Washington State Health Care Authority

Report to the Legislature

Universal Health Care Commission Legislative Report

Engrossed Second Substitute Senate Bill 5399; Section 2(7); Chapter 309; Laws of 2021

November 1, 2022

Table of contents

Glossary of Abbreviations and Acronyms

ABA	Applied Behavior Analysis
ACA	Affordable Care Act
AI/AN	American Indian and Alaska Native
ACH	Accountable Communities of Health
APCD	All-Payer Health Care Claims Database
ARNP	Advanced Registered Nurse Practitioner
ASD	Autism Spectrum Disorder
BBPA	Balance Billing Protection Act
BHP	Washington State Basic Health Plan
BHWAC	Behavioral Health Workforce Advisory Committee
Blue Ribbon Commission	Washington State Blue Ribbon Commission on Health Care Costs and Access
Bree Collaborative	Dr. Robert Bree Collaborative
CAH	critical access hospitals
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
Commission	Universal Health Care Commission
Consortium	Northwest Prescription Drug Consortium
DOH	Department of Health
DSHS	Department of Social and Health Services
EHB	Essential Health Benefits
E&M	evaluation and management
ERISA	Employee Retirement Income Security Act of 1974
FCS	Foundational Community Supports
FFS	fee-for-service
HBE	Washington Health Benefit Exchange
HEDIS	Healthcare Effectiveness Data and Information Set
FEHB	Federal Employees Health Benefits

FMAP	Federal Medical Assistance Percentage
FPL	federal poverty level
FQHC	federally qualified health centers
FTAC	Finance Technical Advisory Committee
HCA	Health Care Authority
HCCTB	Health Care Cost Transparency Board
HHS	Department of Health and Human Services
HI	Hospital Insurance
HTCC	Health Technology Clinical Committee
ICU	Intensive Care Unit
IHCPs	Indian Health Care Provider
IHS	Indian Health Service
IMD	institution for mental diseases
IRS	Internal Revenue Service
L&I	Department of Labor and Industries
LPN	Licensed Practical Nurses
MACPAC	Medicaid and CHIP Payment and Access Commission
MCOs	Managed Care Organization
NAR	Network Adequacy Reports
Network	Washington Health Workforce Sentinel Network
NHOPI	Native Hawaiian or Other Pacific Islander
NYHA	New York State Health Act
OATAC	Operations and Administration Technical Advisory Committee
OEB	Oregon Educators Benefit
OFM	Office of Financial Management
OIC	Office of the Insurance Commissioner
PA	Physician Assistant
PBM	pharmacy benefit manager
PEBB	Public Employees Benefit Board
PHE	Public Health Emergency
PMCC	Performance Measures Coordinating Committee

PDAB	Prescription Drug Affordability Board
QDP	qualified dental plan
QHP	qualified health plan
RN	Registered Nurse
SEBB	School Employees Benefit Board
SHADAC	State Health Access Data Assistance Center
SHI	Statutory Health Insurance
SMI	Supplementary Medical Insurance
SNAP	Supplemental Nutrition Assistance Program
SUD	substance use disorder
TPAs	third-party administrator
UHC Work Group	Universal Health Care Work Group
UMP	Uniform Medical Plan
UW CHWS	University of Washington Center for Health Workforce Studies
VBP	value-based purchasing
VHA	Veteran's Health Administration
WSIPP	Washington State Institute for Public Policy
WVA	Washington Vaccine Association

Executive Summary

Engrossed Second Substitute Senate Bill 5399 (2021) established a permanent Universal Health Care Commission (hereafter Commission) staffed by the Health Care Authority (HCA).[1] The Commission is dedicated to ensuring that all Washingtonians have equitable access to culturally appropriate health care and universal coverage. The Commission strongly encourages and values input from the public in their commitment to find ways to reduce health care costs, reduce health disparities, improve the health and well-being of patients and the health workforce, improve quality, and prepare for the transition to a unified health care financing system. 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."

The Commission's authorizing legislation requires that the Commission submit a baseline report to the Legislature and the governor by November 1, 2022.

With an equity lens, the Commission accomplished significant milestones in its first year of work, including:

- Developed the Commission Charter and Operating Procedures.[2]
- Reviewed and built on the work of the **Universal Health Care Work Group** (Engrossed Substitute House Bill 1109, Section 211, Subsection 57; Chapter 415, Laws of 2019).
- Examined universal health care systems and the core design elements that constitute universal health care systems, including single-payer systems in other countries.
- Engaged with the Health Care Cost Transparency Board (HCCTB) to develop an understanding of health care costs and cost drivers in Washington and to establish cooperation between the Commission and HCCTB.
- Investigated federal barriers to achieving a universal health care system in Washington.
- Developed a phased strategy to move forward on the pathway to a universal health care system.
- Established a Finance Technical Advisory Committee.

The Legislature requested that the Commission make recommendations in their baseline report regarding the specific topics identified in the legislation. The Commission's recommendations are grounded in the Commission's goals and principles to increase access to quality, affordable health care by streamlining access to coverage, reducing fragmentation of health care financing, reducing unnecessary administrative costs, and reducing health disparities. These recommendations include:

[1] See Appendix A for more information on the selection of Commission Members and current Member Roster.
[2] See Appendix B. Charter and Operating Procedures.

- Transitional solutions that support goals of universal coverage including enrollment options, eligibility systems, access to care, quality improvement and increased equity.
    - Establish a sustained funding source for the new coverage solutions being implemented that will ensure long-term coverage for a key uninsured population.
    - Implement the Cascade Care Savings program that may make coverage more affordable for some uninsured individuals currently eligible to purchase QHPs.

- Transitional strategies that can improve affordability and advance the state's readiness to implement a universal health care system:
    - Further align existing public coverage programs which would
        - Control underlying costs of care and administrative costs.
        - Establish more uniform standards for quality of care and coverage.
    - Leverage the work of cost transparency initiatives to develop a broader set of health care cost targets.
    - Implement the Integrated Eligibility and Enrollment Modernization Roadmap[3] that will improve access to coverage and create infrastructure that can be leveraged in a universal health care system.

- Potential pathways to increase Medicaid provider rates as requested by the legislature, including:
    - Enhance adult primary care rates to provide parity between pediatric primary care and adult primary care rates.
    - Enhance behavioral health rates to achieve parity between fee-for-service and managed care behavioral health services.
    - Continue to fund rate enhancements for dental services in targeted programs with lower reimbursement rates such as Medicaid and ensure that enhancements are sufficient to encourage dental provider participation.

[3] Integrated Eligibility and Enrollment Modernization Roadmap Report. Washington Health and Human Services Enterprise Coalition. 2022. **https://www.dshs.wa.gov/sites/default/files/contracts/2223-807/2223-807%20Exhibit%201%20WA%20IEE%20Mod.%20Roadmap%20Report.pdf**

Section 1: Synthesis of past analyses

Introduction

Washington State is a recognized national leader on innovative health policy efforts granting residents access to affordable and quality health care. For over 30 years, these innovative health policy efforts have transformed Washington's health care system. The first section of this report provides a summary of analyses of Washington's health care finance and delivery system in key areas, including key policy interventions that Washington has implemented, such as:

- coverage trends,
- costs,
- quality, and
- provider consolidation trends.

These key policy interventions improve access, affordability, quality, and equity of the health care system. This section also summarizes recent efforts focused on evaluating the impacts of a unified health care financing system/universal health system (universal health care system) in Washington.

The goal of this section of the report focused on synthesis of past analyses is to provide a common understanding of the current state of health care trends and past and recent policy efforts. This overview may help inform future decisions regarding a universal health care system in Washington State.

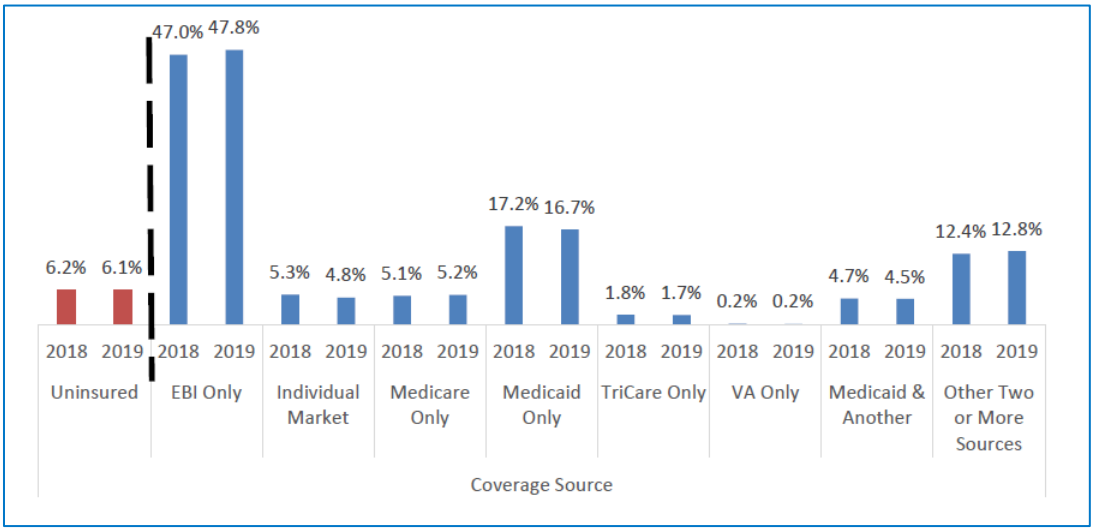
Washington health care coverage analyses and trends

As a national leader in health care system innovation, Washington has sought policy solutions to address coverage gaps well before the Affordable Care Act (ACA). These efforts are detailed in a timeline provided in *Appendix C* (UHC Workgroup Report) and described in this section.

Following passage of the ACA, Washington fully embraced the opportunity to expand Medicaid and offered new subsidized coverage through the Health Benefits Exchange (HBE). Medicaid expansion extended health care coverage to more Washington residents.

The annual report on the rate of uninsured produced by the Office of Financial Management (OFM) details the sources of health coverage for Washingtonians. According to the 2020 report, 47.8 percent of Washingtonians relied on employment-based insurance, 16.7 percent on Apple Health (Medicaid), 4.8 percent on individual market coverage, 5.2 percent on Medicare, 1.7 percent on TriCare, 0.2 percent on Veteran's Affairs, 4.5 percent on Medicaid and another source of coverage, and 12.8 percent on other or two or more sources of coverage. These percentages are illustrated in Figure 1 below.

Figure 1: Source of coverage by percentage, 2018 and 2019, Washington[4]



Uninsured populations

The OFM report also highlighted changes in the uninsured rate between 2013 and 2016. The uninsured rate declined from 14.1 percent in 2013, to 5.4 percent in 2016, then slightly increased to 6.1 percent in 2019 before the start of the COVID-19 pandemic.[5,6]

[4] Reprinted with permission from Statewide Uninsured Rate Remained Unchanged from 2018 to 2019. Office of Financial Management, December 2020. https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief098.pdf

[5] Statewide Uninsured Rate Remained Unchanged from 2018 to 2019. Office of Financial Management, December 2020. https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief098.pdf

[6] The most recent data utilized in this report is from 2019. The Office of Financial Management anticipates an update will be available late in 2022.

In December 2021, the Office of the Insurance Commissioner (OIC) released its Uninsured Report which provides additional specificity about which populations remain uninsured by age, geography, race, and gender and the uninsured trends over time across geography and sociodemographic groups:

- **Geography:** Between 2014 and 2019, the OIC Uninsured Report found that across all counties there were declines in the number of Washingtonians without health insurance. Those declines were more significant in rural compared to urban counties, due in large part to the fact that more individuals in urban counties were already insured in 2014 compared to those in rural counties.
- **Age:** The OIC report also found that residents aged 18 to 44 years had the highest uninsured rate over time with an average of 10 percent, while those 65 years and older had the lowest uninsured rate over time with an average of 0.5 percent, most likely due to Medicare enrollment.
- **Income:** The OIC report noted that individuals with household incomes below $49,999 saw the greatest decrease in the uninsured rate, with a more significant decrease among those with incomes below $25,000, declining from 14.1 percent to 8.9 percent.[7]

Uninsured population by race

OIC's Uninsured Report also provides important insights into uninsured populations by race. People who identify as White, Asian, and multiracial have the lowest uninsured rates statewide at a little over five percent. Individuals who identify in these racial categories as well as individuals who identify as African American/Black, had substantially lower uninsured rates in 2019 than 2014, demonstrating the impact of the ACA's coverage expansions.

OFM's 2020 analysis reports that before the implementation of the ACA in 2013, the uninsured rate for the Hispanic population was 2.5 times the rate of non-Hispanic population. Both populations have seen significant declines in their uninsured rate since 2013, but the disparities persist and are expanding between Hispanic and non-Hispanic populations. In 2019, the uninsured rate for the Hispanic population was nearly four times greater than the non-Hispanic population, as seen in Table 1.[8]

Table 1: Washington uninsured rate for Hispanic vs. non-Hispanic populations, 2013–2019

Uninsured rate	2013	2019
Hispanic	29.8%	16.8%
Non-Hispanic	12.0%	4.5%

The table above shows the uninsured rate for Hispanic and non-Hispanic populations in Washington from 2013 through 2019.

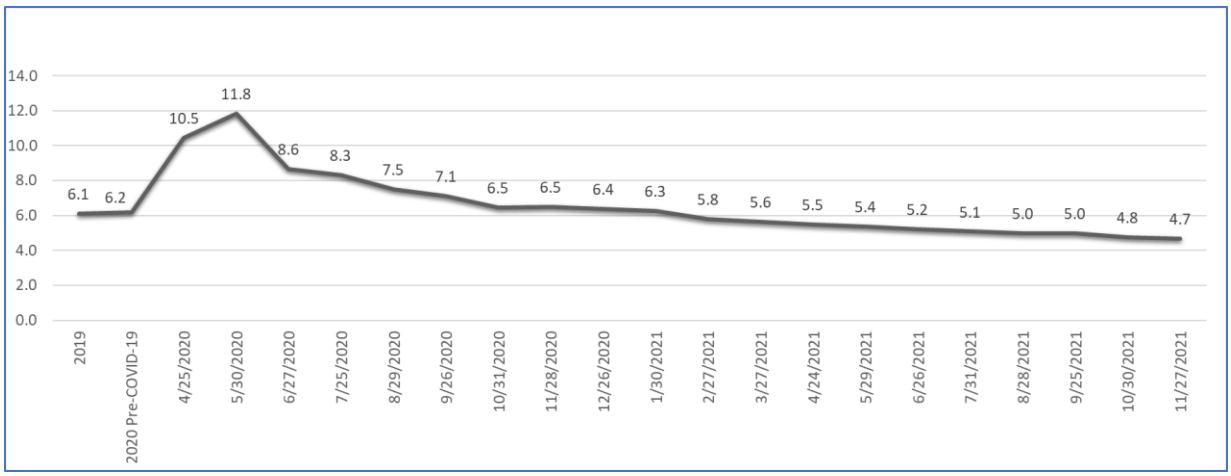
[7] Report on the number of uninsured people in Washington state 2014-2020. Office of the Insurance Commissioner, December 30, 2021. https://www.insurance.wa.gov/sites/default/files/documents/2021-uninsured-report.pdf#:~:text=Washington%20state's%20uninsured%20rate%20was,2014%20and%205.5%25%20in%202017

[8] Statewide Uninsured Rate Remained Unchanged from 2018 to 2019. Office of Financial Management, December 2020. https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief098.pdf

COVID-19 and uninsured populations

The impact of the pandemic on the overall uninsured rate in Washington was significant. There was a spike in the uninsured rate to 11.9 percent in May 2020, which steadily declined thereafter as seen in Figure 2. The most recent monthly data from OFM (November 2021) indicates an uninsured rate of 4.7 percent, which is the lowest uninsured rate since the implementation of the ACA.[9]

Figure 2: Pre-COVID estimated percentage uninsured in Washington 2019–November 2021



This graph shows the estimated percentage of uninsured Washingtonians. The data points are from 2019, pre-COVID-19 2020, and the last week of the month of April 2020 through November 2021.[10]

The lower uninsured rate is reflective of several key policy changes undertaken to mitigate coverage losses during the pandemic. These key policy changes include:

- continuous Medicaid coverage,
- expanded eligibility for premium subsidies to purchase coverage through the Exchange,
- enhanced premium subsidies to improve the affordability of Exchange coverage, and
- increased outreach and enrollment opportunities to obtain coverage.[11]

OFM has monitored the impact of these policies closely and is developing projections about the effect of the end of the Public Health Emergency (PHE) on Washington's uninsured rate.

During the February 2022 Commission meeting, OFM shared a preliminary analysis about these potential impacts. OFM projected a significant bump in the rate of the uninsured, mostly due to the return of temporary disenrollment and re-enrollment in Apple Health. However, work is underway at the Health Care Authority (HCA) and HBE to minimize projected coverage losses. Tracking this data and the impact of

[9] Health Coverage Changes in Washington State since the COVID-19 Pandemic: Office of Financial Management presentation to the Commission, February 25, 2022. https://www.hca.wa.gov/assets/program/uhcc-meeting-materials-20220225.pdf

[10] Ibid. Reprinted with permission from OFM.

[11] "COVID Relief Provisions Stabilized Health Coverage, Improved Access and Affordability." Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/covid-relief-provisions-stabilized-health-coverage-improved-access-and

these efforts to minimize coverage losses will be important information in developing strategies for the transition to universal health coverage.

Cost analyses and trends

Many of Washington's efforts to improve the health care system focus on addressing rising health care costs. In recent years, Washington health care costs increased each year at a pace that exceeds the rate of inflation. In the commercial market, OIC reported a 13-percent increase in costs in 2021, nearly double the rate of inflation at seven percent.[12] Cost growth in Washington also generally exceeds national trends. From 2014–2018, Washington's average annual growth in per person spending on employer-sponsored insurance was 4.9 percent, which is higher than the national average of 4.3 percent. Similarly, in the Medicare market, Washington's average annual growth in per capita health care costs was 2.4 percent between 2007–2018, exceeding the national average of 2.1 percent.[13]

To better understand cost drivers and to address rising health care costs, Washington engaged in several initiatives in recent years, including:

- Health Care Cost Transparency Board
- Prescription Drug Price Transparency Program
- Prescription Drug Affordability Board
- Value-Based Purchasing, and
- OIC's Report on Prior Authorization

These efforts are likely to remain in the forefront of Washington health policy as health care costs continue to increase yearly nationwide.

Health Care Cost Transparency Board

In 2020, the Washington State Legislature created the Health Care Cost Transparency Board (HCCTB) to identify health care cost trends, set a cost-growth benchmark, and develop recommendations to reduce health care costs.[14]

As of September 2021, HCCTB has approved a cost growth benchmark of 3.2 percent for 2022–23, 3 percent for 2024–25, and 2.8 percent by 2026.[15] Washington's benchmark aligns with other states' cost-growth benchmarks, such as in Oregon, Connecticut, Delaware, Massachusetts, and Rhode Island.[16] The HCCTB will be responsible for identifying providers and payers whose cost growth exceeds the benchmark.

---

[12] Health Care Cost Trends. Office of the Insurance Commissioner. **https://www.insurance.wa.gov/health-care-cost-trends**
[13] Health Care Cost Transparency Board slides, June 2021. **https://www.hca.wa.gov/assets/program/hcctb-board-book-20210616.pdf**
[14] Second Substitute House Bill 2457 Chapter 340, Laws of 2020. **https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/2457-S2.SL.pdf?q=20220405153723**
[15] Health Care Cost Transparency Board. September 14, 2021, Meeting Minutes. **https://www.hca.wa.gov/assets/program/board-meeting-summary-20210914.pdf**
[16] Block, R. & Lane, K. (2021). Supporting States to Improve Cost Growth Targets to Improve Affordability. Health Affairs. **https://www.healthaffairs.org/do/10.1377/forefront.20210526.658347/full/**

Data collected in 2022 will help set the baseline for tracking spending growth in future years, which will be measured against the benchmark. Legislation passed in 2022 (SB 5589) will incorporate primary care into the work of HCCTB. Beginning in 2022, HCCTB will annually report on the progress toward primary care expenditures increasing to 12 percent of total health care expenditures.

Prescription Drug Price Transparency Program

In 2019, the Washington State Legislature enacted legislation establishing the Prescription Drug Price Transparency Program (PDPTP) to develop a better understanding of the drivers and impacts of drug costs.[17] Under this program, HCA gathers prescription drug cost information from health insurers, pharmacy benefit managers (PBMs), manufacturers, and other entities to create an annual report on how prescription drugs affect health care costs.

In the first annual report (based on data from 2020 that was reported in 2021), HCA identified that drug price increases may have an impact on health care premiums; however, the extent of the impact could not be identified. This is in some part due to the agency's limitations in its ability to analyze this relationship without a comprehensive set of claims data for all health plans in Washington.[18]

The report suggested several statutory changes, including requiring health insurers, PBMs, manufacturers, and other entities to provide additional data to HCA. These changes would improve the program's ability to understand the impact of prescription drugs on rising health care premiums. Many of these recommendations, including these additional reporting requirements, were included in legislation that passed in 2022 which created the Prescription Drug Affordability Board (PDAB).[19]

Prescription Drug Affordability Board

Beginning in 2023, PDAB is empowered to conduct up to 24 affordability reviews of drugs that have been on the market for at least seven years. This includes drugs dispensed at a retail, specialty, or mail-order pharmacy, but does not include drugs designated by the United States Food and Drug Administration as a drug solely for the treatment of a rare disease or condition. These drugs must also meet the following benchmarks to be considered for an affordability review:

- Brand name prescription drugs that have a
    - Wholesale acquisition cost of $60,000 or more per year or for course of treatment lasting less than one year,
    - Price increase of 15 percent or more in any 12-month period or for a course of treatment lasting less than 12 months, or
    - 50 percent cumulative increase over three years,
- Biosimilar products with an initial wholesale acquisition cost that is not at least 15 percent lower than the referenced biological product, and

[17] Engrossed Second Substitute House Bill 1224 Chapter 334, Laws of 2019. **https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1224-S2.SL.pdf?q=20220404145622**

[18] Health Care Authority. (2022). Prescription Drug Price Transparency – Annual Report. **https://www.hca.wa.gov/assets/program/hca-dpt-annual-report-2022.pdf**

[19] Second Substitute Senate Bill 5532 Chapter 153, Laws of 2022. **https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5532-S2.SL.pdf#page=1**

- Generic drugs with a wholesale acquisition cost of $100 or more for a 30-day supply or less that has increased in price by 200 percent or more in the previous 12 months.

The legislation includes additional parameters for the affordability reviews including establishment of advisory panels. The advisory panels would include stakeholders such as patients, patient advocates and a representative from the pharmaceutical industry. Affordability reviews will be focused on determining if the drug led to or will lead to excess costs or are not sustainable to the health care system over a ten-year period. Beginning January 1, 2027, PDAB will have the authority to set an upper payment limit for up to 12 prescription drugs each year.[20]

Value-based purchasing

As the largest purchaser of health care in Washington, HCA is leading value-based purchasing (VBP) strategies to contain health care costs while improving outcomes. HCA set a target to achieve 90 percent of state-financed health care payments to be under VBP contracts and is making progress toward this goal. HCA's Value-Based Purchasing Roadmap for 2022–2025 sets forth VBP priorities, successes, challenges, and progress to date in implementing VBP arrangements in Washington.[21]

Office of the Insurance Commissioner Report on Prior Authorization

In 2020, the Legislature passed Engrossed Substitute Senate Bill 6404 that requires health carriers with at least one percent market share in Washington to report certain data regarding prior authorization to OIC.[22] Prior authorization is a tool used by carriers to control cost and access to certain benefits. This reporting may offer insightful information that will be helpful in making decisions concerning design elements of a universal system, particularly regarding the appropriate use of prior authorization as a tool to control costs.

Carriers are required to report data annually for the following specified categories of health care services:

- Inpatient medical/surgical
- Outpatient medical/surgical
- Inpatient mental health and substance-use disorder
- Outpatient mental health and substance-use disorder
- Diabetes supplies and equipment, and
- Durable medical equipment

Within these categories of health care services, carriers report:

[20] Ibid.
[21] VBP Roadmap **https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf**
[22] Engrossed Substitute Senate Bill 6404 Chapter 316, Laws of 2020. **https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/6404-S.SL.pdf?q=20220405154910**

- The 10 codes with the highest number of prior authorization requests and the percentage of approved requests
- The 10 codes with the highest percentage of approved prior authorization requests and the total number of approved requests
- The 10 codes with the highest percentage of prior authorization requests that were initially denied and then approved on appeal
- The total number of requests, and
- The average response time in hours for requests in each of the above categories for expedited decisions, standard decisions, and extenuating circumstances decisions

In the 2021 report, OIC stated that the average approval rate across all carriers was 84.4 percent. For the codes with the highest number of prior approval rates, the average approval rates were as follows:

- Outpatient Medical/Surgical: 98.3 percent
- Inpatient Medical/Surgical: 97.8 percent
- Durable Medical Equipment: 96.1 percent
- Inpatient Mental Health/Substance Abuse: 94.5 percent
- Outpatient Mental Health/Substance Abuse: 91.8 percent
- Diabetes Supplies and Equipment: 84.1 percent

OIC also reported the average response times for the codes with the most requests, which were as follows:

- Inpatient Mental Health/Substance Abuse: 14.4 days
- Diabetes Supplies and Equipment: 12.4 days
- Inpatient Medical/Surgical: 10.7 days
- Outpatient Mental Health/Substance Abuse: 6.7 days[23]

Balance Billing Protection Act

Beginning in January 2020, Washington residents were protected from surprise (or balance) billing when receiving emergency care at a medical facility or when treated at an in-network hospital or outpatient surgical facility by an out-of-network provider. The Balance Billing Protection Act (BBPA), passed in 2019,

[23] Health Plan Prior-Authorization Data 2021 Report. Office of the Insurance Commissioner. **https://www.insurance.wa.gov/sites/default/files/documents/health-plan-prior-authorization-data-2021-report.pdf**

applies to all state-regulated health plans and state and school employee benefit plans. Self-funded group plans are not required to comply.[24]

In 2022, Washington's BBPA was updated to comply with the federal No Surprises Act passed in 2020. Emergency services and post-stabilization services are now covered, including behavioral health emergency settings. Consumers cannot be asked to waive these balance billing protections, which protects them from surprise bills for covered services.[25]

Quality analyses and trends

Improving health care quality has been and remains a policy priority for Washington's health care delivery system. Washington policymakers have made several investments and enacted key policies in recent years to monitor and support quality improvements. These include:

- Washington State Health Technology Clinical Committee,
- Dr. Robert Bree Collaborative,
- Washington Statewide Common Measure Set,
- All-Payer Health Care Claims Database (APCD), and
- Washington's Medicaid Transformation Project.

These efforts focus on promoting transparency and improved quality in the health care system are important building blocks to consider in the future design of a universal health care system.

Washington State Health Technology Clinical Committee

The Health Technology Clinical Committee (HTCC) was established in 2006 to make evidence-based coverage determinations for health technologies.[26] The HTCC is supported by HCA's Health Technology Assessment program, which develops and publishes systematic health technology assessment reports on the strength of the evidence for medical devices, procedures, and tests.

The HTCC considers Health Technology Assessment reports and other information, including state utilization and public comments. HTCC's determinations apply to coverage decisions for state health care purchasers, including Medicaid, Uniform Medical Plan, and the Department of Labor and Industries.

Dr. Robert Bree Collaborative

The Legislature established the Dr. Robert Bree Collaborative (Bree Collaborative) in 2011 as a forum for public and private health care stakeholder collaboration to improve quality, health outcomes, and cost

[24] Second Substitute House Bill 1065 Chapter 427, Laws Of 2019. **https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1065-S2.SL.pdf#page=1.**
[25] Engrossed Second Substitute House Bill 1688 Chapter 263, Laws of 2022. **https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1688-S2.SL.pdf#page=1**
[26] Health Care Authority. **Health Technology Clinical Committee** and **Health Technology Assessment.**

effectiveness of care in Washington.[27] Participating experts are nominated by community stakeholders and appointed by the Governor.

Each year, the Bree Collaborative identifies up to three health care service areas with high variation in the delivery of care that do not lead to better care or patient health, or that have demonstrated patient safety issues. The selected service areas are addressed by a work group of experts on the topic who are Bree Collaborative members and other experts in the community. The work group analyzes evidence on best practices for improving quality and reducing practice pattern variation.

The Bree Collaborative recommendations consider existing quality improvement programs and organizations currently working to improve care. HCA incorporates Bree Collaborative recommendations into state-purchased coverage rules.

Washington Statewide Common Measure Set

In 2014, the Legislature established the Washington Statewide Common Measure Set as part of a larger bill focused on "improving the effectiveness of health care purchasing and transforming the health care delivery system."[28] Specifically, the intent of the Statewide Common Measure Set is to minimize variation about how the health care delivery system is measured and monitored.

This legislation established a statewide performance measures committee, known as the Performance Measures Coordinating Committee (PMCC) which is supported by HCA. PMCC includes diverse representation such as state agencies, large and small employers, health plans, federally recognized tribes, patient groups, academics, hospitals, physicians, and consumers.

PMCC identifies and recommends a standard set of health performance measures that are utilized to develop benchmarks to inform health care purchasers. In 2014, a set of measures were introduced and are continually updated by PMCC as new health care measures are developed and priorities for improvement are identified. The most recent set of measures was updated in 2022.[29] The Statewide Common Measure Set is used by HCA to promote quality improvement efforts in Apple Health, the Public Employees Benefits Board (PEBB) and the School Employees Benefits Board (SEBB) using strategies such as value-based purchasing.

All-Payer Health Care Claims Database

The same legislation that established PMCC and the Statewide Common Measure Set also allocated resources to OFM to establish the Washington All-Payer Health Care Claims Database (APCD) to support transparent public reporting of health care information.[30]

APCD contains eligibility, medical, pharmacy, and dental claims representing about 75 percent of the statewide health care claims including Medicaid, Medicare, public employees benefits, and workers'

---

[27] **Bree Collaborative website.**

[28] Engrossed Second Substitute House Bill 2572 Chapter 223, Laws of 2014. **https://lawfilesext.leg.wa.gov/biennium/2013-14/Pdf/Bills/Session%20Laws/House/2572-S2.SL.pdf?q=20220405155431**

[29] Washington Statewide Common Measure Set. **https://www.hca.wa.gov/about-hca/washington-statewide-common-measure-set#what-is-statewide-common-measure-set**

[30] Engrossed Second Substitute House Bill 2572 Chapter 223, Laws of 2014. **https://lawfilesext.leg.wa.gov/biennium/2013-14/Pdf/Bills/Session%20Laws/House/2572-S2.SL.pdf?q=20220405155431**

compensation and more than 50 commercial payers.[31] In 2019, the Legislature transferred the responsibility for APCD to HCA to partner with a lead organization with experience collecting and analyzing claims data.[32] APCD Data is displayed on the Washington HealthCareCompare website, allowing consumers to compare the cost and quality of medical care and services. Consumers can find local prices of a treatment or visit by zip code. APCD data is also used to inform and support other work in Washington examining costs of health care, including BBPA, the OIC's study of health care cost trends, and HCCTB.

Medicaid Transformation Project

Washington is currently in its final year of an 1115 Medicaid waiver that includes five key initiatives to transform the Medicaid program including:

- **Initiative 1:** transformation through Accountable Communities of Health (ACHs) and Indian Health Care Providers (IHCPs). This initiative implements projects that change the way people receive health care in their region. HCA submitted a waiver renewal proposal to the Centers for Medicare and Medicaid Services in July 2022. Efforts to improve quality through value-based payments will continue to be a focus of ongoing transformation efforts.[33]
- **Initiative 2:** supporting older adults and family caregivers. Initiative 2 provides support for Washington's aging population and family caregivers who provide care for their loved ones.
- **Initiative 3:** Foundational Community Supports (FCS). This initiative provides supportive housing and supported employment services to vulnerable Medicaid enrollees.
- **Initiative 4:** substance use disorder (SUD) institution for mental diseases (IMD). Initiative 4 provides greater access to SUD treatment by allowing Washington to use federal funds to pay for SUD treatment in a mental health or SUD facility that qualifies as an IMD. IMDs are large facilities dedicated to psychiatric care (more than 16 beds where more than 50 percent of the residents are admitted for psychiatric care).[34]
- **Initiative 5:** mental health IMD. This initiative provides greater access to in-patient care by allowing Washington State to purchase an average of 30 days of acute inpatient services for Medicaid clients between the ages of 21 and 65 who reside in an IMD.[35]

Through these initiatives, HCA is implementing and overseeing projects that are designed to improve the way people access the health and social supports they need. By further integrating these services and

[31] Washington All-Payer Health Care Claims Database newsletter. **https://www.hca.wa.gov/washington-all-payer-health-care-claims-database-wa-apcd-newsletter**
[32] Engrossed Substitute Senate Bill 5741 Chapter 319, Laws of 2019. **https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5741-S.SL.pdf?q=20220320080426**
[33] Medicaid Transformation Project Renewal **https://www.hca.wa.gov/about-hca/medicaid-transformation-project-mtp/mtp-renewal**
[34] Amendment to Washington's Medicaid Transformation Project (MTP): The substance use disorder IMD initiative. **https://www.hca.wa.gov/assets/program/sud-imd-faq.pdf**
[35] Amendment to Washington's Medicaid Transformation Project: Introducing the mental health IMD initiative. **https://www.hca.wa.gov/assets/program/mental-health-imd-faq.pdf**

supporting providers in the transition to value-based payments, Washington will improve the quality of care people receive.

Health care workforce analyses and trends

Developing and maintaining an adequate health care workforce will be critical to any effort to move toward a universal health care system focused on improving access and quality and reducing costs. Workforce trends will be particularly important considerations when developing a provider reimbursement model.

Physician workforce findings

OFM's Forecasting and Health Care Research Division produces an annual report on Washington's physician supply using data collected from the Network Adequacy Reports (NAR) that health insurance carriers submit monthly to OIC. The 2021 report found that the number of licensed physicians (including Medical Doctors and Doctors of Osteopathy) increased by 769 from 2020 to 2021 for a total of 20,563 licensed physicians. This growth in the number of licensed physicians outpaced the general population increase, resulting in an increase in the physician-to-population ratio from 269 physicians per 100,000 in 2020 to 275 physicians per 100,000 population in 2021. The report also found that the ratio of physicians practicing primary care in comparison to specialty care remained relatively unchanged (declining from 34 percent to 33 percent for primary care and rising to 67 percent from 66 percent for specialty care).

Similar to past annual reports, the physician supply is disproportionately distributed across the state, with more than 40 percent of all physicians located in King County. This is not surprising given that King County accounts for the bulk of the state's population. However, Chelan County, not King County, has the highest ratio of physician-to-population ratio by a significant margin: 532 physicians per 100,000 people versus 383 physicians per 100,000 people. Overall, significant disparities in Washingtonians' access to physicians remains across the state.[36]

Efforts to address shortage of health care workers

The Health Workforce Council was created by the Washington State Legislature in 2003 to investigate and support initiatives to address health care workforce shortages. The Health Workforce Council is responsible for producing an annual report outlining these trends and making recommendations to the Legislature about possible improvements.

Washington Health Workforce Sentinel Network

One of the initiatives of the Health Workforce Council has been the Washington Health Workforce Sentinel Network (Network), created in 2016. The Network is a collaboration of the Health Workforce Council and the University of Washington Center for Health Workforce Studies (UW CHWS). The Network links the health care industry with partners in education and training, policymakers, and other workforce planners to identify and respond to emerging demand changes in the health workforce. The information captured by the Network seeks to provide more insights into the "why" of changes in occupations, roles, and skills needed to deliver quality care.

[36] Office of Financial Management: 2020-21 Physician Supply: Estimates for Washington. **https://ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/workforce/physician_supply_2020-21.pdf**

Since its inception, the Network has tracked health disciplines with exceptionally long vacancies across a number of health care settings.[37] According to the Health Workforce Council Annual Report for 2021, employers in long-term care settings, including skilled nursing facilities, nursing homes, and assisted living facilities, reported significant challenges in hiring enough registered nurses (RNs), nursing assistants, and licensed practical nurses (LPNs). Notably, these workforce challenges are not new, but have become more acute since the COVID-19 pandemic.[38] There are various causes for these shortages such as the lack of adequate training slots for many of these professions, lower salaries in long-term care settings when compared to other settings, and administrative challenges with licensure when moving from other states.

Behavioral Health Workforce Advisory Committee

Another area where there are significant and ongoing healthcare workforce shortages is in behavioral health. According to the 2017 Washington State Behavioral Health Workforce Assessment, "the demand for behavioral health care, including mental health and substance use disorder treatment, exceeds the availability of services throughout the state."[39] This is consistently echoed in the data collected by the Network. Long-term vacancies are also commonplace and have become more acute over the last two years due to the pandemic, during which the demand for behavioral health services has skyrocketed.[40] In response to the significant and enduring gaps in the behavioral health workforce, in 2021 the Legislature formalized an existing stakeholder workgroup that became known as the Behavioral Health Workforce Advisory Committee (BHWAC).

BHWAC issued an interim report in December 2021 with updated policy recommendations to improve hiring and retention. Key recommendations included in the interim report focused on

- increasing Medicaid reimbursement rates for behavioral health providers,
- increasing the ability of behavioral health agencies to accept students/trainees, and
- enhancing training programs to support individuals pursuing careers in behavioral health.

A final report from BHWAC is expected in December 2022.[41]

> Addressing the existing healthcare workforce shortage will be a prerequisite in the transition to a universal health care system.

[37] Health Workforce Council. **https://www.wtb.wa.gov/planning-programs/health-workforce-council/**
[38] Health Workforce Council Annual Report 2021 Annual Report. **https://www.wtb.wa.gov/wp-content/uploads/2022/01/Health-Workforce-Council-Annual-Report-2021.pdf**
[39] 2017 Washington State Behavioral Health Workforce Assessment. **https://www.wtb.wa.gov/wp-content/uploads/2019/05/WA-Behavioral- Health-Workforce-Assessment-2016-17.pdf**
[40] Health Workforce Council Annual Report 2021 Annual Report. **https://www.wtb.wa.gov/wp-content/uploads/2022/01/Health-Workforce-Council-Annual-Report-2021.pdf**
[41] Behavioral Health Workforce Advisory Committee Preliminary Report and Recommendations. **https://www.wtb.wa.gov/wp-content/uploads/2021/12/BHWAC-Preliminary-Report-Final-Draft.pdf**

Market consolidation analyses and trends

Over the last 35 years in Washington, there has been an increase in hospital consolidation because of mergers and acquisitions. This trend is not unique to Washington and is identified in many studies as a contributing factor to higher costs and poorer outcomes in the health care delivery system. Understanding market consolidation trends is an important factor when making design and policy decisions about a universal health care system in Washington.

OFM released a comprehensive report, "Hospital Mergers in Washington 1986–2017" which describes the increased concentration of hospital resources and care as more hospitals in Washington became part of larger hospital systems over the 1986-2017 period.[42] While it does not provide specific data comparing quality and costs of care before and after hospital mergers and acquisitions, it does provide information about how many hospital beds, intensive care units (ICUs), and hospital admissions are concentrated to a few health care systems compared with independent hospitals. The concentration of these resources provides insights into the lack of competition that may contribute to reduced access and higher costs.

The report found that the percentage of hospitals in systems grew from 10 percent in 1986 to almost 50 percent in 2017. This trend was not consistent over the entire time of the study and most of the changes happened between 2006 and 2017. With this shift to larger systems, hospital resources became more concentrated. The number of available hospital beds per 100,000 population decreased from 298 to 170. Meanwhile, the percentage of hospital beds in systems, patient admissions to systems, and ICU beds in systems all increased dramatically as indicated in Table 2.

Table 2: Change in percentage of hospital beds, patient admissions and ICU beds in systems 1986–2017

Percentage of Hospital Beds in Systems	
1986	19%
2017	73%
Percentage of Patient Admissions to Systems	
1986	20%
2017	79%
1986	19%
2017	73%

The above table shows the dramatic increase in percentage of hospital beds, patient admissions, and ICU beds in systems from 1986 to 2017.

OFM's Hospital Mergers Report also provided data about consolidation at the county level across Washington. In 1986, hospitals in systems operated in six counties, each of which had at least one

[42] Office of Financial Management. Hospital Mergers in Washington 1986-2017. https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief105.pdf

independent hospital. These counties accounted for 60 percent of the state population. In total, 29 counties, accounting for 39 percent of Washington's population, were served only by independent hospitals and four counties had no hospitals. In 2017, system hospitals operated in 17 counties. Eight of those counties were served only by system-operated hospitals. Close to 90 percent of the population lived in a county with at least one system hospital, compared to 60 percent in 1986.

The increased consolidation and concentration of health care resources may have an unforeseen impact on the community. One concern articulated in this report was the significant amount of consolidation into Catholic hospital systems which could impact access to women's reproductive health services which has been a long-standing priority for Washington policymakers. This will be an important factor to consider when designing a universal health care system to achieve better outcomes and lower costs.

Seeking comprehensive solutions in Washington: a 35-year journey

Exploring comprehensive solutions to improve quality, lower costs, and improve access to affordable coverage are not new endeavors in Washington. Over the last 30 years, Washington's wide-ranging efforts aimed to provide a comprehensive solution to these pervasive problems, including establishing the Basic Health Plan, the Washington Healthcare Commission (often called the Gardner Commission after then-Governor Booth Gardner), the Washington State Blue Ribbon Commission on Health Care Costs & Access, and the more recent Universal Health Care Work Group.

These efforts, in addition to the targeted efforts described earlier, are foundational steppingstones in Washington's current deliberations and decision-making to develop a universal health care system that will provide affordable and quality health care to all Washingtonians.

Basic Health Plan

Washington began extending coverage to qualified low-income adults and children in 1987 using a state-funded effort called the Washington State Basic Health Plan (BHP). The initial pilot program was expanded statewide in 1993, eventually enrolling over 100,000 low-income, Medicaid-ineligible working adults with incomes under 200 percent of the federal poverty level (FPL).

Enrollment into Washington's BHP continued to grow through the mid-90s and in 2003 reached a peak of 130,000 (the program's enrollment cap at the time).[43] Due to state budget pressures, BHP funding was cut by 43 percent in the 2009–2011 state budget, greatly reducing the number of enrollees and stopping new enrollment. Many BHP enrollees transitioned to Medicaid with the state's Section 1115 waiver and the ACA's Medicaid expansion. The ACA's Basic Health Plan was modeled on Washington's BHP.

Washington Health Care Commission

In 1990, the Washington State Legislature passed Legislative Resolution 4443, which established the Washington Health Care Commission to recommend plans for ensuring access to health care for Washingtonians. The Washington Health Care Commission's final report, released in 1992, defined

[43] Revised Code of Washington (RCW) 70.47.060 permitted the program to temporarily close enrollment to avoid over-expenditures.

universal access as "the right and ability of all Washington residents to receive a comprehensive, uniform, and affordable set of confidential, appropriate, and effective health services" which was called the "uniform set of health services."[44]

The proposed uniform set of health services was to be delivered by competing certified health plans to cover preventive, primary, and acute care. The uniform set of health services also included prescription drugs, dental care, mental health, and substance use disorder services. Long-term care services were planned to be to be phased in. The Washington Health Care Commission stressed that services must be timely and not tied to ability to pay or pre-existing health conditions. Consideration of geographic, demographic, and cultural differences would also be considered in providing services.

A majority of Washington Health Care Commission members wanted a single organization to sponsor coverage for all residents, while others believed employers should be a part of a "pay or play" system that allows the employer to offer coverage or pay into the system. Approved health carriers would compete on price within a maximum allowed premium and under rules set by an independent state commission. Financing would be shared by individuals, employers, and Washington. Carriers would be encouraged to implement capitation and increase provider risk for managing care. The Washington Health Care Commission also recommended seventeen strategies for making the health care liability system less costly, time consuming, and emotionally burdensome for consumers and providers.

Recognizing that implementation would take time, the Washington Health Care Commission recommended immediate action to reauthorize the Basic Health Plan and increase funding for public health programs. Additional recommendations to the Legislature also included: pursuing insurance reforms, implementing guaranteed issue and renewability, creating a prohibition or limit on pre-existing condition exclusions, implementing of modified or strict community rating, and developing small group market reforms.

The Washington Health Services Act of 1993

Based on the recommendations of the Washington Health Care Commission, in 1993 the Washington Legislature passed a comprehensive health law that included many of the recommended elements. Many of these elements would be included in the ACA 15 years later:

- Employer and individual mandates
- Guaranteed issue (insurers may not deny coverage due to pre-existing conditions)
- Required coverage of a basic set of benefits
- Expanded Medicaid eligibility

However, the law was not fully implemented because portions of it were repealed by the 1995 Legislature. These repealed provisions included the individual and employer mandates, the use of certified health plans to deliver coverage based on a uniform set of benefits, and caps on insurance premiums.[45] The law

[44] Washington Health Care Commission: Final Report to Governor Booth Gardner and the Washington State Legislature. November 30, 1992.

[45] Certified health plans were defined by the law as organized delivery systems with financial risk for delivering the uniform benefit package.

retained expansion of the Basic Health Plan and Medicaid for children in families with income up to 200 percent FPL. The guaranteed issue and required coverage of a basic set of benefits provisions of the law were also maintained.

Washington State Blue Ribbon Commission on Health Care Costs & Access

In 2006, the Legislature established the Blue Ribbon Commission on Health Care Costs and Access (Blue Ribbon Commission), which was supported by OFM and charged with delivering a five-year plan for substantially improving access to affordable health care for all Washingtonians. The Blue Ribbon Commission included then-Governor Christine Gregoire, eight legislators, and leaders from OIC, HCA, Department of Health (DOH), Department of Social and Health Services (DSHS), and Department of Labor and Industries (L&I).

Based on the vision of a system that allows every Washingtonian to get needed health care at an affordable price, the group identified four overarching strategies:

- Build a high-quality, high-performing health care system
- Provide affordable health insurance options for individuals and small businesses
- Ensure the health of the next generation
- Promote prevention and healthy lifestyles

The Blue Ribbon Commission made 16 recommendations tied to one or more of the above strategies and included proposed actions. Many of the Blue Ribbon Commission's recommendations were implemented by the state Legislature in 2007, including:

- Using reimbursement to reward quality outcomes
- Increasing consumers' access to information and shared decision making
- Improving primary care and chronic care
- Facilitating secure sharing of health information
- Tracking emergency room use
- Identifying contributors to health care administrative costs and evaluating ways to reduce them
- Designing insurance coverage options that promote prevention and health promotion
- Expanding coverage options
- Increasing public health activities[46]

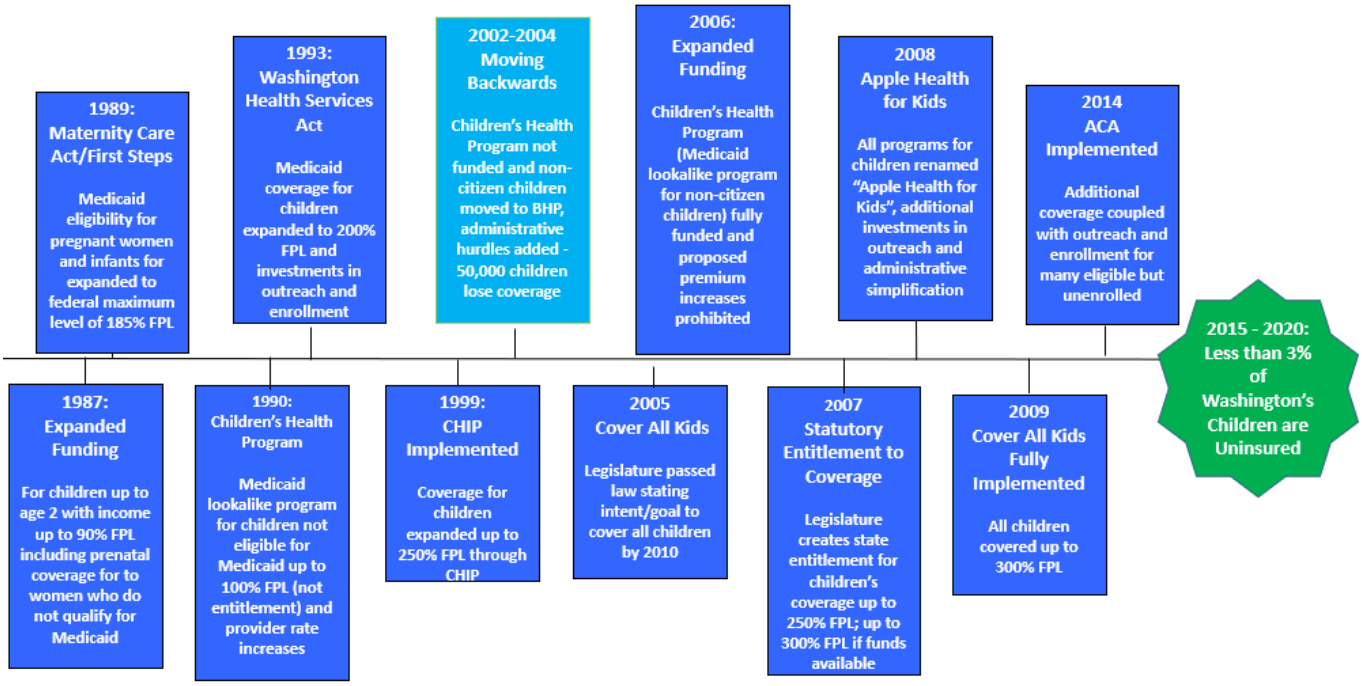
Years ahead of the ACA, the same legislation that created the Blue Ribbon Commission in 2007 also included the requirement to allow purchasers of individual or group coverage the option to cover their unmarried dependents until they reach age 25. This requirement was also implemented for disability insurance. Additionally, the legislation directed DSHS to develop coverage expansion options that could utilize Medicaid, Children's Health Insurance Program (CHIP), and/or BHP.

[46] Engrossed Second Substitute Senate Bill 5930 Chapter 259, Laws of 2007. https://lawfilesext.leg.wa.gov/biennium/2007-08/Pdf/Bills/Session%20Laws/Senate/5930-S2.SL.pdf#page=1

Universal coverage for children

Over 98 percent of Washington children are covered by health insurance, meaning that the state is now considered to have universal child coverage. The process of reaching universal coverage for children took over a decade and involved multiple steps by the Legislature, as seen in Figure 3.

Figure 3: The pathway to universal coverage for children in Washington



Investigating single payer models

In 2018, Washington policymakers allocated resources to investigate the impact of moving to a universal health care system.[47] The first study, conducted by the Washington State Institute for Public Policy (WSIPP), examined various models of universal health care from other countries to gain insights about how these models were constructed and their effectiveness in comparison with the current system in the United States.[48] This study compared the healthcare systems of the United States to 10 comparable "high-income" countries including Japan, Germany, the United Kingdom, France, Canada, Australia, the Netherlands, Sweden, Switzerland, and Denmark. In general, the health care systems of the comparable countries are considered "universal" models to varying degrees. These models included:

- Single payer systems in which the government is the payer and provider (e.g., the United Kingdom)

[47] Engrossed Substitute Senate Bill 6032, Section 606(15), Chapter 299, Laws of 2018. https://app.leg.wa.gov/billsummary?BillNumber=6032&Initiative=false&Year=2017

[48] Washington State Institute for Public Policy: Single-Payer and Universal Coverage Health Systems Final Report, May 2019. https://www.wsipp.wa.gov/ReportFile/1705/Wsipp_Single-Payer-and-Universal-Coverage-Health-Systems-Final-Report_Report.pdf

- Single payer systems in which the government is the payer, but providers are generally private (e.g., Canada)
- Multi-payer systems that combine the governmental oversight and benefit design with private health insurance (e.g., Germany or Japan)

WSIPP's analysis found that the United States spends more on health care on a per capita basis when compared with countries with universal health coverage models. Specifically, the United States spent $9,400 per person on health care in 2016, whereas the selected universal models spent on average $5,000 per person on health care in 2016. This difference in spending was attributed to several factors: higher administrative costs, higher prices, higher utilization of more expensive services,[49] and higher prevalence of newer technology or drugs with "modest or uncertain" effectiveness. However, wait times for certain procedures were lower in the U.S. health care systems and the availability of newer technology was generally higher. Overall, the outcomes of the U.S. systems as compared to the universal systems are mixed. For example, the utilization of preventative care (screenings, immunizations) is higher in the United States, but deaths due to diabetes and other manageable chronic diseases or "avoidable mortality" is also higher.

The WSIPP report concluded that countries providing universal health care systems generally were more successful in limiting health care spending and patients' financial barriers to care while achieving comparable health outcomes to the United States. However, the report noted that comparing these systems to the United States and judging the feasibility of implementing a universal health care system in the US was difficult due to the large differences in population, lifestyle, and general differences in the nature of the comparison countries to the United States, such as governmental policies and taxation systems.

Universal Health Care Work Group

Following the WSIPP study, in 2019, Washington policymakers secured funding to support the Universal Health Care (UHC) Work Group, which was charged with evaluating the potential impacts of moving to universal health care system in Washington.[50] The UHC Work Group produced a comprehensive report of their work and findings that was submitted to the Washington State Legislature in early 2021.[51]

Membership of the UHC Work Group reflected the geographic, socio-economic, ethnic, racial, and gender diversity of Washington's population. The UHC Work Group consisted of 37 stakeholders representing relevant state agencies, legislative leaders from the two largest political parties from both the State House and Senate, health care provider groups, health care associations and health care consumers. The UHC Work Group initially focused on determining and providing guidance on essential elements in a universal health care coverage model for Washington. These elements helped

[49] This is likely due to the general lower threshold of utilization management rules present in private insurance as compared to universal systems.
[50] Engrossed Substitute House Bill 1109, Section 211, Subsection 57;
Chapter 415, Laws of 2019. https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1109-S.SL.pdf?q=20220321001807
[51] Universal Health Care Work Group – Report to Legislature, January 2021. https://www.hca.wa.gov/assets/program/final-universal-health-care-work-group-legislative-report.pdf

design straw models that were then analyzed to understand the costs and savings associated with each.

Universal Health Care Work Group's suggested models

The three models proposed and evaluated by the UHC Work Group to achieve universal coverage included:

- **Model A:** State-governed and state-administered program for all state residents.
- **Model B:** State-governed and health plan-administered program for all state residents.
- **Model C:** Access to coverage for undocumented residents unable to buy coverage, which was termed "fill-in-the-gaps coverage." This model could be expanded to other uninsured or underinsured populations.

The following table provides an overview of some of the key characteristics featured in each model including the populations covered, minimum benefits offered, cost sharing requirements, and provider reimbursement levels. Notably, all three models would continue to have care delivered by private and public providers, clinics, and hospitals.[52]

Table 3: Overview of the characteristics of the UHC Work Group's three models [53]

	Model A	Model B	Model C
Populations	All state residents, including Medicaid, CHIP, Medicare, privately insured, undocumented, and uninsured		Undocumented immigrants
Covered benefits	• Essential health benefits, plus vision for all participants • Dental and long-term care for Medicaid		Essential health benefits
Cost sharing	• No cost sharing • Associated utilization changes		Standard cost sharing
Provider reimbursement	• Reduced pricing variation between populations • Administrative efficiency • Increased purchasing power		Cascade Care reimbursement levels

The above table compares the populations served, covered benefits, cost sharing, and provider reimbursement for Models A, B, and C.

Using the key characteristics identified by the UHC Work Group, an actuarial analysis was conducted to compare the impacts of each of the three models to the status quo including the number of individuals covered, the cost to implement the model, and the potential savings (if applicable) of each model. The key findings are highlighted in Table 2 and summarized further below.

[52] Ibid.
[53] Ibid.

Table 4: UHC Work Group overview of each model's impacts, including potential savings

	Model A	Model B	Model C
Population impacts	• Improved access for the Medicaid population • Improved access for uninsured, undocumented		**Assumes commercial utilization**
Administration	• State administers • Premiums are exempt from state premium tax • Lower system-wide administrative costs	• Health plans administer • Premium tax applies • Lower system-wide administrative costs	**Assumes commercial plan administrative costs**
Expenditures and potential savings for covered populations			
Status quo expenditure	$61.4 billion	$61.4 billion	**Not available**
Model cost estimate	$58.9 billion	$60.6 billion	**$617 million**
Implementation year savings	**$2.4 billion**	**$738 million**	**N/A**

UHC Work Group members were asked to respond to a survey regarding their preference ranking of Models A, B, and C.[54] Twenty-nine of the 37 members participated. Seven of the 29 respondents indicated they abstained from stating a preference. Of the 22 members who stated a preference, the majority ranked Model A as their most preferred model of the three options.

There was a diversity of perspectives about the impacts of each model among the members of the UHC Work Group in achieving the stated goals. Many members recognized that Models A or B were most likely to achieve the coverage, access, and equity goals of a universal health care system while generating health care savings in the long-term when compared with Model C. Model C requires additional state dollars, but does not generate savings to the state, and was not as likely to achieve the goals of a universal system. At the same time, many Work Group members acknowledged that Model C could potentially provide a pathway to moving to a more universal system envisioned in Model A or B.

Recognizing that moving to a universal system would be a multi-year effort, the UHC Work Group included an outline of a transition plan in the report to the Legislature. This multi-year outline incorporated a plan for a short-term focus on coverage that would fill in the gaps. The state is in the process of implementing Model C as evidenced by the additional policies that have been undertaken

[54] Under Model B, there are potentially several paths to universal coverage, including utilizing Model B as a transition to Model A. However, due to modeling restrictions, Model B was proposed with a fixed method of providing universal coverage.

since 2020.[55]

Summarizing the models

Model A (state-governed and state-administered program for all state residents) was projected to cost $58.9 billion and to save $2.5 billion in health care spending in the first year of implementation.[56] Savings were estimated to come from the reduced administrative costs of a single payer, increased state purchasing power over reimbursement rates, and reductions in extraneous spending such as fraud, waste, and abuse expected from the streamlining of the health system. The model would provide coverage to all Washingtonians.

Model B (state-governed and health plan-administered program for all state residents) was projected to cost $60.6 billion and save $783 million in the first year of implementation.[57] Similar in structure to Model A, the state would remain the single payer and overseer of the system, but coverage is administered by insurance companies that contract with the state. Coverage follows Model A, with some modifications to utilization rules due to lack of cost sharing. The lower savings for Model B when compared with Model A are attributed to the increased costs of outsourcing the burden of plan administration to third-party insurers. The model assumes coverage for all Washingtonians.

Model C (access to coverage for undocumented residents unable to buy coverage now, also known as "fill-in-the-gaps" coverage) was projected to increase state costs by about $617 million based on actuarial modeling. Model C is structurally different from Models A and B, focused on adding and enhancing the current system to improve coverage for undocumented individuals who are currently uninsured through increased subsidies or the creation of additional health plan options with a potential to expand to include additional uninsured populations. The model assumes coverage for an additional 124,000 residents.

Implementing Model C

The goal of Model C is to supplement the current system instead of implementing a new structure, like Models A and B. Model C will work to improve coverage for undocumented individuals who are currently uninsured through increased subsidies or the creation of additional health plan options with a potential to expand to include additional uninsured populations. The Cascade Care Program, which includes Cascade Care, Cascade Select (Public Option), and Cascade Care Savings, will provide coverage to individuals who are currently uninsured through increased state subsidies.

Cascade Care

In 2021, Washington offered standard benefit plans through Cascade Care. These plans have the same benefits, which allows consumers to better compare insurance carriers. Cascade Care plans emphasize lower deductibles and provide access to services before having to pay the deductible. Cascade Care is a multi-agency effort involving HBE, HCA, and OIC.

---

[55] Engrossed Substitute Senate Bill 5693. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Passed%20Legislature/5693-S.PL.pdf?q=20220405170049

[56] These estimates are based on actuarial modeling using current utilization and reimbursement trends and assumptions around the development of such a program, such as the elimination of cost sharing and introduction of a single payer.

[57] These estimates are based on actuarial modeling.

Cascade Select

The public option, Cascade Select, was not yet fully implemented at the time of the UHC Work Group discussions and was made available to Washingtonians beginning in 2021. Cascade Select offers health insurance coverage options on the individual market through Washington's Healthplanfinder (operated by HBE). The goals of Cascade Select are to increase the availability of quality, affordable health care coverage in the individual market, and to ensure residents in every Washington county have a choice of qualified health plans (QHPs). As of 2021, only 2.5 percent of all new enrollees selected this plan and it is not yet offered in all counties of the state. [58] However, this program can be used to gauge the effectiveness and feasibility of a larger-scale public program.

Cascade Care Savings Plan

Recognizing that affordability continues to impact uptake of Exchange plans, appropriations were allocated to HBE during the 2021 legislative session to implement a state-funded subsidy plan that will supplement federal health care subsidies for certain income levels in Washington.[59] This program is very similar to the expanded Model C envisioned by the UHC Work Group and can be studied to understand the effects of increasing the amount or eligibility of such subsidies. The subsidies will be available to individuals up to 250 percent FPL who enroll in Cascade Care Gold or Silver plans.

Creating more coverage opportunities for those not currently eligible

During the 2021 session, the Legislature also authorized HBE to seek a federal 1332 waiver to allow more Washingtonians to shop and buy coverage on the Exchange.[60] Additional funding was allocated during the 2022 legislative session to develop new coverage options for undocumented individuals who are currently prohibited from being able to shop, buy, or enroll in many coverage options.

Summary

While the UHC Work Group identified a number of barriers to designing a universal a health care system and developed models to implement a universal health care system, it falls to this Commission to make specific decisions and recommendations about how to address these challenges in the coming years. Section 1's objectives were to:

1) Provide an overview to the Legislature of the current health care system trends that the Commission is considering in its efforts to design a universal health care system with a uniform financing structure required by the authorizing statute.

---

[58] Health Affairs. https://www.healthaffairs.org/do/10.1377/forefront.20210819.347789#:~:text=Enrollment%3A%20In%20the%20first%20year,chose%20a%20Cascade%20Select%20plan.

[59] Senate Bill 5377. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5377-S2.SL.pdf?q=20220224145451

[60] Ibid.

2) Provide an overview of many of the past efforts that have been made to improve Washington's health care system so that the Commission and the Legislature have a common understanding of the starting place for their efforts; and
3) Recognize and highlight Washington's rich history of innovation in addressing pervasive problems in the health care system. This history can be drawn upon to best leverage the existing tools and interventions in future design decisions.

The next sections of the report will:

- Describe the design components of a universal health care system
- Provide an assessment of Washington's readiness to implement those components
- Recommend a strategy to implement the components of a universal health care system
- Recommend options for increasing reimbursement rates for Medicaid
- Recommend policy solutions to address existing coverage gaps
- Recommend options for the development of a finance committee to develop a feasible model to implement universal health coverage

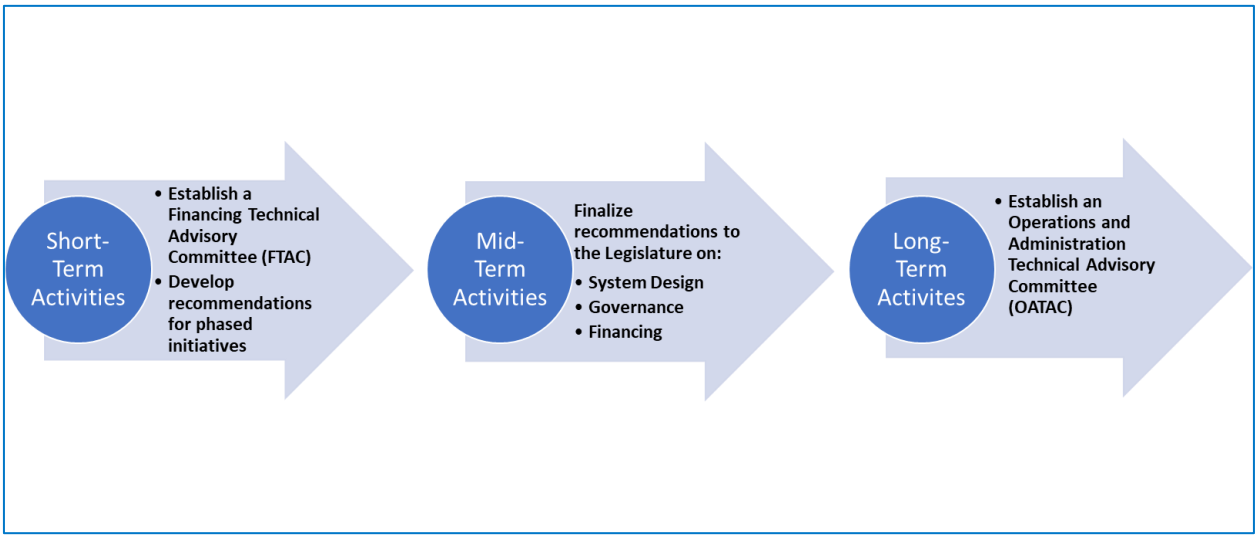
Section 2: Strategies to Move Toward a Universal Health Care System

Introduction

Section 1 of this report describes Washington's long history of innovation and continued efforts to expand access and improve the quality and equity of affordable health care coverage.

This section offers a set of strategies, analyses, and planning activities to move toward a universal health care system, which are summarized in Figure 4.

Figure 4: Proposed sequencing for Commission strategy



This figure shows the short-term, mid-term and long-term activities that move Washington towards a universal health care system.

Later sections of this report outline the key design elements of a universal health care system, options for developing and implementing approaches to these foundational elements, and Washington's readiness to implement those approaches.

Short-term activities

Establish a Finance Technical Advisory Committee (FTAC)

Establishing a Finance Technical Advisory Committee (FTAC) will provide additional insights and technical guidance to the Commission, as directed by the authorizing legislation.[61] This approach is similar to Oregon's Task Force on Universal Health Care and other Washington boards and commissions that utilize advisory committees.

In general, the first set of activities FTAC is tasked with will be to understand and provide guidance to the Commission concerning the functions required to achieve the cost, equity and quality goals envisioned and required by a universal financing system. A more thorough description of the process to establish FTAC is described in Section 7 of this report.

Develop recommendations for phased initiatives

As described in Section 1, Washington has submitted a Section 1332 waiver to CMS to make it possible for more residents to purchase coverage on the Exchange which will remove federal barriers for certain groups.[62]

Once these new initiatives are in place, the principal barrier to universal coverage for Washingtonians will be cost. Therefore, many of the intermediate steps toward a universal health care system will focus on

[61] Engrossed Second Substitute Senate Bill 5399 Chapter 309, Laws of 2021. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5399-S2.SL.pdf?q=20220530104327

[62] Washington has also provided state funding for this group to utilize subsidies in the place of federal subsidies that cannot be utilized for this purpose.

decreasing underlying costs of health care while improving health care quality and reducing inequities in the access and delivery of care.

The Commission will continue its work to enhance, expand, or modify the existing coverage programs informed by the ongoing work of the state agencies responsible for existing coverage programs, the broader private payer and provider community, and FTAC. Future work will lay a foundation for the universal health care system as well as advance cost, quality, and equity goals.

Mid-term activities

Mid-term activities addressed by the Commission are likely to focus on developing functions to advance cost, quality, and equity goals through changes to the existing health care system. The Commission also may focus on critical strategies for establishing a framework for a unified financing system including the following:

- Governance
- Financing strategies
- State and federal authorities and revenue

Governance

The Commission will examine a governance structure that places oversight of the universal health care system under an existing agency, a new agency, or a multi-agency structure. The Commission may provide a framework for establishing authority for this governing structure and ensuring that resources are allocated to implement and maintain the universal health care system.

Financing strategies

In the mid-term, the Commission will further assess and finalize decisions about appropriate financing strategies that leverage federal and state funding sources. An examination of potential revenue sources would be needed particularly if it is determined that state funding will largely replace premiums and out-of-pocket costs that currently finance the health care system. This examination would include an assessment of the impact of shifting away from the currently existing coverage programs for Washington citizens and employers, including an assessment of the overall state-level cost shifts.

- Mid-term work of the Commission will also focus on developing strategies for establishing a federal Medicaid state plan and related waiver authority requests.

State and federal authorities and revenue

After the core functions of a unified health care financing system have been developed, including how those functions should be administered, statutory changes may be necessary to establish a new state entity or expand the authority of an existing entity to administer the universal system. Additionally, federal approval may be needed to access any dollars associated with federal programs such as Medicaid, ACA subsidies, and Medicare.

Long-term activities

Operations and Administration Technical Advisory Committee

Once planning and authorizing the universal health care system is complete, the Commission may refine

the operational and administrative vision for the model that will shape implementation. When FTAC completes its design and planning work, it will sunset and may need to be replaced by a new Operations and Administration Technical Advisory Committee (OATAC). OATAC could focus on operations and administration. It would be responsible for providing technical guidance and support as the new system is operationalized and implemented.

A description of potential activities for OATAC could include:

- Help guide and implement the new system in collaboration with the designated accountable agency or agencies.
- Develop a process for establishing annual performance targets (including those for cost, quality, and equity), a measurement and evaluation strategy to monitor progress towards those targets, and a reporting process to continuously assess the impact of the new system.
- Provide guidance on improving care management for chronic illnesses. Implementing universal access and better management of chronic disease would be expected to reduce annual per member costs over time based on the findings in RAND's analysis of the Oregon universal coverage options.[63]
- Provide guidance on how to leverage the purchasing power of a unified health care financing system such as achieving prescription drug discounts or instituting a hard cap on system spending with clear measures to reduce costs.
- Assist the Commission with various activities.

Assisting the Commission

- OATAC may assist the Commission with developing a communication approach for awareness, establishing a stakeholder input process for refining the design concepts of the new system, and initiating an educational and engagement process in preparation of implementation. It will be important to communicate decisions and timelines to providers, insurers, and consumers.
- OATAC may also assist the Commission with planning the transition from current programs and populations, including mediating impacts of potential job losses. For example, OATAC could assess the following:
    - **Roles and jobs**—Regardless of the model, restructuring the health care system will impact staff in policy, management, actuarial, analytics, eligibility, claims payment, and technology functions.
    - **Provider contracting**—Regardless of the model, there will be transitions to new contracting arrangements between the accountable entity and those providing services. In Model A, this would require the accountable entity to directly contract with providers and health systems. In one version of Model B, plans may need to alter their current contracts with providers and health systems to meet the new unified health system requirements and expectations.
    - **Transitions of care**—State agency and health carrier staff from current programs will need to ensure smooth transitions of care into the new system. This may necessitate

[63] White, C et al. "A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon Research Report". RAND/HMA. https://www.rand.org/pubs/research_reports/RR1662.html

maintenance of current programs as they are closed out to ensure that Washingtonians can complete treatment courses that are in progress.

Summary

As outlined here in Section 2, there are short-term, mid-term, and long-term activities for transitioning Washington to a universal health care system. The proposed approach calls for additional subject matter expertise to support the Commission by establishing two consecutive technical advisory committees. These advisory committees would provide guidance and support to the Commission as it considers key design and implementation decisions.

Section 3: Core components of a universal system

Introduction

The Commission is charged with preparing Washington 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 becomes available.

> This section of the report addresses the Legislature's requirement for the Commission to inventory the key design elements of a universal health care system.

The key design elements are organized into seven core design components to form a framework for the implementation and operation of a universal health care system:

1. **Eligibility and Enrollment**—identify how to cover currently uninsured populations; determine which, if any, existing coverage options will remain; and determine which segments of the existing insured population will be included in the Commission's universal coverage considerations
2. **Benefits and Services**—create an approach to develop standards that ensure equal access to a minimum set of benefits and services
3. **Financing**—define an approach to align or aggregate public funding sources, private sector funding sources; and individual cost-sharing, if any
4. **Provider Reimbursement and Participation**—select a method for paying providers, encouraging their participation, and aligning provider behavior to quality and equity goals

5. **Cost Containment Mechanisms**—establish global budgeting and utilization management functions to control total cost of care
6. **Infrastructure**—invest in administrative and operational capabilities necessary to implement a cohesive model
7. **Governance**—ensure transparency and accountability for planning and implementing the model that includes the voice of consumers in decision-making

These core components align with the framework proposed by the Congressional Budget Office in their 2019 report on single-payer systems.[64]

It is important to note that the other key design elements, including health care quality, equity, and health disparities, identified by the Legislature for the Commission to address in its report are considered strategic goals of the universal health care system. These goals can be achieved through any design, but some design choices have a greater impact than others. As such, quality, equity, and health disparities are discussed within each of the core design components and will be considered at every stage by the Commission in making its final recommendations. The Legislature also set specific goals to implement impactful changes in the current health care system and incorporate into the design of a universal health care system including:

- Supporting quality improvement strategies
- Allowing for quality monitoring and disparities reduction
- Promoting initiatives for improving culturally appropriate health services within public and private health-related agencies
- Supporting strategies to reduce health disparities including, but not limited to, mitigating structural racism and other determinants of equity as set forth by the Office of Equity

In Section 3, we describe and identify key considerations for developing the seven core health system components based on the different approaches to achieving universal health care coverage outlined by UHC Work Group's Models A, B, and C. We then describe Washington's current level of preparedness to meet these core components.

UHC Workgroup models: A starting place

In January 2021, the UHC Work Group released its final report identifying three potential models for Washington to pursue universal health care coverage, as described in Section 1. Throughout this Section 3, and in each discussion of a core design component, the three potential models are used as a starting point to frame the considerations for each design component. As shared in Section 1, the three models proposed and evaluated by the UHC Work Group to achieve universal coverage included:

Table 5: Overview of Universal Health Care Work Group Models[65]

Model A	Model B	Model C

[64] Congressional Budget Office. (2019). Key Design Components and Considerations for Establishing a Single-Payer Health Care System. https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf

[65] Each of these models, their costs estimates and impacts, and savings (if applicable) are described in Section 1 of this report.

• Establishes a single, state-designed coverage plan available to everyone in Washington State. • The state develops the delivery system rules. • There is a standard benefits package. • No insurance companies participate as the state contracts directly with providers and administers all functions currently provided by insurers, including claims payment, utilization management, care coordination, and member and provider services.[66]	• Establishes a single, state-designed coverage plan available to everyone in Washington State. • The state develops the delivery system rules. • There is a standards benefits package. • Unlike Model A, in Model B insurance companies contract with the state to offer plans to Washington residents. As they do today, insurers may develop and maintain provider networks and administer some or all the functions they currently provide, such as claims payment, utilization management, care coordination, and member and provider services.	• Designed to provide coverage to Washingtonians who are now uninsured. • Keeps the varied plans and coverage sources that exist presently. As in Models A and B, the state sets the program and delivery system rules, but carriers meeting participation requirements will provide coverage to eligible individuals. • The model is similar to Cascade Select, with insurers developing and maintaining their own networks and administering the functions they currently provide, such as claims payment, utilization management, care coordination, and member and provider services.

It is important to recognize that under Model B, there are a range of options for which functions could continue to be performed by health plans and which could be performed by the state. For example, Washington could contract with health carriers to provide coverage to residents. Alternatively, Washington could directly contract with providers rather than delegating that responsibility to health carriers, while leaving carriers responsible for more administrative processes such as utilization management and claims payment. In addition, the state could choose to manage more of these responsibilities over time. In this way, Model B could provide a transition to Model A.

Core component 1: Eligibility and enrollment

Under any model to achieve universal coverage, it will be necessary to determine who will be eligible for the program and develop a process for enrollment.

Key considerations:

[66] In some universal health care systems, such as Canada, supplemental insurance could cover services not included in the standard benefit package.

Eligibility for certain populations, such as the following:
- Washington residents
- Out of state residents working for Washington employers,
- Opt-in options for individuals covered by Employer-Sponsored Insurance,
- Self-funded plans,
- Federal Employees Health Benefits, and
- Veterans' Health Administration.

Data and information needed to determine eligibility; and
Eligibility and enrollment processes.

Expanding eligibility

A primary goal of adopting a universal health care system is to extend coverage to those who are currently uninsured. This would include individuals who cannot afford commercial coverage or individuals ineligible for Medicaid or federal subsidies.

Under either universal health care model (Models A and B), all Washington residents could potentially be determined eligible for the program. It would be necessary to determine several eligibility considerations, including:

- 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?
- Would federal employees be covered by federal programs such as Federal Employees Health Benefits and the Veterans Health Administration (VHA) be eligible to opt into the system?
- Would individuals with fully insured, employer-sponsored coverage be eligible to opt in?
- Would individuals with self-funded employer-sponsored coverage be eligible to opt in?
- Would Medicare beneficiaries be included in the program?
- Would the definition of meeting residency requirements for health insurance coverage differ from the current standard of residency determination for the state?[67]

Under Model C, eligibility could be expanded through new programs to populations who are currently uninsured due to a variety of factors, such as income levels, immigration status, lack of eligibility for subsidies, lack of ability to afford employer-sponsored insurance, and other factors that pose barriers to coverage under the current system. In this model, minimal changes would occur to the current system of coverage.

Information for determining eligibility

To maximize coverage and make eligibility determinations as simple and seamless as possible, it will be important to consider options to minimize the amount of information needed to determine eligibility. Under Model A or B, the best approach may be a streamlined process that collects the minimum information necessary to verify eligibility for health coverage while simultaneously collecting the data

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

needed to maintain compliance with federal regulations for Medicaid, Medicare, Exchange subsidies and other federal programs to ensure ongoing contribution of federal funds.

Similarly, setting up processes to validate continued eligibility will reduce costs for maintaining coverage when individuals are no longer eligible for federal programs. Under Model C, the process for determining and redetermining eligibility for the expanded populations would likely be comparable to processes that exist today for determining eligibility for public health care programs and Exchange subsidies.

Eligibility and enrollment process

Under each of the models (A, B, or C), once a person is determined eligible, they would be enrolled into coverage. Under state-administered universal health care (Model A), enrollment could be relatively simple, and auto-enrollment could be used to streamline and maximize enrollments. For example, anyone who currently has coverage under private insurance, or a government program could be auto-enrolled into the program. Individuals without coverage could be auto-enrolled when they seek health care services, file tax returns, or apply for other government programs such as the Supplemental Nutrition Assistance Program (SNAP). In other countries that have adopted single-payer models such as the United Kingdom, individuals are automatically determined eligible at birth, when residency is established, or when a resident registers with a primary care provider.[68]

Under Model B, (the version that involves insurance companies contracting with the state to offer plans to Washington residents), individuals transitioning from private insurance to the state program could be auto-enrolled into a comparable plan, with the option to change coverage. This would be similar to current Exchange re-enrollment processes when an individuals' plan is cancelled, and the Exchange auto-enrolls consumers into the most similar version of a plan available.

Under Model C, individuals could choose a plan by a process similar to what currently exists today through Washington Healthplanfinder. Once an individual is determined eligible for either Apple Health (Medicaid) or subsidies, they are prompted to select a plan from the available options.

Core component 2: Covered benefits and services

Each of the coverage models (A, B, and C) will involve examining what benefits and services will be covered by the model. The UHC Work Group report assumed that the benefits provided under Models A and B will be equivalent to Washington State's Essential Health Benefits (EHB) mandated by the ACA, which includes behavioral health services.

[68] National Health Service. (2022). What is an NHS Number? **https://www.nhs.uk/using-the-nhs/about-the-nhs/what-is-an-nhs-number/.**

Key considerations – Covered benefits & services

- Covered benefits and services
  - Essential Health Benefits
  - Adult Dental to be determined
  - Vision to be determined
  - Benefits mandated by Medicaid
- Cost-sharing for services including premiums, co-pays, and coinsurance
- Development of a single drug formulary or standard drug formularies and how they would impact current programs and the Washington Prescription Drug Program
- Benefit package oversight
- Utilization management and prior authorization requirements

Covered benefits and services

In general, UHC Work Group members discussed the need for a benefit package that improves health and is attractive enough to keep participants enrolled without a mandate to participate in the universal health system. Additional benefits mentioned include dental and hearing, for both adults and children. Model C is the least burdensome approach; the benefits provided would vary depending on the program and plan a person is enrolled in but would be similar to plans offered on the exchange and/or Cascade Care today.

Coverage that meets quality and equity goals

For all three models, it is important to consider whether additional benefits may be required to advance quality and equity goals such as social support services and culturally responsive care and services. For example, Apple Health (Medicaid) provides some benefits that are not included in EHB 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.[69] These additional services could be provided to all Washingtonians (paid for by the state for those who are not Medicaid-eligible) or there could be a mechanism to make sure that everyone who would otherwise be eligible for Medicaid will receive these additional services.

Transparent decision-making and administration

Washington has a long history of transparent, evidence-based decision processes to inform what benefits/services are covered in state-purchased health care programs. For example, health technology assessments are conducted by the independent HTCC and serve Washingtonians by ensuring that certain medical devices, procedures, and tests paid for with state dollars are safe and proven to work.

Administration of the benefit package will also be a critical area of consideration. Establishing who will govern how the benefit package would be regularly updated and adjusted based on new evidence to ensure the required benefits adapt over time to improve the quality and lower the cost of care within the

[69] Another state program that may need to be considered is the Washington CARES Program. Washington CARES is the state's new long-term care benefit, created and signed into law by the Governor in 2019. The program is funded by a payroll tax of up to $0.58 per $100 and has a lifetime benefit of up to $36,500. Premium collections (via the payroll tax) have been delayed until July 2023.

universal health care system. This is particularly important for Models A and B, because once established these benefit packages would need to regularly be examined and updated.

Pharmacy benefits

Under Models A and B, there could be a single drug formulary that would apply to all individuals in the program. The drug formulary developed under this program will need to align with any federal Medicaid and Medicare requirements.

The Washington Prescription Drug Program provides prescription information and assistance for the residents of Washington. As a part of this program, Washington State has partnered with Oregon since 2006 to create the Northwest Prescription Drug Consortium. The Consortium allows state agencies, local governments, businesses, labor organizations, and uninsured individuals to pool their purchasing power to gain bigger discounts on prescription drugs. The work of the Consortium, Prescription Drug Cost Transparency Board, and the PDAB will all need to be included in the consideration of single drug formulary.

Utilization management and prior authorization

Currently, individuals who are enrolled in Apple Health managed care or in commercial coverage are subject to the utilization management and prior authorization policies and procedures of their carrier. Under C, this is not likely to change. Under Model B, the state could focus on efforts to align these processes and requirements across payers and programs. Model A will require examining utilization management and prior authorization processes and determining how the state-administered plan would conduct these activities.

Core component 3: Financing

Under Washington's current health care system, there are multiple sources of funding that pay for health care. The funding sources that pay for an individual's health care will govern the specific benefits individuals receive, the providers they can see, and how much they pay out of pocket. A primary goal of the Commission is to develop a plan for a unified financing system that will simplify and/or minimize these differences and lead to greater access, higher quality, and increased equity for all Washington residents.

To achieve this goal, the different sources of funding must be combined to the greatest extent possible. This begins with assessing which sources will be continued or potentially eliminated due to the structure of the unified health care financing system and identifying potential new sources of funding to ensure coverage can be extended to all Washington residents. Section 7 of this report outlines the complex issues and decisions related to different financing sources to consider in designing a universal health care system. This financing subsection details specific considerations and processes for the Commission to establish a finance committee specifically tasked with addressing these financing questions and considerations.

Key Considerations: role of federal funding sources such as Medicaid, ACA subsidies, and Medicare; role of state funds such as general funds and taxes; and role and appropriateness of consumer cost-sharing.

Federal funding sources

The federal government is responsible for the greatest share of health care spending, at 36.3 percent in 2020.[70] This estimate includes all federal sources including Medicaid, Medicare, coverage for federal employees, and active and retired military. As described in the UHC Work Group Report, the three models assume that all sources of federal funding, such as the federal funding of the Medicaid program and Medicare funding would be preserved to pay for health care costs and administration.

Model C presents the least challenges with respect to retaining federal funding, since the existing federal programs including Medicare, Medicaid, ACA subsidies, tax deduction for employers' contribution to health care, either insured or self-funded remain the same. However, making changes to the current financing system are considerably more complex for Models A and B. Notably, each of the models will require additional state funds to implement. Possible sources to fund these models are described in the following subsections including Medicare funding, Medicaid funding, ACA subsidies, employers, taxes, other sources of insurance, and other revenue sources.

Medicare funding

There are several legal challenges that need to be analyzed and considered to include Medicare funding under either Model A or Model B. The decision to pursue or not pursue inclusion of Medicare into the unified health care financing system development is complex and requires a thorough examination of the regulatory and legal issues and understanding of the Medicare program. The Medicare program consists of several primary components:[71]

- **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 and beneficiary premiums, deductibles, and copays. Part B covers physician visits, outpatient services, preventive services, and some home health visits.
- **Medicare Part C** (Medicare Advantage) is Medicare's managed care program delivered through contracted health plans.[72] Medicare Advantage plans are financed by monthly payments from the federal government based on bids submitted by the plans and monthly premiums.

---

[70] Centers for Medicare and Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet Note: This figure does not account for the federal income tax deductions for employer and individual's health care spending.

[71] For more information on Medicare programs, see Kaiser Family Foundation. (2019). An overview of Medicare. https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/?msclkid=c46e7ab3b3bd11ecb53ed918624357e3

[72] For more information on Medicare Advantage, see Kaiser Family Foundation. (2019). Medicare Advantage. https://www.kff.org/medicare/fact-sheet/medicare-advantage/

- **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.

A key to maintaining a large portion of federal funding is determining if and how Medicare dollars can be used. An important threshold topic for consideration under either Model A or Model B is whether Medicare funding can be used to pay for health care costs for people not eligible for the Medicare program. While this may be considered in more detail in the future, it may be likely that Congress will need to pass legislation for these changes to be possible.

Medicare Part A

The Medicare Part A Trust Fund is projected to be fully depleted in 2026, which raises the question of whether it would be practically and politically viable to provide for the use of this fund to pay for non-Medicare beneficiaries. One other significant consideration under Model A or Model B is whether beneficiaries would continue to have the option to choose "traditional" Medicare, which is administered by the federal government, or to enroll in a Medicare Advantage plan under Medicare Part C. Some states, such as Oregon, have discussed that a single-payer entity could function like a single Medicare Advantage plan that would be offered only to Medicare eligible individuals.[73] This would likely keep the Medicare funding sequestered out of other pooled funding which may make it easier to use Medicare funding, because the funding would not be used to fund non-Medicare eligible people.

Medicare Part D

Medicare Part D, the prescription drug benefit administered by private plans, is another potential source of funding for consideration. This program is financed primarily by general revenues, beneficiary premiums and copays, and state payments for beneficiaries dually eligible for Medicare and Medicaid. To utilize funds from this program, Medicare's integrated funding would need to be examined in detail, especially if the new unified financing system offers a single drug formulary.

The UHC Work Group report assumes that under Model A or Model B there would be a single provider fee schedule for all care and that the rates would be higher than currently paid by Medicaid and Medicare, but that the rates would be lower than what is currently paid by commercial insurers. There are significant legal and regulatory issues around whether the federal government would be willing and able to contribute to the additional costs that would be incurred for care provided to those currently in the Medicaid and Medicare programs, including the higher reimbursement rate. There are also similar questions as to whether the federal government would be willing to share the savings if rates were lower and potential federal savings incurred.[74]

The UHC Work Group report acknowledged the challenges in including Medicare funding and suggested that it might be possible to keep Medicare enrollees in their current coverage under Models A and B. The

[73] Rand Corporation. A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon. https://www.rand.org/pubs/research_reports/RR1662.html

[74] These questions are best answered by seeking legal guidance and through conversations with the federal government about what is possible via waivers and what might require federal legislation.

goals of universal coverage could still be met if the Commission followed this approach for two reasons. First, most providers currently accept Medicare patients and are accustomed to billing under the program. Second, the costs of administering the program are borne entirely by the federal government, so the state may not realize any savings by including it. Finally, as discussed in the UHC Work Group Report, it may be a more financially viable approach to implement because health care needs generally increase with age, resulting in higher per capita costs. Keeping Medicare enrollees in their current coverage rather than including them in the universal health care program would mean that the universal health care program would cost less on a per capita basis.

Utilizing an approach with Medicare distinct from the unified financing system would greatly simplify the legal and administrative obstacles to achieve universal coverage under Models A or B. In addition, as the UHC Work Group report notes, if Medicare reimbursement rates are left as they are, the rates payable by the rest of the program could be higher as a percentage of Medicare rates because of the unrealized per capita savings of not including this population. See Table 6 below (from the UHC Work Group analysis) for more information about the financial impacts as seen through provider reimbursement rates of including or excluding Medicare in rate development.

Table 6: Reimbursement level target before efficiency adjustments[75]

Service category	Reimbursement as a % of Medicare when Medicare is included in Model A	Reimbursement as a % of Medicare when Medicare is excluded in Model A
Hospital services	125%	150%
Physician and clinical services	111%	114%

This table shows the financial impacts as seen through provider reimbursement rates of including or excluding Medicare in Model A.

Medicaid funding

Washington's Medicaid program, Apple Health, which currently serves nearly 2,000,000 Washington residents, is funded by the state general fund and federal matching funds. Eligibility for Apple Health is primarily based on income and most beneficiaries have managed care, where the state pays managed care organizations a monthly premium which pays for all health services provided by the program. Both federal and state law mandate what services must be provided under the program.[76]

Including Medicaid funding as a revenue source for a unified financing system is complex, but less complicated than Medicare because there is an established process and experience with states seeking and obtaining Medicaid flexibilities., This is not the case with the Medicare program. To use existing federal Medicaid funds as a revenue source for the unified financing system, it would be necessary to obtain a waiver from the Centers for Medicare and Medicaid Services (CMS) under Section 1115 of the Social Security Act. Section 1115 gives the Secretary of the Department of Health and Human Services

[75] Universal Health Care Work Group Report, January 2021.
[76] For more information on Medicaid funding, see Snyder, L., Rudowitz. R., (2015). *Medicaid Financing: How Does It Work and What Are the Implications?* Kaiser Family Foundation issue brief. https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/

(HHS) authority to approve experimental, pilot, or demonstration projects by states that are found to be likely to assist in promoting the objectives of the Medicaid program. This authority has been used frequently by states, including Washington. Washington's current 1115 waiver, the Medicaid Transformation Project, is in effect until December 31, 2022, unless CMS authorizes further renewals or extensions.

The two primary ways that a unified health care financing system would promote the objectives of the Medicaid program, which could be included in support of a potential waiver application, are:

1) this change is likely to increase the number of individuals with continuous access to health care, and
2) this is likely to increase the number of providers willing to serve Medicaid enrollees.

If the process for enrollment and determining eligibility is simplified, then more Medicaid-eligible individuals should be covered. In addition, some individuals inevitably fail to obtain new coverage as individuals gain and lose eligibility for Apple Health due to changes in income or employment status. A unified health care financing system could eliminate or greatly reduce this on/off program cycle, which would result in more people having continuous health care coverage

Secondly, the UHC Work Group Report assumed that under Model A or Model B there would be a single fee schedule for provider reimbursement with rates higher than what Medicaid currently pays. This should result in more providers being willing to serve people who would otherwise be eligible for Medicaid, which in turn is likely to reduce the disparities and inequities in access to care.

ACA subsidies

Under the ACA, the federal government provides subsidies in the form of tax credits to help individuals and families pay premiums for health care coverage provided by health plans. Eligibility is determined by income. As with federal Medicaid funding, Washington would need an ACA Section 1332 waiver from CMS to enable the unified health care financing system to include people who otherwise would receive subsidies under the ACA in the new program. This would also shift ACA tax credit funding that is currently provided to individuals and families to the unified health care financing system.

The ACA contains certain "guardrails" that must be satisfied for a Section 1332 waiver to be granted. The changes requested by a state must result in health care coverage that is as comprehensive, affordable, and covers as many individuals as under the current system. In addition, the changes must not increase the federal contributions. It is possible to demonstrate that these guardrails would be met under either Model A or Model B. Additionally, coverage would include all of the EHB mandated by the ACA, and therefore would be as comprehensive. Coverage could be more affordable, although the state would have to demonstrate that any additional taxes on individuals and families would be lower than what they currently pay for health care. As discussed above, more people would be covered by the new program, primarily because people would not lose coverage as they move from one source of coverage to another. In addition, Section 1332 of the ACA authorizes waiver of certain provisions and provides that requests for waivers under Sections 1115 and 1332 may be combined in a single application. Both 1115 and 1332 waivers must be "budget neutral" to the federal government, which means that during the course of the waiver period, federal expenditures must not be more than it would have been without the waiver.

Other revenue sources

To address any gaps in funding because of the transition to a unified financing system, additional funding could be raised through a combination of taxes on businesses and individuals. However, it is important to acknowledge that any discussion about additional taxes and how that tax is collected should take into account the equity impact of the proposed tax on different populations. Under Model C, most sources of funding would remain the same.

Other revenue sources: business taxes

There are two types of business taxes that are generally considered as potential sources of revenue for funding a universal health care system. The first, is a tax on business activity, such as Washington's Business and Occupations tax, which is a gross receipts tax measured on the value of products, gross proceeds of sale, or gross income of the business. The second is a tax on payroll (either based on the number of employees or the amount of wages paid), such as the federal taxes that currently fund the Medicare program and the state taxes that currently fund state unemployment, the workers' compensation system, and the tax that will fund Washington's new long-term care program, Washington CARES.[77]

It is important to note that under current law, employer contributions to employees' health care premiums are deductible from federal income tax. This represents a significant subsidy from the federal government toward the cost of health care. To maintain the benefit of the current tax deduction for employer health care expenditures, the best approach would be to ensure that either type of tax imposed could be deducted from federal taxes.

Other revenue sources: Individual taxes

There are two types of taxes that could be considered as sources of revenue for this type of program. The first is a payroll tax. The second is a sales tax (including taxes on certain types of products that are deemed harmful to individuals or society, such as cigarettes and alcohol).[78]

Sales taxes could be a source of revenue for the program. However, sales tax is complex and if not applied to prevent regressive taxation, it could have a burdensome impact on low-income populations. Sales taxes could be regressive if the taxes take a larger percentage of income from low-income taxpayers than from high-income taxpayers. One way to avoid the disparate impact of these taxes is to exempt necessities such as food from the sales tax, as Washington currently does.

A payroll tax, which currently funds the Medicare program, may be more feasible to implement because it involves less administration. A payroll tax could be imposed only on wages over a certain level which would reduce the possibility of a disparate impact. This would also ensure that those who currently receive subsidies or Medicare do not experience an increase in their cost of health care services.

[77] The implementation of this tax has been delayed until July 2023. https://wacaresfund.wa.gov/about-the-wa-cares-fund/.
[78] Because Washington state does not have an income tax on individuals, this method of taxation has not been considered. However, an income tax is typically simpler to administer.

Employee Retirement Security Act

The federal Employee Retirement Security Act (ERISA) sets minimum standards for health plans established and funded by employers to provide health care to their employees. These "self-funded" or "self-insured" plans place the obligation of paying for health care costs directly on the employer and the employer bears the financial risks associated with that obligation rather than an insurance company. The ERISA statute exempts these plans from most state regulations.[79]

If the federal government makes changes to ERISA that would enable states to wrap employer coverage into a state-based unified health care financing system, it will be necessary to consider whether employers would be able to continue to provide coverage to their employees through self-insurance. It is possible that if a tax is imposed on employers to pay for the program, employers would be discouraged from remaining self-insured. An alternative approach would be to allow employers to remain self-insured, while giving employees the option of enrolling in the state coverage rather than in the employer-sponsored coverage.

Other sources of insurance

It may be beneficial to examine whether health services that are currently paid for by other sources of insurance, such as liability insurance and by the workers' compensation system, would continue to be covered by those programs. In the alternative, the amounts paid into those systems could instead be paid into the unified health care financing system.

Core component 4: Provider reimbursement and participation

One of the more challenging elements in designing a universal health care system is developing an approach to provider reimbursement that ensures providers want to participate in delivering care and services to Washingtonians through this system.

> **Key considerations:** Provider reimbursement methods for centralized rate-setting and single fee schedule, negotiated rates, and value-based payment; and provider participation requirements and incentives.

Reimbursement rates

Developing this approach will involve considering how reimbursement rates will be set and how to encourage alternative payment models that may provide incentives for higher quality care and lower

[79] For more information on the Employee Retirement Income Security Act, see National Association of Insurance Commissioners. (2019). Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation. https://content.naic.org/sites/default/files/publication-ers-om-health-welfare-erisa.pdf?msclkid=93e40b08b3c111eca359435da84df82c

costs. Rate-setting processes could be applied broadly in a unified financing system or more narrowly for specific programs and providers. Rate setting affords the state the opportunity to

- Ensure that providers are adequately reimbursed to encourage provider participation in the universal health care system
- Control costs within the system
- Drive improvements in the quality of care delivered within the system, and
- Ensure equitable access to providers and services

A range of rate-setting approaches could be considered depending on the overall universal health care model. For example, the United Kingdom, and, for certain components of Canada's health system, providers are contracted with or directly employed. On the other hand, France, Germany, Switzerland, Netherlands, and Japan, have established centralized rate-setting for provider reimbursement.[80] This approach is intended to control total health care costs across sectors of the health care system that may be financed by private payers or different government programs.

It is possible that a more phased-in approach that preserves existing frameworks for rate setting, or provider contracting could be appropriate for advancing goals of universal health care. The approach may be easier to initiate and could enable adoption of a universal care model sooner than a non-phased in approach.

Both Models A and B include a single fee schedule that would establish rates for all health care services. One method for accomplishing this would be to set rates at a percentage above the Medicare fee schedule. The UHC Work Group report discussed a single fee schedule which would establish rates that are lower than current commercial rates, but higher than what Medicaid and Medicare pay. The report notes that approval from CMS would be needed for these federal programs to pay different rates than what they pay currently.[81]

Under Models A and B, rates would be set by Washington through an administrative process similar to Apple Health's fee-for-service (FFS) provider payments today. Under Models A and B, it may be possible to set rates for individual health care services, rather than setting rates at a percentage above Medicare for all services. A range of possible options exist under Model C which would not necessarily require changes to the current system of rates, provider reimbursement, or provider participation. However, the State could also choose to regulate provider reimbursement and provider participation more actively for existing programs.

The state of Maryland provides an example of how centralized rate-setting could be applied under a multi-payer system. Maryland, through its Health Services Cost Review Commission, sets rates for all hospitals in the state across all payers, allowing the state to slow the growth of hospital costs across the state.[82]

---

[80] Commonwealth Fund. (2017). *International Profiles of Health Care Systems*. https://www.commonwealthfund.org/publications/fund-reports/2017/may/international-profiles-health-care-systems

[81] This could have implications for meeting budget neutrality under Sections 1115 and 1332 of the Social Security Act. Assuming that these provisions could not be changed, and no additional federal funds could be obtained in order to pay the higher rates provided for by a single fee schedule, Washington may have to provide additional revenue in order to pay the higher rates.

[82] Maryland Health Services Cost Review Commission. (2022). Hospital Rate Setting. https://hscrc.maryland.gov/Pages/rates.aspx

There are additional considerations when evaluating provider reimbursements such as whether reimbursement will be provided directly from the state or through carriers. Cost reduction and transparency measures are additional considerations, such as the newly established Health Care Cost Transparency Board (HCCTB), and how these measures will assist in the future approach to provider reimbursement.

Value-based reimbursement

Universal health care delivered through a single-payer model or incremental model can create opportunities to shift away from FFS to more value-based methodologies of reimbursement. Under these arrangements, providers can receive additional payments or accept down-side risk to provide care and services to certain standards. It may be helpful to establish a process to identify and prioritize target metrics for which providers will be accountable and establish a methodology for collecting data and assessing whether providers have met the target thresholds.

Through value-based reimbursement, Washington can incentivize a range of provider behaviors. For example, this may include reducing disparities for vulnerable populations or improving the treatment for individuals with high priority conditions such as diabetes and substance use disorders. This may also manage costs by reducing unnecessary utilization of health care services. Model A could utilize alternative payment models, similar to what the Centers for Medicare and Medicaid Innovation currently employs.

Washington already applies value-based reimbursement strategies through multiple initiatives and programs. For example, currently a carrier that offering Cascade Select Public Option plans must confirm that at least 30 percent of provider contracts include value-based payment arrangements.[83] The HCA's Value-Based Purchasing Roadmap for 2022–2025 sets forth priorities and goals for value-based purchasing to contain health care costs while improving health care outcomes, including having 90 percent of state-financed health care (Apple Health, PEBB and SEBB) payments in VBP arrangements by the of 2021. [84]

To monitor progress towards this goal, HCA conducts an annual survey of providers and payers to gather information about participation in VBP. The results of the 2021 survey (using 2020 data) found that 77 percent of state-financed health care is in VBP arrangements. While short of the 85 percent benchmark for 2020, this was an increase from 2019 when only 62 percent were in VBP arrangements. Looking at other payers, the survey found that 59 percent of commercial health care and 80 percent of Medicare Advantage were in VBP arrangements in 2020. The HCA Roadmap and the annual survey can serve as a helpful framework for the consideration of value-based reimbursement and as a benchmark for where Washington can further these efforts.

Encouraging provider participation

One consequence of a fragmented health care financing system is that provider reimbursement rates can vary widely depending on the payer. This can be particularly challenging for Medicaid programs which

[83] Public Option Institute. (2020). **https://www.publicoptioninstitute.org/feed-wa-implementation-materials/summary-of-washington-state-gov-inslees-letter-on-implementation-of-cascade-care**
[84] VBP Roadmap. **https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf**

tend to offer lower provider rates than the commercial insurance market or Medicare.[85] This differential in reimbursement rates can lead to limited provider participation in Medicaid and consequently can impact access for Medicaid enrollees.

Reducing the differentials in provider reimbursement is likely to encourage providers to participate in delivering care to all populations and may reduce health care inequities. Under Models A, B and C, there are opportunities to reduce differences in provider reimbursement. Under Models A and B, if rates were set under a single fee schedule across a broader population base, more providers may be incentivized to participate. Some single-payer health systems, such as Indonesia,[86] also actively reimburse at higher rates for providers in underserved communities and regions. This strategy might also be considered to attract and retain health care workers where there are significant workforce shortages.[87]

Under Model C, adjusting reimbursement rates may require a centralized rate-setting structure to ensure similar rates across existing payers and programs. Providers could be required to participate in Medicaid or other programs as a condition of participation in other markets or programs. Additionally, under Model C, the state could remove potential barriers to participation by aligning value-based payment, quality initiatives, and administrative processes across payers.

Additional strategies could be considered to encourage provider participation. For example, the universal health care program could require providers to accept patients under the program and potentially cap rates or services provided outside of the program.

Core component 5: Cost containment elements

One of the critical goals in establishing a universal health care system is to contain costs. For example, holding the total cost of health care below the growth benchmark established under the work of HCCTB is one method to contain costs.

Many of the design elements described in the provider reimbursement and benefits subsections also constitute critical strategies for containing costs. For example, maintaining a benefit package that standardizes high-value benefits and services across all participants, setting provider rates for individual services, and encouraging value-based payment arrangements can all work toward lowering costs of care while improving the quality of care delivered. However, additional design elements could assist with containing total costs. These cost containment measures include examining fraud, waste, and abuse; utilization management; setting cost growth benchmarks; and global budgeting.

Fraud, waste, and abuse

One path to reducing cost throughout the health care system is to drive down utilization due to fraud, waste, and abuse. Nationally, the cost of fraud, waste, and abuse may constitute as much as 10 percent of

[85] Holgash, K., Heberlein, M. (2019). Health Affairs Forefront article. https://www.healthaffairs.org/do/10.1377/forefront.20190401.678690/full/
[86] World Health Organization. (2003). The World Health Report 2003: Shaping the Future. https://www.who.int/whr/2003/en/whr03_en.pdf?msclkid=cd46b569b42011ec98bd5ef5e0ad5a91.
[87] 2021 Paying for Value Survey Results. https://www.hca.wa.gov/assets/program/2021-p4v-survey-exec-summary.pdf

total health care costs.[88] Drivers of fraud, waste, and abuse include duplicated procedures or failures to coordinate care, overtreatment, overpayment, and fraudulent acts by providers or patients.[89]

There are system-wide approaches for addressing fraud, waste, and abuse. As the UHC Work Group noted, a single data set for claims or episodes could exist under Models A and B (paired with advanced analytic methods used today by the federal government, state Medicaid programs, and commercial payers). The data set creates opportunities to detect indicators of fraud, waste, and abuse and intervene to prevent future utilization from occurring or recoup costs for improper utilization.

Utilization management

Utilization management is a core function for most commercial insurance plans, Medicaid managed care organizations, and Medicare Advantage plans. Utilization management is used to reduce inappropriate or unnecessary utilization of health care services. This typically involves the monitoring of utilization, the identification of high-utilization individuals, and intervention to reduce high utilization in the form of care coordination, consumer education, or other methods. Utilization management may also include prior authorization requirements for certain types of services. Some single-payer systems, such as England, Canada, and Taiwan have developed utilization management programs to reduce the cost of care while maintaining quality goals.[90]

Under any of the universal health care models, it will be helpful to consider whether utilization management is an appropriate design element to assist with achieving the state's goals for cost containment. A particularly important consideration will be how certain utilization management controls, such as prior authorization can be utilized to reduce high utilization. Under Model B or C, utilization management could be delegated to participating carriers with requirements for administering utilization management.

Setting cost-growth benchmarks

In 2020, Washington created HCCTB to identify health care cost trends, set a cost-growth benchmark, and develop recommendations to reduce health care costs. As of September 2021, HCCTB has approved a cost growth benchmark of 3.2 percent for 2022–23, three percent for 2024–25, and 2.8 percent by 2026.[91] Washington's benchmark aligns with other states' cost-growth benchmarks, such as in Oregon, Connecticut, Delaware, Massachusetts, and Rhode Island.[92] HCCTB is also responsible for identifying providers and payers whose cost growth exceeds the benchmark. The universal health care system should hold the total cost of health care below the growth benchmark established by HCTTB and is a starting place for additional cost-containment efforts in the future.

---

[88] U.S. Department of Veterans Affairs. (2022). About Fraud, Waste, and Abuse. **https://www.va.gov/COMMUNITYCARE/about_us/POI/poi_fwa.asp#:~:text=Impact%20of%20Fraud%2C%20Waste%2C%20and%20Abuse%20The%20National,high%20as%2010%25%20per%20year%20or%20%24300%20billion.?msclkid=749dea44b4cc11ec9f5b87f0640262ec.**

[89] Lallemand, N. (2012). Reducing Waste in Healthcare. Health Affairs Health Policy Brief.

[90] Commonwealth Fund. (2017). *International Profiles of Health Care Systems*.

[91] Washington State Health Care Authority. Health Care Cost Transparency Board. September 14, 2021, Meeting Minutes. **https://www.hca.wa.gov/assets/program/board-meeting-summary-20210914.pdf**

[92] Block, R. & Lane, K. (2021). *Supporting States to Improve Cost Growth Targets to Improve Affordability.* Health Affairs. **https://www.healthaffairs.org/do/10.1377/forefront.20210526.658347/full/**

Global budgeting

Some single-payer health care systems have adopted global budgeting as a way to incorporate caps on the system-wide growth of health care costs. For example, England sets a global annual health care budget that is then allocated to local organizations that pay for care within their jurisdiction.[93] Taiwan negotiates an annual global budget with key stakeholders for major health care services and allocates the budget across six regions.[94] Under Model A or B, a similar global budget could be established and then adjusted annually to account for growth in need for health care services and for system performance (e.g. if provider rates are insufficient to encourage participation or benefits are too narrow to encourage individuals from participating).

Global budgeting can also be applied to individual providers as a strategy for provider reimbursement. For example, Maryland, as part of its hospital rate-setting program, establishes a global budget for each hospital that caps the payment it can receive from all payers. The Maryland hospital rate-setting program was originally established in the 1970s as a way to control hospital costs on a FFS basis. Over time, the program has evolved to become an all-payer value-based hospital reimbursement model governed by the Maryland Health Services Cost Review Commission aimed at managing total cost of care and improving quality outcomes at a population level. In its current form, each hospital's global budget is based on the projected needs of the population served by each hospital.[95] However, in establishing a global budgeting model, a critical consideration is whether providers are prepared to bear the financial risk if their costs exceed the global budget.

Core component 6: Infrastructure

As the Commission moves from planning into implementation, the governing agencies and partnering stakeholders will need to address a broad range of operational considerations. This includes assessing what structures and processes will remain, and what systems need to be upgraded or modified. These considerations are highly dependent on the overall strategy pursued and the readiness to implement the strategy.

Technology infrastructure

A key driver of implementation complexity will be the technology infrastructure necessary for executing the universal health care strategy. For example, each model will require technology investments for consumer-facing functions such as eligibility and enrollment; consumer assistance; and consumer outreach. To support administrative functions, investments could be needed to issue payments to providers or health plans; manage health care utilization; and monitor fraud, waste, and abuse.

[93] Ibid
[94] Ibid
[95] Mathematica. (2021). Independent Evaluation of the Maryland Total Cost of Care Model. **https://innovation.cms.gov/data-and-reports/2021/md-tcoc-imp-eval-report?msclkid=1a334a44b38f11eca5626a4a717ba358**

Key Considerations – Infrastructure

- Examining what infrastructure can be re-used, delegated, or needs to be developed
  - Technology platforms
  - Human Resources to support existing and added functions
  - Administrative policies and processes

- Accountability for infrastructure investments
  - State investments needed
  - Model participant investments
  - Shared infrastructure investments

Related to the technology infrastructure are considerations regarding data sharing and data management. The infrastructure necessary to share data across all participants in the universal health care system is critical for ensuring that the program objectives for health care quality, financial performance, population health, and health equity are met on multiple levels for individual consumers, providers, and payer organizations. In addition to the technology needed to support higher degrees of data sharing, infrastructure will be needed to establish data standards and common metrics, to analyze the data, and to report on outcomes.

Human resources

Human resources are another core consideration for the development of the model. Staffing needs will have to be assessed and managed, particularly for new state functions, such as rate setting or financial analysis. In addition to these core considerations, many operational decisions will impact the infrastructure needed during the implementation phase. Decisions regarding grievances and appeals, managing the administrative budget, procuring vendors, and contracting with participating providers will determine the infrastructure and systems that may need to be developed or if existing agencies could be utilized or reconfigured.

Core component 7: Governance

A strong governance model is critical for ensuring transparency and accountability. This ensures a voice is given to consumers, whose perspective is essential to decision-making. In ensuring transparency and accountability, there will need to be clear roles and responsibilities for all participants in the process. Moreover, ensuring a governance model that is inclusive of diverse voices representing the populations most impacted by the new system will be a critical component in ensuring that the goal of health equity is realized.

Key considerations – Governance

- Accountability for administering and regulating programs
  - Single new state agency
  - Existing state agency or agencies
  - Combination of new and/or existing state agencies
- Accountability for transparent reporting

One of the primary governance considerations in developing a universal health care system is determining which agency or agencies should administer the program. A single agency or a governance structure that consolidates functions and accountability across existing agencies could be created.

With one agency providing oversight, many administrative functions could be streamlined. In addition, a single agency could facilitate and execute more coordinated strategies to meet the health care goals of the state. A consolidated structure, however, brings together existing resources but requires a strong governance model and robust communication and process mechanisms. Many countries that have adopted a single-payer model place principal accountability for operating the system under a single agency. For example, in the United Kingdom, the National Health Service (NHS) oversees the health systems of each country.[96] Additionally, the state of Vermont, when it created its Green Mountain Care Board, consolidated a wide range of new and existing responsibilities pertaining to the management of health care costs.[97] While there is a wide range of benefits with single agency oversight, there is likely to be initial disruption to current functions and significant costs associated with the implementation.

Each of the universal health care models under consideration will necessitate different governance structures. For example, Model B would likely require less new administrative and regulatory responsibilities relative to Model A because some of those functions would be contracted to a carrier or carriers to perform. Under Model C, there would be no change to the existing structure.

Summary

The objective of Section 3 of this report is to describe the major areas of design components that are critical to developing, implementing, and maintaining a universal health care system and to identify key considerations within each area:

1. Eligibility and Enrollment
2. Benefits and Services
3. Financing
4. Provider Reimbursement and Participation
5. Cost Containment Mechanisms
6. Infrastructure
7. Governance

These core design components provide an operational framework to assess Washington's readiness and inform a strategy for implementing a universal health care system with unified financing and its ability to advance the goals for a universal health care system including containing health care costs, improving the quality of care, promoting health equity, and reducing health disparities.

[96] Berry, N. (2015). How does the NHS compare with health systems in other countries? The Health Foundation. **https://www.health.org.uk/sites/default/files/HowDoesTheNHSCompareWithHealthSystemsInOtherCountries.pdf?msclkid=4a54e776b29c11ec88e9119cc2af8b32.pdf**

[97] Green Mountain Care Board. (2022). **https://gmcboard.vermont.gov/board**

Section 4: Readiness

Introduction

The Legislature directed the Commission to provide an assessment of Washington's current level of preparedness to meet the elements of universal health care with a unified financing system, including but not limited to a single-payer financing system. Washington's readiness to transition will likely evolve as the Commission continues its work because a complete readiness assessment is dependent on finalizing various design elements, including which model of universal health care is chosen. This preliminary assessment will, however, provide initial considerations that will help to inform the Commission's work and potential next steps. Throughout the course of the Commission's work, there will be revisions and expansions to the initial assessment as the unified health care financing system develops.
This section of the report will provide a preliminary readiness assessment of the state's current level of preparedness to implement a unified health care financing system as described in Model A and Model B of the UHC Work Group. This section will also:

- Outline the functions state agencies are currently performing and potential resources available to perform those functions under a unified health care financing system.[98]
- Compare the current health care system with a potential unified health care financing system.
- Identify the steps and considerations necessary to move from the current system to universal health care supported by a unified financing system.

A readiness assessment survey tool was developed and provided to Commission Members to gather information and evaluate Washington's readiness.[99] Individual interviews were also conducted with state agency representatives participating on the Commission. The survey and interviews demonstrated that while Washington has significant resources that could be adapted and expanded to implement a unified health care financing system, major gaps exist.

The assessment revealed important information for consideration, including identifying that state agencies have limited to no experience in directly performing important functions of the health care system. For example, state agencies have not historically performed utilization management functions whereas managed care organizations, private payers, providers, and others typically employ utilization management strategies to coordinate and manage care, to reduce wasteful, unnecessary care, and to contain costs. In some cases, this is done by private entities such as Medicaid Managed Care Organizations and commercial health plans on behalf of state agencies in public programs which the state agency administers (e.g., Apple Health, PEBB, and PEBB).

[98] Washington is currently adopting policies and making budget allocations to achieve Model C.
[99] The survey and interview guide are included in Appendix X.

The assessment of the seven core components of a universal health care system is summarized below in Table 7. This table describes the state's readiness to move from the current system to the potential new model(s). For purposes of assessing Washington's level of preparedness in this report:

- green signifies that the state is ready to implement a particular design element without major additional resources and IT systems, or disruption to existing state programs.
- yellow signifies that the state has some resources, IT systems, and programs that could be modified and expanded to implement the design element.
- red signifies that the state lacks the resources, IT systems, and programs needed to implement the design element or has no history of implementing a similar function.

Preliminary Readiness Assessment Findings	
Core Component	**Readiness Level**
1. Eligibility and Enrollment	Yellow
2. Benefits and Services	Yellow
3. Financing	Red
4. Provider Reimbursement and Participation	Dependent upon Model Design
5. Cost Containment Elements	Model A: Red
	Model B: Yellow
6. Infrastructure	Model A: Red
	Model B: Yellow
7. Governance	Red

Table 7: Summary of readiness to implement core components of a universal health care system with a unified financing system

Core component 1: Eligibility and enrollment — Yellow

The goal of universal health care is to enroll all eligible Washington residents to ensure that they have the best possible access to essential, effective, appropriate, and affordable health care services. In the current system, determinations about coverage eligibility and enrollment vary depending on the coverage source: public programs, employer-sponsored coverage, or the individual market.

There are several challenges to establishing universal eligibility and enrollment processes. Washington lacks a centralized source of information about individuals' existing coverage because the various information technology systems currently in use are not capable of interacting with one another. Similarly, there is no central database of uninsured individuals and families. As a result, systems will need to be developed to effectively transition individuals enrolled in any current system and the uninsured into the new health care system. This will ensure continuous care and will help an individual or family enroll in a unified health care financing system.

This work will vary depending on current coverage: people who have existing coverage will transition into the new system, and people who are uninsured will need to be enrolled into the system. Each of these coverage scenarios presents its own challenges.

Eligibility readiness

Under any universal health care system, eligibility determination is crucial. The nature and extent of the information needed depends to some extent on the design of the new system. However, under any

model, residency status would need to be determined and verified. Residency requirements could include a waiting period or a minimum residency duration to establish eligibility. These requirements would have to be investigated to understand the limitations allowable given the federal right to interstate travel and receipt of public benefits.

Additional information will be needed to determine the eligibility criteria. For example, more information would be needed to determine eligibility for nonresidents such as those eligible for health insurance offered by their Washington-based employer. Similarly, further work may be needed to identify the impacts of eligibility policies, processes, and procedures on specific populations (e.g., tribal members or persons who are incarcerated) and to ensure comprehensive collaboration with all partners such as community-based organizations that can assist with outreach and eligibility determinations.

Modifying existing eligibility verification systems

Washington's robust system to determine eligibility for Apple Health and QHPs could be modified to serve as the eligibility verification system for any universal health care. However, depending on the model chosen for the unified health care financing system, these modifications could be significant and costly. For example, if multiple coverage programs are maintained under the system (e.g., Apple Health, QHPs, PEBB, and SEBB), a unified eligibility platform would need to reconcile multiple sets of eligibility criteria to determine the most appropriate program and, if applicable, relevant subsidies.

Modifications may be more straightforward if all participants have the same eligibility criteria and receive the same benefits under the universal health care system. For example, under Model A, eligibility may presumably be determined based on state residency, with subsidy eligibility determined based on income. This is similar to the eligibility criteria employed by the Exchange in determining eligibility for QHPs and subsidies. Clear criteria and required documentation would need to be identified in the program design and operational implementation phases.

The current eligibility systems would need to be expanded to determine eligibility for the entire population, which will require planning and funding, including some lead time prior to enrollment for system builds and testing. Readiness for eligibility processes will require coordination with Medicare (if Medicare enrollees can be included in the universal health care system). It will also be important to consult with tribal leaders regarding the relationship between the tribal health system and the trust responsibility for the federal government to provided healthcare to American Indians and Alaska Natives (AI/ANs) and the unified financing system. Finally, additional resources would be needed for consumer outreach, education, and support during the eligibility application process.

Enrollment readiness

Once an individual or family is determined to be eligible for coverage under the new system, enrollment processes will be needed to place eligible individuals and families into coverage. The methods for enrollment and the complexity of the processes depend on the design of the universal system.

Currently, Washingtonians often have a choice among health carriers or health plans for their coverage. For public programs and most employer-based coverage, selections are made after reviewing the available options. Occasionally, people are assigned or auto-enrolled into a health plan.[100]

The current process utilized to enroll Washingtonians into Apple Health, QHPs and Cascade Care could be simplified to expand enrollment for a unified health care system envisioned by Model A. While there may be various approaches to Model B, the enrollment processes currently utilized for Apple Health and the Exchange could be expanded upon to enroll the entire eligible population which may streamline enrollment.

Core component 2: Benefits and services — Yellow

Benefits and services will be a critical component of the universal health care system. As discussed in Section 3 of this report, two of the potential coverage models (A or B) will require the state to develop, administer, and assess the performance of covered benefits and services.

Using existing categories and programs as a starting point

The UHC Work Group recommended, as a starting point, that the ACA-mandated categories of services in the EHBs would be provided, with the possibility of additional service categories, including vision and hearing. Among the outstanding considerations is whether other benefits not included in EHBs, such as long-term care and disability services, will be provided by the universal health care system.

Through its existing coverage programs, Washington manages distinct benefits and services packages for Apple Health, PEBB, SEBB, and Cascade Care. As a result, Washington is well positioned to engage stakeholders, develop options, and make decisions regarding the standard benefits and services covered under the unified financing system. However, in many cases, programs including Apple Health, PEBB, SEBB, and other programs offer benefits that are not included in the EHBs.

The ACA-mandated EHB may be a helpful starting point for a standard benefit package, though the difference in benefits between what currently exists under various programs will need to be reconciled. However, to effectively guide this development, it will be important to establish a process to define the specific services within the categories, but also an ongoing process to update the services over time that incorporates new clinical evidence and diverse stakeholder input.

Administering benefits

Once the benefit package is developed, the benefits must be administered. Depending on the coverage model, the state could administer benefits directly, or through third-party administrators, or through contracted health plans. Currently, benefits under Apple Health, PEBB, SEBB, and Cascade Care are administered using a combination of the three methods. More investigation is needed to understand the scalability of each program's benefit administration capabilities.

Further, to support the affordability, quality, and equity goals of the unified financing system, administrators must accommodate any complex eligibility rules, benefit management processes and

[100] This would occur in Apple Health when a person does not make a plan selection and employer-sponsored coverage when only one plan is offered.

value-based payment models as they currently exist or are revised in the future. As such, Washington's readiness to administer benefits is critically tied to decisions regarding the benefits package as well as provider reimbursement, consumer cost-sharing, and financing.

It will also be necessary to assess the performance of the standard benefits and services in advancing affordability, quality, and equity goals. Currently, several coverage programs and agency-housed programs, such as the HCCTB and the APCD, collect and analyze claims, encounter data, and other data. However, more assessment will be needed to determine readiness to support value-based benefit design within the universal health care system. This will be critical in ensuring that incentives are provided and that financial barriers are removed for greater utilization of high value services such as recommended preventive care.

Core component 3: Financing — Red

Health care is currently financed through several different sources and in a variety of ways. Financing sources include direct payments by the federal and state governments for public programs, subsidies for the purchase of health coverage on the Exchange, premiums paid by employers and consumers, and out-of-pocket costs paid by consumers such as copays and coinsurance.
The complexity and cost of the current system make financing one of the most challenging aspects of establishing a universal health care system. Consolidating and simplifying this system is one of the outcomes that supports establishment of a universal health care system. Another likely outcome is reduced financial burden on consumers and increased access to care.

Under either Model A or B, numerous, complex decisions will determine how the system would be financed, as described more fully in Section 3 of this report. *This section of the report may be further revised or developed pending Commission discussions.*

Federal and state funds

Perhaps the most challenging and time-consuming task will be to obtain the federal waivers needed to utilize federal funds to help finance the unified financing system. This work cannot begin until the universal health care system design has been further explored. Significant time will then be needed for waiver drafting and the federal approval process, which could potentially involve both federal agency and Congressional action. The federal government may not agree to approve the entire request, which would require alternative sources of funding to be identified.

In addition, further exploration is needed to determine how to raise state funds to replace the amounts currently paid by businesses and families in the form of premiums and copays. These decisions are likely to be a significant change from what Washingtonians are used to, and this work will be more efficiently conducted once the design of the universal health care system is further developed.

Core component 4: Provider reimbursement and participation — Readiness assessment dependent on model variables

Provider reimbursement is a critical element of any health care system. It must address financial solvency for providers, advance equitable access to affordable health care services, and drive person-centered,

outcomes-based health care delivery. Implementation requires both the operational functions to administer payment and the analytic functions to assess provider performance against quality, cost, and equity targets. Washington's readiness to implement a provider reimbursement model in a unified financing system is greatly dependent on the overall universal health care system, and the methods of provider reimbursement selected for the model.

Provider reimbursement

Depending on the provider reimbursement methods, the assessment reveals varying levels of readiness (green, yellow, or red). For example, if Washington chose to implement a direct provider employment model such as the NHS in the United Kingdom or the VHA, its readiness assessment would be red. Washington has little experience with such a system and the challenges of contracting directly with all the health care providers in the state would be considerably more involved.

However, Washington's readiness to reimburse providers entirely on a FFS basis with a uniform rate structure, as suggested in the UHC Work Group Report, is assessed as green. HCA has experience in paying claims in FFS Medicaid. Until 2011, HCA also contracted directly with providers to establish the Uniform Medical Plan network for PEBB and SEBB. While the scale and scope of these capabilities would need to be greatly expanded, Washington has demonstrated its capacity for provider contracting and FFS claims payment.

Moving to an entirely FFS method of paying providers may be inconsistent with the many efforts Washington, along with other states and the federal government, has made to reduce costs and improve the quality of care using managed, coordinated care models. This may mean moving away from use of value-based provider reimbursement, which may disrupt advances made in quality, equity, and cost containment under value-based provider reimbursement.

Washington's readiness to transition to a system that makes greater use of alternative payment models and provides incentives for higher value care is assessed as yellow. While Washington does not have a history of administering global budgets, it does contract with managed care organizations on a per member per month payment basis and third-party administrators to provide these functions for specific programs.

Contracting with managed care organizations or third parties is similar to what could be done under a variation of Model B. However, the extent to which these capabilities can be scaled to support a universal system requires further assessment and is likely dependent on the specific reimbursement models selected for the financing system. For example, while a third-party administrator under Model B may be able to administer quality bonuses, capitated payments, or value-based contracts in the commercial insurance market, the third-party administrator may not be able to easily implement a global budget for an attributed population.

In addition to these analytic and operational considerations, provider reimbursement under Model A or B would require an agency to have authority to set and pay provider rates. While that authority exists today in limited programmatic contexts (e.g., Apple Health), a unified financing system would require significant expansions of authority for a governing agency to support provider reimbursement models.

Core component 5: Cost containment elements — Red or yellow, depending on model variables

Improved cost containment is one goal of a unified health care financing system. Washington's readiness to implement cost containment in a unified financing system is assessed as red for Model A and yellow for Model B.

Current cost containment efforts

One of the more problematic features of the current health care system is that incentives for payers and providers are not aligned to control costs. Though changes have been made to improve health care financing and cost control, much of the system relies primarily on FFS payments that focus and pay based on volume rather than value. Further, due to the different delivery models and markets, the current health care system is fragmented making it difficult to apply cost containment measures at scale.

Many different efforts to contain costs are underway in Washington, as more fully described in Section 1 of this report. Various entities are currently responsible for managing costs and coordinating care, with various state or federal agencies regulating their activities. For example, HCA oversees Apple Health managed care plans, OIC regulates commercial insurers, and the federal Department of Labor regulates self-funded employers. The state and federal governments have not directly engaged in managing costs and coordinating care to a large extent, with the VHA being a notable exception.

Cost containment for Models A and B

The current efforts of cost and care management are tailored to the respective programs that provide health coverage and are not unified among the different entities implementing them. Under Model A, Washington would need to develop new processes and obtain additional resources to carry out the functions of directly managing costs and coordinating care.

Under one version of Model B that uses carriers to provide health care insurance, the accountable agency administering the new system would need to align the contracted carriers' actions to provide consistent, effective cost containment measures to everyone covered by the system. This could include myriad uniform cost containment and care management approaches such as a common list of clinical guidelines and benefit exclusions, one standardized appeal process, and common prescription medication formularies.[101]

Fraud, waste, and abuse

Reducing fraud, waste, and abuse is another strategy for cost containment that should be considered in the universal health care system.[102] Currently, HCA employs strategies to reduce fraud, waste, and abuse in public health care programs. Further, as part of their regulatory and consumer protection mission, state agencies identify and prevent fraud, waste, and abuse in the provider and private payer markets.

[101] Many existing state initiatives would establish a foundation to support such approaches to better manage cost while improving quality as discussed in Section 1.
[102] Efforts to reduce fraud, waste, and abuse were previously discussed in Section 3.

As the design of the universal health care system is developed, further assessment will be necessary to identify the readiness of these current agencies to support a fraud, waste, and abuse detection program, particularly if the financing system includes complex, value-based provider reimbursement models.

Core component 6: Infrastructure —Red or yellow, depending on model variables

The capacity of the state's existing administrative infrastructure to scale and adapt to the new system is a key determinant of Washington's readiness to implement a unified financing system. The overall readiness of Washington's infrastructure supporting a universal health care system is assessed as red for Model A and yellow for Model B.

Information infrastructure

Technology and data platforms are some of the more important infrastructure considerations necessary to execute the universal health care system.[103] In administering existing coverage programs, Washington utilizes multiple call center and data management platforms for eligibility determinations, enrollment, and claims payment. However, most of the platforms currently in use are not compatible with other systems, making program integration a challenge. Further, given that platforms serving different programs have been developed to widely varying requirements, existing systems may not be well suited to support the unified financing system.

However, there may be eligibility and enrollment platforms, such as the Apple Health and HBE's eligibility platforms, that could be repurposed for eligibility determination with modifications. Or, if utilizing work hours is a key determinant of eligibility, the PEBB and SEBB eligibility platforms could be modified and repurposed. As key design elements of the universal health care system are developed, each of the IT systems utilized in Washington will need to be evaluated for appropriateness and scalability to support the model selected.

Human resource infrastructure

Human resources and staffing are also critical areas of infrastructure readiness. Certain functions needed to implement a universal health care system are currently being performed by the private sector. For example, health insurance carriers currently contract with providers who care for their members. Carriers also help to coordinate and manage care delivered by providers in the community who may not be part of the same health care system. Additionally, carriers perform utilization management to determine whether particular health care services are medically necessary and appropriate. Under Model A, additional state workers may be needed to perform these functions, or in the alternative, enter into contracts with private entities with state workers managing those contracts.

While each agency has a complement of staff to support existing programs, significant planning efforts must be authorized and funded to assess needs pertaining to staff training, management transitions, and integration, particularly for Model A. For example, many of the programs operate call centers to support clients with eligibility determinations, enrollment, and other services. However, call center staff are typically highly trained and expert in the rules and processes for one coverage program and may require

[103] As discussed in Section 3.

additional training to support a unified financing system, even if many of the rules and processes are retained in the new model.

Another consideration for readiness is Washington's ability to support the transition for employees whose service may not be required if organizations and programs (including state agency and private organizations that comprise the current health care system) can be consolidated to support the unified financing system. Training programs can help transition these employees to new employment opportunities, possibly within the universal health care system. Further assessment will be needed to determine whether an existing employment program could fulfill this need.

Finally, assessing human resource needs may also identify needs for new personnel and skill sets that do not currently exist in the state's workforce. For example, provider rate setting in Washington has never been done comprehensively across all payers. Supporting that function under the unified financing system will require combining technical expertise from across all markets. Identifying these needs and developing training programs for employees in the current health care system wherever possible may help mitigate negative consequences of implementing a universal health care system and ease employment concerns through the transition.

Core component 7: Governance — Red

In this report, governance has been identified as a critical design element of the universal financing system. The primary consideration for establishing the governance structure is whether a single agency or multi-agency governance structure should be accountable for overseeing the operation of the universal financing system.

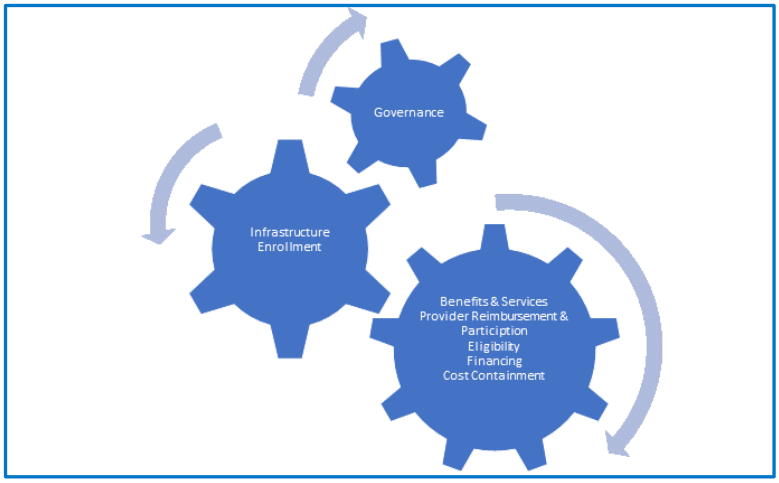
Currently, no single agency or entity performs all the functions necessary for operating a universal financing system or serves all populations and stakeholders that would be served by the system. Additionally, no agency or entity has the authority to operate, oversee, or regulate across the entire healthcare landscape. However, Washington does have a history of shared authorities and collaboration across agencies. For example, HCA, OIC, and HBE collaborate to implement Cascade Care as designated by the Legislature.

Once the accountable agency or agencies are decided, the governing entity is likely to need significant resources and expanded or new authority to oversee and operate the universal financing system. When this critical design element is established, a governance structure and needed resources will need to be reassessed.

Summary

The preliminary readiness assessment reveals several opportunities to build on existing functions, but also identifies some initial areas that will require greater resources and/or new authorities to be able to design and develop a universal health care system. The preliminary readiness assessment also helps to clarify a potential sequencing for how the Commission might approach the system design for these key elements as seen in Figure 5.

Figure 5: Potential sequencing for universal health care system design



Section 5: Medicaid rates

Introduction

Engrossed Second Substitute Senate Bill 5399 directs the Commission to make recommendations for implementing reimbursement rates for health care providers serving Medicaid enrollees a rate that is no less than 80% of the rate paid by Medicare for similar services.[104] Under a universal health care system, the way current Medicaid beneficiaries receive services may be significantly different. In the interim, increasing Medicaid payment rates may improve provider participation in Medicaid, which could improve access to care for Medicaid beneficiaries in the interim.

This section will provide a summary of current Medicaid reimbursement structures, the impact of relatively low reimbursement rates on provider participation in Medicaid, as well as the impact of low payment rates on health care access and equity, and some of the legislative efforts to increase Medicaid rates in Washington. This section will also share the results of financial modeling done by the Financial Analytics Division at HCA to determine the cost to the state and federal government of increasing all Medicaid rates to 80% of Medicare.[105] Finally, the Commission will share recommendations for potential pathways to achieving enhanced Medicaid reimbursement rates.

[104] Engrossed Second Substitute Senate Bill 5399 **https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5399-S2.SL.pdf?q=20220404085215**
[105] Modeling made several assumptions and most services with some exceptions.

Background

Before the passage of the ACA, Medicaid was generally unavailable to non-disabled adults under age 65 years unless they had minor children or were pregnant. The income caps to qualify as a parent/caretaker were very low. However, a provision in the ACA called for the expansion of Medicaid eligibility in order to cover more low-income Americans. Under the expansion, Medicaid eligibility would be extended to adults up to age 64 years with incomes up to 133% FPL (plus a 5% income disregard).[106] Prior to the ACA, states seeking to adopt Medicaid expansion could do so using Section 1115 waiver authority. Washington took the opportunity to do an incremental expansion, extending Medicaid coverage to non-elderly adults up to 133% FPL under the waiver beginning January 1, 2011.[107] [108] The decision and action to adopt early expansion effectively reduced the uninsured rate in Washington. In 2013, the uninsured rate in Washington was 14.1% which dropped to 5.4% by 2016, representing an overall rate decrease of 60%. Over the next several years, the uninsured rate increased slightly and hovered around 6.7% prior to the COVID-19 pandemic.[109]

In 2020, the PHE declaration and subsequent Families First Coronavirus Response Act allotted states' Medicaid programs a temporary 6.2% Federal Medical Assistance Percentage (FMAP) increase in response to widespread unemployment and loss of health coverage. This increase was conditioned on states maintaining Medicaid members' enrollment, including for those newly eligible during this period. As result of these protections, the uninsured rate as of November 2021 was the lowest since the implementation of the ACA at 4.7%.[110]

Medicaid expansion coupled with federal protections from Medicaid disenrollment amid the COVID-19 pandemic have helped to significantly lower the uninsured rate. Since Medicaid expansion, Washington has sought to improve the Medicaid program by improving access to care and improving provider participation in the Medicaid program.

---

[106] 138% FPL total with the income disregard. Patient Protection and Affordable Care Act. 2014. **https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf**

[107] Medicaid expansion under the 1115 demonstration waiver was extended to nonelderly adults up to 133% FPL who were previously enrolled in the state-funded Basic Health Plan or the state Alcohol and Drug Addiction Treatment Support Act programs. Under the waiver, enrollment was capped, and enrollees were subject to cost-sharing which exceeded traditional Medicaid limits. When expansion under the ACA became effective in January 2014, enrollees under the waiver were transitioned to traditional Medicaid coverage. *The Kaiser Commission on Medicaid and the Uninsured. 2014. The Washington State Healthcare Landscape.* **https://www.kff.org/wp-content/uploads/2014/06/8599-the-washington-state-health-care-landscape2.pdf**

[108] As of January 2014, an 1115 waiver was no longer necessary as the adult coverage expansion group were a new eligibility group. Washington implemented this new group on January 1, 2014. Other changes applied to all state Medicaid programs as of 2014, including simplified eligibility determination procedures with a new income counting methodology. The Kaiser Commission on the Uninsured. 2014. The Affordable Care Act's Impact on Medicaid Eligibility, Enrollment, and Benefits for People with Disabilities. **https://www.kff.org/wp-content/uploads/2014/04/8390-02-the-affordable-care-acts-impact-on-medicaid-eligibility.pdf**

[109] The state's uninsured rate increased sharply during the COVID-19 pandemic. At the height of the pandemic lockdown in May 2020, the uninsured rate reached 11.9%. OFM microsimulation model of Washington's unemployment claims during the COVID-19 pandemic and associated health coverage changes. Washington State Office of Financial Management. 2021.

[110] OFM microsimulation model of Washington's unemployment claims during the COVID-19 pandemic and associated health coverage changes. Washington State Office of Financial Management. 2021.

However, physician participation in Medicaid is voluntary. Physician participation in Medicaid is also lower than in the commercial insurance market and in Medicare, particularly among specialists. This shortage of providers has long been associated with low Medicaid payment rates. In fact, physicians cite low rates as the primary barrier to participating in Medicaid.[111] In Washington, Medicaid provider reimbursement rates are not competitive with either commercial plans or Medicare, with Medicaid rates in 2016 at 71% of Medicare averaged across all services and 65% for adult primary care.[112] Additionally, Medicaid payment rates have not kept pace with the cost of services, particularly in FFS Medicaid, and there has been no sustained ongoing rate increase for Medicaid services in over 10 years.[113] Further, the historic lack of provider rate increase in FFS Medicaid disproportionately impacts AI/AN individuals as well as individuals who are dually eligible for Medicare and Medicaid, and Aged, Disabled and Blind populations.[114]While recent legislation successfully increased some Medicaid payment rates, including pediatric primary care, behavioral health under managed care, and dental services for children and adults, provider rates largely have not kept pace with the cost of providing care, especially for these critical services.

Medicaid fee-for-service and managed care

States may offer Medicaid benefits on a FFS basis, through managed care plans, or a combination of both. In Washington, Medicaid enrollees are automatically enrolled into managed care and can choose which plan best fits their needs. Some groups, including Medicare eligible individuals, American Indians, and Alaskan Natives, are exempt from auto-enrollment in Medicaid managed care but may choose to opt into a managed care plan. Some groups can also opt out of coverage under managed care, such as Foster Care Alumni. Some services are always provided on an FFS basis such as long-term care and dental care.

Fee-for-service payment

Under Medicaid FFS, providers are paid directly for each covered service received by a beneficiary. Federal rules allow states broad flexibility in determining FFS provider payments on the condition that payments help to safeguard against unnecessary utilization, and be consistent with access rules, efficiency, economy,

111 Holgash, K. Heberlein, M. 2019. Physician Acceptance of New Medicaid Patients: What Matters and What Doesn't. Health Affairs. **https://www.healthaffairs.org/do/10.1377/forefront.20190401.678690/full/**

[112] Medicaid-to-Medicare Fee Index. 2016. Kaiser Family Foundation. **https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D**

[113]Health Care Authority, 2019, Barriers to Primary Care Access in Apple Health. Senate Health and Long Term Care Committee. **https://www.hca.wa.gov/assets/program/senate-hltc-barriers-primary-care-access-011619.pdf**

[114] Compared to White, non-Hispanic Medicaid enrollees, AI/AN enrollees are significantly less likely to report that it is always or usually easy to get needed medical care, tests, or treatments; significantly less likely to report that it is always or usually easy to get needed mental or behavioral health services; and significantly more likely to report that they are never able to see a specialist as soon as needed. Medicaid revenue is also especially essential for Indian health providers when federal Indian Health Services (IHS) funding is reduced or interrupted. Medicaid and Chip Payment and Access Commission (MACPAC). Medicaid's Role in Health Care for American Indians and Alaska Natives. Issue Brief. 2021. **https://www.macpac.gov/wp-content/uploads/2021/02/Medicaids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf**

and quality of care.[115] Washington uses a provider fee schedule to establish base payment rates, or standardized payment amounts, for Medicaid FFS.[116]

Managed care payment

Managed Care provides comprehensive benefits through Managed Care Organizations (MCOs), which receive a capitated payment to provide services. Federal Medicaid rules allow states to enter into contracts requiring MCOs to adopt minimum fee schedules for network providers that provide a particular service under the contract. [117]

Encounter and cost basis payments

Some Medicaid providers are paid on an encounter basis, such as federally qualified health centers (FQHCs). The FQHC rate covers Medicaid patients a per-visit, all-inclusive payment based on encounters.[118] Other providers, including critical access hospitals (CAHs), are paid on a cost basis (with some exceptions).[119] To be paid by HCA either under FFS or managed care as a CAH, a hospital must be approved by the department of health (DOH) for inclusion in DOH's critical access hospital program.[120] There is an assumption that CAH payments would not be impacted by an increase in Medicaid rates.

Impact of payment rates on provider participation in Medicaid

Providers have long cited Medicaid's low payment rates as the primary barrier to participating in Medicaid. A provision of the ACA intended to encourage primary care physicians to participate in Medicaid required states to temporarily increase Medicaid primary care rates to 100% of Medicare in 2013 and 2014.[121] After raising Medicaid rates during this period, Washington's Medicaid reimbursement returned to pre-ACA levels.[122] The temporary nature of the Medicaid one-time fee bump resulted in limited improvements in provider participation.[123] Several studies investigating the effect of increased rates during this same period noted that the limited duration and design of the payment increase may have not been enough to incentivize providers to participate despite the increase in payment rates.

---

[115] Compilation of the Social Security Laws. State Plans for Medical Assistance. **https://www.ssa.gov/OP_Home/ssact/title19/1902.htm**

[116] The Centers for Medicare & Medicaid Services (CMS) assesses the adequacy of FFS payments when it approves FFS payment methodologies.

[117] Medicaid managed care rates are based upon FFS equivalents, are developed by actuaries and must be approved by CMS.

[118] Encounters are defined to include a documented, face-to-face contact between a user and a provider who exercises independent judgment in the provision of services to the individual. To be included as an encounter, services rendered must be documented. Centers for Medicare and Medicaid Services. Comparing Reimbursement Rates. **https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/understand-the-reimbursement-process**

[119] WAC 182-550-2598

[120] Some tribal facilities qualify as critical access hospitals.

[121] The two-year rate enhancement was funded solely by the federal government. Health Care and Education Reconciliation Act of 2010, Section 1202. **https://www.govinfo.gov/content/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf**

[122] The Health Care Authority models Medicaid rates annually, ensuring budget neutrality. After the ACA temporary rate increase period, Medicaid rates in Washington State returned to the rate that would have followed 2012 rates modeling.

[123]Decker, S. Lipton. B. 2017. Most Newly Insured People In 2014 Were Long-Term Uninsured. **https://pubmed.ncbi.nlm.nih.gov/28069842/**

HCA funded a study by the University of Washington Center for Health Workforce Studies (UW CHWS) to assess the impact of the 2013-2014 Medicaid payment increase on primary care providers' willingness to serve Medicaid patients in Washington State. [124] This study found that the lack of sustainable funding from the one-time fee increase was not incentive enough for some providers to participate in Medicaid and would not impact decisions to accept or continue care for Medicaid patients for most providers. The majority of providers noted that increasing reimbursement rates, as well as other strategies such as streamlining payments and administrative processes, may encourage them to continue seeing or accepting new Medicaid patients.

A 2019 Health Affairs Study reviewed the effects of provider payment rates, Medicaid expansion, and managed care on physician acceptance of new Medicaid patients.[125] Neither Medicaid expansion nor managed care played a significant role in increasing provider participation. However, higher provider payment was associated with higher acceptance rates of Medicaid patients by providers. Further, physicians in states that paid above the median Medicaid-to-Medicare fee ratio (ranging from .66-.72) accepted new Medicaid patients at higher rates than those in states that pay below the median.

Impact of provider rates on health equity and access

Health and health care disparities disproportionately impact individuals and communities of color. For instance, private insurance, primarily employer-sponsored insurance, is the largest source of health care coverage across racial and ethnic groups. However, structural racism has largely shaped employment trajectories for people of color, where compared to their White counterparts, people of color are less likely to be privately insured and are less likely to be employed with employers that offer health

[124] Pattterson DG, Andrilla CHA, Skillman SM, Hanscom J. The Impact of Medicaid Primary Care Payment Increases in Washington state. Seattle, WA: WWAMI Center for Health Workforce Studies, University of Washington, Dec 2014. **http://depts.washington.edu/uwrhrc/uploads/WA%20Medicaid%20Incentive%20Final%20Report%20Dec%201%202014.pdf** The study consisted of two surveys in fall 2014. The first sampled 15 Washington counties and captured the perspectives of 230 primary care physicians in solo and small group practices of 50 physicians or fewer. Physicians sampled had to have reported providing direct patient care in Washington since January 1, 2013 and have a main practice site that was not a federally qualified health centers or Rural Health Clinic (RHC), as these facilities were not eligible for the payment increase. Survey two was directed at leaders of the state's 13 largest healthcare organizations, with a response rate of 53.8%. Provider awareness of the temporary increase varied, where respondents from large healthcare organizations or in private practice were more aware of the Medicaid payment increase compared to primary care physicians in smaller practices. Primary care and large healthcare organizations were polled on the amount of influence primary care physicians had on whether to accept Medicaid patients and who in large healthcare organizations makes this decision. 82.1% of primary care physicians in smaller practices reported that they had "some" or "a great deal" of influence. 42.9% of primary care physicians in large healthcare organizations reported that their primary care physicians had "some" or "a great deal" of influence. 71.4% of large healthcare organizations reported that leadership made the decision. 46.3% of rural primary care physicians, compared with 72.8% of urban primary care physicians, reported they had "a great deal" of influence. Primary care physicians in private practice were 66.9% more likely to perceive they had "a great deal" of influence (76.6% vs. 9.7%). Self-employed primary care physicians were more than three times as likely as other primary care physicians to report having a great deal of influence (86.1% vs. 24.6%).

[125] Holgash, K. Heberlein, M. 2019. Physician Acceptance of New Medicaid Patients: What Matters and What Doesn't. Health Affairs. **https://www.healthaffairs.org/do/10.1377/forefront.20190401.678690/full/**

insurance.[126] People of color are also less likely to report having a personal doctor or health care provider compared to their White counterparts. [127]

People of color are overrepresented in Medicaid compared to other forms of insurance. As of 2020, Medicaid covered about three in ten Black, AI/AN, and Native Hawaiian or Other Pacific Islander (NHOPI) nonelderly adults and more than two in ten Hispanic nonelderly adults, compared to 17% of their White counterparts. For children of color, Medicaid and CHIP (Children's Health Insurance Program) play an even larger role, covering over half of Hispanic, Black, and AIAN children and nearly half of NHOPI children, compared to 27% of White children.

In their 2022 Quarterly Opinion, Millbank stated that relatively low provider payment rates contribute to access barriers for Medicaid enrollees. Millbank cited the 2019 Physician Acceptance of New Medicaid Patients[128] report by the State Health Access Data Assistance Center (SHADAC) to the Medicaid and CHIP Payment and Access Commission (MACPAC). Of providers accepting new patients, 70.8% were accepting new Medicaid patients, compared to 85.3% accepting new Medicare patients and 90% for private insurance. For specialty providers such as psychiatrists, only 35.7% were accepting new Medicaid patients, compared to 62.1% accepting Medicare and 62% accepting private insurance. However, SHADAC found that every 1%-point increase in the Medicaid-to-Medicare fee reimbursement ratio was associated with a 0.78%-point increase in provider acceptance of Medicaid patients.[129]

Millbank stated that advancing the goal of health equity and improving access to care for Medicaid enrollees may require closing provider pay gaps that make Medicaid less attractive to providers.[130] One suggestion to improve care access was to increase Medicaid fees or benchmark Medicaid fees to Medicare where with such a rate increase, the supply of services to Medicaid could increase access and reduce health care disparities.

Other studies support an association between increased Medicaid provider rates and improved access to care. In 2019, the National Bureau of Economic Research assessed the impact of provider rates on adults covered by Medicaid and found that improvements in access to care can have large implications for disparities.[131] Compared to those who were privately insured, Medicaid-covered adults were twice as likely to report difficulties finding physicians willing to accept them as new patients. Medicaid-covered adults

---

126Medicaid and Racial Health Equity. 2022. Kaiser Family Foundation. **https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/**

[127] Breakdown by race/ethnicity: AI/AN: 33.5%, Asian/HOPI: 25.6%, Black: 28%, Hispanic: 38%, White: 17.8%. Adults Who Report Not Having a Personal Doctor/Health Care Provider by Race/Ethnicity. Kaiser Family Foundation. 2020. **https://www.kff.org/other/state-indicator/percent-of-adults-reporting-not-having-a-personal-doctor-by-raceethnicity/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D**

[128] The Physician Acceptance of New Medicaid Patients report by State Health Access Data Assistance Center (SHADAC) to the Medicaid and Chip Payment Access Commission (MACPAC) assessed state policies that could affect acceptance of new Medicaid patients. **https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf**

[129] After adjusting for state demographic characteristics.

[130] Allen H, Golberstein E, Bailey Z. Eliminating Health Disparities Will Require Looking at How Much and How Medicaid Pays Participating Providers. *Milbank Quarterly Opinion.* February 23, 2022. **https://www.milbank.org/quarterly/opinions/eliminating-health-disparities-will-require-looking-at-how-much-and-how-medicaid-pays-participating-providers/**

[131] Alexander, D. Schnell, M. National Bureau of Economic Research. 2019. The Impacts of Physician Payments on Patient Access, Use, and Health. Working Paper 26095. **https://www.nber.org/papers/w26095**

were also nearly three times as likely to report being in fair or poor health. The study found that Medicaid enrollees in states with larger increases in Medicaid provider payments saw greater improvements in access, frequency of office visits, and overall health. [132]

The study also assessed the impact of provider payments on children and found that Medicaid-covered children were twice as likely to be chronically absent from school.[133] However, improvements in health care access resulting from increased payments for physicians lead to improvements in both self-reported health and reductions in school absenteeism due to illness and injury.[134] Most school absences, particularly among young children, are attributable to acute conditions commonly treated in a primary care setting and school absenteeism may be responsive to changes in access to primary care.

Just as Medicaid enrollees may face barriers to accessing primary care due to low payment rates, the mental health system has struggled to meet the demand for services, particularly amid the COVID-19 pandemic and opioid crisis. Though Medicaid enrollees are more likely to experience mental health disorders compared to privately insured patients, [135] nearly a quarter of Washingtonians will struggle with mental health or addiction issues at some point in their lives. However, as of 2018, there was just one mental-health provider for every 360 residents.[136] Further, by county, the ratio of behavioral health providers ranges from one for every 262 people to 1 for every 3,378 people.

Despite state efforts to promote access to behavioral health providers and care, rates of mental illness and overdose deaths in Washington continue to rise. This is especially true for Medicaid enrollees who have higher overall prevalence of moderate to severe mental illness or substance use disorders (SUD).[137] Prior to the pandemic, of adults with any mental illness in Washington, 22.8% reported having Medicaid

---

[132] The study exploited large, exogenous changes in physician reimbursement rates for primary care visits under Medicaid and estimated that an increase in Medicaid payments of $35 (the median increase across states over the federally mandated primary care rate increase) reduced the probability that adult Medicaid beneficiaries were told that a physician was not accepting their insurance by 3.1%, or 38% of the mean. Increasing Medicaid payments by $35 increased the probability that Medicaid beneficiaries had an office visit in the past two weeks by 5% and increased the probability that they report being in excellent or very good health by 3.9%f. Ibid.

[133] Chronic absenteeism is linked to low academic achievement, including test scores, test score growth, and on-time graduation rates. Ibid.

[134] A $35 increase in Medicaid payments lead to an average reduction of 0.79 days missed per year due to illness or injury, or 22% of the mean, and reduced illness-related chronic absenteeism by nearly 50%. Ibid.

[135] Bergamo, C, MD. 2016. Association of Mental Health Disorders and Medicaid with Emergency Department Admissions for Ambulatory Care Sensitive Conditions **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4837066/#:~:text=Adult%20Medicaid%20enrollees%20are%20more,Care%20Sensitive%20Conditions%20(ACSC).**

[136] Access to Behavioral Health Providers. 2018. Department of Health. **https://doh.wa.gov/sites/default/files/legacy/Documents/1000//SHA-AccesstoBehavioralHealthProviders.pdf**

[137] At the national level as of 2020, an estimated 29% of Medicaid-enrolled non-elderly adults have a mental illness, compared to 21% of privately insured and 20% of uninsured people. Saunders, H. 2022. Demographics and Health Insurance Coverage of Nonelderly Adults with Mental Illness and Substance Use Disorders in 2020. **https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/#:~:text=Mental%20illness%20and%20substance%20use%20disorders%20are%20most%20prevalent%20among,and%2020%25%20of%20uninsured%20people**

coverage in the past year.[138] Additionally, compared to non-Medicaid covered individuals, Medicaid enrollees are approximately four times more likely to suffer a fatal overdose involving opioids.[139]

According to the CMS, states that expanded Medicaid have seen improved access to behavioral health and SUD. However, gains in insurance coverage under Medicaid expansion may not guarantee access to office-based treatment. Though a broad range of behavioral health and substance use services are covered under Medicaid, behavioral health providers, particularly specialists, accept Medicaid patients at significantly lower rates compared to Medicare and private insurance.[140]

In addition to low provider rates for primary care and mental health, dental provider rates, particularly for children's dental services, present a significant challenge for dental provider retention and dental providers' acceptance of new Medicaid patients. A study by the Center for Health Workforce Studies at the University of Washington examined Washington's oral health workforce and patient access to care.[141] This study found that only 28% of dentists enrolled in Medicaid were accepting new Medicaid patients. The study also found that recruiting and retaining dental providers to care for rural and underserved populations, including patients covered by Medicaid, was a persistent challenge due to low Medicaid reimbursement rates. However, dental providers reported that increased payment rates were one of the most important factors that would encourage them to care for patients covered under Medicaid.

Children from underserved groups, including populations that currently experience health disparities due to racial and structural inequalities, are at the greatest health risk if challenges in the recruitment and retention of Medicaid dental providers persist. The Arcora Foundation's September 2020 Access to Oral Health Dashboard showed that compared to White children, Hispanic and AI/AN and Pacific Islander children experience approximately 50% more cavities and more than twice the rate of rampant decay. Black/African American and Asian children also experience disproportionately higher rates of untreated tooth decay compared to White children. Additionally, compared to children from higher income households, children from low-income households are twice as likely to suffer untreated tooth decay. Retention of pediatric dental providers is critical to ensuring access to dental care for Medicaid-eligible children.

State and federal efforts have aimed to address access issues and workforce shortages in behavioral health and primary care, and recently in Washington, dental services, especially during the COVID-19 pandemic. However, short-term investments such as one-time payment increases have been shown not to improve provider participation in Medicaid or improve access for patients. Securing permanent rate increases for primary care, behavioral health, and dental providers may be an impactful step to improving

---

[138] Access to Behavioral Health Providers. 2018. Department of Health. **https://doh.wa.gov/sites/default/files/legacy/Documents/1000//SHA-AccesstoBehavioralHealthProviders.pdf**

[139] Among Washington Medicaid enrollees with only SUD and enrollees with both mental health service needs and SUD, there was also a significant increase in heroin overdose deaths. Among all individuals who died from drug overdose between 2006 – 2012 in Washington, 35% were enrolled in Medicaid at some point in the 12 months before death. Xing, J., PhD. 2015. Overdose Deaths among Medicaid Enrollees in Washington State - The Role of Behavioral Health Needs. **https://www.dshs.wa.gov/sites/default/files/rda/reports/research-4-92.pdf.**

[140] Senate Bill 5693 allotted funds to implement a 7% increase to Medicaid reimbursement specifically for community behavioral health providers contracted through managed care organizations (MCOs) to be effective January 1, 2023.

[141] The study used a 2016 provider survey based on 2015 data using information gathered from key informants, Washington licensure data, and surveys of dentists, family physicians, and pediatricians Assessing the Impact of Washington State's Oral Health Workforce on Patient Access to Care. 2017. Center for Health Workforce Studies. University of Washington.

access to care and health equity for Medicaid enrollees in the current system, as well as in the transition to a universal health care system.

Legislative efforts to increase Medicaid provider rates

Washington aims to continue to improve the Medicaid program by improving access to care and improving provider participation in the Medicaid program. Though Medicaid provider rates have largely stagnated for over ten years, several pieces of legislation recently passed that increased provider payment rates for certain services in order to increase access to care for Medicaid enrollees. The next section will highlight some of the recent legislative efforts to increase Medicaid payment rates.

Pediatric primary care reimbursement enhancement, 2018

As stated previously, the ACA provided for an increase in Medicaid provider rates to Medicare rates for certain providers (2013 and 2014). In Washington, evaluation and management (E&M) services and vaccines for Medicaid covered children were codes for which providers could receive enhanced rates during this period.[142] In the years since, the Washington State Legislature tried to increase reimbursement for the same codes, but such an effort was considered too costly and was not funded until 2018.

Finally, Engrossed Second Substitute Senate Bill 6032 (Operating Budget, 2018) appropriated funds for the HCA to increase primary care provider rates for pediatric E&M and vaccine services.[143] These enhanced rates would match the rates under the ACA temporary rate enhancement.

HCA provided a report to the Governor and the Legislature in November 2019, in response to the requirements in ESSB 6032, which detailed the following:

1. How the funds were used to increase provider rates.
2. What percentage increase was provided for pediatric primary care provider evaluation and management (E&M) rates.
3. What percentage increase was provided for pediatric vaccine rates.
4. How utilization changed within each category.
5. How rate increases impacted access to care.

There was difficulty in trying to assess the impact of this rate increase on E&M and vaccination services in the short reporting period. While the utilization of E&M and vaccination services did not seem positively impacted, it was difficult to conclude what effect the rate increase may have had if the number of children in the caseload remained more stable, and if this was a sufficient enough rate increase to stimulate better utilization of these services. The correlating decrease in the number of children in the caseload masked

[142] There are some codes for evaluation and management visits for children ages 19-20 that were not covered under the enhanced rates, though these codes are already reimbursed between 80-83% of Medicare. The E&M codes 99201-99215 are for office visits only and must be billed for professional providers such as physicians (or nursing staff under a physician's supervision), Advanced Registered Nurse Practitioners (ARNPs), and Physician Assistants (PAs).
[143] The enhanced rates began October 1, 2018.

the opportunity to reach any compelling conclusions about how utilization was impacted. [144] It was determined that a longer evaluation period would be required to further assess the impact on the utilization of these services.

Primary care access study, 2018

ESSB 6032 also tasked HCA with coordinating a study and subsequent report to the Legislature due December 2018, to identify strategies and provide recommendations for enhancing access to primary care for Medicaid enrollees. The study was to the extent possible:

1) Review the effect of the ACA temporary rate increase on:
    a. The number of providers serving medical assistance clients.
    b. The number of medical assistance clients receiving services.
    c. Utilization of primary care services.
2) Identify client barriers to accessing primary care services.
3) Identify provider barriers to accepting medical assistance clients.
4) Identify strategies for incentivizing providers to accept more medical assistance clients.
5) Prioritize areas for investment that are likely to have the most impact on increasing access to care.
6) Strategically review the current Medicaid rates and identify specific areas and amounts that may promote access to care.

HCA analyzed changes in access to primary care for Medicaid enrollees between 2012 and 2017. Data was used from 2012 (before the passage of the ACA), 2013 and 2014 (the years that the Medicaid reimbursement rate increased), and 2015 to 2017 (when reimbursement rates returned to pre-ACA levels).[145] Between 2012 and 2017, the 30% increase in primary care providers was outpaced by a 50% increase in Medicaid enrollment. Despite growth in the number of Medicaid providers during this period, declining Healthcare Effectiveness Data and Information Set (HEDIS)[146] and Consumer Assessment of Healthcare Providers and Systems (CAHPS)[147] performance illustrated a negative impact on members' timely and needed access to care.

Providers reported the following as primary barriers to Medicaid participation:

- Payment rates have not kept pace with increasing costs of services.
- Administrative complexity in clinical criteria, claims submission, and payment.
- Challenges in meeting members' complex needs and time requirements.

---

[144] During this reporting period, the number of children ages 0-20 years in the case load dropped by 1.4%. The majority of this reduction was in the 0 to 6 age group. This is notable this is the age when children receive the most E&M and vaccination services, and this change in caseload numbers likely contributed to the decrease in utilization of E&M visit codes and vaccinations administered.

[145] HCA Report to the Legislature. December 1, 2028. Enhancement of Primary Care Access for Medical Assistance Clients Engrossed Substitute Senate Bill 6032, Section 213(eee); Chapter 299; Laws of 2018. **https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=HCA%20Report%20-%20Enhancement%20of%20Primary%20Care%20Access%20for%20Medical%20Assistance%20C..__b77842c4-60b1-4c74-8c97-8f2b355d60a9.pdf**

[146] Performance on 2017 HEDIS adult access to care measure results were at the 40th percent of MCO performance nationwide.

[147] 2017 CAHPS measured results for "Getting Needed Care and Getting Needed Care Quickly" and were at the 20th percent of MCO performance nationwide.

Rate increases remain an important strategy to improving provider participation in Medicaid, particularly in primary care where reimbursement is lower than for specialty care. Further, primary care providers report that in addition to positively impacting access to care for new and current Medicaid enrollees, rate increases are the most successful strategy to encourage providers' willingness to participate in Medicaid. Based on these findings, the following recommendations were provided to the Legislature:

1) Increase primary care rates.
2) Explore opportunities to improve timely primary care provider payment.
3) Streamline the administrative process.
4) Identify options to reduce the financial risk of value-based payment arrangements for primary care providers and critical access services in underserved and rural areas.

Primary care and behavioral health reimbursement enhancement, 2021-2023

The Operating Budget for the 2021-2023 biennium (Engrossed Substitute Senate Bill 5092) allotted funds for Fiscal Years 2022 and 2023 for HCA to implement enhanced Medicaid reimbursement rates in an effort to maintain and increase access for primary care services for Medicaid-enrolled patients. The rate increases apply to both FFS and managed care and are consistent with the temporary rate increase provided under the ACA in 2013 and 2014. The statute directs that:

1) Medicaid payments for adult primary care services be at least 15% above rates that were in effect on January 1, 2019.
2) Medicaid payments for pediatric primary care services be at least 21% above rates that were in effect on January 1, 2019.
3) Medicaid payments for pediatric critical care, neonatal critical care, and neonatal intensive care services be at least 21% above rates that were in effect on January 1, 2019.
4) Certain family planning codes at Title X clinics be increased by at least 162%.
5) A 2% increase for all services paid through the behavioral health portion of managed care capitation rates relative to the reimbursement levels in place as of April 1, 2021. [148]

Rate enhancement for behavioral health, 2021-2023 supplemental operating appropriations (2022)

Engrossed Substitute Senate Bill 5693 allotted funds to implement a 7% increase to Medicaid reimbursement for community behavioral health providers contracted through managed care organizations (MCOs) to be effective January 1, 2023. [149] The rate increase must be implemented to all

[148] *MCO contract subsection 5.20.5: The Contractor will increase provider reimbursement rates by two 2 percent effective April 1, 2021, for providers that deliver contracted Behavioral Health services as described in subsections 17.1.2, 17.1.4.3, 17.1.4.4, 17.1.4.5, 17.1.4.6, 17.1.14, 17.1.15, 17.1.16, 17.1.41, and 17.1.42 of the contract. The Contractor will pay providers that provide Behavioral Health services to patients in primary care settings at a rate no less than those published by HCA for its FFS Mental Health and Psychology Services. The Contractor will also pay providers that provide the following services at a rate no less than those published by HCA for its FFS Physicians Services: 90832, 90833, 90834, 90837, H0004, H0036, H2015, H2021, H0023, 90836, 90838, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171, 90845, 90846, 90847, 90849, 90853, 90785, 90791.*

[149] Engrossed Substitute Senate Bill 5693. 2022. Section 215(58) **https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Passed%20Legislature/5693-S.PL.pdf?q=20220311101341**

behavioral health inpatient, residential, and outpatient providers contracted through the Medicaid MCOs. HCA must employ mechanisms such as directed payment or other options allowable under federal Medicaid law to ensure the funding is used by the MCOs for a 7% provider rate increase as intended and verify this pursuant to the process established in chapter 285, Laws of 2020 (EHB 2584).[150]

Rate enhancement for adult dental services, 2021-2023 operating appropriations and supplemental operating appropriations (2022)

Engrossed Substitute Senate Bill 5092 allotted funds to maintain and increase access to adult dental services under FFS Medicaid up to 100% above existing Medicaid rates beginning July 1, 2021. [151] The 2022 supplemental operating budget continued to fund these rate enhancements.[152] To implement these rate increases, the legislature designated $10,695,000 of the General Fund—State (GF-S) for fiscal year 2022, and $10,695,000 GF-S for fiscal year 2023, and $54,656,000 of the General Fund—Federal (GF-F).

Rate enhancement for children's dental services, 2021-2023 supplemental operating appropriations (2022)

The rate enhancements allotted only for adult dental services in the 2021 operating budget (ESSB 5092) highlighted the differences in payment for children compared to adults. For example, FFS rates for children's dental procedures had not changed since 2009. The costs of technology for some procedures exceeded provider rates which further decreased dental providers' willingness to serve children enrolled in Medicaid. For the 2022 legislative session, the Arcora Foundation advocated to increase all children's dental rates. During the same session, HCA also submitted a Decision Package to increase reimbursement rates to parity with adult rates for diagnostic and preventive dental procedures.[153] The 2022 supplemental operating budget (ESSB 5693[154]) allotted $10,406,000 GF-S and $10,715,000 GF-F to maintain and increase access for children's dental services under FFS Medicaid beginning January 1, 2023, as follows:

- Increase the rates for codes for the access to baby and child dentistry (ABCD) program by 40 percent.
- Increase the rates for codes for children's dental program rates for individuals aged 0-20 years that have a corresponding ABCD code to the current ABCD code rate, plus an additional 10 percent rate increase.
- Increase the rates for codes for children's dental program rates for individuals aged 0-20 years without a corresponding ABCD code to 70 percent of the Medicaid FFS rates for adult dental services in effect on January 1, 2022.

---

[150] Engrossed House Bill 2584. 2020 **https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/2584.SL.pdf?q=20220405103230**

[151] All but two adult dental codes received rate enhancements, including D1516 and D1517. Engrossed Substitute Senate Bill 5092. 2021. **https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Passed%20Legislature/5693-S.PL.pdf?q=20220311101341**

[152] Engrossed Substitute Senate Bill 5693. 2022. **https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5693-S.SL.pdf?q=20220830154538**

[153] The set of diagnostic codes involve x-rays to help compensate for the expense of technology that is now standard of care for taking x-rays. Another set of codes are preventive which will incentivize providers to do more preventive care.

[154] Engrossed Substitute Senate Bill 5693. 2022. **https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Passed%20Legislature/5693-S.PL.pdf?q=20220311101341**

- This increase does not apply to codes with rates already greater than 70 percent of the adult dental services rate.

Payment rate modeling

As directed by the legislature in 2022, HCA analyzed the fiscal impact of raising Medicaid rates to 80% of Medicare. Due to previous analyses of the impact of increased rates on provider participation, there is an expectation that access to care and utilization would increase as a result of a rate increase. While it may initially seem relatively simple to increase Medicaid provider rates to a percentage of Medicare rates, there is great complexity and difficulty in matching rates due to the difference in the respective payers' case mix[155], as well as differences in payment methodology.[156] Additionally, several services provided under Washington's Medicaid do not have Medicare equivalent rates, which can range from a few codes in a program, to an entire program.[157]

Methodology

The analysis did not include Medicaid services provided by State agencies other than HCA. [158] Expenditure amounts were based on Fiscal Year 2023 projected costs.[159] The report estimated the average ratio of FFS Medicaid rates to Medicare rates in Washington's Medicaid program to be 71%, which was assumed a reasonable approximation for this high-level estimate. [160]

Findings

The analysis found that the total fiscal impact for State Fiscal Year 2023 to increase physical health services rates only, with some exclusions to 80% of what Medicare pays would be approximately $864 million. [161] The GF-S portion of the cost impact is about $271 million.

Potential legislative pathways

As demonstrated by the results of HCA's financial modeling, the costs associated with increasing Medicaid rates for most physical health services, excluding including dental, long-term care, or behavioral health

[155] Case mix is a measure used by the Centers for Medicare and Medicaid Services (CMS) to determine hospital reimbursement rates for Medicare and Medicaid enrollees and reflects the diversity, complexity, and severity of patient illnesses treated.
[156]Though Medicare providers must stay within payment rates under the CMS physician fee schedule, each provider has their own rate based on their cost of providing care.
[157]Hospitals are paid differently in Medicare than Medicaid. Medicare uses Medicare Diagnosis Related Groups (MS-DRG), which provides a means of relating a hospital's patient case mix to the costs incurred by the hospital. Medicaid uses All Patient Refined – Diagnosis Related Groups (APR-DRG), which expands the basic DRG structure, but also address patient differences relating to severity of illness and risk of mortality in addition to resource utilization. For facility outpatient services, Medicare uses Ambulatory Patient Classifications (APCs), whereas Medicaid uses the Enhanced Ambulatory Patient Group (EAPG). Changes to rates would reportedly affect supplemental payments received by hospitals currently.
[158] The analysis did not include the amounts spent on services provided to Medicaid enrollees by the Department of Social and Human Services (DSHS) or the Department of Corrections (DOC), for example, long-term care services provided by DSHS.
[159] Health Care Authority. Financial Services Division. February 2022 Expenditure Forecast, version D05 M01.
[160] The ratio of FFS Medicaid to Medicare was based on a 2016 report published by the Kaiser Family Foundation.
[161] The following forecast services were excluded: Pharmacy related forecast services; Dental Services; Durable Medical Equipment; Transportation Services. Community Behavioral Health (CBH) services were excluded from this analysis because many of these services are not currently covered by Medicare. Medicaid payment rates are often higher than Medicare for those outpatient behavioral health services that are covered by both payers.

services, covered by Medicare to 80% of Medicare would cost the state an additional $271 million GF-S per year.[162][163]

Efforts aimed to improve provider payment equity as well as access to care for Medicaid enrollees require a long-term strategic approach. Research shows that temporary rate increases do not translate to improved provider participation in Medicaid or improved access to care. Additionally, attracting more providers to the Medicaid program may require both payment rate increases and administrative simplification.

The Commission recognizes the difficulty in implementing increased Medicaid payment rates across the board for all providers and services. However, it may be more feasible to remain consistent with the Legislature's selected areas of focus over the past several years to develop approaches to achieving the long-term goal of increasing Medicaid payment rates that are 80% of Medicare, such as increasing adult primary care, behavioral health, and dental rates.

Continue enhancing primary care by increasing adult primary care rates to match pediatric primary care rates

Primary care emphasizes health promotion and prevention and is proven to be an equitable, cost-effective, and efficient approach to improve mental and physical health as well as social well-being.[164] The goals of primary care also align with those of universal health coverage to ensure equitable access to affordable, high-quality care for everyone. However, primary care is drastically underfunded in the United States, limiting the potential of primary care to achieve cost savings and quality improvements.

In Washington, Medicaid rates for pediatric primary care services under both FFS and managed care currently average 83% of Medicare.[165] However, adult primary care rates for the same services average just 67% of Medicare. Payment rates that differ depending on a patient's age necessitate having two different provider fee schedules, often leading to confusion for providers as well as administrative complexity and waste.

Increasing rates for adult primary care to match the rates for pediatric primary care would ensure that all primary care rates average at least 80% of Medicare. However, it is important to secure permanent rate increases for these important services, as research shows that temporary rate increases have not translated to improved provider participation in Medicaid or improved access to care for Medicaid enrollees.

Equalizing rates for adult and pediatric primary care aligns with the goals of a universal health care system in two ways. First, this streamlines health care administrative processes and reduces administrative waste. Equalizing rates will eliminate need for two separate provider fee schedules, which may reduce administrative costs, complexity, and waste, and may help to avoid confusion for providers. This may also

[162] The financial analysis provides the estimated cost impact of increasing provider payment rates for services also covered by Medicare and does not account for any impact from rate increases for the excluded services.
[163] It is unknown what savings will be generated. Research has demonstrated that permanently increasing Medicaid rates will likely improve physicians' participation in Medicaid which may improve access to care, reduce health disparities for lower-income individuals.
[164] Primary Health Care. World Health Organization. **https://www.who.int/news-room/fact-sheets/detail/primary-health-care**
[165] HCA estimated rates.

increase the likelihood that more primary care providers will participate in Medicaid, as providers cite administrative complexity, as well as low payment rates, as barriers to their participation. Second, increased primary care provider rates may improve health equity for patients. With permanent rate enhancements for these important services, providers may be more likely to accept new and continue to care for established Medicaid patients, likely improving access, and potentially health outcomes, for Medicaid enrollees. ***Estimates pending**[166]

Continue advancing access to behavioral health services by increasing behavioral health rates for services not included in recent legislative rate enhancements

Washington's mental health system has struggled to meet the demand for services, particularly amid the COVID-19 pandemic and opioid crisis. Despite recent state efforts to promote access to behavioral health providers and care, rates of mental illness and overdose deaths continue to rise.

Though behavioral health and mental health rates were recently enhanced by the Legislature, some services were not included in the rate enhancements. For instance, the Applied Behavior Analysis (ABA) program is a covered benefit for Medicaid clients diagnosed with Autism Spectrum Disorder (ASD). However, the ABA program was not included in the recent legislative rate enhancements and rates have not been increased for these services for some time.

While the Legislature also recently increased managed care rates, FFS behavioral health services were not included in rate increases.[167] Matching Medicaid FFS behavioral health rates to managed care rates aligns with the goals of a universal health care system by reducing barriers to provider participation in Medicaid and increasing the likelihood that providers will not choose to provide services to managed care enrollees over individuals enrolled in Medicaid FFS. Providing parity between FFS and managed care behavioral health services may increase equitable access to services for Medicaid enrollees and advance the goals of a universal health care system. With permanent rate enhancements for these important services, providers may be more likely to accept new Medicaid patients, likely improving access, and potentially health outcomes, for Medicaid enrollees. ***Estimates pending**[168]

Continue enhancing dental care by increasing dental rates

The Commission supports the Legislature's recent efforts to increase Medicaid dental rates for both children and adults in order to maintain and increase access to dental services. The Commission also supports continuing the pathway to increasing children's dental rates across all codes and ensuring that both adult and children's dental rates are sufficient to increase provider participation.

---

[166] Estimates from this analysis may be available by the time the Commission votes on the final report. If these estimates are not available by this time, it will be noted in the final report that estimates are forthcoming.

[167] Fee-for-service behavioral health care rates for higher acuity care.

[168] Estimates from this analysis may be available by the time the Commission votes on the final report. If these estimates are not available by this time, it will be noted in the final report that estimates are forthcoming.

Summary

The COVID-19 pandemic exposed health and health care disparities stemming from past and enduring inequitable policies and practices within and external to the health care system. Enhanced federal Medicaid funding and enrollment protections under the PHE have helped to improve access to care by expanding and protecting Medicaid coverage and reducing the number of uninsured people in Washington. Improving access to primary care and behavioral health services are particularly important to building upon this coverage expansion, improving health equity, and laying a foundation for universal health coverage.

The Legislature recently targeted Medicaid adult and pediatric primary care, behavioral health managed care, and dental services for enhanced payment rates to increase provider participation and improve access to care. This has been a successful strategy and continuing these efforts may be an interim pathway toward increasing all rates. Building upon the Legislature's strategy to prioritize primary care, behavioral health, and dental services by providing ongoing funding for rate increases may be an impactful strategy to improve access to care and health equity for individuals and families covered under Medicaid.

Section 6: Transitional solutions

Introduction

Implementing a universal health care system is a long-term strategy for providing universal access to affordable and quality health care. The previous sections of this report primarily focused on universal health care which described the core design elements and key considerations for their development and implementation. The Commission is also charged with developing intermediate recommendations for coverage expansion consistent with the goals of the universal health care system.

While Washington has made significant gains in reducing rates of uninsured people, approximately 4.7 percent of the population remains without coverage as indicated in the most recently available data from OFM. Notably, this does not capture the number of Washingtonians who are considered "underinsured" meaning that, "their insurance did not adequately protect them against catastrophic health care expenses".[169] Furthermore, disparities in coverage persist, particularly among Hispanic populations. As described in the first section of this report, Washington has already undertaken significant efforts and initiatives to expand access to coverage and improve the quality and affordability of health care for Washingtonians. This section incorporates those efforts and options for transitional improvements to the health care system.

[169] "Insured But Not Protected: How Many Adults Are Underinsured." https://www.commonwealthfund.org/publications/journal-article/2005/jun/insured-not-protected-how-many-adults-are-underinsured.

This section also outlines a set of options that may expand coverage and improve the quality and affordability of health care in Washington. These options include:

- Supporting new coverage solutions for individuals without federally recognized immigration status,
- Implementing the Cascade Care Savings program,
- Further aligning public coverage programs,
- Establishing a broader set of health care cost targets,
- Implementing the Integrated Eligibility and Enrollment Modernization Roadmap, and
- Examining other transitional activities for alignment across coverage markets as to simplify administration and potentially reduce costs.

These options may also serve to lay a foundation for future efforts to establish the universal health care system and assist with short-term goals to improve the current health care system by increasing access and affordability.

Options for expansion of coverage and subsidy programs

Currently, the uninsured population in Washington includes individuals who are prohibited from purchasing or enrolling in coverage options because of their immigration status, as well as individuals for whom current coverage options are unaffordable. Efforts to expand coverage to these groups are currently in development in Washington.

Coverage solution for individuals without federally recognized immigration status

Under the ACA, only lawfully present immigrants can enroll in a QHP. For those individuals who are not eligible to purchase QHPs, limited coverage programs are currently available (e.g., Apple Health is available for children and pregnant individuals and emergency medical coverage is available for individuals with qualifying medical conditions). However, Washington has made significant progress in creating a program to cover individuals without federally recognized immigration status.

In May 2022, HBE and HCA applied for a 1332 Waiver to allow individuals without federally recognized immigration status to purchase QHPs on the Exchange without federal subsidies. Additionally, to further support the affordability of QHPs, Cascade Care Savings will provide state-based subsidies for individuals earning under 250% FPL who purchase Silver or Gold standard plans regardless of their immigration status.

In 2022, legislation passed and dollars were allocated authorizing HCA to develop a coverage program to provide Medicaid look-alike coverage for individuals without federally recognized immigration status earning under 137% FPL. This coverage will be available in 2024 and will expand upon the current coverage options available for this historically underserved and underinsured group. Together, these changes would ensure that virtually all Washingtonians will be eligible for a coverage option regardless of immigration status with fully or partially subsidized coverage for lower-income individuals. While the Legislature has designated resources to design and build the program, resources have not yet been allocated to pay for the coverage itself.

Cascade Care Savings

Federal premium assistance for ACA Marketplace enrollees has been one of the primary strategies for increasing enrollment and expanding coverage through the federal and state-based marketplaces. The 2021 authorizing legislation directed the Exchange to establish Cascade Care Savings, a state premium

assistance program that will begin providing financial assistance in 2023 to Washingtonians with incomes under 250% FPL purchasing a standardized health plan on Washington Healthplanfinder. The legislation appropriated $50 million in funding to subsidize premiums. Subsequently, an additional $5 million was appropriated to subsidize individuals not eligible for federal subsidies.

Options for Improving Affordability

Universal coverage and access are the primary goal of the universal health care system. As part of this goal, the Commission has discussed the need to address and support underinsured populations as the state progresses toward a universal health care system. Reducing underinsurance includes ensuring that affordable coverage meets the health and wellness needs of covered individuals. It also means that services are delivered equitably. In its future work, the Commission will continue to consider short-term options for reducing underinsurance in Washington as a critical step toward universal health care.

It is also important to recognize a critical step to reducing underinsurance is improving the affordability of existing coverage programs. The Commission has considered initial transitional solutions that advance affordability of existing coverage programs and build capabilities that can be leveraged in the future universal healthcare system.

Further Align Public Coverage Programs

As described in Section 1 of this report, Washington has several coverage programs that finance care for a significant portion of Washingtonians, including Apple Health, PEBB, SEBB, and Cascade Care. Each program has a unique design to serve the specific needs of the eligible population as well as to meet federal and state requirements. However, the programs also have many common functions that overlap with core design elements of a universal health care system as described in Section 3 and Section 4 of this report. At the same time, each program manages these functions in slightly different ways either by directly performing, procuring, or delegating to health plans for eligibility and enrollment, provider reimbursement, cost or utilization management, and quality improvement.

Currently, some of these functions align across programs. For example, several programs, including Apple Health and Cascade Care, utilize measures for the Statewide Common Measure Set to help manage quality of care delivered and track health plan performance.[170] As an example of a common plan and benefit design, both the PEBB and SEBB programs utilize the Uniform Medical Plan (UMP), a self-insured plan managed by HCA.[171] This results in same benefits and networks available to employees served by both programs.

Continuing to align coverage programs may

- Help to ensure consistent, equitable and quality coverage across programs,
- Reduce per beneficiary administrative costs for shared functions,
- Enhance the purchasing power of the state when services are jointly purchased across programs, and

[170] Washington Health Care Authority, Statewide Common Measure Set. https://www.hca.wa.gov/about-hca/washington-statewide-common-measure-set#what-is-statewide-common-measure-set

[171] Washington Health Care Authority, Uniform Medical Plan. https://www.hca.wa.gov/about-hca/uniform-medical-plan-ump

- Make it easier for third-party vendors or health plans to participate in multiple coverage programs.

Alignment also simplifies the consolidation of design elements as the state progresses toward implementing a universal health care system.

Use ongoing cost analyses to establish health care cost targets

Section 1 described recent initiatives Washington has undertaken to analyze health care cost drivers including HCCTB, PDPTP, PDAB, Value-Based Purchasing, and the OIC's Report on Prior Authorization. While each of these initiatives has a different charge or purpose, they represent a growing analytic capacity within the state to identify costs across payers and to set costs targets.

In particular, the work and scope of authorities of HCCTB and PDAB could have the ability to analyze a broader range of health care costs and set targets for growth in health care costs in aggregate and per service or of drug prices. Cost growth targets can establish an analytic foundation for key design elements of a unified health care financing system. For example, as cost targets are developed, these can be used to set fee schedules or for developing value-based arrangements for providers participating in coverage programs. As an initial step, Washington could explore how to leverage the work of cost transparency initiatives such as HCCTB can be used to develop a broader set of health care cost targets.

Implement the Integrated Eligibility and Enrollment Modernization Roadmap

In 2021, Washington established the Health and Human Services Enterprise Coalition to review the patchwork of eligibility and enrollment technology platforms that serve the 75 health and human services programs administered by the state.[172] The coalition developed the Integrated Eligibility and Enrollment Modernization Roadmap. This five-year roadmap for implementing an integrated eligibility and enrollment platform in Washington would allow Washingtonians to apply to all available programs in a single streamlined application, receive support through multiple channels, and provide a single eligibility record.[173]

Implementing an integrated platform would support an important infrastructure need for a universal health care system. As a short-term step toward universal health care, it can also make it easier for Washingtonians to apply for coverage and receive financial assistance and other supports for which they are eligible while potentially reducing overall administrative costs. Implementing the Integrated Eligibility and Enrollment Modernization Roadmap may support short-term coverage goals as well as build necessary long-term infrastructure.

---

[172] Engrossed Substitute Senate Bill 5092. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5092-S.sl.pdf

[173] Integrated Eligibility and Enrollment Modernization Roadmap. https://www.wahealthplanfinder.org/content/dam/wahbe-assets/legislation/WA%20IEE%20Modernization%20Roadmap%20Report.pdf

Examining other transitional activities

The Commission will consider transitional activities related to effectiveness of services, utilization management and payment methodologies. This research could inform possible additional transition steps to be taken with respect to current programs. The following are some examples for further consideration: the Bree Collaborative, the Health Technology Assessment Program, administrative simplification across payers, and value-based payment.

Summary

The options discussed in this section could be initiated in parallel to the universal health care planning and development efforts of the Commission. Some options have potential to advance important capabilities that will be necessary for implementing a universal health care system. These transitional, short-term opportunities could expand or improve coverage within the current health care system while aligning with the core principles of universal health care.

Section 7: Finance

Background

In their 2021 report to the legislature, the UHC Work Group noted that the health care system's current financing model has grown increasingly costly and fragmented with no governance structure. Further, pricing of health care products and services is not transparent, and prices for prescription drug and hospital prices can exceed the rate of inflation.

Though Washington continues to make payment and purchasing reform efforts, the current system's increasing annual costs outpace wages and the rate of inflation, which widens gaps in access to health coverage and care. Multiple economic analyses, including analysis conducted by the UHC Work Group, demonstrate that a universal system can improve health equity and access to care, decrease costs, and produce billions in savings per year, all while providing universal coverage to residents.[174]

As described in earlier sections, the UHC Work Group developed three universal health care models through which Washington state could achieve universal coverage. These universal coverage models will be considered including Model A and Model B, as well as unified financing models utilized in other countries, to develop the right approach for Washington. The unified health care financing system will be dependent on the universal health care model developed for implementation. Further, transitioning the state to a unified financing system is dependent on foundational programmatic, legal and financial changes and is contingent upon approval from the federal government.

[174] Senate Bill 5399 **https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Passed%20Legislature/5399-S2.PL.pdf?q=20220223093553**

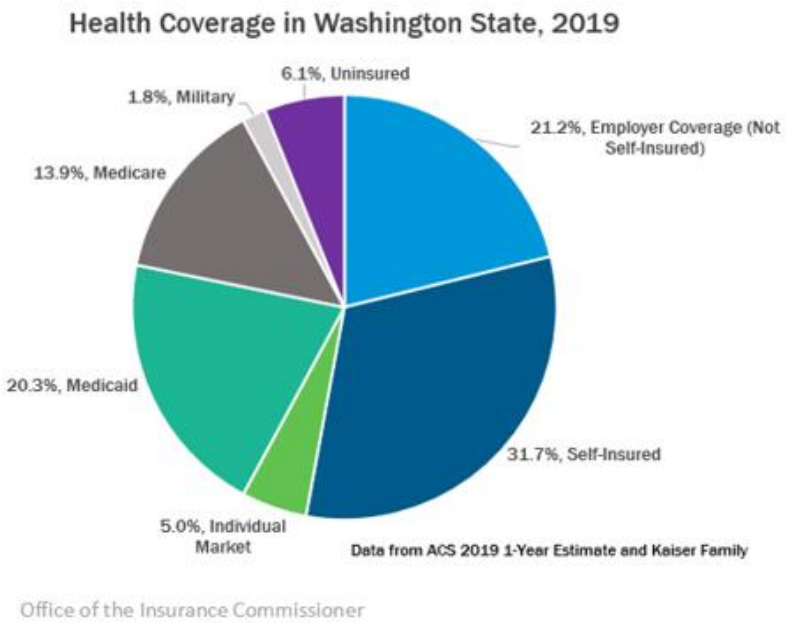
There are multiple sources of funding for health care services in Washington and there are many challenges associated with pooling those funding sources to finance a universal health care system. This section of the report will outline other potential financing considerations which may help inform the design of Washington's unified health care financing system.

This section also will summarize the financing landscape of the current health care system and will provide a brief overview of single-payer models in other countries, including the role of government and how universal coverage is financed. Several financing models will be outlined that may inform Washington's unified health care financing system, including: 1) a universal purchasing program currently used in Washington, 2) all-payer rate setting and global budgets used in the state of Maryland, and 3) evaluations of single-payer proposals by other states. Finally, the Commission recognizes that the subject matter expertise of a finance committee will be essential to informing their planning and decision making. As such, the Commission is in the process of creating a finance technical advisory committee to explore the various barriers and solutions to implementing a sustainable and equitable unified financing system in Washington.

Current health care financing landscape

The U.S. health care system funds and delivers care through a mix of public and private insurers and health care providers (See Table 8). Employer-sponsored insurance, including self-insured and fully-insured employers, is the dominant form of coverage in Washington,[175] followed by Medicaid and Medicare.

Table 8



Health care systems

The following section will outline components of the publicly funded health care system, including governmental insurance programs and other health systems, including Medicaid, Medicare, Indian Health Services, and the VHA.

Medicaid financial overview

The Medicaid program is administered by states and the CMS and is jointly funded by states and the federal government. The federal government pays states a Federal Medical Assistance

175 Pre-COVID-19 pandemic estimate. Health Insurance Coverage of the Total Population 2020. Kaiser Family Foundation. **https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D**

Percentage (FMAP) for qualified Medicaid expenditures. FMAP rates are based on each state's per capita income and range from a statutory minimum of 50% to a statutory maximum of 83%.[176] In Washington State, the FMAP is 50% (which was temporarily increased to 56.2% during the COVID-19 PHE declaration).[177]

States have some flexibility in deciding how to fund their share of Medicaid expenditures. Washington uses state general and other funds to cover the non-federal share of Medicaid funding. [178] In 2020, Medicaid accounted for 25% of the state's total budget. [179]

Medicare financial overview

Medicare is funded solely by the federal government through two Medicare designated trust fund accounts. The Hospital Insurance (HI) Trust Fund covers Medicare Part A (hospital insurance) and is funded through payroll taxes, interest earned on trust fund investments, Social Security taxes, and Medicare Part A premiums.[180] The Supplementary Medical Insurance (SMI) Trust Fund covers Medicare Parts B (medical insurance) and D (drug coverage), and Medicare Program administration. The SMI is funded through enrollee premiums and interest earned on trust fund investments. The Medicare employment tax paid by employers and employees also supports federal funding for Medicare. Payment policies and provider payment rates are set by CMS.

Indian Health Services

AI/AN individuals are eligible to participate in all public, private, and state health programs and have treaty rights to federal health care services though the Department of Health and Human Services (HHS).[181] The Indian Health Service (IHS) is a division operating within HHS through which funding flows for a system of health services programs and facilities to IHS eligible users as defined in the Indian Health Care Improvement Act. Tribal Governments have a government-to-government relationship with the federal government.[182] IHS funding is an appropriation and is not mandatory funding. Once funds for a given year are expended, there are no additional funds available. Due to chronic underfunding of IHS programs and services, Indian Health Care Providers rely on revenues from third-party billing, including Medicaid, Medicare, and private insurance to keep their clinics and health programs operating. Access to care can vary depending

---

[176]Matching Rates. CMS. **https://www.macpac.gov/subtopic/matching-rates/**

[177]Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, 2022. Kaiser Family Foundation. **https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D**

[178] Other state funds and revenue sources can include local funds and provider taxes (as defined by the Centers for Medicare and Medicaid Services). Congressional Research Service. Medicaid Financing and Expenditures. 2020. **https://sgp.fas.org/crs/misc/R42640.pdf**

[179] Medicaid Expenditures as a Percent of Total State Expenditures by Fund. 2020. Kaiser Family Foundation. **https://www.kff.org/medicaid/state-indicator/medicaid-expenditures-as-a-percent-of-total-state-expenditures-by-fund/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D**

[180] Premiums apply only to individuals who are not eligible for premium-free Medicare Part A. Centers for Medicare and Medicaid Services. Original Medicare (Part A and B) Eligibility and Enrollment **https://www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol**

[181] As required by law under 42 CFR 136.61 **https://www.govregs.com/regulations/title42_chapterI_part136_subpartG_section136.61**

[182]The federal government's provision of health services is derived from federal statutes, treaties, court decisions, executive actions, and the Constitution. Congressional Research Service. 2016. The Indian Health Service (IHS): An Overview. **https://crsreports.congress.gov/product/pdf/R/R43330**

on patients' geographical location, where patients often must travel a long distance to receive services.[183]

Military health care

Veteran's Health Administration

The Department of Veterans Affairs oversees the Veteran's Health Administration (VHA) which is the largest integrated health system in the US and covers only veterans.[184] The VHA is funded through general taxation as well as through appropriations by Congress. The federal government sets provider rates and negotiates drug prices. Veterans have little to no out-of-pocket costs for services and prescription drugs. Like IHS, access to care can vary depending on patients' geographical location.

TRICARE

TRICARE is a civilian network that provides health care benefits to active-duty service members, including National Guard and Reserve members and their families. TRICARE is administered by the US Department of Defense and is funded through general taxation and appropriations by Congress.[185] TRICARE enrollees have little to no out-of-pocket costs for services and prescription drugs.

Private health care

As described in earlier sections, the majority of insured Americans receive health care coverage through private insurance. The private insurance market includes the group market (including large and small group) and the individual market. The group market is primarily made up of employer-sponsored insurance. The individual market includes health plans purchased directly from a private health carrier. The following section will outline components of the private health insurance market.

Employer sponsored

The ACA requires employers with fifty or more full-time equivalent employees to provide health coverage to at least 95% of its full-time employees and their dependents and that coverage must meet minimum affordability and value standards. Employers in noncompliance are issued fines and penalties by the Internal Revenue Service (IRS).

Compared to public programs, private health plans reimburse at a significantly higher rate. In 2020, The RAND Corporation (RAND) report entitled, *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans* documented the variation in professional and facility prices for the

[183] Medicaid and Chip Payment and Access Commission (MACPAC). Medicaid's Role in Health Care for American Indians and Alaska Natives. Issue Brief. 2021. **https://www.macpac.gov/wp-content/uploads/2021/02/Medicaids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf**

[184] Those who once served in the military and are no longer in active duty, or who are retired veterans who also meet certain eligibility and health criteria. US Department of Veterans Affairs. **https://www.va.gov/health-care/eligibility/**

[185] Depending on how service members separated from military active duty, they are eligible for either VA or TRICARE coverage. TRICARE. **https://www.tricare.mil/Plans/New**

commercially insured population.[186] Between 2016 and 2018, the rate at which private insurers and employers reimbursed for services increased by 23%. In 2018, across all inpatient and outpatient hospital services, private insurers and employers paid 247% above what Medicare would have paid at the same facilities for the same services. Spending for employer-sponsored health insurance has also accelerated for both employers and employees and reflects the increase in national health care spending.

Federal Employees Health Benefits (FEHB) Program

The Federal Employees Health Benefits (FEHB) Program is the largest employer-sponsored group health insurance in the US and provides health care coverage to federal employees, retirees, and their dependents. Over 131,000 Washingtonians are insured through the FEHB Program.[187] The statute governing FEHB specifies that the federal government and employee or retiree share the cost of health insurance, including premiums, with the federal government contributing the majority (72-75%).[188] The Office of Personnel Management administers the program and contracts with private health carriers to deliver comprehensive health care services. [189]

Public Employee Benefits Board (PEBB) Program and School Employee Benefits Board (SEBB) Program

The Public Employee Benefits Board (PEBB) Program provides health care coverage to state employees, retirees, and their dependents, covering over 385,000 Washingtonians.[190] The School Employee Benefits Board (SEBB) Program provides health care coverage to approximately 269,000 employees and dependents of Washington's school districts and charter schools, and represented employees of Washington's educational service districts.[191] PEBB and SEBB lie within the HCA, the largest purchaser of health coverage in the state. Under HCA, PEBB purchases benefits from private health carriers within the funding approved by the State Legislature. PEBB also approves premium contributions for employees, sets eligibility requirements, and approves benefits of all participating health plans. SEBB authorizes premium contributions and approves plan specifications and carrier selection to leverage efficient purchasing through coordination with PEBB.

---

[186] Using data from 2016 to 2018, the study evaluated hospital spending from self-insured employers, health plans, and state-based all-payer claims databases from 49 states.

[187] Health Coverage in Washington State. 2017 data provided by the Washington State Office of Financial Management. Economic Opportunity Institute. 2020. **http://www.opportunityinstitute.org/research/post/health-coverage-in-washington-state/**

[188] Employees of the United States Postal Service have their share of premiums collectively bargained. Blom, K. Cornell, A. Federal Employees Health Benefits (FEHB) Program: An Overview. Congressional Research Service. 2016. **https://sgp.fas.org/crs/misc/R43922.pdf**

[189] OPM coordinates the administration of FEHB with federal agencies, manages contingency reserve funds for the health plans, and applies sanctions to health care providers according to federal regulations.

[190]PEBB Total Member Enrollment for July 2022 Coverage. **https://www.hca.wa.gov/assets/pebb/pebb-enrollment-202207.pdf**

[191] SEBB Total Member Enrollment for July 2022. **https://www.hca.wa.gov/assets/pebb/sebb-enrollment-202207.pdf**

Individual coverage and Washington's state-based exchange

The ACA requires each state to establish a health insurance exchange where consumers are able to shop for private health insurance plans through a virtual marketplace.[192] Washington adopted a state-based exchange, making the state generally responsible for performing marketplace functions. Through legislation in 2011, HBE was established as a "public-private partnership separate and distinct from the state" to operate the state-based exchange (Senate Bill 5445). Approximately 215,000 individuals receive coverage through Washington's Exchange.

Cascade Care

The Legislature passed Senate Bill 5526 in 2019, establishing Cascade Care standard plan coverage options on the state-based exchange, beginning in 2021. The goal of Cascade Care's standard benefit design is to make care more accessible by lowering deductibles, making cost-sharing more transparent, and providing more services before the deductible as well as enabling consumers to compare plans more easily. Senate Bill 5377, passed by the Legislature in 2021, made improvements to Cascade Care and also directed HBE to establish a state premium assistance program for Cascade Care.

Washington's public option

Public Option plans, or Cascade Select, first became available on the state's exchange in 2021 following the passage of Senate Bill 5526 in 2019. Cascade Select provides health insurance coverage options to the individual market through Washington's Healthplanfinder (offered by HBE. Cascade Select is a multi-agency effort involving HBE, HCA, and OIC. The goals of Cascade Select are to increase the availability of quality, affordable health care coverage in the individual market, and ensure residents in every Washington county have a choice of QHPs. As of 2022, 6,335 residents selected Public Option plans. For Plan Year 2023, Public Option Plans will be available in thirty-four of thirty-nine counties, up from 25 counties in 2022 and 19 counties in 2021. [193] HCA WILL RECHECK THESE NUMBERS TO CONFIRM AFTER PLAN CERTIFICATION IS COMPLTED BY OIC AND HBE.

Public-private coverage

Medicare Advantage (Medicare Part C)

Medicare pays private health plans a capitated payment to provide all Medicare-covered services to individuals who choose to enroll in Medicare Advantage. These plans may be subject to premiums, copays/coinsurance, deductibles, and other out-of-pocket costs. Medicare Advantage plans have grown increasingly popular amongst Medicare enrollees. In Washington, 510,026 Medicare beneficiaries were enrolled in Medicare Advantage plans accounting for approximately

[192] States have the option to develop and host their own exchanges, or let the federal government establish and run exchanges for them. Washington State manages its own exchange.

[193] Washington State Health Benefit Exchange. Effectuated Cascade Care Select Plans by Carrier and County. 3/31/2022.

36% of Medicare beneficiaries in 2020, up from 30% in 2016. [194] The federal government has also steadily increased spending on Medicare Part C. In 2019, the federal government spent an additional $7 billion on Medicare Advantage plans, with an increase of $321 per person compared to beneficiaries in traditional Medicare in 2019.[195]

Financing models in countries with universal health care

The U.S. is the only high-income country that does not provide universal coverage to its residents.[196] Compared to the U.S., other high-income countries have reached universal coverage through a more unified financing system while achieving lower health care expenditures and generally better health outcomes. The following section will outline components of single-payer systems as well as regulated multi-payer systems.

Single-payer

Senate Bill 5399 directs the Commission to prepare the state for the creation of a universal health care system through a unified financing system, including a single-payer financing system. In January 2022, the Washington State Institute for Public Policy (WSIPP) shared with the Commission findings from their 2019 study and final report to the Legislature entitled *Single-Payer and Universal Coverage Systems*. While a single-payer system would likely reduce overall spending on health care, the financing required would impose large new taxes, as is done in other countries, as the system shifts from a combination of public and private coverage to public coverage.

There are two primary models of single-payer systems. In either single-payer model, the government is the only insurer for a standard set of benefits.

1) The first is the Beveridge Model, which is used in Denmark, New Zealand, and the United Kingdom.[197] This model creates a national health service where benefits are standardized across the country and the government acts as the single-payer, eliminating competition in the market, and generally keeping prices low. The government is also active in controlling drug prices, whether through price negotiations with pharmaceutical companies, price caps, or drug formularies among others. Most physicians and other health care workforce are government employees, and clinics and hospitals are government owned. Care is usually free at point of service. A U.S. equivalent to this model of single-payer financing is the VHA. In this single-payer model, there is still a role for private insurance which can be offered by employers or made available for individuals to purchase. In England's NHS for instance, private insurance typically

[194] Compared to 370, 814 Medicare Advantage enrollees in 2016. Total Number of Medicare Beneficiaries. 2020. Kaiser Family Foundation.
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
[195]$11,844 per person in Medicare Advantage compared to $11,523 in traditional Medicare in 2019. Polosky, C. 2021.Payments to Medicare Advantage Plans Boosted Medicare Spending by $7 Billion in 2019. Kaiser Family Foundation.
https://www.kff.org/medicare/press-release/payments-to-medicare-advantage-plans-boosted-medicare-spending-by-7-billion-in-2019/
[196] Commonwealth Fund. 2021.U.S. Health System Ranks Last Among 11 Countries; Many Americans Struggle to Afford Care as Income Inequality Widens. **https://www.commonwealthfund.org/press-release/2021/new-international-study-us-health-system-ranks-last-among-11-countries-many**
[197] Chung, M. Health Care Reform: Learning from Other Major Health Care Systems. Princeton Review.
https://pphr.princeton.edu/2017/12/02/unhealthy-health-care-a-cursory-overview-of-major-health-care-systems/

offers better amenities, faster access to non-urgent care, or choice of specialists.[198] However, there are health equity implications of supplemental private health insurance being available to purchase for more timely care and broader access to providers, as those with higher income can pay for greater access to resources less accessible to others.

2) The second is the National Health Insurance Model, which is practiced in Australia, Canada, and Taiwan. This model establishes a national health insurance system with little cost-sharing. Providers are usually private and reimbursed through a tax-financed government plan. In this single-payer model, private insurance can be purchased to gain faster access to care, or improved choice in provider. In Canada's case, private insurance covers services excluded from universal coverage, such as vision, dental, or prescription drugs.[199] However, the option to purchase complementary private insurance may create inequitable access to services not included under universal coverage benefits. This finance model is similar to the Medicare program in the U.S. where enrollees may also purchase supplemental insurance in addition to their public insurance.

Multi-payer

Most multi-payer systems follow the Bismarck model, where health insurance is mandatory for residents. In this model, Statutory Health Insurance (SHI) is administered by nongovernmental insurers known as "sickness funds," and is funded through premiums.[200] Premiums are calculated as a percentage of income through compulsory payroll deductions by employees and are matched by employers.[201] Some countries have multiple competing insurers as is done in Germany, which helps contain costs by emphasizing managed competition among insurers. Regardless of the number of insurers, the government tightly controls prices for health services. [202]

In Germany, SHI funds are non-profit and must accept any applicant, regardless of preexisting conditions or health risk profile.[203] Individuals with higher incomes often choose to purchase complementary or supplementary insurance policies in addition to SHI for benefits nots covered under SHI, or for amenities such as private hospital rooms. Some groups are exempt from enrolling in SHI, including high-income

---

[198] About 11% of the population purchases supplementary coverage. Commonwealth Fund. 2020. International Health Care System Profiles. England. **https://www.commonwealthfund.org/international-health-policy-center/countries/england#:~:text=Private%20insurance%20offers%20more%20rapid,emergency%20care%2C%20and%20general%20practice.**

[199]About 67% of Canadians have some form of private coverage, typically through an employer. International Health Care System Profiles. Canada. Commonwealth Fund. 2020. **https://www.commonwealthfund.org/international-health-policy-center/countries/canada**

[200]In addition to compulsory wage contributions, income-dependent contributions are paid directly to an individual's sickness fund. Income-dependent contributions to sickness funds are determined by the government. In 2019, the average supplementary contribution rate was approximately 1%. International Health Care System Profiles. Germany. 2020. Commonwealth Fund. **https://www.commonwealthfund.org/international-health-policy-center/countries/germany**

[201] Employees' portion is withheld directly by the employer from the employee's gross salary. The employer is obliged to remit the total contributions to the health insurance carrier on a monthly basis. Working and Living in Germany. 2020. Deloitte. **https://www2.deloitte.com/content/dam/Deloitte/de/Documents/tax/Deloitte-Working-Living-in-Germany-2020.pdf**

[202] Sickness funds compete for patients namely through deductibles, bonuses, and issues of efficiency. Sickness funds' costs are controlled by prohibiting physicians from charging above a set price for services in the SHI benefit catalog, and by allowing the sickness funds to negotiate drug prices with pharmaceutical manufacturers. The Public-Private Option in Germany and Australia: Lessons for the United States. 2020. Millbank Quarterly Opinion. **https://www.milbank.org/quarterly/opinions/the-public-private-option-in-germany-and-australia-lessons-for-the-united-states/**

[203] Doring, A. The German healthcare system. 2017. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3405354/**

individuals who meet a certain income requirement, civil servants, and those who are self-employed. Individuals in these groups may choose to purchase fully substitutive private insurance.[204] However, the federal government regulates private insurance including monthly premiums, as well as provider fees.

Health care providers in Germany are mandated to participate in both SHI and private insurance plans, helping to balance payments from public and private insurance. Out-of-pocket expenses in multi-payer systems vary, though in Germany, most patients enrolled in SHI pay very small co-pays for outpatient or inpatient prescription drugs, medical devices, and hospitalization.

Government Role in Single and Multi-Payer Universal Health Care Systems

In all universal health care systems, whether single or multi-payer, governments play an active role in the oversight and regulation of health care. Governments regulate insurers, which are non-profit entities in most cases. Additionally, the governments typically determine the standardized benefits packages, provide subsidies for low-income residents, establish prices for drugs and procedures, influence contract negotiations between providers and insurers, set the health care policy agenda, and set health budgets. Fees are often determined at the regional or national level through negotiations between providers, insurers, and drug manufacturers. Some governments, including England, set a fixed amount of funding per year for hospitals, known as global budgets, to control health expenditures. Other countries broker collective agreements with providers and insurers to limit cost growth rates.

Taxation in single and multi-payer systems

Universal health care systems are funded mostly through general taxation. Though, this is not to say that there are no premiums or other out-of-pocket costs paid by consumers.

The United Kingdom's NHS single-payer model is funded through general taxation. There, the three (3) main sources of revenue include income tax (27.6%), National Insurance contributions (20%)[205], and sales tax (19.2%).[206] In Canada's single-payer system, national health insurance is funded through earmarked taxes, usually on earned income which accounts for approximately 30% of revenue.[207] Employers in Canada also pay a revenue-based Employer Health Tax that can vary by territory or province.[208]

Multi-payer systems are largely financed through payroll taxes, with contributions from both employers and employees. In France's multi-payer system, social security payroll taxes account for the majority of funding (53%), followed by a national income tax on all earnings (34%), taxes on the pharmaceutical industry and private voluntary health insurance companies (VHI) (12%), and state subsidies (1%).[209]

---

[204] Fully substitutive private insurance covers approximately 11% of population. Ibid.
[205] National Insurance is a payroll tax paid by employers and employees.
[206] Other revenues include tobacco duty (1.3%), alcohol duties (1.7%), council tax (4.9%), business rates (4.2%), and all other taxes collected by Her Majesty's Revenue and Customs (21.1%). RAND Europe. Research Brief. Options for Funding the NHS and Social Care in the UK. **https://www.rand.org/content/dam/rand/pubs/research_briefs/RB10000/RB10079/RAND_RB10079.pdf**
[207] Canadian residents pay a provincial income tax in addition to the federal income tax. Rates and tax brackets may vary by territory or province. **https://www.canada.ca/en/financial-consumer-agency/services/financial-toolkit/taxes-quebec/taxes-quebec-2/5.html**
[208] Ontario Employer Health Tax. **https://www.ontario.ca/document/employer-health-tax-eht#:~:text=Employers%20have%20to%20pay%20Employer,of%20the%20employer%20in%20Ontario**
[209] International Healthcare System Profiles. France. Commonwealth Fund. 2020. **https://www.commonwealthfund.org/international-health-policy-center/countries/france**

Example of models for consideration when transitioning to a universal health care system

Section 3 of this report offered examples of the unique financing approaches utilized in the state of Maryland, including all-payer rate setting and hospital global budgets. Additionally, the Washington Vaccine Association demonstrates a successful purchasing program used to provide universal coverage of vaccines to children in Washington. The following section will outline the funding model behind the Washington Vaccine Association.

The Washington Vaccine Association

Washington began its Universal Childhood Vaccine Program in 1990 to provide vaccines to all children under the age of nineteen, regardless of income.[210] The program was jointly funded by state and federal funds until 2009 when the Legislature eliminated state funding for the program beginning in 2010 due to the state budget deficit. In the 2010 legislative session, then Governor Gregoire signed into law Second Substitute House Bill 2551 that preserved the state's universal vaccine purchase program and established the Washington Vaccine Association as a new entity.

The Washington Vaccine Association (WVA) is a non-profit consortium that collects funds from health carriers and third-party administrators through mandatory assessments to cover the cost of vaccines for all children under the age of nineteen.[211] With funds collected from the assessments, the State DOH is able to purchase vaccines from the US Centers for Disease Control and Prevention at volume rates and deliver them to providers at no cost.

The WVA funding model

1. Each month, the Washington State DOH fulfills enrolled providers' vaccine orders.
2. Healthcare providers then submit claims to payers for vaccines administered to insured children, at no charge to patients.
3. Health plans, carriers, and third-party administrators (TPAs) then pay the Washington Vaccine Association dosage-based assessments for vaccines.
4. On a monthly basis, the Association remits the funds from assessments to DOH for pediatric vaccine purchases.

Benefits of the WVA's universal purchasing program

1. Providers have no financing costs or risk of loss because they receive pediatric vaccines from DOH and can use their existing billing system to trigger WVA's collection of funding from payers.
2. Consolidating ordering, delivery, and storage improves efficiencies for providers.
3. Providers have a stable supply of recommended vaccines.

---

[210]Washington Vaccine Association Financial Statements. Years Ended Jun 30,2021 and 2020. **https://wavaccine.org/wp-content/uploads/2021/11/Washington-Vaccine-Association-Financial-Statements.pdf**

[211] Pursuant to RCW 70.290.075, if the clients represented by the TPA offer private health plan or self-funded employer plan coverage that might include vaccine material being provided to patients under the age of 19, then both state-based and out-of-state TPAs are required to register with the Washington Vaccine Association**. https://wavaccine.org/faqs/**

4. Healthcare savings resultant from bulk purchases by the DOH of all pediatric vaccines at federal contract rates.
5. Centralized vaccine management.
6. Reduced barriers to immunizations.

Single-payer financing models proposed by other states

In recent years, the RAND Corporation evaluated proposals by both Oregon and New York to finance their respective health care systems through a single-payer financing approach. Though some of the nuances of their respective proposals differ, RAND determined that in either approach, the new tax structure should redistribute the burden of financing health care to higher-income earners. RAND noted in both evaluations that the redistribution of who pays for health care may impact the political feasibility of implementing a single-payer model. These proposed single-payer models and their evaluations offer additional considerations in designing a unified health care financing system.

Oregon

In 2017, the Oregon Health Authority sponsored a research study and microsimulation by RAND[212] to review four options for financing health care for state residents. One of the financing models evaluated was a single-payer option. The single-payer model as analyzed by RAND was a state-sponsored plan that would use public financing to provide privately delivered health care for all state residents, including individuals currently enrolled in Medicare and Medicaid, and undocumented immigrants. There would be no cost-sharing for those with income under 250% FPL. For those with incomes above this level, 96% of expenditures (actuarial value), on average, would be covered.[213] There would be no premiums. This option would significantly redistribute the burden of financing health care to higher-income earners. Hospital, physician, and other clinical services payment rates would be 10% below the average rates in the Status Quo.[214]

The single-payer model would be financed through:

1. Income-based state and federal tax payments.
2. Pooling state and federal outlays for current public programs.
3. Employers with twenty or more employees would no longer make tax-advantaged premium payments and would instead pay a new state payroll tax.

RAND determined that the single-payer approach would reduce public sector costs by 20-50% but that the results are sensitive to assumptions including: 1) the insurance operations of PEBB (Public Employee Benefits), OEBB (Oregon Educators Benefit), and Oregon's Healthcare Marketplace are largely

[212]White, C. Eibner, C. Liu, J. 2017. A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon. RAND. **https://www.rand.org/pubs/research_reports/RR1662.html**

[213] RAND simulated a variant on the Single Payer option in which households with incomes above 400 percent of the FPL were enrolled in a plan with 90% actuarial value (AV) rather than 96% AV. Reducing AV for higher-income individuals reduces total system costs by around $600 million and reduces the state financing requirement by around $1.2 billion.

[214] The costs of the Single Payer option vary depending on the generosity of provider payments and on the share of health care expenditures paid by the plan. To quantify the impact of provider payment rates, RAND simulated two variants of the Single Payer option: 1) A low-payment variant in which hospital and physician payment rates were set to equal traditional Medicare. Reducing provider payment rates to this level would exacerbate congestion but would reduce total system costs by nearly $3 billion, and 2) a high-payment variant in which hospital and payment rates were kept equal to the Status Quo. Maintaining provider payment rates at the level of the Status Quo would alleviate some congestion but would increase total system costs by over $2 billion.

redundant,[215] 2) a 30% reduction in the combined administrative costs of public program operations, and 3) one or more administrative contractors would replace health plans, agencies, and contractors in program's administration, including claims processing, utilization review, and provider credentialing. RAND made recommendations to Oregon to effectively implement a single-payer plan:

1. Arrange discussions with the federal government on the feasibility of the necessary waivers or other federal authorities.
2. Seek legal counsel to navigate ERISA (Employee Retirement Income Security Act of 1974) challenges.
3. Review provider payment approaches with CMS and seek input from providers on how provider payment changes could be implemented to promote quality of care and maintain sufficient provider engagement. Value-based payment approaches while reducing unnecessary care should be explored.

New York

In July 2018, the New York Legislature considered the New York State Health Act (NYHA), a state-level single-payer health plan that would provide coverage to all state residents regardless of immigration status and transform the state's delivery and financing of health care. The health care system under the NYHA would shift financing away from premiums and out-of-pocket costs towards a tax-based system, significantly redistributing who pays for health care.

The single-payer system as proposed would be financed primarily through taxes including:

1. Financing through new trust funds from the federal government in lieu of federal financing for health programs already existing (waivers for Medicaid, Medicare, and ACA requirements subject to federal approval).
2. Current state funding for health care programs.
3. Revenues from two (2) new progressively graduated state taxes:
    a. A payroll tax paid jointly by employers and employees at 80% and 20%, respectfully.
    b. A tax on income not subject to the new payroll tax, such as capital gains, interest, and dividends.

RAND was commissioned by the New York State Health Foundation to assess near-term and long-term impacts of the plan on health care coverage, costs, and spending, among other outcomes. [216] RAND made several assumptions in its analysis, including a possible graduated tax schedule. Compared to the status quo, this schedule would substantially reduce health care payments for lower-income residents, with the highest-income residents paying more. [217]

In their analysis, RAND determined that the NYHA single-payer approach could potentially lower payments amongst most New Yorkers, but that the results are sensitive to assumptions regarding uncertain factors, including:

---

[215] The Single Payer option would replace commercial health plans and integrate the Medicaid and Medicare programs, as well as the Marketplace, PEBB, and OEBB.

[216] Liu, H. White, C. Nowak, A. 2018. An Assessment of the New York Health Act. A Single-Payer Option for New York State. Rand. **https://www.rand.org/pubs/research_reports/RR2424.html**

[217] The NYHA would add new progressively graduated payroll and nonpayroll taxes but does not specify the rates or the degree of progressivity. RAND's analysis assumes one possible tax schedule that would reduce payments for the majority of residents but could lead to tax avoidance and migration among a small number of high-income households facing large tax increases. **https://www.rand.org/pubs/research_reports/RR2424.html**

1) the implementation of the program.
2) whether the state could reduce administrative expenses.
3) whether the state is willing and able to negotiate or set price levels and payment rates with providers.
4) the response of high-income residents facing new taxes.
5) the approval of federal waiver, including those to allow for federal funds currently paid to the state and its residents to be redirected to the NYHA.
6) that provider payments would, at least initially, be made on a FFS basis based on a fee schedule.

Advancing health equity through a unified financing system

The Commission recognizes that financing and coverage policies and structures in current health care system have contributed to the discrimination and marginalization of low-income individuals, people with disabilities, and individuals of color. Further, in the current system, an individual's coverage and access to care is largely determined by how the care is financed.

The development and implementation of a unified financing system may create the opportunity to examine these existing harmful structures and to establish a new system that ensures equity and wellbeing for all Washingtonians, including the health care workforce. In examining the implications of a unified health care financing system on health equity, it also will be important to consider the role, if any, of private health insurance. A unified financing system may help further advance an equitable and transparent finance and delivery system as the state can leverage purchasing power to eliminate price variation and inequitable access to care. [218]

Recommendations

The Commission's authorizing legislation directs the Commission to both: (1) create immediate and impactful changes in the health care access and delivery system in Washington and (2) 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. The approach for Washington's unified financing system will depend on the universal health care model selected for implementation. Washington is currently adopting policies and making budget allocations to achieve Model C as proposed by the UHC Work Group. Additional universal coverage models will be considered to inform an approach translatable to Washington, including Models A and B,[219] as well as unified financing models utilized in other countries.

The UHC Work Group identified, but did not significantly address, key barriers to Models A and B. One of the greatest challenges to implementing a universal health care model is the cost to establish and administer the model. Though Model A and Model B project cost savings, the cost to implement either model will create a material financial burden to the State.[220] Other barriers considered by the Work Group include necessary federal waivers from CMS or Congress to implement a universal program for individuals currently eligible for federal programs or enrolled in employer-sponsored health plans, the impact of job

[218] Single-Payer and Universal Coverage Health Systems: Final Report. 2019.Washington State Institute for Public Policy.
[219] As proposed by the Universal Health Care Work Group.
[220] Model A is projected to save $5.6 billion annually, while Model B is projected to earn no steady state annual savings past the implementation year.

loss in eliminating health care functions from the private industry, determining appropriate levels of provider reimbursement, and political opposition to such a change. These barriers and challenges will be a part of the focus of the Commission's upcoming deliberations.

Significant planning, analysis, and evaluation will be required for the transition to and implementation of a unified health care financing system. Consistent with the statutory charge, the Commission created a Finance Technical Advisory Committee to aid the Commission in developing a unified financing system for universal health care in Washington.

1. Creation of a Finance Technical Advisory Committee (FTAC)

The Commission created a Finance Technical Advisory Committee (FTAC). This Committee will provide subject matter expertise and advise the Commission in the creation of a unified health care financing system.

2. Goals

FTAC serves at the direction of the Commission. The goal of FTAC is to provide guidance to the Commission in their development of a financially feasible model to implement universal health care coverage. FTAC members will investigate strategies to develop unified health care financing options for the Commission's consideration. In their work, FTAC will carefully consider the interdependencies between necessary components of a unified financing system and other considerations before the Commission and may provide pros and cons for each option. Finally, FTAC will provide guidance for what entity(s) will implement the unified health care financing system.

3. Roles and responsibilities

HCA will provide the necessary staffing and resources to support FTAC. HCA staff will prepare meeting agendas, provide meeting summaries, support the creation of meeting materials, distribute meeting materials, and will assist with meeting coordination.

The Commission will appoint a Chair for FTAC. The FTAC Chairperson may also be a member of the Commission. The Chairperson will assist with meeting facilitation and must be available for all FTAC meetings, as well as for Commission meetings. The Chair will serve as the liaison between the FTAC and the Commission and will share any relevant discussions or findings at Commission meetings.

The Commission will direct the work of FTAC including the development of a charter. FTAC members will agree to act in accordance with this charter.

4. Committee qualifications

Anyone may nominate a qualified candidate for FTAC, and self-nominees are also welcome. The applicant should hold subject matter expertise in health care financing, which can include, but is not limited to: service delivery; pharmaceutical costs and spending; universal health insurance; rural health; behavioral health financing; dental benefits costs and financing; vision benefits costs and financing; provider reimbursement; coverage and benefits; health care economics; single-

payer revenue models (including taxation and federal and state revenue); single-payer payment models (including Diagnosis Related Group (DRG), global budgets, value-based payment, capitation, directed payments); alternative payment models (including value-based payment); Medicaid financing; Medicare financing; federal waivers; cost sharing; cost containment strategies; ERISA; or pricing. If FTAC is going to discuss the scope of covered services, then participation will be needed by clinicians who understand both the benefits of culturally appropriate, evidence-based care but also the inequitable biases that may be imbedded in clinical guidelines. All FTAC considerations, including potential benefit design must be examined through a nondiscrimination lens, with respect to issues such as age limitations on benefits and formulary design.

5. Subject matter expertise

HCA staff will consult with FTAC if additional subject matter expertise is needed and invite subject matter experts to present to FTAC. Subject matter experts can include, but are not limited to, those with knowledge regarding financing of health care services and programs in Washington, public and private health care expenditures in the state, taxation and other public revenue models, employer-sponsored health coverage, health care benefits, economics, public budgeting and financing, organizational financing, provider reimbursement, health care workforce, and behavioral health financing.

6. Committee appointment

The opportunity to apply for FTAC consideration will be posted to the Commission's web page. The call for applications will be shared by HCA through a GovDelivery announcement when the opportunity to is posted to the Commission's web page. Applicants will need to complete a basic application about the individual, their background/expertise to participate, and why they want to participate on FTAC. Applicants will also include their most recent resume with their application. The posting and opportunity to complete an application will be available for thirty days which may be extended to sixty days, if needed to allow for additional applicants.

The Commission will appoint nine nominees for FTAC members, which includes one consumer representative, and if possible, reserving at least two spots for two state agencies which include the Department of Revenue and OFM.

7. Considerations before FTAC

A primary goal of the Commission is to develop a plan for a unified financing system that will greatly simplify the system and lead to equitable, accessible, high-quality care for all Washington residents. One of the main goals of FTAC will be to provide guidance to the Commission. The following are some of the areas that could be assigned to FTAC by the Commission for guidance:

- Revenue goals and projections
- Scope of coverage, benefits, and cost-sharing, including dental and vision
- Development of fee schedule
- Securing federal funds
- ERISA
- Tax structure, including the impact of the tax structure on equity
- Assessing how to include Medicare beneficiaries
- Administrative cost reduction
- Risk management
- Model development process
- Health equity in financing
- Level of reserves and methods of funding
- Cost sharing
- Workforce
- Provider reimbursement
- medical school, including behavioral health
- Impact of payment model on care quality and equity
- Economic impacts of new taxes
- Care investments, including primary care, behavioral health, community health, and health-related social needs
- Funding for culturally appropriate health care models
- Assessing how federally funded health systems, VHA, and IHS will be included or intersect with the universal health care system
- Financial forecast of changes in demand/utilization, etc.
- Authority and analytic capacity within a new or existing administering agency

Summary

Washington's current health care financing system is costly and complex. Further, the current financing system and delivery system are inextricably linked; an individual's coverage and access to care are determined by the payer or financing source of that coverage.

One of the primary goals of the Commission is to develop a plan for a unified financing system that will lead to equitable access to culturally appropriate care for all Washington residents. The approach for Washington's unified financing system will be dependent on the universal health care model considered for implementation.

There are multiple sources of funding that pay for health care under Washington's current health care system. The strategy for combining those funding sources will be critical to the implementation and success of the unified health care financing system. This and other various challenges associated with maintaining or increasing funding from each funding source will be key considerations before the Commission and FTAC.

The Commission determined that the subject matter expertise of a finance technical advisory committee will be essential to inform decision making and planning. As such, the Commission has begun the process for the creation a Finance Technical Advisory Committee to explore the various barriers and paths to implementing a successful unified financing system in Washington. The Commission and its Finance Technical Advisory Committee will work together closely to explore unified health care financing systems as proposed by the UHC Work Group and as practiced in other countries, as well as other feasible paths to implementing a unified financing system that provides equitable, affordable, high-quality care to all Washingtonians.

Conclusion

Washington continues to be a leader of health care reform and the Commission is dedicated to building on this work by ensuring that all Washingtonians have equitable access to culturally appropriate health care and universal coverage. The Commission will continuing this important work to create a universal health care system, while continuing to examine the current health care system for immediate and impactful changes to increase access to quality, affordable health care by streamlining access to coverage, reducing fragmentation of health care financing, reducing unnecessary administrative costs, reducing health disparities, and establishing mechanisms to expeditiously link residents with their chosen providers.