Joint Task Force on Universal Health Care

April 28, 2022

Chair Bruce Goldberg

Vice-Chair Zeenia Junkeer

Agenda

- Opening remarks
- Public Engagement – Phases 1 and 2
- Communications Workgroup – Update
- Public Comment
- ERA Work Group – Status update
- Wrap up and next steps

Written Public Comment – April

- **Vulnerable children**: ensuring care for Oregon's most vulnerable and disabled children by allowing payment to parents who serve as direct support professionals (DSPs) and personal support workers (PSWs) for their children who require children's intensive in-home services.
- **Lack of affordability**: OHA's report, *Impact of Health Care Costs on People in Oregon*, highlighting the financial burden and inequities Oregon's face paying for health care.
- **Regionality**: importance for the task force to consider cross-sector *community-led* solutions to addressing health care challenges.
- **Medicare**: critical importance of including Medicare-eligible in its proposal to achieve the benefits of a single-payer system.

Public Engagement

Dr. Zeenia Junkeer

Laurel Swerdlow

Phase 1 Findings

Proposed Phase 1 Roundtables

Populations

1. Spanish speakers
2. Black and African American folks
3. Native Americans
4. Pacific Islanders
5. People with disabilities/ Long term care
6. Behavioral health
7. Rural folks

Parameters

- 8-10 participants per group
- Emails and phone calls used for pre-discussion screening
- $100 honorarium
- Two-hour facilitated discussion
- Discussions moderated by a professional moderator
- Discussions held via Zoom

“Discrimination, including racism embedded in the Oregon health system has physically and psychologically harmed the communities with the least access to health care. This includes BIPOC, rural, those living with disabilities, and those navigating the behavioral health system. Structurally discriminatory and racist health policies have resulted in an ever-increasing legacy of health disparities for these Oregon residents.”

Areas of policy alignment

Comprehensive benefits, including dental, mental health and vision

Carefully define "resident"

Coverage of all people living in Oregon, regardless of citizenship

Simple enrollment process

Single state formulary for prescription drugs based on evidence AND community input

Areas of policy alignment (cont.)

Single reimbursement rate to address discrimination against Medicaid enrollees

Ethnically and regionally diverse Board that includes member representation

Members may access care at the provider of their choosing

Broaden access to all provider types

Require culturally responsive care

Policy passage and implementation

- Accountability measures to ensure culturally responsive care
- Outreach and engagement to support members in enrolling, accessing care, and improving health literacy
- Distrust in government and disillusionment will be a barrier to public buy-in
- Financial transparency regarding revenue mechanisms will be critical

Policy Considerations from the Public

Affordability

- Finding: Ensure people pay based on what they can afford
- Consider: Progressive or means-tested premiums for high-income enrollees

Revenue Structure

- Finding: Tax is not progressive if it applies to everyone
- Consider:
  - Structure taxes to minimize burden on low-income
  - Eliminate sales tax
  - Luxury tax

System Costs

- Finding: Avoid increasing taxes
- Consider: Examine cost-drivers to reduce overall cost

Public Engagement Findings

1. Financing of the **health care** system should be **based on what** individuals earn **and what their situation allows.**

2. Avoid placing taxes that have more significant impacts on moderate to low-income families and individuals.

Sources: (1) Lara Phase 1 Report; (2) Lara Recommendations.

Public Engagement Phase 2

“Public engagement” refers to the process of soliciting public input.

It includes community engagement, business community engagement, and health care industry engagement.

Phase 2 Community Listening Sessions

Communities

1. Coastal region
2. Central OR
3. Eastern OR
4. Southern OR
5. Willamette Valley

Parameters

- Two-hour facilitated discussion
- Discussions moderated by a professional moderator
- Discussions will be held via Zoom
- Participatory elements to ensure sessions are more than didactic listening sessions

Phase 2 Specialty Forums

- Total of 6 forums June-August
- Solicit feedback on financial plan and provider participation
- Two-hour discussion facilitated by professional facilitator
- Discussions held via Zoom

Health Care Industry Engagement

- Providers
- Payers
- Hospitals

Business Community

- Large employers
- Small employers
- Unions

Phase 2 next steps

- Convene Public Engagement Workgroup to discuss community listening session outreach and content with Lara Media Services
- Convene Specialty Forum Workgroup to discuss 3 business community forums and 3 health care industry forums with Diana Bianco
- May 19 Task Force sign off on design element decisions to date
- Workgroups work with Diana Bianco, plain language specialist, and/or Lara Media Services on meeting materials

Public Comment

Expenditure & Revenue Work Group

Task Force Update

April 28, 2022

You are here

Senate Bill 770

Task Force Design Choices

- Technical Advisory Groups
- Interim Status Report
- Outstanding Design Elements

Status Quo Estimates

Today: Review Estimates

- Revised Single Payer Expenditures
- *Update* to Preliminary Revenues
- Review Case Studies

Next Steps

- May 13 - final ERA Work Group meeting
- May 19 - Review Final Estimates

ERA UPDATE:

CASE STUDY PARAMETERS

OPTUMAS: CASE STUDIES

Case Study Parameters

Staff Summary

What's a "case study"?

Example:

Annual Impact	Current System	Single Payer Estimate	Notes
Level of Benefits	Basic	Comprehensive	
Household Out of Pocket Expenditures	$10,148	$0	Premiums and cost sharing
Household Premium	$0	$1,077	
Employer Paid Premiums	$0	$0	
Payroll Tax	$0	$7,740	

- **Representative example to illustrate some (but not all) Single Payer impacts**
- **Cases selected to illustrate typical employment and coverage examples**
- **Numbers result from Task Force design choices**

Case Study Parameter: Dental Services

Dental Services

Discussion

- Dental has unique financial/utilization implications for a single payer system.
- Dental caries is leading health issue for children.
- Inclusion of dental should be cautious and incremental.

Assumption for Case Studies:

PEBB-like dental benefit for all, with "intermediate" annual limits and authorizations to be determined by the Single Payer.

Case Study Parameter: Administrative Savings

"Single payer plans provide better care to more people for less money. They achieve this by reducing complexity [and] **reducing administrative costs**."

- Communications WG

Two Kinds of Administrative Savings

Payer Side

- Status quo: multiple payers, wide variance in plans.
- Single payer: one state entity manages one plan.
- Savings compared to multi-payer:
  - Removal of margins (profit)
  - Marketing/ads
  - Efficiency
- Optumas assumes gains in efficiency will take time

Provider Side

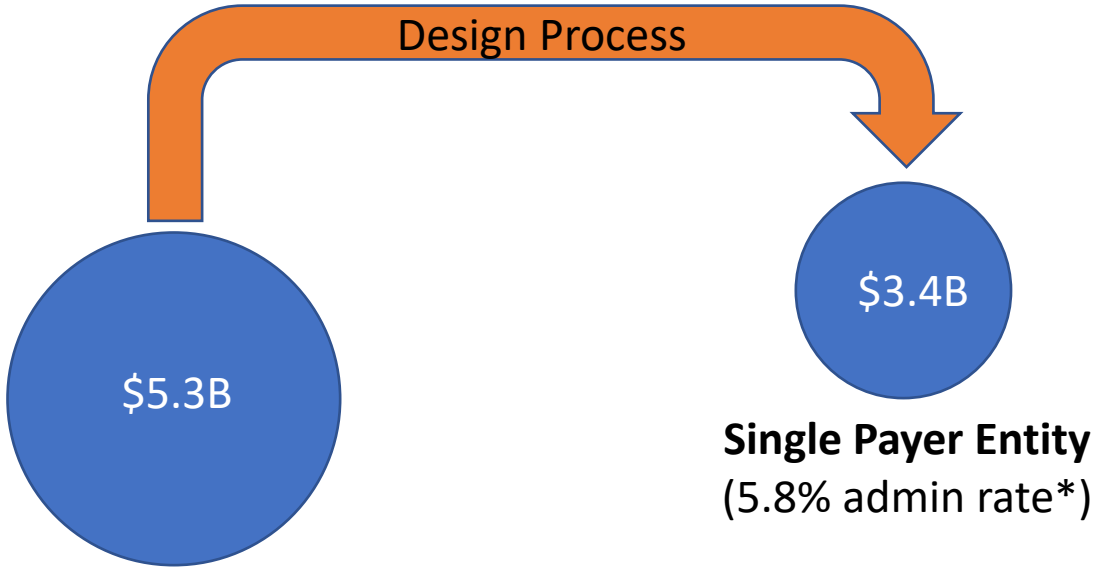
- All providers of all health services
  - Hospital systems, pharmacy, labs, imaging, DME, behavioral health
- Provider-side administration
  - What: Billing/coding, contracting
  - Who: Management, financial services, legal services, consultants.
- Savings: difference in administrative cost of interfacing with multi-payer system vs. single payer

Where is the potential for administrative savings?

Payer side:
Single Payer

Provider Side:
All Health Services

Payer-Side Savings (2026)



Status Quo
Multi- Payer System
(9.1% admin rate)

Single Payer Entity
(5.8% admin rate*)

Savings:

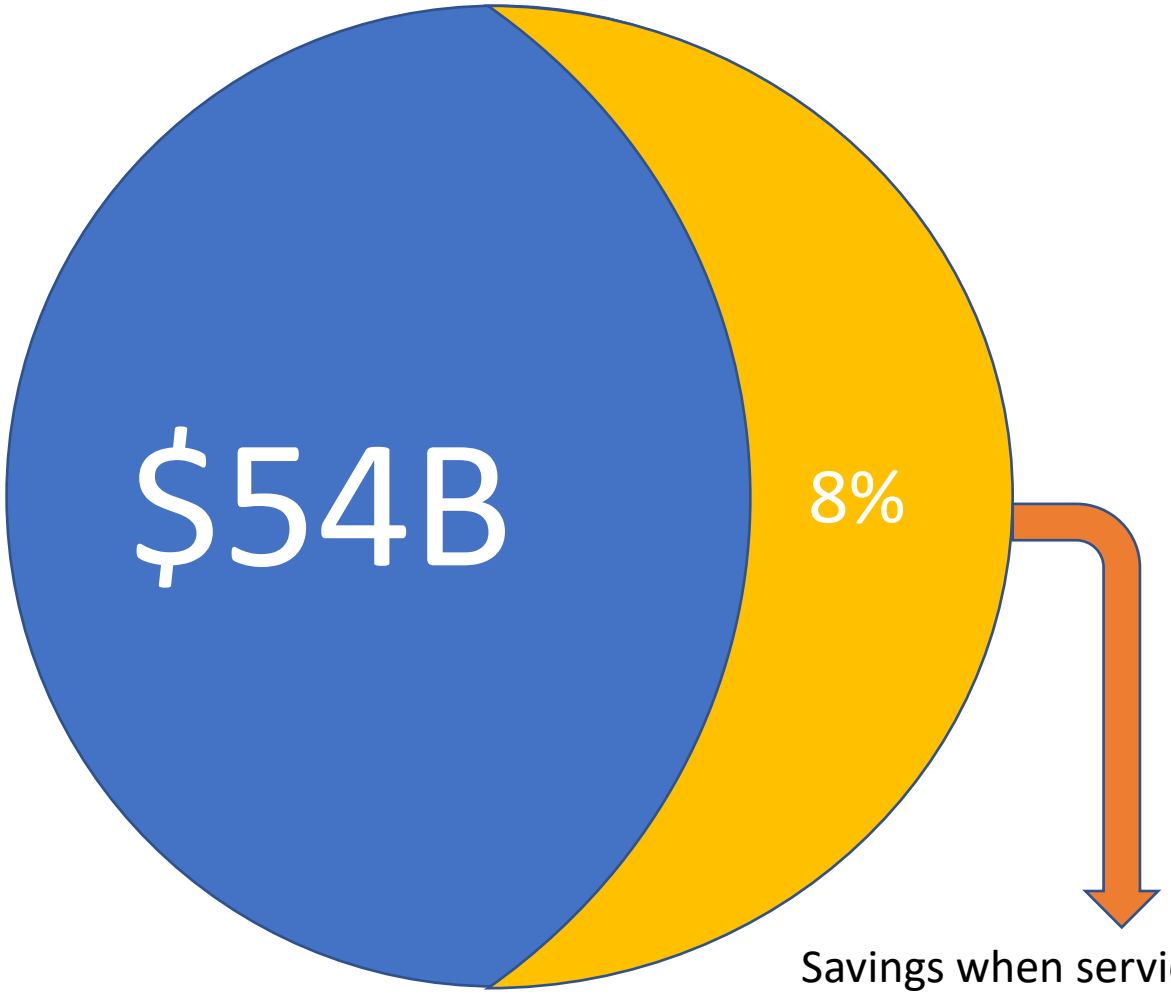
- Margin removal
- Marketing/Ads
- More efficiency with time
- Additional savings with a smaller claims imprint?

*Preliminary 2026 estimates from Optumas.

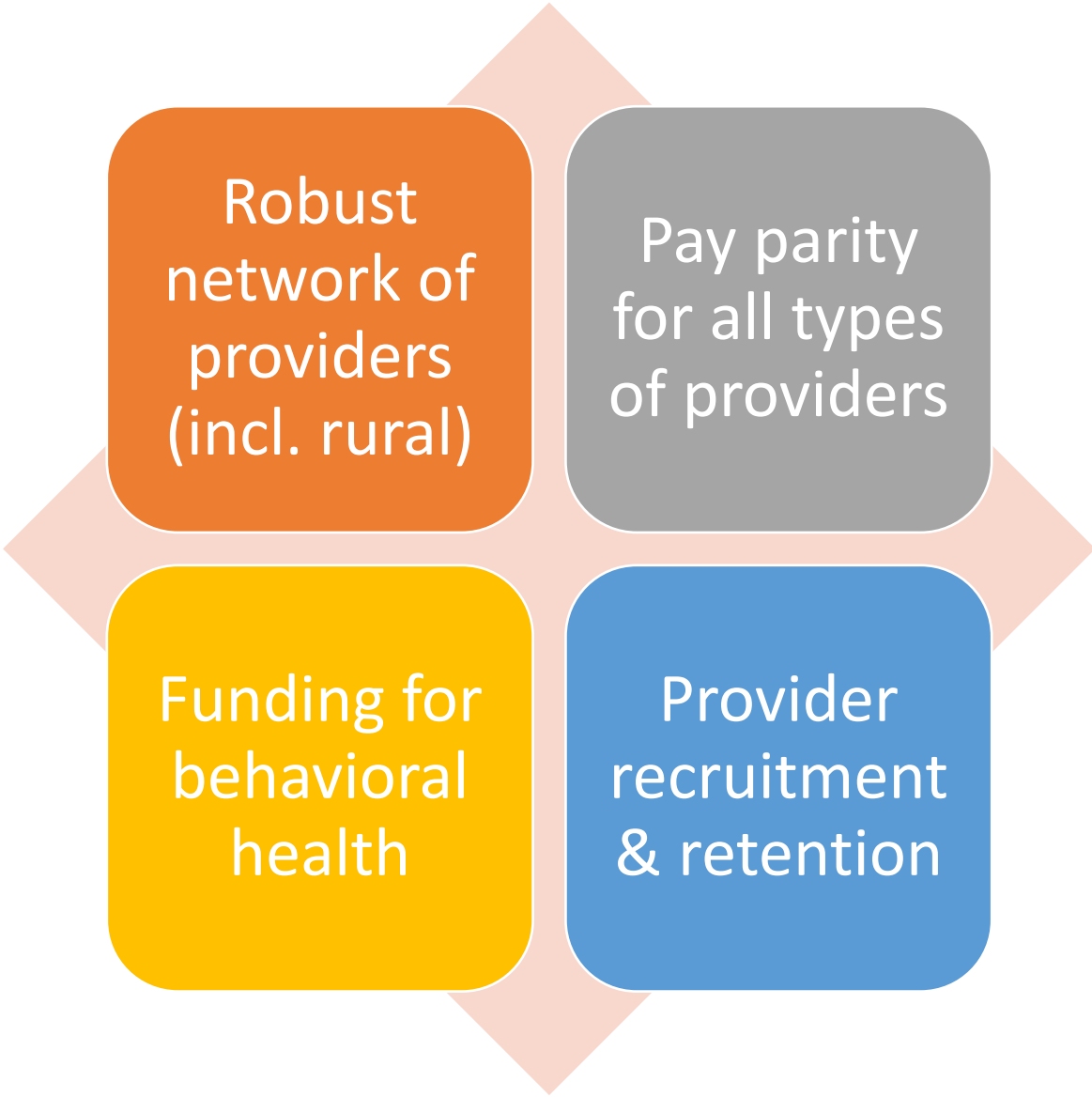
Savings – Provider Side

- Optumas estimates:
  - Low-end: 8% ($4.3B)
  - High-end: 12% ($6.47B)

- **Dr. Hsiao**: “This is the most critical issue in Single Payer design.”
  - The 8-12% estimates are reliable
  - Cannot be addressed in isolation
  - “You need the savings to pay for universality and higher quality.”



Provider-side: Workforce & Network Considerations



Administrative Savings

Discussion

- Continue to explore payer-side savings.
- Provider-side assumptions: cautious and conservative.
- Prioritize behavioral health & rural access.

Assumption for Case Studies: 4% Provider-Side Administrative Savings (2.16B)

Apply the conservative savings estimate (8%), assuming a savings of **4% ($2.16b)** to total service costs, with the remaining savings dedicated to ensuring robust networks, rural access, and funding for mental health.

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Case Study Parameter: Household Contribution (name *TBD*)

Review: Public Engagement Findings

1. Financing of the **health care** system should be **based on what** individuals earn **and what their situation allows.**

2. Avoid placing taxes that have more significant impacts on moderate to low-income families and individuals.

Sources: (1) Lara Phase 1 Report; (2) Lara Recommendations.

Question:

How can people contribute in a way that is equitable, fair, and ensures access to high quality health care for all Oregonians?

Household Contribution (name TBD)

- People contribute to the universal system health care based on what they earn.
- By contributing, people ensure access to high quality care for themselves, their families, and their communities.
- Everyone will contribute unless their household income is below 200% FPL.
- Rate of contribution will increase household earnings (% FPL) up to the full premium.

Household Contribution: Based on % of FPL

Household Income (% of FPL)	Contribution Rate
Up to 200%	0
>200% up to 250%	1%
>250% up to 300%	2%
>300% up to 400%	3.5%
>400% and higher	6.3%

Revenue in 2026: $5.5B

- These example rates are preliminary and are likely to be revised.
- FPL: Federal Poverty Level
- Contribution only if household income is above 200% FPL.

Household Contribution: Bottom Line

People will contribute in a way that is means-tested and predictable.

In the aggregate, households will spend a fraction of the amount they spend on health care in the status quo.

Estimate	Total
Status Quo (premium, co-pay, deductible)	$11b
Single Payer (household contribution)	$5.5b

Household Contribution: Discussion

Revenue considerations:

- Time/expense for start-up?
- Time/expense for collection?
- Educate & inform the public?

Household contribution should be:

- Progressive
- Income-based
- Collected through tax system

Household Contribution (name TBD)

Assumption for Case Studies:

$5.5B aggregate household contribution

- Amount of household contribution determined by household income (%FPL).
- Rate of contribution increases income (%FPL).
- Collected through existing tax/revenue system.

Case Study Parameter: Expenditures & Revenues

- Based on PRELIMINARY estimates.
- Subject to further revision and refinement.

Program	Population	Cost of Care (2026)
Medicaid	905,718	$18.99 B
Medicare	824,538	$19,96 B
CHIP	135,620	$349 M
Individual Exchange	156,152	$769 M
Public Employees Other than PEBB/OEBB	422,899	$2.18 B
Employee/General	1,356,023	$6.71 B
PEBB	144,757	$746 M
OEBB	1440,382	$560 M
Border States Employees	287,314	$1.51 B
Out of Pocket, Charity Care, Community BH	All populations	5.542 B
Total	**4,688,741**	**$57.347 B**

Preliminary Expenditures	
Total (2026)	**$57.347 B**

Status quo expenditures (2026): $57.372B.

	Expenditure Assumptions	Aggregate Impact (2026/Initial Year)
Cost Drivers	Insurance Status Change (uninsured to insured)	$1.09 billion
	Increased Utilization due to Eliminating Cost Sharing	$926 million
	Benefit Change (standard PEBB benefit)	$493 million
	Fee Schedule Normalization (utilization impacting underserved)	$33 million
Cost Savings	Economies of Scale (consolidation of administrators – Maintain RCO)	-$20 million
	Removal of Commissions and Marketing (currently insured products)	-$65 million
	Purchasing Power (pricing negotiation)	-$426 million
	Fraud, Waste, and Abuse	-$546 million
	Health Insurer Fees (Oregon premium tax / assessment)	-$674 million
	Margin Removal (insurance coverage margin)	-$834 million
	Provider-Side Administrative Savings	-$2,156 million
	Dental Services for All	$747million
	Total Single Payer Expenditures:	**$55.94 billion**

Revenue Source	Revenue Assumptions	Revenue
Continuing State/Local Funds (Non-Employee)	Tax funded costs in status quo (state contribution to OHP, community behavioral health.	$3.75 billion
Household Contribution	Assumes FPL% rates; no contribution below 200% FPL.	$5.5 billion
Employer Payroll Tax	Assumes two brackets: 8.6% and 11.5%. Does not include state or local government employers.	$12.5 billion
Local Government Employer Premium Contribution	Many different funding streams (property tax, fees, federal funds). Per Optumas: may be difficult to capture.	$3.96 billion
State Government Employer Premium Contribution	Assumes status quo PEBB/OEBB contributions from employers can be captured separately at historical level.	$2.38 billion
Federal Medicare	Assumes UPL constraint on federal funding.	$12.96 billion
Federal Medicaid	Assumes UPL constraint on federal funding.	$12.12 billion
Federal CHIP	Assumes funding capture at future state expenditure level.	$227 million
Other Federal Funds	Assumes premium assistance for exchange enrollees is captured.	$860 million
Medicare Part B Premiums	Assumes individuals continue to contribute Part B premium amount.	$1.64 billion
Eligible but not Enrolled	Assumes additional federal revenue from additional single payer enrollees.	$73 million
	Total Single Payer Revenues:	**$55.97 billion**

Oregon Health Authority

Preliminary Case Examples

April 28, 2022

CBIZ Optumas

Consultants • Actuaries • Economists

Case Examples

- Private Sector – Large Employer
- Private Sector – Small Employer
- Public Employee
- Medicaid
- Individual Coverage/Marketplace
- Medicare

Benefit Coverage Definitions

- **“Comprehensive Benefits”** include, at a minimum, benefits provided in status quo public employee plans (PEBB), and Oregon Health Plan benefits for those eligible.
- **“Commercial Plan”** – Plans meet requirements for essential health benefits but may include more cost sharing and benefit limits than the public employee plan.
- **“Basic”** – Plan designed to meet minimum requirements for marketplace offerings.
- **“Medicare”** – includes Part A and Part B covered services.

Impact Analysis

- **Level of Benefits:** Basic (Marketplace), Commercial Plan, Comprehensive (Medicaid/PEBB)
- **Household Out of Pocket Expenditures:** Co-pays, deductibles, and in the current system, individual contribution to premium costs
- **Household Premium:** Covered individual(s) contribution to Universal system.
- **Employer-paid Premiums:** Employer contribution to insurance premiums
- **Employer Payroll Tax:** Private sector employer contribution to overall health costs

Caveats / Notes

- Examples use 2022 FPL income thresholds to calculate household premium.
- Difference between total income and household income are ignored.
- Household income is assumed to be 100% wages from employment.
- Difference between household-based FPL calculation and tax return-based FPL calculation are ignored.

Example 1 – Private Sector Large Employer

- **Family Composition:** Two married adults and two children under 18
- **Household Income:** $120,000
- **Current Source of Insurance:** Head of household's employer for family

Annual Impact	Current System	Single Payer Estimate	Notes
Level of Benefits	Commercial Plan	Comprehensive	
Household Out of Pocket Expenditures	$7,702	$0	Premiums and cost sharing
Household Premium	$0	$1,955	
Employer Paid Premiums	$17,770	$0	
Employer Payroll Tax	$0	$10,320	

Impact on Insured

- ✓ Benefit coverage is similar
- ✓ Household OOP is eliminated
- ✓ Premium expense is $1,955

Employer Impact

- ✓ Reduced cost to employer

Example 2 – Private Sector Small Employer

- **Family Composition:** Two married adults and child under 18
- **Household Income:** $90,000
- **Current Source of Insurance:** Marketplace

Annual Impact	Current System	Single Payer Estimate	Notes
Level of Benefits	Basic	Comprehensive	
Household Out of Pocket Expenditures	$10,148	$0	Premiums and cost sharing
Household Premium	$0	$1,077	
Employer Paid Premiums	$0	$0	
Payroll Tax	$0	$7,740	

Impact on Insured

- ✓ Benefit coverage improves
- ✓ Household OOP is eliminated
- ✓ Premium expense is $1,077

Employer Impact

- ✓ Increased cost to employer

Example 3 – Public Sector Employee

- **Family Composition:** Two married adults
- **Taxable Household Income:** $75,000
- **Current Source of Insurance:** PEBB

Annual Impact	Current System	Single Payer Estimate	Notes
Level of Benefits	Comprehensive	Comprehensive	
Household Out of Pocket Expenditures	$2,906	$0	Premiums and cost sharing
Household Premium	$0	$1,206	
Employer Paid Premiums	$17,719	$17,719	
Payroll Tax	$0	$0	State does not pay tax

Impact on Insured

- ✓ Benefit coverage is the same
- ✓ Household OOP is eliminated
- ✓ Premium expense is $1,206

Employer Impact

- ✓ Cost to employer is equal

Example 4 – Medicaid

- **Family Composition:** Adult and child
- **Household Income:** $15,000
- **Current Source of Insurance:** Medicaid

Annual Impact	Current System	Single Payer Estimate	Notes
Level of Benefits	Comprehensive	Comprehensive	
Household Out of Pocket Expenditures	$0	$0	Premiums and cost sharing
Premium	$0	$0	
Employer Premiums	$0	$0	
Payroll Tax	$0	$1,290	

Impact on Insured

- ✓ Benefits are similar
- ✓ No impact to OOP
- ✓ Premium expense is $0

Employer Impact

- ✓ Increased cost to employer

Example 5 – Medicare

- **Family Composition:** Two adults, no dependents
- **Household Income:** $80,000
- **Current Source of Insurance:** Medicare

Annual Impact	Current System	Single Payer Estimate	Notes
Level of Benefits	Medicare	Comprehensive	
Household Out of Pocket Expenditures	$5,750	$1,782	
Household Premium	$0	$1,341	
Employer Premiums	$0	$0	Small Employer No Coverage
Payroll Tax	$0	$6,880	

Impact on Insured

- ✓ Benefits are similar
- ✓ Household OOP is reduced $3,968
- ✓ Medicare premium payment required
- ✓ Non-Medicare Premium expense is $1,341

Employer Impact

- ✓ Increased cost to employer

Example 6 – Individual

- **Family Composition:** Single adult
- **Household Income:** $60,000
- **Current Source of Insurance:** Marketplace

Annual Impact	Current System	Single Payer Estimate	Notes
Level of Benefits	Basic	Comprehensive	
Household Out of Pocket Expenditures	$4,412	$0	Premiums and cost sharing
Premium	$0	$1,035	
Employer Health Care Contribution	$0	$0	Assumes Self Employed
Employer Payroll Tax	$0	$5,160	

Impact on Insured

- ✓ Benefit coverage improves
- ✓ Household OOP is eliminated
- ✓ Premium cost is $1,035

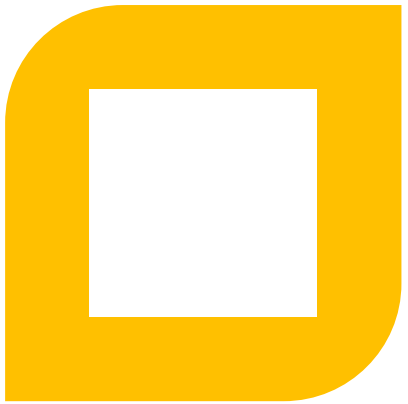
Employer Impact

- ✓ Increased cost to employer

ERA Next Steps

LRO & OPTUMAS FINALIZE ESTIMATES

ERA MEETS 5/13 FOR FINAL ESTIMATES & ANALYSIS



TASK FORCE MEETS 5/19 TO REVIEW FINAL ESTIMATES

Task Force Schedule

- **ERA workgroup** (May 13)
- **Steering committee** (May 5) – call for volunteers
- **TF meeting** (May 19) –
  - Review May 2022 draft proposal
  - Review Final Estimates