Washington State Health Care Authority

Universal Health Care Commission

August 10, 2023

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Universal Health Care Commission
Meeting Materials

August 10, 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

August 10, 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
2:00-2:05 (5 min)	Welcome and call to order	1	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
2:05-2:08 (3 min)	Roll call	1	Mandy Weeks-Green, Manager Health Care Authority
2:08-2:10 (2 min)	Approval of Meeting Summary from 06/13/2023	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
2:25-2:30 (5 min)	FTAC updates	4	Pam MacEwan, FTAC Liaison
2:30-2:35 (5 min)	Commission's initial guidance to FTAC on Medicaid	5	Liz Arjun, Senior Consultant Health Management Associates
2:35-3:35 (60 min)	Washington Health Trust (SB 5335) presentation • Commission Q&A	6	Andre Stackhouse and Erin Georgen, Whole Washington
3:35-3:50 (15 min)	Discussion and prioritization of transitional solutions	7	Liz Arjun, Senior Consultant Health Management Associates
3:50-4:00 (10 min)	2023 Legislative report overview and next steps	8, 9 & 10	Liz Arjun, Senior Consultant 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

June 13, 2023
Health Care Authority
Hybrid meeting held electronically (Zoom) and in-person at the Health Care Authority
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

Bidisha Mandal
Dave Iseminger
Senator Emily Randall
Jane Beyer
Joan Altman
Representative Joe Schmick
Representative Marcus Riccelli
Mohamed Shidane

Members absent

Vicki Lowe, Chair
Senator Ann Rivers
Estell Williams
Kristin Peterson
Nicole Gomez
Stella Vasquez

Call to order

Dave Iseminger, substitute Commission Chair, called the meeting to order at 2:03 p.m.

Agenda items

Welcoming remarks

Dave Iseminger provided a land acknowledgement and welcomed members to the twelfth meeting.

Meeting Summary review from the previous meeting

The Commission members present voted by consensus to adopt the April meeting summary.

Public comment

Dave Iseminger called for comments from the public.

Mike Benefiel remarked that SB 5335 has been ignored by the Legislature but will save lives, money, and provide everyone with comprehensive coverage and urged the Commission not to ignore this bill.

Cris Currie suggested that the most logical transitional goal is for the state to consolidate its existing system and convert to a single-payer system such as the primary care case management model with a non-profit Accountable Care Organization (ACO) administration.

Maureen Brinck-Lund cited the Commission's authorizing legislation (SB 5399), which requires the Commission to submit a baseline report that includes an inventory of the key design elements of a universal health care system and unified financing system including, but not limited to, a single-payer financing system.

Kathryn Lewandowsky clarified that reference to "Medicare Advantage" in SB 5335 has been revised to "Medicare Part C." The intent of the Washington Health Trust is to manage healthcare dollars effectively for Medicare recipients and to create a sustainable healthcare system.

Elizabeth Hovde, Washington Policy Center, urged the Commission to explore ways in which a government-run, taxpayer-financed health care system is causing hardship in other countries and how other states have abandoned their plans for universal health care.

FTAC Updates: Recommendations on Medicare

Pam MacEwan, FTAC Liaison

The Commission directed FTAC to examine pathways to include Medicare in the universal system. Pam MacEwan, FTAC Liaison, outlined the six options examined by FTAC to address coverage gaps for Medicare enrollees. Options were ordered from least feasible to most feasible.

Option 1, an act of Congress or comprehensive waiver, would allow Washington to enroll Medicare enrollees into the universal system and access federal Medicare dollars. Option 1 represents the "North Star" or ideal approach to addressing gaps in affordability and coverage for Medicare enrollees, but FTAC agreed that pursuing this option is not an effective use of resources at this time due to the significant federal barriers.

Option 2, a demonstration waiver, e.g., 1115 a 402b Medicare waiver, would allow Washington to capture Medicare funding but are designed for payment-related reforms. It's unclear how this option could be leveraged to cover premiums, cost-sharing, or additional benefits for Medicare enrollees. This was not seen as a viable option for achieving the goals of the universal system given that the intent of these waivers differs from what the Commission is trying to achieve. FTAC noted that this option could complement other options and could be explored in the future to reduce costs or as a payment model.

In Option 3, Washington would design and implement a Medicare Advantage (MA) plan to provide benefits parity with the universal system. This would be the *only* option for Washington's Medicare enrollees, requiring a federal waiver from the provision that allows for choice and a way to preclude new plans from entering the market. FTAC noted the unlikeliness of obtaining a waiver that would limit freedom of choice, but this option could be a pathway in the future once the value of the universal system has been established.

Option 4, a state-operated MA plan, would compete with other private MA plans, preserve Medicare enrollees' freedom of choice, and allow traditional Medicare to continue. However, the state would face significant

competition by entering a mature MA plan market, risking Medicare enrollees not choosing the state's plan. FTAC did not recommend this option being taken completely off the table, as it could sit alongside Option 6 in the future.

In Option 5, the state would develop and offer a Medigap plan to fill gaps in benefits between Medicare and the universal system. While this option seems feasible in terms of existing legal authorities and is less administratively burdensome, there were concerns that this option would not achieve benefits parity with the universal system. This option would not recoup federal funds nor be available to MA enrollees. The state would need to compete with other Medigap plans in a mature market. There was some interest in this as a short-term option, potentially paired with Option 1 or 2 in the long-term, but most members did not support Option 5 at this time.

Under Option 6, the state would establish a system to directly reimburse Medicare enrollees for cost-sharing and for services covered by the universal system but not covered by Medicare. This allows the most flexibility to fully address gaps, would not require waivers, nor result in legal challenges. Federal dollars would not fund the additional benefits, placing the financial burden on the state. However, FTAC members agreed that at this time, Option 6 presents the best and most feasible pathway. Revisiting Option 6 with further analysis and decision-making must occur after the benefits/services design for the new system is determined. Until then, further analysis to determine what gaps must be filled between existing Medicare benefits/services and that of the new system is not possible. Additional considerations are noted in the Medicare memo.

Commission member Bidisha Mandal asked whether FTAC ultimately recommends that Option 6 be standalone or be paired with either Option 1 or Option 2 (waivers) in the long-term. Pam MacEwan clarified that FTAC recommends Option 6 as the most feasible and could be explored in conjunction with waivers options, but this requires further analysis. Commission member Jane Beyer made clear that the conversation about how to fill gaps in services, benefits, and cost-sharing for Medicare enrollees will happen after the Commission determines the universal system's benefits and services. Dave Iseminger suggested moving to adopt the guidance provided in FTAC's Medicare Memo. Commission member Joan Altman agreed. Bidisha Mandal agreed on condition that it be clarified that Option 6 be explored in conjunction with one of the waiver options.

Commission member Rep. Joe Schmick expressed concerns with adopting these recommendations given that some questions have not been addressed. Pam MacEwan noted that FTAC's recommendations, not set in stone, are guidance to allow the Commission to move forward and continue to answer these questions. Jane Beyer added that FTAC was directed to examine this topic early in the Commission's design work to identify whether the assumption should be that a Medicare waiver would be obtained. FTAC's guidance, at this time, is to not to begin with that assumption, to determine benefits and services, and come back to this discussion exploring whether pursuing a waiver makes sense. The Commission voted to adopt FTAC's guidance in the Medicare Memo pending clarification that Option 6 be explored in conjunction with one of the waiver options (seven for, one opposed).

Presentation: Guidance to FTAC on Employee Retirement Income Security Act of 1974 (ERISA)

Liz Arjun and Gary Cohen, Health Management and Associates (HMA)

In April, the Commission identified several ERISA questions for FTAC's examination. The Commission was asked for any additional items to take back to FTAC. Rep. Schmick asked how it would work to give employers an option to participate in the universal system given that ERISA is federal law. Commission member Mohamed Shidane noted potential health equity and care quality implications if employers can continue providing coverage to their employees. Gary Cohen (HMA) noted the state could make it optional for employers to participate or incentivize employers to participate in the universal system. Dave Iseminger asked as to the implications regarding employer

responsibilities required under the Affordable Care Act (ACA). Jane Beyer asked whether the state could require that employers' minimum coverage match the new system's coverage? HMA will take these topics back to FTAC.

Presentation: Equity innovations in state agencies: A potential framework for the Commission

Quyen Huynh, Health Equity Dir., Health Care Authority (HCA)

Quyen Huynh shared HCA's health equity framework and current equity efforts. In its role to purchase health care for millions of Washingtonians, health equity is at the center of HCA's vision, mission, and strategies. Health equity means that everyone has a fair and just opportunity to be as healthy as possible. Equality and equity are different. Equality is when everyone gets the same thing. Equity is when everyone gets what they need. HCA created the Health Equity Toolkit which helps staff apply an equity lens when designing or evaluating policies, programs, and services.

In 2022, HCA created the Pro-Equity Anti Racism Community Advisory Team (PEAR CAT) to hear from community members how HCA's services and programs impact them. HCA centers diversity, equity, inclusion, and belonging at the state Medicaid agency level. HCA continues to engage communities through this lens to ensure that those who are most disenfranchised have a seat at the table.

Sometimes, well-intentioned policies do not achieve pre-determined goals. Communities most impacted are often not involved/elevated, certainly not from the outset. Those with lived experience are the true experts. Our system was built without intentional equity for so long that some existing infrastructure must be dismantled. Re-distributing power and elevating community voices must move at the pace of the community. Quyen asked the Commission to have a consistent equity framework and equity lens each time decisions are made.

Mohamed Shidane appreciated Quyen's presentation as this is not often discussed and is what Washingtonians and Americans dream of. Joan Altman asked as to the level at which each individual Commission member would use this framework. HCA will build in a process to perform health equity analyses for proposals expected to impact health equity. These analyses will occur prior to the Commission taking action. Commission members voted to adopt and apply the health equity framework to their recommendations (seven for, one opposed).

Presentation: Incorporation of the Washington Health Trust bill into the current workplan

Liz Arjun, HMA

In April, the Commission voted to integrate the Washington Health Trust bill (SB 5335) analysis into the current workplan. In August, Whole Washington will present on SB 5335, after which HMA will compare SB 5335's universal system design and transitional strategies with those being considered by the Commission. Per the Commission's request, SB 5335's foundational design elements were compared with those in the Commission's 2022 legislative report. Beginning in 2025 and until the analysis is complete, each of the Commission's legislative reports will summarize the Washington Health Trust bill and how it would address key design components of a universal system.

Presentation: State agency report out on 2023 legislative session

Evan Klein, Special Asst. for Policy and Legislative Affairs, HCA
Jane Beyer, Senior Policy Advisor, Office of the Insurance Commissioner (OIC)
Joan Altman, Dir. of Gov't Affairs and Strategic Partnerships, Health Benefit Exchange (HBE)

Evan Klein shared HCA's 2023 legislative session priorities. The 2023 operating budget provided $46 million to implement Apple Health expansion coverage beginning January 1, 2024. This program will largely mirror Medicaid coverage and will expand coverage to adults ineligible for Medicaid or federal subsidies by reason of immigration status. There were several provider rate increases for services including behavioral health, applied behavior analysis, and children's dental. SHB 1850 establishes a distressed hospital grant program, reenacts and adjusts the hospital safety net program, and directs HCA to implement a Directed Payment to promote equitable distribution of care by increasing payments to Managed Care Organizations (MCO) to increase reimbursement to designated hospitals.

Jane Beyer shared significant legislation relevant to the OIC. SB 5338 directs OIC to update the essential health benefits (EHB) benchmark plan. SB 5581 directs OIC to conduct a large study as to how to reduce or eliminate cost sharing for maternity care services. HB 1357 puts tighter timeframes for prior authorizations by health carriers and directs that criteria used by carriers to determine medical necessity must be evidence-based and sensitive to equity concerns. There is a budget provision for a health care affordability study, e.g., review of insurance rates, examining consolidation across providers as well as vertical integration. There will be more focus on pharmacy benefit manager issues at the state and national level.

Joan Altman shared significant legislation relevant to HBE that passed this session, some of which echoed HCA's and OIC's. The legislature made investments in the Cascade Care Savings program and the launch and implementation of the state's new 1332 waiver. HBE is a key implementation partner in HCA's directive to implement the previously mentioned mirrored Apple Health program. Several cost containment bills were introduced but did not pass. However, bills passed to protect consumer health data and personally identifiable information which is relevant to the Commission's work to design a universal system.

Commission Member Rep. Marcus Riccelli noted that cost containment bills face significant headwinds. These bills are important to this work and should be examined and tracked by the Commission. Jane Beyer added that HB 1855, dropped at the end of session (did not pass but will be reintroduced in 2024), would preserve coverage of preventive services without cost sharing.

Presentation: Continuing transitional solutions discussion

Liz Arjun, HMA

The Commission is charged with identifying transitional solutions. Both the Commission and FTAC were surveyed about potential transitional solutions. The next step is to prioritize transitional solutions for further study. Transitional solutions were grouped into the following categories: affordability/cost containment/pricing; capacity/infrastructure; coverage/enrollment; providers; purchasing; and subsidies. In preparation for the next meeting, the Commission was asked to think about whether any transitional solutions or categories were missing, and which solutions or categories should be focused on and/or prioritized. Jane Beyer offered to share OIC's report/study schedule and content to help the Commission think about categories/ways to prioritize.

Adjournment

Meeting adjourned at 4:00 p.m.

Next meeting

August 10, 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

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Universal Health Care Commission
Written Comments
Received from May 30

Written Comments Submitted by Email

Additional Comments Received at the June Commission Meeting

- The Zoom video recording is available for viewing here: **https://www.youtube.com/watch?v=Mayg9wEFnwU&feature=youtu.be**

Public comments received since (May 30) through the deadline for comments for the August meeting (July 27)

Submitted by Dave Schuldt

05/31/2023

We need UHC now! I run a small business and the situation is difficult.

Submitted by Liam Diephuis

06/09/2023

Dear Washington State Health Care Authority,

It has come to my attention that Senate Bill 5335, on Developing the Washington health trust, will be debated by the HCA on August 10, 2023. I could present a list of facts and figures about how much the USA spends on a privatized health care system compared to peer nations with singlepayer health care, but I'm assuming the members of the HCA have seen these figures before at some point. Instead, I'd like to ask for consideration of how this bill can uniquely promote the state of Washington.

We have an opportunity with the Washington health trust to be a national leader in improving the quality of life of our residents. We can be known as the healthiest state in the union. Perhaps most importantly, we can inspire similar legislation elsewhere.

Thank you for your time,

-Liam Diephuis

1866 Bender Park Blvd.

Lynden, WA 98264

360 603 2616

Submitted by Cris Currie
6/16/2023

To the UHCC:
I'm Cris Currie from Spokane. Even while discussing transitional ideas, the Commission still has not declared with any specificity what it plans to transition to. The most logical transitional goal is for the state to consolidate its existing system that already serves about 1/3 of the population and convert it to a single-payer system. This means eliminating the 11 commercial Managed Care Organizations, and switching to the alternative Primary Care Case Management model with non-profit ASO administration as Connecticut has done. Along with establishing an All-Payer model coupled with global budgeting for hospitals, as Maryland has done, these moves will not only save billions of dollars but will convince the

feds we are serious and create the perfect foundation for bringing in the other 2/3 of our population. The precedent for the necessary waivers has already been established, so there is no reason to delay.

It has become harder and harder with each meeting to maintain a sense of optimism regarding this Commission, largely because the consultants seem to be in total control of the agenda. They certainly made it clear to the UHC Work Group that they believe a single-payer system is infeasible, so they are apparently avoiding the legislative mandate, the strong preference of the Work Group members, and hundreds of ongoing public comments, to advance discussion of single-payer. One also must assume that the HCA has directed the consultants accordingly. What was really shocking at the June meeting was that there was no mention of the $466,000 budget proviso for the Commission and exactly how it might be spent, nor any thanks given to those of us who proposed and pushed for it! Will the consultants control this too? One wonders if the Commission even cares about public support and comment.

The single bright spot in the June meeting was the plan to include a presentation on SB 5335 by Whole Washington at the August meeting. I hope the Commission devotes at least an hour of the agenda to this very important topic and studies it thoroughly in advance. While the bill has an extensive 20 plus year legislative development history, it is still somewhat incomplete and imperfect. It is, however, an excellent road map that will much more efficiently guide the Commission toward the goal of an equitable, universal, single-payer system, IF the Commission decides to follow its lead and set aside its fears of backlash and infeasibility. As those of us who have been working on this for many years can tell you, real healthcare reform, particularly single-payer, is not for the weak and timid; it definitely requires uncommon courage and a lot of hard work. But until the Commission starts to exert its own leadership towards this goal, I'm afraid the public's patience and funding will run out long before anything of real substance is accomplished.

Submitted by Dave Schuldt

07/05/2023

Hello,

I'm a volunteer with Whole Washington because I know that we need health care not wealth care. While I'm doing OK for now there are many others who suffer all day everyday due to lack of medical care. This commission is a delaying tactic that just prolongs the suffering and reduces people's ability to work and their productivity. Responsible leaders would make this happen so people can get what they need to get their lives back on track and have hope for the future.

We're not going away until we win!

Submitted by Lana Bostic
07/12/2023

Dear Commission Members

Hello I am a retired RN who lives in Federal Way and worked in Health Care for over 40 years! I also volunteer for Whole Washington and believe the Health care is a human right! Too many people are left out because the system is so complicated and not effective! People should not be tied to a job to have health care ! I will be attending the meeting on August 10 and hopefully you will move forward with getting Universal Health care in Washington State Thank you Lana Bostic Federal Way

Submitted by Warren George
07/12/2023

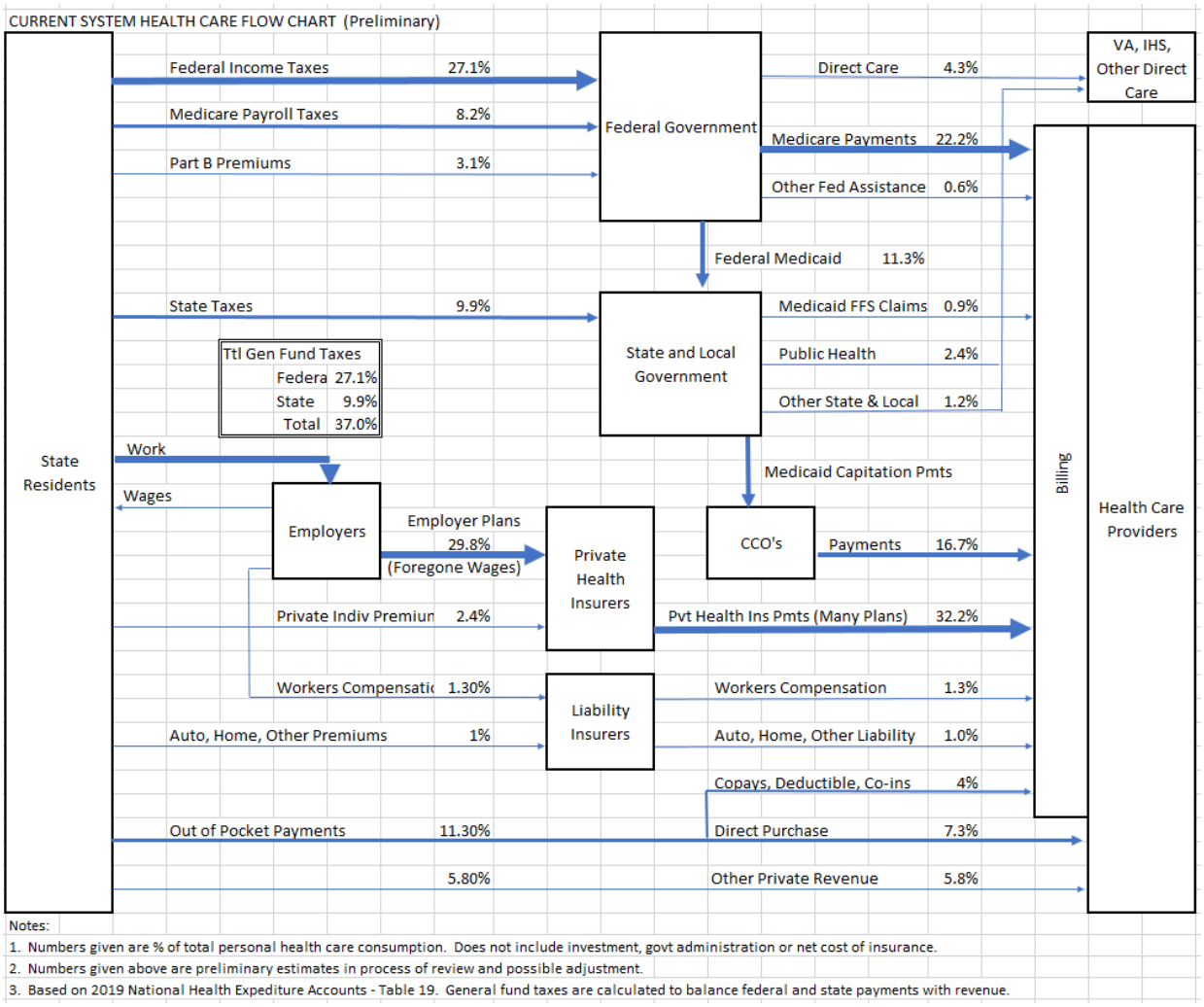
COMPARISON OF HEALTH CARE REFORM ALTERNATIVES

Warren George 7/11/2023

The Oregon Task Force on Universal Health Care identified the three major problems of the current health care system as cost, complexity, and justice.

Evaluating reform alternatives against their ability to address those problems can feel like a daunting task without some sort of roadmap to better understand the current system and the opportunities for change. The flow chart in Figure 1, based primarily on National Health Expenditure Account data, is one way to view how the pieces of the current health care system fit together. At present, this is a working document subject to review and possible adjustment as more detail and possible adjustments for specific states becomes available.

FIGURE 1. Current Health Care Flows as a percentage of total personal care.



While finer granularity can be added to this chart, Figure 1 shows enough detail to begin comparing three commonly mentioned health care reform alternatives:

- Mandatory purchase of private insurance,
- A state based public option,
- A state based single payer system.

These three reform alternatives are discussed further below.

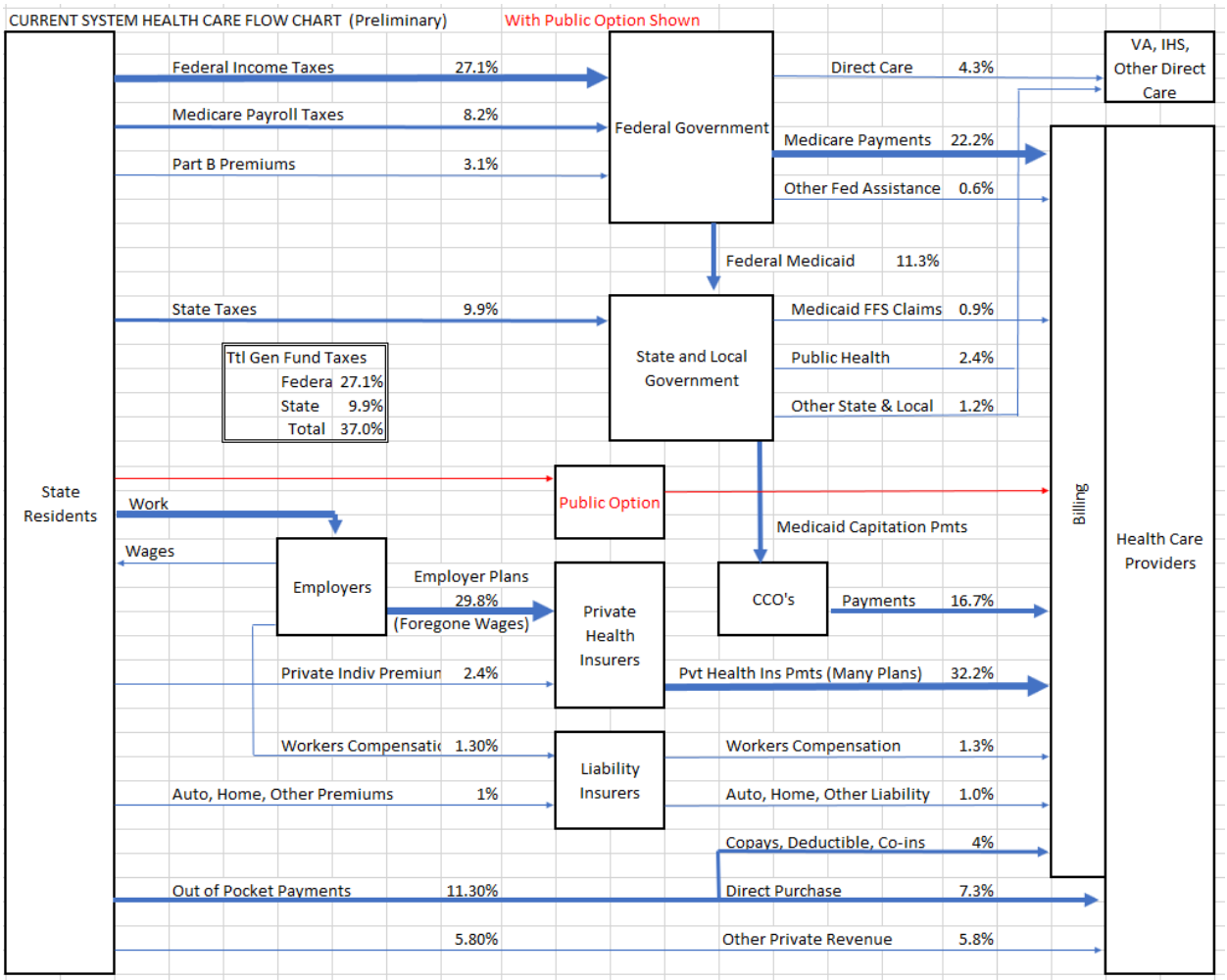
Mandatory Purchase of Private Insurance

This alternative makes no change in the flow chart but might make some small changes in the flow percentages.

A State Based Public Option

This alternative would remove no existing components but would add a new public insurance plan to compete with private insurance. This could be either subsidized by new state taxes, or unsubsidized. An unsubsidized plan is shown in Figure 2.

Figure 2. A State Based Public Option

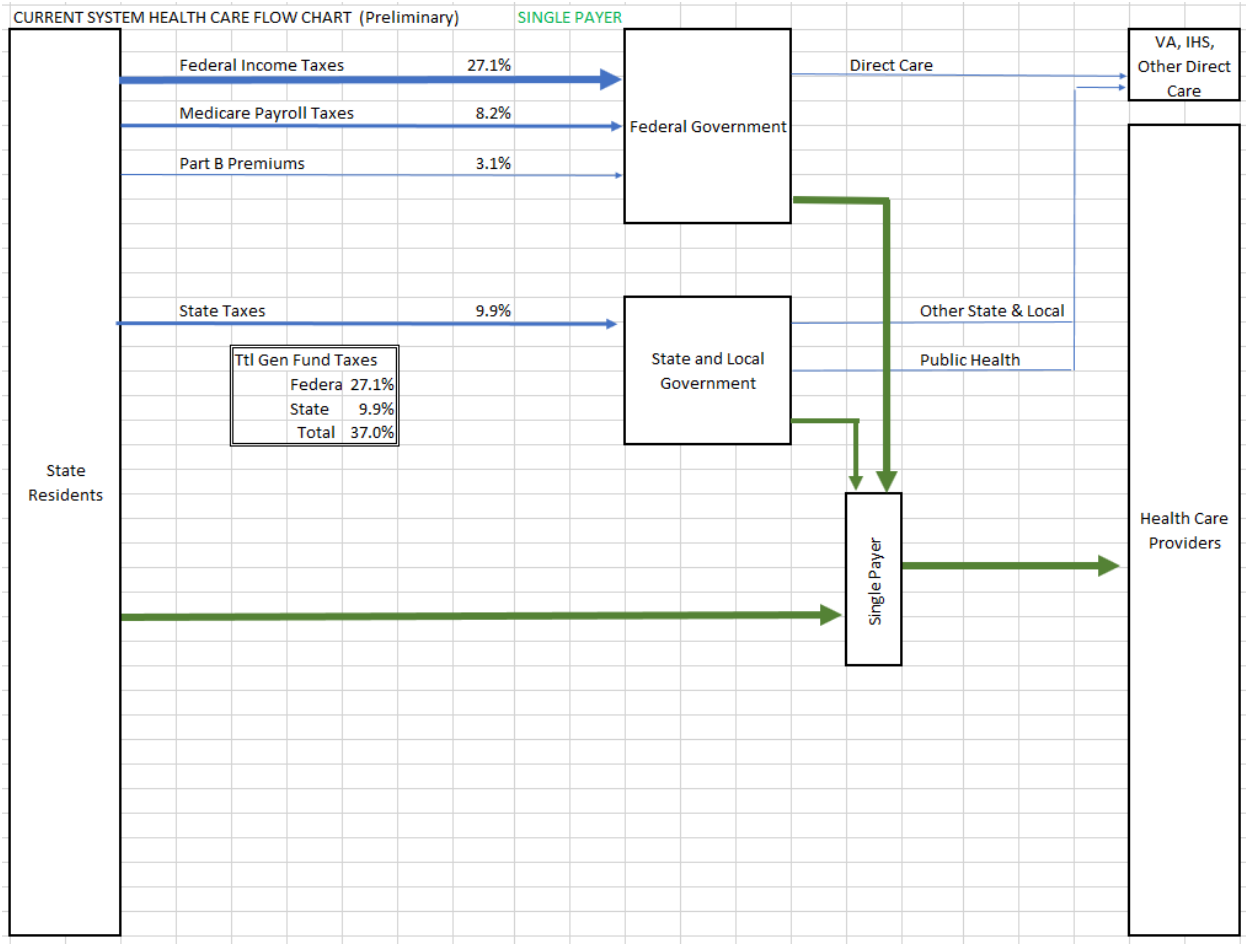


One version of a public option being considered in Oregon and Washington would allow low-income persons whose income is above the Medicaid level, to buy into Medicaid.

A State Based Single Payer

This alternative would replace all current non-governmental finances with a single payer entity. Most individual patient billing would be eliminated, as would health insurance for covered services. Employers would no longer offer health insurance as part of the employment package.

Figure 3. Single Payer

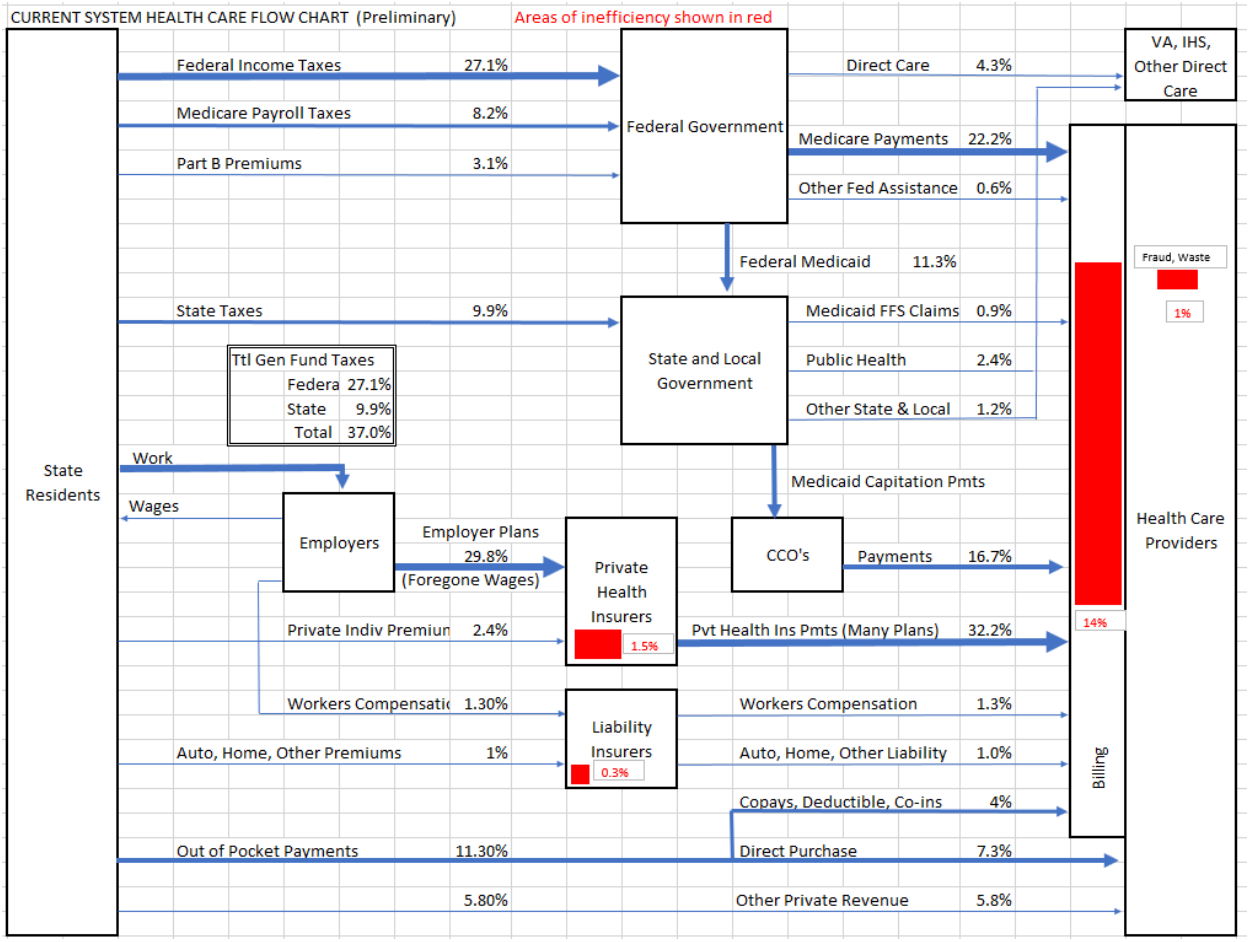


Having defined three alternatives for health care reform, they can be compared on their ability to achieve the three goals of cost reduction, elimination of complexity, and removal of factors which create injustice in access to health care.

COST REDUCTION

Assuming that cost reduction is to be achieved without placing pressure on the quality or available quantity of care, reducing cost must be focused on removing current inefficiencies and not on other means such as limiting provider income. Figure 4 shows the locations of current inefficiencies as identified by Oregon's actuarial consultant Optumas.

FIGURE 4. Current Health Care Flows with areas of inefficiency shown in red.



According to Optumas, the largest inefficiency by far is related to provider billing administration, with lesser inefficiencies identified for changing private insurance to public, and reducing fraud and waste.

Comparing alternatives, mandatory purchase of private insurance would yield no savings since all the identified inefficiencies are left in place.

A public option to compete with private insurance could save a maximum of 1.5% but would likely save less when the cost of public bonds to replace private shareholder capital is taken into account.

A single payer system would address all of the identified inefficiencies for an expected total savings of approximately 16%, some of which could be spent on providing better, more inclusive services.

ELIMINATION OF COMPLEXITY:

Eliminating complexity is almost the same as reducing cost since complexity adds cost. But the stress of deciphering complex bills, the worry of which bills will be paid by insurance, the desperation of the effect on meeting family budgets, and the intimidation of complexity which discourages many from seeking care at all, cannot be measured in terms of dollars.

Comparing the reform alternatives, mandatory purchase of private insurance would retain current billing complexity.

A public option which competes with private insurance actually ADDS to system complexity by increasing the number of system components while eliminating none. A 2021 Health Care Financing Report by the Colorado School of Public Health (lead author Beth McManus) estimated that continuing a multi-payer system with the addition of new public options would increase complexity and add two to three percent to the total cost of health care.

By comparison, a single payer system would profoundly eliminate complexity by eliminating patient by patient billing altogether for most care, replacing billing with year by year global budgets.

REMOVAL OF FACTORS WHICH CREATE INJUSTICE IN HEALTH CARE ACCESS:

Although any component of the health care system can contribute to racial and similar forms of injustice, two of the most obvious contributors in the current system are related to employment and to provider compensation.

About half of the population has their health care tied to employment. Populations which are less likely to be employed in fields that offer employer health benefits are at a distinct health disadvantage.

Another major point of injustice is the current quasi-caste system of provider reimbursement. Providers receive a substantially different amount based on who the patient is. Optumas reports that on average, Oregon providers are paid 69 cents on the dollar for Medicaid patients, 81 cents for Medicare, and $1.37 for patients on private insurance patients. Not only does this differential openly lead to providers limiting the number of Medicare and Medicaid patients they will see, but the differential actively contributes to closure of hospitals and clinics in targeted areas, mostly rural and inner city, where fewer patients have private insurance to balance out losses from treating Medicare and Medicaid patients.

Mandatory purchase of private insurance would not reduce the injustices reflected above.

Likewise, a public option would leave these inequities fully intact. Because a public option would only pertain to a very small percentage of the population currently on individual plans the number of potential participants would be very very small. And any financial benefit to a few who might be willing to buy into Medicaid reimbursement rates will be do so by magnifying the current inequities of unequal reimbursement.

By comparison, a single payer system would eliminate the major causes of injustice by completely eliminating employment requirements and differential reimbursement from the system. In addition, as the single payer entity contracts to provide care with global budgets, it will have tools to contract for care where needed, instead of allowing care to migrate to wealthier regions as the current system does.

And because all residents, including members of tribes, will be eligible to receive care through the single payer system, a century of paying only 30 cents on the dollar to IHS health programs, can be made whole.

SUMMARY

When comparing the health care reform alternatives of mandatory private insurance, a public option, or a single payer system against the goals of cost reduction, elimination of complexity, and removal of injustice, the case for a single payer system is overwhelmingly compelling.

Obstacles exist, but there can be solutions to ease the transition, share savings among all, and to obtain the federal permissions necessary to enable reform.

Submitted by Saint Ontari
07/13/2023

Hey,

My name is Saint Ontari, i am a born and raised WA state resident. I am disabled and in the process of going on SSDI. Once approved I have 9mo left of staying on the excellent Apple Health program we have and will have to cut back drastically on my vital and necessary healthcare after being forced to transition to Medicare.

I proudly signed the petition and voted for the Universal Healthcare bill. In reviewing things I am left wondering though, when it says "Universal Healthcare for all WA state residents" does that also include those of us who are legally disabled and on SSDI once fully realized and implemented?

If this is not going to be the case then my next question is why not? Followed by, what is the justification for creating two healthcare systems wherein one side would continue to perpetuate unnecessary and substantial hardships for the most impoverished, vulnerable and in need of such a system?

My final question is what is the projected timeline (at this time) for full implementation? I want to clarify that I fully understand the difficulty, barriers and massive effort it will take to restructure entirely a broken medical system. Likewise I fully understand that no timeline or information on a "projected timeline" would serve as any kind of guarantee and that nearly all of any information that I am provided is fully subjected to change.

Thank you for your time, your work and I greatly look forward to your response.

Sincerely and gratefully,
Saint

Submitted by Madeline Bishop
07/13/2023

I would like to speak at the 8/10 UHCC meeting. Here are my comments for the record:

I am a retired WA State worker. I want to see the Universal Health Care Commission (UHCC) firm up its proposals and take out the wiggle room. To move forward, we need the UHCC to:

- Set a deadline for the UHCC report to the Legislature,
- Identify which Legislators will introduce and cosponsor single-payer plan legislation,
- Identify a communications strategy to support passing a single-payer plan
- Identify who will take the lead on defending and funding court challenges.

Madeline Bishop from Olympia, WA 98513

Submitted by Sally Anne Sadler
07/20/2023

There are so many reasons why we need a single pair of system, economic justice, compassion, fairness, and also the cost of small businesses. Small businesses in particular cannot compete for a package of benefits that larger companies can. We need a more equitable system.

I employ six people and healthcare is the biggest single expense that I have after the actual paycheck.

I would happily pay my fair share for healthcare that is equitable..

Sally Anne Sadler

Shoreline wa

Submitted by Natalie Caple
07/20/2023

I have epithelial high grade serous ovarian cancer and my husband of 31 years just died fighting a fast progressing cancer called AML after having urter cancer last 2 years that was said to be in remission. One family member having cancer is expensive and stressful . Two n the house hold having cancers is life altering and mind blowing especially after a battle loss and medical debt bills on the way. We in USA need Universal healthcare. Enough said.

Submitted by Arwen Spicer
07/20/2023
Dear Universal Health Care Commission,

I am an adjunct at Clark College in Vancouver, writing to urge you to support the Whole Health Washington Trust.

Because health problems recently required me to scale back my teaching, I had to “choose” to give up my hard won health benefits, which means I am now locked into never teaching more than .49 FTE, lest I “accidentally” get benefits again. Basically, I had to choose to permanently lose almost 50% of my already underpaid salary just to have a reasonable workload I’ve needed in order to heal.

Under Whole Health Washington, this would never happen. Instead of less than 50% of Clark employees having health benefits, 100% would have health benefits. Instead of hearing our students’ stories of going hungry to afford drugs for family members, 100% of our students would have affordable health benefits. Clark itself would save something on the order of $5 million/year (according to my calculation through the Whole Health calculator) in taxpayer money now wasted paying for benefits for less than half its employees, (including having to *still* pay for those who qualify for benefits but waive them, i.e. to pay for literally nothing).

I urge you to stop Washington from wasting more taxpayer money (through both taxes and direct costs) on a system that institutionalizes cruelty, inequity, poverty, and unnecessary death.

We know what works. The rest of the developed world can manage it. We've known this for 30 years. There really is no more excuse.

Thank you.

Sincerely,
Arwen Spicer
Clark College adjunct instructor
Vancouver, WA

Dr. Arwen Spicer
Writer, Educator
www.arwenspicer.com
arwen.spicer@gmail.com

"You can't separate living creatures. Being alive involves them together." --Roj Blake

Submitted by Graham Johnson
07/20/2023
Hello!

I'm so excited to hear that Washington state has a universal healthcare commission! I am basically a single issue voter when it comes to all my elected representatives, and that issue is universal healthcare. I am excited at the possibility of Washington leading the national charge towards doing the right thing and taking care of the American people.

In the early years of my adult life, I always found myself just over the edge of the benefits cliff when it came to Medicaid coverage for myself, my wife, and my growing family. Once Medicaid was is expended in Washington state, it forever changed the trajectory of our family and finances. Before the expansion, we were paying $500 or more each month just in premiums, with a deductible in the thousands. Our healthcare plan at that point was basically to pray that no one got hurt. Unfortunately, that is completely unrealistic when raising children. We were paying over a quarter of our total income just in medical bills and insurance premiums.

When we were pregnant with our third child, we learned that he had a serious heart condition that would require surgery if he survived birth. We found out about his situation when we were just 20 weeks pregnant. If it had not been for Medicaid, we would not have continued the pregnancy. Once he was born, it was determined that he needed a heart transplant to survive. Again, because of Medicaid, we were able to say yes. Our son became the youngest heart transplant recipient in state history thanks to single payer healthcare coverage. Now, he is a healthy 10 year old boy, and we could not be more grateful to the staff of Seattle Children's Hospital, and the taxpayers of Washington state.

Before we were discharged from the hospital with our son, I asked for a copy of the bill - a bill we never received thanks to our coverage. The total was over $1.6 million. Paying a bill of this size would have financially ruined three generations of my family.

Because we had a quarter of our income freed up due to Medicaid, we were able to say yes to other opportunities in our lives that we would have not been able to otherwise. One of those opportunities was taking a new job for myself, a job that paid less, but had great prospects. Another opportunity was for my wife to go back to school and become a healthcare professional herself. Thanks to "universal healthcare" we now have high paying careers and pay more in taxes than we earned when our third son was born. When people ask me how I feel about paying high taxes, I tell them I'm happy about it. I'm happy that the support we received from others allowed us to support others in the future. I'm happy that we can help other parents and children say yes, because the financial strain has been reduced or removed from their decision. I'm happy to pay taxes when they go towards programs that benefit the people.

It's time to extend this protection to every single citizen in the United States. We have the money. We have the need. We must confront greed head on and do what is right for the American people. Let's start with Washington! We can be the healthiest and most prosperous state in the union. Guaranteeing health care coverage to every resident in the state is a great step in that direction.

Graham Johnson
(360) 510-0464

Submitted by Kathryn Tominey
07/20/2023

Current and past proposed legislation allow for out of state providers to apply to be reimbursed but absolutely NOT equivalent to medicare coverage which is everywhere.

I doubt that any provider beyond Portland & Hood River, Oregon or Cour D'Laine Idaho will have any interest in applying. And only providers with current washington state patients.

Hijacking all of medicare and other including Tricare money when you cannot provide equivalent coverage is unacceptable.

Kathryn M Tominey
Medicare & Medigap policy user.

Submitted by Kyle Wojewoda
07/20/2023

Dear UHCC,

I am writing to voice my support for enacting a state-based healthcare plan covering all residents. Organizations such as Whole Washington have pushed for such legislation and I believe this is essential

especially with the federal government failing to act. This country has a mental health and substance abuse crisis — which is visibly present on our streets in Washington State. I urge the commission to study proposals here in the state to expand coverage to all residents.

Thank you,
Kyle Wojewoda

Submitted by Matthew McCoy
07/20/2023

Dear Commission,

In a state and country that purports to lead the world in human rights, the failure to provide free at the point of service health care for all is unacceptable. The state of Washington can show the country that not only is universal health care possible, it is ***cheaper*** and more efficient in a myriad of ways from the rube goldberg structure that currently exists. Please show the courage needed to break from the wasteful system in place.

Thank you,
Matthew McCoy, PhD
Seattle, Washington
206-554-1995

Submitted by Diane Karr
07/20/2023

I want to voice my support for Universal Health Care BUT: I want for there to be research into why the NHS is on the verge of collapse. We need to understand what the pitfalls are and what we in the U.S. can do to prevent such a scenario. We can do better and we MUST do better.

Thank you for your activism in support of healthcare for all -- a basic human right.

Diane Karr

Submitted by Ron Raty
07/21/2023

Although the passing of the ACA certainly helped some insurance issues, issues still exist.

I just received a letter from my doctor asking for a $250 annual membership fee, because they claim my insurance doesn't pay enough. And I have Regence Blue Cross as a Washington State Employee. This is the start of a very dangerous trend.

Submitted by Diane Karr
07/22/2023

I sent an email in support of UHC a few days ago. I just ran across this article. The contents are very alarming and I hope you will address the concerns it reveals:

https://www.aljazeera.com/features/2023/7/21/a-silent-emergency-the-rise-in-suicides-among-uk-doctors

We must push for UHC but there must be attention paid to these potential problems and how the U.S. could avoid them.

Submitted by Norm Conrad
07/22/2023

I wholeheartedly support universal health insurance, enhanced Medicare for All in particular. I lived in Canada for 10+ years. I experienced their Medicare program from BC to Ontario. It is far superior to the money driven system here in the US. And the claims about wait times up there for necessary services are total lies. I could get seen by a doctor far more easily and quickly there than here. Like here, doctors work privately. And remember that Canada has a population about 1/8 that of the US spread over an area roughly the same size as the lower 48 states. That Canada can do this at a far lower per capita basis, or at all, is clear testimony to the inherent advantages of such a universal health insurance system.

A universal health insurance program should start with Medicare, then fold in all the MediGap coverages, add to that coverage for chiropractic, acupuncture and similar outside the box services and and provide real dental, vision and hearing coverage that the Advantage plans use as bait but provide few real benefits to seniors. It's my guess that many or most of those Advantage comeons are kickback schemes considering the limited number of vision, etc. companies they let us work with.

On top of that, there should be zero annual or lifetime limits. There should be zero deductibles. There should be zero or almost zero copays. While there would be some start-up costs and UI benefits paid out for those current administrative people who would no longer be needed to sort through the limitations and arcane rules by the many different insurers, in the not too distant future it will cost less, by a huge margin, than the farce we are currently dealing with.

Then we get into a number of systemic issues regarding actual providers. Hospital monopolies must be broken up and many or most of the hospitals they have closed down must be reopened. The middlemen that bill insurers must be eliminated. Etc., etc.

The current system is a massive ripoff. It must be totally redesigned with universal public health insurance for greatly expanded services and the elimination of the flagrant corruption that characterizes the existing sickness treating instead of curing system.

Thank you.

Norm Conrad

Submitted by Tara Swenson
07/23/2023

Greetings,

I live in Tenino, Washington (Thurston County). I am writing to voice my support for Universal Healthcare. Access to universal healthcare would have life changing impacts for me, my family, and my friends who have all suffered from unreasonable medical bills which have caused economic hardships to us each, in varying degrees. Having universal healthcare would mean not having to live in fear every day of going bankrupt due to an unexpected accident. It would mean more security, and a feeling of hope for our futures. We dream of universal healthcare for the state of Washington, and hope that someday it will be available across the entire country. We ask that you please do whatever you can to help to make this a reality for working class families like us, who simply want to not live in fear of bankruptcy due to health care costs.

Thank you,

Tara Swenson

Submitted by Phil Phrog
07/23/2023

UHCC,

We have a system where we allow the healthcare lobby to give money to legislators with the clear intention to influence them.

Accepting this money and then delaying implementation of universal healthcare is not only a breach of ethics and conflict of interest, it's also both immoral and most likely criminal. Those that don't accept this money but do nothing to help the people are also guilty.

I respectfully ask the Commission to strongly recommend that a single-payer system be enacted asap.

Phil Phrog

Seattle

Submitted by Mike Benefiel
07/24/2023

Commission,
I am sure you are aware that our current healthcare system is responsible for the unnecessarily suffering and deaths of many, many of our friends and family members. This is a horrible crime because dozens of studies have all shown that the reason is that we allow the healthcare industry to put their profits before the lives of our families. Sadly the WA legislature, controlled by Democrats, hasn't put a priority on this crisis. Where is our empathy?
I can only ask that you help the legislature recognize the seriousness of this crisis.

Mike Benefiel, Dem PCO

Submitted by Jenne Alderks
07/24/2023

If Washington State had adopted Whole Washington before the pandemic, I believe my mother would still be alive today and in better health than what prompted her to take her life in 2022.

She was denied further medical care while recovering from a knee injury so she began to pay out of pocket for mobility assistance in a nursing home, when she still needed to be in a rehab center during her recovery. As the bills mounted, she worried about her ability to pay for her care. That worry became so loud and overwhelming she killed herself.

For years, I had urged her to work with a therapist to address the anxiety and trauma that kept her feeling unworthy and paralyzed when making decisions. She had been through so much and needed mental health support but it was not covered by insurance; it was too expensive; she couldn't afford the out of pocket costs on fixed income from SSI. She needed someone other than me and her friends telling her that she was worthy of the investment in herself and she deserved to care for herself and be cared for.

A mental health therapist and good insurance should not be out of reach. I lost my mom to suicide because of health care costs. I have been advocating for a single payer health care system in the state for the last decade knowing what a difference it could make in her life.

Delays to study the options like this commission chose to do resulted in deaths of despair like my mother's. By valuing her life and her human rights, we would have adopted a proposal already. We as a state, as a collection of people with common cause and through common consent, could have witnessed to her that she was worthy, that she was worth it and that her human right to health care and life mattered.

It is heartbreaking to see a system fail our loved ones like the health care system and legislature failed my mother. The best way to heal that wound in my family is to ensure that no other family in our state

experiences similar tragedy and trauma going forward. Maya Angelou said “When you know better, you do better.” Well, Washington State knows better. You took the time to study it out and now it’s time to do better.

When my children with complex challenges (on top dealing with the trauma of losing their live-in grandmother to suicide) are on their own, they will need access to mental health care and disability supports. They deserve a one tier system so they can continue receiving access to quality care. When they have to move off high quality employer sponsored insurance to limited state insurance, they will likely lose access to the services they need to ensure their safety and well-being.

Our communities deserve one high quality level of coverage like the one proposed by Whole Washington. I have already lost three family members to suicide and I really don’t want to lose any of my children to it as well, especially if access to mental health or medical care is the obstacle standing in their way.

Please recommend the adoption of Whole Washington to the legislature. Please save our communities and cities from the trauma of losing our loved ones because they can’t get the care that is their right.

Jenne Alderks
Bothell Washington
1st Legislative District

Submitted by Calvin Snow
07/24/2023

We've heard the testimony of mothers crying because of the horrible treatment their children are getting because of the inhuman healthcare system. This has been going on for decades.

Somehow these tears have no effect on those in the WA legislature who, for some reason, can justify supporting this system that ruins lives and brings unnecessary deaths.

The denial of proper healthcare seems to be bipartisan and the reason is money.

Bribery is where money is paid for a specific outcome. That may be hard to prove in this case, but it's what is happening.

The people of Washington want affordable and decent health care but the legislature bows to the wishes of the all powerful healthcare lobby. While some may argue that there are good, honest people in the legislature, I wonder why they aren't speaking up as we watch the system get worse and worse.

The Democratic party is failing us and we must replace the leadership.

Cal Snow, Independent

Port Orchard

Submitted by Scott Hippe
07/25/2023

Hello,
I'm writing to encourage (implore! beg!) the Universal Health Care Commission to recommend implementing a universal health plan for our state. I'm a family physician and regularly see the negative health effects that our current system causes. Many of my patients can't afford health insurance and delay or decline necessary health care and procedures. Many more have insurance, but similarly can't afford what needs to be done due to ever-rising deductibles and insurance companies who work harder to deny care. As a physician, my practice would be healthier and job satisfaction would be much higher knowing that every individual in my state is covered and can afford to come see me.
-scott

Submitted Lauren Kohl
07/25/2023

Dear Lawmakers,

My family spends thousands of dollars, the majority of it already taxed, on healthcare each year. I work part time and manage our household, my husband works full time and the four of us are on his work insurance.

We have considered and used many ways to lower our bills-using generics, putting off procedures, forgoing preventative care, forgoing mental healthcare, forgoing therapeutic treatments, and using an HSA. We've even considered lowering our income to qualify for state coverage. Nothing works and we end up paying over ten thousand dollars of our taxed income each year before meeting our deductible.

We have payment plans in place to ensure our bills are manageable, but all of this cuts into our ability to save for the kids education, our ability to take vacations, and to save for our own retirement. And for what? Too much of the money we spend on healthcare goes to profits. It's a billion dollar siphon of the savings of working people like us.

Other countries spend less and get better health results. We need nationalized healthcare and we need it today. Healthcare must be a right of all people.

Sincerely,
Lauren K.

Submitted by Shannon Skinner
07/25/2023

Greetings to the Washington Universal Healthcare Commission:

I am unemployed. As you know, in the United States most people rely on their employer to provide health care coverage. When someone loses their job, they lose their health care coverage.

Health care is a human right and should not be linked to employment. If someone becomes sick and loses their job due to prolonged illness, it just doesn't make sense that they also lose their health coverage, does it?

And even when an employer provides medical coverage, increasingly it is not sufficient.

This has to be one of the most American headlines ever:
"How health insurance has become a barrier to health care"
https://www.benefitspro.com/2023/07/20/how-health-insurance-has-become-a-barrier-to-health-care/

Americans are finding good jobs with health benefits, "yet employer-based health insurance does not guarantee access to affordable medical care, emergency services, or prescriptions."

Americans face $88 billion worth of medical bills in collections.

61% of Americans with employer-sponsored health insurance have some form of existing medical debt.

Medical debt is unheard of in every other developed country.

“Human Rights Watch, the nonprofit that for decades has called attention to the victims of war, famine, and political repression around the world, is taking aim at US hospitals for pushing millions of American patients into debt. The scale of this crisis — which is unparalleled among wealthy nations — compelled Human Rights Watch to release the new report.”

https://www.hrw.org/report/2023/06/15/sheeps-clothing/united-states-poorly-regulated-nonprofit-hospitals-undermine

Please consider your potential legacy as legislators. History is watching. You have a chance to make history and improve the lives of your constituents.

Please make universal health care in Washington state a reality and set an example to lead the way for all Americans.

I appreciate your time and attention. Thank you.

Shannon Skinner
2851 Cornwall Ave
Bellingham, WA 98225

Submitted by Jessica Powell
07/25/2023

To whom it may concern:

My name is Jessica Powell and I've been a WA state resident since 2001. With regards to health insurance I have experienced everything from corporate gold plans to medicaid and everything in between. I'm currently on Medicaid (second time in 10 years) and I can honestly say it's the best insurance I've ever had and I'm literally terrified for my business to become successful and I have to wade back into the marketplace because I've been there before.

I worked for a major telecom my first decade in Seattle and rarely had to think of my health care plan, mostly because I was young, and secondly because it was just a good plan. I decided to leave the company, a thing many, including myself for a while, people can't fathom doing because of the loss of health insurance. I moved abroad to India for 4 years and experienced everything there from the traditional ayurvedic hospitals, government hospitals and private hospitals, thanks to a ding dong running head on into me on Denny just a few months before my move. To say I was impressed with what was available in India is an understatement.

I moved back mid 2013 and for about a year I was on Medicaid. I was a property manager and with just one building, I didn't make enough, so I qualified, and my company did not offer insurance to any employee who didn't work in the office. When medical things came up I got the care I needed. I ended up getting a second building and then, I made about $150/month more than the minimum for qualifying for medicaid. I had to go into the marketplace and granted I received a discount, but I went from having virtually everything covered, for NOTHING, to paying $30 a month for the cheapest, most awful plan available because that's all I could afford. I couldn't afford to go to the doctor for ANYTHING because my deductible was through the roof. As I made more money, I got better plans but even still, choosing a plan that my doctors would cover was difficult. Example, my therapist took Regence BUT this very particular Regence plan did NOT cover my therapist, while all their other ones did. I ended up paying $400/month for a premium when I again, barely went to the doctor but I did spend an additional $3000 that year to my therapist.

The next year I finally found a plan that DID cover my therapist. It was a gold Group Health PPO plan and was satisfied and FINALLY was able to see doctors again. Welp, the year after, WA State marketplace CUT ALL PPO plans and went w/ HMO ONLY. NONE of the plans covered my GP or my therapist and I panicked! I'm not speaking hyperbole when I tell you I almost married my friend for his health insurance, something he proactively offered. I had a friend suggest I go work part time as Starbucks, ON TOP of my full time job, just to get insurance! What sort of world do we live in where working 60hr a week is required for us to deserve health care??

What I DID do is BEGGED my boss to let me pay FULL PRICE for the insurance plans the company offered their office staff. After about a month of discussions she said, "Ok, we're going to allow it but you canNOT tell ANYONE! We could get in huge trouble for this." I was RELIEVED so for the next 3 years I paid full price, which ranged from $350-$450/month to continue to be on Group Health PPO (during this time Kaiser bought Group Health). Those were some good years and I was making enough to afford that, even with 2 of those years costing me 20% of my net income because I had a super invasive knee surgery. My last year of working w/ this company they dropped Kaiser as an option because the premium went up to $600+/month for the exact same plan we had the year prior and I lost 1/3 of my job when one of the owners sold a building I was managing and living, so my living expenses increased SIGNIFICANTLY.

To say the stress and panic all of these changes caused was exceptional is also an understatement. At the end of 2020 I was laid off by my company and now unemployed, I was able to, once again, qualify for Medicaid. It's been GLORIOUS! I don't have things like massage, acupuncture or chiropractic but I've been able to get EVERYTHING taken care of and have paid nothing for it. I know this time will at some point come to an end so I'm getting EVERYTHING checked out bcs as a 43 year old woman, I'm not going to need less health care as I age but more. With the 4 plans available I was able to find the 1 that took both my main doctors and it's been such a breeze. I truly consider myself fortunate right now to be a resident of WA State on Apple Health bcs it's truly amazing. While my partner has to be on the phone for hours working out insurance nightmares w/ her corporate plan, I've made one call in the last 3 years and that was an easy call due to some weird verbiage Coordinated Care used in a letter.

Speaking of partner, she is legally separated from her ex-husband but still married to him so she can be on his health insurance, along w/ their 2 kids. I am also on medicaid so if we were to wed, our household would go from paying $150/month in health insurance premiums to upwards of $1000/month and we can't afford that! She can't get divorced and we can't get married BECAUSE OF HEALTH INSURANCE! We aren't a rare instance of this either. I know MANY people who have had to make big life decisions because of one thing, HEALTH INSURANCE.

I'm starting a new business and while I'd really like to say I have a fire under me to make it a success, I know once I cross that threshold of income earning, which is SO SMALL, I'll go back to having absolutely garbage insurance as my options. To have a system that keeps people poor for the sake of being able to have quality health insurance should be criminal. I also know so many people working these corporate jobs as cogs who have dreams of innovating and creating their own visions but because they'd lose their health insurance, they stay at Amazon/MS/FB/etc, miserable, just so they can provide health insurance for themselves and their families. I have friends who worked in different aspects of the medical profession (PTs, MDs) MOVE TO CANADA so they could do the work they were passionate about without having to deal with the nightmare that is our insurance system. Not having universal health care STIFLES innovation and stifles medical professionals ability to have the time, space and capacity to focus on the work that matters.

In Washington State we need Universal Health Care and not just for those financially unfortunate, but for those skirting the lines of income levels AND for those who ARE financially successful but have felt trapped working where they do because of health insurance. Health insurance should NOT be tied to employment in ANYWAY. I don't know the full economics of the options but I know the system we have now is needlessly expensive. If freaking India can figure it out, we can! There are SO MANY western countries who have implemented systems so we KNOW it works and we can pick from the best of all of them to make something that's phenomenal for the people of WA State.

I won't be able to legally marry the woman I love, nor feel safe and comfortable really pushing to make my new business a success until we have some sort of universal/single payer health care system in place.

Thank you for your time.
Jessica C Powell

Submitted by Linda Baker
07/26/2023

Dear Commissioners,

While I am one of the fortunate ones who have good healthcare, as a nurse and therapist, I know how many people are not as fortunate as I am, and as you are. These people, many who suffer in silence, cannot go to a doctor and mental health care provider for fear of losing all they have. In the richest country in the world, we may also be the most out of balance as we spend billions on war machinery, and so little to keep our country healthy. Universal Healthcare should be a right for every citizen and immigrant who seeks refuge in our country. I hope that Washington State will lead the way to making Universal Healthcare a right in our state. Let us be a model for the country! Please do the right thing.

Sincerely,
Linda Baker
Renton,WA

Submitted by Lisa Picatti
07/26/2023

It is time for our state to treat healthcare as something every human should have access to, regardless of income, race, background, housing status, or any other factor that makes any group of people less likely to be able to get the care they need. The current system is beyond broken and impossible to navigate even for someone like me, who prior to retirement, was an employer benefits plan administrator for thirty years. I needed foot surgery and was unable to get clear out of pocket estimates on treatments or procedures so I was unable to "shop around" or really even determine the affordability of care I needed. Thankfully I was able to go forward with care because of our family's substantial income, but for SO many others this is a complete roadblock and they can't get the care they need. If we care for ourselves and fellow humans even a fraction of the amount we claim to, we will start providing healthcare for EVERYONE in our state, without question.

Thank you!

Lisa Picatti
1620 Smith Rd
Zillah WA 98953
509-901-1500
lisaesavage@gmail.com

Submitted by Cris Currie
07/27/2023

I'm Cris Currie, retired RN and member of HCFA-WA.

In an effort to jump start a discussion of the UHCC's vision for Washington's universal health care system, I would like to offer the following. This vision is based on the key design elements inventory prescribed in SB 5399 and expanded in the November 2022 report. It supports the Washington Health Trust bill, is consistent with the Oregon UHC Task Force report, and it further clarifies how the UHCC can address the inventory and the overall direction it intends to take. If members could agree on the direction, it would greatly facilitate the task of prioritizing transitional steps. Steps that will need to be taken anyway as parts of the vision would receive the highest priority. Adopting a common vision will also give the public and the legislature a much clearer picture of what the final product will look like, and it will help generate excitement towards its accomplishment.

A Suggested Vision for the UHCC

Because healthcare is a fundamental element of a just society, the Universal Health Care Commission is committed to designing a unified healthcare financing system, around a single risk pool, that allows providers to bill only one entity according to standard, established rates, thereby dramatically reducing administrative costs. Other cost containment strategies will be widely implemented, while reimbursing providers fairly. High quality, equitable, patient-centered care, will be available to and affordable for all state residents, so every resident can obtain medically necessary services, from any contracted provider, when and where they are needed with minimal effort and out-of-pocket expense. Primary care will be emphasized over specialty care.

The system's governance will be overseen by the state and managed without profit for the public good, but also transparent and truly owned by the communities it serves. Providers will utilize a common electronic medical record that will clinically integrate all services and greatly enhance the continuity of care and improve health outcomes. Anonymous health data will be widely, but confidentially, available for research to improve evidence-based standards of care for all providers. Joining the system will be voluntary for employers, providers, and residents. Ultimately, the ACA Exchange, Medicare, Medicaid, and CHIP will be integrated into the system.

<u>Submitted by Ronnie Shure, Whole Washington</u>
07/27/2023

We would like that UHCC and FTAC choose these transitional solutions:

- develop a plan and financial analysis to
  implement a no-premium qualified health plan (QHP) auto-enrollment for Medicaid beneficiaries
  losing their coverage.
- prepare an analysis of expanding health coverage for low-income Medicare beneficiaries.

Thank you,

ACHIEVING UNIVERSAL, PUBLICLY-FUNDED HEALTH CARE,
Ronnie Shure (he/him)
206-307-9481
President
Health Care for All - Washington

http://www.healthcareforallwa.org/

Medicaid-HBE Auto-Enrollment

REQUEST: Health Care For All – Washington (HCFA-WA) is requesting the Universal Health Care Commission (UHCC) request the Health Care Authority (HCA), Health Benefit Exchange (HBE) and UHCC Financial Technical Advisory Committee (FTAC) develop a plan and financial analysis to implement a no-premium qualified health plan (QHP) auto-enrollment for Medicaid beneficiaries losing their coverage.

BACKGROUND

In general, Medicaid and related programs providers coverage for low-income adults with incomes up to 138 percent of the federal poverty level (FPL), pregnant women with income of to 198 percent of FPL and children in households with incomes up to 317 percent of FPL. Some 2.2 million persons in Washington are receiving coverage through these programs. The HBE QHP plans offer tax credits (premium subsidizes) for individuals and families with incomes up to 400 percent of FPL and out-of-pocket costs savings for persons with incomes up to 250 percent of FPL.

Both the Medicaid programs and HBE contract with health carriers to provide medical coverage to their enrollees. Medicaid is currently contracting with five carriers and HBE is contracting with ten carriers. Four of the five Medicaid carriers are also QHP carriers.

Low-income Individuals and families are able to obtain Medicaid or QHP coverage through HBE's on-line *Washington Healthplanfinder*. However, when an individual or family loses Medicaid coverage due to a change in their income status, they are required to initiate action to enroll in HBE QHP coverage. This can result in a break in their medical coverage and potentially loss of coverage. For example, some 229,000 Medicaid enrollees have lost coverage due to termination of the Families First Coronavirus Response Act (FFCRA) provision that required state's Medicaid programs keep people continuously enrolled through the end of the COVID-19 public health emergency (PHE).[1]

AUTO-ENROLLMENT ANALYSIS

As part of its initial assignments, the UHCC directed FTAC to provide a list of transitional solutions to "*…create immediate and impactful changes in the health care access and delivery system*." Among its

[1] Kaiser Family Foundation's Medicaid Unwinding Tracker reported that as of June 2023, 229,690 enrollees were disenrolled from Medicaid., including 54,440 who were determined ineligible and 175,00 who were terminated for procedural reports.

26 suggested solutions, FTAC recommended auto-enrolling Medicaid beneficiaries losing cover into a no-premium HBE QHP. This can accomplished within existing federal Medicaid enrollment provisions or waivers.

HCFA-WA is requesting the UHCC adopt this solution and direct the FTAC, HBE and HCA to prepare an analysis of Medicaid/HBE auto-enrollment. The analysis would include estimates on reducing lost coverage, *Healthplantfinder* and ACES system revisions and costs, necessary state statutory or rule revisions, and recommendation on preserving consumer choice. The analysis would be completed for the 2025 legislative session.

Low-Income Medicare Expanded Coverage

REQUEST: Health Care For All – Washington (HCFA-WA) is requesting the Universal Health Care Commission's (UHCC) direct its Financial Technical Advisory Committee (FTAC) in coordination with the Department of Social and Health Services (DSHS) and Health Care Authority (HCA) to prepare an analysis of expanding health coverage for low-income Medicare beneficiaries.

BACKGROUND

As part of its initial assignments, UHCC directed FTAC to develop "*…options about how best to address Medicare in the universal health care system they are designing.*"[1] The FTAC outlined six options and concluded there were not available options for incorporating Medicare into a state administered system without Congressional action. However, UHCC adopted Option Six, which is 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.*"[2] There is an existing pathway to achieve this option in part for low-income Medicare beneficiaries through the Medicaid Categorically Needy (CN) Aged, Blind and Disabled (ABD) coverage.

CN ABD coverage provides medical services (e.g., vision, hearing, behavioral health) not covered by Medicare, long-term care services (e.g., nursing home services, home and community-based services, housing support), hospice and nonemergent medical transportation. To be eligible for CN ABD coverage a persons must be age 65 or older, blind or Supplemental Security Income (SSI) defined disabled. The person must have income not greater than the SSI grant standard ($934 per month (77 percent of the Federal Poverty Level (FPL) for a single person or $1,391 per-month (85 percent of FPL for a two-person household) and have exempt resources no greater than $2,000 for an individual or $3,000 for a two-person household. [3] As of December 2023, there some 146,000 Medicare beneficiaries enrolled in Washington's CN ABD coverage. [4]

[1] FTAC UHCC memorandum, "Options for Addressing Medicare in the Universal Health Care Design", UHCC June 13, 2023, materials.
[2] Ibid.
[3] SSI exempts certain resources to support a person. These include: a home that one lives in; one vehicle used for transportation; household good and personal effects; and limited life insurance and burial funds.
[4] Source: Department of Social & Health Services' Research & Data Analysis Division - ProviderOne Client by Month (December 2023 enrollment)

CN ABD EXPANSION

States can expand Medicaid to seniors and people with disabilities whose income exceeds the SSI limit but is below the federal poverty level ($1,215 per month for an individual in 2024). [5] The federal maximum income limit for this pathway is 100% FPL. Based on data used for the 2023 legislative expansion of the Medicaid Qualified Medicare Beneficiary (QMB) expansion from 100 to 110 percent of FPL, there are some 68,000 Medicare beneficiaries in Washington with incomes between 76 and 100 percent of FPL.

According to the Kaiser Family Foundation (KFF) analysis of "Medicaid Eligibility through the Aged, Blind, Disabled Pathway" analysis, 28 states had higher ABD income limits than Washington for an individual in 2022 and 24 states had higher income limits for a two-person household.[6]

HFCA-WA is endorsing the UHCC's guidance to adopt Option 6 to explore recommendation to address gaps in benefits and cost-sharing for Medicare enrollees not available in Medicare program. HFCA-WA is requesting UHCC to direct FTAC in coordination with DSHS and HCA to prepare an analysis of expanding the Medicaid CN ABD coverage for low-income Medicare beneficiaries. The analysis should include a detailed description of the benefit expansion for these beneficiaries, cost estimates for the expansion to 100 percent of FPL through the 42 U.S.C. § § 1396a (a)(10)(A)(ii)(X) option, and necessary system revisions for the expansion. The analysis would be completed for the 2025 legislative session.

[5] 42 U.S.C. § § 1396a (a)(10)(A)(ii)(X); 1396a (m). Sources KFF Survey of Medicaid Financial Eligibility & Enrollment Policies for Seniors & People with Disabilities, Kaiser Family Foundation, July 2022.
[6] https://www.kff.org/medicaid/state-indicator/medicaid-eligibility-through-the-aged-blind-disabled-pathway/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Tab 4

Washington State Health Care Authority

FTAC updates

ERISA

FTAC's July meeting

Pam MacEwan,
FTAC Liaison

ERISA overview

- Evolution of Courts' interpretation of ERISA preemption
- ERISA preemption impacts on state innovation, including universal health care initiatives
- Potential areas of opportunity
  - Participation in universal plan optional for employers
  - Pay or play or "meaningful alternative"
  - Provider incentives or some level of regulation
  - Payroll tax on all employers (Oregon)

ERISA issues in Washington

- Segments of the health care market for which ERISA preemption does not apply
  - Individual market
  - State/local gov't self-funded group health plans (e.g., Uniform Medical Plan (UMP)
- Health policies in Washington that **have** and **have not** brought ERISA challenges and **why**

FTAC's September meeting

Pam MacEwan,
FTAC Liaison

- Examine options to include ERISA
- Assess the pros and cons of each option
- Develop recommendations to the Commission
- Review the Commission's guidance on Medicaid

Finance Technical Advisory Committee (FTAC) Meeting Summary

July 13, 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 committee is available on the FTAC webpage.

Members present

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

Members absent

Esther Lucero
Robert Murray

Call to order

Pam MacEwan, FTC Liaison, called the meeting to order at 2:01 p.m.

Agenda items

Welcoming remarks

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

Meeting Summary review from the previous meeting

One revision was proposed to clarify language in the May 2023 meeting summary. Members present voted by consensus to adopt the meeting summary as amended.

Public comment

Roger Collier asked if costs doubling for some employers via a payroll tax could be deemed as "exorbitant" and in violation of the Employment Retirement Income Security Act of 1974 (ERISA). Roger Collier also asked how far out federal court processes to resolve ERISA preemption would be from Washington's passing of universal health care legislation.

Warren George, former member of Oregon's Task Force on Universal Health Care, encouraged further regional cooperation between Oregon and Washington and noted the benefits of a single-payer system.

Cris Currie, retired RN, remarked that ERISA is only an issue within the context of a single-payer system and encouraged FTAC to clarify with the Commission whether a single-payer health care system is their goal. His report on handling ERISA in a single-payer context is in the written public comments of the May meeting materials.

Marcia Steadman, Health Care for All Washington, noted that Washington's 2023-2025 operating budget allocated funding to support FTAC's work and expects to see a revised workplan and more robust meeting agendas. FTAC members were encouraged to follow Oregon's Task Force on Universal Health Care's example to address ERISA.

Presentation: Updates from the Commission's June meeting and goals of this meeting

Liz Arjun, Health Management and Associates (HMA)
FTAC heard updates from the Commission's June meeting, including the Commission's adoption of FTAC's guidance on Medicare eligibility, transitional solutions, and the Commission's ERISA questions for FTAC. This meeting focused on gathering information on ERISA in preparation for FTAC's discussion in September to develop recommendations for the Commission on ERISA eligibility options. FTAC member Roger Gantz suggested that the Commission coordinate with and leverage the resources of the Health Care Cost Transparency Board to examine ways to address rising health care costs and affordability for consumers.

Presentation: A brief history of ERISA and health care policy

Carmel Shachar, Asst. Clinical Professor of Law and Faculty Dir., Health Law and Policy Clinic, Harvard Law School
ERISA was not intended to be a health care statute but is one. ERISA, a federal statute, governs employer-sponsored health care plans or insurance plans where an employer covers the full financial risk of its employees' claims for health care benefits (known as self-funded). Regulation of ERISA plans is "exclusively a federal concern" and preempts "all state laws insofar as they…relate to any employee benefit plan" (one of the broadest preemption clauses ever written). Most Americans receive health care coverage through this type of health plan.

Prior to the 1990's, a state's statute was deemed in violation of ERISA preemption when it had a connection with or reference to an employer covered benefit plan. In *New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Co*., the state tried to make enrollment in Blue Cross Blue Shield (Blue) plans more attractive by imposing a 24 percent surcharge for hospital services for patients covered by anything other than a Blue plan compared to an 11 percent surcharge for Blue plans. The Supreme Court determined that ERISA did not apply because the law had an indirect economic impact on ERISA plans and did not mandate certain administrative structures or choices. ERISA statute refers to a fee/penalty becoming so "exorbitant" that it's no longer an indirect economic impact; however, there is no definition of "exorbitant."

In *Gobeille v. Liberty Mutual* (2016), the Courts made a more expansive preemptive decision (compared to Travelers). Liberty Mutual brought a case against Vermont that ERISA preempts reporting to the All-Payer Claims Database (APCD) because ERISA already has reporting requirements. In the Court's decision, and for the first time, potential *future* issues with uniformity were considered. Courts agreed with employers since the law governs a central matter of plan administration and interferes with nationally uniform plan administration.

Rutledge v. Pharmaceutical Care Mgmt. (2020) restored ERISA preemption jurisprudence of the 1990's and concerned Arkansas's regulation (Arkansas Act 900) of pharmaceutical benefit managers (PBMs) and drug pricing. PBMs argued that the state regulating what PBMs pay to pharmacies would be regulating ERISA plans since many

of the health plans for which PBMs administer fall under ERISA. The Supreme Court decided that Arkansas's law did not "refer to" ERISA because it applied to PBMs "whether or not they manage an ERISA plan." The majority opinion relied heavily on the Travelers case. Professor Shachar noted that Rutledge may be good news for states hoping to innovate but cautioned not to count on it being the last word on ERISA preemption.

The Gobeille decision shows that ERISA fixes are unlikely. Congress could carve health plans out of ERISA, though they've shown little interest in doing so. The Dept. of Labor (DOL) and the Dept. of Health and Human Services (HHS) could create ERISA carve outs. However, reporting to the APCD is a smaller issue than moving to universal health care and if there's no proactive attempt to smooth the APCD path, it's unlikely that Congress or those federal agencies will be a solution to the problem.

Two cases illustrate ERISA's impact on universal health care attempts. In Maryland's *Retail Industry Leaders Assoc. v. Fielder* (2007), the law targeted Walmart, requiring employers with more than 10,000 employees to spend at least eight percent of their payroll on health care, or else pay the difference between the employer's health care expenditures and the eight percent threshold into a state Medicaid fund (an example of "pay or play"). The only rational choice for Walmart was to spend the required amount on health care benefits. The Fourth Circuit struck down Maryland's "fair share law" because it mandated benefits and did not have an *in*direct economic impact.

In *Golden Gate Restaurant Association v. City and County of San Francisco* (2009), San Francisco issued a tax based on hours worked where employers had discretion about how to spend the expenditures. One option was to pay into a new health care program for low to moderate income residents. The Ninth Circuit reversed the District Court's findings that this program violated ERISA because the ordinance applied regardless of whether employers offered an ERISA plan. Golden Gate was distinguished from Fielder (Maryland) because employers had a "meaningful alternative" to increasing their current health plans and had total discretion about how to spend their mandated contributions. The Ninth Circuit continues to be friendly to this line of thinking, but other Circuits are closer to the Fourth Circuit's thinking on Fielder.

ERISA creates discontinuities within access to reproductive care post the Dobbs decision. Self-funded plans cannot be regulated by states and can likely cover abortion services and care even in states that ban abortions. However, employees would struggle to find providers and it's unknown whether ERISA is a shield against criminal liability. States also can't require employer plans to offer reproductive care. It is possible that a future presidential administration that was anti-abortion could have its DOL issue regulations that no ERISA covered plan could support access to abortion services which could cause issues for a state-based universal health care system.

FTAC member Christine Eibner asked why the Golden State case didn't reach the Supreme Court. It was clarified that the case wasn't pressing enough at the time to be resolved by the Supreme Court.

FTAC member Roger Gantz asked about states' abilities to regulate providers. It was clarified that mandating that providers only bill the universal plan could invite resistance (and potentially lawsuits) from providers, but the state could provide incentives to providers to bill only the universal plan. FTAC member David DiGiuseppe asked whether a state could develop a universal pricing reimbursement scheme that is outside the purview of ERISA. This could be successful if it's keyed to the provider side versus the insurer side. It could have indirect economic impacts on ERISA plans, but the state wouldn't be mandating specific benefits.

David DiGiuseppe asked to clarify that the clear pathways to addressing ERISA challenges are an act of Congress (highly unlikely), and a pay/play/meaningful alternative. Professor Shachar responded that in the latter, and

similar to Golden Gate, the universal plan would be the meaningful alternative where employers could design and offer their own benefits or pay into the universal plan for their employees to access health care.

FTAC member Eddy Rauser asked if Gobeille (APCD reporting) is a litmus test for ERISA being used as a shield against health care reform efforts. Eddy Rauser also asked whether Workers' Compensation is self-funded, and Pam MacEwan clarified that it is self-funded and does not fall under ERISA.

Presentation: ERISA issues in Washington

Commission member Jane Beyer, Senior Health Policy Advisory, Office of the Insurance Commissioner (OIC). Jane Beyer's presentation provided an understanding of what Washington state laws or policies have been tested or challenged, and what hasn't been challenged with regards to ERISA.

About one third of Washingtonians receive health coverage through a self-funded group health plan (SFGHP). The OIC regulates fully-insured small and large group health plans. OIC also has jurisdiction over health plans offered on the individual market. The Washington Legislature is the purchaser for the Uniform Medical Plan (UMP), a SFGHP for state employees that can be regulated by the state. Private SFGHPs are regulated by the DOL/Employee Benefits Services Administration (EBSA). State/local government SFGHPs are accountable to HHS/Centers for Medicare and Medicaid Services (CMS). Washington's future universal system would likely be regulated by an entity established by state law. OIC cannot regulate Taft-Hartley plans.

With regards to benefits, fully-insured health plans must provide benefits that are mandated by both federal and state law. Both private and state/local government SFGHPs must comply with federal laws including ERISA, the Mental Health Parity and Addiction Equity Act (MHPAEA), the Health Insurance Portability and Accountability Act (HIPAA), the Pregnancy Discrimination Act, Americans with Disabilities Act (ADA), Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), preventive services, and the No Surprises Act. The benefits for Washington's future universal system would be defined by state law, but the state-established regulatory entity would need to comply with federal laws that apply to all health plans.

For fully-insured health plans, "provider network adequacy" is defined in Washington state law, plus the Affordable Care Act (ACA) for qualified health plans (QHPs). For both private and state/local government SFGHPs, provider network adequacy is not directly regulated, though indirectly there is some network adequacy via federal laws, e.g., MHPAEA. Provider network adequacy must be defined in state law for the universal system.

The ACA and state law address eligibility for fully-insured health plans. For both private and state/local government SFGHPs, eligibility is set by the plan with certain federal laws such as HIPAA and the ADA playing an indirect role in eligibility. Eligibility for the universal system must be defined by the state.

ERISA was a prominent issue when the Washington Health Services Act (HSA) was enacted in 1993. The HSA included an employer mandate to offer coverage, starting with employers with more than 500 employees in 1995, and extending to all employers by 1997. Employers were required to purchase certified health plans or to enroll employees in the Basic Health Plan or health insurance purchasing cooperative established in the HSA. There was distinct treatment of Taft-Hartley trusts. The HSA directed the Governor to negotiate with Congress to obtain a statutory ERISA waiver. The employer mandate (and other provisions) was repealed in 1995 due to the 1994 election results. Washington did not have the opportunity to pursue an ERISA waiver with Congress.

The Washington Vaccine Association (WVA) (2010) has never brought an ERISA challenge despite SFGPHs being told how to administer benefits. Due to budget constraints in 2009, a group was created to develop a new funding mechanism for the state to continue purchasing and providing childhood vaccines. The WVA was created, where Washington universally purchases childhood vaccines for all children at volume discounted rates from the Centers for Disease Control (CDC) and delivers them to providers at no cost. Health insurers and TPAs of SFGHPs reimburse the WVA for vaccines administered to privately insured children via "dosage-based assessments." The WVA then transfers funds to the Washington Dept. of Health for bulk vaccine purchases. Payers are assessed at rates lower than reimbursing the costs of private purchase of vaccines which is a benefit to employers. All TPAs register with the WVA and there is no cost to patients.

The Partnership Access Line (PAL) has also never brought an ERISA challenge. PAL provides psychiatric consultations for certain providers caring for children and pregnant/postpartum individuals. PAL is insurance agnostic and was initially funded with Medicaid funds, despite some children being ineligible for Medicaid. The Washington Legislature developed an alternative funding mechanism. PAL is administered by the WAPAL Fund - a blend of Medicaid and assessment funding in proportion to the coverage source of people served. For privately insured children, there is quarterly covered-lives assessment on payers, including SFGHPs. The assessment per covered life for fiscal year 2024 is seven cents per-member per-month (PMPM).

Washington's behavioral health (BH) crisis system, also insurance agnostic, is largely funded by Medicaid, federal block grants, and state general funds. The 2023-2025 Operating Budget directs HCA, Medicaid managed care organizations (MCOs), BH administrative service organizations, carriers, self-insured organizations, and BH crisis providers to assess gaps in the current funding model and recommend options for addressing these gaps including, but not limited to, an alternative funding model, e.g., covered-lives assessment, for crisis services.

SB 5213 (did not pass, 2023) would've expanded regulation of PBMs to include contracts with SFGHPs and insurers regulated by OIC. Several states and Congress are examining PBMs' business practices. Some provisions in states' laws are also targeting plan design, e.g., consumer cost-sharing.

David DiGiuseppe asked whether the BH crisis assessment is likely to raise ERISA challenges. Jane Beyer noted that in both Travelers and Rutledge, the Courts allowed additional costs to be imposed on a plan, however it's a question of "how much is too much." By virtue of employers paying the BH assessment, they won't need to pay for those services. Like with the WVA and PAL, this benefits the employer.

David DiGiuseppe asked what an ERISA challenge looks like procedurally. A party files a case in federal district court to review and determine whether a state law violates federal law. The district court will determine whether to put a stay on implementation of the state law pending the court making its decision.

Roger Gantz asked to define "partially insured." Also known as a "level-funded" plan, risk is shared by both the employer (typically small employers) and their TPA and protected by stop-loss coverage. The "attachment point" is the predetermined amount at which the TPA will start to pay claims. OIC regulates how low the attachment can go.

Eddy Rauser asked what made the WVA successful. Jane Beyer replied that an entire legislative interim was spent with multiple stakeholders at the discussion table. Roger Gantz noted that the WVA is like a safe harbor test where the PMPM doesn't impair self-funded plans' ability to design their benefits.

Christine Eibner asked about the viability of taxing employers generally, if not specifically employers that currently offer health insurance. Hypothetically, a state could issue a general tax on all employers, put the revenue in a general fund, and use the fund for a given priority, which could be health care. Jane Beyer replied that that was Oregon's proposal, where it's in the employer's best interest to pay the tax and enroll employees in the universal plan.

Presentation: Next steps

Liz Arjun, HMA

At the Commission's August meeting, Pam MacEwan, FTAC Liaison, will share updates from this meeting. In September, FTAC will discuss and develop recommendations to the Commission on ERISA eligibility. HCA staff will send FTAC members informational materials in preparation of the September meeting.

Adjournment

Meeting adjourned at 3:58 p.m.

Next meeting

September 14, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Tab 5

Washington State Health Care Authority

Washington Universal Health Care Commission

Liz Arjun - HMA

August 10, 2023

Guidance to FTAC

Medicaid

Guidance to FTAC on Medicaid

The Commission identified Eligibility as the first foundational topic for FTAC to address, starting with Medicare, followed by ERISA.

➢What questions would the Commission like have FTAC answer and evaluate regarding **Medicaid** eligibility for the new system?

Tab 6

Washington State Health Care Authority

Understanding the Washington Health Trust

SB.5335 and the path to universal coverage and beyond

Slides submitted 8/2/2023

Presentation on 8/10/2023

For the latest version of these slides and other supplemental materials go to **wholewashington.org/uhcc-presentation**

Today's presenters

Andre Stackhouse

Academic background: BS in Informatics: Human-computer interaction, University of Washington

Professional background: Software engineering at Code.org and Microsoft

Political background: 2020 Democratic Party delegate (state & national), Seattle DSA healthcare working group co-chair, Whole Washington campaign director (I-1471)

Erin Georgen

Academic background: AAS in Physical Therapy, AA in Graphic Design

Professional background: Currently, Technical Communications & Graphic Design. Previous Professional experience includes Health Services Technician in the USCG, Physical Therapist Assistant

Political background: Primary Sponsor of the 2018 Ballot Initiative I-1600

Whole Washington

Whole Washington is a 501(c)4 nonprofit organization founded in 2017 to advance the passage of universal public healthcare at the state, regional, and federal level.

We are the organizers behind **The Washington Health Trust** (WHT) in its multiple iterations both as legislation and ballot initiative.

Sen. Bob Hasegawa - primary sponsor of the Washington Health Trust

Timeline of important healthcare policies

- **2018** - I-1600 - The Whole Washington Health Trust is first introduced to the public as an initiative to the people
- **2019**
  - SB.5222 - The Whole Washington Health Trust is first introduced as legislation in the WA Senate.
  - Long-term Care Act (WA Cares) passes establishing taxes and benefits for long-term care
  - CascadeCare signed into law
- **2021**
  - SB.5399 - The Washington Legislature creates the Universal Health Care Commission (UHCC)
  - I-1362 - Whole Washington Health Trust reintroduced as an initiative to the legislature, income tax removed (replaced with employment tax)
  - SB.5204 - Whole Washington Health Trust reintroduced to Senate with new sponsors and modified employer spending requirement
  - Universal Healthcare Work Group Report published, examines three universal health care models for Washington
  - ESSB 5096 passes - Washington introduces capital gains tax
- **2022**
  - I-1471 - The Whole Washington Health Trust renamed to The Washington Health Trust, individual premium removed, UHCC elevated to WHTB immediately
  - SB.5335 - WHT reintroduced into Senate
  - 1332 Waiver acquired to expand coverage to undocumented residents
- **2023** - Washington State Supreme Court rules capital gains tax is constitutional

Our goals

Today

- A shared definition of universal healthcare
- Explain how the Washington Health Trust works
- Explain our solutions to the known barriers like **ERISA** and **Medicare waivers**
- Answer your questions as best we can

The future

- Establish an ongoing and collaborative relationship with the Universal Health Care Commission (UHCC)
- A more detailed discussion of the financial considerations with the Finance Technical Advisory Committee (FTAC)
- Co-development of universal healthcare policy for recommendation to the WA legislature

Defining Universal Healthcare

Defining Universal Healthcare: World Health Organization

"Universal health coverage means that **all people have access** to the **full range of quality health services** they need, **when and where they need them**, **without financial hardship**."

Key elements found in successful models:

1. Everyone is eligible to enroll or automatically enrolled
2. Universal set of essential health benefits
3. Uniform billing and reimbursement
4. Significantly publicly-funded
5. Non-profit

“Of all the forms of inequality, injustice in health is the most shocking and inhuman because it often results in physical death”

Models considered by the Universal Health Care Work Group

Three models considered

Both before and after models were developed for Work Group consideration, members discussed their perspectives on cost sharing, provider reimbursement, covered benefits, covered populations, and transition issues. They discussed these topics both on their own and in the context of the various models. In December 2020, members also completed a survey in which they ranked the models.

The project team used Work Group discussions, input, and information on international models and prior universal care or coverage concepts in the United States to develop three draft models for Work Group consideration:

- **Model A:** state-governed and administered program for all state residents.
  - Estimated implementation year savings: **$2.5 billion**
  - Estimated annual steady state savings: **$5.6 billion/year**
- **Model B:** state-governed and health plan administered program for all state residents.
  - Estimated implementation year savings: **$738 million**
- **Model C:** access to coverage for undocumented residents unable to buy coverage now. This model could be expanded to other uninsured or underinsured populations.
  - **No system savings**

All models would have care delivered by private and public providers, clinics, and hospitals. The following tables are an overview of each model's characteristics and financial analyses. It compares the model to the status quo and qualitative assessment of the model's potential to achieve Work Group goals.

Table 1: overview of each model's characteristics

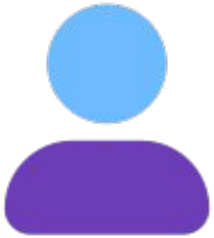
	Model A	Model B	Model C
Populations	All state residents, including Medicaid, Children's Health Insurance Program (CHIP), Medicare, privately insured, undocumented, uninsured		Undocumented immigrants
Covered benefits	• Essential health benefits, plus vision for all participants • Dental and long-term care for Medicaid[1]		Essential health benefits
Cost sharing	• No cost sharing • Associated utilization changes		Standard cost sharing
Provider reimbursement	• Reduced pricing variation between populations • Administrative efficiency • Increased purchasing power		Cascade Care reimbursement levels

The Washington Health Trust

The Washington Health Trust: Origins

- Originally based on and inspired by the Washington Health Security Trust (WHST) developed by Health Care for All Washington.
- Tax funding rates and mechanisms guided by fiscal studies performed by Gerald Friedman, economics professor at the University of Massachusetts at Amherst.
- Technical language reviewed by Employment Security Department (ESD) and Department of Revenue (DOR).
- Key provisions found in Sec 101 were inspired by the core values consistently expressed by community organizations, providers, and individuals.

The Washington Health Trust (WHT)



Creates Public Options that any WA State individual or company can enroll in for coverage.

Generates revenue via taxes to pay for healthcare expenses.

Gives existing entities the authority and responsibilities to transition to and maintain a statewide universal healthcare system.

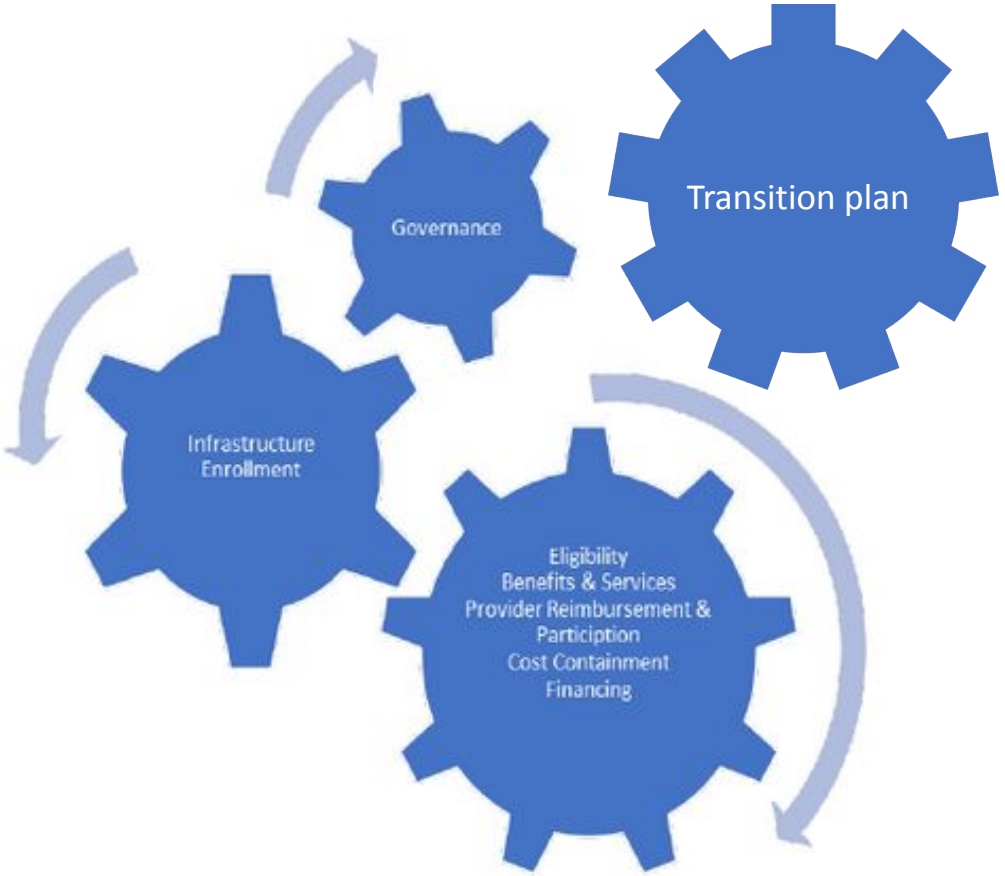
What will the Washington Health Trust legislation do?

- **Creates the Washington Health Trust (WHT)**
  - A bank account to store funds and send reimbursements from
  - A unified financing system for essential health benefits
- **Creates the Washington Health Trust Board (WHTB)**
  - Manages the Washington Health Trust
  - Defines a SINGLE **essential health benefits** and coverage package
  - Ensures all individuals (and their employers) can opt in voluntarily
  - Establishes the mechanisms for annual collective negotiations with qualified providers for reimbursement rates
  - Coordinates with Health Care Authority (HCA) to allocate funding for Community Health Providers to improve access to community-based care
  - Contracts with Centers for Medicare & Medicaid Services (CMS) to offer essential health benefits package to Medicare enrollees as a Medicare Advantage plan managed by CMS
- **Creates a transitional Health Options Program**
  - Managed by Health Care Authority (HCA)
  - Provides cost assistance & enrollment support to uninsured or underinsured
  - Provides oversight on impacts to coverage during transition & recommends policy improvements
- **Establishes funding mechanisms through taxes and enforced by Employment Security Department (ESD) & Department of Revenue (DOR)**
  - New long term capital gains tax (DOR)
  - Employment contribution (payroll tax) to enforce a **required health care expenditure** for each employee by employers (ESD)
  - Sole-proprietor contribution

In a nutshell … a Model A/B hybrid

The Washington Health Trust is an **All Payer** model
with a **Pay-to-Play requirement** for employers
It includes **Public Options** for all Washington residents,
Public Health funding for participating Community Health Providers,
As well as the **financing and transition plans** necessary to achieve universal coverage

Design components developed by the Commission



Governance

Governance: Washington Health Trust Board

- UHCC members given the option to be appointed to the board immediately
- Expands the board to include new members
- Creates committees to represent and collaborate with key stakeholders
  - **Citizen committee** - publishes reports and holds public meetings
  - **Provider committee** - facilitates collective bargaining agreement & negotiates reimbursement rates
  - **Finance committee** - manages the WHT and maintains its revenues and solvency.
- Allocates funding to community health providers
- Supports HCA to acquire federal waivers

Governance: Health Care Authority

- **Provides Accountability and Oversight:** The HCA is the contracting authority for most state-managed publicly funded health benefits. The HCA's existing authorities, responsibilities, and structures are in line with these responsibilities.
- **Coordinates integration efforts:** The HCA leads all Direct Integration efforts for state-managed publicly funded health benefits programs & facilitate enrollment for all residents prior to integration.
- **Acquires federal waivers**: to integrate federal programs and funding into the WHT.

Eligibility

Eligibility: Individuals

- Individual eligibility is based on residency regardless of social determinants of health. All Washington residents are eligible, but so are some nonresidents.
  - Based on Washington state's residency definition (30 days)
- Eligible nonresidents includes the following and can be expanded by the board
  - Students Attending College
  - Workers Employed in WA
  - Spouses and Dependents of Eligible nonresidents

Eligibility: Employers

- **All employers can voluntarily pay ESD to enroll their employees in the WHT.**
  The cost for an employee equals the employers per-employee required health expenditure.
- **All employees in Washington are eligible to enroll even if their employer offers different coverage.**
  Employers can choose to meet their required health spending for an employee in a different way. The employee can still enroll in the WHT voluntarily and apply any amount the employer has paid to ESD towards the cost of enrollment in the WHT.

Benefits & Services

Benefits & Services: Essential Benefits Package

- **Hospital services**, including inpatient and hospital-based outpatient care and 24-hour emergency services
- **Ambulatory** primary and specialty services, including preventative care and chronic disease management
- **Prescription drugs**, medical devices, and biological products
- **Mental health** and substance use disorder treatment services
- **Laboratory** and other **diagnostic services**, including diagnostic imaging services
- **Reproductive**, maternity, and newborn care
- **Pediatric** primary and specialty care
- **Palliative** care and end-of-life care services
- **Oral health, audiology, and vision services**
- Short-term **rehabilitative** and habilitative services and devices
- Licensed naturopathic, acupuncture, and massage therapies

Benefits & Services: Essential Benefits Package

Defining the details of the benefits coverage is the responsibility of the WHT Board (WHTB).

- Must offer the same set of benefits to all enrollees.
- Must meet criteria required for contracting with HCA for existing publicly funded health benefits.
- Can be expanded by the WHTB.

Transitional Benefits Alignment: HCA takes steps to align the **benefits** for all state-managed publicly funded benefits (including the new **Health Options Program**) towards this benefits package.

Provider Reimbursement & Participation

Providers

All licensed providers are eligible to receive reimbursement for services from the WHT, but participation is optional.

All providers and health systems giving care to a WHT enrollee:

- can accept the fee-for-service (FFS) rates set by the WHT Board
- can’t be denied reimbursement by the WHT for any essential health benefits

Rate Estimation: Negotiated by WHTB, but analysis was based on reimbursement rate above Medicare.

Aligned Reimbursement Rates

Negotiated Annually & Set by WHTB in coordination with the HCA

All Providers & Health Systems can accept the negotiated FFS reimbursement rates.
WA Providers & Health Systems can participate in annual collective negotiations to set the rates via

- **Fee-for-service (FFS)** for Private Practice Providers.
- **Global Budgets in combination with FFS** for nonprofit coordinating private practice providers & health systems.

Transitional Rate Alignment: HCA takes steps to align the **reimbursement rates** for all state-managed publicly funded benefits (including the new Health Options Program) towards these rates.

Global budgeting

The WHTB will work with the HCA to make considerations and recommendations with Community Health Providers negotiating for Global Budgets based on:

- **Health needs** of those living in each regional health district
- The **scope of services** the provider offers
- **Quality and effectiveness** of the providers care standards
- **Needs-based assistance** in each regional health district

Cost Containment

Cost containment

The WHT Board is given the responsibility and authority to enact cost controls for the WHT **without limiting access to or reducing quality of care**.

Cost controls designed into SB.5335:

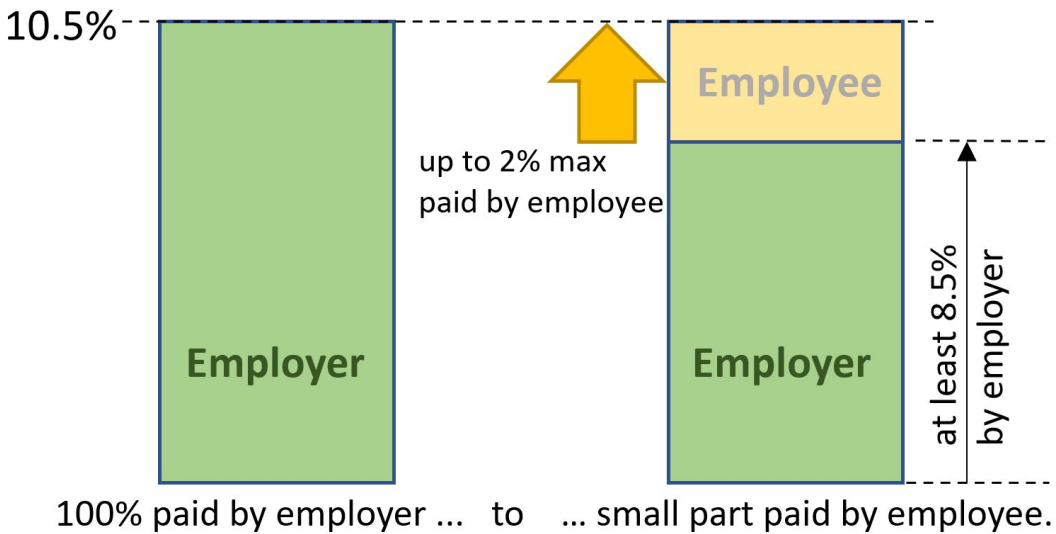
- One *single* Essential Health Benefits package with reliable and just reimbursement rates.
- HCA can take steps to align Benefits & Reimbursement rates for publicly funded benefits programs they manage.

Financing

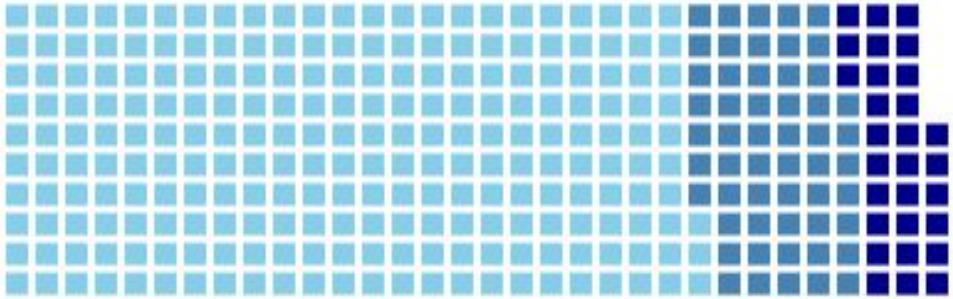
Financing

Employers will contribute	10.5% of wages	• Relieves administrative burden, unpredictable costs of insurance plans for employers • May deduct up to 2% from employee payroll
Employees may contribute	Up to 2.0% of wages	• Employers may cover all or a portion • Payroll deduction, not an out-of-pocket expense • Contributes to the 10.5% employer contribution
Sole Proprietors will contribute	2.0% of earnings	• The first $15,000 won't be taxed
Investors will contribute	8.5% of capital gains	• The first $15,000 won't be taxed • Home sales, retirement accounts and more won't be taxed

Employer / Employee Contribution Flexibility



The bulk of new funding comes from employers



1 square = $100 million
*Under $15k exempt in all categories
Employer responsible for 10.5% but may pass up to 2% to employees

- Employer pays 8.5% of payroll: $23,334m
- Employee pays up to 2% of payroll: $5,490m
- 2% of sole proprietorship: $0.82m
- 8.5% of capital gains: $2,993m

Examples of Employer Expenditures

10.5% with up to 2% paid by employees - Graduated exemption: $3,750 - (25% of total quarterly pay)

Employee's Gross Annual Pay	Earning Percentile	Employer Contribution (8.5-10.5%) per month	Max Employee Contribution (0-2%) per month	Employers Total Required Health Spending per Employee / month
Up to $12,000		$0	$0	$0
$20,000	<25%	$73.83 - $87.50	$0 - $16.67	$87.50
$40,000	25th	$247.91 - $306.25	$0 - $58.34	$306.25
$60,000*	**50th**	**$425.00 - $525.00**	**$0 - $100**	**$525.00**
$100,000		$708.33 - $875.00	$0 - $166.67	$875.00
$275,000	90th	$1,031.25 - $2,406.25	$0 - $1,375.00	$2,406.25

Context

Currently, the average WA employee earns $57,290 annually. The average WA employee pays a monthly average of $475 for individual plans and $1,174 for families. The average cost of employer-sponsored health insurance for employers' annual premiums was $7,739 for single coverage and $22,221 for family coverage. The report also found that the average annual deductible amount, for employees, was $1,669 for covered workers.

Infrastructure

Infrastructure

WHT Board (under the Department of Health)

- Develop & maintain policies, budgets & mechanisms to operate the WHT

HCA

- Provide Oversight & Accountability
- Enrollment Support & Infrastructure
- Coordinate Integration Efforts
- Ensure Equitable Access to Benefits and Cost Assistance for All During Transition

Governor & Legislature

- Make Startup Budget Appropriations
- Review Reports & Follow-up on Recommendations

Employment Security Department (ESD)

- Enforce Required Health Care Expenditures
- Facilitate Employer/Employee Participation

Department of Revenue (DOR)

- Enforce Capital Gains tax

Enrollment

Enrollment

- The enrollment process is not specified in legislation but is managed by the HCA
- Can be done through existing infrastructure like WAHealthPlanFinder
- Businesses may pay for employee enrollment for all employees or on a per-employee basis by paying the employer contribution to ESD
- Small businesses may apply for business assistance with ESD

Working with ERISA

ERISA laws prevent WA from requiring employers who provide ERISA protected health benefits to participate directly in the WHT. However, Washington State Can:

- Require employers to provide coverage for minimum essential coverage.
- Require employers to spend an amount on each employee's health care equal to the cost for enrolling the employee in the WHT.
- Define the health spending that counts towards employers' required health care spending.
- Create a framework to provide Health Coverage & Cost Equity for employees that are not enrolled in the WHT (as well as those who are uninsured or underinsured).
- Cover all kids. This is a benefit to working families that supports all of their employers too.

The Washington Health Trust's ERISA workaround was modeled after Healthy San Francisco's city-option which has survived legal challenges based on ERISA.

Employer Health Spending Equity

All employers are required to pay the **same** percentage of each employee's payroll toward the employee's health care.

Required Health Care Expenditure

10.5%

Private Insurance Option	Direct employee healthcare funding	WA Cares (Long Term Care)

If the employer-sponsored coverage or contributions don't meet or exceed 10.5%, the difference must be paid to the ESD.

Transition

Transition:
Health Options Plan - Support for the Uninsured & Underinsured

Managed by the HCA - The Health Options Plan provides support for enrollment during transition. Ensures Health Coverage & Cost Equity for those not enrolled in WHT.

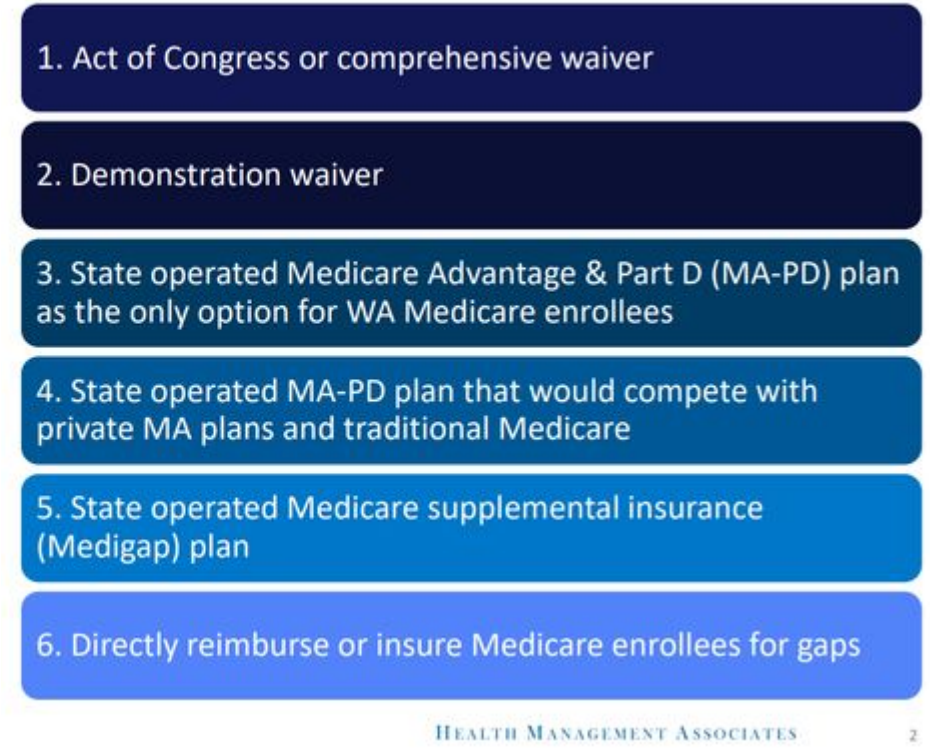
Community Health Access	Medical Reimbursement Accounts
Access to Essential Health Benefits from Community Health Providers	Reimbursements for Out-of-Pocket Costs

Infrastructure: The HCA can expand existing structures/programs currently used to support insurance enrollment and provide insurance assistance (Navigators Program & WAHealthPlanFinder.org).

Transition: Medicare integration & waivers

- The bill instructs HCA to work on a Demonstration waiver (#2)
- During the transition, the WHT is a Medicare Advantage Plan with Part D for those who voluntarily enroll (#4)
- The Health Options Program reimburses for any gaps for those that don't enroll (#6)

We must pass state law & create a universal health care infrastructure before a Federal Waiver for integration can be approved.



Transition: The exchange

- The federal funds for the cost assistance provided through the exchanges are folded into the WHT
  - The WHT would be the only plan with cost assistance
  - The exchange infrastructure can still be used by HCA to support health coverage enrollment and assessing eligibility for medicaid benefits
- Happens after 51% enrollment across all state-managed plans (current: 40%)

Transition: Year-by-year

Year 1	Year 2	Year 3	Year 4	Year 5
DOR collects Capital Gains Tax. (Jan) **Employers** begin to sunset revocable health expenditures. (Jan) **UHCC becomes WHT Board** - Designs the Essential Benefits Package & mechanisms needed to negotiate reimbursement rates with providers. (May) **Legislature** makes start up appropriations (July) **WHT** makes policies needed to offer WHT on the Exchange. (Nov) **HCA** Annual Reports begin. (Nov) **WHT** sends Benefits pkg & actuarial analysis to Gov. (Dec)	**ESD** begins to provide assistance to small businesses. (Jan) **Employers** continue to sunset revocable health expenditures. (Jan) **WHT** adopts a budget & reports to Legislative Committees. (May) **WHT is offered to all Washingtonians & eligible non-residents and businesses. (Nov)** **HCA** submits reports on Waiver progress & any statutes needed to Legislative Committees. (Nov)	**WHT** continues to offer coverage to everyone and coverage begins for enrollees. (Jan) **Employers** can not count revocable expenditures toward their required health expenditure. (Jan) **ESD** collects self-employment contribution from self-employed residents. (Jan)	**WHT** continues to offer coverage to everyone and reimburse providers for enrollees. Essential benefits package includes Long Term Care (Jan) **WHT** makes proposals for integrating federal funds and L&I (Jan) All employers must pay the Required Health Care Expenditure towards each employee's health costs. (Jan) **ESD** begins collecting the Employment Contribution from employers, enforcing the Required Health Care Expenditures. (Jan) **HCA** presents plan to further integrate employee health benefits. (Nov)	**WHT** continues to offer coverage to everyone and enrollees. **WHT** begins integrating federal programs, L&I, and employer health benefits plans based-on opportunities available. **Employers** continue to pay the required health care expenditures for each employee **ESD** begins collecting Employer Contributions for enrollment in WHT from out of state employers of WA residents. **ESD** can begin adjusting to the Required Health Care Expenditure rate in coordination with WHT Employment Investment costs for enrollment.

In a nutshell … a pathway to single payer

The Washington Health Trust is an **All Payer** model
with a **Pay-to-Play requirement** for employers
It includes a **Public Option** for everyone,
Public Health funding for participating Community Health Providers,
As well as the **financing and transition plans** necessary to achieve universal coverage

---

The Washington Health Trust establishes a single benefits package and a public option that can immediately begin to offer everyone coverage.

It outlines a framework and transition plan through voluntary enrollment, employer participation, and integration of state and federal programs which can achieve universal single payer healthcare.

Washington can lead

A road to national single payer through the states

Tab 7

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

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 • Uncovered ambulance services* • Services not covered by the BBPA*	• 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 provider rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

*service could also be categorized under coverage/enrollment

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
- Uncovered ambulance services*
- Services not covered by the BBPA*

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*

*service could also be categorized under coverage/enrollment

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 provider 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 • Uncovered ambulance services* • Services not covered by the BBPA*	• 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 provider rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

*service could also be categorized under coverage/enrollment

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 • Uncovered ambulance services* • Services not covered by the BBPA*	• 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 provider rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

*service could also be categorized under coverage/enrollment

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 • Uncovered ambulance services* • Services not covered by the BBPA*	• 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 provider rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

*service could also be categorized under coverage/enrollment

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 • Uncovered ambulance services* • Services not covered by the BBPA*	• 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 provider rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

*service could also be categorized under coverage/enrollment

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 • Uncovered ambulance services* • Services not covered by the BBPA*	• 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 provider rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

*service could also be categorized under coverage/enrollment

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 • Uncovered ambulance services* • Services not covered by the BBPA*	• 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 provider rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

*service could also be categorized under coverage/enrollment

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 • Uncovered ambulance services* • Services not covered by the BBPA*	• 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 provider rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

*service could also be categorized under coverage/enrollment

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 • Uncovered ambulance services* • Services not covered by the BBPA*	• 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 provider rate regulatory approaches	• Consolidate state purchasing	• Expand premium tax credit • Expanded Health Benefit Exchange Cost-Sharing Subsidies

*service could also be categorized under coverage/enrollment

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.

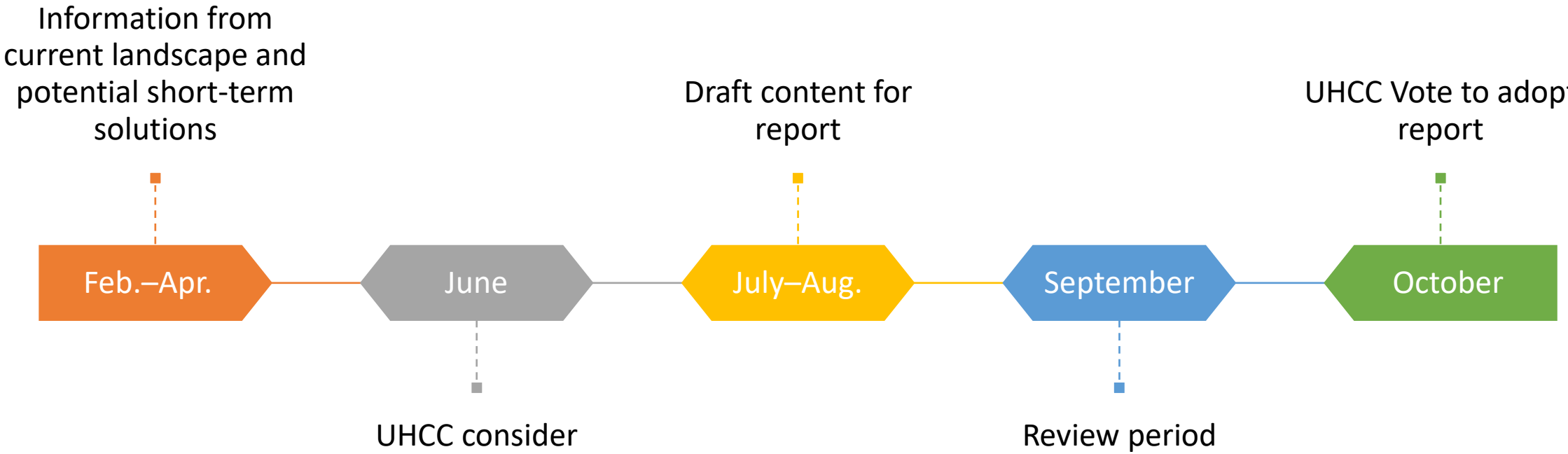
Purchasing	
Consolidate state purchasing	Together, HCA and HBE provide coverage to nearly one-third of all insured residents. The UHCC could design a consolidated state health care plan for individuals receiving coverage under HCA/HBE with a standardized benefit design and payment system, a single enrollment 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 8

Washington State Health Care Authority

Report development timeline



Annual Report Highlights

Launched the Finance Technical Advisory Committee (FTAC)

Adopted equity principles and framework

Considered eligibility for the universal system

- Medicare
- ERISA

Identified areas to consider for transitional policy solutions

Incorporated the work to evaluate the WA Health Trust

FTAC 2023

State and national experts to consider policy and finance options in designing the universal system and offer insights to the Commission in their deliberations

Have either presented or identified experts on Medicare and ERISA to explore options to create universal coverage

Recognize that the “north star” is a unified financing system to support universal coverage but understand that federal barriers could take years to overcome

In the meantime, evaluating options to create universal coverage parity and improve access, equity and quality

Health Equity Framework

HCA's defines health equity as, "*Everyone having a fair and just opportunity to be as healthy as possible*"

Current health care system not designed with this in mind

Well-intentioned policies do not achieve pre-determined goals, where communities most impacted are often not involved or elevated from the outset

Those with lived experience are the true experts, and should have a seat at the table for decision-making

Voted to adopt the HCA Framework and use the HCA Toolkit to support decision-making

Eligibility

Medicare

- Focus today on achieving coverage and affordability parity by wrapping additional benefits and services and ensuring affordability standards that match the universal system for Medicare recipients
- Exploring waivers or supporting Congressional action to obtain Medicare financing
- Have either presented or identified experts on Medicare and ERISA to explore options to create universal coverage

ERISA

- Exploring potential pathways to allow those with ERISA plans to have parity with the universal system

Transitional Solutions

- Most of the transitional solutions recommended in the 2022 report were funded by the Legislature in 2023, e.g., infrastructure investments, increased Medicaid rates
- The Commission is an important platform to consider and propose solutions that can help improve access, affordability, quality and health equity now
- Commission considering what areas to focus on for transitional solutions
  - Focus areas will be included in the 2024 report

Washington Health Trust

Legislative request to review and consider the WA Health Trust bill

Will evaluate the legislation alongside planned topics in Commission's workplan

Initial findings will be included in required report (June 2024)

Tab 9

Washington State Health Care Authority

Washington State Health Care Authority

Report to the Legislature

Universal Health Care Commission Legislative Report

Engrossed Second Substitute Senate Bill 5399; Section 2(7); Chapter 309; Laws of 2021

November 1, 2023

Table of contents

Glossary of abbreviations and acronyms

ABA	Applied Behavior Analysis
ACA	Affordable Care Act
CMS	Centers for Medicare & Medicaid Services
Commission	Universal Health Care Commission
DOH	Department of Health
DSHS	Department of Social and Health Services
EHB	Essential health benefits
ESI	Employer sponsored insurance
ERISA	Employee Retirement Income Security Act of 1974
FFS	Fee-for-service
FPL	Federal poverty level
FTAC	Finance Technical Advisory Committee
GF – S	General Fund - State
HBE or Exchange	Washington Health Benefit Exchange
HCA	Health Care Authority
HCAC	Healthy California for All Commission
HCCTB	Health Care Cost Transparency Board
HHS	U.S. Department of Health and Human Services
HMA	Health Management Associates
IHS	Indian Health Service
MA	Medicare Advantage
MA-PD	Medicare Advantage & Medicare Part D
MCO	Managed care organization
OFM	Office of Financial Management
OIC	Office of the Insurance Commissioner
OPMA	Open Public Meetings Act
PEBB	Public Employees Benefits Board
PHE	Public health emergency
Plan	Oregon's proposed Universal Health Plan
Program	Jamestown Tribal Health Benefits Program

QDP	Qualified dental plan
SEBB	School Employee Benefits Board
SSDI	Social Security Disability Insurance
Task Force	Oregon Joint Task Force on Universal Health Care
TPA	Third-party administrator
VHA	Veterans' Health Administration
UHC Work Group	Universal Health Care Work Group
UMP	Uniform Medical Plan
FY	Fiscal year

Executive summary

This is the Universal Health Care Commission's (Commission) second annual report submitted by the Health Care Authority (HCA) to the Washington State Legislature as directed in Engrossed Second Substitute Senate Bill 5399 (E2SSB 5399), Section 2(7), and enacted as Chapter 309, Laws of 2021. This report builds upon the Commission's 2022 **baseline report** to the Legislature and Governor and describes the Commission's work from September 2022 through September 2023.[1]

In their second year, the Commission strategically structured meetings to target the Legislature's overarching goals that are both forward looking and intended to improve the current health care system. Each meeting focused partly on further exploration and refinement of interim strategies to transition Washington to a universal health care system, and partly on the foundational design components of the future system.

The Commission selected eligibility as the first design component to develop and designated this topic as the primary area of focus for the newly launched Finance Technical Advisory Committee (FTAC).[2] The Commission also determined that discussions and recommendations regarding future system design would be supported by information regarding opportunities within existing authorities, other states and current programs in Washington, and equity principles.

This report details the Commission's work to build upon milestones established in its first year of work, including:

- Initialization and launch of FTAC.
- Continued investigation of federal barriers to achieving a state-based universal health care system with regards to eligibility.
- Assessing eligibility to determine who will need coverage or supplemental coverage in the future universal health care system including:
    - Adoption of guidance from FTAC regarding options to include Medicare enrollees in Washington's universal health care system
    - Initiating evaluation of options to include the Employee Retirement Income Security Act of 1974 (ERISA) covered individuals in Washington's universal health care system.
- Refinement and prioritization of transitional solutions that support goals of improving access to care and affordability and advance the state's readiness to implement a universal health care system.
- Adoption of a health equity framework with which the Commission will evaluate proposals for the universal health care system design and interim solution recommendations.
- Incorporation of the request regarding the Washington Health Trust proposal into the Commission and FTAC's work plan to the extent possible within the requested timeframe and available resources.

[1] The Commission's roster can be found in Appendix B.
[2] FTAC's roster can be found in Appendix C.

The 2023 Legislature also provided General Fund - State (GF - S) funding[3] for work required of HCA as specified in **RCW 41.05.840** for fiscal years (FY) 2024 and 2025. This funding was borne out of the strong advocacy work by countless community members and advocates across Washington. Community members continue to engage with the Commission by attending meetings to provide encouragement, insightful feedback, and often graciously share personal and painful experiences suffered in the current health care system. The community's continued input is instrumental to the Commission's work to ensure that all Washingtonians have equitable access to culturally appropriate and affordable health care. The Commission is currently undertaking strategic planning to determine how to best use this funding, details of which will be included in the 2024 legislative report.

[3] See Appendix A for funding allocated in ESSB 5187 Sec. 211 (58).
https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20230629105003

Developments: October through December 2022

The Commission's baseline report to the Legislature due November 1, 2022, did not capture business from the Commission's October and December meetings. The following developments occurred over the October and December meetings and are described below:

- Vote to approve the baseline report to the Legislature
- Launch of FTAC
- Presentation from Oregon's Joint Task Force on Universal Health Care

Vote to approve the baseline report to the Legislature

For their 2022 baseline report, the Commission was required to make recommendations regarding the specific topics identified in the legislation. The Commission's recommendations were grounded in goals to increase access to quality and affordable health care by streamlining access to coverage, and to reduce fragmentation of health care financing, unnecessary administrative costs, and health disparities. The Commission's 2022 recommendations included:

- Transitional solutions that support goals of universal coverage including enrollment options, eligibility systems, access to care, quality improvement, and increased equity.
- Transitional strategies that can improve affordability and advance the state's readiness to implement a universal health care system.
- Potential pathways to increase Medicaid provider rates as requested by the legislature.[4]

At the October 2022 meeting, one Commission member raised concerns prior to voting to approve the baseline report.[5] Concerns included there being several unanswered questions for the universal health care system design, including eligibility and expectations for who or what entity would be responsible for determining coverage and benefits. The Commission member also suggested that there are pathways other than universal health care that may provide equitable access to coverage and may represent all Washingtonians. Additionally, it was suggested that the Commission first investigate reasons as to why individuals remain uninsured or lack access to care before developing a universal health care system design. Commission members acknowledged that eligibility, coverage and benefits, and other key design components will continue to be developed in the Commission's work to design Washington's new universal health care system.

Members' approval of the baseline legislative report[6 & 7] marked a major milestone in the Commission's work, particularly with the first year being largely focused on the report's development.

[4] The Commission's 2022 recommendations are outlined in greater detail in the Executive Summary of the **baseline report.**

[5] Commission **October 2022 meeting recording**.

[6]The Commission members present voted by majority to adopt the final report (10 for, one opposed).

[7] 11 of 15 members were present for the vote to adopt the 2022 baseline report.

Launch of FTAC

In the U.S., the health care financing and delivery systems are inextricably linked; an individual's coverage and access to care are determined by the payer or financing source of that coverage. Federally funded and/or federally administered health care programs create additional barriers to achieving a state-based universal health care system with unified financing, such as legal obstacles to enrolling individuals receiving health care coverage through federal programs. Developing strategies to support Washington's future health care system requires disentangling how health care has historically been delivered and paid for.

The Commission determined that finance subject matter expertise specializing in health care financing would be essential to informing such strategies. As launched and directed by the Commission, FTAC provides guidance to the Commission in their development of a financially feasible model proposal to implement a universal health care system. FTAC is also charged with investigating strategies to develop unified health care financing options for the Commission's consideration, and to provide pros and cons for each option.

FTAC Application process

FTAC applications (Appendix D*)* were developed based on applications for other Washington state boards and commissions. The Commission reviewed the proposed FTAC application and voted unanimously in favor of initiating the application process pending review of the application by the Office of Equity. [8]

HCA staff conducted extensive outreach to Washington state finance agencies, research and academic institutions, and outside subject matter experts to apply for FTAC. The call for applications was shared by HCA through a GovDelivery[9] announcement and the opportunity to apply was also posted to the Commission's webpage for at least 30 days. Applicants were required to complete and submit the application and their resume to HCA. The Commission received 54 applications and resumes for FTAC appointment consideration.

FTAC Selection process

At the Commission's request, HCA and Health Management Associates (HMA)[10] reviewed each applicant's qualifications (resume and application) and provided recommendations to the Commission of the nine most qualified applicants that would meet the need for varied health care financing subject matter expertise.[11] The Commission voted unanimously to approve the recommended applicants and moved to nominate the consumer representative as the FTAC Liaison to the Commission to create an intentional connection between patients, consumers, FTAC, and the Commission.

[8] The application was reviewed and approved by the Office of Equity prior to its release.
[9] GovDelivery is a web-based e-mail subscription management system used by the Health Care Authority to allow members of the public to subscribe to news and information.
[10] HMA is the Commission's hired consultant.
[11] One position was held for a consumer representative, one position for the Washington Department of Revenue, and one position for the Office of Financial Management. The Commission agreed that FTAC applicants should disclose any conflicts of interest with their application.

FTAC meetings and the Open Public Meetings Act

FTAC's charter was approved by the Commission and outlines the relationship and processes for information exchange between the Commission and FTAC (Appendix E). In accordance with the Commission's authorizing legislation, FTAC is not statutorily subject to the Open Public Meetings Act (OMPA). However, the Commission chose to include a public comment period at each FTAC meeting in alignment with the Commission's open and transparent process that encourages involvement from the public.

Presentation from Oregon's Joint Task Force on Universal Health Care

The Commission received multiple public comments encouraging a presentation from Oregon's Joint Task Force on Universal Health Care (Task Force) on their legislative charge, process, system design and other findings. In response to this request, the Commission invited Task Force representatives, including the Chair, one member, and one key staff member to present at their December 2022 meeting.

Key components of the Oregon Task Force's final report

Oregon's Task Force worked over two years (plus a one-year extension due to COVID) and was charged with developing a state-based single-payer health care system, known as the Plan. [12][13] Key components of the Plan include:

- Eligibility
- Cost-sharing
- Benefits
- Goals
- Provider reimbursement
- Role of private health carriers.

Presenters also shared the six health equity concepts from the Task Force's recommendations. The equity concepts include:

1. All Oregon residents are eligible
2. No payment at the time of service
3. Utilize one benefit plan
4. Normalization of reimbursement
5. Uncouple coverage from employment
6. Address social determinants of health with delivery system savings.

[12] Senate Bill 770. 2019. **https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB770/Introduced**

[13] The Task Force recommended that the Oregon Legislature establish and fund a founding governing board to develop an implementation and financing plan as this component was not addressed by the Task Force due to time constraints. Joint Task Force on Universal Health Care Final Report and Recommendations. Prepared by the Legislative Policy and Research Office. September 2022. **https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/257230**

Public engagement process

The Oregon Task Force's budget included funding for a robust community engagement and stakeholdering process to vet their universal health care proposal. After completion of their final report, the Oregon Task Force held discreet listening sessions with consumers and different sectors of the health care marketplace.

After hearing Oregon's presentation, multiple Commission members agreed that such a public engagement process will be critical to informing Washington's system design proposal. The Commission advocated for developing a similar public engagement process, subject to resources, as Washington's universal health care proposal progresses.

Process and approach to work in 2023

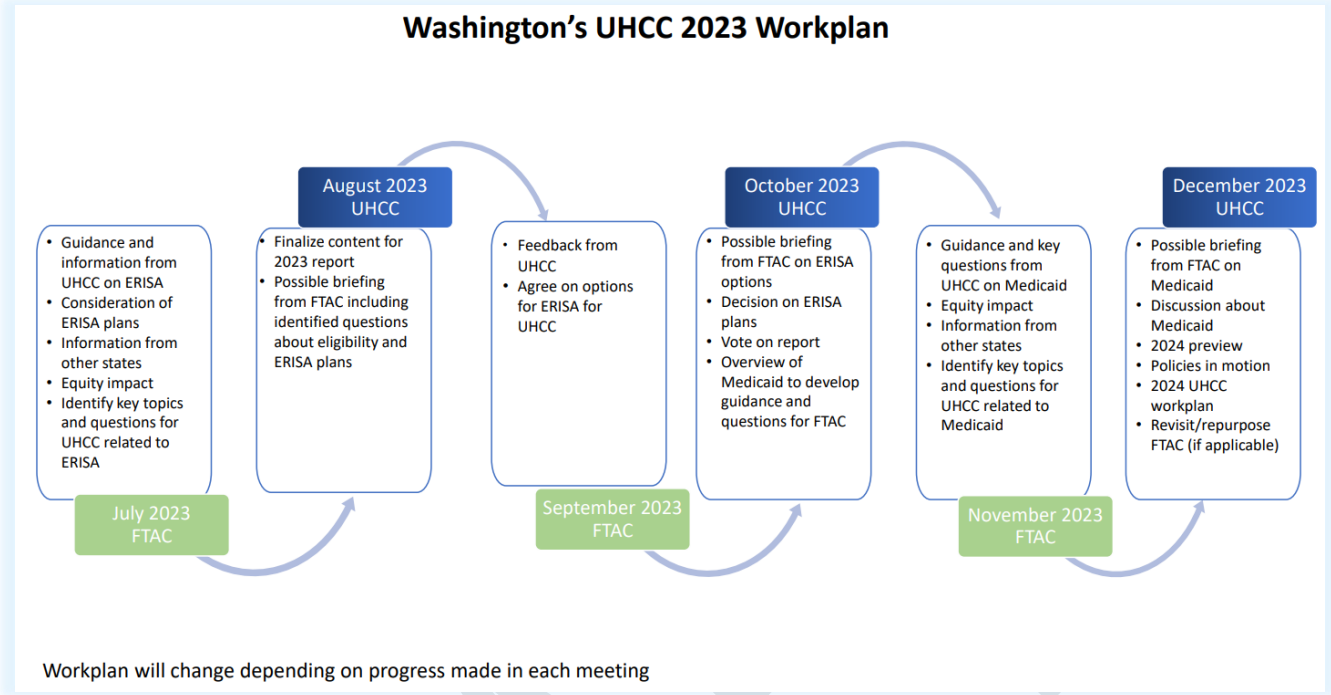
The Commission remains dedicated to its mission to ensure that all Washingtonians have equitable access to culturally appropriate health care and universal coverage, and consistent input from members of the public continues to be a cornerstone of this work. The Commission's first year was primarily focused on the development of the required baseline legislative report. This year was focused on targeting the Legislature's overarching goals for the Commission which are both forward looking in designing the new universal health care system, and reform-focused; intended to improve access, equity, quality, and affordability within the current health care system.

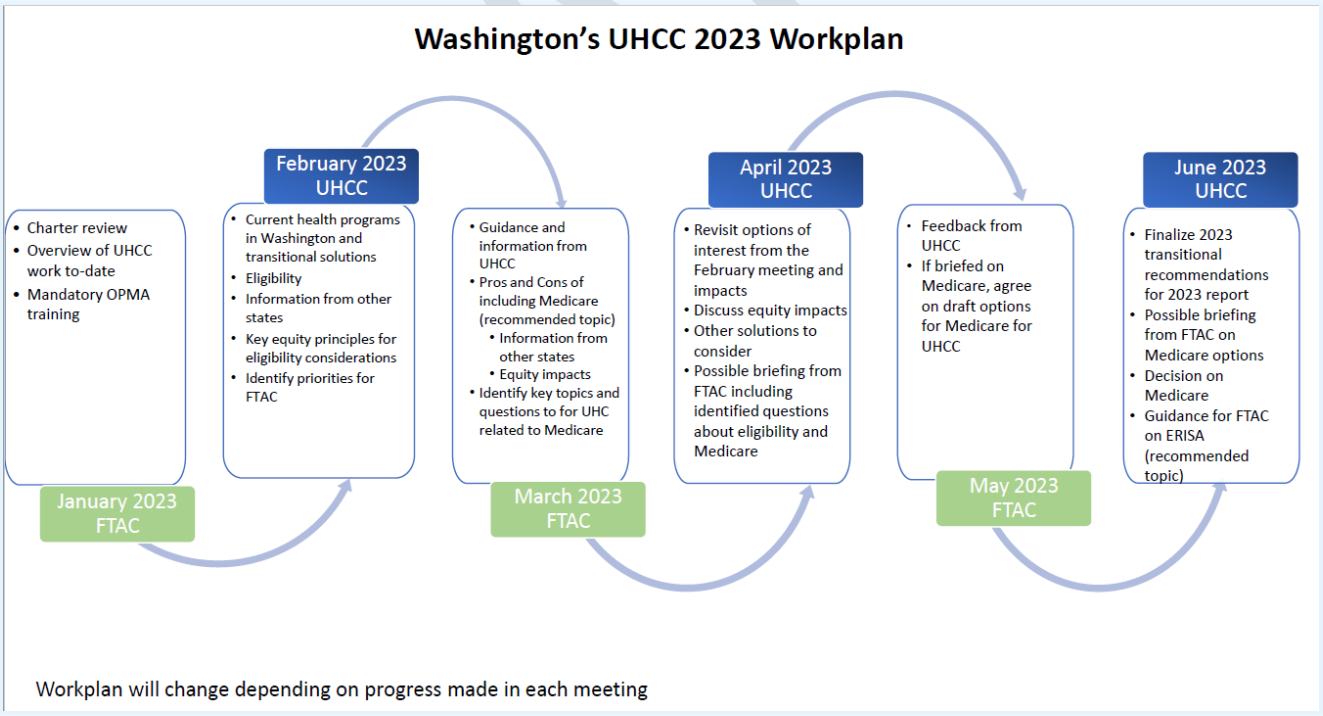
To best meet these goals, the Commission strategically structured meetings to focus partly on the foundational design components of the future system, and partly on further exploration and refinement of strategies to transition Washington to a universal system. Additionally, members determined that because the Commission is permanent and their work to design and transition Washington to the new system will develop over time, meetings should be framed as "iterative." This framing also ensures that short-term solutions are consistent with the vision for the new health care system.

With this framing in mind, the Commission discussed and agreed upon the topics for each of its meetings and each of FTAC's meetings for 2023. Figure 1 illustrates the Commission's workplan.[14]

Figure 1: 2023 workplan

[14] Figure 1 illustrates the 2023 workplan as approved by the Commission. However, the Commission agreed that the workplan is subject to change depending on progress made at each meeting.





In addition to the core meeting topics outlined above, the Commission identified three supplementary topics as elements of the discussion for each design element at meetings. The supplementary topics are summarized below and include:

1. Explore opportunities within current authorities

2. Develop equity principles for designing the new system
3. Assess information on other states and current programs in Washington.

Exploring opportunities within current authorities

The Commission continues to gather information on what existing opportunities could be leveraged to help the state transition to a universal system or could be expanded to serve as a function of the new system. For example, to complement the Commission's work on transitional solutions, FTAC members were also surveyed for additional ideas. FTAC members included in their survey responses information as to whether the state currently has authority to implement any given option.[15]

Additionally, at the conclusion of the 2023 legislative session, Commission members representing state agencies shared legislative updates, providing insight into the Legislature's areas of interest both for the short and long term. [16] This informed the Commission's work to design the new system and to prioritize options that could transition the state to a universal system, details of which are described later in this report.

Developing equity principles for designing the new system

Financing and coverage policies and structures in the current health care system have contributed to the discrimination and marginalization of individuals with disabilities, low-income individuals, and individuals of color. Further, in the current system, an individual's coverage and access to quality care is largely determined by how the care is financed. The development and implementation of a unified financing system to support universal health care is an opportunity to examine existing structures and to establish a new system that ensures equitable access to affordable and quality care and wellbeing for all Washingtonians, including the health care workforce.

To inform the Commission's system design, Commission member Dr. Karen A. Johnson, former Director of the Washington State Office of Equity, presented an overview on equity.[17] Dr. Johnson emphasized several key points for the Commission to consider in their development of a system with guaranteed access to quality, affordable health care for all Washingtonians.

Key points

- Achieving equity will not be accomplished through treating everyone equally, but by treating everyone justly according to their circumstances.
- Bringing the community to the table is essential to the design of a universal healthcare system.
- It is not possible to discuss health equity without acknowledging the impact of racism on the health of communities, families, and children.

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[15] FTAC's proposed transitional solution ideas gathered from their survey responses can be found in Appendix F.
[16] Five state agencies are represented on the Commission. These include the Department of Health, Health Benefit Exchange, HCA, Office of Equity, and Office of the Insurance Commissioner.
[17] Commission **April 2023 meeting recording**.

- Health inequities have implications including economic costs, health care costs, quality of life, and duration of life.

With these considerations, the Commission adopted a health equity framework with which to evaluate proposals to ensure that all recommendations have an equitable impact on all Washingtonians. The health equity framework is detailed later in this report.

Assessing information on other states and current programs in Washington

Washington is not alone in its desire to reform the current health care system while also designing a state-based universal system supported by unified financing. In recent years, both Oregon and California passed legislation creating entities to design respective state-based universal health care systems. Details of these states' work on the topic of eligibility are described later in this report.

While Oregon and California are on paths similar to Washington's, the state of Vermont ventured to implement a state-based, single-payer health care system nearly a decade ago. Though Vermont's universal system did not materialize, the Commission expressed interest in what can be learned about the state's efforts.

In addition to gathering information on developments and lessons learned from other states, Washington's Indian health care delivery system offers an example of a universal system already operational in the state. While not a single-payer system, the Jamestown S'Klallam Tribal Health Benefit Program uses braided funding to finance its delivery system and has achieved 100 percent coverage for Tribal members living in the service area. The principles of this program may offer a potential pathway to achieving 100 percent coverage in the state of Washington. Details of the Jamestown S'Klallam Program are described later in this report.

Areas of Focus

The COVID-19 pandemic exposed health disparities and health care disparities stemming from past and enduring inequitable policies and practices in and outside of the health care system. Additionally, with federal protections from Medicaid disenrollment ending this year, loss of coverage and/or forgoing care due to financial barriers is anticipated for thousands of Washingtonians. As such, the Commission focused on ways to achieve the greatest and most immediate impact for the most amount of people. With this goal in mind, and focusing partly on interim steps and partly on future system design, the Commission agreed to focus on the following areas:

- Eligibility for the future universal system
- Transitional solutions
- Adoption of a health equity framework with which to evaluate proposals for the new system design
- The request to analyze the Washington Health Trust bill.

Universal system design: Eligibility

Achieving universal coverage requires determination of how to design a system where all Washington residents would be eligible for coverage. The Legislature's goal is to include all state residents in Washington's future universal health care system as detailed below. As such, the Commission selected eligibility as the first design component to examine. [18]

Eligibility goals as provided in SB 5399

> "The Universal Health Care Commission is established to create immediate and impactful changes in the health care access and delivery system in Washington and to prepare the state for the **creation of a health care system that provides coverage and access for all Washington residents** through a unified financing system once the necessary federal authority has become available."

In their work to examine paths to achieving universal eligibility for the new system, the Commission identified several considerations and potential challenges. Table 1 outlines the identified eligibility considerations for specific populations.

Table 1: Key eligibility considerations

[18] In their baseline report, the Commission identified the following design components of a universal health care system: cost containment, coverage and benefits, eligibility, enrollment, financing, governance, infrastructure, and provider participation and reimbursement.
https://www.hca.wa.gov/assets/program/commission-baseline-report-20221101.pdf

Eligibility population	Considerations
Washington residents	Would the definition of meeting residency requirements for health insurance coverage differ from the current standard of residency determination for the state?[19 & 20]
Out-of-state residents working for Washington employers	Would out-of-state residents who work for Washington employers be eligible? Would employees who work for national companies and live in Washington be allowed to keep their coverage or be required to enroll in the universal system?
Opt-in options for individuals covered by employer-sponsored insurance	Would individuals with fully insured, employer-sponsored coverage be eligible to opt in?
Self-funded plans	Would individuals with self-funded employer-sponsored coverage be eligible to opt in?
Federal Employees Health Benefits and Veterans' Health Administration (VHA)	Would federal employees be covered by federal programs such as Federal Employees Health Benefits and the VHA be eligible to opt into the system?
Enrollees of insurance programs that are federally funded and/or federally administered, or subject to federal law	Would Medicare enrollees be included in the program? Would Medicaid enrollees be included in the program? Would enrollees of a health plan subject to federal Employee Retirement Income Security Act of 1974 (ERISA) laws be included in the program?

The eligibility barriers for Washington's universal system are largely federal with regulatory and legal implications. For example, Medicare is entirely federal domain both in terms of funding and administration. Conversely, while Medicaid is administered and partly funded by states, the program also receives federal funding. Finally, ERISA preempts state regulation of employer benefits.

[19] Washington Department of Revenue. State residency definition. **https://dor.wa.gov/contact/washington-state-residencydefinition#:~:text=Persons%20are%20considered%20residents%20of,a%20temporary%20or%20transient%20basis.**

[20] Establishing a residency definition could bring in consideration of the constitutional right to travel.

Though Medicare, Medicaid, and ERISA each present significant barriers, the long-term goal for both the Legislature and the Commission is to ensure eligibility for all Washington residents, including enrollees of these respective programs when possible.

Figure 2: Health coverage estimates in Washington, 2021

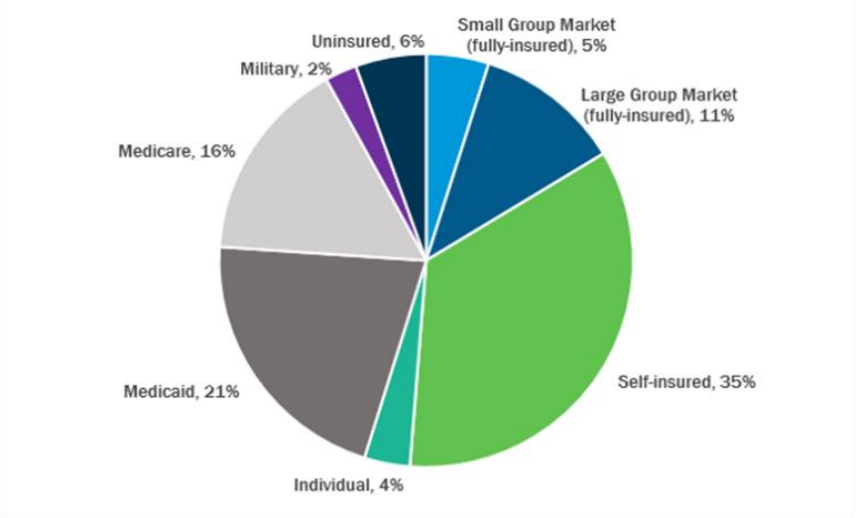

Figure 2 illustrates health coverage estimates in Washington for 2021.[21] When combined, individuals covered by these three types of programs represent nearly 90 percent of Washingtonians. Including enrollees of these programs in the universal system is necessary to ensure that all Washingtonians receive comparable health care benefits and equitable access to care. Additionally, capturing funding from these programs is critical to creating and sustaining Washington's universal system supported by unified financing.

The Commission's eligibility assessment

Including various eligibility groups requires thorough examination of the regulatory and legal barriers and an understanding of each program. FTAC members were selected by the Commission for their extensive subject matter expertise on topics such as this, and the committee was directed by the Commission to examine options to include each of the following eligibility groups in Washington's universal system.

- Medicare-eligible Washingtonians[22]
- Washingtonians receiving health care coverage through an employer (ERISA)[23]

[21] The data in the figure are estimates and provide a reasonable overview of coverage in WA. Data are from OIC internal carrier enrollment reports (using 2021 reports), the American Community Survey's health insurance coverage tables, and Kaiser Family Foundation (KFF) self-insured data. The estimate of individuals in self-funded group health plans is based upon the calculation of known enrollment and national estimates from KFF annual employer health benefit survey and others. Health Coverage Estimates in Washington. 2021. OIC.

[22] KFF. Total Number of Medicare Beneficiaries by Type of Coverage. 2021. **https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D**

[23] Approximately 3.9 million Washingtonians receive health care coverage under a health plan subject to ERISA.

- Medicaid- eligible Washingtonians.[24]

At the Commission's direction, FTAC examined the eligibility groups in the order in which they are listed above. FTAC's work and guidance to the Commission on options to include each eligibility group are described below.

Assessment of options to include Medicare

Medicare is a federal health insurance program for individuals aged 65 and older. Individuals under 65 with long-term disabilities also qualify for Medicare through the Social Security Disability Insurance (SSDI). Approximately 1.4 million Washingtonians are enrolled in Medicare.[25]

The Medicare program consists of four components, including Medicare Parts A, B, C, and D. The financing mechanisms for and services covered under each component are briefly described below.

- **Medicare Part A** is financed primarily by a payroll tax that employers and employees pay into the Medicare Hospital Insurance Trust Fund. Part A covers inpatient hospital stays, skilled nursing facility stays, some home health visits, and hospice care.
- **Medicare Part B** is financed primarily through a combination of general revenues, interest earned on trust fund investments, and beneficiary premiums. Part B covers physician visits, outpatient services, preventive services, and some home health visits.[26]
- **Medicare Part C** (Medicare Advantage) is Medicare's managed care program that combines and delivers Parts A and B through contracted carriers.[27] Medicare Advantage (MA) plans are financed by monthly payments from the federal government based on bids submitted by the carriers and monthly premiums.
    - MA plans have grown increasingly popular amongst Medicare enrollees in Washington. As of March 2023, approximately 663,500 Medicare beneficiaries were enrolled in MA

[24] As of June 2023, approximately 2.3 million Washington residents were enrolled in Apple Health, Washington's Medicaid program. **https://hca-tableau.watech.wa.gov/t/51/views/ClientDashboard-Externalversion/AppleHealthClientDashboard?%3AisGuestRedirectFromVizportal=y&%3Aembed=y**

[25] Monthly enrollment by state. Washington. March 2023. CMS. **https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/monthly/monthly-enrollment-state-2023-03**

[26] Part B spending accounts for the largest share of Medicare benefit spending (48 percent in 2021). What to Know about Medicare Spending and Financing. Kaiser Family Foundation, 2023. **https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/**

[27] MA plans are required to cover all medically necessary services covered by traditional Medicare. However, some plans may offer additional benefits such as vision, hearing, and dental services.

plans.[28] This accounts for roughly 45 percent of Medicare enrollees, up from about 37 percent in March 2020,[29] and approximately 32 percent the same month in 2018.[30 & 31]

- **Medicare Part D** is financed primarily by general revenues, beneficiary premiums and state payments for beneficiaries dually eligible for Medicare and Medicaid. Part D covers outpatient prescription drugs.

Examination of Medicare integration by other states

As previously mentioned, the Commission's strategic plan for 2023 includes gathering information from other states and current programs in Washington. Below are summaries of what the states of Oregon and California have examined with regards to Medicare integration for their respective and future state-based universal health care systems, and the Jamestown S'Klallam Tribal Health Benefit Program in Washington.

The Oregon Task Force's proposed implementation guidance

1. Act of Congress: Federal action to expand states' Medicare authority and/or innovation to establish a state-based single-payer system to support comprehensive benefits with corresponding Medicare funding.
2. Medicare Advantage: State-sponsored MA plan available to supplement benefits of the Plan.
3. Waiver: Oregon obtains CMS approval to use demonstrations and/or innovation to provide benefits to Medicare-eligible Oregonians through mixed funding streams.
4. Wraparound Services: provide Plan-covered services, such as behavioral health or dental care to wrap around services not covered by Medicare.

[28] Monthly enrollment by state. Washington. March 2023. CMS. **https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/monthly/monthly-enrollment-state-2023-03**

[29] Monthly enrollment by state. Washington. March 2020.**https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldatamonthly/monthly-enrollment-state-2020-03**

[30] Monthly enrollment by state. Washington. March 2018. CMS. **https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-State-Items/Monthly-Enrollment-by-State-2018-03**

[31] The federal government has steadily increased spending on Medicare Part C. Beginning in 2023, Medicare spending on Part A and Part B benefits for enrollees in traditional Medicare will be outpaced by Part A and Part B benefits spending for MA enrollees. What to Know about Medicare Spending and Financing. Kaiser Family Foundation. 2023. **https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/**

California

The Healthy California for All Commission (HCAC) was also established in 2019. [32] HCAC is charged with developing a state-based health care delivery system[33] that provides coverage and access for all Californians through a unified financing system, including, but not limited to, a single-payer system.

In 2020, HCAC finalized and submitted an environmental analysis to the governor and state legislature[34] acknowledging the federal barriers to integrating Medicare. HCAC also identified limitations with CMS' waiver authority, stating "it does not appear that CMS' waiver authority is broad enough to allow even a cooperative federal administration to flexibly fund the Medicare portion of a California system of unified financing without statutory change," however further analysis is needed.

HCAC's 2022 final report[35] examined the implications of including or not including Medicare in a state-based universal health care system. HCAC reiterated that a state-based unified financing system cannot be achieved without federal support. However, HCAC members disagreed as to whether federal support for California's unified financing system requires changes to federal law or could be accomplished through existing waiver authority. Some HCAC members noted that even reaching a favorable financing agreement with the federal government could expose California to financial risks in the future should the federal government ever change the terms of the agreement.

Brown & Peisch, a law firm specializing in federally funded health and benefit programs, was invited by the California Department of Health and Human Services to provide additional clarity on available options to integrate Medicare. The primary decision points of Brown & Peisch's legal memo are included below.

Key points of Brown & Peisch's legal memo

- There is no single federal waiver authority that would allow federal funds for Medicare, Medicaid, or Patient Protection and Affordable Care Act (ACA) advance premium tax credits to be redirected. Rather, each funding stream is subject to different authorities that permit the federal Department of Health and Human Services to waive certain federal requirements and limitations.

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[32] Senate Bill (SB) 104 (Chapter 67, Statutes of 2019). **https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB104**

[33] Including a plan with options to transition California to a unified financing system, including, but not limited to, a single-payer financing system.

[34] An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California. Healthy California for All Commission. June 2020. **https://cdn-west-prod-chhs-01.dsh.ca.gov/chhs/uploads/2020/08/24133724/Healthy-California-for-All-Environmental-Analysis-Final-August-24-2020.pdf**

[35] Key Design Considerations for a Unified Health Care Financing System in California. April 2022. **https://www.chhs.ca.gov/wp-content/uploads/2022/05/Key-Design-Considerations-for-a-Unified-Health-Care-System-in-California-Final-Report.pdf**

- Any legal authorities that may allow for redirection of Medicare funding will depend on the current federal administration's interest in supporting states' unified financing systems. Exercise of this authority is unprecedented and politically challenging.[36]
- Alternatively, California could better pursue unified financing through enactment of federal waiver authority that allows states to use federal funding from existing health care programs, including Medicare, to deliver comprehensive health care coverage.[37]

Options to include Medicare and other sources of coverage as demonstrated by the Jamestown S'Klallam Tribal Health Benefit Program

Vicki Lowe, Commission Chair and Executive Director of the American Indian Health Commission for Washington State presented to both the Commission and FTAC about a universal health care system currently existing in Washington. The Jamestown Tribal Health Benefits Program (Program) is an insurance-based program, where coverage is based on all Tribal Citizens having the same level of coverage regardless of income or coverage eligibility.

Under federal law, Indian Health Service (IHS) programs are required to enroll eligible Tribal users in Medicare or Medicaid before purchased and referred care dollars can be accessed.[38] The Program's benefits wrapped around each Tribal Citizen's source of coverage, including Medicare, Medicaid, private and employer sponsored insurance (ESI), which ensured benefits parity across the Program. For Medicare-eligible individuals, the Program purchased supplemental benefits and reimbursed members for out-of-pocket costs such as Medicare Part B premiums.

The Program is not an example of a unified financing system due to its utilization of mixed funding streams. However, the Program achieved 100 percent coverage for Tribal members living in the service area and these principls may offer a pathway to achieving 100 percent coverage in the state of Washington.

FTAC's discussion and guidance on Medicare options for Washington

At the direction of the Commission, FTAC discussed several options to address Washington Medicare enrollees' eligibility in the new system.[39] & [40] This discussion followed presentations about Oregon and California's pursuits of a universal health care system, and Chair Lowe's presentation on the Jamestown S'Klallam Program.

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[36] This could potentially restrict Medicare recipients' choice of providers and could compel providers to participate in a new payment/delivery model. Additionally, California would be seeking to assume responsibility of Medicare recipients' benefits to which they are entitled by statute.

[37] Brown & Peisch cited H.R. 3775, the State-Based Universal Health Care Act (2021), as an example of proposed legislation that would provide California necessary authority for federal funds to be directed to the state as a lump sum.**https://www.congress.gov/bill/117th-congress/house-bill/3775/text?s=1&r=40**

[38] Purchased and referred care is defined as any care received outside of IHS.

[39] FTAC March meeting **recording**.

[40] FTAC May meeting **recording**.

Medicare overview

In May, FTAC reviewed the structure of the Medicare program.[41] The overview also included potential gaps in affordability and access that Medicare enrollees may experience if Medicare is not included in Washington's universal health care system. Table 2 illustrates potential gaps in coverage between the universal system and Medicare and affordability challenges Medicare enrollees might experience compared with Washington's universal health system as envisioned by the Universal Health Care Work Group.[42]

Table 2: Gaps in coverage and affordability for Medicare recipients in Washington's universal health care system

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 signficant cost sharing
Would include vision care, and possibly dental and long-term care	Vision, dental, and long-term care not covered

*The Commission's 2022 report to the state legislature articulated three benefit design options, A, B, and C as envisioned by the Universal Health Care Work Group. Both A and B would eliminate cost sharing.

FTAC examined six options to address potential gaps in benefits and out-of-pocket costs for Medicare enrollees in Washington's universal health care system. The feasibility of various components under each option was assessed and is illustrated in Table 3. Based on this assessment, the six options ordered from least feasible to most feasible (Figure 3) and additional pros and cons of each option were examined.

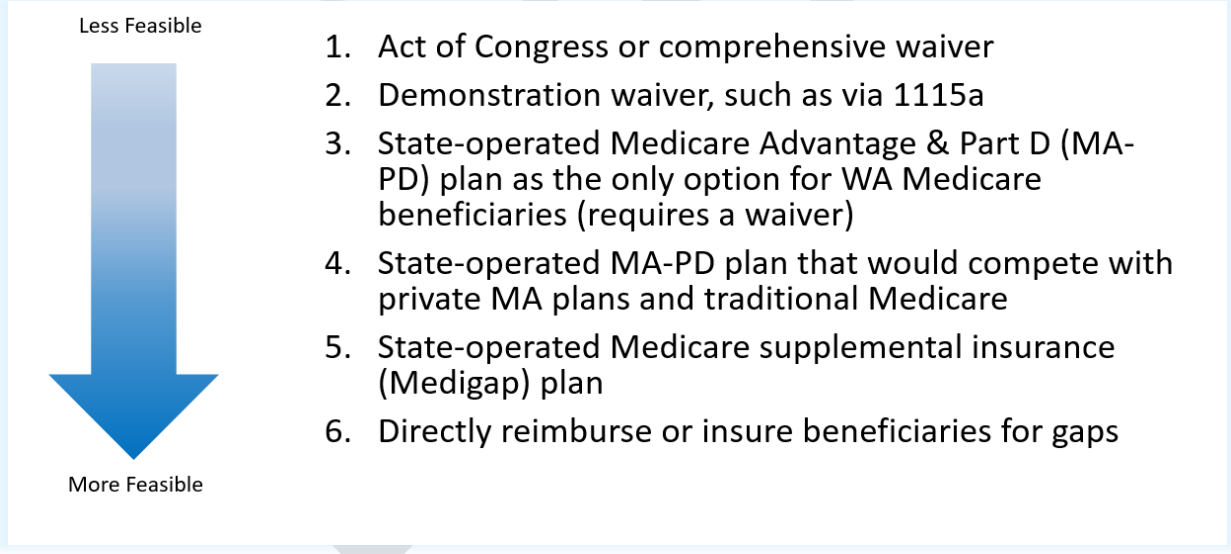
[41] FTAC **May meeting recording**.
[42] The Universal Health Care Work Group preceded the Commission. Work Group Final Report. 2021. **https://www.hca.wa.gov/assets/program/final-universal-health-care-work-group-legislative-report.pdf**

Table 3: Feasibility considerations for options to include Medicare

	Captures federal funding	Waiver or law change required	Level of federal oversight	Preserves beneficiary choice	Covers premiums	Covers cost-sharing	Covers non-covered services
1. Act of Congress	Yes	Yes	Unknown	No	Unclear	Possibly	Possibly
2. Demo waiver	Yes	Yes	High	No	Unclear	Unclear	Unclear
3. MA, only option	Yes	Yes	High	No	Possibly, via rebates	Possibly, via rebates	Possibly, via rebates
4. MA, competes	Yes, for enrollees	Probably not	High	Yes	Possibly, via rebates	Possibly, via rebates	Possibly, via rebates
5. State Medigap	No	Probably not	Medium	Yes	No	Yes	No
6. Reimburse directly	No	Probably not	Low to Medium	Yes	Yes, if covered	Yes, if covered	Yes, if covered

*Most options would also place an administrative burden on the state

Figure 3: Options for incorporating Medicare ordered from least to most feasible



Options to include Medicare in Washington's future universal health care system

Option 1. Act of Congress or comprehensive waiver

Option 1 is an act of Congress, or a comprehensive waiver granted by CMS which if obtained, would allow Washington to enroll all Medicare enrollees into the universal system design and leverage federal

funding,[43] a key advantage of this option. However, there is no legal precedent for such, and it is unlikely to be achieved via legislation through the current Congress. Moreover, Medicare enrollees may still experience some premiums.

FTAC members agreed that Option 1 represents the "North Star," or ideal approach to addressing gaps in affordability and coverage for Medicare enrollees in the universal system, however pursuing Option 1 at this time is not an effective use of resources or time due to the significant federal barriers. Additionally, some members noted that CMS is unlikely to grant a waiver to a new and untested program.

Members recommended that the Commission focus on designing the new system and examine other transitional options to provide coverage and affordability parity for Medicare enrollees, rather than attempting to bring Medicare into the system from the outset.[44] It was also suggested that Washington consider actively partnering with Oregon to examine this option when Oregon's new governance structure[45] overseeing the universal health care system becomes operational.

Option 2. Demonstration Waiver

Option 2 would require Washington to obtain an 1115 Medicaid waiver[46] 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). These waivers must be cost-neutral to the federal government and not compromise the quality of the existing program.

This option would allow the state to capture federal funding, however because these waivers 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 also involve significant oversight and evaluation by the state throughout implementation which would result 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 members agreed that Option 2 is not viable for achieving the goals of the universal system given that the intent of these waivers differs from what the Commission is trying to achieve. However, this option could complement the work being done via the universal health care system in areas such as cost containment and payment reform. Other areas of potential opportunity for the Commission to address payment reform include 2023 legislation (ESSB 5187) directing the Attorney General Office and Office of

[43] This option was used to calculate potential costs and savings of Model A by the Universal Health Care Work Group.
[44] There was some discussion about the potential benefits of contracting with a law firm as California did to better understand necessary preparations to obtain a federal waiver or possible legislative pathways.
[45] Oregon Universal Health Plan Governance Board.
[46] This waiver from CMS would waive Section 1115 of the Social Security Act

the Insurance Commissioner (OIC) to study market consolidations and anticompetition and hospital global budget strategies.[47 & 48]

Option 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, to the extent MA rules allow, would provide benefits parity with Washington's universal system. Under Option 3, the state's MA plan would be the only MA option for Washington's Medicare enrollees.[49]

Members noted several disadvantages to this option. Obligating MA enrollees to enroll in only the state MA plan would require a federal waiver from the provision that allows for choice and to preclude other MA plans from entering the market. This option would also involve resolving payment structures, as MA payments are pegged to Medicare's fee-for-service (FFS) benchmark compared with whatever payment structure is utilized in the universal system, including minimal flexibility associated with benefit and pricing in MA plans. Another disadvantage to this option is the administrative costs the state would incur to develop, implement, and oversee an MA plan, or to contract to do the same. Finally, this option could be subject to legal challenges if Medicare enrollees are prevented from accessing traditional Medicare.

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. Members recommended not expending resources and time on this option, especially at the outset. Some members felt that this option could serve as a pathway in the future once the value of the program has been established. It was noted that the state would likely face downside risk, as the state would likely be reimbursed by CMS on a per-member-per-month basis. Finally, several members expressed concerns regarding the implications of disallowing Medicare enrollees to remain in traditional Medicare or in their current MA plan.

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

Option 4 involves the same scope of work for the state to design and implement an MA plan with many of the same limitations as Option 3. However, under Option 4, the state's MA plan would compete with other private MA plans, where Medicare-eligible Washingtonians wishing to enroll or continue coverage with traditional Medicare could do so. This option does not limit Medicare enrollees' choice, potentially lessening the threat of legal challenges.

FTAC's response to this option was mixed. In addition to the administrative burden of designing and implementing the model like Option 3, the main concern with this option is the competition the state would face by entering a mature MA-PD market with multiple carriers offering over 100 MA plans.

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[47] Sec.126(33) and Sec.144(13). **https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20230629105003**

[48] Some members recommended that any payment reform activity be done in consultation with the Health Care Cost Transparency Board.

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

Additionally, Medicare-eligible Washingtonians may be inclined to renew existing coverage or could select options other than the state's, limiting the potential of federal dollars and the overall impact of this option.

However, FTAC did not recommend this option being completely removed as a possibility. There may be a possibility for this option to sit alongside Option 6 (direct reimbursement of insurance for gaps) in the future.

Option 5. State operated Medicare supplemental insurance (Medigap) plan

Under Option 5, the state would develop and offer a Medigap plan 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 are not covered under Medicare. However, Medigap plans do not cover benefits for hearing, vision, and supplemental drug coverage which does not align with the Commission's goals for the universal system design. Moreover, the state would be limited in its ability to reduce Medicare enrollees' Part B deductibles with this option.[50] Finally, this option would not be available to MA enrollees, nor allow the state to leverage federal Medicare dollars.

FTAC members acknowledged that this option seemed feasible in terms of existing legal authorities and may be the least administratively burdensome to the state to implement. However, there were concerns that this option could not fully address benefits gaps between Medicare and any universal system design because of the extensive and complex regulatory requirements of Medigap plans. Additionally, like Option 4, this offering would require the state compete with other plans in a mature market 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.

Option 6. Directly reimburse or insure Medicare enrollees for gaps

Option 6 would establish a system to directly reimburse enrollees for cost-sharing and for services covered by the universal system but not by Medicare. This option allows the most flexibility to fully address gaps and would not require waivers nor result in legal challenges. Disadvantages to this option include the potential variances between Medicare enrollee 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 federal Medicare dollars.

FTAC members agreed that at this time, Option 6 presents 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.

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[50] Individuals eligible for Medicare on or after January 1, 2020 cannot purchase Medigap plans that cover the Part B deductible, or Plans C or F. **https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf**

FTAC members agreed that 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 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 while federal dollars would not fund these additional benefits, placing the financial burden on the state, this option could be explored in conjunction with one of the waiver options to secure federal funding and/or as a means of payment reform or cost containment.

Additional Medicare considerations for the Commission's consideration

There were additional suggestions offered by FTAC members related to improving cost-sharing and services for Medicare enrollees, mainly through expanding eligibility for the Medicare Savings Program (MSP) and increasing eligibility for dual Medicare/Medicaid beneficiaries.[51] An additional option to expand services for low-income Medicare beneficiaries could be expanding Medicaid Categorically Needy coverage, which would provide full scope Medicaid coverage, including long-term care.[52] These additional considerations were intended to inform the Commission's future discussions about potential transitional solutions that improve coverage available for Washingtonians today that may help pave the way for the universal health care system of tomorrow.

The Commission's vote on Medicare

FTAC members produced a Medicare Memo[53] for the Commission capturing FTAC's discussion and recommendations on options to achieve parity for Medicare enrollees and how to include Medicare in Washington's universal system. FTAC's guidance, including the pros and cons of each option, was provided to the Commission at their June meeting.[54]

While a comprehensive waiver (Option 1) is the most beneficial option and the "North Star" for achieving the goals of a universal health care system supported by unified financing, this option lacks federal authority to implement. FTAC recommended direct reimbursement (Option 6) as the most feasible option for the short term to achieve coverage parity for Medicare enrollees which could be explored in conjunction with one of the waiver options. However, this requires further analysis. FTAC recommended that the Commission determine benefits and services and come back to this discussion to explore whether to pursue a waiver, rather than pursuing a waiver at the outset.

In reviewing FTAC's guidance, one Commission member expressed concerns with adopting FTAC's recommendations on Medicare eligibility given that some questions regarding larger system design, such as benefit design, have not yet been addressed. However, as some Commission members noted, the guidance is not set in stone, but having this guidance allows the Commission to move forward in their

[51] The 2023 legislature took action to expand 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.

[52] **WAC 182-501-0060(6)** lists the general categories of Categorically Needy services. All medically necessary services are covered.

[53] Appendix G.

[54] Eight members were present for the vote. Commission **June meeting recording.**

design work. FTAC was also directed to examine this topic early in the Commission's design work to identify whether the assumption should be that a Medicare waiver could be obtained at this time. The Commission voted to adopt FTAC's guidance in the Medicare Memo (seven for, one opposed).

Preliminary assessment of options to include ERISA-eligible individuals

ERISA is the next eligibility group scheduled to be examined for integration into Washington's universal system. Since ERISA preempts state laws that impact employer benefits, [55] Washington is constrained in its ability to regulate employer benefits or achieve benefits parity between employer benefits and the future system. Pathways for capturing revenue, such as employer contributions, to support the unified financing system must also be thoroughly examined.

The Commission directed FTAC to examine several components of ERISA in addition to surfacing options to include ERISA in Washington's future system. The Commission's questions for FTAC's assessment of ERISA eligibility are outlined below.

Questions from the Commission for FTAC's assessment of ERISA eligibility

- 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, examine how any employer contributions could be captured under the various ERISA eligibility options to fund the new system.
- Potential options to include ERISA and capture revenue to support the unified financing system:
    - Option 1: Employers pay into the universal system and employees are covered by the universal system.
    - Option 2: "Pay or play," where employers have a choice to continue provide coverage to their employees.
        - What are the implications of ACA mandated employer responsibilities?
        - If employers choose to continue providing employees' coverage, could Washington mandate that the minimum essential coverage required under the ACA match the coverage provided under the new system?
        - What are the quality and equity implications of benefits differing between employer coverage and the universal system?

[55] Federal ERISA law sets minimum standards for health plans established and funded by employers to provide health care to their employees. Employer health plans can be "fully insured" or "self-funded". Both types of these health plans must comply with ERISA. However, the state's role varies based upon whether a plan is fully insured or self-funded. An employer that offers a fully insured health plan is paying for premiums to a health insurer and the insurer bears the financial risk of coverage. An employer that offers a self-funded health plan has chosen to bear the financial risk of health care services used by their employees, and often will contract with an outside entity to administer their health plan (called "third party administrators" or "TPAs"). The ERISA statute exempts these plans from most state regulations.

In July, FTAC began gathering information on ERISA in preparation for further discussion and recommendations to the Commission on ERISA eligibility. [56] FTAC's full assessment of ERISA and recommendations to the Commission will take place in September, details of which will be included in the 2024 legislative report. The topics examined at FTAC's July meeting are included below and will also be detailed in the 2024 legislative report.

Topics discussed at FTAC's July meeting

- ERISA case law examples that continue to articulate the ERISA preemption test
- The Supreme Court's interpretation of the ERISA preemption clause
- The impact of ERISA preemption on health care reform and state-based universal health care initiatives
- Washington's health care coverage by market, including fully insured large group and small markets and the self-insured market
- Health plan regulation in Washington, including which entities regulate which health plans, required benefits, provider network adequacy, and eligibility
- Examples of health policy in Washington that has or has not been challenged due to ERISA.

Assessment of options to include Medicaid-eligible individuals

Medicaid is the third eligibility group scheduled to examine for integration into Washington's universal system. Including Medicaid funding as a revenue source for Washington's new system will be complex but perhaps not as complicated as Medicare because there is an established process and experience with states seeking and obtaining Medicaid flexibilities, such as an 1115 waiver from CMS.

Another challenging aspect of integrating Medicaid will be identifying options to achieve benefits parity between Medicaid and the future system. Whereas Medicare's benefits may be less comprehensive than what the Commission envisions for the new system, Apple Health (Medicaid) provides some benefits that are not included in Washington's essential health benefits (EHB) mandated by the ACA such as Long-term Services and Supports and transportation to non-urgent medical appointments. Some of these services are required by federal Medicaid law, while others are required by state law.

With FTAC's guidance, the Commission will need to determine how Apple Health's additional services could be provided to all Washingtonians under the new system or examine mechanisms to ensure that everyone who would otherwise be eligible for Medicaid will receive these additional services. FTAC is scheduled to begin examining options to include Medicaid in the Fall of 2023, findings of which will be included in the Commission's 2024 legislative report.

[56] Presentations by Carmel Shachar, J.D., and Jane Beyer, J.D., can be found in **FTAC's July meeting recording.**

Transitional solutions

In addition to designing Washington's future universal system, the Commission is charged with implementing immediate and impactful changes in Washington's current health care system to increase access to quality, affordable health care by:

- Streamlining access to coverage
- Reducing fragmentation of health care financing across multiple public and private health insurance entities
- Reducing unnecessary administrative costs
- Reducing health disparities
- Establishing mechanisms to expeditiously link residents with their chosen providers.

The Commission's 2022 baseline report identified opportunities to improve the affordability of and access to coverage and care in the current system, including strategies to help transition the state to the universal system. Several of these recommendations were funded by the Legislature during the 2023 legislative session, details of which are described below. This section also outlines the Commission's ongoing work to identify and prioritize opportunities to prepare Washington for the transition to a universal system.

The 2023 Washington Legislature's support of the Commission's 2022 recommended transitional solutions

Several of the Commission's 2022 recommended transitional solutions were funded by the 2023 Washington Legislature. This is perhaps a testament to both the Legislature's commitment to advance state health care reform and the Commission's role in accomplishing that goal as a panel of experts representing the state or as a stakeholder sounding board for opportunities to improve care for Washingtonians. The Commission's 2022 recommended transitional solutions funded by the Legislature are outlined in Table 4 below.

Table 4: Commission's 2022 transitional soltuion recommendations funded by the 2023 Legislature

Commission's 2022 recommendations	Action by the 2023 Legislature
Continue funding the **Cascade Care Savings** program to make coverage more affordable.	Funding provided to HBE to continue administering Cascade Care Savings (premium assistance program) for individuals up to 250 percent of the federal poverty level (FPL) who purchase a health plan on the Exchange.[57]
Increase Medicaid provider rates for **Applied Behavior Analysis** to improve access to care for Medicaid enrollees.	Funding provided to HCA to increase reimbursement rates by 20 percent for Applied Behavior Analysis (ABA) for

[57] ESSB 5187, Sec. 214 (4)(a). Eligible individuals must also meet other eligibility criteria as established in **RCW 43.71.110(4)(a)**.

	individuals with complex behavioral health care needs, and by 15 percent for all other ABA codes.[58]
Increase Medicaid provider rates for **Behavioral Health** to improve access to care for Medicaid enrollees.	Funding provided to HCA to increase behavioral health rates for both Medicaid FFS and managed care providers. [59]
Increase Medicaid provider rates for **Children's dental** to improve access to care for children enrolled in Medicaid.	Funding provided to HCA to increase the children's dental rate[60] by at least 40 percent above the Medicaid FFS rate in effect on January 1, 2023.[61]
Implement the **Integrated Enrollment and Eligibility Modernization Roadmap** to support Information Technology infastructure necessary for a universal health care system.	Funding provided to the Department of Social Health Services (DSHS) for the Integrated Enrollment and Eligibility Modernization Project to create a comprehensive application and benefit status tracker for multiple programs and to establish a foundational platform. **[62]**
Invest in **Apple Health coverage expansion** to increase access to coverage and care.	Funding provided to HCA to expand coverage to adults ineligible for Medicaid or federal subsidies by reason of immigration status. [63]

[58] ESSB 5187, Sec. 211 (49). Codes include 0362T and 0373T beginning January 1, 2024. Does not include Q3014 (telehealth facility procedure code). **https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20230629105003**

[59] ESSB 5187, Sec. 211 (51). Rate increases are effective January 1, 2024 and must be applied to the following codes for children and adults enrolled in Medicaid: 90785, 90791, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90846, 90847, 90849, 90853, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171, H0004, H0023, H0036, and H2015. HCA is directed to implement this rate increase in accordance with the process established in **RCW 71.24.885** (Medicaid rate increases) and must raise the state FFS rates for these codes by up to seven percent (not to exceed the published Medicare rate or an equivalent relative value unit rate if a published Medicare rate is not available). HCA must require in managed care organizations' (MCOs) contracts that beginning January 2024, MCOs pay no lower than the FFS rate for these codes and adjust managed care capitation rates accordingly. Ibid.

[60] For procedure code D1120.

[61] Beginning January 1, 2024.

[62] ESSB 5187, Sec. 205 (11-13) provides funding to the Department of Social and Health Services (DSHS) for the Integrated Enrollment and Eligibility modernization project to create a comprehensive application and benefit status tracker for multiple programs and to establish a foundational platform. Ibid.

[63] ESSB 5187 Sec. 211 (83). Coverage begins July 1, 2024 and will largely mirror the Medicaid benefit. This benefit will be available to individuals aged 19 or older who are not eligible for federal subsidies or Medicaid and are under 138 percent FPL. The program funding is limited, and enrollment will be managed within the funding amount. The population over 138 percent FPL will be eligible for state subsidies through state subsidies and a federal 1332 waiver implemented by the Health Benefit Exchange. Ibid.

The funding of the Commission's above recommendations is a significant achievement given the early stage of this work. The Commission will monitor the implementation and progress of the above transitional solutions as their work to design and transition the state to the future system evolves.

Ongoing work to identify and prioritize transitional solutions

The Commission is encouraged that several of their 2022 recommendations were funded by the 2023 Legislature, though there is more work to be done. This year, the Commission focused on identifying a new set of intermediate strategies that can help improve the current health care system and advance the state's readiness to implement a universal health care system.

In January, Commission members identified new areas of opportunity to explore. As directed by the Commission, FTAC members were also asked to identify additional areas. Together, the Commission and FTAC produced over thirty transitional solutions which were then grouped into categories (Table 5) for the Commission's consideration to prioritize.

Table 5: Transitional solutions categorized and considered by the Commission for prioritization[64]

Category	Transitional solution options
Affordability/cost containment/pricing	• Facilitate accessibility of hospital price transparency data • Out-of-network (OON) price caps • OON price caps for the Cascade Select program • Reduce ACA affordability threshold • Reference based pricing for the Public Employee Benefits Board/School Employee Benefits Board (PEBB/SEBB) • Regulated hospital global budgets • State agency rate normalization
Capacity/infrastructure	• All payer or multi-payer quality program • Enhance telehealth capacity • Improve public health
Coverage/enrollment	• Auto-assign Medicaid enrollment to high-quality/lower-cost plans • Auto-enrollment for Medicaid to no-premium Exchange plans • Immigrant coverage enhancement • Increase participation in the Medicare Savings Program (MSP)[65] • Uninsured analysis • Universal enrollment

[64] Descriptions for the listed options are included in Appendix F.

[65] Expanding eligibility for MSP was also noted in FTAC's guidance to the Commission as a potential pathway to improving cost-sharing and services for existing Medicare enrollees.

Providers	• Motivate interest in preventative and primary care • Network adequacy standards • Provider participation analysis • Standardize claims adjudications • State provider participation • Study of provider rate regulatory approaches
Purchasing	• Consolidate state purchasing
Subsidies	• Expand premium tax credit • Expanded HBE Cost-Sharing Subsidies

The Commission will assess the feasibility and impact of the above transitional solutions. Details of the selection process and selected transitional solutions will be included in the Commission's 2024 legislative report.

Health equity framework to evaluate design proposals

The health equity implications of the larger system's eligibility design were at the center of the Commission's discussions this year. One of the primary health equity concerns was the ability of the state to achieve benefits parity between the new system[66] and Medicare, ERISA, and Medicaid. If the universal system provides comprehensive coverage and benefits but only to a subset of the population (individuals not covered by one of these coverage sources), Washington could perpetuate existing health inequities and health disparities.

This and other health equity implications are critical to assess and consider in the Commission's work to design an equitable health care system. As such, the Commission sought to develop a health equity framework by which to consider and evaluate design proposals. The Commission enlisted the expertise of Dr. Quyen Huynh, Health Equity Director, HCA, to provide further information and guidance on potential health equity frameworks.[67]

Adoption of a health equity framework

Dr. Huynh shared that health equity, defined by HCA as everyone having a fair and just opportunity to be as healthy as possible, is at the center of HCA's vision, mission, and strategies. HCA has been intentional in creating an internal health equity infrastructure to support its external efforts. This includes the development of a health equity framework utilized for decision making in agency's role to purchase

[66] Benefits and services are scheduled to be discussed in 2024.
[67] Commission **June meeting recording**.

health care for millions of Washingtonians. Additionally, HCA's Health Equity Toolkit[68] was developed to help staff apply an equity lens[69] when designing or evaluating policies, programs, and services.

Dr. Huynh cautioned that sometimes, well-intentioned policies do not achieve pre-determined goals, where communities most impacted are often not involved or elevated from the outset. Recognizing that those with lived experience are the true experts, HCA strives to build a two-way relationship with the community and hear from community members how HCA's services and programs impact them.[70] Dr. Huynh explained that HCA centers diversity, equity, inclusion, and belonging at the state Medicaid agency level and continues to engage communities through this lens to ensure that those who are most disenfranchised have a seat at the decision-making table. In addition to advancing health equity, community engagement efforts can build trusting relationships with the communities being served by this work.

Dr. Huynh noted that the current health care system was built without intentional equity. As a result, some existing infrastructure must be dismantled, power re-distributed, and community voices elevated. However, this work must move at the pace of the community. Dr. Huynh implored the Commission to apply a consistent equity framework and an equity lens each time decisions are made.

The Commission agreed that utilization of the health equity framework and Health Equity Toolkit would support their work to design a universal health care system with health equity at its center. The Commission directed staff to build in a health equity analysis process for design proposals expected to impact health equity. These analyses will occur prior to the Commission taking action at meetings, such as final action regarding recommendations. The Commission voted to adopt and apply the health equity framework to their recommendations (seven for, one opposed).[71]

Washington Health Trust analysis request

The Commission received a request from members of the Legislature to conduct an analysis of the Washington Health Trust **(SB 5335)** as introduced in the 2023 legislative session.[72] SB 5335 proposes the creation of the Washington Health Trust within the Washington Department of Health to provide coverage for a set of EHB to all Washington residents.

Per the request, the Commission's analysis should:

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[68] HCA's Health Equity Toolkit also helps staff identify and address health disparities in the development of legislative bill analyses. HCA's Health Equity Toolkit can be found in Appendix H.
[69] Using an equity lens means evaluating something for inequitable health impacts on groups of people.
[70] HCA created the Pro-Equity Anti Racism Community Advisory Team (PEAR CAT) to build community engagement which is not to be confused with stakeholdering. Whereas stakeholdering involves gathering input and feedback from people or groups such as provider groups, hospital associations, or community-based organizations who hold interests in the work, community engagement involves direct contact with the people being served. **HCA's Community Engagement Mini Guide**.
[71] Eight members were present for the vote to adopt and apply the health equity framework.
[72] SB 5335 did not pass out of committee.

- 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, proponents of the bill, to substantively engage with the Commission in the future
- Engage the leaders of Whole Washington throughout the analysis process and report preparation.

The Commission assessed the request and voted unanimously for its incorporation into the Commission and FTAC's work plan to the extent possible within the requested timeframe and available resources.[73] The Commission also invited Whole Washington to present on SB 5335 and the Commission will continue to engage with Whole Washington members throughout the process of analysis and drafting for the 2024 report. Then, beginning in 2025, and until the analysis is complete, each of the Commission's legislative reports will summarize SB 5335 and how it would address key design components of a universal system.

[73] Commission **April meeting recording**.

Conclusion

At the center of the Commission's discussions this year were eligibility for the larger system and the health equity implications of eligibility design. The Commission will assess the health equity impact of this and other design elements as they continue to be developed.

In the short-term, Washington is limited in both its ability to recoup federal funding to support a unified financing system, and to regulate coverage sources subject to or preempted by federal law. However, paths to achieving benefits parity in the short-term for Washingtonians eligible for Medicare, ERISA, and Medicaid have surfaced and will be examined further.

The Commission's authorizing legislation states that subject to sufficient existing agency authority, state agencies may implement transitional strategies that do not require statutory authorization or new funding. The Commission will build upon the success of their recommended transitional solutions being funded by the Legislature and continue to develop interim strategies that ensure equitable access to culturally appropriate health care for all Washingtonians.

Appendix materials

The appendices to this report are as follows:

- Appendix A Funding allocated in ESSB 5187 Sec. 211 (58)
- Appendix B Commission Roster
- Appendix C FTAC Roster
- Appendix D FTAC Application
- Appendix E FTAC Charter
- Appendix F FTAC proposed transitional solutions
- Appendix G FTAC Medicare Memo
- Appendix H HCA Health Equity Toolkit

Tab 10

Washington State Health Care Authority

Next Steps

October

- Vote to adopt the 2023 legislative report
- Preliminary discussion of 2024 work plan
  - With new funding incorporated

Washington State Health Care Authority

Thank you for attending the Universal Health Care Commission meeting!