Washington State Health Care Authority
Report to the Legislature

Universal Health Care Commission

Annual report

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

November 1, 2024

Table of contents

Executive summary 4

Figure 1: Commission work plan 6

Developments: October through December 2023 6

Vote to approve the 2023 report to the Legislature 6

Prioritization of transitional solutions for 2024 7

Table 1: Prioritized transitional solutions 7

Analyzing eligibility of various groups by payer 8

Assessment of FTAC's guidance on ERISA 8

Employers as a predominant source of health care coverage 8

Overview of ERISA 8

Examination of employer (ERISA) integration by other states 9

California 9

Oregon 10

Programs in Washington that achieve universal access to specific benefits across all insurance markets while avoiding an ERISA challenge 11

The Washington Vaccine Association (WVA) 11

The Partnership Access Line (PAL) 11

FTAC's discussion and guidance on ERISA options for Washington 11

Figure 1: Brown's spectrum of options for universal health care 12

Options to include ERISA in Washington's future universal health care system 13

Option 1: Federal waiver 13

Option 2: Optional employer participation 13

Option 3: Pay or play 14

Option 3a: Meaningful alternative (comprehensive public option) 14

Option 4: Provider regulation/incentives 14

Option 5: Payroll tax on all employers 14

Option 6: Combination of two or more options 15

The Commission's vote on ERISA 15

Examination of Medicaid considerations for unified system 16

Assessment of options to include Apple Health (Medicaid) 16

Examination of Medicaid integration by other states 16

Decisions by Oregon's Task Force regarding eligibility 16

Key points in California's eligibility considerations 17
FTAC's discussion and guidance on Medicaid options for Washington 17
Overview 17
Financing 18
Eligible populations 18
Benefits 18
Cost-sharing 18
Program administration 19
Waivers 19
State Plan Amendments vs. waivers 20
Washington's experience with demonstration waivers 20
Provider reimbursement and Medicaid rates 21
Enrollment 21
FTAC discussion 22
Options to include Medicaid in Washington's future universal health care system 22
Commission's discussion on Medicaid 23
Development of the Washington Health Trust analysis report 23
Benefits and services 24
Prior analyses 25
Ongoing transitional solutions 25
Public participation included in Commission's work 26
Conclusion 26
Appendix A: Universal Health Care Commission member roster 27
Appendix B: Finance Technical Advisory Committee (FTAC) member roster 28
Appendix C: FTAC ERISA Memo 29
Appendix D: FTAC Medicaid Memo 29
Appendix E: FTAC Transitional Solutions Survey responses 29

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. Health Care for All – Washington, a group of consumer advocates who've been heavily involved with the Commission since its inception, have also played a role

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

in securing funding for increasing staff levels and consultant supports, supporting the Commission's ongoing mission.

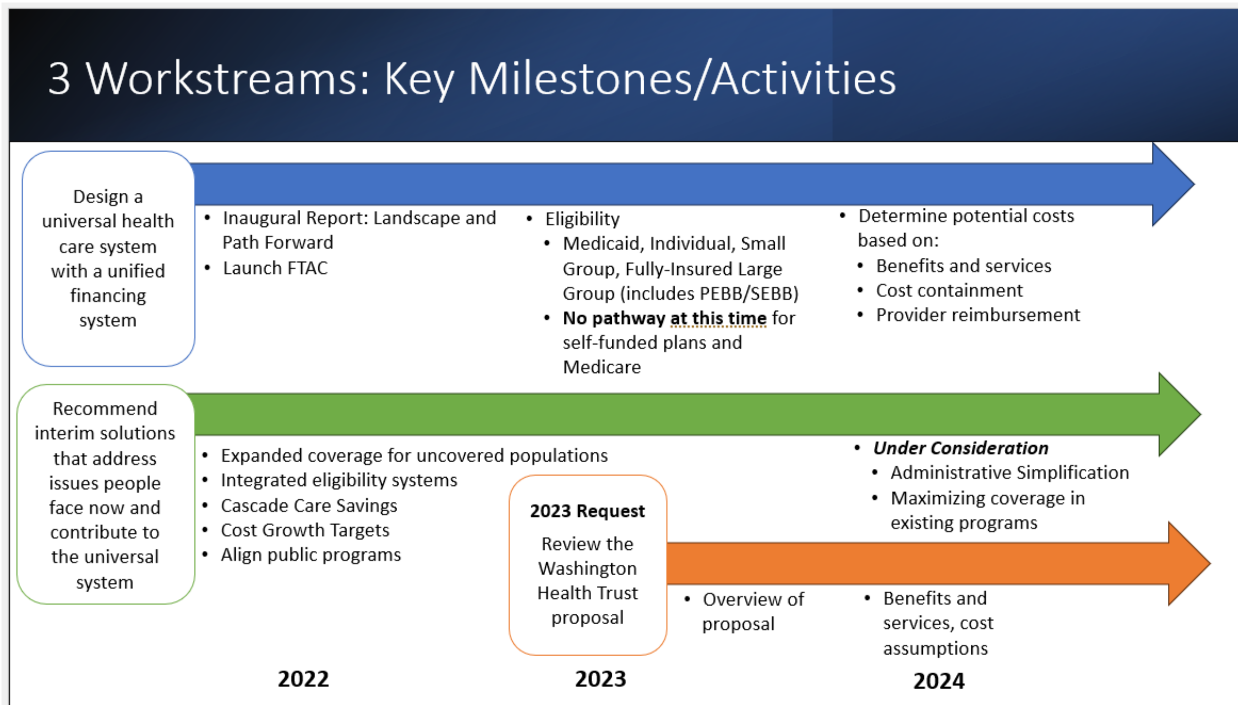
The Commission selected eligibility determination for the future health care system as the first topic of discussion for deliberation. The Commission's preliminary eligibility work to create pathways that include Medicare, Medicaid, and employers in Washington's future health care system concluded in 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] 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."

---

[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

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)).

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."

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]

---

[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.
[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

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 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."

---

and include replacing the "any and all" preemption with floor preemption (which is used in other comparable health statutes), eliminating ERISA's "deemer clause," thus removing barriers around interference with self-funded employer-based plans under ERISA, and adding a statutory waiver provision to ERISA. The fourth proposed option is new jurisprudential interpretations that curtail the courts' vision of ERISA's preemption.

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

[14] The Ninth Circuit also covers Washington.

[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).

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 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

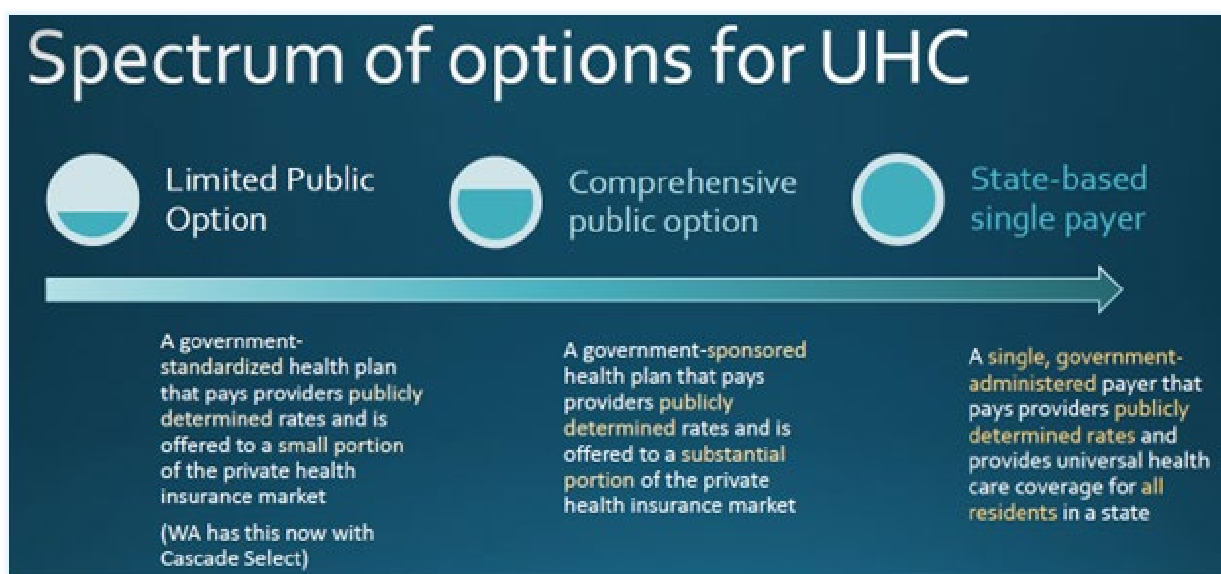
[16] Employer-based health care coverage accounts for 52 percent of Washington resident's' health coverage. Data are from the Office of the Insurance Commissioner (OIC) internal carrier enrollment reports (using 2021 reports), American Community Survey's health insurance coverage tables, and Kaiser Family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

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:

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.

---

[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.

[19] Affordable Care Act tax provisions for large employers

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 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.

---

[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.

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 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

---

[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.

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

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 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

---

[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**.

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

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**.

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.

[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.

- 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.
- 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.

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

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.
- 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]

---

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

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

[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.

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

Program administration

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

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

Waivers

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

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

- If federal law prevents a needed service or benefit:
    - Medicaid cannot pay for "Institutes 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.
- 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.

---

[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**.

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

[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.

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 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

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

[40] FTAC Medicaid memo is available in Appendix D.

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.

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.

---

[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.

[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.

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 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.