Universal Health Care Commission meeting

April 17, 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, April 17, 2025
2:00–5:00 p.m.
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 February meeting minutes	2	Vicki Lowe, Chair
2:10–2:25 (15 min)	Public comment	3	Vicki Lowe, Chair
2:25–2:40 (15 min)	Workplan update and governance discussion **Decision:** Do members of the UHCC want to consider reordering phase 1 to address governance earlier in the design process?	4	Mary Franzen, HCA Liz Arjun, HMA
2:40–3:40 (60 min)	FTAC update and benefit cost analysis report • Commission Q&A • Potential additional modeling	5	David DiGiuseppe, FTAC Liaison to the Universal Health Care Commission
3:40–3:50 (10 min)	**Break**		
3:50–4:45 (55 min)	Follow-up discussion: future direction and possible modeling	5	Liz Arjun, HMA
4:45–5:00 (15 min)	State agency report outs	6	Commission members
5:00	Adjournment		Vicki Lowe, Chair

Tab 2

Washington State Health Care Authority

Universal Health Care Commission meeting minutes

February 13, 2025

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

Note: The meeting materials packet and a full recording of this meeting can be found at: https://www.hca.wa.gov/about-hca/who-we-are/universal-health-care/meetings-and-materials.

All votes made during this meeting are highlighted throughout in blue.

Members present

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

Members absent

Nicole Gomez
Stella Vasquez

Call to order

Vicki Lowe, Chair of the Universal Health Care Commission (UHCC), called the meeting to order at 2:01pm. Sufficient members were present to allow a quorum.

Washington State Health Care Authority

Agenda items

I. Welcoming remarks

Chair Lowe began with a land acknowledgement and welcomed members to the twenty-second meeting of the UHCC. She then introduced Insurance Commissioner Patty Kuderer who shared that the Office of the Insurance Commissioner (OIC) is ready to support the UHCC in their work, and highlighted that universal coverage is paramount and inevitable. Commissioner Kuderer noted that she intends to join future meetings as her schedule allows. Chair Lowe then introduced Ross Valore, Cost Board and Commission Director at HCA. Valore provided a brief background and noted that he is looking forward to building on the work that has been done so far.

II. Meeting minutes

The December 2024 meeting minutes were approved by unanimous vote.

III. Public comment

The following members of the public provided comments:

- **David Loud**, Puget Sound Advocates for Retirement Action and Health Care Is a Human Right
- **Consuelo Echeverria**, Health Care for All – Washington (HCFA – WA)
- **Peter Markus**, Whole Washington
- **Kathryn Lewandowsky**, Whole Washington
- **Brynn Friel**, Washington Community Action Network (CAN)

Topics brought forth during public comments included clarification on the completed phase 1 eligibility milestone, requests for veterans to be eligible for the universal system, requests for the UHCC to leverage existing reports and bills in their work, request to add completion dates to each milestone on the Milestone Tracker, and a request to address governance far sooner than it is currently laid out in the work plan.

Their full testimonies can be found in the meeting recording here (time stamp: 11:14).

IV. Workplan update

Mary Franzen, HCA

Mary Franzen reviewed the Milestone Tracker and provided a recap on "Phase 1 – Eligibility." Chair Lowe spoke directly to the public comment from David Loud, noting that Veterans would likely fall under the uninsured group if they have no other form of coverage outside of the Veterans Administration (VA). She noted that, like Indian Health Services (IHS), the VA is a system of care not coverage.

Franzen then reviewed the goals for 2025 as determined at the last UHCC meeting where 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. UHCC member Jane Beyer noted that if any of the UHCC's transitional solutions would require legislative change or funding, we would likely need to prioritize these sooner as the upcoming legislative session in 2026 will be a short session.

V. Finance Technical Advisory Committee (FTAC) update

David DiGiuseppe, FTAC Liaison

Chair Lowe shared that Pam MacEwan has stepped down from her role as FTAC Liaison to the UHCC and that FTAC member David DiGiuseppe is her replacement. Chair Lowe noted that MacEwan will remain a member of FTAC and thanked her for her work over the last several years. DiGiuseppe then provided an overview of FTAC's January meeting, sharing a recap of the public comments received at the meeting, an update on the Milliman analysis project, and key takeaways from the various cost containment presentations and discussions. His full presentation can be found here (time stamp: 33:08).

Following DiGiuseppe's presentation, UHCC member Jane Beyer asked whether the FTAC cost containment memo will include specific policies outside of reference-based pricing and hospital global budgets. DiGiuseppe confirmed the memo will contain many different cost containment levers beyond these two strategies. Chair Lowe noted that Robert Murray's presentation on Hospital Global Budgets was helpful and again encouraged all UHCC members to review the recording. UHCC member Mohammad Shidane asked for clarification about what a formal endorsement from the UHCC for SB 5083/HB 1123 would look like. After a brief discussion, the members present voted by majority (eight for and one (Representative Schmick) abstained) to have Chair Lowe provide written testimony to the legislature in support of SB 5083/HB 1123 on behalf of the UHCC.

VI. State agency updates

Chair Lowe invited state agency representatives to provide updates from their agencies on work that aligns with the UHCC. The following members provided updates:

- **Dr. Charles Chima**, Department of Health (DOH)
- **Dave Iseminger**, Health Care Authority (HCA)
- **Jane Beyer**, Office of the Insurance Commissioner (OIC)
- **Joan Altman**, Washington Health Benefit Exchange (WAHBE)
- **Omar Santana-Gomez**, Office of Equity (OE)

Topics brought forth included bills relevant to the UHCC this legislative session, the transitional period many agencies are in with interim directors and budget reduction exercises, record-breaking enrollment on the individual market, enhanced premium federal tax credits expiring in 2025, and an analysis on Medicaid churn (2024 WAHBE legislative report available here).

Their full updates can be found in the meeting recording here (time stamp: 51:29).

VII. Reference-based pricing in Oregon, presentation and Q&A

Margaret Smith-Isa, Oregon Health Authority

Margaret Smith-Isa provided an overview of Oregon's use of reference-based pricing for state employee health plans. Oregon uses Medicare rates as the benchmark for measuring cost growth in state employee health plans. Oregon sought to limit state employee insurance premium and out-of-pocket cost growth to the amount insurers and third-party administrators that contract with the state pay for inpatient and

outpatient hospital services. Smith-Isa reported savings during the first two years are estimated at over $160 million

The full presentation and discussion can be found in the meeting recording here (time stamp: 1:08:39).

VIII. Rural health roundtable

Panelists: Brad Becker, Mason Health and The Rural Collaborative; Shane McGuire, Columbia County Health System; Ashlen Strong, Washington State Hospital Association

Moderator: Liz Arjun, Health Management Associates (HMA)

Liz Arjun provided a brief overview of Washington's rural health system and invited panelists to share their perspectives. Panelists noted that the majority of hospitals in Washington's rural health system are tax-supported public hospital districts, that there is an interdependence among hospitals across county lines, and that the hospitals are often the largest employers in rural areas. Panelists then discussed the significant factors contributing to higher costs and how cost containment policies can be designed to avoid negative impacts on rural health access and quality.

The full presentation and discussion can be found in the meeting recording here (time stamp: 2:02:01).

Adjournment

Meeting adjourned at 4:59pm.

Next meeting

Thursday, April 17, 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

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Universal Health Care Commission

Written Comments

Received since January 30, 2025

Written comments submitted via e-mail:

Additional comments received at the February Commission meeting

- The Zoom video recording is available for viewing here: https://youtu.be/t7mgOFGhgPY

From: Lana
To: HCA Universal HCC
Subject: Washington Health Trust
Date: Wednesday, February 12, 2025 12:58:21 PM

External Email

Hello I live in The 30th LD and am a PCO I'm also a retired RN and know the need for adequate Healthcare in our State. I'm also a Volunteer with Whole Washington and we have 2 Bills that need a Hearing this session they are SB 5233 and HB 1445. Washingtonians deserve to have universal healthcare. Please seriously support these bills and help our state!
Thank you
Lana Bostic
Sent from my iPhone

From: Janean Desmarais
To: HCA Universal HCC
Subject: Yes to UHC
Date: Sunday, March 9, 2025 2:10:39 PM

External Email

Good afternoon

I am emailing you regarding my support of Universal Health Care for Washington state. Currently, how the system is set up it makes people beholden to relationships and situations that might be harmful to their health by not providing a system that ensures that people can get health care without having to rely on an employer, spouse, or a partner. Not only that, but by and large since women are still the caregivers that stay at home the cost for their spouses to ensure them is basically punitive. Take my situation, my husband's full coverage PPO plan, including dental/vision is roughly $260 a month. I'm self employed, to have me on his insurance it's about $750 a month. Why? In all reality I'm healthier than he is, but yet mine's $750 a month simply because I'm the spouse. To add to that I have a $2,000+ bill for my colonoscopy and endoscopy because we chose a cheaper Health Saving Account option to see how it would impact our finances, and so far it has not been beneficial. The insurance industry is a racket and the sooner that people in our government realize that and quit stuffing their pockets with lobbyist money the better off the population will be. What I also find interesting is how nobody balks at the fact that people that work for our government basically get Medicare for all as there insurance option and nobody seems to have a problem with it. It's time tax payer funded health benefits were for EVERYONE.

Regards,

Janean Desmarais
Everett, WA
(425) 478-6519

From: Cris
To: HCA Universal HCC
Subject: Comment
Date: Thursday, March 13, 2025 4:51:05 PM

To the UHCC:

The speakers on the rural health roundtable at the February UHCC meeting brought up several good points about how rural healthcare is in more trouble than large urban healthcare. More rural residents are underinsured or completely uninsured, they tend to have less money due to lower wages, they tend to be older and not as healthy, their travel expenses are higher, their facilities have lower volumes, they have less negotiating leverage with carriers, less flexibility in how actual costs are covered, and the economic growth of their communities has largely been stifled.

Shane McGuire pointed out that while a new system does not necessarily need to be a single-payer system, he emphasized the need to have consistent, uniform rules and processes as well as a unified EMR and communications system. I would argue that those kinds of changes will never happen in the absence of a single-payer system. Profit-first commercial insurance companies and provider conglomerates are extremely competitive, and they design their systems in ways they think will make them the most money. They are simply not concerned with consumer convenience or disadvantaged rural economies.

One of the most impactful ways a single-payer, universal system will benefit rural areas is that for the first time, large hospitals will be required to operate on a budget, and they will not be permitted to commingle operational funding with capital expenditures. Currently hospitals pay for expansion projects and new equipment out of their profits (operating margins) after completing a minimally effective certificate of need process. Since there is more money to be made in large urban areas, that is where the vast majority of investment goes. Most of that investment is dedicated toward high tech procedures for people with “good” insurance, and does little to benefit those with chronic disease and poor health habits.

Typically, single-payer systems require hospitals to rigorously demonstrate the need before a separate allocation is granted for these new expenditures. So instead of basing these decisions on competitive or profit generating interests, hospitals will be forced to study utilization trends and adapt to actual community needs. This will likely mean that some funding will be diverted from urban centers and directed toward rural hospitals to convert under-utilized resources, such as inpatient space, to more needed services such as outpatient services, or even to long term care, that better addresses the local needs. Such activities as telemedicine, partnering with regional medical centers, adding a pain clinic or a drug and alcohol unit or dental services, and improving the access to primary, palliative, behavioral health, or urgent care might all be facilitated by the single-payer that can impose uniform rules.

And even more importantly, since every rural resident will have the same health care benefits as every urban resident, people will not have to forgo care due to an inability to pay. With increased utilization it won’t be as difficult to recruit physicians and other professionals to

serve these communities. There will also be much less medical debt such that more rural residents will have more money to spend in their local economy. Those states which have expanded Medicaid, including Idaho, have already experienced some of these dynamics, while those that refused to expand Medicaid have generally experienced ongoing rural healthcare and economic decline.

Cris M. Currie RN (ret.) from Spokane, HCFA-WA

From: Kathryn Lewandowsky
To: HCA Universal FTAC
Subject: Additional Written Comments from Mar_2025 FTAC meeting
Date: Friday, March 21, 2025 10:28:39 AM

External Email

Hello, FTAC members, here are my complete written comments from your March meeting which I did not have enough time to deliver at the meeting. Followed by some additional comments regarding your committee materials discussed on that day.
"Hello FTAC members, Kathryn Lewandowsky, Retired RN and Board vice-chair of Whole Washington. In your packet, you are reminded of the UHCC's mandate from the legislature in 2021 to…
…create immediate and impactful changes in the health care access and delivery system in Washington and to 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." (RCW 41.05.840)

Obviously, in the process of obtaining such "federal authority", many of Washington's residents will lose their savings, their homes, their productivity and for many…their lives. We do not live in a perfect world and we do not have a perfect government. In this last election the citizens of Washington state clearly said that "We live in a liberal state! We care about what happens to our neighbors, our friends and our families." At Whole Washington, We understand that obtaining permission and support from our federal government will be difficult. But the Washington Health Trust can be passed and the transition plan can be started, we can begin to realize savings for our government, our businesses and our citizens.

What IS so ingenious about the Washington Health Trust is that it is NOT dependent on obtaining "federal authority" in advance to begin deconstructing our current unsustainable healthcare system. It allows for a reasonable transition plan to get the ball rolling and CAN make impactful changes that will help all of our state to survive our current crumbling for profit financing system and bumbling federal administration. From research done by other states, it MUST be passed before any "federal authority' can be even applied for.

Even if we could say that people love their health insurance companies, which they clearly don't, we must clearly state again, "The current system is unaffordable, stressful, wasteful, it does not improve people's lives and we are sick and tired of being forced to deal with for profit middle men standing between us and our doctors when we JUST need healthcare!

So, what I would really love is if your committee could please run a dynamic fiscal note in order to discover the true "cost" and potential savings on the proposed funding mechanisms within SB5233/HB1445. "

Additional written comments-

Principle 1 – Adoption of a comprehensive cost containment strategy is an essential prerequisite to prepare Washington state for a universal health care system with unified financing. **Agreed! This is why there must be adoption of a plan that the state can move forward on. Where would we be now if we had adopted a "plan" 2 years ago, 4 years ago, 6 years ago!**

Principle 2 – Adopt transitional cost containment and affordability strategies while state policymakers consider options a universal health care system. **The time for this is long past. It is time to finally make impactful and sustainable change!**

Principle 3 – Adopt evidence-based strategies that do not create barriers to care or disrupt the provision of necessary and high-quality care. **This can not really happen without having collaborative discussions with care providers. This is inherent in the Washington Health Trust through the providers committee!**

Principle 4 – Address health care cost with respect to patient access, quality of care, affordability, price of services, volume of services, and the cost of administration. **This is the main focus of the Washington Health Trust through the Financial and Citizen's committees!**

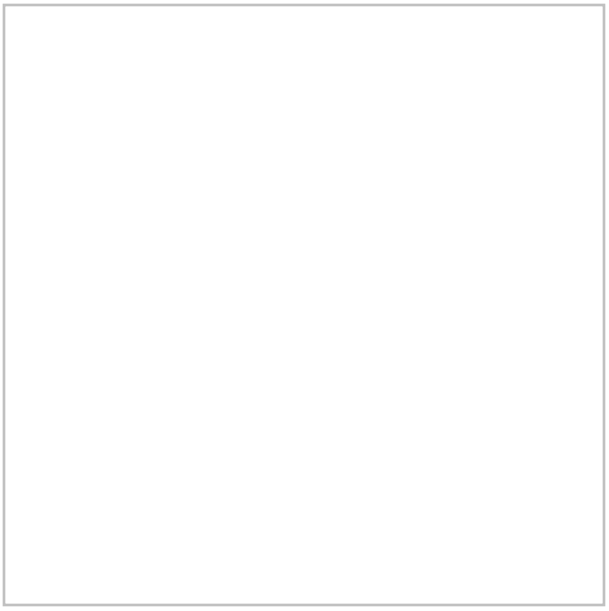
Principle 5 – Identify and focus on primary drivers of health care spending and spending growth, including actions to limit excessive provider price growth, the provision of unnecessary health services, and administrative waste and inefficiency. **Again, this is well covered within the design model of the Washington Health Trust!**

Principle 6 – Utilize a variety of targeted cost containment strategies with flexibility to modify those interventions over time to address unintended consequences and/or improve cost containment success over time. **This is most easily evaluated over time within the construction of the Washington Health Trust through the oversight of the Trust Board and that involves all of the committees created as part of the trust!**

Principle 7 – Align and coordinate cost containment strategies with the work of the Health Care Cost Transparency Board. Adopt transitional and long-term strategies which help Washington meet its health care cost growth benchmarks. **Through passage of the Washington Health Trust the state will have the ability to openly evaluate all of these costs and how to best contain them. Providers and state regulators would no longer be restrained by a system of trade secrets and accounting shuffleboarding that value corporate profits over maintaining sustainable hospitals, encouraging and promoting provider opportunities to practice their trade unencumbered with corporate restraints, thereby creating places of healing rather than Wall Street opportunities for creating wealth over health.**

Principle 8 – Emphasize the goal of improving the overall equity of Washington's health delivery system, including addressing payment equity and systemic inequities, reducing disparities in care quality and access, and other equity goals. Review final decisions with use of the Health Care Authority's health equity toolkit. **Creating the Washington Health Trust would create equal reimbursement of all patients which is fundamental in creating an equitable healthcare system.**

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



SB 5233/HB1445 establishes the Washington Health Trust. Read more about SB5233/HB1445 here!

Comprehensive, no copays or deductibles! Healthcare from Cradle to Grave! We can do this! By Bill or by Ballot! Go to WholeWashington.org and donate today! Donate via Act Blue Donate via Anedot

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

Tab 4

Washington State Health Care Authority

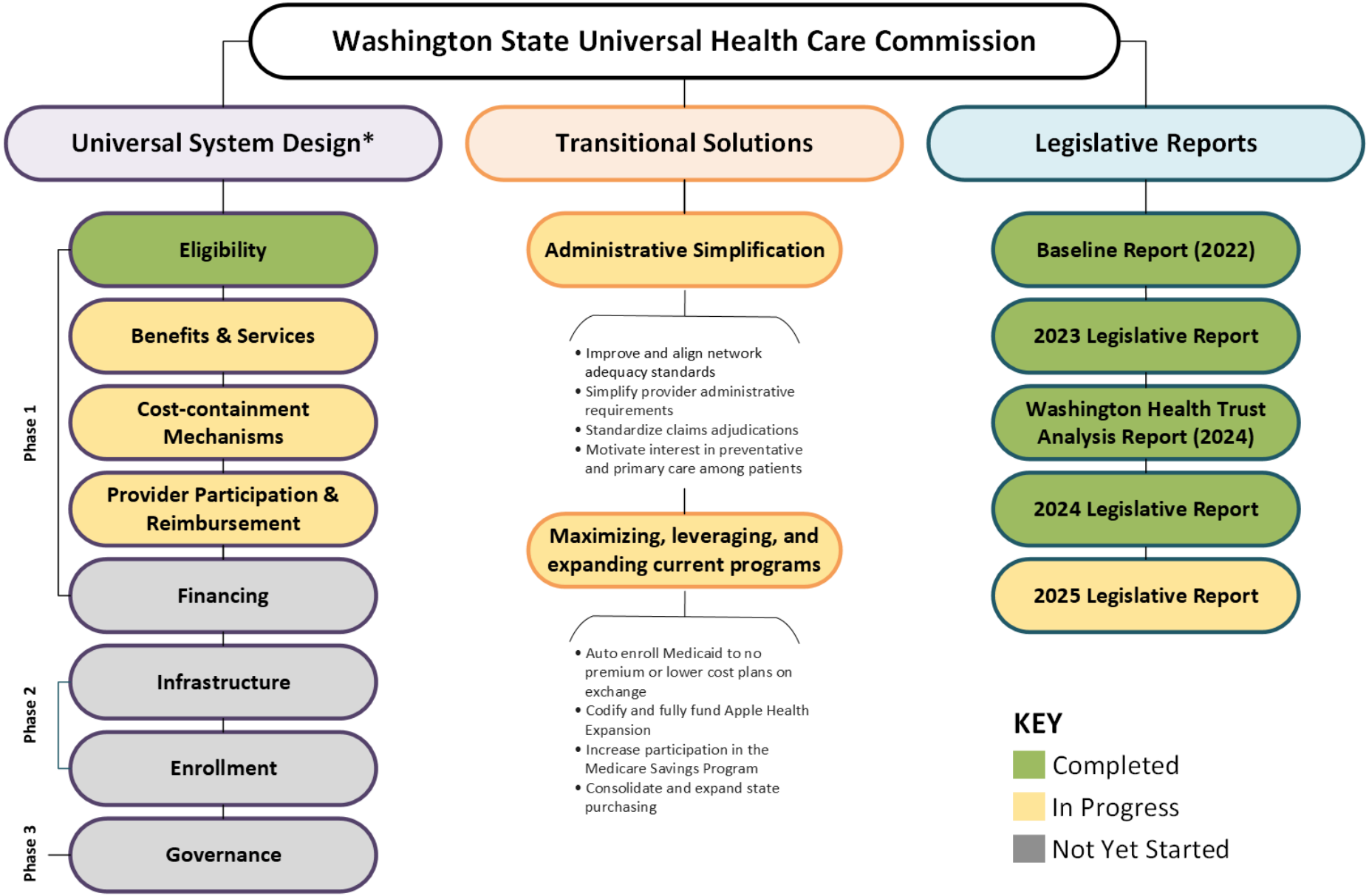
Workplan update

Universal Health Care Commission

April 2025

Milestone tracker

Last updated: 11/21/2024

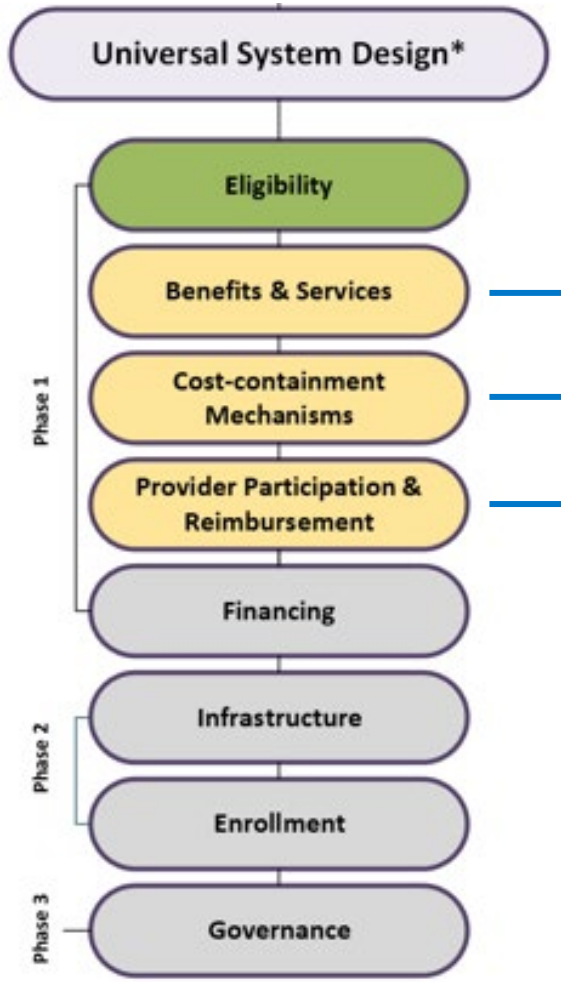


**Health care quality, health equity, and health disparities will be discussed and considered during each of the core universal system design components.*

2025 goals

- Universal design
  - Complete analysis of **benefits and services** and determine prioritization
  - Develop set of recommendations for **cost containment mechanisms**
  - Develop set of recommendations for **provider reimbursement and participation**
- Transitional (interim) solutions (July–December 2025)

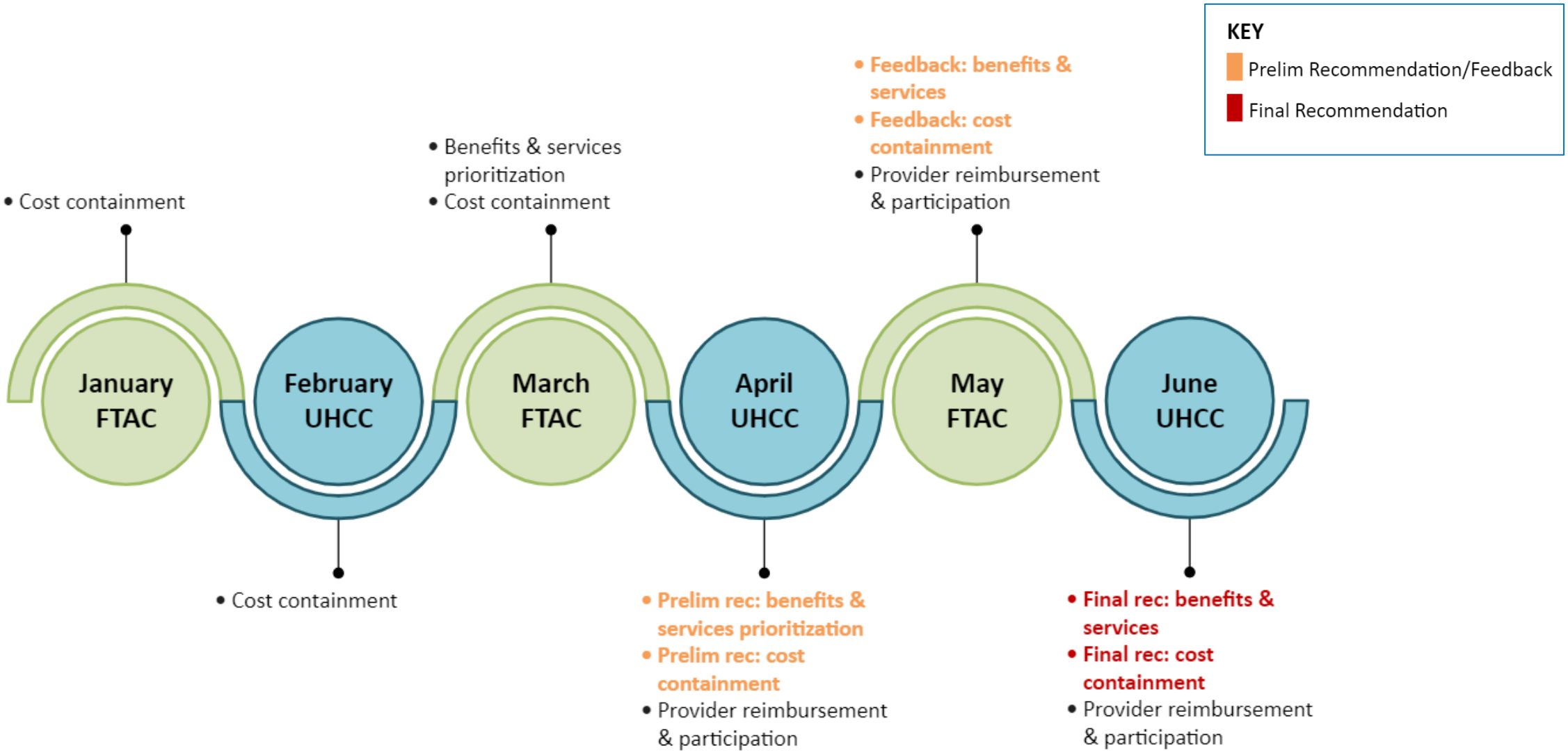
Today's meeting



- Cost analysis report will inform discussion
- Cost sharing is part of analysis discussion
- Provider reimbursement is part of analysis discussion

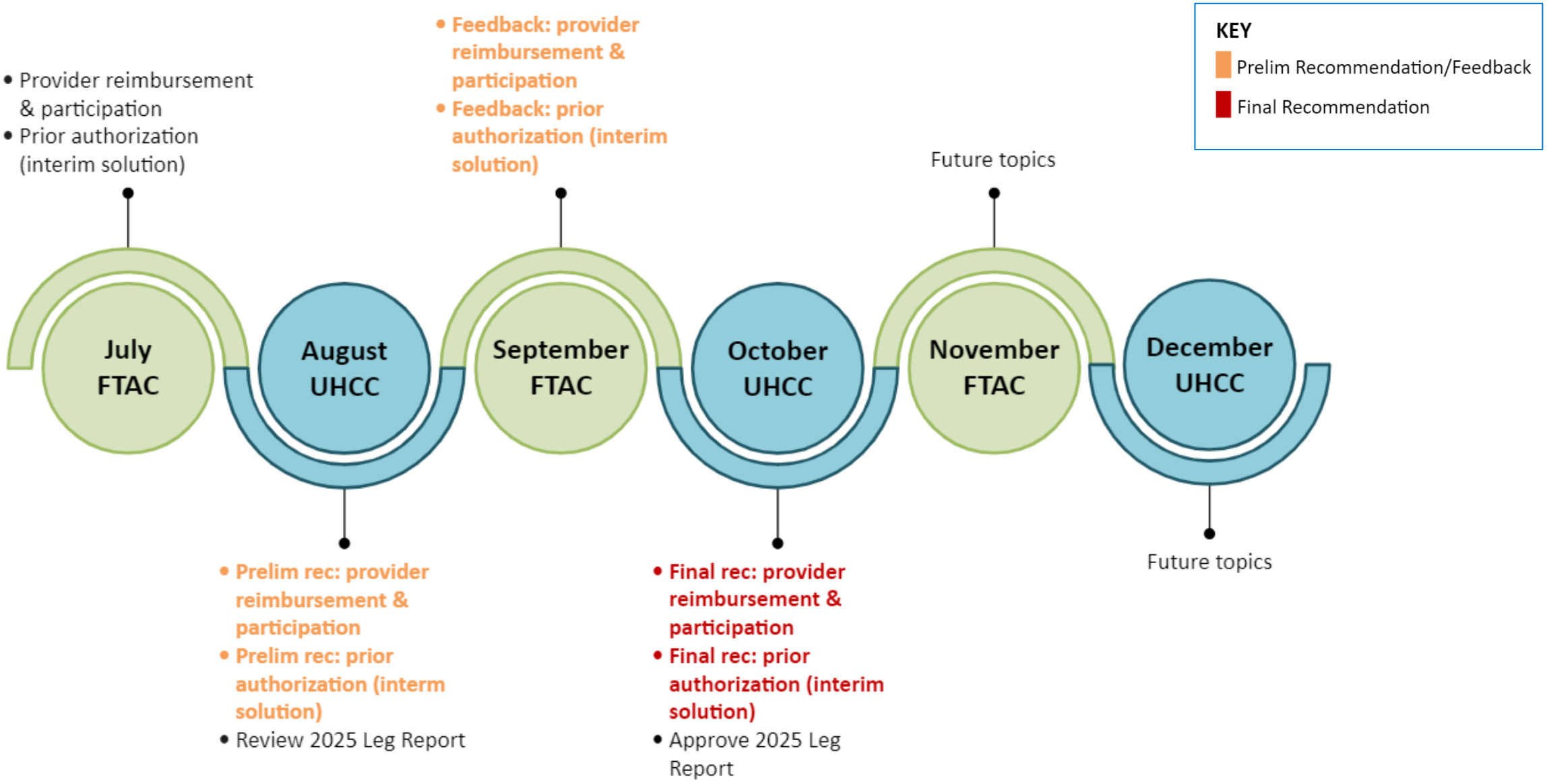
2025 workplan | January–June

Last updated: March 2025

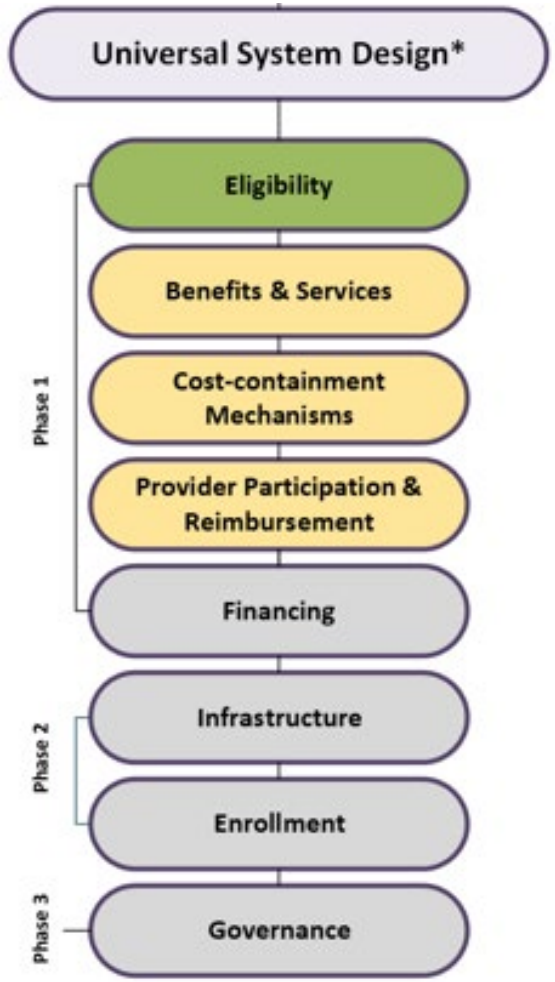


2025 workplan | July–December

Last updated: March 2025



Governance



- Currently in phase 3 of universal design
- Recent public comments ask the Commission to consider addressing governance earlier in a universal design

Governance

- Governing structure that oversees a unified system
  - Ensures transparency and accountability
  - Different from infrastructure (phase 2)
- Proposals and existing universal systems employ different governance structures
  - For example, SB 5233 would create a board of trustees "consisting of 17 members with expertise in health care financing and delivery and representing Washington citizens, business, labor, and health professions…"

Key considerations

- Who administers the program?
- Who regulates the program?

Possible entities

- Existing state agency
- New state agency
- Combination of new and/or existing state agencies
- Health plans (depending on structure)

Discussion

- Do any key considerations need to be resolved to move forward?
- If governance is considered earlier in phase 1, how might that affect the timeline for rest of phase 1?

Decision

- Do members of the Universal Health Care Commission want to consider reordering phase 1 to address governance earlier in the design process?
  - If so, what additional information do you need to make that decision?

Tab 5

Washington State Health Care Authority

FTAC update & benefit cost analysis report

David DiGiuseppe, FTAC Liaison to the Universal Health Care Commission

*Watch the 3/13/25 meeting **here***
*Review the meeting materials **here***

Overview

- 3/13/2025 FTAC meeting topics
  - Public comment
  - Benefit cost analysis
  - Cost containment memo
- FTAC support of the Commission moving forward
  - Framework the Commission can use to direct FTAC activities

March FTAC meeting update

3/13/2025 FTAC – Public Comment

- Advocacy for universal system and reference to studies that have shown system-wide savings relative to status quo
- Advocacy for Washington Health Trust and request for a fiscal note or funding study
- Questions about administrative expense: why excluded from the Milliman HCA study and impact once accounted for
- Advocacy to address governance structure now rather than at the end of the design process

Caveats and Scope - Benefit cost analysis

- Caveats
  - Results **do not** represent FTAC, the Commission, HCA, or Milliman recommendations for:
    - Benefit designs (i.e., services covered, coverage limits, cost sharing)
    - Funding sources
    - Any other component of a universal/unified system
  - **Results constitute a sizing exercise to guide further analysis**
- Scope
  - Estimate of baseline spending in system today, using CY 2023 experience (i.e., **not** trended forward to 2025)
  - Estimates of changing coverage characteristics across scenarios for specific populations

Benefit cost analysis

- Completed analysis = “Round 1”
- *Universal health care system design: Cost of care for select populations under existing benefit designs*
- Addendum: Results by included market segment
  - Illustrates financial impact on each market segment, across scenarios

Results

Scenario	Description	Total Expense ($B)
Baseline	Status quo: mix of Medicaid, uninsured, PEBB/SEBB, individual, other coverage	$16.3

Identified baseline population

- 3,370,000 people
- Includes Medicaid, PEBB/SEBB, individual, uninsured, local government and religious org group plans
- **Excludes other fully insured commercial health plans, ERISA self-insured and Medicare beneficiaries**

Selected benefit design

- Medicaid, PEBB/SEBB, Cascade Care – Silver
- Medicaid members and uninsured persons with incomes below 138% of FPL assumed to have Medicaid services and no cost-sharing in all scenarios
- Cascade Care is Washington's essential health benefits for individual and small group markets

Results

Scenario	Description	Total Expense ($B)*	Difference from Baseline ($B)
Baseline	Status quo	$16.3	
Scenario 1	Transition all covered lives to Medicaid-like service coverage and cost sharing, plus dental	$20.2–$23.7	$3.9–$7.4

- Drivers of results vs. baseline
  - Increased utilization and expense for formerly uninsured patients
  - Increased utilization and expense for non-Medicaid due to elimination of cost sharing

Source: *Universal health care system design: Cost of care for select populations under existing benefit designs*

Results

Scenario	Description	Total Expense ($B)	Difference from Baseline ($B)
Baseline	Status quo	$16.3	
Scenario 2	Transition non-Medicaid eligibles and uninsured above 138% FPL to equivalent of PEBB UMP classic covered services and cost sharing (approx. 13% of actuarial value of medical services paid for by patient), plus dental	$17.3–$20.3	$1.0–$4.0

- Drivers of results vs. baseline
  - Increased utilization and expense for formerly uninsured patients
  - Increased utilization and reduced cost sharing for some non-Medicaid members

Source: *Universal health care system design: Cost of care for select populations under existing benefit designs*

Results

Scenario	Description	Total Expense ($B)	Difference from Baseline ($B)
Baseline	Status quo	$16.3	
Scenario 3	Transition non-Medicaid eligibles and uninsured above 138% FPL to equivalent of Cascade Care Silver essential health benefits and cost sharing (approx. 32% of actuarial value of medical services paid for by patient), plus dental	$15.2–$18.1	($1.1)–$1.8

- Drivers of results vs. baseline
  - Increased utilization and expense for formerly uninsured patients
  - Decreased utilization and increased cost sharing for some non-Medicaid members **(i.e., worse benefits than status quo)**

Source: *Universal health care system design: Cost of care for select populations under existing benefit designs*

Questions/comments?

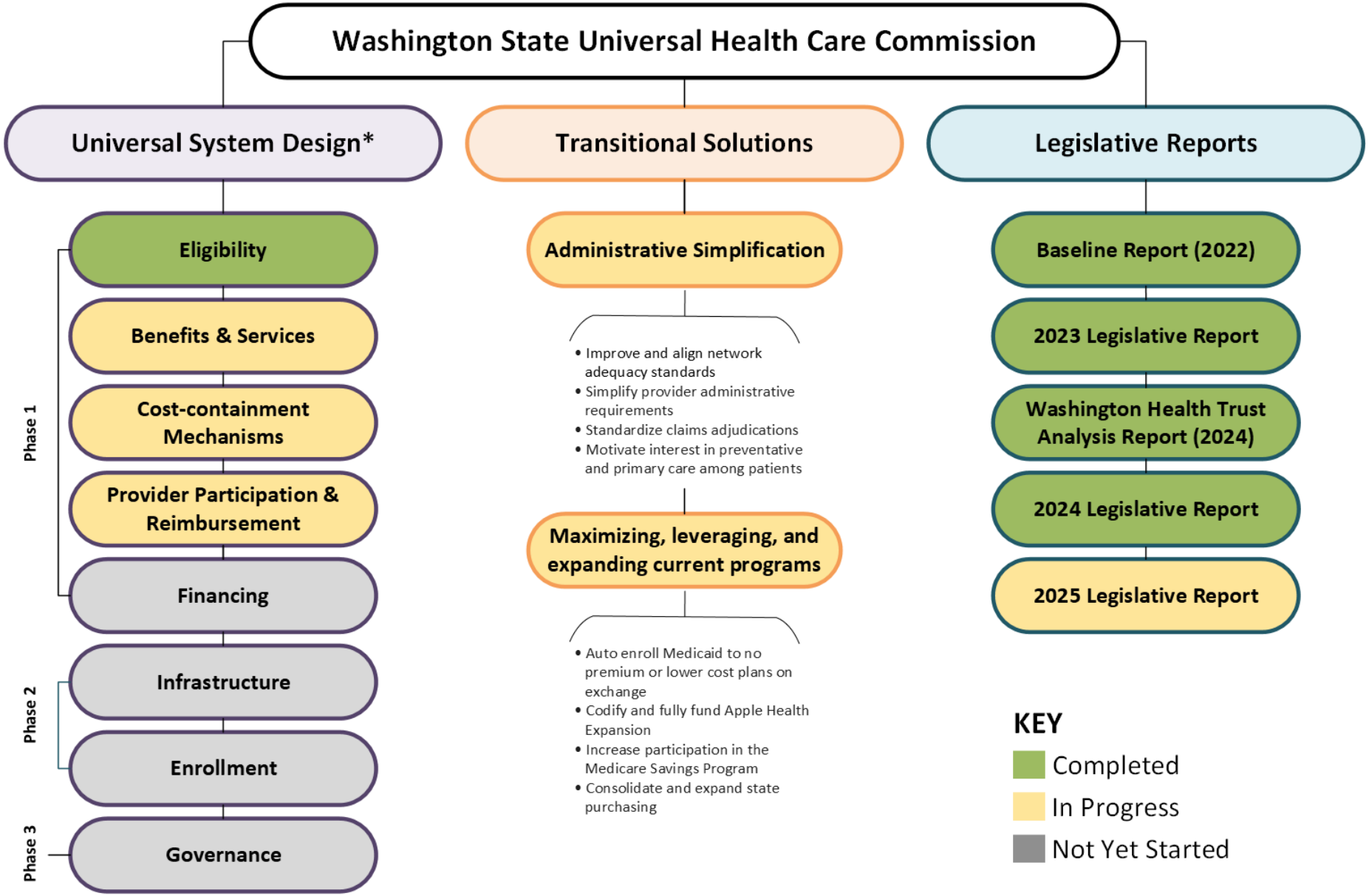
Recommendations for FTAC support

How can FTAC support the Commission?

- Please note that dollar amounts shown on the following slides are:
  - Derived from the benefit cost analysis
  - Presented for illustration purposes, and
  - Subject to change.
- The analysis incorporated a complex array of assumptions.
- Select findings are shown here to highlight significant decisions to be made by the Commission.

Milestone Tracker

Last updated: 11/21/2024



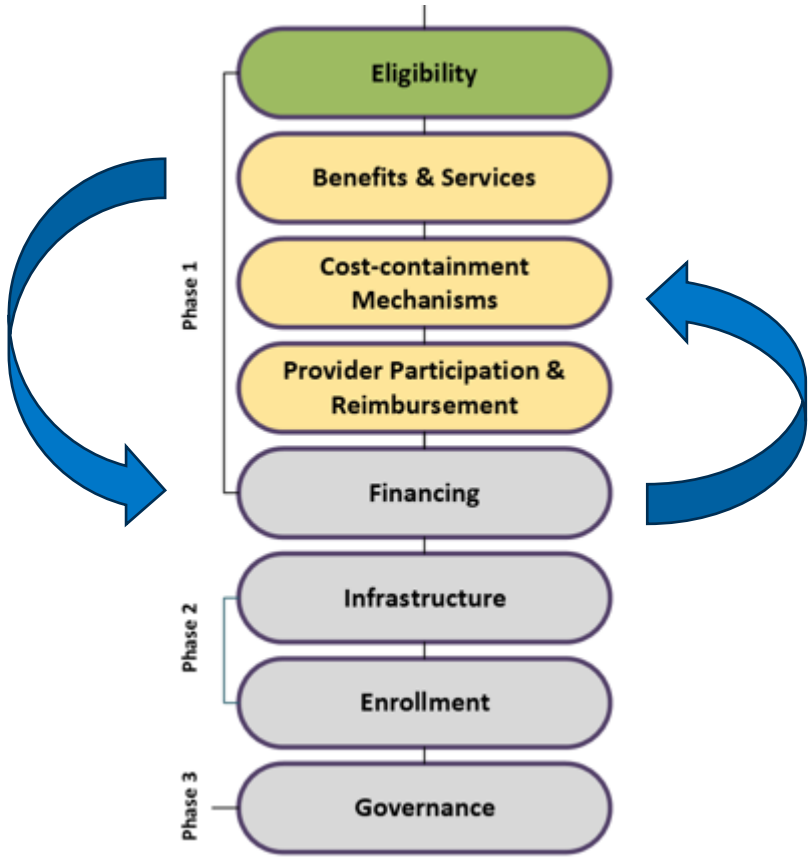
**Health care quality, health equity, and health disparities will be discussed and considered during each of the core universal system design components.*

Guiding principles

- Milestones are interdependent.
- The Universal Health Care Commission's workplan aims to begin addressing financing options in early 2026.
- To prepare, the Commission needs to develop a set of options and expected cost of each option, as well as the Commission's recommendations.

Interdependencies

If the Commission decides to eliminate patient cost sharing, this raises the question of shifting the burden of that cost from the patient to the state, which triggers a financing issue.



If the Commission decides to formulate a legislative request to fund this shift, cost containment strategies will likely be necessary to offset the increased cost to the state.

Current and future analysis

Round 1 (complete)	Round 2 (proposed)	Round 3 (proposed)
Benefit cost analysis, including sensitivity analyses	Further exploration of selected benefit package Exploration of creating 'opt-in' benefits and services for expanded eligibility pool Assessment of projecting cost estimate to a projection year	Cost estimates for various infrastructure options
NOTE: Any future analysis is dependent on funding in the legislative budget.		

Today's objective

Direction from the Commission: Is FTAC on right track?

- No expectation that commissioners digest all material on slides

- For each design component:
  - Open questions that will require Commission decision making
  - FTAC recommendations for next steps

- HMA will facilitate discussion of FTAC recommendations

Benefits & services

Outstanding questions to the Commission

- Which service coverage options should the Legislature consider, beyond those covered by Medicaid, WA Essential Health Benefits and PEBB/SEBB's UMP Classic (all with dental coverage)?
- Which cost sharing options should the Legislature consider, beyond Medicaid (0% of actuarial value (AV) of medical expense), PEBB/SEBB's UMP Classic (13% AV), and Cascade Care – Silver (32% AV)?
- Should benefits and services be standardized across subpopulations? (e.g., should Medicaid beneficiaries continue to have all existing Medicaid services, and should all persons with incomes below 138% FPL have cost sharing under any design?)

FTAC recommendation

- Include additional options if the Commission desires additional options
- Assess feasibility of producing economic model
  - Project baseline and scenario results (currently CY 2023) to CY 2027-8, by subpopulation
  - Basis for understanding of financing requirements and impact by market segment

Eligibility

Options	Difference vs Round 1 Results ($B)*
Include ERISA fully insured population Note: This increases baseline expense from $16.3B to $20.0B. Differences calculated using higher baseline.	($1.3)–$11.0

Outstanding questions to the Commission

- How should additional populations be included? How much does that cost or save?
  - e.g., VA beneficiaries, out-of-state employees working in Washington, federal employees
  - e.g., for VA/IHS beneficiaries, potential wraparound benefit for additional services (similar to Medigap), while maintaining choice of delivery system

FTAC recommendation

- Expand Round 2 analysis to assess cost of including additional populations and wraparound benefits noted above

* Derived from 3/13/2025 FTAC meeting packet, page 55; impact depends on scenario: $11B is max estimate of providing ERISA fully insured members with Medicaid services and 0% cost sharing.

Provider reimbursement

Round 1 & Sensitivity Analyses	Difference vs Round 1 Results ($B)*
125% of Medicare FFS (Round 1 assumption)	
119% of Medicare FFS	($0.9)–($0.8)
131% of Medicare FFS	$0.8–$0.9
160% of Medicare FFS	$4.4–$5.4

Note: Round 1 used a composite provider reimbursement rate based on a weighted average of payers' existing payment rates using Medicare as an index. It is intended to maintain the aggregate level of reimbursement for the baseline population.

Outstanding questions to the Commission

- Does the Commission want to model additional options?
- For example, additional payment rates, or other changes such as increased primary care payments?

FTAC recommendation

- FTAC needs additional time to discuss whether additional options warranted
- Expand Round 2 analysis based on Commission direction and FTAC discussions

*Derived from 3/6/2025 Milliman Report, Appendix C, Exhibit II.3; $ impact depends on scenario

Infrastructure

Outstanding questions to the Commission

- Should a unified system be structured to include health plans (UHCWG Model B) or be administered directly by the state, either through state administered infrastructure (UHCWG Model A) or an Administrative Services Only (ASO) arrangement?
- What administrative responsibilities that health plans provide today would persist under Model A?
- Would Model A generate any savings in administrative expense?

FTAC recommendation

- Conduct analysis to provide the Commission with cost estimates across options

Financing

Outstanding questions to the Commission

- How would costs shift across payers?
- Which agencies/organizations would be responsible to bear the burden of new costs? And risk?

FTAC recommendation

- FTAC provide the Commission a list of options to consider, in consultation with OFM, DOR and legislative finance committee staff

Cost containment

- April Commission mtg: FTAC preliminary recommendations
  - Commission decides direction to FTAC re next steps for benefits and services and provider reimbursement, key components of cost structure
- May FTAC mtg: FTAC review of comprehensive inventory
  - FTAC has itemized approximately 15 strategies based on current practices, recent OIC/AG reports and FTAC expertise
  - FTAC identify subset of strategies appropriate for FTAC deliberation
  - FTAC prepare recommendations for the Commission
- June Commission mtg: FTAC recommendations
  - TBD

Discussion

Addendum: Cost sharing principles

Universal Health Care Commission

Principles of Cost Sharing (adopted 10/2024)

1. Avoid creating barriers to care by considering, among other things, income thresholds and exemptions for cost sharing.
2. Identify selected services (e.g. preventive care or diagnostic screening) that would not be subject to cost sharing.
3. Create cost-sharing structures that are simple, predictable, transparent, and easily understood for providers and individuals seeking care.
4. Review the Commission's final policy decision on cost sharing through the health equity toolkit as adopted by the Commission.
5. Review and revise cost-sharing designs as medical technology and services evolve.

Break

Tab 6

Washington State Health Care Authority

State agency report outs

Washington State Health Care Authority

Washington State Health Care Authority

Thank you for attending the Universal Health Care Commission meeting!