# Joint Task Force on Universal Health Care


April 29, 2021

Chair Bruce Goldberg

Vice-Chair Ed Junkins

# Public Testimony – April

**April 29th** (7 written submissions)

- Concerns about residency status with respect to eligibility criteria for proposed plan (link)
- Emphasizing health systems can led to improve health outcomes, offer higher quality, and lower costs (link)
- Expansive set of considerations around funding a new universal care system (link)
- Reference to Colorado's Health Care for All analysis prepared by Lewin Group (link)
- Ability for Oregonians to access medical care (link)
- Support for a plan that offers all Oregonians access to health care (link)
- Reasons to avoid regional risk-bearing care entities (link)

# Community Outreach

**Vice Chair Junkins**

Oregon Association of Hospitals and Health Systems

# Becky Hultberg, President/CEO

## Joint Task Force on Universal Health Care

April 29, 2020

# Designing a health care system

Who pays?

What services do you pay for?

How do you pay?

# What we want

High quality health care

Prevention

Population health

Appropriate utilization of health care resources

… at the lowest possible cost to the individual and society

# What we get from our payment system

Fee-for-service rewards:

- Volume
- Acuity
- Interventions

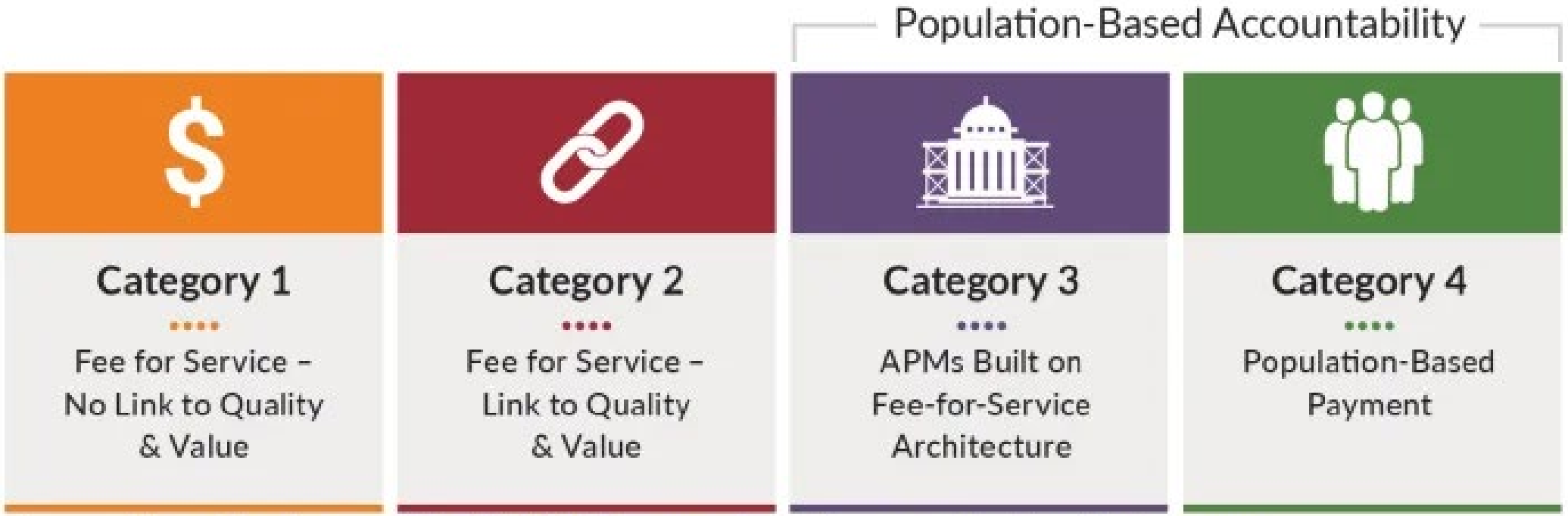
***Why does our current payment system incentivize sick care when we want health care?***

# Incentives are misaligned

The way to is get what we want out of our health care system is by aligning incentives and paying differently for health care.

That's value-based payment.

# What is value-based payment?




Source: Alternative Payment Model (APM) Framework and Progress Tracking Work Group

HCP LAN
Health Care Payment Learning & Action Network

# Moving to value

- Moving from a system that rewards quantity to one that rewards outcomes
- Fundamentally changing the business model of health care
- Operating two systems at once as we make this transition

*This requires health care providers to take huge risk and make massive operational changes.*

# We must choose

# Navigating the transition

TIME

RESOURCES- AND SOMETIMES INITIAL INVESTMENT

ORGANIZATIONAL CAPACITY FOR CHANGE

STABILITY IN THE EXTERNAL ENVIRONMENT

SHARED PUBLIC-PRIVATE COMMITMENT

# To wrap it up…

- Regardless of who pays, how you pay matters.
- We should pay for the outcomes we want, which means moving to value-based payment.
- Moving to value is a huge transition with significant operational implications.
- We need to give the delivery system the time and runway to make this transition.


Thank You

# June Deliverable

**Oliver Droppers**

# Process Milestones (July 2020 – April 2021)

- COVID-19 Pandemic (March 2020); Legislature modifications (Aug. 2020)
- Task Force: 10 meetings, approx. 30 hours (3 meetings left)
- Established Technical Advisory Groups (4 TAGs)
  - Eligibility, Benefits, and Affordability: 8 meetings, 18 hours
  - Provider Reimbursement: 6 meetings, 12 hours
  - Finance and Revenue: 8 meetings, 16 hours (1 meeting left)
  - Governance: 4 meetings, 8 hours (2 meetings left)
- Recruited & Appointed Consumer Advisory Committee: 7 meetings, 14 hours (1 meeting left)
- Intermediate Strategies Work Group: 3 meetings, 6 hours (2 meetings left)
- Unparalleled effort and remarkable commitment among Task Force members amidst a global pandemic and legislative session

# Proposal Progress – To Be Included in June Deliverable

**Proposal Adopted February 25**

Provider Reimbursement

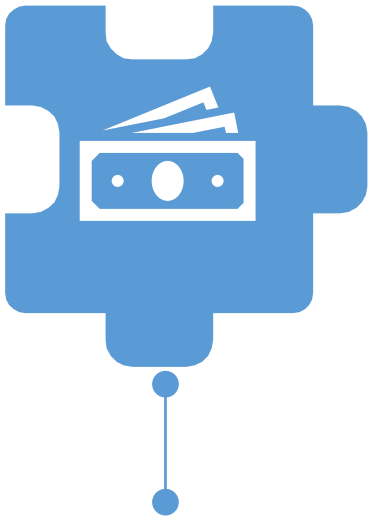
**Proposal Adopted March 25**

Eligibility & Enrollment

**Final Proposal April 29**

Affordability & Covered Benefits

**Proposal – On Target May 27**



Financing and Revenue

**Proposal - On Target May 27**

Governance

# Task Force Meetings May and June 2021

**May**

- F&R Vote
- Governance Vote
- CAC Panel

**Early June**

- Discuss Intermediate Strat.
- Preview June Deliverable
- Legislator Participation

**Late June**

- Review June Deliverable
- Consider Remaining Priorities (if applicable through extension)

# Outstanding Items – for Possible Extension

## Outstanding design elements

- SDOH
- Role of private insurance
- Provider participation
- Private-pay patients
- Implementing portability of benefit
- Long-term services and supports
- Network adequacy
- Provider recruitment/retention
- Transition plan
- Cost control measures

## Federal considerations and waivers

- Waiver applicability; federal approval and feasibility considerations

## Refine benefits proposal and estimate cost

- Potential savings or increased costs

## LRO estimates of revenue package

## Stakeholder engagement

- Solicit input from stakeholders and industry partners
  - Employers, Health Care Industry, Long Term Care, Other?
- Remote community listening forums

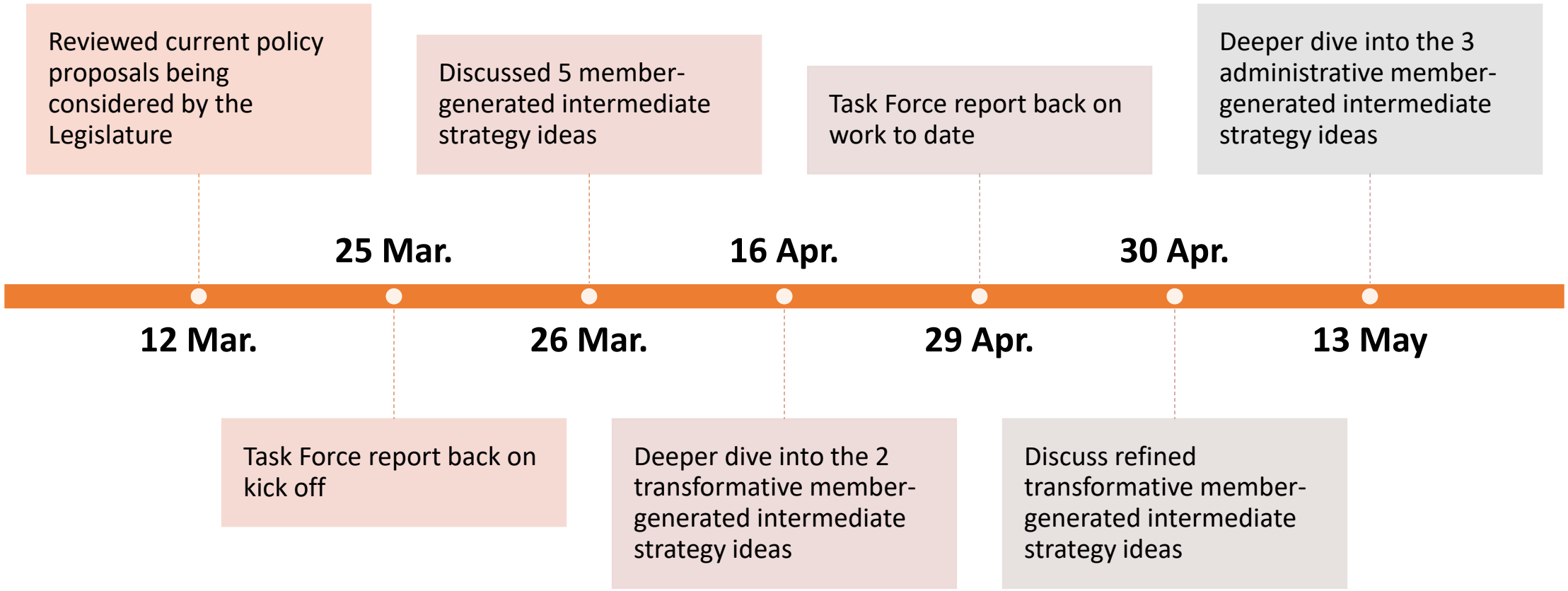
# Intermediate Strategies Workgroup

**Chair Goldberg**

# Charge & deliverables

- Legislative Letter:
  - A small work group, led by the Chair and Vice-chair, to identify intermediate strategies the legislature may consider to promote affordable universal coverage that will be consistent with and form a bridge to the Task Force's long-term, overall plan.
  - Assess and prioritize policies in preparation for the 2022 legislative session: policies which Oregon lawmakers can act upon, are consistent with the goals of the Task Force, and continue to build on Oregon's history of innovation.
  - Include these policy options in the report that is to be prepared by the Task Force in June.
- The Task Force will need to be clear in its report that no intermediate strategies achieve the Task Force goal. Some may be steps in the right direction, but none are sufficient in and of themselves.

# Timeline


Reviewed current policy proposals being considered by the Legislature
Discussed 5 member-generated intermediate strategy ideas
Task Force report back on work to date
Deeper dive into the 3 administrative member-generated intermediate strategy ideas
25 Mar.
16 Apr.
30 Apr.
12 Mar.
26 Mar.
29 Apr.
13 May
Task Force report back on kick off
Deeper dive into the 2 transformative member-generated intermediate strategy ideas
Discuss refined transformative member-generated intermediate strategy ideas

# Member-Generated Intermediate Strategy Ideas

- Transformative ideas
  - Individual Market Transformation
  - Single Payer Medicare
- Administrative ideas
  - CCO consolidation
  - Value-based payment expansion
  - Employer-sponsored health insurance data collection

# Transformative Ideas

**Individual Market Transformation**

- Make the individual market more affordable with a richer, standard benefit package
- 1332 waiver
- State establishes standardized global budget for carriers

**Single Payer Medicare**

- Create a single, statewide, state-run Medicare Advantage plan covering all Medicare enrollees
- More affordable with a richer benefit package
- Consider expanding eligibility to include those aged 55-65

# Questions?

- Given the charge and deliverables, are we headed in the right direction?
- There will be more time to discuss in May/June
- Contact Ed and Bruce if you have an intermediate strategy idea that you would like to add to the list

# Public Comment

**Revised Benefits Proposal**

# Governance TAG Proposal Preview

**John Santa, Governance TAG Lead**

# Governance TAG Workplan

- March 18: TAG Scope & Workplan
- April 1: Values, Role & Structure of Single Payer
- April 15: Role & Structure of Regional Entities
- April 26: Fiduciary Requirements
- May 11: Authority
- May 25: Review Proposal

# Values

1. The single payer is dedicated to improving the health status of individuals, families and communities.
2. Health care, as a fundamental element of a just society, is to be secured for all individuals on an equitable basis by public means.
3. Access to a distribution of health care resources and services according to each individual's needs and location within the state should be available. Race, color, national origin, age, disability, wealth, income, citizenship status, primary language use, genetic conditions, previous or existing medical conditions, religion or sex, including sex stereotyping, gender identity, sexual orientation and pregnancy and related medical conditions, including termination of pregnancy, may not create any barriers to health care nor disparities in health outcomes.
4. The components of the system must be accountable and fully transparent to the public.
5. The single payer will invest in local communities, engage community members and health care clinicians to improve the health of the community and address regional, cultural, socioeconomic disparities in health care.

# Single Payer Entity: Roles

- Apply the reserve powers unique to the single payer for financial management and stewardship
  - Establish all aspects of the budget, lead cost control efforts, support regional economies
- Oversee program administration
- Develop and implement program policy
- Support delivery system reform/improvement
- Achieve health equity to improve access, quality of care
- Support workforce development
- Develops and maintains the population health-based information system
- Maintain a government-to-government relationship with the Tribes

# Single Payer Entity: Structure

The Single Payer should be a public entity designed with features to ensure the following:

- Reporting responsibility to the Oregon Legislature and Governor
- Ability to accept all types of funds (i.e. federal, state, donations etc.)
- The Single Payer budget is not subject to Oregon's tax rebate
- Authority for development and maintenance of prudent financial reserves to ensure solvency and that are protected to be appropriated only for use by the Single Payer

# Single Payer Entity: Board

- The Single Payer board membership will:
    - Require Governor appointment and Senate confirmation
    - Represent a balance of expertise in healthcare and have an authentic community voice
    - Demonstrate no conflicts of interest at time of appointment, during their terms, and for a significant period after leaving the Board.
    - Receive reimbursement for their time
- The Board will have both community and regional/delivery system advisory committees
- Further discussion will be needed to determine the number of board members and the terms of membership

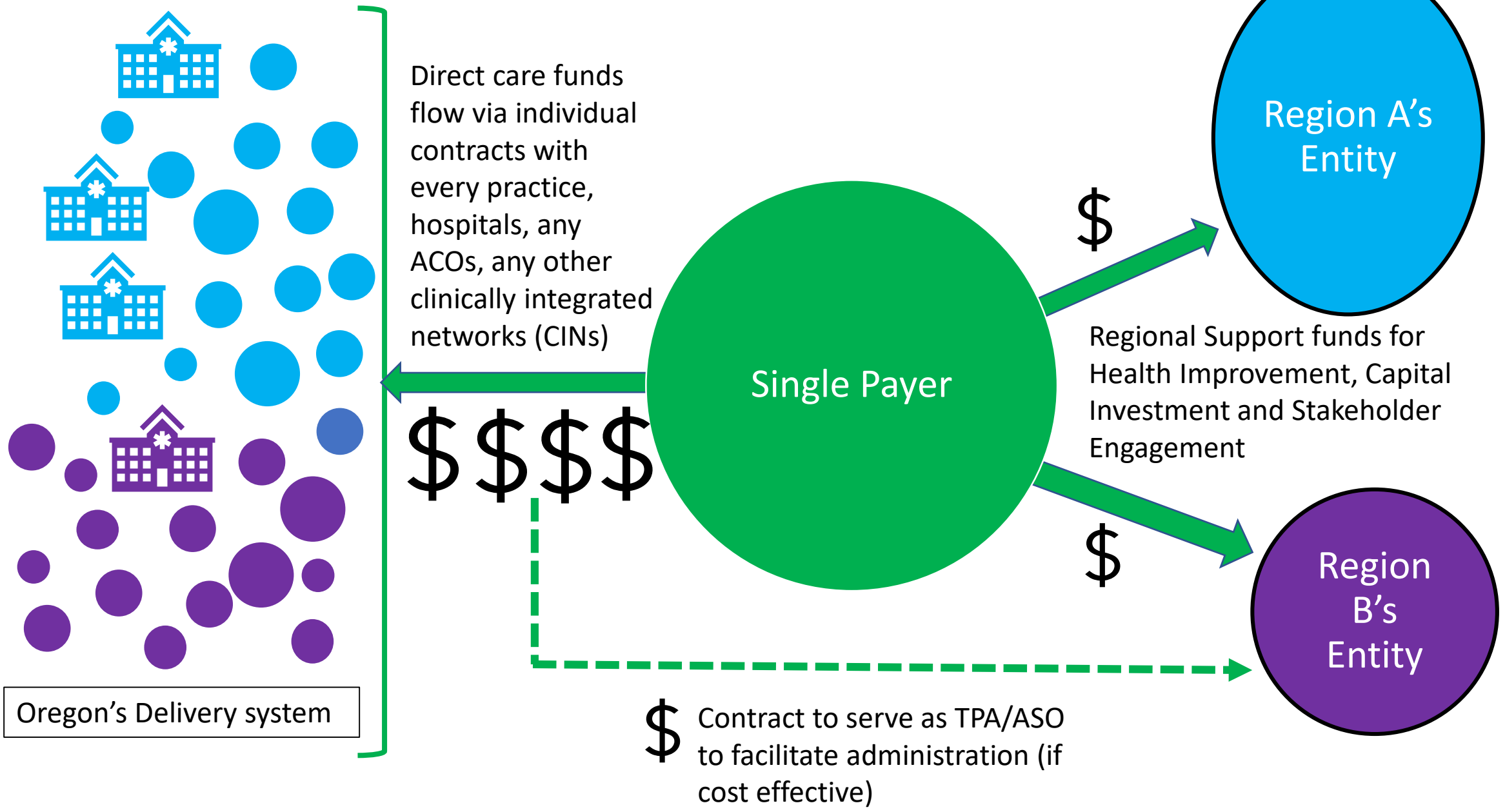
# Regional Entities: Roles

- Advise the Single Payer related to management/implementation/coordination of care for the region which could include:
  - Advise on budget from the Single Payer entity to region's providers
  - Advise on contract and methods for reimbursing providers
- Manage a budget for health improvement, exceptional medical capital and critical infrastructure projects, and ongoing stakeholder engagement
- Ongoing community and stakeholder convening and regional planning processes to assess and prioritize regional health and financial needs, focusing on prevention, chronic conditions and equity
- Local government's work with the Single Payer will be through the Regional Entity(s)
- Assist and advise providers on the creation/improvement of delivery systems, fostering innovation
- Promote collaboration across the regional delivery system and other regions

# Regional Entities:
# Structure and Relationship to Single Payer

- There will be one Regional Entity allowed per region
- The Regional Entities will be as transparent and publicly accountable as the Single Payer
- A board of Regional Entities recommends the budgets and contracts for each region
- The Single Payer determines criteria for Regional Entities
- Regional Entity advises the Single Payer on the following:
  - Regional budgets for provider reimbursement
  - Acceptable methods of provider payment methodologies
  - Cost control efforts
  - Regional budgets for health improvement, exceptional medical capital and critical infrastructure projects, and ongoing stakeholder engagement
  - Provider contracts

# Flow of Funds



# TAG Proposals – Task Force Considerations

- Does the proposal contribute to an equitable, affordable, comprehensive, high quality, publicly funded health care system that can serve all Oregon residents?
- What are the implications?
- Are there barriers to implementation and are they prohibitive?
- Are there additional considerations or alternatives the TAG should consider prior to finalizing the proposal?

# Revised Benefits Proposal

**Eligibility, Benefits & Affordability TAG Plus**

# Recap: Benefits Proposal Timeline

- February 25th Task Force meeting: TF reviewed draft proposal based on PEBB plan with no limits/no cost sharing
  - Robust discussion about establishing places where limits are appropriate, ensure plan is sustainable, how/whether SDOH services fit in
  - Staff edited proposal based on TF feedback to go back to TAG
- March 8th EBA TAG meeting: TAG reviewed edited Benefits proposal
  - Some limitations (cosmetic procedures, hearing aids, glasses/contacts)
  - Minor income-based cost sharing for ER and potentially prescription drugs
  - Recommended pulling out both SDOH and prescription drugs for more study
- March 25th Task Force meeting: TF heard revised Benefits proposal
  - Decided not to take a vote after members expressed concerns over proposal
  - Chair Goldberg directed EBA (plus additional members) to revise recommendations based on TF feedback and bring it back to April TF meeting

# Benefits Feedback from TF (March)

- Ground benefits in evidence-based processes
- Incorporate medical necessity
- Consider mechanisms for utilization management controls
- Revisit premiums on high-income families in order to decrease the burden on low-income families
- Consider a single prescription drug formulary for the state
- Revisit behavioral health

# April 12th EBA Meeting

- EBA TAG + Dr. Metz, Chuck, Dr. Santa & Cherryl
- Discussion of Key Values & Considerations (Glendora)
- Presentations from Jeanene Smith (HMA) to support TAG discussion on 4 issues:
    1. Incorporating evidence-based recommendations into Plan benefit design
    2. Whether premiums should be added for higher income Oregonians
    3. Whether to impose limitations on specific benefit categories
    4. Whether a single formulary should be used for Plan Rx benefit
- Robust discussion led to recommendations & considerations

# Recommendation 1

PEBB should remain the basis for a Plan benefits package

# Rec. 1 Considerations

- Idea of using Oregon Benchmark plan was discussed & rejected for not aligning with TF Values & Goals
- PEBB covers categories that are not part of ACA or OHP (Complementary care, adult dental/vision, infertility)
- OHP offers most flexible mental health coverage (provider type, modality, place of service) & these elements should be incorporated into MH benefit

# Recommendation 2

Benefit coverage details should be guided (where possible) by evidence-based bodies; commit to identifying evidence that is inclusive of diverse populations.

# Rec. 2 Considerations

Moves Plan away from “no limits” into one that aligns with best-available evidence

Some TAG members expressed concern that certain services, and populations, are not well-represented in medical literature. Desire to ensure that evidence “wrap” is not applied rigidly.

# Recommendation 3

The Plan should not impose premiums, copays, deductibles or any other cost-sharing on members.

# Rec. 3 Considerations

- Higher income individuals should contribute more to the Plan; this should happen in financing (taxes) rather than cost sharing
- Peer-reviewed literature is largely unsupportive of the idea that co-pays lead to less costly utilization or improved outcomes
- Premiums and copays could likely not provide significant revenue to offset costs while remaining affordable
- Non-members will be billed for services.

# Recommendation 4

The Plan should adopt a single state formulary for its prescription drug benefit.

# Rec. 4 Considerations

- Allows Plan to operate under a single drug list based on evidence (e.g., Practitioner Managed Preferred Drug List)
- Single payer should also work on purchasing arrangements to reduce cost of prescription drugs
- Need to ensure access to certain specialty drugs which are traditionally excluded from many formularies
- Formulary development may benefit from community input.

# Meetings in May

**Task Force —** May 27, 2021

- Topic: Review of TAG proposals and CAC panel

**Consumer Advisory Committee –** May 17 (4-6pm)

**Advisory Groups**

- Finance and Revenue TAG – TBD
- Governance TAG – May 11, May 25
- Intermediate Strategies Workgroup– April 30, May 13

Access meeting materials and follow the CAC and TAGs at: https://www.oregon.gov/oha/HPA/HP/Pages/Task-Force-Universal-Health-Care.aspx

# Accessing Virtual Meetings

**How to join—**all meetings of the **Consumer Advisory Committee** and the **Technical Advisory Groups** can be accessed via Zoom:

Join Zoom Meeting
Conference Call Phone Number: (669) 254-5252
Meeting ID: 161 411 7859 | Password: 787886

**How to provide public comment**—anyone may provide written or oral public comment to the Consumer Advisory Committee or a Technical Advisory Group

- Please email written comments to jtfuhc.exhibits@oregonlegislature.gov
- Provide oral comment by computer or phone by calling the number above or joining the virtual meeting via Zoom (click on link).

See public comment handout available online - Handout