Member	Bruce Goldberg
Intermediate strategy idea title	Individual Market Consolidation
Intermediate strategy idea summary	Transform the individual market into a single risk pool with a common fee schedule and benefit package. Cost growth kept at ~3% assures long term affordability. Utilize 1332 waiver to capture current federal subsidies. Create a more affordable subsidy program then exists in the current individual market so it is affordable to all who have incomes higher than qualifies for Medicaid.
What problem is being solved?	This improves access, creates a more affordable health benefit, eliminates the cliff that Senator Manning mentions, streamlines administrative functions and creates the basic structure for a universal plan.
Who does it cover?	Individual market enrollees and current uninsured who cannot afford coverage in the individual market
How will it further the work of the Task Force?	Creates what could be the basic structure for a universal health – common fee schedule and benefit package. Improves access to affordable coverage and covers more uninsured.
Key points from 3/26 discussion	This is the ACA individual market. Need to consider whether to create a single risk pool or simply an administratively simplified market with common benefit and fees. State holding the risk or not. Could this apply to the small or large group markets as well? Possibly employers could offer dollars to employees to buy on the individual market What is the provider impact on taking reimbursement off the table for them? This would not work by reducing provider rates substantially. WA public option rates are ~160% of Medicare, leading to low provider participation. Would need to approach the Federal gov through 1332 waiver to get additional financial support, repaid through our being able to keep cost growth at a reasonable level. Currently approx. 160k people in OR individual market Why would Insurers be interested in participating? We would need to work out the extent to which they would assume risk. Is this single payer for the individual market? New market, new product, that would be affordable that the public can buy into. The benefits may mirror the ACA benefit, with the exception of the cost-sharing pieces. This would attempt to address the high deductible plan issue. It would create a common formulary, a drug list that is comprehensive and meets people's needs but does not guarantee any and everything. We may choose to add some benefits that are not currently in the ACA benefit, like mental health. Let's not let the perfect be the enemy of the good here. But specifically around mental health, that is not optional – it needs to be included. Goals: meet healthcare needs, affordable and fiscally sustainable

Member	John Santa
Intermediate strategy idea title	Single Payer Medicare Demonstration/Innovation
Intermediate strategy idea summary	Oregon organizes a proposal to CMS to consider a Demonstration or Innovation model that would create a single payer for Medicare patients in Oregon (statewide or in particular regions). The single payer would organize along the lines the Task Force is developing (i.e., single payer directly contracts with delivery systems via a global budget or capitation with the help of regional subsidiaries or non-risk bearing administrators). To incentivize Medicare patients to participate, we would offer a richer benefit design such as increased mental health benefits and decreased cost sharing. The most ambitious approach would expand eligibility for Medicare to people 60- 64. Medicare currently has an Innovation Center model underway that builds on Maryland's unique regulatory approach to hospital pricing to make the state of Maryland a single payer for Medicare. CMS designated Maryland as the single payer for Medicare in Maryland
What problem is being solved?	How best to make the transition to a single payer for Medicare patients and the Medicare funding stream. Reduce the costs of Medicare especially for lower/middle income Medicare patients. Improve the benefits of Medicare in a direction we think an eventual single benefit design would go ie better mental health, less cost sharing.
Who does it cover?	All Medicare eligible patients residing in Oregon. There likely are 65 and over patients in Oregon who are not eligible for Medicare (maybe 1%) or patients who have to pay partial Part A premiums (maybe 1%). We would need to decide how best to approach them. There are approximately 750000 Medicare patients in Oregon, so maybe 10-15000 uninsured or poorly insured folks. I think about 25% are in Medicaid, are disabled or get some assistance paying Part B premiums. Given current demographics this number is likely to increase in the near term. They have been the majority victims of the COVID 19 epidemic though compared to other states, Oregon Medicare patients have likely done better. They likely have suffered significant non COVID effects---ie cancers not detected, other disease not diagnosed or treated adequately etc. so they are now a sicker population.
How will it further the work of the Task Force?	The work of the Task Force includes all Oregonians. Including Medicare patients successfully is a must. Medicare patients represent 18% of the population but likely 40-50% of health care revenue. There is much more cost sharing in Medicare than many realize especially via premiums for Part B and supplemental Medicare plans. Medicare represents an enormous "business" opportunity for the Task Force that should not be missed and likely should be a priority.
Key points from 3/26 discussion	1) Similar to Bruce Goldberg proposal, but uses Medicare as the entry point via a Medicare Demonstration or Innovation Center that does not require any congressional approval. 2) Meet with federal congressional delegation to see if they would be willing to support approaches that would make this possible. Several members of the Oregon delegation are on record supporting a single payer or a Medicare for All approach.

	3) Using Maryland example NOT to say we should do what Maryland proposes to do. Rather it demonstrated CMS is willing to put a state fully at risk for Medicare**---"The TCOC Model is the first Center for Medicare and Medicaid Innovation (Innovation Center) model to hold a state fully at risk for the total cost of care for Medicare beneficiaries."** The state becomes the single payer when it comes to Medicare. Oregon likely represents about 1% of the Medicare budget---a reasonable size for a Demonstration or Innovation. Maryland has a 6 million population with likely a similar %Medicare population. 4) It is possible that the Demonstration/Innovation could start with a single Medicare Advantage plan and use the Medicare Advantage platform 5) An analysis would need to be done of the current Medicare revenue stream to determine funding options. My rough estimate is Oregon Medicare patients are currently generating 3-4 billion dollars via premiums and cost sharing to fund existing Medicare benefits. Many current Medicare Advantage Plans are at 0 premium (Part B premiums still required). Medicare supplement insurers are charging significant premiums and making significant profits. It is likely current cost sharing in some cases is increasing disease burden rather than decreasing it. Some parts of the Medicare benefit design encourage inefficient if not dangerous testing. Oregon currently likely has below average utilization in Medicare and above average pricing. 6) This would move the direction towards a single payer in a powerful way. It likely does not directly cover many more people but if successful could provide resources to more effectively cover lower and middle income Medicare patients and resources (ie profits) that could be used to expand coverage elsewhere ie that segment of over 65 that is not Medicare eligible. If successful additional benefits and further reduction in cost sharing could be added. 7) This would expand coverage. There is a program that subsidizes Part B for low income Medicare folks. This negotiation could expand that population who receives support. There is also a group of folks who have not reached the minimum Medicare contribution threshold and have to buy in. Medicare recipients would retain their portability of benefit. It is possible that portability could be improved since currently Medicare Advantage portability is limited to one or two months each year and I believe changing out of Medicare supplement is also limited. 8) What efficiencies could we find in the process of streamlining this market? Many of the efficiencies we're counting on now are present in Medicare but there are significant opportunities. While we talk about Medicare having a single benefit, there are several supplemental plans, advantage plans have many different benefit options. There are significant admin expenses allowed for Medicare Advantage and I suspect Medicare supplemental. These are very profitable "markets" for insurers. Hospital prices have significantly increased in Oregon for Medicare. Expanding mental health benefits would be a substantial benefit as would any dental or vision coverage. Likely only about 30% of Medicare folks have any dental coverage so there is a significant dental "cliff."

	9) It will take time to negotiate and implement this. It is possible other states would be interested in a multi-state demonstration. Now is the time to get started on this. It will provide a real world chance to get feedback on the Task Force approach.

Member	Chad Chadwick
Intermediate strategy idea title	CCO Duplication Elimination
Intermediate strategy idea summary	State to limit CCO to prohibit more than one CCO per region. This could be a big enough policy in and of itself, but the workgroup could consider going further by requiring that CCOs be non-profit (public?) entities. Both these shifts would be instrumental in providing incremental actions that are consistent with the values of SB 770 in the reduction of administrative costs not devoted to clinical care and to position the CCOs for the revised role envisioned in the Provider Reimbursement TAG proposal.
What problem is being solved?	<u>Benefits</u>: 1. By reducing CCOs to one per region, you reduce duplication of non-clinical (administrative) costs. 2. Implementation of this strategy would be a clear statewide demonstration of the intent to implement the values of the SB 770 legislation, wherever possible.
Who does it cover?	Medicaid enrollees and any others under the purview of the CCO.
How will it further the work of the Task Force?	It would implement an incremental step in the eventual universal health care system.
Key points from 3/26 discussion	<u>How would we determine the successor CCO</u>? 1. This could be a bidding process that relies on metrics and capabilities. <u>Timing</u>: 1. This is an idea that, if we think it's good, we should be talking to OHA for consideration in the context of the upcoming waiver. 2. Do we need a waiver for this? Likely not. It could be part of the waiver, but it doesn't necessarily have to be. <u>Current Impact</u>: 1. How would this impact provider reimbursement? 2. Regional provider support? 3. If a provider is in a market that has lots of CCOs, providers may prefer this due to clarity or may oppose it - unknown. 4. May enhance focus on SDOH by regions. 5. This is more than reducing administrative costs: it captures opportunities that a single group can capture that cannot be captured by several CCOs. There may be an impact on provider reimbursement that we should consider. **6.** Does this expand coverage to those without coverage or those who cannot afford the coverage they have? If there are dollars saved as the result of this move, perhaps those dollars could be reapplied in a manner that would be helpful.

Member	Chad Chadwick
Intermediate strategy idea title	VBP Expansion
Intermediate strategy idea summary	Expand on the notion of value based payment. The Provider Reimbursement TAG outlined this notion in its proposal: "The TAG wishes to encourage Oregon's emphasis on advanced forms of value-based payment, and expand on the notion of "value." The term "value-based payment" is a historically broad term that applies to many different types of payment arrangements, including capitation, global budgets, prospective episode-based payment, and budget-based models. The TAG wishes to expand on the notion of "value-based payment" as historically used, to allow for community input and prioritization. The system for determining value must be influenced by patient, family and community perspectives. For example, the community should have influence over what outcomes are most important and thus incentivized in payment arrangements."
What problem is being solved?	Misgivings about VBP as it is defined currently create community opposition. Elements of reimbursement such as Behavioral Health, ethnic and tribal considerations could be included specifically. Patient-centric participation can be included.
Who does it cover?	All CCO's, others engaging in VBP.
How will it further the work of the Task Force?	Improved clarity regarding the benefits of VBP, and may soften opposition to current VBP. Patient-centric definition and application furthers SB 770 intent.
Key points from 3/26 discussion	<u>Community Involvement</u>: 1. CCOs are supposed to have Consumer Advisory Committees that do exactly this kind of thing. Are they really doing so? 2. It is not clear to patients and communities what value-based means. People are understandably suspicious when we say less is more. 3. Unclear and varied definitions lead to doubt of intent and suspicions regarding motivations and goals (i.e. rationing, support of the status quo, little citizen involvements). 4. Common goal finding possible - Put all the people in the room who critique VBP and flesh it out, because it seems like if that were done there would be more alignment than we have now. 5. Supports and endorses community involvement and participation in healthcare. 6. Clarity improved - the fact that we have created a complex system and way of talking about it that is incomprehensible is problematic and makes it difficult to obtain consensus of goals and performance. 7. Community building - This is a small step but would engender the kind of community support needed to successfully transform the system. <u>Next steps</u>:

	1. Determine if legislation is needed. What would this bill look like? 2. Common definition and goals needed first. 3. Community location specific for community involvement meetings 4. Equity and constituency specific input is critical. If we are going to convene folks, we need to think of community first, and not have community come into our spaces. This sets a power dynamic that is counterproductive. 5. Always remember to ask: <u>Value to Whom?</u>

Member	Chuck Sheketoff
Intermediate strategy idea title	Cost of Employer-Provided Health Insurance Data Collection
Intermediate strategy idea summary	I propose we ask all businesses filing either corporate excise or income tax forms, or pass through entity returns, to include a new short form (or add lines to the corp excise and income tax forms) that lists the entity's total expenditures on health insurance for the tax year, the number of FTE employees getting insurance during the tax year and the total payroll for those FTE employees. If employer didn't provide insurance it would note that on the form. If employer only provided for part of the year that will be reflected in the number and payroll for FTE. If they self-insure they would include those costs.
What problem is being solved?	We don't have good information on what employers are spending on health insurance
Who does it cover?	Employers – those providing health insurance and those not.
How will it further the work of the Task Force?	Help in figuring out initial and future costs of universal coverage and new taxes
Key points from 3/26 discussion	Generally speaking, this is an attempt to get more information. One issue that keeps coming up is: how much do businesses now pay for healthcare? Businesses have to report a lot of details on their tax returns, so let's include a question that they need to answer related to coverage. We currently ask self-insured plans to voluntarily submit data, but we do not ask for any data from businesses. Are there questions regarding the state authority to ask these questions? Or any questions related to ERISA? Would this require a bill or rulemaking? Dept of Revenue would probably say they need authority. This is an actionable solution to fix a data hole. Should this group think about the data we need broadly? This is a good example of data we need, and perhaps we should assemble a comprehensive list of data that we need, to ensure decisions are being made based on data. For eg: what is the administrative cost in the delivery system for collecting cost sharing? Some of this may be just getting providers to ask and collect data. What information is being collected already, and what do we just need to get disaggregated? Would a voluntary survey provide enough of a sample? No, because we have that already.