Washington State Health Care Authority

Universal Health Care Commission

June 13, 2023

Washington State Health Care Authority

Universal Health Care Commission
Meeting Materials

June 13, 2023
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting materials

Tab 1

Washington State Health Care Authority

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Universal Health Care Commission
AGENDA

June 13, 2023
2:00 p.m. – 4:00 p.m.
Zoom Meeting

Commission Members:					
☐	Vicki Lowe, Chair	☐	Estell Williams	☐	Representative Marcus Riccelli
☐	Senator Ann Rivers	☐	Jane Beyer	☐	Mohamed Shidane
☐	Bidisha Mandal	☐	Joan Altman	☐	Nicole Gomez
☐	Dave Iseminger	☐	Representative Joe Schmick	☐	Stella Vasquez
☐	Senator Emily Randall	☐	Kristin Peterson	☐	

Time	Agenda Items	Tab	Lead
2:00-2:03 (3 min)	Welcome and call to order	1	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
2:03-2:07 (4 min)	Roll call	1	Mandy Weeks-Green, Manager Health Care Authority
2:07-2:10 (3 min)	Approval of Meeting Summary from 04/11/2023	2	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
2:10-2:25 (15 min)	Public comment	3	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
2:25-2:40 (15 min)	FTAC updates • Medicare recommendations • Commission vote to adopt Medicare recommendations	4	Pam MacEwan, FTAC Liaison
2:40-2:50 (10 min)	Guidance from the Commission to FTAC on ERISA	5	Liz Arjun, Senior Consultant Health Management Associates
2:50-3:15 (25 min)	Potential health equity framework • Vote to adopt equity framework	6	Quyen Huynh, Health Equity Director Health Care Authority
3:15-3:25 (10 min)	Revised workplan • Incorporation of Washington Health Trust bill	7	Liz Arjun, Senior Consultant Health Management Associates
3:25-3:45 (20 min)	State agency report out on 2023 legislative session	8	State agencies Dept. of Health, Health Benefit Exchange, Health Care Authority, Office of Equity, Office of the Insurance Commissioner
3:45-4:00 (15 min)	Continuing transitional solutions discussion • FTAC's proposed ideas • Vote to prioritize one category, or to prioritize one idea from each category	9 & 10	Jon Kromm, Principal Health Management Associates
4:00	Adjournment		Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State

Subject to Section 5 of the Laws of 2022, Chapter 115, also known as HB 1329, the Commission has agreed this meeting will be held via Zoom without a physical location.

Tab 2

Universal Health Care Commission Meeting Summary

April 11, 2023
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
Jane Beyer
Joan Altman
Karen Johnson
Kristin Peterson
Mohamed Shindane
Nicole Gomez

Members absent

Senator Ann Rivers
Senator Emily Randall
Estell Williams
Representative Joe Schmick
Representative Marcus Riccelli
Stella Vasquez

Call to order

Vicki Lowe, Commission Chair, called the meeting to order at 2:01 p.m.

Agenda items

Welcoming remarks

Chair Lowe welcomed the members of the Commission to the eleventh meeting.

Meeting Summary review from the previous meeting

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

Finance Technical Advisory Committee (FTAC) Updates

Pam MacEwan, FTAC Liaison, provided updates from FTAC's March meeting. There were three main topics: 1) Transitional solutions, 2) a presentation by Chair Lowe on the Indian Health Delivery System, and 3) Medicare eligibility. Since Health Management and Associates (HMA) is scheduled to provide more detail on the transitional solutions work later in this meeting, updates were focused on the other topics. Chair Lowe's presentation described the Jamestown Program's approach to universal health care which ensures that members experience the same level of benefits regardless of their source of coverage. This presentation grounded FTAC's discussion on options to include Medicare enrollees in the universal system. There is no precedent for a waiver that gives a state control over Medicare funds and program administration. As a result, there was not much energy from FTAC on pursuing a waiver at this time. The major focus of FTAC's next meeting will be to solidify guidance to the Commission on the pursuit of a Medicare waiver, and to draft some pros and cons on waiver alternatives.

Public comment

Chair Lowe called for comments from the public.

Ben Kilfoil lost health coverage due to job loss and if it weren't for his partner's insurance coverage, he would go bankrupt due to the high costs of his essential medication.

Mike Benefiel remarked that transition issues can be handled after a new system is created and that Senate Bill 5335 provides an immediate solution for comprehensive health care.

Nancy Boespflug, Precinct Committee Officer (PCO) 41st District, previously lived in countries with effective universal health care. Any of the three models (as proposed by the Universal Health Care Work Group) would improve what we have. We need political will to move forward.

Elizabeth Hovde, Washington Policy Center, remarked that socialized health care leads to the rationing of care. The Commission should consider access and quality issues in universal health care systems. Health care is a need not a right.

Cris Currie, retired RN, stated that full integration of Medicare should be the goal to create savings and fully fund the universal system. The necessary pieces to begin working on a 1332 waiver application are included in the Washington Health Securities Trust bill.

Noah Peterson supported SB 5335 to avoid needless suffering of the residents of Washington. The Commission should analyze the savings generated by a universal health care system as detailed in their 2022 report.

El Moore shared concerns about aging out of his parents' insurance coverage and cited a report that found that one in three of all COVID deaths were linked to insurance gaps. We need to make the Washington Health Trust a reality.

Judy D'Amore urged the Commission to adopt Model A, sharing that her son and others who are not insured through their employer avoid going to the doctor because of the prohibitive costs.

Kathryn Lewandowsky, RN, noted that overutilization is not the problem in the U.S., rather it is inadequate access

to appropriate care that is a driver of inflated costs. In 2012, Connecticut "un-privatized" their Medicaid program, which has generated savings over time.

Maria Elena Van Gaver, family nurse practitioner, sees daily how the current health care system hurts people and burns out health care workers and urged the Commission to recommend SB 5335 as a path to implement Model A.

David Sattgast shared that due to medical needs, he cannot live independently or without his parents' health care coverage. A universal health care system would allow David to live a happier and independent life without fear of going into medical debt.

Connor Buchanan shared that many older veterans who have served this country cannot afford to age and die in this country without losing their savings due to the cost of care. This continues to cause generational trauma.

Maureen Brinck-Lund, PCO 36th District, is concerned that "single-payer" stipulations in the Commission's legislation is being given short shrift and urged the Commission to instruct FTAC to explore a single-payer option as required by SB 5399.

Marcia Stedman, Health Care for All Washington, recommended setting aside the Employee Retirement Income Security Act of 1974 (ERISA) for now and instead designing a system that prioritizes providing access to care for Washingtonians who don't currently have access.

Joselito Lopez, Washington Community Action Network, suffered two heart attacks resulting in tens of thousands of dollars in medical debt after losing employer sponsored insurance. SB 5355 provides a good starting point as does Oregon's Universal Health Care Task Force report.

Jen Nye is concerned with the subjectivity of some of the Commission's goals, e.g., "affordable." What's affordable for one person may be out of reach for another. Eliminating all out-of-pocket costs is the most humane approach and the Commission should define their goals.

Warren George, former member of Oregon's Task Force on Universal Health Care, shared that Oregon's Task Force found evidence that a public option doesn't go far enough to resolve issues within the current system and advocated for a single-payer system.

Consuelo Echeverria, Health Care for All Washington, suggested that the Commission refer to Oregon's report for steps to consolidate and unify the financing and management of Public Employee Benefits (PEB)/School Employee Benefits (SEB) and other state-based exchange programs as an interim step.

Sarah Weinberg, retired pediatrician, recalled that the Health Options Program (1990) upended her office's billing practices. One useful step for Washington could be to take Medicaid back from private insurers as Connecticut has done.

Emma Devroe noted that universal health care would significantly reduce privatized markups on medication and treatment and allow for an infrastructure that is easily regulated for quality and equitable outcomes.

Ronnie Shure, Health Care for All Washington, remarked that a single-payer health care system is not the same as "socialized medicine." A single-payer system is socialized insurance, just as we have for firefighters and police.

Mason Chittick shared that he and his brother were born with epilepsy and seizures. His parents could barely afford the cost of medicine and treatment, and universal health care would have been so beneficial when he was growing up.

Gareth Morrish stated that in New Zealand, the government subsidizes the cost of medication for individuals who are uninsured. Cutting this component of the health care system is not on the table.

Linda Orgel shared concern that Medicare Advantage is an option being considered to include Medicare enrollees in the universal health care system. Medicare Advantage is private insurance and should not be considered for the universal system.

Members of the public who were unable to provide oral public comments were encouraged to send their written comments to the Commission's inbox.

Presentation: Review of the request regarding the Washington Health Trust Bill (SB 5355)

Chair Vicki Lowe

Chair Lowe reviewed the request by Senators Hasegawa and Cleveland for the Commission to analyze the Washington Health Trust bill. Per the request, the Commission's analysis should: be shared in a report by June 30, 2024; assess whether the proposal aligns with the goals and planned activities of the Commission; assess whether and how the Commission might recommend implementing the proposal, if the Commission considers it within their mission and a viable proposal; identify opportunities for Whole Washington to substantively engage with the Commission in the future; and engage the leaders of Whole Washington throughout the analysis process and report preparation. Commission Member Mohammed Shidane suggested the proponents present to the Commission and Commission Member Nicole Gomez agreed. Commission Member Jane Beyer remarked that it would be helpful to understand how the bill does and does not align with the Commission's current work. Jane Beyer suggested that the Commission inform Senators Hasegawa and Cleveland of areas of the bill that fall outside of the Commission's current work. Chair Lowe noted that no additional funding was allocated for this request and proposed a crosswalk of the ideas between the bill and the Commission's work. Commission Member Kristin Peterson agreed with the proposed crosswalk. Chair Lowe moved for a motion to incorporate the request into the Commission and FTAC's work plan to the extent possible within the requested timeframe. Jane Beyer offered a friendly amendment to end the motion with "and available resources." The Commission voted unanimously to approve the amended motion. At the June meeting, HMA will share options for how the analysis can work into the Commission's current workplan.

Presentation: Equity – An Overview

Dr. Karen A. Johnson (Dr. J.), Director, Washington State Office of Equity

Dr. J. reviewed the work of the Washington State Office of Equity (Office) to inform the Commission's ongoing discussions and design of a universal healthcare system. The vision for the Office of Equity (Office) is for everyone to have full access to the opportunity, power, and resources to flourish and achieve their full potential. In their

directive to create a five-year statewide equity strategic plan, the Office developed a Pro Equity Anti-Racism (PEAR) playbook. PEAR is an "ecosystem" that acknowledges that humans and organizations don't exist in isolation of other systems. PEAR values are the Office's true north, informing service lines such as government policies, laws, and people that powerfully influence who can achieve their full potential. PEAR details the determinants of equity (many of which align with social determinants of health), including equity in quality education, economic justice, and housing. Community is the Office's guiding light. Dr. J. noted that when designing a universal healthcare system, it will be important to bring the community to the table for discussion and decision making.

It's not possible to discuss health equity without acknowledging the impact of racism on the health of communities, families, and children. Structural racism is a system of "othering" that has been used to "other" additional groups and communities such as women and people with disabilities. Since the U.S. has maintained a racialized and segregated society, we have all grown up in a system accustomed to "othering." Health inequities have implications including economic costs, health care costs, quality of life, and duration of life. The Commission should decide what kind of health care should be provided and paid for in the new system in a way that addresses trauma in an equitable way to help Washingtonians be resilient.

Achieving equity will not be accomplished through treating everyone equally, but by treating everyone justly according to their circumstances. Equity considerations include increasing self-awareness, aligning core values and actions, retraining your brain, and taking deliberate equitable action. Dr. J. shared some resources for and examples of how to retrain your brain. Implicit bias refers to unconscious stereotypes toward a group of people that affect our understanding, actions, and decisions. Implicit biases can be positive or negative and they affect us without our conscious awareness or control. Implicit bias affects health equity. The Commission should bring the community to the table as they examine health disparities. What is the aim of our new system? With no *aim*, there is no system. Washington is working to become a state in which everyone belongs. How can the Commission create a system with guaranteed access to quality, affordable health care for all?

Presentation: Continuing Transitional Solutions Discussion

Jon Kromm, HMA

The discussion on transitional solutions was moved to the next meeting due to time constraints.

Presentation: Eligibility: Preliminary ERISA Questions for FTAC

Jon Kromm, HMA

Previously, the Commission identified Eligibility as the first foundational topic for FTAC to address. The Commission was asked what preliminary questions they'd like FTAC to answer and evaluate regarding the Employee Retirement Income Security Act of 1974 (ERISA) eligibility for the universal system. Jane Beyer noted the goal to deliver the greatest benefit to the greatest number of people and motioned that FTAC not focus on obtaining a federal waiver and instead focus on two aspects of ERISA: 1) a "pay or play" option where employers have a choice to continue providing coverage to employees, and 2) an option where employers pay into the universal system and employees are covered by the universal system. Alternatively, Oregon's option would require employers to pay into the system through a payroll tax which eventually becomes financially unfeasible for employers to both pay into the system *and* continue to provide employees' coverage. The goal is to design a system so appealing that employers with self-funded health plans will opt to buy in to the universal system for their employees' coverage. Employers cannot be forced to participate. Jane Beyer was comfortable with FTAC relying on Erin Fuse Brown's legal analysis of ERISA (Appendix A, final report by Oregon's Task Force on Universal Health Care).

Commission Member Dave Iseminger and Commission Member Bidisha Mandal noted that this conversation requires more discussion before reaching a vote. The Commission agreed that Jane Beyer's questions would be a good starting point for FTAC's examination, but not to the exclusion of other things. The Commission agreed not to vote on the motion and to revisit Jane Beyer's motion after further discussion. Bidisha Mandal shared that since employer contributions may be optional, FTAC could examine how any employer contributions could be captured under the various ERISA eligibility options (and estimated dollar values for each option) to fund the new system. Commission Member Joan Altman noted that ERISA law has evolved somewhat and suggested FTAC brining to the Commission some initial guidance, including areas of the law that have changed, areas that are unchanged since the last analysis done on the topic, and any new approaches with potential areas of opportunity. This will narrow the scope of the field on ERISA and help avoid retreading the work that's already been done. Mohammed Shidane suggested that FTAC could review the Washington Health Trust Bill for information regarding ERISA. Chair Lowe noted that the Commission may ask FTAC to review certain aspects of that bill.

HMA briefly reviewed the Commission's workplan. FTAC will continue their work on Medicare and will then begin discussions on ERISA.

Adjournment

Meeting adjourned at 4:19 p.m.

Next meeting

June 13, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission
Written Comments
Received From March 28

Written Comments Submitted by Email

Additional Comments Received at the April Commission Meeting

- The Zoom video recording is available at https://www.youtube.com/watch?v=dayoCsybBFU.

Public comments received since (March 28) through the deadline for comments for the June meeting (May 30)

Submitted by Aaron Prok
04/05/2023

To me, universal healthcare means freedom. Freedom to pursue life, liberty, and happiness without the absurd, dehumanizing shackle of medical expenses. To be free from this financial burden could possibly mean the ability for someone to start a small business, or the ability for someone to return to higher education. All of which is good for the economy. To no longer hesitate going to the hospital due to possible costs would mean less serious diseases getting the chance to develop, which means less strain on the medical system overall.

Submitted by Will Eguamotaren
04/06/2023

Hello! Please pass this bill! You will be an example of what every state in this country needs for its citizens, especially the children which is good quality, cheap and affordable healthcare.

Also, people across are very excited to see progress on the Cascadia high speed rail project, congrats on that!

Solidarity all the way from Tennessee!

Submitted by Quinnton Walker
04/07/2023

Hello, my name is Quinnton Walker. I live in Texas and work as a Barista.

My mom has a rare form of blood cancer. She has been medicated for a few years and I am happy to say she does very well now. I am very aware of the luck we have had with it. Due to its rarity, the medicine is very expensive, not to mention all the doctors appointments and tests she had to run to even get the diagnosis. They originally thought she just had heart issues but since we were able to afford all these tests and doctors. we could find the true reason. I say that we could afford all this but this isn't true. My parents afforded this only through major help through insurance and the facts are that insurance isn't affordable to most. Getting cancer isn't affordable to many either. My mom didn't deserve to live a less full and happy life just because she was too poor to afford treatment.

I thank you for your time and I really hope you consider voting yes on the Washington Healthcare Trust to take a step in the right direction. I hope you all understand how many people's lives this would save and change for the better

Submitted by Amanda Fritz
04/08/2023

Hello,

I am Amanda, and I live in the south. I will soon graduate with a master's degree, and will then be unemployed while I look for work. I will lose my insurance.

During the pandemic, I began seeing mental health professionals. They saved my life, and my graduate student insurance helped with the financial burden. Graduate students are not well-compensated. I still see a psychologist regularly. His aid helps me to function and contribute to society. The out-of-pocket cost is $150 a session.

When I visited a doctor to get blood work done, it cost hundreds of dollars. One regular appointment costs over $100 out of pocket. Any other developed nation would balk at these costs. While I am between occupations, the simple act of remaining healthy will become a serious financial burden. These financial burdens could push me into employment that underutilizes my qualifications, wasting economic potential.

My partner does not qualify for disability in this state, as young men cannot qualify for disability at all, even if they have debilitating arthritis and PTSD. He could become a valuable member of the work force if given the opportunity to be treated, to be helped in any way. In this state, he is neglected. In this state, we do not invest in our citizens.

The Washington Healthcare Trust may be a way to implement universal health care. It is important not just to make Washington better, but to make the entire nation better and more prosperous. Those societies that refuse to invest in their citizens will see their citizens be uninvested in that society. Move swiftly toward a better future: you could save countless lives. This is in everyone's best interest, including your own.

Thank you for your time.

Submitted by El Moore
04/08/2023

To whom it may concern,

Hello, My name is El Moore, and I would love to provide testimony during the UHCC hearing regarding SB 5335. I'm an animation student at Minnesota State University Moorhead that spends his summers in Washington, and has plans to live in Washington after I graduate. I've lightly followed the Whole Washington coalition since the summer of 2022.

I'm a transgender man and rely on hormones for my transition, for now I am on my parent’s insurance but in a couple of years I know I no longer will have that safety net. Testosterone gives me the opportunity to live in a way that's most comfortable for me and it would be devastating on my peace of mind to live without it. I worry about covering both doctor visits and the price of my medication once I am off my parent’s insurance. I worry about procedures most Americans need to go through like getting my wisdom teeth removed because I know dental and trans-related care often become nightmares to navigate under private insurance. I worry if an emergency were to happen if I could cover a hospital bill and my worries are not unfounded.

According to "The Catastrophic Cost of Uninsurance: Covid-19 Cases and Deaths Closely Tied to America's Health Coverage Gaps" report done by the Families USA Foundation, 1 in 3 COVID-19 deaths were linked to gaps in our brutal private-insurance healthcare system. People avoided going to the doctor worrying about being able to afford it and that third of the million lives taken from us were just as much victims of this failing system as victims of the pandemic.

We are one of the only industrialized nations to not guarantee health care as a human right and the Washington Health Trust would guarantee that right to the people of Washington and help set a precedent for other states and hopefully at a national level. The citizens of the United States have been the casualties of a system that should be saving lives for far too long and every day we stall means death to many people in Washington. We need fast and effective action.

I thank you for your consideration of this program, and I implore you to take immediate strides into making it a reality.

-El Moore (he/him)

Submitted by Gareth Morrish
04/08/2023

SB 5335 - Testimony from a citizen abroad

To whom it may concern, Apr 8, 2023, 7:17:56 PM

My name is Gareth. I'm a software engineer from New Zealand, but I was born here in the USA and I've recently returned to pursue my career. I have some thoughts on SB 5335 I'd like to share with you, given my perspective as a relative outsider to my own country.

One of the things I've enjoyed about New Zealand healthcare is that health services are subsidized by the Government. The price of almost any prescription medication is no more than $5 at your local pharmacy, and medical insurance isn't a requirement to get medical attention (Govt. subsidizes treatment for the uninsured, but you can still go private). My GP (General Practitioner) has helped me find an antidepressant that works for me, for no more than $60 a visit and $5 for up to 3 months' worth of meds.

In addition, if you're injured in an accident, the ACC (Accident Compensation Corporation) covers that. Workplace accidents, car accidents, sports injuries, all covered on a no-fault basis. Treatments, lost earnings, home or vehicle modifications, whatever the injured party needs. It's helped many of my friends get the care they need.

It surprises and disheartens me the extra sometimes prohibitive financial effort Americans must go to for essential care, when a small country like New Zealand can take such reasonable steps to ensure care is available. The proposed Washington Health Trust seems to me a step in the right direction, and I urge you to take it to the legislature.

Thank you for taking the time to read my perspective, and for reviewing SB 5335.

Gareth Morrish

Submitted by J.P. Hayes
04/09/2023

My name is JP Hayes, and my uncle died of pancreatic cancer. He didn't fight it, and he died in 2020. Me and my family watched as our goofy uncle Chris slowly got thinner, slowly lost his battle with cancer, and eventually passed away. As hard as it was for us, we didn't have to worry about prices because he

gave up when he heard about the survivability of pancreatic cancer. I can't imagine how hard it must be for the third of cancer patients who go bankrupt paying for treatments.

Submitted by Venus Bloodflow
04/09/2023

I am unable to attend ...so I would like to leave a written comment.

" If I had healthcare while I was working full-time I wouldn't have had to get on Social Security Disability. I would have been able to work much longer before my kidneys failed. It's a miserable life to live on disability and even more miserable knowing that you have a deadly hereditary illness but unable to afford health insurance. With universal healthcare less people will become disableddue to lack of healthcare. This allows us to conitue to be productive members of society." - Venus B.

If there's anything inappropriate about this comment please remove it or let me know. Thanks.

Submitted by Matthew Murzyn
04/09/2023

Hello, my name is Matthew Murzyn. I am a student civil engineering intern from Panama City, Florida. I am affiliated with the Florida Democratic Party, Bay County Democrats, and the organization Progressive Victory.

I personally have struggled many times with the private healthcare system currently set up in the United States, namely in the state of Florida. A prime example of my struggle is with mental health care. In many places where I live, mental health care is not fully covered by private insurance and is quite expensive to pay out of pocket. This is the primary reason why I have not received mental health care in many years, despite desperately needing help in treating my generalized anxiety disorder. Becoming a contributing, productive member of society, who is able form a family while generating profit for an employer is nearly an impossible feat for me due to a lack of affordable access to mental health care. Compared to a European country with universal healthcare, like Norway, affording mental health care would not be a major concern. Yes, there would be wait times, but at least I could get the help I need while not having to worry about not being able to feed myself and pay power and water bills.

Thank you for giving me this chance to write to you. While I am not a resident of Washington state, the Washington Healthcare Trust is of immense interest to me. If Washington state approves of and implements a form of universal healthcare, it would set a standard for the rest of the United States to follow. Many, many individuals such as myself in Washington and throughout the United States struggle like myself with their mental health. If universal heatlhcare comes to fruition, the future for Washington would be much brighter as myself and others would consider moving to the state to become residents get the healthcare we desperately need.

Submitted by Maria Iliescu
04/09/2023

Good Evening,

My name is Maria Iliescu and I am a senior in high school living in Bellevue Washington. Although I have not had much interaction with Washington's healthcare system, I do know people who have.These people have been fortunate enough to be able to afford private insurance, but I fear that if they had not been so affluent their lives would have been much worse. I fear being in an accident not because of the impact it would have to my body but because of the toll it would take on my family and their ability to pay for my college. Having free universal healthcare for all Washingtonians would have a tremendous impact on peoples' lives and would help relieve the great financial burden our medical system places on working class families. I sincerely hope that Washington goes through with the Washington Healthcare Trust's plan to implement universal health care as soon as possible because peoples' lives really do depend on it.

Thank you,

Maria Iliescu

Submitted by Drew Spier
04/09/2023

Good evening,

My name is Drew Spier. As a high schooler in Bellevue, I personally have had very little to do with healthcare, its availability and payments. However, as I transition into college, I will slowly come into more and more contact with the system, and I have already heard the horror stories. The price of ambulance rides, the ridiculous price of life-saving procedures, the life-ruining debt incurred by the current system, all of it scares me more than I'd like to admit. All of these scenarios and more give me more than enough reason to support any efforts to prevent the damages this system causes. Supporting Universal Healthcare and showing interest by sending this email is the least I can do to work towards a more effective system for everyone in the state. Thank you so much for doing what you do, and I hope the change you seek is instituted as quickly as possible.

Good luck,

Drew Spier

Submitted by Calvin Snow
04/10/2023

Commission,

Another legislative session has come and gone with no action to solve the horrible health care system that the Democratic party leadership is so desperately holding on to.
A lot of money was thrown at the problem but it just ended up in the pockets of the insurance corporations.
How can anyone justify allowing our families to suffer while continuing to accept campaign donations from the vulture healthcare lobby?
With half a million of our friends, neighbors and families with zero coverage and millions more with inadequate coverage, how do we justify dragging our feet?
Is it legal to take money from the insurance lobby? Yes, but is it right?

You have a responsibility to our families to do the right thing.

Calvin Snow

Submitted by Michi Okahata
04/10/2023

Hey,
My name is Michi Okahata and I am a senior in high school living in Bellevue Washington. Although I have not had many interactions with Washington's healthcare system, I do know people who have.These people have been fortunate enough to be able to afford private insurance, but I fear that if they had not been so affluent their lives would have been much worse. Having free universal healthcare for all Washingtonians would have a tremendous impact on peoples' lives and would help relieve the great financial burden our medical system places on working class families. I sincerely hope that Washington goes through with the Washington Healthcare Trust's plan to implement universal health care as soon as possible because peoples' lives really do depend on it.

Best,
Michi Okahata

Submitted by Constance Adam
04/10/2023

Good afternoon,

I go by the name Constance, and I would like to voice my support for Washington state to fund its own nonprofit health coverage plan for residents.
I am 24 years old, and I know soon I will no longer be covered by my parents health insurance. When this happens, I expect to be underinsured if not uninsured at least temporarily, because as important as my health is, the costs of living are rising and I don’t get paid enough to cover it all.

I immigrated as a youngster from British Columbia, but as a proud American citizen, it is disheartening that my old home has more robust social safety nets than my new homeland.

I implore the commission to at the very least draft some legislation that would offer health coverage for preventative care, lessening the burden considerably for the most disadvantaged. If the commission could support the Senate Bill 5335, I would appreciate it greatly.

Sincerely,
Constance Adam

Submitted by Elizabeth Hovde
04/10/2023

I'm Elizabeth Hovde from the Washington Policy Center. I direct our Center for Health Care and our Center for Worker Rights. Thanks for your time today.

Universal care sounds good until it doesn't, even before you get to the insurmountable costs that have had other states abandoning their plans. In other experiences with government-run systems, we see that affordability, access and quality do not go together. Individuals' health care does not benefit from taking away decisions made between doctors and patients. Citizens — not governments — are the best advocates for their health care needs.

We need to be careful what we wish for.

As one legislator said in a recent hearing for Senate Joint Memorial 8006, a bill the Legislature is still considering and that asks the federal government to enact universal care or give Washington greater ease in going it alone, "If we actually had universal health care, it'd be interesting to see the other problems that we'd have." That was Rep. Paul Harris from Vancouver. I agree.

As you analyze the Washington Health Trust bill SB 5335, an idea that did not advance in the Legislature, consider what has happened in other states that abandoned their government health care plans.

In Vermont, despite being a small and progressive state, more than a dozen financing concepts showed the only way to set tax rates as low as Vermont officials wanted would mean giving residents skimpier coverage than most insured Vermonters already had, wrote Third Way, a national think tank that champions center-left ideas. It added that the estimated cost of the new system would have been over $5 billion in 2021. "For context, the entire budget for the state of Vermont was $5.01 billion for 2012-2013," Third Way notes.

Officials in Vermont determined that an 11.5% state payroll tax and a 9.5% income tax would be necessary to pay for the new health care system. 'Enormous,' is how the state's then-Democratic governor described the tax hikes needed to fund the plan.

Right now, our state's workers are rightly upset about a new long-term-care payroll tax of 58 cents of every $100 they make and a tax for paid family leave that keeps climbing. These taxes, and future ones that would be enacted for more taxpayer-funded health care, take away people's opportunities to find solutions for life needs that fit their individual situations.

Even if taxpayers wanted new, substantially higher taxes instead of insurance premiums, the pattern of universal, government-run health care is the rationing of medical care. Some patients are denied care to save money. Patient-centered health care is not the priority.

Consider what is happening in other countries with socialized medicine. Just this weekend, I read that Ontario, Canada's most populous province, announced a major expansion of private providers for publicly covered procedures. Premier Doug Ford said the move was needed to address an unsustainable status quo of long wait times.

Access has suffered in both Great Britain and Canada, both of which have taxpayer-funded universal care. The Fraser Institute in Canada found that last year, the average wait time between a primary care provider referral and specialty treatment was almost seven months.

In Great Britain, a Wall Street Journal article recently reported that people who suffer heart attacks or strokes wait more than one and a half hours on average for an ambulance. The Royal College of Emergency Medicine estimates 300 to 500 people suffer premature deaths each week because of lack of access to timely care.

Our third-party payer system is a large part of the problem, as it separates patients from knowledge about health care costs. A universal, taxpayer-funded system would make the problem worse.

We need educated consumers who shop for health care. We need price transparency. A true free-market system would be free of obstacles that limit choice, innovation and competition. Costs will continue to increase as long as someone else is paying for our health care. And we need discussions about the health care system to start from an understanding that health care is not a right. It is a necessity of life, just like food and housing. We shop for those things, and assistance is available for people in need.

The Washington Health Trust is the wrong solution. Socialized health care leads to the rationing of care. Demand always outstrips supply, and patient-centered health care is not the priority.

The state should move personal decisions about health care away from the political process and closer to the patient. Bills like SB 5335 and SJM 8006 would do the opposite.

Instead of universal, government-funded care, we should be looking at innovations all around the nation that provide people with affordable access to needed health care. The choices don't have to be between the hybrid system we have right now and socialized health care.

I'm happy to help with ideas about cost containment, point you to free-market approaches to health care or help with any research needs you have.

Thanks again for your time,

Elizabeth

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Elizabeth Hovde

Director, Centers for Worker Rights & Health Care
Washington Policy Center
www.washingtonpolicy.org
360-241-4653

Submitted by Janet Young
04/10/2023

Dear UHCC,

I write to submit written testimony for consideration at your meeting on April 11, 2023. Thank you for considering the legislative request to study the Washington Health Trust bill (Senate Bill 5335). I would like to encourage you to agree to this request!

I am a volunteer for Whole Washington and personally collected over 1000 signatures in 2022 in support of an initiative version of that bill. While volunteering, I heart overwhelming public support in favor of our efforts, with most people wholeheartedly agreeing that our current system is broken and in urgent need of complete overhaul.

While I do not claim to be an expert on the details of healthcare policy, I believe that that SB5335 lays out important principals that must be followed as we move towards universal healthcare:

- the need is URGENT: study is important, but cannot be used to delay action. If needed we must make a case for more resources to complete the study phase without further delay.

- a SINGLE PAYER solution is essential: in today's world, individuals gain, lose or change employers and health insurers regularly. Even people with good insurance coverage often struggle to understand which providers or treatments are covered and which are not, and it feels like a full time job figuring out the interaction between medical procedures and reimbursements. Single payer system would also greatly reduce administrative overhead and therefore costs. Ill people need to be able to focus on getting care, without additionally worrying about payment/reimbursement/eligibility.

- a NON-PROFIT solution is essential. In our current system, whether patients receive care or are denied it is often driven by financial decisions, whether that be at the level of the insurance company, or the patient themselves considering whether they can afford co-pays/deductibles. The ability to utilize healthcare services should not and cannot be determined by one's material wealth: that has played a large part in generating the homelessness crisis that afflicts our state today.

Please take SB5335's proposals seriously in your study. Whether WA state's future universal health system follows the details of SB5355 or not, it is worth open-minded consideration as an equitable system that could be put into practise TODAY. If there's room for improvement, by all means improve it, but remember that the longer we study this issue before acting, the more people are suffering, dying or going bankrupt because of inadequate health coverage.

Thank you for your work, and for listening.

Best wishes,
Janet Young

Whole Washington volunteer.
Seattle,
WA 98102

Submitted by Laurie Bohm
04/10/2023

Dear UHCC,

Please accept this written testimony for consideration at your meeting on April 11, 2023. I encourage you to agree to the legislative request to study the Washington Health Trust bill (Senate Bill 5335).

SB5335 lays out a well-thought, well-researched foundation with which to move towards universal healthcare.Please remember that:

- The need is URGENT. Study is important, but cannot be used to delay action. Too many people in Washington State are currently suffering, dying, going bankrupt and/or going homeless because of inadequate health coverage.
- A SINGLE PAYER solution is essential. It would greatly reduce administrative overhead and therefore costs. Ill people need to be able to focus on getting care, without additionally worrying about payment/reimbursement/eligibility.
- A NON-PROFIT solution is essential. A company's bottom line should not be a factor in whether a patient can afford care.

Whether WA state's future universal health system follows the details of SB5355 or not, it is worth your consideration as an equitable system that could be put into practice TODAY.

Thank you for your consideration.

Warmly,
Laurie Bohm

Submitted by Robert Galloway
04/10/2023

Hello,

My name is Robert Galloway Hawes. I am a student at University of Oregon in Eugene, Oregon, and I am writing this testimony because I want to encourage you to support the implementation of the Washington Health Trust. Millions of people in America struggle with gaining access to healthcare, and I have personally seen basic appointments become extraordinarily expensive, into the thousands of dollars, though I am lucky enough to be able to pay for them. Implementing this trust could bring the state closer to universal healthcare and help many get medical attention they urgently need, so I implore you to move this proposal forward.

Thank You.

Submitted by Irene Osborn
04/10/2023

Yes for Universal Healthcare!!!!
Just piggyback it to Medicare. Hat system works. It's about time. Hawaii has had it for years.
Irene Osborn
8034 Libby Rd NE
Olympia Wa 98506

Submitted by Robert Gray
04/11/2023

Hello, my name is Robert Gray and I am a Florida resident and nursing student starting this fall. This is an important issue to me because I will be working in the healthcare field, and I have heard so many stories about people who neglect their health because they are afraid they won't be able to afford care, or because they are uninsured.
But I also have personal experience with this myself. My younger brother was diagnosed with Type 1 Diabetes at age 6. On top of the inherent trauma in that situation, I was old enough to know that this would put a financial burden on our family. Fortunately a few years later he got top-tier insurance through my parents' employer but I remember those years as very uncertain. It hurts me to think about what would happen without that insurance, and to know that there are people out there doing essential work for society that simply can't afford a decent standard of care.
I appreciate your time and consideration, and urge you to support the Washington Healthcare Trust in order to implement universal healthcare in WA, and to be a shining beacon for what we can do as a nation.

Submitted by Freya Knarr
04/11/2023

Hello,

I speaking for myself and my wife.

We are encouraged that you are holding a hearing and listening to our comments.

We would like to tell you the importance of universal healthcare. I am disabled with a degenerative disease. While I have good healthcare now, I did not in the past. Had I had healthcare in my young years I would have caught my disease earlier and added many healthy years to my life.

Instead, I am trying to play catch up now that I finally have insurance.

Not having universal healthcare is costing millions of Americans like me more money which leads to ballooning health issues and costs.

Please, for the sake of our livelihoods and our economy, we need universal healthcare.

Thank you for listening.

Sincerely,

Freya Knarr (She/Her)

Submitted by Kryss Mann
04/11/2023

Hello UHCC,
I am unable to attend today's meeting, but would still like to write in about being in favor of the proposed Universal Healthcare for Washington state by Whole Washington and their Health Trust.

My personal story heavily revolves around Healthcare. I am disabled; several years ago my partner and I made the decision to pick up our lives and move across the country from Nebraska to Washington state specifically because the Healthcare access and quality is superior here, along with higher wages.

I now live a full life!
I am the healthiest I have ever been.
We live and work here. We have built community. We are happy.

My Healthcare isn't perfect, but it is better than it was. Things are still expensive and there are too many "middle men" disrupting the flow of care people deserve. Everyone deserves proper Healthcare, unhindered by profit seeking.
This is what a Universal system, or single payer system will accomplish.
Things will be cheaper, easier, and better all around. The data is straight forward in all these regards. That is what the people deserve.
If an entire country not much larger than our state, like Sweden (10.42 million), compared to our 7.74 million,

can pull it off.
Why can't we?

Hopeful for Healthcare,
K.Mann

Submitted by Gina Daskalopoulos
04/11/2023

Hello,

My name is Gina Daskalopoulos. I say yes to Universal Healthcare. I live in Hunt Valley, Maryland. I moved here from Finland about a year ago.

The healthcare system has been my biggest struggle since moving here. In Finland, I paid $50 for a procedure that would cost over $5000 in the US. When I moved to America, I went from paying $0 for therapy to having to pay almost $200 for the same treatment. My insurance has a $6000 deductible, which means I pay premiums every month, only to have to pay the full price for healthcare anyway. When I called in sick for one shift at work, I had to pay a total of $85 for an appointment to get a doctor's note. I encourage you to consider implementing Universal Public Healthcare. Doing so will improve the quality of my and many other Americans' lives.

Thank you.

Regards,
Gina Daskalopoulos

Submitted by Emmet Swibes
04/11/2023

Hello, I am Emmet Swibes, I live in Hammond Indiana, I am not currently employed and am still in schooling, and I am affiliated with democrats and other generally left wing parties. Me and my family for a long time have had struggles with physical and mental health, which has been very challenging and straining for us due to the high cost and relative inaccessibility of a lot of health services. I myself need medication to help with my day to day ability to focus and work, and without it I would have a hard time getting things done. Getting this medication though can be hard at times due to high prices of both talking to a doctor to get a prescription and the cost of the medication itself. My mother and father have several health conditions of their own that requires a lot of treatment that sometimes we just can't afford. When we can, we barely have enough left after to handle our other basic needs and expenses. If we had universal healthcare, my family and thousands like mine would be able to get the medical help we need and would be able to live a happier, healthier, and more productive life while still being able to afford other basic amenities. Without it, thousands may continue to suffer and die simply due to not

being able to access or afford something which should be so basic of right in my opinion. It can't be further stated how urgent of a need this is for so many people, and how many thousands of lives might be able to be saved if implemented as soon as possible. Thank you for taking the time to read my email, and please consider the Washington Healthcare Trust as a way to implement universal health care. I hope you have a lovely day.

Submitted by Soren Ludwig
04/11/2023

Hello,

I'm Soren Ludwig. A laid off software engineer from Microsoft. In six months, my healthcare will drop, and I will have a large spike in costs. Healthcare should not be tied to employment. I shouldn't suddenly have to pay hundreds of extra dollars to receive basic preventative care or medications.

Thank you,
Soren

Submitted by Julia
04/11/2023

Hi!

I'm Julia, I'm from downtown Seattle. I'm a trans woman, which leaves me in constant need of medical services. I'm incredibly lucky, I have a great job that gives me great insurance, but speaking to my friends, to people in my community, I am horrified. I strongly support this bill. Our medical system is fundamentally not doing the thing it is required to do, caring for the health of the people who live here. Look at the world, there are countless stories everywhere you look that clearly illustrate this is not working. Inaction is unsustainable, the status quo is failure. Universal healthcare: this solution is clear and faces no legitimate dispute, only a distraction in the form of a misinformed or corrupt opposition.

Thank you!

Submitted by Orion Canning
04/11/2023

My name is Orion Canning, I live in Olympia Washington. We need a single payer healthcare system. Our society has long prioritised the rights of business to make unrestricted profit over basic human needs. Hospitals have a natural regional monopoly. And because people need medical care to live, it is price inelastic, it does not function with the normal self regulating price controls we expect markets and

competition to create. Hospitals and insurance companies can charge exorbitant prices and people will have to pay them because their only other option is to suffer and die. It is in fact incredibly exploitative, deeply inhumane, and a direct attack on the rights of life, liberty, and the pursuit of happiness of poor people.

We live in a country with the highest wealth inequality, that is constantly growing. It is deeply classist to deny life saving treatment to the poor. We can't let insurance determine prices, We need to make it available at no cost if someone can't afford it. Basic human needs should not be with-held and exploited for profit. This goes for other human needs as well, people should also have a right to shelter, food, utilities (heat, water, sanitation!). None of these are optional, none of these should be privatized or allowed to be exploited for profit. But that is going to be a longer project to untangle and fix. Thank you for working towards a sensible solution for healthcare that helps the people who need it most.

Submitted by Ryan Mandel
04/11/2023

Was listening in on the meeting today on Tuesday April 11th but was not able to speak due to time and personal reasons. But I would like to add my voice to the overwhelming support that the universal healthcare options received. Healthcare is a human right, and I would love for the state that I call home to enshrine that right for all of us.

Thank you,
Ryan Mandel

Submitted by Nicole Minkoff
04/11/2023

My name is Nicole Minkoff and I'm a resident of Seattle, a state employee, and my family receives insurance through PEBB. This makes us incredibly fortunate to have access to excellent health care within the state, and I want to share why I am strongly in favor of an urgent, non-profit, single payer solution to healthcare in Washington and I'd like to share a couple of personal experiences with you.

When my son was 3 days old, he suffered a potentially fatal birth complication that required a visit to the ER and subsequent admission to the NICU at Seattle Children's Hospital. As you can imagine this was an incredibly stressful time made more stressful by not knowing whether providers in the unit would be in network or if we could pay for his care. In the end, our son received excellent care and due to our health insurance, we were responsible "only" for $8,000 out of the total $93,000 bill for those days. Even with great insurance, this could be enough to bankrupt or provide major disruption for many families in WA.

Our state insurance also denied coverage and dragged it out through multiple appeals for tests recommended by my son's healthcare team. When the appeal was escalated to an outside reviewer, the

reviewer immediately identified that this test was medically necessary, obviously clearly within the guidelines, and should be covered. The result was positive but required multiple hours of advocacy and navigating a system that is inaccessible to most families - a point which insurance companies are counting on. Additionally, this resulted in a 11 month delay in treatment and additional diagnostics.

Finally, each year I spend hours resolving issues between the companies managing my pharmacy and medical benefits regarding recognition of the joint deductible and maintaining coverage for current treatment options.

The cost in healthcare is not only the cost in dollars, which is inaccessible and exclusive and causes appalling inequities, but also in stress, a requirement to be savvy and able to navigate systems, and in time. As with financial costs, this burden may seem slight to those with ample resources and few needs, but for those of us with chronic illness, disability, or a lack of time, it's another burden that a single payer option where doctors make the decisions could improve care and quality of life significantly. Thank you.

Nicole Minkoff

Submitted by Ashely Moore
04/11/2023

My name is Ashley Moore, I live in Olympia Washington. My husband and I moved here from Indianapolis about two years ago.

I live with a number of conditions, including late-diagnosed ADHD, severe major depressive disorder, generalized anxiety disorder, chronic migraines, endometriosis, and Complicated PTSD from sustaining years of child abuse and neglect.

I can't work traditional jobs, but I'm working on starting a small business despite my conditions. I tried to get on disability, and despite the psych and medical professionals' opinion that I should qualify as disabled, the government disagreed.
Luckily my husband has a well-paying job and good insurance. But if anything were to happen to him or his job, I would be back to struggling to afford the medication and medical care I need to function on a day-to-day basis.

Health Care should be a Right, and I support Universal and Single-payer Health Care.

Thank you for your time.

Submitted by Natashia Martin
04/11/2023

Good evening,

My name is Natashia Martin, I live on Mercer Island and work in Seattle and am extremely in favor of Washington implementing a state wide universal healthcare system. Last year my little sister who lives with me was attacked outside our home (then in Seattle) unprovoked by an unknown man with a knife as she came home with groceries. She survived this encounter- barely - but required extensive surgery and was unconscious for weeks in the ER. When this happened my sister did not have health insurance, but we are eternally grateful that a social worker at the hospital was able to help get her Apple Health coverage. In the intervening time, this has covered over $700,000 in medical bills. We are not wealthy and I am currently the sole worker my family. Without Apple Health we would undoubtedly have had to declare bankruptcy due to medical debt. Our country is the only "developed" nation on earth that does not provide healthcare for its citizens and since our federal government thus far refuses to address this matter, I'm grateful that Washington is looking to lead the way in providing healthcare to its residents. No one should ever have to go into debt in order not to die.

Thank you for your consideration on this matter,
Natashia Martin

Submitted by Jack Calkins
04/11/2023

Hello,

I wanted to share my story with you. I'm writing in support of SB 5335 Washington Health Trust Bill. I've recently lost my job and at the end of this month, I will lose access to my health care. This means that medications that my family needs to live will now be unavailable to us until I am able to secure employment again. This is cruel. Every individual should have access to healthcare and the medication they require to live their life.

A universal solution is absolutely needed for my family and the long-term future of Washington. Please give a strong consideration to the future lives of all Washingtonians.

Thank you,
Jack Calkins

Submitted by Mason
04/11/2023

My name is Mason and I live in Michigan. Having Healthcare would've made a huge difference for me and my family growing up. I was born with seizures and epilepsy, after 16 years of breaking the bank repeatedly was eventually cured of both, during that time, my family had almost lost our house twice, couldn't afford the toys and niceties one expects most to have growing up, and caused a lot of stress in

my parents relationship. Thank you for this time and I hope you bring universal healthcare forward to Washington.

Submitted by Madeline Bishop
04/12/2023

I strongly favor a WA healthcare plan. My only concern is that WA does not replicate the worst of Medicare Advantage plans by requiring pre-authorization for prescriptions. Any prescription written by a doctor should be honored.

I have a nightmare story of fighting for 3 months to get my husband insulin after I switched from Regence to United Healthcare. No one from Healthcare Authority or United Healthcare would divulge the secret key to getting the required insulin. My husband has been an insulin dependent diabetic for 30 years and I went through a nightmare trying to get him the same insulin amount that he has had for the last 10 years.

Thanks for all your hard work.
Madeline Bishop, Olympia, 98513

Submitted by Erin Georgen
04/17/2023

to achieve universal health care in WA.

I am a 40-year-old single mother and full-time worker living in Eastern Washington. After high school, I served in the USCG, after which I worked as a Physical Therapists Assistant for more than a decade. Over the course of my life, I've had the military's active duty coverage, employer-based coverage, coverage for specific injury-related disabilities through VA and L&I, years of no coverage before the ACA, high deductible health plans and Health Savings accounts, coverage purchased through the HBE, and Medicaid.

Through that experience, I have become a huge advocate for universal healthcare. Not only is it substantially more costly to sustain the current system than it would be to implement any number of universal health coverage approaches, but the administrative burden on providers and patients to navigate coverage options and use benefits creates unnecessary obstacles to quality and effective health care.

If we recognize that there are significant health inequities rooted in an individual's Social Determinants of Health, why would we want to continue a healthcare system in which many of those same social determinants dictate what health insurance coverage an individual and family can enroll in (which inherently dictates their overall costs of care/coverage)?

Beyond that, what benefit is it to providers or patients when an individual must change insurance and navigate new coverage every time their life, family, job, or finances experiences a significant change?

Thank you for your efforts and the thoughtful dialogue during your recent public meeting. I'm sorry that some folks used that opportunity to Zoom bomb and be disruptive instead of sharing their perspective.

Thank you for your time,
Erin Georgen

Submitted by Kathryn Lewandowsky
5/01/2023

Hello, I'm sorry, things have been really b usy for me. I slipped sending in my complete comments for the last Meeting. The time was cut quite a bit and so here are my complete comments.

4/11/2023 UHC Meeting
Hello, for the record my name is Kathryn Lewandowsky, I am a Registered Nurse working in Washington state for 37 years and vice-chair of Whole Washington. I want to make a couple comments on Dr. Stephen Kemple's slides that I shared with the members of the Commission titled, HOW STATES PRIVATIZE AND CAN UNPRIVATIZE MEDICAID!

On slide 23 he discusses that all the evidence shows Over-Utilization is NOT the problem in America. And in fact, it is Americans' inadequate access to appropriate care that is a huge driver of inflated healthcare costs. This is what I have witnessed throughout my career. Most Americans don't like going to the Doctor. But when they are afraid to go to the doctor because they fear what the cost will be, they tend to wait too long and the problem has escalated. This leads to the illness being more costly to treat and often to the treatment being unsuccessful.

On slide 28, please note what Connecticut was able to save by un-privatizing their Medicaid program in 2012. Where, between 2008-2012 the costs for their program rose 45%, they elected to become self insured and also enhanced their support for primary care. This increased the number of doctors who accepted Medicaid patients, reduced ER usage by 25%, and reduced hospital admissions and readmissions by 6%. Six years later they had reduced their Medicaid costs 14%. All by just un-privatizing.

Dr. Kemple mentions that corporate fraud and abuse is both widespread and very expensive. Please understand that every year we have yearly education about the fact that my hospital can be heavily fined if we commit such fraud and abuse with Medicare/Medicaid billing and there are mechanisms for employees to anonymously report such fraud and abuse to CMS if we discover it. Still the relatively few audits of for-profit entities have shown that this is a consistent problem and although the penalties seem very high, they obviously are not high enough to discourage their bad behavior.

I encourage you to please look closely at all of his data and reach out to him if you have any questions.

Thank you for allowing US to speak at the UHC meeting and for the work you are doing.

Kathryn Lewandowsky, BSN, RN
Whole Washington- Board Vice-Chair
One Payer States- Treasurer

Submitted by Mike Benefiel
05/05/2023

To the good people of the Universal Health Care Committee,

I would like to clarify testimony from the Washington Policy Center (WPC).

They say that, “a single-payer universal health care system is not the solution to achieving affordable and accessible health care”. This is contrary to what every modern nation believes. This is also contrary to over two dozen national studies and our own WA Universal Health Care Work Group study. These studies that include studies funded by conservative think tanks all, every single one, agree that a single-payer, government run system will provide healthcare to everyone, save lives and save residents money.

The WPC also states, “ that competition, innovation, and educated consumers are necessary to lower health care costs in Washington.”

One would think that with dozens of insurance corporations in WA and over a hundred different policy choices that that would bring competition? The opposite is true. The insurance corporations act as a single unit having similar prices and benefits, to the detriment of consumers.

As far as innovation, history shows us that innovation is never used to reduce the cost to consumers but often is used to increase the costs.

And as to their claim that better results could be achieved if consumers were more educated. I think this is very indicative of the mind set of those seeking profits off the bad fortunes of others. This insinuates that people are unnecessarily suffering and dying, people are going bankrupt from monstrous healthcare bills because they are not educated. They are blaming the victims.

The WPC claims are not backed up by any studies and they have no plan of their own to provide UHC. In my opinion their agenda is not to help the residents of WA.

Please take advantage of the work that's already been done and review the legislation SB 5335, The Washington Health Trust

Thank you for all your hard work,

Mike Benefiel, Dem PCO, LD 23

Submitted by Elisabeth Tullai
05/07/2023

I have no statistics to share.
I have no great testimony about how the lack of healthcare has destroyed me or anyone I know directly.

I have only fear to share. Fear of loss of all I have due to lack of efficient healthcare. I fear a devastating diagnosis. I fear a horrible automobile accident. I fear bills piling up that will strip me of my home, my meager savings and my dignity.

All I have to say, is that it is time. It is time NOW for Universal Healthcare to feel secure and safe.

We need Universal Healthcare and we need it NOW!

With Respect,

Elisabeth Tullai

Submitted by Calvin Snow
05/07/2023

Commission Members,

The difference between the Oregon Task Force for UHC and this commission is that the Task Forces goal is to build a single payer healthcare system to be implemented by the legislature while the commission has no such goal. The commission has a role to give information to the legislature.
I recommend you start working on legislation or we may never get it done.

Thanks,
C. Snow

Submitted by Consuelo Echeverria
05/11/2023

Dear FTAC Members,

First thank you all very much for your work on the FTAC.

I would like to address a few points on the May 2023 FTAC Agenda.

1. Workplan:

As it is currently scheduled ERISA is on the agenda from June till Nov. While ERISA has de-railed 21 state-based single payer efforts since 2010, Brown and McCuskey, (2019) outline The A,B,C Strategy along with the Non-duplication Provision that should not take five months, almost a half a year, to discuss. Cris Currie's summary of Brown & McCuskey, 2019 in the May 11, 2023, Meeting Materials succinctly lays out The A,B,C Strategy along with the Non-duplication Provision that has already been tried in other states.

Furthermore, in the April UHCC meeting, Jane Beyer, who shared that she has years of experience with ERISA, suggested a vote to put ERISA aside. However, that suggestion was rejected as not all commissioners were present due to the end of the legislative session.

I can not emphasize enough that the next 5 months would be better spent putting ERISA aside and focusing on the vision of the unified, universal health care system we are trying to build. In other words the Washington Health Security Trust. It is within this unified system that immediate needs can be addressed such as developing a plan to purchase PEBB and SEBB benefits together to showcase the State's capacity for managing a unified health care system as suggested by Roger Gantz in the FTAC meeting of March 2023.

2. Medicare: Motion to recommend or not recommend: Number 1 Act of Congress or comprehensive waiver at this time.
I urge the commission to vote for Option Number 1 as communication with DHHS can guide the iterative process of preparing the groundwork in Washington State for a:
"A comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under section 1332 of PPACA and a detailed 10-year budget plan that is deficit neutral."
(https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf)

Ms. Eibner's presentation highlights the real barriers of no precedent and unclear federal support. I would just say that while yes, there is no precedent and unclear federal support, Option 1 is, as the California report says, the "North Star" that should guide all of our efforts. Furthermore, in her presentation there is no mention of the fact that almost 70% of Americans support Medicare for All as the COVID-19 pandemic has revealed the extreme gaps in the US healthcare system. This is not the time to be timid but a time for us to be visionary and gather forces for the "moon-shot" to state based universal health care.

Furthermore, it is unclear to me how a waiver for Washington state would endanger the whole federal program of Medicare. I think that Medicare would still be 'preserved' in the other 49 states.

3. Population-Based Payment and Capitation
We should not be adapting the Population-Based Payment model as it is an iteration of Value Based Payments with the same and new issues that do not exist under a fee-for-service model. Some of the most egregious issues are highlighted below.
Patients do not receive needed care:

Unlike fee-for-service payment where providers are paid for providing services, in the Population-Based Payment model the revenue a provider receives is based on the number of patients cared for, not how many services or types of services used. Therefore, the Population-Based Payment model incentives providers to treat those that are healthy and drop those that are sick as the provider saves money when fewer services are delivered. While looking at this from an equity lens, we know that those who are the sickest are often the oldest, poorest and from minority (BIPOC) communities and from rural communities. In fact, McWilliams et al, highlights that setting population-based payments a current levels risks entrenching levels that are **proven to be insufficient to mitigate** the impact of social determinants on health care use." (McWilliams et al, 2023).

Penalizes providers who care for higher-need patients:
Fee-for-service payment allows providers to be paid for additional services for patients with multiple and complex needs that many poor, old and BIPOC and rural patients have. Conversely, population-based payment models may not adjust payments for patients with new, multiple and or complex problems or those who face non-medical barriers to care as can be the case for many rural patients. This can and does penalize providers who care for high-need patients.

Incentivizes investors and other financial intermediaries:
"Because of the high levels of financial risk associated with population-based payment systems, private investors and financial intermediaries can profit on fixed capitation payments if they can find ways to cherry-pick patients and increase the risk scores assigned to patients, rather than by improving the quality of healthcare services." (CFHCR, accessed May 5, 2023)

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Submitted by Roger Collier
05/30/2023

ERISA and the 2.5 million self-funded Washingtonians

Dear UHCC member:

The UHCC and FTAC are about to consider the potential impact of ERISA and the interactions between ERISA and a single-payer universal healthcare system. This is a vitally important topic. ERISA law governs the extent to which State regulations may impact the self-funded healthcare plans in which two and a half million Washington residents are enrolled – the single largest group who might be covered by a future Washington single-payer system. **Unless ERISA issues can be resolved, there cannot be a single-payer system in our State**.

ERISA presents complex legal issues and its impact in Washington will depend on how single-payer is funded and on the magnitude of the funding burden borne by employers. Surprisingly, however, the UHCC's 2023 work plan includes no analysis of funding issues and no provision for legal review. As I noted in a prior comment: "*Washington has no state income tax to share in single-payer funding and an increase in sales or other taxes could be considered regressive and at odds with the UHCC's emphasis on equity. The alternative of relying [mainly] on a substantial tax on employers could run afoul of a Supreme Court ruling that an "exorbitant" tax would be treated as a mandate and preempted by ERISA.*"

In the following pages I have attempted to "jump start" the UHCC's and FTAC's thinking about ERISA in order to accelerate what (compared with Oregon's Task Force effort) is seeming to be a very, very slow process. I hope you will find it helpful.

Thank you.

Roger Collier

Cc: FTAC members

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ERISA and the 2.5 million self-funded Washingtonians

Three issues to consider for a single-payer plan:

1. Funding
2. ERISA Preemption Risk
3. Timeframe

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1. Funding

The issue: How can a Washington single-payer system be funded without constitutional or ERISA preemption problems?

- **Vermont and Oregon proposals: mix of payroll tax and increased income tax – PROBLEM: not possible in Washington since any income tax is unconstitutional.**
- **Washington Health Security Trust proposal: mix of payroll tax and "health security premium" for residents with incomes over 200 percent of FPL – PROBLEM: could be construed as a form of State income tax (and criticized as regressive if the premium is a fixed amount).**
- **SB5335 proposal: mix of 10.5 percent payroll tax and 8.5 percent tax on capital gains over $15,000 along with tax on sole proprietor income – PROBLEM: could be construed as a "tax on retirees" and in part as an unconstitutional State income tax.**

No detailed analysis of ERISA issues is feasible until the constitutionality of funding has been reviewed.

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2. ERISA Preemption Risk

The issue: ERISA preempts (i.e. overrules) any state regulation that "relates to" private employer sponsored benefits.

The US Supreme Court has not ruled specifically on whether a state single-payer plan would be preempted but has issued decisions which could imply how it might rule, including:

- **ERISA does *not* preempt pay-or-play regulations requiring employers to pay workers additional compensation unless they provide a minimum level of benefits[1] (but pay-or-play is not compatible with universal financing).**
- **ERISA does *not* preempt regulations that merely increase costs or change incentives for employer plans without forcing them to adopt any particular coverage scheme[2].**
- **ERISA does *not* automatically preempt regulations that impose additional taxes on employer plans, *but* there might be a point at which an "exorbitant" tax forcing a "Hobson's**

[1] ERIC v City of Seattle 2022
[2] Metropolitan Life v Massachusetts 1985

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choice" would be treated as a substantive mandate in violation of ERISA[3].

The expert legal opinion on Oregon's single-payer proposal claimed that it should not be preempted since, although payroll taxes based on a percent of wages would encourage a shift to the state single-payer plan, they would not reference any employer's plan nor require a change to an employer plan.

The legal opinion also noted that "the payroll taxes [of 7.25 to 10.5 percent] do not force the [Oregon] employer's choice of coverage or plan design." However, this fails to consider that on average only some 60 percent of employees nationally are currently covered even where benefits are offered and that some employers offer benefits that are significantly less generous than others.

While it is impossible to know how the Supreme Court might rule, employers with less generous current benefits and relatively low enrollment might well find exorbitant a tax based on universal coverage with generous benefits—*a combination that could double an employer's healthcare benefit expenses.*

[3] New York Blue Cross and Blue Shield Plans V. Travelers Insurance 1995

3. Timeframe

The issue: Assuming the UHCC concludes that inclusion of currently self-funded employees in a State single-payer plan would have a reasonable chance of *not* being preempted by ERISA, what may happen and when?

Three major steps will be involved:

- **First, the UHCC must complete its work with a final report to the Legislature, but it is unclear when this might occur. SB5399 specified no deadlines, and there is no UHCC workplan beyond a vague outline for 2023. However, the UHCC budget expires in 2025 so this may determine the timeline for the final report.**
- **Second, the Legislature must take action to create a single-payer plan. Appropriate legislation must pass the State House and Senate and be signed by the Governor. If this legislation is to be based on the UHCC final report, the earliest it could be passed is 2025 (and might well be delayed to 2026).**
- **Third, the single-payer legislation must survive court challenges. Given the potential impact of**

single-payer on insurers and on many businesses, such challenges are almost certain, and some are likely to focus on the ERISA preemption issue. A reasonable expectation is that an initial challenge will be filed in Federal district court, followed by an appeal by the losing party to the federal Ninth Circuit, and then potentially to the US Supreme Court, if the Court takes up the case.

Based on the recent City of Seattle ERISA case, the court process alone could take up to four years, meaning that the ERISA single-payer preemption issue might not be settled until 2029 or even 2030. (This timeline could be further extended if challenges to the constitutionality of the single-payer funding mechanism are first filed in State courts.)

Roger Collier is the retired 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.

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Tab 4

Washington State Health Care Authority

Finance Technical Advisory Committee (FTAC) Meeting Summary

May 11, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
3:00 p.m. – 5:00 p.m.

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

Members present

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

Members absent

Esther Lucero

Call to order

Pam MacEwan, FTAC Liaison, called the third meeting to order at 3:00 p.m.

Agenda items

Welcoming remarks

Pam MacEwan began with a land acknowledgement, reviewed the agenda, and shared the goals of the meeting.

Meeting Summary review from the previous meeting

Two revisions were submitted and shared onscreen to clarify language in the March 2023 meeting summary. Members present voted by consensus to adopt the meeting summary as amended.

Public comment

Kathryn Lewandowsky, RN, remarked on the political challenges in the current health care system and urged FTAC to focus on designing a non-profit universal health care system (and eventually, a single-payer system).

Cris Currie, retired RN, Health Care for All, recommended that the Commission begin engaging with federal authorities to enact legislation for necessary waivers and put Medicare decisions on hold for the time being.

Roger Collier asked whether a waiver is required for a Medigap option, how a direct reimbursement option would be funded, and asked about the likelihood of waiver approvals by lawmakers and Medicare enrollees.

Maureen Brinck-Lund noted that there has been little to no mention of single-payer design despite provisions in SB 5399 to do so, and urged the Commission to begin planning for waiver(s) submission to include federal funding.

Sarah Weinberg remarked that Medicare enrollees would find a universal system favorable relative to the current system and cautioned against using population-based payments or value-based payment arrangements.

Consuelo Echeverria suggested that the next five months be spent developing a single-payer model rather than considering the Employee Retirement Income Security Act of 1974 (ERISA).

Presentation

FTAC Member Christine Eibner, Senior Economist, RAND Corporation
It is important to include Medicare enrollees in Washington's universal health care system to achieve parity both in terms of cost sharing and benefit design. Six proposed options (and the pros and cons of each) were outlined to include Medicare enrollees in the universal system. Options were ordered from least feasible to most feasible.

Options 1 and 2 are variations on waivers. Option 1, an act of Congress/comprehensive waiver, would enable Washington to redirect federal funding for Medicare into the universal system. However, legal advisors to the state of California on this topic found no clear statutory or regulatory pathway enabling the Centers for Medicare and Medicaid Services (CMS) to redirect Medicare funds to a state, even via waiver.

Option 2 is a demonstration waiver, where Washington could develop a payment-focused reform with CMS to be implemented via a waiver, enabling the capture of federal Medicare funding. However, it is unclear how this could be used to cover premiums and cost-sharing or additional benefits. This option may also be subject to legal challenges and could create administrative burdens for the state.

Members discussed additional pros and cons of Options 1 and 2. FTAC Member Roger Gantz noted that budget neutrality is a key component of 1115a waivers. FTAC Member David DiGiuseppe noted that the Commission's 2022 report explored Medicare as a vehicle to lower commercial fee schedules and extract savings systemwide, and suggested that Option 1, although politically challenging, is the only option to achieve this objective. Christine Eibner remarked that Option 2 may also achieve that objective but would give the state less flexibility and control over the system. Maryland has implemented Option 2 to modify the fee schedule to achieve one rate. Roger Gantz suggested Option 1 as a north star and Option 2 as a potential pathway to a comprehensive waiver. FTAC Member Robert (Bob) Murray asked whether any of the options proposed were mutually exclusive. Christine Eibner responded that in general, some options could be combined. David DiGuiseppe was drawn to pursuing Option 1 or 2 in the long-term and potentially partnering with Oregon and California for leverage with CMS and Congress.

Options 3 and 4 are variations on a state-run Medicare Advantage (MA) plan. In Option 3, the state's MA plan would be the only option for Washington Medicare enrollees. To the extent that MA rules allow, this option could be designed to match the universal system. However, a waiver is needed to allow Medicare enrollees a choice between traditional Medicare and MA, and a mechanism to preclude private MA plans from entering the market. The state would need to apply to become a Medicare Advantage Organization (MAO) or contract with an existing MAO, adding administrative costs. Option 3 could be subject to legal challenges if enrollees were denied access to traditional Medicare.

Option 4 maintains Medicare enrollees' choice and the state could design and offer an MA plan with benefits parity to the universal system with fewer legal challenges. However, the state would still need to design and manage the MA plan in addition to the universal system, and MA pricing and benefit design requirements could limit flexibility. Again, the state would either need to apply to be an MAO, or contract with an existing MAO.

Members discussed additional pros and cons of Options 3 and 4. FTAC Member Eddy Rauser asked how either option would function out of state. Current MA rules would apply, and the existing MA delivery system would need to be contended with. Christine Eibner added that it would be difficult for the state to bid competitively enough to achieve benefits parity with the universal system. David DiGiuseppe posed that Option 4 could be a step towards a universal system where the state can gather more experience. Roger Gantz added that there is no existing infrastructure for the state to administer an MA plan. Pam MacEwan noted challenges in restricting consumer choice, though more value can be extracted from a plan when choice is restricted.

Option 5 is a state operated Medigap plan which could be offered by the state to achieve benefits parity between Medicare and the universal system. However, the Medigap plan must have one of 10 specific designs which would not include dental, vision, or drug coverage. Additionally, due to federal rules, this option could not cover the Medicare Part B deductible, nor be available to MA enrollees, nor recoup federal funding.

Under Option 6, the state would reimburse Medicare enrollees directly for Medicare cost-sharing and for services covered in the universal system but not covered by Medicare. However, since enrollees' Part B deductibles couldn't be covered, this option may invite federal scrutiny. This would also be administratively complicated and directly reimbursing enrollees for some services could cause MA carriers to shift rebates to non-reimbursable services.

Members discussed additional pros and cons of Options 5 and 6. Roger Gantz shared that the Medicare Savings Program (MSP) is an existing program that covers out-of-pocket costs for Medicare enrollees up to 100 percent of the federal poverty level (FPL) and could be used as a vehicle to achieve objectives under both Options 5 and 6. For Option 6, eligibility for dual Medicare-Medicaid coverage could be extended. The state could pay the difference for higher income individuals, giving the state flexibility to tailor the income threshold. Kai Yeung noted that Medigap plans would increase fee-for-service (FFS) usage. Roger Gantz stated that the universal system benefit design has not yet been designed which poses a challenge.

Regardless of the approach, it is important to maintain federal funding for low-income enrollees. Dual eligibility is available to low-income Medicare enrollees. The federal government also provides cost-sharing and premium subsidies for low-income Part D enrollees (low-income subsidy (LIS) status). Dual and LIS enrollees could be auto-enrolled and/or reassigned to lower-premium plans.

Introduction to FTAC Member vote

Liz Arjun, HMA

This vote is not about whether Medicare will be included in the universal system, rather it is intended to provide guidance to the Commission on options that allow the design process to advance while ensuring benefits parity for Medicare enrollees now. This vote is not binding forever.

FTAC Member vote: recommendations to the Commission regarding Medicare

Pam MacEwan, FTAC Liaison

Motion to recommend or not recommend Option 1, an act of Congress or comprehensive waiver at this time.

Roger Gantz recommended not pursuing Option 1 at this time due to timing and resources. Though, this is not to suggest that Medicare shouldn't be part of the comprehensive system. Members agreed and recommended that the new system design continue to be developed, recognizing that eventually Medicare will be part of it.

Motion to recommend or not recommend Option 2, a demonstration waiver at this time.
Christine Eibner recommended that Option 2 not be explored as a means to include Medicare enrollees, though this could be explored in the future to reduce costs. Bob Murray agreed, adding that this may be an option for a payment model and Members agreed.

Motion to recommend or not recommend Option 3, a state-operated MA and Part D plan as the only option for Washington Medicare enrollees.
Eddy Rauser questioned the feasibility in the short-term and Kai Yeung noted the significant administrative burden. Pam MacEwan added that this option also restricts Medicare enrollees' choice. Members agreed that the Commission should not pursue Option 3.

Motion to recommend or not recommend Option 4, a state-operated MA and Part D plan that would compete with private MA plans and traditional Medicare.
Kai Yeung noted the administrative burden and questioned the feasibility. Eddy Rauser posed whether this option would be an opportunity for the state learn more, though the state would be competing in a mature market. A majority of Members agreed that though there are several hurdles, this option warrants further examination and should not be taken off the table. Roger Gantz voted no on Option 4 at this time due to a lack of infrastructure/ capacity and potential for exposing the state to downside risks.

Motion to recommend or not recommend Option 5, a state operated Medigap plan.
Bob Murray supported this option, noting the greater political feasibility. Kai Yeung supported this as a short-term option, potentially pairing with Option 1 or 2 in the long-term. However, this option wouldn't apply to MA enrollees which may invite pushback from MA carriers. Eddy Rauser remarked that managed care enrollment has grown significantly, noting several considerations in transitioning to an FFS structure. Roger Gantz voted no on Option 5 at this time, recommending that the Commission continue to endorse the legislature's work to expand the MSP. Pam MacEwan was not supportive of Option 5 at this time, though supported further examination.

Motion to recommend or not recommend Option 6, directly reimbursing or insuring beneficiaries for gaps.
Members generally supported Option 6 with further examination by the Commission. This option could be combined with Option 1 or 2 in the future to support the Commission's long-term goals. Roger Gantz recommended getting a second opinion to analyze the politics of these options and that the Commission connect with Oregon to advance this work. There are existing pathways to move towards what Options 5 and 6 could accomplish.

Presentation

Liz Arjun, HMA
FTAC heard updates from the Commission's April meeting. FTAC's next topic after Medicare is ERISA eligibility. FTAC Members with expertise on ERISA and who could present to the Committee at the July meeting were encouraged to reach out to HCA.

Presentation: Creating and sustaining a universal health care system – introduction to system cost containment strategies

Bob Murray, Assoc. Health Services Researcher, University of California College of the Law, San Francisco.
Bob Murray presented several cost containment models in order of intensity from lowest to highest. Cost growth targets (used in Washington) set a maximum target for the rate at which total health care expenditures can increase in a year. This model provides some transparency and identifies cost drivers but is unlikely to be effective in controlling price growth.

As modeled by Rhode Island, affordability standards authorize the Office of the Health Insurance Commissioner to reject premium rate increases exceeding the consumer price index (CPI-Urban). However, there is no control over providers other than hospitals.

Out-of-network (OON) price caps are a maximum payment which applies when a patient obtains care from a provider outside their insurance network. This gives insurers leverage to negotiate lower in-network prices. This is a lower intensity approach because it regulates such a small sector of the market.

Hospital global budgets are a prospectively determined cap on annual revenues. Global budgets can be 100 percent fixed during a performance year (as done in universal systems in Europe and Canada) or semi-variable, e.g., flexible global budgets. Maryland sets fixed global budgets, which may incentivize shifting care to non-hospital providers or may increase wait times for emergency elective procedures as experienced in Europe.

Recently, prominent economists proposed a system of very high price caps. With this approach, it's recommended that limits on price growth (directed at commercial prices) are imposed. However, this is an intensive regulatory approach since price caps are set on all services. This requires significant data collection and compliance, and both regulatory and legislative authority. There is nuance to how this could be implemented.

A population-based payment system (PBP) is a highly integrated finance and delivery system designed to meet population-level cost and quality targets. This requires significant regulatory oversight. Kaiser is an example of a PBP model and may integrate well with a universal system.

Some of the more complex regulatory systems can be prone to regulatory failure, but states have to start somewhere. The Center for Medicare and Medicaid Innovation (CMMI) will soon propose a model for states to implement global budgets. Bob Murray advocated for a flexible approach to global budgets. Roger Gantz asked whether selective contracting has successfully constrained costs in other states. Bob Murray replied that West Virginia's system regulated commercial payers, setting a rate floor (based on providers' reported cost levels) and a rate ceiling. However, the program was not cost-effective because the rate of growth allowed was not restricted over time. This approach also doesn't control health care volumes. Kai Yeung asked why administrative burdens for price caps couldn't be reduced by implementing caps for services with high price variance. Bob Murray replied that this would still require a significant amount of data collection. Bob Murray offered to provide a more in-depth presentation on select cost containment models in the future.

Adjournment

Meeting adjourned at 5:11 p.m.

Next meeting

July 13, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

FTAC updates

Medicare recommendations

FTAC Medicare recommendations

Pam MacEwan,
FTAC Liaison

1. Act of Congress or comprehensive waiver
2. Demonstration waiver
3. State operated Medicare Advantage & Part D (MA-PD) plan as the only option for WA Medicare enrollees
4. State operated MA-PD plan that would compete with private MA plans and traditional Medicare
5. State operated Medicare supplemental insurance (Medigap) plan
6. Directly reimburse or insure Medicare enrollees for gaps

To: Washington Universal Health Care Commission (UHCC)

From: Finance Technical Advisory Committee (FTAC)

Re: Options for Addressing Medicare in the Universal Health Care Design

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Background

On May 11, 2023, at the direction of the UHCC, the FTAC continued their discussions on a number of options about how best to address Medicare in the universal health care system they are designing. The discussion followed presentations about other states' (Oregon and California) pursuits of a universal health care system, and a presentation from Chair Lowe about how the Jamestown S'Klallam tribe addressed coverage and cost-sharing gaps for Medicare enrollees in the system in place for Tribal members.

FTAC member Christine Eibner, PhD also provided an overview of the Medicare program and key gaps in affordability and access Medicare enrollees may experience if Medicare is not included in some manner in the universal health care system being contemplated in Washington. Dr. Eibner outlined six options to address these gaps for Medicare enrollees in Washington's universal health care system. This memo provides a summary of each option and FTAC's recommendation to the UHCC about these options.

Table 1 from Dr. Eibner's presentation shows the gaps in coverage and affordability challenges Medicare enrollees might experience compared with what they could experience under Washington's universal health system as envisioned by the Universal Health Care Work Group.[1]

UHC Goal	Medicare
No premiums	Premiums required for Parts B and D, and possibly Part C
No cost sharing for UHC options A and B*	Beneficiaries can face significant cost sharing
Would include vision care, and possibly dental and long-term care	Vision, dental, and long-term care not covered

Figure 1: Figure 1: Gaps in Coverage and Affordability for Medicare Recipients in Washington's Universal Health Care System

The six options presented to FTAC were ordered by what is considered the least feasible to the most feasible. There was time for discussion and questions throughout the presentation, followed by a poll of committee members about their support for each option. This memo summarizes each option followed by a brief synopsis of FTAC's discussion and recommendation about the option.

Options and FTAC Response

1. Act of Congress or comprehensive waiver

Option 1, involving an act of Congress or a comprehensive waiver granted by the Centers for Medicare and Medicaid Services (CMS) would allow Washington to enroll all Medicare enrollees into the UHCC

[1] The workgroup existed before to the creation of the Commission and conducted some preliminary analysis of universal health care options for Washington.

design and access the federal dollars that are allocated to cover these individuals. This was the option used to calculate potential costs and savings of Model A in the Universal Health Care Work Group. Access to federal dollars was a key advantage of this option, while the main disadvantages were that there is no legal precedent for this, and it is unlikely to be achieved via legislation in the current Congress. Moreover, Medicare enrollees may still experience some premiums.

FTAC Discussion

FTAC members were clear that Option 1 represents the "North Star" or ideal approach to addressing gaps in affordability and coverage for Medicare enrollees in the universal health care system but agreed that pursuing Option 1 **at this time** was not an effective use of resources or time due to the significant federal barriers and is unlikely to be successful. Members agreed that it was better for the UHCC to focus on designing the new system and find other transitional options to provide coverage and affordability parity for Medicare enrollees through some of the other options available rather than try to bring Medicare into the system from the outset. Some members pointed out that CMS is unlikely to grant a waiver to a new and untested program.

There was some discussion about the potential benefit of contracting with a law firm as California did to better understand what needs to be in place to obtain a federal waiver or possible legislative pathways. Finally, it was suggested that Washington should consider actively partnering with Oregon on Medicare and ERISA options when Oregon's new governance structure ("Oregon Universal Health Plan Governance Board") overseeing the universal health care system is established and operational.

2. Demonstration Waiver

Option 2 would involve the state seeking an 1115 Medicaid waiver or a 402b Medicare waiver. These waivers are generally focused on Medicaid-related payment and delivery system reforms (1115) or Medicare payment-related reforms (402b), must be cost-neutral to the federal government, not compromise the quality of the existing program, and do not provide options to incorporate Medicare into a state-administered program. This option would allow the state to capture Medicare funding, however because they are designed for other purposes, it is unclear how this option could be leveraged to cover premiums, cost-sharing or additional benefits for Medicare enrollees. These waivers involve significant oversight and evaluation by the state throughout implementation resulting in administrative costs and budget neutrality requirements. Additionally, there is no precedent for granting these waivers to achieve Washington's objectives. Finally, there is a possibility that even if granted by CMS, these waivers would be subject to legal challenges.

FTAC Discussion

FTAC members did not see this as a viable option for achieving the goals of the universal health care system given that the intent of these waivers differs from what the UHCC is trying to achieve. However, FTAC members noted that there were other issues that would need to be addressed in the universal health care system focused on payment and costs that could complement the work being done via the universal health care system. Other areas of potential opportunity for the UHCC to address payment reform include 2023 legislation (ESSB 5187, Sec.126(33) and Sec.144(13)) directing the Attorney General Office and Office of the Insurance Commissioner to study market consolidations and anticompetition and

hospital global budget strategies. It was also recommended that any payment reform activity should be done in consultation with the Health Care Cost Transparency Board.

3. State operated Medicare Advantage & Part D (MA-PD) plan as the only option for WA Medicare enrollees

This option would involve designing and implementing a MA-PD plan for Washington's Medicare enrollees that provided comprehensive benefits parity with the benefits in Washington's universal health care system. In this option, this would be the only option for Medicare enrollees in the state.[2] However, there were many disadvantages noted, including that allowing only one MA plan operated by the state would require a federal waiver from the provision that allows for choice, as well as a way to preclude new plans from entering the market. This option would also involve resolving that MA payments are pegged to a fee-for-service benchmark compared with whatever is used to establish payment rates in the universal health care system, including minimal flexibilities associated with benefit and pricing in MA plans. Another disadvantage to this option is the administrative costs for the state to develop and oversee or contract for an MA plan. Finally, this option could be subject to legal challenges if Medicare enrollees are not allowed to access traditional Medicare.

FTAC Discussion

FTAC members agreed that it was difficult to envision how the state could legally implement this option given the unlikeliness of obtaining a waiver that would limit freedom of choice, and that it didn't make sense to expend resources and time on this option, especially at the outset. Some members felt that there could be a pathway using this option at a later date once the value of the program has been established. It was however noted that the state could have downside risk, as the state would likely be reimbursed by CMS on a per-member-per-month basis. Finally, many expressed concerns about taking away choices from current Medicare enrollees by not allowing them to remain in traditional Medicare or in their current MA plans.

4. State operated MA-PD plan that would compete with private MA plans and traditional Medicare

Similar to Option 3, the state would design and operate a MA-PD plan. However, rather than it being the only option available to Medicare enrollees, this option would allow other private MA plans and traditional Medicare to continue and require the state's MA-PD plan to compete with them. It would involve the same scope of work to design and implement with many of the same limitations as Option 3 yet may not face as many legal hurdles because it does not limit Medicare enrollees' choice. However, this is the key disadvantage of this option because Medicare enrollees may choose the other Medicare options rather than the state operated MA-PD plan, limiting the potential federal dollars available and the overall impact.

FTAC Discussion

The FTAC response to this option was mixed, ranging from interested to medium-to-hard nos. The main concern with this option, in addition to the administrative burden of designing and implementing the

[2] There are currently 18 carriers offering 100 MA plan types.

model similar to Option 3, is the competition the state would face by entering a mature MA-PD market with 18 carriers offering over 100 MA plans, and that many Medicare enrollees would select other options and would be inclined to renew existing coverage. One FTAC member noted that the state could be at risk under this option and that it's unlikely that the legislature would be supportive. FTAC did not recommend this option being completely removed from the table and felt that there might be a possibility for this option to sit alongside Option 6 (direct reimbursement of insurance for gaps) in the future.

5. State operated Medicare supplemental insurance (Medigap) plan

Under this option, the state would develop and offer a Medigap plan that seeks to fill gaps in benefits between Medicare and the universal health care system. This option would allow the state to offer benefits to Medicare enrollees that exceed existing Medicare but would still be limited in what is included. Three key benefits that could not be included in the plan include hearing, vision, and supplemental drug coverage, however these benefits are likely to be included in the universal health care system design. Moreover, it would be limited in its ability to lower Medicare enrollees' Part B deductibles. A final disadvantage of this option is that it would not grant Washington access to federal Medicare dollars and would not be available to MA enrollees.

FTAC Discussion

FTAC members acknowledged that this option seemed the most feasible in terms of existing legal authorities and the least administratively burdensome to the state to implement. However, there were many concerns that this option could not fully address gaps between Medicare and any universal system because of the extensive and complex regulatory requirements of Medigap plans. Another issue raised was that similar to Option 4, this offering would enter a mature market and involve competition with other Medigap plans and would not leverage federal funds. There was some interest in this idea as a possible short-term option, potentially paired with Option 1 or 2 in the long-term. However, the majority of FTAC members did not support Option 5 at this time.

6. Directly reimburse or insure Medicare enrollees for gaps

The last option presented to address gaps in benefits and cost-sharing for Medicare enrollees involved establishing a system to directly reimburse enrollees for cost-sharing and for services covered by the universal system but not available in Medicare program. The advantages of this option are that it allows the most flexibility to fully address gaps and would not require waivers nor result in legal challenges. Disadvantages to this option included the potential variances between Medicare recipient choices, with federal rules potentially limiting the ability to wrap around Parts A&B. This option could also invite gaming from MA plans and may be administratively burdensome for the state and consumers. Finally, this option does not allow the state to leverage Medicare dollars as part of the system.

FTAC Discussion

FTAC members agreed that at this time, Option 6 presented the best option and most feasible pathway to address gaps in cost-sharing and benefits for Medicare enrollees. There was interest in learning more about the nuances of Option 6 and how it might be developed in the short-term to ensure parity.

Revisiting Option 6 with further analysis and decision-making will need to occur after the Commission has determined the services and benefits of the new universal health care system design. Until then, further analysis to determine what gaps need to be filled between existing Medicare services and benefits and the services and benefits of the new system design is not possible. It was also noted that federal dollars would not fund these additional benefits, placing the financial burden on the state.

Other Considerations

There were additional comments offered by FTAC members related to improving cost-sharing and services for existing Medicare enrollees, mainly through expanding eligibility for the Medicare Savings Program (MSP) and increasing eligibility for dual Medicare/Medicaid beneficiaries.[3] An additional option to expand services for low-income Medicare beneficiaries could be expanding Medicaid Categorically Needy Aged coverage, which would provide full scope Medicaid coverage, including long-term care. These additional comments were noted to inform the UHCC's future discussions about potential transitional solutions that improve coverage available for Washingtonians today that can help pave the way for the universal health care system of tomorrow.

[3] The 2023 legislature took action to expand the MSP by appropriating $6.3 million, removing asset tests and increasing the Qualified Medicare Beneficiary (QMB) program from 100 to 110 percent of the federal poverty level.

Medicare Recommendations

Commission Member Vote:

Motion to adopt FTAC's Medicare recommendations.

Vicki Lowe, Chair

Tab 5

Washington State Health Care Authority

Washington Universal Health Care Commission

Jon Kromm, Gary Cohen, Liz Arjun - HMA

June 13, 2023

Guidance to FTAC

ERISA

Guidance to FTAC on ERISA

The following emerged at the Commission's April meeting:

- "Pay or play" option where employers have a choice to continue providing coverage to employees, and
- An option where employers pay into the universal system and employees are covered by the universal system
- How ERISA law has evolved, areas of the law that are unchanged since the last analysis done on the topic, and any new approaches with potential areas of opportunity.
- Since employer funding contributions may be optional, FTAC could examine how any employer contributions could be captured under the various ERISA eligibility options (and estimated dollar values or each option) to fund the new system.

Are there any additional questions to consider at this time?

Tab 6

Washington State Health Care Authority

HCA's health equity toolkit
A potential framework for the Commission

Quyen Huynh, Health Equity Director

Presentation to the Universal Health Care Commission

June 13, 2023

Washington State Health Care Authority

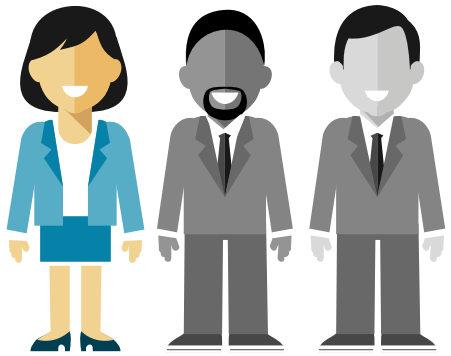
Equity Innovations in State Agencies

Quyen Huynh, DNP, FNP, ARNP, FAAN
Health Equity Director

Washington State Health Care Authority

Health Care Authority (HCA)

We purchase care for 1 in 3 non-Medicare Washington residents.



- HCA is the largest health care purchaser in Washington State. We serve more than 2.5 million people through our:
  - Apple Health (Medicaid) program
  - Public and School Employees Benefits Board (PEBB and SEBB) programs
- We also provide behavioral health services to all residents of Washington State, regardless of insurance.
- Through a wide range of programs and initiatives, HCA ensures Washington residents have access to better health, better care, and lower costs.

Washington State Health Care Authority

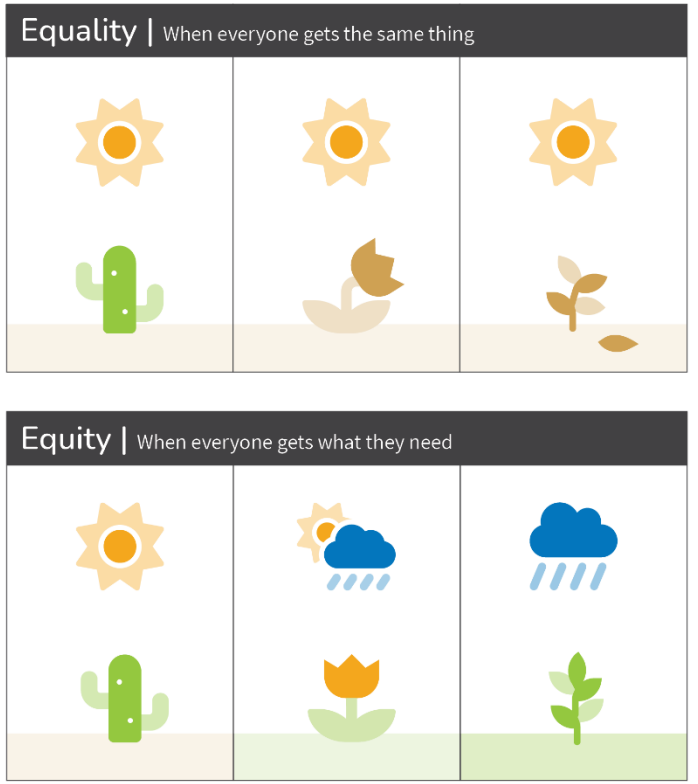
HCA cont'd

- Our approach to health care purchasing:
  - Transforming care: better health and better care at a lower cost
  - Whole-person care: integrating physical and behavioral health services
  - Using data-informed evidence to make purchasing decisions
- Health equity is at the center of our vision, mission and strategies.

Health equity means that everyone has a fair and just opportunity to be as healthy as possible.

This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

What is health equity?



Timeline

What we've accomplished through 2022

2013

Launched the Health Home program in collaboration with DSHS

2014

Began implementing a value-based purchasing approach (paying for quality of care rather than quantity of care)

Received State Innovation Models (SIM) planning and test grants to transform Washington State's health care system

2015

Stood up Accountable Communities of Health as separate, regional entities and developed ACH network

2016

Began implementing Medicaid Transformation Project (MTP)

2018

Division of Behavioral Health and Recovery became part of HCA

2019

Launched School Employees Benefits Board program coverage

Launched COFA Islander coverage

2020

Fully integrated physical and behavioral health statewide

2021

Hired Health Equity Director

Launched the Collaborative Community for Health Equity

Implemented health equity liaison role and liaison committees

2022

Submitted application to renew MTP, which includes specific health equity components

Created a health equity video for nurse leaders in partnership with Washington Center for Nursing

Began Pro-Equity Anti-Racism (PEAR) work

Created the PEAR Community Advisory Team to hear from community members on how HCA's services and programs impact them

Washington State Health Care Authority

How HCA supports health equity

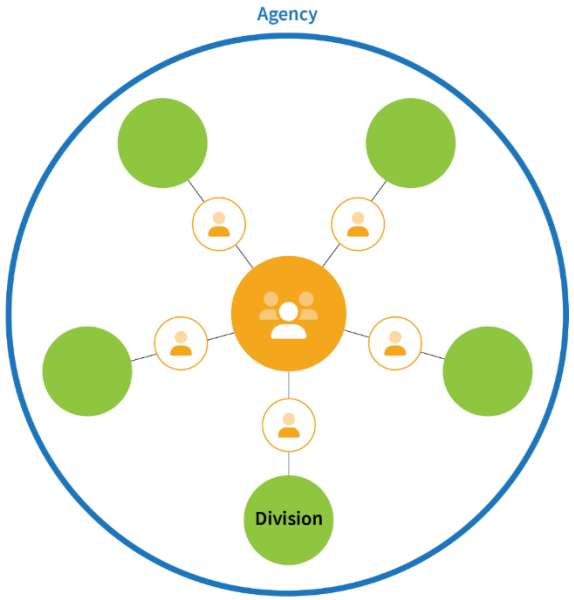
Some background on building our infrastructure and other internal efforts

Washington State Health Care Authority

Building our infrastructure & other internal efforts

Health equity liaisons and committees

Liaisons play a key role in advancing HCA's goal of exemplifying a culture of health equity. They serve as a bridge for their division and help connect our health equity work across the agency. Each HCA division has at least one liaison.



- 2021:
  - **Health Equity Director position established**
  - **Health equity liaisons:**
    - Serve as a bridge for their division and connect our health equity work across the agency.
    - Are responsible for communication, training, and alignment of their division's equity efforts across HCA.
    - Serve on a health equity liaison committee.

Washington State Health Care Authority

Building our infrastructure & other internal efforts, cont'd

- Updated **all employee's position descriptions** to say:
  - *HCA employees will apply an equity lens to their work, which may include but is not limited to all analyses of core business and processes.*
- Created our **Health Equity Toolkit**, which helps HCA apply a health equity lens to our actions, job functions, policies, programs, and services.
  - Using an equity lens means evaluating something for inequitable health impacts on groups of people.
  - The toolkit us identify and address health disparities in the work we do, including legislative bill analysis.

Building our infrastructure & other internal efforts, cont'd

- Created an **internal equity inventory and Equity Inventory Dashboard.**
  - Allows us to collect, track, and view all health equity and diversity, equity, inclusion, and belonging (DEIB) work taking place at HCA.
- Established the **Collaborative Community for Health Equity.**
  - Put on by the Process Design health equity liaison committee.
  - Open to all HCA employees to learn, ask questions, and share resources.
- Developing and sharing **health equity training** with all HCA employees.

Pro-Equity Anti-Racism (PEAR)

- 2022: Governor Inslee issued Executive Order 22-04: Implementing the Washington State PEAR Plan & Playbook.
- Establishing a pro-equity and anti-racist culture:
  - PEAR Team
    - Collection of HCA divisional leadership and health equity liaisons
  - PEAR Community Advisory Team (CAT)
    - Group of community members who share input on how HCA's programs and services impact them and their communities
  - PEAR workstreams
    - Made up of PEAR Team members, HCA divisional leadership, and agency subject matter experts.

About HCA's workstreams

- Engagement & Community Partnerships
- Data Strategy & Reporting
- Leadership & Operations
- Workforce Equity

How our internal efforts are stoking external results

How we're applying our health equity efforts
to benefit the people of Washington State

Washington State Health Care Authority

HCA & health equity

- HCA is making intentional efforts to address health equity and DEIB in all our practices. We are:
  - Applying a health equity lens to programs and HCA's books of business:
    - Health insurance programs, such as Apple Health (Medicaid) and School & Public Employees Benefits Boards (SEBB & PEBB)
    - Prevention, treatment, and recovery behavioral health programs
    - Medicaid Transformation Project (MTP) waiver renewal
    - Managed care organization (MCO) re-procurement
    - Value-based purchasing
    - Efforts to lower health care costs for consumers and increase transparency
    - Eliminating Hepatitis C
    - Contracting language and processes
    - HCA policies, such as Plain Talk

SDOH initiatives

- Integrated eligibility
- Identifying need
  - Managed care organization (MCO) screenings
  - Measuring disparities in quality measures
  - Billing guidance for health-related social needs
  - Z-codes (used to document social determinant of health data)
- Financial incentives (e.g., the Medicaid Quality Improvement Program)

SDOH initiatives, cont'd

- Coverage of services
  - Traditional: transportation, interpreter services, Health Homes
  - Newer: Foundational Community Supports for housing and employment, medical respite
    - MCO value-added benefits (car seats, gym memberships, etc.)
- The Medicaid Transformation Project (MTP) waiver
  - Equity investments
  - Community information exchange
  - Community Hubs
- Doula services

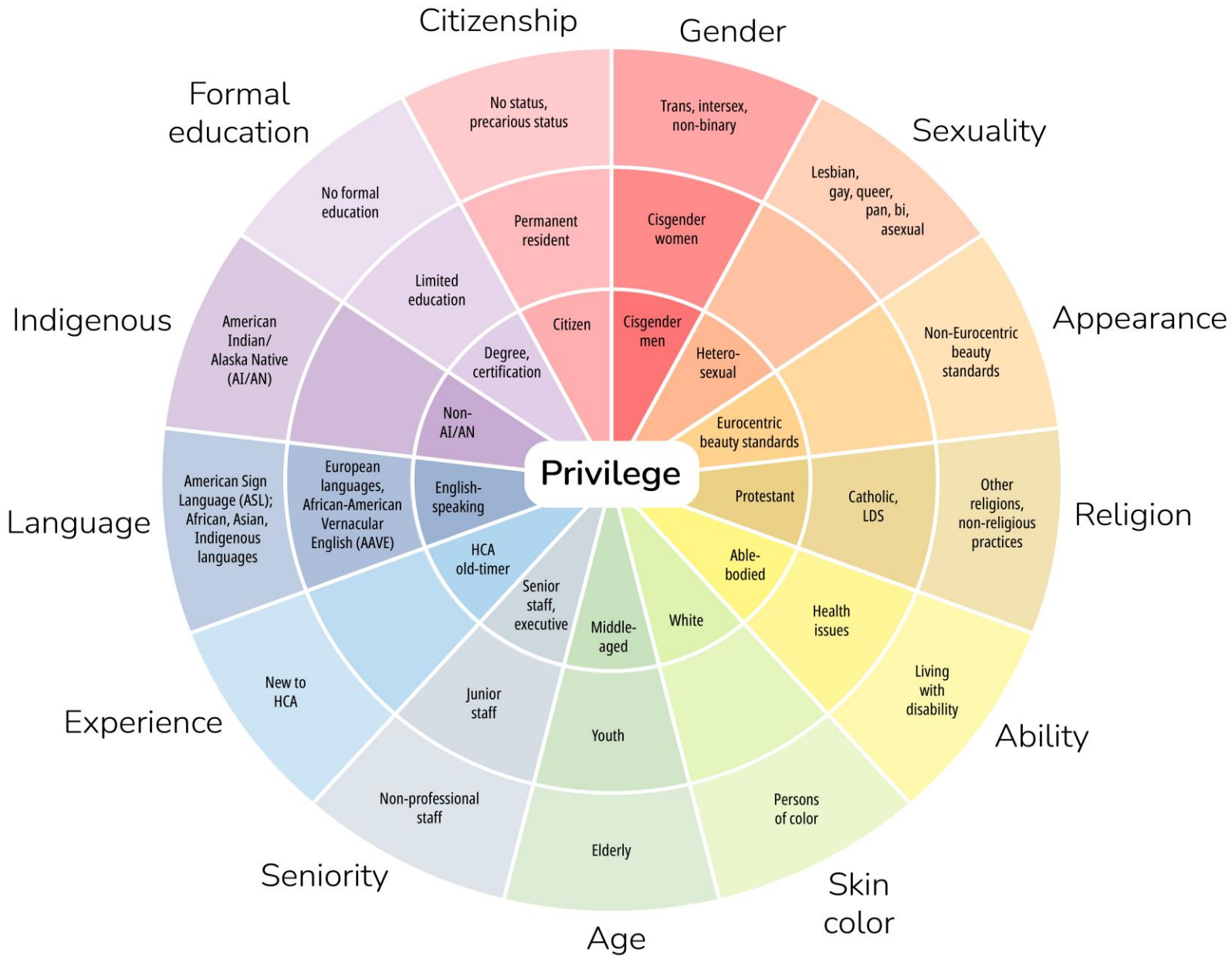
HCA & health equity, cont'd

- Multi-sector collaboration
  - Governor's Interagency Council on Health Disparities
  - Department of Health's (DOH's) Health Equity Zone
  - Health and Human Services (HHS) Interagency Equity Collaborative
  - BREE Collaborative
  - Center for Health Care Strategies – health equity
  - Exploring Funding Mechanisms for Community Engagement & Compensation
- Multistate learning collaboratives
  - Recommendations on best practices for state Medicaid agencies in all 50 states
- Tribal implications

Working differently to build & sustain equity

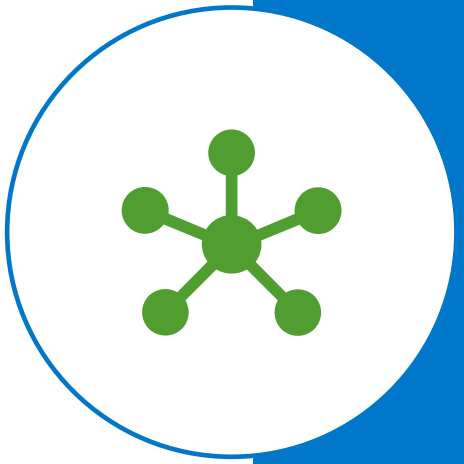
Centering diversity, equity, inclusion and belonging (DEIB) at the state Medicaid agency level

Washington State Health Care Authority


Citizenship
Gender
Formal education
Sexuality
Indigenous
Appearance
Language
Religion
Experience
Ability
Seniority
Skin color
Age
Privilege
No status, precarious status
Trans, intersex, non-binary
No formal education
Lesbian, gay, queer, pan, bi, asexual
Permanent resident
Cisgender women
Limited education
Non-Eurocentric beauty standards
American Indian/ Alaska Native (AI/AN)
Citizen
Cisgender men
Degree, certification
Hetero-sexual
Non-AI/AN
Eurocentric beauty standards
American Sign Language (ASL); African, Asian, Indigenous languages
European languages, African-American Vernacular English (AAVE)
English-speaking
Protestant
Catholic, LDS
Other religions, non-religious practices
HCA old-timer
Able-bodied
Senior staff, executive
Middle-aged
White
Health issues
Living with disability
New to HCA
Junior staff
Youth
Persons of color
Non-professional staff
Elderly

Centering DEIB at Medicaid agencies

- **Why and how:**
  - Impacts of policies:
    - Well-intentioned policies sometimes do not achieve pre-determined goals.
    - Communities most impacted are often not involved/elevated, certainly not from the onset.
    - Those with lived experience are the true experts.
- Barriers:
    - Requires resources to change infrastructures & systems
    - It may take longer “at the pace of community.”
    - It requires redistribution of power
- Commitment to equity requires culture shift
    - Does a rising tide lift all boats?
    - Culture eats strategies



Equity takes time

- We spent centuries building this system, it will take more than a few years to redesign it.

Contact me

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Health Equity Director
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Washington State Health Care Authority

Health equity toolkit

The new Washington State Health Care Authority (HCA) health equity policy No. 1-36 requires all analyses of core business and processes, including bill analysis and issue papers, to include an equity lens.

To assist in implementing this policy, HCA has created this health equity toolkit that all employees can access and use to guide their work.

Foreword

This toolkit is a guide to help employees apply an equity lens to their work and will continue to be transformed according to the needs of the agency. The HCA health equity team recognizes that parts of this toolkit may not be useful or applicable for some staff and divisions. Thus, we will rely on the collective wisdom of our health equity liaisons from all 18 divisions to help us transform and add to this document over time so that it can be useful for all.

Additionally, each divisions' health equity liaison, under the guidance of the Health Equity Director, will build division-specific tools relevant to the functions of their divisions. This toolkit serves as an overarching, high-level guide and as the umbrella under which the individual divisions' tools will reside. In this way, HCA will work together across and within our divisions and programs.

Definitions

Equity lens

Equity lens means to evaluate an action, policy, or program for disparate or inequitable health impacts on people when they are grouped into categories including (but not limited to):

- Age
- Disability
- Gender, gender identity, sex, sexual orientation, or marital or pregnancy status
- Employment, employment status, or access to sustainable job opportunities
- Housing, housing status, access to safe and affordable housing, or housing location
- Income level, education level, or socioeconomic status
- Language preference or English proficiency
- National origin, citizenship, or immigration status
- Race, ethnicity, or color
- Religion or creed
- Veteran or military status

Health disparities

Health disparities refer to avoidable differences in health outcomes experienced by people with one characteristic (race, gender, sexual orientation) as compared to the socially dominant group (e.g., white, male, cis-gender, heterosexual, etc.). Measuring disparities can help benchmark progress toward equity.

Health equity

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[1]

[1] Adopted from the Robert Wood Johnson's definition of health equity

Health inequity	Health inequity refers to health disparities that are unfair and unjust without comparison to another group. An equity frame connects the dots between disparate outcomes and the disparities in power and privilege in which they are rooted. Focusing on disparities can lead to the assumption that one group's behavior, intelligence, or genetics are the cause of any differences. Focusing on inequities draws attention to the root causes of these differences.
Intersectionality	Intersectionality is a framework for understanding how multiple social identities such as race, gender, sexual orientation, and disability intersect to reflect interlocking systems of privilege and oppression (i.e., racism, sexism, classism). The term refers to the interconnected nature of social categories that can create overlapping systems of discrimination or disadvantage.[2] One person might fit into several categories (e.g., transgender veteran, or pregnant person who is experiencing homelessness).
Social determinants of health	Social determinants of health are the conditions in which people live, work, play, pray, and age and that affect health. Social determinants of health encompass multiple levels of experience from social risk factors (such as socioeconomic status, education level, job opportunities) to structural and environmental factors (such as structural racism, poverty, and localized air and water pollution created by economic, political, and social policies). Social determinants of health contribute to wide health disparities and inequities. For example, lack of access to grocery stores with healthy foods is an obstacle to good nutrition, which raises the risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who have access to healthy foods.[3]

Health equity lens tool

Purpose

The purpose of a health equity lens tool is to:

1. Identify potential unintended health impacts (positive or negative) of a planned action, program, or policy on the people we serve;
2. Develop recommendations to mitigate negative outcomes and to maximize positive outcomes on the health of people who experience health inequities;
3. Embed equity across HCA's existing and prospective decision-making models, so that it reflects our core value;
4. Support equity-based improvements in program, service design or resource allocation;
5. Raise awareness about health equity as a catalyst for change throughout the organization.

While the tool can be applied to individual policies, programs and initiatives at the micro level, it can also be applied to processes and policies at the macro level.

Process: How to use this tool

As policies and programs are being designed, reviewed, or implemented, HCA staff and leadership will:

1. Apply this equity toolkit by answering all appropriate questions;

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[2] Adapted from *The Problem with the Phrase: Women and Minorities: Intersectionality—an Important Theoretical Framework for Public Health*, American Journal of Public Health, June 2012

[3] Adapted from Healthy People 2030: https://health.gov/healthypeople/objectives-and-data/social-determinants-health, Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services; and Promoting Health Equity in Medicaid Managed Care: A Guide for States: https://www.shvs.org/wp-content/uploads/2021/09/Promoting-Health-Equity-in-Medicaid-Managed-Care_A-Guide-for-States.pdf, State Health and Value Strategies

2. Consult with health equity liaisons, other health equity entities, resources within and outside the agency, and leadership;
3. Eliminate the inequities or, at the minimum, mitigate negative outcomes by making changes to the programs or policies;
4. Report potential negative outcomes/inequities and program and policy changes to appropriate leadership;
5. Disseminate and communicate learned lessons.

The tool

Please answer all these questions to the best of your ability. If you feel uncertain about your assessment or feel like the tool/questions do not apply to your work, then it might be helpful to talk through this assessment and its application with your division's health equity liaison.

The action

1. What is the action/program/policy being considered?
    a. What is the scope (e.g., budget, policy, program)?
    b. What is the intended outcome?
    c. Who is the executive sponsor for this action/program/policy?
    d. Is there a target population? If yes, how and why was the target population selected?
    e. What quantitative and qualitative data was used to support the need for this action/program/policy?
    f. What current health disparities and health inequities exist around this issue? In addition to health outcomes, consider access to services or resources and social determinants that might be driving the health outcomes?
    g. How easy or hard would it be to reverse or modify the action/program/policy should there be unintended consequences which further inequities and/or cause harm?

Accountability and bias

2. Who is accountable for the action/program/policy?
    a. Who is involved in the action/program/policy?
    b. What biases might the accountable party hold?
    c. Have alternative perspectives been taken into account?
    d. How is the outcome of the assessment being communicated?
3. Analysis, monitoring, and mitigation of outcomes[4]
    a. What are the intended outcomes and possible unintended outcomes of the action/program/policy? (Consider the various social determinants of health that may be present.)
    b. Will any groups or communities disproportionately benefit from the action/program/policy?
    c. Will any groups or communities experience unintended consequences or greater burden, or be left out by this action/program/policy?
    d. Given the above, will the action/program/policy worsen or ignore existing health disparities or health inequities?
    e. If the action/program/policy may have negative impacts on multiple types of groups, consider the multiplier effects for individuals who fall into multiple groups (see definition of intersectionality above).
4. What can and should be done to monitor and mitigate unintended harmful outcomes?
    a. How is the action/program/policy being monitored for harmful outcomes once it has been implemented?
    b. What quantitative and qualitative data are to be used to monitor outcomes?
    c. What is the strategy to mitigate harmful outcomes before they occur? After they occur?

[4] Adapted from the Health Equity Impact Assessment, Ontario Ministry of Health

d. What is the strategy to mitigate the compounding of harmful outcomes on intersectional individuals?

Community engagement

5. How were different communities engaged in the development of this action/program/policy?
    a. Which communities or populations will be most affected? Consider different social determinants of health.
    b. Were known obstacles to health equity considered, such as structural racism or sexism?
    c. Which members of these communities or populations have been informed, involved, and represented in the decision-making process? If none, why?

Tribal implications

6. Are there tribal implications for this action/program/policy?
    a. What data or analyses were used to determine whether there are tribal implications?
    b. If there are tribal implications, was the Office of Tribal Affairs consulted?

    Note: A slightly different analysis is necessary for identifying tribal implications, because the Indian health care delivery system is very different from other health care systems and because federal and state laws require HCA to collaborate with tribes and Indian health care providers as partners.

End result

7. What recommendations will you make based on this assessment?
    a. What needs to change in the proposed action/program/policy to ensure equity?
    b. Who is responsible for implementing these changes?
    c. What competing interests, external to HCA, may influence the ability of the recommendations to be taken?
    d. How will the assessment findings and final decision be communicated back to those most affected by the decision?
    e. Were learned lessons disseminated, communicated or applied to other efforts within HCA?

Additional resources

- Inside HCA Health equity webpage
- Inside HCA Diversity and inclusion webpage
- Hca.wa.gov Health Equity webpage
- What Is The Equity Lens? Multnomah County (Oregon) Office of Diversity and Equity
- Health Equity Impact Assessment, Ontario Ministry of Health
- Healthy People 2030, Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services
- Promoting Health Equity in Medicaid Managed Care: A Guide for States, State Health and Value Strategies

Equity framework

Commission Member Vote:

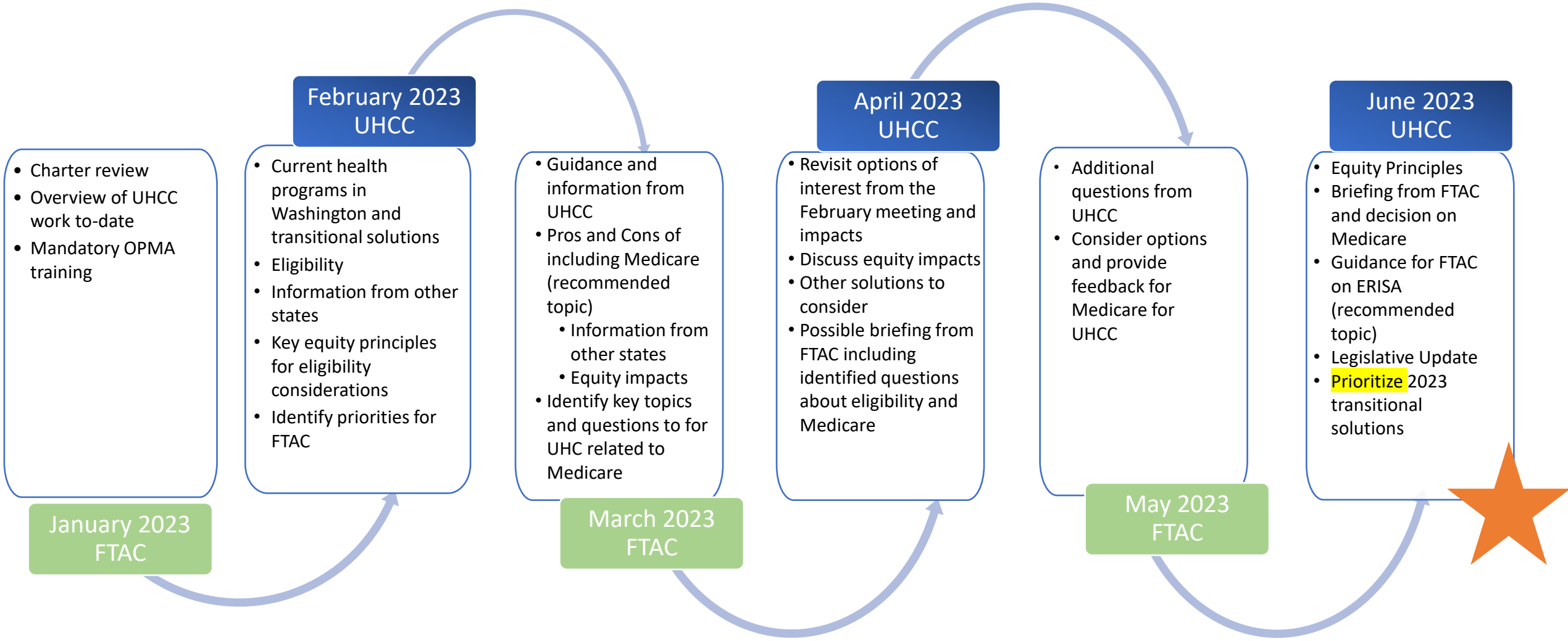
Motion to adopt this equity framework and apply this framework to recommendations made by the Commission

Vicki Lowe, Chair

Tab 7

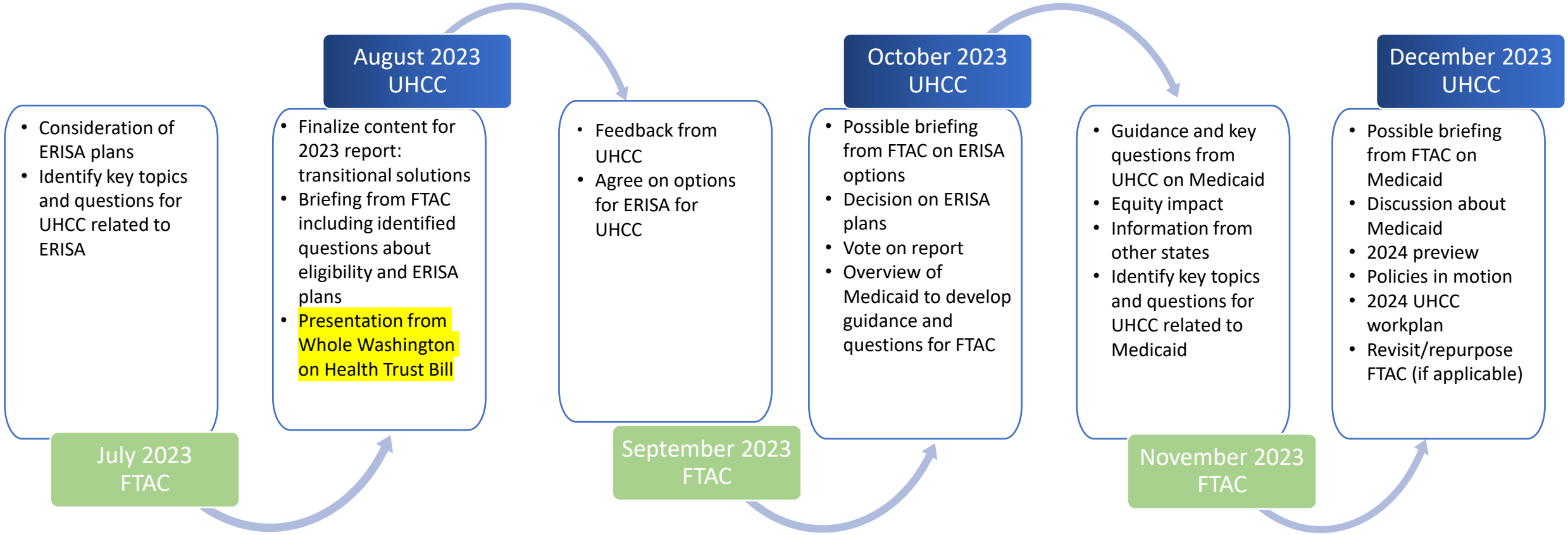
Washington State Health Care Authority

Washington's UHCC 2023 Workplan



Workplan will change depending on progress made in each meeting

Washington's UHCC 2023 Workplan



Workplan will change depending on progress made in each meeting

Addressing the Washington Health Trust Bill (SB 5335) in the Workplan

- Cross-walked the legislation to components UHCC is evaluating to identify key questions that relate to each:[1]

Phase 1: Foundational

- Eligibility
- Benefits & Services
- Provider Reimbursement & Participation
- Cost Containment

Financing

Phase 2: Secondary

- Infrastructure
- Enrollment Processes

Phase 3: Tertiary

- Governance

1 Some components, such as governance, will be woven throughout and other components may overlap

- Whole Washington to present overview of legislation at August meeting
- Some transitional strategies for consideration
- Beginning in 2025, and until the analysis is complete, each report to the Legislature will summarize how the Washington Health Trust Bill would address key components

Tab 8

State agency report out
2023 legislative session

Washington State Health Care Authority

2023 Legislative Session Recap

Evan Klein, Special Assistant
Legislative and Policy Affairs

Washington State Health Care Authority

2023 HCA priorities

- Continuing investments in the behavioral health delivery system
- Building equity through health care access and transformation
- Payment and delivery system transformation
- Technology investments for care coordination
- Prescription drug affordability

Themes

- Behavioral Health Workforce
- Opioid response
- Crisis & diversion
- Affordability
- Hospital financing
- Coverage expansion

Apple Health Expansion

- Expands coverage to adults ineligible for Medicaid or federal subsidies by reason of immigration status
  - Coverage will largely mirror adult Medicaid benefit
  - Must be age 19 or older, not eligible for federal subsidies or Medicaid, and under 138% FPL
- 2022 Operating Budget directed HCA to begin implementation and planning
- 2023 Operating Budget provided $46M in program funding to implement coverage beginning July 1, 2024

Reimbursement Increases

- Behavioral health rate increases
  - Managed care
  - Fee-for-service
  - Provider rates
- Applied Behavior Analysis rates
- BH residential room and board
- Air ambulance
- Professional services
- Children's dental
- Psychiatric per diem rates

Coverage Changes

- Adult acupuncture coverage
- Adult chiropractic coverage
- Adult cochlear implant coverage
- Adjusted hearing aid benefit – HB 1222

IT Infrastructure Investments

- Master person index
- Integrated enrollment and eligibility (*DSHS*)
- Electronic health records (*WATECH*)
- *Community information exchange*

SHB 1850 – Hospital Safety Net

- Current Hospital Safety Net Assessment (HSNA) program expires July 1, 2025
- Assess hospitals at differential rates, based net non-Medicare inpatient and outpatient revenue
- Directs HCA to implement a Directed Payment to promote equitable distribution of care by increasing payments to MCOs to increase reimbursement to designated hospitals
- Establishes a distressed hospital grant program

HB 1269 – Rx Affordability Board

- Prescription Drug Affordability Board (PDAB) – established in 2022 (RCW 70.405)
- **HB 1269** would have lowered the threshold for Rx review from:
  - $60k to $25k per year;
  - An increase of 15% to an increase of 10% per year; or
  - An increase of 50% to an increase of 25% every 3 years.
- Proposed elimination of delays in adoption of rules and upper payment limits
- Proposed UPL disregard for drugs used to treat a rare disease if access was impacted

HB 1508 – Cost Transparency

- Health Care Cost Transparency Board (HCCTB) established in 2020 (RCW 70.390)
  - Reviews annual cost growth & cost drivers
  - Sets growth target for state
- HB 1508 proposed to:
  - Expand the advisory committee structure to the HCCTB
  - Enforce the cost growth benchmark through performance improvement plans and civil penalties
  - Require an underinsurance survey and tax preferences study

Questions

Contact:

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Washington State Health Care Authority

2023 Legislative Session Overview

Washington Health Benefit Exchange
May 2023

Joan Altman (she/her)

Director of Government Affairs and Strategic Partnerships

washington healthbenefitexchange
powering washington healthplanfinder

Exchange Strategic Plan Priorities

- Improve health coverage, affordability, care and outcomes
- Advance diversity, equity and inclusion to narrow health disparities, especially in communities of color
- Leverage the success of HPF technology platform to strategically expand offered services
- Expand innovative approaches to drive health system excellence

2023 Exchange Legislative Priorities

- Increase the availability of quality, affordable health coverage in the individual market
  - Continue state's $55M annual investment in Cascade Care Savings beyond fiscal year 2024

- Expand coverage and reduce disparities
  - Continued support for the launch an implementation of state's new 1332 waiver, including for outreach and community engagement work
  - Continued support for statewide assister network, including an expansion to reach populations who continue to experience disparities in coverage rates and support for additional health literacy efforts (materials development, translations, etc.) to enable people to better understand how to enroll in, use, and pay for their health insurance.

- Continue focus on Healthplanfinder technology and improved consumer experiences
  - Support for Washington Healthplanfinder updates and improvements that were delayed last biennium due to our focus on responding to the COVID pandemic and preparing for the launch of Cascade Care Savings.
  - Continued support to ensure Healthplanfinder is a flexible, accessible, and modern system

- Secure resources needed to operationalize ongoing federal (e.g., Medicaid unwind) and state (e.g., Cascade Care) legislative directives

2023 Budget Highlights

Cascade Care Savings

- Secured $110M for Cascade Care Savings for 2023-2025 biennium
- Will improve affordability for those losing Apple Health (Medicaid) during the unwinding, and those newly eligible for coverage under the 1332 Waiver

Expand Coverage & Reduce Disparities

- Secured $3M for activities that will support for the launch an implementation of state's new 1332 waiver, and $1M for additional equity efforts including tribal support and increased language access and translation

Healthplanfinder technology and improved consumer experiences

- Secured resources to support implementation of federal and state priorities, and to ensure *Healthplanfinder* can remain a flexible, accessible, and modern system

2023 Policy Highlights

Apple Health Expansion

- $46M funding to HCA for a new mirrored Apple Health program for uninsured individuals currently ineligible for Medicaid due to their immigration status (up to 138% FPL).
- Program starts July 1, 2024. Exchange is a key implementation partner.

Coverage & Cost-Sharing Mandates

- Bills passed that required review of new essential health benefits (OIC); require coverage for hearing instruments and colorectal screening; and prohibit or limit cost-sharing for certain services.

Cost Containment Bills

- Bills to expand the scope of the health care cost transparency board and the prescription drug price accountability board, to prohibit anti-competitive clauses in provider contracts, and review and report impacts of mergers and acquisitions did not pass.

Data Privacy Bills

- Bills passed to protect consumer health data and personally identifying information, prohibiting solicitation via robocalls, and ransomware protection.

Exchange Bills of Interest (Passed)

Coverage Mandates	
SSB 5338: Essential health benefit. (Cleveland)	Directs OIC to review essential health benefits benchmark health plan for possible modification and study impacts of including coverage for certain new benefits. (Assumption: benchmark update submission in 2024 for plan year 2026.)
HB 1626: Colorectal screening tests. (Bronoske)	Requires medical assistance programs to cover noninvasive preventive colorectal cancer screenings and colonoscopies performed from a positive test result beginning Jan. 1, 2024.
ESHB 1222: Hearing instruments coverage. (Orwall)	Requires non-grandfathered, large group health plans to cover hearing instruments and modifies current coverage requirements for public employee health plans starting Jan. 1, 2024.
Cost Sharing Mandates	
SB 5242: Abortion cost sharing. (Cleveland)	Prohibits cost sharing for abortion for health plans issued or renewed on/after Jan. 1, 2024.
SSB 5300: Behavioral health continuity. (Dhingra)	Prohibits health plans and state purchased health care programs from substituting nonpreferred drugs behavioral health or serious mental illness prescriptions starting Jan. 1, 2025.
SSB 5396: Breast exam cost sharing. (Wilson, L.)	Prohibits cost sharing for diagnostic and supplemental breast exams for non-grandfathered health plans issued or renewed on/after Jan. 1, 2024.
SSB 5581: Maternal support services. (Muzzall)	Requires OIC, in collaboration with carriers, to develop strategies to reduce or eliminate deductibles and other cost sharing for maternity care services, including prenatal care, delivery, and postpartum care.
SSB 5729: Insulin cost sharing cap. (Keiser)	Removes the expiration date for the requirement of health plans to provide coverage for prescription insulin drugs for diabetes treatment capped at $35 per 30-day supply.

Exchange Bills of Interest (Passed)

Cost Containment	
E2SHB 1357: Prior authorization. (Simmons)	Updates requirements for prior authorization processes for private health insurance, PEBB, SEBB, and Medicaid; expands reporting requirements to include prescription drug data authorization.
Health Care Oversight	
SSB 5121: Health care and behavioral health oversight committee. (Cleveland)	Expands scope of work to include behavioral health and extends the expiration date of the Joint Select Committee on Health Care Oversight to Dec. 31, 2026.
Hospital Financing	
SHB 1850: Hospital safety net. (Macri)	Revises the hospital safety net program (formerly hospital safety net assessment) to require annual assessments on in- and outpatient services, changes the payment amount to hospitals, and creates a Medicaid directed payment program for public hospitals.
Data Privacy	
ESHB 1051: Robocalls and telephone scams. (Leavitt)	Updates statutes prohibiting commercial solicitation using an auto-dialer.
ESHB 1155: Consumer health data. (Slatter / AGO)	Regulates entities that collect, process, share, and sell consumer health data and establishes consumer rights. (HBE exempt.)
ESHB 1335: Personal identifying information. (Hansen)	Prohibits publication of personal identifying information without the express consent of the subject with the intent to harm. (HBE exempt.)
2SSB 5118: Cybersecurity / ransomware. (Boehnke)	Requires Military Dept. and WaTech to establish committees to develop recommendations to strengthen cybersecurity in public and private critical infrastructure sectors.

Exchange Bills of Interest (Did Not Pass)

Coverage Mandates	
HB 1450: Biomarker testing. (Stonier)	Requires private insurance and PEBB/SEBB plans to cover biomarker testing for plans issued or renewed on/after January 1, 2024.
HB 1151: Fertility services. (Stonier)	Requires large group health plans to cover the diagnosis of infertility, treatment for infertility, and standard fertility preservation services.
HB 1079: Whole genome sequencing. (Thai)	Requires HCA to require coverage under medical assistance programs for rapid whole genome sequencing for enrollees up to age one.
Cost Sharing Mandates	
HB 1356: Biosimilar medicines. (Reeves)	Clarifies that health, health carriers, or prescription drug utilization management entities are not prevented from requiring a patient try an interchangeable biological or biosimilar product prior to providing coverage for the equivalent branded prescription drug.
HB 1465: Prescription cost sharing. (Riccelli)	This bill would require health plans issued or renewed on/after January 1, 2025, to decrease cost sharing for prescription drugs by passing savings through to the enrollee at the point of sale..
HB 1725: Insulin access under 21. (Riccelli)	Prohibits cost sharing for insulin for enrollees under age 21 for health plans issued or renewed on/after Jan. 1, 2024, upon launch of a copayment offset program administered by HCA.
SB 5580: Maternal support services and postpartum care. (Muzzall)	Increases the federal poverty level requirement for pregnant and postpartum persons from 193% to 210% and requires updates to related HCA programs.
HB 1855: Preventative services without cost sharing. (Riccelli)	Updates requirements for health plans to cover ACA-designated preventive services without cost sharing.

Exchange Bills of Interest (Did Not Pass)

Premium Assistance	
SB 5632: Striking workers. (Keiser)	Requires HBE to administer a worker health care premium assistance program to help Washington residents who lose employer-based health care coverage resulting from a labor dispute.
Cost Containment	
HB 1508: Health Care Cost Transparency Board. (Macri)	Expands the scope and authority of the Health Care Cost Transparency Board (HCCTB) to conduct data analysis and establish accountability measures for payers and providers who exceed health care cost growth benchmarks.
HB 1269: Prescription Drug Price Accountability Board. (Riccelli)	Amends authority of the Prescription Drug Price Accountability Board, including revising prescription drug threshold prices and percentage increases on prices that trigger review eligibility.
SB 5393: Health care provider contracting. (Robinson)	Prohibits health plans issued or renewed on/after January 1, 2024, from including anti-competitive clauses in contracts between carriers and hospitals, with certain exemptions.
SB 5241: Health care marketplace. (Randall)	Modifies reporting requirements for mergers, acquisitions, or contracting between hospitals and providers. Requires the attorney general to determine impacts on accessible, affordable health care in the state for at least ten years after the transaction occurs.
Hospital Finances	
SB 5767: Hospital excise tax. (Randall)	Establishing excise tax on certain hospitals to fund health care access.
Data Privacy	
HB 1616: Personal data rights charter. (Kloba)	Provides rights to individuals and requirements for governmental and covered entities regarding the collection and use of personal and biometric information.

Exchange Bills of Interest (Did Not Pass)

Equity	
HB 1541: Nothing about us without us act. (Farivar)	Requires all future temporary multi-member task force, work group, or advisory committee established in statute to include in its membership individuals with direct lived experience with the policy or issue being examined.
Miscellaneous	
SB 5335: Washington heath trust. (Hasegawa)	Establishes the Washington Health Trust as a consolidated single-payer insurance program providing universal health care to Washington residents funded through payroll and capital gains taxes.
SB 5530: Whole WA digital experience. (Gildon)	Creates the Whole WA digital experience work group to create a framework for developing a mobile app intended to connect Washington residents with government and service providers.
HB 1320: Access to personnel records. (Reed)	Updates procedures for furnishing employee personnel records within 14 calendar days upon request, establishes a private right of action for requesting employees, and requires redaction of certain information.

Tab 9

Washington State Health Care Authority

Objectives

Select transitional strategies and recommendations to prioritize for further evaluation.

Transitional Solutions

- Commission charged with identifying transitional solutions
- Surveyed Commissioners about potential transitional solutions in January 2023
- Commission requested additional input from the FTAC in February 2023
- Prioritize transitional solutions for further study

FTAC Proposed Transitional Solutions

FTAC Survey Responses[1]

Affordability/cost containment/pricing	
Facilitate accessibility of hospital price transparency data	Excellent resource for price transparency progress achieving its potential: https://www.healthaffairs.org/content/forefront/hospital-price-transparency-progress-and-commitment-achieving-its-potential
Reduce the affordability threshold	Could seek a waiver to reduce the affordability threshold from ~9 percent to something lower—e.g., based on the level of subsidization currently available under the ACA. This would increase costs to the federal government, so CMS would have to agree, or WA would need to subsidize additional costs. Negotiate whether federal tax credits would be provided for this population, and under what constraints. Lowering affordability threshold could result in more employers facing the mandate penalty, which would be an unintended consequence.
Reference based pricing for PEBB/SEBB	Consider reference pricing within the state employee health plan to drive cost savings. This is something that was tried in Montana, but the state backed away from it recently. MT-Eval-Analysis-Final-4-2-2021.pdf (nashp.org) Montana Backs Away From Innovative Hospital Payment Model. Other States Are Watching. | Kaiser Health News (khn.org). There may be resistance from the market. The state has authority to make changes, though costs to the state are likely high.
Regulated hospital global budgets	States including MD, NY, and PA[2] have adopted different forms of global budgeting, and evidence is still emerging. May be worthwhile to consider any lessons learned. There may be resistance from the market. The state has authority to make changes, though costs to the state are likely high. Would require WA legislative authority to first establish and then control the growth of hospital all-payer expenditures. This requires participation of both Medicare and WA Medicaid and could be accomplished via an agreement with CMMI, who will soon be publishing a template for states' implementation of such a payment model. Note: 2023 legislation (ESSB 5187, Sec.126(33) and Sec.144(13)) directing the Attorney General Office and Office of the Insurance Commissioner to study hospital global budget strategies.
Out of network (OON) price caps	OON care generally accounts for 6-10% of total care delivered. Regulating OON service prices would be accomplished by a traditional rate setting system or a system of regulated hospital global budgets.

[1] By request of the Commission, the survey was intended to gather input from FTAC Members on additional interim strategies for the Commission to consider that may advance Washington's transition to a universal health care system. Eight of nine members participated in the survey.

[2] PA has a CMMI hospital global budget demonstration for a group of rural hospitals in the Commonwealth. VT also made use of hospital global budgets in the context of a larger All Payer ACO model it constructed.

	Regulating just OON Prices can have a positive spillover impact (as occurs in Medicare Advantage market) on in-network negotiated rates, giving commercial insurers more negotiating leverage over in-network rates for all providers. This is potentially a lower intensity regulatory approach that could help lower current in-network commercial prices paid by health plans and TPAs. The state has authority to make changes.
OON price caps for public option (Cascade Select)	Consider passing legislation to set price caps on OON prices for the public option which could potentially give public option TPAs more leverage to negotiate lower provider prices. The additional leverage may improve public option affordability by lowering the cap on provider payments from 160% to some lower level.
State agency rate normalization	As an interim step towards a universal financed system, the state should "normalize" Medicaid, PEBB and SEBB rates, beginning with raising Medicaid rates to their Medicare equivalent. [3] The state has authority to make changes, though costs to the state are likely high. Assess revenue options to finance costs of increasing rates, including increasing the managed care premium tax.

Capacity/infrastructure	
All payer or multi-payer quality program, i.e., consolidate state agency managed care quality programs	HCA and HBE currently contract with managed care organizations/administrative service organizations for coverage of enrollees across five health programs (PEBB, SEBB, Retirees, Exchange, and Apple Health). To improve quality and value-based purchasing, the programs should adopt a common set of performance measures and standard quality improvement requirements. There may be resistance from the market.
Enhance telehealth capacity	The state could fund a telehealth system to drive down costs of services. Protecting telehealth and telemedicine that allow medical providers to practice across state.
Improve public health	Supporting preventative care at the state level and setting families up for success will incur less costs for universal coverage in the long term. Costa Rica's public health model for further study: https://www.newyorker.com/magazine/2021/08/30/costa-ricans-live-longer-than-we-do-whats-the-secret The state has authority to make changes, though costs to the state are likely high.

[3] Note, according to a 2019 Kaiser Family Foundation review of states Medicaid physician rates compared to Medicare, Washington has the 35th lowest overall rates.

Merging markets	RAND's examination of the implications of merging markets, e.g., SHOP and the marketplaces, and the marketplaces and Medicaid and found unintended effects on premiums and federal premium tax credits. There may be resistance from the market. Concerns: • Bringing sicker people into the marketplaces can increase premiums and Medicaid enrollees tend to be younger and sicker. • Higher marketplace premiums are bad for unsubsidized people but have ambiguous effects for tax-credit eligible people (because tax credits increase when premiums increase). • Increasing enrollment on the silver marketplace tier can reduce tax credits by diluting the impact of silver loading. In turn, people, particularly in the gold or bronze tier, may end up spending more out of pocket.

Coverage/benefits and enrollment	
Auto-assign Medicaid enrollment to high-quality/lower-cost plans	~45% of Medicaid managed care beneficiaries in WA do not choose a particular plan are auto-assigned to a plan. Reference: https://onepercentsteps.com/policy-briefs/improving-auto-assignment-in-medicaid-managed-care/ Per HCA's website, auto assignment is currently not performed by any notion of a plan's quality or cost https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/wac-182-538-060-managed-care-choice-and-assignment. There may be resistance from the market.
Auto-enrollment for Medicaid to no-premium Exchange	QHP and Medicaid could be opened to serve small businesses and other organizations with lower paid employees. Small business employees must enroll as individuals, or they lose their subsidy. Efforts to change this Federal restriction have been unsuccessful. Could develop wrap around benefits and auto-enrollment between programs to keep people continuously covered. However, there are barriers to auto-enrollment (how to manage consent) and limits/prohibitions to employers contributing to QHP or Medicaid coverage. There are many misconceptions about Medicaid auto assignment, some issues are technical problems. FTAC would need education on this if this topic comes back.
Develop standard benefits across payers	Eliminate low performing plans or rate plans according to quality and cost (somewhat analogous to Medicare Star ratings) https://onepercentsteps.com/policy-briefs/less-is-more-structuring-choice-for-health-insurance-plans/ Set reference balance billing payments at the median for shoppable undifferentiated services, e.g., for a given service, payer would only pay the median price charged by providers. Anything above would be covered by the patient OOP https://onepercentsteps.com/policy-briefs/designing-smart-commercial-insurer-networks/. This would preserve provider choice while containing costs and steer patients to lower cost providers.

Increase participation in the Medicare Savings Program (MSP)	According to MACPAC, a substantial portion of Medicare beneficiaries who are eligible for cost sharing assistance or additional benefits through Medicaid have not enrolled in an MSP program. The 2023 legislature took a step towards expanding the MSP by increasing Qualified Medicare Beneficiaries (QMB) coverage from 100 percent FPL to 110 percent and eliminating asset test requirements. The UHCC should consider endorsing further expansion. The state has authority to expand further, though the costs to the state would be high.
Uninsured Analysis	To determine who is not otherwise ineligible for health coverage or who remains uninsured, request OFM analysis of 2022 data to determine uninsured and underinsured (e.g., out-of-pocket health care cost exceed 10% of income, 5% when income is less than 200% FPL).[4]
Universal enrollment	Explore with state agencies infrastructure that ensures every WA resident is screened for coverage options and enrolled in coverage if uninsured. HBE should identify a default $0 premium plan for individuals where sufficient household/income information and HCA and HBE should facilitate "easy enrollment" for uninsured individuals where Apple Health/$0 default plans are available. Consult with HHSEC to assess likelihood/time frame for achieving a UHC eligibility component of their integrated eligibility and enrollment system (IES). The state has authority to make changes.

Providers	
Motivate interest in preventative and primary care	The dental sector created a cultural norm of two preventive visits per year, though the same routine importance does not exist for primary care apart from well visits for young children and annual wellness visits for seniors. Support for improved Medicaid payments to improve access and sustain providers who serve low income. The state has authority to make changes, though costs to the state are likely high.
Network adequacy standards	Work with OIC and HCA to develop standardization network adequacy metrics and to consolidate the collection and analysis of health plan's provider networks. Annually publish PEBB, SEBB, Exchange and Apple Health by-plan network analysis.
Provider participation analysis	Partner with HCA, OIC and HBE for an analysis comparing trends in provider networks available for the following coverage groups: Apple Health, PEBB, SEBB, Exchange, and OIC regulated large group market.

[4] The 2023 legislature appropriated $49.9 million to provide Medicaid look-alike coverage to non-citizen immigrants with incomes up to 138 percent FPL.

Standardize claims adjudications	Consider ways to standardize/simplify adjudication. e.g., use same forms, same prior authorization criteria, ways to automate adjudication, automatically collect needed clinical/demographic information from the HER.
State provider participation	As a condition for participation in PEBB/SEBB programs, require network provides to enroll in Apple Health plans and accept Medicaid clients. There may be resistance from the market.
Study of provide rate regulatory approaches	Understand the different rate regulatory approaches that WA might implement that could be developed through legislation.

Purchasing	
Consolidate state purchasing	Together, HCA and HBE provide coverage to nearly one-third of all insured residents. The UHCC could design a consolidated state health care plan for individuals receiving coverage under HCA/HBE with a standardized benefit design and payment system, a single enrollment system, and competitive contracting with carriers for all covered programs (limiting the number of plans in each region). This could help reform the current system, reduce state costs in providing coverage, and serve as a foundation for eventually incorporating other coverage groups. Medicaid, PEBB, SEBB, and HBE statutes must be amended to consolidate purchasing across these programs. This would require modeling, actuarial assistance, and consultation with the Governor and Legislature to assess willingness to undertake this major reform. There may be resistance from the market.

Subsidies	
Expand premium tax credit	Dept. of Revenue recently launched the Working Families Tax Credit (WFTC) and includes ITIN filers (those without SSN for tax filing purposes), creating another opportunity for WA to create a relationship with undocumented immigrants, foreign spouses, and dependents of U.S. citizens. • ~100% overlap with WFTC and Temporary assistance for needy families (TANF) and 60-70% estimated overlap of WFTC and supplemental nutrition assistance program (SNAP). Ensure everyone has knowledge/can take advantage of benefits and have resources to supplement the cost of health care. ○ The U.S. HHS (administration of TANF and SNAP) prohibits sharing of identifiable data with IRS's EITC program and discourages state human service agencies from sharing the data with state's EITC programs.
Expanded Health Benefit Exchange Cost-Sharing Subsidies	Consider opportunities to make it easier for people with ESI to enroll on the health insurance marketplaces, ideally with federal tax credits. The state has authority to make changes, though costs to the state are likely high.

Tab 10

Washington State Health Care Authority

Transitional Solutions

Affordability/cost containment/pricing	Capacity/infrastructure	Coverage/enrollment	Providers	Purchasing	Subsidies
• Regulated hospital global budgets • Reduce affordability threshold • Facilitate accessibility of hospital price • Transparency data • Out of Network (OON) price caps • OON price caps for Cascade Select • Reference based pricing for PEBB/SEBB • Rate agency rate normalization	• All payer or multi-payer quality program • Enhance telehealth capacity • Improve public health	• Auto-assign Medicaid enrollment to high-quality/lower-cost plans • Auto-enrollment for Medicaid to no-premium Exchange • Immigrant Coverage Enhancement • Increase participation in the Medicare Savings Program (MSP) • Uninsured Analysis • Universal enrollment	• Motivate interest in preventative and primary care • Network adequacy standards • Provider participation analysis • Standardize claims adjudications • State provider participation • Study of provide rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

Transitional Solutions

Affordability/cost containment/pricing

- Regulated hospital global budgets
- Reduce affordability threshold
- Facilitate accessibility of hospital price
- Transparency data
- Out of Network (OON) price caps
- Out of Network (OON) price caps **for Cascade Select**
- Reference based pricing for PEBB/SEBB
- Rate agency rate normalization

Capacity/infrastructure

- All payer or multi-payer quality program
- Enhance telehealth capacity
- Improve public health

❖ *Is there anything missing?*
❖ *What makes sense to focus on/prioritize*

Transitional Solutions

Coverage/enrollment

- Auto-assign Medicaid enrollment to high-quality/lower-cost plans
- Auto-enrollment for Medicaid to no-premium Exchange
- Immigrant Coverage Enhancement
- Increase participation in the Medicare Savings Program (MSP)
- Uninsured Analysis
- Universal enrollment

Providers

- Motivate interest in preventative and primary care
- Network adequacy standards
- Provider participation analysis
- Standardize claims adjudications
- State provider participation
- Study of provide rate regulatory approaches

- *Is there anything missing?*
- *What makes sense to focus on/prioritize*

Transitional Solutions

Purchasing	Subsidies
•Consolidate state purchasing	•Expand premium tax credit •Expanded Health Benefit Exchange Cost-Sharing Subsidies

- *Is there anything missing?*
- *What makes sense to focus on/prioritize*

Options for vote to prioritize transitional solutions

Choose **one idea from each category** to prioritize for further examination

If selected, depending on time, Commission may choose one idea from each category at their next meeting

Choose **one category** to prioritize for further examination

If selected, the Commission will vote today on which category to prioritize

Commission Member Vote

Motion to choose one idea from each category to prioritize for further examination.

Vicki Lowe, Chair

Affordability/cost containment/pricing	Capacity/infrastructure	Coverage/enrollment	Providers	Purchasing	Subsidies
• Regulated hospital global budgets • Reduce affordability threshold • Facilitate accessibility of hospital price • Transparency data • Out of Network (OON) price caps • OON price caps for Cascade Select • Reference based pricing for PEBB/SEBB • Rate agency rate normalization	• All payer or multi-payer quality program • Enhance telehealth capacity • Improve public health	• Auto-assign Medicaid enrollment to high-quality/lower-cost plans • Auto-enrollment for Medicaid to no-premium Exchange • Immigrant Coverage Enhancement • Increase participation in the Medicare Savings Program (MSP) • Uninsured Analysis • Universal enrollment	• Motivate interest in preventative and primary care • Network adequacy standards • Provider participation analysis • Standardize claims adjudications • State provider participation • Study of provide rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

Commission Member Vote

Motion to prioritize one of the following categories for further examination

Vicki Lowe, Chair

Affordability/cost containment/pricing	Capacity/infrastructure	Coverage/enrollment	Providers	Purchasing	Subsidies
• Regulated hospital global budgets • Reduce affordability threshold • Facilitate accessibility of hospital price • Transparency data • Out of Network (OON) price caps • OON price caps for Cascade Select • Reference based pricing for PEBB/SEBB • Rate agency rate normalization	• All payer or multi-payer quality program • Enhance telehealth capacity • Improve public health	• Auto-assign Medicaid enrollment to high-quality/lower-cost plans • Auto-enrollment for Medicaid to no-premium Exchange • Immigrant Coverage Enhancement • Increase participation in the Medicare Savings Program (MSP) • Uninsured Analysis • Universal enrollment	• Motivate interest in preventative and primary care • Network adequacy standards • Provider participation analysis • Standardize claims adjudications • State provider participation • Study of provide rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

Commission Member Vote

Motion to prioritize affordability/cost containment/pricing, or if time, motion to select one idea from this category.

Vicki Lowe, Chair

Affordability/cost containment/pricing	Capacity/infrastructure	Coverage/enrollment	Providers	Purchasing	Subsidies
• Regulated hospital global budgets • Reduce affordability threshold • Facilitate accessibility of hospital price • Transparency data • Out of Network (OON) price caps • OON price caps for Cascade Select • Reference based pricing for PEBB/SEBB • Rate agency rate normalization	• All payer or multi-payer quality program • Enhance telehealth capacity • Improve public health	• Auto-assign Medicaid enrollment to high-quality/lower-cost plans • Auto-enrollment for Medicaid to no-premium Exchange • Immigrant Coverage Enhancement • Increase participation in the Medicare Savings Program (MSP) • Uninsured Analysis • Universal enrollment	• Motivate interest in preventative and primary care • Network adequacy standards • Provider participation analysis • Standardize claims adjudications • State provider participation • Study of provide rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

Commission Member Vote

Motion to prioritize capacity/infrastructure, or if time, motion to select one idea from this category.

Vicki Lowe, Chair

Affordability/cost containment/pricing	Capacity/infrastructure	Coverage/enrollment	Providers	Purchasing	Subsidies
• Regulated hospital global budgets • Reduce affordability threshold • Facilitate accessibility of hospital price • Transparency data • Out of Network (OON) price caps • OON price caps for Cascade Select • Reference based pricing for PEBB/SEBB • Rate agency rate normalization	• All payer or multi-payer quality program • Enhance telehealth capacity • Improve public health	• Auto-assign Medicaid enrollment to high-quality/lower-cost plans • Auto-enrollment for Medicaid to no-premium Exchange • Immigrant Coverage Enhancement • Increase participation in the Medicare Savings Program (MSP) • Uninsured Analysis • Universal enrollment	• Motivate interest in preventative and primary care • Network adequacy standards • Provider participation analysis • Standardize claims adjudications • State provider participation • Study of provide rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

Commission Member Vote

Motion to prioritize coverage/enrollment, or if time, motion to select one idea from this category.

Vicki Lowe, Chair

Affordability/cost containment/pricing	Capacity/infrastructure	Coverage/enrollment	Providers	Purchasing	Subsidies
• Regulated hospital global budgets • Reduce affordability threshold • Facilitate accessibility of hospital price • Transparency data • Out of Network (OON) price caps • OON price caps for Cascade Select • Reference based pricing for PEBB/SEBB • Rate agency rate normalization	• All payer or multi-payer quality program • Enhance telehealth capacity • Improve public health	• Auto-assign Medicaid enrollment to high-quality/lower-cost plans • Auto-enrollment for Medicaid to no-premium Exchange • Immigrant Coverage Enhancement • Increase participation in the Medicare Savings Program (MSP) • Uninsured Analysis • Universal enrollment	• Motivate interest in preventative and primary care • Network adequacy standards • Provider participation analysis • Standardize claims adjudications • State provider participation • Study of provide rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

Commission Member Vote

Motion to prioritize **providers**, or if time, motion to select one idea from this category.

Vicki Lowe, Chair

Affordability/cost containment/pricing	Capacity/infrastructure	Coverage/enrollment	Providers	Purchasing	Subsidies
• Regulated hospital global budgets • Reduce affordability threshold • Facilitate accessibility of hospital price • Transparency data • Out of Network (OON) price caps • OON price caps for Cascade Select • Reference based pricing for PEBB/SEBB • Rate agency rate normalization	• All payer or multi-payer quality program • Enhance telehealth capacity • Improve public health	• Auto-assign Medicaid enrollment to high-quality/lower-cost plans • Auto-enrollment for Medicaid to no-premium Exchange • Immigrant Coverage Enhancement • Increase participation in the Medicare Savings Program (MSP) • Uninsured Analysis • Universal enrollment	• Motivate interest in preventative and primary care • Network adequacy standards • Provider participation analysis • Standardize claims adjudications • State provider participation • Study of provide rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

Commission Member Vote

Motion to prioritize purchasing, or if time, motion to select one idea from this category.

Vicki Lowe, Chair

Affordability/cost containment/pricing	Capacity/infrastructure	Coverage/enrollment	Providers	Purchasing	Subsidies
• Regulated hospital global budgets • Reduce affordability threshold • Facilitate accessibility of hospital price • Transparency data • Out of Network (OON) price caps • OON price caps for Cascade Select • Reference based pricing for PEBB/SEBB • Rate agency rate normalization	• All payer or multi-payer quality program • Enhance telehealth capacity • Improve public health	• Auto-assign Medicaid enrollment to high-quality/lower-cost plans • Auto-enrollment for Medicaid to no-premium Exchange • Immigrant Coverage Enhancement • Increase participation in the Medicare Savings Program (MSP) • Uninsured Analysis • Universal enrollment	• Motivate interest in preventative and primary care • Network adequacy standards • Provider participation analysis • Standardize claims adjudications • State provider participation • Study of provide rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

Commission Member Vote

Motion to prioritize subsidies, or if time, motion to select one idea from this category.

Vicki Lowe, Chair

Affordability/cost containment/pricing	Capacity/infrastructure	Coverage/enrollment	Providers	Purchasing	Subsidies
• Regulated hospital global budgets • Reduce affordability threshold • Facilitate accessibility of hospital price • Transparency data • Out of Network (OON) price caps • OON price caps for Cascade Select • Reference based pricing for PEBB/SEBB • Rate agency rate normalization	• All payer or multi-payer quality program • Enhance telehealth capacity • Improve public health	• Auto-assign Medicaid enrollment to high-quality/lower-cost plans • Auto-enrollment for Medicaid to no-premium Exchange • Immigrant Coverage Enhancement • Increase participation in the Medicare Savings Program (MSP) • Uninsured Analysis • Universal enrollment	• Motivate interest in preventative and primary care • Network adequacy standards • Provider participation analysis • Standardize claims adjudications • State provider participation • Study of provide rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies