Washington State Health Care Authority

Report to the Legislature

Universal Health Care Commission Legislative Report

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

November 1, 2022

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Glossary of abbreviations and acronyms

ABA	Applied behavior analysis
ACA	Affordable Care Act
ACH/ACHs	Accountable Community of Health/Accountable Communities of Health
AI/AN	American Indian/Alaska Native
ARNP	Advanced registered nurse practitioner
ASD	Autism spectrum disorder
BBPA	Balance Billing Protection Act
BHP	Washington State Basic Health Plan
BHWAC	Behavioral Health Workforce Advisory Committee
Blue Ribbon	Washington State Blue Ribbon Commission on Health Care Costs and Access
Commission	Universal Health Care Commission
Bree Collaborative	Dr. Robert Bree Collaborative
CAH	Critical access hospitals
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
Commission	Universal Health Care Commission
Consortium	Northwest Prescription Drug Consortium
DOH	Department of Health
DSHS	Department of Social and Health Services
E&M	Evaluation and management
EHB	Essential health benefits
ERISA	Employee Retirement Income Security Act of 1974
FEHB	Federal Employees Health Benefits
FFS	Fee-for-service
FMAP	Federal medical assistance percentage
FPL	Federal poverty level
FQHC	Federally qualified health center
FTAC	Finance Technical Advisory Committee

HBE or Exchange	Washington Health Benefit Exchange
HCA	Health Care Authority
HCCTB	Health Care Cost Transparency Board
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HTCC	Health Technology Clinical Committee
ICU	Intensive care unit
IHCPs	Indian health care provider
IHS	Indian Health Service
IMD	Institution for mental diseases
IRS	Internal Revenue Service
L&I	Department of Labor and Industries
LPN	Licensed practical nurses
MACPAC	Medicaid and CHIP Payment and Access Commission
MCOs	Managed care organization
NAR	Network adequacy reports
Network	Washington Health Workforce Sentinel Network
NHOPI	Native Hawaiian and other Pacific Islanders
NYHA	New York State Health Act
OATAC	Operations and Administration Technical Advisory Committee
OEB	Oregon Educators Benefit
OFM	Office of Financial Management
OIC	Office of the Insurance Commissioner
PA	Physician assistant
PBM	Pharmacy benefit manager
PDAB	Prescription Drug Affordability Board
PEBB	Public Employees Benefit Board
PHE	Public health emergency
PMCC	Performance Measures Coordinating Committee
QDP	Qualified dental plan
QHP	Qualified health plan
RN	Registered nurse
SEBB	School Employees Benefit Board

SHADAC	State Health Access Data Assistance Center
SHI	Statutory health insurance
SMI	Supplementary Medical Insurance
SNAP	Supplemental Nutrition Assistance Program
SUD	Substance use disorder
TPA	Third-party administrator
UHC Work Group	Universal Health Care Work Group
UMP	Uniform Medical Plan
UW CHWS	University of Washington Center for Health Workforce Studies
VBP	Value-based purchasing
VHA	Veteran’s Health Administration
WA-APCD	All Payer Claims Database
WSIPP	Washington State Institute for Public Policy
WVA	Washington Vaccine Association

Executive summary

Senate Bill (SB) 5399 (2021) established a permanent Universal Health Care Commission (Commission) staffed by the Health Care Authority (HCA).[1] The Commission is dedicated to ensuring that all Washingtonians have equitable access to culturally appropriate health care and universal coverage.

The Commission strongly encourages and values input from the public in their commitment to find ways to reduce health care costs, reduce health disparities, improve the health and well-being of patients and the health care workforce, improve quality, and prepare for the transition to a unified health care financing system. As directed by the Legislature, the Commission must:

> "Implement immediate and impactful changes in the state's current health care system to increase access to quality, affordable health care by streamlining access to coverage, reducing fragmentation of health care financing across multiple public and private health insurance entities, reducing unnecessary administrative costs, reducing health disparities, and establishing mechanisms to expeditiously link residents with their chosen providers; and
>
> establish the preliminary infrastructure to create a universal health system, including a unified financing system, that controls health care spending so that the system is affordable to the state, employers, and individuals once the necessary federal authorities have been realized. The Legislature further intends that the state, in collaboration with all communities, health plans, and providers, should take steps to improve health outcomes for all residents of the state."

The Commission's authorizing legislation requires that the Commission submit a baseline report to the Legislature and the Governor by November 1, 2022.

The Commission accomplished significant milestones in its first year of work, including:

- Developed the Commission Charter and Operating Procedures.[2]
- Reviewed and built on the work of the **Universal Health Care Work Group** (House Bill (HB)1109, Section 211, Subsection 57; Chapter 415, Laws of 2019).
- Examined universal health care systems and the core design elements that constitute universal health care systems, including single-payer systems in other countries.
- Engaged with the Health Care Cost Transparency Board (HCCTB) to develop an understanding of health care costs and cost drivers in Washington and to establish cooperation between the Commission and HCCTB.
- Investigated federal barriers to achieving a universal health care system in Washington.
- Developed a phased strategy to move forward on the pathway to a universal health care system.
- Established a Finance Technical Advisory Committee (FTAC).

The approach for Washington's unified financing system will depend on the universal health care model selected for implementation. During the initial design process. FTAC will be directed by the Commission to

[1] See Appendix A for more information on the selection of Commission Members and current Member Roster. Additional meeting information, including recordings of the meetings, meeting materials, and meeting summaries, can be found on the Commission's webpage at: https://www.hca.wa.gov/about-hca/universal-health-care-commission

[2] See Appendix B. Charter and Operating Procedures.

carefully consider the interdependencies between necessary components of a unified financing system and other considerations before the Commission and may be asked to provide pros and cons for each option shared with Commission members.

The Legislature requested that the Commission make recommendations in their baseline report regarding the specific topics identified in the legislation. The Commission's recommendations are grounded in the Commission's goals to increase access to quality and affordable health care by streamlining access to coverage, and to reduce fragmentation of health care financing, unnecessary administrative costs, and health disparities. These recommendations include:

- Transitional solutions that support goals of universal coverage including enrollment options, eligibility systems, access to care, quality improvement, and increased equity. These include:
    - Establish a sustained funding source for the new coverage solutions being implemented that will ensure long-term coverage for uninsured populations.
    - Implement and continue funding the Cascade Care Savings program that will make coverage more affordable for the lowest income Exchange customers, including uninsured individuals currently eligible to purchase QHPs.
- Transitional strategies that can improve affordability and advance the state's readiness to implement a universal health care system. These recommendations include:
    - Further align existing public coverage programs which would
        - Control underlying costs of care and administrative costs.
        - Establish uniform standards for quality of care and coverage across various public programs.
        - Help ensure continuity of coverage when Washingtonians transition between coverage programs.
    - Leverage the work of cost transparency initiatives to develop a broader set of health care cost targets.
    - Implement the Integrated Eligibility and Enrollment Modernization Roadmap[3] that will improve access to coverage and create infrastructure that can be leveraged in a universal health care system.
- Potential pathways to increase Medicaid provider rates as requested by the legislature. These recommendations include:
    - Enhance adult primary care rates to provide parity between pediatric primary care and adult primary care rates.
    - Enhance behavioral health rates to achieve parity between fee-for-service and managed care behavioral health services.
    - Continue to fund rate enhancements for dental services in targeted programs with lower reimbursement rates such as Medicaid that are sufficient to encourage dental provider participation.

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[3] Integrated Eligibility and Enrollment Modernization Roadmap Report. Washington Health and Human Services Enterprise Coalition. 2022. https://www.dshs.wa.gov/sites/default/files/contracts/2223-807/2223-807%20Exhibit%201%20WA%20IEE%20Mod.%20Roadmap%20Report.pdf

Section 1: synthesis of past analyses

Introduction

Washington State is a recognized national leader on innovative health policy efforts granting residents access to affordable and quality health care. For over 30 years, these innovative health policy efforts have transformed Washington's health care system. The first section of this report provides a summary of analyses of Washington's health care finance and delivery system in key areas, including key policy interventions that Washington has implemented, such as:

- Coverage trends
- Costs
- Quality
- Provider consolidation trends

These key policy interventions improve access, affordability, quality, and equity of the health care system. This section also summarizes recent efforts focused on evaluating the impacts of a universal health care system with unified financing in Washington.

> The goal of this section of the report, focused on synthesis of past analyses, is to provide a common understanding of the current state of health care trends and past and recent policy efforts. This overview may help inform future decisions regarding a universal health care system in Washington State.

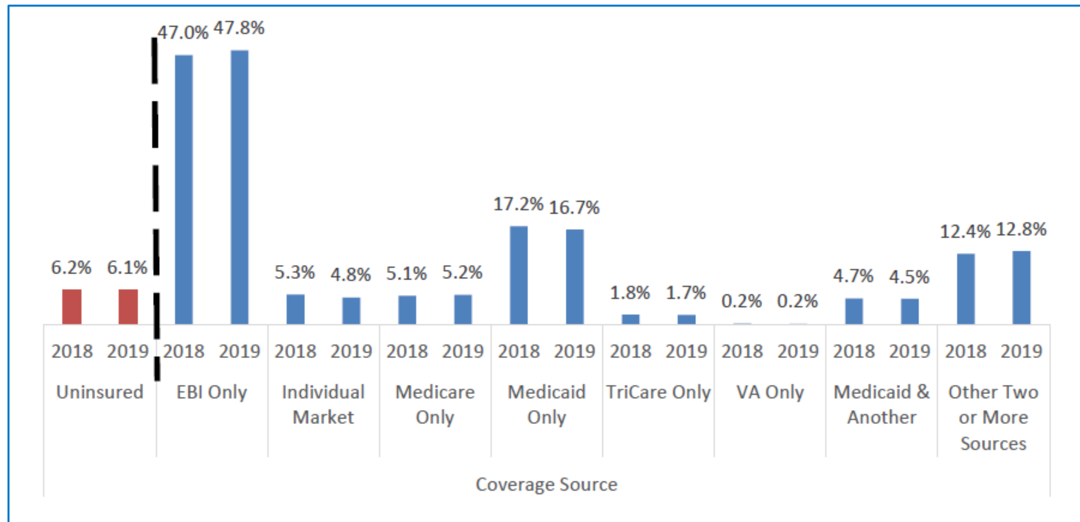
Washington health care coverage analyses and trends

As a national leader in health care system innovation, Washington has sought policy solutions to address coverage gaps well before the Affordable Care Act (ACA). These efforts are detailed in a timeline provided in Appendix C (UHC Work Group Report) and described in this section.

Following passage of the ACA, Washington fully embraced the opportunity to expand Medicaid and offered new subsidized coverage through the Washington Health Benefit Exchange (Exchange or HBE). Medicaid expansion extended health care coverage to more than 500,000 Washington residents.

The annual report on the rate of uninsured, produced by the Office of Financial Management (OFM), details the sources of health coverage for Washingtonians. According to the 2020 report, 47.8 percent of Washingtonians relied on employment-based insurance, 16.7 percent on Apple Health (Medicaid), 4.8 percent on individual market coverage, 5.2 percent on Medicare, 1.7 percent on TRICARE, 0.2 percent on Veteran's Affairs, 4.5 percent on Medicaid and an additional source of coverage, and 12.8 percent on other or two or more sources of coverage. These percentages are illustrated in Figure 1 below.

Figure 1: source of coverage by percentage, 2018 and 2019, Washington[4]



This figure shows where Washingtonians received their health care coverage in 2018 and 2019.

Uninsured populations

The OFM report also highlighted changes in the uninsured rate between 2013 and 2016. The uninsured rate declined from 14.1 percent in 2013 to 5.4 percent in 2016, then slightly increased to 6.1 percent in 2019 before the start of the COVID-19 pandemic.[5,6]

In December 2021, the Office of the Insurance Commissioner (OIC) released its Uninsured Report which provides additional specificity about which populations remain uninsured by age, geography, race, and gender and the uninsured trends over time across geography and sociodemographic groups:

- **Geography:** between 2014 and 2019, the OIC Uninsured Report found that across all counties there were declines in the number of Washingtonians without health insurance. Those declines were more significant in rural compared to urban counties, due in large part to the fact that more individuals in urban counties were already insured in 2014 compared to those in rural counties.
- **Age:** the OIC report also found that residents aged 18 to 44 years had the highest uninsured rate over time with an average of 10 percent, while those 65 years and older had the lowest uninsured rate over time with an average of 0.5 percent, most likely due to Medicare enrollment.
- **Income:** the OIC report noted that individuals with household incomes below $49,999 saw the greatest decrease in the uninsured rate, with a more significant decrease among those with incomes below $25,000, declining from 14.1 percent to 8.9 percent.[7]

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[4] Reprinted with permission from Statewide Uninsured Rate Remained Unchanged from 2018 to 2019. Office of Financial Management, December 2020. https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief098.pdf

[5] Statewide Uninsured Rate Remained Unchanged from 2018 to 2019. Office of Financial Management, December 2020. https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief098.pdf

[6] The most recent data utilized in this report is from 2019. The Office of Financial Management anticipates an update will be available late in 2022.

[7] Report on the number of uninsured people in Washington state 2014-2020. Office of the Insurance Commissioner, December 30, 2021. https://www.insurance.wa.gov/sites/default/files/documents/2021-uninsured-report.pdf#:~:text=Washington%20state's%20uninsured%20rate%20was,2014%20and%205.5%25%20in%202017

Uninsured population by race

OIC's Uninsured Report also provides important insights into uninsured populations by race. Individuals who identify as White, Asian, and multiracial had the lowest uninsured rates statewide at a little over five percent. Individuals who identify in these racial categories as well as individuals who identify as African American/Black, had substantially lower uninsured rates in 2019 than 2014, demonstrating the impact of the ACA's coverage expansions.

OFM's 2020 analysis reports that before the implementation of the ACA in 2013, the uninsured rate for the Hispanic population was 2.5 times the rate of non-Hispanic population. Both populations have seen significant declines in their uninsured rate since 2013, but the disparities persist and are expanding between Hispanic and non-Hispanic populations. In 2019, the uninsured rate for the Hispanic population was nearly four times greater than that for the non-Hispanic population, as seen in Table 1.[8]

Table 1: Washington uninsured rate for Hispanic vs. non-Hispanic populations, 2013–2019

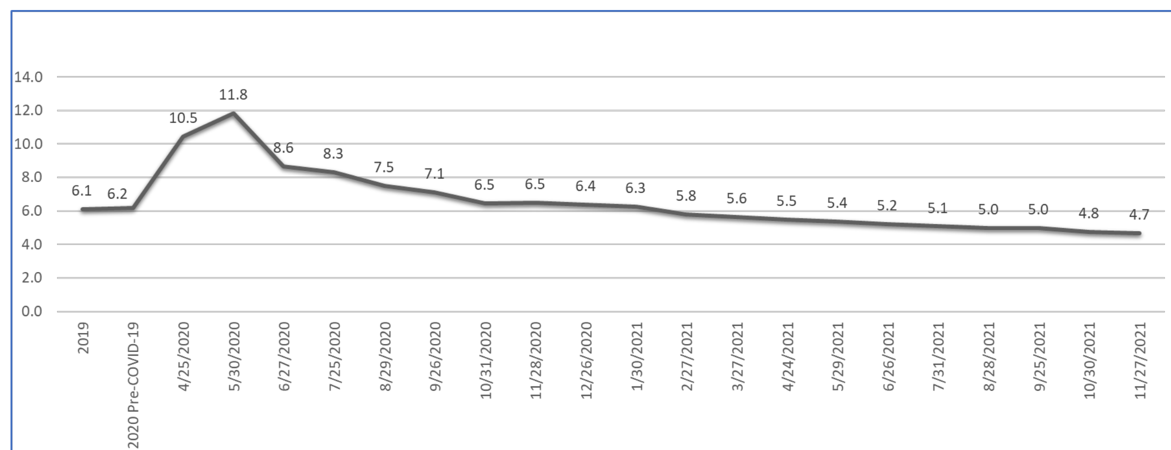
Uninsured rate	2013	2019
Hispanic	29.8%	16.8%
Non-Hispanic	12.0%	4.5%

The table above shows the uninsured rates for Hispanic and non-Hispanic populations in Washington from 2013 through 2019.

COVID-19 and uninsured populations

The impact of the pandemic on the overall uninsured rate in Washington was significant. There was a spike in the uninsured rate to 11.9 percent in May 2020, which steadily declined thereafter as seen in Figure 2. The most recent monthly data from OFM (November 2021) indicates an uninsured rate of 4.7 percent, which is the lowest uninsured rate since the implementation of the ACA.[9]

Figure 2: pre-COVID estimated percentage uninsured in Washington 2019–November 2021



[8] Statewide Uninsured Rate Remained Unchanged from 2018 to 2019. Office of Financial Management, December 2020. https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief098.pdf

[9] Health Coverage Changes in Washington State since the COVID-19 Pandemic: Office of Financial Management presentation to the Commission, February 25, 2022. https://www.hca.wa.gov/assets/program/uhcc-meeting-materials-20220225.pdf

This graph shows the estimated percentage of uninsured Washingtonians. The data points are from 2019, pre-COVID-19 2020, and the last week of the month of April 2020 through November 2021.[10]

The lower uninsured rate is reflective of several key policy changes undertaken to mitigate coverage losses during the pandemic. These key policy changes include:

- Continuous Medicaid coverage
- Expanded eligibility for premium subsidies to purchase coverage through the Exchange
- Enhanced premium subsidies to improve the affordability of Exchange coverage
- Increased outreach and enrollment opportunities to obtain coverage[11]

OFM has monitored the impact of these policies closely and is developing projections of the impact that the end of the Public Health Emergency (PHE) may have on Washington's uninsured rate.

During the February 2022 Commission meeting, OFM shared a preliminary analysis of these potential impacts. OFM projected a significant bump in the rate of uninsured individuals, mostly due to the return of temporary disenrollment and re-enrollment in Apple Health. However, work is underway at HCA and the Exchange to minimize projected coverage losses. Tracking this data and the impact of these efforts to minimize coverage losses will be important information in developing strategies for the transition to universal health coverage.

Cost analyses and trends

Many of Washington's efforts to improve the health care system focus on addressing rising health care costs. In recent years, Washington health care costs increased each year at a pace that exceeds the rate of inflation. In the commercial market, OIC reported a 13-percent increase in costs in 2021, nearly double the rate of inflation at seven percent.[12] Cost growth in Washington also generally exceeds national trends.

From 2014–2018, Washington's average annual growth in per person spending on employer-sponsored insurance was 4.9 percent, which is higher than the national average of 4.3 percent. Similarly, in the Medicare market, Washington's average annual growth in per capita health care costs was 2.4 percent between 2007–2018, exceeding the national average of 2.1 percent.[13]

To better understand cost drivers and to address rising health care costs, Washington State has enacted or implemented several initiatives in recent years:

- Health Care Cost Transparency Board
- Prescription Drug Price Transparency Program
- Prescription Drug Affordability Board
- Value-based purchasing
- OIC's Report on Prior Authorization

These efforts are likely to remain in the forefront of Washington health policy as health care costs continue to increase yearly nationwide.

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[10] Ibid. Reprinted with permission from Office of Financial Management.

[11] "COVID Relief Provisions Stabilized Health Coverage, Improved Access and Affordability." Center on Budget and Policy Priorities. 2022. https://www.cbpp.org/research/health/covid-relief-provisions-stabilized-health-coverage-improved-access-and

[12] Health Care Cost Trends. Office of the Insurance Commissioner. https://www.insurance.wa.gov/health-care-cost-trends

[13] Health Care Cost Transparency Board slides, June 2021. https://www.hca.wa.gov/assets/program/hcctb-board-book-20210616.pdf

Health Care Cost Transparency Board

In 2020, the Washington State Legislature created the Health Care Cost Transparency Board (HCCTB) to identify health care cost trends, set a cost-growth benchmark, and develop recommendations to reduce health care costs.[14] HCCTB was also charged with increasing price transparency.

As of September 2021, HCCTB has approved a cost growth benchmark of 3.2 percent for 2022–23, 3 percent for 2024–25, and 2.8 percent by 2026.[15] Washington's benchmark aligns with other states' cost-growth benchmarks, such as in Oregon, Connecticut, Delaware, Massachusetts, and Rhode Island.[16] The HCCTB will be responsible for identifying providers and payers whose cost growth exceeds the benchmark.

Data collected in 2022 will set the baseline for tracking spending growth in future years, which will be measured against the benchmark. Legislation passed in 2022 (SB 5589) will incorporate primary care into the work of HCCTB. Beginning in 2022, HCCTB will annually report on progress toward primary care expenditures increasing to 12 percent of total health care expenditures.[17]

Prescription Drug Price Transparency Program

In 2019, the Washington State Legislature enacted legislation establishing the Prescription Drug Price Transparency Program (PDPTP) to develop a better understanding of the drivers and impacts of drug costs.[18] Under this program, HCA gathers prescription drug cost information from health carriers, pharmacy benefit managers (PBMs), manufacturers, and other entities to create an annual report on how prescription drugs affect health care costs.

In the first annual report (based on data from 2020 that was reported in 2021), HCA identified that drug price increases may have an impact on health care premiums; however, the extent of the impact could not be identified. This is in some part due to the agency's limitations in its ability to analyze this relationship without a comprehensive set of claims data for all health plans in Washington.[19]

The report suggested several statutory changes, including requiring health carriers, PBMs, manufacturers, and other entities to provide additional data to HCA. These changes would improve the program's ability to understand the impact of prescription drugs on rising health care premiums. Many of these recommendations, including these additional reporting requirements, were included in the legislation that passed in 2022. This legislation also created the Prescription Drug Affordability Board (PDAB).[20]

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[14] Second Substitute House Bill 2457 Chapter 340, Laws of 2020. https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/2457-S2.SL.pdf?q=20220405153723

[15]Health Care Cost Transparency Board. September 14, 2021, Meeting Minutes. https://www.hca.wa.gov/assets/program/board-meeting-summary-20210914.pdf

[16] Block, R. & Lane, K. (2021). Supporting States to Improve Cost Growth Targets to Improve Affordability. Health Affairs. https://www.healthaffairs.org/do/10.1377/forefront.20210526.658347/full/

[17] Health Care Cost Transparency Board must submit a preliminary report by December 1, 2022, including the annual progress report needed for primary care expenditures to reach 12 percent of total health care expenditures in a reasonable amount of time, and how and by whom it should annually be determined whether desired levels of primary care expenditures are being achieved.

[18] Engrossed Second Substitute House Bill 1224 Chapter 334, Laws of 2019. https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1224-S2.SL.pdf?q=20220404145622

[19] Health Care Authority. (2022). Prescription Drug Price Transparency – Annual Report. https://www.hca.wa.gov/assets/program/hca-dpt-annual-report-2022.pdf

[20] Second Substitute Senate Bill 5532 Chapter 153, Laws of 2022. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5532-S2.SL.pdf#page=1

Prescription Drug Affordability Board

Beginning in 2023, PDAB is empowered to conduct up to 24 affordability reviews of drugs that have been on the market for at least seven years. This includes drugs dispensed at a retail, specialty, or mail-order pharmacy, but does not include drugs designated by the United States Food and Drug Administration as a drug solely for the treatment of a rare disease or condition. These drugs must also meet the following benchmarks to be considered for an affordability review:

- Brand name prescription drugs that have a:
  - Wholesale acquisition cost of $60,000 or more per year or for course of treatment lasting less than one year,
  - Price increase of 15 percent or more in any 12-month period or for a course of treatment lasting less than 12 months, or
  - Fifty percent cumulative increase over three years.
- Biosimilar products with an initial wholesale acquisition cost that is not at least 15 percent lower than the referenced biological product.
- Generic drugs with a wholesale acquisition cost of $100 or more for a 30-day supply or less that has increased in price by 200 percent or more in the previous 12 months.

The legislation includes additional parameters for the affordability reviews including establishment of advisory panels. The advisory panels would include stakeholders such as patients, patient advocates, and a representative from the pharmaceutical industry. Affordability reviews will be focused on determining if the drug led to or will lead to excess costs or are not sustainable to the health care system over a ten-year period. Beginning January 1, 2027, PDAB will have the authority to set an upper payment limit for up to 12 prescription drugs each year.[21]

Value-based purchasing

As the largest purchaser of health care in Washington, HCA is leading value-based purchasing (VBP) strategies to contain health care costs while improving outcomes. HCA set a target to achieve 90 percent of state-financed health care payments to be under VBP contracts and is making progress toward this goal. HCA's Value-Based Purchasing Roadmap for 2022–2025 sets forth VBP priorities, successes, challenges, and progress to date in implementing VBP arrangements in Washington.22

Office of the Insurance Commissioner Report on Prior Authorization

In 2020, the Legislature passed SB 6404 that requires health carriers with at least one percent market share in Washington to report certain data regarding prior authorization to OIC.[23] Prior authorization is a tool used by carriers to control cost of and access to certain benefits. This reporting may offer insightful information that will be helpful in making decisions concerning the design elements of a universal system, particularly regarding the appropriate use of prior authorization as a tool to control costs.

Carriers are required to report data annually for the following specified categories of health care services:

- Inpatient medical/surgical

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[21] Ibid.
[22] VBP Roadmap https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf
[23] Engrossed Substitute Senate Bill 6404 Chapter 316, Laws of 2020. https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/6404-S.SL.pdf?q=20220405154910

- Outpatient medical/surgical
- Inpatient mental health and substance-use disorder
- Outpatient mental health and substance-use disorder
- Diabetes supplies and equipment, and
- Durable medical equipment

Within these categories of health care services, carriers report:

- The 10 codes with the highest number of prior authorization requests and the percentage of approved requests.
- The 10 codes with the highest percentage of approved prior authorization requests and the total number of approved requests.
- The 10 codes with the highest percentage of prior authorization requests that were initially denied and then approved on appeal.
  The total number of requests.
- The average response time in hours for requests in each of the above categories for expedited decisions, standard decisions, and extenuating circumstances decisions.

In the 2021 report, OIC stated that the average approval rate across all carriers was 84.4 percent. For the codes with the highest number of prior approval rates, the average approval rates were as follows:

- Outpatient Medical/Surgical: 98.3 percent
- Inpatient Medical/Surgical: 97.8 percent
- Durable Medical Equipment: 96.1 percent
- Inpatient Mental Health/Substance Abuse: 94.5 percent
- Outpatient Mental Health/Substance Abuse: 91.8 percent
- Diabetes Supplies and Equipment: 84.1 percent

OIC also reported the average response times for the codes with the most requests, which were as follows:

- Inpatient Mental Health/Substance Abuse: 14.4 days
- Diabetes Supplies and Equipment: 12.4 days
- Inpatient Medical/Surgical: 10.7 days
- Outpatient Mental Health/Substance Abuse: 6.7 days[24]

Balance Billing Protection Act

Beginning in January 2020, Washington residents were protected from surprise (or balance) billing when receiving emergency care at a medical facility or when treated at an in-network hospital or outpatient surgical facility by an out-of-network provider. The Balance Billing Protection Act (BBPA), passed in 2019, applies to all state-regulated health plans and state and school employee benefit plans. Self-funded group plans are not required to comply.[25]

In 2022, Washington's BBPA was updated to align with the federal No Surprises Act passed in 2020. Emergency services and post-stabilization services are now covered, including behavioral health crisis

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[24] Health Plan Prior-Authorization Data 2021 Report. Office of the Insurance Commissioner. https://www.insurance.wa.gov/sites/default/files/documents/health-plan-prior-authorization-data-2021-report.pdf
[25] Second Substitute House Bill 1065 Chapter 427, Laws Of 2019. https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1065-S2.SL.pdf#page=1.

settings, which are considered emergency services. Consumers cannot be asked to waive these balance billing protections, which protects them from surprise bills for covered services.[26]

Quality analyses and trends

Improving health care quality has been and remains a policy priority for Washington's health care delivery system. Washington policymakers have made several investments and enacted key policies in recent years to monitor and support quality improvements:

- Washington State Health Technology Clinical Committee
- Dr. Robert Bree Collaborative
- Washington Statewide Common Measure Set
- All Payer Health Care Claims Database
- Washington's Medicaid Transformation Project

> These efforts focus on promoting transparency and improved quality in the health care system and are important building blocks to consider in the future design of a universal health care system.

Washington State Health Technology Clinical Committee

The Health Technology Clinical Committee (HTCC) was established in 2006 to make evidence-based coverage determinations for health technologies.[27] The HTCC is supported by HCA's Health Technology Assessment program, which develops and publishes systematic health technology assessment reports on the strength of the evidence for medical devices, procedures, and tests.

The HTCC considers Health Technology Assessment reports and other information, including state utilization and public comments. HTCC's determinations apply to coverage decisions for state health care purchasers, including Medicaid, Uniform Medical Plan, and the Department of Labor and Industries.

Dr. Robert Bree Collaborative

The Legislature established the Dr. Robert Bree Collaborative (Bree Collaborative) in 2011 as a forum for public and private health care stakeholder collaboration to improve quality, health outcomes, and cost effectiveness of care in Washington.[28] Participating experts are nominated by community stakeholders and appointed by the Governor.

Each year, the Bree Collaborative identifies up to three health care service areas with high variation in the delivery of care that do not lead to better care or patient health, or that have demonstrated patient safety issues. The selected service areas are addressed by a work group of experts on the topic who are Bree Collaborative members and other experts in the community. The work group analyzes evidence on best practices for improving quality and reducing practice pattern variation.

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[26] Engrossed Second Substitute House Bill 1688 Chapter 263, Laws of 2022. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1688-S2.SL.pdf#page=1
[27] Health Care Authority. Health Technology Clinical Committee and Health Technology Assessment.
[28] Bree Collaborative website.

The Bree Collaborative recommendations consider existing quality improvement programs and organizations currently working to improve care. HCA incorporates Bree Collaborative recommendations into state-purchased coverage rules.

Washington State Common Measure Set

In 2014, the Legislature established the Washington State Common Measure Set as part of a larger bill focused on "improving the effectiveness of health care purchasing and transforming the health care delivery system."[29] Specifically, the intent of measure set is to minimize variation in how the health care delivery system is measured and monitored.

This legislation established a statewide performance measures committee, known as the Performance Measures Coordinating Committee (PMCC) which is supported by HCA. PMCC includes diverse representation such as state agencies, large and small employers, carriers, federally recognized tribes, patient groups, academics, hospitals, physicians, and consumers.

PMCC identifies and recommends a standard set of health performance measures that are utilized to develop benchmarks to inform health care purchasers. In 2014, a set of measures were introduced. The measures are continually updated by PMCC as new health care measures are developed and priorities for improvement are identified. The most recent set of measures was updated in 2022.[30] The Washington State Common Measure Set is used by HCA to promote quality improvement efforts in Apple Health, the Public Employees Benefits Board (PEBB) and the School Employees Benefits Board (SEBB) using strategies such as value-based purchasing.

All Payer Claims Database

The same legislation that established PMCC and the Washington State Common Measure Set also allocated resources to OFM to establish the Washington All Payer Claims Database (WA-APCD) to support transparent public reporting of health care information.[31]

WA-APCD contains eligibility, medical, pharmacy, and dental claims representing about 75 percent of the statewide health care claims including Medicaid, individual market, Medicare, public employees benefits, workers' compensation, and more than 50 commercial payers.[32] In 2019, the Legislature transferred the responsibility for WA-APCD to HCA to partner with a lead organization with experience collecting and analyzing claims data.[33]

WA-APCD data is displayed on the Washington HealthCareCompare website, allowing consumers to compare the cost and quality of medical care and services. Consumers can find local prices of a treatment or visit by zip code. APCD data is also used to inform and support other work in Washington examining

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[29] Engrossed Second Substitute House Bill 2572 Chapter 223, Laws of 2014. https://lawfilesext.leg.wa.gov/biennium/2013-14/Pdf/Bills/Session%20Laws/House/2572-S2.SL.pdf?q=20220405155431

[30] Washington Statewide Common Measure Set. https://www.hca.wa.gov/about-hca/washington-statewide-common-measure-set#what-is-statewide-common-measure-set

[31] Engrossed Second Substitute House Bill 2572 Chapter 223, Laws of 2014. https://lawfilesext.leg.wa.gov/biennium/2013-14/Pdf/Bills/Session%20Laws/House/2572-S2.SL.pdf?q=20220405155431

[32] Washington All Payer Health Care Claims Database newsletter. https://content.govdelivery.com/accounts/WAHCA/bulletins/2b4351b

[33] Engrossed Substitute Senate Bill 5741 Chapter 319, Laws of 2019. https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5741-S.SL.pdf?q=20220320080426

costs of health care, including BBPA, the OIC's studies of health care cost trends and access to behavioral health services, and HCCTB.

Washington's Medicaid Transformation Project

Washington is currently in its final year of an 1115 Medicaid waiver that includes five key initiatives to transform the Medicaid program including:

- **Initiative 1:** transformation through Accountable Communities of Health (ACHs) and Indian health care providers (IHCPs). This initiative implements projects that change the way individuals receive health care in their region. HCA submitted a waiver renewal proposal to the Centers for Medicare and Medicaid Services in July 2022. Efforts to improve quality through value-based payments will continue to be a focus of ongoing transformation efforts.[34]
- **Initiative 2:** supporting older adults and family caregivers. Initiative 2 provides support for Washington's aging population and family caregivers who provide care for their loved ones.
- **Initiative 3:** Foundational Community Supports (FCS). This initiative provides supportive housing and supported employment services to vulnerable Medicaid enrollees.
- **Initiative 4:** substance use disorder (SUD) institution for mental diseases (IMD). Initiative 4 provides greater access to SUD treatment by allowing Washington to use federal funds to pay for SUD treatment in a mental health or SUD facility that qualifies as an IMD. IMDs are large facilities dedicated to psychiatric care (more than 16 beds where more than 50 percent of the residents are admitted for psychiatric care).[35]
- **Initiative 5:** mental health IMD. This initiative provides greater access to in-patient care by allowing Washington State to purchase an average of 30 days of acute inpatient services for Medicaid clients between the ages of 21 and 65 years who reside in an IMD.[36]

Through these initiatives, HCA is implementing and overseeing projects that are designed to improve the way individuals access the health and social supports they need. By further integrating these services and supporting providers in the transition to value-based payments, Washington will improve the quality of care that individuals receive.

Health care workforce analyses and trends

Developing and maintaining an adequate health care workforce will be critical to any effort to move toward a universal health care system focused on improving access and quality and reducing costs. Workforce trends will be particularly important considerations when developing a provider reimbursement model.

Physician workforce findings

OFM's Forecasting and Health Care Research Division produces an annual report on Washington's physician supply using data collected from the Network Adequacy Reports (NAR) that health insurance

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[34] Medicaid Transformation Project Renewal https://www.hca.wa.gov/about-hca/medicaid-transformation-project-mtp/mtp-renewal

[35] Amendment to Washington's Medicaid Transformation Project (MTP): the substance use disorder IMD initiative. https://www.hca.wa.gov/assets/program/sud-imd-faq.pdf

[36] Amendment to Washington's Medicaid Transformation Project: introducing the mental health IMD initiative. https://www.hca.wa.gov/assets/program/mental-health-imd-faq.pdf

carriers submit monthly to OIC. The 2021 report found that the number of licensed physicians (including Medical Doctors and Doctors of Osteopathy) increased by 769 between 2020 and 2021, from 19,794 to 20,563 licensed physicians.

This growth in the number of licensed physicians outpaced the general population increase, resulting in an increase in the physician-to-population ratio from 269 physicians per 100,000 in 2020 to 275 physicians per 100,000 population in 2021.

The report also found that the ratio of physicians practicing primary care in comparison to specialty care remained relatively unchanged (declining from 34 percent to 33 percent for primary care and rising to 67 percent from 66 percent for specialty care).

Similar to past annual reports, the physician supply is disproportionately distributed across the state, with more than 40 percent of all physicians located in King County. This is not surprising given that King County accounts for the bulk of the state's population. However, Chelan County, not King County, has the highest ratio of physician-to-population ratio by a significant margin: 532 physicians per 100,000 individuals versus 383 physicians per 100,000 people. Overall, significant disparities in Washingtonians' access to physicians remain across the state.[37]

Efforts to address shortage of health care workers

The Health Workforce Council was created by the Washington State Legislature in 2003 to investigate and support initiatives to address health care workforce shortages. The Health Workforce Council is responsible for producing an annual report outlining these trends and making recommendations to the Legislature about possible improvements.

Washington Health Workforce Sentinel Network

One of the initiatives of the Health Workforce Council has been the Washington Health Workforce Sentinel Network (Network), created in 2016. The Network is a collaboration of the Health Workforce Council and the University of Washington Center for Health Workforce Studies (UW CHWS). The Network links the health care industry with partners in education and training, policymakers, and other workforce planners to identify and respond to emerging demand changes in the health workforce. The information captured by the Network seeks to provide more insights into the "why" of changes in occupations, roles, and skills needed to deliver quality care.

Since its inception, the Network has tracked health disciplines with exceptionally long vacancies across a number of health care settings.[38] According to the Health Workforce Council Annual Report for 2021, employers in long-term care settings, including skilled nursing facilities, nursing homes, and assisted living facilities, reported significant challenges in hiring enough registered nurses (RNs), nursing assistants, and licensed practical nurses (LPNs).

Notably, these workforce challenges are not new, but have become more acute since the COVID-19 pandemic.[39] There are various causes for these shortages such as the lack of adequate training slots for

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[37] Office of Financial Management: 2020-21 Physician Supply: Estimates for Washington. https://ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/workforce/physician_supply_2020-21.pdf

[38] Health Workforce Council. https://www.wtb.wa.gov/planning-programs/health-workforce-council/

[39] Health Workforce Council Annual Report 2021 Annual Report. https://www.wtb.wa.gov/wp-content/uploads/2022/01/Health-Workforce-Council-Annual-Report-2021.pdf

many of these professions, lower salaries in long-term care settings compared to other settings, and administrative challenges with licensure when moving from other states.

Behavioral Health Workforce Advisory Committee

Another area experiencing significant and ongoing health care workforce shortages is behavioral health. According to the 2017 Washington State Behavioral Health Workforce Assessment, "the demand for behavioral health care, including mental health and substance use disorder treatment, exceeds the availability of services throughout the state."[40] This is consistently echoed in the data collected by the Network. Long-term vacancies are also commonplace and have become more acute over the last two years due to the pandemic, during which the demand for behavioral health services has skyrocketed.[41] In response to the significant and enduring gaps in the behavioral health workforce, in 2021 the Legislature formalized an existing stakeholder workgroup that became known as the Behavioral Health Workforce Advisory Committee (BHWAC).

BHWAC issued an interim report in December 2021 with updated policy recommendations to improve hiring and retention. Key recommendations included in the interim report focused on

- Increasing Medicaid reimbursement rates for behavioral health providers.
- Increasing the ability of behavioral health agencies to accept students/trainees.
- Enhancing training programs to support individuals pursuing careers in behavioral health.

A final report from BHWAC is expected in December 2022.[42]

> Addressing the existing health care workforce shortage will be a prerequisite in the transition to a universal health care system.

Market consolidation analyses and trends

Over the last 35 years in Washington, there has been an increase in hospital consolidation as a result of mergers, acquisitions, and other types of affiliation among providers. This trend is not unique to Washington and is identified in many studies as a contributing factor to higher costs and poorer outcomes in the health care delivery system.[43]

Along with consolidation among hospitals, Washington also is seeing increased vertical consolidation, such as hospital system purchases of, employment of, or affiliation with physician groups, imaging centers, long term care facilities and ambulatory surgical centers.[44] Understanding market consolidation

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[40] 2017 Washington State Behavioral Health Workforce Assessment. https://familymedicine.uw.edu/chws/wp-content/uploads/sites/5/2018/01/wa_bh_workforce_fr_dec_2017.pdf

[41] Health Workforce Council Annual Report 2021 Annual Report. https://www.wtb.wa.gov/wp-content/uploads/2022/01/Health-Workforce-Council-Annual-Report-2021.pdf

[42] Behavioral Health Workforce Advisory Committee Preliminary Report and Recommendations. https://www.wtb.wa.gov/wp-content/uploads/2021/12/BHWAC-Preliminary-Report-Final-Draft.pdf

[43] Schwartz, K. What We Know About Provider Consolidation. Kaiser Family Foundation. 2020. https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/

[44] A lawsuit was filed after CHI Franciscan acquired the assets of WestSound Orthopedics in Silverdale, Washington and then announced an affiliation with a multi-specialty practice with more than 50 physicians and seven locations throughout Kitsap County. The deals combined the three largest providers of orthopedic physician services in the Kitsap region, which considerably reduced

trends is an important factor when making design and policy decisions about a universal health care system in Washington.

OFM released a comprehensive report, "Hospital Mergers in Washington 1986–2017" which describes the increased concentration of hospital resources and care as more hospitals in Washington became part of larger hospital systems over the 1986-2017 period.[45] While the report does not provide specific data comparing quality and costs of care before and after hospital mergers and acquisitions, it does provide information about how many hospital beds, intensive care units (ICUs), and hospital admissions are concentrated in a few health care systems compared with independent hospitals. The concentration of these resources provides insights into the lack of competition that may contribute to reduced access and higher costs.

The report found that the percentage of hospitals in systems grew from 10 percent in 1986 to almost 50 percent in 2017. This trend was not consistent over the time period of the study; most of the changes happened between 2006 and 2017. With this shift to larger systems, hospital resources have become more concentrated. The number of available hospital beds per 100,000 population decreased from 298 to 170. Meanwhile, the percentage of hospital beds in systems, patient admissions to systems, and ICU beds in systems all increased dramatically as indicated in Table 2.

Table 2: change in percentage of hospital beds, patient admissions and ICU beds in systems 1986–2017

Percentage of hospital beds in systems	
1986	19%
2017	73%
Percentage of patient admissions to systems	
1986	20%
2017	79%
Percentage of ICU beds in systems	
1986	19%
2017	73%

The above table shows the dramatic increase in percentage of hospital beds, patient admissions, and ICU beds in systems from 1986 to 2017.

OFM's Hospital Mergers Report also provided data about consolidation at the county level across Washington. In 1986, hospitals in systems operated in six counties, each of which had at least one independent hospital. These counties accounted for 60 percent of the state population. In total, 29 counties, accounting for 39 percent of Washington's population, were served only by independent hospitals and four counties had no hospital. In 2017, system hospitals operated in 17 counties. Eight of

choices for Kitsap consumers seeking orthopedic services close to home. Washington State Office of the Attorney General. 2019. https://www.atg.wa.gov/news/news-releases/attorney-general-ferguson-chi-franciscan-will-pay-25-million-over-anti

[45] Office of Financial Management. Hospital Mergers in Washington 1986-2017. https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief105.pdf

those counties were served only by system-operated hospitals. Close to 90 percent of the population lived in a county with at least one system hospital, compared to 60 percent in 1986.

The increased consolidation and concentration of health care resources may have an unforeseen impact on the community. One concern articulated in this report was the significant amount of consolidation into Catholic hospital systems which could impact access to reproductive health services which has been a long-standing priority for Washington policymakers. This will be an important factor to consider when designing a universal health care system to achieve better outcomes and lower costs.

Seeking comprehensive solutions in Washington: a 35-year journey

Exploring comprehensive solutions to improve quality, lower costs, and improve access to affordable coverage are not new endeavors in Washington. Over the last 35 years, Washington's wide-ranging efforts aimed to provide a comprehensive solution to these pervasive problems, including establishing the Basic Health Plan, the Washington Healthcare Commission (often called the Gardner Commission after then-Governor Booth Gardner), the Washington State Blue Ribbon Commission on Health Care Costs & Access, and the more recent Universal Health Care Work Group.

These efforts, in addition to the targeted efforts described earlier, are foundational steppingstones in Washington's current deliberations and decision-making to develop a universal health care system that will provide affordable and quality health care to all Washingtonians.

Basic Health Plan

Washington began extending coverage to qualified low-income adults and children in 1987 using a state-funded effort called the Washington State Basic Health Plan (BHP). The initial pilot program was expanded statewide in 1993, eventually enrolling over 100,000 low-income, Medicaid-ineligible working adults with incomes under 200 percent of the federal poverty level (FPL).

Enrollment into Washington's BHP continued to grow through the mid-90s and in 2003 reached a peak of 130,000 (the program's enrollment cap at the time).[46] Due to state budget pressures, BHP funding was cut by 43 percent in the 2009–2011 state budget, greatly reducing the number of enrollees and stopping new enrollment. Many BHP enrollees transitioned to Medicaid with the state's Section 1115 waiver and the ACA's Medicaid expansion. The ACA's Basic Health Plan provision at section 1331 of the Act was modeled on Washington's BHP.

Washington Health Care Commission

In 1990, the Washington State Legislature passed Legislative Resolution 4443, which established the Washington Health Care Commission to recommend plans for ensuring access to health care for Washingtonians. The Washington Health Care Commission's final report, released in 1992, defined universal access as "the right and ability of all Washington residents to receive a comprehensive, uniform, and affordable set of confidential, appropriate, and effective health services" which was called the "uniform set of health services."[47]

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[46] Revised Code of Washington (RCW) 70.47.060 permitted the program to temporarily close enrollment to avoid over-expenditures.
[47] Washington Health Care Commission: Final Report to Governor Booth Gardner and the Washington State Legislature. November 30, 1992.

The proposed uniform set of health services was to be delivered by competing certified health plans to cover preventive, primary, and acute care. The uniform set of health services also included prescription drugs, dental care, mental health, and substance use disorder services. Long-term care services were planned to be phased in. The Washington Health Care Commission stressed that services must be timely and not tied to ability to pay or pre-existing health conditions. Consideration of geographic, demographic, and cultural differences would also be considered in providing services.

A majority of Washington Health Care Commission members wanted a single organization to sponsor coverage for all residents, while others believed employers should be part of a "pay or play" system that allows the employer to offer coverage or pay into the system. Approved health carriers would compete on price within a maximum allowed premium and under rules set by an independent state commission.

Financing would be shared by individuals, employers, and Washington State. Carriers would be encouraged to implement capitation and increase provider risk for managing care. The Washington Health Care Commission also recommended seventeen strategies for making the health care liability system less costly, time consuming, and emotionally burdensome for consumers and providers.

Recognizing that implementation would take time, the Washington Health Care Commission recommended immediate action to reauthorize the Basic Health Plan and increase funding for public health programs. Additional recommendations to the Legislature included: pursuing insurance reforms, implementing guaranteed issue and renewability, creating a prohibition or limit on pre-existing condition exclusions, implementing modified or strict community rating, and developing small group market reforms.

The Washington Health Services Act of 1993

Based on the recommendations of the Washington Health Care Commission, in 1993 the Washington Legislature passed a comprehensive health law that included many of the recommended elements. Many of these elements would be included in the ACA 15 years later:

- Employer and individual mandates
- Guaranteed issue and renewal (insurers may not deny coverage due to pre-existing conditions)
- Required coverage of a basic set of benefits
- Expanded Medicaid eligibility

However, the law was not fully implemented because portions of it were repealed by the 1995 Legislature. These repealed provisions included the individual and employer mandates, the use of certified health plans to deliver coverage based on a uniform set of benefits, and caps on insurance premiums.[48] The law retained expansion of the Basic Health Plan and Medicaid for children in families with income up to 200 percent FPL.

The guaranteed issue and required coverage of a basic set of benefits provisions of the law were also maintained. Within several years of passage of the 1995 legislation, the individual market struggled as carriers withdrew from the market. The 2000 Legislature enacted a number of changes to the individual market in order to restore access to that coverage.[49]

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[48] Certified health plans were defined by the law as organized delivery systems with financial risk for delivering the uniform benefit package.

[49] Chap. 79, Laws of 2000.

Washington State Blue Ribbon Commission on Health Care Costs & Access

In 2006, the Legislature established the Blue Ribbon Commission on Health Care Costs and Access (Blue Ribbon Commission), which was supported by OFM and charged with delivering a five-year plan for substantially improving access to affordable health care for all Washingtonians. The Blue Ribbon Commission included then-Governor Christine Gregoire, eight legislators, and leaders from OIC, HCA, Department of Health (DOH), Department of Social and Health Services (DSHS), and Department of Labor and Industries (L&I).

Based on the vision of a system that allows every Washingtonian to get needed health care at an affordable price, the group identified four overarching strategies:

- Build a high-quality, high-performing health care system.
- Provide affordable health insurance options for individuals and small businesses.
- Ensure the health of the next generation.
- Promote prevention and healthy lifestyles.

The Blue Ribbon Commission made 16 recommendations tied to one or more of the above strategies and included proposed actions. Many of the Blue Ribbon Commission's recommendations were implemented by the state Legislature in 2007, including:

- Using reimbursement to reward quality outcomes.
- Increasing consumers' access to information and shared decision making.
- Improving primary care and chronic care.
- Facilitating secure sharing of health information.
- Tracking emergency room use.
- Identifying contributors to health care administrative costs and evaluating ways to reduce them.
- Designing insurance coverage options that promote prevention and health promotion
- Expanding coverage options.
- Increasing public health activities.[50]

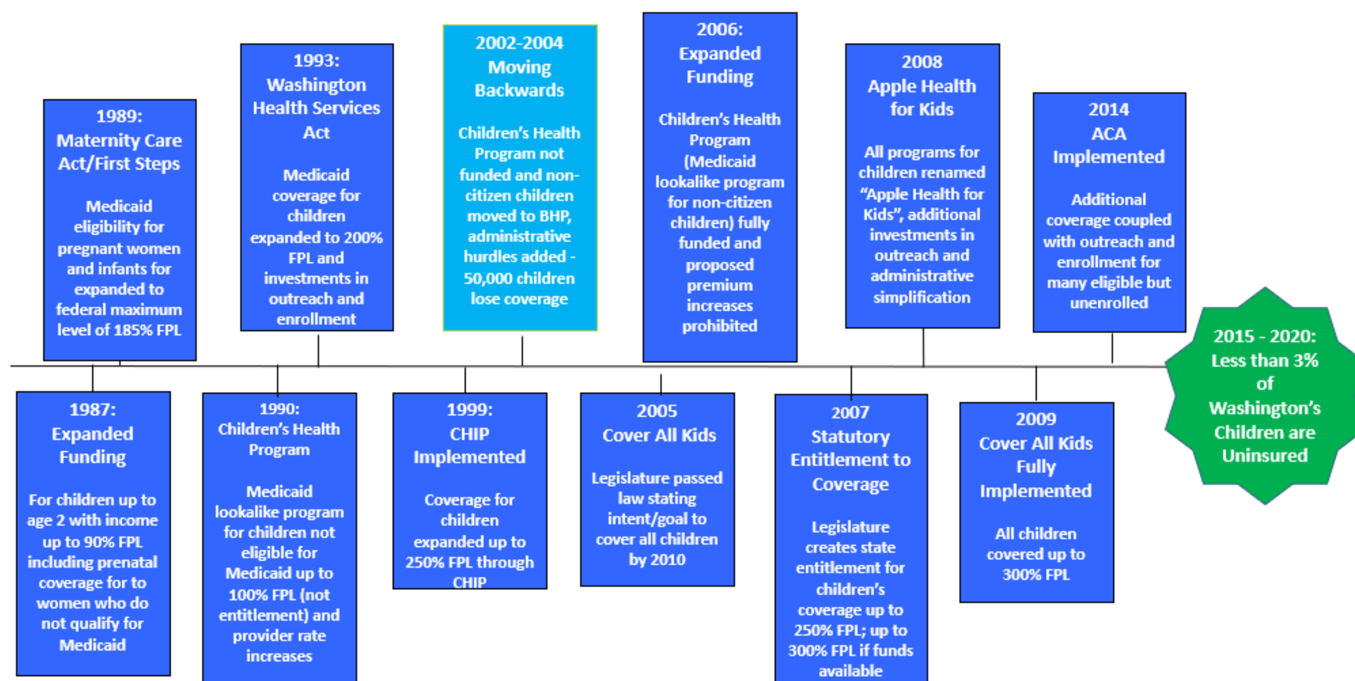
Years ahead of the ACA, the same legislation that created the Blue Ribbon Commission in 2007 also included the requirement to allow purchasers of individual or group coverage the option to cover their unmarried dependents until they reach age 25. This requirement was also implemented for disability insurance. Additionally, the legislation directed DSHS to develop coverage expansion options that could utilize Medicaid, Children's Health Insurance Program (CHIP), and/or BHP.

Universal coverage for children

Over 98 percent of Washington children are covered by health insurance, meaning that the state is now considered to have universal child coverage. The process of reaching universal coverage for children took over a decade and involved multiple steps by the Legislature, as seen in Figure 3.

[50] Engrossed Second Substitute Senate Bill 5930 Chapter 259, Laws of 2007. https://lawfilesext.leg.wa.gov/biennium/2007-08/Pdf/Bills/Session%20Laws/Senate/5930-S2.SL.pdf#page=1

Figure 3: the pathway to universal coverage for children in Washington



This figure shows the legislation and programs that resulted in insuring over 97 percent of Washington's children.

Investigating single payer models

In 2018, Washington policymakers allocated resources to investigate the impact of moving to a universal health care system.[51] The first study, conducted by the Washington State Institute for Public Policy (WSIPP), examined various models of universal health care from other countries to gain insights about how these models were constructed and their effectiveness in comparison with the current system in the United States.[52]

This study compared the health care systems of the United States to 10 comparable "high-income" countries including Japan, Germany, the United Kingdom, France, Canada, Australia, the Netherlands, Sweden, Switzerland, and Denmark. In general, the health care systems of the comparable countries are considered "universal" models to varying degrees. These models included:

- Single payer systems in which the government is the payer and provider (e.g., the United Kingdom).
- Single payer systems in which the government is the payer, but providers are generally private (e.g., Canada).
- Multi-payer systems that combine the governmental oversight and benefit design with private health insurance (e.g., Germany or Japan).

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[51] Engrossed Substitute Senate Bill 6032, Section 606(15), Chapter 299, Laws of 2018. https://app.leg.wa.gov/billsummary?BillNumber=6032&Initiative=false&Year=2017

[52] Washington State Institute for Public Policy: Single-Payer and Universal Coverage Health Systems Final Report, May 2019. https://www.wsipp.wa.gov/ReportFile/1705/Wsipp_Single-Payer-and-Universal-Coverage-Health-Systems-Final-Report_Report.pdf

WSIPP's analysis found that the United States spends more on health care on a per capita basis when compared with countries with universal health coverage models. Specifically, the United States spent $9,400 per person on health care in 2016, whereas the selected universal models spent on average $5,000 per person on health care in 2016. This difference in spending was attributed to several factors: higher administrative costs, higher prices, higher utilization of more expensive services,[53] and higher prevalence of newer technology or drugs with "modest or uncertain" effectiveness. However, wait times for certain procedures were lower in the U.S. health care systems and the availability of newer technology was generally higher.

Overall, the outcomes of the U.S. systems as compared to the universal systems are mixed. For example, the utilization of preventative care (screenings, immunizations) is higher in the United States, but deaths due to diabetes and other manageable chronic diseases or "avoidable mortality" is also higher.

The WSIPP report concluded that countries providing universal health care systems generally were more successful in limiting health care spending and patients' financial barriers to care while achieving comparable health outcomes to the United States. However, the report noted that comparing these systems to the United States and judging the feasibility of implementing a universal health care system in the US was difficult due to the large differences in population, lifestyle, and general differences in the nature of the comparison countries to the United States, such as governmental policies and taxation systems.

Universal Health Care Work Group

Following the WSIPP study, in 2019, Washington policymakers secured funding to support the Universal Health Care (UHC) Work Group, which was charged with evaluating the potential impacts of moving to universal health care system in Washington.[54] The UHC Work Group produced a comprehensive report of their work and findings that was submitted to the Washington State Legislature in early 2021.[55]

Membership of the UHC Work Group reflected the geographic, socio-economic, ethnic, racial, and gender diversity of Washington's population. The UHC Work Group consisted of 37 stakeholders representing relevant state agencies, legislative leaders from the two largest political parties from both the State House and Senate, health care provider groups, health care associations and health care consumers. The UHC Work Group initially focused on determining and providing guidance on essential elements in a universal health care coverage model for Washington. These elements helped design straw models that were then analyzed to understand the costs and savings associated with each.

Universal Health Care Work Group's suggested models

The three models proposed and evaluated by the UHC Work Group to achieve universal coverage included:

- **Model A:** State-governed and state-administered program for all state residents.
- **Model B:** State-governed and health carrier-administered program for all state residents.
- **Model C:** Access to coverage for residents without a federally recognized immigration status

[53] This is likely due to the general lower threshold of utilization management rules present in private insurance as compared to universal systems.
[54] Engrossed Substitute House Bill 1109, Section 211, Subsection 57;
Chapter 415, Laws of 2019. https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1109-S.SL.pdf?q=20220321001807
[55] Universal Health Care Work Group – Report to Legislature, January 2021. https://www.hca.wa.gov/assets/program/final-universal-health-care-work-group-legislative-report.pdf

who are unable to buy coverage, which was termed "fill-in-the-gaps coverage." This model could be expanded to other uninsured or underinsured populations.

The following table provides an overview of some of the key characteristics featured in each model including the populations covered, minimum benefits offered, cost sharing requirements, and provider reimbursement levels. Notably, all three models would continue to have care delivered by private and public providers, clinics, and hospitals.[56]

Table 3: overview of the characteristics of the UHC Work Group's three models [57]

	Model A	Model B	Model C
Populations	All state residents, including Medicaid, CHIP, Medicare, privately insured, uninsured, and without a federally recognized immigration status		Residents without a federally recognized immigration status
Covered benefits	• Essential health benefits, plus vision for all participants • Dental and long-term care for Medicaid		Essential health benefits
Cost sharing	• No cost sharing • Associated utilization changes		Standard cost sharing, includes reductions for those up to 250 percent FPL
Provider reimbursement	• Reduced pricing variation between populations • Administrative efficiency • Increased purchasing power		Cascade Care reimbursement levels

The above table compares the populations served, covered benefits, cost sharing, and provider reimbursement for Models A, B, and C.

Using the key characteristics identified by the UHC Work Group, an actuarial analysis was conducted to compare the impacts of each of the three models to the status quo including the number of individuals covered, the cost to implement the model, and the potential savings (if applicable) of each model. The key findings are highlighted in Table 2 and summarized further below.

Table 4: UHC Work Group overview of each model's impacts, including potential savings

	Model A	Model B	Model C
Population impacts	• Improved access for the Medicaid population • Improved access for uninsured, and residents without a federally recognized immigration status		Improved access for uninsured, and residents without a federally recognized immigration status **Assumes**

[56] Ibid.
[57] Ibid.

			commercial utilization
Administration	• State administers • Premiums are exempt from state premium tax • Lower system-wide administrativ e costs	• Health carriers administer • Premium tax applies • Lower system-wide administrativ e costs	**Assumes commercial plan administrative costs**
Expenditures and potential savings for covered populations			
	Model A	**Model B**	**Model C**
Status quo expenditure	$61.4 billion	$61.4 billion	**Not available**
Model cost estimate	$58.9 billion	$60.6 billion	**$617 million**
Implementation year savings	**$2.4 billion**	**$738 million**	**N/A**

This table shows the impacts, expenditures, and potential savings under each model.

UHC Work Group members were asked to respond to a survey regarding their preference ranking of Models A, B, and C.[58] Twenty-nine of the 37 members participated. Seven of the 29 respondents indicated they abstained from stating a preference. Of the 22 members who stated a preference, the majority ranked Model A as their most preferred model of the three options.

There was a diversity of perspectives about the impacts of each model among the members of the UHC Work Group in achieving the stated goals. Many members recognized that Models A or B were most likely to achieve the coverage, access, and equity goals of a universal health care system while generating health care savings in the long-term when compared with Model C. Model C requires additional state dollars, but does not generate savings to the state, and was not as likely to achieve the goals of a universal system. At the same time, many Work Group members acknowledged that Model C could potentially provide a pathway to moving to a more universal system envisioned in Model A or B.

Recognizing that moving to a universal system would be a multi-year effort, the UHC Work Group included an outline of a transition plan in the report to the Legislature. This multi-year outline incorporated a plan for a short-term focus on coverage that would fill in the gaps. The state is in the process of implementing Model C as evidenced by the additional policies that have been undertaken since 2020.[59]

[58] Under Model B, there are potentially several paths to universal coverage, including utilizing Model B as a transition to Model A. However, due to modeling restrictions, Model B was proposed with a fixed method of providing universal coverage.
[59] Engrossed Substitute Senate Bill 5693. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Passed%20Legislature/5693-S.PL.pdf?q=20220405170049

Summarizing the models

Model A (state-governed and state-administered program for all state residents) was projected to cost $58.9 billion and to save $2.5 billion in health care spending in the first year of implementation and $5.6 billion in annual steady state savings thereafter.[60] Savings were estimated to come from the reduced administrative costs of a single payer, increased state purchasing power over reimbursement rates, and reductions in extraneous spending such as fraud, waste, and abuse expected from the streamlining of the health system. The model would provide coverage to all Washingtonians.

Model B (state-governed and health carrier-administered program for all state residents) was projected to cost $60.6 billion and save $738 million in the first year of implementation.[61] Similar in structure to Model A, the state would remain the single payer and overseer of the system, but coverage is administered by insurance companies that contract with the state. Coverage follows Model A, with some modifications to utilization rules due to lack of cost sharing. The lower savings for Model B when compared with Model A are attributed to the increased costs of outsourcing the burden of plan administration to third-party insurers. The model assumes coverage for all Washingtonians.

Model C (access to coverage for residents without a federally recognized immigration status and are unable to buy coverage now, also known as "fill-in-the-gaps" coverage) was projected to increase state costs by about $617 million based on actuarial modeling. Model C is structurally different from Models A and B, focused on adding and enhancing the current system to improve coverage for individuals without a federally recognized immigration status who are currently uninsured through increased access and subsidies, including through the creation of additional health plan options with a potential to expand coverage to additional uninsured populations. The model assumes coverage for an additional 124,000 residents.

Implementing Model C

The goal of Model C is to supplement the current system instead of implementing a new structure, such as Models A and B. Model C will work to improve coverage for individuals without a federally recognized immigration status who are currently uninsured. The Cascade Care Savings program, if implemented, will provide increased access to health and dental coverage through *Washington Healthplanfinder* and state premium subsidies which will also create additional health plan options for the lowest income Washingtonians.[62]

Cascade plans

The Cascade Care Program, which includes Cascade Care (Cascade plans), Cascade Select (Public Option), and Cascade Care Savings, will provide more affordable, quality coverage to Washingtonians. These initiatives could be leveraged to expand coverage under Model C. In 2021, Washington offered standard benefit plans through Cascade Care. These plans have standard benefits, which allows consumers to better compare insurance carriers. Cascade Care plans emphasize lower deductibles and provide access to services before having to pay the deductible. Cascade Care is a multi-agency effort involving HBE, HCA, and OIC.

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[60] These estimates are based on actuarial modeling using current utilization and reimbursement trends and assumptions around the development of such a program, such as the elimination of cost sharing and introduction of a single payer.

[61] These estimates are based on actuarial modeling.

[62] Cascade Care Savings is a state premium subsidy program launching in 2023, that provides additional premium subsidies for those up to 250 percent FPL, enrolling in silver and gold Cascade Care (standard and public option) plans through Washington Healthplanfinder. A Section 1332 waiver (federal approval pending) would allow those without a federally recognized immigration status to access health and dental coverage and Cascade Care Savings starting in 2024.

Cascade Select (public option) plans

The public option, Cascade Select, was not yet fully implemented at the time of the UHC Work Group discussions and was made available to Washingtonians beginning in 2021. Cascade Select offers health insurance coverage options on the individual market through Washington's Healthplanfinder (operated by HBE). The goals of Cascade Select are to increase the availability of quality, affordable health care coverage in the individual market, and to ensure residents in every Washington county have a choice of qualified health plans (QHPs). As of 2022, only 3 percent of all enrollees selected this plan and it is not yet offered in all counties of the state.[63] However, this program is maturing and growing, which can be used to gauge the effectiveness and feasibility of a larger-scale public program.

Cascade Care Savings Program

Recognizing that affordability continues to impact uptake of Exchange plans, appropriations were allocated to HBE during the 2021 legislative session to implement a state-funded subsidy plan that will supplement federal health care subsidies for certain income levels in Washington.[64] The subsidies will be available to individuals up to 250 percent FPL who enroll in Cascade Care Gold or Silver plans. This program is very similar to the expanded Model C envisioned by the UHC Work Group and can be studied to understand the effects of increasing the amount or eligibility of such subsidies.

Summary

While the UHC Work Group identified a number of barriers to designing a universal a health care system and developed three models and options to implement a universal health care system, it falls to this Commission to make specific decisions and recommendations about how to address these challenges in the coming years. This section (the first section of the report):

- Provides an overview to the Legislature of the current health care system trends that the Commission is considering in its efforts to design a universal health care system with a uniform financing structure required by the authorizing statute.
- Provides an overview of many of the past efforts that have been made to improve Washington's health care system so that the Commission and the Legislature have a common understanding of the starting place for their efforts; and
- Recognizes and highlights Washington's rich history of innovation in addressing pervasive problems in the health care system. This history can be drawn upon to best leverage existing tools and interventions in future design decisions.

The next sections of the report will:

- Describe the design components of a universal health care system.
- Provide an assessment of Washington's readiness to implement those components.
- Recommend a strategy to implement the components of a universal health care system.
- Recommend options for increasing reimbursement rates for Medicaid.

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[63] Health Coverage Enrollment Report Spring 2022. Health Benefit Exchange. 2022. https://www.wahbexchange.org/content/dam/wahbe-assets/reports-data/enrollment-reports/HBE-EnrollmentReport-Spring2022-FINAL.pdf
https://www.healthaffairs.org/do/10.1377/forefront.20210819.347789#:~:text=Enrollment%3A%20In%20the%20first%20year,chose%20a%20Cascade%20Select%20plan.

[64] Senate Bill 5377. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5377-S2.SL.pdf?q=20220224145451

- Recommend policy solutions to address existing coverage gaps.
- Recommend options for the development of a finance committee to develop a feasible model to implement universal health coverage.

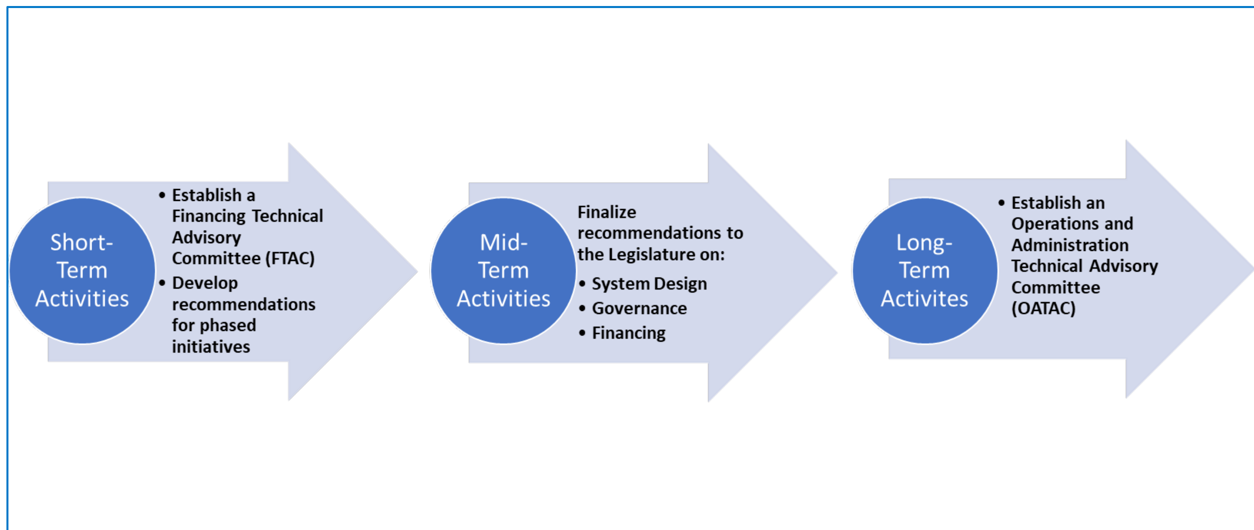
Section 2: strategies to move toward a universal health care system

Introduction

Section 1 of this report describes Washington's long history of innovation. Section 1 also detailed Washington's continued efforts to expand access and improve the quality and equity of affordable health care coverage.

This section offers a set of strategies, analyses, and planning activities to move toward a universal health care system, which are summarized in Figure 4.

Figure 4: proposed sequencing for commission strategy



This figure shows the short-term, mid-term and long-term activities that move Washington toward a universal health care system.

Later sections of this report outline the key design elements of a universal health care system, options for developing and implementing approaches to these foundational elements, and Washington's readiness to implement those approaches.

Short-term activities

Establish a Finance Technical Advisory Committee (FTAC)

Establishing a Finance Technical Advisory Committee (FTAC) will provide additional insights and technical guidance to the Commission, as directed by the authorizing legislation.[65] This approach is similar to

[65] Engrossed Second Substitute Senate Bill 5399 Chapter 309, Laws of 2021. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5399-S2.SL.pdf?q=20220530104327

Oregon's Task Force on Universal Health Care and other Washington boards and commissions that utilize advisory committees.

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

Develop recommendations for phased initiatives

Washington has submitted a federal Section 1332 waiver which, if approved by CMS and the Department of Treasury, would remove the federal barrier that currently prevents individuals without a federally recognized immigration status from purchasing health and dental coverage on the Exchange. Once the federal Section 1332 waiver is approved and implemented, the principal barrier to universal coverage for Washingtonians will be cost. Therefore, many of the intermediate steps toward a universal health care system will focus on decreasing underlying costs of health care while improving health care quality and reducing inequities in the access and delivery of care.

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

Mid-term activities

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

- Governance, implementation, and administration
- Financing strategies
- State and federal authorities and revenue

Governance, implementation, and administration

The Commission will examine a governance structure that places oversight of the universal health care system under an existing agency, a new agency, or a multi-agency structure. The Commission will also consider whether an existing agency, a new agency, or a multi-entity structure will oversee implementation and administration of the universal health care system. Potentially, the Commission, or another entity recommended by the Commission, may have a permanent role in the oversight and governance of any entity's implementation and administration of a universal health care system The Commission may provide a framework for establishing authority for governing structure and ensuring that resources are allocated to implement and maintain the universal health care system.

Financing strategies

In the mid-term, the Commission will further assess and finalize decisions about appropriate financing strategies that leverage federal and state funding sources. An examination of potential revenue sources would be needed particularly if it is determined that state funding will largely replace premiums and out-of-pocket costs that currently finance the health care system. This examination would include an assessment of the impact of shifting away from the currently existing coverage programs for Washington citizens and employers, including an assessment of the overall state-level cost shifts. Mid-term work of the

Commission will also focus on developing strategies for establishing a federal Medicaid state plan and related waiver authority requests.

State and federal authorities and revenue

After the core functions of a unified health care financing system have been developed, including how those functions should be administered, statutory changes will very likely be necessary to establish a new state entity or expand the authority of an existing entity to administer the universal system. Additionally, federal approval will very likely be needed to access any dollars associated with federal programs such as Medicaid, ACA subsidies, and Medicare.

Long-term activities

Operations and Administration Technical Advisory Committee

When FTAC completes its design and planning work, it will sunset and may need to be replaced by a new Operations and Administration Technical Advisory Committee (OATAC) to refine the operational and administrative vision for the proposed universal health care model. OATAC would provide the Commission additional subject matter expertise with a focus on operations and administration for as long as needed by the Commission. OATAC would be directed by the Commission and be responsible for providing technical guidance and support as the Commission continues discussion on how the universal health care system with unified financing will be operationalized and implemented.

A description of potential activities for OATAC could include:

- Help guide and implement planning for the new system.
- Develop a process for establishing annual performance targets (including those for cost, quality, and equity), a measurement and evaluation strategy to monitor progress towards those targets, and a reporting process to continuously assess the impact of the new system.
- Provide guidance on improving care management for chronic illnesses. Implementing universal access and better management of chronic diseases would be expected to reduce annual per member costs over time based on the findings in RAND's analysis of the Oregon universal coverage options.[66]
- Provide guidance to the Commission on how to leverage the purchasing power of a unified health care system with unified financing such as achieving prescription drug discounts or instituting a hard cap on system spending with clear measures to reduce costs.
- Assist the Commission with various activities.

Assisting the commission

OATAC may assist the Commission with developing a communication approach for awareness, establishing a stakeholder input process for refining the design concepts of the new system, and initiating an educational and engagement process in preparation of implementation. It will be important to communicate decisions and timelines to providers, employers, carriers, and consumers.

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

OATAC may also assist the Commission with planning the transition from current programs and populations, including mediating impacts of potential job losses. For example, OATAC could assess the following:

- **Roles and jobs**—regardless of the model, restructuring the health care system will impact staff in policy, management, actuarial, analytics, eligibility determination, claims payment, and technology functions.
- **Provider contracting**—regardless of the model, there will be transitions to new contracting arrangements between the accountable entity and those providing services. In Model A, this would require the accountable entity to directly contract with providers and health systems. In one version of Model B, carriers may need to alter their current contracts with providers and health systems to meet the new unified health system requirements and expectations.
- **Transitions of care**—state agency and health carrier staff from current programs will need to ensure smooth transitions of care into the new system. This may necessitate maintenance of current programs as they are closed out to ensure that Washingtonians can complete treatment courses that are in progress.

Summary

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

Section 3: core components of a universal system

Introduction

The Commission is charged with preparing Washington State for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system once the necessary federal authority becomes available.

> This section of the report addresses the Legislature's requirement for the Commission to inventory the key design elements of a universal health care system.

The key design elements are organized into seven core design components to form a framework for the implementation and operation of a universal health care system:

- **Eligibility and enrollment**—identify how to cover currently uninsured populations; determine which, if any, existing coverage options will remain; and determine which segments of the existing insured population will be included in the Commission's universal coverage considerations.
- **Benefits and services**—create an approach to develop standards that ensure equal access to a minimum set of benefits and services.

- **Financing**—define an approach to align or aggregate public funding sources, private sector funding sources; and individual cost-sharing, if any.
- **Provider reimbursement and participation**—select a method for paying providers, encouraging their participation, and aligning provider behavior to quality and equity goals.
- **Cost containment mechanisms**—establish mechanisms, such as global budgeting and utilization management functions to control total cost of care.
- **Infrastructure**—invest in administrative and operational capabilities necessary to implement a cohesive model.
- **Governance**—ensure transparency and accountability for planning and implementing the model that includes the voice of consumers in decision-making.

These core components align with the framework proposed by the Congressional Budget Office in their 2019 report on single-payer systems.[67]

It is important to note that the other key design elements, including health care quality, equity, and health disparities, identified by the Legislature for the Commission to address in its report are considered strategic goals of the universal health care system. These goals can be achieved through any design, but some design choices have a greater impact than others. As such, quality, equity, and health disparities are discussed within each of the core design components and will be considered at every stage by the Commission in making its final recommendations. The Legislature also set specific goals to implement impactful changes in the current health care system and incorporate into the design of a universal health care system including:

- Supporting quality improvement strategies.
- Allowing for quality monitoring and disparities reduction.
- Promoting initiatives for improving culturally appropriate health services within public and private health-related agencies or organizations.
- Supporting strategies to reduce health disparities including, but not limited to, mitigating structural racism and other determinants of equity as set forth by the Office of Equity.

In Section 3, we describe and identify key considerations for developing the seven core health system components based on the different approaches to achieving universal health care coverage outlined by UHC Work Group's Models A, B, and C. We then describe Washington's current level of preparedness to meet these core components.

UHC Work Group models: a starting place

In January 2021, the UHC Work Group released its final report identifying three potential models for Washington to pursue universal health care coverage, as described in Section 1. Throughout this Section (Core Components of a Universal Health Care System, Section 3), and in each discussion of a core design component, the three potential models are used as a starting point to frame the considerations for each design component. As shared in Section 1, the three models proposed and evaluated by the UHC Work Group to achieve universal coverage included:

[67] Congressional Budget Office. (2019). Key Design Components and Considerations for Establishing a Single-Payer Health Care System. https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf

Table 5: overview of Universal Health Care Work Group Models[68]

Model A	Model B	Model C
• Establishes a single, state-designed coverage plan available to everyone in Washington State. • The state develops the delivery system rules. • There is a standard benefits package. • No insurance companies participate as the state contracts directly with providers and administers all functions currently provided by carriers, including claims payment, utilization management, care coordination, and member and provider services.[69]	• Establishes a single, state-designed coverage plan available to everyone in Washington State. • The state develops the delivery system rules. • There is a standards benefits package. • Unlike Model A, in Model B, health carriers contract with the state to offer plans to Washington residents. As they do today, carriers may develop and maintain provider networks and administer some or all the functions they currently provide, such as claims payment, utilization management, care coordination, and member and provider services.	• Designed to provide coverage to Washingtonians who are now uninsured. • Keeps the varied plans and coverage sources that exist presently. As in Models A and B, the state sets the program and delivery system rules, but carriers meeting participation requirements will provide coverage to eligible individuals. • The model is similar to Cascade Select, with carriers developing and maintaining their own networks and administering the functions they currently provide, such as claims payment, utilization management, care coordination, and member and provider services.

This table shows an overview of the three models developed by the UHC Work Group.

It is important to recognize that under Model B, the state would define uniform policies or procedures that would apply across entities administering any part of the system. There are also a range of options as to which functions could continue to be performed by carriers and which could be performed by the state. For example, Washington could contract with health carriers to provide coverage to residents. Alternatively, Washington could directly contract with providers rather than delegating that responsibility to health carriers, while leaving carriers responsible for more administrative processes such as utilization management and claims payment. In addition, the state could choose to manage more of these responsibilities over time. In this way, Model B could provide a transition to Model A.

Core component 1: eligibility and enrollment

Under any model to achieve universal coverage, it will be necessary to determine who will be eligible for the program and develop a process for enrollment. In determining eligibility, the Commission will consider several key considerations.

[68] Each of these models, their costs estimates and impacts, and savings (if applicable) are described in Section 1 of this report.
[69] In some universal health care systems, such as Canada, supplemental insurance could cover services not included in the standard benefit package.

Key considerations:

Eligibility for certain populations, such as the following:

- Washington residents
- Out-of-state residents working for Washington employers
- Opt-in options for individuals covered by employer-sponsored insurance
- Self-funded plans
- Federal Employees Health Benefits
- Veterans' Health Administration
- Data and information needed to determine eligibility
- Eligibility and enrollment processes

Expanding eligibility

A primary goal of adopting a universal health care system is to extend coverage to those who are currently uninsured. This would include individuals who cannot afford commercial coverage or individuals ineligible for Medicaid or federal subsidies.

Under either universal health care model (Models A and B), all Washington residents could potentially be determined eligible for the program. It would be necessary to determine several eligibility considerations, including:

- Would out-of-state residents who work for Washington employers be eligible?
- Would employees who work for national companies and live in Washington be allowed to keep their coverage or be required to enroll in the universal system?
- Would federal employees be covered by federal programs such as Federal Employees Health Benefits and the Veterans Health Administration (VHA) be eligible to opt into the system?
- Would individuals with fully insured, employer-sponsored coverage be eligible to opt in?
- Would individuals with self-funded employer-sponsored coverage be eligible to opt in?
- Would Medicare beneficiaries be included in the program?
- Would the definition of meeting residency requirements for health insurance coverage differ from the current standard of residency determination for the state?[70 & 71]

Under Model C, eligibility could be expanded through new programs to populations who are currently uninsured due to a variety of factors, such as income levels, immigration status, lack of eligibility for subsidies, lack of ability to afford employer-sponsored insurance, and other factors that pose barriers to coverage under the current system. In this model, minimal changes would occur to the current system of coverage.

Information for determining eligibility

To maximize coverage and make eligibility determinations as simple and seamless as possible, it will be important to consider options to minimize the amount of information needed to determine eligibility. Under Model A or B, the best approach may be a streamlined process that collects the minimum information necessary to verify eligibility for health coverage while simultaneously collecting the data

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

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

needed to maintain compliance with federal regulations for Medicaid, Medicare, Exchange subsidies and other federal programs to ensure ongoing contribution of federal funds.

Similarly, setting up processes to validate continued eligibility will reduce costs for maintaining coverage when individuals are no longer eligible for federal programs. Under Model C, the process for determining and redetermining eligibility for the expanded populations would likely be comparable to processes that exist today for determining eligibility for public health care programs and Exchange coverage and subsidies. Examining how the current process, which serves over 2 million state residents, may be further leveraged to support Model A or B, and could also be pursued.

Eligibility and enrollment process

Under each of the models (A, B, or C), once a person is determined eligible, they would be enrolled into coverage. Under state-administered universal health care (Model A), enrollment could be relatively simple, and auto-enrollment could be used to streamline and maximize enrollments. For example, anyone who currently has coverage under private insurance, or a government program could be auto enrolled into the program.

Individuals without coverage could be auto enrolled when they seek health care services, file tax returns, or apply for other government programs such as the Supplemental Nutrition Assistance Program (SNAP). In other countries that have adopted single-payer models such as the United Kingdom, individuals are automatically determined eligible at birth, when residency is established, or when a resident registers with a primary care provider.[72]

Under Model B, (the version that involves insurance companies contracting with the state to offer plans to Washington residents), individuals transitioning from private insurance to the state program could be auto enrolled into a comparable plan, with the option to change coverage. This would be similar to the current Exchange auto-renewal processes, and the mapping that occurs when an individuals' plan is cancelled.[73]

Under Model C, individuals and families could obtain a plan by a process similar to what currently exists today through Washington Healthplanfinder. Today, once an individual is determined eligible for either Apple Health (Medicaid) or subsidies or private coverage, they have the option of selecting a plan from the available options. Consumer tools are available to help individuals select a plan based on various factors, including cost and the doctors, prescription drugs, and level coverage they prefer based on the services they need.

Core component 2: covered benefits and services

Each of the coverage models (A, B, and C) will involve examining what benefits and services will be covered by the model. The UHC Work Group report assumed that the benefits provided under Models A and B will be equivalent to Washington State's Essential Health Benefits (EHB) mandated by the ACA, which includes behavioral health services.

Key considerations – covered benefits and services

- Covered benefits and services:

[72] National Health Service. (2022). What is an NHS Number? https://www.nhs.uk/using-the-nhs/about-the-nhs/what-is-an-nhs-number/.

[73] The Exchange auto-enrolls consumers into the most similar version of a plan available.

    - Essential health benefits
    - Adult dental to be determined
    - Vision to be determined

- Benefits mandated by Medicaid
    - Cost-sharing for services including premiums, co-pays, and coinsurance
    - Development of a single drug formulary or standard drug formularies and how they would impact current programs and the Washington Prescription Drug Program
    - Benefit package oversight
    - Utilization management and prior authorization requirements

Covered benefits and services

In general, UHC Work Group members discussed the need for a benefit package that improves health and is attractive enough to keep participants enrolled without a mandate to participate in the universal health system. Additional benefits mentioned include dental and hearing, for both adults and children. Model C is the least burdensome approach; the benefits provided would vary depending on the program and plan a person is enrolled in but would be similar to plans offered on the exchange and/or through Cascade Care plans today.

Coverage that meets quality and equity goals

For all three models, it is important to consider whether additional benefits may be required to advance quality and equity goals such as social support services and culturally responsive care and services. For example, Apple Health (Medicaid) provides some benefits that are not included in EHB such as Long-term Services and Supports and transportation to non-urgent medical appointments. Some of these services are required by federal Medicaid law, while others are required by state law.[74] These additional services could be provided to all Washingtonians (paid for by the state for those who are not Medicaid-eligible) or there could be a mechanism to make sure that everyone who would otherwise be eligible for Medicaid will receive these additional services.

Transparent decision-making and administration

Washington has a long history of transparent, evidence-based decision processes to inform what benefits/services are covered in state-purchased health care programs. For example, health technology assessments are conducted by the independent HTCC and serve Washingtonians by ensuring that certain medical devices, procedures, and tests paid for with state dollars are safe and proven to work.

Administration of the benefit package will also be a critical area of consideration. Establishing who will govern how the benefit package would be regularly updated and adjusted based on new evidence to ensure the required benefits adapt over time to improve the quality and lower the cost of care within the universal health care system. This is particularly important for Models A and B, because once established these benefit packages would need to regularly be examined and updated.

[74] Another state program that may need to be considered is the Washington CARES Program. Washington CARES is the state's new long-term care benefit, created and signed into law by the Governor in 2019. The program is funded by a payroll tax of up to $0.58 per $100 and has a lifetime benefit of up to $36,500. Premium collections (via the payroll tax) have been delayed until July 2023.

Pharmacy benefits

Under Models A and B, there could be a single drug formulary that would apply to all individuals in the program. The drug formulary developed under this program will need to align with any federal Medicaid and Medicare requirements.

The Washington Prescription Drug Program provides prescription information and assistance for the residents of Washington. As a part of this program, Washington State has partnered with Oregon since 2006 to create the Northwest Prescription Drug Consortium. The Consortium allows state agencies, local governments, businesses, labor organizations, and uninsured individuals to pool their purchasing power to gain bigger discounts on prescription drugs. The work of the Consortium, Prescription Drug Cost Transparency Board, and the PDAB will all need to be included in the consideration of single drug formulary.

Utilization management and prior authorization

Currently, individuals who are enrolled in Apple Health managed care or in commercial coverage are subject to the utilization management policies and procedures of their carrier. These policies often include prior authorization, concurrent review of services and retrospective review, as well as consideration of whether a service is experimental or investigational. Under Model C, this is not likely to change. Under Model B, the state could focus efforts to align these processes and requirements across payers and programs. Model A will require examining utilization management processes and determining how the state-administered plan would conduct these activities.

Core component 3: financing

Under Washington's current health care system, there are multiple sources of funding that pay for health care. The funding sources that pay for an individual's health care will govern the specific benefits individuals receive, the providers they can see, and how much they pay out of pocket. A primary goal of the Commission is to develop a plan for universal health care with a unified financing system that will simplify and/or minimize these differences and lead to greater access, higher quality, and increased equity for all Washington residents.

To achieve this goal, the different sources of funding must be combined to the greatest extent possible. This begins with assessing which sources will be continued or potentially eliminated due to the structure of the unified health care financing system and identifying potential new sources of funding to ensure coverage can be extended to all Washington residents. Section 7 of this report outlines the complex issues and decisions related to different financing sources to consider in designing a universal health care system. This financing subsection details specific considerations and processes for the Commission to establish a finance committee specifically tasked with addressing these financing questions and considerations.

Key considerations: role of federal funding sources such as Medicaid, ACA subsidies, and Medicare; role of state funds such as general funds and taxes; and role and appropriateness of consumer cost-sharing.

Federal funding sources

The federal government is responsible for the greatest share of health care spending, at 36.3 percent in 2020.[75] This estimate includes all federal sources including Medicaid, Medicare, coverage for federal employees, and active and retired military. As described in the UHC Work Group Report, the three models assume that all sources of federal funding, such as the federal funding of the Medicaid program and Medicare funding would be preserved to pay for health care costs and administration.

Model C presents the least challenges with respect to retaining federal funding, since the existing federal programs including Medicare, Medicaid, ACA subsidies, tax deduction for employers' contribution to health care, either insured or self-funded remain the same. Making changes to the current financing system are considerably more complex for Models A and B. Notably, each of the models will require additional state funds to implement. Possible sources to fund these models are described in the following subsections including Medicare funding, Medicaid funding, ACA subsidies, employers, taxes, other sources of insurance, and other revenue sources.

Medicare funding

There are several legal challenges that need to be analyzed and considered to include Medicare funding under either Model A or Model B. The decision to pursue or not pursue inclusion of Medicare into the unified health care financing system development is complex and requires a thorough examination of the regulatory and legal issues and understanding of the Medicare program. The Medicare program consists of several primary components:[76]

- **Medicare Part A** is financed primarily by a payroll tax that employers and employees pay into the Medicare Hospital Insurance Trust Fund. Part A covers inpatient hospital stays, skilled nursing facility stays, some home health visits, and hospice care.
- **Medicare Part B** is financed primarily through a combination of general revenues, interest earned on trust fund investments, and beneficiary premiums. Part B covers physician visits, outpatient services, preventive services, and some home health visits.
- **Medicare Part C** (Medicare Advantage) is Medicare's managed care program delivered through contracted carriers.[77] Medicare Advantage plans are financed by monthly payments from the federal government based on bids submitted by the carriers and monthly premiums.
- **Medicare Part D** is financed primarily by general revenues, beneficiary premiums and state payments for beneficiaries dually eligible for Medicare and Medicaid. Part D covers outpatient prescription drugs.

A key to maintaining a large portion of federal funding is determining if and how Medicare dollars can be used. An important threshold topic for consideration under either Model A or Model B is whether Medicare funding can be used to pay for health care costs for individuals not eligible for the Medicare program. While this may be considered in more detail in the future, it may be likely that Congress will need to pass legislation for these changes to be possible.

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[75] Centers for Medicare and Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet Note: This figure does not account for the federal income tax deductions for employer and individual's health care spending.

[76] For more information on Medicare programs, see Kaiser Family Foundation. (2019). An overview of Medicare. https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/?msclkid=c46e7ab3b3bd11ecb53ed918624357e3

[77] For more information on Medicare Advantage, see Kaiser Family Foundation. (2019). Medicare Advantage. https://www.kff.org/medicare/fact-sheet/medicare-advantage/

Medicare Part A

The Medicare Part A Trust Fund is projected to be fully depleted in 2026, which raises the question of whether it would be practically and politically viable to provide for the use of this fund to pay for non-Medicare individuals. One other significant consideration under Model A or Model B is whether beneficiaries would continue to have the option to choose "traditional" Medicare, which is administered by the federal government, or to enroll in a Medicare Advantage plan under Medicare Part C.

Some states, such as Oregon, have discussed that a single-payer entity could function like a single Medicare Advantage plan that would be offered only to Medicare eligible individuals.[78] This would likely keep the Medicare funding sequestered out of other pooled funding which may make it easier to use Medicare funding, because the funding would not be used to fund Medicare ineligible individuals.

Medicare Part D

Medicare Part D, the prescription drug benefit administered by private carriers, is another potential source of funding for consideration. This program is financed primarily by general revenues, beneficiary premiums and copays, and state payments for beneficiaries dually eligible for Medicare and Medicaid. To utilize funds from this program, Medicare's integrated funding would need to be examined in detail, especially if the new universal health care system offers a single drug formulary.

The UHC Work Group report assumes that under Model A or Model B there would be a single provider fee schedule for all care and that the rates would be higher than currently paid by Medicaid and Medicare, but that the rates would be lower than what is currently paid by commercial carriers. There are significant legal and regulatory issues around whether the federal government would be willing and able to contribute to the additional costs that would be incurred for care provided to those currently in the Medicaid and Medicare programs, including the higher reimbursement rate. There are also similar questions as to whether the federal government would be willing to share the savings if rates were lowered and federal savings were incurred.[79]

The UHC Work Group report acknowledged the challenges in including Medicare funding and suggested that it might be possible to keep Medicare enrollees in their current coverage under Models A and B. The goals of universal coverage could still be met if the Commission followed this approach for two reasons. First, most providers currently accept Medicare patients and are accustomed to billing under the program. Second, the costs of administering the program are borne entirely by the federal government, so the state may not realize any savings by including it. As discussed in the UHC Work Group Report, it may be a more financially viable approach to implement because health care needs generally increase with age, resulting in higher per capita costs. Keeping Medicare enrollees in their current coverage rather than including them in the universal health care program would mean that the universal health care program would cost less on a per capita basis.

Second, utilizing an approach with Medicare distinct from universal health care with a unified financing system would greatly simplify the legal and administrative obstacles to achieve universal coverage under Models A or B. In addition, as the UHC Work Group report notes, if Medicare reimbursement rates are left as they are, the rates payable by the rest of the program could be higher as a percentage of Medicare

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[78] Rand Corporation. A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon. https://www.rand.org/pubs/research_reports/RR1662.html

[79] These questions are best answered by seeking legal guidance and through conversations with the federal government about what is possible via waivers and what might require federal legislation.

rates because of the unrealized per capita savings of not including this population. See Table 6 below (from the UHC Work Group analysis) for more information about the financial impacts as seen through provider reimbursement rates of including or excluding Medicare in rate development.

Table 6: reimbursement level target before efficiency adjustments[80]

Service category	Reimbursement as a % of Medicare when Medicare is included in Model A	Reimbursement as a % of Medicare when Medicare is excluded in Model A
Hospital services	125%	150%
Physician and clinical services	111%	114%

This table shows the financial impacts as seen through provider reimbursement rates of including or excluding Medicare in Model A.

Medicaid funding

Washington's Medicaid program, Apple Health, which currently serves nearly 2,000,000 Washington residents, is funded by the state general fund and federal matching funds. Eligibility for Apple Health is primarily based on income and most beneficiaries have managed care, where the state pays managed care organizations a monthly premium which pays for almost all health services provided by the program. Both federal and state laws mandate what services must be provided under the program.[81]

Including Medicaid funding as a revenue source for universal health care with a unified financing system is complex, but less complicated than Medicare because there is an established process and experience with states seeking and obtaining Medicaid flexibilities. This is not the case with the Medicare program. To use existing federal Medicaid funds as a revenue source for universal health care with a unified financing system, it would be necessary to obtain a waiver from the Centers for Medicare and Medicaid Services (CMS) under Section 1115 of the Social Security Act.

Section 1115 gives the Secretary of the U.S. Department of Health and Human Services (HHS) authority to approve experimental, pilot, or demonstration projects by states that are found to be likely to assist in promoting the objectives of the Medicaid program. This authority has been used frequently by states, including Washington. Washington's current 1115 waiver, the Medicaid Transformation Project, is in effect until December 31, 2022, unless CMS authorizes further renewals or extensions.

The two primary ways that a unified health care financing system would promote the objectives of the Medicaid program, which could be included in support of a potential waiver application, are:

- This change is likely to increase the number of individuals with continuous access to health care, and
- This is likely to increase the number of providers willing to serve Medicaid enrollees.

If the process for enrollment and determining eligibility is simplified, then more Medicaid-eligible individuals should be covered. In addition, some individuals inevitably fail to obtain new coverage as individuals gain and lose eligibility for Apple Health due to changes in income or employment status. A

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[80] Universal Health Care Work Group Report, January 2021.

[81] For more information on Medicaid funding, see Snyder, L., Rudowitz. R., (2015). Medicaid Financing: How Does It Work and What Are the Implications? Kaiser Family Foundation issue brief. https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/

unified health care financing system could eliminate or greatly reduce this on/off program cycle, which would result in more individuals having continuous health care coverage.

Secondly, the UHC Work Group Report assumed that under Model A or Model B there would be a single fee schedule for provider reimbursement with rates higher than what Medicaid currently pays. This should result in more providers being willing to serve individuals who would otherwise be eligible for Medicaid, which in turn is likely to reduce the disparities and inequities in access to care.

ACA subsidies

Under the ACA, the federal government provides premium subsidies that help individuals and families pay premiums for health care coverage provided by carriers offered through Washington Healthplanfinder. The total amount of federal subsidies drawn down through Washington Healthplanfinder is over $600 million annually. The specific amount that each household received varies based on income, age, geographic location, and other factors. In order to not lose this federal funding, federal waivers would need to be pursued and approved to shift ACA tax credit funding to the unified health care financing system.

The ACA contains certain "guardrails" that must be satisfied for certain waivers to be granted. The changes requested by a state must result in health care coverage that is as comprehensive, affordable, and covers as many individuals as under the current system. In addition, the changes must not increase the federal contributions. Section 1332 of the ACA authorizes waiver of certain provisions and provides that requests for waivers under Sections 1115 and 1332 may be combined in a single application. Both 1115 and 1332 waivers must be "budget neutral" to the federal government, which means that during the course of the waiver period, federal expenditures must not be more than it would have been without the waiver.

It is possible to demonstrate that these guardrails would be met under either Model A or Model B. For example, guardrails could be met if modeling projected that the proposed approach would expand coverage to more individuals and families by reducing the number of people who lose coverage as they move from once source of coverage to another. Additionally, coverage under Model A or B would need to include the EHB mandated by the ACA, and therefore would be as comprehensive as currently available coverage.

Finally, coverage should be more affordable to individuals on a per capita basis under the proposed waiver by reducing the underlying cost of care or through additional state-sponsored subsidies, although the state would have to demonstrate that any additional taxes on individuals and families would be lower than what they currently pay for health care.

Other revenue sources

To address any gaps in funding because of the transition to a universal health care system with unified financing, additional funding could be raised through a combination of taxes on businesses and individuals. However, it is important to acknowledge that any discussion about additional taxes and how that tax is collected should take into account the equity impact of the proposed tax on different populations. Under Model C, most sources of funding would remain the same.

Other revenue sources: business taxes

There are two types of business taxes that are generally considered as potential sources of revenue for funding a universal health care system. The first, is a tax on business activity, such as Washington's Business and Occupations tax, which is a gross receipts tax measured on the value of products, gross proceeds of sale, or gross income of the business. The second is a tax on payroll (either based on the

number of employees or the amount of wages paid), such as the federal taxes that currently fund the Medicare program and the state taxes that currently fund state unemployment, the workers' compensation system, and the tax that will fund Washington's new long-term care program, Washington CARES.[82]

It is important to note that under current law, employer contributions to employees' health care premiums are deductible from federal income tax. This represents a significant subsidy from the federal government toward the cost of health care. To maintain the benefit of the current tax deduction for employer health care expenditures, the best approach would be to ensure that either type of tax imposed could be deducted from federal taxes.

Other revenue sources: individual taxes

There are two types of taxes that could be considered as sources of revenue for this type of program. The first is a payroll tax. The second is a sales tax (including taxes on certain types of products that are deemed harmful to individuals or society, such as cigarettes and alcohol).[83]

Sales taxes could be a source of revenue for the program. However, sales tax is complex and if not applied appropriately to prevent regressive taxation, it could have a burdensome impact on low-income populations. Sales taxes would be considered regressive if the taxes take a larger percentage of income from low-income taxpayers than from high-income taxpayers. One way to avoid the disparate impact of these taxes is to exempt necessities such as food from the sales tax, as Washington currently does.

A payroll tax, which currently funds the Medicare program, may be more feasible to implement because it involves less administration. A payroll tax could be imposed only on wages over a certain level which would reduce the possibility of a disparate impact. This would also ensure that those who currently receive subsidies or Medicare do not experience an increase in their cost of health care services.

Employee Retirement Income Security Act

The federal Employee Retirement Income Security Act (ERISA) sets minimum standards for health plans established and funded by employers to provide health care to their employees. Employer health plans can be "fully-insured" or "self-funded". Both types of these health plans must comply with ERISA. However, the state's role varies based upon whether a plan is fully insured or self-funded.

An employer that offers a fully insured health plan is paying a premium to a health insurer and the insurer bears the financial risk of coverage. An employer that offers a self-funded health plan has chosen to bear the financial risk of health care services used by their health plan participants, and often will contract with an outside entity to administer their health plan (called "third party administrators"). The ERISA statute exempts these plans from most state regulations.[84]

If the federal government makes changes to ERISA that would enable states to wrap employer coverage into a state-based unified health care financing system, it will be necessary to consider whether employers would be able to continue to provide coverage to their employees through a self-funded health plan. It is

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[82] The implementation of this tax has been delayed until July 2023. https://wacaresfund.wa.gov/about-the-wa-cares-fund/.

[83] Because Washington State does not have an income tax on individuals, this method of taxation has not been considered. However, an income tax is typically simpler to administer.

[84] For more information on the Employee Retirement Income Security Act, see National Association of Insurance Commissioners. (2019). Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation. https://content.naic.org/sites/default/files/publication-ers-om-health-welfare-erisa.pdf?msclkid=93e40b08b3c111eca359435da84df82c

possible that if a tax is imposed on employers to pay for the program, employers would be discouraged from remaining self-funded. An alternative approach would be to allow employers to remain self-funded, while giving employees the option of enrolling in the state coverage rather than in the employer-sponsored coverage.

Other sources of insurance

It may be beneficial to examine whether health services that are currently paid for by other sources of insurance, such as liability insurance and by the workers' compensation system, would continue to be covered by those programs. In the alternative, the amounts paid into those systems could instead be paid into the unified health care financing system.

Core component 4: provider reimbursement and participation

One of the more challenging elements in designing a universal health care system is developing an approach to provider reimbursement that incentivizes providers to participate in delivering care and services to Washingtonians through this system.

Key considerations: Provider reimbursement methods for centralized rate-setting and single fee schedule, negotiated rates, and value-based payment; and provider participation requirements and incentives.

Reimbursement rates

Developing this approach will involve considering how reimbursement rates will be set and how to encourage alternative payment models that may provide incentives for higher quality care and lower costs. Rate-setting processes could be applied broadly under universal health care system with unified financing or more narrowly for specific programs and providers. Rate setting affords the state the opportunity to:

- Ensure that providers are adequately reimbursed to encourage provider participation in the universal health care system.
- Control costs within the system.
- Drive improvements in the quality of care delivered within the system.
- Ensure equitable access to providers and services.

A range of rate-setting approaches could be considered depending on the overall universal health care model. For example, the United Kingdom, and, for certain components of Canada's health system, providers are contracted with or directly employed the government. On the other hand, France, Germany, Switzerland, Netherlands, and Japan, have established centralized rate-setting for provider reimbursement without directly employing providers.[85] This approach is intended to control total health care costs across

[85] Commonwealth Fund. (2017). International Profiles of Health Care Systems. https://www.commonwealthfund.org/publications/fund-reports/2017/may/international-profiles-health-care-systems

sectors of the health care system that may be financed by private payers or different government programs.

It is possible that a more phased-in approach that preserves existing frameworks for rate setting, or provider contracting could be appropriate for advancing goals of universal health care. The approach may be easier to initiate and could enable adoption of a universal care model sooner than a non-phased in approach.

Both Models A and B include a single fee schedule that would establish rates for all health care services. One method for accomplishing this would be to set rates at a percentage above the Medicare fee schedule. The UHC Work Group report discussed a single fee schedule which would establish rates that are lower than current commercial rates, but higher than what Medicaid and Medicare pay. The report notes that approval from CMS would be needed for these federal programs to pay different rates than what they pay currently.[86]

Under Models A and B, rates would be set by Washington through an administrative process. Under Models A and B, it may be possible to set rates for individual health care services, rather than setting rates at a percentage above Medicare for all services. A range of possible options exist under Model C which would not necessarily require changes to the current system of rates, provider reimbursement, or provider participation. However, the State could also choose to regulate provider reimbursement and provider participation more actively for existing programs.

The state of Maryland provides an example of how centralized rate-setting could be applied under a multi-payer system. Maryland, through its Health Services Cost Review Commission, sets rates for all hospitals in the state across all payers, allowing the state to slow the growth of hospital costs across the state.[87] In partnership with the federal government, Maryland has implemented a Total Cost of Care model which not only establishes global budgets for hospitals but also incentivizes health systems to coordinate care across hospital and non-hospital care settings and provides resources for care delivery innovation outside of the hospital setting. However, the model does not set reimbursement rates for services delivered outside of the hospital setting.

There are additional considerations when evaluating provider reimbursements such as whether reimbursement will be provided directly from the state or through carriers. Cost reduction and transparency measures are additional considerations, such as the newly established Health Care Cost Transparency Board (HCCTB), and how these measures will assist in the future approach to provider reimbursement.

Value-based reimbursement

Universal health care delivered through a unified financing model can create opportunities to improve quality while decreasing costs. The universal system could shift away from FFS to more value-based methodologies of reimbursement or improve the FFS system. Under value-based reimbursement arrangements, providers can receive additional payments or accept down-side risk to provide care and services to certain standards. It may be helpful to establish a process to identify and prioritize target metrics for which providers will be accountable, such as measures included in the state Common Measure

[86] This could have implications for meeting budget neutrality under Sections 1115 and 1332 of the Social Security Act. Assuming that these provisions could not be changed, and no additional federal funds could be obtained in order to pay the higher rates provided for by a single fee schedule, Washington may have to provide additional revenue in order to pay the higher rates.
[87] Maryland Health Services Cost Review Commission. (2022). Hospital Rate Setting. https://hscrc.maryland.gov/Pages/rates.aspx

set and establish a methodology for collecting data and assessing whether providers have met the target thresholds.

Through value-based reimbursement, Washington aims to incentivize a range of provider behaviors. For example, this may include reducing disparities for vulnerable populations or improving the treatment for individuals with high priority conditions such as diabetes or substance use disorder. This may also manage costs by reducing unnecessary utilization of health care services. Model A could utilize alternative payment models, similar to what the Centers for Medicare and Medicaid Innovation currently employs.

Washington already applies value-based reimbursement strategies through multiple initiatives and programs, and the Commission plans to thoroughly evaluate these strategies and their appropriate application. For example, currently a carrier that offers Cascade Select Public Option plans must confirm that at least 30 percent of provider contracts include value-based payment arrangements.[88] HCA's Value-Based Purchasing Roadmap for 2022–2025 sets forth priorities and goals for value-based purchasing to contain health care costs while improving health care outcomes, including having 90 percent of state-financed health care (Apple Health, PEBB and SEBB) payments in VBP arrangements by the of 2021. [89]

To monitor progress towards this goal, HCA conducts an annual survey of providers and payers to gather information about participation in VBP. The results of the 2021 survey (using 2020 data) found that 77 percent of state-financed health care is in VBP arrangements. While short of the 85 percent benchmark for 2020, this was an increase from 2019 when only 62 percent were in VBP arrangements.

Looking at other payers, the survey found that 59 percent of commercial health care and 80 percent of Medicare Advantage were in VBP arrangements in 2020. The HCA Roadmap and the annual survey may serve as a helpful framework for the Commission to further examine and discuss the impact of VBP arrangements on cost, quality, and equity and to consider where to further these efforts.

Encouraging provider participation

One consequence of a fragmented health care financing system is that provider reimbursement rates can vary widely depending on the payer. This can be particularly challenging for Medicaid programs which tend to offer lower provider rates than the commercial insurance market or Medicare.[90] This differential in reimbursement rates can lead to limited provider participation in Medicaid and consequently can impact access for Medicaid enrollees.

Reducing the differentials in provider reimbursement is likely to encourage providers to participate in delivering care to all populations and may reduce health care inequities. Under Models A, B and C, there are opportunities to reduce differences in provider reimbursement. Under Models A and B, if rates were set under a single fee schedule across a broader population base, more providers may be incentivized to participate. Some single-payer health systems, such as Indonesia,[91] also actively reimburse at higher rates

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[88] Public Option Institute. (2020). Summary of Washington State Gov. Inslee's Letter on Implementation of Cascade Care. https://www.publicoptioninstitute.org/feed-wa-implementation-materials/summary-of-washington-state-gov-inslees-letter-on-implementation-of-cascade-care

[89] VBP Roadmap. https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf

[90] Holgash, K., Heberlein, M. (2019). Health Affairs Forefront article. https://www.healthaffairs.org/do/10.1377/forefront.20190401.678690/full/

[91] World Health Organization. (2003). The World Health Report 2003: Shaping the Future. https://apps.who.int/iris/bitstream/handle/10665/42789/9241562439.pdf?sequence=1&isAllowed=y.

for providers in underserved communities and regions. This strategy might also be considered to attract and retain health care workers where there are significant workforce shortages.[92]

Under Model C, adjusting reimbursement rates may require a centralized rate-setting structure to ensure similar rates across existing payers and programs. Providers could be required to participate in Medicaid or other programs as a condition of participation in other markets or programs. Additionally, under Model C, the state could remove potential barriers to participation by aligning value-based payment, quality initiatives, and administrative processes across payers.

Additional strategies could be considered to encourage provider participation. For example, the universal health care program could require providers to accept patients under the program and potentially cap rates or services provided outside of the program.

Core component 5: additional cost containment elements

One of the critical goals in establishing a universal health care system is to contain costs. For example, holding the total cost of health care below the growth benchmark established under the work of HCCTB is one method to contain costs.

Many of the design elements described in the provider reimbursement and benefits subsections constitute critical strategies for containing costs. For example, maintaining a benefit package that standardizes high-value benefits and services across all participants, setting provider rates for individual services, and encouraging value-based payment arrangements can all work toward lowering costs of care while improving the quality of care delivered. However, additional design elements could assist with containing total costs. These cost containment measures include examining fraud, waste, and abuse; utilization management; setting cost growth benchmarks; and global budgeting.

Fraud, waste, and abuse

One path to reducing cost throughout the health care system is to drive down utilization due to fraud, waste, and abuse. Nationally, the cost of fraud, waste, and abuse may constitute as much as 10 percent of total health care costs.[93] Drivers of fraud, waste, and abuse include duplicated procedures or failures to coordinate care, overtreatment, overpayment, and fraudulent acts by providers or patients.[94]

There are system-wide approaches for addressing fraud, waste, and abuse. As the UHC Work Group noted, a single data set for claims or episodes could exist under Models A and B (paired with advanced analytic methods used today by the federal government, state Medicaid programs, and commercial payers). The data set creates opportunities to detect indicators of fraud, waste, and abuse and intervene to prevent future utilization from occurring or recoup costs for improper utilization.

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[92] 2021 Paying for Value Survey Results. https://www.hca.wa.gov/assets/program/2021-p4v-survey-exec-summary.pdf

[93] U.S. Department of Veterans Affairs. (2022). About Fraud, Waste, and Abuse. https://www.va.gov/COMMUNITYCARE/about_us/POI/poi_fwa.asp#:~:text=Impact%20of%20Fraud%2C%20Waste%2C%20and%20Abuse%20The%20National,high%20as%2010%25%20per%20year%20or%20%24300%20billion.?msclkid=749dea44b4cc11ec9f5b87f0640262ec. Also, Washington Health Alliance. Highlight : Calculating Health Care Waste in Washington State (October 2019). https://wacommunitycheckup.org/highlights/calculating-health-care-waste-in-washington-state-october-2019/

[94] Lallemand, N. (2012). Reducing Waste in Healthcare. Health Affairs Health Policy Brief. https://www.healthaffairs.org/do/10.1377/hpb20121213.959735/

Utilization management

Utilization management is a core function for most commercial insurance plans, Medicaid managed care organizations, and Medicare Advantage plans. Utilization management is used to reduce inappropriate or unnecessary utilization of health care services. This typically involves the monitoring of utilization, the identification of high-utilization individuals, and intervention to reduce high utilization in the form of care coordination, consumer education, or other methods. Utilization management may also include prior authorization requirements for certain types of services. Some single-payer systems, such as England, Canada, and Taiwan have developed utilization management programs to reduce the cost of care while maintaining quality goals.[95]

Under any of the universal health care models, it will be helpful to consider whether utilization management is an appropriate design element to assist with achieving the state's goals for cost containment. A particularly important consideration will be how certain utilization management controls, such as prior authorization can be utilized to reduce high utilization. Under Model B or C, utilization management could be delegated to participating carriers with requirements for administering utilization management.

Setting cost-growth benchmarks

In 2020, Washington created HCCTB to identify health care cost trends, set a cost-growth benchmark, and develop recommendations to reduce health care costs. As of September 2021, HCCTB has approved a cost growth benchmark of 3.2 percent for 2022–23, three percent for 2024–25, and 2.8 percent by 2026.[96] Washington's benchmark aligns with other states' cost-growth benchmarks, such as in Oregon, Connecticut, Delaware, Massachusetts, and Rhode Island.[97] HCCTB is also responsible for identifying providers and payers whose cost growth exceeds the benchmark. The universal health care system should hold the total cost of health care below the growth benchmark established by HCTTB and is a starting place for additional cost-containment efforts in the future.

Global budgeting

Some single-payer health care systems have adopted global budgeting as a way to incorporate caps on the system-wide growth of health care costs. For example, England sets a global annual health care budget that is then allocated to local organizations that pay for care within their jurisdiction.[98] Taiwan negotiates an annual global budget with key stakeholders for major health care services and allocates the budget across six regions.[99] Under Model A or B, a similar global budget could be established and then adjusted annually to account for growth in need for health care services and for system performance (e.g. if provider rates are insufficient to encourage participation or benefits are too narrow to encourage individuals from participating).

Global budgeting can also be applied to individual providers as a strategy for provider reimbursement. For example, Maryland, as part of its hospital rate-setting program, establishes a global budget for each

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[95] Commonwealth Fund. (2017). International Profiles of Health Care Systems. https://www.commonwealthfund.org/publications/fund-reports/2017/may/international-profiles-health-care-systems
[96] Washington State Health Care Authority. Health Care Cost Transparency Board. September 14, 2021, Meeting Minutes. https://www.hca.wa.gov/assets/program/board-meeting-summary-20210914.pdf
[97] Block, R. & Lane, K. (2021). Supporting States to Improve Cost Growth Targets to Improve Affordability. Health Affairs. https://www.healthaffairs.org/do/10.1377/forefront.20210526.658347/full/
[98] Ibid
[99] Ibid

hospital that caps the payment it can receive from all payers. The Maryland hospital rate-setting program was originally established in the 1970s as a way to control hospital costs on an FFS basis.

Over time, the program has evolved to become an all-payer value-based hospital reimbursement model governed by the Maryland Health Services Cost Review Commission aimed at managing total cost of care and improving quality outcomes at a population level. In its current form, each hospital's global budget is based on the projected needs of the population served by each hospital.[100] However, in establishing a global budgeting model, a critical consideration is whether providers are prepared to bear the financial risk if their costs exceed the global budget.

Core component 6: infrastructure

As the Commission moves from planning into implementation, the governing agencies and partnering stakeholders will need to address a broad range of operational considerations. This includes assessing what structures and processes will remain, and what systems need to be upgraded or modified. These considerations are highly dependent on the overall strategy pursued and the readiness to implement the strategy.

Technology infrastructure

A key driver of implementation complexity will be the technology infrastructure necessary for executing the universal health care strategy. For example, each model will require technology investments for consumer-facing functions such as eligibility and enrollment; consumer assistance; and consumer outreach. To support administrative functions, investments could be needed to issue payments to providers or carriers; manage health care utilization; and monitor fraud, waste, and abuse.

Key considerations – infrastructure

- Examining what infrastructure can be re-used, delegated, or needs to be developed
    - Technology platforms
    - Human Resources to support existing and added functions
    - Administrative policies and processes
- Accountability for infrastructure investments
    - State investments needed
    - Model participant investments
    - Shared infrastructure investments

Related to the technology infrastructure are considerations regarding data sharing and data management. The infrastructure necessary to share data across all participants in the universal health care system is critical for ensuring that the program objectives for health care quality, financial performance, population health, and health equity are met on multiple levels for individual consumers, providers, and payer organizations. In addition to the technology needed to support higher degrees of data sharing, infrastructure will be needed to establish data standards and common metrics, to analyze the data, and to report on outcomes.

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[100] Mathematica. (2021). Independent Evaluation of the Maryland Total Cost of Care Model. https://innovation.cms.gov/data-and-reports/2021/md-tcoc-imp-eval-report?msclkid=1a334a44b38f11eca5626a4a717ba358

Human resources

Human resources are another core consideration for the development of the model. Staffing needs will have to be assessed and managed, particularly for new state functions, such as rate setting or financial analysis. In addition to these core considerations, many operational decisions will impact the infrastructure needed during the implementation phase. Decisions regarding grievances and appeals, managing the administrative budget, procuring vendors, and contracting with participating providers will determine the infrastructure and systems that may need to be developed or if existing agencies could be utilized or reconfigured.

Core component 7: governance

A strong governance model is critical for ensuring transparency and accountability. This ensures a voice is given to consumers and purchasers, whose perspective is essential to decision-making. In ensuring transparency and accountability, there will need to be clear roles and responsibilities for all participants in the process. Moreover, ensuring a governance model that is inclusive of diverse voices representing the populations most impacted by the new system will be a critical component in ensuring that the goal of health equity is realized.

Key considerations – governance

- Accountability for administering and regulating programs
  - Single new state agency
  - Existing state agency or agencies
  - Combination of new and/or existing state agencies
- Accountability for transparent reporting

One of the primary governance considerations in developing a universal health care system is determining which agency or agencies should administer the program. A single agency or a governance structure that consolidates functions and accountability across existing agencies could be created.

With one agency providing oversight, many administrative functions could be streamlined. In addition, a single agency could facilitate and execute more coordinated strategies to meet the health care goals of the state. A consolidated structure, however, brings together existing resources but requires a strong governance model and robust communication and process mechanisms. Many countries that have adopted a single-payer model place principal accountability for operating the system under a single agency. For example, in the United Kingdom, the National Health Service (NHS) oversees the health systems of each local governmental entity.[101]

Additionally, the state of Vermont, when it created its Green Mountain Care Board, consolidated a wide range of new and existing responsibilities pertaining to the management of health care costs.[102] While there is a wide range of benefits with single agency oversight, there is likely to be initial disruption to current functions and significant costs associated with the implementation.

Each of the universal health care models under consideration will necessitate different governance structures. For example, Model B would likely require less new administrative and regulatory

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[101] Berry, N. (2015). How does the NHS compare with health systems in other countries? The Health Foundation. https://www.health.org.uk/sites/default/files/HowDoesTheNHSCompareWithHealthSystemsInOtherCountries.pdf?msclkid=4a54e776b29c11ec88e9119cc2af8b32.pdf

[102] Green Mountain Care Board. (2022). https://gmcboard.vermont.gov/board

responsibilities relative to Model A because some of those functions would be contracted to a carrier or carriers to perform. Under Model C, there would be no change to the existing structure.

Summary

The objective of Section 3 of this report is to describe the major areas of design components that are critical to developing, implementing, and maintaining a universal health care system and to identify key considerations within each area:

- Eligibility and enrollment
- Benefits and services
- Financing
- Provider Reimbursement and participation
- Cost containment mechanisms
- Infrastructure
- Governance

These core design components provide an operational framework to assess Washington's readiness and inform a strategy for implementing a universal health care system with unified financing and its ability to advance the goals for a universal health care system including containing health care costs, improving the quality of care, promoting health equity, and reducing health disparities.

Section 4: readiness

Introduction

The Legislature directed the Commission to provide an assessment of Washington's current level of preparedness to meet the elements of universal health care with a unified financing system, including but not limited to a single-payer financing system. Washington's readiness to transition will likely evolve as the Commission continues its work because a complete readiness assessment is dependent on finalizing various design elements, including which model of universal health care is chosen.

This preliminary assessment will, however, provide initial considerations that will help to inform the Commission's work and potential next steps. Throughout the course of the Commission's work, there will be revisions and expansions to the initial assessment as unified health care with a unified health care financing system develops.

This section of the report will provide a preliminary readiness assessment of the state's current level of preparedness to implement a unified health care financing system as described in Model A and Model B of the UHC Work Group. This section will also:

- Outline the functions state agencies are currently performing and potential resources available to perform those functions under a unified health care financing system.[103]
- Compare the current health care system with a potential unified health care financing system.
- Identify the steps and considerations necessary to move from the current system to universal health care supported by a unified financing system.

[103] Washington is currently adopting policies and making budget allocations to achieve Model C.

A readiness assessment survey tool was developed and provided to Commission members to gather information and evaluate Washington's readiness.[104] Individual interviews were also conducted with state agency representatives participating on the Commission. The survey and interviews demonstrated that while Washington has significant resources that could be adapted and expanded to implement a unified health care financing system, major gaps exist.

The assessment revealed important information for consideration, including identifying that state agencies have limited to no experience in directly performing important functions of a new health care system. For example, with the exception of the Medicaid program prior to the use of managed care contracting, state agencies have not historically performed utilization management functions whereas managed care organizations, private payers, and others typically employ utilization management strategies to coordinate and manage care, to reduce wasteful, unnecessary care, and to contain costs. In some cases, this is done by private entities such as Medicaid Managed Care Organizations and commercial carriers on behalf of state agencies in public programs which the state agency administers (e.g., Apple Health, PEBB, and PEBB).

The assessment of the seven core components of a universal health care system is summarized below in Table 7. This table describes the state's readiness to move from the current system to the potential new model(s). For purposes of assessing Washington's level of preparedness in this report:

- Green signifies that the state is ready to implement a particular design element without major additional resources and IT systems, or disruption to existing state programs.
- Yellow signifies that the state has some resources, IT systems, and programs that could be modified and expanded to implement the design element.
- Red signifies that the state lacks the resources, IT systems, and programs needed to implement the design element or has no history of implementing a similar function.

[104] The survey and interview guide are included in Appendix D.

Table 7: summary of readiness to implement core components of a universal health care system with a unified financing system

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

This table summarizes the readiness to implement core components of a univeral health care system with a unified financing system.

Core component 1: eligibility and enrollment — yellow

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

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

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

Eligibility readiness

Under any universal health care system, eligibility determination is crucial. The nature and extent of the information needed depends to some extent on the design of the new system. However, under any model, residency status would need to be determined and verified. Residency requirements could include a waiting period or a minimum residency duration to establish eligibility. These requirements would have to be investigated to understand the limitations allowable given the federal right to interstate travel and receipt of public benefits.

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

Modifying existing eligibility verification systems

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

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

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

Enrollment readiness

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

Currently, Washingtonians often have a choice among health carriers or health plans for their coverage. For public programs and most employer-based coverage, selections are made after reviewing the available options. Occasionally, individuals are assigned or auto enrolled into a health plan.[105]

The current process utilized to enroll Washingtonians into Apple Health, QHPs and Cascade Care could be simplified to expand enrollment for a unified health care system envisioned by Model A. While there may be various approaches to Model B, the enrollment processes currently utilized for Apple Health and the Exchange could be expanded upon to enroll the entire eligible population which may streamline enrollment.

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

Core component 2: benefits and services — yellow

Benefits and services will be a critical component of the universal health care system. As discussed in Section 3 of this report, two of the potential coverage models (A or B) will require the state to develop, administer, and assess the performance of covered benefits and services.

Using existing categories and programs as a starting point

The UHC Work Group recommended, as a starting point, that the ACA-mandated categories of services in the EHBs would be provided, with the possibility of additional service categories, including vision and hearing. Among the outstanding considerations is whether other benefits not included in EHBs, such as long-term care and disability services, will be provided by the universal health care system.

Through its existing coverage programs, Washington manages distinct benefits and services packages for Apple Health, PEBB, SEBB, and Cascade Care. As a result, Washington is well positioned to engage stakeholders, develop options, and make decisions regarding the standard benefits and services covered under the universal health care system with unified financing. However, in many cases, programs including Apple Health, PEBB, SEBB, and other programs offer benefits that are not included in the EHBs.

The ACA-mandated EHB may be a helpful starting point for a standard benefit package, though the difference in benefits between what currently exists under various programs will need to be reconciled. However, to effectively guide this development, it will be important to establish a process to define the specific services within the categories, but also an ongoing process to update the services over time that incorporates new clinical evidence and diverse stakeholder input.

Administering benefits

Once the benefit package is developed, the benefits must be administered. Depending on the coverage model, the state could administer benefits directly, or through third-party administrators (TPAs), or through contracted carriers. Currently, benefits under Apple Health, PEBB, SEBB, and Cascade Care are administered using a combination of the three methods. More investigation is needed to understand the scalability of each program's benefit administration capabilities.

Further, to support the affordability, quality, and equity goals of universal health care with a unified financing system, administrators must accommodate any complex eligibility rules, benefit management processes, and value-based payment models as they currently exist or as revised in the future. As such, Washington's readiness to administer benefits is critically tied to decisions regarding the benefits package as well as provider reimbursement, consumer cost-sharing, and financing.

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

Core component 3: financing — red

Health care is currently financed through several different sources and in a variety of ways. Financing sources include direct payments by the federal and state governments for public programs, subsidies for

the purchase of health coverage on the Exchange, premiums paid by employers and consumers, and out-of-pocket costs paid by consumers such as copays and coinsurance.

The complexity and cost of the current system make financing one of the most challenging aspects of establishing a universal health care system. Consolidating and simplifying this system is one of the outcomes that supports establishment of a universal health care system. Another likely outcome is reduced financial burden on consumers and increased access to care. Under either Model A or B, numerous, complex decisions will determine how the system would be financed, as described more fully in Section 3 of this report.

Federal and state funds

Perhaps the most challenging and time-consuming task will be to obtain the federal waivers needed to utilize federal funds to help finance universal health care supported by a unified financing system. This work cannot begin until the universal health care system design has been further explored. Significant time will then be needed for waiver drafting and the federal approval process, which could potentially involve both federal agency and Congressional action. The federal government may not agree to approve the entire request, which would require alternative sources of funding to be identified.

In addition, further exploration is needed to determine how to raise state funds to replace the amounts currently paid by businesses and families in the form of premiums and copays. These decisions are likely to be a significant change from what Washingtonians are used to, and this work will be more efficiently conducted once the design of the universal health care system is further developed.

Core component 4: provider reimbursement and participation — readiness assessment dependent on model variables

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

Provider reimbursement

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

However, Washington's readiness to reimburse providers entirely on a FFS basis with a uniform rate structure, as suggested in the UHC Work Group Report, is assessed as green. HCA has experience in paying claims in FFS Medicaid. Until 2011, HCA also contracted directly with providers to establish the Uniform Medical Plan network for PEBB and SEBB. While the scale and scope of these capabilities would need to be greatly expanded, Washington has demonstrated its capacity for provider contracting and FFS claims payment.

Moving to an entirely FFS method of paying providers may be inconsistent with the many efforts Washington, along with other states and the federal government, has made to reduce costs and improve the quality of care using managed, coordinated care models. This may mean moving away from use of value-based provider reimbursement, which may disrupt advances made in quality, equity, and cost containment under value-based provider reimbursement.

Washington's readiness to transition to a system that makes greater use of alternative payment models and provides incentives for higher value care is assessed as yellow. While Washington does not have a history of administering global budgets, it does contract with MCOs on a per member per month payment basis and with TPAs to provide these functions for specific programs.

Contracting with MCOs or third parties is similar to what could be done under a variation of Model B. However, the extent to which these capabilities can be scaled to support a universal system requires further assessment and is likely dependent on the specific reimbursement models selected for the financing system. For example, while a TPA under Model B may be able to administer quality bonuses, capitated payments, or value-based contracts in the commercial insurance market, the TPA may not be able to easily implement a global budget for an attributed population.

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

Core component 5: cost containment elements — red or yellow, depending on model variables

Improved cost containment is one goal of a unified health care financing system. Washington's readiness to implement cost containment in a universal health care system supported by unified financing is assessed as red for Model A and yellow for Model B.

Current cost containment efforts

One of the more problematic features of the current health care system is that incentives for payers and providers are not aligned to control costs. Though changes have been made to improve health care financing and cost control, much of the system relies primarily on FFS payments that focus and pay based on volume rather than value. Further, due to the different delivery models and markets, the current health care system is fragmented making it difficult to apply cost containment measures at scale.

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

Cost containment for Models A and B

The current efforts of cost and care management are tailored to the respective programs that provide health coverage and are not unified among the different entities implementing them. Under Model A,

Washington would need to develop new or adapt existing processes and obtain additional resources to carry out the functions of directly managing costs and coordinating care.

Under one version of Model B that uses carriers to provide health care insurance, the accountable agency administering the new system would need to align the contracted carriers' actions to provide consistent, effective cost containment measures to everyone covered by the system. This could include myriad uniform cost containment and care management approaches such as a common list of clinical guidelines and benefit exclusions, one standardized appeal process, and common prescription medication formularies.[106]

Fraud, waste, and abuse

Reducing fraud, waste, and abuse is another strategy for cost containment that should be integrated into the universal health care system.[107] Currently, HCA employs strategies to reduce fraud, waste, and abuse in public health care programs. Further, as part of their regulatory and consumer protection mission, state agencies identify and prevent fraud, waste, and abuse in the provider and private payer markets.

As the design of the universal health care system is developed, further assessment will be necessary to identify the readiness of these current agencies to support a fraud, waste, and abuse detection program, particularly if the financing system includes complex, value-based provider reimbursement models.

Core component 6: infrastructure — red or yellow, depending on model variables

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

Information infrastructure

Technology and data platforms are some of the more important infrastructure considerations necessary to execute the universal health care system.[108] In administering existing coverage programs, Washington utilizes multiple call center and data management platforms for eligibility determinations, enrollment, and claims payment. However, most of the platforms currently in use are not compatible with other systems, making program integration a challenge. Further, given that platforms serving different programs have been developed to widely varying requirements, existing systems may not be well suited to support universal health care with a unified financing system.

However, there may be eligibility and enrollment platforms, such as the Washington Healthplanfinder platform, that could be repurposed for eligibility determination with modifications. Or, if utilizing work hours is a key determinant of eligibility, the PEBB and SEBB eligibility platforms could be modified and repurposed. As key design elements of the universal health care system are developed, each of the IT systems utilized in Washington will need to be evaluated for appropriateness and scalability to support the model selected.

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[106] Many existing state initiatives would establish a foundation to support such approaches to better manage cost while improving quality as discussed in Section 1.
[107] Efforts to reduce fraud, waste, and abuse were previously discussed in Section 3.
[108] As discussed in Section 3.

Human resource infrastructure

Human resources and staffing are also critical areas of infrastructure readiness. Certain functions needed to implement a universal health care system are currently being performed by the private sector. For example, health insurance carriers currently contract with providers who care for their members. Carriers also help to coordinate and manage care delivered by providers in the community who may not be part of the same health care system.

Additionally, carriers perform utilization management to determine whether particular health care services are medically necessary and appropriate. Under Model A, additional state workers may be needed to perform these functions, or in the alternative, enter into contracts with private entities with state workers managing those contracts.

While each agency has a complement of staff to support existing programs, significant planning efforts must be authorized and funded to assess needs pertaining to staff training, management transitions, and integration, particularly for Model A. For example, many of the programs operate call centers to support clients with eligibility determinations, enrollment, and other services. However, call center staff are typically highly trained and expert in the rules and processes for one coverage program and will require additional training to support a universal health care system, even if many of the rules and processes are retained in the new model.

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

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

Core component 7: governance, implementation, and administration — red

In this report, governance, implementation, and administration have been identified as critical design elements of the universal health care system supported by unified financing. The Commission will have a permanent role in oversight of the new system. The primary consideration for establishing implementation and administration structures is whether a single agency or multi-agency structure should be accountable for overseeing the operations of the universal health care system.

Currently, no single agency or entity performs all the functions necessary for operating a universal health care delivery or unified financing system or serves all populations and stakeholders that would be served by the system. Additionally, no agency or entity has the authority to operate, oversee, or regulate across the entire health care landscape. However, Washington does have a history of shared authorities and

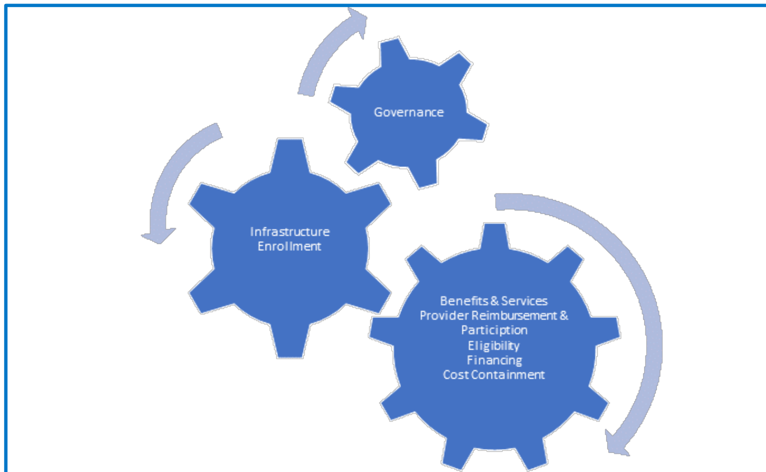
collaboration across agencies. For example, HCA, OIC, and HBE collaborate to implement Cascade Care as designated by the Legislature.

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

Summary

The preliminary readiness assessment reveals several opportunities to build on existing functions, but also identifies some initial areas that will require greater resources and/or new authorities to be able to design and develop a universal health care system. The preliminary readiness assessment also helps to clarify potential sequencing for how the Commission might approach the system design for these key elements as seen in Figure 5.

Figure 5: potential sequencing for universal health care system design



Section 5: Medicaid rates

Introduction

SB 5399 directs the Commission to make recommendations for implementing reimbursement rates for health care providers serving Medicaid enrollees that are no less than 80 percent of the rate paid by Medicare for similar services.[109] Under a universal health care system, the way current Medicaid beneficiaries receive services may be significantly different. In the interim, increasing Medicaid payment rates may improve provider participation in Medicaid, which could improve access to care for Medicaid beneficiaries.

This section provides a summary of:

- Current Medicaid reimbursement structures.
- The impact of relatively low reimbursement rates on provider participation in Medicaid, and the impact of low payment rates on health care access and equity.
- Some of the legislative efforts to increase Medicaid rates in Washington.

This section will also share the results of HCA's financial modeling to determine the cost to the state and federal government of increasing all Medicaid rates to 80 percent of Medicare. Finally, the Commission will share recommendations for potential pathways to achieving enhanced Medicaid reimbursement rates.

Background

Before the passage of the ACA, Medicaid was generally unavailable to non-disabled adults under age 65 years, unless they had minor children or were pregnant. The income caps to qualify as a parent/caretaker were very low. However, a provision in the ACA called for the expansion of Medicaid eligibility to cover more low-income Americans. Under the expansion, Medicaid eligibility extended to adults up to age 64 years with incomes up to 133 percent FPL (plus a five percent income disregard).[110] Prior to the ACA, states seeking to adopt Medicaid expansion could do so using Section 1115 waiver authority.

Washington took the opportunity to do an incremental expansion, extending Medicaid coverage to a capped number of non-elderly adults up to 133 percent FPL under the 1115 waiver beginning January 1, 2011.[111 & 112] The decision and action to adopt early expansion effectively reduced the uninsured rate in

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[109] Engrossed Second Substitute Senate Bill 5399 https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5399-S2.SL.pdf?q=20220404085215

[110] 138 percent FPL total with the income disregard. Patient Protection and Affordable Care Act. 2014. https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

[111] Medicaid expansion under the 1115 demonstration waiver was extended to nonelderly adults up to 133 percent FPL who were previously enrolled in the state-funded Basic Health Plan or the state Alcohol and Drug Addiction Treatment Support Act programs. Individuals under General Assistance – Unemployable (GA-U) were transitioned to Medical Care Services; one of the coverage programs the waiver encompassed. Under the waiver, enrollment was capped, and enrollees were subject to cost-sharing which exceeded traditional Medicaid limits. When expansion under the ACA became effective in January 2014, enrollees under the waiver were transitioned to traditional Medicaid coverage. The Kaiser Commission on Medicaid and the Uninsured. 2014. The Washington State Healthcare Landscape. https://www.kff.org/wp-content/uploads/2014/06/8599-the-washington-state-health-care-landscape2.pdf

[112] As of January 2014, a 1115 waiver was no longer necessary as the adult coverage expansion group were a new eligibility group. Washington implemented this new group on January 1, 2014. Other changes applied to all state Medicaid programs as of 2014, including simplified eligibility determination procedures with a new income counting methodology. The Kaiser Commission on the

Washington. In 2013, the uninsured rate in Washington was 14.1 percent, which dropped to 5.4 percent by 2016, representing an overall rate decrease of 60 percent. Over the next several years, the uninsured rate increased slightly and hovered around 6.7 percent prior to the COVID-19 pandemic.[113]

In 2020, the PHE declaration and subsequent Families First Coronavirus Response Act gave states' Medicaid programs a temporary 6.2 percent Federal Medical Assistance Percentage (FMAP) increase in response to widespread unemployment and loss of health coverage. This increase was conditioned on states maintaining Medicaid members' enrollment, including for those newly eligible during this period. As result of these protections, the uninsured rate as of November 2021 was the lowest since the implementation of the ACA at 4.7 percent.[114]

Medicaid expansion, coupled with federal protections from Medicaid disenrollment from the COVID-19 pandemic, have helped to significantly lower the uninsured rate. Since Medicaid expansion, Washington has sought to improve the Medicaid program by improving access to care and improving provider participation in the Medicaid program.

However, provider participation in Medicaid is voluntary. Physician participation in Medicaid is also lower than in the commercial insurance market and in Medicare, particularly among specialists. This shortage of providers has long been associated with low Medicaid payment rates. In fact, physicians cite low rates as the primary barrier to participating in Medicaid.[115]

In Washington, Medicaid provider reimbursement rates are not competitive with either commercial plans or Medicare. In 2016, Medicaid rates averaged across all services at 71 percent of Medicare. For adult primary care, Medicaid rates were even lower at 65 percent of Medicare.[116] Additionally, Medicaid payment rates have not kept pace with the cost of services, particularly in FFS Medicaid, and there has been no sustained ongoing rate increase for Medicaid services in over 10 years.[117]

Further, the historic lack of provider rate increases in FFS Medicaid disproportionately impacts AI/AN individuals, individuals who are dually eligible for Medicare and Medicaid, and Aged, Disabled and Blind populations.[118] While recent legislation successfully increased some Medicaid payment rates, including

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Uninsured. 2014. The Affordable Care Act's Impact on Medicaid Eligibility, Enrollment, and Benefits for People with Disabilities. https://www.kff.org/wp-content/uploads/2014/04/8390-02-the-affordable-care-acts-impact-on-medicaid-eligibility.pdf

[113] The state's uninsured rate increased sharply during the COVID-19 pandemic. At the height of the pandemic in May 2020, the uninsured rate reached 11.9 percent. OFM microsimulation model of Washington's unemployment claims during the COVID-19 pandemic and associated health coverage changes. Washington State Office of Financial Management. 2021.

[114] OFM microsimulation model of Washington's unemployment claims during the COVID-19 pandemic and associated health coverage changes. Washington State Office of Financial Management. 2021.

[115] Holgash, K. Heberlein, M. 2019. Physician Acceptance of New Medicaid Patients: What Matters and What Doesn't. Health Affairs. https://www.healthaffairs.org/do/10.1377/forefront.20190401.678690/full/

[116] Medicaid-to-Medicare Fee Index. 2016. Kaiser Family Foundation. https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[117]Health Care Authority, 2019, Barriers to Primary Care Access in Apple Health. Senate Health and Long Term Care Committee. https://www.hca.wa.gov/assets/program/senate-hltc-barriers-primary-care-access-011619.pdf

[118] AI/AN enrollees can choose to opt out of managed care coverage and receive health care services under Medicaid FFS. AI/AN individuals are disproportionately impacted by low Medicaid FFS provider rates. Compared to White, non-Hispanic Medicaid enrollees, AI/AN enrollees are significantly less likely to report that it is always or usually easy to get needed medical care, tests, or treatments; significantly less likely to report that it is always or usually easy to get needed mental or behavioral health services; and significantly more likely to report that they are never able to see a specialist as soon as needed. Medicaid revenue is also especially essential for Indian health providers when federal Indian Health Services (IHS) funding is reduced or interrupted. Medicaid and Chip Payment and Access Commission (MACPAC). Medicaid's Role in Health Care for American Indians and Alaska Natives. Issue Brief.

pediatric primary care, behavioral health under managed care, and dental services for children and adults, provider rates largely have not kept pace with the cost of providing care.

Medicaid fee-for-service (FFS) and managed care

States may offer Medicaid benefits on an FFS basis, through managed care plans, or a combination of both. In Washington, Medicaid enrollees are automatically enrolled into managed care and can choose which plan best fits their needs. Some groups, including Medicare-eligible individuals and AI/AN populations, are exempt from auto-enrollment in Medicaid managed care but may choose to opt into a managed care plan. Some groups can also opt out of coverage under managed care, such as Foster Care Alumni. Some services are always provided on an FFS basis, such as long-term care and dental care.

FFS payment

Under Medicaid FFS, providers are paid directly for each covered service received by a beneficiary. Federal rules allow states broad flexibility in determining FFS provider payments on the condition that payments help to safeguard against unnecessary utilization, and be consistent with access rules, efficiency, economy, and quality of care.[119] Washington uses a provider fee schedule to establish base payment rates, or standardized payment amounts, for Medicaid FFS.[120]

Managed care payment

Managed care provides comprehensive benefits through MCOs, which receive a capitated payment to provide services. Federal Medicaid rules allow states to enter into contracts requiring MCOs to adopt minimum fee schedules for network providers who provide a particular service under the contract. Medicaid managed care rates are based upon FFS equivalents, are developed by actuaries and must be approved by CMS. MCO rate setting is also influenced by legislation appropriations for these payments.

Encounter and cost basis payments

Some Medicaid providers are paid on an encounter basis, such as tribal clinics and federally qualified health centers (FQHCs).[121] The FQHC rate covers services provided to Medicaid patients as a per-visit, all-inclusive payment based on encounters.[122] Other providers, including critical access hospitals (CAHs), are paid on a cost basis (with some exceptions).[123] As a result, there is an assumption that CAH payments would not be impacted by an increase in Medicaid rates. To be paid by HCA under FFS or managed care as a CAH, a hospital must be approved by the Department of Health (DOH) for inclusion in DOH's CAH program.[124]

2021. https://www.macpac.gov/wp-content/uploads/2021/02/Medicaids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf

[119] Compilation of the Social Security Laws. State Plans for Medical Assistance. https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

[120] The Centers for Medicare & Medicaid Services (CMS) assesses the adequacy of FFS payments when it approves FFS payment methodologies.

[121] FQHCs are also paid based upon encounter rates for dental services. Federally Qualified Health Centers (FQHC) Billing Guide. 2018. Health Care Authority. https://www.hca.wa.gov/assets/billers-and-providers/FQHC-bi-20180701.pdf

[122] Encounters are defined to include a documented, face-to-face contact between a user and a provider who exercises independent judgment in the provision of services to the individual. To be included as an encounter, services rendered must be documented. Centers for Medicare and Medicaid Services. Comparing Reimbursement Rates. https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/understand-the-reimbursement-process

[123] WAC 182-550-2598.

[124] Some tribal facilities qualify as critical access hospitals.

Impact of payment rates on provider participation in Medicaid

Providers have long cited low payment rates as the primary barrier to participating in Medicaid. A provision of the ACA intended to encourage primary care physicians to participate in Medicaid by temporarily increasing Medicaid primary care rates to 100 percent of Medicare in 2013 and 2014.[125] After raising Medicaid rates during this period, Washington's Medicaid reimbursement returned to pre-ACA levels.[126] This temporary rate increase resulted in limited improvements in provider participation.[127] Several studies investigating the effect of increased rates during this same period noted that the limited duration and design of the payment increase may have not been enough to incentivize providers to participate, despite the increase in payment rates.

HCA funded a study by the University of Washington Center for Health Workforce Studies (UW CHWS) to assess the impact of the 2013-2014 Medicaid payment increase on primary care providers' willingness to serve Medicaid patients in Washington State. [128] The study found that the lack of sustainable funding from the one-time fee increase was not incentive enough for some providers to participate in Medicaid and would not impact decisions to accept or continue care for Medicaid patients for most providers. The majority of providers noted that increasing reimbursement rates, as well as other strategies like streamlining payments and administrative processes, may encourage them to continue seeing or accepting new Medicaid patients.

A 2019 Health Affairs Study reviewed the effects of provider payment rates, Medicaid expansion, and managed care on physician acceptance of new Medicaid patients.[129] Neither Medicaid expansion nor managed care played a significant role in increasing provider participation. However, higher provider payment was associated with higher acceptance rates of Medicaid patients by providers. Further,

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[125] The two-year rate enhancement was funded solely by the federal government. Health Care and Education Reconciliation Act of 2010, Section 1202. https://www.govinfo.gov/content/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf

[126] The Health Care Authority models Medicaid rates annually, ensuring budget neutrality. After the ACA temporary rate increase period, Medicaid rates in Washington State returned to the rate that would have followed 2012 rates modeling.

[127]Decker, S. Lipton. B. 2017. Most Newly Insured People In 2014 Were Long-Term Uninsured. https://pubmed.ncbi.nlm.nih.gov/28069842/

[128] Pattterson DG, Andrilla CHA, Skillman SM, Hanscom J. The Impact of Medicaid Primary Care Payment Increases in Washington State. Seattle, WA: WWAMI Center for Health Workforce Studies, University of Washington, Dec 2014. http://depts.washington.edu/uwrhrc/uploads/WA%20Medicaid%20Incentive%20Final%20Report%20Dec%201%202014.pdf
The study consisted of two surveys in fall 2014. The first sampled 15 Washington counties and captured the perspectives of 230 primary care physicians in solo and small group practices of 50 physicians or fewer. Physicians sampled had to have reported providing direct patient care in Washington since January 1, 2013 and have a main practice site that was not a federally qualified health centers or Rural Health Clinic (RHC), as these facilities were not eligible for the payment increase. Survey two was directed at leaders of the state's 13 largest healthcare organizations, with a response rate of 53.8 percent. Provider awareness of the temporary increase varied, where respondents from large healthcare organizations or in private practice were more aware of the Medicaid payment increase compared to primary care physicians in smaller practices. Primary care and large healthcare organizations were polled on the amount of influence primary care physicians had on whether to accept Medicaid patients and who in large healthcare organizations makes this decision. 82.1 percent of primary care physicians in smaller practices reported that they had "some" or "a great deal" of influence. 42.9 percent of primary care physicians in large healthcare organizations reported that their primary care physicians had "some" or "a great deal" of influence. 71.4 percent of large healthcare organizations reported that leadership made the decision. 46.3 percent of rural primary care physicians, compared with 72.8 percent of urban primary care physicians, reported they had "a great deal" of influence. Primary care physicians in private practice were 66.9 percent more likely to perceive they had "a great deal" of influence (76.6 percent vs. 9.7 percent). Self-employed primary care physicians were more than three times as likely as other primary care physicians to report having a great deal of influence (86.1 percent vs. 24.6 percent).

[129] Holgash, K. Heberlein, M. 2019. Physician Acceptance of New Medicaid Patients: What Matters and What Doesn't. Health Affairs. https://www.healthaffairs.org/do/10.1377/forefront.20190401.678690/full/

physicians in states that paid above the median Medicaid-to-Medicare fee ratio accepted new Medicaid patients at higher rates than those in states that pay below the median.

Impact of provider rates on health equity and access

Health and health care disparities disproportionately impact individuals and communities of color. For instance, private insurance, primarily employer-sponsored insurance, is the largest source of health care coverage across racial and ethnic groups. However, structural racism has largely shaped employment trajectories for individuals of color, where compared to their white counterparts, individuals of color are less likely to be privately insured and be employed with employers that offer health insurance.[130] Individuals of color are also less likely to report having a personal doctor or health care provider compared to their white counterparts. [131] Individuals of color are overrepresented in Medicaid compared to other forms of insurance. As of 2020, Medicaid covered about three in 10 Black, AI/AN, and Native Hawaiian or Other Pacific Islander (NHOPI) nonelderly adults and more than two in 10 Hispanic nonelderly adults, compared to 17 percent of their white counterparts. For children of color, Medicaid and CHIP play an even larger role, covering over half of Hispanic, Black, and AI/AN children and nearly half of NHOPI children, compared to 27 percent of white children.

In their 2022 Quarterly Opinion, Millbank stated that relatively low provider payment rates contribute to access barriers for Medicaid enrollees. Millbank cited the 2019 Physician Acceptance of New Medicaid Patients[132] report by the State Health Access Data Assistance Center (SHADAC) to the Medicaid and CHIP Payment and Access Commission (MACPAC). Of providers accepting new patients, 70.8 percent were accepting new Medicaid patients, compared to 85.3 percent accepting new Medicare patients and 90 percent accepting new patients with private insurance.

For specialty providers like psychiatrists, only 35.7 percent were accepting new Medicaid patients, compared to 62.1 percent accepting Medicare and 62 percent accepting private insurance. However, SHADAC found that every one percentage-point increase in the Medicaid-to-Medicare fee reimbursement ratio was associated with a 0.78 percentage-point increase in provider acceptance of Medicaid patients.[133]

Millbank stated that advancing the goal of health equity and improving access to care for Medicaid enrollees may require closing provider pay gaps that make Medicaid less attractive to providers.[134] One suggestion to improve care access was to increase Medicaid fees or benchmark Medicaid fees to Medicare where with such a rate increase, the supply of services to Medicaid could increase access and reduce health care disparities.

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[130] Medicaid and Racial Health Equity. 2022. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/

[131] Breakdown by race/ethnicity: AI/AN: 33.5 percent, Asian/HOPI: 25.6 percent, Black: 28 percent, Hispanic: 38 percent, White: 17.8 percent. Adults Who Report Not Having a Personal Doctor/Health Care Provider by Race/Ethnicity. Kaiser Family Foundation. 2020. https://www.kff.org/other/state-indicator/percent-of-adults-reporting-not-having-a-personal-doctor-by-raceethnicity/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[132] The Physician Acceptance of New Medicaid Patients report by State Health Access Data Assistance Center (SHADAC) to the Medicaid and Chip Payment Access Commission (MACPAC) assessed state policies that could affect acceptance of new Medicaid patients. https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf

[133] After adjusting for state demographic characteristics.

[134] Allen H, Golberstein E, Bailey Z. Eliminating Health Disparities Will Require Looking at How Much and How Medicaid Pays Participating Providers. *Milbank Quarterly Opinion.* February 23, 2022. https://www.milbank.org/quarterly/opinions/eliminating-health-disparities-will-require-looking-at-how-much-and-how-medicaid-pays-participating-providers/

Other studies support an association between increased Medicaid provider rates and improved access to care. In 2019, the National Bureau of Economic Research assessed the impact of provider rates on adults covered by Medicaid and found that improvements in access to care can have large implications for disparities.[135] Compared to those who were privately insured, Medicaid-covered adults were twice as likely to report difficulties finding physicians willing to accept them as new patients. Medicaid-covered adults were also nearly three times as likely to report being in fair or poor health. The study found that Medicaid enrollees in states with larger increases in Medicaid provider payments saw greater improvements in access, frequency of office visits, and overall health. [136]

The study also assessed the impact of provider payments on children and found that Medicaid-covered children were twice as likely to be chronically absent from school.[137] However, improvements in health care access resulting from increased payments for physicians lead to improvements in both self-reported health and reductions in school absenteeism due to illness and injury.[138] Most school absences, particularly among young children, are attributable to acute conditions commonly treated in a primary care setting and school absenteeism may be responsive to changes in access to primary care.

Just as Medicaid enrollees may face barriers to accessing primary care due to low payment rates, the mental health system has struggled to meet the demand for services, particularly amid the COVID-19 pandemic and opioid crisis. Though Medicaid enrollees are more likely to experience mental health disorders compared to privately insured patients,[139] nearly a quarter of Washingtonians will struggle with mental health or chemical dependency issues at some point in their lives. However, as of 2018, there was just one mental-health provider for every 360 residents.[140] Further, by county, the ratio of behavioral health providers ranges from one for every 262 individuals to one for every 3,378 individuals.

Despite state efforts to promote access to behavioral health providers and care, rates of mental illness and overdose deaths in Washington continue to rise. This is especially true for Medicaid enrollees who have higher overall prevalence of moderate to severe mental illness or substance use disorders (SUD).[141] Prior to the pandemic, of adults with any mental illness in Washington, 22.8 percent reported having Medicaid

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[135] Alexander, D. Schnell, M. National Bureau of Economic Research. 2019. The Impacts of Physician Payments on Patient Access, Use, and Health. Working Paper 26095. https://www.nber.org/papers/w26095

[136] The study exploited large, exogenous changes in physician reimbursement rates for primary care visits under Medicaid and estimated that an increase in Medicaid payments of $35 (the median increase across states over the federally mandated primary care rate increase) reduced the probability that adult Medicaid beneficiaries were told that a physician was not accepting their insurance by 3.1 percent, or 38 percent of the mean. Increasing Medicaid payments by $35 increased the probability that Medicaid beneficiaries had an office visit in the past two weeks by five percent and increased the probability that they report being in excellent or very good health by 3.9 percent. Ibid.

[137] Chronic absenteeism is linked to low academic achievement, including test scores, test score growth, and on-time graduation rates. Ibid.

[138] A $35 increase in Medicaid payments lead to an average reduction of 0.79 days missed per year due to illness or injury, or 22 percent of the mean, and reduced illness-related chronic absenteeism by nearly 50 percent. Ibid.

[139] Bergamo, C, MD. 2016. Association of Mental Health Disorders and Medicaid with Emergency Department Admissions for Ambulatory Care Sensitive Conditions. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4837066/#:~:text=Adult%20Medicaid%20enrollees%20are%20more,Care%20Sensitive%20Conditions%20(ACSC).

[140] Access to Behavioral Health Providers. 2018. Department of Health. https://doh.wa.gov/sites/default/files/legacy/Documents/1000//SHA-AccesstoBehavioralHealthProviders.pdf

[141] At the national level as of 2020, approximately 29 percent of Medicaid-enrolled non-elderly adults have a mental illness, compared to 21 percent of privately insured and 20 percent of uninsured individuals. Saunders, H. 2022. Demographics and Health Insurance Coverage of Nonelderly Adults with Mental Illness and Substance Use Disorders in 2020. https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/#:~:text=Mental%20illness%20and%20substance%20use%20disorders%20are%20most%20prevalent%20among,and%2020%25%20of%20uninsured%20people

coverage in the past year.[142] Additionally, compared to non-Medicaid covered individuals, Medicaid enrollees are approximately four times more likely to suffer a fatal overdose involving opioids.[143]

According to CMS, states that expanded Medicaid have seen improved access to behavioral health and SUD. However, gains in insurance coverage under Medicaid expansion may not guarantee access to office-based treatment. Though a broad range of behavioral health and substance use services are covered under Medicaid, behavioral health providers, particularly specialists, accept Medicaid patients at significantly lower rates compared to Medicare and private insurance.[144]

In addition to low provider rates for primary care and mental health, dental provider rates, particularly for children's dental services, present a significant challenge for dental provider retention and acceptance of new Medicaid patients by dental providers. A study by the Center for Health Workforce Studies at the University of Washington examined Washington's oral health workforce and patient access to care.[145]

This study found that only 28 percent of dentists were accepting new Medicaid patients. The study also found that recruiting and retaining dental providers to care for rural and underserved populations, including patients covered by Medicaid, was a persistent challenge due to low Medicaid reimbursement rates. However, dental providers reported that increased payment rates were one of the most important factors that would encourage them to care for patients covered under Medicaid.

Children from underserved groups, including populations that currently experience health disparities due to racial and structural inequalities, are at the greatest health risk if challenges in the recruitment and retention of Medicaid dental providers persist. The Arcora Foundation's September 2020 Access to Oral Health Dashboard showed that compared to white children, Hispanic and AI/AN and Pacific Islander children experience approximately 50 percent more cavities and more than twice the rate of rampant decay.

Black/African American and Asian children also experience disproportionately higher rates of untreated tooth decay compared to white children. Additionally, compared to children from higher income households, children from low-income households are twice as likely to suffer untreated tooth decay. Retention of pediatric dental providers is critical to ensuring access to dental care for Medicaid-eligible children.

State and federal efforts have aimed to address access issues and workforce shortages in behavioral health and primary care, and recently in Washington, dental services, especially during the COVID-19

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[142] Access to Behavioral Health Providers. 2018. Department of Health. https://doh.wa.gov/sites/default/files/legacy/Documents/1000//SHA-AccesstoBehavioralHealthProviders.pdf

[143] Among Washington Medicaid enrollees with only a substance use disorder and enrollees with both mental health service needs and substance use disorder, there was a significant increase in heroin overdose deaths. Among all individuals who died from drug overdose between 2006 – 2012 in Washington, 35 percent were enrolled in Medicaid at some point in the 12 months before death. Xing, J., PhD. 2015. Overdose Deaths among Medicaid Enrollees in Washington State - The Role of Behavioral Health Needs. https://www.dshs.wa.gov/sites/default/files/rda/reports/research-4-92.pdf.

[144] Senate Bill 5693 allotted funds to implement a seven percent increase to Medicaid reimbursement specifically for community behavioral health providers contracted through MCOs to be effective January 1, 2023.

[145] Among dentists who reported accepting Medicaid for payment and not practicing in FQHCs, an average of 34.8 percent of their patients were covered by Medicaid. Encounter-based Medicaid reimbursement at FQHCs was reported as a potential incentive for providers to spread care over multiple visits for higher reimbursement, thereby exacerbating for patients the barriers of travel and lost work time for services that might otherwise be provided in one visit. The study used a 2016 provider survey based on 2015 data using information gathered from key informants, Washington licensure data, and surveys of dentists, family physicians, and pediatricians. Assessing the Impact of Washington State's Oral Health Workforce on Patient Access to Care. 2017. Center for Health Workforce Studies. University of Washington.

pandemic. However, short-term investments, such as one-time payment increases have been shown to not improve provider participation in Medicaid or improve access for patients. Securing permanent rate increases for primary care, behavioral health, and dental providers may be an impactful step to improving access to care and health equity for Medicaid enrollees in the current system, as well as in the transition to a universal health care system.

Legislative efforts to increase Medicaid provider rates

Washington aims to continue to improve the Medicaid program by improving access to care and improving provider participation in the Medicaid program. Though Medicaid provider rates have largely stagnated for over ten years, several pieces of recent legislations have increased provider payment rates for certain services to increase access to care for Medicaid enrollees. The next section will highlight some of the recent legislative efforts to increase Medicaid payment rates.

Pediatric primary care reimbursement enhancement, 2018

As stated previously, the ACA provided for an increase in Medicaid provider rates to Medicare rates for certain providers (2013 and 2014). In Washington, evaluation and management (E&M) services and vaccines for Medicaid covered children were codes for which providers could receive enhanced rates during this period.[146] In the years since, the Washington State Legislature tried to increase reimbursement for the same codes, but such an effort was considered too costly and was not funded until 2018.

Finally, SB 6032 (Operating Budget, 2018) appropriated funds for HCA to increase primary care provider rates for pediatric E&M and vaccine services.[147] These enhanced rates would match the rates under the ACA temporary rate enhancement.

HCA provided a report to the Governor and the Legislature in November 2019, in response to the requirements in SB 6032, which detailed the following:

- How the funds were used to increase provider rates.
- What percentage increase was provided for pediatric primary care provider E&M rates.
- What percentage increase was provided for pediatric vaccine rates.
- How utilization changed within each category.
- How rate increases impacted access to care.

There was difficulty in trying to assess the impact of this rate increase on E&M and vaccination services in the short reporting period. While the utilization of E&M and vaccination services did not seem positively impacted, it was difficult to conclude what effect the rate increase may have had if the number of children in the caseload remained more stable, and if this was a sufficient enough rate increase to stimulate better utilization of these services.

[146] There are some codes for E & M visits for children ages 19-20 that were not covered under the enhanced rates, though these codes are already reimbursed between 80-83 percent of Medicare. The E&M codes 99201-99215 are for office visits only and must be billed for professional providers such as physicians (or nursing staff under a physician’s supervision), Advanced Registered Nurse Practitioners (ARNPs), and Physician Assistants (PAs).
[147] The enhanced rates began October 1, 2018.

The correlating decrease in the number of children in the caseload masked the opportunity to reach any compelling conclusions about how utilization was impacted. [148] It was determined that a longer evaluation period would be required to further assess the impact on the utilization of these services.

Primary care access study, 2018

SB 6032 also tasked HCA with coordinating a study and subsequent report to the Legislature in December 2018, to identify strategies and provide recommendations for enhancing access to primary care for Medicaid enrollees. The study was to the extent possible, required to:

- Review the effect of the ACA temporary rate increase on:
  - The number of providers serving Medicaid clients.
  - The number of Medicaid receiving services.
  - Utilization of primary care services.
- Identify client barriers to accessing primary care services.
- Identify provider barriers to accepting Medicaid clients.
- Identify strategies for incentivizing providers to accept more Medicaid clients.
- Prioritize areas for investment that are likely to have the most impact on increasing access to care.
- Strategically review the current Medicaid rates and identify specific areas and amounts that may promote access to care.

HCA analyzed changes in access to primary care for Medicaid enrollees between 2012 and 2017. Data was used from 2012 (before the passage of the ACA), 2013 and 2014 (the years that the Medicaid reimbursement rate increased), and 2015 to 2017 (when reimbursement rates returned to pre-ACA levels).[149]

Between 2012 and 2017, there was 30 percent increase in primary care providers, however this was outpaced by a 50 percent increase in Medicaid enrollment. Despite growth in the number of Medicaid providers during this period, declining Healthcare Effectiveness Data and Information Set (HEDIS) 150 and Consumer Assessment of Healthcare Providers and Systems (CAHPS)[151] performance illustrated a negative impact on members' timely and needed access to care.

Providers reported the following as primary barriers to Medicaid participation:

- Payment rates have not kept pace with increasing costs of services.
- Administrative complexity in clinical criteria, claims submission, and payment.
- Challenges in meeting members' complex needs and time requirements.

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[148] During this reporting period, the number of children ages 0-20 years in the case load dropped by 1.4 percent. The majority of this reduction was in the 0 to 6 age group. This is notable this is the age when children receive the most E&M and vaccination services, and this change in caseload numbers likely contributed to the decrease in utilization of E&M visit codes and vaccinations administered.

[149] HCA Report to the Legislature. December 1, 2028. Enhancement of Primary Care Access for Medical Assistance Clients Engrossed Substitute Senate Bill 6032, Section 213 (eee); Chapter 299; Laws of 2018. https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=HCA%20Report%20-%20Enhancement%20of%20Primary%20Care%20Access%20for%20Medical%20Assistance%20C..__b77842c4-60b1-4c74-8c97-8f2b355d60a9.pdf

[150] Performance on 2017 HEDIS adult access to care measure results were at the 40th percent of MCO performance nationwide.

[151] 2017 CAHPS measured results for "Getting Needed Care and Getting Needed Care Quickly" and were at the 20th percent of MCO performance nationwide.

Rate increases remain an important strategy to improving provider participation in Medicaid, particularly in primary care where reimbursement is lower than for specialty care. Further, primary care providers report that in addition to positively impacting access to care for new and current Medicaid enrollees, rate increases are the most successful strategy to encourage providers' willingness to participate in Medicaid. Based on these findings, the following recommendations were provided to the Legislature:

- Increase primary care rates.
- Explore opportunities to improve timely primary care provider payment.
- Streamline the administrative process.
- Identify options to reduce the financial risk of value-based payment arrangements for primary care providers and critical access services in underserved and rural areas.

Primary care and behavioral health reimbursement enhancement, 2021-2023

The Operating Budget for the 2021-2023 biennium (SB 5092) allotted funds for fiscal years 2022 and 2023 for HCA to implement enhanced Medicaid reimbursement rates in an effort to maintain and increase access for primary care services for Medicaid-enrolled patients. The rate increases apply to both FFS and managed care and are consistent with the temporary rate increase provided under the ACA in 2013 and 2014. The statute directs that:

- Medicaid payments for adult primary care services be at least 15 percent above rates that were in effect on January 1, 2019.
- Medicaid payments for pediatric primary care services be at least 21 percent above rates that were in effect on January 1, 2019.
- Medicaid payments for pediatric critical care, neonatal critical care, and neonatal intensive care services be at least 21 percent above rates that were in effect on January 1, 2019.
- Certain family planning codes at Title X clinics be increased by at least 162 percent.
- A two percent increase be provider for all services paid through the behavioral health portion of managed care capitation rates relative to the reimbursement levels in place as of April 1, 2021.[152]

Rate enhancement for behavioral health, 2021-2023 supplemental operating appropriations (2022)

SB 5693 allotted funds to implement a seven percent increase to Medicaid reimbursement for community behavioral health providers contracted through MCOs to be effective January 1, 2023. [153] The rate increase must be implemented to all behavioral health inpatient, residential, and outpatient providers contracted through the Medicaid MCOs. HCA must employ mechanisms allowed under federal Medicaid law to ensure the funding is used by MCOs for a seven percent provider rate increase.[154]

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[152] MCO contract subsection 5.20.5: The Contractor will increase provider reimbursement rates by two 2 percent effective April 1, 2021, for providers that deliver contracted Behavioral Health services as described in subsections 17.1.2, 17.1.4.3, 17.1.4.4, 17.1.4.5, 17.1.4.6, 17.1.14, 17.1.15, 17.1.16, 17.1.41, and 17.1.42 of the contract. The Contractor will pay providers that provide Behavioral Health services to patients in primary care settings at a rate no less than those published by HCA for its FFS Mental Health and Psychology Services. The Contractor will also pay providers that provide the following services at a rate no less than those published by HCA for its FFS Physicians Services: 90832, 90833, 90834, 90837, H0004, H0036, H2015, H2021, H0023, 90836, 90838, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171, 90845, 90846, 90847, 90849, 90853, 90785, 90791.

[153] Engrossed Substitute Senate Bill 5693. 2022. Section 215(58) https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Passed%20Legislature/5693-S.PL.pdf?q=20220311101341

[154] As intended under HB 2584. 2020 https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/2584.SL.pdf?q=20220405103230

Rate enhancement for adult dental services, 2021-2023 operating appropriations and supplemental operating appropriations (2022)

SB 5092 allotted funds to maintain and increase access to adult dental services under FFS Medicaid up to 100 percent above existing Medicaid rates beginning July 1, 2021.[155] The 2022 supplemental operating budget continued to fund these rate enhancements.[156] To implement these rate increases, the Legislature designated $10,695,000 of the General Fund—State (GF-S) for fiscal year 2022, and $10,695,000 GF-S for fiscal year 2023, and $54,656,000 of the General Fund—Federal (GF-F).

Rate enhancement for children's dental services, 2021-2023 supplemental operating appropriations (2022)

The rate enhancements allotted only for adult dental services in the 2021 operating budget (SB 5092) highlighted the differences in payment for children compared to adults. For example, FFS rates for children's dental procedures had not changed since 2009. The costs of technology for some procedures exceeded provider rates which further decreased dental providers' willingness to serve children enrolled in Medicaid. For the 2022 legislative session, the Arcora Foundation advocated to increase all children's dental rates.

During the same session, HCA also asked the Legislature to increase reimbursement rates to match adult rates for diagnostic and preventive dental procedures.[157] The 2022 supplemental operating budget (SB 5693[158]) allotted $10,406,000 GF-S and $10,715,000 GF-F to maintain and increase access for children's dental services under FFS Medicaid beginning January 1, 2023, as follows:

- Increase the rates for codes for the access to baby and child dentistry (ABCD) program by 40 percent.
- Increase the rates for codes for children's dental program rates for individuals ages 0-20 years who have a corresponding ABCD code to the current ABCD code rate, plus an additional 10 percent rate increase.
- Increase the rates for codes for children's dental program rates for individuals ages 0-20 years without a corresponding ABCD code to 70 percent of the Medicaid FFS rates for adult dental services in effect on January 1, 2022.
- This increase does not apply to codes with rates already greater than 70 percent of the adult dental services rate.

Payment rate modeling

As directed by the Legislature in 2022, HCA analyzed the fiscal impact of raising Medicaid rates to 80 percent of Medicare. Due to previous analyses of the impact of increased rates on provider participation, there is an expectation that access to care and utilization would increase as a result of a rate increase.

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[155] All but two adult dental codes received rate enhancements, including D1516 and D1517. Engrossed Substitute Senate Bill 5092. 2021. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Passed%20Legislature/5693-S.PL.pdf?q=20220311101341

[156] Engrossed Substitute Senate Bill 5693. 2022. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5693-S.SL.pdf?q=20220830154538

[157] The set of diagnostic codes involve x-rays to help compensate for the expense of technology that is now standard of care for taking x-rays. Another set of codes are preventive which will incentivize providers to do more preventive care.

[158] Engrossed Substitute Senate Bill 5693. 2022. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Passed%20Legislature/5693-S.PL.pdf?q=20220311101341

While it may initially seem relatively simple to increase Medicaid provider rates to a percentage of Medicare rates, there is great complexity and difficulty in matching rates due to the difference in the respective payers' case mix,[159]as well as differences in payment methodology.[160] Additionally, several services provided under Washington's Medicaid do not have Medicare equivalent rates, which can range from a few codes in a program to an entire program.[161]

Methodology

The analysis did not include Medicaid services provided by state agencies other than HCA. [162] Expenditure amounts were based on fiscal year 2023 projected costs.[163] The ratio of FFS Medicaid to Medicare was based on a 2016 report published by the Kaiser Family Foundation. The report estimated the average ratio of FFS Medicaid rates to Medicare rates in Washington's Medicaid program to be 71 percent, which was assumed a reasonable approximation for this high-level estimate.

Findings

The analysis found that the total fiscal impact for state fiscal year 2023 to increase physical health services rates only, with some exclusions to 80 percent of what Medicare pays would be approximately $864 million.[164] The GF-S portion of the cost impact is approximately $271 million.

Potential legislative pathways

As demonstrated by the results of HCA's financial modeling, the costs associated with increasing Medicaid rates for most physical health services, not including dental, long-term care, or behavioral health services, covered by Medicare to 80 percent of Medicare would cost the state an additional $271 million GF-S per year.[165 & 166]

However, research shows that temporary rate increases do not translate to improved provider participation in Medicaid or improved access to care. Additionally, attracting more providers to participate in Medicaid may require both payment rate increases and administrative simplification. Therefore, efforts

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[159] Case mix is a measure used by the Centers for Medicare and Medicaid Services (CMS) to determine hospital reimbursement rates for Medicare and Medicaid enrollees and reflects the diversity, complexity, and severity of patient illnesses treated.

[160] Though Medicare providers must stay within payment rates under the CMS physician fee schedule, each provider has their own rate based on their cost of providing care.

[161] Hospitals are paid differently in Medicare than Medicaid. Medicare uses Medicare Diagnosis Related Groups (MS-DRG), which provides a means of relating a hospital's patient case mix to the costs incurred by the hospital. Medicaid uses All Patient Refined – Diagnosis Related Groups (APR-DRG), which expands the basic DRG structure, but also address patient differences relating to severity of illness and risk of mortality in addition to resource utilization. For facility outpatient services, Medicare uses Ambulatory Patient Classifications (APCs), whereas Medicaid uses the Enhanced Ambulatory Patient Group (EAPG). Changes to rates would reportedly affect supplemental payments received by hospitals currently.

[162] The analysis did not include the amounts spent on services provided to Medicaid enrollees by the Department of Social and Human Services (DSHS) or the Department of Corrections (DOC), for example, long-term care services provided by DSHS.

[163] Health Care Authority. Financial Services Division. February 2022 Expenditure Forecast, version D05 M01.

[164] The following forecast services were not included: Pharmacy related forecast services; Dental Services; Durable Medical Equipment; Transportation Services. Community Behavioral Health (CBH) services were excluded from this analysis because many of these services are not currently covered by Medicare. Medicaid payment rates are often higher than Medicare for those outpatient behavioral health services that are covered by both payers.

[165] The financial analysis provides the estimated cost impact of increasing provider payment rates for services also covered by Medicare and does not account for any impact from rate increases for the excluded services.

[166] It is unknown what savings will be generated. Research has demonstrated that permanently increasing Medicaid rates will likely improve physicians' participation in Medicaid which may improve access to care, reduce health disparities for lower-income individuals.

aimed to improve provider payment equity as well as access to care for Medicaid enrollees require a long-term strategic approach.

The Commission recognizes the difficulty in implementing increased Medicaid payment rates for all providers and services. However, it may be more feasible to remain consistent with the Legislature's selected areas of focus over the past several years to develop approaches to achieving the long-term goal of increasing Medicaid payment rates that are 80 percent of Medicare, such as increasing adult primary care, behavioral health, and dental rates.

Continue enhancing primary care by increasing adult primary care rates to match pediatric primary care rates

Primary care emphasizes health promotion and prevention and is proven to be an equitable, cost-effective, and efficient approach to improve mental and physical health and social well-being.[167] The goals of primary care also align with those of universal health coverage to ensure equitable access to affordable, high-quality care for everyone. However, primary care is drastically underfunded in the U.S., limiting the potential of primary care to achieve cost savings and quality improvements.

In Washington, rates for pediatric primary care services under both Medicaid FFS and managed care currently average 83 percent of Medicare.[168] However, adult primary care rates for the same services average just 67 percent of Medicare. Payment rates that differ, depending on a patient's age necessitate having two different provider fee schedules, often leading to confusion for providers as well as adding administrative complexity and waste. Increasing rates for adult primary care to match the rates for pediatric primary care would ensure that all primary care rates average at least 80 percent of Medicare.

However, it is important to secure permanent rate increases for these important services, as research shows that temporary rate increases have not translated to improved provider participation in Medicaid or improved access to care for Medicaid enrollees. Equalizing rates for adult and pediatric primary care aligns with the goals of a universal health care system in two ways.

First, this streamlines health care administrative processes and reduces administrative waste. Equalizing rates will eliminate need for two separate provider fee schedules, which may reduce administrative costs, complexity, and waste, and may help to avoid confusion for providers. This may also increase the likelihood that more primary care providers will participate in Medicaid, as providers cite administrative complexity and low payment rates as barriers to their participation.

Second, increased primary care provider rates may improve health equity for patients. With permanent rate enhancements for these important services, providers may be more likely to accept new patients and continue to care for established Medicaid patients, likely improving access and potentially health outcomes for Medicaid enrollees.

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[167] Primary Health Care. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/primary-health-care
[168] HCA estimated rates.

Primary care payment rate modeling and findings

As directed by the Commission, HCA analyzed the fiscal impact of raising adult primary care rates to match pediatric primary care rates.[169] The rate change is assumed to go into effect on January 1, 2024, which leads to only six months of impact for state fiscal year2024. The analysis found that the total fiscal impact for state fiscal year 2024 to increase adult primary care rates to match pediatric primary care rates would be approximately $54,129,153. The GF-S portion of the cost impact is about $13.67 million. For state fiscal years 2025-2027, the total fiscal impact of increasing these rates would be $108,258,307. The GF-S portion of the cost impact is $27,333,999.

Continue advancing access to behavioral health services by increasing behavioral health rates for services that weren't included in recent legislative rate enhancements

Washington's mental health system has struggled to meet the demand for services, particularly amid the COVID-19 pandemic and opioid crisis. Despite recent state efforts to promote access to behavioral health providers and care, rates of mental illness and overdose deaths continue to rise.

Though behavioral health and mental health rates were recently increased by the Legislature, some services were not included in the rate enhancements. For instance, the Applied Behavior Analysis (ABA) program is a covered benefit for Medicaid clients diagnosed with autism spectrum disorder (ASD). The ABA program's rates have not been increased for ASD services for some time.

While the Legislature also recently increased managed care behavioral health rates, FFS behavioral health services were not included in rate increases.[170] Matching Medicaid FFS behavioral health rates to managed care rates aligns with the goals of a universal health care system by reducing barriers to provider participation in Medicaid. Matching rates for FFS and managed care also increases the likelihood that providers will not choose to provide services to managed care enrollees over individuals enrolled in Medicaid FFS.

Matching rates for FFS and managed care behavioral health services may increase equitable access to services for Medicaid enrollees and advance the goals of a universal health care system. With permanent

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[169] Tribal providers are paid an encounter rate which is set by the federal government, currently at $640 per encounter, and are eligible for differential payments. It is extremely rare for an encounter with primary care services to exceed the encounter rate (less than one percent), and if the received services did exceed the encounter rate, the increased rates would apply. Since an increase in primary care related rates for tribal clinics would not increase costs to the state, and because services rarely exceed the current encounter rate, the rate change for tribal providers was not included in the rate change analysis. Instead, increasing primary care rates would decrease the differential payments proportionately to the rate increase. Total annual fiscal impact was calculated as the difference between the estimated cost at the increased rates and the estimated cost at the current FFS rates. Costs were calculated by re-rating the calendar year 2021 utilization at the proposed rate and at the FFS rates, weighted by the forecasted change in eligible individuals for each forecast Medical Eligibility Group (MEG, for recipient aid category) from CY 2021 to FY 2023. It was assumed that the proposed rates could not be lower than the current reimbursement rates. If a current or proposed rate was below the observed rate for managed care, then the observed MCO rate was used in its place. Federal fiscal impact was calculated as the estimated fiscal impact multiplied by the average FMAP for the relevant forecast MEG.

[170] Fee-for-service behavioral health care rates for higher acuity care.

rate enhancements for these important services, providers may be more likely to accept new Medicaid patients, likely improving access and, potential health outcomes for Medicaid enrollees.

Behavioral health payment rate modeling and findings

As directed by the Commission, HCA analyzed the fiscal impact of raising Applied Behavior Analysis (ABA) and selected Behavioral Health FFS reimbursement rates to match managed care.[171] The analysis found that the annual total fiscal impact to increase FFS behavioral health to current managed care rates would be approximately $1,618,796. The GF-S portion of the cost impact is approximately $462,580.

Continue enhancing dental care by increasing dental rates

The Commission supports the Legislature's recent efforts to increase Medicaid dental rates for both children and adults to maintain and increase access to dental services. The Commission also supports continuing the pathway to increasing children's dental rates across all codes and ensuring that adult and children's dental rates are sufficient to increase provider participation.

Summary

The COVID-19 pandemic exposed health disparities and health care disparities stemming from past and enduring inequitable policies and practices in and outside of the health care system. Enhanced federal Medicaid funding and enrollment protections under the PHE have helped to improve access to care by expanding and protecting Medicaid coverage and reducing the number of uninsured individuals in Washington. Improving access to primary care, behavioral health services, and dental services are particularly important to building upon this coverage expansion, improving health equity, and laying a foundation for universal health coverage.[172]

The Legislature recently targeted Medicaid adult and pediatric primary care, behavioral health managed care, and dental services for enhanced payment rates to increase provider participation and improve access to care. This has been a successful strategy to fund rate increases and continuing these efforts may be an interim pathway toward increasing all rates. Building upon the Legislature's strategy to prioritize primary care, behavioral health, and dental services by providing ongoing funding for rate increases may

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[171] Since FFS rates would be adjusting to match the Managed Care average, it was assumed that there would be no managed care fiscal impact. Managed Care Opioid Treatment Program unit costs and other managed care unit costs (ABA excepted) were increased by 32 percent and seven percent respectively over the observed to match the managed care behavioral rate increase expected to go into effect January 2023. Total annual fiscal impact was calculated as the difference between the estimated cost at the increased rates and the estimated cost at the current FFS rates. Costs were calculated by re-rating the CY 2021 utilization at the increased rate and at the current FFS rates, weighted by the forecasted change in eligible individuals for each MEG from CY 2021 to FY 2023. Tribal providers are paid an encounter rate which are set by the federal government, currently at $640 per encounter, and are eligible for differential payments. It is extremely rare for an encounter to exceed the encounter rate (less than one percent), and if the received services did exceed the encounter rate, the increased rates would apply. Since an increase in behavioral health related rates for tribal clinics would not increase costs to the state, and because services rarely exceed the current encounter rate, the rate change for tribal providers was not included in the rate change analysis. Instead, increasing behavioral health rates would decrease the differential payments proportionately to the rate increase. Utilization from FQHCs, Rural Health Clinics (RHCs), Professional Services Supplemental Payment (PSSP) providers, and Tribal providers was not included in this analysis. All relevant FFS claims were included, including services provided for managed care-enrolled clients.

[172] Once the federal PHE ends, HCA will be redetermining eligibility to determine whether individuals who were eligible for Medicaid coverage during the PHE are still eligible.

be an impactful strategy to improve access to care and health equity for individuals and families covered under Medicaid.

Section 6: transitional solutions

Introduction

Implementing a universal health care system is a long-term strategy for providing universal access to affordable and quality health care. The previous sections of this report primarily focused on universal health care which described the core design elements and key considerations for their development and implementation. The Commission has authority to implement transitional strategies that are within current statutory authority and do not require additional funding. The Commission is also charged with developing intermediate recommendations for coverage expansion consistent with the goals of the universal health care system.

While Washington has made significant gains in reducing rates of uninsured individuals, approximately 4.7 percent of the population remains without coverage as indicated in the most recently available data from OFM. Notably, this does not capture the number of Washingtonians who are considered "underinsured" meaning that, "their insurance did not adequately protect them against catastrophic health care expenses".[173] Furthermore, disparities in coverage persist, particularly among Hispanic populations. As described in the first section of this report, Washington has already undertaken significant efforts and initiatives to expand access to coverage and improve the quality and affordability of health care for Washingtonians. This section incorporates those efforts and options for transitional improvements to the health care system.

This section also outlines a set of options that may expand coverage and improve the quality and affordability of health care in Washington. These options include:

- Supporting new coverage solutions for individuals without federally recognized immigration status
- Implementing the Cascade Care Savings program
- Further aligning public coverage programs
- Establishing a broader set of health care cost targets
- Implementing the Integrated Eligibility and Enrollment Modernization Roadmap
- Examining other transitional activities for alignment across coverage markets as to simplify administration and potentially reduce costs

These options may also serve to lay a foundation for future efforts to establish the universal health care system. These options may also assist with short-term goals to improve the current health care system by increasing access and affordability.

[173] Schoen, C. Insured but Not Protected: How Many Adults Are Underinsured. The Commonwealth Fund. https://www.commonwealthfund.org/publications/journal-article/2005/jun/insured-not-protected-how-many-adults-are-underinsured.

Options for expansion of coverage and subsidy programs

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

Coverage solution for individuals without federally recognized immigration status

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

In May 2022, Washington applied for a 1332 Waiver to allow individuals without federally recognized immigration status to purchase QHPs and qualified dental plans (QDPs) on the Exchange starting in 2024. To further support the affordability of QHPs, Cascade Care Savings (state-based premium subsidies) will be available for individuals earning under 250 percent FPL, regardless of their immigration status, who purchase Silver or Gold Cascade Care plans.

In 2022, legislation passed, and dollars were allocated authorizing HCA to develop a coverage program to provide Medicaid look-alike coverage for individuals without federally recognized immigration status earning under 138 percent FPL. This coverage will be available in 2024 if funding is appropriated by the 2023 Legislature and will expand upon the current coverage options available for this historically underserved and underinsured group.

Together, these changes would ensure that virtually all Washingtonians will be eligible for a coverage option regardless of immigration status with fully or partially subsidized coverage for lower-income individuals. While the Legislature has designated resources to design and build the program, resources have not yet been allocated to pay for the Medicaid look-alike coverage itself.

Cascade Care Savings

Federal premium assistance for ACA Marketplace enrollees has been one of the primary strategies for increasing enrollment and expanding coverage through the federal and state-based marketplaces. The 2021 authorizing legislation directed the Exchange to establish Cascade Care Savings, a state premium assistance program that will begin providing financial assistance in 2023 to Washingtonians with incomes under 250 percent FPL purchasing a Cascade Care plan on Washington Healthplanfinder.

This program maximizes available federal funding by requiring that participants first utilize all available federal subsidies. The legislation appropriated $50 million annually for the Cascade Care Savings program. Subsequently, an additional $5 million annually was appropriated to subsidize individuals not eligible for federal subsidies.

Options for improving affordability

Universal coverage and access are the primary goal of the universal health care system. As part of this goal, the Commission has discussed the need to address and support underinsured populations as the state progresses toward a universal health care system. Reducing underinsurance includes ensuring that affordable coverage meets the health and wellness needs of covered individuals.[174] It also means that services are delivered equitably. In its future work, the Commission will continue to consider short-term options for reducing underinsurance in Washington as a critical step toward universal health care.

It is also important to recognize a critical step to reducing underinsurance is improving the affordability of existing coverage programs. The Commission has considered initial transitional solutions that advance affordability of existing coverage programs and build capabilities that can be leveraged in the future universal health care system.

Further align public coverage programs

As described in Section 1 of this report, Washington has several coverage programs that finance care for a significant portion of Washingtonians, including Apple Health, PEBB, SEBB, and Cascade Care. Each program has a unique design to serve the specific needs of the eligible population as well as to meet federal and state requirements. However, the programs also have many common functions that overlap with core design elements of a universal health care system as described in Section 3 and Section 4 of this report. At the same time, each program manages these functions in slightly different ways by directly performing, procuring, or delegating to health carriers, eligibility and enrollment, provider reimbursement, cost or utilization management, and quality improvement functions.

Currently, some of these functions align across programs. For example, several programs, including Apple Health and Cascade Select, utilize measures for the Statewide Common Measure Set to help manage quality of care delivered and track health plan performance.[175] As an example of a common plan and benefit design, both the PEBB and SEBB programs utilize the Uniform Medical Plan (UMP), a self-insured plan managed by HCA.[176] This results in same benefits and provider networks available to employees served by both programs.

Continuing to align coverage programs may:

- Help to ensure consistent, equitable, and quality coverage across programs.
- Reduce per beneficiary administrative costs for shared functions, for the agencies administering the programs and health care providers.
- Enhance the purchasing power of the state when services are jointly purchased across programs
- Make it easier for third-party vendors or carriers to participate in multiple coverage programs.

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[174] The Commonwealth Fund's measure of underinsurance accounts for an insured adult's reported out-of-pocket costs over the course of one year, excluding premiums and the deductible. Individuals are considered underinsured if: their out-of-pocket costs, over the prior 12 months are equal to 10 percent or more of household income; or their out-of-pocket costs over the prior 12 months are equal to 5 percent or more of household income for individuals living under 200 percent FPL ($25,520 for an individual or $52,400 for a family of four in 2020); or their deductible constitutes 5 percent or more of household income. The out-of-pocket cost component of the measure is only triggered when a plan is used by an individual to obtain health care. The definition does not include individuals who are at risk of incurring high costs because of copayments or uncovered services. U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability. Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020. https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial

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

[176] Washington Health Care Authority, Uniform Medical Plan. https://www.hca.wa.gov/about-hca/uniform-medical-plan-ump

- Simplify the consolidation of design elements as the state progresses toward implementing a universal health care system.

Use ongoing cost analyses to establish health care cost targets

Section 1 described recent initiatives Washington has undertaken to analyze health care cost drivers including HCCTB, PDPTP, PDAB, Value-Based Purchasing, and the OIC's Report on Prior Authorization. While each of these initiatives has a different charge or purpose, they represent a growing analytic capacity within the state to identify costs across payers and to set costs targets.

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

Implement the Integrated Eligibility and Enrollment Modernization Roadmap

In 2021, Washington established the Health and Human Services Enterprise Coalition to review the patchwork of eligibility and enrollment technology platforms that serve the 75 health and human services programs administered by the state.[177] The coalition developed the Integrated Eligibility and Enrollment Modernization Roadmap. This five-year roadmap for implementing an integrated eligibility and enrollment platform in Washington would allow Washingtonians to apply to all available programs in a single streamlined application, receive support through multiple channels, and provide a single eligibility record.[178]

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

Examining other transitional activities

The Commission will consider transitional activities related to effectiveness of services, utilization management, and payment methodologies. This research could inform possible additional transition steps

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[177] Engrossed Substitute Senate Bill 5092. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5092-S.sl.pdf
[178] Integrated Eligibility and Enrollment Modernization Roadmap. https://www.wahealthplanfinder.org/content/dam/wahbe-assets/legislation/WA%20IEE%20Modernization%20Roadmap%20Report.pdf

to be taken with respect to current programs. The following are some examples for further consideration: the Bree Collaborative, the Health Technology Assessment Program, administrative simplification across payers, and value-based payment.

Summary

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

Section 7: Finance

Background

In their 2021 report to the Legislature, the UHC Work Group noted that the health care system's current financing model has grown increasingly costly and fragmented with no common governance structure. Further, pricing of health care products and services is not transparent, and prices for prescription drugs and hospital prices can exceed the rate of inflation.

Though Washington continues to make payment and purchasing reform efforts, the current system's increasing annual costs outpace wage growth and the rate of inflation, which widens gaps in access to health coverage and care. Multiple economic analyses, including analysis conducted by the UHC Work Group, demonstrate that a universal system can improve health equity and access to care, decrease costs, and produce billions in savings per year, all while providing universal coverage.[179]

As described in earlier sections, the UHC Work Group developed three universal health care models through which Washington State could achieve universal coverage. Model A and Model B, as well as universal health care and unified financing models utilized in other countries will be considered to develop the right approach for Washington. The unified health care financing system will be dependent on the universal health care model developed for implementation. Further, transitioning the state to universal health care with a unified financing system is dependent on foundational programmatic, legal, and financial changes and is contingent upon approval from the federal government.

There are multiple sources of funding for health care services in Washington and there are many challenges associated with pooling those funding sources to fund a universal health care system. This section of the report will outline other potential financing considerations that may help inform the design of Washington's unified health care financing system. This section also will summarize the financing landscape of the current health care system and will provide a brief overview of single-payer models in other countries, including the role of government and how universal coverage is financed. Several financing models will be outlined that may inform Washington's unified health care financing system, including:

- A universal purchasing program currently used in Washington.

[179] Senate Bill 5399 https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Passed%20Legislature/5399-S2.PL.pdf?q=20220223093553

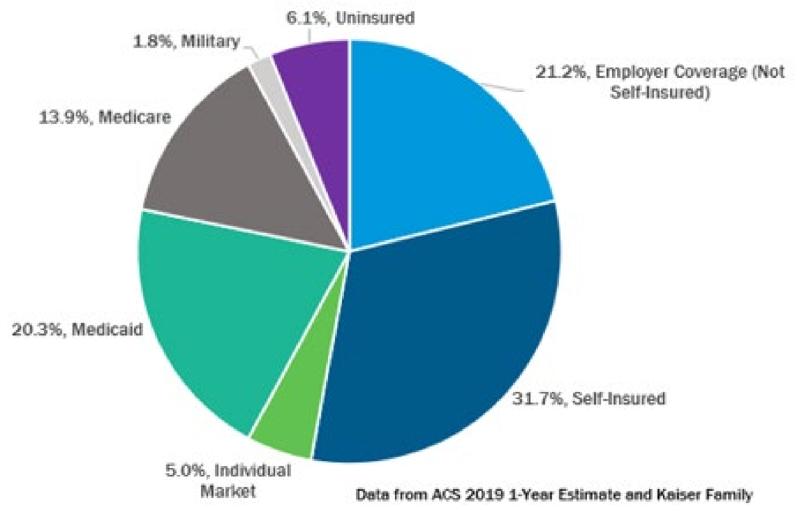
- All-payer rate setting and global budgets used in the state of Maryland.
- Evaluations of single-payer proposals by other states.

Finally, the Commission recognizes that the subject matter expertise of a finance committee will be essential to informing their planning and decision making. As such, the Commission is in the process of creating a Finance Technical Advisory Committee to explore the various barriers and solutions to implementing a sustainable and equitable unified financing system for universal health care in Washington.

Current health care financing landscape

The U.S. health care system funds and delivers care through a mix of public and private insurers and health care providers (See Figure 6). Employer-sponsored insurance, including self-insured and fully insured employers, is the dominant form of coverage in Washington,[180] followed by Medicaid and Medicare.

Figure 6: health coverage in Washington State, 2019



Office of the Insurance Commissioner

Health care systems

The following section will outline components of the publicly funded health care system, including governmental insurance programs and other health systems, including Medicaid, Medicare, Indian Health Services, and the VHA.

Medicaid financial overview

The Medicaid program is administered and jointly funded by states and CMS. The federal government pays states a Federal Medical Assistance Percentage (FMAP) for qualified Medicaid expenditures. FMAP rates are based on each state's per capita income and range from a statutory minimum of 50 percent to a statutory maximum of 83 percent.[181] In Washington State, the FMAP is 50 percent (which was temporarily increased to 56.2 percent during the COVID-19 PHE declaration).[182]

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[180] Pre-COVID-19 pandemic estimate. Health Insurance Coverage of the Total Population 2020. Kaiser Family Foundation. https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[181] Matching Rates. CMS. https://www.macpac.gov/subtopic/matching-rates/

[182] Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, 2022. Kaiser Family Foundation. https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

States have some flexibility in deciding how to fund their share of Medicaid expenditures. Washington uses state general and other funds to cover the non-federal share of Medicaid funding.[183] In 2020, Medicaid accounted for 25 percent of the state's total budget. [184]

Medicare financial overview

Medicare is funded solely by the federal government through two Medicare-designated trust fund accounts. The Hospital Insurance (HI) Trust Fund covers Medicare Part A (hospital insurance) and is funded through payroll taxes, interest earned on trust fund investments, Social Security taxes, and Medicare Part A premiums.[185]

The Supplementary Medical Insurance (SMI) Trust Fund covers Medicare Parts B (medical insurance) and D (drug coverage), and Medicare Program administration. SMI is primarily funded through general revenues, enrollee premiums, and interest earned on trust fund investments. The Medicare employment tax paid by employers and employees also supports federal funding for Medicare. Payment policies and provider payment rates are set by CMS.

Medicare Advantage (Medicare Part C)

Medicare pays private carriers a capitated payment to provide all Medicare-covered services to individuals who choose to enroll in Medicare Advantage. These plans may be subject to premiums, copays/coinsurance, deductibles, and other out-of-pocket costs. Medicare Advantage plans have grown increasingly popular amongst Medicare enrollees.

In Washington, 510,026 Medicare beneficiaries were enrolled in Medicare Advantage plans, accounting for approximately 36 percent of Medicare beneficiaries in 2020, up from 30 percent in 2016. [186] The federal government has also steadily increased spending on Medicare Part C. In 2019, the federal government spent an additional $7 billion on Medicare Advantage plans, with an increase of $321 per person compared to beneficiaries in traditional Medicare in 2019.[187]

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[183] Other state funds and revenue sources can include local funds and provider taxes (as defined by the Centers for Medicare and Medicaid Services). Congressional Research Service. Medicaid Financing and Expenditures. 2020. https://sgp.fas.org/crs/misc/R42640.pdf

[184] Medicaid Expenditures as a Percent of Total State Expenditures by Fund. 2020. Kaiser Family Foundation. https://www.kff.org/medicaid/state-indicator/medicaid-expenditures-as-a-percent-of-total-state-expenditures-by-fund/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[185] Premiums apply only to individuals who are not eligible for premium-free Medicare Part A. Centers for Medicare and Medicaid Services. Original Medicare (Part A and B) Eligibility and Enrollment. https://www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol

[186] Compared to 370, 814 Medicare Advantage enrollees in 2016. Total Number of Medicare Beneficiaries. 2020. Kaiser Family Foundation. https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[187]$11,844 per person in Medicare Advantage compared to $11,523 in traditional Medicare in 2019. Polosky, C. 2021.Payments to Medicare Advantage Plans Boosted Medicare Spending by $7 Billion in 2019. Kaiser Family Foundation. https://www.kff.org/medicare/press-release/payments-to-medicare-advantage-plans-boosted-medicare-spending-by-7-billion-in-2019/

Indian Health Services (IHS)

AI/AN individuals are eligible to participate in all public, private, and state health programs and have treaty rights to federal health care services though HHS.[188] IHS operates within HHS through which funding flows for a system of health services programs and facilities to IHS-eligible users as defined in the Indian Health Care Improvement Act. Tribal Governments have a government-to-government relationship with the federal government.[189] IHS funding is an appropriation and is not mandatory funding. Once funds for a given year are expended, there are no additional funds available.

Due to chronic underfunding of IHS programs and services, IHCPs rely on revenues from third-party billing, including Medicaid, Medicare, and private insurance to keep their clinics and health programs operating. Access to care can vary depending on patients' geographical location; patients often must travel a long distance to receive services.[190]

Military health care

Veteran's Health Administration (VHA)

The Department of Veterans Affairs oversees VHA, which is the largest integrated health system in the U.S. and covers only veterans.[191] The VHA is funded through general taxation as well as through appropriations by Congress. The federal government sets provider rates and negotiates drug prices. Veterans have little to no out-of-pocket costs for services and prescription drugs. Like IHS, access to care can vary depending on patients' geographical location.

TRICARE

TRICARE is a civilian network that provides health care benefits to active-duty service members, including National Guard and Reserve members and their families. TRICARE is administered by the U.S. Department of Defense and is funded through general taxation and appropriations by Congress.[192] TRICARE enrollees have little to no out-of-pocket costs for services and prescription drugs.

Private health care

As described in earlier sections, the majority of insured Americans receive health care coverage through private insurance. The private insurance market includes the group market (including large and small group) and the individual market. The group market is primarily made up of employer-sponsored insurance.[193] The individual market includes health plans purchased directly from a private health carrier. The following section will outline components of the private health insurance market.

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[188] As required by law under 42 CFR 136.61 https://www.govregs.com/regulations/title42_chapterI_part136_subpartG_section136.61

[189]The federal government's provision of health services is derived from federal statutes, treaties, court decisions, executive actions, and the Constitution. Congressional Research Service. 2016. The Indian Health Service (IHS): An Overview. https://crsreports.congress.gov/product/pdf/R/R43330

[190] Medicaid and Chip Payment and Access Commission (MACPAC). Medicaid's Role in Health Care for American Indians and Alaska Natives. Issue Brief. 2021. https://www.macpac.gov/wp-content/uploads/2021/02/Medicaids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf

[191] Those who once served in the military and are no longer in active duty, or who are retired veterans who also meet certain eligibility and health criteria. US Department of Veterans Affairs. https://www.va.gov/health-care/eligibility/

[192] Depending on how service members separated from military active duty, they are eligible for either VA or TRICARE coverage. TRICARE. Ibid.

[193] Employers can be fully insured, where the employer purchases insurance from an insurance carrier, or self-funded, where an employer provides health benefits directly to employees.

Employer-sponsored

The ACA requires employers with fifty or more full-time equivalent employees to provide health coverage to at least 95 percent of its full-time employees and their dependents and that coverage must meet minimum affordability and value standards. Employers in noncompliance are issued fines and penalties by the Internal Revenue Service (IRS).

Compared to public programs, private carriers reimburse at a significantly higher rate. In 2020, The RAND Corporation (RAND) report, *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans*, documented the variation in professional and facility prices for the commercially insured population.[194]

Between 2016 and 2018, the rate at which private insurers and employers reimbursed for services increased by 23 percent. In 2018, across all inpatient and outpatient hospital services, private insurers and employers paid 247 percent above what Medicare would have paid at the same facilities for the same services. Spending for employer-sponsored health insurance has also accelerated for employers and employees and reflects the increase in national health care spending.

Federal Employees Health Benefits (FEHB) Program

This is the largest employer-sponsored group health insurance in the U.S. and provides health care coverage to federal employees, retirees, and their dependents. Over 131,000 Washingtonians are insured through the FEHB Program.[195]

The statute governing FEHB specifies that the federal government and employees or retirees share the cost of health insurance, including premiums, with the federal government contributing the majority portion (72-75 percent).[196] The Office of Personnel Management administers the program and contracts with private health carriers to deliver comprehensive health care services. [197]

PEBB and SEBB programs

Through PEBB, Washington State employees, retirees, and their dependents receive health care coverage, covering over 385,000 Washingtonians.[198] Through SEBB, about 269,000 employees and dependents of Washington's school districts, charter schools, and represented employees of Washington's educational service districts receive health care coverage.[199]

PEBB and SEBB are HCA programs, and HCA is the largest purchaser of health coverage in the state. The PEBB program purchases benefits from private health carriers within the funding approved by the State Legislature.[200]

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[194] Using data from 2016 to 2018, the study evaluated hospital spending from self-insured employers, health plans, and state-based all-payer claims databases from 49 states.

[195] Health Coverage in Washington State. 2017 data provided by the Washington State Office of Financial Management. Economic Opportunity Institute. 2020. https://www.opportunityinstitute.org/research/post/health-coverage-in-washington-state/

[196] Employees of the United States Postal Service have their share of premiums collectively bargained. Blom, K. Cornell, A. Federal Employees Health Benefits (FEHB) Program: An Overview. Congressional Research Service. 2016. https://sgp.fas.org/crs/misc/R43922.pdf

[197] OPM coordinates the administration of FEHB with federal agencies, manages contingency reserve funds for the health plans, and applies sanctions to health care providers according to federal regulations.

[198]PEBB Total Member Enrollment for July 2022 Coverage. https://www.hca.wa.gov/assets/pebb/pebb-enrollment-202207.pdf

[199] SEBB Total Member Enrollment for July 2022. https://www.hca.wa.gov/assets/pebb/sebb-enrollment-202207.pdf

[200] Includes the Uniform Medical Plan, a self-insured health plan offered through PEBB and SEBB and administered by Regence BlueShield and Washington State Rx Services.

PEBB also approves premium contributions for employees, sets eligibility requirements, and approves benefits of all participating health plans. SEBB authorizes premium contributions and approves plan specifications and carrier selection to leverage efficient purchasing through coordination with PEBB.

Individual coverage and Washington's state-based exchange

The ACA requires each state to establish a health insurance exchange where consumers can shop for private health insurance plans through a virtual marketplace.[201] Washington adopted a state-based exchange, making the state generally responsible for performing marketplace functions. Through legislation in 2011, HBE was established as a "public-private partnership separate and distinct from the state" to operate the state-based exchange (SB 5445). Approximately 215,000 individuals receive coverage through Washington's Exchange.

Cascade Care (standard benefit plans and public option)

The Legislature passed SB 5526 in 2019, establishing Cascade Care (standard plans and public option) plan options on the Exchange, beginning in 2021. The goal of the standard benefit design used for standard and public option plans is to make care more accessible. The Cascade Care program does this by lowering deductibles, making cost-sharing more transparent, and providing more services before the deductible as well as enabling consumers to compare plans more easily.

The goal of public option (Cascade Select) plans is to increase the availability of quality, affordable health care coverage in the individual market, and ensure residents in every Washington county have a choice of QHPs. Implementation of the public option is a multi-agency effort involving HBE, HCA, and OIC. As of 2022, 6,335 residents selected public option plans. For Plan Year 2023, public option plans will be available in 34 of 39 counties, up from 25 counties in 2022 and 19 counties in 2021.

SB 5377, passed by the Legislature in 2021, made improvements to Cascade Care and also directed HBE to establish a state premium assistance program linked to Cascade Care plans.

Financing models in countries with universal health care

The U.S. is the only high-income country that does not provide universal coverage to its residents.[202] Compared to the U.S., other high-income countries have reached universal coverage through a more unified financing system while achieving lower health care expenditures and generally better health outcomes. The following section will outline components of single-payer systems as well as regulated multi-payer systems.

Single-payer

SB 5399 directs the Commission to prepare the state for the creation of a universal health care system through a unified financing system, including a single-payer financing system. In January 2022, the Washington State Institute for Public Policy (WSIPP) shared with the Commission findings from their 2019 study and final report to the Legislature entitled Single-Payer and Universal Coverage Systems. While a

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[201] States have the option to develop and host their own exchanges, or let the federal government establish and run exchanges for them. Washington State manages its own exchange.

[202] Commonwealth Fund. 2021.U.S. Health System Ranks Last Among 11 Countries; Many Americans Struggle to Afford Care as Income Inequality Widens. https://www.commonwealthfund.org/press-release/2021/new-international-study-us-health-system-ranks-last-among-11-countries-many

single-payer system would likely reduce overall spending on health care, the financing required would impose large new taxes, as is done in other countries, as the system shifts from a combination of public and private coverage to public coverage.

There are two primary models of single-payer systems: the Beveridge Model and the National Health Insurance Model. In either single-payer model, the government is the only insurer for a standard set of benefits.

The Beveridge Model is used in Denmark, New Zealand, and the United Kingdom.[203] This model creates a national health service where benefits are standardized across the country and the government acts as the single payer, eliminating competition in the market and generally keeping prices low. The government is also active in controlling drug prices, whether through price negotiations with pharmaceutical companies, price caps, or drug formularies among others.

Most physicians and other health care workforce are government employees, and clinics and hospitals are government-owned. Care is usually free at point of service. A U.S. equivalent to this model of single-payer financing is the VHA. In this single-payer model, there is still a role for supplemental private insurance, which can be offered by employers or made available for individuals to purchase. In England's NHS for instance, private insurance typically offers better amenities, faster access to non-urgent care, or choice of specialists.[204] However, there are health equity implications of supplemental private health insurance being available to purchase for more timely care and broader access to providers, as individuals with higher incomes can pay for greater access to resources less accessible to others.

The second is the National Health Insurance Model, which is practiced in Australia, Canada, and Taiwan. This model establishes a national health insurance system with little cost-sharing. Providers are usually private and reimbursed through a tax-financed government plan. In this single-payer model, private insurance can be purchased to gain faster access to care, or improved choice in provider.

In Canada's case, private insurance covers services excluded from universal coverage, such as vision, dental, or prescription drugs.[205] However, the option to purchase complementary private insurance may create inequitable access to services not included under universal coverage benefits. This finance model is similar to the Medicare program in the U.S. where enrollees may also purchase supplemental insurance in addition to their public insurance.

Multi-payer

Most multi-payer systems follow the Bismarck model, where health insurance is mandatory for residents. In this model, Statutory Health Insurance (SHI) is administered by nongovernmental insurers known as "sickness funds," and is funded through premiums.[206] Premiums are calculated as a percentage of income

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[203] Chung, M. Health Care Reform: Learning from Other Major Health Care Systems. Princeton Review. https://pphr.princeton.edu/2017/12/02/unhealthy-health-care-a-cursory-overview-of-major-health-care-systems/

[204] About 11 percent of the population purchases supplementary coverage. Commonwealth Fund. 2020. International Health Care System Profiles. England. https://www.commonwealthfund.org/international-health-policy-center/countries/england#:~:text=Private%20insurance%20offers%20more%20rapid,emergency%20care%2C%20and%20general%20practice.

[205] About 67 percent of Canadians have some form of private coverage, typically through an employer. International Health Care System Profiles. Canada. Commonwealth Fund. 2020. https://www.commonwealthfund.org/international-health-policy-center/countries/canada

[206] In addition to compulsory wage contributions, income-dependent contributions (determined by the government) are paid directly to an individual's sickness fund. In 2019, the average supplementary contribution rate was approximately one percent. International Health Care System Profiles. Germany. 2020. Commonwealth Fund. https://www.commonwealthfund.org/international-health-policy-center/countries/germany

through compulsory payroll deductions by employees and are matched by employers.[207] Some countries have multiple competing insurers as is done in Germany, which helps contain costs by emphasizing managed competition among insurers. Regardless of the number of insurers, the government tightly controls prices for health services. [208]In Germany, SHI funds are non-profit and must accept any applicant, regardless of preexisting conditions or health risk profile.[209]

Individuals with higher incomes often choose to purchase complementary or supplementary insurance policies in addition to SHI for benefits not covered under SHI, or for amenities like private hospital rooms. Some groups are exempt from enrolling in SHI, including high-income individuals who meet a certain income requirement, civil servants, and those who are self-employed. Individuals in these groups may choose to purchase fully substitutive private insurance.[210] However, the federal government regulates private insurance including monthly premiums and provider fees.

Health care providers in Germany are mandated to participate in both SHI and private insurance plans, helping to balance payments from public and private insurance. Out-of-pocket expenses in multi-payer systems vary, though in Germany, most patients enrolled in SHI pay very small co-pays for outpatient or inpatient prescription drugs, medical devices, and hospitalization.

Government role in single and multi-payer universal health care systems

In all universal health care systems, whether single or multi-payer, governments play an active role in the oversight and regulation of health care. Governments regulate insurers, which are non-profit entities in most cases. Additionally, the governments typically determine the standardized benefits packages, provide subsidies for low-income residents, establish prices for drugs and procedures, influence contract negotiations between providers and insurers, set the health care policy agenda, and set health budgets, which may include global budgets for certain providers.

Fees are often determined at the regional or national level through negotiations between providers, insurers, and drug manufacturers. Some governments, including England, set a fixed amount of funding per year for hospitals, known as global budgets, to control health expenditures. Other countries broker collective agreements with providers and insurers to limit cost growth rates.

Taxation in single and multi-payer systems

Universal health care systems are funded mostly through general taxation. However, there may be some out-of-pocket costs paid by consumers. The United Kingdom's NHS single-payer model is funded through general taxation. There, the three main sources of revenue include income tax (accounting for 27.6

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[207] Employees' portion is withheld directly by the employer from the employee's gross salary. The employer is obliged to remit the total contributions to the health insurance carrier on a monthly basis. Working and Living in Germany. 2020. Deloitte. https://www2.deloitte.com/content/dam/Deloitte/de/Documents/tax/Deloitte-Working-Living-in-Germany-2020.pdf

[208] Sickness funds compete for patients namely through deductibles, bonuses, and issues of efficiency. Sickness funds' costs are controlled by prohibiting physicians from charging above a set price for services in the SHI benefit catalog, and by allowing the sickness funds to negotiate drug prices with pharmaceutical manufacturers. The Public-Private Option in Germany and Australia: Lessons for the United States. 2020. Millbank Quarterly Opinion. https://www.milbank.org/quarterly/opinions/the-public-private-option-in-germany-and-australia-lessons-for-the-united-states/

[209] Doring, A. The German healthcare system. 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3405354/

[210] Fully substitutive private insurance covers approximately 11 percent of population. Ibid.

percent of revenue), national insurance contributions (accounting for 20 percent of revenue)[211], and sales tax (accounting for 19.2 percent of revenue).[212] In Canada's single-payer system, national health insurance is funded through earmarked taxes, usually on earned income, which accounts for approximately 30 percent of revenue.[213] Employers in Canada also pay a revenue-based Employer Health Tax that can vary by territory or province.[214]

Multi-payer systems are largely financed through payroll taxes, with contributions from both employers and employees. In France's multi-payer system, social security payroll taxes account for the majority of funding (53 percent), followed by a national income tax on all earnings (34 percent), taxes on the pharmaceutical industry and private voluntary health insurance companies (VHI) (12 percent), and state subsidies (one percent).[215]

Example of models for consideration when transitioning to a universal health care system

Section 3 of this report offered examples of the unique financing approaches utilized in the state of Maryland, including all-payer rate setting and hospital global budgets. Additionally, the Washington Vaccine Association demonstrates a successful purchasing program used to provide universal coverage of vaccines to children in Washington. The following section will outline its funding model.

The Washington Vaccine Association (WVA)

Washington began its Universal Childhood Vaccine Program in 1990 to provide vaccines to all children under the age of 19, regardless of income.[216] Originally, the program was jointly funded by state and federal funds. However, beginning in 2010, the Legislature eliminated state funding for the program due to the state budget deficit. In the 2010 legislative session, Governor Gregoire signed into law HB 2551 that preserved the state's universal vaccine purchase program and established the Washington Vaccine Association as a new entity.

WVA is a non-profit consortium that collects funds from health carriers and TPAs through mandatory assessments to cover the cost of vaccines for all children under the age of 19. [217] With funds collected from the assessments, the DOH can purchase vaccines from the U.S. Centers for Disease Control and Prevention at volume rates and deliver to providers at no cost.

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[211] National Insurance is a payroll tax paid by employers and employees.

[212] Other revenues include tobacco duty (1.3 percent), alcohol duties (1.7 percent), council tax (4.9 percent), business rates (4.2 percent), and all other taxes collected by Her Majesty's Revenue and Customs (21.1percent). RAND Europe. Research Brief. Options for Funding the NHS and Social Care in the UK. https://www.rand.org/content/dam/rand/pubs/research_briefs/RB10000/RB10079/RAND_RB10079.pdf

[213] Canadian residents pay a provincial income tax in addition to the federal income tax. Rates and tax brackets may vary by territory or province. https://www.canada.ca/en/financial-consumer-agency/services/financial-toolkit/taxes-quebec/taxes-quebec-2/5.html

[214] Ontario Employer Health Tax. https://www.ontario.ca/document/employer-health-tax-eht#:~:text=Employers%20have%20to%20pay%20Employer,of%20the%20employer%20in%20Ontario

[215] International Healthcare System Profiles. France. Commonwealth Fund. 2020. https://www.commonwealthfund.org/international-health-policy-center/countries/france

[216]Washington Vaccine Association Financial Statements. Years Ended Jun 30,2021 and 2020. https://wavaccine.org/wp-content/uploads/2021/11/Washington-Vaccine-Association-Financial-Statements.pdf

[217] Pursuant to RCW 70.290.075, if the clients represented by the TPA offer private health plan or self-funded employer plan coverage that might include vaccine material being provided to patients under the age of 19, then both state based and out-of-state TPAs are required to register with the Washington Vaccine Association. https://wavaccine.org/faqs/

The WVA funding model

- Each month, DOH fulfills enrolled providers' vaccine orders.
- Health care providers then submit claims to payers for vaccines administered to insured children, at no charge to patients.
- Health plans, carriers, and TPAs then pay WVA dosage-based assessments for vaccines.
- On a monthly basis, the association remits the funds from assessments to DOH for pediatric vaccine purchases.

Benefits of the WVA's universal purchasing program

- Providers have no financing costs or risk of loss because they receive pediatric vaccines from DOH and can use their existing billing system to trigger WVA's collection of funding from payers.
- Consolidating ordering, delivery, and storage improves efficiencies for providers.
- Providers have a stable supply of recommended vaccines.
- Health care savings are a result from bulk purchases by DOH of all pediatric vaccines at federal contract rates.
- Centralized vaccine management.
- Reduced barriers to immunizations.

Single-payer financing models proposed by other states

In recent years, RAND evaluated proposals by Oregon and New York to finance their respective health care systems through a single-payer financing approach. Though some of the nuances of their respective proposals differ, RAND determined that in either approach, the new tax structure should redistribute the burden of financing health care to higher-income earners.

RAND noted in both evaluations that the redistribution of who pays for health care may impact the political feasibility of implementing a single-payer model. These proposed single-payer models and their evaluations offer additional considerations in designing a unified health care financing system.

Oregon

In 2017, the Oregon Health Authority sponsored a research study and microsimulation by RAND[218] to review four options for financing health care for state residents. One of the financing models Oregon evaluated was a single-payer option. The single-payer model, as analyzed by RAND, was a state-sponsored plan that would use public financing to provide privately delivered health care for all state residents, including individuals currently enrolled in Medicare and Medicaid and residents without a federally recognized immigration status.

There would be no cost-sharing for those with income under 250 percent FPL. For those with incomes above this level, 96 percent of expenditures (actuarial value), on average, would be covered.[219] There would be no premiums. This option would significantly redistribute the burden of financing health care to

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[218]White, C. Eibner, C. Liu, J. 2017. A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon. RAND. https://www.rand.org/pubs/research_reports/RR1662.html

[219] RAND simulated a variant on the Single Payer option in which households with incomes above 400 percent of the FPL were enrolled in a plan with 90 percent actuarial value (AV) rather than 96 percent AV. Reducing AV for higher-income individuals reduces total system costs by around $600 million and reduces the state financing requirement by around $1.2 billion.

higher-income earners. Hospital, physician, and other clinical services payment rates would be 10 percent below the average rates in the status quo.[220]

This single-payer model would be financed through:

- Income-based state and federal tax payments.
- Pooling state and federal outlays for current public programs.
- Employers with 20 or more employees would no longer make tax-advantaged premium payments and would instead pay a new state payroll tax.

RAND determined that the single-payer approach would reduce public sector costs by 20-50 percent but that the results are sensitive to assumptions including: 1) the insurance operations of PEBB, OEBB (Oregon Educators Benefit), and Oregon's Healthcare Marketplace are largely redundant,[221] 2) a 30 percent reduction in the combined administrative costs of public program operations, and 3) one or more administrative contractors would replace health carriers, agencies, and contractors in program's administration, including claims processing, utilization review, and provider credentialing.

RAND provided these recommendations to Oregon to effectively implement a single-payer plan:

- Arrange discussions with the federal government on the feasibility of the necessary waivers or other federal authorities.
- Seek legal counsel to navigate ERISA (Employee Retirement Income Security Act of 1974) challenges.
- Review provider payment approaches with CMS and seek input from providers on how provider payment changes could be implemented to promote quality of care and maintain sufficient provider engagement. Value-based payment approaches while reducing unnecessary care should be explored.

New York

In July 2018, the New York Legislature considered the New York State Health Act (NYHA), a state-level single-payer health plan that would provide coverage to all state residents regardless of immigration status and transform the state's delivery and financing of health care. The health care system under the NYHA would shift financing away from premiums and out-of-pocket costs toward a tax-based system, significantly redistributing who pays for health care.

The single-payer system as proposed would be financed primarily through taxes including:

- Financing through new trust funds from the federal government in lieu of federal financing for health programs already existing (waivers for Medicaid, Medicare, and ACA requirements subject to federal approval).
- Current state funding for health care programs.
- Revenues from two new, progressively graduated state taxes:

[220] The costs of the Single Payer option vary depending on the generosity of provider payments and on the share of health care expenditures paid by the plan. To quantify the impact of provider payment rates, RAND simulated two variants of the Single Payer option: 1) A low-payment variant in which hospital and physician payment rates were set to equal traditional Medicare. Reducing provider payment rates to this level would exacerbate congestion but would reduce total system costs by nearly $3 billion, and 2) a high-payment variant in which hospital and payment rates were kept equal to the Status Quo. Maintaining provider payment rates at the level of the Status Quo would alleviate some congestion but would increase total system costs by over $2 billion.

[221] The Single Payer option would replace commercial health plans and integrate the Medicaid and Medicare programs, as well as the Marketplace, PEBB, and OEBB.

- A payroll tax paid jointly by employers and employees at 80 percent and 20 percent, respectfully.
- A tax on income not subject to the new payroll tax, such as capital gains, interest, and dividends.

RAND was commissioned by the New York State Health Foundation to assess near-term and long-term impacts of the plan on health care coverage, costs, and spending, among other outcomes.[222] RAND made several assumptions in its analysis, including a possible graduated tax schedule. Compared to the status quo, this schedule would substantially reduce health care payments for lower-income residents, with the highest-income residents paying more. [223]

In their analysis, RAND determined that the NYHA single-payer approach could potentially lower payments amongst most New Yorkers, but that the results are sensitive to assumptions regarding uncertain factors, including:

- The implementation of the program.
- Whether the state could reduce administrative expenses.
- Whether the state is willing and able to negotiate or set price levels and payment rates with providers.
- The response of high-income residents facing new taxes.
- The approval of federal waivers, including waivers to allow federal funds currently paid to the state and its residents to be redirected to the NYHA.
- That provider payments would, at least initially, be made on an FFS basis based on a fee schedule.

Advancing health equity through a unified financing system

The Commission recognizes that financing and coverage policies and structures in the current health care system have contributed to the discrimination and marginalization of individuals with disabilities, low-income individuals, and individuals of color. Further, in the current system, an individual's coverage and access to care is largely determined by how the care is financed.

The development and implementation of a unified financing system to support universal health care may create the opportunity to examine these existing harmful structures and to establish a new system that ensures equity and wellbeing for all Washingtonians, including the health care workforce. In examining the implications of a unified health care financing system on health equity, it also will be important to consider the role, if any, of private health insurance. A unified financing system may help further advance an equitable and transparent finance and delivery system as the state can leverage purchasing power to eliminate price variation and inequitable access to care. [224]

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[222]Liu, H. White, C. Nowak, A. 2018. An Assessment of the New York Health Act. A Single-Payer Option for New York State. Rand. https://www.rand.org/pubs/research_reports/RR2424.html
[223] The NYHA would add new progressively graduated payroll and nonpayroll taxes but does not specify the rates or the degree of progressivity. RAND's analysis assumes one possible tax schedule that would reduce payments for the majority of residents but could lead to tax avoidance and migration among a small number of high-income households facing large tax increases. Ibid.
[224] Single-Payer and Universal Coverage Health Systems: Final Report. 2019. Washington State Institute for Public Policy.

Commission's Charge and Goals

The Commission's authorizing legislation directs the Commission to:

- Create immediate and impactful changes in the health care access and delivery system in Washington.
- Prepare the state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system once the necessary federal authority has become available. The approach for Washington's unified financing system will depend on the universal health care model selected for implementation.

Washington is currently adopting policies and making budget allocations to achieve Model C as considered by the UHC Work Group. Additional universal coverage models will be considered to inform an approach translatable to Washington, including Models A and B,[225] as well as unified financing models utilized in other countries.

The UHC Work Group identified, but did not significantly address, key barriers to implementing Models A and B. One of the greatest challenges to implementing a universal health care model is the cost to establish and administer the model. Though Model A and Model B project cost savings, the cost to implement either model will create a material financial burden to the state.[226]

The UHC Work Group considered other barriers and challenges to implementing Models A and B which will be a part of the focus of the Commission's upcoming deliberations. These barriers include:

- Necessary federal waivers from CMS or Congress to implement a universal program for individuals currently eligible for federal programs or enrolled in employer-sponsored health plans.
- Impact of job loss in eliminating health care functions from the private industry.
- Determining appropriate levels of provider reimbursement.
- Informing and involving the public in policy deliberations, and political opposition to system change.

1. Creation of a Finance Technical Advisory Committee (FTAC)

The Commission created FTAC, which will provide subject matter expertise and advise the Commission on issues related to the development of a proposed unified health care financing system.

2. FTAC's Purpose

FTAC serves at the direction of the Commission. The goal of FTAC is to provide guidance to the Commission in their development of a financially feasible model proposal to implement universal health care coverage. FTAC members will investigate strategies to develop unified health care financing options for the Commission's consideration.

FTAC will be directed by the Commission to carefully consider the interdependencies between necessary components of a unified financing system and other considerations before the Commission. FTAC may be asked to provide pros and cons for each option shared with Commission members. Finally, FTAC will provide guidance and options related to entities responsible for implementation and administration of a proposed unified health care financing system.

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[225] As proposed by the Universal Health Care Work Group.

3. Roles and responsibilities

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

The Commission will direct the work of FTAC including the development of a charter. FTAC members will agree to act in accordance with this charter as a condition of serving on the committee.

4. Committee member qualifications

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

If FTAC discusses the scope of covered services, then participation will be needed by clinicians who understand the benefits of culturally appropriate, evidence-based care and the inequitable biases that may be imbedded in clinical guidelines. All FTAC considerations, including potential benefit design, must be examined through a nondiscrimination lens, with respect to issues like age limitations on benefits and formulary design.

5. Additional subject matter expertise

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

6. Committee appointment

The opportunity to apply for FTAC consideration will be posted to the Commission's webpage. The call for applications will be shared by HCA through a GovDelivery announcement. Applicants will complete a basic application about themselves, their relevant background/expertise, and why they want to participate on FTAC. Applicants will also submit their resume. The posting and opportunity to complete an application will be available for 30 days, which may be extended to 60 days, if needed to allow for additional applicants.

The Commission will appoint nine nominees for FTAC members, which includes one consumer representative, and if possible, reserving at least two spots for two state agencies, which include the Department of Revenue and OFM.

7. Considerations before FTAC

A primary goal of the Commission is to develop a proposed plan for universal coverage with a unified financing system that will greatly simplify the health care system and lead to equitable, accessible, high-quality care for all Washington residents. One of the main goals of FTAC will be to provide guidance to

the Commission. The following are some of the areas that could be assigned to FTAC by the Commission for guidance:

- Revenue goals and projections
- Scope of coverage, benefits, and cost-sharing, including dental and vision
- Development of fee schedule
- Securing federal funds
- ERISA
- Tax structure, including the impact of the tax structure on equity
- Assessing how to include Medicare beneficiaries
- Administrative cost reduction
- Risk management
- Model development process
- Health equity in financing
- Level of reserves and methods of funding
- Cost sharing
- Workforce
- Provider reimbursement
- Medical school, including behavioral health
- Impact of payment model on care quality and equity
- Economic impacts of new taxes
- Care investments, including primary care, behavioral health, community health, and health-related social needs
- Funding for culturally appropriate health care models
- Assessing how federally funded health systems, VHA, and IHS will be included or intersect with the universal health care system
- Financial forecast of changes in demand/utilization, etc.
- Authority and analytic capacity within a new or existing administering agency

Summary

Washington's current health care financing system is costly and complex. The current financing and delivery systems are inextricably linked; an individual's coverage and access to care are determined by the payer or financing source of that coverage.

One of the primary goals of the Commission is to develop a proposed plan for a unified financing system that will lead to equitable access to culturally appropriate care for all Washington residents. The approach for Washington's unified financing system will be dependent on the universal health care model proposed for implementation.

There are multiple sources of funding that pay for health care under Washington's current health care system. The strategy for combining those funding sources will be critical to the implementation and success of the unified health care financing system. This and other challenges associated with maintaining or increasing funding from each funding source will be key considerations before the Commission and FTAC.

The Commission determined that the subject matter expertise of FTAC will be essential to inform decision making and planning. As such, the Commission has begun the process of creating FTAC to explore the various barriers and paths to implementing a successful unified financing system in Washington.

The Commission and FTAC will work together closely to explore unified health care financing systems as proposed by the UHC Work Group and as practiced in other countries. The Commission and FTAC will also examine other feasible paths to implementing a unified financing system that provides equitable, affordable, high-quality care to all Washingtonians.

Conclusion

Washington continues to be a leader in health care reform efforts. The Commission is dedicated to building on this work by ensuring that all Washingtonians have equitable access to culturally appropriate health care and universal coverage. The Commission's authorizing legislation states that subject to sufficient existing agency authority, state agencies may implement transitional strategies that do not require statutory authorization or new funding.

The Commission will pursue the important work to develop a proposed universal health care system. The Commission will also continue to examine the current health care system for opportunities to make immediate and impactful changes that increase access to quality, affordable health care. The Commission aims to explore ways to streamline access to coverage, reduce fragmentation of health care financing, reduce unnecessary administrative costs, reduce health disparities, and consider methods to link residents with their chosen providers.

Appendix materials

The appendices to this report are as follows:

- Appendix A – Universal Health Care Commission members
- Appendix B – Universal Health Care Commission charter and operating procedures draft with comments incorporated, December 20, 2021
- Appendix C – Universal Health Care Work Group report to the legislature, January 15, 2021
- Appendix D – Universal Health Care Commission survey

Universal Health Care Commission Members

Per authorizing legislation, fifteen voting members make up the Commission. Commission members were selected as follows:

- Six members appointed by Governor Inslee.
- One member from each of the two largest caucuses of the House of Representatives, appointed by the Speaker of the House.
- One member from each of the two largest caucuses of the Senate, appointed by the President of the Senate.
- The secretary of the Department of Health, or secretary's designee.
- The director of the Health Care Authority (HCA), or director's designee.
- The chief executive officer (CEO) of the Washington Health Benefit Exchange, or CEO's designee.
- The insurance commissioner, or commissioner's designee.
- The director of the Office of Equity, or the director's designee.

Member	Title	Agency/Organization
Vicki Lowe, Commission Chair	Executive Director	American Indian Health Commission for Washington State
Senator Ann Rivers	Senator, 18th Legislative District	Washington State Senate Republicans
Bidisha Mandal, Ph.D.	Professor	School of Economic Sciences, Washington State University
David Iseminger, J.D., M.P.H.	Director of Employees and Retirees Benefits	Health Care Authority
Senator Emily Randall	Senator, 26th Legislative District	Washington State Senate Democrats
Estell Williams, M.D.	Executive Director	Center for Workforce Inclusion and Health Care System Equity, University of Washington School of Medicine
Jane Beyer, J.D.	Senior Health Policy Advisor	Washington State Office of the Insurance Commissioner
Joan Altman, J.D., M.P.H.	Director of Government Affairs and Strategic Partnerships	Health Benefit Exchange
Representative Joe Schmick	Representative, 9th District	Washington State House Republicans
Karen A. Johnson, M.P.A., Ph.D.	Director	Washington State Office of Equity
Kristin Peterson, J.D.	Deputy Secretary for Policy and Planning	Washington State Department of Health
Representative Marcus Riccelli	Representative, 3rd Legislative District	Washington State House Democrats
Mohamed Shidane	Deputy Director	Somali Health Board
Nicole Gomez, M.P.A.	Co-Founder & Board Secretary	Alliance for Healthier Washington
Stella Vasquez	Director of Program Operations	Yakima Valley Farm Workers Clinic

Universal Health Care Commission
Charter and Operating Procedures
Draft with Comments Incorporated
12.20.2021

The purpose of this charter is to clarify the charge and responsibilities of, and expectations for the Universal Health Care Commission (Commission).

I. Vision and Mission

A. Vision

To increase access to quality, affordable health care by streamlining access to universal health coverage.

B. Mission

The Commission's primary objective is to develop a strategy for implementable changes to the state's health care financing and delivery system to increase access to health care and universal coverage, reduce health care costs, reduce health disparities, improve the health and well-being of patients and the health workforce, improve quality, and prepare for the transition to a unified health care financing system. The Commission aims to achieve this objective by: (1) examining data and reports from sources that are monitoring the health care system; (2) assessing the state's current preparedness for a unified health care financing system; (3) developing recommendations to increase access to health care services and health coverage, reduce health care costs, reduce health disparities, improve quality, and (4) preparing for the transition to a unified health care financing system.

II. Universal Health Care Commission Charge

Engrossed Second Substitute Senate Bill 5399, which passed during the 2021 Washington State Legislative Session, established the Universal Health Care Commission (Commission) to develop a strategy for implementable changes to the state's health care financing and delivery system to increase access to health care services and universal health coverage, reduce health care costs, reduce health disparities, improve quality, and preparefor the transition to a unified health care financing system. The Commission's work is primarily broken into two stages:

1. **By November 1, 2022**, the Commission must submit a baseline report to the Legislature, the Governor, and post the report on the Health Care Authority's website. The report must include:
    a. A complete synthesis of analyses done on Washington's existing health care finance and delivery system, including cost, quality, workforce, and provider consolidation trends and how they impact the state's ability to provide all Washingtonians with timely access to high quality, affordable health care.
    b. A strategy for developing implementable changes to the state's health care financing and delivery system to increase access to health care services and universal health coverage, reduce health care costs,

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reduce health disparities, improve quality, and prepare for the transition to a unified health care financing system by actively examining data and reports fromsources that are monitoring the health care system.

c. An inventory of the key design elements of a universal health care system including: (i) a unified financing system including, but not limited to, a single-payer financing system; (ii) eligibility and enrollment processes and requirements; (iii) covered benefits and services; (iv) provider participation; (v) effective and efficient provider payments, including consideration of global budgets and health plan payments; (vi)cost containment and savings strategies that are designed to assure that total health care expenditures do not exceed the health care cost growth benchmark established under chapter 70.390 RCW; (vii) quality improvement strategies; (viii) participant cost sharing, if appropriate; (ix) quality monitoring and disparities reduction; (x) initiatives for improving culturally appropriate health services within public and private health-related agencies; (xi) strategies to reduce health disparitiesincluding, but not limited to, mitigating structural racism and other determinants of health as set forth by the office of equity; (xii) information technology systems and financial management systems;
(xiii) data sharing and transparency; and (xiv) governance and administration structure, including integration of federal funding sources.

d. An assessment of the state's current level of preparedness to meet the key design elements of a universal health care system (immediately above) and steps Washington should take to prepare for a just transition to a unified health care financing system, including a single-payer financing system. Recommendations must include, but are not limited to, administrative changes, reorganization of state programs, retraining programs for displaced workers, federal waivers, and statutory and constitutional changes.

e. Recommendations for implementing reimbursement rates for health care providers serving medical assistance clients who are enrolled in programs under chapter 74.09 RCW at a rate that is no less than 80 percent of the rate paid by Medicare for similar services.

f. Recommendations for coverage expansions to be implemented prior to and consistent with a universal health care system, including potential funding sources; and

g. Recommendations for the creation of a finance committee to develop a financially feasible model to implement universal health care coverage using state and federal funds.

2. **Following the submission of the baseline report on November 1, 2022**, the Commission will submit annual reports to the Legislature and Governor reviewing the work of the Commission, continue strategy development regarding a unified health care financing system, and begin implementation, if possible.

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a. The Commission will continue developing implementable changes to the state's health care financing and delivery system to increase access to health care services and universal health coverage, reduce health care costs, reduce health disparities, improve quality, and prepare for the transition to a unified health care financing system and implement structural changes toprepare the state for a transition to a unified health care financing systemas well continuing to further identify opportunities to implement reformsconsistent with these goals.
b. Subsequent annual reports beginning on November 1, 2023. The report will detail the work of the Commission, the opportunities identified to advance the Commission's goals, which, if any, of the opportunities a state agency is implementing, which, if any, opportunities should be pursued with legislative policy or fiscal authority, and which opportunities have been identified as beneficial, but lack federal authority to implement.

III. Commission Duties and Responsibilities

A. Membership and Term

There are a total of fifteen commission members. Six members are appointed by the Governor, using an equity lens, with knowledge and experience regarding health care coverage, access, and financing, or other relevant expertise, including at least one consumer representative and at least one invitation to an individual representing tribal governments with knowledge of the Indian health care delivery in the state. One member from each of the two largest caucuses of the House of Representatives, appointed by the Speaker of the House of Representatives. One member from each of the two largest caucuses of the Senate, appointed by the President of the Senate. Additional members include the Secretary of the Department of Health, Administrator of the Health Care Authority, the Chief Executive Officer of the Washington Health Benefit Exchange, Insurance Commissioner, and the Director of the Office of Equity, or their designee. The Governor shall also appoint a chairperson from the members for a term of no more than three years.

The Commission will convene beginning in 2021.

B. Commission Member Responsibilities

Members of the Commission agree to fulfill their responsibilities by attending and participating in Commission meetings, studying the available information, directing the work of advisory committees if any are created, and participating in the development of the required reports, including the November 1, 2022, report to the Legislature and Governor as well as the annual reports thereafter.

Members agree to participate in good faith and to act in the best interests of the Commission and its charge. To this end, members agree to place the interests of the state above any political or organizational affiliations or other interests. Members accept the responsibility to collaborate in developing potential recommendations

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that are fair and constructive for the state. Members are expected to consider a range of issues and options to address them, discuss the pros and cons of the issues or options presented, and deliver a set of recommendations with key conclusions. The Commission should include the rationale behind each recommendation adopted.

Specific Commission member responsibilities include:

1. Reviewing background materials and analysis to understand the issues to be addressed in the review and recommendation processes.
2. Working collaboratively with one another to explore issues and develop recommendations.
3. Attending Commission meetings; and
4. Considering and integrating advisory committee recommendations, if any advisory committees are established, and public input into Commission recommendations as appropriate.

C. Vacancies Among Governor-appointed Commission Members

Vacancies among Governor-appointed Commission members for any cause will be filled by an appointment of the Governor. Upon the expiration of a member's term, the member shall continue to serve until a successor has been appointed and has assumed office. If the member to be replaced is the chairperson, the Governor shall appoint a new chair within thirty days after the vacancy occurs.

D. Role of the Washington Health Care Authority (HCA)

HCA shall assist the Commission and, if created, any advisory committees by facilitating meetings, conducting research, distributing information, draft the reports, and advising the members.

E. Chairperson's Role

The chair will encourage full and safe participation by members in all aspects of the process, assist in the process of building consensus, and ensure all participants abide by the expectations for the decision-making process and behavior defined herein. The chair will develop meeting agendas, establish subcommittees if needed, and otherwise ensure an efficient decision-making process. The chair will also serve as the liaison between the Commission and the Legislature, including presenting the report and recommendations of the Commission to legislative committees.

F. Commission Principles

The principles, listed below, are to guide decision-making during the development and adoption of recommendations by the Commission. The principles can be revised if proposed by the chairperson or by majority of members. The Commission's recommendations will:

1. Support the development of the report due by November 1, 2022, and all subsequent reports, to theLegislature and Governor.
2. Increase access to health care services and universal health coverage, reduce health carecosts, reduce health disparities, and improve quality.

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3. Be inclusive of all populations and all categories of spending.
4. Be sensitive to the impact that high health care spending growth has on Washingtonians.
5. Align recommendations with other state health reform initiatives to lower the rate of growth of health care costs, and
6. Be mindful of state financial and staff resources required to implement recommendations.

IV. Operating Procedures

A. Protocols

All participants agree to act in good faith in all aspects of the Commission's deliberations. This includes being honest and refraining from undertaking any actions that will undermine or threaten the deliberative process. It also includes behavior outside of meetings. Expectations include the following:

1. Members should try to attend and participate actively in all meetings. If members cannot attend a meeting, they are requested to advise HCA staff. After missing a meeting, the member should contact staff for a recording of the meeting, or if not available, then a meeting summary and any available notes from the meeting.
2. Members agree to be respectful at all times of other Commission members, staff, and audience members. They will listen to each other and seek to understand the other's perspectives, even if they disagree.
3. Members agree to make every effort to bring all aspects of their concerns about these issues into this process to be addressed.
4. Members agree to refrain from personal attacks, undermining the process or Commission, and publicly criticizing or misstating the positions taken by any other participants during the process.
5. Any written communications, including emails, blogs, and other social networking media, will be mindful of these procedural ground rules and will maintain a respectful tone even if highlighting different perspectives.
6. Members are advised that email, blogs, and other social networking media related to the business of the Commission are considered public documents. Emails and social networking messages meant for the entire group must be distributed via a Commission facilitator.
7. Requests for information made outside of meetings will be directed to HCA staff. Responses to such requests will be limited to items that can be provided within a reasonable amount of time.

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B. Communications

1) Written Communications

Members agree that transparency is essential to the Commission's deliberations. In that regard, members are requested to include both the chair and Commission staff in written communications commenting on the Commission's deliberations from/to interest groups (other than a group specifically represented by a member); these communications will be included in the public record as detailed below and copied to the full Commission as appropriate.

Written comments to the Commission, from both individual Commission members and from agency representatives and the public, should be directed to HCA staff. Written comments will be distributed by HCA staff to the full Commission in conjunction with distribution of meeting materials or at other times at the chair's discretion. Written comments will be posted to the Commission webpage.

2) Media

While not precluded from communicating with the media, Commission members agree to generally defer to the chair for all media communications related to the Commission process and its recommendations. Commission members agree not to negotiate through the media, nor use the media to undermine the Commission's work.

Commission members agree to raise all their concerns, especially those being raised for the first time, at a Commission meeting and not in or through the media.

C. Conduct of Commission Meetings

1) Conduct of Commission Meetings

The Commission will meet by videoconference or in person at times proposed by the chair or by most voting members.

Most voting members constitutes a quorum for the transaction of Commission business. A Commission member may participate by telephone, videoconference, or in person for purposes of a quorum.

Meetings will be conducted in a manner deemed appropriate by the chair to foster collaborative decision-making and consensus building. Robert's Rules of Order will be applied when deemed appropriate.

2) Establishment of Advisory Committees

The Commission may establish advisory committees that include members of the public with knowledge and experience in health care, to support stakeholder engagement and an analytical process by which key design

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options are developed. A member of an advisory committee need not be a member of the commission.

Meetings of advisory committees will be conducted in accordance with the operating procedures in Section V.

3) **Consensus Process/Voting**
A consensus decision-making model will be used to facilitate the Commission's deliberations and to ensure the Commission receives the collective benefit of the individual views, experience, background, training, and expertise of its members. Consensus is a participatory process whereby, on matters of substance, the representatives strive for agreements that they can accept, support, live with, or agree not to oppose.

Members agree that consensus has a high value and that the Commission should strive to achieve it. As such, decisions on Commission recommendations will be made by consensus of all present members unless voting is requested by a Commission member. Voting shall be by roll call. Final action on Commission recommendations requires an affirmative vote of majority of the present Commission members. A Commission member may vote by videoconference, telephone, or in person.

Members will honor decisions made and avoid re-opening issues once resolved.

4) **Documentation**
All meetings of the Commission shall be recorded, and written summaries prepared. The audio records shall be posted on the Commission's public webpage in accordance with Washington law. Meeting agendas, summaries, and supporting materials will also be posted to the Commission's webpage.

Interested parties may receive notice of the Commission meetings and access Commission materials on the website, or via GovDelivery.

At the end of the process, HCA staff will draft recommendations for which there is consensus and any remaining issues on which the Commission did not reach consensus.

D. Public Status of Commission and Advisory Committee Meetings and Records
The Commission and any advisory committee meetings are open to the public and will be conducted under the provisions of Washington's Open Public Meetings Act (Chapter 42.30). Members of the public and legislators may testify before the Commission upon the invitation of the chair or at the invitation of most of the members of the Commission. In the absence of a quorum, the Commission may still receive public testimony.

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Any meeting held outside the Capitol or by videoconference shall adhere to the notice provisions of a regular meeting. Recordings will be made in the same manner as a regular meeting and posted on the Commission webpage. Written summaries will be prepared noting attendance and any subject matter discussed.

Committee records, including formal documents, discussion drafts, meeting summaries and exhibits, are public records. Communications of Commission members are not confidential because the meetings and records of the Commission are open to the public. "Communications" refers to all statements and votes made during the meetings, memoranda, work products, records, documents, or materials developed to fulfill the charge, including electronic mail correspondence. The personal notes of individual members will be public to the extent they relate to the business of the Commission.

E. Amendment of Operating Procedures

These procedures may be changed by an affirmative vote of most of the Commission members, but at least one day's notice of any proposed change shall be given in writing, which can be by electronic communication, to each Commission member.

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Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Universal Health Care Work Group

Engrossed Substitute House Bill 1109, Section 211, Subsection 57;
Chapter 415, Laws of 2019

January 15, 2021

Appendix C

This report was created at the request of the Washington State Legislature. It contains background information, assessment criteria developed by the Work Group, reform models assessed, Work Group feedback, and Work Group responses to a survey about the models.

The report also includes the Legislature's budget proviso, Work Group charter, and meeting summaries. All materials provided at Work Group meetings are available on the Universal Health Care Work Group page.

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Executive summary

On behalf of the Universal Health Care Work Group, Health Care Authority (HCA) submits this report to the Washington State Legislature, as required by Engrossed Substitute House Bill 1109(57); Chapter 415, Laws of 2019. In collaboration with HCA, the Work Group was staffed by a Health Management Associates (HMA), 3Si, and Optumas project team.

Background and process

In 2019, the Legislature directed HCA to convene a Work Group to study and provide recommendations to the Legislature on how to create, implement, maintain, and fund a universal health care system. The 37 members of the Universal Health Care Work Group included a broad range of stakeholders with expertise in the health care financing and delivery system.

Membership reflected the geographic, socio-economic, ethnic, racial, and gender diversity of Washington's population. The Work Group recognizes that it stands on the shoulders of several generations of leaders, stakeholders, and advocates who have improved Washington's health care system over the past 30 years.

The COVID-19 pandemic has led to Washington's deepest economic crisis since the Great Depression. Skyrocketing unemployment has highlighted the inequities and weaknesses of the current health care system, in which tens of thousands of Washingtonians have no health coverage. Approximately 125,000 undocumented residents lack access to basic care.

Affordable, high-quality care is unavailable to many, and the COVID-19 pandemic has emphasized that these challenges threaten everyone's well-being.

Problems with the current system

The Work Group identified several key issues with the current system:

- Not all Washington residents have affordable access to essential, effective, and appropriate health services. Some residents lack coverage and others are underinsured and cannot afford to seek care.
- Disparities in health outcomes exist among Washington residents, and as with others, are worse on average than in comparative countries.
- Rising and uncontrolled health care prices and spending, along with increasing system complexity, harm local and state governments, the economy, consumers, patients, families, providers, employers of all sizes, and taxpayers.

Defining universal health care

The Work Group defined universal health care to mean that all Washington residents can access essential, effective, appropriate, and affordable health care services when and where they need it. The group discussed goals for a universal health care system across seven areas: access, equity, governance, quality, administration, affordability, and feasibility.

Three models considered

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

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

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

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

Table 1: overview of each model's characteristics

<table>
<tr><th></th><th>Model A</th><th>Model B</th><th>Model C</th></tr>
<tr><td>Populations</td><td colspan="2">All state residents, including Medicaid, Children's Health Insurance Program (CHIP), Medicare, privately insured, undocumented, uninsured</td><td>Undocumented immigrants</td></tr>
<tr><td>Covered benefits</td><td colspan="2">• Essential health benefits, plus vision for all participants
• Dental and long-term care for Medicaid[1]</td><td>Essential health benefits</td></tr>
<tr><td>Cost sharing</td><td colspan="2">• No cost sharing
• Associated utilization changes</td><td>Standard cost sharing</td></tr>
<tr><td>Provider reimbursement</td><td colspan="2">• Reduced pricing variation between populations
• Administrative efficiency
• Increased purchasing power</td><td>Cascade Care reimbursement levels</td></tr>
</table>

[1] Dental for all consumers is priced separately to show incremental cost of dental for non-Medicaid consumers.

Table 2: overview of each model's financial analyses

	Model A	Model B	Model C
Population impacts	• Improved access for the Medicaid population • Improved access for uninsured, undocumented		Assumes commercial utilization
Administration	• State administers • Premiums are exempt from state premium tax • Lower system-wide administrative costs	• Health plans administer • Premium tax applies • Lower system-wide administrative costs	Assumes commercial plan administrative costs
Expenditures for covered populations (in millions)			
Status quo expenditure	$61,418	$61,418	Not available
Model cost estimate	$58,942	$60,634	$617
Implementation year savings	$2,476	$738	N/A

The Work Group discussed that Models A and B are designed to include all residents, while Model C focuses on access and affordability for undocumented individuals. Model C does not attempt to address all uninsured or underinsured.

Work Group members noted that, as it is not a universal program, Model C cannot benefit from efficiencies associated with system consolidation. It also does not address affordability for individuals not eligible for subsidies or who cannot afford current cost sharing. Several Work Group members suggested expanding Model C to include more state residents.

Achieving a vision for a universal health care system

To achieve universal health care will require the Legislature, Governor, state agencies, and a range of stakeholders to engage in a series of staged activities that will likely require many transition steps. This includes choosing one model, defining detailed operational plans, and establishing policies to ensure the health reform goals are achieved.

Some Work Group members noted that while Model C would not deliver universal access or achieve desired health reform goals, it should be a step toward universal health care. Model C would provide coverage for a group with immediate need for coverage while a more comprehensive system was being built.

Work Group members acknowledged the need to "fill in the gaps" and to maintain current coverage as the new system is formally adopted, implemented, and operationalized. Ensuring a smooth transition and avoiding disruptions in coverage for Washington State residents requires concerted effort over time, even in the face of fiscal and political challenges. This concept became part of the example transition plan below.

Developing and implementing a transition plan

The transition plan addresses activities across three work streams:

- Protect coverage and reduce uninsurance.

- Define and implement coverage structure, cost containment strategies, administration.
- Define and implement financing, program standards, and transition actions.

The first step in the transition process would be legislation that commits the state to a universal health care system by a certain date. The second step would be near-term efforts to reduce the number of uninsured state residents. Over the following years, the work to build a universal health care system would include:

- Defining the coverage.
- Financing and program standards.
- Developing a financing plan.
- Building governance and administration structures.
- Implementing and administering the universal health care system.[2]

Addressing equity

Many Work Group members stressed the need for a health care system that increases equity in access, care, financing, and outcomes. They discussed using an equity assessment to methodically evaluate and measure a new system as it is designed and implemented. Such assessments, which are used to identify inequitable policies, procedures, practices and outcomes, are in use in Washington, both in the public and private sectors.

Assuming the proposed state Office of Equity is established, any legislation and subsequent commissions and state agencies working to establish a universal health care system should explicitly involve this office and the Governor's Interagency Council on Health Disparities. Involving these groups and Washingtonians of diverse races, ethnicities, and cultures is needed to ensure that equity is addressed in the design of a new system.

Background

Work Group establishment, composition, and process

Work Group participants

House Bill (HB) 1109 (2019) directed HCA to convene a Universal Health Care Work Group to study and provide recommendations to the Legislature on how to create, implement, maintain, and fund a universal health care system. Working with the HCA, the HMA, 3Si, and Optumas project team staffed the Work Group and conducted research and analysis in support of the Work Group's discussions and this report.

HB 1109 provided direction to HCA about the organizations and people to be included in the Work Group. The legislation identified the following as required stakeholders:

- Consumers, patients, and the public.
- Patient advocates and community health advocates.

[2] An example transition plan is available in Appendix I.

- Large and small businesses with experience with large and small group insurance and self-insured models.
- Labor, including experience with Taft-Hartley coverage.
- Health care providers, including those who are self-employed.
- Health care facilities, such as hospitals and clinics.
- Health insurers.
- The Washington Health Benefit Exchange.
- State agencies, including the offices of Financial Management, the Insurance Commissioner, and the State Treasurer, and Department of Revenue.
- Legislators from each caucus of the House of Representatives and the Senate.

HCA also sought to include individuals who:

- Had experience with health care financing and/or health care delivery (including the Department of Health).
- Are affiliated with Tribal health care organizations or knowledgeable about Tribal Health Care systems and programs in the state.
- Demonstrated a willingness and ability to review background materials.

Additionally, HCA staff made a thoughtful and deliberate effort to ensure that membership reflected the geographic, socio-economic, ethnic and racial, and gender diversity of Washington's population. To identify Tribal members, HCA staff consulted with its Office of Tribal Affairs and Analysis Division and several Tribes across Washington.

More than 85 people applied to serve as a member on the Work Group. The Work Group met nine times between September 2019 and December 2020 to discuss problems with the current system, identify goals, assess options, and develop recommendations.

Project team

To help in this work, HCA selected HMA and its subcontractors 3Si and Optumas through a competitive request for proposal process. The HMA team, which included a professional facilitator, actuarial consultants, and subject matter experts provided health care policy analysis, financial analysis, and project management for HCA and the Work Group. The project team met weekly to discuss the project plan, Work Group and stakeholder feedback, and plan Work Group meetings.

Work Group discussions

When the Work Group began meeting in September 2019, they recognized the diversity of opinions and experiences and understood that the group was formed to include a variety of professional and lived experiences and perspectives.

The Work Group gathered information, discussed goals, developed assessment criteria, and explored potential reform models. The intent of this work was to increase their understanding, identify agreement where it existed, and assess reform options in a way that didn't downplay disagreement.

The Work Group developed assessment criteria through discussions of their visions for a desired end state. The Work Group and staff used these criteria, goal statements, and analyses to develop

this report, which provides insights into the models and an example of the steps needed to develop a universal health care program in the state.

Work Group Charter

To guide the Work Group, HCA and HMA developed a draft Charter, which was presented and discussed during the Work Group's first meeting and finalized by the Work Group at the December 2019 meeting. The Charter includes:

- Work Group origins and charge.
- Membership.
- Members' roles and responsibilities, including the chair, facilitator, and project team.
- Meeting processes and decision making.
- Meeting summaries and communication.

Stakeholders, partners, and public engagement

A critical piece of the Work Group's legislative charge is stakeholder and public engagement. The following fundamental objectives and ideas were discussed during the first Work Group meeting and informed the public and stakeholder engagement plan and engagement activities:

- Inform stakeholders, including the public, about the purpose of the Work Group, developing recommendations for the Legislature and the timeline for those recommendations, and how and when stakeholders and the public can get involved.
- Gather input from stakeholders and the public to inform Work Group deliberations.
- Demonstrate transparency and trustworthiness.

Key audiences for this process and final report include:

- Washington State residents, including consumers of health care, patients, and the public, including unserved and underserved populations.
- Patient advocates and community health advocates.
- Tribal partners.
- Large and small businesses.
- Labor unions.
- Health care providers.
- Health care facilities.
- Health insurance carriers.

More information on stakeholder and public engagement is available in Appendix D.

Impact of COVID-19 in Washington and on Work Group

Uninsurance in Washington during the pandemic

While disparities in access to coverage and care existed prior to 2020, the COVID-19 pandemic highlighted the systemic inequities in both health coverage and access to care in Washington. The pandemic also showed that, when some individuals lack access to affordable care, the health and well-being of all members of the community are threatened.

Many Work Group members and members of the public who engaged through public comment noted that the insurance coverage changes associated with COVID-19 job losses also highlighted the need for action in the state. While access data have not yet been compiled for 2020, Office of Financial Management has produced uninsurance estimates for the state and each county. At the state level, 6.7 percent of consumers lacked insurance pre-pandemic (early 2020).[3] The uninsurance rate peaked at 13 percent the week of May 16, 2020, and as of November 14, it was seven percent.

While most Washington residents have access to free COVID-19 testing and vaccines, many uninsured and underinsured residents may not be aware of this access and avoid seeking care due to fear of testing or treatment costs.[4] Uninsured individuals who may not be aware they can get testing at community health centers are particularly likely to avoid seeking care, which limits the state's ability to control the virus.

Work Group adjustments due to COVID-19

Like most organizations and stakeholder-heavy projects, the spread of COVID-19 impacted the Work Group's schedule and plans starting in late winter/early spring 2020. The meeting scheduled for April 2020 was cancelled. It was not possible to move the meeting to an online venue when so many Work Group members and stakeholders were adjusting to Washington's stay at home order and did not all have the technology to support remote engagement. Subsequent meetings were held remotely via Zoom conferencing technology.

To facilitate a productive meeting with such a large group of participants and observers, the project team made pre-recorded presentations available as "homework" for Work Group members and observers. The team also developed Q&As with responses to Work Group members' questions asked before and after meetings.

Most of the Zoom meetings involved "breakout rooms" to facilitate smaller group discussions. Members of the public could listen to one of the small group discussions and everyone heard recaps at the end of the breakout sessions.

A brief history of health reform in Washington

Washington State has long been a leader in efforts to extend meaningful and affordable coverage and care to more people in the state. As indicated in Figure 1, these efforts have been underway for decades and included multiple efforts to expand coverage for children and low-income individuals.

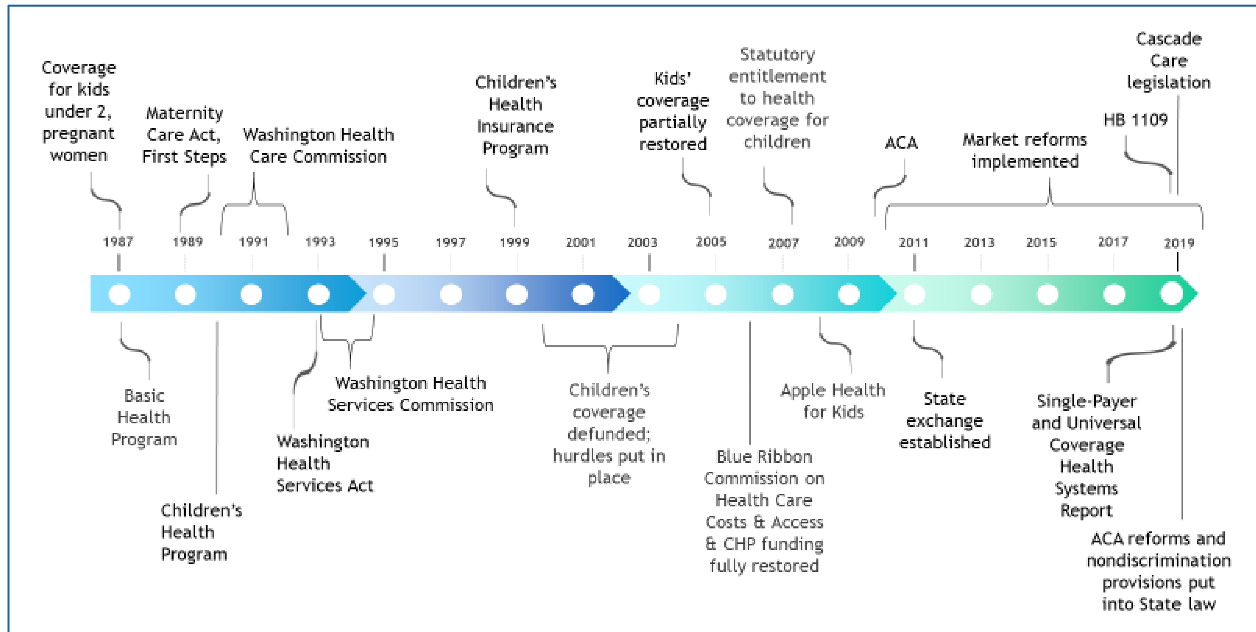
In the decades prior to the passage of the Affordable Care Act (ACA) in 2010 and in the years since, Washington has expanded coverage through the establishment of the:

- Basic Health Plan.
- Washington Health Services Act of 1993.

[3] Washington State Office of Financial Management, Forecasting and Research Division, Health Care Research Center, (Updated) Estimated Impact of COVID-19 on Washington State's Health Coverage, December 2, 2020.
[4] Washington's Health Insurance Commissioner has ordered all regulated health plans to pay for COVID-19 testing and any associated office visits and other tests without any coinsurance, copays, or deductibles. State-regulated health plans include individual, small employer, and some large employer plans. Services include drive-up testing as well as any additional medically necessary testing for the flu or certain other tests for viral respiratory illnesses conducted during the visit. Testing and vaccines are also free for persons with Medicaid or Medicare.

- 2005 legislative action to declare the state's goal of covering all children by 2010.
- Development and operation of a state-based marketplace.
- Implementation of state-level market reforms.

Figure 1: Washington State health reform activities from 1987-2019



Problem statement

The Work Group discussed not all Washington residents have access to effective and appropriate health services now. On average, health outcomes for Washington residents are worse than in nations otherwise comparable to the United States, and Washington residents experience disparities in health outcomes.

Work Group members identified rising health care costs and spending, along with increasing system complexity as harming the state economy, families, employers of all sizes, and taxpayers, and undermining the sustainability of a universal health care system.

At its December 2019 meeting, the Work Group discussed the root causes of uninsurance and underinsurance. Working in small groups before reconvening to compare notes as a large group, the Work Group members laid out a set of problems and issues impacting the state's current health care system.[5] The following reflects Work Group discussions on the root causes of problems with the state's health care system.

[5] Universal Health Care Work Group, Problem Statement and Root Cause Analysis. January 16, 2020.

Problem 1: not all Washington residents have affordable access to essential, effective, and appropriate health services

Work Group members identified problems with access to care, especially the negative impact of cost sharing on affordability of care. In addition, members discussed the issue of networks with limited provider participation and lack of availability of appropriate providers. Provider availability problems were noted to be related to:

- Variance in reimbursement mechanisms and rates.[6 & 7]
- Geography, including particular issues in rural parts of the state.
- Workforce issues, including an inadequate number of health care providers to meet growing demand and the tendency for providers to choose to specialize rather than provide primary care.
- Use of more expensive settings and provider types.

Work Group members raised concerns that because Medicaid and Medicare reimburse less for the same procedures than commercial coverage pays, some residents find it challenging to get services from certain providers.

The group discussed the relative cost of seeking care at a hospital or emergency department rather than a physician's office or primary care clinic. Some members noted that consumers may seek care directly from specialists instead of resolving health concerns with a primary care provider. Others indicated that some specialty care makes more use of expensive procedures and tests.

In addition, Work Group members reported the health care system is not designed around patient needs, including scheduling and transportation. Work Group members added that the events of 2020, including the COVID-19 pandemic and wildfires across the Pacific Northwest, have highlighted and worsened disparities in the state.

Work Group members identified some of the reasons that **some Washington residents lack coverage**:

- Some people earn too much money to qualify for subsidies or publicly funded programs, but cannot afford health care through the Washington Health Benefit Exchange, even with federal premium subsidies.
- Some Washingtonians are not eligible for subsidized health care coverage because of their immigration status. For others, workers with affordable coverage have to pay higher premiums to cover family members.

[6] While state rates vary, at the national level, commercial insurers on average paid 199 percent of Medicare rates (including commercial rates that are an average of 264 percent of Medicare rates for outpatient and 189 percent for inpatient care). Commercial payments are an average of 143 percent of Medicare rates for physician services. Eric Lopez, Tricia Neuman, Gretchen Jacobson, and Larry Levitt, How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature. Apr 15, 2020.
[7] Washington Medicaid rates were an average of 71 percent of Medicare rates in 2016. The U.S. average is 72 percent. Kaiser Family Foundation, Medicaid-to-Medicare Fee Index. 2016.

- Job changes and unemployment can lead workers to lose coverage, interrupting access to existing sources of care.
- Not everyone buys coverage, especially as the ACA mandate to purchase coverage is no longer enforced.

Problem 2: disparities in health outcomes exist among Washington residents, and as with other Americans, are worse on average than in comparative countries

Inequities in access to affordable, quality, and timely health care are rooted in:

- Systemic factors including institutional racism, classism, and other social inequities.
- Unaffordable preventive care, causing people to delay or forgo needed services.
- Inconsistent availability and quality of service providers.
- Lack of culturally attuned care.

Few standards exist for the provision of culturally attuned care, which provider education and training often does not address. Other barriers include a health care workforce that does not reflect the race and ethnic diversity of the state. In addition, many providers only speak English.

Social determinants of health, such as housing, education, and other factors that impact health are not fully addressed or funded at the state or federal level. It is widely recognized that access to social and economic opportunities, availability of resources and supports; community, environmental, and individual safety; and social interactions and relationships impact individual and community health.[8]

However, nonmedical factors are often not taken into consideration. Work Group members identified the siloing of medical and social needs, systemic/institutional racism, and other social inequities as factors impacting residents' health.

The health care system is not person-centered or focused on value. The system incentivizes volume over outcomes and does not support investments in preventive and coordinated health care, behavioral health integration, or end-of-life care. The health care system is complex and difficult to navigate, existing as multiple overlapping systems.

In addition, health care consumers struggle to make informed choices due to a lack of transparency. This makes it difficult to compare providers, treatment options, prices, side effects, or to make informed decisions.

The health care system is not designed to accommodate patient needs. Work Group members identified the business model as a barrier, as providers receive benefit for providing more care but are not generally rewarded for providing better care or improving patient outcomes. Some members pointed out the system includes incentives to treat disease rather than prevent it, while

[8] Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020: Social Determinants of Health.

others noted that reliance on a western model of care has not supported the needs and belief systems of all state residents.

Problem 3: rising and uncontrolled health care prices and spending—along with increasing system complexity—harm local and state governments, the economy, consumers, patients, families, providers, employers of all sizes, and taxpayers

The current health care funding model contributes to uncontrolled spending. Health care financing is fragmented, with no single entity in charge. This allows insurers and providers to avoid costs and risk. In the group market, the funding model is set up to support employers, rather than covered employees and their families.

Prices are not controlled. As noted earlier, the pricing of health care services and products is not transparent. Simultaneously, prescription drug and hospital prices are rising beyond inflation, and duplication of services adds costs. Work Group members noted that residents with complex needs, including a range of physical and behavioral health issues, are not managed holistically. Poor coordination leads to duplication of services and inefficient and ineffective care.

Work Group members noted that administrative overhead is a factor in rising prices, as decentralized and complex administration adds costs and challenges transparency. Others indicated that the prices paid by commercial insurers are also impacted by the system's cross-subsidizing of medical education, the reimbursement of publicly funded care, and care for the uninsured.

Lack of transparency impedes cost control. While there have been efforts to increase transparency regarding the costs and pricing of health care services, limited public information is available. Some transparency efforts have focused on giving consumers information about what providers charge for a given service. Less has been done to clarify underlying costs at a system level.

However, 16 states, including Washington, have established All Payer Claims Databases to collect and analyze health care price and quality information. Some states have taken steps to limit price increases. Additional information on both the actual costs and pricing for services and supplies would greatly enhance the state's ability to establish benchmarks and growth targets. Many players desire to keep information proprietary, which can make such efforts difficult to achieve in a multi-payer system.

Defining universal health care in Washington

As documented in the Work Group's consolidated problem statement, universal health care means:

All Washington residents have access to essential, effective, appropriate and affordable health care services when and where they need it.

This statement is consistent with how the World Health Organization defines universal health coverage: supporting all people and communities in using the full range of health services they need, ensuring individuals receive sufficient quality of care to be effective and that the use of services does not expose the user to financial hardship.[9] This definition stresses that **universal coverage** is designed to ensure individuals' meaningful **access to care.**

The group identified accessible health care as culturally attuned, equitable, and coordinated. Effective and appropriate health care services are comprehensive (including behavioral, oral health, vision, hearing, and end-of-life services) and include preventive, curative, rehabilitative, and palliative care. Affordability concerns the impact on both the individual and on society.

Health reform goals and end-state criteria

The Work Group members were asked to describe what the "end state" would be if a universal health care program was established in Washington. The end-state characteristics were then used to develop overarching goals for health reform and a framework for qualitative assessment criteria that reflected the Work Group's discussions and input. The key goals in this framework include:

- Access
- Equity
- Governance
- Quality
- Administration
- Affordability
- Feasibility

These goals reflect the Work Group discussions and offer a qualitative assessment framework for legislative consideration of reform proposals. While the Work Group was in general agreement on the health reform goals as key concepts important for any chosen reform model's system, they differed on details of focus and priority. In addition, many Work Group members stressed that the details are key—and how the goals are implemented and how criteria are defined will be crucial.

[9] World Health Organization, Universal Health Coverage. January 24, 2019.

Table 3: access criteria

Goal: a system that provides all Washington residents with full access to comprehensive, essential, equitable, effective and appropriate health care services that are affordable to everyone.
• Provides seamless coverage from birth to death (including portability as needed).
• Provides access to comprehensive, essential, effective, and appropriate health services.
• Provides access to affordable care.
• Provides a full range of services (whole-body, holistic health services).
• Promotes high-value care.[10]
• Facilitates the right care, at the right time, in the right setting.
• Promotes preventive health care and utilization of primary care.
• Provides coverage for experimental treatments for rare diseases.
• Allows for complete, adequate, and diverse network of providers.
• Provides access to culturally attuned care.
• Eases health care system navigation for patients and providers.
• Provides psychiatric care in the least restrictive environment necessary.
• Promotes workforce capacity building.

Table 4: equity criteria

GOAL: system promotes equity in access to quality care across race, ethnicity, culture, income, language, geography, gender, disability, and other differences to reduce inappropriate variance in the delivery of care and health outcomes.
• Provides equitable access, based on a person's need and regardless of income, geography, age, gender, disability, or other factors.
• Ensures meaningful access to care in rural and underserved areas and across different cultural, ethnic, language, and other types of communities.
• Promotes individualized and culturally responsive care.
• Increases transparency of health care quality and outcomes.

Table 5: governance criteria

Goal: transparent, accountable, highly responsive governance that maintains Tribal Sovereignty, includes the voices of patients and persons with lived experience, providers and the delivery system, and community-based organizations, and that ensures person-centered care.
• Ensures transparency and accountability in how the model is governed.
• Promotes participation by community-based systems/organizations in governance.
• Respects the importance of informed decision making by the patient.
• Ensures administrative accountability.
• Maintains Tribal Sovereignty and voice in system governance.
• Gives the patient a voice in how the health care system works.

[10] High-value care is a term used by the Institute of Medicine and others to mean care that improves outcomes, quality and value. Committee on the Learning Health Care System in America, Mark Smith, Robert Saunders, Leigh Stuckhardt, and J. Michael McGinnis, Editors, Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. Institute of Medicine of the National Academies. 2013.

Table 6: quality criteria

GOAL: system that promotes the consistent delivery of high-value health services.
• Impact of changes are measurable at system and patient outcome levels.
• Incentivizes or enhances the delivery of high-value health care.
• Includes efforts to improve health care safety and minimize medical errors.
• Supports transparency of health care quality, including reporting of adverse events.
• Reduces inappropriate and unexplained variation in health care delivery in rural and underserved areas and across different cultural, ethnic, language, and other types of communities.

Table 7: affordability criteria

GOAL: system that is affordable to consumers, stakeholders, and the state as a whole.
• Makes system affordable for individuals, families, businesses, taxpayers, and government agencies.
• Implements provider payments that support clinical practice viability and participation in the new program.
• Reduces state expenses and administrative costs relative to current system.
• Includes mechanisms to reduce duplication of services (i.e., via interoperable data systems).
• Includes effective cost controls for all services, including prescription drugs, without compromising access and quality.
• Includes financing that is sufficient, fair, sustainable, and transparent.
• Promotes value-based payments to providers and health systems.

Table 8: administration criteria

GOAL: an administratively simple and efficient system that manages costs effectively and drives out waste.
• Considers impacts of implementation and administration on key delivery system stakeholders, including: ○ Commercial health insurance plans. ○ Medicaid managed care plans. ○ Employers who currently purchase insurance for their employees. ○ Employers who currently **do not** purchase insurance for their employees. ○ Health care providers (including hospital systems and providers). ○ Tribal health. ○ Other stakeholders.
• Supports administrative simplification.
• Facilitates data sharing and data portability.
• Promotes transparency in governance and administration.

Table 9: feasibility criteria

GOAL: a health system that is politically, financially, and administratively achievable and implemented with significant stakeholder engagement and input.
• Addresses implementation challenges due to federal regulations (i.e., federal programs, such as Employee Retirement Income Security Act (ERISA), ACA, Medicare, Medicaid; need for federal waiver, federal regulatory relief, and federal statutory change).
• Addresses feasibility challenges related to political buy-in, implementation, administration, and financing.
• Increases transparency regarding stakeholder interests and priorities.
• Supports phasing/incremental advances toward universal health care.
• Addresses funding sources required for implementation and maintenance.

Quantitative assessment of potential models

The project team used Work Group discussions and input, along with information on international models and prior proposals for universal health care in the United States to develop three draft models for Work Group consideration. This section of the report provides the elements of each of the models and the results of financial analyses comparing the model to the current state.

Data and methodology

Appendix A contains detailed discussion of the data sources and methodology used to develop expenditure and revenue estimates for the status quo and reform models. This includes information on the data sources and methodology:

- Service categories
- Trend factors
- Estimated impacts related to provider administrative efficiencies
- Provider reimbursement rebalancing
- Utilization changes by population
- Impact of eliminating cost sharing
- Impacts of models on purchasing power, program integrity, and plan administration

Essential health benefits defined

The ACA defines essential health benefits (EHBs) as services and supplies falling under ten broad categories:

- Ambulatory/outpatient services
- Emergency services
- Hospitalization
- Pregnancy, maternity, post-partum, and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions to gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The ACA does not include adult dental and vision coverage in EHBs, which is why they are called out separately in Models A and B.

All plans sold on the state and federal marketplaces must provide EHBs as well as any other services or supplies required by the state. Each state defines that plan, which is used as a

benchmark for the state's essential health benefits. The Centers for Medicare & Medicaid Services (CMS) website provides details on Washington's and other states' benchmark plans.[11]

Model A: universal health care, state administration

Under Model A, a single coverage plan is offered to everyone in Washington State, with the state establishing the delivery system rules and administering the coverage. No insurance companies participate, as the state contracts directly with providers and administers all functions currently provided by insurers, including claims payment, utilization management, care coordination, and member and provider services.

Model A: eligibility, covered benefits

Model A covers all state residents without regard to employment, income, immigration status, or documentation. It includes residents who previously had other sources of public or private (individual or group) coverage.

Table 10: assumptions for Model A

Model element	Key assumptions
Populations	• Medicaid • CHIP • Medicare • Private health insurance (employer, state employee, Washington Health Benefit Exchange) • Undocumented Immigrants • Uninsured
Covered benefits	• Essential health benefits as defined by ACA • Dental for Medicaid-eligible only (dental for others is priced separately) • Vision • Long-term care for Medicaid-eligible only
Cost sharing	• No cost sharing • Private insurance utilization changes due to removal of cost sharing
Provider reimbursement	• Reduced pricing variation between covered populations • Administrative efficiency • Increased purchasing power
Population-specific impacts	• Improved access for the Medicaid-eligible population (increased use of some services, decreased hospital utilization) • Improved access and increased utilization for uninsured and undocumented immigrant populations
Administration	• State-administered • Premiums are exempt from state premium tax, impacting cost and revenues • Reflects reductions in system-wide administrative costs

[11] Essential health benefits benchmark plans.

Model A: expenditure projections

Implementation year estimates

The table below shows the anticipated 2022 expenditures with no program changes (status quo) and expenditures under a Model A program. Dollar amounts, shown in millions, are for the implementation year only.

Table 11: Model A calendar year 2022 expenditures – implementation year ($ in millions)[12]

Financing source	Population[13]	Status quo expenditures[14]	Modeled expenditures	Difference
Medicaid	1,704,000	$15,492	$17,253	$1,761
Medicare	1,722,000	$15,478	$17,950	$2,472
CHIP	62,000	$83	$99	$16
Private health insurance	3,674,000	$22,900	$14,889	-$8,011
Uninsured	334,000	$133	$411	$278
Undocumented	124,000	$45	$794	$749
Excluded populations[15]	278,000			
Out-of-pocket expense (excluding Medicare)		$3,046	$3,175	$129
Out-of-pocket expense (Medicare)		$1,156	$1,205	$49
Indian Health Services		$80	$77	-$2
Other private revenues		$3,004	$3,089	$85
Total	**7,897,000**	**$61,418**	**$58,942**	**-$2,476**

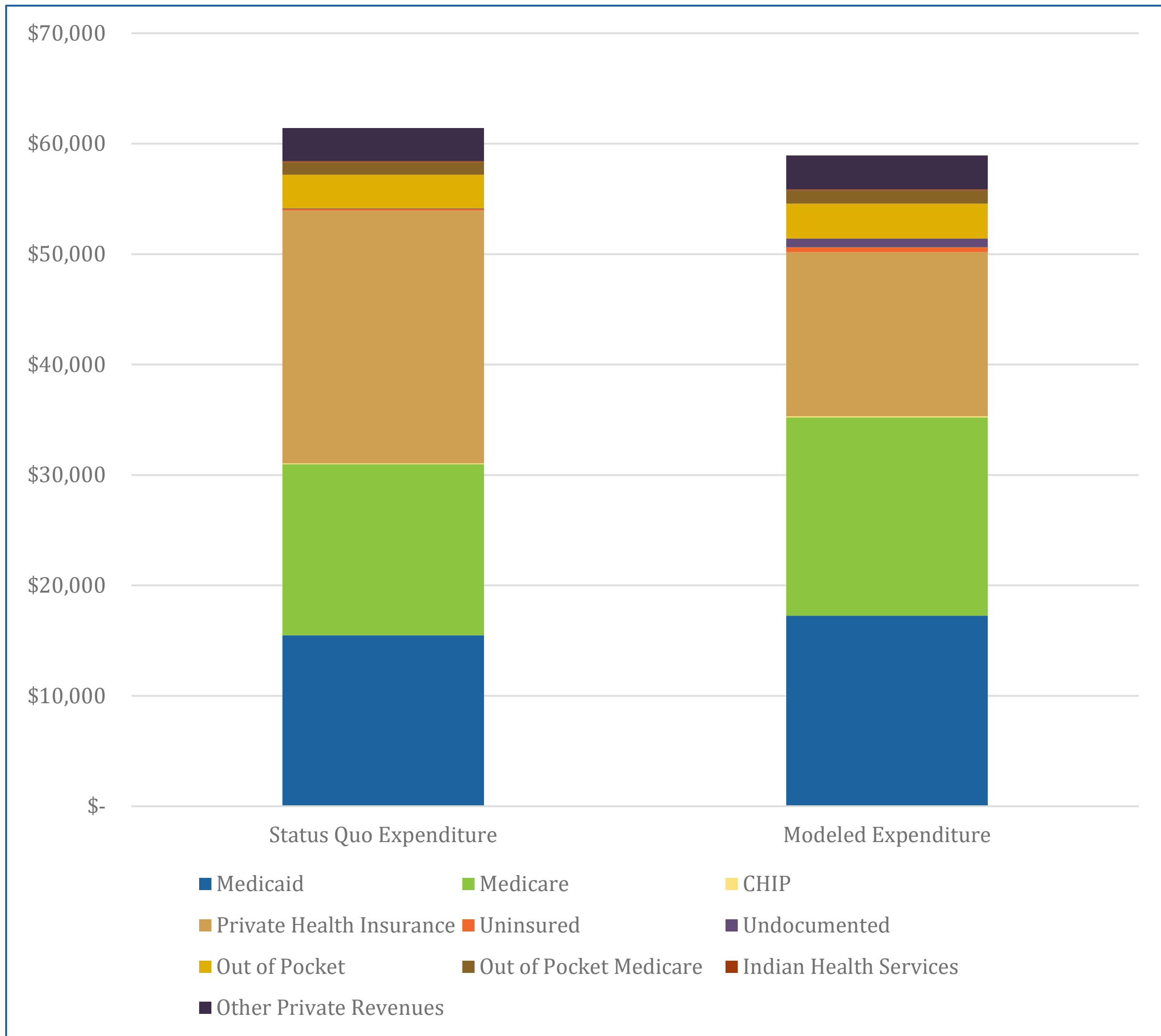
Model A is expected to reduce aggregate system-wide expenditures by **approximately $2.5 billion in the first (implementation) year**.[16] This impact is driven by multiple efficiencies that occur under a single-payer system. These include factors, such as:

- Reduced payer administrative cost.
- Increased state purchasing power.
- Provider administrative efficiencies.
- Program integrity improvements (reducing fraud, waste, and abuse).

In addition, cost savings will likely accrue from other impacts of centralizing the program under the state. For example, under a state-run program, the state can establish regulation that requires increased transparency, which can itself provide cost savings. Other activities, such as establishing maximum prices, support evidence-based care standards and support competition for quality care.

[12] For unrounded expenditures and populations, see Appendix A tables.
[13] Populations are rounded to the nearest 1,000. The Medicaid population totals exclude dually eligible members from the population count. Medicaid reimbursed expenditures for dual eligible persons are reflected in Medicare. All other Medicare-covered expenditures are included in the Medicare row.
[14] Status quo and modeled expenditure totals exclude long-term care and dental for all payers' sources other than Medicaid.
[15] This includes federal employees and active duty military.
[16] Implementation year savings are lower than steady state year savings relative to pre-implementation costs.

Figure 2: status quo vs. Model A – program year 1 expenditures (in millions)



Steady state estimates

The table below shows the anticipated 2022 expenditures with no program changes (status quo) and expenditures under a Model A program. Dollar amounts, shown in millions, show a post-implementation (steady state) year.

Table 12: Model A steady state expenditures – based on 2022 costs ($ in millions)

Financing source	Population[17]	Status quo expenditures[18]	Modeled expenditures[19]	Difference
Medicaid	1,704,000	$15,492	$16,377	$885
Medicare	1,722,000	$15,478	$16,998	$1,520
CHIP	62,000	$83	$93	$10
Private health insurance	3,674,000	$22,900	$13,948	-$8,952
Uninsured	334,000	$133	$384	$250
Undocumented	124,000	$45	$741	$69
Excluded populations[20]	278,000			
Out-of-pocked expense (excluding Medicare)		$3,046	$3,087	$42
Out-of-pocket expense (Medicare)		$1,156	$1,172	$16
Indian Health Services		$80	$73	-$7
Other private revenues		$3,004	$2,899	-$105
Total	**7,897,000**	**$61,418**	**$55,772**	**-$5,646**

Establishing a single provider fee schedule for care to all consumers increases the rate paid to providers for services for previously Medicaid and Medicare-covered individuals. These increases are offset by decreases in the fees paid for care to consumers who were previously commercially insured. This means employer and individual contributions decrease.

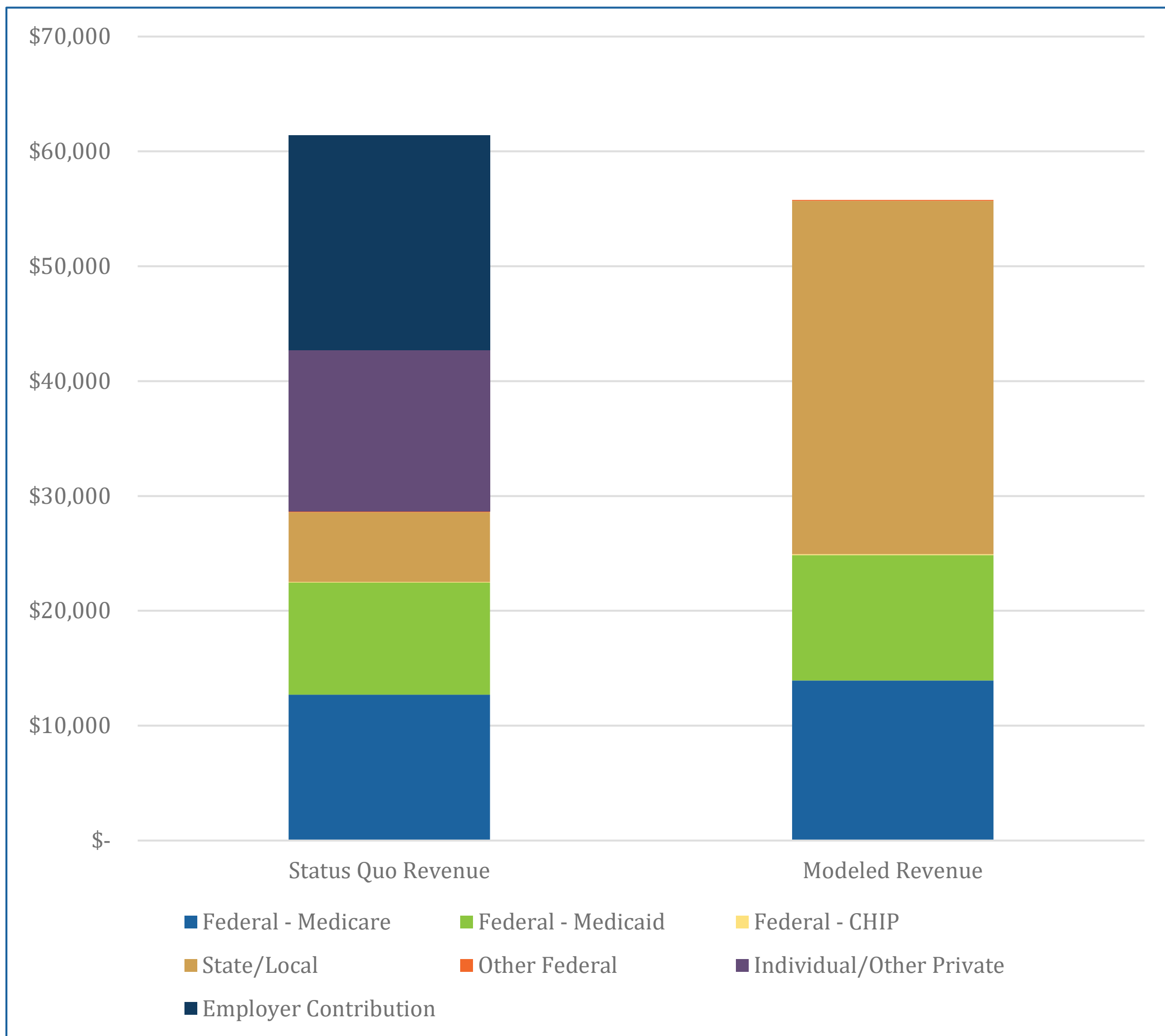
Medicaid is a state- and federal-funded program, with the federal government paying 62 percent of the costs overall.[21] It is unclear if CMS will authorize Medicaid and other public sector programs to increase provider reimbursement compared to current rates.

Additional analysis is needed to understand:

- The impact of lost insurer premium tax revenue.[22]
- The broader economic impact on the state due to industry job loss, tax implications for employers, greater labor mobility, etc.

[17] Populations are rounded to the nearest 1,000. The Medicaid population totals exclude dually eligible (Medicaid-Medicare) members. Medicaid reimbursed expenditures for dual-eligible persons are reflected in Medicare. All other Medicare-covered expenditures are included in the Medicare row.
[18] Status quo and modeled expenditure totals exclude long-term care and dental for all payer sources other than Medicaid.
[19] Estimates are based on all eligible Washington residents participating in Model A.
[20] This includes federal employees and active duty military.
[21] Federal percentage of fiscal year (FY) 2019 benefits and administration in Washington State Medicaid. Congressional Research Service, Medicaid Financing and Expenditures. November 10, 2020.
[22] Premium taxes contribute to the general fund. The Washington Legislature will need to consider the loss of this revenue.

Figure 3: status quo vs. Model A - steady state revenues (in millions)



Model A: estimated multi-year change in program expenditures

The below tables summarizes the total status quo expenditures costs and Model A program costs under different start date assumptions. Weighted average growth rates are based on population-specific national growth weights (from the CMS National Health Expenditures forecast) applied to the modeled estimates of expenditure and enrollment for the relevant populations.

The current 2022 estimates are based on available data from 2018 and include four years of projection. Projections presented in the table become less reliable over time, as it is challenging to predict how dynamics in the health care system will change.

Table 13: five-year growth rates and estimated change in program expenditures based on different starting dates ($ in millions)

Year	Growth rate	Status quo	Implementation year	Differences
2022		$61,418	$58,942	-$2,476
2023	6.2%	$65,226	$62,597	-$2,629
2024	5.9%	$69,055	$66,271	-$2,783
2025	6.1%	$73,243	$70,291	-$2,952
2026	6.2%	$77,804	$74,668	-$3,136
2027	6.0%	$82,479	$79,155	-$3,324

Model A: revenue sources

The below table shows the implementation year (2022) revenue sources supporting the status quo system how those contributions would shift by payer under Model A.

Table 14: Model A calendar year 2022 revenue sources – implementation year (in millions)

Financing source	Status quo revenue	Model A revenue estimate	Difference
Federal share – Medicaid[23]	$12,692	$14,719	$2,027
Federal share – Medicare	$9,760	$11,472	$1,712
Federal share – CHIP	$73	$87	$14
State/local share	$6,052	$32,587	$26,535
Other federal contributions (e.g., Indian Health Services)	$80	$78	-$2
Individual contribution	$14,057		-$14,057
Employer contribution[24]	$18,704		-$18,704
Total	**$61,418**	**$58,942**	**-$2,476**
Dental coverage for populations other than Medicaid[25]			**$3,052**

The below table indicates that in the implementation year, **Model A would cost $2.476 billion less in aggregate than the status quo system**.

Model A establishes a single provider fee schedule for all care. This increases the rates paid by current public sector programs (Medicaid and Medicare, in particular). As both programs utilize federal funding, the model increases the amount of federal funds used compared to the current Medicare and Medicaid programs.

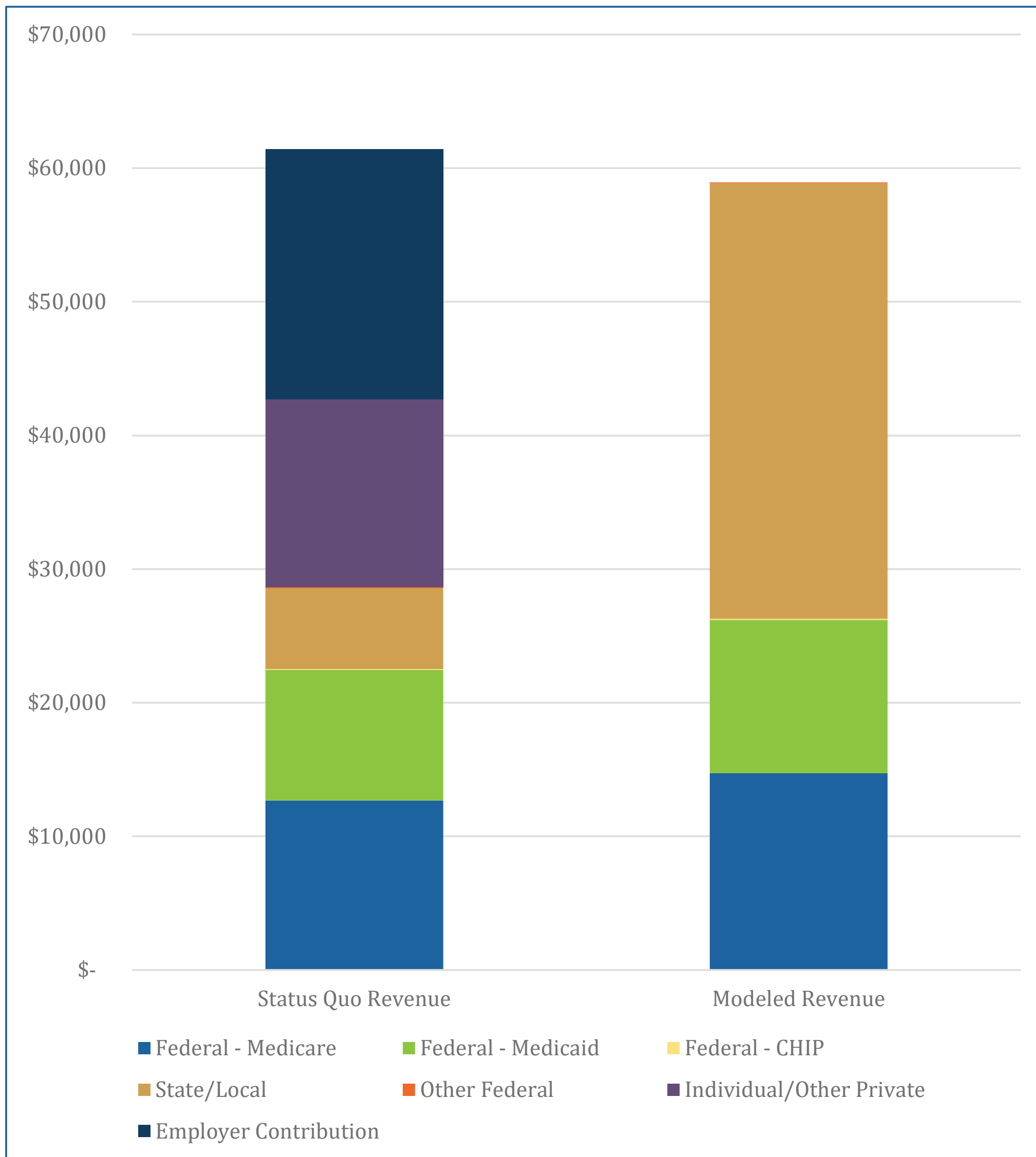
The new single fee schedule is a reduction in rates compared to what is currently paid for by commercial health insurance (employer and individual contributions). As noted previously, it is unknown whether CMS will allow Medicaid and other public sector programs to increase provider reimbursement relative to today.

[23] Medicaid funding is dependent on expenditure authorities awarded to Washington by CMS and changes in federal financial participation rates. Estimates are based on pre-CARES Act federal financial participation rates.
[24] The employer contribution includes state/local funds for public employees.
[25] Additional revenue required for covering dental services for all other populations than Medicaid, federal employees, and military, and assumes "moderate" cost level for dental services.

The Work Group did not address how the state would fund costs needed to replace current individual and employer contributions to coverage. However, the Work Group did discuss that this is an issue requiring specific focus, which could be assigned to a dedicated group as part of the reform development process.

As noted in the expenditure discussion, additional analysis is needed to understand the impact of lost insurer premium tax and of the broader economic impact on the state related to Model A's potential impact on employment, tax implications for employers, greater labor mobility, and related changes.

Figure 4: status quo vs. Model A – program year 1 revenues (in millions)



The following table represents projected calendar year 2022 revenue estimates by financing source. These revenue projections include consideration for cost-shifting dynamics that will occur due to universal health care. Note the following when interpreting the figures in this table:

- The status quo health care system includes significant funding from individual and employer contributions, including state and local public employees. These revenues are assumed to continue under Model A Universal Health Care; however, a mechanism to capture these contributions will need to be developed and implemented by the Legislature. These revenues are illustrated in the "State/local" row for the "Model A revenue estimate" column.
- Model A design includes normalizing provider reimbursement to a single reimbursement schedule. This is a significant change from status quo where reimbursement varies by payer (Medicaid, Medicare, private coverage). Subject to federal approval, this change would increase the amount of federal contributions Washington receives but also increase state general fund obligations.
- Contributions to cover uninsured, undocumented immigrants and out-of-pocket costs are included in "State/local" row for the "Model A revenue estimate" column.
- The revenue model assumes that the state will be successful in preserving federal funding streams for eligible populations, even with the programmatic changes associated with transition to a universal health care model.
- The revised Model A projected expenditures in Table 10 excluded the cost for dental coverage for populations other than Medicaid. The following table separately identifies revenue collections necessary for dental coverage for all populations beyond Medicaid.

Table 15: Model A calendar year 2022 revenue sources – steady state

Financing source	Status quo revenue	Model A revenue estimate	Difference
Federal share – Medicaid	$12,692	$13,938	$1,246
Federal share – Medicare	$9,760	$10,903	$1,143
Federal share – CHIP	$73	$81,984	$8
State/local share	$6,052	$30,775	$24,724
Other federal contributions (e.g., Indian Health Services)	$80	$73	-$7
Individual contribution	$14,057		-$14,057
Employer contribution[26]	$18,704		-$18,704
Total	**$61,418**	**$55,772**	**-$5,646**
Dental coverage for populations other than Medicaid[27]			**$3,052**

Model A: Medicare impact

As the state considers different implementation strategies, some populations will be more challenging to incorporate into the universal health care plan than others. Including Medicare would require CMS to approve a state's request to use Medicare funds in support of its program.

[26] Employer contribution includes state/local funds for public employees.
[27] Additional revenue required for covering dental services for all other populations than Medicaid, federal employees, and military, and assumes "moderate" cost level for dental services.

While Vermont spent many months discussing Medicare participation in its concept for a universal program, no state has gotten CMS to agree. While getting federal approval of a universal care program was especially challenging under the Trump Administration, some Work Group members are hopeful that the Biden Administration will be more open to this kind of effort.[28]

Xavier Becerra, President-elect Biden's choice to be the Secretary of the Department of Health and Human Services supports "Medicare for All" and could approve state requests to include Medicare funds in proposed universal care plans.[29]

The challenge of getting federal approval could result in a phased-in implementation of populations who are eligible for public coverage programs, such as Medicaid and Medicare, or the exclusion of some populations entirely. Excluding one or more populations would impact:

- The total cost of the model.
- Assumptions regarding future state revenue sources.
- Some underlying model assumptions.

If Medicare enrollees were to be excluded, total model costs would be reduced by approximately $15.4 billion. Revenue assumptions change as well. The net effect on the model of removing Medicare is a reduction of $1.5 billion in state funds needed to fund Model A at steady state.

Lastly, removing Medicare alters assumptions that impact other programs as well, such as the level to which reimbursement rates are rebalanced. The table below summarizes the change in assumed reimbursement levels for providers with and without the Medicare-eligible population included in Model A at steady state.

Table 16: reimbursement level target before efficiency adjustments

Service category	Reimbursement as a % of Medicare when Medicare is included in Model A	Reimbursement as a % of Medicare when Medicare is excluded in Model A
Hospital services	125%	150%
Physician and clinical services	111%	114%

Model B: universal health care, delegated administration

As with Model A, Model B establishes a single, state-designed coverage plan available to everyone in Washington State. The state also develops the delivery system rules. Unlike in Model A, Model B insurance companies contract with the state to offer plans to Washington residents.

As they do today, insurers will develop and maintain provider networks and administer some or all of the functions they currently provide, such as claims payment, utilization management, care coordination, and member and provider services.

[28] Virgil Dickson, Verma will reject any single-payer state waivers. Modern Healthcare, July 25, 2018.
[29] Sarah Kliff, Becerra Supports 'Medicare for All' and Could Help States Get There. The New York Times, December 10, 2020.

Model B: eligibility, covered benefits

Model B covers all state residents without regard to employment, income, immigration status, or documentation. This includes residents who previously had other sources of public or private (individual or group) coverage.

Table 17: assumptions for Model B

Model element	Key assumptions
Populations	• Medicaid • CHIP • Medicare • Private health insurance (employer, state employee, or Washington Health Benefit Exchange) • Undocumented immigrants • Uninsured
Covered benefits	• Essential health benefits as defined by ACA • Dental for Medicaid-eligible only (dental for others is priced separately) • Vision • Long-term care for Medicaid-eligible only
Cost sharing	• No cost sharing • Private insurance utilization changes due to removal of cost sharing
Provider reimbursement	• Reduced pricing variation between covered populations • Administrative efficiency • Increased purchasing power
Population-specific impacts	• Improved access for Medicaid-eligible population (increased use of some services, decreased hospital utilization) • Improved access and increased utilization for uninsured and undocumented immigrant populations
Administration	• Administered by managed care plans • Premium tax applies • Reflects reductions in system-wide administrative costs

Model B: expenditures

The below table shows the anticipated 2022 expenditures with no program changes (status quo) and expenditures under a Model B program. Dollar amounts, shown in millions, are for the implementation year only.

Table 18: Model B calendar year 2022 expenditures – implementation year (in millions)[30]

Financing source	Population[31]	Status quo expenditures[32]	Modeled expenditures[33]	Difference
Medicaid	1,704,000	$15,492	$17,748	$2,256
Medicare	1,722,000	$15,478	$18,465	$2,987
CHIP	62,000	$83	$102	$18
Private health insurance	3,674,000	$22,900	$15,316	-$7,583
Uninsured	334,000	$133	$423	$289
Undocumented	124,000	$45	$816	$771
Excluded populations[34]	278,000			
Out-of-pocket expense (excluding Medicare)		$3,046	$3,266	$220
Out-of-pocket expense (Medicare)		$1,156	$1,240	$84
Indian Health Services		$80	$80	-$0.1
Other private revenues		$3,004	$3,178	$174
Total	**7,897,000**	**$61,418**	**$60,634**	**$783**

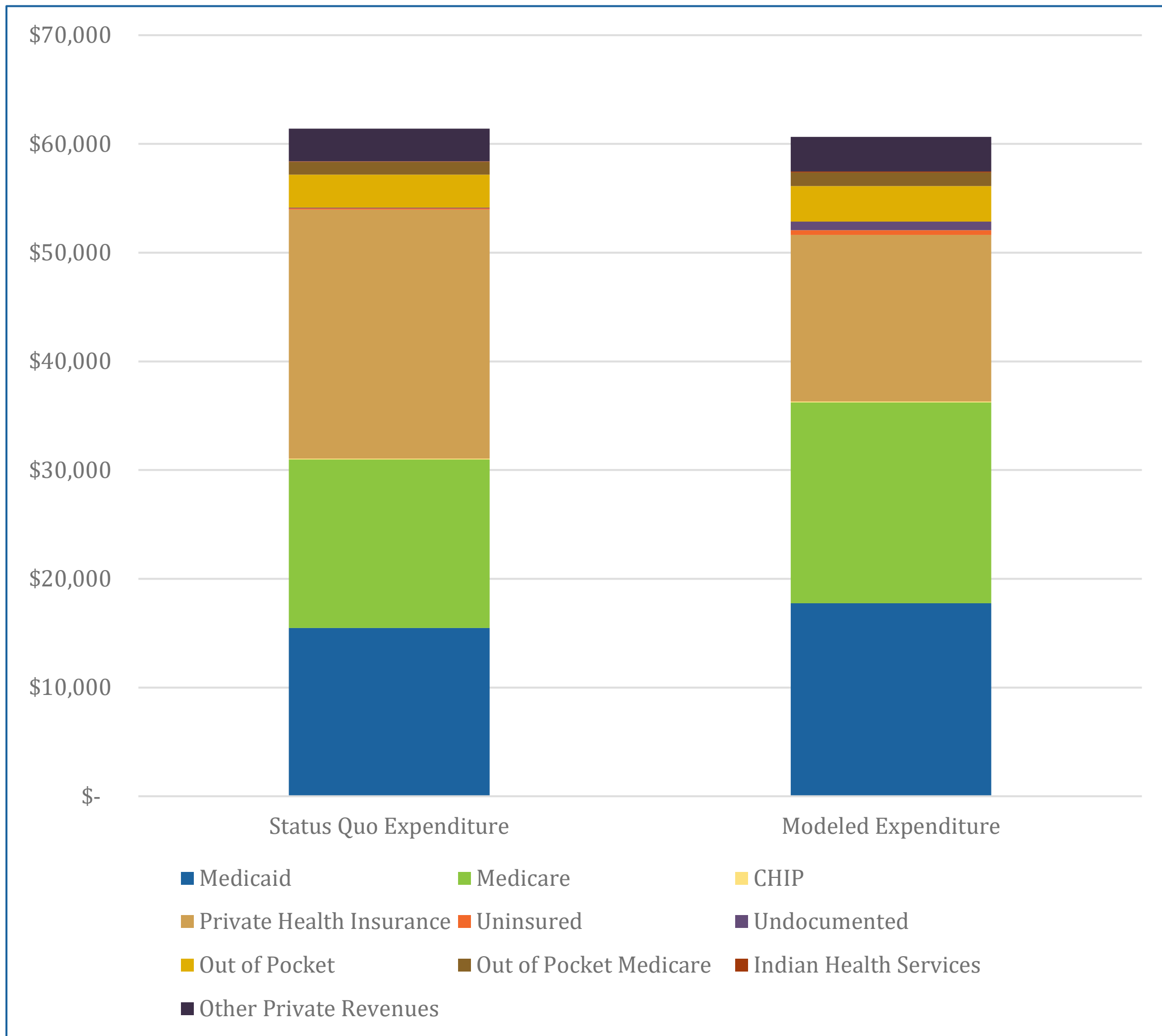
Model B is expected to reduce aggregate system-wide expenditures by approximately $783 million in the first implementation year. This impact is driven by multiple efficiencies that occur under a single-payer system, including:

- Limited reduction in payer administrative cost by reducing the number of payers across the health care system.
- Increased purchasing power.
- Provide administrative efficiencies.
- Program integrity improvements (reducing fraud, waste, and abuse).

As with Model A, Model B cost savings can also be the result of the centralized program's ability to make other changes, such as increased transparency, establishment of maximum prices, and use of care standards that promote outcomes and quality.

[30] For unrounded expenditures and populations, see Appendix A tables.
[31] Populations are rounded to the nearest 1,000. The Medicaid population totals exclude dually eligible members from the population count. Medicaid reimbursed expenditures for dual-eligible persons are reflected in Medicare. All other Medicare-covered expenditures are included in the Medicare row.
[32] Status quo and modeled expenditure totals exclude long-term care and dental for all payers but Medicaid.
[33] Estimates are based on all eligible Washington residents participating in Model B.
[34] This includes federal employees and active duty military.

Figure 5: status quo vs. Model B – program year 1 expenditures (in millions)



Model B: revenue sources

The table below shows the implementation year (2022) revenue sources supporting the status quo system and how those contributions would shift by payer under Model B.

Table 19: Model B calendar year 2022 revenue sources – implementation year (in millions)

Financing source	Status quo revenue	Model B revenue estimate	Difference
Federal share – Medicaid[35]	$12,692	$15,142	$2,450
Federal share – Medicare	$9,760	$11,801	$2,041
Federal share – CHIP	$73	$90	$16
State/local share	$6,052	$33,522	$27,470
Other federal contributions (e.g., Indian Health Services)	$80	$80	-$0.1
Individual contribution	$14,057		-$14,057
Employer contribution[36]	$18,704		-$18,704
Total	$61,418	$60,634	-$783
Dental coverage for populations other than Medicaid[37]			$3,052

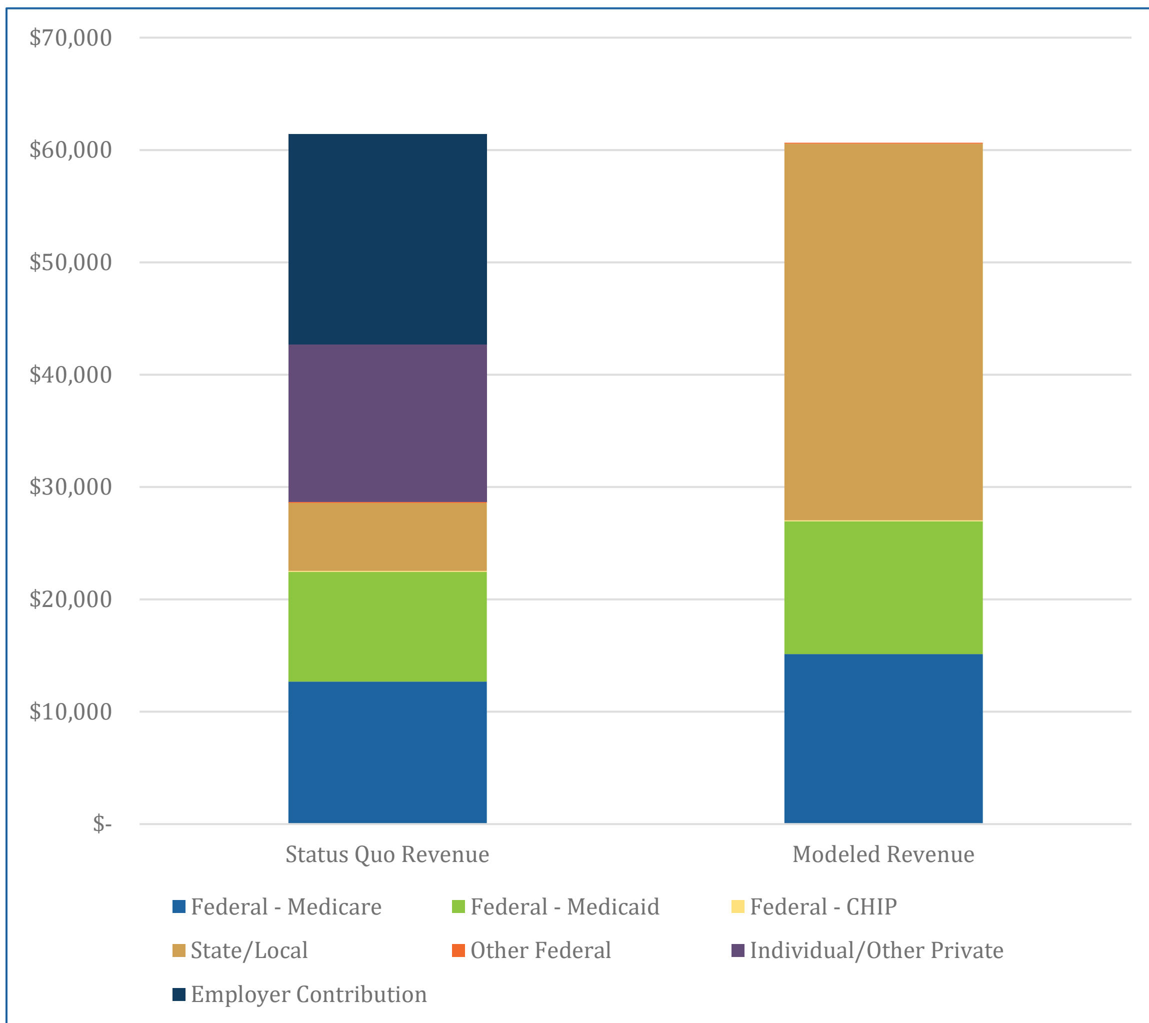
In the implementation year, Model B would cost approximately $783 million less than remaining with the status quo system. As in Model A, Model B establishes a single provider fee schedule. Rates paid by current public sector programs (Medicaid and Medicare) would be relatively higher than at present. Both programs use federal funding, meaning the model would increase the amount of federal funds used compared to today.

The new single fee schedule would be a reduction from rates currently paid for commercial health insurance (employer and individual contributions). As noted previously, it is unknown whether CMS will allow Medicaid and other public sector programs to increase provider reimbursement relative to today.

The Work Group did not address how the state would fund costs needed to replace current individual and employer contributions to coverage. The Work Group did discuss the fact that this is an issue requiring specific focus, which could be assigned to a dedicated group as part of the reform development process.

[35] Medicaid funding is dependent on expenditure authorities awarded to Washington by CMS and changes in federal financial participation rates. Estimates are based on pre-CARES Act federal financial participation rates.
[36] The employer contribution includes state/local funds for public employees.
[37] Additional revenue required for covering dental services for all other populations than Medicaid, federal employees, and military, and assumes "moderate" cost level for dental services.

Figure 6: status quo vs. Model B – program year 1 revenues (in millions)



Model C: "fill in the gaps" for people without coverage

Model C is designed to provide coverage to Washingtonians who are now uninsured. As in Models A and B, the state sets the program and delivery system rules, but insurers that meet participation requirements provide coverage to eligible individuals.

The modeled program is similar to Cascade Care, with insurers developing and maintaining their own networks and administering the functions they currently provide, such as claims payment, utilization management, care coordination, and member and provider services.

Model C: eligibility, covered benefits

Model C offers coverage to a segment of Washingtonians: those who do not have access to affordable coverage through a public program, an employer, or in the individual market. Model C is primarily designed to increase coverage for uninsured undocumented immigrants.

This model could, however, be broadened to include other groups who do not have health insurance now. The model, as developed, was shaped by the availability of data to identify impacts.

Table 20: assumptions for Model C

Model element	Key assumptions
Population	• Undocumented immigrants
Covered benefits	• Essential health benefits as defined by ACA
Cost sharing	• Standard cost sharing (based on current commercial plans)
Provider reimbursement	• Cascade Care reimbursement standards apply
Population-specific impacts	• Assumes utilization similar to commercially insured populations
Administration	• Assumes commercial plan levels of administrative costs

Model C provides coverage for populations without current access to health care coverage through the Washington Health Benefit Exchange due to their documentation status. Currently, the population that cannot access traditional health insurance are individuals who are undocumented and those ineligible for Medicaid and who cannot afford to purchase through the Washington Health Benefit Exchange.

In addition, other Washingtonians have insurance but are challenged by the cost of accessing care. Work Group members have expressed interest in expanding Model C to include options for those who are not well-served by the current system. Washington is already making progress in this arena through **Cascade Care** health plans.[38] Cascade Care may provide access to more affordable standard and public option plans, particularly if state subsidies are made available to consumers accessing Cascade Care plans.

While there was interest in knowing the cost of providing care to undocumented immigrants under the current system, this was not possible due to data limitations. A deeper dive to collect additional data and perform necessary analysis would be required to produce meaningful and supportable estimates.

Care for this population is paid by foundations, charities, other public/private organizations, and uncompensated or charity care provided by hospitals and health care providers. See footnote below for some of the research conducted on the topic over the past ten years.[39]

Cascade Care subsidy analysis

The Cascade Care authorizing statute called for a study on a subsidy program. Wakely Consulting Group's report, which was released in November 2020, analyzed the affordability and access

[38] Washington Health Benefit Exchange website.
[39] Chris Conover, How American Citizens Finance $18.5 Billion In Health Care For Unauthorized Immigrants, Forbes. February 26, 2018.
Rajeev Raghavan, New Opportunities for Funding Dialysis-Dependent Undocumented Individuals Clinical Journal of the American Society of Nephrology. August 30, 2016.
Teresa A. Coughlin et.al., Uncompensated Care for the Uninsured in 2013: A Detailed Examination, The Kaiser Commission on Medicaid and the Uninsured, May 30, 2014.
Nadereh Pourat, et. al., Assessing Health Care Services Used By California's Undocumented Immigrant Population In 2010. Health Affairs Vol. 3, No. 5, May 2014.

impacts of various subsidy mechanisms and amounts on Washington Healthplanfinder customers and the individual market.[40]

Wakely developed an interactive model used to create the six scenarios detailed in the subsidy report. Each scenario is designed to limit the cost of premiums to no more than 10 percent of household income for any consumer with household income up to 500 percent of the federal poverty level.[41]

The report assesses a model that builds on the current federal "advanced premium tax credit" (APTC) model and a fixed monthly amount. Also considered is inclusion of cost sharing assistance beyond the federal cost sharing reductions currently in place under the ACA.

Total state investment was assessed at three levels using variants of the APTC and fixed dollar approaches. The group considered three approaches to funding the subsidies: a per-member/per-month (PMPM) health insurance premium tax, an assessment set as a percentage of claims, and an assessment set as a percent of premium.[42] Wakely's estimated results by scenario are shown below.

Table 21. Wakely: best estimate premium subsidy results by scenario[43]

Premium subsidy program	Total state funding ($ millions)	Number of uninsured take-up	Total customers receiving state subsidies	% of customers with access to plan for less than 10% of income*
Enhanced APTC	$216.9	19,700	175,400	100%
Fixed $135 PMPM	$217.1	23,800	179,800	94%
Fixed $90 PMPM	$152.1	18,700	173,800	92%
Fixed $58 PMPM	$100.7	14,200	168,700	92%
Fixed $48/$96 PMPM	$101.8	14,100	169,400	92%

Detailed discussion of the analysis methodology and results, are available in a report provided by Wakely.[44]

This report could inform recommendations for expansion of Model C to align with the subsidy recommendations, potentially serving as a transition strategy to broader universal health care in the longer term. In addition, should state subsidies be implemented, the incremental funding to implement a universal health care program under Model A or B, and the total number of new insured persons, will shift from the analyses presented here.

As modeled, a state subsidy program of $101-217 million would help 168,700-179,800 individuals afford coverage in the individual market, including 14,100-23,800 uninsured individuals. These costs, if covered through the proposed tax, will be levied on all insured health products in the state.

[40] Pam MacEwan, Cover Memo to Wakely Analysis; Brittney Phillips and Julie Peper, Wakely Consulting Group, Legislative Report: Plan to Implement and Fund State Premium Subsidies. Read the cover memo and actuarial analysis.
[41] $63,800 for individuals, $131,000 for a family of 4 in 2020. Read the current Federal Poverty Guidelines.
[42] All premium tax approaches assessed by the Wakely team impact Taft-Hartley plans, which could lead to labor union opposition to the implementation of such an assessment.
[43] Brittney Phillips and Julie Peper, Wakely Consulting Group, Legislative Report: Plan to Implement and Fund State Premium Subsidies.
[44] Wakely, Legislative Report: Plan to Implement and Fund State Premium Subsidies, Op. Cit.

The impact varies by funding strategy; a claims tax or a covered lives assessment would spread the costs most broadly.

However, if Model C were a step toward a universal health care system rather than an end state, the increase in insured of 23,800 would not substantially change the estimates modeled for Model A or B. The subsidy program addresses affordability for a subset of individuals, but does not:

- Achieve universal health care.
- Tap into efficiencies from system consolidation.
- Solve affordability issues for individuals not eligible for subsidies or who cannot afford cost sharing in the plans they do have.

Model C: expenditures

While status quo expenditures are not available, the estimated current Medicaid cost (Short-Term Emergency Coverage Only) for undocumented Washington residents is $150 million, shared 50-50 by federal and state governments. All other existing system costs for this population are assumed to be individual expense or charity care.

Table 22: cost estimate of Model C (in millions)

Financial assessment	Estimates
Status quo expenditure for covered populations	Not available
Model C cost estimate	$617

Financial impact of Models A, B, and C

Both Models A and B, which cover all Washington residents, **reduce total expenditures compared to the current system**. Model A reduces costs in the implementation year by close to $2.5 billion, while the Model B reduction is $738 million. **Model C increases expenditures** by $617 million in the implementation year.

Table 23: model comparison calendar year 2022 expenditures – implementation costs excluding dental (in millions)

Financial assessment	Model A	Model B	Model C
Status quo expenditure for covered populations	$61,418	$61,418	Not available
Model cost estimate	$58,942	$60,634	$617
Cost savings	-$2.476	-$738	N/A

This table does not include the cost of dental care for populations, other than Medicaid-eligible consumers, in order to compare relevant expenditures between the status quo and each model. Including dental, which has an estimated cost of $3.052 billion in the implementation year, would eliminate implementation year savings.

However, as shown in Table 12, universal health care in a steady state (non-implementation) year shows sufficient savings to remain less costly than the status quo, even when dental costs are included.

Limitations

Federal financial participation

The preceding cost estimate analysis assumes that the current system federal revenues continue for Medicaid, Medicare, and Washington Health Benefit Exchange subsidies. All federally funded programs are governed by statute and regulation. Federal funding is conditional on program compliance with federal regulations.

To implement Model A or B, the state will need to ensure that federal financial participation is maintained or expanded. For example, the state will need to explore available Medicaid waiver authorities and state plan amendments to align covered benefits, provider reimbursement, and mandatory participation of eligible individuals in universal health care.

Given the federal government's Medicare program requirements and historic unwillingness to permit waivers of those rules, the state will need to consider how to operationalize inclusion of current and future Medicare-eligible individuals under Model A or B. This includes considering how to incorporate residents who receive traditional (fee-for-service) Medicare and may purchase supplemental coverage or those enrolled in Medicare Advantage plans.

Over 60 percent of consumers covered through Washington Healthplanfinder are eligible to receive federal subsidies for health insurance premiums.[45] The state will need to consider how to maintain federal insurance subsidies for eligible individuals, including the use of an ACA Section 1332 waiver.

Additional data analysis

The analysis and estimates contained in this report were performed using the best data available. However, the data have some limitations, including:

- Given the lag in data availability, some data are several years old.
- The lack of available, detailed data on demographics and type of service limited the ability to perform more detailed analyses or estimate the impact of provider reimbursement, additional benefits, and out-of-pocket cost sharing

Future cost estimates will require focused analyses specific to each population and covered benefits. Planning for this work should take into account it may take significant time and effort to obtain this detailed data.

[45] In 2019, 61 percent of people purchasing plans through Washington Healthplanfinder received premium tax credits and 32 percent received cost sharing assistance. Nationally, 86 percent of Washington Healthplanfinder consumers used premium tax credits and 50 percent had cost sharing assistance. CMS, Early 2020 Effectuated Enrollment Snapshot. July 23, 2020.

Qualitative assessment of potential models

The Work Group discussed the extent to which the models support the qualitative assessment criteria they developed for the access, governance, quality, equity, administration, feasibility, and affordability goals. The following is a summary of Work Group discussions.

Access

Many Work Group members expressed the view that Model A is more likely to facilitate access for all Washingtonians. Others noted that if Model B were fully implemented, it could also facilitate access. Both A and B establish a coverage system for all residents. Having insurance is associated with better access to care.[46]

It was noted that traditional Medicare functions similarly to Model A, while Medicare Advantage utilizes a Model B structure. Many Work Group members expressed the view that both Models A and B are likely to facilitate seamlessness, portability, and choice of provider. Models A and B's performance on other criteria would depend on how the established system is designed and allocates resources, highlighting the importance of implementation decisions.

A number of Work Group members expressed that Model C would be the least capable of facilitating access.

Governance

Some Work Group members expressed that Model A is more likely to perform well on governance criteria, particularly with respect to Tribal Sovereignty. Participants noted that Models B and C could enable some aspects of governance, although others noted that with more organizations involved, governance becomes more complicated. The accountability of Model A was considered a benefit, with accountability seen as less direct in Model B. Governance would not change from the present under Model C.

Quality and equity

Work Group members expressed a desire for additional clarity on both quality and equity. Some Work Group members indicated that while it would seem obvious that Model A has the potential to promote quality and equity more than the other models, doing so will very much depend on the implementation of any selected model. Members noted that addressing equity and eliminating disparities will require specific efforts to design a system that promotes change and incentivizes relevant, culturally attuned care.

[46] Uninsured respondents in the National Health Insurance Survey were less likely to report having a usual source of care and more likely to postpone or go without care or prescriptions due to cost, compared to respondents with Medicaid or other public coverage or those with private coverage. Rachel Garfield, Kendal Orgera, Anthony Damico, The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act. Kaiser Family Foundation, January 25, 2019.

Many of the quality criteria apply to equity when measuring quality across populations. Overall outcomes can mask how well providers, services, or systems work for individuals of different races, ethnicities, genders, ages, income, regions, or cultures.

In addition, researchers have identified quality measures to identify and monitor disparities in care and to assess interventions intended to reduce disparities. For this reason, quality and equity were discussed together, but some Work Group members indicated a preference to separate equity and quality and move one or more access criteria (such as culturally attuned care) to equity. For this reason, the group created a separate equity goal, with associated criteria, some of which overlap with the quality criteria.

Administration

In general, Work Group members indicated that Model A is more likely to be the most administratively simple and thus save the most in administrative costs. Model B was seen as likely to create savings relative to the status quo. However, because it retains multiple insurers, the savings would not be as large as under Model A.

Streamlining the administration could depend on whether some or all populations currently covered by federal health care programs would maintain their current coverage or be folded into the state system.

Feasibility

Most Work Group members agreed that implementing Model C is the most politically feasible, as a variant of this model already exists. Work Group members discussed that making a large-scale change in the health system would require changes at the state legislative and regulatory levels. It would also require changes at the federal level through waivers to Medicaid, the ACA, and potentially other federal requirements.

The complexity of this endeavor depends on whether some or all populations currently enrolled in federal health care programs would maintain their current coverage or be folded into a reformed system. The quantitative analyses are based on the assumption that all eligible persons and sufficient insurers would participate.

A Work Group member identified that achieving the savings of universal health care system (especially one with a single administrator) requires participation by populations currently eligible for programs regulated, funded, or administered by the federal government.

Medicare and ERISA were called out as particular challenges, as there is no established mechanism for a state to apply for a waiver of federal requirements.[47] In addition, the group recognized that implementation would require CMS approval of a Medicaid waiver. Similarly, an ACA Section 1332 waiver could be the path to incorporating federal tax credit funding and waiving other ACA requirements.

[47] The September meeting materials include a pre-recorded presentation on implementation feasibility related to Medicare and other program requirements.

Other populations and funding streams that will need to be addressed include Tribal members, federal employees, members of Taft-Hartley plans, veterans and active military, and the incarcerated.

Feasibility is also affected by the length of any phase-in or implementation period. A longer phase-in could improve feasibility. As noted by a Work Group member, plan participation under Model B is unknown but could impact the success of this model.

Affordability

Work Group members repeatedly raised affordability in discussions of the end state of universal health care, development of health reform goals, and the impact of each of the three models. Work Group members noted that affordability should be considered on several dimensions, including the consumer, stakeholders, and the state as a whole.

The group discussed affordability from an individual or family's perspective, particularly in terms of the use or elimination of cost sharing, such as co-payments and deductibles. The group also raised the need to understand and mitigate impacts on taxpayers, communities, businesses, and other participants.

The Work Group discussed affordability of premiums and cost sharing in coverage currently available in the individual market. One Work Group member noted that even for individuals receiving premium assistance, member cost sharing in the form of deductibles and co-payments can keep people from using care.

Self-employed consumers and others whose income fluctuates can find themselves paying more than they anticipated for coverage, as income changes impact their eligibility for premium tax credits. This Work Group member expressed concern that offering coverage to more people (Model C) without changing the system's cost structures does not increase affordability for anyone. Other members stressed that to ensure financial sustainability, costs must be reined in before the state focuses on expanding coverage.

In addition, Work Group members stressed the need for any model to ensure long-term sustainability by controlling spending system-wide. Some participants stressed the need to further explore the evidence on the optimal approach to simultaneously ensuring affordability, engaging participants in their care, and preventing overutilization or low-value care.

Other key Work Group discussions

Cost sharing[48]

Model A and Model B were analyzed with the assumption that no cost sharing would be included. This decision came after significant discussion of the topic, where some Work Group members

[48] Cost sharing is any amount a consumer is expected to pay for specific care or services received. This includes deductibles, flat dollar co-payments, and co-insurance (amount assessed as a percent of billed amounts). References to cost sharing in this discussion refer to any cost sharing, except where a specific type of cost sharing is specifically included in the text.

expressed concern that cost sharing would keep consumers from seeking needed care. Others articulated a desire to use cost sharing to limit the use of low-value services.

Work Group members who opposed cost sharing indicated that cost sharing is a barrier to care, citing research shared by the project team and indicated it puts the burden on the consumer to determine whether the care is necessary. These members also noted that cost sharing exacerbates inequities of access and financial burden in the current health care system.

In addition, members identified that administering cost sharing increases provider and health plan costs and noted it didn't make sense to ask the consumer to pay more for care once they have paid premiums. Work Group members said that efforts to improve quality will eventually reduce costs and said that no credible research indicates that cost sharing reduces use of low-value care.

One member noted that the American Indian health care system does not utilize cost sharing and shows no evidence that people overuse it. Another shared that waiving cost sharing for COVID-19 testing has incentivized people to get tested.

Work Group members who wanted to consider the use of modest cost sharing noted that it could support key health system goals. For example, high-value services would not be subject to cost sharing, while other services (such as elective surgery) would require the consumer to pay a share. Another suggested approach was to waive cost sharing for care provided by providers who meet quality and cost standards. Individuals who wanted to see a provider who didn't meet quality standards or was more expensive could pay a portion of the cost.

The Washington Health Benefit Exchange found that flat dollar co-payments (rather than co-insurance as a percent of billed amounts) has a modest impact on inappropriate use. However, they have also seen evidence that high cost sharing leads consumers to defer care.

The California Public Employees' Retirement System (CalPERS) administers pension and health benefits to over 1.6 million California public employees, retirees, and their families. CalPERS uses cost sharing to encourage consumers seeking specific services (such as knee surgery) to use hospitals with which CalPERS has more favorable reimbursement terms.

While Work Group members disagreed on whether the models should include cost sharing, they generally agreed on the following parameters for any use of cost sharing:

- Limit total cost sharing to a percent of income, recognizing this could be expensive to administer.
- Structure cost sharing to avoid catastrophic financial loss for individuals and families.
- Deductibles were not popular; however, if deductibles were included, they should be structured to limit the impact to consumers early in the year to allow costs to be spread over the year.

A Work Group member noted that co-insurance is not transparent and can be difficult for the consumer to understand or calculate ahead of time. Another indicated that co-payments are more desirable than co-insurance because pre-determined flat amounts provide cost predictability. This is particularly important for individuals with chronic disease and others with high-care needs.

Provider reimbursement

The Work Group discussed whether:

- Analysis of Models A and B should assume that providers will experience lower administrative costs in a universal care system.
- These models should assume increased state purchasing power relative to today, which would allow the state to modify provider compensation.

Work Group members indicated that assumptions about the potential for lower administrative costs in the model needed to be specific, realistic, and information-based. Members thought the models should assume a single set of billing rules and rates for all providers. Some noted that savings assumptions should be different for large health systems and small medical practices.

One member suggested the use of cost-based payment for smaller practices like the cost-based reimbursement that Federally Qualified Health Centers receive.

Work Group members recognized that a universal system with state-determined rates will increase transparency and give the state greater purchasing power. Many people noted that savings will depend on program design and implementation. Work Group members also raised the following issues:

- In developing a universal health care program, the state will need to consider how any potential savings are used (e.g., to bring down overall costs or to pay for additional benefits).
- Some federal regulations limit efficiencies and the state's ability to reduce administrative costs. These limitations will need further examination.
- Current efforts to reduce costs and increase transparency in Washington State should inform the development of universal health care program design and implementation.
- Senate House Bill 2457 requires HCA to create a Health Care Cost Transparency Board to establish cost growth benchmarks and will have a role in provider reimbursement.

Work Group members noted that different types of providers (and those in different settings) are reimbursed differently. One member indicated that Medicare hospital reimbursements have increased over the past two decades, while physician and other provider reimbursements have stayed fairly flat.

Another issue raised is that a new system should be designed to increase primary care payments relative to other spending. One suggestion was to start by reducing specialty care reimbursement and applying the lessons from the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely," an initiative that seeks to advance a national dialogue on avoiding unnecessary medical tests, treatments, and procedures.

The Work Group discussed the related point that some providers (e.g., home health workers) are paid significantly less than others and adjustments to provider payments should not exacerbate these differences.

A Work Group member noted that providers can "game" the fee-for-service system by providing more units of care for which they are reimbursed. This incentive could be changed by paying providers and health systems based on quality care and population outcomes.

Overall, Work Group members indicated that they would like universal health care models to reallocate any potential administrative savings to reduce patient costs or invest in better care. They also want to see a system that allows the state to use its purchasing power to drive system change, recognizing that this is a complex issue that will take time and more effort to address.

Covered benefits

The Work Group acknowledged the significant research and deliberation that has occurred in Washington and other states to develop benefits packages. Several Work Group members suggested that a universal health care benefit package build on that existing research.

Work Group members discussed the need for a comprehensive benefit package that improves health and is attractive enough to keep participants enrolled without a mandate. Additional benefits mentioned include dental, hearing, chiropractic care, and acupuncture for both adults and children. Work Group members raised the following as additional considerations for assessing a benefits package:

- Does the model address social determinants of health that may result in cost savings?
- Does the model cover gender-affirming care?
- Does the model cover rare diseases?
- Do the benefits include whole-body, holistic care?
- Are the covered benefits culturally attuned (e.g., is traditional medicine covered)?

As the Work Group examined Model A and B, members generally agreed with using Washington's essential health benefits benchmark as the foundation for benefits under all three models. Many also wanted to include adult vision and dental in the universal health care models but acknowledged this would incur higher costs to the state. To better understand these costs, Work Group members examined the models to see the actuarial outputs with and without vision and dental benefits.

Work Group members wanted to be sure the models include robust mental and behavioral health care benefits. There was discussion that behavioral health was already covered fully or partially within the current system, due to the essential health benefits and Washington's mental health parity laws.

Some Work Group members wanted to include long-term care, but several people noted a robust long-term care benefit would "kill" any proposal due to the cost. Some members acknowledged that if long-term care is included as a benefit, it would have to align with Washington's new long-term care benefit, valued at $36,500 over a lifetime.

When examining Model B (universal health care with delegated administration), a few Work Group members suggested that standardizing the benefit and coverage designs offered would reduce administrative costs and make the health plan options easier to compare directly. Some Work

Group members noted that this approach can be used to support evidence-based care and reduce low-value care, though this approach is not always transparent.

Work Group members discussed the extent to which the state should be an active purchaser under this model, using its large enrollment to reduce costs and improve quality. Generally, Work Group members agreed the state should have a strong role in standardizing and overseeing plans and insurers to avoid many of the pitfalls of the current system, such as limited networks and access to care.

A Work Group member noted that employers use health benefits for recruiting and retention. As such, some larger employers may resist participating in a universal health care program. Another member pointed out that organized labor has shown extensive support for universal health care.

Supplemental or substitute coverage

Some Work Group members expressed interest in allowing individuals covered by a universal system to also buy additional benefit coverage, similar to Medicare supplemental insurance (often called "Medi-Gap" coverage) for the Medicare population. A Work Group member indicated this would be important to the labor community, which has secured many improvements to coverage offered by labor unions. Banning supplemental benefits would threaten the gains won by this sector.

Other Work Group members acknowledged it would be important to consider the potential unintended consequence of allowing those able to afford additional or substitute coverage options to opt out of the universal program, including the potential negative impact on the universal model's risk pool. At the same time, Work Group members suggested that allowing consumers to add coverage or "opt out" might generate acceptance of the new model.

Covered populations

The Work Group's consideration of the populations that should be covered under a new model were informed by discussions of the goals of universal health care coverage. There was strong desire across the Work Group to consider a model that covers all Washington State residents, without regard to age, employment, disability status, geography, or immigration status. The members also discussed the idea of transitioning different populations to a new model, starting with an initially covered population and phasing in additional groups over time.

The Work Group discussed the issues related to including programs funded in part or entirely by the federal government. Ultimately, Models A and B were defined to include all state residents, including those:

- Eligible for Medicaid, CHIP, and Medicare.
- With private market insurance (including employer-based group plans, state employee plans, and individual coverage both in and out of Washington Healthplanfinder).
- Undocumented immigrants.
- Other uninsured people.

Model C assumed participation by Washington residents without access to traditional health insurance coverage, which is primarily the undocumented population.

Inclusion of federally funded program populations

Work Group members understood the challenges involved in including all individuals currently enrolled in federally funded programs, such as administrative hurdles and potential delays in securing federal approval to include these populations.

One participant noted that the Washington Health Security Trust model initially excluded participants in seven types of federally funded programs, with the plan to include them once required waivers were achieved. One Work Group member suggested that individuals with federal coverage could be allowed to "buy into" the Washington plan.

Work Group members grappled with the challenges and time involved in securing agreement from the federal government to allow Medicare to be included in a state universal health care plan. They weighed these issues against the desire for a comprehensive universal health care plan.

In a discussion that occurred before the presidential election, a Work Group member noted that depending on the outcome of the elections, the state could have the opportunity to seek a federal partnership that included Medicare as part of a single-payer system. Other suggestions included creating a state-based Medicare supplement plan to fill gaps in Medicare coverage, and/or designing a universal health care system that could incorporate Medicare in the future.

Some Work Group members indicated that limiting federal involvement by excluding federal programs, such as Medicare, may be a more expedient option. Several Work Group members expressed concern that including Medicare beneficiaries in the program would mean increasing the population risk and costs, as Medicare consumers are older and have more health issues than the population at large.

Work Group members discussed that some federally funded programs, such as Indian Health Services and Tribally-run health facilities pay for health care services, but are not health insurance coverage. It was noted that federal law established Indian Health Services as care of last resort and should be included in the model. Another member noted that the group should keep magnitude in mind: Indian Health Services funding represents a fraction of one percent of Models A and B totals and many Tribal members are currently covered by Medicaid, Medicare, or Tribe-purchased insurance.

Coverage for immigrants not eligible for existing programs

During discussions of Model C, some Work Group members supported this model covering immigrants not currently eligible for coverage through existing programs. A few Work Group members pointed out the COVID-19 pandemic has demonstrated the financial and societal costs of not providing affordable and accessible health care to immigrants. Others stated that it is an ethical requirement to cover this population. Some Work Group members added that immigrants are contributing to the state economy and paying taxes, and as such, should be able to receive benefits.

Unaffordable employee coverage participation

The Work Group discussed the challenges of coverage and care affordability for many Washingtonians eligible for current health insurance options. Many members expressed an interest in finding ways to support that population, while others noted the difficulties in precisely identifying the size of this subpopulation.

Some Work Group members said that employees with income under a specified threshold should be allowed to participate in Model C if it is more affordable than their employer plan. One Work Group member recognized that this could have the unintended consequence of encouraging some employers to drop their group plans, but that was not necessarily bad if the coverage and affordability standards were better in this model. Work Group members noted that this is a step toward de-linking employment and health coverage, which could be a challenging transition for some employers.

Transition issues

The Work Group discussed whether a universal health care model should be done through one simultaneous set of changes that would bring about a new system, or if change should be achieved through a multi-step transition. Most Work Group members agreed that Model C is not a universal health care system, and some saw it as an interim effort to improve coverage and access for populations at highest need while additional work occurred to a desired "end state."

The Work Group heard a summary of the efforts to achieve universal health care for children in Washington. This started with the Legislature stating its goal to cover all the state's children and continuing over the next five years through a series of changes. (See Appendix G for more in this and other Washington health reform efforts over the years.)

Some Work Group members were concerned that a goal with a five- to ten-year timeline put universal health care too far out, while others were more supportive of a multi-year process. Some Work Group members noted that a transition to universal health care would cause significant changes for individuals and industries, including Washington residents working in and around the health insurance industry. One Work Group member said that the state will need to consider how to support the skilled workers in health care administration whose jobs will be changed or eliminated.

Summary of models' ability to achieve goals

The below table presents the project staff's effort to capture the tenor of the Work Group discussions using a red-amber-green scale. For access, governance, quality, equity, administration, and affordability, red indicates the Work Group's sense that a model has very limited ability to meet the goal. Amber indicates the model has some ability to impact the goal. Green indicates that the model could greatly impact achievement of the goal.

For **feasibility**, green indicates that development and implementation will be fairly easy, amber indicates some significant challenges exist, and red indicates there are very large hurdles to implementation. Work Group members were very clear that how a given model is actually implemented would make a substantial difference in the extent to which it could actually help achieve the goals.

Table 24: high-level assessment of models' ability to achieve goals

Goals	Model A	Model B	Model C
Access			
Governance			
Quality			
Equity			

Administration			
Feasibility			
Affordability			

Some Work Group members disagreed with the ratings, particularly for feasibility and affordability. Model A's red rating is based on challenges related to including the Medicare population and associated funding, addressing an ERISA challenge, and overcoming likely opposition by the health insurance industry.

Several Work Group members commented that under the incoming Biden Administration, Model A could be more feasible to implement than previously assessed. As noted elsewhere, President-elect Biden's Health and Human Services nominee, Xavier Becerra, has previously expressed support for universal health care programs and may be receptive to state proposals to waive Medicare requirements.

In addition, the incoming administration is likely to change the requirements for an ACA Section 1332 waiver in ways that would facilitate state efforts to establish a universal health care program. A member also noted that the State Based Universal Health Care Act could get approved if the Senate gains a Democratic majority.

Table 24 only attempts to provide a high-level view of each model's ability to achieve the goals, which we recognize can mask the complexities involved in the work. The colors represent the overall ability to make change, recognizing there are many impacts within a given area. The yet-undefined details of each model will affect the true impact on the identified goals.

Survey of Work Group perspectives

In December 2020, Work Group members were asked to respond to a survey regarding their preference ranking of Models A, B, and C. Twenty-nine of the 37 Work group members participated.[49]

Table 26 provides the responses to the ranking questions. Information from respondents who chose to explain a "none of the above"/non-ranked answer is shown in footnotes. Seven of the 29 respondents indicated they were abstaining from stating a preference; their names and affiliations are listed in Table 27. Table 28 provides the open-ended responses from respondents who chose to include additional information.

Table 25: notes on ranking

- 1 Respondent's most preferred model of the three options
- 2 Respondent's second most preferred model of the three options
- 3 Respondent's least preferred model of the three options
- -- Respondent did not enter a ranking for the model

[49] "Participation" means the individual visited the survey link and either engaged in ranking (22 people) or abstained (seven people). Eight other Work Group members did neither and are not included in the tables.

Table 26: Work Group member responses to the model preference survey

Member[50]	Organization/affiliation	Model ranking		
		A	B	C
Barbara Detering	Kaiser Permanente	2	3	1
Kerstin Powell	Port Gamble S'Klallam Tribe	1	2	3
Randy W Scott	Pacific Health Coalition	1	2	3
Don Hinman	Yakima Neighborhood Health	--	--	2
Dennis Dellwo	State Representative (retired)	1		3
Vicki Lowe	American Indian Health Commission for WA State	1	2	3
Lynnette Vehrs	Washington State Nurses Association	1	3	2
Sarah Weinberg	Physicians for a National Health Program Western WA	1	--[51]	3
Rod Trytko	Anesthesiologist, self employed	--	--	--[52]
Ronnie Shure	Health Care for All - Washington	1	2	3
Peter McGough	Retired; past president WSMA	1	3	2
Jane Beyer	Office of the Insurance Commissioner	--[53]	--	--
Sybill Hyppolite	Washington State Labor Council	1	3	2
Chris Bandoli	Association of WA Healthcare Plans	--	--	1
Nicole Macri	Washington House of Representatives	1	2	3
Bevin McLeod	Alliance for a Healthy Washington	1	2	3
Kelly Powers	2021 Cascade Care Exchange Consumer	1	2	3
Aaron Katz	University of Washington School of Public Health	1	2	3
Mohamed Shidane	Somali Health Board	1	--	3
Richard Kovar MD	Country Doctor Community Health Centers	1	2	3
Patrick Connor	National Federation of Independent Business	2	3	1
Carrie McKenzie	Goldcore Innovations	1	2	3

Table 27: Work Group Members who responded to survey as "abstaining"

Member	Organization/affiliation
Carrie Glover	Dziedzic Public Affairs
Mary Beth Brown	Washington State Department of Health (sub for John Wiesman)
Susan E Birch	Health Care Authority
Emily Randall	Washington Senate
Dean Carlson	Washington Department of Revenue
Rep. Joe Schmick	State Representative
Pam MacEwan	Washington Health Benefit Exchange

[50] Responses are show in the order the Work Group members responded to the survey.
[51] Sarah Weinberg reported: I really think Model B is a waste of taxpayer dollars, so I don't want to rank it at all.
[52] Rod Trytko reported: Model C does not provide universal access.
[53] Jane Beyer reported: I've not had a chance to review these options with the Commissioner, so am not able to express his preference at this time.

Table 28: comments in open-ended survey question[54]

Member	Open-ended comments
Barbara Detering	I believe we are more likely to continue progress on the path to a universal coverage system by taking a stepwise approach. I would want the fill in the gaps to be ON THE PATH to universal coverage
Kerstin Powell	I believe the majority of Americans want Universal Healthcare. I believe there is a lot of push back from the insurance industry and pharmaceutical companies that makes it difficult for the legislator to move it forward. We need to clearly reflect the feedback and input we have gotten from the public and the work group that this is the preferred choice. Thank you.
Dennis Dellwo	We need to have A as our goal. We should not paint it red and say it is unfeasible. C could be a first step, but not our goal.
Vicki Lowe	I think that Model C could be a stepping stone to Model A as we build infrastructure. We keep getting hung up on costs and savings in the short term but I hope our legislators can think further down the road and see the longterm savings to all of our systems for having healthier Washingtonians.
Lynnette Vehrs	Model C only if is State Administered. Keep the insurance companies out! Model C can be used in transition with the main goal for Model A.
Sarah Weinberg	If the work of this WG is going to lead to something other than a long report gathering dust on a shelf, we MUST make a strong recommendation. Model A should be a goal for the state to implement over a few years. Some of the fill-in-the-gaps ideas can provide more immediate aid for people who are really hurting NOW. I see these two ideas as separate from one another.
Rod Trytko	Model A and B not feasible. Model C currently does not provide universal access.
Ronnie Shure	Model C alone will not solve the hidden costs in the current dysfunctional health care system.
Peter McGough	While I support Model A as our destination, political considerations lead me to choose Model C as the way to get to A
Sybill Hyppolite	I support working on option C in the short-term to build toward a broader vision.
Chris Bandoli	My organization can't support Model A or B so I left those without ranking.
Nicole Macri	Option A is where I think we should ultimately go. I agree with comments that implementing the "right" Model C is a necessary and important way to more quickly extend affordable, equitable coverage and access to care on the path to Option A.
Bevin McLeod	My choice is Model A, using a state administered Model C as a bridge to get to A by a specific date. Included in this should be a commission of sorts to work with the state to continue this work and delineate the steps needed to get to Model A via Model C.
Kelly Powers	I recommend Model A as the Desired State Goal to be reached in 2-3 years. Currently, health care insurance premiums on the Exchange are unaffordable and the deductibles and cost sharing is such a burden that we joke we need insurance for our health insurance! Optumas' work shows that Model A will deliver substantial savings of health care spending in our state. It is the best way to address racial and gender inequities in our health care system. We could start ramping up now and have it running in a few years when the COVID crises have passed. We could cover more people at less cost than they are currently paying now. A Model C that intentionally builds toward Model A is the long term sustainable solution that will help the most people for the best value. Thank you to HCA, HMA and Optumas for all your hard work and allowing us to have these discussions.

[54] Comments are shown as the respondents wrote them.

Aaron Katz	I favor the Legislature making a time-certain commitment to a universal coverage system, preferably Model A. I would advocate, in addition, that some form of Model C be developed and implemented in a way that makes further progress in getting people affordable coverage AND builds toward Model A - that is, builds the systems, infrastructure, benefit and payment structures that are compatible with and support of Model A.
Mohamed Shidane	I also agree that Model C can be used as a pathway to get model A.
Richard Kovar	I am voting for universal coverage that is state administered but passes through entities that are prepared to manage care and costs and contract with the state. The rate would be set to cover costs but not profit that goes to shareholders. Thus the only realistic option would need to be via a non profit entity. For profit entities need to be removed from the equation.
Patrick Connor	We have not adequately explored the costs and other barriers to either A or B. (Nor did we give serious consideration to other models or options.) C will happen regardless of what other recommendations are put forth.
Carrie McKenzie	I believe that if done properly, model A will be the most time and cost efficient. But to be successful, you must stop making some people pay more than others. The cost should be the same for everyone. How that gets paid should be separate from what gets charged so that the true cost and inefficiencies stay visible. People should make enough to pay their bills. Allowing those without representation to pay more than those that do have representation should not be allowed. One true price should be established based upon what it actually costs. What salary you make is irrelevant to how much you should be charged for healthcare. It should be based upon the cost of delivery and the prevention of cost gauging.
Rep. Joe Schmick	Universal Healthcare Workgroup personal observations: **Cost of the program.** Plan A cost estimate or expenditures for the calendar year 2022 is $58,942,000,000. The status quo estimate is $61,418,000,000. This would be a potential savings of $2,476,000,000 or 4.1%. The state budget for the 2019-2021 biennium is approximately $54 billion. In essence Universal Healthcare will more than double the state budget. As a policy maker, I would not support dismantling the current system for an estimated savings of 4.1%. I would like to point out as an example, the Urban Institute report for Medicaid expansion predicted that by 2020 there would be 1,473,000 enrollees in our state. The actual monthly average is 1,891,976 for 2020, the difference of 418,976 or 22% higher. Even the best estimate using good data can be off and create huge additional expense to the taxpayer. **Securing waivers from the federal government.** The assumption is that waivers will be issued to Washington State for this program. Waivers for Medicare, Medicaid, Children's Health Insurance Program (CHIP) and Indian Health Services will all have to be in place. The federal government has had a policy that it would look to decrease its oblication to the states. That in turn would leave our state taxpayers holding the bag for any cost overruns. **Opposition from interested parties.** The assumption is that there will be no pushback from private insurers, insureds, self-insured plans, or Taft Hartley plans. We were told in the meetings that the Washington State Labor Council supports Universal Healthcare. I looked up the resolution and it does say that, but only if the universal plan has more coverages and benefits. There has been no discussion about potential opposition-political or legal-likely to arise from private insurers, employers (particularly those that self-insure), private-market insurance policy holders, or others who have made significant investments in the existing system, and may strongly oppose any Universal

	Healthcare proposal put before the Legislature or the voters, either as a referendum or initiative, or seek its nullification in the courts. **Expectations under Universal Healthcare.** After sitting through discussions, the expectation seems to be that your local doctor will be in total control of healthcare. She or he would make the latest drug therapies and procedures readily available which I do not believe will be the case. The reality will be that only once drugs are approved based on the criteria set and them met by an approving State board or other entity will new or experimental drugs or procedures be allowed for the patient. Terms such as "evidence-based practices" were used by the doctors in our discussions, however I don't believe the public understands this to mean only approved procedures and drugs will be allowed when approved by the state. Elective surgeries will also be harder to come by as they will have to be approved by a state entity. **Medical debt providers carry.** When reimbursements drop from what private insurance currently pays down to Medicare levels, how will highly trained professionals pay off school debt? If Washington does not provide a way to pay this debt, what will entice a doctor who trained here to stay particularly when moving elsewhere will put themselves in a better financial situation? If a hospital or health delivery system is unwilling to assume debts of providers due to its own reduced reimbursements levels, how will it attract doctors or other providers? There has been no discussion of the amount taxpayers may be forced to bear to address this concern. **Universal coverage.** Since her proposal will cover anyone in our state, what keeps people from moving here? The state is forbidden to utilize residency requirements for program benefits. In border counties that I represent, many Idaho residents cross the river (in the case of Clarkston) or border, rents a mailbox to establish residency, then receives more generous benefits courtesy of the Washington taxpayers. Universal healthcare would likely attract not just border state neighbors looking for "free" medical treatment, but act as a magnet for sicker individuals. That almost certainly would drive costs up, adding even more cost to an already unaffordable system. **Government run plans.** There have been many comments from the public about not being able to access care, particularly from those enrolled in Medicare and some exchange plans. Barriers could be in the form of co-pays, out of pocket expenses, inability to access procedures or drugs not approved etc. With Universal Healthcare, aren't we just trading one government run program for another with the same or more severe limitations and restrictions?

Achieving a vision for a universal health care system

To achieve universal health care will require the Legislature, Governor, state agencies, and a range of stakeholders to engage in a series of staged activities that will likely require many transition steps. This includes choosing one model, defining detailed operational plans, and establishing policies to ensure the health reform goals are achieved.

Some Work Group members noted that while Model C would not deliver universal access or achieve desired health reform goals, it should be a step toward universal health care. Model C would provide coverage for a group with immediate need for coverage while a more comprehensive system was being built.

Work Group members acknowledged the need to “fill in the gaps” and to maintain current coverage as a new system is formally adopted, implemented, and operationalized. Ensuring a smooth transition and avoiding disruptions in coverage for Washington State residents requires concerted effort over time, even in the face of fiscal and political challenges. This concept became part of the example transition plan laid out below.

Example transition plan

The following is an example transition plan that outlines the steps and work needed to reach a state-level universal health care system.

This process example is not tied to a specific coverage proposal, but instead identifies the steps—including the development of program funding and structure—along with other considerations that will impact the health coverage and health care for Washingtonians.

This example establishes a four-year process that begins in January 2021 and utilizes a dedicated group (a Universal Health Care Commission) that could be legislatively established to spearhead the work. This example transition plan assumes the Universal Health Care Commission (UHCC) would be an action-oriented, focused group, supported by targeted Work Groups used to define specific topics. Stakeholder input is anticipated at multiple points during the process.

The path to universal health care is conducted through three work streams:

Table 29: outline of three work streams

Work Stream 1	Protect coverage and reduce uninsurance.
Work Stream 2	Define and implement coverage structure, cost containment strategies, and administration.
Work Stream 3	Define and implement financing, program standards, and transition actions.

The following table presents the work in the three color-coded work streams, identifying the lead for each step. For more details on each step and a timeline of the example process, see Appendix B.

Table 30: example timeline for universal health care implementation

Activities	Lead(s)	Work streams		
Maintain existing public coverage	Legislature, Governor			
Pass legislation that: • Sets 5-year goal for universal health care. • Establishes a structure for a 5-year plan. • Establishes Universal Health Care Commission (UHCC) and defines a process.	Legislature, Governor			
Initiate UHCC to support and oversee development of Recommendations.	UHCC			
Develop Phase I action plan for coverage of uninsured.	UHCC Phase I Work Group			
Conduct stakeholder engagement – Phase I.	UHCC, state			

Activities	Lead(s)	Work streams
	agencies	
Develop Phase II(a) action plans for: • Cost-containment strategies. • Coverage structure. • Program administration and operations.	UHCC Phase II(a) Work Groups	
Conduct stakeholder engagement – Phase II(a).	UHCC, state agencies	
Finalize Phase I Recommendations to Legislature for coverage of uninsured.	UHCC	
Pass legislation adopting Phase I coverage changes for uninsured.	Legislature, Governor	
Finalize Phase II(a) Recommendations to Legislature re: cost containment, coverage, and program administration/operations.	UHCC	
Implement Phase I changes.	State agencies	
Develop Phase II(b) action plans: • Develop budget and financing strategies. • Develop process for establishing quality goals and administering reporting process. • Operational planning advisory support. • Transition planning.	UHCC Phase II(b) Work Groups	
Conduct stakeholder engagement – Phase II(b).	UHCC, state agencies	
Conduct detailed operational planning.	State agencies	
Finalize Phase II(b) Recommendations to Legislature re: financing, program standards, and transition.	UHCC	
Pass Phase II legislation.	Legislature, Governor	
Conduct Phase II implementation activities.	State agencies, partners	
Enroll eligible people in Phase I coverage.	State agencies, partners	
Enroll eligible people in Phase II coverage.	State agencies, partners	

Other near-term work: equity

Many members of the Work Group expressed the desire for Washington to design and establish a health system that addresses health equity. The Work Group discussed an equity assessment as a way to methodically evaluate and measure the system as it is designed and implemented. The following provides additional information on the use of equity assessments in Washington and a proposed Office of Equity in the state.

An equity assessment is a tool for identifying inequitable policies, procedures, practices, and outcomes. Equity assessments have been used by organizations and groups ranging from governments and public sector agencies, to small nonprofit organizations and large corporations. Such assessments may include identification of institutional inequity, allocation of resources, community engagement, and alignment with organizational priorities. Assessments can be used to identify where changes are needed in existing programs and organizations and to help develop new programs.

Equity assessments are already in use in Washington State. For example, at the local level, the Government Alliance on Race and Equity developed a Racial Equity Toolkit for the City of Seattle.[55] Starting in 2009, all city departments use the Racial Equity Toolkit, including in the preparation of budget proposals. As of 2015, the toolkit became part of how department heads are assessed.

Other equity-focused work is underway at the state level. A proviso in the 2019-2021 biennial operating budget directed the Governor's Interagency Council on Health Disparities to convene and staff an Office of Equity Task Force.[56] The Task Force, which was directed to develop a proposal for a new Washington State Office of Equity, included participants from the state Legislature, representatives of state agencies, councils, commissions, and community representatives.

The Task Force submitted a preliminary report to the Legislature in December 2019, detailing recommendations for the general structure, primary roles, and estimated operating budget of an Office of Equity. The final report was released in July 2020.[57]

In June 2020, the Task Force sent letters to the Governor and legislative leaders restating the need for an Office of Equity, citing the pandemic and calls for racial justice that had highlighted the need for the office over the prior six months. There is an opportunity to leverage the ongoing work on equity in the design of any new health care system.

Issues for future analysis

The budget proviso that established the Work Group included an ambitious list of topics to cover. Given the size and complexity of the task, Work Group members' broad range of perspectives and the challenges presented by the pandemic, some topics were only addressed superficially or noted as future topics for development.

As Washington moves to develop a universal health care program in the state, additional work will be needed to assess and develop recommendations in the following areas:

- Increased transparency across major health system actors to support efforts to more effectively manage care and reduce costs.
- Health system changes to promote quality, evidence-based practices that will support sustainability and affordability.
- Transition steps that recognize and respond to the changes impacting the range of stakeholders, including consumers, businesses, health care providers and facilities, hospitals, health carriers, and state agencies.
- Options to expand or establish health care purchasing in collaboration with neighboring states.

[55] The Government Alliance on Race and Equity is a network of governments across the country working to achieve racial equity and advance opportunities for all. The Alliance supports jurisdictions working to achieve racial equity, assists jurisdictions seeking to start this work, and supporting the work of broadly inclusive local and regional collaborations focused on achieving racial equity.
[56] ESHB 1109 (section 221, subsection 7).
[57] Office of Equity Task Force, Final Proposal. July 2020.

In addition, as a specific universal health care path is developed, additional revenue and financing analyses will be needed.

Although the Work Group was not able to fully address all topics, this should not be seen as a lack of interest or concern. Numerous topics were raised by the Work Group as key elements of overall reform, and some members stressed these efforts should be the focus prior to increasing coverage in the state. The Work Group hopes these issues will be further addressed in the near future.

Appendices

A: budget proviso

B: Work Group Charter

C: Work Group roster

D: engaging stakeholders and the public

E: meeting summaries

F: public comments

G: history of health reform in Washington State

H: detailed quantitative analysis

I: example transition process and timeline

Appendix A: budget proviso

Engrossed Substitute House Bill 1109(57); Chapter 415, Laws of 2019

The health care authority is directed to convene a work group on establishing a universal health care system in Washington. $500,000 of the general fund—state appropriation for fiscal year 2020 is provided solely for the health care authority to contract with one or more consultants to perform any actuarial and financial analyses necessary to develop options under (b)(vi) of this subsection.

(a) The work group must consist of a broad range of stakeholders with expertise in the health care financing and delivery system, including but not limited to:

(i) Consumers, patients, and the general public;

(ii) Patient advocates and community health advocates;

(iii) Large and small businesses with experience with large and small group insurance and self-insured models;

(iv) Labor, including experience with Taft-Hartley coverage;

(v) Health care providers that are self-employed and health care providers that are otherwise employed;

(vi) Health care facilities such as hospitals and clinics;

(vii) Health insurance carriers;

(viii) The Washington health benefit exchange and state agencies, including the office of financial management, the office of the insurance commissioner, the department of revenue, and the office of the state treasurer; and

(ix) Legislators from each caucus of the house of representatives and senate.

(b) The work group must study and make recommendations to the legislature on how to create, implement, maintain, and fund a universal health care system that may include publicly funded, publicly administered, and publicly and privately delivered health care that is sustainable and affordable to all Washington residents including, but not limited to:

(i) Options for increasing coverage and access for uninsured and underinsured populations;

(ii) Transparency measures across major health system actors, including carriers, hospitals, and other health care facilities, pharmaceutical companies, and provider groups that promote understanding and analyses to best manage and lower costs;

(iii) Innovations that will promote quality, evidence-based practices leading to sustainability, and affordability in a universal health care system. When studying innovations under this subsection, the work group must develop recommendations on issues related to covered benefits and quality assurance and consider expanding and supplementing the work of the Robert Bree collaborative and the health technology assessment program;

(iv) Options for ensuring a just transition to a universal healthcare system for all stakeholders including, but not limited to, consumers, businesses, health care providers and facilities, hospitals, health carriers, state agencies, and entities representing both management and labor for these stakeholders;

(v) Options to expand or establish health care purchasing in collaboration with neighboring states; and

(vi) Options for revenue and financing mechanisms to fund the universal health care system. The work group shall contract with one or more consultants to perform any actuarial and financial analyses necessary to develop options under this subsection.

(c) The work group must report its findings and recommendations to the appropriate committees of the legislature by November 15, 2020. Preliminary reports with findings and preliminary recommendations shall be made public and open for public comment by November 15, 2019, and May 15, 2020.

Appendix B: Work Group Charter

Please view the Work Group Charter, which is available on the Universal Health Care Work Group page and affirmed at the December 9, 2020, meeting.

Appendix C: Work Group roster

Please view the Work Group roster, which is available on the Universal Health Care Work Group page.

Appendix D: engaging stakeholders and the public

A critical piece of the Work Group's legislative charge is stakeholder and public engagement. The following fundamental objectives and ideas were discussed during the first meeting and informed the Work Group's activities:

- Inform stakeholders, including the public, about:
    - The purpose of the Work Group.
    - Developing recommendations for the Legislature and the timeline for those recommendations.
    - How and when stakeholders and the public can get involved.
- Gather input from stakeholders and the public to inform work group deliberations.
- Demonstrate transparency and trustworthiness.

Key audiences

- Washington State residents, including consumers of health care, patients, and the public, including unserved and underserved populations.
- Patient advocates and community health advocates.
- Tribal partners.
- Large and small businesses.
- Labor unions.
- Health care providers.
- Health care facilities.
- Health insurance carriers.

Public engagement tactics

- Create a dedicated webpage to post all Work Group-related information.
- Make all work group meetings open to the public. Set meeting dates and times in advance and post the schedule to the webpage.
- Provide public comment period during each meeting. Individuals who signed up for public comment were provided instructions before the meeting and during the public comment part of the meeting.
- Provide alternate ways to make comments for those unable to attend meetings, those uncomfortable with making face-to-face public comment, and those who signed up to provide comment but couldn't because of time limitations.
    - Following each work group meeting, post a video or audio recording of the meeting and provide an opportunity for people to provide feedback on that meeting. The project team will summarize key themes from this feedback and share it with members at the next meeting.
    - Create an online survey to collect structured feedback from people. Include at least one open-ended question to allow for unstructured comments.

    - Provide an email address where stakeholders and the public can submit input related to the Work Group's recommendations to the Legislature. The project team will summarize key themes and share it with members at the next meeting.
- Provide a public comment period following release of draft reports, expected November 15, 2019, and May 15, 2020.
    - Summarize key themes from public comment and provide summary to members.

Public notifications

- Develop an email subscription through GovDelivery where people can sign up to receive updates and announcements on Work Group progress and activities.
- Send out announcements through GovDelivery about Work Group progress and activities, and encourage people to visit the Universal Health Care Work Group webpage.
    - Invite webpage visitors and people who attend meetings to subscribe to receive GovDelivery announcements about the Work Group.
    - Invite members to distribute the webpage link to their networks.
    - Invite legislators to distribute webpage link to their constituents.

Appendix E: meeting summaries

Below are the meeting summaries for each Work Group meeting by date:

- September 20, 2019
- December 9, 2019
- February 7, 2020
- April 22, 2020: this meeting was canceled
- June 24, 2020
- August 25, 2020
- September 16, 2020
- October 7, 2020
- October 29, 2020
- December 9, 2020

All meeting materials, including agendas, summaries, presentations, materials, and meeting recordings are available on the Universal Health Care Work Group webpage.

Appendix F: public comment

The vast majority of people who provided verbal or written public comment supported a universal health care program, primarily Model A. View the summary of all public comments, available on the Universal Health Care Work Group page.

Appendix G: history of health reform in Washington State

Pre-Affordable Care Act efforts

Basic Health Plan

Washington began extending coverage to some low-income adults and children in 1987 using a state-funded effort called the Washington State Basic Health Program (BHP). Authorized by state law, the initial pilot program was expanded statewide in 1993, eventually enrolling over 100,000 low-income, Medicaid-ineligible working adults with incomes under 200 percent of the federal poverty level (FPL).

Enrollment into Washington's BHP continued to grow through the mid-90s and in 2003 reached a peak of 130,000 (the program's enrollment cap at the time).[58] Due to state budget pressures, BHP funding by was cut by 43 percent in the 2009-2011 state budget, greatly reducing the number of enrollees and stopping new enrollment. Many BHP enrollees transitioned to Medicaid with the state's Section 1115 waiver and eligibility expansion. The ACA's Basic Health Program was modeled on Washington's BHP.

Washington Health Care Commission

In 1990, the Washington Legislature passed Legislative Resolution 4443, which established the Washington Health Care Commission (often referred to as the Gardner Commission after then-Governor Booth Gardner) to recommend plans for ensuring access to health care for all people in Washington State.

The final report, released in 1992, defined universal access as "the right and ability of all Washington residents to receive a comprehensive, uniform, and affordable set of confidential, appropriate, and effective health services" that it called the "uniform set of health services."[59]

The proposed comprehensive and affordable benefits package to be delivered by competing certified health plans would cover preventive, primary, and acute care; prescription drugs; mental health and substance use disorder services; and dental care, with long-term care to be phased in.

Additional services would be available through the public health system (funding for public health more than doubled) and supports for the health system would be included in the reforms. The Commission stressed that services must be timely and not tied to ability to pay or pre-existing health conditions. Consideration of geographic, demographic, and cultural differences should also be taken into account in providing services.

A majority of Commission members wanted a single organization to sponsor coverage for all residents, while others believed employers should play a role in a "pay or play" system that allows the employer to offer coverage or pay into the system. Approved plans would compete on price within a maximum allowed premium and under rules set by an independent state commission. Financing

[58] Revised Code of Washington (RCW) 70.47.060 permitted the program to temporarily close enrollment to avoid over-expenditures.
[59] Washington Health Care Commission, Final Report to Governor Booth Gardner and the Washington State Legislature. November 30, 1992.

would be shared by individuals, employers, and government. Plans would be encouraged to implement capitation and increase provider risk for managing care. The Commission also recommended 17 strategies for making the health care liability system less costly, time consuming, and emotionally burdensome for consumers and providers.

Recognizing that implementation would take time, the Commission recommended starting to act immediately by reauthorizing the Basic Health Plan and increasing funding for public health programs. The group recommended that the Legislature should also pursue insurance reforms, including implementing guaranteed issue and renewability, a prohibition or limit on pre-existing condition exclusions, implementation of modified or strict community rating, and the development and implementation of small group market reforms.

The Washington Health Services Act of 1993

Based on the recommendations of the Washington Health Care Commission, in 1993 the Washington Legislature passed a comprehensive health law that included many of the elements that 15 years later would be included in the ACA:

- Employer and individual mandates.
- Guaranteed issue (insurers may not deny coverage due to pre-existing conditions).
- Required coverage of a basic set of benefits.
- Expanded Medicaid eligibility.

The law was not fully implemented, as most of the law (including individual and employer mandates, the use of certified health plans to deliver coverage based on a uniform set of benefits, and caps on insurance premiums) was repealed by the 1995 Legislature. [60]

The expansion of the Basic Health Program and Medicaid for children in families with income up to 200 percent FPL were retained. The guaranteed issue and required benefits provisions of the law were also maintained, but without the other provisions in place, this led to a crisis in the individual insurance market.

Consumers could wait to buy coverage until they needed care, and in response, insurers increased premiums and stopped selling individual market policies. By 1999, none of the 19 insurers that had previously sold individual coverage in Washington offered an individual policy in the state.

Universal coverage for children

With 98 percent of Washington children covered by health insurance, the state is now considered to have universal child coverage. The process of reaching universal coverage for children took over a decade and involved multiple steps by the Legislature:[61]

1987 Funding was expanded to provide coverage for children up to age two in families with income up to 90 percent FPL and prenatal coverage for women who do not qualify for Medicaid.

[60] Certified health plans was defined by the law as organized delivery systems with financial risk for delivering a uniform benefit package.
[61] Georgetown University Health Policy Institute, Center for Children and Families, Washington: Coverage to All Children. February 2009.

1989 The Maternity Care Access Act was passed, authorizing the First Steps program, expanding Medicaid eligibility for pregnant women and infants up to the federal maximum level of 185 percent FPL and increasing access to maternity support services.

1990 The Children's Health Program was established, a state-funded Medicaid lookalike program for children not eligible for Medicaid in families with income up to 100 percent FPL. The coverage was not established as an entitlement, and thus subject to available funds. Provider rate increases were also implemented at this time.

1993 The Washington Health Services Act expanded Medicaid coverage for children with income up to 200 percent FPL and established outreach and enrollment investments.

1999 The Legislature approved the implementation of federal CHIP in the state, which authorized coverage for children in families with income up to 250 percent FPL through CHIP.

Between 2000 and 2004, the Children's Health Program was not funded and noncitizen children were moved to coverage through the Basic Health Plan. In addition, the state implemented administrative hurdles to gaining coverage. Approximately 50,000 children lost coverage during this period.

2005 Then-Governor Christine Gregoire directed the state Medicaid agency to restore 12-month eligibility for children in Medicaid and CHIP and postponed implementation of Medicaid premiums for children. The Legislature passed a law that partially restored prior cuts to the Children's Health Program (allowing a set number of children with income up to 100 percent FPL to gain coverage) and establishing the state's goal of covering all children by 2010.

2006 Funding for the Children's Health Program was fully restored and proposed premium increases for children were permanently prohibited. The restoration eliminated the Children's Health Program waiting list of over 15,000 children.

2007 The Legislature established an entitlement to health coverage for children with income up to 250 percent FPL.

2008 All programs for children were renamed "Apple Health for Kids," and the state made additional investments in outreach and administrative simplification.

2009 All children with income up to 300 percent FPL were made eligible for enrollment in Apple Health for Kids. Children with income under 200 percent FPL could access zero premium coverage, and those with income between 200 and 300 percent FPL had sliding scale premiums based on income. Families with income above 300 percent FPL could purchase state-offered comprehensive health care for their children.

2014 The ACA established additional access to affordable coverage and funded outreach and enrollment that helped bring in many previously eligible but unenrolled children.

Blue Ribbon Commission on Health Care Costs & Access

Established by a budget proviso in 2006, the Washington State Blue Ribbon Commission on Health Care Costs & Access granted state general funds to the Office of Financial Management and a commission tasked with studying health care costs and access.

The Commission, which included the then-Governor, eight legislators and leaders from the Office of the Insurance Commissioner (OIC), HCA, Department of Health, Department of Social and Health

Services, and Department of Labor and Industries was tasked with recommending a sustainable five-year plan for "substantially improving access to affordable health care for all Washington residents" by December 2006.[62]

Based on the vision of a system that allows every Washingtonian to get needed health care at an affordable price, the group identified four overarching strategies:

- Build a high-quality, high-performing health care system.
- Provide affordable health insurance options for individuals and small businesses.
- Ensure the health of the next generation.
- Promote prevention and healthy lifestyles.

Each of the 16 Commission recommendations is tied to one or more of the above strategies and includes proposed actions. The recommendations were:

Table 31: Blue Ribbon Commission on Health Care Costs & Access recommendations

• Use state purchasing to improve health care quality. • Become a leader in the prevention and management of chronic illness. • Provide cost and quality information for consumers and providers. • Deliver on the promise of health information technology. • Reduce unnecessary emergency room visits. • Reduce health care administrative costs. • Support community organizations that promote cost-effective care. • Give individuals and families more choice in selecting private insurance plans that work for them.	• Partner with the federal government to improve coverage. • Organize the insurance market to make it more accessible to consumers. • Address the affordability of coverage for high-cost individuals. • Ensure the health of the next generation by linking insurance coverage with policies that improve children's health. • Initiate strategies to improve childhood nutrition and physical activity. • Pilot a health literacy program for parents and children. • Strengthen the public health system. • Integrate prevention and health promotion into state health programs.

Many of the Commission's recommendations were implemented by the state Legislature in 2007, including:

- Using reimbursement to reward quality outcomes.
- Increasing consumers' access to information and shared decision making.
- Improving primary care and chronic care.
- Facilitating secure sharing of health information.
- Tracking emergency room use.
- Identifying contributors to health care administrative costs and evaluating ways to reduce them.
- Designing insurance coverage options that promote prevention and health promotion.
- Expanding coverage options.
- Increasing public health activities.[63]

[62] The budget proviso, meeting materials, and final report are available on the Commission website.
[63] Washington Laws, 2007 Ch. 259 [1133], Chapter 259 [Engrossed Second Substitute Senate Bill 5930]. Blue Ribbon Commission on Health Care Costs and Access Implementing Recommendations.

Years ahead of the ACA, the legislation included the requirement to allow anyone purchasing individual or group coverage the option to cover their unmarried dependents until they reach age 25. This requirement was also implemented for disability insurance. It also directed the Department of Social and Health Services to develop coverage expansion options that could utilize Medicaid, CHIP and/or the Basic Health Program.

The Department of Financial Management was instructed to design a state-supported reinsurance program for the individual and small group health insurance markets. The Office of Financial Management was tasked with coordinating and conducting strategic health planning.

Commitment to evidence-based medicine in state-purchased health care

Over the better part of a decade, Washington increasingly established standards and programs that support the use of evidence-based medicine for people receiving state-purchased health care. These efforts led to the establishment of several key programs and initiatives, including:

Washington Administrative Code (WAC) defines medical necessity for Medicaid using an evidence-based process.[64] To be considered medically necessary, a treatment is subject to the following standard: "There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service."

The Washington State Health Technology Clinical Committee (HTCC) was established in 2006 to make evidence-based coverage determinations for health technologies.[65] The HTCC is supported by the HCA's Health Technology Assessment program, which develops and publishes systematic health technology assessment reports on the strength of the evidence for medical devices, procedures, and tests.

The HTCC considers Health Technology Assessment reports and other information, including state utilization and public comment. HTCC determinations guide coverage decisions for state health care purchasers, including Medicaid, Uniform Medical Plan, and the Department of Labor and Industries.

The Dr. Robert Bree Collaborative (Bree) was established by the Legislature in 2011 as a forum for public and private health care stakeholders to collaborate to improve quality, health outcomes, and cost effectiveness of care in the state.[66] Participating experts are nominated by community stakeholders and appointed by the Governor. Each year, Bree identifies up to three health care service areas with high variation in the delivery of care that do not lead to better care or patient health, or that have demonstrated patient safety issues.

Most topics are addressed by a work group of experts on the topic who are Bree members and other experts in the community. The work group analyzes evidence on best practices for improving quality and reducing practice pattern variation. Bree recommendations consider existing quality improvement programs and organizations currently working to improve care. HCA reviews and approves Bree recommendations and incorporates them in state-purchased coverage rules.

[64] WAC 182-500-0070.
[65] HCA, Health Technology Clinical Committee; HCA, Health Technology Assessment.
[66] Bree Collaborative website.

Shared decision making

This is the collaborative process of patients and their providers making health care decisions together, using both the best available scientific evidence and the patient's values and preferences.[67] In 2007, Washington passed a Shared Decision Making Pilot as part of the Blue Ribbon Commission bill. In 2012, the Legislature authorized HCA's chief medical officer to certify patient decision aids using criteria from the International Patient Decision Aid Standards (IPDAS) Collaborative.

Starting in 2016, many Washington health care providers have been able to access the tools, training, and technical assistance needed to help them provide patient-centered care.[68] Materials used to engage patients in decision-making exist for conditions such as maternity health, spine care/joint replacement, and cardiac/end-of-life care. Providers can access training on how to conduct shared decision making and use decision aids in their practices.[69]

Changes since the passage of the ACA

In the ten years since the ACA was signed into law in 2010, Washington's uninsurance rate dropped by ten points, to 6.7 percent in early 2020.[70] In addition to supporting the state's expansion of Medicaid to more than half a million previously uninsured low-income adults, the ACA authorized the establishment of health benefit exchanges and financial support for consumers' premium and cost sharing costs.

Washington Health Benefit Exchange

Washington State chose to establish a state-run health benefit exchange and its portal, Washington Healthplanfinder, as the mechanism for providing residents with access to ACA-compliant health and dental coverage, along with premium tax credits and cost sharing reductions (CSRs) for eligible individuals and families.

The Legislature established the Washington Health Benefit Exchange (Exchange) in 2011 as a public-private partnership governed by a bipartisan board.[71] Exchange implementation occurred over the next several years and established requirements for essential health benefits, market rules, and other qualified health plan (QHP) requirements.

The Exchange began offering plans in October 2013 for the 2014 plan year. Eight insurers offered QHPs in 2014. The number of participating insurers has varied somewhat over the years, with current participation of 13 insurers for plan year 2021. Issuer participation varies across the state. Approximately 185,000 Washingtonians had selected coverage through the Exchange for the 2020 plan year.[72] As of December 1, 2020, 193,000 people chose plans for 2021 coverage.

[67] HCA, Shared decision making webpage.
[68] Healthier Washington Practice Transformation Support Hub website.
[69] Shared decision making: online skills course for providers.
[70] 2020 coverage rates differ, as noted later in this section. Washington State Office of Financial Management, op. cit.
[71] Substitute Senate Bill 5445.
[72] Enrollment numbers are from a December 1, 2020, presentation to the Senate Health and Long Term Care Committee.

Other ACA-related market changes

Washington has implemented a number of market decisions since the implementation of the ACA. While not an exhaustive list, this has notably included:

- In 2014, Medicaid enrollment of individuals eligible under the "adult expansion" authorized under the ACA.
- To help stabilize the market, the decision to bar the sale of short-term/limited duration health plans that do not meet ACA requirements. The change went into effect in 2014.
- In response to the 2017 federal discontinuation of CSR payments to insurers but required them to continue subsidizing members' cost sharing, Washington supported insurers' incorporation of those costs into silver plan premiums starting in the 2018 plan year.[73]
- As of 2018, short-term/limited duration health plans may be purchased for no more than three months in a 12-month period.[74]
- In 2019-2020, the Legislature incorporated ACA health insurance reforms and nondiscrimination provisions into chapter 48.43 RCW.[75]

As noted above, some parts of the ACA were made part of state law in 2007. Other ACA provisions were added to state law in 2019 and 2020, ensuring these rules would continue even if the ACA were to be repealed. Consumer protections included the elimination of pre-existing condition exclusions and waiting periods for plans offered in the state. HB 2338 prohibited discrimination in health care coverage, including expanding the definition of mental health care and requiring short-term limited duration health plans and student health plans comply with mental health parity law.

Medicaid Transformation Project

Through the end of 2021, Washington State will receive up to $1.5 billion as part of a Section 1115 Medicaid demonstration waiver, called the Medicaid Transformation Project (MTP). The waiver allows Washington State to implement several initiatives that benefit Apple Health (Medicaid) clients.

HCA works with numerous partners to implement MTP and its five initiatives. This includes departments of Health and Social and Health Services, Accountable Communities of Health, Indian Health Care Providers (IHCPs), physical and behavioral health providers, community and health-based organizations, and many more.

Below is some additional information about the MTP initiatives.

Initiative 1: transformation through Accountable Communities of Health (ACHs) and IHCPs, where ACHs and IHCPs are implementing projects that change the way people receive health care in their region.

[73] After Congress discontinued CSR payments, issuers were allowed to raise the premium for Silver tier plans. This is referred to as Silver plan loading. As ACA premium tax credits are based on the cost of the second lowest-cost Silver plan in the market, any increase in Silver premiums was absorbed by higher tax credits, and this practice maintained lower cost sharing for consumers. Aviva Aron-Dine, Data: Silver Loading Is Boosting Insurance Coverage. Health Affairs Blog, September 17, 2019.
[74] WAC 284-43-8000 - RCW 48.43.005(26), 48.02.060, 48.44.050, and 48.46.200. WSR 18-21-116, § 284-43-8000, effective 11/17/18.
[75] SHB 1870 (2019) and SHB 2338 (2020).

Initiative 2: Long-term services and supports assist Washington's aging population and family caregivers who provide care for their loved ones. This initiative is made up of two programs, Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).

Initiative 3: Foundational Community Supports helps older adults get and keep stable housing and employment. This initiative is made up of two programs, supportive housing and supported employment.

Initiative 4: substance use disorder (SUD) IMD relaxes restrictions on the use of federal funds to pay for people receiving SUD treatment in a mental health or SUD facility, for an average of 30 days. IMDs are large facilities dedicated to psychiatric care (more than 16 beds where more than 50 percent of the residents are admitted for psychiatric care).

Initiative 5: mental health IMD allows Washington State to purchase an average of 30 days of acute inpatient services for Medicaid members between the ages of 21 and 65 who reside in a dedicated, large psychiatric facility that qualifies as an IMD.

Single-payer and universal health care systems report

In 2018, the state Legislature directed the Washington State Institute for Public Policy (WSIPP) to study single-payer and universal health care systems.[76] The report included a review of single-payer models, comparison of model characteristics, and summary of available literature on resulting costs, quality of care, health outcomes, and rates of uninsurance.[77]

The report compared the U.S. health care system to systems in other high-income countries, finding that comparison countries have used a variety of systems to gain universal health care that spends less than the U.S. Both single-payer and multi-payer systems employ mechanisms to control medical services and pharmaceuticals costs. These comparison systems have lower insurer administrative costs.

Single-payer countries also have lower provider administrative costs. Other countries have taken steps to limit utilization of high-margin procedures and advanced imaging and have discouraged the wide use of technologies and medications with limited or unknown effectiveness.

Other countries have limited financial barriers, promoting more equitable access across income groups. While the U.S. spends more, it does not have better overall health outcomes or quality of care. WSIPP was not able to identify how universal health care programs or policies would translate in the U.S. context.

Cascade Care and standardized plans[78]

While many stakeholders supported a "Medicare-for-All" style reform in Washington in 2019, legislators eventually passed Senate Bill 5526, a public option proposal that would add a public QHP option for state residents who lack employer coverage and are not eligible for public programs, such as Medicare or Medicaid.

[76] Engrossed Substitute Senate Bill 6032, Section 606(15), Chapter 299, Laws of 2018.
[77] Washington State Institute for Public Policy, Single-Payer and Universal Coverage Health Systems: Final Report. May 2019.
[78] For more on Cascade Care, see the Exchange's Cascade Care webpage.

The legislation authorized Cascade Care public option plans, which must meet quality and value requirements and conform to standard plan designs that facilitate consumers' plan comparisons.[79]

The legislation tasked HCA, OIC, and the Exchange with developing and implementing Cascade Care. The Exchange oversaw the development of standardized plan designs, HCA led the procurement of the public option plans, and OIC reviewed and approved the health plan filings submitted by the approved insurers. Each public plan issuer submitted health plan rates, information on covered essential health benefits, and network access information. The Exchange developed standardized plan designs for the gold, silver, and bronze plan levels, including a high-deductible health plan that could be paired with a health savings account.

Five contracted carriers are offering Cascade Care plans for the 2021 plan year. Consumers can enroll in a public option plan starting during the open enrollment period that runs November 1-December 15, 2020, with coverage effective January 1, 2021.

While Cascade Care does not include access to premium assistance beyond currently available income-based federal premium tax, the program's authorizing legislation did require the Exchange to study the adoption of additional financial assistance and for the Exchange, HCA, and OIC to submit a plan for implementing and funding premium subsidies for consumers with income up to 500 percent FPL. A contractor conducted that study, with a report due to the Legislature on November 15, 2020.

Health insurance coverage in 2020

At the start of 2020, 6.7 percent of state residents lacked insurance coverage. However, employment and health insurance coverage have both been impacted by the COVID-19 pandemic. As of May 23, 2020, 13 percent of Washington residents lacked insurance, and initial claims for unemployment were also surging in the state. [80]

By November 14, the uninsurance rate had dropped from the May peak to seven percent. The Office of Financial Management estimated that over the course of 2020, the number of uninsured Washingtonians went from 502,300 (end of 2019) to 1,010,700 (May 2020), and to 541,440 (November 2020).

Rates of uninsurance and change over time differ by county, with Yakima County having the highest uninsured rate in (16.3 percent both pre-pandemic and as of November 14). Garfield County currently has the lowest uninsured rate at 3.7 percent, down from 4.1 percent at the start of the year. Twenty-two Washington counties saw an increase in uninsurance since the start of the year, while 15 counties experienced a decrease in uninsurance and the other two experienced change of less than 0.1 percent.

As of September 2020, 1,942,897 people are enrolled in Medicaid in Washington, an increase of over 135,000 people from the same time last year. While some people have newly enrolled in Medicaid since the pandemic, the main reason for the increase is that Washington (like other state Medicaid

[79] Standard plan designs establish the rules for cost sharing across all participating issuers' plans. This means the deductible, out-of-pocket maximum, coinsurance, and copays would be the same in each plan at a given metal level. Keeping these elements the same across plans allows consumers compare plans based on other factors (such as the provider network or customer service).
[80] Washington State Office of Financial Management, op. cit.

programs) has temporarily halted most disenrollments as part of an agreement with the federal government to receive an increase in the federal match rate during the pandemic.

Appendix H: detailed quantitative analysis

Data and methodology

The following presents the analysis performed to develop cost and revenue estimates for each of the three draft model proposals.

Data sources

The data sources utilized to develop cost and revenue estimates for Models A and B include:

Table 32: data sources

Data source	Data sources referenced
National data	• National Health Expenditures (NHE) – (this included national and Washington-specific data where appropriate) • NHE per capita trend projections • Medical Expenditure Survey Panel (available from the Agency for Healthcare Research and Quality) • United States Department of Labor • CMS • Centers for Disease Control and Prevention • American Community Survey (United States Census Bureau)

State of Washington data	• Washington State Health Care Authority
	  ○ Medicaid
	  ○ CHIP
	  ○ Public Employees Benefits Board
	  ○ School Employees Benefits Board
	• Exchange
	• Washington Office of Financial Management
	• Washington Office of the Insurance Commissioner

Other sources	• National Association of Insurance Commissioners annual health insurer filings • Kaiser Family Foundation • Published studies (citations noted in footnotes)

Notes on data reliance

In developing these cost and revenue estimates, Optumas relied on enrollment, expenditures, provider reimbursement, and benefit design from a variety of data sources. This includes national and state-specific sources. The publishers of this information are responsible for its validity and accuracy; however, we have reviewed the information for reasonableness and consistency and its appropriateness for use in the estimates developed.

Due to availability and limitation of available data, it was not practical to perform modeling on or for every circumstance or scenario. Summary information estimates and simplification of calculations may have been incorporated into the modeling. Included with this methodology are limitations and recommendations for additional detailed analysis, dependent on which path may be implemented for the state of Washington.

Optumas is not engaged in the practice of law or providing advice on taxation. The cost and revenue analysis includes commentary on revenue but is not a substitute for legal or taxation advice.

Status quo expenditure development (baseline expenditures)

The status quo presents the estimated cost of implementing each of the models; baseline expenditures for populations and services of interest are estimated. Adjustments that reflect the various impacts associated with each model are then applied to come to a final expenditure estimate. This section outlines the development of status quo expenditure estimates.

Sources

There are many different payer sources that contribute to funding health care expenditures in Washington. These include public programs, private insurance, federal programs, individual contribution, and charitable contributions. An estimate of status quo baseline expenditures captures all relevant expenditures that are included in the proposed universal health care models.

To identify the different payer sources, Optumas relied on NHE funding source categories[81] to inform the funding categories incorporated in the universal health care models. They include the following:

- Out-of-pocket
- Private health insurance
- Medicare
- Medicaid
- CHIP
- Indian Health Services
- General assistance
- Other private revenues

NHE expenditure categories that were excluded from the universal health care models are military coverage, federal employees, research and investment funding, population health, and school and worksite health programs.

While Optumas utilized the NHE funding source categories, the actual expenditures for each category relied on a variety of sources. Actual reported expenditures, such as Medicaid or CHIP, were used where possible. NHE estimates were used for all others where actual information was not available.

Specifically, reported expenditures were utilized for Medicare, Medicaid, and CHIP (reported by the CMS).[82] Imputed values were used for the majority of private health insurance, Indian Health Services, general assistance, and other private revenue. Of note, private health insurance includes employer-sponsored plans that are exempt from detailed utilization and expenditure reporting under federal law. The reliance on imputed statistics highlights the need for data collection strategies in markets that lack transparency.

Imputed expenditures

To impute expenditures, one of two methodologies was used for each funding category. Imputed expenditures are the product of the NHE estimated per capita expenditure and the Washington State population estimate for that funding source **or** are based on the relative percentages of expected expenditures. Private health insurance is the largest imputed category and relied on the former

[81] CMS, National Health Expenditure Accounts: Methodology Paper, 2018.
[82] CMS, State Expenditure Reporting for Medicaid & CHIP.

category. Estimates of the Washington population that utilize private health insurance were applied to the NHE per capita estimate for that category to estimate total expenditures for that population.

Service categories

The cost modeling included adjustments that estimate various effects of transitioning from the current status quo of health care delivery to Models A and B. In many cases, these adjustments—such as provider reimbursement changes—were applicable to specific service categories (e.g., hospital, pharmacy, physician). The distribution of expenditures by service category reported by NHE was applied to each data source to support modeling adjustments.

As several service categories were not included in Models A or B (including over-the-counter medications, investment and research, long-term care, and dental services), in most cases, these service categories were excluded from the distribution process.

Per capita health care trend factors

Because the modeling is on a calendar year (CY) 2022 basis and baseline expenditures are from CY 2018, trends by program were applied to establish a CY 2022 baseline. Trends are based on NHE projections from 2018 through 2022 by funding source. The table below illustrates the annualized trends by major funding source. The annualized trend factor capture both enrollment growth, utilization, and unit cost trend.

Table 33: average annual per capita growth rate, 2018-2022

Funding source	Average annual per capita growth rate, 2018-2022
Medicare	7.5%
Medicaid	4.9%
CHIP	3.6%
Other public	4.9%
Private health insurance	4.4%

Baseline expenditure results

The processes described above result in estimated CY 2022 expenditures by funding source that are limited to populations and categories of service of interest. Status quo expenditures are summarized in the table below.

Table 34: estimated CY 2022 expenditures

Populations[83]	Estimated 2022 population	Estimated status quo expenditure
Medicaid	1.7 million	$15 billion
Medicare	1.7 million	$15 billion
CHIP	62,000	$83 million
Private insurance	3.7 million	$23 billion
Undocumented immigrants	124,000	$45 million
Uninsured	278,000	$134 million
Expenses related to non-coverage health care programs[84]	N/A	$7.2 billion

Universal health care modeling

The status quo 2022 expenditures established for select populations and services, adjustments are applied to estimate the effects of transitioning to a universal health care system. The following sections describe these adjustments. The following sections present adjustments to develop Models A and B expenditures.

Provider administrative efficiencies

Under the status quo system, providers spend significant resources interacting with multiple payers. This includes administrative resources used on contracting, reporting, billing under disparate criteria, and more. Reducing the number of payers to a single-payer under Model A or a small number under Model B will reduce provider costs, which can be used to justify a reduction in provider reimbursement rates.

An aggregate downward adjustment of between 0.6 percent and 2.4 percent (upwards of eight percent for physician services), increasing as the program matures, is incorporated in Models A and B.

It is important to note there is limited information to inform the magnitude of the adjustment. Where there are comparative studies across different systems, it was not apparent that the differences in administrative costs can be solely attributed to interacting with fewer payers.

Other factors, such as high volumes of prior authorization requirements and reporting burden, can contribute to differences in administrative costs in different systems. To achieve these savings, the state will need to commit to designing an administrative structure and billing processes that minimize provider burden. This is especially true for Model B, which retains managed care organizations and some degree of payer fragmentation.

Provider reimbursement rebalancing

In the current health care system, providers receive different levels of payment for the same or similar services based on payer. Generally, Medicaid reimbursement is the lowest, followed by Medicare. Private insurance reimbursement is highest. Status quo variation in provider reimbursement rates by payer would be eliminated under a single-payer system. To account for this

[83] Excludes individuals covered by health insurance provided by Department of Defense, Veteran Affairs, or other federal employee coverage, along with costs associated with care provided through school-based health care programs, worksite health care, workers' compensation, maternal and child health programs, and vocational rehabilitation.
[84] Includes estimates for expenditures that would be captured under a universal model including, charitable care, Indian Health Services, and out-of-pocket expenditures.

effect, the model adjusts expenditures by funding source to reflect pricing normalization associated with transitioning to a single fee schedule.

It is important to note this specific provider reimbursement adjustment included in Models A and B is intended to maintain the aggregate level of reimbursement in the system; however, the impact to each provider will vary. The impact to the provider is directly related to current distribution of insured patients. As a result, some providers may see increases to their total patient revenues, others will experience decreases, and some will not be impacted significantly.

Due to data constraints, the adjustment in the model is limited to the hospital care and physician and clinical services categories. Status quo reimbursement level assumptions are shown in the below table.

Table 35: reimbursement levels as a percent of Medicare

Payer source	Hospital care	Physician and clinical services
Private health insurance	225%	143%
Medicare	100%	100%
Medicaid	90%	75%

Last, please note that estimates for private health insurance vary significantly and are impacted by the lack of reporting by ERISA plans. Statistics for this population are derived from a review of studies conducted by the Kaiser Family Foundation.[85] Medicare statistics are definitionally true. Medicaid statistics are based on anecdotal information from Washington Health Care Association. Because these assumptions are critical for understanding what federal funding will be available to offset state costs under Models A and B, it is important these statistics are updated in the future, should better data become available.

Medicaid population utilization changes due to provider reimbursement changes

Due to the aforementioned provider reimbursement differences between commercial plans and Medicaid, some providers have historically limited the number of Medicaid members they allow on their panels. This has the potential effect of reducing access to preventive care for the Medicaid population.

Under the universal health care model, much of the provider reimbursement variation is eliminated. Consequently, provider participation or availability to those covered would not be influenced by reimbursement differences as they are today. This is expected to increase access to preventive services for the Medicaid-eligible population compared to the access they have today.

Consequently, Models A and B reflect increased utilization of primary care services and decreased utilization of hospital services for this population. Aggregate utilization of physician, clinical, and professional services are assumed to increase by one percent, with a decrease of 0.25 percent in both inpatient and outpatient services.

[85] Eric Lopez, T. (2020, May 01). How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature.

Uninsured population utilization

The current uninsured population is not homogeneous. While the uninsured population includes individuals who do not obtain coverage because they have limited need for health care services, many others have needs but cannot afford coverage. For this latter population, individuals may go without or may delay needed health care services.[86] This delay often leads to worsened conditions when the individual does seek treatment. To account for increased access to care and pent-up demand, a 200 percent increase in utilization is assumed for this population.

Undocumented immigrant utilization

Limited data is reported on the health care costs and utilization patterns for the undocumented population. Under the universal health care models, this population is assumed to have similar pre-adjusted cost and utilization (before efficiencies, rate rebalance, and administrative adjustments are applied) to the privately insured population, or a PMPM cost of approximately $519.

Out-of-pocket cost sharing

Models A and B assume no cost sharing; the model assumes no copays, deductibles, or coinsurance. Approximately $4.2 billion in costs previously incurred by service utilizers are assumed to be covered under Models A and B, and reflect an increased cost to Models A and B that will need to be funded through state revenues.

Utilization impacts associated with removing cost sharing

There are two primary effects from eliminating cost sharing. First, barriers for individuals to access care are eliminated, which will increase the cost for members accessing these services. This also includes increases to appropriate, but elective procedures that were delayed due to cost sharing. Reductions in costs associated with delay of care and exacerbation of conditions can be expected in the longer term beyond the implementation year.

Second, barriers to ineffective or inefficient care are also eliminated. This could potentially result in increases in costs without offsetting beneficial improvements in outcomes or longer term reduced costs. This effect is demonstrated in studies that evaluated emergency department utilization and services considered to be low value, but could not be demonstrated in others.[87, 88, & 89]

The evidence base for the strength of each of these effects is weak and mixed due to the challenge of isolating specific causal relationships in complex and dynamic environments. Economic theory suggests that price sensitivity is inversely related to the perceived need for a service and that larger price differentials may be needed to impact changes in utilization.

[86] Jennifer Tolbert, K. (2020, May 14). Key Facts about the Uninsured Population.
[87] Gruber, Jonathan and Maclean, Johanna Catherine and Wright, Bill and Wilkinson, Eric and Volpp, Kevin, The Impact of Increased Cost Sharing on Utilization of Low Value Services: Evidence from the State of Oregon (January 2017). IZA Discussion Paper No. 10477.
[88] Siddiqui, M., Roberts, E., & Pollack, C. (2015, March). The effect of emergency department copayments for Medicaid beneficiaries following the Deficit Reduction Act of 2005.
[89] Yaremchuk, K., MD, Schwartz, J., MD, MBA, & Nelson, M., BS. (2010). Copayment Levels and Their Influence on Patient Behavior in Emergency Room Utilization in an HMA Population. Copayment Levels and Their Influence on Patient Behavior in Emergency Room Utilization in an HMO Population, 13(1), 26-31.

Because limited information is available on current statewide practices, some increases in utilization of low-value services could occur with the removal of cost sharing if it private insurance plans have been successful in deterring utilization of low-value services through cost sharing policy.

Utilization adjustments to account for the removal of barriers to accessing care include an approximate 1.9 percent increase in the aggregate PMPM costs for the private health insurance population. This is a composite impact that reflects increases to utilization in most services categories, but aggregate decreases in inpatient hospital utilization.

Purchasing power

A universal health care system would consolidate purchasing power under a single entity and will increase negotiation power for high-cost procedures, providers, and can provide greater access to volume-based discounts.

Negotiation power

Work Group feedback suggested that purchasing power could allow for reduced hospital pricing. The data to support an appropriate magnitude or feasibility for an adjustment was not available; however, because this opportunity is plausible, a conservative adjustment a one to two percent reduction in aggregate hospital expenditures is included for Models A and B.

An important advantage of a single-payer system is pricing transparency. When all utilization in a state flows through a single payer, that entity gains insight into pricing variation that is otherwise opaque in a fragmented payer system. This insight could result in even greater reductions in aggregate expenditure if there is significant unwarranted pricing variation in the system today.

Volume-based discounts

The greatest opportunity for volume-based discounts exists for pharmaceutical and durable medical equipment. Aggregate adjustments reducing costs between four to seven percent (increasing as the program achieves steady state) for pharmaceuticals, and one to four percent are incorporated for durable medical equipment.

The adjustment for pharmaceuticals recognizes the fact that less room for greater discounting is available for the Medicaid-eligible population. The Medicaid Prescription Drug Rebate Program uses the greater of a fixed rebate floor the "best price." 42 U.S.C. § 1396r-8 (c) (1)(C) defines best price as the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States.

States can also negotiate additional rebates on top of the federal program. These two factors result in Medicaid programs having access to better net pricing than private plans typically have access to, which is why the model reflects less opportunity for Medicaid utilization than private plans.

The state's ability to achieve this magnitude of savings will be contingent on the states resource investment in analysis and negotiation on pricing with manufacturers.

Program integrity

Under a consolidated payer system, analysis of a statewide comprehensive claims data is possible. One implication is that statistical patterns indicating fraud, waste, and abuse that were not previously detectible across payers becomes apparent and actionable. Estimates of the cost of health care fraud

vary, but the estimates generally range from three to ten percent as noted by the National Health Care Anti-Fraud Association.[90]

An adjustment is included in Models A and B to reflect system-wide reductions in fraud, waste, and abuse. This adjustment ranges from 0.25 to three percent overall once the new system has reached steady state.

It is important to note the transition to Model A or Model B alone is insufficient to achieve the reductions in cost associated with this adjustment. The state would need to invest in staff and tools to aggressively identify, pursue, and prevent fraud, waste, and abuse under the new paradigm. Additionally, savings would accrue to future contract periods and once a state of maximum savings is achieved, additional savings would not occur. However, monitoring would need to continue to ensure fraud, waste, and abuse does not influence future cost inflation.

Plan administration

Models A and B introduce system-wide efficiencies through consolidation of payer functions. The current system of multiple payers results in duplication of infrastructure for claims processing and numerous plan administrative functions. Additionally, under Model A (a state-administered system), private plan margin and risk premium is eliminated.

The aggregate level of administration (including margin) is estimated to be between 8.1 and 8.6 percent. Model A assumes an administrative cost of 4.5 percent. Model B, which leverages managed care entities, assumes a 7.5 percent administrative cost.

While programs like Medicare have been noted to have administrative costs below three percent (below two percent when excluding Medicare Advantage Plans), there are several factors to note as to why this level of efficiency is not achievable, even with Models A or B.

First, Medicare has economies of scale that would continue to dwarf a statewide program in Washington. Medicare is a $644 billion program (ten times larger than the projected costs for Models A or B).[91]

Second, Medicare's low administrative percentage is misleading due to the higher average cost per member for the Medicare population. The actual per member costs associated with Medicare administration are much closer to commercial administrative costs.

Last, Washington will continue to incur significant administrative costs associated with preserving federal funding for Medicaid, CHIP, and Medicare-eligible individuals. This includes compliance and reporting with a broad array of regulations for the Title XVIII (Medicare), Title XIX (Medicaid), and Title XXI (CHIP) programs.

Premium tax

Washington currently imposes a premium tax on health insurers.[92] This premium tax is assumed not to apply to Model A. It is assumed to apply to Model B. This contributes to the difference in

[90] The Challenge of Health Care Fraud. (n.d.).
[91] Budget Basics: Medicare. (2020, July 29).
[92] Revised Code of Washington, Chapter 48.14, Section 48.14.0201, Premium taxes.

administrative cost assumptions between the two models. Importantly, if Model A were to be implemented, the state may need to backfill lost revenues collected from the premium tax.

Dental estimate overview

Standardized dental coverage, based on employer-sponsored and commercial-like, is included in Models A and B and include the following elements:

- Coverage for preventative and diagnostic care, minor, and major (e.g., crowns, bridges dentures, oral surgery, root canals).
- Orthodontia subject to lifetime coverage limits.
- Annual benefit maximums.
- Eliminates out-of-pocket cost sharing.
- Dentist reimbursement consistent with employer-sponsored dental coverage.

The proposed dental coverage for Models A and B would be very close to what individuals currently receive through employer-sponsored, health benefits marketplace and individual coverage, and eliminate out-of-pocket costs up to annual or lifetime benefit maximus. Individuals whose dental services are covered by Medicaid would receive enhancements to their current dental benefits like major restorative and orthodontia. Individuals who are uninsured, including those who are undocumented, do not generally have dental coverage.

A range of dental estimates were developed reflecting variation for factors including the type of dental networks (e.g., managed care versus preferred provider organizations), annual benefit maximums, orthodontia coverage including lifetime limits, and variation in out-of-pocket costs. Model C does not include dental coverage.

Methodology

The source of information influenced the methodology for projecting monthly per-person dental coverage expense. Sources of information based on insured monthly premiums were adjusted to remove the impact of Washington premium tax (if applicable), dental insurer administration and risk margin loadings. Information on reported dental service expenses did not need adjustments to remove premium tax, insurer administration, and risk margin. Please refer to the discussion of data sources for the information collected and evaluated for purposes of this estimate.

The monthly per-person dental expense reflected only insurer dental coverage expenses and required an adjustment to gross up expenses for estimated out-of-pocket cost sharing based on an average actuarial value of 70 percent. This adjustment reflects an annual per-person cost for dental coverage without out-of-pocket costs.

The adjusted data was trended, based on NHE projections for dental services, based on the midpoint period of the data source (CY 2017-2020) to the midpoint of the UHC contract period (CY 2022). Adjustments to reflect provider reimbursement were applied to normalize a dental fee schedule that maintains aggregate reimbursement levels between all payers (Medicaid to employer-sponsored).

Impact on expenditures and revenues

The status quo health care system includes a significant source of funds from the federal government, State of Washington, employer, and individual contributions, including local funds for public employees. Implementing a universal health care system as outlined in Model A and B redistributes

costs and revenues and will require the Legislature to identify and collect revenues to offset new costs incurred the universal health care system.

Providing a standardized dental coverage, without out-of-pocket cost sharing and a uniform dental reimbursement, will require additional federal and state revenues as outlined below:

- **Medicaid:** federal and state revenues will need to increase to cover the modeled dental benefits coverage and increased reimbursement for dental providers.
- **Employer-sponsored, Exchange, and individual marketplace:** additional state revenue will be required to cover the amount of out-of-pocket costs incurred by individuals enrolled in dental coverage employer-sponsored, health benefits marketplace, and individual coverage.
- **Medicare:** additional state revenue will be required to cover the dental benefits coverage and out-of-pocket costs incurred by Medicare-enrolled individuals.
- **Uninsured:** additional state (and potentially federal) revenue will be required to provide dental benefits coverage.
- **Undocumented immigrants:** additional state revenue will be required to provide dental benefits coverage

Results: costs and revenues by scenario

This section is organized to present the following results:

- Model A (universal health care – state-administered): results for implementation year and steady state
- Model B (universal health care – delegated): results for implementation year
- Model C: overview and considerations
- Model design impacts
    - Dental services estimate
    - Cost sharing summary
    - Five-year trend resource

Model A

Table 36: overview of Model A

Covered populations	Benefits	Cost sharing	Provider reimbursement	Population-specific impacts	Administration
• Medicaid • Medicare • CHIP • Private health insurance (employer, state employees, and Exchange) • Undocumented immigrants • Uninsured	• Essential health benefits • Dental for Medicaid-eligible only • Vision • Long-term care for Medicaid-eligible Only	• No cost sharing • Private insurance utilization changes due to removal of cost sharing	• Reduced pricing variation between covered populations • Administrative efficiency • Purchasing power	• Improved access for Medicaid-eligible persons, utilization changes by service type • Reflects increased utilization for uninsured and undocumented immigrant populations	• State-administered • Premiums are exempt from state premium tax impacting cost and revenues • Reflects reductions in system-wide administrative costs

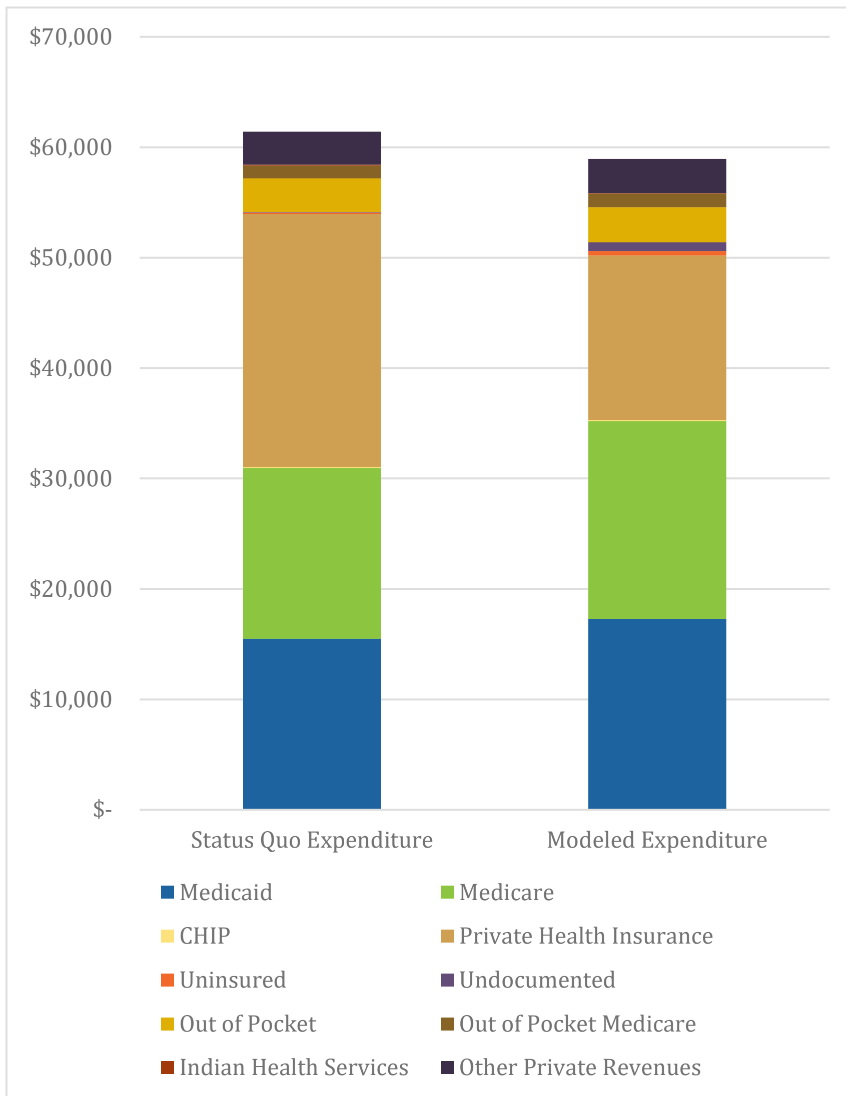
Table 37: Model A CY 2022 expenditure projections – implementation year

Financing source	Population[93]	Status quo expenditures[94]	Modeled expenditures	Differences
Medicaid	1,703,992	$15,492,152,242	$17,252,947,016	$1,760,794,774
Medicare	1,721,504	$15,478,141,127	$17,950,096,666	$2,471,955,539
CHIP	61,707	$83,298,324	$98,892,477	$15,594,153
Private health insurance	3,673,661	$22,899,808,044	$14,888,845,722	$(8,010,962,322)
Uninsured	333,840	$133,818,270	$411,406,833	$277,588,563
Undocumented	124,428	$44,888,791	$793,527,255	$748,638,464
Excluded populations[95]	277,774			
Out-of-pocket expense (excluding Medicare)		$3,045,638,137	$3,174,735,124	$129,096,987
Out-of-pocket expense (Medicare)		$1,156,180,215	$1,205,187,804	$49,007,589
Indian Health Services		$79,843,114	$77,511,016	$(2,332,098)
Other private revenues		$3,003,934,742	$3,088,982,108	$85,047,366

[93] The Medicaid population totals exclude dually eligible members from the population count. Medicaid reimbursed expenditures are reflected in Medicare. All other Medicare-covered expenditures are included in the Medicare row.
[94] Status quo and modeled expenditure totals exclude long-term care and dental for all payer sources other than Medicaid.
[95] This includes federal employees and active duty military.

Total	**7,896,906**	**$61,417,703,006**	**$58,942,132,021**	**$(2,475,570,985)**

Figure 7: status quo vs. Model A – program year 1 expenditures (in millions)



Key notes:

Model A is expected to reduce aggregate system-wide expenditures by approximately **$2.5 billion** in the first implementation year. This impact is driven by multiple efficiencies that occur under a single-payer system. The efficiencies reflect a phase in during the initial year. These include factors, such as:

- Reduced payer administrative cost
- Increased purchasing power
- Health care provider administrative efficiencies
- Program integrity improvements

The below table represents projected CY 2022 revenue estimates by financing source. These revenue projections include consideration for cost-shifting dynamics that will occur due to universal health care. Note the following when interpreting the figures in this table:

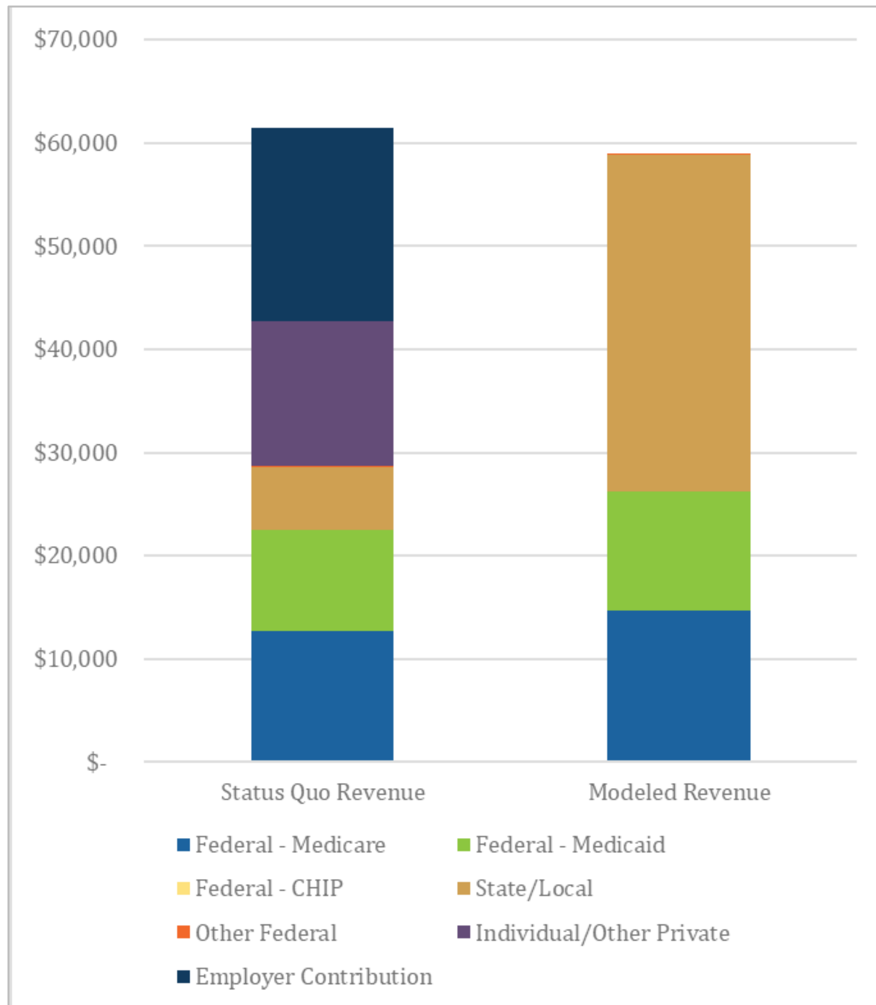
- The status quo health care system includes a significant source of funds from individual and employer contributions, including state and local funds for public employees. These revenues are assumed to continue under Model A universal health care; however, a mechanism to capture these contributions will need to be developed and implemented by the Washington State Legislature. These revenues are illustrated in the "State/local" row for the "Model A revenue estimate" column.
- Model A design includes normalizing provider reimbursement into a single reimbursement schedule. This is a significant change from status quo where reimbursement varies by payer (Medicaid, Medicare, and private coverage). Subject to federal approval, this change would increase the amount of federal contributions Washington receives, but also increase state general fund obligations.
- Contributions to cover uninsured, undocumented immigrants and out-of-pocket costs are included in "State/local" row for the "Model A revenue estimate" column.
- The revenue model assumes the state will be successful in preserving federal funding streams for eligible populations, even with the programmatic changes associated with transition to a universal health care model.
- The revised Model A projected expenditures in Table 10 excluded the cost for dental coverage for populations other than Medicaid. The following table separately identifies revenue collections necessary for dental coverage for all populations beyond Medicaid.

Table 38: Model A CY 2022 revenue sources – implementation year

Financing source	Status quo revenue	Model A revenue estimate	Differences
Federal share – Medicaid[96]	$12,692,075,724	$14,719,079,266	$2,027,003,542
Federal share – Medicare	$9,760,055,912	$11,471,950,522	$1,711,894,610
Federal share – CHIP	$73,302,525	$87,025,380	$13,722,855
State/local share	$6,051,654,951	$32,586,565,837	$26,534,910,886
Other federal contributions (e.g., Indian Health Services)	$79,843,114	$77,511,016	$(2,332,098)
Individual contribution	$14,057,144,852		$(14,057,144,852)
Employer contribution[97]	$18,703,625,927		$(18,703,625,927)
Total	**$61,417,703,006**	**$58,942,132,021**	**$(2,475,570,985)**
Dental coverage for populations other than Medicaid[98]			**$3,052,211,853**

[96] Medicaid funding is dependent on expenditure authorities awarded to Washington by CMS and changes in federal financial participation rates. Estimates are based on pre-CARES Act federal financial participation rates.
[97] The employer contribution includes state/local funds for public employees.
[98] Additional revenue required for covering dental services for all other populations than Medicaid, federal employees, and military. Assumes "moderate" cost level for dental services.

Figure 8: status quo vs. Model A – program year 1 revenues (in millions)



Key notes:

A major contributor to the increase in federal funds is associated with provider reimbursement rate normalization associated with a single-payer fee schedule. There are offsetting decreases to the private health insurance (employer and individual contributions). It is unclear if federal funding will be available to subsidize this effect.

Additional analysis is needed to understand the impact of lost insurer premium tax. Premium taxes contribute to the general fund. The loss of this revenue will need to be considered by the Washington State Legislature.

Additional analysis is needed to understand the broader economic impact on the state due to industry job loss, tax implications for employers, greater labor mobility, etc.

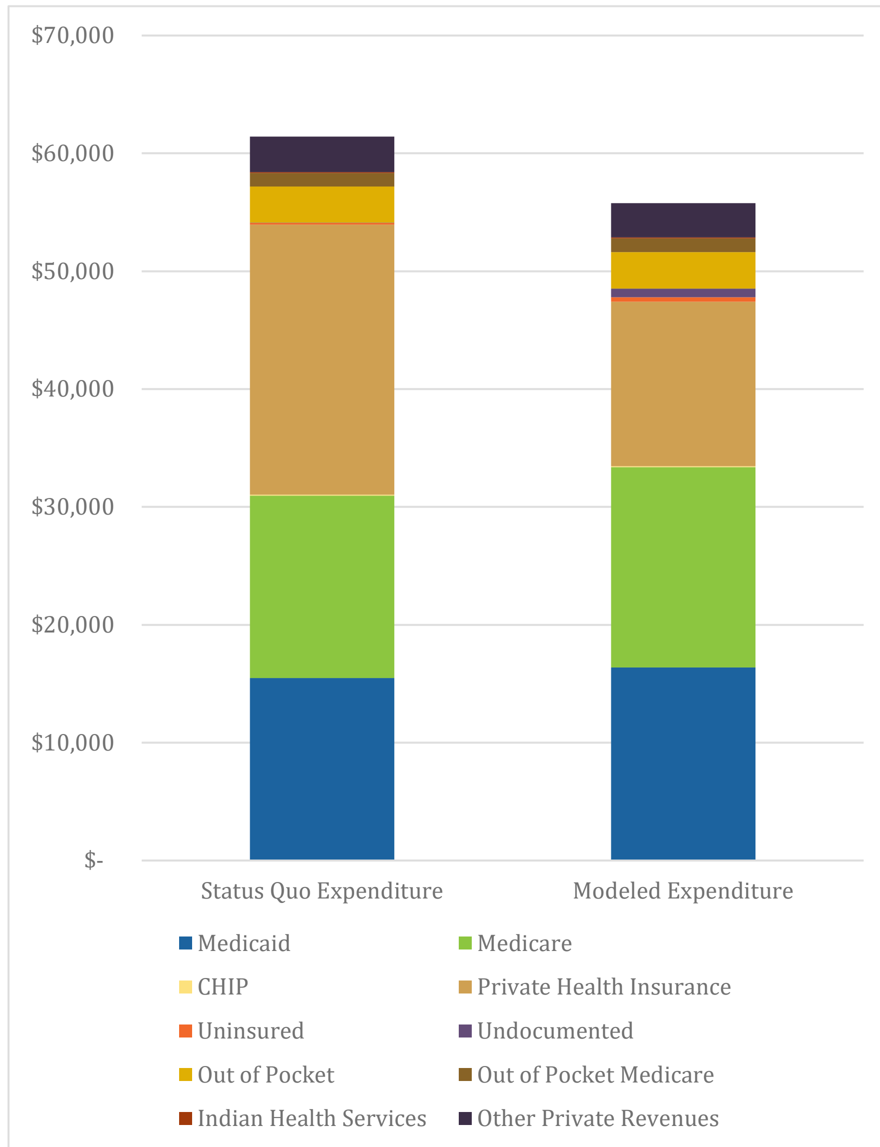
The following table and figure, in CY 2022 dollars, reflect Model A at steady state, or after the program has matured. It is unclear how long it will take for the new program to achieve steady state. The primary difference between implementation year assumptions and steady state is the magnitude of savings associated with the various programatic efficiencies.

Table 39: Model A CY 2022 expenditures – steady state

Financing source	Population[99]	Status quo expenditures[100]	Modeled expenditures	Differences
Medicaid	1,703,992	$15,492,152,242	$16,376,945,975	$884,793,733
Medicare	1,721,504	$15,478,141,127	$16,997,807,187	$1,519,666,060
CHIP	61,707	$83,298,324	$93,163,569	$9,865,245
Private health insurance	3,673,661	$22,899,808,044	$13,947,804,665	$(8,952,003,379)
Uninsured	333,840	$133,818,270	$384,105,435	$250,287,165
Undocumented	124,428	$44,888,791	$740,867,936	$695,979,145
Excluded populations[101]	277,774			
Out-of-pocket expense (excluding Medicare)		$3,045,638,137	$3,087,211,098	$41,572,961
Out-of-pocket expense (Medicare)		$1,156,180,215	$1,171,962,075	$15,781,860
Indian Health Services		$79,843,114	$72,929,817	$(6,913,297)
Other private revenues		$3,003,934,742	$2,899,108,457	$(104,826,285)
Total	**7,896,906**	**$61,417,703,006**	**$55,771,906,214**	**$(5,645,796,792)**

[99] The Medicaid population totals exclude dually eligible members from the population count. Medicaid reimbursed expenditures are reflected in Medicare. All other Medicare-covered expenditures are included in the Medicare row.
[100] Status quo and modeled expenditure totals exclude long-term care and dental for all payer sources other than Medicaid.
[101] This includes federal employees and active duty military.

Figure 9: status quo vs. Model A – steady state expenditures (in millions)



Key notes:

Model A is expected to reduce aggregate system-wide expenditures by approximately **$5.6 billion** at steady state (in CY 2022 dollars). This impact is driven by multiple efficiencies that occur under a single-payer system. These include factors, such as:

- Reduced payer administrative cost
- Increased purchasing power
- Provide administrative efficiencies
- Program integrity improvements

The steady state model reflects higher savings assumptions as the system and data mature under the universal health care model.

The following table represents projected calendar year 2022 revenue estimates by financing source. These revenue projections include consideration for cost-shifting dynamics that will occur due to universal health care. Please note the following when interpreting the figures below:

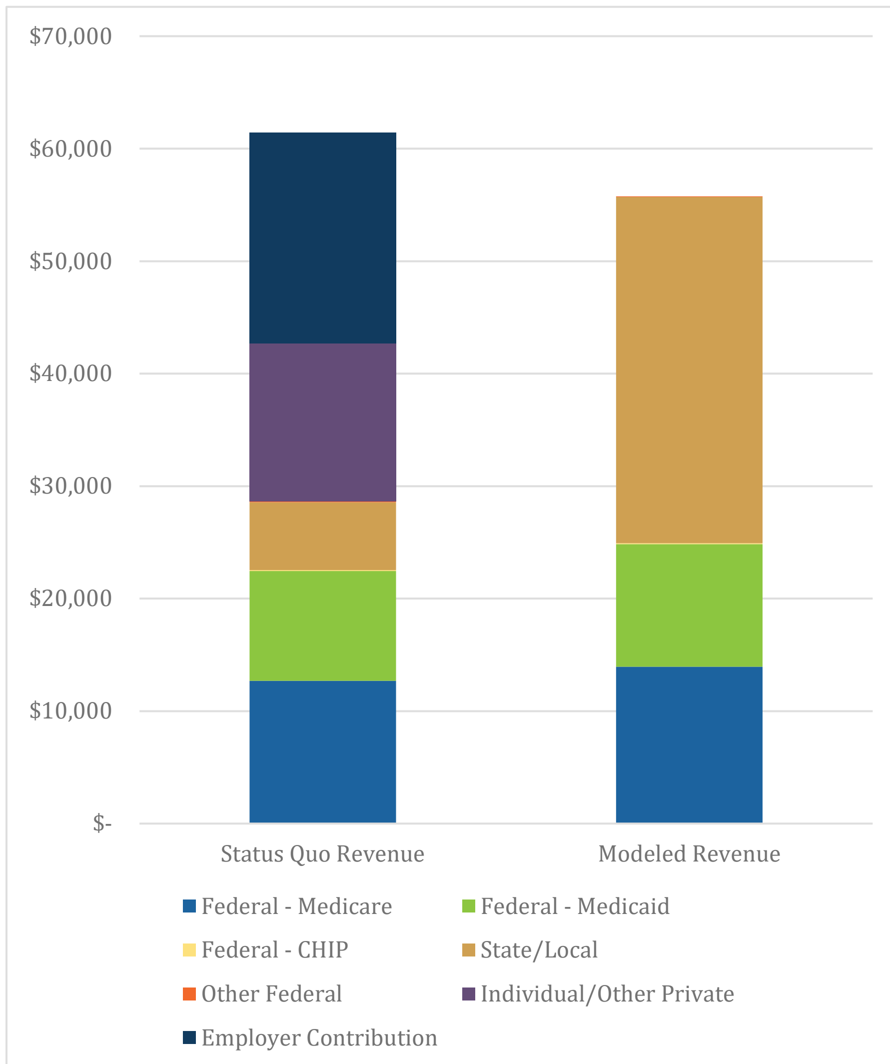
- The status quo health care system includes a significant source of funds from individual and employer contributions, including state and local funds for public employees. These revenues are assumed to continue under Model A universal health care; however, a mechanism to capture these contributions will need to be developed and implemented by the Washington State Legislature. These revenues are illustrated in the "State/local" row for the "Model A revenue estimate" column.
- Model A design includes normalizing provider reimbursement to a single reimbursement schedule. This is a significant change from status quo where reimbursement varies by payer (Medicaid, Medicare, private coverage). Subject to federal approval, this change would increase the amount of federal contributions Washington receives but also increase state general fund obligations.
- Contributions to cover uninsured, undocumented immigrants and out-of-pocket costs are included in "State/local" row for the "Model A revenue estimate" column.
- The revenue model assumes the state will be successful in preserving federal funding streams for eligible populations, even with the programmatic changes associated with transition to a universal health care model.
- The revised Model A projected expenditures in Table 10 excluded the cost for dental coverage for populations other than Medicaid. The following table separately identifies revenue collections necessary for dental coverage for all populations beyond Medicaid.

Table 40: Model A CY 2022 revenue sources – steady state

Financing source	Status quo revenue	Model A revenue estimate	Differences
Federal share – Medicaid	$12,692,075,724	$13,938,201,893	$1,246,126,169
Federal share – Medicare	$9,760,055,912	$10,903,457,002	$1,143,401,089
Federal share – CHIP	$73,302,525	$81,983,941	$8,681,416
State/local Share	$6,051,654,951	$30,775,333,561	$24,723,678,610
Other federal contributions (e.g., Indian Health Services)	$79,843,114	$72,929,817	$(6,913,297)
Individual contribution	$14,057,144,852		$(14,057,144,852)
Employer contribution[102]	$18,703,625,927		$(18,703,625,927)
Total	**$61,417,703,006**	**$55,771,906,214**	**$(5,645,796,792)**
Dental coverage for populations other than Medicaid[103]			**$3,052,211,853**

[102] Employer contribution includes state/local funds for public employees.
[103] Additional revenue required for covering dental services for all other populations than Medicaid, federal employees, and military. Assumes "moderate" cost level for dental services.

Figure 10: status quo vs. Model A – steady state revenues (in millions)



Key notes:

A major contributor to the increase in federal funds is associated with provider reimbursement rate normalization associated with a single-payer fee schedule. There are offsetting decreases to the private health insurance (employer and individual contributions). It is unclear if federal funding will be available to subsidize this effect.

Additional analysis is needed to understand the impact of lost insurer premium tax. Premium taxes contribute to the general fund. The loss of this revenue will need to be considered by the Washington State Legislature.

Additional analysis is needed to understand the broader economic impact on the state due to industry job loss, tax implications for employers, greater labor mobility, etc.

Model B

Table 41: overview of Model B

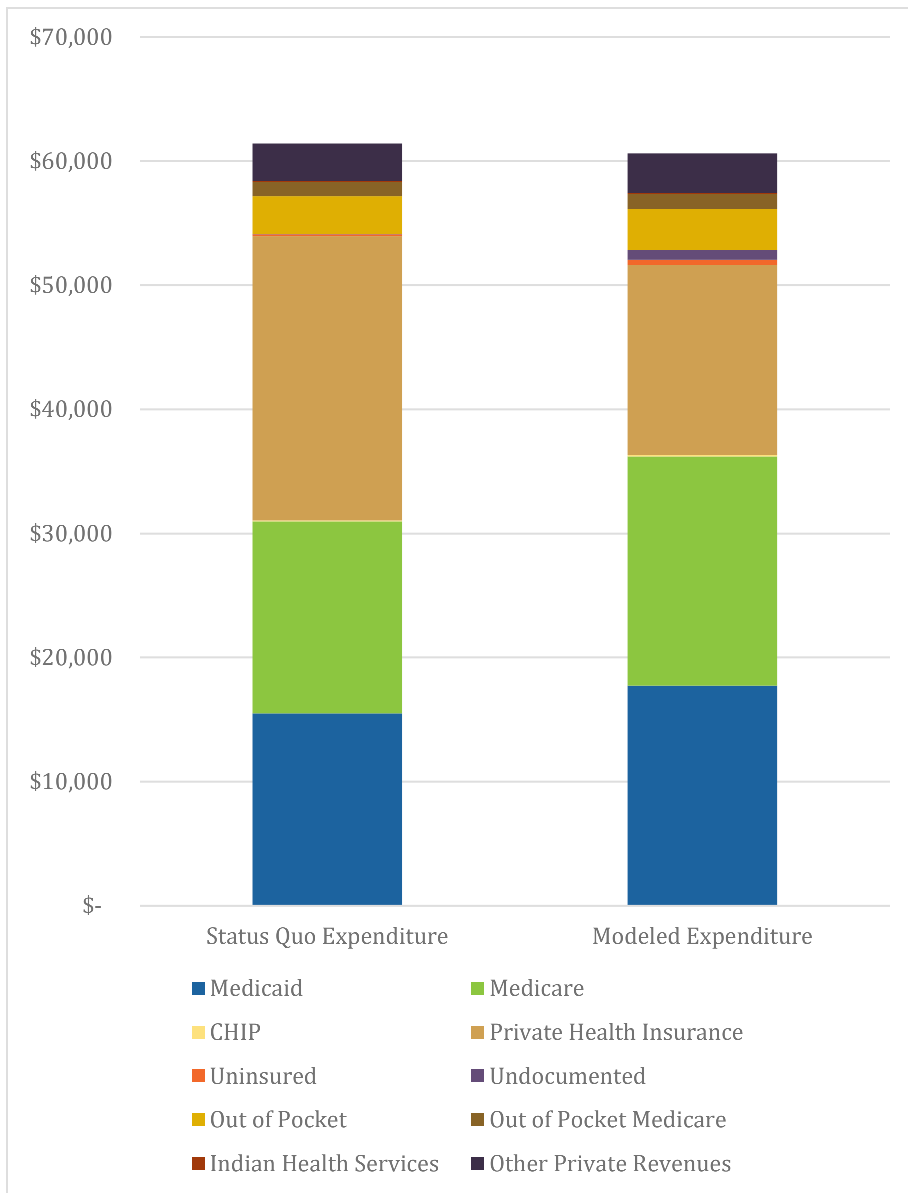
Covered populations	Benefits	Cost sharing	Provider reimbursement	Population-specific impacts	Administration
• Medicaid • Medicare • CHIP • Private health insurance (employer, state employees, and Exchange) • Undocumented immigrants • Uninsured	• Essential health benefits • Dental for Medicaid-eligible only • Vision • Long-term care for Medicaid-eligible only	• No cost sharing • Private insurance utilization changes due to removal of cost sharing	• Reduced pricing variation between covered populations • Administrative efficiency • Purchasing power	• Improved access for Medicaid-eligible persons, utilization changes by service type • Reflects increased utilization for uninsured and undocumented immigrant populations	• Managed care organization-administered • Premium tax applies • Reflects reductions in system-wide administrative costs

Table 42: Model B CY 2022 expenditures – implementation year

Financing source	Population[104]	Status quo expenditures[105]	Modeled expenditures	Differences
Medicaid	1,703,992	15,492,152,242	$17,748,246,930	$2,256,094,688
Medicare	1,721,504	15,478,141,127	$18,465,410,446	$2,987,269,319
CHIP	61,707	$83,298,324	$101,731,496	$18,433,172
Private health insurance	3,673,661	22,899,808,044	$15,316,276,699	$(7,583,531,345)
Uninsured	333,840	$133,818,270	$423,217,556	$289,399,286
Undocumented	124,428	$44,888,791	$816,307,941	$771,419,150
Excluded populations[106]	277,774			
Out-of-pocket expense (excludes Medicare)		$3,045,638,137	$3,265,875,845	$220,237,708
Out-of-pocket expense (Medicare)		$1,156,180,215	$1,239,786,497	$83,606,282
Indian Health Services		$79,843,114	$79,736,212	$(106,902)
Other private revenues		$3,003,934,742	$3,177,661,020	$173,726,278
Total	**7,896,906**	**$61,417,703,006**	**$60,634,250,642**	**$(783,452,364)**

[104] The Medicaid population totals exclude dually eligible members from the population count. Medicaid reimbursed expenditures are reflected in Medicare. All other Medicare covered expenditures are included in the Medicare row.
[105] Status quo and modeled expenditure totals exclude long-term care and dental for all payer sources other than Medicaid.
[106] This includes federal employees and active duty military.

Figure 11: status quo vs. Model B – program year 1 expenditures (in millions)



Key notes:

Model B is expected to reduce aggregate system-wide expenditures by approximately **$783 million** in the first implementation year. This impact is driven by multiple efficiencies that occur under a single-payer system. These include factors, such as:

- Limited reduction in payer administrative cost by reducing the number of payers across the health care system
- Increased purchasing power
- Provide administrative efficiencies
- Program integrity improvements

The following table represents projected CY 2022 revenue estimates by financing source. These revenue projections include consideration for cost-shifting dynamics that will occur due to universal health care. Please note the following when interpreting the figures below:

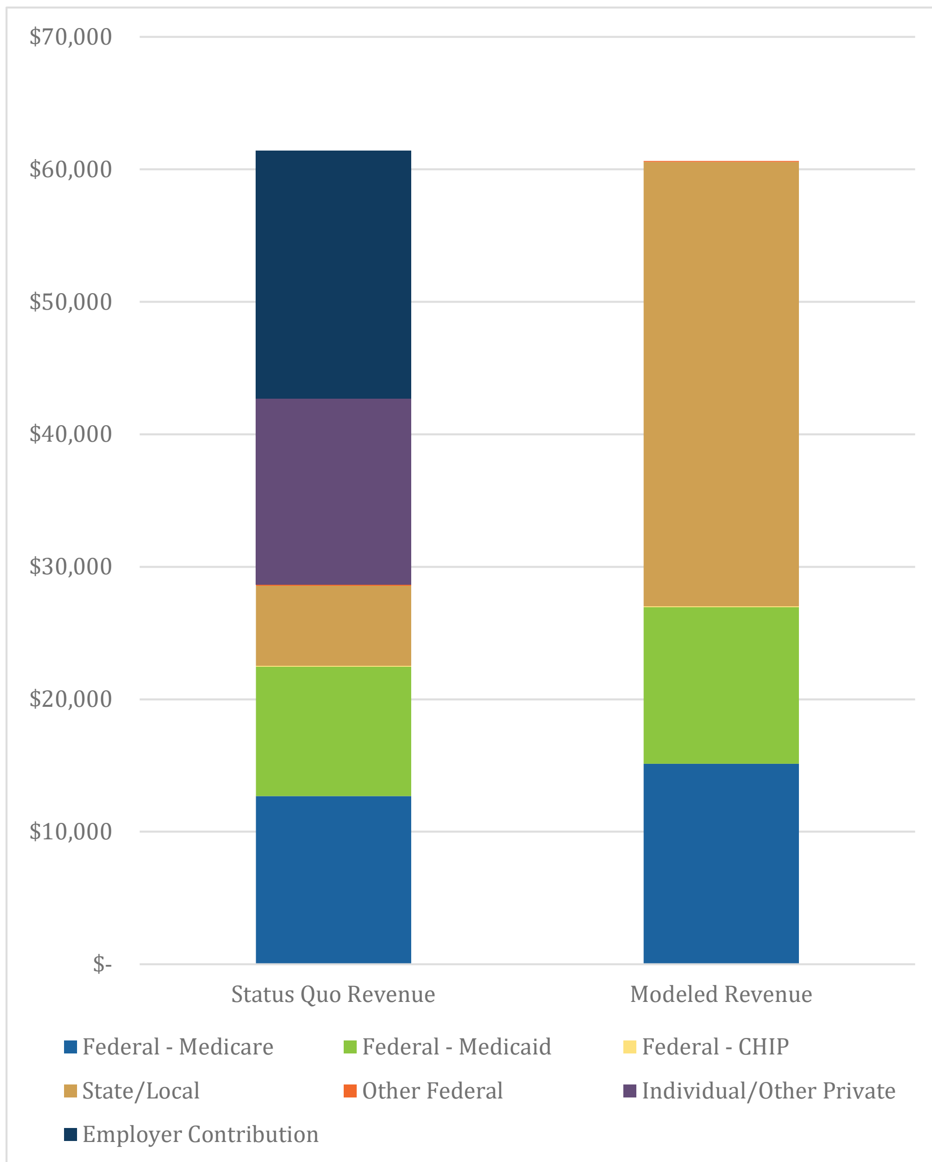
- The status quo health care system includes a significant source of funds from individual and employer contributions, including state and local funds for public employees. These revenues are assumed to continue under Model A universal health care; however, a mechanism to capture these contributions will need to be developed and implemented by the Washington State Legislature. These revenues are illustrated in the State/local row for the Model A Revenue estimate column.
- Model B design includes normalizing provider reimbursement to a single reimbursement schedule. This is a significant change from status quo where reimbursement varies by payer (Medicaid, Medicare, private coverage). Subject to federal approval, this change would increase the amount of federal contributions Washington receives but also increase state general fund obligations.
- Contributions to cover uninsured, undocumented immigrants and out-of-pocket costs are included in State/local row for the Model A Revenue estimate column.
- The revenue model assumes the state will be successful in preserving federal funding streams for eligible populations, even with the programmatic changes associated with transition to a universal health care model.
- The revised Model A projected expenditures in Table 10 excluded the cost for dental coverage for populations other than Medicaid. The following table separately identifies revenue collections necessary for dental coverage for all populations beyond Medicaid.

Table 43: Model B CY 2022 revenue sources – implementation year

Financing source	Status quo revenue	Model B revenue estimate	Differences
Federal share – Medicaid	$12,692,075,724	$15,141,636,566	$2,449,560,842
Federal share – Medicare	$9,760,055,912	$11,801,288,814	$2,041,232,902
Federal share – CHIP	$73,302,525	$89,523,716	$16,221,191
State/local Share	$6,051,654,951	$33,522,065,333	$27,470,410,382
Other federal contributions (e.g., Indian Health Services)	$79,843,114	$79,736,212	$(106,902)
Individual contribution	$14,057,144,852		$(14,057,144,852)
Employer contribution[107]	$18,703,625,927		$(18,703,625,927)
Total	**$61,417,703,006**	**$60,634,250,642**	**$(783,452,364)**
Dental coverage for populations other than Medicaid[108]			**$3,052,211,853**

[107] Employer contribution includes state/local funds for public employees.
[108] Additional revenue required for covering dental services for all other populations than Medicaid, federal employees, and military. Assumes "moderate" cost level for dental services.

Figure 12: status quo vs. Model B – program year 1 revenues (in millions)



Key notes:

A major contributor to the increase in federal funds is associated with provider reimbursement rate normalization associated with a single payer fee schedule. There are offsetting decreases to the private health insurance (employer and individual contributions). It is unclear if federal funding will be available to subsidize this effect.

Additional analysis is needed to understand the broader economic impact on the state due to industry job loss, tax implications for employers, greater labor mobility, etc.

Model C

Table 44: overview of Model C

Covered populations	Benefits	Cost sharing	Provider reimbursement	Population-specific impacts	Administration
Undocumented immigrants	Essential health benefits	Standard cost sharing	Cascade Care reimbursement standards apply	Utilization assumed to be similar to the commercially insured population	Assumes commercial plan levels of administrative costs

Model C provides coverage for populations without access to traditional health insurance coverage, independent of the affordability consideration. Currently, the undocumented population cannot access traditional health insurance.

Workgroup members have expressed interest in expanding Model C to include options for those who cannot afford health insurance under the current system. Washington is already making progress in this arena through **Cascade Care**.[109] Cascade Care provides access to more affordable standard and public option plans.

The authorizing statute also called for a study on a subsidy program. The Cascade Care subsidy option report is forthcoming. This report could inform recommendations for expansion of Model C to align with the subsidy recommendations, potentially serving as a transition strategy to broader universal health care in the longer term.

Table 45: Model C – estimated cost

Population [110]	Estimated total cost
124,428	$617,000,000

- Estimated current Medicaid costs (short-term emergency coverage only): $150 million of which 50 percent is Title XIX federal funds.
- All other existing system costs for this population are assumed to be individual expense or charity care.

[109] Washington Health Benefit Exchange website.
[110] Office of Financial Management estimate.

Model design impacts

Dental services

Except for the Medicaid-eligible population, dental costs are not included in the models above. The below table summarizes the cost of covering the remaining populations that would be included in Model A or Model B. The estimates reflect the following:

- Standard, commercial-like dental program that covers preventative, minor, and major restorative services.
- Annual benefit maximums are included.
- Provider reimbursement is based on commercial dental coverage.
- Dental insurer administration and premium tax are excluded.
- Variation in dental estimates are driven by dental managed care organization vs. preferred provider organization, annual maximum benefits limits, and variation in estimates for the value of out-of-pocket costs.

Table 46: estimated dental costs

	Low	Moderate	High
Average PMPM costs	$38.00	$43.00	$48.00
Total member months[111]	70,981,671	70,981,671	70,981,671
Total cost	$2.70 billion	$3.05 billion	$3.41 billion

Cost sharing

Models A and B reflect the elimination of enrollee out-of-pocket cost sharing. This results in approximately $4.2 billion in costs that were previously paid by individuals who used services and were subject to cost sharing. Eliminating out-of-pocket costs for the consumer is reflected as a plan cost that would be financed through taxes.

Additionally, removing barriers to accessing care is expected to increase utilization of certain services. It is reasonable to expect some offsetting reductions in higher-cost services as a result of removing cost sharing, but it may take time to see improvements in health that generates lower per capita costs.

Depending on utilization controls implemented in Models A and B, removal of cost sharing could increase utilization of elective services. Additional policy development and evaluation will be required to refine cost sharing and its impact on total costs.

Multi-year trend and estimates

The table below summarizes the total status quo expenditures costs and Model A program costs under different start date assumptions. Weighted average growth rates are based on population-specific national growth weights (from the CMS NHE forecast), applied to the modeled estimates of expenditure and enrollment for the relevant populations.

[111] Includes member months for all populations except Medicaid, federal employees, and military.

The current 2022 estimates are based on available data from 2018 and include four years of projection. Projections presented in the table below become less reliable due to the ever-changing dynamics in the health care system.

Table 47: five-year growth rates and estimated change in program expenditures, based on different starting dates

Year	Growth rate	Status quo	Model A implementation year	Differences
2022		$61,417,703,008	$58,942,132,021	$(2,475,570,987)
2023	6.2%	$65,225,600,595	$62,596,544,206	$(2,629,056,389)
2024	5.9%	$69,054,863,351	$66,271,460,392	$(2,783,402,958)
2025	6.1%	$73,242,864,656	$70,290,655,409	$(2,952,209,247)
2026	6.2%	$77,804,052,454	$74,667,994,843	$(3,136,057,611)
2027	6.0%	$82,479,003,533	$79,154,512,088	$(3,324,491,445)

Limitations

Federal financial participation

The cost estimate analysis assumes that the current system federal revenues continue for Medicaid, Medicare, and Exchange subsidies. With all federally funded programs, requirements and processes exist in regulation for each. Funding is conditional based on compliance with federal regulations.

The state will need to ensure that federal revenues are, at a minimum, maintained and in some cases, expanded to address changes in the progression toward Models A or B. For example, the state will need to explore available Medicaid waiver authorities and state plan amendments to align covered benefits, provider reimbursement, and mandatory participation of eligible individuals in universal health care.

For Medicare populations, the state will need to consider how to mandate individuals into coverage for Medicare under Models A or B. This includes considering those who receive Medicare via fee-for-services and may purchase supplemental coverage, or those enrolled in Medicare Advantage plans.

Individuals covered through the Exchange are eligible to receive federal subsidies for health insurance premiums. The state will need to consider how to maintain federal insurance subsidies for eligible individuals.

Additional data analysis

The analysis and estimates contained in this report were performed using the best data available. However, our analysis was limited by issues, such as the age of the data and lack of detailed demographic or type of service data. These issues limited our ability to perform more detailed analyses and estimates of the impact of provider reimbursement, additional benefits, and out-of-pocket cost sharing. Future cost analysis will require focused analysis, specific to each population and covered benefits, and should include processes and time to obtain such detail.

Medicaid: detailed enrollment, claims and utilization analysis by demographic group should be conducted to refine the impact of a standardized benefit package and health care provider reimbursement rebalancing to a standardized fee schedule across the system.

Medicare: Detailed enrollment, claims, and utilization analysis by demographic group should be conducted to refine the impact of a standardized benefit and out-of-pocket costs. Historically, obtaining detailed person-level Medicare data is difficult. Special accommodation from CMS needs to be explored to obtain the information to provide the highest quality information to inform future impacts.

Employer-sponsored information: detailed enrollment, claims and utilization analysis by demographic group, including primary and dependent subscribers, should be conducted. It is important to note a significant portion of employer-sponsored health insurance data is self-funded and was not available beyond aggregated surveys from NHE or Medical Expenditure Panel Survey.

Further, while employer-sponsored insured population information is available through the OIC, the data and information are summarized. Obtaining data from self-funded entities (such as detailed insured information) is necessary to support detailed analysis essential for the state if it progresses toward universal health care Models A or B. The additional detail will allow refined analyses on the impacts of:

- Employer and employee share of premium (for employer-sponsored coverage).
- Out-of-pocket costs.
- Impact of health care provider fee schedule rebalancing to a standardized fee schedule across the system.
- Impact of standardized benefit packages.

Washington Health Benefit Exchange: detailed enrollment, claims, and utilization analysis by should be available through HCA. Analysis can support:

- Individual and federal subsidy share of premium (for Exchange plans).
- Out-of-pocket costs.
- Impact of health care provider fee schedule rebalancing to a standardized fee schedule across the system.

Other data: other health care-specific resources exist, such as state or grant-funded well-child programs, immunization programs, school-based health, mental health and substance use programs, and more. Data was not available from these programs by demographic or with enough detail to consider their influence on health insurance and coverage expenditures.

Appendix I: example of transition process and timeline

This process example includes steps to develop the details of structuring and funding a universal health care program and establishing other elements of a program that impact health coverage and care for Washingtonians.

- The draft example shows a four-year process, starting in January 2021.
- The actual work may take more or less time, but this example gives a view of the work involved and a suggested process for conducting that work.
- A dedicated group, the Universal Health Care Commission (UHCC), could be legislatively established to spearhead the work. A UHCC could include:
    - An action-oriented, focused group of state leaders.
    - Targeted work groups to define specific areas.
    - Stakeholder input at multiple points in the process.
    - Something similar to 1993 Health Care Commission, which requires staffing and resources.

Timeline, work stream, and detailed steps

The next several pages show three views:

- View 1: timeline showing the work to be done by the Legislature, Governor, state agencies, and a possible UHCC.
- View 2: work stream view that shows the three main areas.
- View 3: detailed steps with notes on the lead actors and anticipated timing.

Reform work is intended to enact change in the following areas identified by the Work Group:

- Establish a universal health care goal for the state.
- Maintain coverage gains and extend coverage to the uninsured.
- Implement and administer established program.
- Define coverage.
- Define financing plan and anticipated cost savings.
- Develop program standards, including for quality, access, equity, and other areas.
- Establish and implement a transition plan.

View #1: timeline

Figure 13: key accomplishments for 2021-2022 (the passage or signing of a piece of legislation and coverage start dates)

2021: Jan (1, 15) | Feb (1, 15) | Mar (1, 16) | Apr (1, 16) | May (1, 16) | Jun (1, 16) | Jul (1, 16) | Aug (1, 16) | Sep (1, 16) | Oct (1, 16) | Nov (1, 16) | Dec (1, 16) — 2022: Jan (1, 16) | Feb (1, 16) | Mar (1, 16) | Apr (1, 16) | May (1, 16)

Responsible Parties (primary)	
Legislature	Adopt legislation that sets a 5 year universal coverage goal
	Adopt legislation that authorizes Phase I coverage plan
	Prepare for legislation on Phase II
	Adopt legislation implementing Phase II changes
Governor	Set 5 year universal coverage goal
	Initiate Universal Health Care Commission (UHCC)
State Agencies	Implement Phase I coverage changes
	Coverage available under Phase I
	Prepare WA statute, regulatory change, federal waivers
	Implement Phase II
	Coverage available under Phase II
Universal Health Care Commission and work groups	Establish UHCC as stand-alone entity with staff/resources
	UHCC staff supports Commission and work groups
	Oversee and support work groups
	Action plan for covering the uninsured work group
	Synthesize WG work, present to legislature (Phase I)
	Cost containment strategies work group (Phase IIa)
	Coverage structure work group (Phase IIa)
	Administation and operations work group (Phase IIa)
	Synthesize WG work, present to legislature (Phase IIa)
	Financing strategies, cost modeling work group (Phase IIb)
	Quality goals and reporting process work group (Phase IIb)
	Transition planning work group (Phase IIb)
	Waivers, law and regulatory change work group (Phase IIb)
	Synthesize WG work, present to legislature (Phase IIb)
	Phase II report finalized, delivered to legislature

Figure 14: key accomplishments for 2022-2023 (the passage or signing of a piece of legislation and coverage start dates)

Responsible Parties (primary)	
Legislature	Adopt legislation that sets a 5 year universal coverage goal
	Adopt legislation that authorizes Phase I coverage plan
	Prepare for legislation on Phase II
	Adopt legislation implementing Phase II changes
Governor	Set 5 year universal coverage goal
	Initiate Universal Health Care Commission (UHCC)
State Agencies	Implement Phase I coverage changes
	Coverage available under Phase I
	Prepare WA statute, regulatory change, federal waivers
	Implement Phase II
	Coverage available under Phase II
Universal Health Care Commission and work groups	Establish UHCC as stand-alone entity with staff/resources
	UHCC staff supports Commission and work groups
	Oversee and support work groups
	Action plan for covering the uninsured work group
	Synthesize WG work, present to legislature (Phase I)
	Cost containment strategies work group (Phase IIa)
	Coverage structure work group (Phase IIa)
	Administation and operations work group (Phase IIa)
	Synthesize WG work, present to legislature (Phase IIa)
	Financing strategies, cost modeling work group (Phase IIb)
	Quality goals and reporting process work group (Phase IIb)
	Transition planning work group (Phase IIb)
	Waivers, law and regulatory change work group (Phase IIb)
	Synthesize WG work, present to legislature (Phase IIb)
	Phase II report finalized, delivered to legislature

Appendix C

Figure 15: key accomplishments for 2023-2025 (the passage or signing of a piece of legislation and coverage start dates)

		2023				2024																								2025	
		Nov		Dec		Jan		Feb		Mar		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan	
Responsible Parties (primary)		1	16	1	16	1	16	1	16	1	16	1	16	1	16	1	16	1	16	1	16	1	16	1	16	1	16	1	16	1	16
Legislature	Adopt legislation that sets a 5 year universal coverage goal																														
	Adopt legislation that authorizes Phase I coverage plan																														
	Prepare for legislation on Phase II																														
	Adopt legislation implementing Phase II changes																														
Governor	Set 5 year universal coverage goal																														
	Initiate Universal Health Care Commission (UHCC)																														
State Agencies	Implement Phase I coverage changes																														
	Coverage available under Phase I																														
	Prepare WA statute, regulatory change, federal waivers																														
	Implement Phase II																														
	Coverage available under Phase II																													★	
Universal Health Care Commission and work groups	Establish UHCC as stand-alone entity with staff/resources																														
	UHCC staff supports Commission and work groups																														
	Oversee and support work groups																														
	Action plan for covering the uninsured work group																														
	Synthesize WG work, present to legislature (Phase I)																														
	Cost containment strategies work group (Phase IIa)																														
	Coverage structure work group (Phase IIa)																														
	Administation and operations work group (Phase IIa)																														
	Synthesize WG work, present to legislature (Phase IIa)																														
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	Quality goals and reporting process work group (Phase IIb)																														
	Transition planning work group (Phase IIb)																														
	Waivers, law and regulatory change work group (Phase IIb)																														
	Synthesize WG work, present to legislature (Phase IIb)																														
	Phase II report finalized, delivered to legislature																														

View #2: work streams

Table 48: work stream 1

WORK STREAM 1. Protect coverage and reduce uninsurance	Lead(s)
Pass legislation that: • Sets 5-year goal for universal health care • Establishes a structure for a 5-year plan • Establishes UHCC and defines a process	Legislature, Governor
Initiate UHCC to support and oversee development of Recommendations	UHCC
Develop Phase I action plan for coverage of uninsured	UHCC Phase I work group
Conduct stakeholder engagement	UHCC, state agencies
Finalize Phase I Recommendations to Legislature for coverage of uninsured	UHCC
Pass legislation adopting Phase I coverage changes for uninsured	Legislature, Governor
Implement Phase I changes	State agencies
Enroll eligible people in Phase I coverage	State agencies, partners

Table 49: work stream 2

WORK STREAM 2. Define and implement coverage structure, cost containment strategies, administration	Lead(s)
Pass legislation that: • Sets 5-year goal for universal health care • Establishes a structure for a 5-year plan • Establishes UHCC and defines a process	Legislature, Governor
Initiate UHCC to support and oversee development of Recommendations	UHCC
Develop Phase II(a) action plans for: • Cost-containment strategies • Coverage structure • Program administration and operations	UHCC Phase II(a) work groups
Conduct stakeholder engagement	UHCC, state agencies
Finalize Phase II(a) Recommendations to Legislature re: cost containment, coverage, and program administration/operations	UHCC
Conduct detailed operational planning of coverage, cost containment, administration	State agencies
Pass Phase II legislation	Legislature, Governor
Conduct Phase II implementation activities	State agencies, partners
Enroll eligible people in Phase II coverage	State agencies, partners

Table 50: work stream 3

WORK STREAM 3. Define and implement financing, program standards and transition actions	Lead(s)
Pass legislation that: • Sets 5-year goal for universal health care • Establishes a structure for a 5-year plan • Establishes UHCC and defines a process	Legislature, Governor
Initiate UHCC to support and oversee development of Recommendations	UHCC
Develop Phase II(b) action plans: • Develop budget and financing strategies • Develop process for establishing quality goals and administering reporting process • Operational planning advisory support • Transition planning	UHCC Phase II(b) work groups
Conduct stakeholder engagement	UHCC, state agencies
Finalize Phase II(b) Recommendations to Legislature re: financing, program standards, transition	UHCC
Conduct detailed operational planning of financing program standards, transition	State agencies
Pass Phase II legislation	Legislature, Governor
Conduct Phase II implementation activities for coverage, delivery system, and cost-containment changes, transition efforts	State agencies, partners
Enroll eligible people in Phase I coverage	State agencies, partners

View #3: detailed steps and lead actors

Table 51: detailed steps and lead actors

Action	Lead(s)	When	Notes
Maintain current public sector coverage.	Legislature, Governor	Ongoing	COVID-associated decrease in state revenues could threaten Medicaid and other health programs. The first step to increasing coverage is not to reduce current coverage
Pass legislation that: • Sets 5-year goal for universal health care. • Establishes a structure for a 5-year plan. • Establishes UHCC and defines a process.	Legislature, Governor	2021 legislative session	Bill may include steps to universal health care over time, identifying populations, mechanisms, etc. to get there, including: • Goals. • 5-year plan. • UHCC process/work groups. • Stakeholder engagement and consensus building. • Staffing and professional services support. 2021 session is 105 days.
Initiate UHCC to support and oversee development of Recommendations.	Governor, UHCC team	June 2021	• Governor appoints membership of main body. • Goals for body based on UHCC work group goals.
Support UHCC and work groups.	UHCC, other state agencies	June 2021	UHCC initiates, supports, and monitors work groups.
Develop Phase I action plan for coverage for the uninsured.	Phase I work group	July 2021-Oct. 2021	Plans for addressing the uninsured with short-term implementation.
Collect public input on Phase I action plan.	UHCC, other state agencies	Nov. 2021	Stakeholder input on work group recommendations will inform final UHCC Recommendations
Develop Phase II(a) action plans: • Adopt cost-containment strategies. • Develop coverage structure. • Develop administration and operations.	Phase II(a) work group members, supported by UHCC, other state agencies	Aug. 2021-Feb. 2022	The Phase II(a) work groups will address: • Strategies, such as global payments, growth cap, provider rates, and measures to reduce provider burden/associated costs. • Cost sharing, provider payment model (such as value-based payments). • Alignment of rules across payers, moving to something new, enrollment process, benefits administration, administrative streamlining, health information technology and data sharing (including getting better utilization and provider reimbursement data from ERISA plans). Work groups provide updates to UHCC group.
Collect public input on Phase II(a) action plans.	UHCC, other state agencies	Feb. 2022	Stakeholder input on work group recommendations will inform final UHCC Recommendations.

Action	Lead(s)	When	Notes
Finalize Phase I Recommendations to Legislature.	UHCC	Nov.-Dec. 2021	Incorporates first steps to increase coverage from Phase I work group.
Pass legislation to adopt Phase I coverage changes for uninsured.	Legislature, Governor	2022 legislative session	Incorporates UHCC Recommendations for first steps to increase coverage. 2022 session is 60 days.
Finalize Phase II(a) work group Recommendations.	UHCC, with support from other state agencies	March-April 2022	Incorporates recommendations from cost containment, coverage structure, and administration and operations work groups. Submit to Legislature, Governor.
Initiate implementation of Phase I changes.	State agencies	May 2022	Includes waivers, contracting, and administrative structure.
Develop Phase II(b) action plans: • Develop budget and financing strategies. • Develop process for establishing quality goals and administering reporting process. • Operational planning advisory support. • Transition planning.	Phase II(b) work group members, supported by UHCC, other state agencies	May 2022-Sept. 2022	Informed by results of Phase II(a) efforts, Phase II(b) work groups will address: • Refined cost modeling, establishment of funding sources (including reallocation of and changes to spending by residents, employers, public sector, etc.), use of mandates. • Quality measurement and reporting will be aligned with state public health improvement plan. • Review and advise state operational planning including for adjustments to statutes, regulations, and federal waivers. • Transitioning current programs and populations, mediating impacts to staff of current market participants.
Collect public input on Phase II(b) action plans.	UHCC, other state agencies	Oct. 2022	Stakeholder input on work group recommendations will inform final UHCC Recommendations.
Conduct detailed operational planning.	State agencies	May-Sept. 2022	• Review/advice received from Phase II(b) work groups. • Planning addresses state-level operational, statutory, regulatory changes, federal waivers, etc. • Participants may include Department of Social and Health Services, Office of the Insurance Commissioner, and others.
Finalize Phase II(b) Recommendations.	UHCC, supported by state agencies	Oct.-Nov. 2022	Submit to Legislature, Governor. Could include public input process and/or additional public meetings.
Submit final (Phase II(a & b)) Recommendations to Legislature.	UHCC, supported by state agencies	Jan. 2023	
Pass Phase II bill.	Legislature, Governor	April 2023	Bill may include steps to universal health care over time, identifying populations, mechanisms, etc. to get there as well as details of implementation for health system changes.

Action	Lead(s)	When	Notes
Initiate Phase II implementation activities.	State agencies, other partners (TBD)	Mid-2023	Includes: • Federal waivers. • Additional state law and regulation changes. • Implementation activities for state. • Transitions.
Begin enrollment in Phase I coverage.	TBD	July 2023	Responsible parties will include state and others based on adopted plan.
Implement additional delivery system and cost containment changes.	State agencies, other partners (TBD)	2023 and beyond	Delivery and cost containment changes could be implemented with Phase II or could occur separately.
Begin enrollment in Phase II coverage.	TBD	Jan. 2025 or earlier	May be additional phases if activities are implemented in a more stepped fashion

Universal Health Care Commission Survey

Start of Block: Introduction

Q0 *The Universal Health Care (UHC) Commission is charged with preparing Washington state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system once the necessary federal authority becomes available. Section 3 of the report addresses the Legislature's requirement for the Commission to inventory the key design elements of a universal health care system. The key design elements are organized into seven core design components, not in order of importance, to form a framework for the implementation and operation of a universal health care system:*

1. **Eligibility and Enrollment**—identify how to cover currently uninsured populations; determine which, if any, existing coverage options will remain; and which segments of the existing insured population will be included in the Commission's universal coverage considerations.
2. **Benefits and Services**—create an approach to develop standards that ensure equal access to a minimum set of benefits and services.
3. **Financing**—define an approach to align or aggregate public funding sources, private sector funding sources; and individual cost-sharing, if any.
4. **Provider Reimbursement and Participation**—select a method for paying providers, encouraging their participation, and aligning provider behavior to quality and equity goals.
5. **Cost Containment Mechanisms**—establish global budgeting and utilization management functions to control total cost of care.
6. **Infrastructure**—invest in administrative and operational capabilities necessary to implement a cohesive model.
7. **Governance**—ensure transparency and accountability for planning and implementing the model and that the includes the voice of consumers in decision-making.

These core components align with the framework proposed by the Congressional Budget Office in their 2019 report on single-payer systems. In addition to discussing these elements in Section 3 of the report, the legislation requires the Commission to provide an assessment of the state's current level of preparedness to meet these system elements and identify steps Washington should take for a just transition to a unified health care financing system, including a single-payer financing system.

This survey is designed to help assess preparedness for this transition. In addition, there are some process questions about how best to maximize opportunities for participation in future Commission meetings.

Q1 Do you represent a state agency on the Universal Health Care Commission?

- ○ Yes (1)
- ○ No (2)

Q2 If so, which agency?

- ○ HCA (1)
- ○ OIC (2)
- ○ DOH (3)
- ○ WABHE (4)
- ○ the Office of Equity (5)

Q3 What role(s) does your agency play in administering or regulating health care financing/coverage programs? E.g., have Medicaid, Medicare, qualifies health plans)?

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End of Block: Introduction

Start of Block: Eligibility and Enrollment

Q4 Does your agency operate Eligibility and Enrollment functions to support the programs managed by your agency?

Q4a If yes, please describe the responsibilities/functions provided.

Q5 What are the general factors used to determine Eligibility and Enrollment for these programs?

Q6 What staff, technology programs, and technology systems are in place to support these Eligibility and Enrollment functions?

Q7 What Eligibility and Enrollment functions could be adapted to support universal health coverage?

Q8 What is the level of difficulty that would be required to adapt these functions to support a health care financing/coverage program to support a universal health coverage system?

- Mild (1)
- Moderate (2)
- Major (3)

Q9 What would that effort entail (e.g., what waivers would be required, changes in how Enrollment and Eligibility would be gathered, are there significant legal and operational barriers)?

Q10 What, if any additional resources (e.g., staffing, infrastructure) would the agency need to do this?

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Q11 What suggestions do you have for the initial steps/first steps in the process?

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End of Block: Eligibility and Enrollment

Start of Block: Benefits and Services

Q12 Does your agency procure, regulate, or administer Benefits and Services functions to support the programs managed by your agency?

- Yes (1)
- No (2)

Skip To: End of Block If Does your agency procure, regulate, or administer Benefits and Services functions to support the... = No

Q12a If yes, please describe the responsibilities/functions provided.

Q12b What are the general factors used in procurement, regulation and administration of benefits for these programs?

Q12c What staff, technology programs and technology systems does your agency have in place to support these Benefits and Services functions?

Q12d What Benefits and Services functions can be adapted to support a universal health coverage system?

Q12e If yes, what level of difficulty would be required to adapt these functions to support a universal health coverage system?

- ○ Mild (1)
- ○ Moderate (2)
- ○ Major (3)

Q12f What would that effort entail (e.g., what waivers would be required, what benefits and service functions might change, are there significant legal and operational barriers)?

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Q12g What, if any additional resources (e.g., staffing, infrastructure) would the agency need to do this?

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Q12h What suggestions do you have for the initial steps/first steps that need to be done?

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End of Block: Benefits and Services

Start of Block: Provider Payment

Q13 Does your agency pay providers or regulate provider payment to support the programs managed by your agency?

- Yes (1)
- No (2)

Skip To: End of Block If Does your agency pay providers or regulate provider payment to support the programs managed by yo... = No

Q13a If yes, please describe the responsibilities/functions provided.

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Q13b What are the general factors used in considering provider payments?

Q13c What staff, technology programs, and technology systems are in place to support these provider reimbursement/payment functions?

Q13d What provider reimbursement/payment functions could be adapted to support a universal health coverage system?

Q13e If yes, what level of difficulty would be required to adapt these functions to support a universal health coverage system?

- ○ Mild (1)
- ○ Moderate (2)
- ○ Major (3)

Q13f What effort would that entail (e.g., what waivers would be required, how would provider payments be impacted, are there significant legal and operational barriers)?

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Q13g What, if any additional resources (e.g., staffing, infrastructure) would the agency need to do this?

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Q13h What suggestions do you have for the initial steps/first steps?

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End of Block: Provider Payment

Start of Block: Cost Containment Mechanisms

Q14 Does your agency administer or regulate cost containment mechanisms to support the programs managed by your agency?

- Yes (1)
- No (2)

Skip To: End of Block If Does your agency administer or regulate cost containment mechanisms to support the programs manag... = No

14a If yes, please describe the responsibilities/functions provided.

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Q14b What are the general factors used in considering cost containment mechanisms?

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Q14c What staff, technology programs, and technology systems are in place to support these cost containment mechanisms?

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Q14d What cost containment mechanisms could be adapted to support a universal health coverage system?

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Q14e If yes, what level of difficulty would be required to adapt these functions to support a universal health coverage system?

- ◯ Mild (1)
- ◯ Moderate (2)
- ◯ Major (3)

Q14f What effort would that entail (e.g., what waivers would be required, how would provider payments be impacted, are there significant legal and operational barriers)?

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Q14g What, if any additional resources (e.g., staffing, infrastructure) would the agency need to do this?

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Q14h What suggestions do you have for the initial steps/first steps?

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End of Block: Cost Containment Mechanisms

Start of Block: Funding

Q15 From your perspective, could you envision any options for unifying funding to support universal coverage? If yes, what are they?

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End of Block: Funding

Start of Block: Disparities Reduction and Health Equity

Q16 What activities is your agency or organization engaged in to address health equity, and disparities reduction?

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Q16a From your perspective, could any activities be expanded upon?

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Q16b Do you have recommendations that the Universal Health Care Commission can consider for reducing disparities and increasing health equity?

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End of Block: Disparities Reduction and Health Equity

Start of Block: Quality

Q17 What activities is your agency or organization engaged in to address health care quality?

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Q17a From your perspective, could any activities be expanded upon?

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Q17b Do you have recommendations that the Universal Health Care Commission can consider for improving health care quality?

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End of Block: Quality

Start of Block: Commission Meetings and Process

Q0 The UHC has a limited number of meetings to prepare and review its baseline report due to the Legislature on November 1, 2022. We are interested in finding out if Commission members would like additional discussion time set aside in the meetings. One option for increasing discussion is to develop pre-recorded presentations for Commission members to review in advance of the meetings rather than hearing presentations during the meetings. Commission members would then be asked to send clarifying questions to the consultant team in advance of the meeting and then come prepared to discuss during the meetings.

Q0a Would you like more time to discuss and ask questions during Commission meetings by watching presentation materials in advance of the meeting?

○ Yes (1)

○ No (2)

Qa1 If yes, please describe, for example how much additional time.

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Q0b Would you have time to and would it be helpful to watch a prerecorded 30-45 minute presentation in advance of future meetings?

- Yes (1)
- No (2)

Q18 Do you have other suggestions?

Q19 What additional topics would you like to hear more about?

End of Block: Commission Meetings and Process