Joint Task Force on Universal Health Care

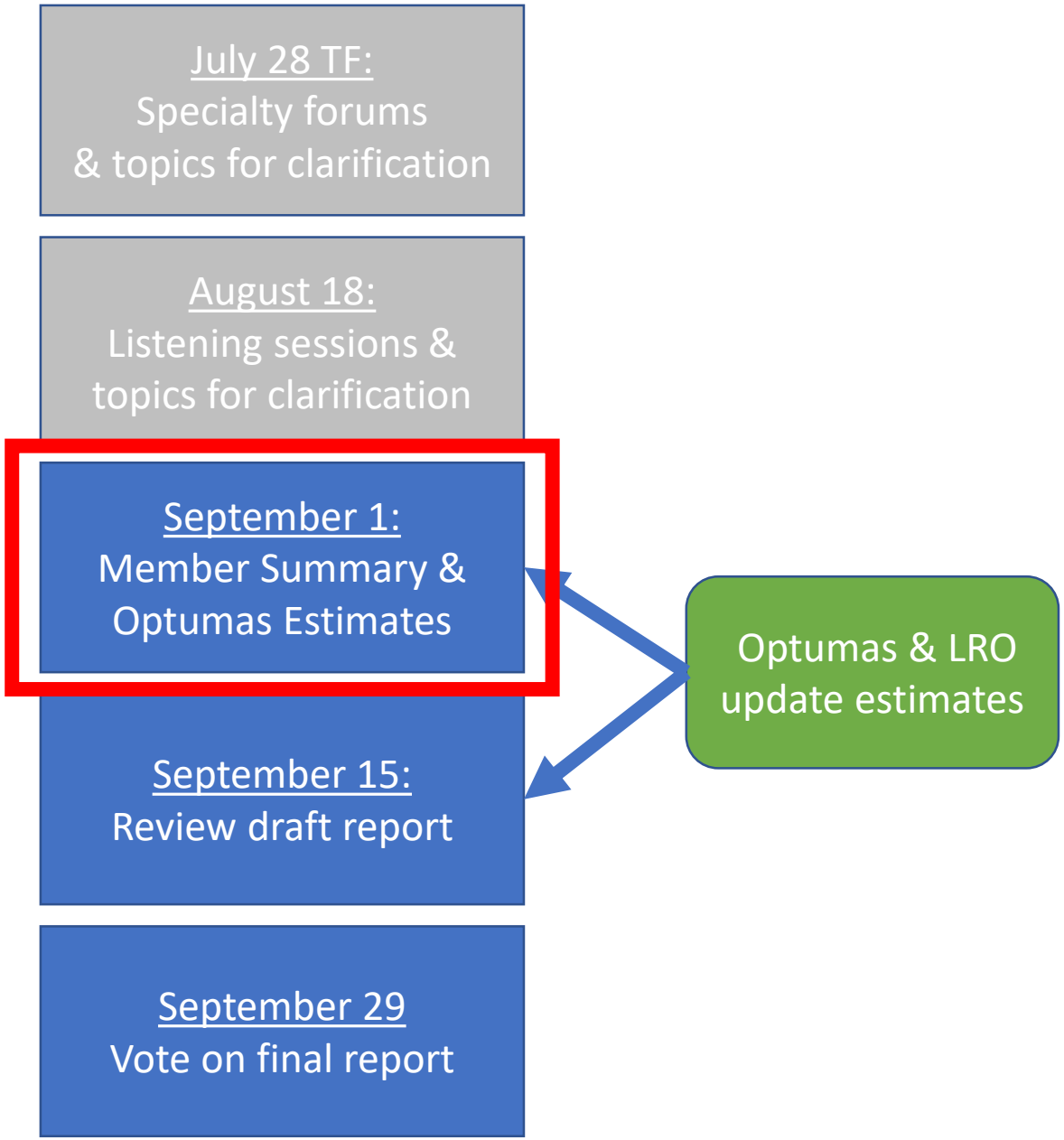
September 1, 2022

1 – 4:30 pm

Today's Agenda

- Public Comment
- ODE: Transition Plan
- Public Engagement Wrap-up
- *BREAK*
- Optumas
- Member Summary

Remaining Meetings



Public Comment

September 1, 2022

Written Comments Received

- Approximately 25 unique messages—received between 8/22 and 9/1— expressing concerns about tax increases. All messages are posted on OLIS as meeting materials for this meeting. Issues include:
  - Oregon's tax rates already high relative to other states
  - Tax increase in context of high prices/inflation
  - Increased SP cost/tax increases due to migration into the state and additional utilization
  - Taxpayers migrating out of the state due to tax increases
  - Lack of transparency about potential tax increases
- "Founding" should not be used with "Governance Board." Suggests impermanence.
- Medicare-eligible Oregonians who pay Part B premiums should be exempt from the personal income tax

Outstanding Design Element: Transition Plan

Final Recommendations

Joint Task Force on Universal Care

September 1, 2022

SB 770

Succinct statements about the actions needed

Priority objectives to complete the transition to a universal system

Timeline for actions and recommendations

Member Proposal: Founding Governance Board

The Task Force on Universal Health Care recommends that the 2023 Legislature create the Founding Governance Board of the Universal Health Plan within the Department of Administrative Services, reporting to the Governor, and provide the authority and funding to:

1) Develop, in collaboration with a representative health care delivery advisory committee, a plan to organize Oregon's health care system to deliver care in a single payer system which is in alignment with the Purposes, Values, and Principles of SB 770 of 2019.
2) Organize and draft Medicaid, Medicare and ACA waivers as needed
3) Complete a macroeconomic analysis of the implementation approaches suggested by the Task Force.
4) Organize a continuous engagement process with Oregon communities
5) Initiate and maintain a government-to-government relationship with Oregon tribes.
6) Assess and maintain inter-government relationships with Oregon counties.

The main objective of the Founding Governance Board is 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 timeframe.

Founding Governance Board: Appointment & Co-Chairs

The Founding Governance Board of the Universal Health Plan be composed of 9 members, appointed by the Governor and approved by the Senate. The membership will reflect the diversity of Oregon's population. Members will be subject to Oregon Ethics and Standards. Members will have an authentic community voice. The size of the Board will increase as implementation occurs to include a member from each Oregon region.

The Founding Governance Board will select two co-chairs from its members, including one co-chair focused on public engagement and one co-chair focused on on the day-to-day operations of the startup phase of the Universal Health Plan.

Founding Governance Board: Composition

Members will be state of Oregon employees. Members will be responsible for the day-to-day operations of the startup phase of the Universal Health Plan. Their collective education and experience will reflect expertise in start up organization efforts, public reorganization, operations, finance, provider relationships, Medicare/Medicaid waivers, communication, actuarial analysis and population/public health. Four members will focus on engagement with Oregonians and providing advice and feedback on a continual basis to the Founding Board. They will bring the following experiences:

1) Experience as a Medicaid patient
2) Experience as a Medicare patient
3) Experience as an advocate for children's health
4) Experience as an advocate for behavioral health
5) Experience as an uninsured person

All Oregonians of diverse cultural, linguistic, ethnicity, race, gender, healthcare providers, & professionals, community health & healthcare advocates, and activists, are encouraged to apply.

Transition Plan ODE: Task Force Recommendation

Given the problems with the existing health care system identified in public input, and given the significant potential of a single payer system, the Joint Task Force on Universal Health Care recommends that the 2023 Legislature appoint a governance board consistent with SB 770 (2019) to complete a full single payer implementation plan for review and consideration by the 2025 Legislature.

Public Engagement Wrap Up

Joint Task Force on Universal Health Care

September 1, 2022

Public Engagement & Plan Design

Aligned Policy Areas

- Access and Affordability – general support for increased access; no out-of-pocket costs (copays or deductibles) (*All groups*)
- Covered Benefits – support for comprehensive coverage and inclusion of dental, vision, and behavioral health (*All groups*)
- Eligibility and Enrollment – all Oregon residents are eligible (*All groups*)
- Equity & SDOH – support for the focus on equity and SDOH (*All groups*)
- Provider Reimbursement – support paying providers directly (*Roundtables & Health Care Industry)*

Partially Aligned Policy Areas

- ERISA – concerns around the plausibility of avoiding ERISA preemption (*Health Care Industry, Insurers, & Business Community*)
- Governance – questions around the make-up and duties of the board.
  - Concerns focused on the political impacts of changing administration and equitable representation of members (*All groups*)
- Ensuring safety and quality as a priority of the plan (*Health Care Industry*)
- Future role for private insurers (*Insurers & Community Sessions*)
- Support for regional involvement (*Health Care Industry & Employers*)

Opportunities for Alignment

- Overall Costs & Revenue Needs (*All groups*)
  - Personal income tax as a burden on individuals and families
  - Negative impact of increasing taxes on businesses; creating new costs, particularly for small businesses (with tight margins) and self-employed Oregonians
- Impact on Oregon's farming and agriculture industry (e.g., seasonal employees) (*Employers*)
- Implementation of competing policies (*Health Care Industry*)
- Feasibility of obtaining a Medicare "waiver" ("untested legal theory") (*Insurers*)
- Medicare enrollees continue to pay Part B/D premiums and new PIT (*Community Listening & Health Care Industry)*
- Multi-State Employers (*Unions & Employers*)
- Transition checkpoints (*Health Care Industry & Community Listening*)
- Workforce impact – training, capacity, shortages (*All groups*)

Summary – Policy Alignment

Aligned

- Access and Affordability
- Comprehensive Benefits
- Eligibility and Enrollment
- Provider Reimbursement
- Equity
- SDOH

Partial Alignment

- ERISA
- Governance
- Patient safety and quality
- Private/Commercial insurers
- Regional involvement

Opportunities for Alignment

- Costs & Proposed Tax Rates
- Farming/Agriculture
- Implementation risk
- Medicare enrollees
- Multi-State Employers
- Workforce
- Community engagement with transition and implementation

Intermission

Oregon Health Authority

Updated Revenue and Expenditure Estimates

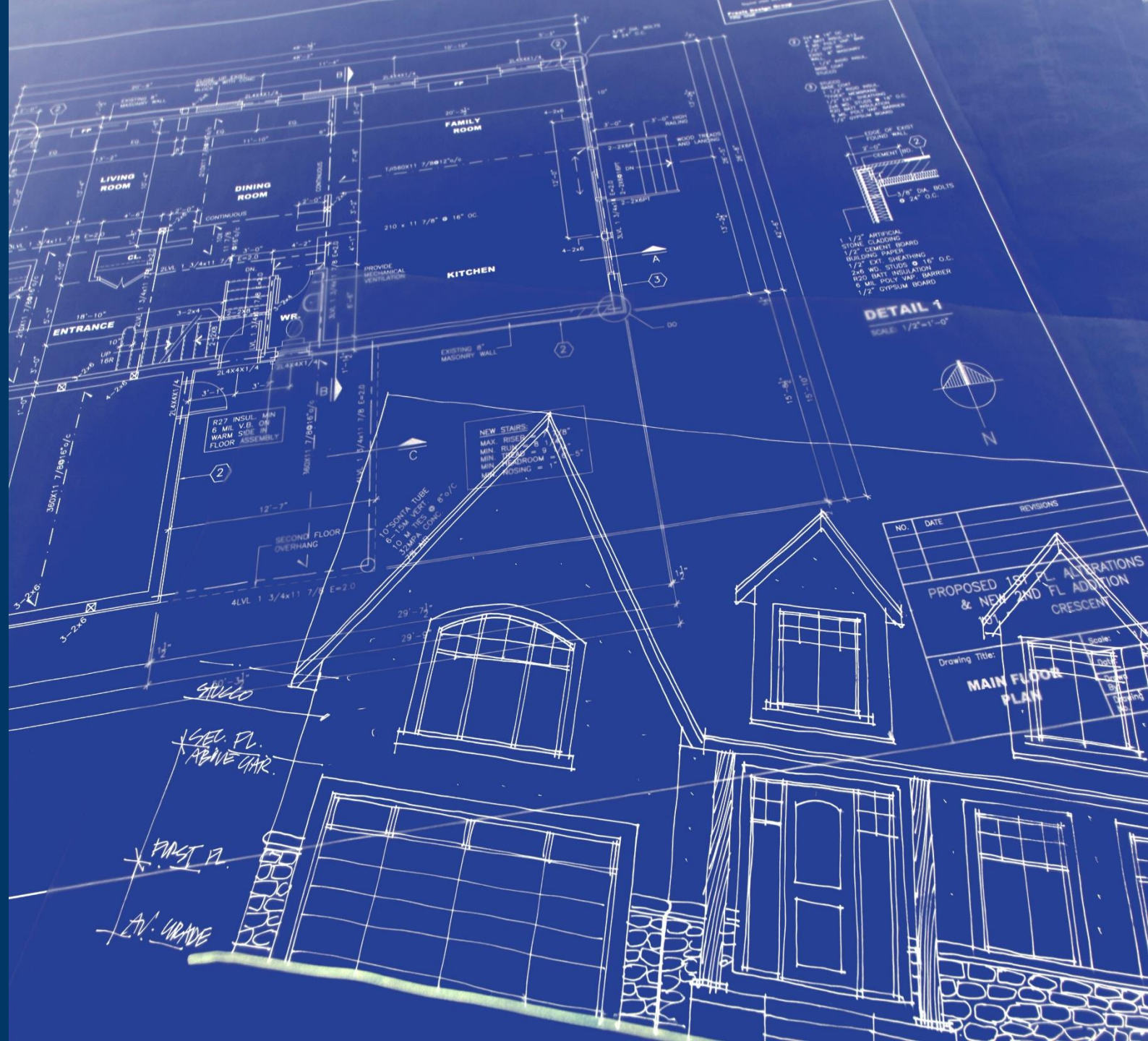
September 1, 2022

CBIZ Optumas

Consultants • Actuaries • Economists

Agenda

- Modeling Overview & Limitations
- Outstanding Questions
- Revised Assumptions
- Results



Modeling Overview and Limitations

Data Availability

The healthcare system is vast and complex. Oregon-specific data sources are not available for every facet of the analysis. In cases where Oregon-specific data sources are unavailable, values are imputed based on best available data which can include national sources, using proxies from similar programs, and other research.

Directly Applicable Evidence

Research studies and comparison programs are used to inform assumptions, but this is done with caution; evidence may not apply as directly under the unique environment you are creating.

Uncertain Impact of COVID and Inflation Long-term

It is unclear what the new normal will look like post COVID. Additionally, the current global instability and economic policies are driving inflation could result in significantly higher future costs; the models and estimates will need to be updated as there is greater clarity regarding these factors in the future.

Modeling Overview and Limitations

Additional Detailed Analysis / Next Steps

The purpose of the expenditure projections and revenue estimates inform Oregon stakeholders of the viability of a single-payer system. Additional analysis based on more refined / specific strategy, that includes program administrative structure, provider payment design, and incorporating actual utilization data obtained through partnership with entities that may not be reporting data currently, (e.g., all payer claims database, Medicare, employer).

- *Discussions need to occur with CMS and other federal partners to understand the flexibilities, limitations, and process steps for implementing universal health care for Medicare, Medicaid and federal marketplace beneficiaries.*
- *Parallel to this process Oregon will need to perform significant detailed analysis of the populations to refine program cost estimates.*

Perform robust economic impact analysis
The single payer policy results in redistribution of wealth of a magnitude that is highly likely to impact economic behavior. These changes in behavior could drive significant changes to revenue need estimates. The current model does not contemplate these impacts.

Outstanding Questions

General

Profits, Margins, and Commissions in Projection

Projected expenditures removed health insurance commissions, premium tax, state/federal tax, and profit margins inherent within the historical expenditures.

Utilization Assumptions

Utilization assumptions vary by population and include a mix of upward and downward adjustments that change over time. Currently utilization increases are incorporated for:

- Impact of eliminating out-of-pocket cost sharing
- Impact of increased provider reimbursement for Medicaid populations
- Impact of standardized benefit plan
- Uninsured

Outstanding Questions

General

ACA Coverage Requirements for Children <26

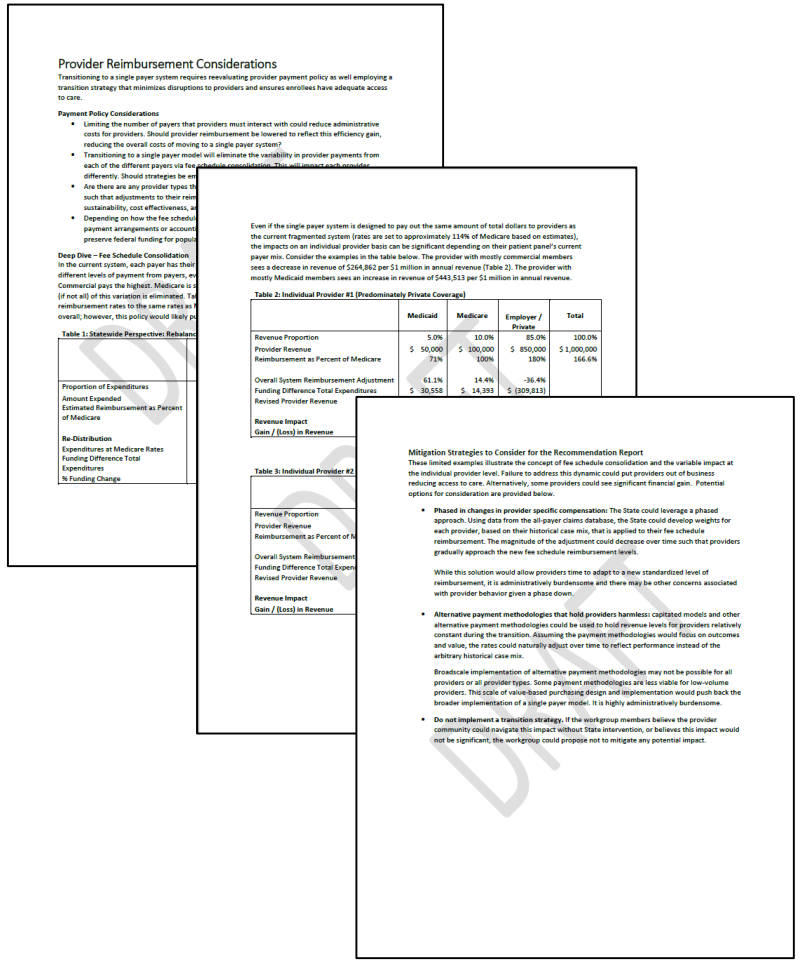
- It is unclear which populations would have mandated coverage under a single-payer system
- ACA requires coverage under certain circumstances, but does not require children to be financial dependents
  - The triggering coverage circumstance (when parents have option of dependent coverage through employer or want to add when purchased through exchange) would not apply under single payer
  - Covering anyone <26 living out-of-state with Oregonian parents would be a significant expansion of coverage relative to status quo
  - Potentially results in supplanting of other states' health care coverage obligations that would have occurred under status quo
  - Status quo many forgo option even if available due to out-of-network costs, having own insurance, etc.
  - Potential options to have a "buy-in" program to offset costs for this population and meet spirit of the law
  - Requires further legal analysis, policy positions on different coverage cases, and discussion with federal government to determine policy to then estimate impact
- Financial dependents are included in the model in most cases
  - Undergraduates report parents' address as permanent residence and are then included in population estimates for forecast
  - Other cases are likely to be nominal due to the strict definition of financial dependent

Outstanding Questions

Provider Reimbursement

Increase in Medicaid Reimbursement

- Reflected in provider brief document presented during January 27th Task Force discussion. Key elements:
  - Current system providers receive different levels of payment (Commercial, Medicare, and Medicaid).
  - Uniform reimbursement for the single payer and maintain level of aggregate spending (no reduction in provider reimbursement).



Outstanding Questions

Provider Reimbursement

What is preventing Oregon from paying Medicare or higher than Medicare today?

Background

- CMS limits federal financial participation for Medicaid to an Upper Payment Limit (UPL) and efficiency principles outlined in the Social Security Act.
- The UPL is an estimate of the amount that would be paid for Medicaid services based on Medicare payment principles.

Financial Limitations

- Because Medicaid is jointly funded between the federal and state government every $1 increase requires Oregon to increase general fund contribution by $0.40 for regular matched populations.

Outstanding Questions

Provider Reimbursement

Is this tried-and-true concept?

- Yes, State's regularly increase provider reimbursement and receive federal matching funds
- The single payer estimates the draw of federal matching funds up to 100% of Medicare reimbursement and then assumes 100% state funds beyond that amount.
- Increasing reimbursement above 100% of Medicare and receiving federal match on the expenditures would require discussion with and pre-approval from CMS.

Federal Tax Liability and Savings Summary

- This is reflected in the modeling adjustment specific to the baseline and projected expenditures of a single payer system.
- Projected revenue is developed based on projected costs and reflect additional state share revenue to support increased Medicaid reimbursement.

Model Updates

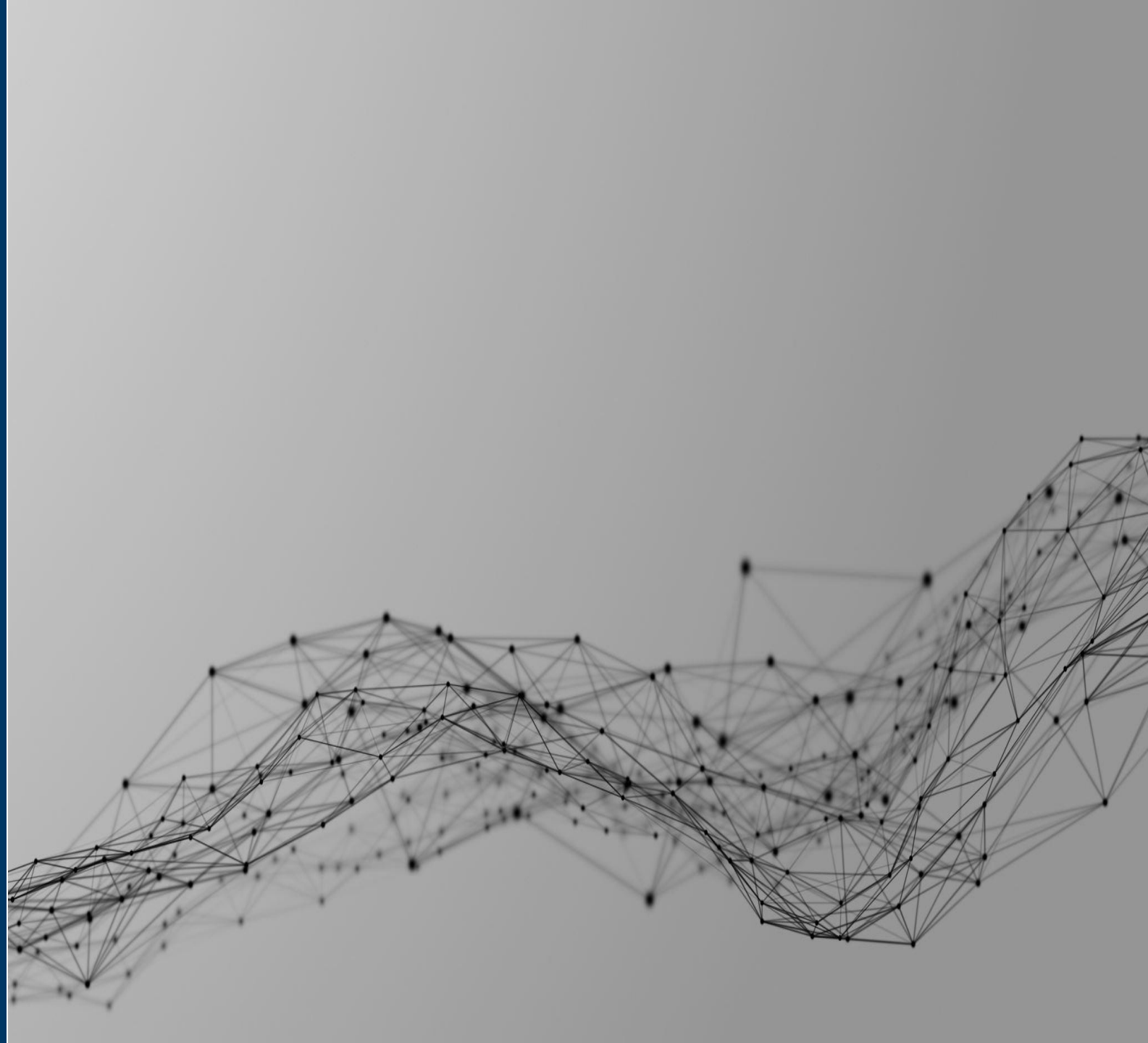
Updates since last presentation of results:

- Removal of state hospitals
- Removal of border-state employee and dependent coverage
  - Related rate rebalance that impacted all other populations
  - Related recalculation of dental plan costs
  - Related recalculation of provider efficiency capture adjustment
- Five-year forecast added
- Minor adjustments for most recent population forecast
- Revenue stream updates (Part B, Part D, enrolled but not eligible)

Due to compounding effects and other cumulative smaller adjustments, the sum of adjustments shown here will not equal the total model change between version.
***Not reflected in summaries that follow but will be show in LRO tax scenarios. Excluded from total.

Results

- Status Quo Expenditures
- Status Quo Revenue
- 2026 Universal Health Care
- 5-Year Projection



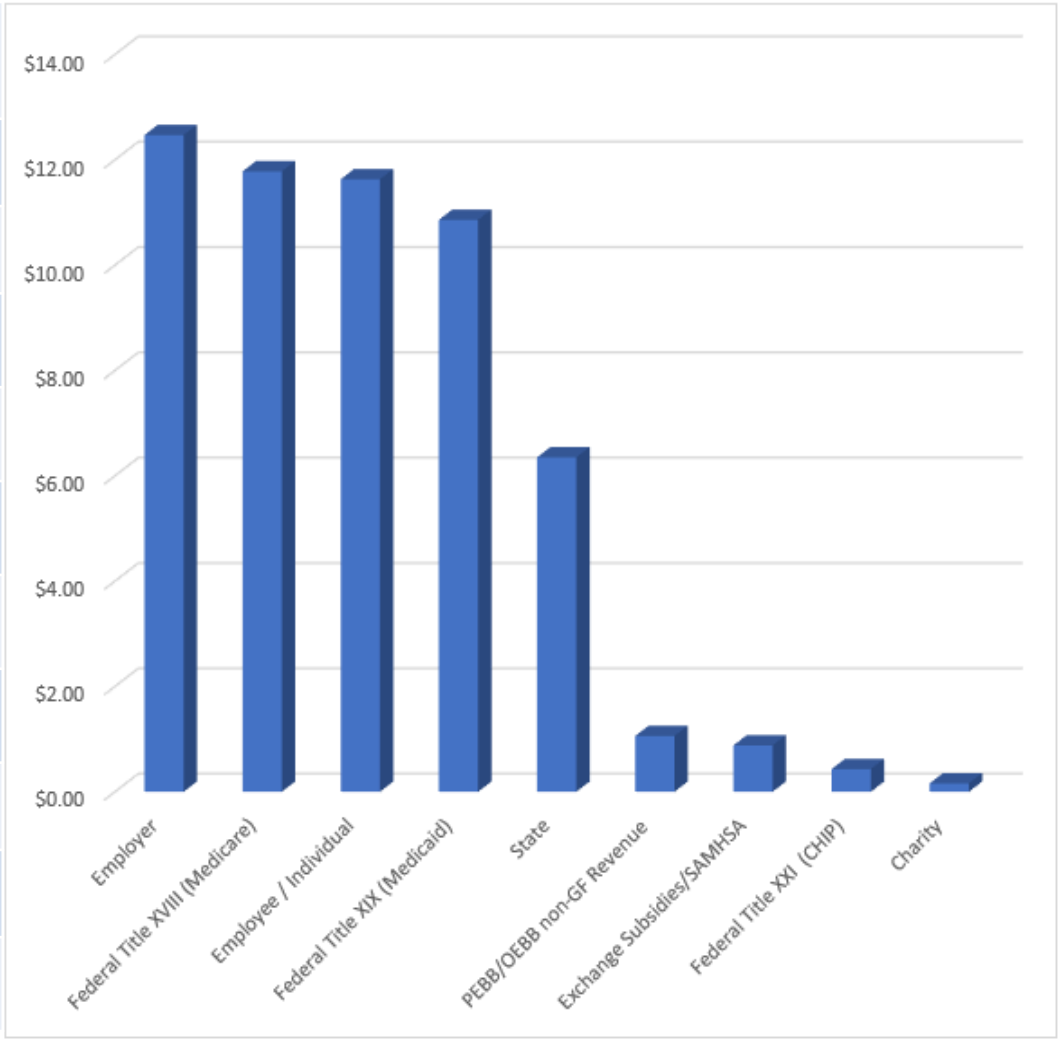
Status Quo Expenditures

Coverage Type	2019 Expenditures	2026 Expenditures	2026 Enrollment
Individual - Exchange	$1.00	$1.39	156
Public Employees Other Than PEBB/OEBB	$2.84	$3.96	422
Employee/Other Individual	$8.66	$12.08	1,353
PEBB	$0.97	$1.36	145
OEBB	$0.73	$1.02	140
Medicare	$9.42	$15.80	823
Medicaid	$9.94	$14.59	904
CHIP	$0.45	$0.66	135
Out of Pocket	$1.54	$2.06	n/a
Uninsured	$1.21	$1.61	315
General Assistance (Charity Care)	$0.12	$0.16	n/a
Community Behavioral Health (non-Medicaid)	$0.70	$0.92	n/a
Total Expenditure	**$37.57**	**$55.60**	**4,433**

Expenditures in billions; caseload in hundred thousands.
Figures may not sum due to rounding.
Due to dual eligibility across programs, figures may be higher or lower than public reported to avoid duplication; per capita calculations will be skewed as a result.
Medicare OOP is included in the Medicare total; OOP for programs and services not covered by the UHC plan are excluded.

2026 Status Quo Revenue

Funding Source Type	Revenue (billions)
Employer	$12.47
Charity	$0.16
Employee / Individual	$11.63
Federal Title XVIII (Medicare)	$11.78
Federal Title XIX (Medicaid)	$10.86
Federal Title XXI (CHIP)	$0.43
Exchange Subsidies/SAMHSA	$0.88
State	$6.35
PEBB/OEBB non-GF Revenue	$1.06
Total Expenditures	**$55.60**

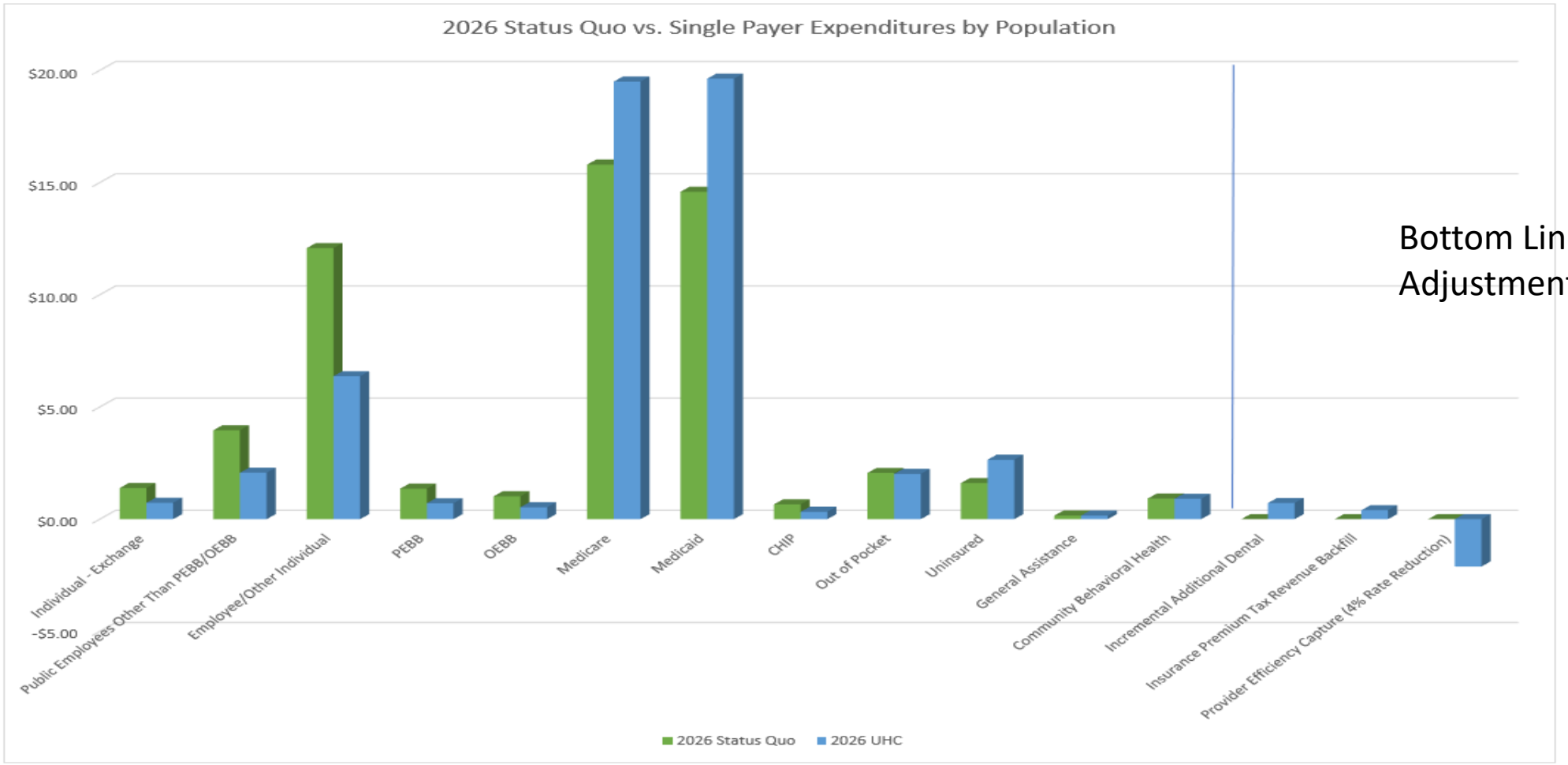


2019 revenues are not an input into the model and were not calculated

2026 UHC Projected Expenditures Comparison

Coverage Type	2026 Status Quo	2026 UHC	Difference
Individual - Exchange	$1.39	$0.73	$(0.66)
Public Employees Other Than PEBB/OEBB	$3.96	$2.07	$(1.89)
Employee/Other Individual	$12.08	$6.37	$(5.71)
PEBB	$1.36	$0.71	$(0.65)
OEBB	$1.02	$0.53	$(0.49)
Medicare	$15.80	$19.50	$3.70
Medicaid	$14.59	$19.63	$5.04
CHIP	$0.66	$0.33	$(0.33)
Out of Pocket	$2.06	$2.02	$(0.04)
Uninsured	$1.61	$2.65	$1.04
General Assistance	$0.16	$0.16	$0.00
Community Behavioral Health	$0.92	$0.91	$(0.01)
Incremental Additional Dental	$0.00	$0.72	$0.72
Insurance Premium Tax Revenue Backfill	$0.00	$0.40	$0.40
Provider Efficiency Capture (4% Rate Reduction)	$0.00	$(2.11)	$(2.11)
Total Expenditure	**$55.60**	**$54.63**	**$(0.97)**

2026 UHC Projected Expenditures Comparison



Bottom Line Adjustments

2026 UHC Projected Revenue Comparison

Funding Source Type	Status Quo	UHC	Difference
Employer premium contribution	$12.47	$0.00	($12.47)
Charity	$0.16	$0.00	($0.16)
Employee / Individual	$11.63	$2.10	($9.5)
Federal Title XVIII (Medicare)	$11.78	$11.78	$0.00
Federal Title XIX (Medicaid)	$10.86	$12.86	$2.00
Federal Title XXI (CHIP)	$0.43	$0.43	$0.00
Exchange subsidies/SAMHSA	$0.87	$1.17	$0.30
PEBB/OEBB non-GF revenue	$1.06	$0.10	($0.96)
State funds and household contribution /employer payroll tax	$6.35	$26.29	(New Tax Liability) $19.93
Total Expenditures	**$55.60**	**$54.63**	**($0.98)**

Figures in billions

Small differences between sums and totals or differences are present due to rounding.

5-Year Projection 2026-2030

Aggregate Dynamics Driving Change in Savings Rate Over Time

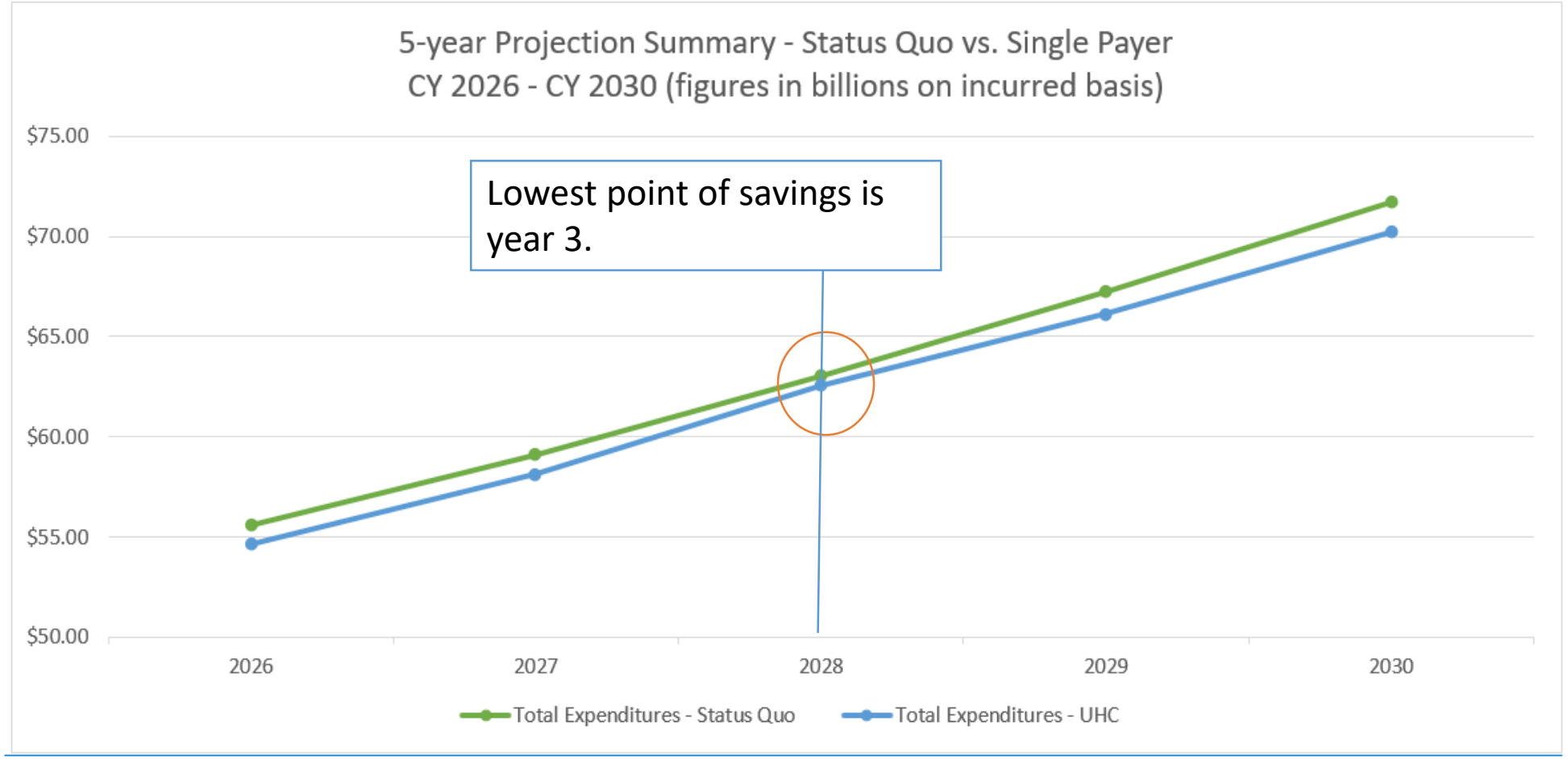
- Three-year ramp-up to fully meeting new utilization demand (upward pressure on costs)
- Three to four years to see notable improved health status contributing to lower costs (downward pressure on costs)
- Administrative competency, infrastructure, and data availability allow for greater savings over time (downward pressure on costs)

Five-year Projection – Status Quo vs. Single Payer

Total Expenditures	2026	2027	2028	2029	2030
Status Quo	$55.60	$59.11	$63.04	$67.24	$71.71
Single Payer	$54.63	$58.13	$62.58	$66.13	$70.18
Difference	$(0.97)	$(0.98)	$(0.46)	$(1.11)	$(1.53)

Figures in billions; minor differences compared to other slides are present due to rounding

5-Year Projection 2026-2030



5-Year Projection 2026-2030 Assumptions

Assumption	2026	2027	2028	2029	2030
Utilization - Removal of Cost Sharing	1.53%	2.15%	3.28%	2.91%	2.73%
Utilization - Fee Schedule Normalization	0.06%	0.07%	0.07%	-0.04%	-0.04%
Utilization - Benefit Change	0.83%	1.07%	1.36%	1.36%	1.37%
Utilization - Coverage Change	1.91%	2.63%	2.56%	2.29%	2.10%
Unit Cost Change - Purchasing Power (Mainly Pharmacy and DME Pricing)	-0.70%	-1.55%	-1.57%	-1.57%	-1.57%
Unit Cost Change - Provider Efficiency Capture	-3.71%	-3.76%	-3.77%	-3.76%	-3.76%
Plan Administrative Efficiency - Fraud, Waste, and Abuse	-0.92%	-1.84%	-2.30%	-2.76%	-3.21%
Plan Administrative Efficiency - Margin Removal	-1.33%	-1.33%	-1.33%	-1.33%	-1.33%
Plan Administrative Efficiency - Economies of Scale	-0.04%	-0.07%	-0.07%	-0.07%	-0.07%
Plan Administrative Efficiency - Removal of Marketing and Commission	-0.12%	-0.11%	-0.10%	-0.10%	-0.09%

Note: some statistics vary by fractions of a percent due to different interaction and compounding effects in the model over time.

Member Summary

Discussion

September 1, 2022

Wrapping Up

Final meetings:

September 15, 1-5 pm

September 29, 1-5 pm

Questions and comments:

JTFUHC@oregonlegislature.gov