Washington State Health Care Authority

Universal Health Care Commission

April 11, 2023

Washington State Health Care Authority

Universal Health Care Commission
Meeting Materials

April 11, 2023
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting materials

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission
AGENDA

April 11, 2023
2:00 p.m. – 4:00 p.m.
Zoom Meeting

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

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome and call to order	1	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
2:05-2:10 (5 min)	Roll call	1	Mandy Weeks-Green, Manager Health Care Authority
2:10-2:15 (5 min)	Approval of Meeting Summary from 02/09/2023	2	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
2:15-2:20 (5 min)	FTAC updates	3	Pam MacEwan, FTAC Liaison
2:20-2:35 (15 min)	Public comment	4	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
2:35-2:45 (10 min)	Review of the request regarding the Washington Health Trust Bill (SB 5335, 2023)	5	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
2:45-3:45 (60 min)	Equity Presentation	6	Dr. Karen A. Johnson, Director Washington State Office of Equity
3:45-4:00 (15 min)	Continuing transitional solutions discussion ○ Update: FTAC's ideas for transitional solutions	7	Jon Kromm, Principal, Gary Cohen, Principal Health Management Associates
4:00	Adjournment		Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State

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

Tab 2

Universal Health Care Commission Meeting Summary

February 9, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

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

Members present

Vicki Lowe, chair
Bidisha Mandal
Dave Iseminger
Jane Beyer
Kristin Peterson
Mohamed Shindane
Nicole Gomez

Members absent

Senator Ann Rivers
Senator Emily Randall
Estell Williams
Joan Altman
Representative Joe Schmick
Karen Johnson
Representative Marcus Riccelli
Stella Vasquez

Call to order

Vicki Lowe, Commission Chair, called the meeting to order at 2:04 p.m.

Agenda items

Welcoming remarks

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

Meeting Summary review from the previous meeting

The Commission Members present voted by consensus to adopt the December 2022 Meeting Summary.

Finance Technical Advisory Committee (FTAC) updates

Pam MacEwan, FTAC Liaison, shared with the Commission the agenda, meeting summary, and updates from FTAC's January meeting.

Public comment

Chair Lowe called for comments from the public.

Mike Benefiel, Democratic Precinct Committee Officer (PCO), LD23, shared findings from the Commonwealth Fund's recent report and encouraged the Commission to recommend that the Senate Health Care Committee hold a public hearing on **SB 5335** regarding the Washington Health Trust (WHT).

Kathryn Lewandowsky, Whole Washington, suggested the Commission review Sec. 101 of SB 5335 (WHT) and urged the Commission to recommend that the Senate Health Care Committee hold a public hearing to discuss the bill further and address possible amendments.

Maureen Brinck-Lund thanked the Commission for their work and shared excitement for both Chair Lowe's presentation on the Indian Health Delivery System and further engagement with community members.

Pam Ketzner recognized the federal barriers to including the Medicare-eligible population in a state-based universal system, noting the WHT's plan to transition Medicare into the Trust (Sec. 113 of SB 5335), and urged the Commission to recommend that the Senate Health Care Committee hold a public hearing on the bill.

Paula Lavelle, Whole Washington, recognized the sacrifice of Indigenous peoples and noted that this and other guiding principles of the WHT are outlined in Sec. 1 of the bill.

Andre Stackhouse, Campaign Director, Whole Washington, gathered over 85,000 signatures to get WHT on the ballot to lead the country in establishing health care as a human right for all residents.

Marcia Steadman, Health Care for All Washington, shared that advocates are working with the state Legislature to obtain additional funding to support monthly meetings for the Commission and FTAC, and an FTAC workgroup structure similar to Oregon's Task Force on Universal Health Care.

Cris Currie created a **document** comparing the Washington Health Securities Trust bill with SB 5335 (WHT) as a tool for the Commission. The revised Washington Health Securities Trust bill can be found **here**.

Sarah Weinberg, retired pediatrician, urged that the universal system have universal eligibility – everybody in, nobody out. If initially, parts of Washington's population retain other sources of health coverage, the universal plan can automatically be secondary to that coverage, leaving no one uninsured or underinsured.

Presentation: Lessons for universal health care from the Indian Health Delivery System

Vicki Lowe, Commission Chair, Executive Director, American Indian Health Commission for WA State

The goals of the presentation were as follows: to understand the differences between 1) systems of care and systems of coverage, and 2) direct care and purchase and referred care; to learn about the Jamestown S'Klallam Tribal Health Benefit Program. Chair Lowe noted that this presentation is high-level and may help the Commission think outside of the box of how health care is being done currently.

Indian Health Services (IHS) is a system of care that includes three facility types: IHS, Tribal facilities, and Urban Indian Health Programs. Providers and facilities are funded on an annual basis with funding based and agreed upon services and user population. Like the Veteran's Administration (VA), IHS is a system of care with coverage based on geography. Facility/ provider payments are based on a per person/per year calculation. IHS funding

occurs after services are received. Prior authorizations are needed for referred services which are based on need and availability of funding. Conversely, a system of coverage is based on finding a contracted provider. Here, there are two types of payments: fee-for-service ((FFS) payment *after* providing services), and per member/per month ((PMPM) payments *prior* to providing services). Washington's current health care system focuses on coverage, but the universal system should be more so a system of care. IHS has been chronically underfunded since inception. Purchased and referred care is defined as any care received outside of IHS. Per federal law, hospitals and specialty providers are paid at Medicare rates, or "Medicare Like Rates." Funding for this and other IHS care is appropriated. The Jamestown Tribal Health Benefits Program (Program) is an insurance-based program. Coverage is based on all Tribal Citizens having the same level of coverage regardless of income or eligibility for insurance coverage. Under federal law, IHS programs are required to enroll eligible Tribal users in Medicare or Medicaid before the purchased and referred care dollars can be accessed. The Program wrapped around Medicare, Medicaid, private and employer-sponsored insurance (ESI) to bring each person to the same level of benefits. For example, the Program purchased supplemental benefits for Medicare-eligible individuals and reimbursed members for their Medicare Part B premiums. The Program achieved 100% coverage for Tribal members living in the service area.
Jane Beyer noted that Medicare rates also apply to Medicare Advantage plans.

Bidisha Mandal asked if eligibility was evaluated annually. Chair Lowe replied that members moving out of the Program's service area must notify the Program and Medicare and Medicaid eligible members must update their insurance information annually.

Chair Lowe urged the Commission to think about the level of benefit to provide under the universal system and then decide how to wrap around benefits so that everyone has the same benefits and access to health care. The Jamestown Program could serve as a feasible transition to universal health care. Dave Iseminger asked how often the floor of the Program's benefits was exceeded by another source of coverage, e.g., ESI coverage being richer than the Program's. Chair Lowe clarified that the Program evened out with other sources of coverage in around 2005. Jane Beyer remarked that the Program used braided funding and maximized and combined into one pot revenue from multiple funding sources (IHS, Medicare, Medicaid, ESI) to determine how generous a benefits package could be. Chair Lowe stated that the base fund for the Program was from IHS (funded at 32 cents for every dollar needed) and third-party payments made the Program viable. Dave Iseminger asked if federal policies, e.g., Medicare Like Rates, were connected to Tribes' treaty rights. Chair Lowe confirmed that treaty rights and other advocacy work by Tribal leaders at the federal level helped to secure those rates.

Presentation: Transitional solutions • FTAC guidelines • Goals and measuring success

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

Jon Kromm, HMA, reviewed the Commission's broad priorities for transitional solutions as determined in 2022. In January 2023, Commission Members provided additional transitional solutions to refine and build upon the 2022 recommendations, including: develop standard benefits across payers; increase the role of consumer/patient engagement; streamline eligibility and enrollment processes; and address workforce shortages to help address system costs. HMA proposed that staff produce a presentation detailing these transitional solutions for the Commission's consideration at their April meeting. Staff would prioritize based on which transitional solutions are high-impact and which are the most feasible for the state to implement. Mohamed Shidane asked whether FTAC's additional suggestions for transitional solutions would come to the Commission for review, and it was decided that that would be the process.

Commission Members voted unanimously to survey FTAC on additional transitional solutions. Commission Members also voted unanimously to adopt the FTAC Charter.

Gary Cohen, HMA, asked what guidance the Commission would like to provide to FTAC for evaluating Medicare eligibility for the new system. Oregon and California examined the Medicare eligibility barriers in a uniform financing system and agree that there is no precedent for a federal waiver that gives a state control over Medicare funds and program administration. This is not to say that a waiver shouldn't be examined, recommended, or pursued. Any pursuit of a waiver should be done soon, as the current administration may be receptive to such a proposal.

Jane Beyer recommended that FTAC look at federal restrictions on a person's ability to shift out of Medicare Advantage (MA) and into Medicare FFS. Additionally, is it better for the state to purchase a Medicare supplemental insurance plan, or to treat the new system like a self-funded plan that wraps around traditional Medicare FFS? Chair Lowe asked what could be done for Medicare beneficiaries living in the state part-time? Dave Iseminger stressed the importance of having coverage for non-Medicare covered services in the retiree community. Can FTAC answer FTAC which, if any, of the Medicare supplemental plans could serve as a starting point, or whether the new system should wrap around Medicare FFS? Dave Iseminger agreed that the federal barriers for shifting out of MA (does not apply for employer-sponsored programs) should be examined by FTAC. HMA added that FTAC could also examine which of the federal MA restrictions are statutory versus regulatory. Dave Iseminger cautioned against taking the path of making the state an MA plan but is interested in FTAC providing any distinctions or flexibilities for the challenges associated with commercial MA. Chair Lowe noted that though the Jamestown S'Klallam program uses funding from multiple sources (IHS, Medicare, Medicaid, etc.), patients view their coverage and experience their care as being under the Tribal program. This should be the same for Medicare beneficiaries, etc. under the new system. Jane Beyer proposed asking FTAC about benefits to having capitated payment per Medicare-eligible persons, versus the state managing wraparound FFS payments.

Pam MacEwan, FTAC Liaison, noted that Medicare is funded via taxes over a person's work life, premiums (Part B once eligible for Medicare), and additional taxes (for certain income levels). Was there consideration of how these might intersect with plans to pull Medicare into the new system? HMA noted that this has not been discussed. Chair Lowe pondered whether the state should purchase for Medicare beneficiaries a Part D plan or create a prescription drug plan. Will this be credible coverage for individuals living in the state part-time? Jane Beyer added potentially exploiting the state's existing relationship with the pharmacy benefits manager (PBM) through PEBB/SEBB. Could FTAC examine the benefits of adding an additional 800,000 people (Medicare beneficiaries) to the state's purchasing power for prescription drugs? Dave Iseminger agreed, noting that Washington and other states leverage this purchasing power through ArrayRx (formerly Northwest Prescription Drug Consortium). Pam MacEwan, FTAC Liaison, encouraged the Commission to provide FTAC specific direction.

Jon Kromm, HMA, proposed that the Commission develop a framework for evaluating transitional solutions and design decisions. Commission agreed on the following broad goals for the universal system: equity; access; affordability; transparency; patient-centeredness; and quality. When asked if goals were missing, Nicole Gomez added ease of use. Mohamed Shidane asked whether the goal of "affordability" referred to consumers or the state. HMA clarified that "affordability" pertained to both. Kristin Peterson added sustainability as a goal, both in terms of consumer affordability and the financing model. The Commission was asked how the list of goals should be prioritized and Chair Lowe suggested moving to the top patient-centeredness and access. Jane Beyer acknowledged there may be conflicting goals, e.g., quality and equity. For example, the new system should cover services that work (based on evidence), but such evidence is based on white, middle-class individuals. When

discussing care that is high-quality or "evidence-based," immediately there are equity implications. Dave Iseminger recommended listing goals in alphabetical order, and Nicole Gomez recommended organizing the goals in a circle (visually).

The Commission voted unanimously for staff to develop a framework for evaluation of design decisions and transitional solutions.

Adjournment

Meeting adjourned at 5:00 p.m.

Next meeting

April 11, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Tab 3

Washington State Health Care Authority

Finance Technical Advisory Committee (FTAC) Meeting Summary

March 9, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
3:00 p.m. – 5:00 p.m.

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

Members present

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

Members absent

Esther Lucero
Ian Doyle

Call to order

called the meeting to order at 3:02 p.m.

Agenda items

Welcoming remarks

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

Meeting Summary review from the previous meeting

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

Public comment

Mike Benefiel, Democratic PCO, LD23, remarked that the Washington Health Trust bill has been introduced in the last three legislative sessions but has been ignored in favor of creating the Commission, which has no published mission or timeline for goals leading to legislation.

Kathryn Lewandowsky, RN, Whole Washington, shared a letter from a colleague whose husband suffered

multiple strokes and open-heart surgery over the last 17 years and requires continuous care. Unable to afford health insurance and medical expenses on one salary, her family lost their home and was forced to file bankruptcy.

Ronnie Shure, Health Care for All Washington, commented that since ways for Medicare to be included in a state-based universal system are uncertain, FTAC should study Medicare from the perspective of a model.

Roger Collier noted the following barriers to including Medicare in the universal system: political will for moving 1M voting seniors from a program they're satisfied with to one that is untested; adding wraparound benefits may be feasible for traditional Medicare enrollees, but not for Medicare Advantage (MA) enrollees (half of Washington's Medicare enrollees) due to federal law; the universal system functioning like an MA plan may encounter fewer obstacles but there will still be opposition from insurers.

Jen Nye, Democratic PCO, LD34, proposed that getting more people insured through publicly funded programs will take the state to universal health care, e.g., a legitimate public option, where enrollees could select coverage on the Exchange, employers could offer it to employees, and the system could eventually fully transition.

Presentation: FTAC ideas for transitional solutions

Liz Arjun and Jon Kromm, Health Management Associates (HMA)

Between their January and March meetings, FTAC Members completed a survey aimed at gathering ideas for transitional solutions to be considered by the Commission. FTAC's survey responses yielded approximately30 ideas. HMA led the committee in a matrix exercise to categorize ideas based on impact and resource intensiveness. Members were asked to discuss and select in which quadrants each idea fit: high impact/less resource intensive; high impact/more resource intensive; low impact/less resource intensive; and low impact/more resource intensive. Discussion began with the ideas proposed by multiple FTAC Members.

The first proposed idea was regulation of hospital global budgets. FTAC Member Roger Gantz asked how global budget models like Maryland's would integrate with a managed care delivery system. FTAC Member Bob Murray replied that a global budget system would be highly complementary with managed care approaches to help control utilization, though it would supplant managed care organizations' (MCOs) ability to set prices, which is not a bad thing. Global budgets create larger purchasing power to achieve cost containment. Maryland's system doesn't need to be duplicated. Global budgets were marked high impact/more resource intensive. FTAC Member Eddy Rauser asked how these fit into managed care capitated amounts. Global budgets govern the amount hospitals charge patients (also applied to managed care) and control the rate of growth of payments over time. The state would set hospitals' rates and pay MCOs a per-member per-month (PMPM) administrative amount. There are major political challenges with this model due to involvement of government regulation. The Centers for Medicare and Medicaid Services (CMS) is proposing a model for global budgets.

The next idea was out-of-network (OON) provider reimbursement caps, which can positively impact insurers' leverage to negotiate lower in-network rates. This requires state oversight to ensure savings pass through to consumers. OON price caps were marked high impact/less resource intensive. Legislation would be required because it would apply to all commercial insurers. OON price caps could range from 170 to200 percent of Medicare, varying by region. The state would need to examine the current level and structure of payment and variances by region. Oregon caps in-network and OON hospital services for state and public employees. FTAC Member Christine Eibner encouraged further study on these ideas before finalizing the matrix. FTAC Member David DiGiuseppe agreed that any of the transitional solutions being proposed would require further study.

The next idea was consolidating state purchasing. Roger Gantz noted that the state controls over 30 percent of the insured market. PEBB and SEBB benefits are not purchased together currently but could be. This idea was marked high impact/more resource intensive. FTAC Member Kai Yeung noted achieving larger goals could be done in phases, e.g., the first step to standardizing benefit design could be standardized measurement of cost and quality.

The next idea was auto-enrollment for Medicaid enrollees to no-premium Exchange plans. Pam MacEwan remarked that this would be less resource intensive and high impact, particularly for uninsured Washingtonians and for individuals whose Medicaid eligibility fluctuates, and Roger Gantz agreed. Eddy Rauser agreed, noting that as the public health emergency unwinds, now is an ideal time to discuss this idea.

Presentation: Lessons for universal health care from the Indian Health Delivery System

Vicki Lowe, Commission Chair, Executive Director, American Indian Health Commission for WA State

The goals of the presentation were to understand the differences between 1) systems of care and systems of coverage, and 2) direct care and purchase and referred care, and to learn about the Jamestown S'Klallam Tribal Health Benefit Program. This presentation is high-level and describes an existing universal health care system.

Indian Health Services (IHS) is a system of care that includes three facility types: IHS, Tribal facilities, and Urban Indian Health Programs. Providers and facilities are funded on an annual basis with funding based and agreed upon services and user population. IHS is a system of care with coverage based on geography. Facility/ provider payments are based on a per person/per year calculation. IHS funding occurs after services are received. Conversely, a system of coverage is based on finding a contracted provider. Here, there are two types of payments: fee-for-service ((FFS) payment after providing services), and PMPM (payment prior to providing services). IHS has been chronically underfunded since its inception. Purchased and referred care is any care received outside of IHS. Per federal law, hospitals and specialty providers are paid at Medicare rates, or "Medicare Like Rates." Funding for this and other IHS care is appropriated.

The Jamestown Tribal Health Benefits Program (Program) is an insurance-based program. Coverage is based on all Tribal Citizens having the same level of coverage regardless of income or coverage eligibility. Under federal law, IHS programs are required to enroll eligible Tribal users in Medicare or Medicaid before the purchased and referred care dollars can be accessed. The Program wrapped around Medicare, Medicaid, private and employer-sponsored insurance (ESI) to deliver the same level of benefits to each person. For example, the Program purchased supplemental benefits for Medicare-eligible individuals and reimbursed members for their Medicare Part B premiums. The Program achieved 100 percent coverage for Tribal members living in the service area.

Member Roger Gantz asked if the Indian Self-Determination and Education Act of 1975 created structures for tribes to operate their own programs. It was clarified that was the case. Roger Gantz noted the major implications for tribes of Washington's universal system and asked for Chair Lowe's guidance. Chair Lowe agreed to share with Members the American Indian Health Commission's draft language for a universal health care bill (shared at the federal level). Kai Yeung asked how this system of care impacts care quality. Native Americans have provided whole-person care since time immemorial and with chronic underfunding, tribes are accustomed to finding any available resources. There is a high level of attention to quality and innovation since providers are less focused on varying reimbursement from different coverage sources.

Presentation: Options to include Medicare enrollees in a state-based universal system

Gary Cohen, HMA

Medicare is a federal program and there is no precedent for a waiver that gives a state control over Medicare funds and program administration. Two pathways to include Medicare in Washington's universal system were identified by the Commission for FTAC's guidance: 1) a state-run MA plan to cover Medicare non-covered benefits, and 2) other options to "wrap around" Medicare benefits.

In the MA option, the state could administer an MA plan that would be available to Washington's Medicare enrollees. Roger Gantz noted that Oregon and California's universal health care proposals embraced Medicare as part of a unified purchasing system, however there was no clear path forward. It would be helpful to have trend analyses, e.g., average per capita growth rates of managed care plans in Washington. Christine Eibner remarked that CMS's payment structure is based on the Medicare FFS benchmark. If FFS doesn't exist, how would payment work? More analysis is required. The MA option would not be mandatory for Medicare enrollees - it would be an option that would need to be attractive to appeal to more people. David DiGiuseppe pondered a situation where the state was precluded from creating an MA plan and was in a competitive environment. It would become increasingly difficult with the new MA star rating and risk adjustment rules. More analysis is required. Roger Gantz posited that the state could build on the UMP retiree plan where the state contracts with Regence, but the state carries the risk. Bob Murray wondered if MA plans could be used to expand coverage to the commercial population by utilizing MA plans' existing infrastructure and arming them with additional capabilities, e.g., OON price caps.

For Medicare wraparound options, Medicare enrollees would receive the same benefits covered under the universal system, regardless of the funding source. Roger Gantz noted that state Medicaid programs do this today for low-income Medicare beneficiaries ("dual-eligibles"). A vision for benefit design would be helpful for this discussion. Roger Gantz suggested not including long-term care in wraparound benefits. There are equity implications of taking away coverage for a service that has been covered previously. David DiGuiseppe suggested an exercise making a theoretical supplement look-alike plan to identify costs. Pam MacEwan noted that the Health Services Act (1993) did not include long-term care, Medicare, or the Aged, Blind, or Disabled program due to high costs. The Commission has not yet decided how or whether to include Medicare in the universal health care system and FTAC's guidance will be key to informing this decision. Pam MacEwan remarked that the pursuit of a waiver is a question of resources, appetite, and feasibility. Currently, the likelihood of succeeding is extremely low. However, there are equity implications of not including Medicare, e.g., enrollees of the universal system potentially having richer benefits than Medicare enrollees. FTAC should provide guidance to the Commission on how to best resolve this, e.g., wraparound benefits. HMA noted the benefit to Washington of demonstrating improved equity, quality and access and reduced costs through consolidating state-run programs, where Congress and/or CMS could be more receptive to granting the state authority of Medicare funding and program administration. Roger Gantz encouraged the Commission to work with Oregon's Universal Health Care Governance Board (once established), so that two states can make the case to CMS and Congress for Medicare authority for state-based universal health care. Pam MacEwan remarked that FTAC's preference not to pursue a waiver at this time will be shared with the Commission, however, the discussion will be revisited at the next FTAC meeting.

Adjournment

Meeting adjourned at 5:04 p.m.

Next meeting

May 11, 2023
Meeting to be held on Zoom
3:00 p.m. – 5:00 p.m.

Tab 4

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission
Written Comments
Received From January 27th

Written Comments Submitted by Email

Additional Comments Received at the February Commission Meeting

- The Zoom video recording is available upon request at HCAUniversalHCC@hca.wa.gov.

Public comments received since (January 27th) through the deadline for comments for the April meeting (March 28th)

Submitted by Paula Lavalle

02/09/2023

Thank you for allowing me to speak today. I am sending in a written version of the comments I gave today:

We acknowledge the original inhabitants of this place, the Ssduhubr (sdo-ho-bsh) people and their successors the Tulalip Tribes, who since time immemorial have hunted, fished, gathered on, and taken care of these lands. We respect their sovereignty, their right to self-determination, and we honor their sacred spiritual connection with the land and water. This land was ceded to the U.S. government under the threat of violence to the Snohomish people. The U.S. has never fully upheld the guarantees it made in the treaty. We recognize the sacrifice made by indigenous people that allows us to live in these beautiful lands.

During and since the writing of the Washington Health trust protections in section 1, it is these words that continue to drive us. "With the intent to start healing the wounds of generations of inequality and to ensure a future where health care is recognized as a basic right afforded to each resident, the people of the state of Washington declare their intention to create a single, primary nonprofit health financing entity called the Washington health trust……that guarantees all residents coverage of a comprehensive set of essential health benefits. "

And by that, we meant "All residents of Washington state"!

Thank you again,
Paula Lavalle

Submitted by Pam Ketzner

02/09/2023

Thank you for the opportunity to speak at the Feb. 9 meeting

Here is my full comment

Appreciated the time to speak

Pam Ketzner MN, RN

Thank You,

How do we transition Medicare into a single payer plan like the Washington Health Trust?
How do we best confront the issue of Medicare enrollees and are we able to roll them into something like the WHT? Do we need to roll them into the WHT? We all know that this is a

complicated issue and Medicare is a federally managed program. So, a lot of thought has gone into addressing the issue of Medicare.

The first thing people need to understand is that, although the most cost effective method of moving to a universal, single payer, comprehensive and truly affordable healthcare plan would be for it to happen at the federal level. But we have to be honest with ourselves. The Feds aren't going to ride in on magnificent steeds to save us all. We're sort of on our own. That said, we've got each other and together we're a pretty smart bunch.

The second thing is that we can't get hung up on demanding that Option A starts as a single payer plan even though we can agree that would be ideal. The WHT has a reasonable transition plan, including transitioning Medicare into the trust. The instructions for how the trust integrates federal programs can be found in Section 113 which is too long for 90 seconds. So, briefly….

1. Initially the trust
2. acts as a secondary Medigap plan for Medicare enrollees. The most affordable on the market.
2. Then, the Healthcare

Authority applies to become a Medicare Advantage plan available on the Washington Health Benefit Exchange. This allows Medicare funds to roll directly into the trust for those who voluntarily enroll.

2. Next the Healthcare
3. Authority and the Governor apply for a Medicare waiver and once that is achieved, then all Medicare recipients residing in Wasington would be rolled into the trust and receive the same benefits of no copays, no deductibles, no networks, with full coverage

4. for vision, dental and hearing. The same benefits as all other residents of Washington and the trust would manage all the healthcare dollars for our state's seniors.
5.

And what if step 3 is not achieved? Well, we just stay at step 2, and if that is delayed, we just stay at step 1.
But really, who would want to deny the savings and benefits that the WHT offers to our seniors?

Therefore, I feel that this commission should recommend to the Senate Healthcare committee to have a hearing on SB 5335 in order to have an appropriate discussion and possible amendments to clarify and improve the language of the Washington Health trust.

Thank you for allowing me to speak today.

Submitted by Cris Currie

02/09/2023

I'm Cris Currie, retired RN from Spokane.

I would just like to let you know that I have put together a document that compares the Washington Health Securities Trust bill with Whole Washington's current SB 5335. I hope that it will be a useful tool as you examine these proposals and put together your own UHC bill. It is

available on the Health Care for All website under General Resources at https://www.healthcareforallwa.org/important_resources_papers. Also now available at the same place is a newly revised version of HCFA's Washington Health Securities Trust bill, last introduced as HB 1104. Thank you.

Submitted by Kathryn Lewandowsky

02/12/2023

Thank you members of the UHC. My name is Kathryn Lewandowsky. I am a Registered Nurse working here in Washington state for 37 years. In my career I have witnessed how our current healthcare industry, from our insurance companies to hospitals and even how our state government has preyed upon our state's residents. This is why I am so committed to fixing the harm that my parents and my generation has inflicted on each other and on our children.

It has come to my attention that many of the Universal Healthcare Commission members may not know what the Washington Health Trust is. You need to have an understanding of the trust and what it does.

Although the introduction to the act pretty much defines it. A better description of what the act is and what it intends to accomplish can be found in Section 101. The WASHINGTON HEALTH TRUST PROTECTIONS. which says….

"During this time of deep racial and socioeconomic inequity, Washingtonians have watched as loved ones and neighbors slipped through the widening gaps in our healthcare system. According to the Washington state department of health, the COVID-19 pandemic has worsened these structural disparities, showing in their recent COVID-19 morbidity report that the death and burden of this pandemic has disproportionately affected those already marginalized and underserved communities. With the intent to start healing the wounds of generations of inequality and to ensure a future where healthcare is recognized as a basic right afforded to each resident, the people of the state of Washington declare their intention to create a single, primary nonprofit health financing entity called the Washington health trust. The trust will simplify health care financing, eliminate administrative waste, respond to the health needs of each regional health district, and guarantee all residents coverage of a comprehensive set of essential health benefits without the burden of premiums, deductibles, copayments, or medical bills."

Therefore I feel that this commission should recommend to the Senate Healthcare committee to have a hearing on SB 5335 in order to have an appropriate discussion and possible amendments to clarify and improve the language of the Washington Health Trust. This is the third legislative session that it has been introduced into our state Senate and it continues to not receive a hearing. Even after us suffering through a global pandemic. It is no longer acceptable. Thank you for the service you provide to the Commission.

Kathryn Lewandowsky, BSN, RN

Whole Washington- Board Vice-Chair

One Payer States- Treasurer

www.Kathryn4LD39.com

Together we can all have healthcare free at the point of service; that is comprehensive with no copays or deductibles and that puts billions of dollars of savings into the pockets of regular people just like you and me!. Healthcare that will take care of all of our people from Cradle to Grave! History is clear that our elected officials will never do this for us. We must do it for the people that we love. Please go to WholeWashington.org and donate today! It will take all of us demanding these basic human rights from the global elite! Together we can do this!

https://secure.actblue.com/donate/whole-washington-1

"Never believe that a few caring people can't change the world, For indeed that's all who ever have" Margaret Mead

Submitted by Kathryn Lewandowsky

02/12/2023

During the meeting an attendee referenced this section in the language of SB5335, “With the intent to start healing the wounds of generations of inequality and to ensure a future where health care is recognized as a basic right afforded to each resident, the people of the state of Washington declare their intention to create a single, primary nonprofit health financing entity called the Washington health trust……that guarantees all residents coverage of a comprehensive set of essential health benefits. “

These words reminded me of the reality that those wounds have been born mostly by our residents of color but never more so than by our tribal nations whose dedication to the care and healing of this land and with their undying spirit we honor and validate today and every day. Atoning for the struggles forced upon their people was in our hearts as we revised and improved the WHT during our application for Initiative 1471.

And so we tried to make sure that their tribal sovereignty was honored and also tried to honor the treaties between their tribes and the US Government. It is wrong that our federal government does not provide the level of healthcare to our Native Americans that they deserve as a basic human right and that they are owed by the US Government. But we as residents of Washington state don’t have to settle for that.

These sections state:

Section 101 (9) Nothing in this chapter is intended to interfere with tribal sovereignty over any federal or state funding set aside for tribal health or Indian health services,

Section 107 (1) (m) (the board is responsible to) Implement policies to ensure that all Washingtonians receive culturally, linguistically, and structurally competent care and address nonfinancial barriers to health care access including developing specific goals and plans and identifying and addressing the needs of vulnerable populations that are most susceptible to health care disparities, particularly targeting disease prevention and health promotion and medical, mental/behavioral health, and public health issues that disproportionately affect the diverse populations where disparities are known to exist,

in order to ensure equitable, appropriate, effective, safe, and high quality care for all, with no gaps in services based on any medically irrelevant factor;

Section 109 (3) Any qualified provider operating as a public hospital or health care facility or public or private nonprofit 501(c) organization with three or more individual practitioners coordinating to deliver essential health benefits may elect to participate as a community health provider. (We intentionally reduced this number in order to make it more inclusive of smaller Tribal health clinics.)

Section 109 (4) The board, in coordination with the health care authority, shall annually negotiate with each community health provider a prospective global budget for operational and other costs to be covered by the trust.

But the language that some of us really wanted to add here in I-1471 and SB5335 was language that the trust would make our tribal nations whole and cover all unreimbursed medical expenses by the IHS. Others felt that language was not necessary. That the current language is enough to guarantee their equal treatment under the law and as our state's first residents. I sort of feel that it still is in order to codify the true intent of the writers of this bill.

I personally feel that it is horrible that our tribal nations are having to purchase for-profit healthcare policies to supplement what our Federal Government won't cover! Because we know full well what a sham for-profit healthcare is and how far more cost effective the WHT would be.

Therefore, I feel that this commission should recommend to the Senate Healthcare committee to have a hearing on SB 5335 in order to have an appropriate discussion and possible amendments to clarify and improve the language of the Washington Health Trust. Thank you for your commitment to this Commission and to our Washington people.

Kathryn Lewandowsky, BSN, RN

Whole Washington- Board Vice-Chair

One Payer States- Treasurer

www.Kathryn4LD39.com

Submitted by Mike Benefiel

03/08/2023

Commission,

The current state of healthcare in WA is horrendous and it's getting worse. Instead of attacking the obvious problem of gross inefficiencies and exorbitant profits of the insurance corporation, the legislature has spent millions of dollars on studies, work groups, commissions and band aid bills that are expensive and only add to the inefficiencies of the current system. While many in WA continue to needlessly suffer due to poor healthcare coverage, the insurances corporations continue to flourish and to reap their immoral profits.

Sen Hasegawa has introduced a bill, for the last 3 sessions that would have provided every resident in the state with essentially free healthcare, but the legislature has stonewalled this legislation.

One might conclude that legislature's healthcare committee members, accepting tens to hundreds of thousands of dollars from the insurance lobby constitutes a major conflict of interest.

How do we rationalize that it's moral to allow insurance corporations to override the treatment choices of doctors based solely on their greedy profit motive? How do we rationalize that corporate profits and campaign contributions are more important that the lives of our loved one?

Senate Bill SJB 8006 will require WA state to request from the Pres Biden administration, waivers for federal healthcare programs in order to allow WA to implement a single-payer healthcare system.

This legislation very clearly outlines the existing problems with our system including the recognition that the basic problem is that the inefficiencies and exorbitant profits of the insurers drive up costs to the point that over half a million WA residents can not afford the policies in spite of available tax payer subsidies.

The legislation goes on to state that a single-payer system would alleviate the current problems which agrees with the UHC Work Group's recommendation.

The UHC Commission needs to acknowledge the problems of the inefficiencies and exorbitant profits of insurers and proceed to establish the basis for a single-payer system as outlined in Sen Hasegawa's bill SB 5335. This bill will immediately provide a baseline for the development of a single-payer system. There is no excuse to continue to ignore this legislation.

The SB 5335, Washington Health Trust system does not require the federal waivers as it can be used as supplemental coverage for existing insurances, so SB 8006 should **not** be used as justification for further delays.

Thank you,

mike benefiel, Democratic PCO LD 23

Submitted by Russell Patterson and Suzanne Whitehead
3/13/2023

Hello,

I'm not sure if this is the appropriate commission to write to, but it's somewhere to start. I'm not sure if you're aware, but the supply of stimulant-based medications for treatment of ADHD is in desperately short supply. I say in short supply but in fact, as of our efforts to locate some today for our kids, there is NO supply! We have heard differing explanations for this lack of supply including increased demand/prescriptions, decreased generic manufacturing, restriction of supply by the drug companies and even limitation of supply by the federal government(!). We do not know the true reason or reasons, but one thing we do know is that patients are suffering. ADHD is the butt of many jokes and is not even considered a "real" disease by some, however it's symptoms and pathology have been well documented and it has been in the Diagnostic Manual and Statistical Manual of Mental Health Disorders (DSM) since 1968, and is one of the most prevalent diseases in our society today (and not just mental health diseases). We ask that some political pressure be placed on the necessary entities to rectify this serious shortage. Imagine if diabetics were suddenly unable to obtain Insulin.

Thank you,
Russell H Patterson
Suzanne Whitehead

Russell H Patterson, VMD, DACVS
5820 16th Ave NE
Seattle, WA 98105
C: 206-550-5850

Submitted by Janis Avery

03/23/2023

Greetings,

My name is Janis Avery and I am a retired executive from the human services sector, advocating for adequate health care for all Washingtonians. I am co-chair of the Children's Campaign Fund PAC and seek racially equitable solutions that help all of us thrive. I collected signatures for the Whole Washington campaign last summer.

My experience: I am a white, privileged woman and I have always had better than average insurance and caring healthcare providers. I have had three rounds of cancer since 2017 and am living well because of that access. I believe everyone should have the same health care coverage that I have - or better because I can afford the annual $2,500 out of pocket maximum and others can't. Even with my educational privilege, when I changed health insurance carriers this year to have consistent access to Fred Hutchison and find I don't understand the new coverage!

When traveling in Egypt several years ago, my then 80-year-old father tripped and fell. His ER visit with scans and x-rays cost $110. Why can't we do that here?

My hopes: I hope the commission will work swiftly to engage Washington state residents in understanding their lived experiences under the current, confusing, complicated and inaccessible health care system. I hope it will work to create a single payer system and remove the profit objective from health care and insurance. The legislature often tinkers with systems. The health care system needs a transformational overhaul. The commission is the group positioned to lead that transformation from inadequate to abundant care, from poorly paid practitioners to fairly paid, to access from barriers, and to equity for everyone so we have a healthy community.

While a transition from health insurance companies to a single payer system will surely be complex, it's time to be honest about the value that insurance companies provide. Their focus is on shareholder value and executive compensation rather than health care. I urge you to step up to the leadership challenge needed and lead the transformational change that will lead to all Washingtonians having access to quality care.

Thank you for courageously engaging in this work! I look forward to watching your progress.

Best wishes,
Janis Avery
1829 S Lane St
Seattle, WA 98144
206-290-3426

Submitted by Steve McMahan

03/23/2023

Hello my name is Steven McMahan, I'm a lifelong resident of Washington and policy analyst with the Washington State Healthcare Authority. Not only do I see the inadequacies in our current healthcare system, I have also experienced it pitfalls personally. I have a condition called postural orthostatic tachycardia syndrome, better known as pots and what that means is when I stand up I get lightheaded, often times it can be ignored for a moment but when I have a bad spell I faint which has caused some injuries. Because my condition is rare, especially among men I have yet to see a specialist for treatment and have had to swap insurances until I can find one that has pots specialists in-network.

I am completely at the mercy of whatever insurance companies wish to cover or not cover regardless of what my primary doctor says as I cannot afford a specialist without insurance. As for my career, our ability to enact or change policies that can bring greater coverage to Washingtonians and simplify the policy and legislation process making it easier for the lay person to understand their benefits is hamstrung by insurance companies who are beholden to their profit margins. We know looking around the world that unless we have a single-payer option we will continue to spend the most on healthcare than any other country, we will never be able to provide coverage that can meet our citizens' needs due to insurance companies needing to ensure they can make a profit off our needs, and the ability to change laws for providing greater access to care to those in unusual circumstances like myself and countless others without enacting Universal Health Care and I believe that we can do that here in Washington all it takes is the courage to say enough is enough.

Submitted by Huckleberry Palmer

03/23/2023

My name is Huckleberry Palmer. I live in Spokane Washington in the 3rd legislative district. I'm one of the tens of thousands of people that occupied downtown Seattle for a week in 1999 to question the wisdom, legitimacy, and inevitability of all major decisions being made by wealthy investors, in an event protesting what was known as the World Trade Organization ministerial meeting in Seattle. You may recall that the suspension of constitutional rights and violent police action response to that demonstration that ensued was extremely disruptive and embarrassing to the liberal politicians running that city, effectively ending the career of then mayor Paul Schell.

Naturally, I don't expect elected officials to choose to do the right thing on their own and eliminate the cynical and parasitic insurance industry from our healthcare system, nor to curb the rampant greed of pharmaceutical companies.

The idea of publicly-run universal health coverage is tremendously popular, however, especially in Washington State. Most people, of course, are kept far too busy trying to make ends meet to regularly participate in influencing political decision-making. But Washington State has an initiative to the legislature process, significantly reducing the institutional barriers to overwhelming public opinion being codified in law. So our State is fertile ground for publicly-run universal health coverage.

Don't be that guy. Don't get in the way. Instead, sell out your insurance company and pharmaceutical buddies out to save your own political skin, and side with the political will of the vast majority of Washingtonians. Of course I don't literally mean that you have a ton of important medical insurance and pharmaceutical industry lobbyist buddies, necessarily. But, as parties to elected officials in this State, you

are virtually guaranteed to move in the circles they move in, and by osmosis to share many of the same appreciations for personally professionally benefitting from established power structures.

So here's the deal. I'll do my best to help build organized public pressure to adopt publicly-run universal health coverage in Washington. You be ready to be one of the earlier politicians to cave to our demands, wrap yourself in the mantle of "leadership" of the cause, and avoid future political disfavor and gain influence when the winds quickly shift and being for publicly-run universal health coverage is suddenly seen by ambitious politicians in this state as the cool thing to do.

Submitted by Colin Ernst
3/23/2023

Hello Universal Health Care Commission,

First off I would like to thank you for your work on this issue, which in my opinion is the single most important way we can address the run-away wealth inequality plaguing our country today.

Most importantly, I would like to say right here in the beginning that the SINGLE-PAYER option should be the main focus of this Commission. We do not need patch work fixes that leave all the profiteering insurance companies with a seat at the table. We need to remove them from the equation and realign costs that don't include layers of bureaucracy and profit extraction. Per capita our system is way more expensive and delivering worse outcomes than countries that utilize SINGLE-PAYER healthcare systems. Moving towards a SINGLE-PAYER system should be the primary focus of this commission.

My name is Colin Ernst and I am a progressive Democrat living in the 36 legislative district. In our current system, my family of three is experiencing three different realities of health insurance. My wife is employed at a small law firm and receives her insurance through them. They do not pay her entire premium (I believe her contribution is $150) and they offer no discounts for spouses or children. Her care has been the most consistent but even in her case she has been watching her plan go through a steady erosion of benefits and increases in deductibles and costs. When she began at the firm 16 years ago they offered a "Gold" level plan which was amazing. Zero deductible and almost full coverage for most medical needs (including pregnancy costs which we were able to use to the tune of $11,000). Needless to say this was not "profitable" for the insurance companies and they no longer offer "gold" plans with those levels of benefits. Since then her deductibles have gone up every year while overall benefits continue to decline. Every year her firm has a meeting detailing the "new plan" and every year benefits decrease. Last year her primary care doctor (who is a part of the Polyclinic) was having contract disputes with her insurance company and she thought she would have to switch doctors (after 16 years with the same PCP). Luckily the two sides were able to work it out but why do we need this kind of annual stress and wondering as the insurance companies look for more ways to squeeze the system???

My daughter has been on AppleCare since she was born and is actually experiencing what it means to be in a Single-Payer system. This has been an enormous relief for us as a family not having to worry if an unexpected illness or injury would turn into a huge overwhelming medical bill. Luckily she has been a relatively healthy child and she hasn't needed any extensive care. That said, as my wife's income has increased we have been steadily creeping towards the eligibility threshold and soon we will be making

too much to continue AppleCare. Technically this has already happened but emergency measures put into place during the pandemic have kept her eligibility intact (the emergency plan says that while the pandemic relief measures are in effect no one will be removed from the program). But as soon as those stop gap provisions are lifted we will be ineligible and she will be forced into the "private insurance" market.

And that is unfortunately where I am. I have been a stay at home dad so I have no employer based insurance and my wife's work plan is too expensive so I get my insurance through the Washington HealthPlan Finder. Ever since the "Affordable Care Act" (sic) was put into place I have been through an annual slog of confusing choices as I try to compare plans and understand what they do and don't cover. Every year the plan that I had would both raise its monthly premium and lower its benefit levels (in the form of higher deductibles and less coverage.) In an effort to "find the best plan" I have changed insurance almost every year for the last five years. Every time I switch plans I have to find a new primary care physician. I have not seen the same doctor twice in ten years. And with my most recent switch the "choice" of PCP's continues to dwindle and I'm forced to go further away from home to see a doctor. Ten years ago my plan was about $250 a month. Now it is almost $600 and my deductible is $2500. This is the equivalent of not having insurance since having to pay $2500 then 30 percent of costs until I reach my out of pocket max of $8500 would be a devastating blow to my family financially. Somehow, even though I have insurance, I do not feel insured. The feeling of being insured is one of "if I get sick I can seek care and not worry that the cost of being sick will bankrupt my family". That is not how I feel. I feel like I am paying a huge chunk of our monthly budget in premiums for a service that will give me nothing. When I get sick the stress of needing to seek medical attention is palpable. If I have to go to the ER my plan pays nothing before the deductible is met and I have an $800 co-pay after that! The last time I was looking at plans this was the status for ER benefits across almost all plans. And since PCP's are booked out months in advance the ER becomes the only point of contact when you need to be seen.

Stress is a major factor in general health and one's ability to recover from illness. A popular paraphrasing of the Hippocratic Oath is "First do no harm." Ironically our medical system INCREASES the amount of stress related to seeking treatment and as a result is actually DOING harm.

This does not have to be the case. We are the only industrialized nation not using a national SINGLE-PAYER system and we pay dearly for it both monetarily and in our basic health outcomes.

I beg of you, Universal Health Care Commission, to establish a SINGLE-PAYER system in Washington State and help blaze a trail to be followed by the rest of the country.

Thank you,
Colin Ernst

Submitted by Arwen Spicer
03/24/2023

Dear Universal Health Care Commission,

My name is Arwen Spicer, and I'm an adjunct professor at Clark College in Vancouver and a member of the Washington Education Association (WEA). I am writing to urge you to pursue only single-payer options in your committee's work.

Our for-profit system is not fixable; its fundamental structure is inefficient and inhumane. It is inefficient because it requires the coordination of uncountable different plans, providers, and employers. It is inhumane because, by design, it profits from human suffering, creating a business *necessity* to manipulate care in order to maximize profit for shareholders.

I have studied the health benefits coverage at Clark College and can share some ways in which the current system does obvious harm:

1. The College **covers less than half its employees**, leaving us to fend for ourselves in finding expensive coverage elsewhere (or staying poor enough to qualify for Medicaid, as many employees are).

2. **Employees without benefits are *required* to work less than 50% FTE in order to *not* qualify**, cutting many employees' potential income in half. It also necessitates routine hiring of extremely part-time adjuncts to cover classes that could otherwise be covered by simply letting an adjunct teach more than half time.

3. Many of our **students lack adequate health coverage**, adding to their ill health and stress that negatively impacts our ability to provide an education.

4. Our current system is an irresponsible **waste of taxpayer money**. One calculation I did using Whole Health Washington's calculator indicated that under the **Whole Health Washington Trust**, Clark College would ***save* $5 million in health benefits** expenses per year, with ***all*** employees and students covered, and most paying ***less* out of pocket** than they do now. This single-payer proposal is a win-win-win, our current system a lose-lose-lose.

5. Clark College always struggles financially. Almost every year, there is talk of millions of dollars in shortfall. **The single change of reforming healthcare would wipe out most of this shortfall**, without having to cut faculty, close programs, and reduce resources for students (as Clark routinely does).

We don't need a commission to research whether single-payer healthcare is better. We know it is. We need you to show the courage to speak this truth now.

Thank you.

Sincerely,

Arwen Spicer

Submitted by Hunter Crawford
03/25/2023
Hello,

My name is Hunter. I'm in my late 30s, living in Clark County with my spouse and child, just outside of Vancouver. I've been a life-long Washington resident.

I'm an instructional multimedia designer, and while I am fortunate enough to have access to healthcare at the moment, that hasn't been the case for much of my adult life. I walk carefully on a bad knee that I injured in my twenties and couldn't get it looked at.

Even with a well-paying job, I've had to worry about high deductibles, premiums cutting out a good chunk of my take home, and the anxiety of making sure everything is within my network.

There still remains a constant fear that losing my job will cost my entire family the ability to have quality care. 6 years ago I lost my job and I was unable to afford COBRA. I'm sure that would be the case again, I'm barely scraping by as it is.

But the really troubling thing is that most of my friends have it worse. I worry about two of my friends with the chronic pain they can't treat. And the friend who can't get full anesthesia for her oral surgery. And the friend who hasn't been able to afford their prescription for years.

The friend in debt from an ambulance ride.

The friend who has never been able to get therapy.

The friend who walked out of a hospital without getting seen.

The friend who went hungry because she couldn't otherwise afford her university health plan.

The friend who can't divorce their abuser without losing care.

The friends who are gone.

I look at my community and it's painfully clear that we are in a crisis—one that I don't see in other countries that have removed the profit incentive from their healthcare.

I'm writing to the UHCC, not only to share my story and my worries, but to implore the commission to focus entirely on a single payer approach. Our system of healthcare segmented by plans, insurance, and hidden costs is anathema to our life, our liberty, and our pursuit of happiness. We need transformational change and we need it now!

Thank you for your time and consideration. I hope you do the right thing.

Best wishes,

Hunter Crawford

Submitted by Kim Harmon
03/26/2023

Greetings Members of the UHCC,

My name is Kim Harmon. I currently live in West Richland, WA and work for WA state (DES). In 2010, at the age of 40, I had a hemorrhagic stroke due to a very rare type of benign brain tumor that my neurosurgeon said had probably been present since birth. I was incredibly fortunate at the time to be

covered by my then-husband's health insurance policy, after having lost my own health insurance when I was laid off from a corporate job.

Since then, I have had to learn how to walk again, swallow, drive and many, many more basic functions. As a recipient of SSDI, I also had Medicare coverage, which is only granted after a 2-year wait period. Even with a Medicare Advantage plan, which is a Medicare plan sold by a private insurance company, the copays were too expensive for me, and I had to stop going to Physical and Occupational therapies.

I know from this very personal experience that anything can happen to anyone at any time. Getting sick or injured is an inevitable part of the human condition. I am fortunate to be able to work again even with a permanent disability. However, many people are not as lucky. Employment-based health insurance coverage leaves far, far too many people physically and financially vulnerable, causing problems for individuals and communities as well. Private insurance companies' for-profit motive makes real care inaccessible, even for people who pay thousands of dollars per year into the system.

With the legislature already working on short-term fixes within the current system, this commission has the incredible opportunity to spark a transformational change to American society, by focusing on a single payer approach. Improving the lives of millions of people will be lauded as one of the most important advancements in human history.

Thank you so much for your time,

Kim Harmon

Kim Harmon
LICSWA
(206) 612-5959
kharmon4@une.edu

Submitted by Joy Currie
03/26/2023

Hello.

I only recently learned of this commission. I look forward to learning about your work.

I am a retired kindergarten/1st grade teacher, and at one time an EVCC family life department parent educator.
The well being of my family, my community, and of all children in general have been priorities of mine my entire adult life.

I recently attended a 38th LD
Town Hall and was very impressed by the depth of knowledge and the real concern expressed by my legislators for serious issues facing us, however I was disappointed that there was no mention of the very real and urgent healthcare crisis facing us as citizens of not only a county, but of this state as well.

I am assuming this is the issue you are tasked with addressing?

I helped to collect some 70,000+ signatures to get a universal single payer healthcare bill, which was written by healthcare professionals and volunteer activists, on this year's ballot. Falling short of the required threshold, it was sent to the legislature in the form of SB 5335. For some reason it did not make it out of committee this legislative session.
This was a well drafted and researched Bill that would not only provide comprehensive healthcare to our citizens, but also billions of $$$ in savings to WA State.

Considering the urgency of the healthcare crisis, it is my sincere hope this commission will focus entirely on a single payer approach, and free up the money to assure our healthcare needs are met

Studies have proven that Single Payer Universal Healthcare saves both money and lives. It frees up money by consolidating our payment systems.

I hope the commission has familiarized itself with SB 5335. It would be a shame for so much work, and research, and documentation to go unnoticed by your group.

Thank you for your time and effort spent on behalf of the public.
I encourage you to be brave, and bold, in your recommendations.
The circumstances require nothing less.

Respectfully,
Joy Currie

Submitted by Lind Orgel
03/27/2023

We urge you to support bringing universal healthcare to Washington State as a leader in assuring citizens have the right to protect their health and the health of their family. We are the only developed nation that not provide public protection for its citizens. Those who can afford private insurance, even Medicare premiums, have no worry, but the majority of people cannot afford going to their doctor or getting their medications. This is a travesty. Healthcare is a human right and we must support initiatives that will provide medical and dental care to all the people.

Thank you
Linda Orgel
Aberdeen WA

Submitted Arthur Grunbaum
03/27/2023

Dear Commissioners

Each of us will age, and as we age our needs and requirements for health services and products will increase. Unfortunately our ability to self-fund those requirements will undoubtably decrease as we age

into retirement. Medicare does not cover it, and private insurance supplements only exacerbate our shrinking income.

Probably the second most expensive outlay, other than education, is healthcare for the emerging population as they become part of the economy.

We must consider the Public Trust, and the public responsibility to care for the young and the aging. The program offered by Whole Washington can make Washington whole and allow us to be leaders in securing the human right to health. Medical, dental and vision are life, we need to make sure that it is available to and for all.

Thank you for your consideration of this important human right.

Arthur (RD) Grunbaum
1128 State Route 105
Aberdeen, Washington 98520

Submitted by Adrian Walsh

03/27/2023

My younger brother passed a week ago. He had a second heart attack at work.
He was worried about his medical bills. When we were young, I'm 59, My mum was a secretary she raised six kids alone, we all had healthcare and we paid nothing!!
Please, for God's sake. You all know, if we had Universal Healthcare i.e. Medicare for all, it would be a boom for businesses no longer responsible for providing mediocre healthcare, people could much easier start their own businesses. And most of all, it would destress society saving "all" of us money.

I have been in healthcare for forty plus years and I personally have not had healthcare coverage for at least 15 years. If I ever got very sick, I could be forced to declare medical bankruptcy, which we are the only country in the world with medical bankruptcies.

Our current private medical insurance main purpose is to make a profit it is not provide healthcare.

Submitted by Cody Staub
03/27/2023

Members of the Universal Health Care Commission:

My name is Cody Staub and I am a resident of Yakima. I am also a registered nurse, with worked experience covering nearly 18 years in healthcare. Currently I am employed in a rural emergency department setting as a board-certified emergency nurse and coordinator overseeing the cardiac, stroke, trauma, and sepsis programs for my hospital. I have served as the president of the Washington State Council of the Emergency Nurses Association, chair of the Resolutions Committee for the national Emergency Nurses Association, and volunteered with free clinics in Yakima, Kittitas, and King counties. I

have a passion for the needs of our underserved population, particularly in rural and resource-limited areas.

I write to you only on behalf of myself but mention my experience to give insight to my perspective. In the years that I have worked in emergency departments across the State of Washington, I have seen and heard countless stories of those struggling with our current healthcare system. The emergency department is truly the safety net for all those who have nowhere else to go, and nearly every patient encounter conveys another way in which this current way of financing healthcare is broken.

As I care for patients and document in the electronic medical record, a window accessible in the top of my computer screen quickly ticks up the charges into the tens of thousands of dollars during their encounter. As I help load a patient to the helipad for air transport, I often feel the satisfaction of knowing that we may have saved a life followed by the despair that it is more likely we have also bankrupted a family. On more than one occasion, patients have shared with me that a trip to the hospital was so expensive they would have been better off dying. I even get the privilege of hearing our financial services staff calling the families of deceased patients to correct addresses so they can make sure the bill gets to the right place, a sad reminder that even after the patient dies the health system is still trying to extract money.

And then there are everyday inefficiencies that we have somehow just accepted. The patient whose doctor refers them to the emergency department because they don't have time to deal with an insurance company to get the MRI or ultrasound the patient needs. The patient who comes in once a month for their blood pressure medication because they can't afford the copay for a doctor's visit. The dozens of phone calls we receive every day asking for some form to be filled out or a referral to be sent so that insurance will pay for their care. These are not uninsured patients, but patients with "good" health insurance.

The most infuriating recent example for me came in treating a young child with a *cryptosporidium* infection. This child had been sick for about a month with severe diarrhea and abdominal pain, had multiple doctor visits, and even a hospitalization at a large children's hospital. When the doctor in our ED finally made a definitive diagnosis, the CDC-recommended treatment was prescribed: a 3-day course of a pill taken twice a day. The patient's mother called us back to say the pharmacy could not fill it because insurance rejected it. The reason: the medication price was over $400 for those six tablets. This same medication costs less than $1 per pill in Canada. The doctor spent the next three days filling out forms and making phone calls to the insurance company, while still caring for sick patients in a busy emergency department. She argued for hours over the CDC treatment guidelines and FDA approval of alternative drugs the insurance company was suggesting. All while this poor child continued to have horrible diarrhea and abdominal pain. Finally, after three days the doctor relented and went along with the insurance company's recommendation despite knowing it would not be as effective or fast acting. Of course, one more rejection from insurance came when the doctor wrote for half a tablet per dose instead of the dose the insurance company felt was more appropriate: 0.38 tablets per dose.

What is so frustrating is that our current system does not need to be the way it is. No other developed country finances their health system this way, and all of them have better health outcomes than we do. We gain no advantage by putting up with the high costs and inefficiencies of our system. I

recall a dinner I had after a conference with a Canadian physician and professor, largely regarded as one of the pioneers of evidence-based medicine. At the dinner, the questions everyone had for him revolved around how to actually implement evidence-based care in the American profit-driven system. His reply was sobering: “Honestly, I have no idea how you’d do it. I don’t have these problems in Canada that you have here in the United States. I can’t even imagine working under these conditions”.

Washington is only a small part of that system, but you have a chance to do something great and show the rest of the country that it does not have to be this way. I plead with the Universal Health Care Commission to narrow their focus to strategies for implementing a single payer solution in the State of Washington to achieve the vision of quality, affordable health care. We urgently need to address the crisis that has been brewing in our healthcare system for decades. Do the brave thing that hospitals and insurance companies will be fighting viciously against, do the right thing for Washingtonians.

Thank you for your time and your service.

Best regards,

Cody Staub

Submitted by Arthur Baines
03/27/2023

Hello,

It is time for our state to treat healthcare as something every human should have access to, regardless of income, race, background, housing status, or any other factor that makes any group of people less likely to be able to get the care they need.

The current system is beyond broken and impossible to navigate even for someone like me, who has a graduate degree in a health-related scientific field (biostatistics). I am unable to get clear out of pocket estimates on treatments or procedures that I need for myself and therefore cannot "shop around" or really even determine the affordability of care I need. Thankfully I am able to go forward with care because of our family's substantial income, for SO many others this is a complete roadblock and they can't get the care they need.

While I was in graduate school we didn't have enough money to just move forward with whatever procedures/treatments doctors recommended, and we had to go forward blindly trusting that we would "figure out" a way to pay for things after the fact. THIS IS NO WAY TO TREAT HUMAN HEALTH.

If we care for ourselves and fellow humans even a fraction of the amount we claim to, we will start providing healthcare for EVERYONE in our state, without question.

Sincerely,
Arthur Baines

Submitted by Aimee Storm
03/27/2023

Hello. I'm Aimee Storm, a born-and-raised Washingtonian, small business owner, and supporter of universal healthcare. Over the last several years it's become obvious that the lack of access to healthcare is bad for Washington and bad for its people. My wife and I had to put off a surgery she needed to repair the complications of a previous surgery for several years, both because we lost our insurance when she was laid off during the pandemic and because of the pandemic itself. Even prior to that, though, we were tied to her previous employers because of the number of surgeries she required.

If we had access to healthcare that wasn't tied to one job, it would free us to seek work in things we truly care about. Right now one of us needs to take corporate work in order to afford health insurance--insurance that doesn't even cover all the costs of our healthcare! Universal healthcare would allow us to direct our energies toward things that improve the world around us--mutual aid, art, and building communities.

Everyone deserves access to healthcare, no matter how able they are to afford it. Washington state needs universal healthcare now.

Thank you,
Aimee

Submitted by Dave Schuldt
03/27/2023

Hi,
I'm a healthy and fit 60 year old whose employer stopped offering health coverage 10 years ago. I have a high deductible plan and a very large savings account. So far it's been OK. Hoping I can hold on this way another 5 years. So that's me.

For the past 2 1/2 years I've been part of a mutual aid group that supports homeless people in Ballard. It's obvious that many of them are dealing with medical conditions sometimes severe. While there are programs that help people in this situation it's not near enough and it's hard to access. It pains me to see this kind of unnecessary suffering. I've never done anything like this and it's been tough mentally. If healthcare was free and easy to get their lives would be so much better and they could get organized, get a job and feel better about themselves. These are the kinds of people that wind up in the emergency rooms costing us way more than it would have to take care of them regularly.

When you compare expenses and outcomes to other countries we are way down the list. As it is now I would encourage foreigners who are considering moving to the US to think twice and tell them how bad our "system" is. You should talk to random people from other countries and hear what the have to say about the way we do healthcare, it's embarrassing.

Dave Schuldt

Submitted by Will Shown
03/27/2023

To the UHCC:

I'm a proud Washington resident, initially from 2013 to 2016, then again from 2019 till today. I spent the gap in between working in Germany, where healthcare is not single-payer, but it is universal by regulation, and the insurers must operate as nonprofits and cover all care recognized by the European Commission. I learned first-hand exactly how vital it is that strictly everyone can get the care they need without risking material precarity.

As Washingtonians without that kind of guarantee, we all live on the brink of either financial disaster or physical suffering because our political system has lacked the will to cut off the middle-men who almost literally sacrifice us for profit. And of course patients aren't the only ones who suffer, our system also exploits care providers, pushing more and more to burn out and exit the profession altogether.

Given our situation, the UHCC's mission statement is poignantly unambitious. We don't just want to expand access incrementally, we want no Washingtonian to ever fear for their life or material wellbeing when they get sick, and we want care from practitioners who aren't burnt out and can give us the best care a rested and respected professional can. If the UHCC can't get behind cutting off the profiteers who put us all in harm's way, then the Commission's endeavor is apparently to obfuscate the issue and collaborate with the insurers who gladly trade Washingtonians' shorter and more precarious lives just to funnel wealth to a precious few. I hope that is not the case, but, if it proves to be, we will surely call out the ruse for what it is.

I hope the UHCC finds the ambition we need in this critical moment. Washington must join the rest of the developed world in guaranteeing affordable healthcare for all its residents. I hope Washington can rely on this Commission to help us get there.

Best wishes,
Will Shown
Senior UX Engineer, Seattle

Submitted by Karen Seeley
03/28/2023

Thank you for inviting public comments regarding the commission's work in bringing Single Payer Universal Health Care to Washington, so that healthcare in Washington is not tied to employment or to a profit making system for insurance companies.

I would like the Commission to respond to the public comments submitted to them so that citizens who express their opinions, are in dialogue with the commission. Without responses from the commission, there is no way for the citizens to know if their suggestions are being considered.

I would like to know, specifically, what the commision has done to make progress in the following areas: 1) overcoming the obstacles involved in the federal waiver process and 2) determining the best legal strategy for dealing with the ERISA laws

Here is a link to one paper assessing the impact of ERISA laws on single payer, universal healthcare and outlining some potential legal solutions
https://scholarship.law.upenn.edu/penn_law_review/vol168/iss2/3/

Karen Seeley

Submitted by Kathryn Lewandowsky
03/28/2023

Hello,
I would like to offer this Power Point Presentation regarding how to and the benefits of unprivatizing our healthcare system put together by Dr. Stephen Kemple, M.D. with his permission for the members of the committee. It is very informative and I will hope to address aspects of it in my limited time for public comment on April 11th. Thank you.

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

A brief history of privatization of public health insurance programs – Medicare, Medicaid, public employee health benefits

Why privatize?

- A lot of money flows through publicly funded healthcare programs:
  - Medicare
  - Medicaid
  - Government employee health benefits.
- Private business interests seek to tap into it.
  - Just processing claims: 2% of healthcare dollar.
  - Taking on insurance risk and managing care: 12-40% of healthcare dollar.

Private interests offer this self-serving--and false--rationale

- Government is always inefficient. Private insurance companies can manage health care to make it more cost-effective.
- Fee-for-service incentivizes doctors to deliver excessive "volume" of largely unnecessary care, and this is the major driver of excess cost in US healthcare.
- Care is "fragmented" under FFS and private health plans and integrated delivery systems can more effectively coordinate care, restrain unnecessary care, improve access, and reduce cost.
- Turning health care funding over to capitated private entities makes cost predictable, and competition and market forces will control cost.

The Affordable Care Act has accelerated privatization

- To control cost, we must "move away from FFS" with its "volume" incentives and replace it with "value-based payment" – shifting insurance risk onto providers of care via capitation and bundled payments,
- We can eliminate "fragmentation" and improve quality by organizing doctors and hospitals into "Accountable Care Organizations" that can accept insurance risk.
- Or have large insurance plans and hospital chains paid via capitation buy up physician practices and "integrate" them.

Evidence shows that Over-utilization is NOT the problem

- U.S. doctor visits and hospital days per capita are among the lowest among industrialized countries.
  - OECD data
- Inadequate access to appropriate care driving costly complications is a far greater problem than unnecessary care due to FFS.
- Excessive administrative cost driving much higher prices is biggest cost driver.
  - Papanicolas, Woskie, Jha. Health Care Spending in the United States and Other High-Income Countries. JAMA 03-13-18
- Exorbitant drug prices is 2nd biggest cost driver

But corporate fraud and abuse by insurance plans, HMOs, Medicare Advantage, and Medicaid Managed Care is widespread and hugely expensive

- Cherry picking and lemon dropping
- Upcoding to inflate severity of diagnoses
- Deceptive marketing
- Denial of necessary care
- Narrow networks, restricted access to care
- Slow claims processing, high rate of denials
- Meaningless “quality” metrics

UPCODING – Physician coding drives "Risk Scores"

Risk Scores Drive Medicare Advantage Payment

Healthy 76F	HCC
Baseline for age	.45
No extra codes	0
	0
	0
	0
	0
	0
	0
Risk Score = 0.45	
CMS pays MA $4,000	

Typical Coding	HCC
Baseline for age	.45
Obesity	0
Type 2 Diabetes	.104
Major Depression	0
CHF	.323
Asthma	0
Ulcer, unspecified	0
CHF*DM	.154
Risk Score = 1.03	
CMS pays MA $9,000	

Detailed Coding	HCC
Baseline for age	.45
Morbid Obesity	.273
DM w/ retinopathy	.318
MD, Sing Ep, Mild	.395
CHF, Class 3	.323
COPD	.328
Ulcer, stage 3	1.204
CHF*DM,COPD	.154, .19
Risk Score = 3.63	
CMS pays MA $32,000	

Source: https://downloads.healthcatalyst.com/wp-content/uploads/2019/04/HCC-coding.png

"Government lawsuit against Kaiser points to a massive fraud problem in Medicare" – LA Times Aug 4, 2021

- ". . allegations that the giant health plan systematically defrauded Medicare by overstating the severity of its patients' medical conditions."
- "It's industry-wide and it's of major proportions"
- "In 2013 alone, according to an audit by the GAO, Medicare overpaid Medicare Advantage providers $14.1 billion, primarily because of 'unsupported diagnoses'."
- ". . almost 10% of the payments to Medicare Advantage organizations were improper. Given that Medicare Advantage providers were paid about $290 billion last year, that means some $30 billion a year may be going astray."

Similar whistleblower lawsuits are pending or have been settled against Medicare Advantage plans run by:

- Signa
- Anthem
- Sutter
- United Health Group
- Humana
- Aetna

AND, Administrative cost can be hidden

- In 2011, after passage of the Affordable Care Act,
- Obama administration negotiated with the health insurance industry and agreed to classify “medical management” as health care, not administration, in calculating “Medical Loss Ratio.”
- “Medical management” includes anything plans do with a stated goal of assuring appropriate utilization, controlling cost, and/or improving quality of care.
- Includes administrative cost of payment reforms with these stated goals.
- All that matters is the stated goal – not the actual outcome. In fact, almost all recent innovations in “medical management” are having the opposite effect of the stated goals.

Medicaid Managed Care

3 Federally Recognized forms of Medicaid

- Original – “Unmanaged Fee-for-Service” (FFS)
- Managed Care Organizations (MCOs) –
  - 1115 waivers to contract Medicaid to private HMO health insurance plans
  - Goals: budgetary predictability, control cost, improve care coordination and quality, enable more flexible benefits, network management, and payment schemes
- Primary Care Case Management (PCCM), or “Managed Fee-for-Service”
  - State retains insurance risk
  - Extra payment to primary care doctors for care coordination
  - 1950 waivers - Interdisciplinary community programs for high-risk patients, intensive case management
  - Behavioral health support

Adoption of Medicaid Managed Care

- 11 states retain Medicaid as a fee-for-service program with the state bearing risk.
- 40 states contract at least AFDC and GA to MCOs
  - Many, including HI, have also included Aged Blind Disabled
- A few states (Oklahoma, North Carolina, Connecticut) have implemented Primary Care Case Management (PCCM) instead of MCOs.

Head-to-head comparisons:

- FFS to MCOs – increases cost, reduces MD participation & access
- FFS to PCCM – NC and OK - improved MD participation and reduced ER and hospital costs
- MCO to PCCM – OK and CT, CT reduced total cost 14% after 6 yr

Medicaid Managed Care - Outcomes

- Medicaid MCOs are very profitable –
  - $1.1B in 2013, increasing to $3.9B in 2015
  - More profit from higher-risk groups -
    - $7 per member for AFDC & GA (kids, mothers, working age adults)
    - $20 per member for ABD (aged, blind, disabled)
    - $90 per member for dual eligible (Medicare and Medicaid)
- "Ghost" physician networks – half of doctors listed in plan directories not available for appointments
- Cloudy accounting -
  - Some mix Medicaid MCO financial data with commercial plan financials
  - Gaming of "Medical Loss Ratio" (MLR)
  - Difficult for states to obtain information to effectively regulate plans or hold them accountable
  - MCOs are often a financial "black box"

Hawaii's Medicaid Experience – Managed Care Organizations (MCO's)

- Converted FFS Medicaid to MCO's - 1994, 2009
- Increased administrative hassles (and cost)
- Declining MD participation
- Worsening access problems
- Accelerated cost increase – 3% > US average 2001-2014 (most recent data)
- Worst for mental illness – 4 yr after Medicaid managed care, > half of psychiatrists dropped out, psychiatric ER and hospital costs increased 30%!!

Kaiser State Health Facts FY '90-'10, Hawaii Health Information Corp 06-26-13

Connecticut Medicaid – Replaced MCOs with PCCM in 2012

- Prior to 2012: Full-risk Medicaid Managed Care Organizations – Costs rose 45% 2008-2012.
- 2012: Eliminated Managed Care Organizations, took back insurance risk and self-insured Medicaid, enhanced funding and support for primary care (ePCCM)
  - Contracted necessary administration to Administrative Services Only (ASO) on non-risk basis, by former local managed care plan.
- 2018: MD acceptance of Medicaid up, ER usage down 25% and hospital admissions and re-admissions down 6%.
- 6 years later, per member Medicaid costs14% lower than in 2012: $706 pmpm in 2012 to $610 pmpm in 2018
- 2020: Medicaid admin costs now 2.8%, including ASO
  - compared to 15-40% for Medicaid MCOs, 12.5% for CT commercial plans

Oklahoma Medicaid – direct comparison study of MCOs with PCCM (in 2009)

- *Concurrently, OHCA issued its first report card comparing SoonerCare Choice (PCCM) with "Plus" (MCO).*
  https://www.cga.ct.gov/2009/rpt/2009-R-0216.htm
  - *The capitation was 16% higher than what these services would have cost on a fee-for-service basis.*
  - *Found the two to be similar in terms of performance and quality, leading the state to question the wisdom of paying the MCOs more.*

How are FFS or PCCM more cost-effective than Medicaid Managed Care

Focus on reducing administrative cost

- Pay independent physicians with a simplified, standardized fee-for-service fee schedule, regulated by the state.
  - Use collective negotiation to keep fee scale reasonable for all.
  - Would cost less than 2% of the healthcare dollar to administer.
- Pool hospital funds from all payers in proportion to the hospital needs of each plan's population, and pay hospitals with global operating budgets.
  - Eliminates cost-shifting among plans and "chargemaster" games
  - Eliminates billing and collections, ~15% of a hospital's budget
- Pay for capital expenditures with a separate fund allocated according to community need.
- Keep Kaiser as integrated hospital-physician group, paid with global operating budget for both hospital and physician group
  - eliminates closed-panel membership and insurance functions.

Capitation vs Budgets

- Capitation conveys insurance risk –
  - fixed payment per person with obligation to cover specified services over specified period of time
  - Opportunity to keep unspent earnings (profit) and risk of loss if more spent than capitated payment
  - Incentive to restrict care, "cherry pick" and "lemon drop"
  - Requires risk adjustment (with increased administrative cost) to supposedly counter incentive to "cherry pick" and "lemon drop."
  - Risk adjustment leads to gaming of diagnoses and documentation to beat risk adjustment formulas.
- Global operating budgets do not convey risk –
  - Based on cost of operations, not opportunity for profit or loss
  - Can be adjusted with changing circumstances
  - No retained earnings – surplus goes to next year's operating budget, losses covered by supplemental appropriations

Price controls for Pharma

- Medicare:
  - Pass national bill to allow Medicare to negotiate prices for drugs and durable medical equipment
- Medicaid:
  - Re-join interstate consortium to negotiate drug prices for Medicaid instead of having Managed Care Plans negotiate drug prices through Pharmacy Benefits Managers.
- Eliminate Pharmacy Benefits Managers
  - Every middle-man takes a cut, and they game the system.

Eliminate fiscal intermediaries for state-funded health benefits

- State pays providers of care directly, with no fiscal intermediaries
- State retains insurance risk and covers ups and downs of care costs year to year from reserve fund
- Necessary administration contracted to Administrative Services Only contractor(s) on non-risk basis:
  - Claims processing
  - Credentialing
  - Administrative support for care coordination programs
  - Quality improvement program administration
  - Customer service
- Community-based care coordination programs funded with non-risk global operating budgets

Care Coordination without full-risk health plans, HMOs, and ACOs

- Fund Care Coordination services directly by state on non-risk basis
- Community-based services for high-risk and special needs patients
- Collaborative Care Model for Psychiatric Consultation to Primary Care. Could also be used for many other specialty consults.
- Quality Improvement based on professional motivation to improve patient care, not Pay-for-Performance
- Example of Connecticut Medicaid

Goal is a universal system covering everyone

- Single-Payer most cost-effective
- "All-Payer" (Maryland) is a compromise allowing multiple payers, but with a single care delivery system
  - everyone has same benefits,
  - same provider network, and
  - providers are paid the same regardless of the source of funding for any individual patient.
  - Allows health plans to exist, but strips them of competitive insurance business model.
  - 90% of cost advantages of single-payer

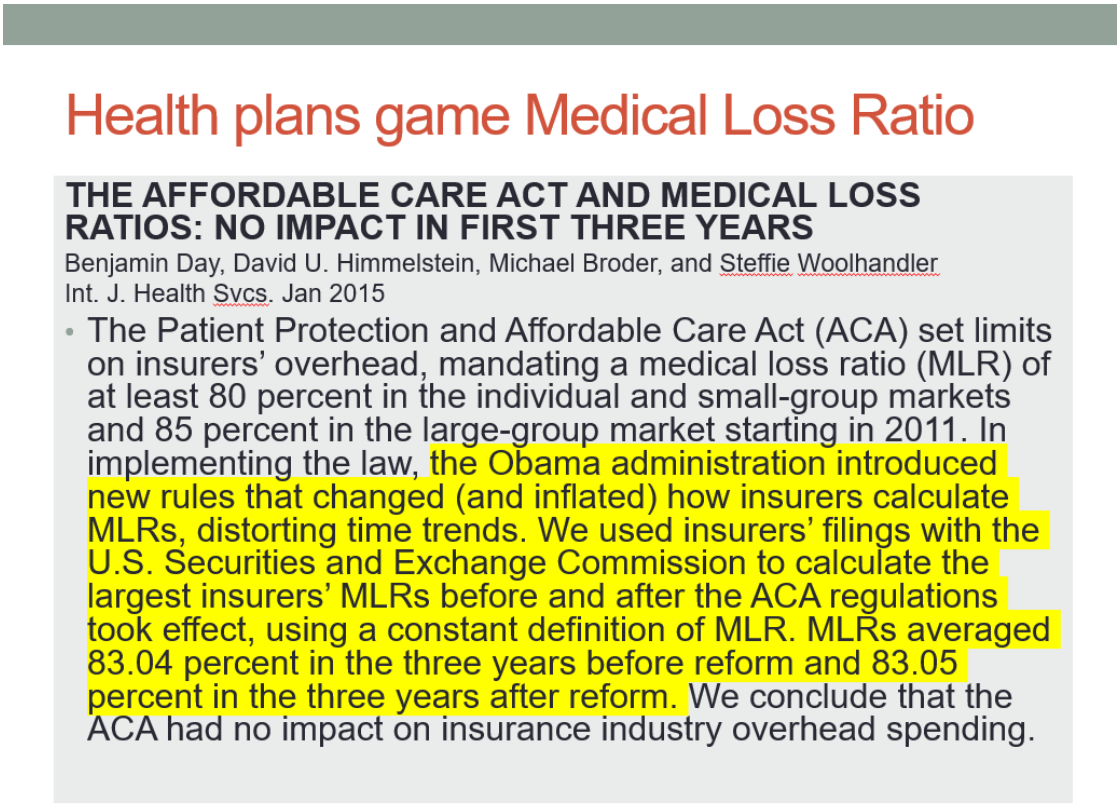
Everybody In, Nobody Out!

- We won't get cost-effective health care from health plans whose business model rewards:
  - denial of care
  - avoidance of covering or paying for the sick
  - unnecessary micromanagement of care
- Single-payer or all-payer:
  - Universal coverage
  - Remove barriers to care in the most cost-effective settings
  - Keep administration simple and overhead costs low
  - Eliminate micromanagement of doctors by insurance companies
  - Stop sabotaging the expertise of doctors and driving them out of practice

Questions?

Contact Info:
stephenbkemble@gmail.com
(808) 497-6521

Questions about adaptation: bzpearson@gmail.com



Submitted by Jen Nye
03/28/2023

Greetings members of the Universal Health Care Commission:

My name is Jennifer Nye & I'm a PCO for the 34th LD in West Seattle.

I would like the commission to consider the feasibility of using a Public Option as a means of transitioning our state to universal healthcare.

Opponents of universal healthcare often use 'government take-over' or 'the removal of choice' to fear-monger, distract, and delay us from making change. In fact, the opposite is true. The choices we're given with private insurance are few and horrible. High deductible/affordable premium or manageable deductible/high premium. Absolutely horrible! The choice of insurance company is already picked for us by our employer. And then, the choice of providers is greatly reduced by networks. The thing is, all of these choices are phony and unnecessary; they're manufactured ways insurance companies create bureaucracy and revenue.

But a legitimate public option would be entirely different. Washingtonians would have a real choice in the market. Plan Model A, if you will. People could select it on the exchange or companies could choose it for their employees. With no election needed, we'd be able to vote for Universal Healthcare by picking the Model A plan, and once Washington reached a predetermined number of sign ups, the system could

fully transition. (So for example, if 60% of our state signed up for Model A, the exchange would be shut down and for profit insurers could no longer provide insurance for necessary healthcare.)

As I mentioned in public comments at the March FTAC meeting, the 'path to Universal Healthcare' should mean getting more and more people on ***publicly*** funded programs. Conversely, when we encourage, assist and applaud individuals for signing up on corporate insurance, we simply make insurance companies richer, more powerful, and more entrenched. We get further away, and subsidies should not be considered progress. They give our taxpayer dollars to profiteers! Getting people on private health insurance is not a one-and-done check-box. People with insurance can still go bankrupt, and they can still be denied the care their doctors prescribe. People *with* insurance are hurting! Insurance is at its heart, is an abusive relationship. Despite a relentless funnel of money from the insured to corporations, those with 'coverage' still don't know what will be denied or what out of pocket costs will be charged. At a time when we need to encourage people to be responsible and seek consistent and preventative care, insurance companies financially discourage it.

I want to thank this commission for its continued work. Your work has generational repercussions. We'll either continue to tweak, rationalize and, attempt to justify a barbaric system or we'll do the brave thing and start the transformation. We can implement, evaluate, and adapt, but we absolutely have to start.

Respectfully,
Jennifer Nye

Submitted by Cris Currie
03/29/2023

UHC Commission:
The issue of dealing with Medicare within a state single-payer system is a relatively simple one at this point and does not deserve extensive attention. What is important is that the options be generally understood and that the preferred option be designated. To that end I've prepared the attached summary of the four options that groups around the country have identified. I hope you find it useful.
Full integration of Medicare into the state system should be the goal, but before that can be accomplished, a waiver application will need to be submitted and negotiations with Health and Human Services will need to take place. That application needs to include a comprehensive UHC program plan that has been approved by the state legislature, along with a 10 year budget, as described in Section 1332 of the ACA. So the top priority for the Commission should be the preparation and passage of a bill that meets the minimum requirements of Section 1332. While parts of the bill would be contingent upon HHS waiver approval it could also include other possible options as alternatives (such as a wraparound). Likewise, the highest priority for the FTAC should be the 10 year budget to accompany the plan. These negotiations need to start soon to take advantage of a favorable administration.
It was Senator Ron Wyden (D-OR) who wrote Section 1332, and it was his intention that it would be sufficient for integrating federal programs into a state universal system. However, there is disagreement about this, which is why the State Based Universal Health Care Act is being reintroduced in Congress this spring and why SJR 8006 is asking the president and Congress to support it. Nevertheless, a Section 1332 waiver is the place to start in determining how the state will handle Medicare and other federal healthcare programs.

Cris M. Currie, RN (ret.) Spokane, WA

The Medicare Problem in Single-Payer

Cris M. Currie, HCFA-WA, with Charlie Swanson, HCFA-OR

There are essentially four options for dealing with Medicare in a single-payer system. How these options would actually play out will only be known after the state passes legislation to authorize a single-payer system and it is then able to apply for Section 1332 waivers to begin negotiations with the federal government. This paper is meant to serve as a framework for further research and discussion and intended to prompt more questions than it answers.

A. The most cost efficient and equitable option is to **integrate** Medicare into the single-payer system. This option is also likely to be the most difficult to achieve. CMS would essentially give the state a block grant either based on the amounts collected from all Washington residents in Medicare including payroll deductions, premiums, and the percentage of federal income tax dedicated to Medicare, or based on the historical values of what Medicare has paid out to recipients in the state as a whole or per beneficiary. The state would then process beneficiary claims and reimburse providers much like existing Medicare Administrative Contractors (MAC). Additional state funding would be needed to secure additional benefits and adjusted provider reimbursements. In Washington, since there is no income tax, it assumed that this funding (see WHST proposal, Sections 10 and 16) will be raised through a payroll tax and individual premiums. Private Medicare Advantage (MA) plans would be prohibited within the state and participation would be mandatory for Medicare beneficiaries. Since there is no available waiver that could accomplish this, it would likely require Congressional action such as the State Based Universal Health Care Act (SBUHCA).

B. The Balanced Budget Act of 1997 established Medicare Part C, later renamed in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as Medicare Advantage. The BBA authorized CMS to contract with private or public organizations to offer a variety of health plan options for beneficiaries. So the state should be able to offer its own **Medicare Advantage plan** to compete with private insurance companies. If SBUHCA were to pass, the state might be able to secure a waiver that would eliminate private plans, but in that case, Option A would be preferable. It is otherwise unlikely that a state could deny a private company a state license to offer MA plans in the state, since federal standards supersede state law with respect to MA plans other than licensing details and laws relating to plan solvency. So beneficiaries would still have a choice between Traditional Medicare and the private and public MA plans.

As an MA entity, the state would receive capitated payments based on CMS's risk formula for each beneficiary. Calculating risk for each beneficiary will also add to the administrative cost, but these payments would undoubtedly be higher than Traditional Medicare's standard payments, since for at least the last 30 years, overpayments to MA plans have been the norm. Providers would bill the state just like any other patient, but including the patient's Medicare number. The state would then reimburse the provider at the standard single-payer rates that

are the same for all classes of providers, and obtain reimbursement from CMS as the secondary payer. Since the state would not have nearly the high administrative costs that private plans have, it could redirect those overpayments toward paying part B premiums and deductibles, adding significant benefits, and adjusting certain reimbursements, making the state plan even more attractive to beneficiaries. For details regarding how physician payments should be adjusted for greatest value go here and here. Go here for hospital payments.

Apparently private MA entities already have the ability to pay providers both above and below standard Medicare rates. Additionally, some providers "not accepting assignment" have the ability to bill the patient an extra "limiting charge," so, while complicated, the state could cover this as well. If necessary, a federal waiver [42 USC 1395b-1] could be sought for changes to payment methods or rates, payments for additional services, or performance or incentive contracts. The problem here is that waivers are only granted for a specified amount of time, and their purpose is to experiment with a policy change at the state level before enacting it nationally. Whether a single state could enact a reimbursement change permanently is doubtful, but CMS could create a rule to allow all states to adjust reimbursements. In any case, private insurers would likely scream unfair competition, and there would be litigation with unpredictable outcomes.

It would, however, be a bit ironic for single-payer advocates to promote the idea of a state offering a MA plan since MA plans and other Medicare privatization efforts are seen as undermining the chances of achieving Medicare for All. However, the main privatization problem stems from the needs of private companies to maximize profits, which can only be done at the expense of the beneficiary. Since the state does not have this requirement, it could run an MA plan much closer to how the plans were originally intended (obviously without the temptation for fraudulent upcoding), benefiting the beneficiary by expanding services and lowering costs, and providing the model for how Improved Medicare for All could operate. But the biggest risk for option B is that the state's plan does not end up being significantly better than the private plans such that it is never able to force the private companies to voluntarily withdraw their plans from the state. However, as with ERISA plans, if Washington Medicare beneficiaries are required to pay the state's health care premiums, they would have no financial incentive to remain in a private plan and continue paying Medicare premiums as well.

C. The third option is for the single-payer to **wrap around** Medicare. The state would obtain a demonstration waiver to serve as a supplemental or Medi-gap plan that would not only cover Medicare deductibles and coinsurance, but also numerous additional benefits, and adjusted reimbursements for certain providers. If the demonstration project is successful, CMS could possibly create a rule that allows all states to offer wraparound plans. However, the Oregon Task Force somehow concluded that provider reimbursements would be outside the state's purview. Beneficiaries could continue paying their Traditional Medicare part B premiums, but more likely the state would pay them in exchange for the beneficiary paying the state's health care premium tax. Beneficiaries would also need to cancel any private supplemental or MA plans. As long as the state's premiums are substantially lower than for private MA and

supplemental plans, Option C should be quite popular with beneficiaries. The 2023 Part B premium is $164.90/month and supplemental plans cost around $200/month.

Providers would bill the state, providing the beneficiary's Medicare number, and the state would pay the provider and seek reimbursement from CMS. Presumably the state would receive less funding than in Option B, as standard fee-for-service rates would apply. The state would also have to bill for every service, instead of receiving capitated lump sums in advance, which could make the administrative costs higher than in Option B. And the state would be in direct competition with private supplemental plans and would likely incur similar charges of unfair competition and litigation. The state would need to negotiate with CMS, but no Congressional approval would likely be necessary. California's AB 1400 advocated Option A and then Option C with "premium support" for Medicare Part D as a backup.

D. The final option is to leave Medicare beneficiaries **completely out** of the single-payer system until Option A can be achieved. This option would minimize the number of residents needing coverage by the state, but would also drastically reduce the revenue for the program. However, it could also lead to a substantial number of providers dropping Medicare beneficiaries as patients because of much lower Medicare reimbursement rates and the added administrative complexity of dealing with two separate systems. So in terms of equity and efficiency, this is the least desirable option, and without both equity and efficiency, the single-payer system will not, and should not, garner legislative approval.

Tab 5

Washington State Health Care Authority

Washington Universal Health Care Commission

Jon Kromm, Gary Cohen - HMA

Presentation to the Washington Universal Health Care Commission

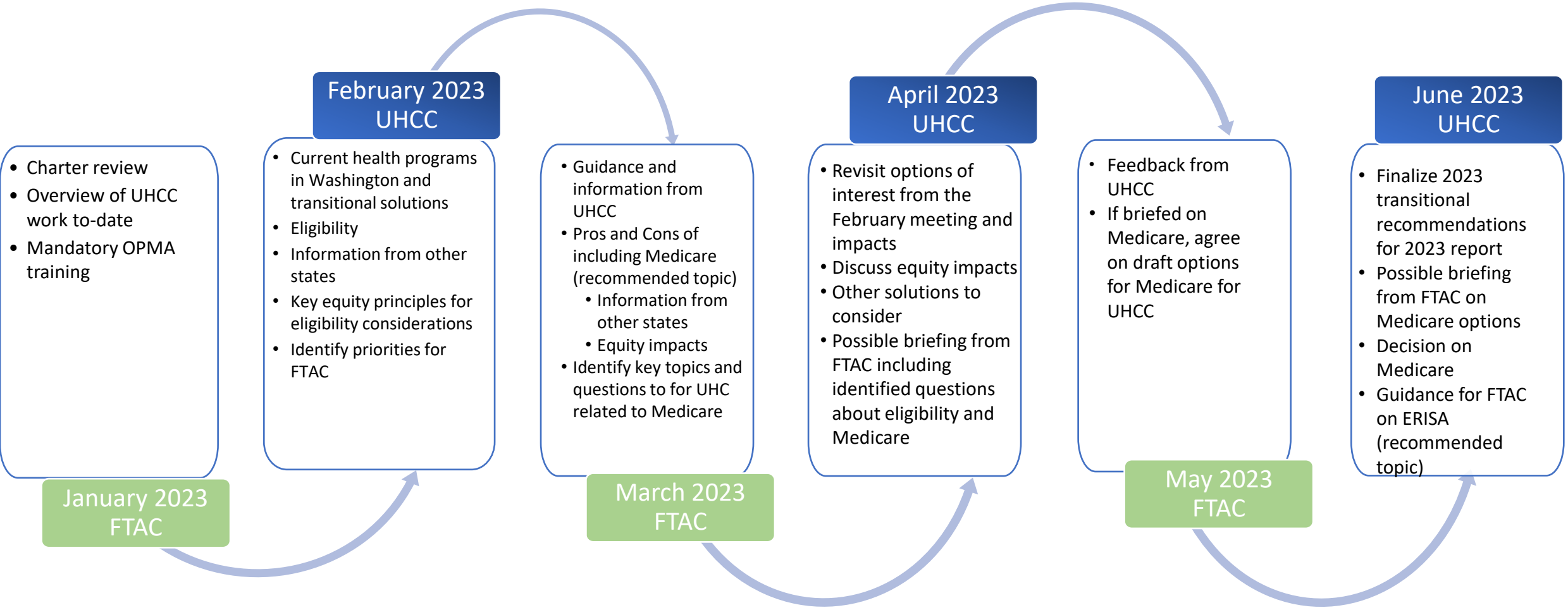
April 11, 2023

Objectives

Review timeline and workplan

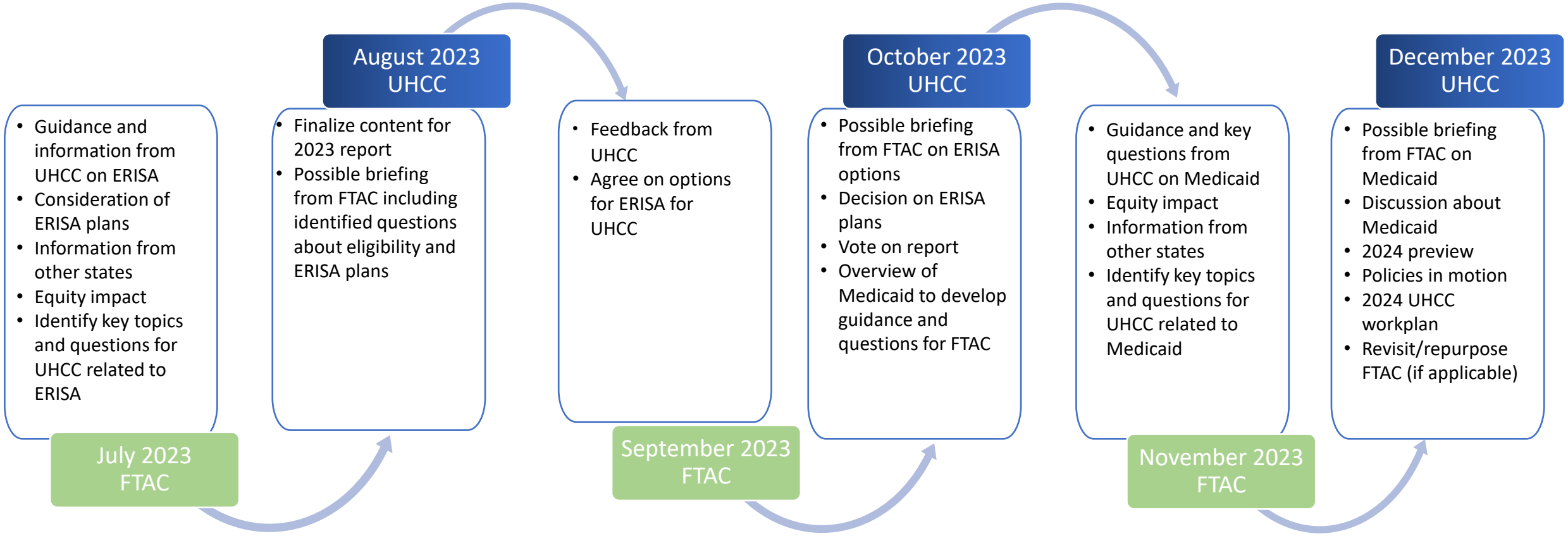
Discuss legislative request for the Commission to analyze the Whole Washington Trust bill

Washington's UHCC 2023 Workplan



Workplan will change depending on progress made in each meeting

Washington's UHCC 2023 Workplan



Workplan will change depending on progress made in each meeting

Request regarding the Washington Health Trust Bill (SB 5335, 2023)

Chair Lowe

The Commission has been requested to analyze the proposal to create the Washington Health Trust. The Commission's analysis should:

- Be shared in a report by June 30, 2024
- Assess whether the proposal aligns with the goals and planned activities of the Commission.
- Assess whether and how the Commission might recommend implementing the proposal, if the Commission considers it within their mission and a viable proposal.
- Identify opportunities for proponents of the proposal to substantively engage with the Commission in the future.
- Engage the leaders of Whole Washington throughout the analysis process and report preparation.

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HMA can outline options for how the analysis can work into the Commission's current work plan.

Questions and considerations for incorporation into workplan:

- How could the Commission structure its analysis to be completed in time, and in a way that aligns with the Commission's work?
- How could the Commission best engage the leaders of Whole Washington throughout the analysis process and report preparation?
- Others?

Washington Health Trust Bill

Commission Member Vote:

Motion to incorporate the request regarding the Washington Health Trust proposal into the Commission and FTAC's work plan to the extent possible within the requested timeframe.

Vicki Lowe, Chair

Next Steps

- HMA and HCA staff will outline options for how the analysis can work into the Commission's current work plan.
- Share updated work plan options with the Commission at the June meeting.

S-0571.1

SENATE BILL 5335

State of Washington 68th Legislature 2023 Regular Session

By Senators Hasegawa, Hunt, Liias, Nguyen, and Stanford

Read first time 01/12/23. Referred to Committee on Health & Long Term Care.

AN ACT Relating to health care financing and development of the Washington health trust to ensure that all Washington residents can enroll in nonprofit health insurance coverage providing an essential set of health benefits, including medical, dental, vision, and prescription drug benefits; adding a new section to chapter 82.32 RCW; adding a new section to chapter 82.04 RCW; adding a new chapter to Title 43 RCW; adding a new chapter to Title 82 RCW; adding a new title to the Revised Code of Washington to be codified as Title 50C RCW; prescribing penalties; providing effective dates; providing a contingent effective date; and providing contingent expiration dates.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Part I
Universal Health Care for Washington State

NEW SECTION. **Sec. 101.** WASHINGTON HEALTH TRUST PROTECTIONS. During this time of deep racial and socioeconomic inequity, Washingtonians have watched as loved ones and neighbors slipped through the widening gaps in our health care system. According to the Washington state department of health, the COVID-19 pandemic has worsened these structural disparities, showing in their recent COVID-19 morbidity report that the death and burden of this pandemic

has disproportionately affected those already marginalized and underserved communities. With the intent to start healing the wounds of generations of inequality and to ensure a future where health care is recognized as a basic right afforded to each resident, the people of the state of Washington declare their intention to create a single, primary nonprofit health financing entity called the Washington health trust. The trust will simplify health care financing, eliminate administrative waste, respond to the health needs of each regional health district, and guarantee all residents coverage of a comprehensive set of essential health benefits without the burden of premiums, deductibles, copayments, or medical bills.

(1) All residents of the state of Washington are eligible for coverage through this chapter.

(2) Individuals enrolled for essential health benefits under this chapter may obtain health services from any participating institution, agency, or individual qualified to provide the service including participating providers outside the state.

(3) Residents may obtain coverage for health care benefits in excess of those available under the trust, including additional benefits that an employer may provide to employees and their dependents and spouses or to former employees and their dependents and spouses.

(4) No person shall, on the basis of race, color, national origin, age, disability, immigration status, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions, be excluded from participation in, be denied the benefits of, or be subjected to discrimination by any participating provider or any entity conducting, administering, or funding a health program or activity, including contracts of insurance, under this chapter.

(5) Participating providers may not be denied reimbursement by the Washington health trust for any essential health benefit that is within the scope of their practice, consistent with the accepted standard of care as described in RCW 7.70.040.

(6) A participating health care provider is not required to furnish any health care service that is outside the scope of their practice or, in the health care provider's reasonable clinical judgment, not consistent with the accepted standard of care as described in RCW 7.70.040.

(7) Participating providers may receive payments from sources other than the trust. However, any provider who does accept payment from the trust for a service must accept that payment, along with applicable copayments, as payment in full.

(8) Any provider, institution, agency, or individual that is qualified to provide a health care service covered under this chapter, is entitled to participate and receive reimbursement as described in section 109 of this act.

(9) Nothing in this chapter is intended to interfere with tribal sovereignty over any federal or state funding set aside for tribal health or Indian health services, including those provided by chapter 43.71B RCW.

NEW SECTION. **Sec. 102.** DEFINITIONS. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Board" means the Washington health trust board of trustees created in section 104 of this act.

(2) "Chair" means the presiding officer of the board.

(3) "Community health access" means a reimbursement system managed by the health care authority for eligible residents to receive essential health services free to the individual at the point of service through community health providers.

(4) "Community health provider" means a qualified provider electing participation in the trust as a coordinating nonprofit health care provider to negotiate reimbursements based on quality and availability of services for residents in each regional health district as described in section 109 of this act.

(5) "Department" means the Washington state department of health.

(6) "Eligible nonresident" shall be defined by the board of trustees created in section 104 of this act, and includes nonresident students attending college within the state, nonresidents employed within the state, and the spouses or domestic partners and dependents of eligible nonresidents.

(7)(a) "Employee" means an individual who is in the employment of an employer.

(b) "Employee" does not include employees of the federal government.

(8) "Employer" has the meaning provided in section 201 of this act.

(9) "Employment investment" means a cost paid by or on behalf of employed individuals for enrollment in the Washington health trust.

(10) "Essential benefits package" means a single comprehensive health insurance that covers essential health benefits.

(11) "Essential health benefits" means any of the following items and services provided on an inpatient or outpatient basis when medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition:

(a) Hospital services, including inpatient and hospital-based outpatient care and 24-hour emergency services;

(b) Ambulatory primary and specialty services, including preventative care and chronic disease management;

(c) Prescription drugs, medical devices, and biological products;

(d) Mental health and substance use disorder treatment services;

(e) Laboratory and other diagnostic services, including diagnostic imaging services;

(f) Reproductive, maternity, and newborn care;

(g) Pediatric primary and specialty care;

(h) Palliative care and end-of-life care services;

(i) Oral health, audiology, and vision services;

(j) Short-term rehabilitative and habilitative services and devices; and

(k) Licensed naturopathic, acupuncture, and massage therapies.

(12) "Essential health benefits-benchmark plan" means the set of benefits that an issuer must include in nongrandfathered plans offered in the individual or small group market in Washington state, as defined in section 1302 of the affordable care act, 124 Stat. 119, P.L. 111–148 (2010), and 45 C.F.R. 156.100.

(13) "Federal poverty level" means the federal poverty guidelines determined annually by the United States department of health and human services or its successor agency.

(14) "Global annual budget" means the specific amount of money required for health care facilities participating for reimbursement as a community health provider to operate as negotiated by the board.

(15) "Health care facility" or "facility" includes any of the following appropriately accredited entities: Hospices and home health agencies licensed pursuant to chapter 70.127 RCW; hospitals licensed pursuant to chapter 70.41 RCW; rural health care facilities as defined in RCW 70.175.020; psychiatric hospitals licensed pursuant to

chapter 71.12 RCW; nursing homes licensed pursuant to chapter 18.51 RCW; community mental health centers licensed pursuant to chapter 71.05 or 71.24 RCW; kidney disease treatment centers; ambulatory surgical facilities licensed under chapter 70.230 RCW; approved drug and alcohol treatment facilities certified by the department of social and health services; such other facilities owned and operated by a political subdivision or instrumentality of the state; a tribally operated facility as defined in RCW 43.71B.010; and such other facilities as required by federal law and implementing regulations.

(16) "Income" means the adjusted gross household income for federal income tax purposes.

(17) "Long-term care" means institutional, residential, outpatient, or community-based services that meet the individual needs of persons of all ages who are limited in their functional capacities or have disabilities and require assistance with performing two or more activities of daily living for an extended or indefinite period of time. These services include case management, protective supervision, in-home care, nursing services, convalescent, custodial, chronic, and terminally ill care.

(18) "Native American" means an American Indian or Alaska Native as defined under 25 U.S.C. Sec. 1603.

(19) "Participating provider" means a person, health care provider, practitioner, health care facility, or entity acting within their scope of practice that has negotiated a written contract to participate and receive reimbursement as described in section 109 of this act.

(20) "Qualified provider" means a person, health care provider, practitioner, health care facility, or entity acting within their scope of practice who is licensed or certified and meets: (a) All the requirements of state law to provide such services in the state where the services are provided; and (b) applicable requirements of federal law to provide such services. "Qualified provider" includes a licensed or certified hospital, clinic, health maintenance organization, or nursing home or an officer, director, employee, or agent thereof acting in the course and scope of their employment.

(21) "Reimbursement accounts" means health care accounts with funds that can be used for essential health benefits incurred by residents and eligible nonresidents with health insurance coverage other than the trust for copayments and out-of-pocket costs.

(22) "Resident" means an individual who presents evidence of established permanent residency in the state of Washington and meets residency requirements consistent with RCW 46.16A.140. "Resident" also includes people and their accompanying family members who are residing in the state for the purpose of engaging in employment for at least one month. The confinement of a person in a nursing home, hospital, or other medical institution in the state may not by itself be sufficient to qualify such person as a resident.

(23) "Revocable expenditure" means a health care expenditure that an employer allocated for use by a covered employee but not actually paid to the employee, or any amount actually paid to a third-party administrator that could revert to the employer at any point. Funds do not have to revert to the employer for the health care expenditure to be revocable. Rather, the entire expenditure is considered revocable if there is the possibility that any or all of it could be returned to the employer, such as flexible spending accounts.

(24) "Trust" means the Washington health trust created in section 103 of this act.

NEW SECTION. **Sec. 103.** WASHINGTON HEALTH TRUST. The Washington health trust is created within the department. The purpose of the trust is to provide coverage for a set of essential health benefits to all Washington residents.

NEW SECTION. **Sec. 104.** THE BOARD OF TRUSTEES. (1) The trust must be governed by a board of trustees consisting of 15 members with expertise in health care financing and delivery and representing Washington citizens, business, labor, and health professions. Trustees must include individuals with knowledge of the health care needs of diverse populations, including low-income, Native American, undocumented, non-English speaking, disabled, rural, incarcerated, and other minority populations. Members of the board must have no pecuniary interest in any business subject to regulation by the board.

(2) The universal health care commission established under RCW 41.05.840 shall assume the responsibility of the board.

(3) If the universal health care commission is disbanded or unable to assume the responsibilities of the board, the board shall be formed using the same process defined in RCW 41.05.840 for full formation no later than May 15, 2024.

(4) A trustee whose term has expired or who otherwise leaves the board must be replaced by gubernatorial appointment. When the person leaving was nominated by one of the caucuses of the house of representatives or the senate, their replacement must be appointed from a list of five nominees submitted by that caucus within 30 days after the vacancy occurs. If the caucus or the insurance commissioner fails to submit the list of nominees or if the nominees do not meet the qualifications specified in subsection (1) of this section, the governor shall appoint a trustee meeting the qualifications specified in subsection (1) of this section at the governor's discretion. A person appointed to replace a trustee who leaves the board before the expiration of their term shall serve only the duration of the unexpired term.

(5) If convinced by a preponderance of the evidence in a due process hearing that a trustee has failed to perform required duties or has a conflict with the public interest, the governor may remove that trustee and appoint another to serve the unexpired term.

(6) Members of the board are subject to chapter 42.52 RCW.

(7) The trustees occupy their positions according to the bylaws, rules, and relevant governing documents of the board and are exempt from chapter 41.06 RCW. The board and its professional staff are subject to the public disclosure provisions of chapter 42.17A RCW. Trustees shall be paid a salary to be fixed by the governor in accordance with RCW 43.03.040. A majority of the board constitutes a quorum for the conduct of business.

NEW SECTION. **Sec. 105.** ADVISORY COMMITTEES. (1) Subject to the approval of the board, the chair shall appoint three standing advisory committees:

(a) A finance committee consisting of financial experts from the office of financial management, the office of the state treasurer, the employment security department, and the office of the insurance commissioner. The finance committee shall recommend specific details for major budget decisions and for appropriations, taxes, and other funding legislation necessary to conduct the operations of the trust;

(b) A citizen committee consisting of balanced representation from health experts, business, labor, and consumers, specifically including representation from populations where health care disparities are known to exist as described in section 107 of this act. The citizen committee shall hold public hearings on priorities

for inclusion in the set of health services to be offered through the trust, survey public satisfaction, investigate complaints, and identify and report on health care access and other priority issues for residents; and

(c) A provider committee consisting of members with broad experience in and knowledge of health care delivery, research, and policy, as well as public and private funding of health care services. The provider committee shall make recommendations to the board on issues related to scope of covered benefits, quality improvement, continuity of care, resource utilization, and other issues as requested by the board.

(2) The board shall consult with the citizen committee at least quarterly, receive its reports and recommendations, and then report to the governor and legislature at least annually regarding board actions in response to citizen committee recommendations. The board shall regularly seek financial recommendations from the finance committee to establish and maintain the trust solvency. The board shall consult with the provider committee to promote development of policy and procedures for administration of reimbursements, negotiations for reimbursements, and related documentation.

(3) Subject to approval of the board, the chair may appoint other committees and task forces as needed.

(4) Members of committees shall receive compensation for their services and shall be reimbursed for their expenses while attending meetings on behalf of the board in accordance with RCW 43.03.250.

NEW SECTION. **Sec. 106.** AUTHORITIES OF THE BOARD CHAIR. The chair is the presiding officer of the board and has the following powers and duties:

(1) Appoint an executive director with the approval of the board;

(2) Enter into contracts on behalf of the board. All contracts are subject to review and binding legal opinions by the attorney general's office if disputed in a due process hearing by a party to such a contract;

(3) Subject to explicit approval of a majority of the board, accept and expend gifts, donations, grants, and other funds received by the board; and

(4) Delegate administrative functions of the board to the executive director and trust staff as necessary to ensure efficient administration.

NEW SECTION. **Sec. 107.** RESPONSIBILITIES OF THE BOARD. (1) With advice from the citizen committee and the provider committee, the board shall:

(a) Establish a single comprehensive benefits package covering essential health benefits to be financed by the trust, as provided in section 108 of this act;

(b) Subject to the funding mechanisms established under this chapter, seek all applicable waivers or demonstration project approvals, or both, so that current federal and state payments for health services to residents will be paid directly or are made otherwise available to the trust;

(c) Prior to full integration of federally qualified trust funds into the trust, establish at their discretion any premiums necessary to operate the trust and make rules, policies, guidelines, and timetables needed for the trust to finance the essential benefits package for residents starting November 1, 2024;

(d) Develop or contract for development of a statewide, anonymous health care data system;

(e) Develop health care practice guidelines and quality standards for the trust;

(f) Develop policies to protect confidentiality of patient's records throughout the health care delivery system and the claims payment system;

(g) Make rules for eligible nonresidents;

(h) Develop or contract for development of an efficient enrollment mechanism for all who are eligible;

(i) Develop or contract for development of a streamlined uniform claims processing system that must pay providers in a timely manner for covered health services;

(j) Develop appeals procedures for residents and providers;

(k) Integrate functions with other state agencies;

(l) Work to balance benefits and provider payments with revenues, and develop effective measures to control excessive and unnecessary health care costs;

(m) Implement policies to ensure that all Washingtonians receive culturally, linguistically, and structurally competent care and address nonfinancial barriers to health care access including developing specific goals and plans and identifying and addressing the needs of vulnerable populations that are most susceptible to health care disparities, particularly targeting disease prevention

and health promotion and medical, mental/behavioral health, and public health issues that disproportionately affect the diverse populations where disparities are known to exist, in order to ensure equitable, appropriate, effective, safe, and high quality care for all, with no gaps in services based on any medically irrelevant factor; and

(n) Develop an annual trust budget.

(2) To the extent that the exercise of any of the powers and duties specified in this section may be inconsistent with the powers and duties of other state agencies, offices, or commissions, the authority of the board supersedes that of such other state agency, office, or commission.

NEW SECTION. **Sec. 108.** COMPREHENSIVE ESSENTIAL HEALTH BENEFITS PACKAGE. (1) The board shall establish a single comprehensive essential benefits package covering essential health benefits that are effective and necessary for the good health of residents and that emphasize preventive, primary, and integrated health care. The board shall ensure that the essential benefits package constitutes coverage at least as comprehensive as the minimum essential coverage for purposes of the federal patient protection and affordable care act.

(2) The board and the department shall, on an ongoing and regular basis, evaluate whether the essential health benefits should be improved or adjusted to promote the health of beneficiaries, account for changes in medical practice or new information from medical research, or respond to other relevant developments in health science, and shall make recommendations to the legislature regarding any such improvements or adjustments.

(3) Subject to a financial analysis demonstrating ongoing sufficient funds in the trust, long-term care shall be a covered benefit on January 1, 2027. Long-term care coverage shall include a uniform initial assessment and coordination between home health, adult day care, and nursing home services, and other treatment alternatives. The board may establish a copayment for long-term nursing home care, to cover some costs of room and board, for residents with household incomes above 150 percent of the federal poverty level.

(4) The board must establish:

(a) A long-term care benefits package; and

(b) Eligibility requirements at least as inclusive as the medicaid standards for Washington on the effective date of this section.

(5) When the board establishes a long-term care benefits package beyond what is described in subsection (4) of this section, the board, in coordination with the office of the insurance commissioner, shall examine possible remedies for residents who have made previous payments for long-term care insurance.

(6) The board shall submit to the governor and legislature by December 1, 2024, and by December 1st of the following years:

(a) The essential benefits package; and

(b) An actuarial analysis of the cost of the package.

NEW SECTION. **Sec. 109.** PARTICIPATING PROVIDERS. (1) The board, in coordination with the health care authority, shall adopt rules and mechanisms permitting qualified providers to collectively negotiate budgets, payment schedules, and other terms and conditions of trust participation.

(2) The board, in coordination with the health care authority and on an annual basis, shall collectively negotiate reimbursement rates with qualified providers not participating as community health providers on a fee-for-service basis.

(3) Any qualified provider operating as a public hospital or health care facility or public or private nonprofit 501(c) organization with three or more individual practitioners coordinating to deliver essential health benefits may elect to participate as a community health provider.

(4) The board, in coordination with the health care authority, shall annually negotiate with each community health provider a prospective global budget for operational and other costs to be covered by the trust. Hospitals and other health care facilities shall be paid on a fee-for-service basis, within the limits of their prospective global annual budget. Individual practitioners who are employed by a community health provider may be paid by salary.

(5) The board shall make appropriate considerations and recommendations during annual negotiations with community health providers including:

(a) Health needs of residents in each regional health district in the state;

(b) The scope of services offered by the provider;

(c) Quality and effectiveness of care standards and safety policies utilized by the provider;

(d) Quality of employment for those employed by the provider; and

(e) Provider coordination with the department of social and health services on delivery of needs-based assistance for which residents in the regional health district are eligible.

(6) The board shall adopt rules ensuring that payment schedules and procedures for mental health services are comparable to other health care services included in the essential benefits package.

(7) The board shall adopt rules ensuring that payment schedules for care provided via telemedicine, as defined in RCW 70.41.020, are at parity levels with equivalent care provided in person.

(8) The board shall study and develop provider payment methods that:

(a) Encourage an integrated multispecialty approach to disease management;

(b) Reward education time spent with patients; and

(c) Include all categories of providers pursuant to rule and RCW 48.43.715.

NEW SECTION. **Sec. 110.** PHARMACEUTICALS, MEDICAL EQUIPMENT, AND BIOLOGICALS. (1) When consistent with federal law, the prices to be paid for covered pharmaceuticals, medical supplies including biological products, and medically necessary assistive equipment shall be negotiated annually by the board for all residents and eligible nonresidents enrolled in the trust.

(2)(a) The board shall establish a prescription drug formulary system, which:

(i) Encourages best practices in prescribing;

(ii) Discourages the use of ineffective, dangerous, or excessively costly medications when better alternatives are available;

(iii) Promotes the use of generic medications to the greatest extent possible; and

(iv) Does not interfere with treatments necessary for appropriate standards of care.

(b) The formulary shall be updated frequently, with advice from clinicians and patients, to add new pharmaceuticals or remove ineffective or dangerous medications from the formulary.

(3) The board shall develop rules for off-formulary medications which allow for patient access without compromising the formulary.

(4) The board may seek other means of financing drugs and durable medical equipment at the lowest possible cost, including bulk purchasing agreements with Washington state tribes.

(5) The board may set a cost-sharing schedule for prescription drugs and biological products for enrolled individuals that: (a) Is evidence-based and encourages the use of generic drugs; (b) does not apply to preventive drugs; and (c) does not exceed $250 annually, adjusted annually for inflation.

NEW SECTION. **Sec. 111.** ENROLLMENT ELIGIBILITY. (1) Residents:

(a) Under the age of 19; or

(b) With dual eligibility for medicare and medicaid;

are exempt from the employment investment established under subsection (2) of this section for enrollment in the Washington health trust and the self-employment investment for enrollment in the trust.

(2) When a resident is employed, an employment investment must be paid by the resident or their employer for enrollment in the trust except as provided in subsection (1) of this section. The employment investment is equal to total required health care expenditures employers must pay to or on behalf of the employee as established in section 202 of this act.

(3) Until full integration of federally qualified trust funds is accomplished, residents, including but not limited to Native American residents, who are covered under federal health programs shall continue to use that coverage, and additional benefits provided by the trust shall extend only to costs not covered by the federal health programs when, subject to subsection (1) of this section:

(a) The resident voluntarily elects to enroll in the trust; and

(b) The resident's wages and net earnings are considered in calculating either the employment or self-employment investment established under this section.

(4) Pending full integration of federally qualified trust funds into the trust, residents who are retirees are eligible for coverage through the trust when they elect the trust coverage as their medicare advantage plan. The board shall make rules and adopt mechanisms to reimburse residents with household incomes below 200 percent of the federal poverty level and all residents who elect to

enroll in the trust for medicare premiums the individual pays while enrolled in the trust until a federal waiver or demonstration project approval as applicable is granted integrating the federally qualified trust funds into the trust.

NEW SECTION. **Sec. 112.** COVERAGE USE AND AVAILABILITY. (1) If an enrolled individual has other health insurance coverage for any essential health benefits provided in the state, the trust benefits provided in this chapter are secondary to that insurance coverage. Nonresidents are covered for emergency services and emergency transportation only, except when the individual is an eligible nonresident and enrolled in the trust for coverage as provided in section 102(6) of this act.

(2) The board shall make provisions for determining reimbursements for covered medical expenses for residents while they are out of the state.

(3) No cost sharing, including deductibles, coinsurance, copayments, or similar charges, may be imposed on an enrolled individual for any benefits provided under this chapter, except:

(a) Cost sharing may be contingent on the inclusion of long-term care coverage beyond what is provided under medicaid; and

(b) As provided in section 110 of this act.

(4) No cost sharing, including deductibles, coinsurance, copayments, or similar charges, may be imposed on enrolled:

(a) Persons under the age of 19;

(b) Residents who are dual eligible medicare and medicaid beneficiaries; or

(c) Adults whose household income is under 200 percent of the federal poverty level.

(5) By October 1, 2024, the board must take all steps necessary, including seeking appropriate approvals from federal entities, to ensure the essential benefits package qualifies as an essential health benefits-benchmark plan for the purposes of contracting to administer all essential health benefits with the following entities as a managed health care system:

(a) The health care authority;

(b) The public employees' benefits board;

(c) Indian health services;

(d) Center for medicare and medicaid services;

(e) The department of social and health services; and

(f) Any other director, entity, or agency with authority to contract administration of essential health benefits to a managed health care system operating in Washington state.

(6) By October 1, 2024, the board shall establish necessary premiums and cost-sharing requirements for eligible individuals enrolled in the program through the Washington health benefits exchange, collect premium and assessment payments from all enrolled eligible individuals, and deposit premium payments in the benefits account created in section 123 of this act. If the eligible individual qualifies for premium subsidies or cost-sharing reductions under the patient protection and affordable care act, the premium or cost-sharing amounts established under this subsection may not exceed the amounts the eligible individual would have paid if they had enrolled in a silver level qualified health plan through the Washington health benefit exchange. The portion of premiums, copays, and out-of-pocket costs enrollees are responsible for after eligible premium subsidies or cost-sharing reductions are applied must be consistent with this section.

(7) On or before November 1, 2025, the board shall:

(a) Begin offering coverage to all residents and eligible nonresidents;

(b) Contract with all entities in subsection (5) of this section for enrollment of residents who are eligible for essential health benefits coverage through a federal or federally funded state health program, except when contingent on approval for full integration of federally qualified trust funds into the trust;

(c) Ensure the operation of the trust is consistent with this chapter; and

(d) Enable the state to provide equitable coverage for all enrolled, including those covered through medicaid and medicare, and maximize the use of appropriate federal funding in the trust.

(8) The board shall not contract the administration of covered benefits for an individual enrolled in the trust to a managed health care system operating for-profit except when the enrolled individual:

(a) Is enrolled in supplemental health insurance coverage through the managed health care system; and

(b) Has elected the benefits administration through the managed health care system.

NEW SECTION. **Sec. 113.** INTEGRATION OF FEDERAL HEALTH COVERAGE PROGRAMS. (1) The health care authority shall determine which state and federal laws affect full integration of federally qualified trust funds into the trust, and report its recommendations for accomplishing such full integration, with any proposed revisions to the Revised Code of Washington, to the governor and the appropriate committees of the legislature by the first date following the effective date of this section.

(2) The governor, in consultation with the board and the health care authority, shall take the following steps in an effort to receive applicable waivers, exemptions, or approval for demonstration projects from federal agencies in order to fully integrate coverage and funding available through federally qualified trust funds into the trust under this chapter:

(a) Negotiate with the federal department of health and human services' health care financing administration to obtain a statutory or regulatory waiver of provisions of the medical assistance statute, Title XIX of the federal social security act and the children's health insurance program including, but not limited to, application for an applicable demonstration project;

(b) Negotiate with the federal department of health and human services to obtain a statutory or regulatory waiver of provisions of the medicare statute, Title XVIII of the federal social security act, that currently constitute barriers to full integration of this chapter or to obtain approval for the trust to operate as a medicare advantage plan or other demonstration project allowing relevant federal funds to flow into the trust;

(c) Negotiate with the federal department of health and human services to obtain any statutory or regulatory waivers of provisions of the United States public health services act, or applicable demonstration project, necessary to ensure integration of federally funded community and migrant health clinics and other health services funded through the public health services act into the trust system under this chapter;

(d) Negotiate with the federal office of personnel management for the inclusion of federal employee health benefits in the trust under this chapter;

(e) Negotiate with the federal department of defense and other federal agencies for the inclusion of the civilian health and medical

program of the uniformed services in the trust under this chapter; and

(f) Request that the United States congress amend the internal revenue code to treat the assessments and any premiums established under this chapter as fully deductible from adjusted gross income.

(3) Beginning November 15, 2024, the health care authority shall submit annual progress reports to the appropriate legislative committees regarding the development of the waiver or demonstration project applications, or other integration measures, and on enrollment of residents into health coverage managed by the health care authority, an entity within the health care authority, or the trust. The report submitted on November 15, 2025, must include a list of any statutory changes necessary to implement full integration of federally qualified trust funds into the trust.

(4) Upon receipt of any waiver or approval for other integration measures under this chapter, the health care authority shall promptly notify in writing the office of the code reviser, the governor, and the appropriate committees of the legislature.

(5) Beginning no later than four years after the effective date of this section, the health care authority, including entities or agencies within the health care authority, shall not contract administration of essential health benefits available through the trust to a managed health care system operating for-profit except when the enrolled individual:

(a) Is also enrolled only in supplemental health insurance coverage through the managed health care system; and

(b) Has elected the benefits administration through the managed health care system.

(6) The health care authority, in coordination with the board and all other agencies within the state, shall take all steps necessary to align reimbursement rates for essential health benefits provided through a program managed by the health care authority or an agency within the state.

NEW SECTION. **Sec. 114.** TRANSITIONAL EMPLOYMENT PROVISIONS. (1) Employers with employees represented by a union and with established health benefit plans negotiated before the effective date of this section:

(a) Shall maintain health benefits at least as comprehensive and affordable to covered employees and retired employees after the effective date of this section; and

(b) Are exempt from owing the required health care expenditures established in section 202 of this act, including the employee share, for each employee offered affordable minimum essential coverage, defined by the patient protection and affordable care act, through the existing employee health benefit plan until a supplemental health benefit plan is negotiated and becomes effective.

(2) Resident employees of Washington employers and enrolled in a health benefit plan described in subsection (1) of this section may:

(a) Participate in the Washington health trust by paying the employment investment, subject to the exclusions in section 111 of this act, to enroll in the trust's essential benefits package as a primary health insurance. Any amount paid to the employment security department on behalf of an employee and not used to reimburse medical expenses for the employee may be applied to the employment investment for enrollment in the Washington health trust at the time the resident employee elects enrollment; or

(b) Participate in the health options program defined in section 127 of this act.

(3) All sole proprietors operating in the state may apply for an exemption from the self-employment contribution established in section 203 of this act if the individual is enrolled in minimal essential coverage, as defined by the patient protection and affordable care act.

(4) This section is subject to section 126 of this act and expires on the first January 1st following the effective date of section 115 of this act.

NEW SECTION. **Sec. 115.** ENROLLMENT CONDITIONAL PROVISIONS. Within one year of the effective date of this section:

(1) Subject to ongoing sufficient funding, the board shall work to reduce deductibles and out-of-pocket costs for all enrolled adults to the fullest extent possible; and

(2) The Washington state health care authority shall apply for a waiver from the provisions of the federal patient protection and affordable care act, P.L. 111-148, as amended by the federal health care and education reconciliation act, P.L. 111-152, to:

(a) Suspend the operation of the Washington health benefit exchange established in chapter 43.71 RCW; and

(b) Enable the state to receive appropriate federal funding in lieu of the federal premium tax credits, federal cost-sharing subsidies, and other federal payments and tax credits that will no longer be necessary due to the suspension of the operations of the Washington health benefit exchange. The health care authority may use existing health benefit exchange resources to facilitate residents' ability to compare and purchase supplemental health insurance.

NEW SECTION. **Sec. 116.** ADMINISTRATIVE COST CONTROLS. (1) Administrative expenses to operate and maintain the trust shall not exceed seven percent of the trust's annual budget. The board shall not shift administrative costs or duties of the trust to providers or to resident beneficiaries.

(2) The board shall work with providers to develop and apply scientifically based utilization standards, to use encounter and prescribing data to detect excessive utilization.

(3) The department shall develop due processes for enforcing appropriate utilization standards, and to identify and prosecute fraud that includes:

(a) Anonymous reporting of any suspected waste, fraud, and abuse; and

(b) An appeals process.

(4) The board may institute other cost-containment measures in order to maintain a balanced budget. The board shall pursue due diligence to ensure that cost-containment measures neither limit access to clinically necessary care or infringe upon legitimate clinical decision making by practitioners or the legitimate decisions of an enrolled individual to receive prescribed essential health benefits.

(5) Administrative expenses must include reasonable funding for the employment security department to carry out its obligations regarding enforcement of required health care expenditures and collection of the employment contributions established in section 202 of this act, the contribution paid by sole proprietors established in section 203 of this act, and the capital gains tax established in section 302 of this act that are among the trust's funding sources.

NEW SECTION. **Sec. 117.** ACTUARIAL ANALYSIS AND REPORTING. Beginning December 15, 2024, the board shall contract annually for an actuarial analysis of the trust's funding needs. The board shall report annually on all the funding mechanisms to the appropriate standing committees of the house of representatives, the senate, and the governor, starting May 15, 2025. The funding mechanisms must contain the following elements:

(1) The employment investment to be paid by or on behalf of employed residents and eligible nonresidents, established in section 111 of this act and under the exemption provided in section 114 of this act;

(2) The long-term capital gains tax established in section 302 of this act;

(3) The self-employment excise tax established in section 203 of this act and under the exemption provided in section 114 of this act;

(4) Any premiums necessary, as established in section 107 of this act and pursuant to sections 111 and 112 of this act, to be paid by enrolled adults, their spouse, or an employer prior to full integration of federally qualified trusts;

(5) A cost-sharing schedule, established in section 110 of this act and pursuant to section 112 of this act, paid by enrolled adults with household incomes exceeding 199 percent of the federal poverty level, their spouse, or an employer; and

(6) Available federal health program funding either pursuant to waivers or other integration measures taken as described in sections 113 and 115 of this act, or by contracting for administration of those benefits as described in section 112 of this act.

NEW SECTION. **Sec. 118.** ALLOCATION OF EXISTING FUNDING. Following the repeal, amendment, or waiver of existing state and federal laws delineated in sections 113 and 115 of this act, all other revenues currently deposited in the public health services account pursuant to RCW 43.72.902 shall be deposited to the reserve account created in section 121 of this act and the benefits account created in section 123 of this act.

NEW SECTION. **Sec. 119.** ALLOCATION OF NEW REVENUES. Revenue derived from the contributions established in sections 202, 203, and 302 of this act and any premiums established under section 107 of this act shall be deposited to the reserve account created in section

121 of this act and the benefits account created in section 123 of this act, and may not be used to pay for medical assistance currently provided under chapter 74.09 RCW or other existing federal and state health care programs. If existing federal and state sources of payment for health services are reduced or terminated after the effective date of this section, the legislature shall replace these appropriations from the general fund.

NEW SECTION. **Sec. 120.** START-UP APPROPRIATIONS. An appropriation by separate act of the legislature may be necessary for the fiscal year ending June 30, 2024, from the general fund to the benefits account for start-up moneys for purposes of this chapter during the period of July 1, 2024, through the second June 30th following the effective date of section 115 of this act.

NEW SECTION. **Sec. 121.** RESERVE ACCOUNT. (1) The reserve account is created in the custody of the state treasurer. The reserve account will accumulate moneys until its value equals 10 percent of the total annual budgeted trust expenditures and then will be considered fully funded, unless the legislature determines that a different level of reserve is necessary and prudent. Whenever the reserve account is fully funded, additional moneys shall be transferred to the benefits account created in section 123 of this act.

(2) Expenditures from the reserve account may be used only for the purposes of health care services and maintenance of the trust. Only the board or the board's designee may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

NEW SECTION. **Sec. 122.** DISPLACED WORKER TRAINING ACCOUNT. (1) The displaced worker training account is created in the custody of the state treasurer. Expenditures from the account may be used only for retraining and job placement of workers displaced by the transition to the trust. Only the board or the board's designee may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

(2) Any funds remaining in the account on the second December 31st following the effective date of section 115 of this act must be

deposited into the benefits account created in section 123 of this act.

(3) This section expires the third January 1st following the effective date of section 115 of this act.

NEW SECTION. **Sec. 123.** BENEFITS ACCOUNT. The benefits account is created in the custody of the state treasurer. Expenditures from the account may be used only for health care services and maintenance of the trust. Only the board or the board's designee may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

NEW SECTION. **Sec. 124.** ANNUAL BUDGET. (1) Beginning May 15, 2025, the board shall adopt, in consultation with the office of financial management, an annual Washington health trust budget. If operation expenses exceed revenues generated in two consecutive years, the board shall recommend adjustments in revenues to the legislature.

(2) The recommended adjustments must also include recommended additional funding sources including, but not limited to, revenues collected under RCW 41.05.120, 41.05.130, 66.24.290, 82.24.020, 82.26.020, 82.08.150, 43.79.480, and 41.05.220.

(3) The recommendations shall specify the amounts that must be deposited in the reserve account created in section 121 of this act, the displaced worker training account created in section 122 of this act, and the benefits account created in section 123 of this act.

(4) Prior to making its recommendations, the board shall conduct at least six public hearings in different geographic regions of the state seeking public input or comment on the recommended funding mechanism.

(5) The legislature shall enact legislation implementing the recommendations of the board during the regular legislative session following the recommendations.

NEW SECTION. **Sec. 125.** COST REPORTING. The board shall:

(1) Report annual changes in total Washington health care costs, along with the financial position and the status of the trust, to the governor, the legislature, and the employment security department at least once a year;

(2) Seek audits annually from the state auditor;

(3) Contract with the state auditor for a performance audit every two years;

(4) Adopt bylaws, rules, and other appropriate governance documents to assure accountability, as well as the open, fair, and effective operation of the trust, including criteria under which reserve funds may be prudently invested subject to advice from the state treasurer and the director of the department of financial management;

(5) Submit any internal rules or policies it adopts to the secretary of state. Internal rules or policies must be made available by the secretary of state for public inspection; and

(6) Collaborate with the health care authority to recommend adjustments to the percent of an employee's wages an employer must pay to or on behalf of an employee for required health care expenditures established in section 202 of this act to the employment security department, including the self-employment contribution and employee deduction. Recommendations must ensure the employment-based contribution percentage rates:

(a) Do not exceed 10.5 percent of an employee's aggregate adjusted quarterly payroll;

(b) Are not higher than is necessary to provide adequate funding for the trust and the health options program as described in section 127 of this act;

(c) Are equal for the self-employment contribution and the employee deduction; and

(d) Do not reduce any individual's access to health care services or enrollment in the trust.

NEW SECTION. **Sec. 126.** CONFORMING EMPLOYER BENEFITS PLANS. (1) Employers may maintain employee benefits plans under the federal employee retirement income security act of 1974.

(2) Irrevocable expenditures.

(a) At least 50 percent of each required health care expenditure for calendar year 2024 must consist of irrevocable expenditures. Revocable expenditures that exceed 40 percent of required health care expenditures shall not be counted toward the employer spending requirement.

(b) At least 80 percent of each required health care expenditure for calendar year 2025 must consist of irrevocable expenditures.

Revocable expenditures that exceed 20 percent of required health care expenditures shall not be counted toward the employer spending requirement.

(c) On and after January 1, 2026, only irrevocable health care expenditures shall be counted toward the employer spending requirement.

(d) Health care expenditures paid to the employment security department or the trust on behalf of an employee are not revocable.

(3) Revocable expenditures. Subject to the limitations in subsection (2) of this section, revocable health care expenditures shall be counted toward the employer spending requirement, provided that:

(a) The expenditure is reasonably calculated to benefit the employee;

(b) No portion of the expenditure is revoked prior to the earliest of: (i) Twenty-four months from the date of the expenditure; (ii) ninety days after separation from employment; or (iii) for revocable expenditures made prior to January 1, 2026, the date that the employee knowingly, voluntarily, and permanently waives in writing the unused portion of such expenditure;

(c) The employee receives from the employer or its agent a written summary within 15 calendar days of the date of the expenditure that includes: (i) The name, address, email address, and telephone number of any third party to whom the expenditure was made; (ii) the date and amount of the expenditure; (iii) a summary of how the benefit may be used, including types of health care services available; (iv) restrictions on the use of this benefit, including maximum dollar value of benefits or account balances; and (v) the date on which any portion of this benefit will be revoked; and

(d) An employee who separates from employment with any amount of unused revocable expenditures receives, within three business days following the separation: (i) A written notice with a summary of how the benefit may be used, including types of health care services available; (ii) restrictions on the use of this benefit, including maximum dollar value of benefits or account balances; and (iii) the date on which the benefit will be revoked.

(4) Effect of court order. If the attorney general certifies to the governor and the legislature that a court of competent jurisdiction has struck down any provision of subsection (3) of this section, or permanently enjoined its enforcement, then only

irrevocable expenditures shall count toward the employer spending requirement as of the first day of the next calendar quarter following the attorney general's certification.

(5) All employers operating in the state may pay the employment contribution for an employee directly to the trust for the purpose of establishing the employee's eligibility to enroll in the trust.

(6) Residents employed in the state and enrolled in minimum essential coverage, as defined by the patient protection and affordable care act, may:

(a) Participate in the medical reimbursement accounts as described in section 127 of this act; or

(b) Elect to apply any unused required health care expenditures an employer paid to the employment security department towards any employment investment required for enrollment in the trust established in section 103 of this act, subject to exclusions defined in section 111 of this act, to enroll in the trust as a primary health insurance.

NEW SECTION. **Sec. 127.** HEALTH OPTIONS PROGRAM. (1) The health care authority shall administer the health options program for residents not enrolled in the trust, which comprises community health access and medical reimbursement accounts. The health care authority shall determine eligibility and benefits under the program component to maximize participants' overall access to health care services.

(2) Under community health access, eligible uninsured Washington residents may obtain essential health benefits from any providers participating in the trust as community health providers. Community health access is not an insurance plan.

(3) Health options program access shall be open to eligible, uninsured Washington residents except when they are eligible to receive benefits under medicare or medicaid. Additional eligibility criteria shall be established by the health care authority, but no person may be excluded from community health access based on employment or immigration status or a preexisting condition.

(4) The health options program may be funded from a variety of sources, including required health care expenditures paid by employers and sole proprietors pursuant to section 202 of this act and from the trust.

(5) Community health access shall use the rates established through annual negotiations by community health providers under the trust as described in section 109 of this act.

(6) Community health access shall provide payment for essential health benefits as defined in section 102 of this act to providers participating in the trust as community health providers as described in section 109 of this act.

(7) The employment security department shall be authorized to transfer payments made by employers to satisfy their health care expenditure requirements as set forth in section 202 of this act to the health care authority. The health care authority shall establish and maintain the medical reimbursement accounts from which employees may obtain reimbursement of health care expenditures in the amount of and under the terms set by the board in annual negotiations with community health providers as established in section 109 of this act.

(8) The health care authority may coordinate with a third-party vendor to administer program operations, including enrollment, tracking service utilization, billing, and communication with the participants.

(9) The health care authority shall develop a plan to more directly integrate employer coverage for essential health benefits and to ensure that employer health care expenditures made to the employment security department pursuant to section 202 of this act can be used to maximize enrollment in health insurance through the trust or medicaid. This plan may include possible options for incenting employers to provide quality, affordable health insurance directly to employees. This plan shall be presented to the legislature annually beginning no later than December 1, 2027, so that it may be considered and approved for full implementation to begin during a marketplace open enrollment period no more than 20 months following approval. Until a plan to integrate employer essential health coverage directly into the trust is approved by the legislature, the health care authority shall continue to administer the health options program, which includes community health access and medical reimbursement accounts, in a manner that is consistent with section 101 of this act.

NEW SECTION. **Sec. 128.** CONFORMING FEDERALLY QUALIFIED TRUST FUNDS. By January 1, 2027, the board shall submit to the legislature

a proposal to integrate those current and future federally qualified trust funds that choose to participate in the trust.

NEW SECTION. **Sec. 129.** CONFORMING LABOR AND INDUSTRIES. By January 1, 2027, the board, in coordination with the department of labor and industries, shall study and make a report to the governor and appropriate committees of the legislature on the coordination of essential health benefits for injured workers under the trust.

Part II
Employment-Based Contributions

NEW SECTION. **Sec. 201.** DEFINITIONS. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Adjusted net earnings from self-employment of sole proprietors" means "net earnings from self-employment of sole proprietors" as defined in section 1402 of the internal revenue code less a number equal to 15,000 reduced by 25 percent of an individual's total net earnings from self-employment of sole proprietors and allocated to the state as provided in section 203 of this act. All numbers less than zero equal zero.

(2) "Adjusted quarterly payroll" means aggregate gross payroll paid to a Washington state resident less the healthy Washington payroll exemption.

(3) "Commissioner" means the commissioner of the department or the commissioner's designee.

(4) "Department" means the employment security department.

(5) "Employee deduction" means the portion of the employer contribution that can be deducted from an employee's paycheck.

(6) "Employer" has the meaning provided in RCW 50A.05.010.

(7) "Employer contribution" means the assessment required by section 202 of this act.

(8) "Employer spending requirement" means the sum total of required health care expenditures that an employer must make for all of its employees.

(9) "Employment" has the meaning provided in RCW 50A.05.010.

(10) "Health care expenditure" means an amount paid by an employer to an employee or a trustee or a third party on behalf of the employee for the purpose of providing or reimbursing the cost of

health care services for employees, their spouses, or both, domestic partners, children, or other dependents. "Health care expenditure" also means an amount paid by an employer to the Washington health trust on behalf of the employee to establish their enrollment in the Washington health trust in the manner and according to the terms set by the health care authority. "Health care expenditure" does not include any amount otherwise required to be paid by federal, state, or local law.

(11) "Health care services" means medical care, services, or goods that may qualify as tax deductible medical care expenses under section 213 of the internal revenue code, or medical care, services, or goods having substantially the same purpose or effect as such deductible expenses.

(12) "Healthy Washington payroll exemption" means a number equal to 3,750 reduced by 25 percent of the total quarterly aggregate gross payroll paid to the employee allocated to the state as provided in section 202 of this act. However, a number less than zero equals zero.

(13) "Individual" means a natural person.

(14) "Internal revenue code" means the United States internal revenue code of 1986, as amended, as of the effective date of this section, or such subsequent date as the department of revenue may provide by rule consistent with the purpose of this chapter.

(15) "Partnership" means an association of two or more persons to carry on as co-owners a business for profit formed under RCW 25.05.055, predecessor law, or comparable law of another jurisdiction.

(16) "Payroll" means any amount paid to Washington state residents and defined as "wages" under section 3121 of the internal revenue code.

(17) "Remuneration" has the meaning provided in RCW 50A.05.010.

(18) "Required health care expenditure" means the health care expenditure that an employer is required to make to, or on behalf of, an employee.

(19) "Resident" means an individual who meets residency requirements consistent with RCW 46.16A.140. "Resident" also includes an individual and the individual's accompanying family members who are residing in the state for the purpose of engaging in employment for at least one month. The confinement of a person in a nursing

home, hospital, or other medical institution in the state may not by itself be sufficient to qualify such person as a resident.

(20) "Service is localized in this state" has the meaning described in RCW 50.04.120.

(21) "Sole proprietor" means:

(a) Any self-employed person, including a sole proprietor or independent contractor; or

(b) A qualified joint venturer as described in Title 26 U.S.C. Sec. 761 of the internal revenue code.

(22) "Taxable year" means the taxpayer's taxable year as determined under the internal revenue code.

(23) "Taxpayer" means an individual subject to tax under this chapter.

(24) "Wage" or "wages" means:

(a) For the purpose of the employer contributions, the remuneration paid by an employer to an employee. The maximum wages subject to an assessment are those wages as set by the commissioner under section 202 of this act;

(b) For the purpose of payment of benefits, the remuneration paid by one or more employers to an employee for employment during the employee's qualifying period. At the request of an employee, wages may be calculated on the basis of remuneration payable. The department shall notify each employee that wages are calculated on the basis of remuneration paid, but at the employee's request a redetermination may be performed and based on remuneration payable;

(c) Adjusted net earnings from self-employment of sole proprietors.

NEW SECTION. **Sec. 202.** EMPLOYER REQUIRED HEALTH CARE EXPENDITURE AND EMPLOYER CONTRIBUTION PROCEDURE. (1)(a) Beginning January 1, 2027, employers shall make required health care expenditures to or on behalf of each employee each quarter. The department shall assess for each individual in employment with an employer and for each sole proprietor an employment contribution based on the amount of the individual's wages subject to section 203 of this act.

(b) The assessment rate shall be equal to 10.5 percent of an employee's aggregate adjusted quarterly payroll or wages and less the employer's health care expenditures for that employee during the same reporting period.

(c) An employer may deduct up to two percent of the required health care expenditure from an employee's wages.

(d) An employer may elect to pay all or any portion of the employee deduction.

(2) The employer must collect from the employees the required health care expenditure provided under this section through payroll deductions and remit the amounts collected to the department or make a health care expenditure to or on behalf of the employee.

(3) Contributions from employers and sole proprietors shall be collected in the manner and at such intervals as provided in this title and directed by the department.

(4) Health care expenditures paid to or on behalf of an employee exceeding the required health care expenditure for the employee must not be counted toward the employer spending requirement except as expressly permitted by the department.

(5) When an employer pays the entire required health care expenditure for an employee to the department the employee is eligible for enrollment in the Washington health trust and the employment contribution required must be deposited in the benefits account created in section 123 of this act.

(6) Beginning January 1, 2025, until May 15, 2028, employers with fewer than 50 employees and that face financial hardship in paying the required health care expenditure may, upon application to the department, be eligible for waivers or reductions in the assessment. The department shall establish rules and procedures governing all aspects of the business assistance program, including application procedures, wages, profits, age of firm, and duration of assistance.

(7) Pending integration of any federally qualified trust funds, such as medicare or medicaid, the payroll of employees covered under these trust funds is exempt from the employer contribution, although the employer may pay health care expenditures to the department on behalf of the employee voluntarily.

(8) Unless repeal, amendment, waiver, or other integration measure for applicable state and federal laws described in section 111 of this act, payroll of Native American residents who do not elect to enroll in the Washington health trust is exempt from the employer contribution.

(9) The department must deposit revenue collected under this section into the medical reimbursement accounts created in section

127 of this act or the Washington health trust benefits account created in section 123 of this act.

(10) To the extent feasible and not inconsistent with the provisions in this chapter, the department shall use the premium assessment, collection, and reporting procedures in Title 50A RCW for the employment contribution assessment, collection, and reporting.

(11) Beginning January 2028 and on a biennial basis, the department shall adjust the required health care expenditures and the employer contribution assessment rate for the following year based on recommendations from the health care authority and the board of the Washington health trust.

NEW SECTION. **Sec. 203.** EMPLOYEE HEALTH EXPENDITURES AND EMPLOYEE DEDUCTION—APPLICABILITY. (1) Beginning January 1, 2027, an employee deduction is imposed on the receipt of wages by residents employed in Washington state. All employers in Washington state must collect the employee deduction on aggregate gross payroll paid to Washington state residents from employee wages and make required health care expenditures, pay the employee deduction to the department in quarterly installments, or pay the employee deduction on behalf of an employee. Except as provided in sections 114 and 202(11) of this act, the employee deduction shall be two percent of the employee's aggregate adjusted quarterly payroll.

(2) The pay or wages from employees who are exempt from the required health care expenditure established in section 202 of this act are exempt from owing the employee deduction on those wages.

(3) Beginning January 1, 2026, residents operating as sole proprietors must pay a self-employment contribution in annual installments to the department of two percent on adjusted net earnings from self-employment.

(4) Partnerships are subject to the employment contribution established in section 202 of this act and are responsible for collecting the employee deduction on behalf of employees as provided in this section.

(5) S corporations are not subject to the employment contribution under this chapter.

NEW SECTION. **Sec. 204.** EMPLOYER WITHHOLDING ESTIMATED EMPLOYEE DEDUCTION. Every employer making a payment of wages or salaries earned in this state by Washington residents, regardless of the place

where the payment is made, and who is required by the internal revenue code to withhold taxes, must deduct and withhold an employee deduction as prescribed by the department by rule. The rules prescribed must reasonably reflect the quarterly tax liability of the employee under this chapter. Every employer making such a deduction and withholding must furnish to the employee a record of the amount of tax deducted and withheld from the employee on forms provided by the department.

NEW SECTION. **Sec. 205.** EMPLOYER IS LIABLE FOR TAX WITHHELD. Any employer required to deduct and withhold the employee deduction imposed by this chapter is liable under section 204 of this act to the department for the payment of the amount deducted and withheld, and is not liable to any other person for the amount of tax deducted and withheld under this chapter or for the act of withholding.

NEW SECTION. **Sec. 206.** CREDITS FOR WITHHELD EMPLOYEE HEALTH CONTRIBUTIONS. The amount deducted and withheld as tax under sections 204 through 221 of this act during any taxable year is allowed as a credit against the employer contribution imposed for the taxable year by this chapter. If the liability of any individual for taxes, interest, penalties, or other amounts due the state of Washington is less than the total amount of the credit which the individual is entitled to claim under this section, the individual is entitled to a refund from the department in the amount of the excess of the credit over the tax otherwise due. If any individual entitled to claim a credit under this section is not otherwise required by this chapter to file a return with the department, a refund may be obtained in the amount of the credit by filing a return with the department, with applicable sections completed, to claim the refund. No credit or refund is allowed under this section unless the credit or refund is claimed on a return filed for the taxable year for which the amount was deducted and withheld.

NEW SECTION. **Sec. 207.** EMPLOYER RESPONSIBILITIES. (1) An employer shall:

(a) Maintain accurate records of health care expenditures, required health care expenditures, and proof of such expenditures made each quarter and each year, and allow the department reasonable

access to such records, provided, however, that employers are not required to maintain such records in any particular form; and

(b) Provide information to the department, or the department designee, on an annual basis containing additional information as the department requires, including information on the employer's compliance with this chapter. The department may not require an employer to provide information in violation of state or federal privacy laws. In the event the information required by the department is comingled with information protected by privacy laws, the employer shall redact the private information. If an employer uses a revocable expenditure to satisfy its obligation to make required health care expenditures for any of its employees, the employer shall also report to the department any conditions or restrictions on the employee's use of the expenditure, and the condition or conditions that permit any portion of the expenditure to be revoked by or returned to the employer.

(2) Where an employer does not maintain or retain adequate records documenting the health care expenditures made, or does not allow the department reasonable access to such records, it shall be presumed that the employer did not make the required health care expenditures for the quarter for which records are lacking, absent clear and convincing evidence otherwise. The department of revenue and the health care authority have the authority to provide any and all nonfinancial information to the department necessary to fulfill the department responsibilities as the enforcing agency under this chapter. With regard to all such information provided by the department of revenue and the health care authority, the department shall be subject to the confidentiality provisions in RCW 82.32.330.

NEW SECTION. **Sec. 208.** PENALTIES FOR FAILURE TO PAY OR COLLECT WITHHOLDINGS. (1) The employee deduction required by this chapter to be collected by the employer is deemed to be held in trust by the employer until the required health care expenditure is made or the assessment is paid to the department.

(2) In case any employer, or a responsible person within the meaning of internal revenue code section 6672, collected the tax and fails to pay it to the department, the employer or responsible person is personally liable to the state for the amount collected. The interest and penalty provisions of chapter 82.32 RCW apply to this section. An employer or other responsible person who appropriates or

converts the employee health assessment is guilty of a gross misdemeanor as provided in chapter 9A.20 RCW.

(3) In case any employer or responsible person within the meaning of internal revenue code section 6672 fails to collect the employee health assessment herein imposed, the employer is still liable to the state for the amount owed.

NEW SECTION. **Sec. 209.** OUT-OF-STATE EMPLOYERS OF WASHINGTON RESIDENTS. By January 1, 2027, the department shall develop policy, procedures, and forms allowing out-of-state employers employing one or more residents of Washington state to voluntarily pay the employer contribution established in section 202 of this act.

NEW SECTION. **Sec. 210.** EMPLOYER REQUIREMENTS. To the extent not inconsistent with the provisions of this chapter, RCW 50A.20.030 applies to the employer requirements imposed under this chapter.

NEW SECTION. **Sec. 211.** UNLAWFUL ACTS—EMPLOYERS. To the extent not inconsistent with the provisions of this chapter, RCW 50A.40.010 applies to the unlawful acts of employers imposed under this chapter.

NEW SECTION. **Sec. 212.** EMPLOYER PENALTIES. To the extent not inconsistent with the provisions of this chapter, RCW 50A.40.010 applies to the employer penalties imposed under this chapter.

NEW SECTION. **Sec. 213.** OUT-OF-STATE EMPLOYEES—CONTRIBUTION WAIVER. An employer may file an application with the department for a conditional waiver for the payment of the employer contribution under section 202 of this act for out-of-state employees for any employees granted a waiver for the family and medical leave premiums defined in RCW 50A.10.040.

NEW SECTION. **Sec. 214.** TERMINATION OR DISPOSAL OF BUSINESS—CONTRIBUTION PAYMENT—SUCCESSOR LIABILITY. Whenever any employer quits business, or sells out, exchanges, or otherwise disposes of the employer's business or stock of goods, any employer contributions payable under this chapter shall become immediately due and payable. The employer shall, within 10 days, make a return and pay the employer contributions due; and any person who becomes a successor to

such business shall become liable for the full amount of the employer contributions and withhold from the purchase price a sum sufficient to pay any employer contributions due from the employer until such time as the employer produces a receipt from the department showing payment in full of any employer contributions due or a certificate that no employer contribution is due and, if such employer contribution is not paid by the employer within 10 days from the date of such sale, exchange, or disposal, the successor shall become liable for the payment of the full amount of employer contributions, and the payment thereof by such successor shall, to the extent thereof, be deemed a payment upon the purchase price, and if such payment is greater in amount than the purchase price the amount of the difference shall become a debt due such successor from the employer. A successor may not be liable for any employer contributions due from the person from whom the successor acquired a business or stock of goods if that person gives written notice to the department of such acquisition and no employer contribution is issued by the department within 180 days of receipt of such notice against the former operator of the business and a copy thereof mailed to such successor.

NEW SECTION. **Sec. 215.** DELINQUENCY—ORDER AND NOTICE OF ASSESSMENT. At any time after the commissioner shall find that any employer contributions, interest, or penalties have become delinquent, the commissioner may issue an order and notice of assessment and enforce collection using a process consistent with those provided for family and medical leave in RCW 50A.45.015 through 50A.45.070 except that:

(1) Interest collected under this section shall be paid into the Washington health trust enforcement account; and

(2) Property acquired by the department may be sold by the commissioner or their representative at public or private sale, and the amount realized shall be placed in the Washington health trust enforcement account.

NEW SECTION. **Sec. 216.** UNCOLLECTIBLE ACCOUNTS. The commissioner may charge off as uncollectible and no longer an asset of the Washington health trust enforcement account, any delinquent assessments, interest, penalties, or credits if the commissioner is

satisfied that there are no cost-effective means of collecting the assessments, interest, penalties, or credits.

NEW SECTION. **Sec. 217.** INSPECTION AND AUDIT. The department may inspect and audit employer files and records relating to the Washington health trust program.

NEW SECTION. **Sec. 218.** ENFORCEMENT ACCOUNT. The Washington health trust enforcement account is created in the custody of the state treasurer. Any penalties and interest collected under this chapter must be deposited into the account and shall be used only for the purposes of administering and enforcing this chapter. Only the commissioner may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

NEW SECTION. **Sec. 219.** AGREEMENT TO WAIVE. (1) Any agreement to waive, release, or commute an individual's right to benefits or any other rights under this chapter is void.

(2) Any assignment, pledge, or encumbrance of any right to benefits that are or may become due or payable under this chapter is void. Such rights to benefits are exempt from levy, execution, attachment, or any other remedy whatsoever provided for the collection of debts. Any waiver of any exemption provided for in this section is void.

NEW SECTION. **Sec. 220.** ALLOCATION OF REVENUES TO BENEFITS ACCOUNT. All revenue from taxes collected by the department under this chapter, including penalties and interest on such taxes, must be deposited in the benefits account created in section 123 of this act.

NEW SECTION. **Sec. 221.** ADOPTION OF RULES. The commissioner shall have the authority to adopt, amend, or rescind rules interpreting and implementing the provisions of this chapter.

NEW SECTION. **Sec. 222.** CONFORMING RCW. To the extent not inconsistent with the provisions of this chapter, chapter 82.32 RCW applies to the administration of taxes imposed under section 203 of this act.

Part III
Capital Gains Investment in Health

NEW SECTION. **Sec. 301.** DEFINITIONS. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Accessory dwelling unit" means a separate habitable living area that is subordinate to the principal single-family dwelling unit, which is either internal to, attached to, or located on the same property tax parcel as, the principal single-family dwelling unit.

(2) "Adjusted capital gain" has the meaning provided in RCW 82.87.020.

(3) "Capital asset" has the same meaning as provided by Title 26 U.S.C. Sec. 1221 of the internal revenue code and also includes any other property if the sale or exchange of the property results in a gain that is treated as a long-term capital gain under Title 26 U.S.C. Sec. 1231 or any other provision of the internal revenue code.

(4) "Department" means the department of revenue.

(5) "Federal net long-term capital gain" has the meaning provided in RCW 82.87.020.

(6) "Individual" means a natural person.

(7) "Internal revenue code" means the United States internal revenue code of 1986, as amended, as of the effective date of this section, or such subsequent date as the department may provide by rule consistent with the purpose of this chapter.

(8) "Long-term capital asset" means a capital asset that is held for more than one year.

(9) "Resident" has the meaning provided in RCW 82.87.020.

(10) "Taxable year" means the taxpayer's taxable year as determined under the internal revenue code.

(11) "Taxpayer" means an individual subject to tax under this chapter.

(12) "Washington investment in health capital gains" means an individual's annual adjusted capital gain under this chapter, for each return filed under this chapter.

NEW SECTION. **Sec. 302.** LONG-TERM CAPITAL GAINS TAX. (1) Beginning January 1, 2024, an excise tax is imposed on all individuals for the privilege of selling or exchanging long-term

capital assets, or receiving Washington capital gains. The tax equals eight and one-half percent multiplied by the individual's Washington capital gains.

(2) If an individual's Washington capital gains are less than zero for a taxable year, no tax is due under this section. No such losses may be carried back or carried forward to another taxable year.

(3) The tax imposed in this section applies to:

(a) The sale or exchange of long-term capital assets owned by the taxpayer, whether the taxpayer was the legal or a beneficial owner of such assets at the time of the sale or exchange; or

(b) Washington capital gains otherwise realized by the taxpayer.

(4) For purposes of this chapter, an individual is a beneficial owner of long-term capital assets held by an entity that is a pass-through or disregarded entity for federal tax purposes, such as a partnership, limited liability company, S corporation, or trust, to the extent of the individual's ownership interest in the entity as reported for federal income tax purposes.

NEW SECTION. **Sec. 303.** EXEMPTS CERTAIN GAINS AND LOSSES. This chapter does not apply to the sale or exchange of:

(1) Any residential dwelling, along with the land upon which the dwelling is located. For the purposes of this subsection, "residential dwelling" means property consisting solely of:

(a) A single-family residence, a residential condominium unit, or a residential cooperative unit, including any accessory dwelling unit associated with such residence or residential unit;

(b) A multifamily residential building consisting of one or more common walls and fewer than four units; or

(c) A floating home as defined in RCW 82.45.032;

(2) Assets held under a retirement savings account under Title 26 U.S.C. Sec. 401(k) of the internal revenue code, a tax-sheltered annuity or a custodial account described in Title 26 U.S.C. Sec. 403(b) of the internal revenue code, a deferred compensation plan under Title 26 U.S.C. Sec. 457(b) of the internal revenue code, an individual retirement account or an individual retirement annuity described in Title 26 U.S.C. Sec. 408 of the internal revenue code, a roth individual retirement account described in Title 26 U.S.C. Sec. 408A of the internal revenue code, an employee defined contribution

program, an employee defined benefit plan, or a similar retirement savings vehicle;

(3) Assets pursuant to or under imminent threat of condemnation proceedings by the United States, the state or any of its political subdivisions, or a municipal corporation;

(4) Cattle, horses, or breeding livestock held for more than 12 months if, for the taxable year of the sale or exchange, more than 50 percent of the taxpayer's gross income for the taxable year, including from the sale or exchange of capital assets, is from farming or ranching;

(5) Agricultural land by an individual who has regular, continuous, and substantial involvement in the operation of the agricultural land that meets the criteria for material participation in an activity under Title 26 U.S.C. Sec. 469(h) of the internal revenue code for the 10 years prior to the date of the sale or exchange of the agricultural land;

(6) Property used in a trade or business if the property qualifies for an income tax deduction under Title 26 U.S.C. Sec. 167 or 179 of the internal revenue code; and

(7) Timber, timberland, or the receipt of Washington capital gains as dividends and distributions from real estate investment trusts derived from gains from the sale or exchange of timber. "Timber" means forest trees, standing or down, on privately or publicly owned land, and includes Christmas trees and short-rotation hardwoods. The sale or exchange of timber includes the cutting or disposal of timber qualifying for capital gains treatment under Title 26 U.S.C. Sec. 631(a) or (b) of the internal revenue code.

NEW SECTION. **Sec. 304.** COMPUTATION OF TAX—DEDUCTION OF PROHIBITED AMOUNTS. In computing tax, there may be deducted from the measure of tax amounts that the state is prohibited from taxing under the state or federal Constitutions.

NEW SECTION. **Sec. 305.** QUALIFIED FAMILY-OWNED SMALL BUSINESS DEDUCTION. (1) In computing tax under this chapter for a taxable year, a taxpayer may deduct adjusted capital gains, to the extent they are included in Washington capital gains, derived in the taxable year from the sale of substantially all of the fair market value of the assets of, or the transfer of substantially all of the taxpayer's interest in, a qualified family-owned small business.

(2) For purposes of this section, the following definitions apply:

(a) "Assets" means real property and personal property, including tangible personal property and intangible property.

(b) "Family" has the same meaning as "member of the family" in RCW 83.100.046.

(c)(i) "Materially participated" means an individual was involved in the operation of a business on a basis that is regular, continuous, and substantial.

(ii) The term "materially participated" must be interpreted consistently with the applicable treasury regulations for section 469 of the internal revenue code, to the extent that such interpretation does not conflict with any provision of this section.

(d) "Qualified family-owned small business" means a business:

(i) In which the taxpayer held a qualifying interest for at least eight years immediately preceding the sale or transfer described in subsection (1) of this section;

(ii) In which the taxpayer or their family member materially participated in operating the business for at least five of the eight years immediately preceding the sale or transfer described in subsection (1) of this section, unless such sale or transfer was to a qualified heir;

(iii)(A) That had no more than 50 full-time employees at any time during the 12-month period immediately preceding the sale or transfer described in subsection (1) of this section.

(B) For purposes of this subsection (2)(d)(iii), "full-time employee" means an employee who is, or any combination of employees who are, paid by the business for at least 1,820 hours of employment, including paid leave, for the 12-month period described in (d)(iii)(A) of this subsection (2); and

(iv) That had worldwide gross revenue of $7,000,000 or less in the 12-month period immediately preceding the sale or transfer described in subsection (1) of this section.

(e) "Qualified heir" means a member of the taxpayer's family.

(f) "Qualifying interest" means:

(i) An interest as a proprietor in a business carried on as a sole proprietorship; or

(ii) An interest in a business if at least:

(A) Fifty percent of the business is owned, directly or indirectly, by the taxpayer and members of the taxpayer's family;

(B) Thirty percent of the business is owned, directly or indirectly, by the taxpayer and members of the taxpayer's family, and at least:

(I) Seventy percent of the business is owned, directly or indirectly, by members of two families; or

(II) Ninety percent of the business is owned, directly or indirectly, by members of three families.

(g) "Substantially all" means at least 90 percent.

NEW SECTION. **Sec. 306.** ADJUSTED CAPITAL GAINS. (1) For purposes of the tax imposed under this chapter, adjusted capital gains are allocated as follows:

(a) Adjusted capital gains from the sale or exchange of real property are allocated to this state if the real property is located in this state or a majority of the fair market value of the real property is located in this state;

(b) Adjusted capital gains from the sale or exchange of tangible personal property are allocated to this state if the property was located in this state at the time of the sale or exchange. Adjusted capital gains from the sale or exchange of tangible personal property are also allocated to this state even though the property was not located in this state at the time of the sale or exchange if:

(i) The property was located in the state at any time during the taxable year in which the sale or exchange occurred or the immediately preceding taxable year;

(ii) The taxpayer was a resident at the time the sale or exchange occurred; and

(iii) The taxpayer is not subject to the payment of an income or excise tax legally imposed on the adjusted capital gain by another taxing jurisdiction; and

(c) Adjusted capital gains derived from intangible personal property are allocated to this state if the taxpayer was domiciled in this state at the time the sale or exchange occurred.

(2) A credit is allowed against the tax imposed in section 302 of this act equal to the amount of any legally imposed income or excise tax paid by the taxpayer to another taxing jurisdiction on capital gains derived from capital assets within the other taxing jurisdiction to the extent such capital gains are included in the taxpayer's Washington capital gains.

(a) The amount of credit under this subsection may not exceed the total amount of tax due under this chapter, and there is no carryback or carryforward of any unused credits.

(b) As used in this section, "taxing jurisdiction" means a state of the United States other than the state of Washington, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any foreign country or political subdivision of a foreign country.

(3) A deduction is allowed against the tax imposed in sections 202 and 203 of this act to the extent necessary to avoid taxing the same amounts under this chapter.

NEW SECTION. **Sec. 307.** DUAL RESIDENCE. (1) If an individual is regarded as a resident both of this state and another jurisdiction for state tax purposes, the department must reduce the tax on that portion of the taxpayer's income which is subjected to tax in both jurisdictions solely by virtue of dual residence, if the other taxing jurisdiction allows a similar reduction.

(2) As used in this section, "taxing jurisdiction" means a state of the United States other than the state of Washington, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any foreign country or political subdivision of a foreign country.

NEW SECTION. **Sec. 308.** TREATMENT OF PARTNERSHIPS AND S CORPORATION INCOME. (1) Partnerships are not subject to the long-term capital gains tax under this chapter. Partners are subject to the long-term capital gains tax under this chapter in their separate or individual capacities.

(2) S corporations are not subject to the long-term capital gains tax under this chapter. Shareholders of S corporations are subject to the long-term capital gains tax under this chapter in their separate or individual capacities.

NEW SECTION. **Sec. 309.** PERSONS REQUIRED TO FILE A STATE RETURN. (1) Only individual and joint taxpayers with federal net long-term capital gains or net earnings from self-employment of sole proprietors in excess of $15,000 on their federal tax return are required to file a capital gains tax return with the department. Each person required to file a return under this chapter must, without

assessment, notice, or demand, pay any tax due thereon to the department on or before the date fixed for the filing of the return.

(2) Except as otherwise provided in this chapter or RCW 82.32.080, taxpayers owing tax under this chapter must file, on forms prescribed by the department, a return with the department on or before the date the taxpayer's federal income tax return for the taxable year is required to be filed along with all schedules and supporting documentation.

(3) If an adjustment to a taxpayer's federal return is made by the taxpayer or the internal revenue service, the taxpayer must, within 90 days of the final determination of the adjustment by the internal revenue service or within 30 days of the filing of a federal return adjusted by the taxpayer, file with the department on forms prescribed by the department a corrected return reflecting the adjustments as finally determined; however, such an amendment of the state return may take place only when the original filing was made in error. The taxpayer must pay any additional tax due resulting from the finally determined internal revenue service adjustment or a taxpayer adjustment without notice and assessment. Notwithstanding any provision of this chapter or any other title to the contrary, the period of limitation for the collection of the additional tax, interest, and penalty due as a result of such an adjustment by the taxpayer or a finally determined internal revenue service adjustment must begin at the later of 30 days following the final determination of the adjustment or the date of the filing of the corrected return.

(4) If a taxpayer required to file a return under this section has obtained an extension of time for filing the federal tax return for the taxable year, the taxpayer is entitled to the same extension of time for filing the return required under this section if the taxpayer provides the department, before the due date provided in subsection (1) of this section, the extension confirmation number or other evidence satisfactory to the department confirming the federal extension. An extension under this subsection for the filing of a return under this chapter is not an extension of time to pay the tax due under this chapter.

(5) If any return due on long-term capital gains under subsection (1) of this section, along with a copy of the federal tax return, is not filed with the department by the due date or any extension granted by the department, the department must assess a penalty in the amount of five percent of the tax due for the taxable year

covered by the return for each month or portion of a month that the return remains unfiled. The total penalty assessed under this subsection may not exceed 25 percent of the tax due for the taxable year covered by the delinquent return.

(a) The penalty under this subsection is in addition to any penalties assessed for the late payment of any tax due on the return.

(b) The department must waive or cancel the penalty imposed under this subsection if:

(i) The department is persuaded that the taxpayer's failure to file the return by the due date was due to circumstances beyond the taxpayer's control; or

(ii) The taxpayer has not been delinquent in filing any return due under this section during the preceding five calendar years.

NEW SECTION. **Sec. 310.** PENALTIES. (1) Any taxpayer who knowingly attempts to evade payment of the tax imposed under this chapter is guilty of a class C felony as provided in chapter 9A.20 RCW.

(2) Any taxpayer who knowingly fails to pay tax, make returns, keep records, or supply information, as required under this title, is guilty of a gross misdemeanor as provided in chapter 9A.20 RCW.

NEW SECTION. **Sec. 311.** INSTRUCTIONS FOR JOINT FILING. (1) If the federal income tax liabilities of both spouses are determined on a joint federal return for the taxable year, they must file a joint return under this chapter.

(2) Except as otherwise provided in this subsection, if the federal income tax liability of either spouse is determined on a separate federal return for the taxable year, they must file separate returns under this chapter. State registered domestic partners may file a joint return under this chapter even if they filed separate federal returns for the taxable year.

(3) In any case in which a joint return is filed under this section, the liability of each spouse or state registered domestic partner is joint and several, unless:

(a) The spouse is relieved of liability for federal tax purposes as provided under Title 26 U.S.C. Sec. 6015 of the internal revenue code; or

(b) The department determines that the domestic partner qualifies for relief as provided by rule of the department. Such rule, to the

extent possible without being inconsistent with this chapter, must follow Title 26 U.S.C. Sec. 6015.

(4) The department must take actions and adopt rules, forms, and procedures to implement this chapter consistently with RCW 26.60.015, notwithstanding any term or provision of this chapter.

NEW SECTION. **Sec. 312.** DUE DATES FOR RETURNS, PENALTIES. The due date of a return required to be filed with the department is the due date of the applicable federal income tax return for federal income tax purposes. The department may grant extensions of time by which returns required to be filed by this chapter may be submitted. The department may grant extensions of time to pay tax with regard to taxes imposed by this chapter. Interest at the rate as specified in RCW 82.32.050 accrues during any extension period and the interest and penalty provisions of chapter 82.32 RCW apply to late payments and deficiencies. RCW 82.32.105 applies to this section.

NEW SECTION. **Sec. 313.** RECORDS AND RETURNS. (1) Every taxpayer with federal net long-term capital gains or net earnings from self-employment of sole proprietors in excess of $15,000 annually must keep records, render statements, make returns, file reports, and perform other acts as the department requires by rule. Each return must be made under penalty of perjury and on forms prescribed by the department. The department may require other statements and reports be made under penalty of perjury and on forms prescribed by the department. The department may require any taxpayer and any person required to deduct and withhold the tax imposed under this chapter to furnish to the department a correct copy of any return or document which the taxpayer has filed with the internal revenue service or received from the internal revenue service.

(2) All books and records and other papers and documents required to be kept under this chapter are subject to inspection by the department at all times during business hours of the day.

NEW SECTION. **Sec. 314.** ALLOCATION OF REVENUES TO BENEFITS ACCOUNT. All revenue from taxes collected by the department under this chapter, including penalties and interest on such taxes, must be deposited in the benefits account created in section 123 of this act.

NEW SECTION. **Sec. 315.** TAXES UNDER THIS CHAPTER IN ADDITION TO OTHER TAXES. The tax imposed under this chapter is in addition to any other taxes imposed by the state or any of its political subdivisions, or a municipal corporation, with respect to the same sale or exchange, including the taxes imposed in or under the authority of chapter 82.04, 82.08, 82.12, 82.14, 82.45, or 82.46 RCW.

NEW SECTION. **Sec. 316.** REFUNDS FOR OVERPAYMENT. The department must refund all taxes improperly paid or collected by the department.

NEW SECTION. **Sec. 317.** A new section is added to chapter 82.32 RCW to read as follows:

ALLOWS STATES TO COORDINATE. (1) The department may enter into reciprocal tax collection agreements with the taxing officials of any other state imposing a specific tax. Agreements authorized under this section must require each state to offset delinquent specified taxes owed by a taxpayer to one party to the agreement, including any associated penalties, interest, or other additions, against refunds of overpaid specified taxes owed to the taxpayer by the other party to the agreement. Such agreements may also include provisions governing the sharing of information relevant to the administration of specified taxes. However, the department may not share return or tax information with other states except as allowed under RCW 82.32.330. Likewise, the department may not share federal tax information with other states without the express written consent of the internal revenue service.

(2) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Specific taxes" means generally applicable state and local sales tax and use taxes, broad-based state gross receipts taxes, state income taxes, and stand-alone state taxes on capital gains or interest and dividends. "Specified taxes" include, but are not limited to, the taxes imposed in or under the authority of chapters 82.04, 82.08, 82.12, 82.14, 82.16, and 82.--- RCW (the new chapter created in section 401(3) of this act), and similar taxes imposed by another state. For purposes of this subsection (2)(a), "gross receipts tax," "income tax," "sales tax," and "use tax" have the meanings provided in RCW 82.56.010.

(b) "State" has the meaning provided in RCW 82.56.010.

NEW SECTION. **Sec. 318.** CONFORMING RCW. To the extent not inconsistent with the provisions of this chapter, the following statutes apply to the administration of taxes imposed under this chapter: RCW 82.32.050, 82.32.055, 82.32.060, 82.32.070, 82.32.080, 82.32.085, 82.32.090, 82.32.100, 82.32.105, 82.32.110, 82.32.117, 82.32.120, 82.32.130, 82.32.135, 82.32.150, 82.32.160, 82.32.170, 82.32.180, 82.32.190, 82.32.200, 82.32.210, 82.32.212, 82.32.220, 82.32.230, 82.32.235, 82.32.237, 82.32.240, 82.32.245, 82.32.265, 82.32.300, 82.32.310, 82.32.320, 82.32.330, 82.32.340, 82.32.350, 82.32.360, 82.32.410, 82.32.805, 82.32.808, and section 317 of this act.

NEW SECTION. **Sec. 319.** A new section is added to chapter 82.04 RCW to read as follows:

A deduction is allowed against a person's gross income of the business to the extent necessary to avoid taxing the same amounts under this chapter and section 302 of this act.

NEW SECTION. **Sec. 320.** RULES. The department may adopt rules for the administration and enforcement of this act.

NEW SECTION. **Sec. 321.** APPEALS. The board of tax appeals has jurisdiction over appeals relating to tax deficiencies and refunds, including penalties and interest, under this chapter. The taxpayer may elect a formal or informal hearing pursuant to RCW 82.03.140. Before appealing to the board of tax appeals, the taxpayer may first elect to address disputes through the department's administrative review process.

NEW SECTION. **Sec. 322.** Notwithstanding any common law rule of strict construction of statutes imposing taxes, this chapter, being necessary for the welfare of the state and its inhabitants, must be liberally construed in support of application of the tax.

Part IV
Miscellaneous

NEW SECTION. **Sec. 401.** CODIFICATION. (1) Sections 101 through 113 and 115 through 129 of this act constitute a new chapter in Title 43 RCW.

(2) Sections 114 and 201 through 222 of this act constitute a new title to be codified as Title 50C RCW.

(3) Sections 301 through 316, 318, and 320 through 322 of this act constitute a new chapter in Title 82 RCW.

NEW SECTION. **Sec. 402.** EFFECTIVE DATES. (1) Sections 101 through 107 of this act take effect February 1, 2024.

(2) Sections 108 through 114, 116 through 119, and 121 through 125 of this act take effect March 1, 2024.

(3) Sections 126 through 129 of this act take effect May 15, 2025.

NEW SECTION. **Sec. 403.** CONTINGENT EFFECTIVE AND EXPIRATION DATES. (1) Section 115 of this act takes effect when 51 percent of residents are enrolled in health insurance coverage managed by:

(a) The health care authority;

(b) An entity within the health care authority; or

(c) The board created in section 104 of this act.

(2) The health care authority must provide notice of the effective date of section 115 of this act and the expiration dates of sections 114 and 122 of this act to affected parties, the chief clerk of the house of representatives, the secretary of the senate, the office of the code reviser, and others as deemed appropriate by the authority.

NEW SECTION. **Sec. 404.** SEVERABILITY. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

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Tab 6

placeholder
(equity presentation)

Washington State Health Care Authority

Tab 7

Washington State Health Care Authority

Objectives

Continue discussion of the Commission's proposed transitional solutions

Review FTAC's proposed transitional solutions

Continuing Discussion: Transitional Solutions

As part of its mission to ensure that all Washingtonians have equitable access to culturally appropriate health care and universal coverage, the Commission is tasked with developing recommendations for transitional solutions that advance universal healthcare goals.

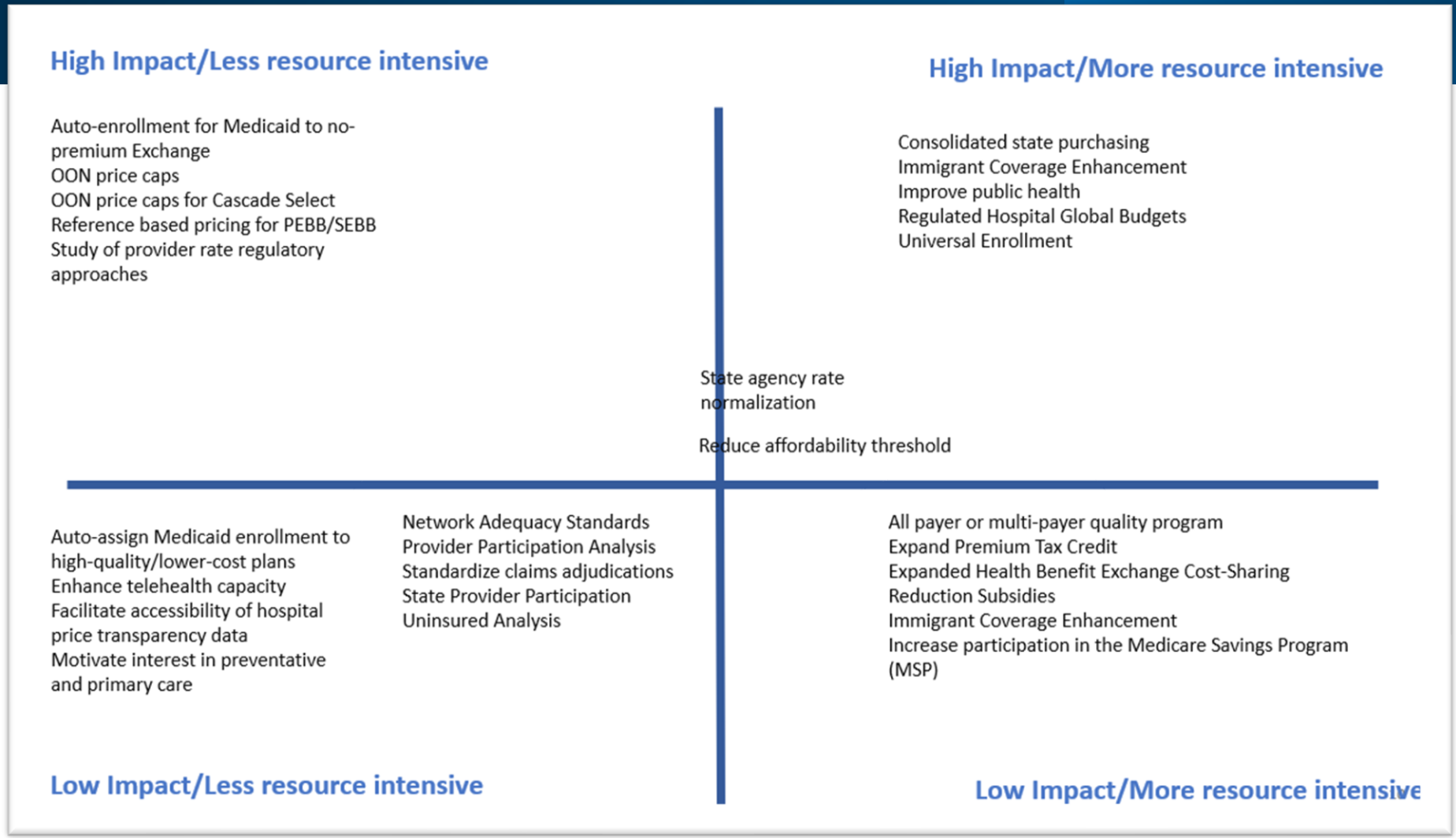
- These transitional solutions would significantly improve the current health care system and are intended to make possible the transition to a universal health care system with a uniform financing system.

The Commission's assignment to FTAC

At their February meeting, the Commission asked FTAC to provide ideas for proposed transitional solutions.

FTAC Members categorized their proposed transitional solutions by impact and resource intensiveness.

Update: FTAC's Transitional Solutions Matrix



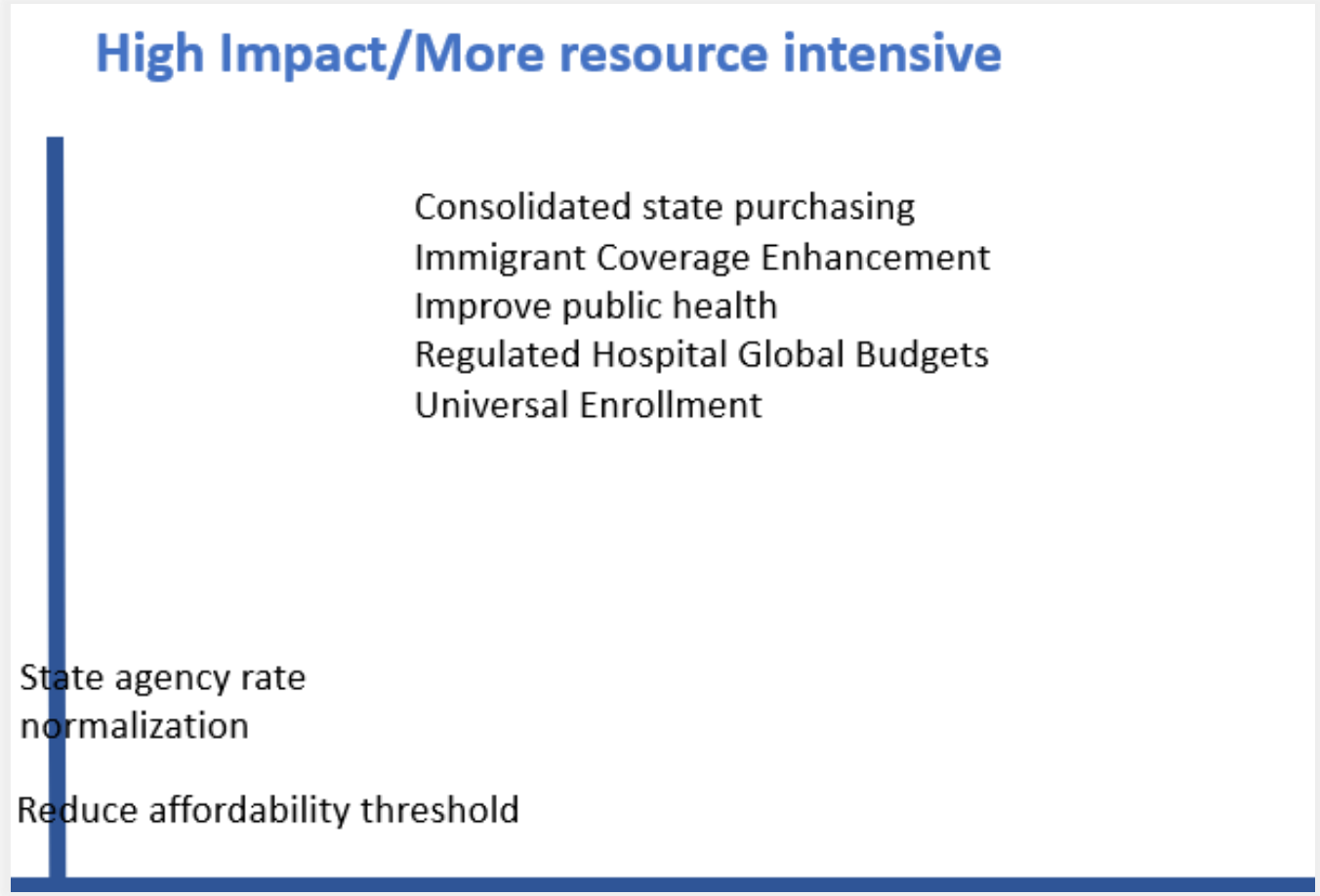
Responses from seven of nine FTAC members. Note, in some cases, multiple members agreed on placement of an idea in one quadrant, and multiple other members placed the same idea in another quadrant.

Update: FTAC's Transitional Solutions Matrix

High Impact/Less resource intensive

Auto-enrollment for Medicaid to no-premium Exchange
OON price caps
OON price caps for Cascade Select
Reference based pricing for PEBB/SEBB
Study of provider rate regulatory approaches

Update: FTAC's Transitional Solutions Matrix



Update: FTAC's Transitional Solutions Matrix

Low Impact/Less resource intensive

Auto-assign Medicaid enrollment to high-quality/lower-cost plans
Enhance telehealth capacity
Facilitate accessibility of hospital price transparency data
Motivate interest in preventative and primary care

Network Adequacy Standards
Provider Participation Analysis
Standardize claims adjudications
State Provider Participation
Uninsured Analysis

Update: FTAC's Transitional Solutions Matrix

Low Impact/More resource intensive

All payer or multi-payer quality program
Expand Premium Tax Credit
Expanded Health Benefit Exchange Cost-Sharing Reduction Subsidies
Immigrant Coverage Enhancement
Increase participation in the Medicare Savings Program (MSP)

Universal health care long-term planning
Eligibility: ERISA

The Commission identified Eligibility as the first foundational topic for FTAC to address with an initial focus on considerations for Medicare followed by considerations for ERISA.

- What questions would the Commission like have FTAC answer and evaluate regarding ERISA eligibility for the new system?

Next Steps

- **April – June**: HMA and HCA work on building out the transitional solutions that could have the highest impact. Commission to develop questions for FTAC's evaluation regarding ERISA.
- **May (FTAC meeting):** Continue working on Medicare eligibility. Begin working on ERISA if time. HMA provide updates on the transitional solutions that emerged as highest impact based on Commission's discussion at April meeting.
- **June (Commission meeting):** Combine and evaluate Commission and FTAC transitional solutions.
- **July (FTAC meeting):** Last opportunity to provide guidance to be included in the Commission's legislative report, including Medicare and ERISA.
- **August (Commission meeting):** Finalize the Commission's recommendations for the legislative report.