Washington State Health Care Authority

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

September 14, 2023

Virtual meeting held electronically (Zoom)

2–4 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the **FTAC webpage**.

Members present

Christine Eibner
David DiGiuseppe
Ian Doyle
Kai Yeung
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Eddy Rauser
Esther Lucero

Call to order

Pam MacEwan, FTAC Liaison, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

Beginning with a land acknowledgement, Pam MacEwan welcomed members of FTAC to the fifth meeting and provided an overview of the agenda.

Meeting summary review from the previous meeting

The Members present voted by consensus to adopt the Meeting Summary from FTAC's July 2023 meeting.

Public comment

Roger Collier asked if costs doubling for some employers via a payroll tax could be deemed as "exorbitant" and in violation of the Employment Retirement Income Security Act of 1974 (ERISA), and how far out the federal court processes to resolve ERISA preemption would be from Washington's passing of universal health care legislation. Roger asked if FTAC would allow them a few minutes at the next meeting to discuss their public option proposal submitted in April.

Kathryn Lewandowsky, Co-Chair, Whole Washington, expressed Whole Washington's interest in sharing the Washington Health Trust proposal (beginning at page 59 of the Commission's August meeting materials), particularly financing-related components, with FTAC members at a future meeting.

Lori Bernstein encouraged FTAC members to watch the recording (timestamp 45:50) of Whole Washington's presentation from the Commission's August meeting.

Maureen Brinck-Lund asked whether the Washington Health Trust proposal could be used as a draft model for achieving universal health care under a single-payer financing system.

Presentation: Large employer perspectives on state-based universal health care

Bill Kramer, Director for Health Policy, Purchaser Business Group on Health

Health benefits are key to large employers' recruitment and retention strategies, but rising health care costs impact employers' ability to remain competitive and increase wages. Some large employers are adopting aggressive cost containment strategies, e.g., mental health and substance use access and quality.

Large employers are likely to have some concerns with universal health care, such as the loss of differentiation in employee recruitment and any new taxes. Further, it may create inequities between employees with universal health care versus those with employer benefits. Finally, employers could feel a loss of control in not being permitted to design health benefits to meet employees' needs. Large employers will fiercely defend ERISA preemption.

Universal health care could be made appealing or acceptable to large employers, e.g., employers having a choice of whether to continue offering health benefits or joining the universal health care system. Some of the most important product features for large employers include provider network, benefits, price, and choice of plans. In a unified financing system, employers could maintain differentiation in employee recruitment by offering other benefits, e.g., retirement, or offering wraparound benefits for any services not covered under the universal plan.

It was noted that based on recent research, large employers nationally are paying between 200-300 percent of Medicare (with variation between and within states) for health benefits. Is there an argument that a universal health care system will relieve some of this pressure for employers? Bill Kramer replied that most employers are focusing their influence on systemic solutions via the public policy arena, e.g., cost growth targets, greater oversight over mergers and acquisitions, etc.

The private sector's concerns over government price controls were noted. Are there areas of commonality? Bill Kramer replied that most large employers accept government intervention in areas where markets don't exist or have failed irreparably.

Presentation: ERISA options for Washington

Erin Fuse Brown, Catherine C. Henson Professor, Director of the Center for Law, Health & Society, Georgia State University College of Law

This presentation was not legal advice. To keep employer-based coverage intact, the drafters of the Affordable Care Act (ACA) created the employer mandate where employers with more than 50 employees that fail to provide "minimum essential coverage" that is "affordable" and offers "minimum value" face a penalty. The employer mandate can be waived by the federal government via a 1332 waiver.

A federal ERISA waiver does not exist, and the U.S. Department of Labor (DOL) (entity that administers ERISA) has no authority to waive ERISA preemption provisions. Federal courts, not the DOL, independently determine whether a state law is in violation of ERISA.

Washington's goal in designing a universal health care system is to include the employer-based market (accounts for 52 percent of Washingtonians' health coverage), without running afoul of ERISA preemption because without it, the universal plan is neither "universal" nor fiscally sustainable. The spectrum of policy design options for a state-based universal health care system depends on how "universal" is defined, e.g., universal eligibility, universal enrollment, etc., and whether the transition happens all at once or on a glide path. Additionally, each model on the spectrum entails balancing policy goals with legal and other tradeoffs.

The first option on the spectrum begins where Washington is currently - offering a limited public option (Cascade Select). This option has limited reach by filling gaps in coverage on the individual market but has no ERISA implications because it does not impact employers.

The next option is a comprehensive public option. This may call for a more heavily regulated or government-sponsored health plan made available to all state residents (including those with employer-based coverage). The multi-payer system would persist, but this option could break the link between employment and health coverage. This option would have universal eligibility and could be used as a glide path to a single-payer system. There could be some legal difficulties under ERISA and require waivers to bring in other payers (Medicare, Medicaid, and ACA).

Furthest on the spectrum is a state-based single-payer plan which the government would administer and provide the same coverage to all state residents, irradicating the current system. This option would have simplified administration with total market reach and universal enrollment. This option invites more legal and political difficulties and would require the same waivers as mentioned above.

There are legal challenges and policy tradeoffs in capturing employer spend via the comprehensive public option. Washington could not mandate that employers offer the comprehensive public option. Instead, structuring the state plan as voluntary for employers/employees would retain a meaningful set of plan choices and avoid ERISA preemption under the current Ninth Circuit precedent in the Golden Gate and City of Seattle cases (see FTAC's July meeting recording, timestamp 23:08 for more detail on these court cases). Funding for this option could be structured to avoid ERISA preemption, e.g., payroll taxes (levied on wages) don't on their face relate or refer to an employer benefit plan. Employers could be exempt from the payroll tax if they offer coverage at least as affordable and comprehensive as the state plan ("Pay or Play"), versus a payroll tax without exemptions which would accelerate a market-shift to the state plan but increase ERISA difficulty, e.g., employers paying both the payroll tax and continuing to offer their own benefits could be deemed "exorbitant" ("exorbitant" is a concept, not a number). The tax implications of this option are outside the scope of this presentation.

There are also legal challenges and policy tradeoffs of capturing employer spend via a state-based single-payer plan. The three primary mechanisms to navigate around ERISA preemption and capture employer expenditures include Type A, Type B, and Type C. Type A, a funding plan, imposes a payroll tax (calculated as a percentage of wages) on employers and/or premiums on individuals. This option incentivizes employers/employees to switch voluntarily to the universal plan to avoid double paying (e.g., paying property taxes to fund public schools and choosing to pay tuition for private school). Whether this is preempted by ERISA depends on how "exorbitant" is interpreted by a court. Additionally, courts could interpret a payroll tax on employers as coercive.

Under Type B, provider restriction, all provider payments would come from the single-payer plan at single-payer rates. Three types of provider restrictions include: 1) universal provider enrollment and ability to contract with alternate plans (likely not preempted), 2) voluntary provider enrollment, but if they join the state plan, they cannot participate in other plans (likely not preempted), and 3) universal provider enrollment without ability to contract with other plans (may be preempted). ERISA does not preempt state regulation of health care providers (has only an indirect effect on employer health benefit plans). The question would be whether the indirect effect is enough that it crosses the line toward coercion, e.g., effectively gutting employer provider networks.

Finally, under Type C, pay and recoup provisions, the single-payer plan can pay for services and seek reimbursement from other payers. This, in combination with some sort of provider restriction gives employer plans a plausible way to continue to exist and may help strengthen the ERISA preemption case for the state.

A single-payer plan should include a combination of a funding plan with payroll taxes, income taxes and/or premiums, provider payment restriction and incentives to participate, pay-and-recoup mechanism, and a severability clause to prevent the system from failing if any one of these provisions was determined to be preempted by ERISA.

Non-duplication prohibits any self-funded health plan from offering coverage that duplicates state plan coverage and is likely preempted. However, prohibition on any state-regulated insurance carrier or plan from offering duplicative coverage is likely not preempted. To avoid making a preempted "reference" to ERISA plans, Washington should not explicitly state that self-funded duplicated coverage is permitted (though it is).

The policy design for Washington's universal health care system will be driven by Washington's goals within legal, financial, and political bounds. There are tradeoffs. ERISA legal challenge is inevitable, but whether the state wins will depend on how the plan is crafted. States currently have the power to and have a strong track record of regulating provider rates, e.g., rate caps. There may be discomfort in preventing providers from contracting with certain entities, but this could be framed as a condition of participating in the single-payer plan.

A committee member asked if a payroll tax imposed on employers without condition would be the least risky from an ERISA standpoint. This could be a good option because it makes no mention of employer health benefit design.

FTAC Member vote: recommendations to the Commission regarding ERISA

Pam MacEwan, FTAC Liaison

This vote is intended to provide guidance to the Commission on ERISA options that allow the design process to advance. This guidance is not binding forever.

FTAC members agreed that Option 1, a federal ERISA waiver, does not exist and is therefore impossible to obtain. Gary Cohen, Health Management Associates, noted that this is in the same category as an act of congress. Given how difficult this would be to achieve, members did not recommend Option 1. One member recommended that the Commission work with Oregon's Universal Health Plan Governance Board to influence federal legislation on ERISA.

FTAC members agreed that Option 2, optional employer participation in the universal plan, will likely avoid ERISA preemption. Any path to including employers should be optional to avoid an ERISA challenge and because it may benefit employers.

Option 3 was a pay or play or meaningful alternative (e.g., comprehensive public option). It was suggested that "pay or play" be separated from "meaningful alternative" because of the differences in financing mechanisms. FTAC member Roger Gantz suggested that consolidated state purchasing could be a path with which to build

other ERISA options. Some members noted that pay or play is likely to be problematic and that the state could accomplish the same goals through a payroll tax. This is perhaps the most nuanced option and requires further study because pay or play could be structured differently or the same as a meaningful alternative.

There was interest in Option 4, provider regulation/incentives, as a means of containing costs to financially sustain the system. This option may have to be done in conjunction with action on Medicare and Medicaid since the provider community may be concerned about losing employer-sponsored coverage rates which tend to be higher.

Members highlighted some of the pros and cons of Option 5, a payroll tax on employers. This may be a more heavy-handed approach from employers' perspective because they'd have no choice but to pay the tax. It may be more politically feasible to begin with Option 3 at the outset where employers would have a choice of whether to pay into the universal system, then transition to Option 5. This requires further exploration. Erin Fuse Brown added that a payroll tax isn't unique to either a comprehensive public option plan or a single-payer plan, rather it's a financing mechanism designed to capture employer dollars and to incentivize people to join the universal plan. The ERISA questions are along the lines of how high the payroll tax is and whether there are exemptions. This option could be attractive to employers because they could raise employees' salaries in lieu of paying for health benefits.

Option 6 was a combination of two or more options. There was interest in exploring ways to combine multiple options in the interim and for the larger system while also getting a clearer understanding of the greater system design, transitional solutions, and policy goals as determined by the Commission.

Any options that FTAC will support will depend on things that haven't been decided yet, e.g., larger system design and strategies to transition the state to a universal health care system. There was agreement among members that participation by employers must be optional, must include provider incentives to contain costs, and a funding mechanism that may or may not have exceptions on employers is required, but this requires further exploration.

Adjournment

Meeting adjourned at 4:02 p.m.

Next meeting

November 9, 2023
Meeting to be held on Zoom
2–4 p.m.