Joint Task Force on Universal Health Care

December 16, 2021

Chair Bruce Goldberg

Vice-Chair Zeenia Junkeer

Agenda

- Opening remarks
- Workgroup updates
- ODE 2: Provider participation conditions
- Public comment
- ODE 3: Supplemental coverage
- Next steps

Written Public Testimony – December

- Provider responsibility for collecting patient information when providing services to non-residents in non-emergency situations; provider choice to bill patients who are non-residents; reimbursement rates for providers who serve individuals not enrolled in the single-payer (out-of-state residents).
- Ability for OHSU to provide quality services to non-residents as a potential revenue source.
- Ensure the Task Force's final proposal will provide publicly funded, equitable, affordable, comprehensive and high-quality health care to **all** Oregon residents; ability to choose one's provider; fair and uniform pricing for medical services; reduce employer costs; reduce administrative burden and costs.
- Human suffering attributed to costly, expensive health insurance and lack of access to services; health care is a human right.
- Financial eligibility for OHP, income limits, and financial cliff for low-income individuals.
- Solicit input from "hospital admissions staff" in how best to connect patients to a new single-payer insurance model.
- Advancing Economic Justice in Oregon: A Conversation with Dr. Darrick Hamilton Video Link: https://www.youtube.com/watch?v=mb-Isq7NoAg

Workgroup updates

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

Community 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

Public engagement next steps

- Three arms of public engagement
  - Community engagement – Lara Media Services, demographically specific roundtables and geographically specific community listening sessions
  - Business and Health Care Industry engagement – Ad hoc public engagement workgroup
  - Other – webinar + google form, additional roundtables or listening sessions, ad hoc presentations
- Timeline
  - Phase I: January – March
  - Phase II: April – July
- Next steps
  - Ad hoc public engagement workgroup develop draft roundtable discussion guide content in consultation with Lara Media Services
  - Task Force review and finalize during January meeting(s)

Expenditures & Revenue Analysis

- ERA workgroup met Dec. 6
  - Reviewed Optumas outstanding modeling questions
  - Prepped for Optumas presentation/discussion at Dec. 21 ERA meeting
- Staff in process of finalizing experts to support workgroup discussions in early 2022
- First deliverable: January 10 Optumas status quo revenue & expenditures

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.

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

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

Policies that disincentivize self-funded plans

- **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.

Conditions of Participation: Options

Option 1

- Provider participation optional
- Prohibit billing Oregon private-pay patients for services covered by the Single Payer
- Restrict rates for billing out-of-state patients seeking services in Oregon
- Single payer may collect payment from secondary plans for services covered by the Single Payer when it is financially prudent to do so

Option 2

- All providers participate
- Allow billing private-pay patients for any service
- Prohibit preferential treatment of private-pay patients
- Restrict rates for billing private-pay patients
- Single payer may collect payment from secondary plans for services covered by the Single Payer when it is financially prudent to do so

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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

Proposed Conditions of Participation: Option 2

Defining "participating provider." Any provider who is licensed or authorized to practice in Oregon, is providing health care services covered by the Single Payer in Oregon and is otherwise in good standing is considered a "participating provider."

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.

Private-pay patients. Private pay patients include out-of-state patients, patients who request to pay out-of-pocket, and self-funded plan beneficiaries. Participating providers are prohibited from giving preferential treatment to private-pay patients. In the event that services covered by the Single Payer are provided to Single Payer patients with complementary coverage, including self-funded plan beneficiaries, the Single Payer may seek reimbursement from the other payer when it is deemed financially prudent to do so. The administrative burden of tracking such instances must fall on the Single Payer, not on providers. The Single Payer is prohibited from collecting reimbursement if the administrative burden of doing so exceeds the amount of the reimbursement.

Voting procedures

- Voting to incorporate draft recommendation in the report disseminated for Phase II public engagement
  - Opportunity to revise following public engagement
- 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
- Final action requires affirmative vote of a majority of voting members (8)
- In the event that a majority oppose, next steps will be determined

ODE 3: Supplemental Coverage

Brian Nieubuurt

Dr. Bruce Goldberg

Potential Coverage Landscape

- **Senate Bill 770**
  - Single payer financing system
  - Universal coverage (“all residents”)
  - Preserve Medicare, Medicaid/CHIP, and ACA coverage requirements
- **Interim Report**
  - PEBB as basis for Plan with evidence-based coverage “limits”
  - No cost-sharing
  - Automatic enrollment with no “opting out”

What is the role of “other” insurance coverage if the Health Care for All Oregon Plan is implemented as currently envisioned by the Senate Bill 770 and the Task Force?

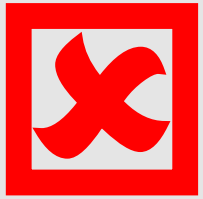
“Other” Insurance Categories

- **Substitutive Insurance** – Coverage that would replace that offered by the Plan
- **Supplementary Insurance** – Coverage that could provide faster or improved access to services covered by the Plan
- **Complementary Insurance** – Fills “gaps” in Plan coverage (e.g., cost-sharing or coverage limits)

Substitutive Insurance

- **All residents and dependents eligible regardless of immigration/citizenship status**
- **No “opting out”**

Supplementary Insurance



- **Potentially undermines equity in access and quality**
- **Compromises financial stability of Plan**
- **Providers not allowed to charge in excess of rates set by Plan**
- **Providers prohibited from providing preferential treatment to patients of other payers**

Complementary Insurance

- **Protects against financial exposure associated with necessary “limits” in Plan coverage**
- **Option for employers to continue to provide employment-based health care benefits**

Recommendations *(DRAFT)*

1. **Expressly PROHIBIT substitutive and supplementary insurance to the extent permitted by state and federal law**
2. **ALLOW complementary insurance that fills gaps in Plan or otherwise provides financial protection for non-covered Plan health care costs**
3. **Regulation of complementary insurance left to DCBS (or other appropriate state agency); should be consistent with Senate Bill 770 values and principles**

Implementation Timeline

Brian Nieubuurt

Dr. Bruce Goldberg

Modeling Estimates

- An implementation timeline is **necessary** to support modeling and generate preliminary set of estimates
- **Straw proposal** timeline is based on a five-year transition period
- **Acknowledges** a series of critical steps necessary to effectuate coverage for Oregonians in a single-payer Plan
  - Enabling legislation
  - Federal Waivers and authorities
  - Creation of Single-payer entity and regional entities
- Task Force will thoroughly assess an implementation timeline for its final report and recommendations in February/March 2022

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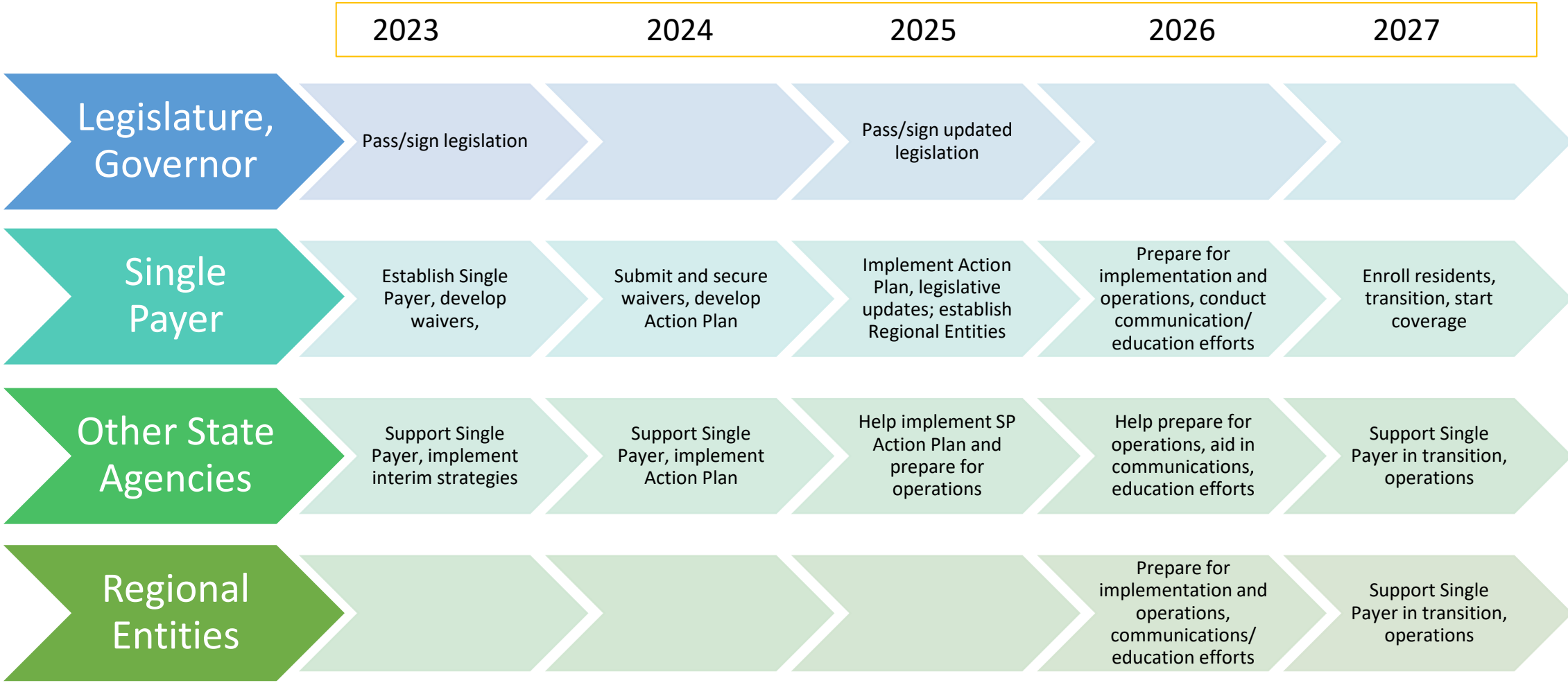
Single Payer Implementation: Overview of Five-Year Timeline



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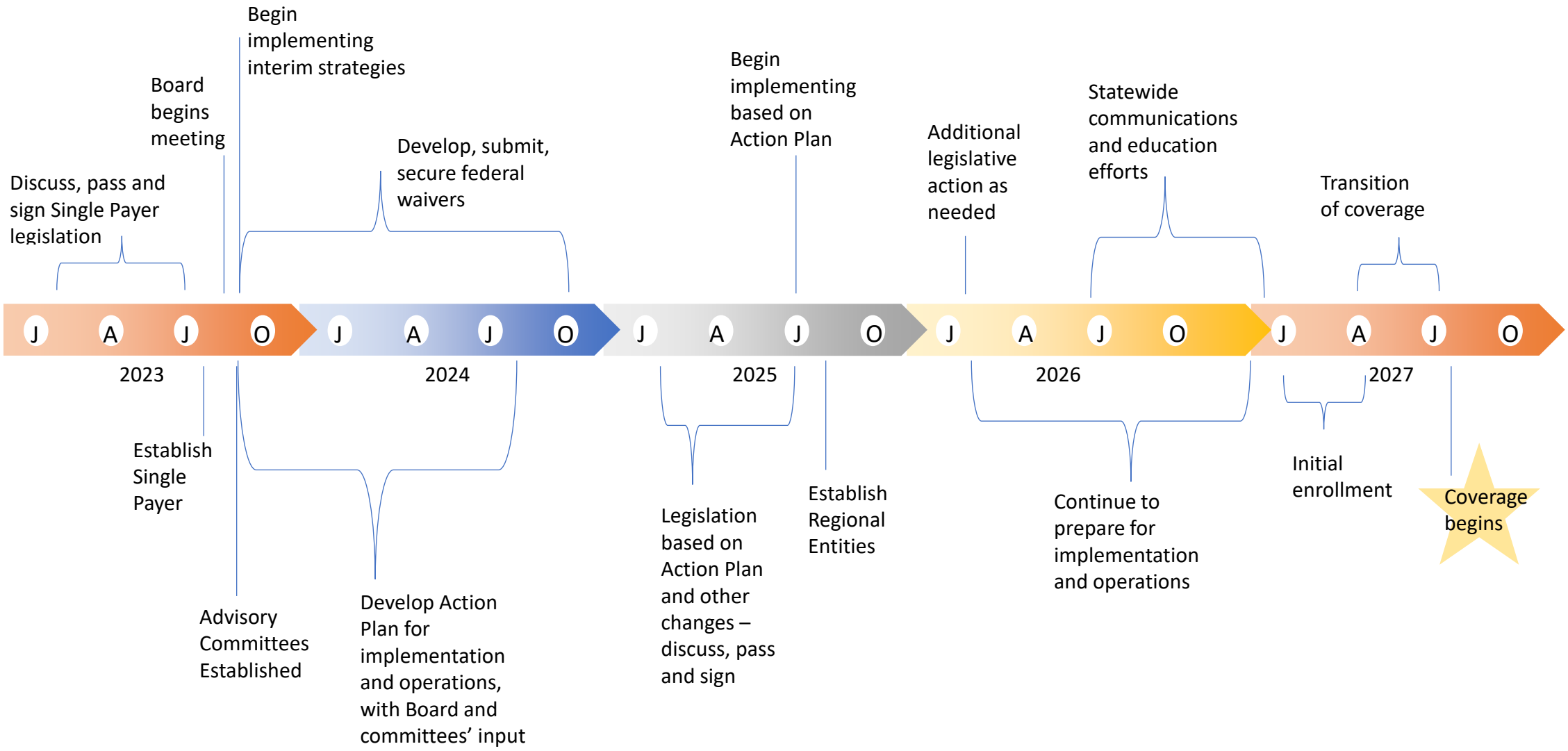

Task Force Schedule

- **Steering Committee** (Dec. 23) – call for volunteers
- **TF meeting** (Jan. 6) – supplemental coverage vote, LTSS discussion, communications workgroup, roundtable discussion content for community engagement
- **ERA workgroup** (meetings TBD)
- **Public engagement ad hoc workgroup** – continue roundtable content development
- **TF meeting** (Jan. 27) – LTSS vote, expenditures and revenue preliminary estimates