Universal Health Care Commission meeting

October 9, 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, October 9, 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 – 2:10 (10 min)	Welcome, roll call, review of previous meeting minutes	1	Vicki Lowe, Chair
2:10 – 2:25 (15 min)	Public comment	2	Vicki Lowe, Chair
2:25 – 2:45 (20 min)	Commission member report outs	3	Commission members
2:45 – 3:15 (30 min)	Workplan update → Eligibility straw proposal → Legislative report	4	Mary Franzen, HCA
3:15 – 3:45 (30 min)	FTAC update → Provider reimbursement → FTAC vacancy	5	Ross Valore, HCA
3:45 – 3:55 (10 min)	BREAK		
3:55 – 4:00 (5 min)	Sec. 1333 interstate compact next steps	6	Mary Franzen, HCA
4:00 – 5:00 (60 min)	2026 proposed workplan discussion	7	Mary Franzen, HCA
5:00	Adjournment		Vicki Lowe, Chair

Washington State Health Care Authority

Universal Health Care Commission meeting minutes

September 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
Joan Altman
Jane Beyer
Senator Annette Cleveland
Nicole Gomez
Theresa Tamura (*representing the Health Care Authority*)
Tao Kwan-Gett
Bidisha Mandal
Representative Joe Schmick
Mohamed Shidane

Members absent

Representative Lisa Parshley
Omar Santana-Gomez

Call to order

Vicki Lowe, Chair of the Universal Health Care Commission (Commission), called the meeting to order at 2:01 p.m. There were enough members for a quorum, so the Commission could hold votes.

Agenda items

Welcoming remarks

Chair Lowe began with a land acknowledgement and welcomed members to the Commission's 25th meeting.

Two new members were welcomed to the Commission, Senator Cleveland and Dr. Tao Kwan-Gett. Chair Lowe noted that Representative Lisa Parshley has also joined the Commission but was unable to attend today's meeting. Lastly, Chair Lowe shared that Stella Vasquez has resigned from her role on the Commission. Vasquez held a governor-appointed seat and the Governor's Office has been informed of the open governor-appointment seats on the Commission.

Meeting minutes

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

Public comment

The following members of the public provided comments:

- **Katherine Lewandowsky**, Whole Washington
- **Emma Heinonen**, Washington Community Action Network (CAN)
- **Lannette Sargent**, Washington CAN
- **Marcia Stedman**, Health Care for All - Washington
- **Annie Fitzgerald**, Whole Washington
- **Kate Rhodes**, Washington CAN
- **Thomas Kennedy**, Whole Washington

Public comment topics included:

- Appreciation for the Advocates Roundtable
- Timing of governance decisions
- Administrative simplification, including streamlining prior authorizations and making billing more transparent
- Support for hospital global budgeting
- Suggested changes to PEBB/SEBB, including consolidating purchasing and expanding enrollment opportunities for local government
- Limiting Health Benefit Exchange offerings to a standard plan
- Explore offering supplemental coverage for services not covered by Medicare
- Treatment decisions, including opposition to AI-generated decisions related to care and opposition to decisions made by those without a medical license
- Request for input on the Washington Health Trust bill

Find full testimonies in the **meeting recording (time stamp 8:01)**.

Advocates Roundtable report out

Vicki Lowe, Chair

Chair Lowe thanked panelists from Health Care for All – Washington, Northwest Health Law Advocates, Washington Community Action Network (CAN), and Whole Washington for joining the Commission at the August 5 Advocates Roundtable. Over a dozen members of the public attended the meeting in person and roughly 75 people joined online.

Commission members shared their reflections from the meeting, including appreciation for learning more about how the advocacy groups work together and hearing panelists' thoughts on cost-containment strategies given the current landscape. Chair Lowe noted that the Commission looks forward to working with advocacy organizations to gather community input and spread the word about the Commission's work moving forward.

Find the full discussion in the **meeting recording (time stamp 23:40).**

Commission member updates

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

- **Elena Soyer**, Health Care Authority (HCA)
- **Joan Altman**, Washington Health Benefit Exchange (WAHBE)
- **Jane Beyer**, Office of the Insurance Commissioner (OIC)
- **Tao Kwan-Gett**, Department of Health (DOH)
- **Senator Annette Cleveland**, Washington State Senate
- **Chair Vicki Lowe**, American Indian Health Commission

Updates touched on the Rural Health Transformation Program, final rate increases for individual health plans, OIC's emergency rule regarding the application of a uniform cost-sharing reduction silver load adjustment factor, the West Coast Health Alliance, the Washington State COVID-19 Vaccine Standing Order, upcoming joint Health Care and Behavioral Health Oversight Committee meetings, upcoming Senate Health and Long-Term Care Committee Legislative Assembly Days in December, and impacts of HR1 on American Indian and Alaskan Natives in the Indian health care delivery system.

Find their full updates in the **meeting recording (time stamp 28:41).**

Workplan update

Ally Power, HCA

Ally Power, Health Policy Analyst at HCA, reviewed the Commission's milestone tracker and noted for today's meeting, the Commission will be reviewing draft straw proposals for eligibility and benefits and services. The new straw proposal format is being piloted in response to Commission members' requests to further document decisions.

Power then outlined next steps for the draft annual report, which was sent to Commission members on Thursday, August 28 and was also included in the Appendix of the September

meeting packet. The final report is due to the Legislature on November 1, and the Commission will vote to adopt this final report at their next meeting on Thursday, October 9. Commission members were encouraged to review the draft and send any edits, comments, questions to the general mailbox or directly to staff. Power then shared the upcoming Commission and FTAC meeting schedule for 2026.

Finally, Power noted the open seat on FTAC and shared that the current FTAC charter states that all vacancies will be filled by the Commission. Power proposed adding language to further outline the process for filling vacancies and the criteria used for reviewing candidates. Commission members requested additional language be added to indicate that FTAC members may be retired health care professionals who are no longer actively practicing and that the vacancy announcement should note that recipients of the announcement should share the information with their networks to help achieve a broad reach. Commission members adopted the revised updated FTAC Charter language and directed HCA staff to publish an announcement for FTAC applicants by unanimous vote. The updated FTAC charter is available here.

Find the full presentation and discussion in the **meeting recording (time stamp 50:57)**.

Section 1333 interstate compacts: Overview and Q&A

Patty Kuderer, Washington Insurance Commissioner; Jason Levitis, The Urban Institute; Randy Pate, Randolph Pate Advisors

Commissioner Kuderer provided opening remarks and noted that this discussion represents the very beginning steps of learning about section 1333 interstate compacts for the Commission. Sec. 1333 interstate compacts are a provision of the Affordable Care Act (ACA) in which two or more states can create a regulatory framework to sell qualified health plans across state lines. They require approval by state legislatures and the federal government.

Subject matter experts Jason Levitis and Randy Pate provided an overview of the topic including key benefits, implementation approaches, and legislative hurdles. Levitis noted that 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. Sec. 1333 includes no language to waive other ACA provisions or to provide federal funding.

Following the presentation, Commission members engaged in a robust discussion of the topic including the potential for joint Basic Health Plans, multi-state agreements for Qualified Health Plan certification criteria, or interstate exchanges. Commission members discussed developing a potential exploratory Work Group, reaching out to counterparts in Oregon, exploring the intersection of sec. 1332 waivers and 1333 compacts, and ensuring that any pursuit would increase coverage and lower costs.

Find the full presentation and discussion in the **meeting recording (time stamp 59:33).**

Washington State Health Care Authority

Finance Technical Advisory Committee (FTAC) update

Ross Valore, HCA

Ross Valore, Board and Commission Director at HCA, provided an update from the July FTAC meeting, which included:

- Overview of public comments received
- Eligibility straw proposal
- Benefits and services straw proposal

Valore then opened up the meeting for discussion of the eligibility straw proposal. Commission members proposed revisions and requested the revised proposal be presented at the October meeting. Valore then opened up the meeting for discussion of the benefits and services straw proposal. Commission members requested framing language be incorporated into the annual report that indicates these straw proposals provide initial recommendations and are part of an iterative approach. Commission members then voted to adopt the benefits and services straw proposal and to incorporate it into the annual report.

Find the full presentation and discussion in the **meeting recording (time stamp 2:07:00).**

Transitional solutions

Vicki Lowe, Chair

Chair Lowe shared the proposed transitional solution topics offered by Commission and FTAC members during the June and July meetings. Chair Lowe also referenced the transitional solutions submitted by Health Care for All – Washington in the written public comments tab. Commission members then named the following priorities:

- Stabilize our current system and identify mitigation strategies regarding federal changes like coverage losses
- Address health care workforce needs in rural areas
- Looking at the financial underpinnings of our current system to address affordability, sustainability, and resilience
- Explore creation of a state-option Medicare Advantage plan
- Consider creating Small Business Health Options Program (SHOP) coverage options

Find the full presentation and discussion in the **meeting recording (time stamp 2:36:17).**

Closing comments and adjournment

The meeting adjourned at 4:53 p.m.

Next meeting

Thursday, October 9, 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 August 28):
  - J. Hilde
  - M. Marie
- Additional comments received during the September UHCC meeting: https://www.youtube.com/watch?v=vnCaQ-mSrB0
- 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: Friday, September 5, 2025 2:27:50 PM

External Email

With "transitional solutions" and "interstate compacts" you are on the right track! We cannot wait for an unlikely-to-ever-happen federal approval of state-sponsored universal health care under the Trump administration nor do we need to. As the West Coast states (and Hawaii!) are now cooperating with creating our own vaccine guidelines, so to our states must cooperate to create a fair and affordable health care system for all our citizens. And we must do it as quickly as possible... we already see for-profit insurance companies planning extreme rate hikes in 2026 just.because.they.can. Those rate hikes, along with the federal administration's cuts to Medicaid and soon Medicare, will result in horrendously plummeting health standards in our West Coast states. If we don't want to end up with the bottom-of-the-barrel statistics of red states (life expectancy, maternal and infant death rates, obesity, diabetes, dementia, etc.) we need to take action and we need to take action NOW.

Thank you for all you do! :-)
Jean Hilde
Shoreline, WA

From: Life With Meme
To: HCA Universal FTAC
Subject: Public comment submission to FTAC
Date: Thursday, September 25, 2025 10:11:30 AM

External Email

I just wanted to say, thank you. I hope that this commission leads to healthcare for all.
Mechelle Marie

Tab 3

Washington State Health Care Authority

State agency reports outs & Commission member updates

Washington State Health Care Authority

Tab 4

Washington State Health Care Authority

Workplan update

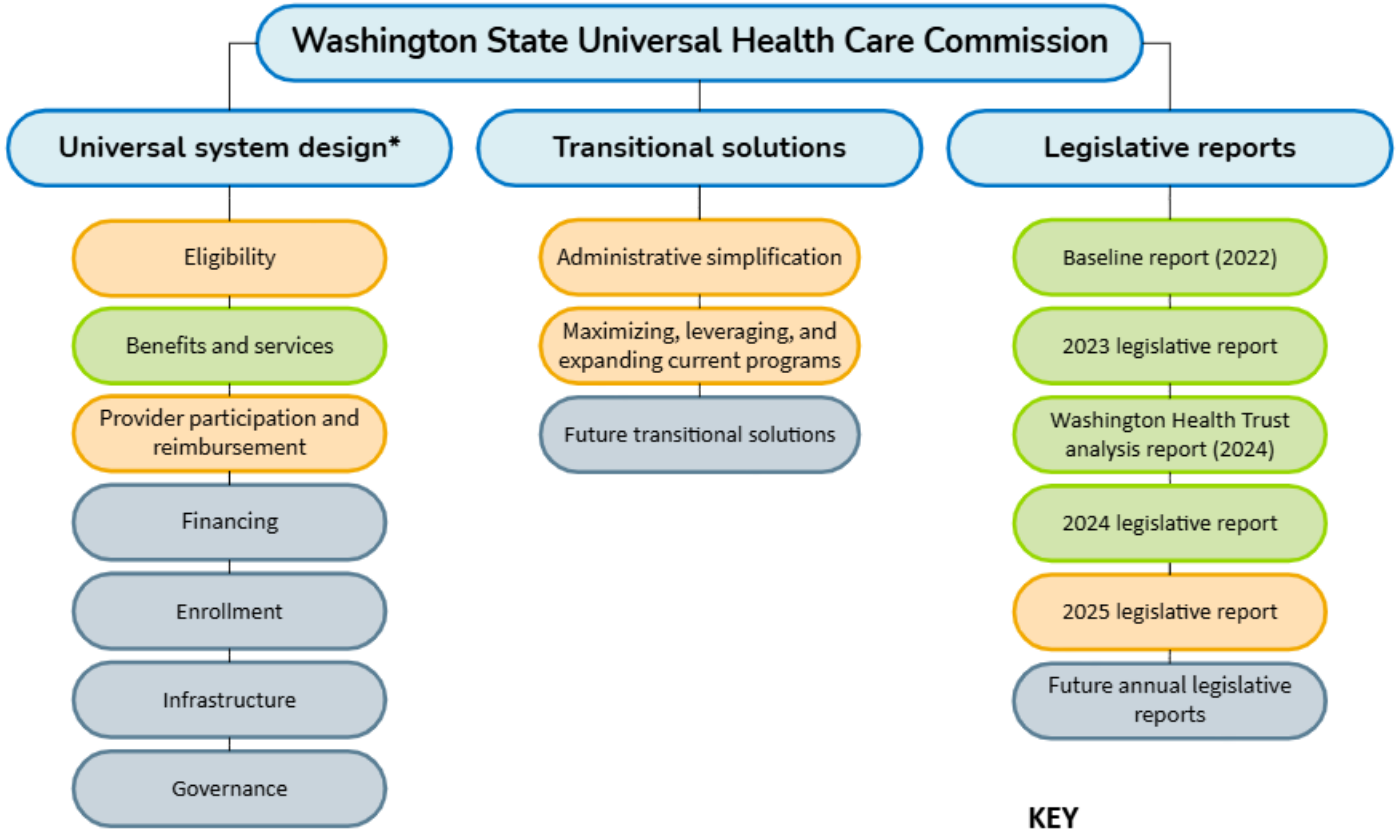
Universal Health Care Commission

Overview

- Workplan status
- Eligibility straw proposal
- Legislative report
- OIC proviso funding

Workplan status

Last updated September 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:

- Eligibility straw proposal
- Provider reimbursement and participation
- 2025 annual report

Straw proposals

- In-depth work by UHCC/FTAC work group
- Standardized format for documenting recommendations and decisions
  - Created at the request of the Commission
  - Modeled after Oregon
  - Intended to document current thinking on topic that can be modified if thinking or design change
  - To be included in 2025 annual report to the Legislature
- UHCC feedback about process?

Eligibility straw proposal

- Latest draft incorporates feedback provided during September meeting
  - Draft was circulated to Commission members on Sept 23 and is included on the following slides
  - Includes an appendix related to AI/AN protections in a state-based universal health care system
- Are there any further changes to the draft eligibility straw proposal?

Universal Health Care Commission: 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; October 9, 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 considering existing definitions (e.g., Washington Department of Revenue or Apple Health, among others).

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, regardless of immigration status. 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

As noted earlier, the long-term goal of a universal system is to include all Washington residents. However, 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).

[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 addition, a section 1332 state innovation waiver may provide a pathway for including the individual and small group markets not subject to the ERISA preemption in a universal system, but further analysis is warranted.

American Indian and Alaska Native Washington residents

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.

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)

Returned for revision

- Please make the following revisions:
  - Remove paragraph about residents without full rights of citizenship and address immigration status elsewhere in the document.
  - State more strongly that the goal of a universal system is to cover all residents of Washington.
  - Revisit/expand definition of resident.
  - Clarify statement about 1332 waivers.

UHCC Feedback (October 9, 2025)

Approved

- Note any revisions

Returned for revision

- Please make the following revisions:

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.

Potential votes

- The Commission approves the eligibility straw proposal.
- The Commission votes to add the approved straw proposal to the 2025 annual report to the Legislature.

2025 annual report to the Legislature

- Latest draft incorporates feedback provided from Commission members via email
  - Updated draft was circulated to Commission members on Sept 23 and is included as an appendix to this packet.
- Are there any further changes to the draft annual report?

Potential vote

- The Commission approves the 2025 annual report to the Legislature.

OIC proviso funding

- In the state budget passed earlier this year, $250,000 of the insurance commissioner's regulatory account funds “an interagency agreement with the health care authority to support economic, actuarial, or other modeling related to design of a universal health care system.”
- HCA and OIC staff will work together to determine appropriate use of funds
  - No decision has been made yet
  - Commission and FTAC will provide guidance

Tab 5

Washington State Health Care Authority

Finance Technical Advisory Committee (FTAC) update

September FTAC meeting recording & materials

Washington State Health Care Authority

Overview: September FTAC meeting

- Public comment
- Provider reimbursement and participation
- FTAC seat opening announcement

Public comment

- Preserving funding and access to behavioral health care, particularly in schools

Provider reimbursement and participation

- Initial discussion and level-set about the topic
- Proposed approach
  - Develop set of guiding principles
    - Similar in structure to cost containment principles
    - Staff is drafting principles, drawing on input from advocacy organizations and FTAC members
  - Consider gradual expansion of a current mechanism (for example, reference-based pricing) in current system
    - Request for level set about final version of SB 5083 and current implementation
    - Gradual expansion will help inform recommendations for universal design
  - Consider current changes in coverage and affordability

Provider reimbursement and participation

- Commission feedback about initial approach
- Additional topics or approaches to consider?

FTAC seat opening announcement

- Interested applicants encouraged to submit resume and cover letter outlining their expertise and interest in serving on FTAC to HCAUniversalFTAC@hca.wa.gov
- Announcement shared via e-mail on Oct. 1, via HCA social media, and on the FTAC webpage
  - Commission members are encouraged to share this call for FTAC applicants with their networks
- 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

Questions?

Washington State Health Care Authority

Universal Health Care Commission meeting

We are currently on a short break

Washington State Health Care Authority

Tab 6

Washington State Health Care Authority

Section 1333 interstate compacts

Universal Health Care Commission

Overview

- Provision of the ACA that allows states to enter into agreements to permit the sale of health insurance across state lines, subject to certain restrictions
  - CMS has not yet promulgated regulations related to 1333 compacts
  - Presentation during September meeting from two subject matter experts
- Next steps identified during September meeting
  - Explore possible intersection of 1332 waiver and 1333 compacts
  - Reach out to counterparts in Oregon
  - Ensure that any change would increase coverage and lower cost

Status update

- HCA and OIC staff are in the process of reaching out to counterparts in Oregon
  - Goal is to form a workgroup that will explore and track Section 1333 interstate compacts as an innovative option
    - UHCC workgroup members: Joan Altman, Jane Beyer, Nicole Gomez
- No current plans to pursue a Section 1333 interstate compact
  - Work group will keep Commission informed as members learn more about 1333 compacts and other options

Tab 7

Washington State Health Care Authority

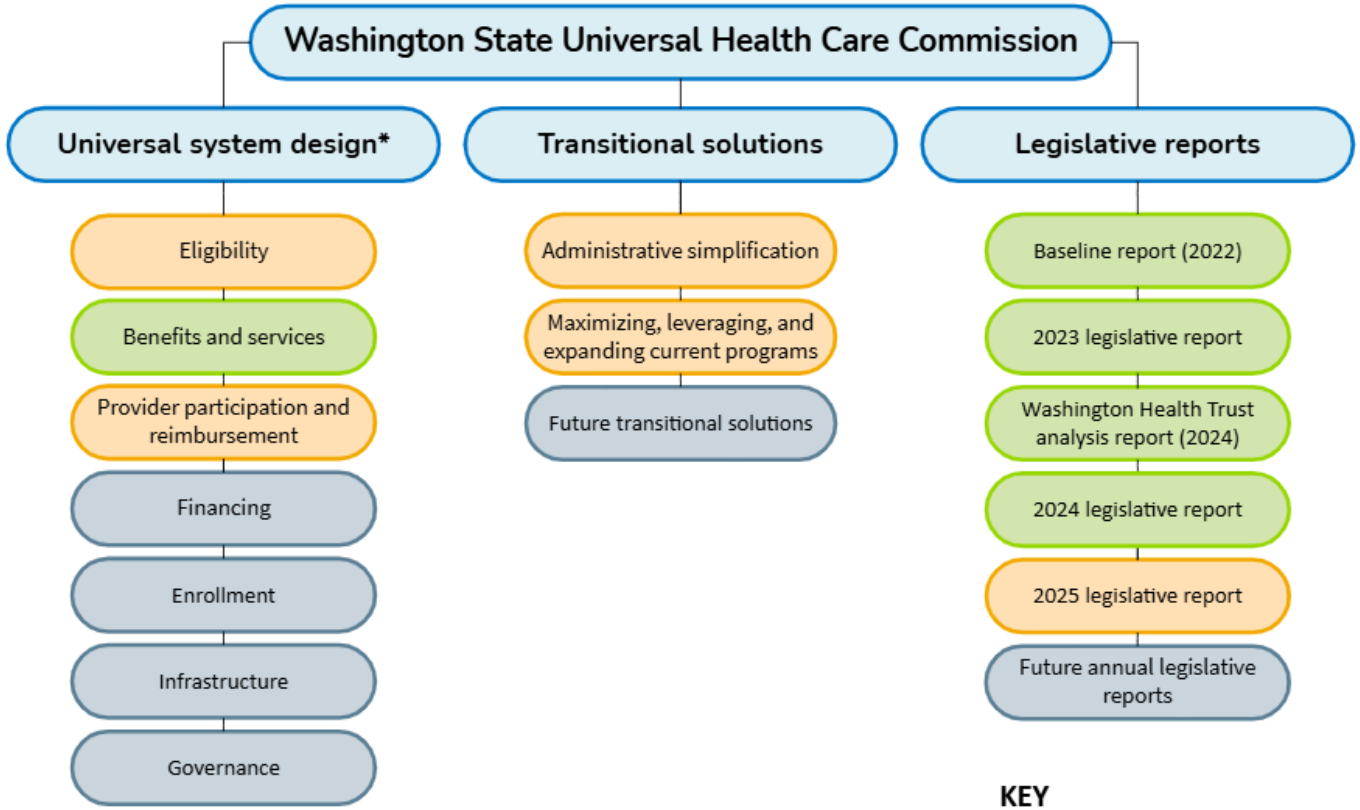
2026 Workplan

Universal Health Care Commission

Overview

- 2025 workplan progress
- Proposed approach for 2026 workplan
  - Commission feedback
- Proposed approach for interim solutions
  - Commission feedback

2025 workplan

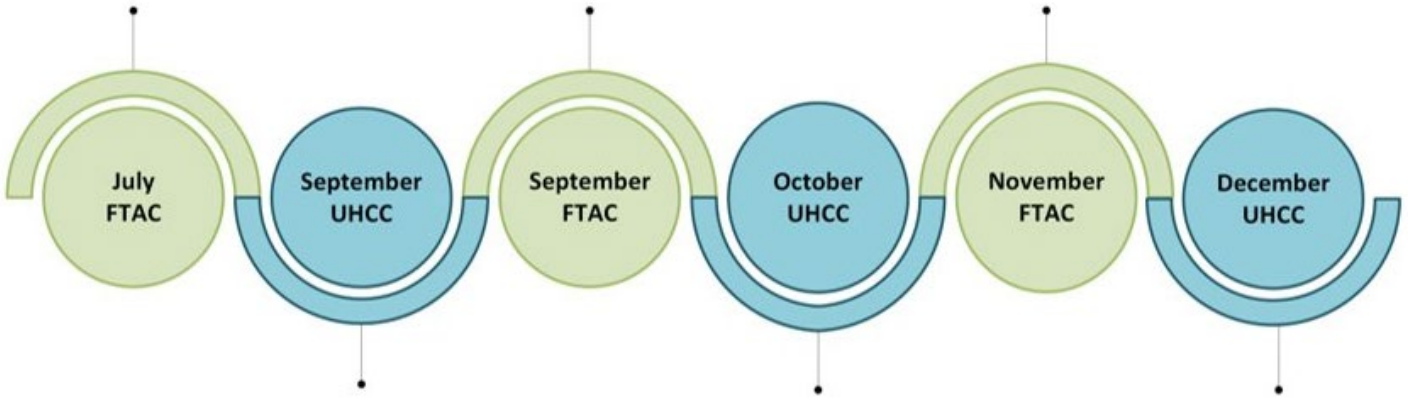


*Cost-containment mechanisms, health care quality, health equity, and health disparities will be discussed and considered during each of the core universal system design components.

- Prioritized three key design elements
  - Benefits and services (straw proposal adopted)
  - Cost containment (woven throughout design elements)
  - Provider reimbursement (in progress)
- Revisited and clarified eligibility
- Goal was to address financing in early 2026

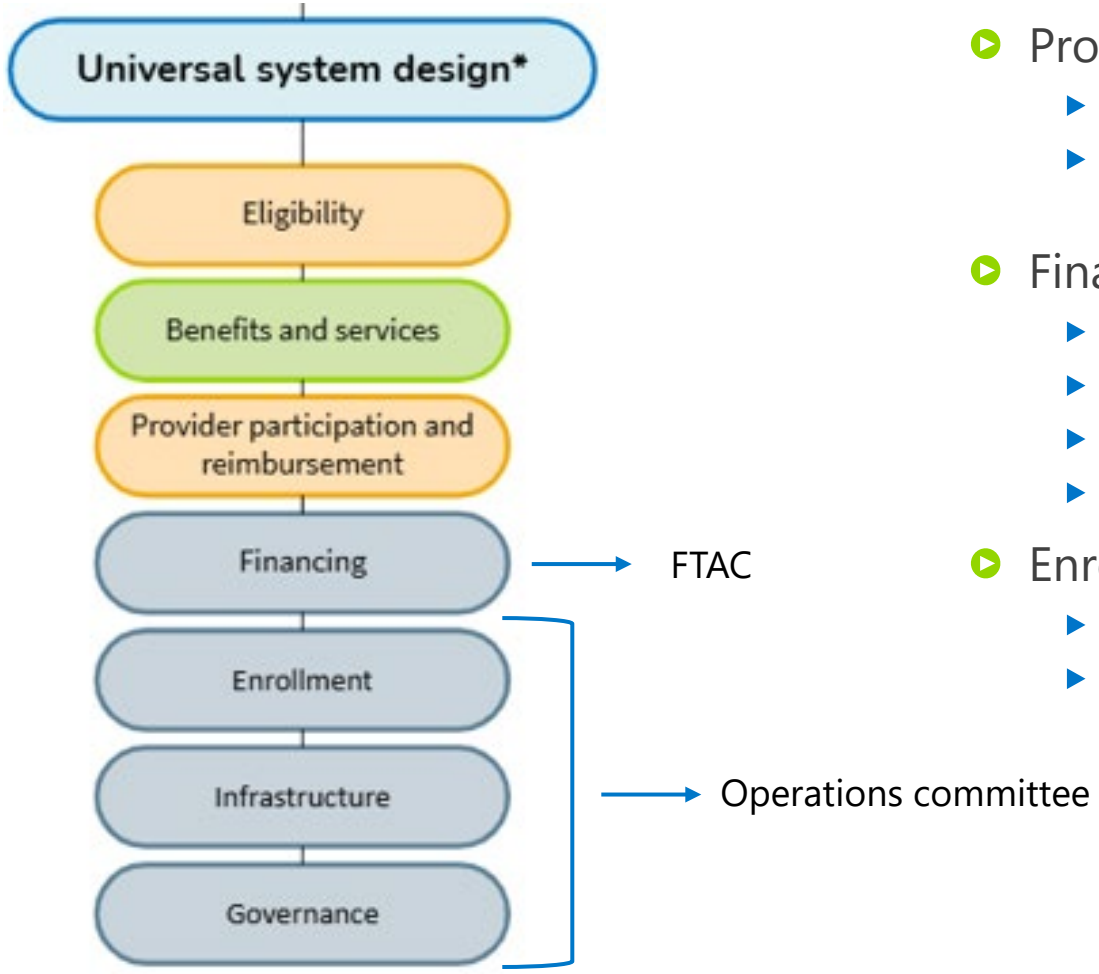
Workflow

- In 2025, topics moved back and forth between Commission and FTAC



- In 2026, we propose parallel workstreams

Proposed approach for 2026 workplan



- Provider participation and reimbursement
  - FTAC continues its work on this design element
  - Recommendation to the Commission, including guiding principles, in early 2026
- Financing
  - FTAC takes lead role on financing in early 2026
  - FTAC continues to update the Commission on its progress
  - Possible use of OIC proviso funding for analysis (TBD)
  - FTAC likely to sunset when recommendations are done
- Enrollment, infrastructure, and governance
  - Stand up an operations committee to take on all three topics
  - Recruitment, development, and launch in 2026

Proposed approach for 2026 workplan

- Commission focuses on interim solutions
- Prioritize interim projects that could serve as pilots for eventual universal design elements
  - Draw on work on other boards and programs, such as the Rural Health Transformation Program, Health Care Cost Transparency Board, among others
- Develop recommendations for Legislature and incorporate into universal design

Discussion

- Is the proposed workplan structure an effective way to divide work among Commission and committee(s)?
- Is an operations committee the most effective way to approach enrollment, infrastructure, and governance?
- Is focusing on potential pilots the appropriate approach for interim solutions?

Transitional solutions

- How might these proposed solutions be explored as pilots for eventual inclusion in universal design?
  - Stabilize our current system and identify mitigation strategies regarding federal changes like coverage losses
  - Address health care workforce needs in rural areas
    - Rural Health Transformation Program
  - Look at the financial underpinnings of our current system to address sustainability and resilience
    - Health Care Cost Transparency Board
  - Explore creation of a state-option Medicare Advantage plan
    - Healthy San Francisco
  - Consider creating Small Business Health Options Program (SHOP) coverage options

Thank you for attending the Universal Health Care Commission meeting

Washington State Health Care Authority

Appendix

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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Table of contents

Glossary

ALF	Assisted Living Facility
AV	Actuarial Value
AWP	Average wholesale price
Commission	Universal Health Care Commission
Cost Board	Health Care Cost Transparency Board
CY	Calendar Year
DOH	Washington State Department of Health
DOR	Washington State Department of Revenue
DSHS	Washington State Department of Social and Health Services
EHR	Electronic Health Records
ER	Emergency Room
ESSB	Engrossed Substitute Senate Bill
FFS	Fee-for-service
FTAC	Finance Technical Advisory Committee
HB	House Bill
HBE	Washington Health Benefit Exchange
HCA	Washington State Health Care Authority
LTSS	Long-term services and support
Medicaid	Washington Apple Health (Medicaid), Apple Health
OFM	Washington State Office of Financial Management
OIC	Washington State Office of the Insurance Commissioner
OoE	Washington State Office of Equity
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

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 held six regular meetings. 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. In addition, the Commission's Finance Technical Advisory Committee (FTAC) held six regular meetings.

The Commission approved this report to the Governor and the Legislature during its MONTH meeting. As specified in statute, this report details the ongoing work of the Commission. Key topic areas during this report year included:

- **Universal design elements**: eligibility, benefits and services, and cost-containment mechanisms
- **Transitional solutions**, including recommendations that were ultimately funded by the Legislature for reference-based pricing and coverage expansion
- Commissioning a **cost analysis report** of several existing benefit plan designs in an initial universal health care system
- Adopting **patient cost-sharing principles** to guide design decisions and analyses

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 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 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 (**Universal Health Care Work Group 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.

During this reporting year (October 2024–September 2025), some legislator and governor-appointed seats experienced vacancies due to results of the November 2024 election. The Governor's Office and legislative leadership worked to fill vacant seats throughout 2025. Refer to 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 Senate Joint Memorial (SJM) 8004 (2025)	Passage of SJM 8004, which requests that the federal government create a universal health care program or reduce barriers and grant appropriate waivers so that Washington state can implement one
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 toward primary care and behavioral health services (2024)	Implemented a new reference-based reimbursement structure and gave HCA authority to enforce compliance (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 for individuals purchasing coverage through the Health Benefit Exchange (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)). The most recent funding is for CY 2026.
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))

Commission recommendations and related legislative hearings	Action by the Legislature
Implement the Integrated Enrollment and Eligibility Modernization Roadmap to support Information Technology infrastructure necessary for a universal health care system (2022)	Funding provided to the Department of Social and Health Services (DSHS) for the Integrated Enrollment and Eligibility Modernization Project to create a comprehensive application and benefit status tracker for multiple programs (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

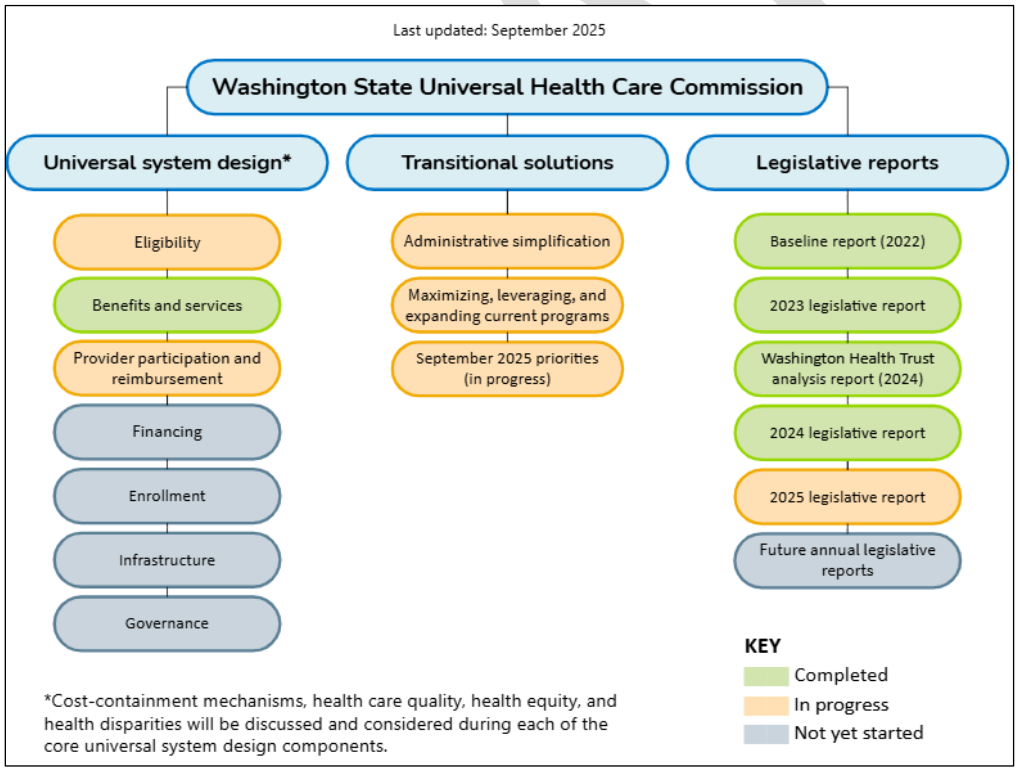
Overview of the year

During fall 2024, the Commission adopted the 2025 workplan (**Figure 2**) 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.

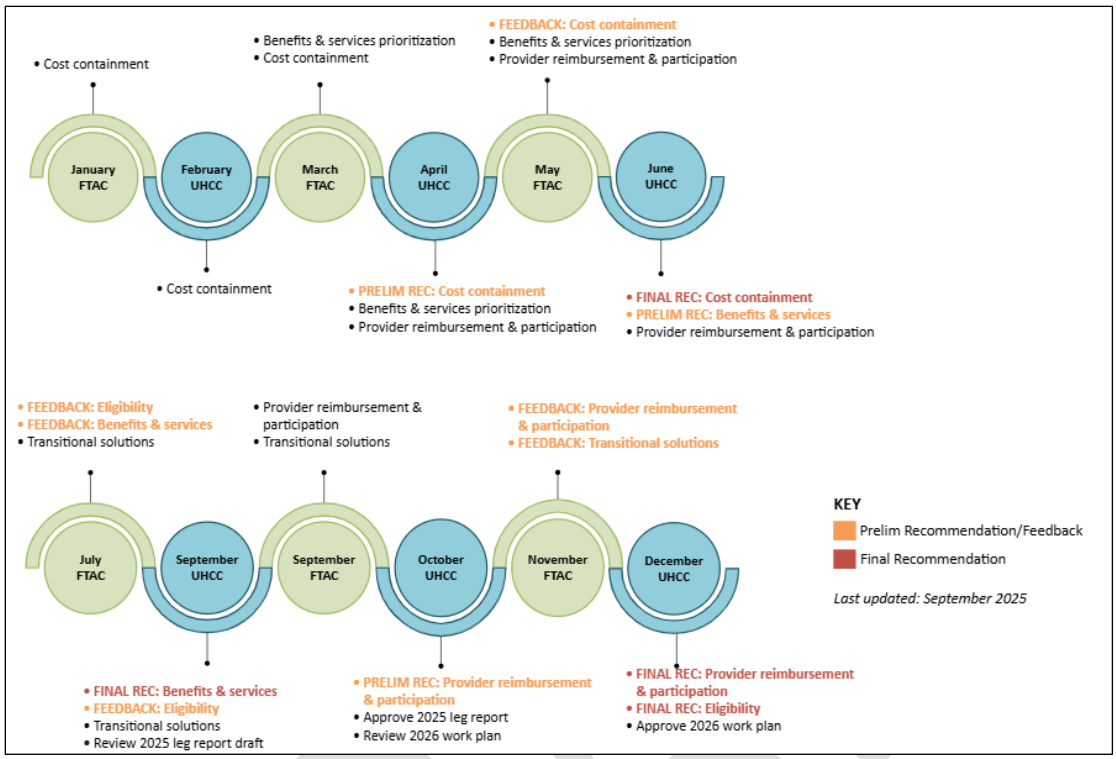
This Commission is grateful to the legislature for additional resources approved in the 2023–2025 budget.[1] The proviso funding supported an additional staff member through June 30, 2025. This staff member worked closely with FTAC members to research topics and develop presentations and recommendations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



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

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



Addressing core design elements

In 2025, the Commission planned to focus 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.

Table 1 details 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	In progress
Benefits & services	Phase 1	Straw proposal adopted
Cost containment	Phase 1	Incorporated throughout*
Provider reimbursement and participation	Phase 1	In progress
Finance	Phase 1	Not yet started
Infrastructure	Phase 2	Not yet started

Core design element*	Workplan	Status
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 initial recommendations

The Commission examined eligibility as its first design component, beginning in 2023.[2] From June to September 2025, following actuarial analyses of selected benefit plans, the ad hoc work group developed—and FTAC revised—a straw proposal on eligibility to update and document the eligibility recommendations of the Commission. The Commission first considered the eligibility straw proposal during its September meeting and adopted it during its October meeting. The eligibility straw proposal is included as Appendix F.

Summary of benefits and services initial recommendations

In addition to the eligibility straw proposal, the ad hoc work group and FTAC developed a benefits and services straw proposal to document the Commission's current conceptualization of and decisions for benefits and services. These straw proposals are iterative in nature, and future meetings and legislative reports will continue to refine the Commission's decisions on these design elements. During the Commission's September 2025 meeting, Commission members reviewed the benefits and services straw proposal and voted to adopt it. The benefits and services straw proposal is included as Appendix G.

Milliman analysis overview

As noted earlier, funding was appropriated in the 2023-2025 operating budget for dedicated actuarial support and economic modeling, as well as additional staff support for FTAC.[3] 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

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

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

In their analysis, Milliman estimated the total cost of care for the population most likely to be included in an initial universal system, based on calendar year 2023 data. The estimated costs were based on three benefit scenarios that represent a range of actuarial values (AV) and were 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 are:

- **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[4] (68% AV)

The study population included approximately 3.4 million individuals and was restricted to individuals not enrolled in Medicare who are 0 through 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. A summary of the report can be found in **Appendix I**.

Key findings

The estimated baseline cost of care for the study population (n=3,370,000) was $16.3 billion. The difference between the baseline cost of care and the benefit designs modeled is as follows:

- 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

All reimbursement rates were set using the payment rates observed in 2023. Provider reimbursement was estimated at rates that would be neutral for each of the inpatient, outpatient, and professional service categories, and in total. The analysis excluded Medicaid long-term services and support (LTSS). Prescription drug reimbursement rates were based on national average drug acquisition costs converted

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

to discounts off average wholesale price (AWP). Dental reimbursement rates were set at PEBB and SEBB rates for the non-Medicaid population and Medicaid rates for the Medicaid population.

The following table 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
Scenario 3 (Cascade Select Silver–like)	$377–$447	$15.2 billion–$18.1 billion

Patient 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 a set of principles to the Commission 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 from 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 by 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 Legislature appropriated funding from the Washington State Office of the Insurance Commissioner (OIC) regulatory account to support the work of the Commission during the 2025-2027 biennium. The legislative proviso appropriates $250,000 "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."[5]

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.

[5]For further details, refer to HB 1178

Cost containment

In the legislation that established the Commission, cost containment was 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 an approach that incorporates cost-containment mechanisms within universal design elements (e.g., benefits and services), as well as 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 presentations and discussions held by the Commission and FTAC over this reporting 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 **patient 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 that incentivize 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 areas 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. Local taxes and levies support hospital districts and can and may make up for hospital operating fund deficits. Panelists discussed the significant factors that contribute to rural hospitals' 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 difficult for rural hospitals and smaller health systems to contract with payors, highlighting that they often lack negotiating power when payors present agreements with payment rates below 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 patient care.
- Palliative care, which is often provided to the sickest patients the hospital serves, is not reimbursed directly. However, according to one panelist, palliative care reduced emergency room (ER) utilization at their hospital by 35% and lowered their 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 developing cost containment strategies. 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, seniors would be forced to move to new facilities outside of their community, 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 information 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 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%. In 2022 cost growth was 3.6%, slightly above the target.

Spending from 2019–2022 was reported by market, with the commercial market growing by 11.5% and Medicare growing by 7.7% during this time. Apple Health enrollment and total spending increased, but per member per month (PMPM) cost slightly decreased by 0.1% 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 and recommendations 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 related to this core design element, including:

- Importance of policies that support rural hospitals and health systems
- Impact of vertical integration and horizontal consolidation on our health care system
- Value-based payment models for primary care
- Looking at how Indian Health Services tackles provider reimbursement, e.g., funding specific hard costs and primary care as "direct care" and a separate per person/per year funding for services that are received outside of the primary care setting; the primary care provider would be responsible for the funding for services outside of the clinic and managing patients' care

The Commission will return to provider reimbursement and participation in late 2025 and 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 following.

Administrative simplification

Prior authorization

During the October 2024 Commission meeting, members received information on prior authorization policies not currently used in Washington, including gold carding (i.e., allowing providers with high approval rates for services to bypass the traditional prior authorization requirements) and standardized forms. Commission members expressed interest in seeing more evidence on these approaches from other states, as well as data on prior authorization request 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. The proposal exempted certain critical access and rural hospitals and set a minimum payment standard 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 prefiled 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.[6] 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 (**Appendix E**). During the 2025 Legislative Session, **ESSB 5083** was enacted to implement a new reference-based reimbursement structure and gave HCA authority to enforce compliance with the new reimbursement structure.

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 that new enrollment had been 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 to address 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.

[6] 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.

Next steps for transitional solutions

When adopting the 2025 workplan, the Commission decided to focus on the core design elements outlined above (i.e., benefits and services, cost containment, and provider reimbursement and participation) 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
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 appreciates legislative support through 2025-2027 funding and acknowledges that 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 advance the state's readiness to implement a universal health care system.

Health equity

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 HCA'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 Sec. 1333 compacts. She proposed the Commission invite the Oregon Universal Health Plan Governance Board (UHPGB) to their September 11 meeting. HCA staff worked with OIC staff to host subject matter experts at the September 11 meeting to provide an overview of 1333 compacts and answer Commission member questions. Following those presentations, the Commission decided to reach out to Oregon's UHPGB to further explore 1333 compacts. Commission members noted that any interstate compact should ensure increased coverage and lower cost. Such efforts were under way as this report was completed.

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. These comments often mentioned multiple topics. Many of the public comments also touched on personal stories about the substantial barriers individuals and families face in Washington's current health care system. Key themes addressed in public comments included:

- **Feedback on design elements (e.g., eligibility) and transitional solutions** (n=30), including requests for clarification on eligibility recommendations, proposals for additional actuarial analyses, and feedback on potential recommendations for 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 the Commission's work. Commission members review and consider all of the public comments received. The Commission has 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 health system 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. 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 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 H**).

Public outreach and presentations

Outreach efforts increased in 2025. Commission leadership and HCA staff participated in events designed to raise awareness and share 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.[7]

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.

[7] 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.

Table 4: SB 5233 proposals and alignment with Commission activities

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 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 modifies and reduces access to federal premium subsidies, which are critical to affordability for consumers. 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.

Updated proposals in SB 5233	Alignment with goals and planned activities of Commission
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 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.	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 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[8]

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 (HBE)
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)

[8] 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	N/A	Governor-appointed
David Iseminger	November 2021	N/A	State agency (HCA)
Jane Beyer	November 2021	N/A	State agency (OIC)
Joan Altman	November 2021	N/A	State agency (HBE)
Mohamed Shidane	November 2021	N/A	Governor-appointed
Nicole Gomez	November 2021	N/A	Governor-appointed
Omar Santana-Gomez	April 2024	N/A	State agency (OoE)
Representative Joe Schmick	November 2021	N/A	Legislator
Representative Lisa Parshley	June 2025	N/A	Legislator
Tao Kwan-Gett	June 2025	N/A	State agency (DOH)
Senator Annette Cleveland	August 2025	N/A	Legislator
Vicki Lowe, Chair	November 2021	N/A	Governor-appointed

C. Finance Technical Advisory Committee roster[9]

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

[9] 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[10]	State agency (DOR)
Christine Eibner	January 2023	N/A	Expertise in health care financing
Roger Gantz	January 2023	N/A	Expertise in health care financing
Esther Lucero	January 2023	N/A	Expertise in health care financing
Robert Murray	January 2023	N/A	Expertise in health care financing
Kai Yeung	January 2023	N/A	Expertise in health care financing
Pam MacEwan	January 2023	N/A	Consumer representative
Eddy Rauser	January 2023	N/A	State agency (OFM)
Matthew Morrissey	August 2025	N/A	State agency (DOR)

[10] 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. Letter of Support: SB 5083/HB112

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

F. Eligibility Straw Proposal

Universal Health Care Commission: 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
Commission Adopted: October 9, 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.[11]

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,[12] 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 considering existing definitions (e.g., Washington Department of Revenue or Apple Health, among others).

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, regardless of immigration status. 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.

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[11] These strategies could include, but are not limited to, consolidating all state agency purchasing (Medicaid/CHIP, PEBB/SEBB and HBE) into a single system.

[12] 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).

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
- 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

As noted earlier, the long-term goal of a universal system is to include all Washington residents. However, 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.[13] 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.[14]

[13] Approximately one-third of employers offer fully insured, as opposed to self-funded, health plans.

[14] Memorandum to Oregon Joint Task Force on Universal Health Care, July 25, 2022

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 may provide a pathway for including the individual and small group markets not subject to the ERISA preemption in a universal system, but further analysis is warranted.

American Indian and Alaska Native Washington residents

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* (document following this straw proposal) and follow 25 USC 1621e regarding reimbursement for health care services.

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 "*Model Language: AI/AN protections in the State-Based Universal Health Care*" following this proposal
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)

Returned for revision

- Please make the following revisions:
  - Remove paragraph about residents without full rights of citizenship
  - State more strongly that the goal of a universal system is to cover all residents of Washington
  - Revisit/expand definition of resident
  - Clarify statement about 1332 waivers

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.

G. Benefits and Services Straw Proposal

Universal Health Care Commission: 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
Commission Adopted: 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.[15]

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.[16] The identified

[15] RCW 41.05.840
[16] 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 refer to the full report for further details.

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 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 and the Commission adopted this straw proposal in September 2025.

Initial 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.[17]
- 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 with the following revision:
  - Add "initial" before recommendations to highlight that these straw proposals are iterative and the Commission will continue to refine as they move through other key design elements in the workplan

[17] 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 from 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 by 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.

H. 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.

I. Milliman Report Brief

As noted earlier in this report, funding was appropriated in the 2023-2025 operating budget for dedicated actuarial support and economic modeling, as well as additional staff support for FTAC. 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.

A summary of this report was provided by Milliman and is included on the following pages. This report brief summarizes the results, methodology, limitations, and considerations from the full report. The full report provides additional and necessary detail, context, and considerations that should be reviewed for a more complete understanding of the summary results presented here. For further details, **read the full Milliman report** online.

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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