Joint Task Force on Universal Health Care

March 10, 2022

Chair Bruce Goldberg

Vice-Chair Zeenia Junkeer

Agenda

- Opening remarks
- ERA update
- Project timeline
- Medicare
- Communications workgroup
- Next steps

Written Public Testimony – March 10

- Importance of creating and implementing a single-payer system that provides comprehensive benefits to all residents; universal health care does not equate to a single-payer system

Expenditures & Revenue Analysis (ERA) Workgroup

Task Force Update

March 10, 2022

ERA members:

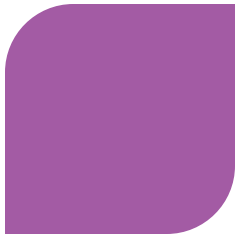
Chad Chadwick
Bruce Goldberg
Sam Metz
Cherryl Ramirez
John Santa
Chuck Sheketoff

INVITED FINANCIAL EXPERTS

OHA/LPRO STAFF

TASK FORCE MEMBERS

ACTUARIAL CONTRACTOR



LEGISLATIVE REVENUE OFFICE

ERA Workplan

Recent Meetings

- January 7: Preliminary analysis of new revenue
- Jan 24: Status quo expenditures
- Feb 4: Planning for ERISA
- Feb 18: Parameters for single payer estimates

Future Meetings

- March 28: Preliminary single payer estimates
- April 13: Review plan design & costs
- Late April: Finalize feedback for final estimates

ERA’s progress to date:

Groundwork for a Financial Model

Preliminary Calendar Year 2019 Revenue Estimates by Source

Revenue Streams	Status Quo Revenues
Employer	$13,134,706,416
Employee/Individual	$8,840,621,158
Federal Title XVII	$7,939,899,816
Federal Title XIX	$7,014,534,661
Federal Title XXI	$291,520,443
Other Federal Funds	$2,112,620,374
State Funds	$2,762,964,911
Charitable Contributions	$195,000,00
Total	$42,291,867,779

Expenditure Estimates

Optumas analysis of status quo costs (shared with full TF on Jan. 27):

Next steps: Preliminary Single Payer estimate (~March 18).

Preliminary analysis of *new* revenue

Projection by Legislative Revenue Office (LRO) with ERA input:

Source (% rate)	Total
Payroll (5/7/9)	$9b
Income (3/5/7/9/11/13)	$5b
Sales (6)	$7b
Totals:	**$21b**

Next steps:

- Determine actual revenue need
- Define tax bases (then rates)

Parameters for cost estimates

Set by Optumas with ERA input, eg:

- Optumas: in Single Payer, will *total* provider compensation be less, more, or the same?
- ERA: For modelling, the same.

Next steps:

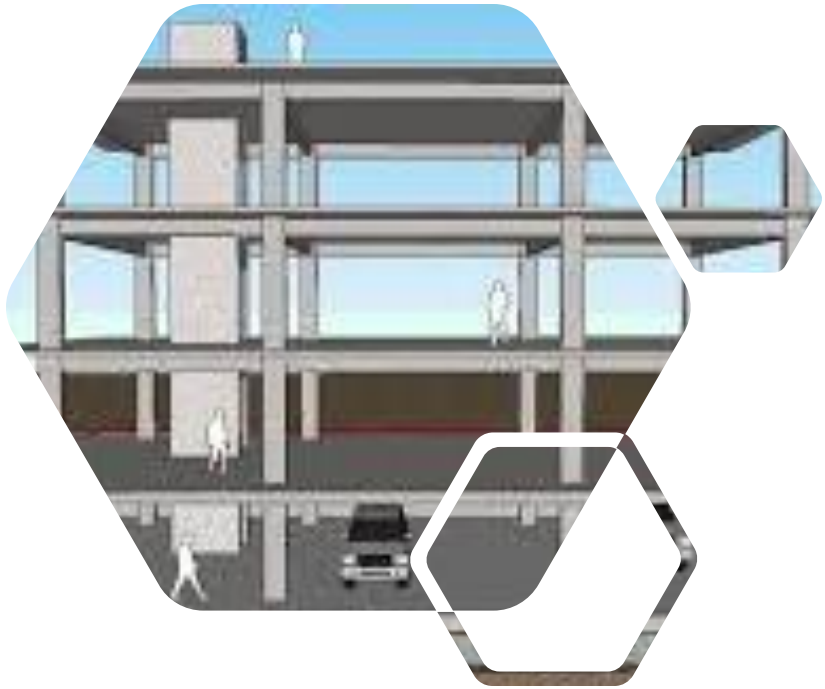
Optumas meets with LRO (March 15)

Preliminary Single Payer estimate (~March 18).

Review for ERISA compliance

Per Fuse Brown & McCuskey:

- Three-prong approach (payroll tax, provider requirements, subrogation)
- PEBB-based plan is a strength
- Supplemental coverage is sound
- Caution: different requirements for ERISA/Non-ERISA plans



ERA’s next steps:

Building out the financial model

Aligning Cost & Revenue

Task:

Determine cost of single payer and new revenue needed to fund it

Next steps:

~March 18: Cost estimates due

March 29: Revisit Revenue estimates

Plan Design & Costs

Task:

Review modelling assumptions in the context of cost and revenue estimates

Next steps:

April 13: Review costs with Dr. Hsiao

Late April: Finalize assumptions for LRO & Optumas final models

Final Financial Estimates

- **Late April**: ERA finalizes inputs for Optumas final model
- **April 28**: ERA presents updated inputs to Task Force
- **Early May**: Final models back from Optumas & LRO
- **May 19**: Task Force reviews final expenditure & revenue analysis

Next ERA Meeting:

March 29, 2022 at 2:30 pm

Daniel.Dietz@oregonlegislature.gov

Laurel.M.Swerdlow@dhsoha.state.or.us

ERA meetings and materials:

Oregon Health Authority : Task Force on Universal Health Care

Workplan

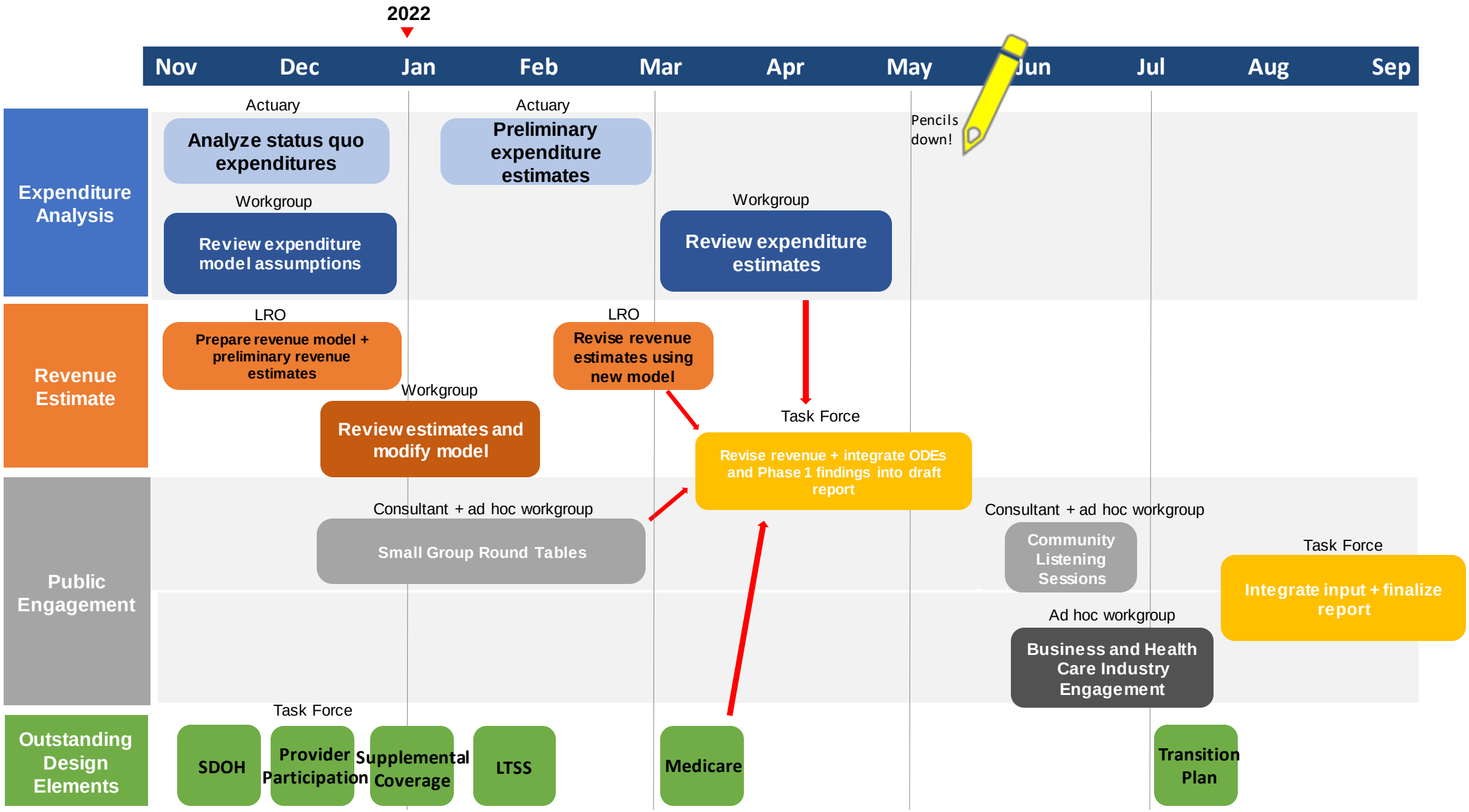
Laurel Swerdlow

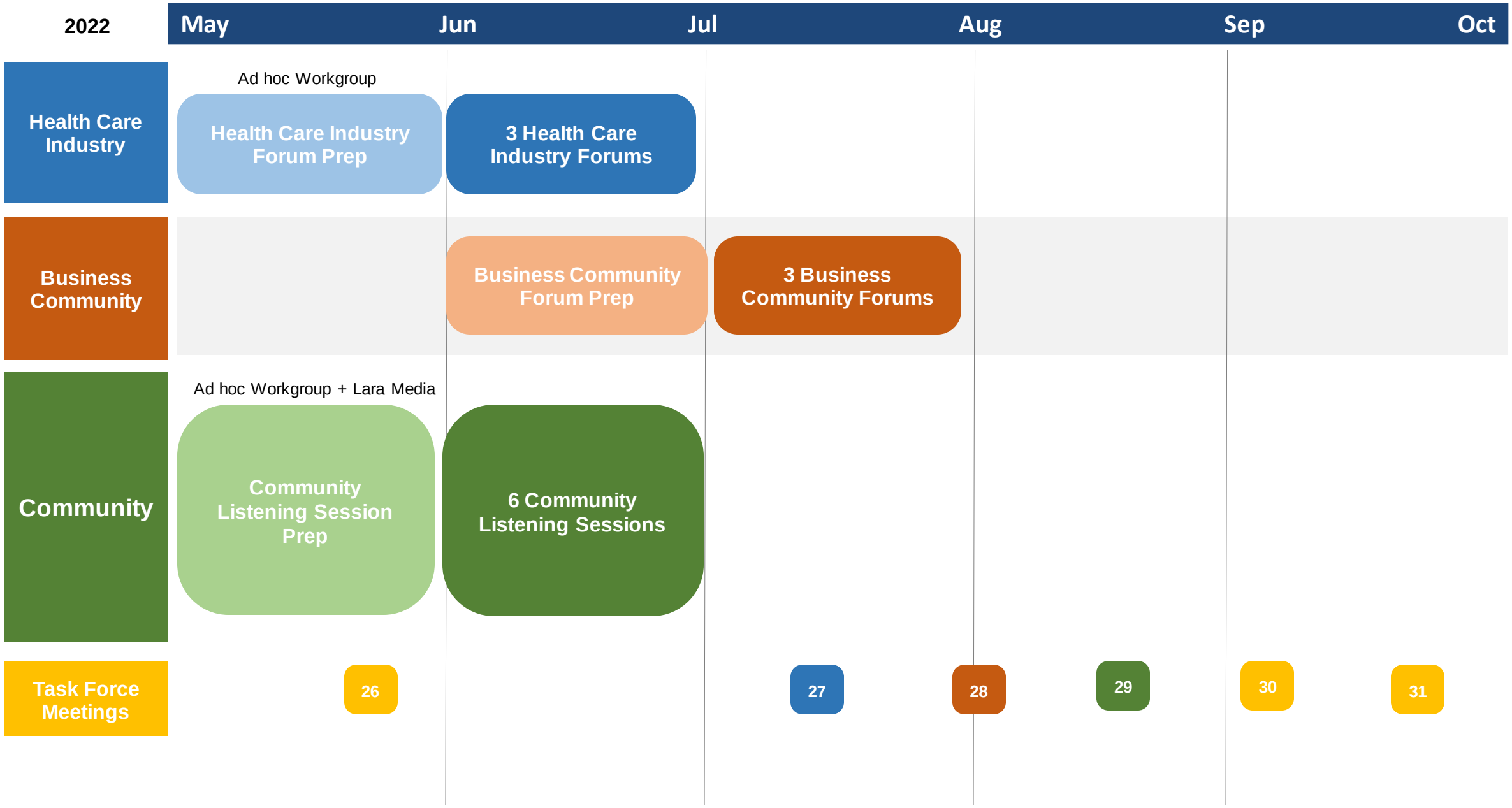
Dr. Zeenia Junkeer

Outstanding Design Elements

- ☑ Address social determinants of health and covering health related services
- ☑ Provider participation requirements and conditions
- ☑ Supplemental coverage
- ☑ Long term care services and supports
- ☐ Medicare
- ☐ High level transition timeline

Moved to ERA: Existence of reserve fund and financial emergency preparedness


2022
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Expenditure Analysis
Revenue Estimate
Public Engagement
Outstanding Design Elements
Actuary
Analyze status quo expenditures
Actuary
Preliminary expenditure estimates
Pencils down!
Workgroup
Review expenditure model assumptions
Workgroup
Review expenditure estimates
LRO
Prepare revenue model + preliminary revenue estimates
LRO
Revise revenue estimates using new model
Workgroup
Review estimates and modify model
Task Force
Revise revenue + integrate ODEs and Phase 1 findings into draft report
Consultant + ad hoc workgroup
Small Group Round Tables
Consultant + ad hoc workgroup
Community Listening Sessions
Task Force
Integrate input + finalize report
Ad hoc workgroup
Business and Health Care Industry Engagement
Task Force
SDOH
Provider Participation
Supplemental Coverage
LTSS
Medicare
Transition Plan


2022
May
Jun
Jul
Aug
Sep
Oct
Health Care Industry
Ad hoc Workgroup
Health Care Industry Forum Prep
3 Health Care Industry Forums
Business Community
Business Community Forum Prep
3 Business Community Forums
Community
Ad hoc Workgroup + Lara Media
Community Listening Session Prep
6 Community Listening Sessions
Task Force Meetings
26
27
28
29
30
31

Outstanding Design Element: Medicare

Background & DRAFT Recommendations

Invited Guest: Lisa Emerson, DCBS | DFR | Policy Section

Joint Task Force on Universal Care

March 10, 2022

Values of Universal Health Care (SB 770)

- Equitable, affordable, and comprehensive
- High quality care
- Available to every Oregonian

The Challenge:

- Medicare is a **federal** program, codified in statute
- The Single Payer is a **state** entity needing authority to integrate federal resources

What is Medicare?

Federal health insurance

- Established by Congress
  - Part A: Hospital Insurance
  - Part B: Medical Insurance
- Subsequent amendments
  - Part C: Medicare Advantage
  - Part D: Prescription Drugs

LBJ signing the SSA Amendments of 1965.

Eligibility

- Age 65 and over
- Under 65 with long-term disability
- End-stage renal disease

Medicare or Medicare Advantage

- “Fee-for-service”
- Part A: Hospital Insurance
- Part B: Medical Insurance
- Option for Part D (Rx)
- Out-of-pocket costs

- Managed care (HMO, PPO) for all Medicare benefits.
- Requires enrollment in Parts A and B; typically includes Part D benefits
- May include supplemental benefits (dental, vision, fitness).
- May limit or cap out-of-pocket

Oregon Data

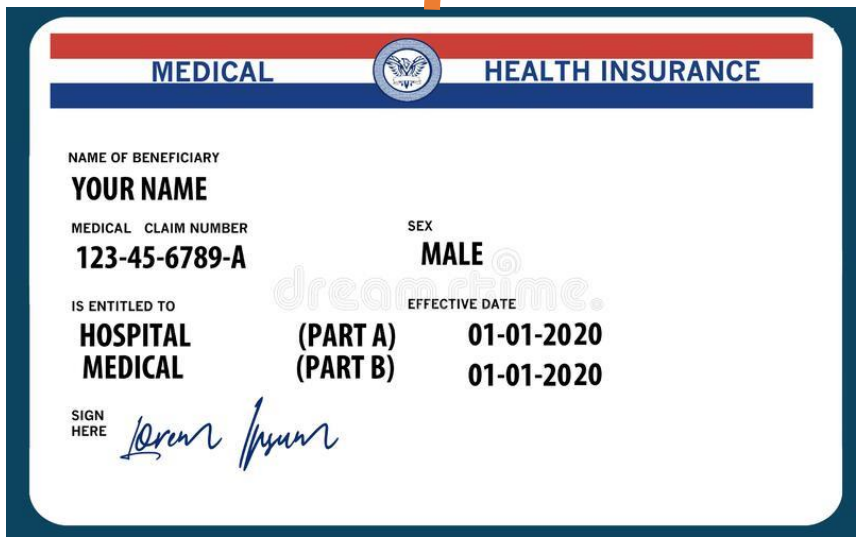
Approx. **880,000** Medicare-eligible Oregonians
- 146,625 are dually-eligible
  - Qualified beneficiaries are enrolled in OHP

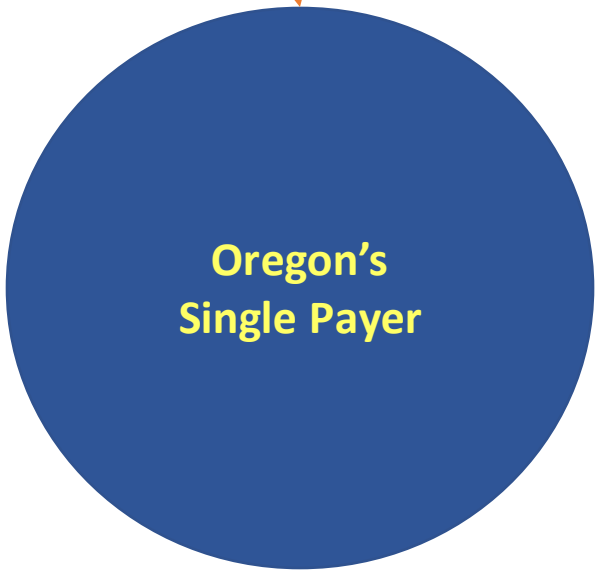
49% of those eligible chose Advantage
- Varies by county, region:
  - Multnomah: 65%, Deschutes: 35%

Total Medicare Spending: **$9.7B**

Sources: CMS, Kaiser Family Foundation, Optumas.

The Question:





Ideally…

- Full integration of Medicare beneficiaries and funding into the Single Payer.
- Beneficiaries get comprehensive benefits.
- CMS pays the Single Payer.

The catch: Congress

- Medicare: a “statutory creature”
- Confers obligations to CMS and choices to beneficiaries
- Limited waiver authorities

About those waivers…

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.

What might the waivers allow?

Uniform Rate Setting

- Maryland (statute + waiver)
- State entity sets rates for all payers (incl. Medicare)
- Mirrors SP design for entity to set provider reimbursement

Accountable Care Orgs (ACOs)

- Vermont (demonstration waiver)
- All-payer (incl. Medicare) advanced payment methods
- Medicare costs -5.5%
- Voluntary, incl. only some systems
- Aligns with existing CCO model?

See ODE background for sources (United States Code, CMS, Vermont report)

Limits of Medicare waivers?

- Need ongoing approval
- No change to coverage
- Budget neutrality
- No block grant to states

State-sponsored Medicare Advantage

Scholars have speculated…

- No statute prohibits public MA plans
- Wraparound benefits to align with SP benefits
- Induce enrollment by eliminating premiums/co-pays

… this might be a viable pathway!

BUT:

- Statutes require enrollee choice of plans
- CMS approves MA plans that meet requirements (need ongoing approval)
- Does statute give CMS authority to approve… *this*?
- MA has struggled with cost containment

See ODE background for sources (Wiley, Chen, Kaiser Health News)

What if Medicare is carved out?

- Eligible Oregonians keep Medicare/MA
- Medicare and MA plans stay as payers
- If Medicare is carved out, consider:
  - Supplement Medicare benefits? Gap coverage?
  - Exempt Medicare enrollees from taxes?
  - Reimburse costs associated with Medicare?
  - Provider networks and rates?
- Dual-eligibles: likely enrolled in SP?

Bringing it all together…

Recommendation

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.

Modelling Implications

Optumas will model Scenarios A and C (Medicare in or out)

LRO will create revenue estimates to align with A and C

Scenario B is highly variable; not included in preliminary estimates

(Assuming Medicare mostly integrated, similar to Scenario A)

Discussion

Communication Work Group

Update to Task Force on Universal Health Care

March 10, 2022

Today’s Discussion

- Principles
- Approach
- First round results
- Second round
- Next steps
- Challenges

Principles

- We are a work group not a decision making group. Our questions and answers describe decisions the Task Force has made, not make them or change them
- Simplicity. Answers should be short, readable, and comprehensible.
- Completeness. Answers should express the main impact of the TF approach and acknowledge exceptions, and/or additional details needed
- Credibility. Answers should reassure readers that the task force has performed due diligence and has investigated most available information.
- Trust. Answers should not appear to be a cover up. We should be straightforward and honest even with difficult questions.

Approach

- Interval virtual meetings
- Eventual three rounds of discussion
- All work group members review draft and suggest changes
- Chair presents draft version to Task Force members for comment and suggestions
- Work group reviews feedback and generates another version for feedback
- Hopefully, eventual consensus document

First Round Feedback

- Shared 13 Questions/Answers that had moved through 10 drafts
- Staff reviewed and made suggestions
- All TF members responded
- 8 members suggested edits of one or more questions
- 4 members suggested one or more new questions
- General comments
  - Term “Single Payer” confusing
  - Concern literacy level too high
  - Short questions and answers best
  - Get feedback from “test groups”
    - Upcoming engagement participants
    - Previous CAC members

Second Round

- Revised Round 1 questions/answers---5 drafts
- Ten additional Round 2 questions---10 drafts
- Staff review
- Edits, new questions, comments solicited from TF

Next Steps

- Complete 3 rounds
  - 25-30 questions
- Develop a list of key definitions
- Suggestions/resources related to a literacy tool or expert
- How best to get public feedback?
  - Make document public when discussed by Task Force
  - Share at engagement meetings
  - Ask for input from former CAC members

Key Challenges

- How to proceed when a TF member(s) oppose(s) content that has clearly been decided on by the TF
- How to proceed when an answer is overall in the correct direction but does not include exceptions, nuances. This is very common.
- How to proceed when an answer does not include details that are important but are beyond what the TF will have time to weigh in on

Task Force Schedule

- **Public engagement workgroup** (Mar. 17, 2-3pm)
- **Task Force Steering committee** (Mar. 17 1-2pm) – call for volunteers
- **ERA workgroup** (Mar. 29, 2:30-5pm)
- **TF meeting** (Mar. 31*) – Expenditures estimates, revenue options, roundtable findings, Medicare vote
  - *March 31 – Task Force will meet for four hours 1-45pm