Joint Task Force on Universal Health Care

November 23, 2021

Chair Bruce Goldberg

Vice-Chair Zeenia Junkeer

Agenda

- Opening remarks
- Workgroup updates
- ODE 1: SDOH
- Public comment
- ODE 2: Provider participation conditions
- Next steps

Public Testimony – November

- **No** written testimony submitted
- **No** individuals signed up to testify

Workgroup check ins

- Public Engagement, Zeenia Junkeer
- Communications, John Santa
- Expenditure and Revenue Analysis, Bruce Goldberg

Expenditures & Revenue Analysis (ERA) Workgroup

Task Force Update

November 23, 2022

ERA members:

Chad Chadwick
Bruce Goldberg
Sam Metz
Cherryl Ramirez
John Santa
Chuck Sheketoff

INVITED FINANCIAL EXPERTS

OHA/LPRO STAFF

TASK FORCE MEMBERS

ACTUARIAL CONTRACTOR

LEGISLATIVE REVENUE OFFICE

ERA Workplan

Expenditures

- Work with Optumas to:
  - Develop estimate of status quo expenditures (January 10)
  - Finalize parameters for single payer estimates (February 15)
  - Review preliminary single payer estimate (March 18)
  - Review final single payer estimate (May 1)

Revenue

- Work with Legislative Revenue Office to:
  - Create preliminary revenue estimates (Dec-Jan)
  - Finalize revenue estimates (April-May)

Policy Experts

Folks with specialized training and experience to assist with:

1. Payroll tax rates and ERISA preemption
2. Revenue & Reserves
   - Oregon's kicker
3. Health Expenditure Analysis
   - Payment structure
   - Reimbursement rates

Next ERA Meeting

December 7th 12 – 2 pm

Sarah.Knipper@dhsoha.state.or.us

Daniel.Dietz@oregonlegislature.gov

ERA materials on OLIS:
https://www.oregonlegislature.gov/committees/2021I1-JTFUHC

Public Engagement

7 Round tables:

- Latinx folks
- Black folks
- Native folks
- Pacific Islanders
- Folks needing disability services and long-term care services
- Folks with behavioral health needs
- Rural folks

5 Community sessions:

- Coastal region
- Central OR
- Eastern OR
- Southern OR
- Willamette Valley

ODE 1:
Social Determinants of Health (SDOH)

Sarah Knipper

Dr. Zeenia Junkeer

Reminder of ODE process

- In consultation with the Steering Committee and other Task Force members, staff develop a draft recommendation presented to the Task Force alongside background material
- Task Force members review and discuss the recommendation Oct 28
- Task Force members offer feedback and revisions after Oct 28 meeting
  - Staff collate feedback and revise recommendation accordingly
- Task Force discusses and votes on revised recommendation at Nov 23 mtg

Voting on language for final report

- Vote to incorporate findings and draft recommendation in the **September 2022 final report** to the Legislature
- Final report will inform legislation, which may go to the ballot
- If passed, the state will promulgate rules to operationalize the new law

Voting procedures

- Recommendations will be made by consensus unless voting is requested
- If requested, voting shall be by roll call: (1) in favor; (2) oppose
  - "In favor" indicates "can accept, support, live with, or agree not to oppose"
- A vote represents that the member will recommend to his or her government, organization, or group that they should support or oppose the voted-upon proposal consistent with the member's vote
- Votes recorded in Task Force's recommendations
- Final action requires affirmative vote of a majority of voting members (8)
- In the event that a majority oppose, next steps will be determined

SDOH Process Recap

- Draft Recommendation document shared with TF ahead of Oct 28th meeting
- Chair Goldberg & VC Junkeer suggested edits – which were presented as part of Oct 28th meeting presentation
- Task Force members offered additional thoughts, comments and suggestions for modification over email
  - See handout: Task Force member feedback
- Staff revised initial draft - made modifications based on TF feedback

Updated SDOH Finding & Recommendations

UPDATED Statements for Discussion

The Task Force on Universal Health Care finds that addressing SDOH-E is foundational for:

- Improving the health status of individuals, families & communities **by addressing racial, ethnic, linguistic, socioeconomic and geographic inequities in health outcomes.**
- Ensuring that Oregon's Health Care for All Oregon Plan (Plan) provides equitable access to person-centered care
- Lowering the overall cost of care and making the Plan financially sustainable and operationally efficient.

The Task Force recommends that the Health Care for All Oregon Board (Board) be directed to:

1. Review and incorporate lessons from *successful* SDOH efforts around the state including, but not limited to, *CCO efforts,* the **SHARE initiative and HB 3353**.
2. Maximize the current federal flexibilities and allowances that exist to address SDOH-E in the Medicare and Medicaid programs. Where community-informed opportunities to address SDOH-E are not eligible for federal financial participation, **the Board should ~~prioritize seeking federal approval *and/*or~~ consider the use of non-federal resources**.

The Task Force recommends that the Health Care for All Oregon Board (Board) be directed to:

3. Prioritize building strong, sustainable, mutually beneficial relationships with existing entities, including public health agencies, social service agencies, and community-based organizations (CBOs) that are already addressing SDOH-E in Oregon's communities. **Regional Entities shall advise the Board on local partnerships that support the needs of their specific communities.**
4. **Create reimbursement arrangements** to support the delivery of **health-related and/or non-medical** services in ways that both respect and address SDOH-E.

The Task Force recommends that the Health Care for All Oregon Board (Board) be directed to:

5. **Develop systems to continuously collect and analyze data on SDOH-E** to ensure investments and prioritize, feedback from enrollees of the Plan and communities regarding the SDOH-E investments.re focused and effective. Data collection should include, and prioritize feedback from enrollees of the Plan and communities receiving SDOH-E investments.

6. **Prioritize spending a portion of savings identified from the Plan (reductions in administrative costs or other health care savings) on services that support SDOH-E in direct partnership with regional entities who can identify community investments that will have both short- and long-term impact on SDOH.**

Task Force Discussion

Preparing for a Vote

Public Comment

ODE 2: Provider Participation Requirements and Conditions

Laurel Swerdlow

Dr. Bruce Goldberg

ODE Goals

- **Provider participation.** Ensure sufficient level of provider participation to fully meet the health care needs of all Plan members, including a sufficient range of specialists and a variety of provider types.
- **Provider availability.** Establish conditions of participation to maximize provider availability for Single Payer patients.

June 2021 Interim Status Report

- Regionally tailored reimbursement methods and rates
- Ensure access to preferred provider
- Broadest possible range of provider types
- Pay parity
- Support workforce recruitment, retention and development, prioritizing recruitment of clinicians of color

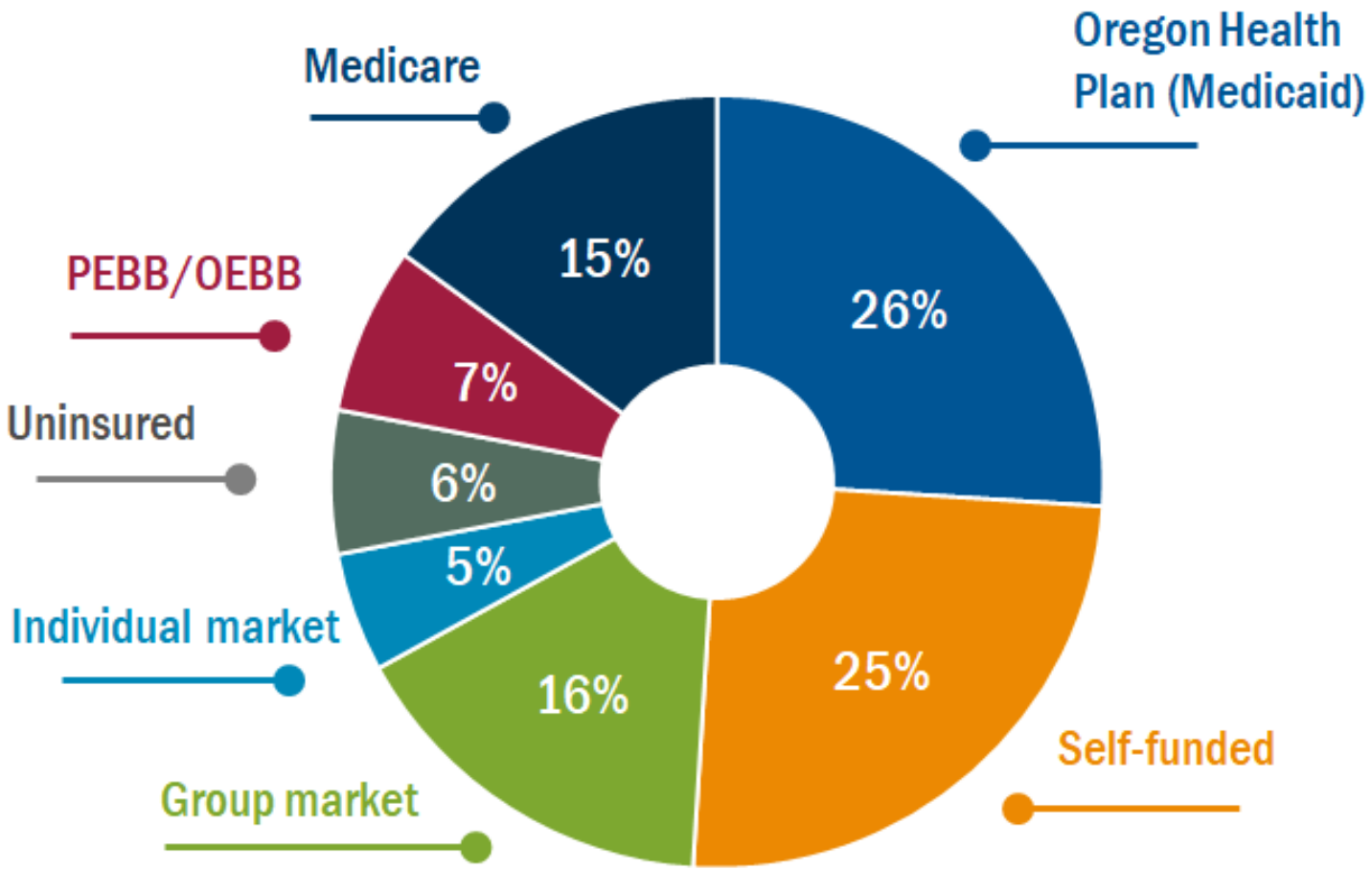
Existing provider recruitment and retention efforts

- Oregon Health Authority Primary Care Office (PCO)
- Health care workforce assessments and analyses
- $19M direct incentives to health professionals (licensed, not licensed, students) to work and remain in communities that experience health inequities
- $14M Healthy Oregon Workforce Training Opportunity Grant Program
- Behavioral Health Workforce Initiative

ERISA threatens provider availability

- Employee Retirement Income Security Act of 1974
- Prohibits regulation of "self-funded plans"
- At minimum, three types of **private-pay** patients:
  - Out of state
  - Out of pocket
  - Self-funded plan beneficiaries
- If participating providers are allowed to bill private-pay patients, and if private-pay rates are permitted to be higher than rates established by the Single Payer entity, providers might prioritize treating private-pay patients
- This could create a two-tier system, decreasing provider availability for enrollees in the Single Payer coverage, resulting in longer wait times

Health Coverage



Will the Single Payer allow **participating providers** to offer services that the Plan covers to **private-pay patients**, including patients paying out of pocket or covered by **self-funded plans**? If so, under what **conditions**?

Policies that increase provider availability

- Prohibit participating providers from collecting private payment for services;
- Specify the number of private-pay patients participating providers are permitted to treat; and/or
- Limit the amount providers can charge private-pay patients

Tools to capture employer expenditures (Fuse Brown & McCuskey)

- **Type A – Funding Plan.** Impose a payroll tax on employers, an income tax on individuals, or both to fund the single-payer plan.
- **Type B – Provider Restriction.** Require or create incentives for all provider payments to be made through the single payer entity at single-payer rates.
- **Type C – Assignment, Subrogation, Secondary-Payer.** Allow the single-payer entity to pay for services and seek reimbursement from employer plans or other collateral sources.

What about mandating participation?

- Likely cannot mandate participation AND prohibit participating providers from collecting payment from third-party payers
- Increases risk of triggering the ERISA preemption clause, which makes void state laws to the extent that they "relate to" employer-sponsored health plans
- However, if forced to choose between covering Single Payer patients and self-funded plan beneficiaries, most providers will likely choose the Single Payer

Conditions of participation options

Option 1

- Provider participation optional
- Prohibit billing private-pay
- Restrict rates
- Assignment/subrogation

Option 2

- Require provider participation
- Allow billing private-pay
- Restrict rates
- Assignment/subrogation

Proposed conditions of participation: Option 1

- **Private-pay patients.** A participating provider shall not solicit or accept payment from any Single Payer member or third party for any health care service covered by the Single Payer and provided to a patient with Single Payer coverage, except as provided under a federal program. This does not preclude the Single Payer from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program.
- **Rate restrictions.** A participating provider shall not charge any rate in excess of the rates established by the Single Payer for any health care service covered by the Single Payer.

Provider participation requirements & conditions: ODE proposal

- Recruitment and retention
- Geographic distribution
- Licensure and authorization
- Out-of-state providers
- "Participating provider"
- Private-pay patients
- Rate restrictions

December Task Force Schedule

- **Steering Committee** (Dec. 1)
- **ERA workgroup** (Dec. 7 and 21)
- **Public engagement ad hoc workgroup** – roundtable content development
- **TF meeting** (Dec. 16) – Provider participation vote, supplemental coverage discussion