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, 2023

Table of contents

Glossary of abbreviations and acronyms

ABA	Applied behavior analysis
ACA	Affordable Care Act
CMS	Centers for Medicare & Medicaid Services
Commission	Universal Health Care Commission
DOH	Department of Health
DSHS	Department of Social and Health Services
EHB	Essential health benefits
ESI	Employer-sponsored insurance
ERISA	Employee Retirement Income Security Act of 1974
FFS	Fee-for-service
FPL	Federal poverty level
FTAC	Finance Technical Advisory Committee
GF - S	General Fund - State
HBE or Exchange	Washington Health Benefit Exchange
HCA	Health Care Authority
HCAC	Healthy California for All Commission
HCCTB	Health Care Cost Transparency Board
HHS	U.S. Department of Health and Human Services
HMA	Health Management Associates
IHS	Indian Health Service
MA	Medicare Advantage
MA-PD	Medicare Advantage & Medicare Part D
MCO	Managed care organization
OFM	Office of Financial Management
OIC	Office of the Insurance Commissioner
OPMA	Open Public Meetings Act
PEBB	Public Employees Benefits Board
PHE	Public health emergency
Plan	Oregon's proposed Universal Health Plan
Program	Jamestown Tribal Health Benefits Program

QDP	Qualified dental plan
SEBB	School Employee Benefits Board
SSDI	Social Security Disability Insurance
Task Force	Oregon Joint Task Force on Universal Health Care
TPA	Third-party administrator
VHA	Veterans Health Administration
UHC Work Group	Universal Health Care Work Group
UMP	Uniform Medical Plan
FY	Fiscal year

Executive summary

This is the Universal Health Care Commission's (Commission) second annual report submitted by the Health Care Authority (HCA) to the Washington State Legislature and Governor as directed in Engrossed Second Substitute Senate Bill 5399 (E2SSB 5399), Section 2(8), and enacted as Chapter 309, Laws of 2021. This report builds upon the Commission's 2022 **baseline report** to the Legislature and Governor and describes the Commission's work from September 2022 through September 2023.[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
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> 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 their second year, the Commission strategically structured meetings to target the Legislature's overarching goals that are both forward-looking and intended to improve upon the current health care system. Each meeting focused partly on further exploration and refinement of interim strategies to transition Washington to a universal health care system, and partly on the foundational design components of the future system.

The Commission selected eligibility as the first design component to develop and designated this topic as the primary area of focus for the newly launched Finance Technical Advisory Committee (FTAC).[2] The Commission also determined that discussions and recommendations regarding future system design would be supported by information regarding opportunities within existing authorities, other states and current programs in Washington, and equity principles.

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

- Initialization and launch of FTAC.
- Identifying the need for federal authority to achieve a state-based universal health care system supported by unified financing, and that pursuit of such authority is a multiyear endeavor.

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

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

The 2023 Legislature also provided General Fund - State (GF - S) funding for work required of HCA as specified in **RCW 41.05.840** for fiscal years (FY) 2024 and 2025. This funding was borne out of the strong advocacy work by community members and advocates across Washington. Community members continue to engage with the Commission by attending meetings to provide encouragement, insightful feedback, and often graciously share personal and painful experiences suffered in the current health care system. The community's continued input is instrumental to the Commission's work to ensure that all Washingtonians have equitable access to culturally appropriate and affordable health care. The Commission is currently undertaking strategic planning to determine how to best use this funding, details of which will be included in the 2024 legislative report.

Developments: October through December 2022

The Commission's baseline report to the Legislature due November 1, 2022, did not capture business from the Commission's October and December meetings. The following developments occurred over the October and December meetings:

- Vote to approve the baseline report to the Legislature
- Launch of FTAC
- Presentation from Oregon's Joint Task Force on Universal Health Care

Vote to approve the baseline report to the Legislature

For their 2022 baseline report, the Commission was required to make recommendations regarding the specific topics identified in the legislation. The Commission's recommendations were grounded in goals to increase access to quality and affordable health care by streamlining access to coverage, and to reduce fragmentation of health care financing, unnecessary administrative costs, and health disparities. The Commission's 2022 recommendations included:

- Transitional solutions that support goals of universal coverage including enrollment options, eligibility systems, access to care, quality improvement, and increased equity.
- Transitional strategies that can improve affordability and advance the state's readiness to implement a universal health care system.
- Potential pathways to increase Medicaid provider rates as requested by the legislature.[3]

At the October 2022 meeting, one Commission member raised concerns prior to voting to approve the baseline report.[4] Concerns included there being several unanswered questions for the universal health care system design, including eligibility and expectations for who or what entity would be responsible for determining coverage and benefits. The Commission member also suggested that there are pathways other than universal health care that may provide equitable access to coverage and may represent all Washingtonians. Additionally, it was suggested that the Commission first investigate reasons as to why individuals remain uninsured or lack access to care before developing a universal health care system design. Commission members acknowledged that eligibility, coverage and benefits, and other key design components will continue to be developed in the Commission's work to design Washington's new universal health care system.

Members' approval of the baseline legislative report[5, 6] marked a major milestone in the Commission's work, particularly with the first year being largely focused on the report's development.

[3] The Commission's 2022 recommendations are outlined in greater detail in the Executive Summary of the **baseline report.**

[4] Commission **October 2022 meeting recording**.

[5]The Commission members present voted by majority to adopt the final report (10 for, one opposed).

[6] 11 of 15 members were present for the vote to adopt the 2022 baseline report.

Launch of FTAC[7]

In the U.S., the health care financing and delivery systems are inextricably linked; an individual's coverage and access to care are determined by the payer or financing source of that coverage. Federally funded and/or federally administered health care programs create additional barriers to achieving a state-based universal health care system with unified financing, such as legal obstacles to enrolling individuals receiving health care coverage through federal programs. Developing strategies to support Washington's future health care system requires disentangling how health care has historically been delivered and paid for.

The Commission determined that finance subject matter expertise specializing in health care financing would be essential to informing such strategies. As launched and 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. FTAC is also charged with investigating strategies to develop unified health care financing options for the Commission's consideration, and to provide pros and cons for each option.

FTAC application process

FTAC applications (Appendix C*)* were developed based on applications for other Washington state boards and commissions. The Commission reviewed the proposed FTAC application and voted unanimously in favor of initiating the application process pending review of the application by the Office of Equity. [8]

HCA staff conducted extensive outreach to Washington state finance agencies, research and academic institutions, and outside subject matter experts to apply for FTAC. The call for applications was shared by HCA through a GovDelivery[9] announcement and the opportunity to apply was also posted to the Commission's webpage for at least 30 days. Applicants were required to complete and submit the application and their resume to HCA. The Commission received 54 applications and resumes for FTAC appointment consideration.

FTAC selection process

At the Commission's request, HCA and Health Management Associates (HMA)[10] reviewed each applicant's qualifications (resume and application) and provided recommendations to the Commission of the nine most qualified applicants that would meet the need for varied health care financing subject matter expertise.[11] The Commission voted unanimously to approve the recommended applicants and moved to nominate the consumer representative as the FTAC Liaison to the Commission to create an intentional connection between patients, consumers, FTAC, and the Commission.

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[7] FTAC's roster of members.

[8] The application was reviewed and approved by the Office of Equity prior to its release.

[9] GovDelivery is a web-based email subscription management system used by the Health Care Authority to allow members of the public to subscribe to news and information.

[10] HMA is the Commission's hired consultant.

[11] One position was held for a consumer representative, one position for the Washington Department of Revenue, and one position for the Office of Financial Management. The Commission agreed that FTAC applicants should disclose any conflicts of interest with their application.

FTAC meetings and the Open Public Meetings Act

FTAC's charter was approved by the Commission and outlines the relationship and processes for information exchange between the Commission and FTAC (Appendix D). In accordance with the Commission's authorizing legislation, FTAC is not statutorily subject to the Open Public Meetings Act (OMPA). However, the Commission chose to include a public comment period at each FTAC meeting in alignment with the Commission's open and transparent process that encourages involvement from the public.

Presentation from Oregon's Joint Task Force on Universal Health Care[12]

The Commission received multiple public comments encouraging a presentation from Oregon's Joint Task Force on Universal Health Care (Task Force) on their legislative charge, process, system design, and other findings. In response to this request, the Commission invited Task Force representatives, including the Chair, one member, and one key staff member, to present at their December 2022 meeting.

Key components of the Oregon Task Force's final report

Oregon's Task Force worked over two years (plus a one-year extension due to COVID) and was charged with developing a state-based single-payer health care system, known as the Plan. [13, 14] Key components of the Plan:

- Eligibility
- Cost-sharing
- Benefits
- Goals
- Provider reimbursement
- Role of private health carriers

Presenters also shared the six health equity concepts from the Task Force's recommendations. The equity concepts include:

1. All Oregon residents are eligible.
2. No payment at the time of service.
3. Utilize one benefit plan.

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[12] The 2023 Oregon Legislature enacted Senate Bill 1089 establishing a Universal Health Plan Governance Board to create a comprehensive plan to finance and administer Oregon's Universal Health Plan based on the recommendations from the Joint Task Force on Universal Health Care. The plan is to be submitted to the Legislature by September 15, 2026.

[13] Senate Bill 770. 2019. https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB770/Introduced

[14] The Task Force recommended that the Oregon Legislature establish and fund a founding governing board to develop an implementation and financing plan as this component was not addressed by the Task Force due to time constraints. Joint Task Force on Universal Health Care Final Report and Recommendations. Prepared by the Legislative Policy and Research Office. September 2022. https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/257230

4. Normalize reimbursement.
5. Uncouple coverage from employment.
6. Address social determinants of health with delivery system savings.

Public engagement process

The Oregon Task Force's budget included funding for a robust community engagement and outreach to key partners to vet their universal health care proposal. After completion of their final report, the Oregon Task Force held discreet listening sessions with consumers and different sectors of the health care marketplace.

After hearing Oregon's presentation, multiple Commission members agreed that such a public engagement process will be critical to informing Washington's system design proposal. The Commission advocated for developing a similar public engagement process, subject to resources, as Washington's universal health care proposal progresses.

Process and approach to work in 2023

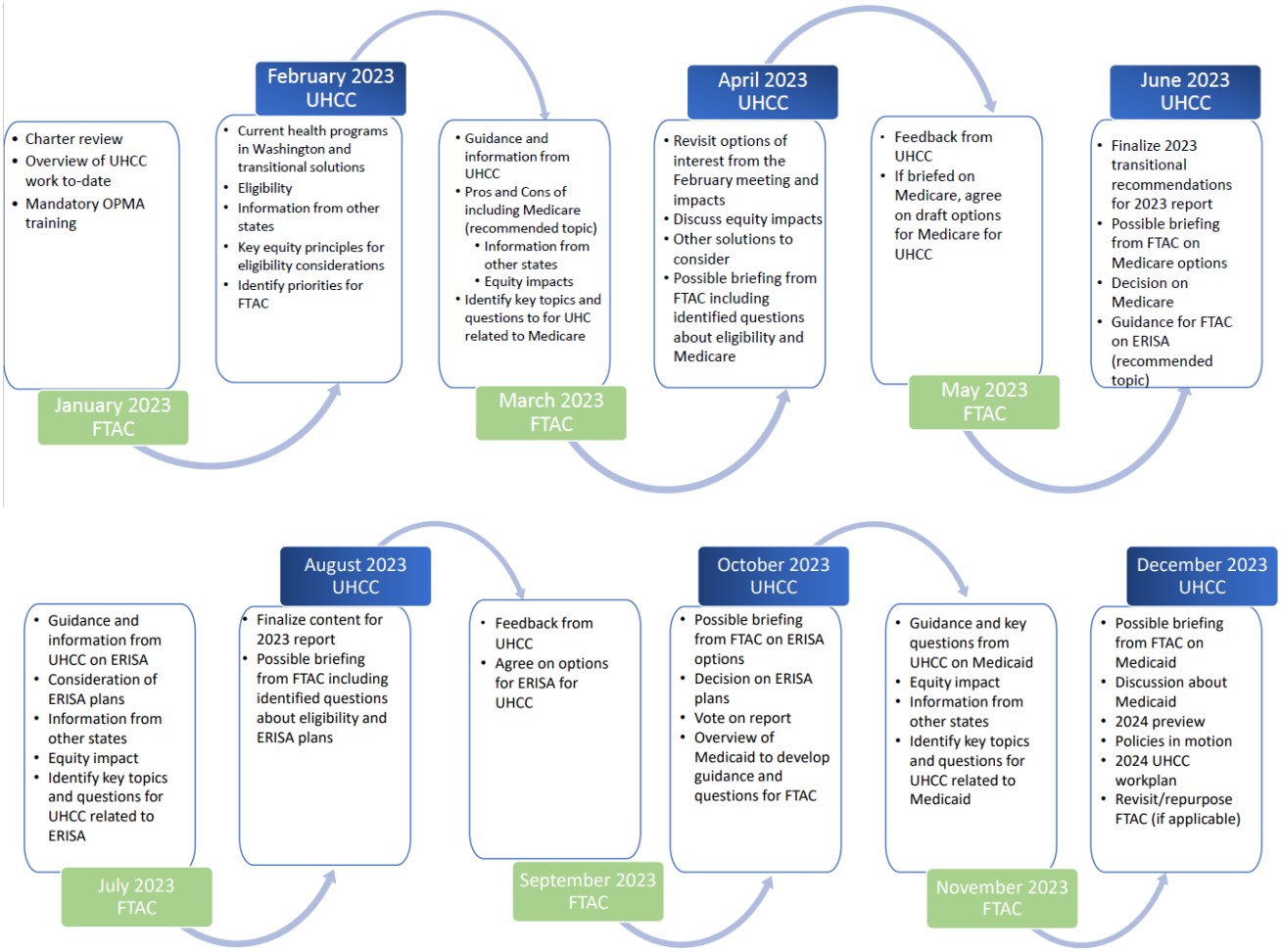
The Commission remains dedicated to its mission to ensure that all Washingtonians have equitable access to culturally appropriate health care and universal coverage, and consistent input from members of the public continues to be a cornerstone of this work. The Commission's first year was primarily focused on the development of the required baseline legislative report. This year was focused on targeting the Legislature's overarching goals for the Commission, which are both forward looking in designing the new universal health care system, and reform-focused; intended to improve access, equity, quality, and affordability within the current health care system.

To best meet these goals, the Commission strategically structured meetings to focus partly on the foundational design components of the future system, and partly on further exploration and refinement of strategies to transition Washington to a universal system. Additionally, members determined that because the Commission is permanent and their work to design and transition Washington to the new system will develop over time, meetings should be framed as "iterative," where an approach or strategy discussed previously may be revisited for refinement. This framing also ensures that short-term solutions are consistent with the vision for the new health care system.

With this framing in mind, the Commission discussed and agreed upon the topics for each of its meetings and each of FTAC's meetings for 2023. Figure 1 illustrates the Commission's workplan.[15]

[15] Figure 1 illustrates the 2023 workplan as approved by the Commission. However, the Commission agreed that the workplan is subject to change depending on progress made at each meeting.

Figure 1: 2023 workplan



Workplan will change depending on progress made in each meeting.

In addition to the core meeting topics outlined above, the Commission identified three supplementary topics as elements of the discussion for each design element at meetings. The supplementary topics include:

1. Explore opportunities within current authorities.
2. Develop equity principles for designing the new system.
3. Assess information on other states and current programs in Washington.

Exploring opportunities within current authorities

The Commission continues to gather information on what existing opportunities could be leveraged to help the state transition to a universal system or could be expanded to serve as a function of the new system. For example, to complement the Commission's work on transitional solutions, FTAC members

were also surveyed for additional ideas. FTAC members included in their survey responses information as to whether the state currently has authority to implement any given option.[16]

Additionally, at the conclusion of the 2023 legislative session, Commission members representing state agencies shared legislative updates, providing insight into the Legislature's areas of interest both for the short and long term. [17] This informed the Commission's work to design the new system and to prioritize options that could transition the state to a universal system, details of which are described later in this report.

Developing equity principles for designing the new system

Financing and coverage policies and structures in the current health care system have contributed to the discrimination and marginalization of individuals with disabilities, low-income individuals, and people of color. Further, in the current system, an individual's coverage and access to quality care is largely determined by how the care is financed. The development and implementation of a unified financing system to support universal health care is an opportunity to examine existing structures and to establish a new system that ensures equitable access to affordable and quality care and wellbeing for all Washingtonians, including the health care workforce.

To inform the Commission's system design, Commission member Dr. Karen A. Johnson, former Director of the Washington State Office of Equity, presented an overview on equity.[18] Dr. Johnson emphasized several key points for the Commission to consider in their development of a system with guaranteed access to quality, affordable health care for all Washingtonians.

Key points

- Achieving equity will not be accomplished through treating everyone equally, but by treating everyone justly according to their circumstances.
- Bringing the community to the table is essential to the design of a universal healthcare system.
- It is not possible to discuss health equity without acknowledging the impact of racism on the health of communities, families, and children.
- Health inequities have implications including economic costs, health care costs, quality of life, and duration of life.

With these considerations, the Commission adopted a health equity framework with which to evaluate proposals to ensure that all recommendations have an equitable impact on all Washingtonians. The health equity framework is detailed later in this report.

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[16] FTAC's proposed transitional solution ideas gathered from their survey responses can be found in Appendix E.

[17] Five state agencies are represented on the Commission. These include the Department of Health, Health Benefit Exchange, HCA, Office of Equity, and Office of the Insurance Commissioner.

[18] Commission **April 2023 meeting recording**.

Assessing information on other states and current programs in Washington

Washington is not alone in its desire to reform the current health care system while also designing a state-based universal system supported by unified financing. In recent years, both Oregon and California passed legislation creating entities to design respective state-based universal health care systems. Details of these states' work on the topic of eligibility are described later in this report.

While Oregon and California are on paths similar to Washington's, the state of Vermont ventured to implement a state-based, single-payer health care system nearly a decade ago. Though Vermont's universal system did not materialize, the Commission expressed interest in what can be learned about the state's efforts.

In addition to gathering information on developments and lessons learned from other states, Washington's Indian health care delivery system offers an example of a universal system already operational in the state. While not a single-payer system, the Jamestown S'Klallam Tribal Health Benefit Program uses braided funding to finance its delivery system and has achieved 100 percent coverage for Tribal members living in the service area. The principles of this program may offer a potential pathway to achieving 100 percent coverage in the state of Washington. Details of the Jamestown S'Klallam Program are described later in this report.

Areas of focus

The COVID-19 pandemic exposed health disparities and health care disparities stemming from past and enduring inequitable policies and practices in and outside of the health care system. Additionally, with federal protections from Medicaid disenrollment ending this year, loss of coverage and/or forgoing care due to financial barriers is anticipated for thousands of Washingtonians. As such, the Commission focused on ways to achieve the greatest and most immediate impact for the most amount of people. With this goal in mind, and focusing partly on interim steps and partly on future system design, the Commission agreed to focus on the following areas:

- Eligibility for the future universal system
- Transitional solutions
- Adoption of a health equity framework with which to evaluate proposals for the new system design
- The request to analyze the Washington Health Trust bill.

Universal system design: eligibility

Achieving universal coverage requires determination of how to design a system where all Washington residents would be eligible for coverage. The Legislature's goal is to include all state residents in Washington's future universal health care system. As such, the Commission selected eligibility as the first design component to examine. [19]

Eligibility goals as provided in SB 5399

> "The Universal Health Care Commission is established to create immediate and impactful changes in the health care access and delivery system in Washington and to prepare the state for the **creation of a health care system that provides coverage and access for all Washington residents** through a unified financing system once the necessary federal authority has become available."

In their work to examine paths to achieving universal eligibility for the new system, the Commission identified several considerations and potential challenges. Table 1 outlines the identified eligibility considerations for specific populations.

[19] In their baseline report, the Commission identified the following design components of a universal health care system: cost containment, coverage and benefits, eligibility, enrollment, financing, governance, infrastructure, and provider participation and reimbursement.
https://www.hca.wa.gov/assets/program/commission-baseline-report-20221101.pdf

Table 1: Key eligibility considerations

Eligibility population	Considerations
Washington residents[20]	Would the definition of meeting residency requirements for health insurance coverage differ from the current standard of residency determination for the state?[21, 22]
Out-of-state residents working for Washington employers	Would out-of-state residents who work for Washington employers be eligible? Would employees who work for national companies and live in Washington be allowed to keep their coverage or be required to enroll in the universal system?
Opt-in options for individuals covered by employer-sponsored insurance	Would individuals with fully insured, employer-sponsored coverage be eligible to opt in?
Self-funded employer health benefit plans	Would individuals with self-funded employer-sponsored coverage be eligible to opt in?
Federal Employees Health Benefits and Veterans' Health Administration (VHA)	Would federal employees be covered by federal programs such as Federal Employees Health Benefits and the VHA be eligible to opt into the system?
Enrollees of insurance programs that are federally funded and/or federally administered, or subject to federal law	Would Medicare enrollees be included in the program? Would Medicaid enrollees be included in the program? Would enrollees of a health plan subject to federal Employee Retirement Income Security Act of 1974 (ERISA) laws be included in the program?

The eligibility barriers for Washington's universal system are largely federal with regulatory and legal implications. For example, Medicare is entirely federal domain both in terms of funding and administration. Conversely, while Medicaid is administered and partly funded by states, the program also receives federal funding. Finally, ERISA preempts state regulation of self-funded employer health benefit plans. Under ERISA, states can regulate fully insured individual and group health plans.

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[20] Consultation with Tribes will also be essential to informing eligibility for the future universal health care system.

[21] Washington Department of Revenue. State residency definition. https://dor.wa.gov/contact/washington-state-residencydefinition#:~:text=Persons%20are%20considered%20residents%20of,a%20temporary%20or%20transient%20basis.

[22] Establishing a residency definition could bring in consideration of the constitutional right to travel.

Figure 2: Health coverage estimates in Washington, 2021

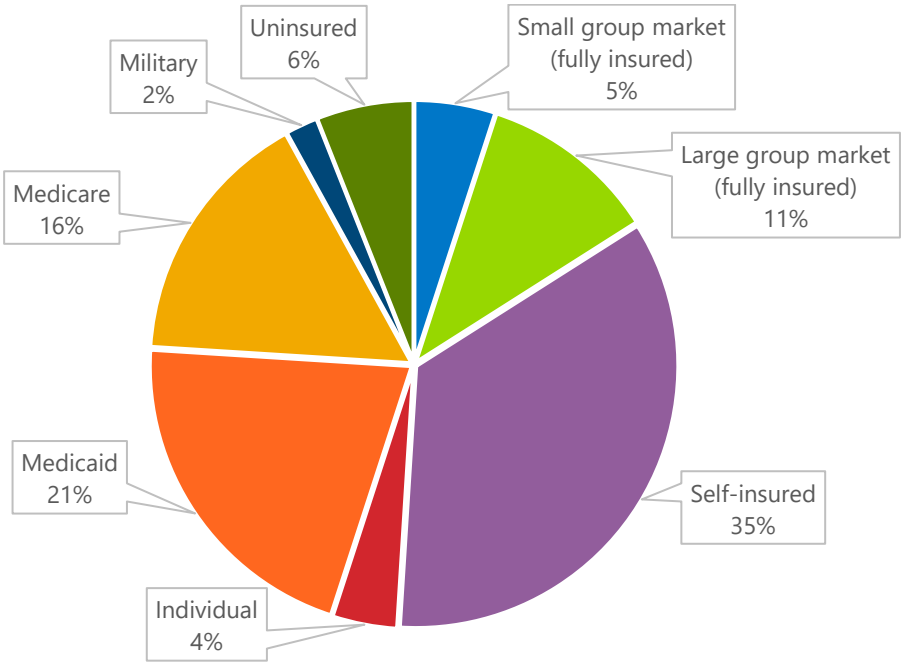

Figure 2 illustrates health coverage estimates in Washington for 2021.[23] When combined, individuals covered by these three types of programs represent nearly 90 percent of Washingtonians. Including enrollees of these programs in the universal system is necessary to ensure that all Washingtonians receive comparable health care benefits and equitable access to care. Additionally, capturing funding from these programs is critical to creating and sustaining Washington's universal system supported by unified financing. Though Medicare, Medicaid, and ERISA each present significant barriers, the long-term goal for both the Legislature and the Commission is to ensure eligibility for all Washington residents, including enrollees of these respective programs when possible.

The Commission's eligibility assessment

Including various eligibility groups requires thorough examination of the regulatory and legal barriers and an understanding of each program. FTAC members were selected by the Commission for their extensive subject matter expertise on topics such as this, and the committee was directed by the Commission to examine options to include each of the following eligibility groups in Washington's universal system.

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

- Medicare-eligible Washingtonians[24]
- Washingtonians receiving health care coverage through an employer (ERISA)[25]
- Medicaid-eligible Washingtonians[26]

At the Commission's direction, FTAC examined the eligibility groups in the order in which they are listed above.

Assessment of options to include Medicare

Medicare is a federal health insurance program for individuals aged 65 and older. Individuals under 65 with long-term disabilities also qualify for Medicare through the Social Security Disability Insurance (SSDI). Approximately 1.4 million Washingtonians are enrolled in Medicare.[27]

The Medicare program consists of four components, including Medicare Parts A, B, C, and D. The financing mechanisms for and services covered under each component are as follows:

- **Medicare Part A** is financed primarily by a payroll tax that employers and employees pay into the Medicare Hospital Insurance Trust Fund. Part A covers inpatient hospital stays, skilled nursing facility stays, some home health visits, and hospice care.
- **Medicare Part B** is financed primarily through a combination of general revenues, interest earned on trust fund investments, and beneficiary premiums. Part B covers physician visits, outpatient services, preventive services, and some home health visits.[28]
- **Medicare Part C** (Medicare Advantage) is Medicare's managed care program that combines and delivers Parts A and B through contracted carriers.[29] Medicare Advantage (MA) plans are financed by monthly payments from the federal government based on bids submitted by the carriers and monthly premiums.
    - MA plans have grown increasingly popular amongst Medicare enrollees in Washington. As of March 2023, approximately 663,500 Medicare beneficiaries were enrolled in MA

[24] KFF. Total Number of Medicare Beneficiaries by Type of Coverage. 2021. https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[25] Approximately 3.9 million Washingtonians receive health care coverage under a health plan subject to ERISA.

[26] As of June 2023, approximately 2.3 million Washington residents were enrolled in Apple Health, Washington's Medicaid program. https://hca-tableau.watech.wa.gov/t/51/views/ClientDashboard-Externalversion/AppleHealthClientDashboard?%3AisGuestRedirectFromVizportal=y&%3Aembed=y

[27] Monthly enrollment by state. Washington. March 2023. CMS. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/monthly/monthly-enrollment-state-2023-03

[28] Part B spending accounts for the largest share of Medicare benefit spending (48 percent in 2021). What to Know about Medicare Spending and Financing. Kaiser Family Foundation, 2023. https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/

[29] MA plans are required to cover all medically necessary services covered by traditional Medicare. However, some plans may offer additional benefits such as vision, hearing, and dental services.

plans.[30] This accounts for roughly 45 percent of Medicare enrollees, up from about 37 percent in March 2020,[31] and approximately 32 percent the same month in 2018.[32, 33]

- **Medicare Part D** is financed primarily by general revenues, beneficiary premiums and state payments for beneficiaries dually eligible for Medicare and Medicaid. Part D covers outpatient prescription drugs.

Examination of Medicare integration by other states

As previously mentioned, the Commission's strategic plan for 2023 includes gathering information from other states and current programs in Washington. The following are summaries of what the states of Oregon and California have examined with regards to Medicare integration for their respective and future state-based universal health care systems, and the Jamestown S'Klallam Tribal Health Benefit Program in Washington.

The Oregon Task Force's proposed implementation guidance

1. Act of Congress: Federal action to expand states' Medicare authority and/or innovation to establish a state-based single-payer system to support comprehensive benefits with corresponding Medicare funding.
2. Medicare Advantage: State-sponsored MA plan available to supplement benefits of the Plan.
3. Waiver: Oregon obtains CMS approval to use demonstrations and/or innovation to provide benefits to Medicare-eligible Oregonians through mixed funding streams.
4. Wraparound Services: provide Plan-covered services, such as behavioral health or dental care to wrap around services not covered by Medicare.

[30] Monthly enrollment by state. Washington. March 2023. CMS. **https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/monthly/monthly-enrollment-state-2023-03**

[31] Monthly enrollment by state. Washington. March 2020. **https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldatamonthly/monthly-enrollment-state-2020-03**

[32] Monthly enrollment by state. Washington. March 2018. CMS. **https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-State-Items/Monthly-Enrollment-by-State-2018-03**

[33] The federal government has steadily increased spending on Medicare Part C. Beginning in 2023, Medicare spending on Part A and Part B benefits for enrollees in traditional Medicare will be outpaced by Part A and Part B benefits spending for MA enrollees. What to Know about Medicare Spending and Financing. Kaiser Family Foundation. 2023. **https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/**

California

The Healthy California for All Commission (HCAC) was also established in 2019.[34] HCAC is charged with developing a state-based health care delivery system[35] that provides coverage and access for all Californians through a unified financing system, including, but not limited to, a single-payer system. In 2020, HCAC finalized and submitted an environmental analysis to the governor and state legislature[36] acknowledging the federal barriers to integrating Medicare. HCAC also identified limitations with CMS' waiver authority, stating "it does not appear that CMS' waiver authority is broad enough to allow even a cooperative federal administration to flexibly fund the Medicare portion of a California system of unified financing without statutory change," however further analysis is needed.

HCAC's 2022 final report[37] examined the implications of including or not including Medicare in a state-based universal health care system. HCAC reiterated that a state-based unified financing system cannot be achieved without federal support. However, HCAC members disagreed as to whether federal support for California's unified financing system requires changes to federal law or could be accomplished through existing waiver authority. Some HCAC members noted that even reaching a favorable financing agreement with the federal government could expose California to financial risks in the future should the federal government ever change the terms of the agreement.

Brown & Peisch, a law firm specializing in federally funded health and benefit programs, was invited by the California Department of Health and Human Services to provide additional clarity on available options to integrate Medicare.

Key points of Brown & Peisch's legal memo

- There is no single federal waiver authority that would allow federal funds for Medicare, Medicaid, or Patient Protection and Affordable Care Act (ACA) advance premium tax credits to be redirected. Rather, each of these funding streams is subject to different authorities that permit the federal Department of Health and Human Services to waive certain federal requirements and limitations.

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

[35] Including a plan with options to transition California to a unified financing system, including, but not limited to, a single-payer financing system.

[36] An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California. Healthy California for All Commission. June 2020. https://cdn-west-prod-chhs-01.dsh.ca.gov/chhs/uploads/2020/08/24133724/Healthy-California-for-All-Environmental-Analysis-Final-August-24-2020.pdf

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

- Any legal authorities that may allow for redirection of Medicare funding will depend on the current federal administration's interest in supporting states' unified financing systems. Exercise of this authority is unprecedented and politically challenging.[38]
- Alternatively, California could better pursue unified financing through enactment of federal waiver authority that allows states to use federal funding from existing health care programs, including Medicare, to deliver comprehensive health care coverage.[39]

Options to include Medicare and other sources of coverage as demonstrated by the Jamestown S'Klallam Tribal Health Benefit Program

Vicki Lowe, Commission Chair and Executive Director of the American Indian Health Commission for Washington State, presented to both the Commission and FTAC about a universal health care system currently existing in Washington. The Jamestown Tribal Health Benefits Program (Program) is an insurance-based program where coverage is based on all Tribal Citizens having the same level of coverage regardless of income or coverage eligibility.

Under federal law, Indian Health Service (IHS) programs are required to enroll eligible Tribal users in Medicare or Medicaid before purchased and referred care dollars can be accessed.[40] The Program's benefits wrapped around each Tribal Citizen's source of coverage, including Medicare, Medicaid, private and employer-sponsored insurance (ESI), which ensured benefits parity across the Program. For Medicare-eligible individuals, the Program purchased supplemental benefits and reimbursed members for out-of-pocket costs such as Medicare Part B premiums.

The Program is not an example of a unified financing system due to its utilization of mixed funding streams. However, the Program achieved 100 percent coverage for Tribal members living in the service area and these principles may offer a pathway to achieving 100 percent coverage in the state of Washington.

FTAC's discussion and guidance on Medicare options for Washington

At the direction of the Commission, FTAC discussed several options to address Washington Medicare enrollees' eligibility in the new system.[41, 42] This discussion followed presentations about Oregon and California's pursuits of a universal health care system, and Chair Lowe's presentation on the Jamestown S'Klallam Program.

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[38] This could potentially restrict Medicare recipients' choice of providers and could compel providers to participate in a new payment/delivery model. Additionally, California would be seeking to assume responsibility of Medicare recipients' benefits to which they are entitled by statute.

[39] Brown & Peisch cited H.R. 3775, the State-Based Universal Health Care Act (2021), as an example of proposed legislation that would provide California necessary authority for federal funds to be directed to the state as a lump sum.**https://www.congress.gov/bill/117th-congress/house-bill/3775/text?s=1&r=40**

[40] Purchased and referred care is defined as any care received outside of IHS.

[41] FTAC March meeting recording.

[42] FTAC May meeting recording.

Medicare overview

In May, FTAC reviewed the structure of the Medicare program.[43] The overview also included potential gaps in affordability and access that Medicare enrollees may experience if Medicare is not included in Washington's universal health care system. Table 2 illustrates potential gaps in coverage between the universal system and Medicare and affordability challenges Medicare enrollees might experience compared with Washington's universal health system as envisioned by the Universal Health Care Work Group.[44]

Table 2: Gaps in coverage and affordability for Medicare recipients in Washington's universal health care system

UHC goal	Medicare
No premiums	Premiums required for Parts B and D, and possibly Part C
No cost sharing for UHC options A and B*	Beneficiaries can face significant cost sharing
Would include vision care, and possibly dental and long-term care	Vision, dental, and long-term care not covered

*The Commission's 2022 report to the state legislature articulated three benefit design options, A, B, and C as envisioned by the Universal Health Care Work Group. Both A and B would eliminate cost sharing.

FTAC examined six options to address potential gaps in benefits and out-of-pocket costs for Medicare enrollees in Washington's universal health care system. The feasibility of various components under each option was assessed and is illustrated in Table 3. Based on this assessment, the six options ordered from least feasible to most feasible (Figure 3) and additional pros and cons of each option were examined.

Table 3: Feasibility considerations for options to include Medicare

	Captures federal funding	Waiver or law change required	Level of federal oversight	Preserves beneficiary choice	Covers premiums	Covers cost-sharing	Covers non-covered services
1. Act of Congress	Yes	Yes	Unknown	No	Unclear	Possibly	Possibly
2. Demo waiver	Yes	Yes	High	No	Unclear	Unclear	Unclear
3. MA, only option	Yes	Yes	High	No	Possibly, via rebates	Possibly, via rebates	Possibly, via rebates

[43] FTAC May meeting recording.
[44] The Universal Health Care Work Group preceded the Commission. Work Group Final Report. 2021. https://www.hca.wa.gov/assets/program/final-universal-health-care-work-group-legislative-report.pdf

4. MA, competes	Yes, for enrollees	Probably not	High	Yes	Possibly, via rebates	Possibly, via rebates	Possibly, via rebates
5. State Medigap	No	Probably not	Medium	Yes	No	Yes	No
6. Reimburse directly	No	Probably not	Low to Medium	Yes	Yes, if covered	Yes, if covered	Yes, if covered

*Most options would also place an administrative burden on the state.

Figure 3: Options for incorporating Medicare ordered from least to most feasible

1. Act of Congress or comprehensive waiver
2. Demonstration waiver, such as via 1115a
3. State-operated Medicare Advantage & Part D (MA-PD) plan as the only option for WA Medicare beneficiaries (requires a waiver)
4. State-operated MA-PD plan that would compete with private MA plans and traditional Medicare
5. State-operated Medicare supplemental insurance (Medigap) plan
6. Directly reimburse or insure beneficiaries for gaps

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

Option 1: act of Congress or comprehensive waiver

Option 1 is an act of Congress or a comprehensive waiver granted by CMS, which, if obtained, would allow Washington to enroll all Medicare enrollees into the universal system design and leverage federal funding,[45] a key advantage of this option. However, there is no legal precedent for such, and it is unlikely to be achieved via legislation through the current Congress. Moreover, Medicare enrollees may still experience some premiums.

FTAC members agreed that Option 1 represents the "North Star," or ideal approach to addressing gaps in affordability and coverage for Medicare enrollees in the universal system, however pursuing Option 1 at

[45] This option was used to calculate potential costs and savings of Model A by the Universal Health Care Work Group.

this time is not an effective use of resources or time due to the significant federal barriers. Additionally, some members noted that CMS is unlikely to grant a waiver to a new and untested program.

Members recommended that the Commission focus on designing the new system and examine other transitional options to provide coverage and affordability parity for Medicare enrollees, rather than attempting to bring Medicare into the system from the outset.[46] It was also suggested that Washington consider actively partnering with Oregon to examine this option when Oregon's new governance structure[47] overseeing the universal health care system becomes operational.

Option 2: demonstration waiver

Option 2 would require Washington to obtain an 1115 Medicaid waiver[48] or a 402b Medicare waiver. These waivers are generally focused on Medicaid-related payment and delivery system reforms (1115) or Medicare payment-related reforms (402b). These waivers must be cost-neutral to the federal government and not compromise the quality of the existing program.

This option would allow the state to capture federal funding, however because these waivers are designed for other purposes, it is unclear how this option could be leveraged to cover premiums, cost-sharing or additional benefits for Medicare enrollees. These waivers also involve significant oversight and evaluation by the state throughout implementation that would result in administrative costs and budget neutrality requirements. Additionally, there is no precedent for granting these waivers to achieve Washington's objectives. Finally, there is a possibility that even if granted by CMS, these waivers would be subject to legal challenges.

FTAC members agreed that Option 2 is not viable for achieving the goals of the universal system given that the intent of these waivers differs from what the Commission is trying to achieve. However, this option could complement the work being done via the universal health care system in areas such as cost containment and payment reform. Other areas of potential opportunity for the Commission to address payment reform include 2023 legislation (ESSB 5187) directing the Attorney General Office and Office of the Insurance Commissioner (OIC) to study market consolidations and anticompetition and hospital global budget strategies.[49, 50]

Option 3: state-operated Medicare Advantage & Part D (MA-PD) plan as the only option for Washington Medicare enrollees

This option would involve designing and implementing a MA-PD plan for Washington's Medicare enrollees that, to the extent MA rules allow, would provide benefits parity with Washington's universal

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[46] There was some discussion about the potential benefits of contracting with a law firm as California did to better understand necessary preparations to obtain a federal waiver or possible legislative pathways.
[47] Oregon Universal Health Plan Governance Board.
[48] This waiver from CMS would waive Section 1115 of the Social Security Act
[49] Sec.126(33) and Sec.144(13). https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20230629105003
[50] Some members recommended that any payment reform activity be done in consultation with the Health Care Cost Transparency Board.

system. Under Option 3, the state's MA plan would be the only MA option for Washington's Medicare enrollees.[51]

Members noted several disadvantages to this option. Obligating MA enrollees to enroll in only the state MA plan would require a federal waiver from the provision that allows for choice and to preclude other MA plans from entering the market. This option would also involve resolving payment structures, as MA payments are tied to Medicare's fee-for-service (FFS) benchmark compared with whatever payment structure is utilized in the universal system. Another disadvantage to this option is the administrative costs the state would incur to develop, implement, and oversee an MA plan, or to contract to do the same. Finally, this option could be subject to legal challenges if Medicare enrollees are prevented from accessing traditional Medicare.

FTAC members agreed that it was difficult to envision how the state could legally implement this option given the unlikeliness of obtaining a waiver that would limit freedom of choice. Members recommended not expending resources and time on this option, especially at the outset. Some members felt that this option could serve as a pathway in the future once the value of the program has been established. It was noted that the state would likely face downside risk, as the state would likely be reimbursed by CMS on a per-member-per-month basis. Finally, several members expressed concerns regarding the implications of disallowing Medicare enrollees to remain in traditional Medicare or in their current MA plan.

Option 4: state-operated MA-PD plan that would compete with private MA plans and traditional Medicare

Option 4 involves the same scope of work for the state to design and implement an MA plan with many of the same limitations as Option 3. However, under Option 4, the state's MA plan would compete with other private MA plans, where Medicare-eligible Washingtonians wishing to enroll or continue coverage with traditional Medicare could do so. This option does not limit Medicare enrollees' choice, potentially lessening the threat of legal challenges.

FTAC's response to this option was mixed. In addition to the administrative burden of designing and implementing the model like Option 3, the main concern with this option is the competition the state would face by entering a mature MA-PD market with multiple carriers offering over 100 MA plans. Additionally, Medicare-eligible Washingtonians may be inclined to renew existing coverage or could select options other than the state's, limiting the potential of federal dollars and the overall impact of this option.

However, FTAC did not recommend this option being completely removed as a possibility. There may be a possibility for this option to sit alongside Option 6 (direct reimbursement of insurance for gaps) in the future.

Option 5: state-operated Medicare supplemental insurance (Medigap) plan

Under Option 5, the state would develop and offer a Medigap plan to fill gaps in benefits between Medicare and the universal health care system. This option would allow the state to offer benefits to Medicare enrollees that are not covered under Medicare. However, Medigap plans do not cover benefits for hearing, vision, and supplemental drug coverage, which does not align with the Commission's goals

[51] There are currently 18 carriers offering 100 MA plan types.

for the universal system design. Moreover, the state would be limited in its ability to reduce Medicare enrollees' Part B deductibles with this option.[52] Finally, this option would not be available to MA enrollees, nor allow the state to leverage federal Medicare dollars.

FTAC members acknowledged that this option seemed feasible in terms of existing legal authorities and may be the least administratively burdensome to the state to implement. However, there were concerns that this option could not fully address benefits gaps between Medicare and any universal system design because of the extensive and complex regulatory requirements of Medigap plans. Additionally, like Option 4, this offering would require the state compete with other plans in a mature market and would not leverage federal funds. There was some interest in this idea as a possible short-term option, potentially paired with Option 1 or 2 in the long-term. However, the majority of FTAC members did not support Option 5 at this time.

Option 6: directly reimburse or insure Medicare enrollees for gaps

Option 6 would establish a system to directly reimburse enrollees for cost-sharing and for services covered by the universal system but not by Medicare. This option allows the most flexibility to fully address gaps and would not require waivers nor result in legal challenges. Disadvantages to this option include the potential variances between Medicare enrollee choices, with federal rules potentially limiting the ability to wrap around Parts A & B. This option could also invite gaming from MA plans and may be administratively burdensome for the state and consumers. Finally, this option does not allow the state to leverage federal Medicare dollars.

FTAC members agreed that at this time, Option 6 presents the best option and most feasible pathway to address gaps in cost-sharing and benefits for Medicare enrollees. There was interest in learning more about the nuances of Option 6 and how it might be developed in the short-term to ensure parity.

FTAC members agreed that revisiting Option 6 with further analysis and decision-making will need to occur after the Commission has determined the services and benefits of the new universal system design. Until then, further analysis to determine what gaps need to be filled between existing Medicare services and benefits, and the services and benefits of the new system design is not possible. It was also noted that while federal dollars would not fund these additional benefits, placing the financial burden on the state, this option could be explored in conjunction with one of the waiver options to secure federal funding and/or as a means of payment reform or cost containment.

Additional Medicare considerations for the Commission's consideration

There were additional suggestions offered by FTAC members related to improving cost-sharing and services for Medicare enrollees, mainly through expanding eligibility for the Medicare Savings Program (MSP) and increasing eligibility for dual Medicare/Medicaid beneficiaries.[53] An additional option to

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[52] Individuals eligible for Medicare on or after January 1, 2020 cannot purchase Medigap plans that cover the Part B deductible, or **Plans C or F. https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf**

[53] The 2023 legislature took action to expand MSP by appropriating $6.3 million, removing asset tests and increasing the Qualified Medicare Beneficiary (QMB) program from 100 to 110 percent of the federal poverty level.

expand services for low-income Medicare beneficiaries could be expanding Medicaid Categorically Needy coverage, which would provide full scope Medicaid coverage, including long-term care.[54] These additional considerations were intended to inform the Commission's future discussions about potential transitional solutions that improve coverage available for Washingtonians today that may help pave the way for the universal health care system of tomorrow.

The Commission's vote on Medicare

FTAC members produced a Medicare Memo[55] for the Commission capturing FTAC's discussion and recommendations on options to achieve parity for Medicare enrollees and how to include Medicare in Washington's universal system. FTAC's guidance, including the pros and cons of each option, was provided to the Commission at their June meeting.[56]

While a comprehensive waiver (Option 1) is the most beneficial option and the "North Star" for achieving the goals of a universal health care system supported by unified financing, this option lacks federal authority to implement. FTAC recommended direct reimbursement (Option 6) as the most feasible option for the short term to achieve coverage parity for Medicare enrollees which could be explored in conjunction with one of the waiver options. However, this requires further analysis. FTAC recommended that the Commission determine benefits and services and come back to this discussion to explore whether to pursue a waiver, rather than pursuing a waiver at the outset.

In reviewing FTAC's guidance, one Commission member expressed concerns with adopting FTAC's recommendations on Medicare eligibility given that some questions regarding larger system design, such as benefit design, have not yet been addressed. However, as some Commission members noted, the guidance is not set in stone, but having this guidance allows the Commission to move forward in their design work. FTAC was also directed to examine this topic early in the Commission's design work to identify whether the assumption should be that a Medicare waiver could be obtained at this time. The Commission voted to adopt FTAC's guidance in the Medicare Memo (seven for, one opposed).

Preliminary assessment of options to include ERISA-eligible individuals

ERISA is the next eligibility group scheduled to be examined for integration into Washington's universal system. Since ERISA preempts state laws that impact employer benefits, [57] Washington is constrained in its

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[54] WAC 182-501-0060(6) lists the general categories of Categorically Needy services. All medically necessary services are covered.

[55] Appendix F.

[56] Eight members were present for the vote. Commission June meeting recording.

[57] Federal ERISA law sets minimum standards for health plans established and funded by employers to provide health care to their employees. Employer health plans can be "fully insured" or "self-funded". Both types of these health plans must comply with ERISA. However, the state's role varies based upon whether a plan is fully insured or self-funded. An employer that offers a fully insured health plan is paying for premiums to a health insurer and the insurer bears the financial risk of coverage. An employer that offers a self-funded health plan has chosen to bear the financial risk of health care services used by their

ability to regulate employer benefits or achieve benefits parity between employer benefits and the future system. Pathways for capturing revenue, such as employer contributions, to support the unified financing system must also be thoroughly examined.

The Commission directed FTAC to examine several components of ERISA in addition to surfacing options to include ERISA in Washington's future system.

Questions and comments from the Commission for FTAC's assessment of ERISA eligibility

- How ERISA law has evolved, areas of the law that are unchanged since the last analysis done on the topic, and any new approaches with potential areas of opportunity?
- Since employer funding contributions may be optional, examine how any employer contributions could be captured under the various ERISA eligibility options to fund the new system.
- Potential options to include ERISA and capture revenue to support the unified financing system:
    - Option 1: Employers pay into the universal system and employees are covered by the universal system.
    - Option 2: "Pay or play," where employers have a choice to continue provide coverage to their employees.
        - What are the implications of ACA mandated employer responsibilities?
        - If employers choose to continue providing employees' coverage, could Washington mandate that the minimum essential coverage required under the ACA match the coverage provided under the new system?
        - What are the quality and equity implications of benefits differing between employer coverage and the universal system?

In July, FTAC began gathering information on ERISA in preparation for further discussion and recommendations to the Commission on ERISA eligibility. [58] FTAC's full assessment of ERISA and recommendations to the Commission will take place in September, details of which will be included in the 2024 legislative report. The topics examined at FTAC's July meeting will also be detailed in the 2024 legislative report.

Topics discussed at FTAC's July meeting

- ERISA case law examples that continue to articulate the ERISA preemption test
- The Supreme Court's interpretation of the ERISA preemption clause
- The impact of ERISA preemption on health care reform and state-based universal health care initiatives

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employees, and often will contract with an outside entity to administer their health plan (called "third party administrators" or "TPAs"). The ERISA statute exempts these plans from most state regulations.

[58] Presentations by Carmel Shachar, J.D., and Jane Beyer, J.D., can be found in **FTAC's July meeting recording.**

- Washington's health care coverage by market, including fully insured large group and small markets and the self-insured market
- Health plan regulation in Washington, including which entities regulate which health plans, required benefits, provider network adequacy, and eligibility
- Examples of health policy in Washington that have or have not been challenged due to ERISA.

Assessment of options to include Medicaid-eligible individuals

Medicaid is the third eligibility group scheduled to be examined for integration into Washington's universal system. Including Medicaid funding as a revenue source for Washington's new system will be complex but perhaps not as complicated as Medicare because there is an established process and experience with states seeking and obtaining Medicaid flexibilities, such as an 1115 waiver from CMS.

Another challenging aspect of integrating Medicaid will be identifying options to achieve benefits parity between Medicaid and the future system. Whereas Medicare's benefits may be less comprehensive than what the Commission envisions for the new system, Apple Health (Medicaid) provides some benefits that are not included in Washington's essential health benefits (EHB) mandated by the ACA such as Long-term Services and Supports and transportation to non-urgent medical appointments. Some of these services are required by federal Medicaid law, while others are required by state law.

With FTAC's guidance, the Commission will need to determine how Apple Health's additional services could be provided to all Washingtonians under the new system or examine mechanisms to ensure that everyone who would otherwise be eligible for Medicaid will receive these additional services. FTAC is scheduled to begin examining options to include Medicaid in the Fall of 2023, findings of which will be included in the Commission's 2024 legislative report.

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

The Commission's 2022 baseline report identified opportunities to improve the affordability of and access to coverage and care in the current system, including strategies to help transition the state to the universal system. Several of these recommendations were funded by the Legislature during the 2023 legislative session, details of which are described below. This section also outlines the Commission's ongoing work to identify and prioritize opportunities to prepare Washington for the transition to a universal system.

The 2023 Washington Legislature's support of the Commission's 2022 recommended transitional solutions

Several of the Commission's 2022 recommended transitional solutions were funded by the 2023 Washington Legislature. This is perhaps a testament to both the Legislature's commitment to advance state health care reform and the Commission's role in accomplishing that goal as a panel of experts representing the state or as a stakeholder sounding board for opportunities to improve care for Washingtonians. The Commission's 2022 recommended transitional solutions funded by the Legislature are outlined in Table 4.

Table 4: Commission's 2022 transitional solution recommendations funded by the 2023 Legislature

Commission's 2022 recommendations	Action by the 2023 Legislature
Continue funding the **Cascade Care Savings** program to make coverage more affordable.	Funding provided to the Washington Health Benefit Exchange (HBE) to continue administering Cascade Care Savings (premium assistance program) for individuals up to 250 percent of the federal poverty level (FPL) who purchase a health plan on the Exchange.[59]
Increase Medicaid provider rates for **applied behavior analysis** (ABA) to improve access to care for Medicaid enrollees.	Funding provided to HCA to increase reimbursement rates by 20 percent for ABA for individuals with complex behavioral health care needs, and by 15 percent for all other ABA codes.[60]
Increase Medicaid provider rates for **behavioral health** to improve access to care for Medicaid enrollees.	Funding provided to HCA to increase behavioral health rates for both Medicaid FFS and managed care providers.[61]

[59] ESSB 5187, Sec. 214 (4)(a). Eligible individuals must also meet other eligibility criteria as established in RCW 43.71.110(4)(a).

[60] ESSB 5187, Sec. 211 (49). Codes include 0362T and 0373T beginning January 1, 2024. Does not include Q3014 (telehealth facility procedure code). https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20230629105003

[61] ESSB 5187, Sec. 211 (51). Rate increases are effective January 1, 2024, and must be applied to the following codes for children and adults enrolled in Medicaid: 90785, 90791, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90846, 90847, 90849, 90853, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171, H0004, H0023, H0036, and H2015. HCA is directed to implement this rate increase in accordance with the process established in **RCW 71.24.885** (Medicaid rate increases) and must raise the state FFS rates for these codes by up to seven percent (not to exceed the published Medicare rate or an equivalent relative value unit rate if a published Medicare rate is not available). HCA must require in managed care organizations' (MCOs) contracts that beginning January 2024, MCOs pay no lower than the FFS rate for these codes and adjust managed care capitation rates accordingly. Ibid.

Increase Medicaid provider rates for **children's dental** to improve access to care for children enrolled in Medicaid.	Funding provided to HCA to increase the children's dental rate[62] by at least 40 percent above the Medicaid FFS rate in effect on January 1, 2023.[63]
Implement the **Integrated Enrollment and Eligibility Modernization Roadmap** to support Information Technology infastructure necessary for a universal health care system.	Funding provided to the Department of Social Health Services (DSHS) for the Integrated Enrollment and Eligibility Modernization Project to create a comprehensive application and benefit status tracker for multiple programs and to establish a foundational platform. [64]
Invest in **Apple Health coverage expansion** to increase access to coverage and care.	Funding provided to HCA to expand coverage to adults ineligible for Medicaid or federal subsidies by reason of immigration status. [65]

The funding of the Commission's above recommendations is a significant achievement given the early stage of this work. The Commission will monitor the implementation and progress of the above transitional solutions as their work to design and transition the state to the future system evolves.

Ongoing work to identify and prioritize transitional solutions

The Commission is encouraged that several of their 2022 recommendations were funded by the 2023 Legislature, though there is more work to be done. This year, the Commission focused on identifying a new set of intermediate strategies that can help improve the current health care system and advance the state's readiness to implement a universal health care system.

In January, Commission members identified new areas of opportunity to explore. As directed by the Commission, FTAC members were also asked to identify additional areas. Together, the Commission and FTAC produced over thirty transitional solutions which were then grouped into categories (Table 5) for the Commission's consideration to prioritize.

Table 5: Transitional solutions categorized and considered by the Commission for prioritization[66]

Category	Transitional solution options
Affordability/cost containment/pricing[67]	• Facilitate accessibility of hospital price transparency data • Out-of-network (OON) price caps

[62] For procedure code D1120.
[63] Beginning January 1, 2024.
[64] ESSB 5187, Sec. 205 (11-13) provides funding to the Department of Social and Health Services (DSHS) for the Integrated Enrollment and Eligibility modernization project to create a comprehensive application and benefit status tracker for multiple programs and to establish a foundational platform. Ibid.
[67] ESSB 5187, Sec. 114 (13) directs OIC to study approaches to improve health care affordability in Washington, including but not limited to those being used or considered by other states with regards to health provider price or rate regulation policies or programs other than traditional health plan rate review

	• OON price caps for the Cascade Select program • Reduce ACA affordability threshold • Reference based pricing for the Public Employee Benefits Board/School Employee Benefits Board (PEBB/SEBB) • Regulated hospital global budgets • State agency rate normalization
Capacity/infrastructure	• All payer or multi-payer quality program • Enhance telehealth capacity • Improve public health
Coverage/enrollment	• Auto-assign Medicaid enrollment to high-quality/lower-cost plans • Auto-enrollment for Medicaid to no-premium Exchange plans • Codify and fully fund Apple Health expansion[68] • Increase participation in the Medicare Savings Program (MSP)[69] • Uninsured analysis • Universal enrollment
Providers	• Motivate interest in preventative and primary care • Network adequacy standards • Provider participation analysis • Standardize claims adjudications • State provider participation

to increase affordability for health insurance purchasers and enrollees, and regulatory approaches to address any anticompetitive impacts of horizontal consolidation and vertical integration in the health care marketplace to supplement federal antitrust law. OIC's preliminary report is due December 1, 2023 with a final report due August 1, 2024. This work is undertaken in partnership with the Washington State Office of the Attorney General and in consultation with HCA, HBE, and the Department of Health. https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20230905081501

[66] Descriptions for the listed options are included in Appendix E.

[67] ESSB 5187, Sec. 114 (13) directs OIC to study approaches to improve health care affordability in Washington, including but not limited to those being used or considered by other states with regards to health provider price or rate regulation policies or programs other than traditional health plan rate review to increase affordability for health insurance purchasers and enrollees, and regulatory approaches to address any anticompetitive impacts of horizontal consolidation and vertical integration in the health care marketplace to supplement federal antitrust law. OIC's preliminary report is due December 1, 2023 with a final report due August 1, 2024. This work is undertaken in partnership with the Washington State Office of the Attorney General and in consultation with HCA, HBE, and the Department of Health. https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20230905081501

[68] Funding provided to HCA to expand coverage to adults ineligible for Medicaid or federal subsidies by reason of immigration status.

[69] Expanding eligibility for MSP was also noted in FTAC's guidance to the Commission as a potential pathway to improving cost-sharing and services for existing Medicare enrollees.

	• Study of provider rate regulatory approaches
Purchasing	• Consolidate state purchasing
Subsidies	• Expand premium tax credit • Expanded HBE Cost-Sharing Subsidies

The Commission will assess the feasibility and impact of the above transitional solutions. Details of the selection process and selected transitional solutions will be included in the Commission's 2024 legislative report.

Health equity framework to evaluate design proposals

The health equity implications of the larger system's eligibility design were at the center of the Commission's discussions this year. One of the primary health equity concerns was the ability of the state to achieve benefits parity between the new system[70] and Medicare, ERISA, and Medicaid. If the universal system provides comprehensive coverage and benefits but only to a subset of the population (individuals not covered by one of these coverage sources), Washington could perpetuate existing health inequities and health disparities.

This and other health equity implications are critical to assess and consider in the Commission's work to design an equitable health care system. As such, the Commission sought to develop a health equity framework by which to consider and evaluate design proposals. The Commission enlisted the expertise of Dr. Quyen Huynh, Health Equity Director, HCA, to provide further information and guidance on potential health equity frameworks.[71]

Adoption of a health equity framework

Dr. Huynh shared that health equity, defined by HCA as everyone having a fair and just opportunity to be as healthy as possible, is at the center of HCA's vision, mission, and strategies. HCA has been intentional in creating an internal health equity infrastructure to support its external efforts. This includes the development of a health equity framework utilized for decision making in agency's role to purchase health care for millions of Washingtonians. Additionally, HCA's Health Equity Toolkit[72] was developed to help staff apply an equity lens[73] when designing or evaluating policies, programs, and services.

Dr. Huynh cautioned that sometimes, well-intentioned policies do not achieve predetermined goals, where communities most impacted are often not involved or elevated from the outset. Recognizing that those with lived experience are the true experts, HCA strives to build a two-way relationship with the community and hear from community members how HCA's services and programs impact them.[74] Dr.

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[70] Benefits and services are scheduled to be discussed in 2024.
[71] Commission **June meeting recording**.
[72] HCA's Health Equity Toolkit also helps staff identify and address health disparities in the development of legislative bill analyses. HCA's Health Equity Toolkit can be found in Appendix G.
[73] Using an equity lens means evaluating something for inequitable health impacts on groups of people.
[74] HCA created the Pro-Equity Anti Racism Community Advisory Team (PEAR CAT) to build community engagement, which involves direct contact with the people being served. This is distinct from gathering

Huynh explained that HCA centers diversity, equity, inclusion, and belonging at the state Medicaid agency level and continues to engage communities through this lens to ensure that those who are most disenfranchised have a seat at the decision-making table. In addition to advancing health equity, community engagement efforts can build trusting relationships with the communities being served by this work.

Dr. Huynh noted that the current health care system was built without intentional equity. As a result, some existing infrastructure must be dismantled, power re-distributed, and community voices elevated. However, this work must move at the pace of the community. Dr. Huynh implored the Commission to apply a consistent equity framework and an equity lens each time decisions are made.

The Commission agreed that utilization of the health equity framework and Health Equity Toolkit would support their work to design a universal health care system with health equity at its center. The Commission directed staff to build in a health equity analysis process for design proposals expected to impact health equity. These analyses will occur prior to the Commission taking action at meetings, such as final action regarding recommendations. The Commission voted to adopt and apply the health equity framework to their recommendations (seven for, one opposed).[75]

Washington Health Trust analysis request

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.[76] SB 5335 proposes the creation of the Washington Health Trust within the Washington Department of Health to provide coverage for a set of EHB to all Washington residents.

Per the request, the Commission's analysis should:

- Be shared in a report by June 30, 2024.
- Assess whether the proposal aligns with the goals and planned activities of the Commission.
- Assess whether and how the Commission might recommend implementing the proposal, if the Commission considers it within their mission and a viable proposal.
- Identify opportunities for Whole Washington, proponents of the bill, to substantively engage with the Commission in the future.
- Engage the leaders of Whole Washington throughout the analysis process and report preparation.

The Commission assessed the request and voted unanimously for its incorporation into the Commission and FTAC's work plan to the extent possible within the requested timeframe and available resources.[77] The Commission also invited Whole Washington to present on SB 5335 and the Commission will continue to engage with Whole Washington members throughout the process of analysis and drafting for the 2024

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input and feedback from key partners such as provider groups, hospital associations, or community-based organizations who hold interests in the work. **HCA's Community Engagement Mini Guide.**

[75] Eight members were present for the vote to adopt and apply the health equity framework.

[76] SB 5335 did not pass out of committee.

[77] Commission **April meeting recording**.

report. Then, beginning in 2025, and until the analysis is complete, each of the Commission's legislative reports will summarize SB 5335 and how it would address key design components of a universal system.

Conclusion

At the center of the Commission's discussions this year were eligibility for the larger system and the health equity implications of eligibility design. The Commission will assess the health equity impact of this and other design elements as they continue to be developed.

In the short-term, Washington is limited in both its ability to recoup federal funding to support a unified financing system, and to regulate coverage sources subject to or preempted by federal law. However, paths to achieving benefits parity in the short-term for Washingtonians eligible for Medicare, ERISA, and Medicaid have surfaced and will be examined further.

The Commission's authorizing legislation states that subject to sufficient existing agency authority, state agencies may implement transitional strategies that do not require statutory authorization or new funding. The Commission will build upon the success of their recommended transitional solutions being funded by the Legislature and continue to develop interim strategies that ensure equitable access to culturally appropriate health care for all Washingtonians.

Appendix materials

The appendices to this report are as follows:

- Appendix A: **Commission roster**
- Appendix B: **FTAC roster**
- Appendix C: **FTAC application**
- Appendix D: **FTAC charter**
- Appendix E: **FTAC proposed transitional solutions**
- Appendix F: **FTAC Medicare Memo**
- Appendix G: **HCA Health Equity Toolkit**
- Appendix H: **Additional comments on this legislative report**

Appendix A: Commission roster

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

Appendix B: FTAC roster

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

Appendix C: FTAC application

View the **FTAC application** on HCA's website.

Appendix D: FTAC charter

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Appendix E: FTAC proposed transitional solutions

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Appendix F: FTAC Medicare Memo

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Appendix G: HCA Health Equity Toolkit

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Appendix H: Additional comments on this legislative report

Comments offered by Commission Member Representative Schmick

1. I believe the assumptions made around ERISA and inclusion of those plans to pay have not been clearly determined by the court. After looking at the portion of the legal opinion (168-U-L-Rev-389) included in the report, I don't believe there is a clear pathway forward on funding coming from ERISA plans. Starting on page 425 and the last paragraph, then continuing through page 428 of the law review, this is basis of my concerns for the ability of the State of Washington to require a tax on ERISA plans to fund universal healthcare.

2. There is an assumption that the level of payment offered will be accepted by providers. Providers already object to the low rates of government plans. According to current Washington law, "A carrier may not require a provider or facility participating in a qualified health plan under RCW 41.05.410 to, as a condition of participation in a qualified health plan under RCW 41.05.410, accept a reimbursement rate for other health plans offered by the carrier at the same rate as the provider or facility is reimbursed for a qualified health plan under RCW 41.05.410. RCW 48.43.775." Even the implementing regulations of the federal No Surprises law have been held to unfairly favor insurers in payment disputes demonstrating provider unwillingness to accept discounted rates for services. (Texas Medical Association, et al. v. United States Department of Health and Human Services) Since therefore it is unclear who all will be paying, it is still unclear in my mind who is going to be considered "in" the program and paying for the program.

3. There is an assumption that providers will stay in the state when proposed reimbursements rates are under current market conditions. I think providers will leave the state if they see opportunities in other states.

4. It is also unclear if permissions or waivers from the federal government to include Medicaid and Medicare patients will even be a possibility. It has been a policy of the federal government that there would have to be savings for the federal portion of these programs before any decisions would be made. I do not think the federal government would allow an unproven proposal to occur such as what Washington state is proposing.

5. The public perception of having government run healthcare for all will have huge hurdles as well. When I asked the question in the last meeting, it was answered with "we will earn the trust". While a noble thought, it does not consider the sentiment found throughout the state and the distrust and lack of confidence in the competence of government.

6. I would like to also state that when consultants make their best predictions with available data, the true outcomes are often inaccurate. For example, a Urban Institute Study stated the Medicaid expansion would see an increase to the roles in the state of Washington of 328,000 additional patients five years after start of the expansion. Three years in, we already enrolled over 500,000 more patients into the program. I am skeptical of the stated savings by instituting universal healthcare.