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# Universal Health Care Commission

April 14, 2022

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## Universal Health Care Commission Meeting Materials

April 14, 2022  
3:00 p.m. – 5:00 p.m.

(Zoom Attendance Only)

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# Agenda

# Tab 1

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## Universal Health Care Commission

April 14, 2022  
3:00 p.m. – 5:00 p.m.  
Zoom Meeting

### AGENDA

#### Commission Members:

<input type="checkbox"/>	Vicki Lowe, Chair	<input type="checkbox"/>	Estell Williams	<input type="checkbox"/>	Kristin Peterson
<input type="checkbox"/>	Senator Ann Rivers	<input type="checkbox"/>	Jane Beyer	<input type="checkbox"/>	Representative Marcus Riccelli
<input type="checkbox"/>	Bidisha Mandal	<input type="checkbox"/>	Joan Altman	<input type="checkbox"/>	Mohamed Shidane
<input type="checkbox"/>	Dave Iseminger	<input type="checkbox"/>	Representative Joe Schmick	<input type="checkbox"/>	Nicole Gomez
<input type="checkbox"/>	Senator Emily Randall	<input type="checkbox"/>	Karen Johnson	<input type="checkbox"/>	Stella Vasquez

Time	Agenda Items	Tab	Lead
3:00-3:05 (5 min)	Welcome and call to order	1	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
3:05-3:10 (5 min)	Roll call	1	Mandy Weeks-Green, Manager Health Care Authority
3:10-3:15 (5 min)	Approval of meeting summary from 2/25/22	2	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
3:15-3:30 (15 min)	Public comment	3	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
3:30-3:50 (20 min)	Legislative updates	4	Evan Klein, Health Care Authority Jane Beyer, Office of the Insurance Commissioner
3:50-4:20 (30 min)	Federal coverage structures and hurdles for state-run financing systems	5	Dan Meuse, Deputy Director, State Health and Values Strategies, Princeton University
4:20-5:00 (40 min)	Report to the Legislature: Inventory of design elements and key consideration	6	Liz Arjun, MPH, MSW, Senior Consultant and Gary Cohen, Principal, Health Management Associates
	Report to the Legislature draft of section 1	7	
	Report to the Legislature draft of section 2	8	
5:00	Adjournment		Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State

*During the COVID-19 public health emergency, and out of an abundance of caution for the health and welfare of the Commission and the public, this meeting of the Universal Health Care Commission will be conducted virtually.*

# Meeting summary

## Tab 2

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# Universal Health Care Commission Meeting Summary

February 25, 2022  
Health Care Authority  
Meeting held electronically (Zoom) and telephonically  
2:00 p.m. – 4:00 p.m.

**Note:** this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the commission is available on the [Universal Health Care Commission webpage](#).

## Members present

Vicki Lowe, chair  
Bidisha Mandal  
Dave Iseminger  
Estell Williams  
Jane Beyer  
Joan Altman  
Kristin Peterson  
Representative Marcus Riccelli  
Mohamed Shindane  
Nicole Gomez  
Stella Vasquez

## Members absent

Senator Ann Rivers  
Senator Emily Randall  
Representative Joe Schmick  
Karen Johnson

## Call to order

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

## Agenda items

### Welcoming remarks

Ms. Peterson began with a land acknowledgement. Ms. Lowe welcomed the members of the Commission to the third meeting. Ms. Lowe provided an overview of the agenda and shared the goals of the meeting.

### Review schedule of upcoming meetings

Mandy Weeks-Green, Coverage and Market Strategies Manager, Health Care Authority shared with the Commission the updated meeting schedule. To ensure there is enough time for discussion on each of the topics required by the Legislature, at this time, it appears necessary to add a meeting in in July. HCA staff will update the public meeting



notice with the Code Reviser to add a meeting in July and will send out meeting invitations to Members once the date and time for the meeting is selected.

## Public comment

Ms. Lowe called for verbal and written (via the Zoom chat) comments from the public.

Mike Benefiel asked how to justify moving cautiously otherwise delaying the implementation of universal health care in this time of crisis. He urged that the Commission reconsider and acknowledge the work done in SB 5204, which includes a transition plan and that does not require federal waivers. (Verbal)

Roxanne Thayer shared that her daughter was unable to receive treatment for her health condition because her providers no longer accepted her insurance. She urged the Commission to immediately implement the Universal Health Care Work Group's Model A option for a universal health care system. (Verbal)

Jeff Silverman asked that the proper E-mail address to which public comments should be sent be noted. (Written)

Michael Mulroy spoke in support of a modified version of Model A. He urged the Commission to review the WSIPP report from the January meeting for roles of private health insurers and employer-provided premiums that work well in other social democracies for a modified and more feasible version of Model A. (Verbal)

Deana Knutsen stressed the importance of having a universal health care system that eliminates the current tiered system and works toward a system that provides equitable, affordable care for *all* Washingtonians. She offered her assistance in moving this work forward. (Verbal)

Consuelo Echeverria spoke to the urgency of the Commission to create advisory committees. She also shared that in her time living in Turkey, the annual cost of medications for her and her mother was affordable. Moving to the US, the cost of her and her mother's medications rose by 450%. (Verbal)

Roger Collier shared three points from his critique of the final report by the Universal Healthcare Workgroup. He suggests that the Commission not let perfect be the enemy of the good in choosing a model to implement. He urged that the Commission to review his critique for steps and recommendations for a phased approach to achieving universal healthcare. (Verbal)

Roxanne Thayer shared, "The Case for Universal Health Care" US News & World Report <https://health.usnews.com/health-care/for-better/articles/the-case-for-universal-health-care>. (Written)

Jim Howe stressed the importance of Labor Unions having a voice in the Commission's advisory committees. There has been significant support among unions for universal healthcare and Medicare for all and great efforts to work towards labor unity on healthcare policy. (Verbal)

Roxanne Thayer shared, "On average, residents of Germany, France, UK, Australia, and the Netherlands reported shorter wait times relative to the U.S." (<https://health.usnews.com/health-care/for-better/articles/the-case-for-universal-health-care>) (Written)

John Kim encouraged the Commission to always have equity (which is not the same as equality) in mind. There is a need for a differentiated approach to reach folks who have been historically underserved. With equity at the

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forefront of all decisions, there is a greater chance that universal health care and universal access for all Washington residents will be the result. (Verbal)

Rosie Anderson shared her experience having no access to affordable health insurance as a temporary worker. She made the decision to forgo health insurance because of cost at an age where she had increased health risks. She also shared her appreciation for the Commission's work. (Verbal)

Mandy Weeks Green, Coverage and Market Strategy Manager, HCA, shared the link to the Commission's webpage to provide more information about the Commission, including contact information: <https://www.hca.wa.gov/about-hca/universal-health-care-commission> (Written)

Roxanne Thayer shared information to address the inaccuracies of slide #25 of Re: the PowerPoint slide #25 presented, at your meeting, on Jan. 4th: "I sold Americans a lie about Canadian medicine. Now we're paying the price." -Wendell Potter, Health Insurance CEO and Whistleblower.  
(<https://www.washingtonpost.com/outlook/2020/08/06/health-insurance-canada-lie/>) (Written)

### Meeting summary review from prior meeting

The Commission Members present voted by consensus to adopt the Meeting Summary from the January 2022 meeting.

### Presentation: Health Coverage Changes in Washington State since the COVID-19 Pandemic

Wei Yen, Director, Senior Forecast and Research Analyst, Office of Financial Management (OFM) shared the OFM microsimulation model of Washington's unemployment claims during the COVID-19 pandemic and associated health coverage changes.

OFM developed a microsimulation model to quantify the impact of the COVID-19 pandemic on health coverage. The project simulated; 1) job loss by occupation by county, 2) changes in employment-based insurance (EBI), 3) family members' coverage changes related to the worker's EBI change, and 4) Medicaid and Exchange enrollment changes. The project product included a weekly report from April to August 2020, as well as a monthly report from September 2020 and internal monitoring thereafter.

Just before the pandemic, the total uninsured rate in Washington State was 6.2%. The total uninsured rate rapidly increased during the pandemic shut down and reached 11.8% by the end of May 2020. The uninsured rate has gradually declined since October 2020, where the current rate is lower than the pre-pandemic rate at 4.7%. Adults 18-64 accounted for most of the changes in the uninsured rates.

Uninsured rates across all occupations were affected in the first few months of the pandemic, though food services, personal care and service, and management had the highest rates of insurance at close to 40%.

All counties had higher uninsured rates at the height of unemployment in 2020, with King and Grays Harbor having the largest changes proportionately. All counties currently have rates lower than their pre-pandemic rates with San Juan, Lincoln, and Garfield's rates more than 50% lower. Franklin has the highest uninsured rate.

During the 2020 shutdown, the decrease in employment-based coverage was the sole driver in the increase of the uninsured. Currently, the temporary suspension of Medicaid eligibility redetermination under the Public Health

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Emergency is the main driver of the uninsured rate being lower than the rate before the pandemic. An end to the PHE could potentially increase the state's uninsured rate to the pre-pandemic level.

### Public Comment on draft charter

Ms. Lowe called for verbal and written (via the Zoom chat) comments from the public regarding the Commission's draft charter.

David Loud remarked that he was happy to see that equity language was incorporated into the value statement in the charter. (Verbal)

Jeff Silverman asked that Dr. Yen's address be reposted. (Written)

Kathryn Lewandowsky stated that she was curious as to the risk people are in financially during movements between employed, unemployed and losses of health insurance. (Written)

Consuelo Echeverria asked that the public comment sign up could be made clearer. (Written)

Jeff Silverman agreed that Ms. Lewandowsky's question regarding folks' financial risk of losing employment and employment-based coverage was a good one. (Written)

Kathryn Lewandowsky remarked that the question of the cost to provide coverage to everyone was calculated with the work of the Universal Healthcare workgroup. (Written)

### Vote on draft charter

The Commission Members present voted by consensus to adopt the draft charter.

### Presentation: Washington's Health Care Cost Transparency Board

AnnaLisa Gellermann, Board Manager, Health Care Authority shared an overview of HCA's Health Care Cost Transparency Board.

A cost growth benchmark is a per annum rate-of-growth benchmark for health care costs for a given state. The goal of pursuing a cost growth benchmark is to increase affordability for Washingtonians through lowering the growth of health care costs to a sustainable rate. The Board's goal is to lower costs without sacrificing quality, access, and spending on health-related social needs.

The Board is made up of 14 members, mostly purchasers. Two advisory committees support the Board: Health Care Providers and Carriers, and an advisory committee on Data issues.

The Board is focused on the problem of high cost. In 2017, the US spent 17.9% of gross domestic product (GDP) on health care services. Switzerland, the country with the second highest share, spent only 12%. Nationally in 2019, total health spending was \$1.4 trillion. Government represents roughly 45% of spending. Additionally, health



services spending outpaces wage growth. Also in 2017, roughly 7% of insured adults and 28% of uninsured adults said they delayed or did not receive medical care due to cost.

The legislative charge under House Bill 2457 (2020) is for the Board to; 1) establish a health care cost growth benchmark and target percentage to limit growth, 2) annually collect payer spending data, 3) determine total health care expenditures annually and trends in growth, 4) analyze Washington specific cost drivers, and 5) provide annual reports and recommendations to the Legislature.

The Board has set the following cost growth benchmarks: 3.2% for 2022-2023; 3.0% for 2023-2025; and 2.8% for 2026.

Washington has received a grant to be part of the Peterson-Milbank Program for Sustainable Health Care Costs, whose goal it is to advance state-based efforts to make health care more affordable. The grant includes assistance for IT and data development and to organize interstate cooperation and education. This work will allow a better state-to-state comparison of health care costs.

The Board will collect data from the following sources for total health care expenditures: Medicare, Medicaid, Medicare-Medicaid “duals,” commercial, L&I’s worker’s compensation, and Department of Corrections.

## Adjournment

Meeting adjourned at 4:03 p.m.

## Next meeting

Thursday, April 14, 2022

Meeting to be held on Zoom

3:00 p.m. – 5:00 p.m.

# Public comment

## Tab 3

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## Universal Health Care Commission

### Written comments

Received from February 11 - March 31, 2022

#### Written comments submitted by email

C. Snow .....	1
I. Yamauchi .....	1
M. Benefiel.....	2
C. Snow .....	2
Roger Collier.....	3

#### Additional comments received at the February 25 Commission meeting:

- The Zoom video recording is available for viewing here:  
<https://www.youtube.com/watch?v=6f8OE5OKFvY&feature=youtu.be>
- The Zoom and meeting questions are available here:  
<https://www.hca.wa.gov/assets/program/uhcc-meeting-chat-20220225.pdf>
- The meeting summary is available here:  
<https://www.hca.wa.gov/assets/program/uhcc-meeting-materials-20220225.pdf>

## **Public comments received since February 11 through the deadline for comments for the April meeting (March 31)**

Submitted by Calvin Snow  
2/13/2022

I hope you agree that accepting money from the healthcare lobby while delaying universal health care is definitely a conflict of interest if not criminal, but most certainly morally wrong while so many are suffering with no or poor coverage.

Lobby money should never come before the health of our families.

Proceeding cautiously in a time of crisis is morally wrong. People are literally dying.

Please do the right thing.

Calvin

Submitted by Isao Yamauchi  
2/22/2022

Hello,

My name is Isao Yamauchi, a resident of Washington state for the last 30 years. I am originally from Japan that provides healthcare to everyone in the country via its universal healthcare system. I am glad to find you today, the committee working on implementing a universal healthcare system in WA. I have a few suggestions that I would like to share.

I am very happy to see that you share your work to the public; however, it seems that not many Washingtonians know about the committee and your work. For example, I was aware of a few healthcare advocate groups existing in WA, but didn't know about the committee until today. Also, it took me a while for to find information of Option A thru C mentioned in this meeting. So, I hope you find ways to make all Washingtonians aware of you and your work.

[January 4, 2022 Universal Health Care Commission meeting - YouTube](#)

Also in the meeting above, there were a few people who showed willingness to work with the committee. Please make sure that the background of everyone involving with your work be available to the public that includes anyone working pro bono.

Thanks again for your work.

Isao

Submitted by Mike Benefiel  
3/19/2022

Respected Commission Members,

I would like to clarify some misinformation I've heard during testimony. The failures of previous attempts by states to implement single payer systems were not the fault of the legislation but of the legislatures. Vermont for example, passed legislation for such a system but never funded it so it died. Most likely they yielded to pressure from the powerful health care lobby. The systems didn't fail but were never tried.

The CBO just confirmed what many have known for years, that we need a single payer system like the Option A our own study confirmed.

Will you be indicating which specific problems you are facing in order to implement a single payer system?

We urgently need fix our terrible system.

Mike Benefiel

Submitted by Calvin Snow  
3/30/2022

UHC Commission,

You've heard all the horrible statistics where our country has the worse health care system of all modern nations. We have over \$200 billion in medical debt while all other modern nations have zero. We have the worst infant and maternal mortality rates. Millions of medical bankruptcies. Tens of thousands die because our system puts corporate profits before lives while Millions needlessly suffer. Maybe the worst is hearing mothers testify that their children are suffering because of decisions where the health-care insurers overrule doctors.

We've known for over a decade that a single-payer universal health care system would cover everyone, save lives and save individuals money.

This is a humanitarian crisis and not the time to proceed cautiously. I recommend:

1. Have more meetings
2. Review SB 5204 and see if it deals with the problems facing us getting a single-payer system like the Work Group recommended.
3. Make a list of the specific problems you see with implementation of a single-payer system.
4. Get a commitment from Senator Cleveland as to when she expects to have legislation for a single-payer system ready to introduce.

As you proceed remember that many are needlessly suffering because of our horrible system that puts health care industry profits before our families' lives.

Calvin Snow, Democratic PCO

Submitted by Roger Collier

March 31, 2022

# **THE WASHINGTON HEALTHCARE PLAN: A PROPOSAL**

**APRIL 2022**

**Roger Collier ([rcollier@rockisland.com](mailto:rcollier@rockisland.com))**

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# THE WASHINGTON HEALTHCARE PLAN: A PROPOSAL

## INTRODUCTION

American healthcare expenditures are the highest in the world, with per capita costs close to twice those of other industrialized nations. The gap continues to widen, with United States' costs growing faster than wages, faster than corporate revenues, and faster than GDP. The State of Washington is a long way from bucking the national trend. Even though Washington's population is younger (and presumably healthier) than most other states', **per capita healthcare costs are above the national average** and continue to rise more rapidly than incomes.

In partial response, in 2021, the State legislature passed Senate Bill 5399 establishing the Universal Health Care Commission *"for the purpose of creating **immediate and impactful changes in Washington's health care access and delivery system** and to prepare the state for the creation of a health care system to provide coverage and access through a universal financing system ... **once federal authority has been acquired.**"*<sup>1</sup>

The Commission's creation was preceded by the formation of work groups whose efforts were recapped in a consultant report that indicated a strong preference for a single statewide, State-administered, system covering almost all State residents.

***However, current federal law does not allow such a single system, the State has no existing capability to administer a program of such size, and the consultant report made multiple dubious financial assumptions.***

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<sup>1</sup> Final Bill Report E2SSB 5399 -- Emphasis added

*Accordingly, an alternative approach to dealing with healthcare costs and access is proposed—one that responds to the first mandate of SB 5399, to create “immediate and impactful changes in Washington’s health care access and delivery system,” but which, if federal law is changed, also offers a possible pathway to universal healthcare: the Washington Healthcare Plan described in this document.*

### **WASHINGTON’S PROBLEMS – AND AN OPPORTUNITY**

Health insurance in Washington, as in every state, is extraordinarily complicated. Washington has more than three hundred insurers, some with only a handful of enrollees, others with billions of dollars of business, collectively with a mindboggling variety of policies. The biggest companies each offer dozens of different benefit packages, resulting in a staggering number of potential choices for consumers.

In turn, healthcare professionals must determine whether and how much they will be paid for treating patients. Is this in-network or out-of-network? Is there a copay to be collected? How much? Or coinsurance? Has the patient’s deductible been satisfied? Is this treatment even covered? Does it require prior authorization? And on and on.

The difficulty of comparing costs and benefits means that many Washingtonians may be paying too much for coverage that doesn’t match their needs, while **the premiums paid are burdened by insurer and provider administrative costs that can consume more than a quarter of the healthcare dollar**. Various national studies<sup>234</sup> estimate typical administrative costs of up to thirty percent or more of premiums, split between insurers and providers, with billing and

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<sup>2</sup> “Costs of Health Care Administration in the United States and Canada,” Steffie Woolhandler, et al, *New England Journal of Medicine* 349 (2003)

<sup>3</sup> “Reducing Health Care Costs: Decreasing Administrative Spending,” Cutler, David M., *Testimony for Senate Committee on Health, Education, Labor and Pensions* (July 31, 2018)

<sup>4</sup> “Overhead Costs for Private Health Insurance Keep Rising, Even as Costs Fall for Other Types of Insurance,” Nick Buffie, *Center for Economic and Policy Research* (February 2017)

payment efforts representing more than half the total<sup>5</sup>, in large part because of the numbers of coverage options and related authorization and payment rules.

As administrator of healthcare coverage for State and local government and school district employees, Medicaid beneficiaries, and Exchange marketplace enrollees – a total of close to three million individuals – **the State of Washington government is in a unique position to control premium costs.**

To do so would mean consolidating elements of various programs, currently spread over multiple State agencies and more than a dozen insurers offering scores of different benefit packages, into a simplified public option. The proposed *Washington Healthcare Plan* would contract competitively with just a handful of insurers, each offering no more than three or four sets of standard benefits. In this more price-competitive but far less complex environment insurers and providers would each experience lower administrative costs (and should pass the savings onto consumers), while trimming profits to keep or grow their business in the face of competitively bid contracts and greater transparency of benefit costs and coverage.

### **THE WASHINGTON HEALTHCARE PLAN PROPOSAL**

The *Washington Healthcare Plan* would comprise four components, each significantly different from today:

- A single enrollment system (versus separate enrollment structures for each program),
- Limits on the number of insurer networks in each region of the State (versus more than a dozen different networks),

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<sup>5</sup> "Excess Administrative Costs Burden the US Healthcare System," Emily Gee, *Center for American Progress*, April 8, 2019.

- Standardized coverage definitions and payment rules (approved by the State), and
- Competitive selection of insurers to cover all programs in each region (versus a variety of approaches to insurer selection).

### **Single enrollment system**

The *Washington Healthcare Plan* enrollment system would support enrollment in the Exchange marketplace for individuals and groups, in the State and local government and school district employee programs, and in Apple Health (except for dual eligible Medicaid enrollees, who could be added later).

The enrollment system would be based on the present Exchange Healthplanfinder system, and would support four functions: determination of program eligibility, including possible diversion to Apple Health for low-income individuals and families; calculation of program-dependent State (or other sponsor) premium subsidy amounts (generally one hundred percent for Medicaid beneficiaries, less for others); enrollee selection of insurer (expected to be a choice between no more than three or four in each region); and enrollee selection of benefit level (with gold, silver, and bronze choices available for all programs except Apple Health). Once enrollment is complete, enrollees would choose a primary care provider from their selected insurer's lists.

### **Fewer Insurers per Region**

The State would be divided into regions, as is currently the case for most other healthcare programs, but the number of regions and their geographic definitions would likely vary from today's structure. The goal would be to have sufficiently large populations in each region to attract competitive bids from insurers while minimizing the State's contract administration costs. A minimum of two insurers per region would be necessary to give enrollees a choice while providing a back-up

in the event of an insurer's possible contract termination. Insurers would be required to offer the same payment rates for all programs except Apple Health and a single common network (but could add providers to meet State or federal mandates for Medicaid benefits; for example, EPSDT screening and non-health social services).

### **Standardized Coverage Definitions**

While covered benefits would not be the same across programs, all services in a "common core" would be required to be defined identically, with the same prior authorization requirements, and subject to State approval. Insurers would have some freedom to add services not included in the common core, while deductibles and copayments would vary depending on the benefit level (Gold, Silver, etc.).

### **Competitive Selection of Insurers**

Insurers would be selected in each region using a competitive procurement approach similar to that currently used for Apple Health. Insurers would be allowed to bid in any number of regions, with selection based on factors including network and individual provider capacity, quality and consumer satisfaction, and price. Bidders would be required to propose a single "package price" covering all programs in each region they bid in order to simplify proposal evaluation, maximize price competition, and encourage Apple Health participation.

### **Access and Equity**

Access to coverage and to care would be enhanced by facilitating enrollment, reducing costs, and requiring insurers to mandate provider acceptance of Medicaid (up to ceiling provider enrollment caps).

In later implementation phases, an employer mandate would be imposed, along with individual coverage incentives, in order to further maximize access to coverage.

Equity issues would become significantly fewer as more of those currently uninsured are able to gain coverage, particularly if the proposed employer mandate makes provision for part-time and seasonal workers.

### **The Long Run: Universal Healthcare**

Universal healthcare will remain an unreachable goal unless federal law is changed. However, success in reducing costs could provide opportunities for some ERISA and Medicare beneficiaries to be brought into the *Washington Healthcare Plan*. Specifically, currently self-insured groups may be attracted by lower costs, while the *Washington Healthcare Plan* might be offered as an option within Medicare Advantage. In addition, in the event that federal law is eventually changed and universal healthcare becomes feasible in Washington, the experience gained with the *Washington Healthcare Plan* will be invaluable.

### **Implementation**

The *Washington Healthcare Plan* would achieve an efficient public option, likely much more attractive than the current Cascade Care Select plan. Because only State-administered and State-sponsored programs would be involved, no ERISA exemption would be needed. However, changes to State regulations would be necessary to establish the new program, and waivers of Title 19 and Affordable Care Act requirements are expected to be required.

Alignment of PEBB, SEBB, and Exchange benefit structures would include recognition of the different premium approaches between the “bulk purchase” rates for PEBB and SEBB versus the individual and family premium rates for the Exchange. (The State is already

considering consolidation of PEBB and SEBB programs, but over a five-year timeframe.)

Other implementation issues include the necessity for “buy-in” by program sponsors, including state agencies and school districts who may have concerns about the inclusion of their programs in a larger consolidated model, but whose members should see less costly coverage. Insurers’ concerns about loss of business in a highly competitive environment must also be recognized. In addition, as the State has experienced with Apple Health procurements, unsuccessful bidders might file protests unless the selection process is clear, comprehensive, and transparent.

The *Washington Healthcare Plan* would be implemented in five phases:

- **Establish Exchange marketplace as public option single enrollment system for all non-ERISA, non-Medicare coverage**
  - a. Enact State legislation
  - b. Obtain Section 1332 waiver (if necessary)
  - c. Make software changes to Healthplanfinder
  - d. Define benefits for each metal level
  
- **Implement *Washington Healthcare Plan* for PEBB, SEBB, and Exchange individuals and families**
  - a. Make software changes to PEBB and SEBB systems
  - b. Solicit insurer bids for each region
  - c. Prepare and disseminate enrollment materials
  - d. Enroll members of each group
  
- **Integrate Apple Health into *Washington Healthcare Plan***
  - a. Obtain Section 1113 and/or 1115 waivers
  - b. Implement full integration of Apple Health
  
- **Implement *Washington Healthcare Plan* for employee groups**

- a. Reestablish SHOP program to provide federal credits
  - b. Implement SHOP for groups up to 50 employees
  - c. Allow all employee groups to join *Washington Health Plan*
- **Design and implement State employer mandate and individual coverage incentives.**
    - a. Determine scope of employer mandate
    - b. Enact employer mandate legislation
    - c. Determine coverage incentive rules and payments
    - d. Obtain Section 1113/1115 waiver for incentives
    - e. Enact coverage incentive legislation
    - f. Implement employer mandate and coverage incentives

### What can we expect?

The *Washington Health Plan* should result in premium reductions for all State-administered and State-sponsored healthcare programs, by:

- Reducing provider and insurer claims submittal and processing efforts, including denials and resubmittals, as a result of cutting the number of participating insurers and benefit options. (A recent study<sup>6</sup> shows that up to forty percent of provider administrative costs could be eliminated with fewer insurers and fewer and simpler coverage options.)
- Further cutting provider and insurer administrative efforts by requiring insurers to adopt common benefit definitions and prior authorization rules.
- Reducing insurer “risk premiums” by spreading risk over more lives by shrinking the number of benefit options.

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<sup>6</sup> “Reducing administrative costs in US health care: Assessing single payer and its alternatives,” David Scheinker et al, *Health Services Research*, March 2021.

- Causing insurers to squeeze profits and overhead to retain or gain business in a highly price-competitive environment—especially as the slices of the “premium revenue pie” become larger with fewer payers—while allowing successful bidders to spread fixed costs over more business.
- Reducing the number of uninsured (details below) from the current six percent, whose “charity care” costs may otherwise be passed on to insurers, and thence to premiums.

The *Washington Health Plan* should also facilitate access to coverage and care as a result of:

- Reducing premiums for most benefit options (see above).
- Making enrollment simpler by reducing the number of insurers and benefit options.
- Requiring insurers to mandate provider acceptance of Apple Health (up to ceiling provider enrollment caps).
- Offering coverage incentives to the newly insured (perhaps in the form of gift cards similar to those already provided by one or two insurers).
- Implementing an employer mandate for all non-ERISA groups.

The *Washington Healthcare Plan* would directly impact only State-administered programs. Federal programs such as TRICARE and VA would be unaffected. However, reductions in Exchange premium rates should attract more individual enrollees and persuade more small employers to switch from their private market plans, in turn putting pressure on competing commercial plans to reduce their rates. For Apple Health, requiring insurers to offer the same networks as other programs would move enrollees more firmly into mainstream healthcare.

*Roger Collier was formerly CEO of a national healthcare consulting firm, where he managed projects for some fifteen state Medicaid agencies, the US Department of Health and Human Services, the US Department of Defense, the national Blue Cross and Blue Shield Association and several individual Blue Cross and Blue Shield Plans, and HMOs including Kaiser and Group Health. He testified on government healthcare issues in Washington DC and before legislative committees in Colorado, Washington and Oregon, and was a panelist for Washington State's 2006 Blue Ribbon Commission on Health Care Costs and Access. He has been quoted in both the regional and national press, including the New York Times.*

*He can be contacted at [rcollier@rockisland.com](mailto:rcollier@rockisland.com).*

# Legislative updates

## Tab 4

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# Balance or “Surprise” Billing -- E2SHB 1688 (Chap. 263, Laws of 2022)

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## Background

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In 2019, the Washington state legislature enacted the [Balance Billing Protection Act](#) (BBPA) which took effect on Jan. 1, 2020. This law prohibits balance billing for emergency services and for non-emergency “surgical and ancillary services” provided at in-network hospitals and ambulatory surgical facilities. Under the law, a consumer cannot be asked by any health care provider, facility or insurer to waive their balance billing protections. The BBPA applies to state-regulated health plans as well as the Public Employee and School Employee Benefits programs. It also applies to self-funded group health plans (employer sponsored plans and Taft/Hartley plans) that have chosen to “opt-in” to follow the BBPA and offer balance billing protections to their enrollees. Over 350 self-funded group health plans have opted to participate in the BBPA.

Since the BBPA took effect, the number of consumer complaints regarding surprise billing has decreased considerably. Also, we have had [limited use](#) of the arbitration system established to resolve disputes between out-of-network health care providers and insurers.

In December 2020, Congress enacted the [No Surprises Act](#) (NSA), as part of the Consolidated Appropriations Act of 2021 ([P.L. 116-260](#)). This law took effect on January 1, 2022 and applies to health plans issued or renewed on or after January 1, 2022. It overlaps with and is similar to Washington’s Balance Billing Protection Act.

The NSA sets minimum or baseline standards for protecting consumers from balance billing and expands coverage of emergency services by insurers. It also provides increased transparency to consumers on their health plan’s provider networks and potential costs of services. While the NSA sets a minimum standard, states are free to have consumer protections in their laws that exceed those of federal law. The NSA applies to all health plans, including health plans offered before the Affordable Care Act went into effect, fully insured health plans that OIC regulates, self-funded group health plans and the Federal Employees Health Benefits program.

### What is balance or “surprise” billing?

Balance or “surprise” billing occurs when you receive a bill from a provider that is not in your health plan’s network. Typically, this happens when you received emergency services or when you had a scheduled procedure at a hospital or ambulatory surgical facility.

## E2SHB 1688 (Chap. 263, Laws of 2022) — Aligning the BBPA and the NSA

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Due to the overlap between provisions of the BBPA and the NSA, failure to align the laws would have resulted in two different laws applying to a single episode of care – for example, the BBPA would apply to a consumer’s emergency care until they are stabilized, and then the NSA would apply to services the consumer receives after they are stabilized. Or the BBPA would apply to a set of “surgical and ancillary services” provided during a planned surgery, but the NSA would apply to additional services received by the consumer during that same procedure. This would have resulted in unnecessary confusion for consumers, providers and insurers, as well as increased administrative costs for providers and insurers.

E2SHB 1688, which went into effect on March 31, 2022, aligns state and federal law, while preserving critical consumer protections in Washington’s Balance Billing Protection Act.

Key provisions of the new law include:

- Adds behavioral health emergency services, such as crisis triage centers and evaluation and treatment facilities, as emergency services providers. Behavioral health emergency and crisis services will be covered without prior authorization and regardless of whether a provider is contracted with a consumer’s health plan.
- Expands the scope of services protected from balance billing to align with those of the NSA, including services provided following an emergency once a consumer has been stabilized and a broader set of non-emergency services provided at in-network hospitals or facilities.
- Preserves the BBPA’s prohibition on asking consumers to waive their balance billing protections.
- Retains the BBPA dispute resolution process (i.e. arbitration) until July 1, 2023 or a later date determined by the Commissioner. After that date, aligns the BBPA with the NSA’s system for independent dispute resolution.
- Clarifies that an insurer cannot use the BBPA or the NSA’s out-of-network provider payment provisions to meet OIC’s provider network access standards. The insurer must have sufficient numbers and types of providers in their contracted provider networks to meet OIC’s standards. In limited circumstances, if an insurer and provider group are unable to reach agreement on a contract, the BBPA arbitration process could be used to establish an interim rate until the parties reach agreement on a contract.
- Clarifies OIC’s authority to enforce all provisions of the NSA and the Consolidated Appropriations Act that apply to or regulate the conduct of insurers.
- Includes an emergency effective date, given that this legislation was enacted after the NSA had already gone into effect. The new law is effective March 31, 2022. OIC has issued a [Technical Assistance Advisory](#) regarding our enforcement of the BBPA and the NSA until new rules are adopted by OIC.

# E2SHB 1688 (Chap. 263, Laws of 2022) – Aligning the No Surprises Act & the Balance Billing Protection Act

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**April 1, 2022**

Issue	Washington Balance Billing Protection Act (BBPA)	E2SHB 1688 as passed Legislature
<b>Applicable plans</b>	State regulated private health insurance, PEBB/SEBB and self-funded health plans that “opt-in”.	<p>Sec. 7: State regulated private health insurance, PEBB/SEBB and self-funded health plans that “opt-in” (325+ plans have opted in).</p> <p>Retains opportunity for self-funded group health plans to opt-in.</p>
<b>Coverage of emergency services</b>	Emergency services provided in a hospital up to point of stabilization must be covered without prior authorization regardless of the network status of the hospital or provider. RCW 48.43.093	<p>Sec. 2, amending RCW 48.43.003 and Sec. 3, amending RCW 48.43.093</p> <p>Emergency services must be covered regardless of the network status of a hospital or provider and without prior authorization.</p> <p>Emergency services encompass screening, stabilization, and post-stabilization, including observation or an inpatient and outpatient stay with respect to the visit during which screening and stabilization services were provided.</p> <p>Behavioral health emergency services providers include, in addition to a hospital emergency department, mobile crisis response teams, crisis triage and stabilization facilities, evaluation and treatment facilities, agencies certified by the state to provide outpatient crisis services and medical withdrawal management services.</p>

Issue	Washington Balance Billing Protection Act (BBPA)	E2SHB 1688 as passed Legislature
		<p>Carrier can require notification of a person’s stabilization or admission by in-network facilities.</p> <p>Carrier can require a hospital or behavioral health emergency services provider to notify them within 48 hours of stabilization if a person needs to be stabilized, or by the end of the business day following the day the stabilization occurs, whichever is later.</p>
<b>Scope of balance billing protections</b>	Emergency medical services and non-emergency “surgical and ancillary services” at in-network facilities.	<p>Sec. 7, amending RCW 48.49.020</p> <p>Includes:</p> <ul style="list-style-type: none"> <li>• Emergency services. Other applicable provisions of the BBPA are amended to reference “behavioral health emergency services providers” so that balance billing protections and other related consumer protections apply to these services as well.</li> <li>• Non-emergency health care services performed by nonparticipating providers at certain participating facilities includes covered items or services other than emergency services with respect to a visit at a participating health care facility, as provided in the No Surprises Act (NSA).</li> </ul> <p>Sec. 21: Directs OIC, in collaboration with the Health Care Authority and the Department of Health, and with input from interested groups, to submit a report and any recommendations to the legislature by October 1, 2023 as to how balance billing for <u>ground ambulance services</u> can be prevented and whether ground ambulance services should be added to the BBPA.</p>
<b>Consumer cost-sharing</b>	Same as if services had been received from an in-network provider.	<p>Sec. 7, amending RCW 48.49.020 &amp; Sec. 8, amending RCW 48.49.030:</p> <p>Same as if services had been received from an in-network provider.</p> <p>Uses NSA method for calculating consumer cost-sharing (aka “qualified payment amount”).</p>

Issue	Washington Balance Billing Protection Act (BBPA)	E2SHB 1688 as passed Legislature
		Consumer cost sharing for services subject to balance billing protections under the NSA and for behavioral health emergency services will be calculated as provided in the NSA, using the “qualifying payment amount”.
<b>Consumer notice of rights</b>	<p>State template for notice.</p> <p>Per OIC rulemaking, must be provided to consumers when scheduling services and directly following receipt of emergency services.</p>	<p>Sec. 13, amending RCW 48.49.060</p> <p>OIC must develop a template for a notice of consumer rights that applies to both the BBPA and the NSA.</p> <p>OIC determines through rulemaking when and how the notice must be provided to consumers.</p>
<b>Waiver of rights</b>	Consumers cannot be asked to waive their balance billing protections.	<p>Sec. 10(2) &amp; Sec. 7(2)(b)</p> <p>Consumers <u>cannot</u> be asked to waive their balance billing protections.</p>
<b>Out of network claim payment standard</b>	Payment is “commercially reasonable amount.”	<p>Sec. 9</p> <p>“Commercially reasonable amount” until July 1, 2023 or later date determined by the Commissioner. At that point, transition to NSA payment standard.</p>
<b>Dispute resolution</b>	Resolved through arbitration if no agreement on payment between the carrier and an out-of-network provider.	<p>Sec. 11, amending RCW 48.49.040</p> <p>BBPA arbitration until July 1, 2023 or later date determined by the Commissioner. At that point, transition to NSA “independent dispute resolution” (IDR) system if out-of-network provider and carrier cannot agree on a commercially reasonable payment.</p> <p>Upon transition to NSA independent dispute resolution system, if behavioral health emergency services payment disputes can be addressed using federal IDR system, use that system. If not possible, use the BBPA dispute resolution process.</p> <p>Air ambulance payment disputes use the NSA IDR system.</p>

Issue	Washington Balance Billing Protection Act (BBPA)	E2SHB 1688 as passed Legislature
		<p>Retains “baseball arbitration” – one party’s final offer is chosen.</p> <p>Revisions were made to BBPA arbitration provisions, some to more closely align to NSA, including:</p> <ul style="list-style-type: none"> <li>• Claims bundling: <ul style="list-style-type: none"> <li>○ Provider groups or individual providers can bundle claims.</li> <li>○ The bundled claims must have the same procedural code, or a comparable code under a difference procedural code system.</li> <li>○ Bundled claims must occur within 30 days of each other.</li> </ul> </li> <li>• Arbitrators <u>must</u> have experience in matters related to medical or health care services.</li> <li>• If parties agree on an out-of-network payment rate at any point before the arbitrator has made their decision, the agreed upon amount is the out-of-network payment rate for the service.</li> <li>• The arbitrator’s decision must include an explanation of the elements relied upon to make their decision and why those elements were relevant to their decision.</li> <li>• The Commissioner may establish arbitrator fee ranges by rule.</li> <li>• Arbitrator fees must be paid by the parties to the arbitrator within 30 days following issuance of the arbitrator’s decision.</li> <li>• The arbitrator’s decision is final and binding on the parties.</li> <li>• If a federal IDR decisionmaker finds that it does not have jurisdiction over a dispute, timeframes related to good faith negotiations and notice for BBPA arbitration are modified.</li> </ul> <p>Section 18 provides for use of the BBPA arbitration process in limited circumstances for services that are subject to balance billing protections when a carrier and out-of-network provider or facility cannot reach agreement on a contract and an amended</p>

Issue	Washington Balance Billing Protection Act (BBPA)	E2SHB 1688 as passed Legislature
		<p>alternate access delivery request (AADR) has been approved by the Commissioner (see Network Adequacy/Sec. 18 below). In these circumstances:</p> <ul style="list-style-type: none"> <li>• The issue before the arbitrator is the commercially reasonable payment for services addressed in the AADR.</li> <li>• The arbitrator chooses the final offer amount of the carrier or the out-of-network provider or facility.</li> <li>• The arbitrator’s decision is final and binding on the parties, and effective for the period from the effective date of the amended AADR to the expiration date of the AADR or the date the parties enter into a contract, whichever occurs first.</li> <li>• From the effective date of the amended AADR to the date the arbitrator issues their decision, the carrier pays a commercially reasonable amount to the provider for the services addressed in the AADR.</li> <li>• For these disputes, the BBPA arbitration process will continue to be used, rather than transitioning to the federal IDR system.</li> </ul>
<b>Network adequacy</b>	<p>OIC must consider whether carrier’s proposed provider network includes a sufficient number of contracted emergency &amp; surgical or ancillary services providers at in-network hospitals or ambulatory surgical facilities.</p>	<p>Sec. 18, amending RCW 48.49.150 (as recodified by this act)</p> <p>When determining the adequacy of a carrier’s provider network, the Commissioner must review the network to determine whether it includes a sufficient number of facility-based providers at the carrier’s in-network hospitals and ambulatory surgical facilities.</p> <p>The Commissioner may allow carriers to submit an alternate access delivery request (AADR) to address a gap in their provider network if the carrier can show that:</p> <ul style="list-style-type: none"> <li>• Consumers won’t pay more than in-network costs, or other arrangements acceptable to the Commissioner have been made</li> </ul>

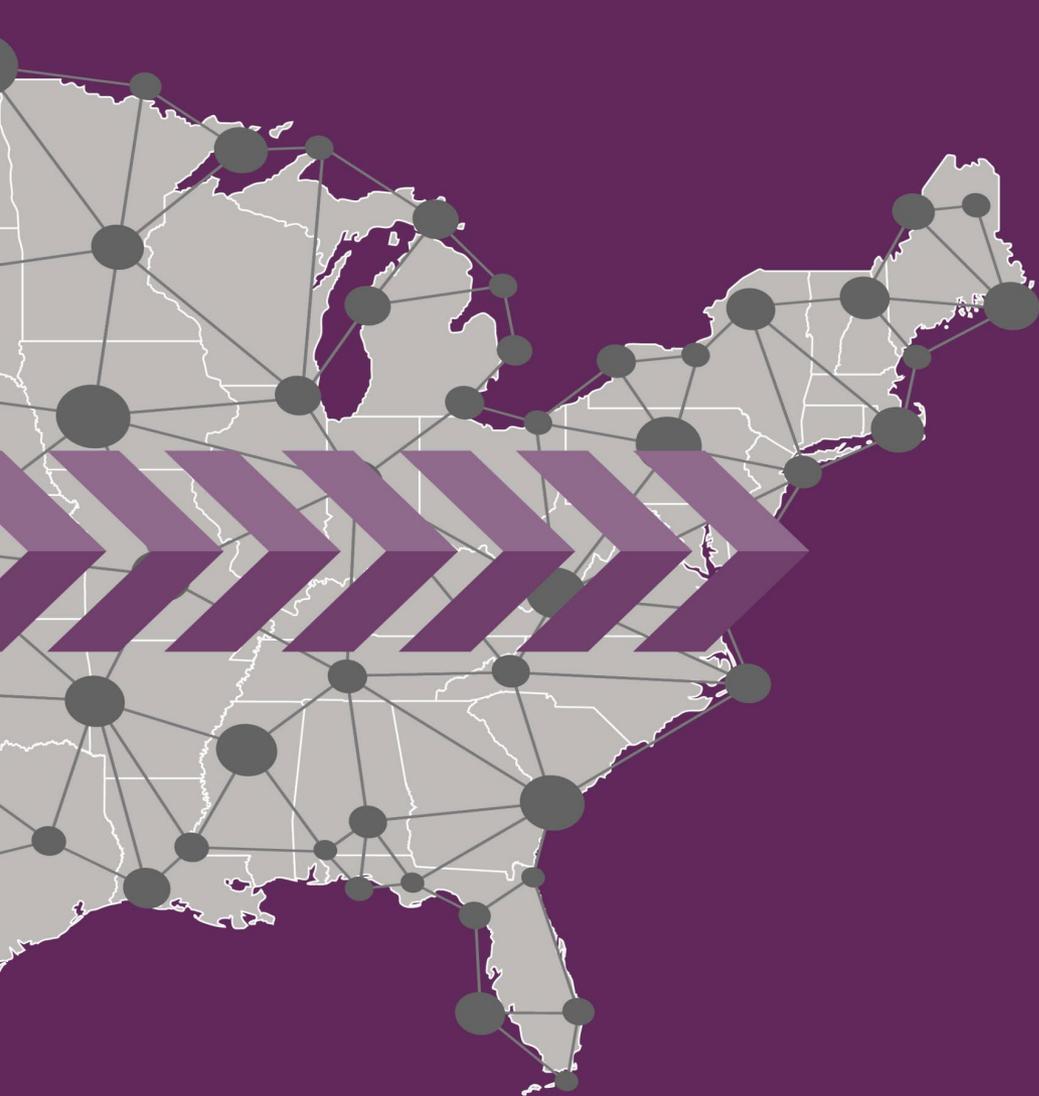
Issue	Washington Balance Billing Protection Act (BBPA)	E2SHB 1688 as passed Legislature
		<ul style="list-style-type: none"> <li>• The carrier has provided evidence of good faith efforts to contract</li> <li>• There is not an available provider for the carrier to contract with for the services, and</li> <li>• For services subject to the balance billing prohibition, the carrier has notified out-of-network providers or facilities that deliver the services referenced in the AADR within 5 days of submitting the AADR request to the Commissioner.</li> </ul> <p>For services subject to the balance billing prohibition, a carrier cannot treat their payment of out-of-network providers or facilities under the BBPA or NSA as a means to satisfy OIC’s network access standards.</p> <p>However, if an AADR has been granted and a carrier meets the following requirements, the Commissioner will allow a carrier to amend its AADR to allow use of the BBPA dispute resolution process to determine the amount that will be paid to out-of-network providers or facilities for the services referenced in the AADR:</p> <ul style="list-style-type: none"> <li>• The carrier’s request to amend the AADR is made at least 3 months after the effective date of the AADR at issue; and</li> <li>• During that 3 month period, the carrier has demonstrated substantial good faith efforts on its part to contract with out-of-network providers or facilities to deliver the services referenced in the AADR.</li> </ul> <p>Once a carrier has notified an out-of-network provider or facility that delivers the services referenced in an AADR, a carrier is not responsible for reimbursing a provider's or facility's charges in excess of the amount charged by the provider or facility for the same or similar service at the time the notification was provided. The provider or facility must accept this reimbursement as payment in full.</p> <p>When determining the adequacy of a carrier's proposed provider network or the ongoing adequacy of a current provider network, beginning January 1, 2023, the</p>

Issue	Washington Balance Billing Protection Act (BBPA)	E2SHB 1688 as passed Legislature
		commissioner must require that the carrier's proposed provider network or in-force provider network include a sufficient number of contracted behavioral health emergency services providers.
<b>Consumer appeals to Independent Review Organization (IRO)</b>	No similar provision.	Sec. 4, amending RCW 48.43.535  Adds NSA provision giving consumers an opportunity to appeal a carrier's adverse decision related to its obligations under the NSA.
<b>Enforcement</b>	Washington State Office of the Insurance Commissioner (carriers)  Washington State Department of Health	New Secs. 5 & 19  OIC will enforce all BBPA and NSA requirements on carriers, with added authority to assess civil monetary penalties for violations, consistent with federal law.  DOH will enforce BBPA and NSA requirements on health care providers, and defers enforcement of requirements applicable to health care facilities and air ambulance providers to the federal gov't (CMS) (Per OIC/DOH/CMS enforcement agreement).
<b>Surprise billing dataset and study on impact of BBPA</b>	OIC must develop a dataset from APCD claims on median in-network allowed amount, median out-of-network allowed amount and median billed charges for services subject to the BBPA.	Sec. 1, amending 43.371.100  Surprise billing data set will be updated to align with the scope of services protected from balance billing in RCW 48.49.020, as amended by E2SHB 1688.  Directs OIC to conduct biennial analysis, beginning in 2022, of the impact of the BBPA and NSA on payments for in-network and out-of-network services and the volume of out-of-network health care services in Washington state.
<b>Effective date</b>	January 1, 2020	Sec. 25: Emergency clause

# Federal coverage structures and hurdles for state-run financing systems

## Tab 5

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**Federal Coverage Structures  
and Hurdles for State-Run  
Financing Systems  
Presentation to the WA  
Universal Health Care  
Commission**

Dan Meuse

April 14, 2022

**STATE**  
Health & Value  
**STRATEGIES**

*Driving Innovation  
Across States*

*A grantee of the Robert Wood Johnson Foundation*

# About State Health and Value Strategies

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State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at [www.shvs.org](http://www.shvs.org).

**Questions?** Email Heather Howard at [heatherh@Princeton.edu](mailto:heatherh@Princeton.edu).

*Support for this presentation was provided by the Robert Wood Johnson Foundation.  
The views expressed here do not necessarily reflect the views of the Foundation.*

# About Dan Meuse

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Dan Meuse serves as the Deputy Director of State Health and Value Strategies, a program of the Robert Wood Johnson Foundation. In this role, Dan manages and coordinates technical assistance providers serving states and works with states to identify their assistance needs and policy goals. He was deeply involved in the implementation of the Affordable Care Act at the state level as Deputy Chief of Staff for Rhode Island's Lieutenant Governor. Dan serves as a Lecturer in Public Affairs at the School of Public and International Affairs at Princeton University.

# How a Person Can Get Coverage Post-ACA



## Public Programs

**Medicare** – 65 and over, some disabled

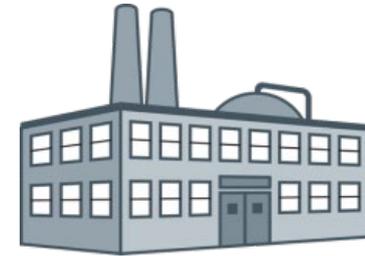
**Medicaid** – Available to everyone under 138% of federal poverty level (except undocumented and LPR<5 years)

**CHIP** – Available to lower-income kids



## Self

Individuals can go to Marketplace to buy coverage, potentially with subsidies. No one can be denied coverage (except undocumented) if they can pay.



## Employer

Most, but not all employers offer coverage to full-time employees. Some offer to part-time.

LPR = Lawful Permanent Resident

# Medicare

## Likely the largest hurdle for state-run health systems

- Approximately 1.29 million residents (17.1% of population)<sup>1</sup>
- Funding decisions are completely under federal control including hospital rates, physician rates, drug costs, covered services and purchasing structures.
- Two states (MD & PA) have some level of control over Medicare payment for hospitals through CMMI waiver.
- Major challenges:
  - Federal government is responsible for any financial risk
  - Medicare is portable – functions basically the same across the country
  - Represents single largest revenue line for most hospitals
- Biggest opportunities:
  - If WA can find savings in Medicare, it could fund coverage for other population groups

<sup>1</sup>: 2019 American Community Survey

# Medicaid/CHIP

## Already a state program but relies on federal funding

- Approximately 2.04 million residents (26.4% of population)<sup>1</sup>
- Funding decisions are generally under state control subject to some federal constraints.
- States can apply for “demonstration waivers” to add populations and change funding and payment models.
- Major challenges:
  - Federal government must approve changes (political risk)
  - Medicaid pays less than Medicare and commercial insurance
  - Disproportionate payer for long-term services, behavioral health, and developmental disabilities
- Biggest opportunities:
  - The state-run system already exists and is mature.

1: November 2021 Medicaid & CHIP Enrollment Data Highlights – CMS/Medicaid.gov

# Individual Market

State can regulate coverage but federal dollars are critical for affordability

- Approximately 240,000 residents (3.1% of population)<sup>1</sup>
- Funding to support affordability is provided through tax credits – but states can capture those dollars for innovations.
- Major challenges:
  - Federal government places limits on how states can innovate
  - Relies on current insurance system
- Biggest opportunities:
  - Models to connect consumers to coverage is well-established and works well
  - Model is easy to scale

1: Washington Healthplanfinder 2022 Open Enrollment Report

# Employer Market

## State lacks enforcement authority over employer actions

- Approximately 4.38 million residents (58.5% of population)<sup>1</sup>
- Two models for coverage – fully insured (state regulated) or self insured (federal oversight)
- Major challenges:
  - Employers currently have federally-granted right to self insure
  - Multi-state employers seek national coverage systems
- Biggest opportunities:
  - Largest pool of portable dollars
  - Employers overpay for services as compared to public programs

1: 2019 American Community Survey

# Federal Silos

Federal authority lives in three departments, multiple agencies

## HHS

### CMS

- Medicare
- Medicaid
- Marketplace

### HRSA

- FQHC
- Hospital payments

## Treasury

### IRS

- Premium Tax Credits
- Employer Health Insurance Exclusion

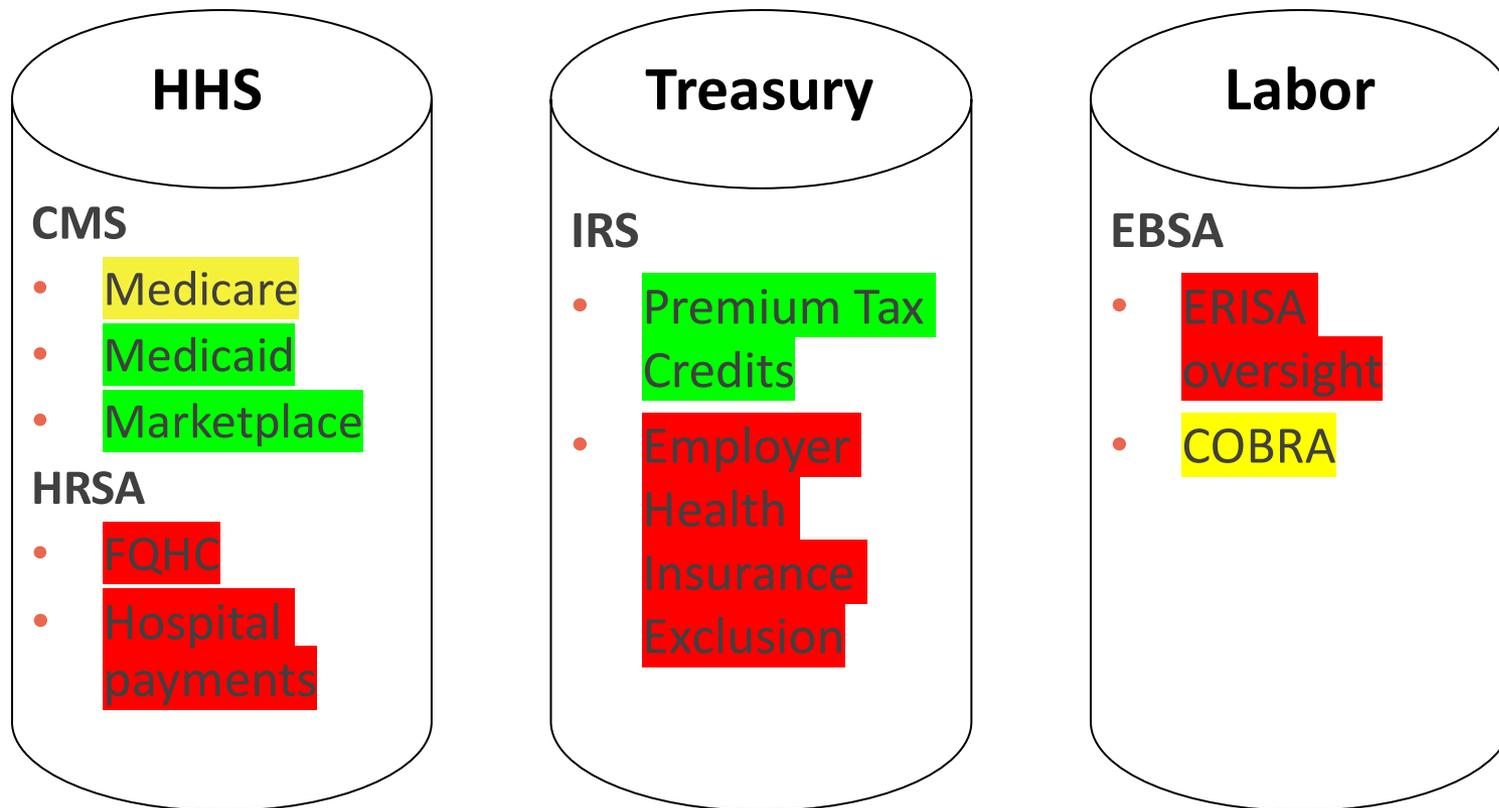
## Labor

### EBSA

- ERISA oversight
- COBRA

# Federal Silos – Flexibility for States

Federal authority lives in three departments, multiple agencies



# The shape of flexibility

The model of “flexibility” looks different to federal officials than to state officials

- Medicare
  - Flexibilities currently available would be in the form of CMMI demonstrations
- Medicaid/CHIP
  - Flexibilities currently available would be in the form of 1115 demonstrations waivers
- Marketplace/APTC
  - Flexibilities currently available would be in the form of 1332 waivers
- Compatibility becomes the critical question
  - Does the current allowable flexibilities work with each other? Would new flexibilities build on current models or be totally new?

# Transitioning to a Unified Funding Model

Even programs with ongoing flexibilities have constraints

- Medicare/Medicaid/Marketplaces – Considered a federal entitlement
  - Any state funding model would need to maintain that entitlement
- Current flexibilities maintain limits (floors and/or ceilings on payments)
  - A single payment rate for a service for anyone in the unified model may not conform to flexibilities granted in Medicare or Medicaid.
  - Generally, the trade for federal flexibility comes at the cost of federal budget certainty
- Crafting a payment model is the biggest challenge
  - There is no single payment structure that can be used for all services
  - Managing a budget will likely require payment model innovations that require provider system participation



# Discussion



**Thank You**

**Dan Meuse**  
Deputy Director  
State Health and Value Strategies  
dmeuse@Princeton.edu  
609-258-7389  
www.shvs.org

# Report to the Legislature: Inventory of design elements and key considerations

## Tab 6

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# Washington Universal Health Care Commission Report to the Legislature: Sections 1 & 3

Liz Arjun & Gary Cohen, HMA

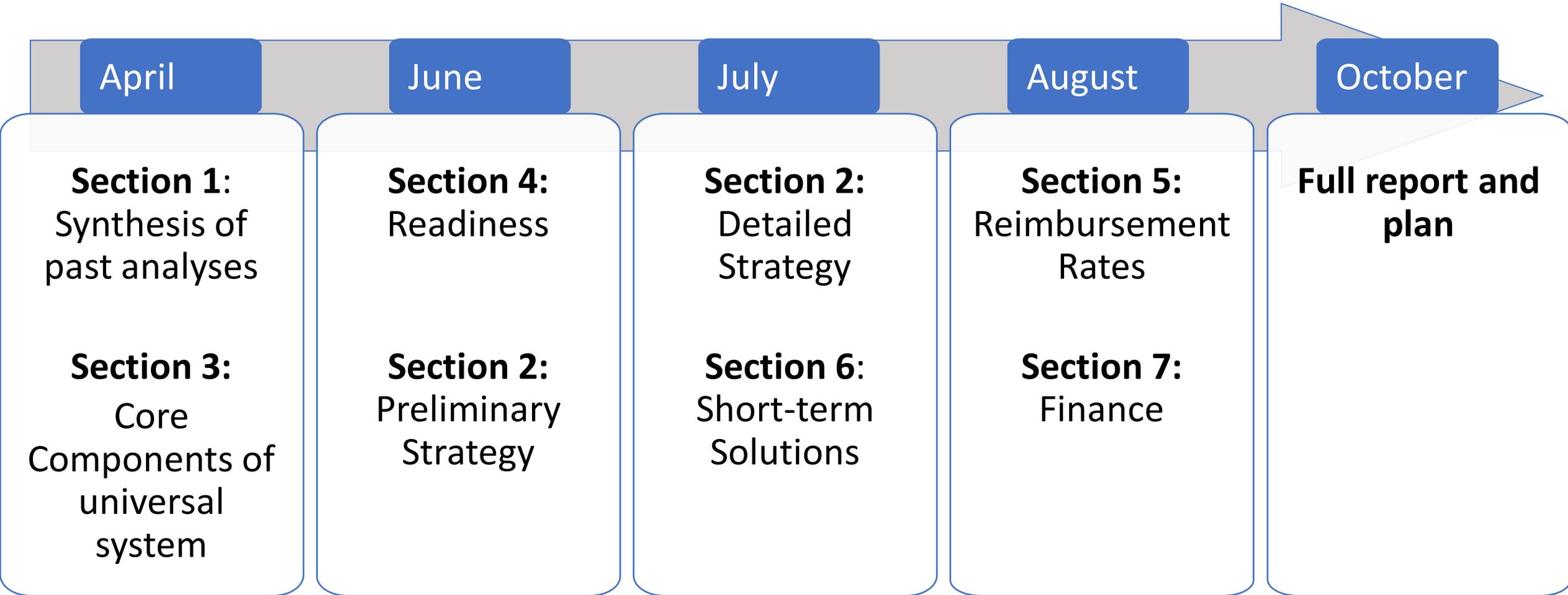
Presentation to the Universal Health Care Commission

April 14, 2022

# Agenda

- Timeline for Report
- Section 1: Overview of Current Landscape and Past Analysis
- Section 3: Inventory of Design Elements
- Key Considerations and Discussion

# Report Development Timeline

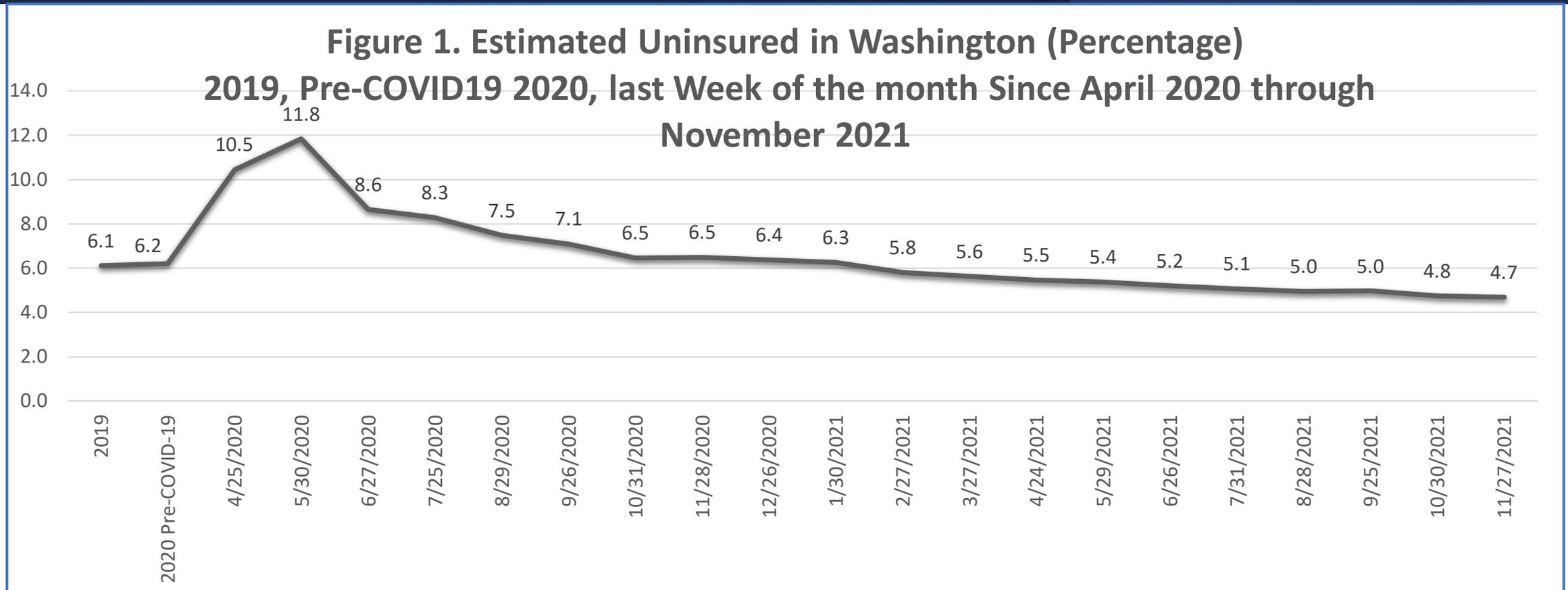


# Goals

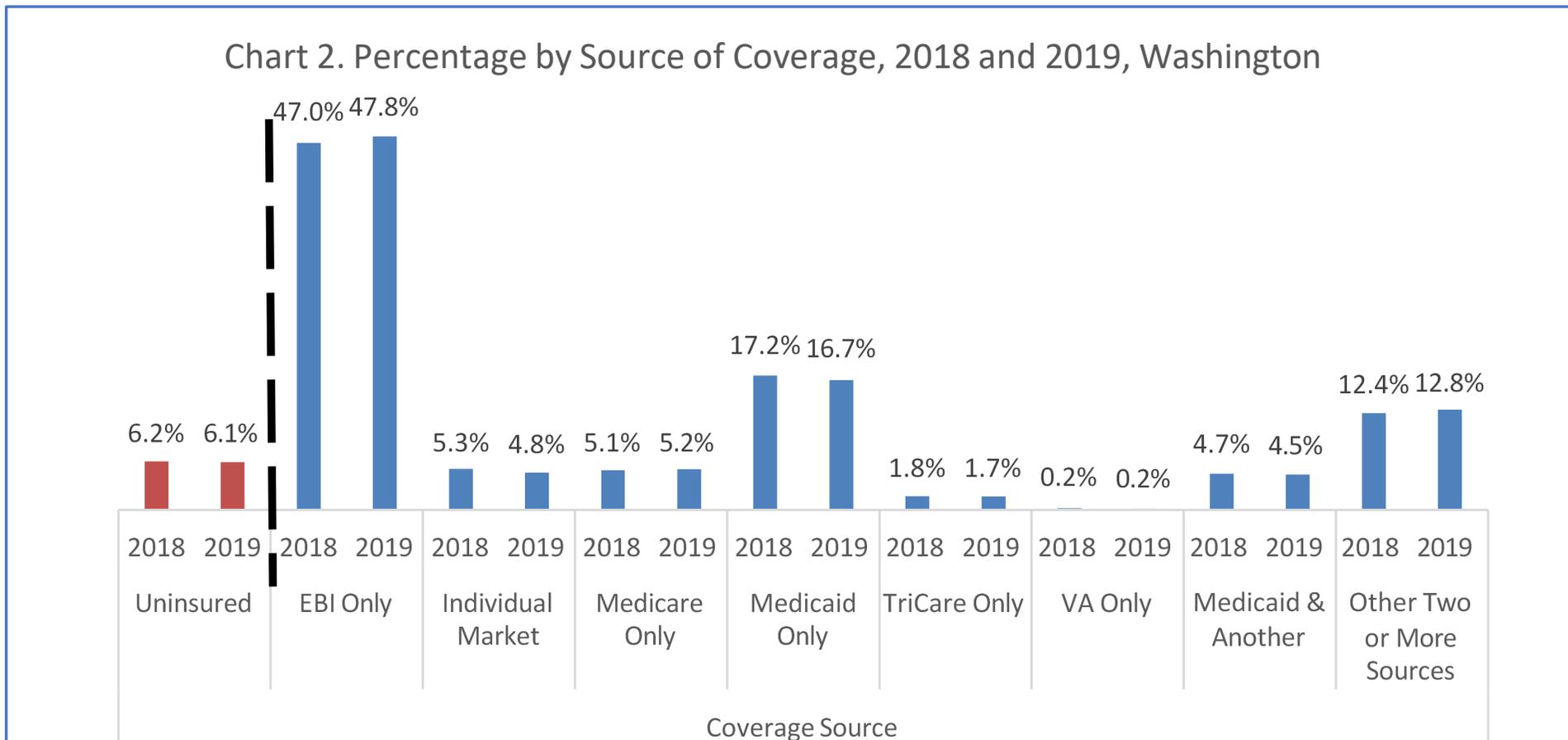
- **Section 1**
  - Ensuring the Commission has a common understanding of the problems in Washington's health care system
  - Many of the policy responses that have been developed to address them
- **Section 3**
  - Helping the Commission to understand the design elements that they will be addressing
  - Distinguishing between core design elements and the "goals of the system"
- **Coming Next**
  - How well is Washington prepared to do these activities?
  - Strategies to get there

# Section 1: Current Landscape and Past Analysis

# Coverage Analyses and Trends



# Coverage Analyses and Trends



# Coverage Analyses and Trends

- The uninsured rate remains higher in rural counties, but the gap between those in rural and urban counties shrunk between 2014 and 2019
- Those who identify as White, Asian, mixed-race and Black all saw declines in the uninsured rate from 2014 to 2019
- Not all populations saw a decline: the uninsured rate in 2019 for American Indian/Alaskan Native, Hawaiian and Pacific Islander, and races not specified exceeded the uninsured rates in 2014
- The uninsured rate for the Hispanic population declined from 29.8% in 2014 to 16.9% in 2019, however the disparity between the uninsured rate for the Hispanic population and the non-Hispanic population has grown from 2.5 times the rate in 2014 to almost 4 times the rate in 2019

# Cost Analyses and Trends

Average annual growth rate for commercial, Medicaid, and Medicare

Payer Type	Average Annual Growth	Since 2016
Commercial	4.9% (2014-2018)	6.7%
Medicare	2.4% (2008-2018)	2.1%
Medicaid	6.7% (2015-2019)	7.3%

2021 OIC analysis reported a 13% increase in costs for commercially-insured populations, nearly twice the rate of inflation

Sources: HCCTB Meeting June 16, 2021 materials prepared by Bailitt  
OIC Report on Report on the number of uninsured people in Washington State, 2021

# Cost Analyses and Trends: Policy Responses

- Value-Based Payments - 2017
  - HCA Goal to move 90% of contracts to VBP arrangements
- Health Care Cost Transparency Board (HCTTB) – 2020
  - September 2021: the Board has approved a cost growth benchmark of 3.2% for 2022-23, 3.0% for 2024-25, and 2.8% by 2026
- Prescription Drug Price Transparency Program – 2019
  - Annual report on whether drug prices are impacting premiums
- Report on Prior Authorization – 2020
  - Required reporting on use of prior authorization for certain categories of services including approval rates and response times
- Prescription Drug Affordability Board – 2022
  - Increased reporting, ability to conduct affordability reviews and set upper payment limits

# Quality Analyses and Trends: Policy Responses

- Washington State Health Technology Clinical Committee – 2006
  - Evidence-based decision-making for health technology
- Dr. Robert Bree Collaborative – 2011
  - Public/Private collaborative to improve quality and outcomes
  - Recommendations drive state purchasing
- Washington Common Measure Set – 2014
  - Statewide performance measures committee to identify and recommend a standard set of health performance measures to establish benchmarks and inform health care purchasers
- All-Payer Claims Database – 2014
  - Contains 75% of claims data to support transparent public reporting of health care information
- Medicaid Transformation Project – 2018 – ongoing
  - Medicaid effort to transform delivery of care, ACHs able to earn dollars by improving on quality metrics

# Workforce Analyses and Trends

Figure 2. Total Practicing Physicians per 100,000 Population, Washington State: 2020 and 2021

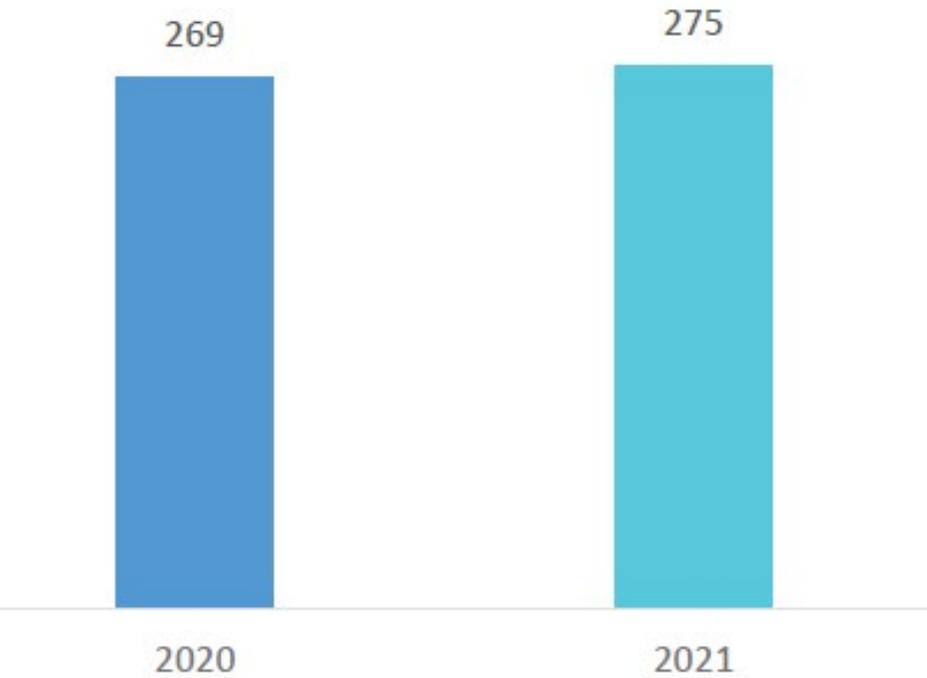
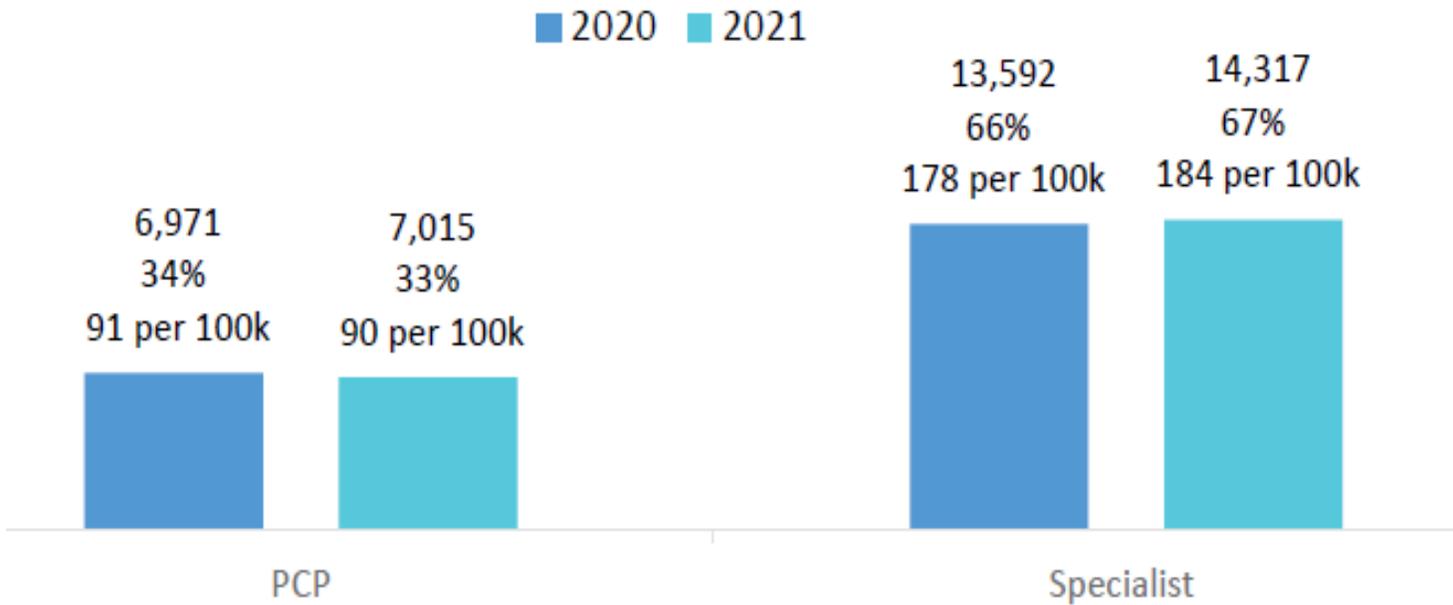


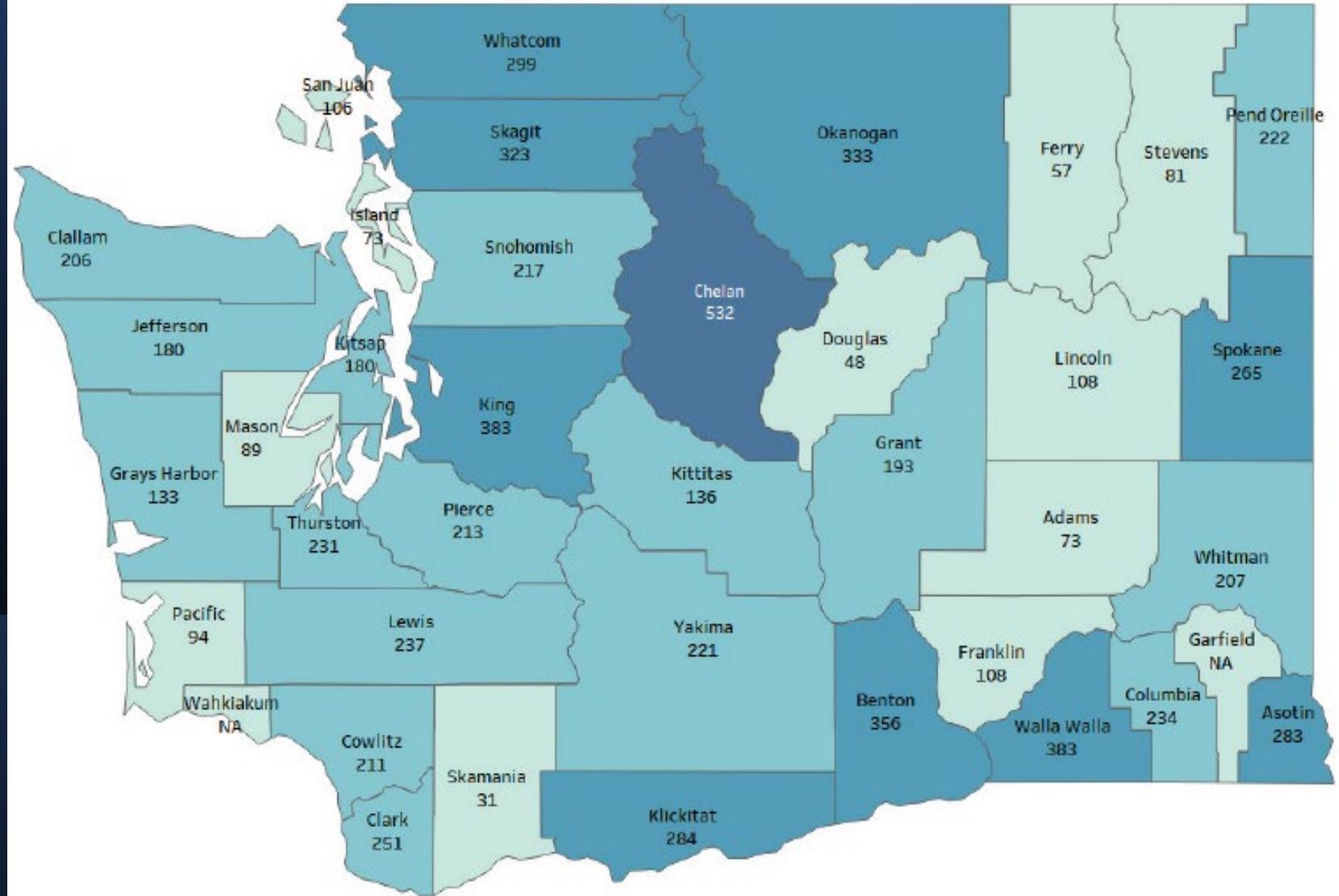
Figure 4. Number, percent and rate (per 100,000) of PCPs and specialists, Washington: 2020 and 2021



Source: 2020-21 Physician Supply: Estimates for Washington- OFM, October 2021

# Workforce Analyses and Trends

Map 4. Number of physicians per 100,000 population: counties, 2021



- Source: 2020-21 Physician Supply: Estimates for Washington- OFM, October 2021

# Workforce Analyses and Trends

Occupation Title	Projected Annual Growth Openings 2024-29	Projected Annual Job Openings 2024-29
Child, Family, and School Social Workers	162	1,135
Counselors	313	1,862
Educational, Guidance, School, and Vocational Counselors	86	747
Healthcare Social Workers	78	577
Healthcare Support Workers	52	487
Home Health and Personal Care Aides	2122	12,698
Licensed Practical and Licensed Vocational Nurses	84	753
Marriage and Family Therapists	10	54
Medical Assistants	308	2,400
Mental Health and Substance Abuse Social Workers	53	358
Nurse Anesthetists	8	53
Nurse Midwives	1	8
Nurse Practitioners	209	681
Nursing Assistants	600	5,250
Psychologists	87	513
Registered Nurses	780	4,700
Social Workers	4	79
Social and Human Service Assistants	264	1,715
Therapists	4	25

Source: Health Workforce Council 2021 Report

# Consolidation Trends and Analysis

- In 1986, hospitals in systems operated hospitals in 6 counties accounting for 60% of the state's population.
- In 2017, close to 90% of the population lived in a county with at least 1 hospital system
- In 1986, there were no counties where systems operated all hospitals.
- In 2017, there were 8 counties where the only hospitals are part of systems

1. Clark

2. Cowlitz

3. Kitsap

4. San Juan

5. Stevens

6. Walla Walla

7. Whatcom

8. Yakima

# Consolidation Trends and Analysis

- The percentage of hospitals in systems grew from 10% in 1986 to almost half in 2017
- Most changes happened between 2006-2017

Percentage of Hospital Beds in Systems	
1986	19%
2017	73%
Percentage of Patient Admissions to Systems	
1986	20%
2017	79%
Percentage of ICU Beds in Systems	
1986	19%
2017	73%

# Consolidation Trends and Analysis

- In 1986, hospitals in systems operated hospitals in 6 counties accounting for 60% of the state's population
- In 2017, close to 90% of the population lived in a county with at least 1 hospital system
- In 2017, systems operated hospitals in 17 counties, 8 of which were only served by system-operated hospitals
- In 1986, there were no counties where systems operated all hospitals, in 2017, there are 8 counties where the only hospitals are part of systems

1. Clark

2. Cowlitz

3. Kitsap

4. San Juan

5. Stevens

6. Walla Walla

7. Whatcom

8. Yakima

# Universal Health Care System Analysis

	<b>Model A</b>	<b>Model B</b>	<b>Model C</b>
	State-administered, single-payer for all state residents	State-governed and health plan administered program for all state residents	Access to coverage for undocumented residents unable to buy coverage now “fill in the gaps.”
<b>Expenditures and potential savings for covered populations</b>			
Status quo expenditure	\$61.4 billion	\$61.4 billion	Not available
Model cost estimate	\$58.9 billion	\$60.6 billion	\$617 million
Implementation year savings	\$2.4 billion	\$738 million	N/A

# Recent Policy Initiatives Impacting the Landscape: Implementing Model C

Maintaining the gains in coverage from PHE continuous enrollment

Addressing Affordability

- Cascade Care Select – impacts becoming apparent
- Cascade Care Savings (begins 2023)

Increasing who can shop and purchase coverage on Exchange

- WABHE 1332 Waiver

# Section 3: Inventory of Design Elements

# Eligibility and Enrollment

- Identify how to cover currently uninsured populations
  - Which segments of the existing insured population will be included in a universal health care system
  - How the remaining segments, if any, will be preserved
- Who is eligible?
    - Washington residents
    - Out-of-state residents working for Washington employers?
    - Allow opt-in for people covered by Employer-Sponsored Insurance, self-funded plans, FEHB, VA?
  - What information must be obtained during enrollment process?
  - What process will be used to enroll people? To what extent can auto-enrollment be used?

# Benefits and Services

Create an approach to develop standards to ensure that individuals covered under the model receive equal access to a minimum set of benefits and services.

## *Considerations for Designing Benefits and Services*

What benefits and services are covered?

- Essential Health Benefits
- Adult Dental?
- Vision?
- Benefits mandated by Medicaid

Would there be a single drug formulary and how would it work with current programs and the Washington Prescription Drug Program?

Will there be cost-sharing for services? (co-pays, etc.)

How will the benefit package be overseen and who will make decisions on any updates or changes?

How will utilization management/prior authorization be done?

# Financing

Identify an approach to align or aggregate public funding sources, private sector funding sources; and individual cost-sharing.

## *How will the new system be funded?*

### Federal funds

- Medicaid
- ACA subsidies
- Medicare

### State funds

- General fund (e.g., Medicaid funding)
- New taxes
  - Payroll tax
  - Revenue tax
  - Sales tax (or “sin” tax)

### Consumers

- Premiums
- Co-pays and co-insurance

# Provider Reimbursement and Participation

- Select a method for paying providers
- Encourage provider participation
- Align provider behavior to quality and equity goals

## How will providers be reimbursed?

- Single fee schedule
  - Percentage above Medicare for all services?
  - Rate-setting by administrative process
- Negotiated rates
  - By state
  - By plans

## How will we structure provider participation?

- Value-based care models
  - Mandate
  - Encourage
- Provider participation
  - Mandate
  - Encourage

# Infrastructure

Invest in administrative and operational capabilities necessary to implement a cohesive model.

## *Key Considerations – Infrastructure*

- What infrastructure can be re-used, delegated, or needs to be developed?
  - Technology platforms
  - Staff and human resources
  - Administrative policies and processes
- Who will be responsible for infrastructure investments?
  - State investments needed
  - Model participant investments
  - Shared infrastructure investments across relevant agencies

# Governance

Ensure transparency and accountability for planning and implementing the unified financing system ~~model~~ and that the voice of consumers is part of ~~central to~~ decision-making.

## *Key Considerations – Governance*

- Who administers the program?
  - Single new state agency
  - Single existing state agency
  - Combination of new and/or existing state agencies
  - Health plans (under Universal Health Care Work Group's Model B)
- Who regulates?
  - Single new state agency
  - Single existing state agency
  - Combination of new and/or existing state agencies

## Coming Next Meeting

- How well is Washington prepared to do these activities?
- Strategies to get there
- Please provide draft feedback and any edits to Mandy Weeks-Green by May 15<sup>th</sup>

# Commission Member Q&A and Discussion

# Appendix

# Workforce Analyses and Trends

**Figure 1. Nursing Homes/Skilled Nursing Facilities  
Occupations with exceptionally long vacancies: 2017-2021**

Rank	Fall 2017*	Summer 2018	Spring 2019	Fall 2019	Spring 2020	Fall 2020	Spring 2021	Fall 2021
1	Nursing assistant	Nursing assistant	Registered nurse	Nursing assistant	Nursing assistant	Nursing assistant	Registered nurse	Registered nurse
2	Registered nurse	Registered nurse	Nursing assistant	Registered nurse	Registered nurse	Registered nurse	Nursing assistant	Licensed practical nurse Nursing assistant
3	Licensed practical nurse	Licensed practical nurse	Licensed practical nurse	Licensed practical nurse	Licensed practical nurse Dentist	Licensed practical nurse	Licensed practical nurse	Occupational therapist Physical therapist
4	Multiple occupations cited at same frequency	Dentist	Occupational therapy assistant Physical therapist	Speech-language therapist	Multiple occupations cited at same frequency	Occupational therapy assistant Physical therapist	Occupational therapist Physical therapist	Speech-language therapist
		Physician/ Surgeon	Social worker Psychologist			Physical therapy assistant Social worker Speech-language therapist		
5		Multiple occupations cited at same frequency	Multiple occupations cited at same frequency	Multiple occupations cited at same frequency		Multiple occupations cited at same frequency	n/a	Multiple occupations cited at same frequency

↑ Most cited

# Workforce Analyses and Trends

**Figure 2. Assisted Living Facilities  
Occupations with exceptionally long vacancies: 2019-2021**

Rank	Spring 2019*	Fall 2019	Spring 2020	Fall 2020	Spring 2021	Fall 2021	
1	Nursing assistant	Nursing assistant	Home health aide or home care aide	Nursing assistant	Nursing assistant	Nursing assistant	
2	Licensed practical nurse	Licensed practical nurse	Licensed practical nurse	Licensed practical nurse	Licensed practical nurse	Registered nurse	
			Registered nurse				
			Nursing assistant				
3	Home health aide or home care aide	Home health aide or home care aide	Multiple occupations cited at the same frequency	Registered nurse	Registered nurse	Home health aide or home care aide	
	Registered nurse	Registered nurse			Personal care aide		
4	Personal care aide	Personal care aide		Multiple occupations cited at the same frequency	Home health aide or home care aide	Cook	Licensed practical nurse
	Chemical dependency professional	Cook				Home health aide or home care aide	
	Social worker						
5	Multiple occupations cited at the same frequency	Multiple occupations cited at the same frequency	Multiple occupations cited at the same frequency	Personal care aide	n/a	Personal care aide	
				Food service			
				Housekeeping			

← Most cited

\*Before Spring 2019, assisted living facility responses were combined with other long-term care facility

# Workforce Analyses and Trends

**Figure 3. Behavioral Health Facilities\***  
**Occupations with exceptionally long vacancies: 2017-2021**

Rank	Fall 2017	Summer 2018	Spring 2019	Fall 2019	Spring 2020	Fall 2020	Spring 2021	Fall 2021
1	Chemical dependency professional	Mental health counselor	Mental health counselor	Mental health counselor	Mental health counselor	Mental health counselor	Mental health counselor	Mental health counselor
2	Mental health counselor	Chemical dependency professional Peer counselor	Chemical dependency professional	Chemical dependency professional	Chemical dependency professional	Chemical dependency professional (SUDP)***	Substance use disorder professional***	Substance use disorder professional***
3	Social worker Nurse practitioner	Nurse practitioner	Social worker	Peer counselor	Social worker	Social worker (Mental Health/SUDP)	Psychiatrist Social worker	Social worker (Mental Health/SUDP)
4	Peer counselor	Social worker Psychiatrist	Marriage & family therapist	Marriage & family therapist	Peer counselor	Registered nurse	Peer counselor	Peer counselor
5	Registered nurse	Marriage & family therapist	Peer counselor Psychiatrist	Social worker	Multiple occupations cited at same frequency	Marriage & family therapist Peer counselor Psychiatrist	Registered nurse	Social worker (Child, Family and School)

↑ Most cited

\*Behavioral/mental health, substance use disorder clinics and residential treatment facilities

\*\*\*Occupation title changed to Substance Use Disorder Professional (SUDP) in 2019

# Washington Universal Health Care Commission report to the Legislature: Draft of section 1

## Tab 7

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## Section 1

### Introduction

Washington State is a recognized national leader on innovative health policy efforts granting residents access to affordable and quality health care. For more than thirty years, these innovative health policy efforts have transformed Washington's health care system. The first section of this report provides a summary of analyses of Washington's health care finance and delivery system in key areas including coverage trends, costs, quality, provider consolidation trends, and key policy interventions that Washington has implemented to make improvements. This section also summarizes recent efforts focused on evaluating the impacts of a unified health care financing system/universal health system (hereafter "universal health care system") in Washington.

The goal of this section is to provide a common understanding of the current state of health care trends and past and recent policy efforts. This overview may help inform future decisions regarding a universal health care system in Washington.

### Washington Health Care Coverage Analyses and Trends

Washington is as a national leader in health care system innovation, seeking policy solutions to address coverage gaps well before the Affordable Care Act (ACA). These efforts are detailed in a timeline provided in *Appendix X (\*to be added from the UHC Workgroup report)* and described in this section. Following passage of the ACA, Washington fully embraced the opportunity to expand Medicaid and offered new subsidized coverage through the Health Benefits Exchange (HBE) which extended health care coverage to more Washington residents.

The Office of Financial Management (OFM) produces an annual report on the rate of uninsured. The reports indicate the uninsured rate declined from 14.1% in 2013, to 5.4% in 2016, then slightly increased to 6.1% in 2019 before the start of the COVID-19 pandemic.<sup>1,2</sup> The OFM report also details information about the sources of health coverage for Washingtonians. According to the 2020 report, 47.8% of Washingtonians relied on employment-based insurance, 16.7% on Apple Health (Medicaid), 4.8% on individual market coverage, 1.7 % on TriCare, 0.2% on Veteran's Affairs, 4.5% on Medicaid and Another Source of Coverage and 12.8% on Other or Two or More Sources of Coverage.

The Office of the Insurance Commissioner (OIC) Uninsured Report released in December 2021 provides additional specificity about which populations remain uninsured by age, geography, race, and gender and what the trends were over time. The OIC Report examined trends in the rate of the uninsured between 2014 and 2019. The OIC Uninsured Report found that across all counties there were declines in the number of Washingtonians without health insurance, but that the declines were more significant in rural compared with urban counties, due in large part to the fact that more individuals in urban counties already had a source of coverage compared with individuals in rural counties in 2014. The OIC also found that residents ages 18 to 44 had the highest uninsured rate over time with an average of 10%, while those 65 years and older had the lowest uninsured rate over time with an average of 0.5%, most likely due to Medicare enrollment. When looking at income, the OIC report noted that individuals with

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<sup>1</sup> Statewide Uninsured Rate Remained Unchanged from 2018 to 2019. Office of Financial Management, December 2020. <https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief098.pdf>

<sup>2</sup> The most recent data utilized in this report is from 2019. The Office of Financial Management anticipates an update will be available late in 2022.

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household incomes below \$49,999 saw the greatest decrease in the uninsured rate, with a more significant decrease for those with incomes below \$25,000, declining from 14.1% to 8.9%.<sup>3</sup>

The OIC Uninsured Report also provides important insights into who is uninsured by race. People who identify as white, Asian, and multiracial have the lowest uninsured rates statewide at a little over 5%. Individuals who identify in these racial categories as well as individuals who identify as African American/Black, had substantially lower uninsured rates in 2019 than 2014, demonstrating the impact of the ACA's coverage expansions. However, the uninsured rate in 2019 for the remaining race categories including American Indian/Alaskan Native, Hawaiian and Pacific Islander and individuals not identifying a race exceeded the uninsured rates in 2014. OFM's 2020 analysis reports that before the implementation of the Affordable Care Act in 2013, the uninsured rate for the Hispanic population was two and half times the rate of non-Hispanic population (29.8% for the Hispanic population compared with 12% for the non-Hispanic population). Both populations have seen significant declines in their uninsured rate since 2013, but the disparities persist and are expanding when comparing the uninsured rate for the Hispanic population with that of the non-Hispanic population. In 2019, the uninsured rate for the Hispanic population was 16.8% compared with 4.5% for the non-Hispanic population, an almost fourfold difference.<sup>4</sup>

The impact of the pandemic on the overall uninsured rate in Washington was significant, resulting in a spike in the uninsured rate to 11.9% in May 2020, which steadily declined thereafter. The most recent monthly data from OFM (November 2021) indicates an uninsured rate of 4.7%, which is the lowest uninsured rate since the implementation of the Affordable Care Act.<sup>5</sup>

The lower uninsured rate is reflective of a number of key policy changes undertaken to mitigate coverage losses during the pandemic. These key policy changes include continuous Medicaid coverage, expanded eligibility for premium subsidies to purchase coverage through the Exchange, enhanced premium subsidies to improve the affordability of Exchange coverage, and increased outreach and enrollment opportunities to obtain coverage.<sup>6</sup> OFM has monitored the impact of these policies closely and is developing projections about the effect of the end of the Public Health Emergency on the state's uninsured rate.

During the February 2022 Universal Health Care Commission (UHC Commission) meeting, OFM shared a preliminary analysis about these potential impacts, projecting a significant bump in the rate of the uninsured, mostly due to the return of temporary disenrollment and re-enrollment in Apple Health. However, work is underway at the Health Care Authority (HCA) and HBE to minimize projected coverage losses. Tracking this data and the impact of these efforts to minimize coverage losses will be important information in developing strategies for the transition to universal health coverage.

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<sup>3</sup> Report on the number of uninsured people in Washington state 2014-2020. Office of the Insurance Commissioner, December 30, 2021. <https://www.insurance.wa.gov/sites/default/files/documents/2021-uninsured-report.pdf#:~:text=Washington%20state's%20uninsured%20rate%20was,2014%20and%205.5%25%20in%202017>

<sup>4</sup> Statewide Uninsured Rate Remained Unchanged from 2018 to 2019. Office of Financial Management, December 2020. <https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief098.pdf>

<sup>5</sup> Health Coverage Changes in Washington State since the COVID-19 Pandemic: Office of Financial Management presentation to the Universal Health Care Commission, February 25, 2022. <https://www.hca.wa.gov/assets/program/uhcc-meeting-materials-20220225.pdf>

<sup>6</sup> "COVID Relief Provisions Stabilized Health Coverage, Improved Access and Affordability." Center on Budget and Policy Priorities. <https://www.cbpp.org/research/health/covid-relief-provisions-stabilized-health-coverage-improved-access-and>

## Cost Analyses and Trends

A large part of Washington's efforts to address problems in the health care system have focused on addressing rising health care costs. These efforts are likely to remain in the forefront of Washington health policy as health care costs continue to increase yearly.

In recent years, Washington health care costs increased each year at a pace that exceeds the rate of inflation. In the commercial market, OIC reported a 13% increase in costs in 2021, nearly double the rate of inflation at 7%.<sup>7</sup> Cost growth in Washington also generally exceeds national trends. From 2014-2018, Washington's average annual growth in per person spending on employer-sponsored insurance was 4.9%, which is higher than the national average of 4.3%. Similarly, in the Medicare market, Washington's average annual growth in per capita health care costs was 2.4% between 2007-2018, exceeding the national average of 2.1%.<sup>8</sup>

To better understand cost drivers and to address rising health care costs, Washington engaged in a number of initiatives over the last several years. These include the Health Care Cost Transparency Board, the Prescription Drug Price Transparency Program, Prescription Drug Affordability Board, Value-Based Purchasing, and the OIC's Report on Prior Authorization.

### *Health Care Cost Transparency Board*

In 2020, the Washington State Legislature created the Health Care Cost Transparency Board (HCCTB) to identify health care cost trends, set a cost-growth benchmark, and develop recommendations to reduce health care costs.<sup>9</sup> As of September 2021, the Board has approved a cost growth benchmark of 3.2% for 2022-23, 3.0% for 2024-25, and 2.8% by 2026.<sup>10</sup> Washington's benchmark aligns with other states' cost-growth benchmarks, such as in Oregon, Connecticut, Delaware, Massachusetts, and Rhode Island.<sup>11</sup> The HCCTB will be responsible for identifying providers and payers whose cost growth exceeds the benchmark.

### *Prescription Drug Price Transparency Program*

In 2019, the Washington State Legislature enacted legislation establishing the Prescription Drug Price Transparency Program to develop a better understanding of the drivers and impacts of drug costs.<sup>12</sup> Under this program, HCA gathers prescription drug cost information from health insurers, pharmacy benefit managers (PBMs), manufacturers, and other entities to create an annual report on how prescription drugs affect health care costs. In first annual report (based on data from 2020 that was reported in 2021), HCA identified that while drug price increases may have an impact on health care premiums, it is unable to describe the specific extent in this first report. This is in some part due to the agency's limitations in its ability to analyze this relationship without a comprehensive set of claims data

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<sup>7</sup> Health Care Cost Trends. Office of the Insurance Commissioner. <https://www.insurance.wa.gov/health-care-cost-trends>

<sup>8</sup> Health Care Cost Transparency Board slides, June 2021. <https://www.hca.wa.gov/assets/program/hcctb-board-book-20210616.pdf>

<sup>9</sup> Second Substitute House Bill 2457 Chapter 340, Laws of 2020. <https://lawfilesexternal.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/2457-S2.SL.pdf?q=20220405153723>

<sup>10</sup>Health Care Cost Transparency Board. September 14, 2021, Meeting Minutes. <https://www.hca.wa.gov/assets/program/board-meeting-summary-20210914.pdf>

<sup>11</sup> Block, R. & Lane, K. (2021). *Supporting States to Improve Cost Growth Targets to Improve Affordability*. Health Affairs. <https://www.healthaffairs.org/doi/10.1377/forefront.20210526.658347/full/>

<sup>12</sup> Engrossed Second Substitute House Bill 1224 Chapter 334, Laws of 2019. <https://lawfilesexternal.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1224-S2.SL.pdf?q=20220404145622>

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for all health plans in the state.<sup>13</sup> The report included several suggested statutory changes to improve the program's ability to understand the impact of prescription drugs on rising health care premiums including requiring health insurers, Pharmacy Benefit Managers (PBMs), manufacturers, and other entities to provide additional data to the HCA. Many of these recommendations, including these additional reporting requirements were included in legislation that passed in 2022 which created the Prescription Drug Affordability Board (PDAB).<sup>14</sup>

### *Prescription Drug Affordability Board*

Beginning in 2023, the PDAB is empowered to conduct up to 24 affordability reviews of drugs that have been on the market for at least seven years, including drugs dispensed at a retail, specialty, or mail-order pharmacy, but does not include drugs designated by the United States Food and Drug Administration as a drug solely for the treatment of a rare disease or condition. These drugs must also meet the following benchmarks to be considered for an affordability review:

- Brand name prescription drugs:
  - Having a wholesale acquisition cost of \$60,000 or more per year or for course of treatment lasting less than one year,
  - Or in the alternative or have a price increase of 15 percent or more in any 12-month period or for a course of treatment lasting less than 12 months,
  - Or a 50 percent cumulative increase over three years,
- Biosimilar products with an initial wholesale acquisition cost that is not at least 15 percent lower than the referenced biological product, and
- Generic drugs with a wholesale acquisition cost of \$100 or more for a 30-day supply or less that has increased in price by 200 percent or more in the previous 12 months.

The legislation includes the additional parameters for the affordability reviews including establishment of advisory panels which include stakeholders such as patients, patient advocates and a representative from the pharmaceutical industry. Affordability reviews will be focused on determining if the drug led to or will lead to excess costs, or are not sustainable to the health care system over a ten-year period. Beginning January 1, 2027, PDAB will have the authority to set an upper payment limit for up to twelve prescription drugs each year.<sup>15</sup>

### *Value-Based Purchasing*

As the largest purchaser of health care in Washington, HCA is leading value-based purchasing (VBP) strategies to contain health care costs while improving outcomes. HCA set a target to achieve 90 percent of state-financed health care payments to be under VBP contracts and is making progress toward this goal. HCA's *Value Based Purchasing Roadmap for 2022-2025* sets forth VBP priorities, successes, challenges, and progress to date in implementing VBP arrangements in Washington.<sup>16</sup>

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<sup>13</sup> Health Care Authority. (2022). Prescription Drug Price Transparency – Annual Report. <https://www.hca.wa.gov/assets/program/hca-dpt-annual-report-2022.pdf>

<sup>14</sup> Second Substitute Senate Bill 5532 Chapter 153, Laws of 2022. <https://lawfilesexternal.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5532-S2.SL.pdf#page=1>

<sup>15</sup> Ibid.

<sup>16</sup> VBP Roadmap <https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf>

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### *Office of the Insurance Commissioner Report on Prior Authorization*

In 2020, the Legislature passed Engrossed Substitute Senate Bill 6404 that requires health carriers with at least 1% market share in Washington to report certain data regarding prior authorization to OIC.<sup>17</sup> Prior authorization is a tool used by carriers to control cost and access to certain benefits. This reporting may offer insightful information that will be helpful in making decisions concerning design elements of a universal system, particularly regarding the appropriate use of prior authorization as a tool to control costs. Carriers are required to report data annually for the following specified categories of health care services:

- Inpatient medical/surgical.
- Outpatient medical/surgical.
- Inpatient mental health and substance-use disorder.
- Outpatient mental health and substance-use disorder.
- Diabetes supplies and equipment.
- Durable medical equipment.

Within these categories of health care services, carriers report:

- Ten codes with the highest number of prior authorization requests and the percentage of approved requests.
- The ten codes with the highest percentage of approved prior authorization requests and the total number of approved requests.
- Ten codes with the highest percentage of prior authorization requests that were initially denied and then approved on appeal.
- The total number of requests.
- The average response time in hours for requests in each of the above categories for expedited decisions, standard decisions, and extenuating circumstances decisions.

The OIC issued the 2021 report on January 1, 2022 and stated that the average approval rate across all carriers was 84.4%. For the codes with the highest number of prior approval rates, the average approval rates were as follows:

- Outpatient Medical/Surgical: 98.3%
- Inpatient Medical/Surgical: 97.8%
- Durable Medical Equipment: 96.1%
- Inpatient Mental Health/Substance Abuse: 94.5%
- Outpatient Mental Health/Substance Abuse: 91.8%
- Diabetes Supplies and Equipment: 84.1%

The OIC also reported the average response times for the codes with the most requests, which were as follows:

- Inpatient Mental Health/Substance Abuse: 14.4 days
- Diabetes Supplies and Equipment: 12.4 days
- Inpatient Medical/Surgical: 10.7 days

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<sup>17</sup> Engrossed Substitute Senate Bill 6404 Chapter 316, Laws of 2020. <https://lawfilesexternal.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/6404-S.SL.pdf?q=20220405154910>

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- Outpatient Mental Health/Substance Abuse: 6.7 days.<sup>18</sup>

### Quality Analyses and Trends

Improving health care quality has been and remains a policy priority for Washington's health care delivery system. Washington policymakers have made several investments and enacted key policies in recent years to monitor and support quality improvements. These include the Washington State Health Technology Clinical Committee, the Dr. Robert Bree Collaborative, the Washington Statewide Common Measure Set, the All-Payer Health Care Claims Database (APCD) and Washington's Medicaid Transformation Project. These efforts focus on promoting transparency and systematic processes to evaluate and support improved quality in the health care system and are important building blocks to consider in the future design of a universal health care system.

#### *The Washington State Health Technology Clinical Committee (HTCC)*

The HTCC was established in 2006 to make evidence-based coverage determinations for health technologies.<sup>19</sup> The HTCC is supported by HCA's Health Technology Assessment program, which develops and publishes systematic health technology assessment reports on the strength of the evidence for medical devices, procedures, and tests.

The HTCC considers Health Technology Assessment reports and other information, including state utilization and public comment. HTCC's determinations guide coverage decisions for state health care purchasers, including Medicaid, Uniform Medical Plan, and the Department of Labor and Industries.

#### *The Dr. Robert Bree Collaborative (Bree Collaborative)*

The Legislature established the Bree Collaborative in 2011 as a forum for public and private health care stakeholder collaboration to improve quality, health outcomes, and cost effectiveness of care in Washington.<sup>20</sup> Participating experts are nominated by community stakeholders and appointed by the Governor. Each year, the Bree Collaborative identifies up to three health care service areas with high variation in the delivery of care that do not lead to better care or patient health, or that have demonstrated patient safety issues. The selected service areas are addressed by a work group of experts on the topic who are Bree Collaborative members and other experts in the community. The work group analyzes evidence on best practices for improving quality and reducing practice pattern variation. The Bree Collaborative recommendations consider existing quality improvement programs and organizations currently working to improve care. HCA incorporates Bree Collaborative recommendations into state-purchased coverage rules.

#### *Washington Statewide Common Measure Set*

In 2014, the Legislature established the Washington Statewide Common Measure Set as part of a larger bill focused on "improving the effectiveness of health care purchasing and transforming the health care delivery system."<sup>21</sup> This legislation established a statewide performance measures committee, known as the Performance Measures Coordinating Committee (PMCC) which is supported by the HCA. The PMCC identifies and recommends a standard set of health performance measures that are utilized to develop

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<sup>18</sup> Health Plan Prior-Authorization Data 2021 Report. Office of the Insurance Commissioner.

<https://www.insurance.wa.gov/sites/default/files/documents/health-plan-prior-authorization-data-2021-report.pdf>

<sup>19</sup> Health Care Authority. [Health Technology Clinical Committee](#) and [Health Technology Assessment](#).

<sup>20</sup> [Bree Collaborative website](#).

<sup>21</sup> Engrossed Second Substitute House Bill 2572 Chapter 223, Laws of 2014.

<https://lawfilesexternal.wa.gov/biennium/2013-14/Pdf/Bills/Session%20Laws/House/2572-S2.SL.pdf?q=20220405155431>

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benchmarks to inform health care purchasers. The PMCC includes diverse representation such as state agencies, large and small employers, health plans, federally recognized tribes, patient groups, academics, hospitals, physicians, and consumers. In 2014, a set of measures were introduced and are continually updated by the PMCC as new health care measures are developed and priorities for improvement are identified. The most recent set of measures was updated in 2022.<sup>22</sup>

### *All-Payer Health Care Claims Database*

The same legislation that established the PMCC and the Statewide Common Measure Set also allocated resources to OFM to establish the Washington All-Payer Health Care Claims Database (WA-APCD) to support transparent public reporting of health care information.<sup>23</sup> The WA-APCD contains eligibility, medical, pharmacy and dental claims representing about 75% of the statewide health care claims, including Medicaid, Medicare, public employees benefits, and workers' compensation and more than 50 commercial payers.<sup>24</sup> In 2019, the Legislature transferred the responsibility for the WA-APCD to HCA to partner with a lead organization with experience collecting and analyzing claims data.<sup>25</sup>

### *Medicaid Transformation Project (MTP)*

Washington is currently in its final year of an 1115 Medicaid waiver that includes five key initiatives to transform the Medicaid program including:

- **Initiative 1:** transformation through Accountable Communities of Health (ACHs) and Indian Health Care Providers (IHCPs): implements projects that change the way people receive health care in their region. HCA is in the process of developing a waiver renewal proposal that will be submitted to the Centers for Medicare and Medicaid Services in Summer 2022. Efforts to improve quality through value-based payments will continue to be a focus of ongoing transformation efforts.<sup>26</sup>
- **Initiative 2:** supporting older adults and family caregivers: providing support for Washington's aging population and family caregivers who provide care for their loved ones.
- **Initiative 3:** Foundational Community Supports (FCS): provides supportive housing and supported employment services to vulnerable Medicaid enrollees.
- **Initiative 4:** substance use disorder (SUD) institution for mental diseases (IMD): provides for greater access to SUD treatment by allowing Washington State to use federal funds to pay for SUD treatment in a mental health or SUD facility that qualifies as an IMD. IMDs are large facilities dedicated to psychiatric care (more than 16 beds where more than 50 percent of the residents are admitted for psychiatric care).<sup>27</sup>

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<sup>22</sup> Washington Statewide Common Measure Set. <https://www.hca.wa.gov/about-hca/washington-statewide-common-measure-set#what-is-statewide-common-measure-set>

<sup>23</sup> Engrossed Second Substitute House Bill 2572 Chapter 223, Laws of 2014. <https://lawfilesexternal.wa.gov/biennium/2013-14/Pdf/Bills/Session%20Laws/House/2572-S2.SL.pdf?q=20220405155431>

<sup>24</sup> Washington All-Payer Health Care Claims Database newsletter. <https://www.hca.wa.gov/washington-all-payer-health-care-claims-database-wa-apcd-newsletter>

<sup>25</sup> Engrossed Substitute Senate Bill 5741 Chapter 319, Laws of 2019. <https://lawfilesexternal.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5741-S.SL.pdf?q=20220320080426>

<sup>26</sup> Medicaid Transformation Project Renewal <https://www.hca.wa.gov/about-hca/medicaid-transformation-project-mtp/mtp-renewal>

<sup>27</sup> Amendment to Washington's Medicaid Transformation Project (MTP): The substance use disorder (SUD) IMD initiative. <https://www.hca.wa.gov/assets/program/sud-imd-faq.pdf>

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- **Initiative 5:** mental health IMD: provides for great access to in-patient care by allowing Washington State to purchase (an average of 30 days) of acute inpatient services for Medicaid clients between the ages of 21 and 65 who reside in an (IMD).<sup>28</sup>

Through these initiatives, HCA is implementing and overseeing projects that are designed to improve the way people access the health and social supports they need. By further integrating these services and supporting providers in the transition to value-based payments, Washington will improve the quality-of-care people receive.

### Health Care Workforce Analyses and Trends

Developing and maintaining an adequate health care workforce will be critical to any effort to move toward a universal health care system focused on improving access and quality and reducing costs. Workforce trends will be particularly important considerations when developing a provider reimbursement model.

OFM's Forecasting and Health Care Research Division produces an annual report on Washington's physician supply using data collected from the Network Adequacy Reports Network (NAR) that health insurance carriers submit monthly to the OIC. The 2021 report found that the number of licensed physicians (including Medical Doctors and Doctors of Osteopathy) increased by 769 from 2020 to 2021 for a total of 20,563 licensed physicians. This growth in the number of licensed physicians outpaced the general population increase, resulting in an increase in the physician-to-population ratio from 269 physicians per 100,000 in 2020 to 275 physicians per 100,000 population in 2021. The report also found that the ratio of physicians practicing primary care in comparison to specialty care remained relatively unchanged (declining from 34% to 33% for primary care and rising to 67% from 66% for specialty care).

Similar to past annual reports, the physician supply is disproportionately distributed across the state, with more than 40% of all physicians located in King County. This is not surprising given that King County accounts for the bulk of the state's population. However, Chelan County, not King County, has the highest ratio of physician-to-population ratio by a significant margin: 532 physicians per 100,000 people versus 383 physicians per 100,000 people. Overall, significant disparities in Washingtonians' access to physicians remains across the state.<sup>29</sup>

The Washington Health Workforce Council was created by the Legislature in 2003 to investigate and support initiatives to address health care workforce shortages. The Council is responsible for producing an annual report outlining these trends and making recommendations to the Legislature about possible improvements. One of the initiatives of the Council has been the Washington Health Workforce Sentinel Network (the Network), created in 2016. The Network is a collaboration of the Council and the University of Washington Center for Health Workforce Studies (UW CHWS). The Network links the health care industry with partners in education and training, policymakers, and other workforce planners to identify and respond to emerging demand changes in the health workforce. The information captured by the Network seeks to provide more insights into the "why" of changes in occupations, roles, and skills needed to deliver quality care.

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<sup>28</sup> Amendment to Washington's Medicaid Transformation Project: Introducing the mental health IMD initiative. <https://www.hca.wa.gov/assets/program/mental-health-imd-faq.pdf>

<sup>29</sup> Office of Financial Management: 2020-21 Physician Supply: Estimates for Washington. [https://ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/workforce/physician\\_supply\\_2020-21.pdf](https://ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/workforce/physician_supply_2020-21.pdf)

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Since its inception, the Network has tracked health disciplines with exceptionally long vacancies across a number of health care settings.<sup>30</sup> According to the Health Workforce Council Annual Report for 2021, employers in Long-Term Care settings, including skilled nursing facilities, nursing homes, and assisted living facilities, reported significant challenges in hiring enough registered nurses (RNs), nursing assistants, and licensed practical nurses (LPNs). Notably, these workforce challenges are not new, but have become more acute since the COVID-19 pandemic.<sup>31</sup> There are various causes for these shortages such as the lack of adequate training slots for many of these professions, lower salaries in Long-Term Care settings when compared with other settings, and administrative challenges with licensure when moving from other states.

Another area where there are significant and ongoing healthcare workforce shortages is in behavioral health. According to the 2017 Washington State Behavioral Health Workforce Assessment, “the demand for behavioral health care, including mental health and substance use disorder treatment, exceeds the availability of services throughout the state.”<sup>32</sup> This is consistently echoed in the data collected by Network. Long-term vacancies were commonplace and have become more acute over the last two years due to the pandemic, during which the demand for behavioral health services has skyrocketed.<sup>33</sup>

In response to the significant and enduring gaps in the behavioral health workforce, in 2021 the Legislature formalized an existing stakeholder workgroup that became known as the Behavioral Health Workforce Advisory Committee (BHWAC). BHWAC issued an interim report in December 2021 with updated policy recommendations to improve hiring and retention. Key recommendations included in the interim report focused on increasing Medicaid reimbursement rates for behavioral health providers, increasing the ability of behavioral health agencies to accept students/trainees and enhancing training programs to support individuals pursuing careers in behavioral health. A final report from the BHWAC is expected in December 2022.<sup>34</sup> Recognizing and understanding the existing healthcare workforce shortages will be an important factor that will need to be addressed in the transition to a universal health care system.

### Market Consolidation Analyses and Trends

Over the last 35 years in Washington, there has been an increase in hospital consolidation because of mergers and acquisitions. This trend is not unique to Washington and is identified in many studies as a contributing factor to higher costs and poorer outcomes in the health care delivery system. Understanding these trends is an important factor when making design and policy decisions about a universal health care system in Washington.

OFM released a comprehensive report, “Hospital Mergers in Washington 1986-2017” which describes the increased concentration of hospital resources and care as more hospitals in Washington became part of larger hospital systems over the 1986-2017 period.<sup>35</sup> While it does not provide specific data

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<sup>30</sup> Health Workforce Council. <https://www.wtb.wa.gov/planning-programs/health-workforce-council/>

<sup>31</sup> Health Workforce Council Annual Report 2021 Annual Report. <https://www.wtb.wa.gov/wp-content/uploads/2022/01/Health-Workforce-Council-Annual-Report-2021.pdf>

<sup>32</sup> 2017 Washington State Behavioral Health Workforce Assessment. <https://www.wtb.wa.gov/wp-content/uploads/2019/05/WA-Behavioral-Health-Workforce-Assessment-2016-17.pdf>

<sup>33</sup> Health Workforce Council Annual Report 2021 Annual Report. <https://www.wtb.wa.gov/wp-content/uploads/2022/01/Health-Workforce-Council-Annual-Report-2021.pdf>

<sup>34</sup> Behavioral Health Workforce Advisory Committee Preliminary Report and Recommendations. <https://www.wtb.wa.gov/wp-content/uploads/2021/12/BHWAC-Preliminary-Report-Final-Draft.pdf>

<sup>35</sup> Office of Financial Management. Hospital Mergers in Washington 1986-2017. <https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief105.pdf>

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comparing quality and costs of care before and after hospital mergers and acquisitions, it does provide information about how many hospital beds, ICUs, and hospital admissions are concentrated to a few health care systems compared with independent hospitals. The concentration of these resources provides insights into the lack of competition that may contribute to reduced access and higher costs.

The report found that the percentage of hospitals in systems grew from 10% in 1986 to almost half in 2017. This trend was not consistent over the entire time of the study and most of the changes happened between 2006 and 2017. With this shift to larger systems, hospital resources became more concentrated as indicated by the following:

- The number of available hospital beds per 100,000 population decreased from 298 to 170
- The percentage of beds in hospital systems increased from 19% to 73% between 1986-2017
- The percentage of patient admissions to system hospitals compared to independent hospitals rose from 20% to 79% from 1986-2017
- The percentage of ICU beds found in system hospitals rose from 19% to 73% between 1986 and 2017

OFM's Hospital Mergers Report also provided data about consolidation at county level across the state. In 1986, hospitals in systems operated in six counties that accounted for 60% of the state population. Each of these six counties also had at least one independent hospital. In total, twenty-nine counties accounting for 39% of the state's population were served only by independent hospitals and four counties had no hospitals. In 2017, systems operated hospitals in seventeen counties. Eight of those counties were served only by system-operated hospitals. Close to 90% of the population lived in a county with at least one system hospital, compared to 60% in 1986.

The increased consolidation and concentration of health care resources may have an unforeseen impact on the community. This will be an important factor to consider when designing a universal health care system to achieve better outcomes and lower costs.

### [Seeking Comprehensive Solutions in Washington: A 35-year Journey](#)

Exploring comprehensive solutions to improve quality, lower costs, and improve access to affordable coverage are not new endeavors in Washington. Over the last thirty years, Washington's wide-ranging efforts aimed to provide a comprehensive solution to these pervasive problems, including the Basic Health Plan, the Washington Healthcare Commission (often called the Gardner Commission), the Washington State Blue Ribbon Commission on Health Care Costs & Access, and the more recent Universal Health Care Work Group. These efforts, in addition to the targeted efforts described earlier, are foundational steppingstones in Washington's current deliberations and decision-making to develop a universal health care system that will provide affordable and quality health care to all Washingtonians.

#### [Basic Health Plan](#)

Washington began extending coverage to qualified low-income adults and children in 1987 using a state-funded effort called the Washington State Basic Health Program (BHP). The initial pilot program was expanded statewide in 1993, eventually enrolling over 100,000 low-income, Medicaid-ineligible working adults with incomes under 200 percent of the federal poverty level (FPL).

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Enrollment into Washington's BHP continued to grow through the mid-90s and in 2003 reached a peak of 130,000 (the program's enrollment cap at the time).<sup>36</sup> Due to state budget pressures, BHP funding was cut by 43 percent in the 2009-2011 state budget, greatly reducing the number of enrollees and stopping new enrollment. Many BHP enrollees transitioned to Medicaid with the state's Section 1115 waiver and eligibility expansion. The ACA's Basic Health Program was modeled on Washington's BHP.

### *Washington Health Care Commission*

In 1990, the Washington State Legislature passed Legislative Resolution 4443, which established the Washington Health Care Commission to recommend plans for ensuring access to health care for Washingtonians.<sup>37</sup> The Washington Health Care Commission's final report, released in 1992, defined universal access as "the right and ability of all Washington residents to receive a comprehensive, uniform, and affordable set of confidential, appropriate, and effective health services" which was called the "uniform set of health services."<sup>38</sup>

The proposed uniform set of health services was to be delivered by competing certified health plans to cover preventive, primary, and acute care. The uniform set of health services also included prescription drugs, dental care, mental health and substance use disorder services. Long-term care services were planned to be phased in. The Commission stressed that services must be timely and not tied to ability to pay or pre-existing health conditions. Consideration of geographic, demographic, and cultural differences would also be taken into account in providing services.

A majority of Commission members wanted a single organization to sponsor coverage for all residents, while others believed employers should be a part of a "pay or play" system that allows the employer to offer coverage or pay into the system. Approved health carriers would compete on price within a maximum allowed premium and under rules set by an independent state commission. Financing would be shared by individuals, employers, and Washington state. Carriers would be encouraged to implement capitation and increase provider risk for managing care. The Commission also recommended seventeen strategies for making the health care liability system less costly, time consuming, and emotionally burdensome for consumers and providers.

Recognizing that implementation would take time, the Commission recommended immediate action to reauthorizing the Basic Health Plan and increasing funding for public health programs. The group recommended that the Legislature should also pursue insurance reforms, including implementing guaranteed issue and renewability, a prohibition or limit on pre-existing condition exclusions, implementation of modified or strict community rating, and the development and implementation of small group market reforms.

### *The Washington Health Services Act of 1993*

Based on the recommendations of the Washington Health Care Commission, in 1993 the Washington Legislature passed a comprehensive health law that included many of the recommended elements. Many of these elements would be included in the ACA fifteen years later:

- Employer and individual mandates
- Guaranteed issue (insurers may not deny coverage due to pre-existing conditions)

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<sup>36</sup> Revised Code of Washington (RCW) 70.47.060 permitted the program to temporarily close enrollment to avoid over-expenditures.

<sup>37</sup> This Commission is often referred to as the Gardner Commission after then-Governor Booth Gardner.

<sup>38</sup> Washington Health Care Commission: Final Report to Governor Booth Gardner and the Washington State Legislature. November 30, 1992.

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- Required coverage of a basic set of benefits
- Expanded Medicaid eligibility

However, the law was not fully implemented because it was repealed by the 1995 Legislature. These repealed provisions included the individual and employer mandates, the use of certified health plans to deliver coverage based on a uniform set of benefits, and caps on insurance premiums.<sup>39</sup> The law retained expansion of the Basic Health Program and Medicaid for children in families with income up to 200 percent FPL. The guaranteed issue and required coverage of a basic set of benefits provisions of the law were also maintained.

### *Washington State Blue Ribbon Commission on Health Care Costs & Access*

In 2006, the Legislature established the Blue Ribbon Commission on Health Care Costs and Access, which was supported by OFM, and charged with delivering a five-year plan for substantially improving access to affordable health care for all Washingtonians. The Commission included then-Governor Christine Gregoire, eight legislators, and leaders from OIC, HCA, Department of Health (DOH), Department of Social and Health Services (DSHS), and Department of Labor and Industries (L&I).

Based on the vision of a system that allows every Washingtonian to get needed health care at an affordable price, the group identified four overarching strategies:

- Build a high-quality, high-performing health care system
- Provide affordable health insurance options for individuals and small businesses
- Ensure the health of the next generation
- Promote prevention and healthy lifestyles

The Commission made sixteen recommendations tied to one or more of the above strategies and included proposed actions. Many of the Commission's recommendations were implemented by the state Legislature in 2007, including:

- Using reimbursement to reward quality outcomes
- Increasing consumers' access to information and shared decision making
- Improving primary care and chronic care
- Facilitating secure sharing of health information
- Tracking emergency room use
- Identifying contributors to health care administrative costs and evaluating ways to reduce them
- Designing insurance coverage options that promote prevention and health promotion.
- Expanding coverage options
- Increasing public health activities<sup>40</sup>

Years ahead of the ACA, the same legislation that created the Commission in 2007 also included the requirement to allow purchasers of individual or group coverage the option to cover their unmarried dependents until they reach age 25. This requirement was also implemented for disability insurance. Additionally, the legislation directed the DSHS to develop coverage expansion options that could utilize

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<sup>39</sup> Certified health plans were defined by the law as organized delivery systems with financial risk for delivering the uniform benefit package.

<sup>40</sup> Engrossed Second Substitute Senate Bill 5930 Chapter 259, Laws of 2007.

<https://lawfilesexternal.wa.gov/biennium/2007-08/Pdf/Bills/Session%20Laws/Senate/5930-S2.SL.pdf#page=1>

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Medicaid, CHIP and/or the Basic Health Program.

### *Investigating Single Payer Models*

In 2018, Washington policymakers allocated resources to investigate the impact of moving to a universal health care system.<sup>41</sup> The first study, conducted by the Washington State Institute for Public Policy (WSIPP), examined various models of universal health care from other countries to gain insights about how these models were constructed and their effectiveness in comparison with the current US system.<sup>42</sup> This study compared the healthcare systems of the US to ten comparable “high-income” countries including Japan, Germany, the United Kingdom, France, Canada, Australia, the Netherlands, Sweden, Switzerland, and Denmark. In general, the health care systems of the comparable countries are considered “universal” models to varying degrees. These models included:

- Single payer systems in which the government is the payer and provider (e.g., the United Kingdom).
- Single payer systems in which the government is the payer, but providers are generally private (e.g., Canada).
- Multi-payer systems that combine the governmental oversight and benefit design with private health insurance (e.g., Germany or Japan).

WSIPP’s analysis found that the US spends more on health care on a per capita basis when compared with countries with universal health coverage models. Specifically, the US spent \$9,400 per person on health care in 2016, whereas the selected universal models spent on average \$5,000 per person on health care in 2016. This difference in spending was attributed to several factors: higher administrative costs, higher prices, higher utilization of more expensive services,<sup>43</sup> and higher prevalence of newer technology or drugs with “modest or uncertain” effectiveness. However, wait times for certain procedures were lower in the US systems and the availability of newer technology was generally higher. Overall, the outcomes of the US systems as compared to the universal systems are mixed. For example, the utilization of preventative care (screenings, immunizations) is higher in the US, but deaths due to diabetes and other manageable chronic diseases or “avoidable mortality” is also higher.

The WSIPP report concluded that countries providing universal health care systems generally were more successful in limiting health care spending and patients’ financial barriers to care while achieving comparable health outcomes to the US. However, the report noted that comparing these systems to the US and judging the feasibility of implementing a universal health care system in the US was difficult due to the large differences in population, lifestyle, and general differences in the nature of the comparison countries to the US, such as governmental policies and taxation systems.

### *The Universal Health Care Work Group*

Following the WSIPP study, in 2019, Washington policymakers secured funding to support the Universal Health Care (UHC) Work Group, which was charged with evaluating the potential impacts of moving to

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<sup>41</sup> Engrossed Substitute Senate Bill 6032, Section 606(15), Chapter 299, Laws of 2018.

<https://app.leg.wa.gov/billssummary?BillNumber=6032&Initiative=false&Year=2017>

<sup>42</sup> Washington State Institute for Public Policy: Single-Payer and Universal Coverage Health Systems Final Report, May 2019. [https://www.wsipp.wa.gov/ReportFile/1705/Wsipp\\_Single-Payer-and-Universal-Coverage-Health-Systems-Final-Report\\_Report.pdf](https://www.wsipp.wa.gov/ReportFile/1705/Wsipp_Single-Payer-and-Universal-Coverage-Health-Systems-Final-Report_Report.pdf)

<sup>43</sup> This is likely due to the general lower threshold of utilization management rules present in private insurance as compared to universal systems.

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universal health care system in Washington.<sup>44</sup> The Work Group produced a comprehensive report of their work and findings that was submitted to the Washington State Legislature in early 2021.<sup>45</sup>

Membership of the UHC Work Group reflected the geographic, socio-economic, ethnic, racial, and gender diversity of Washington’s population. The Work Group consisted of 37 stakeholders representing relevant state agencies, legislative leaders from the two largest political parties from both the State House and Senate, health care provider groups, health care associations and health care consumers. The Work Group initially focused on determining and providing guidance on essential elements in a universal health care coverage model for Washington. These elements helped design straw models that were then analyzed to understand the costs and savings associated with each. The three models proposed and evaluated by the Work Group to achieve universal coverage included:

- **Model A:** State-governed and administered program for all state residents.
- **Model B:** State-governed and health plan administered program for all state residents.
- **Model C:** Access to coverage for undocumented residents unable to buy coverage, which was termed “fill in the gaps coverage.” This model could be expanded to other uninsured or underinsured populations.

The following table provides an overview of some of the key characteristics featured in each model including the populations covered, minimum benefits offered, cost sharing requirements, and provider reimbursement levels. Notably, all three models would continue to have care delivered by private and public providers, clinics, and hospitals.<sup>46</sup>

**Table 1: Overview of the Characteristics of the UHC Work Group’s Three Models**<sup>47</sup>

	<b>Model A</b>	<b>Model B</b>	<b>Model C</b>
<b>Populations</b>	All state residents, including Medicaid, Children’s Health Insurance Program (CHIP), Medicare, privately insured, undocumented, uninsured		Undocumented immigrants
<b>Covered benefits</b>	<ul style="list-style-type: none"><li>• Essential health benefits, plus vision for all participants</li><li>• Dental and long-term care for Medicaid<sup>1</sup></li></ul>		Essential health benefits
<b>Cost sharing</b>	<ul style="list-style-type: none"><li>• No cost sharing</li><li>• Associated utilization changes</li></ul>		Standard cost sharing
<b>Provider reimbursement</b>	<ul style="list-style-type: none"><li>• Reduced pricing variation between populations</li><li>• Administrative efficiency</li><li>• Increased purchasing power</li></ul>		Cascade Care reimbursement levels

Using the key characteristics identified by the Work Group, an actuarial analysis was conducted to compare the impacts of each of the three models to the status quo including the number of individuals covered, the cost to implement the model and the potential savings (if applicable) of each model. The key findings are highlighted in Table 2 and summarized further below.

<sup>44</sup> Engrossed Substitute House Bill 1109, Section 211, Subsection 57; Chapter 415, Laws of 2019. Retrieved from: <https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1109-S.SL.pdf?q=20220321001807>

<sup>45</sup> Universal Health Care Work Group – Report to Legislature, January 2021 <https://www.hca.wa.gov/assets/program/final-universal-health-care-work-group-legislative-report.pdf>

<sup>46</sup> Ibid.

<sup>47</sup> Ibid.

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**Table 2: UHC Work Group Overview of each model’s impacts, including potential savings**

	<b>Model A</b>	<b>Model B</b>	<b>Model C</b>
<b>Population impacts</b>	<ul style="list-style-type: none"> <li>Improved access for the Medicaid population</li> <li>Improved access for uninsured, undocumented</li> </ul>		Assumes commercial utilization
<b>Administration</b>	<ul style="list-style-type: none"> <li>State administers</li> <li>Premiums are exempt from state premium tax</li> <li>Lower system-wide administrative costs</li> </ul>	<ul style="list-style-type: none"> <li>Health plans administer</li> <li>Premium tax applies</li> <li>Lower system-wide administrative costs</li> </ul>	Assumes commercial plan administrative costs
<b>Expenditures and potential savings for covered populations</b>			
<b>Status quo expenditure</b>	\$61.4 billion	\$61.4 billion	Not available
<b>Model cost estimate</b>	\$58.9 billion	\$60.6 billion	\$617 million
<b>Implementation year savings</b>	\$2.4 billion	\$738 million	N/A

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There was a diversity of perspectives about the impacts of each model among the members of the UHC Work Group in achieving the stated goals. Many Work Group members recognized that Models A or B were most likely to achieve the coverage, access, and equity goals of a universal health care system while generating health care savings in the long-term when compared with Model C. Like Models A and B, Model C requires additional state dollars, but does not generate savings to the state, and was not as likely to achieve the goals of a universal system. At the same time, many Work Group members did acknowledge that Model C could potentially provide a pathway to moving to a more universal system envisioned in Model A or B.

Recognizing that moving to a universal system would be a multi-year effort, the Work Group included an outline of a transition plan in the report to the Legislature. This multi-year outline incorporated a plan for a short-term focus on coverage that would fill in the gaps. The state is in the process of implementing Model C as evidenced by the additional policies that have been undertaken since 2020.<sup>48</sup>

### Implementing Model C

#### *Cascade Select*

The public option, Cascade Select, was not yet fully implemented at the time of the UHC Workgroup discussions and was made available to Washingtonians beginning in 2021. Cascade Select offers health insurance coverage options on the individual market through Washington’s Healthplanfinder (operated by the Health Benefit Exchange). Cascade Care is a multi-agency effort involving HBE, Health Care Authority (HCA), and Office of the Insurance Commissioner (OIC). The goals of Cascade Select are to increase the availability of quality, affordable health care coverage in the individual market, and ensure residents in every Washington county have a choice of qualified health plans. As of 2021, only 2.5% of all new enrollees selected this plan and it is not yet offered in all

### SUMMARIZING THE MODELS

**Model A (state-governed and administered program for all state residents)** was projected to cost \$58.9 billion and to save \$2.5 billion in health care spending in the first year of implementation. These estimates are based on actuarial modeling using current utilization and reimbursement trends and assumptions around the development of such a program, such as the elimination of cost sharing and introduction of a single payor. Savings were estimated to come from the reduced administrative costs of a single payer, increased state purchasing power over reimbursement rates, and reductions in extraneous spending such as fraud, waste, and abuse expected from the streamlining of the health system. The model would provide coverage to all Washingtonians.

**Model B (state-governed and health plan administered program for all state residents)** was projected to cost \$60.6 billion and save \$783 million in the first year of implementation. These estimates are based on actuarial modeling. Similar in structure to Model A, the State would remain the single payer and overseer of the system, but coverage is administered by insurance companies that contract with the State. Coverage follows Model A, with some modifications to utilization rules due to lack of cost sharing. The lower savings for Model B when compared with Model A are attributed to the increased costs of outsourcing the burden of plan administration to third-party insurers. The model assumes coverage for all Washingtonians.

**Model C (access to coverage for undocumented residents unable to buy coverage now or “fill in the gaps”)** was projected to increase state costs by about \$617 million based on actuarial modeling. Model C is structurally different from Models A & B, focused on adding and enhancing the current system to improve coverage for undocumented individuals who are currently uninsured through increased subsidies or the creation of additional health plan options with a potential to expand to include additional uninsured populations. The model assumes coverage for an additional 124,000 residents.

<sup>48</sup> Engrossed Substitute Senate Bill 5693. <https://lawfilesextra.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Passed%20Legislature/5693-S.PL.pdf?q=20220405170049>

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counties of the State.<sup>49</sup> However, this program can be used to gauge the effectiveness and feasibility of a larger-scale public program.

### *Cascade Care Savings Plan*

Recognizing that affordability continues to impact uptake of Exchange plans, appropriations were allocated to HBE during the 2021 legislative session to implement a state-funded subsidy plan that will supplement federal health care subsidies for certain income levels in Washington.<sup>50</sup> This program is very similar to the expanded Model C envisioned by the UHC Work Group and can be studied to understand the effects of increasing the amount or eligibility of such subsidies.

### *Creating More Coverage Opportunities for those Not Currently Eligible*

Also during the 2021 session, the Legislature authorized HBE to seek a federal 1332 waiver to allow more Washingtonians to shop and buy coverage on the Exchange.<sup>51</sup> Additional funding was allocated during the 2022 legislative session to develop new coverage options for undocumented individuals who are currently prohibited from being able to shop, buy or enroll in many coverage options.

### Summary

While the UHC Work Group identified a number of barriers to designing a universal a health care system and developed models to implement a universal health care system, it falls to this Commission to make specific decisions and recommendations about how to address these challenges in the coming years. *Section 1's* objectives were to 1) to provide an overview to the Legislature of the current health care system trends that the UHC Commission is considering in its efforts to design a universal health care system with a uniform financing structure required by the authorizing statute; 2) to provide an overview of many of the past efforts that have been made to improve Washington's health care system so that the Commission and the Legislature have a common understanding of the starting place for their efforts; and 3) to recognize and highlight Washington's rich history of innovation in addressing pervasive problems in the health care system that can be drawn upon to best leverage the existing tools and interventions in future design decisions. The next sections of the report will:

- Describe the design components of a universal health care system
- Provide an assessment of Washington's readiness to implement those components
- Recommend a strategy to implement the components of a universal health care system
- Recommend options for increasing reimbursement rates for Medicaid
- Recommend policy solutions to address existing coverage gaps
- Recommend options for the development of a finance committee to develop a feasible model to implement universal health coverage.

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<sup>49</sup> Health Affairs.

<https://www.healthaffairs.org/doi/10.1377/forefront.20210819.347789#:~:text=Enrollment%3A%20In%20the%20first%20year,chose%20a%20Cascade%20Select%20plan.>

<sup>50</sup> <https://lawfilesexternal.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5377-S2.SL.pdf?q=20220224145451>

<sup>51</sup> Ibid.

# Washington Universal Health Care Commission report to the Legislature: Draft of Section 3

## Tab 8

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## Section 3

### Introduction

The Universal Health Care (UHC) Commission is charged with preparing Washington 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 becomes available. This section of the report addresses the Legislature's requirement for the Commission to inventory the key design elements of a universal health care system. The key design elements are organized into seven core design components to form a framework for the implementation and operation of a universal health care system:

1. **Eligibility and Enrollment**—identify how to cover currently uninsured populations; determine which, if any, existing coverage options will remain; and which segments of the existing insured population will be included in the Commission's universal coverage considerations.
2. **Benefits and Services**—create an approach to develop standards that ensure equal access to a minimum set of benefits and services.
3. **Financing**—define an approach to align or aggregate public funding sources, private sector funding sources; and individual cost-sharing, if any.
4. **Provider Reimbursement and Participation**—select a method for paying providers, encouraging their participation, and aligning provider behavior to quality and equity goals.
5. **Cost Containment Mechanisms**—establish global budgeting and utilization management functions to control total cost of care.
6. **Infrastructure**—invest in administrative and operational capabilities necessary to implement a cohesive model.
7. **Governance**—ensure transparency and accountability for planning and implementing the model and that the includes the voice of consumers in decision-making.

These core components align with the framework proposed by the Congressional Budget Office in their 2019 report on single-payer systems.<sup>1</sup> It is important to note that the other the key design elements, including health care quality, equity, and health disparities, identified by the Legislature for the Commission to address in its report are considered strategic goals of the universal health care system. These goals can be achieved through any design, but some design choices have a greater impact than others. As such, quality, equity, and health disparities are discussed within each of the core design components and will be taken into account at every stage by the Commission in making its final recommendations. The Legislature also set specific goals to implement impactful changes in the current health care system and incorporate into the design of a universal health care system including:

- Supporting quality improvement strategies.
- Allowing for quality monitoring and disparities reduction.
- Promoting initiatives for improving culturally appropriate health services within public and private health-related agencies.
- Supporting strategies to reduce health disparities including, but not limited to, mitigating structural racism and other determinants of health as set forth by the Office of Equity.

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<sup>1</sup> Congressional Budget Office. (2019). Key Design Components and Considerations for Establishing a Single-Payer Health Care System. <https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf>

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In *Section 3*, we describe and identify key considerations for developing the seven core health system components based on the different approaches to achieving universal health care coverage outlined by UHC Work Group’s Models A, B, and C. We then describe Washington’s current level of preparedness to meet these core components.<sup>2</sup>

### *The UHC Workgroup Models: A Starting Place*

In January 2021, the UHC Work Group released its final report identifying three potential models for Washington to pursue universal health care coverage, as described in *Section 1*. Throughout this *Section 3*, and in each discussion of a core design component, the three potential models are used as a starting point to frame the considerations for each design component. As shared in *Section 1*, the three models proposed and evaluated by the UHC Work Group to achieve universal coverage included:

- **Model A:** State-governed and administered program for all state residents.
- **Model B:** State-governed and health plan administered program for all state residents.
- **Model C:** Access to coverage for undocumented residents unable to buy coverage, or “fill in the gaps coverage.” This model could be expanded to include other uninsured or underinsured populations.

Table 1: Overview of Universal Health Care Work Group Models<sup>3</sup>

Model A	Model B	Model C
<ul style="list-style-type: none"> <li>• Establishes a single, state-designed coverage plan available to everyone in Washington State.</li> <li>• The state develops the delivery system rules.</li> <li>• There is a standard benefits package.</li> <li>• 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.<sup>4</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Establishes a single, state-designed coverage plan available to everyone in Washington State.</li> <li>• The state develops the delivery system rules.</li> <li>• There is a standards benefits package.</li> <li>• Unlike Model A, in Model B insurance companies contract with the state to offer plans to Washington residents. As they do today, insurers may develop and maintain provider networks and administer some or all of the functions they currently provide, such as claims payment, utilization management, care coordination, and member and provider services.</li> </ul>	<ul style="list-style-type: none"> <li>• Designed to provide coverage to Washingtonians who are now uninsured.</li> <li>• Keeps the varied plans and coverage sources that exist presently. As in Models A and B, the state sets the program and delivery system rules, but carriers meeting participation requirements will provide coverage to eligible individuals.</li> <li>• The model is similar to Cascade Select, with insurers developing and maintaining their own networks and administering the functions they currently provide, such as claims payment, utilization management, care coordination, and member and provider services.</li> </ul>

<sup>2</sup> **Section 4 to be populated in a later draft for the Commission.**

<sup>3</sup> Each of these models, their costs estimates and impacts, and savings (if applicable) are described in *Section 1* of this report.

<sup>4</sup> In some universal health care systems, such as Canada, supplemental insurance could cover services not included in the standard benefit package.

It is important to recognize that under Model B, there are a range of options for which functions could continue to be performed by health plans and which could be performed by the state. For example, Washington could contract with health carriers to provide coverage to residents. Alternatively, Washington could directly contract with providers rather than delegating that responsibility to health carriers, while leaving carriers responsible for more administrative processes such as utilization management and claims payment. In addition, the state could choose to manage more of these responsibilities over time. In this way, Model B could provide a transition to Model A.

### Core Component 1: Eligibility & Enrollment

Under any model to achieve universal coverage, it will be necessary to determine who will be eligible for the program and develop a process for enrollment. A primary goal of adopting a universal health care system is to extend coverage to those who are currently uninsured such as individuals who cannot afford commercial coverage or individuals ineligible for Medicaid or federal subsidies due to their immigration status. Under either universal health care model, state-administered or multi-plan, state-governed models (Model A or B), all Washington residents could potentially be determined eligible for the program. It would be necessary to determine several eligibility considerations, including:

<p><b>Key Considerations – Eligibility &amp; Enrollment</b></p> <ul style="list-style-type: none"><li>➤ Eligibility for certain populations such as the following:<ul style="list-style-type: none"><li>• Washington residents</li><li>• Out-of-state residents working for Washington employers</li><li>• Opt-in options for people covered by Employer-Sponsored Insurance, self-funded plans, Federal Employees Health Benefits, Veterans Health Administration</li></ul></li><li>➤ Data and information needed to determine eligibility</li><li>➤ Eligibility and enrollment processes</li></ul>
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- Would out-of-state residents who work for Washington employers be eligible?
- Would employees who work for national companies and live in Washington be allowed to keep their coverage or be required to enroll in the universal system?
- Would federal employees be covered by federal programs such as Federal Employees Health Benefits and the Veterans Health Administration be eligible to opt into the system?
- Would individuals with fully-insured employer-sponsored coverage be eligible to opt in?
- Would individuals with self-funded employer-sponsored coverage be eligible to opt in?
- Would Medicare beneficiaries be included in the program?
- Would the definition of meeting residency requirements for health insurance coverage differ from the current standard of residency determination for the state?<sup>5</sup>

Under Model C, eligibility could be expanded through new programs to populations who are currently uninsured due to a variety of factors, such as income levels, immigration status, lack of eligibility for subsidies, lack of ability to afford employer sponsored insurance, and other factors that pose barriers to

<sup>5</sup> Washington Department of Revenue. State residency definition. <https://dor.wa.gov/contact/washington-state-residency-definition#:~:text=Persons%20are%20considered%20residents%20of,a%20temporary%20or%20transient%20basis>

coverage under the current system. In this model, minimal changes would occur to the current system of coverage.

*Information for Determining Eligibility*

To maximize coverage and make eligibility determinations as simple and seamless as possible, it will be important to consider options to minimize the amount of information needed to determine eligibility. Under Model A or B, the best approach may be a streamlined process that collects the minimum information necessary to verify eligibility for health coverage while simultaneously collecting the data needed to maintain compliance with federal regulations for the Medicaid, Medicare, Exchange subsidies and other federal programs to ensure ongoing contribution of federal funds. Similarly, setting up processes to validate continued eligibility will reduce costs for maintaining coverage when individuals are no longer eligible for federal programs. Under Model C, the process for determining and redetermining eligibility for the expanded populations would likely be comparable to processes that exist today for determining eligibility for public health care programs and Exchange subsidies.

*Eligibility and Enrollment Process*

Under each of the models (A, B or C), once a person is determined eligible, they would be enrolled into coverage. Under state-administered universal health care (Model A), enrollment could be relatively simple, and auto-enrollment could be used to streamline and maximize enrollments. For example, anyone who currently has coverage under private insurance or a government program could be auto enrolled into the program. Individuals without coverage could be auto enrolled when they seek health care services, file tax returns, or apply for other government programs such as the Supplemental Nutrition Assistance Program (SNAP). In other countries that have adopted single-payer models such as the United Kingdom, individuals are automatically determined eligible at birth, when residency is established, or when a resident registers with a primary care provider.<sup>6</sup>

Under Model B, (the version that involves insurance companies contracting with the state to offer plans to Washington residents), individuals transitioning from private insurance to the state program could be auto enrolled into a comparable plan, with the option to change coverage. This would be similar to current Exchange re-enrollment processes when an individual's plan is cancelled, and the Exchange auto enrolls consumers into the most similar version of a plan available.

Under Model C, individuals could choose a plan by a process similar to what currently exists today through Washington Healthplanfinder. Once an individual is determined eligible for either Apple Health (Medicaid) or subsidies, they are prompted to select a plan from the available options.

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<sup>6</sup> National Health Service. (2022). What is an NHS Number? <https://www.nhs.uk/using-the-nhs/about-the-nhs/what-is-an-nhs-number/>.

## Core Component 2: Covered Benefits & Services

Each of the coverage models (A, B, and C) will involve examining what benefits and services will be covered by the model. The UHC Work Group report assumed that the benefits provided under Models A and B will be equivalent to Washington State's Essential Health Benefits (EHB) mandated by the ACA, which includes behavioral health services. In general, UHC Work Group members discussed the need for a benefit package that improves health and is attractive enough to keep participants enrolled without a mandate to participate in the universal health system. Additional benefits mentioned include dental and hearing, for both adults and children. Model C is the least burdensome approach; the benefits provided would vary depending on the program and plan a person is enrolled in but would be similar to plans offered on the exchange and/or Cascade Care today. For all three models, it is important to consider whether additional benefits may be required to advance quality and equity goals such as social support services and culturally responsive care and services. For example, Apple Health (Medicaid) provides some benefits that are not included in EHB such as Long-term Services and Supports and transportation to non-urgent medical appointments. Some of these services are required by federal Medicaid law, while others are required by state law. These additional services could be provided to all Washingtonians (paid for by the state for those who are not Medicaid-eligible) or there could be a mechanism to make sure that everyone who would otherwise be eligible for Medicaid will receive these additional services.

Washington has a long history of transparent, evidence-based decision processes to inform what benefits/services are covered in state-purchased health care programs. For example, health technology assessments are conducted by the independent Health Technology Clinical Committee and serve Washingtonians by ensuring that certain medical devices, procedures, and tests paid for with state dollars are safe and proven to work.

Administration of the benefit package will also be a critical area of consideration. Establishing who will govern how the benefit package would be regularly updated and adjusted based on new evidence to ensure the required benefits adapt over time to improve the quality and lower the cost of care within the universal health care system. This is particularly important for Models A and B, because once established these benefit packages would need to regularly be examined and updated.

### Pharmacy Benefits

Under Models A and B, there could be a single drug formulary that would apply to all individuals in the program. The drug formulary developed under this program will need to align with any federal Medicaid

### **Key Considerations – Covered Benefits & Services**

- Covered benefits and services
  - Essential Health Benefits
  - Adult Dental to be determined
  - Vision to be determined
  - Benefits mandated by Medicaid
- Cost-sharing for services including premiums, co-pays, and coinsurance
- Development of a single drug formulary or standard drug formularies and how they would impact current programs and the Washington Prescription Drug Program
- Benefit package oversight
- Utilization management and prior authorization requirements

and Medicare requirements. The Washington Prescription Drug Program provides prescription information and assistance for the residents of Washington. As a part of this program, Washington State has partnered with Oregon since 2006 to create the Northwest Prescription Drug Consortium which allows state agencies, local governments, businesses, labor organizations, and uninsured individuals to pool their purchasing power to gain bigger discounts on prescription drugs. This and the work of the Prescription Drug Cost Transparency Board will both need to be included in the consideration of single drug formulary.

Currently, individuals who are enrolled in Apple Health managed care or in commercial coverage are subject to the utilization management and prior authorization policies and procedures of their carrier. Under Models B and C, this is not likely to change. Model A will require examining utilization management and prior authorization processes and determining how the state-administered plan would conduct these activities.<sup>7</sup>

### Core Component 3: Financing

Under Washington’s current health care system, there are multiple sources of funding that pay for health care. The funding sources that pay for an individual’s health care will govern the specific benefits individuals receive, the providers they can see, and how much they must pay out of pocket. One of the primary goals of the Universal Health Care Commission is to develop a plan for a unified financing system that will simplify these differences and lead to greater access, higher quality, and increased equity for all Washington residents.

To achieve this goal, the different sources of funding must be combined to the greatest extent possible. This begins with assessing which sources will be continued or potentially eliminated due to the structure of the unified health care financing system and identifying potential new sources of funding to ensure coverage can be extended to all Washington residents. This financing subsection outlines the complex issues and decisions related to different financing sources to consider in designing a universal health care system. *Section 7* of this report details specific considerations and processes for the Commission to establish a finance committee specifically tasked with addressing these financing questions and considerations.<sup>8</sup>

<p><b>Key Considerations – Financing</b></p> <ul style="list-style-type: none"><li>➤ Role of federal funding sources such as Medicaid, ACA subsidies, and Medicare</li><li>➤ Role of state funds such as general funds and taxes</li><li>➤ Role and appropriateness of consumer cost-sharing</li></ul>
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### Federal Funding Sources

The federal government is responsible for the greatest share of health care spending, at 36.3% in 2020.<sup>9</sup> This estimate includes all federal sources including Medicaid, Medicare, coverage for federal employees, active and retired military. As described in the UHC Work Group Report, the three models assume that all sources of federal funding, such as the federal funding of the Medicaid program and Medicare funding would be preserved to pay for health care costs and administration.

<sup>7</sup> **Section 4 to be populated in a later draft for the Commission.**

<sup>8</sup> **Section 7 to be developed in a later draft for the Commission.**

<sup>9</sup> Centers for Medicare and Medicaid. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet> Note: This figure does not take into account the federal income tax deductions for employer and individual’s health care spending.

Model C presents the least challenges with respect to retaining federal funding, since the existing federal programs including Medicare, Medicaid, ACA subsidies, tax deduction for employers' contribution to health care, either insured or self-funded remain the same. However, making changes to the current financing system are considerably more complex for Models A and B. Notably, each of the models will require additional state funds to implement. Possible sources to fund these models are described in the following subsections including Medicare funding, Medicaid funding, ACA subsidies, employers, taxes, other sources of insurance, and other revenue sources.

#### *Medicare Funding*

There are a number of legal challenges that need to be analyzed and considered to include Medicare funding under either Model A or Model B. The decision to pursue or not pursue inclusion of Medicare into the unified health care financing system development is complex and requires a thorough examination of the regulatory and legal issues and understanding of the Medicare program. The Medicare program consists of several primary components:<sup>10</sup>

- **Medicare Part A** is financed primarily by a payroll tax that employers and employees pay into the Medicare Hospital Insurance Trust Fund. Part A covers inpatient hospital stays, skilled nursing facility stays, some home health visits, and hospice care.
- **Medicare Part B** is financed primarily through a combination of general revenues and beneficiary premiums, deductibles and copays. Part B covers physician visits, outpatient services, preventive services, and some home health visits.
- **Medicare Part C** (Medicare Advantage) is Medicare's managed care program delivered through contracted health plans.<sup>11</sup> Medicare Advantage plans are financed by monthly payments from the federal government based on bids submitted by the plans and monthly premiums.
- **Medicare Part D** is financed primarily by general revenues, beneficiary premiums and state payments for beneficiaries dually eligible for Medicare and Medicaid. Part D covers outpatient prescription drugs.

A key to maintaining a large portion of federal funding is determining if and how Medicare dollars can be used. An important threshold topic for consideration under either Model A or Model B is whether Medicare funding can be used to pay for health care costs for people not eligible for the Medicare program. While this may be considered in more detail in the future, it may be likely that Congress will need to pass legislation for these changes to be possible.

The Medicare Part A Trust Fund is projected to be fully depleted in 2026, which raises the question of whether it would be practically and politically viable to provide for the use of this fund to pay for non-Medicare beneficiaries. One other significant consideration under Model A or Model B is whether beneficiaries would continue to have the option to choose "traditional" Medicare, which is administered by the federal government, or to enroll in a Medicare Advantage plan under Medicare Part C. Some states, such as Oregon, have discussed that a single payer entity could function like a single Medicare

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<sup>10</sup> For more information on Medicare programs, see Kaiser Family Foundation. (2019). *An overview of Medicare*. <https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/?msclkid=c46e7ab3b3bd11ecb53ed918624357e3>

<sup>11</sup> For more information on Medicare Advantage, see Kaiser Family Foundation. (2019). *Medicare Advantage*. <https://www.kff.org/medicare/fact-sheet/medicare-advantage/>

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Advantage plan that would be offered only to Medicare eligible individuals.<sup>12</sup> This would likely keep the Medicare funding sequestered out of other pooled funding which may make it easier to use Medicare funding, because the funding would not be used to fund non-Medicare eligible people.

Medicare Part D, the prescription drug benefit administered by private plans, is another potential source of funding for consideration. This program is financed primarily by general revenues, beneficiary premiums and copays, and state payments for beneficiaries dually eligible for Medicare and Medicaid. To utilize funds from this program, Medicare's integrated funding would need to be examined in great detail, especially if the new unified financing system offers a single drug formulary.

The UHC Work Group report assumes that under Model A or Model B there would be a single provider fee schedule for all care and that the rates would be higher than currently paid by Medicaid and Medicare, but rates would be lower than what is currently paid by commercial insurers. There are significant legal and regulatory issues around whether the federal government would be willing and able to contribute to the additional costs that would be incurred for care provided to those currently in the Medicaid and Medicare programs, including the higher reimbursement rate.

The UHC Work Group report acknowledged the challenges in including Medicare funding and suggested that it might be possible to keep Medicare enrollees in their current coverage under Models A and B. The goals of universal coverage could still be met if the Commission followed this approach for two reasons. First, most providers currently accept Medicare patients and are accustomed to billing under the program. Second, the costs of administering the program are borne entirely by the federal government, so the state may not realize any savings by including it. Finally, as discussed in the UHC Work Group Report, it may be a more financially viable approach to implement because health care needs generally increase with age, resulting in higher per capita costs. Keeping Medicare enrollees in their current coverage rather than including them in the universal health care program would mean that the universal health care program would cost less on a per capita basis.

Utilizing an approach with Medicare distinct from the unified financing system would greatly simplify the legal and administrative obstacles to achieve universal coverage under Models A or B. In addition, as the UHC Work Group report notes, if Medicare reimbursement rates are left as they are, the rates payable by the rest of the program could be higher as a percentage of Medicare rates because of the per capita savings of not including this population. See Table 2 below (from the UHC Work Group analysis) for more information about the financial impacts as seen through provider reimbursement rates of including or excluding Medicare in rate development.

**Table 2: reimbursement level target before efficiency adjustments<sup>13</sup>**

Service category	Reimbursement as a % of Medicare when Medicare is included in Model A	Reimbursement as a % of Medicare when Medicare is excluded in Model A
Hospital services	125%	150%
Physician and clinical services	111%	114%

<sup>12</sup> Rand Corporation. A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon. [https://www.rand.org/pubs/research\\_reports/RR1662.html](https://www.rand.org/pubs/research_reports/RR1662.html)

<sup>13</sup> Universal Health Care Work Group Report, January 2021

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### *Medicaid Funding*

Washington's Medicaid program, Apple Health, which currently serves nearly two million Washington residents, is funded by the state general fund and federal matching funds. Eligibility for Apple Health is primarily based on income and most beneficiaries have managed care, where the state pays managed care organizations a monthly premium which pays for all health services provided by the program. Both federal and state law mandate what services must be provided under the program.<sup>14</sup>

Including Medicaid funding as a revenue source for a unified financing system is complex, but less complicated than Medicare because there is an established process and experience with states seeking and obtaining Medicaid flexibilities, which is not the case with the Medicare program. To use existing federal Medicaid funds as a revenue source for the unified financing system, it would be necessary to obtain a waiver from the Centers for Medicare and Medicaid Services (CMS) under Section 1115 of the Social Security Act. Section 1115 gives the Secretary of the Department of Health and Human Services authority to approve experimental, pilot, or demonstration projects by states that are found to be likely to assist in promoting the objectives of the Medicaid program. This authority has been used frequently by states, including Washington. Washington's current 1115 waiver, the Medicaid Transformation Project, is in effect until December 31, 2022, unless CMS authorizes further renewals or extensions.

The two primary ways that a unified health care financing system would promote the objectives of the Medicaid program, which could be included in support of a potential waiver application are: 1) this change is likely to increase the number of individuals with continuous access to health care, and 2) this is likely to increase the number of providers willing to serve Medicaid enrollees. If the process for enrollment and determining eligibility is simplified, then more Medicaid-eligible individuals should be covered. In addition, some individuals inevitably fail to obtain new coverage as individuals gain and lose eligibility for Apple Health due to changes in income or employment status more. A unified health care financing system could eliminate or greatly reduce this on/off program cycle, which would result in more people having continuous health care coverage.

Secondly, the UHC Work Group Report assumed that under Model A or Model B there would be a single fee schedule for provider reimbursement with rates higher than what Medicaid currently pays. This should result in more providers being willing to serve people who would otherwise be eligible for Medicaid, which in turn is likely to reduce the disparities and inequities in access to care.

### *ACA Subsidies*

Under the ACA, the federal government provides subsidies in the form of tax credits to help individuals and families pay premiums for health care coverage provided by health plans. Eligibility is determined by income. As with federal Medicaid funding, Washington would need an ACA Section 1332 waiver from CMS to enable the unified health care financing system to include people who otherwise would receive subsidies under the ACA in the new program. This would also shift ACA tax credit funding that is currently provided to individuals and families to the unified health care financing system.

The ACA contains certain "guardrails" that must be satisfied for a Section 1332 waiver to be granted. The changes requested by a state must result in health care coverage that is as comprehensive,

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<sup>14</sup> For more information on Medicaid funding, see Snyder, L., Rudowitz, R., (2015). *Medicaid Financing: How Does It Work and What Are the Implications?* Kaiser Family Foundation issue brief. <https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/>

affordable, and covers as many individuals as under the current system. In addition, the changes must not increase the federal contributions. It is possible to demonstrate that these guardrails would be met under either Model A or Model B. Additionally, coverage would include all of the Essential Health Benefits mandated by the ACA, and therefore would be as comprehensive. Coverage could be more affordable, although the state would have to demonstrate that any additional taxes on individuals and families would be lower than what they currently pay for health care. As discussed above, more people would be covered by the new program, primarily because people would not lose coverage as they move from one source of coverage to another. In addition, Section 1332 of the ACA authorizes waiver of certain provisions and provides that requests for waivers under Sections 1115 and 1332 may be combined in a single application. Both 1115 and 1332 waivers must be “budget neutral” to the federal government, which means that during the course of the waiver period, federal expenditures must not be more than it would have been without the waiver.

#### *Other Revenue Sources*

To address any gaps in funding because of the transition to a unified financing system, additional funding could be raised through a combination of taxes on businesses and individuals. However, it is important to acknowledge that any discussion about additional taxes and how that tax is collected should take into account the equity impact of the proposed tax on different populations. Under Model C, most sources of funding would remain the same.

#### *Other Revenue Sources: Business Taxes*

There are two types of business taxes that are generally considered as potential sources of revenue for funding a universal health care system. The first, is a tax on business activity, such as Washington’s Business and Occupations tax, which is a gross receipts tax measured on the value of products, gross proceeds of sale, or gross income of the business. The second is a tax on payroll (either based on the number of employees or the amount of wages paid), such as the federal taxes that currently fund the Medicare program and the state taxes that currently fund state unemployment, the workers’ compensation system, and the recently enacted tax that will fund long-term care.

It is important to note that under current law, employer contributions to employees’ health care premiums are deductible from federal income tax. This represents a significant subsidy from the federal government toward the cost of health care. To maintain the benefit of the current tax deduction for employer health care expenditures, the best approach would be to ensure that either type of tax imposed could be deducted from federal taxes.

#### *Individual Taxes*

There are two types of taxes that could be considered as sources of revenue for this type of program. The first is a payroll tax. The second is a sales tax (including taxes on certain types of products that are deemed harmful to individuals or society, such as cigarettes and alcohol).<sup>15</sup>

Sales taxes could be a source of revenue for the program. However, sales tax is complex and if not applied to prevent regressive taxation, it could have a burdensome impact on low-income populations. Sales taxes could be regressive if the taxes take a larger percentage of income from low-income

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<sup>15</sup> Because Washington state does not have an income tax on individuals, this method of taxation has not been considered. However, an income tax is typically easier to administer.

taxpayers than from high-income taxpayers. One way to avoid the disparate impact of these taxes is to exempt necessities such as food from the sales tax, as Washington currently does.

A payroll tax, which currently funds the Medicare program, may be more feasible to implement because it involves less administration. A payroll tax could be imposed only on wages over a certain level which would reduce the possibility of a disparate impact. This would also ensure that those who currently receive subsidies or Medicare do not experience an increase in their cost of health care services. It would also be necessary to consider the impacts of a progressive tax which would fall more heavily on those earning higher incomes.

#### *Employee Retirement Security Act (ERISA)*

The federal Employee Retirement Security Act (ERISA) sets minimum standards for health plans established and funded by employers to provide health care to their employees. These “self-funded” or “self-insured” plans place the obligation of paying for health care costs directly on the employer and the employer bears the financial risks associated with that obligation rather than an insurance company. The ERISA statute exempts these plans from most state regulation.<sup>16</sup>

If the federal government makes changes to ERISA that would enable states to wrap employer coverage into a state-based unified health care financing system, it will be necessary to consider whether employers would be able to continue to provide coverage to their employees through self-insurance. It is possible that if a tax is imposed on employers to pay for the program, employers would be discouraged from remaining self-insured. An alternative approach would be to allow employers to continue to be self-insured, while giving employees the option of enrolling in the state coverage rather than in the employer-sponsored coverage.

#### *Other Sources of Insurance*

It may be beneficial to examine whether health services that are currently paid for by other sources of insurance, such as liability insurance and by the workers’ compensation system, would continue to be covered by those programs. In the alternative, the amounts paid into those systems could instead be paid into the unified health care financing system.<sup>17</sup>

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<sup>16</sup> For more information on ERISA, see National Association of Insurance Commissioners. (2019). Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation. <https://content.naic.org/sites/default/files/publication-ers-om-health-welfare-erisa.pdf?msclkid=93e40b08b3c111eca359435da84df82c>

<sup>17</sup> **Section 4 to be populated in a later draft for the Commission.**

#### Core Component 4: Provider Reimbursement and Participation

One of the more challenging elements in designing a universal health care system is developing an approach to provider reimbursement that will ensure providers want to participate in delivering care and services to Washingtonians through this system. This will involve considering how reimbursement rates will be set and how to encourage alternative payment models that may provide incentives for higher quality care and lower costs. Rate setting processes could be applied broadly in a unified financing system or more narrowly for specific programs and providers. Rate setting affords the state the opportunity to ensure that providers are adequately reimbursed to encourage provider participation in the universal health care system, control costs within the system; drive improvements in the quality of care delivered within the system; and ensure equitable access to providers and services.

This range of rate-setting approaches can be considered depending on the overall universal health care model. For example, for countries like the United Kingdom and, for certain components of Canada's health system, directly employ or contract with providers. Other countries, such as France, Germany, Switzerland, Netherlands, and Japan, have established centralized rate-setting for provider reimbursement.<sup>18</sup> This approach is intended to control total health care costs across sectors of the health care system that may be financed by private payers or different government programs.

It is possible that a more phased-in approach that preserves existing frameworks for rate setting or provider contracting could be appropriate for advancing goals of universal health care. The approach may be easier to initiate and could enable adoption of a universal care model sooner than a non-phased in approach.

Both Models A and B provide for a single fee schedule that would establish rates for all health care services. One method for accomplishing this would be to set rates at a percentage above the Medicare fee schedule. The UHC Work Group report discussed a single fee schedule which would establish rates that are lower than current commercial rates, but higher than what Medicaid and Medicare pay. The report notes that approval from CMS would be needed for these federal programs to pay different rates than what they pay currently.<sup>19</sup>

Under Models A and B, rates would be set by Washington through an administrative process similar to Apple Health's fee-for-service provider payments today. Under Models A and B, it may be possible to set rates for individual health care services, rather than setting rates at a percentage above Medicare for all

#### **Key Considerations – Provider Reimbursement and Participation**

- Provider reimbursement methods
  - Centralized rate-setting and single fee schedule
  - Negotiated rates
  - Value-based payment
- Provider participation requirements and incentives

<sup>18</sup> Commonwealth Fund. (2017). *International Profiles of Health Care Systems*.

<https://www.commonwealthfund.org/publications/fund-reports/2017/may/international-profiles-health-care-systems>

<sup>19</sup> This could have implications for meeting budget neutrality under Sections 1115 and 1332 of the Social Security Act. Assuming that these provisions could not be changed, and no additional federal funds could be obtained in order to pay the higher rates provided for by Washington's single fee schedule, the state may have to provide additional revenue in order to pay the higher rates.

services. Model C would not necessarily require changes to the current system of rates and provider reimbursements. In this model, providers would continue to have the choice whether to participate in each of these systems.

However, the state of Maryland provides an example of how centralized rate-setting could be applied under a multi-payer system. Maryland, through its Health Services Cost Review Commission, sets rates for all hospitals in the state across all payers, allowing the state to slow the growth of hospital costs across the state.<sup>20</sup>

There are additional considerations when evaluating provider reimbursements such as whether reimbursement will be provided directly from the state or through carriers. Cost reduction and transparency measures are additional considerations, such as the newly established Health Care Cost Transparency Board, and how these measures will assist in the future approach to provider reimbursement.

#### *Value-based Reimbursement*

Universal health care delivered through a single payer model or incremental model can create opportunities to shift away from fee-for-service to more value-based methodologies of reimbursement. Under these arrangements, providers can receive additional payments or accept down-side risk to provide care and services to certain standards. It may be helpful to establish a process to identify and prioritize target metrics for which providers will be accountable and establish a methodology for collecting data and assessing whether providers have met the target thresholds.

Through value-based reimbursement, Washington can incentivize a range of provider behaviors. For example, this may include reducing disparities for vulnerable populations or improving the treatment for individuals with high priority conditions such as diabetes and substance use disorders. This may also manage costs by reducing preventable utilization of health care services. Model A could utilize alternative payment models, similar to what the Centers for Medicare and Medicaid Innovation currently employs. Washington already applies value-based reimbursement strategies through multiple initiatives and programs. For example, currently offering a Cascade Public Option plan must confirm that at least 30 percent of provider contracts include value-based payment arrangements.<sup>21</sup> The HCA's Value Based Purchasing Roadmap for 2022-2025 sets forth priorities and goals for value-based purchasing to contain health care costs while improving health care outcomes. This can serve as a helpful framework for the consideration of value-based reimbursement.<sup>22</sup>

#### *Encouraging Provider Participation*

One consequence of a fragmented health care financing system is that provider reimbursement rates can vary widely depending on the payer. This can be particularly challenging for Medicaid programs which tend to offer lower provider rates than the commercial insurance market or Medicare.<sup>23</sup> This

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<sup>20</sup> Maryland Health Services Cost Review Commission. (2022). Hospital Rate Setting.

<https://hscrc.maryland.gov/Pages/rates.aspx>

<sup>21</sup> Public Option Institute. (2020). <https://www.publicoptioninstitute.org/feed-wa-implementation-materials/summary-of-washington-state-gov-inslees-letter-on-implementation-of-cascade-care>

<sup>22</sup> VBP Roadmap. ( <https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf>

<sup>23</sup> Holgash, K., Heberlein, M. (2019). Health Affairs Forefront article.

<https://www.healthaffairs.org/doi/10.1377/forefront.20190401.678690/full/>

differential in reimbursement rates can lead to limited provider participation in Medicaid and consequently can impact access for Medicaid enrollees.

Reducing the differentials in provider reimbursement is likely to encourage providers to participate in delivering care to all populations and may reduce health care inequities. Under Models A, B and C, there are opportunities to reduce differences in provider reimbursement. Under Models A and B, if rates were set under a single fee schedule across a broader population base, more providers may be incentivized to participate. Some single-payer health systems, such as Indonesia,<sup>24</sup> also actively reimburse at higher rates for providers in underserved communities and regions.

Under Model C, adjusting reimbursement rates may require a centralized rate-setting structure to ensure more even rates across existing payers and programs. Providers could be required to participate in Medicaid or other programs as a condition of participation in other markets or programs. Additionally, under Model C, the state could remove potential barriers to participation by aligning value-based payment, quality initiatives, and administrative processes across payers.

Additional strategies could be considered to encourage provider participation. For example, the universal health care program could require providers to accept patients under the program and potentially cap rates or services provided outside of the program.<sup>25</sup>

### Core Component 5: Cost Containment Elements

One of the critical goals in establishing a universal health care system is to hold the total cost of health care below the growth benchmark established under the work of the Health Care Cost Transparency Board. Many of the design elements described in the provider reimbursement and benefits subsections constitute critical strategies for containing costs. For example, maintaining a benefit package that standardizes high-value benefits and services across all participants, setting provider rates for individual services, and encouraging value-based payment arrangements can all work toward lowering costs of care while improving the quality of care delivered. However additional design elements could assist with containing total costs. These cost containment measures include examining fraud, waste and abuse, utilization management, setting cost growth benchmarks, and global budgeting.

#### *Fraud, Waste, and Abuse*

One path to reducing cost throughout the health care system is to drive down utilization due to fraud, waste, and abuse. Nationally, the cost of fraud, waste, and abuse may constitute as much as 10% of total health care costs.<sup>26</sup> Drivers of fraud, waste, and abuse include duplicated procedures or failures to coordinate care, overtreatment, overpayment, and fraudulent acts by providers or patients.<sup>27</sup>

There are system-wide approaches for addressing fraud, waste, and abuse. As the UHC Work Group noted, a single data set for claims or episodes could exist under Models A and B (paired with advanced

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<sup>24</sup> World Health Organization. (2003). The World Health Report 2003: Shaping the Future. [https://www.who.int/whr/2003/en/whr03\\_en.pdf?msclkid=cd46b569b42011ec98bd5ef5e0ad5a91](https://www.who.int/whr/2003/en/whr03_en.pdf?msclkid=cd46b569b42011ec98bd5ef5e0ad5a91).

<sup>25</sup> **Section 4 to be populated in a later draft for the Commission.**

<sup>26</sup> U.S. Department of Veterans Affairs. (2022). About Fraud, Waste, and Abuse. [https://www.va.gov/COMMUNITYCARE/about\\_us/POI/poi\\_fwa.asp#:~:text=Impact%20of%20Fraud%2C%20Waste%2C%20and%20Abuse%20The%20National,high%20as%2010%25%20per%20year%20or%20%24300%20billion.?msclkid=749dea44b4cc11ec9f5b87f0640262ec](https://www.va.gov/COMMUNITYCARE/about_us/POI/poi_fwa.asp#:~:text=Impact%20of%20Fraud%2C%20Waste%2C%20and%20Abuse%20The%20National,high%20as%2010%25%20per%20year%20or%20%24300%20billion.?msclkid=749dea44b4cc11ec9f5b87f0640262ec).

<sup>27</sup> Lallemand, N. (2012). Reducing Waste in Healthcare. Health Affairs Health Policy Brief.

analytic methods used today by the federal government, state Medicaid programs, and commercial payers). The data set creates opportunities to detect indicators of fraud, waste, and abuse and intervene to prevent future utilization from occurring or recoup costs for improper utilization.

#### *Utilization Management*

Utilization management is a core function for most commercial insurance plans, Medicaid managed care organizations, and Medicare Advantage plans. Utilization management is used to reduce inappropriate or unnecessary utilization of health care services. Utilization management typically involves the monitoring of utilization, the identification of high utilization individuals, and intervention to reduce high utilization in the form of care coordination, consumer education, or other methods. Utilization management may also include prior authorization requirements for certain types of services. Some single-payer systems, such as England, Canada, and Taiwan have developed utilization management programs to reduce the cost of care while maintaining quality goals.<sup>28</sup>

Under any of the universal health care models, it will be helpful to consider whether utilization management is an appropriate design element to assist with achieving the state's goals for cost containment. A particularly important consideration will be how certain utilization management controls, such as prior authorization can be utilized to reduce high utilization. Under Model B or C, utilization management could be delegated to participating carriers with requirements for administering utilization management.

#### *Setting Cost-Growth Benchmarks*

In 2020, Washington created the Health Care Cost Transparency Board to identify health care cost trends, set a cost-growth benchmark, and develop recommendations to reduce health care costs. As of September 2021, the Board has approved a cost growth benchmark of 3.2% for 2022-23, 3.0% for 2024-25, and 2.8% by 2026.<sup>29</sup> Washington's benchmark aligns with other states' cost-growth benchmarks, such as in Oregon, Connecticut, Delaware, Massachusetts, and Rhode Island.<sup>30</sup> The HCCTB is also responsible for identifying providers and payers whose cost growth exceeds the benchmark. The universal health care system should hold the total cost of health care below the growth benchmark established by the HCTTB and is a starting place for additional cost-containment efforts in the future.

#### *Global Budgeting*

Some single-payer health care systems have adopted global budgeting as a way to incorporate caps on the system-wide growth of health care costs. For example, England sets a global annual health care budget that is then allocated to local organizations that pay for care within their jurisdiction.<sup>31</sup> Taiwan negotiates an annual global budget with key stakeholders for major health care services and allocates the budget across six regions.<sup>32</sup> Under Model A or B, a similar global budget could be established and then adjusted annually to account for growth in need for health care services and for system

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<sup>28</sup> Commonwealth Fund. (2017). *International Profiles of Health Care Systems*.

<sup>29</sup> Washington State Health Care Authority. Health Care Cost Transparency Board. September 14, 2021, Meeting Minutes. <https://www.hca.wa.gov/assets/program/board-meeting-summary-20210914.pdf>

<sup>30</sup> Block, R. & Lane, K. (2021). *Supporting States to Improve Cost Growth Targets to Improve Affordability*. Health Affairs. <https://www.healthaffairs.org/doi/10.1377/forefront.20210526.658347/full/>

<sup>31</sup> Ibid

<sup>32</sup> Ibid

performance (e.g. if provider rates are insufficient to encourage participation or benefits are too narrow to encourage individuals from participating).

Global budgeting can also be applied to individual providers as a strategy for provider reimbursement. For example, Maryland, as part of its hospital rate-setting program, establishes a global budget for each hospital that caps the payment it can receive from all payers. The global budget is based on the projected needs of the population served by each hospital.<sup>33</sup> However, in establishing a global budgeting model, a critical consideration is whether providers are prepared to bear the financial risk if their costs exceed the global budget.<sup>34</sup>

### Core Component 6: Infrastructure

As the Commission moves from planning into implementation, the governing agencies and partnering stakeholders will need to address a broad range of operational considerations. This includes assessing what structures and processes will remain, and what systems need to be upgraded or modified. These considerations are highly dependent on the overall strategy pursued and the readiness to implement the strategy.

A key driver of implementation complexity will be the technology infrastructure necessary for executing the universal health care strategy. For example, each model will require technology investments for consumer-facing functions such as eligibility and enrollment; consumer assistance; and consumer outreach. To support administrative functions, investments could be needed to issue payments to providers or health plans; manage health care utilization; and monitor fraud, waste, and abuse.

Related to the technology infrastructure are considerations regarding data sharing and data management. The infrastructure necessary to share data across all participants in the universal health care system is critical for ensuring that the program objectives for health care quality, financial performance, population health, and health equity are met on multiple levels for individual consumers, provider and payer organizations. In addition to the technology needed to support higher degrees of data sharing, infrastructure will be needed to establish data standards and common metrics, to analyze the data, and to report on outcomes.

#### **Key Considerations – Infrastructure**

- Examining what infrastructure can be re-used, delegated, or needs to be developed
  - Technology platforms
  - Human Resources to support existing and added functions
  - Administrative policies and processes
- Accountability for infrastructure investments
  - State investments needed
  - Model participant investments
  - Shared infrastructure investments

Human resources are another core consideration for the development of the model. Staffing needs will need to be assessed and managed, particularly for new state functions, such as rate setting or financial analysis. In addition to these core considerations, many operational decisions will impact the infrastructure needed during the implementation phase.

<sup>33</sup> Mathematica. (2021). Independent Evaluation of the Maryland Total Cost of Care Model.

<https://innovation.cms.gov/data-and-reports/2021/md-tcoc-imp-eval-report?msclkid=1a334a44b38f11eca5626a4a717ba358>

<sup>34</sup> **Section 4 to be populated in a later draft for the Commission.**

Decisions regarding grievances and appeals, managing the administrative budget, procuring vendors, and contracting with participating providers will determine the infrastructure and systems that may need to be developed or utilize existing agencies.<sup>35</sup>

### Core Component 7: Governance

A strong governance model is critical for ensuring transparency and accountability. This ensures a voice is given to consumers, whose perspective is essential to decision-making. In ensuring transparency and accountability, there will need to be clear roles and responsibilities for all participants in the process. Moreover, ensuring a governance model that is inclusive of diverse voices representing the populations most impacted by the new system will be a critical component in ensuring the goal of health equity are realized.

One of the primary governance considerations in developing a universal health care system is determining which agency or agencies should administer the program. A single agency or a governance structure that consolidates functions and accountability across existing agencies could be created.

With one agency providing oversight, many administrative functions could be streamlined. In addition, a single agency could facilitate and execute more coordinated strategies to meet the health care goals of the state. A consolidated structure, however, brings together existing resources but requires a strong governance model and robust communication and process mechanisms. Many countries that have adopted a single-payer model place principal accountability for operating the system under a single agency. For example, in the United Kingdom, the National Health Service oversees the health systems of each country.<sup>36</sup> Additionally, the state of Vermont, when it created its Green Mountain Care Board, consolidated a wide range of new and existing responsibilities pertaining to the management of health care costs.<sup>37</sup> While there is a wide range of benefits with single agency oversight, there is likely to be initial disruption to current functions and significant costs associated with the implementation.

Each of the universal health care models under consideration will necessitate different governance structures. For example, Model B would likely require less new administrative and regulatory responsibilities relative to Model A because some of those functions would be contracted to a carrier or carriers to perform. Under Model C, there would be no change to the existing structure.<sup>38</sup>

#### **Key Considerations – Governance**

- Accountability for administering and regulating programs
  - Single new state agency
  - Existing state agency or agencies
  - Combination of new and/or existing state agencies
- Accountability for transparent reporting

<sup>35</sup> **Section 4 to be populated in a later draft for the Commission.**

<sup>36</sup> Berry, N. (2015). *How does the NHS compare with health systems in other countries?* The Health Foundation. <https://www.health.org.uk/sites/default/files/HowDoesTheNHSCompareWithHealthSystemsInOtherCountries.pdf?msclkid=4a54e776b29c11ec88e9119cc2af8b32.pdf>

<sup>37</sup> Green Mountain Care Board. (2022). <https://gmcboard.vermont.gov/board>

<sup>38</sup> **Section 4 to be populated in a later draft for the Commission.**

## Summary

The objective of *Section 3* of this report is to describe the major areas of design components that are critical to developing, implementing, and maintaining a universal health care system and identify key considerations within each area:

1. Eligibility and Enrollment
2. Benefits and Services
3. Financing
4. Provider Reimbursement and Participation
5. Cost Containment Mechanisms
6. Infrastructure
7. Governance

These core design components provide an operational framework to assess Washington's readiness and inform a strategy for implementing a universal health care system with unified financing and its ability to advance the goals for a universal health care system including containing health care costs, improving the quality of care, promoting health equity, and reducing health disparities.

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