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

Interim Status Report

June 2021

TASK FORCE ON UNIVERSAL HEALTH CARE

TO: Oregon Legislative Assembly
RE: Interim Status Report July 2020-June 2021

In 2019, Oregon legislators created the Joint Task Force on Universal Health Care (Senate Bill 770), with the goal of establishing the first state single-payer system in the country. The Task Force was charged with designing a health care financing system that is equitable, affordable, and available to all residents; a system that recognizes health care as a fundamental element of a just society.

As the Task Force approaches an important juncture in its work, this interim progress report is submitted for your consideration. The progress report provides an overall summary of the work to date, the rationale for its initial design considerations, and a description of the work that is expected to be completed with additional time and resources. ***The work of the Task Force is incomplete, and we anticipate that with needed additional work and community engagement the recommendations will further develop and change.***

Based on a set of guiding principles, the 20-member Task Force has been working tirelessly, determined to craft a feasible single-payer proposal in the time permitted by the bill. With limited resources, facing a delayed start due to an unprecedented global pandemic, and adapting to a remote collaborative process, the Task Force has made considerable progress in developing a preliminary set of design proposals, offering an unfinished blueprint for universal coverage in Oregon. To be clear, the work is incomplete and requires additional time and resources from the legislature if this effort is to succeed. To be determined are legal and financial hurdles; the design of a fair tax and revenue proposal; the uncoupling of health coverage from employment; and the procurement of an exemption to ERISA pre-emption, as well as necessary federal waivers. The Task Force remains optimistic Senate Bill 428 (2021) will afford it the ability to finish its work.

In January, legislators also called upon the Task Force to identify intermediate strategies to promote affordable universal coverage consistent with and forming a bridge to the Task Force's long-term, overall plan in preparation for the 2022 legislative session. The group embraced this additional opportunity and delivered a set of policy options also described in this interim progress report.

Robust community engagement is required to complete the work envisioned in SB 770. Public input and awareness will be critical to ensure the final design proposal by the Task Force meets the unique needs of residents across Oregon. The engagement plan will include meeting with individuals and families who live in underserved and rural areas; speaking with marginalized populations, including BIPOC communities and tribal communities; and seeking meaningful participation from and to empower those who are often excluded from the policy process, among other important groups.

It has been a privilege to be trusted by legislators and Governor Brown to complete the work to date and to contribute to a process that will lead Oregon to be the first state to craft a comprehensive single-payer proposal for consideration by the Legislative Assembly. The members of the Task Force are humbled by and honored with this responsibility.

Respectfully submitted,

Bruce Goldberg, Chair

Edward Junkins, Vice-Chair

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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 work of the Task Force is guided by a central principle: health care is a fundamental right and only a single payer system will be able to address the health disparities and disfunction within the current health care system by ensuring all individuals are provided health care on an equitable basis. The goal is a publicly funded single payer 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 Advisory Groups (TAGs): Eligibility, Benefits and Affordability; Provider Reimbursement; Finance and Revenue; and Governance. In total, the TAGs held 28 meetings over a nine-month period, presented proposals to the Task Force and revised these 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, which met monthly. Lastly, as requested by the legislative members serving on the Task Force, a separate Intermediate Strategies Work Group 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 the 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 September 2022 to further develop and refine recommendations. Should the Legislative Assembly approve this extension, Task Force members wish to engage in a robust community engagement process to solicit feedback on preliminary recommendations summarized in the Plan 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.

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 collaborate with the public through Oregon and further develop and refine a Plan that will provide universal coverage for all Oregon residents.

Eligibility and Enrollment

- Everyone residing in Oregon is eligible for the Plan through a simple enrollment process.

Covered Benefits

- 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-informed 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.

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.
- Single Payer will maintain a government-to-government relationship with the Sovereign Tribes as a government entity.
- 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.

Program Funding

- Assumes existing state and federal health care revenue will be applied to the Plan.
- 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.
- Program will be structured to be financially sustainable and promote affordability for all residents.

The work of the Task Force is **incomplete**. The initial set of preliminary recommendations outlined in this status report require refinement, expertise, and public collaboration in order to finalize a Plan for Oregon to consider as envisioned by SB 770. There is significant work that remains, including: decisions on outstanding design elements; refined estimates of total projected health care expenditures; estimates of potential cost savings accrued from administrative simplification; revenue estimates resulting from new revenue sources; legal analysis of federal and state authorities to determine ongoing federal and state financial contributions; and analysis of combined costs and savings for households and select stakeholder groups under the Plan as compared to the status quo.

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INTRODUCTION

For decades, even after passage of the Affordable Care Act (ACA), a number of trends highlight the inherent challenges states face in moving towards a state-based system of universal care for all residents. In Oregon, these trends include:[1]

- Prices for health care services are rising
- Premiums and deductibles are growing faster than household incomes
- Growing burden of health care costs is resulting in Oregonians not seeking or delaying care, and/or being unable to pay their medical bills
- Black people, Indigenous people and other people of color are more likely to be uninsured than their white counterparts
- Among the insured, 50 percent of people with health insurance remain underinsured (i.e., insured but unable to afford cost-sharing including monthly premiums and co-pays)
- Employer-sponsored coverage is increasingly too expensive for businesses, individuals, and families, growing three times faster than personal income
- Individuals and families are increasingly churning on and off public and private health insurance
- Health care financing system is increasingly fragmented, inefficient, and administratively complex

The cost of health care in Oregon is projected to continue growing faster than both the state's economy and Oregonians' wages. When the cost of health care grows faster than the economy and wages, Oregonians are left paying a larger percentage of their income on health care. Rising health care costs also mean less money for investments in wages, retirement, and critical public services.[2] As these trends continue, states are seeking policy proposals, ranging from incremental efforts to address rising health care costs to designing systems that advance universal health care.

COVID-19 has impacted Oregonians in multiple ways, including employment, access to insurance coverage and use of health care. The pandemic only exacerbated and magnified a number of historic challenges facing Oregonians, including inadequate access to high-quality care, coverage inequity, health disparities, marginal care, disproportionally high rates of disease burden and illness among Black people, Indigenous people, and other people of color, and other structural challenges in our fragmented health care system. The crisis created by COVID-19 also raises questions regarding the role of the public sector in addressing health inequities and ensuring equitable access and culturally appropriate services to communities of color and marginalized communities.

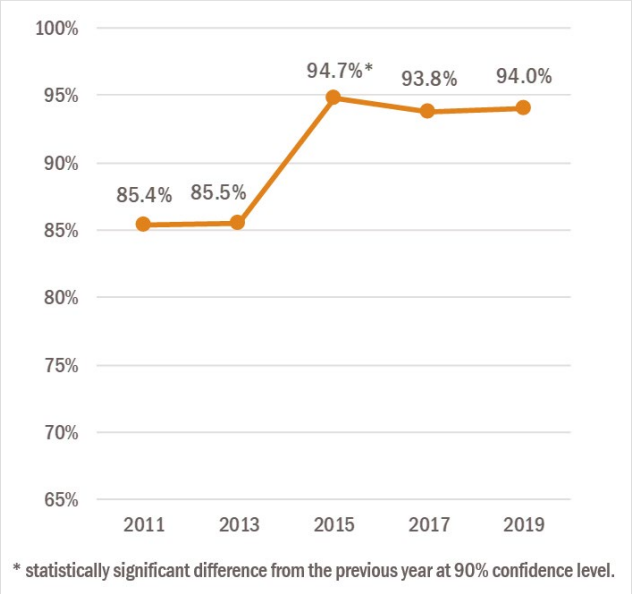
[1] Oregon Health Authority (Aug. 21, 2020). Oregon Health Care Landscape. https://olis.oregonlegislature.gov/liz/2019I1/Downloads/CommitteeMeetingDocument/225798

[2] Oregon Health Authority, Sustainable Health Care Cost Growth Target Recommendations Report (Dec. 2020). https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost%20Growth%20Target%20Committee%20Recommendations%20Report%20DRAFT%2012.22.2020.pdf

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. [3] 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.[4]

Figure 1. Percent of Oregonians Insured in 2019



Source: Oregon Health Insurance Survey (2019). [5]

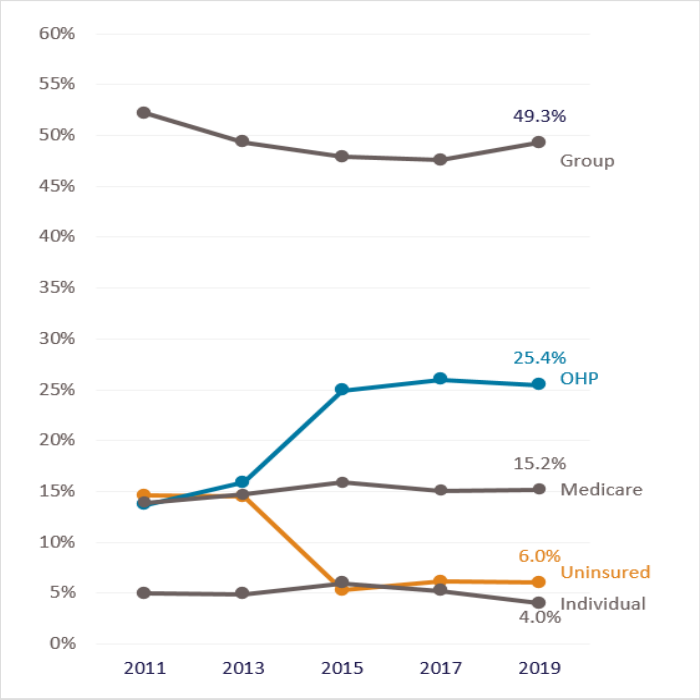
In 2019, about six percent of Oregonians were uninsured. More than three-fourths of those uninsured were eligible for either Medicaid or a subsidized individual plan; approximately 26% were eligible for the Oregon Health Plan but not enrolled, and another 52 percent were eligible for financial assistance through the Affordable Care Act marketplace but did not purchase coverage.[6] Some proportion of the remaining uninsured population is ineligible for public coverage based on their immigration status. Beyond the unauthorized immigrant population, there are many Oregonians with a valid immigration status that does not qualify them for comprehensive coverage, including the Legal Permanent Resident (LPR) population. Individuals residing in the U.S. for less than five years (or who are otherwise not naturalized), face a 5-year waiting period to obtain coverage. In 2019 there were 8,521 LPRs in Oregon (Source: U.S. Department of Homeland Security.)

[3] Oregon Health Authority, Oregon Health Insurance Survey (OHIS), 2019. https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Insurance-Data.aspx
[4] https://www.commonwealthfund.org/blog/2021/update-how-many-americans-have-lost-jobs-employer-health-coverage-during-pandemic
[5] OHIS, op. cit. *Point-in-time health insurance coverage rates, 2011-2019*
[6] Oregon Health Authority, Oregon Health Insurance Survey (OHIS), 2019.

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.

According to the Oregon Employment Department, in 2019, approximately, 59 percent of all private employers (2,700 employers) offered health benefits to some or all employees. Offerings differed by industry and employee type. A 2019 survey indicated that only 30 percent of small Oregon businesses employing less than 50 employees offered employer-sponsored coverage, as compared to 93 percent of larger business.[7] Furthermore, two out of 10 employers extended health benefits to part-time workers in the industries with the most prevalent offerings including private education services, health care, and professional and technical services.[8] Two-thirds of Oregon employers that provided health benefits report that high cost is the most important effect on their business or workforce over the past year. Employers also reported the high cost of providing health benefits impacted their budgets, reduced their profits, and placed financial burden on their companies. [9]

Figure 2. Insurance Coverage 2017-2019



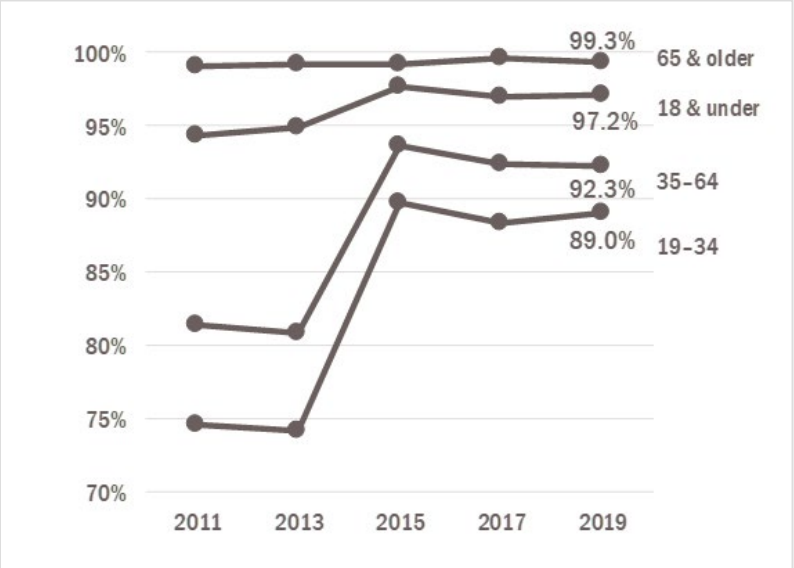
Source: Oregon Health Insurance Survey (2019). [10]

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.[11] Between 2010 and 2016, premiums increased an average of 25 percent and deductibles rose by 77 percent, while

[7] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey-Insurance Component, 2012-2019. Medical Expenditure Panel Survey Private Sector Insurance Component, Table II.A.2. https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2019/tiia2.htm
[8] Oregon Employment Department (Jan. 2019). Employer-provided Benefits: Offering, Enrollment, and Rising Costs. https://www.qualityinfo.org/documents/10182/13336/Employer-Provided+Benefits+Offerings%2C+Enrollment%2C+and+Rising+Costs?version=1.0
[9] Ibid.
[10] OHIS, ibid. *Point-in-time health insurance coverage rates, 2011-2019*
[11] Measuring the Burden of Health Care Costs on Working Families, 2019. https://ldi.upenn.edu/healthpolicysense/measuring-burden-health-care-costs-working-families

household income only increased 15 percent. Total premiums have grown three times faster than personal income, and the percentage of premiums paid by workers has grown almost four times as fast. See Figure 3.

Figure 3. Percentage of Insured Young Adults



Source: Oregon Health Insurance Survey [12]

The pandemic has highlighted structural problems in the system, especially inequities in access and care. It also exposed system inefficiencies that existed previously.

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
- 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.

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 Employee Retirement Income Security Act of 1974 (ERISA).

[12] OHIS, op. cit. *Point-in-time health insurance coverage rates, 2011-2019*

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.[13]

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.[14] 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.[15] Similar with 1115 waivers, the alternative program also cannot increase federal costs.

State Efforts to Establish Universal Health Care Programs

As directed by SB 770, 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 (H. 202, 2011), Colorado (Amendment 69, 2016), California (SB 562, 2017) and New York (AB 4738, 2017). Information on efforts in California, Colorado, New York and Vermont. The Task Force reflected that all four attempts failed, at least in part, due to insufficient or unpopular financing mechanisms.

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.[16] 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, as previously stated, 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 (see next page):[17]

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[13] 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.

[14] 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.

[15] 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

[16] 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

[17] Universal Access to Care Work Group, Report on Barriers and Incremental Steps to Universal Access. Legislative Policy and Research Office, 2018.

- 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
- Difficulty in evaluating short- and long-term impacts around cost and utilization 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 preliminary recommendations.

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: 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.[18] The mandate was not implemented, but the state did expand its Medicaid program and named it the Oregon Health Plan.[19]

2002: Oregon Comprehensive Health Care Finance Act

The Oregon Comprehensive Health Care Finance Act of 2002 (Ballot Measure 23) was a citizen's initiative petition that would have created a single payer health care system to provide health care to every person in Oregon starting in 2005.[20]

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 (see next page):

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https://www.oregonlegislature.gov/salinas/HealthCareDocuments/UAC%20Work%20Group%20Report%20%20FINAL%2012.10.18%20.pdf

[18] Robert A. Berenson, Emily Hayes, Nicole Cafarella Lallem and, Health Care Stewardship: Oregon Case Study, Urban Institute, January 20, 2016. https://www.urban.org/research/publication/health-care-stewardship-oregon-case-study

[19] Oregon Senate Bill 27 became Oregon Revised Statutes §§ 414.025 - 414.750 (1989) https://www.oregonlegislature.gov/bills_laws/ors/ors414.html

[20] Oregon Legislative Revenue Office, Research Brief: Ballot Measure 23 Health Care Finance Plan. October 2002. https://www.oregonlegislature.gov/lro/Documents/rb11_02ballotmeasure23.pdf

(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*.[21] The study found that a health care program covering all state 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: 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.[22] The "Hope Amendment" proposes adding language to the state constitution directing 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 Legislative Assembly as Senate Joint Resolution 12. The resolution passed and will be sent to the voters to consider during the November 2022 general election.[23]

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 Legislative Assembly (December 2018) that included the following recommendations for incremental state-level policy approaches intended to move the state toward a universal coverage program:[24]

- **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.

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[21] 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
[22] 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
[23] 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
[24] 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

- **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 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 public option (see House Bill 2012 A) proposal amended into SB 770 in the 2019 session.

TASK FORCE COMPOSITION AND STRUCTURE

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

The Task Force was to begin meeting in March 2020 but was delayed due to the COVID-19 pandemic. In the August 2020 2nd Special Session, resources for the Task Force's work were reduced, including the three FTE staff originally allocated in 2019.[25] The timeline, however, did not change with a report still due in June 2021. In 2021, the Task Force recognized the need to continue its work during an "extension" of the timeline into 2022.

To maintain a transparent process and accommodate COVID-19 restrictions on in-person gatherings, the Task Force, TAGs, CAC and work groups have exclusively met virtually. Meetings were live-streamed via the Oregon Legislative Information System, and recordings were posted online.[26] Meeting links were made available to the public, and every Task Force and TAG meeting included an opportunity for written and oral public comment. Members of the general public were additionally encouraged to share public comment in writing. [27,28]

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 Two 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.*[29]

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 Four 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
- System must be accountable and transparent and include meaningful public participation

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[25] 80th Oregon Legislative Assembly, Enrolled Senate Bill 5723, 2020. https://olis.oregonlegislature.gov/liz/2020S2/Measures/Overview/SB5723
[26] 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
[27] Task Force Guide (Dec. 2020). How to Register for Remote Public Testimony on the Task Force on Universal Health Care. https://olis.oregonlegislature.gov/liz/2019I1/Downloads/CommitteeMeetingDocument/227016
[28] Task Force Guide (Dec. 2020). Providing Public Comment at the Consumer Advisory Committee or Technical Advisory Groups. https://olis.oregonlegislature.gov/liz/2019I1/Downloads/CommitteeMeetingDocument/227222
[29] 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 Five 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.** 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-Informed Coverage.** 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 Six 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 House Bill 3260 (2013)
- 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.[30]

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.[31] Rules and operating procedures (Appendix B), approved on September 29, 2020, governed Task Force operations and meeting procedure.

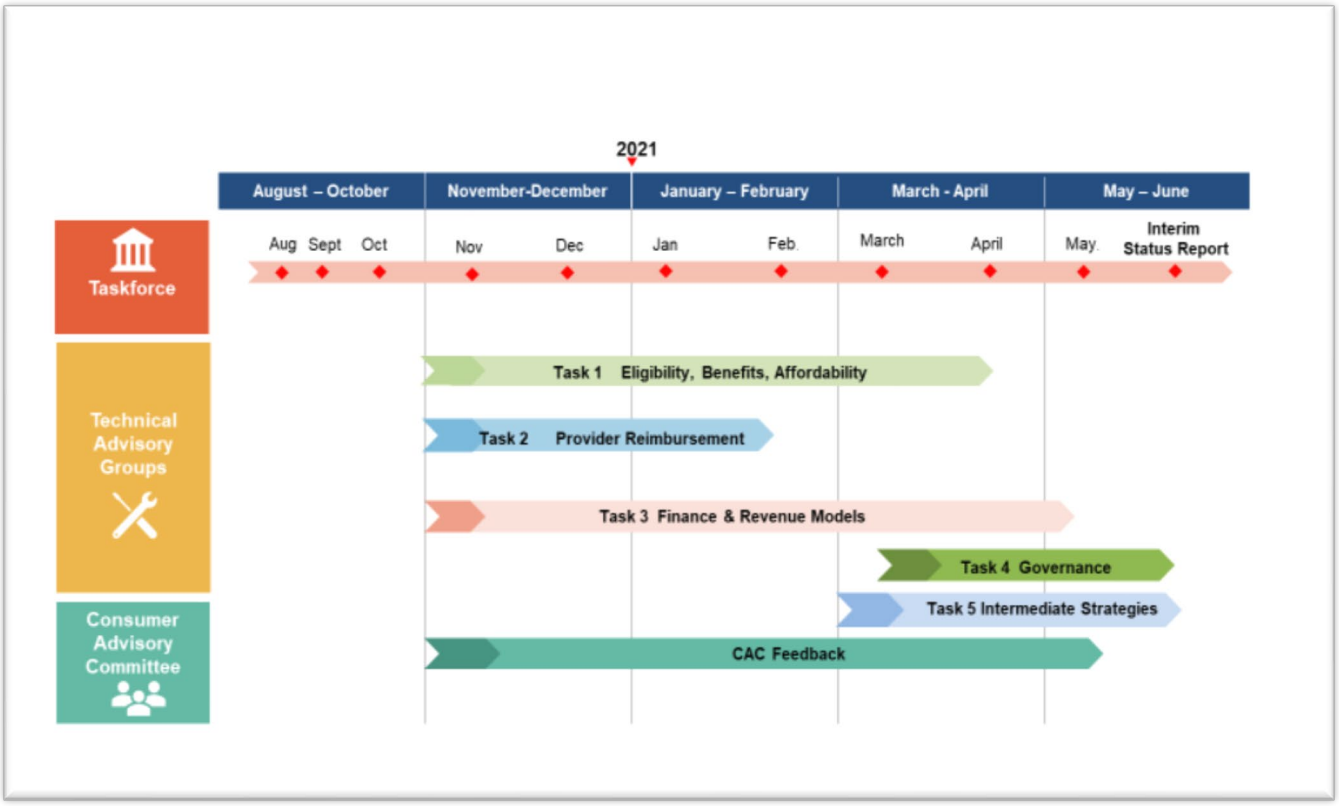
Technical Advisory Groups (TAGs)

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 (EBA); Provider Reimbursement; Finance and Revenue; and Governance.[32]

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 members, key tasks, meeting topics, proposals and proposal vote counts are included in Appendix E. Details of the work plan and timeline are depicted in Figure 4 (see next page).

[30] Additional details can be found in Section 7 of SB 770.
[31] https://olis.oregonlegislature.gov/liz/2019I1/Committees/JTFUHC/Overview
[32] Technical Advisory Group information, including charters and meeting materials, is available in Appendix E and on the OHA website: https://www.oregon.gov/oha/HPA/HP/Pages/Task-Force-Universal-Health-Care.aspx

Figure 4. SB 770 Health Plan Design – Work Plan and Timeline



Consumer Advisory Committee (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.[33]

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 for input on from the CAC. Input was used to inform proposals developed by the TAGs. Feedback from the CAC is highlighted in a memo (Appendix C) received by the Task Force in May during a joint meeting of the CAC and the Task Force.[34]

Intermediate Strategies Work Group

In January 2021, legislator members of the Task Force asked it to include in its report a discussion of intermediate strategies that could form a bridge to a single payer system.[35] This led to the formation of the Intermediate Strategies Work Group, which met five times between March and May 2021.

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[33] 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

[34] Consumer Advisory Committee (May 27, 2021). Memo to the Task Force. https://olis.oregonlegislature.gov/liz/2019I1/Downloads/CommitteeMeetingDocument/243443

[35] Oregon Senator Manning, and Oregon Representatives Hayden and Wilde, Letter to the Members of the Task Force on Universal Health Care. January 21, 2021.

TASK FORCE PRELIMINARY RECOMMENDATIONS

Summarized in this section 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.

For each recommended proposal, individual members had one vote except nonvoting members (i.e., legislators, 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 approval of a recommendation, a majority is defined as at least 51 percent of the Task Force voting membership (i.e., eight of the 14 voting members).

The final TAG proposals as presented to the Task Force are included in Appendix E, along with the Task Force vote counts on each proposal and a summary of each Task Force discussion. What follows are the key elements of these proposals, including amendments based on Task Force discussion.

Eligibility and Enrollment

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

- **Equitable** – All elements of the 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. 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.

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 every eligible person enrolling. An enrollment requirement is consistent with both the Vermont and New

https://www.oregon.gov/oha/HPA/HP/TFUHC%20Meeting%20Documents/Intermediate-Strategies-Work-Group-Legislator-Letter.pdf

York proposals. Requiring enrollment impacts Plan financing and requires further exploration to address issues such as the financial participation of Oregon and multi-state employers.

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 Medicare and 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 demonstrate residency, beyond the traditional mechanisms, such as a utility or credit card bill or driver's license or state issued ID. Examples of documents that could be considered as proof may include a letter from an Oregon human services agency attesting to residency or a receipt from a motel, hotel, campground or RV park showing current residency in Oregon.[36]

Eligibility will be tracked in a centralized database to which all providers have access. 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 "verifying" eligibility is not a barrier to receiving care as providers will be able to quickly and easily confirm enrollment at the point of care An easy to manage mechanism and process for confirming coverage will need to be established.

Once established, eligibility will not need to be periodically re-confirmed. To satisfy the 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 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 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.[37] 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.

Eligibility for Oregonians will no longer be connected with employment or employment status. 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 need to separate health insurance coverage from employment. Separating coverage from employment while retaining employer contributions to the system is complicated by ERISA and will likely impact the Plan's financing.

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

Temporary residents and visitors will receive treatment for injury and acute illness while in Oregon. These individuals, if insured, will have their insurance billed for services received**.** This

[36] ODOT Residence Address Guidance https://www.oregon.gov/odot/forms/dmv/7182fill.pdf
[37] https://www.rand.org/pubs/research_reports/RR2424.html

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 a sizable number of temporary residents and visitors will have insurance coverage, which be billed by the Plan. The Task Force also recognizes concerns about sustainability, risk pools, and maximizing federal match that are relevant to this recommendation.

Benefits Coverage and Design

The benefits coverage and design preliminary proposal is intended to support the development of a benefits package that is equitable, comprehensive, inclusive and meets the needs of all Oregonians.

Oregon Public Employees' Benefit Board (PEBB) 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 PEBB provides coverage for benefit categories not included in the ACA Essential Services or the Oregon Benchmark (e.g., complementary care, adult dental, adult vision), or OHP (infertility services).

Behavioral 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. Provision of behavioral health services should be supported through care integration provided in both primary care and behavioral health clinics. Integrating care must not unintentionally redirect reimbursement away from behavioral health to physical health. In order to fully participate in a global budget and value-based purchasing with risk, behavioral health providers must be able to share in the savings they have generated for the medical part of the health system. Community behavioral health safety net providers must be recognized as providing essential services and adequately funded so they are able to continue to provide critical health services and supports.

Coverage in individual benefit categories will be guided, where possible, by evidence-informed criteria with a commitment to identifying evidence inclusive of diverse populations. 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-informed practices (e.g., USPSTF, HERC, ACIP). [38] While the Task Force supports limits on certain categories of care strictly based on the clinical literature, members expressed concern that particular 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-informed coverage decisions incorporate the members' individual needs and circumstances, while also controlling costs in a finite resource environment.

Use of a single state formulary for its prescription drug benefit. The Plan will operate under a single drug list 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. Additional work is needed to determine the process for negotiating drug purchases on behalf of the Plan.

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.

[38] The U.S. 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

No premiums, copays, deductibles, or other cost sharing on members.[39] 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 enrollee cost-sharing typically used in health care included monthly premiums, co-pays, or co-insurance. Peer-reviewed literature indicates that co-pays do not contribute to improved health 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, with members noting that if premiums are needed to generate adequate revenue, premiums ought to 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 critical, it is not a distinct set of benefits that could be easily defined at this stage in the process. SDOH is an evolving and complex policy area and should not be rushed. It is recommended that further work is necessary to focus on how best to address SDOH. This effort should:

- Finalize a definition of SDOH for the Plan that can build on OHA's existing definition and clearly acknowledges racism and colonialism as important social determinants; and,
- 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 and Disability Services

The Task Force acknowledged the importance of long-term care and disability services and that additional work will be required to determine how best to incorporate this in the Plan.

Provider Reimbursement

The Provider Reimbursement recommendations resulted from the work of the Provider Reimbursement TAG and the Governance TAG. The original Provider Reimbursement TAG proposal recommended that Regional Entities would be responsible for managing within a global budget. This implied that the Regional Entities would be responsible for contracting with providers and ensuring cost containment.

The Task Force later approved the Governance TAG proposal, which revised the Provider Reimbursement TAG proposal, and instead proposed that the Single Payer will apply the reserve powers unique to the Single Payer for financial management and stewardship. In this revised structure, the Single Payer will contract directly with providers. Regional Entities will serve in an advisory role, advising 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 following section describes the sections of the Provider Reimbursement TAG proposal as approved by the Task Force that were not subsequently revised by the Governance TAG.

[39] 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.

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. Individuals who reside near neighboring states (WA, CA, or ID) may continue receiving care in these states if clinically appropriate and feasible.

Reimbursement methods and rates will be regionally tailored to meet the needs of providers and the populations they serve. The single payer entity will set a global budget, which may include capitated rates, for each region. Global budgets will be based on enrolled membership and demographics, ensuring adequate funds are allocated for members with complex medical and behavioral needs. Pending federal approval(s), the single payer entity will blend multiple funding sources, including Medicare, Medicaid, and new revenues to fund the global budgets. While Regional Entities will advise the Single Payer on the appropriate methods of reimbursement in each region, the Task Force included one exception to this regional variability: the single payer will not reimburse institutional providers, like hospitals, fee-for-service.

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 health care providers serving marginalized communities. These adjustments may be incorporated into the 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 should 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 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. Furthermore, community behavioral health safety net providers must be recognized and adequately funded so they may continue to offer critical preventive health services.

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. Envisioned is a system where the broadest possible range of provider types are eligible for the reimbursement opportunities. This includes, but is not limited to, traditional health care workers.

Improve pay parity. It is recommended to improve pay parity across types of individual providers within specialties to foster services that are preventive, offer cost avoidance opportunities, or are not currently adequate for enhanced recruitment and retention of health care professionals. This includes primary care, physical health, behavioral health, vision, dental, naturopathic physicians, and traditional healthcare workers. The Plan will need to consider parity in pay across individual provider types, in administrative burden between behavioral and physical health providers, and in reimbursement of services across all groups of health care providers. This is essential to retain and recruit providers, to increase access to health care, and to improve health outcomes.

Advance forms of value-based payment. The Plan builds on Oregon's emphasis on advanced forms of value-based payment and expands 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 and will place a priority on keeping its own administrative costs low.

Governance and Structure

The governance proposal developed by the Governance TAG and approved by the Task Force includes a list of guiding values intended to govern the Single Payer Board.

The guiding values are:

- 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.
- 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.
- Regional Entities must prioritize their obligations to individuals, families, and communities of Oregon with the sound stewardship of taxpayer dollars.
- Components of the system must be accountable and fully transparent to the public.
- As a government entity, maintain a government-to-government relationship with the tribes.

Single Payer Structure

Public entity governed by a board. The Single Payer will be a public entity with reporting responsibility to the Oregon Legislative Assembly 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.

Board members represent a balance of expertise in health care and have an authentic community voice. 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.

Board will have both community and regional/delivery system advisory committees. Additional discussion is 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 need to recruit and hire key staff. Staff should not be political appointees.

Single Payer Roles

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

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

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.

Support delivery system reform and improvement. This includes development of value-based payment mechanisms, tracking spending and utilization, data analysis, and reporting.

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.

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.

Develop and maintain a population-based health 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

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.

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.

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.

Regional Entities Roles

Advisory, convening, regional planning and delivery system reform. 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. 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. The Regional Entities will be responsible for:

- 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
- Managing a budget for health improvement, medical capital and infrastructure projects, and ongoing stakeholder engagement.

- Supporting health equity through 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
- Engaging local government and its work
- Assisting 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
- Promoting collaboration across the regional delivery system and other regions
- Managing provider contracts

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.

Public Trust Fund and Authorities

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

At a minimum, the legislature will need to:

- Establish the Single Payer and codify it as an independent public entity, such as Oregon Health and Science University (OHSU) or State Accident Insurance Fund (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 (see next page, pg. 24):

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)
- Set and distribute the budget for the Regional Entities
- Set up appropriate financial reserves
- 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
- Oversee and delegate to the Regional Entities a budget for health improvement, medical capital and infrastructure projects
- Maintain government-to-government relationship with tribes
- Manage government-to-government relationship with other states/countries

Plan Administrative Authorities to:

- Establish covered benefits for all Oregonians
- Work (through the Regional Entities) with local governments on the single-,payer program
- Contract with providers
- Develop and implement payment methodologies, and pay for covered services
- Administer the program and ensure quality operations, including ability to subcontract for program administration if cost efficient
- 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
- Conduct bulk or multi-state purchasing approaches

Data Collection, Analysis and Distribution Authorities to:

- Collect any needed data for tracking spending, utilization, and reliable information to evaluate systemwide performance, quality, and equity
- Allow access to the above data

Additional authorities - federal law, state regulations and waiver authorities. Amendments to federal waivers and to federal and state law will be needed to authorize implementation of the Plan. The specifics of each of the requested authorities will require a detailed analysis of current Medicaid, Medicare and other federal and state statutes as final details of the Plan are completed. The areas of needed changes will likely include the following:

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

Program Funding – Revenue

The following section describes the revenue proposal as developed by the Finance and Revenue TAG and approved by the Task Force. The Task Force has not yet had the time or resources to develop or review cost estimates for the Plan. Developing cost estimates requires an iterative process based on refining covered benefits, cost-sharing, utilization rates, provider reimbursement, administrative savings and cost containment mechanisms proposed in the final Plan.

The Task Force recognizes that these revenue recommendations are one element of the needed financial proposal, and will need to be accompanied by a comprehensive financial analysis 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

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.

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.

Payroll tax will be assessed on the employer; tax applies to all firms regardless of size. 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.[40]

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 making the plan ERISA-proof will be difficult, and requires legal advice not available to the Task Force to date.

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.

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 1 for the full list of tax rates by income for single and married joint filers.

Table 1. 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	$250,001 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 (see Table 2):

Table 2. Example Tax Rates for Illustration Purposes

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
Total Tax Due	$200,100	--	$17,003

[40] 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 may pay higher rates for income in those tiers.

Oregon may 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:

- **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 groceries and utilities.
- **State will establish a refundable sales tax credit to decrease burden on low-income families.** Individuals and families earning below 200 percent FPL will be eligible for a 100 percent credit of the sales tax based on family size.[41] Households with income up to 300 percent FPL will receive a partial credit.[42]

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 may 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.

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

INTERMEDIATE STRATEGIES WORK GROUP

In January 2021, state legislators issued a letter (Appendix D) requesting the Task Force include in its report a discussion of intermediate strategies that could form a bridge to a single payer system. This led to the formation of the Intermediate Strategies workgroup, which met five times between March and May 2021. The six members of the workgroup came up with five strategies:

1. Individual Market Transformation;
2. Single Payer Medicare Advantage;
3. CCO Consolidation;
4. VBP Expansion; and
5. Employer Health Cost Data Collection.

The first two strategies offer a more transformational approach, while the latter three are more administrative in nature. None of the strategies are intended to be a replacement for the SB 770 proposal, and if implemented, would not replace the existing need for a single payer system.

Concept One - Individual Market Transformation	
Overview	• Reform ACA individual market with a better, standardized benefit package, greatly reduced cost-sharing & global budget • Requires a 1332 waiver through CMS • Single benefit package, no copays or deductibles • Ensure affordability through income-based premiums (collected and managed by state) • Carriers held to global budget with capped annual growth of ~3%
Policy Objectives	✓ Reduce number of uninsured ✓ Strengthen coverage for underinsured ✓ Test Single Payer concepts (political feasibility, waiver flexibility, admin savings, single benefit package, global budget)

Concept Two - Single Payer Medicare Advantage	
Overview	• Create state-run Medicare Advantage plan that is only Medicare Advantage plan inthe state (becomes Single Payer in Medicare Advantage market) • Lower premiums and cost sharing for low and middle-income enrollees; cost sharing from higher income individuals would be arevenue source • More robust mental health benefit than current Medicare Advantage plans (fundedfrom savings from Single Payer approach) • Would require CMS demonstration project
Policy Objectives	✓ Pilot Single Payer approach ✓ Strengthen Medicare Advantage coverage

Concept Three - Consolidation of Coordinated Care Organizations (CCOs)	
Overview	• Prohibit more than 1 CCO per region • Potentially require that CCOs be non-profit entities
Policy Objectives	✓ Reduce administrative costs not related to clinical care ✓ Position CCOs for the role envisioned in Task Forcerecommendations

Concept Four - Value Based Payment (VBP) Expansion	
Overview	• Expand on idea of VBP through community engagement • Community input helps drive prioritization of outcomes and what is incentivized • Focus engagement on underserved communities – rural, tribes, racial/ethnic minorities
Policy Objective	✓ Aid in increasing community buy-in of VBP and ensure it is more aligned with community priorities

Concept Five - Employer Health Cost Data Collection	
Overview	• Require all businesses filing corporate excise or income tax forms, or pass-thru entity forms, to report total annual health expenditures and payroll for FTE/employees covered
Policy Objective	✓ Address gap in our data – we do not know what employers spend on health care. This would help in determining cost of future universal coverage & payroll taxes.

NEXT STEPS: TASK FORCE EXTENSION SB 428 (2021-2022)

If granted an extension and sufficient funding through Senate Bill 428, the Task Force will complete its charge by engaging in key activities between July 2021 and September 2022 related to public engagement, outstanding design elements, and legal and financial analysis. The Task Force will collaborate with members of the public regarding its work to date. It will further expand on its work by developing policy proposals related to the Plan's treatment of social determinants of health, the ability for the Single Payer to ensure network adequacy, provider participation in the Plan, the role of private insurance, private pay patients, financial emergency preparedness, and a transition plan.

A high-priority in an extension if for the Task Force to develop a financial plan, which will consist of refined total projected health care expenditure estimates, including estimated administrative savings; revenue estimates resulting from new revenue sources; legal analysis of federal and state authorities to determine ongoing federal and state financial contributions; and analysis of combined costs and savings for households and select stakeholder groups under the Plan as compared to the status quo. Feedback from the general public, outstanding design elements, and the financial plan will be integrated into a final report submitted to the legislature no later than September 2022.

If the Task Force is not granted an extension through SB 428, the Task Force will be unable to complete its charge outlined in SB 770, and this status report is incomplete at best.

Appendix E1. Eligibility, Benefits and Affordability TAG

Members: Glendora Claybrooks (Lead); Michael Collins; Dr. Zeenia Junkeer; Dr. Ed Junkins; Dr. Sharon Stanphill

Key Tasks – Correlates to SB 770 Plan Elements A, C, E, G, I, J, L

1. Prepare benefit coverage criteria to guide the Board in determining which health care services are necessary for the maintenance of health, the prevention of health problems, the treatment or rehabilitation of health conditions, and long term and respite care.
2. Address issues related to the provision of services to nonresidents who receive services in this state and to plan participants who receive services outside this state.
3. Develop guidance on cost containment measures (deductibles, premiums, copayments, or other enrollee means-tested cost-sharing mechanisms), and the effect of these measures on equitable access to quality diagnosis and care.
4. Highlight existing health disparities related to eligibility, benefits and affordability and propose Task Force considerations for achieving health equity (e.g., ensuring benefit coverage needed by marginalized communities; proposing policies to close enrollment gaps among BIPOC and other marginalized populations).
5. Identify areas of greatest potential impact to consumers and develop specific questions to elicit feedback from the Consumer Advisory Committee (CAC). Provide direction on the mission, values, and goals of the single payer, using SB 770 Section 4 as a starting point

Meetings

November 5: TAG Scope & Workplan; Eligibility & Enrollment

November 19: Eligibility & Enrollment

December 3: Eligibility & Enrollment

December 17: Eligibility & Enrollment; Benefits

January 20: Benefits & Affordability

February 10: Benefits & Affordability

March 8: Eligibility & Enrollment; Benefits & Affordability

April 12: Benefits

Eligibility & Enrollment Final Proposal: March 25, 2021

Values

The EBA TAG believes that the issues of Eligibility, Benefits and Affordability are foundational to the work of the SB 770 Task Force. The TAG's work is grounded in shared values; all EBA recommendations 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

Eligibility

- All Oregon residents and their dependents are eligible, regardless of citizenship or immigration status
    - As required by SB 770
    - "Everybody In, Nobody Out" is a bedrock principle of the Plan
- All out-of-state residents in Washington, Idaho and California who 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 "nonresident who works full time in this state and contributes to the plan"
    - There should be some threshold that is potentially less than full time and takes into consideration that employers may currently offer "full time" benefits to those working fewer than 40 hours per week
    - Further work is needed on this definition and should happen in consultation with employers
- Temporary residents and visitors shall be eligible for coverage of injury and acute illness while here, at a minimum, if they do not have their own insurance coverage
    - This attempts to balance the values of equity, inclusivity and comprehensiveness with a recognition of finite resources
    - Many visitors would have other insurance which could be billed by the Plan
    - TAG is also interested in pursuing retroactive coverage of temporary residents if/when they establish residency
- Any eligible person will be automatically enrolled in the Plan; "opting out" is not a relevant concept for this Plan
    - The Plan will not mandate that individuals receive health care services if they choose not to, but the sustainability of the plan is dependent on having every eligible person enrolled in the Plan

Establishing/Demonstrating Eligibility

- There will be no income limits or means-testing to demonstrate eligibility
    - "Everybody In, Nobody Out" is a bedrock principle of the Plan
- There will be no waiting period (for out-of-state individuals employed by Oregon employers) or minimum residency duration (for Oregonians) in order to establish eligibility
- Eligibility should be tracked in a centralized database to which all providers have access. In addition, providers should be able to confirm enrollment at the point of need
    - "No Wrong Door" policy for individuals to get care which eliminates barriers
    - Whether someone is scheduling care in advance or needs urgent/emergency care, their coverage should be easily confirmed by the provider
    - 'Proving' eligibility should not be a barrier to receiving necessary care
    - Once established, eligibility should not need to be regularly re-confirmed

How Plan will Include Individuals with Other Coverage

- At a minimum, the Plan should cover individuals with OHP/Medicaid; ideally the Plan would also cover individuals with Medicare and TRICARE if feasible
    - Full integration with all other public programs is the desired outcome
- Eligibility should be disconnected from employment. Individuals who currently receive coverage form their employer will now receive coverage from Plan
    - Tying employment to health insurance promotes inequitable access and outcomes
- Enrollment should be simple and straightforward; enrollment for OHP, Medicare or Tricare will be seamlessly integrated with Plan
    - Reflects EBA values of Simple and Comprehensive

Task Force Discussion: Eligibility & Enrollment

The Eligibility & Enrollment proposal was presented to the Task Force for a vote on March 25, 2021. Discussion focused on two primary elements of the proposal: (1) the recommendation to offer reduced coverage for visitors and temporary residents; and (2) the definition of out-of-state residents who are eligible for the plan due to being employed with an Oregon-based company. Many Task Force members had reservations about the feasibility and costs of extending coverage for illness and injury to visitors, although it was made clear that any visitor insurance would be billed for services provided while in Oregon. Still, Task Force members who voted “Approve with reservations” were clear that they would be interested in a future change to the proposal that removed visitor coverage. The discussion around out-of-state residents was focused on a clarification from a prior draft version of the proposal; in this version, the definition of out-of-state residents was limited to those individuals (and their dependents) who live in a state sharing a border with Oregon (CA, ID or WA) and either commute to work into Oregon or live “within a commutable distance” from their Oregon-based employer. This specificity was clarified during the discussion.

Votes: Eligibility & Enrollment

Approve: Leslie Rogers

Approve with reservations: Lionel Chadwick, Dwight Dill, Glendora Claybrooks, Zeenia Junkeer, Edward Junkins, Cherryl Ramirez, Deborah Riddick, John Santa, Chuck Sheketoff

Do not approve: Bruce Goldberg, Samuel Metz

Absent: Sharon Stanphill

Benefits & Affordability Final Proposal: April 29, 2021

- The PEBB plan should remain the basis for a Plan benefits package
    - The idea of using the Oregon Benchmark plan was rejected as it is not sufficiently comprehensive to meet the values and goals of the Task Force
    - PEBB provides coverage for certain benefit categories not included under the ACA Essential Services or Oregon Benchmark (complementary care, adult dental, adult vision), or OHP (infertility).

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

- Coverage details within each benefit category should be guided where possible by evidence-informed recommendations and bodies (e.g., USPSTF, HERC, ACIP) with a commitment to identifying evidence that is inclusive of diverse populations
    - This moves the Plan away from "no limits" recommendations into a benefits plan that would align with best-available evidence-informed best practice; it may be helpful to look at how OHP incorporates annual or biannual limits on categories such as hearing and vision based on evidence-informed literature
    - Some members of the TAG expressed concern, however, that certain types of benefits and services and their impact on some populations are not always well represented in the medical literature (e.g., gender-affirming care, complementary medicine) and there needs to be a way of ensuring that an evidence-informed "wrap" is not applied rigidly
- The Plan should not impose premiums, copays, deductibles, or any other cost-sharing on any members[43]
    - Higher income individuals should contribute more to the cost of the plan; however, this contribution should be handled in the financing of the plan (progressive income tax, payroll tax, etc.) rather than through cost sharing.
    - Peer-reviewed literature is largely unsupportive of the idea that co-pays lead to better outcomes or less costly utilization
    - It is unlikely that premiums and co-pays would be a significant source of revenue to offset Plan costs while still remaining affordable to members
    - Non-members will be billed for services
- The Plan should adopt a single state formulary for its prescription drug benefit.
    - This recommendation does not deal with purchasing; however, it would allow for 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 inclusive of diverse populations.
    - The Single Payer should also work on other purchasing arrangements or other means to reduce the cost of prescription drugs
    - There are specialty drugs for cancer and other serious conditions that may not be traditionally covered by a formulary; the Plan must have a way of identifying access to
    - these drugs
    - It may be helpful to solicit community input to govern development of the formulary

Task Force Discussion: Benefits & Affordability

The Benefits & Affordability Proposal was brought to the Task Force for discussion and a final vote on April 29th, 2021. The Task Force did vote to accept the proposal, with 2 members voting to accept the proposal, 10 members voting to accept with reservations and 1 member voting against the

[43] The workgroup was clearly opposed to premiums. However, there was some discussion that if premiums are needed for revenue, it would be recommended that they be collected via the Dept of Revenue to optimize efficiency and reduce administrative costs to the Single Payer and that clinical care not be withheld in order to confirm premium payment.

proposal. The discussion and reservations were primarily focused the lack of any cost sharing for higher income members, which is a point that not all members agreed with. Some members felt it was important for higher income individuals to have some premiums both for equity and also for revenue generation. However, the proposal as passed maintains that there should be no cost sharing of any kind for any enrollees, and that higher income individuals should contribute more to the plan through the Plan financing mechanisms (taxes).

Votes: Benefits & Affordability

Approve: Edward Junkins, Samuel Metz

Approve with reservations: Chad Chadwick, Michael Collins, Dwight Dill, Glendora Claybrooks, Zeenia Junkeer, Cherryl Ramirez, Deborah Riddick, Leslie Rogers, John Santa, Chuck Sheketoff

Do not approve: Bruce Goldberg

Absent: Sharon Stanphill

Appendix E2. Provider Reimbursement TAG

Members: Chad Chadwick (Lead), Dwight Dill, Zeenia Junkeer, Cherryl Ramirez, Deborah Riddick

Key Tasks – Correlates to SB 770 Plan Elements H, O

1. Propose methods for reimbursing providers for the cost of care as described below, or using an alternative method that is similarly equitable and cost-effective:
    a. Individual providers shall be paid:
        i. on a fee-for-services basis;
        ii. as employees of institutional providers or members of group practices that are reimbursed with global budgets;
        iii. or as individual providers in group practices that receive capitation payments for providing outpatient services; and
    b. Institutional providers shall be paid with global budgets that include separate capital budgets, determined through regional planning, and operational budgets.
    c. Group practices may be reimbursed with capitation payments if they primarily use individual providers to deliver care, do not use capitation payments to reimburse hospital services, and do not incentivize providers to utilize services.
2. Consider how reimbursement methods may differ across provider types as relevant (physical health, behavioral health, long term care, etc.)
3. Consider the Health Care for All Oregon Board's role in workforce recruitment, retention and development.
4. Highlight existing health disparities related to provider reimbursement and propose Task Force considerations for achieving health equity (e.g., ensuring sufficient recruitment of BIPOC providers).
5. Prioritize areas of greatest potential impact to consumers and develop specific questions to elicit feedback from the Consumer Advisory Council (CAC).

Meetings

November 6: TAG charge, scope, expectations and deliverables

November 20: Provider types; reimbursement models; current reimbursement landscape

December 4: Institutional provider types and reimbursement models; capital budget approaches

December 18: Reimbursement methods for providers not easily classified; reimbursement methods for institutional providers; capital budgets for distribution of resources to rural and disadvantaged providers

January 15: Value-based payment; proposal

February 2: Updates to proposal

Provider Reimbursement Final Proposal: February 25

The Provider Reimbursement Technical Advisory Group (the TAG) of the Task Force on Universal Health Care (the Task Force) proposes a model of reimbursement in which reimbursement methods and rates are regionally tailored in order to meet the varying needs of providers and the populations they serve.

First, 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.

Then, each regional entity will establish methods for reimbursing providers, which may include capitation and/or fee schedule. Provider reimbursement rates may be adjusted based on patient complexity, regional priorities etc. Regional entities will develop their priorities based on local stakeholder input. Regional entities will be responsible for managing within the global budget or capitated rate. Within each region, providers receive the determined reimbursement, regardless of the original funding source.

In this system, member benefits will be accessible with all participating providers throughout the state and across regions. Members may access care at the provider of their choosing, regardless of the physical region of the provider or enrollee.

Regionalization

While the TAG does not propose how regional entities will be structured and governed, leaving those determinations to the Governance TAG, regional entities will have some delegated authority from the state to manage / implement / coordinate care for the region. As part of coordinating care, regional entities will participate in routine regional planning processes that are locally influenced and include assessment of regional medical and financial needs.

The TAG differentiates its proposal from Accountable Care Organization (ACO) and Coordinated Care Organization (CCO) models.

- Like in the CCO model, the TAG envisions:
    - A regionalized model that includes a network of all types of providers who have agreed to work together in their local communities.
    - Regional entities will receive global budgets or capitated payments to coordinate care, with clear state directives to focus on prevention and helping people manage chronic conditions, and to contract with and reimburse providers.
- Unlike in the CCO model, the TAG envisions:
    - All enrollees receive the same benefits, determined at the state level, regardless of region.
    - Only one regional entity will serve a geographic region, maximizing finances available for care.
    - State approved methodologies regarding how regions may or may not reimburse providers.
    - The state will limit retention of funds and require community reinvestment of dollars that exceed retention caps.
- Unlike in the Medicare ACO model, the TAG does not wish to adopt a medical model of reimbursement to ensure providers responsible for the behavioral and social needs of the population are appropriately reflected in the reimbursement model.

Capital Budget Allocation

The TAG proposes that all providers are responsible for their own routine organizational capital (for example, new computers). However, the TAG proposes that regions are allocated a separate budget that would be managed by the regional entity for exceptional medical capital (for example, an MRI machine) and critical infrastructure projects (for example, a new hospital building) which they may dispense to providers for large expenditures that exceed a pre-determined amount and have broad community value. The state (and/or a state/stakeholder public process) will define what is considered "routine" and what is considered "exceptional."

Routine community needs assessments will inform the state's allocation of regional budgets, including capital budgets, and the region's subsequent use of these funds. Providers will apply to regions for funding for exceptional capital projects, and regions will assess regional need through a locally influenced process, and allocate funds accordingly. When implementing any approved capital projects, regional entities should prioritize contractors who identify as Black, Indigenous, or other people of color. The process for regional determination of need for capital expenditures will be set at the state level.

Providers are responsible for their own administrative costs. Administrative costs for regions are included in the capitation rates or global budgets for each region that will be established by the state, and regional entities will reflect administrative costs in their provider reimbursement schedules. Administrative costs must not exceed a predetermined ceiling.

Additional Reimbursement Opportunities

The TAG proposes the following reimbursement opportunities:

Statewide re-balancing adjustment. In an effort to address regional disparities in access to care, the TAG proposes augmented rates as follows:

- Rural and frontier providers receive X% higher reimbursement rates
- Providers receive X% higher rates when serving members of marginalized communities

These adjustments may be incorporated into the state rate setting process and/or regional reimbursement development.

The definitions of "rural and frontier" and "marginalized communities", as well as the exact rate increase would be determined at the state level. Providers would be required to indicate how they will be using additional funding to improve quality of care for underserved populations.

Demonstration projects for value enhancement. The TAG proposes regions may apply for supplemental funds to increase regional value of care. Such projects may include, but are not limited to:

  - Provider and workforce recruitment and retention, especially in rural areas, and especially providers who identify as Black, Indigenous, and other people of color
  - Improving behavioral health access
  - Expanded use of mid-level practitioners

- Innovations that improve value and access to care for marginalized patients and/or to improve access to care in rural and frontier communities

Principles

The TAG proposes additional principles that would frame the development of the regional model of reimbursement:

Marginalized communities. Given the complex healthcare needs of marginalized communities, the TAG seeks a reimbursement model that allocates sufficient funds to healthcare providers serving marginalized communities.

Behavioral Healthcare

The TAG specifically highlights the desire to meet the needs of behavioral health providers.

- Behavioral health providers are not easily classified as individual, institutional or group practice providers.
- Medicare Accountable Care Organizations have operated using a medical model of reimbursement, rather than a biopsychosocial model, which does not meet the needs of behavioral health providers or the people they serve.
- There is a need for bidirectional integration of primary care and behavioral health for mild to moderate cases. However, this integration should 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.

Regionalization

- Rural providers, especially rural institutional providers, have different needs than their urban counterparts.
- The TAG seeks a reimbursement model that acknowledges the differing reimbursement needs of rural and urban providers.

Local Influence

- Local providers know the healthcare needs of their community best, which is why the TAG seeks a reimbursement model that values local participation and influence in the structure.

Administrative Efficiency

- The TAG reaffirms the stated goal of SB 770 for administrative simplification.

One Entity Per Region

- The TAG believes there should only be one regional entity in a geographic region. This offers cost efficiency and broad community participation without duplication.

State Financial Predictability

- The TAG values state financial predictability and endorses the financial predictability that regional budgets would provide.

Fee-for-Service

- The TAG proposes that the state create a framework for how regions can reimburse providers.

- As part of this framework, the TAG proposes the state prohibit regions from reimbursing institutional providers (as defined in SB770) fee-for-service.
- While fee-for-service may be appropriate for some individual provider reimbursement, the TAG notes that they seek a model that incentivizes providers for holistic care, and fee-for-service often does not achieve that goal.

Pay Parity

- The TAG has reiterated the need 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 should include such groups as primary care physical health, behavioral health, vision, dental, naturopathic physicians, traditional healthcare workers.

Advanced Forms of Value-based Payment

- The TAG wishes to encourage Oregon's emphasis on advanced forms of value-based payment, and expand on the notion of "value."
- The term "value-based payment" is a historically broad term that applies to many different types of payment arrangements, including capitation, global budgets, prospective episode-based payment, and budget-based models.
- The TAG wishes to expand on the notion of "value-based payment" as historically used, to allow for community input and prioritization.
- The system for determining value must be influenced by patient, family and community perspectives.
    - For example, the community should have influence over what outcomes are most important and thus incentivized in payment arrangements.

Preserving and Expanding Types of Participating Providers

- The TAG wants to 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.

Portability of Benefit

- The regional care group model should not restrict patient access to care.
- Patient benefits should be accessible with all participating providers throughout the state and across regions.

Task Force Discussion

The Task Force unanimously approved the proposal without reservation. However, the subsequent Governance TAG proposal revised the Provider Reimbursement TAG recommendations. The Provider TAG had proposed, "Regional entities will be responsible for managing within the global budget or capitated rate." The Governance TAG proposed instead that the Single Payer will apply the reserve powers unique to the Single Payer for financial management and stewardship, and that Regional Entities would serve in an advisory role, advising the Single Payer on the budget and reimbursement methods appropriate for the region.

Votes

Approve: Glendora Claybrooks, Dwight Dill, Bruce Goldberg, Zeenia Junkeer, Edward Junkins, Samuel Metz, Deborah Riddick, Cherryl Ramirez, Leslie Rogers, John Santa, Chuck Sheketoff

Absent: Lionel Chadwick, Sharon Stanphill

Appendix E3. Governance TAG

Members: John Santa (Lead) Bruce Goldberg, Deborah Riddick, Chuck Sheketoff

Key Tasks – Correlates to SB 770 Plan Elements A, C, E, G, I, J, L

1. Provide direction on the mission, values, and goals of the single payer, using SB 770 Section 4 as a starting point
2. Determine the structure and role of the single payer
    a. What are the responsibilities of the single payer?
    b. Determine the role of the single payer in controlling cost
    c. Is it public or quasi-public? Are there requirements regarding filing status? Are there requirements regarding subsidiaries?
    d. To whom does the single payer report?
    e. Guidance on structure of the board
    f. What fiduciary requirements are needed for the revenue generated to fund the Plan?
    g. Guidance regarding the definition of the term “public trust” as used in SB770
    h. How will Public Health be integrated into the system?
    i. How will the single payer respect tribal sovereignty in implementing the Plan?
3. Determine the structure and role of regional entities
    a. What are the responsibilities of the regional entities?
    b. Determine the role of regional entities in controlling cost
    c. What type of organizational structure will be required, if any, of a regional entity?
    d. What will be the relationship between the single payer and regional entities?
    e. How will the single payer and regional entities navigate circumstances that give rise to unexpected financial hardship?
4. Determine the authority necessary for the single payer and regional entities to operate:
    a. Authority to administer the Plan
    b. Authority to define and conduct enrollment processes and administer the Plan
    c. Authority to collect revenue
    d. Authority to control costs
    e. Authority to submit waivers related to Plan administration
5. Offer a set of considerations for the Consumer Advisory Committee to address related board design and governance.

Meetings

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

Final Proposal: May 27, 2021

Values

The following may be used to provide direction on the mission, values, and goals of the Single Payer:

1. The Single Payer is dedicated to improving the health status of individuals, families, andcommunities.
2. Health care, as a fundamental element of a just society, is to be secured for all individuals on anequitable basis by public means.
3. Access to a distribution of health care resources and services according to individuals' needs andlocations 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 and governance of the system must be accountable and transparent to thepublic.
5. The Single Payer will invest in local communities and engage community members and healthcare providers in improving the health of the communities and addressing regional, cultural, socioeconomic, and racial disparities in health care.
6. The Single Payer and Regional Entities must prioritize their obligations to individuals, familiesand communities of Oregon with the sound stewardship of taxpayer dollars

Roles

The Single Payer entity will have the following roles:

- **Apply the reserve powers unique to the Single Payer for financial management and stewardship, including:**
  - Establishing all aspect of global budget which includes:
    - Designing payment structures and rate setting to the delivery systems
    - Ensure that payments are adjusted for reduction in administrative costs
  - Leading quality improvement and cost control efforts
    - Development of performance improvements broadly
    - Administrative simplification
    - Set utilization control policies
    - Organization of large capital investments to ensure improved access to care andhealth equity
    - Explore multi-state purchasing approaches
    - Prevent fraud, waste, and abuse
  - Supporting regional economies
- **Oversee program administration.** Ensure quality operations, including but not limited to:
  - 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

- **Develop and implement program policy, including:**
  - Determining coverage, including monitoring and addressing changes to health care (e.g.technologies, therapies, pharmaceuticals)
  - Strategic planning for long-term system success
- **Support delivery system reform/improvement**
  - This includes development of value-based payment mechanisms, tracking spending andutilization, data analysis, and reporting
- **Achieve health equity to improve access, quality of care**
  - This includes goal setting, data analysis and reporting (utilization, quality, outcomes) andobtaining reliable information about race, ethnicity, and other aspects at the time of participants' registration
- **Support workforce development, including:**
  - Identification of workforce needs and capacity
  - Work with stakeholders on approaches to address needed funding and training needs
  - Support workforce recruitment, retention and development, prioritizing recruitment of clinicians of color
- **Develops and maintains the population health-based information system**
  - The information system will:
    - Include clinical, financial, utilization, quality, and other needed information to evaluatesystemwide performance and quality
    - Ensure transparency with access to the data for the population at large

Single Payer role in the context of tribal sovereignty

- As a government entity, the Single Payer should maintain a government-to-government relationshipwith the tribes
- At the level of an individual, tribal members would have the ability to seek care within the IndianHealth Service tribal systems, as well as be eligible for the Single Payer
- Further discussions with tribal leaders will be needed in the development of the Single Payerregarding the relationship of the tribal health system and the Single Payer

Structure

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

- Legislative Assembly and Governor
- Ability to accept all types of funds (e.g. federal, state, donations)
- The Single Payer revenue is not subject to Oregon's kicker tax rebate
- Authority for development and maintenance of prudent financial reserves to ensure solvency. Thesereserves can only be appropriated by the Single Payer.

Board

- Single Payer board membership will:
  - Require Governor appointment and Senate confirmation
  - Represent a balance of expertise in health care and have an authentic community voice
  - Demonstrate no conflicts of interest at time of appointment, during their terms, and for asignificant period after leaving the Board
  - Receive remuneration for their time
- 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 ofmembership
- The Board will recruit and hire key staff for the Single Payer. Single Payer staff will not be politicallyappointed

Regional Entities: Roles

Regional Entities will have the following roles:

- Advise the Single Payer related to management/implementation/coordination of care for the regionwhich 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, medical capital and infrastructure projects, and ongoingstakeholder 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, foster innovation, andprovide input on how incentives should be targeted and measured
- Promote collaboration across the regional delivery system and other regions

Regional Entities: Structure

- 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 number of regions and boundaries will be determined by the single payer. Novel approachesshould be considered such as the regional equity coalition design or other alignments with community or regional structures

Regional Entity Relationship with the Single Payer Includes:

- The Single Payer determines criteria for Regional Entities
    - The Single Payer will consider existing stakeholder engagement structures like RegionalHealth Equity Coalitions in determining regions
- Single payer will ensure that the Regional Entity is regularly convening and engaging stakeholders inthe region
- The Single payer will ensure that the Regional Entity conducts ongoing stakeholder engagement as the regional entities determine spending for health improvement, medical capital and infrastructureprojects, and regional involvement in efforts to address social determinants of health
- 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, medical capital and infrastructure projects, andongoing stakeholder engagement
    - Provider contracts
    - How performance incentives should be targeted and measured

- 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 provesto be cost effective without undermining other values important to the success of the Single Payer

Single Payer Fiduciary Responsibilities

- Establishes the Single Payer budget to ensure adequate resources for both covered services and administrative costs to achieve the goals and vision of the Single Payer program
- Establishes and ensures appropriate restricted reserves
- Establishes budget for each region's delivery system
    - Regional Entities advise
- Establishes contracts with every provider including the establishment of payment levels and methods. Ensures that payments are adjusted for reduction in administrative costs
- Responsible for claims payment for covered services
- Establishes and administers quality improvement and cost containment mechanisms
- Establishes budgets for the Regional Entities
    - Regional entities advise with input from their regions' stakeholders and community members
    - Includes funding for regional infrastructure and capital investments
    - Includes funding for regional investment for delivery system innovation
- Establishes a mechanism to receive gifts, donations and other revenue such as a foundation
- Continually establishes plans for emergency preparedness
- The Single Payer will be regularly subject to external audit

Single Payer Public Trust Fund – Example Legislative Language

- **The Oregon Single Payer Public Trust Fund** is established separate and distinct from the GeneralFund. 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 federallaw. (*e.g. for Medicaid, Medicare*)

Required Single Payer 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 relationships with Tribes
  Government-to-government relationships with other states or 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

Specific current federal & state law/regulations may need adjustment for the Single Payer program and may need waiver approval or law changes to authorize. These could include federal law, state regulations and waiver authorities:
- **Medicaid waiver authority**, including:
  - Amend Oregon's Medicaid 1115 demonstration waiver
  - Other waiver authority as needed
- **Medicare exemption or demonstration**
- **ACA requirements**, which could include:
  - Section 1332 waiver authority to diverge from ACA rules on how coverage is obtained,paid for, benefits provided or other current commercial plan requirements
- **ERISA pre-emption exemption**
- **Federal budget neutrality**
- **State law/regulation**

For consideration during a possible extension

- Invest in services and supports to address social determinants of health.
- Ensure that the workforce is working at the "top of their license," meaning providers practice to the full extent of their education and training, instead of spending time doingtasks that could be performed by someone with less education/training.

Task Force Discussion

The majority of the Task Force approved the proposal without reservation. Members with reservations highlighted the need to refine the role of the Single Payer so that it appropriately respects tribal sovereignty. Some members noted the need to further refine the role of regional governance, and voiced concerns about the transition away from regional managed care.

Votes

Approve: Glendora Claybrooks, Dwight Dill, Bruce Goldberg, Samuel Metz, Cheryl Ramirez, Leslie Rogers, Zeenia Junkeer, John Santa, Chuck Sheketoff

Approve with reservations: Michael Collins, Edward Junkins

Absent: Chad Chadwick, Michael Collins, Sharon Stanphill

Appendix E4. Finance and Revenue TAG

Members: Chuck Sheketoff (Lead), Samuel Metz, Chad Chadwick, Glendora Claybrooks, Dwight Dill, Cherryl Ramirez, Les Rogers, John Santa

Key Tasks – Correlates to SB 770 Plan Elements C, D, E, G

1. Establish parameters that will guide external development of cost estimates for the plan, including but not limited to cost estimates for:
    a. Including all Oregon residents in the Health Care for All Oregon Plan (the Plan) without decreasing the ability of any individual to obtain affordable health care coverage if the Individual moves out of this state; and
    b. the provider payment methods designed by the Task Force for the Plan.
2. Establish parameters to estimate savings and expenditures of the Plan, relative to the current health care system.
3. Assess and offer guidance on revenue options that may include, but are not limited to:
    a. Redirection of current public agency expenditures;
    b. An employer payroll tax based on progressive principles that protect small businesses and that tend to preserve or enhance federal tax expenditures for Oregon employers who pay the costs of their employees' health care; and
4. A dedicated revenue stream based on progressive taxes that do not impose a burden on individuals who would otherwise qualify for medical assistance (Medicaid). Propose Task Force considerations for the potential use of means-tested copayments or deductibles, including but not limited to, the effect of increased administrative complexity and the resulting costs that cause patients to delay getting necessary care, resulting in more severe consequences for their health.
5. Highlight existing health disparities related to financing and revenue and propose Task Force considerations for achieving health equity (e.g., progressive revenue mechanisms, minimizing cost burdens to marginalized populations).
6. Identify areas of greatest potential impact to consumers and develop specific questions to elicit feedback from the Consumer Advisory Committee (CAC).

Meetings

November 4: TAG Scope & Workplan

December 15: Total Health Expenditures

January 14: Overview of Oregon's Revenue System by Legislative Revenue Office

February 3: Cost Estimates

February 19: Develop Revenue Packages for Analysis

March 17: Revenue Methods Estimator

March 31: Task Force Feedback

April 13: Health Economist Jack Meyer and Revisit Proposal

May 3: ITEP Estimates and Finalize Proposal

Finance and Revenue Final Proposal: May 27, 2021

Principles

The TAG developed the following working list of principles to guide their assessment of revenue package options.

Progressive. The tax rate increases as the taxpayer's ability to pay (as determined by their income) increases. In reviewing packages, the TAG will consider: how progressive is the revenue source and is there a way to make it less regressive/more progressive?

Easy to understand. Is the new revenue stream easy to understand by those having to pay it?

Stable. A stable financing system is one that can weather economic and demographic changes. No source is stable; they all change over time based on economic activity or population changes. In reviewing packages, the TAG will consider: what can be done to increase overall stability of the revenue package?

Permanent. Is the revenue package as permanent as anything? For example, the TAG would prefer to eliminate sunset clauses on relevant revenue streams.

Predictable. Can government officials fairly predict how much revenue will be generated?

Scalable and Adequate. If universal health care implementation is over a period of time, are revenue sources scalable to meet the revenue needed for full implementation?

ERISA Considerations. We want to minimize vulnerability to ERISA court challenges and may want automatic triggers on certain revenue streams to mitigate impact if there is an effective challenge.

Dedicated Trust Fund. As opposed to pulling from the general fund, the TAG seeks a dedicated trust fund that is not subject to the state kicker to support the Plan.

Maximize Federal Dollars. Consider opportunities to maximize federal match dollars before turning to new revenue streams.

Constraints

What is presented here are estimates based on data easily available to staff from a variety of publicly available sources, including a 2018 RAND Corporation evaluation of options for financing health care in Oregon which included a single payer model as one option,[44] and the Oregon Legislative Revenue Office's Basic Facts 2020.[45] The TAG's revenue goal and estimates of revenues from different sources are preliminary and cannot be relied upon for making final decisions. The TAG's ability to develop more accurate and detailed cost and revenue estimates is constrained by several factors. These constraints include:

Legislative Authority & Funding

- SB 770 did not allocate funding for the Legislative Revenue Office (LRO) to generate estimates of revenue package proposals, so input and assistance is necessarily limited, especially during a legislative session.

Ambiguities Related to Plan Eligibility and Benefits

[44] White, Chapin, Christine Eibner, Jodi L. Liu, Carter C. Price, Nora Leibowitz, Gretchen Morley, Jeanene Smith, Tina Edlund, and Jack Meyer, Financing Health Care in Oregon: Four Policy Options. Santa Monica, CA: RAND Corporation, 2017. https://www.rand.org/pubs/presentations/PT162.html

[45] https://www.oregonlegislature.gov/lro/Documents/Basic%20Facts%202020b.pdf

- The Task Force's Eligibility, Benefits and Affordability (EBA) TAG recommended that visitors be included in the Plan on a more limited basis (coverage of acute injuries and other necessary care). This inclusion of visitors complicates estimates because comparable data on this population does not exist for the purposes of estimating costs
- When estimating the cost of a single payer system in Oregon, the RAND report used the essential health benefits benchmark plan and applied some cost sharing. The benefits package currently under consideration by the Task Force is far more comprehensive than the state benchmark plan and is largely free of cost sharing; this design has not been incorporated into any single payer estimates, and requires further refinement before it can be used to estimate cost.

Administrative Savings

- It is expected that the Plan will yield certain administrative savings. However, the extent of these savings is unknown and extremely difficult to predict accurately at this time.

Timing

- Data is not scaled to 2021 projections, or to projections of a future and more likely implementation year. Like data used by other TAGs, some of the underlying data comes from different years. COVID-19 health expenditures and the impact COVID-19 had on the economy have not been factored, nor have federal tax law changes, or Oregon's response to those changes. When it is time for a final decision by the legislature, projections will be made on cost and revenue sides for the year they choose for implementation and those may vary significantly from the numbers the Task Force is working with.

- Since the TAGs have been operating concurrently, the Finance & Revenue TAG has had to move forward on revenue options without having time or ability to comprehensively analyze and incorporate the financial implications of other TAG proposals.

- The TAG, like the rest of the Task Force, faced significant time constraints in developing this proposal since the timeline of the Task Force was compressed due to COVID-19.

The RAND report and other studies have illustrated that single payer plans cost as much or less than the status quo. The TAG therefore decided it would be reasonable to start with the estimates of the current healthcare system as a projection for the cost of a single payer system. Based on the RAND report estimates of the cost of the current system, and the estimated total of federal and state dollars that could theoretically be applied to the system pending federal administrative and congressional approvals, the TAG determined the state would need to raise at minimum an additional $14 billion, and some on the TAG feel more comfortable with an assumption of $20 billion (or more) to account for some of the unknowns listed above.

Revenue Method Parameters

The TAG considered a range of revenue methods, and ultimately proposes a package that incorporates a new payroll tax, an increase to the personal income tax, as well as the creation of a sales tax. They propose the following parameters guide development of these three taxes:

Payroll Tax

- Applies 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 should consider how to best frame this parameter so as not to eliminate its intent in the case of federal changes.
- Like traditional payroll taxes, this method would apply only to wage-based income. Non-wage income, like capital gains and dividends, would continue to be taxed under the income tax component of this proposal.
- The payroll tax is to be assessed on the employer. If it is deemed that this would increase the risk of an ERISA challenge, or if there is a successful ERISA challenge, this parameter would shift and the employee would be responsible for paying the tax.[46]
- It applies to all firms, rather than firms based on a particular size as was used in the RAND analysis.
- The base payroll tax rate suggested by the TAG is believed to be less than the current cost of health insurance to employers who provide it.

Income Tax

- Increases rates for all households with income above a moderately low eligibility threshold (300% FPL, or approximately $79,000 for a family of 4).
- It establishes at least one new bracket for high income earners (e.g., household income over $200k is taxed at 13%).

Sales Tax[47]

- The rate is no more than 6%
    - This rate was selected to be in alignment with the sales taxes in neighboring states.
- It applies to all goods and services except “essential goods and services,” with a narrow definition of “essential goods and services.” (e.g., groceries & utilities)
- It includes a refundable sales tax credit to decrease the burden on low-income families.

[46] The TAG had extensive discussions about this parameter. There is a concern that having the payroll tax paid by employers would increase the risk of businesses taking legal action against the state, claiming violation of the Employee Retirement Income Security Act (ERISA). Since economists suggest an employer-paid payroll tax would be borne at least in part by employees anyway, some members argued the TAG should be agnostic on who would pay this tax. Others argued that the Plan is vulnerable to an ERISA challenge regardless of who pays the payroll tax. These members proposed that employers would be getting a windfall under the Plan, because employers would no longer need to pay for employer sponsored insurance, so employers should 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. The parameter as stated attempts to address these concerns.

[47] The TAG had extensive discussions about whether to include a sales tax in the proposed revenue package. Opponents argued sales taxes are too regressive, even with a credit for low-income individuals. They additionally noted that Oregon voters have regularly rejected a sales tax, so inclusion of a sales tax in the package would decrease the likelihood of electoral passage. However, proponents made three key arguments. First, a package that includes only a payroll tax and income tax would require such high rate increases to generate sufficient revenue that it would not be tenable among voters either. Second, they argued that sales taxes add stability and predictability to a tax package that would be otherwise unstable and unpredictable. Third, sales taxes generate revenue from visitors which would be important to consider if the Plan includes coverage for that population.

- Individuals and families earning below 200% FPL would be eligible for a 100% credit of the sales tax based on family size; those earning up to 300% FPL would have a partial credit

Order of Operations
When determining rates for the full package, the payroll tax rates should be set first, followed by the income tax rates. If it is determined that additional revenue from a sales tax is needed, the sales tax rate should be set at no more than 6%, and further increases to the payroll and income taxes s for high income earners should be considered in order to generate the revenue needed.

Task Force Discussion

The Task Force heard the Revenue proposal at its May 27, 2021 meeting and engaged in substantive discussion on the proposal's components before voting on whether to approve it. Task Force members expressed concerns in two areas: (1) whether the proposed sales tax should include a specific rate (6%) in the proposal; and (2) a broader concern that this proposal is an incomplete part of what is needed for the final financial proposal. Regarding the first point, one Task Force member requested an edit to the proposal that would strike the specific 6% rate from the sales tax section. The Task Force voted on whether to make that change, and it passed with 9 members voting "Yes" and two members voting "No."

On the second point, there was concern that while the revenue proposal represents solid progress, it is still quite high level and requires additional expertise beyond what was available to the project. Much work still needs to be done to work through the details of the revenue proposal. In addition, many Task Force members pointed out that viewing revenue recommendations without also seeing the costs and potential savings of the plan is misleading. Many members felt strongly that, in the case of an extension, this proposal would require significant modifications and deeper analysis to solidify the components of the revenue and their implications, as well as additional work on the costs and savings.

Votes

Approved: Samuel Metz

Approved with reservations: Glendora Claybrooks, Michael Collins, Dwight Dill, Bruce Goldberg, Zeenia Junkeer, Edward Junkins, Cheryl Ramirez, Leslie Rogers, John Santa, Chuck Sheketoff

Absent: Lionel Chadwick, Deborah Riddick, Sharon Stanphill