Universal Health Care Commission meeting

October 15, 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, October 15, 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
2:00–2:10 (10 min)	Welcome, roll call, review of previous meeting minutes	1	Vicki Lowe, Chair
2:10 – 2:20 (10 min)	2027-2029 state budget update & discussion	2	Mich'l Needham, Chief Policy Officer, HCA
2:20 – 2:35 (15 min)	Public comment	3	Vicki Lowe, Chair
2:35 – 2:55 (20 min)	State agency report outs and Commission member updates	4	Commission members
2:55 - 3:05 (10 min)	2026 annual report to the Legislature ➢ **Potential vote to approve 2026 annual report**	5	Mary Franzen, HCA
3:05 – 3:20 (15 min)	OIC proviso and workplan updates	6	Ross Valore, HCA Mary Franzen, HCA
3:20 – 3:30 (10 min)	FTAC report out	7	Pam MacEwan, FTAC liaison
3:30 – 3:40 (10 min)	**BREAK**		
3:40 – 4:30 (50 min)	Foundational questions	8	Mary Franzen, HCA Ross Valore, HCA
4:30 – 5:00 (30 min)	Outstanding design elements: enrollment, infrastructure, and governance	9	Mary Franzen, HCA
5:00	Adjournment		Vicki Lowe, Chair

Tab 2

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission meeting minutes

September 3, 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

Nicole Gomez
Tao Kwan-Gett
Mich'l Needham (representing HCA in Dave Iseminger's absence)
Representative Lisa Parshley
Kumhee Ro
Representative Joe Schmick
Mohamed Shidane
Ingrid Ulrey
Niasha Williams
Laura Kate Zaichkin (representing WAHBE in Joan Altman's absence)

Members absent

Senator Annette Cleveland
Omar Santana-Gomez

Call to order

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

Agenda items

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Washington State Health Care Authority

Welcoming remarks

Chair Lowe welcomed Commission members to the September 3 meeting. She welcomed two new members: Kumhee Ro and Naisha Williams. She also noted that Bidisha Mandal has left the Commission.

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

Advocates' Roundtable

The first hour of the meeting was devoted to an advocates' roundtable focused on financing. HCA Agency Director Ryan Moran kicked off the event with an overview of Washington's current fiscal situation and HCA's recent work on affordability. He noted the importance of continuing the work to design a universal system and shared Commission accomplishments over the past year.

Listen to Dr. Moran's remarks (time stamp 5:12)

Four advocacy organizations participated in the roundtable: Health Care for All – Washington, Northwest Health Law Advocates, WashingtonCAN (Community Action Network), and Whole Washington. The discussion began with advocates answering questions from the Commission about principles that should guide a financing system, as well as which funding mechanisms are most often discussed and supported among health care advocates. Their answers (time stamp 26:33) shed light on the topic for the Commission and its Finance Technical Advisory Committee.

Next the Commission answered questions from advocacy organizations regarding possible design of a universal health system, including the establishment and governance of a health trust, potential cost-sharing mechanisms, and work plan schedule. Please note that Commission's answers (time stamp 50:09) represent the Commission as a whole and are based on previous votes. In addition, some Commission members offered their individual responses to the questions.

The Commission thanks the organizations for their partnership. Following the roundtable, the Commission returned to its regular business.

June 2026 meeting minutes

Commission members approved the June 2026 minutes by unanimous vote.

Public comment

Chair Lowe stated that since the last meeting, the Commission received written comments from the public that included information about universal system design proposals in other states, opposition to focusing on universal primary care than a full universal system, and a proposal to set deadlines for the Commission's work and seek further clarification regarding

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the form of its final deliverable to the Legislature.

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

- Cris Currie, Health Care for All - Washington
- Jennifer Brackeen, Washington State Hospital Association
- Jamie Keenan-deVargas

Themes from the public comments include:

- Encouragement to look at universal health care proposals in other states, in part to ensure Washington's system would be compatible with other states' systems
- Support for improving primary care access and affordability, but caution against reducing hospital reimbursement as a way to achieve those goals
- Support for tax reform

The public comment portion of the meeting begins at time stamp 1:17:52.

Universal primary care work group report out

Patty Kuderer, Washington State Insurance Commissioner
Ingrid Ulrey, Office of the Insurance Commissioner
Hiroshi Nakano, FTAC member
Rep. Lisa Parshley
Mary Franzen, HCA

Washington State Insurance Commissioner Patty Kuderer and the universal primary care work group provided an update on agency request legislation under development by the Office of the Insurance Commissioner (OIC). The legislation seeks to increase access to primary care and directs OIC to "develop a new multi-payor common fund and prospective payment model for primary care." The work group was formed in early 2026 when the proposal for universal primary care was first described to the Commission.

The Commission voted to support "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." The Commission further requested regular updates.

The primary care discussion begins at time stamp 1:26:35

Workplan update

Mary Franzen, HCA

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Mary Franzen of HCA delivered a very brief workplan update, noting that a draft 2026 annual report was included in the September 3 meeting packet. She requested comments from Commission members by Thursday, Sept. 16. An updated version of the annual report will be presented to the Commission for final approval at its October 15 meeting.

FTAC report out

Pam MacEwan, FTAC liaison

FTAC liaison Pam MacEwan updated the Commission about FTAC's most recent meeting. She shared that FTAC approved the provider reimbursement proposal and was submitting it for the Commission's consideration and approval.

She noted that FTAC's next area of focus is financing, and the committee began its initial discussions in August.

The FTAC report out begins at time stamp 2:08:53.

Provider reimbursement proposal

Harrison Fontaine, HCA

Harrison Fontaine, senior health policy analyst at HCA, reviewed three provider reimbursement documents: guiding principles, provider reimbursement proposal, and implementation roadmaps suggested by FTAC.

The Commission voted to adopt the provider reimbursement proposal.

The provider reimbursement proposal discussion begins at time stamp 2:21:00.

Enrollment, infrastructure, and governance

Mary Franzen, HCA

Mary Franzen reminded Commission members of an early 2026 discussion about three design elements that will be undertaken by the Commission: enrollment, infrastructure, and governance. During the previous conversation, Commission members considered whether it was the appropriate time to decide some foundational design questions, such as whether the universal system will be single- or multi-payer, whether insurance carriers will play any role, and which entity should bear the financial risk. HCA staff will further research those questions for Commission consideration.

The discussion about the three design elements begins at time stamp 2:28:09.

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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:

- **Laura Zaichkin**, Washington Health Benefit Exchange (WHBE)
- **Tao Kwan-Gett**, Department of Health (DOH)
- **Mich'l Needham**, HCA
- **Ingrid Ulrey**, OIC

Commission members described efforts to help people in Washington preserve their health care coverage. Looking ahead to 2027, the Exchange expects at least 80% of its enrollees will experience rate increases of 20% or more and is seeking ways to mitigate potential coverage loss. HCA continues to implement federally mandated changes and is working to help people in Washington maintain coverage.

The Office of the Insurance Commissioner acknowledged that expected rate increases could affect consumers. OIC also is preparing reports for the Legislature about, among other things, balanced billing and protection from out-of-network costs.

The Washington Department of Health is enacting a new framework that organizes its work around two pillars: public health and health care.

State agency report outs begin at time stamp 2:46:45.

Closing comments and adjournment

The meeting adjourned at 5:02 p.m.

Next meeting

Thursday, October 15, 2026, from 2–5 p.m.

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

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2027-2029 state budget update

Washington State Health Care Authority

Overview

- Governor Ferguson’s budget directive
- HCA’s 2027 priorities
- Budget reduction options
- Anticipated timeline

Budget directive

- 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."
  - "The Governor has requested agencies, in addition to carefully reviewing base budget expenditures, specifically consider: Programs created or expanded after January 1, 2019 …."

HCA's 2027 priorities

- Agency request legislation and decision packages reflect the agency's legislative priorities and seek resources to ensure that
  - As many Washingtonians as possible can keep their health care coverage
  - We are in compliance with federal regulations to avoid any fiscal consequences

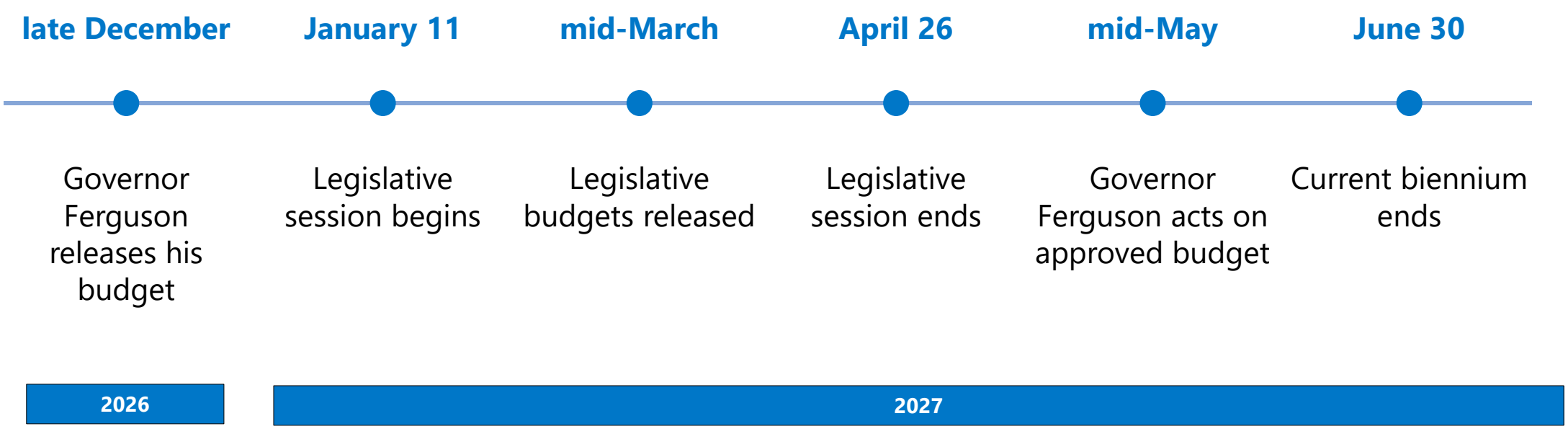
HCA's 2027 priorities (cont.)

- Responding to federal activity
- Maintaining and ensuring access to Apple Health
- IT investments
- Tribal health
- Behavioral health
- Rates, benefits, and operations
- Budget reduction options

Budget reduction options

- More than 25 proposals in four different categories
  - Changes to benefit design
  - Changes to eligibility criteria
  - Changes to provider rates
  - Changes to contracts, studies, and workgroups
- Within the fourth category – changes to contracts, studies, and workgroups – there are more than 10 proposals
  - The Universal Health Care Commission appears in the menu of options

Anticipated timeline



Questions?

Washington State Health Care Authority

Tab 3

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 August 21 – October 1, 2026):
  - C. Currie
  - S. McEvoy
  - R. Shure / Health Care for All – Washington
  - S. McEvoy

Universal Health Care Commission
Public 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**.

Public comment from Cris Currie
submitted Sept. 21, 2026

Thank you for deciding to finally discuss the concept of single-payer, a statutorily required framework for Washington's universal healthcare. Single-payer (aka Model A) has already been defined by the UHC Work Group:

"Under Model A, a single coverage plan is offered to everyone in Washington State, with the state establishing the delivery system rules and administering the coverage. No insurance companies participate, as the state contracts directly with providers and administers all functions currently provided by insurers, including claims payment, utilization management, care coordination, and member and provider services."

While no insurance companies can participate in the basic coverage, allowance can be made for carriers to offer supplemental insurance for services not covered by the basic plan. The state can also contract with Administrative Service Organizations (ASOs) to handle day-to-day management. As for the biggest reasons to adopt a single-payer system, starting with Apple Health, I would refer you to my eBook called A Medicare for All Q & A, Version 8.1, especially chapters 8, 10, 11, 12, 16, 19, 20, 21, 22, 30, 31, 38, 42, and 45. But here I want to focus on the question of whether Managed Care Organizations (MCOs, aka insurance carriers) can adequately shield the state against fraud or truly offer budget predictability, and what it means for the state to be the risk bearer.

In March of 2026, the Minnesota legislature held two informational hearings on SF3612/HF3476 which would eliminate MCOs from their Medicaid program with the option to replace them with one or more ASOs. During the hearings, Republicans and MCO representatives raised additional points in defense of the MCOs. After a representative from the MN Council of Health Plans stated that MCOs have a vested interest in preventing fraud and that this bill would eliminate that, Republicans pounced on the Department of Human Services (DHS) for not catching the Medicaid autism program fraud and similar cases much earlier. They seemed to believe that somehow the MCOs were protecting the state from fraud while the state was being lax. While there is no argument that the state could have been more vigilant, the financial loss has been greatly exaggerated and used for political purposes, while much bigger Medicaid and Medicare scams in Republican states have received relatively little attention.

CMS requires each MCO to have a compliance program designed to "guard against fraud, waste, and abuse" including seven elements. These programs are proprietary, and best practices are not shared between MCOs. Claims data and provider

payments are also kept confidential, so investigating fraud within an MCO is very difficult. But supporters of the bill complained that the state still has to pay the MCOs for whatever penalties or losses to fraud they might incur. In fact, CMS has identified managed care as being one of the service areas "where there may be high-risk program integrity vulnerabilities," simply because of the exceptionally high degree of complexity and variety involved in the multiple, unaccountable payment systems.

In assessing whether state government should rely on these compliance programs, one need look no further than the second largest Medicaid fraud settlement in Washington history: the case of Centene, owner of Washington's Coordinated Care. A $19 million settlement in 2022 resolved allegations that Centene overcharged Apple Health for pharmacy benefit management services. State Attorney General Bob Ferguson filed suit after a whistleblower complaint, along with the AGs of 19 other states for a total settlement amount so far of over $1 billion. Centene is the nation's largest Medicaid MCO and reported $163 billion in revenue in 2024, primarily from government programs.

In another large settlement, in 2025, Ferguson's Office of Medicaid Fraud Control Division sued Lincare, a respiratory equipment company, for allegedly overbilling 565 patients in Apple Health, "including managed care entities," by more than $500,000. The company agreed to settle for $1.15 million. Evidently, the MCOs failed to recognize this massive overbilling, despite Lincare's history. In 2023, Lincare settled a similar lawsuit for $29 million in the Eastern District of Washington for overbilling Medicare and Medicare Advantage Plans. Again, whistleblowers within Lincare alerted state and federal authorities. Plan administrators were apparently not otherwise aware of the problem. Fraud is a pervasive, expensive problem across the U.S. that is also difficult to detect, but MCOs are not any more capable of detecting it than are state agencies. They are, however, more capable of concealing or ignoring it. A 2018 OIG study found numerous weaknesses in MCO fraud compliance programs.

One of the frequently heard reasons for why states switched to MCOs for Medicaid was budget predictability, a feature that rightfully appeals to most lawmakers. By contract, each MCO is given a certain amount of money per member per month, and the MCO is required to stay within that "capitated" rate for the length of the contract. But according to one study, "managed care use has been concentrated among the enrollees with the most stable spending, resulting in only small gains to budget predictability." For example, most MCOs do not cover the aged, blind and disabled populations, since they would greatly increase the risk exposure through greater unpredictability in medical costs. Most states, including Washington, insure their most high-risk populations with the Fee for Service (FFS) model. Across all markets, MCOs

have focused on cherry-picking the healthiest of people and leaving the sickest for government to insure. For states like Washington and Minnesota where the Medicaid population keeps increasing, eligibility keeps expanding, benefits are regularly added, and prices keep going up, long term budget predictability is mostly a fallacy.

While capitation cannot control prices or enrollment, it also leads to unintended consequences for enrollees. Whatever MCOs don't spend on patient care, they can retain, provided they have spent their contracted minimum. This creates an incentive to minimize spending on patient services, which is why the number of Medicaid claim denials through prior authorization has been increasing far beyond even Medicare Advantage denial rates. Limited provider networks and increased cost sharing are two other strategies MCOs use to decrease utilization, especially for their more expensive enrollees. Further, since they know the average Medicaid enrollee only stays continuously in Medicaid for less than ten months, MCOs have little incentive to spend money on preventive care, especially since for-profit MCOs tend to be primarily focused on their quarterly returns to investors. This *churn* frequency is likely to increase as eligibility rules become tighter.

If the MCOs should spend more than the contracted amount, they will need to at least temporarily absorb the loss. Hence, capitation creates the illusion that risk has been offloaded from the state to the MCO. However, CMS requires that states pay the MCOs "actuarially sound" rates that will prevent bankruptcy, but if they do happen to lose money, the state will likely just need to pay them more the next year

Plus, while an insurance company is able to offer *an individual* the advantage of a large risk pool in which to minimize their individual risk, an insurance company cannot offer a state that same advantage, because the state is able to insure millions of people without insurance company involvement. With such a fragmented risk pool, each of our five MCOs is exposed to far more risk than the state would be if it were to directly insure the entire pool. If non-risk-bearing ASOs are substituted for the MCOs, then the state must assume the risk for the entire Medicaid pool and not just for its FFS enrollees. But with millions of people in the pool, the risk is extremely small.

In summary, fraud protection and risk-bearing are two highly promoted features of managed care that are largely fallacies and should not serve as reasons to retain the MCOs. A single-payer system will be far more effective.

Dear UHCC commissioners,

As a universal healthcare (UHC) advocate, advocacy volunteer for HCFA WA (healthcare for all WA) policy committee, Whole Washington nurses group and HCHR (Healthcare is a human right) HUX co-chair, I am committed to making UHC a reality in WA state and the USA.

I attended and spoke as an advocate and member of HCHR at the September roundtable meeting with the UHCC. I was surrounded by like-minded passionate commission members and advocates. It felt powerful.

It is IMPERATIVE that we act quickly and wisely to take advantage of this unique time in life with the healthcare crisis, impending doom of federal cuts and a broken 'for profit'' healthcare system.

To restate the UHCC aim: As directed by the Legislature (RCW 41.05.840), 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."

Please take ACTION on these items, vote and use the money.

OIC has allotted UHCC $250k to advance UHCC in WA state. Use it or lose it by end of June 2027.

UHCC has voted to use the money to seed research on a cost analysis and benefits of meeting the goal of 12% of health care spending be on primary care and follow the outcomes over time.

UHCC has voted to spend OIC funding $250000 on:

1. Test the hypothesis that spending 12 percent on primary care saves money elsewhere in the system. If so, how much is saved?
2. Model costs of different administrative structures, potentially drawing from experiences of other states. Structures could include, but are not limited to: -Fee-

for-service (FFS) or managed care payment -State-run or third-party administration - Application of CT's model of state-administered, managed FFS

Warren George a past commissioner w Oregon's universal healthcare commission, states that there are several actuarial companies to pursue. FTAC and UHC advocate groups like us at HUX can get you those names asap.

We don't want to repeat Oregon's error when hiring companies to do the studies. So the collaboration and due diligence of all of us will serve us well.

Sincerely,
Shari McEvoy ARNP, retired.

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

HCFA's Guiding Principles for Universal Health Care in Washington

Shari McEvoy ARNP HCFAWA policy committee member
May 2025 and revised April 2026

Governance

1 A dedicated Trust will be created within an autonomous entity of state government to collect revenue and provide a set of medically necessary health benefits for all state residents.

2 The Trust will be governed by a Board of Trustees, initially appointed by the governor, and advised by at least 3 standing committees, including a financial, a technical, and a citizen's advisory committee.

3 The Board's activities will be fully transparent and accountable to the public. The Board will develop the detailed policies concerning administration, medical records, budgeting, working with the legislature, quality assurance and program evaluation, contracting, participation, provider qualifications and reimbursement, eligibility, cost control, benefits, future planning, social determinants of health, standards of practice, long-term care, and research.

4 The Board will hire an executive director who will in turn hire staff with approval by the Board.

Contracts with Administrative Service Organizations will be permitted.

Delivery

5 Private health plans that duplicate benefits of the Trust will no longer be sold in Washington, but private supplemental plans will be permitted.

6 Primary, integrated care will be prioritized over specialty care.

7 Providers will only bill the Trust according to uniform rates established by the Board, through a streamlined administrative system, and may not accept additional payments for covered services.

8 Patients may see any licensed provider who has contracted with the Trust. No more narrow networks.

9 Clinical decisions will be made by health professionals and their patients rather than

administrative personnel. Prior authorizations will be minimized. When necessary the process will be streamlined and standardized.

10 Providers will utilize a common electronic medical record, and its data will be widely, but confidentially, available for research into best practices.

11 Social determinants of health and disparities such as racism will also be remedied.

Funding

12 The funding mechanism will include a mandatory employer payroll assessment and individual assessments as needed as determined by the revenue department, the Office of Financial Management, and the legislature.

13 A variety of cost containment strategies will be developed, including elements of global budgeting, price caps, streamlined administration, administrative expense caps, bulk purchasing with other states, competitive selective contracting, and reference-based pricing, while reimbursing providers and manufacturers fairly.

14 Current state funded health plans, including Medicaid, will be integrated first, followed by the Health Benefit Exchange, and individual and employer based plans. Ultimately Medicare will also be integrated as much as possible through waiver negotiations with federal authorities.

15 Minimal cost sharing may be necessary at the point of service, with a goal of zero cost sharing.

16 Benefits, reserve, displaced worker, and education accounts will be established within the Trust.

Eligibility

17 Joining the system will be voluntary for individuals, providers and employers.

18 All state residents will be eligible to participate in a single risk pool, including those employed in another state, those receiving care in another state, and those temporarily living in another state.

19 Non-residents will be covered for emergency care only.

Full Washington Health Security Trust text in legislative bill format available at www.hcfawa.org/resources.

Tab 4

Washington State Health Care Authority

State agency reports outs & Commission member updates

Washington State Health Care Authority

Tab 5

Washington State Health Care Authority

2026 annual report to the Legislature

Washington State Health Care Authority

Overview

- Revised draft in meeting materials as Appendix A
- Key dates
  - ✓ September 3: Initial draft shared with Commission
  - ✓ September 17: deadline for Commission feedback on initial draft
  - ✓ October 1: Revised draft shared with Commission members via email
  - → October 15: Request for Commission approval of revised draft
    November 1: Annual report due to the Legislature

2026 annual report updates

- Inclusion of approved provider reimbursement proposal
- Description of September 3 advocates roundtable
- Updated public comment tally and topics
- OIC's primary care proposal
  - Commission vote
  - September 1 concept paper

Questions and vote

- Questions/comments about the annual report?

- **Suggested vote:**
  The Commission approves the attached draft of the 2026 annual report for submission to the Legislature.

Tab 6

Washington State Health Care Authority

OIC proviso update

Washington State Health Care Authority

Current Proviso Research Questions

- Original research questions approved by Commission at 4.30.26 meeting

1. Vendor shall analyze, through economic modeling, whether savings would be realized by the Washington health care system if 12 percent of total medical expenses were spent on primary care and, if so, when the cost savings would be realized.

2. What health care administrative structure is the most cost efficient?

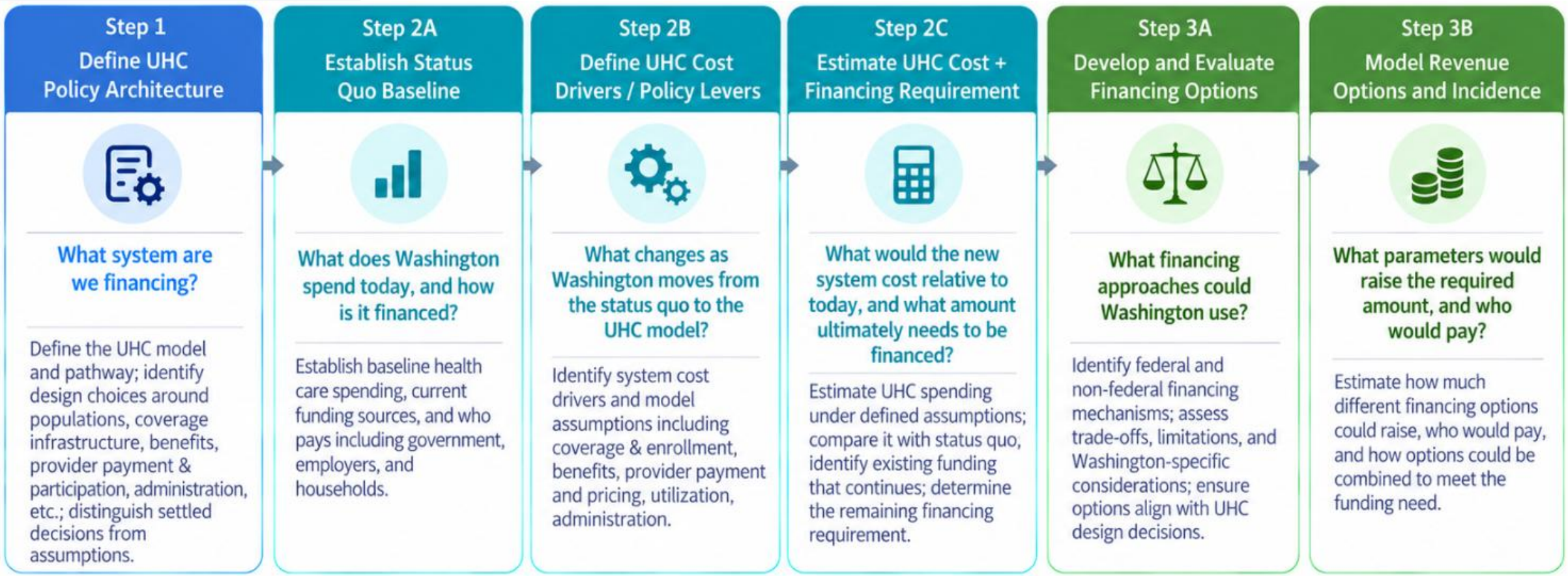
Washington UHC Framework and OIC Scope of Work Ideas

BerryDunn

10.13.26

UHC Financing Framework

A sequenced approach from UHC design through costing and financing



*The Administrative Structure analysis spans Steps 1 and 2B; Primary Care analysis falls within Step 2B/C.

**Comprehensive UHC cost modeling (Step 2C) depends on further development of Steps 1, 2A, and 2B. Revenue/distributional modeling (Step 3B) is the final downstream step and depends on completion of the preceding design, costing, and financing-option work.

Potential Option #1 for BerryDunn Support[1]

- UHC Policy Architecture & Analytic Support
  - Support Commission/FTAC in resolving and sequencing remaining UHC design decisions; evaluate policy options and trade-offs through targeted research and iterative analysis; and integrate individual design elements into a coherent UHC architecture. *Step 1*
- Illustrative Deliverables
  - Integrated UHC architecture framework
  - Analytic or policy memos on priority UHC design questions
  - Strategic roadmap of UHC pathways

Potential Option #2 for BerryDunn Support[1]

- Baseline Reconciliation, Cost Assumptions & Targeted Modeling
  - Reconcile existing analyses to establish a consistent status-quo spending and financing baseline; synthesize prior modeling into a common UHC cost-assumption framework; and conduct targeted analysis or modeling of priority design components where material gaps remain. *Steps 2A–2B*
- Illustrative Deliverables
  - Reconciled status-quo spending and financing baseline report
  - UHC cost-assumption framework
  - Analytic report on priority UHC cost drivers

Potential Option #3 for BerryDunn Support[1]

Financing Options & Policy Analysis

- Build on FTAC's financing work to identify and evaluate federal and non-federal financing approaches; assess key trade-offs and Washington-specific considerations; and examine how financing choices interact with UHC design decisions and implementation pathways. *Step 3A*

Illustrative Deliverables

- Comparative assessment of non-federal financing approaches
- Federal financing and authority analysis memo
- Report on how financing approaches interact with UHC design options

[1] Elements of Options 1–3 could be combined into a focused workplan based on HCA, Commission, and FTAC priorities and the available budget through June 2027. The options presented are illustrative and intended to support SoW discussion.

Workplan update

Washington State Health Care Authority

Universal Health Care Commission

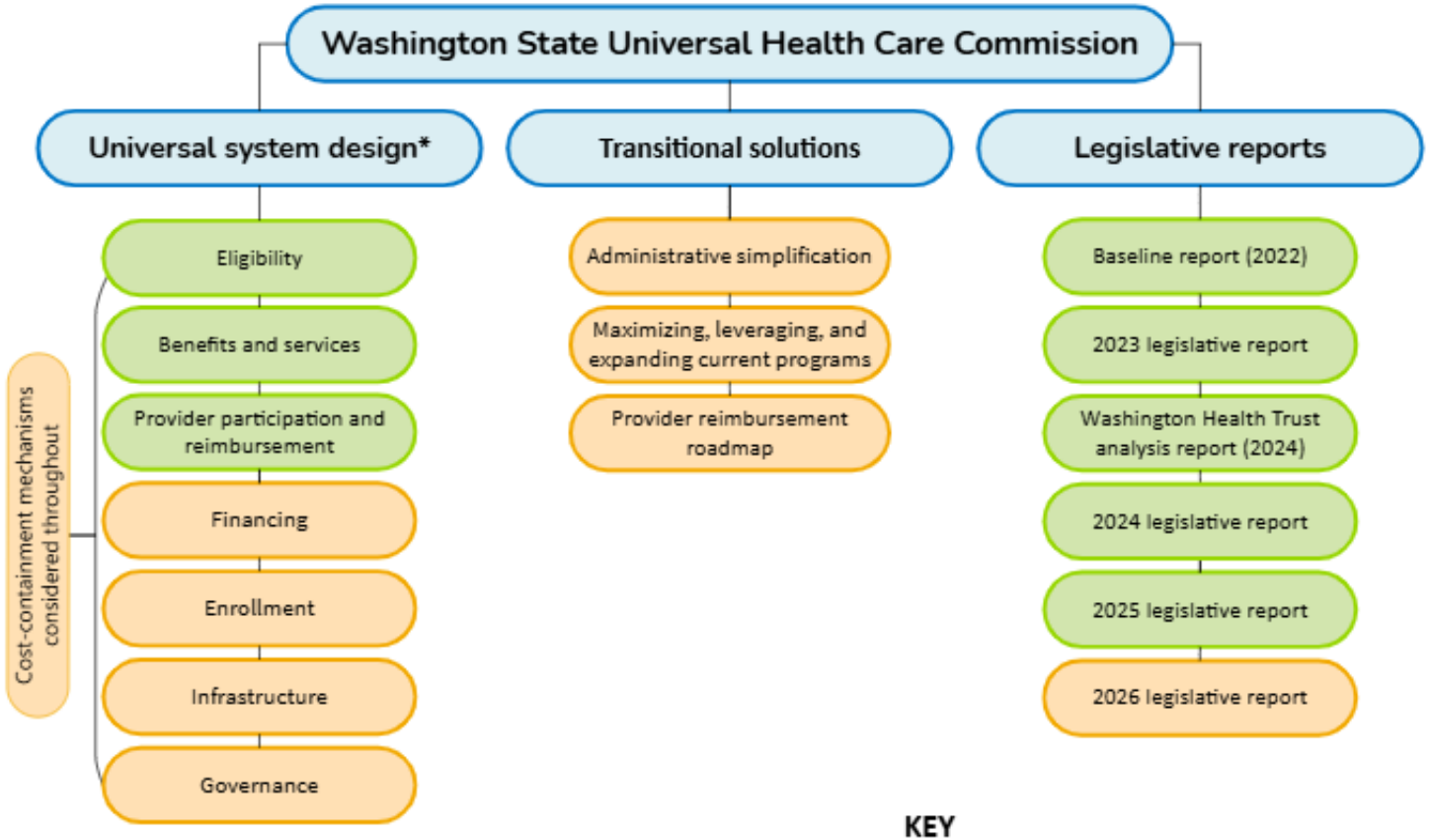
- As directed by the Legislature (RCW 41.05.840), the Commission must:

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

Workplan status



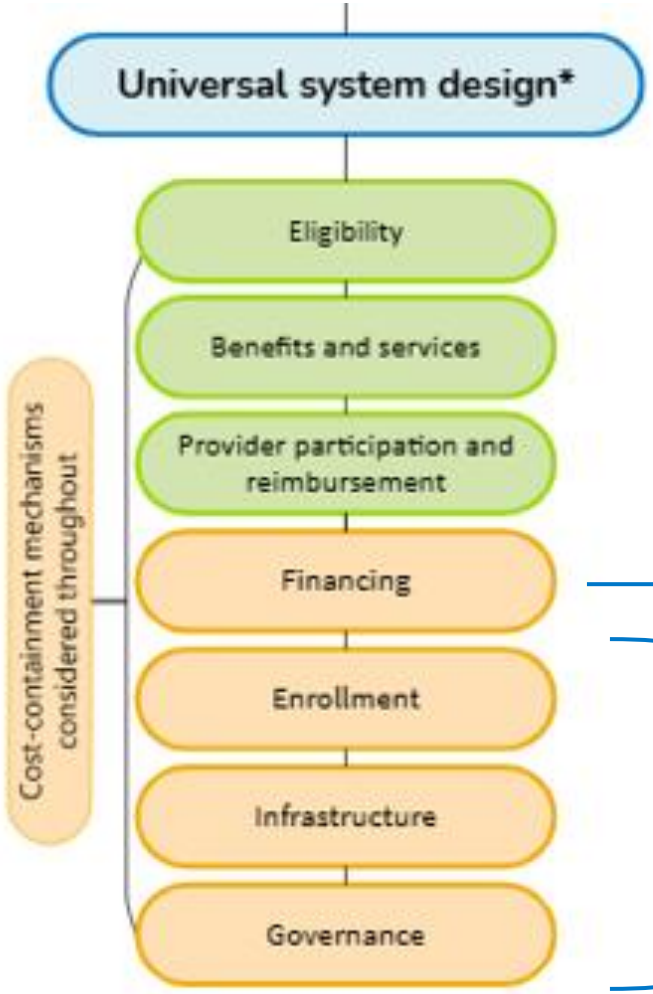
*Health care quality, health equity, and health disparities will be discussed and considered during each of the core universal system design components.

KEY

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

Last updated September 2026

Workplan status



FTAC
Target completion date: Q2 2027

Universal Health Care Commission
Target completion date: late 2027

Reconciliation of design elements and preparation of final deliverable
Target completion date: end of 2028

2027 workplan

- Greater reliance on work groups as Commission tackles three design elements
- Fewer Commission meetings, with additional updates between meetings

2027 meeting dates	
FTAC	**Commission**
February 4	March 18
May 6	June 3
August 26	September 30
November 4	December 2

Work group

- Members lend time and expertise to specific design element
- Members help draft and review materials
- Group develops materials for consideration and approval by full Commission

Work group structure

- Volunteers from larger body (Commission or FTAC)
  - Need to make sure work group membership does not constitute a quorum
- Smaller, more focused meetings to address topic in greater detail
  - One 60-minute meeting per month
  - Managed and facilitated by HCA staff member

Questions?

Washington State Health Care Authority

Tab 7

Washington State Health Care Authority

Finance Technical Advisory Committee (FTAC) report out

September 2026 FTAC meeting recording & materials

Washington State Health Care Authority

Overview

- Public comment
- Financing
  - Work group formation
  - Initial considerations

Public comment

- Public comments begin at time stamp 2:43
  - Recommendations for financing mechanisms
  - Support for universal health care
  - Support for increased resources for behavioral health, dental, and vision care

Finance design overview

- FTAC and work groups will lead initial drafting of finance design element
  - Iterative process with commission
- FTAC will help identify key decision points for the WG to address
- Some aspects of finance design depend on resources not yet available

Finance work group foundational tasks

- Develop scope for financing design element, including tasks below:
  - Determine general principles (evaluation criteria) guiding element design
    - E.g., Financing should be adequate and stable
  - Describe and evaluate revenue options for financing plan
    - E.g., If the sales tax were raised, what are expected impacts on equity?
    - E.g., Review methods of revenue collection to withstand legal challenges, including ERISA
  - Develop a set of attributes for a financing plan
    - What are the critical aspects of plan design?
    - What considerations and requirements should a financing plan address?

Initial Considerations

- Stability:
  - How does the universal financing plan ensure adequate funds to cover expenditures in short and long term?
  - Transition funding
- State landscape:
  - What are state specific considerations in developing a universal financing plan for Washington?

Questions?

Washington State Health Care Authority

Universal Health Care Commission meeting

We are currently on a short break

Washington State Health Care Authority

Tab 8

Washington State Health Care Authority

Foundational questions

- Will the universal system be single or multi-payer?
- Do commercial carriers play any role?
- Answers will help inform financing and infrastructure

Single payer

- Single payer refers to a health system that is financed by a single entity; in its common usage, that single entity is government.
- Government is the payer for services, and such payments are typically financed by taxes, but there is no implication that government employs the providers or owns provider organizations.

Single-Payer, Multiple-Payer, and State-Based Financing of Health Care: Introduction to the Special Section
https://pmc.ncbi.nlm.nih.gov/articles/PMC6775924/

Multi-payer

- Multiple payer refers to a health system that is financed through more than a single entity, one of which may include government.
- Private health insurance companies can participate in multiple-payer systems, with financing through individual premiums paid directly by beneficiaries, employers, and, in some cases, government.

Single-Payer, Multiple-Payer, and State-Based Financing of Health Care: Introduction to the Special Section
https://pmc.ncbi.nlm.nih.gov/articles/PMC6775924/

Single v. multi-payer

- "Healthcare reform in Colorado introducing universal health coverage that is either a multi-payer or single payer system has the potential to increase access to care, improve health outcomes, and possibly provide sector-specific employment benefits. Our cost estimates suggest that a multi-payer universal health care system will likely lead to small increases in the total cost of Colorado's health care system."

Health Care Financing Report, Colorado School of Public Health
https://content.leg.colorado.gov/sites/default/files/images/lcs/health_care_financing_report_-_co_school_of_public_health.pdf

Single v. multi-payer

- "Introduction of a full publicly financed and privately delivered health care system could yield significant healthcare savings, particularly if pricing regulations are put in place to control cost growth in the future. The financial health of hospitals and clinics and clinician retention should all be carefully considered with any potential pricing regulations."

Health Care Financing Report, Colorado School of Public Health
https://content.leg.colorado.gov/sites/default/files/images/lcs/health_care_financing_report_-_co_school_of_public_health.pdf

Single v. multi-payer: coverage

- Whether a health care system is single or multiple payer does not in and of itself define the system in terms of coverage. Universal coverage means simply that all people within a particular jurisdiction have access to health insurance, be it single or multiple payer.

Single-Payer, Multiple-Payer, and State-Based Financing of Health Care: Introduction to the Special Section
https://pmc.ncbi.nlm.nih.gov/articles/PMC6775924/

Single v. multi-payer: examples

- Canada
  - Single-payer system administered at provincial level
- Germany
  - Multi-payer systems that combine governmental oversight and benefit design with pubic and private health insurance options

Single payer

Pro	Con
• Single administrative process, possibly resulting in administrative savings • Affordability at point of service • Greater opportunity for cost control • Uniform reimbursement rates eliminate disincentive to treat patients whose coverage pays lower rates	• Health care spending may be pitted against other governmental spending priorities • Significant administrative challenges to eliminate all current coverage and move everyone into a new government program in a short period of time • Could shift payment to structure that is unfamiliar to patients and taxpayers, possibly raising taxes to offset other funding mechanisms

https://www.urban.org/sites/default/files/publication/99918/pros_and_cons_of_a_single-payer_plan.pdf

Multi-payer

Pro	Con
• Greater patient choice • Eliminates need for sizable new government entity • Less administrative burden to implement	• Fewer cost controls • Some studies suggest less cost savings compared to single payer • Could result in unequal access or quality based on payer

https://www.urban.org/sites/default/files/publication/99918/pros_and_cons_of_a_single-payer_plan.pdf

Model A & Model B

- **Model A:** State-governed and state-administered program for all state residents
- **Model B:** State-governed and health carrier-administered program for all state residents

Universal Health Care Commission Baseline Report, 2022
https://www.hca.wa.gov/assets/program/commission-baseline-report-20221101.pdf

Model A & Model B

Model A: state-administered	Model B: carrier-administered
• Establishes a single, state-designed coverage plan available to everyone in Washington State.	
• The state develops the delivery system rules.	
• There is a standard benefits package.	
• No insurance companies participate as the state contracts directly with providers and administers all functions currently provided by carriers, including claims payment, utilization management, care coordination, and member and provider services.	• Health carriers contract with the state to offer plans to Washington residents. As they do today, carriers may develop and maintain provider networks and administer some or all the functions they currently provide, such as claims payment, utilization management, care coordination, and member and provider services.

Universal Health Care Commission Baseline Report, 2022
https://www.hca.wa.gov/assets/program/commission-baseline-report-20221101.pdf

Discussion

- Assumption: starting from current state, need to work toward universal system gradually
- Past discussions suggest
  - Begin with multi-payer, move toward single payer
  - Begin with Model B, move toward Model A
- Is that the correct course of action?
- Other comments and questions

Tab 9

Washington State Health Care Authority

Enrollment, infrastructure, and governance

Universal Health Care Commission

Overview

- Enrollment, infrastructure, and governance
  - Background
  - Proposed definitions
  - Call for volunteers

Background

- Commission decided to be the lead entity addressing enrollment, infrastructure, and governance
- Discussions during February and September meetings

Proposed definition: Enrollment

- Front end: Process the member completes to enroll in a universal benefit plan
  - Identification of the system to be used for enrollment (existing or new)
  - When enrollment occurs and any special enrollment periods
- Back end: Verification and privacy protection to support enrollment
  - Define and manage required data inputs
  - Verification v. attestation requirements

Proposed definition: Infrastructure

- Systems that support care delivery and coordination for universal benefit members. Some examples include
  - 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

Proposed definition: 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 universal system
- There will need to be clear roles and responsibilities for all participants in the process

Examples in existing system

- Enrollment
  - Healthplanfinder
- Infrastructure
  - Washington Health Benefit Exchange in partnership with HCA and OIC
- Governance
  - Exchange Board

Discussion

- Does the Commission agree with the proposed definitions?
- Volunteers for enrollment work group

Questions?

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

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 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...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**).

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 Appendix A and Appendix 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 Appendix D and Appendix E for current and all-time FTAC member rosters.

When appropriate, the Commission and the Health Care Cost Transparency Board align their focus and work products to support each other's goals.

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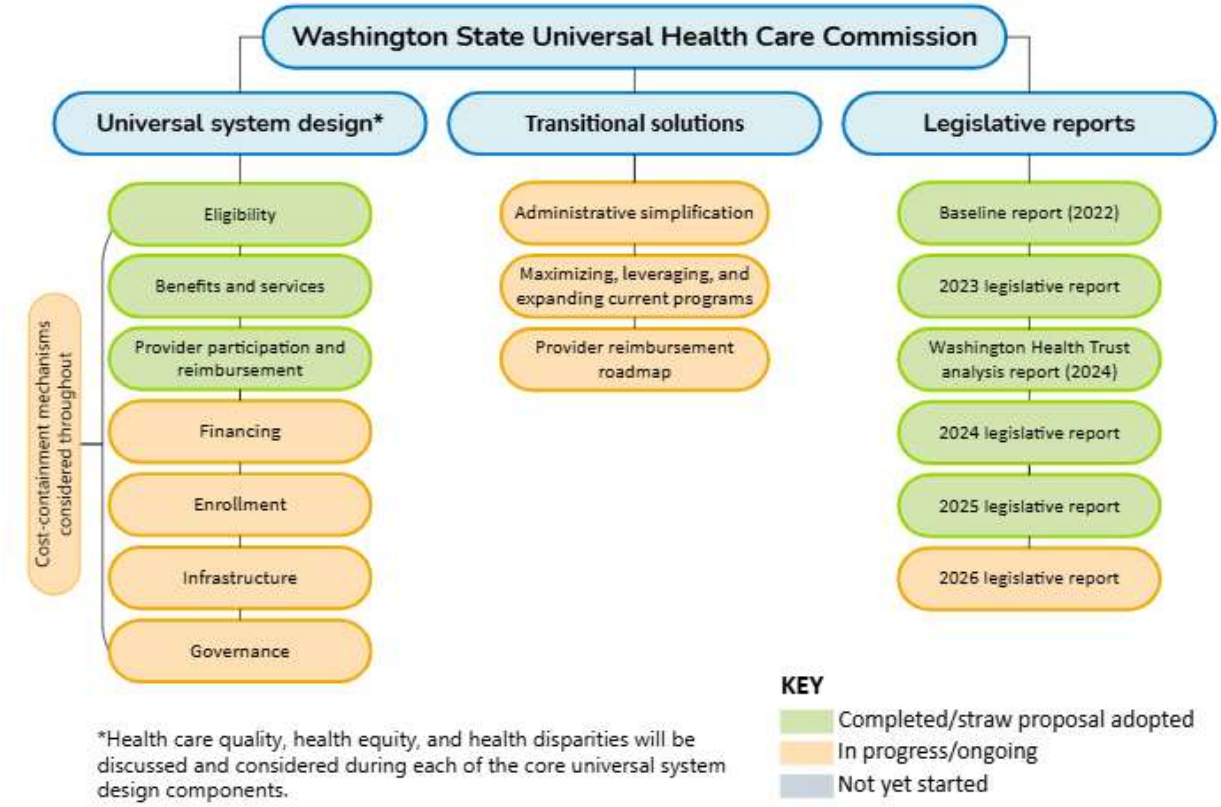
Workplan annual update: October ’25–September ’26

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.

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 significant 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 propose different payment mechanisms, suggest a possible sequence of implementation, 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 September 3, 2026. 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 its approval of the provider reimbursement proposal and submission to the Commission for consideration, 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 those instruments would operate. This work was informed by similar efforts in other states.

A finance work group was formed in August 2026 and will continue its work into 2027. The group's efforts may include 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

Beginning in late 2026, the Commission will lead the work on three outstanding design elements: enrollment, infrastructure, and governance. Before addressing these specific elements, the Commission will consider additional foundational elements of a universal system, such as whether the system will be single- or multi-payer, and what entity will bear the financial risk.

Phased implementation

As the Commission designs a universal system, it also considers 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 a cohesive implementation plan that incorporates and sequences transitional approaches following 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 Insurance Commissioner's regulatory account in the 2025–2027 budget. The OIC proviso funding supports "economic, actuarial, [and] 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**.

To support the analysis, the Commission also established a work group 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, OIC shared a proposal to design a primary care financing and payment model outside the traditional insurance-funded system. 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 September 2026 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 approved the following recommendation from the work group: "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."

The work group suggested that OIC use its seat on the Commission as the vehicle for delivering updates.

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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 September 2026, the Commission and FTAC received 50 written public comments and 60 oral public comments during regular public 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
- 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

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- Support for **firm deadlines** to be set for the completion of the Commission's work

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 provided a platform for input at its second advocates roundtable. The Commission incorporated the roundtable into its **regular meeting on September 3, 2026**. There were virtual and in-person attendance options with approximately 15 members of the public attending the meeting in person and roughly 50 people joining online. Most Commission members and several FTAC members attended in person and virtually.

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. Director Moran referred to the June 2026 economic forecast for Washington state, which was the most recent forecast available at the time of the meeting. He noted that projected revenues were $427 million less than the previous biennium. At the same time, health care costs continue to rise. He highlighted HCA's effort to address affordability and the Commission's accomplishments over the previous year.

Health care advocates and the Commission submitted questions to each other in advance. In their responses, advocates stressed the need for financing mechanisms to be equitable, easily understood, and legally defensible. They recommended that governance structures be designed to earn and maintain public trust, possibly through public or non-profit stewardship.

Commission responses included the intention to consider various financing mechanisms, including, but not limited to, establishing a public trust. The Commission noted that financing is often a combination of employer, government, and individual contributions. In addition, part of the Commission's ongoing work is learning from other states' work—their proposals and experiences in developing policy and bringing the proposal to their respective state legislatures.

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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 of 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. 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 and 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 (DOH)	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 (OoE)	State agency (OoE)

B. Universal Health Care Commission members (all time)

Governor-appointed seats

Member	Term begin	Term end
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

Member	Term begin	Term end
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

Member	Term begin	Term end
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.

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- 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.

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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:

- 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.

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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:

- 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.
- 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.

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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 and 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.
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 draft

Design 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: September 3, 2026
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 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.

[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)

[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.

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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 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:

- HGBs that are **largely fixed** and set both a hard cap and a hard floor on annual revenues charged and realized by a hospital
- **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

[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.

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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
- 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 (VBP) 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

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

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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, 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.

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[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.

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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 success looks 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 feedback | August 6, 2026

FTAC voted to approve draft.

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H. Office of the Insurance Commissioner primary care concept paper

See the following page for the legislative proposal from OIC.

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OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Ensuring Access to Primary Care

2027 Legislative Proposal, Concept Paper as of 9/1/2026

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 bill establishes that the legislature intends to pursue the design of a financing and payment model through which primary care services could be accessed outside of traditional insurance; and establishes the following goals:

- 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 Governor, the Health Care Authority, the Department of Health, and Tribal Leaders, 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.

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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 aligned 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