Universal Health Care Commission meeting

August 15, 2024

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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, August 15, 2024
2:00 – 5:00 PM
Hybrid Zoom and in-person meeting

Commission members:		
☐ Vicki Lowe, Chair	☐ Senator Emily Randall	☐ Mohamed Shidane
☐ Senator Ann Rivers	☐ Jane Beyer	☐ Nicole Gomez
☐ Bidisha Mandal	☐ Joan Altman	☐ Omar Santana-Gomez
☐ Charles Chima	☐ Representative Joe Schmick	☐ Stella Vasquez
☐ Dave Iseminger	☐ Representative Marcus Riccelli	☐

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome & call to order	1	Vicki Lowe, Chair and Executive Director, American Indian Health Commission for Washington State
2:05-2:08 (3 min)	Roll call	1	Mary Franzen, Commission Manager Health Care Authority
2:08-2:10 (2 min)	Approval of Meeting Summary from June 4, 2024	2	Vicki Lowe, Chair and Executive Director, American Indian Health Commission for Washington State
2:10-2:30 (20 min)	Apple Health Expansion	3	Becky Carrell, Deputy Division Director, Medicaid Programs Health Care Authority
2:30-3:30 (60 min)	Prior authorization: The Balancing Act of Cost Containment and Access to Care	4	Michelle Long, Senior Health Policy Consultant Kaiser Family Foundation Nico Janssen and Joyce Brake, Washington State Office of the Insurance Commissioner
3:30-3:55 (25 min)	Discussion: Commission direction on prior authorization	5	Facilitated by Gary Cohen, Principal Health Management Associates
3:55-4:00 (5 min)	Break		
4:00-4:15 (15 min)	Public comment	6	Vicki Lowe, Chair and Executive Director, American Indian Health Commission for Washington State
4:15-4:30 (15 min)	Discussion and potential vote: - Prior authorization - Continuing support for Apple Health Expansion	7	Facilitated by Liz Arjun, Principal Health Management Associates
4:30-440 (10 min)	FTAC updates	8	Pam MacEwan, FTAC Liaison
4:40-5:00 (20 min)	State agency report outs	9	Commission Members
5:00	Adjournment		Vicki Lowe, Chair and Executive Director, American Indian Health Commission for Washington State

Tab 2

Washington State Health Care Authority

Universal Health Care Commission meeting summary

June 4, 2024

Hybrid meeting held electronically (Zoom) and in-person at the Health Care Authority.
2:00–5:00 p.m.

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

Members present

Vicki Lowe, Chair
Bidisha Mandal
Charles Chima
Dave Iseminger
Jane Beyer
Joan Altman
Megan Matthews
Representative Joe Schmick
Representative Marcus Riccelli
Nicole Gomez

Members absent

Senator Ann Rivers
Senator Emily Randall
Estell Williams
Mohamed Shidane
Omar Santana-Gomez
Stella Vasquez

Call to order

Vicki Lowe, Chair of the Universal Health Care Commission, called the meeting to order at 2:00 p.m.

Agenda items

Welcoming remarks

Chair Lowe began with a land acknowledgement and welcomed members to the eighteenth meeting and provided an overview of the meeting objectives.

Washington State Health Care Authority

Meeting summary review from the previous meeting

The Commission members voted by consensus to adopt the April 2024 meeting summary.

Public comment

Cris Currie submitted a public comment, emphasizing his view that the Commission is not providing adequate opportunity to discuss concerns.

John Godfrey, program manager at the Washington Community Action Network, spoke in support of administrative simplification. Their membership is excited about accelerating the integration of physical and behavioral health and support progress in standardizing prior authorization processes. John also noted that ultimately, administrative simplification is not enough without substantial structural changes to the health care system.

Raleigh Watts thanked the Commission and elected officials for their work. He noted that meeting material packets were received just before the meeting began. As a citizen who cares about this work, Raleigh wants the Commission to set a standard for publishing meeting materials with adequate time for public review.

Marcia Stedman addressed the Whole Washington report, wondering whether there has been discussion or further action from the Commission or FTAC and is calling for further action by the Commission.

Kathryn Lewandowsky noted that Whole Washington is conducting Town Halls and phone banking, sharing a response from one volunteer who felt that the work of the Commission will be unable to achieve the systemwide transformation it seeks and called for stronger action.

Pam Ketzner shared a story highlighting the medical mismanagement of her son in the current system and called for immediate reform.

FTAC Updates

Pam MacEwan, FTAC Liaison

Pam updated the Commission on the previous FTAC meeting, including an overview of health plan cost and benefit design, discussion on the challenge of benefit design comparison, discussion of options for comparison and importance of cost assumptions and cost control, a presentation on the Health Care Cost Transparency Board. Pam noted that suggestions on further areas for FTAC to explore are welcomed.

State Agency Report Outs

DOH, HCA, OIC, and WAHBE

DOH: No major updates to report.

HCA: Currently sharing information from the Health Care Cost Transparency Board about costs in the system and how to equalize and provide relief from costs. HCA is also looking at topics in preparation for the next legislative session, including around increasing equity and access to care. HCA is also currently working on rate development for PEBB and SEBB programs and is looking to increase alignment between the programs. HCA is working on a report, due at the end of the year, on further legislative consolidation of PEBB and SEBB programs. Finally, some work around prescription drug affordability is expected next year.

OIC: OIC will be releasing a maternity care cost sharing report by July 1st. An affordability report will be coming out August 1st, which will cover several affordability initiatives. OIC has also launched into rulemaking around bills that passed the legislature, including ground ambulance billing, prior authorization, and PBM regulation. The agency is also working on a joint effort with HCA to deliver a model around authorization for residential substance use treatment, with the goal of coming up with one common set of criteria that would apply across the board.

WAHBE: WAHBE is in the midst of implementing a two-pronged immigrant health coverage expansion. The first piece was allowing the purchase of qualified health and dental plans by immigrants without federally

recognized immigration status. The agency saw around 24,000 individuals look at options with several thousand signing up. They are now also working on rolling out Medicaid expansion to this population in collaboration with HCA. On the affordability front, OIC is working with a federal delegation on enhanced federal subsidies for the individual market. Finally, the agency is working on an auto-enrollment study, looking at ways to support people transitioning from Medicaid to individual market coverage. This report will come out later this Fall.

Whole Washington Draft Report

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

The floor was opened to discussion on moving the draft report forward. Representative Schmick submitted comments on the draft, which were added to the appendix of the report. No further discussion took place. The Commission members voted by consensus to adopt the report and move it forward to the legislature.

Commission Progress and Workplan Update

Liz Arjun, Health Management Associates (HMA)

An update was provided on the three workstreams: 1) designing a universal health care system with a unified financing system, 2) recommending interim solutions, and 3) reviewing the Washington Health Trust proposal.

On workstream 1, progress includes determining eligibility for the uniform financing system, which will include Medicaid, individual market plans, small group market plans, fully insured large group plans (including PEBB/SEBB) and the uninsured. Upcoming work includes an actuarial analysis of benefits and services.

On workstream 2, recommendations to date include expanding coverage for uncovered populations, integrated eligibility systems, Cascade Care savings, cost growth targets, and efforts to align public programs. Upcoming focus areas include administrative simplification and maximizing coverage in existing programs.

On workstream 3, Whole Washington has presented to the Commission on the proposal and the Commission has developed a draft report. Continued presentations are expected as work continues.

Commission Efforts on Administrative Simplification to Date

Liz Arjun, Health Management Associates (HMA)

A recap of what previous meetings have covered on administrative simplification was provided, including hearing from national experts about the potential savings from administrative simplification and from HCA's medical director on efforts to promote admin simplification in February. In April, OneHealthPort presented on their efforts leading administrative simplification.

One thing noted by OIC was that the legislature has been passing bills promoting administrative simplification across public programs (e.g., prior authorization issue). The legislature is better understanding the importance of having consistency across these programs. Representative Schmick questioned why—given the potential savings—there is reluctance on these efforts. OIC noted that changes to systems are difficult and getting providers and carriers on board is challenging.

Administrative Simplification, Panel Presentation

Several panelists representing the provider perspective on administrative simplification presented to the Commission.

Jeb Shepard, Director of Policy at Washington State Medical Association

The presentation discussed the high levels of administrative burden impacting clinicians, leading to burnout, and noting that this is a top issue for physicians and practices. Examples of administrative burden include insurance approvals, prior authorization, coding and billing, and practice management. Some of these, like practice management, exist regardless of the type of health care system in place, but others are made worse by the current fragmented health care system. Administrative costs are a growing weight on the system, representing between 25 – 31% of health care spending, and the growth of administrators has far outpaced

growth in physicians. Prior authorization alone costs between $23 and $31 billion annually, and denials are often overturned, adding to frustrations with the process. Solutions to these issues include accounting for cost burden in reimbursement rates, eliminating or improving administrative processes, and evaluating the impact of policies on small, rural, and underserved practices.

Diana Huang, MD, Family Physician at Swedish Downtown Primary Care

The presentation discussed the impact of administrative burden on the supply of physicians, with Dr. Huang noting that physicians leaving residency at the University of Washington are advised to accept roles at 0.8 FTE rather than 1.0 because there is so much administrative work layered on top of patient time. When Dr. Huang was a 1.0 FTE, she would spend weekends on administrative work. The burden can lead physicians and other clinicians to leave practice entirely. Dr. Huang also highlighted stories of patients impacted by administrative burdens like prior authorization. One unique burden called out was the impact of different drug formularies used by different payers. When patients switch insurance, they may no longer have easy access to medications they were already using effectively which can lead to health complications.

Samuel Wilcoxson, Compliance and Ethics Administrator at Premera

The presentation highlighted the unique perspective of carriers on the barriers to administrative simplification, which include variations across markets and lines of business, cybersecurity and data privacy concerns surrounding new technologies, knowledge gaps amid these evolving technologies, and shifting regulatory requirements. Mr. Wilcoxson also highlighted to need to ensure the system does not create a patchwork of interoperability, requiring expensive front-end investments that don't guarantee provider adoption. It is important to get provider buy-in for these technologies.

Steve Woolworth, PhD, CEO at Evergreen Treatment Services

The presentation highlighted the perspective of administrative burden in treating behavioral health and substance use disorders through an example of Evergreen's mobile methadone units, used to treat opioid use disorder. Amid changing licensing requirements, it took the state of Washington 19 months to re-authorize the mobile teams amid the coordination between federal and state agencies. Over that time, hundreds of people died as there were no other providers for these services, services which had existed for decades prior to the administrative changes.

Commission Questions

Panelists were asked to name their top two administrative simplification issues. Jeb Shepard cited prior authorization and licensure delays but noted that the turnaround time on licensure has improved in recent years. Dr. Huang also cited prior authorization and highlighted the issues of communication between clinics and pharmacies, though was unsure if there was a role for the Commission to play in addressing this issue. Samuel Wilcoxson pointed out that there is a lot of state and federal activity, including in Washington, on improving prior authorization processes, but emphasized the need to avoid a patchwork of solutions creating new administrative burdens. He also cited the issue of provider buy-in to new technologies. Dr. Woolworth noted issues with payers reimbursing for claims and data sharing, particularly around ED utilization.

Another question was asked on the impact of value-based payment (VBP) quality standards on administrative burden. Panelists noted that VBP adoption can be overwhelming, especially for smaller practices that don't have the resources and separate administrative teams of larger systems, and the challenge of keeping up with ever-changing metrics of focus.

Next Steps on Administrative Simplification

Liz Arjun, Health Management Associates (HMA)

Commission members were asked which areas of administration simplification should be further explored. Responses included better understanding the administrative burden of VBP, especially in rural areas; communication between clinics and pharmacies; modeling the savings of reductions in administrative burden;

the impact of the lack of uniformity in drug formularies; and better understanding where a universal system helps, hinders, or makes no impact on administrative burden issues.

Adjournment

Meeting adjourned at 5:00 p.m.

Next meeting

August 15, 2024
Meeting to be held on Zoom and in-person at HCA.
2–5 p.m.

Tab 3

Washington State Health Care Authority

Apple Health Expansion

Universal Health Care Commission

Washington State Health Care Authority

Background of Apple Health Expansion

- Prior to, Apple Health Expansion HCA implemented several Apple Health (Medicaid) programs that are available to individuals not qualified for federally subsidized coverage because of their immigration status.

  - Medical Care Services (MCS)
  - Alien Emergency Medical (AEM)
  - Apple Health for Pregnant Individuals
  - After-Pregnancy Coverage (APC)
  - Apple Health for Kids

Background of Apple Health Expansion

- The State's investment of additional funding for Apple Health Expansion provides a new option for individuals who do not qualify for Apple Health (Medicaid) programs because of their immigration status.
  - 2022
    - Legislature provided funding to operationalize this program and directed HCA to prepare to implement Apple Health Expansion.
  - 2023
    - Legislature directed the agency to implement on July 1, 2024 with a limited pool of funding.
      - Program funding was not at the level requested.
      - Recognize there are more immigrant community members who would be enrolled for this program than funding can support.
  - 2024
    - Legislature increased funding levels for the program.

Program Eligibility

- Individuals may be eligible if they:
  - Are a Washington resident age 19 or older,
  - Have countable income under 138% of the federal poverty level,
  - Do not qualify for other Apple Health programs based on immigration status,
  - Are not pregnant or did not have a pregnancy end in the last 12 months, and
  - Are not eligible for federal advance premium tax credits through the individual market or federally funded medical assistance programs.

Implementation

- HCA's approach to implementing Apple Health Expansion:
  - Create a program that is like Apple Health (Medicaid) Integrated Managed Care.
  - Provide coverage to as many eligible individuals as possible.
  - Wherever possible, draw down federal match to maximize the program's limited budget.

Implementation

- Given the short timeline for implementation, HCA conducted a 2-part readiness review assessment of its current Apple Health (Medicaid) MCOs. In the end HCA awarded contracts to:
  - Coordinated Care of Washington
  - Community Health Plan of Washington
  - Molina Health Care of Washington
  - United Health Care of Washington

Implementation

- HCA estimated the service costs of the program using the following key inputs:
  - Actuarially developed managed care rates, these rates broke down the enrolment population into 3 age bands: 19-34, 35-64, 65-99
  - Fee for service costs like Non-Emergency Medical Transportation and high-cost pharmaceuticals
  - Member mix assumptions, the expected number of enrollees in each age band
  - Assumed program churn.
  - HCA set aside 3% ($2.16 million) as a reserve to cover unexpected costs.
- After reserves, the program has around $70M per FY to expend on service delivery.

Go-Live

- On June 20th the state began accepting applications for the program.
- Closely monitored enrollment of both population groups.
  - On June 21st HCA closed enrollment for 19–64-year-olds (MAGI)
  - On July 3rd HCA closed enrollment for 65+ (Classic)

Enrollment

- Total enrollment: 11,936
  - 300 additional pending cases waiting verification
  - After-Pregnancy Coverage (APC) and Apple Health for Kids transitioning through the end of July
- Coverage requested in 34 out of 39 counties
- Language assistance requested in 35 languages

*Eligibility data is of July 3, 2024

Washington State Health Care Authority

Transitional groups

Population	Number
APC/kids turning 19*	172
AEM	691
QHP	879
Extended foster care	20

*APC and Apple Health for Kids turning 19 will have until the end of July to transition

***In order to protect the privacy of clients, cell in this data product that contain small numbers (numbers 1 to 10) are not displayed.

Washington State Health Care Authority

Note: Eligibility data is of July 3, 2024

Apple Health Expansion

Enrollment age breakout

19-25	26-34	34-44	45-54	55-64	65+
1,116	2,123	3,503	3,037	1,461	692

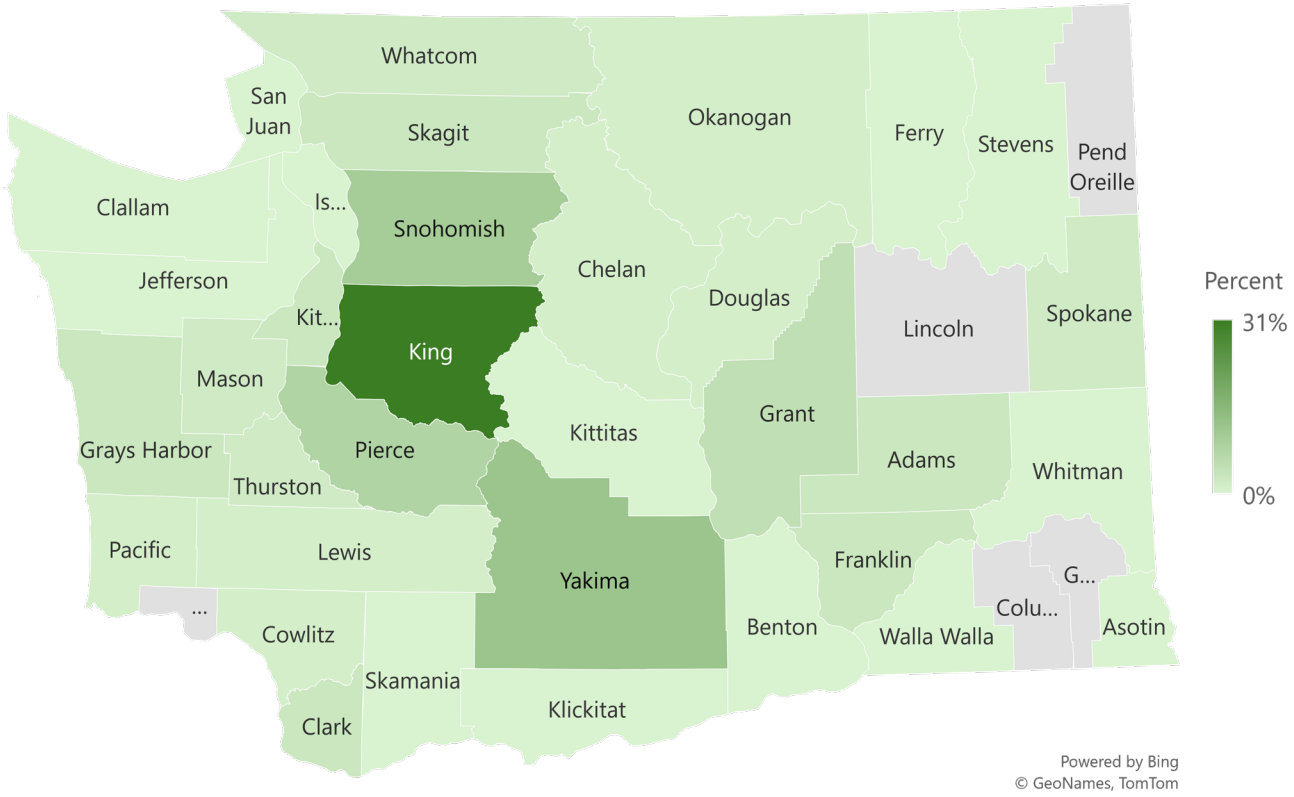
Enrollment by region

Salish	Thurston -Mason	Great- Rivers	Pierce	King	North Central	Greater Columbia	South west	Spokane	North Sound
428	434	584	958	3,654	880	2,211	392	597	1,665

Note: Eligibility data is of July 3, 2024

Washington State Health Care Authority

Enrollment by county



Counties not represented: Columbia, Garfield, Lincoln, Pend Oreille, and Wahkiakum

Note: Eligibility data is of July 3, 2024

Washington State Health Care Authority

Clients by race

Race	Number		Race	Number
Other	6,131		Vietnamese	20
Unreported	2,531		Filipino	19
White	2,440		Asian	15
Black/African American	435		Guamanian	--*
Other Asian Pacific Islander	76		Laotian	--
Chinese	63		Japanese	--
Asian Indian	49		Samoan	--
Korean	56		Cambodian	--
American Indian	27		Hawaiian	--
Thai	20			

*In order to protect the privacy of clients, cell in this data product that contain small numbers (numbers 1 to 10) are not displayed.

Note: Eligibility data is of July 3, 2024

Washington State Health Care Authority

Hispanic origin

Origin	Number
Mexican/Mexican American/Chicano	6,582
Other Spanish	2,961
Not reported	1,184
Not Spanish or Hispanic	1,125
Cuban	12
Puerto Rican	--*

*In order to protect the privacy of clients, cell in this data product that contain small numbers (numbers 1 to 10) are not displayed.

Note: Eligibility data is of July 3, 2024

Washington State Health Care Authority

Language preference

Language	Number	Language	Number	Language	Number
Spanish	9,364	Thai	--	Farsi	--
English	1,960	Ukrainian	--	French-Creole	--
Portuguese	190	Punjabi	--	Tamil	--
French	112	Romanian	--	Tibetan	--
Chinese	49	Swahili	--	Bengali	--
Korean	41	Vietnamese	--	Burmese	--
Large Print English	24	Tigrigna	--	Indonesian	--
Other	19	Dari	--	Japanese	--
Russian	17	Turkish	--	Pashto	--
Somali	13	Amharic	--	Samoan	--
Haitian-Creole	12	Albanian	--	Tongan	--
Cambodian	11	Hindi	--	Trukese	--
Arabic	--*	Tagalog	--		

*In order to protect the privacy of clients, cell in this data product that contain small numbers (numbers 1 to 10) are not displayed.

Washington State Health Care Authority

Note: Eligibility data is of July 3, 2024

Enrollment Management

- HCA will closely monitor the expense of the program and use the Apple Health Expansion Enrollment Management policy to fill available space.
  - HCA will randomly select individuals who have received a denial due to the enrollment cap. This includes clients from the following groups:
    - Submitted an application on or after June 20, 2024
    - Were enrolled in Apple Health for Kids, Alien Emergency Medical (AEM), or After-Pregnancy Coverage who meet eligibility requirements for Apple Health Expansion and their coverage ended after the cap was met
    - Are enrolled in a qualified health plan through Health Benefit Exchange's 1332 waiver and applied after April 30, 2024
- HCA developed this approach in coordination with community representatives and continues to work with community to update its approach to enrolling eligible individuals as space becomes available.

Temporary Community Engagement Advisory Committee

- Temporary Community Engagement Advisory Committee
  - Collaborated facilitation between HCA, HBE and DSHS.
  - Includes advocates, community based-organizations, and individuals with lived experience.
  - Provides opportunity for feedback and input into different implementation elements:
    - Feedback and input on client outreach efforts for both Apple Health Expansion and HBE's 1332 Waiver Qualified Health and Dental plans
    - Emergency rules.
    - Readiness review activities for Apple Health Expansion

Next Steps for Community Engagement

- Permanent Community Engagement Committee
  - Continued collaboration between HCA, HBE, and DSHS to facilitate a permanent committee to support both Apple Health Expansion and 1332 Waiver Qualified Health Plans.
  - Broaden membership to include Apple Health Expansion enrollees.
  - Continue to provide opportunities for community feedback, input, and transparency into some aspects of the Apple Health Expansion program:
    - Outreach
    - Enrollment management policy
    - Enrollment data
    - Policy changes

Next Steps for Apple Health Expansion

- Public comment on enrollment management policy.
- Legislative report due November 1st
  - Any data relating to the actual and/or forecasted expenditures and expenditures.
  - Agency's experience in implementing a capped budget program.
  - Lessons learned at implementation.
  - Availability of any federal program or rule change that expands access. For example, the impact of Deferred Action for Childhood Arrivals (DACA) rule changes.
- Decision Package
  - Requests funding to provide coverage to more enrollees with enrollment growth phasing in over the biennium.

Questions

Washington State Health Care Authority

Contact us

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Washington State Health Care Authority

Resources

- Client eligibility dashboard
  - https://www.hca.wa.gov/about-hca/data-and-reports/client-eligibility-data-dashboard
- Office of Financial Management Population and Demographics
  - https://ofm.wa.gov/washington-data-research/population-demographics
- Migration Policy Institute
  - https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/WA

Tab 4

Washington State Health Care Authority

Prior Authorization

The Balancing Act of Cost Containment and Access to Care

Michelle Long, MPH
Senior Policy Analyst
Program on Patient and Consumer Protection, KFF

Washington Universal Health Care Commission
August 15, 2024

KFF
The independent source for health policy research, polling, and news.

PRESENTATION OVERVIEW

- Introduction to Prior Authorization
- Recent Federal Laws and Regulations
- State Initiatives
- Considerations for Washington
- Questions

KFF

Introduction to Prior Authorization

Prior Authorization

What is it and why do plans use it?

- Pre-approval from a health plan for services and drugs to be covered
- Used by private plans, state employee health plans, Medicare Advantage, Medicaid to promote safe, evidence-based, cost-efficient care
  - More often applied to higher cost services such as DME, genetic testing, GLP-1s, MRIs, and inpatient hospital stays
  - May substitute one service for another (e.g., physical therapy instead of back surgery, use of a lower-cost therapeutic equivalent drug instead of a higher-cost specialty drug)
- Reasons for PA denials
  - Not medically necessary, insufficient documentation, incorrect billing codes, duplicate claim
- Perspectives differ
  - Health plans: Prevents enrollees from receiving unnecessary, inappropriate, or low-value services/drugs
  - Providers: Burden on physicians
  - Patients: Delayed or forgone needed care

Prior Authorization

How commonly is it used?

- PA practices vary by payer, state, and type of service/drug
- Current law and publicly available data for private insurance largely unrealized
- KFF analysis of CMS transparency data: 8% of 45M IN claim denials in Healthcare.gov plans were for lack of PA or referral in 2021, though some data are missing
- 99% of MA enrollees were in plan with PA in 2022
- >2 million of the 35 million PA requests submitted to MA in 2021 were fully or partially denied. Only 11% of denials were appealed, with a success rate of 82%
- 2023 HHS OIG report found Medicaid MCOs denied 1 in 8 PA requests and that most states have limited oversight of PA denial
- 2021 survey of state employee health plan administrators identified found excessive or inappropriate utilization is a primary cost containment initiative, with more than half of states implementing PA in past 3 years

Prior Authorization (PA) - Insurer Perspectives

Thirty percent of all heath care spending in the United States may be unnecessary, and in many cases harmful to patients. Indeed, every year low-value care costs the U.S. health care system $340 billion. Eighty-seven percent of doctors have reported negative impacts from low-value care.

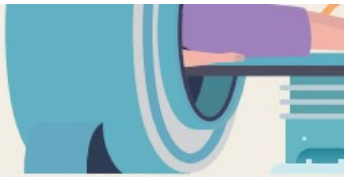
A Common Barrier to Automating Prior Authorization Programs

71% Provider Does Not Use Electronic Health Records Enabled for Electronic Prior Authorization

The Most Common Reason for an Initial Prior Authorization Request to Be Denied is that:

86% The provider did not submit the clinical information necessary with the initial request

Imaging (MRI, CT, X-Ray)



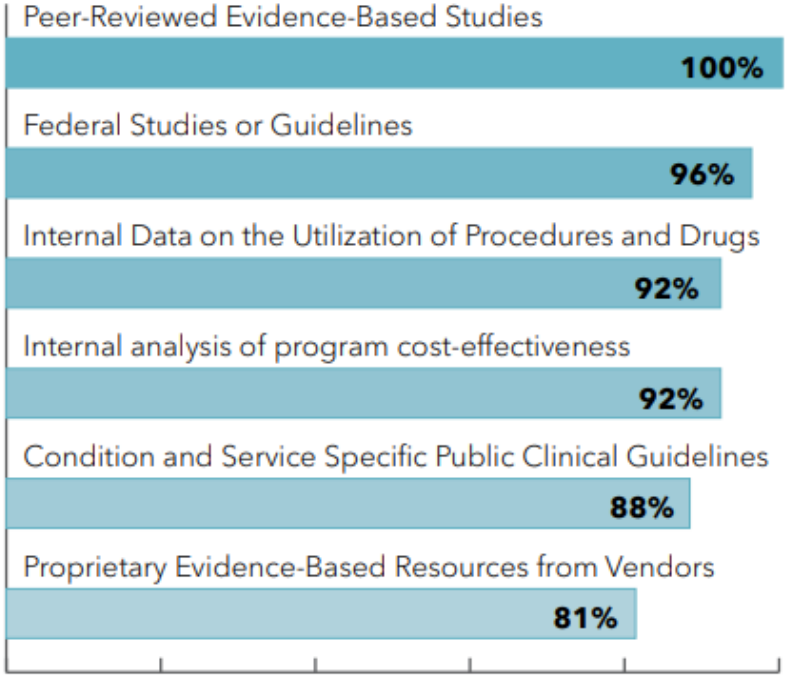
Approximately 20-30% of patients with low back pain have unnecessary imaging ordered early in their course of care.

Early imaging can cost significantly more than recommended alternatives like physical therapy ($2,500 more for MRIs, $19,900 more for CT scans).

Out-of-pocket costs to the patient can average $319 for in-network imaging to $630 for out-of-network imaging.

In addition to greater acute care costs, early imaging is associated with more back surgery, greater use of prescription opioids, and a higher final pain score.

Evidence-Based Resources Used to Design Prior Authorization Programs



83% of commercial enrollees are in plans where less than **10% of drugs** are subject to prior authorization

92% of commercial enrollees are in plans where less than **24% of services** are subject to prior authorization

SOURCE: AHIP prior authorization survey of health plans, 2022; AHIP prior authorization fact sheet, 2023

Prior Authorization (PA) - Provider Perspectives

On average, practices complete

43

PAs per physician, per week

Physicians and their staff spend

12 HOURS

each week completing PAs

More than **1 in 3** or

35%

of physicians have staff who work exclusively on PA

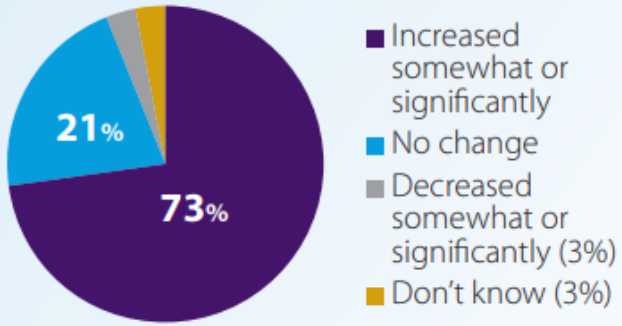
PA denials

More than

1 in 4 (27%)

physicians report that PAs are **often** or **always** denied

Q: How has the number of PA denials changed over the last five years?



95%

of physicians report that PA **somewhat or significantly increases** physician burnout

PA appeals

Fewer than

1 in 5 (18%)

physicians report that they **always** appeal an adverse PA decision

Why don't physicians appeal?

62% report that they do not believe the appeal will be successful based on past experience

48% report that patient care cannot wait for the health plan to approve the PA

48% report that they have insufficient practice staff resources/time

SOURCE: 2023 AMA Prior Authorization (PA) Physician Survey

Prior Authorization (PA) - Industry Consensus Statement

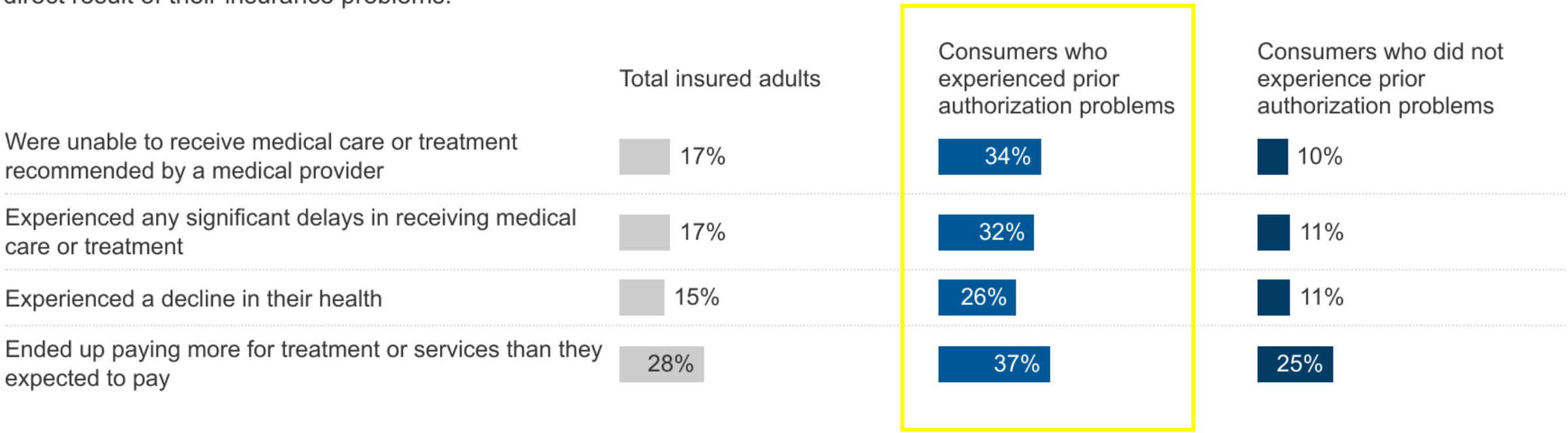
- Issued in 2018 by AMA, AHA, APhA, MGMA, AHIP, BCBS
- Industry-identified opportunities for improvement:
  - Selective application
  - Program review and volume adjustment
  - Transparency and communication
  - Continuity of patient care
  - Automation to improve transparency and efficiency

CS category	What do the numbers say?
Selective application of PA	• Only **8%** of physicians report contracting with health plans that offer programs that exempt providers from PA (e.g, gold card programs).
PA program review and volume adjustment	• A strong majority of physicians report that the number of PAs required for prescription medications **(83%)** and medical services **(82%)** has **increased** over the last five years. • **Over half (55%)** of physicians report that PA is **at least sometimes** required for a generic medication.
Transparency and communication regarding PA	• A majority of physicians report that it is **difficult to determine** whether a prescription medication **(63%)** or medical service **(59%)** requires PA. • Nearly **one in three (29%)** physicians report that the PA requirement information provided in their electronic health record (EHR)/e-prescribing system is **rarely or never** accurate.
Continuity of patient care	• An overwhelming majority **(88%)** of physicians report that PA interferes with continuity of care. • **Almost three out of five (59%)** physicians report that PA **at least sometimes** destabilizes a patient whose condition was previously stabilized on a specific treatment plan.
Automation to improve transparency and efficiency	• Physicians report **phone** as the most commonly used method for completing PAs. • **Only 23%** of physicians report that their EHR system offers electronic PA for prescription medications.

SOURCE: 2018 Consensus Statement on Improving the Prior Authorization Process

Consumers Whose Insurance Problems Include Prior Authorization Are More Likely To Experience Serious Consequences

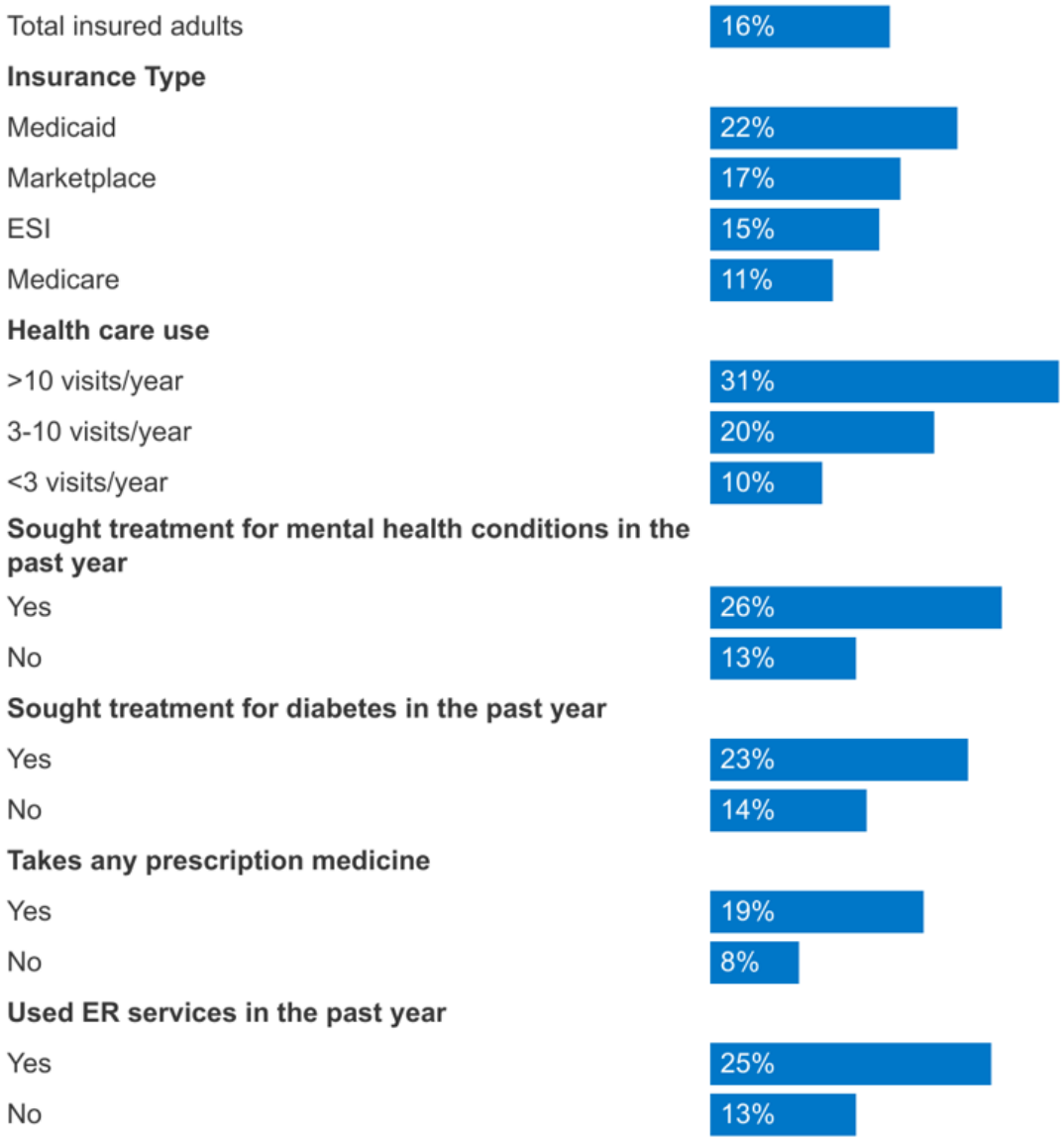
Percent of insured adults who had a problem with their health insurance in the past 12 months and say they experienced the following as a direct result of their insurance problems:



SOURCE: Consumer Problems with Prior Authorization: Evidence from KFF Survey, 2023

Characteristics of Consumers Who Reported Prior Authorization Problems

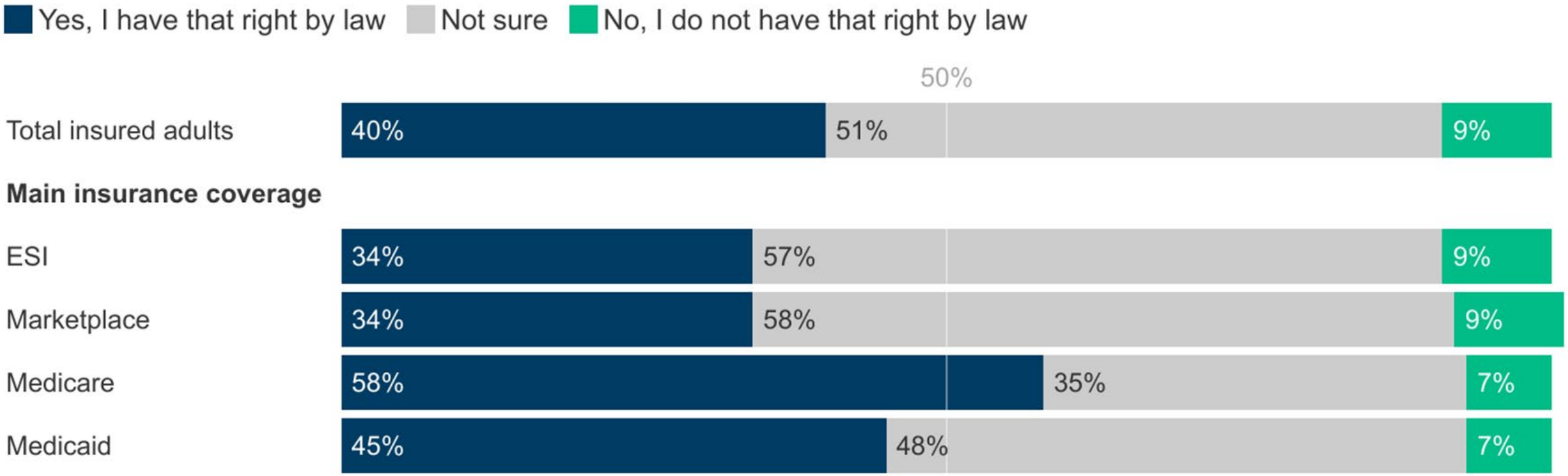
Percent of insured adults who say their health insurance denied or delayed prior approval for a treatment, service, visit, or drug before they received it in the past 12 months



SOURCE: Consumer Problems with Prior Authorization: Evidence from KFF Survey, 2023

Most Insured Adults Are Unaware They Have A Right To Appeal Insurance Decisions

As far as you know, if your health insurance refuses to cover medical services you think you need, do you have the legal right to appeal to a government agency or an independent medical expert?



SOURCE: Consumer Problems with Prior Authorization: Evidence from KFF Survey, 2023

Prior Authorization

System Impacts

- Net impact of PA across all systems and benefits is mixed and limited
- Cost savings could be realized for PA for certain items or services (e.g., powered wheelchairs, diagnostic imaging, specialty drugs) and reviews of use in publicly-funded programs by GAO and MedPAC recommend their use (with oversight)
- Could shift use of potentially harmful services or drugs to those that are less harmful (e.g., removal of PA for medication-assisted opioid treatment led to decrease in opioid use)
- Extent to which PA reduced health care spending overall not clear; could increase total costs for certain patients

Recent Federal Laws and Regulations

Recent Federal Regulations

Medicare Advantage

- New federal Medicare rules specify:
  - When MA plans can require PA (confirm diagnoses and other medical criteria, medical necessity, clinically appropriate)
  - Duration of PA approval
  - Transition period for continuity of care
  - Review of denials by health care professional w/ expertise in that field of medicine
  - AI determinations must factor in patient-specific facts and circumstances
  - Provider notification of reason for denial
  - Evaluate effects of PA on those with certain social risk factors

Recent Federal Regulations

Advancing Interoperability and Improving Prior Authorization Processes

- Who does it apply to?
  - FFM QHPs
  - Medicaid
  - CHIP
  - MA
- What does it do?
  - Electronic data sharing/APIs
  - Transparency requirements
  - Aggregate information about claims denials
  - Shortens timeframe for decisions
  - Expected to save at least $16 billion over 10 years by cutting care delays and provider administrative burden, and electronic streamlining
  - Expected to cost payers nearly $1.6B over 10 years
- What does it not do?
  - Prescription drugs
  - Most employer plans
  - Processes for determining how decisions are made
  - Information on specific services denied
  - APIs voluntary
  - Appeals structures

Recent Federal Regulations

Advancing Interoperability and Improving Prior Authorization Processes

Federal Standards For Prior Authorization Decision For Impacted Payers, Current and New (Starting January 2026)

	Current		New	
	Standard	Expedited	Standard	Expedited
Medicare Advantage	14 calendar days	72 hours	7 calendar days	Unchanged
Medicaid Managed Care	14 calendar days	72 hours	7 calendar days	Unchanged
CHIP Managed Care	14 calendar days	72 hours	7 calendar days	Unchanged
Medicaid FFS	Not specified in federal regulation	Not specified in federal regulation	7 calendar days	72 hours
CHIP FFS	14 calendar days	Not specified in federal regulation	7 calendar days	72 hours
QHPs on FFEs	15 days	72 hours	Unchanged	Unchanged

Source: CMS Final Rule, 2024 • Get the data • Download PNG

KFF

Related Federal Laws

MHPAEA, ACA, NSA

- Federal Mental Health Parity and Addiction Act
  - Plans must document use of and rationale for PA for covered medical and behavioral health care services
  - Compliance slow, but increasing enforcement has required plans to eliminate PA for certain behavioral health treatments due to alleged parity violations

- Affordable Care Act
  - No PA for emergency care
  - Report data on claims payment practices and denials (largely un-implemented)

- No Surprises Act
  - No surprise bills for most emergency services even if obtained w/out PA

Recent Proposed Federal Laws

Improving Seniors' Timely Access to Care Act

- Reforms PA in Medicare Advantage
- Was introduced in 2021 and passed the House but died in the Senate after CBO projected costs of $16B over ten years
- Informal CBO score after new federal rule issued dropped estimated cost
- S. 4532/H.R. 8702 re-introduced in June 2024
- What does it do?
    - Mandates compliance with uniform electronic prior authorization technical standards
    - Bars MA plans from utilizing faxes or proprietary payer portals that don't meet standards
    - Includes robust transparency requirements (e.g., disclosure of policies and evidence utilized in formulating prior authorization, listing of all services subjected to prior authorization, how many services are denied and overturned on appeal, etc.)
    - Permits insurers to create gold-carding programs
    - CMS must submit report to Congress on PA use in MA and what constitutes "real-time decisions" for "routinely approved services."
    - Explicit delegation to HHS to establish technical standards and enforce timely responses
- Applies to items and services but not Part D drugs

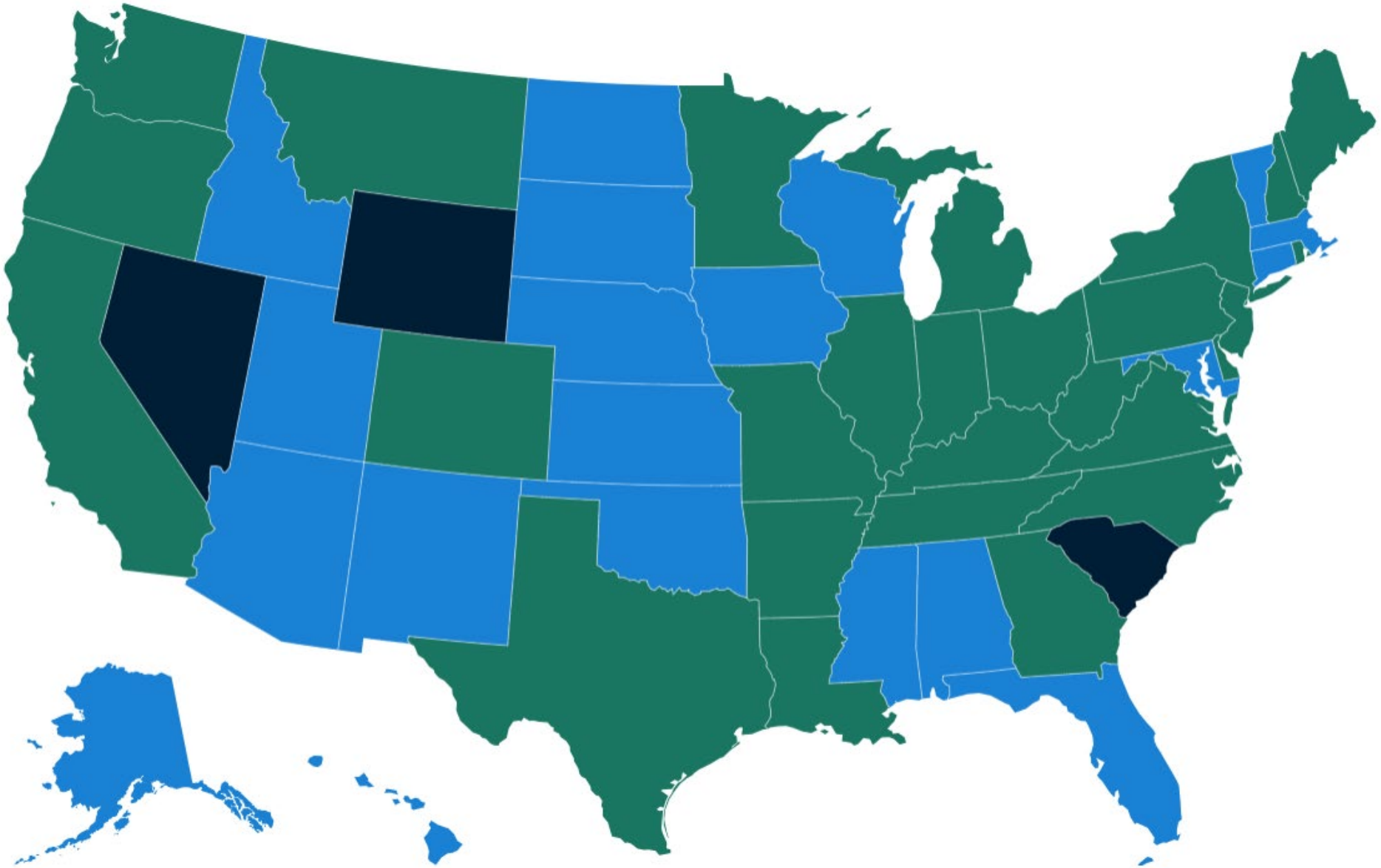
State Initiatives

State Initiatives

- Nearly all states have passed laws to reform prior auth practices (clinical criteria, transparency, wait times, administrative efficiency, etc.)
- More than 90 PA reform bills have been introduced in 30 states in 2024
- Common reform themes:
  - Transparency
  - Standardized request forms
  - Electronic processes
  - Response timeframes
  - Clinical review standards
  - Exceptions and ”gold carding”
  - Continuity of care

Nearly All States Have Passed Laws to Regulate Health Plans' Use of Prior Authorization

Comprehensive prior authorization law | Less comprehensive prior authorization law | No prior authorization law



Source: AMA 2024 Prior Authorization State Law Chart • Get the data

KFF

State Prior Authorization Laws and Regulations, as of Apr. 2024

	WA	AR	IL	TX
Transparency	X	X	X	X
Standardized request forms		X	X	X
Electronic processes required	X	X	X	
Response timeframes	X	X	X	X
Standards for Clinical Criteria	X	X	X	X
Standards for Clinical Personnel	X	X	X	X
Peer-to-Peer Opportunity		X		X
“Gold Carding”		X		X
Disease/Service Exceptions	X	X	X	
Continuity of Care	X	X	X	X

SOURCE: The Good, The Bad, The Costly: State Efforts to Reform Prior Authorization Practices (2024). Georgetown University Center on Health Insurance Reforms.

Other State Initiatives

- NY prohibition on PA during first days of inpatient admission for mental health treatment for children
- CA plans must use generally-accepted standards of care developed by non-profit association for relevant clinical specialty in determining medical necessity (rather than plans' own clinical criteria)
- CA coverage of at least 1 therapeutically equivalent HIV/AIDS prevention drug, device, product w/out PA
- TN plans can't require PA for OUD treatment, ME plans can't require any PA for MAT for pregnant women

State Initiatives

Impacts and Tradeoffs

- Gold carding
  - Can reduce provider burdens, but can increase costs to insurers and could result in inequities for different patient populations if only certain providers or services are gold carded
- Disease/Treatment Exceptions
  - Can improve timely access to care (e.g., SUDs, PrEP, cancer testing and treatment) but the selection of specific exceptions could be politically fraught and arbitrary
- Clinical Review Standards
  - Offers important guardrails and protections against inappropriate denials, but require resources to update as clinical recommendations change
- Transparency
  - Opportunity to understand insurer practices and inform future policymaking, but increases administrative burden and costs for insurers

State Initiatives

Impacts and Tradeoffs

- Response timeframes
  - Can speed patient access to care, but insurers concerned rushed decisions could compromise accuracy and safety
- Peer Review
  - Can lead to more evidence-based decisions, but overly strict credentialing requirements can reduce the pool of reviewers, potentially causing delays and increasing costs for insurers
- Standardization of forms and processes
  - Streamlining can reduce administrative burden for providers but insurers still maintain some discretion over the process, resulting in non-standardized processes
- Use of Automation/AI
  - Can make decisions faster, more efficient, and less burdensome, but concerns about inequitable algorithms and removal of provider expertise
- Use of Automation/AI
  - Can make decisions faster, more efficient, and less burdensome, but concerns about inequitable

State Initiatives

Impacts

- In VT, Marketplace insurers predict significant cost increases as a result for 2025

- Study estimated PA elimination on current services in Massachusetts commercial and MCO markets could increase premiums by 5%-nearly 7% PMPM ($28-$37) based on scope, due in large part to increased used of specialty drugs
    - Plans could direct resources to increase retrospective reviews for fraud, waste, and abuse and payment integrity efforts to manage cost and quality

- 2021 survey of state employee health plan administrators found more than half of states implemented UM but only a handful report it resulted in cost savings (provider payments and network designs were reported to result in cost savings more frequently)

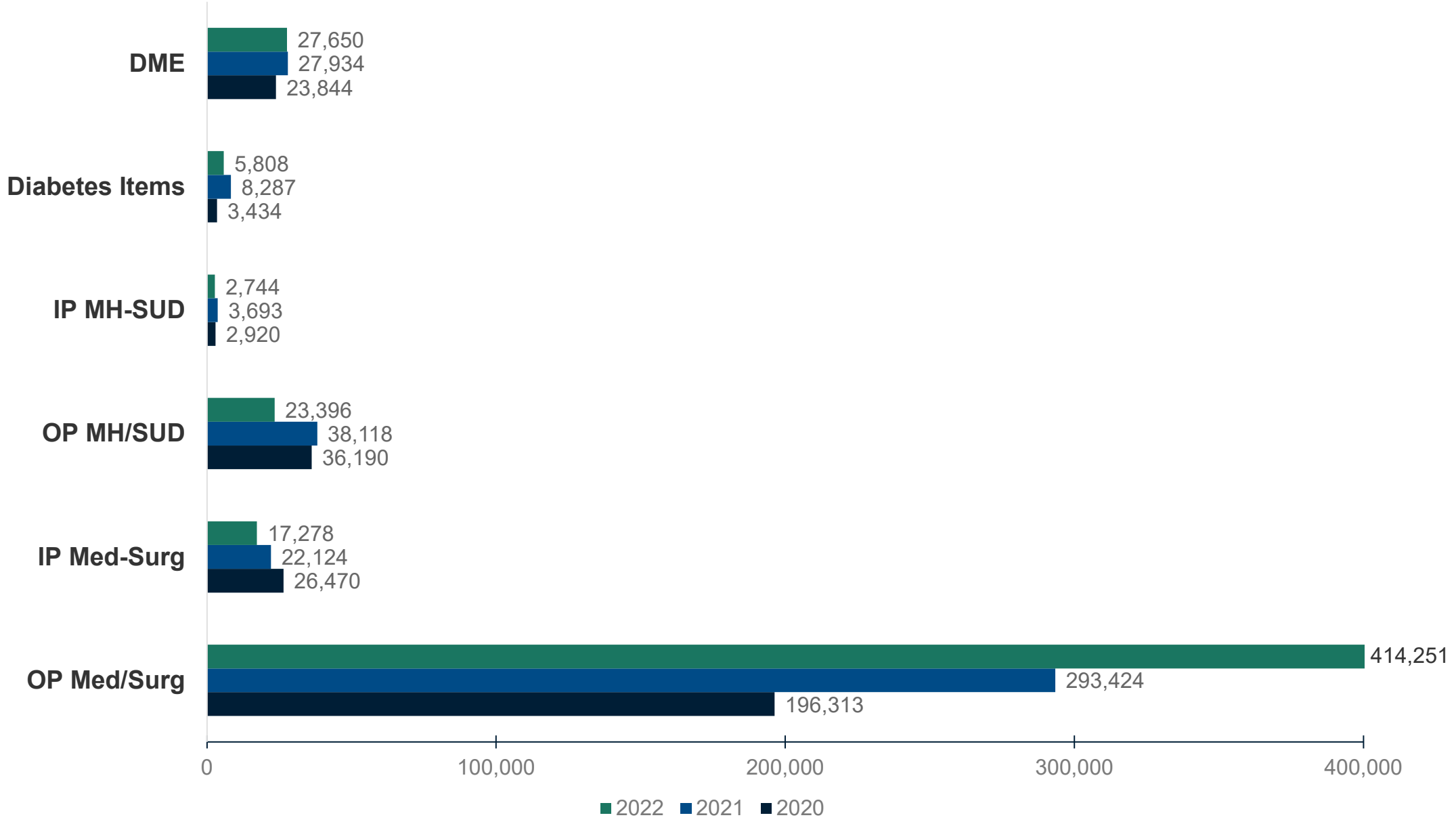
- PA for antipsychotic drugs for schizophrenia in Georgia Medicaid reduced utilization and improved health outcomes and lowered costs

- PA for antipsychotic and anticonvulsant drugs for bipolar disorder in Maine Medicaid reduced utilization and spending but increased risk of discontinuance

Washington State

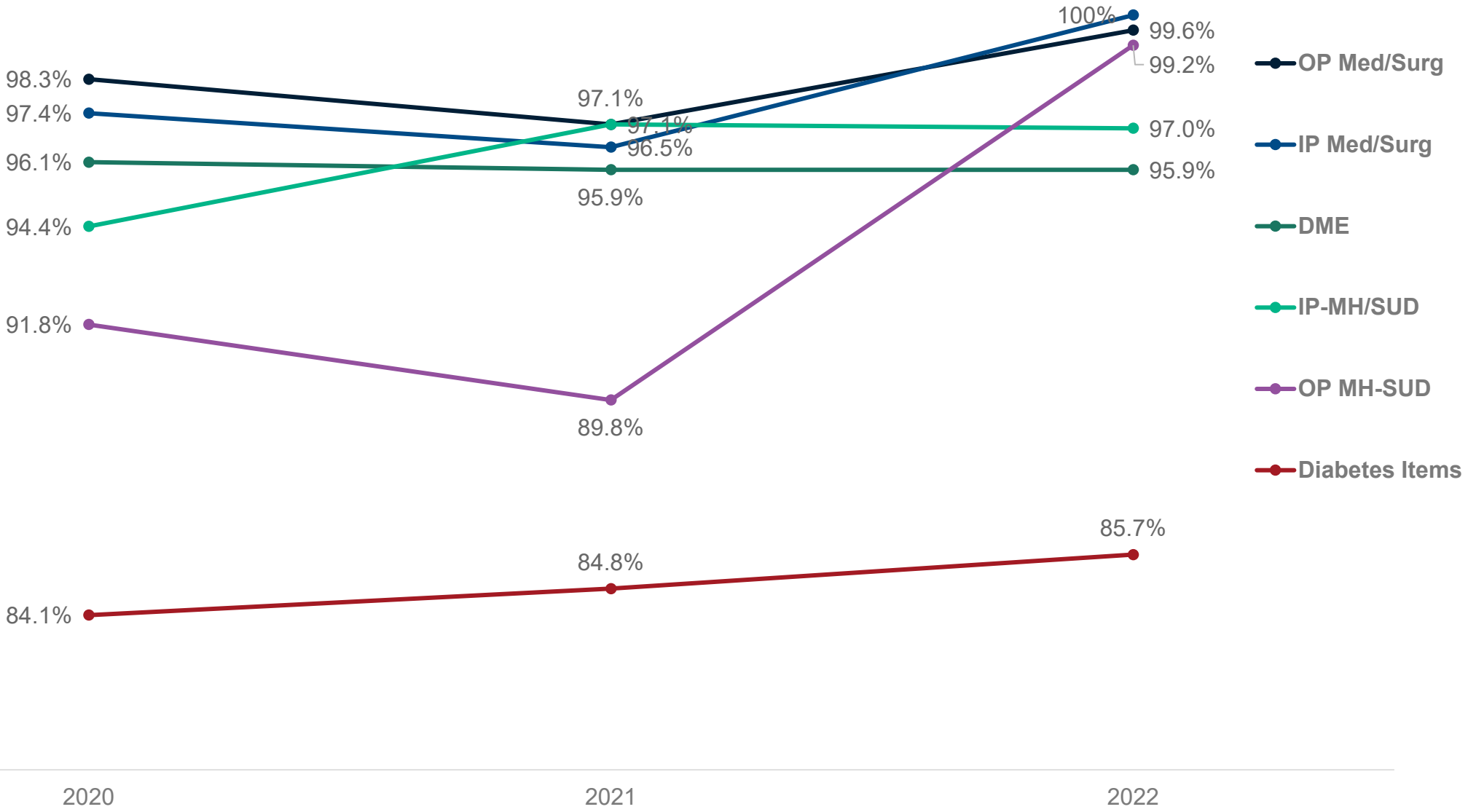
- Starting to enforce the federal regs early
- State law currently requires carriers with at least 1% market share in Washington must report certain data regarding prior authorization to OIC
    - Inpatient and Outpatient medical/surgical
    - Inpatient and Outpatient mental health and SUD
    - Diabetes supplies and equipment
    - Durable medical equipment
- Within those categories, carriers must report:
    - 10 codes w/ highest number prior auth requests and percent that were approved
    - 10 codes w/ highest percentage of approved prior auth requests and total number of approved requests
    - 10 codes w/ highest percentage of prior auth requests that were initially denied and then approved on appeal
    - Average response time in hours for requests in each of the categories above for expedited decisions, standard decisions, and extenuating circumstances decisions

Total Prior Authorization Requests by Service Category, 2020-2022



SOURCE: Office of the Insurance Commissioner. 2023 Health Plan Prior Authorization Data Report.

Prior Authorization Approval Rates by Service Category, 2020-2022



SOURCE: Office of the Insurance Commissioner. 2023 Health Plan Prior Authorization Data Report.

Considerations for Washington

Considerations for Washington

Potential Strategies

- Standardization
  - Services/drugs covered
  - Submission processes
- Automation
  - Electronic PA requests
  - Real-time coverage inquiries
- Strategic application
  - Sunset programs
  - “Gold carding”
- Provider processes
  - Adoption of EHRs
  - Centralized clinical teams to handle PAs

Considerations for Washington

Overarching Questions

- Does it save money for patients?
- Does it save money for the payer?
- What is the value-add?
- Health equity?
- Use of AI?
- Nimbleness to adapt to changing technologies and treatments?
- Compliance/enforcement?
- How will success be measured?
  - Reporting and data needs (e.g., PA requests and denials by service and enrollee characteristics)

QUESTIONS?

For more information, contact: MichelleL@kff.org

Washington's Prior Authorization Modernization

Universal Health Care Commission

Joyce Brake, Policy and Rules Manager

August 15, 2024

OFFICE of the
INSURANCE
COMMISSIONER
WASHINGTON STATE

Washington's Prior Authorization Prohibitions

Carriers cannot require prior authorization for:

- First three days of inpatient substance use disorder treatment or first two days of withdrawal management. (RCW 48.43.761)
- Opioid use disorder medications (at least one in each of the three major Food and Drug Administration-approved drug classes; RCW 48.43.760)
- Emergency services, including behavioral health crisis services and emergency ground ambulance transports (RCW 48.43.093; RCW 48.43.121, effective 1/1/25)
- Drugs that comprise at least one regimen recommended by the Centers for Disease Control and Prevention for Human Immunodeficiency Virus postexposure prophylaxis. (RCW 48.43.440, effective 1/1/25)
- Certain cancer biomarker testing (RCW 48.43.810)

Policy Goals

- To improve health outcomes by preventing delays in care.
- To pull out the red tape within the prior authorization process, which adds to provider burnout.

Washington's Prior Authorization Modernization

- Shortens turnaround times for standard and expedited prior authorization requests.
- Applies to health care services and prescription drugs.
- Timelines differ depending on electronic or non-electronic submission.

Washington's Prior Authorization Modernization

- Defines standard and expedited prior authorization requests. OIC and HCA chose to define electronic and non-electronic prior authorization submissions.
- **Plain speak emphasis:** Requires carriers to communicate prior authorization requirements in detailed, easily understandable language.
- Requirements must be publicly available and based on peer-reviewed, evidence-based clinical review criteria that is evaluated and updated annually.
- Clinical review criteria must accommodate new and emerging information related to the appropriateness of clinical criteria with respect to black and indigenous people, other people of color, and underserved populations.

Washington's Prior Authorization Modernization

Requires process automation through an application programming interface by 2026 (for health care services) and 2027 (for prescription drugs).

Washington's Law vs. Federal Rule

Issue	RCW 48.43.830	Final federal rule
Health plans/programs subject to the rule	Fully insured health plans, including qualified health plans offered on the Health Benefit Exchange; PEBB/SEBB plans; Medicaid MCOs	Medicaid; Children's Health Insurance Program; Medicare Advantage and qualified health plans offered through the federally facilitated Exchange
Scope of services	Health care services, including Durable Medical Equipment (DME) Prescription drugs	Items and services within a medical benefit, including DME, excluding prescription drugs.
Components of prior authorization Application Programming Interface (API)	The API must use health level HL 7 Fast Healthcare Interoperability Resources (FHIR) in accordance with federal standards that: • Automates the process to determine whether a prior authorization is required for durable medical equipment or a health care service; • Allows providers to query the carrier's prior authorization documentation requirements; • Supports an automated approach using nonproprietary open workflows to compile and exchange the necessary data elements to populate the prior authorization requirements that are compliant with HIPAA or have an exception from CMS; and • Indicates that a prior authorization denial or authorization of a service less intensive than that included in the original request is an adverse benefit determination and is subject to the carrier's grievance and appeal process under RCW **48.43.535**. Same requirements apply to prescription drug prior authorization APIs but are effective January 1, 2027.	Must implement and maintain an HL7 FHIR API that: • Includes the payer's list of covered items and services (excluding drugs) that require prior authorization; • Identifies all documentation required for approval of any items or services that require prior authorization; • Supports a HIPAA-compliant prior authorization request and response; and • Communicates whether the payer approves the prior authorization request (and the date or circumstance under which the authorization ends), denies the prior authorization request (with a specific reason), or requests more information.
Enforcement	On December 20, 2023, OIC issued a Technical Assistance Advisory OIC TAA (12/20/23) stating that OIC will enforce the requirement to provide the API interface for health care services prior authorizations beginning January 1, 2026 and for prescription drug prior authorizations beginning January 1, 2027.	Prior authorization API for medical items and services (excluding prescription drugs) must be implemented by January 1, 2027.

Questions?

Jane Beyer
Senior Health Policy Advisor
Jane.Beyer@oic.wa.gov
(360) 725-7043

Joyce Brake
Policy and Rules Manager
Joyce.Brake@oic.wa.gov
(360) 725-7041

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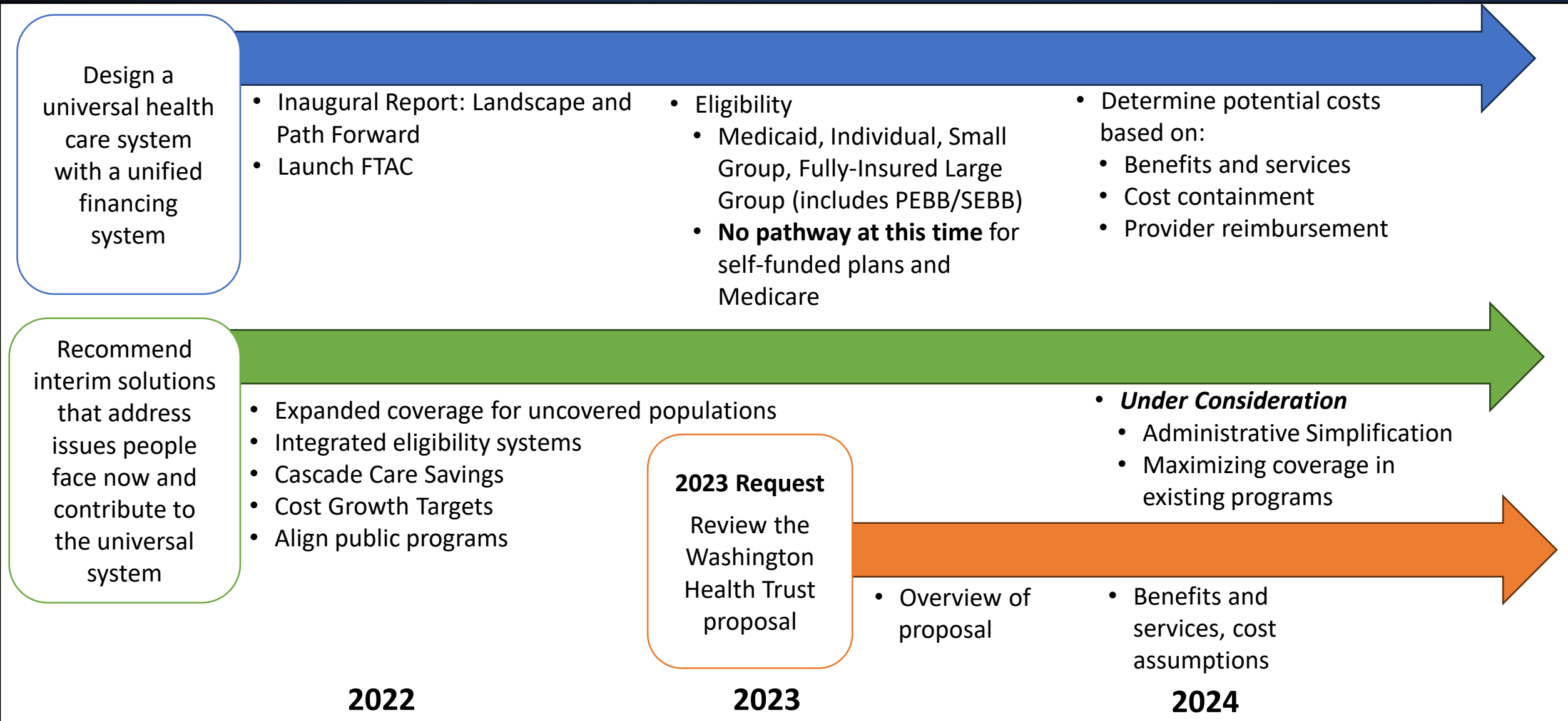
- www.insurance.wa.gov

Tab 5

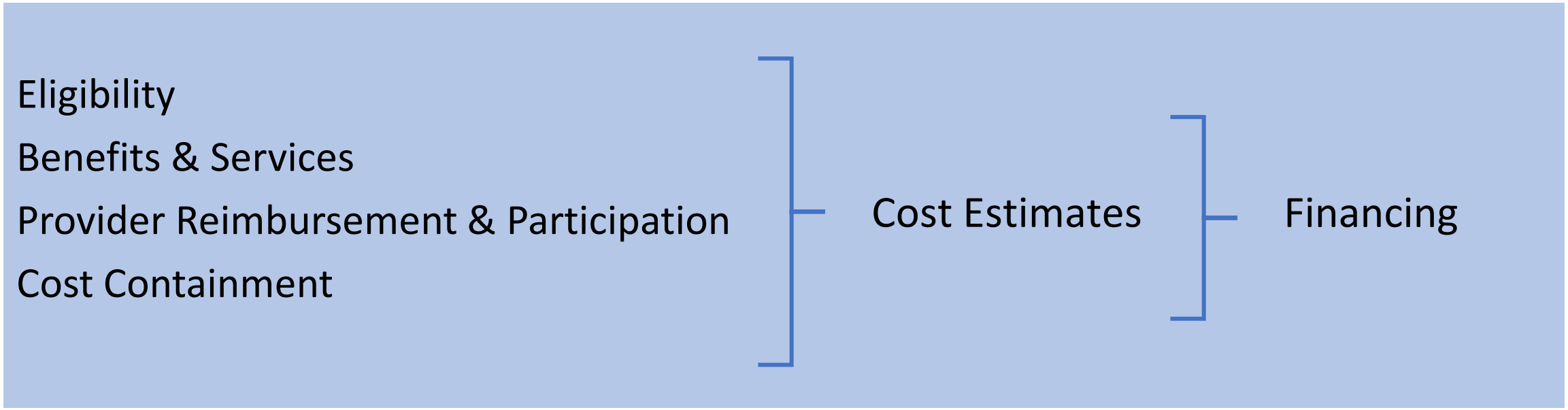
Washington State Health Care Authority

Commission Progress and Workplan Update

3 Workstreams: Key Milestones/Activities



Workstream 1: Universal System Design



Workstream 2: Interim or Transitional Solutions

2024 Areas Being Considered

- ❑ Administrative Simplification
- ❑ Maximizing coverage in existing programs
  - ❑ Auto-enroll Medicaid to no-premium or lower-cost plans Exchange
  - ❑ Codify and fully fund Apple Health expansion
  - ❑ Increase participation in the Medicare Savings Program
  - ❑ Consolidate and expand purchasing

Workstream 2: Administrative Simplification

February

National experts about potential savings associated with administrative simplification efforts in the health care system and five functional areas of focus

HCA's Medical Director about efforts to promote administrative simplification

April

OneHealthPort and efforts to support administrative simplification in Washington

June

Provider perspectives on administrative simplification

Today

Focus on Prior Authorization

Recommendations

Prior Authorization: Discussion Questions

- What else would you like to know more about in relation to Prior Authorization?

- Is there a particular area you would like to see the Commission focus on (in addition to what OIC shared they are doing) to improve the Prior Authorization process in our current system?

  - Gold carding
  - Standardized forms
  - Others

- What (if any) role do you see for Prior Authorization in the universal system?

- Would you like to make a recommendation about improving the Prior Authorization process?

Appendix materials for this section

HCA Initiatives in Administrative Burden Reduction

- **Alignment and oversight** across a number of programs and contracts
- Leading development of the **Washington State Action Plan for Removing Barriers to Health and Human Services**
- Staff the **Performance Measures Coordinating Committee**
- Multi-payer collaborative for **Primary Care Transformation**
- **Interoperability rules implementation** with focus on **Prior Authorization**
- Participant in the **Administrative Simplification program** led by OneHealthPort under oversight of OIC

Local Opportunities

Expert stakeholder review	Use Subject Matter Expert workgroup to prospectively review legislation and/or policy recommendations that impact health services administration
Pre-service	Pre and prior authorization is only one of many checks providers need to make prior to service in order to be assured of claims payment- move beyond traditional methods
Consumer engagement	Putting “patients in the center” and “meeting people where they are” are widely held aspirational goals – also state and federal laws require “simplified” consumer access to their health information
Performance measurement	WA State has a Performance Measurement Coordinating Committee and local expert organizations. How can we become more innovative using what’s in place.
SDOH/enhanced demographics	Broad agreement that improving health means addressing determinants of health and inequities – this will require measurement How can we adopt best practices from the get-go and avoid building silos and deploying incompatible proprietary approaches as we enter this new space?
Behavioral health	How can we enhance and accelerate clinical integration by better blending the administrative elements of physical and behavioral health?

Universal Health Care Committee meeting

We are currently on a short break

Washington State Health Care Authority

Tab 6

Washington State Health Care Authority

Public Comment

From: PAM KETZNER
To: HCA Universal HCC
Subject: public comment at tomorrow"s meeting
Date: Monday, June 3, 2024 8:18:32 PM

External Email

Hello,
My name is Pam Ketzner, I would like to make a public comment at the Universal Health Care Commission meeting on June 4th, 2023.
2 years ago, my son had an unfortunate experience at the hospital in Bellingham. While he was suffering from a severe mental breakdown, he realized he needed to go seek care at an inpatient facility immediately. After finding out online that the hospital had a facility that purported to offer the necessary services, he then took the bus to the location. However, upon arrival, he discovered that neither the security guard nor the front desk personnel were aware of any inpatient services at that facility, which further exacerbated his distress as he had just seen this information on their website. Not thinking straight and his phone nearing the end of its battery life, he accepted their offer for an emergency room visit assuming he must have read it wrong. After taking vitals they led him to a room where he accepted a ketamine treatment and was administered initially the wrong dose. After they adjusted the dose, he was then left in the extremely cold room for nearly 6 hours.
Eventually two social workers arrived and discussed future treatment plans, and he was referred to several local inpatient facilities. However, these facilities ended up turning him away, citing his recent ER admission for psychological issues as evidence that he was a danger to himself and required continuous supervision.
Thus, due to the hospital's initial mismanagement, he was unable to obtain the necessary care that he deserved to get, and as a result, we had to turn to alternative methods of treatment which were much more expensive.
The alternative therapy cost $3500 for 6 doses.
If you have ever had a family member talk about suicide it never leaves your mind. Please work harder at getting Universal Healthcare in our State. It is the right thing to do for all of us. We need it now.
Thank you
Pam Ketzner RN
253-312-2367

From: Diana Huang
To: HCA Universal HCC
Subject: Clarification on comments made at 6/4 meeting
Date: Wednesday, June 5, 2024 7:38:25 AM

External Email

Hello,
It was lovely to speak to the commission at the recent meeting, I really appreciate all of your attention to this complex and important work. I did want to clarify regarding value based payment that I (and I think most physicians) think it is the way we should be moving, however the way that it is being implemented by many insurers currently is an excessive amount of box checking that can hasten burnout. Some of the boxes matter (cancer screening, high blood pressure, diabetes control), many other things don't. I mentioned HCC codes with Medicare for things like diabetes and heart failure because those are obvious, meaningful ones, but there are hundreds of these codes that flag for us of varying importance and now there is a similar system, HHS codes, designed for those on Affordable Care Act plans, that adds hundreds more codes to track other clinical complexity that isn't captured in the Medicare HCC codes. When HHS codes were announced at our quality meeting last year, one of the physicians (an internist who has been practicing for decades) said she felt physically nauseous at the idea of another pop up to work through every time she is trying to get into the patient chart. Even though we are participating in contracts that use these, we're not communicating much about it to clinicians yet since it may drive people to leave practice and that's not worth it. It's not that these things don't have potential value, but a good clinician would be addressing things with the appropriate prioritization and still might not get "credit" for it if they don't document in exactly the right way. The vast majority of the burden for quality metrics falls on primary care, and right now all primary care providers in the big systems are caring for more than their share of patients since so many people have left medicine in the last few years. One way systems try to help save us from learning the minutiae of how to document it is to hire clinical people who just look at charts and send us messages saying, "did you mean to say this?" and we review and accept suggestions if appropriate, but this is more administrative time. With this, similar to with prior authorization, I think the key to a manageable system is focusing on a smaller set of quality metrics that are uniform across payers. One good example of this is blood pressure control - most value-based contracts care about this which has allowed us to hire people to help patients with their control with good results. The details are really important - choosing metrics that matter for patient outcomes, and capturing data in a way that is minimally burdensome for clinicians.

I hope this is helpful, and I'm happy to be a resource to the commission in the future if you would find it valuable. This is my personal email. Your work matters. Thank you again!

Diana

Sent from my phone

Diana Huang
Family Physician, Swedish Downtown Primary Care
MD/MA Urban Bioethics, Temple University

From: Kathryn Lewandowsky
To: HCA Universal HCC
Subject: Written Comments for the UHCC
Date: Tuesday, May 7, 2024 6:24:24 PM

External Email

Here is a copy of my comments from the last UHCC meeting. I do not remember if I was able to make all of my statements within the time allotted.

Thank you Chair Lowe and members of the UHCC for allowing me to speak today. My name is Kathyn Lewandowsky and I am Board Vice-Chair for Whole Washington and a recently retired Registered Nurse here in Washington.

While trying to review the meeting materials, I was intrigued regarding the statement that Dr. Friedman anticipates healthcare costs doubling in the next 10 years. So I had to go back to review his studies. It seems that what he said was in his first financial analysis done for WW was on page 48 was. "Without reform, the cost of health care under the current system is expected to double over the next decade…"

I believe the important point here is the "without reform". Our current system rewards these increased costs in the form of bonuses to well paid CEO's and shareholders who are often the same people. While these increased costs then translate to ever higher profits are welcomed by the for-profit health insurance industry and other members of the Medical Industrial Complex, I'm going to be frank, these increased costs in healthcare are unsustainable.

And so this is your role. It is your role to do what you can to make real reforms to our healthcare system in order to create an equitable, comprehensive and affordable Universal healthcare system for all of our people.

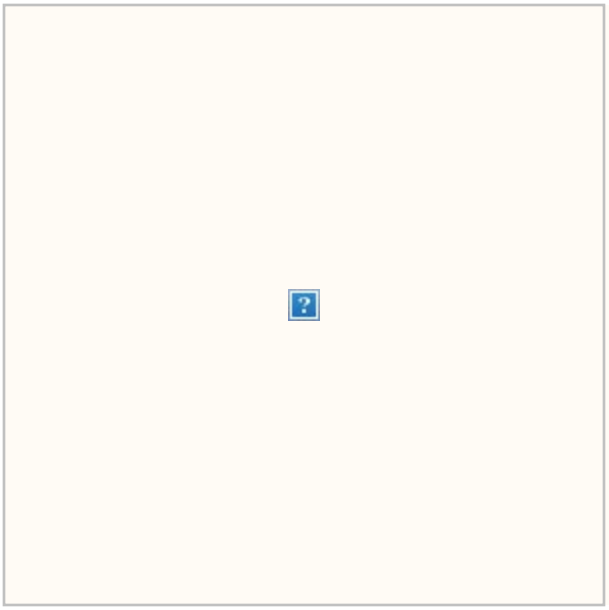
We are frustrated and disappointed that recommendations to continue to analyze the feasibility of SB 5335 or Option A from the states workgroup are not making any headway to comprehensive healthcare reform. We all know that it saves money and we all have known that for decades. What we would like to see is some dialogue regarding, how do we

best pay for this? We have proposed options and we know they may not be ideal especially in light of more recent events. Let's please talk about that. What are your ideas for funding Option A? Let's get on with making true progress!

Also, one of the recommendations from the FTAC committee was to look at systems of social insurance where our for-profit health insurance companies just need to be more tightly regulated. This has been accomplished in several other countries. But, still they do not show the cost control as the countries who have a single payer system. And unfortunately, we live in a country where our highest court in the land has said that political donations by corporations are a protected first amendment right of free speech for those corporations. Our country's corporations have the use of our healthcare dollars to "speak freely" to our elected officials. You can call it anything you want, we know the truth; this interpretation is political bribery! At some point, if we are to remain a true Democracy, we will have to deal with this assault on our constitution. Possibly sooner rather than later.

Thank you for allowing me to submit these comments.

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



SB 5335 establishes the Washington Health Trust and outlines funding, benefits

coverage, provider reimbursements, and implementation. Whole Washington works to build legislative support for the Washington Health Trust, requiring majority support in the House, Senate, and from the Governor. Read more about SB 5335. We also work through the Ballot Initiative process when our legislative process fails us.

Give Us a High Five!

Together we can all have healthcare free at the point of service; that is comprehensive with no copays or deductibles and that puts billions of dollars of savings into the pockets of regular people just like you and me!. Healthcare that will take care of all of our people from Cradle to Grave! Please go to WholeWashington.org and donate today! It will take all of us demanding these basic human rights from the global elite! Together we can do this!

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

From: Kathryn Lewandowsky
To: HCA Universal HCC
Subject: Written comments
Date: Tuesday, June 4, 2024 10:19:57 PM

Hello members of the Universal Healthcare Commission. Here are my written comments, uncondensed from my public comments of today.

My name is Kathryn Lewandowsky, BSN, RN, Vice Chair of Whole Washington.

We are currently in the middle of our Town Halls, traveling around the state to speak to people directly, to hear their healthcare stories and to share with them how we believe the Washington Health Trust can fix their problems. It's been stressful, tiring, but also very enlightening.

We've also been doing phone banking to promote these Town Halls, and last week I volunteered with that for the first time. On my very first call, rather than getting a voicemail, I actually had a volunteer answer. She is a provider, works in a clinic in Seattle and is a supporter and a donor to Whole Washington.

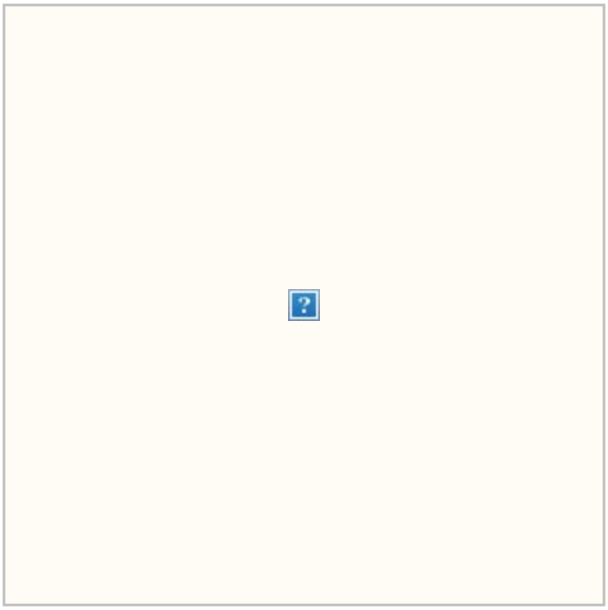
I'd like to share with you the gist of a long, 20 minute conversation so I'll trim it down. But, I want to try and deliver this shortened version with the same intensity and tone that she used with me. And so, I apologize in advance!

She said to me, "You know, I like you guys, but I gotta be honest. It's never gonna work! Right now I hate my country! I hate our healthcare system! I detest the ACA! I am sick of dealing with insurance companies! And having these town halls won't help! Collecting signatures won't do it! It's a waste of time! It will never get on the ballot! If it does, there is no way it will pass! Our country is OWNED by the billionaires and they will never let anything like this happen! The only thing that will make any difference is DIRECT ACTION! We need to stop everything, to obstruct everything! We need to shut this country down. That is the only way we can make a difference!"

Whew! I tried very hard to listen, to redirect her to what we were trying to do, to encourage her to come to our volunteer meeting. To somehow give her some hope. But, In the end, I could really give her no evidence disputing that she is not wrong!

So I ask again, when are the positions on this commission going to be filled with people who care about fixing this corrupt system? We haven't had a citizen's rep in more than a year! We have never had a full cohort of electeds attend a meeting. They arrive late, and leave early. Why are they on it? If I had that sort of work ethic during my career as a nurse, I would have been fired! I have never been fired! You all know what needs to be done to truly fix this horrific system and deliver to our people a healthcare system they can be proud of! So, can we please get to work NOW! THANK YOU!

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



SB 5335 establishes the Washington Health Trust and outlines funding, benefits coverage, provider reimbursements, and implementation. Whole Washington works to build legislative support for the Washington Health Trust, requiring majority support in the House, Senate, and from the Governor. Read more about SB 5335. We also work through the Ballot Initiative process when our legislative process fails us.

Give Us a High Five!

Together we can all have healthcare free at the point of service; that is comprehensive with no copays or deductibles and that puts billions of dollars of savings into the pockets of regular people just like you and me!. Healthcare that will take care of all of our people from Cradle to Grave! Please go to WholeWashington.org and donate today! It will take all of us demanding these basic human rights from the global elite! Together we can do this!

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

Tab 7

Washington State Health Care Authority

Commission Discussion and Potential Votes

Potential Commission Member Vote #1: Apple Health Expansion

Motion: The Commission continue its support for the Apple Health expansion program, including recommending additional funding for this program.

Potential Commission Member Vote #2: Administrative Simplification

Motion: The Commission recommends the Legislature develop and consider legislation to implement a standardized form for Prior Authorization across all payers and providers.

and/or

Motion: The Commission recommends the Legislature develop and consider legislation to implement gold carding program.

Appendix: Workplan and Past Decisions

2024 Universal Health Care Commission Workplan

January 2024 FTAC

- Medicaid Discussion Part 2
- Waivers to expand eligibility
- Federal barriers for asset tests

February 2024 Commission

- State Agency Updates
- Medicaid Options from FTAC
- Benefits and Services Overview and Approach
- Identify priorities questions for FTAC
- Administrative Simplification and Provider Participation

March 2024 FTAC

- Updates from Commission
- Benefits and Services
- Evaluation of Whole WA proposal

April 2024 Commission

- State Agency Updates
- Report out from FTAC on Benefits and Services
- Administrative Simplification continued

May 2024 FTAC

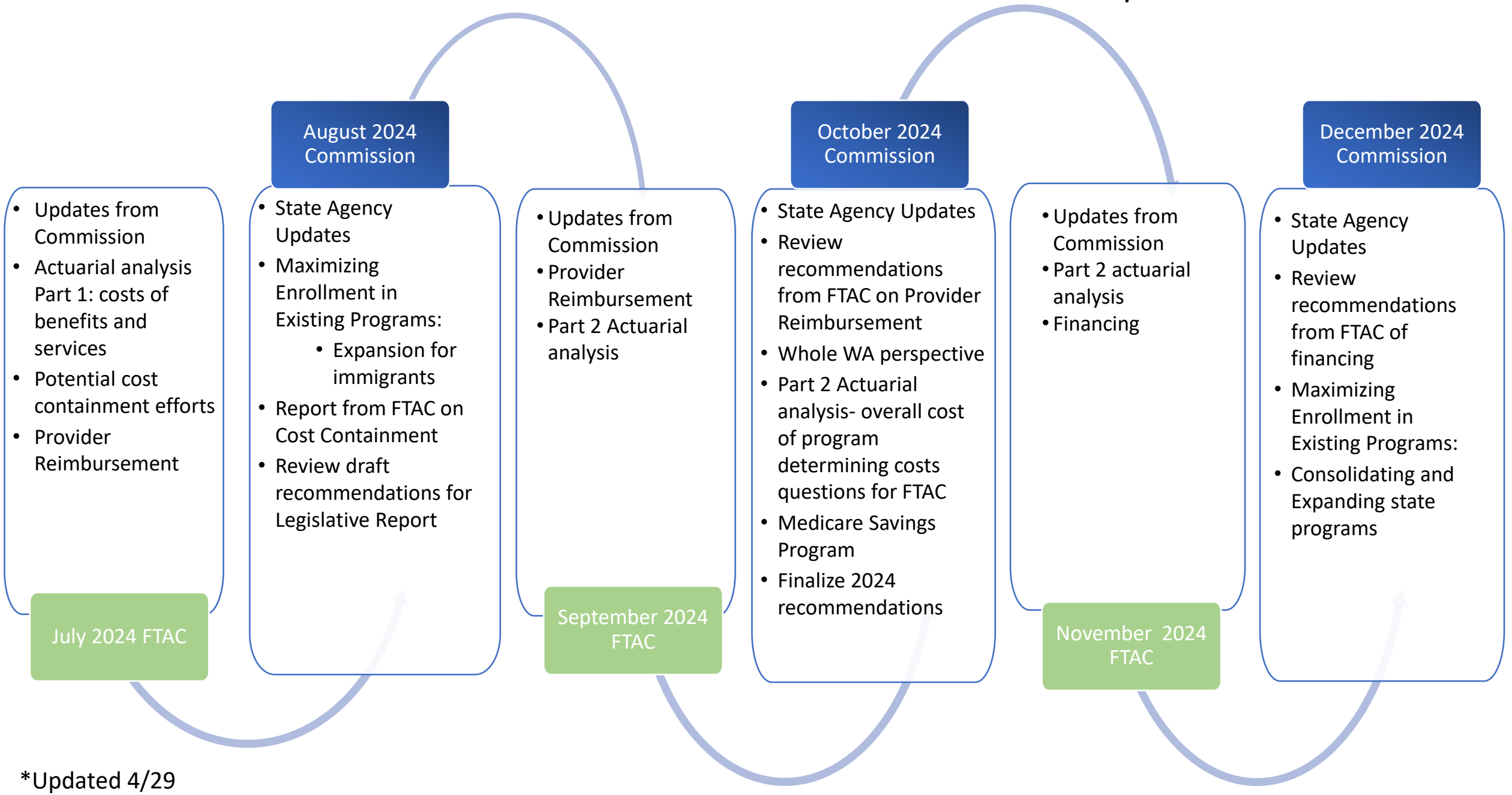
- Updates from Commission
- How are costs set
- Cost containment (previously in November
- Update on actuarial work

June 2024 Commission

- State Agency Updates
- Actuarial Analysis Part 1: Costs of benefits and services
- Recommendations on Administrative Simplification and Provider Participation
- Considerations for cost containment from FTAC
- Whole WA perspective
- Questions/guidance for for FTAC
- Maximizing Enrollment in Existing Programs:
  - Auto-enrollment

*Updated 4/29/24

2024 Universal Health Care Commission Draft Workplan



*Updated 4/29

Workstream 1: Decisions made or in process by the Commission for Universal Health Care System with Unified Financing

- ✓ **Determined eligibility in order to establish foundation for other Phase 1 decision points**

- ✓ **For now,** the universal health care system with a uniform financing system should be designed to include those enrolled in:
  - ✓ Medicaid
  - ✓ Individual Market plans
  - ✓ Small Group Market plans
  - ✓ Fully Insured large group plans (including PEBB/SEBB)
  - ✓ The uninsured

- ✓ **Self-Funded Plans**
  - ✓ Will explore the possibility that self-insured employers could offer their employees the option to enroll in the system
  - ✓ Will explore the possibility that self-insured employers would be required to offer coverage equivalent to what the system provides or pay a tax to help fund the system

- ✓ **Medicare**
  - ✓ Will consider options to achieve coverage parity for Medicare enrollees

Tab 8

Washington State Health Care Authority

Workstream 1: Universal System Design: FTAC Update

Pam MacEwan, FTAC Liaison

FTAC's July meeting

Pam MacEwan,
FTAC Liaison

Considerations for Consumer Cost Sharing in a System of Universal Health Coverage

Presentation by Anya Rader Wallack & Hannah Turner, HMA

- Different types of cost sharing
- Cost sharing in other countries
- Overview of cost sharing in various Washington plans
- Experience developing universal plans in other states

FTAC discussion of cost sharing within universal system in Washington

- Goal is not to affect utilization, but to distribute costs in a fair and equitable way
- FTAC members are interested in learning the total costs of various benefit plans when applied to larger populations

FTAC's July meeting

David DiGiuseppe,
Alternate FTAC Liaison

Pam MacEwan,
FTAC Liaison

FTAC voted to explore engaging Milliman for the following analyses:

•**Step 1:** Estimate and compare the annualized total cost of care for three different benefit packages if provided to the entire population that would be covered by a uniform financing system: (1) Cascade Care Silver benefit coverage plus adult dental; (2) PEBB/SEBB benefit coverage plus adult dental and (3) Apple Health Medicaid managed care benefit design plus adult dental (i.e., excluding LTSS and other non-dental Medicaid FFS benefits). FTAC members will work with Milliman to provide further guidance about which PEBB/SEBB plan to model, as well as which benefits to include and exclude from Apple Health plans.

•**Step 2:** Model different cost sharing options, ranging from $0 to higher levels, possibly on a sliding scale based on a person's income. The details of this step will be further refined as the work progresses.

Tab 9

Washington State Health Care Authority

State Agency Report Outs

DOH, HCA, OIC and WABHE

Tab 10

Washington State Health Care Authority

Washington State Health Care Authority

Report to the Legislature

Universal Health Care Commission

Annual Report

Engrossed Second Substitute Senate Bill 5399; Section 2(8); Chapter 309; Laws of 2021

November 1, 2024

Table of contents

TO BE UPDATED

Glossary of abbreviations and acronyms

ACA	Affordable Care Act
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
Commission	Universal Health Care Commission
DHS	Oregon Department of Human Services
DOH	Department of Health
DSHS	Department of Social and Health Services
EHB	Essential health benefits
EPSTD	Early and periodic screening, diagnostic and treatment
ESI	Employer-sponsored insurance
ERISA	Employee Retirement Income Security Act of 1974
FFS	Fee-for-service
FPL	Federal poverty level
FTAC	Finance Technical Advisory Committee
GF - S	General Fund - State
HBE or Exchange	Washington Health Benefit Exchange
HCA	Health Care Authority
HCAC	Healthy California for All Commission
HCCTB	Health Care Cost Transparency Board
HHS	U.S. Department of Health and Human Services
HMA	Health Management Associates
IHS	Indian Health Service
IMD	Institutes of Mental Disease
LTSS	Long-term Services & Supports
MA	Medicare Advantage
MA-PD	Medicare Advantage & Medicare Part D
MCO	Managed care organization
OFM	Office of Financial Management
OIC	Office of the Insurance Commissioner

OPMA	Open Public Meetings Act
PEBB	Public Employees Benefits Board
PHE	Public health emergency
Plan	Oregon's Universal Health Plan
SEBB	School Employee Benefits Board
SSDI	Social Security Disability Insurance
Task Force	Oregon Joint Task Force on Universal Health Care
TPA	Third-party administrator
UHC Work Group	Universal Health Care Work Group
UMP	Uniform Medical Plan
FY	Fiscal year

Executive summary

This is the Universal Health Care Commission's (Commission) third annual report submitted by the Health Care Authority (HCA) to the Washington State Legislature and Governor as directed in Engrossed Second Substitute Senate Bill 5399 (E2SSB 5399), Section 2(8), and enacted as Chapter 309, Laws of 2021. This report builds upon the Commission's **2023 annual report** to the Legislature and Governor and describes the Commission's work from September 2023 through September 2024.[1] As directed by the Legislature, the Commission must:

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

In its third year, the Commission continued to structure meetings to target the Legislature's overarching goals that are both forward-looking and intended to improve upon the current health care system. Each meeting focused partly on further exploration and refinement of interim strategies to transition Washington to a universal health care system, and partly on the foundational design components of the future system.

The 2023 Legislature also provided General Fund - State (GF - S) funding for work required of HCA as specified in RCW 41.05.840 for fiscal years (FY) 2024 and 2025. The Commission was able to extend meetings from two hours to three hours and extend its Advisory Committee Meetings with this additional funding. This afforded the Commission additional time for planning, discussion and deliberation. Community members continue to engage with the Commission by attending meetings to provide encouragement and insightful feedback. Community members often share personal and sometimes painful experiences suffered in the current health care system. The community's continued input is instrumental to the Commission's work to ensure that all Washingtonians have equitable access to culturally appropriate and affordable health care.

Determining eligibility for the future health care system was selected by the Commission as the first topic of discussion for deliberation. The Commission's preliminary eligibility work to surface pathways to

[1] The Commission's roster can be found in Appendix A.

include Medicare, Medicaid, and employers in Washington's future health care system concluded in February. The Commission began work on its next design topic, benefits and services, in March.

This report details the Commission's work to build upon milestones established in its second year of work, including:

- Determining benefits and services for the future universal health care system. This work is informed by
    - Preliminary eligibility work to determine who will need coverage or supplemental coverage in the future universal health care system
    - Focus on including the three eligibility groups presenting the most significant challenges to federal authority:
        - Guidance from FTAC regarding options to include Medicare enrollees, those covered by large employers in self-funded plans, and Medicaid enrollees in Washington's universal health care system.
- Prioritizing transitional solutions that support goals of improving access to care and affordability, while also advancing the state's readiness to implement a universal health care system.
- Incorporating the evaluation of the Washington Health Trust proposal into the Commission and FTAC's work plan to the extent possible within the requested timeframe and available resources.

Developments: October through December 2023

The Commission's report to the Legislature due November 1, 2023, did not capture business from the Commission's October and December meetings. The following developments occurred over the October and December meetings and are captured in this report:

- Vote to approve the 2023 report to the Legislature
- Selection of three categories of transitional solutions to prioritize in 2024
- Assessment of the Finance Technical Advisory Committee (FTAC)'s guidance on ERISA
- Development and adoption of the 2024 workplan
- Interest in developing a community engagement process once the benefits and services for the new system are determined and within resources

Vote to approve the 2023 report to the Legislature

The Commission's work continues to be grounded in its goals to increase access to quality and affordable health care by streamlining access to coverage, and to reduce fragmentation of health care financing, unnecessary administrative costs, and health disparities. Building upon their work and baseline report in 2022, the Commission's 2023 report captured developments in the overall system design and strategies to transition the state to a universal health care system, including:

- Identifying the need for federal authority to achieve a state-based universal health care system supported by unified financing, and that pursuit of such authority is a multiyear endeavor.
- Assessing eligibility to determine who will need coverage or supplemental coverage in the future universal health care system including three eligibility groups presenting significant challenges to federal authority:
    - Adoption of guidance from FTAC regarding options to include Medicare enrollees in Washington's universal health care system
    - Initiating evaluation of options to include the Employee Retirement Income Security Act of 1974 (ERISA) covered individuals in Washington's universal health care system.
    - Identifying preliminary considerations for integration of Washington's Medicaid program.
- Refinement of transitional solutions that support goals of improving access to care and affordability and advance the state's readiness to implement a universal health care system.
- Adoption of a health equity framework with which the Commission will evaluate proposals for the universal health care system design and interim solution recommendations.
- Incorporation of the request regarding the Washington Health Trust proposal into the Commission and FTAC's work plan to the extent possible within the requested timeframe and available resources.

At the October 2023 meeting, the Commission members present voted unanimously to adopt the final report.

Prioritization of transitional solutions for 2024

In its **2023 annual report**, the Commission identified several categories of policy levers that can help improve the current health care system and advance the state's readiness to implement a universal health care system. At their December meeting, the Commission selected three of the categories to prioritize in 2024 (below). These categories were selected for prioritization based on their anticipated impact and with an understanding that implementing a universal health care system will require connecting, simplifying, and consolidating existing state programs.

Administrative simplification and increase provider participation in public programs	Maximizing, leveraging, and expanding current programs	Being addressed elsewhere (will be reported on in Commission meetings)
• Improve and align network adequacy standards • Simplify provider administrative requirements • Standardize claims adjudications • Motivate interest in preventative and primary care among providers	• Auto-enroll Medicaid to no-premium or lower-cost plans on the Exchange • Codify and fully fund Apple Health Expansion • Increase participation in the Medicare Savings Program • Consolidate and expand state purchasing	• Services not covered by the Balanced Billing Protection Act ○ Uncovered ambulance services • Provider rate regulation

The Commission also assessed how best to sequence and track this work. Members noted that advancements in state policy occur on a biennial basis per Washington's legislative sessions. Members agreed that developing a biennial timeline for each short-term policy will help track and demonstrate progress. This biennial timeline is detailed later in this report.

Assessment of FTAC's guidance on the Employee Retirement Income Security Act of 1974 (ERISA)

As directed by the Commission, FTAC provides guidance to the Commission in their development of a financially feasible model proposal to implement a universal health care system.[2] FTAC also is charged with investigating strategies to develop unified health care financing options for the Commission's consideration, and to provide pros and cons for each option.

The Commission selected eligibility as the first design component to develop and designated this topic as the primary area of focus for FTAC in 2023. After their assessment of options to include Medicare,[3] FTAC examined employer integration into Washington's universal system.

[2] The FTAC roster can be found in Appendix B.
[3] FTAC's assessment of Medicare can be found in the Commission's 2023 annual report to the legislature.

Employers as a predominant source of health care coverage

Like most Americans, most Washingtonians receive health care coverage through their employer, the genesis of which dates to World War II.[4] In 2022, the most recent year for which information is available, slightly more than 50 percent of Washingtonians received health care coverage through their employer,[5] making integration of employers especially important for the financial viability of Washington's universal health care system. However, federal law exempts very large employers from state regulation. While incorporating large employers will be a particularly difficult undertaking, without them, Washington's future health care system will be neither sustainable nor universal.

Overview of ERISA

Employer-sponsored health benefit plans can be fully insured or self-funded. If offering a fully insured plan, an employer pays premiums to a health insurer, and the insurer bears the financial risk. Under a self-funded plan, the employer bears the financial risk. States can regulate fully insured health benefit plans. The Employee Retirement Income Security Act of 1974 (ERISA), a federal statute, preempts state regulation of self-funded employer health benefit plans.[6]This preemption leaves states no authority to regulate self-funded plans.

While ERISA was not intended to be a health care statute, it is practically applied as one because of its preemption clause regarding state laws. Section 514(a) of ERISA preempts "all state laws insofar as they…relate to any employee benefit plan."

The broad ERISA preemption constrains Washington's ability to regulate employer benefits or achieve benefits parity between employer benefits and the future system. Pathways for capturing revenue to support the unified financing system, such as employer contributions, must be thoroughly examined.

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[4] With much of the labor force called to military service in the early 1940's, employers increased wages to compete for talent which economists predicted could lead to unmanageable inflation. In response, laws were passed[4] to freeze salaries and wages, indirectly incentivizing employers to compete for talent through other means, such as health care benefits. Publicly financed programs such as Medicare and Medicaid were born two decades later to address coverage for retirees and individuals in lower-paying jobs without health benefits. Employers continue to serve as the predominant source of health care coverage for employed Americans.

[5] https://www.kff.org/other/state-indicator/total-population/, https://www.shadac.org/state/wa

[6] Federal ERISA law sets minimum standards for health plans established and funded by employers to provide health care to their employees. Employer health plans can be "fully insured" or "self-funded". Both types of these health plans must comply with ERISA. However, the state's role varies based upon whether a plan is fully insured or self-funded. An employer that offers a fully insured health plan is paying for premiums to a health insurer and the insurer bears the financial risk of coverage. An employer that offers a self-funded health plan has chosen to bear the financial risk of health care services used by their employees, and often will contract with an outside entity to administer their health plan (called "third party administrators" or "TPAs"). The ERISA statute exempts these plans from most state regulations.

Examination of employer (ERISA) integration by other states

The Commission's strategic plan for 2023 included gathering information from other states and current programs in Washington. Other states, including Oregon and California, have examined prospects for ERISA integration for their respective and future state-based universal health care systems, details of which are summarized below. This section also includes efforts in Washington to achieve universal access to specific health benefits across all insurance markets while avoiding an ERISA challenge.

California

Established in 2019, the Healthy California for All Commission (HCAC)[7] was charged with developing a state-based health care delivery system that provides coverage and access for all Californians through a unified financing system, including, but not limited to, a single-payer system. HCAC's 2022 final report[8] examined the conflicts between unified financing proposals and ERISA law. HCAC noted that a state-based unified financing system cannot be achieved without federal support, but that unlike Medicare and Medicaid, "ERISA does not contain any waiver provisions to allow state-level health reform experimentation."

HCAC largely relied on a publication by Erin Fuse Brown and Elizabeth McCuskey, experts on ERISA law, for clarity on available options to integrate employers into California's single payer proposal.[9] Several states have introduced legislation for a unified health care financing system. Between 2010-19, more than 60 single-payer bills, including models designed to avoid ERISA preemption, were introduced in 21 state legislatures. While no universal health care plan has passed into law[10] and thus no ERISA models have been tested in court, the three ERISA models most advanced by legislators proposing single-payer bills over that period include:

1. Economic incentives – Use payroll taxes, income taxes, or both to raise revenue to pay for the universal plan.[11]
2. Provider regulations - Restrict providers participating in the universal plan from billing any third party other than the universal plan.

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[7] Senate Bill (SB) 104 (Chapter 67, Statutes of 2019). **https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB104**

[8] ERISA Considerations for Unified Financing. Key Design Considerations for a Unified Health Care Financing System in California. April 2022. **https://www.chhs.ca.gov/wp-content/uploads/2022/05/Key-Design-Considerations-for-a-Unified-Health-Care-System-in-California-Final-Report.pdf**

[9] Fuse Brown, E. C., & McCuskey, E. Y. (2019). Federalism, ERISA, and State Single-Payer Health Care. U. Pa. L. Rev., 168, 389. **https://papers .ssrn.com/sol3/papers.cfm?abstract_id=3395462**

[10] Excluding Vermont's abandoned **Green Mountain Care**.

[11] This approach is designed to incentivize employers/employees to drop employer coverage (or offer supplemental coverage for benefits not covered under the universal plan) to avoid having to contribute to both the universal plan and employer coverage.

3. Assignment/subrogation/secondary-payer provisions - Allow the universal plan to pay for services and then seek reimbursement from patients' employer-based health plans.[12]

Brown and McCuskey noted the courts' historical reading of the statutes do not conform with the original Congressional intent of ERISA. With paths to action by Congress and the courts on ERISA uncharted and unpredictable, the authors recommend states utilize a combination of economic incentives, provider regulation, and assignment/subrogation/ secondary-payer provisions. This approach may stand the greatest chance of avoiding ERISA preemption in states' efforts to integrate employers into a state-based universal plan/system.

Oregon

In their 2022 Final Report and proposed Universal Health Plan (Plan),[13] Oregon's Joint Task Force on Universal Health Care (Task Force) chose to combine several elements to consolidate employer and employee spending on health care into the Plan. These elements include:

(1) A payroll tax levied on all employers
(2) Restrictions on coverage duplication by state-regulated health insurers
(3) Regulation of participating provider reimbursement

Like California, Oregon enlisted the expertise of Brown and McCuskey to assess ERISA preemption issues in their Plan. Brown and McCuskey posited that when combined, the elements above would likely survive ERISA preemption. Additionally, this approach would still encourage employers and employees to shift to the Universal Health Plan.

Brown and McCuskey also offered that Oregon may be in good standing to integrate employers and employees and thus fund their Plan. An excerpt from Brown and McCuskey's analysis of this point is included below.

> "The Ninth Circuit Court of Appeals, which covers Oregon[14], has particularly strong precedent upholding states' ability to enforce payroll taxes to fund public health care programs. Ordinances passed by the cities of San Francisco and Seattle required employers to contribute to public programs that would cover their employees if the employers did not offer their own coverage. The Ninth Circuit held that these so-called "pay-or-play" laws created economic incentives for employers, but not to the point that they would effectively force the employer to start or stop

[12] Brown and McCuskey noted the courts' historical reading of the statutes that do not conform with the original Congressional intent of ERISA and offered four possible solutions at the congressional and courts levels to achieve goals for state-level unified financing and that avoid an ERISA challenge. The first three options are congressional amendments and include replacing the "any and all" preemption with floor preemption (which is used in other comparable health statutes), eliminating ERISA's "deemer clause" thus removing barriers around interference with self-funded employer-based plans under ERISA, and adding a statutory waiver provision to ERISA. The fourth proposed option is new jurisprudential interpretations that curtail the courts' vision of ERISA's preemption.

[13] Joint Task Force on Universal Health Care **Final Report and Recommendations**. Prepared by the Legislative Policy and Research Office. September 2022.

[14] The Ninth Circuit also covers Washington.

offering particular benefits.15 While these ordinances calculated the taxes on employers in part based on the employers' benefit choices, the Ninth Circuit held that the establishment of a public-program alternative preserved the employers' benefit choices enough to avoid preemption."

Programs in Washington that achieve universal access to specific benefits across all insurance markets while avoiding an ERISA challenge

In addition to examining efforts in other states, the Commission continues to gather information on relevant programs in Washington. The section below describes efforts in Washington to achieve universal access to specific health benefits across all insurance markets while avoiding an ERISA challenge.

The Washington Vaccine Association (WVA)

The WVA dictates how all health plans, including ERISA plans, administer vaccine benefits. Under the WVA, Washington universally purchases childhood vaccines for all children at volume discounted rates from the Centers for Disease Control (CDC) and delivers them to providers at no cost. Health insurers and Third-Party Administrators (TPAs) of self-funded plans reimburse the WVA for vaccines administered to privately insured children via "dosage-based assessments." The WVA then transfers funds to the Washington Department of Health for bulk vaccine purchases. Payers are assessed at rates lower than reimbursing the costs of private purchase of vaccines, which is a benefit to employers. All TPAs register with the WVA and there is no cost to patients.

The Partnership Access Line (PAL)

This program provides psychiatric consultations for certain providers caring for children and pregnant and postpartum individuals. PAL is insurance agnostic and was initially funded with Medicaid funds, despite some children being ineligible for Medicaid. The Washington Legislature developed an alternative funding mechanism. PAL is administered by the Washington Partnership Access Line (WAPAL) Fund which is a blend of Medicaid and assessment funding in proportion to the coverage source of people served. For privately insured children, there is a quarterly assessment on payers based on their covered lives, including ERISA plans. The assessment per covered life for fiscal year 2024 is seven cents per-member per-month (PMPM).

FTAC's discussion and guidance on ERISA options for Washington

The Commission's goal is to design a universal health care system that includes the employer-based market[16] without running afoul of ERISA preemption. Without the employer-based market, a plan is

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[15] ***Golden Gate Restaurant Association v. City and County of San Francisco***, 546 F.3d 639, 642 (9th Cir. 2008); ***ERISA Indus. Comm. v. City of Seattle, 840 Fed***. Appx. 248 (9th Cir. 2021).

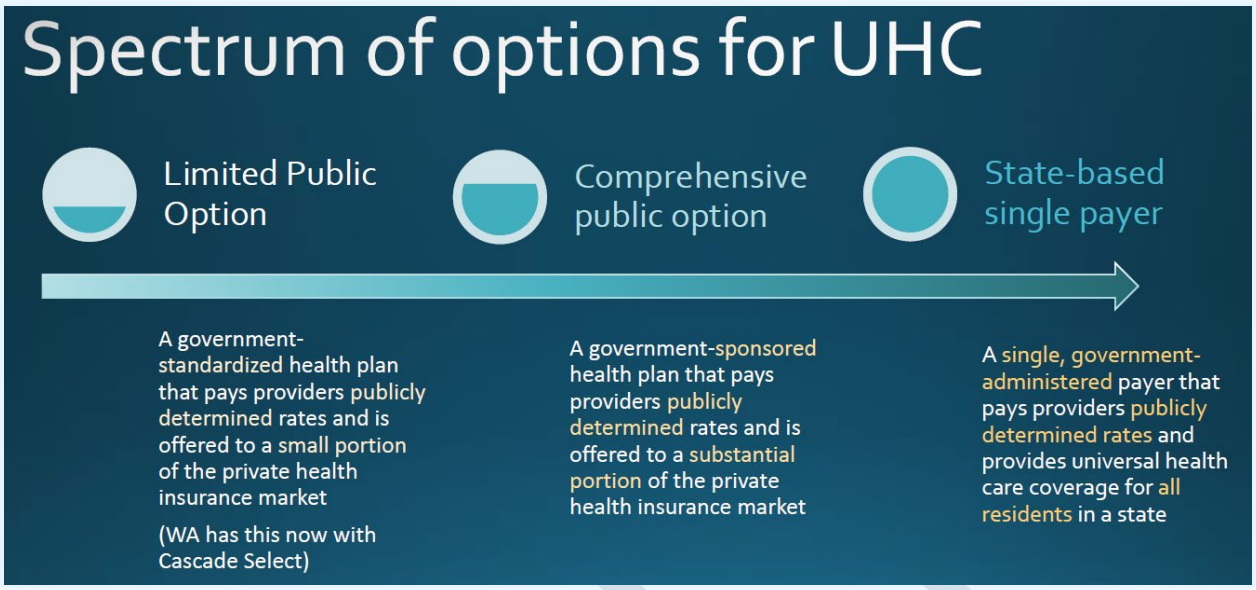
[16] Employer-based health care coverage accounts for 52 percent of Washingtonians' health coverage. Data are from OIC internal carrier enrollment reports (using 2021 reports), the American Community Survey's health insurance coverage tables, and Kaiser Family Foundation (KFF) self-insured data. The estimate of individuals in self-funded group health plans is based upon the calculation of known enrollment and national estimates from KFF annual employer health benefit survey and others. Health Coverage Estimates in Washington. 2021. OIC.

neither universal nor fiscally sustainable. The Commission directed FTAC to examine several components of ERISA in addition to surfacing options to include employers in Washington's future system. Approximately one-third of Washingtonians are covered by self-insured employer group plans. Therefore, any state laws passed by the Washington Legislature related to employer health benefits could be preempted by ERISA in relation to these plans. Additionally, with a belief that the ability to design and offer health care coverage helps differentiate an employer when competing for talent, large employers could fiercely defend ERISA. [17] Given these challenges, careful consideration of ERISA is necessary in the Commission's efforts to design a universal system with equitable benefits for all Washingtonians.

To better assess ERISA preemption issues and potential options, FTAC invited to their September meeting law professor Erin Fuse Brown, an ERISA expert who has advised both Oregon and California's universal health care efforts. Professor Fuse Brown described some potential options for designing a system that would achieve the policy goal of including as many employers as possible (including self-funded group plans) and would be more likely to survive a challenge brought under ERISA. [18] Professor Fuse Brown's presentation focused on the potential impact of ERISA on three models of a universal coverage system:

[17] With the understanding that large employers must be included and will be impacted by universal health care implementation, FTAC examined large employer perspectives on state-based universal health care.[17] With a belief that the ability to design and offer health care coverage helps differentiate in competition for talent, large employers would fiercely defend ERISA. Presentations by Bill Kramer and Erin Fuse Brown, JD, MPH, can be found in **FTAC's September meeting recording.** Some large employers may believe that they can do a better job for their employees than the government would and generally resist what they perceive to be intrusive government regulation, such as price-setting, while acknowledging that the costs associated with providing these benefits is increasing. However, large employers generally will accept government intervention in areas where no market exists or areas where the market has failed irreparably, e.g., drug price controls. This information also helped identify ways that universal health care could be made appealing or acceptable to large employers, including administrative simplicity, better cost control, and employers' participation in the universal health care system being optional.

[18] Professor Fuse Brown introduced her presentation with an overview of the Affordable Care Act (ACA) requirements of large employers. Employers with 50 or more full-time employees must offer affordable/minimum value medical coverage to their full-time employees and their dependents or face penalties. **https://www.irs.gov/affordable-care-act/employers/affordable-care-act-tax-provisions-for-large-employers**



Erin Fuse Brown's presentation to FTAC, September 14, 2023

Following this, FTAC discussed six options for how to include employers in Washington's universal health care system and avoid ERISA preemption. A summary of each option and FTAC's guidance to the Commission is included in the sections below.

Options to include ERISA in Washington's future universal health care system

Option 1. Federal waiver

There is no authority in the ERISA statute for a federal administration to waive any provisions in ERISA.[19] Therefore, only an act of Congress could eliminate or modify ERISA preemption, which would allow the Commission to design a system that includes universal enrollment and mandatory participation by employers and providers. As an example, the Affordable Care Act (ACA) included an "employer mandate" which requires all large employers to provide minimum essential coverage that is affordable, offers minimum value, or if it fails to do so, to pay a penalty for each full-time employee who receives a subsidy and purchases coverage on an exchange. This provision is not preempted by ERISA because the ACA is a co-equal federal law.[20]

FTAC determined that no waiver is possible and that pursuing an act of Congress is not feasible at this time. One FTAC member recommended that the Commission partner with Oregon and California to develop federal legislation to allow states' incorporation of large employers into their respective unified health care financing systems.

[19] Specifically, the U.S. Department of Labor, which enforces ERISA, has no authority to waive its provisions. This is unlike the waiver authorities granted to CMS under Medicare and Medicaid.
[20] The employer mandate can be waived by the federal government via a 1332 waiver.

Option 2. Optional employer participation

Option 2 would provide all employers (including self-funded and fully insured group plans) the option to pay for their employees to be covered by the universal health care system. Employers would also remain free to provide their own self-funded health coverage. Washington's universal health care system would need to be attractive enough (e.g., less cost to the employer, less administratively burdensome) that employers would forgo offering their self-funded plans. This option would not be vulnerable to a challenge under ERISA since it does not interfere with employers' freedom to offer their own plans.

However, if significant numbers of employers choose to continue offering their own plans, the universal system would not be able to recoup employer expenditures as part of its financing. Additionally, the universal system's risk pool could be adversely affected since employees in self-funded plans tend to be healthier compared to the rest of the population.

FTAC members agreed that optional employer participation should be included as one part of the design of the universal system. They also discussed ways to finance the universal system to address the problems raised by this option, as discussed below.

Option 3. Pay or play

Under this option, employers are given a choice: they can choose to pay a tax, such as payroll or revenue taxes, or they can continue to offer their own health coverage. If they continue to offer their own coverage, they are exempted from the tax specified above ("Pay or play"). This option is likely to survive an ERISA challenge but would be less likely to provide an incentive for employers to forgo offering their employer-based plans. FTAC members agreed that "pay or play" is an option that should be further explored for inclusion in the universal system design.

Option 3a. Meaningful alternative (comprehensive public option)

An extension of "pay or play," a meaningful alternative, or an alternative to employers' current coverage, could be structured as a comprehensive public option as outlined by Professor Fuse Brown. This option, more expansive than Washington's current public option program, Cascade Select,[21] is focused on designing a plan that offers an option for Washingtonians that employees could opt into. FTAC members expressed support for designing a meaningful alternative that could eventually attract employers, or even serve as a glide path to a single-payer system.

[21] In 2021, Washington state became the first in the nation to offer a public option health plan, known as Cascade Select, through its state-based marketplace. A Cascade Select plan has a standard benefit design with additional requirements, such as incorporating community quality standards, value-based purchasing, and ensuring aggregate limits on provider reimbursement. These standards help increase access to high-value care at a lower cost. Cascade Select is a multi-agency effort involving, HCA, the Exchange, and Office of the Insurance Commissioner. See HCA's **2022 report** to the Legislature.

Option 4. Provider regulation/incentives

This option incentivizes health care providers to accept patients covered by the universal system, on the assumption that as providers migrate toward a state-sponsored plan, employers would follow.[22] This may include provisions requiring providers to accept patients under the new system while also being able to contract with other plans, or to accept only such patients if they choose to accept them. These provisions do not raise any concerns under ERISA, although there may be other legal implications that were beyond the scope of FTAC's discussion.

Requiring providers to contract with the universal plan without the ability to contract with other plans may be preempted by ERISA. This option does not capture revenue and would therefore need to be combined with another option to create a sustainable system.

There was broad agreement among FTAC members that provider regulation and incentives must be part of the design of the universal system, not only to achieve universality in principle, but also to provide the state with levers to finance a universal system. Further analysis and discussion will be needed to expand upon this option to understand specific policy requirements, political hurdles, and cost impacts.

Option 5. Payroll tax on all employers

Under this option, a payroll tax would be levied on all employers. Employers would be free to continue to offer their own plans to their employees. However, there would be no exemption from the obligation to pay the tax for employers who offer their own plans (so-called "Pay *and* play").[23] Whether this option would be preempted by ERISA is uncertain and it would depend on whether the courts viewed the payroll tax to be "exorbitant."[24]

This option could be useful in obtaining the necessary funding for the universal system. Additionally, it is not tied directly to providing health care and may be less likely to trigger an ERISA challenge. In this context, the explicit focus is not on compelling employers to participate, but rather on obtaining funding for the system.[25] FTAC members were interested in further exploring what payroll tax structure could be considered palatable to employers and not "exorbitant" by the courts to obtain funding in the future.

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[22] This option also includes ways to reduce costs to make the system more financially sustainable, such as rate caps or rate regulation.

[23] Professor Fuse Brown offered the analogy that all homeowners are required to pay property taxes which fund public education. They are free to send their children to private schools but remain obligated to pay their property tax.

[24] There is no set threshold for when a tax becomes "exorbitant" for ERISA preemption purposes. However, in *New York State Conference of Blue Cross & Blue Shield Plans et al. V. Travelers Insurance Co. et al*, the Supreme Court found that a 24 percent surcharge on commercial insurance claims to hospitals was not exorbitant. **Travelers, 514 U.S. 645**.

[25] FTAC members were interested in further exploring what payroll tax structure could be considered palatable by employers and not "exorbitant" by the courts to obtain funding in the future.

Option 6. Combination of two or more options

The options discussed above are not mutually exclusive, and two or more could be combined. FTAC members agreed that a combination of Option 2, (giving employers the option to continue providing self-funded plans) coupled with Option 3a (providing a meaningful alternative to employers' current coverage) that incorporates components of Option 4 (strategies to require or incentivize provider participation while reducing costs), should be part of the universal system. This approach would offer a meaningful alternative to current employer-offered plans and would include strategies to address access and cost. However, it is not yet clear how best to capture employer contributions and incentivize them to permit their employees to enroll in the universal system.

Legal challenges may be inevitable and would create delays in implementing a universal system. A combination of approaches that includes options which are not likely to be challenged could ensure some aspects of reform could be implemented without delay. A final determination of the best policies to pursue will depend on future decisions about the structure of the universal health plan, and ERISA will need to be revisited once design of the system is further developed or completed.

The Commission's vote on ERISA

FTAC members produced for the Commission an ERISA Memo[26] capturing FTAC's discussion and recommendations. The Commission recognizes that unlike the waiver authorities granted to CMS under Medicare and Medicaid, there is no such authority in the ERISA statute. However, including employers and employees is necessary to ensure that Washington's universal health care system is indeed universal and fiscally sustainable.

One Commission member raised concerns about adopting FTAC's recommendations regarding a payroll tax on all employers regardless of whether they offer employees health benefits and referred to the aforementioned Ninth Circuit's upholding of San Francisco and Seattle's establishment of respective public-program alternatives that preserved employers' benefit choices enough to avoid preemption. Removing the option for employers to offset their current benefit expenditures against the tax could expose the state to more legal risks under ERISA.

As some Commission members noted, FTAC's guidance is not set in stone, but having this guidance allows the Commission to move forward in their design work. The Commission unanimously voted to take under advisement FTAC's guidance on ERISA in their universal health care system design work and to revisit the ERISA topic, including a potential employer payroll tax, as more design elements are developed.

Interest in developing a community engagement process once benefits and services are determined

The Commission remains dedicated to its mission to ensure that all Washingtonians have equitable access to culturally appropriate health care and universal coverage. Consistent input from members of the public continues to be a cornerstone of this work.

[26] FTAC ERISA memo can be found in Appendix C.

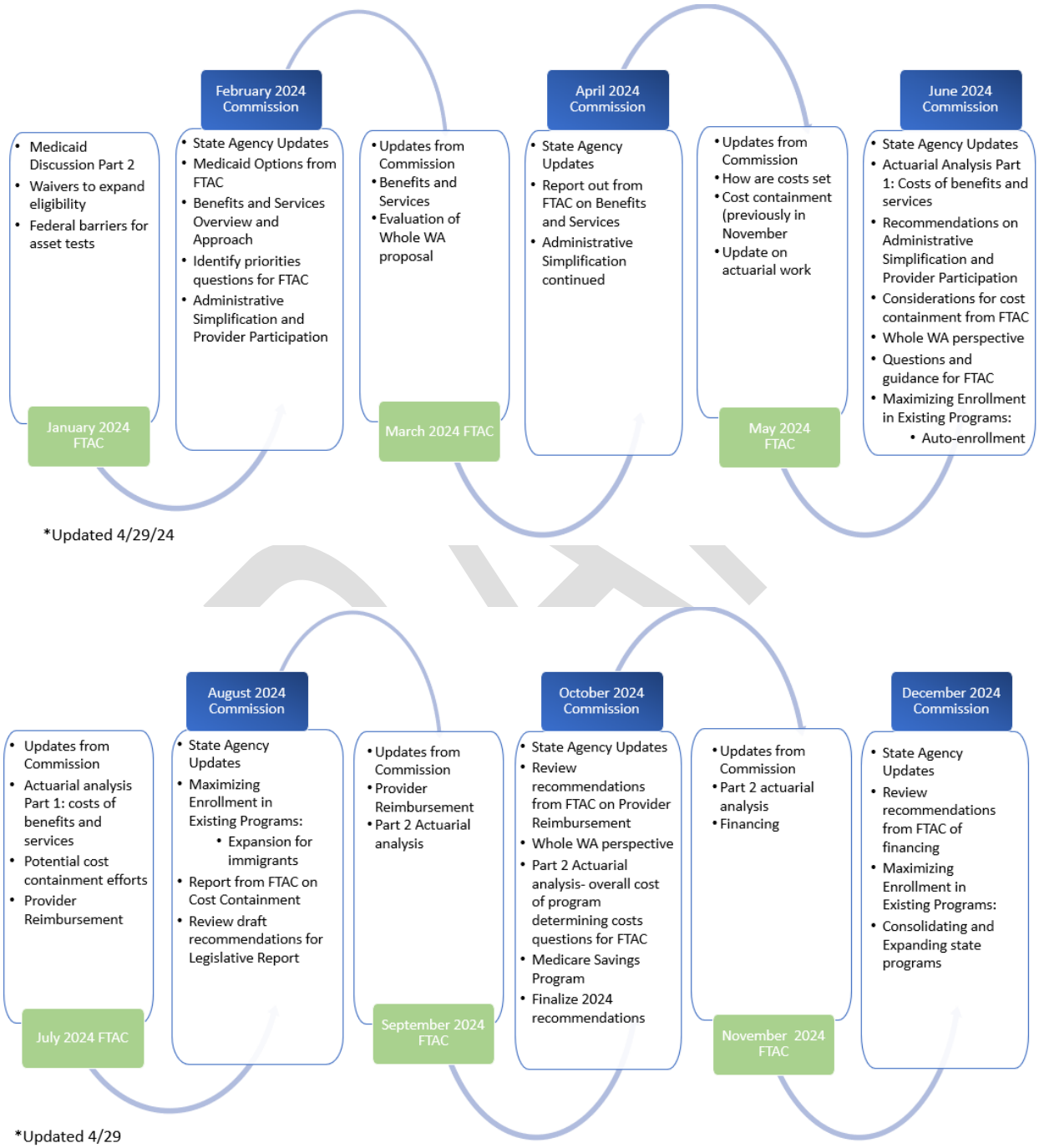
In addition to holding 15 minutes at each meeting to hear from members of the public, there was interest in hearing more from community members on specific design elements of Washington's universal health care system, particularly benefits and services. Commission members agreed that a community engagement process should be established once benefits and services are developed and within resources.

Process and approach to work in 2024

The Commission's third year remains focused on targeting the Legislature's overarching goals for the Commission, which are both forward looking in designing the new universal health care system, and reform-focused; intended to improve access, equity, quality, and affordability within the current health care system.

The Commission extended the length of meetings from two hours to three and continued to structure meetings to focus partly on the universal system design, and partly on interim strategies. The Commission discussed and agreed upon the topics for each of its meetings and each of FTAC's meetings for 2024. Figure 1 illustrates the Commission's workplan.

Figure 1


January 2024 FTAC
• Medicaid Discussion Part 2
• Waivers to expand eligibility
• Federal barriers for asset tests
February 2024 Commission
• State Agency Updates
• Medicaid Options from FTAC
• Benefits and Services Overview and Approach
• Identify priorities questions for FTAC
• Administrative Simplification and Provider Participation
March 2024 FTAC
• Updates from Commission
• Benefits and Services
• Evaluation of Whole WA proposal
April 2024 Commission
• State Agency Updates
• Report out from FTAC on Benefits and Services
• Administrative Simplification continued
May 2024 FTAC
• Updates from Commission
• How are costs set
• Cost containment (previously in November
• Update on actuarial work
June 2024 Commission
• State Agency Updates
• Actuarial Analysis Part 1: Costs of benefits and services
• Recommendations on Administrative Simplification and Provider Participation
• Considerations for cost containment from FTAC
• Whole WA perspective
• Questions and guidance for FTAC
• Maximizing Enrollment in Existing Programs:
• Auto-enrollment
*Updated 4/29/24
July 2024 FTAC
• Updates from Commission
• Actuarial analysis Part 1: costs of benefits and services
• Potential cost containment efforts
• Provider Reimbursement
August 2024 Commission
• State Agency Updates
• Maximizing Enrollment in Existing Programs:
• Expansion for immigrants
• Report from FTAC on Cost Containment
• Review draft recommendations for Legislative Report
September 2024 FTAC
• Updates from Commission
• Provider Reimbursement
• Part 2 Actuarial analysis
October 2024 Commission
• State Agency Updates
• Review recommendations from FTAC on Provider Reimbursement
• Whole WA perspective
• Part 2 Actuarial analysis- overall cost of program determining costs questions for FTAC
• Medicare Savings Program
• Finalize 2024 recommendations
November 2024 FTAC
• Updates from Commission
• Part 2 actuarial analysis
• Financing
December 2024 Commission
• State Agency Updates
• Review recommendations from FTAC of financing
• Maximizing Enrollment in Existing Programs:
• Consolidating and Expanding state programs
*Updated 4/29

Areas of focus

Universal system design: eligibility continued

The Legislature's goal is to include all state residents in Washington's future universal health care system. Achieving universal coverage requires determination of how to design a system where all Washington residents would be eligible for coverage. However, including various eligibility groups requires thorough examination of the regulatory and legal barriers and an understanding of each program.

Last year, the Commission assessed eligibility for Medicare enrollees and pathways to incorporate federal Medicare funds to support Washington's future system, details of which are included in the Commission's **2023 report**. Similar discussions regarding ways to include self-funded employers and their employees were discussed at the end of 2023 and are detailed earlier in this report.

Assessment of options to include Medicaid (Apple Health)

Medicaid was the Commission's last eligibility group to assess. Unlike Medicare and self-funded employer plans that fall under ERISA preemption (described above), Medicaid may present more feasible opportunities to include enrollees in a universal health care system supported by unified financing. Medicaid is administered by states and jointly financed by states and the federal government, and tools are made available to states to model and test Medicaid innovations. However, Medicaid presents significant challenges in terms of the comparative richness of benefits guaranteed to enrollees and the comparatively lower provider reimbursement rates.[27]

FTAC was directed by the Commission to examine options to include Medicaid enrollees in Washington's universal system. Details on the Commission's assessment of and FTAC's guidance on Medicaid options are highlighted below. This section also includes summaries of efforts in other states, including Oregon and California, to integrate Medicaid enrollees into their respective proposed universal health care systems.

Examination of Medicaid integration by other states

The Commission continues gathering information from other states' experiences designing a state-based universal health care system supported by unified financing. Below are summaries of examinations completed by Oregon and California related to Medicaid integration for their respective state-based universal health care systems.

Decisions by Oregon's Task Force regarding eligibility[28]

- The Task Force anticipated that Oregon's Plan will include a minimally burdensome mechanism to confirm Medicaid eligibility based on age, disability status, and/or income.
- Oregon's Plan may not cover benefits currently covered by Medicaid. These benefits could include

[27] Any increase in Medicaid provider reimbursement rates will be an additional cost to the state.
[28] Oregon Joint Task Force on Universal Health Care **Final Report**. 2022.

    - Benefits authorized through Oregon's 1115 demonstration waiver
    - Early and periodic screening, diagnostic and treatment (EPSTD) requirements for children
    - Nursing facility and home-and community-based long term care services.
- Individuals currently eligible for long-term services and supports (LTSS) will continue to receive these benefits through Medicaid and the Oregon Department of Human Services (DHS).[29] The Plan's Governance Board, in collaboration with DHS, will study how to further integrate LTSS in the future.

Key points in California's eligibility considerations[30]

- If the federal government allows federal Medicare and Medicaid funds and ACA premium subsidies to be redirected to the unified financing pool, then the state may be required to track Californians' eligibility information for one or more of those programs once the new system is implemented.
- Additional data reporting, (e.g., federally defined eligibility categories for public programs) could add administrative complexity and influence system design decisions.
- Achieving a unified financing system requires tradeoffs. For example, LTSS are covered by Medicaid but not covered by most other coverage sources. However, California seeks to ensure that its program is available to all residents, while mitigating the risk that non-residents would visit California to receive such benefits, thereby driving up costs.

FTAC's discussion and guidance on Medicaid options for Washington

At the direction of the Commission, FTAC examined pathways to address Washington Medicaid enrollees' eligibility in the new system. FTAC's Medicaid discussions spanned two meetings. [31 & 32] FTAC members produced a Medicaid Memo[33] for the Commission capturing FTAC's discussion and recommendations on options as outlined below.

Overview

Given the significant role Medicaid plays in Washington's health care system, the number of residents who rely on Medicaid as their source of health coverage, and the complexity of the program rules, Medicaid will be a foundational component of the Commission's design for the universal system. While Medicare and self-funded employer-sponsored plans present significant federal barriers, Medicaid may present a path forward.

Financing

Medicaid is administered by states and jointly financed by states and the federal government (the Centers for Medicare and Medicaid Services (CMS)). CMS provides rules and oversight of the program with which

[29] The Universal Health Plan would also cover some skilled nursing and home health care.
[30] **Key Design Considerations for a Unified Health Care Financing System in California**.
[31] FTAC November meeting **recording**.
[32] FTAC January meeting **recording**.
[33] FTAC Medicaid memo can be found in Appendix D.

states must comply to obtain federal matching dollars through the Federal Medical Assistance Percentage (FMAP)[34]. Washington's FMAP is 50 percent.

Eligible populations

To receive federal funding, states must cover certain mandatory populations in their Medicaid program:

- Children through age 18 in families with income below 138 percent of the federal poverty level (FPL)
- Certain parents or caretakers with very low income
- People who are pregnant and have income below 138 percent FPL
- Seniors and people with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program.

States may also receive federal Medicaid funds to cover additional populations:

- Adults and children in the groups listed above whose income exceeds the limits for mandatory coverage
- Seniors and people with disabilities not receiving SSI and with income below the poverty line
- "Medically needy" people and other people with higher income who need long-term services and supports[35]
- Non-disabled adults with income below 138 percent FPL, including those without children.

Benefits

There are 15 mandatory benefits states must provide and 28 optional services that states may elect to cover. All mandatory benefits must be provided to mandatory populations. Optional benefits may be provided to some, but not all, optional populations.

Apple Health provides all mandatory and all optional benefits depending upon the specific eligibility category. Compared to employer-based coverage, individual market coverage, and Medicare, Washington's Medicaid program offers the largest array of health benefits and long-term care and support services.

Cost-sharing

States may require cost-sharing payments form certain groups of Medicaid beneficiaries, such as enrollment fees, premiums, deductibles, coinsurance, or copayments, among others. The total cost of

[34] The FMAP is computed by a formula that considers the average per capita income for each state relative to the national average.

[35] Medically Needy is a phrase used to describe optional coverage for persons who do not quality for Categorically Needy Medicaid programs due to income.

premiums and other cost sharing incurred by all individuals in a Medicaid household may not exceed five percent of the family's income.[36]

Washington's Medicaid program does not have any premium or point-of-service cost-sharing requirements. Washington's Children's Health Insurance Program (CHIP), the Medicaid program for children in households with incomes greater than 210 percent FPL, imposes modest premiums.

Program administration

States began enrolling most of their Medicaid clients into comprehensive, risk-based managed care arrangements beginning in the 1990s. These efforts were designed to provide more predictability over future state budget costs; create greater accountability for health outcomes; provide support for systematic efforts to measure, report, and monitor performance, access, and quality; and improve care management and care coordination.

While the shift to managed care has increased budget predictability for states, the evidence about the impact of managed care on access to care and costs remains limited. More than 85 percent of Washington's Medicaid enrollees are enrolled in Medicaid Managed Care through five managed care organizations (MCOs).

Waivers

To include Medicaid enrollees in a universal financing system administered by the state, it will be necessary to change the relationship between the state and the federal government with respect to the implementation of the program. One way to make these changes is through waivers permitted by CMS.

States use 1115 waivers for broad authorities to carry out demonstrations or to test new ideas that further the goals of the Medicaid program. Examples of how states have used, or are currently using, 1115 waivers include:

- If federal law prevents a needed service or benefit:
    - Medicaid cannot pay for "Institutes of Mental Disease" (IMD) – inpatient mental health services at a designated facility – for patients aged 21-64.
    - Substance-use disorder (SUD) treatment may require an inpatient stay and states have used 1115 waivers to allow IMD services for SUD.
- If federal law prevents a desired population from being covered:

[36] Cost-sharing can be applied to the following populations: Pregnant women and infants with family income at or above 150 percent FPL, Qualified disabled and working individuals with income above 150 percent FPL, Disabled working individuals eligible under the Ticket to Work and Work Incentives Improvement Act of 1999, Disabled children eligible under the Family Opportunity Act (FOA), and medically needy individuals.

    - Medicaid cannot pay for health services for incarcerated individuals, except for inpatient hospitalization.
    - Some states' 1115 waivers provide pre- and post-release health services to incarcerated individuals, along with services to help the individual re-enter the community.
- If federal law prevents certain program administration elements:
    - Medicaid does not allow premiums except under certain circumstances. Some states have obtained 1115 waivers to apply premiums and co-pays to the ACA expansion population.

Section 1115 waivers are approved at the discretion of the Department of Health and Human Services Secretary, must be budget neutral to the federal government, and must further the goals of the Medicaid program. The approval process can take years for complex waivers, including a review by the Office of Management and Budget.

In evaluating a waiver proposal, CMS does not consider contingencies. For example, if a state applies for a Medicaid 1115 waiver that cross-references savings contingent on approval of a 1332 waiver related to Exchange coverage, CMS will not consider the projected savings from the 1332 waiver in determining whether the proposed 1115 waiver satisfies the budget neutrality requirement. Additionally, 1115 waivers require significant evaluation, reporting, and oversight to ensure program integrity and provide information about the impacts of the flexibilities they are testing.

States have used or are using 1115 waivers to expand Medicaid eligibility to limited populations including:

- Incarcerated individuals 30-90 days pre-release
- Post-partum individuals
- Individuals with SUD
- Individuals up to 200 percent FPL
- Caregivers of children and adults
- Seniors with mental health needs

State Plan Amendments vs. waivers

States also have sought Medicaid eligibility expansions through State Plan Amendments (SPA). Unlike a waiver, a SPA would require the state to put up additional matching dollars and provide mandatory or optional benefits depending on the population. In addition, a SPA would be a relatively permanent change to the state's Medicaid program that would not have to be renewed every five years (as a waiver does). A SPA creates an entitlement where all those who apply and enroll must be served all the benefits for that particular program.

On the other hand, a waiver would allow for different benefit packages to expanded populations, allow for premiums and co-pays, and potentially allow the state to explore other funding options.

One question the Commission asked FTAC to consider when examining Medicaid eligibility is whether states would need a waiver to eliminate the asset test for certain individuals who are in Classic Medicaid. In their discussions, FTAC uncovered that either a waiver or SPA could eliminate the asset test, offering

Arizona as an example of a state using a SPA, and California as an example of a state using an 1115 waiver.

Washington's experience with demonstration waivers

FTAC also examined Washington's experience applying for and obtaining waivers from CMS. States proposing a demonstration waiver must develop a concept paper describing the state's idea (often informed by legislative direction); data collection; completeness review; Tribal consultation; public comment and negotiations.

Large and complex waivers can take a significant amount of time to negotiate. For instance, Washington's recent 1115 renewal was negotiated for a year before some components were approved. In terms of the work required after waiver approval, there is a sizeable amount of program implementation activities and reporting requirements of the state.

Provider reimbursement and Medicaid rates

In response to the Commission's questions regarding lower Medicaid provider reimbursement rates, FTAC reviewed a **study** about the characteristics of primary care providers who do not accept Medicaid patients and some potential policy interventions.[37] The study found that in a survey of 1,731 primary care practices, 17 percent had no Medicaid revenue. Practices with no Medicaid revenue were on average smaller, independent, had a higher proportion of primary care physicians in the practice, were more likely to be urban, in low poverty areas, and in states that did not expanded Medicaid. Some of the common reasons identified for not accepting Medicaid included:

- Organizational capabilities and infrastructure
- Access to a large enough patient base outside of Medicaid
- Less advanced population health and IT capabilities
- Hesitancy among providers to accept patients who rely on Medicaid as their source of health coverage.

Some suggestions by the study author that the Commission might consider to increase the number of primary care providers accepting Medicaid include:

- Increase reimbursement rates (most difficult to implement)
- Focus efforts on smaller, independent practices and what they need (e.g., streamlining billing and administrative requirements, timelier claims processing, more technical assistance)
- Target efforts to practices residing in areas with more individuals receiving Medicaid may be more likely to move from the 0 percent to >0-10 percent category
- Harness power of consolidated systems and managed care.

Enrollment

One of the Commission's goals is to expand or repurpose existing infrastructure where possible to support the state's transition to and implementation of a universal health care system. Currently,

[37] Dr. Spivack, co-author of *Avoiding Medicaid: Characteristics Of Primary Care Practices With No Medicaid Revenue,* presented on the study at FTAC's November meeting. November FTAC meeting **recording**.

enrollment for both Apple Health (HCA's domain) and Qualified Health Plans, or QHPs (Exchange), is administered through a shared eligibility and enrollment system operated by the Exchange through Washingtonhealthplanfinder.com. Altogether, one out of four Washingtonians (over two million individuals) use this site to find health coverage and/or financial assistance to obtain health coverage.

This enrollment system interfaces with other data sources to offer an integrated and streamlined application process for Washingtonians seeking health care coverage. HCA and the Exchange share the mission to offer a streamlined process for Washington residents to search, shop, enroll and obtain financial assistance to obtain health coverage and continue work to strengthen the shared Medicaid and QHP enrollment process.

Washington will need to continue requiring a significant amount of eligibility information for Medicaid enrollees to obtain federal matching funds even with an 1115 waiver. However, the shared Medicaid/QHP enrollment platform establishes a strong foundation that can be leveraged to gather this information.

FTAC discussion

Additional questions/topics that will be important when considering how to incorporate Medicaid include:

- Given the lower Medicaid provider reimbursement rates relative to other payers like Medicare and commercial plans, at what rate will providers under the new system be paid, and how will continuing Medicaid providers be paid relative to the new rate?
- The effectiveness of MCOs in Medicaid compared to a different administrative model, e.g., Connecticut's transition from managed care to fee-for-service (FFS).
- Ensuring that the state can obtain all the information necessary to maintain federal match.
    - What needs to be done to make Washington's programs more seamlessly integrated, and what have other states done in this space?
- Accounting for supplemental payments that are made to hospitals and other providers that make Medicaid rates comparable to Medicare.
- When considering increasing Medicaid rates, it is important to avoid simply increasing to commercial rates because Medicare payments are generally adequate for cost-efficient hospitals. In addition, for some rural hospitals, Medicaid supplemental payments are available and result in payments that in some cases exceed commercial rates.
- An actuarial analysis may be helpful to better understand benefit levels and provider reimbursement rate adequacy.

In general, FTAC members expressed the need for additional information. There was continued discussion about how Medicaid rates would need to be addressed as part of the universal design but that it was not essential in the consideration of whether FTAC could make a recommendation about Medicaid as part of the universal system.[38]

[38] An FTAC member and Medicaid expert shared a memo with FTAC in advance of the January meeting outlining other considerations related to what is necessary in a waiver application to implement the future universal system design, which is included in Appendix D. FTAC felt it would be important to revisit this memo, considerations, and the questions above as the Commission continues to discuss the universal system design in the future.

Options to include Medicaid in Washington's future universal health care system

FTAC surfaced pathways to include Medicaid in the universal system. FTAC's recommendations provide guidance to allow design work to advance, though Medicaid will need to be revisited over the course of the Commission's design work for the larger system.

Washington's Medicaid program provides the richest benefit of any payer and could be something to aspire to for coverage under Washington's universal health care system (though members largely agreed that including LTSS as a covered benefit is not likely – at least not at the start). Administrative processes would need to change to integrate Medicaid into a unified financing system. FTAC members agreed that both 1115 waivers and SPAs should be considered as tools to achieve this and other policy goals.

First, FTAC recommended that the Commission consider pursuing Medicaid waivers and SPAs as needed to include Medicaid enrollees in Washington's universal health care system, details of which will need to be developed once benefits and services and other design elements are determined.

Access to care issues persist for Medicaid patients, though it would be a mistake to recommend targeted provider rate increases without first understanding where the issues are and why, and potential unintended consequences of increasing rates. Medicaid payments are significantly lower than Medicare and commercial rates, though it is less clear whether increasing payments for certain practices will result in increased access for Medicaid patients. FTAC members recommended that the Commission pursue analysis to understand Medicaid provider reimbursement in Washington and how it impacts provider willingness to accept Medicaid enrollees.

Administrative complexity has been cited by providers as a barrier to participating in Medicaid. FTAC recommended that in their transitional solutions work, the Commission consider paths to simplify administration for the Medicaid program which may help motivate provider participation in Medicaid.

Finally, FTAC members felt strongly that given Medicaid's significant role in Washington's health care coverage and the greater feasibility[39] of including Medicaid in Washington's unified financing system, that Medicaid should be considered and revisited alongside decision making for other larger system design elements.

The Commission's discussion on Medicaid

FTAC's guidance was provided to the Commission at their February meeting.[40] The Commission agreed with FTAC that benefits and services will need to be determined before more work can be done on the finer points of how to include Medicaid. The Commission also agreed that continuously revisiting Medicaid in conjunction with determining other design elements will be important, considering the nuances of the Medicaid program, e.g., lower provider reimbursement, richer benefits package, etc.

[39] Compared to the feasibility of including Medicare and self-funded employers.
[40] FTAC Medicaid Memo can be found in Appendix D.

Ongoing transitional solutions work

In addition to designing Washington's future universal system, the Commission is charged with implementing immediate and impactful changes in Washington's current health care system to increase access to quality, affordable health care by:

- Streamlining access to coverage.
- Reducing fragmentation of health care financing across multiple public and private health insurance entities.
- Reducing unnecessary administrative costs.
- Reducing health disparities.
- Establishing mechanisms to expeditiously link residents with their chosen providers.

Updates on the Washington Health trust analysis request

In 2023, the Commission received a request from members of the Legislature to conduct an analysis of the Washington Health Trust (SB 5335) as introduced in the 2023 legislative session. SB 5335 proposes the creation of the Washington Health Trust (Trust) within the Washington Department of Health to provide coverage for a set of essential health benefits (EHB) to all Washington residents.

Last year, the Commission voted for the request's incorporation into the Commission and FTAC's work plan to the extent possible within the requested timeframe and available resources. Per the request, the Commission invited Whole Washington to present at several meetings[41 & 42 & 43] to examine areas of alignment between the Commission and those proposed in the Trust. As required, the Commission's report[44] was submitted to the Legislature.[45] Highlights of the report include:

- Assessment of whether elements of the Trust proposal align with the goals and planned activities of the Commission, including
    - SB 5335's approach to eligibility and enrollment
    - SB 5335's approach to benefits and services

Beginning in 2025, and until the analysis is complete, each of the Commission's legislative reports will summarize SB 5335 and how it would address key design components of a universal system. The Commission will continue to engage with Whole Washington members throughout the analysis and report development process.

[41] August Commission meeting **recording.**
[42] December Commission meeting **recording.**
[43] March FTAC meeting recording.
[44] Washington Health Trust (SB 5335) analysis report
[45] The Commission voted to adopt the Whole Washington report at their June meeting.

Benefits and services

After eligibility, the Commission selected benefits and services as the next design component to examine.[46] One of the goals in designing a state-based universal health care system is to ensure that all Washingtonians receive comparable health care benefits and equitable access to care.

Currently, there are varying levels of benefits across coverage sources and even within the same coverage source. For example, unlike Medicaid, Medicare does not cover vision, hearing, dental services, LTSS, or certain drugs. However, individuals dually eligible for Medicare and Medicaid[47] could receive these benefits as supplemental coverage through Medicaid. Additionally, private coverage sources can vary. Health plans offered on Washington's Exchange, even metal tiers offered by the same health carrier, can vary in their cost-sharing requirements.

The challenges in integrating Medicare, self-funded employer plans, and Medicaid into Washington's future system, particularly at the outset, raise concerns regarding the quality and equity implications of benefits differing among coverage sources. When designing benefits for a new system, it is important to consider which benefits may help advance quality and equity goals, such as social support services and culturally responsive care and services. Such services may increase costs to the state. However, further perpetuating such fragmentation has had considerable cost implications both in terms of financial costs to the state and consumers, and in terms of years of healthy life lost for many Washingtonians. The Commission seeks to design a system that prioritizes prevention and equitable access to appropriate care, which may in the long term reduce overall costs.

Prior analyses

In its early stages of benefit design, the Commission has looked to work that already has been done in this arena. The Universal Health Care Work Group (Work Group), predecessor to the Commission, recommended that the ACA-mandated categories of services defined in the Essential Health Benefits (EHB) be provided with the possibility of additional service categories, including vision. Among the outstanding considerations was whether other benefits not included in the EHB, such as LTSS, would be provided. Other states, including California and Vermont, also modeled their respective universal health care benefits after the EHB. Whole Washington also selected the EHB for SB 5335's benefit design, details of which will be covered later in this section. Conversely, Oregon selected their state's public employee/school employee plan for the basis of their state-based universal health plan.

The Commission sought to compare covered benefits under some of the richer benefits packages under Medicaid and PEBB/SEBB's Uniform Medical Plan (UMP). However, creating a tool to do so has proved challenging. For example, Medicaid provides benefits that are required by CMS to obtain federal matching dollars, and fully insured market plans must provide state-mandated benefits not required in the EHB.

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[46] In their **baseline report**, the Commission identified the following design components of a universal health care system: cost containment, coverage and benefits, eligibility, enrollment, financing, governance, infrastructure, and provider participation and reimbursement.

[47] Lower income Medicare enrollees may qualify for supplemental coverage and benefits through Medicaid.

Given these challenges, the Commission enlisted FTAC's expertise on the approach for an actuarial analysis to compare benefits across Medicaid, UMP, and Washington's EHB.

As FTAC noted, there will be a high degree of overlap among the three, and general benefit design may not have much impact on the total cost of care. As such, the issues of interest for the actuarial analysis will be around the scope of services, allowed quantities of services (duration), and cost-sharing. FTAC agreed that the Commission should consider the following for an actuarial analysis:

- Begin with UMP or EHB and layer on additional benefits to be modeled.
- Cascade Care (standard qualified health plans on the Exchange) could serve as the starting point for the EHB to understand the cost-sharing impact on premiums across the Bronze, Silver, and Gold metal levels, and then assess whether Medicaid and UMP cover anything different.

Other dimensions of benefit design should be considered in future discussions, including prior authorization, supplemental benefits outside of the universal plan's covered benefits, point of service cost sharing, and a standardized provider reimbursement rate.

Conclusion

Building upon previous years' work, the Commission continued to explore and refine system design, focusing largely on eligibility. The Commission examined options to cover three eligibilty groups that pose significant challenges. The Commission's work was informed by FTAC analyses. Other states, notably Oregon and California, generously shared their experiences and lessons learned. Throughout the process, the Commission remained committed to creating a system that provides equitable and culturally appropriate health care for all Washingtonians.

The Commission continued its charge to pursue near-term improvements to the current health care delivery system. With an eye toward improvements that also could be part of a universal system, the Commission considered areas of focus for adminstrative simplification, notably reform to the prior authorization.

Finally, the Commission and FTAC contributed to the Legislature's consideration of the Washington Health Trust proposal, submitting an initial analysis report to lawmakers.

Appendix materials

The appendices to this report are as follows:

- Appendix A: Commission roster
- Appendix B: FTAC roster
- Appendix C: FTAC ERISA memo to the Commission
- Appendix D: FTAC Medicaid memo to the Commission

Appendix A: Commission roster

View the **Commission's roster of members** on HCA's web site.

Appendix B: FTAC roster

View the FTAC roster of members on HCA's website.

Appendix C: FTAC ERISA memo to the Commission

Link to ERISA memo here

Appendix D: FTAC Medicaid memo to the Commission

Link to Medicaid memo here

Washington State Health Care Authority

Thank you for attending the Universal Health Care Commission meeting!