Universal Health Care Commission meeting

June 4, 2024

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Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Universal Health Care Commission

Agenda

Tuesday, June 4, 2024

2:00 – 5:00 PM

Hybrid Zoom and in-person meeting

Commission members:		
☐ Vicki Lowe, Chair	☐ Senator Emily Randall	☐ Representative Marcus Riccelli
☐ Senator Ann Rivers	☐ Estell Williams	☐ Mohamed Shidane
☐ Bidisha Mandal	☐ Jane Beyer	☐ Nicole Gomez
☐ Charles Chima	☐ Joan Altman	☐ Omar Santana-Gomez
☐ Dave Iseminger	☐ Representative Joe Schmick	☐ Stella Vasquez

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome & call to order	1	Vicki Lowe, Chair and Executive Director, American Indian Health Commission for Washington State
2:05-2:08 (3 min)	Roll call	1	Mandy Weeks-Green, Boards and Commissions Dir. Health Care Authority
2:08-2:10 (2 min)	Approval of Meeting Summary from 04/17/2024	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 and Executive Director, American Indian Health Commission for Washington State
2:25-2:35 (10 min)	FTAC updates	4	Pam MacEwan, FTAC Liaison
2:35-2:45 (10 min)	State agency report outs	5	Commission Members
2:45-2:50 (5 min)	Whole Washington draft report	6	Vicki Lowe, Chair and Executive Director, American Indian Health Commission for Washington State
2:50-3:00 (10 min)	Progress status	7	Liz Arjun, Principal Health Management Associates
3:00-3:05 (5 min)	Break		
3:00-3:05 **(5 min)**	Administrative simplification summary	8	Liz Arjun, Principal Health Management Associates
3:15-4:40 (85 min)	Administrative simplification – Panel presentation followed by Q & A for panelists and discussion	9	Panel Members Representing Providers and Carriers
4:40-5:00 (20 min)	Next steps on administrative simplification	10	Liz Arjun, Principal Health Management Associates
5:00	Adjournment		Vicki Lowe, Chair and Executive Director, American Indian Health Commission for Washington State

Meeting Objectives

- Where the Commission is the process of universal health care system design
- Hear updates from state agency partners
- Receive an update from FTAC on guidance for actuarial analysis on benefits and services, cost containment, financing
- Approve report to the Legislature about the Washington Health Trust Bill (SB 5335)
- Hear from a panel of providers about how and what administrative simplification efforts could make a difference and begin to consider recommendations

Tab 2

Washington State Health Care Authority

Universal Health Care Commission meeting summary

April 17, 2024

Hybrid meeting held electronically (Zoom) and in-person at the Health Care Authority (HCA)
2–5 p.m.

Note: this meeting was recorded in its entirety. The recording and all materials provided to and considered by the Commission is available on the Universal Health Care Commission webpage.

Members present

Vicki Lowe, Chair
Bidisha Mandal
Charles Chima
Jane Beyer
Joan Altman
Representative Joe Schmick
Representative Marcus Riccelli
Mohamed Shidane
Omar Santana-Gomez

Members absent

Senator Ann Rivers
Dave Iseminger
Senator Emily Randall
Estell Williams
Nicole Gomez
Stella Vasquez

Call to order

Vicki Lowe, Commission Chair, called the meeting to order at 2:10 p.m.

Agenda items

Welcoming remarks

Chair Lowe began with a land acknowledgement and welcomed members to the seventeenth meeting.

Meeting summary review from the previous meeting

The Commission members **voted by consensus to adopt the February 2024 meeting summary**.

Public comment

Roger Collier sought to correct the March FTAC meeting summary to reflect his comment noting a $2B error in Whole Washington's projected savings calculation for SB 5335.

Marcia Stedman, Health Care for All Washington, agreed that there are barriers to implementing universal health care system but encouraged the Commission to focus on what can be done now.

Kathryn Lewandowsky, Whole Washington, sought to correct a sentence in the Commission's draft report on SB 5335, and encouraged dialogue by the Commission on how to best finance a new system.

Aaron Katz suggested that the weight of discussions be on integrating financing and defragmenting the health care system. The Commission was also encouraged to be guided by public comments in their deliberations.

Elizabeth Reisner, Whole Washington, urged the Commission to take seriously FTAC's comments on SB 5335 and noted the many advocates who are invested in this work.

FTAC updates: actuarial analysis considerations and review of SB 5335's benefits and financing

David DiGiuseppe, FTAC Liaison Alternate

FTAC's March meeting focused on approaches to benefit design. FTAC also heard from Whole Washington on the proposed benefit design and financing under SB 5335. FTAC and Whole Washington largely agree on the goals for addressing fragmentation, inequitable access to care and coverage, and high costs. Whole Washington's savings estimates are based on self-funded group (employer) health plans, Medicare, and Medicaid markets having been consolidated into a unifed system. However, last year, FTAC determined this to be politically and legally infeasible in the near term due to federal barriers.

Whole Washington's plan would begin as Model B (health plan administered) as proposed by the Universal Health Care Work Group, and would transition over time to Model A (state-administered), where the purported greatest opportunity for savings would be achieved due to the elimination of insurance and provider administrative expenses. However, per Whole Washington's slides, estimated savings from price adjustments were slightly higher than estimated savings from elimination of administrative expense. FTAC noted that price, not administrative expense, is the primary driver of costs. FTAC questioned the practicality of eliminating administrative expense to the degree assumed by Whole Washington.

FTAC also assessed considerations for the Commission's actuarial analysis of benefits across Medicaid, the Public Employee Benefits Board/School Employee Benefits Board (PEBB/SEBB), and the essential health benefits (EHB) mandated under the Affordable Care Act (ACA). FTAC recommends first modeling PEBB/ SEBB, then comparing with the EHB, Cascade Care, and Medicaid. Cost sharing is also critical to discuss. High cost sharing makes care unaffordable to people, and low cost sharing makes coverage expensive to the payer.

Commission members discussed whether and why (or why not) to model any cost sharing in the actuarial analysis. Exchange plans' differing actuarial values (AV) may give insight into the impacts of cost sharing on utilization. After discussion, a motion, and a second, **the Commission voted unanimously to direct FTAC to evaluate modeling that includes one iteration comparing UMP, EHB, and Medicaid with zero cost sharing, as well as iterations that reflect some levels of cost-sharing. In the second phase of modeling (introducing some cost sharing), the Commission will be interested in the impacts that cost-sharing may have on utilization.**

2024 legislative session updates

The Legislature passed HB 1508 directing new work for the Health Care Cost Transparency Board which will be helpful for the Commission's discussions on how to reduce total health care expenditures. The Legislature also passed a bill to cap cost-sharing for highly utilized services, and preserved coverage for preventive services without cost sharing. ESB 5241 (Keep Our Care Act) failed and concerned the state's role in oversight over mergers and acquisitions of large health systems. HB 2476 also failed and concerned a covered lives assessment

for Medicaid and commercial plans that would have increased some Medicaid reimbursement rates to that of Medicare. The Legislature increased investments in the Apple Health Expansion (immigrant health coverage) program. Enhanced federal subsidies for Exchange plans are ending in 2025, though the 2024 session sustained state premium subsidies through 2025 which may help maintain coverage gains. Legislation passed to prohibit balanced billing for ground ambulance services. SB 5213 increasing regulation of Pharmacy Benefit Managers also passed. The Office of the Insurance Commissioner and Health Care Authority are directed to work with insurers and providers to create a uniform system to process authorizations across PEBB/SEBB, Medicaid, and commercial health plans for residential substance use disorder treatment.

Presentation: Administrative simplification – a local perspective

Richard Rubin, Executive Dir., Washington Healthcare Forum

The Washington Healthcare Forum (Forum) Administrative Simplification (Admin Simp) Program brings together health plans, public payers, hospitals, practices, and public policy makers to develop policies, best practices and technology solutions in support of its simplification mission from an operational level. While it may be unlikely that simplification efforts translate into hard dollar savings for the health system, Admin Simp is important for other reasons. For example, health care consists of many different enterprises, where the default goal is to build enterprise solutions, often creating more complexity. As overall complexity increases, so does the burden of that complexity on individuals, e.g., health care workforce and patients.

Looking at opportunities in this area, it's important to be mindful of not being "too early" (it's not an issue today but will be in a few years), "too late" (time and resources were already dedicated to building one thing, and no more will be spent to change it), "too small to matter," or "too big to be true." The Forum has seen the most impact when an opportunity has some market momentum, can leverage existing investments with feasible wins within reach, and where meaningful action can be taken at the state level.

One local area of opportunity is to utilize a subject matter expert workgroup to prospectively review legislation and/or policy recommendations that impact health services administration. Additionally, performance measurement is a key component of value-based strategies. There is broad agreement that improving health means addressing determinants of health and inequities, and this will require measurement. Putting "patients in the center" and "meeting people where they are" are also widely held aspirational goals. As the Commission designs a universal health care system for Washington, a goal could be to adopt best practices from the start and avoid building silos and deploying incompatible proprietary approaches. Additionally, it is crucial to include input and engagement from communities who have historically been harmed by the current system. It's also important to recognize that artificial intelligence (AI) is increasingly used in health care, and the information AI utilizes to "learn" could reflect historical references and biases. As such, transparency will be important to garner trust from the community.

Next steps

The Commission will begin review their draft report to the Legislature on Whole Washington's proposed SB 5335 and will vote on its adoption this June. Also this June, the Commission will hear updates on the actuarial analysis. One Commission member suggested dedicating time at the June meeting to review the report on SB 5335, as well as to find ways to hear Commissionioners' response to public comments at meetings.

Adjournment

Meeting adjourned at 5:00 p.m.

Next meeting

June 4, 2024
Meeting to be held on Zoom and in-person at HCA
2–5 p.m.

Tab 3

Washington State Health Care Authority

Universal Health Care Commission
Written Comments

Written Comments Submitted by Email

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Additional Comments Received at the April Commission Meeting

- The Zoom video recording is available for viewing here: https://www.youtube.com/watch?v=osHGGsk_Sjs

From: Cris
To: HCA Universal HCC
Subject: June Public Comment
Date: Monday, May 20, 2024 10:41:41 AM

External Email

To the UHCC:

Despite attempts by Vicki and Pam to reassure the public that the UHCC and FTAC are listening to and concerned about public comment, it has become painfully obvious that neither group is actually interested in the public's views. I believe the reason is that the public, at both the Work Group and the UHCC meetings, has been insistent that the Commission unequivocally declare their commitment to a single-payer, state-based, universal healthcare system to replace the existing multi-corporate-based managed care chaos. There frankly is no other viable option that will save the needed funds and also provide simplified, high quality, universal coverage at an affordable price.

Since the HCA and Commission members appear too afraid to upset the proverbial apple cart, they have chosen to completely ignore public comment and treat it only as a perfunctory exercise to satisfy the law. If members were truly serious about it, they would actually respond to specific points, and use them as a springboard for in-depth discussion. Members would attempt to learn from those who are more knowledgeable about the single-payer universe than are they. Instead, members, consultants and staff prefer the safety of keeping discussions and presentations limited to that which is familiar as well as aspects of the current system that might be improved while keeping all the current power players in place. With this mindset, we will never get to real reform.

It also bears noting that numerous bills have passed in the last four legislative sessions that will incrementally improve healthcare in this state, but the UHCC played absolutely no role in advancing any of them. Rather, it was the public that pushed for them and made them happen! Of particular note were the three 2024 budget provisos that will help fund some important transitional steps toward single-payer. It was this same public that pushed for creation of the Commission, and we had high hopes that it would be a collaborative relationship. Unfortunately, due to fear and turf protection, that apparently is not to be.

It is well past time for the Commission to fulfill its mandate to establish the preliminary infrastructure of a single-payer system. The public strongly believes that using the Washington Health Security Trust and/or the Washington Health Trust as the template is by far the most efficient path to this objective. The draft plan could then undergo a preliminary review by CMMI before a final funding plan is presented to the legislature and a waiver application is submitted. But since this comment will undoubtedly be ignored as well, many of us are now considering other strategies to achieve those goals.

Cris M. Currie   Mead, WA

Tab 4

Workstream 1: Universal System Design: FTAC Update

Pam MacEwan, FTAC Liaison

FTAC Topics In May

- 1. Overview of health plan cost and benefit design including cost sharing and population and provider assumptions.
- 2. Discussion with actuaries on the challenge of benefit design comparison.
- 3. Committee discussion of options for comparison and importance of cost assumptions and cost control.
- 4. Presentation on Health Care Cost Transparency Board.
- 5. Next meeting to focus on comparison of benefit options.

Washington State Health Care Authority

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

May 9, 2024
Virtual meeting held electronically (Zoom)
2–4:30 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
Pam MacEwan
Roger Gantz

Members absent

Esther Lucero
Kai Yeung
Robert Murray

Call to order

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

Agenda items

Welcoming remarks

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

Meeting summary review from the previous meeting

The Members present **voted by consensus to adopt the March 2024 meeting summary**, following revisions proposed by Roger Gantz (removing "originally intended for mothers and children" in in paragraph four of the Benefits & Services Discussion and revising language in paragraph seven of the Benefits & Services Discussion to say "FTAC considered the following for actuarial analysis" rather than "FTAC agreed that the Commission should consider the following for an actuarial analysis.")

Public comment

Raleigh Watts, volunteer with Whole Washington, noting that the date for deciding on benefits and services had been extended beyond the original June deadline, implored FTAC to continue moving forward on this decision, despite not yet having full information on financing.

Kathryn Lewandowsky, Vice Chair at Whole Washington, wished to stress that Whole Washington is concerned about wealth inequality, seeing the funding of the health trust as a good way to "neutralize" this issue. Regarding SB 5335 revisions, premiums were removed as they were unnecessary, but did not repeal capital gains tax despite not needing the funds. Washington Supreme Court clarified that capital gains tax is not income tax, leaving open the question of what should be done. Wish to have a conversation on what is best to do to ensure sustainability of trust fund and ensure it is funded by and for the benefit of all Washington residents.

Commission updates & goals for today

Liz Arjun, Health Management Associates (HMA)

Liz Arjun provided an update on the workplan, noting that the focus for 2024 is on determining the costs of the unified health care system based on decisions about what benefits and services are covered, cost containment, and provider reimbursement. Also under consideration is administrative simplification and maximizing coverage in existing programs.

Commission updates included 1) additional funding being made available for expanded Medicaid and undocumented residents, which provides a path to covering all Washingtonians, 2) deciding that the decision on cost sharing would be made after deciding on benefits and services, and 3) beginning actuarial analyses with PEBB/SEBB, Silver Plans on the Exchange, and expanded Medicaid (i.e., dental, vision).

Presentation: Framework for Benefit Design and Cost Structure

David DiGiuseppe, Vice President of Healthcare Economics, Community Health Plan of Washington (CHPW)

David's presentation provided a high-level overview of how payers estimate costs in order to price their products. The first thing payers do is identify the population and historical experience (i.e., claims), which includes services covered, utilization rates, and cost per unit of service. Payers then project future enrollment—driven by population growth, individual decision marking, and market dynamics—and expenses, which include new services covered, utilization rate trend, and cost per unit of service trend. Finally, they overlay administrative expenses (e.g., network contracting, utilization management, sales and marketing, IT/finance/HR. These factors combined result in a model covering 100% of the total cost of care.

This framework doesn't cover who pays for care (i.e., health plan vs. patient out-of-pocket), but provides a starting point for FTAC to evaluate the impact of different choices (e.g., removing cost sharing, covering more services, covering broader population, raising new tax revenue, etc.). The presentation also offered a few options for evaluating opportunities to reduce costs in terms of healthcare expenses (e.g., hospital global budgets, spending caps) and administrative expenses (e.g., identifying essential admin costs, role of payers).

Next steps for FTAC include discussing whether an actuarial study will be helpful to the Commission by illustrating the cost savings potential of each strategy and whether FTAC has a role in describing the political challenges associates with each cost reduction opportunity.

Discussion

FTAC members discussed the implications of modeling out healthcare costs, including whether to focus first on reducing the total cost of care or on reducing cost sharing for Washingtonians. They also discussed implications of assumptions made in modeling, including the challenges of accurately predicting the impact of changes to cost structure and benefit design. Ultimately, FTAC wants to be able to provide feedback to the Commission on things that might have been overlooked and tradeoffs. FTAC members also suggested following up with Milliman actuaries with specific questions as the work progresses.

Presentation & Discussion: Health Care Cost Transparency Board

Ross McCool, Operations Research Specialist, Health Care Authority

Washington is one of nine states with a spending growth benchmark, starting at 3.2% in 2022 and going to 2.8% by 2026. The spending data is sourced from aggregate expenditure data from payers that includes both claims-based and non-claims-based expenditures. Spending is measured according to the following formula: **Total Medical Expense** (claims payments + all other payments not included on claims + cost sharing paid my members) + **Net Cost of Private Health Insurance** (administrative costs) = **Total Health Care Expenditures**. The Board is monitoring spending at both the state and market (i.e., Medicare, Medicaid, commercial) levels and plans to expand to evaluate at the payer and large provider levels in the future.

In 2019, total health care expenditures were $48 billion, rising 7.2% between 2017 and 2018 and 5.8% between 2018 and 2019. Medicare spending is growing slower than Medicaid or commercial; Medicaid is growing at the fastest rate (11.5% between 2017 and 2018 and 9.8% between 2018 and 2019), but per capita spending is still lower than other markets. Hospital outpatient services were a significant driver of growth overall, especially in the commercial market. Non-claims spending was the largest growth driver in the Medicaid market, though FTAC members pointed out that this could just be reflecting capitated payments and not the underlying spending on other categories like hospital in- and outpatient or primary and specialty care.

The work of the Board has been focused on taking in the data and understanding it, but in recent months, conversations have begun to shift to what options are available to address these issues. From a broader list, the Board selected several options for study, including limiting facility fees, restricting anti-competitive clauses in contracting, mergers and acquisitions/private equity purchasing of health care providers, and provider rate setting/price growth caps. The Washington Office of the insurance Commissioners (OIC) is also doing research on options to address health care costs. FTAC members expressed interest in collaboration with the OIC and other agencies doing similar and complementary work.

No votes were taken.

Adjournment

Meeting adjourned at 4:33 p.m.

Next meeting

July 11, 2024
Meeting to be held on Zoom
2–4:30 p.m.

Tab 5

State Agency Report Outs

DOH, HCA, OIC and WABHE

Tab 6

Workstream 3: Washington Health Trust (SB 5335)

Commission Vote:
Approve the Report on the Washington Health Trust Bill (SB 5335) to the Legislature

Universal Health Care Commission

Washington Health Trust (SB 5335) analysis report

Legislative report

June 30, 2024

DRAFT

Washington Health Trust analysis report

Acknowledgements

The Universal Health Care Commission (Commission) would like to thank the leaders and members of Whole Washington for their collaboration and important contributions to this report. Whole Washington is a grassroots coalition that supports both state and national efforts working to make Universal Healthcare a reality. This report is being submitted in response to the legislative request for an assessment of the Washington Health Trust proposal's alignment with the goals and planned activities of the Commission, and whether and how the Commission might recommend implementing the proposal if considered within the Commission's mission and a viable proposal. Elements of the Washington Health Trust proposal not captured in this report will continue to be assessed in collaboration with Whole Washington and will be included in the Commission's annual report beginning in 2025 until the analysis is complete.

DRAFT

Executive summary

In 2023, the Commission received a request from members of the Legislature to assess whether and how the Commission might recommend implementing the Washington Health Trust (**SB 5335**) proposal as introduced in the 2023 legislative session, if the Commission considers it within their mission and a viable proposal. SB 5335 proposes the creation of the Washington Health Trust within the Washington Department of Health to provide coverage for a set of essential health benefits (EHB) to all Washington residents.

In response to this request, the Commission voted to incorporate the assessment of SB 5335 into the Commission's work plan to the extent possible within the requested timeframe and available resources. At this time, it is not possible to recommend whether and how the Trust might be implemented because the Commission is still early in its universal health care system design work and a complete assessment of a proposed universal health care system will take time and careful consideration. Additionally, there are outstanding questions regarding the SB 5335 proposal that will need to be answered to determine whether it is a viable proposal and how it would be implemented.

However, the Commission did examine areas of alignment between their work to date and SB 5335. Whole Washington accepted invitations to present to both the Commission and their subcommittee on finance (the Financial Technical Advisory Committee also referred to as FTAC) across several meetings. [1] & [2] & [3] Specifically, this report includes an assessment of whether elements of the proposal align with the goals and planned activities of the Commission, including

- Eligibility
- Enrollment
- Benefits & Services

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 health care system. The Commission will continue to engage with Whole Washington members throughout the analysis and report development process.

How to read this report

This report aims to identify areas of alignment between the Commission and SB 5335 on larger health care system design. The report contains summaries of key considerations and decision points by the Commission and proposals in SB 5335, followed by an alignment table for each design element. Each alignment table illustrates areas of alignment and/or the degree of the alignment between the Commission and SB 5335 for each design element. Areas of alignment may change over the course of the Commisison's deliberations. For purposes of reading the alignment tables:

- Green signifies full alignment between the Commission and SB 5335
- Yellow signifies some areas of alignment between the Commission and SB 5335
- Red signifies no alignment between the Commission and SB 5335

[1] Commission's **August 2023 meeting recording**.
[2] Commission's **December 2023 meeting recording**.
[3] Finance Technical Advisory Committee **March 2024 meeting recording**.

- Gray signifies that determining alingment bears further analysis and is not possible at this time.

DRAFT

Background

The Commission's charge

As directed by the Legislature, the Commission must:

> "Implement immediate and impactful changes in the state'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, and establishing mechanisms to expeditiously link residents with their chosen providers; and
>
> establish the preliminary infrastructure to create a universal health system, including a unified financing system, that controls health care spending so that the system is affordable to the state, employers, and individuals once the necessary federal authorities have been realized. The Legislature further intends that the state, in collaboration with all communities, health plans, and providers, should take steps to improve health outcomes for all residents of the state."

Washington has long been a leader of health care reform in the U.S., however gaps in coverage, health equity, affordability, and access to culturally competent, high quality care persist for too many Washingtonians. The Commission remains committed to finding ways to achieve the greatest and most immediate impact for the greatest number of people. With this goal in mind, and focusing partly on interim steps and partly on future system design, the Commission has focused its work on the following areas:

- The **baseline report** (2022) to the Legislature and subsequent **annual report** (2023)
- Determining eligibility for the future universal health care system
- Preliminary discussions on benefits and services for the future universal health care system
- Identifying ways to improve the current health care system that will also support the state's transition to a universal health care system
- Adoption of a health equity framework with which to evaluate proposals for the new system design
- The request to analyze the Washington Health Trust (Trust) bill.

As requested by members of the Legislature, this report will focus on areas of alignment between the Commission and SB 5335. As time and resources have allowed, the areas of alignment outlined in this report include larger system design elements including eligibility and benefits and services. Interim strategies and other design elements will be included in the Commission's annual reports to the Legislature beginnning in 2025.

DRAFT

Eligibility and enrollment

Background

Achieving universal coverage requires determination of how to design a system through which 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 such, the Commission selected eligibility as the first design component to examine.[4]

The three programs which cover the greatest number of Washingtonians include Medicare, self-funded employers, and Medicaid. Fully integrating enrollees of these programs in the universal system, both in terms of administration and financing, is important to achieving administrative simplicity and savings that would come with a universal health care system. However, each presents significant barriers with respect to the ability to include their enrollees in Washington's universal system. These barriers are largely due to provisions of federal law and regulation. For example, Medicare is an 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 and federal law establishes certain eligibility criteria. Finally, federal law preempts state regulation of self-funded employer health benefit plans.

In their eligibility discussions, the Commission has identified potential pathways for enrollees of these programs, particularly Medicare[5] and self-funded employer plan enrollees, to receive the same benefits as those offered under the universal system while maintaining separate administration of those programs. Ultimately, 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.

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.[6]

[4] 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.

[5] This is especially true of Medicare, both because it is unlikely that Congress would turn the program over to states and also because of the budgetary burden it would place on states.

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

DRAFT

Commission

The Commission consulted with their Finance Technical Advisory Committee (FTAC)[7] on options to address potential gaps in benefits and out-of-pocket costs for Medicare enrollees in Washington's future universal health care system. Six options[8] were evaluated along with the pros and cons of each.[9]

Of the six options, establishing a system to directly reimburse Medicare enrollees for cost-sharing and for services covered by the universal system but not by Medicare would be the most expedient for the state to implement. For example, this option allows the most flexibility to fully address gaps and would not require waivers nor result in delays due to legal challenges. This option could also be explored in conjunction with a waiver as a tool for cost containment.

However, disadvantages to this option include the potential variances between Medicare enrollee choices, with federal rules potentially limiting the ability to wrap around Medicare Parts A[10] & B[11]. This option could also invite gaming from Medicare Advantage (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.

A waiver[12] is the ideal approach to both integrating Medicare dollars and addressing coverage and affordability gaps for Medicare enrollees in the universal system. However, currently, pursuit of such a waiver is not an effective use of resources or time due to legal uncertainty over whether action by Congress would be needed. Additionally, the **Centers for Medicare and Medicaid Services (CMS) is unlikely to grant a waiver to a new and untested program, even if it is determined that it has the authority to do so.[13]**

Direct reimbursement, which could be explored in conjunction with a waiver, is the most feasible option for the short term to achieve policy goals. This option will be revisited with further analysis to determine what gaps need to be filled between existing Medicare services and that of the new system once more system design elements have been determined by the Commission.

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[7] **FTAC roster**.

[8] Evaluated options include an act of Congress, demonstration waiver, a Medicare Advantage (MA) plan as the only option for Medicare enrollees, an MA plan designed by the state that competes with other MA plans on the market, a state-designed and offered Medigap plan, and direct reimbursement.

[9] The Commission's full eligibility assessment for Medicare-eligible Washingtonians can be found in Appendix A.

[10] Inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.

[11] Preventative services, outpatient care, certain doctors' services, and medical supplies.

[12] If obtained, a comprehensive waiver granted by CMS would allow Washington to enroll all Medicare enrollees into the universal system design and leverage federal funding, a key advantage of this option. However, FTAC identified that there is no legal precedent for such, and it is unlikely to be achieved via legislation through the current Congress.

[13] In their environmental analysis to the governor and state legislature, the Healthy California for All Commission (HCAC), also charged with developing a state-based universal health care system, 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.

DRAFT

SB 5335

Under SB 5335, Medicare enrollees would be eligible to enroll in health care coverage under the Washington Health Trust (Trust).[14] SB 5335 recognizes that in the long term, integration of federal Medicare dollars would be essential to supporting and sustaining the Trust. To address gaps in coverage and cost-sharing for Medicare-eligible Washingtonians in the interim, SB 5355 proposes the creation of a state funded and managed Medicare Advantage – Part D (MA-PD) plan. The MA plan under the Trust would compete with private MA plans and traditional Medicare and be available to Medicare enrollees who elect the Trust coverage as their MA plan.[15 & 16]

A state designed and administered MA-PD was also assessed by the Commission. For the state, 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. This option does not limit Medicare enrollees' choice because Medicare-eligible Washingtonians would be able to enroll in the state's MA plan, a private MA plan, or in traditional Medicare. Making this option voluntary could potentially mitigate the threat of legal challenges that may arise if Medicare enrollees were forced to enroll in the state's MA plan.

In the Commission's assessment, there are some limitations with this option. For example, payment structures would need to be resolved, as MA payments are tied to Medicare's fee-for-service (FFS) benchmark compared with whatever payment structure is utilized in the universal system.[17] Another limitation of 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. The main concern with this option **is the competition the state would face by entering a mature MA-PD market** in Washington with multiple carriers offering over 100 MA plans and that these plans are portable outside of the state of Washignton.[18] Additionally, Medicare enrollees 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, the Commission did not recommend this option being completely removed as a possibility for including Medicare enrollees in a future universal health care system. There may be a possibility in the future for this option to sit alongside direct reimbursement to address gaps and this requires further assessment.

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[14] Proposed enrollment and eligiblity components of SB 5335 are outlined in its Sec. 111. All

[15] The bill is silent on what entity would be charged with designing and implementing the MA-PD plan, though it is intended as state funded and managed.

[16] Medicare enrollees with household incomes below 200 percent of the federal poverty level (FPL) who chose to enroll in the Trust would be reimbursed for Medicare premiums until federal Medicare dollars could be integrated to support the Trust. Design and implementation of reimbursement mechanisms would be at the discretion of the Washington Health Trust Board of Trustees established in Sec. 104.

[17] The Commission is scheduled to begin discussions on provider reimbursement in 2024, though this is subject to change pending progress made on other scheduled design elements throughout the year.

[18] Portability of health care plans across states may be very attractive to some Medicare enrollees, who would not select a state-based health plan.

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Alignment between the Commission and SB 5335 for Medicare enrollees

The Commisison and SB 5335 are aligned in the goal of providing access to coverage and care for Medicare-eligible Washingtonionas under a state-based universal health care system. However, the means by which this goal is achieved in the interim may differ, at least in the Commisison's preliminary eligiblity deliberations.

It is not yet possible to determine whether the Commission and SB 5335 are aligned on intermediate strategies. The Commission plans to conduct further analysis once more design components of the universal system are determined, such as benefits and services. It will be especially important to assess any unintended consequences, potential legal challenges, health equity impacts, and costs and/or savings to the state.

The Commission and SB 5335 do align on the long-term goal to secure a waiver to integrate federal Medicare dollars. Additionally, SB 5335 gives discretion to the Health Care Authority (HCA) to develop a federal waiver to integrate Medicare funds. Details on the proposed waiver development process are outlined in Sec. 113 of SB 5335.[19]

Table 1 below outlines areas of alignment between the Commission's preliminary eligibility work and SB 5335. Green represents alignment and gray signifies that determining alingment requires further analysis.

Table 1: Medicare eligibilty areas of alignment

	Commission	SB 5335
Goal	Medicare enrollees are eligible for coverage and care under Washington's universal health care system[20] and federal Medicare funds can be accessed to support a unified financing system.	
Transition [21]	Directly reimburse Medicare enrollees for cost-sharing and services covered by the universal system but not by Medicare.[22] This option could be explored in conjunction with a waiver in the short term to achieve policy goals.	Supplement Medicare with a publicly funded and managed Medicare Advantage & Part D (MA-PD) plan that would compete with other private MA plans and traditional Medicare.
Long term	A federal waiver is the ideal approach to both integrating Medicare dollars and addressing coverage and affordability gaps for Medicare enrollees in the universal system. Securing such a waiver will take significant resources and time. Additionally, to be	

[19] Directives to HCA are outlined in SB 5335 under Sec. 113.

[20] SB 5399 stipulates that all residents would be eligible for coverage and access to care through a unified financing system once the necessary federal authority has become available.

[21] In the Commission's preliminary assessment, direct reimbursement surfaced as the most feasible option to include Medicare enrollees in a state-based universal health care system. However, this could be explored in conjunction with a waiver to contain costs. Additionally, the Commission did not remove for consideration a state-designed and operated MA-PD plan, though this requires further analysis.

[22] More details will be developed once benefits and services and other design components are determined.

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	successful, the federal government may require the program to be tested and operational before considering granting a waiver.

Employers

Employers serve as a major source of health care coverage for Washingtonians. This makes integration of employers especially important both for making the new system universal and for the financial viability of Washington's unified financing system.

Commission

Washington can regulate employers with fully insured individual and group health plans. However, the Employee Retirement Income Security Act of 1974 (ERISA), a federal statute, preempts state regulation of self-funded employer health benefit plans,[23] or insurance plans where an employer covers the full financial risk of its employees' claims for health care benefits. Per the ERISA statute, regulation of ERISA plans is "exclusively a federal concern" and preempts "all state laws insofar as they…relate to any employee benefit plan," constraining Washington's 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 be thoroughly examined.[24]

Unlike the waiver authorities granted to CMS under Medicare and Medicaid, there is no such authority in the ERISA statute. Legal challenges may be inevitable, and this requires further analysis. However, the Commission is taking into consideration experiences from other states. For instance, the Ninth Circuit Court of Appeals has upheld the establishment by the cities of San Francisco and Seattle of respective public-program alternatives, finding that they preserved employers' benefit choices sufficiently to avoid ERISA preemption. As demonstrated by both cities, providing employers a meaningful alternative to providing their own coverage, such as a new universal plan, would allow employers to choose whether to opt in and may therefore survive an ERISA challenge. This could eventually attract employers, or even serve as a glide-path to a single-payer system.

The Commission has also discussed the legal benefits of making participation in the new system voluntary for employers subject to ERISA. However, this would make funding for the new system less secure and less predictable.

[23] 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.

[24] The Commission's full eligibility assessment for individuals receiving health care coverage through self-funded employer plans can be found in Appendix B.

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Provider regulation and/or incentives must also be considered as a part of the design of the universal system, not only to achieve universality in principle, but also to provide the state with levers to achieve a unified financing system in practice. However, requiring providers to contract with the universal plan without the ability to contract with other plans may be preempted by ERISA. Further analysis and discussion will be needed to expand upon this option to understand specific policy requirements, political hurdles, and cost impacts.

A mechanism to capture revenue from large employers will also be critical. However, it's important to consider the inverse relationship between the financial security a funding mechanism may provide and the potential risk to the state that mechanism runs in terms of running afoul of ERISA. For example, a payroll tax on all employers regardless of whether they continue to offer employees health care coverage may provide a more reliable stream of revenue, but may also make the state vulnerable to, and unlikely to win, an ERISA challenge. A funding mechanism, in combination with some or all the above policy levers, will need to be examined with the assumption that there will be an ERISA challenge(s). This requires further analysis. The Commission plans to further discuss the best strategy to give the state a stronger footing in the likely event of an ERISA challenge.

Finally, large employers are likely to fiercely defend ERISA, and their perspectives on state-based universal health care and buy-in will need to be carefully considered. Continuing to engage large employers will also be important to identifying opportunities to make a universal system more appealing or acceptable, including administrative simplicity, better cost control, and optional participation in the universal health care system. More specific policy levers to integrate employers into the universal health care system will be revisited once more design elements of the larger system are determined.

SB 5335

SB 5335 recognizes the barriers brought by ERISA preemption of large employer health plans. SB 5335's approach to include employees and integrate employer funding to support the Trust is modeled after Healthy San Fransisco,[25] a public-program alternative that preserved employers' benefit choices enough to avoid ERISA preemption. Employers would have the option to either maintain existing employee benefits plans or to allow employees to enroll in coverage under the Trust.

However, employers would be required to pay a minimum percentage of each employee's payroll toward that employee's health care. Per SB 5335, Sec. 202 (1)(b), employers' minimum required health care expenditure would be 10.5 percent of an employee's aggregate adjusted quarterly payroll or wages and less the employer's health care expenditures for that employee during the same reporting period. An

[25] *Golden Gate Restaurant Association v. City and County of San Francisco et al.*, Supreme Court of the United States, Case No. 08-1515. It was ruled that the program's requirement of employers in San Francisco to spend a minimum amount per hour on healthcare for their employees does not violate ERISA because it provides options for employers to comply with the requirement. Additionally, it is not specified what benefits employers must provide in their ERISA plans, nor are employers required to provide coverage through an ERISA plan. A timeline of the key events in the case can be found **here**.

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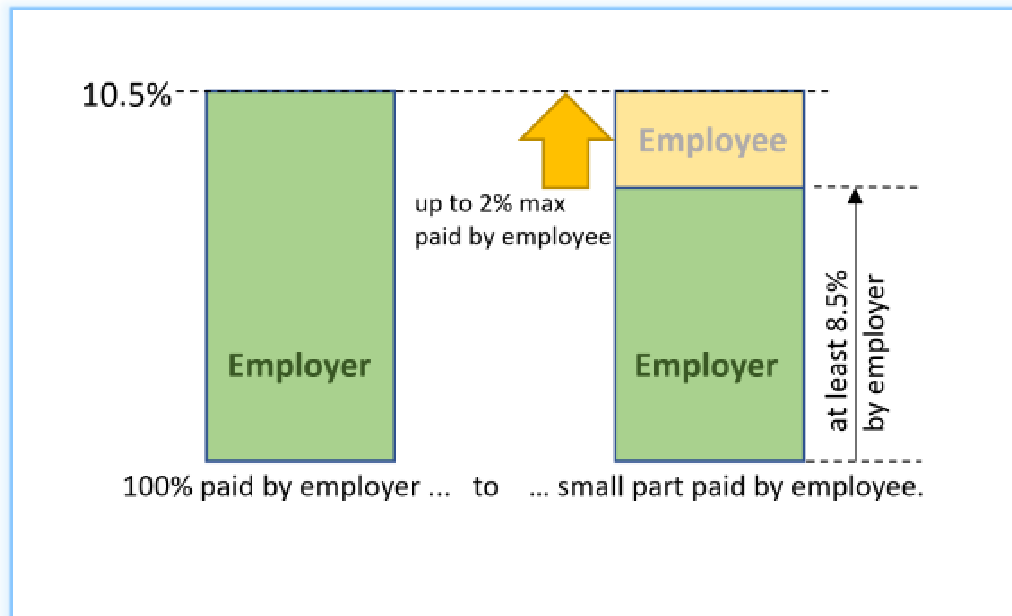
employer may elect to deduct up to two percent of the required health care expenditure from an employee's wages. This per-employee required health expenditure would serve as the means of employer revenue to support the Trust and is illustrated in Figure 1[26] below.

Figure 1: Employer/employee contribution



All licensed providers would be eligible to receive reimbursement for services from the Trust, but participation would be optional. Annually, the Washington Health Trust Board (Board),[27] in coordination with HCA, would collectively negotiate reimbursement rates with qualified providers[28] on a fee-for-service (FFS) basis.[29]

Alignment between the Commission and SB 5335 for self-funded employers

The Commisison and SB 5335 are aligned in the goal of providing access to coverage and care for Washingtonians who currently receive health care coverage through their employer. The Commission and SB5335 are also fairly aligned on how to integrate self-funded employers, depending on what the courts determine is legal. The Commission will further analyze options to integrate employees and employers once more design components of the universal system are determined. At that point, the Commission will also assess any unintended consequences, mitigatation strategies for inevitable legal challenges, health

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[26] Figure provided by Whole Washington.
[27] As defined in Sec. 102.
[28] Not including providers participating as community health providers as defined in Sec. 102.
[29] Sec. 109 directs that provider rates are at the discretion of the Washington Health Trust Board and HCA and their established mechanisms permitting qualified providers to collectively negotiate budgets, payment schedules, and other terms and conditions of Trust participation.

equity impacts, and costs and/or savings to the state. Alignment between the Commission and SB 5335 can also be further assessed and determined at that time.

Table 2 below outlines areas of alignment between the Commission's preliminary eligibility work and SB 5335. Green represents alignment, yellow signifies some alignment, and gray signifies that determining alingment requires further analysis.

Table 2: Employer eligiblity areas of alignment

	Commission	SB 5335
Goal	Integrate employees and employers into Washington's universal health care system and generate revenue from employers to support a unified financing system.	
Transition /long term (Assuming no changes in federal ERISA law)	Voluntary employer participation in the universal health care system may help mitigate legal challenges.	Employers may choose between continuing to offer employees existing private coverage or to allow employees to receive coverage under the Trust.
Transition /long term (Assuming no changes in federal ERISA law)	Offering employers a meaningful alternative to their exisiting employee coverage has been successful in other cities/states and may, alongside other policy levers, survive an ERISA challenge.	Modeled after San Francisco's experience, the Trust aims to offer employers a meaningful alternative to their exisiting employee coverage.
Transition /long term (Assuming no changes in federal ERISA law)	Financial contributions from employers will be key to supporting and sustaining the universal health care system.	Modeled after San Fransisco, creates a per-employee required health expenditure to generate revenue to support the Trust
Transition /long term (Assuming no changes in federal ERISA law)	Provider regulation/incentives will be needed to achieve universality and to provide the state with levers to achieve feasibility of financing a universal system.	Voluntary provider participation, but all providers would be eligible to receive (and not be denied) reimbursement. Participating providers could collectively negotiate reimbursement rates with the authorizing entities.

Medicaid (Apple Health)

Given the significant role Medicaid plays in Washington's health care system, the number of residents who rely on Medicaid as their source of health coverage, and the complexity of the program rules, Medicaid will be a foundational component of the Commission's design for the universal system. While Medicare and ERISA present significant federal barriers, there may be a path forward for Medicaid.

Commission[30]

Medicaid is jointly financed by states and the federal government. CMS provides the rules and oversight with which states must comply in administering the program to obtain federal matching dollars through the Federal Medical Assistance (FMAP).[31 & 32 & 33]

The Medicaid program has the largest array of health benefits and long-term care and support services in comparison to employer-based coverage, individual market coverage, and Medicare. To receive FMAP funds, there are 15 mandatory benefits states must provide and 28 optional services that states may elect to cover.[34] Washington's Medicaid program, or Apple Health, provides all mandatory and all optional benefits depending upon the specific eligibility category. [35]

States can require certain groups of Medicaid beneficiaries to pay enrollment fees, premiums, deductibles, coinsurance, copayments, or similar cost-sharing amounts. However, the total amount of premiums and cost sharing incurred by all individuals in a Medicaid household may not exceed five percent of the

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[30] See Appendix C for the Commission's eligibility assessment of Medicaid.

[31] The FMAP is computed by a formula that considers the average per capita income for each state relative to the national average. Washington's FMAP is 50 percent.

[32] To receive federal funding, states must cover certain "mandatory" populations in their Medicaid program. Medicaid mandatory populations include children through age 18 in families with income below 138 percent of the federal poverty level (FPL), certain parents or caretakers with very low income, people who are pregnant and have income below 138 percent FPL, seniors and people with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program.

[33] States may also receive federal Medicaid funds to cover "optional" populations. Medicaid optional populations include adults and children in the groups listed above whose income exceeds the limits for "mandatory" coverage, seniors and people with disabilities not receiving SSI and with income below the poverty line, "medically needy" people and other people with higher income who need long-term services and supports, with the Affordable Care Act (ACA) expansion, non-disabled adults with income below 138 percent FPL, including those without children. "Medically Needy" is a phrase used to describe optional coverage for persons who do not quality for Categorically Needy Medicaid programs due to income.

[34] All mandatory benefits must be provided to mandatory populations. Optional benefits may be provided to some, but not all, optional populations.

[35] States began to enroll most of their Medicaid clients in comprehensive, risk-based managed care arrangements beginning in the 1990s. These efforts were driven by many reasons, including a desire to provide more predictability over future state budget costs. Other reasons include greater accountability for outcomes, more support for systematic efforts to measure, report, and monitor performance, access, and quality, and the potential to improve care management and care coordination. More than 85 percent of Washington's Medicaid beneficiaries are enrolled in Medicaid Managed Care Organizations (MCOs).

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family's monthly or quarterly income.[36] Apple Health does not have any premium or point-of-service cost-sharing requirements.[37]

To include Medicaid beneficiaries in a unified financing system administered by the state, it will be necessary to change the relationship between the state and the federal government with respect to the implementation of the program. One way to make these changes is through demonstration waivers permitted by CMS.

States use 1115 waivers for broad authorities to carry out demonstrations or test new ideas that further the goals of the Medicaid program by doing something in a different way. Some examples of how states have used or are currently using 1115 waivers include:

- If federal law prevents a needed service or benefit[38]
- If federal law prevents a desired population from being covered[39]
- If federal law prevents certain program administration elements[40]

Section 1115 waivers are approved "at the discretion of the Department of Health and Human Services (DHHS) Secretary," must be budget neutral to the federal government, and must further the objectives of the Medicaid program.[41] The approval process can take years for complex waivers, including a review by the Office of Management and Budget.

Additionally, in its review process, CMS does not consider contingencies. For example, if a state applies for a Medicaid 1115 waiver that cross-references savings contingent on approval of a 1332 waiver related to Exchange coverage, CMS will not consider the projected savings from the 1332 waiver in determining whether the proposed 1115 waiver satisfies the budget neutrality requirement. Further, 1115 waivers

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[36] Cost-sharing can be applied to the following populations including pregnant women and infants with family income at or above 150 percent FPL, qualified disabled and working individuals with income above 150 percent FPL, disabled working individuals eligible under the Ticket to Work and Work Incentives Improvement Act of 1999, disabled children eligible under the Family Opportunity Act (FOA), and medically needy individuals.

[37] Washington's Children's Health Insurance Program (CHIP), the Medicaid program for children in households with incomes greater than 210 percent FPL, imposes modest premiums.

[38] Medicaid cannot pay for "Institutes of Mental Disease" (IMD), or inpatient mental health services at a designated facility, for patients aged 21-64, or substance-use disorder (SUD) treatment, as this may require an inpatient stay and states have used 1115 waivers to allow IMD services for SUD and mental health services.

[39] Medicaid cannot pay for health services for incarcerated individuals, except for inpatient hospitalization. Many states are seeking flexibility to provide services to individuals who are incarcerated as they approach their release date to support transitions to the community.

[40] Medicaid does not allow premiums except under certain circumstances. Some states have obtained 1115 waivers to apply premiums and co-pays to the ACA expansion population.

[41] Section 1115 research and demonstration waivers. Medicaid and CHIP Payment and Access Commission. **https://www.macpac.gov/subtopic/section-1115-research-and-demonstration-waivers/**

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require significant evaluation, reporting, and oversight to ensure program integrity and provide information about the impacts of the flexibilities they are testing.

Some states have sought eligibility expansions through State Plan Amendments (SPA). Compared to a waiver, a SPA would require a state to put up additional matching dollars and provide mandatory or optional benefits depending on the population. In addition, a SPA would be a relatively permanent change to a state's Medicaid program that wouldn't have to be renewed every five years (as a waiver does) and it creates an entitlement where all those who apply and enroll must be served all the benefits for that particular program. On the other hand, a waiver would allow for different benefit packages to expanded populations, allow for premiums and co-pays, and most importantly, allow a state to obtain credits for state spending (rather than allocate matching dollars) to finance the coverage so long as it is budget neutral to the federal government. States can use either a SPA or waiver to eliminate asset tests required in Classic Medicaid. Recently, Arizona has used a SPA while California is using its 1115 waiver to do so.

Ongoing discussion

The Commission's discussions regarding options to incorporate Medicaid in Washington's universal system continue. Additional questions/topics that will be important when considering how to incorporate Medicaid include:

- Given the lower Medicaid provider reimbursement rates relative to other payers like Medicare and commercial plans, at what rate will providers under the new system be paid, and how will continuing Medicaid providers be paid relative to the new rate?
- The effectiveness of MCOs in Medicaid compared to a different administrative model, e.g., Connecticut's transition from managed care to fee-for-service (FFS).
- Ensuring that the state can obtain all the information necessary to maintain federal match.
    - What needs to be done to make Washington's programs more seamlessly integrated, and what have other states done in this space?
- Accounting for supplemental payments that are made to hospitals and other providers that make Medicaid rates similar to Medicare.
- When considering increasing Medicaid rates, it is important to avoid simply defaulting to commercial rates because Medicare payments are generally adequate for cost-efficient hospitals.
- An actuarial analysis may be helpful to better understand benefit levels and provider reimbursement rate adequacy.

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SB 5335

SB 5335's goal is to provide equitable coverage through the proposed Trust for all, including those covered through Medicaid, and to maximize the use of federal funding in the Trust. Per SB 5335, development of a demonstration waiver to incorporate federal Medicaid funding into the Trust would be at the discretion of HCA. SB 5335 directs HCA to

> "Negotiate with the federal Department of Health and Human Services' Health Care Financing Administration to obtain a statutory or regulatory waiver of provisions of the Medicaid statute, Title XIX of the federal Social Security Act, and CHIP including, but not limited to, application for an applicable demonstration project."

As noted previously, Medicaid provider reimbursement can be significantly less than that of Medicare or commercial payers. This will need to be addressed in integrating the Medicaid program into a universal health care system supported by unified financing. Whole Washington, proponents of SB 5335, propose that the Trust would reimburse providers at an increased negotiated rate for all residents with hopes that advancing provider payment equity would also advance health equity for all patients.[42]

Alignment between the Commission and SB 5335 for Medicaid

The Commisison and SB 5335 are aligned in the goal of providing access to coverage and care for Washingtonians who currently receive health care coverage through Medicaid. However, the Commission aims to continuously analyze options to integrate Medicaid alongside their discussions regarding benefits and services and provider reimbursement for the new system. At that point, the Commission will also assess any unintended consequences, health equity impacts, and costs and/or savings to the state. More specific areas of alignment between the Commission and SB 5335 can also be assessed and determined at that time.

Table 3 below outlines areas of alignment between the Commission's preliminary eligibility work and SB 5335. Green represents alignment, yellow represents some areas of alignment, and gray signifies that determining alingment requires further analysis.

Table 3: Medicaid eligibilty areas of alignment

	Commission	SB 5335
Goal	Integrate Medicaid funding to support Washington's unified financing system.	
Transition	1115 waivers and SPAs may offer pathways to integrate federal Medicaid funding to support a unified financing system.	HCA is directed to negotiate with federal DHHS to obtain a demonstration waiver.

[42] Sec. 109 of SB 5335 directs that the Washington Health Trust Board of Trustees (Board) (established in Sec. 102), in coordination with HCA, must adopt rules and mechanisms to permit providers to collectively negotiate budgets, payment schedules, and other terms and conditions of Trust participation. Additionally, the Board, in coordination with HCA, must annually and collectively negotiate reimbursement rates with providers on a fee-for-service basis.

Long term	Utilize tools such as demonstration waivers and/or SPAs as appropriate to integrate federal Medicaid funding.	Utilize a federal 1115 waiver to integrate federal Medicaid funding.
Long term	Further analysis is needed to determine where Medicaid reimbursement rates should increase. This is especially important because lower Medicaid rates often disincentivize providers from participating in Medicaid, creating barriers to access for Medicaid patients.[43]	Reimbursement for all providers, including Medicaid providers, will be set at an increased rate (relative to the status quo) to be negotiated by the Board in coordination with HCA and providers participating in the Trust.

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Enrollment infrastructure

Commission and SB 5335

The Commission and SB 5335 share the goal of expanding or repurposing existing infrastructure where possible to support the state's transition to and implementation of a universal health care system. The Commission and SB 5335 have identified an existing health care coverage enrollment process which could be expanded to facilitate enrollment for the future system.

Alignment between the Commission and SB 5335

Currently, enrollment for both Apple Health (HCA's domain) and Qualified Health Plans, or QHPs (Exchange), is administered through a shared eligibility and enrollment system operated by the Exchange through Washingtonhealthplanfinder.com. Altogether, one out of four Washingtonians (over two million individuals) use this site to find health coverage and/or financial assistance to obtain health coverage. This enrollment system interfaces with other data sources to offer an integrated and streamlined application process for Washingtonians seeking health care coverage. HCA and the Exchange share the mission to offer a streamlined process for Washington residents to search, shop, enroll and obtain financial assistance to obtain health coverage and continue work to strengthen the shared Medicaid and QHP enrollment process.

Table 4 below outlines areas of alignment between the Commission's preliminary eligibility work and SB 5335. Green represents alignment.

Table 4: Enrollment areas of alignment

	Commission	SB 5335
Goal	Employ a user-friendly, efficient enrollment mechanism to enable all Washingtonians to enroll in the universal health care system.	

[43] Some providers, e.g., rural hospitals, receive Medicaid reimbursement at rates similar to that of Medicare and even commercial plans due to supplemental payments.

Transition	Strengthen existing enrollment infrastructure utilized for Medicaid and QHPs to prepare the state for the transition to a universal health care system.
Long term	Strengthen and expand existing enrollment infrastructure utilized for Medicaid and QHPs to faciliate enrollment for the universal health care system.

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Benefits and services

Background

One of the goals in designing a state-based universal health care system is to ensure that all Washingtonians receive comparable health care benefits and equitable access to care. After eligibility, the Commission selected benefits and services as the second design component of the new health care system to examine.[44]

Currently, there are varying levels of covered benefits across health care coverage sources and even within the same coverage source. For example, unlike Medicaid, Medicare does not cover vision, hearing, dental, or Long-Term Services & Supports (LTSS). However, individuals dually eligible for Medicare and Medicaid[45] could receive such benefits as supplemental coverage through Medicaid. Additionally, benefits offered under private coverage can vary. For instance, for coverage offered on the state's Exchange, provider networks and cost-sharing can vary by metal tier even under the same health carrier.

Commission

As previously noted, there are significant challenges to fully integrating the existing health care coverage sources into the new health care system, not the least of which are the quality and equity implications of varying benefits (particularly at the outset). The Commission aims to design a benefits package for the new system that prioritizes prevention, comprehensive coverage, and equitable access to appropriate care, while recognizing that the more robust the benefits, the more costs could increase to the state at the outset.

In its early stages of benefit design, the Commission has looked to work that has already been done in this space. The Universal Health Care Work Group (Work Group),[46] predecessor to the Commission, recommended that the ACA-mandated categories of services defined in the Essential Health Benefits (EHB) be provided with the possibility of additional service categories, including vision. Among the outstanding considerations was whether other benefits not included in the EHB,[47] such as LTSS, would be provided.[48] Other states, including California and Vermont, also modeled their respective universal health care benefits after the EHB. Whole Washington also selected the EHB for SB 5335's benefit design, details of which will be covered later in this section. Conversely, Oregon selected their state's public employee/school employee plan for the basis of their state-based universal health plan.

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[44] 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.
[45] Lower income Medicare enrollees may qualify for supplemental coverage and benefits through Medicaid.
[46] **Work Group Final Report**. 2021.
[47] The covered benefits under the EHB will be detailed in the section describing SB 5335's proposed benefits and services.
[48] All plans sold on the state and federal marketplaces must provide EHBs as well as any other services or supplies required by the state. Each state defines that plan, which is used as a benchmark for the state's essential health benefits. The **CMS website** provides details on Washington's benchmark plan.

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The Commission sought to compare covered benefits under some of the richer benefits packages under Medicaid and PEBB/SEBB's Uniform Medical Plan (UMP), however creating a tool to do so has proved challenging. For example, Medicaid provides benefits that are required by CMS to obtain federal matching dollars, and fully insured market plans must provide state-mandated benefits not required in the EHB. Given these challenges, the Commission enlisted FTAC's expertise on the approach for an actuarial analysis to compare benefits across Medicaid, UMP, and Washington's EHB.

As FTAC noted, there will be a high degree of overlap between the three, and general benefit design may not have much impact on the total cost of care. As such, the issues of interest for the actuarial analysis will be around the scope of services, allowed quantities of services (duration), and cost-sharing. FTAC agreed that the Commission should consider the following for an actuarial analysis:

- Begin with UMP or EHB and layer on additional benefits to be modeled.
    - Cascade Care (standard qualified health plans on the Exchange)[49] could serve as the starting point for the EHB to understand the cost-sharing impact on premiums across the Bronze, Silver, and Gold metal levels, and then assess whether Medicaid and UMP cover anything different.
- Other dimensions of benefit design should be considered in future discussions, including prior authorization, supplemental benefits outside of the universal plan's covered benefits, point of service cost sharing, and a standardized provider reimbursement rate.

FTAC's considerations and recommendations will be shared with the Commission at their April 14 meeting. The Commission's editing of this report will be underway at that time, so findings from the actuarial analysis, and additional discussions and decisions on benefits and services will be provided in the Commission's 2025 report to the Legislature.

SB 5335

The health care coverage proposed under SB 5335 is inspired by the World Health Organization's definition of universal health care coverage, where "all people have access to the full range of quality health services they need, when and where they need them, without financial hardship."[50 & 51] Text from SB 5335 describing Whole Washington's vision for coverage under the Trust is also captured below.

> "With the intent to start healing the wounds of generations of inequality and to ensure a future where health care is recognized as a basic right afforded to each resident, the people of the state of Washington declare their intention to create a single, primary nonprofit health financing entity called the Washington Health Trust. The Trust will simplify health care financing, eliminate administrative waste, respond to the health needs of each regional health district, and **guarantee all residents coverage of a comprehensive set of essential**

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[49] In 2019, **Senate Bill 5526** established standardized plans and the public option on the Health Benefit Exchange.

[50] **World Health Organization's** definition of universal health coverage.

[51] Residents would also be free to obtain coverage for the health care benefits not covered under the Trust. The Trust does would not interfere with benefits related to Labor & Industries (L&I), Veterans Affairs (VA), or Indian Health Services (IHS) or their funding.

health benefits without the burden of premiums, deductibles, copayments, or medical bills. "

The proposed coverage offered under SB 5335 is based on the covered benefits under the EHB and is outlined below. SB 5335 also includes language to explicitly cover certain populations and categories of care including gender-transition care, reproductive care, and individuals affected by the justice system.

EHB categories

- 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[52]
- Short-term rehabilitative and habilitative services and devices
- Licensed naturopathic, acupuncture, and massage therapies

SB 5335 would also cover hospice and end of life care, and long-term care benefits at least at the standards of Medicaid coverage, though these benefits would not be offered at the outset. Rather, these benefits are intended to be phased in within four years of the Trust's implementation.

Revenue and financing

Revenue

The Trust's revenue sources would include an employer payroll tax, an employee payroll tax, a sole proprietorship tax, and a capital gains tax as outlined in Table 5 below.[53] This approach compared to the status quo is proposed to lessen the financial burden imposed on individuals, families, and employers.

Table 5: SB 5335 revenue structure

SB 5335 revenue contributions by population	
Employers[54]	10.5 percent of wages

[52] Oral health, audiology, and vision services are not required service categories under the ACA.
[53] The Capital gains tax was ruled by the 2023 Washington State Supreme Court as constitutional exempting the first $250,000. **https://dor.wa.gov/about/news-releases/2023/capital-gains-excise-tax-ruled-constitutional**
[54] Employers would collect a contribution for each employee. After an exemption, the employer contribution would be a total of 10.5 percent of gross pay. Employers could deduct up to two percent from the employee's wages. The exemption calculation is $15,000 less the gross pay multiplied by one quarter of one percent (.25%). The exemption would not apply for any gross pay above $60,000.

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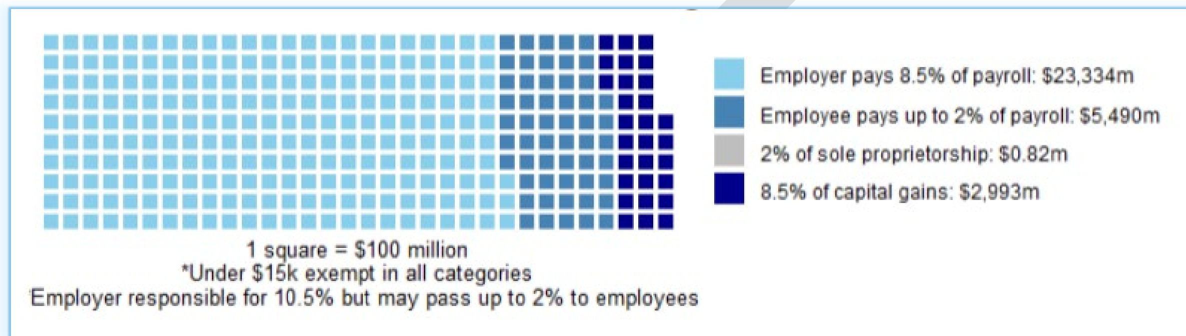
Employees[55]	Up to 2 percent of wages payroll deduction
Self-employed individuals[56]	2 percent of earnings of wages
Investors[57]	8.5 percent of capital gains

This revenue structure assumes that Whole Washington's approach to integrate funding from self-funded employers, the Trust's primary source of revenue, would not be preempted by ERISA and would survive related legal challenges. Figure 3 illustrates the breakdown of the revenue contributions by population and Figure 4 provides examples of employer expenditures under the proposed revenue structure.

Figure 3: Breakdown of SB 5335 funding



[55] Employers would be assessed a payroll contribution and may choose to deduct a portion directly from employee's wages. After an exemption, the maximum amount an employer could deduct is two percent of the employee's gross pay. The employer may choose to pay some or all the payroll contribution as a benefit of employment. The exemption is $15,000 less gross pay multiplied by one quarter of one percent (.25 percent). The exemption would not apply for pay above $60,000. The employee deduction would not apply to employees 65 years or older.

[56] Self-employed individuals would be assessed an annual contribution on their earnings. After an exemption, the self-employment contribution would be two percent of adjusted net earnings. The exemption calculation is $15,000 less the adjusted net earnings multiplied by one quarter of a percent (.25%). The exemption would not apply for net earnings above $60,000.

[57] After an exemption, an 8.5 percent tax contribution would be assessed on net long-term capital gains (LTCG) for LTCG over $15,000. The tax would not apply to residential or home sales, agriculture income, or retirement accounts. The exemption calculation is $15,00 less the LTCG multiplied by one quarter of one percent (.25 percent). The exemption would not apply for any LTCG above $60,000.

Figure 4: 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

Financing SB 5335

Whole Washington projects[58 & 59] that the greatest cost reductions for a new system would be realized by consolidating the existing public-private coverage into a new publicly funded and publicly administered health care system like that described in the Work Group's Model A (state administered).[60 & 61] This is predicated on the idea of a single payer system, whereby self-funded employer health plans, Medicare and Medicaid markets have been consolidated. However, FTAC determined this to be politically and legally infeasible in the near term due to barriers presented by federal regulations.

SB 5335 also describes a period where the Trust, beginning as Model B (state-designed plan privately administered),[61] would progressively transition to Model A over approximately five years. As such, the cost-savings projected under Model A would not be achieved any sooner than five years from the time of the Trust's implementation.

The Work Group's Models A and B are perhaps proxies in principle for the Trust's transitional path from the status quo, through Model B, to Model A. However, the Work Group's projected cost savings for Model A, the Trust's ultimate destination, does not compare with SB 5335's economic analysis of the same model. The Work Group and Whole Washington used different methodologies to project cost savings, however it is unclear whether the differing methodologies are the sole reason for such discrepancies. At the writing of this report, the Commission has not assessed in depth the discrepancies between SB 5335's

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[58] Gerald Friedman, PhD. SB 5335 Economic Analysis. 2021. **https://wholewashington.org/friedman-financial-analysis-2021/**

[59] The Work Group also projected the greatest cost reductions under a publicly financed and publicly administered health care system.

[60] More details on the Work Group's proposed Model A can be found starting on page 23 of the Work Group's 2021 **final report**.

[61] More details on the Work Group's proposed Model B can be found starting on page 32 of the Work Group's 2021 **final report.**

economic analysis and the Work Group's. This can be assessed further in the Commission's continuing work to analyze SB 5335.

FTAC shared with the Commission their concern that Whole Washington's proposed financing model underestimates the cost of their proposal, which may mean a higher tax burden required to finance their vision of universal health care. Whole Washington described their analysis as a starting point and indicated that their future plans account for co-developed analyses. FTAC voiced support for the idea of consensus-based modeling.

Alignment between the Commission and SB 5335

The Commission and SB 5335 align on the desire to design a new health care system with a benefits package that prioritizes prevention, comprehensive coverage, and equitable access to appropriate care. However, FTAC heard expert testimony[62] that it would be all but impossible to attain ERISA and Medicare waivers to achieve a unified financing system, making it more challenging to finance or implement a universal system under Whole Washington's principals.

Given political and legal realities, FTAC submits a more realistic view of the likelihood of receiving waivers from the Federal government for Medicare and ERISA plans, encouraging a more flexible, options-based approach to making fundamental changes to the health care system. To this end, FTAC's recommendations to the Commission offer options to achieve benefits parity in the near term between these programs and what is offered under the universal health care system.

Table 6 below outlines areas of alignment between the Commission's very early benefits and services discussions and SB 5335. Green represents alignment and gray signifies that determining alingment requires further analysis.

Table 6: Benefits and services areas of alignment

	Commission	SB 5335
Goal	A benefits package that prioritizes prevention, comprehensive coverage, and equitable access to appropriate care	
Transition	Not yet discussed	Comprehensive coverage based on the EHB under the ACA (*not* including LTSS) with no cost-sharing.
Long term	Not yet discussed	Comprehensive coverage based on the EHB under the ACA, including LTSS with no cost-sharing.

In addition to designing a benefits package, the finance experts on the Commission's FTAC caution that more work must be done now to address overall health care spending in Washington to make any new

[62] FTAC's **May 2023 meeting** was focused on Medicare options. FTAC's **July** and **September 2023** meetings were focused on ERISA options.

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system financially viable and sustainable.[63] In their benefits discussions and with the findings of the actuarial analysis, the Commission will need to decide on whether cost-sharing will be incorporated in the new system. SB 5335 explicitly opposes this idea, though most Washingtonians would be paying for their health care through a new tax.

SB 5335's economic analysis names health care administration as the greatest source of waste and inefficiency in the existing system. For example, the administrative costs for private insurers account for roughly 17 percent of operating expenditures, compared to only two percent under Medicare fee-for-service (FFS).[64] While it is true that Medicare maintains much lower administrative costs compared to private health carriers, it is important to note the distinction that private health carriers often maintain administrative functions not provided by Medicare FFS. For example, Medicaid Managed Care Organizations (MCOs) can provide case management and care coordination for enrollees.

According to Whole Washington's March presentation to FTAC,[65] estimated savings from price adjustments were actually slightly higher than estimated savings from elimination of administrative expense.[66] FTAC questioned the practicality of eliminating administrative expense to the degree assumed by Whole Washington.[67]

Whole Washington agrees that private health carriers are not the sole contributor to higher health care costs, nor are they the only opposition to universal health care. FTAC asserts that increasing health care expenditures are driven largely by consolidation which drives price increases which drives spending. Since Washington's health care system is highly consolidated,[68] FTAC has stressed that addressing rising health care expenditures should be an immediate focus of the work to design a new system.

Whole Washington's economic analysis relies on various assumptions and the Commission will need to progress in their design of a new universal system and continue to engage with Whole Washington to determine whether the Commission's modeling will share those underlying assumptions. Having broader participation and consensus on a cost analysis will also lend credibility to these ongoing discussions, and the Commission anxiously awaits the findings of their actuarial analysis on benefits across the three payers identified.

[63] FTAC has noted that increasing costs are resultant of price increases driven by consolidation.
[64] Archer, D. Medicare Is More Efficient Than Private Insurance. **Health Affairs**. 2021.
[65] FTAC **March 2024** meeting.
[66] Price adjustments are the primary source of savings in The Work Group's Model A savings estimates.
[67] FTAC acknowledged that administrative costs are an issue. However, FTAC underscored that administrative expense is not the primary reason for the cost of the US healthcare system, but rather prices are the primary driver. FTAC noted that price adjustments would face resistance from hospitals and providers.

[68] Washington State's health care system has seen significant horizontal consolidation and vertical integration across health care providers, facilities, and insurers over the last three decades. Washington Office of the Insurance Commissioner **Preliminary Report on Health Care Affordability**. November 29, 2023.

Conclusion

SB 5335 offers eligibility and enrollment proposals not dissimilar from the Commission's early work, and the Commission will be better able to assess alignment with regards to benefits and services as work on this topic progresses. The Commission will continue to create opportunities to connect with Whole Washington to further assess elements of SB 5335 not captured in this report. The Commission would again like to thank the leaders and members of Whole Washington for their collaboration and important contributions to this report.

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Appendix A: Additional Comments on this Report

Comments offered by Representative Schmick

1. I don't believe that the federal government will allow such a big change to an unproven system.
2. Along with the first point, then I conclude that waivers to move us to this system will not happen.
3. There is an assumption that people with employer sponsored plans, self-funded plans, or ERISA plans will want to participate in a government run health plan.
4. There is an assumption that providers will be willing to accept Medicare reimbursement levels.
5. This proposal puts the government in direct competition with private sectors with the sale of Medicare Part D sponsored by our state government.
6. Without employers mandatory participation, sustainable funding for the new system is less secure and less predictable.
7. There is reference to incentives to entice providers which will be another added cost. Will these incentives be a one-time event or on-going additional cost?
8. There will be additional administrative burdens in complying with payroll tax and deductions for every participating employer.
9. Will companies view universal government run healthcare as a reason to locate in Washington or a reason to locate elsewhere? Since self-employed individuals are included in this proposal, I again wonder if they will want to locate here?
10. It has been the policy of the federal government to lessen the federal government's financial obligation to the states. If the Medicaid reimbursement levels move to Medicare levels, this will obligate the federal government to increased expenditures which is not congruent with current policy.
11. With allowing groups of providers to negotiate rates, I am concerned again about claimed savings of a universal system. I see no cost containment strategies being considered.

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Tab 7

Commission Progress and Workplan Update

3 Workstreams: Key Milestones/Activities

Design a universal health care system with a unified financing system

- Inaugural Report: Landscape and Path Forward
- Launch FTAC

- Eligibility
  - Medicaid, Individual, Small Group, Fully-Insured Large Group (includes PEBB/SEBB)
  - **No pathway at this time** for self-funded plans and Medicare

- Determine potential costs based on:
  - Benefits and services
  - Cost containment
  - Provider reimbursement

Recommend interim solutions that address issues people face now and contribute to the universal system

- Expanded coverage for uncovered populations
- Integrated eligibility systems
- Cascade Care Savings
- Cost Growth Targets
- Align public programs

- ***Under Consideration***
  - Administrative Simplification
  - Maximizing coverage in existing programs

2023 Request

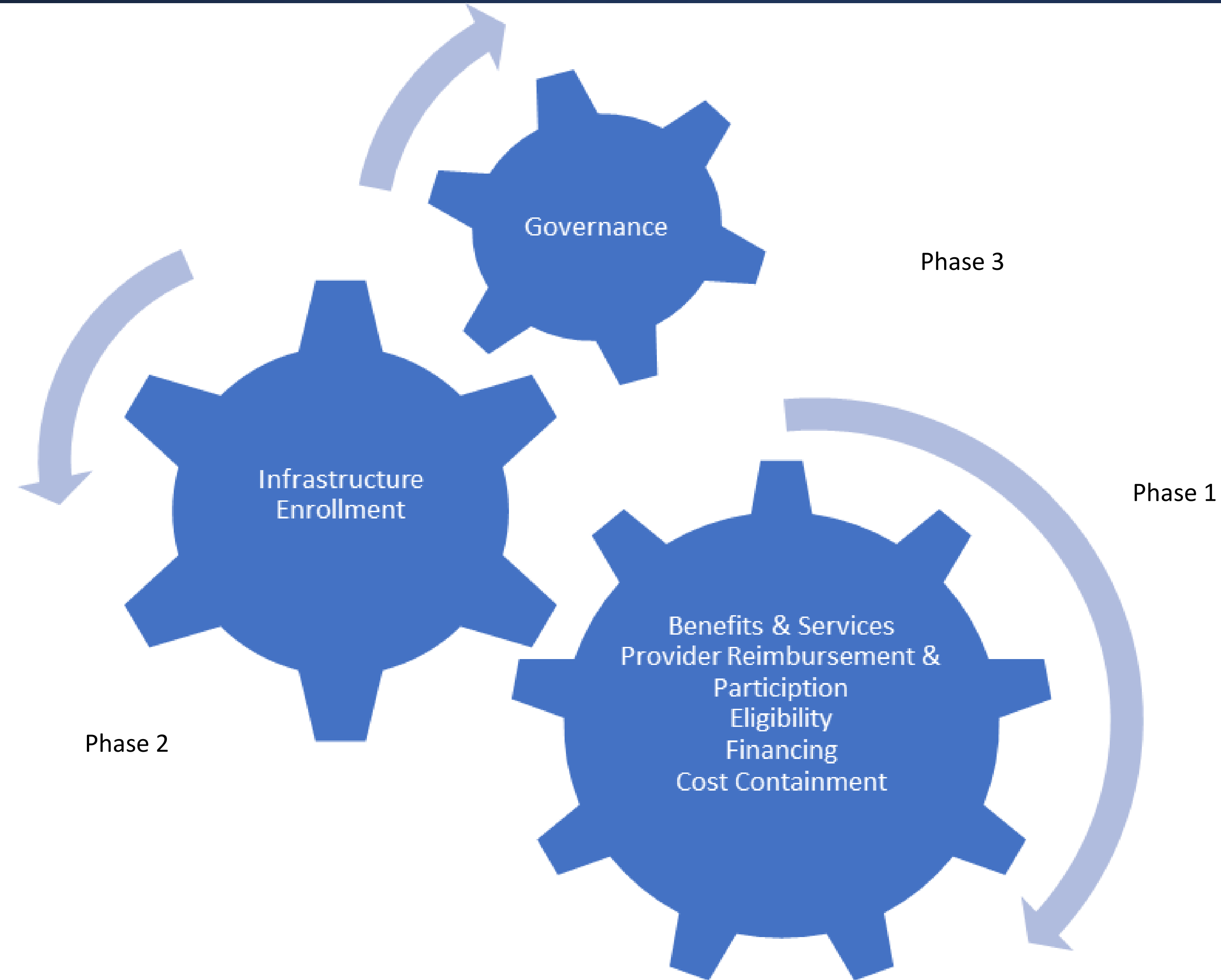
Review the Washington Health Trust proposal

- Overview of proposal

- Benefits and services, cost assumptions

2022 | **2023** | **2024**

Workstream 1: Universal System Design



Workstream 1: Universal System Design

Eligibility

Benefits & Services

Provider Reimbursement & Participation

Cost Containment

Cost Estimates

Financing

Workstream 1: Decisions made or in process by the Commission for Universal Health Care System with Unified Financing

- ✓ **Determined eligibility in order to establish foundation for other Phase 1 decision points**

- ✓ **For now,** the universal health care system with a uniform financing system should be designed to include those enrolled in:
  - ✓ Medicaid
  - ✓ Individual Market plans
  - ✓ Small Group Market plans
  - ✓ Fully Insured large group plans (including PEBB/SEBB)
  - ✓ The uninsured

- ✓ **Self-Funded Plans**
  - ✓ Will explore the possibility that self-insured employers could offer their employees the option to enroll in the system
  - ✓ Will explore the possibility that self-insured employers would be required to offer coverage equivalent to what the system provides or pay a tax to help fund the system

- ✓ **Medicare**
  - ✓ Will consider options to achieve coverage parity for Medicare enrollees

Workstream 1: Decisions made or in process by the Commission for Universal Health Care System with Unified Financing

- ✓Given direction to FTAC to provide guidance to develop an actuarial analysis that provides a rough estimate of the cost to provide benefits and services in:
    - ✓PEBB/SEBB Uniform Medical Plan
    - ✓Essential Health Benefits
    - ✓Cascade Care Plan
    - ✓Medicaid dental, vision
- ✓Given direction to FTAC to provide guidance on the actuarial analysis that shows the cost of eliminating or minimizing enrollees’ out of pocket costs

Workstream 2: Interim or Transitional Solutions

Recommendations to Date

- ✓ Expanded coverage for uncovered populations
- ✓ Integrated eligibility systems
- ✓ Cascade Care Savings
- ✓ Cost Growth Targets
- ✓ Align public programs

2024 Areas Being Considered

- ❑ Administrative Simplification
- ❑ Maximizing coverage in existing programs
  - ❑ Auto-enroll Medicaid to no-premium or lower-cost plans Exchange
  - ❑ Codify and fully fund Apple Health expansion
  - ❑ Increase participation in the Medicare Savings Program
  - ❑ Consolidate and expand purchasing

Workstream 3: Review the Washington Health Trust Bill (SB 5335)

- ✓ Presentations to:
  - ✓ Commission on the overall proposal
  - ✓ FTAC on benefits and services and cost savings assumptions
- ✓ Draft Report

- ❑ Continue presentations and dialogue about WHT Bill as design continues

Tab 8

Workstream 2: Transitional/Interim Administrative Simplification

Administrative Simplification

February

National experts about potential savings associated with administrative simplification efforts in the health care system and five functional areas of focus

HCA's Medical Director about efforts to promote administrative simplification

April

OneHealthPort and efforts to support administrative simplification in Washington

Today's Focus

Provider perspectives

Begin to focus on developing recommendations

DOCUMENT INTENDED TO PROVIDE INSIGHT BASED ON CURRENTLY AVAILABLE INFORMATION FOR CONSIDERATION AND NOT SPECIFIC ADVICE

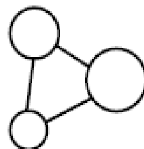
Cost drivers were regrouped into 5 functional focus areas that represent majority of administrative spending…

xx% Percentage of total administrative spending

21%

Financial transactions ecosystem

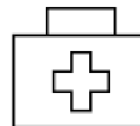
The movement of all payments, claims, and billing throughout the healthcare ecosystem (e.g., payers, hospitals, physician groups, and customers)



11%

Administrative clinical support functions

Activities that have a clinical component to them (e.g., nursing admin, case management), which can be patient facing and require some clinical expertise, but are not related to the hands-on care of patients



9%

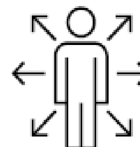
Customer and patient services

The set of activities and processes that provide services to customers, typically done via call centers and increasingly moving towards digital and self-serve functions

14%

Industry-specific operational functions

Back-office, non-clinical functions that are mostly industry-specific (e.g., underwriting, enrollment)



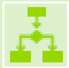
39%

Industry-agnostic corporate functions

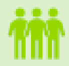
Back-office, non-clinical functions that are mostly industry-agnostic (e.g., finance, HR)

Source: Sahni NR, Mishra P, Carrus B, Cutler DM. Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare. McKinsey & Company. October 20, 2021

HCA Initiatives in Administrative Burden Reduction



Alignment and oversight across a number of programs and contracts



Leading development of the **Washington State Action Plan for Removing Barriers to Health and Human Services**

Staff the **Performance Measures Coordinating Committee**

Multi-payer collaborative for **Primary Care Transformation**

Interoperability rules implementation with focus on **Prior Authorization**

Participant in the **Administrative Simplification program** led by OneHealthPort under oversight of OIC

Local Opportunities

Expert stakeholder review

Use Subject Matter Expert workgroup to prospectively review legislation and/or policy recommendations that impact health services administration

Pre-service

Pre-authorization is only one of many checks providers need to make prior to service in order to be assured of claims payment- move beyond traditional methods

Consumer engagement

Putting "patients in the center" and "meeting people where they are" are widely held aspirational goals – also state and federal laws require "simplified" consumer access to their health information

Performance measurement

WA State has a Performance Measurement Coordinating Committee and local expert organizations. How can we become more innovative using what's in place.

SDOH/enhanced demographics

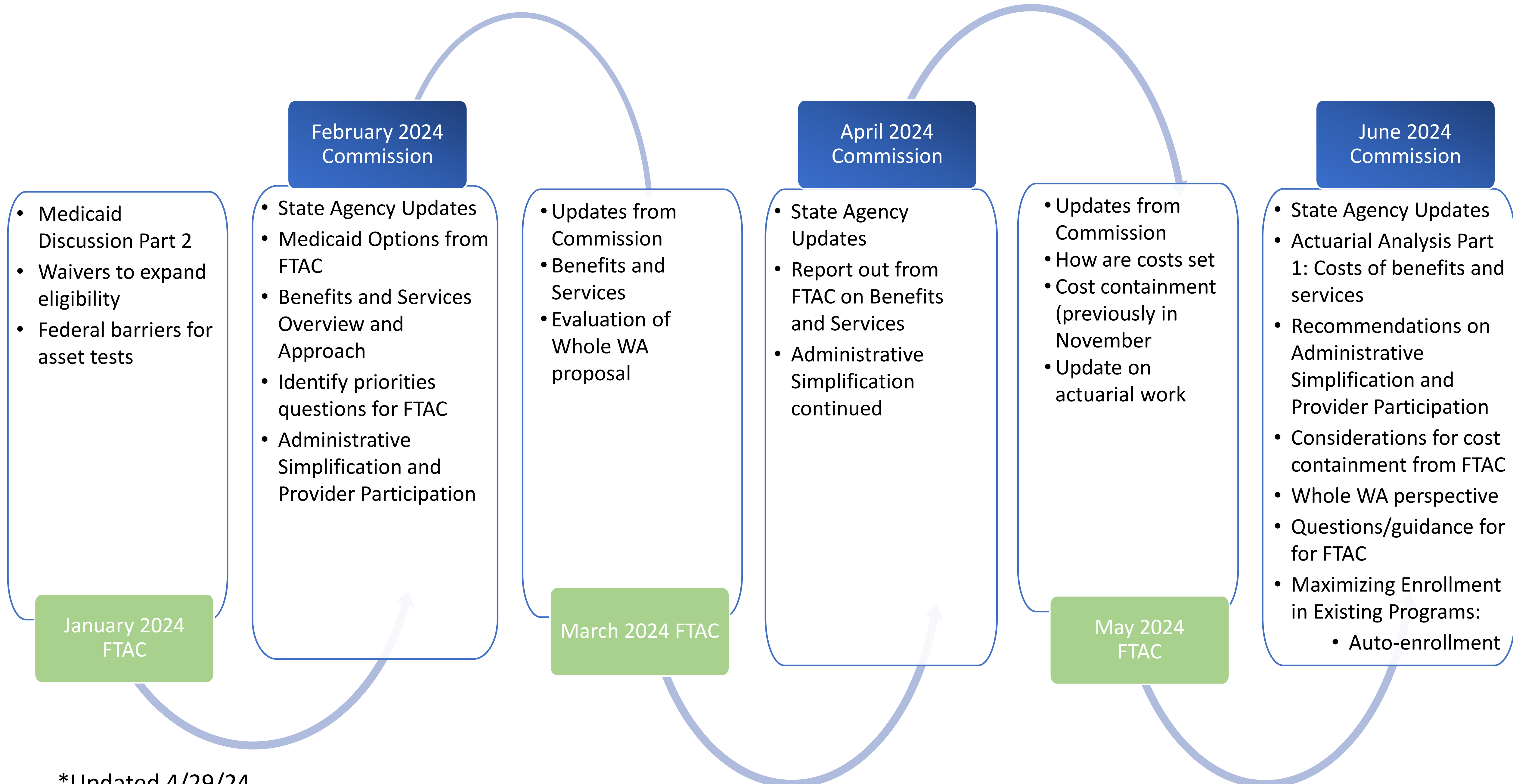
Broad agreement that improving health means addressing determinants of health and inequities – this will require measurement

How can we adopt best practices from the get-go and avoid building silos and deploying incompatible proprietary approaches as we enter this new space?

Behavioral health

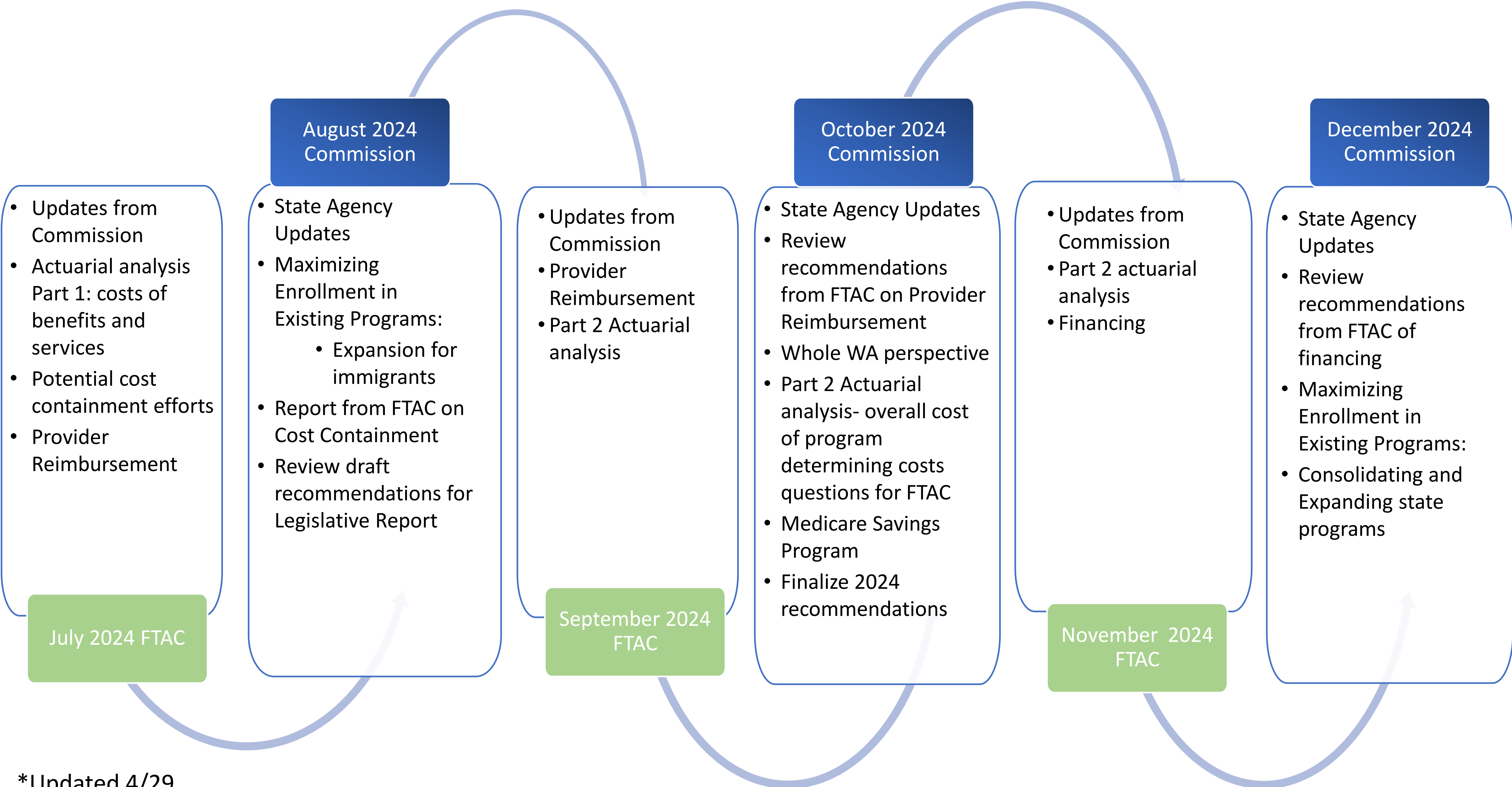
How can we enhance and accelerate clinical integration by better blending the administrative elements of physical and behavioral health?

2024 Universal Health Care Commission Workplan



*Updated 4/29/24

2024 Universal Health Care Commission Draft Workplan



*Updated 4/29

Tab 9

Panel on Administrative Simplification

Panel Members Include:

- Diana Huang, Family Medicine
- Jeb Shepard, Washington State Medical Association
- Samuel Wilcoxson, Premera
- Steve Woolworth, Evergreen Treatment Services

Tab 10

Washington State
Health Care Authority

Next Steps for Administrative Simplification

- What areas of administrative simplification or ideas for administrative simplification would you like to dive deeper into?

- What do you need for that exploration?

Thank you for attending the Universal Health Care Commission meeting!