Joint Task Force on Universal Health Care (Senate Bill 770, 2019)

Preliminary Status Report

June 2021

Placeholder for Cover Letter from Chair and Co-Chair

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TASK FORCE MEMBERS

Senator James Manning (District 7)

Representative Cedric Hayden (District 7)

Representative Marty Wilde (District 11)

Patrick Allen, Director, Oregon Health Authority (non-voting member)

Lionel "Chad" Chadwick, Rural Health Representative

Glendora Claybrooks, Public Member Representative

Michael Collins, Tribal Representative

Dwight Dill, Social Services Representative

Bruce Goldberg, Licensed Health Care Professional

Claire Hall, Association of Oregon Counties (non-voting member)

Zeenia Junkeer, Alternative Therapy Services Representative

Ed Junkins, Rural Health Representative

Sam Metz, Medical and Surgical Services Representative

Cherryl Ramirez, Behavioral Health Representative

Deborah Riddick, Nursing Services Representative

Leslie Rodgers, Services for Persons with Disabilities Representative

John Santa, Quality Assurance and Healthcare Accountability Representative

TK Keen, Administrator, Division of Financial Regulation, Department of Consumer and Business Services (non-voting member)

Chuck Sheketoff, Public Member Representative

Sharon Stanphill, Public Health Services Representative

Executive Summary

Senate Bill (SB) 770 (2019) established Oregon's Task Force on Universal Health Care (Task Force), charged with developing recommendations for the design of the Health Care for All Oregon Plan (Plan). The legislation envisions a publicly funded universal health care system that is equitable, affordable and comprehensive, provides high quality health care and is available to all Oregonians.

The Task Force held 14 virtual meetings between July 2020 and June 2021. Meetings were delayed for five months due to the COVID-19 pandemic. The Task Force developed proposals through four Technical Assistance Groups (TAGs): Eligibility, Benefits and Affordability; Provider Reimbursement; Finance and Revenue; and Governance. The TAGs each presented proposals to the Task Force and revised proposals based on Task Force feedback. Revised proposals were then voted on by the Task Force. In addition, the Task Force was advised by the Consumer Advisory Committee (CAC), a diverse 14-member group providing consumer perspectives to the TAGs and Task Force. Lastly, as requested by the legislative members serving on the Task Force, a separate Intermediate Strategies Workgroup explored policy proposals that could form a bridge to the Plan.

Due to the complexity of the requirements as specified in Senate Bill 770, the delayed start of the Task Force and reduction in resources and staffing due to COVID-19 pandemic, the Task Force was not able to complete the requirements of SB 770. In the 2021 legislative session, legislative members of the Task Force proposed Senate Bill 428 (2021) to extend the work of the Task Force through January 2022 to further develop and refine recommendations. Should the Legislature approve this extension, Task Force members wish to engage in a robust community engagement process to solicit feedback on its recommendations to date. Without an extension, the Task Force, at a minimum recognized it should provide the Legislative Assembly with an informative progress report highlighting its work to date.

[Add next steps section here based on June 9 discussion of the draft extension workplan proposal. Include details from the TF perspective about how these recommendations are in progress, and need additional development during the extension, especially through the process of community engagement]

Task Force Preliminary Recommendations

Summarized below are preliminary recommendations put forward by the Task Force outlining a plan. The recommendations provide an initial blueprint of the Plan as envisioned in SB 770. The Task Force recognizes the challenging work that remains unfinished and appreciates any opportunity granted by an extension to gain public feedback and further develop and refine a Plan that will provide universal coverage for all Oregon residents.

Eligibility and Enrollment

- Everyone in Oregon is eligible for the Plan through a simple and easy enrollment process.
- Out-of-state residents who work for Oregon-based employers, and their dependents, are eligible for the Plan

Covered Benefits

- The benefits package will be comparable to the Oregon PEBB (Public Employees Benefit Board) benefits package, which covers primary and preventive care, prescription drugs, laboratory services,

emergency services, hospitalization, behavioral health and substance use disorder services, prenatal, maternity and newborn care, dental and vision care, complementary care and physical and occupational therapy. The benefits are to align with the best available evidence-based practice for the relevant populations and should include a single state formulary for prescription drugs based on evidence and community input.

- Members will not pay premiums, copays, deductibles, or any other cost sharing.
- Long term care may be incorporated into the Plan under the current level of services and supports covered by Medicaid.

Provider Reimbursement

- Regional Entities are to advise the Single Payer on methods and rates of reimbursement that are regionally appropriate.
- Members will be able to access their preferred provider, who will be reimbursed based on region and populations served. The Plan is to advance value-based payments and expand on the notion of "value-based payment" as historically used, to allow for community input and prioritization.

Governance

- Creation of a Single Payer, which will be a public entity with fiduciary responsibility for the Plan, and processes to ensure transparency and public accountability.
- Public trust fund is to be separate from the General Fund.
- As a government entity, the Single Payer will maintain a government-to-government relationship with the Sovereign Tribes.
- Single Payer is to establish budgets for the Plan, regional delivery systems, and Regional Entities.
- Regional Entities are to play advisory and planning roles to support the Single Payer and respond to the unique needs of the diverse communities across Oregon.
- Additional work is needed to assess what Federal and state authorities may need to be adjusted to authorize the plan

Program Funding

- Assumes existing state and federal health care revenue will be applied to the Plan.
- Additional revenue will be generated by a combination of additional payroll and income taxes and other taxes, if needed, and established as a progressive tax structure.

The work of the Task Force is incomplete, and the initial set of preliminary recommendations require refinement, expertise, and public feedback in order to finalize a Plan for Oregon to consider as envisioned by SB 770.

Table of Contents

Introduction

COVID-19 has impacted Oregonians in multiple ways, including employment, access to insurance coverage and use of health care. Even prior to the pandemic, Oregonians grappled with the need for and cost of health coverage. The following highlights the pre-pandemic coverage landscape and concerns facing many Oregonians related to health care and health insurance.

Background

Between 2013 and 2015, in the wake of changes brought on by the Affordable Care Act, the rate of insurance coverage in Oregon grew by almost 10 percentage points (85.5% to 94.7%) and has remained stable since then. Prior to the COVID-19 pandemic, 94 percent of Oregonians (3.96 million people) had some form of insurance coverage. [1] While we do not yet know how many Oregonians lost coverage due to the COVID-19 pandemic, national estimates indicate that the impact may be smaller than originally anticipated.[2]
[Placeholder for insurance coverage by year graph, OHIS]

Almost half of those with coverage receive it through employer plans. The State of Oregon is the single largest health care purchaser in the state, as it covers 1.3 million people, including public employees and educators and Oregon Health Plan (OHP) members. Additional detail on insurance coverage is provided in Appendix X. [Placeholder for purchaser pie chart]

Even among those with health coverage, many Oregonians struggle with the costs of premiums and care. A 2019 analysis by researchers at the University of Pennsylvania found that on average, Oregon families spent 29 percent of their household income on insurance premiums in 2016.[3] Between 2010 and 2016, premiums increased an average of 25 percent and deductibles rose by 77 percent, while household income only increased 15 percent. Total premiums have grown three times faster than personal income, and the percent of premiums paid by workers has grown almost four times as fast. [Placeholder for income vs premiums graph]

The pandemic has highlighted structural problems in the system, especially inequities in access and care. It also exposed system inefficiencies that existed previously. Additional details on how costs have impacted Oregonians are provided in Appendix X.

International Models for Universal Health Care

There is no one model for universal health care programs across nations. Review of international models shows countries have made a range of choices about the key design elements:

- Authority and control: centralized vs. delegated regional/local
- Comprehensiveness of benefits: comprehensive to basic

[1] Oregon Health Authority, Oregon Health Insurance Survey, 2019. https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Insurance-Data.aspx
[2] https://www.commonwealthfund.org/blog/2021/update-how-many-americans-have-lost-jobs-employer-health-coverage-during-pandemic
[3] Measuring the Burden of Health Care Costs on Working Families, 2019. https://ldi.upenn.edu/healthpolicysense/measuring-burden-health-care-costs-working-families

- Out-of-pocket expenditures as percentage of total health expenditures
- Role of supplemental or secondary private insurance

While universal programs vary, countries with single-payer universal programs tend to utilize a centralized financial and regulatory structure and either eliminate or modify the use of private health insurers. Decisions about covered services, member cost sharing, provider payment rates and administrative costs vary. These variables determine the program cost to the nation. Additional information on international models are in Appendix X.

Federalism and States

While we can look to other countries for ideas on how to structure a universal coverage program, designing a program in a U.S. state must also take into account the distribution of authorities between the federal government and states. In particular, states are impacted by federal statute and regulation, including Medicare and the Employer Retirement Income Security Act of 1974 (ERISA).

The federal government is the largest funder of health care in the country and sets the rules for the use of those services. Medicare is operated by the federal government and its contractors. At present, there is no clear way to use Medicare funds to support a single payer program, although the program does have some pathways to waive program rules in support of innovative reform. Programs authorized under a Medicare waiver must not increase costs for the federal government and enrollment can only be made mandatory through Congressional action.[4]

To encourage state innovation, federal Medicaid law includes the ability for states to request waivers of federal requirements, but not everything can be waived (and changes must not increase costs for the federal government (i.e., "budget neutrality"). Over the past 30 years, Oregon has leveraged its Section 1115 Medicaid waiver to implement Oregon's Prioritized List, the creation of Coordinated Care Organizations (CCOs), adoption of global budgets for CCOs, and more.

Similarly, the Affordable Care Act (ACA) includes a waiver provision, although states have primarily used it to establish reinsurance programs.[5] The ACA's Section 1332 allows states to request authority to waive provisions of the law and regulations, as long as coverage and benefits under an alternative program must be at least as comprehensive and affordable as without the waiver and must cover as many people.[6] The alternative program also cannot increase federal costs.

State Efforts to Establish Universal Health Care Programs

As directed by SB770, the Task Force began by conducting a scan of states' efforts to provide universal health care coverage broadly, as well as specific attempts to implement single payer health care financing systems. The Task Force compared analyses of proposals from Vermont (HB 202, 2011), Colorado (Amendment 69,

[4] Section 402 of Public Law 92-603 gives CMS permission to waive Medicare payment and benefit statutes for demonstration projects. Section 222(b) of the Social Security Act Amendments of 1972 allows demonstrations that experiment with the Medicare payment methodology.

[5] Hawaii has a waiver of the ACA's SHOP provisions to accommodate its state employer mandate, which has been in place since 1974. Georgia's waiver was approved by the Trump Administration but is now in court, as is the federal guidance that made Georgia's plan possible.

[6] The Commonwealth Fund, The ACA's Innovation Waiver Program: A State-by-State Look. November 2, 2020. https://www.commonwealthfund.org/publications/maps-and-interactives/2020/nov/acas-innovation-waiver-program-state-state-look

2016), California (SB 562, 2017) and New York (AB 4738, 2017). Information on efforts in California, Colorado, New York and Vermont is included in Appendix X.

The Task Force reflected that all four attempts failed, at least in part, due to insufficient or unpopular financing mechanisms. The Task Force also considered Maryland's all-payer rate-setting system for hospital services, which began implementation in 2014, as an example of state-managed Medicare, and Connecticut's managed fee-for-service Medicaid system that began in 2012 was noted as a model for regionalized administration of a single risk pool.

Similarities in State Universal Health Care Proposals

State-developed universal health care proposals share several characteristics, including comprehensive benefits, little to no cost sharing and patient choice of provider.[7] Most efforts also propose ways to address administrative costs and to modify medical care delivery and costs, including payment reform efforts.

Over the past decade, California, Colorado, New York and Vermont have all attempted to pass universal health care legislation. While each state has had its own challenges, researchers have identified the following issues impacting efforts to implement universal health care programs at the state level: [8]

- ERISA limitation of states' ability to effect changes to employer sponsored coverage
- Federal government control of Medicare, Medicaid, ACA, and Veteran's Administration funds
- Effort to develop, get approval for and manage multiple comprehensive waivers
- Legal complexity involved with implementing revenue programs
- Raising sufficient tax revenue to fund the proposal
- Short term disruption of transitioning from mixed private public approach to another system
- Cost and utilization impact of universal free or very low-cost access to care

The Task Force noted many of these challenges and considered ways to mitigate them as they developed their recommendations.

[7] Staff presentation to the Joint Task Force on Universal Health Care, October 14, 2020.
https://olis.oregonlegislature.gov/liz/2019I1/Downloads/CommitteeMeetingDocument/226777
William C. Hsiao, State-Based Single-Payer Health Care — A Solution for the United States? The New England Journal of Medicine 364;13. March 31, 2011. https://nejm.org

[8] Universal Access to Care Work Group, Report on Barriers and Incremental Steps to Universal Access. Legislative Policy and Research Office, 2018.
https://www.oregonlegislature.gov/salinas/HealthCareDocuments/UAC%20Work%20Group%20Report%20%20FINAL%2012.10.18%20.pdf

Brief History of Oregon Universal Care Efforts

Oregon has a robust history of tackling health care challenges going back over thirty years. While not all health reform work in Oregon has focused on universal coverage, the Oregon Legislature has considered measures related to universal health care in the years prior to the passage of Senate Bill 770, which established the Task Force on Universal Health Care.

1989: the Oregon Health Plan Launched

In 1989, Oregon enacted a series of health reforms, including an employer mandate, with the goal of achieving universal coverage in the state.[9] The mandate was not implemented, but the state did expand its Medicaid program and named it the Oregon Health Plan.[10]

2002: The Oregon Comprehensive Health Care Finance Act

The Oregon Comprehensive Health Care Finance Act of 2002 (Ballot Measure 23) was a legislatively referred state statute that would have created a single-payer health care system to provide health care to every person in Oregon starting in 2005.[11]

The proposal would have merged all existing health care funding streams, including personal and employer taxes, federal health programs, and the state workers' compensation system, into a single financing system. The state health care program would have been administered by a new public non-profit corporation, the Oregon Health Care Finance Board. The new system, financed by a personal income and new payroll tax, would have covered all medically necessary health care costs, with no deductibles or other participant cost-sharing. Proposed benefits included prescription medications, preventive care, mental health services, long-term care, dental and vision care, as well as alternative therapies. Oregon voters rejected Ballot Measure 23 in a November 2002 vote.

2013-2017: Study of Options for Financing Health Care Delivery in Oregon

House Bill 3260 (2013) identified the characteristics of what the Legislature considered the best system for delivering and financing health care in Oregon and required the Oregon Health Authority (OHA) to contract for and oversee a study of the following options for financing health care delivery in the state:

(a) Publicly financed universal health care using a single payer model
(b) Publicly financed universal health care administered through commercial insurers
(c) Adding a public option plan to the existing options available to consumers

The study was funded in 2015 and OHA selected the RAND Corporation (RAND) and its subcontractor partner Health Management Associates to develop the 2017 report, *A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon*.[12] The study found that a health care program covering all state

[9] Robert A. Berenson, Emily Hayes, Nicole Cafarella Lallemand, Health Care Stewardship: Oregon Case Study, Urban Institute, January 20, 2016. https://www.urban.org/research/publication/health-care-stewardship-oregon-case-study
[10] Oregon Senate Bill 27 became Oregon Revised Statutes §§ 414.025 - 414.750 (1989) https://www.oregonlegislature.gov/bills_laws/ors/ors414.html
[11] Oregon Legislative Revenue Office, Research Brief: Ballot Measure 23 Health Care Finance Plan. October 2002. https://www.oregonlegislature.gov/lro/Documents/rb11_02ballotmeasure23.pdf
[12] Chapin White, et.al., A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon. 2017. https://www.oregon.gov/OHA/HPA/Documents/Four-Options-Financing-Health-Care-Delivery-Report.pdf

residents could be achieved for less than the cost of the current system. The distribution of costs and how the system changes depend on the model.

2013 – 2021: The Healthcare Options Provided Efficiently (HOPE) Amendment

Starting in the 2013 legislative session and again in 2015, 2018 and 2020, Representative Mitch Greenlick sponsored a House Joint Resolution (HJR) to amend the Oregon constitution and implement universal health care.[13] The so-called "Hope Amendment" proposed adding language to the state constitution that would require the state to ensure every resident has access to cost-effective, clinically appropriate, affordable health care. After Representative Greenlick passed away in 2020, the Hope Amendment was brought to the 2021 Legislature as Senate Joint Resolution 12. The resolution passed and will be sent to the voters to consider during the November 2022 general election. [14]

2018: Universal Access to Care Work Group

The Oregon Legislature's House Committee on Health Care established the Universal Access to Care Work Group (UAC Work Group). The UAC Work Group included three members of the House Committee on Health Care and representatives of commercial insurers, CCOs, hospital systems, health reform advocates, behavioral health, health care safety net, providers, and trade associations. The UAC Work Group issued a final report to the Legislature (December 2018) that included the following recommendations for incremental State-level policy approaches intended to move the state toward a universal coverage program:[15]

- **Premium Assistance Program.** Expand the role and use of premium assistance programs.
- **Enrollment Assistance and Outreach.** Increase enrollment and improve risk mix through outreach to the 80 percent of the uninsured estimated to be eligible for Medicaid or federal subsidy support.
- **Consumer Coverage Simplification.** Evaluate uniformity among Oregon's Marketplace and OHP products.
- **Administrative Simplification.** Reduce administrative costs associated with provider billing and insurance-related activities.
- **Plan Uniformity.** Explore a single set of benefits across public and privately financed health plans.
- **Primary Care Trust Fund.** Assess a single payment and delivery system for primary care services.
- **Shared Responsibility Mandate.** Evaluate a shared responsibility mandate with revenue funding market stabilization and consumer affordability initiatives.
- **Medicaid-like Buy-in.** Evaluate a coverage program for lower-income Oregonians not eligible for Medicaid or federal subsidies through the Marketplace.
- **Expansion of the Coordinated Care Model.** Expand Oregon's reform model beyond OHP to all commercial health carriers and health plans offered in Oregon based on: best practices to manage

[13] Elizabeth Hayes, Resolution making health care a right in Oregon moves closer to ballot; Portland Business Journal, February 26, 2020. https://www.bizjournals.com/portland/news/2020/02/26/resolution-making-health-care-a-right-in-oregon.html

[14] Elizabeth Hayes, House committee grapples with bill to make health care a right in Oregon, Portland Business Journal, May 7, 2021. https://www.bizjournals.com/portland/news/2021/05/07/health-care-right.html?ana=e_ptl_bn_editorschoice_editorschoice&j=90559561&t=Breaking%20News&mkt_tok=NjczLVVXWS0yMjkAAAF89naoMY3_cqifv4pmff-cn-3ZTJM3vQF1VCCCLdZmBrQFtTYzzPF-LnM3xcK05WOSPHCYId7Oh9dFMKVTOXMHZeb56CZSTR46plru1gTj3GWORhL8

[15] Universal Access to Care Work Group, Report on Barriers and Incremental Steps to Universal Access. Legislative Policy and Research Office, 2018. https://www.oregonlegislature.gov/salinas/HealthCareDocuments/UAC%20Work%20Group%20Report%20%20FINAL%2012.10.18%20.pdf

and coordinate care; shared responsibility for health; transparency in price and quality; measuring performance; paying for outcomes and health; and a sustainable rate of growth.

The UAC Work Group's work and recommendations informed the development of SB 770 in the 2019 session.

Task Force Composition and Structure

The Impact of COVID-19 on the Work of the Task Force

The Task Force was slated to begin meeting in March 2020 but was delayed due to COVID-19. In the August 2020 2nd Special Session, resources for the Task Force's work were cut, including the three FTE staff originally allocated.[16] The timeline remained the same with a report due in June 2021. The Task Force identified the need to continue its work during an "extension" of the timeline into the second half of 2021.

To maintain a transparent process and accommodate COVID-19 restrictions on in-person gatherings, the Task Force, TAGs, CAC and workgroups have exclusively met online. Meetings were live-streamed via the Oregon Legislative Information System, and recordings were posted online.[17] Meeting links were made available to the public, and every Task Force and TAG meeting included an opportunity for public comment. Members of the general public were additionally encouraged to share public comment in writing.

Senate Bill 770

Senate Bill 770 went into effect on July 23, 2019, establishing the Task Force on Universal Health Care. See Appendix A for the full text of SB 770.

Charge

Section 2 of SB 770 lays out the work of the Task Force:

> *"The Task Force on Universal Health Care is established to recommend the design of the Health Care for All Oregon Plan, a universal health care system, administered by the Health Care for All Oregon Board, that is equitable, affordable and comprehensive, provides high quality health care and is publicly funded and available to every individual residing in Oregon.*[18]

The Task Force is charged with making recommendations for a functional single payer health care system that is responsive to the needs and expectations of the residents of this state. This includes the financing of such a system and the structure and governance of the Board that would oversee the Health Care for All Oregon Plan.

Values

Section 4 directed the Task Force to consider the following values as it developed recommendations for the creation and operation of the Health Care for All Oregon Plan:

- Health care should be provided to all using a public means
- Health care must be equitable, which means it must take into account each individual's circumstances, identities and the structural and environmental conditions in which they live
- The system must be accountable and transparent and include meaningful public participation

[16] 80th Oregon Legislative Assembly, Enrolled Senate Bill 5723, 2020.
https://olis.oregonlegislature.gov/liz/2020S2/Measures/Overview/SB5723
[17] Task Force meeting recordings located at https://olis.oregonlegislature.gov/liz/2019I1/Committees/JTFUHC/Overview
TAG meeting recordings located at https://www.oregon.gov/oha/HPA/HP/Pages/Task-Force-Universal-Health-Care.aspx
[18] 80th Oregon Legislative Assembly, Enrolled Senate Bill 770, 2019.
https://olis.leg.state.or.us/liz/2019r1/Downloads/MeasureDocument/SB770/Enrolled

- Funding for the plan is a public trust, with any excess revenue returned to that public trust

Principles

Section 5 required the Task Force to consider four principles in the development of its recommendations for a universal health care plan. These principles are:

- **Choice of Provider.** A participant in the plan may choose any individual provider who is licensed, certified or registered in this state or any group practice.
- **Provider Participation.** 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.
- **Medical Necessity is Participant and Provider-driven.** A participant and the participant's provider shall determine, within the scope of services covered within each category of care and within the plan's parameters for standards of care and requirements for prior authorization, whether a treatment is medically necessary or medically appropriate for that participant.
- **Continuous and Evidence Based Coverage.** The plan should cover services from birth to death, based on evidence-informed decisions as determined by the Health Care for All Oregon Board.

Scope

Section 6 outlines the scope of the Task Force's work. In addition to requiring the Task Force to be guided by the values and principles described above, a recommended plan must be a single payer health care financing system. In addition, a proposed plan must:

- Ensure that individuals receiving services from the federal Veterans Health Administration or Indian Health Service can participate in the plan and continue to receive services through these other systems
- Equitably and uniformly include all residents and constitute creditable coverage
- Maintain access to services required under Medicare, federal and state Medicaid and the Children's Health Insurance Program requirements, the ACA and other state or federal programs

The legislation laid out parameters for the plan design, including that the Task Force should estimate plan costs and use the payment methodologies laid out for institutional providers, group practice providers, and individual providers. The Task Force was directed to:

- Reflect on how existing local, state, federal and Tribal organizations would be impacted
- Consider the issues raised by the RAND report authorized by HB 3260
- Review other state efforts to establish single payer universal coverage programs
- Incorporate the work of health care professional boards and commissions

Report Requirements

The Task Force was directed to solicit public input from a range of Oregonians, including those in rural and underserved communities. The Task Force findings and recommendations for a plan should include actions and timelines, the degree of consensus and the priority of each recommendation, based on urgency and importance. The report must include recommendations for the work of the Board, including but not limited to its structure and administrative, financial, legal, oversight and other roles. Other elements to be

addressed include transition planning, cost containment measures, provider reimbursement mechanisms, and changes to federal or state law or waivers of existing requirements that would be needed.[19]

Membership

Task Force members were nominated by the Governor and confirmed by the Senate in February 2020. The Task Force consisted of 14 voting members from a wide range of backgrounds, and seven non-voting members from state and local government.

Meetings

On July 22, 2020, the Task Force held its first meeting to introduce participants and elect a chair and vice chair. The Task Force met virtually 14 times between July 2020 and June 2021, at least monthly, with two meetings in January 2021 and two meetings in June 2021.[20]

Technical Advisory Groups (TAGs)

The Task Force established four Technical Advisory Groups (TAGs) composed of Task Force members, charged with developing proposals for Task Force consideration: Eligibility, Benefits and Affordability; Provider Reimbursement; Finance and Revenue; and Governance.[21]

Starting in November 2020, the TAGs met to discuss the issues in their respective scopes and develop proposals. Beginning in February 2021, the TAGs presented their proposals to the Task Force, and subsequently convened a final TAG meeting to integrate Task Force feedback; the Task Force then voted on the revised proposals. For each proposal, Task Force members were instructed to vote either "Accept", "Accept with Reservations" or "Do Not Accept." The TAG proposals are included in Appendix X.

[Placeholder for graphic: chart with months / TAG meetings]

Consumer Advisory Council (CAC)

The Task Force established a CAC to provide input from a consumer perspective. Based on the representation requirements called out in SB 770 and the Task Force's desire to prioritize diversity in geography, race, ethnicity, gender, sexual identity, sexual orientation and disability status, a Task Force subcommittee reviewed over 100 applications and recommended the participation of a diverse group of 13 individuals, with the approval of the full Task Force.[22]

The CAC began meeting in October 2020 and provided input into the Task Force and TAGs. At each meeting, Task Force and TAG members identified questions they hoped to get input on from the CAC. Input was used to shape proposals.

[Placeholder for sidebar or callout box with examples of the questions that were shared with CAC]

[19] Additional details can be found in Section 7 of SB 770.
[20] https://olis.oregonlegislature.gov/liz/2019I1/Committees/JTFUHC/Overview
[21] Technical Advisory Group information, including charters and meeting materials, is available in Appendix D and on the OHA website: https://www.oregon.gov/oha/HPA/HP/Pages/Task-Force-Universal-Health-Care.aspx
[22] The CAC also included two Task Force members who served as CAC chair and co-chair and were non-voting members of the CAC. Information on the selection process and membership is available on the Task Force website: https://olis.oregonlegislature.gov/liz/2019I1/Downloads/CommitteeMeetingDocument/226585

Intermediate Strategies Workgroup

In January 2020, state legislators asked the Task Force to include in its report a discussion of intermediate strategies that could form a bridge to a single payer system.[23] This led to the formation of the Intermediate Strategies workgroup, which met five times between March and May 2021.

[23] Oregon Senator Manning, and Oregon Representatives Hayden and Wilde, Letter to the Members of the Task Force on Universal Health Care. January 21, 2021. https://www.oregon.gov/oha/HPA/HP/TFUHC%20Meeting%20Documents/Intermediate-Strategies-Work-Group-Legislator-Letter.pdf

Task Force Preliminary Recommendations

Below are preliminary recommendations put forward by the Task Force. The recommendations provide an initial blueprint of the Plan as envisioned in SB 770. The Task Force recognizes the challenging work that remains unfinished and appreciates any opportunity granted by an extension to gain public feedback and further develop and refine a Plan that will provide universal coverage for all Oregon residents.

Each Task Force member has one vote except non-voting members (i.e., Legislative Assembly members, OHA and DCBS Directors or their designees(s), and Association of Counties representative). It is important to note that approval of the preliminary recommendations described below were not unanimous, with members often voting "approve with reservations" for individual Plan design elements and in some instances a minority of members voting "not to approve." For review and approval of recommendations, a majority is defined as at least 51 percent of the Task Force voting membership (eight of the 14 voting members).

Eligibility and Enrollment

The eligibility recommendation is grounded in the following shared values, that a universal health care program should be:

- **Equitable** – All elements of the proposed plan must facilitate access to care for communities historically underserved through intentionally created systems of oppression.
- **Inclusive** – Plan policies and elements must be designed to meet the needs of all Oregonians.
- **Simple** – Plan processes and policies must be simple and easy to access by all Oregonians.
- **Comprehensive** – Access to care and benefits must clearly and completely cover the needs of Oregonians

All Oregon residents and their dependents will be eligible, regardless of citizenship or immigration status. This is a clear requirement of SB 770. Additional work may be needed to identify how this will impact specific populations (e.g., Tribal members, those who are incarcerated) and how to ensure comprehensive collaboration with all partners.

Individual Tribal members will have the ability to seek care within the Indian Health Service Tribal systems and will be eligible for care through the Plan. During the development of the Single Payer, additional discussions with Tribal leaders will be needed regarding the relationship of the Tribal health system and the Single Payer.

All out-of-state residents who live in Washington, Idaho or California and either commute to work for Oregon-based employers or work remotely within a commutable distance, and their dependents, are eligible, regardless of citizenship or immigration status. SB 770 requires coverage of a "non-resident who works full time in this state and contributes to the plan." The Task Force discussed whether to limit eligibility for non-Oregonians to people who work in Oregon but live out of state. On the question of whether to include part-time Oregon workers who live out of state, one suggestion was to extend coverage to part-time employees commuting to Oregon for work when the Oregon employers currently offer full benefits to employees working less than 40 hours per week.

The Task Force also discussed the meaning of an "Oregon-based employer" and the need to distinguish between a Washington resident who works for Nike in Hillsboro and a New York resident who works for a

Nike store in Manhattan. Vermont proposed covering "non-residents who commute into Vermont to work for Vermont businesses,"[24] which approaches the intent of this provision of the Plan. The EBA TAG defined a "commutable" distance as 50-70 miles. While additional work is needed to fully define "visitor coverage," at a minimum the Task Force recommended that the Plan could offer a reduced set of benefits to temporary residents and visitors, which will cover care for injuries or acute illnesses.

Any eligible person will be automatically enrolled in the Plan; "opting out" is not a relevant concept for this Plan. Choice is an important value, and the Plan will not mandate that individuals receive health care services if they choose not to. However, the sustainability of the Plan depends on having every eligible person enrolled. An enrollment mandate is consistent with both the Vermont and New York proposals. Mandating enrollment impacts plan financing and issues such as the financial participation of Oregon and multi-state employers requires further exploration.

No income limits or means-testing to demonstrate eligibility. This recommendation is based on the first recommendation, inclusion of all Oregonians in the Plan. Additional work is needed to determine how eligibility will be determined in order to secure federal funding associated with Medicaid-eligible Oregonians.

No waiting period or minimum residency duration to establish eligibility. The Plan will provide a broad range of options for individuals to 'prove' residency, beyond the traditional mechanisms, such as a utility or credit card bill or driver's license. Examples of documents that could be used as proof include a letter from an Oregon relief/human services agency attesting to residency or a receipt from a motel, hotel, campground or RV park showing that current residence in Oregon.[25] One outstanding question is the mechanism by which eligible out-of-state employees will demonstrate eligibility for the Plan.

Eligibility will be tracked in a centralized database to which all providers have access. In addition, providers will be able to confirm enrollment at the point of need. To eliminate access barriers, there will be a "No Wrong Door" policy for individuals seeking care. Coverage will be easily confirmed by a provider so that 'proving' eligibility is not a barrier to receiving care. An easy to manage mechanism and process for confirming coverage will need to be established.

Once established, eligibility will not need to be regularly re-confirmed. To satisfy Centers for Medicare and Medicaid Services (CMS) requirements for drawing down federal dollars, the Plan requires a mechanism to confirm Medicaid and/or Medicare eligibility for some Plan participants based on age, disability status and/or income. This process will be as minimally burdensome as possible.

Cover individuals with Oregon Health Plan Coverage (Medicaid); If feasible, The Plan will also cover individuals with Medicare and TRICARE. The Task Force's preferred final outcome is full integration of public programs into the state's universal Plan. This is similar to New York's single-payer proposal, which outlined a full integration path and identified Medicaid integration as a minimum outcome.[26] Integrating Medicaid-eligible residents requires CMS waiver approval. Similarly, pursuing a Plan that also encompasses Medicare requires a waiver, which has not yet been accomplished by any other state.

[24] https://hcr.vermont.gov/sites/hcr/files/pdfs/GMC%20FINAL%20REPORT%20123014.pdf
[25] ODOT Residence Address Guidance https://www.oregon.gov/odot/dmv/pages/driverid/idproof.aspx
[26] https://www.rand.org/pubs/research_reports/RR2424.html

Eligibility will be disconnected from employment. Individuals who currently receive coverage from their employer will receive coverage from the Plan. Tying employment to health insurance promotes inequitable access and outcomes. The Task Force and its CAC both affirmed the desire to separate health insurance access from employment. Separating coverage from employment while retaining employer contributions to the system is complicated by ERISA and impacts the Plan's financing.

Enrollment will be simple and straightforward. Enrollment for OHP, Medicare or TRICARE will be seamlessly integrated with Plan. This recommendation reflects the values developed by the EBA TAG: simplicity and comprehensiveness.

Temporary residents and visitors shall be eligible for coverage of injury and acute illness while in Oregon if they do not have their own insurance coverage. This recommendation is based on the values of equity, inclusivity and comprehensiveness. There should be additional work to more fully define "visitor coverage" and to ensure there is some level of visitor contribution to the plan (e.g., a sales tax). It is expected that many temporary residents and visitors would have insurance which would be billed by the Plan. The Task Force also recognizes legitimate concerns about sustainability, risk pools and maximizing Federal match that are relevant to this recommendation.

Benefits Design

The benefits design recommendations are intended to support the development of a benefits package that is equitable, comprehensive, inclusive and meets the needs of Oregonians.

The Oregon Public Employees' Benefit Board plan will be the basis for a Plan benefits package. While several benefit packages were considered as the basis of the Plan's benefit package, the Oregon Benchmark plan was rejected as not sufficiently comprehensive to meet the Task Force values and goals. Oregon's Public Employees' Benefit Board (PEBB) provides coverage for certain benefit categories not included in the ACA Essential Services or the Oregon Benchmark (complementary care, adult dental, adult vision), or OHP (infertility).

The mental health benefit design will be influenced by OHP. Task Force members noted that OHP is more flexible and has wider coverage of mental health benefits (provider type, place of service, array of services) than most commercial coverage. PEBB operates more like commercial plans and the TAG wants to ensure that behavioral health is comprehensively covered.

Coverage details within each benefit category will be guided where possible by evidence-based recommendations and bodies (e.g., USPSTF, HERC, ACIP) with a commitment to identifying evidence that is inclusive of diverse populations.[27] This Task Force recommendation moves the Plan away from the "no limits" recommendation initially considered, toward a benefits plan that will align with best-available evidence-based best practice. While the Task Force supported limits on some categories of care strictly based on the evidence base, some members expressed concern that certain types of benefits and services and their impacts on some populations are not always well represented in the medical literature (e.g., gender-affirming care, complementary medicine). The Plan will include ways to ensure that evidence-based coverage decisions incorporate the members' individual needs and circumstances, while also controlling costs in a finite resource environment.

The Plan will adopt a single state formulary for its prescription drug benefit. This recommendation does not deal with purchasing, but will encourage the Plan to operate under a single drug list developed based on evidence such as Oregon's current Practitioner Managed Preferred Drug List with similar considerations for including evidence criteria that is inclusive of diverse populations.

The Single Payer will also work on other purchasing arrangements or other means to reduce the cost of prescription drugs. For example, some specialty drugs for cancer and other serious conditions may not be traditionally covered by a formulary and the Plan must have a way to allow appropriate access to these drugs. It may be helpful to solicit community input to govern development of the formulary.

[27] The US Preventive Services Taskforce (USPSTF) is an independent panel of national disease prevention and evidence-based medicine experts that makes evidence-based recommendations about clinical preventive services. The Health Evidence Review Commission (HERC) reviews clinical evidence to guide the OHA in making benefit-related decisions. The Advisory Committee on Immunization Practices (ACIP) is a group of medical and public health experts that develop recommendations on the use of vaccines in the U.S. civilian population.

Cost Sharing

The Plan will not impose premiums, copays, deductibles, or any other cost sharing on any members.[28] Higher income individuals will contribute more to the cost of the plan through income-based contributions as identified in the Revenue recommendations, rather than through participant cost-sharing. Peer-reviewed literature largely indicates that co-pays do not lead to better outcomes or less costly utilization. In addition, premiums and co-pays are unlikely to be significant sources of revenue at levels that are affordable to members.

The EBA TAG opposed the use of premiums, but some members noted that if premiums are needed to generate Plan revenue, they be collected by the Department of Revenue to optimize efficiency and reduce Plan administrative costs. Access to clinical care will not be tied to confirmation of premium payment.

Social Determinants of Health (SDOH)

The Task Force discussed the impacts of Social Determinants of Health and decided that while very important, it is not a distinct set of benefits that could be defined at this stage in the process. SDOH is an evolving and complex area and will not be rushed, and it was recommended further work will focus on how best to address SDOH. This effort will:

1. Finalize a definition of SDOH for the Plan that can build on the existing OHA definition and clearly acknowledges racism and colonialism as important social determinants.
2. Develop recommendations about how the Plan will address SDOH. The timeline of this work may depend on whether the Task Force is granted a legislative extension.

Long Term Care

The Task Force decided to incorporate long term care into the Plan under the current level of services and supports covered by Medicaid

Additional Considerations

The following items came up in TAG discussions and require additional consideration:

1. Encourage shared decision-making between the patients and their provider
2. Ensure there is adequate availability of providers to serve Plan participants

[28] While the Task Force approved this as part of the proposed recommendations, some members felt strongly that premiums for high-income individuals should be considered later as part of the Plan.

Provider Reimbursement

The Provider Reimbursement TAG proposed that Regional Entities will advise the Single Payer on methods and rates of reimbursement that will be regionally appropriate for institutional providers, group practice providers and individual providers (as defined by SB 770). The Provider Reimbursement TAG proposal as approved by the Task Force included one exception to this regional variability: the Single Payer will not reimburse institutional providers, like hospitals, fee-for-service.

Some components of the Provider Reimbursement TAG proposal were subsequently revised by the Governance TAG, and those revisions were approved by the Task Force. The following section describes the sections of the Provider Reimbursement TAG proposal as approved by the Task Force that were not subsequently revised.

Members may access care at the provider of their choosing, regardless of the physical region of the provider or enrollee. The Plan will not restrict patient access to care. Patient benefits will be accessible with all participating providers throughout the state and across regions.

Reimbursement methods and rates will be regionally tailored to meet the varying needs of providers and the populations they serve. The state will set a global budget, which may include capitated rates, for each region. Global budgets will be based on enrolled membership and demographics, ensuring sufficient funds are allocated for members with complex medical and behavioral needs. Pending waiver approval, the state will blend multiple funding sources, including Medicare, Medicaid and new revenues to fund the global budgets. Global budgets and/or capitated rates may have regional adjustments.

Rural, urban and marginalized communities

The reimbursement model will acknowledge the differing reimbursement needs of rural and urban providers with rural and frontier providers receiving higher reimbursement rates. Given the complex healthcare needs of marginalized communities, the Plan will have a reimbursement model that allocates sufficient funds to healthcare providers serving marginalized communities. These adjustments may be incorporated into the state rate setting process and/or regional reimbursement development.

Behavioral Health

There is a need for bidirectional integration of primary care and behavioral health for mild to moderate cases. However, this integration will not unintentionally redirect reimbursement away from behavioral health providers towards physical health providers. Until behavioral health providers share in the savings recouped by the medical system that were generated by behavioral health providers, it is not possible for behavioral health providers to rely solely on a global budget or to accept downside risk contracts. Community behavioral health safety net providers must be recognized and adequately funded so they may continue to offer critical preventive health services.

The Plan will preserve and expand types of participating providers. The Single Payer will ensure providers with a broad range of credentials are able to participate in the plan. The TAG envisions a system in which the

broadest possible range of provider types are eligible for the reimbursement opportunities outlined in this proposal. This includes, but is not limited to, traditional healthcare workers.

The Plan will improve pay parity. It is recommended to improve pay parity across types of individual providers within specialties to foster services that may be preventive, offer cost avoidance opportunities, or are not currently adequate for enhanced recruitment and retention. This will include such groups as primary care physical health, behavioral health, vision, dental, naturopathic physicians, traditional healthcare workers.

The Plan will advance forms of value-based payment. The Plan will 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 Plan will 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 will have influence over what outcomes are most important and thus incentivized in payment arrangements.

Support administrative simplification and efficiency. Providers are responsible for their own administrative costs. The Plan administrative costs must not exceed a predetermined ceiling.

Governance and Structure

The governance proposal developed by the Governance TAG and approved by the Task Force included a list of guiding values intended to ground the Single Payer Board:

- The Single Payer is dedicated to improving the health status of individuals, families, and communities.
- Health care, as a fundamental element of a just society, is to be secured for all individuals on an equitable basis by public means.
- Access to a distribution of health care resources and services according to each individual's needs and location within the state will 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.
- The components of the system must be accountable and fully transparent to the public.
- The Single Payer will invest in local communities and engage community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic, and racial disparities in health care.
- The Single Payer and Regional Entities must prioritize their obligations to individuals, families, and communities of Oregon with the sound stewardship of taxpayer dollars

Single Payer Structure

The Single Payer will be a public entity governed by a board. The Single Payer will be a public entity with reporting responsibility to the Oregon Legislature and Governor. It will have the authority to accept all types of funds (i.e., federal, state, donations) and will not be subject to Oregon's tax rebate. The Single Payer will have authority for developing and maintaining prudent financial reserves to ensure solvency. Funds appropriated for the Plan are only for use by the Single Payer.

The members of the Single Payer Board will represent a balance of expertise in healthcare and have an authentic community voice. Board members will be appointed by the Governor and confirmed by the Senate and will not demonstrate conflicts of interest at time of appointment, during their terms, and for a significant period after leaving the Board. Board members will be compensated for their time.

The Board will have both community and regional/delivery system advisory committees. Additional discussion will be needed to determine the number of Board members and their terms of membership, as well as the key staff positions to be established for the Single Payer and its Board. The Board will recruit and hire key staff for the Single Payer. Single Payer staff will not be politically appointed.

Single Payer Roles

Single Payer will apply the reserve powers unique to the Single Payer for financial management and stewardship. The Single Payer will establish all aspects of regional global budgets, lead quality and cost control efforts, support regional economies and as possible, will direct funds to entities addressing social determinants of health. Responsibilities related to the global budget include designing payment structures

and rate setting to the delivery systems and ensuring payments are adjusted for reductions in administrative costs associated with the system. Quality and cost control efforts include:

- Development of performance improvements broadly
- Administrative simplification
- Set utilization control policies
- Organization of large capital investments to ensure improved access to care and health equity
- Explore multi-state purchasing approaches
- Prevent fraud, waste, and abuse

The Single Payer will oversee program administration and ensure quality operations. The Single Payer will be responsible for the following program administration and quality oversight functions:

- Claims administration
- Financial management
- Data collection, analysis, and evaluation
- Quality assurance and improvement, patient safety, and patients' experience
- Customer service, including complaints, grievances, member education and communication

The Single Payer will develop and implement program policy. The Single Payer will determine coverage including monitoring and addressing changes to health care (i.e., technologies, therapies, pharmaceuticals) and conduct strategic planning for longer-term system success.

The Single Payer will support delivery system reform and improvement. This includes development of value-based payment mechanisms, tracking spending and utilization, data analysis and reporting.

The Single Payer will achieve health equity to improve access and quality of care. This includes goal setting, data analysis and reporting (utilization, quality, outcomes) and reliable information about race, ethnicity, and other aspects at the time of registration.

The Single Payer will support workforce development. Workforce development will include identification of workforce capacity compared to Oregonians' needs and working with stakeholders to address needed funding and develop opportunities for and access to training. The Single Payer will support workforce recruitment, retention and development, prioritizing recruitment of clinicians of color.

The Single Payer will develop and maintain the population health-based information system. The population-based health information system will include clinical, financial, utilization, quality, and other data needed to evaluate systemwide performance and quality. The system will be built and maintained to provide transparency and access to the data for the population at large.

Fiduciary Responsibility

The Single Payer will establish a budget that ensures adequate resources for both covered services and administrative costs to achieve the goals and vision of the Single Payer program.

This responsibility will include establishing and ensuring appropriate restricted reserves, and establishing a mechanism to receive gifts, donations, grants and other revenue. The Single Payer will establish and maintain plans for emergency preparedness. The Single Payer will be subject to regular external audits.

The Single Payer will establish budgets for each region's delivery system. With advice from the Regional Entities, the Single Payer will establish a budget for each region's delivery system. The Single Payer will establish contracts with every provider including the establishment of payment levels and methods. It will ensure that payments are adjusted for reduction in administrative costs and are responsible for claims payment for covered services. The Single Payer will establish and administer quality improvement and cost containment mechanisms.

The Single Payer will establish budgets for the regional entities. The Regional Entities will advise the Single Payer, with input from their regions' stakeholders and community members. The regional entities' budgets will include funding for regional infrastructure and capital investments, as well as funding for regional investment for delivery system innovation.

As a government entity, the Single Payer will maintain a government-to-government relationship with the Tribes.

Regional Entities Roles

Regional Entities will have advisory, convening, regional planning and delivery system reform roles. The Task Force recommends that the Single Payer plan operate in partnership with a network of Regional Entities. These entities will support the Single Payer in convening and collaborating with stakeholders and ensuring that the Single Payer is responsive to the unique needs of the wide range of communities across the State. This includes the following responsibilities:

- Advising the Single Payer related to management/implementation/coordination of care for the region, which could include counseling on budget issues from the Single Payer entity to region's providers and providing support on contract and methods for reimbursing providers
- Manage a budget for health improvement, medical capital and 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 Entities
- Assist and advise providers on the creation/improvement of delivery systems, foster innovation, promote quality and cost control efforts, and provide input on how incentives will be targeted and measured
- Promote collaboration across the regional delivery system and other regions
- Provider contracts

The Single Payer may contract with a Regional Entity to serve as a Third-Party Administrator or Administrative Services Organization to facilitate health care administration if this approach proves to be cost effective without undermining other values important to the success of the Single Payer.

Regional Entities Structure

There will be one Regional Entity per region; Regional Entities will be as transparent and publicly accountable as the Single Payer. A board of Regional Entities will recommend budgets and contracts to the Single Payer entity for each region. The Single Payer will determine the number of regions and their boundaries. The Task Force recommends that novel approaches will be considered, such as the regional equity coalition design or other alignments with community or regional structures.

The Single Payer will determine the criteria for Regional Entities and will ensure that each Regional Entity is regularly convening and engaging stakeholders in the region. The Single Payer's role will include ensuring that the Regional Entity conducts ongoing stakeholder engagement as part of the Regional Entity's work to determine spending for health improvement, medical capital and infrastructure projects.

[Add graphic representing the structure and roles of the Single Payer and the Regional Entities.]

Public Trust Fund and Authorities

The Governance TAG discussed the following authorities for establishing the Single Payer, which were approved by the Task Force:

The Legislature will need to:

- Establish the Single Payer and codify it as an independent public entity, such as OHSU or SAIF, responsible for providing universal, publicly funded health coverage for Oregonians
- Establish the Single Payer Public Trust Fund.

The Task Force suggested sample legislative language to establish the Single Payer Public Trust Fund:

The Oregon Single Payer Public Trust Fund will be established separate and distinct from the General Fund. The Oregon Single Payer Public Trust Fund may include:

- Federal funds from Title XIX or XXI of the Social Security Act, and state matching funds, that are made available to the fund.
- Contributions from the United States Government and its agencies for which the state is eligible provided for purposes that are consistent with the goals of the Oregon Single Payer program.
- Moneys dedicated or appropriated to the Oregon Single Payer Public Trust by the Legislative Assembly for carrying out the provisions of the Oregon Single Payer Program.
- Health care premium contributions.
- Interest earnings from the investment of moneys in the fund.
- Gifts, grants or contributions from any source, whether public or private, for the purpose of carrying out the provisions of the Single Payer Program.

All moneys in the Oregon Single Payer Public Trust Fund are continuously appropriated to the Oregon Single Payer to carry out the mission and vision of the Oregon Single Payer program. The Oregon Single Payer Public Trust shall be segregated into subaccounts as required by federal law. (*e.g. for Medicaid, Medicare*)

Authorities needed by the Single Payer

The Single Payer entity will need the following authorities:

Financial Authorities:

- To set its operating budget (subject to Legislative accountability)
- To set and distribute the budget for the regional entities
- To set up appropriate financial reserves
- To apply and accept grant dollars

Governance Authorities:

- To establish the Single Payer Board, any subcommittees or advisory committees and determine the Board/committee governance structure

- To oversee and delegate to the Regional Entities a budget for health improvement, medical capital and infrastructure projects
- To maintain government-to-government relationship with Tribes
- Government-to-government relationship with other states/countries

Plan Administrative Authorities:

- To establish covered benefits for all Oregonians
- To work (through the Regional Entities) with local governments on the single payer program
- To contract with providers
- To develop and implement payment methodologies, and pay for covered services
- To administer the program and ensure quality operations, including ability to subcontract for program administration if cost efficient
- To develop and implement program policies

Quality Assurance and Cost Containment Authorities:

- To implement quality assurance and cost-control measures to ensure safety, equity and patient experience
- To conduct bulk or multi-state purchasing approaches

Data Collection, Analysis and Distribution Authorities:

- To collect any needed data for tracking spending, utilization and reliable REALD/SOGI information to evaluate systemwide performance, quality and equity
- To allow access to the above data

Additional authorities - federal law, state regulations and waiver authorities. Specific current federal and state law/regulations may need adjustment for the Plan and may need waiver approval or law changes to authorize it. The specifics of each of the requested authorities will require a detailed analysis of current Medicaid, Medicare and other federal and state regulations/statutes as final details of the Plan are completed. The areas of needed changes will likely include the following:

1. **Medicaid waiver authority**, including:
    1. Amend Oregon's Medicaid 1115 demonstration waiver
    2. Other waiver authority as needed
2. **Medicare exemption**
3. **ACA requirements**, which could include:
    1. Section 1332 waiver authority to diverge from ACA rules on how coverage is obtained, paid for, benefits provided or other current commercial plan requirements
4. **ERISA pre-emption**
5. **Federal budget neutrality**
6. **State law/regulation**

Funding the Plan

The following section describes the revenue proposal as developed by the Finance and Revenue TAG and approved by the Task Force.

The Task Force recognizes that these revenue recommendations will need to be accompanied by additional financial analyses related to expected costs of the Plan and anticipated savings. Viewing the revenue recommendations in isolation may be misleading as they do not incorporate a "total cost" or "total savings" approach to understanding the overall financial implications of the plan. It is understood that the tax recommendations below will be paired with likely reductions in administrative costs, individual health care expenditures and employer outlays. These will need to be analyzed and presented in concert with the revenue plan at a later date in order to give a fuller picture of the financial implications of the plan.

The revenue recommendation is grounded in the following principles:

- **Progressive.** The tax rate increases as the taxpayer income (ability to pay) increases.
- **Easy to understand.** Taxpayers will understand how the tax works/how to pay it.
- **Stable.** A financing system that can weather economic and demographic changes.
- **Permanent.** The revenue stream will not include an automatic sunset.
- **Predictable.** Program officials will be able to identify the amount that a source can raise
- **Scalable & Adequate.** The source will support universal health care implementation over time and support full implementation needs.
- **Address ERISA considerations.** Avoid being vulnerable to ERISA court challenges and consider automatic triggers on other revenue streams in response to an effective ERISA challenge.
- **Dedicated trust fund.** All revenue raised to support the Plan will go into a dedicated fund that is not subject to the state "kicker" law.
- **Maximize federal dollars.** Consider opportunities to maximize federal revenue sources before turning to new revenue streams.

The Task Force recommended funding the Plan with a combination of a new payroll tax, an increase in the personal income tax, and the creation of a sales tax. While additional work will be needed to further refine the assessment rates, the Task Force recommends the following parameters guide development of these three taxes:

Payroll Tax Parameters

The payroll tax will apply a flat rate on wages up to the Federal Insurance Contributions Act (FICA) limit (currently ~$138,000, subject to annual increase), and higher rates on income over the FICA limit.

Rates will rise as income increases over the FICA limit, adding progressivity to the tax. Since the federal government may revise or eliminate the FICA limit, the legislature will consider how to best frame this parameter so as not to eliminate its intent in the case of federal changes.

The payroll tax applies only to wage-based income. Non-wage income, like capital gains and dividends, will continue to be taxed under the income tax component of this proposal.

The payroll tax will be assessed on the employer. The Task Force discussed whether an employer-paid payroll tax will lead employers to challenge the tax in court as a violation of ERISA. The group considered economists' argument that an employer-paid payroll tax will be borne at least in part by employees.[29]

These members proposed that employers will be getting a windfall under the Plan, because employers will no longer need to pay for employer sponsored insurance, so employers will pay this tax to ensure they are paying their fair share. If the employers do not pay the payroll tax and also stop providing employer-provided insurance, businesses income tax revenues will go up because taxable income will increase due to having fewer expenses. Also discussed was the fact that no plan is fully ERISA-proof.

Additional work is needed to identify the extent to which an employer-focused payroll tax increases likelihood of an ERISA challenge. If it is determined that the risk is high or if there is a successful ERISA challenge, the payroll tax can be made employee-facing.

The payroll tax applies to all firms, regardless of size.

Income Tax Parameters

The Income tax adjustment is a rate increase for all households above a moderately low eligibility threshold (300% FPL, or approximately $79,000 for a family of 4). At present, most Oregon taxpayers are subject to more than one tax rate. Individual taxpayers pay 4.75% on their first $3,600 of income and 6.75% on income between $3,601 and $9,050 for an individual. See Table XX for the full list of tax rates by income for single and married joint filers.

Table XX. Current Oregon Income Tax Rates

Taxable Income		Tax Rate
Single Filers	**Married Joint Filers**	
$0 - $3,600	$0 - $7,200	4.75%
$3,601 - $9,050	$7,201 - $18,100	6.75%
$9,051 - $125,000	$18,101 - $250,000	8.75%
$125,001 and up	$250,000 and up	9.9%

For example, a married couple filing together with $200,100 in combined annual income pays $17,003 in Oregon taxes, based on the following formula:

Income	Example Income	Associated Tax Rate	Amount Due (rounded)
$0 - $7,200	$7,200	4.75%	$342
$7,201 - $18,100	$10,900	6.75%	$736
$18,101 - $250,000	$182,000	8.75%	$15,925
$250,000 and up	$0	9.9%	$0
Total Tax Due	$200,100	--	$17,003

[29] https://www.taxpolicycenter.org/briefing-book/how-are-federal-taxes-distributed
https://www.taxpolicycenter.org/resources/tpcs-microsimulation-model-faq
https://www.taxpolicycenter.org/taxvox/most-households-its-about-payroll-tax-not-income-tax

Under this plan, the income tax rate for many Oregonians with income impacted by the third tax tier and above will pay higher rates for income in those tiers.

Oregon will establish at least one new income tax bracket for high income earners. The example household from above with income of $200,100/year will have some of their income taxed at 13 percent a year. If the new bracket starts at $200,001, the example household will pay a total Oregon tax of $17,007, as $100 of their annual income will be subject to the higher tax rate.

Sales Tax Parameters

If additional revenue is needed to support the Plan, Oregon would establish a dedicated sales tax with the following parameters:

The sales tax applies to all goods and services except "essential goods and services." "Essential goods and services" will be defined narrowly to include items such as on groceries and utilities.

The state will establish a refundable sales tax credit to decrease burden on low-income families. Individuals and families earning below 200% will be eligible for a 100% credit of the sales tax based on family size.[30] Households with income up to 300% FPL will receive a partial credit.[31]

Recommended Order for Establishing Taxes

In determining rates for the full package, the payroll tax rates will be set first, followed by changes to income tax rates. After the payroll tax and income tax rates are set and likely collections determined, if additional revenue is needed a sales tax will be established. In addition, as an alternative to the sales tax, further increases to the payroll and income taxes for high income earners will be considered to generate the revenue needed.

[30] In 2021, 200% of the federal poverty level is $25,520/year for an individual and $52,400/year for a family of four.
[31] In 2021, 300% of the federal poverty level is $38,280/year for an individual and $78,600/year for a family of four.

Next Steps

SB 428 (2021) - Task Force Extension

[Placeholder to be added following discussion of the extension workplan proposal]

Intermediate Strategies

[Placeholder suggestion for where to outline proposed intermediate strategies as developed by the Intermediate Strategies Workgroup]

Works Cited

Appendix A. SB 770

[include full text of SB 770]

Appendix B. Task Force Rules and Operating Procedures

[include either full text of rules, and operating procedures, or links to materials online]

Appendix C. Task Force, TAG and Committee Materials

[include either full documents or links to materials online]

Appendix C1 – Task Force

membership, staff, charter, meetings (structure/process/topics addressed), decision-making process

Appendix C2 – Technical Advisory Committees

membership, staff, charter, meetings (structure/process/topics addressed)

Includes the following

- Appendix C 2(a) Governance TAG
- Appendix C 2(b) F&R
- Appendix C 2(c) EBA
- Appendix C 2(d) Provider Reimbursement

Appendix C3 – Consumer Advisory Committee

membership, charter, nomination process, meetings, input to TAGs

Appendix C4 – Summary of Public Comment

Appendix C5– Interim Strategies Workgroup [placeholder, pending TF discussion]

Appendix D. TAG proposals

[include either full text or links to materials online]

Appendix E. Misc.