To: Joint Task Force on Universal Health Care

From: Tom Sincic, President Health Care for All Oregon

Date: November 18, 2020

The importance of this undertaking and the dedication you who have committed your time and expertise to do this work is very much appreciated. We recognize the breadth and scope of this groundbreaking task and provide these comments and information in an effort to assist the Task Force members and further clarify, from our perspective, specific work for each TAG. It is the result of our efforts to assure that the many facets of the law are each dressed by the most appropriate TAG as outlined in their charge and sequential work plan. We hope the Task Force Members find our analysis and comments relevant and useful. We stand ready to clarify or assist the Task Force in any way as requested.

Background and Commentary.

A group of dedicated HCAO volunteers served as the primary drafters of SB 770 under the guidance and leadership of Senator James Manning. We thank the staff for sorting out many of the details to create and timelines. Now that the work is underway by this dedicated committee and the TAGs have been created, we have done a review of the plan and provide this information and analysis.

SB 770 establishes the Joint Task Force on Universal Health Care to plan a universal single payer healthcare system for Oregon based on a set of values and principles with a statewide public input process.

It was created after already considering lessons learned from the other states. Primary in the process are the public input and the keeping those with conflicts of interest out of the decision-making process who would undermine the work. Oregon is not Vermont, New York, Colorado, or California—this is Oregon. The inability to achieve in those states were primarily political.

The Purposes, Values and Principles should be foremost during deliberations and decisions. It starts with consideration of the bill elements and understanding what will be required to meet the purposes. Identifying barriers and making proposals to eliminate them will be important.

The bill outlines what the transparent interaction with and inclusion of the public should look like. This is meant to focus on listening. (The bill does not request that the committee create a messaging plan to build legislative support. While public input is essential in the process, the bill does not request the committee to consider any public messaging after delivering recommendations to the legislature.)

It is well recognized that the timeline provided is compressed because of delays and funding cut due to Covid. Task Force members are likely aware that there was a legislative proposal in the 2020 session to extend the timeline but the session was abruptly ended before the final necessary vote was taken. Senator Manning has introduced a Legislative Concept (LC) for 2021 to extend the timeline with the intention of also restoring the funding.

The text below is taken directly from the bill/work plans with very little commentary which is indicated in brackets and/or red. The numerical and letter references may be different.

[Scope of Work Outline for Task Force and TAGS as taken from SB 770]

The Task Force on Universal Health Care shall produce findings and recommendations … for a **well-functioning single payer health care financing system** that is responsive to the needs and expectations of the residents of this state by:

(1) Improving the health status of individuals, families, and communities;
(2) Defending against threats to the health of the residents of this state;
(3) Protecting individuals from the financial consequences of ill health;
(4) Providing equitable access to person-centered care;
(5) Removing cost as a barrier to accessing health care;
(6) Removing any financial incentive for a health care practitioner to provide care to one patient rather than another;
(7) Making it possible for individuals to participate in decisions affecting their health and the health system;
(8) Establishing measurable health care goals and guidelines that align with other state and federal health standards; and
(9) Promoting continuous quality improvement and fostering inter-organizational collaboration.

The Task Force's recommendations must be succinct statements and include actions and timelines, the degree of consensus and the priority of each recommendation, based on urgency and importance. The Task Force may defer any recommendations to be determined by the board.

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

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:
    - (A) 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;
    - (B) Cost control features such as multistate purchasing.
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 as described in section 7(2) of this 2019 Act and recommendations regarding the appropriate reimbursement for the cost of services provided to plan participants when they are traveling outside this state;
p) Recommendations for long term care services and supports that are tailored to each individual's needs based on an assessment.

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
- Deferred items to the Board
- Include an Executive Summary in compliance with ORS 192.245

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. *(Details needed here. Suggest Patient Rights' Tag)*
- 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 *(AFF0RDABILITY SHOULG NOT BE PART OF THIS TASK; NEEDS SEPARATE DISCUSSION AS CURRENT SYSTEM NOT AFFORDABLE)* (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. The plan will cover services from birth to death, based on evidence-informed decisions as determined by the Health Care for All Oregon Board.

Criteria **may include**, but are not limited to, the following:

- Whether the services are cost-effective and based on evidence-informed from multiple sources as determined by the Health Care for All Oregon Board;
- 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 non-institutional 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 plan may not discriminate against any individual provider who is licensed, certified or registered in this state to provide services covered by the plan and who is acting within the provider's scope of practice.

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
- A group practice may be reimbursed with capitation payments if the group practice:

- (A) Primarily uses individual providers in the group practice to deliver care in the group practice's facilities;
- (B) Does not use capitation payments to reimburse the cost of hospital services;
- C) Does not offer financial incentives to individual providers in the group practice based on the utilization of 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 individual hospitals, and not for 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** (workforce recruitment is elsewhere in document)

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.

- Financially sustainable and cost-effective health care for the benefit of businesses, families, individuals and state and local governments;

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;
- **Regional and community-based systems integrated with community programs to contribute to the health of individuals and communities;**
- **Regional planning for cost-effective, reasonable capital expenditures that promote regional equity;**
- **Funding for the modernization of public health, under ORS 431.001 to 431.550, as an integral component of cost efficiency in an integrated health care system;**

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.

A description of how the Health Care for All Oregon Board or another entity may enhance:

- **(A) Access to comprehensive, high quality, patient-centered, patient-empowered, equitable and publicly funded health care for all individuals;**
- **An ongoing and deepening collaboration with Indian tribes and other organizations providing health care that will not be under the authority of the board.**

Task Force on Universal Health Care—Elements that need additional attention. These are taken directly from the Bill.

[Missing—Public Participation TAG]

- The components of the system must be accountable and fully transparent to the public with regard to information, decision-making and management through meaningful public participation in decisions affecting people's health care. This starts with the development of the Plan. **[Value 3] [This is a listening process.]**
- A statewide public input process.
- Responsive to the needs and expectations of the residents of this state.
- The task force's recommendations must ensure:
    - (a) Public access to state, regional and local reports and forecasts of revenue expenditures;
    - (b) That the reports and forecasts 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; and
    - (c) That the information can be used to evaluate programs and policies, while protecting patient confidentiality.
- In developing recommendations to the Legislative Assembly for the plan, the taskforce shall engage in a public process to solicit public input on the elements of the plan described in subsections (1), (4), (7) and (8) of this section. The public process must:
    - (a) Ensure input from individuals in rural and underserved communities and from individuals in communities that experience health care disparities;
    - (b) Solicit public comments statewide while providing to the public evidence-based information developed by the task force about the health care costs of a single payer health care financing system, including the cost estimates developed under subsection (2) of this section as compared to the current system;
    - Solicit the perspectives of:
        - (A) Individuals throughout the range of communities that experience health care disparities;
        - (B) A range of businesses, based on industry and employer size;
        - (C) Individuals whose insurance coverage represents a range of current insurance types and individuals who are uninsured or underinsured;(D)
        - Individuals with a range of health care needs, including individuals needing disability services and long term care services who have experienced the financial and social effects of policies requiring them to exhaust a large portion of their resources before qualifying for long term care services paid for by the medical assistance program.

[Patient Rights and Patient Records (Suggested TAG)]

- The task force's recommendations for the duties of the Health Care for All Oregon Board and the details of the Health Care for All Oregon Plan must ensure, by considering the following factors, that patients are empowered to protect their health, their rights and their privacy:
    - (a) Access to patient advocates who are responsible to the patient and maintain patient confidentiality and whose responsibilities include but are not limited to addressing concerns about providers and helping patients navigate the process of obtaining medical care;

- (b) Access to culturally and linguistically appropriate care and service;
- (c) The patient's ability to obtain needed care when a treating provider is unable or un-willing to provide the care;
- (d) Paying providers to complete forms or perform other administrative functions to assist patients in qualifying for disability benefits, family medical leave or other income supports;
- (e) The patient's access to and control of medical records, including:
  - (A) Empowering patients to control access to their medical records and obtain independent second opinions, unless there are clear medical reasons not to do so;
  - (B) Requiring that a patient or the patient's designee be provided a complete copy of the patient's health records promptly after every interaction or visit with a provider;
  - (C) Ensuring that the copy of the health records provided to a patient includes all data used in the care of that patient; and
  - (D) Requiring that the patient or the patient's designee provide approval before any for-warding of the patient's data to, or access of the patient's data by, family members, caregivers, other providers or researchers.

[Long Term Care (Suggested TAG although listed in above)]

- In developing recommendations for long term care services and supports for the plan under subsection (4)(p) of this section, the task force shall convene an advisory committee that includes:
  - (a) Persons with disabilities who receive long term services and supports;
  - (b) Older adults who receive long term services and supports;
  - (c) Individuals representing persons with disabilities and older adults;
  - (d) Members of groups that represent the diversity, including by gender, race and economic status, of individuals who have disabilities;
  - (e) Providers of long term services and supports, including in-home care providers who are represented by organized labor, and family attendants and caregivers who provide long term services and supports; and
  - (f) Academics and researchers in relevant fields of study.
- Notwithstanding subsection (4)(p) of this section, the task force may explore the effects of excluding long term care services from the plan, including but not limited to the social, financial and administrative costs.