HEALTH CARE FOR ALL OREGON PLAN
REQUIREMENTS, KEY TASKS, & CONSIDERATIONS

At the August 21st meeting, staff with the Legislative Policy and Research Office (LPRO) outlined five key tasks based on Senate Bill 770 (2019). Members offered their initial thoughts and recommendations as to how best to complete the work outlined in the legislation including the option of forming technical advisory groups (TAGs) as necessary.

Senate Bill 770 requires the Task Force to make findings and recommendations on 16 different elements (a-p):

a) Governance and Leadership of the Health Care for All Oregon Board (Board)
b) List of federal and state laws, rules, state contracts or agreements, court actions or decisions that may facilitate, constrain, or prevent implementation of the plan
c) Health Care for All Oregon Plan's (Plan) economic sustainability, operational efficiency and cost control measures
d) Features of the Plan that are necessary to continue to receive federal funding that is currently available to the state and estimates of the amount of the federal funding that will be available
e) Fiduciary requirements for the revenue generated to fund the Plan
f) Requirements for the purchase of reinsurance
g) Bonding authority that may be necessary
h) Board's role in workforce recruitment, retention and development
i) Process for the Board to develop statewide goals, objectives and ongoing review
j) Appropriate relationship between the Board and regional or local authorities regarding oversight of health activities, health care systems and providers to promote community health reinvestment, equity and accountability
k) Criteria to guide the Board in determining which health care services are necessary for the maintenance of health, the prevention of health problems, the treatment or rehabilitation of health conditions and long term and respite care
l) Process to track and resolve complaints, grievances and appeals, including establishing an Office of the Patient Advocate
m) Options for transition planning, including an impact analysis on existing health systems, providers and patient relationships
n) Options for incorporating cost containment measures
o) Methods for reimbursing providers for the cost of care
p) Recommendations for long term care services and supports that are tailored to each individual's needs based on an assessment

The draft workplan is intended to solicit feedback and guidance from the Task Force. During the September 22 meeting, LPRO staff will summarize members' feedback and prepare a revised workplan. The draft workplan reflects the list of tasks and considerations outlined in the following pages. The five tasks are directly taken from Senate Bill 770.

REPORT & PLAN DESIGN CONSIDERATIONS

The **final report** and **recommendations** must be succinct statements and include:

- Actions and timelines,
- Degree of consensus and the priority of each recommendation, and
- Based on urgency and importance

I. Plan Design Considerations

Adhere to the values and principles described in the Principles and Values section:

- Be a single payer health care financing system;
- Ensure that individuals who receive services from the VA or the Indian Health Services may be enrolled in the plan while continuing to receive the services;
- Equitably and uniformly include all residents in the plan without decreasing the ability of any individual to obtain affordable health care coverage if the individual moves out of this state by obtaining a waiver of federal requirements that pose barriers to achieving the goal or by adopting other approaches; and
- Preserve the coverage of the health services currently required by Medicare, Medicaid, the Children's Health Insurance Program, Affordable Care Act (P.L. 111-148), and any other state or federal program.

Additional considerations for the Task Force include:

- How the plan will impact the structure of existing state and local boards and commissions, counties, cities and special service districts, as well as the United States Government, other states and Indian tribes;
- Issues raised in the report entitled "*A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon*;"
- Investigate other states' attempts at providing universal coverage and using single payer health care financing systems, including the outcomes of the attempts; and
- Work by existing health care professional boards and commissions to incorporate important aspects of the work of the health care professional boards and commissions into recommendations for the plan.
- Waivers of federal laws or other federal approval that will be necessary to enable a person who is a resident of this state and who has other coverage that is not subject to state regulation to enroll in the plan without jeopardizing eligibility for the other coverage if the person moves out of this state.
- How patients are empowered to protect their health, their rights and their privacy in the Health Care for Oregon Plan.
- Public access to state, regional and local reports that are accurate, timely, of sufficient detail and presented in a way that is understandable to the public to inform policy making and the allocation or reallocation of public resources.

TASK 1: ELIGIBILITY, COVERED BENEFITS, AND AFFORDABILITY (Plan Elements K, N)

I. Plan Eligibility

The Plan **shall allow** participation by any individual who:

- Resides in this state;
- Is a nonresident who works full time in this state and contributes to the plan; or
- Is a nonresident who is a dependent of an individual described in first two bullets

The Task Force's recommendations **shall address** issues related to the provision of services to nonresidents who receive services in this state and to plan participants who receive services outside this state.

II. Health Care Services

The Task Force shall develop criteria to guide the board in determining which health care services are necessary for the maintenance of health, the prevention of health problems, the treatment or rehabilitation of health conditions and long term and respite care. Criteria **may include**, but are not limited to, the following:

- Whether the services are cost-effective and based on evidence from multiple sources;
- Whether the services are currently covered by the health benefit plans offered by PEBB/OEBB;
- Whether the services are designated as effective by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices, the Health Resources and Services Administration's Bright Futures Program, the Institute of Medicine Committee on Preventive Services for Women or the Health Evidence Review Commission;
- Whether the evidence on the effectiveness of services comes from peer-reviewed medical literature, existing assessments and recommendations from state and federal boards and commissions and other peer-reviewed sources; and
- Whether the services are based on information provided by the Traditional Health Workers Commission established in ORS 413.600;
- A process to track and resolve complaints, grievances and appeals, including establishing an Office of the Patient Advocate;
- Options for transition planning, including an impact analysis on existing health systems, providers and patient relationships;
- Options for incorporating cost containment measures such as prior approval and prior authorization requirements and the effect of such measures on equitable access to quality diagnosis and care;

Long-term Care Services

Recommendations for long term care services and supports that are tailored to each individual's needs based on an assessment. The services and supports may include:

- broad spectrum of long-term services and supports, including home and community-based settings or other noninstitutional settings;
- Services that meet the physical, mental and social needs of individuals while allowing them maximum possible autonomy and maximum civic, social and economic participation;
- Long term services and supports that are not based on the individual's type of disability, level of disability, service needs or age;
- Services provided in the least restrictive setting appropriate to the individual's needs;
- Services provided in a manner that allows persons with disabilities to maintain their independence, self- determination and dignity;
- Services and supports that are of equal quality and accessibility in every geographic region of this state; and,
- Services and supports that give the individual the opportunity to direct the services.

TASK 2: PROVIDER REIMBURSEMENT MODELS (Plan Elements H, O)

I. Methods for Provider Reimbursement

The Task Force recommendations should address methods for reimbursing providers for the cost of care as described below:

- Providers shall be paid using an alternative method that is similarly equitable and cost-effective; and
- Individual providers licensed in this state shall be paid: on a fee-for-services basis; as employees of institutional providers or members of group practices that are reimbursed with global budgets; or as individual providers in group practices that receive capitation payments for providing outpatient services

Senate Bill 770 specifies that institutional providers shall be paid with global budgets that include separate capital budgets, determined through regional planning, and operational budgets. The Task Force shall evaluate and propose budgets for hospitals, entities that own multiple hospitals, clinics or other providers of health care services or goods.

The Task Force's recommendations shall also address issues related to the provision of services to nonresidents who receive services in this state and to plan participants who receive services outside this state, and Board's role in workforce recruitment, retention and development

TASK 3: FINANCIAL & EXPENDITURE ESTIMATES (Plan Elements C, E, F, G)

I. Cost Estimate Expenditures

Develop cost estimates for the plan, **including but not limited to** cost estimates for:

- The approach recommended for achieving a single payer health care financing system; and
- The payment method designed by the Task Force using fee-for-services basis or alternative method.

Estimates of the savings and expenditure increases under the plan, relative to the current health care system, **including but not limited to**:

- Savings from eliminating waste in the current system and from administrative simplification, fraud reduction, monopsony power, simplification of electronic documentation and other factors that the Task Force identifies;
- Savings from eliminating the cost of insurance that currently provides medical benefits that would be provided through the plan; and
- Increased costs due to providing better health care to more individuals than under the current health care system;
- Estimates of the expected health care expenditures under the plan, compared to the current health care system, reported in categories similar to the National Health Expenditure Accounts compiled by the Centers for Medicare and Medicaid Services (CMS), **including, at a minimum**:
  - Personal health care expenditures;
  - Health consumption expenditures; and
  - State health expenditures;
- Estimates of how much of the expenditures on the plan will be made from moneys currently spent on health care in this state from both state and federal sources and redirected or utilized, in an equitable and comprehensive manner, to the plan;
- Estimates of the amount, if any, of additional state revenue that will be required; and
- Results of the Task Force's evaluation of the impact on individuals, communities and the state if the current level of health care spending continues without implementing the plan, using existing reports and analysis where available.

TASK 4: REVENUE MODELS (Plan Elements F, G)

I. Revenue Recommendations

The Task Force's findings and recommendations regarding revenue for the plan, including redirecting existing health care moneys under subsection (7)(d) of this section must be ranked according to explicit criteria, including the degree to which an individual class of individuals or organization would experience an increase or decrease in the direct or indirect financial burden or whether they would experience no change. Revenue options **may include, but are not limited to**, the following:

- The redirection of current public agency expenditures;
- An employer payroll tax based on progressive principles that protect small businesses and that tend to preserve or enhance federal tax expenditures for Oregon employers that pay the costs of their employees' health care; and
- A dedicated revenue stream based on progressive taxes that do not impose a burden on individuals who would otherwise qualify for medical assistance.

The Task Force may explore the effect of means-tested copayments or deductibles, including but not limited to the effect of increased administrative complexity and the resulting costs that cause patients to delay getting necessary care, resulting in more severe consequences for their health.

TASK 5: BOARD DESIGN AND GOVERNANCE PLAN (Plan Elements A, C, E, F, G, I, J, L)

I. Financial Governance

The plan's economic sustainability, operational efficiency and cost control measures that include, but are not limited to, the following:

- A financial governance system supported by relevant legislation, financial audit and public expenditure reviews and clear operational rules to ensure efficient use of public funds; and
- Cost control features such as multistate purchasing;

Fiduciary requirements for the revenue generated to fund the plan, including, but not limited to, the following:

- A dedicated fund, separate and distinct from the General Fund, that is held in trust for the residents of this state;
- Restrictions to be authorized by the board on the use of the trust fund;
- A process for creating a reserve fund by retaining moneys in the trust fund if, over the course of a year, revenue exceeds costs; and
- Required accounting methods that eliminate the potential for misuse of public funds, detect inaccuracies in provider reimbursement and use the most rigorous generally accepted accounting principles, including annual external audits and audits at the time of each transition in the board's executive management;
    - Requirements for the purchase of reinsurance;
    - Bonding authority that may be necessary;
    - The board's role in workforce recruitment, retention and development;
    - A process for the board to develop statewide goals, objectives and ongoing review;
    - The appropriate relationship between the board and regional or local authorities regarding oversight of health activities, health care systems and providers to promote community health reinvestment, equity and accountability.

II. Health Care for All Oregon Board

Board recommendations **must include:**

- Governance and leadership of the board
- Composition and representation of the membership of the board, appointed or otherwise selected using an open and equitable selection process;
- Statutory authority the board must have to establish policies, guidelines, mandates, incentives and enforcement needed to develop a highly effective and responsive single payer health care financing system;
- Ethical standards and the enforcement of the ethical standards for members of the board such that there are the most rigorous protections and prohibitions from actual or perceived economic conflicts of interest; and
- Steps for ensuring that there is no disproportionate influence by any individual, organization, government, industry, business or profession in any decision-making by the board.