Universal Health Care Commission meeting

September 11, 2025

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Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission

Agenda

Thursday, September 11, 2025
2 – 5 p.m.
Hybrid meeting (Zoom and in-person)

Commission members:		
Vicki Lowe (Chair)	David Iseminger	Representative Joe Schmick
Joan Altman	Tao Kwan-Gett	Mohamed Shidane
Jane Beyer	Bidisha Mandal	OPEN SEAT (gov appointment)
Senator Annette Cleveland	Representative Lisa Parshley	OPEN SEAT (gov appointment)
Nicole Gomez	Omar Santana-Gomez	OPEN SEAT (legislator)

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome, roll call, review of previous meeting minutes	1	Vicki Lowe, Chair
2:05 – 2:20 (15 min)	Public comment	2	Vicki Lowe, Chair
2:20 – 2:30 (10 min)	Advocates Roundtable report out	3	Vicki Lowe, Chair
2:30 – 2:50 (20 min)	Commission member report outs	4	Commission members
2:50 – 3:00 (10 min)	Workplan update: 2025 leg report, FTAC appointments	5	Ally Power, HCA
3:00 – 3:35 (35 min)	Section 1333 interstate compacts: Overview and Q&A	6	Patty Kuderer, Washington Insurance Commissioner Jason Levitis, The Urban Institute Randy Pate, Randolph Pate Advisors
3:35 – 3:40 (5 min)	BREAK		
3:40 – 4:15 (35 min)	FTAC update & straw proposals → Potential vote on straw proposals	7	Ross Valore, HCA
4:15 – 5:00 (45 min)	Transitional solutions	8	Vicki Lowe, Chair
5:00	Adjournment		Vicki Lowe, Chair

Washington State Health Care Authority

Universal Health Care Commission meeting minutes

June 11, 2025

Hybrid meeting held on Zoom and in person at the Health Care Authority (HCA) from 2–5 p.m.

Note: The meeting materials packet and a full recording of this meeting can be found on the **Commission's meetings and materials page**.

All votes made during this meeting are highlighted throughout in blue.

Members present

Vicki Lowe, Chair
Bidisha Mandal
Charles Chima
Dave Iseminger
Nico Janssen (representing the Office of the Insurance Commissioner)
Joan Altman
Representative Joe Schmick
Mohamed Shidane
Nicole Gomez
Omar Santana-Gomez

Members absent

Stella Vasquez

Call to order

Vicki Lowe, Chair of the Universal Health Care Commission (Commission), called the meeting to order at 2:02 p.m. There were enough members for a quorum, so the Commission could hold votes.

Agenda items

I. Welcoming remarks

Chair Lowe began with a land acknowledgement and welcomed members to the Commission's 24th meeting.

II. Meeting minutes

Commission members approved the April 2025 meeting minutes by unanimous vote.

III. Public comment

The following members of the public provided comments:

- **Andre Stackhouse**, Whole Washington
- **Edourd Lassalle**, Kenmore resident
- **Kathryn Lewandowsky**, Whole Washington

Public comment topics included:

- Support for state-based universal health system bills and a reminder that the Commission must recommend a unified financing system that includes (but is not limited to) a single-payer system
- General support for universal health care
- Recommendations for future actuarial analyses
- Recommendations to support rural hospitals through governance

Find full testimonies in the **meeting recording (time stamp 6:11)**.

IV. Interstate health care compacts

Insurance Commissioner Patty Kuderer, Office of the Insurance Commissioner (OIC)

Insurance Commissioner Patty Kuderer shared a brief overview of interstate health care compacts, also referred to as 1333 compacts. She proposed the Commission invite the Oregon Universal Health Plan Governance Board to the September 2025 meeting.

At that meeting, both groups could learn more about 1333 compacts and hold an open discussion about potential opportunities to work together on a universal health care system that benefits both states.

Find Commissioner Kuderer's full remarks in the **meeting recording (time stamp 14:47)**.

V. State agency updates

Chair Lowe invited state agency representatives to provide updates from their agencies on work that aligns with the Commission. The following members provided updates:

- **Dr. Charles Chima**, Department of Health (DOH)
- **Dave Iseminger**, Health Care Authority (HCA)
- **Nico Janssen**, Office of the Insurance Commissioner (OIC)
- **Joan Altman**, Washington Health Benefit Exchange (WAHBE)
- **Omar Santana-Gomez**, Office of Equity (OOE)

Commission members discussed various topics, including:

- Announcement of the new DOH Secretary of Health (Dennis Worsham)
- Potential implications from federal-level decisions
- State budget impacts
- Update on the SB 5083 implementation process
- Upcoming PEBB/SEBB rate publication
- Proposed carrier rates

Find their full updates in the **meeting recording (time stamp 18:27)**.

VI. Budget, workplan, and charter update

Mary Franzen and Todd Bratton, HCA

Franzen provided an update to the 2025 meeting schedule and reviewed the timeline for the annual legislative report. She also discussed budget impacts to the Commission, including staff reduction and the termination of consultant support. Franzen highlighted that the 2025–2027 budget contains new proviso funding from the OIC to support economic, actuarial, or other modeling related to design of a universal health care system.

Franzen then reviewed a potential update to the attendance policy in the FTAC charter that would require HCA staff to notify FTAC members that miss three meetings in a calendar year, or three consecutive meetings in a twelve-month period, that they may be removed due to attendance. Determination of whether an FTAC member will be removed will be at the sole discretion of the Commission. Commission members voted unanimously to adopt the updated attendance policy for the FTAC charter.

Bratton then provided an update on cost containment as it relates to the Commission's workplan. Bratton noted that he anticipates the cost containment milestone will remain "in progress" as the Commission's work continues throughout the milestone phases. This is due to the Commission's ongoing work around transitional solutions and key design elements. For example, cost containment mechanisms will continue to be a part of benefits and services, provider reimbursement, and infrastructure. Commission members had no questions or discussion regarding this update.

Find the full presentation and discussion in the **meeting recording (time stamp 35:59)**.

VII. Finance Technical Advisory Committee (FTAC) update

David DiGiuseppe, FTAC lead

DiGiuseppe provided an update from the May FTAC meeting which included:

- Overview of the public comments received
- Timing of governance in the workplan
- Open questions from the benefit cost analysis
- Introduction of a potential Commission-FTAC workgroup

DiGiuseppe noted that FTAC members appreciated the rationale for accelerating governance in the workplan but recommended maintaining the current phasing approach.

DiGiuseppe then presented on the various Commission and FTAC discussions regarding benefits and services, eligibility, and provider reimbursement and participation. DiGiuseppe noted that all of **FTAC's meetings are recorded and available online** along with the meeting packets that include any material considered by FTAC.

Find the full presentation and discussion in the **meeting recording (time stamp 1:02:53)**.

VIII. Governance examples and discussion

Mary Franzen, HCA and Liz Arjun, HMA

Franzen provided examples of governance from Oregon's Universal Health Plan Governance Board and the Washington State Health Benefit Exchange as requested by the Commission at their April meeting. Franzen noted both groups' governance structures were included in the legislation that established them.

Commission members agreed that transparency and accountability are key in this work and that governance is an important design element, but that changing the timing of governance in the Commission's workplan wasn't needed at this time. During future meetings, the Commission may consider moving governance from Phase 3 to Phase 2 to allow for considering governance at the same time as infrastructure.

Find the full presentation and discussion in the **meeting recording (time stamp 1:39:19)**.

Washington State Health Care Authority

IX. Next steps discussion

Liz Arjun, HMA

Arjun led a discussion on what options the Commission could develop now regarding provider reimbursement and participation in a unified system. Commission members discussed:

- Importance of policies that support our rural hospitals,
- Impact of vertical integration and horizontal consolidation on our health care system
- Value-based payment models for primary care
- Delivery system throughlines
- Looking at how Indian Health Services tackles provider reimbursement

Arjun then led a discussion on transitional solutions, noting that previous Commission topics have included Medicare savings, the Small Business Health Options Program (SHOP), and prior authorization. Commission members discussed several potential priorities, including:

- Mitigation strategies regarding federal changes like coverage losses
- Building on work the Commission had done previously (e.g., administrative simplification)
- Addressing health care workforce needs in rural areas

Find the full discussion in the **meeting recording (time stamp 2:12:02)**.

Closing comments and adjournment

Chair Lowe reminded Commission members about the upcoming Advocates Roundtable special meeting and that the August meeting date had been changed to Thursday, September 11, 2025. The meeting adjourned at 4:49 p.m.

Next meeting

Thursday, September 11, 2025, from 2–5 p.m.

The meeting will be held on Zoom and in person at HCA.

Tab 2

Washington State Health Care Authority

Public Comment

Washington State Health Care Authority

Universal Health Care Commission
Written Comments

- Written comments submitted via e-mail (received since May 28, 2025):
  - J. Hilde
  - L. Johns-Brown
  - R. Shure
  - C. Currie
  - C. Currie
  - M. Brinck-Lund and R. Watts
- Additional comments received during the June UHCC meeting: June 11, 2025, Universal Health Care Commission - YouTube
- Public comments can be provided orally during the meeting's public comment period or in written form at any time to the Commission's inbox at **HCAUniversalHCC@hca.wa.gov**.

From: jmhilde
To: HCA Universal HCC
Subject: Public comment submission
Date: Thursday, June 5, 2025 1:31:40 PM

External Email

The recent break-up between Aetna and UW Medicine will leave thousands of patients without needed care and all because of money. Profit made on the backs of sick people, or people trying not to get sick, should never ever have been allowed. We need public health care and we need it now. Thanks for doing the hard work.

Jean Hilde
Shoreline, WA

HEALTH CARE FOR ALL - WASHINGTON

Dedicated to achieving universal, publicly funded, single-payer health care

June 9, 29025

Good afternoon, Chair Lowe and members of the Universal Health Care Commission;

I am writing today to share with you the governance elements in Health Care for All Washington's (HCFA-WA) Washington Health Security Trust Document (WHST). Attached are both the governance elements of the WHST and the full WHST.

HCFA-WA strongly urges the UHCC to move up the governance discussion in the current UHCC work plan timeline. Governance refers to the foundational structure for how the system will be administered, while infrastructure refers to the more technological, day-to-day management mechanics.

HCFA-WA's suggested governance structure is a dedicated trust that covers all residents and is established within an autonomous entity of state government. It is governed by a board of directors in cooperation with several advisory committees. We believe that is an ideal structure. Since no insurance companies participate in the governance, it reflects the Model A structure as determined by the Universal Health Care Work Group, whose work was completed in December of 2020.

HCFA-WA is urging the UHCC to both move up the timing of the governance discussion because to most accurately predict the total cost of the system, it is necessary to first know the design and cost of the governance structure. An example of how not having the governance discussion and recommendations done earlier in the current process is Milliman's difficulty in predicting the total costs for the three benefit designs that have been identified.

Please note that in the attached WHST document, the governing structure is established in the first few pages. This has been the standard format for all of the other 20 plus states that have introduced single-payer legislation.

We look forward to discussing this further at the upcoming UHCC meeting on June 11th!

Sincerely;

Ronnie Shure
President
Health Care for All - Washington

The Washington Health Security Trust's Vision for UHC Governance

NEW SECTION. **Section 3.** ESTABLISHING THE TRUST

An autonomous entity within state government known as the Washington health security trust is created, with a start-up appropriation from the general fund. The purpose of the trust is to provide coverage for a set of health benefits for all state residents.

NEW SECTION. **Section 4.** GOVERNING BOARD

(1) The trust shall be governed by a board of trustees consisting of nine members with expertise in health care financing and delivery, and representing Washington citizens, business, labor, and health professions. Trustees must include individuals with knowledge of the health care needs of diverse populations, including low-income, Native American, undocumented, non-English speaking, disabled, rural, and other minority populations. Members of the board shall have no pecuniary interest in any business subject to regulation by the board.

(a) By October 1st following the effective date of this section, each of the two largest caucuses in both the house of representatives and the senate shall submit to the governor a list of five nominees who are not legislators or employees of the state or its political subdivisions, with no caucus submitting the same nominee.

(b) By December 15th following the effective date of this section, the governor shall appoint the initial trustees. The governor shall appoint one trustee from each of the lists submitted by the house of representatives and the senate. If a caucus fails to submit a list as required in (a) of this subsection, or if the nominees on the list do not meet the qualifications specified in subsection (1) of this section the governor shall appoint a substitute trustee meeting the qualifications specified in subsection (1) of this section at his or her discretion.

(c) Of the initial trustees, three shall be appointed to terms of two years, three shall be appointed to terms of four years, and three shall be appointed to terms of six years. Thereafter, trustees shall be appointed to six-year terms. Trustees may be appointed to multiple terms.

(d) The governor shall appoint one of the initial trustees as the initial chair of the board. The board shall then elect its own chair and co-chair from its members. The term of a chair and co-chair elected by the board expires upon the expiration of his or her term on the board.

(3) If convinced by a preponderance of the evidence in a due process hearing that a trustee has failed to perform required duties or has a conflict with the public interest, the governor may remove that trustee and appoint another to serve the unexpired term.

(4) A trustee whose term has expired or who otherwise leaves the board must be replaced by gubernatorial appointment. When the person leaving was nominated by one of the caucuses of the house of representatives or the senate, his or her replacement must be appointed from a list of five nominees submitted by that caucus within thirty days after the vacancy occurs. If the caucus fails to submit the list of nominees, or if the nominees do not meet the qualifications specified in subsection (1) of this section, the governor shall appoint a trustee meeting the qualifications specified in subsection (1) of this section at the governor's discretion. A person appointed to replace a trustee who leaves the board prior to the expiration of his or her term shall serve only the duration of the unexpired term.

(5) The initial board shall convene no later than three months following the initial appointment.

(6) Members of the board are subject to chapter 42.52 RCW.

(7) The trustees occupy their positions according to the bylaws, rules, and relevant governing documents of the board and are exempt from chapter 41.06 RCW. The board and its professional staff are subject to the public disclosure provisions of chapter 42.17A RCW. Trustees shall be paid a salary to be fixed by the governor in accordance with 43.03.040 RCW. Six trustees constitute a quorum for the conduct of business.

NEW SECTION. **Section 5.** COMMITTEES

(1) Subject to the approval of the board, the chair shall appoint three standing committees:

(a) A financial advisory committee consisting of financial experts from the office of financial management, the office of the state treasurer, and the office of the insurance commissioner. The financial advisory committee shall recommend specific details for major budget decisions, including provider reimbursements, and for appropriations, taxes, and other funding legislation necessary to conduct the operations of the Washington health security trust;

(b) A citizens' advisory committee consisting of balanced representation from health experts, business, labor, patients, and the general public. The citizens' advisory committee shall hold public hearings on priorities for inclusion in the set of health services to be covered, survey public satisfaction, investigate complaints, and identify and report on health care access, equity, provider reimbursement, and other priority issues for residents; and

(c) A technical advisory committee consisting of members with broad experience in and knowledge of clinical health care, research, and policy, the evaluation of efficacy and cost effectiveness of diagnostic testing, treatments, pharmaceuticals, medical devices, and electronic medical record and billing systems, as well as public and private funding of health care services. The technical advisory committee shall make recommendations to the board on technical issues related to covered benefits, provider reimbursements, quality assurance, utilization, and other issues as requested by the board. In consultation with the citizens advisory committee, develop provider network adequacy standards taking into account wait and travel times to access care.

(2) The board shall consult with the citizens' advisory committee at least quarterly, receive its reports and recommendations, and then report to the governor and legislature at least annually on board actions in response to citizens' advisory committee input. The board shall also seek financially sound recommendations from the financial advisory committee whenever the board requests funding legislation necessary to operate the Washington health security trust and whenever the board considers major budget decisions.

(3) Subject to approval of the board, the chair may appoint other committees and task forces as needed.

(4) Members of committees shall serve without compensation for their services but shall be reimbursed for their expenses while attending meetings on behalf of the board in accordance with 43.03.050 and 43.03.060 RCW.

NEW SECTION. **Section 6.** DUTIES OF THE CHAIR

The chair is the presiding officer of the board and has the following powers and duties:

(1) Hire an executive director, who will then hire staff, with the approval of the board;

(2) Enter into contracts on behalf of the board. All contracts are subject to review and binding legal opinions by the attorney general's office if disputed in a due process hearing by a party to such a contract;

(3) Subject to explicit approval of a majority of the board, accept and expend gifts, donations, grants, and other funds received by the board; and

(4) Delegate administrative functions of the board to the executive director and staff of the trust as necessary to ensure efficient administration.

NEW SECTION. **Section 7.** DUTIES OF THE BOARD

(1) The board shall:

(a) with advice from the citizens' advisory committee and the technical advisory committee, establish and keep current a set of health services to be financed by the trust, as provided in Section 11 of this act;

(b) subject to the funding mechanism established pursuant to the recommendations made under Section 16 of this act, seek all necessary waivers so that current federal state payments for health services to residents will be paid directly to the trust;

(c) subject to the funding mechanism established pursuant to the recommendations made under section 16 of this act, request legislation authorizing the health security assessments and premiums necessary to operate the trust and make rules, policies, guidelines, and timetables needed for the trust to finance the set of health services for all residents starting the second May 15th following the effective date of this section;

(d) develop or contract for development of a statewide, anonymous health care data system to use for quality assurance and cost containment;

(e) with advice from the technical advisory committee, develop health care practice guidelines and quality standards;

(f) develop policies to protect confidentiality of patient records throughout the health care delivery system and the claims payment system;

(g) make eligibility rules, including eligibility for residents temporarily out-of-state, those who are employed in another state, and those receiving medically necessary care in another state;

(h) develop or contract for development of a streamlined uniform claims processing system that must pay providers in a timely manner for covered health services;

(i) develop appeals procedures for residents and providers;

(j) integrate functions with other state agencies;

(k) work with the citizens' advisory committee and the technical advisory committee to balance benefits and provider payments with revenues, and develop effective measures to control excessive and unnecessary health care costs;

(l) address nonfinancial barriers to health care access;

(m) monitor population migration into Washington state to detect any trends related to availability of universal health care coverage;

(n) develop an annual budget for the trust;

(o) establish and use a process to enter into voluntary participation agreements with health care providers and other contractors;

(p) establish policies to reduce health disparities including, but not limited to, mitigating structural racism and other determinants of health as set forth by the office of equity;

(q) redesign purchasing and payment methods to promote payment models such as fee-for-service that incentivize higher quality of care and the appropriate utilization of care;

(r) in cooperation with Washington's Accountable Communities of Health, establish a process of holding regional public hearings on a regular basis to receive comments, complaints,

and suggestions regarding regional health care needs. Reports shall be submitted to the board to ensure that regional concerns are considered in the development and update of future plans;

(s) develop procedures for closely supervising any contractors charged with trust operations;

(t) develop a cost control model for provider, device, and pharmaceutical payments; and

(u) develop a procedure for community needs assessments across the state in cooperation with local providers and the Department of Health.

(2) To the extent that the exercise of any of the powers and duties specified in this section may be inconsistent with the powers and duties of other state agencies, offices, or commissions, the authority of the board supersedes that of such other state agency, office, or commission.

NEW SECTION. **Section 8.** ANNUAL BUDGET

Beginning the third May 15th following the effective date of this section, the board shall adopt, in consultation with the office of financial management, an annual Washington health security trust budget. Except by legislative approval, each annual budget shall not exceed the budget for the preceding year by more than the Washington state consumer price index. If operations expenses exceed revenues generated in two consecutive years, the board shall recommend adjustments in either benefits or revenues, or both, to the legislature.

NEW SECTION. **Section 9.** FINANCIAL ACCOUNTABILITY

(1) The board shall report annual changes in total Washington health care costs, along with the financial position and the status of the trust, to the governor and legislature at least once a year.

(2) The board shall seek audits annually from the state auditor.

(3) The board shall contract with the state auditor for a performance audit every two years.

(4) The board shall adopt bylaws, rules, and other appropriate governance documents to assure accountable, open, fair, effective operations of the trust, including rules under which reserve funds may be prudently invested subject to advice of the state treasurer and the director of the department of financial management.

(5) The board shall submit any internal rules or policies it adopts to the secretary of state. The internal rules or policies must be made available by the secretary of state for public inspection.

EVERYBODY IN, NOBODY OUT.

PO Box 30506, Seattle, WA 98113-0506 • www.hcfawa.org

TO: Members of The Universal Health Care Commission
FROM: Health Care for All - Washington (HCFA-WA)
DATE; August 13, 2025
RE: Recommendations for Transitional Solutions for 2025

On behalf of HCFA-WA, I am writing today to share our recommendations for the Transitional Solutions to be included in the 2025 Universal Health Care Commission Report to the Legislature.

Given the recent actions in Washington DC, that have critical impacts on both Medicaid and other ACA elements adopted by our state, we know the top priority will be to find ways to protect our current health care delivery system.

Therefore, our top recommendation reflects that reality. However, we also believe it is important to continue to find ways to consolidate and streamline our delivery system, in ways that will lead to improved services for enrollees, but also save state dollars.

We ask that FTAC given serious consideration to and support for the following:

1. Protection of current level funding for Medicaid and programs at the Health Benefit Exchange, including those serving those who currently do not qualify for federal programs
2. Administrative Simplification (listed as recommendations in the 2025 Report) :
    - Improve and align network adequacy standards
    - Continue to simplify provider administrative requirements ● Standardize Claims adjudication
      ** Note that HB 1813, HB 1706 and SB 5331, which passed during the 2025 Legislative session, each address, in part, these three items, but more can more done in each of the bulleted items**
3. Consolidate and expand state purchasing :
    - Support passage of SB 5086, by Senator Robinson/ HB 1330 by Representative Lekanoff, which would consolidate purchasing of SEBB/PEBB (this bill also, as currently written, consolidates the PEBB and SEBB Boards)

    - Expand efforts to enroll local governmental entities in PEBB
4. Streamline purchasing of HBE plans:
    - Support legislation to direct the HBE qualified benefits to have "standardized cost-sharing across each of the three metal plans
5. Address the impacts of corporate practice of medicine
    - Support SB 5087, by Senator Robinson, that would prohibit the corporate practice of health care except through a professional service corporation or limited liability company. The bill would also prohibit non-licensed individuals from interfering with the clinical decision making of health care providers providing care at licensed facilities.

Thank you for your consideration of these recommendations and for your continued work to find ways to move our state to a single payor, universal health care system.

Sincerely,
Ronnie Shure, President
Health Care for All - Washington
Rushure64@gmail.com

August 18, 2025
From: Cris M. Currie and the Health Care for All-WA Policy Committee
To: Members of the UHCC and Staff:

We would like to offer some detailed background information concerning provider reimbursement with which we think all Commission members should become familiar.

First, while so-called Value-Based Payment (VBP) models are currently in fashion for reducing healthcare costs, empirical evidence for their effectiveness is weak. The idea is to financially penalize doctors and hospitals for not improving a patient's condition (or a large provider's financial condition) and reward positive results, even though whether or not a patient improves is dependent upon numerous factors that are beyond the control of healthcare practitioners. Among these social determinants of health are low income, being non-white, poor nutrition, lack of education, physical and cognitive limitations, and unavailable or unreliable caregivers. Additionally, different people often respond to the same treatments unpredictably, and sometimes, standard treatments are inappropriate for certain patients. Because Medicare does not currently track social determinants of health, it is impossible to really know their full effects. What *is* known is that most patients need much more time and attention than is currently reimbursable, to ensure that they understand and can follow the prescribed treatments. Consequently, VBP schemes, including the Resource-Based Relative Value Scale used by Medicare, belittle the role of the physician, often substituting that role for a set of preprogrammed algorithms which will never account for social determinants. They often lead to increased costs in the long run, higher death rates, and higher rates of burn-out among practitioners.

Title IX, Section 903 of the Medicare for All Act of 2023 terminates all VBP programs, listing them by name, because they simply have no place in a single-payer system that attempts to correct structural failures. Kenneth Kizer, former VHA Director, summed it up well when he said, "In part why the American health care system is so screwed up is that it is so influenced by health care economists who tend to think money is the only thing that drives behavior" [Gordon, S. (2018). Wounds of War: How the VA delivers health, healing, and hope to the nation's veterans. ILR Press, Ithaca, NY., p. 33].

Clearly alternative models of provider participation and reimbursement are needed in our UHC system. With regard to participation, HCFA-WA's Washington Health Security Trust (WHST) document specifies that one of the duties of the governing board is to "establish and use a process to enter into voluntary participation agreements with health care providers and other contractors" [WHST Section 7(1)(o)]. These agreements need to specify how providers will be paid.

Secondly, the WHST Section 13 spells out the following provider payment principles:

(1) After consulting with all three advisory committees, the board shall establish reasonable payment rates for health care practitioners, hospitals, devices, and pharmaceuticals. Practitioners should be reimbursed based on their training, expertise, and time needed for each procedure, rather than on an assigned value to the procedure itself.

(2) The board shall adopt a cost control model for payments by the trust. The model could include elements of global budgeting, price caps, reference-based pricing, or any other government controlled system designed to place limits on rising prices.

(3) The board shall adopt rules ensuring that payment schedules and procedures for mental health services are comparable to other health care services.

(4) The board shall study and seek to develop provider payment methods that:

(a) encourage care coordination and integration; and

(b) reward education time spent with patients.

(5) Nothing in this act shall be construed to limit a provider's right to receive payments from sources other than the trust. However, any provider who does accept payment from the trust for a covered benefit must accept that payment as payment in full.

The Center for Healthcare Quality and Payment Reform has put together an excellent webpage that points out the many flaws in pay for performance schemes as well as a very detailed description of what a quality patient-centered payment system should include. Dr. Stephen Kemble has written extensively about this in relation to single-payer design. He put together a list of principles for physician payment and a more detailed explanation of his fee-for-time proposal. His most recent article in Counterpunch is also well worth reading. The video of his excellent June 2025 presentation for One Payer States on healthcare financial basics for policy makers can be viewed here.

With regard to provider reimbursement and provider participation, HCFA-WA strongly encourages the UHCC to review both the WHST and the above resources prior to discussing this design element. Thank you.

From: Cris
To: HCA Universal HCC
Subject: Vision, Values & Principles
Date: Monday, August 18, 2025 1:49:40 PM
Attachments: Values Comment Aug 2025.docx

External Email

Mary and Ally:
Attached is a document regarding what Health Care for All Washington would like to see as the fundamental vision, values and principles of the universal health care system for Washington. We would strongly encourage the Commission to adopt a similar list sometime soon, so that it will have a consistent set of criteria by which to judge proposed components of the various design elements. Please let me know if you have any questions. Thanks.
Cris

Universal Health Care for Washington State

Vision: The state of Washington will create a single health care entity called the Washington Health Security Trust (WHST) that will publicly finance high quality, comprehensive, affordable, equitable, readily accessible, and accountable, health care benefits for all Washington residents, including those now covered by federally sponsored health programs and those covered by commercial health insurance and self-funded employer plans.

Values:
(A) Health care, as a fundamental element of a just society, must be secured for all individuals on an equitable basis by public means*, independent of employment*, similar to public education, public safety and public infrastructure;
(B) Race, color, national origin, age, disability, wealth, income, citizenship status, primary language, genetic conditions, previous or existing medical conditions, religion or sex, including sex stereotyping, gender identity, sexual orientation and pregnancy and pregnancy-related medical conditions may not create barriers to health care nor result in disparities in health outcomes due to the lack of access to care;
(C) The components of the Universal Health Plan must be *fair, simple*, accountable and fully transparent to the public regarding information, decision-making and management through meaningful public participation; and
(D) Funding for the Universal Health Plan is a public trust and any savings or excess revenue must be returned to the public trust;

Principles:
(A) *Resident and provider participation is voluntary*, and a participant in the Universal Health Plan may choose any individual provider who is licensed, certified or registered in this state or may choose any group practice;
(B) The plan may not discriminate against any individual health care provider who is licensed, certified or registered in this state to provide services covered by the plan and who is acting within the provider's scope of practice;
(C) A participant in the plan and the participant's health care provider shall determine, within the scope of services covered within each category of care and within the plan's parameters for standards of care and requirements for prior authorization, whether a service or good is medically necessary or medically appropriate for the participant;
(D) The plan shall cover health care services and goods from birth to death *for all Washington residents*, based on evidence-informed decisions as determined by the board; *and*
(E) The plan will limit rising health care prices and eliminate unnecessary administrative costs resulting from the current fragmented system of multiple insurers; and
(F) The plan will include a displaced worker training account for transitional retraining and job placement assistance.

Note: Values and principles taken from Oregon SB 1089, Section 2, except for italicized additions from the Washington Health Security Trust.

Health Care is a **Human Right**

August 28, 2025

To the Universal Health Care Commission,

The advocacy community represented by the Health Care Is a Human Right (HCHR) coalition offers a hearty “THANK YOU” to the Commission for the August 5 Advocacy Roundtable. The seven panelists representing five organizations and the scores of in-person and on-line observers felt the Roundtable was the start of a useful conversation that we hope will continue. We appreciated the opportunity to exchange views on complicated issues outside of the narrow parameters of public comment periods at scheduled meetings. Thank you to the Commissioners, FTAC members, and elected officials who attended. We appreciate that UHCC and FTAC members are volunteers too and that we all, in our own way, can identify as advocates for universal health care.

We would like to offer our assistance to the work of the Commission and the FTAC in the following areas. These topics were introduced at the Roundtable.

1. Engaging communities: As the Commission works to broaden public awareness and involvement in its work, we offer to help connect our local constituencies to the work of the Commission by organizing in-person meetings, both on-line and in person. For example, we offer to organize listening sessions across the state, along the lines of Oregon’s approach. Additionally, we offer to assist with the development of a social media strategy.
2. Providing research and information and participating in work groups: Given our connections to efforts throughout the country, we offer volunteer time to research and share information from national sources and states that provide models. This might be particularly helpful given the reduction in staff and consultant support.

3. Helping connect the Commission and the legislature: We offer to work in partnership with the Commission to ask the legislature to hear and react to concrete proposals for universal coverage that have already been introduced in each chamber.
4. Supporting the Commission's work to adopt a vision: While the 2022 Baseline Report describes universal models, the Commission has yet to build these models into a vision for the future or adopt principles to support a vision. We offer to participate with Commission members to draft a statement of vision, values, and principles that the full Commission can then consider, revise, and adopt.
5. Engaging Labor: In light of the Washington State Labor Council's July 2025 convention resolution in support of universal single-payer health plans at both the state and federal levels, we think it's critically important for the Commission to hear from and engage with Labor. We have been working with a number of Labor partners on this issue and we can help the UHCC develop direct participation with Labor. We offer to invite our labor partners to give a presentation at an upcoming Commission meeting.

We offer this partnership with a **voice of urgency**. Our constituents cannot abide by the possibility that hundreds of thousands of people in Washington state could lose Apple Health / Medicaid coverage in the near future, as well as a similar number losing enhanced premium tax credits through our state Health Benefit Exchange. It is a critical time to support the safety net for people in need with bold vision.

Each of the organizations in the HCHR coalition brings unique strengths. The HUX Subcommittee of HCHR is glad to be a point of contact for the Commission staff to organize how specific individuals or organizations can be mobilized as needed. Though some activities may require resources, most are already part of the volunteer efforts of our coalition's membership.

Thank you,

Raleigh & Mo

Maureen Brinck-Lund & Raleigh Watts
Health Care Advocates
Co-Chairs - HCHR-UHCC Subcommittee, "HUX"

Tab 3

Washington State Health Care Authority

Advocates Roundtable report out

Washington State Health Care Authority

Written responses from advocates

- The document following this slide was prepared by members of:
  - Health Care for All – WA
  - Health Care is a Human Right
  - Northwest Health Law Advocates
  - Washington Community Action Network (CAN)
  - Whole Washington
- It include advocates written responses to the Advocates Roundtable questions from the Commission's August 5 special meeting

Universal Health Care Commission Advocates Roundtable: Responses to Washington State Health Care Authority Questions

Date: August 5, 2025

Roundtable Objective: To collectively answer five key questions from HCA about universal health care in Washington, drawing on the expertise and unique perspectives of each organization.

Question 1: Introductions and Vision

Please take five minutes to introduce your organization. Tell us about your vision for universal health care in Washington, your organization's efforts toward that vision, and how you complement other organizations' efforts.

Health Care is a Human Right - Nathan Rodke, Co-Chair of HCHR Steering Committee - We're a community and labor coalition of over 40 sponsoring members, including all our presenters today, and many more allied members. Our goal is to achieve universal health care on both the state and federal levels. We have an Organizing Committee, Policy Committee, Communications Committee, and a committee, known as HUX, which regularly engages with the Commission to help it achieve its legislative mandate.

Whole Washington (WW):

- Intro: Whole Washington is a grassroots universal healthcare action organization.
- Vision: Our vision is a comprehensive, statewide universal healthcare system known as the Washington Health Trust (WHT).
- Efforts: We have advocated for this policy since 2018 through both initiative and legislative forms. The WHT is currently active legislation (House Bill 1445 and Senate Bill 5233). We represent hundreds of thousands of Washingtonians who have signed official ballot petitions.
- Complementary Role: We complement other organizations by pushing for a specific, comprehensive policy framework.

Washington CAN:

- Intro: We are part of the Healthcare is a Human Right coalition, with staff co-chairing the Organizing and Steering Committees.
- Vision: Our vision is a not-for-profit health plan for everyone in Washington, with a structure built around health benefits for people in all corners of the state, including immigrants and the incarcerated. Our ultimate goal is a national single-payer plan like an improved and expanded Medicare for All, believing that state-based universal public health plans are the most effective pathway to achieving that national vision.
- Efforts: We have a full-time field and phone canvass team and an organizing department that actively fosters community feedback and engagement. We hear about the impacts of inaccessible and unaffordable healthcare every day and work to counter hospital mergers and other corporate consolidation efforts.

- Complementary Role: We serve as a dedicated grassroots voice that mobilizes and educates the public. Our work is particularly focused on building a broad coalition that includes a powerful labor contingent. The overwhelming support for a single-payer resolution adopted at the WSLC convention on July 24, which calls on state legislators to introduce policies consistent with single-payer, is a testament to the critical need for active involvement from Labor. We are working closely with our labor partners to ensure these principles are at the forefront of the conversation.

Northwest Health Law Advocates (NoHLA):

- Intro: Northwest Health Law Advocates is a public interest law nonprofit that has worked to expand access to healthcare for all Washingtonians since 1999. We serve on the Steering Committee of the Health Care Is a Human Right Coalition.
- Vision: Our long-term vision is a universal healthcare system where essential care is a basic human right, treated like a public utility with public delivery infrastructure and publicly-accountable spending.
- Efforts: We approach this work with a legal lens rooted in our partnership with legal services organizations. We push for universal healthcare that is guaranteed as a legal right for all while serving as a watchdog to ensure those rights are honored. We tend toward more incremental change, with the understanding that government systems take time to perfect.
- Complementary Role: Our role in the advocacy landscape is to provide a legal perspective, identifying opportunities and challenges in government-administered systems and ensuring vulnerable people don't fall through the cracks. We can see through decades of experience that the private healthcare industry has failed to deliver care, and we believe the only path forward is a different system, though we understand this will take time to build.

Healthcare for All Washington (HCFA-WA):

- Intro: HCFA-WA is WA's oldest grassroots volunteer organization dedicated to universal healthcare. We have experience in mounting an initiative campaign as well as working with key legislative allies to sponsor our Washington Health Security Trust legislation from 2003 – 2018. The Board of Directors includes healthcare professionals, individuals with experience working on the 1993 and 1994 health reform efforts in Washington state, and long-time advocates focused on equitable and accessible healthcare for all Washington residents.
- Vision: Our vision is a comprehensive, integrated single-payer system for all Washington residents, publicly financed, and publicly and privately delivered.
- Efforts: Our statewide volunteer organization focuses on single-payer health care policy and transitional solutions necessary to develop infrastructure for the future universal single-payer health system. We are actively involved with the Universal Health Care Commission (UHCC) and its subcommittees, providing public comments, advocating for specific policy recommendations, and securing funding to carry out studies that support those recommendations. We actively lobbied for both the UHCC and its predecessor, the UHC Work Group.
- Complementary Role: We serve on the HCHR Steering and Policy Committees and its HUX Committee that holds the Commission accountable to its legislative mandate. We work with allied organizations to share information and build a unified front, publishing monthly recaps of each UHCC and FTAC meeting in our member e-bulletins. HCFA-WA members serve on the Board of the Puget Sound Advocates for Retirement Action (PSARA), the Health Care Cost Board, and the Prescription Drug Affordability Board.

Question 2: Financing - Lead org in answering at roundtable: Whole WA

The Commission plans to take up financing in early 2026. What funding mechanisms is your organization aware of, and what recommendations do you have in terms of funding universal health care?

Whole Washington (WW):

- Summary: Academic research shows that a unified financing system would be more cost-efficient than the status quo.
- Recommendations: The Washington Health Trust would be publicly financed, removing all premiums, deductibles, and co-pays. The majority of funding would come from a graduated employer payroll assessment (4.5% to 10.5%), with up to 2% deductible from the employee's wage. We believe Washington's high GDP per capita means the state can afford a world-class system that also provides significant cost relief.

Washington CAN:

- Summary: We need a sustainable and equitable system that addresses the state's regressive tax structure. Washington has the 49th most regressive tax structure in the country, and in 2024, voters showed they agree that corporations and the wealthy should pay their fair share.
- Recommendations: Funding could come from a progressive income tax, an increased capital gains tax, and a tax on employers. We also need to broadly examine how we can tax the ultra-wealthy in our state. Additionally, we believe we should look ahead to federal support. After 2028, we can hope to pass supportive legislation like the federal State-Based Universal Health Care Act (SBUHCA) bills, which are designed to help states finance their own universal health care systems and provide for multi-state plans. Our Legislature, in passing SJM 8004 in 2025, has requested this support from the federal government.

Northwest Health Law Advocates (NoHLA):

- Summary: We have already made more progress on the financing question than we realize. The state already spends more of its GDP on healthcare than many other countries, so the conversation should be about spending that money better.
- Recommendations: We are overdue for a conversation about the social compact between those who need care and the businesses and individuals who benefit financially from a healthy populace. We should explore a system where employers pay a fee for the privilege of leveraging our public systems, similar to a toll, which could be more affordable than what many small businesses are paying today. This approach would open a dialogue about how to make sure those who benefit from public health also contribute to it.

Healthcare for All Washington (HCFA-WA):

- Summary: The funding mechanism should be a combination of mandatory assessments and cost-containment strategies.
- Recommendations: The system should be funded through a mandatory employer payroll assessment and individual assessments as needed. Cost-containment strategies should include global budgeting, price caps, bulk purchasing, and streamlined administration. The

system should ultimately integrate existing state plans like PEBB, SEBB, and Medicaid, and seek federal waivers to include Medicare. We advocate for a goal of zero cost-sharing at the point of service.

Question 3: Communication & Hurdles - Lead org in answering at roundtable: WA CAN

What are some of the best ways you have found to communicate with people about universal health care? What are the biggest hurdles? And how do you think the Commission can best gather input?

Whole Washington (WW):

- Communication: Effective communication starts with meeting people where they are. Polling shows that over 85% of Washingtonians want change. We should discuss solutions that directly address their primary frustrations with the current system.
- Hurdles: We need to assure people that a new system would decouple coverage from employment, provide comprehensive coverage, eliminate provider networks, and control costs with transparent pricing.
- Commission Input: The Commission should gather input by focusing on people's primary frustrations and ensuring that proposed solutions address these concerns.

Washington CAN:

- Communication: We have found that people know where to start when it comes to the problems with our current system: reform that makes healthcare a public good relies on reducing administrative costs and barriers to care access that have been put in place by health insurance companies. Access to affordable care also pits patients against the interests of hospitals and pharmaceutical companies. The best way to communicate is to connect the issue directly to people's lived experiences of rising costs and denied care. We need to frame the solution as our elected representatives and government taking on the profiteers and financiers to control and lower costs and to ensure everyone has a health plan that works for them.
- Hurdles: A major obstacle is widespread apathy and a pervasive lack of confidence in established institutions. Regular people see escalating costs alongside a decline in access and quality of care, yet proposals with broad popular support consistently fail to advance. This highlights the disproportionate influence of industry stakeholders and a lack of revenue to meet public needs. Another hurdle is the inevitable disagreements on funding and among stakeholders, which can be a distraction from the shared goal of improving care for everyone.
- Commission Input: The Commission should continue to engage with community members as trusted messengers to rebuild trust and gather input.

Northwest Health Law Advocates (NoHLA):

- Communication: We should gather input directly through surveys of Washingtonians and Washington-based employers. People are very knowledgeable about the challenges they face in the current system, and the vast majority want significant changes. We can ask

people around the state what their ideal healthcare system would look like and who would pay for it.
- Hurdles: People may not understand all the nuances of specific laws, but they can certainly understand the trade-offs in our healthcare system today.
- Commission Input: Surveys and roundtables don't have to be expensive to offer insight. It would be particularly important to include small and large businesses and other healthcare purchasers in those conversations to gather a full range of perspectives.

Healthcare for All Washington (HCFA-WA):

- Communication: We should ask the public to list their vision, values, and principles for healthcare, and then compare it to the UHCC's list. Once a draft plan is established, it should be presented to as many community and professional groups as possible.
- Hurdles: The biggest hurdles are public distrust of the government, fear of change, and the fact that some people are happy with their current system.
- Commission Input: The Commission should hold open public meetings across the state to share the plan, answer questions, and gather public experiences and contact information for future meetings, especially after the plan is designed.

Question 4: Long-Term Sustainability - Lead org in answering at roundtable: Whole WA

Do you have any suggestions for the UHCC as to how to approach this long-term change management effort to ensure that Washington's universal health care system is sustainable in the long term?

Whole Washington (WW):

- Suggestions: The state needs to commit to a long-term vision of universal healthcare and announce a clear plan and timeline, similar to the development of the LINK light rail system.
- Sustainability: The system can only prove itself once people are able to enroll and experience its benefits. There is little evidence that a longer transition improves outcomes. Taiwan, for example, increased coverage from 60% to over 92% in its first year.

Washington CAN:

- Suggestions: For long-term sustainability, we must have sustainable funding mechanisms and strong laws that control costs of care in place. We must also protect traditional Medicare and push back against consolidation and private equity in the healthcare sector.
- Sustainability: Key elements for sustainability include negotiating bulk purchasing for all prescription drugs, using global budgets for hospital systems, and providing incentives for primary care and low or no fees at the point of service.
- Transitional Approach: We need incentives to retain Washington medical school graduates within the state to address substantial provider shortages. A critical part of our long-term strategy is also to work toward multi-state compacts as interim steps along the way. These compacts, which would be facilitated by legislation like the SBUHCA bills, would allow states to share resources and build a stronger, more resilient system together.

Northwest Health Law Advocates (NoHLA):

- Suggestions: There are three additional suggestions to enhance the durability of any reforms. First, work toward bipartisan solutions on a state level, as the bipartisan UHCC Board is a good start. Second, involve healthcare providers in the solutions from the start to discuss trade-offs, such as accepting lower reimbursement in exchange for less administrative burden.
- Sustainability: We can learn from other countries that have recently transitioned to universal healthcare. They succeeded by picking a model that responds to their unique starting conditions and cultural features, rather than scrapping everything. We should build on familiar concepts like Medicare, Medicaid, and PEBB/SEBB.
- Transitional Approach: A successful system requires a willingness to change and adapt over time as the population and its needs change.

Healthcare for All Washington (HCFA-WA):

- Suggestions: A trust with dedicated funding should be established within an independent state institution. A well-built governing board needs to be put in place to make decisions on the myriad of details.
- Transitional Approach: The state should seek federal waivers as soon as possible through the Affordable Care Act, Medicaid, and Medicare. We should fund the system through a payroll tax (to be out of reach of ERISA) and restrict providers from billing anyone but the unified state plan.
- Support Federal legislation, e.g., the State Based Universal Health Care Act (HR 4406, S 2286) that would provide access to the Federal waivers states need to enable their state plans.

Question 5: Interim Solutions - Lead org in answering at roundtable: HCFA WA

As you know, the Universal Health Care Commission has a two-part charge: design a universal system and look for interim solutions. Does your organization have priorities for interim solutions to improve our current system?

Whole Washington (WW):

- Priorities: The expansion of public coverage to a widening population should be the top priority, with a goal of universal eligibility as soon as possible.
- Examples: The Canadian system began by covering hospital services. All minors could be fully covered by Medicaid or another state health plan. Public coverage could begin with primary care, prescription drugs, and other preventative services. State plans could be consolidated and de-privatized.

Washington CAN:

- Priorities: Our priorities for interim solutions are focused on addressing the immediate financial and systemic barriers people face. People know where the problems are: with the insurance companies, hospital conglomerates, and pharmaceutical companies that profit

from the system. In order to mitigate potential Medicaid cuts, ACA cuts, and threats to Medicare, we'll need to pass more laws that control costs of services and provide oversight to hospital mergers.
- Examples: Our organization wants to see all hospital systems move away from negotiating with insurance companies and, instead, negotiate with the government on global budgets. This is a critical step toward controlling costs and ensuring that care decisions are based on patient need, not profit. It also aligns with the overwhelming support from Labor, as reflected in the recent WSLC convention resolution, for policies consistent with single-payer principles.

Northwest Health Law Advocates (NoHLA):

- Priorities: We must not backslide on the commitment to basic coverage and care for all Washingtonians, despite federal challenges. Now is a time to reorganize the money we are already spending to protect care for the most people.
- Examples: Interim solutions could involve revisiting how we organize our safety net for uninsured people and which entities pay into it. We should also review how we can best leverage federal funding streams from the ground up, rather than trying to adapt old systems. We need to tighten the regulatory environment on corporations ready to profit from a chaotic environment. As an example, if a hospital is at risk of closure due to federal cuts, we should have a public dialogue about what the community actually needs and how to fill those gaps with investment that is set up for long-term public accountability.

Healthcare for All Washington (HCFA-WA):

- Priorities: Our priority is to design a single-payer system, but in the interim, we should consolidate purchasing and expand public plan options.
- Examples: Consolidate purchasing for PEBB, SEBB, Medicaid, and the Health Benefit Exchange. Expand pathways for local public entities to join PEBB. Enable the Health Benefit Exchange to only offer standardized, public option plans. Expand cost-saving efforts of state boards.

Tab 4

Washington State Health Care Authority

State agency report outs & Commission member updates

Washington State Health Care Authority

Tab 5

Washington State Health Care Authority

Workplan update

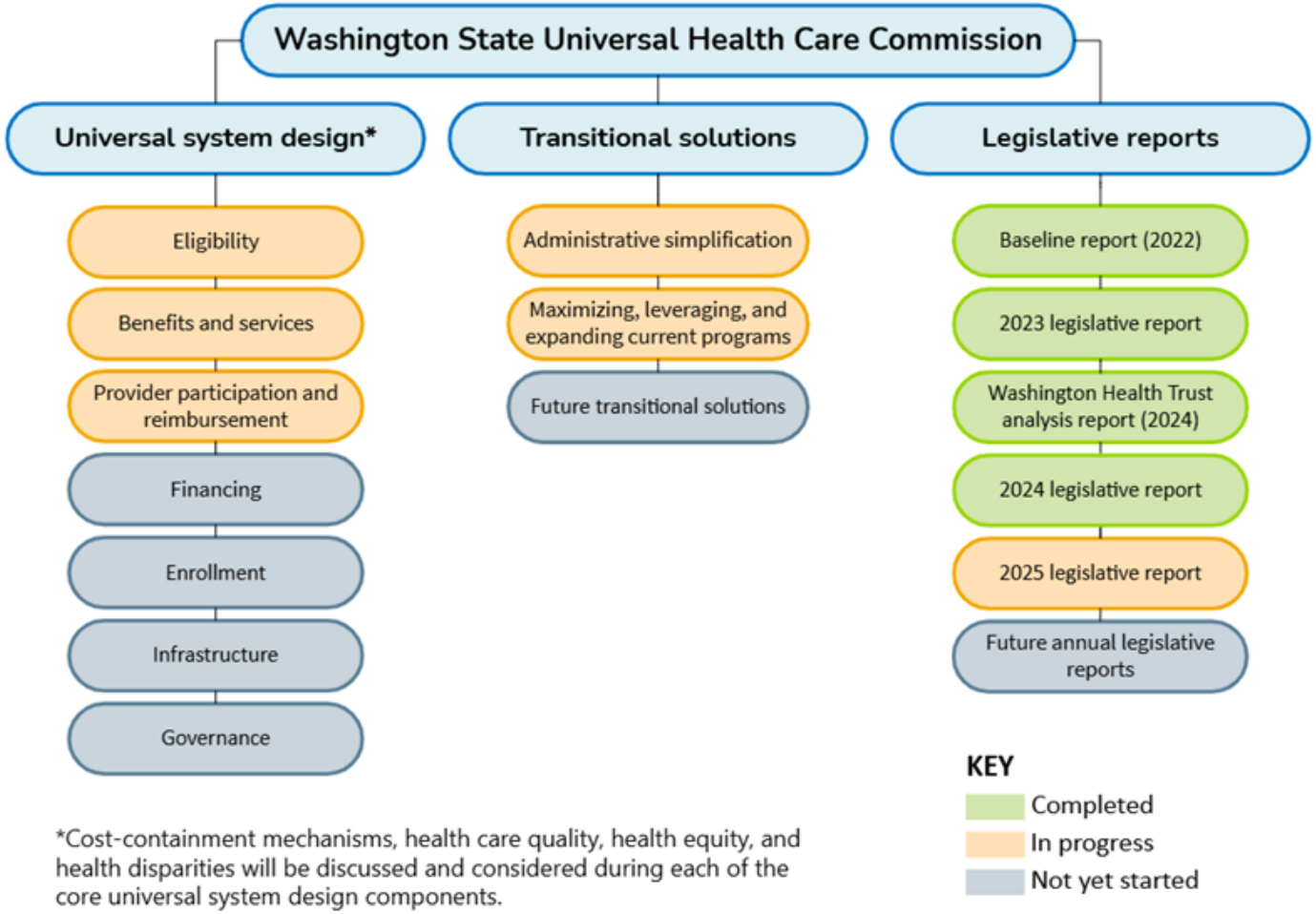
Universal Health Care Commission

Overview

- Workplan status
- 2025 annual report
- 2026 meeting dates
- FTAC appointment process

Workplan status

Last updated August 2025



*Cost-containment mechanisms, health care quality, health equity, and health disparities will be discussed and considered during each of the core universal system design components.

On today's agenda:

- Straw proposals
  - Eligibility
  - Benefits & services
- Next steps for transitional solutions
- 2025 legislative report

2025 annual report

- Draft circulated to Commission members on August 28
  - Also included in appendix of this meeting packet
- Final report due to the Legislature on November 1, 2025
  - Actions taken at today's meeting will be incorporated into final draft
- Commission input:
  - Comments via email to HCAUniversalHCC@hca.wa.gov
  - Vote on final report during October 9 Commission meeting

2026 meeting dates

Universal Health Care Commission (2-5pm PT)

- Thursday, February 12, 2026
- Thursday, April 30, 2026
- Thursday, June 18, 2026
- Thursday, September 3, 2026
- Thursday, October 15, 2026
- Thursday, December 10, 2026

Finance Technical Advisory Committee (2-4:30pm PT)

- Thursday, January 16, 2026
- Thursday, March 19, 2026
- Thursday, May 14, 2026
- Thursday, July 16, 2026
- Thursday, September 24, 2026
- Thursday, November 12, 2026

FTAC appointment process: current charter

C. Vacancies Among FTAC Members

Vacancies among FTAC members will be filled by the Commission.

Request to add additional information regarding:

- *Process for filling vacancies*
- *Criteria for reviewing candidates*

FTAC appointment process: proposed update

C. Vacancies Among FTAC Members

Vacancies among FTAC members will be filled by the Commission. When a seat becomes available, the Commission will announce the vacancy and direct HCA staff to circulate a vacancy announcement through Commission and FTAC GovDelivery channels. Interested individuals must have subject matter expertise in health care financing, which may include actuarial expertise, federal health care financing, unified health care financing, health care cost expertise, understanding how dollars flow through the health system, and/or understanding of payer/provider contracting. HCA staff will collect and circulate all FTAC applications to the Commission for review. The selection process will occur during an open public meeting of the Commission, in which the Commission will appoint a new member by a majority vote.

Note there are three dedicated FTAC positions: one from the Washington State Office of Financial Management (OFM), one from the Washington State Department of Revenue (DOR), and one consumer representative. The consumer representative represents the consumer perspective on issues and actions before FTAC and facilitates dialogue on issues that affect consumers. The consumer representative may bring expertise with specific communities or groups, including but not limited to race/ethnicity, language, individuals who are differently abled, age, gender identity, sexual orientation, social class, insurance status, and intersections among these communities or identities. Health care industry professionals, including but not limited to clinicians and administrators, are not considered consumer representatives for the purposes of FTAC.

Proposed vote

- Draft language:
  The Commission adopts the proposed changes to the FTAC Charter and directs HCA staff to publish a call for applications for the vacant FTAC seat.

Universal Health Care Commission's
Finance Technical Advisory Committee

Charter and Operating Procedures

The purpose of this charter is to clarify the charge and responsibilities of, and expectations for the finance technical advisory committee (FTAC) as established by the Universal Health Care Commission (Commission).

I. Vision and Mission

A. Vision

To provide guidance for consideration of the Commission in development of a financially feasible model to implement universal health care coverage in Washington.

B. Mission

FTAC serves at the direction of the Commission. The goal of FTAC is to provide guidance to the Commission on financially feasible model options to implement universal health care coverage in Washington. FTAC members will investigate strategies to develop unified health care financing options for the Commission and as directed by the Commission, including but not limited to a single-payer system. In their work, FTAC is directed by the Commission to carefully consider the interdependencies between necessary components of a unified financing system and other considerations before the Commission. FTAC may be asked to provide the Commission pros and cons of each option while keeping in mind the impact of those options on patients. Finally, FTAC will provide guidance and options related to entities responsible for implementation and administration of a proposed unified health care financing system.

II. FTAC Charge

Per the Commission's authorizing legislation, and in its 2022 report to the Legislature, the Commission established a finance technical advisory committee. The Commission directs FTAC to provide option-based guidance for the development of a financially feasible model to implement universal health care coverage using state and federal funds.

In their annual report to the Legislature and Governor, the Commission will detail their work, including FTAC's directives, discussions, and provided options with continued strategy development regarding a unified health care financing system, and implementation, if possible. The report due annually on **November 1**, will detail

the opportunities identified by the Commission and FTAC to advance the Commission's goals, including those identified in the legislation and annual reporting requirements.

III. FTAC Duties and Responsibilities

A. Membership and Term

The Commission will appoint nine FTAC members, which includes one consumer representative, and if possible, reserving at least two spots for two state agencies which include the Department of Revenue and the Office of Financial Management.

For the near future, and unless changed by the Commission, FTAC will meet between Commission meetings on a bimonthly basis. This schedule will continue until the Commission deems it appropriate to revise FTAC's meeting schedule, or FTAC completes its goals. FTAC members should review materials before meetings and attend meetings.

FTAC will convene beginning in 2023.

B. FTAC Member Responsibilities

Members of FTAC agree to fulfill their responsibilities by serving at the direction of the Commission, attending and participating in FTAC meetings, and studying the available information. Also as directed by the Commission, FTAC members agree to participate in the development of the Commission's required reports, including the November 1, 2023 report to the Legislature and Governor and annual reports thereafter until FTAC's sunset.

FTAC members provide option-based guidance to the Commission. The Commission will consider FTAC guidance in its decision making for transitioning Washington to a universal health care system supported by a unified financing system, and/or transitional solutions to make immediate and impactful changes to improve the current health care delivery and/or financing system. Outside subject matter experts may be invited to present to FTAC at their meetings on a singular or recurring basis. However, outside subject matter experts will not be official members of FTAC.

Members of FTAC agree to participate in good faith and to act in the best interests of the Commission and its charge. To this end, FTAC members agree to place the interests of the Commission and the state above any political or organizational affiliations or other interests. FTAC members accept the

responsibility to collaborate in developing option-based guidance and pros and cons of those options to the Commission that are fair and constructive for the Commission. FTAC members are expected to consider a range of issues and options to address them, discuss the pros and cons of the issues or options, and present them to the Commission, while keeping in mind the impact of those options on patients. FTAC will include the rationale behind each option provided to the Commission.

Specific FTAC member responsibilities include:

1. Attending FTAC meetings and reviewing materials provided in advance of the meeting.
2. Reviewing background materials, including:
    - the Commission's November 1, 2022 report to the Legislature and Governor to understand issues under consideration by the Commission and the Commission's recommendations to the Legislature.
    - the Universal Health Care Work Group's final report to the Legislature (January 2021), particularly the revenue and financing modeling for Models A and B as proposed by the Work Group.
3. Working collaboratively with one another to explore issues as directed by the Commission.
4. Hearing from invited outside subject matter experts, as needed.
5. Developing option-based guidance to the Commission with pros and cons of each option, while keeping in mind the impact of those options on patients.
6. Some of the following areas could be assigned by the Commission for guidance, including but not limited to:
    - Revenue goals and projections
    - Scope of coverage, benefits, and cost-sharing, including dental and vision
    - Development of fee schedule
    - Securing federal funds
    - Employee Retirement Income Security Act (ERISA)
    - Tax structure, including the impact of the tax structure on equity
    - Assessing how to include Medicare beneficiaries
    - Administrative cost reduction
    - Risk management
    - Model development process

- Health equity in financing
- Level of reserves and methods of funding
- Cost sharing
- Health care and administrative workforce
- Provider reimbursement
- Impact of payment model on care quality and equity
- Economic impacts of new taxes
- Care investments, including primary care, behavioral health, community health, and health-related social needs
- Funding for culturally appropriate health care models
- Assessing how federally funded health systems, VHA, and IHS will be included or intersect with the universal health care system
- Financial forecast of changes in demand/utilization, etc.
- Authority and analytic capacity within a new or existing administering agency

C. Vacancies Among FTAC Members

Vacancies among FTAC members will be filled by the Commission. When a seat becomes available, the Commission will announce the vacancy and direct HCA staff to circulate a vacancy announcement through Commission and FTAC GovDelivery channels. Interested individuals must have subject matter expertise in health care financing, which may include actuarial expertise, federal health care financing, unified health care financing, health care cost expertise, understanding how dollars flow through the health system, and/or understanding of payer/provider contracting. HCA staff will collect and circulate all FTAC applications to the Commission for review. The selection process will occur during an open public meeting of the Commission, in which the Commission will appoint a new member by a majority vote.

Note there are three dedicated FTAC positions: one from the Washington State Office of Financial Management (OFM), one from the Washington State Department of Revenue (DOR), and one consumer representative. The consumer representative represents the consumer perspective on issues and actions before FTAC and facilitates dialogue on issues that affect consumers. The consumer representative may bring expertise with specific communities or groups, including but not limited to race/ethnicity, language, individuals who are differently abled, age, gender identity, sexual orientation, social class, insurance status, and intersections among these communities or identities. Health care industry professionals, including but not limited to clinicians and administrators, are not considered consumer representatives for the purposes of FTAC.

D. Role of the Washington Health Care Authority (HCA)

HCA assists the Commission and shall assist FTAC by facilitating meetings, conducting research, distributing information, drafting reports, and advising FTAC members.

E. FTAC Lead's Role

The FTAC lead will be designated by the Commission. The FTAC lead will encourage full and safe participation by FTAC members in all aspects of the process, assist in the process of building options-based guidance for the Commission, and ensure all participants abide by the expectations for discussion processes and behavior defined herein.

The FTAC lead will develop meeting agendas, share with the Commission FTAC's proposed options for outside expertise, organize invitations from outside expertise, and otherwise ensure an efficient decision-making process. The FTAC lead will also serve as the liaison between FTAC and the Commission, including presenting to the Commission FTAC's option-based guidance with pros and cons.

F. FTAC Principles

The principles listed below are to guide FTAC's process to provide guidance to the Commission. The principles have been established by the Commission and can be revised if proposed by the FTAC lead or by majority of Commission members. FTAC's guidance will:

1. Support the development of the report due annually by November 1, and all subsequent reports until FTAC's sunset, to the Legislature and Governor.
2. Provide options to the Commission that increase access to health care services and universal health coverage, reduce health care costs, reduce health disparities, and improve quality.
3. Be inclusive of all populations and all categories of spending.
4. Be sensitive to the impact that high health care spending growth has on Washingtonians.
5. Align guidance to the Commission with other state health reform initiatives to lower the rate of growth of health care costs.
6. Be mindful of state financial and staff resources required to implement options.

IV. Operating Procedures

A. Protocols

All participants agree to act in good faith in all aspects of FTAC's discussions. This includes being honest and refraining from undertaking any actions that will undermine or threaten the deliberative process. It also includes behavior outside of meetings. Expectations include the following:

1. Members should attend and participate actively in all meetings. If members cannot attend a meeting, they are requested to advise HCA staff. After missing a meeting, the member should contact staff for a recording of the meeting, or if not available, then a meeting summary and any available notes from the meeting.
2. Members agree to be respectful at all times of other FTAC members, Commission members, staff, and audience members. They will listen to each other and seek to understand the other's perspectives, even if they disagree.
3. Members agree to make every effort to bring all aspects of their concerns about these issues into this process.
4. Members agree to refrain from personal attacks, undermining the process of FTAC or the Commission, and publicly criticizing or misstating the positions taken by any other participants during the process.
5. Any written communications, including emails, blogs, and other social networking media, will be mindful of these procedural ground rules and will maintain a respectful tone even if highlighting different perspectives.
6. Members are advised that email, blogs, and other social networking media related to the business of FTAC or the Commission are considered public documents. Emails and social networking messages meant for the entire group must be distributed via HCA staff.
7. Requests for information made outside of meetings will be directed to HCA staff. Responses to such requests will be limited to items that can be provided within a reasonable amount of time.

B. Communications

1. Written Communications

Members agree that transparency is essential to FTAC's discussions and the Commission's deliberations. In that regard, members are requested to include both the FTAC lead and HCA staff in written communications commenting on FTAC's discussions or the Commission's deliberations from/to interest groups (other than a group specifically represented by a member); these communications

will be included in the public record as detailed below and copied to FTAC and the full Commission as appropriate.

Written comments to FTAC, from both individual FTAC members and from agency representatives and the public, should be directed to HCA staff. Written comments will be distributed by HCA staff to FTAC and the full Commission in conjunction with distribution of meeting materials or at other times at the FTAC lead's discretion. Written comments will be posted to the Commission's webpage.

2. **Media**
While not precluded from communicating with the media, FTAC members agree to generally defer to the FTAC lead for all media communications related to FTAC or the Commission's process and its work. FTAC members agree not to negotiate through the media, nor use the media to undermine FTAC or the Commission's work.

FTAC members agree to raise all their concerns, especially those being raised for the first time, at an FTAC meeting or to the FTAC lead and not in or through the media.

C. Conduct of FTAC Meetings

1. **Conduct of FTAC Meetings**
For the near future, FTAC will meet by videoconference bi-monthly unless changed by the Commission. An FTAC member may participate by telephone, videoconference, or in person for purposes of a quorum.

Meetings will be conducted in a manner deemed appropriate by the Commission and FTAC lead to foster collaborative discussion. Robert's Rules of Order will be applied when deemed appropriate.

2. **Conflict of Interest**
In the event that an FTAC member has a conflict of interest, an FTAC member must disclose the interest to HCA staff and will be ineligible to vote on guidance to the Commission.

3. **Documentation**
All FTAC meetings shall be recorded, and written summaries prepared. The meeting recordings shall be posted on the Commission's public webpage in accordance with Washington law. Meeting agendas,

summaries, and supporting materials will also be posted to the Commission's webpage. Interested parties may receive notice of FTAC meetings and access FTAC materials on the website, or via GovDelivery.

D. Public Status of FTAC Meetings and Records

The Universal Health Care Commission meetings are conducted under the provisions of Washington's Open Public Meetings Act (Chapter 42.30). Though FTAC meetings are open to the public, meetings are not conducted under the provisions of Washington's Open Public Meetings Act (Chapter 42.30). Members of the public and legislators may testify before FTAC at the time designated for public testimony. In the absence of a quorum, FTAC may still receive public testimony. Any meeting held outside the Capitol or by videoconference shall adhere to the notice provisions of a regular meeting. Recordings will be made in the same manner as a regular meeting and posted on the Commission's webpage. Written summaries will be prepared noting attendance and any subject matter discussed.

FTAC records, including formal documents, discussion drafts, meeting summaries and exhibits, are public records. Communications of FTAC members are not confidential because the meetings and records of FTAC are open to the public. "Communications" refers to all statements and votes made during the meetings, memoranda, work products, records, documents, or materials developed to fulfill the charge, including electronic mail correspondence. The personal notes of individual FTAC members will be public to the extent they relate to the business of the Commission and/or FTAC.

E. Amendment of Operating Procedures

These procedures may be changed by an affirmative vote of most of the Commission members, but at least one day's notice of any proposed change shall be given in writing, which can be by electronic communication, to each Commission member.

F. Attendance

Regular attendance of FTAC members is essential for the work of FTAC to proceed according to the Commission-approved workplan and to provide timely feedback to the Commission.

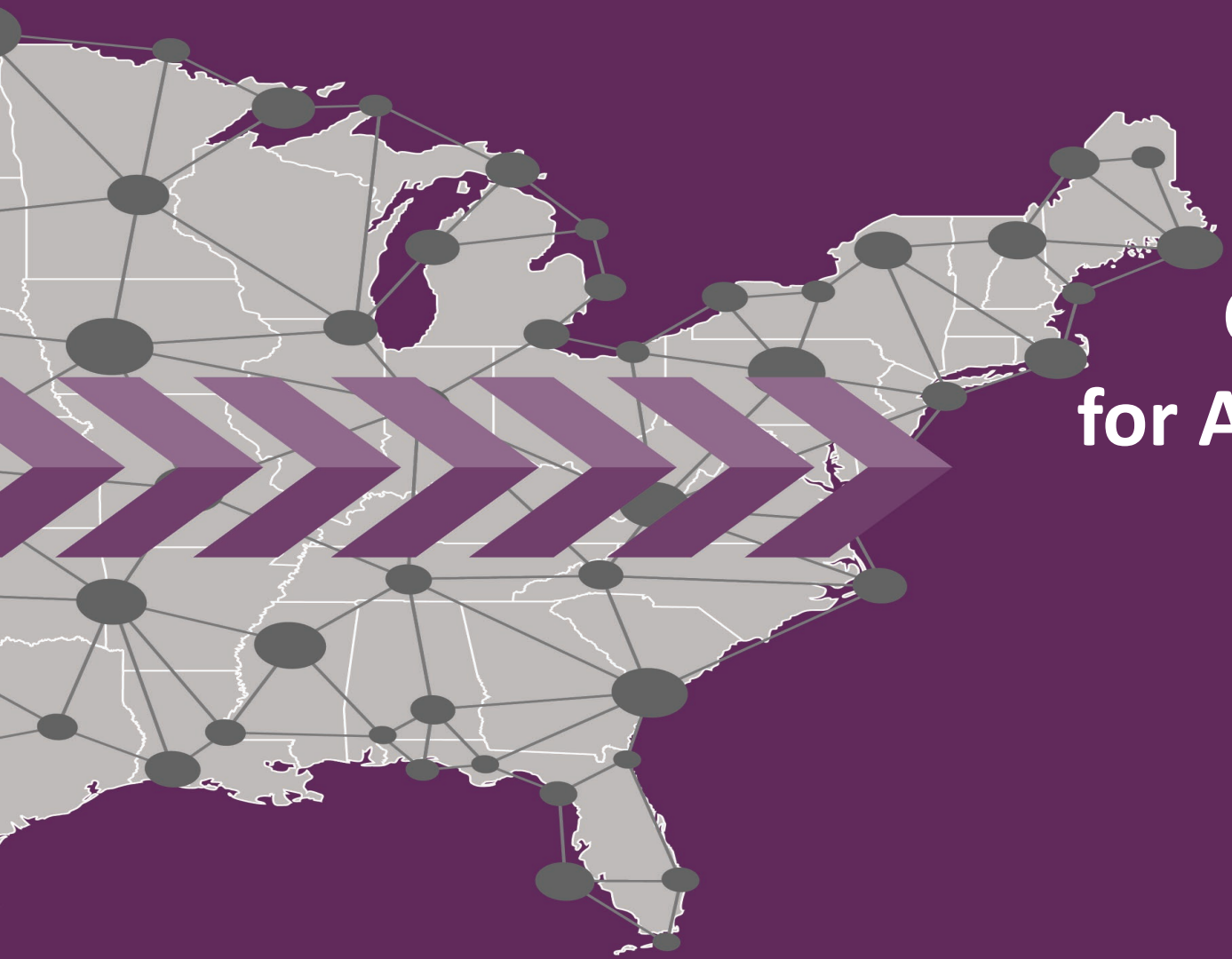
If an FTAC member misses three meetings in a calendar year, or three consecutive meetings in a twelve-month period, the FTAC member will be notified by HCA staff supporting the work of the Commission that they may be

removed due to attendance.

Determination of whether an FTAC member will be removed is at sole discretion of the Commission.

Tab 6

Washington State Health Care Authority



Section 1333 Compacts as a Tool for Achieving Universal Health Coverage

Presentation to the Washington State Universal Health Care Commission

Jason Levitis

September 11, 2025

STATE Health & Value STRATEGIES

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

Support for this presentation was provided by the Robert Wood Johnson Foundation.
The views expressed here do not necessarily reflect the views of the Foundation.

About the Urban Institute

The Urban Institute is a nonprofit research organization founded on one simple idea: To improve lives and strengthen communities, we need practices and policies that work. For more than 50 years, that has been our charge. By equipping changemakers with evidence and solutions, together we can create a future where every person and community has the opportunity and power to thrive.

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Introduction

Today we will consider sec. 1333 compacts as a potential tool for meeting the goals of the Washington Universal Health Care Commission

- Among the several flexibilities provided to states by the ACA is "**heath care choice compacts**" under sec. 1333.
- Sec. 1333 allows states to enter into agreements to **permit the sale of health insurance across state lines**, subject to certain restrictions.
- **CMS has never promulgated regulations** implementing sec. 1333, and no state has attempted to use it.
- Current CCIIO leadership has expressed strong interest and **appears to be moving towards implementation.**

IN BRIEF:

- A sec. 1333 compact could potentially be part of a package of reforms to move towards universal coverage
- But there is great uncertainty about how sec. 1333 will be implemented, which attaches risk to pursuing the program. And under a straightforward interpretation, sec. 1333 has substantial shortcomings as a tool for pursuing universal coverage.

Agenda

- Marketplace-Related Flexibilities under the ACA
- Section 1333: Statutory Provisions
- Section 1333: History and State of Play
- How Section 1333 Compares to other ACA Flexibilities
- Considerations for the Washington Universal Health Care Commission

Marketplace-Related Flexibilities under the ACA

Basic Health Program – ACA sec. 1331	State Innovation Waivers – ACA sec. 1332

• Permits states to **replace subsidized Marketplace coverage with a Medicaid-like public program** for individuals with incomes between 133 and 200 percent of the poverty line
• States **receive funding equal to 95% of the Marketplace subsidies** enrollees would have received on the Marketplace
• **Four states** have opted for Basic Health Programs, including Oregon
	• Permits states to **waive or modify specific ACA coverage provisions**, including Marketplace subsidies, the employer mandate, and rules for Marketplaces and some of the rules for plans offered there
	• Waivers must satisfy **4 statutory "guardrails."** They can't:
	  ○ Reduce coverage
	  ○ Reduce the affordability of coverage
	  ○ Reduce the comprehensiveness of coverage
	  ○ Increase federal deficits
	• If the waiver creates federal savings by reducing Marketplace subsidies, the state can generally receive that amount as "pass-through funding"
	• **Discretionary**: HHS and Treasury "may" but are not required to approve any waiver
	• **More than 20 states** have been granted 1332 waivers. The vast majority (including Oregon's) support reinsurance programs, but a few (including Washington's) achieve other goals.
	• *For states seeking to expand coverage,* ***sec. 1332's deficit neutrality guardrail has been a key barrier.***

Marketplace-Related Flexibilities under the ACA (cont.)

Interstate Exchanges – ACA sec. 1311(f)(1)	Multistate Plans – ACA sec. 1334	Health Care Choice Compacts – ACA sec. 1333
• Provides that "**[a]n Exchange may operate in more than one State** if…each State in which such Exchange operates permits such operation; and…the Secretary approves such regional or interstate Exchange." • None have been established	• Requires the federal Office of Personnel Management to contract with private insurers to offer Marketplace coverage nationwide • The program was **discontinued in 2020 due to lack of insurer interest**	• Authorizes state agreements to permit the sale of health insurance across state lines, subject to certain restrictions • None have been established ★ ***Our focus today***

Statutory Provisions of Sec. 1333

- Permits two or more states to enter into a compact under which a health plan licensed in one state can be offered in the Marketplace in all such states
- Such plans are **generally subject only to the laws and regulations of the state in which the plan was issued**.
- However, the plan:
  - Is subject to the rules on market conduct, network adequacy, consumer protection, and rating from the enrollee's state of residence
  - Must be licensed in each state or must submit to each state's jurisdiction for purposes of the protections above
  - Must clearly notify consumers that the policy may not be subject to all the rules of the state where the consumer resides.

Compacts must satisfy five statutory "guardrails," including the four from sec. 1332. They CANNOT:

Reduce coverage

Reduce the affordability of coverage

Reduce the comprehensiveness of coverage

Increase federal deficits

Weaken enforcement of the state rules above

Statutory Provisions of Sec. 1333 (Cont.)

- Sec. 1333 includes no language to waive other ACA provisions or to provide federal funding
- **Federal discretion**: HHS "may" but is not required to approve a compact
- **NAIC role**: CMS must issue regulations "in consultation with the National Association of Insurance Commissioners"
- **State legislation**: Each state must enact a law that specifically authorizes the state to enter into the agreement

The concept of **"interstate compacts" appears in the Constitution**, which provides that states may not enter interstate compacts without the consent of Congress. The Supreme Court has interpreted this to mean that Congressional consent is required for *compacts that abridge federal authority.*

Section 1333: History and State of Play

CMS has issued no regulations implementing sec. 1333, and no state has sought to enter a sec. 1333 compact

- In 2019, CMS issued a request for information seeking comment on potential implementation.
- **Peter Nelson**, the current director of the Center for Consumer Information and Insurance Oversight (CCIIO)—the branch of CMS with jurisdiction over sec. 1333—**published a piece last year highlighting opportunities created by sec. 1333** and arguing for expansive interpretations of its authority.
- CMS recently **indicated that it intended to move forward with rulemaking** and requested the required consultation from NAIC.

Uncertainty about Sec. 1333 Implementation

Because there are no regulations or other rulemaking on sec. 1333 and no experience with it, there is tremendous uncertainty about how it would play out.

Legal interpretations and rulemaking

- Interpretation of guardrails
- Interaction with 1332 waivers, and implication of any changes to sec. 1332 rules
- Scope of authority to depart from federal rules

Procedural questions

- Application contents, actuarial analysis, etc.
- Application timeline
- Public notice, comment, and tribal consultation
- Monitoring, oversight, and periodic reporting

Exercise of CMS discretion

Considerations for Washington under a Straightforward Interpretation of Sec. 1333

Under a straightforward interpretation:

- Compacts plans could share a risk pool and meet most rules of only one state
- They wouldn't permit other changes to federal rules
- Guardrails interpretations might be similar to those under sec. 1332
- Procedures for applying, approval, and monitoring might be similar to those under sec. 1332.

Potential Implications for Washington

- Could permit Washington to benefit from an **expanded risk pool**
- Could potentially be used **in concert with an interstate Exchange under sec. 1311(f)(1)** so that multiple states could share a single Marketplace with a single set of plans
- Could permit the sale of plans in Washington that **do not meet all state requirements**
- Would require **extensive coordination** with other compact states
- **Would not on its own expand coverage or streamline payment systems**

Outstanding Questions under a Straightforward Interpretation of Sec. 1333

- Specific requirements for application contents, actuarial analysis, public notice and comment, tribal consultation, and ongoing reporting
- Rules for coordination with sec. 1332 waivers
- Exercise of federal discretion
- Rules for reconsideration and termination
- Market outcomes:
  - Would issuers participate?
  - Would premiums fall?
  - Would consumers enroll?

Considerations under an Expansive Interpretation of Sec. 1333

Whether or not consistent with the statute, rulemaking could potentially provide that sec. 1333 creates authority to depart from additional federal rules, provide funding, and be immune from federal reconsideration.

Such an approach would also come with substantial risks and limitations for Washington:

- Litigation risk
- Exercise of discretion
- Deficit neutrality guardrail

Thank You

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Washington State Universal Health Care Commission Meeting

9.11.2025

StatesWork

StatesWork's threefold mission is to:

- **Support State Leadership.** Assist states in managing issues affecting health, safety, welfare, and quality of life.
- **Foster Collaborative Innovation.** Provide a collaborative space and incubator for ideas that drive healthcare transformation, emphasizing private sector competition, cost reduction, and improved access.
- **Optimize Taxpayer Resources.** Enhance the effective use of federal and state resources for sustainable healthcare programs.

Contact: randy@stateswork.org | randy@randolphpateadvisors.com

Background

Section 1333 of the Affordable Care Act allows states to create interstate "Health Care Choice Compacts" that can streamline health insurance regulation and potentially improve markets

- These compacts become federal law when approved
- While CMS sought public comment on how to implement this provision in 2019, no regulations have been issued yet

Some Key Benefits

- **Regulatory Stability:** In theory, could protect against seesawing federal regulations between administrations
- **State Control:** Returns significant regulatory authority to states (similar to 1332 waivers but perhaps with slightly different flexibility)
- **Permanent Structure:** Creates lasting arrangements that future administrations–again at least in theory–must honor
- **Market Improvements:** Potential to address structural ACA issues like premium inflation, network adequacy, and high cost-sharing

Implementation Approaches

- **Minimalist Approach:** Focus on stabilizing current ACA requirements by transferring administration to states (e.g., pick a set of regs you like and stick with them)
- **Comprehensive Approach:** Create alternative regulatory structures while meeting ACA guardrails
- **Hybrid Options:** Customize which aspects remain federal vs. state-controlled

Compact Requirements

- **Must be enacted through state law in each participating state**
- **Must meet five guardrails a to Section 1332 waivers:**
  - Coverage as comprehensive as ACA
  - Cost protections as affordable as ACA
  - Comparable number of residents covered
  - Cannot increase federal deficit
  - No weakening of state consumer protection laws

Some Potential Pathways for Federal Implementation of Section 1333

Regulatory Approaches

- **Complete Implementation Framework**: CMS could promulgate comprehensive regulations defining all aspects of Section 1333 implementation, creating a clear pathway for states
    - Could provide robust templates and/or model compact examples with language and concepts for expedited approval
- **Minimalist Framework:** Alternatively, they could establish only basic guardrail requirements while maximizing state flexibility in compact design
- **Expedited Review Process:** CMS might also create fast-track approval process for compacts meeting certain baseline requirements

State Considerations for Section 1333 Compacts

Division of Federal vs. State Authority

- **Regulatory Domain Decisions:** States must decide which aspects of the ACA to maintain under federal oversight (e.g., risk adjustment) versus state control
- **Challenge:** Federal expertise in certain technical areas like risk adjustment models may be difficult to replicate at the state level
- **Administrative Capacity:** States need to assess their readiness to take on expanded regulatory functions and implementation costs
- **Transition Strategy:** Creating a phased approach to transferring regulatory authority allows for capability building and reduces disruption

State Considerations for Section 1333 Compacts

Distribution of Authority Between States

- **Regulatory Headquarters:** States might designate one state's regulatory framework as primary (similar to corporate headquarters in multi-state businesses)
- **Challenge:** States with stronger consumer protections may resist yielding to states with fewer protections
- **Exceptions Management:** The compact must address which market conduct, network adequacy, and consumer protection standards remain with the purchaser's state
- **State Sovereignty Concerns:** Legislatures may be reluctant to give up traditional sovereignty over insurance regulation
- **Transition Strategy:** Creating a phased approach to transferring regulatory authority allows for capability building and reduces disruption
- **Political Alignment:** Finding partner states with compatible political views on health insurance regulation presents a significant challenge

State Considerations for Section 1333 Compacts

Legal and Legislative Hurdles

- **Authorizing Legislation:** Designing state legislation that provides sufficient authority while maintaining oversight
- **Challenge:** Different state legislative procedures and sessions can delay implementation
- **Compact Amendment Process:** Creating mechanisms for future adjustments without requiring complete reauthorization
- **Legal Challenges:** Preparing for potential litigation over compact provisions from opposition stakeholders
- **Federal Rulemaking Requirements:** Absence of federal Section 1333 implementation regulations creates uncertainty

Some Potential Action Steps for States

- Enact authorizing legislation in interested states
- Consider starting with a planning commission to develop proposals
- Identify and work with like-minded states with similar regulatory approaches
- Engage with CMS on ideas and approval requirements

Questions?

Washington State Health Care Authority

Discussion

- Is there any additional information the Commission would like regarding Sec. 1333 Compacts?
- Would the Commission like staff to engage Oregon about their potential interest in Sec. 1333 compacts?
- If staff and Commission members devote time to Sec. 1333 compacts, how will that impact the current workplan?

Universal Health Care Commission meeting

We are currently on a short break

Washington State Health Care Authority

Tab 7

Washington State Health Care Authority

Finance Technical Advisory Committee (FTAC) update

July FTAC meeting recording & materials

Washington State Health Care Authority

Overview: July FTAC meeting

- Public comment
  - A request to consider addressing governance earlier in the workplan
  - A request to seek funding for the implementation of universal health care in Washington state immediately
  - Recommendations for future actuarial analyses
  - Support for the Universal Health Care Commission's upcoming Advocates Roundtable and request that FTAC members attend
- Straw proposals (next slide)
- Transitional solutions (tab 8)

Straw proposals

- In-depth work by UHCC/FTAC work group
- Two rounds of review from full FTAC membership
- Standardized format for documenting decisions
- Today's agenda: consideration for final adoption
  - Eligibility
  - Benefits & services

Universal Health Care Commission: DRAFT Straw Proposal

Committee: Finance Technical Advisory Committee (FTAC)
Commission/Committee Lead(s): UHCC/FTAC Work Group
FTAC Review: July 17, 2025
Commission Review: September 11, 2025
Proposal ID: 2025-01
Core Design Element/Milestone: Eligibility

Summary

This proposal outlines recommendations for addressing eligibility in a universal health care system in Washington state. The goal of a unified system is to include all Washington residents in the future universal health care system. However, current federal law poses significant barriers to including all people in the state. Until federal law changes, the Universal Health Care Commission (Commission) will focus on an initially identified eligible population as it seeks ways to expand the eligible population and studies transitional eligibility solutions.[1]

The Commission is aware that other states designing a universal system may pursue a different timeline and path toward universal coverage.

Background

The Commission examined eligibility as its first design component,[2] beginning in 2023. Later, following actuarial analyses of selected benefit plans, the Finance Technical Advisory Committee (FTAC) and an ad hoc work group (made up of three Commission members and three FTAC members) further explored eligibility. When defining "Washington resident," for purposes of eligibility for universal coverage, the Commission recommends following the Washington Department of Revenue definition.

Recommendations

The Commission, FTAC, and the work group identified populations that could potentially be eligible in a state-based universal health coverage system now. Eligible populations are based on the individual's current health care coverage. The Commission is aware that the federal budget passed in July 2025 could affect health care availability and affordability for many people in Washington. The Commission will continue to monitor these changes and may adjust future modeling or design recommendations, as necessary.

The initial group of Washington residents likely to be eligible to be covered by a universal system include those covered by:

- Medicaid
- Children's Health Insurance Program (CHIP)
- Individual health plans

[1] These strategies could include, but are not limited to, consolidating all state agency purchasing (Medicaid/CHIP, PEBB/SEBB and WHBE) into a single system.
[2] For initial assessments of eligibility, see UHCC 2023 Legislative Report (pp. 15-29), UHCC Washington Health Trust Analysis Report (pp. 6-15), and UHCC 2024 Legislative Report (pp. 8-23).

- Small group health plans not subject to the Employee Retirement Income Security Act of 1974 (ERISA) preemption rule
- Private sector employer-sponsored health plans subject to the ERISA preemption rule
    - Note: This is a modest assumption based on creation of payment mechanism. See more below.
- Public Employees Benefits Board/School Employees Benefits Board (PEBB/SEBB) plans
- Local government plans
- Tribal health coverage
- Uninsured

Many Washington residents have health coverage that cannot be incorporated into a state administered health care system without additional federal authority, effectively excluding them, for now, from a statewide universal system. Furthermore, it is unknown whether or when states will gain control of the financing for these federally regulated benefits and services. However, a unified system could provide coverage *in addition to* existing coverage. Those federally excluded populations include (but are not limited to) those covered by:

- Medicare
- Federal Employee Health Benefits (FEHB) plans
- Tricare

Private sector employer-sponsored health plans

Of the groups listed above, those enrolled in private sector employer-sponsored health plans present a special case. The federal ERISA statute governs private group health plans, which can be fully insured or self-funded, at the employer's option. States cannot regulate "central matters of plan administration" for these ERISA-governed health plans. However, states *can* regulate the fully insured health plans that employers offer.[3] The state cannot direct whether an employer offers coverage (although the Affordable Care Act requires employers of more than 50 people to offer minimum essential coverage or pay a tax penalty). In addition, the state cannot direct what type of coverage an employer must offer, other than indirectly through regulation of fully insured health plans.

The most likely path to covering individuals who now get their coverage through a private employer's health plan would be through some form of payment mechanism. A memo prepared for the Oregon Joint Task Force on Universal Health Care suggests mechanisms that could survive a legal challenge in the 9th Circuit, which includes Washington and Oregon. [4]

While these mechanisms may survive legal challenges, not all employers would necessarily forgo offering employer-based plans. The Commission recommends exploring this option with expectations for a modest rate of uptake (e.g., 25 percent).

In addition, a section 1332 state innovation waiver could provide a pathway for including the individual and small group markets not subject to the ERISA preemption in a universal system.

American Indian and Alaska Native Washington residents

[3] Approximately one-third of employers offer fully insured, as opposed to self-funded, health plans.
[4] Memorandum to Oregon Joint Task Force on Universal Health Care, July 25, 2022

In a government-to-government relationship, the state should work with tribes to explore mechanisms to allow American Indian and Alaska Native (AI/AN) residents to enroll in a universal system in lieu of tribal health plans. Such mechanisms should adhere to *Model Language: AI/AN protections in the State-Based Universal Health Care* (Appendix A) and follow 25 USC 1621e regarding reimbursement for health care services.

Residents without full rights of citizenship

The state must determine whether to include residents without full rights of citizenship in its universal design. The state may choose to follow the current structure of existing Washington programs. For example, Apple Health Expansion provides coverage to Washington residents 19 years or older with certain immigration status whose income is up to 138 percent of the federal poverty level (FPL). In addition, Washington's Apple Health for Kids program provides coverage for children in households up to 315 percent of FPL, regardless of immigration status.

Population (by current coverage)	Likely eligible in initial universal health system (Y/N)	Potential pathway(s) to eligibility	Notes
Medicaid	Yes	1115A demonstration waiver	
CHIP	Yes	1115A demonstration waiver	
Individual health plans	Yes	Section 1332 waiver	
Small group market plans not subject to the ERISA preemption rule, such as association health plans	Yes	Section 1332 waiver	
Private sector employer-sponsored health plans subject to the ERISA preemption rule	Yes (at their option)	Creation of a payment mechanism	Modest assumption based on creation of payment mechanism
PEBB/SEBB plans	Yes	Amend RCW 41.05.21	
Local government plans	Yes	NA	
Tribal health coverage	Yes (at their option)	Mechanisms created through a government-to-government relationship between the state and tribes	See Appendix A
Uninsured	Yes	NA	
Medicare	No	Medicare waiver or change in federal law	Joint Task Force on Universal Health Care Final Report Recommendations Oct 2022.pdf, p. 22

FEHB plans	No	Waiver or change in federal law	
Tricare	No	Waiver or change in federal law	

FTAC Feedback (July 17, 2025)

Returned for revision

- Please make the following revisions:
  - Add note about potential federal implications given recent changes at the federal level
  - Update the table populations to match the populations outlined in the recommendation section as likely eligible and federally excluded
  - Define Washington residents
  - Include large and small group health plans explicitly
  - Add the government-to-government relationship for working with American Indian and Alaska Native Washington Residents
  - Provide more details about potential pathways for eligibility

UHCC Feedback (September 11, 2025)

Approved

- UHCC adopts this design proposal as written.

Returned for revision

- Please make the following revisions:
  - [Enter revisions/notes]

American Indian Health Commission
for Washington State

Seattle Indian Health Board
For the Love of Native People

Model Language: AI/AN Protections in the State-Based Universal Health Care

Sec. 1 – **Federal Trust Responsibility to provide health care to American Indians and Alaska Natives** – Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.

Sec. 2 – **Definition of Indian Health Care Provider** – the term "Indian Health Care Provider" (IHCP) is as defined by 42. CFR 438.14(a).

Sec. 3 – **Definition of Indian** – the term "Indian" is as defined by 42 C.F.R. § 447.50 (as in effect on July 1, 2010).

Sec. 4 – **No Cost Sharing for Items or Services Furnished to Indians** – No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service through the state universal health care plan.

Sec. 5 – **Exemption from Mandatory Enrollment for Indians** – A state may not require the enrollment in a state universal health care plan an individual who is an Indian as defined by 42 C.F.R. § 447.50 (as in effect on July 1, 2010).

Sec. 6 – **Network Access for Indian Health Care Providers** – issuers authorized within the state universal health care plan must offer to contract with Indian Health Care Providers operating within the area served by the plan.

Sec. 7 – **Assurance of Payment to Indian Health Care Providers for Provision of Covered Services** – an issuer operating within the state universal health care plan will agree to pay Indian Health Care Providers, whether such providers are participating or nonparticipating providers with respect to the entity, for covered services provided to those Indian enrollees who are eligible to receive services from such providers at a rate equal to the rate negotiated between such entity and the provider involved or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a participating provider which is not an Indian Health Care Provider.

American Indian Health Commission
for Washington State

Seattle Indian Health Board
For the Love of Native People

AI/AN Protections in the State-Based Universal Health Care Act of 2017

Sec. 8 – **Indian Health Care Provider Contract Addendum** – all issuers operating within the state universal health care plan will include a standard contract addendum when contracting with Indian Health Care Providers. The contract addendum will be developed in consultation with tribes and in conference with Urban Indian Health Programs operating within the service area of the state universal health care plan.

Sec. 9 – **Reaffirmation of the Sovereignty of Indian Tribes and the Trust Responsibility** – The treatment of "Indians" as defined by 42 C.F.R. § 447.50 (as in effect on July 1, 2010) under this legislation does not constitute invidious racial discrimination in violation of the Due Process Clause of the Fifth or Fourteenth Amendments but is reasonable and rationally designed to further the health of Indians.

Sec. 10 – **Tribal Consultation and Urban Confer** – (a) In the case of any State in which 1 or more Indian Health Care Programs furnishes health care services, the state will provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Care Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and that—(b) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians or Indian Health Care Programs; and (c) may include appointment of an advisory committee and of a designee of such Indian Health Care Programs to the medical care advisory committee advising the State on its state universal health care plan under this title.

Sec. 11 – **Full Funding of the Indian Health Services** – To ensure fulfillment of the federal government's trust responsibility to Tribes, American Indians and Alaska Natives, universal health care must include full funding and **mandatory** appropriations.

Universal Health Care Commission: DRAFT Straw Proposal

Committee: Finance Technical Advisory Committee (FTAC)
Commission/Committee Lead(s): UHCC/FTAC Work Group
FTAC Review: July 17, 2025
Commission Review: September 11, 2025
Proposal ID: 2025-02
Core Design Element/Milestone: Benefits and services

Summary

This proposal includes recommendations for benefits and services design in a universal health care system in Washington state. The proposal provides the Universal Health Care Commission (Commission) with options for developing uniform benefits and services coverage for residents of Washington. Among the key components of benefit design are covered services and consumer cost sharing. Additional components, such as prior authorization, are not included in this discussion.

Background

The Commission was established "... 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 federal authority is granted. Benefits and services design is one of the key elements required to prepare the state.[1]

From May 2024 – June 2025, the Commission and its Finance Technical Advisory Committee (FTAC) compared costs of benefit design scenarios. The Commission chose three existing health benefit plans to compare in the study:

- Medicaid (100% actuarial value)
- Uniform Medical Plan (UMP) Classic (87-90% actuarial value)
- Cascade Select Silver (68% actuarial value)

An actuarial analysis, completed in March 2025, compared the costs of pooling an identified population of Washington residents into each of these benefit scenarios.[2] The identified population aligns with the Commission's previous recommendation regarding eligibility (Proposal ID 2025-01). The completed actuarial analysis can be found here.

Results

The Commission determined that UMP Classic, with the addition of dental coverage, should be the starting point for the benefits and services design, and that a Medicaid-like design with no patient cost sharing should be an aspirational goal. The Commission also recommended retaining Scenario 3 (Cascade Select Silver plan standard benefits and cost sharing) as a cost neutral point of reference. With this initial direction, FTAC recommended forming a work group

[1] RCW 41.05.840

[2] Note that a hybrid benefit design was applied to the Cascade Select Silver and UMP scenarios in which the "Medicaid-eligible" population estimate received Medicaid-like benefits with no cost sharing. Additionally, and per FTAC liaison guidance, the study population did not include the fully-insured population. This population was included in the sensitivity analyses. Please see the full report for further details.

of Commission and FTAC members to refine the recommendation. The work group held its first meeting in June 2025 and provided recommendations for FTAC review in July 2025. FTAC members provided feedback on the initial recommendations for Commission review in September 2025.

Recommendations

- The benefits and services design should be a "standardized benefit design" for all Washington residents in the new system.
    - Medicaid-eligible beneficiaries would continue to receive state plan and waiver services above and beyond this standardized benefit design.
    - Washington residents could obtain services not covered in this standardized benefit design through supplemental or out-of-pocket payments.
- Retain UMP Classic (87-90% actuarial value) as the *starting point* for benefits and services design under a universal system and include the same covered services as those covered by UMP Classic.
    - Determine whether to retain UMP Classic's current mix of coinsurance (primarily for medical care) and co-payments (primarily for pharmacy). If not, then determine the preferred balance and distribution of coinsurance and co-payments.
    - Cost sharing should include subsidies for low-income enrollees with incomes between 100 percent and 250 percent of the federal poverty level (FPL).
    - Individuals with incomes below 100 percent of FPL would have no cost sharing.
- Cost-sharing design options should begin with establishing an array of cost-sharing actuarial values (AV) from UMP's 90% AV to 100% AV.
- When further defining consumer cost sharing, begin by setting boundaries for key indicators known to drive consumer preferences. Such indicators could include, but are not limited to:
    - Premiums
    - Services covered prior to deductible being met
    - Amount of any deductible
    - Use of fixed copayments rather than coinsurance
    - Out-of-pocket maximums
- Ensure that any cost-sharing design aligns with the cost-sharing principles developed by FTAC and approved by the Commission.[3]

[3] The Commission adopted the following principles at their October 2024 meeting:

- Avoid creating barriers to care by considering, among other things, income thresholds and exemptions for cost sharing.
- Identify selected services (e.g., preventive care or diagnostic screening) that would not be subject to cost sharing.
- Create cost-sharing structures that are simple, predictable, transparent, and easily understood for providers and individuals seeking care.
- Review the Commission's final policy decision on cost sharing through the health equity toolkit as adopted by the Commission.
- Review and revise cost-sharing designs as medical technology and services evolve.

- Determine priorities for possible future actuarial and forecasting studies for the Commission's consideration.

FTAC Feedback (July 17, 2025)

Returned for revision

- Please make the following revisions:
  - Add a technical footnote regarding the hybrid benefits modeled in the Milliman analysis and note that the fully-insured population was excluded from the study population but included in the sensitivity analysis per FTAC liaison guidance
  - Add in Commission desire to retain Scenario 3 (Cascade Silver plan standard benefits and cost sharing) as a cost neutral point of reference moving forward
  - Add in standard design language
  - Add additional cost-sharing language

UHCC Feedback (September 11, 2025)

Approved

- UHCC adopts this straw proposal as written.

Returned for revision

- Please make the following revisions:
  - [Enter revisions/notes]

Tab 8

Washington State Health Care Authority

Transitional solutions

Universal Health Care Commission

Transitional solutions: initial discussions

- During the 6/11 & 7/17 meetings, Commission and FTAC members discussed several potential topics, including:

Proposed transitional solution topics	Proposed by
Mitigation strategies regarding federal changes like coverage losses	Commission
Looking at the financial underpinnings of our current system to address affordability	FTAC
Stabilization of our current system (e.g., maintaining people's access to coverage, supporting rural hospitals)	FTAC
Building on work the Commission had done previously (e.g., administrative simplification/prior authorization)	Commission, FTAC
Developing a list of the transitional solutions the Commission has already identified to see what has already been done	FTAC
Addressing health care workforce needs in rural areas	Commission
Expanding and consolidating state purchasing	FTAC
Supporting small businesses providing health insurance to their employees (e.g., the Small Business Health Options Program (SHOP))	Commission

Transitional solutions: prioritization

- **Which transitional solutions do Commission members believe are most critical for advancing the state's readiness for a universal health care system?**

- **What transitional solution should be prioritized for action first?**
  - To facilitate the Commission's potential recommendations to the legislature on this topic, what specific background information, datasets, or analyses are most crucial for informing your decision-making?
  - Are there any recommendations for transitional solutions Commission members would like to add to the 2025 Legislate Report to put in front of the Legislature ahead of the 2026 session?

Thank you for attending the Universal Health Care Commission meeting

Washington State Health Care Authority

Appendix

Washington State Health Care Authority

Washington State Health Care Authority

Report to the Legislature

Universal Health Care Commission

Annual report DRAFT

Engrossed Substitute Senate Bill (ESSB) 5399 (Chapter 309, Laws of 2021, codified at RCW 41.05.840)

November 1, 2025

Universal Health Care Commission Annual Report

Acknowledgements

The Health Care Authority wrote this report in collaboration with the Universal Health Care Commission (Commission). The Commission reviewed and approved the recommendations contained in this report on DATE.

The Commission thanks past and present members of the Finance Technical Advisory Committee for their continued guidance and expertise.

Washington State Health Care Authority

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Glossary

ALF	Assisted Living Facility
AV	Actuarial Value
Commission	Universal Health Care Commission
Cost Board	Health Care Cost Transparency Board
DOH	Washington State Department of Health
DOR	Department of Revenue
EHR	Electronic Health Records
ER	Emergency Room
ESSB	Engrossed Substitute Senate Bill
FFS	Fee-for-service
FTAC	Finance Technical Advisory Committee
HCA	Washington State Health Care Authority
HB	House Bill
Medicaid	Washington Apple Health (Medicaid), Apple Health
OFM	Washington State Office of Financial Management
OoE	Washington State Office of Equity
OIC	Washington State Office of the Insurance Commissioner
OPMA	Open Public Meetings Act
PEBB/SEBB	Public Employees Benefit Board/School Employees Benefit Board
PMPM	Per member per month
RCW	Revised Code of Washington
SB	Senate Bill
UHCWG	Universal Health Care Work Group
UMP	Uniform Medical Plan
WHBE	Washington Health Benefit Exchange

Executive Summary

This is the Universal Health Care Commission's (Commission) fourth annual report submitted by the Washington State Health Care Authority (HCA) to the Washington State Legislature and Governor as directed in RCW 41.05.840.

This report builds upon the Commission's previous annual reports to the Legislature and Governor and describes the Commission's work from October 2024 through September 2025. During this period, the Commission convened six regular meetings. In addition, the Commission held an Advocates Roundtable, convened as a special meeting on August 5, to foster continued input from health care advocates across Washington. The meeting provided a less formal setting for interaction among health care advocates, Commission members, and Legislators.

The Commission approved this report to the Governor and the Legislature during the MONTH meeting. As specified in statute, this report provides the following recommendations for the state:

1. [HCA staff to update with key recommendations from the eligibility straw proposal after the September 2025 meeting]
2. [HCA staff to update with key recommendations from the benefits and services straw proposal after the September 2025 meeting]
3. [HCA staff to update with key recommendations after the transitional solutions discussion at the September 2025 meeting]

Amid changes in health care policy and funding at the federal and state level, the Commission remains focused on its charge to design a unified system that ultimately would provide health care coverage to all people in Washington.

Background

Washington has long been a leader of health care reform in the United States; however, gaps in coverage, health equity, affordability, and access to culturally competent, high-quality care persist for too many Washingtonians. As directed by the Legislature, the Commission must:

> "...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." (RCW 41.05.840).

The Commission remains committed to finding ways to achieve these immediate and impactful changes for the greatest number of people. With this goal in mind and a focus on interim steps and future system design, the Commission has completed their baseline report (2022), as well as subsequent annual reports (2023, 2024) to the Legislature.

Brief overview of the establishment of the Commission

Universal Health Care Work Group (UHCWG) Final Report (2021)

In 2019, the Legislature directed HCA to convene a work group to study and provide recommendations to the Legislature on how to create, implement, maintain, and fund a universal health care system. In January 2021, the UHCWG published its final report (UHCWG final report to the Legislature). This report included an example transition plan that outlined the steps and work needed to reach a state-level universal health care system and called for the establishment of a universal health care commission to spearhead the work.

ESSB 5399 (2021)

In January 2021, SB 5399 ("Concerning the Creation of a Universal Health Care Commission") was introduced. This bill created a permanent universal health care commission to develop an actionable plan to achieve universal coverage in Washington. The Washington State Legislature passed ESSB 5399 (Chapter 309, Laws of 2021, codified at RCW 41.05.840), and in November 2021 the Commission held its first meeting.

Commission member appointments

As directed in RCW 41.05.840, the Commission has fifteen voting seats, including legislators, state agency representatives, and governor-appointed members.

Note that during the reporting year (October 2024–September 2025), some legislator and governor-appointed seats experienced vacancies due to results from the November 2024 election. The Governor's office and legislative leadership worked to fill vacant seats throughout 2025. See the Appendix for the Commission's member roster as of August 15, 2025.

Previous Commission recommendations and related action by the Legislature (2022–2025)

Commission recommendations and related legislative hearings	Action by the Legislature
Commission staff presented an update on the Commission's work at the House Health Care and Wellness Committee Public Hearing for SJM 8004 (2025)	Requested the federal government create a universal health care program or reduce barriers and grant appropriate waivers so that Washington state can implement one (SJM 8004)
Support for the principle of using reference-based pricing for public employee health insurance plans, not only to contain costs, but also to rebalance resources (2024)	Granted rulemaking power to HCA to enforce compliance and implement a new reference-based reimbursement structure (ESSB 5083)
Consistent support for the Apple Health Expansion program, including recommending additional funding for the program after its initial rollout (2024)	Funding provided to HCA to continue implementation of the Apple Health Expansion program (ESSB 5167, Sec. 211 (52))
Continue funding the Cascade Care Savings program to make coverage more affordable (2022)	Funding provided to the Washington Health Benefit Exchange to administer Cascade Care Savings for income-eligible individuals who purchase a health plan on the exchange (RCW 43.71.110(4)(a))
Increase Washington Apple Health (Medicaid) provider rates for applied behavior analysis (ABA) to improve access to care for Apple Health enrollees (2022)	Funding provided to HCA to increase reimbursement rates by 20% for ABA for individuals with complex behavioral health care needs and by 15% for all other ABA codes (ESSB 5187, Sec. 211 (49))
Increase Apple Health provider rates for behavioral health to improve access to care for Apple Health enrollees (2022)	Funding provided to HCA to increase behavioral health provider rates for both Apple Health fee-for-service (FFS) and managed care organizations (ESSB 5187, Sec. 211 (51))
Increase Apple Health provider rates for children's dental to improve access to care for children enrolled in Apple Health (2022)	Funding provided to HCA to increase the children's dental rate by at least 40% above the Apple Health FFS rate in effect on January 1, 2023 (ESSB 5187, Sec. 211 (74))
Implement the Integrated Enrollment and Eligibility Modernization Roadmap to support Information Technology	Funding provided to the Department of Social and Health Services (DSHS) for the Integrated Enrollment and Eligibility Modernization Project to create a comprehensive application

Commission recommendations and related legislative hearings	Action by the Legislature
infrastructure necessary for a universal health care system (2022)	and benefit status tracker for multiple programs (ESSB 5187, Sec. 205 (11-13))
Invest in Apple Health Expansion to increase access to coverage and care (2022)	Funding provided to HCA to expand coverage to adults ineligible for Apple Health or federal subsidies by reason of immigration status (ESSB 5187, Sec. 211 (85))

Workplan annual update: October '24 – September '25

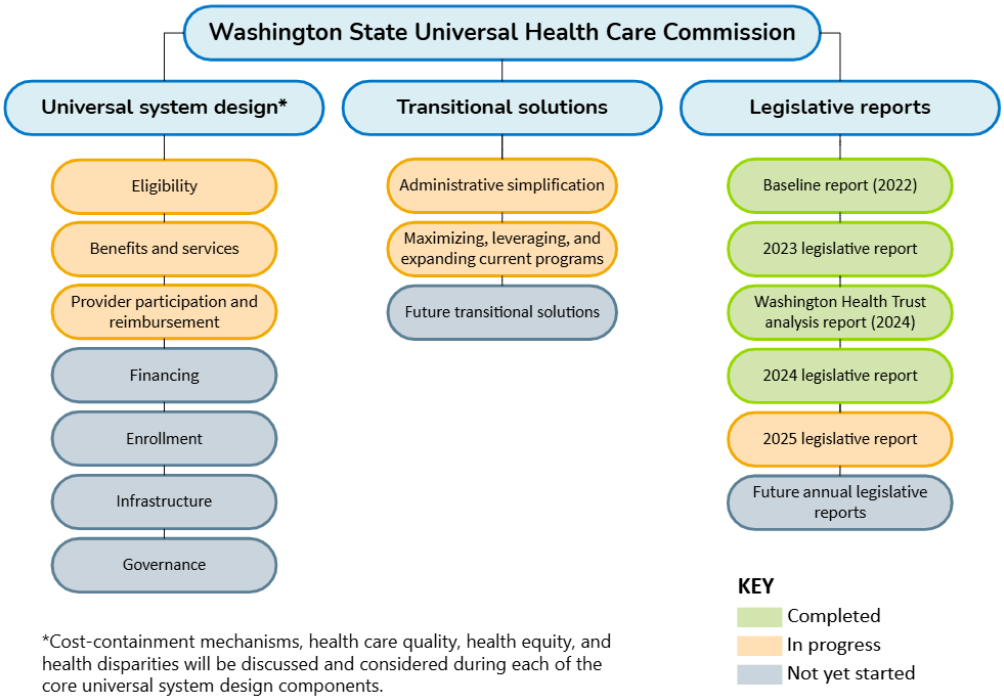
Overview of the year

During Fall 2024, the Commission adopted the 2025 workplan (**Figure 1**) to advance its two-part directive to prepare for a unified system and to identify transitional solutions. To implement the 2025 workplan, the Commission met every other month for three hours, with in-person and virtual attendance options. These meetings were facilitated by HCA staff and the recordings, along with the meeting minutes, are available on HCA's webpage for the Commission's meetings.

The Finance Technical Advisory Committee (FTAC), whose work supports the Commission, met every other month for two and half hours — typically during the months when the Commission did not meet. These virtual meetings were also facilitated by HCA staff and the recordings along with the meeting minutes are hosted on HCA's webpage for FTAC.

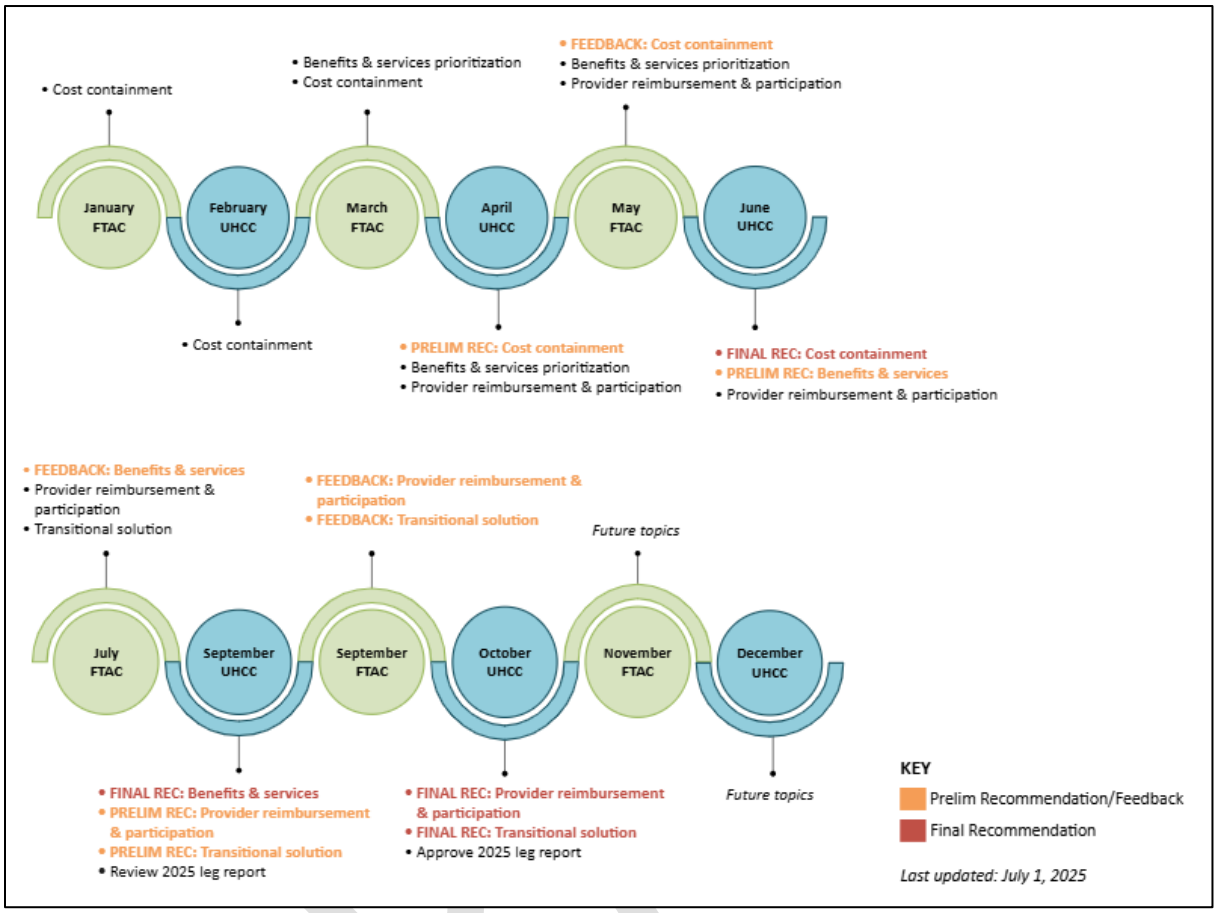
This Commission is grateful to the legislature for additional resources approved in the 2023–2025 budget.[1] The proviso funding supported an additional staff member through June 30, 2025. This staff member worked closely with FTAC members to research topics and develop presentations and recommendations for the Commission. The proviso funding also supported actuarial analysis described later this report.

Figure 1. The Universal Health Care Commission's Milestone Tracker (as of August 2025).



[1] For further details, refer to ESSB 5187, Sec. 211 (58).

Figure 2. The Universal Health Care Commission's 2025 Workplan (as of August 2025).



Addressing core design elements

In 2025, the Commission focused on three of the core design elements outlined in their foundational 2022 baseline report: cost containment, benefits and services, and provider reimbursement and participation. The Commission decided to focus on these core design elements during the first half of 2025, and to revisit transitional solutions in the latter part of the year once the Washington state 2025 legislative session ended.

Below is a table of the core design elements for a universal system, where they fall in the Commission's overall workplan, and the Commission's progress status of each element as of the writing of this report.

Table 1. Universal system core design element progress.

Core design element	Workplan	Status
Eligibility	Phase 1	Complete
Benefits & services	Phase 1	In progress
Cost containment	Phase 1	Incorporated throughout*
Provider reimbursement and participation	Phase 1	In progress

Core design element	Workplan	Status
Finance	Phase 1	Not yet started
Infrastructure	Phase 2	Not yet started
Enrollment	Phase 2	Not yet started
Governance	Phase 3	Not yet started

*Cost-containment mechanisms, health care quality, health equity, and health disparities are discussed and considered during each of the core universal system design components.

Benefits and services

After a preliminary assessment on eligibility, the Commission turned to benefits and services in early 2024 as it began exploring options for estimating the cost estimates of various benefit design scenarios. Later, following an actuarial analysis of selected benefit design plans in Spring 2025, the Commission, FTAC, and an ad hoc Work Group (made up of three Commission members and three FTAC members) further explored eligibility alongside benefits and services.

Summary of eligibility recommendations

[HCA Staff will update this section with the Eligibility straw proposal as adopted during the September 2025 meeting]

Summary of benefits and services recommendations

[HCA Staff will update this section with the Benefits & Services straw proposal as adopted during the September 2025 meeting]

Milliman analysis overview

As noted earlier, in the 2023–2025 budget, the Commission was allotted proviso funding for dedicated actuarial support and economic modeling, as well as additional staff support for FTAC.[2] On behalf of the Commission and with additional guidance from FTAC, HCA commissioned Milliman to perform a cost analysis of several existing benefit plan designs applied to a potential population identified as those most likely to be included in an initial universal health care system.

Three FTAC members volunteered additional time to provide technical consultation to the Milliman actuaries on this benefit scenario cost analysis: David DiGiuseppe, Roger Gantz, and Eddy Rauser. During these meetings they clarified technical details and reviewed preliminary results. These FTAC representatives met with actuaries from Milliman semi-monthly and provided ongoing updates to FTAC and the Commission from November 2024 to March 2025. In addition, the FTAC members helped clarify Milliman results to Commission members and the public. The Commission thanks them for their time, dedication, and expertise.

Background

[2]For further details, refer to ESSB 5187, Sec. 211 (58).

In their analysis, Milliman estimated the total cost of care for the identified study population, based on calendar year 2023 data. The estimated costs came from three benefit scenarios that represented a range of actuarial values (AV) and compared to an estimated baseline cost of care. The cost estimates included the costs of medical services, prescription drugs, and dental care. The analysis did not include administrative costs.

The three benefit and cost-sharing scenarios modeled included:

- **Scenario 1:** Medicaid-like health plan with no patient cost sharing (100% AV)
- **Scenario 2:** Public Employees Benefit Board (PEBB)–like health plan, with Uniform Medical Plan (UMP) Classic health insurance benefits and cost sharing (87% AV)
- **Scenario 3:** Cascade Select Silver-like health plan with standard benefits that meet or exceed ACA standards of cost and covered services[3] (68% AV)

The study population included approximately 3.4 million individuals and didn't include those less than 65 years of age. Per guidance from the Commission and FTAC, the study population included the following populations:

- Medicaid enrolled (excluding people eligible for both Medicare and Medicaid)
- Persons covered by the state government's PEBB/SEBB health plans
- Persons covered by individual, local government, or religious organization health plans
- Uninsured persons

Additional sensitivity analyses were conducted and included fully insured commercial group plans that had been excluded in the primary analysis. For further details about the study population and methodology, read the full Milliman report online. Find a summary of the report under Appendix E.

Key findings

The estimated baseline cost of care for the study population (n=3,370,000) was $16.3 billion. The difference from this baseline in the estimated cost of care for the study population by scenario was:

- Scenario 1 (Medicaid-like): $3.9 billion–$7.4 billion
- Scenario 2 (PEBB/SEBB-like): $1 billion–$4 billion
- Scenario 3 (Cascade Select Silver–like): ($1.1 billion)–$1.8 billion

The table below presents the estimated cost of care for the study population under the three benefit and cost-sharing scenarios modeled.

Table 2. Estimated per member per month (PMPM) cost and total expense by scenario

Scenario	PMPM	Total expense
Baseline	NA	$16.3 billion
Scenario 1 (Medicaid-like)	$500–$586	$20.2 billion–$23.7 billion
Scenario 2 (PEBB/SEBB-like)	$427–$502	$17.3 billion–$20.3 billion

[3]For a summary of benefits by scenario, refer to Appendix D (pg. 61) in the full Milliman report.

Scenario	PMPM	Total expense
Scenario 3 (Cascade Select Silver–like)	$377–$447	$15.2 billion–$18.1 billion

Cost-sharing principles

The Commission requested assistance from FTAC to develop cost-sharing principles to guide the benefit design work and final recommendations for patient cost sharing. FTAC reviewed current research on cost sharing and presented the Commission with a set of principles to guide future consideration of cost-sharing models. The Commission adopted the following principles at their October 2024 meeting:

- Avoid creating barriers to care by considering, among other things, income thresholds and exemptions for cost sharing.
- Identify selected services (e.g., preventive care or diagnostic screening) that would not be subject to cost sharing.
- Create cost-sharing structures that are simple, predictable, transparent, and easily understood for providers and individuals seeking care.
- Review the Commission's final policy decision on cost sharing through the HCA Health Equity Toolkit as adopted by the Commission.
- Review and revise cost-sharing designs as medical technology and services evolve.

Future analysis

The Washington State Office of the Insurance Commissioner (OIC) generously offered funding to the Commission for the 2025–2027 biennium. The legislative proviso allots $250,000 of the insurance commissioner's regulatory account "solely for the commissioner to enter into an interagency agreement with the health care authority to support economic, actuarial, or other modeling related to design of a universal health care system."[4]

The Commission is grateful for the support and looks forward to working with OIC and HCA staff to determine future analyses that will move the Commission's work forward.

Cost containment

In the legislation that established the Commission, cost containment one of the key design elements for a universal system. Specifically, the Legislature directed the Commission to identify:

> "Cost containment and savings strategies that are designed to assure that total health care expenditures do not exceed the health care cost growth benchmark…" (RCW 41.05.840 (7C)).

Initially, the Commission planned to address cost containment as a standalone design element. In 2025, as the Commission further explored the topic, they adopted a new approach to incorporate cost-containment mechanisms within universal design elements (e.g., benefits and services), as well as an emphasis on aligning with the direction and recommendations of the Washington State Health Care Cost Transparency Board (Cost Board). The following section outlines the various cost containment

[4]For further details, refer to HB 1178

presentations and discussions held by the Commission and FTAC over the report period, where topics align within the core design elements, and how the Commission plans to address cost containment moving forward.

Cost containment within core design elements

The Commission considered and discussed cost containment within benefits and services by conducting benefit scenario cost analyses and adopting the cost-sharing principles developed by FTAC to guide future recommendations. Review the earlier benefits and services section for more on the cost-containment aspects of the benefit design work.

The Commission also considered cost containment in their initial discussions on provider reimbursement and participation, e.g., by discussing value-based payment models for primary care incentivizing primary care physicians to reduce health care spending. Moving forward, the Commission plans to continue incorporating cost-containment mechanisms within universal design elements, such as financing and infrastructure.

Rural health systems and cost containment

The Commission sought input on cost-containment strategies from subject matter experts in rural health systems and hosted a rural health roundtable during their February 2025 meeting. Panelists from rural hospitals, the Washington State Hospital Association, and the Rural Collaborative began by defining rural and noting challenges unique to rural areas, including:

- Rural is more than county lines and population per square mile
- There is limited hospital bed capacity in Washington state and many of our hospitals are interdependent

Most hospitals in Washington's rural health system are tax-supported public hospital districts, so public funding often makes up for deficits. Panelists discussed the significant factors that can contribute to their higher costs, including:

- Labor
- Upkeep of older facilities
- Electronic health record (EHR) updates
- Lack of funding for patient transportation to non-emergent appointments
- Low patient volume
- Older, sicker patient populations

Panelists shared that it is also difficult for rural hospitals and smaller health systems to contract with payors, highlighting that they often lack negotiating power when payors present agreements that are under the facility's costs of operation. Significant variability in the rules and processes across payor plans also adds to rural hospitals' administrative costs.

Panelists emphasized that cost-containment policies need to be designed to avoid negative impacts on rural health access and quality. They provided guidance and examples, sharing that:

- Cost-containment policies need to focus on holistic, long-term solutions rather than short-sighted savings
- Rural hospital global budgets must be based on all costs, not only those that are allowable

- Funding for unmet social needs, like transportation to non-emergent appointments, will help keep patients out of the hospital, which in turn will lower the total cost of care per beneficiary
- Palliative care, which is often provided to the sickest patient panel the hospital serves, is not reimbursed directly. However, according to one panelist, palliative care reduced emergency room (ER) utilization at their hospital by 35 percent and thus lowered costs
- The development of a common EHR system for unified communication and care delivery across the state would help with overhead and other administrative costs

Panelists also encouraged policymakers to consider aging-in-place policies when working on cost containment. One panelist shared that many of their community members in long-term care facilities are on Apple Health and that if their assisted living facility (ALF) closed, they would have to spread their Apple Health members across the state because there are so few Apple Health beds available.

Alignment with the Health Care Cost Transparency Board

During the January 2025 FTAC meeting Sheryll Namingit, HCA health economics research manager, provided background on total health care spending data and the health care cost growth benchmark for Washington. Namingit briefly outlined the data and analytic initiatives that are the responsibility of the Health Care Cost Transparency Board (Cost Board).

One of the Cost Board's responsibilities is setting an annual cost growth benchmark and measuring performance. The recent benchmark report and data compares performance against the 2022 target of 3.2 percent. In 2022 cost growth was 3.6 percent, slightly above the target.

Spending from 2019–2022 was reported by market, with the commercial market growing by 11.5 percent and Medicare growing by 7.7 percent during this time. Apple Health enrollment and total spending increased, but per member per month (PMPM) cost slightly decreased by 0.1 percent from 2019–2022.

FTAC members discussed the Cost Board's opportunities to further identify cost drivers at the provider level and expressed interest in continued updates on the Cost Board's work. HCA staff provided ongoing updates to FTAC and Commission members regarding Cost Board meetings, including an overview of hospital cost growth in Washington state and strategies to address it. FTAC member Robert Murray also presented on Hospital Global Budgets at the June 3 Cost Board meeting.

During their June 2025 meeting, Commission members agreed with FTAC's guidance to build off the work of the Cost Board and to incorporate its strategies into universal design and transitional solutions.

Provider reimbursement and participation

The Commission's initial discussion on provider reimbursement and participation in a unified system took place at the June meeting. Commission members discussed a variety of options to consider for this core design element, including:

- Importance of policies that support rural hospitals
- Impact of vertical integration and horizontal consolidation on our health care system
- Value-based payment models for primary care
- Delivery system throughlines
- Looking at how Indian Health Services tackles provider reimbursement

The Commission will return to provider reimbursement and participation in late 2025, early 2026. The 2026 Annual Legislative Report will include decisions made on this core design element.

Transitional solutions

In Fall 2024 the Commission focused on two primary areas for transitional solutions:

- Administrative simplification
- Maximizing, leveraging, and expanding current programs

An overview of the Commission's work, including recommendations to the Legislature, for these two topics is below.

Administrative simplification

Prior authorization

During the October 2024 Commission meeting, Commission members received information on prior authorization policies not currently used in Washington, including gold carding and standardized forms. Commission members expressed interest in seeing more evidence on these approaches in other states, as well as data on approval rates, costs, and impacts across payers and providers. Commission members requested FTAC explore the potential impacts of these policies and the role of prior authorization in a universal system. However, at the next Commission meeting, in December 2024, members decided to table transitional solutions work until the latter part of 2025. Given the Commission's shift in focus to core design elements, it was determined that FTAC should pause on its prior authorization work until further notice.

Maximizing, leveraging, and expanding current programs

State approaches to access and affordability

During the December 2024 Commission meeting, Evan Klein, special assistant for legislative and policy affairs at HCA, presented on a proposed agency request bill, which would become SB 5083: Ensuring access to primary care, behavioral health, and affordable hospital services.

This bill called for reference-based pricing (RBP) for the Public Employees Benefits Board (PEBB) and the School Employees Benefits Board (SEBB), which includes the Uniform Medical Plan (UMP) administered through Regence, as well as Premera and Kaiser Permanente. Klein noted that PEBB/SEBB makes up about 20% of Washington state's commercial market and that current cost trends for consumers are unsustainable in the long term.

At the time of Klein's presentation, the proposed bill adopted a phased-in approach and aimed to maintain health plan networks and stabilize long-term affordability by requiring hospitals to contract with PEBB/SEBB plans that offer in good faith to contract, and by capping reimbursement for inpatient and outpatient hospital services. It also required sustained and increased reimbursement for critical access, rural, and children's hospitals as well as for primary care and behavioral health services.

Following the presentation, Commission members voted to support the principle of using reference-based pricing for PEBB/SEBB, not only to contain costs, but also to rebalance resources. The bill pre-filed for introduction on December 19, 2024.

At their next meeting (February 2025), Commission members heard from Margaret Smith-Isa, Program Development Lead at Oregon Health Authority. She provided an overview of Oregon's use of reference-

based pricing for their state employee health plans. Oregon's estimated savings were over $100 million in the first two years.[5] During this meeting, the Commission voted by majority to provide written testimony to the legislature in support of SB 5083/HB 1123 (Representative Schmick abstained).

Chair Lowe submitted written testimony on behalf of the Commission to the Senate Ways and Means and House Appropriations committees in support of SB 5083/HB 1123 on February 26, 2025 (See Appendix F). During the 2025 Legislative Session, the Legislature granted rulemaking power to HCA to enforce compliance and implement a new reference-based reimbursement structure (ESSB 5083).

Apple Health Expansion program

Becky Carrell, Deputy Director of the Medicaid Programs Division at HCA, presented information on Apple Health Expansion efforts during the October 2024 Commission meeting. Carrell noted the program enrolled more than 12,000 individuals and new enrollment was closed as funding is capped. HCA requested an increase in funding to allow enrollment of an additional 14,000 individuals by 2027, in the annual budget decision packages submitted to the Governor.

Several Commission members shared their support for the program, while noting there are many competing budget priorities for addressing access, affordability, and quality of care. Ultimately, the Commission voted by majority to recommend the Legislature continue funding the Apple Health Expansion program (Representatives Riccelli and Schmick abstained). During the 2025 Legislative Session, the Legislature provided funding to HCA to maintain the Apple Health Expansion program (ESSB 5167, Sec. 211 (52)) at the capped enrollment levels.

Next steps for transitional solutions

When adopting the 2025 work plan, the Commission decided to focus on the core design elements outlined above (e.g., benefits and services) during the first half of 2025, and to revisit transitional solutions in the latter part of the year. This would allow the Commission to tailor their transitional solutions work to the outcomes of the 2025 Legislative Session.

In an initial discussion at their June meeting, Commission members identified new areas of opportunity to explore for transitional solutions given current changes at the federal level. The Commission also asked FTAC members to identify additional topics. Together, the Commission and FTAC produced several options (Table 3), which the Commission reviewed at their September 2025 meeting.

Table 3. Transitional solutions considered by the Commission for prioritization.

Proposed transitional solution topics	Proposed by
Mitigation strategies regarding federal changes like coverage losses	Commission
Looking at the financial underpinnings of our current system to address affordability	FTAC

[5] Murray, R. C., et al. (2024). Hospital Facility Prices Declined As A Result Of Oregon's Hospital Payment Cap. *Health Affairs*, *43*(3), 424–432.

Proposed transitional solution topics	Proposed by
Stabilization of our current system, e.g., maintaining people's access to coverage, supporting rural hospitals	FTAC
Building on work the Commission had done previously (e.g., administrative simplification/prior authorization)	Commission, FTAC
Developing a list of the transitional solutions the commission has already identified to see what has already been done	FTAC
Addressing health care workforce needs in rural areas	Commission
Expanding and consolidating state purchasing	FTAC
Supporting small businesses providing health insurance to their employees (e.g., the Small Business Health Options Program (SHOP))	Commission

The Commission feels encouraged that the 2025 Legislature funded the Commission's 2024 recommendations, though they acknowledge there is still significant work to be done. Looking ahead, the Commission plans to focus on transitional solutions that can help stabilize Washington's health care system and also advance the state's readiness to implement a universal health care system.

Health equity

The Commission notes in its milestone tracker, that health care quality, health equity, and health disparities will be discussed and considered during each of the core universal system design components. To ensure this, in 2023, the Commission adopted the use of the Health Care Authority's Health Equity Toolkit to evaluate its final recommendations to the Legislature. The Commission agreed that utilization of the HCA Health Equity Toolkit would support their work to design a universal health care system with health equity at its center. In planning for 2026, the Commission will have the opportunity to decide whether current recommendations on eligibility and benefits and services are ready to evaluate using the toolkit.

Interstate health care compacts

During the June 11 Commission meeting, Insurance Commissioner Patty Kuderer shared a brief overview of interstate health care compacts, also referred to as 1333 compacts. She proposed the Commission invite the Oregon Universal Health Plan Governance Board (UHPGB) to their September 11 meeting. HCA staff worked with Oregon UHPGB and OIC staff to host subject matter experts at the September 11 meeting to provide an overview of 1333 compacts and answer Commission member questions. [HCA staff will update this section with discussion held/decisions made during the September 2025 meeting]

Community engagement

Consistent engagement with the public continues to be a cornerstone of the Commission's work. Input from health care reform advocates and other stakeholders informs decisions and priorities. It also provides an invaluable link to communities across Washington.

Public comment opportunities

Every meeting of both the Commission and FTAC provides multiple avenues for public input. The Commission and FTAC accept written comments two weeks before each meeting. In addition, interested parties are welcome to speak during the public comment period of each meeting either by registering in advance or signaling their interest during the meeting.

Advocates offer their perspectives on the design of a universal system, financing, pending legislation, and workplan progress, among other topics. Commission members endeavor to be responsive to advocates' concerns.

Public comment themes

The Commission welcomes and encourages input from the public and appreciates all feedback received. From September 2024 to August 2025, the Commission and FTAC received 36 written public comments and 44 oral public comments during regular public meetings. Many of the public comments touched on personal stories about the substantial barriers individuals and families have faced in Washington's current healthcare system. Public comments often referred to multiple topics. A list of key themes addressed included:

- **Design element and transitional solution feedback** (n=30), including requests for clarification on eligibility, future actuarial analyses requests, and feedback on prior authorization
- General support for universal health care in Washington state (n=25)
- **Process improvement** (n=21), including requests to create a tracker for the Commission's ongoing work, questions about the public comment process, and feedback on the timing of governance in the workplan
- **Legislative requests** (n=19), including requests to support SB 5233 (Developing the Washington Health Trust) and SB 5083 (Ensuring access to primary care, behavioral health, and affordable hospital services)
- **Incorporating past work** (n=5), including requests to incorporate findings and recommendations from the Universal Health Care Work Group (UHCWG) into the Commission's ongoing work

Public comment is an essential part of this work, and Commission members review and consider all of the public comments received. The Commission incorporated many of the key themes expressed by the public into its work over the reporting period, including:

- The development of the milestone tracker and 2025 workplan visualizations
- Considering governance earlier in the workplan, including presentations on other governance examples in Washington and Oregon and multiple discussions during regular meetings
- Hosting an advocates roundtable to include more opportunities for the Commission to hear from universal health care advocacy organizations
- Providing additional clarification for the public comment process during meetings, including when and how the Commission responds to public comment
- Improving the public comment process by incorporating report outs from FTAC to the Commission about public comment received and vice versa
- Developing straw proposals to document Commission decisions regarding key design elements including eligibility

- Incorporating report outs from the Health Care Cost Transparency Board, the Washington Health Benefit Exchange, the Office of the Insurance Commissioner, and other state agencies and programs

Advocates roundtable

In addition to encouraging public comment at every meeting, the Commission convened its first advocates roundtable in August 2025. The Commission added the roundtable to its calendar as a special meeting and structured it in accordance with the Open Public Meetings Act (OPMA). There were virtual and in-person attendance options with over a dozen members of the public attending the meeting in person and roughly 75 people joining online via Zoom. A majority of Commission and FTAC members attended.

Representatives of the following advocacy organizations took part in the discussion:

- Health Care for All – Washington
- Northwest Health Law Advocates
- Washington Community Action Network (CAN)
- Whole Washington

HCA staff moderated the discussion, which included questions designed to help advocates inform the Commission's ongoing work. Follow-up questions from Commission and FTAC members furthered the discussion, with a focus on upcoming workplan topics, such as financing, and best practices for gathering public input. Panelists shared their willingness to work with the Commission to gather community input and to help spread the word about the Commission's ongoing work. They also expressed a sense of urgency around the Legislature needing to pass a universal health care bill.

Commission and FTAC members also responded to questions prepared ahead of time by Health Care is a Human Right - Washington, a coalition that includes each of the advocacy organizations that took part in the discussion. Commission and FTAC members reflected on the importance of addressing how the work is paced and noted the Commission's limited staffing and resources. The Commission also expressed interest in engaging with labor organizations and continuing to work with each of the advocacy organizations present to move its work forward.

After the meeting, HCA staff shared the advocates full written responses with all Commission and FTAC members and met with several of the advocates to discuss potential next steps (to review the advocates full written responses refer to Appendix G).

Public outreach and presentations

Outreach efforts increased in 2025. Commission leadership and HCA staff participated in events designed to raise awareness progress toward universal health care in Washington. In these presentations, Commission members and staff described the parameters of universal health care systems, offered updates of Washington's progress, and placed the Commission's ongoing work in the context of statewide and national efforts.

Speaking opportunities included the fall 2024 Inland Northwest State of Reform Health Policy Conference in Spokane, a meeting of the statewide Retired Public Employees Council of Washington, and a community partner meeting of the King County-based North Urban Human Services Alliance. The Commission continues to seek out speaking opportunities.

Commission staff also appreciated the opportunity to present updates to the House Health Care & Wellness committee in March 2025 as it deliberated SJM 8004. Staff members appreciated legislators' questions and followed up by sharing the 2025 workplan and further details about possible waivers.

Washington Health Trust Analysis Report update

After their initial analysis of the proposal to create a Washington Health Trust (SB 5335) in 2024 (see Washington Health Trust (SB 5335) analysis report), the Commission received an additional request from members of the Legislature to conduct an analysis of the most recent Washington Health Trust proposal (SB 5233) as introduced in the 2025 legislative session.[6]

SB 5233 proposes the creation of the Washington Health Trust, a universal health care system for state residents. Key provisions include coverage for essential health benefits, such as primary care, dental, vision, mental health, and prescription drugs; restrictions on premiums, copayments, and deductibles; administrative cost reductions; and governance by a newly established board. Updates in SB 5233 include revised board formation criteria, specified provider reimbursement arrangements, updated funding mechanisms, the creation of a capital improvement account, and changes to the state's capital gains law.

Per the request from members of the Legislature, the Commission's analysis assesses whether the updated proposal "aligns with the goals and planned activities of the Commission." In accordance with the 2024 Washington Health Trust analysis report, beginning in 2025, subsequent analyses are included in the Commission's annual report.

To identify key updates in the more recently introduced bill, Commission staff compared the text of SB 5355 and SB 5233.

Updated proposals in SB 5233	Alignment with goals and planned activities of Commission
Section 105, SB 5233 Creation of a Board of Trustees to govern the Washington Health Trust, "consisting of 17 members with expertise in health care financing and delivery and representing Washington citizens, business, labor, and health professions…." Trustees are a combination of state agency directors, or their designees, and governor-appointed members.	The Commission is aware of the importance of a governing body to oversee a universal system, as well as the need to preserve public trust. In the current workplan, determining the governance structure will be completed at the end of phase 2. While the board structure and membership proposed in SB 5233 may not be the precise model ultimately recommended by the Commission, it already has informed Commission discussion on governance and almost certainly will be considered among the models for governance. The Commission also is likely to examine governance structures for similar bodies in other

[6] SB 5233 (Developing the Washington health trust) was introduced January 14, 2025, and a companion bill was introduced the House of Representatives (HB 1445) on January 21. Neither bill advanced beyond committee in its respective chamber.

	states, as well as Washington's Health Benefit Exchange.
Section 109, SB 5233 Qualified providers will "negotiate their reimbursement through the global budgeting process."	Global budgeting aligns with the Commission's goal to design a universal system that contains costs and simplifies administrative processes for providers. The Commission and FTAC are considering several funding mechanisms, including global budgeting and reference-based pricing. Further, FTAC and the Commission are aware that different funding mechanisms may be appropriate for care delivered in rural and urban settings, and their final recommendation may include more than one mechanism. The Commission will continue to consider global budgeting, among other funding mechanisms, in its universal design.
Section 115, SB 5233 Consolidate all state and federal funding of plans on the Washington Health Benefit Exchange into the Washington Health Trust	Since the introduction and consideration of SB 5233, the U.S. Congress passed a budget bill that greatly alters the funding for state benefit exchanges. The Commission continues to monitor changes in federal funding and will adjust its recommendations accordingly. In addition, every Commission meeting includes updates from members who represent five different state agencies. Those updates will further inform the Commission about the impacts of changes in federal funding.
Section 123, SB 5233 Creation of capital improvements account to be used only for capital improvements and new facilities, with the board as the sole authorizing authority for expenditures. Community needs assessments will inform funding decisions.	The Commission will consider financing and infrastructure in later phases of its workplan. A mechanism such as a capital improvement account may be considered among options to ensure adequate capital funding for new and existing facilities.
Section 302, SB 5233	The Commission and FTAC plan to begin considering financing options in early 2026. It is possible that a change in the state's capital gains

Increase in Washington long-term capital gains tax rate, with all new revenue funding the Washington Health Trust For net earnings in excess of $300,000, an additional two percent is levied in addition to 8 existing capital gains taxes.	tax will be among the topics presented to the Commission for consideration. The Commission is aware that in early 2025, Gov. Ferguson indicated he is very unlikely to approve any significant increase in the state's capital gains tax and that any proposed increase or change might not withstand legal challenges.

Conclusion

The Commission continues to evaluate and recommend core components of a universal health care system. Key design elements addressed in 2025 include cost containment, benefits and services design, provider reimbursement, and further refinement of earlier work related to eligibility. In addition, the Commission remains focused on transitional solutions to improve the existing health care delivery system, such as administrative simplification.

The Commission benefits from input from people throughout Washington. Over the past year, Commission members and staff have broadened their outreach efforts, while also strengthening relationships with the health care advocacy community. The Commission thanks advocates, health care providers and administrators, and organizational leaders who lend their time and expertise to the many topics the Commission undertakes. Each topic brings its own complexity, and different perspectives help Commission members understand and balance the many components that will make up a universal health care system.

Appendices

A. Universal Health Care Commission roster[7]

Seat	Member	Title, Agency	Appointment Type
1	Vicki Lowe, Chair	Executive Director, American Indian Health Commission	Governor-appointed
2	Nicole Gomez	Co-Founder & Board Secretary, Alliance for Healthier Washington	Governor-appointed
3	Bidisha Mandal	Professor, School of Economic Sciences, Washington State University	Governor-appointed
4	Mohamed Shidane	Deputy Director, Somali Health Board	Governor-appointed
5	OPEN SEAT		Governor-appointed
6	OPEN SEAT		Governor-appointed
7	Senator Annette Cleveland	Senator, 49th District, Washington State Senate Democrats	Legislator
8	OPEN SEAT	Senator, Washington State Senate Republicans	Legislator
9	Representative Joe Schmick	Representative, 9th District, Washington State House Republicans	Legislator
10	Representative Lisa Parshley	Representative, 22nd District, Washington State House Democrats	Legislator
11	Dr. Tao Kwan-Gett	State Health Officer, Department of Health	State agency (DOH)
12	David Iseminger	Director of Employees and Retirees Benefits, Health Care Authority	State agency (HCA)
13	Joan Altman	Director of Government Affairs and Strategic Partnerships, Washington Health Benefit Exchange	State agency (WHBE)
14	Jane Beyer	Senior Health Policy Advisor, Office of the Insurance Commissioner	State agency (OIC)
15	Omar Santana-Gomez	Director of Policy and Legislative Affairs, Office of Equity	State agency (OoE)

[7] As of August 15, 2025

B. Universal Health Care Commission members (all time)

Member	Term Begin	Term End	Appointment Type
Stella Vasquez	November 2021	July 2025	Governor-appointed
Charles Chima	February 2024	June 2025	State agency (DOH)
Representative Marcus Riccelli	November 2021	January 2025	Legislator
Senator Ann Rivers	November 2021	January 2025	Legislator
Senator Emily Randall	November 2021	January 2025	Legislator
Kristin Peterson	November 2021	December 2023	State agency (DOH)
Karen Johnson	November 2021	April 2023	State agency (OoE)
Estell Williams	November 2021	October 2022	Governor-appointed
Bidisha Mandal	November 2021	NA	Governor-appointed
David Iseminger	November 2021	NA	State agency (HCA)
Jane Beyer	November 2021	NA	State agency (OIC)
Joan Altman	November 2021	NA	State agency (WHBE)
Mohamed Shidane	November 2021	NA	Governor-appointed
Nicole Gomez	November 2021	NA	Governor-appointed
Omar Santana-Gomez	April 2024	NA	State agency (OoE)
Representative Joe Schmick	November 2021	NA	Legislator
Representative Lisa Parshley	June 2025	NA	Legislator
Tao Kwan-Gett	June 2025	NA	State agency (DOH)
Senator Annette Cleveland	August 2025	NA	Legislator
Vicki Lowe, Chair	November 2021	NA	Governor-appointed

C. Finance Technical Advisory Committee roster[8]

Seat	Member	Title, Agency	Appointment Type
1	Christine Eibner	Senior Economist, RAND	Expertise in health care financing
2	Roger Gantz	Senior Research Manager (retired), Department of Social and Health Services	Expertise in health care financing
3	Esther Lucero	President and CEO	Expertise in health care financing
4	Robert Murray	President, Global Health Payment LLC	Expertise in health care financing
5	Kai Yeung	Senior Healthcare Research Scientist / Associate Professor, Amazon University of Washington	Expertise in health care financing
6	Pam MacEwan	CEO (retired), Washington Health Benefit Exchange	Consumer representative
7	Eddy Rauser	Senior Data Scientist, Office of Financial Management	State agency (OFM)
8	Matthew Morrissey	Legislative Policy Coordinator, Department of Revenue	State agency (DOR)
9	OPEN SEAT		Expertise in health care financing

[8] As of August 15, 2025

D. Finance Technical Advisory Committee members (all time)

Member	Term Begin	Term End	Appointment Type
David DiGiuseppe	January 2023	July 2025	Expertise in health care financing
Ian Doyle	January 2023	August 2025[9]	State agency (DOR)
Christine Eibner	January 2023	NA	Expertise in health care financing
Roger Gantz	January 2023	NA	Expertise in health care financing
Esther Lucero	January 2023	NA	Expertise in health care financing
Robert Murray	January 2023	NA	Expertise in health care financing
Kai Yeung	January 2023	NA	Expertise in health care financing
Pam MacEwan	January 2023	NA	Consumer representative
Eddy Rauser	January 2023	NA	State agency (OFM)
Matthew Morrissey	August 2025	NA	State agency (DOR)

[9] FTAC member Ian Doyle took a leave of absence, effective August 1, 2025 through the end of 2025. During this time, Matthew Morrissey served as his designee.

E. Milliman Report Brief

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MILLIMAN REPORT BRIEF

Finance Technical Advisory Committee: Universal Health Care System Design

Cost of care for select populations under existing benefit designs (brief)

Commissioned by Washington State Health Care Authority

Ben Diederich, FSA, MAAA
Mark Franklin, ASA, MAAA
Menko Ypma, ASA, MAAA
Peter Hallum, ASA, MAAA

Milliman

Estimating the cost of care for a potential universal health care system design in the state of Washington.

This report brief summarizes the results, methodology, limitations, and considerations found in the associated report also called, "Finance Technical Advisory Committee: Universal Health Care System Design," available at this link. This companion report provides additional and necessary detail, context, and considerations that should be reviewed for a more complete understanding of the summary results presented here.

The report and report brief were drafted by Milliman, on behalf of the Washington State Health Care Authority (HCA), and for the Finance Technical Advisory Committee (FTAC). FTAC supports the Universal Health Care Commission by providing technical guidance and options related to a potential universal health care system's design.

The report and report brief are not intended to determine or suggest any specific policy action or final program structure or design, and persons should consult qualified professionals before taking specific actions. We are not advocating for the benefit structures, enrollment eligibility, provider reimbursement rates, or other elements of the underlying assumptions, and we have not examined the feasibility of the benefit designs. Additionally, we do not intend to benefit or create a legal duty to any third-party recipient of this work.

Cost of care estimates

We have estimated the calendar year 2023 (CY23) cost of care for a potential population to be included in a universal health care system (hereafter referred to as the Identified Population). The costs are estimated under three benefit scenarios[1] and are compared to the estimated baseline cost of care[2] for the Identified Population. These estimates include the costs of medical services, prescription drugs, and dental care, but exclude the substantial administrative costs that would be associated with the management of the Identified Population. The term "payer" is used to refer to the health insurer (i.e., not the patient who may be responsible for a portion of the cost of care).

Per the FTAC, the following populations are included as the Identified Population (restricted to individuals not enrolled in Medicare who are less than 65 years of age):

- Medicaid enrolled (excluding duals);
- Persons covered by the state government's Public Employees Benefit Board (PEBB) or School Employees Benefit Board (SEBB) health plans;
- Persons covered by individual, local government, or religious organization health plans; and
- Uninsured persons.

In total, this is approximately 3.4 million individuals.

In addition to these groups, but presented as a separate sensitivity test, we estimated the cost of including persons enrolled in fully insured group health plans not included in the above list. This sensitivity test of an alternative Identified Population is found below.

At the direction of HCA and FTAC, we have modeled three benefit and cost sharing scenarios:

1. A Medicaid-like health plan (i.e., no patient cost sharing),
2. A PEBB Classic health plan-like structure, and
3. A Cascade Silver-like structure (i.e., essential health benefits with approximately 70% actuarial value / 30% patient pay on average).

The costs were modeled based on CY23 included populations, where provider reimbursement was estimated at rates that would be neutral for each of the inpatient, outpatient, and professional service categories, and in total. Medicaid long-term services and support (LTSS) were excluded.

[1] The three benefit scenarios are selected from existing plan designs in the health insurance market and do not represent plan designs that are ultimately intended for any future universal health care system. Instead, these several plan designs provide a wide spectrum of benefits and cost sharing to help the reader understand the interplay among benefits, cost sharing, and expected payer costs.

[2] The baseline cost of care is an estimate of CY23 costs for the Identified Population (or alternative Identified Population), inclusive of subpopulations of the Identified Population that are not presently paid for by the State (e.g., costs covered by individual plans). These are provided for comparison to the expected costs under the several benefit scenarios provided for a universal health care system.

Under the first scenario, all persons would be eligible for the Medicaid benefit. Under the second and third scenarios, CY23 Medicaid enrolled individuals would continue to have a Medicaid benefit, but all others would have the benefits in each scenario's description. Prescription drug and dental costs are estimated at current Medicaid costs for the Medicaid population and PEBB- and SEBB-like rates for the non-Medicaid population.

FIGURE 1: ESTIMATED CY23 PLAN PAID[A] – IDENTIFIED POPULATION

BASELINE/SCENARIO BENFITS AND COST SHARING	PAYER PAID PMPM[B,C]	TOTAL ANNUAL PAYER PAID
Total State program costs		$13.6 billion
Medicaid[D]	$408	$9.6 billion
PEBB[E]	$628	$2.2 billion
SEBB[E]	$551	$1.8 billion
Non-state program costs[F,G]		$2.7 billion
Total baseline costs		$16.3 billion
Sc. 1: Medicaid-like	$500 - $586	$20.2 - $23.7 billion
Sc. 2: PEBB-like	$427 - $502	$17.3 - $20.3 billion
Sc. 3: Cascade Silver-like	$377 - $447	$15.2 - $18.1 billion

(A) Totals include medical, pharmacy, and dental costs paid for by the plans (i.e., exclude patient paid cost of care), and exclude non-benefit expenses. Dental costs are not included in the non-state program cost baseline amount as those costs were not available for these populations.
(B) Per member per month
(C) Baseline payer paid amounts (e.g., Medicaid) are not directly comparable to the scenarios' ranges. The scenarios ranges are a composite of all baseline populations and individual subpopulations scenario results, like Medicaid, may have increased or decreased relative to the baseline.
(D) Costs are inclusive of both State and federal funding and based on CY23 reimbursement rates (i.e., exclude substantial payment rate changes since CY23).
(E) Note that these totals may include some coordination of benefit payments made by other payers which are not part of a state program.
(F) Includes local government, religious organization, and individual health plans and the uninsured.
(G) A portion of individual insurance premiums are paid for by the state via the Washington State Premium Assistance Program. These premium payments cover some of the costs reported in this line. In the biennial 2024 - 2025 Washington State budget $100 million was funded to cover individual market premiums through this program.

The results in Figure 1 are based on a total population of 3.4 million persons from the groups listed above.

Variability, limitations, and further considerations

FULLY INSURED GROUP HEALTH PLANS

Based on guidance from HCA, we understand all fully insured commercial group health plans may be included in an alternative Identified Population. In such a case, the Identified Population and associated baseline total costs increase, and so do the estimated costs of the several scenarios. Figure 2 reports the results of this larger alternative Identified Population of 4.1 million persons.

FIGURE 2: EST. CY23 PLAN PAID – ALTERNATIVE IDENTIFIED POP.[A]

BASELINE/SCENARIO BENFITS AND COST SHARING	PAYER PAID PMPM	TOTAL ANNUAL PAYER PAID
Total State program costs		$13.6 billion
Medicaid	$408	$9.6 billion
PEBB	$628	$2.2 billion
SEBB	$551	$1.8 billion
Non-State program costs[B]		$6.3 billion
Total baseline costs		$20.0 billion
Sc. 1: Medicaid-like	$539 - $633	$26.5 - $31.0 billion
Sc. 2: PEBB-like	$445 - $523	$21.8 - $25.7 billion
Sc. 3: Cascade Silver-like	$382 - $454	$18.7 - $22.3 billion

(A) See notes associated with Figure 1.
(B) Includes fully insured commercial, local government, religious organization, and individual health plans and the uninsured.

Because of the inclusion of the fully insured commercial group population, the payment neutral reimbursement rates for providers is higher in this sensitivity test than in the Figure 1 results reported above.

OTHER VARIABILITY AND ACCOMMODATIONS

Estimates of costs for the Identified Population have many sources of variability including, but not limited to:

- Errors or incomplete information in the data sources of population sizes and costs,
- Changes or inaccurate measurement of historical reimbursement rates,
- Changes in Medicaid eligibility status and enrollment rates,
- Administration and medical management practices, and
- Assumptions based on benchmark populations' health care utilization habits and their comparability to the actual Identified Population.[3]

We have attempted to account for these sources of variability in the ranges of results reported in the figures above. The specific sensitivity tests completed were:

- Increasing the uninsured population's estimated utilization and reimbursement rates by +25%,
- Varying medical service reimbursement rates by +/- 5%,
- Varying pharmacy discounted drug costs by +/- 5%,
- Testing lower rates of medical management (e.g., fee for service-like limited medical management),
- Modulating expected utilization rates by +/- 3%, and

[3] Because of limitations in the information available to us, we combined disparate data sources. We were not always able to reconcile differences between sources, and at times had to extrapolate using Milliman benchmark data. This approach results in some uncertainty in our estimates of actual baseline costs for the Identified Population. See the full report for more information regarding this limitation.

- Assuming higher and lower rates of Medicaid eligible enrollment (i.e., higher or lower rates of enrollment in the Identified Population of individuals eligible for zero cost sharing).

The ranges stated in Figures 1 and 2 do not include the full effects of all sensitivity tests simultaneously. While we believe the ranges cited are reasonable, results could fall outside those ranges should the assumptions be significantly more or less favorable than actual experience.

The results of these sensitivity tests and more detail about the methodology is available in the complete report.

VARIABILITY IN APPROACH AND ASSUMPTIONS

Because the estimates are subject to significant variability based on the starting assumptions and methodology employed, similar analyses performed by other qualified individuals may yield meaningfully different estimates.

FURTHER CONSIDERATIONS

Certain important considerations associated with the design and implementation of a potential universal health care system were outside of the scope of this analysis. While not addressed in this document, these items are discussed in limited detail in the complete report:

- Administrative costs and structure;
- Detailed reimbursement for medical services, drugs, and dental;
- Impacts external to the design that affect the health insurance and provider markets within Washington State;
- Pent-up demand in the Identified Population; and
- Changes of benefit designs relative to baseline population benefits (e.g., the improvement or erosion of benefits for individuals transferring from one of the coverage types in the baseline to those in the scenarios).

Other material considerations exist and may be discovered as the Identified Population and potential designs are further analyzed, developed, and feedback is received from stakeholders.

THIS IS NOT A PROJECTION

These estimates are limited in scope. Critically, the estimates do not constitute a projection; they are the estimated costs of the Identified Population in CY23. This means they do not include estimated cost and utilization trends, or the associated increase in variability for such projections. Moreover, large and known reimbursement changes have occurred since CY23, including substantial increases in Medicaid payments for some hospital providers. Because of these limitations, and others, the estimates are not representative of an expected cost in CY25, the time of publication of this report brief, or any other period after CY23.

Methodology and data sources

METHODOLOGY

We completed the following steps to develop the results included in this report brief and the associated report:

1. Collected data and base assumptions for each subpopulation of the Identified Population including:
   a. Enrollment statistics by subpopulation;
   b. CY23 cost of medical care, including cost of care by service category where possible, prescription drugs, and dental services;
   c. Estimates of reimbursement rates for care, including provider reimbursement rates, drug costs, etc.; and
   d. Other necessary information (e.g., details of benefit structures, implied medical management, etc.).
2. Calculated estimates of aggregate payment-neutral reimbursement rates across the Identified Population. These estimates represent reimbursement rates that, if applied consistently across the population, would result in the same aggregate provider revenue in the baseline, before scenario-specific adjustments.
3. Estimated the utilization and costs for each of the included subpopulations under each scenario and sensitivity test:
   a. For the Medicaid subpopulation, we estimate the impact of the shift from the current reimbursement rates to the estimated payment-neutral rates.[4]
   b. For the uninsured subpopulation, we divide it into the portion of the subpopulation presumed eligible for Medicaid in CY23 and the remainder of the subpopulation. We use these segmented subpopulation estimates to re-weight the final scenario and sensitivity test results.
   c. For each of the other included subpopulations (PEBB, SEBB, local government and religious organization plans, and individually insured), we separately modeled the impacts of the scenarios and sensitivity tests.
4. Create composite scenario and sensitivity test results by weighting the by-subpopulation results, as described in (3).

DATA SOURCES

We relied on many sources of CY23 reporting and assumptions including but not limited to the following:

- Data provided by HCA for the purposes of this report;

[4] Note that because the Medicaid benefit was used for the Medicaid enrolled population in all three scenarios, except for the addition of the uninsured and sensitivity testing of results, this represents all the changes included in modeling of the Medicaid enrolled subpopulation's costs.

- Data published by the National Association of Insurance Commissioners, US Department of Labor, Washington State Office of the Insurance Commissioner, KFF, Centers for Medicare & Medicaid Services (CMS), among others;
- Benchmark data, models, and prior analyses developed by Milliman; and
- Similar analyses performed by other states.

Caveats

This report brief represents an abbreviated version of the report cited above. The complete report provides additional and necessary detail, context, and considerations that should be reviewed for a fuller understanding of the results presented here.

We have developed certain models to estimate the values included in this report. The intent of the models was to estimate the cost of care of several benefit and cost sharing scenarios for the Identified Population on a CY23 basis. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

In preparation of the analysis, we relied upon the accuracy of data and information gathered from or provided to us by CMS, data partners, and other organizations as cited in the report. We have not audited this information, although we have reviewed it for reasonableness. If the underlying data or information is inaccurate or incomplete, the results of the analysis may likewise be inaccurate or incomplete.

We have also relied on the data and other information provided by HCA, UHCC, and FTAC for this analysis. We have performed a limited review of this information and checked for reasonableness and consistency. We have not found material defects discrepancies in the data or information used other than those described in the report, which also describes how those defects and discrepancies were addressed to enable this analysis to be performed. If there are other material defects in the data or other information, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of this assignment.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Peter Hallum, Ben Diederich, Mark Franklin, and Menko Ypma are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this report.

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F. Letter of Support: SB 5083/HB1123

UHCC letter of support_HB1123 SB

To: Chair June Robinson and members of the Senate Ways and Means Committee

From: Vicki Lowe
Chair, Universal Health Care Commission

Re: Universal Health Care Commission support for HB 1123/SB 5083

On behalf of the Universal Health Care Commission, I'm writing to express the Commission's support for HB 1123/SB 5083, Ensuring access to primary care, behavioral health, and affordable hospital services. The Commission supports these bills to slow the growth of health care costs and to rebalance resources.

Commission members include representatives from community and labor groups, state agencies, and the Legislature. Together we fulfill the two-part charge laid out in RCW 41.05.840: to create immediate and impactful changes in the health care access and delivery system, and to prepare the state for the creation of a health care system that provides coverage and access for all Washington residents.

The Commission supports these bills because they meet both our short- and long-term goals. In the near term, they will help control costs and make health care — particularly primary and behavioral health care — more affordable and accessible. In the longer term, these bills lay the groundwork for cost containment mechanisms that could be key features of a universal system design.

Please note that Commission member Representative Joe Schmick, the one legislator present at the February 13 Commission meeting, abstained from the vote to support these bills.

These bills lower costs and increase access, and the Commission respectfully requests your support. Thank you for your attention.

cc:
Joan Altman
Jane Beyer
Charles Chima, MD
Nicole Gomez
Dave Iseminger
Bidisha Mandal
Omar Santana-Gomez
Representative Joe Schmick
Mohamed Shidane
Stella Vasquez

G. Written Responses from Advocacy Groups to the Advocates Roundtable Panelist Questions

Roundtable Objective: To collectively answer five key questions from HCA about universal health care in Washington, drawing on the expertise and unique perspectives of each organization.

Question 1: Introductions and Vision

Please take five minutes to introduce your organization. Tell us about your vision for universal health care in Washington, your organization's efforts toward that vision, and how you complement other organizations' efforts.

Health Care is a Human Right - Nathan Rodke, Co-Chair of HCHR Steering Committee - We're a community and labor coalition of over 40 sponsoring members, including all our presenters today, and many more allied members. Our goal is to achieve universal health care on both the state and federal levels. We have an Organizing Committee, Policy Committee, Communications Committee, and a committee, known as HUX, which regularly engages with the Commission to help it achieve its legislative mandate.

Whole Washington (WW):

- Intro: Whole Washington is a grassroots universal healthcare action organization.
- Vision: Our vision is a comprehensive, statewide universal healthcare system known as the Washington Health Trust (WHT).
- Efforts: We have advocated for this policy since 2018 through both initiative and legislative forms. The WHT is currently active legislation (House Bill 1445 and Senate Bill 5233). We represent hundreds of thousands of Washingtonians who have signed official ballot petitions.
- Complementary Role: We complement other organizations by pushing for a specific, comprehensive policy framework.

Washington CAN:

- Intro: We are part of the Healthcare is a Human Right coalition, with staff co-chairing the Organizing and Steering Committees.
- Vision: Our vision is a not-for-profit health plan for everyone in Washington, with a structure built around health benefits for people in all corners of the state, including immigrants and the incarcerated. Our ultimate goal is a national single-payer plan like an improved and expanded Medicare for All, believing that state-based universal public health plans are the most effective pathway to achieving that national vision.
- Efforts: We have a full-time field and phone canvass team and an organizing department that actively fosters community feedback and engagement. We hear about the impacts of inaccessible and unaffordable healthcare every day and work to counter hospital mergers and other corporate consolidation efforts.
- Complementary Role: We serve as a dedicated grassroots voice that mobilizes and educates the public. Our work is particularly focused on building a broad coalition that includes a powerful labor contingent. The overwhelming support for a single-payer resolution adopted at the WSLC

convention on July 24, which calls on state legislators to introduce policies consistent with single-payer, is a testament to the critical need for active involvement from Labor. We are working closely with our labor partners to ensure these principles are at the forefront of the conversation.

Northwest Health Law Advocates (NoHLA):

- Intro: Northwest Health Law Advocates is a public interest law nonprofit that has worked to expand access to healthcare for all Washingtonians since 1999. We serve on the Steering Committee of the Health Care Is a Human Right Coalition.
- Vision: Our long-term vision is a universal healthcare system where essential care is a basic human right, treated like a public utility with public delivery infrastructure and publicly-accountable spending.
- Efforts: We approach this work with a legal lens rooted in our partnership with legal services organizations. We push for universal healthcare that is guaranteed as a legal right for all while serving as a watchdog to ensure those rights are honored. We tend toward more incremental change, with the understanding that government systems take time to perfect.
- Complementary Role: Our role in the advocacy landscape is to provide a legal perspective, identifying opportunities and challenges in government-administered systems and ensuring vulnerable people don't fall through the cracks. We can see through decades of experience that the private healthcare industry has failed to deliver care, and we believe the only path forward is a different system, though we understand this will take time to build.

Healthcare for All Washington (HCFA-WA):

- Intro: HCFA-WA is WA's oldest grassroots volunteer organization dedicated to universal healthcare. We have experience in mounting an initiative campaign as well as working with key legislative allies to sponsor our Washington Health Security Trust legislation from 2003 – 2018. The Board of Directors includes healthcare professionals, individuals with experience working on the 1993 and 1994 health reform efforts in Washington state, and long-time advocates focused on equitable and accessible healthcare for all Washington residents.
- Vision: Our vision is a comprehensive, integrated single-payer system for all Washington residents, publicly financed, and publicly and privately delivered.
- Efforts: Our statewide volunteer organization focuses on single-payer health care policy and transitional solutions necessary to develop infrastructure for the future universal single-payer health system. We are actively involved with the Universal Health Care Commission (UHCC) and its subcommittees, providing public comments, advocating for specific policy recommendations, and securing funding to carry out studies that support those recommendations. We actively lobbied for both the UHCC and its predecessor, the UHC Work Group.
- Complementary Role: We serve on the HCHR Steering and Policy Committees and its HUX Committee that holds the Commission accountable to its legislative mandate. We work with allied organizations to share information and build a unified front, publishing monthly recaps of each UHCC and FTAC meeting in our member e-bulletins. HCFA-WA members serve on the Board of the Puget Sound Advocates for Retirement Action (PSARA), the Health Care Cost Board, and the Prescription Drug Affordability Board.

Question 2: Financing - Lead org in answering at roundtable: Whole WA

The Commission plans to take up financing in early 2026. What funding mechanisms is your organization aware of, and what recommendations do you have in terms of funding universal health care?

Whole Washington (WW):

- Summary: Academic research shows that a unified financing system would be more cost-efficient than the status quo.
- Recommendations: The Washington Health Trust would be publicly financed, removing all premiums, deductibles, and co-pays. The majority of funding would come from a graduated employer payroll assessment (4.5% to 10.5%), with up to 2% deductible from the employee's wage. We believe Washington's high GDP per capita means the state can afford a world-class system that also provides significant cost relief.

Washington CAN:

- Summary: We need a sustainable and equitable system that addresses the state's regressive tax structure. Washington has the 49th most regressive tax structure in the country, and in 2024, voters showed they agree that corporations and the wealthy should pay their fair share.
- Recommendations: Funding could come from a progressive income tax, an increased capital gains tax, and a tax on employers. We also need to broadly examine how we can tax the ultra-wealthy in our state. Additionally, we believe we should look ahead to federal support. After 2028, we can hope to pass supportive legislation like the federal State-Based Universal Health Care Act (SBUHCA) bills, which are designed to help states finance their own universal health care systems and provide for multi-state plans. Our Legislature, in passing SJM 8004 in 2025, has requested this support from the federal government.

Northwest Health Law Advocates (NoHLA):

- Summary: We have already made more progress on the financing question than we realize. The state already spends more of its GDP on healthcare than many other countries, so the conversation should be about spending that money better.
- Recommendations: We are overdue for a conversation about the social compact between those who need care and the businesses and individuals who benefit financially from a healthy populace. We should explore a system where employers pay a fee for the privilege of leveraging our public systems, similar to a toll, which could be more affordable than what many small businesses are paying today. This approach would open a dialogue about how to make sure those who benefit from public health also contribute to it.

Healthcare for All Washington (HCFA-WA):

- Summary: The funding mechanism should be a combination of mandatory assessments and cost-containment strategies.
- Recommendations: The system should be funded through a mandatory employer payroll assessment and individual assessments as needed. Cost-containment strategies should include global budgeting, price caps, bulk purchasing, and streamlined administration. The system should

ultimately integrate existing state plans like PEBB, SEBB, and Medicaid, and seek federal waivers to include Medicare. We advocate for a goal of zero cost-sharing at the point of service.

Question 3: Communication & Hurdles - Lead org in answering at roundtable: WA CAN

What are some of the best ways you have found to communicate with people about universal health care? What are the biggest hurdles? And how do you think the Commission can best gather input?

Whole Washington (WW):

- Communication: Effective communication starts with meeting people where they are. Polling shows that over 85% of Washingtonians want change. We should discuss solutions that directly address their primary frustrations with the current system.
- Hurdles: We need to assure people that a new system would decouple coverage from employment, provide comprehensive coverage, eliminate provider networks, and control costs with transparent pricing.
- Commission Input: The Commission should gather input by focusing on people's primary frustrations and ensuring that proposed solutions address these concerns.

Washington CAN:

- Communication: We have found that people know where to start when it comes to the problems with our current system: reform that makes healthcare a public good relies on reducing administrative costs and barriers to care access that have been put in place by health insurance companies. Access to affordable care also pits patients against the interests of hospitals and pharmaceutical companies. The best way to communicate is to connect the issue directly to people's lived experiences of rising costs and denied care. We need to frame the solution as our elected representatives and government taking on the profiteers and financiers to control and lower costs and to ensure everyone has a health plan that works for them.
- Hurdles: A major obstacle is widespread apathy and a pervasive lack of confidence in established institutions. Regular people see escalating costs alongside a decline in access and quality of care, yet proposals with broad popular support consistently fail to advance. This highlights the disproportionate influence of industry stakeholders and a lack of revenue to meet public needs. Another hurdle is the inevitable disagreements on funding and among stakeholders, which can be a distraction from the shared goal of improving care for everyone.
- Commission Input: The Commission should continue to engage with community members as trusted messengers to rebuild trust and gather input.

Northwest Health Law Advocates (NoHLA):

- Communication: We should gather input directly through surveys of Washingtonians and Washington-based employers. People are very knowledgeable about the challenges they face in the current system, and the vast majority want significant changes. We can ask people around the state what their ideal healthcare system would look like and who would pay for it.
- Hurdles: People may not understand all the nuances of specific laws, but they can certainly understand the trade-offs in our healthcare system today.

- Commission Input: Surveys and roundtables don't have to be expensive to offer insight. It would be particularly important to include small and large businesses and other healthcare purchasers in those conversations to gather a full range of perspectives.

Healthcare for All Washington (HCFA-WA):

- Communication: We should ask the public to list their vision, values, and principles for healthcare, and then compare it to the UHCC's list. Once a draft plan is established, it should be presented to as many community and professional groups as possible.
- Hurdles: The biggest hurdles are public distrust of the government, fear of change, and the fact that some people are happy with their current system.
- Commission Input: The Commission should hold open public meetings across the state to share the plan, answer questions, and gather public experiences and contact information for future meetings, especially after the plan is designed.

Question 4: Long-Term Sustainability - Lead org in answering at roundtable: Whole WA

Do you have any suggestions for the UHCC as to how to approach this long-term change management effort to ensure that Washington's universal health care system is sustainable in the long term?

Whole Washington (WW):

- Suggestions: The state needs to commit to a long-term vision of universal healthcare and announce a clear plan and timeline, similar to the development of the LINK light rail system.
- Sustainability: The system can only prove itself once people are able to enroll and experience its benefits. There is little evidence that a longer transition improves outcomes. Taiwan, for example, increased coverage from 60% to over 92% in its first year.

Washington CAN:

- Suggestions: For long-term sustainability, we must have sustainable funding mechanisms and strong laws that control costs of care in place. We must also protect traditional Medicare and push back against consolidation and private equity in the healthcare sector.
- Sustainability: Key elements for sustainability include negotiating bulk purchasing for all prescription drugs, using global budgets for hospital systems, and providing incentives for primary care and low or no fees at the point of service.
- Transitional Approach: We need incentives to retain Washington medical school graduates within the state to address substantial provider shortages. A critical part of our long-term strategy is also to work toward multi-state compacts as interim steps along the way. These compacts, which would be facilitated by legislation like the SBUHCA bills, would allow states to share resources and build a stronger, more resilient system together.

Northwest Health Law Advocates (NoHLA):

- Suggestions: There are three additional suggestions to enhance the durability of any reforms. First, work toward bipartisan solutions on a state level, as the bipartisan UHCC Board is a good

start. Second, involve healthcare providers in the solutions from the start to discuss trade-offs, such as accepting lower reimbursement in exchange for less administrative burden.

- Sustainability: We can learn from other countries that have recently transitioned to universal healthcare. They succeeded by picking a model that responds to their unique starting conditions and cultural features, rather than scrapping everything. We should build on familiar concepts like Medicare, Medicaid, and PEBB/SEBB.
- Transitional Approach: A successful system requires a willingness to change and adapt over time as the population and its needs change.

Healthcare for All Washington (HCFA-WA):

- Suggestions: A trust with dedicated funding should be established within an independent state institution. A well-built governing board needs to be put in place to make decisions on the myriad of details.
- Transitional Approach: The state should seek federal waivers as soon as possible through the Affordable Care Act, Medicaid, and Medicare. We should fund the system through a payroll tax (to be out of reach of ERISA) and restrict providers from billing anyone but the unified state plan.
- Support Federal legislation, e.g., the State Based Universal Health Care Act (HR 4406, S 2286) that would provide access to the Federal waivers states need to enable their state plans.

Question 5: Interim Solutions - Lead org in answering at roundtable: HCFA WA

As you know, the Universal Health Care Commission has a two-part charge: design a universal system and look for interim solutions. Does your organization have priorities for interim solutions to improve our current system?

Whole Washington (WW):

- Priorities: The expansion of public coverage to a widening population should be the top priority, with a goal of universal eligibility as soon as possible.
- Examples: The Canadian system began by covering hospital services. All minors could be fully covered by Medicaid or another state health plan. Public coverage could begin with primary care, prescription drugs, and other preventative services. State plans could be consolidated and de-privatized.

Washington CAN:

- Priorities: Our priorities for interim solutions are focused on addressing the immediate financial and systemic barriers people face. People know where the problems are: with the insurance companies, hospital conglomerates, and pharmaceutical companies that profit from the system. In order to mitigate potential Medicaid cuts, ACA cuts, and threats to Medicare, we'll need to pass more laws that control costs of services and provide oversight to hospital mergers.
- Examples: Our organization wants to see all hospital systems move away from negotiating with insurance companies and, instead, negotiate with the government on global budgets. This is a critical step toward controlling costs and ensuring that care decisions are based on patient need,

not profit. It also aligns with the overwhelming support from Labor, as reflected in the recent WSLC convention resolution, for policies consistent with single-payer principles.

Northwest Health Law Advocates (NoHLA):

- Priorities: We must not backslide on the commitment to basic coverage and care for all Washingtonians, despite federal challenges. Now is a time to reorganize the money we are already spending to protect care for the most people.
- Examples: Interim solutions could involve revisiting how we organize our safety net for uninsured people and which entities pay into it. We should also review how we can best leverage federal funding streams from the ground up, rather than trying to adapt old systems. We need to tighten the regulatory environment on corporations ready to profit from a chaotic environment. As an example, if a hospital is at risk of closure due to federal cuts, we should have a public dialogue about what the community actually needs and how to fill those gaps with investment that is set up for long-term public accountability.

Healthcare for All Washington (HCFA-WA):

- Priorities: Our priority is to design a single-payer system, but in the interim, we should consolidate purchasing and expand public plan options.
- Examples: Consolidate purchasing for PEBB, SEBB, Medicaid, and the Health Benefit Exchange. Expand pathways for local public entities to join PEBB. Enable the Health Benefit Exchange to only offer standardized, public option plans. Expand cost-saving efforts of state boards.