Washington State Health Care Authority

REPORT TO THE LEGISLATURE

HMA Optumas

Universal Health Care Work Group

Engrossed Substitute House Bill 1109, Section 211, Subsection 57;
Chapter 415, Laws of 2019

January 15, 2021

Universal Health Care Work Group

This report was created at the request of the Washington State Legislature. It contains background information, assessment criteria developed by the Work Group, reform models assessed, Work Group feedback, and Work Group responses to a survey about the models.

The report also includes the Legislature's budget proviso, Work Group charter, and meeting summaries. All materials provided at Work Group meetings are available on the Universal Health Care Work Group page.

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Executive summary

On behalf of the Universal Health Care Work Group, Health Care Authority (HCA) submits this report to the Washington State Legislature, as required by Engrossed Substitute House Bill 1109(57); Chapter 415, Laws of 2019. In collaboration with HCA, the Work Group was staffed by a Health Management Associates (HMA), 3Si, and Optumas project team.

Background and process

In 2019, the Legislature directed HCA to convene a Work Group to study and provide recommendations to the Legislature on how to create, implement, maintain, and fund a universal health care system. The 37 members of the Universal Health Care Work Group included a broad range of stakeholders with expertise in the health care financing and delivery system.

Membership reflected the geographic, socio-economic, ethnic, racial, and gender diversity of Washington's population. The Work Group recognizes that it stands on the shoulders of several generations of leaders, stakeholders, and advocates who have improved Washington's health care system over the past 30 years.

The COVID-19 pandemic has led to Washington's deepest economic crisis since the Great Depression. Skyrocketing unemployment has highlighted the inequities and weaknesses of the current health care system, in which tens of thousands of Washingtonians have no health coverage. Approximately 125,000 undocumented residents lack access to basic care.

Affordable, high-quality care is unavailable to many, and the COVID-19 pandemic has emphasized that these challenges threaten everyone's well-being.

Problems with the current system

The Work Group identified several key issues with the current system:

- Not all Washington residents have affordable access to essential, effective, and appropriate health services. Some residents lack coverage and others are underinsured and cannot afford to seek care.
- Disparities in health outcomes exist among Washington residents, and as with others, are worse on average than in comparative countries.
- Rising and uncontrolled health care prices and spending, along with increasing system complexity, harm local and state governments, the economy, consumers, patients, families, providers, employers of all sizes, and taxpayers.

Defining universal health care

The Work Group defined universal health care to mean that all Washington residents can access essential, effective, appropriate, and affordable health care services when and where they need it. The group discussed goals for a universal health care system across seven areas: access, equity, governance, quality, administration, affordability, and feasibility.

Three models considered

Both before and after models were developed for Work Group consideration, members discussed their perspectives on cost sharing, provider reimbursement, covered benefits, covered populations, and transition issues. They discussed these topics both on their own and in the context of the various models. In December 2020, members also completed a survey in which they ranked the models.

The project team used Work Group discussions, input, and information on international models and prior universal care or coverage concepts in the United States to develop three draft models for Work Group consideration:

- **Model A:** state-governed and administered program for all state residents.
  - Estimated implementation year savings: **$2.5 billion**
  - Estimated annual steady state savings: **$5.6 billion/year**
- **Model B:** state-governed and health plan administered program for all state residents.
  - Estimated implementation year savings: **$738 million**
- **Model C:** access to coverage for undocumented residents unable to buy coverage now. This model could be expanded to other uninsured or underinsured populations.
  - **No system savings**

All models would have care delivered by private and public providers, clinics, and hospitals. The following tables are an overview of each model's characteristics and financial analyses. It compares the model to the status quo and qualitative assessment of the model's potential to achieve Work Group goals.

Table 1: overview of each model's characteristics

	Model A	Model B	Model C
Populations	All state residents, including Medicaid, Children's Health Insurance Program (CHIP), Medicare, privately insured, undocumented, uninsured		Undocumented immigrants
Covered benefits	• Essential health benefits, plus vision for all participants • Dental and long-term care for Medicaid[1]		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

[1] Dental for all consumers is priced separately to show incremental cost of dental for non-Medicaid consumers.

Table 2: overview of each model's financial analyses

	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 for covered populations (in millions)			
Status quo expenditure	$61,418	$61,418	Not available
Model cost estimate	$58,942	$60,634	$617
Implementation year savings	$2,476	$738	N/A

The Work Group discussed that Models A and B are designed to include all residents, while Model C focuses on access and affordability for undocumented individuals. Model C does not attempt to address all uninsured or underinsured.

Work Group members noted that, as it is not a universal program, Model C cannot benefit from efficiencies associated with system consolidation. It also does not address affordability for individuals not eligible for subsidies or who cannot afford current cost sharing. Several Work Group members suggested expanding Model C to include more state residents.

Achieving a vision for a universal health care system

To achieve universal health care will require the Legislature, Governor, state agencies, and a range of stakeholders to engage in a series of staged activities that will likely require many transition steps. This includes choosing one model, defining detailed operational plans, and establishing policies to ensure the health reform goals are achieved.

Some Work Group members noted that while Model C would not deliver universal access or achieve desired health reform goals, it should be a step toward universal health care. Model C would provide coverage for a group with immediate need for coverage while a more comprehensive system was being built.

Work Group members acknowledged the need to "fill in the gaps" and to maintain current coverage as the new system is formally adopted, implemented, and operationalized. Ensuring a smooth transition and avoiding disruptions in coverage for Washington State residents requires concerted effort over time, even in the face of fiscal and political challenges. This concept became part of the example transition plan below.

Developing and implementing a transition plan

The transition plan addresses activities across three work streams:

- Protect coverage and reduce uninsurance.

- Define and implement coverage structure, cost containment strategies, administration.
- Define and implement financing, program standards, and transition actions.

The first step in the transition process would be legislation that commits the state to a universal health care system by a certain date. The second step would be near-term efforts to reduce the number of uninsured state residents. Over the following years, the work to build a universal health care system would include:

- Defining the coverage.
- Financing and program standards.
- Developing a financing plan.
- Building governance and administration structures.
- Implementing and administering the universal health care system.[2]

Addressing equity

Many Work Group members stressed the need for a health care system that increases equity in access, care, financing, and outcomes. They discussed using an equity assessment to methodically evaluate and measure a new system as it is designed and implemented. Such assessments, which are used to identify inequitable policies, procedures, practices and outcomes, are in use in Washington, both in the public and private sectors.

Assuming the proposed state Office of Equity is established, any legislation and subsequent commissions and state agencies working to establish a universal health care system should explicitly involve this office and the Governor's Interagency Council on Health Disparities. Involving these groups and Washingtonians of diverse races, ethnicities, and cultures is needed to ensure that equity is addressed in the design of a new system.

Background

Work Group establishment, composition, and process

Work Group participants

House Bill (HB) 1109 (2019) directed HCA to convene a Universal Health Care Work Group to study and provide recommendations to the Legislature on how to create, implement, maintain, and fund a universal health care system. Working with the HCA, the HMA, 3Si, and Optumas project team staffed the Work Group and conducted research and analysis in support of the Work Group's discussions and this report.

HB 1109 provided direction to HCA about the organizations and people to be included in the Work Group. The legislation identified the following as required stakeholders:

- Consumers, patients, and the public.
- Patient advocates and community health advocates.

[2] An example transition plan is available in Appendix I.

- Large and small businesses with experience with large and small group insurance and self-insured models.
- Labor, including experience with Taft-Hartley coverage.
- Health care providers, including those who are self-employed.
- Health care facilities, such as hospitals and clinics.
- Health insurers.
- The Washington Health Benefit Exchange.
- State agencies, including the offices of Financial Management, the Insurance Commissioner, and the State Treasurer, and Department of Revenue.
- Legislators from each caucus of the House of Representatives and the Senate.

HCA also sought to include individuals who:

- Had experience with health care financing and/or health care delivery (including the Department of Health).
- Are affiliated with Tribal health care organizations or knowledgeable about Tribal Health Care systems and programs in the state.
- Demonstrated a willingness and ability to review background materials.

Additionally, HCA staff made a thoughtful and deliberate effort to ensure that membership reflected the geographic, socio-economic, ethnic and racial, and gender diversity of Washington's population. To identify Tribal members, HCA staff consulted with its Office of Tribal Affairs and Analysis Division and several Tribes across Washington.

More than 85 people applied to serve as a member on the Work Group. The Work Group met nine times between September 2019 and December 2020 to discuss problems with the current system, identify goals, assess options, and develop recommendations.

Project team

To help in this work, HCA selected HMA and its subcontractors 3Si and Optumas through a competitive request for proposal process. The HMA team, which included a professional facilitator, actuarial consultants, and subject matter experts provided health care policy analysis, financial analysis, and project management for HCA and the Work Group. The project team met weekly to discuss the project plan, Work Group and stakeholder feedback, and plan Work Group meetings.

Work Group discussions

When the Work Group began meeting in September 2019, they recognized the diversity of opinions and experiences and understood that the group was formed to include a variety of professional and lived experiences and perspectives.

The Work Group gathered information, discussed goals, developed assessment criteria, and explored potential reform models. The intent of this work was to increase their understanding, identify agreement where it existed, and assess reform options in a way that didn't downplay disagreement.

The Work Group developed assessment criteria through discussions of their visions for a desired end state. The Work Group and staff used these criteria, goal statements, and analyses to develop

this report, which provides insights into the models and an example of the steps needed to develop a universal health care program in the state.

Work Group Charter

To guide the Work Group, HCA and HMA developed a draft Charter, which was presented and discussed during the Work Group's first meeting and finalized by the Work Group at the December 2019 meeting. The Charter includes:

- Work Group origins and charge.
- Membership.
- Members' roles and responsibilities, including the chair, facilitator, and project team.
- Meeting processes and decision making.
- Meeting summaries and communication.

Stakeholders, partners, and public engagement

A critical piece of the Work Group's legislative charge is stakeholder and public engagement. The following fundamental objectives and ideas were discussed during the first Work Group meeting and informed the public and stakeholder engagement plan and engagement activities:

- Inform stakeholders, including the public, about the purpose of the Work Group, developing recommendations for the Legislature and the timeline for those recommendations, and how and when stakeholders and the public can get involved.
- Gather input from stakeholders and the public to inform Work Group deliberations.
- Demonstrate transparency and trustworthiness.

Key audiences for this process and final report include:

- Washington State residents, including consumers of health care, patients, and the public, including unserved and underserved populations.
- Patient advocates and community health advocates.
- Tribal partners.
- Large and small businesses.
- Labor unions.
- Health care providers.
- Health care facilities.
- Health insurance carriers.

More information on stakeholder and public engagement is available in Appendix D.

Impact of COVID-19 in Washington and on Work Group

Uninsurance in Washington during the pandemic

While disparities in access to coverage and care existed prior to 2020, the COVID-19 pandemic highlighted the systemic inequities in both health coverage and access to care in Washington. The pandemic also showed that, when some individuals lack access to affordable care, the health and well-being of all members of the community are threatened.

Many Work Group members and members of the public who engaged through public comment noted that the insurance coverage changes associated with COVID-19 job losses also highlighted the need for action in the state. While access data have not yet been compiled for 2020, Office of Financial Management has produced uninsurance estimates for the state and each county. At the state level, 6.7 percent of consumers lacked insurance pre-pandemic (early 2020).[3] The uninsurance rate peaked at 13 percent the week of May 16, 2020, and as of November 14, it was seven percent.

While most Washington residents have access to free COVID-19 testing and vaccines, many uninsured and underinsured residents may not be aware of this access and avoid seeking care due to fear of testing or treatment costs.[4] Uninsured individuals who may not be aware they can get testing at community health centers are particularly likely to avoid seeking care, which limits the state's ability to control the virus.

Work Group adjustments due to COVID-19

Like most organizations and stakeholder-heavy projects, the spread of COVID-19 impacted the Work Group's schedule and plans starting in late winter/early spring 2020. The meeting scheduled for April 2020 was cancelled. It was not possible to move the meeting to an online venue when so many Work Group members and stakeholders were adjusting to Washington's stay at home order and did not all have the technology to support remote engagement. Subsequent meetings were held remotely via Zoom conferencing technology.

To facilitate a productive meeting with such a large group of participants and observers, the project team made pre-recorded presentations available as "homework" for Work Group members and observers. The team also developed Q&As with responses to Work Group members' questions asked before and after meetings.

Most of the Zoom meetings involved "breakout rooms" to facilitate smaller group discussions. Members of the public could listen to one of the small group discussions and everyone heard recaps at the end of the breakout sessions.

A brief history of health reform in Washington

Washington State has long been a leader in efforts to extend meaningful and affordable coverage and care to more people in the state. As indicated in Figure 1, these efforts have been underway for decades and included multiple efforts to expand coverage for children and low-income individuals.

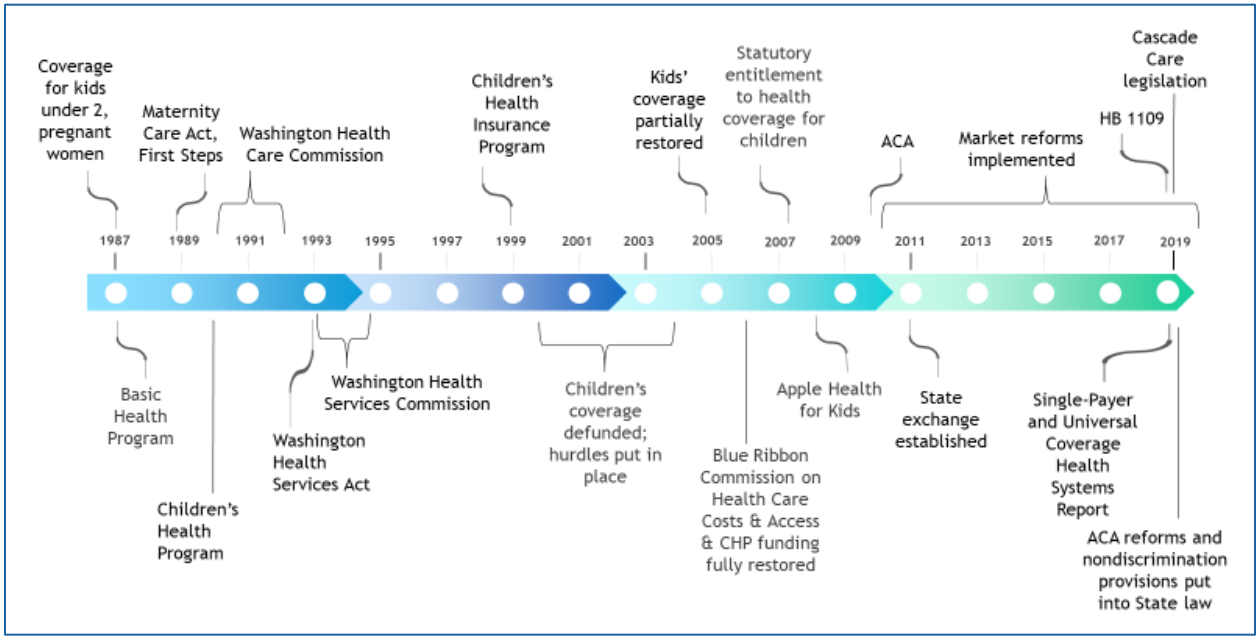
In the decades prior to the passage of the Affordable Care Act (ACA) in 2010 and in the years since, Washington has expanded coverage through the establishment of the:

- Basic Health Plan.
- Washington Health Services Act of 1993.

[3] Washington State Office of Financial Management, Forecasting and Research Division, Health Care Research Center, (Updated) Estimated Impact of COVID-19 on Washington State's Health Coverage, December 2, 2020.
[4] Washington's Health Insurance Commissioner has ordered all regulated health plans to pay for COVID-19 testing and any associated office visits and other tests without any coinsurance, copays, or deductibles. State-regulated health plans include individual, small employer, and some large employer plans. Services include drive-up testing as well as any additional medically necessary testing for the flu or certain other tests for viral respiratory illnesses conducted during the visit. Testing and vaccines are also free for persons with Medicaid or Medicare.

- 2005 legislative action to declare the state's goal of covering all children by 2010.
- Development and operation of a state-based marketplace.
- Implementation of state-level market reforms.

Figure 1: Washington State health reform activities from 1987-2019



Problem statement

The Work Group discussed not all Washington residents have access to effective and appropriate health services now. On average, health outcomes for Washington residents are worse than in nations otherwise comparable to the United States, and Washington residents experience disparities in health outcomes.

Work Group members identified rising health care costs and spending, along with increasing system complexity as harming the state economy, families, employers of all sizes, and taxpayers, and undermining the sustainability of a universal health care system.

At its December 2019 meeting, the Work Group discussed the root causes of uninsurance and underinsurance. Working in small groups before reconvening to compare notes as a large group, the Work Group members laid out a set of problems and issues impacting the state's current health care system.[5] The following reflects Work Group discussions on the root causes of problems with the state's health care system.

[5] Universal Health Care Work Group, Problem Statement and Root Cause Analysis. January 16, 2020.

Problem 1: not all Washington residents have affordable access to essential, effective, and appropriate health services

Work Group members identified problems with access to care, especially the negative impact of cost sharing on affordability of care. In addition, members discussed the issue of networks with limited provider participation and lack of availability of appropriate providers. Provider availability problems were noted to be related to:

- Variance in reimbursement mechanisms and rates.[6 & 7]
- Geography, including particular issues in rural parts of the state.
- Workforce issues, including an inadequate number of health care providers to meet growing demand and the tendency for providers to choose to specialize rather than provide primary care.
- Use of more expensive settings and provider types.

Work Group members raised concerns that because Medicaid and Medicare reimburse less for the same procedures than commercial coverage pays, some residents find it challenging to get services from certain providers.

The group discussed the relative cost of seeking care at a hospital or emergency department rather than a physician's office or primary care clinic. Some members noted that consumers may seek care directly from specialists instead of resolving health concerns with a primary care provider. Others indicated that some specialty care makes more use of expensive procedures and tests.

In addition, Work Group members reported the health care system is not designed around patient needs, including scheduling and transportation. Work Group members added that the events of 2020, including the COVID-19 pandemic and wildfires across the Pacific Northwest, have highlighted and worsened disparities in the state.

Work Group members identified some of the reasons that **some Washington residents lack coverage**:

- Some people earn too much money to qualify for subsidies or publicly funded programs, but cannot afford health care through the Washington Health Benefit Exchange, even with federal premium subsidies.
- Some Washingtonians are not eligible for subsidized health care coverage because of their immigration status. For others, workers with affordable coverage have to pay higher premiums to cover family members.

[6] While state rates vary, at the national level, commercial insurers on average paid 199 percent of Medicare rates (including commercial rates that are an average of 264 percent of Medicare rates for outpatient and 189 percent for inpatient care). Commercial payments are an average of 143 percent of Medicare rates for physician services. Eric Lopez, Tricia Neuman, Gretchen Jacobson, and Larry Levitt, How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature. Apr 15, 2020.

[7] Washington Medicaid rates were an average of 71 percent of Medicare rates in 2016. The U.S. average is 72 percent. Kaiser Family Foundation, Medicaid-to-Medicare Fee Index. 2016.

- Job changes and unemployment can lead workers to lose coverage, interrupting access to existing sources of care.
- Not everyone buys coverage, especially as the ACA mandate to purchase coverage is no longer enforced.

Problem 2: disparities in health outcomes exist among Washington residents, and as with other Americans, are worse on average than in comparative countries

Inequities in access to affordable, quality, and timely health care are rooted in:

- Systemic factors including institutional racism, classism, and other social inequities.
- Unaffordable preventive care, causing people to delay or forgo needed services.
- Inconsistent availability and quality of service providers.
- Lack of culturally attuned care.

Few standards exist for the provision of culturally attuned care, which provider education and training often does not address. Other barriers include a health care workforce that does not reflect the race and ethnic diversity of the state. In addition, many providers only speak English.

Social determinants of health, such as housing, education, and other factors that impact health are not fully addressed or funded at the state or federal level. It is widely recognized that access to social and economic opportunities, availability of resources and supports; community, environmental, and individual safety; and social interactions and relationships impact individual and community health.[8]

However, nonmedical factors are often not taken into consideration. Work Group members identified the siloing of medical and social needs, systemic/institutional racism, and other social inequities as factors impacting residents' health.

The health care system is not person-centered or focused on value. The system incentivizes volume over outcomes and does not support investments in preventive and coordinated health care, behavioral health integration, or end-of-life care. The health care system is complex and difficult to navigate, existing as multiple overlapping systems.

In addition, health care consumers struggle to make informed choices due to a lack of transparency. This makes it difficult to compare providers, treatment options, prices, side effects, or to make informed decisions.

The health care system is not designed to accommodate patient needs. Work Group members identified the business model as a barrier, as providers receive benefit for providing more care but are not generally rewarded for providing better care or improving patient outcomes. Some members pointed out the system includes incentives to treat disease rather than prevent it, while

[8] Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020: Social Determinants of Health.

others noted that reliance on a western model of care has not supported the needs and belief systems of all state residents.

Problem 3: rising and uncontrolled health care prices and spending—along with increasing system complexity—harm local and state governments, the economy, consumers, patients, families, providers, employers of all sizes, and taxpayers

The current health care funding model contributes to uncontrolled spending. Health care financing is fragmented, with no single entity in charge. This allows insurers and providers to avoid costs and risk. In the group market, the funding model is set up to support employers, rather than covered employees and their families.

Prices are not controlled. As noted earlier, the pricing of health care services and products is not transparent. Simultaneously, prescription drug and hospital prices are rising beyond inflation, and duplication of services adds costs. Work Group members noted that residents with complex needs, including a range of physical and behavioral health issues, are not managed holistically. Poor coordination leads to duplication of services and inefficient and ineffective care.

Work Group members noted that administrative overhead is a factor in rising prices, as decentralized and complex administration adds costs and challenges transparency. Others indicated that the prices paid by commercial insurers are also impacted by the system's cross-subsidizing of medical education, the reimbursement of publicly funded care, and care for the uninsured.

Lack of transparency impedes cost control. While there have been efforts to increase transparency regarding the costs and pricing of health care services, limited public information is available. Some transparency efforts have focused on giving consumers information about what providers charge for a given service. Less has been done to clarify underlying costs at a system level.

However, 16 states, including Washington, have established All Payer Claims Databases to collect and analyze health care price and quality information. Some states have taken steps to limit price increases. Additional information on both the actual costs and pricing for services and supplies would greatly enhance the state's ability to establish benchmarks and growth targets. Many players desire to keep information proprietary, which can make such efforts difficult to achieve in a multi-payer system.

Defining universal health care in Washington

As documented in the Work Group's consolidated problem statement, universal health care means:

All Washington residents have access to essential, effective, appropriate and affordable health care services when and where they need it.

This statement is consistent with how the World Health Organization defines universal health coverage: supporting all people and communities in using the full range of health services they need, ensuring individuals receive sufficient quality of care to be effective and that the use of services does not expose the user to financial hardship.[9] This definition stresses that **universal coverage** is designed to ensure individuals' meaningful **access to care.**

The group identified accessible health care as culturally attuned, equitable, and coordinated. Effective and appropriate health care services are comprehensive (including behavioral, oral health, vision, hearing, and end-of-life services) and include preventive, curative, rehabilitative, and palliative care. Affordability concerns the impact on both the individual and on society.

Health reform goals and end-state criteria

The Work Group members were asked to describe what the "end state" would be if a universal health care program was established in Washington. The end-state characteristics were then used to develop overarching goals for health reform and a framework for qualitative assessment criteria that reflected the Work Group's discussions and input. The key goals in this framework include:

- Access
- Equity
- Governance
- Quality
- Administration
- Affordability
- Feasibility

These goals reflect the Work Group discussions and offer a qualitative assessment framework for legislative consideration of reform proposals. While the Work Group was in general agreement on the health reform goals as key concepts important for any chosen reform model's system, they differed on details of focus and priority. In addition, many Work Group members stressed that the details are key—and how the goals are implemented and how criteria are defined will be crucial.

[9] World Health Organization, Universal Health Coverage. January 24, 2019.

Table 3: access criteria

Goal: a system that provides all Washington residents with full access to comprehensive, essential, equitable, effective and appropriate health care services that are affordable to everyone.
• Provides seamless coverage from birth to death (including portability as needed).
• Provides access to comprehensive, essential, effective, and appropriate health services.
• Provides access to affordable care.
• Provides a full range of services (whole-body, holistic health services).
• Promotes high-value care.[10]
• Facilitates the right care, at the right time, in the right setting.
• Promotes preventive health care and utilization of primary care.
• Provides coverage for experimental treatments for rare diseases.
• Allows for complete, adequate, and diverse network of providers.
• Provides access to culturally attuned care.
• Eases health care system navigation for patients and providers.
• Provides psychiatric care in the least restrictive environment necessary.
• Promotes workforce capacity building.

Table 4: equity criteria

GOAL: system promotes equity in access to quality care across race, ethnicity, culture, income, language, geography, gender, disability, and other differences to reduce inappropriate variance in the delivery of care and health outcomes.
• Provides equitable access, based on a person's need and regardless of income, geography, age, gender, disability, or other factors.
• Ensures meaningful access to care in rural and underserved areas and across different cultural, ethnic, language, and other types of communities.
• Promotes individualized and culturally responsive care.
• Increases transparency of health care quality and outcomes.

Table 5: governance criteria

Goal: transparent, accountable, highly responsive governance that maintains Tribal Sovereignty, includes the voices of patients and persons with lived experience, providers and the delivery system, and community-based organizations, and that ensures person-centered care.
• Ensures transparency and accountability in how the model is governed.
• Promotes participation by community-based systems/organizations in governance.
• Respects the importance of informed decision making by the patient.
• Ensures administrative accountability.
• Maintains Tribal Sovereignty and voice in system governance.
• Gives the patient a voice in how the health care system works.

[10] High-value care is a term used by the Institute of Medicine and others to mean care that improves outcomes, quality and value. Committee on the Learning Health Care System in America, Mark Smith, Robert Saunders, Leigh Stuckhardt, and J. Michael McGinnis, Editors, Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. Institute of Medicine of the National Academies. 2013.

Table 6: quality criteria

GOAL: system that promotes the consistent delivery of high-value health services.
• Impact of changes are measurable at system and patient outcome levels.
• Incentivizes or enhances the delivery of high-value health care.
• Includes efforts to improve health care safety and minimize medical errors.
• Supports transparency of health care quality, including reporting of adverse events.
• Reduces inappropriate and unexplained variation in health care delivery in rural and underserved areas and across different cultural, ethnic, language, and other types of communities.

Table 7: affordability criteria

GOAL: system that is affordable to consumers, stakeholders, and the state as a whole.
• Makes system affordable for individuals, families, businesses, taxpayers, and government agencies.
• Implements provider payments that support clinical practice viability and participation in the new program.
• Reduces state expenses and administrative costs relative to current system.
• Includes mechanisms to reduce duplication of services (i.e., via interoperable data systems).
• Includes effective cost controls for all services, including prescription drugs, without compromising access and quality.
• Includes financing that is sufficient, fair, sustainable, and transparent.
• Promotes value-based payments to providers and health systems.

Table 8: administration criteria

GOAL: an administratively simple and efficient system that manages costs effectively and drives out waste.

• Considers impacts of implementation and administration on key delivery system stakeholders, including:
  ○ Commercial health insurance plans.
  ○ Medicaid managed care plans.
  ○ Employers who currently purchase insurance for their employees.
  ○ Employers who currently **do not** purchase insurance for their employees.
  ○ Health care providers (including hospital systems and providers).
  ○ Tribal health.
  ○ Other stakeholders.

• Supports administrative simplification.
• Facilitates data sharing and data portability.
• Promotes transparency in governance and administration.

Table 9: feasibility criteria

GOAL: a health system that is politically, financially, and administratively achievable and implemented with significant stakeholder engagement and input.
• Addresses implementation challenges due to federal regulations (i.e., federal programs, such as Employee Retirement Income Security Act (ERISA), ACA, Medicare, Medicaid; need for federal waiver, federal regulatory relief, and federal statutory change).
• Addresses feasibility challenges related to political buy-in, implementation, administration, and financing.
• Increases transparency regarding stakeholder interests and priorities.
• Supports phasing/incremental advances toward universal health care.
• Addresses funding sources required for implementation and maintenance.

Quantitative assessment of potential models

The project team used Work Group discussions and input, along with information on international models and prior proposals for universal health care in the United States to develop three draft models for Work Group consideration. This section of the report provides the elements of each of the models and the results of financial analyses comparing the model to the current state.

Data and methodology

Appendix A contains detailed discussion of the data sources and methodology used to develop expenditure and revenue estimates for the status quo and reform models. This includes information on the data sources and methodology:

- Service categories
- Trend factors
- Estimated impacts related to provider administrative efficiencies
- Provider reimbursement rebalancing
- Utilization changes by population
- Impact of eliminating cost sharing
- Impacts of models on purchasing power, program integrity, and plan administration

Essential health benefits defined

The ACA defines essential health benefits (EHBs) as services and supplies falling under ten broad categories:

- Ambulatory/outpatient services
- Emergency services
- Hospitalization
- Pregnancy, maternity, post-partum, and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions to gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The ACA does not include adult dental and vision coverage in EHBs, which is why they are called out separately in Models A and B.

All plans sold on the state and federal marketplaces must provide EHBs as well as any other services or supplies required by the state. Each state defines that plan, which is used as a

benchmark for the state's essential health benefits. The Centers for Medicare & Medicaid Services (CMS) website provides details on Washington's and other states' benchmark plans.[11]

Model A: universal health care, state administration

Under Model A, a single coverage plan is offered to everyone in Washington State, with the state establishing the delivery system rules and administering the coverage. 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.

Model A: eligibility, covered benefits

Model A covers all state residents without regard to employment, income, immigration status, or documentation. It includes residents who previously had other sources of public or private (individual or group) coverage.

Table 10: assumptions for Model A

Model element	Key assumptions
Populations	• Medicaid • CHIP • Medicare • Private health insurance (employer, state employee, Washington Health Benefit Exchange) • Undocumented Immigrants • Uninsured
Covered benefits	• Essential health benefits as defined by ACA • Dental for Medicaid-eligible only (dental for others is priced separately) • Vision • Long-term care for Medicaid-eligible only
Cost sharing	• No cost sharing • Private insurance utilization changes due to removal of cost sharing
Provider reimbursement	• Reduced pricing variation between covered populations • Administrative efficiency • Increased purchasing power
Population-specific impacts	• Improved access for the Medicaid-eligible population (increased use of some services, decreased hospital utilization) • Improved access and increased utilization for uninsured and undocumented immigrant populations
Administration	• State-administered • Premiums are exempt from state premium tax, impacting cost and revenues • Reflects reductions in system-wide administrative costs

[11] Essential health benefits benchmark plans.

Model A: expenditure projections

Implementation year estimates

The table below shows the anticipated 2022 expenditures with no program changes (status quo) and expenditures under a Model A program. Dollar amounts, shown in millions, are for the implementation year only.

Table 11: Model A calendar year 2022 expenditures – implementation year ($ in millions)[12]

Financing source	Population[13]	Status quo expenditures[14]	Modeled expenditures	Difference
Medicaid	1,704,000	$15,492	$17,253	$1,761
Medicare	1,722,000	$15,478	$17,950	$2,472
CHIP	62,000	$83	$99	$16
Private health insurance	3,674,000	$22,900	$14,889	-$8,011
Uninsured	334,000	$133	$411	$278
Undocumented	124,000	$45	$794	$749
Excluded populations[15]	278,000			
Out-of-pocket expense (excluding Medicare)		$3,046	$3,175	$129
Out-of-pocket expense (Medicare)		$1,156	$1,205	$49
Indian Health Services		$80	$77	-$2
Other private revenues		$3,004	$3,089	$85
Total	**7,897,000**	**$61,418**	**$58,942**	**-$2,476**

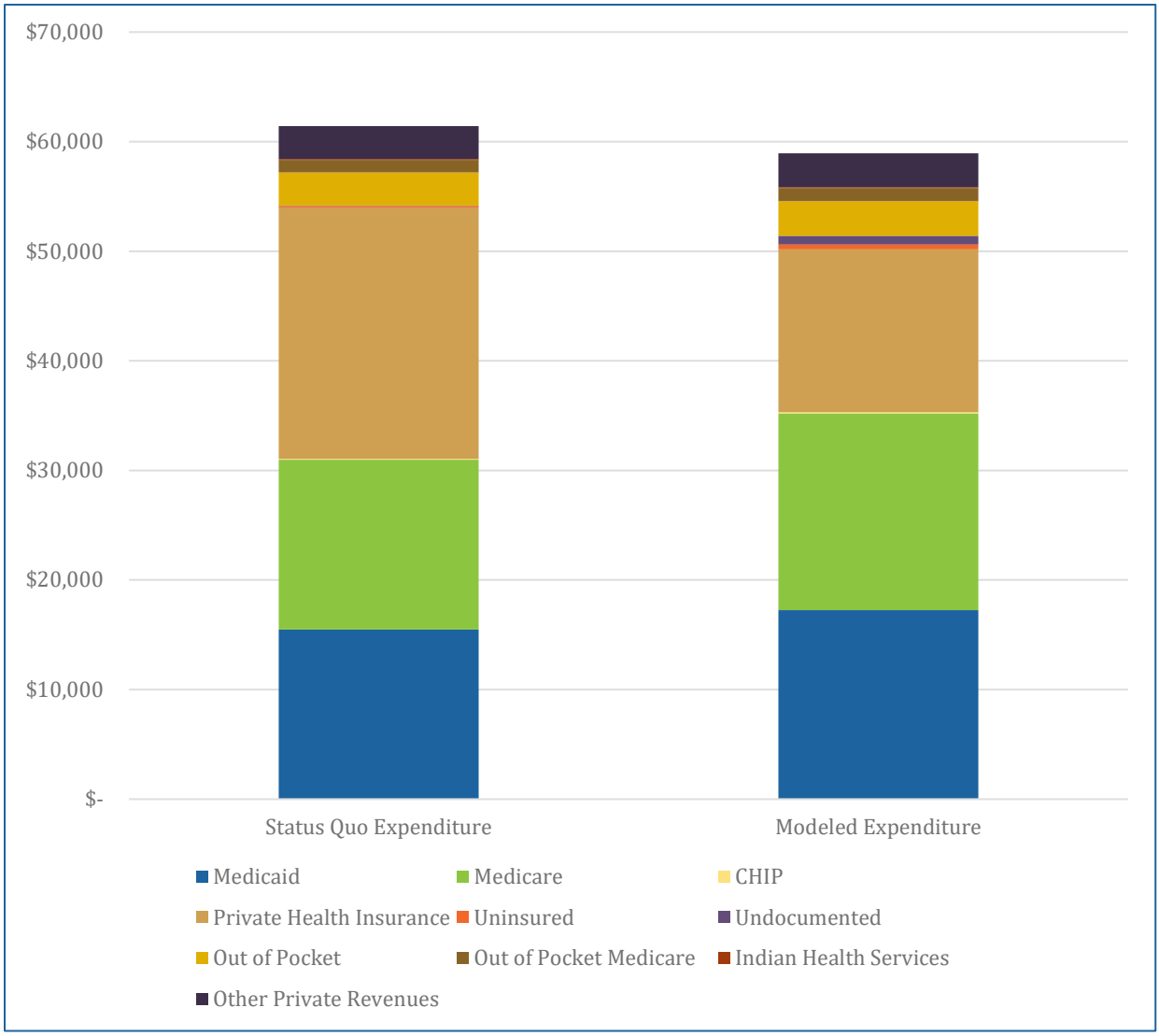
Model A is expected to reduce aggregate system-wide expenditures by **approximately $2.5 billion in the first (implementation) year**.[16] This impact is driven by multiple efficiencies that occur under a single-payer system. These include factors, such as:

- Reduced payer administrative cost.
- Increased state purchasing power.
- Provider administrative efficiencies.
- Program integrity improvements (reducing fraud, waste, and abuse).

In addition, cost savings will likely accrue from other impacts of centralizing the program under the state. For example, under a state-run program, the state can establish regulation that requires increased transparency, which can itself provide cost savings. Other activities, such as establishing maximum prices, support evidence-based care standards and support competition for quality care.

[12] For unrounded expenditures and populations, see Appendix A tables.
[13] Populations are rounded to the nearest 1,000. The Medicaid population totals exclude dually eligible members from the population count. Medicaid reimbursed expenditures for dual eligible persons are reflected in Medicare. All other Medicare-covered expenditures are included in the Medicare row.
[14] Status quo and modeled expenditure totals exclude long-term care and dental for all payers' sources other than Medicaid.
[15] This includes federal employees and active duty military.
[16] Implementation year savings are lower than steady state year savings relative to pre-implementation costs.

Figure 2: status quo vs. Model A – program year 1 expenditures (in millions)



Steady state estimates

The table below shows the anticipated 2022 expenditures with no program changes (status quo) and expenditures under a Model A program. Dollar amounts, shown in millions, show a post-implementation (steady state) year.

Table 12: Model A steady state expenditures – based on 2022 costs ($ in millions)

Financing source	Population[17]	Status quo expenditures[18]	Modeled expenditures[19]	Difference
Medicaid	1,704,000	$15,492	$16,377	$885
Medicare	1,722,000	$15,478	$16,998	$1,520
CHIP	62,000	$83	$93	$10
Private health insurance	3,674,000	$22,900	$13,948	-$8,952
Uninsured	334,000	$133	$384	$250
Undocumented	124,000	$45	$741	$69
Excluded populations[20]	278,000			
Out-of-pocked expense (excluding Medicare)		$3,046	$3,087	$42
Out-of-pocket expense (Medicare)		$1,156	$1,172	$16
Indian Health Services		$80	$73	-$7
Other private revenues		$3,004	$2,899	-$105
Total	**7,897,000**	**$61,418**	**$55,772**	**-$5,646**

Establishing a single provider fee schedule for care to all consumers increases the rate paid to providers for services for previously Medicaid and Medicare-covered individuals. These increases are offset by decreases in the fees paid for care to consumers who were previously commercially insured. This means employer and individual contributions decrease.

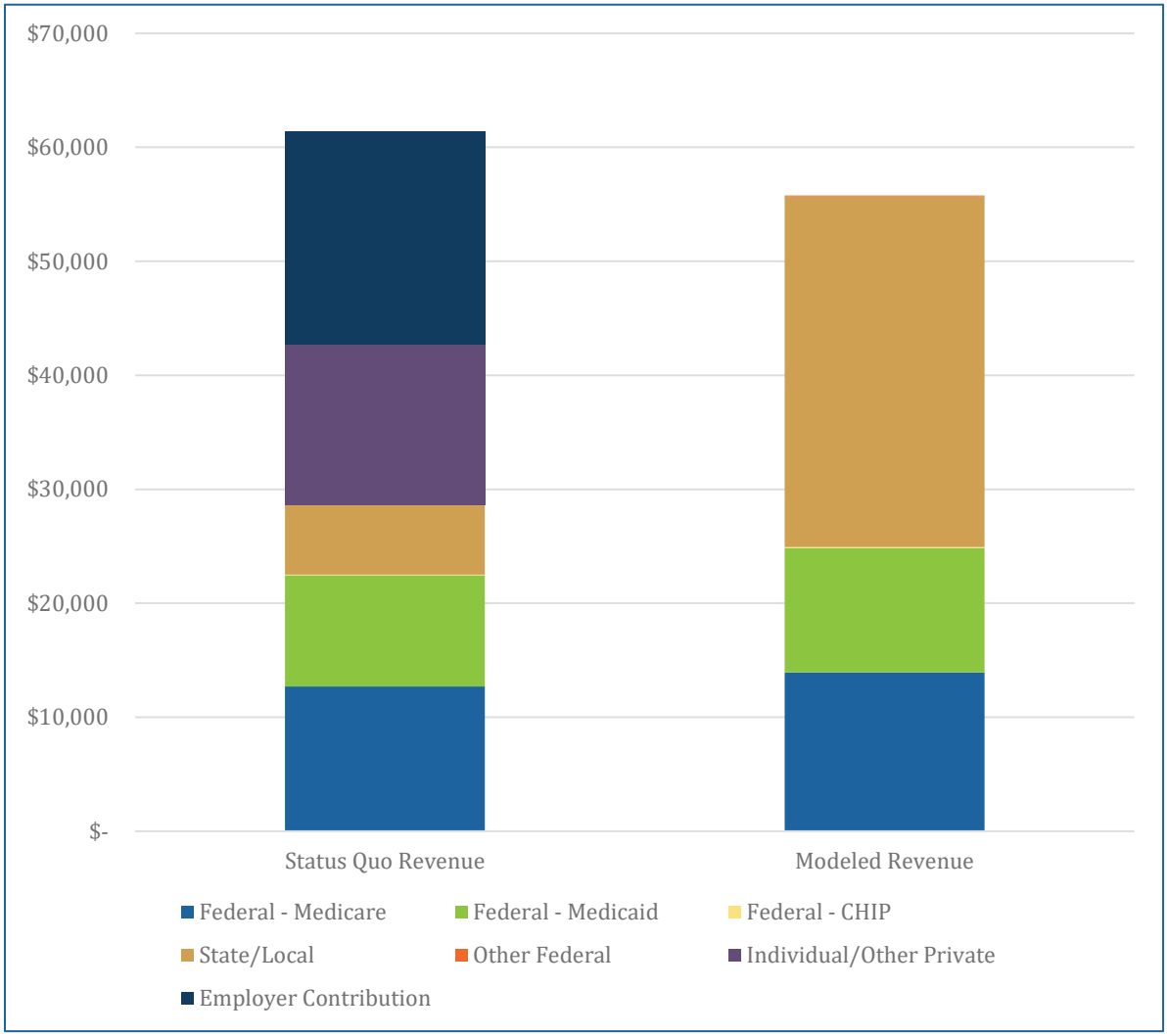
Medicaid is a state- and federal-funded program, with the federal government paying 62 percent of the costs overall.[21] It is unclear if CMS will authorize Medicaid and other public sector programs to increase provider reimbursement compared to current rates.

Additional analysis is needed to understand:

- The impact of lost insurer premium tax revenue.[22]
- The broader economic impact on the state due to industry job loss, tax implications for employers, greater labor mobility, etc.

[17] Populations are rounded to the nearest 1,000. The Medicaid population totals exclude dually eligible (Medicaid-Medicare) members. Medicaid reimbursed expenditures for dual-eligible persons are reflected in Medicare. All other Medicare-covered expenditures are included in the Medicare row.
[18] Status quo and modeled expenditure totals exclude long-term care and dental for all payer sources other than Medicaid.
[19] Estimates are based on all eligible Washington residents participating in Model A.
[20] This includes federal employees and active duty military.
[21] Federal percentage of fiscal year (FY) 2019 benefits and administration in Washington State Medicaid. Congressional Research Service, Medicaid Financing and Expenditures. November 10, 2020.
[22] Premium taxes contribute to the general fund. The Washington Legislature will need to consider the loss of this revenue.

Figure 3: status quo vs. Model A - steady state revenues (in millions)



Model A: estimated multi-year change in program expenditures

The below tables summarizes the total status quo expenditures costs and Model A program costs under different start date assumptions. Weighted average growth rates are based on population-specific national growth weights (from the CMS National Health Expenditures forecast) applied to the modeled estimates of expenditure and enrollment for the relevant populations.

The current 2022 estimates are based on available data from 2018 and include four years of projection. Projections presented in the table become less reliable over time, as it is challenging to predict how dynamics in the health care system will change.

Table 13: five-year growth rates and estimated change in program expenditures based on different starting dates ($ in millions)

Year	Growth rate	Status quo	Implementation year	Differences
2022		$61,418	$58,942	-$2,476
2023	6.2%	$65,226	$62,597	-$2,629
2024	5.9%	$69,055	$66,271	-$2,783
2025	6.1%	$73,243	$70,291	-$2,952
2026	6.2%	$77,804	$74,668	-$3,136
2027	6.0%	$82,479	$79,155	-$3,324

Model A: revenue sources

The below table shows the implementation year (2022) revenue sources supporting the status quo system how those contributions would shift by payer under Model A.

Table 14: Model A calendar year 2022 revenue sources – implementation year (in millions)

Financing source	Status quo revenue	Model A revenue estimate	Difference
Federal share – Medicaid[23]	$12,692	$14,719	$2,027
Federal share – Medicare	$9,760	$11,472	$1,712
Federal share – CHIP	$73	$87	$14
State/local share	$6,052	$32,587	$26,535
Other federal contributions (e.g., Indian Health Services)	$80	$78	-$2
Individual contribution	$14,057		-$14,057
Employer contribution[24]	$18,704		-$18,704
Total	**$61,418**	**$58,942**	**-$2,476**
Dental coverage for populations other than Medicaid[25]			**$3,052**

The below table indicates that in the implementation year, **Model A would cost $2.476 billion less in aggregate than the status quo system**.

Model A establishes a single provider fee schedule for all care. This increases the rates paid by current public sector programs (Medicaid and Medicare, in particular). As both programs utilize federal funding, the model increases the amount of federal funds used compared to the current Medicare and Medicaid programs.

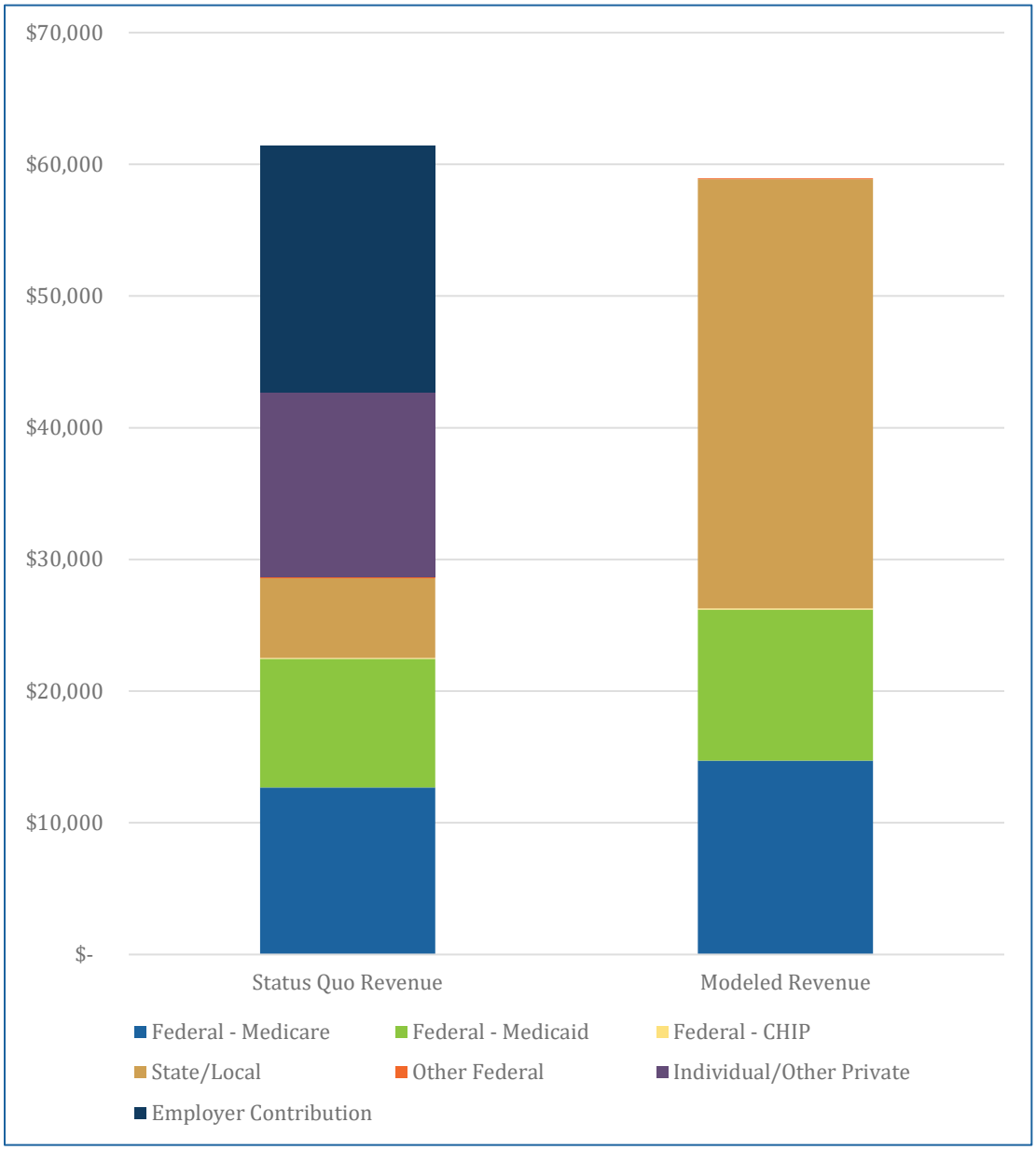
The new single fee schedule is a reduction in rates compared to what is currently paid for by commercial health insurance (employer and individual contributions). As noted previously, it is unknown whether CMS will allow Medicaid and other public sector programs to increase provider reimbursement relative to today.

[23] Medicaid funding is dependent on expenditure authorities awarded to Washington by CMS and changes in federal financial participation rates. Estimates are based on pre-CARES Act federal financial participation rates.
[24] The employer contribution includes state/local funds for public employees.
[25] Additional revenue required for covering dental services for all other populations than Medicaid, federal employees, and military, and assumes "moderate" cost level for dental services.

The Work Group did not address how the state would fund costs needed to replace current individual and employer contributions to coverage. However, the Work Group did discuss that this is an issue requiring specific focus, which could be assigned to a dedicated group as part of the reform development process.

As noted in the expenditure discussion, additional analysis is needed to understand the impact of lost insurer premium tax and of the broader economic impact on the state related to Model A's potential impact on employment, tax implications for employers, greater labor mobility, and related changes.

Figure 4: status quo vs. Model A – program year 1 revenues (in millions)



The following table represents projected calendar year 2022 revenue estimates by financing source. These revenue projections include consideration for cost-shifting dynamics that will occur due to universal health care. Note the following when interpreting the figures in this table:

- The status quo health care system includes significant funding from individual and employer contributions, including state and local public employees. These revenues are assumed to continue under Model A Universal Health Care; however, a mechanism to capture these contributions will need to be developed and implemented by the Legislature. These revenues are illustrated in the "State/local" row for the "Model A revenue estimate" column.
- Model A design includes normalizing provider reimbursement to a single reimbursement schedule. This is a significant change from status quo where reimbursement varies by payer (Medicaid, Medicare, private coverage). Subject to federal approval, this change would increase the amount of federal contributions Washington receives but also increase state general fund obligations.
- Contributions to cover uninsured, undocumented immigrants and out-of-pocket costs are included in "State/local" row for the "Model A revenue estimate" column.
- The revenue model assumes that the state will be successful in preserving federal funding streams for eligible populations, even with the programmatic changes associated with transition to a universal health care model.
- The revised Model A projected expenditures in Table 10 excluded the cost for dental coverage for populations other than Medicaid. The following table separately identifies revenue collections necessary for dental coverage for all populations beyond Medicaid.

Table 15: Model A calendar year 2022 revenue sources – steady state

Financing source	Status quo revenue	Model A revenue estimate	Difference
Federal share – Medicaid	$12,692	$13,938	$1,246
Federal share – Medicare	$9,760	$10,903	$1,143
Federal share – CHIP	$73	$81,984	$8
State/local share	$6,052	$30,775	$24,724
Other federal contributions (e.g., Indian Health Services)	$80	$73	-$7
Individual contribution	$14,057		-$14,057
Employer contribution[26]	$18,704		-$18,704
Total	**$61,418**	**$55,772**	**-$5,646**
Dental coverage for populations other than Medicaid[27]			**$3,052**

Model A: Medicare impact

As the state considers different implementation strategies, some populations will be more challenging to incorporate into the universal health care plan than others. Including Medicare would require CMS to approve a state's request to use Medicare funds in support of its program.

[26] Employer contribution includes state/local funds for public employees.
[27] Additional revenue required for covering dental services for all other populations than Medicaid, federal employees, and military, and assumes "moderate" cost level for dental services.

While Vermont spent many months discussing Medicare participation in its concept for a universal program, no state has gotten CMS to agree. While getting federal approval of a universal care program was especially challenging under the Trump Administration, some Work Group members are hopeful that the Biden Administration will be more open to this kind of effort.[28]

Xavier Becerra, President-elect Biden's choice to be the Secretary of the Department of Health and Human Services supports "Medicare for All" and could approve state requests to include Medicare funds in proposed universal care plans.[29]

The challenge of getting federal approval could result in a phased-in implementation of populations who are eligible for public coverage programs, such as Medicaid and Medicare, or the exclusion of some populations entirely. Excluding one or more populations would impact:

- The total cost of the model.
- Assumptions regarding future state revenue sources.
- Some underlying model assumptions.

If Medicare enrollees were to be excluded, total model costs would be reduced by approximately $15.4 billion. Revenue assumptions change as well. The net effect on the model of removing Medicare is a reduction of $1.5 billion in state funds needed to fund Model A at steady state.

Lastly, removing Medicare alters assumptions that impact other programs as well, such as the level to which reimbursement rates are rebalanced. The table below summarizes the change in assumed reimbursement levels for providers with and without the Medicare-eligible population included in Model A at steady state.

Table 16: reimbursement level target before efficiency adjustments

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%

Model B: universal health care, delegated administration

As with Model A, Model B establishes a single, state-designed coverage plan available to everyone in Washington State. The state also develops the delivery system rules. Unlike in Model A, Model B insurance companies contract with the state to offer plans to Washington residents.

As they do today, insurers will develop and maintain provider networks and administer some or all of the functions they currently provide, such as claims payment, utilization management, care coordination, and member and provider services.

[28] Virgil Dickson, Verma will reject any single-payer state waivers. Modern Healthcare, July 25, 2018.
[29] Sarah Kliff, Becerra Supports 'Medicare for All' and Could Help States Get There. The New York Times, December 10, 2020.

Model B: eligibility, covered benefits

Model B covers all state residents without regard to employment, income, immigration status, or documentation. This includes residents who previously had other sources of public or private (individual or group) coverage.

Table 17: assumptions for Model B

Model element	Key assumptions
Populations	• Medicaid • CHIP • Medicare • Private health insurance (employer, state employee, or Washington Health Benefit Exchange) • Undocumented immigrants • Uninsured
Covered benefits	• Essential health benefits as defined by ACA • Dental for Medicaid-eligible only (dental for others is priced separately) • Vision • Long-term care for Medicaid-eligible only
Cost sharing	• No cost sharing • Private insurance utilization changes due to removal of cost sharing
Provider reimbursement	• Reduced pricing variation between covered populations • Administrative efficiency • Increased purchasing power
Population-specific impacts	• Improved access for Medicaid-eligible population (increased use of some services, decreased hospital utilization) • Improved access and increased utilization for uninsured and undocumented immigrant populations
Administration	• Administered by managed care plans • Premium tax applies • Reflects reductions in system-wide administrative costs

Model B: expenditures

The below table shows the anticipated 2022 expenditures with no program changes (status quo) and expenditures under a Model B program. Dollar amounts, shown in millions, are for the implementation year only.

Table 18: Model B calendar year 2022 expenditures – implementation year (in millions)[30]

Financing source	Population[31]	Status quo expenditures[32]	Modeled expenditures[33]	Difference
Medicaid	1,704,000	$15,492	$17,748	$2,256
Medicare	1,722,000	$15,478	$18,465	$2,987
CHIP	62,000	$83	$102	$18
Private health insurance	3,674,000	$22,900	$15,316	-$7,583
Uninsured	334,000	$133	$423	$289
Undocumented	124,000	$45	$816	$771
Excluded populations[34]	278,000			
Out-of-pocket expense (excluding Medicare)		$3,046	$3,266	$220
Out-of-pocket expense (Medicare)		$1,156	$1,240	$84
Indian Health Services		$80	$80	-$0.1
Other private revenues		$3,004	$3,178	$174
Total	**7,897,000**	**$61,418**	**$60,634**	**$783**

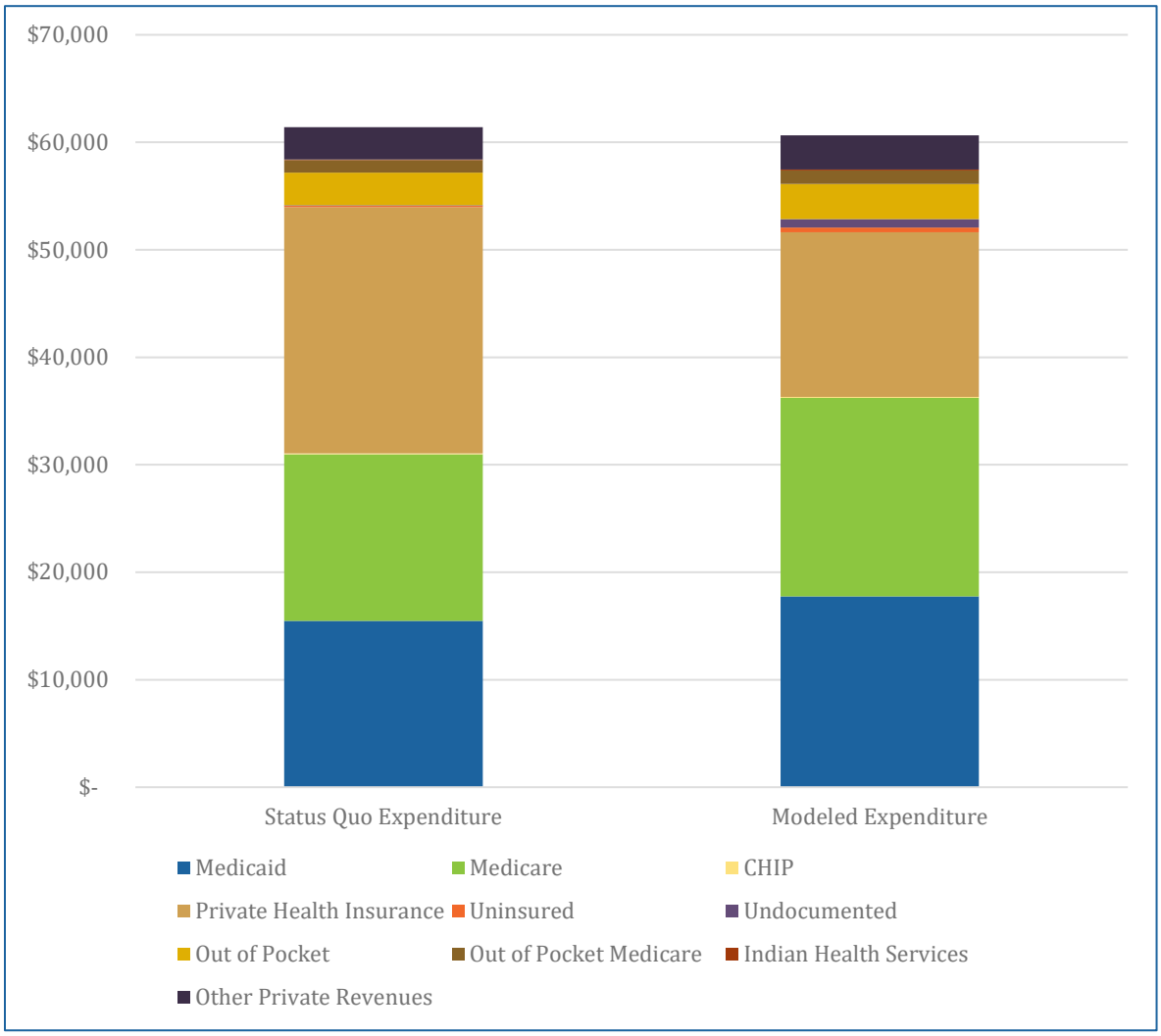
Model B is expected to reduce aggregate system-wide expenditures by approximately $783 million in the first implementation year. This impact is driven by multiple efficiencies that occur under a single-payer system, including:

- Limited reduction in payer administrative cost by reducing the number of payers across the health care system.
- Increased purchasing power.
- Provide administrative efficiencies.
- Program integrity improvements (reducing fraud, waste, and abuse).

As with Model A, Model B cost savings can also be the result of the centralized program's ability to make other changes, such as increased transparency, establishment of maximum prices, and use of care standards that promote outcomes and quality.

[30] For unrounded expenditures and populations, see Appendix A tables.
[31] Populations are rounded to the nearest 1,000. The Medicaid population totals exclude dually eligible members from the population count. Medicaid reimbursed expenditures for dual-eligible persons are reflected in Medicare. All other Medicare-covered expenditures are included in the Medicare row.
[32] Status quo and modeled expenditure totals exclude long-term care and dental for all payers but Medicaid.
[33] Estimates are based on all eligible Washington residents participating in Model B.
[34] This includes federal employees and active duty military.

Figure 5: status quo vs. Model B – program year 1 expenditures (in millions)



Model B: revenue sources

The table below shows the implementation year (2022) revenue sources supporting the status quo system and how those contributions would shift by payer under Model B.

Table 19: Model B calendar year 2022 revenue sources – implementation year (in millions)

Financing source	Status quo revenue	Model B revenue estimate	Difference
Federal share – Medicaid[35]	$12,692	$15,142	$2,450
Federal share – Medicare	$9,760	$11,801	$2,041
Federal share – CHIP	$73	$90	$16
State/local share	$6,052	$33,522	$27,470
Other federal contributions (e.g., Indian Health Services)	$80	$80	-$0.1
Individual contribution	$14,057		-$14,057
Employer contribution[36]	$18,704		-$18,704
Total	$61,418	$60,634	-$783
Dental coverage for populations other than Medicaid[37]			$3,052

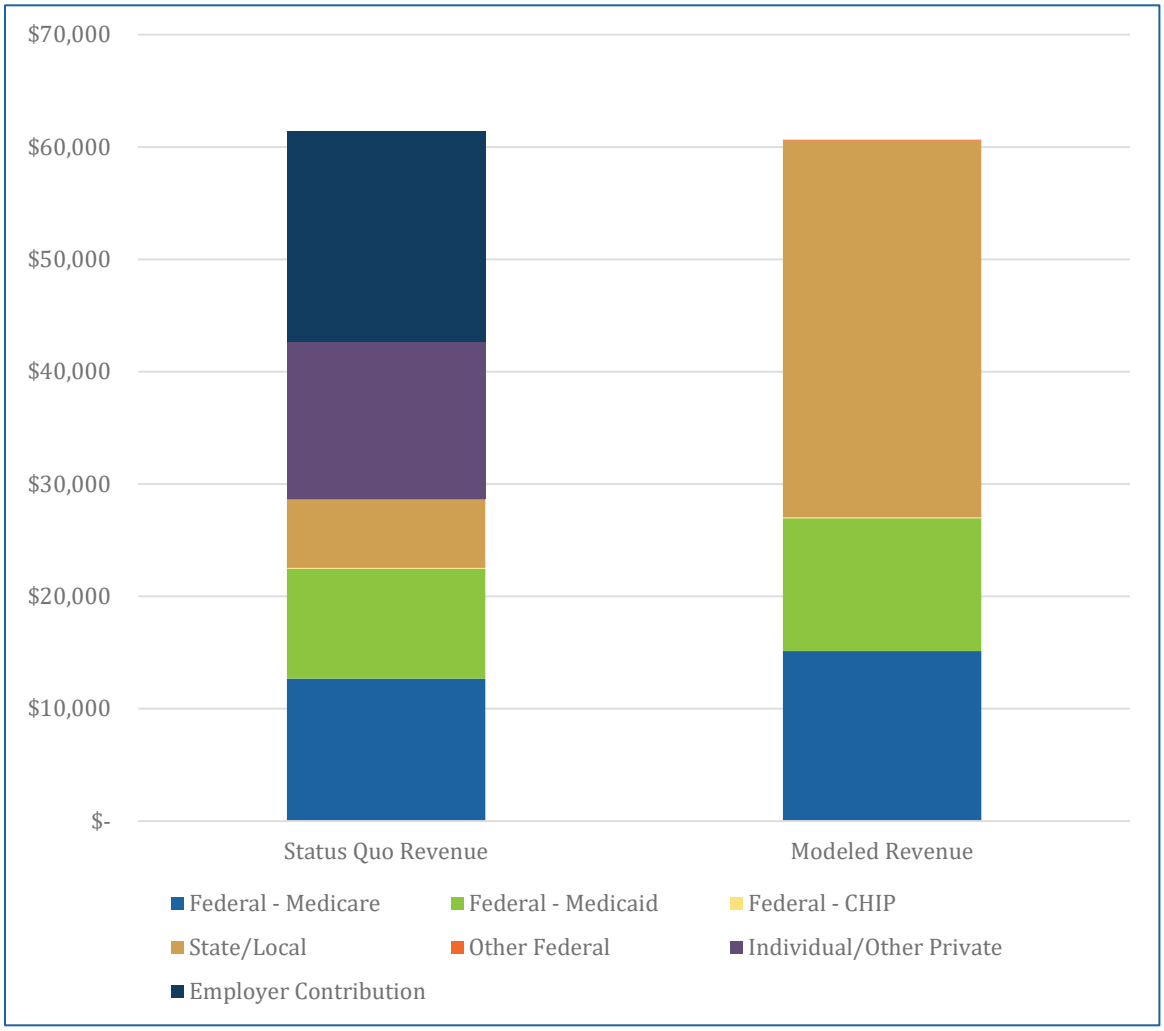
In the implementation year, Model B would cost approximately $783 million less than remaining with the status quo system. As in Model A, Model B establishes a single provider fee schedule. Rates paid by current public sector programs (Medicaid and Medicare) would be relatively higher than at present. Both programs use federal funding, meaning the model would increase the amount of federal funds used compared to today.

The new single fee schedule would be a reduction from rates currently paid for commercial health insurance (employer and individual contributions). As noted previously, it is unknown whether CMS will allow Medicaid and other public sector programs to increase provider reimbursement relative to today.

The Work Group did not address how the state would fund costs needed to replace current individual and employer contributions to coverage. The Work Group did discuss the fact that this is an issue requiring specific focus, which could be assigned to a dedicated group as part of the reform development process.

[35] Medicaid funding is dependent on expenditure authorities awarded to Washington by CMS and changes in federal financial participation rates. Estimates are based on pre-CARES Act federal financial participation rates.
[36] The employer contribution includes state/local funds for public employees.
[37] Additional revenue required for covering dental services for all other populations than Medicaid, federal employees, and military, and assumes "moderate" cost level for dental services.

Figure 6: status quo vs. Model B – program year 1 revenues (in millions)



Model C: "fill in the gaps" for people without coverage

Model C is designed to provide coverage to Washingtonians who are now uninsured. As in Models A and B, the state sets the program and delivery system rules, but insurers that meet participation requirements provide coverage to eligible individuals.

The modeled program is similar to Cascade Care, 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.

Model C: eligibility, covered benefits

Model C offers coverage to a segment of Washingtonians: those who do not have access to affordable coverage through a public program, an employer, or in the individual market. Model C is primarily designed to increase coverage for uninsured undocumented immigrants.

This model could, however, be broadened to include other groups who do not have health insurance now. The model, as developed, was shaped by the availability of data to identify impacts.

Table 20: assumptions for Model C

Model element	Key assumptions
Population	• Undocumented immigrants
Covered benefits	• Essential health benefits as defined by ACA
Cost sharing	• Standard cost sharing (based on current commercial plans)
Provider reimbursement	• Cascade Care reimbursement standards apply
Population-specific impacts	• Assumes utilization similar to commercially insured populations
Administration	• Assumes commercial plan levels of administrative costs

Model C provides coverage for populations without current access to health care coverage through the Washington Health Benefit Exchange due to their documentation status. Currently, the population that cannot access traditional health insurance are individuals who are undocumented and those ineligible for Medicaid and who cannot afford to purchase through the Washington Health Benefit Exchange.

In addition, other Washingtonians have insurance but are challenged by the cost of accessing care. Work Group members have expressed interest in expanding Model C to include options for those who are not well-served by the current system. Washington is already making progress in this arena through **Cascade Care** health plans.[38] Cascade Care may provide access to more affordable standard and public option plans, particularly if state subsidies are made available to consumers accessing Cascade Care plans.

While there was interest in knowing the cost of providing care to undocumented immigrants under the current system, this was not possible due to data limitations. A deeper dive to collect additional data and perform necessary analysis would be required to produce meaningful and supportable estimates.

Care for this population is paid by foundations, charities, other public/private organizations, and uncompensated or charity care provided by hospitals and health care providers. See footnote below for some of the research conducted on the topic over the past ten years.[39]

Cascade Care subsidy analysis

The Cascade Care authorizing statute called for a study on a subsidy program. Wakely Consulting Group's report, which was released in November 2020, analyzed the affordability and access

[38] Washington Health Benefit Exchange website.

[39] Chris Conover, How American Citizens Finance $18.5 Billion In Health Care For Unauthorized Immigrants, Forbes. February 26, 2018.
Rajeev Raghavan, New Opportunities for Funding Dialysis-Dependent Undocumented Individuals Clinical Journal of the American Society of Nephrology. August 30, 2016.
Teresa A. Coughlin et.al., Uncompensated Care for the Uninsured in 2013: A Detailed Examination, The Kaiser Commission on Medicaid and the Uninsured, May 30, 2014.
Nadereh Pourat, et. al., Assessing Health Care Services Used By California's Undocumented Immigrant Population In 2010. Health Affairs Vol. 3, No. 5, May 2014.

impacts of various subsidy mechanisms and amounts on Washington Healthplanfinder customers and the individual market.[40]

Wakely developed an interactive model used to create the six scenarios detailed in the subsidy report. Each scenario is designed to limit the cost of premiums to no more than 10 percent of household income for any consumer with household income up to 500 percent of the federal poverty level.[41]

The report assesses a model that builds on the current federal "advanced premium tax credit" (APTC) model and a fixed monthly amount. Also considered is inclusion of cost sharing assistance beyond the federal cost sharing reductions currently in place under the ACA.

Total state investment was assessed at three levels using variants of the APTC and fixed dollar approaches. The group considered three approaches to funding the subsidies: a per-member/per-month (PMPM) health insurance premium tax, an assessment set as a percentage of claims, and an assessment set as a percent of premium.[42] Wakely's estimated results by scenario are shown below.

Table 21. Wakely: best estimate premium subsidy results by scenario[43]

Premium subsidy program	Total state funding ($ millions)	Number of uninsured take-up	Total customers receiving state subsidies	% of customers with access to plan for less than 10% of income*
Enhanced APTC	$216.9	19,700	175,400	100%
Fixed $135 PMPM	$217.1	23,800	179,800	94%
Fixed $90 PMPM	$152.1	18,700	173,800	92%
Fixed $58 PMPM	$100.7	14,200	168,700	92%
Fixed $48/$96 PMPM	$101.8	14,100	169,400	92%

Detailed discussion of the analysis methodology and results, are available in a report provided by Wakely.[44]

This report could inform recommendations for expansion of Model C to align with the subsidy recommendations, potentially serving as a transition strategy to broader universal health care in the longer term. In addition, should state subsidies be implemented, the incremental funding to implement a universal health care program under Model A or B, and the total number of new insured persons, will shift from the analyses presented here.

As modeled, a state subsidy program of $101-217 million would help 168,700-179,800 individuals afford coverage in the individual market, including 14,100-23,800 uninsured individuals. These costs, if covered through the proposed tax, will be levied on all insured health products in the state.

[40] Pam MacEwan, Cover Memo to Wakely Analysis; Brittney Phillips and Julie Peper, Wakely Consulting Group, Legislative Report: Plan to Implement and Fund State Premium Subsidies. Read the cover memo and actuarial analysis.
[41] $63,800 for individuals, $131,000 for a family of 4 in 2020. Read the current Federal Poverty Guidelines.
[42] All premium tax approaches assessed by the Wakely team impact Taft-Hartley plans, which could lead to labor union opposition to the implementation of such an assessment.
[43] Brittney Phillips and Julie Peper, Wakely Consulting Group, Legislative Report: Plan to Implement and Fund State Premium Subsidies.
[44] Wakely, Legislative Report: Plan to Implement and Fund State Premium Subsidies, Op. Cit.

The impact varies by funding strategy; a claims tax or a covered lives assessment would spread the costs most broadly.

However, if Model C were a step toward a universal health care system rather than an end state, the increase in insured of 23,800 would not substantially change the estimates modeled for Model A or B. The subsidy program addresses affordability for a subset of individuals, but does not:

- Achieve universal health care.
- Tap into efficiencies from system consolidation.
- Solve affordability issues for individuals not eligible for subsidies or who cannot afford cost sharing in the plans they do have.

Model C: expenditures

While status quo expenditures are not available, the estimated current Medicaid cost (Short-Term Emergency Coverage Only) for undocumented Washington residents is $150 million, shared 50-50 by federal and state governments. All other existing system costs for this population are assumed to be individual expense or charity care.

Table 22: cost estimate of Model C (in millions)

Financial assessment	Estimates
Status quo expenditure for covered populations	Not available
Model C cost estimate	$617

Financial impact of Models A, B, and C

Both Models A and B, which cover all Washington residents, **reduce total expenditures compared to the current system**. Model A reduces costs in the implementation year by close to $2.5 billion, while the Model B reduction is $738 million. **Model C increases expenditures** by $617 million in the implementation year.

Table 23: model comparison calendar year 2022 expenditures – implementation costs excluding dental (in millions)

Financial assessment	Model A	Model B	Model C
Status quo expenditure for covered populations	$61,418	$61,418	Not available
Model cost estimate	$58,942	$60,634	$617
Cost savings	-$2.476	-$738	N/A

This table does not include the cost of dental care for populations, other than Medicaid-eligible consumers, in order to compare relevant expenditures between the status quo and each model. Including dental, which has an estimated cost of $3.052 billion in the implementation year, would eliminate implementation year savings.

However, as shown in Table 12, universal health care in a steady state (non-implementation) year shows sufficient savings to remain less costly than the status quo, even when dental costs are included.

Limitations

Federal financial participation

The preceding cost estimate analysis assumes that the current system federal revenues continue for Medicaid, Medicare, and Washington Health Benefit Exchange subsidies. All federally funded programs are governed by statute and regulation. Federal funding is conditional on program compliance with federal regulations.

To implement Model A or B, the state will need to ensure that federal financial participation is maintained or expanded. For example, the state will need to explore available Medicaid waiver authorities and state plan amendments to align covered benefits, provider reimbursement, and mandatory participation of eligible individuals in universal health care.

Given the federal government's Medicare program requirements and historic unwillingness to permit waivers of those rules, the state will need to consider how to operationalize inclusion of current and future Medicare-eligible individuals under Model A or B. This includes considering how to incorporate residents who receive traditional (fee-for-service) Medicare and may purchase supplemental coverage or those enrolled in Medicare Advantage plans.

Over 60 percent of consumers covered through Washington Healthplanfinder are eligible to receive federal subsidies for health insurance premiums.[45] The state will need to consider how to maintain federal insurance subsidies for eligible individuals, including the use of an ACA Section 1332 waiver.

Additional data analysis

The analysis and estimates contained in this report were performed using the best data available. However, the data have some limitations, including:

- Given the lag in data availability, some data are several years old.
- The lack of available, detailed data on demographics and type of service limited the ability to perform more detailed analyses or estimate the impact of provider reimbursement, additional benefits, and out-of-pocket cost sharing

Future cost estimates will require focused analyses specific to each population and covered benefits. Planning for this work should take into account it may take significant time and effort to obtain this detailed data.

[45] In 2019, 61 percent of people purchasing plans through Washington Healthplanfinder received premium tax credits and 32 percent received cost sharing assistance. Nationally, 86 percent of Washington Healthplanfinder consumers used premium tax credits and 50 percent had cost sharing assistance. CMS, Early 2020 Effectuated Enrollment Snapshot. July 23, 2020.

Qualitative assessment of potential models

The Work Group discussed the extent to which the models support the qualitative assessment criteria they developed for the access, governance, quality, equity, administration, feasibility, and affordability goals. The following is a summary of Work Group discussions.

Access

Many Work Group members expressed the view that Model A is more likely to facilitate access for all Washingtonians. Others noted that if Model B were fully implemented, it could also facilitate access. Both A and B establish a coverage system for all residents. Having insurance is associated with better access to care.[46]

It was noted that traditional Medicare functions similarly to Model A, while Medicare Advantage utilizes a Model B structure. Many Work Group members expressed the view that both Models A and B are likely to facilitate seamlessness, portability, and choice of provider. Models A and B's performance on other criteria would depend on how the established system is designed and allocates resources, highlighting the importance of implementation decisions.

A number of Work Group members expressed that Model C would be the least capable of facilitating access.

Governance

Some Work Group members expressed that Model A is more likely to perform well on governance criteria, particularly with respect to Tribal Sovereignty. Participants noted that Models B and C could enable some aspects of governance, although others noted that with more organizations involved, governance becomes more complicated. The accountability of Model A was considered a benefit, with accountability seen as less direct in Model B. Governance would not change from the present under Model C.

Quality and equity

Work Group members expressed a desire for additional clarity on both quality and equity. Some Work Group members indicated that while it would seem obvious that Model A has the potential to promote quality and equity more than the other models, doing so will very much depend on the implementation of any selected model. Members noted that addressing equity and eliminating disparities will require specific efforts to design a system that promotes change and incentivizes relevant, culturally attuned care.

[46] Uninsured respondents in the National Health Insurance Survey were less likely to report having a usual source of care and more likely to postpone or go without care or prescriptions due to cost, compared to respondents with Medicaid or other public coverage or those with private coverage. Rachel Garfield, Kendal Orgera, Anthony Damico, The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act. Kaiser Family Foundation, January 25, 2019.

Many of the quality criteria apply to equity when measuring quality across populations. Overall outcomes can mask how well providers, services, or systems work for individuals of different races, ethnicities, genders, ages, income, regions, or cultures.

In addition, researchers have identified quality measures to identify and monitor disparities in care and to assess interventions intended to reduce disparities. For this reason, quality and equity were discussed together, but some Work Group members indicated a preference to separate equity and quality and move one or more access criteria (such as culturally attuned care) to equity. For this reason, the group created a separate equity goal, with associated criteria, some of which overlap with the quality criteria.

Administration

In general, Work Group members indicated that Model A is more likely to be the most administratively simple and thus save the most in administrative costs. Model B was seen as likely to create savings relative to the status quo. However, because it retains multiple insurers, the savings would not be as large as under Model A.

Streamlining the administration could depend on whether some or all populations currently covered by federal health care programs would maintain their current coverage or be folded into the state system.

Feasibility

Most Work Group members agreed that implementing Model C is the most politically feasible, as a variant of this model already exists. Work Group members discussed that making a large-scale change in the health system would require changes at the state legislative and regulatory levels. It would also require changes at the federal level through waivers to Medicaid, the ACA, and potentially other federal requirements.

The complexity of this endeavor depends on whether some or all populations currently enrolled in federal health care programs would maintain their current coverage or be folded into a reformed system. The quantitative analyses are based on the assumption that all eligible persons and sufficient insurers would participate.

A Work Group member identified that achieving the savings of universal health care system (especially one with a single administrator) requires participation by populations currently eligible for programs regulated, funded, or administered by the federal government.

Medicare and ERISA were called out as particular challenges, as there is no established mechanism for a state to apply for a waiver of federal requirements.[47] In addition, the group recognized that implementation would require CMS approval of a Medicaid waiver. Similarly, an ACA Section 1332 waiver could be the path to incorporating federal tax credit funding and waiving other ACA requirements.

[47] The September meeting materials include a pre-recorded presentation on implementation feasibility related to Medicare and other program requirements.

Other populations and funding streams that will need to be addressed include Tribal members, federal employees, members of Taft-Hartley plans, veterans and active military, and the incarcerated.

Feasibility is also affected by the length of any phase-in or implementation period. A longer phase-in could improve feasibility. As noted by a Work Group member, plan participation under Model B is unknown but could impact the success of this model.

Affordability

Work Group members repeatedly raised affordability in discussions of the end state of universal health care, development of health reform goals, and the impact of each of the three models. Work Group members noted that affordability should be considered on several dimensions, including the consumer, stakeholders, and the state as a whole.

The group discussed affordability from an individual or family's perspective, particularly in terms of the use or elimination of cost sharing, such as co-payments and deductibles. The group also raised the need to understand and mitigate impacts on taxpayers, communities, businesses, and other participants.

The Work Group discussed affordability of premiums and cost sharing in coverage currently available in the individual market. One Work Group member noted that even for individuals receiving premium assistance, member cost sharing in the form of deductibles and co-payments can keep people from using care.

Self-employed consumers and others whose income fluctuates can find themselves paying more than they anticipated for coverage, as income changes impact their eligibility for premium tax credits. This Work Group member expressed concern that offering coverage to more people (Model C) without changing the system's cost structures does not increase affordability for anyone. Other members stressed that to ensure financial sustainability, costs must be reined in before the state focuses on expanding coverage.

In addition, Work Group members stressed the need for any model to ensure long-term sustainability by controlling spending system-wide. Some participants stressed the need to further explore the evidence on the optimal approach to simultaneously ensuring affordability, engaging participants in their care, and preventing overutilization or low-value care.

Other key Work Group discussions

Cost sharing[48]

Model A and Model B were analyzed with the assumption that no cost sharing would be included. This decision came after significant discussion of the topic, where some Work Group members

[48] Cost sharing is any amount a consumer is expected to pay for specific care or services received. This includes deductibles, flat dollar co-payments, and co-insurance (amount assessed as a percent of billed amounts). References to cost sharing in this discussion refer to any cost sharing, except where a specific type of cost sharing is specifically included in the text.

expressed concern that cost sharing would keep consumers from seeking needed care. Others articulated a desire to use cost sharing to limit the use of low-value services.

Work Group members who opposed cost sharing indicated that cost sharing is a barrier to care, citing research shared by the project team and indicated it puts the burden on the consumer to determine whether the care is necessary. These members also noted that cost sharing exacerbates inequities of access and financial burden in the current health care system.

In addition, members identified that administering cost sharing increases provider and health plan costs and noted it didn't make sense to ask the consumer to pay more for care once they have paid premiums. Work Group members said that efforts to improve quality will eventually reduce costs and said that no credible research indicates that cost sharing reduces use of low-value care.

One member noted that the American Indian health care system does not utilize cost sharing and shows no evidence that people overuse it. Another shared that waiving cost sharing for COVID-19 testing has incentivized people to get tested.

Work Group members who wanted to consider the use of modest cost sharing noted that it could support key health system goals. For example, high-value services would not be subject to cost sharing, while other services (such as elective surgery) would require the consumer to pay a share. Another suggested approach was to waive cost sharing for care provided by providers who meet quality and cost standards. Individuals who wanted to see a provider who didn't meet quality standards or was more expensive could pay a portion of the cost.

The Washington Health Benefit Exchange found that flat dollar co-payments (rather than co-insurance as a percent of billed amounts) has a modest impact on inappropriate use. However, they have also seen evidence that high cost sharing leads consumers to defer care.

The California Public Employees' Retirement System (CalPERS) administers pension and health benefits to over 1.6 million California public employees, retirees, and their families. CalPERS uses cost sharing to encourage consumers seeking specific services (such as knee surgery) to use hospitals with which CalPERS has more favorable reimbursement terms.

While Work Group members disagreed on whether the models should include cost sharing, they generally agreed on the following parameters for any use of cost sharing:

- Limit total cost sharing to a percent of income, recognizing this could be expensive to administer.
- Structure cost sharing to avoid catastrophic financial loss for individuals and families.
- Deductibles were not popular; however, if deductibles were included, they should be structured to limit the impact to consumers early in the year to allow costs to be spread over the year.

A Work Group member noted that co-insurance is not transparent and can be difficult for the consumer to understand or calculate ahead of time. Another indicated that co-payments are more desirable than co-insurance because pre-determined flat amounts provide cost predictability. This is particularly important for individuals with chronic disease and others with high-care needs.

Provider reimbursement

The Work Group discussed whether:

- Analysis of Models A and B should assume that providers will experience lower administrative costs in a universal care system.
- These models should assume increased state purchasing power relative to today, which would allow the state to modify provider compensation.

Work Group members indicated that assumptions about the potential for lower administrative costs in the model needed to be specific, realistic, and information-based. Members thought the models should assume a single set of billing rules and rates for all providers. Some noted that savings assumptions should be different for large health systems and small medical practices.

One member suggested the use of cost-based payment for smaller practices like the cost-based reimbursement that Federally Qualified Health Centers receive.

Work Group members recognized that a universal system with state-determined rates will increase transparency and give the state greater purchasing power. Many people noted that savings will depend on program design and implementation. Work Group members also raised the following issues:

- In developing a universal health care program, the state will need to consider how any potential savings are used (e.g., to bring down overall costs or to pay for additional benefits).
- Some federal regulations limit efficiencies and the state's ability to reduce administrative costs. These limitations will need further examination.
- Current efforts to reduce costs and increase transparency in Washington State should inform the development of universal health care program design and implementation.
- Senate House Bill 2457 requires HCA to create a Health Care Cost Transparency Board to establish cost growth benchmarks and will have a role in provider reimbursement.

Work Group members noted that different types of providers (and those in different settings) are reimbursed differently. One member indicated that Medicare hospital reimbursements have increased over the past two decades, while physician and other provider reimbursements have stayed fairly flat.

Another issue raised is that a new system should be designed to increase primary care payments relative to other spending. One suggestion was to start by reducing specialty care reimbursement and applying the lessons from the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely," an initiative that seeks to advance a national dialogue on avoiding unnecessary medical tests, treatments, and procedures.

The Work Group discussed the related point that some providers (e.g., home health workers) are paid significantly less than others and adjustments to provider payments should not exacerbate these differences.

A Work Group member noted that providers can "game" the fee-for-service system by providing more units of care for which they are reimbursed. This incentive could be changed by paying providers and health systems based on quality care and population outcomes.

Overall, Work Group members indicated that they would like universal health care models to reallocate any potential administrative savings to reduce patient costs or invest in better care. They also want to see a system that allows the state to use its purchasing power to drive system change, recognizing that this is a complex issue that will take time and more effort to address.

Covered benefits

The Work Group acknowledged the significant research and deliberation that has occurred in Washington and other states to develop benefits packages. Several Work Group members suggested that a universal health care benefit package build on that existing research.

Work Group members discussed the need for a comprehensive benefit package that improves health and is attractive enough to keep participants enrolled without a mandate. Additional benefits mentioned include dental, hearing, chiropractic care, and acupuncture for both adults and children. Work Group members raised the following as additional considerations for assessing a benefits package:

- Does the model address social determinants of health that may result in cost savings?
- Does the model cover gender-affirming care?
- Does the model cover rare diseases?
- Do the benefits include whole-body, holistic care?
- Are the covered benefits culturally attuned (e.g., is traditional medicine covered)?

As the Work Group examined Model A and B, members generally agreed with using Washington's essential health benefits benchmark as the foundation for benefits under all three models. Many also wanted to include adult vision and dental in the universal health care models but acknowledged this would incur higher costs to the state. To better understand these costs, Work Group members examined the models to see the actuarial outputs with and without vision and dental benefits.

Work Group members wanted to be sure the models include robust mental and behavioral health care benefits. There was discussion that behavioral health was already covered fully or partially within the current system, due to the essential health benefits and Washington's mental health parity laws.

Some Work Group members wanted to include long-term care, but several people noted a robust long-term care benefit would "kill" any proposal due to the cost. Some members acknowledged that if long-term care is included as a benefit, it would have to align with Washington's new long-term care benefit, valued at $36,500 over a lifetime.

When examining Model B (universal health care with delegated administration), a few Work Group members suggested that standardizing the benefit and coverage designs offered would reduce administrative costs and make the health plan options easier to compare directly. Some Work

Group members noted that this approach can be used to support evidence-based care and reduce low-value care, though this approach is not always transparent.

Work Group members discussed the extent to which the state should be an active purchaser under this model, using its large enrollment to reduce costs and improve quality. Generally, Work Group members agreed the state should have a strong role in standardizing and overseeing plans and insurers to avoid many of the pitfalls of the current system, such as limited networks and access to care.

A Work Group member noted that employers use health benefits for recruiting and retention. As such, some larger employers may resist participating in a universal health care program. Another member pointed out that organized labor has shown extensive support for universal health care.

Supplemental or substitute coverage

Some Work Group members expressed interest in allowing individuals covered by a universal system to also buy additional benefit coverage, similar to Medicare supplemental insurance (often called "Medi-Gap" coverage) for the Medicare population. A Work Group member indicated this would be important to the labor community, which has secured many improvements to coverage offered by labor unions. Banning supplemental benefits would threaten the gains won by this sector.

Other Work Group members acknowledged it would be important to consider the potential unintended consequence of allowing those able to afford additional or substitute coverage options to opt out of the universal program, including the potential negative impact on the universal model's risk pool. At the same time, Work Group members suggested that allowing consumers to add coverage or "opt out" might generate acceptance of the new model.

Covered populations

The Work Group's consideration of the populations that should be covered under a new model were informed by discussions of the goals of universal health care coverage. There was strong desire across the Work Group to consider a model that covers all Washington State residents, without regard to age, employment, disability status, geography, or immigration status. The members also discussed the idea of transitioning different populations to a new model, starting with an initially covered population and phasing in additional groups over time.

The Work Group discussed the issues related to including programs funded in part or entirely by the federal government. Ultimately, Models A and B were defined to include all state residents, including those:

- Eligible for Medicaid, CHIP, and Medicare.
- With private market insurance (including employer-based group plans, state employee plans, and individual coverage both in and out of Washington Healthplanfinder).
- Undocumented immigrants.
- Other uninsured people.

Model C assumed participation by Washington residents without access to traditional health insurance coverage, which is primarily the undocumented population.

Inclusion of federally funded program populations

Work Group members understood the challenges involved in including all individuals currently enrolled in federally funded programs, such as administrative hurdles and potential delays in securing federal approval to include these populations.

One participant noted that the Washington Health Security Trust model initially excluded participants in seven types of federally funded programs, with the plan to include them once required waivers were achieved. One Work Group member suggested that individuals with federal coverage could be allowed to "buy into" the Washington plan.

Work Group members grappled with the challenges and time involved in securing agreement from the federal government to allow Medicare to be included in a state universal health care plan. They weighed these issues against the desire for a comprehensive universal health care plan.

In a discussion that occurred before the presidential election, a Work Group member noted that depending on the outcome of the elections, the state could have the opportunity to seek a federal partnership that included Medicare as part of a single-payer system. Other suggestions included creating a state-based Medicare supplement plan to fill gaps in Medicare coverage, and/or designing a universal health care system that could incorporate Medicare in the future.

Some Work Group members indicated that limiting federal involvement by excluding federal programs, such as Medicare, may be a more expedient option. Several Work Group members expressed concern that including Medicare beneficiaries in the program would mean increasing the population risk and costs, as Medicare consumers are older and have more health issues than the population at large.

Work Group members discussed that some federally funded programs, such as Indian Health Services and Tribally-run health facilities pay for health care services, but are not health insurance coverage. It was noted that federal law established Indian Health Services as care of last resort and should be included in the model. Another member noted that the group should keep magnitude in mind: Indian Health Services funding represents a fraction of one percent of Models A and B totals and many Tribal members are currently covered by Medicaid, Medicare, or Tribe-purchased insurance.

Coverage for immigrants not eligible for existing programs

During discussions of Model C, some Work Group members supported this model covering immigrants not currently eligible for coverage through existing programs. A few Work Group members pointed out the COVID-19 pandemic has demonstrated the financial and societal costs of not providing affordable and accessible health care to immigrants. Others stated that it is an ethical requirement to cover this population. Some Work Group members added that immigrants are contributing to the state economy and paying taxes, and as such, should be able to receive benefits.

Unaffordable employee coverage participation

The Work Group discussed the challenges of coverage and care affordability for many Washingtonians eligible for current health insurance options. Many members expressed an interest in finding ways to support that population, while others noted the difficulties in precisely identifying the size of this subpopulation.

Some Work Group members said that employees with income under a specified threshold should be allowed to participate in Model C if it is more affordable than their employer plan. One Work Group member recognized that this could have the unintended consequence of encouraging some employers to drop their group plans, but that was not necessarily bad if the coverage and affordability standards were better in this model. Work Group members noted that this is a step toward de-linking employment and health coverage, which could be a challenging transition for some employers.

Transition issues

The Work Group discussed whether a universal health care model should be done through one simultaneous set of changes that would bring about a new system, or if change should be achieved through a multi-step transition. Most Work Group members agreed that Model C is not a universal health care system, and some saw it as an interim effort to improve coverage and access for populations at highest need while additional work occurred to a desired "end state."

The Work Group heard a summary of the efforts to achieve universal health care for children in Washington. This started with the Legislature stating its goal to cover all the state's children and continuing over the next five years through a series of changes. (See Appendix G for more in this and other Washington health reform efforts over the years.)

Some Work Group members were concerned that a goal with a five- to ten-year timeline put universal health care too far out, while others were more supportive of a multi-year process. Some Work Group members noted that a transition to universal health care would cause significant changes for individuals and industries, including Washington residents working in and around the health insurance industry. One Work Group member said that the state will need to consider how to support the skilled workers in health care administration whose jobs will be changed or eliminated.

Summary of models' ability to achieve goals

The below table presents the project staff's effort to capture the tenor of the Work Group discussions using a red-amber-green scale. For access, governance, quality, equity, administration, and affordability, red indicates the Work Group's sense that a model has very limited ability to meet the goal. Amber indicates the model has some ability to impact the goal. Green indicates that the model could greatly impact achievement of the goal.

For **feasibility**, green indicates that development and implementation will be fairly easy, amber indicates some significant challenges exist, and red indicates there are very large hurdles to implementation. Work Group members were very clear that how a given model is actually implemented would make a substantial difference in the extent to which it could actually help achieve the goals.

Table 24: high-level assessment of models' ability to achieve goals

Goals	Model A	Model B	Model C
Access			
Governance			
Quality			
Equity			

Administration			
Feasibility			
Affordability			

Some Work Group members disagreed with the ratings, particularly for feasibility and affordability. Model A's red rating is based on challenges related to including the Medicare population and associated funding, addressing an ERISA challenge, and overcoming likely opposition by the health insurance industry.

Several Work Group members commented that under the incoming Biden Administration, Model A could be more feasible to implement than previously assessed. As noted elsewhere, President-elect Biden's Health and Human Services nominee, Xavier Becerra, has previously expressed support for universal health care programs and may be receptive to state proposals to waive Medicare requirements.

In addition, the incoming administration is likely to change the requirements for an ACA Section 1332 waiver in ways that would facilitate state efforts to establish a universal health care program. A member also noted that the State Based Universal Health Care Act could get approved if the Senate gains a Democratic majority.

Table 24 only attempts to provide a high-level view of each model's ability to achieve the goals, which we recognize can mask the complexities involved in the work. The colors represent the overall ability to make change, recognizing there are many impacts within a given area. The yet-undefined details of each model will affect the true impact on the identified goals.

Survey of Work Group perspectives

In December 2020, Work Group members were asked to respond to a survey regarding their preference ranking of Models A, B, and C. Twenty-nine of the 37 Work group members participated.[49]

Table 26 provides the responses to the ranking questions. Information from respondents who chose to explain a "none of the above"/non-ranked answer is shown in footnotes. Seven of the 29 respondents indicated they were abstaining from stating a preference; their names and affiliations are listed in Table 27. Table 28 provides the open-ended responses from respondents who chose to include additional information.

Table 25: notes on ranking

- 1 Respondent's most preferred model of the three options
- 2 Respondent's second most preferred model of the three options
- 3 Respondent's least preferred model of the three options
- -- Respondent did not enter a ranking for the model

[49] "Participation" means the individual visited the survey link and either engaged in ranking (22 people) or abstained (seven people). Eight other Work Group members did neither and are not included in the tables.

Table 26: Work Group member responses to the model preference survey

Member[50]	Organization/affiliation	Model ranking		
		A	B	C
Barbara Detering	Kaiser Permanente	2	3	1
Kerstin Powell	Port Gamble S'Klallam Tribe	1	2	3
Randy W Scott	Pacific Health Coalition	1	2	3
Don Hinman	Yakima Neighborhood Health	--	--	2
Dennis Dellwo	State Representative (retired)	1		3
Vicki Lowe	American Indian Health Commission for WA State	1	2	3
Lynnette Vehrs	Washington State Nurses Association	1	3	2
Sarah Weinberg	Physicians for a National Health Program Western WA	1	--[51]	3
Rod Trytko	Anesthesiologist, self employed	--	--	--[52]
Ronnie Shure	Health Care for All - Washington	1	2	3
Peter McGough	Retired; past president WSMA	1	3	2
Jane Beyer	Office of the Insurance Commissioner	--[53]	--	--
Sybill Hyppolite	Washington State Labor Council	1	3	2
Chris Bandoli	Association of WA Healthcare Plans	--	--	1
Nicole Macri	Washington House of Representatives	1	2	3
Bevin McLeod	Alliance for a Healthy Washington	1	2	3
Kelly Powers	2021 Cascade Care Exchange Consumer	1	2	3
Aaron Katz	University of Washington School of Public Health	1	2	3
Mohamed Shidane	Somali Health Board	1	--	3
Richard Kovar MD	Country Doctor Community Health Centers	1	2	3
Patrick Connor	National Federation of Independent Business	2	3	1
Carrie McKenzie	Goldcore Innovations	1	2	3

Table 27: Work Group Members who responded to survey as "abstaining"

Member	Organization/affiliation
Carrie Glover	Dziedzic Public Affairs
Mary Beth Brown	Washington State Department of Health (sub for John Wiesman)
Susan E Birch	Health Care Authority
Emily Randall	Washington Senate
Dean Carlson	Washington Department of Revenue
Rep. Joe Schmick	State Representative
Pam MacEwan	Washington Health Benefit Exchange

[50] Responses are show in the order the Work Group members responded to the survey.
[51] Sarah Weinberg reported: I really think Model B is a waste of taxpayer dollars, so I don't want to rank it at all.
[52] Rod Trytko reported: Model C does not provide universal access.
[53] Jane Beyer reported: I've not had a chance to review these options with the Commissioner, so am not able to express his preference at this time.

Table 28: comments in open-ended survey question[54]

Member	Open-ended comments
Barbara Detering	I believe we are more likely to continue progress on the path to a universal coverage system by taking a stepwise approach. I would want the fill in the gaps to be ON THE PATH to universal coverage
Kerstin Powell	I believe the majority of Americans want Universal Healthcare. I believe there is a lot of push back from the insurance industry and pharmaceutical companies that makes it difficult for the legislator to move it forward. We need to clearly reflect the feedback and input we have gotten from the public and the work group that this is the preferred choice. Thank you.
Dennis Dellwo	We need to have A as our goal. We should not paint it red and say it is unfeasible. C could be a first step, but not our goal.
Vicki Lowe	I think that Model C could be a stepping stone to Model A as we build infrastructure. We keep getting hung up on costs and savings in the short term but I hope our legislators can think further down the road and see the longterm savings to all of our systems for having healthier Washingtonians.
Lynnette Vehrs	Model C only if is State Administered. Keep the insurance companies out! Model C can be used in transition with the main goal for Model A.
Sarah Weinberg	If the work of this WG is going to lead to something other than a long report gathering dust on a shelf, we MUST make a strong recommendation. Model A should be a goal for the state to implement over a few years. Some of the fill-in-the-gaps ideas can provide more immediate aid for people who are really hurting NOW. I see these two ideas as separate from one another.
Rod Trytko	Model A and B not feasible. Model C currently does not provide universal access.
Ronnie Shure	Model C alone will not solve the hidden costs in the current dysfunctional health care system.
Peter McGough	While I support Model A as our destination, political considerations lead me to choose Model C as the way to get to A
Sybill Hyppolite	I support working on option C in the short-term to build toward a broader vision.
Chris Bandoli	My organization can't support Model A or B so I left those without ranking.
Nicole Macri	Option A is where I think we should ultimately go. I agree with comments that implementing the "right" Model C is a necessary and important way to more quickly extend affordable, equitable coverage and access to care on the path to Option A.
Bevin McLeod	My choice is Model A, using a state administered Model C as a bridge to get to A by a specific date. Included in this should be a commission of sorts to work with the state to continue this work and delineate the steps needed to get to Model A via Model C.
Kelly Powers	I recommend Model A as the Desired State Goal to be reached in 2-3 years. Currently, health care insurance premiums on the Exchange are unaffordable and the deductibles and cost sharing is such a burden that we joke we need insurance for our health insurance! Optumas' work shows that Model A will deliver substantial savings of health care spending in our state. It is the best way to address racial and gender inequities in our health care system. We could start ramping up now and have it running in a few years when the COVID crises have passed. We could cover more people at less cost than they are currently paying now. A Model C that intentionally builds toward Model A is the long term sustainable solution that will help the most people for the best value. Thank you to HCA, HMA and Optumas for all your hard work and allowing us to have these discussions.

[54] Comments are shown as the respondents wrote them.

Aaron Katz	I favor the Legislature making a time-certain commitment to a universal coverage system, preferably Model A. I would advocate, in addition, that some form of Model C be developed and implemented in a way that makes further progress in getting people affordable coverage AND builds toward Model A - that is, builds the systems, infrastructure, benefit and payment structures that are compatible with and support of Model A.
Mohamed Shidane	I also agree that Model C can be used as a pathway to get model A.
Richard Kovar	I am voting for universal coverage that is state administered but passes through entities that are prepared to manage care and costs and contract with the state. The rate would be set to cover costs but not profit that goes to shareholders. Thus the only realistic option would need to be via a non profit entity. For profit entities need to be removed from the equation.
Patrick Connor	We have not adequately explored the costs and other barriers to either A or B. (Nor did we give serious consideration to other models or options.) C will happen regardless of what other recommendations are put forth.
Carrie McKenzie	I believe that if done properly, model A will be the most time and cost efficient. But to be successful, you must stop making some people pay more than others. The cost should be the same for everyone. How that gets paid should be separate from what gets charged so that the true cost and inefficiencies stay visible. People should make enough to pay their bills. Allowing those without representation to pay more than those that do have representation should not be allowed. One true price should be established based upon what it actually costs. What salary you make is irrelevant to how much you should be charged for healthcare. It should be based upon the cost of delivery and the prevention of cost gauging.
Rep. Joe Schmick	Universal Healthcare Workgroup personal observations: **Cost of the program.** Plan A cost estimate or expenditures for the calendar year 2022 is $58,942,000,000. The status quo estimate is $61,418,000,000. This would be a potential savings of $2,476,000,000 or 4.1%. The state budget for the 2019-2021 biennium is approximately $54 billion. In essence Universal Healthcare will more than double the state budget. As a policy maker, I would not support dismantling the current system for an estimated savings of 4.1%. I would like to point out as an example, the Urban Institute report for Medicaid expansion predicted that by 2020 there would be 1,473,000 enrollees in our state. The actual monthly average is 1,891,976 for 2020, the difference of 418,976 or 22% higher. Even the best estimate using good data can be off and create huge additional expense to the taxpayer. **Securing waivers from the federal government.** The assumption is that waivers will be issued to Washington State for this program. Waivers for Medicare, Medicaid, Children's Health Insurance Program (CHIP) and Indian Health Services will all have to be in place. The federal government has had a policy that it would look to decrease its oblication to the states. That in turn would leave our state taxpayers holding the bag for any cost overruns. **Opposition from interested parties.** The assumption is that there will be no pushback from private insurers, insureds, self-insured plans, or Taft Hartley plans. We were told in the meetings that the Washington State Labor Council supports Universal Healthcare. I looked up the resolution and it does say that, but only if the universal plan has more coverages and benefits. There has been no discussion about potential opposition-political or legal-likely to arise from private insurers, employers (particularly those that self-insure), private-market insurance policy holders, or others who have made significant investments in the existing system, and may strongly oppose any Universal

	Healthcare proposal put before the Legislature or the voters, either as a referendum or initiative, or seek its nullification in the courts. **Expectations under Universal Healthcare.** After sitting through discussions, the expectation seems to be that your local doctor will be in total control of healthcare. She or he would make the latest drug therapies and procedures readily available which I do not believe will be the case. The reality will be that only once drugs are approved based on the criteria set and them met by an approving State board or other entity will new or experimental drugs or procedures be allowed for the patient. Terms such as "evidence-based practices" were used by the doctors in our discussions, however I don't believe the public understands this to mean only approved procedures and drugs will be allowed when approved by the state. Elective surgeries will also be harder to come by as they will have to be approved by a state entity. **Medical debt providers carry.** When reimbursements drop from what private insurance currently pays down to Medicare levels, how will highly trained professionals pay off school debt? If Washington does not provide a way to pay this debt, what will entice a doctor who trained here to stay particularly when moving elsewhere will put themselves in a better financial situation? If a hospital or health delivery system is unwilling to assume debts of providers due to its own reduced reimbursements levels, how will it attract doctors or other providers? There has been no discussion of the amount taxpayers may be forced to bear to address this concern. **Universal coverage.** Since her proposal will cover anyone in our state, what keeps people from moving here? The state is forbidden to utilize residency requirements for program benefits. In border counties that I represent, many Idaho residents cross the river (in the case of Clarkston) or border, rents a mailbox to establish residency, then receives more generous benefits courtesy of the Washington taxpayers. Universal healthcare would likely attract not just border state neighbors looking for "free" medical treatment, but act as a magnet for sicker individuals. That almost certainly would drive costs up, adding even more cost to an already unaffordable system. **Government run plans.** There have been many comments from the public about not being able to access care, particularly from those enrolled in Medicare and some exchange plans. Barriers could be in the form of co-pays, out of pocket expenses, inability to access procedures or drugs not approved etc. With Universal Healthcare, aren't we just trading one government run program for another with the same or more severe limitations and restrictions?

Achieving a vision for a universal health care system

To achieve universal health care will require the Legislature, Governor, state agencies, and a range of stakeholders to engage in a series of staged activities that will likely require many transition steps. This includes choosing one model, defining detailed operational plans, and establishing policies to ensure the health reform goals are achieved.

Some Work Group members noted that while Model C would not deliver universal access or achieve desired health reform goals, it should be a step toward universal health care. Model C would provide coverage for a group with immediate need for coverage while a more comprehensive system was being built.

Work Group members acknowledged the need to "fill in the gaps" and to maintain current coverage as a new system is formally adopted, implemented, and operationalized. Ensuring a smooth transition and avoiding disruptions in coverage for Washington State residents requires concerted effort over time, even in the face of fiscal and political challenges. This concept became part of the example transition plan laid out below.

Example transition plan

The following is an example transition plan that outlines the steps and work needed to reach a state-level universal health care system.

This process example is not tied to a specific coverage proposal, but instead identifies the steps—including the development of program funding and structure—along with other considerations that will impact the health coverage and health care for Washingtonians.

This example establishes a four-year process that begins in January 2021 and utilizes a dedicated group (a Universal Health Care Commission) that could be legislatively established to spearhead the work. This example transition plan assumes the Universal Health Care Commission (UHCC) would be an action-oriented, focused group, supported by targeted Work Groups used to define specific topics. Stakeholder input is anticipated at multiple points during the process.

The path to universal health care is conducted through three work streams:

Table 29: outline of three work streams

Work Stream 1	Protect coverage and reduce uninsurance.
Work Stream 2	Define and implement coverage structure, cost containment strategies, and administration.
Work Stream 3	Define and implement financing, program standards, and transition actions.

The following table presents the work in the three color-coded work streams, identifying the lead for each step. For more details on each step and a timeline of the example process, see Appendix B.

Table 30: example timeline for universal health care implementation

Activities	Lead(s)	Work streams		
Maintain existing public coverage	Legislature, Governor			
Pass legislation that: • Sets 5-year goal for universal health care. • Establishes a structure for a 5-year plan. • Establishes Universal Health Care Commission (UHCC) and defines a process.	Legislature, Governor			
Initiate UHCC to support and oversee development of Recommendations.	UHCC			
Develop Phase I action plan for coverage of uninsured.	UHCC Phase I Work Group			
Conduct stakeholder engagement – Phase I.	UHCC, state			

Activities	Lead(s)	Work streams		
	agencies			
Develop Phase II(a) action plans for: • Cost-containment strategies. • Coverage structure. • Program administration and operations.	UHCC Phase II(a) Work Groups			
Conduct stakeholder engagement – Phase II(a).	UHCC, state agencies			
Finalize Phase I Recommendations to Legislature for coverage of uninsured.	UHCC			
Pass legislation adopting Phase I coverage changes for uninsured.	Legislature, Governor			
Finalize Phase II(a) Recommendations to Legislature re: cost containment, coverage, and program administration/operations.	UHCC			
Implement Phase I changes.	State agencies			
Develop Phase II(b) action plans: • Develop budget and financing strategies. • Develop process for establishing quality goals and administering reporting process. • Operational planning advisory support. • Transition planning.	UHCC Phase II(b) Work Groups			
Conduct stakeholder engagement – Phase II(b).	UHCC, state agencies			
Conduct detailed operational planning.	State agencies			
Finalize Phase II(b) Recommendations to Legislature re: financing, program standards, and transition.	UHCC			
Pass Phase II legislation.	Legislature, Governor			
Conduct Phase II implementation activities.	State agencies, partners			
Enroll eligible people in Phase I coverage.	State agencies, partners			
Enroll eligible people in Phase II coverage.	State agencies, partners			

Other near-term work: equity

Many members of the Work Group expressed the desire for Washington to design and establish a health system that addresses health equity. The Work Group discussed an equity assessment as a way to methodically evaluate and measure the system as it is designed and implemented. The following provides additional information on the use of equity assessments in Washington and a proposed Office of Equity in the state.

An equity assessment is a tool for identifying inequitable policies, procedures, practices, and outcomes. Equity assessments have been used by organizations and groups ranging from governments and public sector agencies, to small nonprofit organizations and large corporations. Such assessments may include identification of institutional inequity, allocation of resources, community engagement, and alignment with organizational priorities. Assessments can be used to identify where changes are needed in existing programs and organizations and to help develop new programs.

Equity assessments are already in use in Washington State. For example, at the local level, the Government Alliance on Race and Equity developed a Racial Equity Toolkit for the City of Seattle.[55] Starting in 2009, all city departments use the Racial Equity Toolkit, including in the preparation of budget proposals. As of 2015, the toolkit became part of how department heads are assessed.

Other equity-focused work is underway at the state level. A proviso in the 2019-2021 biennial operating budget directed the Governor's Interagency Council on Health Disparities to convene and staff an Office of Equity Task Force.[56] The Task Force, which was directed to develop a proposal for a new Washington State Office of Equity, included participants from the state Legislature, representatives of state agencies, councils, commissions, and community representatives.

The Task Force submitted a preliminary report to the Legislature in December 2019, detailing recommendations for the general structure, primary roles, and estimated operating budget of an Office of Equity. The final report was released in July 2020.[57]

In June 2020, the Task Force sent letters to the Governor and legislative leaders restating the need for an Office of Equity, citing the pandemic and calls for racial justice that had highlighted the need for the office over the prior six months. There is an opportunity to leverage the ongoing work on equity in the design of any new health care system.

Issues for future analysis

The budget proviso that established the Work Group included an ambitious list of topics to cover. Given the size and complexity of the task, Work Group members' broad range of perspectives and the challenges presented by the pandemic, some topics were only addressed superficially or noted as future topics for development.

As Washington moves to develop a universal health care program in the state, additional work will be needed to assess and develop recommendations in the following areas:

- Increased transparency across major health system actors to support efforts to more effectively manage care and reduce costs.
- Health system changes to promote quality, evidence-based practices that will support sustainability and affordability.
- Transition steps that recognize and respond to the changes impacting the range of stakeholders, including consumers, businesses, health care providers and facilities, hospitals, health carriers, and state agencies.
- Options to expand or establish health care purchasing in collaboration with neighboring states.

[55] The Government Alliance on Race and Equity is a network of governments across the country working to achieve racial equity and advance opportunities for all. The Alliance supports jurisdictions working to achieve racial equity, assists jurisdictions seeking to start this work, and supporting the work of broadly inclusive local and regional collaborations focused on achieving racial equity.
[56] ESHB 1109 (section 221, subsection 7).
[57] Office of Equity Task Force, Final Proposal. July 2020.

In addition, as a specific universal health care path is developed, additional revenue and financing analyses will be needed.

Although the Work Group was not able to fully address all topics, this should not be seen as a lack of interest or concern. Numerous topics were raised by the Work Group as key elements of overall reform, and some members stressed these efforts should be the focus prior to increasing coverage in the state. The Work Group hopes these issues will be further addressed in the near future.

Appendices

A: budget proviso

B: Work Group Charter

C: Work Group roster

D: engaging stakeholders and the public

E: meeting summaries

F: public comments

G: history of health reform in Washington State

H: detailed quantitative analysis

I: example transition process and timeline

Appendix A: budget proviso

Engrossed Substitute House Bill 1109(57); Chapter 415, Laws of 2019

The health care authority is directed to convene a work group on establishing a universal health care system in Washington. $500,000 of the general fund—state appropriation for fiscal year 2020 is provided solely for the health care authority to contract with one or more consultants to perform any actuarial and financial analyses necessary to develop options under (b)(vi) of this subsection.

(a) The work group must consist of a broad range of stakeholders with expertise in the health care financing and delivery system, including but not limited to:

(i) Consumers, patients, and the general public;

(ii) Patient advocates and community health advocates;

(iii) Large and small businesses with experience with large and small group insurance and self-insured models;

(iv) Labor, including experience with Taft-Hartley coverage;

(v) Health care providers that are self-employed and health care providers that are otherwise employed;

(vi) Health care facilities such as hospitals and clinics;

(vii) Health insurance carriers;

(viii) The Washington health benefit exchange and state agencies, including the office of financial management, the office of the insurance commissioner, the department of revenue, and the office of the state treasurer; and

(ix) Legislators from each caucus of the house of representatives and senate.

(b) The work group must study and make recommendations to the legislature on how to create, implement, maintain, and fund a universal health care system that may include publicly funded, publicly administered, and publicly and privately delivered health care that is sustainable and affordable to all Washington residents including, but not limited to:

(i) Options for increasing coverage and access for uninsured and underinsured populations;

(ii) Transparency measures across major health system actors, including carriers, hospitals, and other health care facilities, pharmaceutical companies, and provider groups that promote understanding and analyses to best manage and lower costs;

(iii) Innovations that will promote quality, evidence-based practices leading to sustainability, and affordability in a universal health care system. When studying innovations under this subsection, the work group must develop recommendations on issues related to covered benefits and quality assurance and consider expanding and supplementing the work of the Robert Bree collaborative and the health technology assessment program;

(iv) Options for ensuring a just transition to a universal healthcare system for all stakeholders including, but not limited to, consumers, businesses, health care providers and facilities, hospitals, health carriers, state agencies, and entities representing both management and labor for these stakeholders;

(v) Options to expand or establish health care purchasing in collaboration with neighboring states; and

(vi) Options for revenue and financing mechanisms to fund the universal health care system. The work group shall contract with one or more consultants to perform any actuarial and financial analyses necessary to develop options under this subsection.

(c) The work group must report its findings and recommendations to the appropriate committees of the legislature by November 15, 2020. Preliminary reports with findings and preliminary recommendations shall be made public and open for public comment by November 15, 2019, and May 15, 2020.

Appendix B: Work Group Charter

Please view the Work Group Charter, which is available on the Universal Health Care Work Group page and affirmed at the December 9, 2020, meeting.

Appendix C: Work Group roster

Please view the Work Group roster, which is available on the Universal Health Care Work Group page.

Appendix D: engaging stakeholders and the public

A critical piece of the Work Group's legislative charge is stakeholder and public engagement. The following fundamental objectives and ideas were discussed during the first meeting and informed the Work Group's activities:

- Inform stakeholders, including the public, about:
    - The purpose of the Work Group.
    - Developing recommendations for the Legislature and the timeline for those recommendations.
    - How and when stakeholders and the public can get involved.
- Gather input from stakeholders and the public to inform work group deliberations.
- Demonstrate transparency and trustworthiness.

Key audiences

- Washington State residents, including consumers of health care, patients, and the public, including unserved and underserved populations.
- Patient advocates and community health advocates.
- Tribal partners.
- Large and small businesses.
- Labor unions.
- Health care providers.
- Health care facilities.
- Health insurance carriers.

Public engagement tactics

- Create a dedicated webpage to post all Work Group-related information.
- Make all work group meetings open to the public. Set meeting dates and times in advance and post the schedule to the webpage.
- Provide public comment period during each meeting. Individuals who signed up for public comment were provided instructions before the meeting and during the public comment part of the meeting.
- Provide alternate ways to make comments for those unable to attend meetings, those uncomfortable with making face-to-face public comment, and those who signed up to provide comment but couldn't because of time limitations.
    - Following each work group meeting, post a video or audio recording of the meeting and provide an opportunity for people to provide feedback on that meeting. The project team will summarize key themes from this feedback and share it with members at the next meeting.
    - Create an online survey to collect structured feedback from people. Include at least one open-ended question to allow for unstructured comments.

    - Provide an email address where stakeholders and the public can submit input related to the Work Group's recommendations to the Legislature. The project team will summarize key themes and share it with members at the next meeting.
- Provide a public comment period following release of draft reports, expected November 15, 2019, and May 15, 2020.
    - Summarize key themes from public comment and provide summary to members.

Public notifications

- Develop an email subscription through GovDelivery where people can sign up to receive updates and announcements on Work Group progress and activities.
- Send out announcements through GovDelivery about Work Group progress and activities, and encourage people to visit the Universal Health Care Work Group webpage.
    - Invite webpage visitors and people who attend meetings to subscribe to receive GovDelivery announcements about the Work Group.
    - Invite members to distribute the webpage link to their networks.
    - Invite legislators to distribute webpage link to their constituents.

Appendix E: meeting summaries

Below are the meeting summaries for each Work Group meeting by date:

- September 20, 2019
- December 9, 2019
- February 7, 2020
- April 22, 2020: this meeting was canceled
- June 24, 2020
- August 25, 2020
- September 16, 2020
- October 7, 2020
- October 29, 2020
- December 9, 2020

All meeting materials, including agendas, summaries, presentations, materials, and meeting recordings are available on the Universal Health Care Work Group webpage.

Appendix F: public comment

The vast majority of people who provided verbal or written public comment supported a universal health care program, primarily Model A. View the summary of all public comments, available on the Universal Health Care Work Group page.

Appendix G: history of health reform in Washington State

Pre-Affordable Care Act efforts

Basic Health Plan

Washington began extending coverage to some low-income adults and children in 1987 using a state-funded effort called the Washington State Basic Health Program (BHP). Authorized by state law, 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).[58] Due to state budget pressures, BHP funding by 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 eligibility expansion. The ACA's Basic Health Program was modeled on Washington's BHP.

Washington Health Care Commission

In 1990, the Washington Legislature passed Legislative Resolution 4443, which established the Washington Health Care Commission (often referred to as the Gardner Commission after then-Governor Booth Gardner) to recommend plans for ensuring access to health care for all people in Washington State.

The final report, released in 1992, defined 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" that it called the "uniform set of health services."[59]

The proposed comprehensive and affordable benefits package to be delivered by competing certified health plans would cover preventive, primary, and acute care; prescription drugs; mental health and substance use disorder services; and dental care, with long-term care to be phased in.

Additional services would be available through the public health system (funding for public health more than doubled) and supports for the health system would be included in the reforms. The 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 should also be taken into account in providing services.

A majority of Commission members wanted a single organization to sponsor coverage for all residents, while others believed employers should play a role in a "pay or play" system that allows the employer to offer coverage or pay into the system. Approved plans would compete on price within a maximum allowed premium and under rules set by an independent state commission. Financing

[58] Revised Code of Washington (RCW) 70.47.060 permitted the program to temporarily close enrollment to avoid over-expenditures.
[59] Washington Health Care Commission, Final Report to Governor Booth Gardner and the Washington State Legislature. November 30, 1992.

would be shared by individuals, employers, and government. Plans would be encouraged to implement capitation and increase provider risk for managing care. The Commission also recommended 17 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 Commission recommended starting to act immediately by reauthorizing the Basic Health Plan and increasing funding for public health programs. The group recommended that the Legislature should also pursue insurance reforms, including implementing guaranteed issue and renewability, a prohibition or limit on pre-existing condition exclusions, implementation of modified or strict community rating, and the development and implementation of 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 elements that 15 years later would be included in the ACA:

- 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.

The law was not fully implemented, as most of the law (including 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) was repealed by the 1995 Legislature. [60]

The expansion of the Basic Health Program and Medicaid for children in families with income up to 200 percent FPL were retained. The guaranteed issue and required benefits provisions of the law were also maintained, but without the other provisions in place, this led to a crisis in the individual insurance market.

Consumers could wait to buy coverage until they needed care, and in response, insurers increased premiums and stopped selling individual market policies. By 1999, none of the 19 insurers that had previously sold individual coverage in Washington offered an individual policy in the state.

Universal coverage for children

With 98 percent of Washington children covered by health insurance, 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:[61]

1987 Funding was expanded to provide coverage for children up to age two in families with income up to 90 percent FPL and prenatal coverage for women who do not qualify for Medicaid.

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

[61] Georgetown University Health Policy Institute, Center for Children and Families, Washington: Coverage to All Children. February 2009.

1989 The Maternity Care Access Act was passed, authorizing the First Steps program, expanding Medicaid eligibility for pregnant women and infants up to the federal maximum level of 185 percent FPL and increasing access to maternity support services.

1990 The Children's Health Program was established, a state-funded Medicaid lookalike program for children not eligible for Medicaid in families with income up to 100 percent FPL. The coverage was not established as an entitlement, and thus subject to available funds. Provider rate increases were also implemented at this time.

1993 The Washington Health Services Act expanded Medicaid coverage for children with income up to 200 percent FPL and established outreach and enrollment investments.

1999 The Legislature approved the implementation of federal CHIP in the state, which authorized coverage for children in families with income up to 250 percent FPL through CHIP.

Between 2000 and 2004, the Children's Health Program was not funded and noncitizen children were moved to coverage through the Basic Health Plan. In addition, the state implemented administrative hurdles to gaining coverage. Approximately 50,000 children lost coverage during this period.

2005 Then-Governor Christine Gregoire directed the state Medicaid agency to restore 12-month eligibility for children in Medicaid and CHIP and postponed implementation of Medicaid premiums for children. The Legislature passed a law that partially restored prior cuts to the Children's Health Program (allowing a set number of children with income up to 100 percent FPL to gain coverage) and establishing the state's goal of covering all children by 2010.

2006 Funding for the Children's Health Program was fully restored and proposed premium increases for children were permanently prohibited. The restoration eliminated the Children's Health Program waiting list of over 15,000 children.

2007 The Legislature established an entitlement to health coverage for children with income up to 250 percent FPL.

2008 All programs for children were renamed "Apple Health for Kids," and the state made additional investments in outreach and administrative simplification.

2009 All children with income up to 300 percent FPL were made eligible for enrollment in Apple Health for Kids. Children with income under 200 percent FPL could access zero premium coverage, and those with income between 200 and 300 percent FPL had sliding scale premiums based on income. Families with income above 300 percent FPL could purchase state-offered comprehensive health care for their children.

2014 The ACA established additional access to affordable coverage and funded outreach and enrollment that helped bring in many previously eligible but unenrolled children.

Blue Ribbon Commission on Health Care Costs & Access

Established by a budget proviso in 2006, the Washington State Blue Ribbon Commission on Health Care Costs & Access granted state general funds to the Office of Financial Management and a commission tasked with studying health care costs and access.

The Commission, which included the then-Governor, eight legislators and leaders from the Office of the Insurance Commissioner (OIC), HCA, Department of Health, Department of Social and Health

Services, and Department of Labor and Industries was tasked with recommending a sustainable five-year plan for "substantially improving access to affordable health care for all Washington residents" by December 2006.[62]

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.

Each of the 16 Commission recommendations is tied to one or more of the above strategies and includes proposed actions. The recommendations were:

Table 31: Blue Ribbon Commission on Health Care Costs & Access recommendations

• Use state purchasing to improve health care quality. • Become a leader in the prevention and management of chronic illness. • Provide cost and quality information for consumers and providers. • Deliver on the promise of health information technology. • Reduce unnecessary emergency room visits. • Reduce health care administrative costs. • Support community organizations that promote cost-effective care. • Give individuals and families more choice in selecting private insurance plans that work for them.	• Partner with the federal government to improve coverage. • Organize the insurance market to make it more accessible to consumers. • Address the affordability of coverage for high-cost individuals. • Ensure the health of the next generation by linking insurance coverage with policies that improve children's health. • Initiate strategies to improve childhood nutrition and physical activity. • Pilot a health literacy program for parents and children. • Strengthen the public health system. • Integrate prevention and health promotion into state health programs.

Many of the 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.[63]

[62] The budget proviso, meeting materials, and final report are available on the Commission website.
[63] Washington Laws, 2007 Ch. 259 [1133], Chapter 259 [Engrossed Second Substitute Senate Bill 5930]. Blue Ribbon Commission on Health Care Costs and Access Implementing Recommendations.

Years ahead of the ACA, the legislation included the requirement to allow anyone purchasing individual or group coverage the option to cover their unmarried dependents until they reach age 25. This requirement was also implemented for disability insurance. It also directed the Department of Social and Health Services to develop coverage expansion options that could utilize Medicaid, CHIP and/or the Basic Health Program.

The Department of Financial Management was instructed to design a state-supported reinsurance program for the individual and small group health insurance markets. The Office of Financial Management was tasked with coordinating and conducting strategic health planning.

Commitment to evidence-based medicine in state-purchased health care

Over the better part of a decade, Washington increasingly established standards and programs that support the use of evidence-based medicine for people receiving state-purchased health care. These efforts led to the establishment of several key programs and initiatives, including:

Washington Administrative Code (WAC) defines medical necessity for Medicaid using an evidence-based process.[64] To be considered medically necessary, a treatment is subject to the following standard: "There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service."

The Washington State Health Technology Clinical Committee (HTCC) was established in 2006 to make evidence-based coverage determinations for health technologies.[65] The HTCC is supported by the 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 comment. HTCC determinations guide coverage decisions for state health care purchasers, including Medicaid, Uniform Medical Plan, and the Department of Labor and Industries.

The Dr. Robert Bree Collaborative (Bree) was established by the Legislature in 2011 as a forum for public and private health care stakeholders to collaborate to improve quality, health outcomes, and cost effectiveness of care in the state.[66] Participating experts are nominated by community stakeholders and appointed by the Governor. Each year, Bree 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.

Most topics are addressed by a work group of experts on the topic who are Bree members and other experts in the community. The work group analyzes evidence on best practices for improving quality and reducing practice pattern variation. Bree recommendations consider existing quality improvement programs and organizations currently working to improve care. HCA reviews and approves Bree recommendations and incorporates them in state-purchased coverage rules.

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[64] WAC 182-500-0070.
[65] HCA, Health Technology Clinical Committee; HCA, Health Technology Assessment.
[66] Bree Collaborative website.

Shared decision making

This is the collaborative process of patients and their providers making health care decisions together, using both the best available scientific evidence and the patient's values and preferences.[67] In 2007, Washington passed a Shared Decision Making Pilot as part of the Blue Ribbon Commission bill. In 2012, the Legislature authorized HCA's chief medical officer to certify patient decision aids using criteria from the International Patient Decision Aid Standards (IPDAS) Collaborative.

Starting in 2016, many Washington health care providers have been able to access the tools, training, and technical assistance needed to help them provide patient-centered care.[68] Materials used to engage patients in decision-making exist for conditions such as maternity health, spine care/joint replacement, and cardiac/end-of-life care. Providers can access training on how to conduct shared decision making and use decision aids in their practices.[69]

Changes since the passage of the ACA

In the ten years since the ACA was signed into law in 2010, Washington's uninsurance rate dropped by ten points, to 6.7 percent in early 2020.[70] In addition to supporting the state's expansion of Medicaid to more than half a million previously uninsured low-income adults, the ACA authorized the establishment of health benefit exchanges and financial support for consumers' premium and cost sharing costs.

Washington Health Benefit Exchange

Washington State chose to establish a state-run health benefit exchange and its portal, Washington Healthplanfinder, as the mechanism for providing residents with access to ACA-compliant health and dental coverage, along with premium tax credits and cost sharing reductions (CSRs) for eligible individuals and families.

The Legislature established the Washington Health Benefit Exchange (Exchange) in 2011 as a public-private partnership governed by a bipartisan board.[71] Exchange implementation occurred over the next several years and established requirements for essential health benefits, market rules, and other qualified health plan (QHP) requirements.

The Exchange began offering plans in October 2013 for the 2014 plan year. Eight insurers offered QHPs in 2014. The number of participating insurers has varied somewhat over the years, with current participation of 13 insurers for plan year 2021. Issuer participation varies across the state. Approximately 185,000 Washingtonians had selected coverage through the Exchange for the 2020 plan year.[72] As of December 1, 2020, 193,000 people chose plans for 2021 coverage.

[67] HCA, Shared decision making webpage.
[68] Healthier Washington Practice Transformation Support Hub website.
[69] Shared decision making: online skills course for providers.
[70] 2020 coverage rates differ, as noted later in this section. Washington State Office of Financial Management, op. cit.
[71] Substitute Senate Bill 5445.
[72] Enrollment numbers are from a December 1, 2020, presentation to the Senate Health and Long Term Care Committee.

Other ACA-related market changes

Washington has implemented a number of market decisions since the implementation of the ACA. While not an exhaustive list, this has notably included:

- In 2014, Medicaid enrollment of individuals eligible under the "adult expansion" authorized under the ACA.
- To help stabilize the market, the decision to bar the sale of short-term/limited duration health plans that do not meet ACA requirements. The change went into effect in 2014.
- In response to the 2017 federal discontinuation of CSR payments to insurers but required them to continue subsidizing members' cost sharing, Washington supported insurers' incorporation of those costs into silver plan premiums starting in the 2018 plan year.[73]
- As of 2018, short-term/limited duration health plans may be purchased for no more than three months in a 12-month period.[74]
- In 2019-2020, the Legislature incorporated ACA health insurance reforms and nondiscrimination provisions into chapter 48.43 RCW.[75]

As noted above, some parts of the ACA were made part of state law in 2007. Other ACA provisions were added to state law in 2019 and 2020, ensuring these rules would continue even if the ACA were to be repealed. Consumer protections included the elimination of pre-existing condition exclusions and waiting periods for plans offered in the state. HB 2338 prohibited discrimination in health care coverage, including expanding the definition of mental health care and requiring short-term limited duration health plans and student health plans comply with mental health parity law.

Medicaid Transformation Project

Through the end of 2021, Washington State will receive up to $1.5 billion as part of a Section 1115 Medicaid demonstration waiver, called the Medicaid Transformation Project (MTP). The waiver allows Washington State to implement several initiatives that benefit Apple Health (Medicaid) clients.

HCA works with numerous partners to implement MTP and its five initiatives. This includes departments of Health and Social and Health Services, Accountable Communities of Health, Indian Health Care Providers (IHCPs), physical and behavioral health providers, community and health-based organizations, and many more.

Below is some additional information about the MTP initiatives.

Initiative 1: transformation through Accountable Communities of Health (ACHs) and IHCPs, where ACHs and IHCPs are implementing projects that change the way people receive health care in their region.

[73] After Congress discontinued CSR payments, issuers were allowed to raise the premium for Silver tier plans. This is referred to as Silver plan loading. As ACA premium tax credits are based on the cost of the second lowest-cost Silver plan in the market, any increase in Silver premiums was absorbed by higher tax credits, and this practice maintained lower cost sharing for consumers. Aviva Aron-Dine, Data: Silver Loading Is Boosting Insurance Coverage. Health Affairs Blog, September 17, 2019.

[74] WAC 284-43-8000 - RCW 48.43.005(26), 48.02.060, 48.44.050, and 48.46.200. WSR 18-21-116, § 284-43-8000, effective 11/17/18.

[75] SHB 1870 (2019) and SHB 2338 (2020).

Initiative 2: Long-term services and supports assist Washington's aging population and family caregivers who provide care for their loved ones. This initiative is made up of two programs, Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).

Initiative 3: Foundational Community Supports helps older adults get and keep stable housing and employment. This initiative is made up of two programs, supportive housing and supported employment.

Initiative 4: substance use disorder (SUD) IMD relaxes restrictions on the use of federal funds to pay for people receiving SUD treatment in a mental health or SUD facility, for an average of 30 days. 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).

Initiative 5: mental health IMD allows Washington State to purchase an average of 30 days of acute inpatient services for Medicaid members between the ages of 21 and 65 who reside in a dedicated, large psychiatric facility that qualifies as an IMD.

Single-payer and universal health care systems report

In 2018, the state Legislature directed the Washington State Institute for Public Policy (WSIPP) to study single-payer and universal health care systems.[76] The report included a review of single-payer models, comparison of model characteristics, and summary of available literature on resulting costs, quality of care, health outcomes, and rates of uninsurance.[77]

The report compared the U.S. health care system to systems in other high-income countries, finding that comparison countries have used a variety of systems to gain universal health care that spends less than the U.S. Both single-payer and multi-payer systems employ mechanisms to control medical services and pharmaceuticals costs. These comparison systems have lower insurer administrative costs.

Single-payer countries also have lower provider administrative costs. Other countries have taken steps to limit utilization of high-margin procedures and advanced imaging and have discouraged the wide use of technologies and medications with limited or unknown effectiveness.

Other countries have limited financial barriers, promoting more equitable access across income groups. While the U.S. spends more, it does not have better overall health outcomes or quality of care. WSIPP was not able to identify how universal health care programs or policies would translate in the U.S. context.

Cascade Care and standardized plans[78]

While many stakeholders supported a "Medicare-for-All" style reform in Washington in 2019, legislators eventually passed Senate Bill 5526, a public option proposal that would add a public QHP option for state residents who lack employer coverage and are not eligible for public programs, such as Medicare or Medicaid.

[76] Engrossed Substitute Senate Bill 6032, Section 606(15), Chapter 299, Laws of 2018.
[77] Washington State Institute for Public Policy, Single-Payer and Universal Coverage Health Systems: Final Report. May 2019.
[78] For more on Cascade Care, see the Exchange's Cascade Care webpage.

The legislation authorized Cascade Care public option plans, which must meet quality and value requirements and conform to standard plan designs that facilitate consumers' plan comparisons.[79]

The legislation tasked HCA, OIC, and the Exchange with developing and implementing Cascade Care. The Exchange oversaw the development of standardized plan designs, HCA led the procurement of the public option plans, and OIC reviewed and approved the health plan filings submitted by the approved insurers. Each public plan issuer submitted health plan rates, information on covered essential health benefits, and network access information. The Exchange developed standardized plan designs for the gold, silver, and bronze plan levels, including a high-deductible health plan that could be paired with a health savings account.

Five contracted carriers are offering Cascade Care plans for the 2021 plan year. Consumers can enroll in a public option plan starting during the open enrollment period that runs November 1-December 15, 2020, with coverage effective January 1, 2021.

While Cascade Care does not include access to premium assistance beyond currently available income-based federal premium tax, the program's authorizing legislation did require the Exchange to study the adoption of additional financial assistance and for the Exchange, HCA, and OIC to submit a plan for implementing and funding premium subsidies for consumers with income up to 500 percent FPL. A contractor conducted that study, with a report due to the Legislature on November 15, 2020.

Health insurance coverage in 2020

At the start of 2020, 6.7 percent of state residents lacked insurance coverage. However, employment and health insurance coverage have both been impacted by the COVID-19 pandemic. As of May 23, 2020, 13 percent of Washington residents lacked insurance, and initial claims for unemployment were also surging in the state. [80]

By November 14, the uninsurance rate had dropped from the May peak to seven percent. The Office of Financial Management estimated that over the course of 2020, the number of uninsured Washingtonians went from 502,300 (end of 2019) to 1,010,700 (May 2020), and to 541,440 (November 2020).

Rates of uninsurance and change over time differ by county, with Yakima County having the highest uninsured rate in (16.3 percent both pre-pandemic and as of November 14). Garfield County currently has the lowest uninsured rate at 3.7 percent, down from 4.1 percent at the start of the year. Twenty-two Washington counties saw an increase in uninsurance since the start of the year, while 15 counties experienced a decrease in uninsurance and the other two experienced change of less than 0.1 percent.

As of September 2020, 1,942,897 people are enrolled in Medicaid in Washington, an increase of over 135,000 people from the same time last year. While some people have newly enrolled in Medicaid since the pandemic, the main reason for the increase is that Washington (like other state Medicaid

[79] Standard plan designs establish the rules for cost sharing across all participating issuers' plans. This means the deductible, out-of-pocket maximum, coinsurance, and copays would be the same in each plan at a given metal level. Keeping these elements the same across plans allows consumers compare plans based on other factors (such as the provider network or customer service).

[80] Washington State Office of Financial Management, op. cit.

programs) has temporarily halted most disenrollments as part of an agreement with the federal government to receive an increase in the federal match rate during the pandemic.

Appendix H: detailed quantitative analysis

Data and methodology

The following presents the analysis performed to develop cost and revenue estimates for each of the three draft model proposals.

Data sources

The data sources utilized to develop cost and revenue estimates for Models A and B include:

Table 32: data sources

Data source	Data sources referenced
National data	• National Health Expenditures (NHE) – (this included national and Washington-specific data where appropriate) • NHE per capita trend projections • Medical Expenditure Survey Panel (available from the Agency for Healthcare Research and Quality) • United States Department of Labor • CMS • Centers for Disease Control and Prevention • American Community Survey (United States Census Bureau)

State of Washington data	• Washington State Health Care Authority
	  ○ Medicaid
	  ○ CHIP
	  ○ Public Employees Benefits Board
	  ○ School Employees Benefits Board
	• Exchange
	• Washington Office of Financial Management
	• Washington Office of the Insurance Commissioner

Other sources	• National Association of Insurance Commissioners annual health insurer filings • Kaiser Family Foundation • Published studies (citations noted in footnotes)

Notes on data reliance

In developing these cost and revenue estimates, Optumas relied on enrollment, expenditures, provider reimbursement, and benefit design from a variety of data sources. This includes national and state-specific sources. The publishers of this information are responsible for its validity and accuracy; however, we have reviewed the information for reasonableness and consistency and its appropriateness for use in the estimates developed.

Due to availability and limitation of available data, it was not practical to perform modeling on or for every circumstance or scenario. Summary information estimates and simplification of calculations may have been incorporated into the modeling. Included with this methodology are limitations and recommendations for additional detailed analysis, dependent on which path may be implemented for the state of Washington.

Optumas is not engaged in the practice of law or providing advice on taxation. The cost and revenue analysis includes commentary on revenue but is not a substitute for legal or taxation advice.

Status quo expenditure development (baseline expenditures)

The status quo presents the estimated cost of implementing each of the models; baseline expenditures for populations and services of interest are estimated. Adjustments that reflect the various impacts associated with each model are then applied to come to a final expenditure estimate. This section outlines the development of status quo expenditure estimates.

Sources

There are many different payer sources that contribute to funding health care expenditures in Washington. These include public programs, private insurance, federal programs, individual contribution, and charitable contributions. An estimate of status quo baseline expenditures captures all relevant expenditures that are included in the proposed universal health care models.

To identify the different payer sources, Optumas relied on NHE funding source categories[81] to inform the funding categories incorporated in the universal health care models. They include the following:

- Out-of-pocket
- Private health insurance
- Medicare
- Medicaid
- CHIP
- Indian Health Services
- General assistance
- Other private revenues

NHE expenditure categories that were excluded from the universal health care models are military coverage, federal employees, research and investment funding, population health, and school and worksite health programs.

While Optumas utilized the NHE funding source categories, the actual expenditures for each category relied on a variety of sources. Actual reported expenditures, such as Medicaid or CHIP, were used where possible. NHE estimates were used for all others where actual information was not available.

Specifically, reported expenditures were utilized for Medicare, Medicaid, and CHIP (reported by the CMS).[82] Imputed values were used for the majority of private health insurance, Indian Health Services, general assistance, and other private revenue. Of note, private health insurance includes employer-sponsored plans that are exempt from detailed utilization and expenditure reporting under federal law. The reliance on imputed statistics highlights the need for data collection strategies in markets that lack transparency.

Imputed expenditures

To impute expenditures, one of two methodologies was used for each funding category. Imputed expenditures are the product of the NHE estimated per capita expenditure and the Washington State population estimate for that funding source **or** are based on the relative percentages of expected expenditures. Private health insurance is the largest imputed category and relied on the former

[81] CMS, National Health Expenditure Accounts: Methodology Paper, 2018.
[82] CMS, State Expenditure Reporting for Medicaid & CHIP.

category. Estimates of the Washington population that utilize private health insurance were applied to the NHE per capita estimate for that category to estimate total expenditures for that population.

Service categories

The cost modeling included adjustments that estimate various effects of transitioning from the current status quo of health care delivery to Models A and B. In many cases, these adjustments—such as provider reimbursement changes—were applicable to specific service categories (e.g., hospital, pharmacy, physician). The distribution of expenditures by service category reported by NHE was applied to each data source to support modeling adjustments.

As several service categories were not included in Models A or B (including over-the-counter medications, investment and research, long-term care, and dental services), in most cases, these service categories were excluded from the distribution process.

Per capita health care trend factors

Because the modeling is on a calendar year (CY) 2022 basis and baseline expenditures are from CY 2018, trends by program were applied to establish a CY 2022 baseline. Trends are based on NHE projections from 2018 through 2022 by funding source. The table below illustrates the annualized trends by major funding source. The annualized trend factor capture both enrollment growth, utilization, and unit cost trend.

Table 33: average annual per capita growth rate, 2018-2022

Funding source	Average annual per capita growth rate, 2018-2022
Medicare	7.5%
Medicaid	4.9%
CHIP	3.6%
Other public	4.9%
Private health insurance	4.4%

Baseline expenditure results

The processes described above result in estimated CY 2022 expenditures by funding source that are limited to populations and categories of service of interest. Status quo expenditures are summarized in the table below.

Table 34: estimated CY 2022 expenditures

Populations[83]	Estimated 2022 population	Estimated status quo expenditure
Medicaid	1.7 million	$15 billion
Medicare	1.7 million	$15 billion
CHIP	62,000	$83 million
Private insurance	3.7 million	$23 billion
Undocumented immigrants	124,000	$45 million
Uninsured	278,000	$134 million
Expenses related to non-coverage health care programs[84]	N/A	$7.2 billion

Universal health care modeling

The status quo 2022 expenditures established for select populations and services, adjustments are applied to estimate the effects of transitioning to a universal health care system. The following sections describe these adjustments. The following sections present adjustments to develop Models A and B expenditures.

Provider administrative efficiencies

Under the status quo system, providers spend significant resources interacting with multiple payers. This includes administrative resources used on contracting, reporting, billing under disparate criteria, and more. Reducing the number of payers to a single-payer under Model A or a small number under Model B will reduce provider costs, which can be used to justify a reduction in provider reimbursement rates.

An aggregate downward adjustment of between 0.6 percent and 2.4 percent (upwards of eight percent for physician services), increasing as the program matures, is incorporated in Models A and B.

It is important to note there is limited information to inform the magnitude of the adjustment. Where there are comparative studies across different systems, it was not apparent that the differences in administrative costs can be solely attributed to interacting with fewer payers.

Other factors, such as high volumes of prior authorization requirements and reporting burden, can contribute to differences in administrative costs in different systems. To achieve these savings, the state will need to commit to designing an administrative structure and billing processes that minimize provider burden. This is especially true for Model B, which retains managed care organizations and some degree of payer fragmentation.

Provider reimbursement rebalancing

In the current health care system, providers receive different levels of payment for the same or similar services based on payer. Generally, Medicaid reimbursement is the lowest, followed by Medicare. Private insurance reimbursement is highest. Status quo variation in provider reimbursement rates by payer would be eliminated under a single-payer system. To account for this

[83] Excludes individuals covered by health insurance provided by Department of Defense, Veteran Affairs, or other federal employee coverage, along with costs associated with care provided through school-based health care programs, worksite health care, workers' compensation, maternal and child health programs, and vocational rehabilitation.
[84] Includes estimates for expenditures that would be captured under a universal model including, charitable care, Indian Health Services, and out-of-pocket expenditures.

effect, the model adjusts expenditures by funding source to reflect pricing normalization associated with transitioning to a single fee schedule.

It is important to note this specific provider reimbursement adjustment included in Models A and B is intended to maintain the aggregate level of reimbursement in the system; however, the impact to each provider will vary. The impact to the provider is directly related to current distribution of insured patients. As a result, some providers may see increases to their total patient revenues, others will experience decreases, and some will not be impacted significantly.

Due to data constraints, the adjustment in the model is limited to the hospital care and physician and clinical services categories. Status quo reimbursement level assumptions are shown in the below table.

Table 35: reimbursement levels as a percent of Medicare

Payer source	Hospital care	Physician and clinical services
Private health insurance	225%	143%
Medicare	100%	100%
Medicaid	90%	75%

Last, please note that estimates for private health insurance vary significantly and are impacted by the lack of reporting by ERISA plans. Statistics for this population are derived from a review of studies conducted by the Kaiser Family Foundation.[85] Medicare statistics are definitionally true. Medicaid statistics are based on anecdotal information from Washington Health Care Association. Because these assumptions are critical for understanding what federal funding will be available to offset state costs under Models A and B, it is important these statistics are updated in the future, should better data become available.

Medicaid population utilization changes due to provider reimbursement changes

Due to the aforementioned provider reimbursement differences between commercial plans and Medicaid, some providers have historically limited the number of Medicaid members they allow on their panels. This has the potential effect of reducing access to preventive care for the Medicaid population.

Under the universal health care model, much of the provider reimbursement variation is eliminated. Consequently, provider participation or availability to those covered would not be influenced by reimbursement differences as they are today. This is expected to increase access to preventive services for the Medicaid-eligible population compared to the access they have today.

Consequently, Models A and B reflect increased utilization of primary care services and decreased utilization of hospital services for this population. Aggregate utilization of physician, clinical, and professional services are assumed to increase by one percent, with a decrease of 0.25 percent in both inpatient and outpatient services.

[85] Eric Lopez, T. (2020, May 01). How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature.

Uninsured population utilization

The current uninsured population is not homogeneous. While the uninsured population includes individuals who do not obtain coverage because they have limited need for health care services, many others have needs but cannot afford coverage. For this latter population, individuals may go without or may delay needed health care services.[86] This delay often leads to worsened conditions when the individual does seek treatment. To account for increased access to care and pent-up demand, a 200 percent increase in utilization is assumed for this population.

Undocumented immigrant utilization

Limited data is reported on the health care costs and utilization patterns for the undocumented population. Under the universal health care models, this population is assumed to have similar pre-adjusted cost and utilization (before efficiencies, rate rebalance, and administrative adjustments are applied) to the privately insured population, or a PMPM cost of approximately $519.

Out-of-pocket cost sharing

Models A and B assume no cost sharing; the model assumes no copays, deductibles, or coinsurance. Approximately $4.2 billion in costs previously incurred by service utilizers are assumed to be covered under Models A and B, and reflect an increased cost to Models A and B that will need to be funded through state revenues.

Utilization impacts associated with removing cost sharing

There are two primary effects from eliminating cost sharing. First, barriers for individuals to access care are eliminated, which will increase the cost for members accessing these services. This also includes increases to appropriate, but elective procedures that were delayed due to cost sharing. Reductions in costs associated with delay of care and exacerbation of conditions can be expected in the longer term beyond the implementation year.

Second, barriers to ineffective or inefficient care are also eliminated. This could potentially result in increases in costs without offsetting beneficial improvements in outcomes or longer term reduced costs. This effect is demonstrated in studies that evaluated emergency department utilization and services considered to be low value, but could not be demonstrated in others.[87, 88, & 89]

The evidence base for the strength of each of these effects is weak and mixed due to the challenge of isolating specific causal relationships in complex and dynamic environments. Economic theory suggests that price sensitivity is inversely related to the perceived need for a service and that larger price differentials may be needed to impact changes in utilization.

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[86] Jennifer Tolbert, K. (2020, May 14). Key Facts about the Uninsured Population.

[87] Gruber, Jonathan and Maclean, Johanna Catherine and Wright, Bill and Wilkinson, Eric and Volpp, Kevin, The Impact of Increased Cost Sharing on Utilization of Low Value Services: Evidence from the State of Oregon (January 2017). IZA Discussion Paper No. 10477.

[88] Siddiqui, M., Roberts, E., & Pollack, C. (2015, March). The effect of emergency department copayments for Medicaid beneficiaries following the Deficit Reduction Act of 2005.

[89] Yaremchuk, K., MD, Schwartz, J., MD, MBA, & Nelson, M., BS. (2010). Copayment Levels and Their Influence on Patient Behavior in Emergency Room Utilization in an HMA Population. Copayment Levels and Their Influence on Patient Behavior in Emergency Room Utilization in an HMO Population, 13(1), 26-31.

Because limited information is available on current statewide practices, some increases in utilization of low-value services could occur with the removal of cost sharing if it private insurance plans have been successful in deterring utilization of low-value services through cost sharing policy.

Utilization adjustments to account for the removal of barriers to accessing care include an approximate 1.9 percent increase in the aggregate PMPM costs for the private health insurance population. This is a composite impact that reflects increases to utilization in most services categories, but aggregate decreases in inpatient hospital utilization.

Purchasing power

A universal health care system would consolidate purchasing power under a single entity and will increase negotiation power for high-cost procedures, providers, and can provide greater access to volume-based discounts.

Negotiation power

Work Group feedback suggested that purchasing power could allow for reduced hospital pricing. The data to support an appropriate magnitude or feasibility for an adjustment was not available; however, because this opportunity is plausible, a conservative adjustment a one to two percent reduction in aggregate hospital expenditures is included for Models A and B.

An important advantage of a single-payer system is pricing transparency. When all utilization in a state flows through a single payer, that entity gains insight into pricing variation that is otherwise opaque in a fragmented payer system. This insight could result in even greater reductions in aggregate expenditure if there is significant unwarranted pricing variation in the system today.

Volume-based discounts

The greatest opportunity for volume-based discounts exists for pharmaceutical and durable medical equipment. Aggregate adjustments reducing costs between four to seven percent (increasing as the program achieves steady state) for pharmaceuticals, and one to four percent are incorporated for durable medical equipment.

The adjustment for pharmaceuticals recognizes the fact that less room for greater discounting is available for the Medicaid-eligible population. The Medicaid Prescription Drug Rebate Program uses the greater of a fixed rebate floor the "best price." 42 U.S.C. § 1396r-8 (c) (1)(C) defines best price as the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States.

States can also negotiate additional rebates on top of the federal program. These two factors result in Medicaid programs having access to better net pricing than private plans typically have access to, which is why the model reflects less opportunity for Medicaid utilization than private plans.

The state's ability to achieve this magnitude of savings will be contingent on the states resource investment in analysis and negotiation on pricing with manufacturers.

Program integrity

Under a consolidated payer system, analysis of a statewide comprehensive claims data is possible. One implication is that statistical patterns indicating fraud, waste, and abuse that were not previously detectible across payers becomes apparent and actionable. Estimates of the cost of health care fraud

vary, but the estimates generally range from three to ten percent as noted by the National Health Care Anti-Fraud Association.[90]

An adjustment is included in Models A and B to reflect system-wide reductions in fraud, waste, and abuse. This adjustment ranges from 0.25 to three percent overall once the new system has reached steady state.

It is important to note the transition to Model A or Model B alone is insufficient to achieve the reductions in cost associated with this adjustment. The state would need to invest in staff and tools to aggressively identify, pursue, and prevent fraud, waste, and abuse under the new paradigm. Additionally, savings would accrue to future contract periods and once a state of maximum savings is achieved, additional savings would not occur. However, monitoring would need to continue to ensure fraud, waste, and abuse does not influence future cost inflation.

Plan administration

Models A and B introduce system-wide efficiencies through consolidation of payer functions. The current system of multiple payers results in duplication of infrastructure for claims processing and numerous plan administrative functions. Additionally, under Model A (a state-administered system), private plan margin and risk premium is eliminated.

The aggregate level of administration (including margin) is estimated to be between 8.1 and 8.6 percent. Model A assumes an administrative cost of 4.5 percent. Model B, which leverages managed care entities, assumes a 7.5 percent administrative cost.

While programs like Medicare have been noted to have administrative costs below three percent (below two percent when excluding Medicare Advantage Plans), there are several factors to note as to why this level of efficiency is not achievable, even with Models A or B.

First, Medicare has economies of scale that would continue to dwarf a statewide program in Washington. Medicare is a $644 billion program (ten times larger than the projected costs for Models A or B).[91]

Second, Medicare's low administrative percentage is misleading due to the higher average cost per member for the Medicare population. The actual per member costs associated with Medicare administration are much closer to commercial administrative costs.

Last, Washington will continue to incur significant administrative costs associated with preserving federal funding for Medicaid, CHIP, and Medicare-eligible individuals. This includes compliance and reporting with a broad array of regulations for the Title XVIII (Medicare), Title XIX (Medicaid), and Title XXI (CHIP) programs.

Premium tax

Washington currently imposes a premium tax on health insurers.[92] This premium tax is assumed not to apply to Model A. It is assumed to apply to Model B. This contributes to the difference in

[90] The Challenge of Health Care Fraud. (n.d.).
[91] Budget Basics: Medicare. (2020, July 29).
[92] Revised Code of Washington, Chapter 48.14, Section 48.14.0201, Premium taxes.

administrative cost assumptions between the two models. Importantly, if Model A were to be implemented, the state may need to backfill lost revenues collected from the premium tax.

Dental estimate overview

Standardized dental coverage, based on employer-sponsored and commercial-like, is included in Models A and B and include the following elements:

- Coverage for preventative and diagnostic care, minor, and major (e.g., crowns, bridges dentures, oral surgery, root canals).
- Orthodontia subject to lifetime coverage limits.
- Annual benefit maximums.
- Eliminates out-of-pocket cost sharing.
- Dentist reimbursement consistent with employer-sponsored dental coverage.

The proposed dental coverage for Models A and B would be very close to what individuals currently receive through employer-sponsored, health benefits marketplace and individual coverage, and eliminate out-of-pocket costs up to annual or lifetime benefit maximus. Individuals whose dental services are covered by Medicaid would receive enhancements to their current dental benefits like major restorative and orthodontia. Individuals who are uninsured, including those who are undocumented, do not generally have dental coverage.

A range of dental estimates were developed reflecting variation for factors including the type of dental networks (e.g., managed care versus preferred provider organizations), annual benefit maximums, orthodontia coverage including lifetime limits, and variation in out-of-pocket costs. Model C does not include dental coverage.

Methodology

The source of information influenced the methodology for projecting monthly per-person dental coverage expense. Sources of information based on insured monthly premiums were adjusted to remove the impact of Washington premium tax (if applicable), dental insurer administration and risk margin loadings. Information on reported dental service expenses did not need adjustments to remove premium tax, insurer administration, and risk margin. Please refer to the discussion of data sources for the information collected and evaluated for purposes of this estimate.

The monthly per-person dental expense reflected only insurer dental coverage expenses and required an adjustment to gross up expenses for estimated out-of-pocket cost sharing based on an average actuarial value of 70 percent. This adjustment reflects an annual per-person cost for dental coverage without out-of-pocket costs.

The adjusted data was trended, based on NHE projections for dental services, based on the midpoint period of the data source (CY 2017-2020) to the midpoint of the UHC contract period (CY 2022). Adjustments to reflect provider reimbursement were applied to normalize a dental fee schedule that maintains aggregate reimbursement levels between all payers (Medicaid to employer-sponsored).

Impact on expenditures and revenues

The status quo health care system includes a significant source of funds from the federal government, State of Washington, employer, and individual contributions, including local funds for public employees. Implementing a universal health care system as outlined in Model A and B redistributes

costs and revenues and will require the Legislature to identify and collect revenues to offset new costs incurred the universal health care system.

Providing a standardized dental coverage, without out-of-pocket cost sharing and a uniform dental reimbursement, will require additional federal and state revenues as outlined below:

- **Medicaid:** federal and state revenues will need to increase to cover the modeled dental benefits coverage and increased reimbursement for dental providers.
- **Employer-sponsored, Exchange, and individual marketplace:** additional state revenue will be required to cover the amount of out-of-pocket costs incurred by individuals enrolled in dental coverage employer-sponsored, health benefits marketplace, and individual coverage.
- **Medicare:** additional state revenue will be required to cover the dental benefits coverage and out-of-pocket costs incurred by Medicare-enrolled individuals.
- **Uninsured:** additional state (and potentially federal) revenue will be required to provide dental benefits coverage.
- **Undocumented immigrants:** additional state revenue will be required to provide dental benefits coverage

Results: costs and revenues by scenario

This section is organized to present the following results:

- Model A (universal health care – state-administered): results for implementation year and steady state
- Model B (universal health care – delegated): results for implementation year
- Model C: overview and considerations
- Model design impacts
    - Dental services estimate
    - Cost sharing summary
    - Five-year trend resource

Model A

Table 36: overview of Model A

Covered populations	Benefits	Cost sharing	Provider reimbursement	Population-specific impacts	Administration
• Medicaid • Medicare • CHIP • Private health insurance (employer, state employees, and Exchange) • Undocumented immigrants • Uninsured	• Essential health benefits • Dental for Medicaid-eligible only • Vision • Long-term care for Medicaid-eligible Only	• No cost sharing • Private insurance utilization changes due to removal of cost sharing	• Reduced pricing variation between covered populations • Administrative efficiency • Purchasing power	• Improved access for Medicaid-eligible persons, utilization changes by service type • Reflects increased utilization for uninsured and undocumented immigrant populations	• State-administered • Premiums are exempt from state premium tax impacting cost and revenues • Reflects reductions in system-wide administrative costs

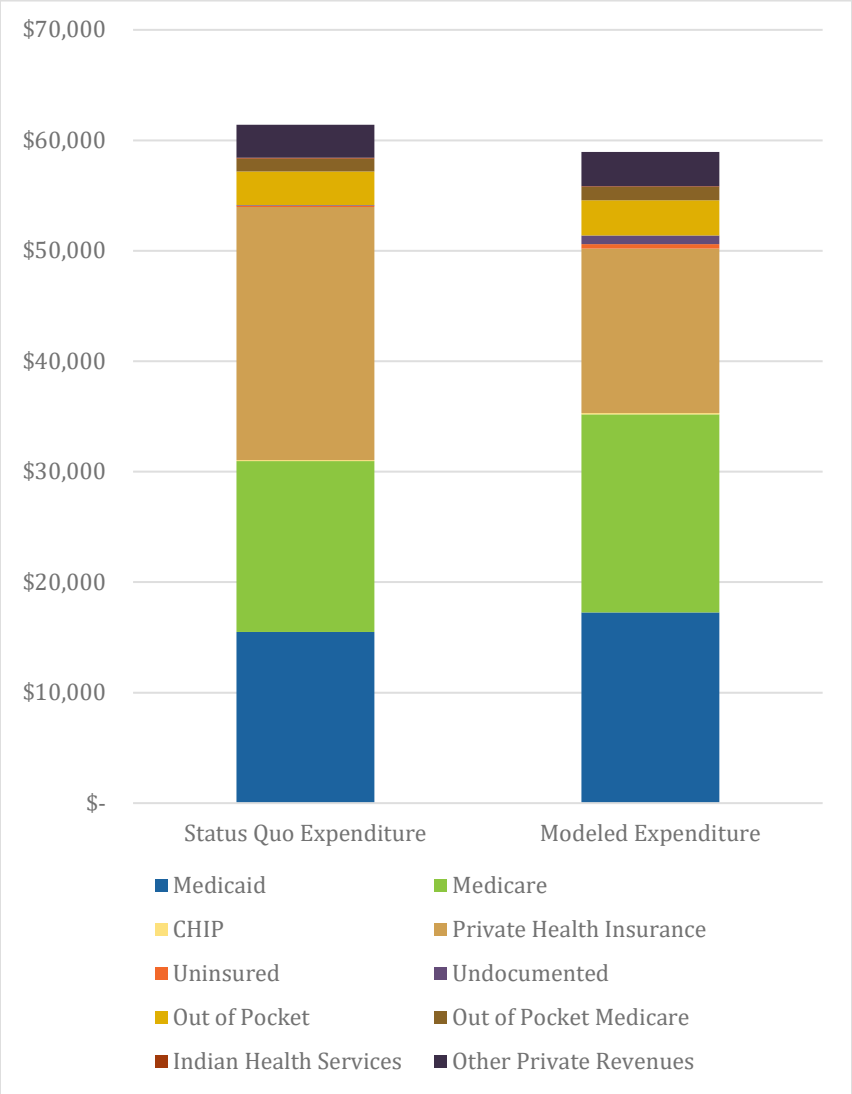
Table 37: Model A CY 2022 expenditure projections – implementation year

Financing source	Population[93]	Status quo expenditures[94]	Modeled expenditures	Differences
Medicaid	1,703,992	$15,492,152,242	$17,252,947,016	$1,760,794,774
Medicare	1,721,504	$15,478,141,127	$17,950,096,666	$2,471,955,539
CHIP	61,707	$83,298,324	$98,892,477	$15,594,153
Private health insurance	3,673,661	$22,899,808,044	$14,888,845,722	$(8,010,962,322)
Uninsured	333,840	$133,818,270	$411,406,833	$277,588,563
Undocumented	124,428	$44,888,791	$793,527,255	$748,638,464
Excluded populations[95]	277,774			
Out-of-pocket expense (excluding Medicare)		$3,045,638,137	$3,174,735,124	$129,096,987
Out-of-pocket expense (Medicare)		$1,156,180,215	$1,205,187,804	$49,007,589
Indian Health Services		$79,843,114	$77,511,016	$(2,332,098)
Other private revenues		$3,003,934,742	$3,088,982,108	$85,047,366

[93] The Medicaid population totals exclude dually eligible members from the population count. Medicaid reimbursed expenditures are reflected in Medicare. All other Medicare-covered expenditures are included in the Medicare row.
[94] Status quo and modeled expenditure totals exclude long-term care and dental for all payer sources other than Medicaid.
[95] This includes federal employees and active duty military.

Total	**7,896,906**	**$61,417,703,006**	**$58,942,132,021**	**$(2,475,570,985)**

Figure 7: status quo vs. Model A – program year 1 expenditures (in millions)



Key notes:

Model A is expected to reduce aggregate system-wide expenditures by approximately **$2.5 billion** in the first implementation year. This impact is driven by multiple efficiencies that occur under a single-payer system. The efficiencies reflect a phase in during the initial year. These include factors, such as:

- Reduced payer administrative cost
- Increased purchasing power
- Health care provider administrative efficiencies
- Program integrity improvements

The below table represents projected CY 2022 revenue estimates by financing source. These revenue projections include consideration for cost-shifting dynamics that will occur due to universal health care. Note the following when interpreting the figures in this table:

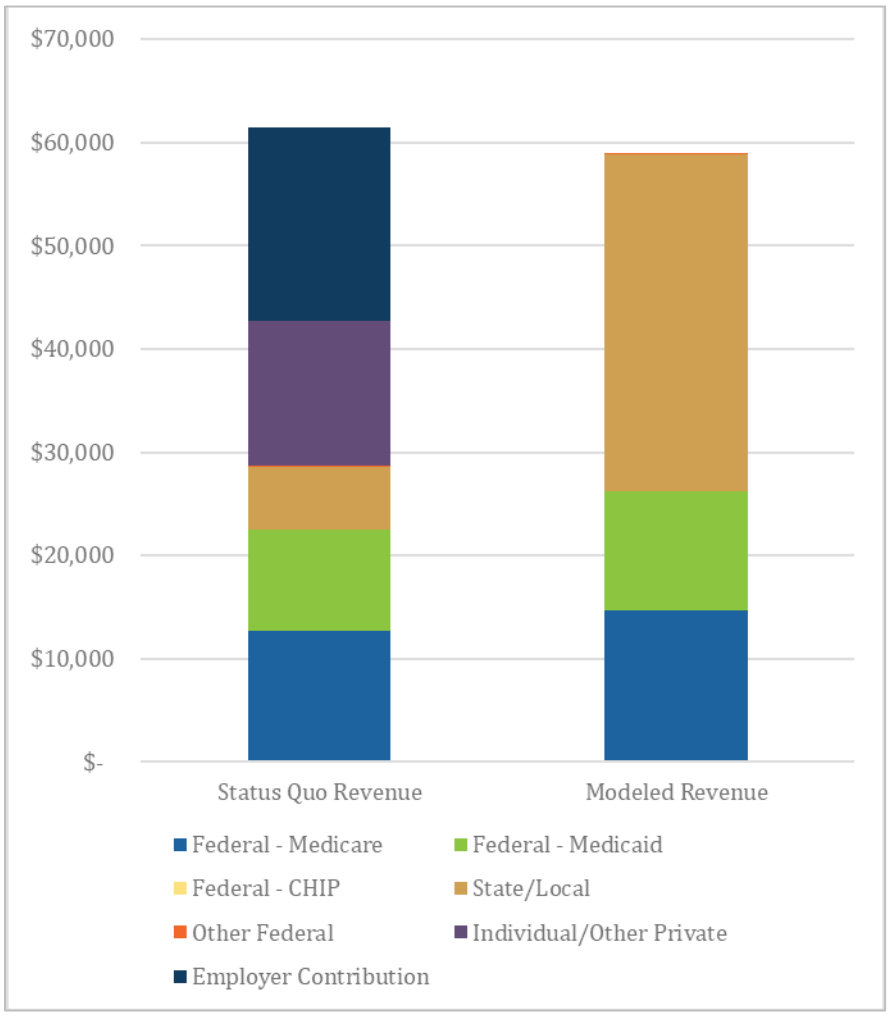
- The status quo health care system includes a significant source of funds from individual and employer contributions, including state and local funds for public employees. These revenues are assumed to continue under Model A universal health care; however, a mechanism to capture these contributions will need to be developed and implemented by the Washington State Legislature. These revenues are illustrated in the "State/local" row for the "Model A revenue estimate" column.
- Model A design includes normalizing provider reimbursement into a single reimbursement schedule. This is a significant change from status quo where reimbursement varies by payer (Medicaid, Medicare, and private coverage). Subject to federal approval, this change would increase the amount of federal contributions Washington receives, but also increase state general fund obligations.
- Contributions to cover uninsured, undocumented immigrants and out-of-pocket costs are included in "State/local" row for the "Model A revenue estimate" column.
- The revenue model assumes the state will be successful in preserving federal funding streams for eligible populations, even with the programmatic changes associated with transition to a universal health care model.
- The revised Model A projected expenditures in Table 10 excluded the cost for dental coverage for populations other than Medicaid. The following table separately identifies revenue collections necessary for dental coverage for all populations beyond Medicaid.

Table 38: Model A CY 2022 revenue sources – implementation year

Financing source	Status quo revenue	Model A revenue estimate	Differences
Federal share – Medicaid[96]	$12,692,075,724	$14,719,079,266	$2,027,003,542
Federal share – Medicare	$9,760,055,912	$11,471,950,522	$1,711,894,610
Federal share – CHIP	$73,302,525	$87,025,380	$13,722,855
State/local share	$6,051,654,951	$32,586,565,837	$26,534,910,886
Other federal contributions (e.g., Indian Health Services)	$79,843,114	$77,511,016	$(2,332,098)
Individual contribution	$14,057,144,852		$(14,057,144,852)
Employer contribution[97]	$18,703,625,927		$(18,703,625,927)
Total	**$61,417,703,006**	**$58,942,132,021**	**$(2,475,570,985)**
Dental coverage for populations other than Medicaid[98]			**$3,052,211,853**

[96] Medicaid funding is dependent on expenditure authorities awarded to Washington by CMS and changes in federal financial participation rates. Estimates are based on pre-CARES Act federal financial participation rates.
[97] The employer contribution includes state/local funds for public employees.
[98] Additional revenue required for covering dental services for all other populations than Medicaid, federal employees, and military. Assumes "moderate" cost level for dental services.

Figure 8: status quo vs. Model A – program year 1 revenues (in millions)



Key notes:

A major contributor to the increase in federal funds is associated with provider reimbursement rate normalization associated with a single-payer fee schedule. There are offsetting decreases to the private health insurance (employer and individual contributions). It is unclear if federal funding will be available to subsidize this effect.

Additional analysis is needed to understand the impact of lost insurer premium tax. Premium taxes contribute to the general fund. The loss of this revenue will need to be considered by the Washington State Legislature.

Additional analysis is needed to understand the broader economic impact on the state due to industry job loss, tax implications for employers, greater labor mobility, etc.

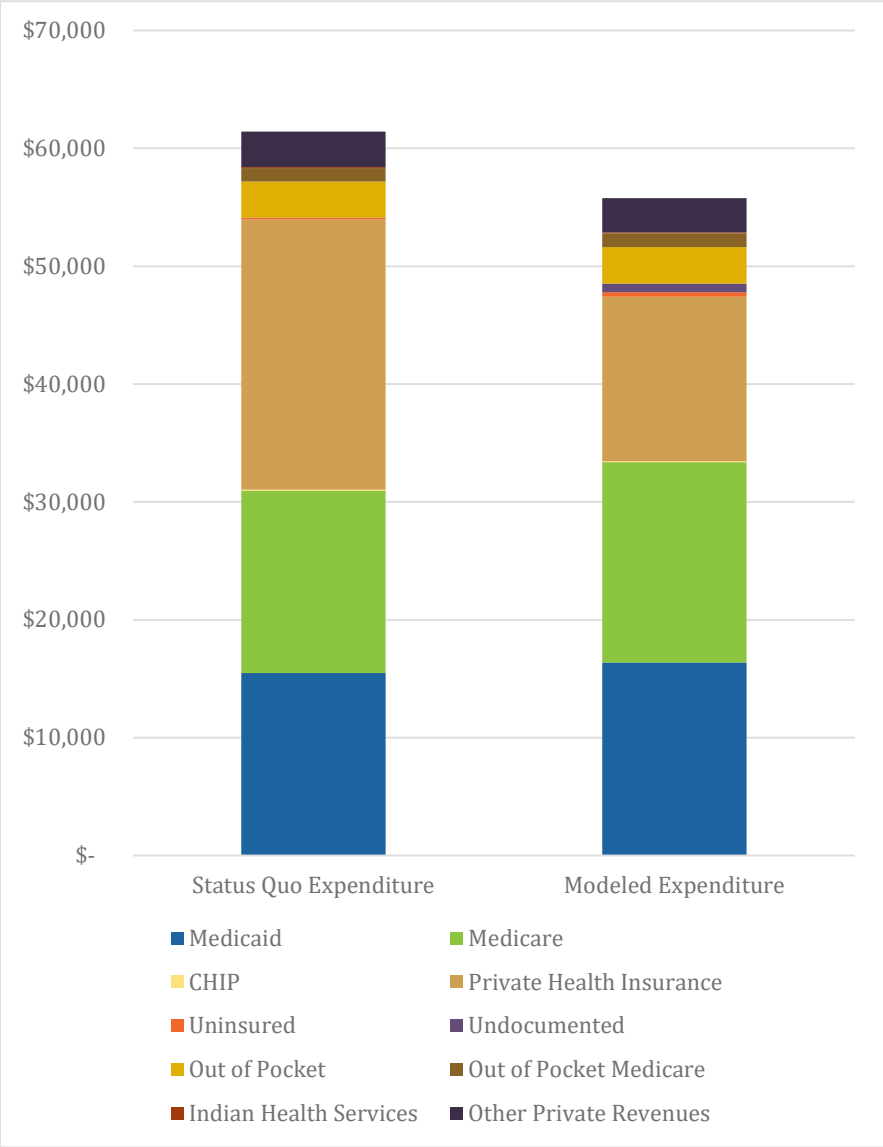
The following table and figure, in CY 2022 dollars, reflect Model A at steady state, or after the program has matured. It is unclear how long it will take for the new program to achieve steady state. The primary difference between implementation year assumptions and steady state is the magnitude of savings associated with the various programatic efficiencies.

Table 39: Model A CY 2022 expenditures – steady state

Financing source	Population[99]	Status quo expenditures[100]	Modeled expenditures	Differences
Medicaid	1,703,992	$15,492,152,242	$16,376,945,975	$884,793,733
Medicare	1,721,504	$15,478,141,127	$16,997,807,187	$1,519,666,060
CHIP	61,707	$83,298,324	$93,163,569	$9,865,245
Private health insurance	3,673,661	$22,899,808,044	$13,947,804,665	$(8,952,003,379)
Uninsured	333,840	$133,818,270	$384,105,435	$250,287,165
Undocumented	124,428	$44,888,791	$740,867,936	$695,979,145
Excluded populations[101]	277,774			
Out-of-pocket expense (excluding Medicare)		$3,045,638,137	$3,087,211,098	$41,572,961
Out-of-pocket expense (Medicare)		$1,156,180,215	$1,171,962,075	$15,781,860
Indian Health Services		$79,843,114	$72,929,817	$(6,913,297)
Other private revenues		$3,003,934,742	$2,899,108,457	$(104,826,285)
Total	**7,896,906**	**$61,417,703,006**	**$55,771,906,214**	**$(5,645,796,792)**

[99] The Medicaid population totals exclude dually eligible members from the population count. Medicaid reimbursed expenditures are reflected in Medicare. All other Medicare-covered expenditures are included in the Medicare row.
[100] Status quo and modeled expenditure totals exclude long-term care and dental for all payer sources other than Medicaid.
[101] This includes federal employees and active duty military.

Figure 9: status quo vs. Model A – steady state expenditures (in millions)



Key notes:

Model A is expected to reduce aggregate system-wide expenditures by approximately **$5.6 billion** at steady state (in CY 2022 dollars). This impact is driven by multiple efficiencies that occur under a single-payer system. These include factors, such as:

- Reduced payer administrative cost
- Increased purchasing power
- Provide administrative efficiencies
- Program integrity improvements

The steady state model reflects higher savings assumptions as the system and data mature under the universal health care model.

The following table represents projected calendar year 2022 revenue estimates by financing source. These revenue projections include consideration for cost-shifting dynamics that will occur due to universal health care. Please note the following when interpreting the figures below:

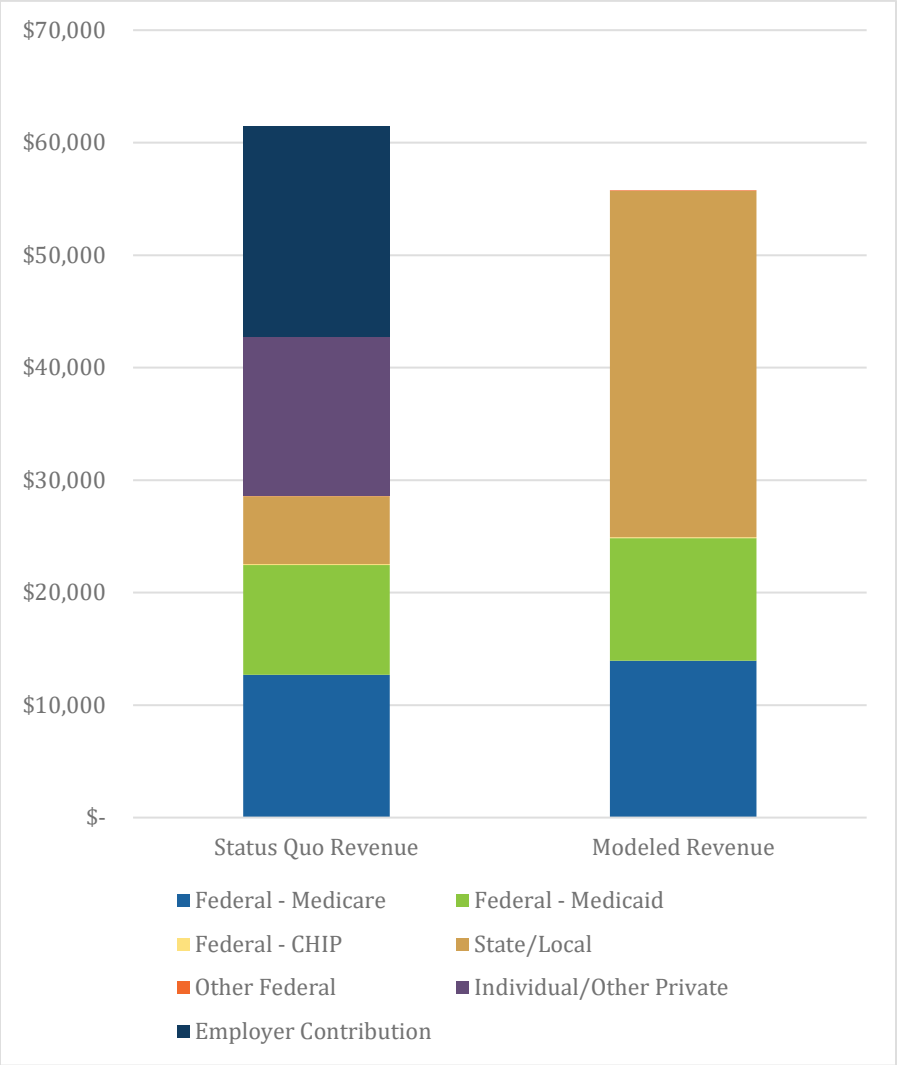
- The status quo health care system includes a significant source of funds from individual and employer contributions, including state and local funds for public employees. These revenues are assumed to continue under Model A universal health care; however, a mechanism to capture these contributions will need to be developed and implemented by the Washington State Legislature. These revenues are illustrated in the "State/local" row for the "Model A revenue estimate" column.
- Model A design includes normalizing provider reimbursement to a single reimbursement schedule. This is a significant change from status quo where reimbursement varies by payer (Medicaid, Medicare, private coverage). Subject to federal approval, this change would increase the amount of federal contributions Washington receives but also increase state general fund obligations.
- Contributions to cover uninsured, undocumented immigrants and out-of-pocket costs are included in "State/local" row for the "Model A revenue estimate" column.
- The revenue model assumes the state will be successful in preserving federal funding streams for eligible populations, even with the programmatic changes associated with transition to a universal health care model.
- The revised Model A projected expenditures in Table 10 excluded the cost for dental coverage for populations other than Medicaid. The following table separately identifies revenue collections necessary for dental coverage for all populations beyond Medicaid.

Table 40: Model A CY 2022 revenue sources – steady state

Financing source	Status quo revenue	Model A revenue estimate	Differences
Federal share – Medicaid	$12,692,075,724	$13,938,201,893	$1,246,126,169
Federal share – Medicare	$9,760,055,912	$10,903,457,002	$1,143,401,089
Federal share – CHIP	$73,302,525	$81,983,941	$8,681,416
State/local Share	$6,051,654,951	$30,775,333,561	$24,723,678,610
Other federal contributions (e.g., Indian Health Services)	$79,843,114	$72,929,817	$(6,913,297)
Individual contribution	$14,057,144,852		$(14,057,144,852)
Employer contribution[102]	$18,703,625,927		$(18,703,625,927)
Total	**$61,417,703,006**	**$55,771,906,214**	**$(5,645,796,792)**
Dental coverage for populations other than Medicaid[103]			**$3,052,211,853**

[102] Employer contribution includes state/local funds for public employees.
[103] Additional revenue required for covering dental services for all other populations than Medicaid, federal employees, and military. Assumes "moderate" cost level for dental services.

Figure 10: status quo vs. Model A – steady state revenues (in millions)



Key notes:

A major contributor to the increase in federal funds is associated with provider reimbursement rate normalization associated with a single-payer fee schedule. There are offsetting decreases to the private health insurance (employer and individual contributions). It is unclear if federal funding will be available to subsidize this effect.

Additional analysis is needed to understand the impact of lost insurer premium tax. Premium taxes contribute to the general fund. The loss of this revenue will need to be considered by the Washington State Legislature.

Additional analysis is needed to understand the broader economic impact on the state due to industry job loss, tax implications for employers, greater labor mobility, etc.

Model B

Table 41: overview of Model B

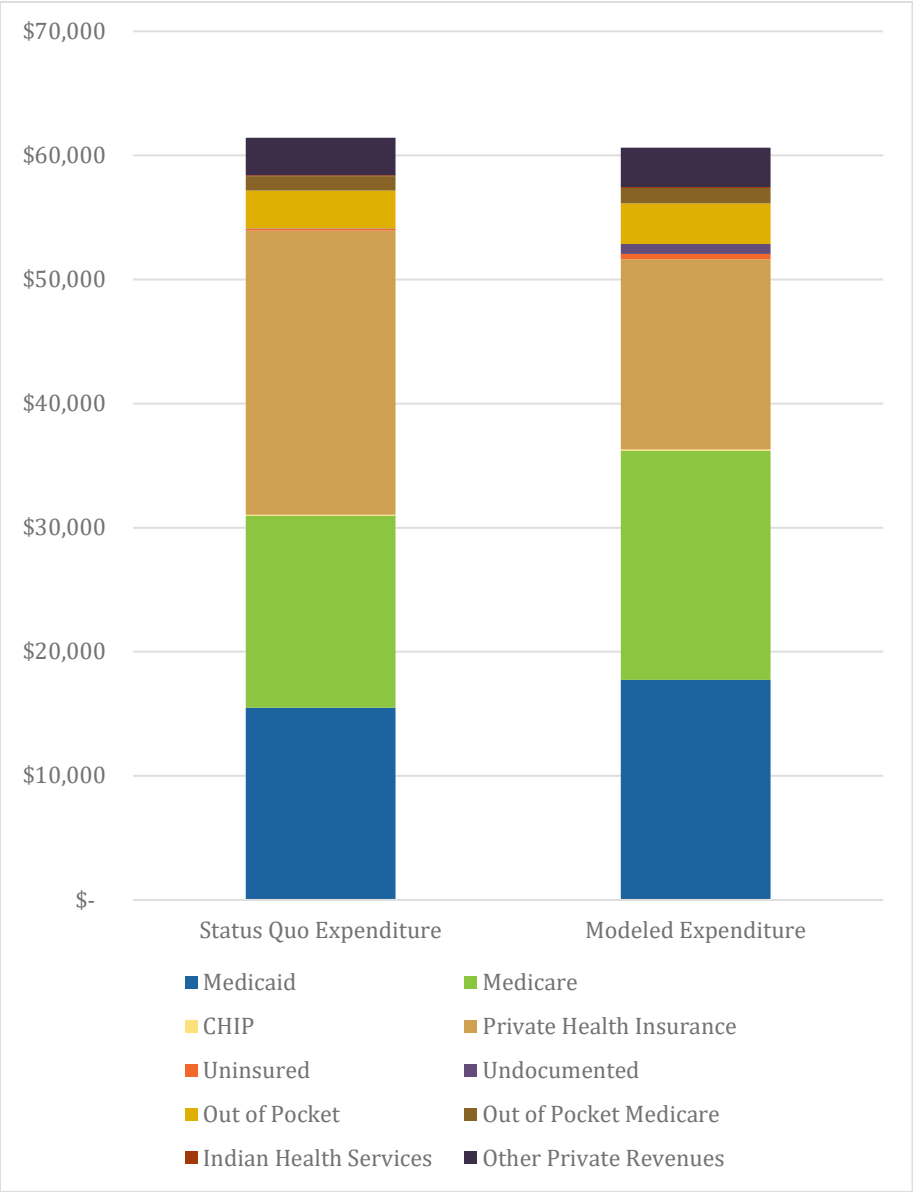
Covered populations	Benefits	Cost sharing	Provider reimbursement	Population-specific impacts	Administration
• Medicaid • Medicare • CHIP • Private health insurance (employer, state employees, and Exchange) • Undocumented immigrants • Uninsured	• Essential health benefits • Dental for Medicaid-eligible only • Vision • Long-term care for Medicaid-eligible only	• No cost sharing • Private insurance utilization changes due to removal of cost sharing	• Reduced pricing variation between covered populations • Administrative efficiency • Purchasing power	• Improved access for Medicaid-eligible persons, utilization changes by service type • Reflects increased utilization for uninsured and undocumented immigrant populations	• Managed care organization-administered • Premium tax applies • Reflects reductions in system-wide administrative costs

Table 42: Model B CY 2022 expenditures – implementation year

Financing source	Population[104]	Status quo expenditures[105]	Modeled expenditures	Differences
Medicaid	1,703,992	15,492,152,242	$17,748,246,930	$2,256,094,688
Medicare	1,721,504	15,478,141,127	$18,465,410,446	$2,987,269,319
CHIP	61,707	$83,298,324	$101,731,496	$18,433,172
Private health insurance	3,673,661	22,899,808,044	$15,316,276,699	$(7,583,531,345)
Uninsured	333,840	$133,818,270	$423,217,556	$289,399,286
Undocumented	124,428	$44,888,791	$816,307,941	$771,419,150
Excluded populations[106]	277,774			
Out-of-pocket expense (excludes Medicare)		$3,045,638,137	$3,265,875,845	$220,237,708
Out-of-pocket expense (Medicare)		$1,156,180,215	$1,239,786,497	$83,606,282
Indian Health Services		$79,843,114	$79,736,212	$(106,902)
Other private revenues		$3,003,934,742	$3,177,661,020	$173,726,278
Total	**7,896,906**	**$61,417,703,006**	**$60,634,250,642**	**$(783,452,364)**

[104] The Medicaid population totals exclude dually eligible members from the population count. Medicaid reimbursed expenditures are reflected in Medicare. All other Medicare covered expenditures are included in the Medicare row.
[105] Status quo and modeled expenditure totals exclude long-term care and dental for all payer sources other than Medicaid.
[106] This includes federal employees and active duty military.

Figure 11: status quo vs. Model B – program year 1 expenditures (in millions)



Key notes:

Model B is expected to reduce aggregate system-wide expenditures by approximately **$783 million** in the first implementation year. This impact is driven by multiple efficiencies that occur under a single-payer system. These include factors, such as:

- Limited reduction in payer administrative cost by reducing the number of payers across the health care system
- Increased purchasing power
- Provide administrative efficiencies
- Program integrity improvements

The following table represents projected CY 2022 revenue estimates by financing source. These revenue projections include consideration for cost-shifting dynamics that will occur due to universal health care. Please note the following when interpreting the figures below:

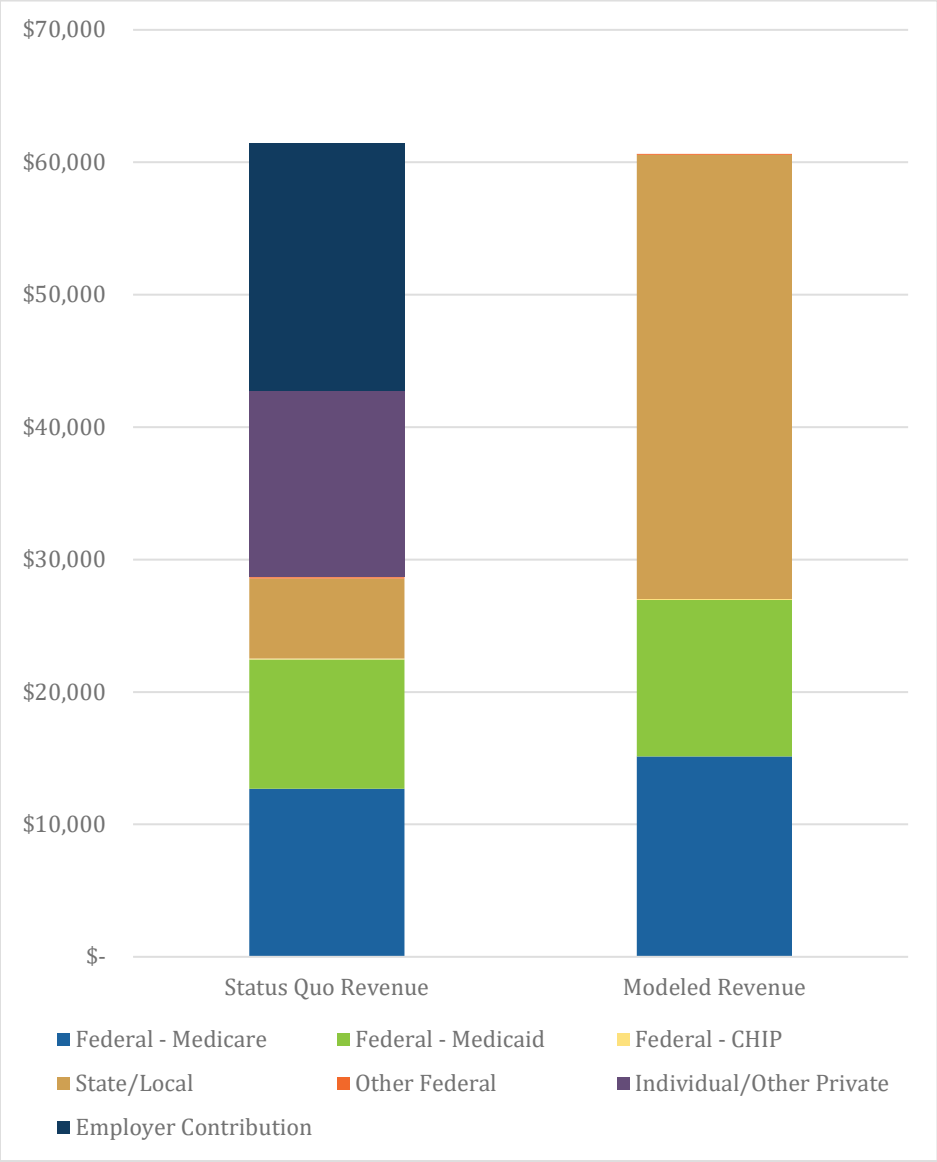
- The status quo health care system includes a significant source of funds from individual and employer contributions, including state and local funds for public employees. These revenues are assumed to continue under Model A universal health care; however, a mechanism to capture these contributions will need to be developed and implemented by the Washington State Legislature. These revenues are illustrated in the State/local row for the Model A Revenue estimate column.
- Model B design includes normalizing provider reimbursement to a single reimbursement schedule. This is a significant change from status quo where reimbursement varies by payer (Medicaid, Medicare, private coverage). Subject to federal approval, this change would increase the amount of federal contributions Washington receives but also increase state general fund obligations.
- Contributions to cover uninsured, undocumented immigrants and out-of-pocket costs are included in State/local row for the Model A Revenue estimate column.
- The revenue model assumes the state will be successful in preserving federal funding streams for eligible populations, even with the programmatic changes associated with transition to a universal health care model.
- The revised Model A projected expenditures in Table 10 excluded the cost for dental coverage for populations other than Medicaid. The following table separately identifies revenue collections necessary for dental coverage for all populations beyond Medicaid.

Table 43: Model B CY 2022 revenue sources – implementation year

Financing source	Status quo revenue	Model B revenue estimate	Differences
Federal share – Medicaid	$12,692,075,724	$15,141,636,566	$2,449,560,842
Federal share – Medicare	$9,760,055,912	$11,801,288,814	$2,041,232,902
Federal share – CHIP	$73,302,525	$89,523,716	$16,221,191
State/local Share	$6,051,654,951	$33,522,065,333	$27,470,410,382
Other federal contributions (e.g., Indian Health Services)	$79,843,114	$79,736,212	$(106,902)
Individual contribution	$14,057,144,852		$(14,057,144,852)
Employer contribution[107]	$18,703,625,927		$(18,703,625,927)
Total	**$61,417,703,006**	**$60,634,250,642**	**$(783,452,364)**
Dental coverage for populations other than Medicaid[108]			**$3,052,211,853**

[107] Employer contribution includes state/local funds for public employees.
[108] Additional revenue required for covering dental services for all other populations than Medicaid, federal employees, and military. Assumes "moderate" cost level for dental services.

Figure 12: status quo vs. Model B – program year 1 revenues (in millions)



Key notes:

A major contributor to the increase in federal funds is associated with provider reimbursement rate normalization associated with a single payer fee schedule. There are offsetting decreases to the private health insurance (employer and individual contributions). It is unclear if federal funding will be available to subsidize this effect.

Additional analysis is needed to understand the broader economic impact on the state due to industry job loss, tax implications for employers, greater labor mobility, etc.

Model C

Table 44: overview of Model C

Covered populations	Benefits	Cost sharing	Provider reimbursement	Population-specific impacts	Administration
Undocumented immigrants	Essential health benefits	Standard cost sharing	Cascade Care reimbursement standards apply	Utilization assumed to be similar to the commercially insured population	Assumes commercial plan levels of administrative costs

Model C provides coverage for populations without access to traditional health insurance coverage, independent of the affordability consideration. Currently, the undocumented population cannot access traditional health insurance.

Workgroup members have expressed interest in expanding Model C to include options for those who cannot afford health insurance under the current system. Washington is already making progress in this arena through **Cascade Care**.[109] Cascade Care provides access to more affordable standard and public option plans.

The authorizing statute also called for a study on a subsidy program. The Cascade Care subsidy option report is forthcoming. This report could inform recommendations for expansion of Model C to align with the subsidy recommendations, potentially serving as a transition strategy to broader universal health care in the longer term.

Table 45: Model C – estimated cost

Population [110]	Estimated total cost
124,428	$617,000,000

- Estimated current Medicaid costs (short-term emergency coverage only): $150 million of which 50 percent is Title XIX federal funds.
- All other existing system costs for this population are assumed to be individual expense or charity care.

[109] Washington Health Benefit Exchange website.
[110] Office of Financial Management estimate.

Model design impacts

Dental services

Except for the Medicaid-eligible population, dental costs are not included in the models above. The below table summarizes the cost of covering the remaining populations that would be included in Model A or Model B. The estimates reflect the following:

- Standard, commercial-like dental program that covers preventative, minor, and major restorative services.
- Annual benefit maximums are included.
- Provider reimbursement is based on commercial dental coverage.
- Dental insurer administration and premium tax are excluded.
- Variation in dental estimates are driven by dental managed care organization vs. preferred provider organization, annual maximum benefits limits, and variation in estimates for the value of out-of-pocket costs.

Table 46: estimated dental costs

	Low	Moderate	High
Average PMPM costs	$38.00	$43.00	$48.00
Total member months[111]	70,981,671	70,981,671	70,981,671
Total cost	$2.70 billion	$3.05 billion	$3.41 billion

Cost sharing

Models A and B reflect the elimination of enrollee out-of-pocket cost sharing. This results in approximately $4.2 billion in costs that were previously paid by individuals who used services and were subject to cost sharing. Eliminating out-of-pocket costs for the consumer is reflected as a plan cost that would be financed through taxes.

Additionally, removing barriers to accessing care is expected to increase utilization of certain services. It is reasonable to expect some offsetting reductions in higher-cost services as a result of removing cost sharing, but it may take time to see improvements in health that generates lower per capita costs.

Depending on utilization controls implemented in Models A and B, removal of cost sharing could increase utilization of elective services. Additional policy development and evaluation will be required to refine cost sharing and its impact on total costs.

Multi-year trend and estimates

The table below summarizes the total status quo expenditures costs and Model A program costs under different start date assumptions. Weighted average growth rates are based on population-specific national growth weights (from the CMS NHE forecast), applied to the modeled estimates of expenditure and enrollment for the relevant populations.

[111] Includes member months for all populations except Medicaid, federal employees, and military.

The current 2022 estimates are based on available data from 2018 and include four years of projection. Projections presented in the table below become less reliable due to the ever-changing dynamics in the health care system.

Table 47: five-year growth rates and estimated change in program expenditures, based on different starting dates

Year	Growth rate	Status quo	Model A implementation year	Differences
2022		$61,417,703,008	$58,942,132,021	$(2,475,570,987)
2023	6.2%	$65,225,600,595	$62,596,544,206	$(2,629,056,389)
2024	5.9%	$69,054,863,351	$66,271,460,392	$(2,783,402,958)
2025	6.1%	$73,242,864,656	$70,290,655,409	$(2,952,209,247)
2026	6.2%	$77,804,052,454	$74,667,994,843	$(3,136,057,611)
2027	6.0%	$82,479,003,533	$79,154,512,088	$(3,324,491,445)

Limitations

Federal financial participation

The cost estimate analysis assumes that the current system federal revenues continue for Medicaid, Medicare, and Exchange subsidies. With all federally funded programs, requirements and processes exist in regulation for each. Funding is conditional based on compliance with federal regulations.

The state will need to ensure that federal revenues are, at a minimum, maintained and in some cases, expanded to address changes in the progression toward Models A or B. For example, the state will need to explore available Medicaid waiver authorities and state plan amendments to align covered benefits, provider reimbursement, and mandatory participation of eligible individuals in universal health care.

For Medicare populations, the state will need to consider how to mandate individuals into coverage for Medicare under Models A or B. This includes considering those who receive Medicare via fee-for-services and may purchase supplemental coverage, or those enrolled in Medicare Advantage plans.

Individuals covered through the Exchange are eligible to receive federal subsidies for health insurance premiums. The state will need to consider how to maintain federal insurance subsidies for eligible individuals.

Additional data analysis

The analysis and estimates contained in this report were performed using the best data available. However, our analysis was limited by issues, such as the age of the data and lack of detailed demographic or type of service data. These issues limited our ability to perform more detailed analyses and estimates of the impact of provider reimbursement, additional benefits, and out-of-pocket cost sharing. Future cost analysis will require focused analysis, specific to each population and covered benefits, and should include processes and time to obtain such detail.

Medicaid: detailed enrollment, claims and utilization analysis by demographic group should be conducted to refine the impact of a standardized benefit package and health care provider reimbursement rebalancing to a standardized fee schedule across the system.

Medicare: Detailed enrollment, claims, and utilization analysis by demographic group should be conducted to refine the impact of a standardized benefit and out-of-pocket costs. Historically, obtaining detailed person-level Medicare data is difficult. Special accommodation from CMS needs to be explored to obtain the information to provide the highest quality information to inform future impacts.

Employer-sponsored information: detailed enrollment, claims and utilization analysis by demographic group, including primary and dependent subscribers, should be conducted. It is important to note a significant portion of employer-sponsored health insurance data is self-funded and was not available beyond aggregated surveys from NHE or Medical Expenditure Panel Survey.

Further, while employer-sponsored insured population information is available through the OIC, the data and information are summarized. Obtaining data from self-funded entities (such as detailed insured information) is necessary to support detailed analysis essential for the state if it progresses toward universal health care Models A or B. The additional detail will allow refined analyses on the impacts of:

- Employer and employee share of premium (for employer-sponsored coverage).
- Out-of-pocket costs.
- Impact of health care provider fee schedule rebalancing to a standardized fee schedule across the system.
- Impact of standardized benefit packages.

Washington Health Benefit Exchange: detailed enrollment, claims, and utilization analysis by should be available through HCA. Analysis can support:

- Individual and federal subsidy share of premium (for Exchange plans).
- Out-of-pocket costs.
- Impact of health care provider fee schedule rebalancing to a standardized fee schedule across the system.

Other data: other health care-specific resources exist, such as state or grant-funded well-child programs, immunization programs, school-based health, mental health and substance use programs, and more. Data was not available from these programs by demographic or with enough detail to consider their influence on health insurance and coverage expenditures.

Appendix I: example of transition process and timeline

This process example includes steps to develop the details of structuring and funding a universal health care program and establishing other elements of a program that impact health coverage and care for Washingtonians.

- The draft example shows a four-year process, starting in January 2021.
- The actual work may take more or less time, but this example gives a view of the work involved and a suggested process for conducting that work.
- A dedicated group, the Universal Health Care Commission (UHCC), could be legislatively established to spearhead the work. A UHCC could include:
    - An action-oriented, focused group of state leaders.
    - Targeted work groups to define specific areas.
    - Stakeholder input at multiple points in the process.
    - Something similar to 1993 Health Care Commission, which requires staffing and resources.

Timeline, work stream, and detailed steps

The next several pages show three views:

- View 1: timeline showing the work to be done by the Legislature, Governor, state agencies, and a possible UHCC.
- View 2: work stream view that shows the three main areas.
- View 3: detailed steps with notes on the lead actors and anticipated timing.

Reform work is intended to enact change in the following areas identified by the Work Group:

- Establish a universal health care goal for the state.
- Maintain coverage gains and extend coverage to the uninsured.
- Implement and administer established program.
- Define coverage.
- Define financing plan and anticipated cost savings.
- Develop program standards, including for quality, access, equity, and other areas.
- Establish and implement a transition plan.

View #1: timeline

Figure 13: key accomplishments for 2021-2022 (the passage or signing of a piece of legislation and coverage start dates)

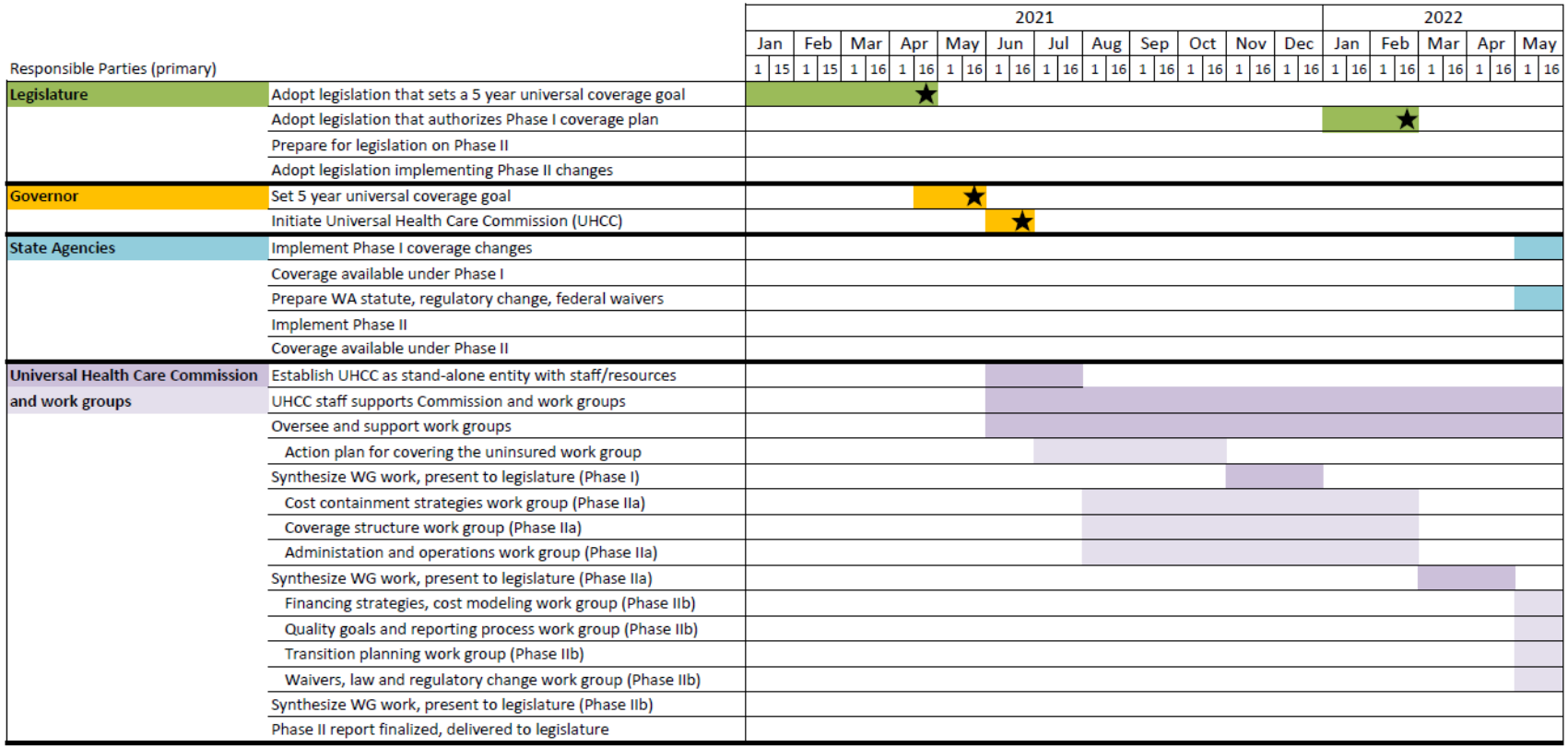


Figure 14: key accomplishments for 2022-2023 (the passage or signing of a piece of legislation and coverage start dates)

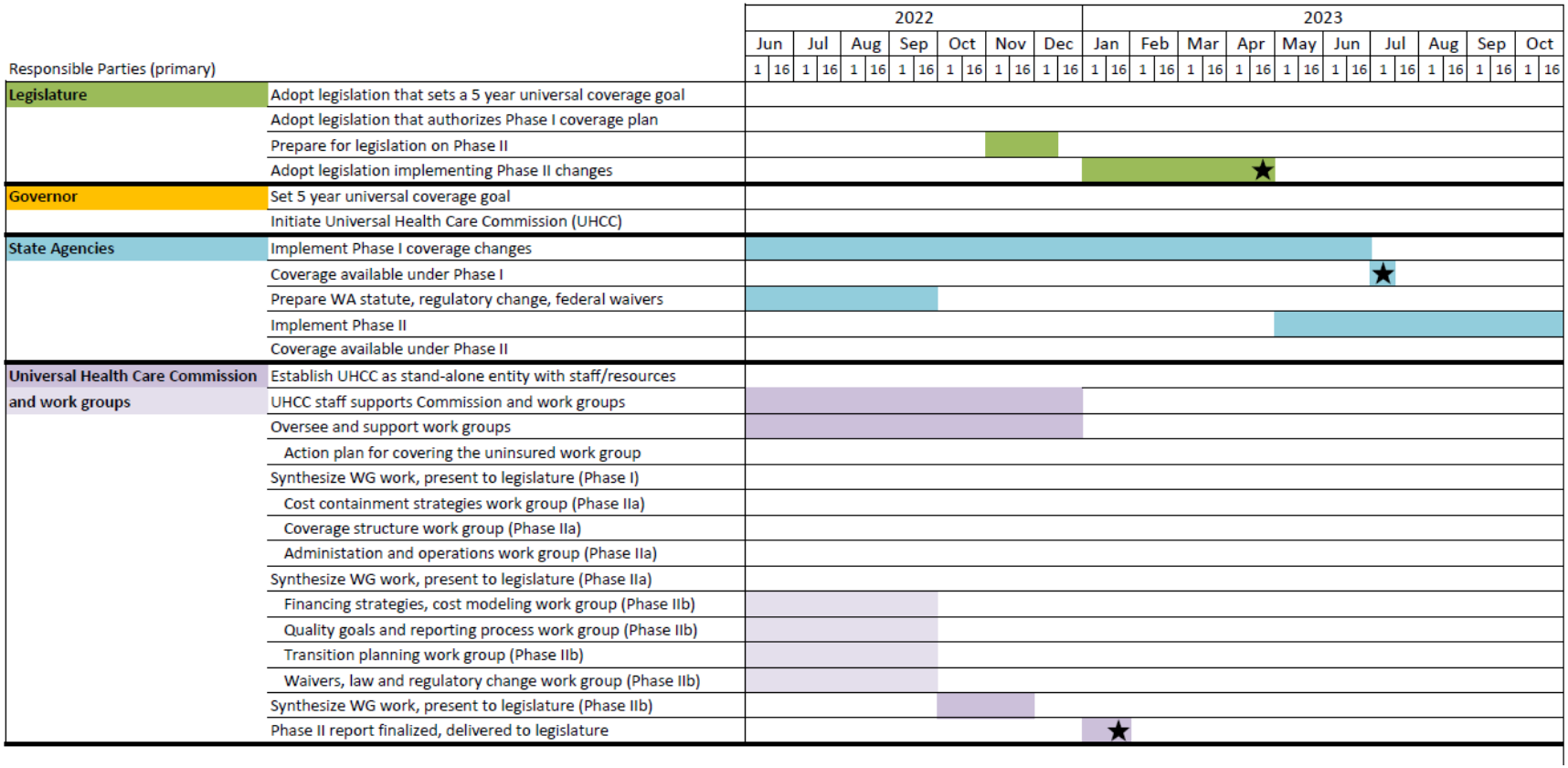
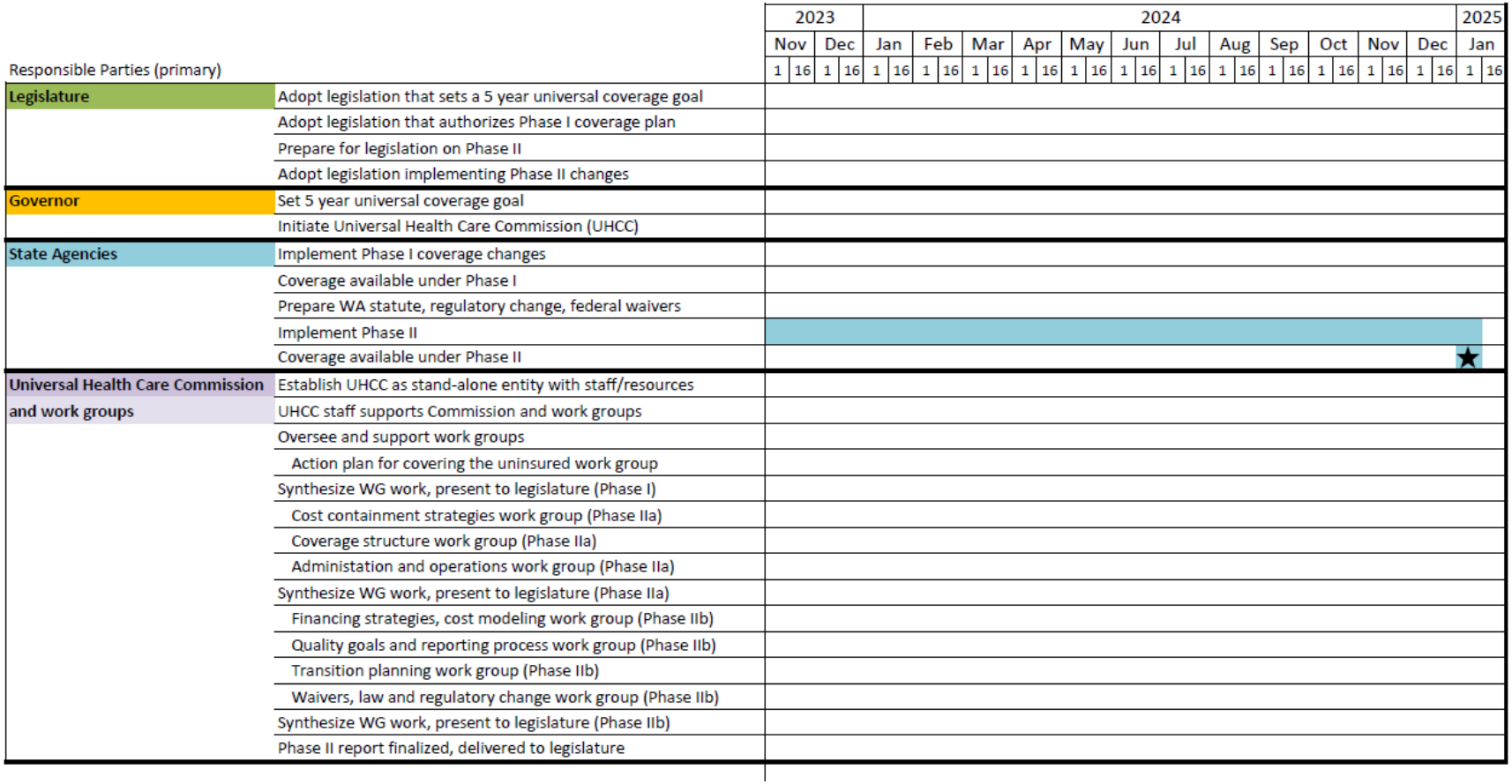


Figure 15: key accomplishments for 2023-2025 (the passage or signing of a piece of legislation and coverage start dates)



View #2: work streams

Table 48: work stream 1

WORK STREAM 1. Protect coverage and reduce uninsurance	Lead(s)
Pass legislation that: • Sets 5-year goal for universal health care • Establishes a structure for a 5-year plan • Establishes UHCC and defines a process	Legislature, Governor
Initiate UHCC to support and oversee development of Recommendations	UHCC
Develop Phase I action plan for coverage of uninsured	UHCC Phase I work group
Conduct stakeholder engagement	UHCC, state agencies
Finalize Phase I Recommendations to Legislature for coverage of uninsured	UHCC
Pass legislation adopting Phase I coverage changes for uninsured	Legislature, Governor
Implement Phase I changes	State agencies
Enroll eligible people in Phase I coverage	State agencies, partners

Table 49: work stream 2

WORK STREAM 2. Define and implement coverage structure, cost containment strategies, administration	Lead(s)
Pass legislation that: • Sets 5-year goal for universal health care • Establishes a structure for a 5-year plan • Establishes UHCC and defines a process	Legislature, Governor
Initiate UHCC to support and oversee development of Recommendations	UHCC
Develop Phase II(a) action plans for: • Cost-containment strategies • Coverage structure • Program administration and operations	UHCC Phase II(a) work groups
Conduct stakeholder engagement	UHCC, state agencies
Finalize Phase II(a) Recommendations to Legislature re: cost containment, coverage, and program administration/operations	UHCC
Conduct detailed operational planning of coverage, cost containment, administration	State agencies
Pass Phase II legislation	Legislature, Governor
Conduct Phase II implementation activities	State agencies, partners
Enroll eligible people in Phase II coverage	State agencies, partners

Table 50: work stream 3

WORK STREAM 3. Define and implement financing, program standards and transition actions	Lead(s)
Pass legislation that: • Sets 5-year goal for universal health care • Establishes a structure for a 5-year plan • Establishes UHCC and defines a process	Legislature, Governor
Initiate UHCC to support and oversee development of Recommendations	UHCC
Develop Phase II(b) action plans: • Develop budget and financing strategies • Develop process for establishing quality goals and administering reporting process • Operational planning advisory support • Transition planning	UHCC Phase II(b) work groups
Conduct stakeholder engagement	UHCC, state agencies
Finalize Phase II(b) Recommendations to Legislature re: financing, program standards, transition	UHCC
Conduct detailed operational planning of financing program standards, transition	State agencies
Pass Phase II legislation	Legislature, Governor
Conduct Phase II implementation activities for coverage, delivery system, and cost-containment changes, transition efforts	State agencies, partners
Enroll eligible people in Phase I coverage	State agencies, partners

View #3: detailed steps and lead actors

Table 51: detailed steps and lead actors

Action	Lead(s)	When	Notes
Maintain current public sector coverage.	Legislature, Governor	Ongoing	COVID-associated decrease in state revenues could threaten Medicaid and other health programs. The first step to increasing coverage is not to reduce current coverage
Pass legislation that: • Sets 5-year goal for universal health care. • Establishes a structure for a 5-year plan. • Establishes UHCC and defines a process.	Legislature, Governor	2021 legislative session	Bill may include steps to universal health care over time, identifying populations, mechanisms, etc. to get there, including: • Goals. • 5-year plan. • UHCC process/work groups. • Stakeholder engagement and consensus building. • Staffing and professional services support. 2021 session is 105 days.
Initiate UHCC to support and oversee development of Recommendations.	Governor, UHCC team	June 2021	• Governor appoints membership of main body. • Goals for body based on UHCC work group goals.
Support UHCC and work groups.	UHCC, other state agencies	June 2021	UHCC initiates, supports, and monitors work groups.
Develop Phase I action plan for coverage for the uninsured.	Phase I work group	July 2021-Oct. 2021	Plans for addressing the uninsured with short-term implementation.
Collect public input on Phase I action plan.	UHCC, other state agencies	Nov. 2021	Stakeholder input on work group recommendations will inform final UHCC Recommendations
Develop Phase II(a) action plans: • Adopt cost-containment strategies. • Develop coverage structure. • Develop administration and operations.	Phase II(a) work group members, supported by UHCC, other state agencies	Aug. 2021-Feb. 2022	The Phase II(a) work groups will address: • Strategies, such as global payments, growth cap, provider rates, and measures to reduce provider burden/associated costs. • Cost sharing, provider payment model (such as value-based payments). • Alignment of rules across payers, moving to something new, enrollment process, benefits administration, administrative streamlining, health information technology and data sharing (including getting better utilization and provider reimbursement data from ERISA plans). Work groups provide updates to UHCC group.
Collect public input on Phase II(a) action plans.	UHCC, other state agencies	Feb. 2022	Stakeholder input on work group recommendations will inform final UHCC Recommendations.

Action	Lead(s)	When	Notes
Finalize Phase I Recommendations to Legislature.	UHCC	Nov.-Dec. 2021	Incorporates first steps to increase coverage from Phase I work group.
Pass legislation to adopt Phase I coverage changes for uninsured.	Legislature, Governor	2022 legislative session	Incorporates UHCC Recommendations for first steps to increase coverage. 2022 session is 60 days.
Finalize Phase II(a) work group Recommendations.	UHCC, with support from other state agencies	March-April 2022	Incorporates recommendations from cost containment, coverage structure, and administration and operations work groups. Submit to Legislature, Governor.
Initiate implementation of Phase I changes.	State agencies	May 2022	Includes waivers, contracting, and administrative structure.
Develop Phase II(b) action plans: • Develop budget and financing strategies. • Develop process for establishing quality goals and administering reporting process. • Operational planning advisory support. • Transition planning.	Phase II(b) work group members, supported by UHCC, other state agencies	May 2022-Sept. 2022	Informed by results of Phase II(a) efforts, Phase II(b) work groups will address: • Refined cost modeling, establishment of funding sources (including reallocation of and changes to spending by residents, employers, public sector, etc.), use of mandates. • Quality measurement and reporting will be aligned with state public health improvement plan. • Review and advise state operational planning including for adjustments to statutes, regulations, and federal waivers. • Transitioning current programs and populations, mediating impacts to staff of current market participants.
Collect public input on Phase II(b) action plans.	UHCC, other state agencies	Oct. 2022	Stakeholder input on work group recommendations will inform final UHCC Recommendations.
Conduct detailed operational planning.	State agencies	May-Sept. 2022	• Review/advice received from Phase II(b) work groups. • Planning addresses state-level operational, statutory, regulatory changes, federal waivers, etc. • Participants may include Department of Social and Health Services, Office of the Insurance Commissioner, and others.
Finalize Phase II(b) Recommendations.	UHCC, supported by state agencies	Oct.-Nov. 2022	Submit to Legislature, Governor. Could include public input process and/or additional public meetings.
Submit final (Phase II(a & b)) Recommendations to Legislature.	UHCC, supported by state agencies	Jan. 2023	
Pass Phase II bill.	Legislature, Governor	April 2023	Bill may include steps to universal health care over time, identifying populations, mechanisms, etc. to get there as well as details of implementation for health system changes.

Action	Lead(s)	When	Notes
Initiate Phase II implementation activities.	State agencies, other partners (TBD)	Mid-2023	Includes: • Federal waivers. • Additional state law and regulation changes. • Implementation activities for state. • Transitions.
Begin enrollment in Phase I coverage.	TBD	July 2023	Responsible parties will include state and others based on adopted plan.
Implement additional delivery system and cost containment changes.	State agencies, other partners (TBD)	2023 and beyond	Delivery and cost containment changes could be implemented with Phase II or could occur separately.
Begin enrollment in Phase II coverage.	TBD	Jan. 2025 or earlier	May be additional phases if activities are implemented in a more stepped fashion