Universal Health Care Commission meeting

September 3, 2026

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Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission

Agenda

Thursday, September 3, 2026
2–5 p.m.
Hybrid meeting (Teams and in-person)

Commission members:

Vicki Lowe (Chair)
Joan Altman
Senator Annette Cleveland
Nicole Gomez
David Iseminger
Tao Kwan-Gett
Representative Lisa Parshley
Kumhee Ro
Omar Santana-Gomez
Representative Joe Schmick
Mohamed Shidane
Ingrid Ulrey
Naisha Williams

Time	Agenda Items	Tab	Lead
2:00–2:05 (5 min)	Welcome and roll call	1	Vicki Lowe, Chair
2:05–3:05 (60 min)	Advocates roundtable	2	Ryan Moran, HCA Director Mary Franzen, Coverage Strategies Manager, HCA Representatives from Health Care for All – Washington, Northwest Health Law Advocates, WashingtonCAN, and Whole Washington
3:05 – 3:10 (5 min)	Approval of June meeting minutes and introduction of new members	3	Vicki Lowe, Chair
3:10 – 3:25 (15 min)	Public comment	4	Vicki Lowe, Chair
3:25 – 3:45 (20 min)	Universal primary care workgroup report out ➢ **Potential vote related to OIC's design and study of a primary care model**	5	Jenn Scott, Senior Policy Analyst, HCA Workgroup members
3:45 – 3:50 (5 min)	Workplan update	6	Mary Franzen, HCA
3:50 – 4:00 (10 min)	**BREAK**		
4:00 – 4:15 (15 min)	FTAC report out	7	Pam MacEwan, FTAC Liaison
4:15–4:25 (10 min)	Provider reimbursement proposal ➢ **Potential vote to approve proposal**	8	Harrison Fontaine, Senior Policy Analyst, HCA
4:25 – 4:45 (20 min)	Enrollment, Infrastructure, and Governance: foundational questions	9	HCA staff

4:45 – 5:00 (10 min)	State agency report outs	10	Commission members
5:00	Adjournment		Vicki Lowe, Chair

Tab 2

Washington State Health Care Authority

Advocates' Roundtable

September 3, 2026

Washington State Health Care Authority

Roundtable agenda

- Director Moran introductory remarks
- Discussion
  - Advocates' responses to HCA's question
  - HCA responses to advocates' questions
    - Individual input from Commission members, as appropriate

Introduction

Director Ryan Moran

Washington State Health Care Authority

Current economic conditions

- Revenue forecast, June 2026
  - Major GF-S revenue collections came in $103.6 million, or 2.4%, below the February forecast
  - Projected revenues reduced by $427 million in the 2025–27 biennium, with additional reductions expected in later biennia
  - June 2026 Washington Monthly Economic Report
- Next forecast in late September

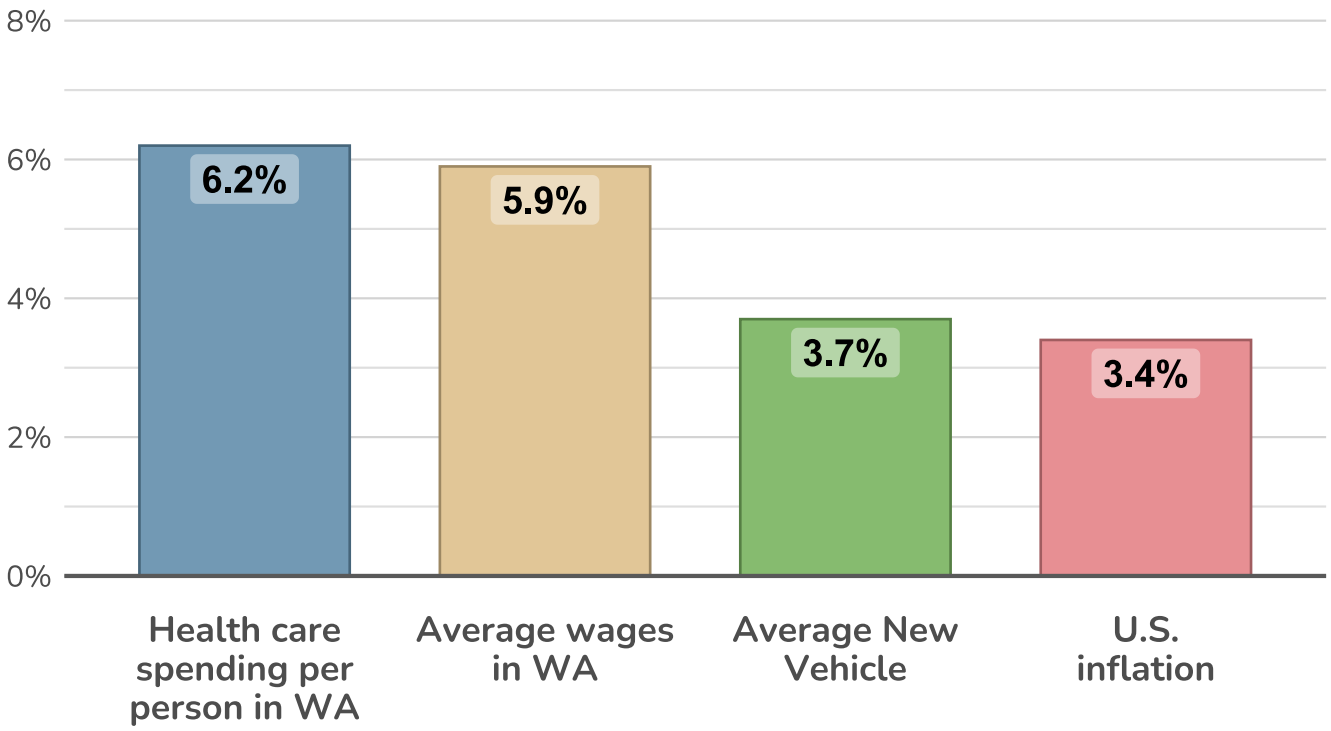
Current economic conditions

- Directive from Gov. Ferguson and the Office of Financial Management
  - OFM Budget Instructions Memo (June 5, 2026)
  - “This year’s revenue forecasts will likely not provide sufficient support for the maintenance of current programs, let alone any expansions…”
  - “Agencies should plan to pause the phase-in of most new programs and not propose the creation of additional programs."

Health care costs

- 2023 statewide growth in spending per member per year was at 6.2%, well above the 3.2% benchmark.
- During the same period, overall inflation was 3.4%.

Health care spending growth in context
2022 - 2023



Sources: Health Care Cost Transparency Board, WA Employment Security Department, Federal Reserve Bank of St. Louis, Bureau of Labor Statistics

Spending type: THCE

Washington State Health Care Authority

Health care costs

- 2023 statewide growth in spending per member per year of 6.2% is the second-highest growth rate since the Cost Board began collecting data.
  - All markets exceeded the benchmark.
  - The growth rates for the commercial and Medicare markets were the second-highest since data has been collected, exceeded only by growth in 2021 after the pandemic-related disruptions of 2020.
  - The proportion of carriers and providers exceeding the benchmark varied by market.

Market	Carriers exceeding the benchmark	Providers exceeding the benchmark
Commercial	82%	63%
Medicare	80%	80%
Medicaid	60%	41%

HCA work on affordability*

- APCD (2014)
- Payer price transparency (2016)
- Prescription drug price transparency (2019)
- Cascade Select (public option with reference pricing) (2019)
- Health Care Cost Transparency Board (2020)
- Prescription Drug Affordability Board (2022)
- Hospital price transparency (2025)
  - SSB 5493
- Reference based pricing (2025)
  - E2SSB 5083
  - Beginning January 2027, HCA will implement price limits for how much PEBB and SEBB plans will pay providers

*years correspond with legislative action

Commission progress

- Welcomed two new members appointed by Gov. Ferguson
- Expanded FTAC membership and revised charter
- Three components related to provider reimbursement
  - Guiding principles
  - Reimbursement proposal
  - Implementation roadmap
- Decision regarding research to be funded by OIC proviso
- Embarking on enrollment, infrastructure, and governance

Short-term purchasing priorities for 2027

- **Public Option ARL**
  - Advances reference pricing across additional markets
  - Alignment of reimbursement policy across PEBB/SEBB and individual market
- **Reduce administrative burden for providers**
  - Standardize Provider Credentialing across MCOs
  - Explore improvements with utilization management and prior authorization
  - In future years, expand to PEBB/SEBB
- **Assess opportunities for Behavioral Health and crisis services**
  - Continue to explore mechanisms for sustaining crisis services funding, including Medicaid and commercial insurance payment policy.
- **Focus on Medicaid HR1 implementation and program improvements**
  - Continue to explore improvements for customers, providers, quality and compliance, and affordability through contractual levers, while mitigating coverage losses and changes in payment with new HR1 limitations

Discussion

Washington State Health Care Authority

Questions for advocates

- What guiding principles should inform FTAC and the Commission as they discuss financing mechanisms?
  - FTAC and the Commission have developed guiding principles for some of the design elements of a universal system. What would be your most important guiding principles for financing?

- In your work in communities across Washington, what financing mechanisms do you hear about?

Discussion – Question 1

- What guiding principles should inform FTAC and the Commission as they discuss financing mechanisms?
  - FTAC and the Commission have developed guiding principles for some of the design elements of a universal system. What would be your most important guiding principles for financing?

Discussion – Question 2

- In your work in communities across Washington, what financing mechanisms do you hear about?

Questions for the Commission

- Would you consider a public trust funded by an assessment to be paid by all employers in Washington state and a monthly premium to be paid by Washington residents with incomes over 200 percent of the Federal Poverty Level?
- In alignment with the goals of RCW 41.05.840 to establish a unified financing health care system for all Washington residents, what is the anticipated timeline, final deliverable scope, and necessary transition milestones for the Commission's recommendations to the Legislature?
- Has the Commission identified any potential sources of universal health care revenue, including the models proposed in the Washington Health Trust and Washington Health Security Trust, that it would recommend for additional development, or any which it believes should be dismissed?

Discussion – Question 1

- Would you consider a public trust funded by an assessment to be paid by all employers in Washington state and a monthly premium to be paid by Washington residents with incomes over 200 percent of the Federal Poverty Level?
  - Would you support exemptions for people covered by Medicare and Apple Health and all people under 18?
  - Would you support coverage with no copayment, deductible, coinsurance, or any other form of cost sharing for all covered benefits under the trust?
  - Would you support an actuarial analysis of the funding needs for the trust with a detailed funding mechanism?

Discussion – Question 2

- In alignment with the goals of RCW 41.05.840 to establish a unified financing health care system for all Washington residents, what is the anticipated timeline, final deliverable scope, and necessary transition milestones for the Commission's recommendations to the Legislature—specifically regarding how this new system will be structured, governed, funded, and evaluated for total cost and potential savings compared to our current model?

Discussion – Question 3

- Has the Commission identified any potential sources of universal health care revenue, including the models proposed in the Washington Health Trust and Washington Health Security Trust, that it would recommend for additional development, or any which it believes should be dismissed?

Tab 3

Washington State Health Care Authority

Welcome, new members

- Kumhee Ro
- Naisha Williams

Washington State Health Care Authority

Universal Health Care Commission meeting minutes

June 18, 2026

Hybrid meeting held via Teams 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
Senator Annette Cleveland
Nicole Gomez
David Iseminger
Tao Kwan-Gett
Representative Lisa Parshley
Representative Joe Schmick
Mohamed Shidane
Ingrid Ulrey

Members absent

Bidisha Mandal
Omar Santana-Gomez

Call to order

Chair Vicki Lowe called the meeting to order at 2:03 p.m.

Agenda items

Welcoming remarks

Chair Lowe welcomed Commission members to the April 30 meeting. She welcomed Ingrid Ulrey of the Office of the Insurance Commissioner, who is joining the Commission upon Jane Beyer's retirement from state service.

Mary Franzen, Coverage Strategies Manager, Health Care Authority (HCA), conducted roll call. There were enough members for a quorum.

April 2026 meeting minutes

Commission members approved the April 2026 minutes by unanimous vote.

Public comment

Chair Lowe stated that since the last meeting, the Commission has received written comments from the public in support of the Commission's mission and encouragement to keep working toward the goal of universal health care for people in Washington. Comments included support for and opposition to adopting universal primary care as an interim solution, as well as questions about the details of the proposal. Other written comments described efforts to improve primary care in Washington and how best to spend OIC proviso funding.

The following members of the public provided comments during the meeting:

- Cris Currie, Health Care for All - Washington
- Shari McEvoy, Health Care for All - Washington
- Kathryn Lewandowsky, Whole Washington
- Jane Grafton, Whole Washington

Themes from the public comments include:

- Suggestion to replace Medicaid managed care organizations with an administrative service organization
- Encouragement to focus on completion of key design elements
- Request to study financing mechanisms for a universal system, possibly working with researchers in Washington and Colorado

Public comment begins at meeting recording time stamp 6:01.

State agency report outs and 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 provided updates:

- **Patty Kuderer,** Washington Office of the Insurance Commissioner (OIC)

- **Joan Altman**, Washington Health Benefit Exchange (WHBE)
- **Tao Kwan-Gett**, Department of Health (DOH)
- **Dave Iseminger**, HCA
- **Senator Annette Cleveland**

Insurance Commissioner Patty Kuderer shared that Ingrid Ulrey has joined OIC as a senior health policy advisor and now serves on the Commission. She thanked Commission members for their feedback and consideration of universal primary care as part of the ongoing work toward a universal health care system.

Other Commission members' updates described efforts to mitigate proposed health insurance rate increases and to provide coverage options for those who may lose Medicaid eligibility. Proposed 2027 premiums for plans that cover public employees were expected to be made public during the week of June 22, with a vote to approve in July. Looking ahead to the next six to 12 months, HCA will be implementing the more frequent Medicaid eligibility determinations mandated by HR1.

The Department of Health is monitoring travelers who may have been exposed to Ebola virus and providing appropriate testing, if necessary. To date, there are no cases in Washington. The department continues to monitor measles cases and is working with partners to increase adult vaccination. DOH is developing a four-year strategy to increase immunizations among people of all ages in Washington.

Senator Annette Cleveland reminded members that legislative work continues even when the Legislature is not in session. She noted an upcoming meeting of the Senate Health & Long Term Care Committee on June 30.

State agency report outs begin at meeting recording time stamp 15:06.

Workplan update and FTAC report out

Mary Franzen, HCA

Mary Franzen reminded Commission members of the two-part charge contained in RCW 41.05.840 and the status of core design elements.

Reporting on the May FTAC meeting, Franzen noted there were lengthy discussions among members about the provider reimbursement proposal and how best to use OIC proviso funds for further study. More information about both topics, including FTAC feedback, was provided in presentations later in the Commission meeting.

Find the full presentation and discussion in the **meeting recording (time stamp 35:38).**

Washington State Health Care Authority

Universal primary care workgroup report out

Ingrid Ulrey, Office of the Insurance Commissioner
Hiroshi Nakano, FTAC member
Mary Franzen, HCA
Jenn Scott, HCA

Mary Franzen described the universal primary care (UPC) model introduced during the Commission's February 2026 meeting by Jane Beyer. Materials describing the proposal in more detail were developed by OIC and included in the meeting packet as Appendix A.

Hiroshi Nakano, an FTAC member who is part of the universal primary care workgroup, shared information from the workgroup meeting. While acknowledging that the proposal has not yet been fully scoped, the workgroup expressed support for universal primary care. He noted UPC is a possible avenue for improving primary care access in Washington while a full universal system is being developed.

Commission members considered whether UPC fits into the conceptual framework of the Commission's ongoing work, either as a transitional solution or a foundational step on the way to a universal system.

Commission member Ingrid Ulrey noted that many of the key design elements for a full universal system also need to be fleshed out for a universal primary care system. She thanked Health Care for All – Washington for the many questions that provided that would help shape a universal primary care system.

Commission members' questions included how to measure the success of a universal primary care system, how such a system could reduce administrative burden or increase the primary care workforce, and where the proposal might fit into the Commission's workplan. Commission members requested that the workgroup meet again to address additional questions, with an anticipated vote on Sept. 3.

The presentation begins at meeting recording time stamp 41:39.

OIC proviso funding

Jenn Scott, HCA

Jenn Scott, senior policy analyst at HCA, presented three topics of study that could be funded by $250,000 in proviso funding allocated by OIC. The three ideas were developed over the course of discussions with the Commission, FTAC, HCA staff, and other stakeholders. FTAC members provided expressed their preferences and provided feedback.

Commission members voted to fund a study that explores the following: Test the hypothesis that spending 12 percent on primary care saves money elsewhere in the system. If so, how

much is saved? If funding allows, the Commission voted to explore different administrative structures that could support a universal system.

Presentation and discussion begin at meeting time stamp 1:35:00.

Provider reimbursement

Harrison Fontaine, HCA

Harrison Fontaine, senior policy analyst at HCA, described content and progress of the provider reimbursement proposal. Commission members asked several clarifying questions, including further detail on the effect and implementation of reference-based pricing.

Commission members voted on the proposal, but several members had left before the vote was held, and there was no longer a quorum. Commission members will consider the proposal at their September meeting.

The provider reimbursement presentation begins at meeting recording time stamp 2:18:19.

Closing comments and adjournment

The meeting adjourned at 5 p.m.

Next meeting

Thursday, Sept. 3, 2026, from 2–5 p.m.

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

Tab 4

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 June 5 – Aug. 20, 2026):
  - C. Currie
  - S. McEvoy
  - R. Shure / Health Care for All – Washington
  - T. Russell
  - R. Shure / Health Care for All – Washington
  - Health Care for All - Washington

Universal Health Care Commission
Written Comments

- 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**.

Financing Plans for Single-Payer in Other States
Prepared by Cris M. Currie August 2026

Washington: HCFA's Washington Health Securities Trust (WHST), formerly HB 1104 from 2019, has funding guidelines in Section 16. Whole Washington's SB 5233 for 2025 covers revenue in Sections 202 and 302. The suggested revenue sources in Gerald Friedman's 2021 Washington study are covered on pages 14 and 15.

Oregon: The UHC Task Force Report recommended revenue sources are on pages 42-45. The Governing Board's March 2026 report includes tentative financing options on pages 12-13.

New York: S 3425 The New York Health Act of 2025-26. Section 4, the financing section, starts on page 22. The July 2026 PERI Report highlights the NYHA with financing options on pages 15-20. An expanded report is due soon.

Massachusetts: HD 1228 or SD 2341, Medicare for All in Massachusetts for 2025. Section 19, the revenue sources section, starts on page 28, line 553.

California: AB 1900, The Guaranteed Health Care for All Act of 2026 does not specify a funding plan. A general statement on funding can be found in Chapter 7 (Funding) Article 3 (CalCare Financing) Section 100680,. A separate funding proposal was introduced in 2021 as ACA-11. Revenue sources are also discussed on pages 36-37 of the 2022 Healthy California for All Commission Report.

Colorado: HB 25-045 for 2025. The bill requires the Colorado school of public health to analyze model legislation for implementing a publicly financed and privately delivered universal health-care payment system for Colorado that directly compensates providers. Report is due Dec 31, 2026. The original CO initiative for single-payer healthcare can be found here and the funding mechanism is described in Section 9.

Illinois: HB 3780 for 2025. The Illinois Universal Health Care Act. Revenue sources are listed on page 8.

Minnesota: SF 1643 or HF 1774, the Minnesota Health Plan of 2021. The funding principles can be found in Article 4.

Michigan: HB 4407 for 2025 HB 4893 for 2023, The MIcare Act. Defers the financing plan for separate legislation, as yet to be introduced. Five financing principles are listed in Chapter 4, Section 402.

Ohio: SB 78 for 2025, The Ohio Health Care Plan. Section 3920.28 (page 35) lists possible revenue sources. Section 3920.22 (page 30) has an interesting section on emergency cost control measures.

Vermont: H 276 of 2021, Green Mountain Care. The most recent proposal for universal, single-payer healthcare envisions a gradual ten year introduction, starting with primary care. Several funding principles are listed in Section 4, page 20.

Rhode Island: S 0572 for 2023, RI Comprehensive Health Insurance Program. Financing is discussed starting on page 14 (Section 23-99-12). The initial revenue proposal is to be submitted once waiver negotiations have been deemed sufficient by the director. Taxation is outlined on pages 16-17.

South Carolina: H3726 for 2015. The Palmetto Comprehensive Health Care Act. Taxation principles are listed in Section 4.

Pennsylvania: HB 1688 from 2017. The PA Health Care Plan Act. Funding sources are addressed on pages 31-34. Efforts to establish a UHC Commission are ongoing.

Missouri: HB 395 for 2017. The Missouri Universal Health Assurance Program. Revenue sources via the income tax are covered in Section 354.804.

Iowa: HF 2352 for 2018. The Healthy Iowa Program. A trust fund is established in Section 22 but no revenue guidelines are specified.

New Mexico: SB 279 for 2019. The NM Health Security Act. Section 47 requires a legislative committee to conduct a fiscal analysis and project plan costs and a review of financing options.

Maine: HP 1026 of 2011. The Maine Health Care Plan. Bare minimum financing principles are on page 8. Revenue sources are not specified.

Maryland: HB 1186 of 2009. The Maryland Health Security Act. The bill envisioned creating a Fund Board to ensure that the revenue is sufficient to meet the need. No revenue sources are specified except "progressive payroll premiums." HB 329 from 2023 was a bill to establish a Universal Health Care Commission.

New Jersey: A2269 of 2018. The bill attempted to extend Medicare coverage to all state residents.

Utah: SB 300 from 2026. The Utah Cares Act. Section 26C-1-103 establishes a trust fund, but is rather vague concerning revenue sources, other than a possible Utah Health Care Tax. Its goal is to convert the public employee health plan to one available for all residents.

Virginia: HB 2271 from 2021 was a single-payer study bill proposal. Efforts to reintroduce the study bill are ongoing.

New Hampshire: HB 353 from 2024. A bill to establish an interstate compact for universal healthcare.

Hawaii: SB 1179 from 2025. Malama Care. Required the Hawaii Health Care Authority to develop a full business plan for single-payer healthcare.

Connecticut: HB 5340 from 2021 attempted to establish self-insured single-payer healthcare. HB 5485 from 2023 proposed a contract for a cost-benefit analysis of a possible HUSKY for All universal healthcare program. RB 7101 from 2025 also proposed a single-payer commission.

From: Shari McEvoy

Dear commissioners,

Today I am speaking as a WA resident and nurse Practitioner . I also volunteer with many organizations to bring publicly funded single payer universal healthcare for all to wa state and eventually or simultaneously to the USA.

The national nurses united has 250,000 members and are creating effective coalitions across the US to make Medicare for all a reality.

Here are some important updates about the insurance industry's early efforts to derail the giant strides the universal healthcare commissions and advocate agencies have made.

Please do not try to feed into their trap and lose focus on the UHCC mandates by diverting UHCC resources and focusing on universal primary.

The NNU is fighting against this billionaire funded plan to focus on primary care and ignore the elephant in the room. The exponential cost of healthcare!

Here are the real threats:

New billionaire-backed think tank is trying to divert momentum away from Medicare for All and into a package of reforms that will not come anywhere close to solving the problems of our for-profit health care system.

The Searchlight Institute was founded to fight back against the progressive movement and push (out-of-touch), "centrist" policies.

They recently released their "Making Health Care More Available" plan with the shiny promise of free primary care and very little under the surface. The People's Policy Project outlines just how badly this "alternative" falls short of Medicare for All — let us break it down for you.

Free primary care for all sounds good on paper, but it would only cover up to 1.8% of total out-of-pocket health care spending *at most* — drops in the bucket compared to what we need.1

Another proposal of theirs is to **restore Biden-era ACA subsidies, but only in states that have expanded Medicaid.** That only covers 2.4% of the U.S. population and leaves millions of people in ten states with higher prices than everyone else.2

People's Policy Project summarized this package perfectly:

“[The Searchlight plan] is clearly inferior to a Medicare for All type system on all the relevant policy axes. The point of this proposal seems to have been to generate a flashy headline about free primary care for all, which it did, but that headline policy amounts to almost nothing and the overall grab bag of proposals is internally contradictory, cruel in places, and simply not up to the task at hand.”

Searchlight would rather nibble around the edges than fight for true systemic reform that would guarantee health care for everyone. Their goal is to stifle the popular demand for Medicare for All and maintain the status quo in Washington by pushing half-measures that won't fully solve our deeply broken system.

Instead of several small fixes that could be stymied at every turn, we’re demanding the whole thing: Medicare for All and *nothing less! #1*

Here at the UHCC we have RCW mandates that direct the UHCC to full universal healthcare with the emphasis on primary care but includes specialty care hospitals as well.

“the UHCC is established to create immediate and impactful changes in the health care access and delivery system in wa state…

that provides coverage and access for all WA residents through a unified financing system…”

…b) a strategy for developing implementable changes to the states healthcare financing and delivery system to increase access to health care services, health coverage, reduce health care costs…prepare for the transition to a unified healthcare financing system…

Data sharing and transparency.

Cost containment and savings strategies. (see “removing the middleman from healthcare” to save millions to a billion dollars annually, and Friedman study)#2,3”

I would like the commission to show transparency and share the updated recommendations of the universal primary care sub committee work to date.

1. https://act.medicare4all.org/go/103444?t=3&akid=334484%2E1575290%2E2mVP97
2. https://wholewashington.org/studies/
3. https://pnhp.org/removing-the-middlemen-from-medicaid/

EVERYBODY IN, **NOBODY OUT.**

Health Care for All – Washington
PO Box 30506, Seattle, WA 98113-0506 • (206) 289-0685 • www.hcfawa.org

August 18, 2026

TO: Chair Vicki Lowe and Members of the Washington State Universal Health Care Commission

FROM: Ronnie Shure, President, Health Care for All - Washington

RE: Working together on legislation for the 2027 legislative session

I am writing today on behalf of Health Care for All - Washington (HCFA-WA) to invite the Universal Health Care Commission (UHCC) members and staff to work with HCFA-WA on legislation to set due dates for key components of a universal healthcare system and, if needed, clarify other aspects of the UHCC's work.

The original legislation that created the UHCC did not include any directions about either due dates for key universal health care components or a due date for the final proposal. Given the many changes the federal government is making, and is anticipated to continue to make, setting a final product due date seems out of reach. However, in our discussions with many legislators over the past several months, there is a desire to establish due dates for key components. We heard repeatedly that setting such timelines would provide the opportunity to increase the profile of the UHCC and its work, educate new members about the UHCC's goals and mission and keep legislators more engaged in the UHCC's work. This is particularly important given the many difficult choices facing the Governor and legislators when writing the 2027–29 biennial budget.

HCFA-WA has a history of supporting the work of the UHCC and we are excited about partnering with the UHCC on drafting legislation to set due dates for key components of the universal healthcare system. We will be attending the Advocates Roundtable at the September 3rd UHCC meeting and the regular UHCC meeting afterwards.

We plan to share an outline of the proposed legislation by the end of September and are asking now for time on the agenda at the October 15th UHCC meeting to discuss this outline. Please feel free to send me any questions at rushure64@gmail.com.

Sincerely,
Ronnie Shure

Outlook

Written comments for UHCC meeting on September 3, 2026

From Trish Russell <trish.russell50@gmail.com>
Date Thu 8/20/2026 4:51 PM
To HCA Universal HCC <HCAUniversalHCC@hca.wa.gov>

External Email

My name is Trish Russell. I am a retired family physician and am writing with my concerns about the UHCC's recent pivot from the evaluation of universal health care coverage options to an investigation of universal primary care as an initial step on the path to universal health care.

Health Care for All Washington, the Health Care is a Human Right's HUX comittee and Whole Washington have advocated that enhanced primary care be incorporated into a universal health care system, if possible, but that universal health care rather than a universal primary care system be prioritized. I agree with other individuals and with these organizations that universal health care is the more sensible and needed solution to our health care access problems.

In his letter to UHCC and FTAC dated May 28, 2026 regarding proviso funding proposals, FTAC member Roger Ganz argues that a universal primary care system is not the best way to get to universal health care and notes several practical considerations regarding the ability to achieve universal primary care at this point.

My understanding of the UHCC discussions about a possible universal primary care program in WA state is that it envisions a small pilot for patients with some form of existing coverage and will require the availability of services to be embedded in clinics for some of the desired enhancements. This can be difficult for large systems (I know this from briefly participating in the UW AIM center Collaborative Care Project) and will likely be impossible for most small independent practices even with increased compensation.

Should universal primary care become available to uninsured persons, they will lack coverage for events that primary care cannot provide. Primary care delivered in a medical home setting has been proven to reduce ER visits and hospitalizations but they will still occur. Expenses due to medically necessary testing and treatments are already major contributors to medical debt. Some will still die due to the inability to pay for these treatments without wrap around services.

Who pays for screening mammograms and colonoscopies if a person has primary care only? Who pays for lab work needed to monitor chronic care conditions? We can manage a lot but what is a person to do if they need a procedure, such as ablation for atrial fibrillation, are taken to the ER after falling off their roof? What will the options be if a cancer is detected?

In 2025, CMS began an enhanced primary care program trial. It is a patient opt-in, captitated program and early indications are that it is helpful in providing better care for high risk patients and better reimbursement for primary care for Medicare patients in health care systems that are able to offer the required integrated services. It would make sense for this type of trial with other payors in WA once we have universal access in place.

We have a severe primary care provider shortage. Tacoma, where I live and practiced, just lost a family medicine residency program. Even if it could be accomplished, do we really want to offer universal primary care before doing the work needed to increase the pool of PCPs? Universal health care that eliminates or reduces networks and decreases administrative burden would likely be a retention and recruitment tool for our state while the the Cost Board's Primary Committee continues to work on other options to increase the primary care work force here.

As a former PCP, I believe an eventual universal primary care system has merit and may be a worthy eventual goal. Given the increasing numbers of people who are losing coverage now, however, I believe working toward universal health care is the more

urgent priority. If it is possible to incorporate some elements of enhanced primary care - great - but Washingtonians deserve universal health care, in any event, sooner than later.

Patricia J Russell, MD. Retired Nov 2024.
Whole Washington Volunteer

HEALTH CARE FOR ALL – WASHINGTON
hcfawa.org

August 20, 2026

TO: Ingrid Ulrey, Senior Health Policy Advisory
Office of the Insurance Commissioner

FROM: Ronnie Shure, President
Health Care for All - Washington

RE: OIC Draft Legislation Ensuring Access to Primary Care

On behalf of Health Care for All – Washington (HCFA-WA), I want to thank you for the opportunity to comment on the Office of Insurance Commissioner's (OIC) discussion draft legislation, which seeks legislative authorization to study the design of a primary care financing and payment model design. As outlined in the draft proposal, OIC would submit an implementation plan by June 30, 2028, covering the elements outlined in Section 2 of the draft legislation.

As you know, HCFA-WA has been actively working with the Universal Health Care Commission (UHCC) to develop a design and financing of a state administered system that would provide comprehensive health care coverage for all Washington residents. As part of our work, we have followed OIC's presentations to the UHCC and its Finance Technical Advisory Committee (FTAC). We have also had the opportunity to meet with Commissioner Kuderer to discuss both our potential legislative initiative for the 2027 session and the Commissioner's thoughts on a universal primary care system as a step to achieve universal coverage. As part of these discussions, we share some initial thoughts and concerns on the universal primary care strategy with both the UHCC and Commissioner Kuderer (see attached letter).

Following our initial review and comments on the OIC discussion draft, and as outlined in our UHCC memo, we have three basic concerns with the OIC proposal. One is that OIC's proposal not be viewed by the legislature, UHCC or stakeholders as re-directing the UHCC from its basic mandate set forth in E2SSB 5399 to develop a universal system that provides the full array of essential health benefits to all residents. The second is that OIC's work be coordinated with the UHCC and Health Care Cost Transparency Board (HCCTB) work. Given our state's fiscal constraints, it is critical that OIC and the UHCC closely work together in addressing common issues, such as Medicare and ERISA participation, in these universal system designs.
Ingrid Ulrey

Our third area of concern is regarding the relationship between universal primary care program and the E2SSB 5399 universal system. It is our understanding that the universal primary care system is viewed as a foundation for the universal system. We hope that OIC's study would lay out the necessary steps from universal primary care to comprehensive coverage, including addressing the constraints of existing federal legislation.

We want to again thank you for the opportunity to review your discussion draft. Hopefully, our suggested revisions will be considered for future draft language. Finally, please know that HCFA-WA looks forward to working with you as OIC proceeds with its work in developing a universal primary care design.

Cc: Nico Janssen, OIC Senior Health Policy Analyst

Attachments

HCA-WA UHCC April 30th UHCC Agenda Items

EVERYBODY IN, NOBODY OUT.

PO Box 30506, Seattle, WA 98113-0506 • (206) 289-0685 • www.hcfawa.org

April 28, 2026

TO: Universal Health Care Commission Chair Vicki Lowe and Members of the Commission

FROM: Health Care For All Washington

RE: April 30th UHCC Agenda Items

Health Care For All Washington (HCFA-WA) is writing today to provide input on the following items listed on the April 30th UHCC agenda:

- Part 1 - The Office of the Insurance Commissioner's (OIC) Universal Primary Care Proposal
- Part 2 - The use of the $250,000 provided by the OIC to the Universal Health Care Commission (UHCC for research in to support the UHCC and its Financial Technical Advisory Committee (FTAC)

Part 1 - HCFA-WA appreciates the work that the Commissioner Kuderer and staff at the OIC have done to bring forward the idea of creating a Universal Primary Care system in Washington State. We expect that the OIC's next steps will be to create a study to delve deeper into how to address key aspects of how such a system could be created and how possible hurdles to creating it could be addressed. We are eager to learn more about the process for looking at how such a system could work through such a study. In regard to such a study, we suggest that the following questions be addressed (this is not intended as an exhaustive list):

1. If the goal is to have all primary care in the state of Washington be delivered through a separate system, how would the following health care insurance programs be made to participate?
    a. Medicaid
    b. Medicare
    c. ERISA Plans
    d. CHAMPUS
    e. Other plans not currently under state purview
2. Will the primary care only system be a state run system? Would parts of running it be contracted out to an ASO? Or is some other mechanism being considered?
3. What funding mechanism be used to pay for both the delivery of primary care services and the administrative costs of the new system?
4. Will the state be the sole risk bearing entity or will primary care providers share in that?

5. Is there a definition of primary care services that the proposal will use or will a new definition/list of services be developed?

6. What will be the impact of health insurance premiums if primary care services are removed from what they offer, since primary care accounts for small part of where the costs are?

7. What is the expectation on how such a model will make health care more affordable and less fragmented?

8. How will this proposal address the current shortage of primary care providers in our state, particularly in the more rural areas?

9. How will the payment model account for the different margins that large clinics could have, versus smaller clinics and individual practitioners?

10. Is there an intent to expand the definition of primary care to include behavioral health benefits in some way? The AIMS model is based on creating coordinating care teams for individuals with high level mental health issues, is the idea to expand that through this new, separate primary care system?

11. How will care coordination happen between primary care providers currently in coordinated health delivery systems? For example, if a primary care physician in the new system needed to refer a patient to a specialist, what process would need to be in place for that to occur?

12. Will this proposal also include strategies for addressing how to get more primary care providers, to address the current shortage?

13. How will the new system that pays primary care under capitation payment arranges address the financial incentive to over-refer challenging cases to specialist?

14. Will prior authorization still exist?

15. Will primary care providers be paid the same regardless of their patients' health insurance?

16. Given that under the RBRVS payment system commonly used to pay physician, would the payment system be rebalanced to pay primary care relative more compared to specialty services?

17. Will capitation or bundled payment systems employ a risk-adjustment mechanism to address more challenging patients?

18. Will other types of providers including ARNPs, physician assistances, and nurse practitioners participle as primary care providers?

19. How would Medicare/Medicaid FQHC and RHC entities be treated in the universal primary care system?

20. Will the universal primary care system employ quality metrics (e.g., HEDIS, CAPS) to monitor the system?

21. Will individuals be able to choose their primary care provider in the new system?

22. Will individuals be able to change their primary care provider in a plan year, or are they locked in for a given period?

Part 2 - HCFA-WA is also asking the UHCC consider the following options for how to use the $250,000 graciously provided by the OIC, to support UHCC/FTAC research needs:

1. Complete the actuarial design analysis to allow the commission to complete a set of benefit designs for the legislature. The Milliman model previously done, needs to be revised to model to the Uniform Medical Plan and Essential Health Benefits benchmark plan for all enrollees regardless of income and to do premium estimates at 100%, 95%, 90% and 85% actuarial value.

2. Economic modeling to estimate the type and amount of revenue/tax sources needed for a universal health care system. Including analysis on existing funding levels and sources for health coverage in our state, including ERISA, Medicare etc.

3. Modeling for strategies to unify our state health care programs to lay the ground work for a universal healthcare system in WA state. (for example: making all plans at the Health Benefit Exchange public option plans).

Thank you for considering these options,
Ronnie Shure, President
Health Care for All - Washington

Tab 5

Washington State Health Care Authority

Universal primary care workgroup

Washington State Health Care Authority

Overview

- Updated OIC discussion draft (Appendix A)
- OIC update
- Potential vote

Primary care agency request bill – update

Universal Health Care Commission

Ingrid Ulrey, Senior Health Policy Advisor

September 3, 2026

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Update – Ensuring Access to Primary Care

- OIC request legislation for 2027 addresses the problem of poor access, long wait times and underinvestment in primary care.
- It directs the OIC, in consultation with HCA and stakeholders, to develop a new multi-payor common fund and prospective payment model for primary care.
- A report and proposed implementation plan, which would begin with markets under state jurisdiction, would be due to the legislature by 6/30/2028.
- Planning funds would come from OIC's regulatory account.

Stakeholder Outreach

The proposed legislation has been informed by discussions with a broad range of stakeholders including:

- ✓ Consumers advocates
- ✓ Primary care providers
- ✓ Hospital and specialty care providers
- ✓ Business and labor representatives
- ✓ Health insurance carriers
- ✓ State agency partners
- ✓ Legislators
- ✓ Leaders from other states

Engagement with UHCC

- OIC's request legislation is independent of UHCC's work plan.
- It compliments, but doesn't seek to alter, UHCC work to develop comprehensive universal health care system.
- OIC welcomes ongoing feedback and engagement with UHCC and will keep the commission regularly updated on progress.

Potential vote

- **DRAFT:** The Commission supports OIC's design and study of a primary care financing and payment model through which timely, comprehensive primary care could be covered outside the traditional insurance-based benefits design. The Commission requests regular updates and will consult with and inform the OIC and other stakeholders on this topic, as appropriate.

  Note: The workgroup suggests OIC use its seat on the Commission as the vehicle for updates.

Tab 6

Washington State Health Care Authority

Workplan update

Universal Health Care Commission

Universal Health Care Commission

- As directed by the Legislature (RCW 41.05.840), the Commission must:

Transitional solutions

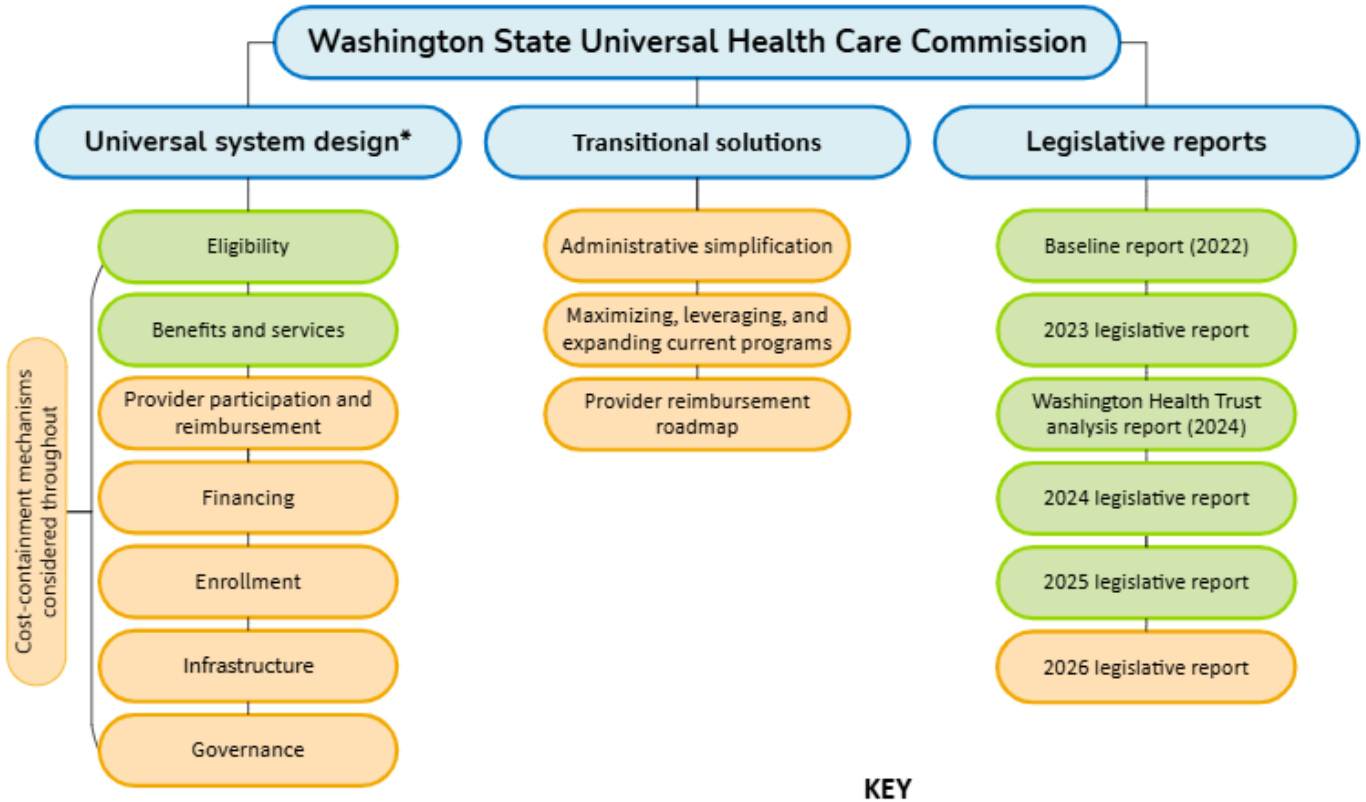
"…create immediate and impactful changes in the health care access and delivery system in Washington and to prepare the state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system once the necessary federal authority has become available."

Universal system design

Universal Health Care Commission

- RCW 41.05.840 lists “inventory of the key design elements of a universal health care system” (Section 7(c))
- Key design elements are reflected in the workplan
  - Among the key design elements is a “unified financing system including, but not limited to, a single-payer financing system”

Workplan status



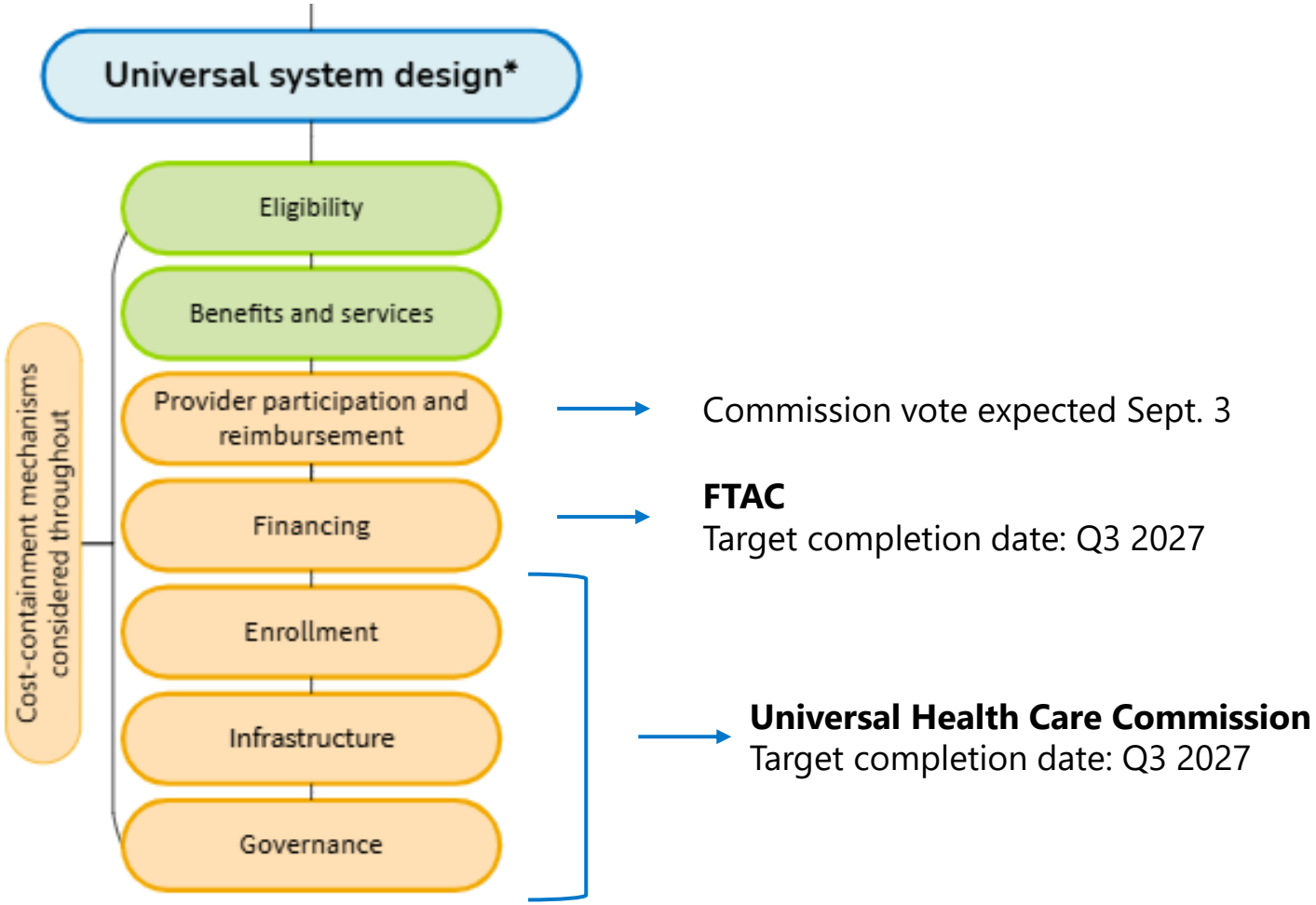
*Health care quality, health equity, and health disparities will be discussed and considered during each of the core universal system design components.

KEY

- Completed/straw proposal adopted
- In progress/ongoing
- Not yet started

Last updated August 2026

Workplan status



On today's agenda:

- Provider participation and reimbursement
  - Proposal
- Financing
- Enrollment, infrastructure, and governance

Draft 2026 annual report

- Included as Appendix E
- Key dates
  - Please submit feedback to HCAUniversalHCC@hca.wa.gov by Sept. 17
  - Oct. 15: Revised report will be included in October meeting packet for final approval
  - Nov. 1: Submit to Legislature

Universal Health Care Commission meeting

We are currently on a short break

Washington State Health Care Authority

Tab 7

Washington State Health Care Authority

Finance Technical Advisory Committee (FTAC) report out

August 2026 FTAC meeting recording & materials

Washington State Health Care Authority

Overview

- Public comment
- Provider reimbursement
- Financing

Public comment

- Public comments begin at time stamp 02:14
  - Support for creating a health trust to fund a universal system

Provider reimbursement

- Discussion begins at time stamp 22:29
- Updates to provider reimbursement proposal and FTAC suggested roadmaps
  - Proposal included as Appendix B
  - Roadmap included as Appendix C
- **FTAC voted to approve the provider reimbursement proposal and submit it to the Commission for consideration and approval**
  - Later on today's agenda

Financing

- Discussion begins at time stamp: 1:09:56
- Preliminary discussion to define scope
  - Principles and functions of a universal financing system
  - Evaluation criteria
- Expecting an iterative process with Commission
- Looking to other states for examples
  - Started with Oregon
  - Staff drafting brief on key features and principles in other states
- Formed FTAC workgroup to focus on financing

Financing principles in select states

- Review of state reports on universal health care*
  - OR, CA, VT
- Survey of common principles (states)
  - Stable and sufficient: able to withstand fluctuations and generate predictable revenue (OR, CA, VT**)
    - Scalable, adequate, permanent: revenue is sufficient to meet implementation needs and does not sunset
    - Broad-base: broad tax with a low rate is preferable
    - Multiple streams: revenue plan must cover costs of operation, start up, reserves, and transition
  - Defensible: compliant with federal law, including ERISA (OR, CA, VT)
  - Equitable (OR, CA, VT)
    - Progressive: tax increases with taxpayers' ability to pay
  - Understandable: easy to understand or explain (OR, CA, VT**)

*Select reports: Pathways to a Unified Health Care Financing System in CA, Comprehensive Plan to Finance and Administer a Universal Health Plan in Oregon (draft), The Vermont Option, Achieving Affordable Universal Health Care . Privately commissioned reports were not included in this analysis. CO has a publicly commissioned, privately funded report due Dec 31, 2026

** Authors note difficulty with public understanding of the financing plan.

Common financing considerations

- Dedicated trust
- Preserving current revenue streams
  - e.g., Medicare and Medicaid, payroll tax exemption for employer sponsored insurance
  - Aligning coverage
    - Primary or secondary coverage
      - E.g., Primary coverage: the universal plan would serve as the first payer for covered services.
  - Cost sharing
    - Premiums, deductibles, copay
- Savings assumptions
  - Administrative savings, provider reimbursement, and drug savings

Questions?

Washington State Health Care Authority

Tab 8

Washington State Health Care Authority

Provider reimbursement proposal

Universal Health Care Commission

Provider reimbursement overview

- Review of work products:
  - Proposal (Appendix B)
    - Guiding principles
  - Roadmap draft (Appendix C)
- Proposal vote

Provider reimbursement work products

Proposal* (design element)	**Implementation roadmap** (transitional solution)
• Recommendations for **payment mechanisms** that could be implemented on a small scale • **Approaches for subsequent expansion** • Recommendations for **provider participation and data** collection/use	• Recommendations for **implementation pathways** (i.e., transitional solutions) to universal reimbursement design • **Sequence** mechanisms and describe expansion • **Evaluation** of payment mechanism impacts • Description of **implementation benefits and what success looks like**

- *Note: FTAC and UHCC previously approved provider reimbursement guiding principles, which will be included as an appendix to the Proposal.

Potential vote

- Proposal
  - FTAC recommended Proposal to the commission at their August meeting
- FTAC completed a proposed transitional solution: the Provider Reimbursement roadmap
- FTAC focus has shifted to financing
- Approval of Proposal allows for edits and additions later in the process

Questions?

Washington State Health Care Authority

Tab 9

Washington State Health Care Authority

Enrollment, infrastructure, and governance

Universal Health Care Commission

Overview

- Background
- Foundational questions

Background

- Commission decided to be the lead entity addressing enrollment, infrastructure, and governance
- Discussion during February meeting
  - Past slides in Appendix D
  - Joined by Dr. Miriam McDonnell, Oregon Universal Health Plan Governance Board
- Raised foundational questions

Foundational questions

- Will the universal system be single or multi-payer?
- Do commercial carriers play any role?
- Who bears the financial risk?

Questions to the Commission

- Is this the right place to start?
- What will help you answer these questions?
- Are these still the right questions so we can embark on the three design elements?

Tab 10

Washington State Health Care Authority

State agency reports outs & Commission member updates

Washington State Health Care Authority

Thank you for attending the Universal Health Care Commission meeting

Washington State Health Care Authority

Appendix A

Washington State Health Care Authority

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Ensuring Access to Primary Care

2027 State Legislative Proposal, Concept Paper as of 8/25/2026

Background

This legislative proposal addresses the problem of poor access, long wait times and underinvestment in primary care in Washington state. Even with insurance, many Washingtonians struggle to find a primary care provider who will accept them into their practice. And for the growing number of people losing their health coverage due to federal policy changes, this access gap is even more severe.

The research is clear, primary care is the fundamental building block for keeping people healthy and containing health care costs.[i] In 2022, the Washington state legislature established a primary care spending goal of 12 percent of total medical expenses, and yet, spending continues to hover around 4 percent.[ii] To get our state on track to meet this goal and fortify our primary care system for the future, this proposal recommends the development of a new financing and payment model.

This model would replace complex fee-for-service insurance billing with a multi-payor financed common fund that would pay providers based on a per member per month payment for each patient attributed to their practice. As existing innovations demonstrate, administrative simplification and predictable, prospective payment enable providers to spend less time on paperwork and more time with patients. Moving in this direction will lay the foundation for Washington to ensure access to advanced primary care for all Washingtonians.

Proposed Bill Summary

The proposed legislation establishes the following goals for a multi-payor financed common fund and prospective payment model for primary care in Washington state:

- Ensure access to timely, high-quality, comprehensive primary care and preventive health services for Washington residents;
- Simplify administrative requirements for primary care providers and practices;
- Improve the health of residents and reduce their need for hospitalizations and emergency department visits.

It directs the Office of the Insurance Commissioner (OIC) to work in collaboration with the Health Care Authority and in consultation with stakeholders to design and develop this model and submit a report and proposed implementation plan to the legislature by June 30, 2028.

This initial work would be funded from the OIC's regulatory account.

For more information contact: Ingrid Ulrey, Senior Health Policy Advisory, Ingrid.Ulrey@oic.wa.gov

Primary Care System Challenges

Poor access, fragmented care and high costs.

- In Washington, approximately one out of every five adults lack a usual source of primary care, which means they lack a regular doctor, clinic or health center where they can consistently go for medical advice or routine check-ups.[iii]
- Up to one out of every 10 Americans now name an urgent care center, a "minute clinic" or walk-in pharmacy as the place they go for care.[iv]
- Having a usual source of primary care is associated with 54 percent lower total health care expenditures for adults managing a chronic condition.[v]

Provider burnout and workforce shortages.

- More than 5 million Washingtonians live in an area with a shortage of primary care health providers.[vi]
- Primary care providers have low compensation compared to other providers and experience increased burnout and reduced job satisfaction, with 44% identifying administrative burden as the primary reason for their distress.[vii]
- Washington is failing to prepare enough primary care providers for the future, and hospitals are cancelling family residency slots to focus on more lucrative specialties. [viii]

High-cost hospital care is driving unsustainable cost growth.

- Timely access to comprehensive primary care improves chronic disease management and reduces emergency room visits and hospitalizations.[ix]
- Approximately 40 percent of all Emergency Department claims in Washington state are "primary care sensitive" and could be avoided with better coordinated primary care.[x]

Designing a Model for the Future

In Washington, some large employers are moving away from using traditional insurance and paying directly for primary care[xi], and a growing number of Washingtonians are choosing to enroll in Direct Primary Care practices.[xii] These models replace traditional coding, billing, and prior authorization processes with prospective, direct payments to the practice. While these private sector innovations show promise in improving patient outcomes and reducing emergency department and hospital care costs, they are unavailable or unaffordable to most Washingtonians.

To take this innovation to scale, state health policy leadership is needed. National thought leaders recommend that states consider pooling existing resources from multiple payors through the establishment of a common fund as a key strategy to simplify payment and sustain primary care as a more universal, common good.[xiii] This approach would ensure access to primary care, while leaving in place traditional insurance which would "wrap around" and continue to cover all other benefits. Moving in this direction would put Washington on track to fortify our primary system, contain costs and ensure access to primary care for all Washingtonians.

Key areas to consider

The development of the new financing and payment model will require research and analysis, economic modeling and deep stakeholder engagement across a broad range of issues, including:

- **Governance** – Structure and process for establishing a Board of Directors and identification of oversight authority and requirements.
- **Financing** – Identification of revenue sources including existing resources attributed to primary care, and long-term savings generated by the model. Process to consolidate diverse revenue streams into a single financial repository and maintain solvency reserves.
- **Enrollment** – Consumer eligibility, enrollment, and attribution or assignment of member groups or individual consumers to participating providers or practices.
- **Provider participation requirements** – Definition of eligible primary care providers, credentialing, data sharing agreements and quality metrics.
- **Scope of benefits** - Primary care covered services and delivery models to incorporate, including consideration of advanced primary care, behavioral health integration and team-based care.
- **Reimbursement** – process for developing a prospective, per member, per month prospective payment structure, and risk adjustment or reinsurance programs;
- **Administrative simplification** - consideration of ways to simplify, reduce or eliminate traditional administrative requirements such as coding, billing, claims, prior authorization, credentialing, contracting, and reporting;
- **Wraparound insurance integration** – process and procedure to define how the new model would interact with health insurance markets and public coverage programs, prevent cost shifting and support care coordination.
- **Primary care workforce strategies –** how the model, and other state policy efforts, could improve the supply of primary care providers.

Sample implementation plan

A recommendation for phased implementation of the new model across health insurance markets and coverage programs would account for necessary federal approvals. Sample phrases:

- Phase 1 – Develop the organization and IT systems
- Phase 2 – Launch geographic pilots
- Phase 3 – Expand into state jurisdiction markets
- Phase 4 – Open to small and large group market participation
- Phase 5 – Open to beneficiaries of federally administered programs

Footnotes

[i] Physicians Foundation, https://www.milbank.org/publications/investing-in-primary-care-the-missing-strategy-in-americas-fight-against-chronic-disease/

[ii] Health Care Cost Transparency Board, https://www.hca.wa.gov/assets/program/cost-board-primary-care-meeting-20260423.pdf

[iii] Milbank Memorial Fund, https://www.milbank.org/primary-care-scorecard/

[iv] Health Care Science, https://www.milbank.org/primary-care-scorecard/

[v] Milbank Memorial Fund, https://www.milbank.org/primary-care-scorecard/

[vi] Health Resources Services Administration, https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/State-of-the-Primary-Care-Workforce-2025.pdf

[vii] Commonwealth Fund, https://www.commonwealthfund.org/publications/surveys/2025/nov/causes-impacts-burnout-primary-care-physicians-10-countries

[viii] Seattle Times, https://www.seattletimes.com/seattle-news/health/providence-swedish-to-cut-residency-slots-citing-looming-medicaid-cuts/

[ix] Physicians Foundation, https://www.milbank.org/publications/investing-in-primary-care-the-missing-strategy-in-americas-fight-against-chronic-disease/

[x] WA Office of Financial Management, https://ofm.wa.gov/wp-content/uploads/sites/default/files/public/dataresearch/researchbriefs/brief115.pdf

[xi] Boeing Primary Care+ FAQs, https://boeingprimarycare.com/wp-content/uploads/2025/03/Primary-Care-Puget-Sound-FAQs_031725.pdf

[xii] WA Office of the Insurance Commissioner, https://www.insurance.wa.gov/sites/default/files/2025-11/direct-practices-report-2025.pdf

[xiii] Journal of American Medicine, https://jamanetwork.com/journals/jama/article-abstract/2849331

Appendix B

Washington State Health Care Authority

FTAC Provider reimbursement proposal

- Draft proposal (Appendix C) current sections:
  - Summary & Background
  - Payment mechanisms
    - Price and spending regulation
    - Leveraging state purchasing power
  - Phased implementation approaches
  - Provider participation
    - Incentives during phased implementation approach
    - Mandatory participation in payment mechanisms
  - Oversight and data collection
    - Data collection and governance
    - Data use and payment system oversight
  - Alignment with ongoing work

Health Care Authority
Universal Health Care Commission

Provider participation and reimbursement

DRAFT

Notes

Committee: Finance Technical Advisory Committee (FTAC)
Commission/committee lead(s): Roger Gantz, Pam MacEwan, Bob Murray, Eddy Rauser, and Sarah Hughling.
FTAC initial review: March 19, 2026
FTAC approved: August 6, 2026

Commission review: April 30, 2026

Commission adopted: [Month Day, Year]

Proposal ID: 2026-03
Core design element/milestone: Provider Reimbursement and Participation

Summary

This proposal includes recommendations for provider reimbursement and participation under a universal health care delivery system in Washington state. Creating a universal health care delivery system in the state will require development of state-regulated provider reimbursement mechanisms to constrain costs driven by growth in provider prices, administration, and overall spending. Accordingly, the development of mandatory (required and enforced by state law) payment mechanisms is essential in advance of and during the implementation of a universal system. In parallel, the state should strengthen and leverage its purchasing power to take the lead in transitional cost-containment strategies. These strategies are exemplified in the recent enactment of reference-based pricing for certain public employees.

It will take time to sort out the key components of a universal system. In the meantime, the state should continue to pursue the implementation of regulated health care price and spending mechanisms. This will improve stability and affordability health care in the short term, while enhancing long term prospects for universal financing. Considerations of cost containment have been woven throughout the Commission's design of a universal system, and efforts to contain costs inform these recommendations as well.

Regardless of the specific payment mechanisms chosen, this proposal recommends a gradual approach to implementation. Large-scale changes implemented simultaneously could prove too disruptive to the health care system. Rather, the Commission recommends implementing new

payment mechanisms incrementally, with gradual application to different provider settings, services, or patient populations. These initial recommendations fall within the realm of transitional solutions – part of the Commission's charge – and will inform later design decisions for a universal system.

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. Provider reimbursement and participation design is one of the key elements required to prepare the state.[1]

Beginning in late 2025, the Commission and its Finance Technical Advisory Committee (FTAC) formally began work on provider reimbursement as a core design element of a universal system in Washington. The Commission adopted a set of guiding principles (Appendix A) on April 30, 2026. These guiding principles informed this proposal and may serve future regulatory decisions in a universal system. Recommendations are grouped by how provider payments are structured (payment mechanisms), and how to incrementally expand payment mechanisms to additional circumstances (implementation approaches). Specific pathways that detail how specific payment mechanisms may be implemented are included in the implementation roadmap (Appendix B).

Recommendations

The Commission recommends implementing gradual changes that can be evaluated over time, adjusted as necessary, and expanded as appropriate. This approach helps ensure sustainability by avoiding sudden, large-scale changes that could disrupt care. Payment mechanisms described below may be first implemented in narrow market segments (e.g., state agency purchasing), allowing for opportunities to refine and improve an approach before recommending large-scale adoption and/or making final recommendations for a universal system. The Commission recommends that participation be mandatory for the included providers and care settings.

Payment mechanisms

Price and payment regulation

A key issue both in Washington and nationally relates to distortions embedded in the Medicare fee-for-service physician fee schedule. These distortions result in underpayment for certain services and care settings (e.g., primary care, behavioral health care, and rural or underserved areas, among others). This fee schedule is also the basis provider payments from Medicaid, Medicare Advantage and most commercial insurers[2]. As noted in Principles 2 & 5, a payment

[1] RCW 41.05.840

[2] An American Medical Association (AMA) survey of 127 public and private payers found that 77% use the Medicare RBRVS to set their payment rates. (American Medical Association. *Medicare RBRVS: The Physicians' Guide 2013*. Chicago, IL: American Medical Association; 2013)

DRAFT

system should rebalance payments toward traditionally under-resourced services and settings while improving affordability through cost containment[3].

To achieve these goals, the Commission first looks to an initiative already in place in Washington as both a possible payment mechanism and an example of how to begin a phased approach. Beginning in January 2027, under RCW 41.05.028, payment rates for certain public employees at most hospitals in Washington will be based on a percentage of Medicare reimbursement rates[4]. That payment mechanism, known as Reference-Based Pricing (RBP), can also be used to correct for underpayments by setting a floor for payments to other providers and settings. As RCW 41.05.028 is implemented, Washington will utilize this feature as well by mandating a price floor for primary care payments in the state's Public Employee Benefit (PEB) and State Employee Benefit (SEB) programs.

A payment approach that may be implemented as a progression from RBP is Out-of- Network (OON) payment caps for hospital care or other services provided to commercially insured patients. The use of RBP caps (tied to a percentage of Medicare payments) for all OON hospital services in the state could address the issue of surprise hospital bills for patients. More importantly, OON price caps is a low-intensity way of creating limitations on hospital prices paid by commercial insurance companies. Price caps for all OON hospital services for the commercially insured would confer additional pricing leverage to commercial insurers in their negotiations with hospitals and health systems by moderating the consequences of the health system leaving the network. Effectively, this would cap in-network prices at or below the OON price cap[5]. This approach could provide the state with an interim step in extending aspects of the current RBP mechanism[6], without imposing RBPs on all hospital services in the state, while still imposing significant pressure on commercially negotiated hospital prices.

To address volume-based incentives that impact traditional fee-for-service (FFS) mechanisms (including RBP and OON caps), payment mechanisms that expand the bundle of services being paid for – such as bundled payments and hospital global budgets (HGB) –should be considered. Bundled payments are structured to cover all services associated with a diagnosis or procedure over a specified period. Service bundles can vary in breadth and may cover services provided by an entire care team. This feature makes conditions that require care coordination, such as specialty psychiatric or maternal care, good first candidates for this type of payment[7]. Bundled payments for certain psychiatric and obstetric care services are currently implemented in Washington State[8]. Potential impacts of this payment mechanism, including on administrative

[3] See Appendix A: Provider reimbursement guiding principles for detail on goals of a payment system. Additional consideration for specific settings (e.g., rural and underserved regions) can be found in Appendix B: Provider reimbursement roadmap.
[4] RCW 41.05.028 contains exemptions for certain care settings, including pediatric and rural hospitals.
[5] Robert Murray and Jack Keane, *Setting Caps on Out-of-Network Hospital Payments: A Low-Intensity Regulatory Intervention for Reducing Hospital Prices Overall* (Commonwealth Fund, May 2022). https://doi.org/10.26099/tvdr-1w88
[6] RCW 41.05.028 sets OON rate caps for most hospitals that are out of network for public and school employees.
[7] Jeroen N. Struijs et al., *Bundled-Payment Models Around the World: How They Work and What Their Impact Has Been* (Commonwealth Fund, Apr. 2020). https://doi.org/10.26099/936s-0y65
[8] See the Collaborative Care Model and Global Obstetrical Care in Apple Health billing guides.

complexity, patient selection, and the financial stability of low-resource providers, should be monitored during implementation.

Another payment mechanism that may be considered for these incremental steps is hospital global budgets (HGBs). Hospital global budgets establish a predetermined amount paid to hospitals for all inpatient and outpatient services. There are two different versions of HGBs: 1) HGBs that are largely fixed and set both a hard cap and a hard floor on annual revenues charged and realized by a hospital; 2) Flexible HGBs, which make use of a Volume Adjustment System to reduce the incentives of fee-for-service payment systems that induce hospitals to increase volumes of care unnecessarily and fund hospitals' fixed costs when volumes decline. The State should consider the advantages and disadvantages of both HGB approaches. These budgets should be mandatory for all payers but certain types of hospitals may be exempt initially. Careful consideration should be made regarding criteria for base payment rates, which may be adjusted based on factors like actual patient volume. When implemented effectively, HGBs allow for prospective, predictable payments that can stabilize hospitals currently subject to unpredictable revenue, fluctuating patient volumes, and a wide range of prices.

Leveraging state market power

To leverage the role of the state purchasing to advance cost containment goals, the state could expand its use of open competitive contracting. Unlike traditional, limited competition contracting where an organization invites only prequalified entities to submit a bid, under open competitive contracting, the state establishes specifications (e.g., quantity, quality), then seeks competitive bids from all licensed bidders. This mechanism can be used for a variety of health care management services, including managed care organization (MCO) procurement, where organizations respond to the invitation and are selected to provide coverage for defined period(often three to five years). The state retains policy control over the service, while the contractor produces the service under public oversight. Critically, the state's purchasing leverage may be expanded and linked, improving the prospects of cost containment with contracted carriers.

Phased implementation approach

Regardless of the payment mechanism selected, the Commission recommends starting with an identified population and/or care setting before applying that mechanism to additional enrollees or care settings. Lessons learned from initial implementation will inform and refine future initiatives. Before recommending the expansion of any approach, the Commission will ensure that the mechanism supports a system with unified financing and promotes equitable access to care.

Possible ways to expand a given approach include, but are not limited to:

- Applying the mechanism to an additional set of providers
- Applying the mechanism to additional care settings
- Applying the mechanism to additional services
- Applying mechanism to a greater proportion of provider budget

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- Consolidating and extending state market power.

Provider participation

Reimbursement systems should be designed to make billing and payment processes as simple, consistent, and transparent as possible. Eventually, in a universal system, the Commission envisions a standardized process that will reduce administrative burden on providers.

Reimbursement changes and administrative simplification will incentivize some providers to participate in the aspects of the system where these changes are first implemented. Beyond administrative simplification, potential advantages to providers include greater stability in rural and underserved areas, predictable and prospective payments, increased reimbursement for currently underfunded services (e.g., primary care and behavioral health), and greater satisfaction among clinicians[9]. Ultimately, these incentives may increase participation and contribute to stronger provider networks, especially where services were previously underfunded.

While provider incentives may reinforce the effect of transitional payment mechanisms, mandatory provider participation in payment models is necessary to achieve cost containment in most contexts. The history of payment initiatives and Value Based Payment models has demonstrated that voluntary payment initiatives (such as ACOs or other VBP strategies) have not effectively controlled the growth of provider prices and spending. This is because providers with the highest prices and spending are allowed to opt out. For this reason, voluntary models do not have the ability to enforce limits on price and spending growth in a comprehensive way.

Data collection and oversight

The Commission recommends that the governing body that oversees the universal system collect data from payers and providers as different reimbursement mechanisms are implemented. This governing body should establish principles for people-centered data governance that furthers accountability, transparency, and public trust. Such principles may address data collection impact, ownership/access, consent, secondary use, and individual rights.

Data collection should be as complete as possible while minimizing impact on reporting entities. Currently, several separate and complementary data streams provide an incomplete picture of health care spending. Payment-relevant data currently collected by these separate systems should be incorporated into the universal system's All Payer Claims Database (APCD)[10]. This additional data should include non-claims spending and more complete geographic, race,

[9] Current provider reimbursement models can contribute to clinician burnout and moral injury, in part through overreliance on financial incentives to promote quality care.

[10] Payment-related data is currently distributed across multiple operationally distinct systems, none of which was designed for cross-payer analytic use. Realizing the full value of a universal APCD requires a data governance infrastructure that integrates these data streams into a single harmonizing source capable of supporting expenditure forecasting, rate-setting, research, and public transparency that could support the use cases enumerated in this section.

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ethnicity, and language information for patients. A health care entity registry should be developed to analyze how spending accrues to relevant groups.

Data could be used to:

- Inform rate setting, priority-setting, benefits design, payment mechanisms, and resource allocation.
- Determine whether elements of the current payment mechanism, such as base rates, need to be adjusted[11]
    - Adjust identified elements accurately and fairly.
    - Identify the need for exceptions or modifications to preserve access to care.
- Determine appropriate expansion of a payment mechanism.
- Determine whether entities that fall under a reimbursement mechanism are shifting care or altering billing practices to avoid cost containment measures.
- Oversee the payment system, including understanding the sources of payment and access variation
    - Understand how critical measures (utilization, access, costs, outcomes, social determinants, commercial determinants, etc.) vary across payers, delivery systems, and services.
    - Integrate information across reporting systems to provide a comprehensive source for system evaluation.
    - Detect and manage high-need/-cost members and provider services, including instances of financial waste/fraud/ abuse.
- Evaluate and set health system performance measures goals for public reporting.

Alignment with ongoing work

The Commission will continue to monitor and learn from other ongoing initiatives related to provider reimbursement, health care costs, and delivery models. Those efforts include:

- Health Care Cost Transparency Board
- Prescription Drug Affordability Board
- Rural Health Transformation Program
- Medicaid Transformation Project (Washington's Medicaid 1115 waiver)
- Traditional Health Care Practices waiver
- Value-based Purchasing
- Office of the Insurance Commissioner
- Washington Health Benefit Exchange
- Department of Health
- Other states' past and current experiences with cost boards, universal health care commissions, and alternate payment models including Massachusetts, Vermont, Oregon, Maryland, and California.

[11] E.g., risk adjustment and rate cell analysis.

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Draft Review History

FTAC feedback | March 19, 2026

- Consider adding bundled payments to payment mechanisms
- Add a broad statement about why the memo- and aspects of others- focuses on transitional solutions
- Further explain and connect what is meant by 'payment mechanisms' and 'implementation approaches'
- Consider adding a standalone section describing the proposed universal, direct primary care transitional mechanism/approach

UHCC feedback | April 30, 2026

- Concern that reference-based pricing or HGB could destabilize rural hospitals.
- Request to clarify how consolidating and leveraging purchasing power/open competitive contracting differs from existing strategies
- Request to clarify what consequences an opt out provision would have re: mandatory vs. voluntary provider participation
- Inclusion of what does success look like (evaluation criteria) for payment mechanisms
- Inclusion of contract durations and notification periods for provider predictability
- Review of unsuccessful related legislation to address issues related to provider reimbursement

FTAC feedback| May 14, 2026

- Request to include other relevant data systems (e.g., Provider One) and how they may be integrated with the APCD.
- Concern that current draft suggests RBP is the singular solution to fee schedule distortions.
- Need to address how payment policies (especially in rural and low-volume settings) address problems and incentives with changing patient volumes. This can be done in the Roadmap if the Proposal is sufficiently clear and footnoted.

FTAC Vote Approving Draft | August 6, 2026

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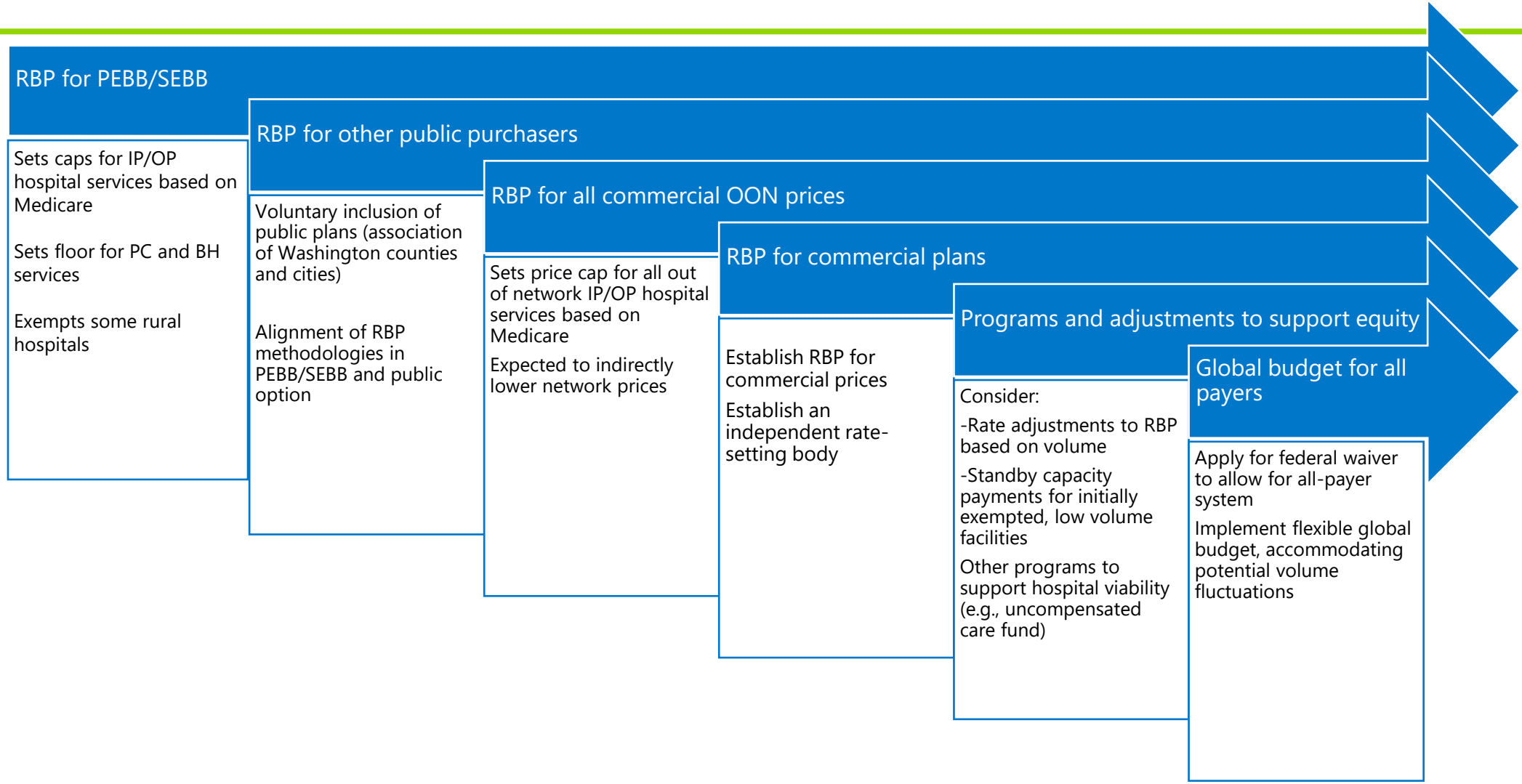
Appendix C

Washington State Health Care Authority

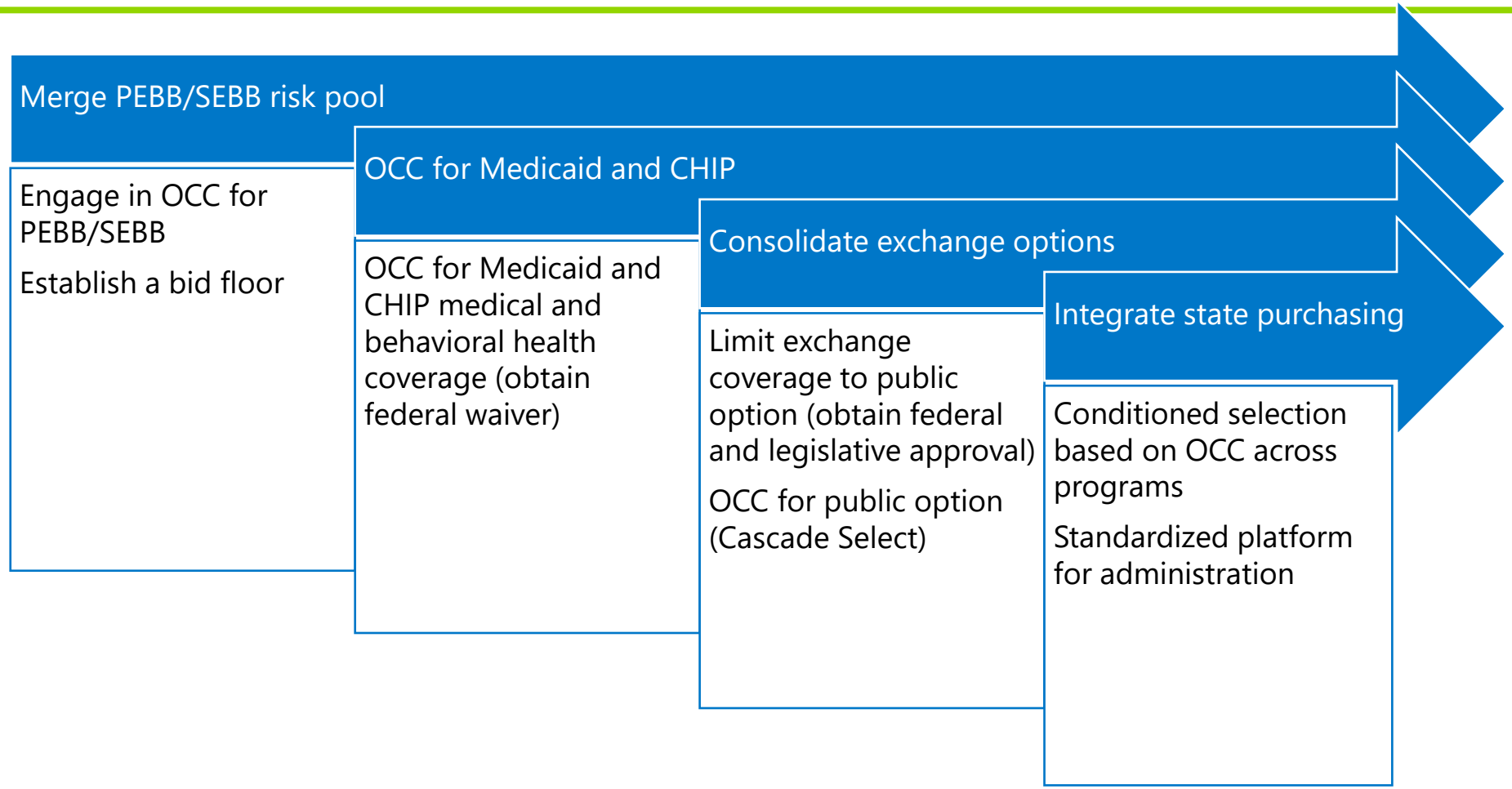
FTAC provider reimbursement roadmap

- Describes possible phased implementation
- Two suggested pathways to date
  - Hospital spending
  - Contracting/consolidated purchasing
- Evaluation of impact and conclusion
  - Patient equity
  - Rebalancing system investments
  - Provider financial stability

FTAC proposed transitional pathway 1



FTAC proposed transitional pathway 2



FTAC Provider Reimbursement Roadmap

Background:

Washington is in the midst of an extensive planning effort to "*create immediate and impactful changes in the health care access and delivery system in Washington and 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*."[1] The Financial Technical Advisory Committee (FTAC) was assembled to provide policy and technical input regarding this effort, which can be started by the development of effective government administered initiatives to control health care price and spending growth to:

1) Make the state's health system more affordable, and
2) Improve the financial feasibility of its universal coverage initiative.

The following draft outlines a series of steps the state could implement to assist in the achievement of these two goals.

Transitional pathway 1:

Hospital price and spending regulation

Step 1: Implementation of Reference Based Price (RBP) caps, linked to federal Medicare hospital payment levels, on hospital prices for state and public employees administered by the Public Employee Benefits Board (PEBB) and School Employees Benefit Board (SEBB).

During the 2025 legislative session Washington passed price cap legislation to help Washington's PEBB and SEBB to control the growth in hospital payments to curtail the growth in the programs' spending on hospital care and maintain or improve the affordability of insurance coverage for these state and public employees.

This legislation empowered the PEBB and SEBB to set RBP caps on hospital prices paid by the benefit programs. It closely parallels the implementation of a similar spending control program implemented in Oregon for their public and state employees. The Oregon initiative was found to effectively control spending on hospital care and generate needed savings for the state, without creating significant negative impacts on hospitals.[2] Washington's legislation provides the state with an ideal first step to begin its future healthcare price and spending control strategies for the following reasons:

[1] RCW 41.05.840

[2] Murray RC., A. Ryan and CM Whaley. Hospital Finances, Operations and Patient Experience Remain Stable after Oregon's Hospital Price Cap was Implemented. Health Affairs. December 2025.

1) If the state's experience parallels that of Oregon, Washington will improve the affordability of a key public insurance program while also saving state funds. These savings can be redeployed to bolster primary and under resourced care, avoid increased beneficiary premiums, and help the State finance cutbacks in federal Medicaid funding.
2) The RBP cap program is designed to be easily administered, giving the state valuable experience implementing a government-administered and regulated hospital pricing program which it can build on in an incremental and deliberate way to design broader healthcare spending control models.
3) Success of both the Oregon and Washington RBP cap models can provide the state with an initial proof of concept experience with provider rate setting, demonstrating that these models can be easily administered and effective in maintaining or improving the affordability of health insurance coverage when applied to segments of Washington's healthcare sector.

Step 2: Efforts to promote the participation of public insurance purchasing organizations in PEBB and align RBP in public programs.

Once Washington's RBP hospital cap program is operational and demonstrates the ability to constrain hospital prices, the state may encourage additional public entities, such as Washington's county and city governments, to participate by joining the Public Employee Benefits Board (PEBB) program. This expansion will help improve the viability of these other public insurance programs and further demonstrate the effectiveness of RBP caps to control hospital price and spending growth, without imposing deleterious impacts on hospitals. Representatives from some Washington counties have expressed interest in the RBP cap approach. They and other counties may wish to participate in this program.

Additionally, to work towards a consistent and cohesive reimbursement system, Washington should consider aligning policy for its RBP efforts across PEBB/SEBB and the individual market public option (Cascade Select). Currently, Cascade Select establishes an aggregate cap for providers and facilities for covered benefits. This cap is set at 160% of Medicare rates, with reimbursement floors set for critical access hospitals, sole community hospitals, and primary care services. Legislation to adjust RBP policy in Cascade Select could instead apply caps to each service (e.g., each inpatient or outpatient service). While care should be taken to avoid any potential impacts on federal tax credits[3],

[3] Care should be taken to implement in a way that ensures that any lowered federal tax credits are avoided or recaptured. The federal advanced premium tax credits (APTC) are calculated based on premiums of the second lowest available silver plan. As of 2023, Cascade Select rates were the lowest-premium silver plans in 31 of the 37 counties where Cascade Select was available.

service-based RBP could yield additional savings to the plan, simplify administration, and further the provider rate setting proof of concept.

Step 3: Legislation to apply RBP caps on payments by all private insurers for Out-of-Network (OON) hospital services.

In keeping with the State's intent to implement price and spending constraints in an incremental fashion, the next step the State could take would be to pass legislation imposing RBP Caps (also linked at a proportion of Medicare hospital payment levels) to all OON payments made by private insurers licensed to operate in Washington.

There is strong evidence (from the imposition of OON price caps in the Medicare Advantage market) to suggest that OON price caps can greatly strengthen the negotiating leverage of private insurers relative to hospitals and result in lower year over year increases in private insurer spending on hospital care.[4] Although OON hospital care only accounts for between 6-9% of hospital spending, capping OON hospital prices will neutralize an effective negotiating tactic that hospitals use in their price negotiations with insurers: the potential to go Out-of-Network and charge full price (which is often double or triple contracted prices). Setting an OON price cap at, for example, 200% of Medicare would mean that the insurer could negotiate prices covering both in- and out-of-network services at or below 200% of Medicare (i.e., if the hospital refused such a negotiated result, the OON price cap law would automatically impose such a payment level on the hospital). Legislation authorizing the use of RBP Caps for hospital OON care should indicate that the state has the authority to mandate the payment levels charged by hospitals covered by the legislation.

This proposed third step is considered a low intensity regulatory strategy because it would only apply to 6-9% of private insurance payments. However, the impact of improving insurer negotiating leverage over contracted in-network hospital rates can help curtail the price escalation insurers face due to the growing market dominance of an increasingly consolidated hospital industry. It could also overcome the flaws in the federal No-Surprises Act (NSA), which has been ineffective because it defaults to an Independent Dispute Resolution (IDR) process that is costly and has not effectively capped surprise bills.[5]

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[4] Robert Murray and Jack Keane. *Setting Caps on Out-of-Network Hospital Payments: A Low-Intensity Regulatory Intervention for Reducing Hospital Prices Overall* .Commonwealth Fund. May 2022.
[5] Hoadley, J., Watts, K., Keith, K., & DeGarmo, E. *The No Surprises Act IDR process: An early look at 2025 data*. Health Affairs Forefront. March 20, 2026.

Step 4(a): Development of a politically independent regulatory commission or board and pass legislation to apply RBP caps on hospital payments for all private insurers licensed to operate in the state.

Recently, Vermont passed legislation directing the state's independent healthcare regulatory board, the Green Mountain Care Board (GMCB), to implement a RBP cap (linked to a proportion of Medicare hospital payment levels) on all private insurance hospital payments in the state beginning in 2027.

Washington could introduce similar legislation along with the development of an independent regulatory Commission or Board, similar to Vermont's GMCB or Maryland's Health Services Cost Review Commission (HSCRC). Such an independent agency would be well-suited to oversee a system of RBP caps on all hospital prices for private insurer hospital payments and any future government-administered hospital spending control systems. As discussed below, various structural safeguards could be applied to this regulatory structure to help prevent regulatory failure and regulatory capture.

Such a board could also determine which hospital types are subject to these spending control systems. Rural facilities, exempt from early steps of hospital spending controls, may be folded into the system at this point. Legislators and the governing board should consider various options, including those outlined below, to address how to adequately fund these facilities.

RBP caps can be set at levels that are appropriate for Washington, balancing the need for hospital price and spending constraint, while at the same time gradually imposing appropriate limits on hospital prices. Authorizing legislation should specify that the state has the legal authority to determine the amounts that hospitals charge payers or individual patients for inpatient and outpatient hospital services rendered. Such a regulated system may be applied to all fully-insured and self-funded plans.[6] A RBP cap program linked to Medicare hospital payment levels has the following key advantages:

1) This system is easy to implement and administer avoiding the tendency of past state efforts to construct elaborate hospital price control models that become ineffective because of their inherent complexity;

[6] Although the New York Travelers Insurance ERISA challenge, which argued that state rate setting was pre-empted by ERISA, was ultimately overturned by the Supreme Court of the U.S., the question remains as to whether a state can legally require self-funded ERISA plans to be subject to state rate setting. This topic should be investigated further. However, if the state were to implement a regulated pricing system that clearly was more cost effective for these self-funded plans, they would be likely to opt into such a system voluntarily.

2) The system can be implemented without the need for a large governmental staff to operate and enforce compliance with the system;

3) Different price cap levels can be established for different types of hospitals. Price floors may also be considered. Setting price floors (minimum reimbursement rates) for certain financially challenged institutions may even result in payment increases;

4) The system can be the basis for a set of far more equitable and rational regulated hospital base rates (a starting set of actual regulated payment levels per hospital service similar to the rate structure implemented by both the Medicare and Medicaid programs). [7]

This system of private sector base rates can be parlayed into a broader hospital rate regulatory system with an independent board or commission overseeing, administering and ensuring hospitals and payers comply with the system.

Step 4(b): **Payment adjustments and programs to support stability and equity**

Once a system of more rational and equitable hospital base rates is established for privately insured patients, the state could consider the implementation of other rate setting adjustments, methodologies, and policy programs. To ensure adequate payment among low and fluctuating patient volumes, especially in rural areas, the state could choose between several approaches, including those below:

1. The state can implement a Volume Adjustment System (VAS) as a relatively simple overlay adjustment on base payment levels to counter the incentives in fee-for-service (FFS) payment models to induce hospitals to increase their volume of services improve their profitably. The use of a VAS specific to private insurer rates can neutralize hospitals' tendency to provide large quantities of low-value and unnecessary care to generate surplus revenues.[8] Similarly, VAS

[7] Medicare payment levels have the distinct advantage of being set with a consistent relationship to actual relative cost levels by service. A set of private sector rates linked to Medicare, then can help eliminate existing price distortions and inequities of privately negotiated hospital prices, which has resulted in an array of prices that do not reflect the cost of delivering a service and result in severe misallocations of resources and other distortions. A regulatory board or commission can oversee such a system and gradually phase all hospital rates to reflect a consistent proportion of Medicare payment levels and thus create a far more rational (from an economic standpoint – i.e., in markets, prices that reflect cost result in a better allocation of resources and more equitable payments) hospital payment system.

[8] A VAS is designed as an automatic adjustment to regulated hospital prices to remove the excess of marginal revenue over marginal cost for hospitals paid under an itemized FFS payment structure. This tendency of hospitals to increase their volume of services, whether they are needed or not, is a function of hospital cost structures which contain both fixed (the cost of buildings, fixed equipment, fixed staffing, etc.) and variable costs (the cost of supplies, drugs, variable staffing and other costs that vary with volume). The Maryland rate setting Commission roughly quantified that medium to large hospitals have a cost structure that is 50%

may be used to increase payments if volume decreases to support the stability of rural and low-volume facilities.

2. Alternatively, the state can implement standby capacity payments to apply to the rural and low-resource hospitals that were carved out of initial price caps for public employee beneficiaries. These additional payments can ensure financial stability and capacity for responsiveness regardless of fluctuations in patient volume.[9]

The state can also consider programs to assist hospitals in the funding of uncompensated care (UC). Given the cutbacks in subsidized private insurance and Medicaid programs, hospital UC is likely to increase rapidly in future years. Such a system will be increasingly attractive to hospitals as their UC grows rapidly over time and can support the financial viability of hospitals that service patients in rural and underserved areas of the state.

Step 5: Application to the Centers for Medicare and Medicaid Services (CMS) and the Centers for Medicare & Medicaid Innovation (CMMI) for an All-Payer Waiver for Hospital Payments.

Once Washington has organized and operated a system of more equitable and rational base hospital rates (made possible by linking regulated payment levels directly to a multiple of Medicare payments by service), the state can apply to CMS and the CMMI for a Medicare/Medicaid waiver to allow the state's independent commission or board to set and control the rate of growth of all hospital payments in the State. An all-payer system has the distinct advantage of creating more consistent and rational payments and rate control policies, as well as the ability to spread the burden of financing hospital UC more equitably.

The State could also use this authority to create a system of flexible Hospital Global Budgets (HGBs), potentially utilizing the VAS for hospital payments from private insurers, Medicare and Medicaid.[10] As system of Flexible HGBs has distinct advantages over the

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variable and 50% fixed. Under this type of cost structure, hospitals can generate significant surplus revenues and profits by increasing their number of admissions, ER visits, diagnostic tests and therapies. Under FFS payment, the hospital is paid 100 cents on the dollar for each new, incremental service is provides above a baseline level when it only costs them approximately 50 cents on the dollar (i.e., its variable cost percentage) to produce those new services. This is the primary reason why FFS payment systems induce providers to generate significant levels of unnecessary and low-value care. The use of VAS, which can be applied to system that regulates private insurer hospital rates, can neutralize this unfortunate weakness of FFS payment.

[9] Harold D. Miller. *Better ways to pay rural hospitals and physicians. Value-based payments that sustain essential services in rural communities*.

[10] Typically, these budgets are based on historical revenue. For hospitals exempted from initial spending regulations, the state should consider additional factors to assess if this historical revenue is adequate to support necessary functions.

largely fixed HGBs implemented by Maryland for all of its hospitals in 2014. While the Maryland fixed HGBs did save Medicare money over time, these savings were generated on Medicare payments that had traditionally been 30% higher than average Medicare hospital payment nationally. Thus, these savings were achieved in an environment where Medicare already drastically overpaid Maryland hospitals for Medicare services.

Importantly, placing a hard cap on all hospital payments, regardless of volume changes, induced hospitals to stint on care, which increased wait times for care (as it did in various Europe countries that adopted fixed budgets) and shift care to non-hospital providers, resulting in double payment by payers. This double payment occurred because the costs of the shifted services remained a part of each hospital's fixed budget (i.e., the state lacked the data or ability to reduce budgets when care shifted). All-payers in Maryland continued to pay hospitals for their fixed historically established budgets and paid for these shifted services again when the services shifted out of the hospital setting.

With these more complicated hospital rate setting approaches, the State must be careful to avoid making their systems too complex and difficult to understand by payers and hospitals, a dynamic which resulted in considerable regulatory failure in past state-based rates-setting systems. Additionally, states can configure their regulatory oversight agencies in ways that help prevent the other key vulnerability of regulatory systems, regulatory capture.[11]

Transitional pathway 2:
Consolidating state purchasers and leveraging market power

Open Competitive Contracting Components & Process

Open competitive contracting for health care services offers public and private purchasers of health coverage a vehicle for cost containment. Competitive contracting allows eligible vendors to vie for a contract in a transparent marketplace where agencies can select the best value based on a combination of price and quality. The term "open" is used because all vendors meeting the contract requirements can submit a bid. Current statute and rule specify the requirements to solicit, submit, and evaluate bids as part of the open competitive contracting process.[12] Before the process begins, an actuarial analysis to determine acceptable bid prices may be performed, including a floor and upper limit range. The floor is needed to ensure that a carrier will not offer too low a bid to get a

[11] Murray R. Rate Regulation Revisited: *Managing Regulatory Failure and Regulatory Capture in Health Care*. Millbank Memorial Fund. October 2022.
[12] See Chapter 39.26 RCW , Chapter 200-320 WAC , Chapter 48.44 RCW.

contract. The contracts awarded are for a set period (often three to five years) and include a defined spending growth trend.

A recent example of limited competitive contracting in Washington is following the implementation of the state's public option plan (Cascade Select). In 2023, HCA solicited bids for the public option plan from eligible health insurance carriers, and three of the five carriers that submitted bids were selected. Following this change, public option premiums were 3.0% lower than the year prior, compared to a 6-10% increase for other plans that did not engage in competitive contracting.[13]

Open competitive contracting with health carriers would begin with state agencies. Approximately 2.0 million people in state sponsored health coverage receive their coverage through health carriers.[14] Over a multi-year period, contracting would be phased in with the eventual goal that HCA contracts for PEBB/SEBB, Health Benefit Exchange, and Medicaid coverage in linked process that would leverage the market power of 2.7 million enrollees to further contain escalating spending.

Although the steps below detail how purchasing leverage and open competitive contracting can be an engine for savings in Managed Care Organization (MCO) contracts, a similar strategy could be used to realize savings through state contracts for other services, such as Administrative Service Organizations.

Step 1: Merge PEBB and SEBB into a single risk pool.

The first step in this implementation strategy is for the Health Care Authority (HCA) to contract for PEBB and SEBB coverage in a combined risk pool. Currently, the Health Care Authority (HCA) contracts with two carriers for PEBB and SEBB. Under the proposed open competitive contracting, the request for proposals for coverage would be opened to all licensed health carriers. While members could elect to continue their coverage through the Uniform Medical Plan (UMP), as administrative service organization (ASO) delivery system under contract with Regence, the competitive procurement would be based on all 575,000 active enrollees[15].

[13] Washington State Health Care Authority. *Cascade Select Public Option*. Report to Legislature. October 18, 2023.

[14] Washington State Health Care Authority. Apple Health Client Eligibility Dashboard. (Accessed August 7, 2026)

[15] Washington State Health Care Authority. Cost Driver Analysis Presentation to the Health Care Cost Transparency Board. March 25, 2026.

HCA has statutory authority to engage in open competitive contracting for PEBB and SEBB. Statute states that the PEBB and SEBB may implement strategies to promote managed competition including *"... soliciting competitive bids for the [health] benefit package".*[16] However, HCA may need additional administrative funding to undertake this strategy. This may include funds for actuarial assistance to establish a bid floor and avoid problems with vendors submitting bids that are too low.

Step 2: Begin open competitive contracting for other public programs: Medicaid and CHIP. The Health Care Authority could next engage in open competitive contracting for Medicaid as well as CHIP medical and behavioral health coverage. Nearly two million people are enrolled in Medicaid with 83% enrolled in managed care with five health carriers. Because federal Medicaid law requires that states' Medicaid managed care rates meet actuarial soundness requirements, HCA may need to seek an 1115a waiver of these provisions to employ rates that are based on best prices from a competitive contracting process.[17] [18] As with PEBB/SEBB procurement, the Medicaid RFP process for coverage would be opened to all licensed health carriers.

Step 3. Consolidate exchange options.

The Health Benefit Exchange (HBE) could next seek approval from the legislature to limit Exchange coverage to the public option (Cascade Select) and engage in open competitive contracting. Currently the public option has the lowest priced coverage, and 115,000 (40%) enrollees are already enrolled in public option plans. With legislative approval to expand its authority to undertake competitive contracting, HBE would work with HCA and OIC to competitively contract for all 290,000 enrollees[19]. Federal waivers of ACA

[16] RCW 41.05.021(2)(b)

[17] Section 1115a of the Social Security Act gives the HHS Secretary broad authority to waiver certain provisions in Title XIX (Medicaid). However, these waivers must meet a budget neutrality test, which would be accomplished by demonstrating that open-competitive contracting results in carrier rates below the actuarial soundness standard.

[18] The Medicaid Managed Care Organization (MCO) actuarial soundness rule, defined in 42 CFR § 438.4, requires that capitation rates paid by states to MCOs be certified by actuaries to cover all reasonable, appropriate, and attainable costs for providing services. Rates must be developed according to generally accepted actuarial principles to ensure financial stability, beneficiary access to care, and proper, non-arbitrary rate-setting.

[19] RCW 41.04.410 directs HBE and HCA to contract with carriers to expand public option coverage statewide. This authority was used by HCA to engage in competitive contracting. However, this authority was to obtain statewide coverage, and broader authority is likely needed.

provisions may be required to limit the exchange to public option plans, and this should be evaluated before pursuing legislative approvals[20].

Step 4. Integrate state purchasing across PEBB/SEBB, Medicaid, CHIP, and exchange plans.

To address legislative directives to "*integrate purchasing for all publicly sponsored health services in order to maximize the cost control potential and promote the most efficient methods of financing and coordinating services*.". HCA should next pursue consolidated purchasing for all state covered programs. While beyond the scope of this brief, the purchasing would seek to leverage purchasing for some 2.9 million covered lives, which accounts for approximately 35% of all Washington residents with health insurance. This consolidation does not imply that the programs would be in the same risk pool. Rather, conditioned selection would be based on competitive prices across all the programs. Together, the above steps could create a platform to eventually allow all employers to seek health care coverage for their employees through consolidated state markets. It would also provide a platform for standardizing program administration with respect to service authorization, billing and payment, network adequacy, provider credentialling, and quality performance requirements—which could lead to further savings.

Evaluation of Impact

While the state progresses along these transitional pathways, it should also further develop its data collection and oversight capabilities. General goals for data collection, data system integration, and data analysis described in the provider reimbursement Proposal. The state should also make specific efforts to evaluate the impact of implementing different payment mechanisms. As the state implements early transitional solutions and analyzes their impact, capacity should also be built out to iteratively improve data collection and evaluation.

- To assess impacts on patient equity and ensure transitional solutions are not inadvertently creating barriers to care, the state should focus on measures of access to appropriate care, especially using patient utilization and measures when available. [21] Impacts can be assessed by how such measures vary across providers, payers, region (e.g., districts), and patient characteristics.
- To measure progress towards rebalancing health care investments towards primary, behavioral health, and preventive care, specific definitions of these

[20] 42 USC Ch. 157

categories should be developed to enable rigorous analysis. APCD-based analyses utilizing these definitions would allow policymakers to understand how transitional solutions are affecting investments in these categories. Similarly, as spending regulation of specific categories (such as hospital spending) is implemented, these measurements are critical to detect spending shifts to other categories and settings.

- To evaluate and project impact on provider entities' financial stability, the state may use its harmonized data source to assess the solvency and capital structure of facilities or their parent organizations through a defined set of indicators. To achieve this, a comprehensive APCD that is inclusive of non-claims spending may be leveraged in combination with a provider entity registry that documents parent/child relationships within the health system. A separate set of financial indicators, as well as actuarial sensitivity testing to assess hospital finances and identify minimum thresholds to cover operating and standby costs, may be considered for hospitals exempt from initial RBP implementation for public employee beneficiaries.[22]

Conclusion

The two parallel pathways above reflect complementary approaches to address the Commission's charge to prepare the state for the development of a Universal Health care system and suggest solutions that may facilitate a transition to the universal system.

Open competitive contracting, when coupled with consolidated public purchasing, could lower premiums and out-of-pocket costs for approximately one third of Washington residents. Effectively implemented hospital price and spending regulation would address a key driver of escalating healthcare spending for the privately insured. Additionally, this approach would reduce price inequity, increase payment predictability, and begin the process of rebalancing payments to support currently underfunded care.

State capacity would be built -- along with a more coherent and affordable system -- over time. The ability to evaluate and adjust at each step means that policymakers could successfully respond to unanticipated impacts or events. These pathways, if successful, will increase the feasibility of a universal health care system.

[22] Reiter KL. *CAH Financial Indicators Report: Summary of Indicator Medians by State* .May 2026.

Appendix D

Washington State Health Care Authority

Define elements: Enrollment

- ***Process*** the member completes to enroll in a universal benefit plan
- Includes
  - Identification of the system to be used for enrollment (existing or new)
  - When enrollment occurs and any special enrollment periods
  - Whether supplemental benefits will be offered and if so, how member will enroll

Define element: Infrastructure

- ***Systems*** that support care delivery and coordination for universal benefit members
- Includes
  - Provider contracting
  - Coordination of benefits
  - Member disputes
  - Provider disputes
  - Appeals of determinations
  - Prior authorization
  - Customer service
  - Provider services
  - Payment and billing
  - Contract negotiation and management
  - Carriers or not?

Define element: Governance

- From the Baseline Report: “The Commission will assess whether oversight for the implementation and administration of the transition to UHC will be under:
  - An existing agency
  - A new agency or
  - A multi-agency structure
- They will also determine which entity may have a permanent role in oversight and governance of the UHC system.
- There will need to be clear roles and responsibilities for all participants in the process.

Appendix E

Washington State Health Care Authority

Washington State Health Care Authority

Report to the Legislature

Universal Health Care Commission

Annual report

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

November 1, 2026

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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Executive summary

The Universal Health Care Commission (Commission) continues its progress toward its long-term goal—designing a system of universal coverage for all people in Washington—aware that its ongoing work coincides with rapid changes in access and affordability currently affecting the entire health care system. Over the past year, the Commission has sought to align its work more closely with existing initiatives in Washington and other states, as well as fulfill its mandates as directed in **RCW 41.05.840**.

In the past year, the Commission tackled the highly complex topic of provider reimbursement, while laying the groundwork for future design elements, such as financing and governance. In addition, the Commission strengthened and expanded ongoing relationships with other states working to design universal coverage. HCA staff and Commission members are in regular contact with counterparts in Oregon, California, New Mexico, Vermont, and Massachusetts. Washington is emerging as a key strategic partner in efforts to create a state-based universal health care system.

The Commission relies on support from its Finance Technical Advisory Committee (FTAC) and the continued input from an engaged health care advocacy community. During its September 3 regular meeting, the Commission held an advocates roundtable [INSERT LINK TO RECORDING] discussion focused on financing. The event provided a learning opportunity to gather further input from established advocacy organizations.

The Commission approved this report to the Governor and the Legislature during its DATE meeting.

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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**).

Brief overview of the establishment of the Commission

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 2021, 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 appointments and committee membership

As directed in RCW 41.05.840, the Commission has 15 voting seats, including legislators, state agency representatives, and governor-appointed members.

During this reporting year (October 2025–September 2026), some legislator and governor-appointed seats experienced vacancies, and the Governor's Office and legislative leadership worked to fill vacant seats throughout 2026. Current and all-time Commission rosters are included as Appendices A and B.

The Finance Technical Advisory Committee (FTAC) was established in 2023 to lend deeper financial expertise to the Commission's work. During the past year, the Commission clarified attendance expectations for FTAC members and expanded membership to up to 10 members. See Appendix C for the updated FTAC charter and Appendices D and E for current and all-time FTAC member rosters.

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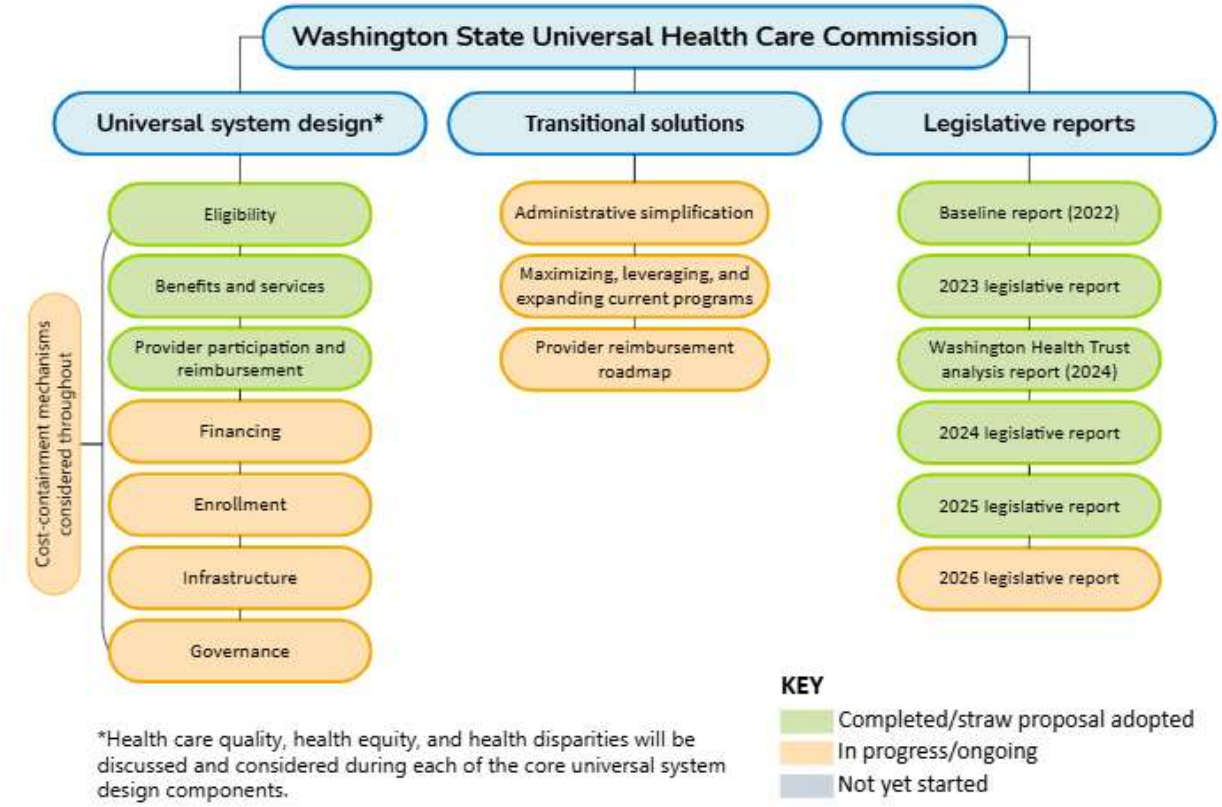
Workplan annual update: October ’25–September ’26

Overview of the year

The Commission continues to follow the workplan adopted in fall 2024 (**Figure 1**) to advance its two-part directive to prepare for a unified system and to identify transitional solutions. As identified by the Commission over the course of its work, transitional solutions may include endorsement of bills before the Legislature or support for interim programs and initiatives that address health care access and affordability, among others.

Figure 1. Universal Health Care Commission’s milestone tracker (as of September 2026)



Meeting cadence

From October 2025 through September 2026, the Commission held six regular meetings, and FTAC held six meetings. Meeting recordings, along with minutes, are available on HCA’s webpage for the Commission’s meetings. FTAC recordings and minutes are hosted on HCA’s webpage for FTAC.

Work groups

Throughout the past year, members of both the Commission and FTAC have generously offered their time and expertise to work groups focused on specific design elements and facilitated by HCA staff. These smaller work groups, which meet outside regularly scheduled meetings, have been integral to progress toward universal system design, especially as HCA staff and consultant support has been further reduced.

The Commission plans to revisit the design elements after completing the initial design, allowing the Commission to create a cohesive proposal.

Addressing core design elements

To expedite progress on core design elements and accommodate staff changes, in late 2025 the Commission revised its approach to drafting the core design elements. Commission members will form work groups to draft designs for infrastructure, enrollment, and governance, while FTAC is responsible for initial designs for provider reimbursement and finance. The Commission must approve all proposals.

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 on each element as of the writing of this report.

Table 1. Universal system core design element progress

Core design element	Initial design draft	Status
Eligibility	FTAC	Approved, see 2025 annual report, Appendix F
Benefits and services	FTAC	Approved, see 2025 annual report, Appendix G
Cost containment	FTAC	Incorporated throughout
Provider reimbursement: guiding principles	FTAC	Approved, see Appendix F
Provider reimbursement: proposal	FTAC	Approved, see Appendix G
Finance	FTAC	In progress
Infrastructure	Commission	In progress
Enrollment	Commission	In progress
Governance	Commission	In progress

Cost containment has been, and will continue to be, integrated throughout design elements. Cost containment considerations figure prominently in provider reimbursement design (as part of price regulation and leveraging state market power; see Appendix G) and will also be critical to infrastructure design (as part of reducing administrative cost through streamlined processes). Many of these mechanisms may be implemented before a full universal system is in place to improve affordability for patients and improve the financial viability of a universal system. Other descriptions of cost containment in approved design proposals can be found in the **2025 legislative report.**

Provider participation and reimbursement

A work group composed of FTAC members met several times in late 2025 through 2026, lending their expertise to design a framework for provider reimbursement and participation in the universal system. The work group recommended that any changes to the payment system be implemented incrementally to avoid too great a disruption to the current delivery system. It drafted three documents to help shape reimbursement in a universal system:

- Guiding principles: These 10 key principles inform the proposed design and may ultimately inform a universal governance body. They emphasize the importance of a uniform and consistent reimbursement system, improving access and affordability, and aligning payment policy with other aspects of a universal system (Appendix F).
- Proposal: These recommendations for payment mechanisms could first be implemented on a small scale. The proposal also offers approaches for subsequent expansion of these mechanisms and suggestions for provider participation and data collection and use. The proposed payment mechanisms include potential ways to regulate provider payments and price, as well as strategies to leverage state market power for lower prices (Appendix G).
- Roadmap: These implementation pathways suggested by FTAC sequence payment mechanisms and describe how they may be expanded. A provider payment regulation pathway describes a stepwise approach to addressing high and highly variable provider prices, while a second pathway outlines gradual steps to increasing state purchasing power and coverage. It also considers how potential implementation impacts may be evaluated and describes expected benefits of completing the pathways.

The commission approved the guiding principles on April 30, 2026, and the proposal on DATE. Throughout the proposal, principles, and roadmap documents, recommendations for provider reimbursement provide the outlines of a reimbursement system that is potentially more rational, equitable, and sustainable than the current payment system. Goals of these recommendations include more affordable care for patients and reduced burnout for providers.

Finance

Following approval of the provider reimbursement proposal, FTAC began its work on finding ways to finance a universal system. The committee outlined principles and evaluation criteria for potential revenue instruments for a universal system. FTAC also began to outline necessary attributes of a financing plan, describe potential revenue instruments, and consider the regulatory structures under which of those instruments would operate. This work was informed by similar efforts in other states.

A work group was formed in August 2026 and will continue its work into 2027. Among its likely topics are examining current financing mechanisms and estimating total costs of a universal system, with the goal of providing the Commission information about current revenue streams, an approximate revenue target, and potential revenue sources to meet that target.

Enrollment, infrastructure, and governance

Section to be updated after the September 2026 meeting.

Phased implementation

As the commission designs a universal system, it also has considered ways to ease the transition to a universal system. Phased implementation could allow the state to build necessary administrative and regulatory capacity, while containing costs and pursuing federal waivers necessary for implementation. Effective phasing, planning, and leveraging transitional solutions may help Washington avoid pitfalls faced by other states.

As work groups continue to draft core design elements, they will consider transitional approaches and universal system design, as outlined below. Transitional approaches comprise Phase 1 and 2, whereas Phase 3 is the full universal design.

1) Early implementation, with focus on affordability, simplification, and access
2) Implementation of design elements to the extent possible without federal waivers
3) Full implementation, contingent upon approval of waivers

Following the completion of the universal system design, the Commission will turn its focus to an implementation plan that incorporates and sequences transitional approaches into a cohesive implementation plan that follows these three phases.

Office of the Insurance Commissioner proviso funding

This Commission is grateful to the Office of the Insurance Commissioner (OIC) for $250,000 from the commissioner's regulatory account in the 2025–2027 budget. The OIC proviso funding supports "economic, actuarial, other modeling related to the design of a universal health care system." The proviso funding must be used by June 30, 2027.

At the June 18, 2026, meeting, the Commission considered several different questions for analysis and discussed the merits of each. Ultimately, the Commission approved the following two questions for analysis by an external contractor with the proviso funds.

1. Analyze through economic modeling whether savings would be realized by the Washington health care system if 12% of total medical expenses were spent on primary care and, if so, when the cost savings would be realized.
2. Analyze the costs of different administrative structures to determine which is most cost efficient.

The 12% primary care spending target aligns with the goal set by the Legislature in RCW 70.390.080, as well as the work of the Health Care Cost Transparency Board.

The Commission also established a work group to support the analysis made up of Commission and FTAC members. Initially, the work group will help refine research questions and provide any clarification to the contractor. As work progresses, the work group will provide updates to the Commission and review preliminary and final deliverables to ensure they meet the Commission's expectations.

The Commission expects a final report analyzing the research questions to be issued by June 2027 and a presentation to the Commission of the findings by the contractor. Findings from the analysis will inform the Commission's recommendations on administrative structures for a universal system and inform which cost containment strategies are incorporated into design elements.

Primary care financing and payment model

In February 2026, the Office of the Insurance Commissioner (OIC) shared a proposal to design a primary care financing and payment model outside the traditional insurance-funded system, initially referred to as universal primary care. Under the OIC proposal, primary care coverage would be carved out of commercial insurance benefits and would instead be a service available to all Washingtonians through a common funding source. A discussion memo prepared by OIC is included as Appendix H.

FTAC provided feedback on this proposal during its March meeting. Following the initial discussion in February, a joint Commission-FTAC work group further explored the proposal, its relationship to a

comprehensive universal system, and how its design and implementation might align with the Commission's core mission. June and September Commission meetings included work group report-outs and the opportunity for Commission members to seek clarification about the proposal and the Commission's potential role in design.

In September, the Commission voted [in favor of/against] a motion to [INSERT TEXT OF FINAL MOTION].

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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.

HCA staff thanks the HUX committee of Health Care is a Human Right, particularly the committee's liaisons, for their continued partnership and open dialogue. HUX's feedback and collaboration help strengthen the Commission's relationship with the advocacy community.

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. Participants may comment virtually or in person during the public comment period.

Advocates offer their perspectives on the design of a universal system, financing, pending legislation, and workplan progress, among other topics. Although the structure of open public meetings does not allow for direct, immediate response, Commission members often acknowledge and respond to comments later in the meeting when appropriate and endeavor always to be responsive to advocates' concerns. In addition, members of the Commission and FTAC deliver report outs at each other's meetings, and presenters include an overview of their respective public comments.

Public comment themes

The Commission welcomes and encourages input from the public and appreciates all feedback received. From September 2025 to August 2026, the Commission and FTAC received 44 written public comments and 57 oral public comments during regular public meetings [UPDATE AFTER SEPTEMBER UHCC AND FTAC MEETINGS]. These comments often mentioned multiple topics. Many of the public comments also touched on personal stories about coverage loss, affordability, and the difficulties of navigating a fragmented health care system, particularly for those with complex medical needs. Key themes addressed in public comments included:

- Concerns about the impact of **changes in federal policy** and the **effects of private equity** investment in health care
- General support for universal health care in Washington state, including support for a **single-payer model**
- Request for a **centralized repository** of Commission proposals and workplan updates
- Feedback about proposed **provider reimbursement models**, including support for hospital global budgets
- Input about the role of **managed care organizations (MCOs)**, including the request to explore de-privatizing Medicaid and limiting MCOs' role in a universal system to temporary administrative functions
- Comments both for and against incorporating **universal primary care** into the Commission's workplan**,** as well as requests for further detail about the proposal

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- Suggested topics for use of **OIC proviso funding,** including requests to use the funds to explore cost and financing, and not to use the funds to explore a topic related to universal primary care

Public comment is an essential part of the Commission's work. Commission members review and consider all 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:

- Creating a **what we're working on** webpage
- Adopting suggested revisions to provider reimbursement guiding principles
- Determining appropriate role of the Commission during OIC's development of its primary care proposal
- Using OIC proviso funds on topic related to cost and financing
- Hosting a second advocates roundtable focused on ways to finance a universal system

Advocates roundtable

In addition to encouraging public comment at every meeting, the Commission convened its second advocates roundtable in September 2026 [INSERT LINK TO RECORDING]. The Commission incorporated the roundtable into its regular meeting on September 3, 2026. There were virtual and in-person attendance options with X members of the public attending the meeting in person and roughly Y people joining online. Commission and FTAC members attended. [UPDATE ATTENDANCE NUMBERS]

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

The 2026 advocates roundtable focused on financing. HCA Director Ryan Moran kicked off the event, and Coverage Strategies Manager Mary Franzen moderated the discussion. Commission members and advocacy groups submitted questions to each other ahead of time. [UPDATE AFTER SEPTEMBER MEETING]

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Conclusion

The Commission continues its steady pace toward designing key elements of a universal health care system. While remaining focused on the fundamental components of a future system, the Commission also is keenly aware of the present difficulties facing many people in Washington, who often face barriers to care. It is within this landscape that the Commission seeks a balance between near- and long-term changes that will increase access and affordability.

The Commission is very grateful to the many stakeholders who support and inform its work, including FTAC members, health care advocates, subject matter experts from Washington and other states, providers, and consumers. Together their time and expertise help shape the varied elements that will come together to form a universal system.

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Appendices

A. Universal Health Care Commission roster for 2026

Seat	Member	Title, Agency	Appointment Type
1	Vicki Lowe, Chair	Executive Director, American Indian Health Commission	Governor-appointed
2	Nicole Gomez	Lobbyist, Washington Federation of State Employees	Governor-appointed
3	**Open seat**		Governor-appointed
4	Mohamed Shidane	Deputy Director, Somali Health Board	Governor-appointed
5	Dr. Naisha Williams	Care Coordination Program Director, City of Seattle	Governor-appointed
6	Dr. Kumhee Ro	Associate Professor, Seattle University	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 Coverage Strategies and Expansion, Washington Health Benefit Exchange	State agency (HBE)
14	Ingrid Ulrey	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)

B. Universal Health Care Commission members (all time)

Member	Term Begin	Term End
Governor-appointed seats		
Vicki Lowe, Chair	November 2021	N/A
Nicole Gomez	November 2021	N/A
Bidisha Mandal	November 2021	June 2026
Dr. Kumhee Ro	August 2026	N/A
Mohamed Shidane	November 2021	N/A
Stella Vasquez	November 2021	July 2025
Estell Williams	November 2021	October 2022
State agency seats		
Kristin Peterson (DOH)	November 2021	December 2023
Charles Chima (DOH)	February 2024	June 2025
Dr. Tao Kwan-Gett (DOH)	June 2025	N/A
Joan Altman (HBE)	November 2021	N/A
David Iseminger (HCA)	November 2021	N/A
Jane Beyer (OIC)	November 2021	June 2026
Ingrid Ulrey (OIC)	July 2026	N/A
Karen Johnson (OoE)	November 2021	April 2023
Omar Santana-Gomez (OoE)	April 2024	N/A
Legislative seats		
Senator Annette Cleveland	August 2025	N/A
Representative Lisa Parshley	June 2025	N/A
Senator Emily Randall	November 2021	January 2025
Representative Marcus Ricelli	November 2021	January 2025
Senator Ann Rivers	November 2021	January 2025
Representative Joe Schmick	November 2021	N/A

C. Finance Technical Advisory Committee charter

Universal Health Care Commission's Finance Technical Advisory Committee charter and operating procedures

Last updated December 11, 2025

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

I. Vision and mission

A. Vision

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

B. Mission

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

II. FTAC charge

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

In their annual report to the Legislature and Governor, the Commission will detail their work, including FTAC's directives, discussions, and provided options with continued strategy development regarding a unified health care financing system, and implementation, if possible. The report due annually on November 1 will detail the opportunities identified by the Commission and FTAC to advance the Commission's goals, including those identified in the legislation and annual reporting requirements.

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III. FTAC duties and responsibilities

A. Membership and term

The Commission will appoint up to 10 FTAC members, which includes one consumer representative, and if possible, reserving at least two spots for two state agencies which include the Department of Revenue and the Office of Financial Management.

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

FTAC will convene beginning in 2023.

B. FTAC member responsibilities

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

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

Members of FTAC agree to participate in good faith and to act in the best interests of the Commission and its charge. To this end, FTAC members agree to place the interests of the Commission and the state above any political or organizational affiliations or other interests. FTAC members accept the responsibility to collaborate in developing option-based guidance and pros and cons of those options to the Commission that are fair and constructive for the Commission. FTAC members are expected to consider a range of issues and options to address them, discuss the pros and cons of the issues or options, and present them to the Commission, while keeping in mind the impact of those options on patients. FTAC will include the rationale behind each option provided to the Commission.

Specific FTAC member responsibilities include:

- Attending FTAC meetings and reviewing materials provided in advance of the meeting.
- Reviewing background materials, including:
    - The Commission's November 1, 2022, report to the Legislature and Governor to understand issues under consideration by the Commission and the Commission's recommendations to the Legislature.
    - The Universal Health Care Work Group's final report to the Legislature (January 2021), particularly the revenue and financing modeling for Models A and B as proposed by the Work Group.
- Working collaboratively with one another to explore issues as directed by the Commission.
- Hearing from invited outside subject matter experts, as needed.
- Developing option-based guidance to the Commission with pros and cons of each option, while keeping in mind the impact of those options on patients.
- Some of the following areas could be assigned by the Commission for guidance, including but not limited to:
    - Revenue goals and projections
    - Scope of coverage, benefits, and cost-sharing, including dental and vision

Development of fee schedule
Securing federal funds
Employee Retirement Income Security Act (ERISA)
Tax structure, including the impact of the tax structure on equity
Assessing how to include Medicare beneficiaries
Administrative cost reduction
Risk management
Model development process
Health equity in financing
Level of reserves and methods of funding
Cost sharing
Health care and administrative workforce
Provider reimbursement
Impact of payment model on care quality and equity
Economic impacts of new taxes
Care investments, including primary care, behavioral health, community health, and health-related social needs
Funding for culturally appropriate health care models
Assessing how federally funded health systems, VHA, and IHS will be included or intersect with the universal health care system
Financial forecast of changes in demand/utilization, etc.
Authority and analytic capacity within a new or existing administering agency

C. Vacancies among FTAC members

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

Note there are three dedicated FTAC positions: one from the Washington State Office of Financial Management (OFM), one from the Washington State Department of Revenue (DOR), and one consumer representative. The consumer representative represents the consumer perspective on issues and actions before FTAC and facilitates dialogue on issues that affect consumers. The consumer representative may bring expertise with specific communities or groups, including but not limited to race/ethnicity, language, individuals who are differently abled, age, gender identity, sexual orientation, social class, insurance status, and intersections among these communities or identities. Health care industry professionals, including but not limited to clinicians and administrators, are not considered consumer representatives for the purposes of FTAC. FTAC members, including the consumer representative, may be retired health care professionals who are no longer actively practicing.

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

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

E. FTAC lead's role

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

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

F. FTAC principles

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

1. Support the development of the report due annually by November 1, and all subsequent reports until FTAC's sunset, to the Legislature and Governor.

Provide options to the Commission that increase access to health care services and universal health coverage, reduce health care costs, reduce health disparities, and improve quality.

Be inclusive of all populations and all categories of spending.

Be sensitive to the impact that high health care spending growth has on Washingtonians.

Align guidance to the Commission with other state health reform initiatives to lower the rate of growth of health care costs.

Be mindful of state financial and staff resources required to implement options.

IV. Operating procedures

A. Protocols

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

1. Members should attend and participate actively in all meetings. If members cannot attend a meeting, they are requested to advise HCA staff. After missing a meeting, the member should contact staff for a recording of the meeting, or if not available, then a meeting summary and any available notes from the meeting.

Members agree to be respectful at all times of other FTAC members, Commission members, staff, and audience members. They will listen to each other and seek to understand the other's perspectives, even if they disagree.

Members agree to make every effort to bring all aspects of their concerns about these issues into this process.

Members agree to refrain from personal attacks, undermining the process of FTAC or the Commission, and publicly criticizing or misstating the positions taken by any other participants during the process.

Any written communications, including emails, blogs, and other social networking media, will be mindful of these procedural ground rules and will maintain a respectful tone even if highlighting different perspectives.

Members are advised that email, blogs, and other social networking media related to the business of FTAC or the Commission are considered public documents. Emails and social networking messages meant for the entire group must be distributed via HCA staff.

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Requests for information made outside of meetings will be directed to HCA staff. Responses to such requests will be limited to items that can be provided within a reasonable amount of time.

B. Communications

1. Written communications

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

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

2. Media

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

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

C. Conduct of FTAC meetings

1. Conduct of FTAC meetings

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

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

2. Conflict of interest

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

3. Documentation

All FTAC meetings shall be recorded, and written summaries prepared. The meeting recordings shall be posted on the Commission's public webpage in accordance with Washington law. Meeting agendas, summaries, and supporting materials will also be posted to the Commission's webpage. Interested parties may receive notice of FTAC meetings and access FTAC materials on the website, or via GovDelivery.

D. Public status of FTAC meetings and records

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

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

E. Amendment of operating procedures

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

F. Attendance

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

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

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

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D. Finance Technical Advisory Committee roster for 2026

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	Robert Murray	President, Global Health Payment LLC	Expertise in health care financing
4	Kai Yeung	Senior Healthcare Research Scientist / Associate Professor, Amazon University of Washington	Expertise in health care financing
5	Pam MacEwan	CEO (retired), Washington Health Benefit Exchange	Consumer representative
6	Eddy Rauser	Senior Data Scientist, Office of Financial Management	State agency (OFM)
7	Matthew Morrissey	Legislative Policy Coordinator, Department of Revenue	State agency (DOR)
8	Hiroshi Nakano	Consultant	Expertise in health care financing
9	Sarah Huling, EdD, MBA	Triple S Consultants, LLC	Expertise in health care financing

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E. 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	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	August 2026	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)
Hiroshi Nakano	January 2026	N/A	Expertise in health care financing
Sarah Huling	January 2026	N/A	Expertise in health care financing

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F. Provider reimbursement guiding principles

1. **Create uniform and consistent reimbursement systems across all providers and payers**
   The reimbursement system should use consistent reimbursement designs and rates for all enrollees (regardless of income, race, or source of coverage) in the universal financing system.

2. **Improve affordability of the health care system**
   The reimbursement system should improve and sustain affordability by promoting cost containment and increasing efficiency.

3. **Maintain and improve access to needed care**
   The reimbursement system should promote the availability of needed and appropriate care for all enrollees, with a particular focus on people in rural and medically underserved areas.

4. **Maintain and improve fairness and equity of the reimbursement system**
   The reimbursement system should promote equity, including paying providers consistent rates for the same services (e.g., consistent rates with flexibility to adjust payments for rural and medically underserved areas).

5. **Rebalance payments to support traditionally underfunded care**
   The reimbursement system should rebalance provider reimbursement to promote access to traditionally underfunded care and enhance population health (e.g., primary, preventive, and outpatient behavioral health services.

6. **Support clinicians to improve care**
   The reimbursement system should support clinicians in improving the quality of care and reducing unnecessary or harmful care.

7. **Standardize key aspects of payment administration**
   The reimbursement system should have single standardized systems for eligibility verification, prior authorization, billing and claims processing, and post-service and follow-up administration.

8. **Assure reimbursement system transparency and accountability**
   The reimbursement system should make appropriate data publicly available to demonstrate that regulating agencies, providers, and payers are meeting key policy goals.

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9. **Assure reimbursement system stability and predictability**
   Implement gradual and incremental changes in reimbursement policies to promote the overall predictability and stability of the payment/financing system.

10. **Ensure that payment policy aligns with policy related to health system capacity and financing**
    Integrate and coordinate payment and health care capacity, staffing, and financing policies to ensure adequate access to affordable care.

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G. Provider reimbursement proposal

Provider participation and reimbursement

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Notes

Committee: Finance Technical Advisory Committee (FTAC)
Commission/committee lead(s): Roger Gantz, Pam MacEwan, Bob Murray, Eddy Rauser, and Sarah Hughling.
FTAC initial review: March 19, 2026
FTAC approved: August 6, 2026

Commission review: April 30, 2026

Commission adopted: [Month Day, Year]

Proposal ID: 2026-03
Core design element/milestone: Provider Reimbursement and Participation

Summary

This proposal includes recommendations for provider reimbursement and participation under a universal health care delivery system in Washington state. Creating a universal health care delivery system in the state will require development of state-regulated provider reimbursement mechanisms to constrain costs driven by growth in provider prices, administration, and overall spending. Accordingly, the development of mandatory (required and enforced by state law) payment mechanisms is essential in advance of and during the implementation of a universal system. In parallel, the state should strengthen and leverage its purchasing power to take the lead in transitional cost-containment strategies. These strategies are exemplified in the recent enactment of reference-based pricing for certain public employees.

It will take time to sort out the key components of a universal system. In the meantime, the state should continue to pursue the implementation of regulated health care price and spending mechanisms. This will improve stability and affordability health care in the short term, while enhancing long term prospects for universal financing. Considerations of cost containment have been woven throughout the Commission's design of a universal system, and efforts to contain costs inform these recommendations as well.

Regardless of the specific payment mechanisms chosen, this proposal recommends a gradual approach to implementation. Large-scale changes implemented simultaneously could prove too disruptive to the health care system. Rather, the Commission recommends implementing new payment mechanisms incrementally, with gradual application to different provider settings,

services, or patient populations. These initial recommendations fall within the realm of transitional solutions – part of the Commission's charge – and will inform later design decisions for a universal system.

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. Provider reimbursement and participation design is one of the key elements required to prepare the state.[1]

Beginning in late 2025, the Commission and its Finance Technical Advisory Committee (FTAC) formally began work on provider reimbursement as a core design element of a universal system in Washington. The Commission adopted a set of guiding principles (Appendix A) on April 30, 2026. These guiding principles informed this proposal and may serve future regulatory decisions in a universal system. Recommendations are grouped by how provider payments are structured (payment mechanisms), and how to incrementally expand payment mechanisms to additional circumstances (implementation approaches). Specific pathways that detail how specific payment mechanisms may be implemented are included in the implementation roadmap (Appendix B).

Recommendations

The Commission recommends implementing gradual changes that can be evaluated over time, adjusted as necessary, and expanded as appropriate. This approach helps ensure sustainability by avoiding sudden, large-scale changes that could disrupt care. Payment mechanisms described below may be first implemented in narrow market segments (e.g., state agency purchasing), allowing for opportunities to refine and improve an approach before recommending large-scale adoption and/or making final recommendations for a universal system. The Commission recommends that participation be mandatory for the included providers and care settings.

Payment mechanisms

Price and payment regulation

A key issue both in Washington and nationally relates to distortions embedded in the Medicare fee-for-service physician fee schedule. These distortions result in underpayment for certain services and care settings (e.g., primary care, behavioral health care, and rural or underserved areas, among others). This fee schedule is also the basis provider payments from Medicaid, Medicare Advantage and most commercial insurers[2]. As noted in Principles 2 & 5, a payment

[1] RCW 41.05.840

[2] An American Medical Association (AMA) survey of 127 public and private payers found that 77% use the Medicare RBRVS to set their payment rates. (American Medical Association. *Medicare RBRVS: The Physicians' Guide 2013*. Chicago, IL: American Medical Association; 2013)

system should rebalance payments toward traditionally under-resourced services and settings while improving affordability through cost containment[3].

To achieve these goals, the Commission first looks to an initiative already in place in Washington as both a possible payment mechanism and an example of how to begin a phased approach. Beginning in January 2027, under RCW 41.05.028, payment rates for certain public employees at most hospitals in Washington will be based on a percentage of Medicare reimbursement rates[4]. That payment mechanism, known as Reference-Based Pricing (RBP), can also be used to correct for underpayments by setting a floor for payments to other providers and settings. As RCW 41.05.028 is implemented, Washington will utilize this feature as well by mandating a price floor for primary care payments in the state's Public Employee Benefit (PEB) and State Employee Benefit (SEB) programs.

A payment approach that may be implemented as a progression from RBP is Out-of- Network (OON) payment caps for hospital care or other services provided to commercially insured patients. The use of RBP caps (tied to a percentage of Medicare payments) for all OON hospital services in the state could address the issue of surprise hospital bills for patients. More importantly, OON price caps is a low-intensity way of creating limitations on hospital prices paid by commercial insurance companies. Price caps for all OON hospital services for the commercially insured would confer additional pricing leverage to commercial insurers in their negotiations with hospitals and health systems by moderating the consequences of the health system leaving the network. Effectively, this would cap in-network prices at or below the OON price cap[5]. This approach could provide the state with an interim step in extending aspects of the current RBP mechanism[6], without imposing RBPs on all hospital services in the state, while still imposing significant pressure on commercially negotiated hospital prices.

To address volume-based incentives that impact traditional fee-for-service (FFS) mechanisms (including RBP and OON caps), payment mechanisms that expand the bundle of services being paid for – such as bundled payments and hospital global budgets (HGB) –should be considered. Bundled payments are structured to cover all services associated with a diagnosis or procedure over a specified period. Service bundles can vary in breadth and may cover services provided by an entire care team. This feature makes conditions that require care coordination, such as specialty psychiatric or maternal care, good first candidates for this type of payment[7]. Bundled

[3] See Appendix A: Provider reimbursement guiding principles for detail on goals of a payment system. Additional consideration for specific settings (e.g., rural and underserved regions) can be found in Appendix B: Provider reimbursement roadmap.

[4] RCW 41.05.028 contains exemptions for certain care settings, including pediatric and rural hospitals.

[5] Robert Murray and Jack Keane, *Setting Caps on Out-of-Network Hospital Payments: A Low-Intensity Regulatory Intervention for Reducing Hospital Prices Overall* (Commonwealth Fund, May 2022). https://doi.org/10.26099/tvdr-1w88

[6] RCW 41.05.028 sets OON rate caps for most hospitals that are out of network for public and school employees.

[7] Jeroen N. Struijs et al., *Bundled-Payment Models Around the World: How They Work and What Their Impact Has Been* (Commonwealth Fund, Apr. 2020). https://doi.org/10.26099/936s-0y65

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payments for certain psychiatric and obstetric care services are currently implemented in Washington State[8]. Potential impacts of this payment mechanism, including on administrative complexity, patient selection, and the financial stability of low-resource providers, should be monitored during implementation.

Another payment mechanism that may be considered for these incremental steps is hospital global budgets (HGBs). Hospital global budgets establish a predetermined amount paid to hospitals for all inpatient and outpatient services. There are two different versions of HGBs: 1) HGBs that are largely fixed and set both a hard cap and a hard floor on annual revenues charged and realized by a hospital; 2) Flexible HGBs, which make use of a Volume Adjustment System to reduce the incentives of fee-for-service payment systems that induce hospitals to increase volumes of care unnecessarily and fund hospitals' fixed costs when volumes decline. The State should consider the advantages and disadvantages of both HGB approaches. These budgets should be mandatory for all payers but certain types of hospitals may be exempt initially. Careful consideration should be made regarding criteria for base payment rates, which may be adjusted based on factors like actual patient volume. When implemented effectively, HGBs allow for prospective, predictable payments that can stabilize hospitals currently subject to unpredictable revenue, fluctuating patient volumes, and a wide range of prices.

Leveraging state market power

To leverage the role of the state purchasing to advance cost containment goals, the state could expand its use of open competitive contracting. Unlike traditional, limited competition contracting where an organization invites only prequalified entities to submit a bid, under open competitive contracting, the state establishes specifications (e.g., quantity, quality), then seeks competitive bids from all licensed bidders. This mechanism can be used for a variety of health care management services, including managed care organization (MCO) procurement, where organizations respond to the invitation and are selected to provide coverage for defined period(often three to five years). The state retains policy control over the service, while the contractor produces the service under public oversight. Critically, the state's purchasing leverage may be expanded and linked, improving the prospects of cost containment with contracted carriers.

Phased implementation approach

Regardless of the payment mechanism selected, the Commission recommends starting with an identified population and/or care setting before applying that mechanism to additional enrollees or care settings. Lessons learned from initial implementation will inform and refine future initiatives. Before recommending the expansion of any approach, the Commission will ensure that the mechanism supports a system with unified financing and promotes equitable access to care.

[8] See the Collaborative Care Model and Global Obstetrical Care in Apple Health billing guides.

Possible ways to expand a given approach include, but are not limited to:

- Applying the mechanism to an additional set of providers
- Applying the mechanism to additional care settings
- Applying the mechanism to additional services
- Applying mechanism to a greater proportion of provider budget
- Consolidating and extending state market power.

Provider participation

Reimbursement systems should be designed to make billing and payment processes as simple, consistent, and transparent as possible. Eventually, in a universal system, the Commission envisions a standardized process that will reduce administrative burden on providers.

Reimbursement changes and administrative simplification will incentivize some providers to participate in the aspects of the system where these changes are first implemented. Beyond administrative simplification, potential advantages to providers include greater stability in rural and underserved areas, predictable and prospective payments, increased reimbursement for currently underfunded services (e.g., primary care and behavioral health), and greater satisfaction among clinicians[9]. Ultimately, these incentives may increase participation and contribute to stronger provider networks, especially where services were previously underfunded.

While provider incentives may reinforce the effect of transitional payment mechanisms, mandatory provider participation in payment models is necessary to achieve cost containment in most contexts. The history of payment initiatives and Value Based Payment models has demonstrated that voluntary payment initiatives (such as ACOs or other VBP strategies) have not effectively controlled the growth of provider prices and spending. This is because providers with the highest prices and spending are allowed to opt out. For this reason, voluntary models do not have the ability to enforce limits on price and spending growth in a comprehensive way.

Data collection and oversight

The Commission recommends that the governing body that oversees the universal system collect data from payers and providers as different reimbursement mechanisms are implemented. This governing body should establish principles for people-centered data governance that furthers accountability, transparency, and public trust. Such principles may address data collection impact, ownership/access, consent, secondary use, and individual rights.

Data collection should be as complete as possible while minimizing impact on reporting entities. Currently, several separate and complementary data streams provide an incomplete picture of

[9] Current provider reimbursement models can contribute to clinician burnout and moral injury, in part through overreliance on financial incentives to promote quality care.

health care spending. Payment-relevant data currently collected by these separate systems should be incorporated into the universal system's All Payer Claims Database (APCD)[10]. This additional data should include non-claims spending and more complete geographic, race, ethnicity, and language information for patients. A health care entity registry should be developed to analyze how spending accrues to relevant groups.

Data could be used to:

- Inform rate setting, priority-setting, benefits design, payment mechanisms, and resource allocation.
- Determine whether elements of the current payment mechanism, such as base rates, need to be adjusted[11]
    - Adjust identified elements accurately and fairly.
    - Identify the need for exceptions or modifications to preserve access to care.
- Determine appropriate expansion of a payment mechanism.
- Determine whether entities that fall under a reimbursement mechanism are shifting care or altering billing practices to avoid cost containment measures.
- Oversee the payment system, including understanding the sources of payment and access variation
    - Understand how critical measures (utilization, access, costs, outcomes, social determinants, commercial determinants, etc.) vary across payers, delivery systems, and services.
    - Integrate information across reporting systems to provide a comprehensive source for system evaluation.
    - Detect and manage high-need/-cost members and provider services, including instances of financial waste/fraud/ abuse.
- Evaluate and set health system performance measures goals for public reporting.

Alignment with ongoing work

The Commission will continue to monitor and learn from other ongoing initiatives related to provider reimbursement, health care costs, and delivery models. Those efforts include:

- Health Care Cost Transparency Board
- Prescription Drug Affordability Board
- Rural Health Transformation Program
- Medicaid Transformation Project (Washington's Medicaid 1115 waiver)
- Traditional Health Care Practices waiver

[10]Payment-related data is currently distributed across multiple operationally distinct systems, none of which was designed for cross-payer analytic use. Realizing the full value of a universal APCD requires a data governance infrastructure that integrates these data streams into a single harmonizing source capable of supporting expenditure forecasting, rate-setting, research, and public transparency that could support the use cases enumerated in this section.

[11] E.g., risk adjustment and rate cell analysis.

- Value-based Purchasing
- Office of the Insurance Commissioner
- Washington Health Benefit Exchange
- Department of Health
- Other states' past and current experiences with cost boards, universal health care commissions, and alternate payment models including Massachusetts, Vermont, Oregon, Maryland, and California.

Draft Review History

FTAC feedback | March 19, 2026

- Consider adding bundled payments to payment mechanisms
- Add a broad statement about why the memo- and aspects of others- focuses on transitional solutions
- Further explain and connect what is meant by 'payment mechanisms' and 'implementation approaches'
- Consider adding a standalone section describing the proposed universal, direct primary care transitional mechanism/approach

UHCC feedback | April 30, 2026

- Concern that reference-based pricing or HGB could destabilize rural hospitals.
- Request to clarify how consolidating and leveraging purchasing power/open competitive contracting differs from existing strategies
- Request to clarify what consequences an opt out provision would have re: mandatory vs. voluntary provider participation
- Inclusion of what does success look like (evaluation criteria) for payment mechanisms
- Inclusion of contract durations and notification periods for provider predictability
- Review of unsuccessful related legislation to address issues related to provider reimbursement

FTAC feedback| May 14, 2026

- Request to include other relevant data systems (e.g., Provider One) and how they may be integrated with the APCD.
- Concern that current draft suggests RBP is the singular solution to fee schedule distortions.
- Need to address how payment policies (especially in rural and low-volume settings) address problems and incentives with changing patient volumes. This can be done in the Roadmap if the Proposal is sufficiently clear and footnoted.

FTAC Vote Approving Draft | August 6, 2026

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H. Office of the Insurance Commissioner primary care concept paper

Most recent draft to be included

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