~~percent~~ were in VBP arrangements. Looking at other payers, the survey found that 59% ~~percent~~ of commercial health care

[23] Maryland Health Services Cost Review Commission. (2022). Hospital Rate Setting. https://hscrc.maryland.gov/Pages/rates.aspx

[24] Public Option Institute. (2020). https://www.publicoptioninstitute.org/feed-wa-implementation-materials/summary-of-washington-state-gov-inslees-letter-on-implementation-of-cascade-care

[25] VBP Roadmap. (https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf

and 80% ~~percent~~ of Medicare Advantage were in VBP arrangements in 2020. The HCA Roadmap and the annual survey ~~is~~ can serve as a helpful framework for the consideration of value-based reimbursement and as a benchmark for where Washington can further these efforts.

Encouraging Provider Participation

One (1) consequence of a fragmented health care financing system is that provider reimbursement rates can vary widely depending on the payer. This can be particularly challenging for Medicaid programs which tend to offer lower provider rates than the commercial insurance market or Medicare.[26] This differential in reimbursement rates can lead to limited provider participation in Medicaid and consequently can impact access for Medicaid enrollees.

Reducing the differentials in provider reimbursement is likely to encourage providers to participate in delivering care to all populations and may reduce health care inequities. Under Models A, B and C, there are opportunities to reduce differences in provider reimbursement. Under Models A and B, if rates were set under a single fee schedule across a broader population base, more providers may be incentivized to participate. Some single-payer health systems, such as Indonesia,[27] also actively reimburse at higher rates for providers in underserved communities and regions. This ~~tactic~~strategy might also be considered to attract and retain health care workers where there are significant workforce shortages.[28]

Under Model C, adjusting reimbursement rates may require a centralized rate-setting structure to ensure ~~more even~~similar rates across existing payers and programs. Providers could be required to participate in Medicaid or other programs as a condition of participation in other markets or programs. Additionally, under Model C, the state could remove potential barriers to participation by aligning value-based payment, quality initiatives, and administrative processes across payers.

Additional strategies could be considered to encourage provider participation. For example, the universal health care program could require providers to accept patients under the program and potentially cap rates or services provided outside of the program.[29]

Core Component 5: Cost Containment Elements

One of the critical goals in establishing a universal health care system is to hold the total cost of health care below the growth benchmark established under the work of the Health Care Cost Transparency Board. Many of the design elements described in the provider reimbursement and benefits subsections constitute critical strategies for containing costs. For example, maintaining a benefit package that standardizes high-value benefits and services across all participants, setting provider rates for individual services, and encouraging value-based payment arrangements can all work toward lowering costs of care while improving the quality of care delivered. However additional design elements could assist with containing total costs. These cost containment measures include examining fraud, waste and abuse, utilization management, setting cost growth benchmarks, and global budgeting.

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[26] Holgash, K., Heberlein, M. (2019). Health Affairs Forefront article. https://www.healthaffairs.org/do/10.1377/forefront.20190401.678690/full/

[27] World Health Organization. (2003). The World Health Report 2003: Shaping the Future. https://www.who.int/whr/2003/en/whr03_en.pdf?msclkid=cd46b569b42011ec98bd5ef5e0ad5a91.

[28] 2021 Paying for Value Survey Results. https://www.hca.wa.gov/assets/program/2021-p4v-survey-exec-summary.pdf

[29] ***Section 4*** **to be populated in a later draft for the Commission.**

Fraud, Waste, and Abuse

One (1) path to reducing cost throughout the health care system is to drive down utilization due to fraud, waste, and abuse. Nationally, the cost of fraud, waste, and abuse may constitute as much as 10% of total health care costs.[30] Drivers of fraud, waste, and abuse include duplicated procedures or failures to coordinate care, overtreatment, overpayment, and fraudulent acts by providers or patients.[31]

There are system-wide approaches for addressing fraud, waste, and abuse. As the UHC Work Group noted, a single data set for claims or episodes could exist under Models A and B (paired with advanced analytic methods used today by the federal government, state Medicaid programs, and commercial payers). The data set creates opportunities to detect indicators of fraud, waste, and abuse and intervene to prevent future utilization from occurring or recoup costs for improper utilization.

Utilization Management

Utilization management is a core function for most commercial insurance plans, Medicaid managed care organizations, and Medicare Advantage plans. Utilization management is used to reduce inappropriate or unnecessary utilization of health care services. Utilization management typically involves the monitoring of utilization, the identification of high utilization individuals, and intervention to reduce high utilization in the form of care coordination, consumer education, or other methods. Utilization management may also include prior authorization requirements for certain types of services. Some single-payer systems, such as England, Canada, and Taiwan have developed utilization management programs to reduce the cost of care while maintaining quality goals.[32]

Under any of the universal health care models, it will be helpful to consider whether utilization management is an appropriate design element to assist with achieving the state's goals for cost containment. A particularly important consideration will be how certain utilization management controls, such as prior authorization can be utilized to reduce high utilization. Under Model B or C, utilization management could be delegated to participating carriers with requirements for administering utilization management.

Setting Cost-Growth Benchmarks

In 2020, Washington created the Health Care Cost Transparency Board to identify health care cost trends, set a cost-growth benchmark, and develop recommendations to reduce health care costs. As of September 2021, the Board has approved a cost growth benchmark of three point two percent (3.2%) for 2022-23, three percent (3.0%) for 2024-25, and two point eight percent (2.8%) by 2026.[33] Washington's benchmark aligns with other states' cost-growth benchmarks, such as in Oregon, Connecticut, Delaware, Massachusetts, and Rhode Island.[34] The HCCTB is also responsible for identifying

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[30] U.S. Department of Veterans Affairs. (2022). About Fraud, Waste, and Abuse. https://www.va.gov/COMMUNITYCARE/about_us/POI/poi_fwa.asp#:~:text=Impact%20of%20Fraud%2C%20Waste%2C%20and%20Abuse%20The%20National,high%20as%2010%25%20per%20year%20or%20%24300%20billion.?msclkid=749dea44b4cc11ec9f5b87f0640262ec.

[31] Lallemand, N. (2012). Reducing Waste in Healthcare. Health Affairs Health Policy Brief.

[32] Commonwealth Fund. (2017). *International Profiles of Health Care Systems*.

[33] Washington State Health Care Authority. Health Care Cost Transparency Board. September 14, 2021, Meeting Minutes. https://www.hca.wa.gov/assets/program/board-meeting-summary-20210914.pdf

[34] Block, R. & Lane, K. (2021). *Supporting States to Improve Cost Growth Targets to Improve Affordability.* Health Affairs. https://www.healthaffairs.org/do/10.1377/forefront.20210526.658347/full/

providers and payers whose cost growth exceeds the benchmark. The universal health care system should hold the total cost of health care below the growth benchmark established by the HCTTB and is a starting place for additional cost-containment efforts in the future.

Global Budgeting

Some single-payer health care systems have adopted global budgeting as a way to incorporate caps on the system-wide growth of health care costs. For example, England sets a global annual health care budget that is then allocated to local organizations that pay for care within their jurisdiction.[35] Taiwan negotiates an annual global budget with key stakeholders for major health care services and allocates the budget across six (6) regions.[36] Under Model A or B, a similar global budget could be established and then adjusted annually to account for growth in need for health care services and for system performance (e.g. if provider rates are insufficient to encourage participation or benefits are too narrow to encourage individuals from participating).

Global budgeting can also be applied to individual providers as a strategy for provider reimbursement. For example, Maryland, as part of its hospital rate-setting program, establishes a global budget for each hospital that caps the payment it can receive from all payers. The Maryland hospital rate-setting program was originally established in the 1970s as a way to control hospital costs on a fee-for-service basis. Over time, the program has evolved to become an all-payer value-based hospital reimbursement model governed by the Maryland Health Services Cost Review Commission aimed at managing total cost of care and improving quality outcomes at a population level. In it current form, each hospital's ~~The~~ global budget is based on the projected needs of the population served by each hospital.[37] However, in establishing a global budgeting model, a critical consideration is whether providers are prepared to bear the financial risk if their costs exceed the global budget.[38]

Core Component 6: Infrastructure

As the Commission moves from planning into implementation, the governing agencies and partnering stakeholders will need to address a broad range of operational considerations. This includes assessing what structures and processes will remain, and what systems need to be upgraded or modified. These considerations are highly dependent on the overall strategy pursued and the readiness to implement the strategy.

[35] Ibid
[36] Ibid
[37] Mathematica. (2021). Independent Evaluation of the Maryland Total Cost of Care Model. https://innovation.cms.gov/data-and-reports/2021/md-tcoc-imp-eval-report?msclkid=1a334a44b38f11eca5626a4a717ba358
[38] ***Section 4*** **to be populated in a later draft for the Commission.**

A key driver of implementation complexity will be the technology infrastructure necessary for executing the universal health care strategy. For example, each model will require technology investments for consumer-facing functions such as eligibility and enrollment; consumer assistance; and consumer outreach. To support administrative functions, investments could be needed to issue payments to providers or health plans; manage health care utilization; and monitor fraud, waste, and abuse.

Related to the technology infrastructure are considerations regarding data sharing and data management. The infrastructure necessary to share data across all participants in the universal health care system is critical for ensuring that the program objectives for health care quality, financial performance, population health, and health equity are met on multiple levels for individual consumers, providers and payer organizations. In addition to the technology needed to support higher degrees of data sharing, infrastructure will be needed to establish data standards and common metrics, to analyze the data, and to report on outcomes.

Key Considerations – Infrastructure

- Examining what infrastructure can be re-used, delegated, or needs to be developed
  - Technology platforms
  - Human Resources to support existing and added functions
  - Administrative policies and processes
- Accountability for infrastructure investments
  - State investments needed
  - Model participant investments
  - Shared infrastructure investments

Human resources are another core consideration for the development of the model. Staffing needs will ~~need~~have to be assessed and managed, particularly for new state functions, such as rate setting or financial analysis. In addition to these core considerations, many operational decisions will impact the infrastructure needed during the implementation phase. Decisions regarding grievances and appeals, managing the administrative budget, procuring vendors, and contracting with participating providers will determine the infrastructure and systems that may need to be developed or if ~~or utilize~~ existing agencies could be utilized or reconfigured.[39]

Core Component 7: Governance

A strong governance model is critical for ensuring transparency and accountability. This ensures a voice is given to consumers, whose perspective is ~~be~~ essential to decision-making. In ensuring transparency and accountability, there will need to be clear roles and responsibilities for all participants in the process. Moreover, ensuring a governance model that is inclusive of diverse voices representing the populations most impacted by the new system will be a critical component in ensuring that the goal of health equity is~~are~~ realized.

[39] ***Section 4*** **to be populated in a later draft for the Commission.**

One (1) of the primary governance considerations in developing a universal health care system is determining which agency or agencies should administer the program. A single agency or a governance structure that consolidates functions and accountability across existing agencies could be created.

Key Considerations – Governance

- Accountability for administering and regulating programs
  - Single new state agency
  - Existing state agency or agencies
  - Combination of new and/or existing state agencies
- Accountability for transparent reporting

With one (1) agency providing oversight, many administrative functions could be streamlined. In addition, a single agency could facilitate and execute more coordinated strategies to meet the health care goals of the state. A consolidated structure, however, brings together existing resources but requires a strong governance model and robust communication and process mechanisms. Many countries that have adopted a single-payer model place principal accountability for operating the system under a single agency. For example, in the United Kingdom, the National Health Service oversees the health systems of each country.[40] Additionally, the state of Vermont, when it created its Green Mountain Care Board, consolidated a wide range of new and existing responsibilities pertaining to the management of health care costs.[41] While there is a wide range of benefits with single agency oversight, there is likely to be initial disruption to current functions and significant costs associated with the implementation.

Each of the universal health care models under consideration will necessitate different governance structures. For example, Model B would likely require less new administrative and regulatory responsibilities relative to Model A because some of those functions would be contracted to a carrier or carriers to perform. Under Model C, there would be no change to the existing structure.[42]

Summary

The objective of *Section 3* of this report is to describe the major areas of design components that are critical to developing, implementing, and maintaining a universal health care system and to identify key considerations within each area:

1. Eligibility and Enrollment
2. Benefits and Services
3. Financing
4. Provider Reimbursement and Participation
5. Cost Containment Mechanisms
6. Infrastructure
7. Governance

[40] Berry, N. (2015). *How does the NHS compare with health systems in other countries*? The Health Foundation. https://www.health.org.uk/sites/default/files/HowDoesTheNHSCompareWithHealthSystemsInOtherCountries.pdf?msclkid=4a54e776b29c11ec88e9119cc2af8b32.pdf

[41] Green Mountain Care Board. (2022). https://gmcboard.vermont.gov/board

[42] ***Section 4* to be populated in a later draft for the Commission.**

These core design components provide an operational framework to assess Washington's readiness and inform a strategy for implementing a universal health care system with unified financing and its ability to advance the goals for a universal health care system including containing health care costs, improving the quality of care, promoting health equity, and reducing health disparities.