Universal Health Care Commission meeting

October 12, 2023

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Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission
Meeting Materials

October 12, 2023
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting materials

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Tab 1

Washington State Health Care Authority

Universal Health Care Commission
AGENDA

October 12, 2023
2:00 p.m. – 4:00 p.m.
Hybrid Zoom and in-person meeting

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

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome and call to order	1	Vicki Lowe, Chair Executive Director, American Indian Health Commission for Washington State
2:05-2:10 (5 min)	Roll call	1	Mandy Weeks-Green, Manager Health Care Authority
2:10-2:15 (5 min)	Approval of Meeting Summary from 08/10/2023	2	Vicki Lowe, Chair Executive Director, American Indian Health Commission for Washington State
2:15-2:30 (15 min)	Public comment	3	Vicki Lowe, Chair Executive Director, American Indian Health Commission for Washington State
2:30-2:40 (10 min)	FTAC updates • ERISA guidance	4	Pam MacEwan, FTAC Liaison
2:40-2:55 (15 min)	Commission discussion on ERISA	5	Liz Arjun, Senior Consultant and Gary Cohen, Principal Health Management Associates
2:55-3:00 (5 min)	Last year in review for report development • Adoption of final report to the Legislature	6	Vicki Lowe, Chair Executive Director, American Indian Health Commission for Washington State
3:00-4:00 (60 min)	Planning for 2024 & transitional solutions	7	Liz Arjun, Senior Consultant and Gary Cohen, Principal Health Management Associates
4:00	Adjournment		Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State

Tab 2

Washington State Health Care Authority

Universal Health Care Commission Meeting Summary

August 10, 2023
Health Care Authority
Hybrid meeting held electronically (Zoom) and in-person at the Health Care Authority
2:00 p.m. – 4:00 p.m.

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

Members present

Vicki Lowe, Chair
Bidisha Mandal
Jane Beyer
Representative Joe Schmick
Representative Marcus Riccelli
Mohamed Shidane
Nicole Gomez

Members absent

Senator Ann Rivers
Dave Iseminger
Senator Emily Randall
Estell Williams
Joan Altman
Kristin Peterson
Stella Vasquez

Call to order

Vicki Lowe, Commission Chair, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

Chair Lowe began with a land acknowledgement and welcomed Commission members to the thirteenth meeting.

Meeting summary review from the previous meeting

The Commission members present voted by consensus to adopt the June meeting summary.

Public comment

Chair Lowe called for comments from the public.

Meike Weyrauch shared that people in Cowlitz county are increasingly facing barriers to accessing care and

encouraged the Commission to financially incentivize providers to practice in small and rural counties.

Madeline Bishop, retired state worker, supported Washington's universal health care (UHC) plan being based on the existing Uniform Medical Plan. The Commission should also identify the following: legislators to champion the UHC; a communications strategy to get legislation passed; and who will defend and fund any court challenges.

Lisa Gaynor, a widow and constituent of Cowlitz county, does not work for an employer that provides health care coverage. It has been challenging to find affordable health care coverage, let alone in-network providers who are taking new patients. People in Washington need easy, affordable health care coverage.

Ronnie Shure, President, Health Care for All – Washington (HCFA-WA), remarked on the difficulty of transitioning Medicaid enrollees into the new system due to potential differing levels of benefits. The Commission should build upon their work to address issues for low-income Medicare beneficiaries.

Cris Currie, (HCFA-WA), noted that a suggested draft vision for Washington's UHC is included in this meeting's written public comments. The Commission's agreement on an overall direction would facilitate the task of prioritizing transitional solutions and will give the Legislature and the public a clearer picture of the future UHC.

Warren George, former member of Oregon's Joint Task Force on Universal Health Care, announced that Senate Bill 1089 passed and was recently signed by the governor. The bill establishes a governing board for UHC in Oregon. The Commission was encouraged to refer to this meeting's written public comments for more information on nuances of single-payer systems.

Michael Hubbart, retired actuary, lived in the United Kingdom for several years and had a positive experience with their National Health Services (NHS). The greatest issue with the current U.S. health care system is the complexity. A single-payer system is simpler and may lead to improved health outcomes.

Emily Brice, Deputy Dir., Northwest Health Law Advocates, suggested the following transitional solutions for prioritization: continue to address undocumented immigrant health; fill gaps in benefits and affordability for Medicare enrollees; support efforts to unify health coverage to eligibility and enrollment systems; explore universal enrollment screening at key life transitions; work towards consolidation in state health care purchasing where doing so could expand access; study the state's prevalence of underinsurance across all markets; and explore opportunities to make care more affordable by pegging to the Medicare benchmark.

Mason Chittick shared that growing up, his family could barely afford the cost of medicine and treatment for his health conditions, and universal health care would have been very beneficial.

Commission member Mohamed Shidane thanked members of the public for their comments and shared his experience with health care costs. Though his employer provides health care coverage for employees, half of his paycheck is still spent on the cost of health care coverage for he and his family.

Robin Thayer remarked that the Kitsap County Board of Health declared a health care crisis in Kitsap County due

to shutdowns and takeovers of medical facilities by large, faith-based health systems, and health care plans not providing patients access to providers in the county in which they live.

FTAC updates: First discussion on Employee Retirement Income Security Act of 1974 (ERISA)

Pam MacEwan, FTAC Liaison

The Commission directed FTAC to examine pathways to include ERISA in Washington's universal health care system. FTAC's July meeting was focused on information gathering on ERISA issues both in Washington and at the national level. FTAC heard from two presenters. The first was Professor Carmel Shachar from the Harvard School of Law who provided an overview of ERISA, including the evolution of Courts' interpretation of ERISA preemption, ERISA preemption impacts on state innovation (including universal health care initiatives), and potential areas of opportunity. FTAC also heard from Commission member Jane Beyer, Senior Health Policy Advisor at the Office of the Insurance Commissioner on ERISA issues specific to Washington. This included an overview of segments of the health care market for which ERISA preemption does not apply and Washington health policies that have and have not brought ERISA challenges and why. In September, FTAC will dive deeper into options to include ERISA, assess the pros and cons of each option, and develop recommendations to the Commission.

Presentation: Guidance to FTAC on Medicaid

Liz Arjun, Health Management and Associates (HMA)

The Commission was asked what preliminary questions they'd like FTAC to answer and evaluate regarding Medicaid eligibility for the universal health care system. Commission member Jane Beyer suggested getting a sense of what other states have done with 1115 waivers to expand eligibility. Chair Lowe added exploring federal barriers with regards to asset limitations for enrollees of classic Medicaid. Does a comparison of benefits exist for Medicare, Medicaid, and Public Employee Benefits (PEB)? Commission member Bidisha Mandal asked whether there is a map of providers in Washington who are not accepting Medicaid (often due to low Medicaid reimbursement rates). Mandy Weeks-Green, Dir., Health Care Cost Transparency Board, Health Care Authority (HCA), remarked that provider directories are unreliable because they're constantly changing. Jane Beyer added that state agencies work to ensure network access but it's difficult to identify which providers have room in their practice and/or are willing to participate in Medicaid. FTAC should surface reasons for Medicaid enrollees' access issues in addition to low reimbursement rates. Chair Lowe remarked that without a federal waiver to include Medicaid, even if the universal health care system can wrap around Medicaid benefits, there will still be provider reimbursement issues. FTAC should examine federal boundaries in terms of Medicaid provider reimbursement. Chair Lowe also noted examining the connection between the primary care certification work group and Medicaid.

Presentation: Understanding the Washington Health Trust

Andre Stackhouse and Erin Georgen, Whole Washington

Whole Washington is a 501(c)4 nonprofit organization founded in 2017 to advance the passage of universal public health care at the state, regional, and federal level. Whole Washington is the organization behind the Washington Health Trust (WHT) in multiple iterations both as legislation (most recently, Senate Bill 5335) and ballot initiatives. Whole Washington's goals are to establish an ongoing and collaborative relationship with the Commission and to co-develop universal health care policy for recommendation to the Washington Legislature. Whole Washington's definition of universal health care aligns with that of the World Health Organization, where "…all people have access to the full range of quality health services they need, when and where they need them, without financial hardship."

The WHT, a hybrid of Model A and Model B (as defined by the Universal Health Care Work Group that preceded the Commission), would begin as Model B and transition over time to Model A. The WHT would be an all-payer model

with public options for all Washington residents, public health funding for participating community health providers, and the financing and transition plans necessary to achieve universal coverage.

The WHT would create the Washington Health Trust Board (WHTB) for which Commission members could be appointed. WHTB's committees would include a citizen committee, a provider committee, and a finance committee. HCA would lead all direct integration efforts for state-managed and publicly funded health benefits programs, facilitate enrollment for all residents prior to integration, and acquire federal waivers.

All Washington residents would be eligible, but so would some nonresidents including students attending college, workers employed in Washington, and spouses and dependents of eligible nonresidents.

The WHT would offer an essential health benefits (EHB) package defined by the WHTB. HCA would need to align the benefits for all state-managed publicly funded benefits towards the WHT.

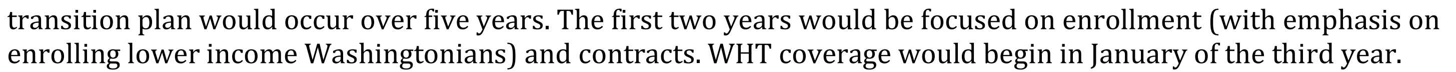
Provider participation would be optional. Providers and health systems giving care to a WHT enrollee could not be denied reimbursement for any service covered under the EHB. Provider rates would be negotiated by the WHTB in coordination with HCA on an annual basis with providers' input and participation. Washington providers and health systems could participate in annual collective negotiations to set rates.

The WHTB would be responsible for enacting cost controls without limiting access to or reducing quality of care. Cost containment approaches outlined in SB 5335 include the single EHB and aligning benefits and reimbursement rates for publicly funded benefits programs.

Co-pays, deductibles, and premiums would be eliminated. Instead, the WHT would be funded through public financing. All employers would be required to pay the same percentage of each employee's payroll toward the employee's health care regardless of whether an employer continues to offer health care coverage other than the WHT. Employers would contribute 10.5 percent of wages and could deduct up to two percent from employee payroll. Employees could contribute up to two percent of their wages via a payroll deduction, of which employers could cover all or a portion. The up to two percent employee contribution would count towards the 10.5 percent employer contribution. Sole proprietors would contribute two percent of earnings (the first $15,000 would not be taxed). Investors would contribute 8.5 percent of capital gains (the first $15,000 would not be taxed). The WHT would use a quarterly graduated exemption for required employer expenditures.

ERISA laws prevent Washington from requiring employers who provide health benefits to participate directly in the WHT. However, Whole Washington suggested that the state could require employers to provide coverage for minimum essential coverage and require employers to spend a certain amount on each employee's health care and could define the spending amount. The WHT's ERISA workaround was modeled after Healthy San Francisco's city-option which has survived ERISA legal challenges.

SB 5335 instructs HCA to pursue a demonstration waiver to integrate Medicare into WHT. During the transition to WHT, the WHT would be a Medicare Advantage plan with Part D for those who voluntarily enroll. The Health Options Program (managed by HCA) would reimburse for any gaps for those who don't enroll. Washington must pass state law and create a universal health care infrastructure before a federal waiver for integration can be approved. Whole Washington recommends that federal funds currently providing cost assistance through the Health Benefit Exchange be folded into the WHT which would be the only plan with cost assistance. WHT's



transition plan would occur over five years. The first two years would be focused on enrollment (with emphasis on enrolling lower income Washingtonians) and contracts. WHT coverage would begin in January of the third year.

Jane Beyer asked for clarification on the employers pay-or-play component. It was clarified that the amount employers are required to pay is per-employee. Initially, employers could meet the required expenditure by continuing to provide non-WHT coverage. Commission Member Rep. Joe Schmick asked how to address any reluctance to enroll due to mistrust in the government. It was clarified that the WHT is a voluntary model and that some people don't trust health insurance companies to manage their current coverage. It will be important to provide people with a better experience compared to the current system and it will take time to build trust. Mohamed Shidane asked how soon the transition plan could begin. It was clarified that while it could take two years to begin enrollment, it may be achieved sooner if the WHTB and HCA can transition things more quickly. Immediate policy action is necessary to get universal health care established in Washington as soon as possible.

Presentation: Continuing transitional solutions discussion

Liz Arjun, HMA

The Commission is charged with identifying transitional solutions. Both the Commission and FTAC were surveyed about potential transitional solutions. The next step is to prioritize transitional solutions for further study. Transitional solutions have been grouped into the following categories: affordability/cost containment/pricing; capacity/infrastructure; coverage/enrollment; providers; purchasing; and subsidies. The Commission was asked whether any ideas or categories were missing.

Commission member Rep. Marcus Riccelli suggested adding "strengthen the work of the Health Care Cost Transparency Board" to the affordability/cost containment/pricing category. Jane Beyer suggested adding "anti-competitive contracting," e.g., between an insurer and a physician's group, to either the providers category or the affordability category. Chair Lowe suggested modifying "consolidate state purchasing" to "consolidate and expand state purchasing" under the purchasing category.

Presentation: Draft 2023 legislative report

Liz Arjun, HMA

Commission members' review of the draft 2023 legislative report is underway. The report describes five highlights of the Commission's work this year, including the launch of FTAC, the adoption of a health equity framework, Medicare and ERISA eligibility considerations for the new system, identification of areas to consider for transitional policy solutions, and incorporating the work to evaluate the Washington Health Trust. The Commission will vote to adopt the report at their October meeting.

Adjournment

Meeting adjourned at 4:00 p.m.

Next meeting

October 12, 2023

Meeting to be held on Zoom and in-person at the Health Care Authority

2:00 p.m. – 4:00 p.m.

Tab 3

Washington State
Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission
Written Comments
Received from July 28

Written Comments Submitted by Email

W. Bronston 1
T. Jensen 1
E. Brice 1
M. Zamora 4
C. Chance 5
T. Huang 6
K. Barry 6
E. Mikami 6

Additional Comments Received at the August Commission Meeting

- The Zoom video recording is available for viewing here: https://youtu.be/OfmjgTRkYYc

Public comments received since (July 28) through the deadline for comments for the October meeting (September 28)

Submitted by William Bronston
08/09/2023

Please disseminate www.ourhealth.pub as a strategic draft policy model to enhance the Washington site single payer proposal to discuss and weigh pending framing the paradigm shift sought.

William Bronston , MD

Submitted by Trent Jensen
08/09/2023

Good evening,
I am Trent Jensen, a current Junior at the University of Washington majoring in political science. I came across this commission and am very interested in contributing to the goal of establishing universal healthcare in the state of Washington. I don't know if volunteer or internship positions are available for the commission but if there is a way to get involved, I would deeply appreciate information on those opportunities.
Thank you,
Trent Jensen

Submitted by Emily Brice
08/10/2023

Dear Commission members and staff:

Please see the attached public comment from Northwest Health Law Advocates, regarding transitional solutions the Commission may wish to prioritize.

Thank you for your consideration.

Emily Brice *(she/her)*

Deputy Director

Northwest Health Law Advocates

(c) 773-870-2755 (e) emily@nohla.org

August 10, 2023

Submitted by email: hcauniversalhcc@hca.wa.gov

Dear Members of the Universal Health Care Commission and staff:

For over two decades, Northwest Health Law Advocates has worked to expand access to health care in Washington. Despite advances in that period, far too many Washingtonians continue to lack affordable, quality health care. We welcome the Commission's work to urgently advance transitional solutions toward a universal health care system.

We offer the following preliminary comments as you consider transitional solutions to help Washington prepare for universal health care:

1. Use statutory intent language as a decision-making rubric.
Any transitional solutions should make progress toward all three intent criteria identified in the Commission's enabling statute (E2SB 5399), which directs the Commission to work toward three goals:
(2) The legislature intends to create a permanent universal health care commission to:
(a) Implement immediate and impactful changes in the state's current health care system to increase access to quality, affordable health care by streamlining access to coverage, reducing fragmentation of health care financing across multiple public and private health insurance entities, reducing unnecessary administrative costs, reducing health disparities, and establishing mechanisms to expeditiously link residents with their chosen providers; and
(b) Establish the preliminary infrastructure to create a universal health system, including a unified financing system, that controls health care spending so that the system is affordable to the state, employers, and individuals, once the necessary federal authorities have been realized.
(3) The legislature further intends that the state, in collaboration with all communities, health plans, and providers, should take steps to improve health outcomes for all residents of the state.

2. Based on that rubric, select transitional solutions that can advance coverage, affordability, and purchasing strategies in the near-to-mid term.
Many of the transitional solutions the Commission has discussed are promising and worthy of consideration over time. As the Commission prioritizes and narrows the initial solutions, we suggest using the above decision-making rubric to prioritize the following transitional solutions:

- Continue to address undocumented immigrant health;
- Fill gaps in affordability and benefits for Medicare enrollees;
- Support efforts to unify health coverage eligibility & enrollment systems;
- Explore universal enrollment screening at key life transitions;
- Work toward consolidation in state health care purchasing where doing so expands access;
- Study the state prevalence of underinsurance across all market segments; and
- Explore opportunities to make care more affordable by pegging to a Medicare benchmark.

Please see the attached Appendix for more details about these preliminary recommendations. We look

forward to continuing to share input as your dialogue continues.

Sincerely,
Emily Brice
Deputy Director
Northwest Health Law Advocates
emily@nohla.org

Appendix: Suggested Preliminary Priorities for Transitional Solutions

Priority	Description *(and any progress to date)*	FTAC Bucket	Immediate & impactful change?	Infrastructure for universal health care?	Improve health outcomes?
Immigrant health	Work toward fully funding affordable undocumented immigrant health programs at parity with state residents *(partially-funded programs launching in 2024)*	Coverage/ enrollment	Yes, current funding levels fall far short of immediate need	Yes, closes the largest remaining gap in health coverage access	Yes, severe disparities for undocumented immigrants currently prevent access
Medicare gaps	Address gaps in Medicare benefits and affordability by expanding dual-eligibility for Medicaid or Medicare Savings Programs *(proposed steps in HB 1313)*	Coverage/ enrollment	Yes, state has ready options to address benefits and affordability gaps and has already started studying options	Yes, filling known Medicare gaps would allow the program to serve as a better benchmark for a universal system	Yes, severe disparities for low-income Medicare enrollees currently prevent access
Unified eligibility & enrollment	Support and accelerate work toward a unified health (and other benefit) eligibility & enrollment system across HCA, DSHS, and HBE *(under development with "HHS Coalition" agencies)*	Coverage/ enrollment	Yes, current system is fragmented and challenging to navigate	Yes, single portal is essential to operationalizing future universal health care	Yes, high rates of "churn" between current systems causes care delays
Universal enrollment screening	Explore state agency infrastructure to ensure every WA resident is screened for coverage options through an "easy enrollment process" if uninsured, including a default "best match" plan with zero premiums if available *(other states have implemented)*	Coverage/ enrollment	Yes, many of remaining uninsured could be eligible for low-cost coverage if aware (e.g., new state residents, newborns)	Yes, establishing "easy enrollment" default processes ensures that everyone is accounted for in new system	Yes, evidence shows that enrollment "nudges" reduce mortality

Consolidated purchasing	Study opportunities to consolidate state purchasing across PEBB/SEBB, Apple Health, and Cascade Care - including evaluation of differences in plan participation; risk pool status; provider networks, benefits, prescription drugs, and enrollee protections	Purchasing	Yes, for example, better coordinating purchasing for Apple Health and Cascade Care could reduce coverage/care disruptions for people <250% FPL	Yes, finding ways to streamline and better leverage existing state purchased care is critical to building a universal system and could produce efficiencies (e.g., streamlining PEBB/SEBB)	Potentially, depending on further study
Under-insurance	Study the prevalence of underinsurance on a state level across market segments, as part of broader efforts to measure and monitor the impact of health spending *(proposed steps in HB 1508)*	Affordability/ cost containment/ pricing	Yes, national evidence suggests underinsurance is rising dramatically, but there is no state data to monitor the trend	Yes, measuring gaps in the existing insurance system helps build support to transition to a universal system	Yes, would offer information about why patients are delaying or forgoing needed care
Medicare-based pricing	Study opportunities to expand access to facilities, providers, and prescription drugs via pricing structures that use a percentage of Medicare as a benchmark reference *(OIC/AGO are studying related concepts in study required by 2023 operating budget)* *(OIC Ground Ambulance Balance Billing Workgroup is exploring a Medicare-based reimbursement structure to prevent ground ambulance balance-billing)*	Affordability/ cost containment/ pricing	Yes, affordability is a pressing problem that is preventing access to care	Yes, normalizing rates against a stable benchmark will support a single payer framework	Potentially, depending on further study

Submitted by Michelle Zamora
08/23/2023

My name is Michelle Zamora and I am a resident of Washington state and reside in the city of Tacoma. I am disabled and suffer from PTSD and mental health issues. I received social security disability monthly and live off of that income. I'm also single and have been homeless chronically and have recently gotten out of homelessness into an apartment in October of 2022.

I have been denied medical savings plan through department of health and social services August 23rd, 2023 because my SSDI Fix income has exceeded over the limit of $1646.00 by $230. The medical health plan savings helps me pay for medical health coverage premium through Medicare of $164.90 a month deducted from my social security disability income.

Department of health and social services has also decreased food stamp assistance coverage $23 a month. And I feel that that's unfair and unjust due to the inflation and gasoline, food and increase in cost of Living in Washington state.

It's a simple fix on this problem of the required income limit to get approved for medical savings plan in Washington State. The medical savings plan income limits for assistance needs to be adjusted with the cost of living COLA.

The savings program is not in balance with individuals income properly to be fair and concise. And that's the reason why my total fix income is over $230 of the $1646.00 limit required to receive assistance to help pay for medical premium part a and part b through Medicare of $164.90.

Washington State medical savings plan program is designed to help those unfortunate individuals who are disable or seniors 65 years old and older.

I'm requesting for the medical savings program required income limits of $1,646 to be adjusted with cost of living COLA.!

As my social security disability income is adjusted annually due to the increasing cost of living. It would be fair and just to adjust the income limits on medical savings program in Washington State due to the increase on cost of living.

The only assistance I currently receive through the department of health and social service at this time is $23 of food stamps monthly. I feel is unfair and was not considered with the cost of living today 2023.

I know that the food banks are available but the food is not good that's given to the general public at Pierce county food banks. Not sure where the grant money goes for that assistance but it's definitely not at the food bank.

Please contact me for more information because I have a hard time of expressing this issue on this email.

Thank you for your time and I hope that this reaches the right senator or congress person that can listen and know that it needs to be adjusted as well due to cost of living to make it fair.

Sincerely,

Michelle Zamora
253-290-3010
michelleflauta56@gmail.com

Submitted by Cynthia Chance
09/12/2023

We need to move ahead with a single payor system. There are too many companies trying to extract money from the system. Too many private companies are after a piece of the pie!!

Submitted by Tina Huang
09/12/2023

The best health outcomes in the world are NOT in the US despite the fact that we spend infinitely more on healthcare than anyone else.

Cuba spends only a fraction of what we do and have much better health outcomes. Why? Because without huge profit incentives, they

focus on what is important, NOT on what lines the pockets of big pharma.

We need a system that prioritizes the health of Washingtonians, and single payer are infinitely more cost effective!

Let's get our priorities straight and implement single payer in Washington!

-Tina Huang, Ph.D.

Submitted by Kyong Barry
09/12/2023

Please watch the video from Whole Washington on how single payer will work in Wa state and how we could eventually get it for the whole nation and how many lives we could save and how much we could s as be the American people!! For profit healthcare doesn't work for the people it only works for the Big Pharma, hospitals, CEO 's of these corporations. While these corporations are making billions in profits our children, parents, grandparents are dying because they don't have the healthcare they deserve. We all deserve good healthcare not just the rich people who can afford excellent care!!

Thank you for reading my beliefs which most people know agree with.

Kyong Barry
132 Milwaukee Blvd South,
Algona, Wa
98001
253-229-2239

Submitted by Ernest Mikami
09/20/2023

I have a few concerns of the way this program is suggested to be funded. We want something to net a gain--not just redistribute wealth and net an overall loss to Washington State.

1. Proposal contains 10.5% payroll tax of which up to 2% is paid by employee.

2. Sole Proprietor pays 2% on net earnings.
Does this include business run by married couples? What if the business is barely earning anything? Free insurance? Even if they are making a lot of money, why are they paying 2% when everyone else is paying 10.5%?

3. 8.5% Capital gains tax with $15,000 exemption (in addition to the 7% Capital Gains tax with a $250,000 exemption that is currently heading to U.S. Supreme Court). Why is this group unfairly targeted to pay twice and without limit?

Looking at these funding source, what happens to those who are not paying any of these tax? They aren't working, they aren't running a business, they aren't investing in the financial market (perhaps they make money on real estate). Do they get free health insurance?

What about Military and civilian personnel stationed in Washington State? They already have excellent health insurance.

There's no cap to any of the proposed tax unlike most Universal Healthcare systems in other countries. With most Universal Healthcare systems, the premium is capped at a point when they are already paying the at or near the full value of their own health insurance much like Affordable Care Act insurance tax credit disappearing with income and also Income Related Monthly Adjustment Amount (IRMAA) for Medicare Part B and Drug Coverage.

Many employers have employer sponsored group health insurance where the employer pays a very large percentage of the premiums with the balance paid by the employee. The employer portion is always tax-deductible at the federal corporate tax level. The employee portion is often also tax deductible for federal income tax and Social Security Tax and Medicare Tax purpose if the employer has a section 125 cafeteria plan.

Your proposal changes that structure so that instead of paying a tax deductible health insurance premium, you now charge payroll and capital gains tax both of which severely limits the ability to deduct the expense for various tax purpose. So just from funding structure, it is already a net loss for Washington State.

Does this group even understand why Federal Capital Gains tax rate is deliberately set lower than the ordinary income tax rate? The purpose is to reduce (but not eliminate double taxation) due to combination of corporate income tax paid by the underlying corporation the investor invests in and the personal income tax paid by the investor.

Much of the capital gains is lost by inflation. So when a person pays capital gains tax, they are not only paying tax on the gain, but also on the portion of the "gain" that happens just to keep up with inflation. In fact, it is entirely possible and often realistic to be losing purchasing power in many cases after tax and inflation.

The other reason the capital gains tax rate at federal level is lower is to promote investment activity which with any luck will grow the economy itself and increase the total tax revenue.

So it is highly counterproductive to add capital tax of any type even with a substantial exemption such as the one that is in place right now with a $250,000 exemption. We need to promote growth, not limit it.

By the way, this $15,000 exemption, is it indexed to inflation? It doesn't take too many years to produce $15,000 of unrealized gain with even a modest amount of accumulated investment effort. The goal may have been to buy a car, spend it on down payment for a house, or even just getting the roof replaced. All of these things can often produce larger than $15,000 of capital gains, especially if this isn't indexed to inflation. So this will impact the middle-class and a large percentage of the voting population. It reduces revenue because a person who may wanted to spent more money will think twice because it'll trigger this

additional tax. That hesitation results in reduced sales within Washington State which reduces sales tax revenue and is worse for the economy, job growth, and total tax revenue.

The report showed an illustration of countries with universal healthcare having lower cost and longer life. But does this commission understand how lower cost was achieved? Most Universal Healthcare plans have cost controls to the provider. Every covered medical procedure, prescription drugs, services, durable goods, etc. is negotiated with the provider. Medicare already does this to some extent. HMO's and PPO's also already do these things and many are non-profit and have subscriber base which exceeds the entire Washington State population. Size matters a lot because they can simply refuse to allow the service to be provided within your network or HMO members if the price isn't agreed upon.

If you attempt to do that within Washington State, what will happen? The provider may just leave the State all together. Recall the capital gains and payroll tax? What professions actually pays enough to be generating a lot of payroll tax and capital gain tax and for that matter property tax and sales tax? Many are in health care. So this attempt play Robinhood needs to stop. We are all in the same team. Come up with a plan that will reduce expense for everyone. Not just redistribute wealth at expense of huge loss in tax deduction opportunities. That will only lead to those who can pay to leave the state because it ends up costing more to stay in this state and they will take their business along with the jobs they created with them. We will attract unemployed and lower income individuals to come to our state to try to get free healthcare because the tax being proposed aren't impacting them or impacting them at a lower rate than in other states. How can this ever be at least revenue neutral?

Do not assume Universal Healthcare will reduce cost. A dumb way to implement will raise cost such as the one that is being proposed so far.

You need a tax expert review these types of proposal. You need to review what many other existing Universal Healthcare system are doing to keep costs down, have fairness no matter where you are in your own financial situation. Not many people can afford the full health care cost including those who may occasionally produce $15,000 in capital gains. It doesn't make sense for anyone to be paying many times the value of their health insurance just because they have a higher salary or realize larger capital gains. Most rely on employer coverage anyway. As bad as the current system may be, it does encourage people to be employed in part to get affordable health coverage at least until Medicare age. Sometimes, trying to do too much especially at state level does more harm than good. Be extra careful to not randomly come up with ideas that ends up costing us more by attracting the wrong people and driving away the more successful population.

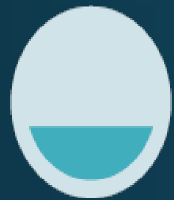
I think this needs to be worked on at the federal level. This is way beyond the resource of this state to resolve on its own. Accept that fact and work with federal representative and Senator to figure something out _the right way_.

Tab 4

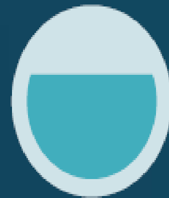
FTAC updates

ERISA recommendations

Spectrum of options for UHC



Limited Public Option



Comprehensive public option

State-based single payer

A government-standardized health plan that pays providers publicly determined rates and is offered to a small portion of the private health insurance market

(WA has this now with Cascade Select)

A government-sponsored health plan that pays providers publicly determined rates and is offered to a substantial portion of the private health insurance market

A single, government-administered payer that pays providers publicly determined rates and provides universal health care coverage for all residents in a state

Professor Erin Fuse Brown
September 14, 2023 FTAC meeting

FTAC ERISA guidance

Pam MacEwan, FTAC Liaison

1. Act of Congress or federal waiver at this time
2. Optional for employers to participate
3. Pay or play

   3a. Meaningful alternative (e.g., comprehensive public option)
4. Provider incentives/regulation
5. Payroll tax on all employers
6. Combination of two or more options

FTAC ERISA guidance

Pam MacEwan, FTAC Liaison

1. Act of Congress or federal waiver at this time

- Unlike waiver authorities granted to CMS under Medicare and Medicaid, **there is no authority** in the ERISA statute for a federal administration to waive any provisions in ERISA.
- Only an act of Congress could eliminate or modify ERISA preemption.

FTAC recommends that pursuing an act of Congress is not feasible at this time.

FTAC ERISA guidance

Pam MacEwan, FTAC Liaison

2. Optional for employers to participate

- Employers free to continue offering their own plans.
- Goal: develop a universal health care plan (UHC) attractive enough that employers forgo offering their own coverage.

Pro: not vulnerable to an ERISA challenge since it does not interfere with employers' freedom to offer their own plans.

Con: May not capture enough employer expenditures to sustain UHC.

Con: UHC risk pool impacts

FTAC ERISA guidance

Pam MacEwan, FTAC Liaison

3. Pay or play

- Employers given a choice:

Pay a tax, e.g., payroll tax, to cover employees

Or

Continue to offer their own health coverage and be exempt from the tax ("pay or play").

Pro: Likely to survive an ERISA challenge

Con: May not be incentive enough for employers to forgo offering employer-based plans and may not capture enough employer expenditures to sustain UHC.

Con: Potential disparities in benefits between UHC and employer-based plans.

FTAC ERISA guidance

Pam MacEwan, FTAC Liaison

3a. Meaningful alternative (comprehensive public option)

- **A** “meaningful alternative” to an employer’s existing coverage
- Could be structured as a comprehensive public option, e.g., more expansive than WA’s current public option program that employees could opt into.

Pro: Likely to survive an ERISA challenge

Pro: Possible glide path to single-payer

Con: May be disparities in benefits between UHC and employer-based plans could still exist.

Con: May not capture all employer expenditures, at least at first, to sustain UHC.

FTAC ERISA guidance

Pam MacEwan, FTAC Liaison

4. Provider incentives/regulation

- Requiring providers to contract with UHC without the ability to contract with other plans may be preempted by ERISA.
- Does not capture revenue, so would need to combine with another option to create a sustainable system.

Pro: Includes ways to reduce costs, e.g., rate caps or rate regulation, to make the system more financially sustainable.

Con: May bring legal challenges (not ERISA)

FTAC
ERISA guidance

Pam MacEwan,
FTAC Liaison

5. Payroll tax on all employers

- Employers free to continue offering their own coverage, though not exempt from obligation to pay the tax

Pro: Would help fund UHC

Pro: Less likely to trigger an ERISA challenge because it does not reference employer benefit design

Con: Could be preempted if the courts viewed the payroll tax to be "exorbitant"

Con: May not be favorable to large employers

FTAC ERISA guidance

Pam MacEwan,
FTAC Liaison

6. Combination of two or more options

Option 2 – optional for employers to participate

Option 3a – provide a meaningful alternative to employers' current coverage

Option 4 – provider incentives/regulation

Option 5 – funding mechanism

To: Universal Health Care Commission (UHCC)

From: Finance Technical Advisory Committee (FTAC)

Re: Options for Addressing the Employee Retirement Income Security Act of 1974 (ERISA) in the Universal Health Care Design

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Background

At its June 13, 2023, meeting, the Universal Health Care Commission (UHCC) requested guidance from FTAC with respect to the following topics relating to ERISA:

- "Pay or play" option where employers have a choice to continue providing coverage to employees;
- An option where employers pay into the universal system and employees are covered by the universal system;
- Discussion of how ERISA law has evolved, areas of the law that are unchanged since the last analysis done on the topic, and any new approaches with potential areas of opportunity; and
- Since employer funding contributions may be optional, FTAC could examine how any employer contributions could be captured under the various ERISA eligibility options (and estimated dollar values for each option) to fund the new system.

Given the complexity of the law and its application, FTAC members discussed ERISA application over two meetings. First, FTAC members were provided a general overview of the history of the ERISA law overall, followed by a presentation about the history of policies in Washington that touched on ERISA at the July 13, 2023, meeting. Presenters included Carmel Shachar, Asst. Clinical Professor of Law and Faculty Dir., Health Law and Policy Clinic, Harvard Law School, and Jane Beyer, Senior Policy Advisory to Insurance Commissioner Mike Kriedler, and UHCC member.

Dr. Shachar explained that while ERISA was not intended to be a health care statute, it is practically applied as one because of its preemption clause regarding state laws. ERISA, a federal statute, governs employers sponsored health care plans or insurance plans when an employer covers the full financial risk of its employees' claims for health care benefits (known as self-funded group health plans). Regulation of ERISA plans is "exclusively a federal concern" and preempts "all state laws insofar as they…relate to any employee benefit plan" (as she pointed out, it is one of the broadest preemption clauses ever written). She further detailed that most Americans receive health care coverage from their employer and that most large employers offer this type of health plan. Approximately one-third of Washingtonians are covered by ERISA plans. This means that any state laws passed by the Washington Legislature related to employer health benefits could be preempted by ERISA in relation to these plans; therefore, careful consideration of ERISA is necessary in the Commission's efforts to design a universal system with equitable benefits for all Washingtonians.

Ms. Beyer presented several examples in which Washington's Legislature sought to achieve universal access to specific benefits across all insurance markets while avoiding an ERISA challenge including:

- **The Washington Vaccine Association (WVA):** dictates how all plans (including ERISA plans) administer vaccine benefits. Under the WVA, Washington universally purchases childhood vaccines for all children at volume discounted rates from the Centers for Disease Control (CDC) and delivers them to providers at no cost. Health insurers and Third-Party Administrators (TPAs) of self-funded plans reimburse the WVA for vaccines administered to privately insured children via "dosage-based assessments." The WVA then transfers funds to the Washington Dept. of Health for bulk vaccine purchases. Payers are assessed at rates lower than reimbursing the costs of private purchase of vaccines, which is a benefit to employers. All TPAs register with the WVA and there is no cost to patients.
- **The Partnership Access Line (PAL)**: provides psychiatric consultations for certain providers caring for children and pregnant/postpartum individuals. PAL is insurance agnostic and was initially funded with Medicaid funds, despite some children being ineligible for Medicaid. The Washington Legislature developed an alternative funding mechanism. PAL is administered by the WAPAL Fund - a blend of Medicaid and assessment funding in proportion to the coverage source of people served. For privately insured children, there is a quarterly assessment on payers based on their covered lives, including ERISA plans. The assessment per covered life for fiscal year 2024 is seven cents per-member per-month (PMPM).
- **Washington's behavioral health (BH) crisis system**: largely funded by Medicaid, federal block grants, and state general funds and provides a firehouse model (open to all) of behavioral health crisis services. The 2023-2025 Operating Budget directs the Health Care Authority (HCA), Medicaid managed care organizations (MCOs), BH administrative service organizations, carriers, self-insured organizations, and BH crisis providers to assess gaps in the current funding model and recommend options for addressing these gaps including, but not limited to, an alternative funding model, e.g., covered-lives assessment, for crisis services.

These presentations were followed by additional presentations and discussions at the September 14, 2023, FTAC meeting, focused on understanding potential options for how the Commission might address ERISA in its universal design and how large self-funded employers might react to any proposals that emerge from the Commission. William Kramer, Senior Advisor at the Purchaser Business Group on Health, discussed large employers' views of state efforts to create a universal health care system. Mr. Kramer stated that employers would "fiercely defend" ERISA preemption, because they believe that the ability to design the health coverage employers offer to their employees helps differentiate them in competition for talent. He also stated that employers believe that they can do a better job for their employees than the government would and generally resist what they perceive to be intrusive government regulation, such as price-setting, while acknowledging that the costs associated with providing these benefits is increasing. Mr. Kramer also noted that large employers generally will accept government intervention in areas where no market exists or areas where the market has failed irreparably, e.g., drug price controls.

Following this presentation, law professor Erin Fuse Brown, an ERISA expert who has advised both Oregon and California's universal health care efforts, gave a presentation on ERISA and described some potential options for designing a system that would achieve the policy goal of including as many employers as possible (including self-funded plans) and would be more likely to survive a challenge brought under ERISA. Professor Fuse Brown introduced her presentation with an overview of the Affordable Care Act (ACA) requirements of large employers. Her presentation then focused on the potential impact of ERISA on three models of a universal coverage system:

Erin Fuse Brown's presentation to FTAC, September 14, 2023

Following this, FTAC discussed six options for how to include employers in Washington's universal health care system and avoid ERISA preemption. This memo provides a summary of each option and FTAC's guidance to the UHCC about these options. Although FTAC did not take a formal vote, a consensus did emerge, as is discussed below. FTAC members agreed that a combination of options represents the most promising approach. They concluded that a final determination of the best policies to pursue will depend on decisions about the structure of the universal health plan that the Commission has not yet considered, so that the ERISA issue will need to be addressed again when further design on the system is complete.

Options and FTAC Response

1. Federal waiver at this time.

As Professor Fuse Brown made clear during her presentation, there is no authority in the ERISA statute for a federal administration to waive any provisions in ERISA. Specifically, the U.S. Department of Labor, which enforces ERISA, has no authority to waive its provisions. This is unlike the waiver authorities granted to CMS under Medicare and Medicaid. Therefore, only an act of Congress could eliminate or modify ERISA preemption, which would allow UHCC to design a system that includes universal enrollment and mandatory participation by employers and providers. As an example, the Affordable Care Act (ACA) included an "employer mandate" which requires all large employers to provide minimum essential coverage that is affordable, offers minimum value, or if it fails to do so, to pay a penalty for each full-time employee who receives a subsidy and purchases coverage on an exchange. This provision is not preempted by ERISA because the ACA is a co-equal federal law.[1]

FTAC Discussion

[1] The employer mandate can be waived by the federal government via a 1332 waiver.

Similar to FTAC's discussion of Medicare options, FTAC quickly determined that no waiver is possible and that pursuing an act of Congress is not feasible at this time. One FTAC member raised the idea of UHCC partnering with Oregon and California to develop federal legislation to allow states' incorporation of large employers into their respective unified health care financing systems.

2. Optional employer participation

Option 2 would provide that all employers (including self-insured and fully-insured employer-based plans) have the option to pay for their employees to be covered by the universal health care system. Employers would also remain free to provide their own self-funded health coverage. The goal with this option would be to develop a universal health care system that would be attractive enough that employers would forgo offering their self-funded plans because joining the universal system would be less expensive, reduce employers' administrative burden, and make it easier for employees to obtain the health care they need at lower costs to them. One advantage to this option is that it would not be vulnerable to a challenge under ERISA since it does not interfere with employers' freedom to offer their own plans. A downside, however, is that if significant numbers of employers choose to continue offering their own plans, the universal system would not be able to recoup employer expenditures as part of its financing. In addition, the risk pool in the universal system would be adversely affected since employees in self-funded plans tend to be healthier than the rest of the population.

FTAC Discussion

FTAC members agreed that optional employer participation should be included as one part of the design of the universal system. They also discussed ways to finance the universal system to address the problems raised by this option, as discussed below.

3. Pay or play

Under this option, employers are given a choice: they can choose to pay a tax, which could be in the form of a payroll tax or a tax on revenue, or they can continue to offer their own health coverage. If they continue to offer their own coverage, they are exempted from the payroll tax ("Pay or play"). This option is likely to survive an ERISA challenge but would be less likely to provide an incentive for employers to forgo offering their employer-based plans.

FTAC Discussion

FTAC members agreed that "pay or play" is an option that should be further explored to be considered in the design of the universal system.

3a. Meaningful alternative (comprehensive public option)

This option was originally combined with Option 3, though some FTAC members felt that this option is an extension of "pay or play." A meaningful alternative, or an alternative to employers' current coverage, could be structured as a comprehensive public option as outlined by Professor Fuse Brown. This option, more expansive than Washington's current public option program, Cascade Select, is focused on designing a plan that offers an option for Washingtonians that employees could opt into.

FTAC Discussion

FTAC members expressed support for designing a meaningful alternative that could eventually attract employers, or even serve as a glide-path to a single-payer system. One FTAC member suggested an

interim step in creating a comprehensive public option would be to consolidate state purchasing for state and school employees and use it as a platform for a public option.

4. Provider regulation/incentives

This option concerns ways to provide incentives to health care providers to accept patients covered by the universal system, the idea being that as providers migrate toward a state-sponsored plan, employers would follow. They include provisions requiring providers to accept patients under the new system while also being able to contract with other plans, or to accept only such patients if they choose to accept them. These provisions do not raise any concerns under ERISA, although there may be other legal considerations that were beyond the scope of FTAC's discussion. Requiring providers to contract with the universal plan without the ability to contract with other plans may be preempted by ERISA. This option does not capture revenue and would therefore need to be combined with another option to create a sustainable system.

This option also includes ways to reduce costs to make the system more financially sustainable, such as rate caps or rate regulation.

FTAC Discussion

There was broad agreement among FTAC members that Option 4 must be a part of the design of the universal system, not only to achieve universality in principle, but also to provide the state with levers to achieve feasibility of financing a universal system in practice. Further analysis and discussion will be needed to expand upon this option, to understand specific policy requirements, political hurdles, and cost impacts.

5. Payroll tax on all employers

Under this option, a payroll tax would be levied on all employers. While employers would be free to continue to offer their own plans to their employees, there would be no exemption from the obligation to pay the tax for those employers who choose to do so (so-called "Pay and play"). Professor Fuse Brown offered the analogy that all homeowners are required to pay property taxes which fund public education. They are free to send their children to private schools but remain obligated to pay their property tax. Whether this option would be preempted by ERISA is uncertain; it would depend on whether the courts viewed the payroll tax to be "exorbitant."

FTAC Discussion

More than one FTAC member recognized that this option could be useful in obtaining the necessary funding for the universal system. Additionally, it is not tied directly to providing health care and may be less likely to trigger an ERISA challenge. In this context, the explicit focus is not on compelling employers to participate, but rather on obtaining funding for the system. FTAC members were interested in further exploring what payroll tax structure could be considered palatable by employers and not "exorbitant" by the courts to obtain funding in the future. Some potential areas that offer examples for what this could look like in Washington were offered in Ms. Beyer's presentation in July.

6. Combination of two or more options

The options discussed above are not mutually exclusive, and two or more could be combined.

FTAC Discussion

FTAC members agreed that a combination of Option 2, (giving employers the option to continue providing self-funded plans) coupled with Option 3a (providing a meaningful alternative to employers'

current coverage) that incorporates components of Option 4 (strategies to require or incentivize provider participation while reducing costs), should be part of the universal system. This approach is focused on designing a system that would offer a meaningful alternative to what employers offer currently that would be available to Washingtonians with strategies to address access and cost. It is not yet clear the best method of capturing employer contributions and incentivizing them to permit their employees to enroll in the universal system. FTAC members agreed that these issues should be revisited once additional elements of the system, such as the benefits to be offered and the method(s) of provider reimbursement, have been developed by the Commission. Presenters noted that legal challenges may be inevitable which would create delays in implementing a universal system. A combination of approaches that includes options that are not likely to be challenged could ensure some aspects of reform could be implemented without delay.

These issues can be revisited as the UHCC develops more clarity around policy goals for a universal system.

Finance Technical Advisory Committee (FTAC) Meeting Summary

September 14, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

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

Members present

Christine Eibner
David DiGiuseppe
Ian Doyle
Kai Yeung
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Eddy Rauser
Esther Lucero

Call to order

Pam MacEwan, FTAC Liaison, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

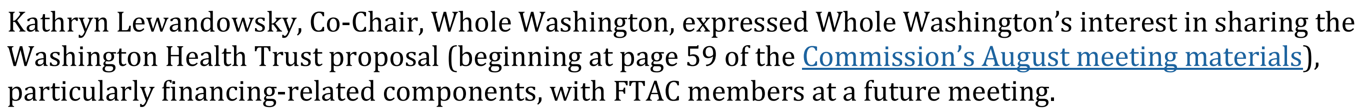
Beginning with a land acknowledgement, Pam MacEwan welcomed members of FTAC to the fifth meeting and provided an overview of the agenda.

Meeting Summary review from the previous meeting

The Members present voted by consensus to adopt the Meeting Summary from FTAC's July 2023 meeting.

Public comment

Roger Collier asked if costs doubling for some employers via a payroll tax could be deemed as "exorbitant" and in violation of the Employment Retirement Income Security Act of 1974 (ERISA), and how far out the federal court processes to resolve ERISA preemption would be from Washington's passing of universal health care legislation. Roger asked if FTAC would allow them a few minutes at the next meeting to discuss their public option proposal submitted in April.



Kathryn Lewandowsky, Co-Chair, Whole Washington, expressed Whole Washington's interest in sharing the Washington Health Trust proposal (beginning at page 59 of the Commission's August meeting materials), particularly financing-related components, with FTAC members at a future meeting.

Lori Bernstein encouraged FTAC members to watch the recording (timestamp 45:50) of Whole Washington's presentation from the Commission's August meeting.

Maureen Brinck-Lund asked whether the Washington Health Trust proposal could be used as a draft model for achieving universal health care under a single-payer financing system.

Presentation: Large employer perspectives on state-based universal health care

Bill Kramer, Director for Health Policy, Purchaser Business Group on Health
Currently, large employers face challenges in offering employees health benefits. Health benefits are key to large employers' recruitment and retention strategies, but rising health care costs impact employers' ability to remain competitive and increase wages. Some large employers are adopting aggressive cost containment strategies, e.g., mental health and substance use access and quality.

Large employers are likely to have some concerns with universal health care, such as the loss of differentiation in employee recruitment and any new taxes. For multi-state employers, the administrative burden could increase in having to comply with different state laws. Further, it may create inequities between employees with universal health care versus those with employer benefits. Finally, employers could feel a loss of control in not being permitted to design health benefits to meet employees' needs. Large employers will fiercely defend ERISA preemption.

Universal health care could be made appealing or acceptable to large employers, e.g., employers having a choice of whether to continue offering health benefits or joining the universal health care system. Some of the most important product features for large employers include provider network, benefits, price, and choice of plans. Achieving better cost control and administrative simplicity could also make universal health care appealing.

International employers appreciate the simplicity of health care systems in other countries and accept the fragmented and complex American system. In a single-payer system, employers could maintain differentiation in employee recruitment by offering other benefits, e.g., retirement, or offering wraparound benefits for any services not covered under the universal plan.

It was noted that based on recent research, large employers nationally are paying between 200-300 percent of Medicare (with variation between and within states) for health benefits. Is there an argument that a universal health care system will relieve some of this pressure for employers? Bill Kramer replied that most employers are focusing their influence on systemic solutions via the public policy arena, e.g., cost growth targets, greater oversight over mergers and acquisitions, etc.

The private sector's concerns over government price controls were noted. Are there areas of commonality? Bill Kramer replied that most large employers accept government intervention in areas where markets don't exist or have failed irreparably.

Presentation: ERISA options for Washington

Erin Fuse Brown, Catherine C. Henson Professor, Director of the Center for Law, Health & Society, Georgia State University College of Law
This presentation was not legal advice. To keep employer-based coverage intact, the drafters of the Affordable Care Act (ACA) created the employer mandate where employers with more than 50 employees that fail to provide "minimum essential coverage" that is "affordable" and offers "minimum value" face a penalty. The employer mandate can be waived by the federal government via a 1332 waiver.

While fully insured employer plans are regulated by state insurance laws, self-funded employer plans are subject to ERISA. A federal ERISA waiver does not exist, and the U.S. Department of Labor (DOL) (entity that administers ERISA) has no authority to waive ERISA preemption provisions. Federal courts, not the DOL, independently determine whether a state law is in violation of ERISA.

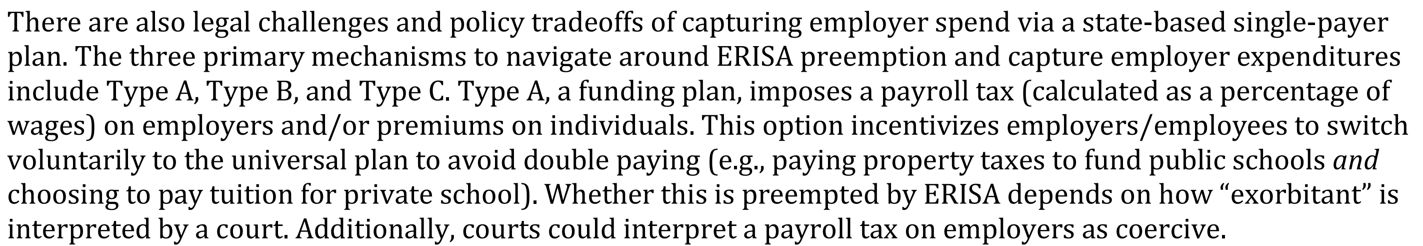
Washington's goal in designing a universal health care system is to include the employer-based market (accounts for 52 percent of Washingtonians' health coverage), without running afoul of ERISA preemption because without it, the universal plan is neither "universal" nor fiscally sustainable. The spectrum of policy design options for a state-based universal health care system depends on how "universal" is defined, e.g., universal eligibility, universal enrollment, etc., and whether the transition happens all at once or on a glide path. Additionally, each model on the spectrum entails balancing policy goals with legal and other tradeoffs.

The first option on the spectrum begins where Washington is currently - offering a limited public option (Cascade Select). This option has limited reach by filling gaps in coverage on the individual market but has no ERISA implications because it does not impact employers.

The next option is a comprehensive public option. This may call for a more heavily regulated or government-sponsored health plan made available to all state residents (including those with employer-based coverage). The multi-payer system would persist, but this option could break the link between employment and health coverage. This option would have universal eligibility and could be used as a glide path to a single-payer system. There could be some legal difficulties under ERISA and require waivers to bring in other payers (Medicare, Medicaid, and ACA).

Furthest on the spectrum is a state-based single-payer plan which the government would administer and provide the same coverage to all state residents, irradicating the current system. This option would have simplified administration with total market reach and universal enrollment. This option invites more legal and political difficulties and would require the same waivers as mentioned above.

There are legal challenges and policy tradeoffs in capturing employer spend via the comprehensive public option. Washington could not mandate that employers offer the comprehensive public option. Instead, structuring the state plan as voluntary for employers/employees would retain a meaningful set of plan choices and avoid ERISA preemption under the current Ninth Circuit precedent in the *Golden Gate* and *City of Seattle* cases (see FTAC's July meeting recording, timestamp 23:08 for more detail on these court cases). Funding for this option could be structured to avoid ERISA preemption, e.g., payroll taxes (levied on wages) don't on their face relate or refer to an employer benefit plan. Employers could be exempt from the payroll tax if they offer coverage at least as affordable and comprehensive as the state plan ("Pay or Play"), versus a payroll tax *without* exemptions which would accelerate a market-shift to the state plan but increase ERISA difficulty, e.g., employers paying both the payroll tax and continuing to offer their own benefits could be deemed "exorbitant" ("exorbitant" is a concept, not a number). The tax implications of this option are outside the scope of this presentation.



There are also legal challenges and policy tradeoffs of capturing employer spend via a state-based single-payer plan. The three primary mechanisms to navigate around ERISA preemption and capture employer expenditures include Type A, Type B, and Type C. Type A, a funding plan, imposes a payroll tax (calculated as a percentage of wages) on employers and/or premiums on individuals. This option incentivizes employers/employees to switch voluntarily to the universal plan to avoid double paying (e.g., paying property taxes to fund public schools *and* choosing to pay tuition for private school). Whether this is preempted by ERISA depends on how "exorbitant" is interpreted by a court. Additionally, courts could interpret a payroll tax on employers as coercive.

Under Type B, provider restriction, all provider payments would come from the single-payer plan at single-payer rates. Three types of provider restrictions include: 1) universal provider enrollment and ability to contract with alternate plans (likely not preempted), 2) voluntary provider enrollment, but if they join the state plan, they cannot participate in other plans (likely not preempted), and 3) universal provider enrollment without ability to contract with other plans (may be preempted). ERISA does not preempt state regulation of health care providers (has only an indirect effect on employer health benefit plans). The question would be whether the indirect effect is enough that it crosses the line toward coercion, e.g., effectively gutting employer provider networks.

Finally, under Type C, pay and recoup provisions, the single-payer plan can pay for services and seek reimbursement from other payers. This, in combination with some sort of provider restriction gives employer plans a plausible way to continue to exist and may help strengthen the ERISA preemption case for the state.

A single-payer plan should include a combination of a funding plan with payroll taxes, income taxes and/or premiums, provider payment restriction and incentives to participate, pay-and-recoup mechanism, and a severability clause to prevent the system from failing if any one of these provisions was determined to be preempted by ERISA.

Non-duplication prohibits any self-funded health plan from offering coverage that duplicates state plan coverage and is likely preempted. However, prohibition on any state-regulated insurance carrier or plan from offering duplicative coverage is likely not preempted. To avoid making a preempted "reference" to ERISA plans, Washington should not explicitly state that self-funded duplicated coverage is permitted (though it is).

The policy design for Washington's universal health care system will be driven by Washington's goals within legal, financial, and political bounds. There are tradeoffs. ERISA legal challenge is inevitable, but whether the state wins will depend on how the plan is crafted. States currently have the power to and have a strong track record of regulating provider rates, e.g., rate caps. There may be discomfort in preventing providers from contracting with certain entities, but this could be framed as a condition of participating in the single-payer plan.

A committee member asked if a payroll tax imposed on employers without condition would be the least risky from an ERISA standpoint. This could be a good option because it makes no mention of employer health benefit design.

FTAC Member vote: recommendations to the Commission regarding ERISA

Pam MacEwan, FTAC Liaison

This vote is intended to provide guidance to the Commission on ERISA options that allow the design process to advance. This guidance is not binding forever.

FTAC members agreed that Option 1, a federal ERISA waiver, does not exist and is therefore impossible to obtain. Gary Cohen, Health Management Associates, noted that this is in the same category as an act of congress. Given

how difficult this would be to achieve, members did not recommend Option 1. One member suggested that the Commission work with Oregon's Universal Health Plan Governance Board to influence federal legislation on ERISA.

FTAC members agreed that Option 2, optional employer participation in the universal plan, will likely avoid ERISA preemption. Any path to including employers should be optional to avoid an ERISA challenge and because it may benefit employers.

Option 3 was a pay or play or meaningful alternative (e.g., comprehensive public option). It was suggested that "pay or play" be separated from "meaningful alternative" because of the differences in financing mechanisms. FTAC member Roger Gantz suggested that consolidated state purchasing could be a path with which to build other ERISA options. Some members noted that pay or play is likely to be problematic and that the state could accomplish the same goals through a payroll tax. This is perhaps the most nuanced option and requires further study because pay or play could be structured differently or the same as a meaningful alternative.

There was interest in Option 4, provider regulation/incentives, as a means of containing costs to financially sustain the system. This option may have to be done in conjunction with action on Medicare and Medicaid since the provider community may be concerned about losing employer-sponsored coverage rates which tend to be higher.

Members highlighted some of the pros and cons of Option 5, a payroll tax on employers. This may be a more heavy-handed approach from employers' perspective because they'd have no choice but to pay the tax. It may be more politically feasible to begin with Option 3 at the outset where employers would have a choice of whether to pay into the universal system, then transition to Option 5. This requires further exploration. Erin Fuse Brown added that a payroll tax isn't unique to either a comprehensive public option plan or a single-payer plan, rather it's a financing mechanism designed to capture employer dollars and to incentivize people to join the universal plan. The ERISA questions are along the lines of how high the payroll tax is and whether there are exemptions. This option could be attractive to employers because they could raise employees' salaries in lieu of paying for health benefits.

Option 6 was a combination of two or more options. There was interest in exploring ways to combine multiple options in the interim and for the larger system while also getting a clearer understanding of the greater system design, transitional solutions, and policy goals as determined by the Commission.

Any options that FTAC will support will depend on things that haven't been decided yet, e.g., larger system design and strategies to transition the state to a universal health care system. There was agreement among members that participation by employers must be optional, must include provider incentives to contain costs, and a funding mechanism that may or may not have exceptions on employers is required, but this requires further exploration.

Adjournment

Meeting adjourned at 4:02 p.m.

Next meeting

November 9, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Tab 5

ERISA Discussion

Do Commission members have additional ERISA questions for FTAC?

Or

Would Commission members prefer to vote whether to adopt these recommendation and move forward with system design (including interim strategies) and come back to ERISA once more design components have been addressed?

Tab 6

2023 legislative report

Commission Member Vote:

Motion to adopt 2023 legislative report

Vicki Lowe, Chair

Washington State Health Care Authority
Report to the Legislature

Universal Health Care Commission Legislative Report

Engrossed Second Substitute Senate Bill 5399; Section 2(7); Chapter 309; Laws of 2021

November 1, 2023

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Glossary of abbreviations and acronyms

ABA	Applied behavior analysis
ACA	Affordable Care Act
CMS	Centers for Medicare & Medicaid Services
Commission	Universal Health Care Commission
DOH	Department of Health
DSHS	Department of Social and Health Services
EHB	Essential health benefits
ESI	Employer-sponsored insurance
ERISA	Employee Retirement Income Security Act of 1974
FFS	Fee-for-service
FPL	Federal poverty level
FTAC	Finance Technical Advisory Committee
GF - S	General Fund - State
HBE or Exchange	Washington Health Benefit Exchange
HCA	Health Care Authority
HCAC	Healthy California for All Commission
HCCTB	Health Care Cost Transparency Board
HHS	U.S. Department of Health and Human Services
HMA	Health Management Associates
IHS	Indian Health Service
MA	Medicare Advantage
MA-PD	Medicare Advantage & Medicare Part D
MCO	Managed care organization
OFM	Office of Financial Management
OIC	Office of the Insurance Commissioner
OPMA	Open Public Meetings Act
PEBB	Public Employees Benefits Board
PHE	Public health emergency
Plan	Oregon's proposed Universal Health Plan
Program	Jamestown Tribal Health Benefits Program

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QDP	Qualified dental plan
SEBB	School Employee Benefits Board
SSDI	Social Security Disability Insurance
Task Force	Oregon Joint Task Force on Universal Health Care
TPA	Third-party administrator
VHA	Veterans Health Administration
UHC Work Group	Universal Health Care Work Group
UMP	Uniform Medical Plan
FY	Fiscal year

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Executive summary

This is the Universal Health Care Commission's (Commission) second annual report submitted by the Health Care Authority (HCA) to the Washington State Legislature as directed in Engrossed Second Substitute Senate Bill 5399 (E2SSB 5399), Section 2(7), and enacted as Chapter 309, Laws of 2021. This report builds upon the Commission's 2022 **baseline report** to the Legislature and Governor and describes the Commission's work from September 2022 through September 2023.[1] As directed by the Legislature, the Commission must:

> "Implement immediate and impactful changes in the state's current health care system to increase access to quality, affordable health care by streamlining access to coverage, reducing fragmentation of health care financing across multiple public and private health insurance entities, reducing unnecessary administrative costs, reducing health disparities, and establishing mechanisms to expeditiously link residents with their chosen providers; and
>
> establish the preliminary infrastructure to create a universal health system, including a unified financing system, that controls health care spending so that the system is affordable to the state, employers, and individuals once the necessary federal authorities have been realized. The Legislature further intends that the state, in collaboration with all communities, health plans, and providers, should take steps to improve health outcomes for all residents of the state."

In their second year, the Commission strategically structured meetings to target the Legislature's overarching goals that are both forward-looking and intended to improve upon the current health care system. Each meeting focused partly on further exploration and refinement of interim strategies to transition Washington to a universal health care system, and partly on the foundational design components of the future system.

The Commission selected eligibility as the first design component to develop and designated this topic as the primary area of focus for the newly launched Finance Technical Advisory Committee (FTAC).[2] The Commission also determined that discussions and recommendations regarding future system design would be supported by information regarding opportunities within existing authorities, other states and current programs in Washington, and equity principles.

This report details the Commission's work to build upon milestones established in its first year of work, including:

- Initialization and launch of FTAC.
- Identifying the need for federal authority to achieve a state-based universal health care system supported by unified financing, and that pursuit of such authority is a multiyear endeavor.

[1] The Commission's roster can be found in Appendix A.

[2] FTAC's roster can be found in Appendix B.

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- Assessing eligibility to determine who will need coverage or supplemental coverage in the future universal health care system including the two eligibility groups presenting the most significant challenges to federal authority:
    - Adoption of guidance from FTAC regarding options to include Medicare enrollees in Washington's universal health care system
    - Initiating evaluation of options to include the Employee Retirement Income Security Act of 1974 (ERISA) covered individuals in Washington's universal health care system.
- Refinement and prioritization of transitional solutions that support goals of improving access to care and affordability and advance the state's readiness to implement a universal health care system.
- Adoption of a health equity framework with which the Commission will evaluate proposals for the universal health care system design and interim solution recommendations.
- Incorporation of the request regarding the Washington Health Trust proposal into the Commission and FTAC's work plan to the extent possible within the requested timeframe and available resources.

The 2023 Legislature also provided General Fund - State (GF - S) funding[3] for work required of HCA as specified in RCW 41.05.840 for fiscal years (FY) 2024 and 2025. This funding was borne out of the strong advocacy work by community members and advocates across Washington. Community members continue to engage with the Commission by attending meetings to provide encouragement, insightful feedback, and often graciously share personal and painful experiences suffered in the current health care system. The community's continued input is instrumental to the Commission's work to ensure that all Washingtonians have equitable access to culturally appropriate and affordable health care. The Commission is currently undertaking strategic planning to determine how to best use this funding, details of which will be included in the 2024 legislative report.

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[3] See Appendix C for a description of the funding allocated in ESSB 5187 Sec. 211 (58). https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20230629105003

Developments: October through December 2022

The Commission's baseline report to the Legislature due November 1, 2022, did not capture business from the Commission's October and December meetings. The following developments occurred over the October and December meetings:

- Vote to approve the baseline report to the Legislature
- Launch of FTAC
- Presentation from Oregon's Joint Task Force on Universal Health Care

Vote to approve the baseline report to the Legislature

For their 2022 baseline report, the Commission was required to make recommendations regarding the specific topics identified in the legislation. The Commission's recommendations were grounded in goals to increase access to quality and affordable health care by streamlining access to coverage, and to reduce fragmentation of health care financing, unnecessary administrative costs, and health disparities. The Commission's 2022 recommendations included:

- Transitional solutions that support goals of universal coverage including enrollment options, eligibility systems, access to care, quality improvement, and increased equity.
- Transitional strategies that can improve affordability and advance the state's readiness to implement a universal health care system.
- Potential pathways to increase Medicaid provider rates as requested by the legislature.[4]

At the October 2022 meeting, one Commission member raised concerns prior to voting to approve the baseline report.[5] Concerns included there being several unanswered questions for the universal health care system design, including eligibility and expectations for who or what entity would be responsible for determining coverage and benefits. The Commission member also suggested that there are pathways other than universal health care that may provide equitable access to coverage and may represent all Washingtonians. Additionally, it was suggested that the Commission first investigate reasons as to why individuals remain uninsured or lack access to care before developing a universal health care system design. Commission members acknowledged that eligibility, coverage and benefits, and other key design components will continue to be developed in the Commission's work to design Washington's new universal health care system.

Members' approval of the baseline legislative report[6, 7] marked a major milestone in the Commission's work, particularly with the first year being largely focused on the report's development.

[4] The Commission's 2022 recommendations are outlined in greater detail in the Executive Summary of the baseline report.

[5] Commission October 2022 meeting recording.

[6] The Commission members present voted by majority to adopt the final report (10 for, one opposed).

[7] 11 of 15 members were present for the vote to adopt the 2022 baseline report.

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Launch of FTAC[8]

In the U.S., the health care financing and delivery systems are inextricably linked; an individual's coverage and access to care are determined by the payer or financing source of that coverage. Federally funded and/or federally administered health care programs create additional barriers to achieving a state-based universal health care system with unified financing, such as legal obstacles to enrolling individuals receiving health care coverage through federal programs. Developing strategies to support Washington's future health care system requires disentangling how health care has historically been delivered and paid for.

The Commission determined that finance subject matter expertise specializing in health care financing would be essential to informing such strategies. As launched and directed by the Commission, FTAC provides guidance to the Commission in their development of a financially feasible model proposal to implement a universal health care system. FTAC is also charged with investigating strategies to develop unified health care financing options for the Commission's consideration, and to provide pros and cons for each option.

FTAC application process

FTAC applications (Appendix D*)* were developed based on applications for other Washington state boards and commissions. The Commission reviewed the proposed FTAC application and voted unanimously in favor of initiating the application process pending review of the application by the Office of Equity. [9]

HCA staff conducted extensive outreach to Washington state finance agencies, research and academic institutions, and outside subject matter experts to apply for FTAC. The call for applications was shared by HCA through a GovDelivery[10] announcement and the opportunity to apply was also posted to the Commission's webpage for at least 30 days. Applicants were required to complete and submit the application and their resume to HCA. The Commission received 54 applications and resumes for FTAC appointment consideration.

FTAC selection process

At the Commission's request, HCA and Health Management Associates (HMA)[11] reviewed each applicant's qualifications (resume and application) and provided recommendations to the Commission of the nine most qualified applicants that would meet the need for varied health care financing subject matter expertise.[12] The Commission voted unanimously to approve the recommended applicants and moved to nominate the consumer representative as the FTAC Liaison to the Commission to create an intentional connection between patients, consumers, FTAC, and the Commission.

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[8] FTAC's roster of members.

[9] The application was reviewed and approved by the Office of Equity prior to its release.

[10] GovDelivery is a web-based email subscription management system used by the Health Care Authority to allow members of the public to subscribe to news and information.

[11] HMA is the Commission's hired consultant.

[12] One position was held for a consumer representative, one position for the Washington Department of Revenue, and one position for the Office of Financial Management. The Commission agreed that FTAC applicants should disclose any conflicts of interest with their application.

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FTAC meetings and the Open Public Meetings Act

FTAC's charter was approved by the Commission and outlines the relationship and processes for information exchange between the Commission and FTAC (Appendix E). In accordance with the Commission's authorizing legislation, FTAC is not statutorily subject to the Open Public Meetings Act (OMPA). However, the Commission chose to include a public comment period at each FTAC meeting in alignment with the Commission's open and transparent process that encourages involvement from the public.

Presentation from Oregon's Joint Task Force on Universal Health Care[13]

The Commission received multiple public comments encouraging a presentation from Oregon's Joint Task Force on Universal Health Care (Task Force) on their legislative charge, process, system design, and other findings. In response to this request, the Commission invited Task Force representatives, including the Chair, one member, and one key staff member, to present at their December 2022 meeting.

Key components of the Oregon Task Force's final report

Oregon's Task Force worked over two years (plus a one-year extension due to COVID) and was charged with developing a state-based single-payer health care system, known as the Plan. [14, 15] Key components of the Plan:

- Eligibility
- Cost-sharing
- Benefits
- Goals
- Provider reimbursement
- Role of private health carriers

Presenters also shared the six health equity concepts from the Task Force's recommendations. The equity concepts include:

1. All Oregon residents are eligible.
2. No payment at the time of service.
3. Utilize one benefit plan.

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[13] The 2023 Oregon Legislature enacted Senate Bill 1089 establishing a Universal Health Plan Governance Board to create a comprehensive plan to finance and administer Oregon's Universal Health Plan based on the recommendations from the Joint Task Force on Universal Health Care. The plan is to be submitted to the Legislature by September 15, 2026.

[14] Senate Bill 770. 2019. https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB770/Introduced

[15] The Task Force recommended that the Oregon Legislature establish and fund a founding governing board to develop an implementation and financing plan as this component was not addressed by the Task Force due to time constraints. Joint Task Force on Universal Health Care Final Report and Recommendations. Prepared by the Legislative Policy and Research Office. September 2022. https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/257230

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4. Normalize reimbursement.
5. Uncouple coverage from employment.
6. Address social determinants of health with delivery system savings.

Public engagement process

The Oregon Task Force's budget included funding for a robust community engagement and outreach to key partners to vet their universal health care proposal. After completion of their final report, the Oregon Task Force held discreet listening sessions with consumers and different sectors of the health care marketplace.

After hearing Oregon's presentation, multiple Commission members agreed that such a public engagement process will be critical to informing Washington's system design proposal. The Commission advocated for developing a similar public engagement process, subject to resources, as Washington's universal health care proposal progresses.

Process and approach to work in 2023

The Commission remains dedicated to its mission to ensure that all Washingtonians have equitable access to culturally appropriate health care and universal coverage, and consistent input from members of the public continues to be a cornerstone of this work. The Commission's first year was primarily focused on the development of the required baseline legislative report. This year was focused on targeting the Legislature's overarching goals for the Commission, which are both forward looking in designing the new universal health care system, and reform-focused; intended to improve access, equity, quality, and affordability within the current health care system.

To best meet these goals, the Commission strategically structured meetings to focus partly on the foundational design components of the future system, and partly on further exploration and refinement of strategies to transition Washington to a universal system. Additionally, members determined that because the Commission is permanent and their work to design and transition Washington to the new system will develop over time, meetings should be framed as "iterative," where an approach or strategy discussed previously may be revisited for refinement. This framing also ensures that short-term solutions are consistent with the vision for the new health care system.

With this framing in mind, the Commission discussed and agreed upon the topics for each of its meetings and each of FTAC's meetings for 2023. Figure 1 illustrates the Commission's workplan.[16]

[16] Figure 1 illustrates the 2023 workplan as approved by the Commission. However, the Commission agreed that the workplan is subject to change depending on progress made at each meeting.

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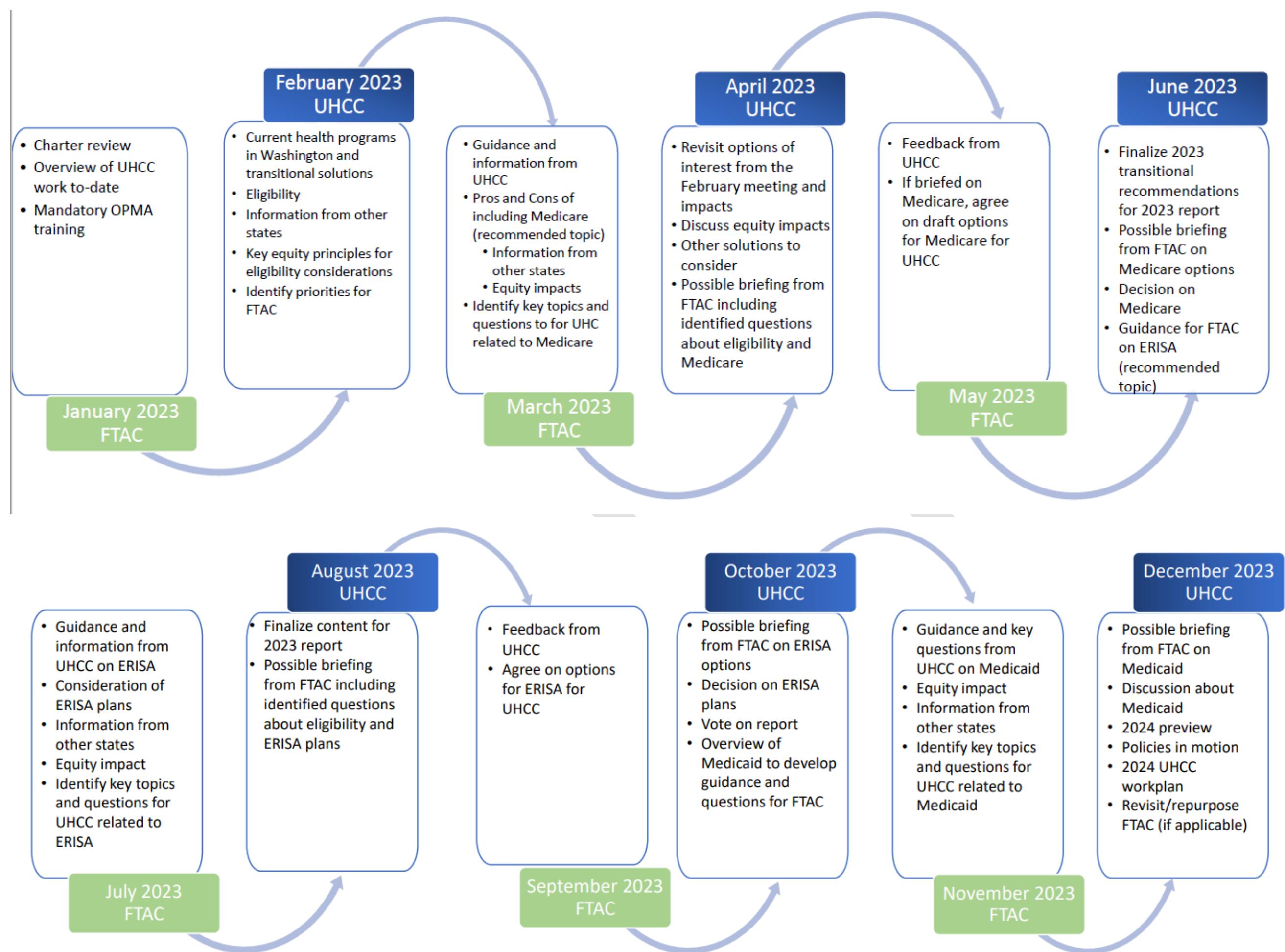
Figure 1: 2023 workplan



Workplan will change depending on progress made in each meeting.

In addition to the core meeting topics outlined above, the Commission identified three supplementary topics as elements of the discussion for each design element at meetings. The supplementary topics include:

1. Explore opportunities within current authorities.
2. Develop equity principles for designing the new system.
3. Assess information on other states and current programs in Washington.

Exploring opportunities within current authorities

The Commission continues to gather information on what existing opportunities could be leveraged to help the state transition to a universal system or could be expanded to serve as a function of the new system. For example, to complement the Commission's work on transitional solutions, FTAC members

were also surveyed for additional ideas. FTAC members included in their survey responses information as to whether the state currently has authority to implement any given option.[17]

Additionally, at the conclusion of the 2023 legislative session, Commission members representing state agencies shared legislative updates, providing insight into the Legislature's areas of interest both for the short and long term. [18] This informed the Commission's work to design the new system and to prioritize options that could transition the state to a universal system, details of which are described later in this report.

Developing equity principles for designing the new system

Financing and coverage policies and structures in the current health care system have contributed to the discrimination and marginalization of individuals with disabilities, low-income individuals, and people of color. Further, in the current system, an individual's coverage and access to quality care is largely determined by how the care is financed. The development and implementation of a unified financing system to support universal health care is an opportunity to examine existing structures and to establish a new system that ensures equitable access to affordable and quality care and wellbeing for all Washingtonians, including the health care workforce.

To inform the Commission's system design, Commission member Dr. Karen A. Johnson, former Director of the Washington State Office of Equity, presented an overview on equity.[19] Dr. Johnson emphasized several key points for the Commission to consider in their development of a system with guaranteed access to quality, affordable health care for all Washingtonians.

Key points

- Achieving equity will not be accomplished through treating everyone equally, but by treating everyone justly according to their circumstances.
- Bringing the community to the table is essential to the design of a universal healthcare system.
- It is not possible to discuss health equity without acknowledging the impact of racism on the health of communities, families, and children.
- Health inequities have implications including economic costs, health care costs, quality of life, and duration of life.

With these considerations, the Commission adopted a health equity framework with which to evaluate proposals to ensure that all recommendations have an equitable impact on all Washingtonians. The health equity framework is detailed later in this report.

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[17] FTAC's proposed transitional solution ideas gathered from their survey responses can be found in Appendix F.

[18] Five state agencies are represented on the Commission. These include the Department of Health, Health Benefit Exchange, HCA, Office of Equity, and Office of the Insurance Commissioner.

[19] Commission April 2023 meeting recording.

Assessing information on other states and current programs in Washington

Washington is not alone in its desire to reform the current health care system while also designing a state-based universal system supported by unified financing. In recent years, both Oregon and California passed legislation creating entities to design respective state-based universal health care systems. Details of these states' work on the topic of eligibility are described later in this report.

While Oregon and California are on paths similar to Washington's, the state of Vermont ventured to implement a state-based, single-payer health care system nearly a decade ago. Though Vermont's universal system did not materialize, the Commission expressed interest in what can be learned about the state's efforts.

In addition to gathering information on developments and lessons learned from other states, Washington's Indian health care delivery system offers an example of a universal system already operational in the state. While not a single-payer system, the Jamestown S'Klallam Tribal Health Benefit Program uses braided funding to finance its delivery system and has achieved 100 percent coverage for Tribal members living in the service area. The principles of this program may offer a potential pathway to achieving 100 percent coverage in the state of Washington. Details of the Jamestown S'Klallam Program are described later in this report.

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Areas of focus

The COVID-19 pandemic exposed health disparities and health care disparities stemming from past and enduring inequitable policies and practices in and outside of the health care system. Additionally, with federal protections from Medicaid disenrollment ending this year, loss of coverage and/or forgoing care due to financial barriers is anticipated for thousands of Washingtonians. As such, the Commission focused on ways to achieve the greatest and most immediate impact for the most amount of people. With this goal in mind, and focusing partly on interim steps and partly on future system design, the Commission agreed to focus on the following areas:

- Eligibility for the future universal system
- Transitional solutions
- Adoption of a health equity framework with which to evaluate proposals for the new system design
- The request to analyze the Washington Health Trust bill.

Universal system design: eligibility

Achieving universal coverage requires determination of how to design a system where all Washington residents would be eligible for coverage. The Legislature's goal is to include all state residents in Washington's future universal health care system. As such, the Commission selected eligibility as the first design component to examine. [20]

Eligibility goals as provided in SB 5399

> "The Universal Health Care Commission is established to create immediate and impactful changes in the health care access and delivery system in Washington and to prepare the 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 has become available."

In their work to examine paths to achieving universal eligibility for the new system, the Commission identified several considerations and potential challenges. Table 1 outlines the identified eligibility considerations for specific populations.

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[20] In their baseline report, the Commission identified the following design components of a universal health care system: cost containment, coverage and benefits, eligibility, enrollment, financing, governance, infrastructure, and provider participation and reimbursement.
https://www.hca.wa.gov/assets/program/commission-baseline-report-20221101.pdf

Table 1: Key eligibility considerations

Eligibility population	Considerations
Washington residents[21]	Would the definition of meeting residency requirements for health insurance coverage differ from the current standard of residency determination for the state?[22, 23]
Out-of-state residents working for Washington employers	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?
Opt-in options for individuals covered by employer-sponsored insurance	Would individuals with fully insured, employer-sponsored coverage be eligible to opt in?
Self-funded employer health benefit plans	Would individuals with self-funded employer-sponsored coverage be eligible to opt in?
Federal Employees Health Benefits and Veterans' Health Administration (VHA)	Would federal employees be covered by federal programs such as Federal Employees Health Benefits and the VHA be eligible to opt into the system?
Enrollees of insurance programs that are federally funded and/or federally administered, or subject to federal law	Would Medicare enrollees be included in the program? Would Medicaid enrollees be included in the program? Would enrollees of a health plan subject to federal Employee Retirement Income Security Act of 1974 (ERISA) laws be included in the program?

The eligibility barriers for Washington's universal system are largely federal with regulatory and legal implications. For example, Medicare is entirely federal domain both in terms of funding and administration. Conversely, while Medicaid is administered and partly funded by states, the program also receives federal funding. Finally, ERISA preempts state regulation of self-funded employer health benefit plans. Under ERISA, states can regulate fully insured individual and group health plans.

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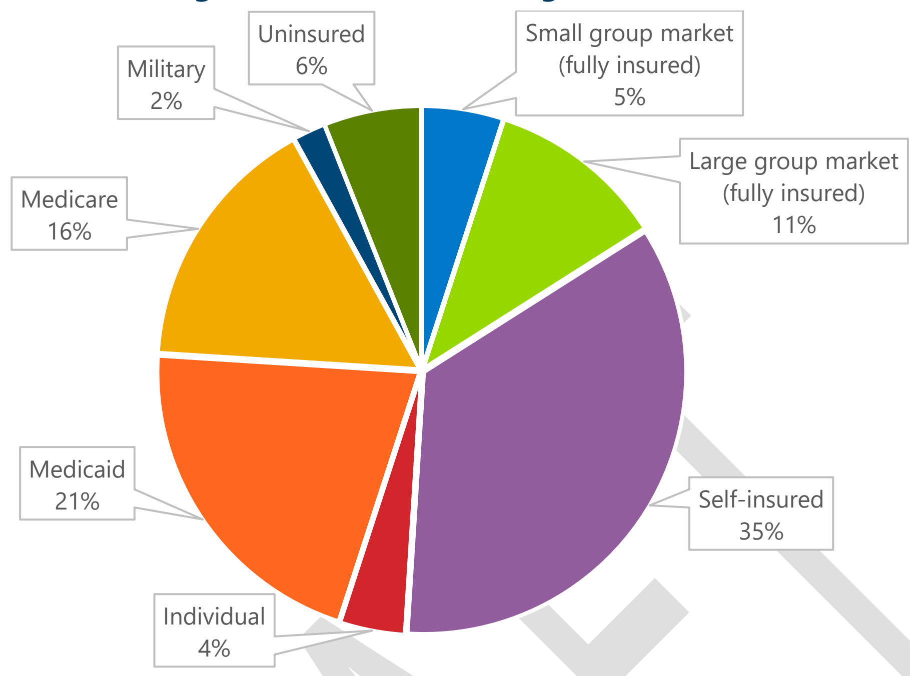
[21] Consultation with Tribes will also be essential to informing eligibility for the future universal health care system.
[22] Washington Department of Revenue. State residency definition.
https://dor.wa.gov/contact/washington-state-residencydefinition#:~:text=Persons%20are%20considered%20residents%20of,a%20temporary%20or%20transient%20basis.
[23] Establishing a residency definition could bring in consideration of the constitutional right to travel.

Figure 2: Health coverage estimates in Washington, 2021



Though Medicare, Medicaid, and ERISA each present significant barriers, the long-term goal for both the Legislature and the Commission is to ensure eligibility for all Washington residents, including enrollees of these respective programs when possible.

Figure 2 illustrates health coverage estimates in Washington for 2021.[24] When combined, individuals covered by these three types of programs represent nearly 90 percent of Washingtonians. Including enrollees of these programs in the universal system is necessary to ensure that all Washingtonians receive comparable health care benefits and equitable access to care. Additionally, capturing funding from these programs is critical to creating and sustaining Washington's universal system supported by unified financing.

The Commission's eligibility assessment

Including various eligibility groups requires thorough examination of the regulatory and legal barriers and an understanding of each program. FTAC members were selected by the Commission for their extensive subject matter expertise on topics such as this, and the committee was directed by the Commission to examine options to include each of the following eligibility groups in Washington's universal system.

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[24] The data in the figure are estimates and provide a reasonable overview of coverage in Washington. Data are from OIC internal carrier enrollment reports (using 2021 reports), the American Community Survey's health insurance coverage tables, and Kaiser Family Foundation (KFF) self-insured data. The estimate of individuals in self-funded group health plans is based upon the calculation of known enrollment and national estimates from KFF annual employer health benefit survey and others. Health Coverage Estimates in Washington. 2021. OIC.

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- Medicare-eligible Washingtonians[25]
- Washingtonians receiving health care coverage through an employer (ERISA)[26]
- Medicaid-eligible Washingtonians[27]

At the Commission's direction, FTAC examined the eligibility groups in the order in which they are listed above.

Assessment of options to include Medicare

Medicare is a federal health insurance program for individuals aged 65 and older. Individuals under 65 with long-term disabilities also qualify for Medicare through the Social Security Disability Insurance (SSDI). Approximately 1.4 million Washingtonians are enrolled in Medicare.[28]

The Medicare program consists of four components, including Medicare Parts A, B, C, and D. The financing mechanisms for and services covered under each component are as follows:

- **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, interest earned on trust fund investments, and beneficiary premiums. Part B covers physician visits, outpatient services, preventive services, and some home health visits.[29]
- **Medicare Part C** (Medicare Advantage) is Medicare's managed care program that combines and delivers Parts A and B through contracted carriers.[30] Medicare Advantage (MA) plans are financed by monthly payments from the federal government based on bids submitted by the carriers and monthly premiums.
    - MA plans have grown increasingly popular amongst Medicare enrollees in Washington. As of March 2023, approximately 663,500 Medicare beneficiaries were enrolled in MA

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[25] KFF. Total Number of Medicare Beneficiaries by Type of Coverage. 2021. https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[26] Approximately 3.9 million Washingtonians receive health care coverage under a health plan subject to ERISA.

[27] As of June 2023, approximately 2.3 million Washington residents were enrolled in Apple Health, Washington's Medicaid program. https://hca-tableau.watech.wa.gov/t/51/views/ClientDashboard-Externalversion/AppleHealthClientDashboard?%3AisGuestRedirectFromVizportal=y&%3Aembed=y

[28] Monthly enrollment by state. Washington. March 2023. CMS. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/monthly/monthly-enrollment-state-2023-03

[29] Part B spending accounts for the largest share of Medicare benefit spending (48 percent in 2021). What to Know about Medicare Spending and Financing. Kaiser Family Foundation, 2023. https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/

[30] MA plans are required to cover all medically necessary services covered by traditional Medicare. However, some plans may offer additional benefits such as vision, hearing, and dental services.

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plans.[31] This accounts for roughly 45 percent of Medicare enrollees, up from about 37 percent in March 2020,[32] and approximately 32 percent the same month in 2018.[33, 34]

- **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.

Examination of Medicare integration by other states

As previously mentioned, the Commission's strategic plan for 2023 includes gathering information from other states and current programs in Washington. The following are summaries of what the states of Oregon and California have examined with regards to Medicare integration for their respective and future state-based universal health care systems, and the Jamestown S'Klallam Tribal Health Benefit Program in Washington.

The Oregon Task Force's proposed implementation guidance

1. Act of Congress: Federal action to expand states' Medicare authority and/or innovation to establish a state-based single-payer system to support comprehensive benefits with corresponding Medicare funding.
2. Medicare Advantage: State-sponsored MA plan available to supplement benefits of the Plan.
3. Waiver: Oregon obtains CMS approval to use demonstrations and/or innovation to provide benefits to Medicare-eligible Oregonians through mixed funding streams.
4. Wraparound Services: provide Plan-covered services, such as behavioral health or dental care to wrap around services not covered by Medicare.

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[31] Monthly enrollment by state. Washington. March 2023. CMS. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/monthly/monthly-enrollment-state-2023-03

[32] Monthly enrollment by state. Washington. March 2020. https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldatamonthly/monthly-enrollment-state-2020-03

[33] Monthly enrollment by state. Washington. March 2018. CMS. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-State-Items/Monthly-Enrollment-by-State-2018-03

[34] The federal government has steadily increased spending on Medicare Part C. Beginning in 2023, Medicare spending on Part A and Part B benefits for enrollees in traditional Medicare will be outpaced by Part A and Part B benefits spending for MA enrollees. What to Know about Medicare Spending and Financing. Kaiser Family Foundation. 2023. https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/

California

The Healthy California for All Commission (HCAC) was also established in 2019.[35] HCAC is charged with developing a state-based health care delivery system[36] that provides coverage and access for all Californians through a unified financing system, including, but not limited to, a single-payer system. In 2020, HCAC finalized and submitted an environmental analysis to the governor and state legislature[37] acknowledging the federal barriers to integrating Medicare. HCAC also identified limitations with CMS' waiver authority, stating "it does not appear that CMS' waiver authority is broad enough to allow even a cooperative federal administration to flexibly fund the Medicare portion of a California system of unified financing without statutory change," however further analysis is needed.

HCAC's 2022 final report[38] examined the implications of including or not including Medicare in a state-based universal health care system. HCAC reiterated that a state-based unified financing system cannot be achieved without federal support. However, HCAC members disagreed as to whether federal support for California's unified financing system requires changes to federal law or could be accomplished through existing waiver authority. Some HCAC members noted that even reaching a favorable financing agreement with the federal government could expose California to financial risks in the future should the federal government ever change the terms of the agreement.

Brown & Peisch, a law firm specializing in federally funded health and benefit programs, was invited by the California Department of Health and Human Services to provide additional clarity on available options to integrate Medicare.

Key points of Brown & Peisch's legal memo

- There is no single federal waiver authority that would allow federal funds for Medicare, Medicaid, or Patient Protection and Affordable Care Act (ACA) advance premium tax credits to be redirected. Rather, each of these funding streams is subject to different authorities that permit the federal Department of Health and Human Services to waive certain federal requirements and limitations.

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[35] Senate Bill (SB) 104 (Chapter 67, Statutes of 2019). https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB104

[36] Including a plan with options to transition California to a unified financing system, including, but not limited to, a single-payer financing system.

[37] An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California. Healthy California for All Commission. June 2020. https://cdn-west-prod-chhs-01.dsh.ca.gov/chhs/uploads/2020/08/24133724/Healthy-California-for-All-Environmental-Analysis-Final-August-24-2020.pdf

[38] Key Design Considerations for a Unified Health Care Financing System in California. April 2022. https://www.chhs.ca.gov/wp-content/uploads/2022/05/Key-Design-Considerations-for-a-Unified-Health-Care-System-in-California-Final-Report.pdf

- Any legal authorities that may allow for redirection of Medicare funding will depend on the current federal administration's interest in supporting states' unified financing systems. Exercise of this authority is unprecedented and politically challenging.[39]
- Alternatively, California could better pursue unified financing through enactment of federal waiver authority that allows states to use federal funding from existing health care programs, including Medicare, to deliver comprehensive health care coverage.[40]

Options to include Medicare and other sources of coverage as demonstrated by the Jamestown S'Klallam Tribal Health Benefit Program

Vicki Lowe, Commission Chair and Executive Director of the American Indian Health Commission for Washington State, presented to both the Commission and FTAC about a universal health care system currently existing in Washington. The Jamestown Tribal Health Benefits Program (Program) is an insurance-based program where coverage is based on all Tribal Citizens having the same level of coverage regardless of income or coverage eligibility.

Under federal law, Indian Health Service (IHS) programs are required to enroll eligible Tribal users in Medicare or Medicaid before purchased and referred care dollars can be accessed.[41] The Program's benefits wrapped around each Tribal Citizen's source of coverage, including Medicare, Medicaid, private and employer-sponsored insurance (ESI), which ensured benefits parity across the Program. For Medicare-eligible individuals, the Program purchased supplemental benefits and reimbursed members for out-of-pocket costs such as Medicare Part B premiums.

The Program is not an example of a unified financing system due to its utilization of mixed funding streams. However, the Program achieved 100 percent coverage for Tribal members living in the service area and these principles may offer a pathway to achieving 100 percent coverage in the state of Washington.

FTAC's discussion and guidance on Medicare options for Washington

At the direction of the Commission, FTAC discussed several options to address Washington Medicare enrollees' eligibility in the new system.[42, 43] This discussion followed presentations about Oregon and California's pursuits of a universal health care system, and Chair Lowe's presentation on the Jamestown S'Klallam Program.

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[39] This could potentially restrict Medicare recipients' choice of providers and could compel providers to participate in a new payment/delivery model. Additionally, California would be seeking to assume responsibility of Medicare recipients' benefits to which they are entitled by statute.

[40] Brown & Peisch cited H.R. 3775, the State-Based Universal Health Care Act (2021), as an example of proposed legislation that would provide California necessary authority for federal funds to be directed to the state as a lump sum.**https://www.congress.gov/bill/117th-congress/house-bill/3775/text?s=1&r=40**

[41] Purchased and referred care is defined as any care received outside of IHS.

[42] FTAC March meeting recording.

[43] FTAC May meeting recording.

Medicare overview

In May, FTAC reviewed the structure of the Medicare program.[44] The overview also included potential gaps in affordability and access that Medicare enrollees may experience if Medicare is not included in Washington's universal health care system. Table 2 illustrates potential gaps in coverage between the universal system and Medicare and affordability challenges Medicare enrollees might experience compared with Washington's universal health system as envisioned by the Universal Health Care Work Group.[45]

Table 2: Gaps in coverage and affordability for Medicare recipients in Washington's universal health care system

UHC goal	Medicare
No premiums	Premiums required for Parts B and D, and possibly Part C
No cost sharing for UHC options A and B*	Beneficiaries can face significant cost sharing
Would include vision care, and possibly dental and long-term care	Vision, dental, and long-term care not covered

*The Commission's 2022 report to the state legislature articulated three benefit design options, A, B, and C as envisioned by the Universal Health Care Work Group. Both A and B would eliminate cost sharing.

FTAC examined six options to address potential gaps in benefits and out-of-pocket costs for Medicare enrollees in Washington's universal health care system. The feasibility of various components under each option was assessed and is illustrated in Table 3. Based on this assessment, the six options ordered from least feasible to most feasible (Figure 3) and additional pros and cons of each option were examined.

Table 3: Feasibility considerations for options to include Medicare

	Captures federal funding	Waiver or law change required	Level of federal oversight	Preserves beneficiary choice	Covers premiums	Covers cost-sharing	Covers non-covered services
1. Act of Congress	Yes	Yes	Unknown	No	Unclear	Possibly	Possibly
2. Demo waiver	Yes	Yes	High	No	Unclear	Unclear	Unclear
3. MA, only option	Yes	Yes	High	No	Possibly, via rebates	Possibly, via rebates	Possibly, via rebates

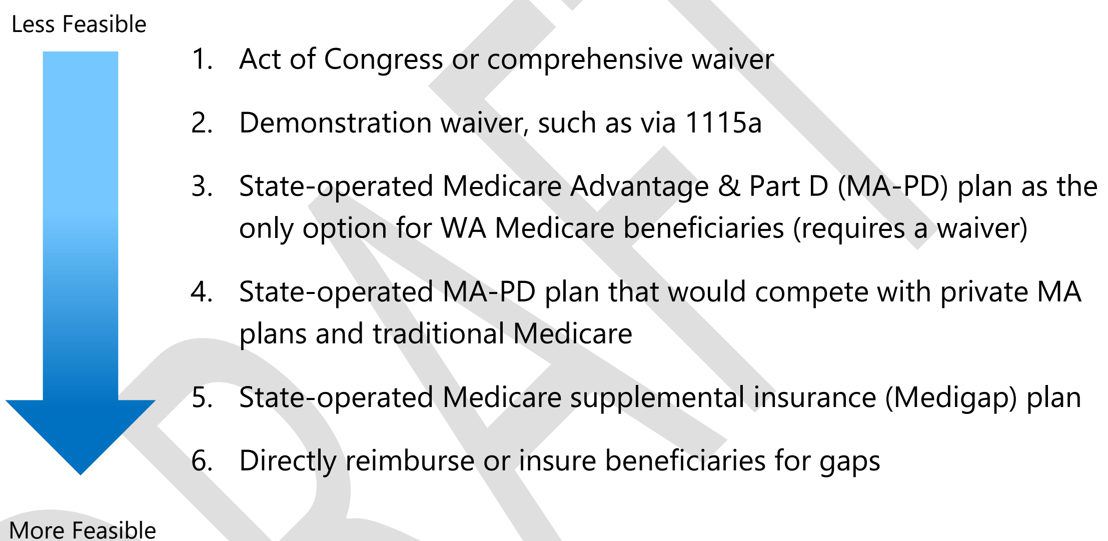
[44] FTAC May meeting recording.

[45] The Universal Health Care Work Group preceded the Commission. Work Group Final Report. 2021. https://www.hca.wa.gov/assets/program/final-universal-health-care-work-group-legislative-report.pdf

4. MA, competes	Yes, for enrollees	Probably not	High	Yes	Possibly, via rebates	Possibly, via rebates	Possibly, via rebates
5. State Medigap	No	Probably not	Medium	Yes	No	Yes	No
6. Reimburse directly	No	Probably not	Low to Medium	Yes	Yes, if covered	Yes, if covered	Yes, if covered

*Most options would also place an administrative burden on the state.

Figure 3: Options for incorporating Medicare ordered from least to most feasible



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Options to include Medicare in Washington's future universal health care system

Option 1: act of Congress or comprehensive waiver

Option 1 is an act of Congress or a comprehensive waiver granted by CMS, which, if obtained, would allow Washington to enroll all Medicare enrollees into the universal system design and leverage federal funding,[46] a key advantage of this option. However, there is no legal precedent for such, and it is unlikely to be achieved via legislation through the current Congress. Moreover, Medicare enrollees may still experience some premiums.

FTAC members agreed that Option 1 represents the "North Star," or ideal approach to addressing gaps in affordability and coverage for Medicare enrollees in the universal system, however pursuing Option 1 at

[46] This option was used to calculate potential costs and savings of Model A by the Universal Health Care Work Group.

this time is not an effective use of resources or time due to the significant federal barriers. Additionally, some members noted that CMS is unlikely to grant a waiver to a new and untested program.

Members recommended that the Commission focus on designing the new system and examine other transitional options to provide coverage and affordability parity for Medicare enrollees, rather than attempting to bring Medicare into the system from the outset.[47] It was also suggested that Washington consider actively partnering with Oregon to examine this option when Oregon's new governance structure[48] overseeing the universal health care system becomes operational.

Option 2: demonstration waiver

Option 2 would require Washington to obtain an 1115 Medicaid waiver[49] or a 402b Medicare waiver. These waivers are generally focused on Medicaid-related payment and delivery system reforms (1115) or Medicare payment-related reforms (402b). These waivers must be cost-neutral to the federal government and not compromise the quality of the existing program.

This option would allow the state to capture federal funding, however because these waivers are designed for other purposes, it is unclear how this option could be leveraged to cover premiums, cost-sharing or additional benefits for Medicare enrollees. These waivers also involve significant oversight and evaluation by the state throughout implementation that would result in administrative costs and budget neutrality requirements. Additionally, there is no precedent for granting these waivers to achieve Washington's objectives. Finally, there is a possibility that even if granted by CMS, these waivers would be subject to legal challenges.

FTAC members agreed that Option 2 is not viable for achieving the goals of the universal system given that the intent of these waivers differs from what the Commission is trying to achieve. However, this option could complement the work being done via the universal health care system in areas such as cost containment and payment reform. Other areas of potential opportunity for the Commission to address payment reform include 2023 legislation (ESSB 5187) directing the Attorney General Office and Office of the Insurance Commissioner (OIC) to study market consolidations and anticompetition and hospital global budget strategies.[50, 51]

Option 3: state-operated Medicare Advantage & Part D (MA-PD) plan as the only option for Washington Medicare enrollees

This option would involve designing and implementing a MA-PD plan for Washington's Medicare enrollees that, to the extent MA rules allow, would provide benefits parity with Washington's universal

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[47] There was some discussion about the potential benefits of contracting with a law firm as California did to better understand necessary preparations to obtain a federal waiver or possible legislative pathways.
[48] Oregon Universal Health Plan Governance Board.
[49] This waiver from CMS would waive Section 1115 of the Social Security Act
[50] Sec.126(33) and Sec.144(13). https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20230629105003
[51] Some members recommended that any payment reform activity be done in consultation with the Health Care Cost Transparency Board.

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system. Under Option 3, the state's MA plan would be the only MA option for Washington's Medicare enrollees.[52]

Members noted several disadvantages to this option. Obligating MA enrollees to enroll in only the state MA plan would require a federal waiver from the provision that allows for choice and to preclude other MA plans from entering the market. This option would also involve resolving payment structures, as MA payments are tied to Medicare's fee-for-service (FFS) benchmark compared with whatever payment structure is utilized in the universal system. Another disadvantage to this option is the administrative costs the state would incur to develop, implement, and oversee an MA plan, or to contract to do the same. Finally, this option could be subject to legal challenges if Medicare enrollees are prevented from accessing traditional Medicare.

FTAC members agreed that it was difficult to envision how the state could legally implement this option given the unlikeliness of obtaining a waiver that would limit freedom of choice. Members recommended not expending resources and time on this option, especially at the outset. Some members felt that this option could serve as a pathway in the future once the value of the program has been established. It was noted that the state would likely face downside risk, as the state would likely be reimbursed by CMS on a per-member-per-month basis. Finally, several members expressed concerns regarding the implications of disallowing Medicare enrollees to remain in traditional Medicare or in their current MA plan.

Option 4: state-operated MA-PD plan that would compete with private MA plans and traditional Medicare

Option 4 involves the same scope of work for the state to design and implement an MA plan with many of the same limitations as Option 3. However, under Option 4, the state's MA plan would compete with other private MA plans, where Medicare-eligible Washingtonians wishing to enroll or continue coverage with traditional Medicare could do so. This option does not limit Medicare enrollees' choice, potentially lessening the threat of legal challenges.

FTAC's response to this option was mixed. In addition to the administrative burden of designing and implementing the model like Option 3, the main concern with this option is the competition the state would face by entering a mature MA-PD market with multiple carriers offering over 100 MA plans. Additionally, Medicare-eligible Washingtonians may be inclined to renew existing coverage or could select options other than the state's, limiting the potential of federal dollars and the overall impact of this option.

However, FTAC did not recommend this option being completely removed as a possibility. There may be a possibility for this option to sit alongside Option 6 (direct reimbursement of insurance for gaps) in the future.

Option 5: state-operated Medicare supplemental insurance (Medigap) plan

Under Option 5, the state would develop and offer a Medigap plan to fill gaps in benefits between Medicare and the universal health care system. This option would allow the state to offer benefits to Medicare enrollees that are not covered under Medicare. However, Medigap plans do not cover benefits for hearing, vision, and supplemental drug coverage, which does not align with the Commission's goals

[52] There are currently 18 carriers offering 100 MA plan types.

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for the universal system design. Moreover, the state would be limited in its ability to reduce Medicare enrollees' Part B deductibles with this option.[53] Finally, this option would not be available to MA enrollees, nor allow the state to leverage federal Medicare dollars.

FTAC members acknowledged that this option seemed feasible in terms of existing legal authorities and may be the least administratively burdensome to the state to implement. However, there were concerns that this option could not fully address benefits gaps between Medicare and any universal system design because of the extensive and complex regulatory requirements of Medigap plans. Additionally, like Option 4, this offering would require the state compete with other plans in a mature market and would not leverage federal funds. There was some interest in this idea as a possible short-term option, potentially paired with Option 1 or 2 in the long-term. However, the majority of FTAC members did not support Option 5 at this time.

Option 6: directly reimburse or insure Medicare enrollees for gaps

Option 6 would establish a system to directly reimburse enrollees for cost-sharing and for services covered by the universal system but not by Medicare. This option allows the most flexibility to fully address gaps and would not require waivers nor result in legal challenges. Disadvantages to this option include the potential variances between Medicare enrollee choices, with federal rules potentially limiting the ability to wrap around Parts A & B. This option could also invite gaming from MA plans and may be administratively burdensome for the state and consumers. Finally, this option does not allow the state to leverage federal Medicare dollars.

FTAC members agreed that at this time, Option 6 presents the best option and most feasible pathway to address gaps in cost-sharing and benefits for Medicare enrollees. There was interest in learning more about the nuances of Option 6 and how it might be developed in the short-term to ensure parity.

FTAC members agreed that revisiting Option 6 with further analysis and decision-making will need to occur after the Commission has determined the services and benefits of the new universal system design. Until then, further analysis to determine what gaps need to be filled between existing Medicare services and benefits, and the services and benefits of the new system design is not possible. It was also noted that while federal dollars would not fund these additional benefits, placing the financial burden on the state, this option could be explored in conjunction with one of the waiver options to secure federal funding and/or as a means of payment reform or cost containment.

Additional Medicare considerations for the Commission's consideration

There were additional suggestions offered by FTAC members related to improving cost-sharing and services for Medicare enrollees, mainly through expanding eligibility for the Medicare Savings Program (MSP) and increasing eligibility for dual Medicare/Medicaid beneficiaries.[54] An additional option to expand

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[53] Individuals eligible for Medicare on or after January 1, 2020 cannot purchase Medigap plans that cover the Part B deductible, or Plans C or F. https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf

[54] The 2023 legislature took action to expand MSP by appropriating $6.3 million, removing asset tests and increasing the Qualified Medicare Beneficiary (QMB) program from 100 to 110 percent of the federal poverty level.

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services for low-income Medicare beneficiaries could be expanding Medicaid Categorically Needy coverage, which would provide full scope Medicaid coverage, including long-term care.[55] These additional considerations were intended to inform the Commission's future discussions about potential transitional solutions that improve coverage available for Washingtonians today that may help pave the way for the universal health care system of tomorrow.

The Commission's vote on Medicare

FTAC members produced a Medicare Memo[56] for the Commission capturing FTAC's discussion and recommendations on options to achieve parity for Medicare enrollees and how to include Medicare in Washington's universal system. FTAC's guidance, including the pros and cons of each option, was provided to the Commission at their June meeting.[57]

While a comprehensive waiver (Option 1) is the most beneficial option and the "North Star" for achieving the goals of a universal health care system supported by unified financing, this option lacks federal authority to implement. FTAC recommended direct reimbursement (Option 6) as the most feasible option for the short term to achieve coverage parity for Medicare enrollees which could be explored in conjunction with one of the waiver options. However, this requires further analysis. FTAC recommended that the Commission determine benefits and services and come back to this discussion to explore whether to pursue a waiver, rather than pursuing a waiver at the outset.

In reviewing FTAC's guidance, one Commission member expressed concerns with adopting FTAC's recommendations on Medicare eligibility given that some questions regarding larger system design, such as benefit design, have not yet been addressed. However, as some Commission members noted, the guidance is not set in stone, but having this guidance allows the Commission to move forward in their design work. FTAC was also directed to examine this topic early in the Commission's design work to identify whether the assumption should be that a Medicare waiver could be obtained at this time. The Commission voted to adopt FTAC's guidance in the Medicare Memo (seven for, one opposed).

Preliminary assessment of options to include ERISA-eligible individuals

ERISA is the next eligibility group scheduled to be examined for integration into Washington's universal system. Since ERISA preempts state laws that impact employer benefits, [58] Washington is constrained in its

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[55] WAC 182-501-0060(6) lists the general categories of Categorically Needy services. All medically necessary services are covered.

[56] Appendix G.

[57] Eight members were present for the vote. Commission June meeting recording.

[58] Federal ERISA law sets minimum standards for health plans established and funded by employers to provide health care to their employees. Employer health plans can be "fully insured" or "self-funded". Both types of these health plans must comply with ERISA. However, the state's role varies based upon whether a plan is fully insured or self-funded. An employer that offers a fully insured health plan is paying for premiums to a health insurer and the insurer bears the financial risk of coverage. An employer that offers a self-funded health plan has chosen to bear the financial risk of health care services used by their

ability to regulate employer benefits or achieve benefits parity between employer benefits and the future system. Pathways for capturing revenue, such as employer contributions, to support the unified financing system must also be thoroughly examined.

The Commission directed FTAC to examine several components of ERISA in addition to surfacing options to include ERISA in Washington's future system.

Questions and comments from the Commission for FTAC's assessment of ERISA eligibility

- How ERISA law has evolved, areas of the law that are unchanged since the last analysis done on the topic, and any new approaches with potential areas of opportunity?
- Since employer funding contributions may be optional, examine how any employer contributions could be captured under the various ERISA eligibility options to fund the new system.
- Potential options to include ERISA and capture revenue to support the unified financing system:
    - Option 1: Employers pay into the universal system and employees are covered by the universal system.
    - Option 2: "Pay or play," where employers have a choice to continue provide coverage to their employees.
        - What are the implications of ACA mandated employer responsibilities?
        - If employers choose to continue providing employees' coverage, could Washington mandate that the minimum essential coverage required under the ACA match the coverage provided under the new system?
        - What are the quality and equity implications of benefits differing between employer coverage and the universal system?

In July, FTAC began gathering information on ERISA in preparation for further discussion and recommendations to the Commission on ERISA eligibility.[59] FTAC's full assessment of ERISA and recommendations to the Commission will take place in September, details of which will be included in the 2024 legislative report. The topics examined at FTAC's July meeting will also be detailed in the 2024 legislative report.

Topics discussed at FTAC's July meeting

- ERISA case law examples that continue to articulate the ERISA preemption test
- The Supreme Court's interpretation of the ERISA preemption clause
- The impact of ERISA preemption on health care reform and state-based universal health care initiatives

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employees, and often will contract with an outside entity to administer their health plan (called "third party administrators" or "TPAs"). The ERISA statute exempts these plans from most state regulations.

[59] Presentations by Carmel Shachar, J.D., and Jane Beyer, J.D., can be found in FTAC's July meeting recording.

- Washington’s health care coverage by market, including fully insured large group and small markets and the self-insured market
- Health plan regulation in Washington, including which entities regulate which health plans, required benefits, provider network adequacy, and eligibility
- Examples of health policy in Washington that have or have not been challenged due to ERISA.

Assessment of options to include Medicaid-eligible individuals

Medicaid is the third eligibility group scheduled to be examined for integration into Washington’s universal system. Including Medicaid funding as a revenue source for Washington’s new system will be complex but perhaps not as complicated as Medicare because there is an established process and experience with states seeking and obtaining Medicaid flexibilities, such as an 1115 waiver from CMS.

Another challenging aspect of integrating Medicaid will be identifying options to achieve benefits parity between Medicaid and the future system. Whereas Medicare’s benefits may be less comprehensive than what the Commission envisions for the new system, Apple Health (Medicaid) provides some benefits that are not included in Washington’s essential health benefits (EHB) mandated by the ACA 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.

With FTAC’s guidance, the Commission will need to determine how Apple Health’s additional services could be provided to all Washingtonians under the new system or examine mechanisms to ensure that everyone who would otherwise be eligible for Medicaid will receive these additional services. FTAC is scheduled to begin examining options to include Medicaid in the Fall of 2023, findings of which will be included in the Commission’s 2024 legislative report.

Transitional solutions

In addition to designing Washington’s future universal system, the Commission is charged with implementing immediate and impactful changes in Washington’s current health care system to increase access to quality, affordable health care by:

- Streamlining access to coverage.
- Reducing fragmentation of health care financing across multiple public and private health insurance entities.
- Reducing unnecessary administrative costs.
- Reducing health disparities.
- Establishing mechanisms to expeditiously link residents with their chosen providers.

The Commission’s 2022 baseline report identified opportunities to improve the affordability of and access to coverage and care in the current system, including strategies to help transition the state to the universal system. Several of these recommendations were funded by the Legislature during the 2023 legislative session, details of which are described below. This section also outlines the Commission’s ongoing work to identify and prioritize opportunities to prepare Washington for the transition to a universal system.

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The 2023 Washington Legislature's support of the Commission's 2022 recommended transitional solutions

Several of the Commission's 2022 recommended transitional solutions were funded by the 2023 Washington Legislature. This is perhaps a testament to both the Legislature's commitment to advance state health care reform and the Commission's role in accomplishing that goal as a panel of experts representing the state or as a stakeholder sounding board for opportunities to improve care for Washingtonians. The Commission's 2022 recommended transitional solutions funded by the Legislature are outlined in Table 4.

Table 4: Commission's 2022 transitional solution recommendations funded by the 2023 Legislature

Commission's 2022 recommendations	Action by the 2023 Legislature
Continue funding the **Cascade Care Savings** program to make coverage more affordable.	Funding provided to the Washington Health Benefit Exchange (HBE) to continue administering Cascade Care Savings (premium assistance program) for individuals up to 250 percent of the federal poverty level (FPL) who purchase a health plan on the Exchange.[60]
Increase Medicaid provider rates for **applied behavior analysis** (ABA) to improve access to care for Medicaid enrollees.	Funding provided to HCA to increase reimbursement rates by 20 percent for ABA for individuals with complex behavioral health care needs, and by 15 percent for all other ABA codes.[61]
Increase Medicaid provider rates for **behavioral health** to improve access to care for Medicaid enrollees.	Funding provided to HCA to increase behavioral health rates for both Medicaid FFS and managed care providers.[62]

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[60] ESSB 5187, Sec. 214 (4)(a). Eligible individuals must also meet other eligibility criteria as established in RCW 43.71.110(4)(a).

[61] ESSB 5187, Sec. 211 (49). Codes include 0362T and 0373T beginning January 1, 2024. Does not include Q3014 (telehealth facility procedure code). https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20230629105003

[62] ESSB 5187, Sec. 211 (51). Rate increases are effective January 1, 2024, and must be applied to the following codes for children and adults enrolled in Medicaid: 90785, 90791, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90846, 90847, 90849, 90853, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171, H0004, H0023, H0036, and H2015. HCA is directed to implement this rate increase in accordance with the process established in **RCW 71.24.885** (Medicaid rate increases) and must raise the state FFS rates for these codes by up to seven percent (not to exceed the published Medicare rate or an equivalent relative value unit rate if a published Medicare rate is not available). HCA must require in managed care organizations' (MCOs) contracts that beginning January 2024, MCOs pay no lower than the FFS rate for these codes and adjust managed care capitation rates accordingly. Ibid.

Increase Medicaid provider rates for **children's dental** to improve access to care for children enrolled in Medicaid.	Funding provided to HCA to increase the children's dental rate[63] by at least 40 percent above the Medicaid FFS rate in effect on January 1, 2023.[64]
Implement the **Integrated Enrollment and Eligibility Modernization Roadmap** to support Information Technology infastructure necessary for a universal health care system.	Funding provided to the Department of Social Health Services (DSHS) for the Integrated Enrollment and Eligibility Modernization Project to create a comprehensive application and benefit status tracker for multiple programs and to establish a foundational platform. [65]
Invest in **Apple Health coverage expansion** to increase access to coverage and care.	Funding provided to HCA to expand coverage to adults ineligible for Medicaid or federal subsidies by reason of immigration status. [66]

The funding of the Commission's above recommendations is a significant achievement given the early stage of this work. The Commission will monitor the implementation and progress of the above transitional solutions as their work to design and transition the state to the future system evolves.

Ongoing work to identify and prioritize transitional solutions

The Commission is encouraged that several of their 2022 recommendations were funded by the 2023 Legislature, though there is more work to be done. This year, the Commission focused on identifying a new set of intermediate strategies that can help improve the current health care system and advance the state's readiness to implement a universal health care system.

In January, Commission members identified new areas of opportunity to explore. As directed by the Commission, FTAC members were also asked to identify additional areas. Together, the Commission and FTAC produced over thirty transitional solutions which were then grouped into categories (Table 5) for the Commission's consideration to prioritize.

Table 5: Transitional solutions categorized and considered by the Commission for prioritization[67]

Category	Transitional solution options
Affordability/cost containment/pricing[68]	• Facilitate accessibility of hospital price transparency data • Out-of-network (OON) price caps

[63] For procedure code D1120.
[64] Beginning January 1, 2024.
[65] ESSB 5187, Sec. 205 (11-13) provides funding to the Department of Social and Health Services (DSHS) for the Integrated Enrollment and Eligibility modernization project to create a comprehensive application and benefit status tracker for multiple programs and to establish a foundational platform. Ibid.
[68] ESSB 5187, Sec. 114 (13) directs OIC to study approaches to improve health care affordability in Washington, including but not limited to those being used or considered by other states with regards to health provider price or rate regulation policies or programs other than traditional health plan rate review

	• OON price caps for the Cascade Select program • Reduce ACA affordability threshold • Reference based pricing for the Public Employee Benefits Board/School Employee Benefits Board (PEBB/SEBB) • Regulated hospital global budgets • State agency rate normalization
Capacity/infrastructure	• All payer or multi-payer quality program • Enhance telehealth capacity • Improve public health
Coverage/enrollment	• Auto-assign Medicaid enrollment to high-quality/lower-cost plans • Auto-enrollment for Medicaid to no-premium Exchange plans • Codify and fully fund Apple Health expansion[69] • Increase participation in the Medicare Savings Program (MSP)[70] • Uninsured analysis • Universal enrollment
Providers	• Motivate interest in preventative and primary care • Network adequacy standards • Provider participation analysis • Standardize claims adjudications • State provider participation

to increase affordability for health insurance purchasers and enrollees, and regulatory approaches to address any anticompetitive impacts of horizontal consolidation and vertical integration in the health care marketplace to supplement federal antitrust law. OIC's preliminary report is due December 1, 2023 with a final report due August 1, 2024. This work is undertaken in partnership with the Washington State Office of the Attorney General and in consultation with HCA, HBE, and the Department of Health. https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20230905081501

[67] Descriptions for the listed options are included in Appendix F.

[68] ESSB 5187, Sec. 114 (13) directs OIC to study approaches to improve health care affordability in Washington, including but not limited to those being used or considered by other states with regards to health provider price or rate regulation policies or programs other than traditional health plan rate review to increase affordability for health insurance purchasers and enrollees, and regulatory approaches to address any anticompetitive impacts of horizontal consolidation and vertical integration in the health care marketplace to supplement federal antitrust law. OIC's preliminary report is due December 1, 2023 with a final report due August 1, 2024. This work is undertaken in partnership with the Washington State Office of the Attorney General and in consultation with HCA, HBE, and the Department of Health. https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20230905081501

[69] Funding provided to HCA to expand coverage to adults ineligible for Medicaid or federal subsidies by reason of immigration status.

[70] Expanding eligibility for MSP was also noted in FTAC's guidance to the Commission as a potential pathway to improving cost-sharing and services for existing Medicare enrollees.

	• Study of provider rate regulatory approaches
Purchasing	• Consolidate state purchasing
Subsidies	• Expand premium tax credit • Expanded HBE Cost-Sharing Subsidies

The Commission will assess the feasibility and impact of the above transitional solutions. Details of the selection process and selected transitional solutions will be included in the Commission's 2024 legislative report.

Health equity framework to evaluate design proposals

The health equity implications of the larger system's eligibility design were at the center of the Commission's discussions this year. One of the primary health equity concerns was the ability of the state to achieve benefits parity between the new system[71] and Medicare, ERISA, and Medicaid. If the universal system provides comprehensive coverage and benefits but only to a subset of the population (individuals not covered by one of these coverage sources), Washington could perpetuate existing health inequities and health disparities.

This and other health equity implications are critical to assess and consider in the Commission's work to design an equitable health care system. As such, the Commission sought to develop a health equity framework by which to consider and evaluate design proposals. The Commission enlisted the expertise of Dr. Quyen Huynh, Health Equity Director, HCA, to provide further information and guidance on potential health equity frameworks.[72]

Adoption of a health equity framework

Dr. Huynh shared that health equity, defined by HCA as everyone having a fair and just opportunity to be as healthy as possible, is at the center of HCA's vision, mission, and strategies. HCA has been intentional in creating an internal health equity infrastructure to support its external efforts. This includes the development of a health equity framework utilized for decision making in agency's role to purchase health care for millions of Washingtonians. Additionally, HCA's Health Equity Toolkit[73] was developed to help staff apply an equity lens[74] when designing or evaluating policies, programs, and services.

Dr. Huynh cautioned that sometimes, well-intentioned policies do not achieve predetermined goals, where communities most impacted are often not involved or elevated from the outset. Recognizing that those with lived experience are the true experts, HCA strives to build a two-way relationship with the community and hear from community members how HCA's services and programs impact them.[75] Dr.

[71] Benefits and services are scheduled to be discussed in 2024.
[72] Commission June meeting recording.
[73] HCA's Health Equity Toolkit also helps staff identify and address health disparities in the development of legislative bill analyses. HCA's Health Equity Toolkit can be found in Appendix H.
[74] Using an equity lens means evaluating something for inequitable health impacts on groups of people.
[75] HCA created the Pro-Equity Anti Racism Community Advisory Team (PEAR CAT) to build community engagement, which involves direct contact with the people being served. This is distinct from gathering

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Huynh explained that HCA centers diversity, equity, inclusion, and belonging at the state Medicaid agency level and continues to engage communities through this lens to ensure that those who are most disenfranchised have a seat at the decision-making table. In addition to advancing health equity, community engagement efforts can build trusting relationships with the communities being served by this work.

Dr. Huynh noted that the current health care system was built without intentional equity. As a result, some existing infrastructure must be dismantled, power re-distributed, and community voices elevated. However, this work must move at the pace of the community. Dr. Huynh implored the Commission to apply a consistent equity framework and an equity lens each time decisions are made.

The Commission agreed that utilization of the health equity framework and Health Equity Toolkit would support their work to design a universal health care system with health equity at its center. The Commission directed staff to build in a health equity analysis process for design proposals expected to impact health equity. These analyses will occur prior to the Commission taking action at meetings, such as final action regarding recommendations. The Commission voted to adopt and apply the health equity framework to their recommendations (seven for, one opposed).[76]

Washington Health Trust analysis request

The Commission received a request from members of the Legislature to conduct an analysis of the Washington Health Trust (SB 5335) as introduced in the 2023 legislative session.[77] SB 5335 proposes the creation of the Washington Health Trust within the Washington Department of Health to provide coverage for a set of EHB to all Washington residents.

Per the request, the Commission's analysis should:

- Be shared in a report by June 30, 2024.
- Assess whether the proposal aligns with the goals and planned activities of the Commission.
- Assess whether and how the Commission might recommend implementing the proposal, if the Commission considers it within their mission and a viable proposal.
- Identify opportunities for Whole Washington, proponents of the bill, to substantively engage with the Commission in the future.
- Engage the leaders of Whole Washington throughout the analysis process and report preparation.

The Commission assessed the request and voted unanimously for its incorporation into the Commission and FTAC's work plan to the extent possible within the requested timeframe and available resources.[78] The Commission also invited Whole Washington to present on SB 5335 and the Commission will continue to engage with Whole Washington members throughout the process of analysis and drafting for the 2024

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input and feedback from key partners such as provider groups, hospital associations, or community-based organizations who hold interests in the work. HCA's Community Engagement Mini Guide.

[76] Eight members were present for the vote to adopt and apply the health equity framework.

[77] SB 5335 did not pass out of committee.

[78] Commission April meeting recording.

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report. Then, beginning in 2025, and until the analysis is complete, each of the Commission's legislative reports will summarize SB 5335 and how it would address key design components of a universal system.

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Conclusion

At the center of the Commission's discussions this year were eligibility for the larger system and the health equity implications of eligibility design. The Commission will assess the health equity impact of this and other design elements as they continue to be developed.

In the short-term, Washington is limited in both its ability to recoup federal funding to support a unified financing system, and to regulate coverage sources subject to or preempted by federal law. However, paths to achieving benefits parity in the short-term for Washingtonians eligible for Medicare, ERISA, and Medicaid have surfaced and will be examined further.

The Commission's authorizing legislation states that subject to sufficient existing agency authority, state agencies may implement transitional strategies that do not require statutory authorization or new funding. The Commission will build upon the success of their recommended transitional solutions being funded by the Legislature and continue to develop interim strategies that ensure equitable access to culturally appropriate health care for all Washingtonians.

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Appendix materials

The appendices to this report are as follows:

- Appendix A: Commission roster
- Appendix B: FTAC roster
- Appendix C: Funding allocated in ESSB 5187 Sec. 211 (58), 2023
- Appendix D: FTAC application
- Appendix E: FTAC charter
- Appendix F: FTAC proposed transitional solutions
- Appendix G: FTAC Medicare Memo
- Appendix H: HCA Health Equity Toolkit

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Appendix A: Commission roster

View the Commission's roster of members on HCA's website.

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Appendix B: FTAC roster

View the FTAC's roster of members on HCA's website.

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Appendix C: Funding allocated in ESSB 5187 Sec. 211 (58), 2023

The amounts provided in ESSB 5187 Sec. 211 (58), 2023 are outlined by fiscal year (FY).

FY 2024:

- $598,000 General Fund – State (GF – S) is provided:
  - $216,000 for staff dedicated to contract procurement, meeting coordination, legislative reporting, federal application requirements, and administrative support.
  - $132,000 for additional staff dedicated to the work of FTAC.
  - $250,000 for consultant services, dedicated actuarial support, and economic modeling.

FY 2025:

- $591,000 GF – S is provided:
  - $216,000 for staff dedicated to contract procurement, meeting coordination, legislative reporting, federal application requirements, and administrative support.
  - $125,000 for additional staff dedicated to the work of FTAC.
  - $250,000 for consultant services, dedicated actuarial support, and economic modeling.

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Appendix D: FTAC application

View the FTAC application on HCA's website.

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Appendix E: FTAC charter

View the FTAC charter on HCA's website.

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Appendix F: FTAC proposed transitional solutions

View the FTAC proposed transitional solutions on HCA's website.

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Appendix G: FTAC Medicare Memo

View the FTAC Medicare Memo on HCA's website.

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Appendix H: HCA Health Equity Toolkit

View the **HCA Health Equity Toolkit** on HCA's website.

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Appendix I: Additional comments on this legislative report

Comments offered by Commission Member Representative Schmick

1. I believe the assumptions made around ERISA and inclusion of those plans to pay have not been clearly determined by the court. After looking at the portion of the legal opinion (168-U-L-Rev-389) included in the report, I don't believe there is a clear pathway forward on funding coming from ERISA plans. Starting on page 425 and the last paragraph, then continuing through page 428 of the law review, this is basis of my concerns for the ability of the State of Washington to require a tax on ERISA plans to fund universal healthcare.

2. There is an assumption that the level of payment offered will be accepted by providers. Providers already object to the low rates of government plans. According to current Washington law, "A carrier may not require a provider or facility participating in a qualified health plan under RCW 41.05.410 to, as a condition of participation in a qualified health plan under RCW 41.05.410, accept a reimbursement rate for other health plans offered by the carrier at the same rate as the provider or facility is reimbursed for a qualified health plan under RCW 41.05.410. RCW 48.43.775." Even the implementing regulations of the federal No Surprises law have been held to unfairly favor insurers in payment disputes demonstrating provider unwillingness to accept discounted rates for services. (Texas Medical Association, et al. v. United States Department of Health and Human Services) Since therefore it is unclear who all will be paying, it is still unclear in my mind who is going to be considered "in" the program and paying for the program.

3. There is an assumption that providers will stay in the state when proposed reimbursements rates are under current market conditions. I think providers will leave the state if they see opportunities in other states.

4. It is also unclear if permissions or waivers from the federal government to include Medicaid and Medicare patients will even be a possibility. It has been a policy of the federal government that there would have to be savings for the federal portion of these programs before any decisions would be made. I do not think the federal government would allow an unproven proposal to occur such as what Washington state is proposing.

5. The public perception of having government run healthcare for all will have huge hurdles as well. When I asked the question in the last meeting, it was answered with "we will earn the trust". While a noble thought, it does not consider the sentiment found throughout the state and the distrust and lack of confidence in the competence of government.

6. I would like to also state that when consultants make their best predictions with available data, the true outcomes are often inaccurate. For example, a Urban Institute Study stated the Medicaid expansion would see an increase to the roles in the state of Washington of 328,000 additional patients five years after start of the expansion. Three years in, we already enrolled over 500,000 more patients into the program. I am skeptical of the stated savings by instituting universal healthcare.

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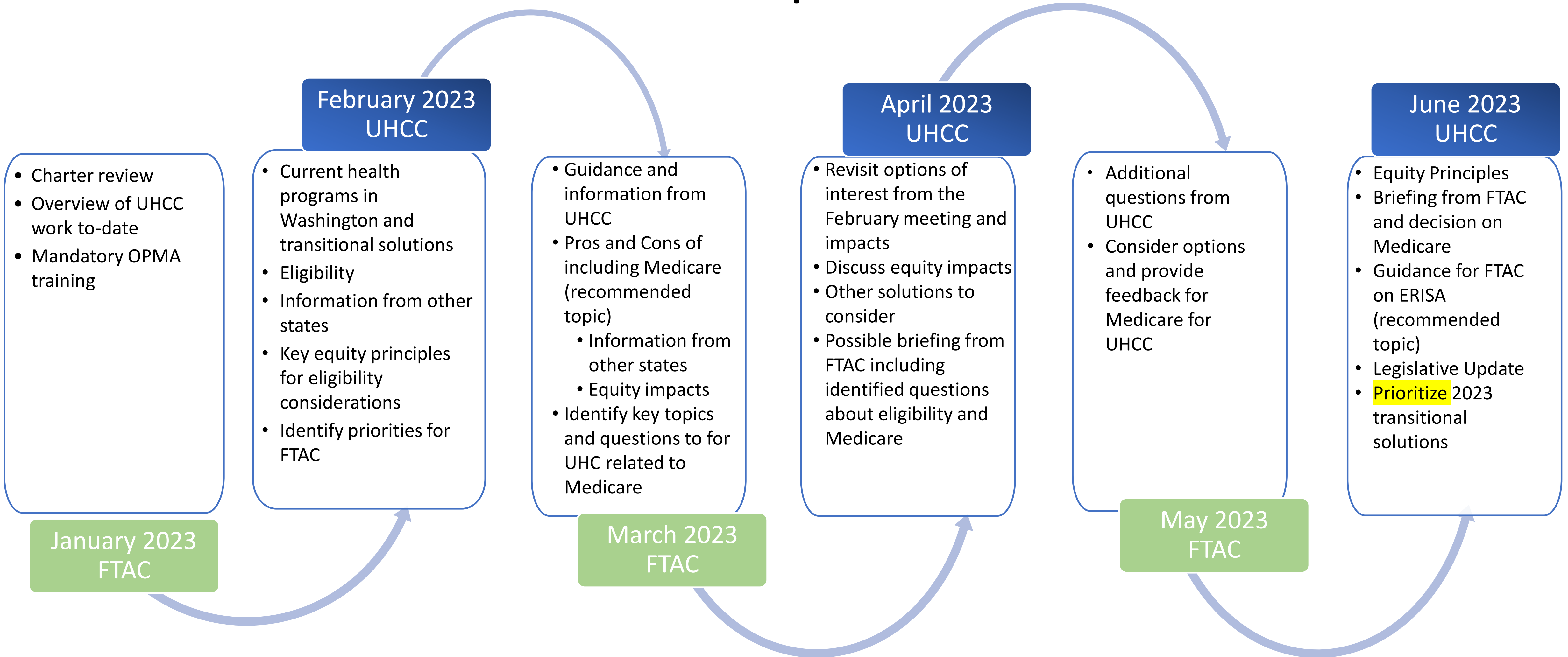
Tab 7

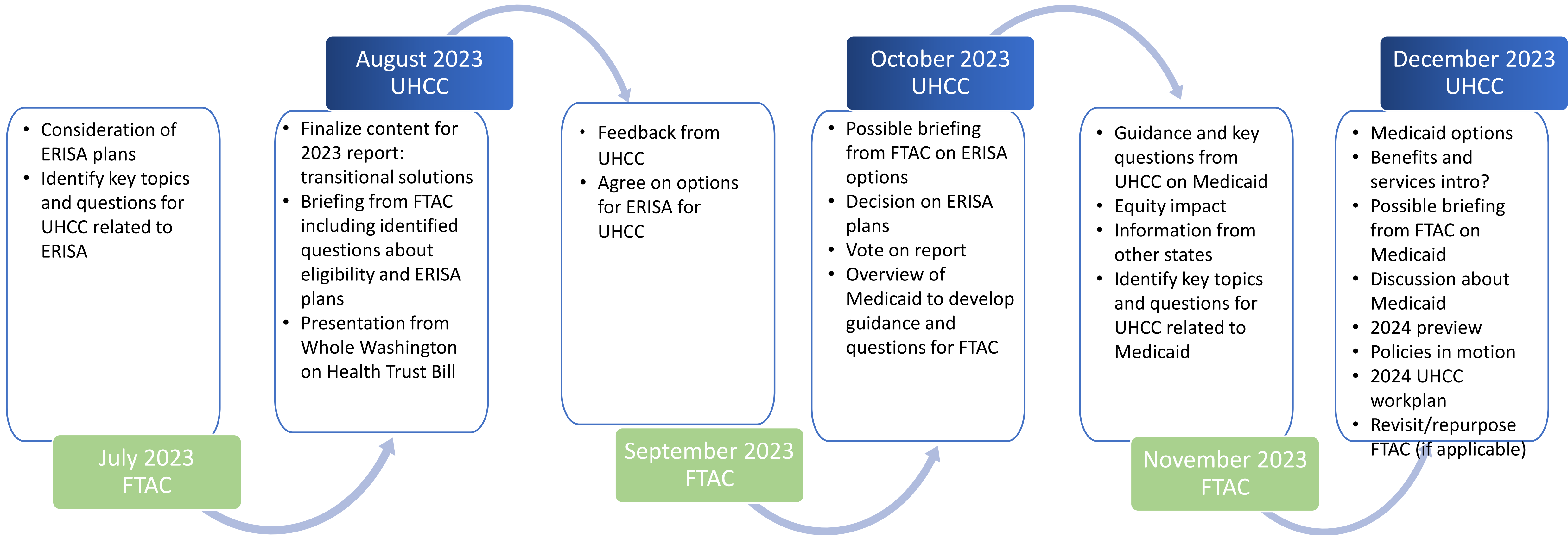
Developing the 2024 Workplan

Washington's UHCC 2023 Workplan



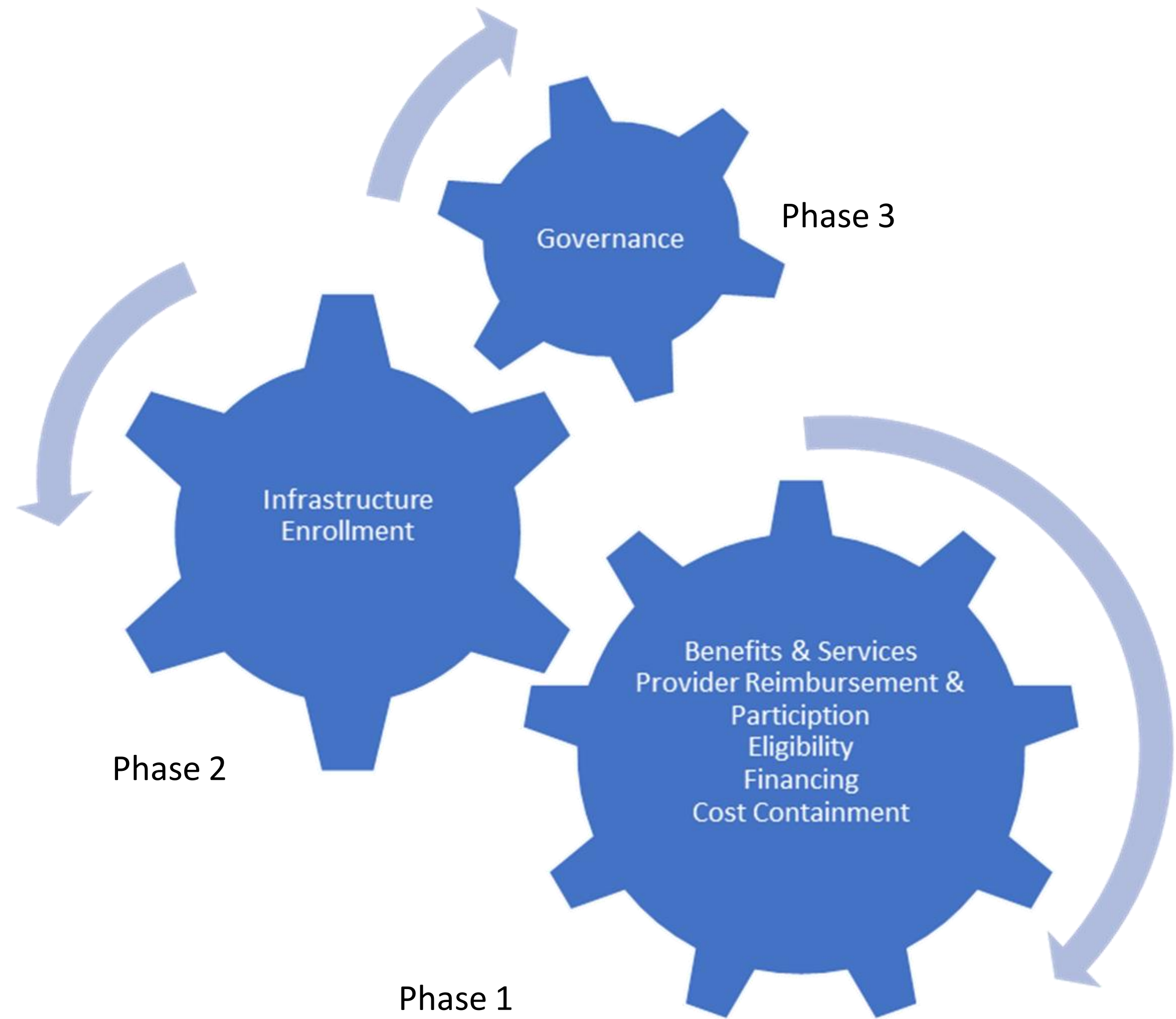
Workplan will change depending on progress made in each meeting

Washington's UHCC 2023 Workplan

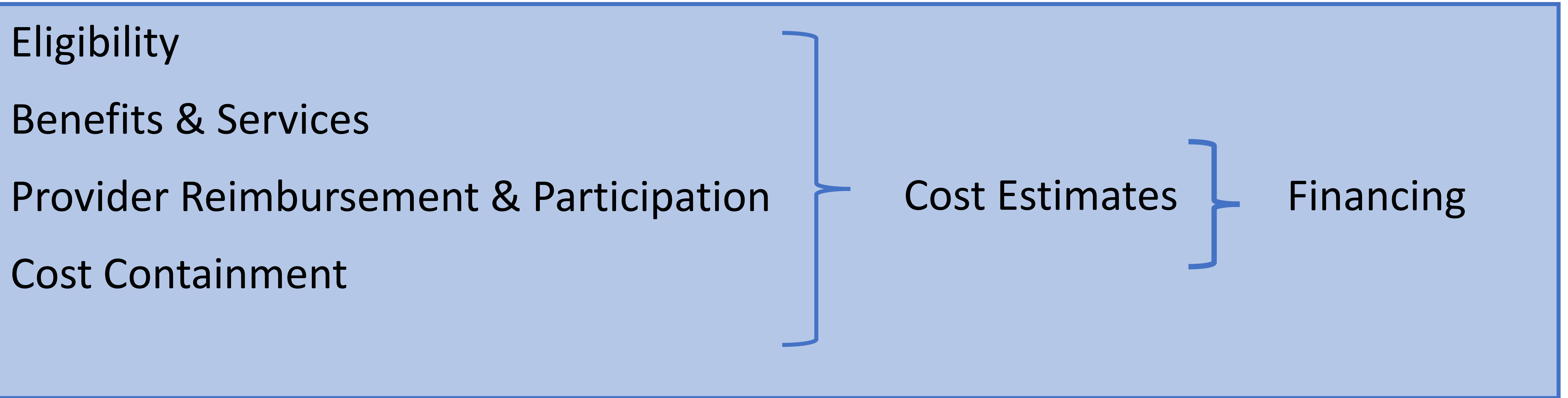


Workplan will change depending on progress made in each meeting

Design Components



2024 Goals: Continue Developing Phase 1 Design



Alignment with and support from the 2023 Legislature

Transitional Solutions

The following transitional solutions proposed by the Commission in the Baseline Report (2022) were funded by the Legislature in 2023:

- Continue funding Cascade Care Savings.
- Implement the Integrated Enrollment and Eligibility Modernization Roadmap.
- Invest in Apple Health coverage expansion.
- Increase Medicaid provider rates for:
  - Applied Behavior Analysis
  - Behavioral Health
  - Children's dental

Proviso Funding

Advocates were instrumental in the 2023 Operating Budget allocating HCA additional resources for through FY 2025:

- Additional staff to support the work of the Commission and FTAC
- Consultant services, dedicated actuarial support, and economic modeling

2024: Short-Term Solutions

The Commission is charged with recommending short term solutions that improve access, affordability, quality and contribute to the long-term goal of universal coverage

Proposed Approach

- Consider ongoing initiatives (e.g., Apple Health expansion, Health Care Cost Transparency Board, Medicare Savings Program)
- Identify additional strategies or policies that could make an impact
- Use the HCA equity framework to evaluate policy proposals
- Develop recommendations to the Legislature

2024: Universal Health Care Design Process Considerations

- Benefits and services for the future system is the next topic identified for design
- The Commission voted to adopt HCA's equity framework and voiced strong support for more community engagement

Potential Ideas

- Once benefits and services are proposed:
  - Is there interest in developing a community engagement process for feedback on benefits and services proposals?
- How should new modeling funds be utilized?
  - Enrollment modeling for eligibility variations?
  - Once benefits and services are determined, modeling on the costs?
  - Other ideas?
- Increase the frequency of meetings to every 6 weeks, or extend current bi-monthly meetings?
- Other ideas?

Objectives

Select transitional strategies and recommendations to prioritize for further evaluation.

Transitional Solutions

- Commission charged with identifying transitional solutions
- Surveyed Commissioners about potential transitional solutions in January 2023
- Commission requested additional input from the FTAC in February 2023
- Prioritize transitional solutions for further study
- Commission members polled on which categories should be prioritized

Transitional Solutions

Affordability/cost containment/pricing	Capacity/infrastructure	Coverage/enrollment	Providers	Purchasing	Subsidies
• Regulated hospital global budgets • Reduce affordability threshold (ACA) • Facilitate accessibility of hospital price • Transparency data • Out of Network (OON) price caps • OON price caps for Cascade Select • Reference based pricing for PEBB/SEBB • State agency rate normalization • Strengthen the Health Care Cost Transparency Board • Uncovered ambulance services* • Services not covered by the BBPA*	• All payer or multi-payer quality program • Enhance telehealth capacity • Improve public health	• Auto-assign Medicaid enrollment to high-quality/lower-cost plans • Auto-enrollment for Medicaid to no-premium Exchange • Codify and fully fund Apple Health expansion • Increase participation in the Medicare Savings Program (MSP) • Uninsured Analysis • Universal enrollment	• Motivate interest in preventative and primary care • Network adequacy standards • Provider participation analysis • Standardize claims adjudications • State provider participation • Study of provider rate regulatory approaches	• Consolidate and expand state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

*service could also be categorized under coverage/enrollment

FTAC Proposed Transitional Solutions

FTAC Survey Responses[1]

Affordability/cost containment/pricing	
Facilitate accessibility of hospital price transparency data	Excellent resource for price transparency progress achieving its potential: https://www.healthaffairs.org/content/forefront/hospital-price-transparency-progress-and-commitment-achieving-its-potential
Reduce the affordability threshold	Could seek a waiver to reduce the affordability threshold from ~9 percent to something lower—e.g., based on the level of subsidization currently available under the ACA. This would increase costs to the federal government, so CMS would have to agree, or WA would need to subsidize additional costs. Negotiate whether federal tax credits would be provided for this population, and under what constraints. Lowering affordability threshold could result in more employers facing the mandate penalty, which would be an unintended consequence.
Reference based pricing for PEBB/SEBB	Consider reference pricing within the state employee health plan to drive cost savings. This is something that was tried in Montana, but the state backed away from it recently. MT-Eval-Analysis-Final-4-2-2021.pdf (nashp.org) Montana Backs Away From Innovative Hospital Payment Model. Other States Are Watching. | Kaiser Health News (khn.org). There may be resistance from the market. The state has authority to make changes, though costs to the state are likely high.
Regulated hospital global budgets	States including MD, NY, and PA[2] have adopted different forms of global budgeting, and evidence is still emerging. May be worthwhile to consider any lessons learned. There may be resistance from the market. The state has authority to make changes, though costs to the state are likely high. Would require WA legislative authority to first establish and then control the growth of hospital all-payer expenditures. This requires participation of both Medicare and WA Medicaid and could be accomplished via an agreement with CMMI, who will soon be publishing a template for states' implementation of such a payment model. Note: 2023 legislation (ESSB 5187, Sec.126(33) and Sec.144(13)) directing the Attorney General Office and Office of the Insurance Commissioner to study hospital global budget strategies.
Out of network (OON) price caps	OON care generally accounts for 6-10% of total care delivered. Regulating OON service prices would be accomplished by a traditional rate setting system or a system of regulated hospital global budgets.

[1] By request of the Commission, the survey was intended to gather input from FTAC Members on additional interim strategies for the Commission to consider that may advance Washington's transition to a universal health care system. Eight of nine members participated in the survey.

[2] PA has a CMMI hospital global budget demonstration for a group of rural hospitals in the Commonwealth. VT also made use of hospital global budgets in the context of a larger All Payer ACO model it constructed.

	Regulating just OON Prices can have a positive spillover impact (as occurs in Medicare Advantage market) on in-network negotiated rates, giving commercial insurers more negotiating leverage over in-network rates for all providers. This is potentially a lower intensity regulatory approach that could help lower current in-network commercial prices paid by health plans and TPAs. The state has authority to make changes.
OON price caps for public option (Cascade Select)	Consider passing legislation to set price caps on OON prices for the public option which could potentially give public option TPAs more leverage to negotiate lower provider prices. The additional leverage may improve public option affordability by lowering the cap on provider payments from 160% to some lower level.
State agency rate normalization	As an interim step towards a universal financed system, the state should “normalize” Medicaid, PEBB and SEBB rates, beginning with raising Medicaid rates to their Medicare equivalent. [3] The state has authority to make changes, though costs to the state are likely high. Assess revenue options to finance costs of increasing rates, including increasing the managed care premium tax.

Capacity/infrastructure	
All payer or multi-payer quality program, i.e., consolidate state agency managed care quality programs	HCA and HBE currently contract with managed care organizations/administrative service organizations for coverage of enrollees across five health programs (PEBB, SEBB, Retirees, Exchange, and Apple Health). To improve quality and value-based purchasing, the programs should adopt a common set of performance measures and standard quality improvement requirements. There may be resistance from the market.
Enhance telehealth capacity	The state could fund a telehealth system to drive down costs of services. Protecting telehealth and telemedicine that allow medical providers to practice across state.
Improve public health	Supporting preventative care at the state level and setting families up for success will incur less costs for universal coverage in the long term. Costa Rica’s public health model for further study: https://www.newyorker.com/magazine/2021/08/30/costa-ricans-live-longer-than-we-do-whats-the-secret The state has authority to make changes, though costs to the state are likely high.

[3] Note, according to a 2019 Kaiser Family Foundation review of states Medicaid physician rates compared to Medicare, Washington has the 35th lowest overall rates.

Merging markets	RAND's examination of the implications of merging markets, e.g., SHOP and the marketplaces, and the marketplaces and Medicaid and found unintended effects on premiums and federal premium tax credits. There may be resistance from the market. Concerns: • Bringing sicker people into the marketplaces can increase premiums and Medicaid enrollees tend to be younger and sicker. • Higher marketplace premiums are bad for unsubsidized people but have ambiguous effects for tax-credit eligible people (because tax credits increase when premiums increase). • Increasing enrollment on the silver marketplace tier can reduce tax credits by diluting the impact of silver loading. In turn, people, particularly in the gold or bronze tier, may end up spending more out of pocket.

Coverage/benefits and enrollment	
Auto-assign Medicaid enrollment to high-quality/lower-cost plans	~45% of Medicaid managed care beneficiaries in WA do not choose a particular plan are auto-assigned to a plan. Reference: https://onepercentsteps.com/policy-briefs/improving-auto-assignment-in-medicaid-managed-care/ Per HCA's website, auto assignment is currently not performed by any notion of a plan's quality or cost https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/wac-182-538-060-managed-care-choice-and-assignment. There may be resistance from the market.
Auto-enrollment for Medicaid to no-premium Exchange	QHP and Medicaid could be opened to serve small businesses and other organizations with lower paid employees. Small business employees must enroll as individuals, or they lose their subsidy. Efforts to change this Federal restriction have been unsuccessful. Could develop wrap around benefits and auto-enrollment between programs to keep people continuously covered. However, there are barriers to auto-enrollment (how to manage consent) and limits/prohibitions to employers contributing to QHP or Medicaid coverage. There are many misconceptions about Medicaid auto assignment, some issues are technical problems. FTAC would need education on this if this topic comes back.
Develop standard benefits across payers	Eliminate low performing plans or rate plans according to quality and cost (somewhat analogous to Medicare Star ratings) https://onepercentsteps.com/policy-briefs/less-is-more-structuring-choice-for-health-insurance-plans/ Set reference balance billing payments at the median for shoppable undifferentiated services, e.g., for a given service, payer would only pay the median price charged by providers. Anything above would be covered by the patient OOP https://onepercentsteps.com/policy-briefs/designing-smart-commercial-insurer-networks/. This would preserve provider choice while containing costs and steer patients to lower cost providers.

Increase participation in the Medicare Savings Program (MSP)	According to MACPAC, a substantial portion of Medicare beneficiaries who are eligible for cost sharing assistance or additional benefits through Medicaid have not enrolled in an MSP program. The 2023 legislature took a step towards expanding the MSP by increasing Qualified Medicare Beneficiaries (QMB) coverage from 100 percent FPL to 110 percent and eliminating asset test requirements. The UHCC should consider endorsing further expansion. The state has authority to expand further, though the costs to the state would be high.
Uninsured Analysis	To determine who is not otherwise ineligible for health coverage or who remains uninsured, request OFM analysis of 2022 data to determine uninsured and underinsured (e.g., out-of-pocket health care cost exceed 10% of income, 5% when income is less than 200% FPL).[4]
Universal enrollment	Explore with state agencies infrastructure that ensures every WA resident is screened for coverage options and enrolled in coverage if uninsured. HBE should identify a default $0 premium plan for individuals where sufficient household/income information and HCA and HBE should facilitate "easy enrollment" for uninsured individuals where Apple Health/$0 default plans are available. Consult with HHSEC to assess likelihood/time frame for achieving a UHC eligibility component of their integrated eligibility and enrollment system (IES). The state has authority to make changes.

Providers	
Motivate interest in preventative and primary care	The dental sector created a cultural norm of two preventive visits per year, though the same routine importance does not exist for primary care apart from well visits for young children and annual wellness visits for seniors. Support for improved Medicaid payments to improve access and sustain providers who serve low income. The state has authority to make changes, though costs to the state are likely high.
Network adequacy standards	Work with OIC and HCA to develop standardization network adequacy metrics and to consolidate the collection and analysis of health plan's provider networks. Annually publish PEBB, SEBB, Exchange and Apple Health by-plan network analysis.
Provider participation analysis	Partner with HCA, OIC and HBE for an analysis comparing trends in provider networks available for the following coverage groups: Apple Health, PEBB, SEBB, Exchange, and OIC regulated large group market.

[4] The 2023 legislature appropriated $49.9 million to provide Medicaid look-alike coverage to non-citizen immigrants with incomes up to 138 percent FPL.

Standardize claims adjudications	Consider ways to standardize/simplify adjudication. e.g., use same forms, same prior authorization criteria, ways to automate adjudication, automatically collect needed clinical/demographic information from the HER.
State provider participation	As a condition for participation in PEBB/SEBB programs, require network provides to enroll in Apple Health plans and accept Medicaid clients. There may be resistance from the market.
Study of provide rate regulatory approaches	Understand the different rate regulatory approaches that WA might implement that could be developed through legislation.

Purchasing	
Consolidate state purchasing	Together, HCA and HBE provide coverage to nearly one-third of all insured residents. The UHCC could design a consolidated state health care plan for individuals receiving coverage under HCA/HBE with a standardized benefit design and payment system, a single enrollment system, and competitive contracting with carriers for all covered programs (limiting the number of plans in each region). This could help reform the current system, reduce state costs in providing coverage, and serve as a foundation for eventually incorporating other coverage groups. Medicaid, PEBB, SEBB, and HBE statutes must be amended to consolidate purchasing across these programs. This would require modeling, actuarial assistance, and consultation with the Governor and Legislature to assess willingness to undertake this major reform. There may be resistance from the market.

Subsidies	
Expand premium tax credit	Dept. of Revenue recently launched the Working Families Tax Credit (WFTC) and includes ITIN filers (those without SSN for tax filing purposes), creating another opportunity for WA to create a relationship with undocumented immigrants, foreign spouses, and dependents of U.S. citizens. • ~100% overlap with WFTC and Temporary assistance for needy families (TANF) and 60-70% estimated overlap of WFTC and supplemental nutrition assistance program (SNAP). Ensure everyone has knowledge/can take advantage of benefits and have resources to supplement the cost of health care. ○ The U.S. HHS (administration of TANF and SNAP) prohibits sharing of identifiable data with IRS's EITC program and discourages state human service agencies from sharing the data with state's EITC programs.
Expanded Health Benefit Exchange Cost-Sharing Subsidies	Consider opportunities to make it easier for people with ESI to enroll on the health insurance marketplaces, ideally with federal tax credits. The state has authority to make changes, though costs to the state are likely high.

Thank you for attending the Universal Health Care Commission meeting!