Oregon Legislative Assembly

October 14, 2020

Joint Task Force on Universal Health Care

AGENDA

National and International Perspectives - Universal Coverage Models

Kenneth Thorpe, Robert Woodruff Professor of Health Policy, Emory University

States' Efforts to Achieve Universal Access to Care

LPRO Staff

Task Force Discussion - State-based Universal Systems of Coverage

LPRO Staff

Technical Advisory Groups (TAG) - Finalize Workplan and Next Steps

Chair Goldberg and Vice-Chair Junkins

Public Testimony 3:40 - 4:00pm

Today's Objectives

- Roadshow by visiting recent coverage initiatives in other states
- Identify lessons from past efforts to achieve universal coverage
- Review key components for a state-based universal system of coverage
- Assess current landscape (ACA, ERISA, federal waivers, COVID-19)
- Identify aspects of the existing system that work well in Oregon
- Start to organize design considerations relevant to inform and guide the Technical Advisory Groups

Opening Reflections

"Solving the intertwined problems of costs and access through systemic reform"

"A better health care system, not a perfect health care system..."

"Single-payer is not a one-size-fits-all approach"

"States as Policy Laboratories...."

Overview of Resources to Support Taskforce

Agency/Entity	Support	Resources *Staff FTE varies*
LPRO (task force lead)	• Lead task force planning, provide ongoing structural support • Provide revenue consultation • Coordinate with OHA, DCBS and Contractor to address task force needs	Lead policy staff Administrative support Revenue analyst Consultation
OHA (task force support)	• Support task force, TAG and CAC operations • Develop policy and data briefs and other meeting materials, provide subject matter expertise on state and federal laws and regulations, other states, and previous Oregon work on universal access/coverage topics • Coordinate with LPRO, DCBS and Contractor to address task force needs	2 dedicated part-time policy analysts with support from senior policy analyst and managers.
DCBS (task force support)	• Coordinate with LPRO, OHA and Contractor to address task force needs • Provide consultation and guidance for project team as requested	Senior policy analyst consultation
Independent Contractor	• Coordinate with LPRO, OHA and DCBS to address task force needs • Provide flexible technical assistance related to task force goals and requirements, which may include developing meeting materials and policy documents, providing subject matter expertise, and facilitation for task force, TAG, and/or CAC conversations.	Up to 65 hours of consultant time per month (Nov – June)

Discussion Guide

1. What challenges or obstacles do you foresee in designing the Health Care for All Oregon Plan?
2. What lessons or insights can you draw based on states' past efforts to achieve state-based universal coverage as well as from international models?
3. What are the most urgent (or critical) policy or design considerations the Task Force (Technical Advisory Groups) will need to address?
4. What aspects of the current system, if any, work well in Oregon? (**new*)

States' Efforts to Enact Universal Health Care

Vermont
(House Bill 202 2011)

Basic design: 94% Actuarial Value (AV) coverage for all residents and commuters, excluding Medicare and TRICARE

Financing: 11.5% payroll tax and sliding scale "Public Premium"

Barriers: (1) Higher-than-expected costs during a weak economy, (2) concerns about acquiring initial reserves, (3) issues acquiring federal waivers, (4) lack of confidence after problematic Exchange launch, and (5) poor polling

Status: Planning bill signed into law; Governor Shumlin ended the initiative in 2014; implementing voluntary "All-payer" ACO model

Colorado
(Amendment 69 2016)

Basic design: No cost-sharing plan for all residents, excluding Medicare and TRICARE which got supplemental coverage

Financing: 10% payroll tax and 10% tax on other income

Barriers: (1) concerns about election and management structure of the cooperative that would run the program, (2) concerns about interaction with existing constitutional requirements, (3) concerns about insufficient funding based on outside projects, and (4) lack of support from top officials

Status: Measure placed on the ballot and failed to pass: 21% yes to 78% no

California
(Senate Bill 562 2017)

Basic design: No cost-sharing coverage for all residents; Medicare excluded but covered by wrap-around elements

Financing: No official source; state estimates suggested 15% payroll tax

Barriers: (1) Senate did not take up the issue, officially, over concerns about the lack of detail and possible action from federal administration, (2) constitutional constraints would likely require the measure to go the ballot, (3) polling indicated 65% of residents supported concept; support dropped to 42% when voters were told about a tax increase

Status: Governor Newsom's Healthy California for All Commission (hiatus)

New York
(Assembly Bill 4738 2017)

Basic design: No cost-sharing coverage for all residents; Medicare and Medicaid potentially excluded with waivers not provided but strongly integrated

Financing: No official amount, but was supposed to be payroll tax and non-payroll tax

Barriers: Limited support in the Senate to the general concept; limited on policy details

Status: Legislation failed in policy committee

Comparisons of States' Proposal by Key Design Elements

	Vermont	Colorado	California	New York
Eligibility	All Vermont residents except Medicare or TRICARE. Non-residents who commute into Vermont to work for Vermont businesses.	All Colorado residents except those covered by Medicare and TRICARE. ColoradoCare would have been a supplemental care for TRICARE and Medicare. ColoradoCare would have also offered a Medicare Advantage plan.	All resident of California. Seniors would have been required to enroll in Medicare Parts A, B, and D.	All New York residents (although if waivers weren't obtained, it would have attempted to make it as seamless as possible for those technically covered by Medicaid and Medicare).
Benefits	Primary, preventive, mental health, and chronic care. Hospitalization, rehabilitation, labs, prescription drugs. Dental and vision for children. No dental and vision for adults or long-term care for people who don't qualify under Medicaid.	Primary, preventive, mental health, chronic care. Primary, preventive, mental health, and chronic care. Hospitalization, rehabilitation, labs, prescription drugs. Dental and vision for children. No dental and vision for adults. At least long-term care for people who don't qualify under Medicaid.	"All services covered by Medi-Cal, Medicare, the essential health benefits, and all health plan/insurance mandated benefits. Benefits required include chiropractic, vision, dental, ancillary health or social services previously covered by a regional center, skilled nursing facility care, and therapies shown by the National Institutes of Health, National Center for Complementary and Integrative Health to be safe and effective."	All health services covered by child health plus, Medicaid, Medicare, ACA, state civil service law, except long term care which would have been dealt with separately.
Affordability/ Cost-sharing	Minor cost-sharing coverage (94 percent actuarial value insurance).	No cost-sharing.	No cost-sharing.	No cost-sharing.
Administration	The Green Mountain Care Board (five members nominated by a committee and appointed by the Governor) would oversee a program operated as a public-private partnership between the state of Vermont and a strong private sector partner under either a "designated public utility" or a "designated facilitator" model.	ColoradoCare would have been run as a cooperative. It would have been controlled by a 21-member board of trustees elected in special non-partisan co-op elections that would be separate from regular state government elections.	Healthy California would have been an independent public entity run by a nine-member board.	New York Health program would have been created in the Department of Health and managed by a 29-member board of trustees.
Financing	11.5% payroll tax, sliding scale "public premium" up to 9.5% Adjusted Gross Income, some cost-sharing, existing state funds and federal waiver funds.	10% payroll tax and 10% non-payroll income premium, existing state funds and federal waiver funds.	SB 562 provided no financing mechanism beyond existing state funds and federal waiver funds. Officials estimated it would require a 15% payroll tax.	Legislation provided no financing mechanism beyond existing state funds and federal funds. Intent was to fund program by "progressively graduated tax on all payroll" income and "progressively graduated tax on taxable income not subject to the payroll tax."
Unique Challenges	Concerns about generating sufficient reserves to launch the program. Lack of credibility after failure of state-run exchange. Difficulty securing federal waivers. Higher than expected costs of projects.	Outside independent analysis projected tax revenue could be insufficient.	No defined financing plan. Required the issue to be placed on the ballot to exempt it from existing constitutional requirements.	Legislation failed in the Senate.

General Observations – State Perspectives

- ERISA restricts a state's options when impacting employer-sponsored coverage
- Federalism - federal authority to redirect funds from Medicare, Medicaid, Affordable Care Act (ACA), Veteran's Administration
- Feasibility of multiple (comprehensive) federal waivers (1115/1332)
- Legal considerations (e.g., state authority to impose employer payroll tax for revenue; large companies that operate in multiple states)
- Sufficient tax revenue to fund the proposal
- Transitioning from mixed private-public approach to another system inherent challenges and potential disruptions (e.g., short-term)
- Each proposal encountered its own unique set of challenges

Shared Challenges

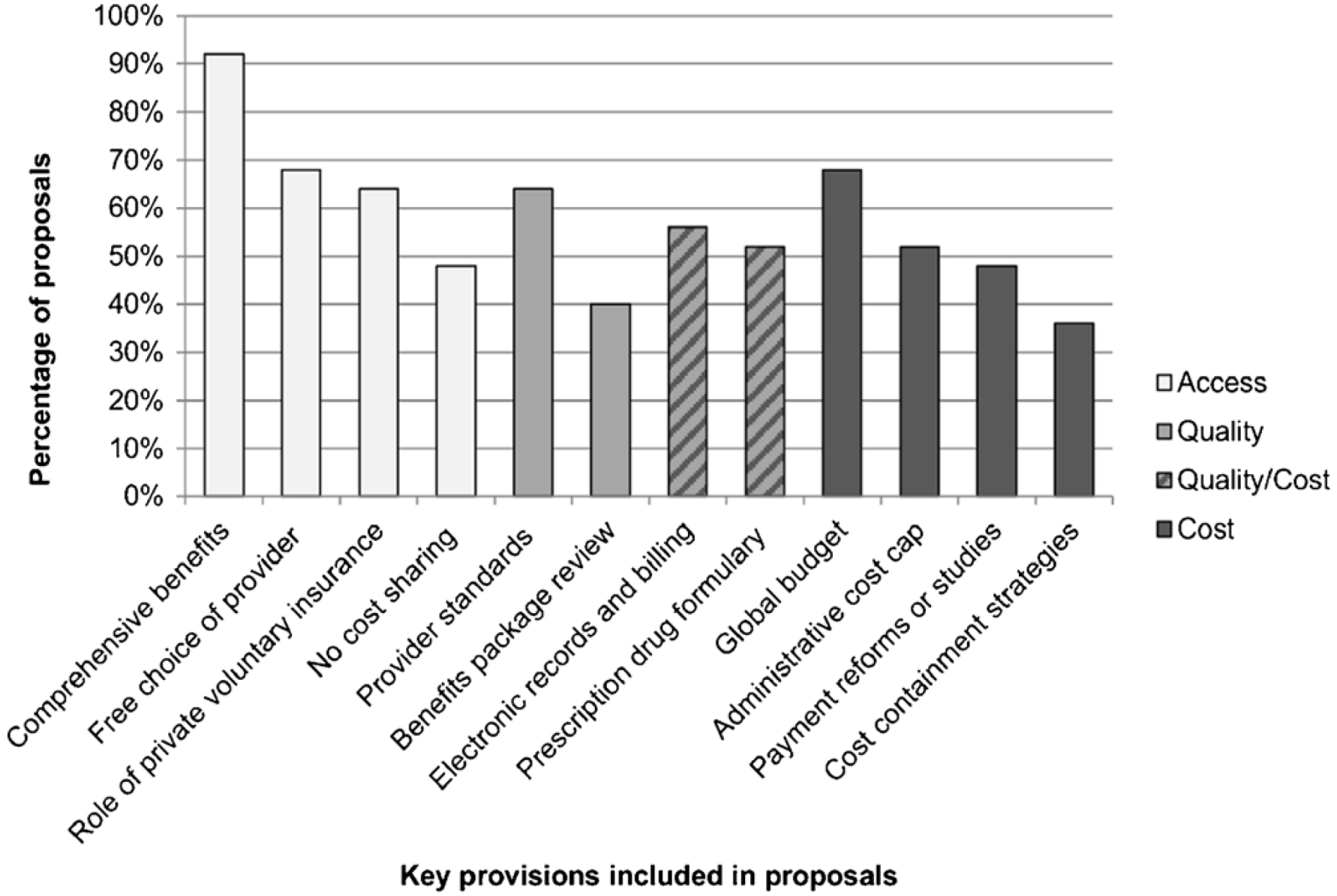
- Federal Employee Retirement Income Security Act (ERISA) makes the process of enacting universal care significantly more complicated
- Multiple federal waivers may be necessary
- No true "single" payer proposal
- Free-at-point-of-service projected to increase utilization and cost
- Details matter

Single-Payer Proposals — Common Elements

- Comprehensive benefits; periodic reviews of the package
- Patient choice of providers
- Little or no cost sharing
- Role of private insurance
- Provider guidelines and standards
- Electronic medical records and billing
- Prescription drug formulary
- Global budgets and payment reform
- Administrative cost thresholds
- Payment reform and studies
- Authority to implement cost-containment strategies.

Source: Liu, J., Brook, R. (May 2017). *What is Single-Payer Health Care? A Review of Definitions and Proposals in the U.S.* J Gen Intern Med 32(7) 822-21.

Access, Quality, and Cost Provisions



Source: Liu, J., Brook, R. (May 2017). *What is Single-Payer Health Care? A Review of Definitions and Proposals in the U.S.* J Gen Intern Med 32(7) 822-21.

Discussion Question #1

What challenges or obstacles do you foresee in designing the Health Care for All Oregon Plan?

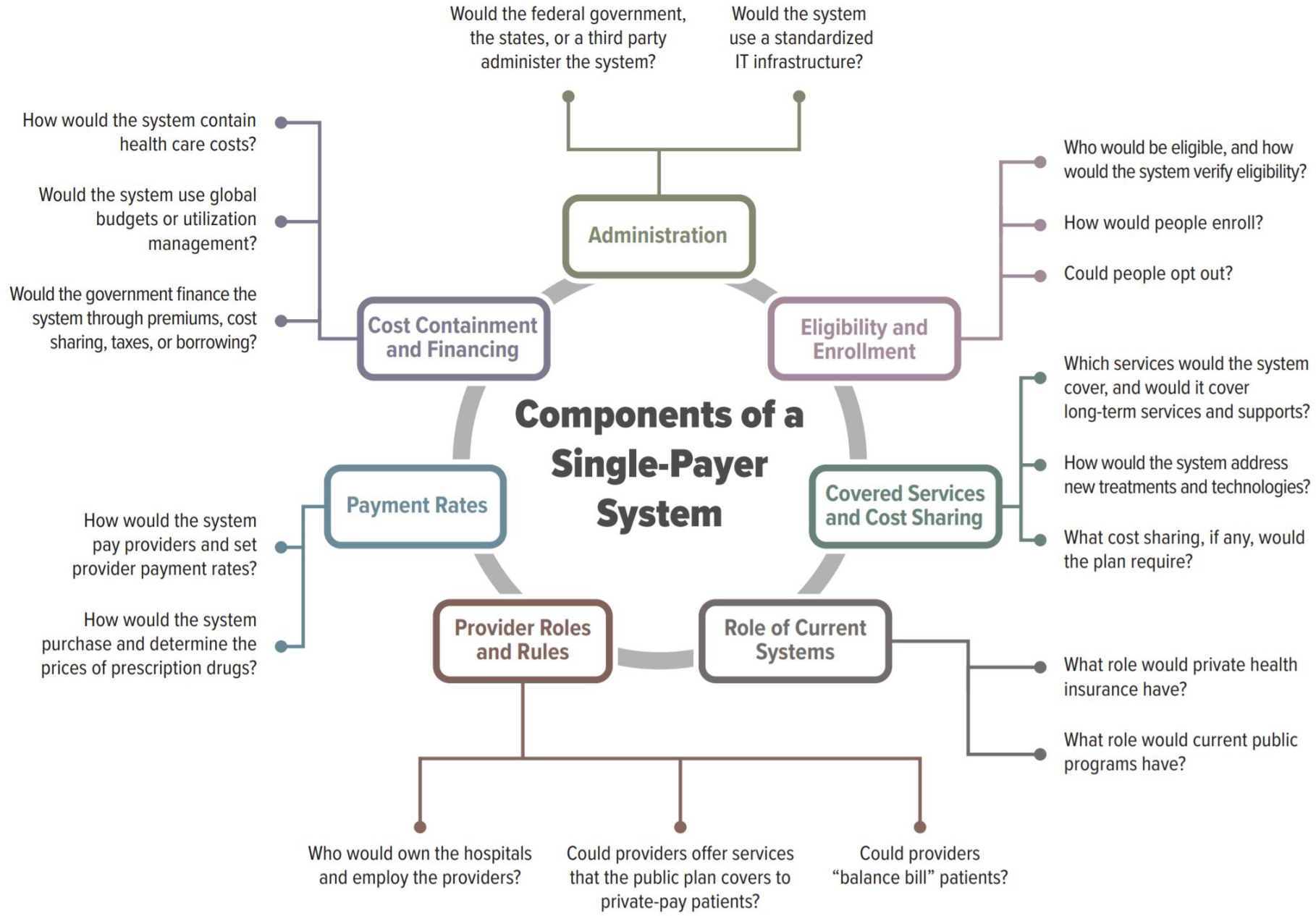
Members' Responses (staff note-taking)

- X, Y, Z

Universal Systems of Coverage – International Perspectives

Discussion Guide

1. What challenges or obstacles do you foresee in designing the Health Care for All Oregon Plan?
2. What are the most urgent or critical policy or design considerations the Task Force (Technical Advisory Groups) will need to address?
3. What lessons or insights can you draw based on states' past efforts to achieve state-based universal coverage as well as from international models?
4. What aspects of the current system, if any, work well in Oregon? (**new*)



Source: Congressional Budget Office (May 2019). *Key Design Components and Considerations for Establishing a Single-Payer Health Care System.*

Exhibit 1. Health System Structure in 12 Countries

Structure	Country	National financing role	National policy-setting	Regional/ Local financing role	Regional/ Local policy-setting	Administration
Largely federal	France[a]	X	X			Public
	Netherlands[b]	X	X			Public funds and premiums flow to competing private, for-profit insurers
	Singapore[c]	X	X			Direct pay
	Taiwan[d]	X	X			Public funds flow directly to providers
Central policy with regional flexibility	Australia[e]	X	X	X	X	Regions (in public system)
	Denmark[f]	Block grants	X	X	X	Regions
	England[g]	X	X		X	Local clinical commissioning groups
	Norway[h]	X	X	X	X	Municipalities
Regional control under broad national constraints	Canada[i]	Block grants	Minimal	X	X	Provincial governments
	Germany[j]	X	X	X	X	Public funds flow to competing, not-for-profit insurers (sickness funds)
	Sweden[k]		X	X	X	Counties/municipalities
	Switzerland[l]	X	X		X	Public funds and premiums flow to competing, not-for-profit insurers

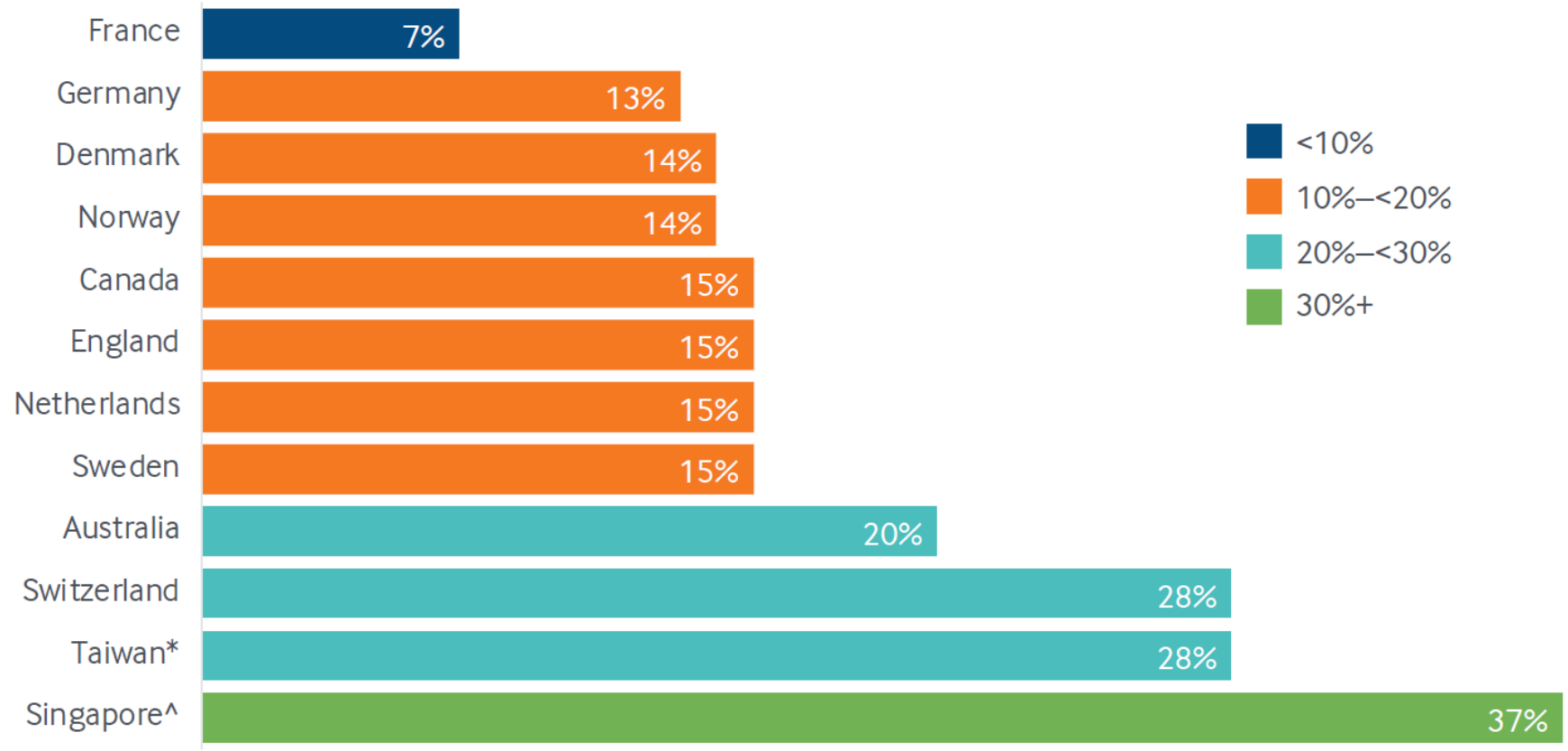
Source: Commonwealth Fund (April 2019). *Issue Brief: Considering "Single-payer" proposals in the U.S.: Lessons Learned from Abroad*

Exhibit 2. Scope of Coverage and Point-of-Service Payments in 12 Countries

	Country	Benefits	Cost-sharing
Comprehensive, free or low-cost at the point of service	Denmark[a]	Mental health, dental, outpatient drugs	Drugs only, capped at about $600
	England[b]	Mental health, outpatient drugs, rehab	Drugs only, about $12.50 per prescription
	Germany[c]	Mental health, dental, sickness pay	Hospital days and drugs, about $12.50 each
Broad public insurance with moderate cost-sharing	Australia[d]	Inpatient, outpatient, drugs	Specialist visits $60; drug costs vary by income ($5–$35)
	France[e]	Rehab, drugs, some dental	Cost-sharing mainly covered by universal supplemental coverage; some doctors balance bill
	Netherlands[f]	Drugs, pediatric dental	$465 deductible (excludes primary care); coinsurance for some services (varies by income)
	Norway[g]	Subsidized dental and drugs	Copayments for visits and drugs, capped at $240 or less
	Singapore[h]	Comprehensive	Deductibles
	Sweden[i]	Subsidized dental and drugs	Copayments for visits and drugs, capped at $120 or less
	Switzerland[j]	Some mental health, drugs	Copayments and deductibles
	Taiwan[k]	Comprehensive	Up to $1,200 per inpatient episode
Narrow national benefits package, no cost-sharing for publicly insured services	Canada[l]	Inpatient, outpatient, drug coverage varies by province	No cost-sharing for publicly-insured services; private coverage (i.e., for drugs) may include cost-sharing

Source: Commonwealth Fund (April 2019). *Issue Brief: Considering "Single-payer" proposals in the U.S.: Lessons Learned from Abroad*

Exhibit 3. Out-of-Pocket Expenditures as a Percentage of Total National Health Expenditures in 12 Countries



Note: Per capita health expenditures in selected countries in 2016 (in U.S. dollars).
Data: Statista, 2016, except * OECD Health Statistics, 2016, and ^ World Bank, 2015.

Source: Commonwealth Fund (April 2019). *Issue Brief: Considering "Single-payer" proposals in the U.S.: Lessons Learned from Abroad*

Exhibit 4. Structure of Substitute Primary Private Health Insurance

Countries	Features
Australia[a]	• Government incentivizes the purchase of private health insurance through a tax rebate. Failure to enroll in private health insurance by age 30 results in a 2% penalty added to the base premium in each subsequent year (56% of the population purchases such coverage). • People who earn above a certain threshold pay an income tax surcharge if they do not buy private insurance. • Private hospital coverage is supplementary, allowing access to any hospital or provider (47% hold this coverage).
England[b]	• 11% of the population purchases (usually employer-sponsored) private health insurance as a full or partial substitute to public insurance. • Private insurance enables faster and more convenient access to care and a free choice of specialists. • Most private plans do not cover mental health care, maternity care, emergency care, or general practice.
Germany[c]	• 11% of the population purchases private health insurance as a full substitute for public insurance. • Germany's 42 private health insurance companies offer plans that are nearly identical to the public plans but have risk-adjusted premiums and cover copayments for services such as dental care.

Data: a. Lucinda Glover, "The Australian Health Care System," in *International Profiles of Health Care Systems*, ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 11–19. b. Ruth Thorlby and Sandeepa Arora, "The English Health Care System," in *International Profiles of Health Care Systems*, ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 49–57. c. Miriam Blümel and Reinhard Busse, "The German Health Care System," in *International Profiles of Health Care Systems*, ed. Elias Mossialos et al. (Commonwealth Fund, May 2017), 69–76.

Source: Commonwealth Fund (April 2019). *Issue Brief: Considering "Single-payer" proposals in the U.S.: Lessons Learned from Abroad*

General Observations – International Perspectives

- Single-payer proposals tend to share these goals: centralized financial and regulatory structure of the system, (2) expansion of public benefits package, (3) elimination of or modified role for private health insurance.
- Commonwealth's review of 12 high-income countries highlights the wide range of designs among universal coverage systems.
- Depending on key features of the new system, will health care spending in Oregon increase, decrease, status quo (services covered, patients' cost-sharing requirements, provider payment rates, administrative costs)
- Key Design Elements:
  - Centralized vs. delegated regional/local authority and control
  - Level of comprehensiveness of the types of benefits: comprehensive to basic
  - Out-of-pocket expenditures as percentage of total health expenditures
  - Role of supplemental or secondary private insurance

Source: Commonwealth Fund (April 2019). *Issue Brief: Considering "Single-payer" proposals in the U.S.: Lessons Learned from Abroad*

Discussion Question #2

What lessons or insights can you draw based on states' past efforts to achieve state-based universal coverage as well as from international models?

Members Responses (staff note taking)

- X, Y, Z

SB 770 Design Components

Components and design of the system will affect its participants and total health care expenditures and vary significantly depending on the details of the system's structure and operation (**partial list below*)

Eligibility and Enrollment – opting out (moral/religious reasons); eligible to receive a tax credit or deduction; out-of-state coverage & coverage of nonresidents
Services Covered – more or less expansive benefit coverage; new treatments and technologies
Cost-sharing requirements – will nominal to no cost-sharing increase utilization; role of value-based benefit design (?)
Payment Rates – may influence the amount of provider participation, impacting the available supply and quantity of care available; two-tiered system
Administrative Costs – lower administrative costs
Transition – significant changes for individuals, families, providers, insurers, employers

Source: Congressional Budget Office, Key Design Components and Considerations for Establishing a Single-payer Health Care System (May 2019), www.cbo.gov/publication/55150

Design Considerations for Technical Advisory Groups

- **How** would the Board administer the health plan?
- **Who** would be eligible for the plan, and what benefits would it cover?
- **What** cost sharing, if any, would the plan require?
- **What** role, if any, would private insurance and other current public programs have?
- **Which** providers would be allowed to participate?
- **How** would the Board set provider payment rates and purchase prescription drugs?
- **How** would the system contain health care costs?
- **How** would the system be financed?

Discussion Question #3

What are the most critical policy or design considerations the Technical Advisory Groups will need to address?

Members' Responses (staff note-taking)

- X, Y, Z

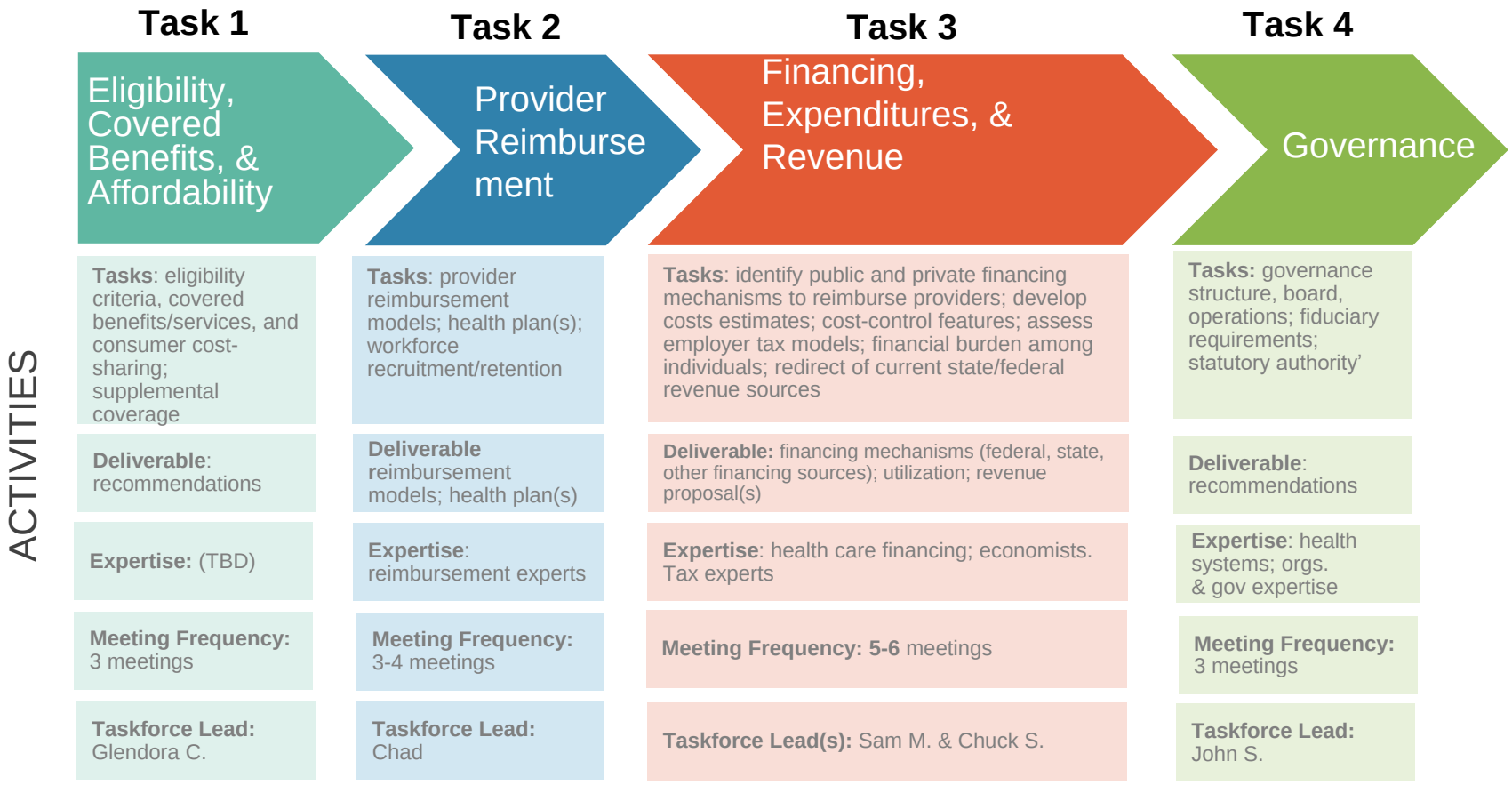
Discussion Question #4

What aspects of the current system, if any, work well in Oregon?

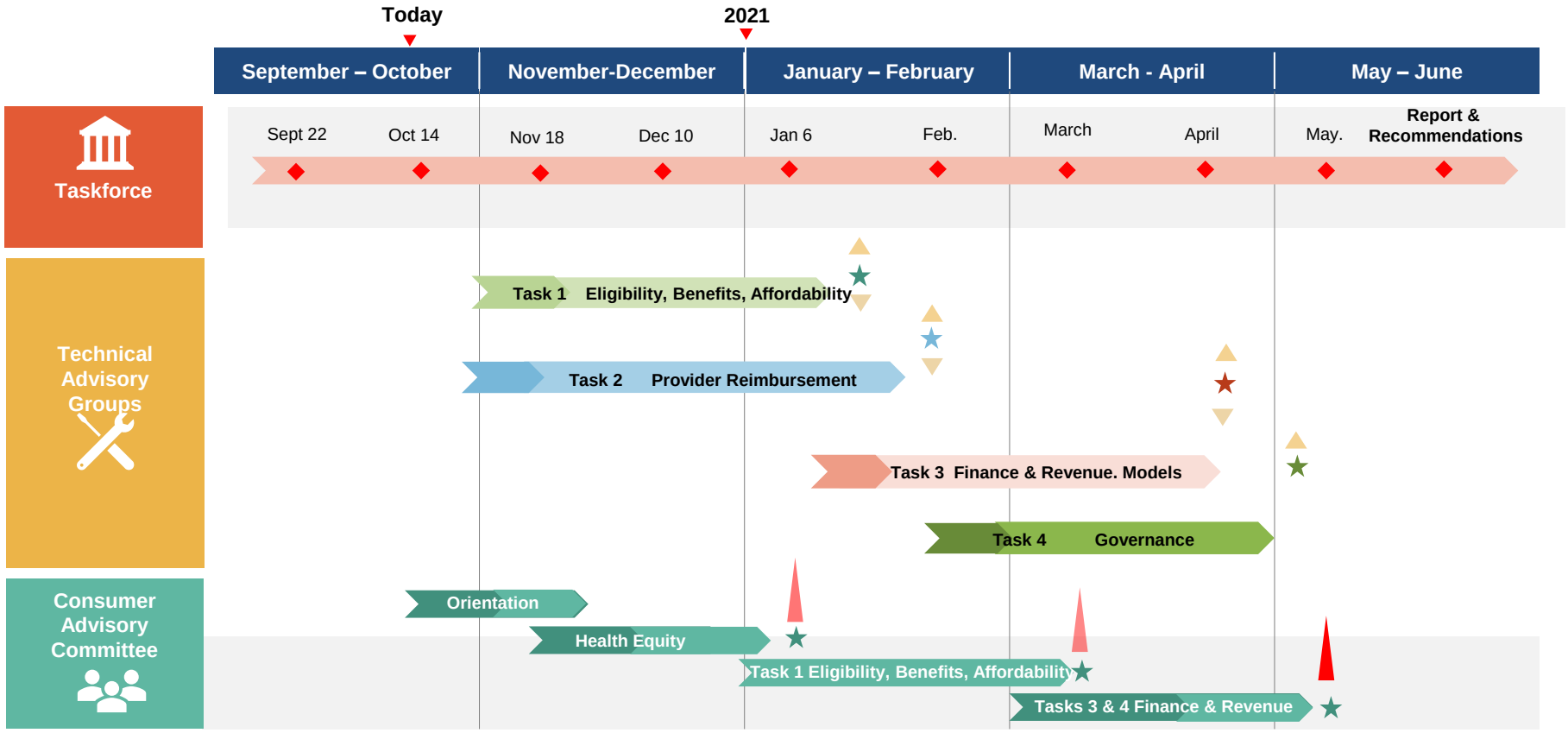
Members' Responses (staff note-taking)

Technical Advisory Groups

SB 770 – Proposed Technical Advisory Groups (TAGs)



Taskforce Timeline (Revised Draft Oct. 2020)



Eligibility, Benefits & Affordability (Nov-Jan 2021)

Glendora Claybrooks (Lead)
Michael Collins
Zeenia Junkeer
Ed Junkins
Sharon Stanphill

Provider Reimbursement (Nov-Jan 2021)

Lionel "Chad" Chadwick (Lead)
Dwight Dill
Cherryl Ramirez
Deborah Riddick
Zeenia Junkeer

Financing & Revenue (mid-Jan-April 2021)

Chuck Sheketoff (Co-Lead)
Sam Metz (Co-Lead)
Les Rogers
Lionel "Chad" Chadwick
Glendora Claybrooks
Dwight Dill
Cherryl Ramirez
John Santa

Governance (Feb-April 2021)

John Santa (lead)
Bruce Goldberg
Deborah Riddick
Chuck Sheketoff

Technical Advisory Group
Draft Project Charter Elements

- KEY TASKS (PLAN ELEMENTS)
- MATERIALS & RESOURCES
- PROCESS CONSIDERATIONS
- DELIVERABLE
- SUBJECT MATTER EXPERTISE
- TIMELINE & MEETING FREQUENCY
- MEMBERSHIP & STAFF

Question:

Any proposed changes to TAG membership, elements in the project scope statements, timelines, or general feedback?

Task Force Feedback (staff note taking)

- X, Y, Z

SB 770 Work Flow Diagram

SB 770 Taskforce
Step 1: Full taskforce orientation

Consumer Advisory Committee (CAC)
Step 3: Review Technical Advisory Groups' recommendations through a consumer lens

Technical Advisory Groups (TAGs)
Step 2: hear invited experts, develop recommendations (or) proposals; flag consumer input

SB 770 Taskforce
Step 4: Reviews guidance from TAGs & CAC; finalizes recommendations

SB 770 Work Flow Diagram (cont.)

Step 1
Taskforce receives orientation to policy issue(s), develops criteria, confirms guidance for TAGs

Step 2
Technical Advisory Group(s)

SB 770 Work Flow Diagram (cont.)

Step 1
Taskforce

Step 3
Consumer Advisory Committee

Step 2
Technical Advisory Group(s) solicit expert testimony; discuss key issues; develops recommendations or proposals

SB 770 Work Flow Diagram (cont.)

Step 3
Review TAG recommendations through a consumer lens; develop guidance for taskforce

Step 2
Technical Advisory Group(s)

Step 4
Taskforce

SB 770 Work Flow Diagram (cont.)

Step 4
Reviews guidance from TAGs & CAC; finalizes & adopts recommendations

Step 3
Consumer Advisory Committee