

# Universal Health Care Commission's Finance Technical Advisory Committee meeting

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May 14, 2026

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# Tab 1

Universal Health Care Commission's  
Finance Technical Advisory  
Committee (FTAC) **Agenda**

May 14, 2026  
2-4:30 p.m.  
Teams meeting

Members		
<input type="checkbox"/> Christine Eibner	<input type="checkbox"/> Kai Yeung	<input type="checkbox"/> Robert Murray
<input type="checkbox"/> Eddy Rauser	<input type="checkbox"/> Matthew Morrissey	<input type="checkbox"/> Roger Gantz
<input type="checkbox"/> Esther Lucero	<input type="checkbox"/> Pam MacEwan	<input type="checkbox"/> Sarah Huling
<input type="checkbox"/> Hiroshi Nakano		

Time	Agenda items	Tab	Lead
<b>2:00-2:10</b> (10 min)	Welcome, roll call, review of meeting minutes	1	Pam MacEwan, FTAC Lead
<b>2:10-2:25</b> (15 min)	Public comment	2	Mary Franzen, HCA
<b>2:25-2:30</b> (5 min)	Workplan update	3	Mary Franzen, HCA
<b>2:30-2:45</b> (15 min)	Universal Health Care Commission meeting report out	4	Pam MacEwan, FTAC Lead
<b>2:45-3:35</b> (50 min)	Provider reimbursement: proposal and roadmap	5	Harrison Fontaine, HCA
	<b>Break</b>		
<b>3:45-4:30</b> (45 min)	OIC proviso funding	6	Jenn Scott, HCA
<b>4:30</b>	Adjournment		Pam MacEwan, FTAC Lead

# Universal Health Care Commission's Finance Technical Advisory Committee (FTAC) meeting minutes

**March 19, 2026**

Virtual meeting held on Teams from 2–4:30 p.m.

**Note:** The meeting materials packet and a full recording of this meeting can be found on the [Commission's FTAC page](#).

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

## Members present

Christine Eibner  
Roger Gantz  
Sarah Huling  
Pam MacEwan  
Matthew Morrissey  
Robert Murray  
Hiroshi Nakano  
Eddy Rauser

## Members absent

Kai Yeung  
Esther Lucero

## Call to order

Pam MacEwan, FTAC liaison, called the meeting to order at 2:00 p.m. Committee staff provided reminders regarding the transition to Microsoft Teams, noting differences compared to Zoom. There were enough members for a quorum, so the committee could hold votes.

## Agenda items

### Meeting minutes

Committee members approved the [January 15, 2026, meeting minutes by majority vote](#).

### Public comment

The following members of the public provided comments:

- Jane Grafton, Whole Washington member
- Kathryn Lewandowsky, retired RN and Whole Washington member
- Chris Currie, retired RN and Health Care for All - Washington committee member
- Thomas Kennedy, Whole Washington member

Public comment topics included: Interest in utilizing the OIC proviso funds for analysis of universal health care financing and the costs to individuals and employers, support of universal primary care as an affordable step toward universal coverage, opposition to linking reimbursement to quality metrics in the guiding principles, and support for a public corporation model for administering primary care rather than private managed care organizations (MCOs).

Find this section in the meeting ([time stamp 04:19](#)).

Note: One member of the public signed up for public comment but had technical difficulties unmuting to verbally share their comment. The comment was collected via email and is included below:

Hello. My name is Maureen Brinck-Lund. I co-chair the HUX sub-committee with Health Care is a Human Right, (HCHR) which is a consortium of community and labor groups advocating for Universal Single Payer Health Care.

“HUX” is made up of individuals from a variety of organizations that follow, track, and attempt to give helpful comments to the UHCC and FTAC.

(I like to joke that “HUX” is an old Latin word that means persistence and sometimes repetition.)

My comment today is a repeat of one I first made at January’s FTAC meeting and again at last month’s UHCC meeting. Under Tab 5 for today’s meeting we see a discussion about possible uses for the OIC funding.

HUX members would like to reiterate our concept of using the OIC funds to study options for financing the whole universal health care system; a study to measure the possible overall costs and benefits to any final proposal.

By financing we mean an economic analysis of how to pay for universal coverage. Different from actuarial analyses, of which many have already been done

The study would address three basic questions:

- What are the funding sources, and funding levels, that could generate enough money to pay for the health care provided to Washington residents?
- What is the estimated range of how much individual Washington residents will pay, per year, individually (not in the aggregate), to fund the new universal health care system.
- How does the estimated cost to individuals compare with what individuals currently pay?

Answers to these could illustrate how the state and the state’s residents can benefit from proposed changes to the existing system and serve to cultivate support and attention needed to adopt a proposed system.

## Workplan update

### Mary Franzen, Coverage Strategies Manager, HCA

Staff reviewed the two-part charge of the Commission: developing transitional solutions for immediate impact and designing a universal system for all Washingtonians. Current FTAC work focuses on provider participation, reimbursement, and financing. The commission will be working on design elements including enrollment, infrastructure, and governance. A new [“what we’re working on” webpage](#) tracks approved proposals.

Find this section in the meeting recording ([time stamp 18:36](#)).

## Universal Health Care Commission meeting report out

Pam MacEwan, Liaison

Pam MacEwan provided a report out on the recent Commission meeting, which focused on provider reimbursement guiding principles, the current Commission suggestions for use of the OIC proviso funding, and next steps for these workstreams. The Commission suggested the OIC proviso funds support the study of provider reimbursement or financing. They suggested a reimbursement proposal should center primary and behavioral care and accepted FTAC's offer for a provider reimbursement roadmap.

Find this section in the meeting recording ([time stamp 21:50](#)).

### OIC proviso funding

Jenn Scott, HCA

Jenn Scott provided an overview of OIC proviso funding. Two hundred and fifty thousand dollars must be spent by June 30, 2027, for "economic, actuarial, or other modeling related to design of a universal health care system" relating to an outstanding design element. Previously shared ideas for potential analyses suggested by FTAC, UHCC, and members of the public were reviewed. Staff will start the contract process and develop a brief proposal based on suggested analyses.

Find this section in the meeting recording ([time stamp: 28:50](#)).

### Proposed interim solution

Jane Beyer, OIC

Jane Beyer expanded on the idea proposed in the February commission meeting to create a universal benefit package for primary care. This benefit as part of a universal primary care system would be carved out of traditional health insurance. Key features include prospective payments to providers based on patient pools rather than fee-for-service, integrated behavioral health and community health workers, and consistent quality measures to reduce administrative burden. FTAC members discussed the need to prevent a two-tiered system, the importance of risk adjustment, and rural-specific challenges.

Find this section in the meeting recording ([time stamp 34:40](#)).

### Provider reimbursement workgroup

Harrison Fontaine, HCA

Harrison Fontaine presented updates on three core work products: guiding principles, provider reimbursement proposal, and a newly conceived implementation roadmap. Specific sections of the proposal, including payment mechanisms and implementation approaches were discussed. Members suggested adding bundled payments (such as maternity care bundles) as an additional payment mechanism. Following public comment, the committee agreed to move away from "incentivizing" providers with quality metrics and leaned instead towards language about "supporting" providers to promote high-quality care.

Find this section in the meeting recording ([time stamp 1:41:29](#)).

## Closing comments and adjournment

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The meeting adjourned at 4:32 p.m.

## Next meeting

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Thursday, May 14, 2026, from 2–4:30 p.m. The meeting will be held on Microsoft Teams.

# Tab 2

# Public comment

# Universal Health Care Commission's Finance Technical Advisory Committee Written Comments

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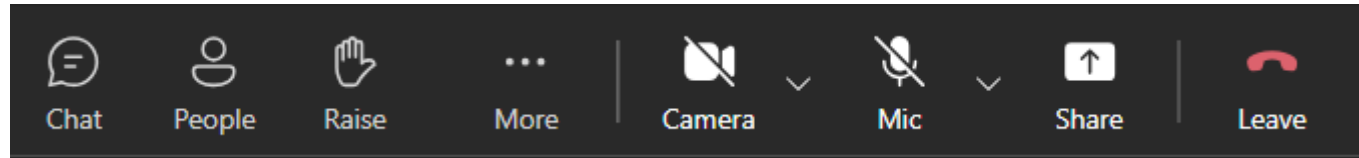
- ▶ No written comments were submitted via e-mail from March 6–April 30
- ▶ Oral comments received during the March FTAC meeting (time stamp 4:19)
- ▶ Public comments can be provided orally during the meeting's public comment period or in written form at any time to FTAC's inbox at [HCAUniversalFTAC@hca.wa.gov](mailto:HCAUniversalFTAC@hca.wa.gov)



Microsoft Teams

# Microsoft Teams meeting tools

- ▶ Available tools are in the right-hand corner of your meeting window.



- ▶ Webcam / Camera



- ▶ Mute / Unmute



- ▶ Raise hand



**Note:** You will be highlighted for the host when hand is raised.

# Tab 3

# Workplan update

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Finance Technical Advisory Committee

# Universal Health Care Commission

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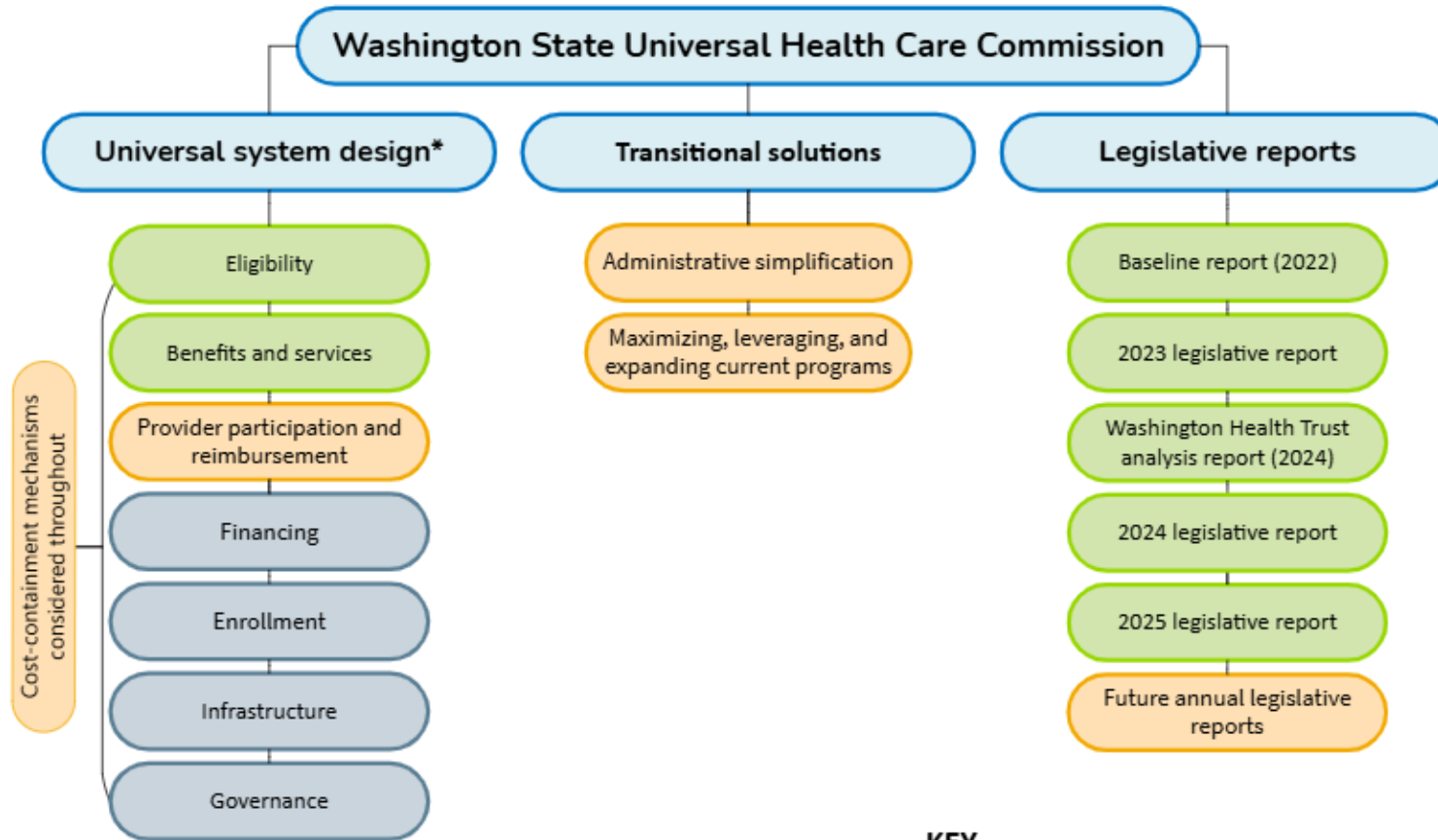
- ▶ As directed by the Legislature (RCW [41.05.840](#)), the Commission must:

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

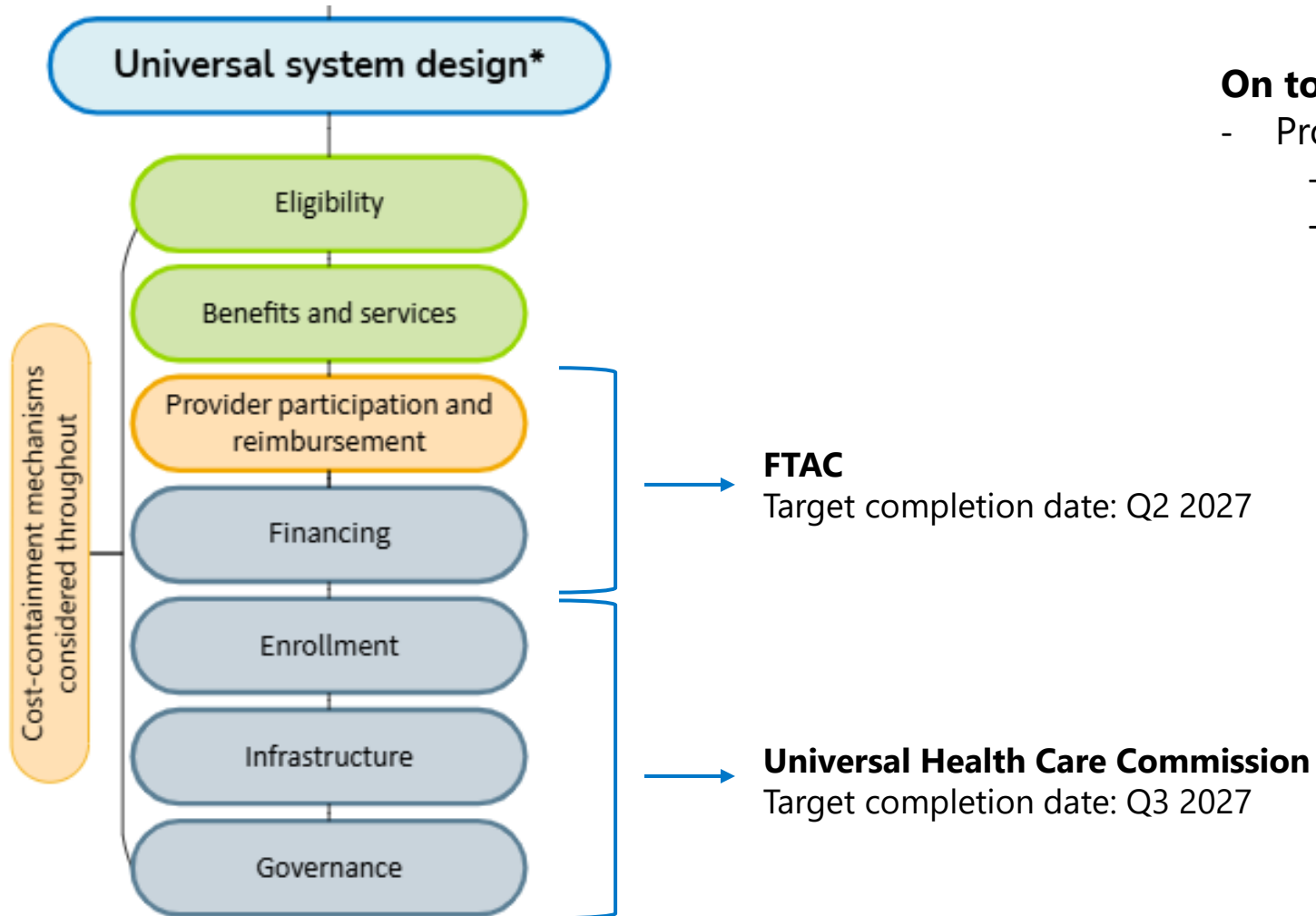
# Workplan status



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

Last updated March 2026

# Workplan status



## On today's agenda:

- Provider participation and reimbursement
  - Draft proposal
  - Roadmap

# Questions?

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# Tab 4

# Universal Health Care Commission update

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April Universal Commission meeting  
recording and materials

# Overview

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- ▶ Public comment
- ▶ Universal primary care proposal
- ▶ OIC proviso funding
- ▶ Feedback on provider reimbursement

# Public comment

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- ▶ Large turnout for public comment, both in person and remotely (time stamp 4:20)
- ▶ Encouragement to continue working toward a universal health care system
- ▶ Personal stories about navigating a fragmented health care system
- ▶ Support for the reimbursement guiding principles

# Public comment

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- ▶ Encouragement to include recommendations related to governance in the November 2026 report to the Legislature
- ▶ Recommendation to design a universal system that does not include managed care organizations for anything other than temporary administrative support
- ▶ Urgency of providing care to those who are losing coverage due to recent changes in federal eligibility rules

# Public comment

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## ▶ Universal primary care proposal

- ▶ Support for universal primary care to provide consistent, long-term stability for patients, with an emphasis on preventive and coordinated care
- ▶ Request not to adopt universal primary care as a transitional solution
- ▶ Concern about diverting attention from design of universal system and setting back progress already made
- ▶ Questions about the proposal's feasibility and whether it's an appropriate step toward a universal system
- ▶ Benefits of direct primary care, including reduced cost

# Public comment

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## ▶ OIC proviso funding

- ▶ Suggested topics of study included administrative cost analysis of benefit packages, examination of the type and amount of revenue tax sources needed for universal system, and strategies for unifying state health care programs
- ▶ Request not to use OIC proviso funding on topic related to universal primary care
- ▶ Suggestion to conduct economic analysis of how to pay for universal coverage

# Universal primary care proposal

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- ▶ Presented to FTAC in March and Universal Commission in April
  - ▶ Universal Commission [presentation and discussion](#) (time stamp 53:14)
  - ▶ Proposal overview included as Appendix A
- ▶ Ultimately, the Universal Commission will decide whether to adopt this proposal as a transitional solution

# Universal primary care proposal

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- ▶ FTAC's feedback from March meeting was shared with commission members during the April meeting
  - ▶ No answers yet, but awareness of and appreciation for the thoughtful questions
  - ▶ Commission members noted that many design questions apply to both universal primary care and the eventual universal system
  - ▶ Work group will help explore the proposal

# Provider reimbursement

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- ▶ Commission approved provider reimbursement guiding principles with one minor revision to principle #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.

# Tab 5

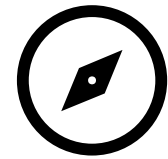
# Provider reimbursement

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# Work products

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- ▶ Provider reimbursement work products:
  - ✓ **Guiding principles:** key values to inform the proposal and future regulatory decisions
  - **Design element proposal:** set of recommendations that could be implemented on a smaller scale, then broadened
  - **Implementation roadmap:** recommendations for potential pathways to universal care that place payment mechanisms in order and describe how mechanisms could be broadened



# Schedule for work products

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## ▶ Progress to date:

### ▶ January-April

- ▶ FTAC, workgroup, and commission revised draft Proposal and approved Guiding Principles
- ▶ Workgroup drafted Roadmap

## ▶ Upcoming:

### ▶ May

- ▶ FTAC revision and feedback on Proposal and Roadmap

### ▶ June

- ▶ UHCC review and potential vote to approve Proposal and Roadmap

# What's out of scope?

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- ▶ Who pays providers (infrastructure/finance)
- ▶ Who oversees the payment system (governance)
  - ▶ Who makes future decisions about who is subject to payment mechanisms\*
- ▶ Specifics of how care is managed in a universal system (infrastructure)

\*The governing body would rely on guiding principles where relevant.

# Provider reimbursement proposal

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## ▶ **Current sections:**

- ▶ Summary & background
- ▶ Payment mechanisms
  - Reference based pricing & hospital global budgets
- ▶ Phased approaches
- ▶ Provider incentives
  - Incentivized vs. mandatory participation
- ▶ Oversight and data collection
- ▶ Alignment with ongoing work

How will these mechanisms impact rural facilities (e.g., CAH, SCH)?  
-They are currently carved out

What would opting out look like?  
-Opting out isn't feasible if cost containment is the goal.\*

\* Regulation of provider price would likely survive an ERISA challenge (see Roadmap)

# Addressing concerns of under resourced and rural providers

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- ▶ Certain types of rural hospitals are currently carved out of PEBB/SEBB reference-based pricing
  - ▶ Carve out could continue unless/until a governing body decides otherwise
  - ▶ Beyond the guiding principles, what may inform a governing body?
    - ▶ How do the exempted facilities contribute to spending growth?
    - ▶ What criteria should be considered to ensure capacity and sustainability?
- ▶ Uncompensated care fund
  - ▶ Mitigating consequences of market and/or regulatory failure

# Roadmap contents and review

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- ▶ Introduction
- ▶ Transitional pathway #1
  - ▶ Hospitals
- ▶ Transitional pathway #2
  - ▶ Managed care organization (MCO) contracting
- ▶ Conclusion
  - ▶ What success looks like

# Potential vote

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- ▶ Note revisions, if any.

- ▶ **Potential vote #1:**

FTAC approves the draft **proposal** for provider reimbursement (as revised) and submits it to the Universal Commission for its consideration.

- ▶ **Potential vote #2:**

FTAC approves the draft **roadmap** for provider reimbursement (as revised) and submits it to the Universal Commission for its consideration.

# Questions?

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# Finance Technical Advisory Committee meeting

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We're currently on  
a short break

# Tab 6

# OIC proviso

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# OLC proviso: Overview

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- ▶ \$250,000 for economic, actuarial, or other modeling related to design of a universal health care system.
- ▶ Spending deadline: June 30, 2027
- ▶ Provides guidance for making a recommendation, not the recommendation itself

# Commission direction for proviso spending

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- ▶ Universal Commission requested focus areas
  - ▶ Financing or provider reimbursement
- ▶ Analysis should address both universal primary care and universal health care
- ▶ High level areas of inquiry:
  - ▶ Cost for each system
  - ▶ Funding source(s)
  - ▶ Overlap in financing between universal primary care and eventual universal system

# Scoping questions

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- ▶ Are these the right areas for consideration?
- ▶ Are there other topics?
- ▶ How might we scope the analysis to:
  - ▶ Answer the questions
  - ▶ Complete by June 2027
  - ▶ Stay within budget

# Area 1: Cost for UPC & UHC

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- ▶ What is the most appropriate method to estimate cost?
- ▶ How much would a universal system cost?
- ▶ What is the best way to break out primary care costs?

# Area 2: Funding sources

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- ▶ What are potential funding sources for a universal system?
  - ▶ For example, an inventory of revenue sources
- ▶ What are the potential funding sources for UPC?
- ▶ How can we determine whether the same funding source might apply to both systems?

# Area 3: Overlap in financing UPC and UHC

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- ▶ How can we investigate whether the same financing mechanisms might apply to both UPC and UHC?
- ▶ How does the cost of UPC compare to full UHC? What percentage of the total price?

# Next steps

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## ▶ Staff will:

- ▶ Synthesize ideas present for the Universal Commission's consideration
- ▶ Start the contract process

# Questions?

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Thank you for attending the  
Finance Technical Advisory  
Committee meeting

# Appendix A

# Universal primary care proposal overview

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- ▶ Design a model for universal primary care (UPC)
  - ▶ Primary care is offered to all Washington residents as a non-insurance benefit (carved out of the health insurance system)
  - ▶ Consumer health insurance wraps around and coordinates with PC providers to cover other services
  - ▶ Build on evidence-based PC models, (e.g., UW AIMS Center Collaborative Care model)
  - ▶ Care is delivered by an interdisciplinary care team integrating behavioral health, advanced PC, and care coordination.

# Universal primary care proposal overview

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- ▶ Single set of quality measures, potentially drawn from the [Washington State Common Measure Set](#)
- ▶ Clinicians make decisions about services and patient care
- ▶ Capitated provider payments to bring predictable revenue to PC practices
- ▶ Consideration of attribution methodology, need for risk adjustment, or other transitional steps

# Appendix B

# Provider participation and reimbursement

## Design DRAFT

### Notes

**Committee:** Finance Technical Advisory Committee (FTAC)

**Commission/committee lead(s):** [Roger Gantz](#), [Pam MacEwan](#), [Bob Murray](#), and [Eddy Rauser](#).

FTAC initial review: March 19, 2026

**Commission review:** April 30, 2026

**Commission adopted:** [Month Day, Year]

**Proposal ID:** 2026-03

**Core design element/milestone:** [Provider Reimbursement and Participation](#)

### Summary

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

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

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

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

## Background

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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.<sup>1</sup>

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

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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

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<sup>2</sup> in Washington will be based on a percentage of Medicare reimbursement rates.

That payment mechanism, known as Reference-Based Pricing (RBP), could also be applied to payments to non-hospital-based providers. In addition, as noted in Principle #5, a payment structure could rebalance payments toward traditionally under-resourced services and settings (e.g., primary care, behavioral health care, and rural or underserved areas, among others). In this regard, a key issue both in Washington and nationally relates to distortions embedded in the

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<sup>1</sup> [RCW 41.05.840](#)

<sup>2</sup> RCW 41.05.028 contains exemptions for certain care settings, including pediatric and rural hospitals.

Medicare fee-for-service physician fee schedule that result in underpayment for primary and preventive care services. This fee schedule is also the basis for non-hospital provider payments from Medicaid, Medicare Advantage and most commercial insurers<sup>3</sup>. The state could consider using RBP to correct these distortions. It has started to do so for hospital and primary care payments under the state's PEBB and SEBB programs per [RCW 41.05.028](#).

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<sup>4</sup>. This approach could provide the state with an interim step in extending aspects of the current RBP mechanism<sup>5</sup>, 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<sup>6</sup>. Bundled payments for certain psychiatric and obstetric care services are currently implemented in Washington State<sup>7</sup>. Potential impacts of this payment mechanism, including on administrative complexity, patient selection, and the financial stability of low-resource providers, should be monitored during implementation.

Another payment mechanism that may be considered for these incremental steps is hospital global budgets (HGBs). Hospital global budgets establish a predetermined amount paid to hospitals for all inpatient and outpatient services. There are two different versions of HGBs: 1) HGBs that are largely fixed and set both a hard cap and a hard floor on annual revenues charged and realized by a hospital; 2) Flexible HGBs, which make use of a Volume Adjustment System to

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<sup>3</sup> 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)

<sup>4</sup> 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>

<sup>5</sup> RCW 41.05.028 sets OON rate caps for most hospitals that are out of network for public and school employees.

<sup>6</sup> 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>

<sup>7</sup> See the Collaborative Care Model and Global Obstetrical Care in Apple Health billing guides.

reduce the incentives of fee-for-service payment systems that induce hospitals to increase volumes of care unnecessarily and fund hospitals' fixed costs when volumes decline. The State should consider the advantages and disadvantages of both HGB approaches. These budgets should be mandatory for all payers but certain types of hospitals may be exempt initially. Careful consideration should be made regarding criteria for base payment rates, which may be adjusted based on factors like actual patient volume. When implemented effectively, HGBs allow for prospective, predictable payments that can stabilize hospitals currently subject to unpredictable revenue, fluctuating patient volumes, and a wide range of prices.

#### **Leveraging state market power**

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

### *Phased implementation approach*

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

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

- Applying the mechanism to an additional set of providers
- Applying the mechanism to additional care settings
- Applying the mechanism to additional services
- Applying mechanism to a greater proportion of provider budget
- 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<sup>8</sup>. Ultimately, these incentives may increase participation and contribute to stronger provider networks, especially where services were previously underfunded.

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

## Data collection and oversight

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

Data collection should be as complete as possible while minimizing impact on reporting entities. Currently, several separate and complementary data streams provide an incomplete picture of health care spending. Data currently collected by these separate systems should be incorporated into the universal system's All Payer Claims Database (APCD). 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<sup>9</sup>
  - 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.

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<sup>8</sup> Current provider reimbursement models can contribute to clinician burnout and moral injury, in part through overreliance on financial incentives to promote quality care.

<sup>9</sup> E.g., risk adjustment and rate cell analysis.

- 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.

## Draft Review History

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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’
- Add a standalone section describing the proposed universal, direct primary care transitional mechanism/approach

UHCC feedback | April 30, 2026

- Comments: concern that reference-based pricing or HGB could destabilize rural hospitals. The updated draft exempts rural/safety net hospitals exempt from initial pricing regulation, as they were in SB5083 (2025) and briefly considers factors if including these facilities in later steps. Additionally, the roadmap links to a study of implementation impacts in Oregon. Request to clarify how consolidating and leveraging purchasing power/open competitive contracting differs from existing strategies
- Request to clarify what consequences an opt out provision would have re: mandatory vs. voluntary provider participation
- Inclusion of what does success look like (evaluation criteria) for payment mechanisms
- Inclusion of contract durations and notification periods for provider predictability
- Review of unsuccessful related legislation to address issues related to provider reimbursement

DRAFT

# Appendix C

# Provider participation and reimbursement

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## Roadmap DRAFT

### Notes

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**Committee:** Finance Technical Advisory Committee (FTAC)

**Commission/committee lead(s):** Roger Gantz, Pam MacEwan, Bob Murray, and Eddy Rauser.

**FTAC review:** May 14, 2026

**Commission review:** [Month Day, Year]

**Commission adopted:** [Month Day, Year]

**Proposal ID:** 2026-03

**Core design element/milestone:** [Provider Reimbursement and Participation](#)

### Background

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Washington is in the midst of an extensive planning effort to move the State toward the development of a Universal Healthcare Insurance coverage and financing system for all State residents. The Financial Technical Advisory Committee (FTAC) was assembled to provide policy and technical input regarding this effort. FTAC believes that for this effort to be successful the State should develop effective government administered initiatives to control health care price and spending growth to: 1) make the State's health system more affordable, and 2) improve the financial feasibility of its universal coverage initiative. The following draft outline provides a series of steps the State could implement to assist in the achievement of these two goals.

### Transitional pathway 1:

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#### Hospital price and spending regulation

**Step 1 (2027-2028): Implementation of a Reference Based Price (RBP) Caps, linked to federal Medicare hospital payment levels, on hospital prices for State and Public employees administered by the Public Employee Benefits Board (PEBB) and School Employees Benefit Board (SEBB).**

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

This legislation empowered the PEBB and SEBB to set RBP Caps on hospital prices paid by the benefit programs. It closely parallels the implementation of a similar spending control program implemented in Oregon for their Public and State Employees. The Oregon initiative was found to effectively control spending on hospital care, generate needed savings for the State, without creating significant negative impacts on hospitals.<sup>1</sup> Washington’s legislation provides the State with an ideal first step to begin its future healthcare price and spending control strategies for the following reasons:

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

### **Step 2 (2027-2028): Efforts to Promote the Participation of all Large Public Insurance Purchasing Organizations in Washington.**

Once Washington’s RBP hospital cap program is operational and demonstrating the ability to constrain hospital prices, the state should strongly encourage additional public entities, such as Washington’s county and city governments, to participate in the program. This expansion will help improve the viability of these other public insurance programs and further demonstrate the effectiveness of RBP Caps to control hospital price and spending growth, without imposing deleterious impacts on hospitals. Some Washington counties have expressed interest in the RBP Cap approach. They and other counties may wish to participate in this program.

### **Step 3 (2028-2029): Legislation to Apply RBP Caps on Payments by all Private Insurers for Out-of-Network (OON) Hospital Services.**

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

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<sup>1</sup> Murray RC., A. Ryan and CM Whaley. Hospital Finances, Operations and Patient Experience Remain Stable after Oregon’s Hospital Price Cap was Implemented. Health Affairs. December 2025.

<https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00682>

There is strong evidence (from the imposition of OON price caps in the Medicare Advantage market) to suggest that OON price caps can greatly strengthen the negotiating leverage of private insurers relative to hospitals and result in lower year over year increases in private insurer spending on hospital care. Although OON hospital care only accounts for between 6-9% of hospital spending, capping OON hospital prices will neutralize an effective negotiating tactic that hospitals use in their price negotiations with insurers, threatening to terminate their insurance contract, go “out-of-network” and charge the insurers beneficiaries full charges (which are often double or triple contracted prices). Facing the prospect of spending much higher amounts on hospital care, and a reduction in the insurer’s network, insurers regularly acquiesce to hospital demands for large annual payment increases in their contracted rates. Setting an OON price cap at say 200% of Medicare would mean that the insurer could easily demand contractually negotiated prices covering both in- and out-of-network services at or below 200% of Medicare (i.e., if the hospital refused such a negotiated result, the OON price cap law would automatically impose such a payment level on the hospital).

This proposed third step is considered a lower intensity regulatory strategy because it would only apply to 6-9% of private insurance payments. However, the impact of improving insurer negotiating leverage over contracted in-network hospital rates can help curtail the rapid annual price escalation insurers face due to the growing market dominance of an increasingly consolidated hospital industry. It could also overcome the flaws in the federal No-Surprises Act (NSA), which has been ineffective because it defaults to an “Independent Dispute Resolution” (IDR) process that is costly, cumbersome and favors providers and fails to adequately cap surprise bills.

Legislation authorizing the use of RBP Caps for hospital OON care should indicate that the state has the authority to mandate the payment levels charged by hospitals covered by the legislation.

#### **Step 4 (2029-2030): Legislation to Apply RBP Caps on Hospital Payments for all Private Insurers Licensed to Operate in the State and Development of a Politically Independent Regulatory Commission or Board.**

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

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

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

- 1) This system is easy to implement and administer avoiding the tendency of past state efforts to construct elaborate and overly complicated hospital price control models that become ineffective because of their inherent complexity;
- 2) The system can be implemented without the need for a large governmental staff to operate and enforce compliance with the system;
- 3) Different price cap levels can be established for different types of hospitals, even resulting in price increases for certain financially challenged institutions (such as small/rural hospitals) in the state;
- 4) The system can be the basis for a set of far more equitable and rational regulated hospital "base" rates<sup>2</sup> (a starting set of actual regulated payment levels per hospital service similar to the rate structure implemented by both the Medicare and Medicaid programs).

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

- 5) The state can implement a Volume Adjustment System (VAS) as a relatively simple overlay adjustment on these base payment levels to counter the inherent incentives in fee-for-service (FFS) payment models to induce hospitals to unnecessarily increase their volume of services in order to improve their profitably. The use of a VAS specific to private insurer rates can neutralize hospitals' tendency to provide large quantities of low-value and unnecessary care to generate surplus revenues.<sup>3</sup>

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<sup>2</sup> Medicare payment levels have the distinct advantage of being set with a consistent relationship to actual relative cost levels by service. A set of commercial sector rates linked to Medicare, then can help eliminate existing price distortions and inequities of privately negotiated hospital prices, which has resulted in an array of prices that do not reflect the cost of delivering a service and result in severe misallocations of resources and other distortions. A regulatory board or commission can oversee such a system and gradually phase all hospital rates to reflect a consistent proportion of Medicare payment levels and thus create a far more rational (from an economic standpoint – i.e., in markets, prices that reflect cost result in a better allocation of resources and more equitable payments) hospital payment system.

<sup>3</sup> Note: A VAS is designed as an automatic adjustment to regulated hospital prices to remove the excess of marginal revenue over marginal cost for hospitals paid under an itemized FFS payment structure. This tendency of hospitals to increase their volume of services, whether they are needed or not, is a function of hospital cost structures which contain both fixed (the cost of buildings, fixed equipment, fixed staffing, etc.) and variable costs (the cost of supplies, drugs, variable staffing and other costs that vary with volume). The Maryland rate setting

Once a system of more rational and equitable hospital base rates is established for commercially insured patients, the State could consider the implementation of other rate setting adjustments, methodologies and policy programs. One program the state should consider would be a method of assisting hospitals in the funding of Uncompensated Care (UC). Given the cutbacks in subsidized private insurance and Medicaid programs, hospital UC is likely to increase rapidly in future years. Such a system will be increasingly attractive to hospitals as their UC grows rapidly over time and can support the financial viability of hospitals that service patients in rural and underserved areas of the State.

**Step 5 (2029-2030): Application to the Centers for Medicare and Medicaid Services (CMS) and the Centers for Medicare & Medicaid Innovation (CMMI) for an All-Payer Waiver for Hospital Payments.**

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

The State could also use this authority to create a system of "flexible" Hospital Global Budgets (HGBs), utilizing the VAS for hospital payments from commercial insurers, Medicare and Medicaid. As system of Flexible HGBs has distinct advantages over the largely fixed HGBs implemented by Maryland for all of its hospitals in 2014. While the Maryland fixed HGBs did save Medicare money over time, these savings were generated on Medicare payments that had traditionally been 30% higher than average Medicare hospital payment nationally. Thus, these savings were achieved in an environment where Medicare already drastically overpaid Maryland hospitals for Medicare services.

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

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

With these more complicated hospital rate setting approaches, the State must be careful to avoid making their systems too complex and difficult to understand by payers and hospitals, a dynamic which resulted in considerable regulatory failure in past state-based rates-setting systems. Additionally, states can configure their regulatory oversight agencies in ways that help prevent the other key vulnerability of regulatory systems, regulatory capture.<sup>4</sup>

## Transitional pathway 2

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### Open Competitive Contracting

Open competitive contracting for health care services offers purchasers a vehicle for cost containment. Competitive contracting allows eligible vendors to vie for a contract in a transparent marketplace where agencies can select the best value based on a combination of price and quality. The term “open” is used because all vendors meeting the contract requirements can submit a bid. Current statute and rule specify the requirements to solicit, submit, and evaluate bids as part of the open competitive contracting process, as well as how awards are made and disputed.<sup>5</sup> The contracts awarded are for a set period (e.g., three to five years). Importantly, before the process begins, an actuarial analysis to determine acceptable bid prices should be performed, including a floor and upper limit range. The floor is needed to ensure that a carrier will not offer too low a bid to get a contract.

A recent example of limited competitive contracting in Washington was following the implementation of the state’s public option plan (Cascade Select) in plan year (PY) 2021. For PY 2023, HCA required the five participating health carriers to submit bids and county coverage proposed. HCA selected three of the carriers based on price and access. Subsequently, public option premiums were 3.0% lower than in PY 2023, compared to a 10% increase for non-standard plans and a 6% increase for standard cost-sharing plans.<sup>6</sup>

Open competitive contracting with health carriers would begin with state agencies. Over 2 million people in state sponsored health coverage receive their coverage through health carriers. Over a multi-year period, contracting would be phased in with the eventual goal that HCA contracts for PEBB/SEBB, Health Benefit Exchange, and Medicaid coverage in linked process that would leverage the market power of 2.9 million enrollees to further contain escalating spending (Table 1).

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<sup>4</sup> Murray R. Rate Regulation Revisited: Managing Regulatory Failure and Regulatory Capture in Health Care. October 2022. The Milbank Memorial Fund. [https://www.milbank.org/wp-content/uploads/2022/10/Murray\\_Regulation\\_393.pdf](https://www.milbank.org/wp-content/uploads/2022/10/Murray_Regulation_393.pdf)

<sup>5</sup> See Chapter 39.26 RCW , Chapter 200-320 WAC , Chapter 48.44 RCW

<sup>6</sup> “Cascade Select Public Option Report” to Health Care Cost Transparency Board (October 18, 2023).

Table 1. State health care program enrollment and MCO participation

State Health Care Program			
Program	Total	MCO Member	Percent MCO Enrollment
Medicaid	1,930,654	1,601,542	83.0%
PEBB	298,424	52,395	17.6%
SEBB	285,469	141,865	49.7%
HBE	290,120	290,120	100.0%
Total	2,804,667	2,085,922	74.4%

**Step 1: Combine state employee coverage. Merge PEBB and SEBB into a single risk pool.**

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

Based on a preliminary assessment, HCA has statutory authority to engage in open competitive contracting for PEBB and SEBB. RCW 41.05.021(2)(b) states that the PEBB and SEBB may implement strategies to promote managed competition including "... *soliciting competitive bids for the [health] benefit package*". However, HCA would likely need additional administrative funding to undertake this strategy. This may include funds for actuarial assistance to establish a bid floor and avoid problems with vendors submitting bids that are too low. <sup>[4]</sup>

**Step 2: Obtain federal waiver and begin open competitive contracting for Medicaid and CHIP.**

The Health Care Authority should next engage in open competitive contracting for Medicaid as well as CHIP medical and behavioral health coverage. Some 1.9 million people are enrolled in Medicaid with 83% enrolled in managed care with five health carriers. As with PEBB/SEBB procurement, the Medicaid RFP process for coverage would be opened to all licensed health carriers. Because federal Medicaid law and regulation requires that states' Medicaid managed care rates meet "actuarial soundness" requirements, HCA may need to seek an 1115a waiver of

these provisions to employ rates that are based on best-prices from a competitive contracting process.<sup>7 8</sup>

### **Step 3. Obtain legislative approval to allow the Exchange to offer only the public option and engage in open competitive contracting.**

The Health Benefit Exchange (HBE) should next seek approval from the legislature to limit Exchange coverage to the public option (Cascade Select) and engage in open competitive contracting. Currently the public option has the lowest priced coverage, and 115,000 (40%) enrollees are already enrolled in public option plans. With legislative approval to expand its authority to undertake competitive contracting, HBE could work with HCA and Office of the Insurance Commissioner (OIC) to competitively contract for all 290,000 enrollees<sup>9</sup>. Federal waivers of ACA provisions may be required to limit the exchange to public option plans, and this should be evaluated before pursuing legislative approvals.<sup>10</sup>

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

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

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<sup>7</sup> Section 1115a of the Social Security Act gives the HHS Secretary broad authority to waive certain provisions in Title XIX (Medicaid). However, these waivers must meet a “budget neutrality” test, which would be accomplished by demonstrating that open-competitive contracting results in health carrier rates below the “actuarial soundness” standard.

<sup>8</sup> <sup>[5]</sup> The Medicaid Managed Care Organization (MCO) actuarial soundness rule, defined in 42 CFR § 438.4, requires that capitation rates paid by states to MCOs be certified by actuaries to cover all reasonable, appropriate, and attainable costs for providing services. Rates must be developed according to generally accepted actuarial principles to ensure financial stability, beneficiary access to care, and proper, non-arbitrary rate-setting.

<sup>9</sup> E2SB 5377.Sec.5 (RCW 41.04.410) directed HBE and HCA to contract with carriers to expand public option coverage statewide. This authority was used by HCA to engage in competitive contracting. However, this authority was to obtain statewide coverage, and broader authority is likely needed.

<sup>10</sup> See 42 USC Ch. 157 for specific language of ACA provisions.

provider credentialing, and quality performance requirements—which could lead to further savings.

## Conclusion

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The two parallel pathways above reflect complementary approaches to address the Commission’s charge to “... create immediate and impactful changes in the health care access and delivery system in Washington and prepare the state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system.” Effectively implemented hospital price and spending regulations would address a key driver of escalating healthcare spending for the commercially insured. Open competitive contracting, when coupled with consolidated public purchasing, could lower premiums and out-of-pocket costs for approximately one third of Washington residents. Additionally, this approach would reduce price inequity, increase payment predictability, and begin the process of rebalancing payments to support currently underfunded care. State capacity would be built – along with a more stable and affordable system – over time. The ability to evaluate and adjust at each step means that policymakers could successfully respond to unanticipated impacts or events. If these pathways are successfully implemented, they will increase the feasibility of a universal health care system.