Joint Task Force on Universal Health Care
Outstanding Design Element 6: Medicare
DRAFT

I. Goals of Medicare Outstanding Design Element (ODE)

Senate Bill 770 requires the Task Force to develop a universal plan that covers every Oregonian.[1] To do this, the Task Force must consider how to integrate Oregonians with other forms of coverage, including Medicare. Medicare is a federal program with limited state-level flexibility. The goals of this ODE are to:

1. Review components of the Medicare system and Oregon data, including dual eligibility and enrollment in Medicare Advantage plans;
2. Explore pathways to integrate Medicare-eligible Oregonians into Single Payer coverage;
3. Recommend that Medicare-eligible Oregonians be covered by the Single Payer to the extent permitted by statute and waiver authorities, and if not permitted, that Medicare be "carved out" of the Single Payer.

II. Background: How Medicare Operates

Medicare is a federal health insurance program for individuals age 65 and over or individuals under 65 who have a long-term disability, and/or have end-stage renal disease. Medicare was created by Congress in 1965 and at that time consisted of two components, which together are referred to as "original Medicare" and operated on a "fee-for-service" basis[2]:

- Part A: Hospital insurance
- Part B: Medical insurance (i.e., outpatient services)

Later legislation enabled the federal Medicare program to contract with public or private entities to offer health plan options for Medicare members as an alternative to original Medicare and to offer prescription drug benefits[3]:

- Part C: Medicare Advantage plans
- Part D: Prescription drug benefit

Today, eligible individuals may choose to enroll in Medicare Part A and B only or add a Medicare Advantage (MA) plan, in addition to Part A and B, for all Medicare benefits. MA plans require enrollment in Medicare Part A and B and then provide managed care (i.e., HMO, PPO), receiving capitated payments from CMS to cover Medicare services.[4] MA plans may include supplemental benefits (dental, eyeglasses, or fitness), capped monthly premiums, and limits on out-of-pocket costs. While most beneficiaries choose original Medicare (58%) over MA (42%), enrollment in MA has increased over the last decade, nearly doubling.[5]

Additionally, some individuals are eligible for both Medicare and Medicaid, including Medicaid beneficiaries who age into the Medicare program, and individuals under 65 who qualify for both programs. These "dual eligibles" have access to some or all Medicare/Medicaid benefits.[6]

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[1] Senate Bill 770 (2019); Interim Status Report (June 2021)
[2] CMS, Original Medicare (Part A and B) Eligibility and Enrollment (retrieved March 1, 2022).
[3] CMS, Health Plans- General Information (retrieved March 1, 2022).
[4] Kaiser Family Foundation (KFF). Medicare Advantage Fact Sheet. (retrieved March 2, 2022)
[5] Kaiser Family Foundation (KFF), Medicare Advantage in 2021 (June 2021).
[6] CMS, Dually Eligible Individuals – Categories (retrieved March 1, 2022).

III. Medicare in Oregon

Approximately 880,000 Oregonians are enrolled in Medicare,[7] including 146,625 individuals who are dually eligible.[8] Oregon's Medicaid 1115 Waiver requires automatic enrollment of dual eligibles with Coordinated Care Organizations (CCOs).[9] Among Medicare-only beneficiaries, nearly 49% are enrolled in Medicare Advantage plans, including those administered by CCOs.[10]

Table 1. Medicare Enrollment in Oregon, Feb. 2022[11]

County	Eligible Population	MA Enrolled	MA Penetration
Baker	5,263	350	6.65%
Benton	18,235	9,599	52.64%
Clackamas	90,086	59,317	65.84%
Clatsop	11,244	714	6.35%
Columbia	12,656	7,324	57.87%
Coos	21,233	4,997	23.53%
Crook	7,570	2,630	34.74%
Curry	9,644	1,638	16.98%
Deschutes	48,628	17,665	36.33%
Douglas	35,006	15,031	42.94%
Gilliam	579	41	7.08%
Grant	2,343	440	18.78%
Harney	2,100	151	7.19%
Hood River	4,635	1,277	27.55%
Jackson	58,470	24,836	42.48%
Jefferson	5,722	2,157	37.70%
Josephine	27,055	13,561	50.12%
Klamath	18,370	6,266	34.11%

County	Eligible Population	MA Enrolled	MA Penetration
Lake	2,382	207	8.69%
Lane	92,128	54,571	59.23%
Lincoln	17,670	4,722	26.72%
Linn	30,637	17,939	58.55%
Malheur	6,346	1,644	25.91%
Marion	67,245	42,362	63.00%
Morrow	2,273	195	8.58%
Multnomah	130,614	85,205	65.23%
Polk	19,345	12,228	63.21%
Sherman	552	98	17.75%
Tillamook	8,653	2,139	24.72%
Umatilla	15,044	1,223	8.13%
Union	6,656	729	10.95%
Wallowa	2,594	189	7.29%
Wasco	6,579	1,612	24.50%
Washington	95,108	60,521	63.63%
Wheeler	516	95	18.41%
Yamhill	22,656	12,733	56.20%

IV. Federal Law, Medicare Waivers, and Single Payer Concepts

Congress codified Medicare's eligibility, benefits, and funding mechanisms in the Social Security Act (SSA).[12] While the SSA gives CMS certain authority to waive statutory requirements, Medicare waivers are limited and mostly untested.[13] No Medicare waiver allows a state to cover its Medicare-eligible population in a non-Medicare plan using federal funding.[14] This scenario requires an act of Congress. Current federal limitations include but are not limited to:

- Budget neutrality for any state-based Medicare waiver proposal
- Reducing or eliminating enrollee choices specific to the offering of health plans
- Inability for CMS to block grant federal Medicare funding to states

To expand CMS's authority to waive Medicare requirements **requires** Congressional action. Congress could allow CMS to make block grant payments to states for Medicare services or

[7] KFF, Total Number of Medicare Beneficiaries (retrieved March 1, 2022).
[8] CMS, MMCO Statistical & Analytic Reports, (retrieved March 2, 2022)
[9] Oregon Health Authority. Duals Automated Enrollment Implementation (March 8, 2018).
[10] KFF, Medicare Advantage in 2021 (June 2021) at Table 6.
[11] CMS, Monthly Enrollment by Contract/Plan/State/County (February 2022).
[12] Social Security Act, 42 U.S.C. 1395 et seq (2021).
[13] Lindsay F. Wiley, Medicaid for All? Ohio State Univ. Law Rev. (2018) at 879.
[14] Lanhee J. Chen and James C. Capretta, Current Federal Health Care Waiver Authorities Will Not Pave the Way for the New York Health Act (January 2020).

relax requirements for Medicare Advantage to allow state offered MA plans to fully absorb Medicare. In these scenarios, states could enroll Medicare-eligible residents in a comprehensive plan and receive corresponding federal funds. Federal legislation is necessary to expand Medicare innovation and allow Oregon to move toward a true single payer system.

Without new federal legislation, existing waiver authority may allow for incremental, partial integration of Medicare-eligible residents into a single payer plan (see Table 2).[15] While the available flexibilities allow for some innovation, there is no obvious pathway or clear authority to enable a state to combine multiple revenue streams into a single plan.

Table 2. Federal Medicare Waivers[16]

Authority	Description	Limitations
42 U.S. Code § 1315a - Center for Medicare and Medicaid Innovation	Establishes the Center for Medicare & Medicaid Innovation (CMMI) to support state demonstrations. Specifically allows states to "test and evaluate systems of all-payer payment reform."	Requires innovations to achieve budget neutrality. No block grant to states. Requires ongoing approval.
42 U.S.C. § 1395b-1 - Incentives for economy while maintaining or improving quality in provision of health services	CMS may approve demonstration projects, including through grants or contracts awarded to public agencies, to experiment with new Medicare payment and reimbursement systems.	Does not provide for states to alter the choices available to Medicare beneficiaries. No block grant to states. Requires ongoing approval.
42 U.S.C. § 1395f - Conditions of and limitations on payment for services	Establishes requirements for Medicare payment to hospitals. Exempts Maryland from federal requirements.	Applies only to Maryland.

Two existing Medicare demonstrations, in Maryland and Vermont, braid federal Medicare payments together with public and private funding streams. These include value-based payment concepts that might dovetail with Oregon's single payer design. However, while demonstrations allow CMS to pay states for some Medicare services, they do not alter coverage or benefits for enrollees, and the results have been mixed.[17] State-sponsored Medicare Advantage, a concept put forward by scholars, faces operational headwinds. The complexity and variability of waivers requires states to take a pragmatic approach to Medicare, including the possibility that the Medicare-eligible populations would be "carved-out" of single payer coverage.

[15] *Id.*
[16] *Id. See* Chart 3.
[17] *See* Ezekiel Emanuel et al, Meaningful Value-Based Payment Reform, Health Affairs (February 25, 2022); *but see* Adam Atherly et al, Despite Early Success, Vermont's All-Payer Waiver Faces Persistent Implementation Challenges, Health Affairs (January 25, 2021).

Maryland: Uniform Rate-Setting

Maryland has statutory authority and a longstanding agreement with CMS to set hospital rates, including for Medicare enrollees.[18] Under Maryland's all payer model, an independent state entity sets hospital rates. All payers (including Medicare) are charged the same rate for the same service at the same hospital. Recently, Maryland initiated a new agreement with CMS to limit the per capital cost of Medicare in Maryland; this effort includes incentive payments to hospitals and other health system partners, including primary care providers, to reduce costs while maintaining or improving quality.[19]

Some features of Maryland's approach could align with Oregon's Single Payer. The Task Force has recommended that the Single Payer set rates for providers and global budgets for hospitals. However, efforts to level rates across provider types in Oregon could increase Medicare costs, which would run afoul of statutory budget neutrality requirements. Additionally, any rate-setting mechanism for Medicare requires ongoing CMS approval, which could be withheld by the current or a future administration.

Vermont: All-Payer Accountable Care Organizations

In 2016, Vermont received a CMS waiver to enable "accountable care organizations" (ACOs) to combine payments from Medicare and other payers and then align payments and quality measures for providers.[20] Providers chose whether to participate, meaning that ACOs are not implemented throughout the state or truly inclusive of all payers.

Oregon's Coordinated Care Organizations (CCOs) could serve as ACOs and advise both the Single Payer and Medicare on value-based payments. If Oregon achieves savings like Vermont,[21] it could level pay across providers and achieve budget neutrality. However, it is unclear if the savings found among some providers in Vermont could be captured across the entire state of Oregon, across time, and in the context of a newly implemented system.

State-Sponsored Medicare Advantage (No existing example)

Scholars have theorized that a state-sponsored Medicare Advantage plan could compete with private Medicare Advantage plans or replace them entirely.[22] A state-sponsored MA plan could receive payment from CMS for coverage of Parts A and B[23] and then supplement MA benefits to align with the Single Payer plan. The state-sponsored MA plan could induce enrollment if it did not require premiums or co-pays, or if the state restricted other MA plans.

State-sponsored MA offerings are certain to be challenged by Medicare-eligible individuals arguing that they do not have the choices provided under federal law. For Medicare-eligible Oregonians who travel or spend time in other states, any state-sponsored MA plan with different out-of-state benefits would need to be addressed. Some current MA enrollees may prefer continuity over the more robust benefits of a state plan.

If a state-sponsored MA plan survived a legal challenge, the state would assume significant financial risk. MA expenditures have grown at a higher rate across time than other insurance

[18] 42 U.S.C. 1395f (2021). See also, CMS, Maryland All Payer Model (retrieved March 2, 2022).
[19] CMS, Maryland Total Cost of Care Model (retrieved March 2, 2022).
[20] CMS, Vermont All Payer ACO Model (retrieved March 2, 2022).
[21] Sai Loganathan, Evaluation of the Vermont All-Payer Accountable Care Organization Model at 64 (August 2021) (identifying a reduction in Medicare Parts A & B spending of 5.5 percent).
[22] *See* Wiley at 880; Chen and Capretta at 11.
[23] 42 U.S. Code § 1395w–21(i)(1) (2021).

offerings.[24] Some supplemental benefits are not allowed in MA plans, meaning the state-sponsored MA plan may differ from the Single Payer plan, or add cost to the state. Depending on the structure of a state-sponsored MA plan, states would need to consider allowing private supplemental plans to exist to fill in any potential coverage gaps.

Medicare "Carve-Out"

Given the limits of Medicare waivers, in a fallback scenario, Medicare enrollees would remain in original Medicare and Medicare Advantage plans even as other Oregonians join the Single Payer.[25] In this scenario, Medicare and Medicare Advantage plans continue to contract with providers who would also be subject to certain Single Payer provider requirements.

If Medicare continues to cover Oregonians, several policy considerations emerge. The state will need to consider the impact on provider networks if reimbursement rates vary between Medicare and the Single Payer. For Medicare enrollees, the state will need to consider whether people with out-of-pocket medical costs should also contribute via payroll tax, income tax, or sales tax. The state could provide additional services to Medicare beneficiaries, reimburse out-of-pocket costs, or provide tax credits or exemptions.

Any implications for Oregonians who are dually eligible will need to be addressed. Since Oregon's Medicaid 1115 Waiver requires automatic enrollment in CCO plans, it is likely that dual eligibles would be included in the Single Payer plan along with other Medicaid-eligible Oregonians, though additional waiver authority may be required.

V. Draft Recommendations

The Task Force recommends that Medicare-eligible Oregonians will be covered by the Single Payer to the extent permitted by federal law and waiver authority.

Because inclusion of Medicare-eligible Oregonians will depend on Congressional action and/or CMS approval, the Task Force recommends the following order of operation:

Scenario A: Medicare-eligible Oregonians will be fully covered by the Single Payer, which will receive funding from CMS to provide comprehensive benefits. This will require an act of Congress to expand Medicare waiver authority and/or allow further state innovation.

Scenario B: Consistent with existing waiver and demonstration authorities, Medicare-eligible Oregonians will be enrolled in the Single Payer and receive comprehensive benefits through mixed funding streams, which may include uniform rate-setting, accountable care organizations, and/or a state-sponsored Medicare Advantage plan.

Scenario C: Oregon's Medicare-eligible population will be "carved out" out of the Single Payer and will continue to be covered by Medicare and Medicare Advantage plans. Oregonians who remain in Medicare may be exempt from certain taxes, eligible for tax credits, or reimbursed for medical expenses.

See Table 3 on page 6.

[24] Fred Schulte, Medicare Advantage's cost to taxpayers has soared in recent years, research finds, Kaiser Health News (Nov. 11, 2021).
[25] *See* Chen and Capretta at 6 (in Vermont's plan, Medicare and MA plans continued in the state).

Table 3. Medicare/Single Payer Scenarios

Considerations	Plan A Full Inclusion	Plan B Integration	Plan C Carve out
Approval	Congress	CMS	None needed
Federal Funding	CMS pays state to cover people eligible for Medicare	CMS negotiates to pay state pursuant to rate-setting, ACO, or MA agreement	CMS directly reimburses providers and MA Plans
State Funding	Additional state funding needed for comprehensive plan	Additional state funding needed for comprehensive plan	No state funding
Covered Benefits	Full coverage under Single Payer plan	Medicare plus wraparound benefits to align with SP plan	CMS current benefit structure
Enrollee Participation	Mandatory	Mandatory/induced	Optional
Enrollment Choice	Eliminates	Limits	Preserves
Private Carriers	No longer exist	Restricts	Allows private MA
Cost-sharing	No cost-sharing	No cost-sharing	Yes
Provider Reimbursement	Fixed reimbursement set by Single Payer	Rate-setting and global budgets	Outside of Single Payer purview

VI. Modelling Considerations

The actuarial work plan for single payer expenditures will include estimates for scenarios in which Medicare-eligible Oregonians are fully included in the single payer (Plan A) or fully carved out (Plan C). Staff will request revenue estimates to correspond with both scenarios.

Because Plan B includes a range of waiver-dependent strategies in which Medicare-enrollees are variably integrated into the Single Payer, preliminary estimates will not include modelling of Plan B scenarios.