# Universal Health Care Commission meeting

February 13, 2025

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Washington State Health Care Authority

# Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

# Universal Health Care Commission

## Agenda

**Thursday, February 13, 2025**
**2:00 – 5:00 PM**
**Hybrid Zoom and in-person meeting**

| Commission members: | | |
|---|---|---|
| ☐ Vicki Lowe, Chair | ☐ Jane Beyer | ☐ Nicole Gomez |
| ☐ Bidisha Mandal | ☐ Joan Altman | ☐ Omar Santana-Gomez |
| ☐ Charles Chima | ☐ Representative Joe Schmick | ☐ Stella Vasquez |
| ☐ Dave Iseminger | ☐ Mohamed Shidane | |

| Time | Agenda Items | Tab | Lead |
|---|---|---|---|
| **2:00 – 2:05** (5 min) | Welcome and call to order | 1 | Vicki Lowe, Chair |
| **2:05 – 2:08** (3 min) | Roll call | | Mary Franzen, HCA |
| **2:08 – 2:10** (2 min) | Approval of 12/05/2024 Meeting Summary | 2 | Vicki Lowe, Chair |
| **2:10 – 2:25** (15 min) | Public comment | 3 | Vicki Lowe, Chair |
| **2:25 – 2:40** (15 min) | Workplan update | 4 | Mary Franzen, HCA |
| **2:40 – 3:00** (20 min) | FTAC update | 5 | David DiGiuseppe, FTAC Liaison |
| **3:00 – 3:15** (15 min) | State agency report outs | 6 | Commission members |
| **3:15 – 3:50** (35 min) | Reference-based pricing in Oregon, presentation and Q&A | 7 | Margaret Smith-Isa, Oregon Health Authority |
| **3:50 – 4:00** (10 min) | BREAK | | |
| **4:00 – 5:00** (60 min) | Rural health roundtable | 8 | Brad Becker, Mason Health and The Rural Collaborative<br>Shane McGuire, Columbia County Health System<br>Ashlen Strong, Washington State Hospital Association<br>Liz Arjun, HMA |
| **5:00** | Adjournment | | Vicki Lowe, Chair |

# Tab 2

Washington State Health Care Authority

# Universal Health Care Commission meeting summary

## December 5, 2024

Hybrid meeting held on Zoom and in person at the Health Care Authority (HCA)
2–5 pm

**Note:** This meeting was recorded in its entirety. The recording and all materials provided to and considered by the Commission are available on the Universal Health Care Commission webpage. Additionally, votes made by the Commission during this meeting are highlighted below in blue.

## Members present

Vicki Lowe, Chair
Bidisha Mandal
Charles Chima
Dave Iseminger
Jane Beyer
Joan Altman
Representative Joe Schmick
Mohamed Shidane
Nicole Gomez

## Members absent

Senator Ann Rivers
Senator Emily Randall
Representative Marcus Riccelli
Omar Santana-Gomez
Stella Vasquez

## Call to order

Vicki Lowe, Chair of the Universal Health Care Commission, called the meeting to order at 2:02 pm.

Washington State Health Care Authority

# Agenda items

## I. Welcoming remarks

Chair Lowe began with a land acknowledgement and welcomed members to the twenty-first meeting of the Commission.

## II. Meeting summary

Commission members voted to accept the October 2024 meeting summary.

## III. State agency updates

Chair Lowe invited state agency representatives to provide any updates to their agencies given the recent national and state elections.

**Office of the Insurance Commissioner (OIC):** Commission member Jane Beyer shared that Commissioner-elect Patty Kuderer will be sworn in on January 15. Beyer noted that universal health care is an issue of great importance to Commissioner-elect Kuderer.

**Department of Health (DOH):** Commission member Dr. Charles Chima noted that the current Secretary of Health, Dr. Umair Shah, will be stepping down in January. Dr. Chima discussed DOH's certificate of need and state health assessment work that is expected to continue into the new year under a new Secretary.

**Health Care Authority (HCA):** Commission member Dave Iseminger noted that with the new governor-elect many state agencies are awaiting a variety of appointments, including the next director of the HCA. Iseminger mentioned the Dec. 2 directive from Gov. Jay Inslee freezing travel, hiring, and contracting. Iseminger also highlighted some of HCA's recently published legislative reports, which can be found here.

**Washington Health Benefit Exchange (WAHBE):** Commission member Joan Altman mentioned that WAHBE and HCA are working on joint messaging about continued program availability and privacy protections for specific communities. WAHBE is also requesting the state maintain or increase state subsidies in order to help mitigate the expected loss of the enhanced federal subsidies.

## IV. Public comment

Kathryn Lewandowsky, Whole Washington, noted that in light of the expected budget deficit in Washington state, it will be important to provide economic relief to residents and stimulate the state's economy through the Washington Health Trust (SB 5335). Lewandowsky asked the Commission to request a dynamic fiscal note on the new Washington Health Trust language as soon as possible.

David Loud, Health Care Is a Human Right, discussed the Commission's Milestone Tracker and disagreed that the Commission had completed Phase 1: Eligibility. Loud asked Commission members to review the Health Care for All – Washington (HCFA – WA) proposal and address issues such as voluntary enrollment, auto-enrollment, and residency definitions, among others. Loud also recommended that the Universal System should welcome any veteran who chooses to use it.

Ronnie Shure, HCFA – WA, urged the Commission to support the proposed reference-based pricing legislation for public and school employees in Washington State (PEBB/SEBB). Ronnie also highlighted the savings that Oregon and Cascade Care have generated through reference-based pricing.

# V. Finance Technical Advisory Committee (FTAC) update

***Pam MacEwan, FTAC Liaison***

Pam MacEwan reported on FTAC's November meeting, which included an initial discussion of prior authorization as requested by the Commission, an update on the Milliman analysis project, and an introduction to cost containment mechanisms, such as price caps and a public utility model. MacEwan shared that FTAC ran out of time for the prior authorization discussion and that the committee will continue to discuss it at future meetings. Regarding the Milliman analysis project, MacEwan noted that final results are now expected in March 2025 due to a slight delay caused by data-sharing requirements.

MacEwan also shared that FTAC agreed by consensus to: (1) Recommend the Commission considers supporting transitional efforts which utilize reference-based pricing; (2) Recommend the Commission considers including reference-based pricing and other cost containment strategies for universal design; (3) Continue to explore cost containment strategies as directed by the Commission.

# VI. State approaches to access and affordability

***Evan Klein, HCA***

Evan Klein presented on a proposed agency request bill for reference-based pricing (RBP) for the Public Employees Benefits Board (PEBB) and the School Employees Benefits Board (SEBB), which includes the Uniform Medical Plan (UMP) administered through Regence, as well as Premera and Kaiser Permanente. Klein noted that PEBB/SEBB makes up about 20% of Washington state's commercial market and that current cost trends for consumers are unsustainable in the long term. He highlighted that this proposed bill builds on lessons learned from other successful RBP initiatives, including Washington state's Cascade Select and Oregon's RBP legislation for their state employee health plans. Klein noted that independent audits of Oregon's program found substantial savings to the state and a decrease in consumer's out-of-pocket spending.

The proposed bill adopts a phased-in approach over four years and aims to maintain health plan networks and stabilize long-term affordability by requiring hospitals to contract with PEBB/SEBB plans that offer in good faith to contract, and by capping reimbursement for inpatient and outpatient hospital services. It also would require sustained and increased reimbursement for critical access, rural, and children's hospitals as well as for primary care and behavioral health services. Klein noted that the proposal is also posted **online** and that initial modeling suggests cost avoidance in the realm of $75 million in 2027, increasing to over $240 million by 2030.

There was a robust discussion and vote following the presentation. Commission members voted to support the principle of using reference-based pricing for PEBB/SEBB, not only to contain costs, but also to rebalance resources, while recognizing that over the course of the legislative session there will likely be revisions to the bill language.

Washington State Health Care Authority

## VII. Cost containment discussion

***Liz Arjun, HMA***

Liz Arjun led a discussion on the next steps for cost containment, beginning with whether the Commission would like FTAC to continue evaluating reference-based pricing as a tool for cost containment in the universal system design. Commission members expressed interest in learning from other states active in this space and hearing more from FTAC about out-of-network rate caps, the public utility model, hospital global budgets, data reporting and transparency enforcement, medical loss ratio, Washington's administrative code, and prescription costs.

## VIII. 2025 Workplan discussion

***Mary Franzen, HCA***

Mary Franzen reviewed the Commission's charge from the legislature to identify transitional solutions and develop a universal system design. Franzen then presented the Milestone Tracker, which illustrates where the Commission is in the process of this work. For 2025, the Commission plans to address benefits and services, cost containment, and provider reimbursement and participation in the universal system, as well as continue work on transitional solutions. The current plan is to have most of Phase 1 in place in order to tackle financing in early 2026. Franzen then presented a workplan graphic highlighting which topics will be addressed during the 2025 meeting dates.

Commission members agreed to review more material and presentations in between meetings, to allow for more time for discussion and recommendations during meetings in 2025. Commission members also requested brief summaries of FTAC meetings moving forward. Several Commission members also expressed interest in moving quicker on this work, while also noting the need for the analytical work underway to wrap up in order to do so. Finally, Commission members agreed to focus on universal system design in the first half of 2025, returning to transitional solutions in the latter part of the year. This will allow the Commission to tailor their transitional solutions work to the outcomes of the 2025 Legislative Session.

# Adjournment

Meeting adjourned at 4:55 pm.

# Next meeting

**Thursday, February 13, 2025 from 2-5pm**
Meeting to be held on Zoom and in person at HCA

# Tab 3

Washington State Health Care Authority

# Public comment

Washington State Health Care Authority

Washington State Health Care Authority

# Universal Health Care Commission

## Written Comments

## Received since November 21, 2024

## Written comments submitted via e-mail:



## Additional comments received at the December 5, 2024 Commission meeting:

- The Zoom video recording is available for viewing here: https://www.youtube.com/watch?v=DD5iBWErHxk

**From:** Cris
**To:** HCA Universal HCC; HCA Universal FTAC
**Subject:** Public comment
**Date:** Saturday, November 23, 2024 4:46:18 PM

External Email

UHCC and FTAC:

I'm Cris Currie, retired RN from Spokane and Health Care for All-WA policy committee member.

Avoiding unnecessary health care is a complex issue that insurance companies have historically manipulated to their advantage. By erecting barriers to getting care, such as prior authorization and frequent denials, copayments and deductibles, limited provider networks, and value-based payments, they have reduced utilization in the U.S. to one of the lowest rates in the developed world. While denying care has dramatically increased insurance company profits, it has also contributed to some of the worst health outcomes in the developed world. The theory has always been that doctors cannot be trusted to order only what is medically necessary, so there must be an independent third party to oversee their decisions and deny care when it is unnecessary. Clearly, this strategy has been a colossal failure, such that the "treatment" is worse than the "disease."

Numerous studies have been done on unnecessary care, particularly diagnostic testing. Many suggest that about one-third to one-half of the testing is unnecessary, and one survey found that most physicians still see it as a serious problem. However, it is not always easy to decide what is necessary and what isn't. For example, simply having a negative test result does not mean it was unnecessary if it ruled out some serious conditions, especially if it was part of a triage protocol. Having a surgery that didn't help might not have been unnecessary if it was a last resort for treating a debilitating condition for which all other remedies had failed. However, prescribing an antibiotic for a viral infection because the patient demands a medical treatment is definitely unnecessary, expensive and counterproductive.

The Choosing Wisely Campaign sponsored by the American Board of Internal Medicine Foundation, was an 11 year program, ending in 2023, that sought to promote conversations between clinicians and patients in choosing care that is supported by evidence, does not duplicate other tests or procedures already received, is free from harm, and is truly necessary. According to its website, "Choosing Wisely" generated countless conversations in the exam room and across the health system, stimulated thousands of journal articles, inspired more than two dozen similar campaigns in other countries, and influenced many projects that explored ways to reduce overuse and unnecessary services and improve patient outcomes." It also resulted in lists of over 700 likely unnecessary tests and procedures for very specific situations by over 80 specialty medical societies. A brochure was also produced for patients with five questions they should ask before agreeing to a test or procedure.

Of course, conversations in the exam room will not be very effective if the physician is not educated as to the latest evidence-based recommendations. In a very interesting 2021 study in Poland, researchers selected 617 physicians who generated above average referrals to

diagnostic tests and sent them printed practice recommendations for each of the studied diagnoses. This intervention decreased the use of MRI and CT scans by 26% in neurology and 42% in orthopedics without decreasing patient satisfaction. It decreased the number of laboratory tests by 68%, especially in gynecology. These results are comparable to other studies where education was emphasized showing a 25-55% decrease in testing. This study was only possible because in Poland, an electronic medical records system is used that easily shows all medical events undertaken by doctors and the results, so comparisons can be made between individual physicians. Apparently, faculty at UVMC have figured out how to compare broad data with individual use as well.

But what are some other reasons why unnecessary testing is ordered? According to one survey of physicians, the top reason was malpractice concerns, followed by a need to be sure everything was considered, and wanting to please patients who insist on the test. Not having enough time with patients was also frequently mentioned. Other studies list such extrinsic influences as intense industry marketing, pressure to utilize technological advances and the promotion of questionable screening programs, competing corporate priorities particularly with respect to time spent with patients, ambiguous practice guidelines, discomfort with uncertainty, and inadequate access to medical records.

So might this research help inform the design of a system which could minimize unnecessary care without compromising the delivery of needed care, and not tied to financial outcomes or lead to moral injury? I believe a single-payer system definitely has this capability.

A single-payer has the authority to establish and enforce uniform regulations for all providers participating in the system. Therefore, there would be no need to get resistant, profit-first providers and carriers to agree on a cooperative, patient-first approach. It could restructure or eliminate the administrative burden of preauthorization requirements which second-guess practitioner judgment; it could severely limit denials of care, establish a completely open network, eliminate or greatly reduce cost sharing requirements, and make sure providers incur no unreimbursed patient contact by paying them based on their time, training, and expertise rather than the "value" of each patient's diagnosis or outcome. It could design an electronic medical record that is truly interoperable and reflects genuine clinical needs rather than corporate carrier needs, so that every patient experience can contribute to the research on evidence-based practice, and every practitioner's ordering habits can be compared. It could then design a uniform system of recommending and disseminating that information to all practitioners as well as patients, including warnings embedded in the EMR. It could even offer "decision aids" to help promote efficient exam room discussions. The EMR could also be designed to better keep patient medical histories up to date and easily accessed via an electronic ID card. A single-payer could eliminate the transparency problems of proprietary financial data maintained by hospitals and carriers, thereby making it possible to eliminate the financial incentives to over-testing. And finally, a single-payer system would greatly reduce claims for special compensatory damages in malpractice litigation since a defendant would no longer need to cover present or future medical bills for the plaintiff.

Each of these measures to reduce unnecessary medical care is far more effective than anything the private insurance industry has ever devised, but implementing them all will require a major shift to a unified, single-payer financial system.

**HEALTH CARE FOR ALL – WASHINGTON**
http://www.hcfawa.org/

TO: Vicki Lowe, Commission Chair
Universal Health Care Commission

FROM: Ronnie Shure, President
Health Care For All - Washington

RE: UHCC Vote to Support HCA PEBB/SEBB Reference Pricing

I am writing on behalf of Health Care For All Washington (HCFA-WA) to ask the Universal Health Care Commission (UHCC) support the Health Care Authority's (HCA) proposed legislation (Z-0050) to implement referenced-based pricing for inpatient and outpatient services for public employee (PEBB) and school district employee (SEBB) purchased healthcare.

HCFA-WA understands the importance that healthcare cost-containment plays in sustaining our state's healthcare coverage for PEBB/SEBB employees, and for maintaining our state's commitment for low- and moderate-income coverage provided by Medicaid and the state's Health Benefit Exchange (HBE). HFCA-WA appreciates that UHCC has embraced cost-containment strategies as part of it designs of the E2SSB 5399 unified financing system for all Washington residents, and as one of its transitional solutions.

As outlined in the materials provided by HCA on Z-0050 for your December 5th meeting, a number of states have embarked on the use of reference-based pricing. For example, Oregon enacted 2017 legislation (Senate Bill 1067) that implemented referenced-based hospital service pricing for public and school district employees in 2019. Their Willis Towers Watson audit reported that they saved $59 million in 2020 and an estimated savings of $112 million in 2021. In their December 5th meeting materials, HCA is forecasting a $56 million in its 2027 implementation year. The HBE has recently reported material savings for their public option plan through the use of reference-based pricing.

Given the significant fiscal challenges our state is facing over the next four years (estimated to be $10 to $12 billion), we believe it is urgent that HCA proceed with the adoption of reference-based pricing for PEBB/SEBB members. The enactment of enabling legislation this session is an essential first-step.

HCFA-WA therefore request that the UHCC formally vote to support HCA's proposed reference-based pricing, and that UHCC members assist in the work of passing this legislation in the 2025 legislation session.

Cc: UHCC Member
Sue Burch
Mary Franzen

**From:** brandi
**To:** HCA Universal HCC
**Subject:** End "for profit" Healthcare
**Date:** Tuesday, December 17, 2024 10:21:20 PM

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External Email

My name is Brandi Cleveland and I live in Bellingham, Washington. I'm 51 years old and I am an example of what it is like to have cancer in the USA.

I was grateful to receive health insurance coverage from my employer. It seemed like a simple system until I got sick. I was diagnosed with HGSOC in January 2024. My employer had just changed my insurance plan before I was diagnosed and my long-term doctor was no longer in network. We were just figuring out that I had cancer and I couldn't see her anymore. She gave me my last test results over the phone because she didn't want to charge me out of pocket for an office visit.

After more tests and referrals, I went on medical leave from working to start aggressive chemotherapy. As soon as I stopped working, I couldn't keep my employer-based insurance. It was incredibly stressful to navigate losing insurance coverage while undergoing cancer treatment. For the first time in my life, I had no income and one of my biggest worries was insurance and medical bills. I was lucky because the Washington Health Care Authority helped me get set up on Medicaid with no gaps in coverage, and I got to continue my treatment. The hospital where I am being treated offers all Medicaid patients financial charity which has kept my medical bills low so far.

I haven't been able to work since I started treatment. I qualified for Social Security Disability about 8 months after I applied. I now receive about 20% of my previous income for myself and an additional small amount for my daughter until she graduates high school in June. It doesn't cover my monthly expenses, but it absolutely helps. Except that it's too high of a monthly income for Medicaid, and I got disqualified and immediately lost my health insurance again. I did not see this coming. Now I'm forced to change my insurance coverage for the third time in 12 months while having cancer.

It's really frightening. I don't want to lose my doctor. She is helping me qualify for ground breaking medications that might extend my life. I'm in the middle of treatment and testing. I have already been through so much. I need this hospital to be in network and I don't want to be exposed to my own medical bills because I can't afford them. The infusions, scans, lab work, medications, and doctor visits would break me in one month. What if I have a hospitalization or a recurrence? The costs to treat cancer are ridiculously high.

I'm not an insurance specialist. The people at the Healthcare Exchange can only give me a list of plans which I can enroll in and tell me my monthly payment. They can't give advice and only have the most rudimentary information of cost and deductible. I have to pick one of these for myself. It's so stressful to make the wrong choice and possibly end up with bad coverage or in a situation where I can't continue my treatment.

They directed me to a broker who they said would have more detailed information. She didn't. She recommended that I take the very first plan the system populated. She couldn't tell me if my doctor was in network or what my cost would be for chemotherapy. She couldn't answer if my scans would be covered or if I would need a referral to see an oncologist.

I have spent about 9 hours on the phone and online trying to make a good choice. I call my doctor's offices to ask if they accept the insurance. They say they do but only non-select plans. I call the HCA to ask if the one I am offered is a select plan. They use gold, silver, and bronze

to describe the plans and don't know how those relate to premium and select coverage. They say my doctor isn't listed, but the practitioners are often out of date, so I should call the doctor to ask. But the doctor already told me they take some of the plans but not the select tier. I read online reviews for this insurance and they are terrible. Oh, but they are a Fortune 500 company- that's reassuring right? I call the insurance plan to try and understand the coverage. They say my doctor is in network. They say that I won't need a referral to get treatment since the doctor is in network. But they can't send me anything in writing to confirm what we have discussed.

This decision could ruin me. I just picked the plan. My deadline is tomorrow and I can't get the information that I need to make a good choice.

And this is what ALL sick people have to go through in the USA while we are sick.

This is exactly how people go bankrupt from medical bills. We are sick, we are tired, we are in pain, we might die, and we're supposed to have the time, energy, mental acuity, and will to successfully navigate the medical industrial complex.

I think Washington is one of the best states to be living in with a severe medical condition. A lot of the states aren't even trying to take care of their sick people. But even in a state with some safety net, it's still so much bureaucratic red tape, confusion, lack of information.

We should have Universal Healthcare in the US. I'm glad this topic is seeing some daylight.

END "FOR PROFIT" HEALTHCARE NOW!!

Thank you for reading my story.

Brandi Cleveland

**From:** David Loud
**To:** HCA Universal HCC
**Subject:** Public comment submission
**Date:** Thursday, December 5, 2024 2:41:14 PM



Hello, UHCC Commissioners and staff:

Here is my public comment for your December 5 meeting - most of which I shared at the meeting itself.

The Commission's Milestone Tracker shows just one area of completion: Eligibility in the Universal System Design. But even this topic is far from completed!

Please look at the latest iteration below of Health Care for All's WA Health Security Trust proposal. It lists eligibility issues that to my knowledge the Commission has not discussed, such as:

- Voluntary enrollment
- Automatic enrollment at birth
- Definition of "all residents"
- Residents temporarily out of state, who work in another state, or who live in another state but work in WA
- Those who need specialized care in another state or country

At the October meeting, I heard it said that Veterans would not be eligible because they have the VA system. But only a minority of Veterans use the VA system. Even for those who do use the VA, some are not eligible for all VA services and must also rely on other sources of care. I believe the universal system should welcome any Veteran who elects to use it.

The Milestone Tracker is a great idea. Please make sure it's accurate, and that it is date stamped for every update. The Commission needs to pick up the pace of its work!

Thank you,

David Loud
Puget Sound Advocates for Retirement Action
Health Care Is a Human Right WA

Addendum:

Here is the latest version of the WA Health Security Trusts's eligibility language:

(1) All Washington residents are eligible for coverage through the trust. The board shall establish a process for automatic trust enrollment at the time of birth in Washington or at the time a person establishes residency as defined in this act.
(2) If a resident has health insurance coverage for any health services provided in the state, the benefits provided in this act are secondary to that insurance.
(3) Until federal waivers are accomplished, residents covered under federal health programs shall continue to use that coverage, and benefits provided by the trust shall extend only to costs not covered by the federal health programs unless:
(a) The resident voluntarily elects to participate in the trust;
(b) the resident's pay is considered in calculating the employer's health security assessment established pursuant to the recommendations made under Section 16 of this act; and
(c) either the employer or the employee pays the health security premium established pursuant to the recommendations made under Section 16 of this act.
(4) Nonresidents are covered for emergency services and emergency transportation only. The board shall make provisions for determining eligibility for coverage for residents while they are temporarily out of the state and for residents who are employed in another state. If a resident receives medically necessary care in another state, the resident will be reimbursed by the trust according to rules established by the board.
(13) "Resident" means an individual who presents evidence of established, permanent residency in the state of Washington, who did not enter the state for the primary purpose of obtaining health services. "Resident" also includes those meeting the Apple Health Residency Requirements in WAC 182-503-0502 and 182-503-0525.

**From:** Peter Markus
**To:** HCA Universal HCC
**Subject:** Public Comment Milestone Tracker Chart.
**Date:** Wednesday, December 4, 2024 4:10:05 PM
**Attachments:** image.png

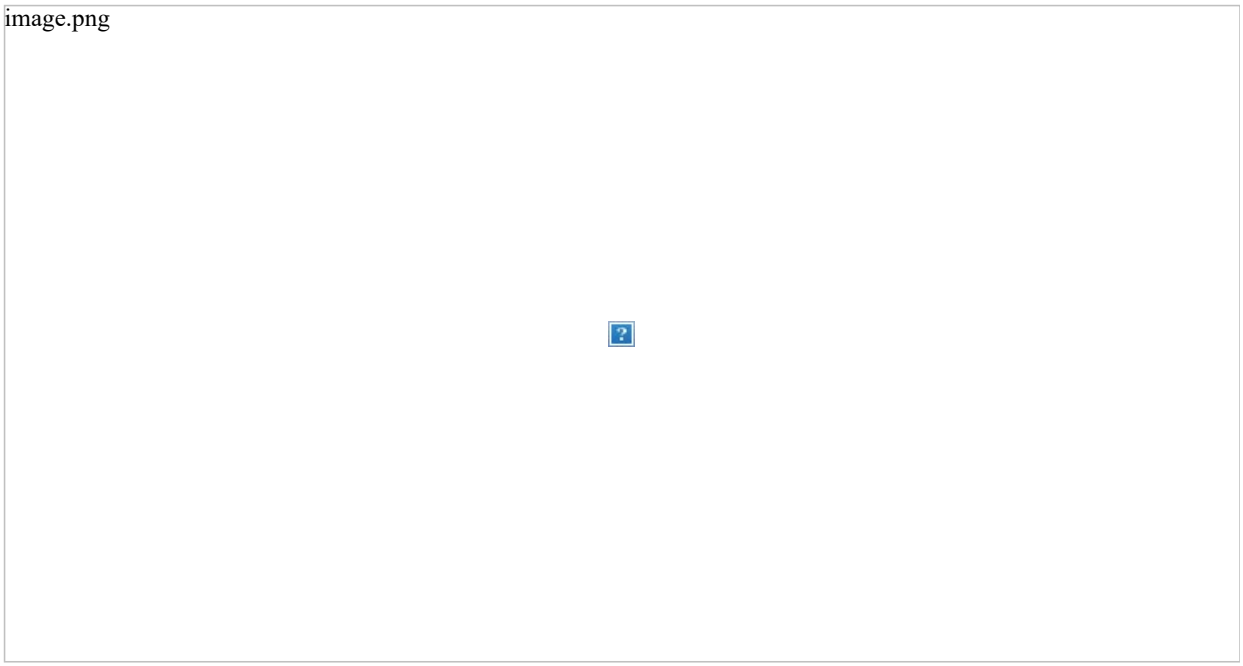
External Email

Public Comment for UHCC meeting, December 5th, 2024.

Thank you for providing the Milestone Tracker chart in the meeting materials! It provides meeting participants a good review of what the necessary tasks are and how much progress has been made toward their completion. **I highly recommend discussing the chart and the progress made at the beginning of each UHCC meeting.** Also, I recommend assigning planned completion dates to each of the phases, not just to phase I, as is presently shown in my attached chart. Better yet, consider assigning dates to each of the milestones.

In addition, is there a report or a record of decision showing the output of the completed milestone, "Eligibility"?

image.png



Thanks, and keep up the good work!

Peter Markus
Whole Washington

**From:** Tom Werner
**To:** HCA Universal HCC
**Subject:** Momentum
**Date:** Monday, January 6, 2025 1:07:26 PM

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External Email

Hello Universal Health Care Commission,

I'm hoping by now that you can sense the momentum in pushing ahead with universal healthcare for WA residents. As my wife and I consider retirement in the next few years, we will be taking a hard look at our state and whether to remain and even influence our kids to stay or go.

The current for-profit healthcare model in our country is unbearable, and people are finally speaking up. However, between the corporate capture of our federal politicians or the conservative view that business is better than government at providing healthcare, we have no hope of any progress.

Now seems like the time for WA to take a lead and demonstrate what we already know works in every country in the world and that is a single payer system that is either taxed or available to purchase for a fraction of the cost of for-profit Wall Street care.

Thank you,
Tom

**From:** Aimee Storm
**To:** HCA Universal HCC
**Subject:** Public Comment Submission
**Date:** Friday, January 10, 2025 11:40:54 AM

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External Email

Hello, Universal Health Care Commission. My name is Aimee Storm and I'm from Seattle. Here is my public comment:

My wife and I are "comfortable" financially and have "good" insurance, and we are still held back from seeking necessary care by the financial cost. Our insurance has a $4500 deductible, meaning we have to pay $4500 *out of our own pockets* in addition to our monthly premium before our insurance - the insurance we pay for - will deign to cover our actual medical costs. $4500 is more than a full month's wages for me and my wife.

I need to get back into therapy; I will have to pay at least $150 out of pocket per therapy session until we meet our deductible. Should my wife decide to also return to therapy, she also has to pay $150 per session. Assuming we each go to only *one* therapy session a month (which is likely insufficient for actual effective treatment), we're stuck paying $300 a month for care because our insurance simply won't cover it. If we go every two weeks, that's **$600 a month** we have to come up with somewhere in our budget on top of any doctor's appointments or urgent care we need, which also isn't covered until we meet our deductible. We don't *have* an extra $600 a month! It's unacceptable to expect us to cover *all* our own healthcare costs out of pocket when we already pay for insurance!

We pay **thousands** a year for the privilege of paying **thousands more** a year before our health insurance will actually cover our care. I want to remind you, this is with ostensibly ***good*** health insurance subsidized by the company where my wife works, which is known for its generous employee benefits. I have friends working at non-profits that *don't* offer employee benefits, and the only health insurance they can afford requires them to drive an hour outside of the city to find a doctor that's actually covered. I have other friends with no healthcare at all, because they simply can't afford it.

We need healthcare reform, and we need it now. ***This cannot wait.***

Thank you for your time,
Aimee Storm

**From:** larryowens2
**To:** HCA Universal HCC
**Subject:** Public Comment
**Date:** Saturday, January 11, 2025 8:40:56 PM

External Email

I'm writing to you asking you to support SB 5233 - 2025-26, Developing the Washington health trust. Senator Hasegawa is the prime sponsor.

As you undoubtedly know, our healthcare system is truly broken. Across the 32nd LD where I live, the state, and the nation, people are struggling with healthcare costs, denials by insurance companies, and worse. The Washington Health Trust is an excellent way to move forward; instead of multiple private insurance companies and multiple programs, the Washington Health Trust (WHT) would pay the healthcare expenses of Washington State residents.

Studies have shown that this could save Washington billions of dollars per year while expanding and enhancing coverage to all Washingtonians!

The private health insurance companies offer little true value. They are middlemen who are money and paperwork handlers that generate massive bureaucracy, inefficiency and overhead. We deserve better and for less money.

Before I was able to switch to Medicare, I had a Medicare "Advantage" PPO plan that United Healthcare unilaterally decided they wouldn't allow their subsidiary, Optum, to accept any more. They dropped ALL Advantage PPO's except for the ones offered by their parent company, United Healthcare. As a result of their greed I lost my urologist, oncologist, family practice doctor and access to the Everett clinic right here in Shoreline where I live - unless I wanted to pay for Out of Network prices. To put this into perspective I've been living with cancer for over 16 years.

The Washington Health Trust would make sure that this kind of thing never happened to anyone else.

The incoming POTUS has made it clear he and his administration will be going after public healthcare programs and WE, in Washington, need to have a solution. The WHT is a huge step in that direction and I urge every legislator to co-sponsor the legislation and be a strong voice for it in this session.

Respectfully,

Larry Owens
16744 Wallingford Ave N.
Shoreline, WA 98133

| | |
|---|---|
| **From:** | Aaron B Katz {he, him, his} |
| **To:** | HCA Universal FTAC |
| **Cc:** | HCA Universal HCC |
| **Subject:** | Public comment submission to FTAC |
| **Date:** | Wednesday, January 15, 2025 4:42:49 PM |



Dear FTAC Members,

Some thoughts about your, and the Commission's, 2025 work plan.

First, it's good to see the work plan's priority given to design of a universal system. That focus has been long in coming.

I note that Slide 23 (also 25) shows the stepwise topics UHCC will take up in this system design work: Provider Participation and Financing at the end of Phase 1; Infrastructure and Enrollment in Phase 2; and then last, in Phase 3, Governance.

I'd like to suggest that Governance is the single most important feature of a unified system and the feature most related to its success in controlling future spending and assuring effective and efficient services. It's much more important, in my view, than the details of provider payment, for example, even though we ruminate (a lot!) on payment methods.

If you look at the histories of, for example, the German (and Japanese, since the latter was based on the former) social insurance model or Canada's single payer system or Britain's National Health Service, you'll see that the first and critical step in each case was determining what public body or process would be responsible for governing the new system and assuring affordability, access, and equity. Only later were decisions made about how to pay hospitals and doctors, etc.

I urge you to take up Governance much sooner in this year's work plan, as the success of the rest of the system's design rests upon it.

Thank you.

Cc. Universal Health Care Commission

Aaron

Aaron Katz, Principal Lecturer Emeritus
School of Public Health
University of Washington

**From:** Wallross
**To:** Simmons, Tarra
**Cc:** HCA Universal HCC
**Subject:** Hooray for HB1445!
**Date:** Thursday, January 23, 2025 3:57:33 PM

External Email

Dear Rep. Simmons:

Thank you so much for co-sponsoring HB1445, in furtherance of developing the Washington Health Trust!

I am a constituent, having lived in the 23rd for 30 years. In 2023, I retired after teaching in the CKSD for 26 years, and although I'm fast approaching Medicare eligibility, I've long felt that Medicare for All was the best idea to have never been accomplished.

With your support and advocacy for this bill, I hope we can see a day soon where my children, now 24 & 19, won't have to fret over unreasonable insurance companies' control of their healthcare access and affordability.

Thanks again,

Wallace Ross
859 NE Cimeron Court
Bremerton 98311

**Please note:**

While the Universal Health Care Commission was cc'd on this message, the Commission did not sponsor the bill.

# Tab 4

Washington State Health Care Authority

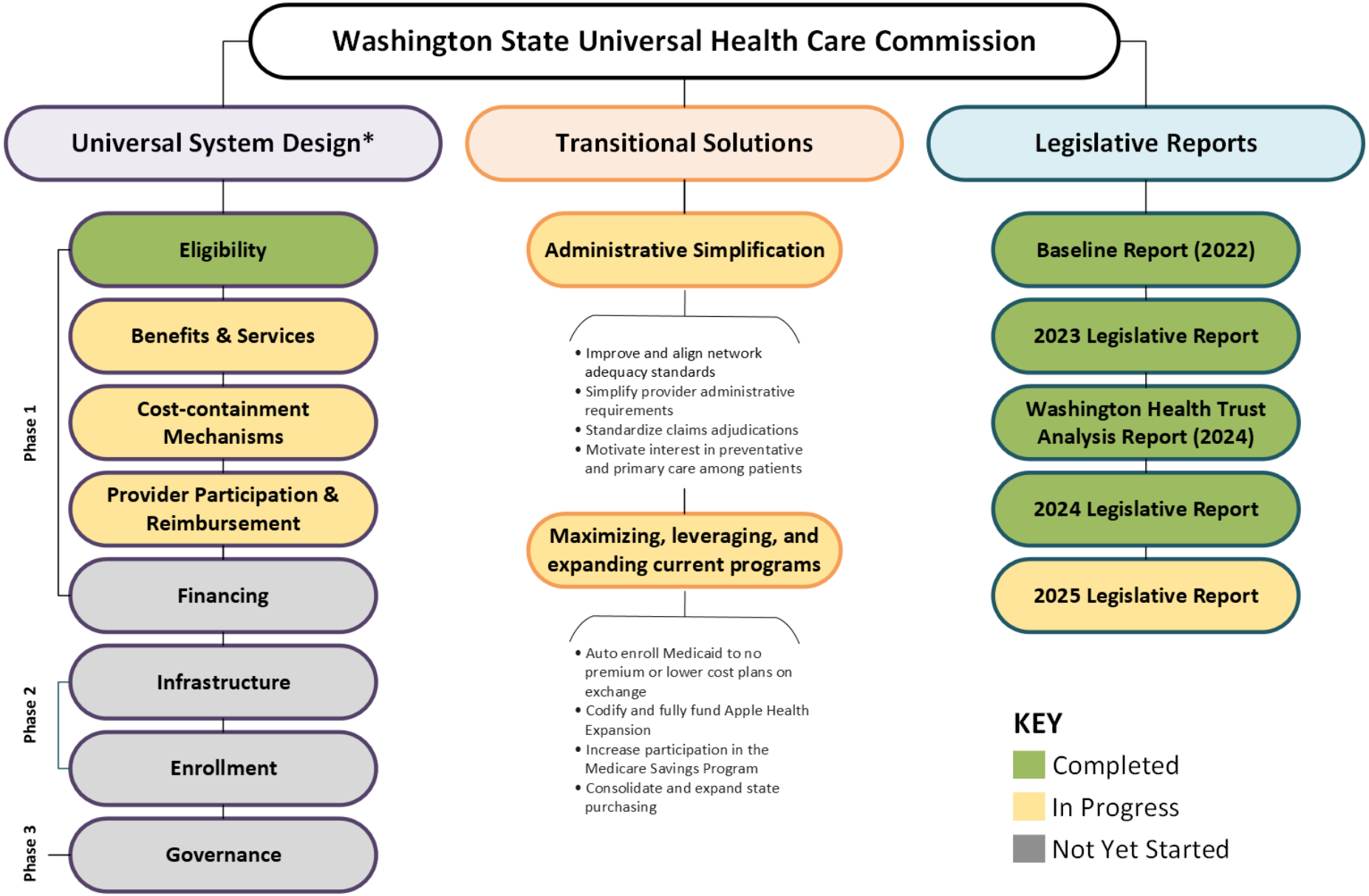
# Workplan update

Universal Health Care Commission

*February 2025*

# Milestone Tracker

Last updated: 11/21/2024




**Health care quality, health equity, and health disparities will be discussed and considered during each of the core universal system design components.*

# Recap: Phase 1 - Eligibility

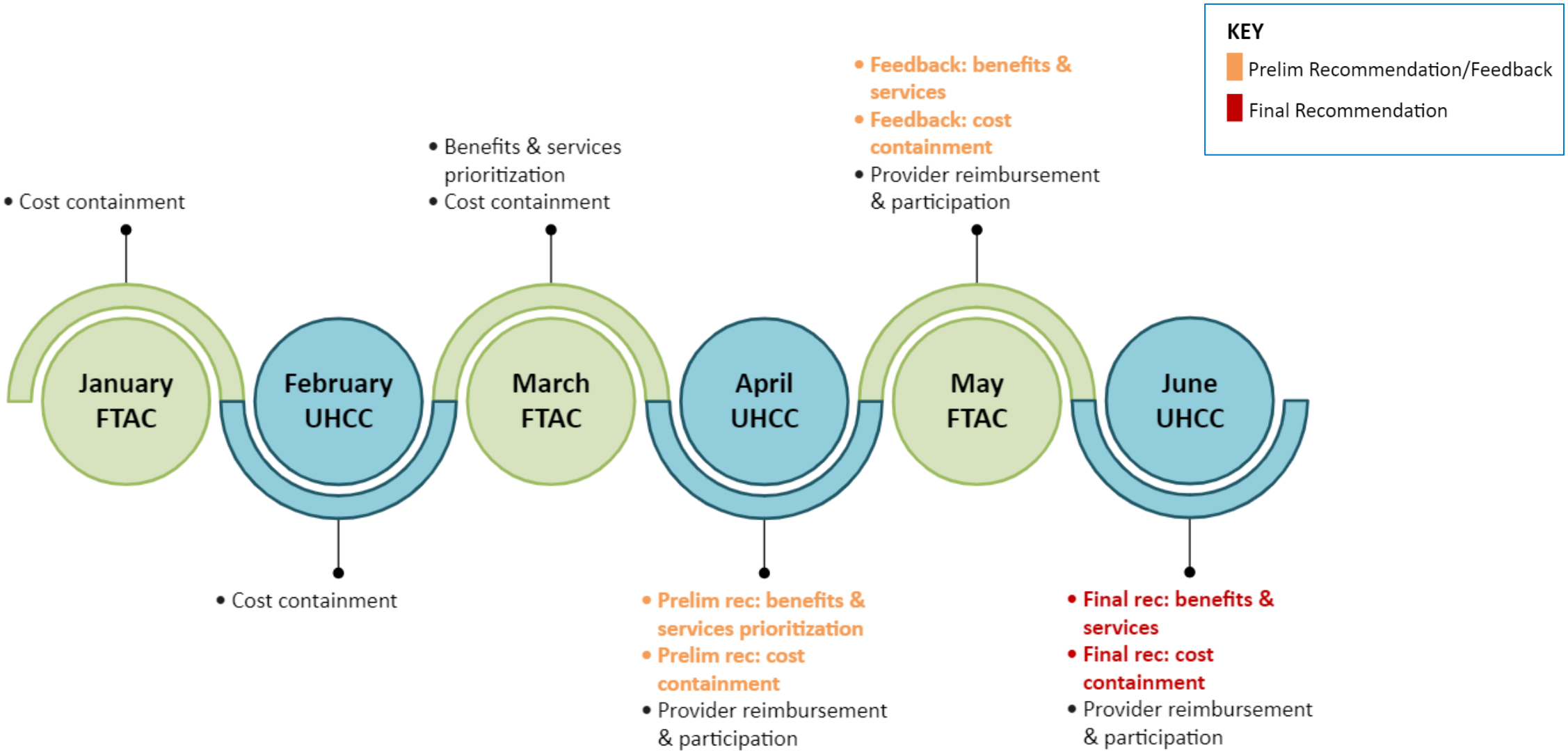
- In 2024 the Commission determined eligibility in order to establish the foundation for other Phase 1 decision points
- People most likely to be included in a universal health care system with uniform financing are those currently covered by:
  - Medicaid
  - Individual health plans
  - Fully-insured group health plans (small and large)
  - All PEBB/SEBB plans, including the lives of local governmental entities that have opted to participate in PEBB/SEBB
  - Uninsured people

# 2025 Goals

- Universal Design (January – June 2025)
  - Develop set of recommendations for **cost containment mechanisms**
  - Complete analysis of **benefits and services** and determine prioritization
  - Develop set of recommendations for **provider reimbursement and participation**
- Transitional (Interim) Solutions (July – December 2025)

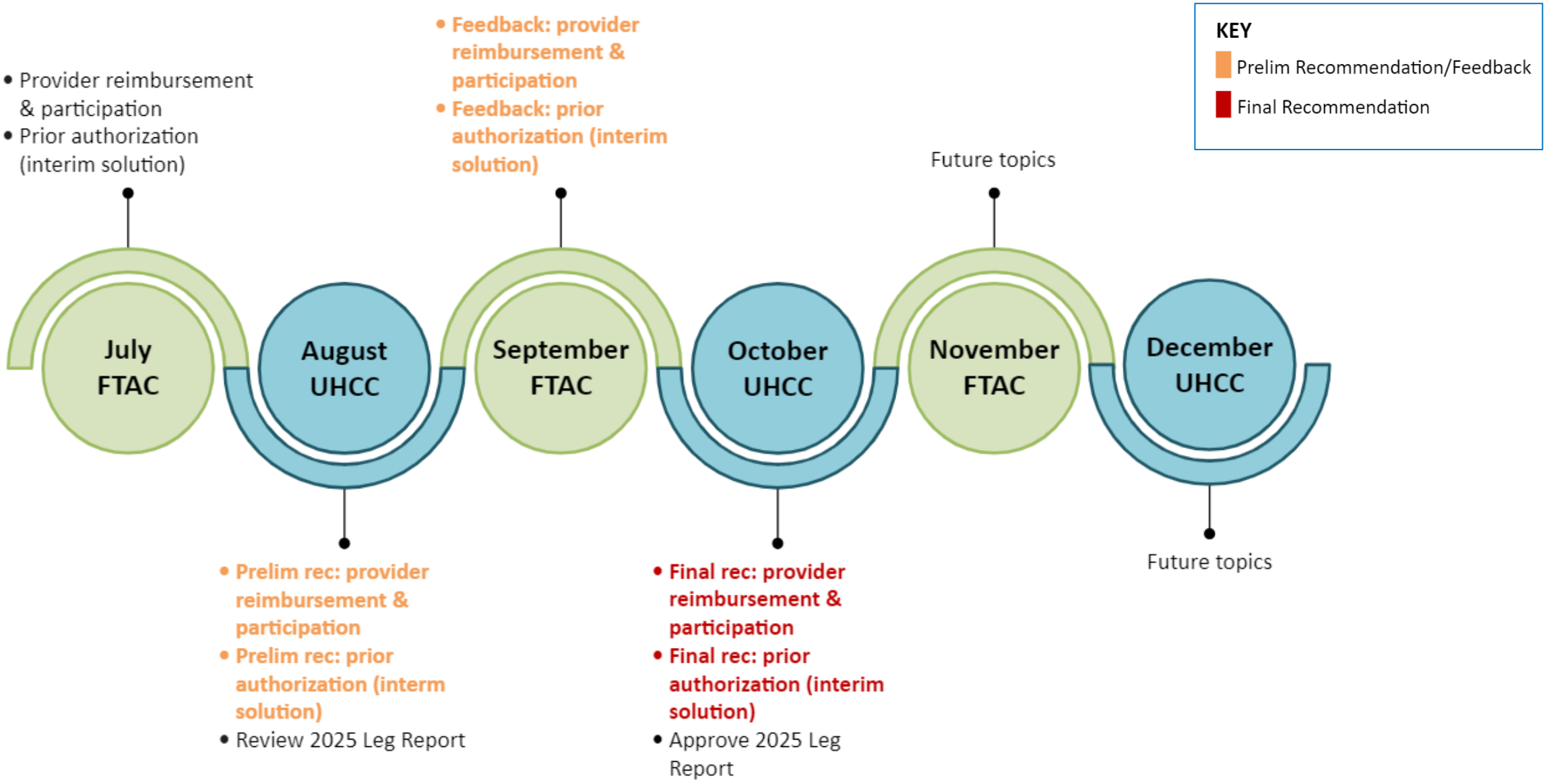
# 2025 Workplan

*Last updated: January 2025*



# 2025 Workplan

*Last updated: January 2025*



# Tab 5

Washington State Health Care Authority

# FTAC update

David DiGiuseppe, FTAC Liaison

*Watch the 1/16/25 meeting **here***

*Review the meeting materials **here***

Washington State Health Care Authority

# January FTAC meeting

- FTAC liaison update
- Public comment recap
  - Revised Washington Health Trust bill, HB 5233
  - Urging adoption of single payer system
  - Request to focus on governance first (currently Phase 3)
- Cost modeling: Milliman analysis update
- Cost containment
  - Health Care Cost Transparency Board benchmark report
  - Hospital global budgets
  - Reference-based pricing
- Benefits & services: brief introduction

# Milliman analysis update

- Ongoing meetings with FTAC liaisons
- Revised timeline of analysis and reports
  - February 2025: Interim report to internal staff at HCA
  - March 2025: Final report to FTAC
  - April 2025: Presentation to UHCC

# Health Care Cost Transparency Board benchmark report update

- Overall, per-member spending increased by 3.6% in 2022
  - This increase was above the 3.2% growth benchmark set by the Cost Board
  - Marketwise, only the Medicare market exceeded the benchmark
- FTAC members expressed interest in continuing to hear about the Cost Board's work
- Recording available here

# Hospital global budgets (HGBs)

- FTAC member Bob Murray provided an overview of an all-payer flexible HGB model
  - Flexes with volume changes, covering marginal cost of hospital (and potentially other) services
  - The state then has legal authority to control the growth of budgets to meet state affordability goals
  - Flexible HGB model is "lower-intensity" to administer than existing fixed HGB models (e.g., Maryland)
- Commission members are encouraged to watch the presentation here
- FTAC members support idea of UHCC inviting Bob Murray's to present to UHCC/HCCTB

# Reference-based pricing & PEBB/SEBB

- FTAC members discussed how reference-based pricing could be a more widely accepted first step toward cost containment, compared to HGB
- FTAC members believe it would be meaningful for the Commission to formally endorse SB 5083 and HB 1123 (the PEBB/SEBB access and affordability bill), recognizing that to date the Commission has taken a more general approach to support (there was no formal vote or action on this matter)

# Next steps

- Wrap up cost containment:
  - Categorize cost containment principles and tools
- Start on benefits & services
- Next FTAC meeting:
  - **March 13, 2025 from 2-4:30pm** on Zoom
  - For more details visit the FTAC webpage

# Questions/Comments?

# Tab 6

Washington State Health Care Authority

# State agency report outs

Washington State Health Care Authority

# Tab 7

Washington State Health Care Authority




# Medicare Benchmarked Reference Pricing in Oregon's State Employee Health Plans

# Discussion Overview

- Oregon's state employee health plans
- Challenges - cost growth & payment variation
- SB 1067 (2017) – Hospital Payment Limit
- Savings
- Impact
- Considerations

# Oregon's Public Employee Plans

The Oregon Educators Benefit Board (OEBB) and Public Employees' Benefit Board (PEBB) are Oregon's public sector employee health benefit programs.

oebb Provides benefits for 240+ school districts & community colleges

pebb Public Employees' Benefit Board Provides benefits for 200+ state agencies & universities

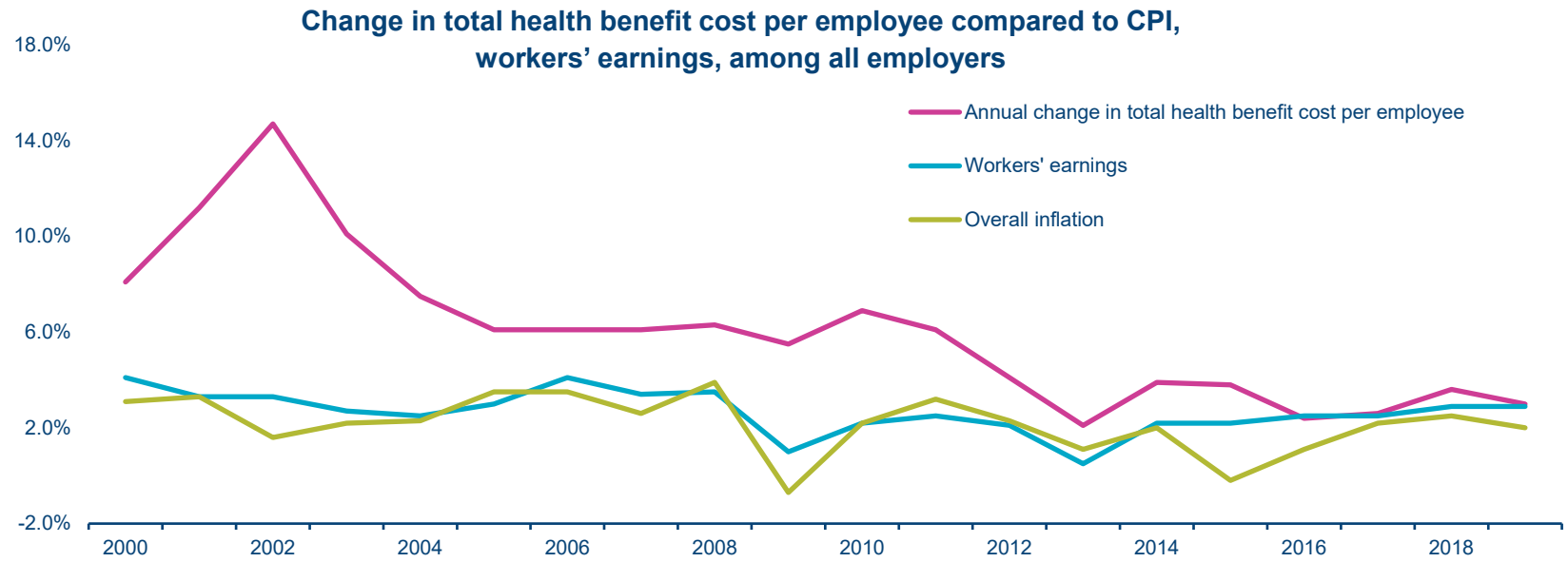
Together the programs cover 300,000 people – about 15% of Oregon's commercially insured.

# OEBB and PEBB

- Provide comprehensive, high-quality benefit plans to the agencies, universities, and school districts that employ Oregon's state workers, educators, and school district employees
- Ensure the benefit plans offered promote prevention, support employee health, and advance health equity
- Manage costs so that benefit plans are affordable to employers and employees

# Challenge: Health Benefit Cost Growth

Like most employer sponsored benefit plans, OEBB and PEBB have long worked to manage health benefit cost challenges.

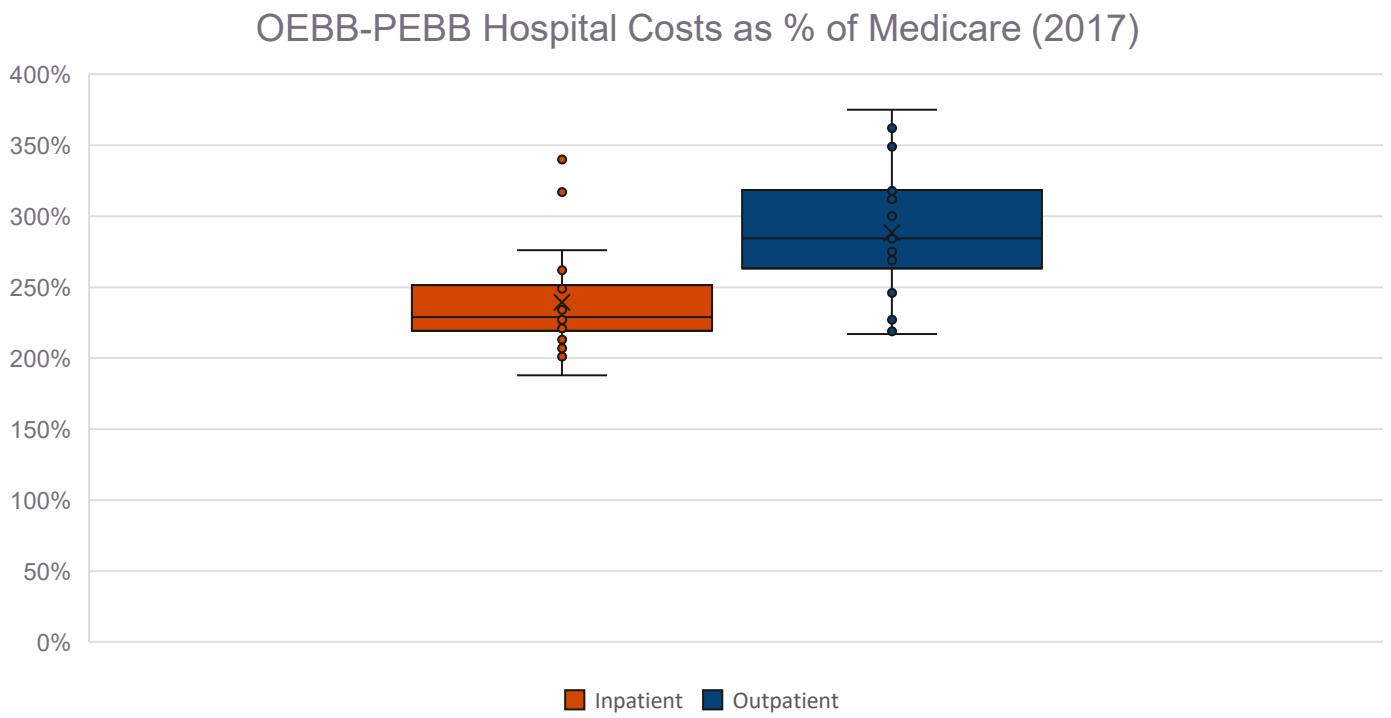



Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April); Bureau of Labor Statistics, Seasonally Adjusted Weekly Earnings from the Current Employment Statistics Survey (April to April).

# Challenge: Payment Variation

OEBB and PEBB data examining payment levels at large hospitals showed variation across hospitals.

Payment levels at these hospitals ranged from 185% to 340% Medicare for inpatient services and from 215% to 375% Medicare for outpatient services.



# SB 1067 (2017)

In 2017 Senate Bill 1067 was passed by the Oregon Legislature and included two major provisions related to public employee health benefit costs

- 3.4% limit on OEBB & PEBB benefit plan annual cost & premium growth
- Limit on the amount insurers and third-party administrators that contract with OEBB and PEBB can pay for inpatient and outpatient hospital services

# Hospital Payment Limit

- OEBB & PEBB's insurers & TPAs are prohibited from paying more than twice the amount Medicare would pay for inpatient and outpatient services at network hospitals
- Limit is 185% Medicare for non-network
- Applies to hospital services only, not professional fees
- Does not apply to out of state hospital services (HB 2266, 2019)
- Hospitals paid in accordance with the limit may not balance bill
- Some hospitals are exempt, generally small/rural hospitals - 24 of the state's 62 hospitals are under the payment limit

# Hospital Payment Limit

Agency rules establish further requirements (OAR 101-080-0010 and 111-080-0065)

- CMS-designated children's hospitals excluded (only a few in the state)
- Actual payments are the lesser of billed charges, the insurer/TPA's contracted rates, or the statutory payment limit
  - Medicare rates are not an ideal benchmark for certain types of care common in younger/commercial populations – for example, maternity, newborns
  - Payments at or near 200% Medicare on these services can result in payment levels far above typical commercial rates

# Hospital Payment Limit

- Carriers and TPAs negotiate contracts with providers – OEBB and PEBB do not participate in these negotiations
- No contracted hospitals left the network due to payment cap implementation
- Hospitals expressed concerns about potential impact on their revenue
- Some indicators that hospitals sought increases up to the 200% Medicare limit on services that were previously paid below that level
- No evidence of inappropriate increases in service use

# Savings

- Effective date October 2019 for OEBB, January 2020 for PEBB
- Almost 70% OEBB-PEBB hospital use occurs in capped facilities
- Savings during first two years estimated at over $160M

| Year | Savings | Total Medical + Rx Costs |
|---|---|---|
| 2020 | $59 million, about 14% of claims subject to limit<br>• Inpatient: ($5 million)<br>• Outpatient: $64 million | $1.25 billion |
| 2021 | $112 million, about 30% of claims subject to limit<br>• Inpatient: $38 million<br>• Outpatient: $74 million | $1.60 billion |

# Savings

- Savings concentrated in outpatient - higher relative to Medicare prior to limit
  - Outpatient services at capped hospitals averaged ~285% Medicare at baseline
  - Inpatient services at capped hospitals averaged ~235% Medicare at baseline, with some hospitals below 200% Medicare for inpatient rates

- First year savings were lower than initial projection of $81M
  - Reduced utilization during Covid pandemic
  - Unintended higher payments on maternity/newborn services at launch cancelled out inpatient savings (addressed through updated rules)

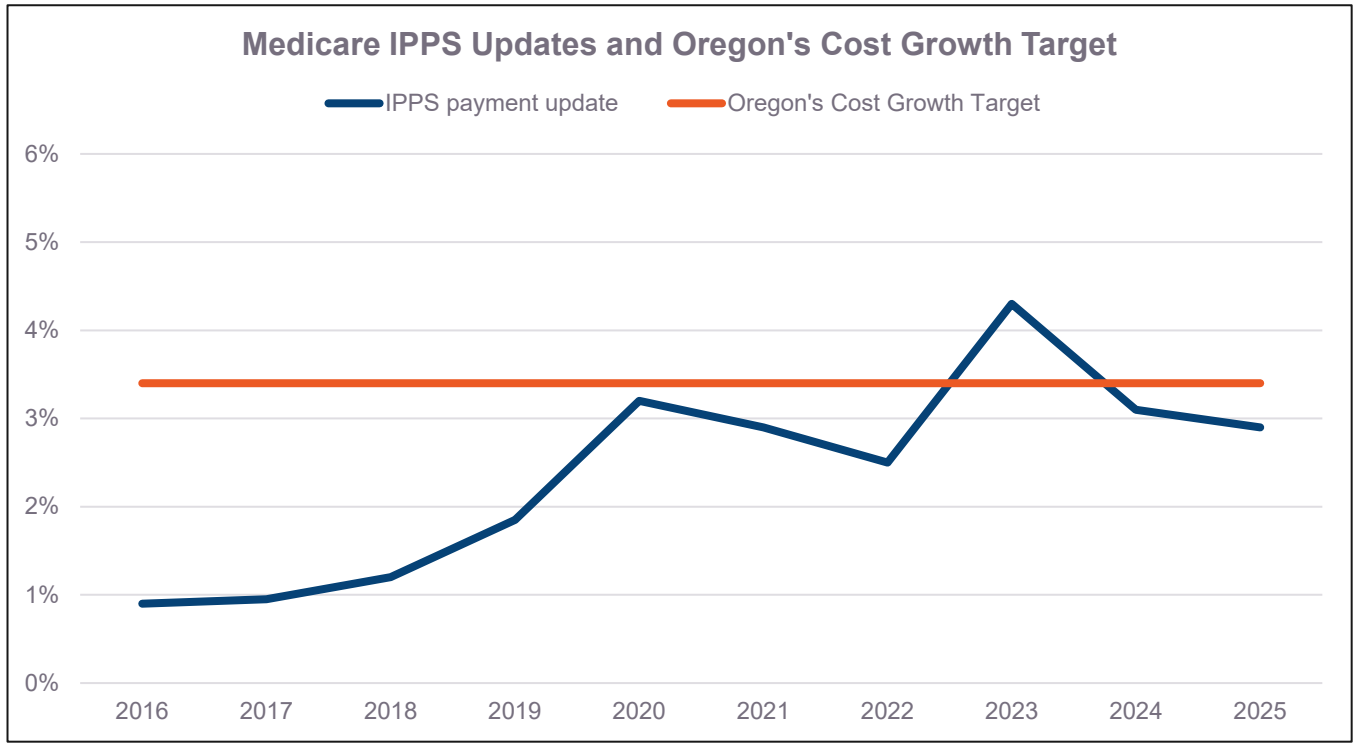
# Impact

- Carriers and TPAs contracted with OEBB and PEBB have maintained networks alongside reduced payment levels
- No concerns or disruption expressed by covered employees – majority of employees are likely unaware of this policy
- Inpatient payments at capped hospitals average roughly 165% Medicare*
- Outpatient payments at capped hospitals average roughly 190% Medicare*
- Analyses to date have not found evidence of disproportionate impacts on other commercial plans

*Based on 2022 OEBB and PEBB payments

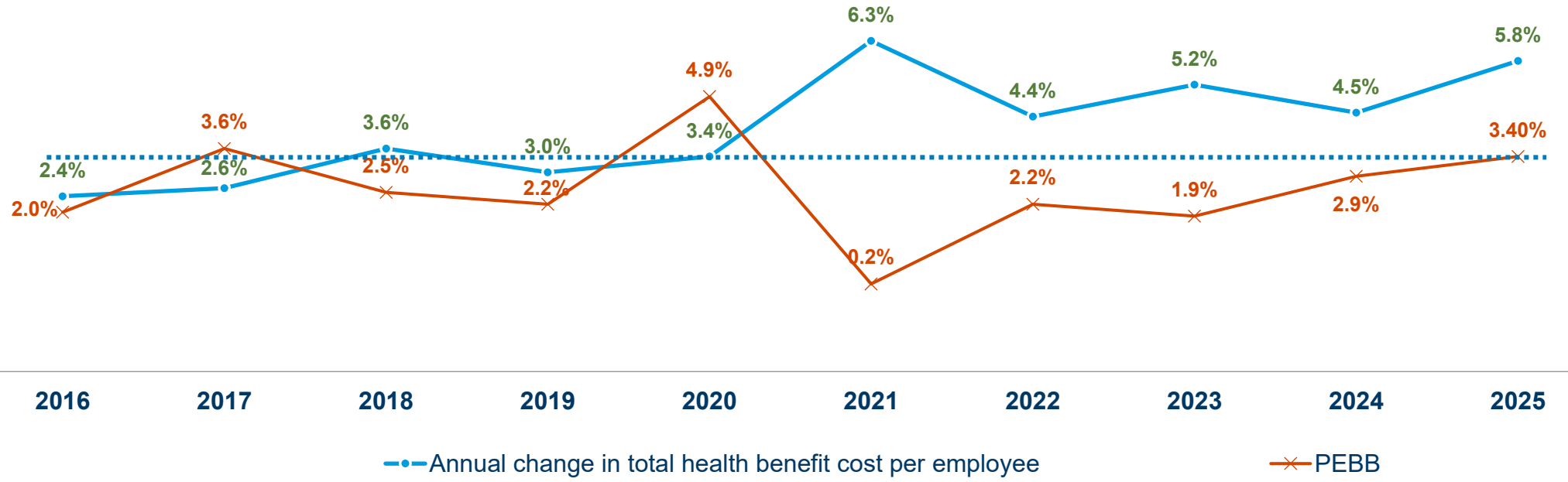
# Impact

- Progress towards sustainable rate of annual cost growth
- CMS annual rate updates for IPPS generally fall near or below 3.4%
- 3.4% limit on OEBB and PEBB annual benefit program cost growth aligns with Oregon’s statewide target for sustainable health care cost growth.



# PEBB's Year-Over-Year Cost Growth Compared to Large Employers

## Health Benefit Cost Growth Remains High in 2025




PEBB's annual cost growth has generally stayed at or below the 3.4% mandate – however, maintaining sustainable cost growth is an ongoing challenge.

Beginning in 2020, survey results are based on employers with 50 or more employees. 2025 benchmark cost increase is projected.

Source: Mercer's National Survey of Employer-Sponsored Health Plans (beginning in 2020 results are based on employers with 50 or more employees); Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April) 1993-2024; Bureau of Labor Statistics, Seasonally Adjusted Weekly Earnings from the Current Employment Statistics Survey (April to April) 1993-2024

# Considerations

- Payment limits are one approach to support sustainable cost growth, but continued strategies needed to manage health care cost increases

- Medicare is a useful, reasonably transparent, and broadly familiar price benchmark, however, thoughtfully consider nuances in applying Medicare rates to commercial plans
  - May not be the most accurate price benchmark for services infrequently used by Medicare population (for example, maternity, neonates)
  - Consider how retroactive Medicare rate adjustments CMS may provide could impact commercial plan administration

# Considerations

- Payment ceilings absolutely impact contract negotiations and specifics of that impact vary by community.
  - May influence some providers to seek increases beyond current payment levels
  - May influence providers' perspectives on advancing Value-Based Payments (VBP) and transition away from fee for service

- Payment ceiling level, included benefit programs, and exempt providers are all features that can be informed by data analyses and local considerations.

# Thank You

Margaret Smith-Isa, Program Specialist
Oregon Educators Benefit Board & Public Employees' Benefit Board
margaret.g.smith-isa@oha.oregon.gov

OREGON HEALTH AUTHORITY

# Break

# Tab 8

Washington State Health Care Authority

# Rural health roundtable

Brad Becker, Mason Health and The Rural Collaborative

Shane McGuire, Columbia County Health System

Ashlen Strong, Washington State Hospital Association

Washington State Health Care Authority

# Purpose

- Discuss the unique opportunities and challenges facing rural communities in Washington within the context of a universal health system and the Commission's ongoing cost-containment work
- Identify solutions to ensure equitable, high-quality, and financially sustainable health care for rural communities

# Outline

- Washington state rural health overview
- Snapshot of the Commission's cost-containment work
- Panelist introductions
- Roundtable
- Q&A
- Wrap-up

# What is rural?

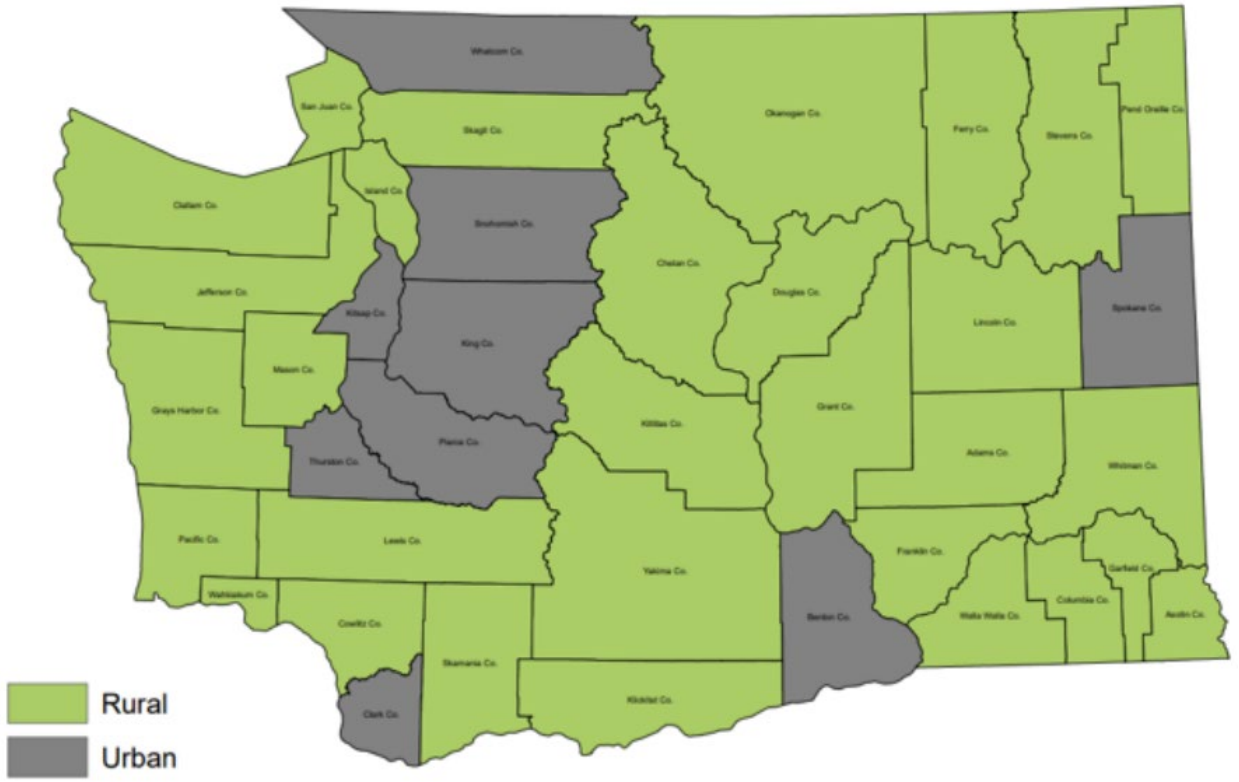
## State at a glance:

**State Population**
**7,864,400**

**% of population considered rural:**
**21%**

### Rural Health and Safety Net Service Sites:

| | | |
|---|---|---|
| **39** Critical Access Hospitals | **6** Rural Hospitals | **34** Tribal Clinics |
| **123** Rural Health Clinics | **44** Free Clinics | **218** Rural Federally Qualified Health Center Sites |




Based on Washington State Office of Financial Management. Reviewed in 2021

**Sources:** Washington State Department of Health, https://doh.wa.gov/sites/default/files/2023-09/609026.pdf (2023); https://doh.wa.gov/sites/default/files/2022-09/609003.pdf (2021)

# Cost containment and the Commission

- The Legislature has tasked the Commission with preparing the state for universal health care, with unified financing, if federally authorized
- Cost containment is one design element the Commission is currently working on
- So far, the commission and FTAC have discussed the following cost-containment mechanisms:
  - Reference-based pricing
  - Global hospital budgets
- Cost-containment mechanisms also include examining fraud, waste, and abuse; utilization management; setting cost growth benchmarks; and more

# Panelist introductions

- **Brad Becker**, Senior Director Payer Strategy
  Mason Health and The Rural Collaborative
- **Shane McGuire**, Chief Executive Officer
  Columbia County Health System
- **Ashlen Strong**, Vice President, Government Affairs
  Washington State Hospital Association

# What are the most significant factors contributing to higher costs for rural health care that need to be considered in a universal system?

# Imagine the current health care system is gone, and a new system is in place.

# What do you need to make a new system sustainable?

# How can cost containment be designed to avoid negative impacts on rural health access and quality?

# What rural-specific considerations should be included in the design of a universal system?

# Q&A with Commission members

Washington State Health Care Authority

# Thank you for attending the Universal Health Care Commission meeting!