Task Force on Universal Health Care

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Design Framework

December 8, 2020

To assist the Universal Health Care Task Force in completing the tasks specified in Senate Bill 770 (2019) and the Technical Advisory Groups (TAGs), project staff developed a draft design framework. The framework is intended to; (1) highlight a list of key considerations for each design element of the Health Care for All Oregon Plan (the Plan), (2) identify interdependencies among TAGs by design features, and (3) outline a set of questions related to the each design element.

As reflected in the project charters for the TAGs, there are design choices and policy decisions that need to be carefully defined and assessed to inform the final recommendations put forth by the Task Force in June. The framework seeks to reflect recent conversations among the TAGs by outlining questions and issues that start to bring into better focus the key design features of the Plan. The framework is intended to support the policy development work of the TAGs. For example, as policy proposals are considered by one TAG, the framework can track whether and how that proposal may affect the work of another TAG. In other words, capturing major cross-cutting issues that are likely to be considered by multiple TAGs. This process is fundamental given the multiple goals and outcomes of the TAGs.[1]

The framework is a working draft and shared with the expectation the members will refine and add to the set of questions, as needed, based on discussions by the Task Force, TAGs, and Consumer Advisory Committee. As the TAGs work through their project scope charters and develop a set of proposals, members will be able to fill-in the final column ("draft proposals").

[1] California Health Care Foundation. Key Questions When Considering a State-based, Single-payer System in California. November 2017. Accessed at: https://www.oregon.gov/oha/HPA/HP/TFUHC%20Meeting%20Documents/CA-KeyQuestionsSinglePayer.pdf

Plan Feature	Design Element	Key Considerations	TAG Interdependencies†	Description of Issue	Draft Proposal(s)
Eligibility	Eligibility	• U.S. citizens who are state residents • Lawfully present immigrants who are state residents • Undocumented immigrants • Temporary residents and visitors • Residents who work outside of Oregon • Nonresidents working in Oregon and dependents • Nonresidents employed by Oregon-based companies • Medicare, VA, Tricare, Indian Health Service, other	*Eligibility, Benefits, & Affordability (EBA)* *Finance & Revenue*	1. Who will be eligible for the Plan? 2. How will eligibility impact cost? 3. Depending on Plan eligibility, what is the likelihood of feasibility from a federal perspective? What federal approvals are necessary? 4. For eligible enrollees that live out-of-state, how will the Plan pay for patients who seek care out of state?	
	Enrollment mechanism	• Duration of residency/waiting period • Criteria for short-term/long-term visitors • Income-based eligibility • Eligibility based on criteria for current public programs	*EBA* *Finance & Revenue* Governance	1. When does eligibility begin? 2. How will the Plan verify eligibility? 3. Will mechanisms to determine eligibility rely on administrative oversight; if yes, how will these impact cost? 4. What documentation is required to demonstrate eligibility? 5. What triggers termination of eligibility and disenrollment? 6. How will the Plan bill patients who cannot demonstrate eligibility? 7. What is the likelihood of feasibility from a federal perspective? What federal approvals are required?	
	Enrollment requirements	• Autoenrollment (passive enrollment) • Enrollment periods	*EBA* *Finance & Revenue* *Governance*	1. What new administration roles and functions are required, and how much time will it take to establish those? 2. Can enrollment be integrated into existing enrollment programs or processes? Or will enrollment operate separately from enrollment for other public programs?	
	Opt-out provisions	• Consumer choice • Moral and religious preferences	*EBA* *Finance & Revenue* *Governance*	1. Can individuals opt out of Plan coverage? If so, will these individuals be required to pay into the Plan or have alternative coverage? 2. Will individuals who opt out impact the cost and administrative	

† *Italicized* indicates the health plan design element is cross-cutting and seeks to identify which TAG(s) are most likely involved in drafting a proposal for the Task Force to consider.

PLAN FEATURE	DESIGN ELEMENT	KEY CONSIDERATIONS	TAG INTERDEPENDENCIES†	DESCRIPTION OF ISSUE	DRAFT PROPOSAL(S)
				oversight of the Plan? 3. Will employers be able to opt-in or out to participating in the Plan for their employees (and for contributions)?	
Covered Benefits	Covered services	• 10 Essential Health Benefits (ACA) • Medicaid (Oregon Health Plan) • Behavioral health • Adult dental, vision, and hearing • Medical management (diabetes, asthma, other chronic conditions) • Non-traditional health services (acupuncture, naturopathic, chiropractic) • Long-term care services and supports	*EBA* *Provider Reimbursement* Finance & Revenue	1. How will services currently covered by Medicare and/or Medicaid be handled? If there are services currently covered in Medicare/Medicaid not covered by the Plan, how will these be handled? 2. How will the scope of what is covered impact provider participation and reimbursement? 3. How will the scope of what is covered impact the overall cost? 4. Will there be tiers of coverage, or will the Plan offer a single set of benefits?	
	New treatments and technologies	• Adoption and coverage of new medical technologies	*EBA* *Finance & Revenue* *Governance*	1. How will coverage of new treatments and technologies be determined? 2. How will coverage for new treatments and technologies impact cost?	
Affordability	Cost-sharing	• Premiums • Deductibles • Co-pays	*EBA* *Finance & Revenue* Provider Reimbursement	1. If there's cost-sharing, will it be based on an individual's ability to pay (e.g., means-tested)? 2. How will cost-sharing impact affordability for enrollees (e.g., measured by out-of-pocket costs as a proportion of income? 3. Based on cost-sharing structure, what is the projected impact on access to primary care, specialty care, or specific benefits (e.g., behavioral health)? 4. What impacts will limited-to-no cost-sharing have on demand? 5. If no enrollee cost-sharing, what are the impacts to utilization controls? 6. What is the impact on "congestion," measured by the difference in provider availability and consumer demand? 7. How will cost-sharing impact the overall cost of the Plan?	

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Role of current health plans	Multi-insurers (private insurers) or limited role for current insurers	• Retain commercial carriers to administer plan • Limit commercial carriers to supplemental or substitutive coverage	*Governance* *Finance & Revenue*	1. What is the role for private insurance, and how will it impact provider participation, overall cost, and administrative scope? 2. Will the Plan be offered by multiple carriers to promote competition? 3. Will employers still be able to offer substitutive or supplemental coverage?	
	Public programs	• Medicaid • Medicare • Tricare • Indian Health Services • Health Care Safety Net (FQHCs/RHCs)	*Governance* *EBA* *Provider Reimbursement* *Finance & Revenue*	1. If one or more public program is excluded, will the program operate outside of the Plan? 2. Will some of the services, if not covered by the Plan, continue to be provided by a public program?	
Provider Participation and Reimbursement	Provider participation	• Licensed, certified, registered, credentialed, non-licensed, other	*Provider Reimbursement* *Governance* Finance & Revenue	1. Will provider participation be voluntary or required? If voluntary, will enrollees be able to see any provider? 2. How will the Plan determine which types of providers can participate? 3. Can providers offer services that the Plan covers to private-pay patients? 4. How will determinations regarding private-pay patients impact provider participation, overall cost and administrative scope?	
	Provider types	• Individual providers • Group practitioners • Institutional providers (hospitals, health systems) • Unique providers	*Provider Reimbursement* Finance & Revenue Governance	1. How will providers be reimbursed under the Plan? How will reimbursement differ across provider types? 2. How will the Plan reimburse providers who are not easily identifiable as individual providers, group practice providers, or institutional providers?	
	Services payment	• Primary care services • In-patient/hospital services • Special services • Long-term care (TBD)	*Provider Reimbursement* Finance & Revenue Governance	1. Will primary care providers be paid differently than specialists? 2. Will reimbursement rates account for underserved areas and communities? If yes, how? 3. How will provider reimbursement impact provider participation and overall cost?	
	Prescription drugs	• Multi-state purchasing • 3rd party administrator (PBM) • Other	*Finance & Revenue* *Governance*	1. How will prescription drugs impact the scope of coverage and overall cost? 2. Will prescription drugs include the use of a formulary? 3. What type of administrative function is necessary?	

PLAN FEATURE	DESIGN ELEMENT	KEY CONSIDERATIONS	TAG INTERDEPENDENCIES†	DESCRIPTION OF ISSUE	DRAFT PROPOSAL(S)
	Care coordination, quality improvement and value	• Quality incentives • Defining value	*Provider Reimbursement Governance*	1. Will the Plan promote quality and value in the health care system? 2. What are the incentives implicit in the financing mechanism to promote quality and value? 3. What is the potential impact on safety of care? 4. Will payments be structured to encourage care coordination and integration? If yes, how?	
Cost Containment and Financing	Cost containment	• Utilization management (e.g., prior authorization) • Cost-growth target • Regulatory authority	*Governance Finance & Revenue* Provider Reimbursement	1. How will the Plan contain health care costs? 2. What are the incentives implicit in the financing mechanism to contain costs? 3. Will cost containment mechanisms promote value in the health care system? 4. What methods or principles will be used to determine periodic changes in reimbursement rates? 5. How will provider reimbursement rates change overtime?	
	Provider payment methods	• Fee-for-service • Bundled and episode-based payments • Global Budgets • Capitated payments	*Governance Provider Reimbursement* Finance & Revenue	1. How will proposed payment method(s) impact administrative costs, provider participation, and incentives to offer services? 2. What providers will be included in a global budget model? 3. Will global budgets apply only to hospitals, or to all wrap-around health delivery systems? 4. How will the Plan unify behavioral health financing across public and private sectors?	
Revenue	Main sources of funding	• Payroll/employer tax • Sales tax • Premiums • Federal financing	Finance & Revenue Governance Provider Reimbursement	1. What is the projected revenue needed to fund the Plan annually? What revenues are needed in total, for benefit categories, and on a per enrollee basis? 2. What current state expenditures will be redirected to fund the Plan? 3. What is the impact on the federal contribution to health spending in Oregon? 4. Will the government finance the Plan through premiums, cost sharing, taxes, or borrowing? 5. Depending on financing approach, what is the likelihood of feasibility from a federal perspective? 6. What waivers are necessary and what is the likelihood of federal approvals?	

Plan Feature	Design Element	Key Considerations	TAG Interdependencies†	Description of Issue	Draft Proposal(s)
				7. Is the financing adequate? Is the financing sustainable? 8. Will the Plan advance the goals of equity in finance?	
	Employer taxes and/or contributions	• ERISA • Substitute/supplemental coverage	Finance & Revenue Governance EBA Provider Reimbursement	1. Will employers be required to contribute? Which employers will be exempt, if any? 2. Will employers be allowed to offer their own insurance instead of the Plan? 3. What are the ERISA considerations? What is the likelihood of ERISA preemption(s) if funding includes employer assessment?	
Governance & Administration	Structure	• Board structure & authority • Administration • Complaints, grievances, and appeals • Provider participation • Provider recruitment & retention	Governance Provider Reimbursement	1. What role will the Board have in containing costs and decision-making regarding the scope of coverage and provider reimbursement? 2. Will the governance and administrative structure have appropriate checks and balances to minimize the risk of regulatory capture? 3. Will the governance and administrative structure allow for data-driven, evidence-based policy development and implementation decisions? 4. What are the potential effects on the health care professional workforce and the health care industry labor market in the short term? What are the potential effects on the workforce pipeline? 5. How will the Board transition from the status quo to the new Plan?	
	Administration of the Plan	• State • Local or regional authorities • Third-party administrator(s) • CCO-like entities	Governance Provider Reimbursement Finance & Revenue	1. How will the administrative structure impact administrative costs and provider participation? 2. What mechanisms will be in place for containing administrative costs? (e.g. percentage of total cost of plan?)	