Universal Health Care Commission meeting

October 10, 2024

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Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Universal Health Care Commission

Agenda

Thursday, October 10, 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 and call to order	1	Vicki Lowe, Chair
2:05-2:08 (3 min)	Roll call		Mary Franzen, HCA
2:08-2:10 (2 min)	Approval of Meeting Summary from 08/15/2024	2	Vicki Lowe, Chair
2:10-2:25 (15 min)	Public comment	3	Mary Franzen, HCA
2:25-2:30 (5 min)	Project status update	4	Liz Arjun, Health Management Associates
2:30-2:45 (15 min)	FTAC updates and discussion of cost sharing principles	5	Pam MacEwan, FTAC Liaison Mary Franzen, HCA
2:45–2:50 (5 min)	Approval of 2024 Annual Report to the Legislature	6	Vicki Lowe, Chair
2:50-3:00 (10 min)	State agency report outs	7	Commission members
3:00–3:10 (10 min)	Apple Health Expansion update and discussion • Potential vote	8	Rebecca Carrell, Deputy Division Director, Medicaid Programs, Washington State Health Care Authority

Continued on page 2

3:10- 3:50 (40 min)	OIC Health Care Affordability Report and discussion	9	Jane Beyer, Senior Health Policy Advisor Washington State Office of the Insurance Commissioner
3:50 – 3:55 (5 min)	BREAK		
3:55-4:30 (35 min)	Prior authorization focus area(s) and discussion	10	Liz Arjun and Gary Cohen Health Management Associates
4:30–5:00 (30 min)	Next steps discussion	11	Liz Arjun and Gary Cohen Health Management Associates
5:00	Adjournment		Vicki Lowe, Chair

Tab 2

Washington State Health Care Authority

Universal Health Care Commission meeting summary

August 15, 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
Joan Altman
Representative Joe Schmick
Representative Marcus Riccelli
Mohamed Shidane

Members absent

Senator Ann Rivers
Charles Chima
Dave Iseminger
Senator Emily Randall
Jane Beyer
Nicole Gomez
Omar Santana-Gomez
Stella Vasquez

Call to order

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

Agenda items

Welcoming remarks

Chair Lowe began with a land acknowledgement and welcomed members to the nineteenth meeting. She shared Estell Williams has resigned from the Universal Health Care Commission due to personal reasons. Chair Lowe then provided an overview of the meeting objectives.

Meeting summary review from the previous meeting

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

Presentation: Apple Health Expansion

Becky Carrell, Deputy Director, Medicaid Programs Division, Washington State Health Care Authority, updated the Commission about the state's recent experience with Apple Health Expansion. Under Apple Health Expansion, the state implemented several Apple Health (Medicaid) programs that are available to individuals not qualified for federally subsidized coverage because of their immigration status. The program was launched on July 1, 2024 with a limited pool of funding. Becky noted there are more immigrant community members who would enroll in this program than funding can support.

Apple Health Expansion was designed to be as similar as possible to Apple Health Integrated Managed Care and to provide coverage to as many eligible people as possible. When possible, Washington drew down federal match to maximize funding.

Becky provided an overview of timing and enrollment: The state began accepting applications on June 20, 2024. On June 21, the enrollment cap was reached for individuals aged 19-64. On July 3, the cap was reached for individuals over age 65. As of July 3, total enrollment in Apple Health Expansion was 11,936 individuals in 34 of Washington's 39 counties.

Becky noted that the temporary community advisory committee that helped guide the work will be transitioned into a permanent advisory committee.

Chair Lowe noted that the Commission has supported Apple Health Expansion efforts in the past.

In response to a question from a Commission member, Becky shared that approximately 5,000 eligible individuals were denied coverage due to limited enrollment. She said that in the coming year HCA will work closely with managed care organizations and community-based organization to continue outreach and help individuals enroll as space becomes available.

Presentations: Prior Authorization

Gary Cohen of Health Management Associates (HMA) began the discussion by noting that the Commission has considered several areas of administrative simplification, including prior authorization. The Commission will make recommendations on that topic in the future.

Michelle Long, a senior health policy analyst with KFF, then presented *Prior Authorization: The Balancing Act of Cost Containment and Access to Care*. She defined prior authorization as pre-approval from a health plan for services and drugs to be covered. She noted that it's a commonly used tool to promote safe, evidence-based, cost-efficient care.

She also acknowledged that perspectives differ. Health plans may see prior authorization as an effective way to prevent unnecessary or low-value services, while providers often see prior authorization as administratively burdensome. Patients, meanwhile, may face delays or denials for needed care.

Michelle shared results from a 2023 KFF survey that showed patients who reported prior authorization problems are more likely to experience serious consequences, such as delayed care, a decline in their health, or higher than expected cost for care. In addition, certain individuals – including those covered by Medicaid and those with more than 10 visits per year – are more likely to experience prior authorization problems. On a system level, the overall effect of prior authorization is unclear, and it may increase total costs for certain patients.

She described a federal regulation that went into effect in January 2024: Advancing Interoperability and Improving Prior Authorization Processes. The regulation is designed to increase interoperability, improve transparency, and shorten timelines in programs overseen by CMS. It also creates an avenue for patients to access prior authorization information electronically. The regulation does not apply to prescription drugs, most employer plans, decision making processes, or information related to denials.

At a state level, she described various efforts around the country to regulate prior authorization, with goals such as standardization, automation, credentialing and "gold carding," or improving provider processes. Considerations for states include savings for patients and/or payers, health equity, compliance and enforcement, and how to measure success.

Next, Joyce Brake, Policy and Rules Manager at the Office of the Insurance Commissioner, spoke about prior authorization modernization in Washington. She spoke of prior authorization prohibitions currently in place in Washington, such as certain substance use disorder treatments and emergency treatments.

Joyce described the state's prior authorization modernization efforts, which began in 2023 and sought to improve outcomes by preventing delays in care and to reduce administrative burdens on providers. HB 1357 shortens the turnaround time for prior authorization requests and applies to services and prescription drugs, with timelines differing by electronic and non-electronic submission.

Washington's modernization efforts require process automation through an application programming interface (API) by 2026 for health care services and by 2027 for prescription drugs.

Discussion: Prior Authorization

Gary Cohen, Health Management Associates (HMA)

Commission members were asked what else they would like to know about prior authorization and if there is a specific approach the Commission might recommend. Further, Gary posed the question of what, if any, role prior authorization should play in a universal system and whether the Commission would like to make any recommendations about improving the prior authorization process.

Mohamed Shidane asked when the Commission should make such decisions and begin the design process that fits the needs of people in Washington. Gary responded that the Commission could consider prior authorization as a shorter-term goal, as well as part of a universal system. He also noted that Commission should address the role, if any, that health plans could play. Chair Lowe noted that prior authorization is not used as extensively in the fee-for-service environment.

Bidisha Mandal asked for more information about gold carding and who would qualify. Gary responded that gold carding could be based on individual providers' track record of approvals, as well as on the procedure itself.

Rep. Schmick asked about defining value for the patient and the health plan. Considerations include saving money and making sure patients get the right care. Additional questions about who makes the determination and oversight were added.

Rep. Riccelli noted that electronic submissions could reduce the number of denials, since many denials are the result of incomplete information in the submission. Another area of interest is the gap between federal reform efforts and ongoing work in Washington.

The Commission did not make a recommendation regarding prior authorization in part because members wanted to hear input from Commission members who were absent.

Public comment

Rep. Riccelli noted that the House Health Care and Wellness Committee is holding a remote Work Session on September 23, 2024, from 10:30am-12pm, and that there will also be an opportunity for public comment during the session.

Kathryn Lewandowsky, Vice Chair of Whole Washington, thanked the Commission for including PEBB, SEBB, and small markets in the universal health care conversation. Kathryn also shared that in a recent Whole Washington Town Hall, small business owners reported they want to provide healthcare to their employees but are unable to due to cost. Kathryn hopes the commission will consider small business owners in the unified financing plan.

John Godfrey, program manager at the Washington Community Action Network, spoke in support of Kathryn's comments noting that as a small business owner himself, health insurance for his staff is a significant and rising cost. John also stated that standardizing and drastically minimizing prior authorization should be an important goal for our state. John spoke in support of the Commission discussion around expanding Apple Health. He also expressed concern about the pace of designing a universal health care system and questioned when the overall design, including a unified financing system, would be on the Commission's agenda.

Discussion: Apple Health Expansion

Liz Arjun, HMA

Liz reminded everyone that supporting Apple Health Expansion was a key piece of this Commission's first set of recommendations. She shared that the Health Care Authority is developing a decision package to add more slots next year or over the course of the biennium. Commission members were asked if there were any questions or comments about the decision package or Apple Health Expansion generally. Joan Altman commented that an outstanding need has been demonstrated in the rollout of the program and noted that to the extent that the Commission has already acted to support the program, there is nothing from today's presentation that would change that view for her. Chair Lowe spoke in support of Joan's comments.

Liz shared draft language for the Commission to make a motion or revise: "The Commission continue its support for the Apple Health expansion program, including recommending additional funding for this program." Joan noted that the Commission has not yet seen HCA's decision package or funding request details. Rep. Schmick spoke in opposition of expanding the program, commenting that we are severely underpaying providers. In response to a potential friendly amendment from Chair Lowe, Rep. Schmick declined. Bidisha Mandal asked what the additional funding for the program would bring and whether it would bring funding for providers as well. In response, Mandy Weeks-Green, Board and Commission Director at HCA, commented that the additional funding would go to pay for premium coverage for those programs. Joan Altman concurred, commenting that in her understanding, the package being contemplated would increase the number of spots for people to come off the waitlist in successive years. Joan believed this did not include funding for Medicaid providers, but that there is a separate bill vehicle that has been looking to do that.

As a quorum was not present, a vote could not be taken.

FTAC Updates

Pam MacEwan, FTAC Liaison

Pam updated the Commission on the previous FTAC meeting, including a brief overview of consumer cost sharing within a system of universal health coverage. FTAC voted to explore engaging Milliman for two analyses on this topic: (1) Estimate and compare the annualized total cost of care for three different benefit packages if provided to the select population that would be covered by a uniform financing system; (2) Model different cost sharing options from $0 to higher levels. Chair Lowe indicated it would be helpful to see cost sharing at the premium level rather than at point of service.

Rep. Riccelli noted there was legislation last year to standardize plans on the exchange and one of the opposition comments was that the legislation was trying to create universal health care. He spoke to the momentum a significant policy intervention like standardized plans could bring for the Commission's work. Joan Altman added that the standardized plans on the exchange have consistently lower cost sharing than non-standardized plans.

Pam indicated that FTAC needs latitude in how they guide Milliman on these analyses. Chair Lowe acknowledged FTAC's expertise in this area and the Commission's appreciation.

State Agency Report Outs

DOH, HCA, OIC, and WAHBE

DOH: Not present.

HCA: No major updates to report.

OIC: Not present.

WAHBE: WAHBE launched the qualified health plan expansion in early 2024. A report on the populations reached will be available in Fall 2024. With Cascade Care, the agency is revisiting legislation that would standardize plans in the market. The agency is also looking at affordability issues given federal subsidies may expire in calendar year 2025, with more to come on this topic. Finally, the agency is working on a legislatively directed study on automatically enrolling people transitioning from Medicaid to individual market coverage.

Annual report to the legislature

Chair Lowe reminded Commission members that a draft of the annual report that's due to the legislature Nov. 1 was included in the meeting packet. Staff requested Commission comments in writing by Friday. Aug. 30.

Adjournment

Meeting adjourned at 4:50 p.m.

Next meeting

October 10, 2024
Meeting to be held on Zoom and in-person at HCA.
2–5 p.m.

Tab 3

Washington State Health Care Authority

Universal Health Care Commission
Written Comments

Received From 8/16/2024

Written Comments Submitted by Email

Ronnie Shure, HCFA WA....1
Cris Currie....2
Andre Stackhouse, Whole Washington....3

Additional Comments Received at the August Commission Meeting

- The Zoom video recording is available for viewing here: https://youtu.be/xUdQZoBk_18?si=y-bImpCeOnMepwzZ

HEALTH CARE FOR ALL – WASHINGTON
hcfawa.org

August 29, 2024

TO: Vicki Lowe, Chair, and
Members of the Universal Health Care Commission

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

RE: Comments/Suggestion on the UHCC Draft 2024 Report

On behalf of Health Care For All Washington (HCFA-WA), I want to thank you for providing us with the opportunity to make the following recommendations for amendment/additions to the Universal Health Care Commission's (UHCC) draft 2024 annual report.

E2SSB 5399, Section 2, directs the UHCC annual report to:

> *"……detail the work of the commission, the opportunities identified to advance the goals under subsection (7) of this section, which, if any, of the opportunities a state agency is implementing, which, if any, opportunities should be pursued with legislative policy or fiscal authority, and which opportunities have been identified as beneficial, but lack federal authority to implement."…..This includes "Recommendations for coverage expansions to be implemented prior to and consistent with a universal health care system, including potential funding source(s)…"*

The draft of the UHCC 2024 report provided for review includes an update on the UHCC's and the Financial Technical Advisory Committee's (FTAC) work to date, but the draft report does NOT, in the main, provide recommendations / guidance for the Governor, state agencies, or the state Legislature for actions to be taken by them in 2025.

HCFA-WA's suggestions/recommendations, therefore, are focused on for those bodies to consider for action in the 2025 session:

1. **Apple Health Expansion**

   The legislature and/or Governor should provide additional funding to support the Apple Health Expansion program

At their April 15, 2024 meeting, the majority of the UHCC members present voted in support of the following motion: **"The Commission continue its support for the Apple Health expansion program, including recommending additional funding for this program."**

HCFA-WA recommends including this motion in the UHCC's 2024 report. HCFA-WA further recommends that the Apple Health Expansion program be codified in Chapter 74.09 RCW and that the UHCC's 2024 report include this recommendation.

2. Expanding Access to Medicaid for low-income individuals on Medicare

The 2024 Supplemental Operating Budget (ESSB 5950, Section 208 (10) – CN ABD Expansion) - funded a study, being done by DSHS Research and Data Analysis Division (RDA), to provide fiscal information to the Legislature increasing the income level for low-income individuals on Medicare for eligibility for Medicaid. Currently that eligibility is limited to those with income of 75% federal poverty level (FPL) or less. The study will provide information on the cost of increasing that eligibility in increments from 80% FPL to 100% FPL. In addition, the study will provide fiscal information on the cost of doing away with the asset limits at all levels, from 75% FPL to 100% FPL.

HCFA-WA asks that **The Commission recommends in their 2024 report that the 2025 legislature take action on one, or more, of the options that will be provided by the study, to expand access to Medicaid for low-income Medicare recipients.**

This is consistent with the language included in last year's UHCC reports transitional solutions list of: "Increase participation in the Medicare Saving Program"

3. Consolidation of PEBB/SEBB for Health Care Purchasing

The 2024 Supplemental Operating Budget (ESSB 5950, Section 212(8) PEBB/SEBB Consolidation) provided funding for an updated study at the Health Care Authority, on the cost benefits of consolidating the PEBB and SEBB programs, for the purchasing of health care coverage.

HCFA-WA asks that **the Commission recommends in their 2024 report that the Governor and Legislature adopt recommendations from this PEBB/SEBB study** during the 2025 legislative session.

This is consistent with the UHCC's a transitional recommendation in last year's report on "Consolidate and expand (health care) state purchasing."

4. **Create and fund a Medicaid to Washington Health Benefit Exchange enrollment bridge**

   The 2024 Supplemental Operating Budget (ESSB 5950, Section 214 (9) Medicaid/WHBE Enrollment Bridge) provided funding for a study at the Washington Health Benefit Exchange (WHBE) to provide recommendations to the legislature for ways to create a "bridge" to better transition individuals losing Medicaid coverage, to no cost and/or low-cost health plans at the WHBE.

   HCFA-WA asks that **the Commission recommends in their 2024 report that the Governor and Legislature adopt and fund the recommendation from this study to create a Medicaid to WHBE enrollment bridge.**

This is consistent with the UHCC's transitional solution , in last year's report, to "Auto-enroll former Medicaid recipients into no-premium or lower-cost plans on the Exchange."

5. Formal Decision-Making Process

HCFA-WA recommends that the UHCC 2024 report include information regarding the adoption of a formal, recorded decision making process for all UHCC and FTAC meetings, and all decisions made in those meetings. In addition, HCFA-WA recommends that more time in each UHCC and FTAC meeting be provided for the members to discuss pending decisions among themselves, rather than filling the bulk of the meeting times with reports from staff and consultants. The goal should be for the members to be informed with sufficient time to discuss and review provided information prior to making decisions and recommendations.

Thank you for your attention to these recommendations. Please feel free to contact me, if you, or the UHCC members have any questions regarding the above recommendations. One of the primary goals of HCFA-WA is to support the work of the UHCC and FTAC, so that we can continue to move our state ever closer to a single payer, universal healthcare system

Cc:
    Mary Franzen, HCA
    Mandy Weeks-Green, HCA

From: Cris
To: HCA Universal FTAC; HCA Universal HCC
Subject: public comment
Date: Thursday, August 29, 2024 5:05:26 PM

External Email

To FTAC and UHCC:

I am proposing several modifications to the Washington Securities Health Trust (HB 1104 from 2019) as previously revised, since it is still a work in progress. Two of these are relevant to recent UHCC and FTAC meetings. The first is to Section 16(c) which currently states: (c) A resident shall not be required to pay a copayment, coinsurance, deductible, or any other form of cost sharing at point of care for all covered benefits under the trust. I want to change it to:

(c) Cost sharing in the form of deductibles and copayments at the time of service shall not be required for any covered benefits under the trust. Coinsurance, not to exceed 10% and with an annual cap, is permitted for treatment procedures, specified prescription drugs and biological products, but not for primary care visits, therapy evaluation visits, preventive procedures or routine diagnostic procedures. Coinsurance for institutional long term care is also permitted. Coinsurance may not be required of residents under the age of 21 or adults whose household income is under 200% of the federal poverty level.

There should be no copay or deductible at the time of service (as in Canada) that discourages doctor visits and evaluations, but the patient will probably still need to contribute directly to the ultimate cost of specific services (up to a cap that could vary with income) in addition to monthly premiums/taxes. This will help keep premiums/taxes affordable and assuage those who think they should not be paying for someone else's health care. Cost sharing should only be done on the back end as with payments for other consumer services. But everyone needs to know the exact, standardized additional cost of treatment up front (as with other consumer services), so they can decide after diagnosis and before treatment begins if the cost and risk are worth it. The French have a great system, except the providers should not have to be involved in accepting payments from patients. That adds too much provider expense and administrative hassle. There is also no need for multiple carriers to run their administrative services through employers. While an employer payroll tax should still help fund the program, all cost sharing, premiums, taxes, and reimbursements should be handled directly by the preferably nonprofit Administrative Service Organization(s) hired and supervised by the single-payer according to pre-established, negotiated fees.

The other change, indicated in bold type, is to Section 11(l): "health care items and services covered under the trust shall not be subject to prior authorization, **beyond what is required by Medicare for a well-defined purpose**, or a limitation applied through the use of step therapy protocols. The determination of medical necessity or appropriateness shall be made by the resident's health care professional who is treating that individual and is authorized to make that determination."

Prior authorization was started by Medicare in the late 1960s and was meant to be used sparingly, as it is still used for a limited set of treatments. The main problem now is that private insurers are using it to extremes in order to deny care and increase profits. Our state-

based system should retain the option to use this tool if needed, but only for very limited purposes.

I would hope that the UHCC could soon begin to agree on parameters such as these so that an overall structure could start to take shape. However for that to happen, background information will need to be presented in advance in written or recorded form, so precious meeting time can be used for discussion of the material and decision making.

Cris M. Currie, RN (ret.)

Whole Washington

Response to Washington Health Trust (SB.5335) analysis report

August 2024

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Acknowledgements

Whole Washington (Whole WA) thanks the Universal Health Care Commission (Commission) for their analysis of the Washington Health Trust (SB.5335) and the publication of this report (WHT Analysis Report).

We also thank Senator Annette Cleveland for taking the initiative of requesting that the Commission do this work.

Last, we make special thanks to Senator Bob Hasegawa for doing the incredible work of introducing universal public healthcare in the form of The Washington Health Trust into the last six legislative sessions first as SB.5222 in 2018, then as SB.5204 in 2020, and last as SB.5335 in 2022 - all of which created the legislative language that is under review in this report.

The public of Washington is both more involved and better informed because of this report having been made. We look forward to our ongoing collaboration on making universal public healthcare a reality in Washington and we are hopeful for significant progress in the upcoming legislative biennium.

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Executive Summary

This is a detailed response to the Washington Health Trust (SB 5335) Analysis Report conducted by the Commission's Financial Technical Advisory Committee (FTAC) and approved by the Commission. The report is available at www.wholewashington.org/commission and the Reports section of the Commission website.

The report came at the request from members of the Legislature. This response is written by Whole Washington executive director Andre Stackhouse and may be cosigned by other organizations and individuals. This response is intended to summarize what Whole WA sees as the key takeaways that we hope are emphasized in your upcoming annual Report to the Legislature (November Report). We also suggest what we see as the most appropriate follow up work to progress our goals forward.

This response is currently a draft. It also makes reference to a draft of the November Report. As such, there is still considerable room for the contents of this response to change as additional feedback is collected from our community as well as our conversation with the Commission develops. Where we reference the opinions, decisions, and perspective of the Commission we hope to characterize them accurately - if at any point we misunderstand or misrepresent the work of the Commission please let us know and we are happy to amend and clarify.

For the latest version of this response go to:
https://docs.google.com/document/d/1Ht3GB__L6N0MUbrdGCmNU8Ca1aFvOwNAE8-fKKamC_4/edit?usp=sharing

The response is also be linked at:
www.wholewashington.org/commission

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Key takeaways

Our reading of this report is that there is considerable alignment between the goals and analysis of the Commission and the design of the Washington Health Trust and its supporting analysis. While the Washington Health Trust compiles a comprehensive health care system design including transition and financing into a single piece of legislation, we consider many of the Commission's findings and recommendations to effectively be recommending different components of the Washington Heath Trust's transition and implementation. Whether passed in a single piece of comprehensive legislation or across multiple pieces of incremental legislation, universal health care must be implemented one step at a time and it appears there are many steps we agree on.

Eligibility

- The Legislature, Commission, and WHT understand universal eligibility to include all residents of Washington state.
- The WHT additionally includes some eligible nonresidents including in-state workers who reside in a different state, and in-state students from out of state. It is unclear if the Commission has determined which if any nonstate residents would be included in their eligibility criteria.
- While Whole WA imagines that it will be either necessary or ideal to include some nonresidents, we consider state residency to be a reasonable baseline eligibility requirement.
- Whole WA suggests that on eligibility questions that relate to out-of-state residents who work in Washington that design and collaboration with the Universal Health Plan Governance Board of Oregon is important.
- Whole WA recommends the Commission emphasize a firm commitment to state residency as the basis for eligibility in its November Report with room for expansion to other populations as additional design and analysis is completed.

Medicaid integration

- The Legislature, Commission, and Whole WA are aligned on the goal of incorporating Medicaid enrollees and all state and federal Medicaid dollars into our state's universal health care system (UHCS).
- Whole WA and the Commission both identify federal waivers as pathways to integration while the Commission's report also discusses the use of State Plan Amendments (SPAs) as a potential long-term integration strategy.
    - "Compared to a waiver, a SPA would require a 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 a state's Medicaid program that wouldn't have to be renewed every five years (as a waiver does) and it creates an entitlement where all those who apply and enroll must be served all the benefits for that program." (Analysis Report page 14).

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- Based on the Commission's analysis, Whole WA believes that SPAs may offer the best long-term solution to Medicaid integration as the more permanent transition and uniform benefits both match Whole WA and WHT's intention to create a stable, permanent, and fair UHCS.

- Whole WA recommends Medicaid as the ideal public health system to begin the establishment of a unified financing system, public trust, and public option as its lack of any premiums or point-of-use cost sharing makes it most closely resemble the intended design of the WHT.
- Current Medicaid reimbursement rates are considered a potential challenge of integrating Medicaid into a state UHCS.

Medicare integration

- The Legislature, Commission, and Whole WA are aligned on the goal of incorporating Medicare enrollees and federal Medicare dollars into our state's universal health care system (UHCS).
- The Commission and Whole WA agree that federal waivers are the ideal long-term solution to Medicare integration but may take time to acquire.
- WHT aims to introduce a public Medicare Advantage option to allow for voluntary enrollment into the state's UHCS, the Commission believes this is possible but may face significant challenges.
- The Commission believes that direct reimbursement is the most feasible short-term solution to Medicare integration which would not require a federal waiver and would be unlikely to face legal challenges. Whole WA agrees with this assessment and is open to this pathway as the initial transition step to Medicare integration.
- The Commission believes that the three pathways outlined above (direct reimbursement, federal waiver, public Medicare Advantage option) may exist alongside each other, Whole WA agrees with this assessment and considers each option to present advantages. We recommend advancing work on all three paths and beginning with direct reimbursement.
- Whole WA recommends that the Commission include in its November Report that Medicare integration is not understood as a significant barrier to the establishment of a unified financing system, public trust, and public option while Medicare continues to operate in its current form.

Self-funded employer plans

- The Legislature, Commission, and Whole WA are aligned on the goal of incorporating employers and employees into our state's UHCS.
- The Legislature, Commission, and Whole WA agree on the importance and challenge of navigating federal ERISA regulations but agree that there may be paths forward. However, it is also likely that a legal challenge will be pushed regardless, necessitating careful legal review and a design resistant to litigation on these grounds.

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- Unlike with Medicare, there are currently no established federal waivers to be exempted from ERISA limitations, though they could be established in the future possibly through federal legislation like the State-Based Universal Health Care Act (SBUHCA).
- The Commission does not at this time recommend incorporating self-funded employer plans that are protected under ERISA without further review while the WHT establishes voluntary enrollment combined with an employer mandate to provide coverage of the employers choosing to all employees up to a minimum spending requirement.
- While Whole WA maintains confidence and optimism in the legality and durability of its universal health care system design, we and the Commission agree that there is fundamental ambiguity in the rules and how courts would decide given a case.
- For this reason, we understand the Commission does not recommend any changes at all to self-funded employer plans protected by ERISA. While the WHT articulates its transition for these plans, Whole WA does not believe integration of these plans is necessary for the establishment of the WHT or similar publicly funded and/or administered trust open for enrollment to the public.
- For additional information and strategies regarding navigating ERISA in the design of a statewide universal health care system, we suggest the Commission consult A Road Map to 'Single-Payer' published by Public Citizen.
- Whole WA recommends that the Commission include in its November Report a firm commitment to the intention to integrate self-funded employer plans into the state UHCS.
- Whole WA recommends that the Commission include in its November Report that ERISA not be treated as a barrier to the establishment of a unified financing system, public trust, and public option open to individuals and employers to enroll and that all requirements and incentives to integrate ERISA-protected plans be considered after additional analysis.

Benefits & services

- "The Commission aims to design a benefits package for the new system that prioritizes prevention, comprehensive coverage, and equitable access to appropriate care"
- Whole WA has oriented its benefits around the general concept of "comprehensive coverage" of medically-necessary care across the entire state's population.
- While Whole WA has articulated a fairly specific benefits package, the Commission has yet to make clear decisions about what a benefits package for their recommended state UHCS would include.
- The WHT covers long term services & supports (LTSS) including hospice and end-of-life care, and long-term care benefits at least at the standards of Medicaid coverage, but these benefits would not be offered at the outset. Rather, these benefits are intended to be phased in within four years of the Trust's implementation. The Commission has not yet made a decision regarding coverage of LTSS.
- Whole WA recommends that the Commision include in its November Report a clear recommendation ACA mandated EHBs be set as the absolute minimum benefits package for the state UHCS with room for expansion as additional analysis and decisions are completed.

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Costs, administrative waste, and prices

- Whole WA has run two economic studies analyzing the costs of a statewide UHCS in the form of the WHT.
- While the Commission has not run its own cost-analysis, it has based much of its work off of prior work including the Universal Health Care Work Group Report.
- Prior to the UHC Work Group Report the Legislature commissioned a report from the Washington State Institute for Public Policy which conducted a meta-analysis of economic studies across US states and global health care systems.
- While the systems and the methodologies of the studies all differ, there is consensus between them all that universal health care provides a net savings on total health care spending compared to the status quo.
- The WHT Analysis Report articulates some skepticism of Whole WA's projections on savings through administrative efficiency and emphasizes the role that high prices play on total cost.
- Whole Washington's economic analysis was conducted without assumption of significant price adjustment and therefore does not find significant savings in price adjustments. However, this assumption was made not to assume that prices do not contribute to high total costs or that significant savings could not be found through price controls but instead an attempt to find enough savings through administrative efficiency such that prices would not need to be significantly adjusted. It is a means of conducting a more conservative analysis. The Washington Health Trust gives the Washington Health Trust Board the ability to enact price controls where necessary and to negotiate on drug prices. In this sense, both Whole WA and the WHT recognize the role of price inflation has played in the inflation of health care costs and are open to mechanisms to address and bring down prices.

Cost sharing

- Whole WA understands cost sharing to be a part of virtually any/every UHC system in the world and would be in Washington as well.
- Whole WA identifies excessively complicated cost sharing as contributing to administrative waste and less cost transparency resulting in higher prices, vectors for waste, fraud, and abuse, and an overall more expensive health care system.
- We understand point-of-service cost sharing to have negative impacts including
    - Complicating billing by splitting the bill more ways and necessitating more collection infrastructure including on providers.
    - Reducing health care utilization much of which is likely medically and financially advisable and should not be skipped/delayed.
    - In this way, Whole WA understands point-of-service cost sharing to be especially counter to the goals of prevention and equity.
- Whole WA views hospital and insurance networks and "out of network" cost sharing as primarily a barrier to patients seeking care from the provider of their choosing and are therefore undesirable.

DRAFT

- Whole WA recognizes that some providers appreciate prior authorization, case management, care coordination, and denials of insurance claims when they filter out health care utilization that they would not medically recommend - however Whole WA believes this is an inappropriate role for an insurer to play and that it is a responsibility to providers to make their medical recommendations clear to clients rather than leaning on bureaucracy to avoid the conversation.
- WHT is designed and intended to eliminate all point-of-service cost sharing.
- Whole WA seeks to be evidence-based in our system design and therefore is open to forms of cost sharing in which there exists evidence that they improve affordability or outcomes at either the individual or public health level.

Requests for the November Report to the Legislature

Whole WA has not yet had the capacity to do a detailed reading and analysis of the draft of the November Report included on pages 111-147 of the meeting materials of the August Commission meeting. However, we offer the following initial feedback on the sections that make reference to the WHT and the Analysis Report.

- A more detailed summary of the Washington Health Trust Analysis Report and its findings especially on points of alignment, decisions, and pathways forward.
- Points of alignment, decisions, and pathways forward identified in this report should be articulated in the form of clear policy recommendations to the legislature to be advanced in the next legislative biennium.
- In particular, Whole WA believes the Commission should make the following specific recommendations to the Legislature in its November Report.
    - The establishment of a public trust to consolidate funding for state health plans including PEBB, SEBB, and Medicaid.
    - The consolidation of PEBB and SEBB and Medicaid into a single benefits package administered by one board while covering all current enrollees.
- An outline of future planned analysis and decisions including a general timeline should be included to set expectations on what further questions will be answered at a future date.
- The full Analysis Report should be included in the November Report in the Appendix.

Requests for next steps, future work, and further decisions

- Synthesizing a 10-year cost analysis with some affordances for transition, uncertainty, and variations in potential system design.
- Identification of potential sources of revenue to finance a universal public health care system including overprovision for the development of a healthy surplus, changes in economic conditions, and other potentially unknown or hidden costs.
- An actuarial analysis which reconciles the differences in methodology and findings between the UHC Work Group Report and the analyses run by Dr. Friedman on behalf of Whole WA.

DRAFT

- A review and report on the Fiscal Note conducted by the Washington Office of Financial Management on SB.5222 (the original Washington Health Trust bill introduced in 2019).
- Clear definition, decisions, and recommendations on which benefits & services the Commission believes the state UHCS should include as essential health benefits available to all enrollees.

Cosigners

Organizations

- Whole Washington

Individuals

- Andre Stackhouse *Whole Washington Executive Director*

DRAFT

Appendix A

Below is a slide which summarizes key decisions made by the Commission as discussed in the August Commission meeting and published in the meeting materials. This is the last slide within Tab 7 of the August meeting materials.

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

Appendix B

Fiscal note conducted by the office of Financial Management for SB.5222, the original Washington Health Trust bill introduced in 2018: https://fnspublic.ofm.wa.gov/FNSPublicSearch/GetPDF?packageID=56734

DRAFT

Tab 4

Project Status Update

Liz Arjun, *HMA*

3 Workstreams

Design a universal health care system with a unified financing system

- ✓ Inaugural Report: Landscape and Path Forward
- ✓ Launch FTAC

- ✓ Eligibility
  - ✓ Medicaid, Individual, Small Group, Fully-Insured Large Group (includes PEBB/SEBB)
  - ✓ **No pathway at this time** for self-funded plans and Medicare

- Determine potential costs based on:
  - Benefits and services
  - Cost containment
  - Provider reimbursement

Recommend interim solutions that address issues people face now and contribute to the universal system

- ✓ Expanded coverage for uncovered populations
- ✓ Integrated eligibility systems
- ✓ Cascade Care Savings
- ✓ Cost Growth Targets
- ✓ Align public programs

- ***Under Consideration***
  - Administrative Simplification
  - Maximizing coverage in existing programs

2023 Request

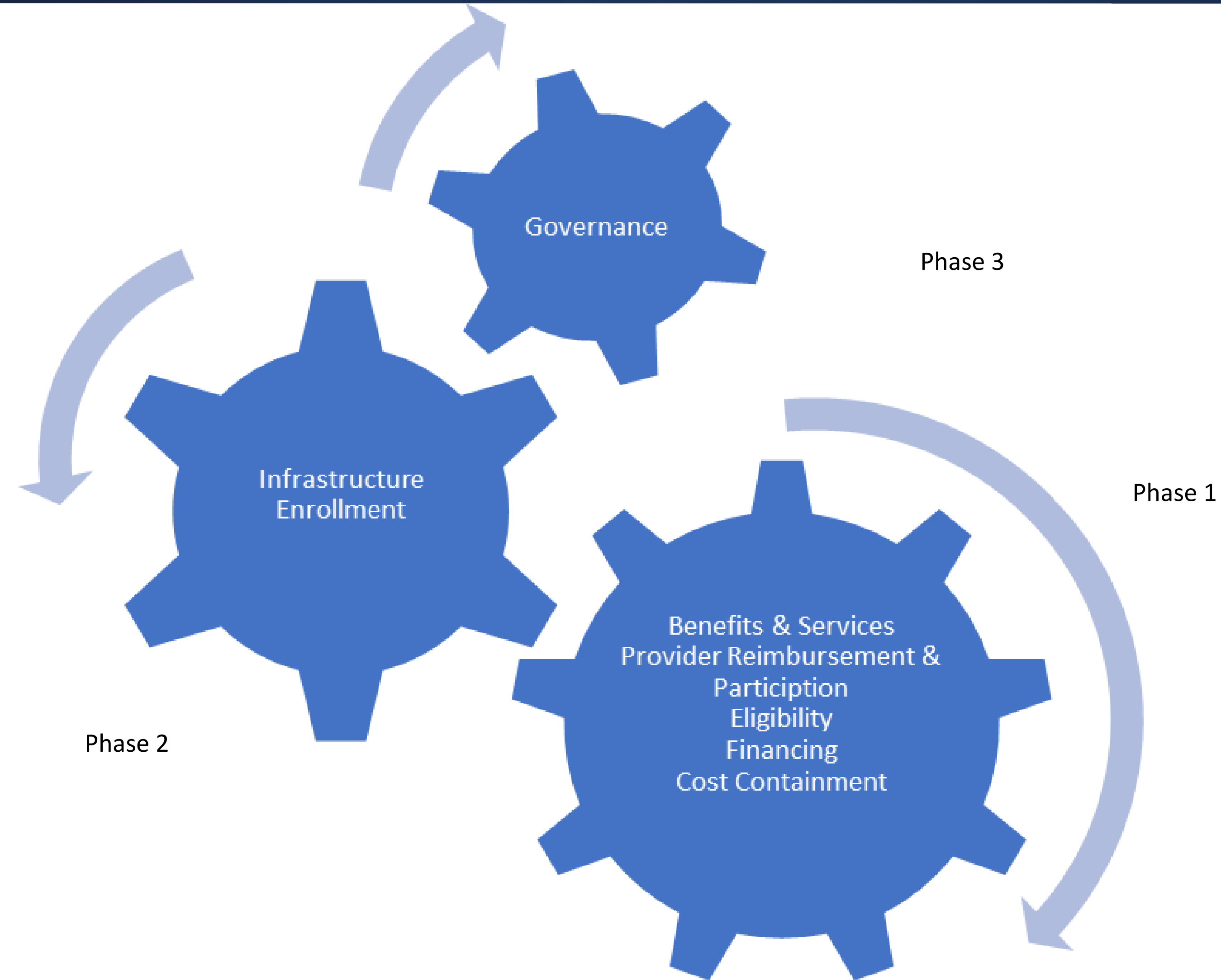
Review the Washington Health Trust proposal

- Overview of proposal

- Benefits and services, cost assumptions

2022 **2023** **2024**

Workstream 1 (Universal System Design)



Workstream 1 (Universal System Design)

Eligibility ✓

Benefits & Services

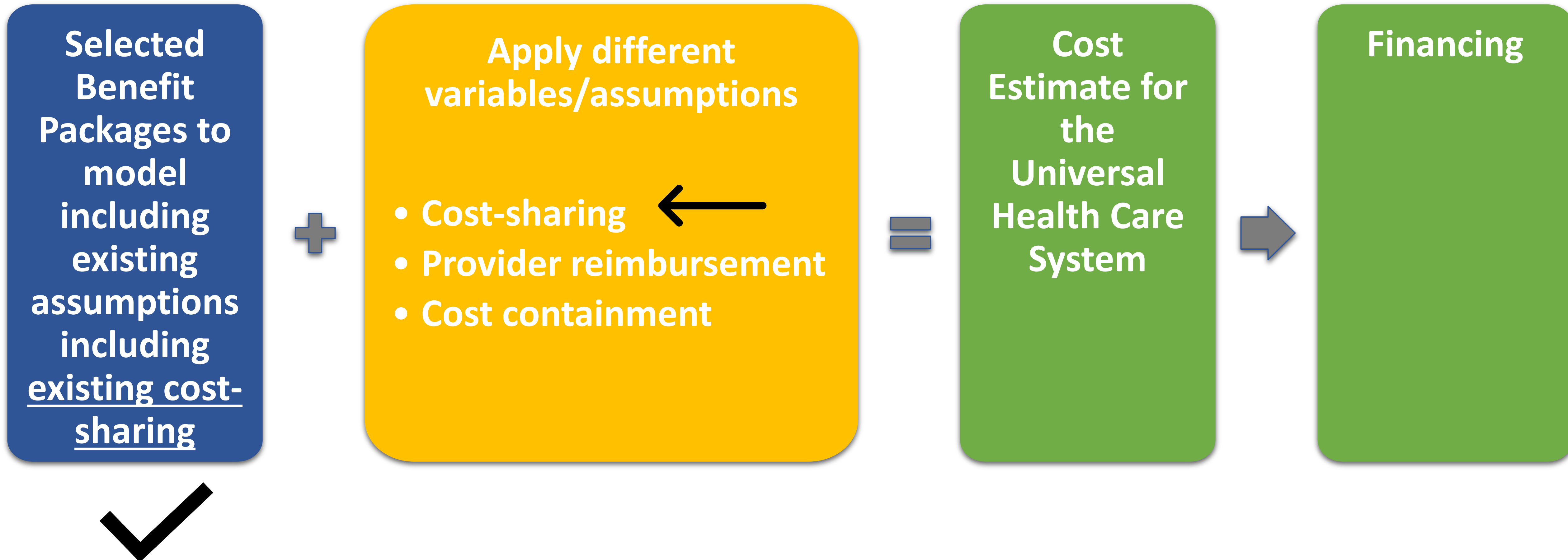
Provider Reimbursement & Participation

Cost Containment

Cost Estimates

Financing

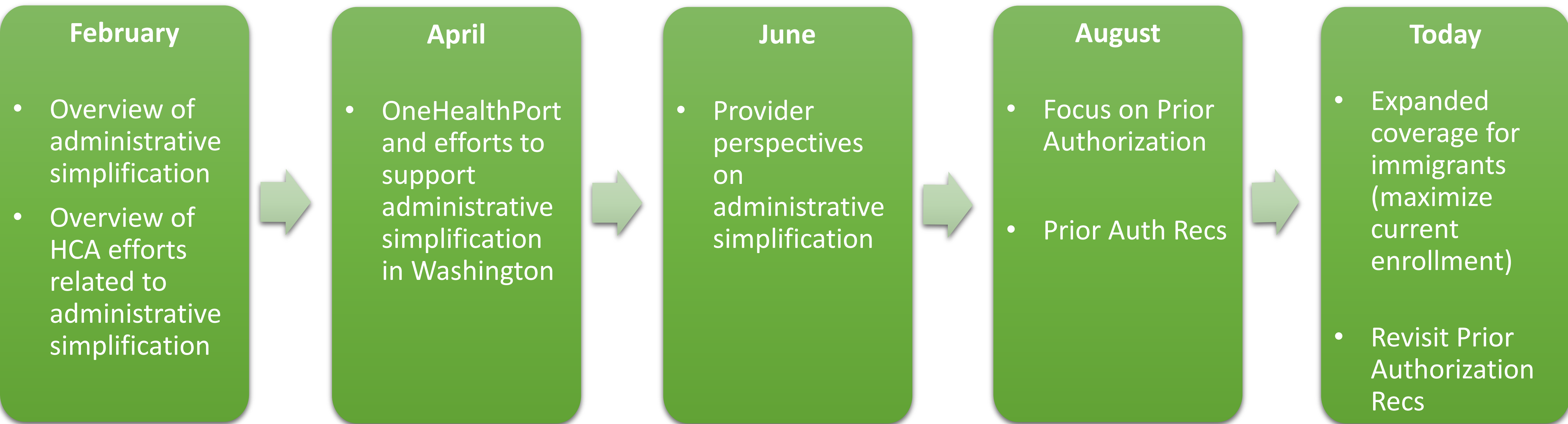
Workstream 1 (Universal System Design): Status



Workstream 2 (Transitional Solutions)

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

Workstream 2 (Transitional Solutions)



Tab 5

Workstream 1 (Universal System Design): FTAC Update

Pam MacEwan, *FTAC Liaison*
Mary Franzen, *HCA*

FTAC update

As directed by the Universal Health Care Commission, FTAC continues to analyze cost and cost-sharing models

- Presentations and discussions about cost sharing during July and September FTAC meetings
- Decision to engage Milliman to model cost-sharing scenarios with varying benefits
- Suggested principles of cost sharing

Cost and cost-sharing analysis
Population

- Milliman will model cost-sharing scenarios for the population assumed to be eligible to enroll in universal coverage in Washington.

  - Age 64 and under, not enrolled in Medicare, TRICARE, VA health benefits, or an ERISA qualifying plan
  - This includes the uninsured, individual market coverage, public employees, school employees, small group, fully insured, and Medicaid

Cost and cost-sharing analysis
Benefit packages

- ❖ Milliman will model cost-sharing scenarios for three identified benefit packages for the identified population (without a sliding-scale cost share structure)

Scenario Title	Non-Medicaid Enrollees	Medicaid Eligibility Status
1. Medicaid	Medicaid cost sharing	Medicaid cost sharing
2. PEBB/SEBB	PEBB/SEBB cost sharing	Medicaid cost sharing
3. Cascade Care Silver	Cascade Care Silver cost sharing	Medicaid cost sharing

For consideration: principles of cost sharing

- As directed by the Universal Health Care Commission, FTAC undertook analysis and consideration of cost sharing.

- Research is evolving.
  - Some studies were conducted when cost-sharing scenarios were very different from what they are today.
  - Some studies focused only on certain populations.
  - Different studies suggest different effects on utilization and health outcomes.

- **More detail is contained in a PDF in your meeting packet.**

For consideration: principles of cost sharing

If the Commission pursues cost sharing, FTAC offers the following principles for consideration:

1. Seek cost-sharing arrangements that do not create barriers to care.
2. Identify selected services (e.g., preventive care or diagnostic screening) that would not be subject to cost sharing.
3. Vary cost-sharing requirements based on an individual's income. Consider minimal or zero cost sharing for individuals below a defined income level.

For consideration: principles of cost sharing

If the Commission pursues cost sharing, FTAC offers the following principles for consideration:

4. Create cost-sharing structures that are simple, predictable, transparent, and easily understood for individuals seeking care.

5. Review the Commission's final policy decision on cost sharing through the health equity toolkit as adopted by the Commission.

6. Review and revise cost-sharing designs as medical technology and services evolve.

For consideration: principles of cost sharing

Questions / Discussion

FTAC report out to the Universal Health Care Commission:
Principles of Cost Sharing

At the request of the Universal Health Care Commission, the Finance and Technical Advisory Committee (FTAC) has undertaken efforts to explore cost-sharing options.

During their July 11 meeting, FTAC members heard a report about cost-sharing options applied to universal systems in other states, notably Vermont. Cost-sharing options discussed included deductibles, co-insurance, and point-of-service co-pays. The presentation was followed by a robust discussion among FTAC members.

During their September 10 meeting, FTAC members continued their consideration of cost-sharing principles. Research on cost-sharing is evolving, with studies conducted at different points in time when very different cost-sharing structures were in place.

With these discussions in mind, if the Commission pursues cost sharing, FTAC offers the following principles for consideration:

1. Seek cost-sharing arrangements that do not create barriers to care.
2. Identify selected services (e.g. preventive care or diagnostic screening) that would not be subject to cost sharing.
3. Vary cost-sharing requirements based on an individual's income. Consider minimal or zero cost sharing for individuals below a defined income level.
4. Create cost-sharing structures that are simple, predictable, transparent, and easily understood for individuals seeking care.
5. Review the Commission's final policy decision on cost sharing through the health equity toolkit as adopted by the Commission.
6. Review and revise cost-sharing designs as medical technology and services evolve.

Appendix

Following is additional detail about FTAC's discussions. Drawing on past research, as well as expert presentations, FTAC members offered the following observations for discussion:

1. Cost sharing may reduce overall spending on health care services.[1]
2. Reduced spending results from fewer patient encounters. The unit prices of care are not affected.[1]
3. Participants with cost sharing were more likely to make fewer medical visits and were admitted to hospitals less frequently.[1]
4. Even relatively small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services.[2]
5. Cost sharing may reduce the use of effective and less effective services about equally.[1]
6. Similarly, the Oregon Experiment showed that among the Medicaid population, coverage with no cost-sharing had no impact in blood pressure, cholesterol or diabetes outcomes. However, health insurance did increase the use of health care services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain.[3,4]
7. The Washington State Health Care Affordability Survey, conducted in June 2024, found that 57 percent of respondents have avoided seeking medical treatment or modified their use of prescriptions in the last year due to the cost. Of those who reported experiencing difficulty, 34 percent said out-of-pocket medical costs were too high.[5]

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[1] The Health Insurance Experiment: A classic RAND study speaks to the current health care reform debate | RAND. (2006). https://www.rand.org/pubs/research_briefs/RB9174.html

[2] The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings, KFF, (2017) https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[3] Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., Schneider, E. C., Wright, B. J., Zaslavsky, A. M., & Finkelstein, A. N. (2013). The Oregon Experiment — Effects of Medicaid on Clinical Outcomes. New England Journal of Medicine, 368(18), 1713–1722. https://doi.org/10.1056/nejmsa1212321

[4] Oregon Health Insurance Experiment - Results. NBER. (2013). https://www.nber.org/programs-projects/projects-and-centers/oregon-health-insurance-experiment/oregon-health-insurance-experiment-results

[5] 2024 Washington Health Care Affordability Survey, https://fairhealthprices.org/wp-content/uploads/2024/08/Report-2024-WA-Health-Care-Affordability-Survey.pdf

8. Studies suggest that the lack of insurance coverage/increasing cost-sharing is associated with increased mortality, particularly among older and poorer adults.[6,7,8]
9. While some studies suggest cost-sharing reduces outpatient care, it may increase inpatient care due to delayed treatment.

[6] Goldin, J., Lurie, I. Z., & McCubbin, J. (2020). Health Insurance and mortality: Experimental evidence from taxpayer outreach. *The Quarterly Journal of Economics*, *136*(1), 1–49. https://doi.org/10.1093/qje/qjaa029
[7] Miller, S., Johnson, N., & Wherry, L. R. (2019, July 22). *Medicaid and mortality: New evidence from linked survey and Administrative Data*. NBER. https://www.nber.org/papers/w26081
[8] Chandra, A., Flack, E., & Obermeyer, Z. (2021, February 8). *The health costs of cost-sharing*. NBER. https://www.nber.org/papers/w28439

Tab 6

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

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Executive summary

This is the Universal Health Care Commission's (Commission's) third annual report, submitted by the Health Care Authority (HCA) to the Washington State Legislature and Governor as directed in Senate Bill (SB) 5399. 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 forward-looking and intended to improve on 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.
- The foundational design components of that future system.

In 2023 Legislature also provided General Fund – State (GF-S) funding for work required of HCA as specified in Revised Code of Washington (RCW) 41.05.840 for fiscal years (FY) 2024 and 2025. The Commission extended meetings from two hours to three hours and expanded 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 people in Washington have equitable access to culturally appropriate and affordable health care.

The Commission selected eligibility determination for the future health care system as the first topic of discussion for deliberation. The Commission's preliminary eligibility work to create pathways that include

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[1] The Commission's member roster is available in Appendix A.

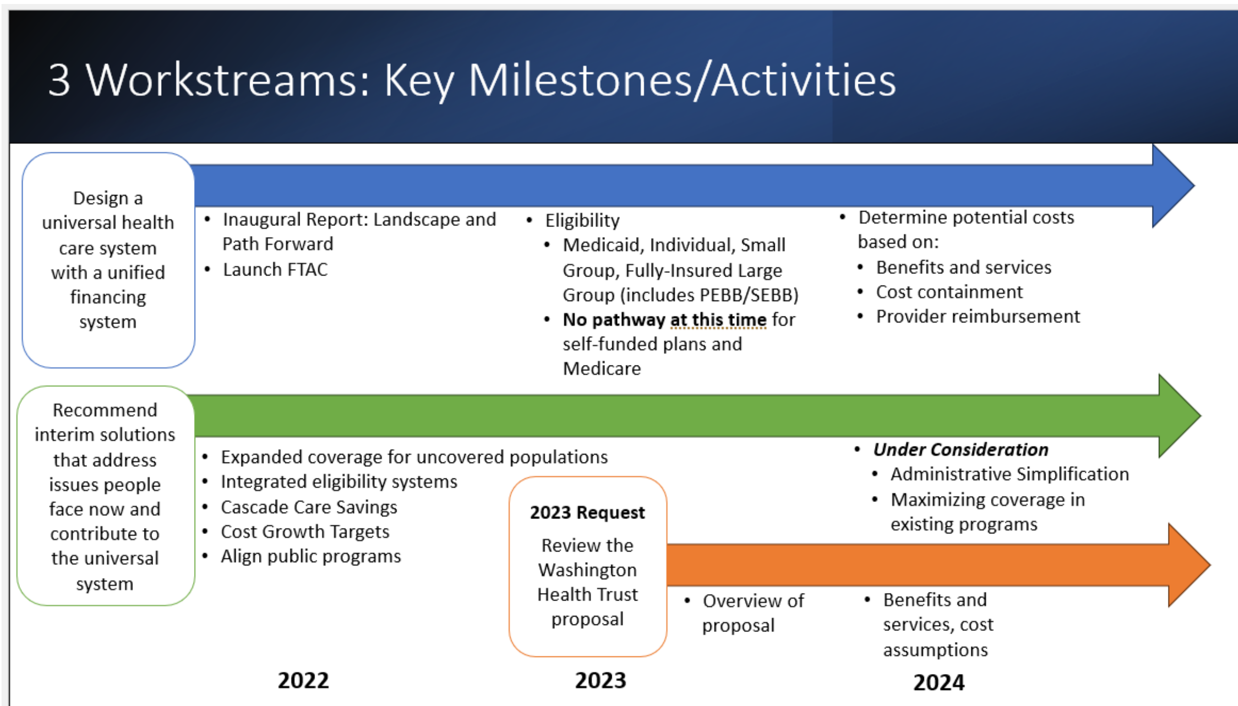
Medicare, Medicaid, and employers in Washington's future health care system concluded in February. The Commission began work on its next design topic, benefits and services, in March.

This report details the Commission's work to build on 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.
  - A focus on including the three eligibility groups presenting the most significant challenges to federal authority:
    - Guidance from the Finance Technical Advisory Committee (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.

The figure below illustrates the Commission's past and ongoing workstreams.

Figure 1: Commission work plan



Developments: October through December 2023

The Commission's report to the Legislature (November 1, 2023) did not capture business from the Commission's October and December meetings. The following developments occurred during these months:

- Vote to approve the 2023 report to the Legislature
- Selection of three categories of transitional solutions to prioritize in 2024
- Assessment of FTAC's guidance on the Employee Retirement Income Security Act of 1974 (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 the scope of 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 1) Streamlining access to coverage and reduce fragmentation of health care financing, 2) Unnecessary administrative costs, and 3) Health disparities. Building on 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. This included:

- Identifying the need for federal authority to achieve a state-based universal health care system supported by unified financing, and that pursuing such authority is a multi-year 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 ERISA-covered individuals in Washington's universal health care system.
  - Identifying preliminary considerations for integration of Washington's Medicaid program.
- Refining 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.
- Adopting a health equity framework with which the Commission will evaluate proposals for the universal health care system design and interim solution recommendations.

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

Prioritization of transitional solutions for 2024

In the **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.

Table 1: Prioritized transitional solutions

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

Analyzing eligibility of various groups by payer

Assessment of FTAC's guidance on 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 is also responsible for investigating strategies to develop unified health care financing options for the Commission's consideration, and 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.

Employers as a predominant source of health care coverage

Like most Americans, most people in Washington receive health care coverage through their employer, which dates back to World War II.[4] In 2022, the most recent year for which information is available, slightly more than 50 percent of Washington residents received health care coverage through their employer,[5]

[2] The FTAC member roster is available in Appendix B.
[3] FTAC's assessment of Medicare is available in the Commission's 2023 annual report to the Legislature.
[4] With much of the labor force called to military service in the early 1940s, employers increased wages to compete for talent, which economists predicted could lead to unmanageable inflation. In response, laws were passed to freeze salaries and wages, indirectly incentivizing employers to compete for talent through other means like health care benefits. Publicly financed programs like 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] See Kaiser Family Foundation's Health Insurance Coverage of the Total Population table

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. 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.

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, examined prospects for ERISA integration for their respective and future state-based universal health care systems. This section of the report 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 people in California 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."

---

6 Federal ERISA law sets minimum standards for health plans established and funded by employers to provide health care to their employees. An employer that offers a self-funded health plan often will contract with an outside entity to administer their health plan (called "third party administrators (TPAs)).

7 Senate Bill (SB) 104 (Chapter 67, Statutes of 2019).

8 ERISA Considerations for Unified Financing. Key Design Considerations for a Unified Health Care Financing System in California. April 2022.

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 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 no ERISA models have been tested in court, the three ERISA models most advanced by legislators proposing single-payer bills include:

1. Economic incentives – Uses payroll taxes, income taxes, or both to raise revenue to pay for the universal plan.[11]
2. Provider regulations – Restricts providers participating in the universal plan from billing any third party other than the universal plan.
3. Assignment/subrogation/secondary-payer provisions –- Allows 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, Brown and McCuskey 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 their Plan. These elements include:

4. A payroll tax levied on all employers.
5. Restrictions on coverage duplication by state-regulated health insurers.
6. 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

---

[9] Fuse Brown, E. C., & McCuskey, E. Y. (2019). Federalism, ERISA, and State Single-Payer Health Care. U. Pa. L. Rev., 168, 389.

[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 the universal plan **and** employer coverage.

[12] Brown and McCuskey 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.

ERISA preemption. Additionally, this approach would still encourage employers and employees to shift to the Plan.

Brown and McCuskey also offered that Oregon may be in good standing to integrate employers and employees and fund their Plan. Brown and McCuskey's provide this analysis:.

> "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 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)

WVA dictates how all health plans, including ERISA plans, administer vaccine benefits. Under WVA, Washington universally purchases childhood vaccines for all children at volume-discounted rates from the Centers for Disease Control and Prevention (CDC) and delivers them to providers at no cost. Health insurers and TPAs of self-funded plans reimburse WVA for vaccines administered to privately insured children via dosage-based assessments.

WVA then transfers funds to the Washington State 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 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 covers these services regardless of a person's insurance. PAL initially was

[14] The Ninth Circuit also covers Washington.

[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).

funded with Medicaid funds, despite some children being ineligible for Medicaid. The Washington State 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 for payers based on their covered lives, including ERISA plans. The assessment per covered life for FY 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 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 Washington residents are covered by self-insured employer group plans. Therefore, any state laws passed by the 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 people in Washington.

To better assess ERISA preemption issues and potential options, FTAC invited law professor Erin Fuse Brown to their September meeting. 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] Brown's presentation focused on the potential impact of ERISA on three models of a universal coverage system:

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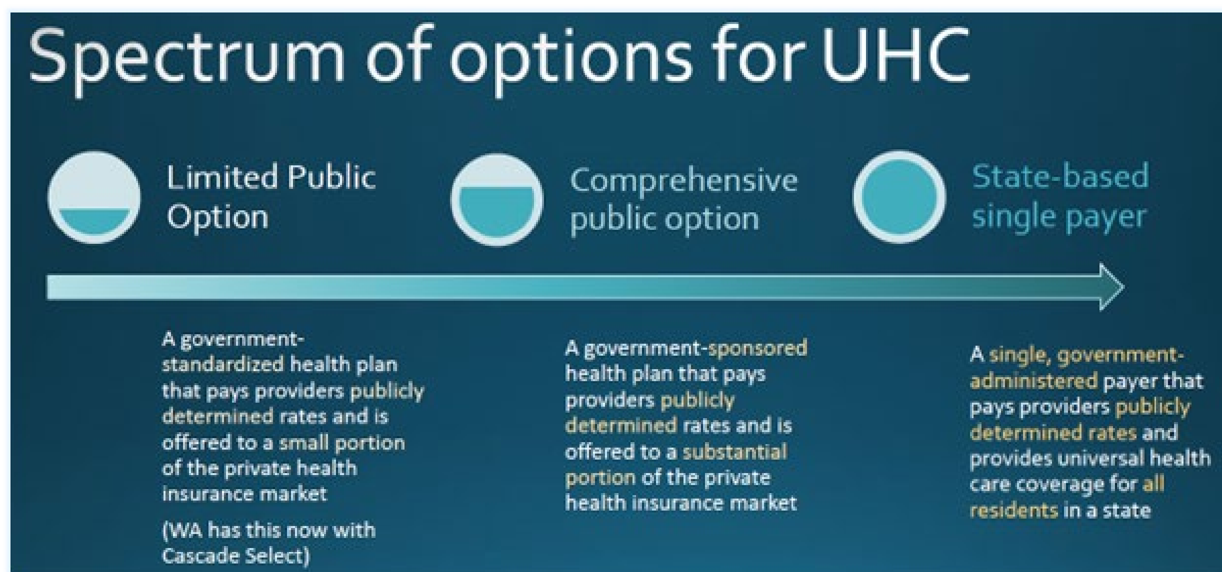
[16] Employer-based health care coverage accounts for 52 percent of Washington resident's' health coverage. Data are from the Office of the Insurance Commissioner (OIC) internal carrier enrollment reports (using 2021 reports), American Community Survey's health insurance coverage tables, and Kaiser Family 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.

[17] Some large employers may believe they can do a better job for their employees than the government and generally resist what they perceive as intrusive government regulation, such as price-setting, while acknowledging that the costs associated with providing these benefits is increasing.

[18] Presentations by Bill Kramer and Erin Fuse Brown, JD, MPH, is available in FTAC's September meeting recording.

Figure 1: Brown's spectrum of options for universal health care



Brown began her presentation with an overview of the Affordable Care Act (ACA) requirements of large employers. Under ACA, 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.[19]

Following this, FTAC discussed six options for how to include employers in Washington's universal health care system and avoid ERISA preemption.

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.[20] 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, 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 ACA is a co-equal federal law.[21]

FTAC determined that no waiver is possible and 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

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[19] Affordable Care Act tax provisions for large employers

[20] 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 the Centers for Medicare & Medicaid Services (CMS) under Medicare and Medicaid.

[21] The employer mandate can be waived by the federal government via a 1332 waiver.

federal legislation to allow states' incorporation of large employers into their respective unified health care financing systems.

Option 2: Optional employer participation

This option 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.

Washington has had success with the concept of optional employer participation, notably the Balance Billing Protection Act, which allows employers offering self-funded coverage to opt in to offering employees protection from surprise billing. Presumably employers perceived benefits for employees by opting in to a state law that offers additional protection.

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.

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 forego 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 Brown. This option, more expansive than Washington's current public option program, Cascade Select,[22] is focused on designing a plan that offers an option for Washington residents that employees could opt into. FTAC members expressed

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[22] 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 Washington Health Benefit Exchange, and OIC. See HCA's **2022 report** to the Legislature.

support for designing a meaningful alternative that could eventually attract employers, or even serve as a glide path to a single-payer system.

Option 4: Provider regulation/incentives

This option incentivizes health care providers to accept patients covered by the universal system, based on the assumption that as providers migrate toward a state-sponsored plan, employers would follow.[23] This may include provisions that require 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 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 provide the state with levers to finance a universal system. Further analysis and discussion are 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 placed 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).[24] 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."[25]

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 persuading employers to participate, but rather on obtaining funding for the system. FTAC members were interested in further exploring what payroll tax structure could be considered acceptable to 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

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

[24] 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.

[25] 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**.

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 combination 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 employees to enroll in the universal system.

Legal challenges may be inevitable and create delays in implementing a universal system. A combination of approaches that includes options not likely to be challenged is a possible pathway to reform that 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. This member referred to the 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 FTAC's guidance on ERISA under advisement in their universal health care system design work. The Commission plans to revisit the ERISA topic, including a potential employer payroll tax, as more design elements are developed.

Examination of Medicaid considerations for unified system

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 ways to incorporate federal Medicare funds to support Washington's future system. Details of this assessment are available in the Commission's **2023 report**.

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[26] FTAC ERISA memo is available in Appendix C.

Assessment of options to include Apple Health (Medicaid)

Medicaid was the Commission's last eligibility group to assess. Unlike Medicare and self-funded employer plans that fall under ERISA preemption, 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. 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]

The Commission directed 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 of the report also includes summaries of efforts in other states, including Oregon and California, to integrate Medicaid enrollees into their proposed universal health care systems.

Examination of Medicaid integration by other states

The Commission continues gathering information from other states' experiences in 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:
  - 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, California may be required to track residents' eligibility information for one or more of those programs once the new system is implemented.

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[27] Any increase in Medicaid provider reimbursement rates would be an additional cost to the state.

[28] Oregon Joint Task Force on Universal Health Care **final report**. 2022.

[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**.

- 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 (CMS). CMS provides rules and oversight of the program with which 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.

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[31] FTAC November meeting **recording**.
[32] FTAC January meeting **recording**.
[33] FTAC Medicaid memo is available in Appendix D.
[34] FMAP is computed by a formula that considers the average per capita income for each state relative to the national average.

- 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 LTSS.[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 mandatory and 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, copayments, among others. The total cost of 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.

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[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.

[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.

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 for 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:
  - 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 reenter their 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 for all those who apply and enroll must be served all the benefits for that 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 more than a year before some components were approved. Following approval, the state embarks on a considerable number of complex implementation projects, as well as detailed data tracking and reporting requirements.

Washington's first 1115 waiver focused largely on behavioral health and primary care integration and payment reform. The state's current waiver includes reentry services for individuals leaving carceral settings and an innovative model for using Medicaid funds to pay for health-related social needs services. While neither of the Washington's 1115 Medicaid waivers addressed universal coverage, the state's success with waiver approval and implementation suggest Washington is well positioned, should CMS consider universal coverage in future waivers.

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.

[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**.

- 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 increasing 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 greater than 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, 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 Washington Healthplanfinder. Altogether, one out of four Washington residents (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.
    - How can Washington's programs become 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]

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. These details 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

[38] An FTAC member and Medicaid expert shared a memo with FTAC before the January meeting, outlining other considerations related to what is necessary in a waiver application to implement the future universal system design. This memo is available in Appendix D. FTAC believed 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.

[39] Compared to the feasibility of including Medicare and self-funded employers.

Medicaid should be considered and revisited alongside decision making for other larger system design elements.

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.

Development of the Washington Health Trust analysis report

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.

SB 5335 analysis did not address alignment in areas, including administrative design and financing because the Commission has not yet made recommendations on these topics. As the Commission's workplan proceeds, alignment with current versions of SB 5335 will be addressed and reported.

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[40] FTAC Medicaid memo is available in Appendix D.
[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 Washington residents 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 in terms of financial costs to the state and consumers, and years of healthy life lost for many Washington residents. 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 already existing work already completed 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 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 EHB. Whole Washington also selected EHB for SB 5335's benefit design. 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 Public and School Employees Benefits Boards' (PEBB and 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 EHB. Given these challenges, the Commission enlisted FTAC's

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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, provider participation, and reimbursement.

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

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, 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 on 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 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.

With feedback from the Commission, FTAC finalized their request for an actuarial comparison between plans in September. Individual members of FTAC (up to three) were requested to provide feedback weekly as cost estimates and analysis moves forward.

The Commission continues to address other dimensions of benefit design, including prior authorization. Future topics to address include supplemental benefits outside of the universal plan's covered benefits, point of service cost sharing, and a standardized provider reimbursement rate.

Ongoing transitional solutions

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 fragmented 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.

Public participation included in Commission's work

The Commission expressed interest in developing a community engagement process once benefits and services are determined. The Commission remains dedicated to its mission to ensure all Washington residents 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.

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 added to the work plan and should be established to gather community input once benefit and service proposals are developed.

Conclusion

Building upon previous years' work, the Commission continues to explore and refine system design, focusing largely on eligibility. The Commission examined options to cover three eligibility 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 remains committed to creating a system that provides equitable and culturally appropriate health care for all people in Washington.

The Commission continued its charge to pursue near-term improvements to the current health care delivery system. With an eye toward improvements that could also be part of a universal system, the Commission considered areas of focus for administrative 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 A: Universal Health Care Commission member roster

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

Appendix B: Finance Technical Advisory Committee (FTAC) member roster

Name	Organization	Finance expertise
Pam MacEwan*	CEO (retired), Health Benefit Exchange	Consumer representative
Christine Eibner	Senior Economist, RAND corporation	Microsimulations, approaches to 1115 and 1332 waivers, recouping federal funding for Medicaid, Medicare, and marketplace
Dave DiGiuseppe	Vice President, Healthcare Economics, Community Health Plan of Washington (CHPW)	BA in Economics, predictive modeling for case management outreach, financing health-related social needs
Eddy Rauser	Washington State Office of Financial Management (OFM)	State finance agency
Esther Lucero	President and CEO, Seattle Indian Health Board	Federal waivers, pharmaceutical costs and spending, behavioral health financing, Medicaid and Medicare funding, dental benefits costs and financing
Ian Doyle	Washington State Department of Revenue	State finance/revenue agency
Kai Yeung	Senior Healthcare Research Scientist, Amazon Affiliate Associate Professor, University of Washington (UW)	PharmD, PhD in Pharmaceutical Economics & Outcomes Research, clinical pharmacist, pharmaceutical cost effectiveness and poly analysis, simulation modeling
Robert Murray	President, Global Health Payment LLC	Former Executive Director of Maryland Health Services Cost Review Commission (hospital rate setting and global budgets), reimbursement systems for health care providers
Roger Gantz	Senior Research Manager (retired), Research & Data Analysis division of the Washington State Department of Social and Health Services (DSHS)	BA in economics and finance, federal waivers, caseload and fiscal forecasting, Medicaid Policy director and reimbursement manager

Appendix C: FTAC ERISA Memo

View the FTAC ERISA memo.

Appendix D: FTAC Medicaid Memo

View the FTAC Medicaid memo.

Appendix E: FTAC Transitional Solutions Survey responses

View the FTAC Transitional Solutions Survey responses.

Tab 7

State agency report outs

Tab 8

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.

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: 12,161
  - Coverage requested in 34 out of 39 counties
  - Language assistance requested in 35 languages

Note: Data as of September 10, 2024

Apple Health Expansion funding

- Seeking funding to increase program budget by $84M
- Proposing increasing available slots in program by up to 14,000
  - Would bring total enrollment up to 26,000+ in program by 2027
- Includes:
  - Updated agency administrative costs
  - Funding to reimbursement community members participating on community engagement committee
  - Funding to continue development of an IT-based waitlist solution
  - Funding to support additional outreach activities

Questions

Potential Commission Member Vote: *Apple Health Expansion*

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

Appendix

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

- 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.

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

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

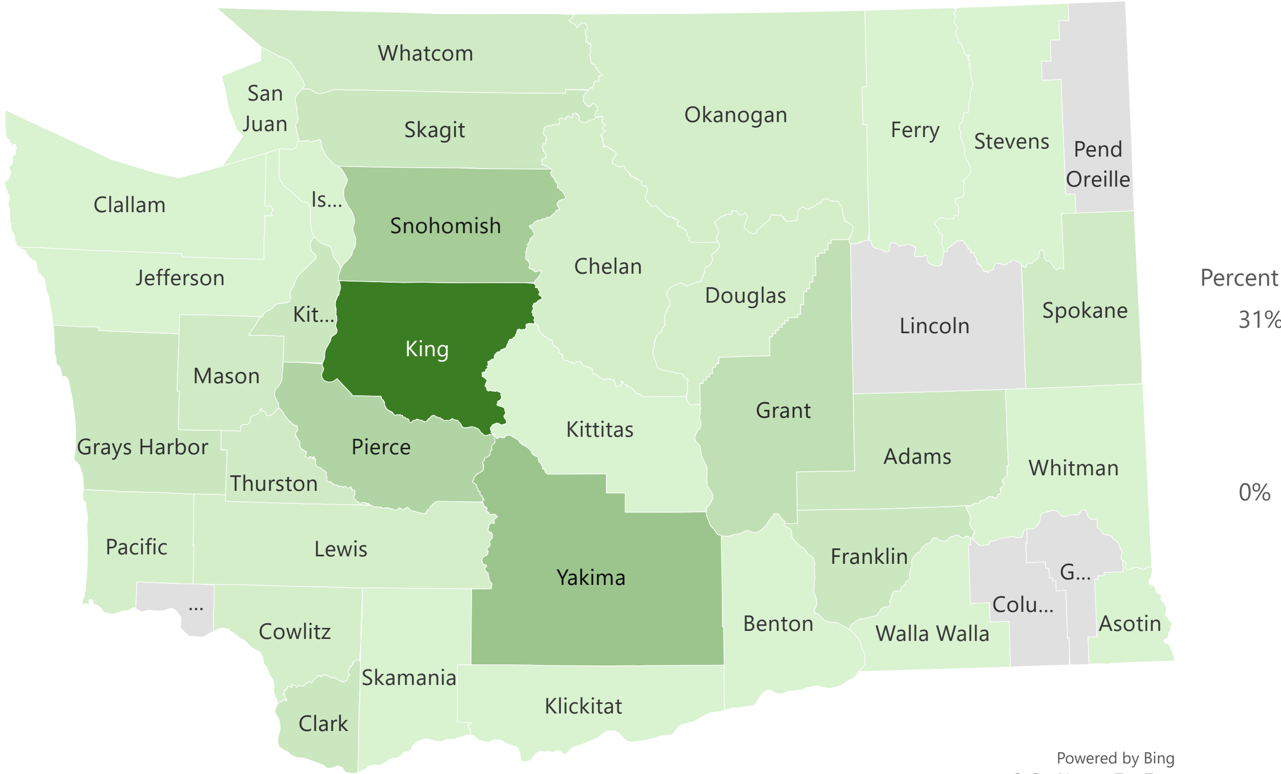
Clients by race

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

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

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.

Washington State Health Care Authority

Note: Eligibility data is of July 3, 2024

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.

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 9

Final Report on Health Care Affordability

Presentation to Health Care Cost Transparency Board

Jane Beyer, Senior Health Policy Advisor
Nico Janssen, Senior Health Policy Analyst

September 19, 2024

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Legislative direction

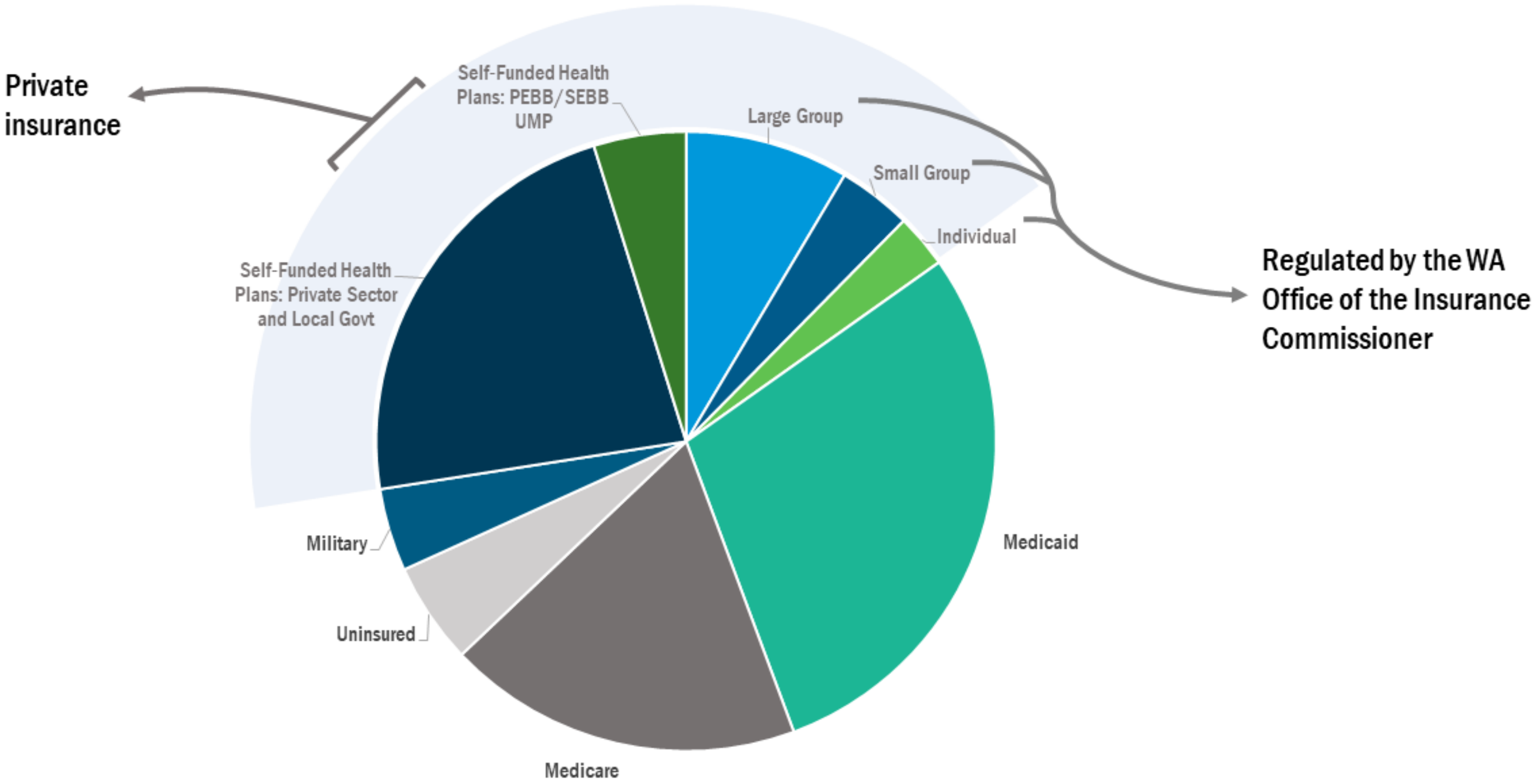
Legislative direction

- In 2023, the Legislature directed the Office of the Insurance Commissioner and the Office of the Attorney General to evaluate policy options that could improve overall affordability for consumers, employers and taxpayers.

    - Preliminary Reports – December 1, 2023
    - Final report – August 1, 2024

Source: ESSB 5187, Sec 144(13) & Sec. 126(33)

Health Care Costs are Rising Regardless of the Source of Health Coverage



Key Findings from the Preliminary Report

OIC's Preliminary Report

1. The structure of Washington's current health care system

2. An overview of potential policy options to improve health care affordability

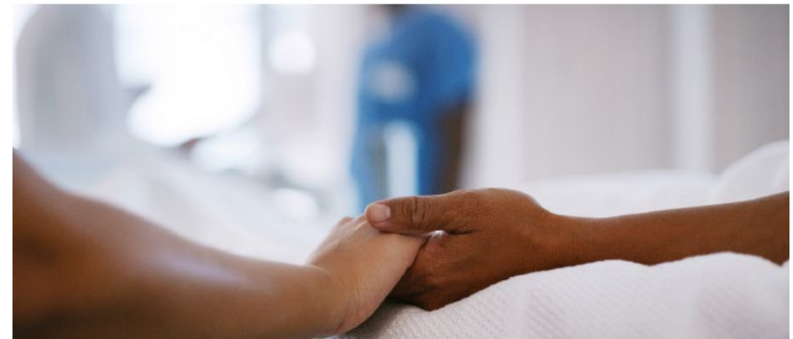
WWW.HEALTHMANAGEMENT.COM

WA OIC Preliminary Report on Health Care Affordability

November 29, 2023

Prepared By
Health Management Associates

With an Introduction From
The Office of the Insurance Commissioner



Vertical Integration and Horizontal Consolidation Among Providers and Facilities

- 40 of the 101 hospitals in the state are part of the five largest hospital systems
- 79.51% of all licensed beds are part of multi-hospital systems
- In 2022, 9% of hospital systems owned skilled nursing facilities (SNFs), 82% owned hospital-affiliated clinics, 28% owned freestanding clinics, and 13% own a home health agency
- Approximately 50% of physicians are employed by hospitals and of these, 65.6% are employed by multi-hospital systems

Vertical Integration Among Insurers

- Insurers or their holding companies are vertically integrated with other parts of the health care system, including:
    - Pharmacy benefit managers (PBMs)
    - Pharmacy services
    - Physician services
    - Health care benefit managers
    - Third-party administrators
    - Data and analytics
- These companies "touch" many aspects of the care that Washingtonians receive

Private Equity in WA's health care system

- From 2014–2023, there were 97 private equity acquisitions within the health care sector in Washington State
- Key investment areas: specialists (dermatology, ophthalmology, gastroenterology, primary care, OB/GYN, radiology, orthopedics, oncology, urology, and cardiology) and other health care facilities and services, e.g. hospice and home health care
- Private equity involved in physician staffing companies:
  - TeamHealth – 1 of 6 largest emergency medicine staffing companies nationally
  - US Anesthesia Partners – Operates in 8 states and the largest majority physician-own + led anesthesia group in the PNW

Selected Policy Options

Establish a reinsurance program in the individual and small group markets

Increase the medical loss ratio standard

Use reference-based pricing

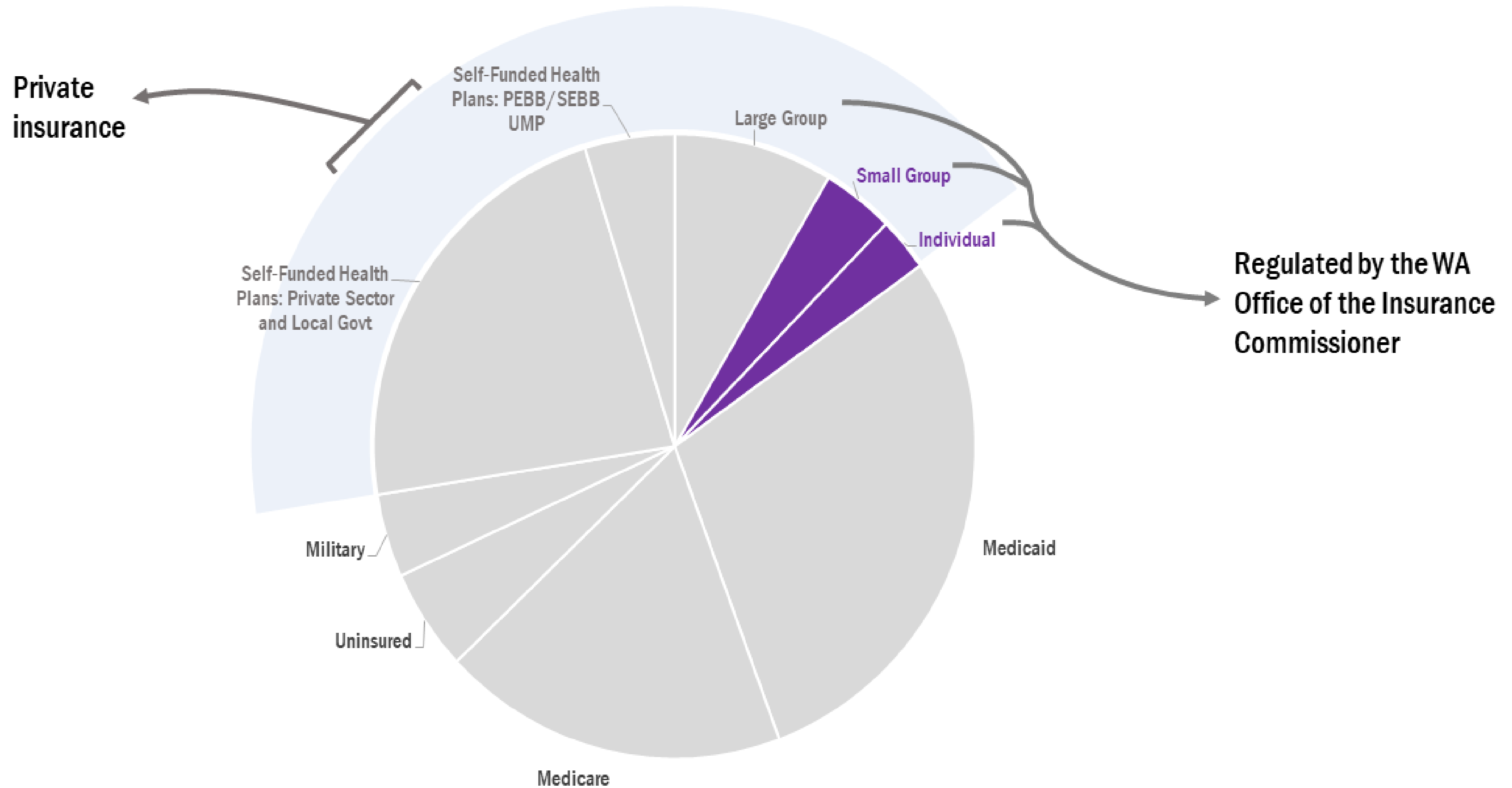
Use hospital global budgeting

Meeting the Health Care Cost Transparency Board Targets

** Referred to Create an all-payer model for hospital services, as in Maryland , in the legislation*

Establish a reinsurance program for individual and/or small group heath plans

Reinsurance Program: Markets Impacted



Reinsurance Program: Background

- Reinsurance programs lower premiums for consumers by paying a portion of high-cost claims, giving more certainty to health insurers
- 17 states have reinsurance programs, and these programs lowered premiums from 5% to 38% in 2022
- Washington considered reinsurance in 2018 but did not enact it due to the potential cost to the state
- Reinsurance programs mostly impact people not eligible for premium subsidies through the Washington Health Benefit Exchange
- This report estimates the impact of a reinsurance program that would reduce premiums by 10%

Reinsurance Program: Impacts of a 10% Premium Reduction

10% Premium Reduction thru Reinsurance in the Individual Market, 2025–2026

Metric	2025 (ARPA)	2026 (No ARPA)
2025 Enrollment Without Reinsurance	251,000	188,000
2025 Enrollment With Reinsurance	255,000	192,000
Total Premiums	$1,765,100,000	$1,555,300,000
Approximate Reinsurance Dollars Needed	$176,000,000	$153,000,000
• **Federal share thru "pass-through"**	$134,100,000	$93,900,000
• **State share**	$41,900,000	$59,100,000
Pass-Through Savings Percent	76%	61%

[1] The American Rescue Plan Act (ARPA) enhanced APTC subsidies beginning in April 2021, increasing the absolute amount of APTC paid and thereby boosting the federal pass-through amounts by nearly 30 percent. The enhanced ARPA subsidies are due to expire at the end of 2025. Assuming that they are not extended, federal pass-through funding will be lower in 2026 than in 2025.

Reinsurance Program: Impacts of a 10% Premium Reduction

10% Premium Reduction thru Reinsurance, 2025–2029

Metric	Individual ACA	Small Group
Market Enrollment	192,000 to 289,000	215,000 to 279,000
Impact on Premiums	$744 to $999	$765 to $1,176
Aggregate Savings to Consumer (millions)	$173.0 to $219.0	$164.0 to $328.0
State Funding Needed (millions)	$42.0 to $84.0	$147.0 to $294.0

**Figures offer a potential range of impact across each year of the 5-year period, and are not aggregated

[1] The American Rescue Plan Act (ARPA) enhanced APTC subsidies beginning in April 2021, increasing the absolute amount of APTC paid and thereby boosting the federal pass-through amounts by nearly 30 percent. The enhanced ARPA subsidies are due to expire at the end of 2025. Assuming that they are not extended, federal pass-through funding will be lower in 2026 than in 2025.

Reinsurance Program: Economic Impact of a 10% Reduction in Small Group Market

Labor Market Effects due to Reinsurance in 2025−2029 (Millions USD)

Wage/Employment Impacts: • Increased employment • Part-time to Full-time • Employee Savings	Net Impact After Taxes • Social Security • Medicare • Federal income tax	Total Impact (includes Indirect): + Indirect Impacts • Household spending + Net Impact After Taxes
$1,686	$1,306	$2,375

The economic model also estimates **$210.4 million in additional tax revenue** for Washington in 2025−2029.

**Numbers are aggregated across the 5-year period.

Reinsurance Pros & Cons

Key Takeaway: Lowers premiums in targeted markets but requires significant state funding.

State Cost Net of Pass-through Funding (millions USD):
Individual Market: $42–$84 million
Small Group Market: $147–$294 million

Advantages

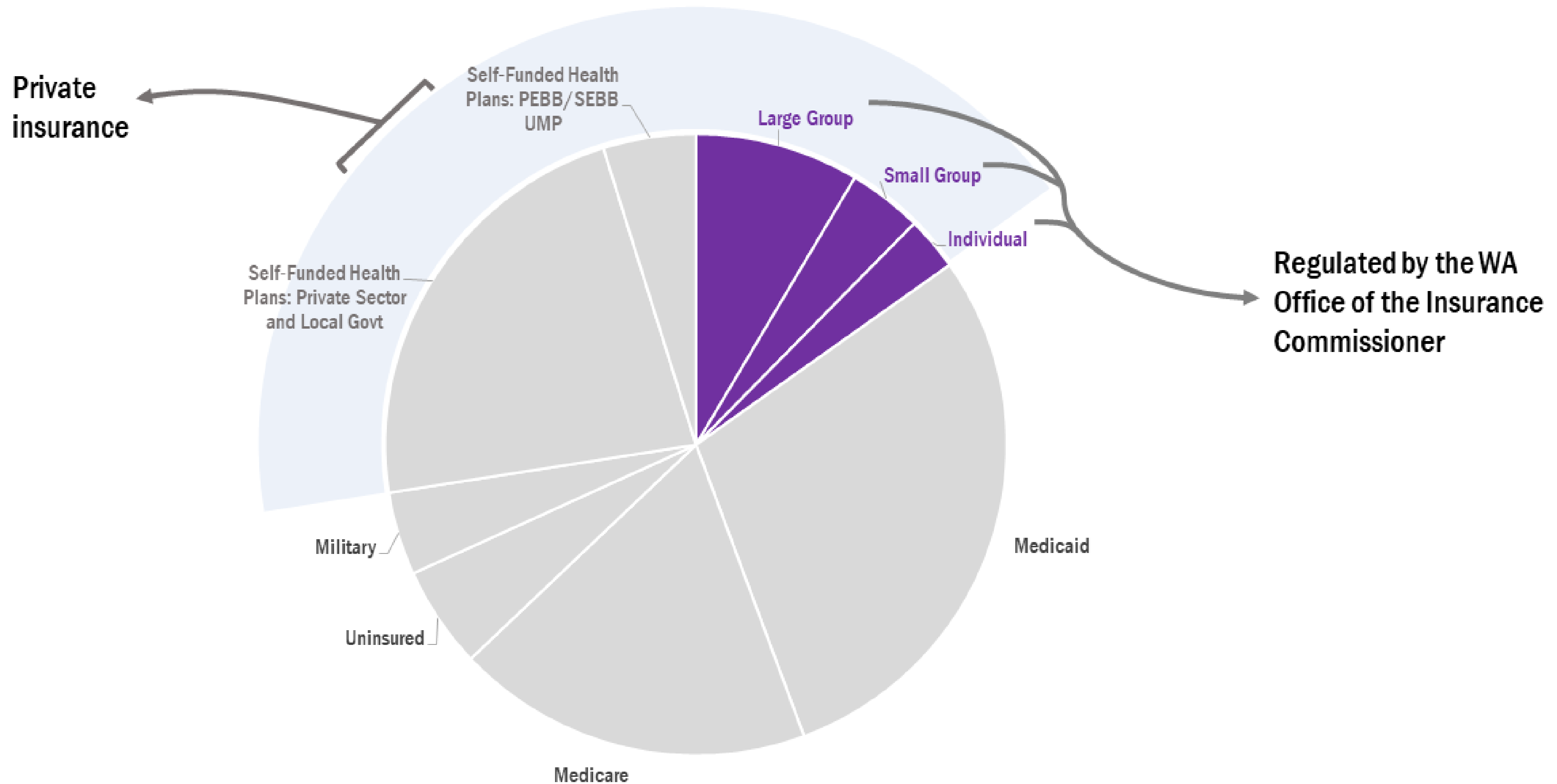
- **Shown to reduce unsubsidized premiums and potentially increase enrollment**
- **Greater impact on middle-Income Consumers**
- **Successfully implemented in 17 states and relatively simple**

Disadvantages

- **Requires significant state funding**
- **limited impact on lowest Income Consumers**
- **Insurers may be more conservative in their assessment of the impact**

Increase insurers’ medical loss ratio standard

Increase the Medical Loss Ratio Standard: Markets Impacted



Increase the Medical Loss Ratio Standard: Background

- Current federal law requires that insurers spend a minimum amount of premium dollars on medical care or quality improvement – 80% for individual/small group market and 85% for fully-insured large group market
- Insurers that don't meet this ratio must return excess to enrollees and/or employers through refunds or rebates
- This report studied the impact of increasing the standard to 88%
- Most insurers in Washington have neared or met the 88% standard in recent years

Increase the Medical Loss Ratio Standard: Actuarial Impacts

Summary of Impacts: Revised MLR Requirement Set at 88 Percent, 2025–2029

Metric	Individual ACA	Small Group	Fully Insured Large Group
Impact on Enrollment	189,000 to 252,000	303,000 to 304,000	1,063,000 to 1,065,000
Impact on Premiums	$616 to $829	$451 to $535	$577 to $674
Aggregate Savings	$37.1 to $45.4	$17.2 to $28.8	$36.1 to $50.6

** Figures offer a potential range of impact across each year of the 5-year period, and are not aggregated

Increase the Medical Loss Ratio Standard: Economic Impacts in Group Markets

Total Impact of Labor Effects from Medical Loss Ratio Implementation for 2025–2029 (Millions USD)

Wage/Employment Impacts: • Increased employment • Part-time to Full-time • Employee Savings	Net Impact After Taxes • Social Security • Medicare • Federal income tax	Total Impact (includes Indirect): + Indirect Impacts • Household spending • Tax Revenues + Net Impact After Taxes
$1,156	$895.2	$1,628

The economic model also estimates **$144 million in additional tax revenue** for Washington in 2025–2029.

**Numbers are aggregated across the 5-year period.

Increase the Medical Loss Ratio: Summary

Key Takeaway: Provides slightly lower premiums to people with fully-insured health plans, resulting in modest savings.
State Cost: None

Advantages

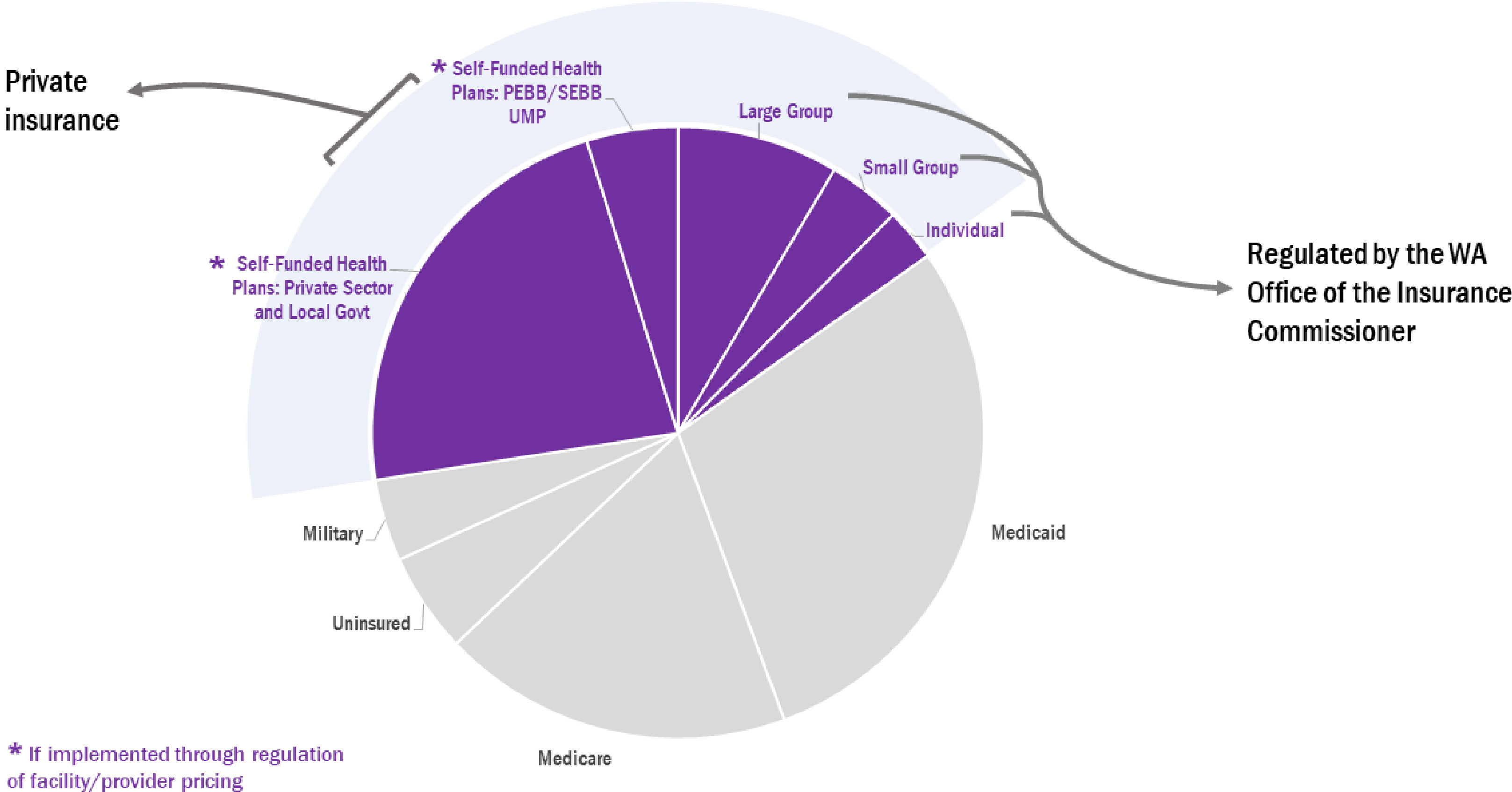
- **Low cost to administer depending on program design**
- **No state funding necessary**

Disadvantages

- **Limited impact on low-income consumers**
- **Modest impact on premiums**
- **Could possibly cause some insurers to leave the market, although most insurers at or near 88% MLR**

Use Reference-Based Pricing

Use Reference-Based Pricing: Markets Impacted



Reference-Based Pricing: Background

- Establishes standard reimbursement rates for a set of health services that are tied to a defined pricing level, such as a percentage above what Medicare pays.

- Oregon uses reference-based pricing for their state employee programs (and school employees) and has realized significant savings as a result. Also showed savings in Montana when in effect there.

- Washington uses reference-based pricing for the public option plan, Cascade Select. Provider reimbursement is limited to 160% of Medicare in the aggregate. To date, premium increases have been lower than other plans on the Exchange.

** Potential data issues with Washington's APCD resulted in significant uncertainty on the effects of a reference-based pricing program.*

2022 APCD claims repriced to % of Medicare

Health care service	Percent of Medicare
Mental health/SUD professional fees	88%
Primary care providers	149%
Specialists	144%
Hospital – Emergency room visit	309%
Hospital – Outpatient surgery	232%
Hospital -- Inpatient surgery	202%

Reference-Based Pricing: Actuarial Impacts

Summary of Impact of Reference-Based Pricing Set at 160% of Medicare 2025−2029

Impact Metric	Description
Cost savings	3% to 19% reduction in health care spending
Enrollment impact	Higher Enrollment due to greater affordability (exact enrollment change dependent on size and scope of program)
Washingtonians affected	Up to entire commercial market (4.3 million), if program caps what providers and facilities can charge, rather than regulating what insurers can pay for services

Reference-Based Pricing: Economic Impacts

Total Impact of Labor Market Effects from Reference-Based Pricing Set at 160% of Medicare for 2027 (Millions USD)

Wage/Employment Impacts: • Increased employment • Part-time to Full-time • Employee Savings	Net Impact After Taxes • Social Security • Medicare • Federal income tax	Total Impact (includes Indirect): + Indirect Impacts • Household spending • Tax Revenues + Net Impact After Taxes
$227.80	$176.43	$320.81

The economic model also estimates **$24.9 million in additional tax revenue** for Washington in 2027

Use Reference-Based Pricing: Summary

Key Takeaway: Could improve affordability for the greatest number of Washingtonians by addressing the underlying price of health care services, but likely operationally complex to implement

State Cost: No direct costs but substantial operational costs.

Advantages

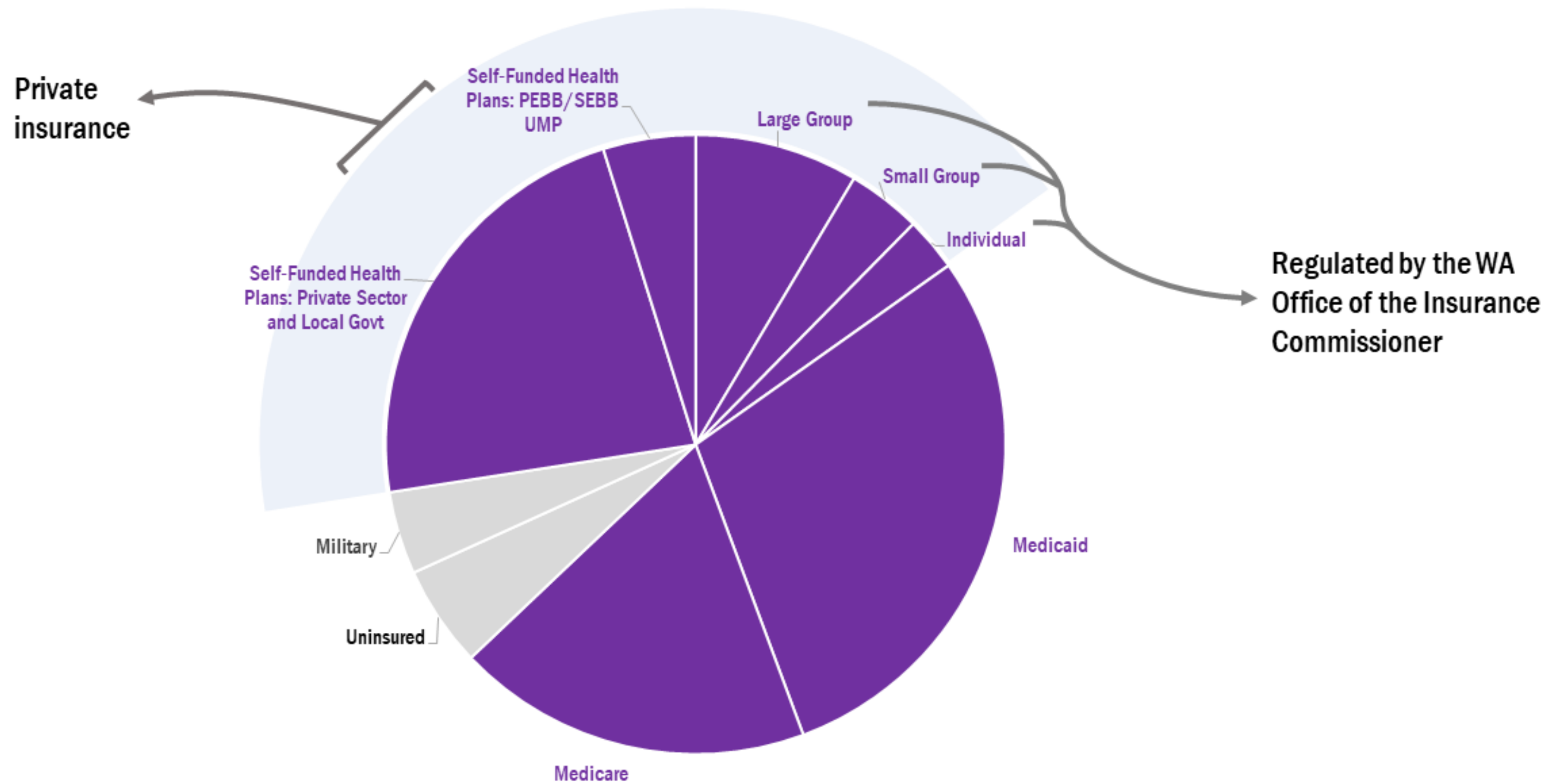
- **Cost savings achieved by directly affecting the price of health care services**
- **Can incentivize key services and redistribute health care spending**
- **Increases health care pricing and spending transparency**

Disadvantages

- **Complex to implement and administer**
- **Could cause significant disruption in the health care delivery system**

Use Hospital Global Budgeting

Hospital Global Budgeting: Markets Impacted



Hospital Global Budgeting: Background

- Hospital Global Budgets establish rates for hospitals that are the same for all payers and set hospital-specific revenue budgets.
- Designed to incentivize hospitals to shift away from increasing revenue by increasing the volume of services they provide and instead adopt measures to control costs and increase efficiency.
- To date, only Maryland has implemented such a model; Washington had a hospital rate-setting statute like Maryland's in the 1970's and ‘80s that was repealed in 1989.

Hospital Global Budgeting: Background

- The report studied the impact of limiting hospital cost growth to 2.8% per year on a per-person (per capita) basis, to align with Washington Health Care Cost Transparency Board (HCCT Bd.) cost growth benchmark.

- The report evaluated a scenario in which participation is mandatory for all acute care hospitals – except critical access, psychiatric, rehabilitation, and children's hospitals.

- Like Maryland, a global budget should be paired with required care transformation activities (e.g., quality of care and primary care investments).

Hospital Global Budgeting: Actuarial Impacts

Summary of Impact of Hospital Global Budget in 2025–2029

Impact Metric	Description
Cost savings	0% to 7.1% reduction in hospital costs (exact savings dependent on program implementation details)
Enrollment impact	Higher enrollment due to greater affordability (exact enrollment change dependent on size and scope of program)
Washingtonians affected	All

**Numbers given offer a potential range of impact across each year of the 5-year period, and are not aggregated

Hospital Global Budgeting: Economic Impacts

Total Impact of Hospital Global Budgeting over 2025–2029 (Millions USD)

Wage/Employment Impacts:
 	
• Increased employment
• Part-time to Full-time
• Employee Savings
	Net Impact After Taxes
	
	• Social Security
	• Medicare
	• Federal income tax
		Total Impact (includes Indirect):
		
		+ Indirect Impacts
		  • Household spending
		  • Tax Revenues
		
		+ Net Impact After Taxes

$4,370	$3,384	$6,154

The economic model also estimates **$529.2 million in additional tax revenue** for Washington in 2026-2029

**Numbers are aggregated across the 5-year period.

Hospital Global Budgeting: Summary

Key Takeaway: Has potential to improve affordability for the greatest number of Washingtonians by controlling the growth in hospital costs, but at significant implementation costs.

State Cost: Substantial operational costs.

Advantages

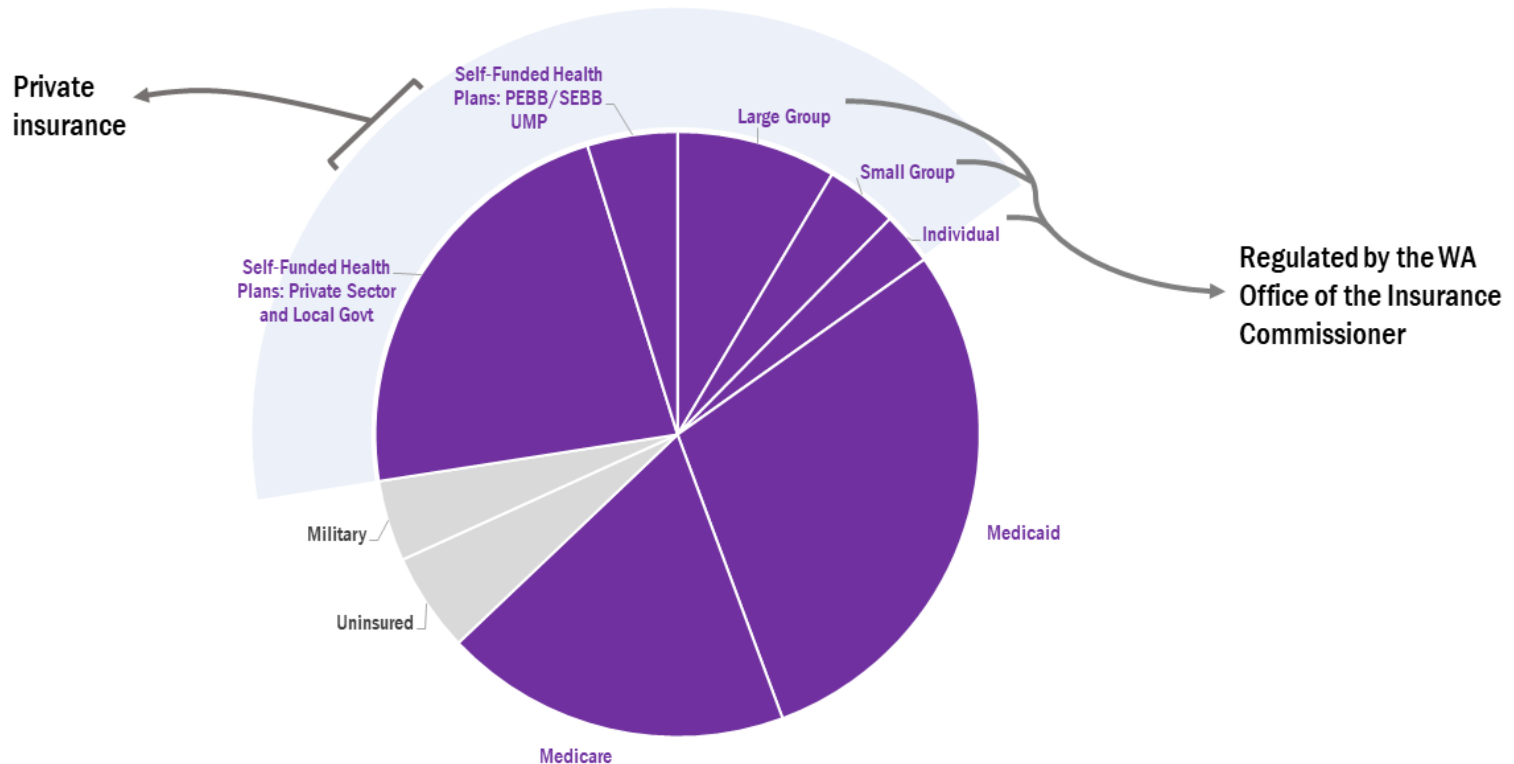
- **Potential for large effect**
- **Incentivize investments in high value services, e.g.**
  - **Primary Care**
  - **Behavioral Health**
  - **Complex Discharge**

Disadvantages

- **Operational complexity**
- **Could seriously impact hospital financing; exemptions can be made for certain types of hospitals**
- **Federal approval needed to include Medicaid/Medicare**

Impact of Meeting HCCT Board Benchmarks on Health Care Spending and the Economy

Meeting the HCCT Board Targets: Markets Impacted



HCCT Board: Background

- Currently *measures and reports on* annual health care cost growth. Can identify providers and insurers with costs that exceed the benchmark
- Potential policy option: add enforcement authority such as imposing performance improvement plans, fines, or other penalties for providers and insurers that exceed the benchmarks
- California, Massachusetts, and Oregon cost boards have enforcement authority

Impact of Meeting Benchmarks on Spending

Table 52: Impact of Meeting Spending Growth Benchmarks for 2025–2029 (Millions USD)

Year(s)	Spending Growth	Projected Savings
2025	3.00%	$1,420
2026	2.80%	$1,621
2027	2.80%	$1,708
2028	2.80%	$1,801
2029	2.80%	$1,898
2025-2029	2.84% (Avg)	$8,447

HCCT Board: Economic Impacts

Total Impact of Labor Market Effects from Benchmarks in 2025–2029 (Millions USD)

Wage/Employment Impacts: • Increased employment • Part-time to Full-time • Employee Savings	Net Impact After Taxes • Social Security • Medicare • Federal income tax	Total Impact (includes Indirect): + Indirect Impacts • Household spending • Tax Revenues + Net Impact After Taxes
$7,433	$5,757	$10,468

The economic model estimates **$927.5 million in additional tax revenue** for Washington in 2026-2029

**Numbers are aggregated across the 5-year period.

Meeting the HCCT Board Targets: Summary

Key Takeaway: Directly lowers the growth in health care costs for the entire state, but without any enforcement mechanism, the benchmarks are unlikely to lower health care expenditures or drive significant changes in provider or insurer behavior.
State Cost: Substantial operational costs.

Advantages

- **Greatest impact on health care costs in the state**
- **Least intrusive mechanism**
- **Most flexible approach**

Disadvantages

- **Unlikely to be effective without enforcement**
- **Potentially protects high-cost providers and insurers**
- **Least targeted approach**

Final Affordability Report – In Conclusion

- The five policy options can meaningfully improve health care affordability, benefiting individuals, families, employers and state revenues

- Each option has its own advantages and disadvantages

- The report aims to give policymakers Washington-specific data as they consider approaches to improve health care affordability

Questions?

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Report is available at: https://www.insurance.wa.gov/sites/default/files/documents/oic-final-health-care-affordability-report-073024_1.pdf

Connect with us!

- Facebook: https://www.facebook.com/WSOIC
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- www.insurance.wa.gov

Universal Health Care Committee meeting

We are currently on a short break

Tab 10

Workstream 2 (Transitional Solutions): Administrative Simplification

Prior Authorization

Three potential areas of focus:

1. Gold carding
2. Standardized forms
3. Reducing or eliminating prior authorization requirements by code type, focusing on those with consistently high approval rates

Prior Authorization: Gold Carding

Gold carding programs aim to reduce the volume of prior authorization requests.

- Many insurers implement elements of gold carding, but application varies across payers and can be confusing/frustrating for providers and patients.
- Legislation typically requires insurers to exempt certain providers from prior authorization if they have a history of high prior authorization approval rates. Arrangements are reviewed periodically.
- 5 states have enacted legislation (LA, MI, TX, VT, WV)
- Washington does not have gold carding legislation

SOURCES: The Good, The Bad, The Costly: State Efforts to Reform Prior Authorization Practices (July 2024) Georgetown University Center on Health Insurance Reforms, States Target Health Insurers' 'Prior Authorization' Red Tape (February 2024) KFF.

Gold Carding

Gold Carding	
Pros	Reduction of administrative burden Increase access for patients May improve efficiency May improve health outcomes
Cons	Confusion amongst participating providers as to when applicable Low volume providers may not see benefit May increase occurrences of inappropriate care May increase total cost of care Possible inequities if only certain providers attain gold carding privileges
Impact	Efforts to reduce provider frustration with the process must balance cost containment and necessity of care while also acknowledging the high rates of approval.
Implementation	Stakeholders report mixed results from state laws, some ongoing confusion and some positive feedback from providers who perform routine services like radiology.

Prior Authorization: Standardized Forms

In 2023 Washington enacted E2SHB 1357 (prior authorization modernization legislation) and the Office of the Insurance Commissioner is currently working on final rule-making.

- Covers requirements for electronic and non-electronic prior authorization requests
- Requires automation and interoperability across payers
- Washington's law puts the state on schedule to meet new federal requirements of CMS Interoperability and Prior Authorization Final Rule CMS-0057-F | CMS

Standardized Forms

- Washington law does not require a standardized form across payer types
- Several states have implemented standardized forms for electronic and paper submission (e.g., Texas and Arizona)

Standardized Forms

Standardized forms	
Pros	May reduce confusion May improve efficiency May improve data collection uniformity May prevent submission of incomplete information (which often results in a denial)
Cons	Complicated requests may require non standardized information Self funded plans may not be required to implement Changing required fields could disrupt ongoing data collection and analysis
Impact	Efforts to reduce administrative burden through standardization of preauthorization requests should consider data and reporting issues.
Implementation	State law may not apply to all plans, creating additional confusion.

Discussion

Has the Commission reviewed enough material to make a recommendation on gold carding and/or standardized forms?

If not, what additional information does the Commission need?

Potential Recommendations

- *The Commission recommends the Legislature develop and consider legislation to implement a gold carding program.*

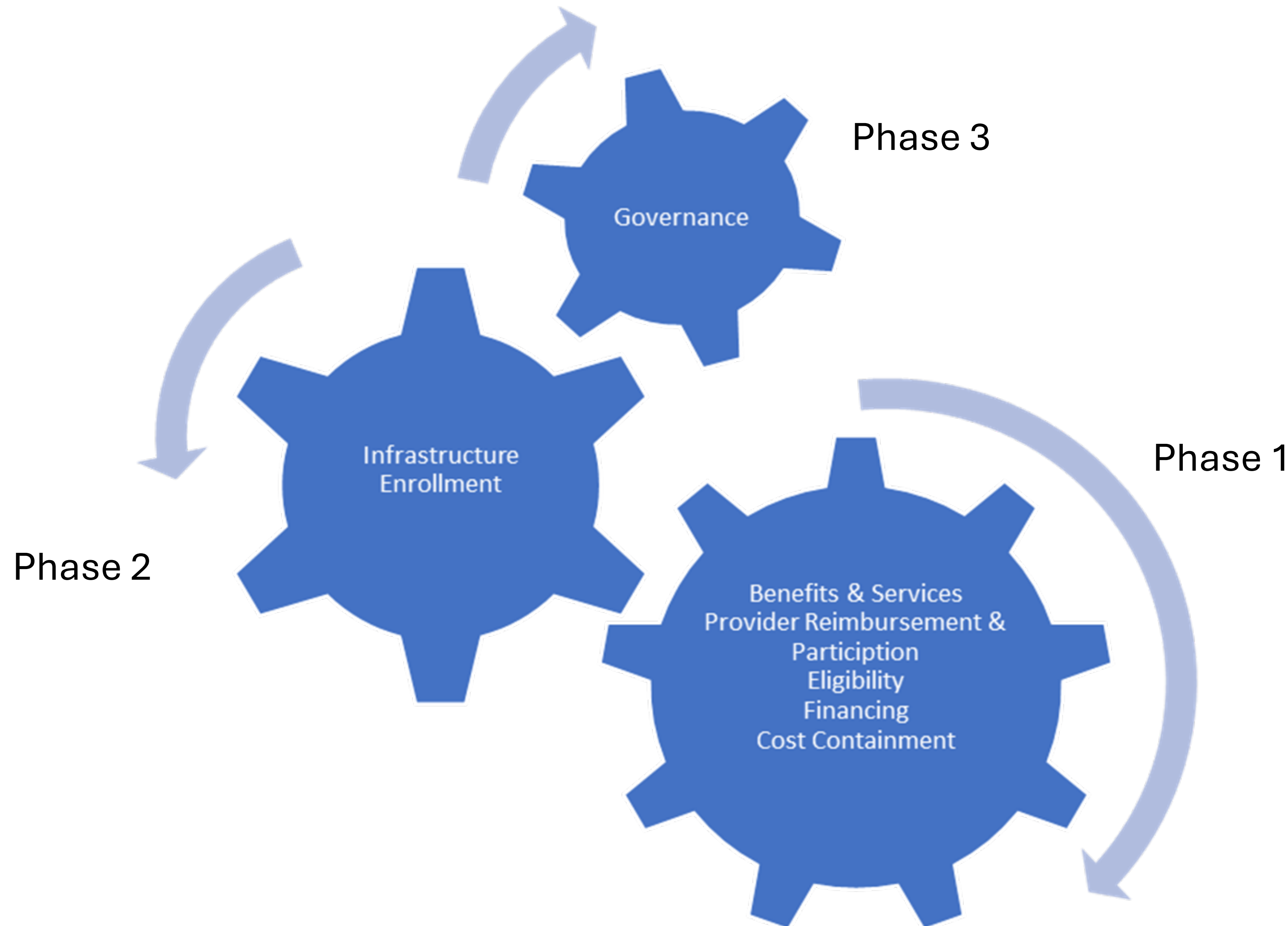
- *The Commission recommends the Legislature develop and consider legislation to implement a standardized form for Prior Authorization across all payers and providers.*

Tab 11

Next Steps

Gary Cohen, *HMA*

Next Steps: Universal Design (Workstream 1)



We heard today about some ideas for provider reimbursement and participation from the OIC report. Are there ideas you would like to hear more about?

What does the Commission want to keep working on, and what could be sent to FTAC?

Next Steps: Transitional Solutions (Workstream 2)

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

Does the Commission want to continue discussing **administrative simplification?**

Does the Commission want to move to **another transitional solution?**

Washington State Health Care Authority

Thank you for attending the Universal Health Care Commission meeting!