

Universal Health Care Commission

July 13, 2022

Universal Health Care Commission Meeting Materials

July 13, 2022
3:00 p.m. – 5:00 p.m.

(Zoom Attendance Only)

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Agenda

Tab 1

Universal Health Care Commission

July 13, 2022
3:00 p.m. – 5:00 p.m.
Zoom Meeting

AGENDA

Commission Members:

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

Time	Agenda Items	Tab	Lead
3:00-3:05 (5 min)	Welcome and call to order	1	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
3:05-3:15 (10 min)	Roll call	1	Mandy Weeks-Green, Manager Health Care Authority
3:15-3:20 (5 min)	Approval of Meeting Summary from 6/16/2022	2	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
3:20-3:35 (15 min)	Public comment	3	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
3:35-5:00 (85 min)	Report to the Legislature draft sections 2 and 6, including Finance Technical Advisory Committee (FTAC), with Commission member feedback and discussion <ul style="list-style-type: none"> For reference, updated section 2 can be found under Tab 5 For reference, section 6 can be found under Tab 6 For reference, FTAC materials can be found under Tab 7 	4-7	Liz Arjun, Senior Consultant, Gary Cohen, Principal, and Jon Kromm, Principal Health Management Associates
5:00	Adjournment <ul style="list-style-type: none"> For reference, updated section 4 can be found under Tab 8 	8	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State

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

Meeting summary

Tab 2

Universal Health Care Commission Meeting Summary

June 16, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
3:00 p.m. – 5:00 p.m.

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

Members present

Vicki Lowe, chair
Dave Iseminger
Estell Williams
Jane Beyer
Joan Altman
Representative Joe Schmick
Karen Johnson
Representative Marcus Riccelli
Nicole Gomez

Members absent

Senator Ann Rivers
Bidisha Mandal
Senator Emily Randall
Kristin Peterson
Mohamed Shindane
Stella Vasquez

Call to order

Vicki Lowe, Commission Chair, called the meeting to order at 3:02 p.m.

Agenda items

Welcoming remarks


Chair Vicki Lowe welcomed the members of the Commission to the fifth meeting. Vicki Lowe provided an overview of the agenda and shared the goals of the meeting. Members shared what brings them joy in their work during roll call.

Virtual Meetings Update

Commission Members voted unanimously to continue to hold virtual-only meetings.

Meeting Summary review from the previous meeting

Universal Health Care Commission meeting summary
DRAFT
06/16/2022



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

Public Comment

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

Roger Collier remarked that a universal health care system in Washington is not yet feasible due to several legal barriers, and suggested that the Commission has a unique opportunity to propose changes to state laws and regulations that could reduce health care costs and improve access for Washingtonians. (Verbal)

Cris Currie remarked that it is not the goal of this Commission to determine the subjective feasibility of this project. Cris Currie also shared three major types of mechanisms for transitioning employer self-funded plans to a state-based single-payer system in a [Pennsylvania Law Review article](#) from 2020. (Verbal)

Maureen Brinck-Lund shared that it is part of the Commission's charge to create immediate and impactful changes to the current health care system and suggested that the Commission consider bringing new legislation to the 2023 legislative session, especially given the start of a new biennium in 2023. (Verbal)

Deana Knutsen stressed the importance of looking beyond the flaws of the current system and to be innovative in the vision for universal health care. Deana Knutsen suggested that all Commission Members must be heard because they represent various groups and communities in Washington. (Verbal)

Marcia Stedman shared concern of a seeming lack of urgency given that the Commission's report is due to the Legislature this year. Marcia Stedman shared concern regarding the color coding in the draft report illustrating the feasibility of some reforms but is encouraged by the Commission's expertise and experience in this field. (Verbal)


Kathryn Lewandowsky voiced support of the Commission's mission to create a comprehensive financing plan for universal health care in Washington, as well as support for Model A as proposed by the Universal Health Care Work Group. (Verbal)

Nathan Rodke remarked that the US is the only country to leverage excessive health care costs onto patients. Nathan Rodke shared strong support for Model A, but suggested that the Washington Legislature may not be ready for Model A. (Verbal)

David Loud shared interest in Roger Collier's (member of the public) proposal for interim steps to reducing costs and improving access, and suggested Commission Members have time at each meeting to discuss the mission and vision for universal health care. (Verbal)

Kathleen Randall suggested that if including Medicare beneficiaries in the universal health care system is not feasible initially, that it may be possible for universal coverage to become a Medicare supplement. Kathleen Randall voiced support of the Commission developing a pathway for Washington to become part of a Medicare for All Plan (federal) if/when the plan is developed. (Verbal)

Commission Member, Joan Altman, remarked on the benefit of benefit standardization in the Exchange. (Written)



Kathleen Randall shared support for one benefits package and suggested that patients could be registered into the State plan via a simple registration system as they seek care. With no levels of coverage, there is no option for discrimination. (Written)

Aruna Bhuta remarked on healthcare providers not accepting Medicaid rates which can limit access to care or cause delays. (Written)

Kathleen Randall remarked that providers should be paid for all care they prescribe, with perhaps the exception of care that is not a medical necessity. (Written)

Nathan Rodke shared agreement with Chair Vicki regarding cost-sharing. (Written)

Commission Member, Jane Beyer, shared a Kaiser Health News article regarding Americans' medical debt. <https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/> (Written)

Kathleen Randall suggested that it may be appropriate to refer individuals seeking care inappropriately to behavioral health care for anxiety disorders, not to be ignored as nuisance patients, and shared the Public Health Model as a potential means of provider compensation. (Written)

Aruna Bhuta asked what can be learned from original Medicare. (Written)


Presentation: Liz Arjun, Gary Cohen, and Jon Kromm, Health Management and Associates, shared a timeline for the development of the Commission's report due to the Legislature in November 2022, in addition to section 4 and section 2 of the draft report. Section 4 assesses Washington's readiness to implement key design components of a universal health care system, and section 2 covers proposed strategies for developing implementable changes to Washington's health care financing and delivery system.

Section 4 focused on providing an assessment of Washington's current level of preparedness to meet the elements of a unified health care financing and delivery system. For purposes of assessing Washington's level of preparedness in the draft report, *Green* signifies that Washington is ready to implement a particular design element without major additional resources and IT systems or disruption to existing State programs; *Yellow* signifies that Washington has some resources, IT systems, and programs that could be modified and expanded to implement the design element or has no history of implementing a similar function.

Eligibility and enrollment readiness for a universal health care system was assessed as *Yellow*, for reasons including a lack of a centralized system with information about existing coverage, and that existing systems are not interoperable. Additionally, though there are robust systems in place for Apple Health and Qualified Health Plans via Healthplanfinder, modifications would be costly. Further, enrolling uninsured individuals and transitioning individuals from existing coverage requires significant and ongoing resources.

Commission Member Discussion on Eligibility and Enrollment

Dave Iseminger shared that the fragmentation of the various eligibility processes in Washington impacts individuals and families. There are multiple manual processes to understand even among the coverage programs housed under HCA, in addition to the eligibility processes within the Health Benefit Exchange (HBE). A single eligibility system is necessary for a universal health care system.



Joan Altman echoed Dave Iseminger's comments and remarked that the HHS (Health and Human Services) Enterprise Coalition is currently exploring their HHS Roadmap to determine how and where Healthplanfinder and other State systems could be further leveraged and integrated. There has been interagency commitment and legislative commitment to charting a path forward to leverage investments Washington has made in IT.

Jane Beyer pondered whether there is an existing universal data system (which may not capture anyone who moves into the state but could capture who was born in the state) that could be utilized to capture a large portion of the population for enrollment and eligibility.

Karen Johnson shared that viewing universal health care as a system through an equity lens inspires reflection on the trauma that oppression brings, including the generational trauma brought on by the genocide of Indigenous peoples and the enslavement of African peoples in building this country. Karen Johnson urged Commission Members to think about how to address this in this work and is concerned about the health status and mental status of those who have experienced such trauma.

Chair Vicki Lowe agreed with Karen Johnson and pointed to the barriers BIPOC individuals face in signing up for State agency programs and services because of past trauma, including generational trauma. Vicki Lowe's organization is working with Tribal liaisons on building a report for the American Indian/Alaskan Native (AI/AN) populations to identify more of these barriers.

Karen Johnson suggested that there may be lessons learned from the universal health care system under Veterans Affairs that could be translatable to Washington's universal system. Veterans Affairs leveraged people in Veterans' lives to help redesign the system with actively engaged staff who delivered a superior customer experience to Veterans that also honored their experience and in a way that maintained their dignity and humanity.

Nicole Gomez recommended that any new eligibility system should be user friendly and simple to ensure an equitable process.


Representative Schmick suggested that the Commission clarify who the eligibility system is ultimately for if Medicare and Medicaid enrollees are not covered under the universal system.

Benefits and services were assessed as *Yellow* for reasons including varied benefit packages, and because Washington's experience managing benefits under Apple Health, PEBB and SEBB, are conducted largely through managed care plans and commercial carriers providing administrative functions. In its final report, the Universal Health Care Work Group assumed that the benefits covered under a universal system included Essential Health Benefits as defined by the Affordable Care Act (ACA), including vision and dental, as well as long-term care (for Medicaid eligible individuals only). However, this was not a comment on what all Work Group members wanted or what was ideal. HMA asked Commission Members' views on what the set of benefits should be.

[Commission Member Discussion on Benefits and Services](#)

Jane Beyer pondered how to remove deductibles and cost sharing so that individuals can actually access their benefits and noted the several proposals in the Washington Legislature to add benefits to the mandated benefits. However, the ACA provides that if a state wants to add benefits to the Essential Health





Benefits, the state must bear the cost. Jane Beyer stressed the importance of having any established benefits package evolve with evidence-based advances in medical care.

Estelle Williams echoed Jane Beyer's comments, especially given that medical care is evolving as health inequities and health disparities are being recognized, and we are understanding from where these inequities and disparities stem and how they can be addressed. Estelle Williams stressed the importance of ensuring that individuals from a marginalized identify are included in advances in medical care and do not incur additional costs.

Chair Vicki Lowe stressed that access to care should be inclusive of medical, dental, hearing, vision, and behavioral health.

Dave Iseminger echoed Chair Vicki Lowe's comments, remarking how often dental care is left out of medical care and suggested that small benefit design changes can have powerful impacts on perception of a benefit and perception of actual or non-existent care and price. There is a mandatory dental benefit in the PEBB and SEBB programs and premiums are covered fully by the employer.

The Work Group report mentioned the idea of supplemental insurance being available to purchase in addition to the essential benefits under a universal system. Commission Members were asked their thoughts on whether the idea of supplemental insurance is worth pursuing, considering the equity implications.

[Commission Member Discussion on Supplemental Insurance Options](#)

Dave Iseminger remarked that having the ability to purchase private insurance highlights a very clear inequity because some individuals could afford enhanced benefits, and some could not. Having a flat amount for covered services provided to enrollees will make the system simpler, help avoid confusion, and help with predictability.

Joan Altman shared that HBE is reviewing "choice overload." Additionally, standardization has been a way to help individuals who purchase on the individual market make informed choices.

Jane Beyer stated that Medicaid has a richer benefits package because it acknowledges the fact that eligible individuals do not have money available to pay for a service not covered under the benefits package.


Chair Vicki Lowe remarked that cost sharing is an equity issue and inhibits individuals, particularly lower income individuals, from getting care.

The UHC Work Group report did not provide details on provider reimbursement beyond assuming that there would be a fee schedule set by the State, with rates higher than public programs currently and lower than commercial rates. Commission Members were asked whether the universal health care system should continue and build upon efforts to pay for health care other than by a fee-for-service (FFS) model in order to promote affordability, quality, and equity goals.

[Commission Member Discussion on Provider Reimbursement and Participation](#)

Jane Beyer shared concern in moving away completely from the FFS system because there has been significant horizontal and vertical consolidation in health care with an increase in private equity money in health care. Jane Beyer cautioned against creating value-based payment (VBP) models that could force





providers to sell their practice due to capacity issues. Jane Beyer shared that in recent evidence reviews of outcomes of VBP models, the research is mixed, especially in terms of the impact of VBP models on price, and urged that the Commission explicitly address these issues in its discussion of moving to VBP.

Chair Vicki Lowe echoed Jane Beyer's comments and shared that Indian Health Care Providers are also concerned about fully moving to VBP as well, particularly with respect to rural health care providers. It may be helpful to do some sort of cost-based reimbursement to ensure that providers are paid at least the cost to provide care. Vicki Lowe also suggested that providers in cities should not be paid more than providers in rural areas. The cost of providing care must be part of the equation.

Nicole Gomez sees costs and payments through the lens of Workers Compensation, which utilizes a fee schedule. This may be a possibility for a streamlined payment system that could be translatable to a universal system.

Currently, most of the cost containment efforts across Washington are not aligned. The new system will also require significant resources dedicated to aligning IT systems to support a universal system. There may be an opportunity for the State to transition gradually with taking on more functions of the system.

Section 2 covered proposed strategies for developing implementable changes to Washington's health care financing and delivery system. HMA shared an illustration outlining the foundational elements of a universal health care system, including benefits and services, eligibility, financing, and provider reimbursement. These elements as proposed, could help guide decision making around infrastructure, enrollment, cost containment elements, and governance. Several Commission Members noted that cost containment elements could be considered a foundational element, rather than a secondary element.

HMA also shared actions the Commission could take in the short-term, mid-term, and long-term in considering the model for implementation. In the near term, the Commission could focus on establishing a financing technical advisory committee to carry out the initial exploration and details of models. Also in the near term, the Commission could focus some of its work on making implementable changes to the current system to improve access to coverage and care. Additionally, the Commission could develop recommendations for phased initiatives and a pathway to ready the existing system for the transition to a universal system. In the mid-term, the Commission could finalize recommendations to the Legislature on each of the core design elements and how each element will be implemented. In the long-term, the Commission could establish technical advisory work groups to develop operational details of the universal system.

Adjournment

Meeting adjourned at 5:05 p.m.

Next meeting

Wednesday, July 13, 2022
Meeting to be held on Zoom
3:00 p.m. – 5:00 p.m.

Public comment

Tab 3

**Universal Health Care Commission
Written Comments**

Received From June 3rd

Written Comments Submitted by Email

K. Powers	1
C. Snow	1
M. Benefiel	2
C. Currie	3

Additional Comments Received at the June 16th Commission Meeting

- The Zoom video recording is available for viewing here:
<https://www.youtube.com/watch?v=aseqWNml1Kk&feature=youtu.be>
- The Zoom and meeting questions are available here:
<https://www.hca.wa.gov/assets/program/uhcc-meeting-chat-20220616.pdf>
- The Meeting Summary is available here:
<https://www.hca.wa.gov/assets/program/uhcc-meeting-summary-20220616.pdf>

Public comments received since June 3rd DATE through the deadline for comments for the July meeting (June 29th)

Submitted by Kelly Powers

6/8/2022

Dear UHC Commissioners,

Several of us have been thinking about the consultant's advice at the April 2022 UHC Commission meeting urging the Commission to address Medicare first thing.

It might be a reasonable interim step to cover Washingtonians ages 0 thru 64. We could set aside what the consultant considered to be the most challenging waiver requirement needed for diverting Medicare funds. This would leave a popular program intact. Providers and patients might appreciate the stability and familiarity of Medicare as Washington moves to a unified financing system.

Optumas presented some back-of-the-napkin estimates to the Work Group in Sept 2020 that left Medicare as is. Those were very preliminary numbers, and other assumptions don't match up with the assumptions in the UHC Work Group's Final Report so the analysis would probably need to be updated and harmonized to be useful. (Apples to apples, oranges to oranges comparisons)

Given this, we propose an **update of Models A and B using the assumptions of the Work Group with one difference — that Models A and B just covered WA residents ages 0 thru age 64.** So Medicare would continue to cover and pay for Medicare-eligible patients. We would expect some savings as those needing the most care would be covered by Medicare.

Thank you for considering it,

Kelly Powers

Health Care is a Human Right - WA

Co-Chair HCHR Universal Health Care Commission Subcommittee

Everyone deserves quality, affordable health care.

Submitted by Calvin Snow

6/8/2022

UHC Commission,

I know you are all aware of the horror stories from far too many people. Everyone in the 99% are getting too little for too much money for health care. We have a system where the insurance companies get away

with denying 25% of claims because of their profit motive. People lose homes, jobs, their health and even their lives because we allow the health care lobby to rule our legislature.

Legislation exists today and has existed for a decade that would save lives and money for WA residents. Why won't this commission look at the legislation to see if it will work? Why start from scratch and proceed with caution when people's lives are at stake?

I can only believe that the powerful health care lobby and the legislators that they fund don't want to see a single-payer system implemented and are "encouraging" the commission to go slow with no end in sight.

To me delaying the implementation of a system that will save lives by "proceeding with caution" is a moral issue.

Think of those needlessly suffering as we "proceed with caution".
Please help the people of WA.

Calvin Snow
Seattle

Submitted by Mike Benefiel

6/10/2022

UHC Commission,

"A third of physicians report that prior authorization delays have resulted in a serious adverse event for a patient in their care; 24% report that prior authorization delays have resulted in a patient's hospitalization."

This is the system that our legislature is tightly holding onto.

People suffer and die unnecessarily because of our reluctance to buck the powerful health care lobby.

We've heard testimony with mothers crying because their children are suffering because of profit driven decisions by health insurers. How can we turn our backs?

Please do what you can to bring about a rapid implementation of a single-payer universal health care system and fight off the attempts to dilute the system to appease the powerful health care lobby.

Thank you,

Mike Benefiel, Democratic PCO, Kitsap

Submitted by Cris Currie

6/16/2022

My name is Cris Currie and I'm a retired RN from Spokane. First, I want to commend the consultants for providing such a detailed summary of the challenges to creating the first state based universal healthcare system in the country, but I would also remind them that it is not the goal of this Commission to determine the subjective feasibility of this noble project. My fear is that the color coding oversimplifies and negatively diverts attention from the *actual* mission which is to establish a workable structure for universal healthcare. While making an infrastructure readiness assessment is moderately important, what is most important is that the *people* of this state are more than ready for affordable, high quality, universal healthcare, and we are anxious to get it done!

Senators Wyden and Sanders certainly had single-payer in mind when they wrote and advocated for the ACA's Section 1332, even though, for political reasons, they didn't mention the idea of single-payer in the ACA. [See [here](#) and [here](#).] Just as prompt action regarding initiating a 1332 waiver discussion with federal officials is very important, it is also important to plan the state's response to likely ERISA litigation, since past jurisprudence has not been particularly helpful for healthcare reform. However, our 9th Circuit made an encouraging decision in 2008 in [Golden Gate Restaurant Assoc vs City & County of San Francisco](#) that helped further define the limits of ERISA preemption related to pay or play provisions with "meaningful alternatives." Then in 2016 the U.S. Supreme Court even added a modicum of further encouragement by rejecting "uncritical literalism" in the interpretation of ERISA in [Gobeille vs. Liberty Mutual](#) in relation to Vermont's all payer data base.

Based on these and other court cases, Brown & McCuskey have proposed three major types of mechanisms for transitioning employer self-funded plans to a state-based single-payer system in their [Pennsylvania Law Review article](#) from 2020. For maximum effect, they recommend incorporating all three provisions. The most important is funding through a payroll tax, preferably split between the employer and employee. The second is a provision to restrict participating providers from billing anyone but the single-payer for services rendered to a covered individual. The third is a subrogation clause that allows the single-payer to pay for an employee's medical bills and seek reimbursement from the employer during the transition. One additional provision the authors mention is "pay or play" similar to the ACA's employer mandate. According to former Vermont governor Peter Shumlin, dealing with ERISA was "easy." "You just tell employers they will have to pay the payroll tax whether they keep their self-insured plan or not." [See [here](#) at about 27:35.] In other words, ERISA may be a barrier against

state regulation of self-funded employer health plans, but it is far from insurmountable. So please don't be discouraged by the doomsayers and their infeasibility predictions. The state can in fact provide superior health benefits to all Washingtonians regardless of whether or not employers continue to offer ERISA plans, and I would strongly encourage Commission members to delve into these details and discuss them thoroughly.

Thank you again for the opportunity to comment.

Report to the Legislature – Sections 2 and 6

Tab 4

Washington Universal Health Care Commission Report to the Legislature: Sections 2 & 6

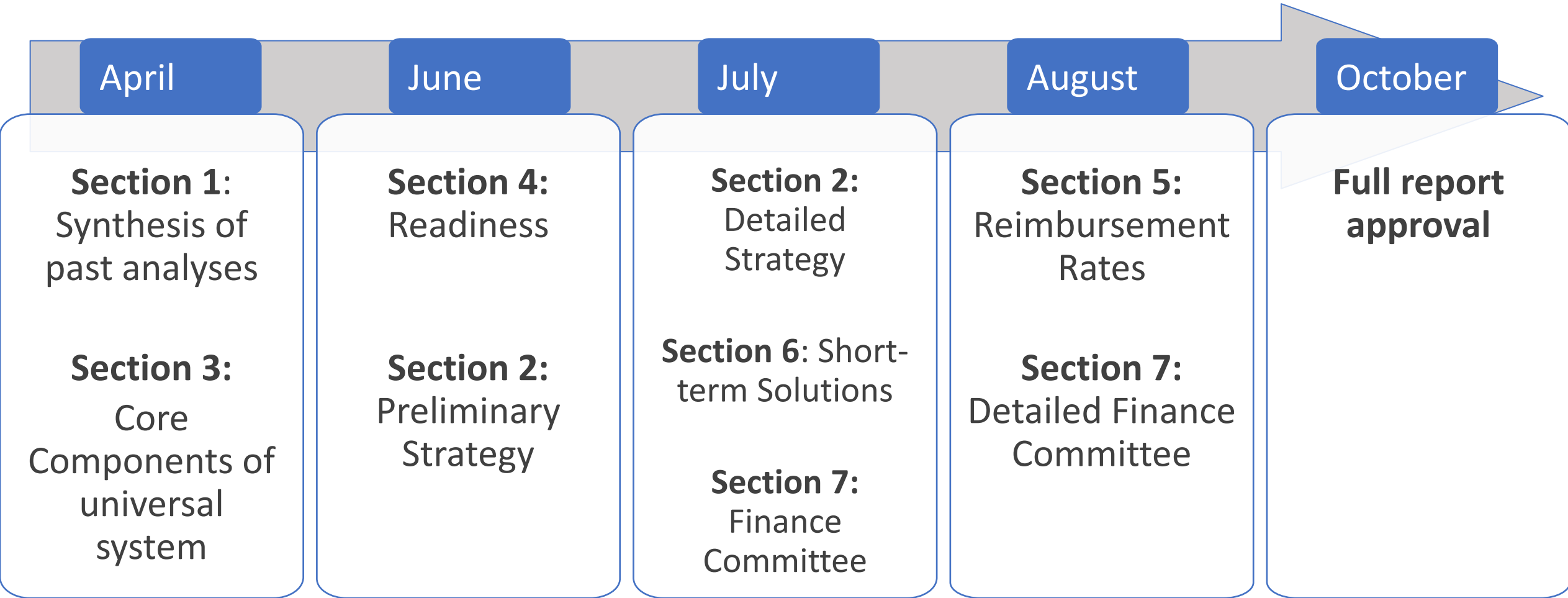
Liz Arjun, Senior Consultant - HMA
Gary Cohen, Principal - HMA
Jon Kromm, Principal - HMA

Presentation to the Universal Health Care Commission
July 13, 2022

Agenda

- Timeline
- Goals for Today
- Section 2:
 - Proposed Strategy
 - Finance Technical Advisory Committee
 - Discussion
- Section 6:
 - Short-Term Solutions
 - Discussion
- Next Steps

Report Development Timeline



Today's Goals

1. Review a proposed strategy for future Commission work to design a universal health care system.
2. Discuss transitional solutions that will move the state further along to a universal health care system.
3. Consider recommendations including:
 - A strategy for future Commission work to design a universal health care system.
 - Establishing a finance committee.
 - Potential transitional solutions that move the state further towards a universal health care system.

Section 2: Proposed Strategy

Short-Term Activities

- Establish a Financing Technical Advisory Committee (FTAC)
- Develop recommendations for phased initiatives

Mid-Term Activities

- Finalize recommendations to the Legislature on:
- System Design
 - Governance
 - Financing

Long-Term Activities

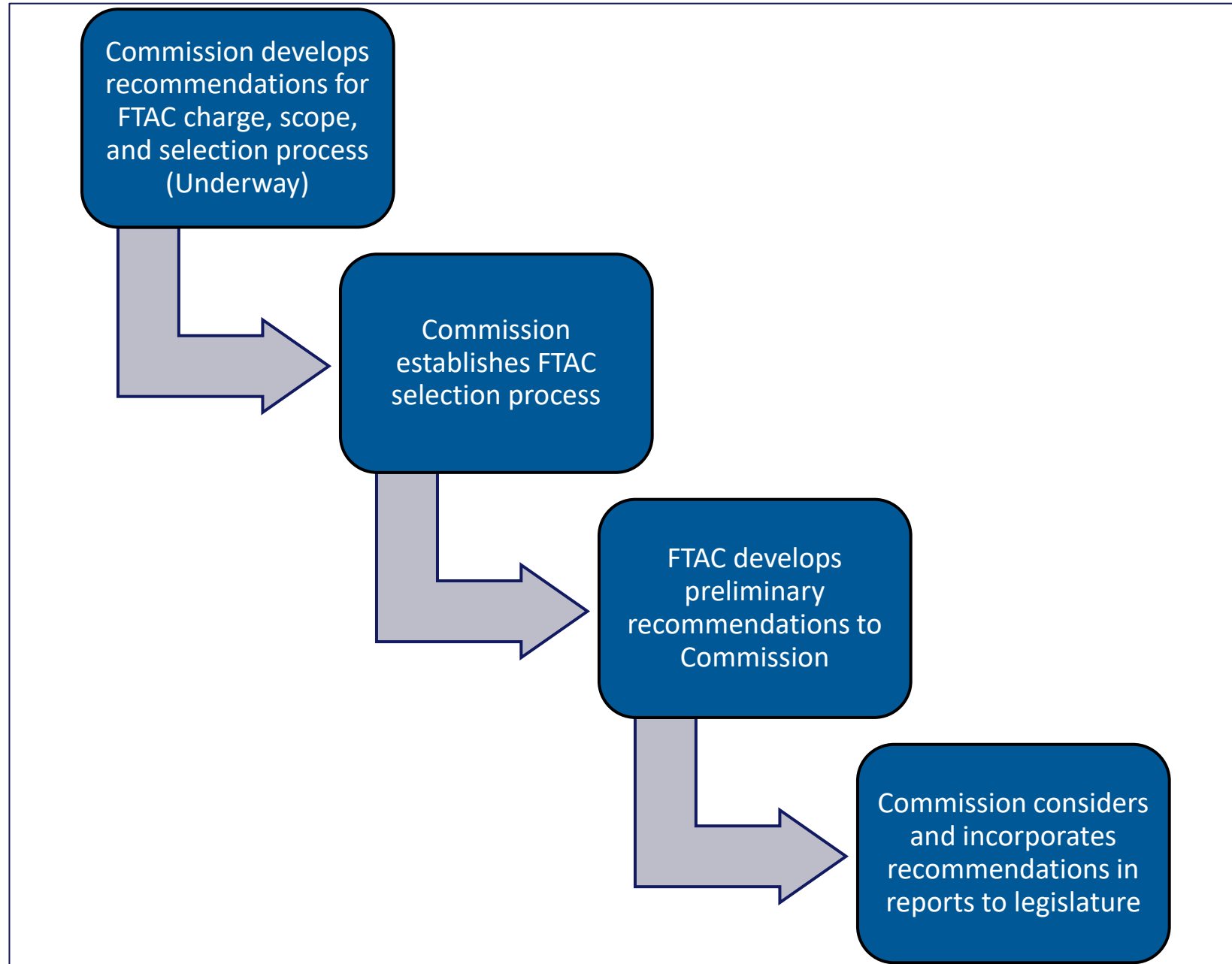
- Establish an Operations and Administration Technical Advisory Committee (OATAC)

Proposed Strategy

Finance Technical Advisory Committee (FTAC)

Create a finance technical advisory committee (FTAC) to provide subject matter expertise and advise the Commission on the development of a financially feasible model to implement a unified health care financing system.

FTAC Plan

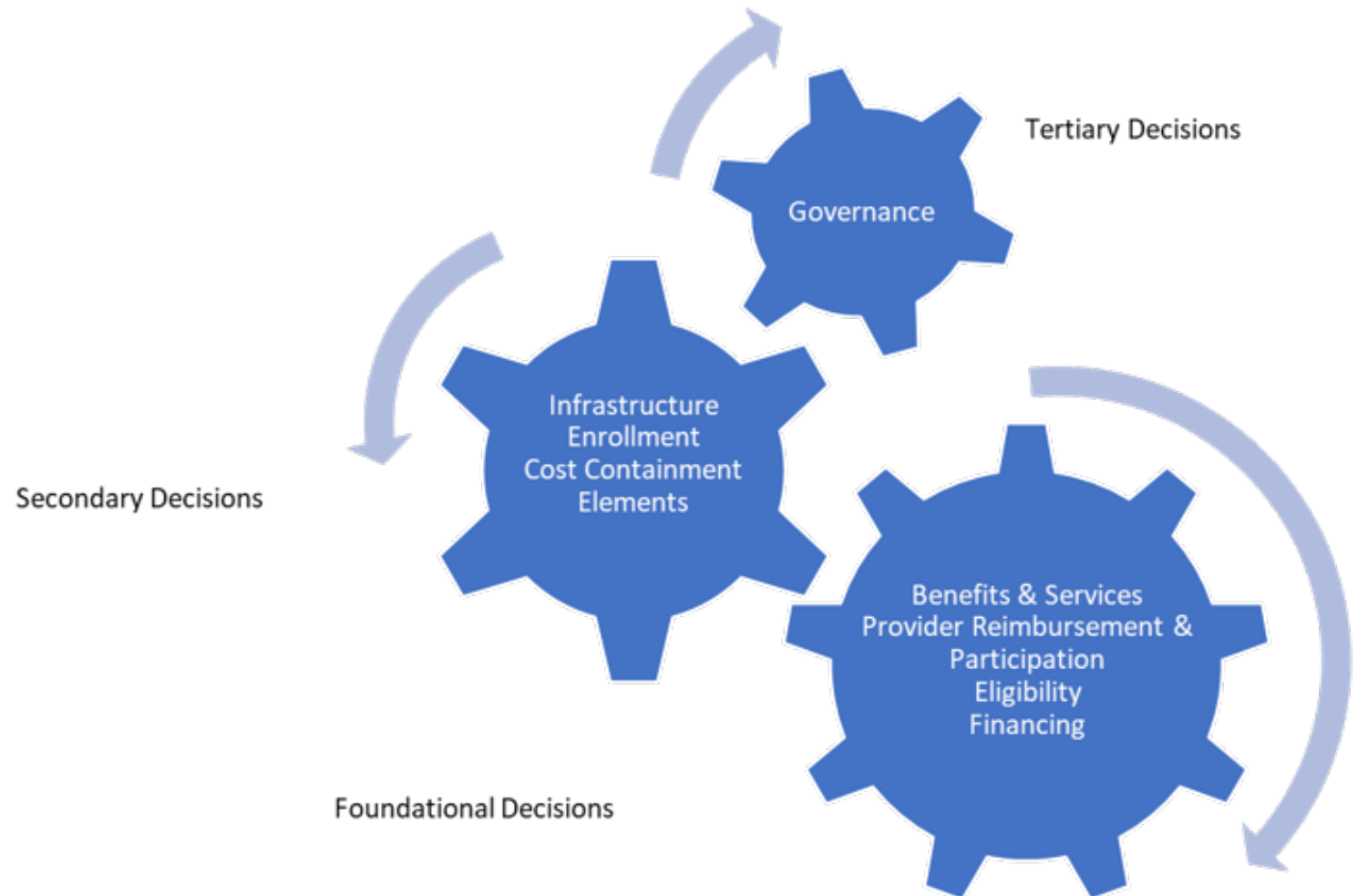


FTAC Goals

- Consider options for the key design elements of a universal health care system
- Examine inequities in the current health care financing system and consider the impact of financing proposals on equity
- Incorporate evidence-based strategies
- Consult with subject matter experts
- Identify interdependencies
- Federal waiver strategies
- Advise the Commission

FTAC Goals

- FTAC will prioritize analysis of foundational design elements first to inform Commission decision-making and recommendations.



FTAC Roles

The FTAC Chairperson will:

- Be appointed by the Commission
- Serve as FTAC point of contact.
- Assist with meeting facilitation and planning.
- Share relevant discussions or findings with the Commission.

HCA will provide necessary staffing resources to support FTAC. HCA staff will:

- Prepare meeting agendas, provide meeting summaries, arrange meeting materials and distribute meeting materials, and will assist with meeting coordination needs.
- Coordinate with the committee lead on facilitation and planning.

FTAC Meetings

- FTAC will meet between Commission meetings for 2 hours on a bi-monthly basis.
 - This schedule will continue until the Commission deems it appropriate to revise FTAC's meeting schedule, or FTAC completes its goals.
 - FTAC members should be prepared to commit to between 4-6 hours per month for 2 years in order to review materials and attend meetings.

FTAC Appointment

- The opportunity to apply would be shared through a GovDelivery announcement and posted to the Commission's web page and be available for 60 days.
- The Commission will appoint 7 members, including 1 consumer representative, and if possible, 1 member from the Office of Financial Management and 1 member from the Department of Revenue.
- The Commission will appoint the FTAC Chairperson.

FTAC Qualifications

FTAC applicants should hold subject matter expertise in health care financing and/or revenue, including:

financing and payment solutions that ensure equity

service delivery

pharmaceutical costs and spending

universal health insurance

rural health care delivery and financing

behavioral health financing

provider reimbursement

coverage and benefits

health care economics

single-payer revenue and payment models

alternative payment models

Medicaid financing

Medicare financing

federal waivers

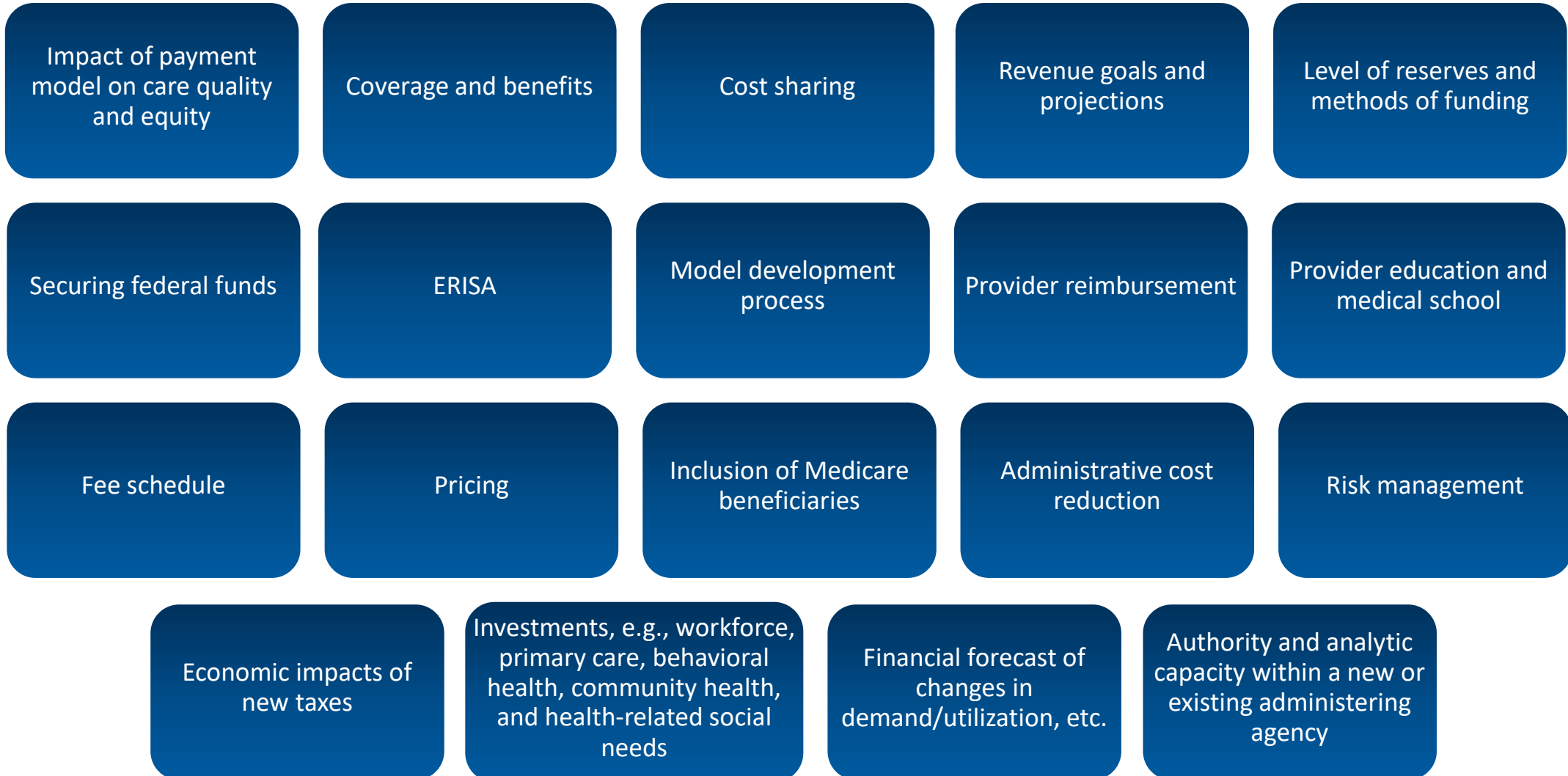
employer-sponsored insurance

ERISA

cost sharing

cost containment strategies

FTAC Considerations



Discussion



Section 6: Transitional Solutions

Identified Options for Transitional Solutions

The Commission has discussed measures that would expand coverage for currently uninsured individuals:

- Establishing a sustained funding source for the new coverage solutions being implemented for individuals without federally recognized immigration status will ensure long-term coverage for a key uninsured population.
- Implementing the Cascade Care Savings program that may make coverage more affordable for some uninsured individuals currently eligible to purchase QHPs.

Identified Options for Transitional Solutions

The Commission has discussed potential transitional strategies that can improve affordability and advance the State's readiness to implement a universal health care system:

- Further aligning existing public coverage programs can help those programs
 - Control underlying costs of care and administrative costs
 - Establish more uniform standards for quality of care and coverage
- Establishing a broader set of health care cost targets is an important precursor to a provider reimbursement/universal financing system
- Implementing the Integrated Eligibility and Enrollment Modernization Roadmap improves access to coverage and other supports and creates infrastructure that can be leveraged in a universal health care system

Additional Options for Transitional Solutions

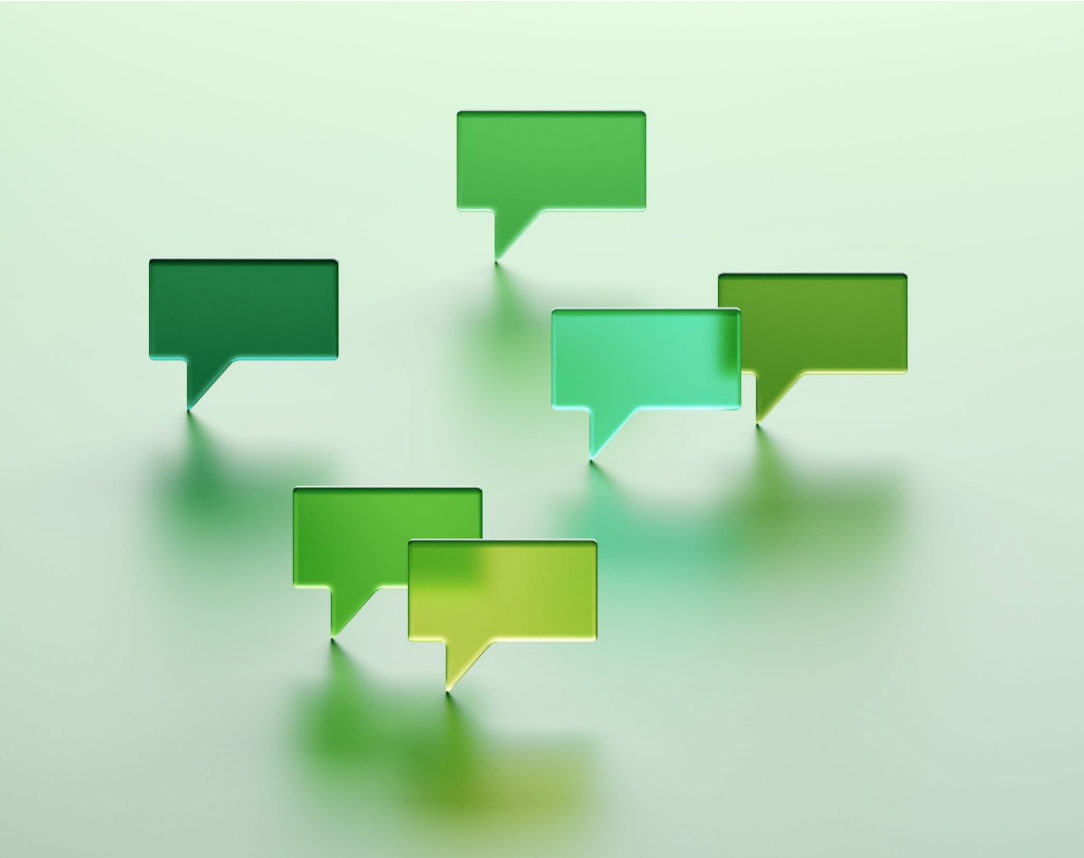
What additional opportunities exist to expand access to coverage through the following programs or markets?

- Medicaid
- Individual market
- Employer-sponsored coverage
- Other programs

What additional opportunities exist to improve affordability and quality of coverage through the following programs or markets?

- Medicaid
- Individual market
- Employer-sponsored coverage
- Medicare
- Other programs

Discussion



What's Next

- Refining Sections 2 and 6
- Reviewing report Sections 5 (provider reimbursement rates) and 7 (FTAC)
- Finalizing the full report

Report to the Legislature – Section 2 (revised)

Tab 5

Section 2: Strategies to Move Toward a Universal Health Care System

Introduction

Section 1 of this report describes Washington’s long history of innovation and continued efforts to expand access and improve the quality and equity of affordable health care coverage. Later sections of this report outline the key design elements of a universal health care system, options for developing and implementing approaches to these foundational elements, and Washington’s readiness to implement those approaches. This section offers a set of strategies, analyses, and planning activities to move toward a universal health care system, which are summarized in Figure 1.

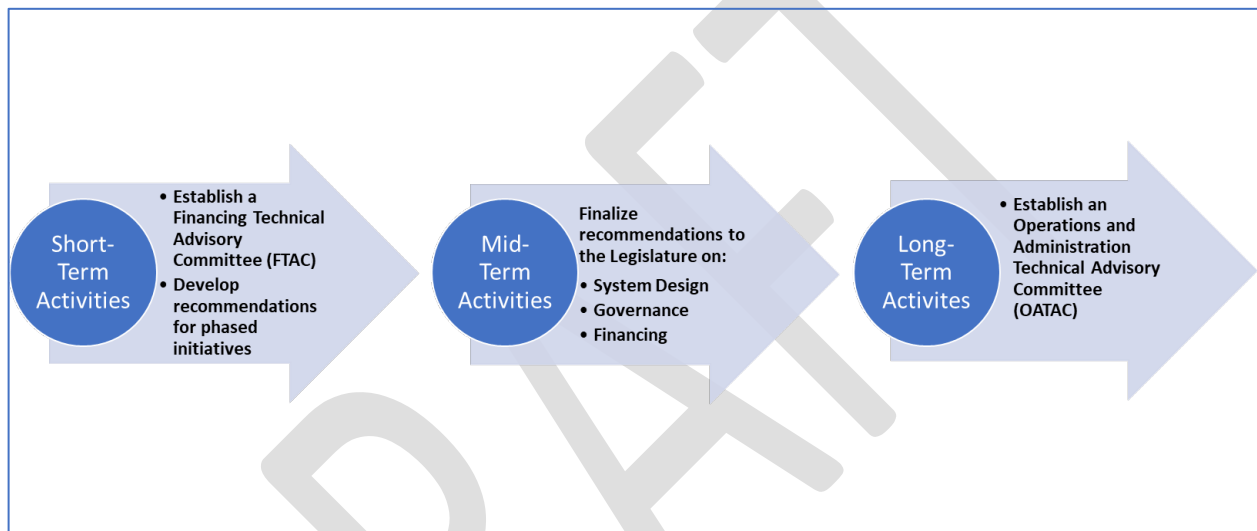


Figure 1: Proposed Sequencing for Universal Health Care Commission Strategy

Short-Term Activities

Establishing a Financing Technical Advisory Committee (FTAC)

Establishing a Financing Technical Advisory Committee (FTAC) will provide additional insights and technical guidance to the Commission, as directed by the authorizing legislation.¹ This approach is similar to Oregon’s Task Force on Universal Health Care and other Washington boards and commissions that utilize advisory committees.

In general, the first set of activities FTAC is tasked with will be to understand and provide guidance to the Commission concerning the functions required to achieve the cost, equity and quality goals envisioned and required by a universal financing system. A more thorough description of the process to establish FTAC is described in Section 7 of this report.

Develop Recommendations for Phased Initiatives

As described in Section 1, Washington has submitted a Section 1332 waiver to CMS to make it possible for more residents to purchase coverage on the Exchange which will remove federal barriers for certain

¹ Engrossed Second Substitute Senate Bill 5399 Chapter 309, Laws of 2021.
<https://lawfilesexternal.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5399-S2.SL.pdf?q=20220530104327>

groups.² Once these new initiatives are in place, the principal barrier to universal coverage for Washingtonians will be cost. Therefore, many of the intermediate steps toward a universal health care system will focus on decreasing underlying costs of health care while improving health care quality and reducing inequities in the access and delivery of care.

The Commission will continue its work to enhance, expand, or modify the existing coverage programs informed by the ongoing work of the state agencies responsible for existing coverage programs, the broader private payer and provider community, and FTAC. Future work will lay a foundation for the universal health care system as well as advance cost, quality, and equity goals.

Mid-Range Activities

Mid-range activities addressed by the Commission are likely to focus on developing functions to advance cost, quality, and equity goals through changes to the existing health care system. The Commission also may focus on critical strategies for establishing a framework for a unified financing system including the following:

- *Governance:* The Commission will examine a governance structure that places oversight of the universal health care system under an existing agency, a new agency, or a multi-agency structure. The Commission may provide a framework for establishing authority for this governing structure and ensuring that resources are allocated to implement and maintain the universal health care system.
- *Financing Strategies:* In the mid-term, the Commission will further assess and finalize decisions about appropriate financing strategies that leverage federal and state funding sources. An examination of potential revenue sources would be needed particularly if it is determined that state funding will largely replace premiums and out-of-pocket costs that currently finance the health care system. This examination would include an assessment of the impact of shifting away from the currently existing coverage programs for Washington citizens and employers, including an assessment of the overall state-level cost shifts. Mid-term work of the Commission will also focus on developing strategies for establishing a federal Medicaid state plan and related waiver authority requests.
- *State and Federal Authorities and Revenue:* After the core functions of a unified health care financing system have been developed, and how those functions should be administered, statutory changes may be necessary to establish a new state entity or expand the authority of an existing entity to administer the universal system. Additionally, federal approval may be needed to access any dollars associated with federal programs such as Medicaid, ACA subsidies, and Medicare.

Long-Term Activities

Operations and Administration Technical Advisory Committee

Once planning and authorizing the universal health care system is complete, the Commission may refine the operational and administrative vision for the model that will shape implementation. When FTAC sunsets as it completes its design and planning work, a new Operations and Administration Technical Advisory Committee (OATAC) as in Figure 1, focused on operations and administration, may need to be

² Washington has also provided state funding for this group to utilize subsidies in the place of federal subsidies that cannot be utilized for this purpose.

established. OATAC would be responsible for providing technical guidance and support as the new system is operationalized and implemented. A description of potential activities for OATAC would include:

- Working with the designated accountable agency or agencies, OATAC would help to guide and implement the new system.
- OATAC would develop a process for establishing annual performance targets (including those for cost, quality, and equity), a measurement and evaluation strategy to monitor progress towards those targets, and a reporting process to continuously assess the impact of the new system.
- OATAC may also provide guidance on improving care management for chronic illnesses. Implementing universal access and better management of chronic disease would be expected to reduce annual per member costs over time based on the findings in RAND's analysis of the Oregon universal coverage options.³
- OATAC would provide guidance on how to leverage the purchasing power of a unified health care financing system such as achieving prescription drug discounts or instituting a hard cap on system spending with clear measures to reduce costs.
- OATAC may assist the Commission with developing a communication approach for awareness and a stakeholder input process for refining the design concepts of the new system and to initiate an educational and engagement process in preparation of implementation. It will be important to communicate decisions and timelines to providers, insurers, and consumers.
- OATAC may assist the Commission with planning the transition from current programs and populations, including mediating impacts of potential job losses. For example, OATAC could assess the following:
 - *Roles and Jobs:* Regardless of the model, restructuring the health care system will impact staff in policy, management, actuarial, analytics, eligibility, claims payment, and technology functions.
 - *Provider Contracting:* Regardless of the model, there will be transitions to new contracting arrangements between the accountable entity and those providing services. In Model A, this would require the accountable entity to directly contract with providers and health systems. In one version of Model B, plans may need to alter their current contracts with providers and health systems to meet the new unified health system requirements and expectations.
 - *Transitions of Care:* State agency and health carrier staff from current programs will need to ensure smooth transitions of care into the new system. This may necessitate maintenance of current programs as they are closed out to ensure that Washingtonians can complete treatment courses that are in progress.

Summary

As outlined here in Section 2, there are short-term, mid-term, and long-term activities for transitioning Washington to a universal health care system. The proposed approach calls for additional subject matter expertise to support the Commission by establishing two consecutive technical advisory committees.

³ White, C et al. "A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon Research Report". RAND/HMA. https://www.rand.org/pubs/research_reports/RR1662.html

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These advisory committees would provide guidance and support to the Commission as it considers key design and implementation decisions.

DRAFT

Report to the Legislature – Section 6

Tab 6

Section 6

Introduction

Implementing a universal health care system is a long-term strategy for providing universal access to affordable and quality health care. The previous sections of this report describe the core design elements of a universal health care system and key considerations for their development and implementation. The Commission is also charged with developing intermediate recommendations for coverage expansion consistent with the goals of the universal health care system.

While Washington has made significant gains in reducing rates of uninsured, approximately four-point seven percent (4.7%) of the population remains without coverage as indicated in the most recently available data from OFM. Furthermore, disparities in coverage persist, particularly among Hispanic populations. As described in the first section of this report, Washington has already undertaken significant efforts and initiatives to expand access to coverage and improve the quality and affordability of health care for Washingtonians. This section incorporates those efforts and options for transitional improvements to the health care system.

This section also outlines a set of options that may expand coverage and improve the quality and affordability of health care in Washington. These options may also serve to lay a foundation for future efforts to establish the universal health care system and assist with short-term goals to improve the current health care system by increasing access and affordability:

- **Funding new coverage solutions for individuals without federally recognized immigration status;**
- **Implementing the Cascade Care Savings program;**
- **Further aligning public coverage programs;**
- **Establishing a broader set of health care cost targets; and**
- **Implementing the Integrated Eligibility and Enrollment Modernization Roadmap**

Options for Expansion of Coverage and Subsidy Programs

Currently, the uninsured population in Washington includes individuals who because of their immigration status, are prohibited from purchasing or enrolling in coverage options, as well as individuals for whom current coverage options are unaffordable. Efforts to expand coverage to these groups are currently in development in Washington.

Coverage Solution for Individuals without Federally Recognized Immigration Status

Under the ACA, only lawfully present immigrants can enroll in a qualified health plan (QHP). For those individuals who are not eligible to purchase QHPs, limited coverage programs are currently available (e.g., Apple Health is available for children and pregnant individuals and emergency medical coverage is available for individuals with qualifying medical conditions). However, Washington has made significant progress in creating a program to cover individuals without federally recognized immigration status.

In May 2022, WAHBE and HCA applied for a 1332 Waiver to allow individuals without federally recognized immigration status to purchase QHPs on the Exchange without federal subsidies. Additionally, Cascade Care Savings will provide state-based subsidies for individuals earning under 250% FPL purchasing Silver or Gold standard plans regardless of their immigration status in order to further support the affordability of QHPs.

Additionally, legislation passed in 2022 authorized HCA to develop a coverage program to provide Medicaid look-alike coverage for individuals without federally recognized immigration status earning

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under 137% FPL. This coverage will be available in 2024 and will expand upon the current coverage options available for this historically underserved and underinsured group. Together, these coverage options would ensure that virtually all Washingtonians will be eligible for a coverage option regardless of immigration status with fully or partially subsidized coverage for lower-income individuals.

Cascade Care Savings

Premium assistance for ACA Marketplace enrollees has been one of the primary strategies for increasing enrollment and expanding coverage through the Federal and State-based Marketplaces. The 2021 authorizing legislation directed the Exchange to establish Cascade Care Savings, a State premium assistance program that will begin providing financial assistance in 2023 to Washingtonians with incomes under 250% FPL purchasing a standardized health plan on Washington Healthplanfinder. The legislation appropriated \$50 million in funding to subsidize premiums. Subsequently, an additional \$5 million was appropriated to subsidize individuals not eligible for federal subsidies.

Options for Improving Affordability and Quality of Coverage

Universal coverage is a primary goal of the universal health care system. Intermediate steps could also advance universal health care while addressing the underlying costs of health care and improving the quality of care delivered through existing coverage.

Further Align Public Coverage Programs

As described in Section 1 of this report, Washington has several coverage programs that finance care for a significant portion of Washingtonians including Apple Health, PEBB, SEBB, and Cascade Care. Each program has a unique design to serve the specific needs of the eligible population as well as to meet federal and state requirements. However, the programs also have many common functions that overlap with core design elements of a universal health care system as described in Section 3 and Section 4 of this report. For example, each program directly performs, procures, or delegates to a health plan eligibility and enrollment, provider reimbursement, cost or utilization management, and quality improvement.

Currently, some of these functions align across programs. For example, several programs, including Apple Health and Cascade Care utilize measures for the Statewide Common Measure Set to help manage quality of care delivered and track health plan performance.¹ As an example of common plan and benefit design, both the PEBB and SEBB programs utilize the Uniform Medical Plan (UMP), a self-insured plan managed by HCA.² This makes the same benefits and networks available to employees served by both programs.

Continuing to align coverage programs may help to ensure consistent, high-quality coverage across programs; reduce per beneficiary administrative costs for shared functions; enhance the purchasing power of the state when services are jointly purchased across programs; and make it easier for third-party vendors or health plans to participate in multiple coverage programs. Alignment also simplifies the consolidation of design elements as the State progresses toward implementing a universal health care system.

¹ Washington Health Care Authority, Statewide Common Measure Set. <https://www.hca.wa.gov/about-hca/washington-statewide-common-measure-set#what-is-statewide-common-measure-set>

² Washington Health Care Authority, Uniform Medical Plan. <https://www.hca.wa.gov/about-hca/uniform-medical-plan-ump>

Use Ongoing Cost Analyses to Establish Health Care Cost Targets

Section 1 described recent initiatives Washington has undertaken to analyze health care cost drivers including the Health Care Cost Transparency Board, the Prescription Drug Price Transparency Program, the Prescription Drug Affordability Board, Value-Based Purchasing, and the OIC's Report on Prior Authorization. While each of these initiatives has a different charge or purpose, they represent a growing analytic capacity within the State to identify costs across payers and to set costs targets.

In particular, the work and scope of authorities of the Health Care Cost Transparency Board and Prescription Drug Affordability Board could have the ability to analyze a broader range of health care costs and set targets for growth in health care costs in aggregate and per service or drug. Cost growth targets can establish an analytic foundation for key design elements of a unified health care financing system. For example, as cost targets are developed, these can be used to set fee schedules or for developing value-based arrangements for providers participating in coverage programs. As an initial step, Washington could explore how cost transparency initiatives can be used to develop a broader set of health care cost targets.

Implement the Integrated Eligibility and Enrollment Modernization Roadmap

In 2021, Washington established a Health and Human Services Enterprise Coalition to review the patchwork of eligibility and enrollment technology platforms that serve the seventy-five (75) health and human services programs administered by the state.³ The coalition developed the Integrated Eligibility and Enrollment Modernization Roadmap. This five (5)-year roadmap for implementing an integrated eligibility and enrollment platform in Washington would allow Washingtonians to apply to all available programs in a single streamlined application, receive support through multiple channels, and provide a single eligibility record.⁴

Implementing an integrated platform would support an important infrastructure need for a universal health care system. It can also, as a short-term step toward universal health care, make it easier for Washingtonians to apply for coverage and receive financial assistance and other supports for which they are eligible while potentially reducing overall administrative costs. Implementing the Integrated Eligibility and Enrollment Modernization Roadmap may support short-term coverage goals as well as builds necessary long-term infrastructure.

Summary

The options discussed in this section could be initiated in parallel to the universal health care planning and development efforts of the Commission. Some options have potential to advance important capabilities that will be necessary for implementing a universal health care system. These transitional, short-term opportunities could expand or improve coverage within the current health care system while aligning with the core principles of universal health care.

³ Engrossed Substitute Senate Bill 5092. <https://lawfilesexternal.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5092-S.sl.pdf>

⁴ Integrated Eligibility and Enrollment Modernization Roadmap. <https://www.wahealthplanfinder.org/content/dam/wahbe-assets/legislation/WA%20IEE%20Modernization%20Roadmap%20Report.pdf>

Finance Technical Advisory Committee (FTAC)

Tab 7

Washington State Universal Health Care Commission

Finance Technical Advisory Committee (FTAC) Recommendations

Significant planning, analyses, and evaluation will be required for the transition to and implementation of a unified health care financing system. Consistent with the statutory charge, the Universal Health Care Commission may recommend the creation of a finance committee to aid the Commission in developing a unified financing system for universal health care in Washington.

Creation of FTAC

A finance technical advisory committee (FTAC) could be created with the goal to provide subject matter expertise and advise the Commission. FTAC will also assist the Commission with the development of a financially feasible model to implement a unified health care financing system.

Goals

The goal of FTAC is to advise the Commission in their development of a financially feasible model to implement universal health care coverage. Members of FTAC will work with an equity lens to investigate evidence-based strategies to develop unified health care financing proposals for the Commission's consideration. In their work, FTAC members will carefully consider the interdependencies between proposals for a unified financing system and other considerations before the Commission. Finally, FTAC will make recommendations for what entity(s) will implement the unified health care financing system.

FTAC Roles and Responsibilities

The Health Care Authority (HCA) will provide the necessary staffing and resources to support FTAC. HCA staff will prepare meeting agendas, provide meeting summaries, support the creation of meeting materials, distribute meeting materials, and will assist with meeting coordination.

The Commission will appoint a Chair for FTAC. The Chair of FTAC may also be a member of the Commission. The Chairperson will assist with meeting facilitation and must be available for all FTAC meetings, as well as for Universal Health Care Commission meetings. The Chair will serve as the liaison between FTAC and the Commission and will share any relevant discussions or findings at Commission meetings.

Subject Matter Expertise

HCA staff will consult with FTAC, if additional subject matter expertise is needed, and invite subject matter experts to present to FTAC. Subject matter experts will include, but are not limited to, those with knowledge regarding financing of health care services and programs in Washington, public and private health care expenditures in the state, taxation and other public revenue models, employer-sponsored health coverage, health care benefits, economics, public budgeting and financing, organizational financing, and behavioral health financing.

Meetings

FTAC will meet between Commission meetings on a bi-monthly basis. FTAC will continue this schedule until the Commission deems it appropriate to revise FTAC's meeting schedule or FTAC completes its goals.

Appointment

The opportunity to apply for FTAC membership consideration will be posted to the Universal Health Care Commission’s web page. The call for applications will be shared by HCA through a GovDelivery announcement when the opportunity to is posted to the Commission’s web page. Nominees will need to complete a basic application about the individual, their background/expertise to participate, and why they want to participate on FTAC. Nominees will also submit their most recent resume. The posting and opportunity to complete an application will be available for at least sixty (60) days, which may be extended, if needed to allow for additional applicants.

All application materials will be shared with the Commission. If more than thirty (30) applications are received, the thirty (30) most qualified applicants will be presented to the Commission. The Commission will appoint seven (7) nominees for FTAC membership, which includes one (1) consumer representative, and if possible, reserving at least one (1) spot for the Department of Revenue and one (1) spot for the Office of Financial Management.

Qualifications

Anyone may nominate a qualified candidate for FTAC, and self-nominees are also welcome. The applicant should hold subject matter expertise in health care financing, including but not limited to: service delivery; pharmaceutical costs and spending; universal health insurance; rural health; behavioral health financing; provider reimbursement; coverage and benefits; health care economics; single-payer revenue models (including taxation and federal and state revenue); single-payer payment models (including Diagnosis Related Group (DRG), global budgets, value-based payment, capitation, directed payments); alternative payment models (including value-based payment); Medicaid financing; Medicare financing; federal waivers; cost sharing; cost containment strategies; ERISA; or pricing.

Considerations Before FTAC

A primary goal of the Universal Health Care Commission is to develop a plan for a uniform financing system that will greatly simplify the system and lead to equitable, accessible, high-quality care for all Washington residents. One of the main goals of FTAC will be to make recommendations for which entity(s) will be responsible for implementing a unified health care financing system. The following offer some of the interdependencies of a unified financing system and the larger universal health care system, and considerations that may inform FTAC’s recommendations regarding who and/or which entity(s) will implement the unified health care financing system:

- Revenue goals and projections
- Scope of coverage, benefits and cost-sharing
- Development of fee schedule
- Securing federal funds
- ERISA
- Tax structure, including the impact of the tax structure on equity
- Assessing how to include Medicare beneficiaries
- Administrative cost reduction
- Risk management
- Model development process
- Health equity in financing
- Level of reserves and methods of funding
- Workforce and Provider reimbursement
- Impact of payment model on care quality and equity
- Economic impacts of new taxes
- Care investments, including primary care, behavioral health, community health, and health-related social needs
- Financial forecast of changes in demand/utilization, etc.
- Authority and analytic capacity within a new or existing administering agency

Finance Technical Advisory Committee for the Universal Health Care Commission

Call for Applications

The Washington State Universal Health Care Commission is seeking qualified members for the new Finance Technical Advisory Committee.

Finance Technical Advisory Committee (FTAC)

The health care system's current financing model has grown increasingly costly. Though Washington continues to make payment and purchasing reform efforts, the current health care system's increasing annual costs outpace wages and inflation and widen gaps in access to health coverage and care. Multiple economic analyses, including analysis by Washington's [Universal Health Care Work Group](#), demonstrate that a universal health care system can improve health equity and access to care, decrease costs, and will produce billions in savings per year, while providing universal coverage to resident.

The [Universal Health Care Commission](#) was created by [Senate Bill 5399](#). The Commission is charged with making the health care system more accessible by increasing access to quality, affordable health care by preparing Washington state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system once the federal government approves the new universal health care system. The cost to establish and administer such a system will create a material financial burden to the state and will be one of the greatest challenges to implementing a unified financing system.

Significant planning, analyses, and evaluation will be required for the transition to and implementation of a unified health care financing system. Consistent with the Universal Health Care Commission's statutory charge, it has made recommendations for the creation of a finance and revenue technical advisory committee (FTAC) to aid the Commission in developing a unified financing system for universal health care in Washington. The Commission will provide a recommended agenda for the work of the FTAC, culminating in a final report and set of recommendations on options for the Commission to consider.

Purpose

A primary goal of the Universal Health Care Commission is to develop a plan for a uniform financing system that will greatly simplify the system and lead to equitable, accessible, high-quality care for all Washington residents. The goal of FTAC is to advise the Commission in their development of a financially feasible model to implement universal health care coverage. Members of FTAC will consider and recommend options and strategies for unified health care financing for the Commission's consideration. In their work, FTAC members will carefully consider the interdependencies between proposals for a unified financing system and other considerations before the Commission, including the impact on the existing healthcare landscape and resources necessary for implementing the system. Finally, FTAC will make recommendations for what entity(s) will implement the unified health care financing system.

Appointment and Qualifications

The Commission will appoint seven (7) nominees for FTAC membership, including one (1) consumer representative, and if possible, reserving at least two (2) spots for two (2) state agencies which include the Department of Revenue the Office of Financial Management. Anyone may nominate a qualified candidate, and self-nominees are also welcome. Applicants will need to complete a basic application about the individual, their background/expertise to participate, and why they want to participate on FTAC, as well as attaching their most recent resume to the submission. The posting and opportunity to complete an application will be available for sixty (60) days.

The applicant should hold subject matter expertise in health care financing, including but not limited to: service delivery; pharmaceutical costs and spending; universal health insurance; rural health; behavioral health financing; provider reimbursement; coverage and benefits; health care economics; single-payer revenue models (including taxation and federal and state revenue); single-payer payment models (including Diagnosis Related Group (DRG), global budgets, value-based payment, capitation, directed payments); alternative payment models (including value-based payment); Medicaid financing; Medicare financing; federal waivers; cost sharing; cost containment strategies; ERISA; and/or pricing.

How to Apply

If you are interested in being considered for FTAC membership, please complete the Finance Technical Advisory Committee Application, available on the Universal Health Care Commission's webpage, and submit to HCAUniversalHCC@hca.wa.gov.

Applications will be accepted for 60 days through **TBD, 2022**. All application materials will be shared with and considered by the Commission. FTAC members will be appointed by the Washington State Universal Health Care Commission.

Additional Information

For more information about the Universal Health Care Commission, including past and upcoming meetings, please visit: <https://www.hca.wa.gov/about-hca/universal-health-care-commission>

You can also reach out to Mandy Weeks-Green, the Coverage and Marketing Strategies Manager at the Health Care Authority at HCAUniversalHCC@hca.wa.gov.

For more information about the Universal Health Care Work Group, please visit: <https://www.hca.wa.gov/about-hca/universal-health-care-workgroup>

If you would like to stay informed about the Universal Health Care Commission's work, please visit their [webpage](#) and/or [sign up for email updates](#).

Report to the Legislature – Section 4 (revised)

Tab 8

Section 4: Readiness

Introduction

The Legislature directed the UHC Commission to provide an assessment of Washington's current level of preparedness to meet the elements of universal health care with a unified financing system, including, but not limited to a single-payer financing system. *Section 4* provides a preliminary readiness assessment of the state's current level of preparedness to implement a unified health care financing system as described in Model A and Model B of the UHC Work Group. It outlines the functions state agencies are currently performing and potential resources available to perform those functions under a unified health care financing system.¹ Additionally, *Section 4* compares the current health care system with a potential unified health care financing system and identifies the steps and considerations necessary to move from the current system to universal health care supported by a unified financing system.

Washington's readiness to transition will likely evolve as the Commission continues its work, as a complete readiness assessment is dependent on finalizing various design elements, including which model of universal health care is chosen. This preliminary assessment will, however, provide initial considerations that will help to inform the Commission's work and potential next steps. Throughout the course of the Commission's work, there will be revisions and expansions to the initial assessment as the unified health care financing system develops.

A readiness assessment survey tool was developed and provided to Commission Members to gather information and evaluate Washington's readiness.² Individual interviews were also conducted with state agency representatives participating on the Commission. The survey and interviews demonstrated that while Washington has significant resources that could be adapted and expanded to implement a unified health care financing system, major gaps exist. The assessment revealed important information for consideration, including identifying that state agencies have limited to no experience in directly performing important functions of the health care system. For example, state agencies have not historically performed utilization management functions whereas managed care organizations, private payers, providers, and others typically employ utilization management strategies to coordinate and manage care, to reduce wasteful, unnecessary care, and to contain costs. In some cases, this is done by private entities such as Medicaid Managed Care Organizations and commercial health plans on behalf of state agencies in public programs which the state agency administers (e.g., Apple Health, School Employees Benefits Board (SEBB), Public Employees Benefits Board (PEBB)).

The assessment of the seven core components of a universal health care system is summarized in Table 1 (*see below*). This table describes the state's readiness to move from the current system to the potential new model(s). For purposes of assessing Washington's level of preparedness in this report, Green signifies that the State is ready to implement a particular design element without major

¹ Washington is currently adopting policies and making budget allocations to achieve Model C.

² **The survey and interview guide are included in Appendix X.**

additional resources and IT systems or disruption to existing state programs; Yellow signifies that the state has some resources, IT systems, and programs that could be modified and expanded to implement the design element; and Red signifies that the state lacks the resources, IT systems, and programs needed to implement the design element or has no history of implementing a similar function.

Preliminary Readiness Assessment Findings	
Core Component	Readiness Level
1. Eligibility and Enrollment	Yellow
2. Benefits and Services	Yellow
3. Financing	Red
4. Provider Reimbursement and Participation	Dependent upon Model Design
5. Cost Containment Elements	Model A: Red
	Model B: Yellow
6. Infrastructure	Model A: Red
	Model B: Yellow
7. Governance	Red

Table 1: Summary of Readiness to Implement Core Components of a Universal Health Care System with a Unified Financing System

Core Component 1: Eligibility and Enrollment

The goal of universal health care is to enroll all eligible Washington residents to ensure that they have the best possible access to essential, effective, appropriate, and affordable health care services. In the current system, determinations about coverage eligibility and enrollment vary depending on the coverage source: public programs, employer-sponsored coverage, or the individual market.

There are several challenges to establishing universal eligibility and enrollment processes. Washington lacks a centralized source of information about individuals’ existing coverage because the various information technology systems currently in use are not capable of interacting with one another. Similarly, there is no central database of uninsured individuals and families. As a result, systems will need to be developed to effectively transition individuals enrolled in any current system and the uninsured into the new health care system. This will ensure continuous care and will help determine whether an individual or family is eligible to enroll in a unified health care financing system.

This work will vary depending on current coverage: people who have existing coverage will transition into the new system, and people who are uninsured will need to be enrolled into the system. Each of these coverage scenarios presents its own challenges.

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Eligibility Readiness = Yellow

Under any universal health care system, eligibility determination is crucial. The nature and extent of the information needed depends to some extent on the design of the new system. However, under any model, residency status would need to be determined and verified. Residency requirements could include a waiting period or a minimum residency duration to establish eligibility.

Additional information will be needed to determine the eligibility criteria. For example, more information would be needed to determine eligibility for non-residents such as those eligible for health insurance offered by their Washington-based employer. Similarly, further work may be needed to identify the impacts of eligibility policies, processes, and procedures on specific populations (e.g., tribal members or persons who are incarcerated) and to ensure comprehensive collaboration with all partners such as community-based organizations that can assist with outreach and eligibility determinations.

Washington's robust system to determine eligibility for Apple Health and Qualified Health Plans (QHPs) could be modified to serve as the eligibility verification system for any universal health care. However, depending on the model chosen for the unified health care financing system, these modifications could be significant and costly. For example, if multiple coverage programs are maintained under the system (e.g., Apple Health, QHPs, PEBB, and SEBB), a unified eligibility platform would need to reconcile multiple sets of eligibility criteria to determine the most appropriate program and, if applicable, relevant subsidies.

Modifications may be more straightforward if all participants have the same eligibility criteria and receive the same benefits under the universal health care system. For example, under Model A, eligibility may presumably be determined based on state residency, with subsidy eligibility determined based on income. This is similar to the eligibility criteria employed by the Exchange in determining eligibility for QHPs and subsidies. Clear criteria and required documentation would need to be identified in the program design and operational implementation phases.

The current eligibility systems would need to be expanded to determine eligibility for the entire population, which will require planning and funding, including some lead time prior to enrollment for system builds and testing. Readiness for eligibility processes will require coordination with Medicare (if Medicare enrollees can be included in the universal health care system). It will also be important to consult with tribal leaders regarding the relationship between the tribal health system and the unified financing system. Finally, additional resources would be needed for consumer outreach, education, and support during the eligibility application process.

Enrollment Readiness = Yellow

Once an individual or family is determined to be eligible for coverage under the new system, enrollment processes will be needed to place eligible individuals and families into coverage. The methods for enrollment and the complexity of the processes depend on the design of the universal system.

Currently, Washingtonians often have a choice among health carriers or health plans for their coverage. For public programs and most employer-based coverage, selections are made after reviewing the available options. Occasionally, people are assigned or auto-enrolled into a plan.³ Under Model A,

³ This would occur in Apple Health when a person does not make a plan selection and employer-sponsored coverage when only one plan is offered.

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enrollment could be relatively streamlined since everyone who is eligible would be enrolled in the state-administered program. While there may be various approaches to Model B, the enrollment processes currently utilized for Apple Health and the Exchange could be expanded upon to enroll the entire eligible population which may streamline enrollment.

Core Component 2: Benefits and Services = Yellow

Benefits and services will be a critical component of the universal health care system. As discussed in *Section 3* of this report, two of the potential coverage models (A or B) will require the state to develop, administer, and assess the performance of covered benefits and services. The UHC Work Group recommended, as a starting point, that the ACA-mandated Essential Health Benefits (EHB) would be provided, with the possibility of additional benefits, including vision and hearing. Among the outstanding considerations is whether other benefits not included in EHB, such as long-term care and disability services, will be provided by the universal health care system.

Through its existing coverage programs, Washington manages distinct benefits and services packages for Apple Health, PEBB, SEBB, and Cascade Care. As a result, Washington is well positioned to engage stakeholders, develop options, and make decisions regarding the standard benefits and services covered under the unified financing system. However, in many cases, programs including Apple Health, PEBB, SEBB, and other programs offer benefits that are not included in the EHB. The ACA-mandated EHB may be a helpful starting point for a standard benefit package, though the difference in benefits between what currently exists under various programs will need to be reconciled.

Once the benefit package is developed, the benefits must be administered. Depending on the coverage model, the state could administer benefits directly, or through third-party administrators, or through contracted health plans. Currently, benefits under Apple Health, PEBB, SEBB, and Cascade Care are administered using a combination of the three methods. More investigation is needed to understand the scalability of each program's benefit administration capabilities. Further, to support the affordability, quality, and equity goals of the unified financing system, administrators must accommodate any complex eligibility rules and value-based payment models as they currently exist and in the future. As such, Washington's readiness to administer benefits is critically tied to decisions regarding the benefits package as well as provider reimbursement, consumer cost-sharing, and financing.

It will also be necessary to assess the performance of the standard benefits and services in advancing affordability, quality, and equity goals. Currently, several coverage programs and agency-housed programs such as the Health Care Cost Transparency Board (HCCTB) and the All-Payer Claims Database (APCD) collect and analyze claims, encounter data, and other data. However, more assessment will be needed to determine readiness to support value-based benefit design within the universal health care system. This will be critical in ensuring that incentives are provided and that financial barriers are removed for greater utilization of high value services such as recommended preventive care.

Core Component 3: Financing = Red

Health care is currently financed through several different sources and in a variety of ways. Financing sources include direct payments by the federal and state governments for public programs, subsidies for the purchase of health coverage on the Exchange, premiums paid by employers and consumers, and out-of-pocket costs paid by consumers such as copays and coinsurance. The complexity and cost of the

current system make financing one of the most challenging aspects of establishing a universal health care system. Consolidating and simplifying this system is one of the outcomes that supports establishment of a universal health care system. Another likely outcome is reduced financial burden on consumers and increased access to care.

Under either Model A or B, numerous, complex decisions will determine how the system would be financed, as described more fully in *Section 3* of this report. Perhaps the most challenging and time-consuming task will be to obtain the federal waivers needed to utilize federal funds to help finance the unified financing system. This work cannot begin until the universal health care system design has been further explored. Significant time will then be needed for waiver drafting and the federal approval process. The federal government may not agree to approve the entire request, which would require alternative sources of funding to be identified. In addition, further exploration is needed to determine how to raise state funds to replace the amounts currently paid by businesses and families in the form of premiums and copays. These decisions are likely to be controversial, and this work will be more efficiently conducted once the design of the universal health care system is further developed.

Core Component 4: Provider Reimbursement and Participation = Readiness Assessment Dependent on Model Variables

Provider reimbursement is a critical element of any health care system. It must ensure financial solvency for providers, advance equitable access to affordable health care services, and drive value-based health care delivery. Implementation requires both the operational functions to administer payment and the analytic functions to assess provider performance against quality, cost, and equity targets. Washington's readiness to implement a provider reimbursement model in a unified financing system is greatly dependent on the overall universal health care system, and the methods of provider reimbursement selected for the model.

Depending on the provider reimbursement methods, the assessment reveals varying levels of readiness (green, yellow, or red). For example, if Washington chose to implement a direct provider employment model such as the National Health Service in the United Kingdom or the Veterans' Health Administration in the U.S., its readiness assessment would be red. Washington has little experience with such a system and the challenges of contracting directly with all the health care providers in the state would be considerably more involved.

However, Washington's readiness to reimburse providers entirely on a fee-for-service (FFS) basis with a uniform rate structure, as suggested in the UHC Work Group Report, is assessed as green. HCA has experience in paying claims in FFS Medicaid. Until 2011, HCA also contracted directly with providers to establish the Uniform Medical Plan network for PEBB and SEBB. While the scale and scope of these capabilities would need to be greatly expanded, Washington has demonstrated its capacity for provider contracting and FFS claims payment. Moving to an entirely FFS method of paying providers may be inconsistent with the many efforts Washington, along with other states and the federal government, has made to reduce costs and improve the quality of care using managed, coordinated care models. This may mean moving away from use of value-based provider reimbursement, which may disrupt advances made in quality, equity, and cost containment under value-based provider reimbursement.

Washington's readiness to transition to a system that makes greater use of alternative payment models and provides incentives for higher value care is assessed as yellow. While Washington does not have a

history of administering global budgets, it does contract with managed care organizations and third-party administrators to provide these functions for specific programs. This is similar to what could be done under a variation of Model B. However, the extent to which these capabilities can be scaled to support a universal system requires further assessment and is likely dependent on the specific reimbursement models selected for the financing system. For example, while a third-party administrator under Model B may be able to administer quality bonuses, capitated payments, or value-based contracts in the commercial insurance market, the third-party administrator may not be able to easily implement a global budget for an attributed population.

In addition to these analytic and operational considerations, provider reimbursement under Model A or B would require an agency to have authority to set and pay provider rates. While that authority exists today in limited programmatic contexts (e.g., Apple Health), a unified financing system would require significant expansions of authority for a governing agency to support provider reimbursement models.

Core Component 5: Cost Containment Elements = Readiness Assessment Red or Yellow, Depending on Model Variables

Improved cost containment is one goal of a unified health care financing system. Washington's readiness to implement cost containment in a unified financing system is assessed as red for Model A and yellow for Model B. One of the more problematic features of the current health care system is that incentives for payers and providers are not aligned to control costs. Though changes have been made to improve health care financing and cost control, much of the system relies primarily on fee-for-service payments that focuses and pays based on volume rather than value. Further, due to the different delivery models and markets, the current health care system is fragmented making it difficult to apply cost containment measures at scale.

Many different efforts to contain costs are underway in Washington, as more fully described in *Section 1* of this report. Various entities are currently responsible for managing costs and coordinating care, with various state or federal agencies regulating their activities. For example, HCA oversees Apple Health managed care plans, OIC regulates commercial insurers, and the federal Department of Labor regulates self-funded employers. The state and federal governments have not directly engaged in managing costs and coordinating care to a large extent, with the Veterans' Health Administration being a notable exception.

Under Model A, Washington would need to develop new processes and obtain additional resources to carry out the functions of directly managing costs and coordinating care. The current efforts of cost and care management are tailored to the respective programs that provide health coverage and are not unified among the different entities implementing them. Under one version of Model B that uses carriers to provide health care insurance, the accountable agency administering the new system would need to align the contracted carriers' actions to provide consistent, effective cost containment measures to everyone covered by the system. This could include myriad uniform cost containment and care management approaches such as a common list of clinical guidelines and benefit exclusions, one standardized appeal process, and common prescription medication formularies.⁴

⁴ Many existing state initiatives would establish a foundation to support such approaches to better manage cost while improving quality as discussed in *Section 1*.

Reducing fraud, waste, and abuse is another strategy for cost containment that should be considered in the universal health care system.⁵ Currently, HCA employs strategies to reduce fraud, waste, and abuse in public health care programs. Further, as part of their regulatory and consumer protection mission, state agencies identify and prevent fraud, waste, and abuse in the provider and private payer markets. As the design of the universal health care system is developed, further assessment will be necessary to identify the readiness of these current agencies to support a fraud, waste, and abuse detection program, particularly if the financing system includes complex, value-based provider reimbursement models.

Core Component 6: Infrastructure = Readiness Assessment Red or Yellow, Depending on Model Variables

The capacity of the state's existing administrative infrastructure to scale and adapt to the new system is a key determinant of Washington's readiness to implement a unified financing system. The overall readiness of Washington's infrastructure supporting a universal health care system is assessed as red for Model A and yellow for Model B.

Technology and data platforms are some of the more important infrastructure considerations necessary to execute the universal health care system.⁶ In administering existing coverage programs, Washington utilizes multiple call center and data management platforms for assessing claims, eligibility, and enrollment. However, most of the platforms currently in use are not compatible with other systems, making program integration a challenge. Further, given that platforms serving different programs have been developed to widely varying requirements, existing systems may not be well suited to support the unified financing system. However, there may be eligibility and enrollment platforms, such as the Apple Health and HBE's eligibility platforms, that could be repurposed for eligibility determination with modifications. Or, if utilizing work hours is a key determinant of eligibility, the PEBB and SEBB eligibility platforms could be modified and repurposed. As key design elements of the universal health care system are developed, each of the IT systems utilized in Washington will need to be evaluated for appropriateness and scalability to support the model selected.

Human resources and staffing are also critical areas of infrastructure readiness. Certain functions needed to implement a universal health care system are currently being performed by the private sector. For example, health insurance carriers currently contract with providers who care for their members. Carriers also help to coordinate and manage care delivered by providers in the community who may not be part of the same health care system. Additionally, carriers perform utilization management to ensure that care is medically necessary and appropriate. Under Model A, additional state workers may be needed to perform these functions, or in the alternative, enter into contracts with private entities with state workers managing those contracts. While each agency has a complement of staff to support existing programs, significant planning efforts must be invested to assess needs pertaining to training, management transitions, and integration, particularly for Model A. For example, many of the programs operate call centers to support clients with eligibility determinations, enrollment, and other services. However, call center staff are typically highly trained and expert in the rules and

⁵ Efforts to reduce fraud, waste and abuse were previously discussed in *Section 3*.

⁶ Technology and data platforms were previously discussed in *Section 3*.

processes for one coverage program and may require additional training to support a unified financing system, even if many of the rules and processes are retained in the new model.

Another consideration for readiness is Washington's ability to support the transition for employees whose service may not be required if agencies and programs can be consolidated to support the unified financing system. Training programs can help transition these employees to new employment opportunities, possibly within the universal health care system. Further assessment will be needed to determine whether an existing employment program could fulfill this need.

Finally, assessing human resource needs may also identify needs for new personnel and skill sets that do not currently exist in the state's workforce. For example, provider rate setting in Washington has never been done comprehensively across all payers. Supporting that function under the unified financing system will require combining technical expertise from across all markets. Identifying these needs and developing training programs for employees in the current health care system wherever possible may help mitigate negative consequences of implementing a universal health care system, and ease employment concerns through the transition.

Core Component 7: Governance = Red

In this report, governance has been identified as a critical design element of the universal financing system. The primary consideration for establishing the governance structure is whether a single agency or multi-agency governance structure should be accountable for overseeing the operation of the universal financing system.

Currently, no single agency or entity performs all the functions necessary for operating a universal financing system or serves all populations and stakeholders that would be served by the system. Additionally, no agency or entity has the authority to operate, oversee, or regulate across the entire healthcare landscape. However, Washington does have a history of shared authorities and collaboration across agencies. For example, HCA, OIC, and WAHBE collaborate to implement Cascade Care as designated by the Legislature.

Once the accountable agency or agencies are decided, the governing entity is likely to need significant resources and expanded or new authority to oversee and operate the universal financing system. When this critical design element is established, a governance structure and needed resources will need to be reassessed.

Summary

The preliminary readiness assessment reveals several opportunities to build on existing functions, but also identifies some initial areas that will require greater resources and/or new authorities to be able to design and develop a universal health care system. It also helps to clarify a potential sequencing for how the Commission might approach the system design for these key elements according to those that are foundational, secondary, or tertiary as seen in Figure 1.

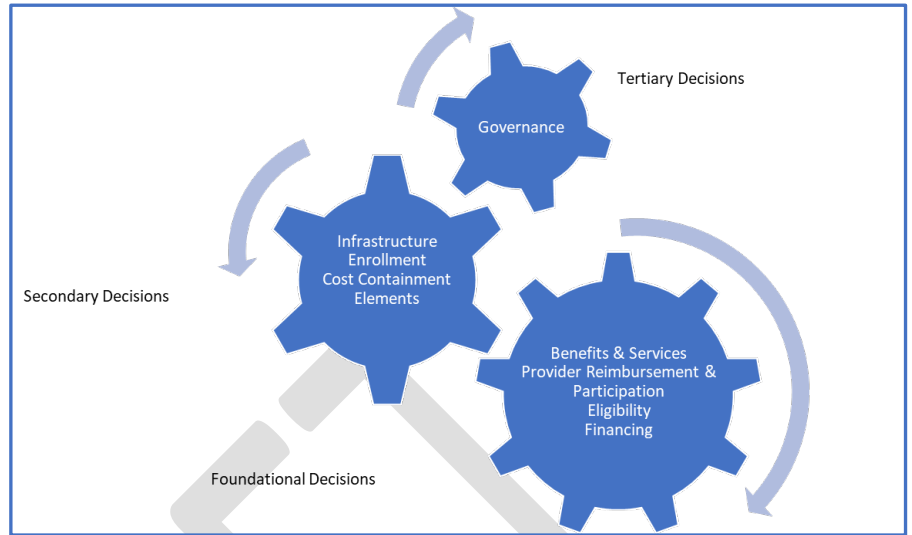


Figure 1: Potential Sequencing for Universal Health Care System Design

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