

# Universal Health Care Commission

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## Washington Health Trust (SB 5335) analysis report

June 2024

# Washington Health Trust analysis report

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## Acknowledgements

The Universal Health Care Commission (Commission) thanks 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 health care a reality.

The Commission, with support from the Health Care Authority (HCA), is submitting this report in response to the Legislature's request for an assessment to determine:

- If the Washington Trust Fund proposal aligns with the goals and planned activities of the Commission.
- 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. The Commission will include this information in their future annual reports, beginning in 2025, until the analysis is complete.

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## Executive summary

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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 (Senate Bill (SB) 5335) proposal as introduced in the 2023 legislative session, and if the Commission considers it within their mission and a viable proposal. SB 5335 proposes the creation of the Washington Health Trust within the Department of Health (DOH) 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. 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 examined areas of alignment between their work to date and SB 5335. Whole Washington accepted invitations to present to the Commission and their Financial Technical Advisory Committee (FTAC) across several meetings.<sup>1, 2, & 3</sup> 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 and services

Due to timing and capacity, the Commission has not analyzed the Washington Health Trust's administrative and operational aspects. To ensure a substantive analysis of the proposal, the Commission will analyze the Washington Health Trust's administrative and operation design when the Commission begins the research and planning phase. This will include administrative and operational design as a part of the Commission's workplan for the design of a universal health care system.

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 on the development process.

## How to read this report

This report aims to identify areas of alignment between the Commission and SB 5335 on a 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 Commission'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.
- Gray signifies that determining alignment needs further analysis and is not possible currently.

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<sup>1</sup> Commission's [August 2023 meeting recording](#).

<sup>2</sup> Commission's [December 2023 meeting recording](#).

<sup>3</sup> Finance Technical Advisory Committee [March 2024 meeting recording](#).

## Background

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### 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 future system design—the Commission has focused its work in 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

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, benefits, and services. Interim strategies and other design elements will be included in future Commission annual reports to the Legislature, beginning in 2025.

## Eligibility & enrollment

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### 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.<sup>4</sup>

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 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 identified potential pathways for enrollees of these programs—particularly Medicare<sup>5</sup> 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 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.<sup>6</sup>

### Commission

The Commission consulted with FTAC<sup>7</sup> 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<sup>8</sup> were evaluated, along with the pros and cons of each.

Of the six options, establishing a system to directly reimburse Medicare enrollees for cost-sharing and services covered by the universal system (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.

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<sup>4</sup> 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.

<sup>5</sup> This is especially true of Medicare because it is unlikely that Congress would turn the program over to states and the budgetary burden it would place on states.

<sup>6</sup> [Monthly enrollment by state. Washington. March 2023. CMS.](#)

<sup>7</sup> [FTAC roster.](#)

<sup>8</sup> 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.

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<sup>9</sup> and B<sup>10</sup>. This option could also invite gaming from MA plans and may be administratively burdensome for the state and consumers. Finally, this option does not allow the state to leverage federal Medicare dollars.

A waiver<sup>11</sup> is the ideal approach to 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 & Medicaid Services (CMS) is unlikely to grant a waiver to a new and untested program, even if determined that it has the authority to do so.<sup>12</sup>

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.

## SB 5335

Under this legislation, Medicare enrollees would be eligible to enroll in health care coverage under the Washington Health Trust.<sup>13</sup> 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 5335 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.<sup>14</sup>

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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 to 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.<sup>16</sup>

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

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<sup>9</sup> Inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.

<sup>10</sup> Preventative services, outpatient care, certain doctors' services, and medical supplies.

<sup>11</sup> 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.

<sup>12</sup> 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."

<sup>13</sup> Proposed enrollment and eligibility components of SB 5335 are outlined in Sec. 111.

<sup>14</sup> 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.

<sup>15</sup> 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.

<sup>16</sup> The Commission is scheduled to begin discussions on provider reimbursement in 2024, pending progress made on other scheduled design elements throughout the year.

plans and that these plans are portable outside of the state of Washington.<sup>17</sup> 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.

## Alignment between the Commission & SB 5335 for Medicare enrollees

The Commission and SB 5335 are aligned in the goal of providing access to coverage and care for Medicare-eligible Washingtonians under a state-based universal health care system. However, how this goal is achieved in the interim may differ, at least in the Commission's preliminary eligibility 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 when 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 align on the long-term goal to secure a waiver to integrate federal Medicare dollars. Additionally, SB 5335 gives discretion to 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.<sup>18</sup>

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 alignment requires further analysis.

**Table 1: Medicare eligibility areas of alignment**

	Commission	SB 5335
<b>Goal</b>	Medicare enrollees are eligible for coverage and care under Washington's universal health care system <sup>19</sup> and federal Medicare funds can be accessed to support a unified financing system.	
<b>Transition<sup>20</sup></b>	Directly reimburse Medicare enrollees for cost-sharing and services covered by the universal system but not Medicare. <sup>21</sup> 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 MA-PD plan that would compete with other private MA plans and traditional Medicare.
<b>Long term</b>	A federal waiver is the ideal approach to 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 successful, the federal government may require the program to be tested and operational before considering granting a waiver.	

<sup>17</sup> Portability of health care plans across states may be very attractive to some Medicare enrollees who would not select a state-based health plan.

<sup>18</sup> Directives to HCA are outlined in SB 5335 under Sec. 113.

<sup>19</sup> 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.

<sup>20</sup> 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.

<sup>21</sup> More details will be developed once benefits and services and other design components are determined.



# 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<sup>22</sup> 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.<sup>23</sup>

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 considering 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.

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 are needed to explore 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 that 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, needs 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.

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<sup>22</sup> 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 (TPAs)). The ERISA statute exempts these plans from most state regulations.

<sup>23</sup> The Commission's full eligibility assessment for individuals receiving health care coverage through self-funded employer plans is available in Appendix B.

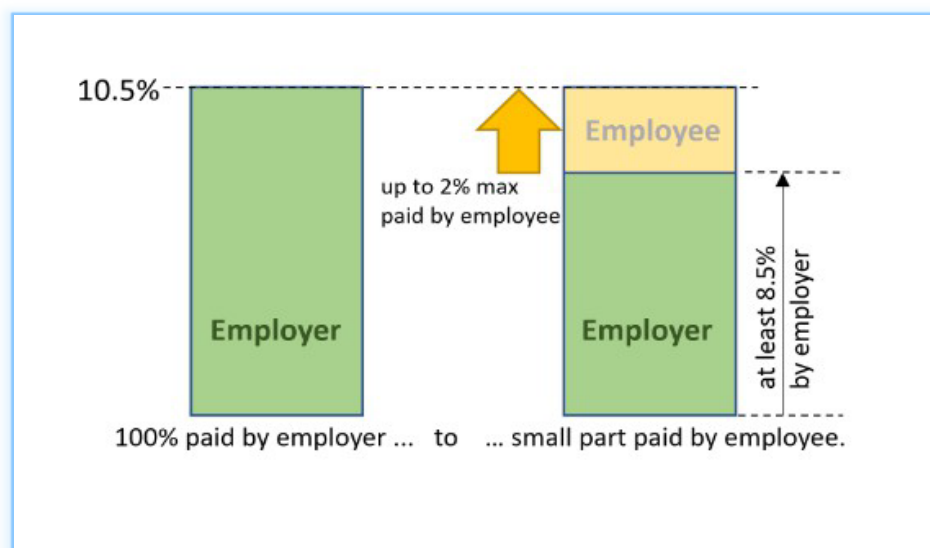
Finally, large employers are likely to fiercely defend ERISA, and their perspectives on state-based universal health care and buy-in will need to be carefully considered. Continuing to engage large employers will also be important to identifying opportunities to make a universal system more appealing 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

This legislation 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 Francisco,<sup>24</sup> 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 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 the figure<sup>25</sup> below.

**Figure 1: Employer/employee contribution**



<sup>24</sup> *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 health care 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. [View the timeline of key events in the case.](#)

<sup>25</sup> Figure provided by Whole Washington.

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,<sup>26</sup> in coordination with HCA, would collectively negotiate reimbursement rates with qualified providers<sup>27</sup> on an FFS basis.<sup>28</sup>

## Alignment between the Commission & SB 5335 for self-funded employers

The Commission and SB 5335 are aligned with the goal of providing access to coverage and care for Washingtonians who currently receive health care coverage through their employer. The Commission and SB 5335 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, mitigation strategies for inevitable legal challenges, health 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 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 alignment requires further analysis.

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<sup>26</sup> As defined in Sec. 102.

<sup>27</sup> Not including providers participating as community health providers as defined in Sec. 102.

<sup>28</sup> Sec. 109 directs that provider rates are at the discretion of the Washington Health Trust Board, HCA, and HCA’s established mechanisms that allow qualified providers to collectively negotiate budgets, payment schedules, and other terms and conditions of Trust participation.

**Table 2: Employer eligibility areas of alignment**

Commission		SB 5335
<b>Goal</b>	Integrate employees and employers into Washington’s universal health care system and generate revenue from employers to support a unified financing system.	
<b>Transition /long-term</b>  (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 allow them to receive coverage under the Trust.
<b>Transition /long-term</b>  (assuming no changes in federal ERISA law)	Offering employers a meaningful alternative to their existing employee coverage has been successful in other cities/states and may, alongside other policy levers, endure an ERISA challenge.	Modeled after San Francisco’s experience, the Trust aims to offer employers a meaningful alternative to their existing employee coverage.
<b>Transition /long-term</b>  (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 Francisco, the Trust creates a per-employee-required health expenditure to generate revenue to support the Trust.
<b>Transition /long-term</b>  (assuming no changes in federal ERISA law)	Provider regulation/incentives are 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.

## Apple Health (Medicaid)

Medicaid plays a significant role in Washington’s health care system. Because of 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<sup>29</sup>

Medicaid is jointly financed by states and the federal government. CMS provides the rules and oversight in which states must comply in administering the program to obtain federal matching dollars through the Federal Medical Assistance Percentage (FMAP).<sup>30, 31, & 32</sup>

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 that states must provide and 28 optional services they can elect to cover.<sup>33</sup> Apple Health, Washington's Medicaid program, provides all mandatory and optional benefits, depending upon the specific eligibility category.<sup>34</sup>

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 family's monthly or quarterly income.<sup>35</sup> Apple Health does not have any premium or point-of-service cost-sharing requirements.<sup>36</sup>

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 Medicaid 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 Medicaid 1115 waivers include if federal law prevents:

- A needed service or benefit<sup>37</sup>
- A desired population from being covered<sup>38</sup>
- Certain program administration elements<sup>39</sup>

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<sup>29</sup> See Appendix C for the Commission's eligibility assessment of Medicaid.

<sup>30</sup> 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.

<sup>31</sup> 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 FPL; certain parents or caretakers with very low income; people who are pregnant and have income below 138 percent FPL; and seniors and people with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program.

<sup>32</sup> 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 FPL; medically needy people and other people with higher income who need long-term services and supports, and 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 qualify for Categorically Needy Medicaid programs due to income.

<sup>33</sup> All mandatory benefits must be provided to mandatory populations. Optional benefits may be provided to some, but not all, optional populations.

<sup>34</sup> 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 included 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).

<sup>35</sup> 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.

<sup>36</sup> 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.

<sup>37</sup> Medicaid cannot pay for institutions for mental disease (IMDs) or inpatient mental health services at a designated facility for patients aged 21-64 or substance-use disorder (SUD) treatment. This may require an inpatient stay, and states have used 1115 waivers to allow IMD services for SUD and mental health services.

<sup>38</sup> 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.

<sup>39</sup> 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.

Section 1115 waivers are approved “at the discretion of the Department of Health and Human Services (DHHS) Secretary,” be budget-neutral to the federal government, and must further the objectives of the Medicaid program.<sup>40</sup> 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,<sup>41</sup> 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 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 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 to ask 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 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 like 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.

## SB 5335

The goal is to provide equitable coverage through the proposed Trust for everyone, 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:

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<sup>40</sup> [Section 1115 research and demonstration waivers. Medicaid and CHIP Payment and Access Commission.](#)

<sup>41</sup> Individuals and families can purchase health care on the individual market, available through Washington Healthplanfinder and from the Health Benefit Exchange (Exchange).

“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 and 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.<sup>42</sup>

## Alignment between the Commission & SB 5335 for Medicaid

The Commission 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 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 alignment requires further analysis.

**Table 3: Medicaid eligibility areas of alignment**

	Commission	SB 5335
<b>Goal</b>	Integrate Medicaid funding to support Washington’s unified financing system.	
<b>Transition</b>	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.
<b>Long term</b>	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.
<b>Long term</b>	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. <sup>43</sup>	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.

<sup>42</sup> Sec. 109 of SB 5335 directs that the Washington Health Trust Board of Trustees, 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 an FFS basis.

<sup>43</sup> Some providers, e.g., rural hospitals, receive Medicaid reimbursement at rates like Medicare or commercial plans due to supplemental payments.

# Enrollment infrastructure

## Commission & 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 that could be expanded to facilitate enrollment for the future system.

## Alignment between the Commission & SB 5335

Currently, enrollment for both Apple Health (HCA's domain) and Qualified Health Plans, or QHPs (Exchange's domain), is administered through a shared eligibility and enrollment system operated by the Exchange through [Washingtonhealthplanfinder.com](http://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 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.	
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 facilitate enrollment for the universal health care system.	



## Benefits & services

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### 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.<sup>44</sup>

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<sup>45</sup> could receive such benefits as supplemental coverage through Medicaid. Additionally, benefits offered under private coverage can vary. For instance, for coverage offered on the 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 already exists in this space. The Universal Health Care Work Group,<sup>46</sup> predecessor to the Commission, recommended that the ACA-mandated categories of services defined in the 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,<sup>47</sup> such as LTSS, would be provided.<sup>48</sup>

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.

The Commission sought to compare covered benefits under some of the richer benefits packages under Medicaid and the Public Employees Benefits and School Employees Benefits Boards' (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. 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 the EHB and layer on additional benefits to be modeled.

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<sup>44</sup> 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.

<sup>45</sup> Lower income Medicare enrollees may qualify for supplemental coverage and benefits through Medicaid.

<sup>46</sup> [Work Group Final Report. 2021.](#)

<sup>47</sup> The covered benefits under the EHB will be detailed in the section describing SB 5335's proposed benefits and services.

<sup>48</sup> All plans sold on the state and federal marketplaces must provide EHBs and 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.

- Cascade Care (standard qualified health plans on the Exchange)<sup>49</sup> 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, 2024, 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.”<sup>50 & 51</sup> Language from SB 5335 describing Whole Washington’s vision for coverage under the Trust also states:

**“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 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 SUD 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<sup>52</sup>
- Short-term rehabilitative and habilitative services and devices

<sup>49</sup> In 2019, [Senate Bill 5526](#) established standardized plans and the public option on the Exchange.

<sup>50</sup> [World Health Organization’s](#) definition of universal health coverage.

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

<sup>52</sup> Oral health, audiology, and vision services are not required service categories under the ACA.

- 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 & 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.<sup>53</sup> 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	
<b>Employers<sup>54</sup></b>	10.5 percent of wages
<b>Employees<sup>55</sup></b>	Up to 2 percent of wages payroll deduction
<b>Self-employed individuals<sup>56</sup></b>	2 percent of earnings of wages
<b>Investors<sup>57</sup></b>	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.

<sup>53</sup> [The Capital gains tax was ruled by the 2023 Washington State Supreme Court as constitutional exempting the first \\$250,000.](#)

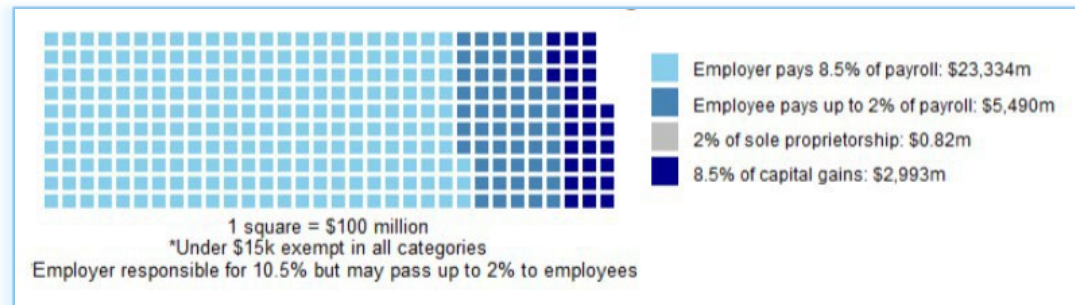
<sup>54</sup> Employers would be assessed a payroll contribution and may choose to deduct a portion directly from employee’s wages. After an exemption, the maximum amount an employer could deduct is two percent of the employee’s gross pay. The employer may choose to pay some or all the payroll contribution 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.

<sup>55</sup> 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.

<sup>56</sup> 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.

<sup>57</sup> 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 \$15,000 less the LTCG multiplied by one quarter of one percent (.25 percent). The exemption would not apply for any LTCG above \$60,000.

**Figure 2: Breakdown of SB 5335 funding**



**Figure 3: 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
<b>\$60,000*</b>	<b>50th</b>	<b>\$425.00 - \$525.00</b>	<b>\$0 - \$100</b>	<b>\$525.00</b>
\$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<sup>58 & 59</sup> 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).<sup>60 & 61</sup> 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),<sup>62</sup> would progressively transition to Model A over approximately five years. 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

<sup>58</sup> Gerald Friedman, PhD. *SB 5335 Economic Analysis*. 2021.

<sup>59</sup> The Work Group also projected the greatest cost reductions under a publicly financed and publicly administered health care system.

<sup>60</sup> More details on the Work Group's proposed Model A is available on page 23 of the [Work Group's 2021 final report](#).

<sup>61</sup> More details on the Work Group's proposed Model B is available on page 32 of the [Work Group's 2021 final report](#).

<sup>62</sup> FTAC's [May 2023 meeting](#) focused on Medicare options. FTAC's [July](#) and [September](#) 2023 meetings were focused on ERISA options.

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 and the Work Group's economic analysis. This will 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 & 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<sup>61</sup> 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 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 alignment requires further analysis.

**Table 6: Benefits and services areas of alignment**

Commission		SB 5335
<b>Goal</b>	A benefits package that prioritizes prevention, comprehensive coverage, and equitable access to appropriate care.	
<b>Transition</b>	Not yet discussed	Comprehensive coverage based on the EHB under the ACA (not including LTSS) with no cost-sharing.
<b>Long term</b>	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 Commission's FTAC caution that more work must be done now to address overall health care spending in Washington to make any new system financially viable and sustainable.<sup>63</sup> 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

<sup>63</sup> FTAC has noted that increasing costs are resultant of price increases driven by consolidation.

of operating expenditures, compared to only two percent under Medicare FFS.<sup>64</sup> 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 MCOs can provide case management and care coordination for enrollees.

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

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 and spending. Since Washington's health care system is highly consolidated,<sup>68</sup> 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.

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<sup>64</sup> Archer, D. Medicare Is More Efficient Than Private Insurance. [Health Affairs](#). 2021.

<sup>65</sup> [FTAC March 2024 meeting](#).

<sup>66</sup> Price adjustments are the primary source of savings in the Work Group's Model A savings estimates.

<sup>67</sup> FTAC acknowledged that administrative costs are an issue. However, FTAC underscored that administrative expense is not the primary reason for the cost of the U.S. healthcare system, but rather prices are the primary driver. FTAC noted that price adjustments would face resistance from hospitals and providers.

<sup>68</sup> 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. Read the Washington Office of the Insurance Commissioner [Preliminary Report on Health Care Affordability](#), published November 29, 2023.

## Conclusion

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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 again thanks the leaders and members of Whole Washington for their collaboration and important contributions to this report.

## Appendix A: Additional comments on this report

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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 [*sic*] 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 [*sic*] 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.



## Appendix B: Senate request for analysis

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The next page contains the request from the Washington State Senate for the Commission to analyze the proposal to create a Washington Health Trust fund in SB 5335.



Legislative Building  
Olympia, WA 98504-0482

## Washington State Senate

Phone: (360) 786-7550  
FAX: (360) 786-1999

March 2, 2023

Vicki Lowe, Commission Chair  
Washington State Universal Health Care Commission  
Washington State Health Care Authority  
626 8th Avenue SE  
Olympia, WA 98501

Dear Commissioner Lowe,

Thank you for your leadership in advancing the work of the Washington State Universal Health Care Commission (Commission). We are writing to request that the Commission perform an analysis of the proposal to create a Washington Health Trust. The proposal is contained within SB 5335 (2023), sponsored by Senator Hasegawa, and is included in this communication.

We are interested in an assessment of whether the proposal aligns with the goals and planned activities of the Commission, and whether and how the Commission might recommend implementing the proposal contained within SB 5335 if you consider it within your mission and a viable proposal. We request that findings from this analysis be shared in a report by June 30, 2024. In particular, please identify any opportunities for proponents of the Washington Health Trust proposal to substantively engage with the Commission in the future.

The proponent for this proposal is Whole Washington (contact: Andre Stackhouse – captainstack@gmail.com). We request that the Commission collaborates with the leaders of Whole Washington throughout the analysis process and report preparation.

Thank you for your consideration of this request and we look forward to receiving your report. Please contact either of our offices if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Annette Cleveland".

Senator Annette Cleveland  
Chair, Senate Health and Long-Term Care  
Committee  
49<sup>th</sup> Legislative District

A handwritten signature in black ink that reads "Bob Hasegawa".

Senator Bob Hasegawa  
Majority Caucus Chair, Senate Democratic  
Caucus  
11<sup>th</sup> Legislative District

Cc:

Senator Emily Randall Senator, Washington State Senate Democratic Caucus  
Senator Ann Rivers, Washington State Senate Republican Caucus  
Representative Marcus Riccelli, Washington State House Democratic Caucus  
Representative Joe Schmick Representative, Washington State House Republican Caucus  
Bidisha Mandal, Washington State University  
David Iseminger, Washington State Health Care Authority  
Estell Williams, University of Washington School of Medicine  
Jane Beyer, Washington State Office of the Insurance Commissioner  
Joan Altman, Washington Health Benefit Exchange  
Karen A. Johnson, Washington State Office of Equity  
Kristin Peterson, Washington State Department of Health  
Mohamed Shidane, Somali Health Board  
Nicole Gomez, Alliance for Healthier Washington  
Stella Vasquez, Yakima Valley Farm Workers Clinic  
Sue Birch, Washington State Health Care Authority  
Mich'I Needham, Washington State Health Care Authority  
Evan Klein, Washington State Health Care Authority  
Shawn O'Neill, Washington Health Care Authority  
Mandy Weeks-Green, Washington Health Care Authority  
Thea Byrd, Washington State Senate Democratic Caucus  
Andre Stackhouse, Whole Washington  
Ronnie Shure, Health Care for All- Washington

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