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Legislative Policy and
Research Office

Universal Access to Care Work Group

Report on Barriers and Incremental Steps to Universal Access

December 2018

UNIVERSAL ACCESS TO HEALTH CARE WORK GROUP

TO: House Interim Committee on Health Care
FROM: Rep. Andrea Salinas, Rep. Barbara Smith Warner, Rep. A. Richard Vial
DATE: Dec. 12, 2018

Chair Greenlick, Members of the House Committee on Health Care, and interested parties:

As members of the Oregon House of Representatives serving on the Universal Access to Healthcare Work Group, we want to provide some context for the conversations we had in the work group over the past year. The following report will shed light on our research and findings. As a precursor, here are some notable impressions and opinions we determined collectively.

We agree that "universal access to care" means better access to care for more people at a lower cost. This must include better quality care and health outcomes than our current health care system delivers. We recognize that our current system is excessively expensive and has not produced results.

While some advocates have pushed for a single-payer system as the best answer for curbing costs, reducing administrative waste and fixing other flaws, paying for a universal coverage system presents challenges that are difficult to overcome at this time. The state would need to capture the current taxes many Oregonians pay, as well as the taxes their employers pay for their health care, in order to pay for that system to produce a budget-neutral impact on consumers. Oregon would also need a waiver from the federal government to accomplish this. Getting that federal waiver is unlikely under our current administration. But this does not mean we cannot now make progress toward this goal.

To make progress toward this goal, the Universal Access to Healthcare Work Group agrees on numerous topics that require further exploration if we are to get closer to universal access to care. This includes a Medicaid-like buy-in to provide care for individuals and families not eligible for Medicaid or federal subsidies through the Affordable Care Act. Coordinated care organizations and their networks would deliver this care using the coordinated care model. We also believe the state should explore a shared responsibility mandate as part of a broader health care package. This policy should be coupled with other policy changes that move us toward a payment system that rewards better health care and outcomes.

This group believes that creating a universal system of primary care for all residents could be a first step toward an ultimate universal coverage system. We think the legislature should discuss this further during the 2019 session.

Members of the work group have already agreed to continue this discussion through the Oregon Health Policy Board and engage in more public dialogue. These will be critical conversations for any movement to rearrange Oregon's entire health care delivery and payment system. Ultimately, these conversations will lead us on a path toward universal access to care.

Andrea Salinas — Representative Andrea Salinas, House District 38

Barbara Smith Warner — Representative Barbara Smith Warner, House District 45

A. R. Vial — Representative A. Richard Vial, House District 26

EXECUTIVE SUMMARY

BACKGROUND

In 2018, the Oregon House Committee on Health Care created the Universal Access to Care (UAC) Work Group to develop a set of policy considerations for the legislature in its effort to achieve "universal access to an adequate level of high quality health care at an affordable cost" (ORS 414.018). The bipartisan work group was tasked with five goals: to inform legislators; to help the legislature develop a vision for change; to develop an incremental roadmap to creating a system of universal and affordable health coverage for all Oregon residents; to promote choice of providers, transparency, and accountability; and to improve the health of Oregonians.

This report documents the activities and discussions of the UAC Work Group and summarizes the main policy topics considered by members. As members acknowledged, the work group did not achieve consensus on any of the policy approaches. The intent of this report is to highlight key aspects of the barriers to achieving a state-based system of universal care in Oregon and approaches that may help the state increase coverage within the current system. The report provides an international comparison that offers important insights on the potential pathways and essential components Oregon should consider in moving towards a universal system of coverage.

SUMMARY OF WORK GROUP ACTIVITY

Over an eleven-month period, 15 members including three legislators met monthly to examine the challenges and barriers to universal coverage for all Oregonians. The work group explored a variety of policy proposals, drawing from models of universal health care in other countries and initiatives around universal health care in other states, and sought to outline long-term policies needed to move Oregon towards a system of affordable, universal access to appropriate health care. Activities included review of comprehensive research and information provided by national and state health policy experts; investigation of international models of universal health care and financing; robust discussion and debate among members; and several exercises. Through this work, members learned about and provided feedback on over a dozen policy concepts including the concepts of a single-payer vs. all-payer model—recognizing there are different approaches to achieving a state-based system of universal coverage and access.

The UAC Work Group has put forth a set of policy approaches for the legislature to consider. The list of policy approaches is not comprehensive, exhaustive, nor complete. Rather, the list is a framework and provides a foundation for future statewide discussions on creating a state-based universal system of care.

POLICY APPROACHES

Due to time constraints and the inherent complexities in designing a state-based system for universal health care, the work group was unable to complete all five of its assigned tasks in 2018. The compromise, albeit unsatisfactory, is a list of approaches that warrant further and more in-depth research, analysis, and careful deliberation among policy makers and stakeholders during and after the 2019 legislative session. Each policy approach needs careful consideration to fully understand

its impact on coverage, access, and affordability to consumers, and disruption of the existing health care system. All of these policy choices are further complicated by barriers imposed by federal Employee Retirement Income Security Act of 1974 (ERISA), Medicaid and Medicare laws, and the Affordable Care Act (ACA). The options also require difficult political choices: new tax revenue to fund subsidies and coverage expansion; changes to provider reimbursement rates and models; and potentially reducing preferences and choices of consumers, employers, and bargaining units. Most studies of state-based universal health care plans, including Oregon's RAND study, demonstrate that universal care plans do not increase total health care spending and have the potential to reduce per-capita expenditures. If Oregon considers a universal health care plan in which the state takes responsibility for collecting all health care funds, Oregon will need tax revenues to replace health care funds currently spent privately (e.g., employer-sponsored plans). This task of imposing new taxes is daunting, regardless of intent.

The policy options are complex, and necessarily involve interrelated benefits, trade-offs, and unanticipated impacts. A few examples highlight this complexity: eliminating member out-of-pocket costs (copays, deductibles, and coinsurance) to remove barriers to access may result in higher overall premiums or global budget costs; standardizing benefit design to a single simplified benefit plan may eliminate choice and hinder innovation; standardizing provider reimbursement models may simplify administration but hinder innovation and experimentation to improve patient outcomes; and finally, allowing full patient choice with open provider networks of all licensed providers may not achieve the consistent quality of narrow networks selected for value and outcomes.

Members opted to identify the current challenges and barriers under the status quo, outline an initial vision for a system of universal health care, and offer policy approaches to address coverage gaps, improve affordability, and offer possible steps towards universal health care in Oregon. Summarized below are incremental state-level policy approaches explored by the work group to make it easier for individuals to access and maintain health insurance coverage.

Incremental State-level Policy Approaches to Advance Universal Coverage	
Premium Assistance Program	Expand the role and use of premium assistance programs drawing on lessons and opportunities from Project Access NOW and the COFA program managed by Department of Consumer and Business Services (DCBS).
Enrollment Assistance and Outreach	Increase enrollment and improve risk mix by investing in extensive outreach efforts to ensure the 80 percent of the uninsured who are estimated to be eligible for Medicaid or federal subsidy support are aware of their options and purchase coverage.
Consumer Coverage Simplification	Evaluate uniformity among health insurance products between Oregon's Marketplace and the Oregon Health Plan.
Administrative Simplification	Reduce administrative costs associated with provider billing and insurance-related activities in Oregon. For example, require the use of a single common billing form and system used by all participants involved in financing and delivery of health care.

Plan Uniformity	Explore a single set of benefits across public and privately financed health care plans in Oregon.
Primary Care Trust Fund	Assess a single payment and universal health care delivery system for primary care services in this state.
Shared Responsibility Mandate	Evaluate a shared responsibility mandate that would impose penalties for those who don't maintain coverage. Revenue could fund market stabilization and consumer affordability initiatives.
Medicaid-like Buy-in	Evaluate a coverage program that targets lower-income individuals and families not eligible for Medicaid or federal subsidies through the Marketplace.
Expansion of the coordinated care model	Expand the state's reform model beyond Medicaid and coordinated care organizations (CCOs) to all commercial health carriers and health plans offered in Oregon based on the six key elements: (1) best practices to manage and coordinate care, (2) shared responsibility for health, (3) transparency in price and quality, (4) measuring performance, (5) paying for outcomes and health, and (6) a sustainable rate of growth.

The work group discussed the importance of public opinion and the need to directly engage Oregonians on health coverage, affordability, and access to quality health care services including a focus on potential disruption and choices tied to transitioning the state to a universal coverage system.

NEXT STEPS

The work group recognizes Oregon's current health care system is not compatible with a state-based universal health care system without significant and unprecedented changes at the federal level, including congressional action. The reality is that Oregon receives more than 50 percent of its current health care funding from federal programs: Medicare and Medicaid. Moreover, all states will encounter challenges related to employer-sponsored coverage (e.g., ERISA) in the consideration of a universal health care system. An important next step in Oregon is meaningful consumer engagement around issues including provider choice, benefit coverage, eligibility, and financing required to fund a universal health care system.

The preferences and policy issues outlined in the work group's report acknowledge the inherent challenges and trade-offs Oregon will encounter in working to create a universal system of health care, while temporarily setting aside the question of relying on federal funding and permissions. The work group outlines key features of financing, delivery, and organization of a universal health care system including potential goals and priorities for a new system. An important next step is to develop and refine a set of shared goals and values among all Oregonians in creating accessible health care for all in the state.

WORK GROUP MEMBERS

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Representative Barbara Smith Warner, House District 45
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The work group engaged in a series of exercises and activities to develop the information provided in this report. Throughout this work, individuals not serving on the work group also significantly contributed in the development of the content provided in the report, as well as offered expertise when requested. The following individuals are acknowledged for assisting the work group:

Zachary Goldman, Oregon Health Authority
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WORK GROUP PROCESS AND ACTIVITIES

In recent years, states have explored comprehensive reform of their health care systems. Colorado, California, and Vermont have proposed legislation to establish affordable universal systems of health care. These reform proposals have been aimed at addressing consumer affordability, expanding coverage to the uninsured, better controlling costs, and reducing administrative costs and complexities attributed to the current federal health care system. Such efforts continue, considering recent uncertainty with Congress and the recent efforts to repeal the federal Affordable Care Act (ACA) in 2017.

Given the federal uncertainty with the ACA, the chair of the House Committee on Health Care created a work group tasked with developing a set of recommendations for the Oregon Legislative Assembly to guide consideration of approaches that would achieve "universal access to an adequate level of high quality health care at an affordable cost" (ORS 414.018) for all Oregonians and would promote long-term financial stability of the state's health care system. The goal of the work group was to help legislators and policy makers develop a vision for change – an incremental roadmap to creating a system of universal and affordable health care for all Oregon residents; one which would promote choice of providers, increase transparency and accountability, and improve the health of Oregonians.

The work group was tasked with the following:

a) Identify incremental state-level policy changes to make it easier for individuals to access and maintain coverage, whether through their employer or through existing or new publicly funded programs.
b) Describe potential changes to employer-sponsored coverage and commercial plans, including the extent to which existing coverage mechanisms are compatible with a universal coverage system. Determine what mechanisms, if any, are needed to minimize disruption to the current health care system.
c) Explore whether new governance models are needed to achieve universal access, including major components and functions of any such model.
d) Explore long-term sustainable funding sources that can raise sufficient revenue to finance universal access, including local, state, and federal funding availability.
e) Investigate the federal waivers and permissions that would be required for Oregon to maximize federal funding for the provision of health care services.

Members of the work group represented different stakeholders in the delivery and financing of health care in Oregon, including representatives from commercial insurers, CCOs, hospital systems, health reform advocates, behavioral health, health care safety net, providers, and trade associations.[1] Representative Andrea Salinas chaired the work group. Representatives Barbara Smith Warner and A. Richard Vial served on the work group. Senator Michael Dembrow also participated when possible.

[1] Universal Access to Care Work Group. *Updated Roster*. July 2018. https://www.oregonlegislature.gov/committees/hhc/WorkgroupDocuments/staff%20-%20(announcement%2007-19-2018%20meeting).pdf

The work group met monthly, from January through November 2018, and is submitting a report and a set of proposed policy considerations to the House Interim Committee on Health Care. The report identifies barriers to and incremental steps for moving Oregon towards a financially sustainable, universal, and affordable health care system. A public comment period was held at each meeting. This provided the public the opportunity to share information or feedback directly with the work group on topics related to its work. Figure 1 outlines the work plan and key topics presented to members.

Figure 1. Timeline of Work Group Activities

Timeline	Activities
January	Affordable Care Act: Impact on Oregon
February	Assessment of Options for Financing Health Care in Oregon: 2017 RAND Research Report
March	Health Insurance Coverage in Oregon in 2017: Oregon Health Insurance Survey Results
April	What is Universal Access and Coverage in Oregon – Financing, Eligibility, and Coverage
May	Universal Coverage Systems in Other Countries – International Perspective
June	State Efforts to Achieve Universal Coverage Oregon's Health Care Safety Net: Provider Perspectives
July	Oregon's Health Insurance Marketplace Medicaid Buy-in Federal Considerations
August	Universal Coverage Efforts in California Oregon Marketplace Advisory Committee Medicaid Buy-in – Oregon Policy Approaches and Design
September	Medicaid Buy-in – Oregon Policy Approaches and Design (cont.) Premium Assistance in Oregon
October	Shared Responsibility Mandate Rhode Island's Market Stability Work Group Medicaid Buy-in – Oregon Policy Approaches and Design (cont.)
November	Primary Care Funding Review Draft Report

The work group may continue its work after the 2019 legislative session at the formal request of the chair of the House Committee on Health Care.

HEALTH COVERAGE IN OREGON 2017

The work group initially focused on the congressional actions in 2017 and 2018 that sought to repeal key tenets of the Affordable Care Act (ACA) and the potential impact to Oregon. At the work group's first meeting in January, the Oregon Health Authority (OHA) and Department of Consumer and Business Services (DCBS) presented six ways repeal of the ACA would impact Medicaid and the Marketplace in Oregon:[2]

- Fewer Oregonians could have health coverage particularly individuals and families with low incomes including working families (see UAC brief).
- Fewer Oregonians would have access to appropriate care including primary and preventive care.
- Health care costs would rise, and uncompensated care would increase.
- The state's economy and budget would be impacted as the result of job growth in health care following implementation of ACA and federal funding for the Medicaid expansion population.
- Individuals could lose health insurance coverage, including those with pre-existing conditions.
- Loss of federal funding for public health services available through the ACA.

The information presented by OHA and DCBS helped to establish an understanding of the effects of the ACA in Oregon including expanding health coverage, reducing the uninsured rate, and federal funding for Medicaid expansion and the Marketplace.

OREGON HEALTH INSURANCE SURVEY: COVERAGE STATUS AS OF 2017

In March, staff with the Oregon Health Authority presented the results from the 2017 Oregon Health Insurance Survey (OHIS), which is fielded every two years. The survey collects information about health insurance coverage, access to care, and affordability in Oregon. The survey used landline and cell phone numbers in Oregon and was distributed across the state by region, race and ethnicity, and age.[3]

More than 9,000 Oregon households completed the survey between March and August of 2017. The results provide information on:

- Public and private insurance coverage
- Uninsured and underinsured
- Coverage transitions and gaps
- Costs, out-of-pocket, medical bills/debt, and premiums and deductibles

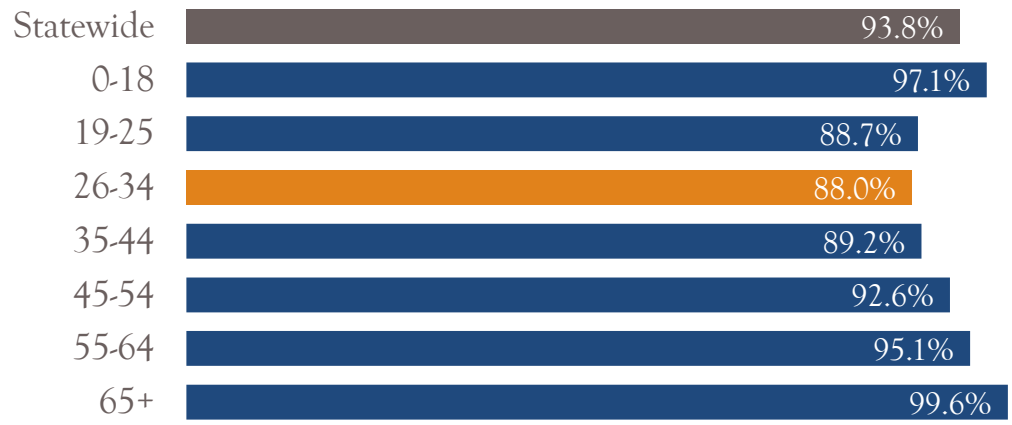
According to OHIS, in 2017, 93.8 percent of individuals, or approximately 3.75 million Oregonians, had health insurance coverage. The results indicate 245,000 individuals were uninsured during this time period. Among those surveyed, approximately 11 percent of individuals were uninsured or had a coverage gap in the past 12 months. Health insurance coverage by age is provided in Figure 2. The

[2] Oregon Health Authority and Department of Consumer and Business Services (January 2018). *Affordable Care Act (ACA): Impact on Oregon*. Retrieved from: https://www.oregonlegislature.gov/committees/hhc/WorkgroupDocuments/Tim%20Sweeney,%20OHA;%20Zachary%20Goldman,%20OHA;%20Rick%20Blackwell,%20DCBS%20(handout%2001-09-2018%20meeting).pdf

[3] For more information about OHIS, please see: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Insurance-Data.aspx

largest uninsured group is 26- to 34-year-olds. Children (ages 0-18) and older adults (aged 65+) had the lowest rates of uninsurance.

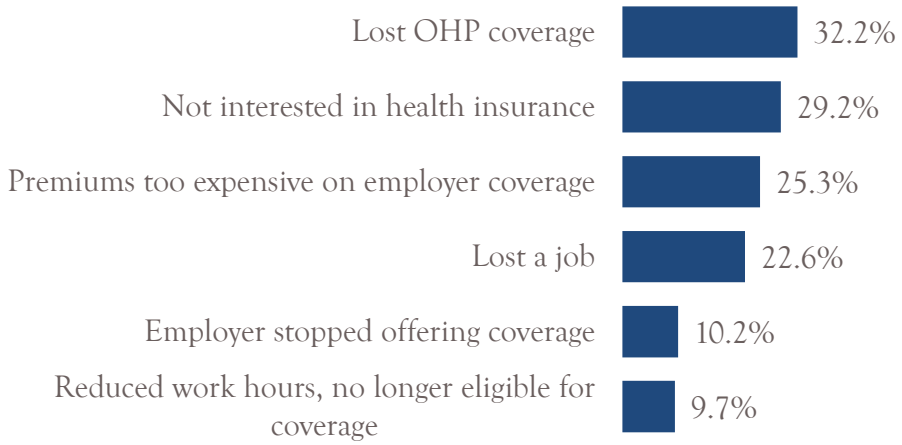
Figure 2. Insurance Coverage by Age



Source: OHA OHIS 2017 Results

The survey inquired as to why an individual was uninsured at the time of the survey. The adults surveyed indicated the top three most frequent reasons for being uninsured at the time of the survey were: (1) loss of Medicaid coverage, (2) not interested in health coverage, and (3) employer-sponsored coverage is too expensive, or employer stopped offering coverage. Figure 3 provides details on the reasons individuals indicated for being uninsured. The survey reported on the length of time individuals were without insurance ranging from one month to five years or more.

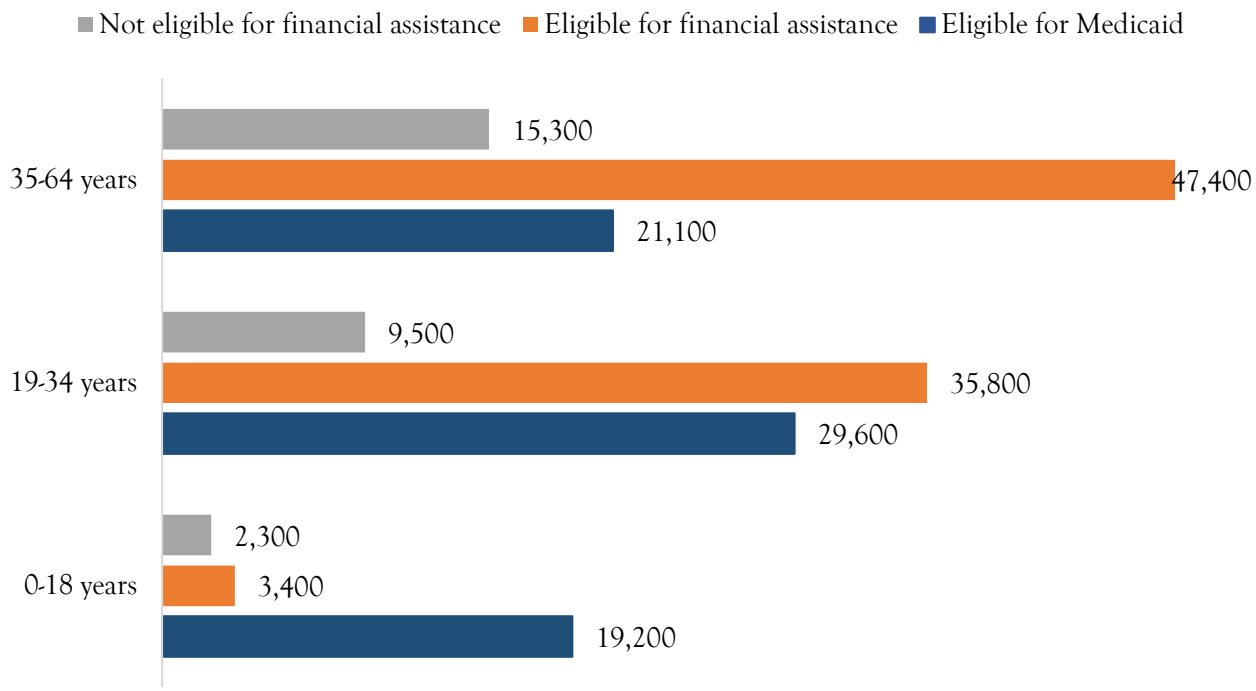
Figure 3. Reasons Individuals Were Uninsured in 2017



Source: OHA OHIS 2017 Results

Among the 245,600 uninsured, approximately 80 percent (roughly 196,000 individuals) are estimated to qualify for Medicaid through the Oregon Health Plan (OHP) or federal financial assistance through the Marketplace (Figure 4).

Figure 4. Estimated Number of Uninsured U.S. Born Adults in Oregon Eligible for Medicaid or Federal Subsidies by Age Group (2017)



Source: OHA *OHIS 2017 Results*

According to the Oregon Health Authority, key takeaways from the 2017 OHIS results are:[4]

- The number of uninsured has dropped post-ACA; among those uninsured, 53 percent were uninsured for 12 months or longer and 30 percent say they don't want coverage.
- By race and ethnicity, Hispanics are the most likely to be uninsured.
- Individuals with incomes between 101-200 percent of the federal poverty level (FPL) had the highest proportion of being uninsured (~10 percent).
- Having no health insurance is related to difficulty paying for health care.
- Around 50 percent of people with health insurance were underinsured.
- Over 80 percent of uninsured Oregonians are likely eligible for OHP or financial assistance through the exchange.
- People with individual coverage paid the most out-of-pocket for care in the past year.

[4] Oregon Health Authority (March 2018). 2017 Oregon Health Insurance Survey: Summary and Results. See:https://www.oregonlegislature.gov/committees/hhc/WorkgroupDocuments/Stacey%20Schubert,%20OHA;%20Rebekah%20Gould,%20OHA%20(report%2003-22-2018%20meeting).pdf

RAND Research Study (2017): Financing Health Care Delivery in Oregon

In February, the principle investigator on a comprehensive study that analyzed three specific versions of options for financing health care delivery in Oregon as directed by House Bill 3260 (2013)[5] presented to the work group. RAND projected the impacts of each option relative to the status quo: maintaining the state's expansion of Medicaid and subsidies for nongroup coverage through the Marketplace, as established by the Affordable Care Act (ACA) in 2020. The report describes three options for financing health care for residents of the state of Oregon and compares the projected impacts and feasibility of each option. Two of the options would achieve universal coverage for residents of Oregon, while the remaining option would add a state-sponsored plan to the ACA Marketplace (Figures 5 and 6). As stated by the researchers, the results were intended to "help guide policymakers in Oregon, and in other states, as they assess alternative approaches to maintaining or expanding health insurance coverage and improving health care delivery."

Figure 5. Health Care Financing Options

SINGLE PAYER	HEALTH CARE INGENUITY PLAN (HCIP)	PUBLIC OPTION	STATUS QUO
• Universal coverage • Low or no cost sharing • State-administered plan • Tax-financed	• Universal coverage • Income-based cost sharing • Competing private plans • Tax-financed	• Add a state-administered option in the marketplace	• Continue with currently available options

Source: RAND Corporation (2017 report). A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon.

The RAND study financing options outlined in Figure 6 consisted of different financing sources to fund each coverage option. As outlined by HB 3260, the RAND team modeled each option including different funding sources as illustrated in Figure 6. The underlying importance of this work is the evaluation of potential effects of new tax revenues that could be used to fund a system of universal coverage, including pooling of federal and state funding sources, and new taxes. The RAND model and its estimates offer a basis to start examining alternative financial arrangements any state will need to consider in creating a universal system of coverage.

[5] See Oregon Chapter Law 712 (2013).
https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2013orLaw0712.pdf

Figure 6. Health Care Financing Options: Funding Sources

	SINGLE PAYER	HCIP	PUBLIC OPTION
Federal funding	✓	✓	✓
New state payroll tax	✓		
Increase in state income tax	✓		
Reduce provider payment rates	✓		
New state sales tax		✓	

Source: RAND Corporation (2017 report). A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon.

The analysis from the RAND study indicates that any option would involve interrelated benefits and trade-offs (Figure 7). Specifically, any state will need to seek waivers from the federal government and a federal exemption from ERISA to allow federal outlays for current programs, including Medicaid and Medicare, to be redirected to finance universal coverage. Finally, universal coverage without new tax revenues, significant administrative savings, or reductions in provider reimbursement presents significant implementation barriers.

Figure 7. Health Care Financing Options: Evaluation of Options

	SINGLE PAYER	HCIP	PUBLIC OPTION
ENROLLMENT	Large increase	Large increase	Small increase
FINANCIAL BARRIERS	Much lower for low-income residents	Lower for low-income residents	Slightly lower for participants
SYSTEM COSTS	Little change	Increase	Decrease
PROVIDER REIMBURSMENT	Decrease	Increase	Decrease
SERVICE AVAILABILITY	Worsens	Improves	Little change
STATE ECONOMY	Increase employment 0.1%	Increase GSP 0.4%, increase employment 0.8%	Decrease employment 0.5%
FEASBILITY	Very challenging	Challenging	Feasible

Source: RAND Corporation (2017 report). A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon.

WHAT IS UNIVERSAL COVERAGE?

To aid the work group in completing the tasks specified in the December 2017 workplan, staff developed a set of questions.[6] Summarized are work group member responses grouped by key themes based on discussions in March and April of 2018. The responses, collectively, provide an initial roadmap for what universal coverage in Oregon might look like and offer policy choices that "bring into focus" what universal coverage could mean in Oregon. The information below also provides insight into key policy decisions and design issues that policy makers and legislators will need to address if a state-based universal system of coverage is proposed in Oregon.

1. WHAT DOES "UNIVERSAL ACCESS TO CARE" MEAN IN OREGON?

Members frequently responded to this question with "*access to high-quality, affordable, comprehensive, and medically appropriate health care*." Members commented that universal access entails ensuring an "everybody in, nobody out" approach. Two additional aspects identified were elimination of financial barriers for consumers and allowing choice of providers. The premise is an individual's inability to pay creates financial barriers that can result in delaying or avoiding accessing critical services.

- ✓ Everyone in, no one out
- ✓ Remove financial barriers to accessing coverage and services
- ✓ Ability to pay
- ✓ Address costs
- ✓ Priority list of covered benefits
- ✓ Consumer choice of providers
- ✓ Promote individual and community health

Several issues emerged from members' responses (see "key issues" table below). First, the group considered whether to focus on an incremental approach; expanding coverage and access to the remaining uninsured and underinsured through the state's existing coverage system. Second, members commented that universal coverage does not necessarily equate to universal access to health services in Oregon (***universal coverage ≠ universal access***). Members expressed concern with barriers to access including geographic barriers; lack of access to primary and specialty providers; and lack of access to culturally appropriate services. Summarized below are key issues members identified.

Key Issues
• Distinction between establishing universal *coverage* through a health insurance model and ensuring universal *access* to primary and preventive services for all Oregonians. • Establish a set of basic benefits (medical, dental, and mental health) for underinsured and uninsured, versus offering a richer benefit package (e.g., benefits offered through the Oregon Health Plan or the Affordable Care Act's 10 essential health benefits). • Financing and costs of a universal access system depend on the model.

[6] Questions are modified from the California Health Care Foundation's Key Questions When Considering a State-based, Single-payer System in California (Nov. 13, 2017)

2. What problems is the work group being tasked to solve in Oregon?

Members identified the key problems as: (1) ability to address factors attributed to the current level of health care expenditures in Oregon, and (2) designing a system to ensure universal health care that is financially feasible. Members recognized the importance of understanding the current level of health care expenditures in Oregon by coverage type and by funding source (public and private coverage sources). Members also identified cost drivers such as administrative complexity, which contributes to excessive expenditures of the current coverage and delivery model, and pharmaceutical costs. Members also clearly identified the need for a long-term funding model that is sustainable to finance services for all individuals.

- ✓ Identify policy pathway(s) to universal coverage
- ✓ Better care, more people, less money
- ✓ Access to services (rural/urban, income disparities)
- ✓ Affordability and cost drivers
- ✓ Administrative burden and system complexity
- ✓ Payer differentials
- ✓ Financial accountability
- ✓ Accountability for performance and outcomes (quality of care, financial incentives, and health outcomes)

Members described designing a model that will make "universal access…a reality" in Oregon. Members also suggested the state build on existing reform models that include the 15 coordinated care organizations (CCOs) and the state's patient-centered primary care home (PCPCH) program.

Key problems described are identifying options for providing universal access to care, estimating the potential costs for such options, and determining funding sources.

Key Issues
• Lack of agreement on what is meant by "universal health care" and how to address identified cost drivers. • Differences in access among the insured and uninsured and their ability (or inability) to pay. • Bridging existing gaps in insurance coverage, incrementally, which may lead to more affordable and accessible health care services. • Interest in expanding access to the uninsured and making health care more affordable and accessible to the underinsured by focusing on a subset of the state's population. • Identify intermediate steps for Oregon to take towards universal access to care (example offered was to develop a policy glide path, long-term).

3. WHAT ARE THE BARRIERS TO ACHIEVING A UNIVERSAL AND AFFORDABLE SYSTEM OF HEALTH COVERAGE IN OREGON?

Members identified a range of barriers in designing and adopting a universal system of health care. A key barrier is federal law and the role of the Employee Retirement Income Security Act of 1974 (ERISA), which serves as a predominant coverage mechanism in the United States. Members identified a potential need for congressional action to allow states to adopt legislation that affects employer-sponsored health coverage, concerns with ERISA preemptions, creating new requirements for employers, or redirecting funding currently provided through employer-based health insurance. This issue also affects states potentially seeking federal flexibility and approval to utilize federal funding for Medicare and Medicaid beyond existing federal law (e.g., 1332 waivers).

- ✓ Administrative complexities – system, employer, insurer, provider, and consumer
- ✓ Structural changes
- ✓ Minimizing disruption to existing system
- ✓ Public perception
- ✓ Federal limitations including ERISA
- ✓ Funding "system" and "family/individual" level
- ✓ Stable and sustainable revenue and financing for universal coverage

The complexity of the existing coverage and delivery system also was identified as a challenge. Examples shared were multiple benefit schedules, inefficient billing and reimbursement mechanisms, extensive variation with drug formularies and health plans, provider networks, and the multitude of public and private coverage options. Related are the additional costs created by the administrative complexity of the existing health system for providers and consumers. Members discussed certain components of the current system that may be incorporated or restructured in a universal system to be explored.

Members also identified as a challenge the issue of public support for, and trust in, a system designed to achieve universal coverage, particularly the potential for additional funding mechanisms (e.g., taxes). Another barrier is ensuring individuals eligible for existing coverage programs are enrolled and working to ensure people are not "falling through the cracks" with the current coverage system.

Key Issues
• Affordability: lowering out-of-pocket costs for individuals (i.e., premiums and cost sharing) to purchase insurance if uninsured. • Address underlying complexity of health care system including administrative inefficiencies and costs for providers as well as for consumers. • Identify aspects of the existing system that are working well. • Assess the federal landscape including ERISA, ACA, Medicare, Medicaid, and potential need for enabling legislation from Congress.

4. What sources of funding can be made available to support a universal and affordable system of health coverage in Oregon?

The work group discussed new revenue sources to potentially fund universal coverage: personal income tax, payroll tax, flat tax, state sales tax, and claims tax.[7] Key is considering a broad base solution that is equitable to all payers. Use of existing funding was also discussed, from both public and private sources. This may require redirecting or redeploying employer-sponsored coverage out-of-pocket costs, federal funding for Medicare and Medicaid, and current state funding of Medicaid. Another critical consideration is identifying the amount of administrative costs, potential savings, and averted future costs.

- ✓ Employers/payroll tax
- ✓ Sales tax
- ✓ Claims tax
- ✓ Income tax
- ✓ Mixed/blended funding
- ✓ Avoid more expensive, future cost
- ✓ Redistribution of existing funds in current system

Key Issues
• Determine the mix of funds necessary to financing universal access – federal, state, and private funds and potential use of federal waivers. • Consider ability to pay and means testing for individuals. • Potential administrative cost savings by simplifying the "system". • Consideration of a broad base of funding for the state's health care priorities.

5. What entity would ensure access to health care services for all Oregon residents, or would the state retain existing coverage programs?

The work group had the least amount of time to review responses to this question. Several members suggested creating a new state agency, as well as establishing a "Trust" to fund health care services (e.g., Primary Care Trust). Others suggested leveraging existing programs and infrastructure, specifically the Oregon Health Authority, which could be assigned responsibility for ensuring access to care. Another suggestion is a new public-private entity such as the State Accident Insurance Fund (SAIF).

- ✓ Public/private entity - existing or new (e.g., SAIF)
- ✓ State
- ✓ Create a public option
- ✓ Establish Medicaid buy-in program through CCOs
- ✓ Statewide or regional CCO-like model
- ✓ Leverage OHP program to establish "universal coverage"
- ✓ Community governance

Several members commented on expanding Medicaid through CCOs by establishing a Medicaid buy-in option. Another suggestion was to create a new health plan through the Marketplace mirroring the Oregon Health Plan and operated through existing CCOs' provider networks. The rationale is to build on Oregon's CCO model.

[7] In 2011, Michigan enacted a Health Insurance Claims Assessment, which assesses a 1 percent tax on all paid claims by fully-insured and self-insured plans. Funds generated are used to finance a portion of the state's Medicaid program.

Key Issues
• Establish level of reimbursement for providers, in a single payment system or expand one or more existing programs to ensure access for under and uninsured. Develop cost estimates based on potential reimbursement preferences (Medicare, Medicaid, other. • Establish a public option for the individual market through the Marketplace such as a "Medicaid buy-in" proposal to offer an "OHP CCO-like product."

6. Would payments to providers of health care services be set and structured? If so, how?

Members responses ranged from maintaining existing fee-for-service (FFS) arrangements based on a set fee schedule to capitation and global budgets. Several concepts reflected in the responses are structuring payments to incentivize delivery and utilization of primary and preventive services; requiring payments that reflect value of services and are tied to health outcomes; and designing incentives to improve access to care in areas of higher need and to serve populations with complex health needs.

- ✓ Use of capitation and global budgets (risk sharing)
- ✓ Payment structure to incentivize types of care (e.g., primary)
- ✓ Different payment structures
- ✓ Pay for outcomes, not FFS basis
- ✓ Negotiate prices and reimbursements with providers

The work group also considered alternative payment structures for different types of services or programs. Members commented on continuing to allow providers and payers to negotiate prices to set reimbursement rates. Other members suggest standardizing compensation across provider types including reducing reimbursement rates for specialty care (e.g., decreasing payment differential among primary and specialty providers). A key theme was the use of global budgets and structuring provider payments using a per-member, per-month approach (PMPM) (i.e., a predetermined, fixed amount). For a prospective payment system (e.g., PMPM model) which is reflected in a capitation and global budget model, members commented on the importance of risk adjustment based on the case mix of covered individuals in a defined geographic area to reflect health status. Members also learned about the Oregon Primary Care Payment Reform Collaborative and their work including consideration of a single payment model.

Key Issues
• Emphasize paying providers to reflect value of services, not price, according to an individual's insurance coverage type and status. Use value-based payments and incentives rather than paying for volume of services. • Lack of consensus on how to structure payments for providers; use of global budget and PMPM were most frequently mentioned. • Establish a payment structure that reflects differences in health status, service needs, and geographic areas (i.e., underserved areas and populations groups).

7. What would be the conditions of provider participation?

Members suggested providers be allowed to participate if they met certain conditions: (1) agree to publicly report on quality, cost, and patient satisfaction; (2) use contracts to be held accountable for quality and health outcomes; and (3) accept standardized reimbursement methodology and payment rate(s). Several members commented on establishing a set of statewide standards providers would need to meet as a pre-condition to participate, building on Oregon's Patient-Centered Primary Care Home program as a model.

- ✓ No exclusions
- ✓ Professional licensure as a condition of provider participation
- ✓ Require provider contracts tied to quality and outcomes

Another condition mentioned was using incentives to encourage provider participation. The example offered was if a provider elects to receive public funds (e.g., Medicaid or PEBB), that provider is then required to see all patients regardless of coverage type. The most frequent response was restricting access to state licensure to incentivize a provider's willingness to participate in a statewide program.

Key Issues
• Importance of not excluding any providers from participating (i.e., inclusivity). • Incentives vs. penalty approach to ensure provider participation. • Role of conditioning professional state licensure on willingness of a provider to participate. • Require contracts with providers as means to ensure accountability for quality and outcomes.

8. Who would be eligible to use the system?

Members most frequently responded that any resident in Oregon ought to be eligible to use a system offering universal access to care. Among the considerations were length of residency (e.g., minimum of 12-months) and whether an individual is employed in Oregon. Another design consideration was whether to consider a system that deploys the use of incentives or penalties to encourage widespread participation among residents. An example offered was a coverage mandate modeled after the federal Affordable Care Act's (ACA) "individual mandate" provision, in which individuals are penalized for not having coverage.

Members discussed the potential complexities of creating and maintaining an eligibility determination system if a specified set of criteria were used to determine coverage eligibility. Another issue is whether temporary residents (e.g., visitors) would be financially responsible for any services received while visiting the state (e.g., accessing emergency medical services due to an acute illness). Lastly, members briefly considered the issue of individuals migrating from out-of-state to access affordable coverage.

- ✓ All residents, everyone
- ✓ Length of in-state residency
- ✓ Coverage mandate to incentivize participation

Key Issues
• Inclusive coverage model; all individuals residing in Oregon are to be covered. • Consider establishing a length of residency requirement versus allowing anyone to receive care regardless of length of residency or employment status.

9. What should be the covered benefits and services?

- ✓ All services
- ✓ OHP Prioritized List of Health Services
- ✓ Prioritize coverage of preventive and primary care
- ✓ Consider coverage of non-traditional benefits such as services to address social determinants of health

Members considered different covered benefits in Medicare, Medicaid, and the ACA's 10 essential health benefits (EHBs), which are services health plans are required to offer including inpatient and outpatient services, prescription drugs, mental health, and other services. An alternative is to develop a set of benefits more limited in scope that focus on primary and preventive services. Members agreed that any benefit package would cover all services with no services excluded or annual benefit limitations.

Members also expressed interest in covering benefits and services based on their clinical effectiveness, modeled after OHP's Prioritized List. Several members commented on the importance of including social services and non-health related services to address the broader social determinants of health.

Key Issues
• Essential or basic benefit package only covering primary and preventive services, compared to a more comprehensive benefit package modeled on benefits in Medicaid. • Potential role of incorporating a coverage mechanism modeled after Oregon's Prioritized List to promote evidence-based services (i.e., level of and process for determining covered benefits).

10. Would a new system of governance and administrative structure be needed?

Member responses varied with the most frequent being to expand and build upon the coordinated care organization (CCO) model of governance—one which is based on public-private partnerships with a governing board and promotes public participation. Another theme is the need to restructure the existing system in manageable "segments" starting with different provider organizations. A member also suggested that the governing entity share in upside and downside financial risk.

- ✓ It depends…
- ✓ Quasi-public/private entity (e.g., SAIF)
- ✓ Third-party administrator (TPA)

Key Issues
• Adopt and/or reform key elements of the CCO governance model. • Create a two-tiered system, one public and one for commercial entities.

Concluding Remarks

The work group's efforts provide an important foundation for future discussions in Oregon. The preferences and policy issues outlined in the work group's report acknowledge the inherent challenges and trade-offs Oregon will encounter in working to create a universal system of health care, while temporarily setting aside the question of relying on federal funding and permissions. The work group effectively outlined key features on financing, delivery, and organization of a universal coverage system including potential goals and priorities for a new system. An important next step is to develop and refine a set of shared goals and values among all Oregonians in creating accessible health care for all in the state.

INTERNATIONAL COMPARISON OF HEALTH SYSTEMS

In May, the work group explored universal coverage systems in other countries. Two international experts, Theodore Marmor and Kieke Okma, engaged in a discourse with members on perspectives around universal coverage in other countries. Jonathan Walker, a graduate student at Portland State University, prepared an international comparison of health care systems for the work group in which he presented information on Australia, Canada, Germany, and Switzerland.[8] These four examples provide perspectives on the differences and similarities in the structures of national health care systems, and how these countries handle key policy considerations described at the end of this section (information provided by Mr. Walker). It is important to note that in other countries with universal coverage, health coverage and employment are separate; employers do not provide or choose insurance plans, level and type of benefit coverage, or out-of-pocket costs. The international comparison offers potential steps states, including Oregon, may explore.

The Commonwealth Fund published a report in 2017 entitled "Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care."[9] The report compares the health care systems of 11 countries: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. Based on 72 indicators in five domains, the performance of the U.S. health care system ranked last overall. The U.S. spends more money for poorer outcomes than other high-income countries. In 2014, the United States spent 16.6 percent of its GDP on health care, compared to 9 percent to 11.4 percent spending among the other ten countries in the report. Out of 11 countries in each of the five domains evaluated by the report, the United States scored as follows: 5th in Care Process, 11th in Access, 10th in Administrative Efficiency, 11th in Equity, and 11th in Health Care Outcomes.

Noted in the report are the vast differences in the health care models of the three top-performing countries. In the U.K., general tax revenue pays for the population's health care. In Australia, single-payer universal insurance through Medicare is funded by tax revenue, and about half of the population chooses to purchase private insurance. The Netherlands has a multi-payer system of private insurers that funds health care for its citizens; these insurers are financed through a pool of community-rated premiums and payroll taxes. Some aspects of these systems are already functioning in the U.S. The report also noted that the United States is the only high-income country without a universal system of health care.

[8] See full report. Jonathan Walker (May 2018). International Comparison of Health Care Systems. Prepared for the Universal Access to Care Work Group. Accessed at: https://www.oregonlegislature.gov/committees/hhc/WorkgroupDocuments/Jon%20Walker,%20Graduate%20Student,%20Portland%20State%20University%20(report%2006-21-2018%20meeting).pdf

[9] Schneider, E., Sarnark, D., Squires, D., Shah, A., & Doty, M. **Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care,* 2017. Commonwealth Fund. Retrieved on Nov. 27, 2018 at: https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2017_jul_schneider_mirror_mirror_2017.pdf

Summarized below are key components that comprise all-payer systems.

How basic health insurance is structured (all-payer or single-payer): among industrialized countries, health care systems often fall into two broad categories: (1) heavily regulated all-payer systems with multiple insurers or (2) single-payer systems where the government directly provides basic insurance.

How provider rates are determined: in all-payer systems, a mechanism is used to set prices for all insurers; either the government does this directly, or an agreement is reached among the insurers and providers. In single-payer systems, the government sets reimbursement rates or directly employs providers in government-run hospitals. Rate setting often entails regulating the salaries of physicians, level of administrative spending by insurers, and pharmaceutical costs.

How the system is financed: national health care systems generally fall into either a social insurance model (where individuals pay a premium/payroll tax approximately equal to their health care costs) or a "pay as you go" model (where health care is funded by general tax revenue).

How individual cost-sharing is handled: cost-sharing ranges from minimal to significant deductibles/coinsurance paid by individuals.

What degree of duplicate, complementary, and supplementary insurance is allowed/used:[10] duplicate insurance is defined as insurance that covers procedures also covered by the basic insurance program but offers greater network size, faster access, or greater level of care. Complementary insurance refers to insurance that covers part or all of the cost-sharing in the basic health system. Supplementary insurance refers to insurance that covers procedures not covered by the basic program such as dental, vision, certain drugs, and orthodontics.

Level of managed care/utilization management: degree to which systems use health maintenance organizations (HMOs), limit choice, or require provider gatekeeping.

Hospital ownership: the percentage of hospitals that are public, not-for-profit, and for-profit.

[10] Different countries use different definitions of these terms depending on the insurance structure. There is not always a clear distinction between these types of additional coverage. Complementary insurance can function like duplicate insurance by paying the difference for high-cost providers. Definitions for these terms come from OECD Health Statistics 2017 Definitions, Sources and Methods retrieved May 16, 2018. http://stats.oecd.org/fileview2.aspx?IDFile=e11b92da-6cc5-4cea-afe9-1d4cce02e5a4

Design Choices Among International Countries

Several fundamental design concepts exist among international systems, including and beyond the four aforementioned countries, which are highlighted below.

Design Choices Among International Countries	
Government Rate-Setting	Countries that set prices tend to use three basic models: (1) a single universal price (Japan, Canada, United Kingdom, Norway); (2) a ceiling to hold prices down with managed care arrangements that charge less (Switzerland, Medicare Advantage); or (3) an expected floor, which providers are encouraged to accept as full payment, but can balance-bill for more (Australia & France). As a result, for several systems, the default is effectively a preferred provider organization (PPO) with higher cost-sharing, but an individual can reduce their out -of-pocket costs by opting for managed care. For others, the default is a managed-care arrangement, where an individual has the choice to pay additional costs to access a larger network of providers.
Administrative Costs	Single-payer systems tend to have lower administrative costs than all-payer systems as individual plan choice increases administrative costs. Systems financed by multiple payers have a more complex reimbursement scheme and tend to have higher administrative costs. Offering individuals insurance choices often necessitates risk-adjusting, which adds administrative costs.
Standardized Cost-Sharing	In countries with significant cost-sharing, implementation is normally standardized. For example, governments set coinsurance rates, set copays, and/or set deductibles that are universal or near-universal. Countries that use cost-sharing employ a variety of mechanisms to reduce out-of-pocket cost for the lowest-income individuals. Mechanisms include exempting low-income people from coinsurance, sending people to providers who are not required to charge cost-sharing fees, or providing public complementary insurance for low-income people.
Gatekeeping	Countries that aim for an equalitarian system with a single-payer approach tend to have nominal to no cost-sharing. Rather they have robust gatekeeping policies to manage resources and utilization of services.

For a complete summary of individual country profiles, see the full report prepared by Mr. Walker.

KEY DESIGN CONSIDERATIONS AND ELEMENTS OF ALL-PAYER MODELS

To understand countries' health care systems, it is important to understand the core components that comprise all-payer systems among the four countries analyzed (by Mr. Walker): Australia, Canada, Germany, and Switzerland. There are five key components:

1. **Subsidies to make insurance affordable to everyone –** there are individuals who are unable to afford their full health care costs, so to make the system universal, governments subsidize a portion of the population to ensure no one pays over a set percentage of income. This is achieved through direct subsidies to individuals or indirect subsidies to providers or insurers to hold premiums down.
2. **A single rate-setting mechanism –** a core component of all-payer systems is an entity that sets providers rates, either as a single price, a ceiling, or a widely accepted base with a fee schedule.
3. **Robust risk adjusting mechanisms –** multiple competing insurers require complex risk adjustment payments between insurers.[11]
4. **Regulation to modify behaviors by insurers and providers –** even an advanced and well-financed risk adjustment mechanism is imperfect. Thus, a robust health system may benefit from a strong regulatory mechanism. For example, most all-payer countries require mandatory health insurance to be not-for-profit, prohibit risk selection, and allow a single universal benefit package to be sold to simplify comparisons across plans.
5. **Mechanism to reduce free riders –** such as an individual mandate, an automatic deduction from all employer payroll, employment assigned coverage, loss of coverage, asset seizure, or requirement to pay months/years of delinquent premiums to regain coverage. Countries differ in how they use and enforce such mechanisms.

As concluded by Mr. Walker, industrialized countries vary in financing universal health care, providing health insurance, levels of benefits, and managing individuals' total health care use. A country can have an all-payer system with high-cost sharing or virtually no cost-sharing. A country can offer individuals a wide choice of insurers in an all-payer system or no choice, allow a private supplementary insurance market or no supplementary insurance with either an all-payer or single-payer model. "Private" insurance markets can be highly regulated by government.

Below is a table comparing the United States to the health care systems in Australia, Canada, Germany, France, Japan, UK, Switzerland, and Sweden. Eight countries were included to provide an indication of patterns that exist across multiple industrialized nations. These eight countries include a broad range of insurance structures and health system designs.

[11] Ministry of Health, Welfare and Sport. (August 10, 2012) Risk adjustment under the Health Insurance Act in the Netherlands. (pg 6,7) Retrieved March 20, 2018 from https://www.government.nl/documents/leaflets/2012/08/10/risk-adjustment-under-the-health-insurance-act-in-the- netherlands

	Switzerland	Germany	Japan	France	Australia	Canada	UK	Sweden	US Overall	US Medicare
Health Insurance Structure	All-payer (insurer choice)	All-payer (insurer choice)	All-payer (assigned insurers)	All-payer (assigned insurers)	Single-payer	Single-payer	Single-payer	Single-payer	Multiple payer	Single-payer, all- payer mix
Degree government sets provider rates (1-total govt 10-no govt)	3	2	1	3	3	1	1	1	8	5
Administrative on insurance side % of total spending	4%	5%	1%	1%	3%	3%	2%	2%	8%	2%*
Generalist pay (Ration of remuneration to mean wages)	$122,000* (NA)	$154,126 (3.3)	$124,558 (NA)	$111,769 (2.6)	$108,564 (2.1)	$146,286 (3.0)	$134,671 (3.1)	$86,607(2.0)	$218,173 (3.6)	NR
Specialist pay (Ratio of remuneration to mean wages)	NA	$181,243 (3.9)	NA	$153,180 (3.6)	$202,291 (3.8)	$188,260 (3.9)	$171,987 (3.4)	$98,452 (2.3)	$316,000 (5.3)	NR
Drug spending per capita	$939	$667	$837	$697	$560	$613	$779	$566	$1,443	NR
How the system is financed	Premiums and general funds	Mostly a payroll tax premium	Premiums or payroll taxes and general funds	Payroll tax, dedicated income tax, excise taxes	General funds and a payroll tax	Mainly general funds, some payroll tax/premiums	General funds	General funds (mainly local income taxes)	Premiums, payroll taxes, general funds	Premiums, payroll taxes, general funds
Level of cost sharing	high	very low	high	moderately low	zero-very low	zero	zero	low	very high	high
Had medical problem but skipped treatment	22%	7%	NA	17%	14%	16%	7%	8%	33%	NR
Duplicate, complementary, or supplementary insurance	Supplementary common	Duplicate 11% of population, Some supplementary and complementary	Complementary and supplementary common	Complementary 95%	Supplementary and/or duplicate 57%	Supplementary common	Duplicate roughly 10% of population	Duplicate roughly 10% of population	Varied (undefinable)	Supplementary and complementary
Level of managed care/gatekeeping	Moderate varied	low	low	moderate varied	moderate varied	high	high	low	Moderate varied	Moderate varied
Who owns the hospitals	21% public. 25% non-profit. 54% private	48% public, 35% non-profit, 17% private (beds)	15% public, 85% not-profit	67% public, 8% non-profit, 25% for profit (beds)	65% public, 35% private	Mainly public and non-profit	Almost all public, some private	Almost all public, some private	15% public, 70% non-profit, 15% for-profit	NR
Level of care utilization	Moderately high	High	Very high	Moderate	Moderately high	Moderate	low	Moderately low	Moderate	Moderate
Health care spending as percentage of GDP	12.4%	11.3%	10.9%	11%	9.6%	10.3%	9.7%	11.9%	17.8%	NR

STATE EFFORTS TO ENACT UNIVERSAL HEALTH CARE

This section summarizes recent state efforts to enact universal health care. It reviews key policy decisions made in each state's design and identifies contributing factors that led to these efforts failing in their respective legislative assemblies. Jonathan Walker also prepared a report based on states that have engaged in policy efforts around universal coverage in the past decade: Vermont, Colorado, New York, and California. In 2011, Vermont adopted a law to create a single-payer health care system; the governor then oversaw the design of the single-payer system. Vermont, however, decided not to implement the proposal after the initiative failed to pass a subsequent funding bill. In 2016, Colorado voted on a constitutional amendment to create a single-payer system called ColoradoCare, which voters rejected. In New York and California, elected officials recently introduced legislation in support of universal coverage. The legislation has not passed in either state. See Table 2 on pg. 23 for a comparison of the four states.

SHARED CHALLENGES AND LESSONS

An examination of these states' efforts finds several challenges and lessons for states exploring universal coverage policies to consider:

Federal Employee Retirement Income Security Act (ERISA) makes the process significantly more complicated: all four initiatives proposed redirecting the money that public and private entities in the state currently spend on health care into a new centralized system. The predominant approach would require large employers to standardize their private insurance or mandate they buy a new public insurance plan for their employees. This approach is similar to how other industrialized countries have approached creating a universal system. However, federal ERISA prohibits states from pursuing these paths.[12] As a result, all four plans relied on employer payroll taxes, which creates both political and financial issues.

Free-at-point-of-service results project increased utilization and higher than expected costs: currently, the U.S. health care system relies on out-of-pocket costs as a direct and indirect utilization management tool. All four proposals called for minimal or no cost-sharing. Furthermore, none of the four states' proposals explicitly created a clear alternative form of utilization management. ColoradoCare proposed that individuals would have the "right to choose their primary health care providers."[13] The Vermont plan referenced the possibility of a designated primary care provider to coordinate an individual's care, but the idea was not presented with sufficient detail such that it could be scored.[14] This resulted in higher-than-expected costs in official estimates using current models. Such outcomes may create the need for higher tax rates or reductions in provider rates to offset additional health care expenditures. National research highlights this dynamic in that a

[12] White C, Eibner C, Liu JL, et al. A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon. *Rand Health Quarterly*. 2017;7(1):1.

[13] Colorado Amendent 69 (2016) http://www.coloradocare.org/wp-content/uploads/2016/04/amendment-reformatted12.27.15.pdf

[14] Office of Governor Peter Shumlin. (December 14, 2014) Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Health Care System. p. 18 Retrieved March 24, 2018 http://hcr.vermont.gov/sites/hcr/files/pdfs/GMC%20FINAL%20REPORT%20123014.pdf

national single-payer system with minimal to no cost-sharing would increase national health care expenditures by $435 billion, annually, due to increases in utilization. This figure, however, does not factor in other savings and reduced costs related to administration, price changes, and implementation. A single-payer system with a cost-sharing structure modeled after federal Medicare may reduce national health care expenditures by $179 billion before incorporating other possible savings.[15]

Long-term care expenditures excluded: long-term care services are excluded in proposed coverage programs except in several instances for individuals who qualify under Medicaid.

Multiple federal waivers: all four states' proposals require federal 1115 Medicaid Waivers, 1332 Waivers of the ACA, and potentially, federal Medicare waivers. The potential challenge in obtaining a federal Medicare waiver has led states to explore options to keep individuals enrolled in Medicare (and TRICARE), and offer supplemental coverage. There is no guarantee that federal waivers will be considered or approved.

No true "single" payer proposal: states are limited in their ability to repurpose federal health care funds, including redirecting federal financial resources tied to Medicare and TRICARE. Moreover, workers commute into states, individuals travel in and out of states, and states have limited to no discretion in enacting changes that impact ERISA-based insurance coverage in a state.

Details matter: the failure of the Colorado ballot measure was due in part to concerns about its specific design issues among possible supporters. For example, the cooperative which would have run Colorado's new health care plan had potentially unconstitutional rules governing the election of its board.[16]

For a complete summary of each state, see the full report by Mr. Walker.

Although it was only discussed briefly in the work group discussions, it is worth mentioning Oregon Ballot Measure 23 from 2002, which sought to create a single-payer universal access system. Measure 23 is part of our health policy history and predates the aforementioned state efforts.

[15] Liu, Jodi L., Exploring Single-Payer Alternatives for Health Care Reform. Santa Monica, CA: RAND Corporation, 2016. https://www.rand.org/pubs/rgs_dissertations/RGSD375.html.

[16] Matthews, D. (September 14, 2017) Single-payer health care failed miserably in Colorado last year. Here's why. Vox. Retrieved March 24, 2018 https://www.vox.com/policy-and-politics/2017/9/14/16296132/colorado-single-payer-ballot-initiative-failur

Table 2. Comparisons of States' Proposal by Key Design Elements

	Vermont	Colorado	California	New York
Eligibility	All Vermont residents except Medicare or TRICARE. Non-residents who commute into Vermont to work for Vermont businesses.	All Colorado residents except those covered by Medicare and TRICARE. ColoradoCare would have been a supplemental care for TRICARE and Medicare. ColoradoCare would have also offered a Medicare Advantage plan.	All resident of California. Seniors would have been required to enroll in Medicare Parts A, B, and D.	All New York residents (although if waivers weren't obtained, it would have attempted to make it as seamless as possible for those technically covered by Medicaid and Medicare).
Benefits	Primary, preventive, mental health, and chronic care. Hospitalization, rehabilitation, labs, prescription drugs. Dental and vision for children. No dental and vision for adults or long-term care for people who don't qualify under Medicaid.	Primary, preventive, mental health, chronic care. Primary, preventive, mental health, and chronic care. Hospitalization, rehabilitation, labs, prescription drugs. Dental and vision for children. No dental and vision for adults. At least long-term care for people who don't qualify under Medicaid.	"All services covered by Medi-Cal, Medicare, the essential health benefits, and all health plan/insurance mandated benefits. Benefits required include chiropractic, vision, dental, ancillary health or social services previously covered by a regional center, skilled nursing facility care, and therapies shown by the National Institutes of Health, National Center for Complementary and Integrative Health to be safe and effective."	All health services covered by child health plus, Medicaid, Medicare, ACA, state civil service law, except long term care which would have been dealt with separately.
Affordability/ Cost-sharing	Minor cost-sharing coverage (94 percent actuarial value insurance).	No cost-sharing.	No cost-sharing.	No cost-sharing.
Administration	The Green Mountain Care Board (five members nominated by a committee and appointed by the Governor) would oversee a program operated as a public-private partnership between the state of Vermont and a strong private sector partner under either a "designated public utility" or a "designated facilitator" model.	ColoradoCare would have been run as a cooperative. It would have been controlled by a 21-member board of trustees elected in special non-partisan co-op elections that would be separate from regular state government elections.	Healthy California would have been an independent public entity run by a nine-member board.	New York Health program would have been created in the Department of Health and managed by a 29-member board of trustees.
Financing	11.5% payroll tax, sliding scale "public premium" up to 9.5% Adjusted Gross Income, some cost-sharing, existing state funds and federal waiver funds.	10% payroll tax and 10% non-payroll income premium, existing state funds and federal waiver funds.	SB 562 provided no financing mechanism beyond existing state funds and federal waiver funds. Officials estimated it would require a 15% payroll tax.	Legislation provided no financing mechanism beyond existing state funds and federal funds. Intent was to fund program by "progressively graduated tax on all payroll" income and "progressively graduated tax on taxable income not subject to the payroll tax."
Unique Challenges	Concerns about generating sufficient reserves to launch the program. Lack of credibility after failure of state-run exchange. Difficulty securing federal waivers. Higher than expected costs of projects.	Outside independent analysis projected tax revenue could be insufficient.	No defined financing plan. Required the issue to be placed on the ballot to exempt it from existing constitutional requirements.	Legislation failed in the Senate.

INCREMENTAL EFFORTS TOWARD UNIVERSAL HEALTH CARE

The work group explored incremental state-level policy changes that may advance the state towards universal coverage. Three policy proposals are summarized below.

- Premium Assistance
- State Shared Responsibility Coverage Mandate
- Medicaid-like Buy-in

PREMIUM ASSISTANCE - PROJECT ACCESS NOW

Staff with Project Access NOW provided an overview of the organization's premium assistance program, created in 2014. This is a financial assistance program funded by hospitals and health systems in the Portland Metro area. The program serves low-income residents providing monthly premium payments, reduced out-of-pocket costs, pharmacy co-pay assistance, and navigation of health care and the state's ACA Marketplace. The active carriers in 2017 were Kaiser Permanente, Moda Health, PacificSource Health Plans, and Providence Health and Services. Eligibility for the program is based on income, residency, and eligibility for premium tax credits through the ACA. In 2017, the premium assistance program paid $1 million for the premiums of families served. The program recently launched a new pilot program to waive co-pays for pharmacy benefits. [17]

In 2017, the program was able to serve 573 households providing coverage to 718 individuals with enrollment doubling compared to 2016.[18] Staff shared challenges encountered with administering the premium assistance program:

- Relationships with insurance carriers
- Processes for third-party payments
- Single contact at insurance carrier billing offices
- Helping clients understand and utilize their insurance and prior authorization
- Providers' differing policies
- Client navigation and follow up
- Rate changes
- Changes in eligibility and transitioning clients
- Ineligible populations
- Tax credit reconciliation

Members briefly discussed the potential for a state-based or regional program to expand the role and use of premium assistance programs drawing on lessons learned and opportunities from Project Access NOW and the COFA program managed by Department of Consumer and Business Services (DCBS).

[17] Project Access NOW (2018). 2017 Premium Assistance Report. See: https://www.oregonlegislature.gov/committees/hhc/WorkgroupDocuments/Sheila%20Hale,%20Benjamin%20Becerra,%20Linzay%20Barnhart,%20Project%20Access%20NOW%20(handout%20(2)%2008-23-2018%20meeting).pdf

[18] Project Access NOW (September 20, 2018). Presentation to the Work Group. https://www.oregonlegislature.gov/committees/hhc/WorkgroupDocuments/Sheila%20Hale,%20Benjamin%20Becerra,%20Linzay%20Barnhart,%20Project%20Access%20NOW%20(presentation%2009-20-2018%20meeting).pdf

State-based Shared Responsibility Coverage Mandate

In 2018, Congress eliminated the ACA's financial penalty for individuals who do not have insurance starting in 2019. In response, states are moving forward with state-level individual insurance mandates including New Jersey, Rhode Island, and Vermont, among others. States are considering a shared responsibility mandate and imposing penalties for those who do not maintain coverage (to replace the federal ACA individual mandate penalties that will be eliminated in 2019). This policy approach may generate state revenue and incentivize currently uninsured adults to obtain coverage, if affordable.

In 2006, Massachusetts enacted the landmark health care reform design to expand health coverage by establishing a requirement that adults enroll in health coverage or pay a penalty. The mandate was to reflect the principle of "shared responsibility" between governments and individuals. The mandate comprises three pillars: coverage standards, affordability standards, and penalties and exemptions. Looking to Massachusetts, upon passage of the ACA, the state reduced any individual liability by the amount owed to the federal government to avoid double-penalizing state residents. Massachusetts uses state tax data to understand the demographics of individuals without coverage to tailor outreach and communication efforts. Table 3 provides an overview of the penalty amounts by income level in Massachusetts.

Table 3. Massachusetts Individual Mandate Penalties - 2017[19]

Massachusetts Individual Mandate Penalties - 2017					
Income category	150.1-200% FPL	200.1-250% FPL	250.1-300% FPL	Above 300% FPL - Age 18-30	Above 300% FPL – Age 31+
Penalty	$21/month $252/year	$41/month $492/year	$62/month $744/year	$74/month $888/year	$96/month $1,152/year

Source: Massachusetts Health Connector

States exploring establishing an individual mandate must evaluate the following key components:[20]

1. Individual Mandate – Enforcement Mechanisms
    a. Definition of qualifying coverage
    b. Exemptions
    c. Penalty calculation
2. Reporting Requirement for Certain Coverage Providers
    a. Requires minimal effort on top of federal reporting
    b. Federal programs exempted
3. Procedures for Granting Certain Exemptions
    a. Hardship and religious conscience exemptions
4. Notification of Uninsured about Coverage Options (optional)

[19] The Massachusetts Individual Mandate: Design, Administration, and Results: https://www.mahealthconnector.org/wp-content/uploads/Individual-Mandate-Report-Nov2017.pdf

[20] See Jason Levitis (2018). Designing a State Individual Mandate. State Health and Value Strategies.

States are considering uses for potential revenue generated from the penalties including funding market stabilization and consumer affordability initiatives. These initiatives include allocating revenue to fund a state reinsurance fund to reduce premiums such as in New Jersey. Maryland is proposing using estimated revenues to finance state-funded premium assistance or cost-sharing subsidies to address consumer affordability. Connecticut's proposal would allow individuals who paid the penalty to use these funds to pay for out-of-pocket health care expenses.

In October, Zach Sherman, Director of Rhode Island's HealthSource (i.e., the state's Marketplace), presented the work of the state's Market Stability Workgroup focusing on their "Shared Responsibility" proposal (see presentation). Rhode Island is pursuing a state-based shared responsibility requirement modeled after the federal individual mandate provision in the ACA. The state is moving forward with a state-level shared responsibility program to incentivize individuals to seek insurance coverage, help stabilize the risk pool, generate revenue to support affordability programs, and provide data on the uninsured. The state estimates the shared responsibility proposal, if adopted, will generate approximately $10.6 million in 2020.

The Urban Institute conducted a national analysis on how state-based individual mandates affect health insurance coverage and premium costs. The researchers provided state-by-state estimates including estimates for Oregon. On average, the state mandates would reduce marketplace premiums by 11.8 percent if all states adopted the ACA's federal individual mandate structure. Tables 4 and 5 provide estimates that if Oregon were to have an individual mandate in place in 2019, approximately 53,000 uninsured Oregonians would have coverage through three coverage mechanisms: (1) employer-sponsored coverage, (2) non-group (individual market), and (3) Medicaid.

Table 4. Marketplace monthly single premium for a 40-year-old adult, current law and with individual mandate in Oregon, 2019

	Current Law	With individual mandate in Oregon	Percent Change
Oregon	$450	$390	⬇ 13.4%
U.S. Average	$530	$470	⬇ 11.8%

Source: Urban Institute, Health Insurance Policy Simulation Model (HIPSM) 2018

Table 5. Difference and Percent Difference in Insurance Coverage in 2019 and 2022

	Employer		Non-group		Medicaid and CHIP		Uninsured	
	Difference from current law	Percent difference	Difference from current law	Percent difference	Difference from current law	Percent difference	Difference from current law	Percent difference
2019	11,000	.6%	34,000	21.6%	8,000	.8%	-53,000	16.7%
2022	43,000	2.4%	58,000	41.5%	11,000	1.1%	111,00	29.3%

Source: Urban Institute, Health Insurance Policy Simulation Model (HIPSM) 2018

It is important to note that the impact on coverage and premiums from establishing an individual mandate in Oregon, will vary based on the components and structure of the mandate. Additional analysis is also needed to evaluate whether the effect of the individual mandate, over time, will reduce the number of uninsured and decrease the annual growth in premiums due to a larger risk pool.

MEDICAID-LIKE BUY-IN

States are exploring the concept of a Medicaid buy-in program to establish a new coverage program targeting lower-income individuals and families not eligible for Medicaid or federal subsidies through the Marketplace. The work group explored a range of design considerations for establishing a Medicaid buy-in option in Oregon. Based on members' written feedback and work group discussions, an emerging proposal for consideration is a product that is offered statewide and outside the individual Affordable Care Act (ACA) market ("off the Exchange"). The product could be offered statewide, leverage Oregon's existing Medicaid infrastructure, provide a comparable level of benefits as covered in the OHP, and utilize existing provider networks managed by CCOs and affiliated partners.

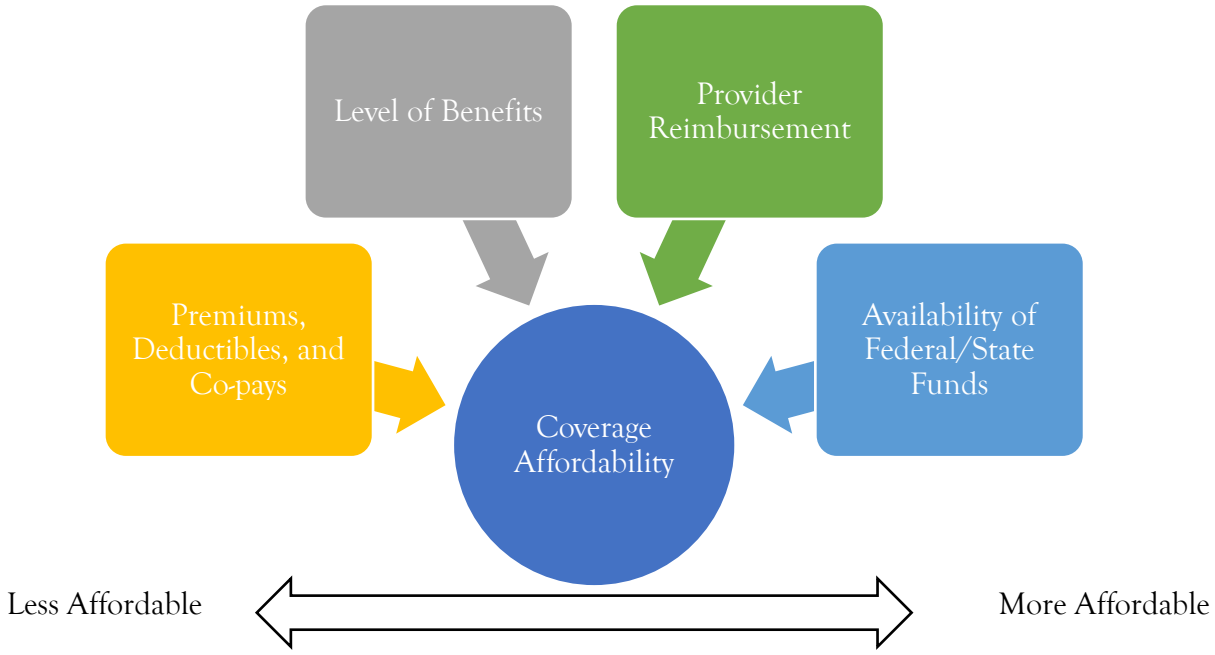
Members provided written feedback that was used to design a Medicaid-like buy-in model with three different options, all offered off the Marketplace without pursuit of a federal 1332 waiver. Summarized below are members' input on seven key design aspects (see full summary).

1. **Policy Goal:** Medicaid buy-in potentially moves Oregon closer to universal access by bringing more Oregonians into a coverage program.
2. **Target Population(s):** individuals who do not qualify for Medicaid or federal subsidies on the Marketplace.
3. **Program Administration:** CCOs enroll and administer the program, manage member premiums, and provider reimbursement and networks.
4. **Benefits:** OHP for adults including dental and vision.
5. **Out-of-pocket Costs:** no deductibles or co-pays at the point of care with members paying the entirety of the monthly premiums.
6. **Enrollee Premiums:** premiums based on Medicaid per-member, per-month rates paid to CCOs (e.g., ACA adult population with regional adjustments).
7. **Provider Reimbursement:** rates in Medicaid utilizing existing payment models by CCOs with the goal of deploying value-based payment methodologies.

In considering the Medicaid buy-in proposals, there are four factors that influence the overall costs for health coverage. For each factor, depending on the preferences of the work group, adjustments to one or more of the factors can increase or decrease the potential "affordability" associated with each proposal. See figure 8 on next page. Such factors, depending on their direction, may impact any potential uptake among individuals in Oregon. These factors may also be further affected by an individual's or family's insurance status including but not limited to reasons for being uninsured and/or underinsured, health status, and geographic location, among other factors that influence coverage and affordability.[21]

[21] Oregon Health Authority (2018). Oregon Health Insurance Survey – Early Release Results.

Figure 8. Key Factors that Influence Coverage Affordability



Members also expressed concerns about introducing a Medicaid buy-in product or program that may undermine the ability to deliver health care to the significant population in commercial or self-funded health plans; or, to destabilize the ability of CCOs to deliver OHP under the terms of the 1115 waiver by shifting focus or risk to areas outside of their core expertise.

Staff with the Oregon Health Authority and the Department of Consumer and Business Services presented to the work group on Medicaid buy- straw proposals. Agency staff described the implications of each proposal (see October 18 presentation). Information presented also provided financial estimates with respect to different premiums solely for illustrative purposes. Members raised several issues:

- Whether CCOs want to offer a Medicaid buy-in proposal(s) in Oregon.
- Provider networks and different reimbursement rates in Medicaid compared to commercial plans.
- Data on potential target populations by income level.
- Potential limitations of a 1332 waiver with respect to securing additional federal funding.

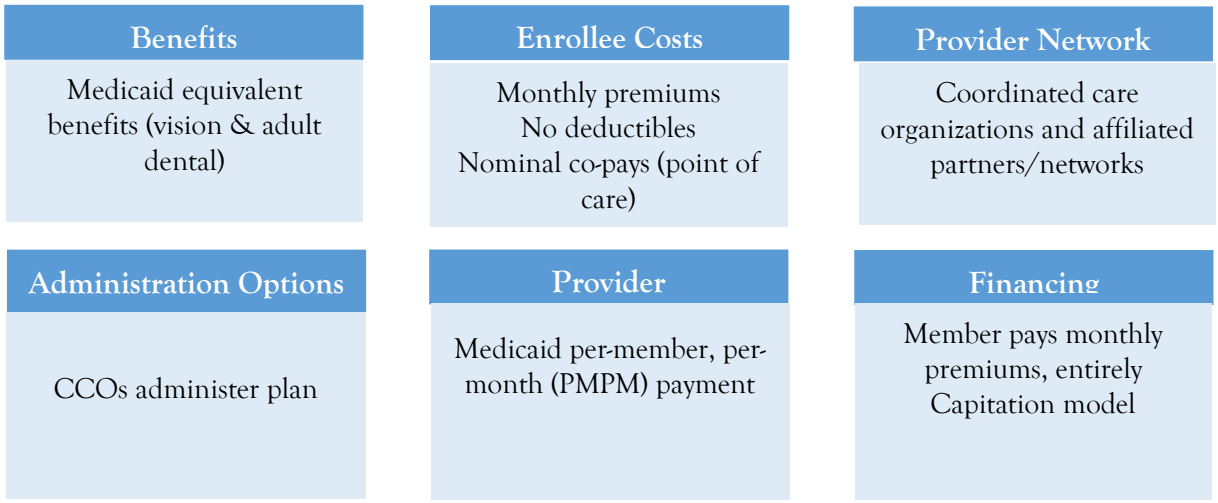
Moving forward, it may be worth exploring options around a 1332 waiver to leverage federal funding for a Medicaid buy-in program. Such a waiver is required to preserve federal subsidies available to individuals who currently receive federal subsidies on the Marketplace. If Oregon were to pursue a 1332 waiver as part of establishing a Medicaid buy-in plan, this approach could potentially provide CCOs with additional patients with greater ability to pay, a healthier risk pool, and an ability to reimburse providers above Medicaid rates. Countervailing considerations are that the Medicaid buy-in option may distract CCOs' focus on successfully achieving CCO 2.0 objectives; may disrupt commercial and CCO provider networks as more patient care is reimbursed at Medicaid rates; and may create unintended selection issues in individual and small group markets when eligible members

opt for the Medicaid buy-in. The work group also noted that the federal political and administrative environment under the current administration may make it unlikely that Oregon could obtain a 1332 waiver for a Medicaid buy-in option.[22]

A Medicaid-like buy-in product in Oregon could provide coverage options with greater affordability for targeted groups of individuals and families in Oregon who are currently uninsured or underinsured, including unsubsidized individuals who pay the full cost of premiums (i.e., greater than 400 percent of federal poverty level (FPL)). The work group indicated an interest in considering proposals to offer the program as an unsubsidized plan offered off the Exchange, which would preclude individuals eligible for federal subsidies from using these subsidies to purchase coverage. The goal of this approach is to establish a program that likely will not require a section 1332 wavier. The proposed model would mirror Medicaid-level benefits delivered through CCOs. Monthly premiums paid entirely by enrollees would support funding. Other design elements for the Medicaid buy-in model are outlined in Figure 9.

There are several issues with the model as proposed by the work group. First, the state would not be able to receive any federal pass-through funding that might otherwise be available by establishing a plan off the Exchange without a federal 1332 waiver. Second, if the plan is established with a risk pool separate from Oregon's individual market, it could impact the individual market risk pool due to the uncertainty of the health profile of potential enrollees (i.e., healthier or less healthy enrollees).

Figure 9. UAC Work Group Preliminary Proposed Model Design Elements



[22] After the work group concluded its decision on Medicaid buy-in, CMS released guidance on section 1332 waivers to "increase choice and competition with the insurance marketplace" referred to as State Relief and Empowerment Waivers. Guidance released on October 22, 2018.

In October, members asked staff to research available data on potential populations that might be served by a Medicaid-like buy-in option in Oregon.[23] Staff reviewed several national and state data sources on health insurance status to identify potential population estimates for the proposal as discussed. The potential population groups are:[24]

- Low income
- Unsubsidized (over 400 percent FPL, immigration status, individuals not eligible for Medicaid or federal subsidies)
- Small businesses

In response to the work group's request, it is useful to understand Oregon's current commercial market. Individuals enrolled in individual health coverage in a product offered "off-Exchange" may be eligible for federal subsidies (i.e., tax credits) and opt to purchase these health plans at full cost (i.e., not publicly subsidized). According to the 2016 estimates from the U.S. Department of Health and Human Services, approximately 26,000 Oregonians are premium tax-credit eligible but enrolled in an off-Exchange plan.

Data from Oregon's commercial market (summarized in Table 6) and includes group and non-group insurance types. This provides some context of the insurance market in Oregon and the populations that may benefit from a Medicaid buy-in product. Group insurance includes small-group, large-group, self-insured, associations, trusts, and Multiple Employer Welfare Arrangements (MEWAs).[25] Non-group insurance involves individuals directly purchasing individual plans on and off the Exchange.

Table 6. Oregon Health Insurance Enrollment (June 2018)

Type of Insurance			Individuals Enrolled
Commercial Market	Individual	On Exchange	130,766
		Off Exchange	57,910
	Small Group (2-50 employees)	On Exchange	1,056
		Off Exchange	174,170
	Large Group (50+ employees)		600,468
	Associations, Trusts, and MEWAs		165,006
	Student Plans (offered by universities and colleges)		11,901
		Total Commercial	**1,141,429**
	Self-Insured		835,789
	Stop Loss Only		182,428
Grand Total (excluding public enrollees and uninsured			**2,159,616**
	Medicaid** (March 2018)		1,104,071
	Uninsured+ (2017)		245,000

Sources: Oregon Department of Consumer and Business Services, Oregon Health Authority's Oregon Health Insurance Survey 2017

***Enrollment as of March 2018.*

+Based on the 2017 OHIS early survey results.

[23] It is important to note that when Medicaid buy-in is referenced through this document, it is referring to a health plan product offered outside of the federal Medicaid program that resembles several aspects of the state's Medicaid benefit package, but is not a plan offered through Medicaid.

[24] See Manatt webinar Oct. 11, 2018 for additional information on population groups and other design considerations.

[25] See DCBS for definitions of insurance types: https://dfr.oregon.gov/business/reg/reports-data/annual-health-insurance-report/Documents/quarterly/quarterly-enrollment-definitions.pdf

UAC Work Group – Medicaid Buy-in Design by Population Groups

As a result of the work group's discussion in October, and upon review of available data sources on health insurance coverage, staff reorganized the design considerations matrix based on potential eligibility groups. The revised set of options outlined in the matrix below are oriented around defining a set of targeted eligible populations as the principle design consideration. There are other considerations in designing a Medicaid buy-in option reflected in the table (see next page) and which have been carried forward from earlier iterations.

It is important to note several limitations, particularly that a number of different data sources and calendar years have been used to offer a profile of the potential eligible or target populations. The estimates do not reflect current levels, including the uninsured in 2018, the number of individuals likely to enroll in Marketplace coverage for 2019, and any potential effects from the elimination of the individual mandate starting in 2019. Due to the different data sources and point-in-time estimates, the figures offered below do not offer a complete profile or accurate information for those interested in a Medicaid buy-in in Oregon for any population group.

Model summary: Medicaid Buy-in Program offered Off-Exchange to provide eligible individuals an option to purchase an insurance product with OHP-level benefits administered by CCOs			
	Individuals not eligible for Medicaid or federal marketplace subsidies based on immigration status.	**Individuals not able to obtain affordable coverage in the individual market.**	**Small employers (<50 employees) affordable coverage options**
Eligible Populations and Estimates	• **20,630** adults ages 19-64 between 0-400% Federal Poverty Level (FPL) <u>not</u> eligible for Medicaid or federal subsidies in the Marketplace • ~**3,500-6,500** legal permanent residents who are in households less than 138 % FPL who would otherwise be eligible for Medicaid except they have been in the country for less than five years (Oregon Center for Public Policy) • ~**130,000** estimated unauthorized immigrants in Oregon (2014)[26]	• **22,805** individuals and families between 138-400% FPL without offer of employer-sponsored coverage and NOT eligible for federal subsidies on the Marketplace (see pg. 7 for description of the ACA's "family glitch") • **27,559** individuals and families over 400% FPL <u>without</u> affordable employer-sponsored coverage • **6,041** individuals and families over 400% FPL <u>with</u> affordable employer-sponsored coverage	• ~**101,381** firms <50 employees, accounting for 632,325 employees • Representing 39.2 % of covered employment and 31.1 % of wages Q 1 2018) • **174,170** enrolled in Small Group off-exchange (June 2018) • **1,056** enrolled in small group on Exchange (DCBS 2018) • <u>Unknown</u> - percentage of employees (632,325) that enroll in affordable coverage from their "small employer"
Coverage Barriers [27]	• Affordability of premiums, deductibles, and out-of-pocket costs (e.g., underinsured) • Change in eligibility for publicly financed or coverage subsidies (e.g., loss of OHP coverage) • Lost employment coverage or employer stopped offering coverage	• Affordability of premiums, deductibles, and out-of-pocket costs (e.g., underinsured) • Change in eligibility for publicly financed or coverage subsidies (e.g., loss of OHP coverage) • Lost employment coverage or employer stopped offering coverage	• Employers unable to offer affordable coverage to employees or their dependents • Premiums too expensive on employer coverage • Employer stopped offering coverage
State Considerations	• Potential for market destabilization: disruption to existing carriers and Marketplace enrollees; on and off the Exchange • Network adequacy and solvency requirements • Requires licensing CCOs as commercial insurers • Potentially complicate transition to CCO 2.0 • Potentially establish separate state reinsurance program to attract CCOs and limit volatility (requires funding)	• Potential for market destabilization: disruption to existing carriers and Marketplace enrollees; on and off the Exchange • Ensure network adequacy requirements • State legislation to allow CCOs to offer Medicaid buy-in plans (i.e., licensing CCOs as commercial insurers) • Potentially establish separate state reinsurance program to attract CCOs and limit volatility (requires funding)	• Potential for market destabilization: disruption to existing carriers and Marketplace enrollees; on and off the Exchange • Network adequacy requirements • Likely requires state legislation to establish requirements • Potential disruption to CCOs and transition to CCO 2.0
Implementation Considerations	• Required or voluntary participation by CCOs • Program administrator (OHA, DCBS, other) • Potential need for eligibility system • Setting initial premiums will be complicated; risk-sharing solution may be needed • Adverse selection; initial enrollees may have high-costs or health care needs • Requires additional information, analysis, and financial modeling (particularly to assess potential impacts on the risk pool in the Marketplace)	• Required or voluntary participation by CCOs • Potential eligibility system • Protect Marketplace and commercial offerings available currently on and off Exchange • Eligible individuals purchase coverage directly from CCOs • Maintain risk pool for individual market • Requires additional information, analysis, and financial modeling (particularly to assess potential impacts on the risk pool in the Marketplace)	• Required or voluntary participation by CCOs • Disruption to current risk pool for small group market

[26] PEW Research Center Estimates based on American Community Survey data. http://www.pewhispanic.org/interactives/unauthorized-trends/
[27] Barriers are based on the results of the 2017 Oregon Health Insurance Survey - Uninsurance Fact Sheet 2017.

PRIMARY CARE TRUST

A handful of states are exploring the concept of a "Primary Care Trust" aimed to create a universal health care system for all primary care services by strengthening the financial investment in a primary care system using a single payment model. Legislatures in Rhode Island and Vermont have introduced legislation seeking to create a "Primary Care Trust."[28] The legislative proposals from these two states share a number of similarities:

1. single payment system for providing universal access to primary care services
2. requirement for health insurers to allocate a portion of medical spending to primary care
3. establishment of a "trust" to provide payment for services
4. use of financial incentives for providers to participate

Key features of this policy approach are to contain growth in overall health care expenditures by investing funding into primary care and ensuring that all the residents of a state have access to primary care services without any cost-sharing. Vermont's legislation, Senate Bill 53, aimed to establish the framework for creating a universal system of primary care that would be publicly funded. Specifically, Vermont's legislation, if passed, requires a stakeholder group to develop a list of recommendations that included the types of services that would comprise "primary care," affordability of primary care services, and benefit coordination. The group would then submit an operational plan if it determined the benefits would outweigh the estimated costs.[29] Vermont intends to build on its All-Payer ACO agreement with the Centers for Medicare and Medicaid Services (CMS) which includes the use of federal Medicaid and Medicare funds in the state.

Rhode Island's approach seeks to create "Neighborhood Health Stations" in communities across the state that serve as "medical homes" for the community. These stations would be responsible for providing medical and behavioral services, oral health, physical therapy, home health, chronic disease self-management, and emergency services.[30] For every 10,000-15,000 residents, there would be a place-based "station" (i.e., neighborhood medical home) responsible for improving public health of a community using a cross-disciplinary team of health care and public health professionals. Funding for the stations would be managed by a single non-profit organization responsible for paying for all primary care services in the state. The majority of funding would be capitation-based with a focus on simplifying administration, billing, and avoiding waste. Health stations would be paid according to four key functions: (1) access to clinic services, (2) breadth of services, (3) quality improvement and health outcomes, and (4) population penetration. To fund the program, the state would assess health insurers a fee of 10 percent of their total projected medical spending. Revenue generated from the insurer assessment would be used to directly pay for essential health services provided by a station.

Oregon has a successful statewide patient-centered medical home program, the Patient-Centered Primary Care Home Program (PCPCH). As of 2018, approximately 650 clinics have been recognized as medical homes in the state's PCPCH program. Recent legislation requires health insurers to

[28] Vermont, Primary Care Trust Act Senate Bill 53 (Dec. 2017); Rhode Island House Bill 7866 (2018)
[29] Vermont Legislative Joint Fiscal Office, Fiscal Note (April 18, 2018)
[30] Fine, Michael, Rhode Island Department of Health. (Nov. 18, 2014). *Rhode Island Primary Care Trust: A strategy for neighborhood transformation.* Presentation to Annual American Public Health Association.

report on the percentage of spending that is allocated to primary care services. [31] Moreover, in 2017, the Legislative Assembly passed Senate Bill 934 requiring commercial carriers and CCOs to allocate 12 percent of their total health care expenditures to primary care by 2023. The most recent report on primary care spending (February 2018) stated that CCOs allocated 8.9 to 34.6 percent of spending to primary care, commercial carriers allocated 6.9 to 17.1 percent, and PEBB and OEBB allocated 10.4 to 17.0 percent.[32] This represents approximately 62 percent of Oregon's population and an estimated $1.5 billion spend on primary care out of $11 billion of total spending in 2016.

In 2015, a report by researchers with Portland State University evaluated the effectiveness of the state's medical home program. [33]The findings indicate that the program reduced total expenditures by 4.2 percent for individuals that received care from a medical home. The findings also estimated $240 million in savings over the first three years of the statewide program (2011-2014).

On November 15, Dr. Glenn Rodriguez presented on the state's medical home initiatives and the concept of a primary care trust.[34] According to Dr. Rodriguez, the next steps in primary care transformation are:

- universal access to primary care services without financial barriers,
- payment model which supports the PCPCH model of care, and
- payment standardization to decrease administrative costs and demands.

Dr. Rodriguez concluded his presentation by briefly discussing the following policy approaches for Oregon:

- make incremental improvements on Oregon journey: (1) standardize definition of "primary care" to align with national consensus and (2) adopt recommendations of the Primary Care Payment Reform Collaborative to implement a single payment methodology; or
- establish a universally accessible, publicly funded primary care system in Oregon modeled after examples from Vermont and Rhode Island.

The work group did not have time to analyze and discuss the implications and impacts on CCOs, commercial plans, and other government health coverage if the state were to carve out and create a publicly funded, universally accessible primary care system.

[31] Oregon Senate Bill 231 (2015), House Bill 4017 (2016), Senate Bill 934 (2017)

[3232] Oregon Health Authority and Department for Consumer and Business Services (February 2018). *Primary Care Spending on Oregon: A report to the Oregon Legislature.*

[33]Gelmon. S., Wallace, N., Sandberg, B., Petchel, S., & Bouranis, N. (September 2016). Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Findings. Portland State University, Portland, OR.

[34] Glenn Rodriguez, (November 15, 2018). Universal Access to Primary Care: A foundation for Health Care System Reform in Oregon (see slides 5-9).

WORK GROUP OBSERVATIONS

This section summarizes the list of concepts and policy approaches identified by the work group as an initial roadmap to developing a "system of universal and affordable health coverage for all Oregon residents" (pg. 1, UAC Work Group Charter, 2017). The list below is not comprehensive, exhaustive, nor complete. Rather, the list is the initial body of work put forward by the work group based on 11 months of research and deliberations. The policy approaches were developed in accordance with the charge to examine "relevant current information from other states address and analyze key barriers to advancing universal, affordable health coverage including potential trade-offs."

The information is organized according to the tasks put forth in the group's 2017 charter. Due to time constraints and the inherent complexities in designing a state-based system in a federalist system of government and federal constraints, the work group is unable to complete the tasks by the end of the calendar year. The compromise, although unsatisfactory, is a list of concepts that warrant further and more in-depth exploration, robust research and analysis, and careful deliberation among policy makers and stakeholders before, during, and after the 2019 legislative session.

The work group recognizes Oregon's current health care system is not compatible with a state-based universal coverage system without significant and unprecedented changes at the federal level, including congressional action. This reality is that Oregon receives more than 50 percent of its current funding for health care from federal programs, Medicare and Medicaid. Moreover, states will encounter challenges related to employer-sponsored coverage (e.g., Employee Retirement Income Security Act). An important next step is meaningful consumer engagement in Oregon around a host of issues, including provider choice, benefit coverage, eligibility, and namely, financing required to fund a universal coverage system.

Summarized below are incremental state-level policy approaches explored by the work group to make it easier for individuals to access and maintain health care coverage, whether through their employers or through existing or new publicly funded programs.

INCREMENTAL STATE-LEVEL POLICY APPROACHES TO ADVANCE UNIVERSAL COVERAGE	
Premium Assistance Program	Expand the role and use of premium assistance programs drawing on lessons and opportunities from Project Access NOW and the COFA program managed by Department of Consumer and Business Services (DCBS).
Enrollment Assistance and Outreach	Increase enrollment and improve risk mix by investing in extensive outreach efforts to ensure 80 percent of the uninsured, who are estimated to be eligible for Medicaid or federal subsidy support, are aware of their options and purchase coverage.
Consumer Coverage Simplification	Evaluate uniformity among health insurance products between Oregon's Marketplace and the Oregon Health Plan.
Administrative Simplification	Reduce administrative costs associated with provider billing and insurance -related activities in Oregon. For example, require the use of a

Administrative Simplification	Reduce administrative costs associated with provider billing and insurance-related activities in Oregon. For example, require the use of a single common billing form and system used by all participants involved in financing and delivery of health care.
Plan Uniformity	Explore a single set of benefits across public and privately financed health care plans in Oregon.
Primary Care Trust Fund	Assess a single payment and universal health care delivery system for primary care services in this state.
Shared Responsibility Mandate	Evaluate a shared responsibility mandate that would impose penalties for those who don't maintain coverage. Revenue could fund market stabilization and consumer affordability initiatives.
Medicaid-like Buy-in	Evaluate a coverage program that targets lower-income individuals and families not eligible for Medicaid or federal subsidies through the Marketplace.
Expansion of the Coordinated Care Model	Expand the state's reform model beyond Medicaid and coordinated care organizations (CCOs) to all commercial health carriers and health plans offered in Oregon based on the six key elements: (1) best practices to manage and coordinate care, (2) shared responsibility for health, (3) transparency in price and quality, (4) measuring performance, (5) paying for outcomes and health, and (6) a sustainable rate of growth.

The work group discussed the importance of public opinion and the need to directly engage Oregonians on health coverage, affordability, and access to quality health care services including a focus on potential disruption and choices tied to transitioning the state to a universal coverage

Based on the international comparative assessment, the work group also recognizes that potential new governance models and incremental design considerations are critical factors in creating universal access and could result in significant disruption and unintended consequences to the existing system. Information below is drawn from international perspectives on universal coverage models that provide comprehensive, affordable, high-quality health care coverage for all residents.

INTERNATIONAL DESIGN CONSIDERATIONS TO ADVANCE UNIVERSAL COVERAGE	
Simplify and standardize cost-sharing	Across payers and markets (public and private).
Ownership models	Alterative models for provider and hospital ownership (e.g., public, not-for-profit, and for-profit).
Provider reimbursement	Evaluate different models for establishing and setting provider reimbursement rates and alternative payment models building on existing and planned reform initiatives underway in Oregon.
New governance models for a state-based coverage system	Establish a board of trustees to run a new public cooperative to provide universal health care to residents in the state and operate all aspects of the state's current health care programs.

Through the RAND study, the work group noted potential changes to employer-sponsored coverage and commercial plans, including the extent to which existing coverage mechanisms are compatible with a universal coverage system. Key was recognition that transitioning to a universal system of coverage would create significant disruption to the current health care system.

FUNDING CONSIDERATIONS TO ADVANCE UNIVERSAL COVERAGE (RAND STUDY 2017)	
Single-payer	Use public financing to provide privately delivered health care for all Oregon residents, including people currently enrolled in Medicare and Medicaid and undocumented immigrants. A state-administered plan, low or no cost-sharing, tax-financed using state income tax and a new state payroll tax.
Health Care Ingenuity Plan	A public financing pool for coverage in commercial health plans for all Oregon residents (including undocumented immigrants) except Medicare beneficiaries, who would retain their Medicare coverage (including supplemental Medicaid coverage for "dual eligibles"). Offered by competing private plans, income-based cost-sharing, tax-financed based on a new state sales tax.
Public Option	A state-operated plan to compete with private Marketplace plans; available to residents and immigrants eligible to purchase on the Marketplace. State would fund start-up costs.

Lastly, the work group briefly explored the critical barrier with federal waivers and permissions that would be required for Oregon to maximize federal funding for the provision of health care services. One proposal to address the issue is **House Resolution (HR)** 6097 (2018) introduced in Congress and co-sponsored by three Oregon congressional members. This proposal would expand the current Affordable Care Act (ACA) section 1332 waiver to include waivers from multiple federal laws currently preventing state-based universal care. Importantly, it allows Employee Retirement Income Security Act (ERISA) and Medicare waivers, which currently do not exist. The proposed waiver would remove restrictions imposed by the ACA, Medicare, Medicaid, Children's Health Insurance Program (CHIP), federal employee health insurance benefits, TRICARE, and ERISA. Funds otherwise spent on state residents by federal programs would be "passed through" to the state.

At its final meeting, the work group evaluated each policy proposal. Members were invited to offer their perspectives on the advantages and disadvantages of the individual proposals and indicate if they support each proposal as an "incremental step" to increasing health coverage in Oregon. Summarized on the next pages are members' responses, including their preferences. It is important to note that the work group does not formally recommend any of the policy approaches. Rather, the proposals offer a menu of options for the Oregon Legislative Assembly to consider—a framework and a foundation for future statewide discussions on creating a state-based universal system of care.

Policy Approach		Potential Advantages	Potential Disadvantages
Premium Assistance Program	Expand the role and use of premium assistance programs drawing on lessons and opportunities from Project Access NOW and the COFA program managed by Department of Consumer and Business Services (DCBS).	• Good incremental step while we move to bigger change.	• Philanthropy only goes so far • Statewide scale of programs and funding • Could require more work and money than is rewarded • High cost for minimal yield—focused on gaps in dysfunctional system • Use of assistance funds to purchase bad insurance

Green	Yes, I support this policy as an incremental step to increasing health coverage (2 green)
Yellow	I am neutral on this policy approach (2 yellow)
Red	No, I do not support this policy as an incremental step to increasing health coverage (2 red)
Blue	I need more information before I can form an opinion (4 blue)

Policy Approach		Potential Advantages	Potential Disadvantages
Enrollment Assistance and Outreach	Increase enrollment and improve risk mix by investing in extensive outreach efforts to ensure 80 percent of the uninsured, who are estimated to be eligible for Medicaid or federal subsidy support, are aware of their options and purchase coverage.	• Consider measures which address "churn"—stabilize those on and off • Absolutely needed for complicated enrollment; re-enrollment problems stemming from continuous technology issues • Capture fed money for consumers • (1) focus on presumptive Medicaid eligibility; (2) reduce number of transitions and eligibility determinations	• Band-aid to compensate for a complex dysfunctional system • Would need to understand the return on investment; state and federal barriers for this program • Funding to support assistance and outreach • Always good to maximize coverage but would be incremental at best

Green	Yes, I support this policy as an incremental step to increasing health coverage (9 green)
Yellow	I am neutral on this policy approach (0 yellow)
Red	No, I do not support this policy as an incremental step to increasing health coverage (1 red)
Blue	I need more information before I can form an opinion (0 blue)

Policy Approach		Potential Advantages	Potential Disadvantages
Administrative Simplification	Reduce administrative costs associated with provider billing and insurance-related activities in Oregon. For example, require the use of a single common billing form and system used by all participants involved in financing and delivery of health care.	• Great for providers which is great for access and providers happy with health programs. • Half of administrative costs are unnecessary; result of too many payers with different expectations and billing/ payment practices.	• (1) include efforts to reduce cost of eligibility approach; (2) include efforts to replace fee-for-service. • Do not want to sacrifice the quality, accountability, and subsequent innovation that requires admin. workload. • Is this realistic? Cover Oregon failed in 2014. Not confident in the state's ability to achieve this. • Most admin simplicity will require disruptions, not incremental approaches. • How does this improve access?

Green	Yes, I support this policy as an incremental step to increasing health coverage (4 green)
Yellow	I am neutral on this policy approach (4 yellow)
Red	No, I do not support this policy as an incremental step to increasing health coverage (0 red)
Blue	I need more information before I can form an opinion (3 blue)

Additional Notes

- Encourage Oregon congressional delegation to support HJR 6097.
- Important goal—very unclear how to achieve with multi-payer system.

Policy Approach		Potential Advantages	Potential Disadvantages
Plan Uniformity	Explore a single set of benefits across public and privately financed health care plans in Oregon.	• Dependable benefit package for everyone. • Demonstrated ability of Oregon's Prioritized List • (1) we have done this already (2) need to figure out private-side piece.	• Moves away from concept of community-based care. • How is this different from ACA mandated coverage? • How are federal permissions for Medicare, Medicaid, and ERISA?

Green	Yes, I support this policy as an incremental step to increasing health coverage (5 green)
Yellow	I am neutral on this policy approach (2 yellow)
Red	No, I do not support this policy as an incremental step to increasing health coverage (1 red)
Blue	I need more information before I can form an opinion (2 blue)

Additional Notes

- Encouage all health insurance plans to be completely pre-paid (no copay or deductible).
- Very difficult to do for a multi-payer system.
- Concept: health insurance policy as a life-time contract, independent of employer, location, age, income.

Policy Approach		Potential Advantages	Potential Disadvantages
Primary Care Trust Fund	Assess a single payment and universal health care delivery system for primary care services in this state.	• Great for providers which has great up/downstream impact. • Useful structural change. • Primary care unique! Reward innovation, effort, accountability, community approach. • Good issue for focus of next work group. Builds on much current work. • The more gravity and consistency we have in primary care, the more we improve "health" and cost. • Practical exercise of the other "expansion of coordinated care model." • This is a real step to universal access.	• Don't want to move back to fee-for-service. • Not sure impact on integration of behavioral health and oral health. • Difficult to include multi-state integrated health systems (i.e., Kaiser, Providence).

Green	Yes, I support this policy as an incremental step to increasing health coverage (8 green)
Yellow	I am neutral on this policy approach (1 yellow)
Red	No, I do not support this policy as an incremental step to increasing health coverage (0 red)
Blue	I need more information before I can form an opinion (3 blue)

Additional Notes

- Expand Oregon tax revenues to produce stable sustainable funding of health care – either public or private subsidies.

Policy Approach		Potential Advantages	Potential Disadvantages
Shared Responsibility Mandate	Evaluate a shared responsibility mandate that would impose penalties for those who don't maintain coverage. Revenue could fund market stabilization and consumer affordability initiatives.	• More fair to people who are insured • One flaw to CCO 1.0 was presumption of high patient involvement; has not happened as planned. This might encourage more engagement in system • Focus this on people > 400% FPL. Use tax mechanism.	• Didn't like it for ACA; don't like it for state. • Increases reliance on insurance model, which tends to lead to higher costs. • Politically explosive. Not necessary to achieve health care reform. • Would compel people to buy bad insurance. • "Mandate" is not to engage insurance—encourage healthy behaviors.
Green	Yes, I support this policy as an incremental step to increasing health coverage (5 green)		
Yellow	I am neutral on this policy approach (0 yellow)		
Red	No, I do not support this policy as an incremental step to increasing health coverage (4 red)		
Blue	I need more information before I can form an opinion (2 blue)		

Policy Approach		Potential Advantages	Potential Disadvantages
Medicaid-like Buy-in	Evaluate a coverage program that targets lower-income individuals and families not eligible for Medicaid or federal subsidies through the Marketplace.	• Focus on Medicaid eligible. Acknowledge presumption eligibility. Look for federal and innovative funding. • Best way to create an affordable quality plan for the uninsured. Expands CCO model. Helps CCOs meet 3.4% by creating healthier risk pool. • Build on success of CCO model. • Expand coverage and expose CCOs to public. • Limited impact but helpful step if can build on current systems.	• Marketplace destabilization. • Relies on the federal government as the funding partners for the foundation of the system. • Medicaid is currently run through CCOs, which break up the risk pool. This tends to lead to higher admin costs and greater inequities. • Medicaid buy-in could dilute providers' willingness to serve the Medicaid eligible population. • Some CCOs are not community-based, transparent, accountable organizations, and have fought efforts to make them be. • Can those eligible afford the product without financial assistance?
Green	Yes, I support this policy as an incremental step to increasing health coverage (4 green)		
Yellow	I am neutral on this policy approach (4 yellow)		
Red	No, I do not support this policy as an incremental step to increasing health coverage (1 red)		
Blue	I need more information before I can form an opinion (1 blue)		

Policy Approach		Potential Advantages	Potential Disadvantages
Expansion of the coordinated care model	Expand the state's reform model beyond Medicaid and coordinated care organizations (CCOs) to all commercial health carriers and health plans offered in Oregon based on the coordinated care model.	• Best idea ever • Most disruptive • CCO model is an important innovation driver. Expanding the state's ability to grow innovation is huge! • Enormous investment already in place. Community emphasis key, not rates.	• Multiple risk-bearing entities tend to complicate administration. Coordination is good, risk-bearing (insurance model) is problematic. • CCOs are still resisting transparency, citing trade secrets, proprietary info; this thwarts transparency. • How does this expand access? • CCO model is still permissive of "for profit" ≠ public good motivations. • Very difficult. Misplaced focus for reform efforts.

Green	Yes, I support this policy as an incremental step to increasing health coverage (7 green)
Yellow	I am neutral on this policy approach (0 yellow)
Red	No, I do not support this policy as an incremental step to increasing health coverage (1 red)
Blue	I need more information before I can form an opinion (3 blue)

APPENDIX A – WORK GROUP PRESENTATIONS AND MATERIALS

Meeting date	Presenter, associated documents
January 9, 2018	**LPRO Staff** - Oregon's Options to Overhaul Health Care Financing Research Brief, RAND Corporation 2017 **Tim Sweeney, OHA; Zachary Goldman, OHA; Rick Blackwell, DCBS** - Affordable Care Act (ACA): Impact on Oregon 2017
February 23, 2018	**Chapin White, RAND Corporation** - A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon, RAND Corporation 2017
March 22, 2018	**Stacey Schubert, OHA; Rebekah Gould, OHA** - Oregon Health Insurance Survey early release results
April 19, 2018	**Jeremy Vandehey, OHA; Jon Collins, OHA** - 2017 Oregon Health Insurance Survey presentation
May 23, 2018	**LPRO Staff** – Health Care Spending in the United States and Other High-Income Countries by Irene Papanicolas, Llana Woskie, Ashish Jha; JAMA
June 21, 2018	**Jon Walker, Graduate Student, Portland State University** – (1) International Comparison of Health Care Systems (2) State Efforts to Enact Universal Health Care **LPRO Staff** – (1) Oregon Health Authority DRAFT OHIS Coverage Gaps report (2) Oregon Health Authority DRAFT OHIS Underinsurance report (3) Oregon Health Authority DRAFT OHIS Uninsurance with Reasons report
July 19, 2018	**LPRO Staff** – Manatt Health - Medicaid Buy-in State Options, Design Considerations, and Section 1332 Waiver Implications **Charlie Swanson, Health Care for All Oregon** – (1) H.R. 6097 (2) H.R. 6097 summary
August 23, 2018	**LPRO Staff** – A Framework for Evaluating Medicaid Buy-in Proposals by David Anderson, Emma Sandoe; HealthAffairs

	Jesse O'Brien, Senior Policy Analyst, DCBS – Health Insurance Marketplace Annual Report **Andrew Bindman, Professor of Medicine and Epidemiology and Biostatistics, USC -** A Path to Universal Coverage and Unified Health Care Financing in California **Sunshine Moore, Regional Director, State Affairs, America's Health Insurance Plans –** Medicaid Buy-In presentation
September 20, 2018	**Sheila Hale, Benjamin Becerra, Linzay Barnhart, Project Access NOW –** (1) Premium Assistance Program Annual Report Executive Summary (2) 2017 Premium Assistance Report Infographic (3) Premium Assistance Program presentation
October 18, 2018	**LPRO Staff –** (1) How Would State-Based Individual Mandates Affect Health Insurance Coverage and Premium Costs? by Linda J. Blumberg, Matthew Buettgens, John Holahan; Urban Institute (2)The Massachusetts Individual Mandate: Design, Administration, and Results by Marissa Woltmann, Audrey Gasteier; Massachusetts Health Connector (3) Maintaining the Stability of Rhode Island's Health Insurance Markets: Key Findings of the Market Stability Workgroup **Zachary Sherman, Director, HealthSource Rhode Island –** Presentation to the Oregon Universal Access to Care Work Group
November 15, 2018	**LPRO Staff –** (1)Medicaid-like Buy-in - Brief (2)Rhode Island H 7866 (2018) Primary Care Trust Act (3) Insurance Churning Rates for Low-income Adults Under Health Reform: Lower than Expected, Health Affairs Article (2016)

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