# JOINT TASK FORCE ON UNIVERSAL HEALTH CARE
# SUMMARY REPORT

## SUMMARY AND KEY TAKEAWAYS

In 2019 Oregon's legislature created the Joint Task Force on Universal Health Care (the Task Force). The enabling legislation, Senate Bill 770, charged the Task Force with design of a universal, single payer health care plan for Oregon consistent with values and priorities expressed in the bill.

Today, Oregon's health care is delivered through an inefficient, expensive, and complex structure. Oregon's health care relies on many private, public, and taxpayer-subsidized insurance plans. It significantly depends on employment for health care insurance and access. It is comprised of a variety of health care benefit plans, provider networks, and insurance plans. Movement by Oregonians between different insurance plans means that each year thousands of Oregonians are occasionally or entirely without insurance or access.

Health care in Oregon is inequitably delivered. Too many Oregonians, because of their race, age, income, geography, or insurance, endure vastly different health care access, varied health care quality, and wide-ranging health outcomes.

Health insurance itself imposes increasing costs both to families and to employers who include the costs for health insurance as worker benefits. High health care costs generate debt and bankruptcy for many Oregonians.

**The Task Force designed a health care system providing more Oregonians with better and more equitable care for less money.**

The Task Force's plan provides a universal set of health care benefits to all Oregonians; ensures every Oregonian has access to behavioral, vision, hearing, and dental care; eliminates need for premiums and out of pocket costs such as deductibles and co-pays; allows providers to bill only one entity; provides Oregonians with one set of procedures, goods, and services; and allows Oregonians to seek services from any provider in the state. Payment levels to providers will not be based on the source of the funds (e.g., cash from patients, private insurance, or public insurance programs). Actuaries predict the plan will cost less per Oregonian than our current structure.

The Task Force's plan has six key takeaways to accomplish the above tasks:

1. **"Single payer" is the only solution**

   Americans spend twice as much for health care as residents of other industrialized nations. The Task Force is convinced that a single payer system is the only documented format that can provide Oregonians with better care to more people for less money. A single payer system means one entity – a single payer – collects all health care revenues and pays all providers for all health care costs.

   The universal health care plan in this report establishes a single payer system.

2. **This plan is a first but not final step toward equitable health care**

   Care that is gender-affirming, culturally appropriate, and equitable requires that all Oregonians enjoy immediate and equal access to health care regardless of where they live, their income, their employment, or their age.

This plan begins to address health care inequities by providing all Oregonians with the same access, the same benefits, and the same network of providers, and by ensuring that providers receive the same payment regardless of their patient.

Truly equitable healthy communities require work beyond this plan. With its regional entities, the statewide single payer board is uniquely well-positioned to work with multiple communities. The Task Force encourages the legislature to continue to address equity issues and to fund and address social determinants of health such as homelessness and the need for affordable housing.

3. **The plan requires new taxes to replace current insurance and out-of-pocket spending and dedicated revenue for the single payer plan**

   This plan requires preservation of all current state and federal health care spending, including behavioral health care. Oregonians would no longer pay premiums, deductibles, co-pays, co-insurance, or other out of pocket spending. Instead, the legislature will enact new taxes to more equitably collect the funds. The Task Force tax plan is just one of many examples, leaving the choice of collecting revenues to the legislature. Regardless of how taxes are collected, the revenue must be based on Oregonians' ability to pay.

   All state and federal revenues for health care will go directly into the single payer's trust account, not the state General Fund. Dedicated funding and independent but accountable governance by the single payer board are critical for establishing public trust. Dedicated funding and independent accountable governance also assure the continuation of quality health care during pandemics and economic downturns.

4. **The plan uncouples health care access from employment**

   Employer-sponsored health insurance impedes equitable health care. This plan removes employment status as a health care barrier. Employers who today include health insurance in benefit packages will be among the "winners" who see their business costs go down. Removing employment status as a condition of health care access benefits both the economy and the health of Oregonians.

5. **This plan frees providers and the single payer board from the administrative costs of billing, collections, authorizations, audits, and disputes, giving the delivery system and single payer board more time and resources to improve health and reduce increases in Oregon's health care spending.**

   With this plan, providers do not need to collect funds from patients or navigate complex billing requirements of multiple insurance companies, multiple benefit plans, and multiple payment schemes. The single payer will determine patient eligibility for Oregon's health care system and collect revenue for prompt and reliable provider payment. This simplified billing allows providers to dedicate more time and energy to patient care. The single payer plan significantly reduces administrative duplication, marketing expenses, and confusion about prices and costs.

6. **This plan calls on the 2023 Legislature to create a single payer board using the Task Force plan as a guide**

   The Task Force calls on the 2023 legislature to create and fund the single payer system's founding governance board to supervise key transition efforts, such as seeking federal waivers needed to fully operate the plan and work with Oregon's delivery system

to transition to the single payer system. The Task Force deliberately focused on the main components of a single payer system and outlined values and principles that guided their work. SB 770 and the Task Force's principles give the single payer board direction for addressing the many details, including the provider payments for particular services, as well as implementation decisions.

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## KEY ELEMENTS OF THE SINGLE PAYER PLAN

### KEY ELEMENT: ELIGIBILITY AND ENROLLMENT

All people who live in Oregon will qualify for the plan. SB 770 directed the Task Force to cover all Oregon residents with the single payer plan. While "resident" was not defined in SB 770, the Task Force decided that the board needs to write the eligibility rules defining who is a "resident" while ensuring that a broad definition that is easy to apply and verify is used, such as eligibility to vote in Oregon as proof of residency.

Some state databases, such as voter registration rolls, will clearly inform the single payer about who is a resident and thus eligible and automatically enrolled. If not clear from an existing database, all people not registered to vote in another state or country and, if both 16 or older and a US citizen is registered or eligible to register to vote in Oregon, or if under 16 or a non-citizen and would otherwise be eligible to register to vote in Oregon but for the age or citizenship status, should be considered residents.

Because the single payer will need to maximize the use of federal health care dollars, the single payer will need to collect other information on residents using the single payer system, such as their age or income or proof of enrollment in Medicare. While health care providers will not be burdened with determining residency status, they will need to inquire about residency and some other information to help identify non-residents who the single payer will need to bill for reimbursement. Employment status will not be a criterion in establishing whether someone is a resident.

As with many insurance carriers now, when Oregonians travel out of state the single payer plan will cover their health care. This would work the same way for visitors to Oregon; they would be able to access care if needed, and then the single payer would bill the out-of-state residents' insurance for reimbursement. And the single payer board will adopt rules allowing Oregon residents to utilize necessary out-of-state health care providers just as they can today.

The Task Force recommends a simple and easy enrollment process that ensures "there is no wrong door" for seeking enrollment, and no incorrect or time-bound way to get enrolled. For example, when people move to Oregon there will be no waiting period for enrollment. Once a person is a resident, the person is covered. The single payer governing board will need to work with, and initially may need to expand the workforce of, insurance application assisters to get all existing residents enrolled.

## KEY ELEMENT: HEALTH CARE BENEFITS OREGONIANS WILL ENJOY

Oregonians will receive the same health care benefits, regardless of the region where they work or reside. The benefits provided by the single payer will be comprehensive. The Task Force recommends that the health care benefits be robust and leave no area of health care uncovered. The Task Force recognizes that the plans enjoyed by state employees provide a good model, albeit even they need to be enriched in a couple of areas. The actuaries working for the Task Force were directed to use the state employees' plan with enhancements in the dental, behavioral, and hearing care areas when they modeled the costs of the full plan. The details of what goods and services will be in the actual benefit plan will be decided by the Universal Health Plan's board of directors.

## KEY ELEMENT: PROVIDER PARTICIPATION, WORKFORCE ISSUES, AND PAYMENT COMPONENTS

The Task Force decided that the single payer system must have a provider reimbursement structure that meets a number of goals and objectives, including: no patient payment at the time of service or applied at a later date; parity in payment for services to all Oregonians equally; reduction of providers' administrative costs; reimbursement levels that are fair, adequate, and sustainable and can serve as a provider recruitment and retention tools; and, cost controls that are effective, fair, and not punitive to the provider.

The Universal Health Plan is directed to include cultural, geographic and specialty parity and equity priorities in the reimbursement system and is encouraged to ensure availability of physician extenders such as nurse practitioners and other alternative approaches to enhancing the workforce.

### A Regional Delivery System

In accordance with SB770 the Task Force embraced the establishment of delivery system with regionally sensitive global budgets for each region, based on enrolled membership and demographics and the need to correct for historical deficiencies in and between regions and groups of Oregonians. Only one regional entity will serve a geographic region.

The regional entities will be encouraged by the statewide single payer board to apply to the statewide entity for demonstration project funding to test new strategies to address longstanding inequities and problems. These may include improving behavioral health access, expanded use of mid-level and alternative practitioners, and the need for innovations that improve value and access to care for historically marginalized patients or to improve access to care in rural and frontier communities.

While oversight and administration of the single payer plan will be done by the statewide board and entity, each regional entity will propose methods for reimbursing providers in their region. Regional entities will be encouraged to develop their priorities based on local stakeholder input and be instrumental in ensuring providers in the region achieve statewide goals and objectives.

How the regional entities will be structured and governed will be determined by the Universal Health Plan's board during the transition and implementation phases. The Task Force expects regional entities will have some delegated authority to participate in the management and coordination of care for the region.

**Optional and Exclusive Provider Eligibility**

All licensed, registered or authorized providers will be presumptively eligible to participate in the single payer plan, and if they choose to do so they will have to agree not to participate in other substitutive plans or practices that may be created and not to ever bill an Oregonian for services or goods provided under the single payer plan. Providers could, however, participate in plans or practices providing services not covered by the single payer plan, such as a plan providing cosmetic surgery. The single payer system is expected to require increasing the number of health care providers serving currently underserved communities and individuals. This is especially important in rural areas.

**Residents needing health care in other states**

The single payer board shall establish and maintain procedures and standards for recognizing, monitoring and reimbursing health care providers located outside of Oregon for purposes of providing coverage under the single payer system for a member who requires out-of-state health care services.

**Capital Expenditures**

The Task Force plan proposes that all providers will be responsible for their own routine organizational capital expenditures such as new computers. The statewide entity will, however, allocate to regions a budget for exceptional or large scale medical capital investments such as purchasing MRI machines or building hospital expansions. The allocations by the statewide entity will be based on community needs assessments conducted by the regional entities.

**Health Care Workforce Challenges**

The Task Force recognizes that today there are significant health care workforce challenges, such as marginalized and rural or frontier communities with too few providers and too few providers of behavioral health care services.

**Global Budgets, Fee for Services, Value Based Pay, and Parity**

The Task Force is also critical of how providers are currently paid for services. Consistent with SB 770, the Task Force encourages provider reimbursement approaches that prohibit reimbursing institutional providers under fee-for-service provisions. While fee-for-service may be appropriate for some individual provider reimbursements, organizations such as hospitals should be budgeted globally. The Task Force encourages evidence-based care delivery, though it recognizes that incentives to providers for holistic care and appropriate evidence based alternative care are also valuable.

The Task Force believes that there is a need to improve pay parity across types of individual providers to better foster preventive services, offer cost avoidance opportunities, or enhance workforce recruitment and retention. Moreover, the Task Force acknowledges Oregon's interest to date on forms of value-based payments, and encourages community input and prioritization in establishing value based payments under the single payer system. The system for determining value must be influenced by patients and families as well as regional and community norms and perspectives.

## KEY ELEMENT: GOVERNANCE AND TRANSITION

The most important task for the 2023 Legislature is to establish the governance approach guiding the founding and accountable operation of the Universal Health Plan. The single payer entity – the Universal Health Plan – will be a nonprofit public corporation that relies on a trust fund managed through the state treasurer's office separate and distinct from the General Fund to pay for Oregonians' health care.

### Founding Board

The Task Force recommends that a "founding board" of the Universal Health Plan be created in statute and members appointed in 2023. The founding board should reflect the values and structure of the Universal Health Plan as described in the body of this report, including regional diversity and board members who each have an authentic community voice.

Initial activities of the founding board should be to prioritize collaborative implementation planning discussions with all elements of the Oregon health care delivery system, organization and drafting of Medicaid, Medicare and other necessary federal waivers, a macroeconomic analysis of the implementation approaches to be pursued, and a constant process of engagement with Oregon's patient and taxpayer communities. The founding board needs to define and initiate the government-to-government relationship with Oregon tribes. The board's planning should prioritize health equity, community investment and equitable distribution of resources.

The board will work with state agencies through this period identifying transition issues and collaborative opportunities. The board should establish the regions and planning should take place with communities in each region identifying likely available resources, needed resources and next steps needed to organize regional entities that will advise the board and shape the delivery of care in each region and the distribution of resources needed to implement.

The founding board should have a bill drafted for the 2025 legislative session creating the nonprofit public corporation that will serve as the single payer entity and giving the board the authorities needed to begin implementation of the Universal Health Plan in the 2025-2027 biennium. The board's bill draft should include a recommendation regarding an increase in the size and makeup of the board as implementation approaches with an emphasis on representation from every region in Oregon.

### Transparency and Accountability

All of the board's work should be transparent and subject to Oregon's public records and meetings laws. Decision making should not only occur in public but should also include input from the public that is sought in a timely fashion. The board must be held accountable for its work.

**Composition of Founding Board**

The founding board should be composed of nine (9) members, appointed by the Governor and approved by the Senate. The membership should reflect the diversity of Oregon's population. All members should be free of conflict of interest, have experience with public service, and be committed to full transparency. Five (5) members should be employed full time, four (4) part time. The full-time employed members should be responsible for the day-to-day operations of the start-up phase of the Universal Health Plan. Their education and experience should reflect expertise in organizational start up, public agency operations, finance, provider relations, Medicare and Medicaid waivers, and actuarial analysis.

The four (4) part-time employed members should focus on public engagement with Oregonians and providing advice and feedback on a continual basis to the full board of the Universal Health Plan and staff working to implement the plan. As a group they should bring the following experiences to the job: experience as a Medicaid patient, experience as a Medicare patient, experience as an advocate for children, experience as an advocate for behavioral health.

The main objective of the founding board will be to report to the 2025 legislature on progress made towards a single payer health system with specific recommendations for next steps towards implementation in the 2025-2027-time frame. The Founding Board should include a recommendation related to increase in size of the Board with an emphasis on representation from every region in Oregon.

The founding board will select a full-time member as chair and a part-time member as cochair. Current and former Oregonians involved in health care administration and delivery should be encouraged to apply.

## KEY ELEMENT: COST

NOTE: this needs drafting or incorporated into next "Key Element" as "Funding and Cost"

## KEY ELEMENT: FUNDING

At the heart of the single payer system is a revised funding system. In the current system, individuals, employers, and the state and federal governments all pay for health care. In the new model, a single fund would combine federal and state revenue to pay for health care.

The Task Force envisions funds to pay for the universal care will come from three places: (1) re-direction of existing state government revenues spent on health care from Oregon taxpayers and from federal sources directly to the new Universal Health Plan's trust fund; (2) projected savings in the health care system by creation of the more efficient single payer model; and (3) new public revenues in the form of tax contributions to replace current premiums and out of pocket expenditures.

**Redirection of Existing Revenues**

To achieve the full benefits of a single payer system, current federal and state public spending on Medicare and Medicaid must be redirected to the Universal Health Plan in such a way that the single payer can combine all funds into one financial pool (a trust fund) for reimbursement of medical care. This will require federal officials to waive some federal restrictions or new federal legislation by Congress.

The federal action will need to assure Oregon that it can continue to collect federal funds for the populations covered by the federally funded programs at the current funding level indefinitely and adjusted for changes in the populations eligible for those programs over time.

**Cost reductions**

To meet the cost reductions factored into the actuarial analysis the assumptions made by the actuaries must be met. A portion of the savings is expected to be used to reduce the amount of new revenue which would otherwise be required to replace private premiums and out of pocket expenses.

**New Revenue**

After reviewing a comprehensive list of possible taxes, the Task Force focused on three types of taxes that could be used to raise revenues: a tax on payroll applied at the employer level, a tax on personal income, and a sales tax.

After much deliberation, Task Force members came to the consensus that while there was an excellent case to be made for a sales tax that also incorporated a tax credit for low- to moderate-income households, historic voter distain for a sales tax in Oregon has been so overwhelming that public support for universal health care should not be dependent on such an unpopular revenue plan.

The Task Force took a tax on corporate profits off the table because Oregon corporations are so easily able to avoid the corporate profits tax that little can be gained by a new profits tax. This left a combination of a payroll tax and a tax on Oregonian's income. That said, the legislature is certainly free to put a sales tax or a corporate profits tax, or both, back on the table.

The payroll tax rate considered by the Task Force would increase for higher income workers so it would be less regressive than the flat and capped federal payroll taxes. The Task Force considered a 7.25 percent tax on wages up to $160,000 and10.5 percent on wages in excess of $160,000. Economists are in almost universal agreement that a payroll tax paid by an employer is essentially paid for by the employee in lower wages. Consistent with that economic principle, the federal and state income tax codes consider health insurance expenses paid for by employers to be remuneration to the employees, although both the federal and state tax codes exempt that remuneration from taxation of the employees' income.

Importantly, even if the payroll tax is fully paid by employers, the payroll tax for health care at the levels considered by the Task Force would be less than what employers now typically pay for insurance as a percent of payroll. Thus, generally speaking, employers who today provide health insurance as a compensation benefit would save money under the Universal Health Plan payroll tax, while employers who do not provide health insurance as an employee benefit would not enjoy a savings.

The new tax on personal income considered by the Task Force would be based on ability to pay and would make Oregon's full personal income tax scheme more based on ability to pay (i.e., progressive) and Oregon' overall tax system would become more based on ability to pay, as well.

The marginal rates and income brackets the Task Force considered are:

- No additional personal income tax up for households up to 200 percent (i.e., two times) the federal poverty level, which for a four person household is $55,500 in 2022);
- A 1.0 percent tax on household income between 200 and 250 percent of poverty, which for a four-person household in 2022 is income between $55,500 and $69.375;
- A 2 percent tax on household income between 250 and 300 percent of poverty, which for a four-person household in 2022 is income between $69,375 and $83,250;
- A 3.5 percent tax on household income between 300 and 400 percent of poverty, which for a four-person household in 2022 is income between $83.250 and $111,000; and
- A 9.3 percent tax on household income of $111,000 or more for a four-person household in 2022.

Household income would not include income exempt from taxation under the Oregon Constitution, such as federal Social Security and railroad retirement benefits.

Because there is no shortage of options for how to design a payroll or income tax and the decision is ultimately one to be made by the legislature, the Task Force chose to consider what it developed and discussed as mere examples – not a Task Force proposal – that can give initial guidance to the legislature.

The founding board and the legislature will need to discuss a number of issues that the Task Force did not have time or resources to explore such as startup costs, reserve accounts and reinsurance, and bonding requirements. None of these additional issues are unique to establishing the single payer system and all of them have been addressed in other policy arenas.

## KEY ELEMENT: MEDICARE

All Oregonians should be treated equitably when it comes to access and navigation of the health care system, including seniors with Medicare. The Task Force's single payer approach relies on efficiencies created when a single payer is deployed. The current complex structure comprised of multiple funding sources using multiple payers who offer multiple benefit plans, along with cost sharing and other administrative obstacles creates a challenge. Incorporating Medicare is uniquely difficult because virtually all of the funding for Medicare comes from the federal government and about 900,000 senior who are Medicare participants.

Despite having health insurance coverage under Medicare, the majority of Oregon seniors experience significant challenges in accessing and financing their health care. If the Medicare population is not properly incorporated into the single payer system, seniors would have less access, less coverage and likely lower quality care than other Oregonians. To ensure Medicare participants are fully incorporated, seniors will need to continue to make contributions to Medicare which will come back to Oregon for the single payer coverage and make tax contributions to the single payer plan if they are working or have income other than retirement income exempt from taxation by Oregon's constitution.

The Universal Health Plan designed by the Task Force will be unique in terms of its approach to Medicare. All Medicare patients who are Oregon residents would be eligible. All patients

would be able to access all available providers and the payment rates to providers "normalized" – the same for all Oregon residents – discouraging discrimination by providers in choosing patients based on payment rates. Oregon would not be requesting additional funds from Medicare to cover cost sharing or the additional benefits in the single payer system that are not covered by Medicare. It is possible that alternatives currently available from Medicare, such as Medicare Advantage, could be used to implement the Medicare portion of the Task Force strategy.

Due to the need at the federal level to stabilize Medicare funding by 2026, Medicare will be undergoing significant changes in the same time frame as the Universal Health Plan design comes together. Oregon needs to be ready with a transformative proposal. In a number of states Medicare has recognized transformative approaches for Medicare. The current federal administration has strongly signaled an interest in Medicare transformations that will improve health equity and increase involvement of patients and providers and increase transparency. There is no health plan design in use today that can match the Task Force design when it comes to equity, patient and provider involvement, and transparency. The need to stabilize and the interest in transformative approaches makes now an appropriate time to approach the Biden Administration about this design.

There are multiple potential pathways for a single payer to include all Medicare patients. The most likely pathway is for Oregon to offer a single Medicare Advantage plan within the Universal Health Plan that all Medicare patients will be enrolled in once Medicare eligibility is confirmed. As is proposed by the Task Force for other Oregon populations, Oregon would prohibit insurers from offering any benefit plans that duplicate the Universal Health Plan's benefits for Medicare eligible Oregonians. In other words, there would be no supplemental Medicare insurance, ACOs or private sector Medicare Advantage plans. While it is possible that other Medicare options, including traditional Medicare approaches, could be employed by a single payer to reach equity with the Universal Health Plan design, these approaches would be more challenging to administer.

The recommendation by the Task Force to pursue options with Medicare would enable Oregon to treat Medicare patients equitably under the Universal Health Plan. The negotiation with Medicare would be strengthened by a commitment from the Oregon Legislature and Governor to support the Universal Health Plan design and specify that Universal Health Plan officials are authorized to negotiate such an arrangement with Medicare. Preliminary discussions with Medicare should occur in the 2023-2025 period further identifying options and including them in a macroeconomic analysis.

## KEY ELEMENT: EQUITY

The Task Force's plan will provide a universal set of health care benefits to all Oregonians; ensure every Oregonian has access to behavioral, vision, hearing, and dental care often not adequately included in many insurance plans today; and, eliminate the need for Oregonians to pay premiums and out of pocket costs. The plan eliminates differences in payment to providers and makes it so that providers are paid the same regardless of an individual's financial or health care coverage circumstances.

This plan addresses and assures health equity. Health inequity exists in all aspects of our society. Oregon's current Medicaid, Medicare, private employer-sponsored health insurance coverage partnerships and Coordinated Care Organizations have not adequately addressed health inequities. The current insurance and delivery systems are comprised of the wealthy, privileged, powerful, and well-positioned stakeholders who created our existing inequitable

social structures. As currently structured, these entities have led to growing public concerns about an unequal and inequitable healthcare delivery system.

Assuring health equity will require eliminating organizational and institutional barriers such as practices, policies, programs, procedures, consumer behaviors, and financial management around appropriate distributions of social determinants of health (SDOH) and health equity requirements. These efforts must be inclusive and address cultural, linguistic, environmental, political, and economic inequalities. Using these various lenses to design a transformative system will help eliminate health disparities, inequalities, and inequities.

Health equity will be achieved only when inequality and unfairness in the distribution of SDOH resources result in the elimination of unevenly distributed health insurance coverage plans, limited sharing of health information and access to health care services. By addressing these issues the Universal Health Plan board will highlight policies and procedures of inclusion that connect the intersectionality of gender, sexual orientation, LGBTQIA, race, ethnicity, and other SDOH and equity elements.

An effective health equity policy provides a health-promoting supportive system of quality of care and accessible services to all Oregon residents with fair and equal benefits for all Oregonians. The Universal Health Plan board's health equity policy must consider community-based health organizations, managed care systems, and health care providers (including physicians, nurses, licensed practitioners) and other allied health stakeholders.

## KEY ELEMENT: HEALTH CARE WORKFORCE

As envisioned by SB 770, the single payer board will have a role in workforce recruitment, retention, and development. Oregon's health care workforce faces challenges of filling vacancies, meeting demand for services, filling entry-level positions, and correcting historically understaffed areas such as direct support to the disability community, and certified nursing assistants. The workforce challenges are exacerbated by systemic inequities and geographic disparities.

The single payer board needs to assess the education and credentialling requirements of a number of health care occupations that have been constraining the supply of workers while attempting to improve the quality of work by those health care workers. Physical and occupational therapy workers and registered nurses are examples of positions that are in short supply and many believe education and licensing requirements carry much of the burden for the problem. The single payer board needs to be involved in efforts to reduce the cost of education of health care workers so that more people can enter the field and there are an adequate number of slots in the educational institutions.

The single payer board must work to address education and licensing programs and play an active role in increasing the training capacity of those entities that train the health care workforce, especially in the nursing arena. The board must encourage geographically diverse investments in health care workforce training, and support wages needed to supply the necessary instructors to train the future health care workforce. The board should explore involvement in the National Nurse Licensure Compact and other similar licensure reciprocity agreements licensed health care workers.

## KEY ELEMENT: COMPLIANCE WITH ERISA

The Task Force knows that the Employment Retirement Income Security Act (ERISA) will be a barrier to creating a state-based universal health care system. So that it can best design a universal plan that may survive an ERISA challenge the Task Force retained the services of two national ERISA experts, Elizabeth McCusky and Erin Fuse Brown. The Task Force plan includes three elements that achieve that goal while still moving Oregon from an employer-based health insurance system to a Universal Health Plan. These elements include: (1) a payroll tax levied on all employers at a level that does not control an employer's decisions about employee benefits; (2) restrictions on coverage duplication by state-regulated health insurers; and (3) provider participation is optional but exclusive. These elements are structured in a way that the overall plan will likely survive an ERISA preemption challenge, while still making space for employers and employees to have freedom to choose to be in the Universal Health Care plan.

The payroll tax is levied on all employers and is moderately progressive, as it increases based on an employee's wages. The tax is unrelated to an employer's benefits plans and is not contingent on an employer's benefits plan. Like employers' insurance payments, the payroll tax is an allowable customary and usual business expense.

Employers would no longer need to provide health insurance benefits, and they would still have the option to offer self-funded plans. The coverage duplication provisions in the Task Force plan allow complementary private coverage for those services and costs not covered by the Plan. This allows employers to offer complementary coverage as a benefit – either by purchasing it from an insurer or self-funding this coverage. The Proposal thus preserves meaningful choices for employers: offer self-funded duplicative coverage, offer complementary coverage, offer no coverage and rely entirely on the Universal Health Plan to take care of the health of their employees.

Finally, all licensed or authorized providers in good standing will be eligible to be participating providers. Participating providers will agree not to participate in other substitutive plans or practices that may be created and not to ever bill an Oregonian for services or goods provided under the single payer plan. The state Universal Health Plan will pay providers directly. The Universal Health Plan will be secondary to any forms of substitutive coverage employers choose to offer.

An appendix to the report includes a July 25, 2022, memo from Elizabeth McCuskey and Erin Fuse Brown that provides additional details of how the plan properly avoids running afoul of ERISA.

Health insurers would have a more limited role than in the current system. Insurers would be able to offer extra insurance to cover benefits or services not offered by the Universal Health Plan (supplemental plans). This could include such things as long-term care, services that have a limit or certain prescription drugs that are not covered by the Universal Health Plan.

State-regulated insurance companies would not be allowed to offer insurance that would take the place of the Universal Health Plan. The Universal Health Plan would be the main administrator of health care benefits in Oregon. The Plan might also contract with third parties such as private insurance companies to help with administration of benefits or payments.

## KEY ELEMENT: FEDERAL WAIVERS AND COOPERATION

In the current system, individuals, employers, and the state and federal governments all pay for health care. In the new model, a single fund would combine federal and state revenue to pay for health care.

Oregon will need to obtain a waiver from federal law (an "1115 Medicaid Waiver") to include all Medicaid recipients in the Universal Health Plan and to secure the federal funds that currently fund Oregon's Medicaid system.

All Medicaid recipients would be enrolled in and covered by the Universal Health Plan. The one exception is that Medicaid recipients would continue to receive the required Medicaid benefit package which provides some additional services beyond the Universal Health Plan Benefit. Providers would be paid the prevailing Universal Health Plan rate. The same Medicaid long-term care would be provided as a benefit to Medicaid recipients outside the Universal Health Plan. The Medicaid long-term care benefit would be administered as it currently is by the Department of Human Services.

Oregon will require federal waivers (approvals) for Medicaid, Medicare and Marketplace funds to be used for the Universal Health Plan and for the state to provide the Universal Health Plan benefit to those eligible for Medicaid, Medicare and the Marketplace through the Affordable Care Act. Oregon may be able to proceed with 1115 and 1332 waivers along with approval from the federal Center for Medicare and Medicaid Innovation to accomplish this, but it is not guaranteed. The Task Force supports federal legislation for a "super waiver" that would provide a single federal authority for states to establish universal health care plans.