Prepared by
Legislative Policy and
Research Office

Joint Task Force on Universal Health Care

Final Report and Recommendations

September 2022

TASK FORCE MEMBERS

Senator James Manning (Senate District 7) (nonvoting member)
Senator Dick Anderson (Senate District 5) (nonvoting member)
Representative Cedric Hayden (House District 7) (nonvoting member)

Lionel "Chad" Chadwick, Rural Health Representative
Glendora Claybrooks, Public Member Representative
Michael Collins, Tribal Representative
Dwight Dill, Social Services Representative
Warren George, Fiscal Management and Change Management Representative
Dr. Bruce Goldberg, Licensed Health Care Professional
Dr. Zeenia Junkeer, Alternative Therapy Services Representative
TK Keen, Administrator, Division of Financial Regulation, Department of Consumer and Business Services (nonvoting member)
Dr. Sharon Meieran, Association of Oregon Counties (nonvoting member)
Dr. Samuel Metz, Medical and Surgical Services Representative
Cherryl Ramirez, Behavioral Health Representative
Leslie Rogers, Services for Persons with Disabilities Representative
Dr. John Santa, Quality Assurance and Healthcare Accountability Representative
Chuck Sheketoff, Public Member Representative
Christy Simila, Nursing Services Representative
Jeremy Vandehey, Oregon Health Authority (nonvoting member)

ABOUT THIS REPORT

This report was prepared by staff at the Oregon Legislative Policy and Research Office (LPRO) and the Oregon Health Authority:

Daniel Dietz
Legislative Analyst

Oliver Droppers
Legislative Analyst

Danielle Ross
Committee Assistant

Nikki Olson
Health Policy Development Manager

Devlin Prince
Policy Analyst

LPRO provides centralized, professional, and nonpartisan research, issue analysis, and committee management services for the Legislative Assembly. The Legislative Policy and Research Office does not provide legal advice. This document contains general information that is current as of the date of publication. Subsequent action by the legislative, executive, or judicial branches may affect accuracy.

LPRO thanks Laurel Swerdlow, Sarah Knipper, and Sarah Bartleman of the Oregon Health Authority, for ongoing support to the Task Force; Christopher Allanach and Kyle Easton with the Oregon Legislative Revenue Office for the revenue expertise; Jared Nason and Shane Mofford with CBIZ Optumas for their professionally-sound actuarial work and financing expertise. LPRO also acknowledges a number of national experts who engaged with the Task Force in its journey: Rebecca Schoon, PhD, Pacific University; Erin C. Fuse Brown, JD, MPH, Georgia State University College of Law William C. Hsiao, PhD, K.T. Li Professor of Economics, Emeritus, in Department of Health Policy and Management and Department of Global Health and Population, at Harvard T.H. Chan School of Public Health; Jodi L. Liu, PhD, MSPH, RAND Corporation; and Elizabeth Y. McCuskey, JD, MPH, University of Massachusetts School of Law. Finally, LPRO also acknowledges the exceptional and extraordinary professionalism provided by Lara Media and Diana Bianco throughout the public engagement effort.

LETTER FROM THE CHAIR AND VICE CHAIR

This page intentionally left blank

TABLE OF CONTENTS

BACKGROUND

For decades, even after passage of the Affordable Care Act (ACA), a number of trends highlight the inherent challenges states face in moving towards a state-based system of universal care for all residents. In Oregon, these trends include:[1]

- Prices for health care services are rising
- Premiums and deductibles are growing faster than household incomes
- Growing burden of health care costs is resulting in Oregonians not seeking or delaying care, and/or being unable to pay their medical bills
- Black people, Indigenous people and other people of color are more likely to be uninsured than their white counterparts
- Among the insured, 50 percent of people with health insurance remain underinsured (i.e., insured but unable to afford cost-sharing including monthly premiums and co-pays)
- Employer-sponsored coverage is increasingly too expensive for businesses, individuals, and families, growing three times faster than personal income
- Individuals and families are increasingly churning on and off public and private health insurance
- Health care financing system is increasingly fragmented, inefficient, and administratively complex

The cost of health care in Oregon is projected to continue growing faster than both the state's economy and Oregonians' wages. When the cost of health care grows faster than the economy and wages, Oregonians are left paying a larger percentage of their income on health care. Rising health care costs also mean less money for investments in wages, retirement, and critical public services.[2] As these trends continue, states are seeking policy proposals, ranging from incremental efforts to address rising health care costs to designing systems that advance universal health care.

Starting in 2020, COVID-19 has impacted Oregonians in multiple ways, including employment, access to insurance coverage and use of health care. The pandemic only exacerbated and magnified the challenges facing Oregonians, including inadequate access to high-quality care, coverage inequity, health disparities, marginal care, disproportionally high rates of disease burden and illness among Black people, Indigenous people, and other people of color, and other structural challenges in our fragmented health care system. The crisis created by COVID-19 also raises questions regarding the role of the public sector in addressing health inequities and ensuring equitable access and culturally appropriate services to communities of color and marginalized communities.

[1] Oregon Health Authority (Aug. 21, 2020). Oregon Health Care Landscape. https://olis.oregonlegislature.gov/liz/2019I1/Downloads/CommitteeMeetingDocument/225798
[2] Oregon Health Authority, Sustainable Health Care Cost Growth Target Recommendations Report (Dec. 2020). https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost%20Growth%20Target%20Committee%20Recommendations%20Report%20DRAFT%2012.22.2020.pdf

The multiple challenges facing Oregon's health care financing and delivery system led legislators to (1) explore whether a universal system of care is feasible, and (2) seek information about projected costs, expenditures, and potential administrative savings from a state-based single-payer system. Most recently, California and Washington established legislative commissions to study designs for universal health care systems. In 2019, the Oregon Legislative Assembly enacted Senate Bill 770 (2019) creating the Joint Task Force on Universal Health Care to "*recommend… a universal health care system, administered by the Health Care for All Oregon Board, that is equitable, affordable and comprehensive, provides high quality health care and is publicly funded and available to every individual residing in Oregon*."

This report is the product of Oregon's Joint Task Force on Universal Health Care ("Task Force") to design a single payer health care financing system.

International Models for Universal Health Care

As directed by SB 770, the Task Force began by conducting a scan of efforts in other states to provide universal health care coverage along with international models for universal coverage and financing. Key insights are summarized below. There is no one model for universal health care programs across nations. Review of international models shows countries have made a range of choices about the key design elements:

- Authority and governance: centralized vs. regional/local authority
- Comprehensiveness of benefits: comprehensive to basic
- Out-of-pocket expenditures as a percentage of total health expenditures
- Role of supplemental or secondary private insurance

While universal programs vary, countries with single payer universal programs tend to utilize a centralized financial and regulatory structure and either eliminate or modify the use of private health insurers. Decisions about covered services, member cost sharing, provider payment rates and administrative costs vary. These variables determine the program cost to the nation.

Federalism and State Single Payer

In the United States, the distribution of authority between the federal government and states constrains the policy options available in a state single payer system. Federal health care programs, including Medicare, Medicaid, and the Affordable Care Act (ACA), would require groundbreaking waivers or changes to law for any state to fully administer federal funds. The Employee Retirement Income Security Act of 1974 (ERISA) preempts state regulation of employer benefits, leaving a narrow pathway for states to integrate employers and employees into a single payer system.

The federal government is the largest funder of health care in the country and sets the rules for the use of its programs and funds. To encourage state innovation, federal law allows states to request waivers of federal requirements, but not everything can be waived. At present, there is no clear way for a state to use Medicare funds in its single-payer program, although some rules may be waived to support reforms, including innovative payment systems and equity-centered accountable care organizations.

ERISA provides a federal regulatory framework for employers to offer health care and retirement benefits to employees. Because it is a federal law that governs benefits across states, regulations of benefits at the state level are preempted by ERISA. Legal scholars including Task Force consultants Elizabeth McCuskey and Erin Fuse Brown have identified strategies for states to avoid ERISA preemption by designing revenue systems that allow employers the option to continue offering benefits. Analysis by McCuskey and Fuse Brown on the ERISA implications of the Task Force's plan design are presented in Appendix A.

The Task Force designed its plan so that it may achieve consistency with the distribution of state and federal health care authorities. This includes a framework that may allow for a novel state-based Medicare Advantage program. It also includes a revenue system in which employers would contribute to the cost of health care for all Oregonians while retaining the flexibility to offer self-funded plans to employees.

State Efforts to Establish Universal Health Care Programs

In each phase of its work, the Task Force considered the efforts and lessons learned in other states to provide universal health care coverage, including attempts to transition to unified financing systems. The Task Force compared analyses of proposals from Vermont (H. 202, 2011), Colorado (Amendment 69, 2016), California (SB 562, 2017) and New York (AB 4738, 2017). The Task Force reflected that all four attempts failed, at least in part, due to insufficient or unpopular financing mechanisms.

More recently, legislatures in Washington and California launched efforts like Oregon's Task Force to study designs for universal health care systems. In 2019, the Washington State Legislature created a work group to provide recommendations on how to create, implement, maintain, and fund a universal health care system.[3] Based on these recommendations, the Washington State Legislature acted in 2021 to establish Washington's Universal Health Care Commission. The Commission's objective is to prepare the state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system. As of August of 2022, the Commission is assessing the readiness of state institutions to transition and has created a finance technical advisory committee to further develop a system of unified financing.[4]

The Healthy California for All Commission, established by the California Legislature in 2019, produced its report on "Key Design Considerations for a Unified Health Care Financing System" in April of 2022.[5] Like Washington, the objective of California's commission is to establish a "unified financing system," terminology that may allow for more nuanced approaches to reimbursement and revenues than a pure single payer approach.[6] As in Washington,

[3] Washington Universal Health Care Work Group, Report to the Legislature (January 15, 2021).
[4] Washington Health Care Authority, Universal Health Care Commission (retrieved September 5, 2022)
[5] Healthy California for All Commission, Key Design Considerations for a Unified Health Care Financing System in California (April 2022). Report was prepared by California Health and Human Services Agency, with consultancy from California University of California, San Francisco, and approved by the Healthy California for All Commission.
[6] *Id. See* discussion at p. 34-37.

commissioners in California determined that significant work would be needed to secure federal waivers and financing.[7]

Brief History of Oregon Universal Care Efforts

Oregon has a history of tackling health care challenges going back over thirty years. While not all health reform work in Oregon has focused on universal coverage, the Oregon legislature has considered measures related to universal health care in the years prior to the passage of Senate Bill 770, which established the Task Force.

1989: Oregon Health Plan Launched. In 1989, Oregon enacted a series of health reforms, including an employer mandate, with the goal of achieving universal coverage in the state.8F8 The mandate was not implemented, but the state did expand its Medicaid program and named it the Oregon Health Plan.[9]

2002: Oregon Comprehensive Health Care Finance Act. The Oregon Comprehensive Health Care Finance Act of 2002 (Ballot Measure 23) was a citizen's initiative petition that would have created a single payer health care system to provide health care to every person in Oregon starting in 2005.[10] The proposal would have merged all existing health care funding streams, including personal and employer taxes, federal health programs, and the state workers' compensation system, into a single financing system. The state health care program would have been administered by a new public non-profit corporation, the Oregon Health Care Finance Board. The new system, financed by a personal income and new payroll tax, would have covered all medically necessary health care costs, with no deductibles or other Community members cost-sharing. Proposed benefits included prescription medications, preventive care, mental health services, long-term care, dental and vision care, as well as alternative therapies. Oregon voters rejected Ballot Measure 23 in a November 2002 vote.

2013-2017: Study of Options for Financing Health Care Delivery in Oregon. House Bill 3260 (2013) identified the characteristics of what the legislature considered the best system for delivering and financing health care in Oregon and required the Oregon Health Authority (OHA) to contract for and oversee a study of the following options for financing health care delivery in the state:

(a) Publicly financed universal health care using a single-payer model
(b) Publicly financed universal health care administered through commercial insurers
(c) Adding a public option plan to the existing options available to consumers

The study was funded in 2015 and OHA selected the RAND Corporation (RAND) and its subcontractor partner Health Management Associates to develop the 2017 report, *A*

[7] *Id.. See* discussion at p. 76-86.
[8] Robert A. Berenson et al, Health Care Stewardship: Oregon Case Study, Urban Institute, January 20, 2016. https://www.urban.org/research/publication/health-care-stewardship-oregon-case-study
[9] Oregon Senate Bill 27 became Oregon Revised Statutes §§ 414.025 - 414.750 (1989) https://www.oregonlegislature.gov/bills_laws/ors/ors414.html
[10] Oregon Legislative Revenue Office, Research Brief: Ballot Measure 23 Health Care Finance Plan. October 2002. https://www.oregonlegislature.gov/lro/Documents/rb11_02ballotmeasure23.pdf

Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon.11F[11] The study found that a health care program covering all state residents could be achieved for less than the cost of the current system. The distribution of costs and how the system changes depend on the model.

2013 – 2021: Healthcare Options Provided Efficiently (HOPE) Amendment. Starting in the 2013 legislative session and again in 2015, 2018 and 2020, Representative Mitch Greenlick sponsored a House Joint Resolution (HJR) to amend the Oregon Constitution and implement universal health care.[12] The "Hope Amendment" proposes adding language to the state constitution directing the state to ensure every resident has access to cost-effective, clinically appropriate, affordable health care. After Representative Greenlick passed away in 2020, the Hope Amendment was brought to the 2021 Legislative Assembly as Senate Joint Resolution 12. The resolution passed and will be sent to the voters to consider during the November 2022 general election.[13]

---

[11] Chapin White, et.al., A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon. 2017. https://www.oregon.gov/OHA/HPA/Documents/Four-Options-Financing-Health-Care-Delivery-Report.pdf
[12] Elizabeth Hayes, Resolution making health care a right in Oregon moves closer to ballot; Portland Business Journal, February 26, 2020. https://www.bizjournals.com/portland/news/2020/02/26/resolution-making-health-care-a-right-in-oregon.html
[13] Elizabeth Hayes, House committee grapples with bill to make health care a right in Oregon, Portland Business Journal, May 7, 2021. https://www.bizjournals.com/portland/news/2021/05/07/health-care-right.html?ana=e_ptl_bn_editorschoice_editorschoice&j=90559561&t=Breaking%20News&mkt_tok=NjczLVVXWS0yMjkAAAF89naoMY3_cqifv4pmff-cn-3ZTJM3vQF1VCCCLdZmBrQFtTYzzPF-LnM3xcK05WOSPHCYId7Oh9dFMKVTOXMHZeb56CZSTR46plru1gTj3GWORhL8

TASK FORCE COMPOSITION AND STRUCTURE

Membership

Task Force members were nominated by the Governor and confirmed by the Senate in February 2020. The Task Force consisted of 14 voting members from a wide range of backgrounds, and seven non-voting members from state and local government. In February 2022, two new members of the task were appointed by the Governor and confirmed by the Senate.

Meetings

On July 22, 2020, the Task Force held its first meeting to introduce members and elect a chair and vice chair. The Task Force met virtually 30 times between July 2020 and September 2022, at least monthly, and occasionally biweekly to fulfill the requirements of SB 770. In addition to the regular meetings of the Task Force, members routinely engaged in advisory and work groups over its two-year period that included:

- Three Technical Advisory Groups (TAGs) – 28 meetings
- Consumer Advisory Committee – 9 meetings
- Intermediate Strategies Work Group – 5 meetings
- Expenditure & Revenue Analysis Work Group – 11 meetings
- Public Engagement community listening sessions and specialty forums – 13 meetings

The level of engagement and commitment to the Task Force is remarkable during its two-year period. In total, active members of the task force contributed over 100 hours in attending regular Task Force meetings. Moreover, if one accounts for the number of advisory and work group meetings supported by the Task Force and its membership, voting members contributed on average 250 hours of unpaid volunteer service. To highlight the level of commitment, members attended weekend and evening meetings held as part of their community engagement efforts.

Impact of COVID-19 Pandemic on the Task Force

The Task Force was to begin meeting in March 2020 but was delayed due to the COVID-19 pandemic. In the August 2020 2nd Special Session, resources for the Task Force's work were reduced, including the three FTE staff originally allocated in 2019 to the Oregon Health Authority (OHA).[14] In 2021, the Task Force recognized the need to continue its work during an "extension" of the timeline into 2022. The Task Force submitted an interim status report on June 29, 2022 (link).

In the 2021 legislative session, Senator Manning introduced Senate Bill 428, which passed, extending the deadline to submit its report to the Legislative Assembly to September 30, 2022. Senate Bill 428 also allocated additional funding to OHA to support staff and professional

[14] 80th Oregon Legislative Assembly, Enrolled Senate Bill 5723, 2020. https://olis.oregonlegislature.gov/liz/2020S2/Measures/Overview/SB5723

services including contracting with CBIZ Optumas for actuarial analysis and Lara Media for public engagement.

To maintain a transparent process and accommodate COVID-19 restrictions on in-person gatherings, the Task Force, TAGs, CAC and work groups exclusively met virtually.[15] Meetings were live streamed via the Oregon Legislative Information System, and recordings were posted online. [26] Meeting links were made available to the public, and every Task Force and TAG meeting included an opportunity for written and oral public comment. Members of the public were additionally encouraged to share public comment in writing.[16]

Senate Bill 770

Senate Bill 770 went into effect on July 23, 2019, establishing the Task Force on Universal Health Care. Section Two of SB 770 lays out the work of the Task Force:

> *"The Task Force on Universal Health Care is established to recommend the design of the Health Care for All Oregon Plan, a universal health care system, administered by the Health Care for All Oregon Board, that is equitable, affordable and comprehensive, provides high quality health care and is publicly funded and available to every individual residing in Oregon."*[17]

The Task Force was charged with making recommendations for a functional single payer health care system that is responsive to the needs and expectations of the residents of this state. This includes the financing of such a system and the structure and governance of the board that would oversee a Universal Health Plan ("Plan").

Values. Section Four of SB 770 directed the Task Force to consider the following values as it developed recommendations for the creation and operation of the Plan:

- Health care should be provided to all using a public means
- Health care must be equitable, which means it must consider each individual's circumstances, identities and the structural and environmental conditions in which they live
- System must be accountable and transparent and include meaningful public participation
- Funding for the Plan is a public trust, with any excess revenue returned to that public trust

Principles. Section Five required the Task Force to consider four principles in the development of its recommendations for a universal health care plan. These principles are:

- *Choice of Provider.* A participant in the Plan may choose any individual provider who is licensed, certified or registered in this state or any group practice.

[15] Technical Advisory Group information, including charters and meeting materials, is available on the OHA website: https://www.oregon.gov/oha/HPA/HP/Pages/Task-Force-Universal-Health-Care.aspx
[16] Task Force Guide (Dec. 2020). Providing Public Comment at the Consumer Advisory Committee or Technical Advisory Groups. https://olis.oregonlegislature.gov/liz/2019I1/Downloads/CommitteeMeetingDocument/227222
[17] 80th Oregon Legislative Assembly, Enrolled Senate Bill 770, 2019. https://olis.leg.state.or.us/liz/2019r1/Downloads/MeasureDocument/SB770/Enrolled

- Provider Participation. Plan may not discriminate against any individual provider who is licensed, certified or registered in this state to provide services covered by the Plan and who is acting within the provider's scope of practice.
- *Medical Necessity is Community members and Provider-driven*. A participant and the participant's provider shall determine, within the scope of services covered within each category of care and within the Plan's parameters for standards of care and requirements for prior authorization, whether a treatment is medically necessary or medically appropriate for that Community members.
- *Continuous and Evidence-Informed Coverage*. Plan should cover services from birth to death, based on evidence-informed decisions as determined by the Health Care for All

Technical Advisory Groups (TAGs) 2020-2021

The Task Force established four Technical Advisory Groups (TAGs) composed of Task Force members, charged with developing proposals for Task Force consideration: Eligibility, Benefits and Affordability (EBA); Provider Reimbursement; Finance and Revenue; and Governance.[18]

Starting in November 2020, the TAGs met to discuss the issues in their respective scopes and develop proposals. Beginning in February 2021, the TAGs presented their proposals to the Task Force, and subsequently convened a final TAG meeting to integrate Task Force feedback; the Task Force then voted on the revised proposals. For each proposal, Task Force members were instructed to vote either "Accept," "Accept with Reservations," or "Do Not Accept." The TAG members, key tasks, meeting topics, proposals and proposal vote counts are available online.[19]

Consumer Advisory Committee (CAC) 2020-2021

The Task Force established a CAC to provide input from a consumer perspective. Based on the representation requirements called out in SB 770 and the Task Force's desire to prioritize diversity in geography, race, ethnicity, gender, sexual identity, sexual orientation and disability status, a Task Force subcommittee reviewed over 100 applications and recommended the participation of a diverse group of 13 individuals, with the approval of the full Task Force.[20]

The CAC began meeting in October 2020 and provided input into the Task Force and TAGs. At each meeting, Task Force and TAG members identified questions for input on from the CAC. Input was used to inform proposals developed by the TAGs. Feedback from the CAC is highlighted in a memo received by the Task Force in May during a joint meeting of the CAC and the Task Force.[21]

Intermediate Strategies Work Group 2021

In January 2021, legislator members of the Task Force asked for the June 2021 interim status report to include a discussion of intermediate strategies that could form a bridge to a single

[18] Technical Advisory Group information, including charters and meeting materials, is available on the OHA website: https://www.oregon.gov/oha/HPA/HP/Pages/Task-Force-Universal-Health-Care.aspx
[19] Ibid.
[20] The CAC also included two Task Force members who served as CAC chair and co-chair and were non-voting members of the CAC. Information on the selection process and membership is available on the Task Force website: https://olis.oregonlegislature.gov/liz/2019I1/Downloads/CommitteeMeetingDocument/226585
[21] Consumer Advisory Committee Memo to the Joint Task Force May 2021). https://olis.oregonlegislature.gov/liz/2019I1/Downloads/CommitteeMeetingDocument/243443

payer system. [35] This led to the formation of the Intermediate Strategies Work Group, which met five times between March and May 2021. The Intermediate Strategies Work Group proposed five concepts: [22]

1. Individual market transformation to reform the ACA individual market with a standardized benefit package, reduced enrollee cost-sharing, and a global budget.
2. Creation of a state-run Medicare Advantage plan wit lower premiums and cost-sharing for members.
3. Limit one coordinated care organization (CCO) per defined region and potentially require CCOs be non-profit entities.
4. Expand value-based payment though community engagement and input to prioritize outcomes and incentives.
5. Employer health cost data collection that requires all businesses that file corporate excise or income tax forms to report total annual health care expenditures and payroll for their employees.

The first two strategies offer a more transformational approach, while the latter three are more administrative in nature. None of the strategies are intended to be a replacement for the SB 770 proposal, and if implemented, would not replace the existing need for a single payer system.

Expenditure & Revenue Analysis Work Group 2022

The Expenditure & Revenue Analysis Work Group ("ERA Work Group") was convened to review technical aspects of revenue and expenditure models, consult with the Legislative Revenue Office (LRO) and the actuarial contractor (Optumas), and guide discussions with the full Task Force. The ERA Work Group consisted of Task Force members. Across eleven meetings, members consulted with financial experts, worked on modelling assumptions, and reviewed estimates.

The ERA Work Group received expertise and analysis from consultants, partners, and guests with relevant knowledge about health care regulation and financing:

- Professors Erin Fuse Brown and Elizabeth McCuskey, experts on the Employee Retirement Income Security Act (ERISA) and its single payer implications,[23] provided their analysis of the Plan Proposal.[24] See Appendix A for ERISA analysis provided by Professors Fuse Brown and McCuskey.

- CBIZ Optumas ("Optumas"), a nationally recognized actuarial firm with expertise in health reform, was retained to analyze status quo health expenditures and revenues in Oregon and to estimate expenditures and revenue needs in a single payer system.[25] See Appendix B for Optumas's full report.

---

[22] Intermediate Strategies Work Group Concept Summaries, June 9, 2021. https://olis.oregonlegislature.gov/liz/2019I1/Downloads/CommitteeMeetingDocument/244574

[23] Erin C. Fuse Brown & Elizabeth Y. McCuskey, Federalism, ERISA, and State Single-Payer Health Care, 168 U. Pa. L. Rev. 389 (2020).

[24] Professors McCuskey and Fuse Brown presented strategies to avoid ERISA preemption (ERA Meeting #6 Recording) along with an analysis of Oregon's Plan Proposal (appendix TK).

[25] Optumas deliverables included an overview of the modelling process (slides), preliminary estimates (slides), case studies (slides), and a final report (appendix TK).

- Oregon Legislative Revenue Office ("LRO"), a non-partisan legislative service agency that provides research and analysis on tax policy for legislators and committees, provided examples of payroll tax and personal income tax concepts for consideration by the ERA Work Group and the Task Force.[26] See Appendix C for LRO's Summary.
- Dr. William Hsiao, who helped design Vermont's single payer system and has counseled other states and countries on their design, provided the ERA Work Group with pathways to potential savings, along with support and review throughout the actuarial process.[27]
- Dr. Jodi Liu, whose scholarship includes micro-simulations of single payer systems in Oregon and New York, provided comments on the economic implications of single payer systems.[28]

The ERA Work Group brought key analysis and recommendations related to financial issues to the full Task Force for consideration.

Senate Bill 428 (2021) Member Feedback and Priorities

With passage of Senate Bill 428 and a one-year extension of the task force, the summer of 2021 served as a mid-point for the Task Force. Project staff held informational conversations with voting members of the Task Force using a set of questions for members. The questions were designed to: solicit members' reflections after a year of work and success: what's worked well, input on areas for improvement, and suggestions for the future; gather members' perspectives on public engagement to inform planning for consumer engagement to take place during part of the extension; and seek feedback on the draft extension plan based on the timeline provided SB 428.

Thirteen of the fourteen voting members were able to participate in the conversations. The information provided offered insight into key policy decisions and design issues that the Task Force needed to address as it developed its proposal for a state-based universal system of coverage granted with the extension provided by SB 428 (2021).[29] Based on the interviews and Task Force discussion, members prioritized the following activities to support it work:

- Prioritize financial analysis, public engagement; and remaining Outstanding Design Elements
- Develop a credible, accurate, and complete financial and revenue analysis that informs who will benefit from the Plan
- Engage BIPOC and rural communities to refine the draft Plan
- Engage conventional critics of Single Payer Systems

These priorities informed the work led by the Task Force between August 2021 through September 2022.

[26] LRO provided a series of informal estimates to assist the Task Force to understand the implications of various revenue proposals. Their final report to the Task Force is included at Appendix TK.
[27] Dr. Hsiao presented analysis of potential savings in a single payer system (ERA Meeting #5 recording).
[28] Dr. Liu discussed economic implications of single payer systems with ERA members (ERA Meeting #11 Recording).
[29] Id.

Throughout the two-year period, members intentionally and proactively sought to create public engagement opportunities to inform its design proposal. The Task Force provided fact sheets, extensive public comment opportunities, held trained facilitated focus groups, and worked directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered. Key for the Task Force was to inform, consult, and involve the public throughout its process to:

- Gather input on the plan design proposal from individuals directly or indirectly affected, to build trust and support
- Provide space for the public to learn, react, ask questions, offer criticisms
- Engage with skeptical members of public
- Directly engage with communities to develop acceptance from the affected public
- Directly engage with industry stakeholders to identify concerns and trade-offs

To foster the level of public engagement prioritized by the Task Force, members directed the Oregon Health Authority to hire professional, trained facilitators to community with communities across the state. Critically, for the Task Force was to uphold its commitment to public engagement, which valued soliciting public input that included community engagement, business engagement, and health care industry engagement.

Public Engagement Ad Hoc Work Group

The Task Force established a Public Engagement work group to draft question topics for the phase one roundtable discussions. Task Force members in this small work group were responsible for reviewing plans for public engagement (including community engagement, health care industry engagement and business engagement), recruiting Community memberss, and supporting content development for engagement sessions. This work group also gave feedback and direction for all continued phase two community-focused public engagement.

The public engagement work group began meeting in August 2021 and held multiple meetings to clarify, discuss, and uplift all public engagement activities. The guidance from this workgroup provided a framework for a third-party facilitator to hold community listening sessions.

Communications Work Ad Hoc Group

The Task Force established a communications work group to create and distribute information to the public relating to the work of the Plan.[30] Based on the values called out in SB 770 and the Task Force's goal of being fully transparent on the components of the system, the work group reviewed decisions made by the full Task Force through July 2022 and created materials to be shared with the public.

- A one-page summary of key messaging points drawn from the Interim Status Report.
- List of Frequently Asked Questions (FAQs)

[30] Joint Task Force on Universal Health Care – 2021-22 Work Groups Oct. 2021, accessible at: https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/250085

- Draft written communication related to public engagement and other key developments.

The workgroup followed principles of simplicity, completeness, credibility, and trust.[31] The communication work group began meeting in November 2021 and, with plain-language consultation, produced a Questions and Answers document (at Appendix G). This document highlighted key elements of the draft plan to be used for public engagement messaging and feedback.

---

[31] Slide 40 of March 10, 2022 Task Force Meeting.
https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/254761

UNIVERSAL HEALTH PLAN – POLICY ANALYSIS

The Task Force developed a blueprint for the system of state-based universal care envisioned in SB 770. The Task Force's Plan Proposal, developed for public engagement, represents the design choices of the Task Force, informed by technical advisory groups and offered in plain language. The accompanying analysis includes rationale, policy considerations, and references to the resources on which the Task Force relied.

The Recommended Plan Proposal includes the following elements:

- Eligibility and Enrollment
- Covered Benefits
- Long-term Supports and Services (LTSS)
- Payment for Health Care
- Medicare
- Health Care Providers
- Provider Reimbursement
- Private Insurance
- Employers and Employees
- Social Determinants of Health (SDOH)
- Nine Federally Recognized Tribes of Oregon
- Governance
- Transition Plan
- Funding
-

Eligibility and Enrollment

Plan Proposal: *All people who live in Oregon will qualify for the Universal Health Plan ("the Plan"). This means all will get the health care they need no matter their job, income, immigration status, or Tribal membership. It will be simple to enroll at health care offices.*

The Task Force designed policies for eligibility and enrollment to be equitable, inclusive, simple and comprehensive.[32] All Oregonians will be eligible for the Plan regardless of whether their employers choose to offer health benefits. Eligibility will not be subject to income or asset limits, though some information may be needed for Oregonians who qualify for federal programs such as Medicare or Medicaid.[33] Immigration status will not be a condition of eligibility. Individual members of the Nine Federally Recognized Tribes of Oregon will have the ability to seek care through the Plan or through the Indian Health Service and Tribal health systems.

[32] For Task Force analysis of eligibility and enrollment, see the Interim Status Report at p. 13-15 and 32-34.
[33] In the Interim Status Report, the Task Force recommended that eligibility be determined without income limits or means-testing, and that once established, eligibility would not be needlessly reconfirmed. The Task Force anticipates that the Plan will include a mechanism to confirm Medicaid and/or Medicare eligibility based on age, disability status, and/or income. This process will be as minimally burdensome as possible.

To eliminate barriers to access, there will be a "no wrong door" policy for individuals seeking care. Any eligible person will be automatically enrolled in the Plan and coverage can be easily confirmed at the point of care. While "opting out" is not be a relevant concept, the Plan will not require that individuals receive health care services if they choose not to.

The Task Force carefully considered options for non-residents of Oregon who work for Oregon-based employers and live near the Oregon border,[34] as well as temporary residents and visitors who need treatment for injury or acute illness while in Oregon. Ultimately, the Task Force determined that the Plan will cover Oregon residents only.[35]

The Plan will seek reimbursement for services received by temporary residents and visitors for injuries or acute illness. The Plan also will cover Oregonians who travel outside the state just as commercial plans cover out-of-state travel in the current system.

Covered Benefits

Plan Proposal: *The Universal Health Plan is based on the benefits public employees get now. The benefits will be more generous than most current plans. The Plan will cover services offered now to people on Medicaid, Medicare, or Affordable Care Act plans.*

The Plan will increase funding for behavioral health services and benefits that exist today. This is because a portion of the money saved will be put towards the behavioral health system.

The benefits covered by the Universal Health Plan will be equitable, comprehensive, inclusive, and will meet the needs of all people of Oregon.[36] While the Task Force considered several options, it found that plans offered by Oregon's Public Employees' Benefit Board (PEBB)[37] cover more benefit categories than the ACA's essential benefits (for example, complementary care, adult dental, adult vision) or the Oregon Health Plan (for example, infertility services). For this reason, the Task Force recommends PEBB plans as the basis for its benefits package.[38]

---

[34] *See* Sheketoff, Chuck, Defining Resident for Universal Health Care, Joint Task Force on Universal Care (July 7, 2022) (proposing that residency be defined consistent with definitions for voting). *See also*, Oregon Department of Transportation, Residency Address Guidance (last retrieved August 20, 2022) (proof of residency may be established by a letter from an Oregon human services agency attesting to residency or a receipt from a motel, hotel, campground, or RV park showing current residency in Oregon).

[35] Joint Task Force on Universal Care, Slide Presentation at slide 59 (July 28, 2022) (inclusion of non-residents who work for Oregon-based employers and live near the Oregon border would cost the Universal Health Plan an additional $1.49B (2026). Employers may continue to administer health insurance benefits for those employees.

[36] For Task Force analysis of covered benefits, see the Interim Status Report at p. 16, 34-36.

[37] See, e.g., Moda Health, Medical plan summaries of benefits and coverage (last retrieved August 24, 2022). See also, Providence Health, Forms and Benefit Information (last retrieved August 24, 2022).

[38] The Plan should ensure that evidence-informed coverage decisions incorporate the members' individual needs and circumstances, while also controlling costs in a finite resource environment. While the Task Force supports limits on certain categories of care strictly based on the clinical literature, members expressed concern that some populations are not always well represented in the medical literature (e.g., gender-affirming care, complementary medicine). Coverage in individual benefit categories should be guided, where possible, by evidence-informed criteria with a commitment to identifying evidence inclusive of diverse populations (see, e.g., USPSTF, HERC, ACIP).

The Plan will also cover, at a minimum, the services available now through Medicaid and Medicare. Specifically, behavioral health benefits will be influenced by the Oregon Health Plan, which is more flexible and has wider coverage of mental health benefits (provider type, place of service, array of services). The Task Force designed the Plan to allow for additional funding for behavioral health.[39]

The Plan will operate with a single drug list, such as Oregon's current Practitioner Managed Preferred Drug List, and will follow evidence-based criteria that is inclusive of diverse populations. The Plan will also work on other purchasing arrangements and strategies to reduce the cost of prescription drugs.[40] For example, some specialty drugs for cancer and other serious conditions may not be covered by the formulary, and the Plan must have a way to allow appropriate access to these drugs.

Long-Term Supports and Services

Plan Proposal: *People who qualify for long-term care will continue to receive benefits and services through Medicaid and the Oregon Department of Human Services (ODHS). The Plan will also cover some skilled nursing and home health care. The Plan's governance board will work with ODHS to study how the Plan might further integrate long-term care in the future.*

The Task Force carefully considered whether and how to include Long-Term Supports and Services (LTSS) within the Plan. To ensure continuity of care for Oregonians who rely on these services, the Task Force recommends that LTSS continue to be administered by ODHS, with individuals having the option to purchase LTSS insurance from private carriers.[41]

Programs such as PACE and Project Independence will continue in their current form. ODHS will continue to license and monitor LTSS facilities, adult foster homes, and service providers. The Plan will work to assure a functional and efficient system of transitions of care from hospitals to less acute settings.

The Plan will partner with ODHS to develop and fund innovative approaches to providing LTSS for those in need of such services. Once established, the Plan's governance board would collaborate with ODHS to study the social, financial, and administrative impacts of including

[39] Joint Task Force on Universal Health Care, Slide Presentation (April 28, 2022) (members assumed that $2.16B (2026) in savings would remain with health systems to allow for increased funding for behavioral health among other priorities. *See also*, Interim Status Report at 16 (in order to fully participate in a global budget and value-based purchasing with risk, behavioral health providers must be able to share in the savings they have generated for the medical part of the health system).
[40] *See* Juliette Cubanski et al, How Will the Prescription Drug Provisions in the Inflation Reduction Act Affect Medicare Beneficiaries? Kaiser Family Foundation (August 18, 2022). During the drafting of this report, Congress passed the Inflation Reduction Act of 2022, which will require the federal government to negotiate prices for some high-cost drugs covered under Medicare. It will also require drug manufacturers to pay rebates if they increase prices faster than inflation for drugs used by Medicare beneficiaries. These policies may have implications for Oregonians eligible for Medicare who would be covered under the Universal Health Plan.
[41] Joint Task Force on Universal Health Care, Outstanding Design Element: Long-Term Supports and Services (January 26, 2022).

within the single payer system the administration of LTSS for people who are eligible for Medicaid and/or Medicare, providing recommendations to the Legislature.

Payment for Health Care

Plan Proposal: *The Universal Health Plan will not require patients to pay when receiving care. There shall be no co-pays or deductibles. Instead, people will pay new taxes based on their ability to pay. Under the Plan, medical debt for covered services will no longer exist. This is because all covered services will be fully paid by the Plan.*

Consistent with SB 770's values of equity and inclusivity, the Task Force designed the Plan so that no payment will be required at the point-of-service.[42] The Task Force's actuarial analysis indicates that removal of cost-sharing will increase utilization, but that it will also improve health outcomes, off-setting some of the cost in increased utilization.[43]

Members considered the use of premiums, both for high-income individuals[44] and as an alternative to the personal income tax.[45] Ultimately, the Task Force decided against the use of premiums, with members noting that revenue should be collected through existing systems (that is, Department of Revenue) to optimize efficiency and reduce Plan administrative costs.

Individuals may wish to keep paying out-of-pocket for their own care, including patients who do not live in Oregon and self-funded plan beneficiaries. To the extent permitted by law, participating providers in the Universal Health Plan would not be allowed to give preferential treatment to private-pay patients, or to charge more for their care.

Medicare

Plan Proposal: *People who qualify for Medicare will be covered by the Universal Health Plan to the extent allowed by federal law. The federal government will need to approve changes to bring Medicare into the Plan as envisioned by the Task Force. Those who qualify for Medicare will have all the benefits currently available in Medicare plus new benefits offered in the Universal Health Plan.*

Integration of Medicare is among the most challenging issues for a state single payer system. Approximately 880,000 Oregonians are currently enrolled in Medicare, including 146,625

[42] For Task Force analysis of cost sharing, see the Interim Status Report at 17.
[43] CBIZ Optumas, Key Assumptions: Utilization, Slide 25 (March 31, 2022).
[44] Interim Status Report at 17.
[45] Expenditure and Revenues Work Group, Slide Presentation, slides 20-26 (April 21, 2022). Members explored the concept of a health care premium in lieu of the personal income tax. For households to contribute by paying a health care premium in place of the personal income tax would be responsive to the public engagement finding that "individuals should pay for health care based on what they earn and what their situation allows." A premium that is based on income relative to the federal poverty limit would align with certain features of the Affordable Care Act.

individuals who are dually eligible for Medicare and Medicaid.[46] Because Medicare is a program of the federal government with specific requirements imposed by Congress, for the Plan to fully include Oregon's Medicare-eligible population, Congress will need to change current federal law, or Oregon will need to secure a novel, unprecedented waiver of federal requirements.

It is unknown if Congress will pass enabling legislation to allow states to directly receive and disburse Medicare funds in the near- or long-term future.[47] If Oregon conditions its Plan on an act of Congress, implementation could be delayed indefinitely. Even if Congress does not act to allow state health plans to administer Medicare benefits, Oregon could explore innovative strategies such as a state-based Medicare Advantage plan or a demonstration that would allow the Plan to include Medicare-eligible Oregonians.

Medicare Advantage (MA)

A state-sponsored MA plan could receive payment from CMS[48] and then provide supplemental benefits to align with the Universal Health Plan. MA plans must be approved by CMS, meaning that CMS must determine that it has authority from Congress to approve a state-sponsored plan that would align with the Universal Health Plan. This would be the first state-sponsored MA plan and would face legal and operational challenges.

It is unclear whether federal statutes allow a state to require enrollment in its MA plan or restrict competing MA plans.[49] Alternatively, the state MA plan could compete with other commercial MA offerings, inducing enrollment with more benefits at lower cost. In this sense, a state-sponsored MA plan may allow the Universal Health Plan to phase-in enrollees without restricting choice.

Federal Waiver of Statutory Medicare Requirements

Waivers of federal Medicare requirements may also allow Oregon to work toward integration of Medicare into the Universal Health Plan. Maryland and Vermont have been able to braid federal Medicare payments with public and private funding; however, their waivers do not alter

[46] KFF, Total Number of Medicare Beneficiaries (retrieved March 1, 2022). CMS, MMCO Statistical & Analytic Reports, (retrieved March 2, 2022).

[47] *See, e.g.,* H.R.1976 - Medicare for All Act of 2021 (Introduced March 17, 2021 and referred to committee). This bill would have established a national health insurance program to be administered by the Department of Health and Human Services (HHS), obviating the need for state health care financing systems.

[48] 42 U.S. Code § 1395w–21(i)(1) (2021).

[49] The laws and regulations governing Medicare Advantage are organized around the concept of choice—for individuals to choose among competing MA plans or traditional Medicare. 42 U.S. Code § 1395w–21. While a state can offer a competing Medicare Advantage plan, the statutes have no mechanism for automatic enrollment in a specific plan, or for other CMS-approved plans to be shut out of the market. Carriers that offer MA plans must be licensed by states, but any further state regulation of MA is expressly preempted. 42 CFR § 422.402. In short, it is unclear how the Medicare Advantage program that Congress envisioned—to create competition and choice—could be leveraged by the state to require participation in state plan and to prohibit competing plans. *But see*, Caroline Brown et al, Legal Memo on Unified Financing of State Health Coverage, Healthy California for All Commission, Final Report, (April 2022) at Appendix C (discussing whether CMMI may waive the statutory provision that Medicare beneficiaries may choose between traditional Medicare and among available Medicare Advantage plans).

coverage or benefits for enrollees, and implementation has had mixed results.[50] An emerging demonstration offered by CMS, the Realizing Equity, Access, and Community Health (REACH) model, encourages states to form accountable care organizations (ACOs) for Medicare that emphasize underserved communities. This concept aligns with Oregon's existing health equity efforts and those described in Task Force findings related to social determinants of health (SDOH). Like other Medicare waivers, the REACH model would not allow Oregon full authority over Medicare funds, nor would it alter coverage or benefits for enrollees.

Table 1. Federal Medicare Waivers

Authority	SEC. 402 OF THE SOCIAL SECURITY ACT (SSA) [42 U.S.C. § 1395b-1]	SEC. 1115A OF THE SSA [42 U.S. Code § 1315a]	SECTION 1332 OF THE AFFORDABLE CARE ACT [42 U.S. Code § 18052]	SECTION 1814(B) OF THE SSA [42 U.S.C. § 1395f]
Description	CMS may approve demonstration projects, including through grants or contracts awarded to public agencies, to experiment with new Medicare payment systems.	Center for Medicare & Medicaid Innovation allows states to test and evaluate systems of all-payer payment reform.	Allows one application for waivers available under SSA and ACA.	Establishes requirements for Medicare payment to hospitals. Exempts Maryland from federal requirements.
Limitations	Does not allow states to alter the choices available to Medicare beneficiaries. No block grant to states. Requires ongoing approval.	Requires innovations to achieve budget neutrality. No block grant to states. Requires ongoing approval.	Does not change or expand authority under Sections 402 to 1115A of SSA.	Applies only to Maryland.

Source: Legislative Policy and Research Office

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

Medicare and Wraparound Services

Finally, if Oregon were unable to obtain federal permissions to integrate Medicare into the Universal Health Plan as envisioned, an alternative is offering wraparound services, such as behavioral health or dental care, to Oregonians who remain in Medicare.[51] Oregonians with Medicare could also be exempt from certain taxes, eligible for tax credits, and/or reimbursed for medical expenses.

[51] If Medicare-eligible Oregonians were not allowed by CMS to be included in the Universal Health Plan, the impact would reduce the need for new revenue by -$1.49B (2026). Optumas Slide Presentation, August 18, 2022. While the cost of providing PEBB-like benefits to Medicare-eligible Oregonians is estimated to be more than $1.49B, excluding Medicare would result in increases to reimbursement rates for remaining populations.

Table 2. Medicare Scenarios

	Act of Congress	MA or Waiver	Wraparound
Approval	Congress	CMS approval	None needed
Federal Funding	CMS could pay state to cover people eligible for Medicare	CMS negotiates to pay state pursuant to rate-setting, ACO, or MA agreement	CMS directly reimburses providers and MA Plans for Parts A & B
State Funding	Additional state funding needed for comprehensive plan	Additional state funding needed for comprehensive plan	State funds any additional services (for example, dental, MH)
Covered Benefits	Full coverage under Single Payer plan	Medicare plus wraparound benefits to align with SP plan	CMS benefit structure; specified state benefits
Participation	Mandatory	Optional	Optional
Enrollment Choice	Could eliminate	Preserves	Preserves
Private Carriers	No longer exist	Likely to allow private MA	Allows private MA
Cost-sharing	TBD	Premiums only	Premiums + co-pay
Provider Reimbursement	Reimbursement set by Single Payer	Rate-setting and global budgets	Outside of Single Payer purview

Source: Legislative Policy and Research Office

Inclusion of Medicare-eligible Oregonians in the Universal Health Plan is contingent on congressional action and/or CMS approval. The Task Force recommends the following approaches, prioritizing those that are the most legally plausible to fully integrate Medicare.

Implementation Guidance

1. *Act of Congress*: Federal action to expand Medicare waiver authority and/or innovation to allow the Single Payer to cover Medicare-eligible Oregonians with corresponding funding from CMS to support comprehensive benefits.
2. *Medicare Advantage*: State-sponsored plan available to Medicare-eligible Oregonians with supplementary benefits mirroring the Single Payer plan.
3. *Waiver*: CMS approval for the state to use demonstrations and other innovations to provide benefits to Medicare-eligible Oregonians through mixed funding streams.
4. *Wraparound Services*: The Plan provides specified services, such as behavioral health or dental care, to Oregonians who remain in Medicare. Oregonians with Medicare may

also be exempt from certain taxes, eligible for tax credits, and/or reimbursed for medical expenses.

Health Care Providers

Plan Proposal: *The Universal Health Plan will work with a wide range of health care professionals. This includes doctors, nurses, allied health providers, behavioral health providers, traditional health workers and other health care professionals. The Plan will prioritize having a more diverse workforce. The workforce is to reflect Oregon's diverse communities and offer culturally appropriate care. Different kinds of providers would be available throughout the state.*

The Universal Health Plan will build on Oregon's current efforts to recruit and retain health care providers.[52] The Plan will prioritize recruitment of a diverse and representative range of providers. The plan will also work to expand networks of different kinds of providers, including behavioral health providers, traditional health workers, and non-physician provider personnel. The Universal Health Plan is to be advised by regional entities on reimbursement rates and approaches to ensure robust networks across the state (see the following "Governance" section for additional details on the role of regional entities).

The Task Force recommends that "participating providers" include any individual, group practice or institutional provider (including hospitals and health systems) that are licensed or authorized to practice in Oregon, in good standing, and that provide services covered by the Plan. Because employers may choose to offer health benefits, participating providers may also serve Oregonians covered by self-funded plans.[53] While the Task Force has recommended that participating providers not be allowed to charge rates more than the rates established by the Universal Health Plan, this policy may need further development to be consistent with ERISA.

Provider Reimbursement

Plan Proposal: *The Plan will pay providers directly. The rates of pay will be set by region to account for different health care needs and costs in parts of the state.*

In the current system, payment rates vary by payer. For instance, payment rates for Medicare are different than those for private insurance or Medicaid. The Plan will reduce this variation in payments. Global budgets, where providers are paid in advance to care for patients, and other alternative payment arrangements will be used to improve outcomes and value over time.

The Universal Health Plan is be designed so that, all together, Oregon's health systems will have more money to provide care to the people of Oregon. Clinicians and health systems can save money because they no longer have to manage so many insurance groups and

[52] Joint Task Force on Universal Health Care, Outstanding Design Element: Provider Participation Conditions & Requirements (December 16, 2021) at Appendix A.
[53] *See* Elizabeth Y. McCuskey & Erin C. Fuse Brown, Memorandum: Analysis of ERISA Preemption Issues for Universal Health Plan Proposal (July 25, 2022).

administrative complexities. That means the money saved could go to rural networks and behavioral health.

The Task Force considered concepts related to provider reimbursement in multiple phases of its work, including the Provider Reimbursement TAG[54] and in the consideration of actuarial estimates by the ERA Work Group.[55] Through these processes, several key principles emerged:

- Health systems must be adequately funded to ensure robust networks of different providers throughout the state. For this reason, the Task Force made conservative assumptions about administrative savings for providers, modelling a system with sufficient funds to ensure robust networks, including behavioral health providers, in both urban and rural settings.[56]
- In the current system, there is wide variation in reimbursement for providers who see more patients with commercial insurance versus Oregon Health Plan coverage. The Task Force envisions a reimbursement model with more pay parity among providers who serve different populations, resulting in more equitable care for patients.
- While pay parity is a priority, the reimbursement model will also account for the differing reimbursement needs of providers in rural and urban settings and in underserved communities.
- To balance these priorities, the Plan entity will set global budgets for each region. Global budgets would be based on enrolled membership and demographics, ensuring adequate funds are allocated for members with complex medical, dental, and behavioral needs.

The Task Force emphasized the importance of maintaining adequate funding within the health care delivery system in every discussion related to provider reimbursement. While other state single payer designs have assumed administrative savings for health care delivery systems of 8–12%,[57] the Task Force opted to assume only 4% savings ($2.23 billion in 2026). If the Universal Health Plan achieves the rate of savings projected by experts, the funding (an additional $2.23–$4.46 billion in 2026) would be available to ensure robust networks throughout the state.

The Task Force highlighted the need to improve pay parity both across and within provider types. This includes increasing parity for primary care, physical health, behavioral health, vision, dental, naturopathic physicians, and traditional health workers, among others. The Plan will need to consider differences in administrative burden among different kinds of providers. The Plan will also increase parity between providers who currently see more patients with commercial insurance compared to the Oregon Health Plan or Medicare coverage.[58]

[54] See Provider Reimbursement Technical Advisory Group, Interim Status Report at Appendix E2.
[55] Optumas, Provider Reimbursement Considerations, ERA Meeting #4 (January 24, 2022).
[56] See, e.g., Task Force Meeting August 18, 2022. For further details, see the Funding section in this report.
[57] Task Force consultants Optumas and Dr. William Hsiao estimated that providers and health systems will save 8-12% of their total expenditures compared to a multi-payer system.
[58] Optumas Final Report at Appendix B.

Reimbursement methods and rates are to be regionally tailored to meet the needs of providers and the populations they serve.[59] Rural and urban providers have different funding needs and will receive reimbursement rates to meet their needs. The Plan would be responsive to medically underserved communities and those with more complex health care needs. These adjustments would be incorporated into the rate setting process with regional input (see the "Governance" section for more details).

While Regional Entities are to advise on the appropriate methods of reimbursement in each region, the Task Force included one exception to this regional variability: the Universal Health Plan entity would not reimburse institutional providers, like hospitals, in a traditional fee-for-service model.

The Task Force determined a need for bidirectional integration of primary care and behavioral health for mild to moderate cases. However, this integration should not unintentionally, redirect reimbursement away from behavioral health providers toward physical health providers. Until behavioral health providers share in the savings they produce that is recouped by the medical system, it is not possible for behavioral health providers to rely solely on a global budget. Furthermore, community behavioral health safety net providers must be adequately funded so they continue to offer critical preventive health services.

The Plan seeks to build on Oregon's experience with advanced forms of value-based payment,[60] but with an expanded notion of "value." The term "value-based payment" is a historically broad term that applies to many different types of payment arrangements, including capitation, global budgets, prospective episode-based payment, and budget-based models.[61] The Plan, in consultation with its regional entities and through continuous public engagement, would expand on the notion of "value-based payment" as historically used to allow for community input and prioritization. The system for determining value will be influenced by patient and community perspectives. For example, regional communities would have influence over what outcomes are most important and thus incentivized in payment arrangements.

Private Insurance

Plan Proposal: *Insurers will conceivably 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. This could include certain prescription drugs or long-term care. State-regulated insurance companies would not be allowed to offer insurance that would take the place of the Plan, to the extent permitted by law. The Universal Health Plan will serve as the*

[59] For the Task Force analysis of provider reimbursement, see p. 17-19 and 37-42 of the Interim Status Report. See also, CBIZ Optumas, Provider Reimbursement Considerations (January 26, 2022).
[60] Oregon Health Authority, Oregon's Roadmap to Value-Based Payment (retrieved September 5, 2022).
[61] See Health Care Learning and Action Network, Alternative Payment Model Framework (2017). Health information technology and information exchange are important to achieving savings and improving outcomes in advanced payment methodologies. Further work would be needed for to develop the Plan's payment systems, including implementation costs and the potential savings and improved outcomes they may achieve. See the Transition Plan section for more details.

main administrator of health care benefits in Oregon. The Plan may contract with third parties, such as private insurance carriers, to help with administration.

The Task Force's design choices related to provider participation and reimbursement result in a reduced role for private insurance as it is currently utilized in Oregon. Even so, implementation of the Plan as currently envisioned may not entirely remove the desire for, and potentially utility of, health-related insurance products that coexist with the Plan.[62]

In single payer systems around the world in which private insurers continue to operate, the forms of coverage they offer may be substitutive, supplementary, or complementary to the universal plan:[63]

- "Substitutive coverage" describes coverage that replaces coverage offered by the public plan, either to individuals who are excluded or opt out of coverage.
- "Supplementary coverage" describes insurance coverage providing faster or improved access to services covered by the plan.
- "Complementary coverage" describes coverage of a gap in the public plan either by covering statutory cost-sharing or services that are not otherwise covered by the plan.

Senate Bill 770 established the fundamental value that access to health care services should be equitable. The Task Force determined that this value requires all eligible individuals to be enrolled in the Plan.[64] The Task Force further concluded that an option to "opt out" of the Plan and to pay for substitutive coverage will undermine the financial sustainability of the Plan. To the extent that regulation of substitutive coverage is within the state's control, the state may seek to restrict such offerings.

Self-funded health insurance coverage offered by employers is protected from state regulation by ERISA.[65] To the extent that employer-sponsored coverage could be similarly comprehensive to that offered by the Plan, and that enrollment in employer-sponsored plans could be preferred by some individuals, these plans are likely beyond the ability of the state to regulate.[66]

The equity value established in Senate Bill 770 also challenges the concept of supplementary coverage. If individuals can purchase enhancements to the Plan's coverage, the result would create different levels of access to quality care based on ability to pay. For this reason, the Task Force recommends, as with substitutive coverage, that state-regulated insurance companies be prohibited from offering supplementary insurance plans to the extent permitted by state and federal law.

---

[62] Joint Task Force on Universal Health Care, Outstanding Design Element: Private Insurance (January 6, 2022).
[63] Liu JL, Brook RH. What is Single-Payer Health Care? A Review of Definitions and Proposals in the U.S. J Gen Intern Med. 2017 Jul;32(7):822-831. doi: 10.1007/s11606-017-4063-5. Epub 2017 May 10. PMID: 28493177; PMCID: PMC5481251.
[64] Interim Status Report at 13-15.
[65] 29 U.S.C. 18.
[66] *See*, Elizabeth Y. McCuskey & Erin C. Fuse Brown, Memorandum: Analysis of ERISA Preemption Issues for Universal Health Plan Proposal (July 25, 2022).

In contrast to substitutive and supplementary coverage, complementary insurance can exist consistent with Plan values and principles. Whereas supplementary coverage has the potential to enhance plan coverage in ways that undermine equity in access and quality, complementary coverage seeks to provide additional protection from financial exposure to health care related expenses that may exist due to gaps in Plan coverage. For example, the Task Force recommends adopting a single state formulary for the Plan's prescription drug benefit, potentially exposing Plan members to the cost of drugs not on the formulary. Complementary coverage could insure against this exposure. Long-Term Services and Supports are another benefit category for which individuals may seek coverage of services that would be complementary to the Plan.

As complementary insurance could coexist with Plan coverage consistent with the values and principles of Senate Bill 770, this coverage may be utilized by employers to continue to offer health care insurance as an employment benefit. Regulation of complementary insurance should remain with the Department of Consumer and Business Services (DCBS) or another agency with applicable regulatory authority. Plans should be offered on a guaranteed issue basis (allowing enrollment regardless of health status, age, gender, or other factors that might predict the use of services) and should be subject to rate review.

If services covered by the Universal Health Plan are provided to members through another form of coverage, including self-funded plans, the Universal Health Plan may seek reimbursement from the other payer when it is deemed financially prudent to do so. The administrative burden of tracking such instances must fall on the Universal Health Plan, not providers. The Universal Health Plan should not seek reimbursement when the administrative burden of doing so exceeds the reimbursement amount.

Employers and Employees

Plan Proposal: *In the current health care system, certain employers must provide insurance to employees or pay a penalty if they do not. The size of the business determines whether they share responsibility for health insurance. For some employees, health insurance is an important part of their compensation. Related, unions often bargain for health insurance.*

The Universal Health Plan will uncouple health insurance from employment. This means that employers will no longer need to provide health benefits. All employers will contribute to the health of all Oregon residents by paying a progressive payroll tax. This will include any employers who choose to fund their own insurance plans to offer to employees.

The Task Force envisions a system in which all people are eligible for insurance whether or not they work for an employer who offers benefits. Consistent with ERISA, employers may choose to provide benefits to employees through health insurance plans that are self-funded (meaning

the employer bears the insurance risk of the plan).[67] In the new system, all employers will be required to financially contribute to the health of Oregonians through the Employer Payroll Tax, even if they choose to offer benefits. The Task Force anticipates that many employers will choose not to offer coverage, instead allowing employees to be covered by the Universal Health Plan.

In engagement opportunities designed for employers to provide feedback about the Universal Health Plan, some employers expressed concern about the potential impact of the Employer Payroll Tax on employers that do not provide insurance to employees in the current system.[68] Task Force members suggested various approaches to this issue, including the possibility of exempting employers below a certain size from the tax, or assessing the tax based on a calculation of revenue generated per employee.[69] The Task Force determined that economic impacts on different kinds of employers need to be studied further (see "Transition Plan" section.

The Task Force considered whether public employers should be subject to a payroll tax, like private employers, or whether state revenues that pay for employee benefits in the current system would be redirected to the Universal Health Plan entity. Public employee benefits are funded from a variety of sources, including local property taxes along with state, federal and other funds. It is not clear how the differing funding streams could be redirected to the Plan on an ongoing basis.[70] For these reasons, in the Task Force's financial analysis, it is assumed that public employers will pay the payroll tax, and general fund revenues that pay for public employee benefits currently will be redirected to the Plan.[71] Local, federal and other fund dollars that pay for employee health benefit are not assumed to be redirected to the Plan, and may represent an opportunity to reduce the Plan's need for additional state revenues.

All Oregonians would be eligible for coverage in the Universal Health Plan whether or not they are offered coverage in an employer's self-funded plan. Employees who are offered coverage in an employer's self-funded plan would have the option to seek care through the Universal Health Plan or the self-funded plan. The Universal Health Plan should have the option to subrogate (meaning to take over administration for) claims paid by self-funded employers to reduce or potentially eliminate administrative burden to patients or providers.[72]

Employees who work for unions are uniquely situated because, in many cases, they have bargained with employers for health care benefits.[73] Some union-represented employees are eligible for health benefits negotiated with multi-state employers ("Taft-Harley" plans) and may need to keep the coverage offered through their employment so they may access care when assigned for work in other states. Further study of this issue is needed to determine policy implications for certain employees who are represented by unions.

---

[67] *See*, Elizabeth Y. McCuskey & Erin C. Fuse Brown, Memorandum: Analysis of ERISA Preemption Issues for Universal Health Plan Proposal (July 25, 2022).
[68] Specialty Forum Summary at Appendix G.
[69] Joint Task Force on Universal Health Care, Slide Presentation, slide 63 (July 28, 2022).
[70] Presentation Slides, ERA Meeting #11 (May 12, 2022).
[71] Optumas, Presentation slides, Joint Task Force on Universal Health Care (May 19, 2022)
[72] *Id.*
[73] Reference to specialty interest forum section (unions)

The Task Force considered whether the Universal Health Plan might take over medical claims related to workers' compensation.[74] The Task Force's actuarial model assumes that workers' compensation would remain separate from the Plan. Integrating coverage of medical claims related to on-the-job injuries may reduce administrative costs. However, including workers' compensation raises several questions, including how to ensure employers will prioritize safety, and how to assign cost for activities that pose a higher risk. The Task Force determined that further study is needed to determine whether to include claims related to workers' compensation in the Universal Health Plan.

Social Determinants of Health (SDOH)

Plan Proposal: *Conditions in people's lives — including housing, education, job opportunities, nutrition and factors such as racism, discrimination and violence — affect health outcomes. These conditions are called social determinants of health (SDOH). The Plan will seek, whenever possible, to address these conditions.*

The Task Force determined that addressing SDOH in the Plan is foundational for improving the health status of individuals, families and communities by addressing racial, ethnic, linguistic, socioeconomic and geographic inequities in health outcomes.[75] The Task Force strongly recommends that in implementing the Plan, the legislature direct the Plan's governance board to:

1. Review and incorporate lessons from SDOH efforts around the state including, but not limited to, the SHARE Initiative[76] and House Bill 3353 (2021).[77]

2. Maximize the current federal flexibilities and allowances that exist to address SDOH in the Medicare and Medicaid programs. Where community-informed opportunities to address SDOH are not eligible for federal financial participation, the board should prioritize seeking federal approval or consider the use of non-federal resources.

3. Prioritize building strong, sustainable, mutually beneficial relationships with existing entities, including public health agencies, social service agencies and community-based organizations that are already addressing SDOH in Oregon's communities. Regional Entities will advise the board on local partnerships that support the needs of their specific communities.

4. Create reimbursement arrangements to support the delivery of health-related and/or non-medical services in ways that both respect and address SDOH.

5. Develop systems to continuously collect and analyze data on SDOH to ensure investments are focused and effective. Data collection should include and prioritize feedback from enrollees of the Plan and communities receiving the SDOH investments.

[74] Joint Task Force on Universal Health Care, Slide Presentation, slide 58 (July 28, 2022).
[75] Joint Task Force on Universal Health Care, Outstanding Design Element: Social Determinants of Health (November 23, 2022).
[76] Oregon Health Authority, SHARE Initiative (last retrieved August 24, 2022)
[77] H.B. 3353 (2021)

6. Prioritize spending a portion of savings identified from the Plan (reductions in administration costs or other health care savings) on services that support SDOH in direct partnership with Regional Entities who can identify community investments that will have both short- and long-term impact on SDOH.

In sum, the Task Force recognizes that addressing SDOH is paramount to a successful universal health care plan and cannot be accomplished through a traditional benefit structure.

Nine Federally Recognized Tribes of Oregon

Plan Proposal: *Tribal members will have the choice to enroll in the Universal Health Plan. Tribal providers can participate in the Plan. The board overseeing the Plan will seek to have a government-to-government relationship with the Tribes. It will not change the services that Indian Health Services or Tribal health systems currently provide.*

Tribal members may continue to seek care through Indian Health Services and Tribal health systems and will also be eligible for care through the Plan. During the transition to a system of universal care, additional discussions with Tribal leaders are needed regarding the health needs of the Tribes and the relationship between the Tribal health system and the Universal Health Plan. Once established, the governance board should maintain a government-to-government relationship with the Tribes.

Governance Board

Plan Proposal: *The Universal Health Plan will be a public program. A board would govern it. That board shall report to the Legislative Assembly and the Governor. Board members are to represent a variety of health care professionals and community voices. Regional groups will advise the Plan to respond to the unique needs of the diverse communities across Oregon.*

The Task Force envisions a governing board that is independent from other state agencies to oversee transition activities and then implement and operate the Universal Health Plan. Initially, the Task Force recommended that the board be established as a public corporation, like the SAIF Corporation or Oregon Health Sciences University. In discussing the details of transition, the Task Force determined, if not a public corporation, the board could also reside administratively within a state agency, such as the Department of Administrative Services.[78]

[78] The Task Force addressed governance of the Universal Health Plan in two separate phases of its work. In the Interim Status Report, the Governance Technical Advisory Group formulated the specific operational functions, authorities, and values of governing board. Then, in its approach to transition planning, the Task Force offered additional guidance for the structure and composition of the board.

Examples of independent health care decision-making bodies in other states include Washington's Universal Health Care Commission,[79] Vermont's Green Mountain Care Board,[80] and the Maryland Health Services Cost Review Commission.[81] Members of the Task Force also cited the example of the SAIF Corporation, whose five-member board directs the public corporation that administers workers' compensation benefits in Oregon.[82]

Key considerations for Oregon's board include its composition, size and the authorities and resources required to complete its priority objectives. The legislature will also need to determine how the board will be appointed and confirmed.

Board Composition, Size and Appointment

The Task Force envisions a board with a balance of expertise and perspectives. The board should have nine members, including five members with technical expertise in health care delivery, finance, and operations, and four members focused on public engagement. Among members, the board will to include perspectives of people who have experience as patients with the Oregon Health Plan and Medicare, as well as experience being uninsured. Members should also have experience working with the health care needs of people of different ages and people with behavioral health needs.

Comparable decision-making bodies in other states have wide ranges of size, expertise, and experience. Vermont and Maryland provide examples of professional, working boards of five to seven members with authority to make key policy decisions. Boards in Vermont and Maryland, consisting health care administrators, providers, and scholars, are smaller than groups in Washington and Oregon that engaged in universal health care design (15 and 13 members, respectively). While smaller boards may move nimbly through complex health policy issues, such as securing waivers and setting provider reimbursement rates, larger board allows for broader representation and more perspectives. Table 3 provides additional details (see next page).

[79] Wa. Senate Bill 5399 (2021) (establishing Washington's Universal Health Care Commission to develop "implementable changes to the state's health care financing and delivery system." *See also*, Universal Health Care Commission, Commission Members, Washington State Health Care Authority (retrieved July 15 (2022). Commission includes six governor appointees, four legislators, and five executive branch seats.
[80] Green Mountain Care Board, State of Vermont (retrieved July 15. 2022). The five-member board was established in 2011 as Vermont moved toward establishing a state single payer system. The board now oversees policies including Vermont's all-payer Medicare waiver and accountable care organizations.
[81] Health Services Cost Review Commission, State of Maryland (retrieved July 21, 2022). Maryland's seven-member board sets rates for Maryland's all-payer system that was created by federal statute and ongoing waivers from the Centers for Medicare and Medicaid Services (CMS).
[82] SAIF Corporation, Board of Directors (Retrieved July 15, 2022).

Table 3. Examples of Health Policy Boards and Commissions

Board	Task Force Proposal (OR)	Universal H.C. Commission (WA)	Green Mountain Care Board (VT)	Cost Review Commission (MD)
Composition	Mix of technical expertise and lived experience	Legislators, agency officials, hospital and insurance executives	Former medical executives, scholars and attorneys	Providers, administrators, scholars
Size	Nine members	Fifteen members	Five members	Seven members
Authorities and objectives	Transition and implementation of Universal Health Plan	Transition planning for Universal Care	Established during single payer effort; now oversees waivers, policies	Oversees Maryland's all-payer system with CMS waivers
How appointed	Gov. appointees	Legislators, Gov. appointees, agency officials	Nominating committee, Gov. appointment	Gov. appointees

Source: Legislative Policy and Research Office

Oregon's board will be unique in its inclusion of members with lived experienced within health care programs from the patient perspective. The Task Force anticipates the number of board members may change as it moves from transition activities to oversight of operations. A larger board will allow for more representation of Oregon's geographic and cultural diversity. Another policy consideration to support the vision of a diverse and representative board is the creation of a nominating committee that selects candidates pursuant to statutory criteria prior to appointment by the Governor.[83] Once appointed, members would be subject to state ethics and transparency standards.

The legislature would need to determine the resources needed for the board to meet its objectives. The Task Force anticipates that the transition effort will be a full-time commitment for board members, who would be compensated.[84] The board would likely seek expertise from contractors in technical areas, such as waiver applications, taxation and revenue, legal counsel, and additional economic analysis.[85] The board will require the support of staff for research and policy analysis, coordination with agencies and other entities,[86] administrative support for board and committee meetings, coordination with contractors, and other activities.[87]

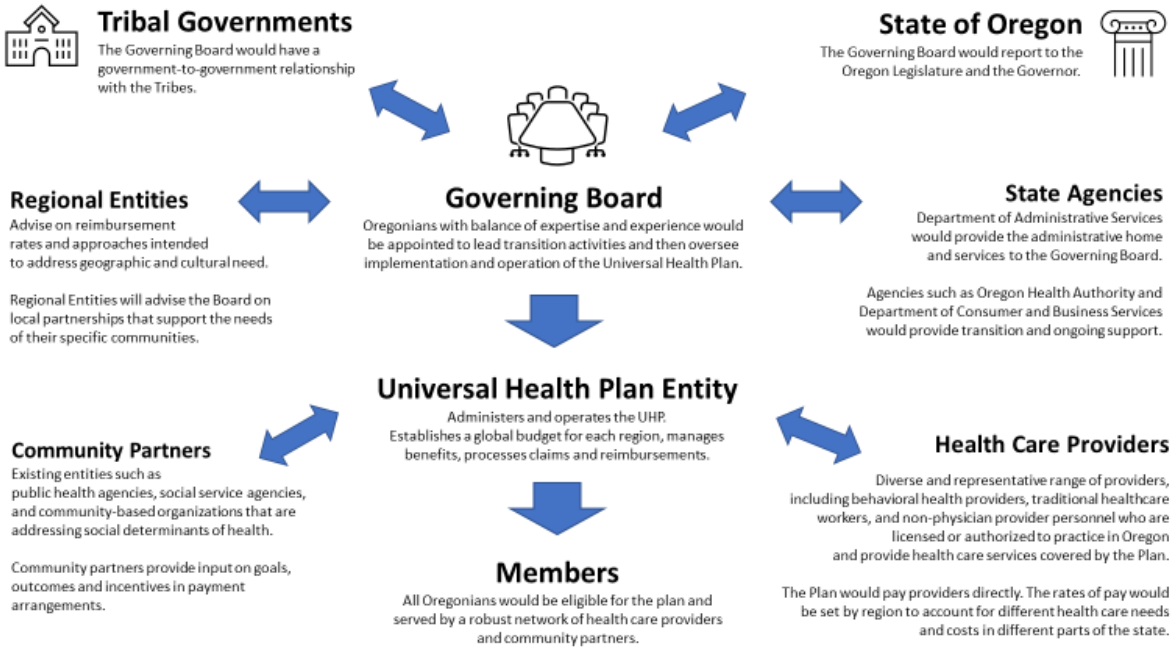
[83] 18 V.S.A. § 9390. Nominating Committee consists of nine members, including legislators and Governor appointees.
[84] *Id. See also*, 18 V.S.A. § 9372 (providing for members of Vermont's Green Mountain Care Board to be compensated at the rate of state court judges).
[85] *See, e.g.*, Arjun, Liz et al, Washington Universal Health Care Commission Report to the Legislature, Health Management Associates, slides 31-109 (June 16, 2022).
[86] E.g., Oregon Health Policy Board, Cost Growth Target Advisory Committee, and Prescription Drug Advisory Board.
[87] See, e.g., Green Mountain Care Board, Staff Directory (retrieved July 21, 2021) (including executive assistants, legal counsel, and policy and data analysts, etc.)

Board Authorities and Relationships

Oregon's board should be established with the authority to complete the priority objectives of its transition plan (see "Transition Plan" section for details). Specifically, the governance board will need the authorities currently designated to the Oregon Health Authority to secure necessary waivers from CMS and to administer federally funded health programs. If the board is established as an independent public corporation or as an entity within the Department of Administrative Services, it will need the Oregon Health Authority to secure any necessary waivers to implement and operate the Plan. The legislature may need to transfer OHA's authorities to the board, making it Oregon's designated health agency for the purposes of working with CMS to administer federal health care funds. The legislature will need to establish the legal and regulatory framework for the Universal Health Plan entity, under the oversight of the board, to administer benefits, processes claims, and critically, to build reserves.

In creating the board, the Task Force recommends that the legislature establish a public trust fund, separate and distinct from Oregon's General Fund, which would combine state, federal and other funds necessary to operate the Plan. This would include but is not limited to federal funds from Title XIX (Medicaid) and XXI (CHIP) of the Social Security Act along with revenues dedicated or appropriated by the legislature for carrying out the provisions of the Plan. Revenues from the Plan's proposed personal income tax and employer payroll tax are likely subject to the "kicker" provision in Oregon's constitution. It will be difficult for the Plan to accumulate the reserves needed to withstand variances in expenditures and revenues. Oregon would possibly require amending its constitution to allow the accumulation of the reserves needed to operate the plan.

Table 4. Governing Board Structure and Relationships.



Source: Legislative Policy and Research Office

The board will work collaboratively with partners across the health care system, including hospitals, providers, insurers and coordinated care organizations, to unwind the existing health care financing system and prepare to implement the Universal Health Plan. The board will also work closely with agencies (Oregon Health Authority, Department of Human Services, Department of Business and Consumer Services, Department of Revenue) that have the technical capacity and authority to implement the Plan and support its ongoing operations. The legislature may direct the agencies to support the work of the board.[88]

The Task Force recommends that the board operate in partnership with a network of regional entities. These entities are responsible for convening and collaborating with stakeholders in each region, ensuring that the Universal Health Plan is responsive to the unique needs of the wide array of communities across the state. The regional entities will advise with relation to coordination and delivery of care in each region, which may include advising on budgets, reimbursement methods, and capital spending for providers in the region.[89]

[88] See, e.g., SB 770, as introduced, at Section 23. "All agencies of state government, as defined in ORS 174.111, are directed to assist the commission in the performance of its duties and, to the extent permitted by laws relating to confidentiality, to furnish such information and advice as the members of the commission consider necessary to perform their duties."
[89] Interim Status Report at Appendix E3 Governance Technical Advisory Group.

Transition Plan

Plan Proposal: *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.*

Senate Bill 770 requires the Task Force to develop recommendations to the Oregon Legislature with timelines and actions needed to establish a system of universal care, including:

- Succinct statements about actions needed to establish the Universal Health Plan,
- Priority objectives to complete the transition to the Universal Health Plan, and
- A timeline for actions and recommendations to the Oregon Legislature.

Significant work remains to transition to a system of universal health care. Oregon needs to secure groundbreaking waivers and approvals to administer federal health care programs, including Medicare. The state also needs to build a governing board and entity capable of administering health care benefits for all Oregon residents. The state's workforce will need to adjust to changes to the private insurance sector along with increased demand for health care. Critically, Oregon would need to develop specific, detailed strategies to raise necessary revenues and to maintain reserves, which will likely require an amendment to the Oregon Constitution.

To accomplish these and other tasks, the Task Force recommends that Oregon's 2023 Legislature establish a governing board to work on priority objectives including federal waivers and authorities, agency integration, funding and workforce readiness. The board should report back to the legislature in advance of the 2025 session with recommendations for legislation to implement the Universal Health Plan.

Once established, the board will work to address the following priority objectives:

> **Waivers and approvals**: An early objective of the board would be to engage with federal authorities to seek necessary approvals to implement the Plan. The board should need to start immediately and work closely with the Oregon Health Authority and the Governor's Office to secure approvals from CMS for federal funding.
>
> **Agency integration**: Once established, the board will need to assess the readiness of key institutions and develop a detailed plan of action in collaboration with partner agencies.[90] As above, the board shall work closely with the Oregon Health Authority to secure necessary federal waivers and approvals. Other state agencies, including the Department of Consumer and Business Services and the Department of Human

[90] Wa. Senate Bill 5399. See also, Arjun *et al*, *supra* note 9. Since it was established in Washington's 2021 legislative session, the Washington Universal Health Care Commission has worked with its consultant, Health Management Associates, to study the readiness of Washington's agencies and health care institutions to transition to a system of universal care.

Services, will need to determine if and how their existing systems for health insurance, Medicaid and care delivery will integrate with the Universal Health Plan.

The board must work with agencies to identify existing statutory authorities along with IT infrastructure for quality reporting, data analytics, claims processing, eligibility, and enrollment programs. The board will evaluate how to work with existing boards, commissions and councils with functions related to health care and insurance.

Workforce: The Universal Health Plan is designed to change how health care is financed and delivered. This may result in changes to Oregon's health care workforce. On the administrative side, private insurance companies will continue to exist but may play a more limited role. Professionals who currently work in claims processing and benefit administration for private insurers and provider offices will require training and support before and during the transition.[91] The Universal Health Plan entity will need to recruit, hire, and train a robust staff to administer benefits for everyone in the state.

On the provider side, the Universal Health Plan would need to maintain a robust network of practitioners across the state. Given workforce challenges in Oregon's current system,[92] the board, in consultation with regional entities, will need to offer competitive rates of reimbursement, pursue innovative strategies such as rural residency programs, and build upon existing incentives for providers, such as loan repayment and tax credits for rural providers.[93]

Funding: While the Task Force and its actuary studied the prospective expenditures associated with a single payer health care system, a full analysis of the economic impacts of the proposed policy is needed.[94] In addition to the workforce implications above, the board should study and address impacts specific to employers of different sizes, employees of Oregon-based companies who reside in border states, and employees covered by Taft-Hartley plans.

The board would need to detail the Universal Health Plan's administrative structure (payment, quality, reporting, transparency, program integrity, etc.) to develop a precise accounting of the resources needed for the entity that would implement and operate the plan.[95] Sufficient funding (and a specific timeline) would be needed to wind down the existing system, implement the new administrative structure, and begin paying benefits.

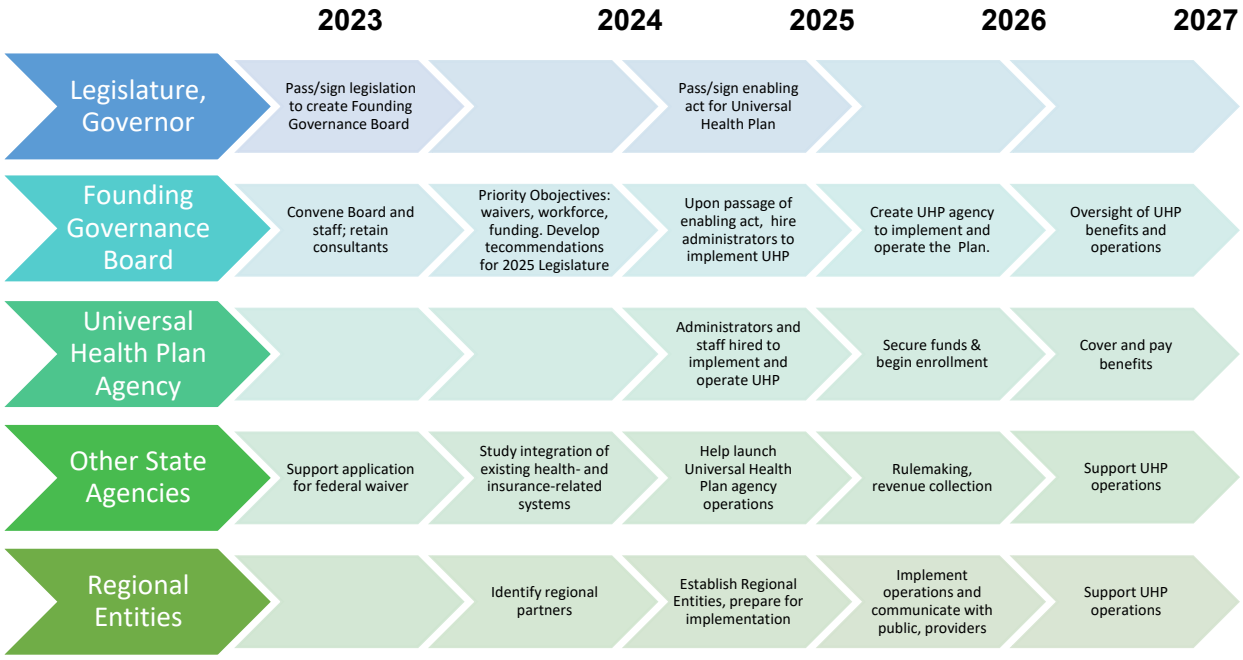
A critical component of the transition is to secure federal funding sources (Medicare, Medicaid, ACA funds) and state revenues (payroll tax, personal income tax) sufficient to build reserves and process claims.

---

[91] White, Chapin, et al, A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon, RAND Corporation (2017) (estimating that a single payer health care system in Oregon would reduce insurance-related jobs by 2,700 but would increase overall jobs by 5,800.)
[92] Oregon Health Authority, Oregon's Health Care Workforce (February 2021).
[93] *See* Office of Rural Health, OHSU (retrieved July 20, 2022).
[94] *See, e.g.,* White, et al, finding that the overall macroeconomic impact of a single payer system would increase overall employment in the state by 0.1%).
[95] CBIZ Optumas, Single Payer Operations/Administration, ERA Work Group (February 18, 2022).

The board should establish an advisory committee of health care delivery partners to develop plans to unwind the existing health care financing system and prepare to implement the Universal Health Plan.[96] Throughout the transition and implementation phases, the board must work with providers to and health systems to monitor quality and costs.

Table 5. Implementation Timeline



Source: Legislative Policy and Research Office

In advance of the 2025 legislative session, the board would recommend enabling legislation for the Plan, including authority and funding for its operations. The board will then oversee the creation of the entity that would implement and operate the Plan.

Funding

Plan Element Summary: *In the current system, individuals, employers, and the state and federal government all pay for health care. In the new model, a single fund will combine federal and state revenue to pay for health care.*

In the Universal Health Plan, all employers are to contribute to the health of people in Oregon by paying a tax. The tax rate will be based on employee wages and is progressive. The higher the employees' wages, the higher the tax rate the employer will pay. Employers will no longer need to provide health benefits. But they will have the option to offer self-funded plans. A self-funded plan means the employer carries the risk of the insurance plan.

[96] John Santa, Task Force Recommendation for Governance (September 1, 2022).

Instead of premiums, co-pays and deductibles, higher-income people will pay income taxes. Households with income below 200% of the Federal Poverty Level (FPL) will not pay income tax for health care expenses. Households with income above 200% FPL will contribute based on ability to pay, and in the aggregate, may pay less than they do now for out-of-pocket-expenses.

The Task Force commissioned an actuarial firm to study Oregon's current health care expenditures and then project the costs and revenues needed for a single payer system in 2026 dollars.[97] It is estimated that a single payer system will cost $980 million less in 2026 than Oregon's current system. Employers and individuals will pay less — in the aggregate — than they pay for health care in the current system. The way that people pay for health care will be different, with new taxes replacing cost sharing (premiums, deductibles, co-pays). Additional work is needed to study the feasibility of securing the revenues needed to fund a single payer system, along with the overall economic impact of the Task Force proposal.

Universal Health Plan Expenditures

To meet objectives of SB 770, the Task Force designed a health care financing system—with one payer and one plan—for all Oregonians. The Task Force designed the Universal Health Plan to provide better care to more people at a lower total cost. Based on legislative timelines and the planning needed to transition to the new system, the Task Force studied estimated costs (expenditures) in 2026 dollars. The study shows a potential savings of $980 million in the first year of the Plan.

Table 6. Current System and Universal Health Plan Costs (2026)

Program	Expenditure
Current system	$56.60 billion
Universal Health Plan	$54.63 billion
Projected savings	$980 million

Data: Optumas Final Report at Appendix B
Source: Legislative Policy and Research Office

Despite providing more benefits to more people, in 2026, the Universal Health Plan is estimated to cost less than the current system. The Plan's estimated total savings is based on a new system where utilization will increased when people can access care without cost-sharing,[98] providing the more comprehensive benefits package offered by PEBB to all Oregonians,[99] and covering those people who, in the current system, are uninsured.[100] These additional costs, however, are offset by administrative savings, removal of certain profits from the insurance system, and decreased costs from reducing fraud, waste and abuse that occurs in the current system.

[97] See Optumas Final Report at Appendix B.
[98] Optumas, Slide Presentation to Task Force, slide 22 (March 31, 2022).
[99] Optumas, Slide Presentation to Task Force, slide 24 (March 31, 2022).
[100] Optumas, Slide Presentation to Task Force, slide 25 (March 31, 2022).

Table 7. Change to Costs in a Universal System

Universal Health Plan	Cost Factors
Increased utilization	↑ Increase in Cost
Upgrade to PEBB benefits	↑ Increase in Cost
Covering the uninsured	↑ Increase in Cost
Improved purchasing power	↓ Decrease in Cost
Administrative savings	↓ Decrease in Cost
Decreased fraud, waste and abuse	↓ Decrease in Cost
Removal of insurer profits	↓ Decrease in Cost
Aggregate savings	**$980 million**

Data: Optumas Report at Appendix B.
Source: Legislative Policy and Research Office

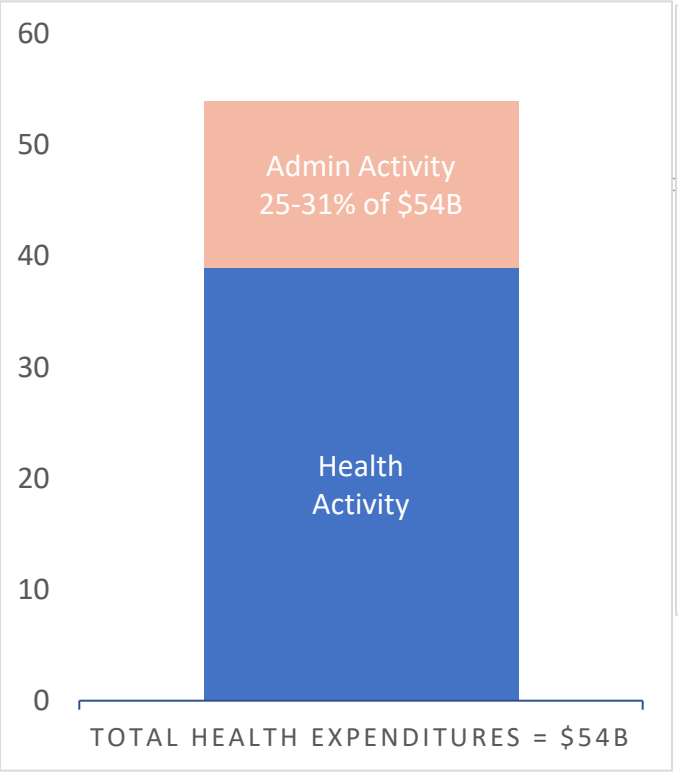
The potential for administrative savings is a key reason why a single payer system may be able to offer better care to more people at a lower cost. It is helpful to think about savings in a single payer system in two ways:

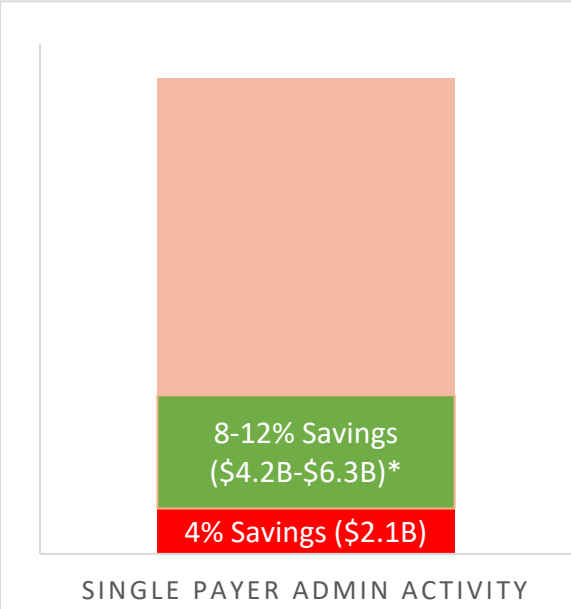
1. **Payer savings**. Payer savings result when the various plans and payers in the current system are replaced by a single plan administered by one entity, in this case the board.[101] and are projected to increase as the single payer entity gains efficiency with time.[102] Some Task Force members noted that the single payer entity should be able to achieve additional savings.[103] For example, additional savings may be achieved by spending less to process claims depending on the structure of provider reimbursement systems.

2. **Health system savings**: Health system savings can be achieved when the health care delivery system (providers, hospitals, labs, pharmacies, etc.,) no longer interfaces with multiple plans and payers. As a result of reducing the administrative cost of billing and insurance-related activities within the health care system, Optumas estimates savings of $2.10 billion in 2026. Table 8 illustrates the percentage of total health care systems dedicated to administrative activities — along with the potential for greater administrative savings in a single payer system.

[101] Joint Task Force on Universal Health Care, Slide Presentation, slide 29 (April 28, 2022).
[102] Optumas Final Report at Appendix B.
[103] The percentage of total health expenditures spent on payer-side administrative activities is estimated to be approximately 6%, compared to an estimate of 9.1% in the status quo. Some Task Force members felt that, based on Medicare and other countries, the single payer entity could achieve a percentage of 4% or lower.

Table 8. Health System Savings





*Task Force consultants Optumas and Dr. William Hsiao estimated that health systems save 8-12% of their overall costs in a single payer system.

Data: Optumas Report at Appendix B.
Source: Legislative Policy and Research Office

The savings that can be achieved within health systems are important to the goals of Senate Bill 770. It is estimated that 25-31% of all health system expenditures are administrative activities.[104] The majority of those costs are related to billing and insurance. Task Force consultants Optumas and Dr. William Hsiao estimated that providers and health systems will save 8-12% of their total expenditures compared to a multi-payer system.[105] The Task Force opted to use the more conservative rate of 4% ($2.1 billion in 2026), leaving additional savings within health systems for behavioral health and to ensure robust provider networks.[106]

Revenues

While the Universal Health Plan will cost less in the aggregate than the current system, the way that health care is funded will change significantly. In the new model, a single fund will combine federal and state revenues, including new payroll and income taxes, to pay for health care for all Oregonians.

[104] Richman et al, "Billing And Insurance–Related Administrative Costs: A Cross-National Analysis," HEALTH AFFAIRS 41, NO. 8 (2022): 1098–1106.
[105] Expenditure and Revenue Work Group, Presentation Slides, (January 24, 2022).
[106] Joint Task Force on Universal Care, Presentation Slides (August 18, 2022). As an alternative, if the Task Force opted to approve a provider side estimate of 10%, as suggested by Dr. Hsiao, savings in this alternative assumption could be used to reduce the personal income tax to approximately 5%.

This single fund will include funds that currently pay for care for people who are eligible for Medicare, Medicaid, Children's Health Insurance Program and other federal programs. Federal waivers and approvals are necessary to secure these funds. It is estimated that federal contributions to Oregonians' health care will increase because the federal government would match increases to provider reimbursement rates, including for Oregonians eligible for Medicaid, up to the Medicare Upper Payment Limit.[107]

Additionally, the Plan assumes individuals eligible for Medicare will continue to pay their Part B and Part D premiums.[108] Further work is needed to determine how premiums would be collected and applied by the Plan toward the cost of care. The Task Force received comments in its public engagement process about the need to balance the obligation of Medicare-eligible Oregonians to pay premiums along with new taxes.

Table 9. Universal Health Plan Revenues

Revenue Source	2026 $
Medicaid	$12.9 billion
Medicare	$12.5 billion
Other Federal	$ 3.7 billion
Employer Payroll Tax	$12.3 billion
Health Care Income Tax	$ 7.6 billion
Other/State	$ 6.6 billion
Total	$55.6 billion

Data: Optumas Report at Appendix B.
Source: Legislative Policy and Research Office

Table 9 shows the combined sources of funding for the Universal Health Plan. Funding would include state revenues that in the current system pay for state health programs, like community behavioral health. Finally, funding will need to include new sources of revenue to pay for the Universal Health Plan, including contributions from employers and individuals.

In the Universal Health Plan, all employers will contribute to the heath of people in Oregon by paying a tax. The tax rate should be based on employee wages and be progressive in its structure: the higher the employees' wages, the higher the tax rate the employer would pay.

[107] Optumas, Presentation to the Task Force, September 1, 2022.
[108] Optumas, Presentation to the Task Force, August 18, 2022.

Table 10. Employer Payroll Tax

Employee Wage	Tax Rate
Wages below $160,000	7.25%
Wages above $160,000	10.50%

The Legislative Revenue Office estimated example Employer Payroll Tax rates that would result in a total contribution from employers in 2026 of $12.3 billion, representing a decrease of approximately $170 million from what employers would pay in employee premiums in the current system ($12.47 billion in 2026). Table 10 shows example rates to meet this total.

Instead of paying premiums, co-pays and deductibles, individuals in Oregon would contribute to the Universal Health Plan through a tax on income. Unlike Oregon's existing state income tax, the health care income tax would be based on household income relative to the Federal Poverty Level (FPL). Households with income below 200% FPL would not pay income tax for health care expenses. In 2022, a family of four that earns $55,500 would be at 200% of the FPL.[109] For households with income above 200% FPL, instead of premiums, co-pays and deductibles, people would pay more income taxes.

Table 11. Health Care Income Tax

Health Care Income Tax	Tax Rate
Below 200% FPL	**0%**
200 – 250% FPL	**1.00%**
250 – 300% FPL	**1.75%**
300 – 400% FPL	**2.50%**
Above 400% FPL	**8.20%**

Source: Legislative Policy and Research Office

The Legislative Revenue Office estimates that the total payment from households in 2026 would be $9.7 billion. This includes approximately $7.6 billion from the new health care income tax along with $2.1 billion in Medicare premiums. This would be a decrease from what households would pay in premiums, deductibles, and co-pays in the current system ($12.63 billion in 2026). Table 11 shows example rates to meet this total

Table 12 shows how, in the aggregate, households and employers will contribute less to the cost of health care than in the current system, while the contribution from the federal government will be greater.

[109] Additional examples of household contributions were presented by Optumas to the ERA Work Group at ERA Meeting #11 (May 13, 2022).

Table 12. Current System versus Universal Health Plan Revenues

Revenue	Households	Employer	Fed./Other	Totals
Current System	$12.63 billion	$12.47 billion	$31.33 billion	$58.12 billion
Universal Health Plan	$9.7 billion	$12.3 billion	$33.68 billion	$57.13 billion
Projected Savings	$1.65 billion	$1.69 billion	($2.35) billion	$980 million

Data: Optumas Report at Appendix B.

Funding: Next Steps

Before Oregon would be ready operate a single payer plan, significant work remains to study and secure the funding that would be needed, including:

- **Securing federal funds.** The Task Force's proposal depends on Oregon securing novel permission to receive and spend federal health care funds. Beyond the waivers or approvals necessary to administer funds for Medicaid- and Medicare-eligible Oregonians, the federal government would need to provide increased funding to match Oregon's provider reimbursement rates.[110] Oregon will need to engage with the Centers for Medicare and Medicaid Services (CMS) to determine whether, how, and when federal funds may be available to Oregon's single payer health care system.
- **Start-up costs**. Although the expenditure estimates include the Plan's operating budget, they do not account for resources that would be needed to implement the Plan's administrative structure systems for payment, quality, reporting, transparency, program integrity, etc.
- **Tax rates**. The Task Force considered various pathways to generating the revenue that would be needed to replace traditional contributions to health care expenditures from individuals and employers. While the example rates for payroll and personal income taxes would produce the revenue needed, the Task Force determined that further analysis of rates and impacts on individuals and employers is needed.[111]
- **Reserves**. The single payer system will need to build and maintain reserves sufficient to withstand variance in expenditures and revenue streams. Because of Oregon's tax kicker, it may be necessary to amend the Oregon Constitution for the Universal Health Plan to build reserves sufficient to withstand revenue shortfalls.
- **Micro- and macroeconomic analysis.** Further study is needed to understand the economic impacts of transitioning to a single payer system of health care at the level of individuals, firms, sectors and the overall economy. One way to study these impacts would be through microsimulation.[112] Another important analysis would be a dynamic modelling of the impact of the new taxes on Oregon's economy.

[110] Task Force meeting Sept 1, 2022.
[111] Task Force meeting July 28, 2022.
[112] Jodi Liu, discussion, ERA Work Group Meeting #11 (May 13, 2022). Making insurance available to all Oregonians without regard to employment status may have additional effects on employers and employees. Analysis of other single payer designs has shown net increases in employment. Further analysis is needed to understand how improved access to health care would affect Oregon's workforce.

PUBLIC ENGAGEMENT

Senate Bill 770 expressly directed the Task Force to engage in a robust public process to solicit input from people throughout Oregon. The process was intentionally designed to ensure engagement statewide and input from individuals in rural and underserved communities.[113] The Task Force solicited the perspectives of representatives from specialty interest areas: health care industry, small and large employers, and unions.[114] The Task Force held public engagement meetings from February through July of 2022 in which they reviewed the Plan proposal as it was developed, inviting input from the public and fielding questions on the Plan.

The public engagement process occurred in two phases:

> **Phase One** focused on priority populations in Oregon as identified by the Task Force in consultation with the language of SB 770, including but not limited to, Black & African-American people, people with disabilities or Long-term care needs, and Native American people.[115]
> **Phase Two** included two distinct efforts - one focused on community listening sessions with the general public across regions of Oregon, and the other on the specialty interest forums.

Facilitation of all sessions was completed through third party organizations with direct expertise in working with public and industry engagement. Lara Media Services assisted with Phase One roundtables and the regional community listening sessions; Diana Bianco, with Artemis Consulting, assisted with Phase Two specialty interest forums.

Phase One
The Task Force planned seven demographically-specific roundtable discussions to solicit feedback on the draft June 2022 Plan Proposal. The Task Force's goal was to hear from historically underserved communities, including Black, indigenous, people of color, rural, people with disabilities, and mental health issues. They wanted to hear and understand their views, opinions, hopes, and challenges related to meeting their health care needs.

There was one roundtable discussion for the following communities: Latinos/as/x who speak Spanish, Black and African-American community, Native Americans, Pacific Islanders, people needing disability services and long-term care services, individuals who navigate the behavioral health system, and those living in rural parts of Oregon. The seven roundtables were held virtually in January and February 2022, and included facilitators and several Task Force members.

[113] 80th Oregon Legislative Assembly, Enrolled Senate Bill 770, 2019. https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB770/Enrolled
[114] Slides 33 and 34, Task Force meeting. September 30th, 2021 https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/249936
[115] Slide 9 from October 28th, 2021 Task Force Meeting, https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/250117

The Public Engagement Workgroup, made up of a subset of Task Force members, was tasked with drafting question topics to prioritize for the roundtable discussion guide. The Workgroup focused on developing topics for public engagement and brought those back to the Task Force, jointly coming to an agreement on a general prioritization of topics. After topics were prioritized, the Workgroup collaborated with Lara Media Services on the exact wording of the questions.

Summarized below are highlights from the roundtable discussions:[116]

Eligibility. In alignment with the Plan, participants expressed a desire to see all people living in Oregon covered by the Plan regardless of citizenship. Participants also noted that the Plan should carefully define what it means to be a "resident" of Oregon as a key component of the eligibility criteria for the Plan. Part of their concern is whether individuals who do not reside in Oregon would travel to receive services and limit access to critical services for Oregon residents.

Enrollment. In alignment with the Task Force Plan, participants stressed that the enrollment process be as simple as possible to remove unnecessary barriers, automatically enrolled, and leverage enrollment systems for other publicly funded programs such as SNAP or TANF. Participants also expressed interested in having volunteers and nonprofits assist with navigating enrollment process, easy online accessibility applications and materials.

Coverage. In alignment with the Plan, participants described a preference for comprehensive benefits including dental, mental health and vision. Feedback also included a preference for a single state formulary for affordable prescription drugs based that would be developed based on evidence and community input. From of all the services recommended for increased coverage, the most prevalent was mental health. Communities perceive that mental health has been stigmatized by their and other cultures for far too long. People need a holistic health system, but mental health is commonly ignored, and this ignorance and stigmatization can cause more damage to those suffering greatly from its effects

Affordability. Participants expressed the need to ensure that any costs to support the Plan be based on people paying what they can afford. A core theme throughout participants voices is the financial burden many health care services pose to individuals and families. The affordability of services depends on available funds. Many participants echoed the sentiments in this quote, "you only get the care you can afford, not what you need." The Task Force should take this recommendation into consideration in how the Plan revenue structure is designed, ensuring that taxes that apply to everyone are progressive. In general, participants expressed a desire to avoid increasing taxes, especially on moderate to low-income families. Moreover, many participants believe that healthcare is a "fundamental human right, not a privilege."

[116] Highlights are attributed to findings prepared by Lara Media and its Group Discussion Research Synopsis Report, April 22, 2022. Available here: https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/255209

Provider Reimbursement. Participants described the experience of having Medicaid coverage as having a different "tier" of access to care compared to other forms of coverage. They cited Medicaid's lower provider reimbursement rates as the cause of reducing access to the providers they want to see. Several participants wanted to ensure the Plan supported equity in access to care by ensuring a single reimbursement rate for providers. The Task Force and the Plan are in alignment with these values and strategies.

Social Determinants of Health. Participants expressed the necessity for aid in areas related to social determinants of health. Emphasis was placed on health literacy and culturally appropriate resources. Participants articulated the need for access and affordability of the Plan to also cover SDOH, such as transportation to appointments, proper nutrition, and housing support.

Governance. In alignment with the Plan, participants emphasized the importance of an ethnically and regionally diverse Board that includes a variety of member representation. One of the most significant concerns participants expressed was the belief that ethnic-specific, regionally specific, and diverse representatives will be missing from the board's operation. Many participants agree that they often felt that their communities are brushed aside on essential matters and that representatives for other boards and legislative matters do not accurately represent the people and their needs objectively. In sum, they advocated that more representatives should come from BIPOC and historically marginalized groups with diverse ages, backgrounds, education, and experience.

Provider Participation. Participants communicated a desire to be able to access care with the provider of their choosing and wanted to ensure the Plan was designed in a way that did not limit enrollee choice of provider. In addition, participants expressed that they want to ensure the Plan broadens access to all provider types and in particular, increase access to culturally responsive care. It is imperative for many participants to work with providers who respect and understand their backgrounds, cultural norms, and experiences. Many immigrants feel that their care has been more dignifying when their providers are multicultural or come from communities of color. The most complex field of inquiry came from Oregonians in the rural, mental health, and Spanish-speaking disabilities sessions, who questioned if this availability to providers will extend to those outside of Oregon. With most specialists and large health care providers in Portland and the greater Willamette Valley, many participants living in rural areas or outside the Willamette Valley have to travel long distances to reach specialized or even essential health care providers within their insurance program.

For a more comprehensive understanding of the roundtable methodology, results, and findings, see appendix of Lara Media Services Report.

Phase Two

Phase Two of the Public Engagement forums occurred from June through July of 2022 and had two areas of focus. The first area was broad public engagement focused on regions across the

state and the other on the health care industry, employers, and labor. The goals for phase two were to[117]:

- Share key elements of the Plan
- Explain the Task Force's process thus far
- Provide authentic space for public to learn, react, and ask questions
- Receive feedback from a plurality of communities on specific questions and issues
- Allow space to build trust between and among the public and Task Force

Regional Community Listening Sessions
Seven virtual community listening sessions, each two hours long, were held for the following regions:

- Coastal (Clatsop, Columbia, Coos, Lincoln, Tillamook)
- Central (Crook, Deschutes, Hood River, Jefferson, Sherman, Wasco)
- Eastern (Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, Wheeler)
- Southern (Curry, Douglas, Jackson, Josephine, Klamath)
- Portland Metro Area (Clackamas, Multnomah, Washington)
- Willamette Valley (Benton, Lane, Linn, Marion, Polk, Yamhill)
- Statewide Spanish (*one additional session was held in Spanish for Spanish-speaking people throughout Oregon)

Combined, the sessions had approximately 230 total individuals come, listen, and provide comments, questions, and feedback for the task force. The open forum style allowed anyone to ask questions and provide input.

Key findings from the community listening sessions pulled from the Lara Media August 2022 report.[118]

Access and Affordability. Community members focused on accessibility of health care especially when it comes to traveling out of state and the ability to select a provider. Community members emphasized concern around the provider shortage and if the new system would be more accessible than the current health care system in Oregon. Furthermore, residents worried that this new system would result in more extended waiting periods and discrimination.

Insurance Companies. Throughout the community listening sessions, community members relayed concerns around the unknown impacts the Plan would have on the costs of services with private and commercial insurance companies. Most regions also voiced concerns about how the Task Force would integrate insurance companies and other existing health plans into

[117] Goals were discussed at the May 11, 2022 Public Engagement Workgroup meeting
[118] Highlights are attributed to findings prepared by Lara Media and its Community Listening Session Research Synopsis Report, August 2022. Available here: https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/256515

the UHCP - like Kaiser and Veterans' Affairs, what these new plans would look like, and what new benefits this plan would provide.

Coverage and Benefits. Overall Community members emphasized the importance of comprehensive coverage to include, gender-affirming care and various specific services, such as chiropractors, acupuncture, nutrition, physical therapy, and lactation consultants. Furthermore, residents focused on long-term care and chronic illnesses, and the inclusion of these types of care.

Health Care Providers. Community members expressed concerns around how providers would be paid and the impact the Plan would have on provider salary and recruitment. Community members also questioned how the Plan would influence using primary care providers instead of emergency care. Residents questioned the impact the Plan would have on health care administration and the paperwork or documentation health care providers would have to fill out. Community sessions also raised concerns about privatization; individuals wondered if hospitals would continue to be privately owned and, if yes, would they be allowed to turn patients away.

Employers and Employees. Community members questioned how the Plan would benefit employees and employers. They wanted to understand how the Plan would be implemented by employers, if the new Plan would be better than what their current employer provides, and if the Board would eliminate employer-based insurance.

Governance. When it came to governance, community members focused on the implementation of the Plan and if the Plan's governing board would fully represent the people of Oregon. They also focused on how their voice could be continually involved in the governance of the Plan. Residents also recommended that the board receive input from CBOs and statewide health counselors and address business-model concerns of private providers and policy-makers

Cost and Funding. Community members expressed concern over the new taxes required to fund the Plan and if these taxes were fair and how to improve them. Furthermore, residents questioned the sustainability of the Plan and if costs included additional funding for unforeseen expenditures, such as overutilization and system abuse.

Medicare and Medicaid. Community members expressed concern over continuing to pay Medicare premiums and confusion on how Medicare and Medicaid would be integrated into the Plan.

Eligibility and Enrollment. Public input questioned eligibility and how the Plan would handle those moving in and out of Oregon. It also focused on including Oregon residents regardless of immigration status and a full acceptance of all Oregon residents.

Health Equity. Community members supported a focus on equity and emphasized the importance of equity in the Plan. Residents emphasized the lack of equity many Black,

Indigenous people of color experience in the current health care system and the Plan's ability to resolve these.

Overall, community members showed interest in a new health care system for the state. They focused on the necessity of health care and had trepidations around the capacity of a universal health system, such as longer wait times for patients. Participants were eager to continue learning about how universal health care would work and wanted continued engagement with the process. Though much of the summary above notes the questions and concerns of Oregon residents, the vast majority of those who participated expressed excitement to see movement towards a Universal Health Plan and thought it would bring great value to Oregonians.

For a more comprehensive understanding of the Community Listening Sessions methodology, results, and findings, see appendix Lara Media Report Community Listening Session Research Synopsis.

Specialty Interest Forums

The Joint Task Force on Universal Health Care held seven Specialty Interest Forums for the business community and health care industry from June through August 2022 to solicit feedback on the Task Force's Plan proposal for a Universal Health Plan in Oregon. These two-hour virtual forums sought input and discussion about the Plan and its potential impact on a variety of entities and sectors. The forums were planned by a subgroup of Task Force members with assistance from staff and a consultant specializing in facilitation and community engagement. In seeking broad participation, staff and Task Force members sent invitations to a variety of associations and professional organizations, such as the American Federation of Labor and Congress of Industrial Organizations, the Oregon Business Council, and the Oregon Association of Hospitals and Health Systems and requested representatives to participate in the forums.

The Task Force planned three forums for the health care industry:

- Health Care Professionals
- Insurance Carriers & CCO's
- Hospitals and Health Systems

Similarly, the Task Force organized forums for three groups from the business community:

- Large employers
- Small employers
- Unions

Interest and availability to participate varied among the groups. Overall, the Task Force got input from 37 participants across the seven forums. And kept the forums attendance to small numbers to encourage participation and vivid discussions. Insurance carriers opted to share their feedback via a letter in lieu of attending the specialty interest forum.

Key findings from the specialty interest forums for some of the topics included in Task Force policy recommendations:

Access and Affordability / Eligibility and Enrollment. In alignment with the Plan and the values it signifies, many forum participants highlighted the importance of the Plan's role in improving access to health care. Some forum participants voiced support for the Plan's approach to having no co-pay or deductibles, which can impact access to care. Union representatives did indicate interest in the possibility of a progressive co-pay system where wealthier people paid more in order to balance concerns that younger adults who have lower utilization, and may not want to be taxed more. Employer forum representatives suggested the Task Force consider rethinking copays as a way to channel people away from low-value/high-cost health care to high-value/low-cost care.

There was a general expression of hope, especially among health care professionals and providers, that the Plan could ultimately improve capacity in the system through streamlining administrative functions and increasing access and reducing costs to patients. Among those recommendations was to ensure a simple in- and out-of-state payment process. There was consensus among health care system and hospital representatives that the Plan would need clear guidelines for navigating relationships with out-of-state insurers and managing out-of-state payments.

Providers, as well as representatives from health care systems and hospitals expressed concern around having adequate workforce and infrastructure for the expected increase in health care usage that would occur with universal health care. They recommended a focus on building a stable infrastructure and attracting and retaining providers in underserved areas of the state.

Covered Benefits. Forum participants echoed the Plan's proposal of offering full coverage and benefits, which includes dental and vision, but included a recommendation from unions to ensure there is a clear understanding of utilization and needs of younger adults as well as an recommendation from providers that there be inclusion of long-term care services and supports. Union representatives had general agreement with the Plan's inclusion of a comprehensive benefits package, but requested the Task Force consider expanding benefits to include culturally specific systems of care, such as indigenous health care systems and "alternative" health care (including naturopathic providers and acupuncture), as well as additional LGBTQ+ benefits and coverage. Union representatives uniquely and strongly emphasized the critical linkage between health benefits and union contract negotiations, explaining that health care benefits dominate union negotiations and union members have forgone increases to wages to ensure robust health benefits. Union representatives expressed concern that benefits under the proposal could be less, in both quantity and quality, than the benefits many unions have negotiated.

Health Care Providers. Health care providers and professionals were encouraged at the potential of the Plan to improve capacity in the system, but as mentioned above in the learnings on access, it was recommended that the Task Force do more to prioritize a robust workforce, including focusing on health system capacity and potential provider shortage. Health care providers and professionals also noted an interest in using evidence-based decision making in the formation and future implementation of the universal health care. There was feedback and concern from providers around ensuring patient safety and health care quality, desiring that quality and safety should not be sacrificed as the Plan is implemented and there should be special planning and attention paid to the smooth transition for patients.

Cost and Funding / Employers and Employees. Participants observed that the current system is unsustainable, and the Plan addressed many of the current challenges, and in particular participants were optimistic about the Plan's potential to control health care cost growth. Participants did offer concerns about the approach to taxes in funding the Plan and the burden it placed on individuals and businesses. Union representatives expressed a desire that more consideration be given to the balance of wages, taxes, and costs of the Plan, asking for clarity around the income breakdown for household contributions and the impact increased taxes would have on wages.

Insurers expressed significant concern that support for raising taxes to fund the Plan was an unrealistic expectation and wanted to see a more robust analysis on the impact increased taxes would have on Oregon's economy. Employer forum participants felt that the burden of the business tax would fall inordinately on small businesses and expressed concern for how that would impact wages. Participants highlighted that increased costs would be especially challenging for those businesses that do not offer health insurance. They further noted the administrative and financial burden on small businesses could vary greatly given the variety of small businesses as well as the variability in taxes based on employment status (part-time, full-time, seasonal employees, etc.). Among the employer representatives was an Oregon farmer that expressed concern about the impact of additional taxes on the farming community, rising costs, the challenges of having seasonal workers, and how large farms have a mix of large and small business qualities. The Community members asked that the Task Force consider the labor-intensive nature of farming as it considers new taxes and regulatory costs.

Employer forum participants generally recognized the value of decoupling employment from insurance, though some union representatives noted the operational challenge this could pose to navigating contracts with multi-state employers and advised the Task Force to take this into consideration. Relatedly, participants shared the complexities around employment in noncontiguous states, traveling workforces and funding and compensation connected to where a person lives rather than where they work.

Union and employer representatives enquired about the impact of costs and benefits on employers that continued to offer ERISA plans and questioned the general plausibility of the Plan when considering ERISA. Participants questioned the feasibility of such a large overhaul of

the health care system and shared anxiety about potential repercussions on the economy, residents of the state, and the growth of future businesses.

Governance / Transition Plan. Forum participants agreed with the Plan's emphasis on the need for regional and local involvement and control of the Plan. In every forum, some element was raised regarding the need for a clear transition, administration, and an implementation plan. Health care systems and hospitals noted that given the significance of the change that would occur under the Task Force's proposal, the Plan will need to have a clear and practical transition plan from the current health care system. The term "transition checkpoints" was used to describe step by step measurements and markers to ease the state and health care industry into a new system to minimize shock.

Key considerations raised include the costs to transition the workforce, mechanisms to continue local and regional accountability and involvement, and a process to ensure collaboration and dialogue with hospitals and health systems. Health care systems and hospitals representatives expressed concerns about how the Plan meshed with numerous health reform initiatives underway and how the health care system will balance those efforts with the implementation of the Plan. Another implementation question was raised around how youth on their parent's coverage would transition to the Plan.

In relationship to a transition plan and timing, insurers noted that in order to preserve the gains in coverage made during the public health emergency, the state's current focus should be on policy making intended to stabilize the current system and the health care markets in order to minimize care disruption and unintended consequences.

Medicare and Medicaid. Medicare was discussed among large employers, who expressed concern and confusion around the inclusion of Medicare enrollees in the Plan as uncertain given the significant legal and regulatory challenges.

Focus on Equity. There was general agreement in the value and attention the Plan pays to equity and social determinants of health, with union and provider representatives noting interest in seeing certain populations having access to key services and supports.

For a more detailed understanding of the individual Specialty Forum findings, see appendix Specialty Interest Summary.

Public Engagement Alignment Summary

Following the completion of the Task Force's multiple phases of engagement, the Task Force compared the feedback it received to elements of the Plan, identifying places where the Plan is in alignment with public input and places where further work is needed. This section highlights some of the key findings, but is not an exhaustive list.

Aligned Policy Areas. The following policy areas shared strong alignment and support in the public input process.

- **Access and Affordability** – There was general support for increased access to and ease in accessing the health care system. The public generally liked no out-of-pocket costs at time of service and no copays or deductibles, though some special interest representatives noted that copays could be used to disincentivize some forms of utilization.
- **Covered Benefits** – The public provided overall support for comprehensive coverage, especially with the inclusion of dental, vision, and behavioral health benefits. (*All groups*)
- **Eligibility and Enrollment** – Many participants agreed to full eligibility and that all Oregon residents are eligible. The public engagement sessions illuminated the need for the Task Force to have clear definitions of providers and residents. (*All groups)*
- **Equity & SDOH** – Participants supported the focus on equity and continued inclusion of social determinants of health This confirmed the Task Force's initial plans and allowed the Task Force to have Health Equity as a leading pillar in the creation and implementation of the Universal Health Plan. (*All groups*)
- **Provider Reimbursement** – There was support for paying providers directly. This was especially supported when payments between out-of-state health care users and other insurance plans would need to interact with providers. (*Roundtables & Health Care Industry)*

Partially Aligned Policy Areas. The following policy areas were met with general approval, but feedback and recommendations suggested some of these areas to be incomplete or unfinished. Participants either expressed concern, confusion, or questioned these areas, suggesting more work or research was needed.

- **ERISA** – Concerns focused around the plausibility of avoiding ERISA preemption. Many participants understood the Task Force took this into consideration but still questioned the feasibility. (*Health Care Industry, Insurers, & Business Community*)
- **Governance** – Questions and concerns focused on the make-up and duties of the board. Concerns emphasized the political impacts of changing administration and equitable representation of members. (*All groups*)
- **Health Care Safety and Quality –** Participants wanted to ensure that safety and quality are a priority of the Plan. Many public participants stressed that this should be more of a priority of the Plan and questioned the practical inclusion of quality and safety of care. (*Health Care Industry*)
- **Role of Private Insurers** - Generally people understood how private insurance would be incorporated into the Plan, and that it could offer supplemental coverage of benefits not covered. However, people still expressed concerns about the changes the Plan would have on the range and cost of services insurance companies cover within Oregon. (*Insurers & Community Sessions*) The public shared concerns that private insurance costs would become unobtainable for people that wanted it. This is part of the larger picture of many people asking for a macro economic analysis for Oregon and how the Plan could truly impact health care costs and businesses.

- **Support for Regional Involvement** - Public participants emphasized the need for continued local and regional involvement throughout the transition and implementation phases of the Plan. The need for this centered on regional differences and needs, especially rural areas and boarder counties. (*Health Care Industry & Employers*)
- **Administrative Costs –** Insurers expressed concern that the 4% administrative fee assumed in cost estimates was not a feasible estimate, citing 6% as more realistic. The Task Force later revisited this assumption and confirmed that its model will assume a 6% rate. *(Insurers)*

Opportunities for Alignment. Throughout the public engagement process, participants provided input on key areas where they felt the proposed Plan could better align with opinions and concerns.

- **Overall Costs & Revenue Needs** - Repeated public input centered on the large costs for the Plan and taxes to fulfill revenue needs. Adding a personal income tax creates a burden on individuals and families, especially those moderate to low incomes. Furthermore, groups expressed concern over the negative impact of increasing taxes on businesses and creating new costs, particularly for small businesses and self-employed people living in Oregon. (*All groups*)
- **Impact on Farming and Agriculture -** Input included concern about the impact of additional taxes on the farming community, rising costs, the challenges of having seasonal workers, and how large farms have a mix of large and small business qualities. The participants asked that the Task Force consider the labor-intensive nature of farming as it considers new taxes and regulatory costs (e.g., seasonal employees) (*Employers*)
- **Implementation of Competing Policies -** Implementation concerns focused on how multiple health reform proposals exist and the ability for hospitals to balance the implementation and importance of all of these. (*Health Care Industry*)
- **Medicare Feasibility -** Public input included concerns around gaining federal approval for the inclusion of Medicare into the state's single payer system. There are currently no states that have such a design and the federal government would have to approve this. (*Insurers*)
- **Medicare Premiums -** Public input emphasized the burden placed on Medicare beneficiaries who have to continue to pay Parts B and D premiums as well as the new personal income tax that the Plan would require. (*Community Listening & Health Care Industry)*
- **Multi-State Employers and Employees** - Additional feedback centered on the challenges some groups would have to navigate contracts with multi-state employers. Relatedly, participants shared the complexities around employment in noncontiguous states, traveling workforces, and funding and compensation connected to where a person lives rather than where they work. (*Unions & Employers*)
- **Transition Checkpoints** - During the specialty interest forums it was discussed the benefits and consequences universal health care could have on small to large businesses. The Task Force used this information to clarify the necessity to have

continued input from the business community during the transition. (*Health Care Industry & Community Listening*)

- **Workforce Impact** – Throughout all public engagement sessions, participants commented on the current state of the health care system workforce and expressed concerns that the Plan may accelerate issues, such as long wait times, provider shortages, and overall less capacity for the increasing numbers of users. A larger macro-economic analysis was discussed to fully understand the impact the Plan would have on Oregon's workforce and what kind of trainings would be needed. (*All groups*)

The various public engagement strategies resulted in robust and valuable input and influenced the Task Force by providing informing policy development of the Universal Health Plan. As Task Force members developed details around the Plan, the importance of community engagement is included in their descriptions. For example, members' description of the founding governance board includes designated roles for continued community engagement. Both phases of public engagement provided the Task Force with the public's perspective on key implications of the Plan, much of which provided valuable insights and nuance not otherwise available to the Task Force, shedding much needed light on what resonates with the public and areas where the complexities involved in achieving the goals of the Plan could be further addressed.

Table of Appendices

Appendix A **Memorandum: Analysis of ERISA Preemption Issues**
Professors Elizabeth McCuskey and Erin Fuse Brown

MEMORANDUM

To:	Oregon Joint Task Force on Universal Health Care
From:	Elizabeth Y. McCuskey & Erin C. Fuse Brown
CC:	Oliver Droppers Daniel Dietz
Date:	July 25, 2022
Re:	Analysis of ERISA Preemption Issues for Universal Health Plan Proposal (June 2022) – Oregon Services PO Numbers 174361 & 174397

This memorandum analyzes the Oregon Joint Task Force on Universal Health Care's (the "Task Force") June 2022 Universal Health Plan Proposal (the "Proposal") in light of potential preemption by the federal Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1144(a). Pursuant to the Statement of Work for the PO Numbers referenced above, this memorandum covers revenue mechanism design options, while focusing on ERISA preemption analysis for the design choices reflected in the Proposal.

In addition to the materials discussed during our live presentations to the Task Force on January 6, 2021 and February 4, 2022, the Task Force has provided us with the following documents:

- Universal Health Plan Proposal – June 2022
- Universal Health Plan – Questions and Answers
- Summary of Policy Decisions
- Task Force Meeting Slides – May 19, 2022.

The analysis in this memo proceeds as follows:

SUMMARY

To finance and maintain universal health plans, states must grapple with the existence of employer-sponsored insurance and ERISA's broad preemption of state regulation that "relates to" employer-sponsored benefits. The Proposal's funding mechanism of a payroll tax on employers, keyed to wages, is likely to avoid the kind of connection to employers' benefit choices that would trigger ERISA preemption. The Proposal preserves employers' ability to offer benefits outside the Universal Health Plan, which further severs the Proposal from any preempted "relation to" employers' benefit decisions.

ERISA PREEMPTION ISSUES & DESIGN OPTIONS FOR STATE SINGLE-PAYER PLANS

The Task Force's goal of designing a publicly-funded universal health plan for all Oregon residents requires consideration of mechanisms to consolidate the existing sources of health care funding into one publicly-funded program. The major source of private health care coverage is employer-sponsored health benefits, which currently cover nearly half of the people in Oregon.[1]

Employer-sponsored benefits are largely governed by federal law through the Employee Retirement Security Act of 1974 (ERISA).[2] ERISA supplies some rules that private employer-sponsored plans must follow, but ERISA does not apply to governmental employers or churches as employers.[3] Most notably, however, ERISA preempts state regulation that "relates to" private employer-sponsored benefits.[4] The Supreme Court has held that state laws impermissibly "relate to" employee benefit plans by making "reference to" those plans,[5] when they "act immediately and exclusively upon ERISA plans," or make "the existence of ERISA plans essential to the law's operation."[6] State laws also may "relate to" ERISA plans by having too strong a "connection with" them, such as when a state law "governs a central matter of plan administration," "interferes with nationally uniform plan administration,"[7] or indirectly "force[s] an [employer] plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers."[8] ERISA does, however, allow states to regulate insurance carriers that may sell plans to employers. But the preemption provision has been held to prohibit states from applying their insurance regulations to "self-funded" plans in which the employer assumes the financial risk of providing health benefits and typically uses a third-party contractor to administer the benefits.[9]

ERISA preemption is complex and opaque. A state seeking to consolidate employers' health care spending into a publicly-financed plan must therefore design the plan to avoid the preempted "relation to" employer-sponsored benefits. The Supreme Court recently offered some welcome clarity, holding that a state law with indirect economic effects on employer plans did not have a "connection with" those plans that would trigger ERISA preemption.[10] The Court reinforced that "ERISA does not pre-empt state [] regulations that merely increase costs or alter incentives for [employer] plans without forcing plans to adopt any particular scheme of substantive coverage."[11]

While a state-law mandate that employers provide certain benefits or cease providing benefits would almost certainly be preempted because it directly interferes in employers' benefit decisions, there are many other design options that do not directly interfere.

---

[1] Oregon Health Authority, Health Insurance Coverage in Oregon, *Types of Health Insurance Coverage* (Jan. 2022) (survey data from 2021 show 47.2% of people covered by group plans, down from 49.3% before the COVID-19 pandemic).

[2] 29 U.S.C. § 1001 *et seq*.

[3] *See* 29 U.S.C. § 1002.

[4] 29 U.S.C. § 1141(a).

[5] New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995).

[6] Cal. Div. of Labor Standards Enf't v. Dillingham Contr., N.A., Inc., 519 U.S. 316, 325 (1997).

[7] Egelhoff v. Egelhoff, 532 U.S. 141, 148 (2001).

[8] *Travelers*, 514 U.S. at 668. *See* Shaw v. Delta Air Lines, 463 U.S. 85, 97–100 (1983) (laws effectively requiring employers to "pay employees specific benefits" are preempted).

[9] Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985); FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990).

[10] Rutledge v. Pharmaceutical Care Management Ass'n, 141 S.Ct. 474 (Dec. 2020).

[11] *Id.*

Primarily, those options include payroll taxes, provider restrictions, and assignment or secondary-payer provisions.[12]

States have wide latitude to levy taxes. In Oregon's Proposal, a combination of payroll and income taxes does most of the work of capturing employer expenditures, individual health spending, and providing incentives for both employers and employees to drop their employer-based coverage in favor of single-payer coverage. The payroll taxes are calculated as a percentage of wages, and therefore do not reference an employer's health benefit plan. Nor do they require employers to alter their employee benefit plans – they merely encourage a shift to the state's health plan. With a payroll tax, the employer is not forced to drop its coverage, and it does not have to change anything about the way it structures or administers its plan.

The Ninth Circuit Court of Appeals, which covers Oregon, has particularly strong precedent upholding states' ability to enforce payroll taxes to fund public health care programs. Ordinances passed by the cities of San Francisco and Seattle required employers to contribute to public programs that would cover their employees if the employers did not offer their own coverage. The Ninth Circuit held that these so-called "pay-or-play" laws created economic incentives for employers, but not to the point that they would effectively force the employer to start or stop offering particular benefits.[13] While these ordinances calculated the taxes on employers in part based on the employers' benefit choices, the Ninth Circuit held that the establishment of a public-program alternative preserved the employers' benefit choices enough to avoid preemption.[14]

The Supreme Court has upheld states' abilities to regulate medical providers, despite the indirect impact that those provider regulations might have on employer-sponsored health plans' costs and incentives.[15] That leaves states with the design option of using provider restrictions to move networks and covered employees into the publicly-funded system. A provider restriction tells providers that if they participate in the single-payer plan, they can only bill the single-payer plan at single-payer rates. They cannot bill the patient or other payers, which also eases the administrative burden on providers from negotiating with and billing multiple payers. A provider restriction creates additional incentives for employees to drop their employer-plans because it could shrink the network of participating providers in employer-based plans.

Similarly, a state could make its public plan the secondary payer and seek reimbursement from existing employer plans as primary payers, meaning they have the primary obligation to pay for covered services. These pay-and-recoup provisions enable those employers who wish to continue providing benefits to do so and allows the single-payer plan to capture some of that spending. If a patient covered by the public plan also has employer coverage, the public plan can pay providers for services and then seek reimbursement from the employer plan as a collateral source of coverage, such as an employer-based plan. Combining this sort of secondary-payer provision with a provider restriction may help states survive ERISA challenge because the combination gives the employer plan a more

---

[12] For an extended analysis of these options, consider Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. Pa. L. Rev. 389 (2020).

[13] *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 546 F.3d 639, 642 (9th Cir. 2008); *ERISA Indus. Comm. v. City of Seattle*, 840 Fed. Appx. 248 (9th Cir. 2021).

[14] The preemption status of such pay-or-play provisions has not been settled at the Supreme Court level. The plaintiffs in the Seattle case have petitioned the Supreme Court to review the Ninth Circuit's decision but as of the date of this memo, the Court has not decided whether to hear the case. And the Fourth Circuit has held that a differently-designed pay-or-play tax in Maryland was preempted.

[15] *See Rutledge* and *Travelers*.

plausible way to continue to exist. If the provider cannot bill the employer plan, then the single payer will pay for the care, then turn around and seek reimbursement from the employer plan for an enrollee with dual coverage.

Our analysis is that each of those design options could survive ERISA preemption, though some are trickier than others. In the end, there are good arguments for why each of these provisions would survive an ERISA preemption challenge. However, ERISA cases are nothing if not unpredictable and inconsistent, so the result in any particular court is not guaranteed.

ERISA Preemption Issues in Universal Health Plan Proposal Provisions

Payroll Tax

The two most important ERISA preemption issues for payroll taxes are whether they are based on the private employers' benefits decisions, and whether the tax rate would be considered so "exorbitant" that it would in effect force the employer to make a particular choice about its benefits. The Proposal's plan to impose a payroll tax on employers to contribute to funding the Universal Health Plan seems to avoid both issues. By making the payroll tax progressively based on employee wages,[16] the Proposal's tax does not directly reference employers' benefit plans or make the tax contingent on them.

While there is no set threshold for when a tax becomes "exorbitant" for ERISA preemption purposes, the Supreme Court found that a 24% surcharge on commercial insurance claims to hospitals was not exorbitant.[17] The Ninth Circuit upheld a Seattle ordinance that required employers make a monthly expenditure of $420 per employee for health care,[18] and upheld a San Francisco ordinance that required employers contribute $1.17 to $1.76 per hour worked to cover employees' health care.[19] While the Supreme Court has left open the possibility that higher taxes could cross the threshold of "exorbitant," its most recent opinion in *Rutledge* suggests that the threshold would remain high and that the Court views such provisions with "indirect economic effects" on employer decisions as mostly not within the scope of preemption.

As of May 2022, the Task Force has considered marginal rates for the payroll tax of 7.25% for wages ≤$160K and 10.5% for wages above $160K.[20] Though payroll taxes may affect an employer's decision whether to offer its own supplementary health plan or change the financial incentives, the payroll taxes at this level do not force the employer's choice of substantive coverage or plan design. The existence of the Universal Health Plan as a meaningful alternative to employers offering their own private plans also weakens the ERISA preemption argument. The proposal would not require employers to spend any funds on health benefit plans at all, let alone dictate their covered benefits, funding levels, or plan administration.

The payroll tax will create some disuniformity for multi-state employers, but this is even less of a concern after *Rutledge*, which said, "Crucially, not every state law that affects an

[16] Proposal at page 4.

[17] *Travelers*, 514 U.S. 645.

[18] *ERISA Indus. Comm. v. City of Seattle*, 2020 WL 2307481, at *1 (W.D. Wash. May 8, 2020), *aff'd*, 840 F. App'x 248 (9th Cir. 2021).

[19] *Golden Gate Rest. Ass'n v. City & Cnty. of San Francisco*, 546 F.3d 639, 644 (9th Cir. 2008).

[20] Task Force Meeting Slides – May 19, 2022.

ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan. That is especially so if a law merely affects costs."[21]

Thus a payroll tax can be imposed on a mandatory basis, as long as it is not at a rate high enough to force employers to drop or add coverage, and as long as it is not too directly based on the employers' benefits decisions. The household contribution to Plan funding via an income tax payment would not implicate ERISA preemption because it acts entirely on individuals, rather than employers or their insurers.[22] We understand the Proposal to apply the payroll tax to all employers, without exception.

Task force members have requested additional clarification about three aspects of the payroll tax and ERISA.

- First, on whether the payroll tax is employer-facing, employee-facing, or split between them—from an ERISA standpoint, it does not matter what share of the payroll tax is paid by the employer or employee, so long as the payroll tax does not reference or depend on the existence or amount of the employer's health benefit plan spending or cross the undefined threshold of exorbitance, discussed above. Nevertheless, the employee-share of a payroll tax, like a household income tax, would be subject to the federal cap on the deductibility of state and local taxes, which is beyond the scope of this project.
- Second, self-funded employer plans can be subject to the payroll tax to the same extent as fully insured employer plans. The ERISA analysis is the same for both types of plans.
- Third, *where* the payroll tax revenue is deposited (in a general fund vs. special fund for the universal health plan) does not meaningfully alter the ERISA analysis. To the extent that the tax is deposited in a special fund for the universal coverage plan, this may strengthen the case against ERISA preemption under the Ninth Circuit's precedents involving pay-or-play requirements in San Francisco and Seattle by offering employers the universal coverage plan as a legitimate choice and alternative to offering their own coverage.

Coverage Duplication

ERISA preemption cases have emphasized that state laws can avoid a preempted "connection with" employers' benefit plans by preserving meaningful choices for employers. The indirect economic effects on decision-making from a payroll tax is one way to avoid directly forcing employers' choices. Preserving employers' ability to decide whether or not to offer benefits is another way. So, a state law that expressly prohibited employers from offering health care benefits would almost certainly be preempted by ERISA because it directly references the employers' plans *and* directly targets the employer's decision about these benefits. But a law that preserves employers' ability to decide whether to offer benefits, but gives them economic incentives to drop coverage in favor of a public plan would likely avoid preemption.

Because ERISA allows states to enforce their regulations on insurers, a state law prohibiting *insurers* from offering plans that duplicate coverage from the state's public plan confidently avoids preemption. That, however, would leave employers able to self-fund plans that duplicate coverage and compete with the state plan. As the Proposal notes,

[21] *Rutledge*, 141 S. Ct. at 480.
[22] Though it is beyond the scope of this project, we note below that personal income taxes may implicate the federal SALT (State and Local Tax exemption) for higher-income taxpayers.

"Employers would no longer need to provide health benefits. But they would have the option to offer self-funded plans.[23] To avoid making a preempted "reference" to employer-sponsored benefits, it is recommended that the state law not expressly state the fact that employers would still be allowed to self-fund substitutive coverage.

The coverage duplication provisions that the Task Force considered in its January 2022 Outstanding Design Elements would allow *complementary* private coverage for those services and costs *not* covered by the Plan. This provision maintains an additional aspect of employers' choice about benefits by allowing them to offer complementary coverage as a benefit – either by purchasing it from an insurer or self-funding this coverage.

The Proposal thus preserves meaningful choice for employers along three lines: offer self-funded duplicative coverage, offer complementary coverage, offer no coverage and rely entirely on the Universal Health Plan.

Provider Participation & Reimbursement

The Supreme Court has held that state regulation of medical providers is largely outside the scope of ERISA preemption, even when that regulation influences the cost of services providers provide to employer plans.[24] The Court has not, however, considered whether a state law that deprives employer plans of a feasible provider network would effectively force the employer to drop its benefit plan.

The Proposal contemplates that the "Plan would pay providers directly" at rates set by region.[25] The Task Force's January 2022 Outstanding Design Elements described that the Plan would cover services from all providers licensed or authorized to practice in Oregon in good standing as "participating providers." If providers who participate in the state Plan are not permitted to continue contracting with (and being reimbursed by) self-funded employer-based plans, this may implicate ERISA if it is effectively forcing employers to drop their plans because there will be no providers to create a network for that plan.

If participating providers *are* allowed to continue contracting with (and being reimbursed by) employer plans, then a couple of policy-design questions about the status of complementary versus duplicative coverage (discussed in the previous section) would arise.

First, if participating providers provide services covered by the Plan to patients who also have employer-funded coverage, the Plan would need to rely on a mechanism to seek reimbursement from the employer-funded coverage as the primary payer. To the extent that substitutive employer-based coverage may continue to exist, the state may need to capture some the employers' expenditures on claims. It could also do so by designating the Plan as the *secondary payer*, so the primary obligation to pay falls on the substitutive form of coverage, and the Plan only must pay the difference to the provider if the amount paid by substitutive plan is less than the Plan's rate or pay for cost sharing (such as a deductible) that is not covered by the employer plan but is covered by the state Plan. A provision that makes the state Plan secondary to any other forms of substitutive coverage a beneficiary may have can also be paired with a *subrogation* provision that allows the Plan to assert the right of the beneficiary to reimbursement against the substitutive plan. This would allow the state Plan to pay for the services of a beneficiary, and then seek reimbursement via subrogation from the primary payer (the substitutive plan) that is

[23] Proposal at page 4.

[24] *Travelers*, 514 U.S. 645 (reaffirmed in *Rutledge*, 141 S. Ct. at 480).

[25] Proposal at page 2.

responsible for paying for the care. Because secondary payer and subrogation provisions preserve the employers' options of maintaining their own plans and do not interfere with such plans' beneficiary status or benefit choices, they should avoid ERISA preemption.

Second, providers may value the reduced administrative burden of participating only in the state Plan. To avoid ERISA preemption challenges, the state may want to allow participating providers to contract with ERISA plans, bill them, and accept higher rates from them. Yet some providers may voluntarily stop contracting with ERISA plans because they value the administrative benefits of only participating in the single-payer plan. Other providers may want to keep participating in ERISA plans (to be able to earn more), but then those providers would need to bear the administrative burdens of negotiating with these plans, billing, and then repaying any amounts previously paid by the single-payer plan for beneficiaries with dual-coverage.

Third, to mitigate legal challenges, provider participation in the Plan can be made optional but exclusive, where provider's voluntary participation in the state Plan means they cannot participate in other plans of coverage offered within the state. Note that this is slightly different than the Proposal's presumptive *enrollment* of all providers that are licensed and in good standing in the Plan. This alternative would make all licensed providers presumptively *eligible* to participate in the Plan, but if they choose to do so, they would have to agree not to participate in other substitutive plans. Presumptive provider enrollment plus a prohibition on contracting with other plans raises greater legal risks, whereas presumptive provider eligibility with voluntary enrollment conditioned upon exclusive participation in the state Plan would mitigate some of these risks. The tradeoff is that while large providers (such as hospitals) that depend on patient volume may need to participate in the Plan, smaller providers (such as certain physicians or specialists) may choose not to participate in the Plan in order to maintain a concierge practice of private-paying purchasers.

CONCLUSION

Oregon's 2022 Universal Health Plan Proposal contains several elements to consolidate employer and employee spending on health care into the Universal Health Plan: (1) a payroll tax levied on all employers; (2) restrictions on coverage duplication by state-regulated health insurers; and (3) regulation of participating provider reimbursement. These elements are structured in a way that will likely survive ERISA preemption, while still encouraging employers and employees to shift to the Universal Health Plan. Finally, we have offered thoughts on provider reimbursement and participation to allow the Universal Health Plan to survive ERISA challenges, draw maximum provider participation, and allow the state to recoup payments for services from substitutive forms of coverage that may persist after the Universal Health Plan is implemented. While beyond the scope of our work on this Project, we laud the Task Force's careful consideration of policy design to advance health care equity and access for Oregonians while navigating the complicated labyrinth of ERISA preemption.

Appendix B **Universal Health Care Financial Modeling**
CBIZ Optumas

Universal Health Care Financial Modeling

DRAFT

September 9, 2022

Table of Contents

Executive Summary

The Task Force on Universal Health Care, established by Senate Bill 770, was charged with recommending a universal health care system that offers equitable, affordable, comprehensive, high quality, publicly funded health care to all Oregon residents.[1] The Task Force included 19 members plus staff from the Oregon Legislative Policy and Research Office (LPRO) and the Oregon Health Authority (OHA).

In partnership with the Task Force on Universal Health Care, CBIZ Optumas (Optumas) developed estimated expenditure, savings, and revenue needs for a universal health care system.

Scope of Analysis

Universal Health Care estimates were developed from analysis of publicly available enrollment, expenditure, and revenue data for health care services based on Universal Health Care system design elements determined by the Task Force. The modeling reflects estimates stratified by payer source (e.g., State of Oregon, federal government, employer sponsored insurance, households, etc.) and includes several adjustments to reflect the design decisions of the Task Force including:

- Status quo (current health care system) enrollment, expenditures, and revenue sources for 2026.
- Five-year Universal Health Care projections for 2026 through 2030.
- Consideration for the inclusion and exclusion of Medicare and its impact on existing and new revenue sources.
- Future design considerations and key assumptions about the design and operation of the Universal Health Care system that impact the modeling estimates.

External Consultants

Throughout the performance of the scope of work, the Task Force sought input from the following external consultants who helped inform the approach described in this document:

- Chris Allanach, Oregon Legislative Revenue Office
- Kyle Easton, Oregon Legislative Revenue Office
- Erin C. Fuse Brown, JD, MPH, Georgia State University College of Law
- William C. Hsiao, PhD, K.T. Li Professor of Economics, Emeritus, in Department of Health Policy and Management and Department of Global Health and Population, at Harvard T.H. Chan School of Public Health
- Jodi L. Liu, PhD, MSPH, RAND Corporation
- Elizabeth Y. McCuskey, JD, MPH, University of Massachusetts School of Law

[1] https://www.oregon.gov/oha/HPA/HP/Pages/Task-Force-Universal-Health-Care.aspx

Universal Health Care Design Overview

Covered Populations	All permanent Oregon residents including Medicare and undocumented immigrants
Excluded Populations	Military (e.g., Department of Defense, Veterans Affairs)
Benefit Plan	Equivalent to average Public Employees' Benefit Board (PEBB) coverage levels, including dental
Cost Sharing	Eliminate all cost sharing (co-payments, deductibles, and coinsurance)
Provider Reimbursement	Single fee schedule for all covered populations and services with no differences between reimbursement for Medicaid, Medicare, or other program eligibility. The projected Universal Health Care system reflects a 4.0% discount below the projected status quo aggregate provider reimbursement.
Administration	To be determined
Availability of Private Insurance	The single payer system will be the only health coverage system available to Oregon residents. Private coverage such as supplemental coverage would not be permitted.

2026 Fiscal Impact Summary

Enrollment (projected total individuals)	4,432,700
Baseline (status quo) in billions	$55.60
Universal Health Care in billions	$54.63
Savings in billions	($0.98)

Universal Health Care Expenditure Modeling

Program Design, Policy, and Operation Assumptions

This section describes the conceptual-level policies developed by the Task Force regarding the program design and operations that informed the single payer fiscal impact projections. It also provides context regarding key model limitations.

Universal Health Care Elements

Populations	All permanent Oregon residents including Medicare and undocumented immigrants Excludes Military (e.g., Department of Defense, Veterans Affairs)
Excluded Populations	Military (e.g., Department of Defense, Veterans Affairs)
Benefit Plan	Equivalent to average Public Employees' Benefit Board (PEBB) coverage levels, including dental

Cost Sharing	No copays, deductibles, or coinsurance
Provider Reimbursement	4% below status quo aggregate reimbursement levels with no differences in reimbursement due to Medicaid, Medicare, or other program eligibility
Administration	To be determined
Availability of Private Insurance	The single payer system will be the only health coverage system available to Oregon residents. Private coverage such as supplemental coverage is not permissible.

Modeling Approach

While Optumas utilized the NHE funding source categories, the actual expenditures for each category relied on a variety of sources. Where available, actual reported expenditures such as Medicaid or CHIP were used. For all others, where actual information was not available, imputed results from the NHE estimates were used. Specifically, reported expenditures were utilized for Medicare, Medicaid, and CHIP (reported by the Centers for Medicare and Medicaid Services). Imputed values were used for most of Private Health Insurance, General Assistance, and Other Private Revenue. Of note, Private Health Insurance includes employer sponsored plans that are exempt from detailed utilization and expenditure reporting under federal law. The reliance on imputed statistics highlights the need for data collection strategies in markets that lack transparency.

Imputed Expenditures

To impute expenditures, one of two methodologies was used for each funding category. Imputed expenditures are either the product of the NHE estimated per capita expenditure and the Oregon state population estimate for that funding source or are based on the relative percentages of expected expenditures. Private Health Insurance is the largest imputed category and relied on the former category; estimates of the Oregon population that utilize private health insurance were applied to the NHE per capita estimate for that category to estimate total expenditures for that population. Note that subsets of the private health insurance population were identified by the Task Force for additional analysis. These populations were removed from the private health insurance population and have differing data sources noted in later sections.

Modeling Disclaimer / Limitations

In developing the expenditure and revenue estimates, Optumas relied on enrollment, expenditures, provider reimbursement, and benefit design from a variety of data sources including national and state-specific sources. The publishers of this data are responsible for its validity and accuracy; however, we have reviewed the information for reasonableness and consistency and its appropriateness for use in the estimates developed.

Due to availability and limitation of available data, it was not practical to perform modeling for every circumstance or scenario. For example, health care utilization data was not available for most of the populations covered in the baseline or the single payer. Summary information estimates and simplification of calculations may have been incorporated into the modeling. Included with this methodology are limitations and recommendations for additional detailed analysis, dependent on which path may be implemented for the state of Oregon.

As Oregon continues to explore implementation of a Universal Health Care system, significant and detailed analysis for individual populations will be necessary to refine the impacts of the adjustments outlined in this document and the final estimate. Importantly, as policies are developed at a more granular level, population-specific impacts will need to be reevaluated through the lens of that policy.

Estimates reflect what is achievable under a single payer system given the high-level constraints provided by the Task Force. The accuracy of the estimates will depend on many factors such as how the plan is implemented (nuanced benefit decisions, robustness of program integrity efforts, strategy for reducing pharmacy costs, etc.), the status of the economy when the plan is implemented, lasting pandemic impacts, and more. Projections are provided through 2030. The opportunity for deviation from what was assumed in the model and the actual context the plan operates under in 2030 could be significant.

The projected revenue need is based solely on the projection of health care expenditures and related administrative costs. Because implementation of a single payer system will create potentially significant economic impacts that will vary based on the individuals' incomes and other characteristics and will have a profound impact on employers that will likely alter both individual and business behaviors, the fiscal impact analysis will need to be coupled with a robust economic impact analysis to determine the full revenue need.

With regards to revenue, Optumas is not engaged in the practice of law or provides advice on taxation. The cost and revenue analysis includes commentary on revenue but is not a substitute for legal or taxation advice.

Lastly, the model makes multiple assumptions regarding the availability of state and federal funding sources. The state will need to coordinate with the relevant stakeholders, including the federal government, to validate these assumptions prior to finalizing a taxation strategy, budgetary impact, or any other related financial analysis.

Data Availability

The healthcare system is vast and complex. Oregon-specific data sources are not available for every facet of the analysis. Where possible, reported actuals are utilized for the preliminary estimates. Estimates for current payer sources with incomplete public reporting are generated using extrapolation of national data coupled with state-specific data sources to triangulate a reasonable result. 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 directly to the unique environment envisioned under the single payer system. Additionally, nearly all design elements of the Universal Health Care model are at the conceptual level of detail. Further policy and operational detail clarification would be required to evaluate the degree of applicability of any evidence as evidence can only be directly applied when the contexts are sufficiently similar.

Uncertain Impact of COVID and Inflation Long-term

The data evaluation and modeling were performed during the COVID-19 public health emergency. Uncertainty remains as to what the new normal will look like post COVID. Additionally, the current global instability and economic policies driving inflation could result in significantly higher future costs; the models and estimates will need to be updated when there is greater clarity regarding these factors in the future.

Baseline Data Sources

The data sources utilized to develop cost and revenue estimates are outlined in Table 1 below.

Table 1: Data Sources

Data Source Type	Data Sources
National	• National Health Expenditures (NHE) – (this included national and Oregon specific data where appropriate) • NHE per capita trend projections • Centers for Medicare and Medicaid

State Specific	• Oregon Health Authority
	  ◦ Medicaid
	  ◦ Children's Health Insurance Program (CHIP)
	  ◦ Public Employees
	  ◦ School Employees
	  ◦ Health Benefits Exchange
	• Oregon Legislative Revenue Office

Other	• Kaiser Family Foundation • Published studies (citations noted in footnotes throughout this document)

There are many different payer sources that contribute to funding health care expenditures in Oregon. These include public programs, private insurance, federal programs, individual contributions, and charitable contributions. An estimate of status quo baseline expenditures captures all relevant expenditures that are included in the proposed Universal Health Care models. To identify the different payer sources, Optumas relied on the NHE funding source categories to inform the funding categories incorporated in the Universal Health Care models.

National Health Expenditures Population and Payer Definitions

Definitions for the funding source categories, as outlined in the National Health Expenditure Accounts: Methodology Paper, 2020 Definitions, Sources, and Methods are described below.[2]

Out-of-Pocket

Out-of-pocket (OOP) funding is defined as direct spending by consumers for all health care goods and services. This includes the amount paid out-of-pocket for services not covered by insurance; the amount of coinsurance and deductibles required by PHI and by public programs such as Medicare and Medicaid (and not paid by some other third party); and payments from health and flexible savings accounts. The definition and estimates for OOP spending is the same in the traditional source of funds estimates and in the sponsor analysis, where it is included with spending by the households. Cost-sharing subsidies for eligible individuals in the Marketplace are excluded from out-of-pocket spending. Health insurance premiums are not included in out-of-pocket.

Private Health Insurance

Private health insurance expenditures in the sponsor analysis are disaggregated into employer-sponsored insurance and directly purchased insurance. These expenditures are then further allocated into the sponsors that finance these expenditures which include households, private business and governments.

Medicare

Medicare is one of the major government health care programs in the U.S. and covers people aged 65 and over, people under the age of 65 with certain disabilities, and people of all ages with end-stage renal disease (ESRD). The Medicare program is financed by several different mechanisms.

- The Hospital Insurance (HI) Trust Fund is primarily financed through Federal Insurance Contributions Act (FICA) taxes on covered payroll, plus interest income, taxation of benefits, voluntary premiums, and other revenues
- The Supplementary Medical Insurance (SMI) Trust Fund is financed through general revenues, premiums (Part B, Part D, and Medicare Premium Buy-in Programs by Medicaid), state phase-down payments, and interest income.

[2] https://www.cms.gov/files/document/definitions-sources-and-methods.pdf

In the sponsor analysis, an increase in the assets of the Medicare HI Trust Fund allow for immediate reductions in current federal general funding obligations for Medicare. These surpluses are recorded as special interest-bearing treasury obligations and are combined with all other general revenue. The surplus is reported as an offset to the difference between program outlays and the dedicated financing sources of Medicare since the surplus decreases the amount of general revenues necessary to pay for health care.

Medicare spending is disaggregated to reflect these different financing sources in the sponsor analysis. The HI payroll taxes paid by employers (private, federal, state, and local employers), along with one-half of the self-employed payroll taxes, are assigned to businesses and federal and state/local governments. The employees' share of HI payroll taxes, together with the other half of the self-employed payroll taxes, HI taxation of benefits, and SMI premiums, are considered household spending (Social Security Administration (1987-2020) and the Medicare Trustees Report (August 2021)).

Estimates for the Medicare Premium Buy-in program (payments made by state Medicaid programs for Medicare Part A and Part B premiums for eligible individuals) and receipts from states for phased-down Medicaid contributions for Part D are allocated to state and local governments. Additionally, the federal Medicaid program pays for Medicare premiums as part of the buy-in program. The remaining Medicare expenditures are roughly equal to trust fund interest income and federal general revenue contributions to Medicare and are included in the federal government category.

Medicaid

Medicaid is a combined federal and state program for the poor and medically indigent. Estimates of spending are reflected in both federal and state spending from a sponsor perspective.

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) is a joint federal/State program that provides health insurance for children in families that do not have health insurance coverage and are not eligible for Medicaid.

General Assistance

The component of general assistance included in the model is limited to the subset of charitable giving that would be subsumed by the single-payer system. The estimation strategy for this component relied on data provided by the state; no NHE estimates were used.

Excluded Populations and Programs

Military Department of Defense (DOD) and Veterans Affairs federal employees, research and investment funding, population health, and school and worksite health programs were excluded from reported NHE expenditure categories. Indian Health Services are also excluded, except for Indian Health Services funding covered through the Medicaid program.

National Health Expenditures Service Categories

The historical NHE data included expenditures reported for broad categories of service and included the following services described in National Health Expenditure Accounts: Methodology Paper, 2020 Definitions, Sources, and Methods are described below[3]:

Hospital Care

Covers all services provided by hospitals to patients. These include room and board, ancillary charges, services of resident physicians, inpatient pharmacy, hospital-based nursing home and home health care, and any other services billed by hospitals in the United States. The value of hospital services is measured by total net revenue, which equals gross patient revenues (charges) less contractual adjustments, bad debts, and charity care. It also includes government tax appropriations as well as non-patient and non-operating revenues. Hospitals fall into NAICS 622 Hospitals.

Physician and Clinical Services:

Covers services provided in establishments operated by Doctors of Medicine (M.D.) and Doctors of Osteopathy (D.O.), outpatient care centers, plus the portion of medical laboratories services that are billed independently by the laboratories. This category also includes services rendered by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) in hospitals, if the physician bills independently for those services. Clinical services provided in freestanding outpatient clinics operated by the U.S. Department of Veterans Affairs, the U.S. Coast Guard Academy, the U.S. Department of Defense, and the U.S. Indian Health Service are also included. The establishments included in Physician and Clinical Services are classified in NAICS 6211-Offices of Physicians, NAICS 6214-Outpatient Care Centers, and a portion of NAICS 6215-Medical and Diagnostic Laboratories.

Other Professional Services

Covers services provided in establishments operated by health practitioners other than physicians and dentists. These professional services include those provided by private-duty nurses, chiropractors, podiatrists, optometrists, and physical, occupational and speech therapists, among others. These establishments are classified in NAICS-6213 Offices of Other Health Practitioners. Dental Services: Covers services provided in establishments operated by a Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.) or a Doctor of Dental Science (D.D.Sc.). These establishments are classified as NAICS 6212 Offices of Dentists.

Other Health, Residential, and Personal Care:

This category includes spending for Medicaid home and community-based waivers, care provided in residential care facilities, ambulance services, school health and worksite health care. Generally, these programs provide payments for services in non-traditional settings such as community centers, senior

[3] https://www.cms.gov/files/document/quick-definitions-national-health-expenditures-accounts-nhea-categories.pdf

citizens centers, schools, and military field stations. The residential establishments are classified as facilities for the intellectually disabled (NAICS 62321), and mental health and substance abuse facilities (NAICS 62322). The ambulance establishments are classified as Ambulance services (NAICS 62191).

Home Health Care

Covers medical care provided in the home by freestanding home health agencies (HHAs). Medical equipment sales or rentals not billed through HHAs and non-medical types of home care (e.g., Meals on Wheels, chore-worker services, friendly visits, or other custodial services) are excluded. These freestanding HHAs are establishments that fall into NAICS 6216-Home Health Care Services.

Nursing Care Facilities and Continuing Care Retirement Communities

Covers nursing and rehabilitative services provided in freestanding nursing home facilities. These services are generally provided for an extended period of time by registered or licensed practical nurses and other staff. Care received in state & local government facilities and nursing facilities operated by the U.S. Department of Veterans Affairs are also included. These establishments are classified in NAICS 6231-Nursing Care Facilities and NAICS 623311-Continuing Care Retirement Communities with on-site nursing care facilities[4].

Prescription Drugs

Covers the "retail" sales of human-use dosage-form drugs, biological drugs, and diagnostic products that are available only by a prescription.

Durable Medical Equipment

Covers "retail" sales of items such as contact lenses, eyeglasses and other ophthalmic products, surgical and orthopedic products, hearing aids, wheelchairs, and medical equipment rentals.

Other Non-Durable Medical Products

Covers the "retail" sales of non-prescription drugs and medical sundries.

Adjustments Applied to the Category of Service Information

The cost projections included adjustments that estimate various effects of the transitioning from the current baseline of health care delivery to the Universal Care Model. In many cases these adjustments, such as provider reimbursement changes, were applicable to specific service categories (e.g., hospital, pharmacy, physician). The distribution of expenditures by service category reported by NHE was applied to each data source to support modeling adjustments.

---

[4] In the Plan Proposal, OHDS would continue to administer Medicaid LTSS benefits for those who are eligible, and that coverage would not be universal - pending further study prior to integration into the Universal Health Plan. 42 CFR § 431.10 requires each state to have a Single State Agency that administers the Medicaid program and all related funding; consequently, funding would flow through the single payer for these services even though portions of program administration are delegated to OHDS. Expenditures for Medicaid LSS benefits are included in the model, but do not reflect the availability of a comprehensive LTSS benefit or full administration of the services.

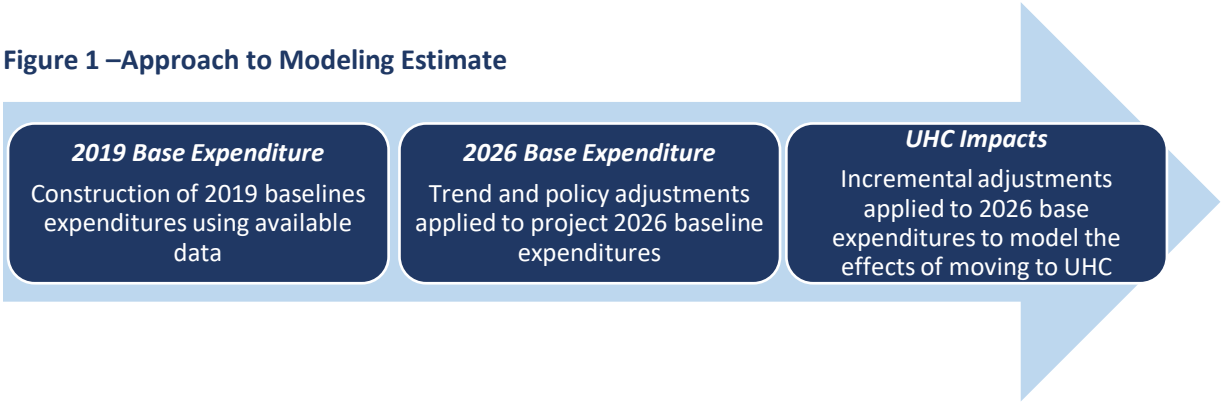
Service Category Exclusions

Long-term care services are not a fully covered benefit in the model. Medicaid beneficiaries will continue to receive long-term care services; other populations can access skilled nursing facilities for time-limited post-acute treatment only. Out-of-pocket costs for long-term care have been excluded for the model.

Universal Health Care Expenditure Projection Development

The process to develop the Universal Health Care, (single payer), estimates included selecting and analyzing data to develop a baseline expenditures and revenue for the populations and services included in the single payer system design. Figure 1 illustrates the three major components and approach for developing single payer estimates followed by detailed discussion of the components including considerations included in the single payer cost estimates. The single payer cost estimates and projected revenue from existing sources include administrative expenditures necessary for operating the single payer system.

Figure 1 –Approach to Modeling Estimate



The following sections present the organization and analysis of the 2019 base enrollment and expenditures and adjustments to develop the 2026 single payer estimates followed by revenue needs.

2019 Base Expenditures

The base expenditure period was constructed to organize estimated enrollment and expenditures for 2019. This information is used as the basis to project and adjust the baseline to match Task Force design decisions for the single payer to develop expenditure estimate for 2026-2030. The population categories, referred to as coverage type and expenditure types, are presented in Table 2 below.

Table 2 – Baseline and Projection Coverage and Expenditure Types

Coverage Types	Expenditure Types
• Individual – Exchange • Public Employees Other Than PEBB/OEBB • Employer/Other Individual • Oregon Public Employees (PEBB) • Oregon Educators (OEBB) • Medicare • Medicaid • Uninsured	• Out-of-Pocket Costs • General Assistance (Charity care) • Community Behavioral Health (non-Medicaid)

Enrollment and expenditures by coverage and expenditure type for calendar year 2019 (CY19) are aggregated in Table 3 below. This information serves as the basis for projecting the CY 2026 Baseline and then adjusted to reflect transition to the proposed single payer system. Projected 2026 information is used to evaluate revenue need presented in section "Evaluating Revenue to Support Universal Health Care".

Table 3 – CY2019 Baseline Enrollment and Expenditures

Coverage Type / Expenditure Type	Enrollment	2019 Baseline Expenditures (In millions)
Individual – Exchange	148,180	$996
Public Employees Other Than PEBB/OEBB	401,310	$2,842
Employer/Other Individual	1,286,797	$8,657
Oregon Public Employees (PEBB)	137,367	$973
Oregon Educators (OEBB)	133,215	$730
Medicare	782,445	$9,420
Medicaid	859,481	$9,936
Children's Health Insurance Program (CHIP)	128,696	$448
Uninsured	299,241	$1,208
Out-of-Pocket	n/a	$1,543
General Assistance (charity care)	n/a	$121
Community Behavioral Health (non-Medicaid)	n/a	$695
Total	**4,176,732**	**$37,570**

Table Notes:

1. *Due to dual eligibility across programs, figures present may be higher or lower than public reported and to avoid duplication resulting in skewed per capita calculations as a result.*
2. *Medicare out-of-pocket is included in the Medicare total line.*
3. *Out-of-pocket costs for programs and services not included in the Universal Health Care plan are excluded.*
4. *Total values may differ due to rounding.*

Additional notes about Coverage Types

Individual – Exchange

Expenditures and enrollment for this category were provided by the state as part of an ad hoc data request. State staff noted that federal reporting of enrollment is overstated due to inclusion of individuals that select plans but do not move forward with purchasing them. Consequently, figures reported in the projections may not align with federal reporting.

Public Employees Other Than PEBB/OEBB

Estimates for this cohort's enrollment were derived using population estimates from the US Census Bureau while per capita costs were aligned with state public employees in the model.[5] The expenditure and enrollment data for PEBB/OEBB were taken from public reporting.[6]

Medicaid and CHIP

Expenditures for these populations are based on the federal Medicaid Budget & Expenditure System (MBES), also reported by the Kaiser Family Foundation.[7, 8]

General Assistance (charity care)

Expenditures for this charitable giving that would be subsumed by the single payer were based on reporting from the Oregon Health Authority.[9] Reporting on hospital charitable giving overstates what would transition to the single payer as it includes costs not associated with provision of services that would be compensated under single payer; consequently, the model assumes only 10% of the reported charitable giving constitutes costs for the future single payer system.

Community Behavioral Health

Expenditures for Community Behavioral Health are based on figures provided by the state as part of an ad hoc data request. The expenditure estimates include state and federal (SAMHSA) spending on community behavioral health services excluding Medicaid funded programs and state psychiatric hospitals.

Trend Factors

Trend factors are used to project the CY19 Baseline enrollment and expenditures to CY26. Annualized trend factors between CY20 and CY30 are published by the State of Oregon Department of Administrative

[5] 2019 ASPEP Datasets & Tables (census.gov)
[6] https://www.oregon.gov/oha/OEBB/DemographicReports/OEBB%20Demographic%20Report%202018-2019.pdf
[7] Medicaid Budget & Expenditure System (MBES) | CMS
[8] State Category | Medicaid & CHIP | KFF
[9] Oregon Health Authority : OHA releases hospital community benefit report : External Relations Division : State of Oregon

Services. Table 4 illustrates the annualized trend factors by year to project Oregon's total population over time.[10]

For projection purposes, impacts related to the COVID-19 public health emergency and recent observed inflation rates are not considered within these trend factors.

Table 4 – Average Aggregate Population Growth Rates 2020 - 2030

Year	Total Population	Percent Change
2020	4,243,791	0.69%
2021	4,266,560	0.54%
2022	4,296,800	0.71%
2023	4,331,100	0.80%
2024	4,366,900	0.83%
2025	4,404,000	0.85%
2026	4,432,700	0.65%
2027	4,468,800	0.81%
2028	4,505,500	0.82%
2029	4,542,800	0.83%
2030	4,580,700	0.83%

Table 5 illustrates the annualized trend factors, by major funding source, published in the NHE. To project CY19 to CY26, the annual factors for each year were aggregated to develop an annual average growth rate over a seven-year period.

Table 5 – Average Annual Growth Rates, 2019 – 2026

Funding Source	Minimum	Maximum	Average Annual
Private Health Insurance (all types) Employer sponsored coverage Oregon public and education employees Municipal public employees Individual (exchange coverage)	4.0%	5.2%	4.9%
Medicare	7.2%	8.0%	7.7%
Medicaid	4.5%	6.8%	5.6%
Children's Health Insurance Program (CHIP)	4.5%	6.8%	5.6%
Out of Pocket and Uninsured	4.0%	4.3%	4.2%
Other	3.6%	4.3%	4.1%

[10] State of Oregon: Economic analysis - Demographic forecast

Funding Source	Minimum	Maximum	Average Annual
General Assistance (charity care) Community behavioral health (non-Medicaid)			
Aggregate	**4.0%**	**5.2%**	**5.7%**

Table Notes:

1. *The table reflects per capita growth assumptions; enrollment is trended separately.*
2. *Statistics do not include the recent effects of inflation, nor any projection for the increased levels of inflation likely to occur in the near term.*
3. *Trend assumptions by funding source are sourced from the National Health Expenditures forecast.*

Universal Health Care System Projections

The following sections present the development 2026-2030 single payer expenditure and revenue projections based on 2019 baseline expenditures The estimate presented is based on the program design determined by the Oregon Task Force on Universal Health Care.

Readers and users of the information contained in this document should consider constraints and assumptions for these projections including:

- The assumptions in this section reflect the first year of model implementation. Impacts will change in future years as the model matures.
- How the single payer is operationalized, including nuanced benefit coverage decisions, will have a significant impact on whether the projected expenditures come to fruition. For example, the modeling assumes improved efficacy in fraud, waste, and abuse detection due to the consolidation of all health insurance data under a single source, increasing the likelihood of detecting statistical deviations that indicate fraud. While this could theoretically result in reduced total costs, if the state builds a program with inadequate Program Integrity, costs could instead increase.
- Assumptions are predicated on a combination of research (including information provided by the Task Force and consulting experts) and professional judgement. Research can rarely be applied directly or in isolation because the conditions under which the study or other programs operated are different than what you have in Oregon.

Baseline Adjustments and Impacts

Expenditure and revenue projections were developed through a series of adjustments to project 2019 Baseline to the single payer system. The following sections provide information specific to the individual adjustments applied to the 2019 baseline. The adjustments are organized into the following major classifications:

- Utilization – changes to the volume of services used
- Unit Price – changes to price level of individual services
- Plan Administrative Efficiency – changes to administrative costs
- Other Adjustments – changes to system financing not otherwise captured

The above referenced adjustments including direction and 2026 impacts are summarized in Table 6 below.

Table 6 – Summary of Adjustments to Develop CY2026 Single Payer Expenditure Projection

Adjustment Classification	Cost Estimate Adjustment Description	Impact	Aggregate Expenditure (2026 Initial Year)[11]
Utilization	Utilization Impacts Associated with Eliminating Cost Sharing	↑	$851 M
	Fee Schedule Normalization (Underserved Populations)	↑	$35 M
	Benefit Change (Standardized Benefit Plan)	↑	$438 M
	Incremental Additional Dental Coverage	↑	$723 M
	Coverage for Uninsured Populations	↑	$1.09 B
Unit Cost	Purchasing Power (Price Negotiation)	↓	-$408 M
	Fee Schedule Normalization (Rebalance Unit Pricing)	=	$0
	Provider Rate Change (Administrative Efficiency)	↓	($2.11) B
Plan Administrative Efficiency	Fraud, Waste, and Abuse	↓	($529) M
	Margin Removal (Insurance Margin)	↓	($758) M
	Economies of Scale (Eliminating Insurance Carriers)	↓	($20) M
	Removal of Commissions and Marketing (Insured Carriers)	↓	($65) M
Other Adjustments	Health Insurer Fees (Oregon premium tax – Net Adjustment)	↓	($226) M
Total Impact of Adjustments		↓	**($979) M**

[11] M = Millions, B = Billions

Utilization Adjustments

Introduction

Utilization adjustments in the model include factors that are likely to change behaviors that will result in different utilization patterns than under the status quo system. In most cases, the proposed design of the Universal Health Care program will result in upward pressure on utilization. That said, increases in appropriate upstream care can translate to reductions in emergent care and service utilization associated with treatment of poorly managed chronic disease in the mid to longer-term.

Most of the factors that increase demand for services take effect immediately with implementation of the single-payer system; however, there are a multitude of supply-side constraints. Major supply-side constraints include the following:

- workforce capacity, particularly for behavioral health and certain specialties;
- an adjustment period for providers to learn how to engage the new system;
- the new payment system working through inevitable implementation challenges;
- several months of providers having to continue to interact with this historical system (claims runout, audits, contract closeout, payment disputes, etc.), and
- potential labor challenges that stem from individuals' behavior change due to new tax and single-payer implementation.

To account for both the supply and demand-side dynamics, the model assumes a gradual expansion of increased utilization rather than an immediate full impact. Through Task Force discussions, feedback identified that the approximate 4% utilization adjustment assumed in the projection is lower than most other studies have assumed (closer to 8%). Given the factors noted above, we believe there is a compelling need to assume a transition to higher utilization levels over time. This is reflected in the five-year forecast in later sections.

Utilization Impacts Associated with Eliminating Cost Sharing

The single payer design eliminates beneficiary cost sharing, health care costs covered by insurance that individuals pay out of their own pocket. Cost sharing varies by insured program but includes deductibles, coinsurance, and co-payments. Insurance premiums and non-covered services are not considered cost sharing.

Cost sharing is designed to influence an individual's decision to seek health care and serve as a basis to reduce unnecessary utilization and to reduce total payer expenditures. Particularly for discretionary or non-emergent services cost sharing influences how individuals seek, delay, or forego diagnosis and treatment of health-related conditions. This is supported through the practice of health care plans excluding preventative health care from cost sharing. Cost sharing is a common design element in the

benefit plans for individuals covered by Medicare, employer sponsored or individual insurance and typically excluded for Medicaid and CHIP enrollees.[12]

Removing cost sharing will immediately increase the utilization of health care services, which will increase costs. Increased utilization associated with eliminating cost sharing occurs in two ways:

a. **First, barriers for individuals to access care are eliminated, which will increase the cost for members accessing these services** – Increased utilization that results in an improvement to an individual's health is beneficial for the individual and the health system over the long term by reducing cost growth over the long term.

b. **Second, barriers to ineffective or inefficient care are also eliminated** – Health care service utilization that results in no change to the individual's health status compared to what would have happened under the baseline period. The costs associated with this category are attributed to more frequent use of services without changes in the health status of the covered individual.

Evidence for each of the effects of (a) and (b) is weak and mixed due to the challenge of isolating specific causal relationships in complex and dynamic environments. Economic theory suggests that price sensitivity is inversely related to the perceived need for a service and that larger price differentials may be needed to impact changes in utilization. Because limited information is available on current state-wide practices, some increases in utilization of low value services could occur with the removal of cost sharing if it is the case that private insurance plans have been successful in deterring utilization of low-value services through cost sharing policy.

The basis for the assumed cost impacts considered:

- Increase in utilization is offset in case a), but only in the longer term whereas case b) isn't offset and represents a pure increase in utilization.
- Greater increases in utilization are assumed for services where cost sharing is disproportionately high for discretionary improvements in care. An example of this is for dental care.
- The available research is often based on a combination of studies that suggest increases in utilization when cost sharing is removed or that utilization is decreased when cost sharing is applied. For example, one research study evaluated suggested a correlation of a 0.15% change in utilization per 1.0% change in price as the general average of studies at the time (2002)[13]. Other studies noted anecdotes about changes in utilization in response to specific policies implemented in the health care delivery system.

[12] Limited cost sharing is permissible in Medicaid and CHIP; however, since enactment of the ACA, Oregon opted for no cost sharing requirements on its Medicaid and CHIP populations.

[13] /tardir/tiffs/a403148.tiff (dtic.mil)

The adjustment to remove cost sharing was applied by population type and major service category (e.g., physician, pharmacy, durable medical equipment).

Impact

The impact of eliminating cost sharing increases cost for the single payer by 1.53% or $851 million on a 2026 basis. The impact varied by population (some populations having little or no impact from the change) and the following service categories:

- Maximum adjustment of 1.5% for most service categories
- Maximum adjustment of 2.5% for pharmaceuticals
- Maximum adjustment of 10% for durable medical equipment
- Maximum adjustment of 25% for dental services

Actual experience driven by several variables including other policy decisions and implementation challenges, will result in variations to the assumptions described above.

Fee Schedule Normalization

Fee schedule normalization means the impact associated with increased utilization among the Oregon Medicaid population under a single payer system. In the status quo system, a significant difference exists in the level of health care provider reimbursement between Medicaid, Medicare and those covered by commercial insurance (employer, individual and group coverage). Reimbursement differences between Medicaid, Medicare and commercial insurance can result in constraints in the availability of health care providers for Medicaid beneficiaries. This is because health care providers can choose to limit contracting or exposure to individuals covered by Medicaid.

It is important to note this adjustment is specific to increased access and is not the impact of overall provider reimbursement policies in the single payer, which is addressed in a separate section, Unit Price Adjustments.

The fee schedule normalization adjustment reflects increased utilization associated with expanded access for individuals eligible for Medicaid to health providers (e.g., physicians) across Oregon. It also assumes a slight reduction in utilization of hospital emergency departments. In future periods of the single payer, improved access to upstream interventions could result in reductions to costs for exacerbation of conditions and/or reductions to emergency services utilization.

Impact

The impact of this adjustment increases overall cost for the single payer system 0.06% or $35 million on a 2026 basis. The increased cost was applicable primarily to physicians while reductions were assumed for hospital emergency-based care as outlined below:

- +3.0% for physician and clinical services
- -0.5% for (emergency room) based care

Actual experience, driven by several variables including other policy decisions and implementation challenges, will result in variations to the assumptions described above.

Benefit Package Change

A significant design element of the single payer is adopting a standardized benefit plan, (aka benefit package). The single payer benefit plan and projections are based on the Oregon PEBB health coverage. The public employees benefit plan provides comprehensive health benefits coverage and is considered to have a more robust benefit plan than is offered through Medicare, average employer, or average individual coverage.

The baseline experience, except for Medicaid, includes a variety of benefit plans within each population. Developing an adjustment to account for the benefit plan change is limited based on the level of information available from the 2019 baseline data sources. The adjustment estimate assumes that 80% of the difference in per capita costs between populations represented in the baseline is attributed to the benefit plan. While the single payer will adopt the public employees benefit plan, Medicaid eligible individuals will continue to receive the Medicaid benefit package plus any services covered through the single payer benefit plan that are not covered by Medicaid. It is possible that Medicaid eligible individuals will have additional benefits, not covered by the single payer plan. Examples of these additional services includes early and periodic screening, diagnostic and treatment (EPSTD) requirements for children, benefits authorized through Oregon's 1115 demonstration, and nursing facility and home-and community-based long term care services for qualified individuals.

Impact

The 2026 estimates included increasing program expenditures by 2.0% for employer and individuals enrolled in exchange plans and 1.0% for individuals covered by Medicare. The aggregate impact of the benefit package change increased the total projected expenditures by 0.78% or $438 million.

Dental Benefit

The plan design of the single payer includes implementing standardized dental coverage, based on the mid-point or intermediate Oregon Public Employees dental benefit offering options, and is included in the single payer benefit plan. The dental benefit coverage is like coverage included in employer-sponsored, health benefits marketplace, and individual coverage. The dental benefit plan would be an enhancement to current Medicaid dental benefits and will include:

- Coverage for preventative and diagnostic care, minor and major (e.g., crowns, bridges, dentures, oral surgery, root canals)
- Limited orthodontia, subject to lifetime coverage limits
- Annual benefit maximums
- Eliminates out-of-pocket cost sharing
- Dentist reimbursement consistent with employer sponsored dental coverage.

2026 cost estimates were based on the projected per capita cost, excluding dental insurer administration and risk margin loadings similar to the cost of mid-level dental benefits covered in public employee benefit less existing dental related expenditures by coverage type. Expenditures for dental services are reflected in the 2026 baseline but vary by coverage type.

Impact

The estimated additional funding needed to provide the level of dental coverage included in the single-payer plan is $723 million.

Coverage for Uninsured Populations

The uninsured population in the 2019 baseline represents approximately 299,000 individuals, or approximately 7.2% of the population in 2019. Estimates of the size of this population vary. The American Community Survey estimated an uninsured rate of 7.2%.[14] The Oregon Health Insurance Survey estimated an uninsured rate of approximately 6% in 2019.[15] Current coverage rates have been artificially inflated by the public health emergency. For the purposes of the analysis, the more conservative estimate (7.2%) was used.

The uninsured population are not a homogeneous group and include populations who:

- Do not seek insurance coverage because they have low need or no immediate need for health care
- Have health care needs that go unmet due to the inability to afford insurance and do not qualify for or are willing to pursue Medicaid coverage
- Are undocumented immigrants

The cost adjustment reflected in the 2026 single payer uses 80% of the average per capita cost for hospital and physician services from the projected 2026 individual insured population.

Impact

The impact of covering the uninsured is a significant addition to the cost of the single payer, increasing 2026 expenditure estimates by 1.91% or $1.09 billion in CY 2026. The is only the incremental new costs associated with insurance coverage driven changes in utilization. Costs that were previously out-of-pocket expenses for the population would be covered through state revenue as well.

Unit Price Adjustments

Purchasing Power

Implementing the proposed single payer system will consolidate the current fragmented system of reimbursement resulting in an increase in price negotiation power. Theoretically, all health care related

[14] 2019-ACS-Factsheet-OR-and-US-f.pdf (oregon.gov)
[15] Workbook: Oregon Uninsurance Rates (state.or.us)

services could be impacted by price negotiations; however, for 2026 single payer estimates the Task Force focused on high-cost procedures, pharmaceuticals, hospital services, and durable medical equipment for adjustment.

Adjustments to pharmaceuticals included in the projection recognize limitations for greater discounting for Medicaid eligible populations due to the Medicaid Prescription Drug Rebate Program (MDRP). The MDRP; "Best Price", is defined as the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States.[16] States can also negotiate additional rebates on top of the federal program. These two factors result in Medicaid programs having access to better net pricing than private plans typically have access to, which is why the model reflects less opportunity for Medicaid than private plans.

The Best Price component of the Medicaid Prescription Drug Rebate Program serves as a constraint for other populations as well. Because a manufacturer's rebates in other states reflect the best negotiated price, manufacturers have a powerful incentive not to negotiate rates below the best negotiated price with Oregon's single payer system. Negotiating lower pharmaceutical prices could result in a nationwide increase in rebates with significant cost to the manufacturer. In consultation with Dr. Hsiao, a potential opportunity was identified where the state would waive participation in the MDRP, operate the purchasing of pharmaceuticals through an entity exempt from the Best Price provision, and renegotiate the price of all drugs separately. This strategy is theoretical and has not been tested by any state. It would require federal approval and implement necessary state infrastructure to renegotiate all drug rebates with all manufactures. Given these factors, the model does not assume the novel solution would be implemented during the forecast period but acknowledges it could be a potential solution in the longer term.

While the 2026 cost estimates assume cost savings associated through price negotiations, the success and level of savings will be dependent on infrastructure including extensive pharmacy and provider pricing analysis, utilization tracking, and rate negotiation teams to achieve the savings associated with this assumption. If the single payer does not operationalize the infrastructure, the savings assumed in the projection may not materialize. Potential savings are assumed to increase over time as infrastructure improves.

The assumed impact of this adjustment focuses on three primary services, pharmaceuticals, durable medical equipment, and hospital services.

- Pharmaceuticals 0% to -3%
- Durable medical equipment 0% to -3%
- Hospital services -1.0% to -3.0%

[16] 42 U.S.C. § 1396r-8 (c) (1)(C)

Impact

The unit price adjustments applicable to the above-listed services result in a reduction of 0.7% or $408 million in CY 2026.

Standardized Fee Schedule

The 2019 baseline reflects significant variation in the reimbursement by payer for the same or similar health care service. Medicaid reimbursement is the lowest, followed by Medicare, and commercial insurance reimbursement is highest. The 2019 baseline reflects the following variation in provider reimbursement relative to Medicare:

- Commercial insurance (employer sponsored / private health insurance) is approximately 170% of Medicare[17]
- Medicaid is approximately 85% of Medicare [18, 19]

The single payer system will eliminate this variation through adopting a standardized fee schedule for every covered individual in the single payer. The Task Force sought to maintain the aggregate level of provider reimbursement inherent within the baseline and projected to 2026 levels, $53.9 billion. To maintain the aggregate level of reimbursement and accounting for the compounding effects with other adjustments, the standardized fee schedule reflected in the projection is assumed to be 124% of Medicare.

A standardized fee schedule will uniquely impact every health care provider based on two elements:

- Their current level of reimbursement by payer
- Their payer mix (proportion of reimbursement from commercial, Medicare or Medicaid payers).

Based on these elements, some health care providers may experience increases to their total patient revenues, others will experience decreases, and some will not be impacted significantly. Transformation to the single payer system will require more comprehensive analysis and reevaluation of the level of provider payment for transition strategies that minimize disruptions to health care providers and ensure that the individuals covered have adequate access to care.

One benefit of a standardized fee schedule is a reduction in the amount of resources required by health care providers to manage multiple insurance payers related to reimbursement, practices, requirements (e.g., prior authorization), collection of patient cost sharing, and the submission of claims.

[17] https://healthcostinstitute.org/hcci-research/comparing-commercial-and-medicare-professional-service-prices
[18] Medicaid Hospital Payment - A Comparison across States and to Medicare (macpac.gov)
[19] Medicaid-to-Medicare Fee Index | KFF

Impact

In aggregate this change is zero overall because the re-balancing maintains the 2026 projected service (impact does not apply to administrative costs) expenditures of $51.8 billion. Commercial reimbursement will decrease 45.7%, Medicare will increase 24.3% and Medicaid will increase by 39.34%.

Provider Rate Change (Administrative Efficiency)

In the health care system today, health care providers dedicate significant administrative resources to manage and receive payment for their services through relationships with multiple insurance carriers and health programs. These administrative activities include negotiating contracts and reimbursement, adhering to a variety of insurance carrier requirements (e.g., prior authorization, or care management), preparing, submitting claims, resolving claims payment denials and reporting. Many of these administrative functions will be eliminated or their burden reduced through standardized benefit plan, fee schedule and uniform processes prescribed by the single payer. These savings can result in a variety of impacts in provider costs.

The adjustment to reflect health care provider efficiency was based on the following considerations:

- Approximately 13.0% of total patient revenue supports the billing and insurance related costs for health care providers on average with potential efficiency of 25.0% to 75.0%.
- William C. Hsiao, PhD, served as expert consultation on potential administrative efficiency savings. Based on his expertise and years of research in this area, he indicated that between 8-12% of provider costs can be attributed to the administrative burden of a fragmented multi-payer system and represent a savings opportunity when transitioning to a single-payer system. The actual efficiency gained by health care providers under a single payer system would be heavily influenced by how the single payer system plan is designed and operationalized. To achieve savings, Oregon will need to be committed to designing an administrative structure, including billing processes, that reduces the burden on the health care provider.
- Provider efficiencies should consider that it would take multiple years to fully manifest due to a combination of claims runout with multiple payers from the current system, completion of audits, quality measurement and payments under current contracts.
- Efficiency gains would vary by provider type, size, and other characteristics.
- The Expenditure, Revenue, and Analysis (ERA) workgroup indicated a policy of a 4% provider efficiency capture, which is half of the low-end estimate of potential provider efficiency gain under a single payer system.

As noted within the standardized fee schedule discussion, the projected aggregate 2026 provider reimbursement is $52.7 billion. Every 1.0% reduction to provider reimbursement yields a reduction of $527 million. The range of potential savings realized through consolidating to a single payer system is outlined in Table 7.

Table 7 – Range of Efficiency and Impact

Efficiency Gain Percentage	8.0%	12.0%
Fiscal Impact	$4.2 billion	$6.3 billion

Impact

The 2026 cost estimate for the single payer estimates reflects a 4.0% decrease in service costs (-3.71% in total costs) or $2.10 billion reduction for provider efficiency gains from the elimination of these administrative functions incurred in the baseline period.

Plan Administration

Fraud, Waste, and Abuse

Health care costs for fraud, waste, and abuse estimates vary widely, but are believed to contribute as much as 25% of total health care costs.[20, 21, 22] One contributing factor to fraud is fragmentation of payers as certain types of fraud may be easier to accomplish across multiple payers compared to a single payer due to the ability to perform statistical analysis on the broader data under single payer.

A single payer system will support the state implementing a program that leverages the comprehensive data set for which it will have access to implement fraud, waste, and abuse reduction. These reduction impacts will not be immediate. As the single payer is implemented, the current system will wind down. Efforts to develop practices to monitor, identify and implement will require the infrastructure to include prepayment review analytics and significant program integrity efforts. Additionally, once the single payer achieves maximum savings, additional savings will not continue to occur.

Impact

Considering the transition activities from current state to the single payer in the initial year and the required investment to develop monitoring processes, a 0.92% reduction or $529 million was applied across all populations and services in the single payer. It is important to note that absent a steadfast focus on fraud, waste and abuse, savings cannot be achieved.

Private Health Insurance Margin Elimination

The single payer system will eliminate private health insurance carriers that administer commercial, Medicare and Medicaid managed care programs. Insurance margin represents expenses incurred by insurance carriers to operate risk-based insurance contracts and includes elements such as risk margin, cost of capital and profit. Margin is not the administrative cost for insurance carriers which broadly includes member services, medical management, and claims processing, for example. Under the single

[20] 16 Devastating Medicare Fraud Statistics: How Bad Is It? (safeatlast.co)
[21] Why You Should Care About Healthcare Fraud, Waste and Abuse - Gray Matter Analytics
[22] Waste in the US Health Care System: Estimated Costs and Potential for Savings - PubMed (nih.gov)

payer, many of the administrative expenditures incurred by private insurance will transition to the single payer system administrator.

The health insurer margin adjustment reduces the projected 2026 administrative costs by 25%, the assumed portion of administrative cost.

Impact

Removing margin reduces aggregate 2026 expenditure projections by 1.33% or $758 million.

Administrative Cost Economies of Scale

The single payer system will be operated by the state. In this capacity, the state will be responsible for implementing necessary systems and processes to perform duplicative administrative functions that are performed by numerous insurance carriers in the baseline. Examples of these functions include eligibility, claims adjudication, provider credentialing, utilization management, and quality improvement and member services.

The administrative structure of the single payer has not yet been designed beyond this initial concept level. Extensive design work is necessary to identify, define, plan, and implement each function of the single payer with substantial consideration how the functions will be operationalized in order to refine administrative efficiency assumptions. Given the expansive scope, anticipated compliance requirements with federal regulations for different populations, the need to establish significant infrastructure to achieve the savings outcomes included in other sections (pharmacy, program integrity, etc.), efficiency savings are muted.

Impact

In aggregate for every 1.0% reduction in administrative costs would save approximately $40 million. Given the implementation costs required to implement the single payer system, the 2026 administrative cost is reduced by 0.5% which results in reduction of aggregate health care expenditures by 0.04% or $20 million.

Removing Private Health Insurance Marketing and Commissions

The baseline expenditures include administrative costs incurred by health insurance carries for marketing and licensed agents plus fees paid by insurers to insurance brokers. Insurance brokers represent consumers, (e.g., businesses or individuals), and facilitate the selection and purchase of health insurance by assisting purchasers and providing them guidance, information, and recommendations. When brokers facilitate the purchase of health insurance, they are reimbursed fees by the insurance carrier.

The single payer system will continue to incur some marketing and member engagement expenses, but these costs will not be present at the same level as in the baseline period. Costs for insurance brokers is expected to be eliminated from the single payer system. To determine the value of the anticipated

reduction in expenditures was based on Oregon-specific estimates available from Kaiser Family Foundation.[23]

Impact

In aggregate the impact of eliminating the marketing, agent and broker commissions will reduce total expenditures of the single payer system by 0.12% or $65 million annually.

Other Adjustments

Eliminating Premium Fees and Premium Taxes

Baseline health care administrative expenditures include premium taxes and other insurance assessments. The value of these expenditures is included in the administrative cost for insured populations (employer, individual, state, and federal government) covered through risk-based insurance carriers. Self-funded insurance programs are typically exempt from these taxes. Oregon assesses a 2.0% tax on health insurance premiums.

The premium tax today is a cost for all insured populations, this includes Medicaid managed care; however, Medicaid managed care is partially financed through contributions from the federal government. In Medicaid managed care, the federal contribution is leveraged for the premium tax inherent within Medicaid managed care capitation payments and generates additional federal dollars for the state.

The single payer system will not be subject to the premium tax. This will decrease total health care expenditures; however, with the elimination of the premium tax, Oregon will realize a reduction in tax receipts generated from the premium tax plus the additional federal dollars received for Medicaid through the federal contribution. Eliminating this revenue stream reduces single payer expenditure estimates and revenue collected in the baseline, and increases the funding need to backfill state revenues used for other programs.

In the model, Medicaid federal funding associated with premium tax is assumed to continue under waiver authority and revenues that would be lost outside of the Medicaid program are added as a cost to the model that would need to be backfilled through new taxes.

Impact

In aggregate the net impact of eliminating the premium tax and backfilling lost state revenue outside of the Medicaid program will reduce total expenditures of the single payer system by 0.4% or $226 million in CY 2026.

[23] Broker Compensation by Health Insurance Market | KFF

Single Payer Administrative Costs

After reflecting the administrative plan efficiencies discussed in the above sections, the 2026 projected expenditures reflect an aggregate administration cost of 6.06% or $3.25 billion. The administrative costs reflected are intended to support:

- Implementation (building) activities
- Transition activities
- Enrollment, including marketing and member services
- Finance, accounting, federal claiming, and reporting functions
- Contractor management (includes procurement for variety of external operational vendors)
- Provider and medical management
- Provider payments (claims processing)
- Analytics and population health
- Quality and expenditures to improve the population's health that are not direct medical services (potentially significant depending on the final program design)

The Task Force desires an administratively efficient single payer program and recognize that excessive administrative costs impact the total cost of the program and the revenue needed. Significant discussion about the administrative costs for the single payer occurred over multiple meetings with the Task Force. During these discussions the Task Force and Optumas addressed the following:

- Alignment to Medicare's administrative cost percentage
- Administrative cost percentage of health care programs in other high-income countries
- Single-payer implementation and operational costs
- Costs associated with winding down existing health care programs
- Federal reporting and operational requirements for administering the Medicaid program. Examples of these functions include adherence to emerging federal guidance, enrollment processes, expenditure tracking and reporting, quality evaluations, ongoing waiver demonstration, and directed payment monitoring.

Not all these points are directly comparable to the single payer context, for example Medicare administrative costs have recently been quoted between 2.0% - 4.0% but this is based on a Medicare per capita that is more than two times larger than the average per capita for private insurance. Additionally other countries with single payer systems who may report similar administrative cost percentages do not have the same administrative requirements that would be imposed on the single payer. The model constructs an estimate of the status quo administrative costs and incrementally adjusts the expected administrative costs based on isolatable factors (described in earlier sections). As the administrative design is further developed, the administrative cost assumptions should be reevaluated.

Single Payer Cost Estimates (2026 – Implementation Year)

Table 8 below summarizes the fiscal impact estimates on a 2026 basis. The cost estimates are on a total fund basis. In aggregate across all funding sources, the model projects an approximate 1 billion dollar decrease in expenditures in the initial year of implementation. It is important to note that individual impacts will vary significantly.

Table 8 – CY2019 and CY2026 Baseline Expenditure Estimates (in billions)

Coverage / Expenditure Type	2019 Expenditures	2026 Enrollment	2026 Status Quo Expenditures	2026 Single Payer Expenditures	Difference
Individual – Exchange	$996	155,846	$1,389	$729	($660)
Public Employees Other Than PEBB/OEBB	$2,842	422,071	$3,965	$2,068	($1,896)
Employer Sponsored Insurance/Other Individual	$8,657	1,353,366	$12,077	$6,371	($5,706)
Oregon Public Employees (PEBB)	$973	144,473	$1,357	$708	($649)
Oregon Educators (OEBB)	$730	140,107	$1,018	$531	($487)
Medicare	$9,420	822,923	$15,804	$19,501	$3,697
Medicaid	$9,936	903,944	$14,590	$19,631	$5,041
Children's Health Insurance Program (CHIP)	$448	135,354	$659	$331	($327)
Out of Pocket	$1,543	n/a	$2,056	$2,022	($34)
Uninsured	$1,208	314,722	$1,610	$2,652	$1,043
General Assistance (Charity Care)	$121	n/a	$161	$157	($3)
Community Behavioral Health (non-Medicaid)	$695	n/a	$919	$910	($9)
Sub Total Expenditure	**$39,082**	**4,432,700**	**$58,121**	**$55,613**	**$9**
Bottom Line Adjustment – Dental	n/a	n/a	n/a	$723	$723
Bottom Line Adjustment – Premium Tax Backfill	n/a	n/a	n/a	$396	$396
Bottom Line Adjustment – Provider Efficiency Capture of 4%	n/a	n/a	n/a	($2,106)	($2,106)
Total Expenditure	**$39,082**	**4,432,700**	**$55,603**	**$54,626**	**($977)**

Table Notes:

1. *Due to dual eligibility across programs, enrollment figures have been adjusted to avoid duplication resulting in skewed per capita calculations.*
2. *Medicare out-of-pocket is included in the Medicare total; out-of-pocket costs for programs and services not covered by the UHC plan are excluded.*
3. *Small differences in totals and differences may be present due to rounding.*

Single Payer Cost Estimates (5 Year Estimate)

Table 9 below summarizes the aggregate projection of status quo expenditures compared to expenditures under the single-payer system for CY 2026 through CY 2030. Table 10 summarizes the net aggregate impact of major assumptions by year.

Table 9 – 5-year Baseline vs. Single Payer Estimates (in billions)

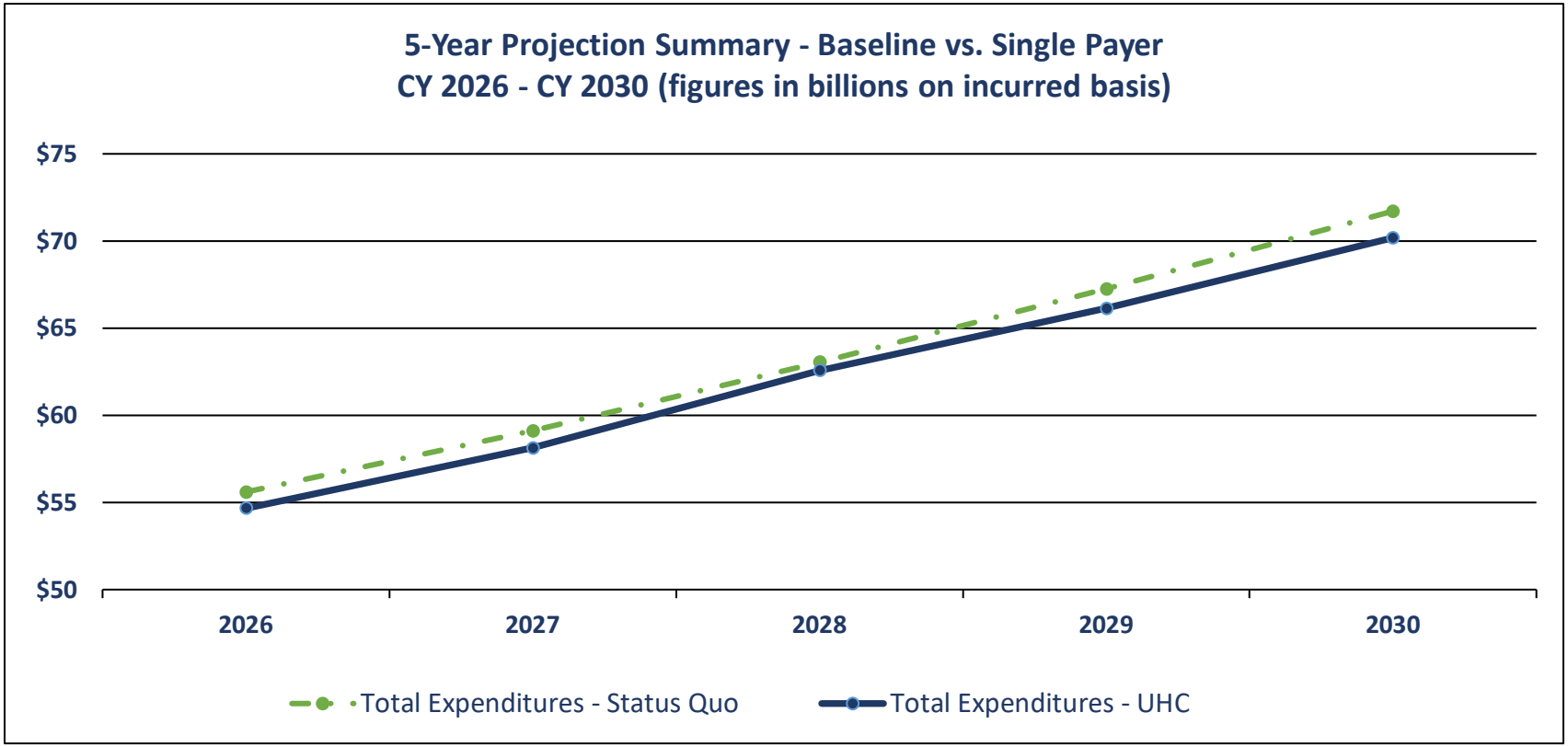
	2026	2027	2028	2029	2030
Total Expenditures – Baseline	$55.60	$59.11	$63.04	$67.24	$71.71
Total Expenditures – Single Payer	$54.62	$58.13	$62.58	$66.13	$70.18
Difference	**($0.98)**	**($0.98)**	**($0.46)**	**($1.11)**	**($1.53)**

Table 10 – Aggregate Net Assumptions for 5-year Projection

Assumption	2026	2027	2028	2029	2030
Utilization (Eliminate 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)	0.78%	1.07%	1.36%	1.36%	1.37%
Utilization (Uninsured Coverage)	1.91%	2.63%	2.56%	2.29%	2.10%
Unit Cost Change - Purchasing Power (Price Negotiation)	-0.70%	-1.55%	-1.57%	-1.57%	-1.57%
Unit Cost Change - Provider Rate Change (Administrative Efficiency)	-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 (Remove Private Health Insurance Margin)	-1.33%	-1.33%	-1.32%	-1.33%	-1.33%
Plan Administrative Efficiency (Economies of Scale)	-0.04%	-0.07%	-0.07%	-0.07%	-0.07%
Plan Administrative Efficiency (Removal Marketing and Commissions)	-0.12%	-0.11%	-0.10%	-0.10%	-0.09%
Other Adjustments (Removal of Premium Tax)	-0.40%	-0.40%	-0.42%	-0.42%	-0.42%

Figure 2 – 5-Year Projection

Figure 2 illustrates the 5-Year projection figures from Table 9.



Evaluating Revenue to Support Universal Health Care

Table 10, on the following page, compares revenue sources between the 2026 Baseline ("as is") versus 2026 single payer. The primary difference, as illustrated in the table, is that under the single payer system, contributions for health insurance coverage that are provided through employers, or the insurance marketplace are eliminated and replaced by employer payroll tax and household contributions in the form of a tax or premium contribution. Revenue projections reflect assumptions that Oregon will successfully capture expenditure contributions from the federal government and state and local.

The revenue estimates presented in Table 10 reflect the following major assumptions:

- Oregon will continue to receive premium subsidies available for eligible individuals who receive premium subsidies for health insurance purchased from the Affordable Care Act health insurance exchange / marketplace.
    - An adjustment to capture federal revenue for individuals that are eligible, but not receiving federal subsidies is included in the model. The estimated revenue associated with this adjustment is $299 million. The estimate is calculated as the total uninsured estimate from the model excluding an estimate of the undocumented population that are without insurance multiplied by the estimated percent that is eligible for premium assistance and the average subsidy per member.[24, 25, 26, 27]

- Oregon will continue to receive federal financial participation (federal match) for Medicaid and CHIP programs. **The model assumes that policies implemented in the single payer system that result in higher costs than the Medicaid upper payment limit would require contributions from payroll taxes that are not federally matched.**
    - An adjustment to capture federal revenue for individuals that are eligible, but not enrolled is included in the model. This is estimated as a $77 million revenue adjustment. Additionally, three months of retroactivity for this population is included for an additional $6 million adjustment, or $83 million in total. The adjustment is calculated as the estimated number of EBNE multiplied by the assumed uninsured per capita expenditure in the model, Universal Health Care growth factor and aggregate average Medicaid match rate from the model. [28]
- Oregon will receive Medicare funding from the federal government that is consistent with the baseline and program growth. This includes beneficiary Medicare Part B and Medicare Part D

[24] Key Facts about the Uninsured Population | KFF
[25] Workbook: Oregon Uninsurance Rates (state.or.us)
[26] Note the Oregon Insurance Survey overstates potential enrolled but not eligible because it does not account for undocumented immigrants lacking eligibility for subsidies.
[27] 2022 Obamacare subsidy calculator | healthinsurance.org
[28] The EBNE estimate was provided by a Taskforce member. Optumas did not find an Oregon-specific resource but was able to verify the estimate was of similar relative magnitude as other states where EBNE estimates were reported.

premium contributions.[29, 30, 31] **Policies implemented in the single payer system that result in higher costs than the baseline would require contributions from payroll taxes.**

- Oregon will continue General Fund budget appropriations to support health coverage expenditures for Public and Education employees including contributions from county and local governments. Non-General Fund revenues are assumed to be replaced with tax revenues. This policy was developed by the Task Force. Additional legal review is required.

- The household contribution and employer payroll tax will generate revenue lost through eliminating private health insurance covered in the Baseline through employer and employee premiums.

Table 11 –2026 Revenue Estimates (in billions)

Program / Population	2026 Baseline	Single Payer	Difference
Employer premium contribution	$12.47	$0.00	($12.47)
Charity	$0.16	$0.00	($0.16)
Employee / Individual Medicare premiums are only individual contributions under single payer	$12.63	$2.10	($9.52)
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	$0.88	$1.17	$0.30
State Funds and Household contribution and employer payroll tax	$6.35	$26.29	$19.93
PEBB/OEBB non-GF Revenue	$1.06	$0.00	($1.06)
Total Expenditures	**$55.60**	**$55.60**	**($0.98)**

Additional Modeling Considerations

Financial Reserve

The State of Oregon will bear 100% of the financial risks for health care reimbursement incurred by Oregonians in the single payer system. These financial risks are like those assumed by health insurers today but on a significantly larger scale.

The Oregon constitution, like most states, requires a balanced budget and tax collections must be sufficient to support expenditures in the fiscal year.[32] The state will have to establish significant financial

[29] Average Cost of Medicare Part D | 2022 Medicare Prescription Drug Plans (medicareadvantage.com)
[30] https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldatamonthly/monthly-enrollment-state-2022-04
[31] A Simple Change To The Medicare Part D Low-Income Subsidy Program Could Save $5 Billion | Health Affairs
[32] https://www.ncsl.org/research/fiscal-policy/state-constitutional-and-statutory-requirements-fo.aspx#or

reserves for the initial years of the single payer to accommodate expenditure obligations that exceed revenue collections. The financial reserve will need to be established to ensure ongoing operation of the single payer for unplanned or expected circumstances. Specifically, these include the following:

- Expenditures associated with costs incurred in periods prior to the implementation of the single payer, often referred to incurred but not paid liabilities. These can include outstanding payments for contractors, health care costs for Medicaid fee-for-service populations, premium payments for state employees, recoupments by the federal government for prior period federal match contributions.
- Expenditures that are incurred and payable during the operation of the single payer that have significantly deviated from projections and other unforeseen outlier events.
- Tax revenue collection shortfalls.

Assessing and establishing the level of reserves needed will need to include identifying all potential liabilities incurred prior to the single payer, and the probability and costs of outliers that may occur during the single payer operations.

The Optumas model is a budgetary projection, not actuarily sound rates for the population with quantifiable confidence intervals. Absent utilization data that can be analyzed for variation over time, trend, outliers, and other elements of the financial design, Optumas is not recommending a specific risk reserve amount. The Oregon Division of Financial Regulation regulates insurer capital and surplus requirements for the state. The standards used by the Division are established by the National Association of Insurance Commissioners. These standards account for several factors and assets categories that serve as an input into the risk-based capital standards.[33] Multiple factors that contribute to the risk-based capital and surplus calculation have not yet been developed (e.g., is the fund held in a trust that is invested and rolls over from year to year or funded through annual state appropriations?). As the state's financing, investment, and model development progresses, the state will need to leverage the Division of Financial Regulation to assist in determining appropriate surplus reserves.

Population Coverage Considerations

Border Employees

The Task Force contemplated extending coverage to employees that live in border states but work in Oregon. The size of this population and their dependents is estimated to be 286,751, which is based on a combination of public reporting by the Oregon Employment Department and the average dependent rate found in the PEBB program.[34]

The total costs of including this population in the model were estimated to be $2.55 billion. Including this population impacts the cost estimate for all other populations to pricing normalization; consequently, prior reporting of the cost for this population when included in the model are different than the estimated costs when it is removed.

[33] Division of Financial Regulation : Financial regulation : Annual health insurance report : State of Oregon
[34] Oregon's Nonresident Workers - Article Display Content - QualityInfo

Medicare

Members of the Task Force expressed interest in understanding the impact of removing Medicare from the model. Including Medicare in the single payer system raises several unique challenges. These include maintaining infrastructure to comply with oversight and reporting requirements for the population, identifying equitable mechanisms to preserve current Part B and Part D premium contributions, and calibration of tax policy to ensure equitable tax treatment for individuals that are working and receiving Medicare.

The revised new revenue need, when removing the Medicare population, is approximately $18.4 billion. This includes removal of savings from the provider efficiency capture and removal of additional new costs for the dental benefit. It is important to note that this revenue need also assumes removal of the border state employees. Changes to other population assumptions could impact the cost of including or excluding Medicare due to interaction effects.

Transforming the current health care delivery system to Universal Care and a single payer should also address Medicare's unique populations and coverage considerations including the following dynamics of the Medicare program:

- **Medicare Coverage Elements – Part A (earned), Part B (optional), Part D**
    - Part A which is earned based on taxes paid while working. Beneficiaries who are entitled to Part A do not pay a monthly premium. Those who are not eligible to receive Part A premium free can pay for coverage monthly. Those who are not entitled to Part A must purchase Part A when first eligible, (usually at 65 years old) or may be subject to pay a penalty when enrolling after they are eligible.

    - Part B provides coverage for services including physician, outpatient care, laboratory, radiology services not covered by Part A. Coverage for Part B is optional; however, financial penalties are levied for late enrollment in Part B coverage.

    - Part D provides for prescription drug coverage to eligible Medicare beneficiaries. Coverage is available only through private companies. Most Medicare Advantage plans (Part C) have prescription drug coverage or coverage is available through prescription drug plans. Those who do not enroll but could have enrolled are subject to penalties.

- **Choice (fee-for-service delivery, supplemental coverage, and Medicare Advantage)**
  Currently Medicare eligible beneficiaries who are eligible for Parts A and B have an option to receive Medicare via fee-for-service, (Original Medicaid), which is often combined with supplemental insurance coverage plan obtained through private companies. Part D, drug coverage is obtained through a Medicare drug plan.

  Alternatively, Medicaid eligible beneficiaries may elect to enroll in Medicare Advantage who receive care, including Part D, through a managed care organization. Single payer will eliminate these options and choice may be eliminated.

- **Part time or seasonal residents who may reside in a different state during the year**
  Some residents may live outside Oregon for some portion of the year. This creates a unique situation where an enrollee in the Universal System may incur non-emergency health care costs outside the state. These services would not be rendered by Oregon single payer contracted providers which means that payment for health care services provided may also include financial liability for the beneficiary for charges billed by the out-of-state provider that exceed payment from the Oregon single payer system.

ACA Coverage Requirements

A question was introduced by the Task Force about Affordable Care Act (ACA) requirements related to coverage requirements for dependents under the age of 26. This question will need to be explored further since the ACA dependent coverage applies only as an option under certain circumstances and that circumstance may be eliminated as part of negotiations with the federal government for the single payer system.

It is unclear if Oregon would be required to provide coverage and, if so, to whom.

- The first concept is about providing health care coverage for financial dependents that live out-of-state (dependent children and dependent relatives). It is reasonable to assume this is a small population due to how financial dependency is defined. Undergraduate students will use their parents' address as their permanent address and are therefore included in the state population and coverage estimates.

- The second concept is about covering the ACA mandated population that is living out-of-state, which is a completely different but overlapping cohort (you don't have to be a financial dependent but can remain on parent's insurance until 26). For this second group, it could be quite large. This latter group warrants additional conversation. Specifically, the Task Force would need to break the population out into different scenarios and decide if it is their intent to provide coverage under that scenario or if they would assume waiving coverage requirements. A blanket assumption of coverage would result in Oregon paying for individuals that would otherwise be covered by other state Medicaid agencies at a cost to other states and would likely result in significantly greater coverage of out-of-state children of Oregonians than occurs under the status quo.

General Federal Funding Considerations

A key assumption underlying the expenditure revenue projections presented in this report is that Oregon can continue to receive federal contributions for Medicaid, Medicare, and federal health insurance exchange subsidies. Discussions need to occur with CMS and other impacted federal partners to understand flexibilities, limitations, steps and process for implementing Universal Health Care. Based on guidance, the expenditure and revenue projections may need to be re-evaluated and revised.

Appendix C **Proposed Universal Health Care Tax Examples**
Legislative Revenue Office (LRO)

Proposed Universal Health Care Taxes

The funding mechanisms considered by the Task Forces are truly a first step. There are several caveats and limitations for stakeholders to keep in mind when considering such a transformative change. To start, these two funding mechanisms, a payroll tax and an income tax, address different aspects of the funding needs. In some ways, the payroll tax is simply a direct replacement of employer-paid health insurance with an employer paid tax. This is a fundamental shift from an employee benefit driven by market forces to legally required payments to the state. Depending on a given employer's situation, any such payroll tax may be more or less than any existing health insurance payments. The proposed income tax may look similar to the existing personal income tax but has some notable differences.

Income Tax

The income tax base for the Universal Health Care Income Tax (UHCIT) is Total Income reported on a taxpayer's federal income tax return minus Social Security income (exempt from tax by Oregon's constitution) and tax-exempt federal pension income. Total Income includes: wages & salaries, interest & dividends, pensions, capital gains, business, rental real estate, and other forms of income. It does not include any deductions from these sources of income.

Income Tax Brackets and "Quasi" Federal Poverty Level

The UHC Task Force requested universal health care income tax proposals to be based on a marginal income tax bracket structure utilizing federal poverty level. The policy intent is for the marginal tax rates to increase as a household's income increases, as compared to federal poverty level. Two sources from which to base poverty level are the poverty thresholds updated each year by the Census Bureau and the poverty guidelines which are updated annually by the US Dept. of Health & Human Services. Generally, the poverty guidelines are used for administrative purposes such as determining financial eligibility for certain programs.[1] The poverty guidelines vary by family size. The 2022 poverty guidelines are displayed in the table to the right.

2022 Poverty Guidelines				
HH Size	FPL	200% FPL	300% FPL	400% FPL
1	13,590	27,180	40,770	54,360
2	18,310	36,620	54,930	73,240
3	23,030	46,060	69,090	92,120
4	27,750	55,500	83,250	111,000
5	32,470	64,940	97,410	129,880
6	37,190	74,380	111,570	148,760
7	41,910	83,820	125,730	167,640
8	46,630	93,260	139,890	186,520

The poverty guidelines are based on a concept of household income which can differ from the income reported on a tax return. Different sources of income are utilized when describing household income for poverty guideline purposes as compared to income used for personal income tax purposes. For UHCIT modelling purposes, quasi federal poverty level (QFPL) was used. The basis for QFPL is the federal poverty guidelines, however, QFPL differs from FPL in that QFPL applies the federal poverty guideline amount at the tax unit level rather than a household. For a tax unit, household size is based on the number of individuals and dependents claimed on the tax return. For example, a mixed generational household comprising two married individuals with two dependent children and a non-dependent grandparent would be two taxing units (married filing jointly with two kids, and one single filer return) with QFPL household sizes of 4 and 1 respectively (whereas the household size for FPL purposes is 5).

[1] See https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Payroll Tax

The payroll tax base is comprised of two parts, one based on employee wages paid by employers (tax base identical to Oregon's unemployment insurance tax base) and a tax levied on self-employment income. The proposed tax brackets and rates are imposed on self-employment income as reported on IRS Schedule SE (existing self-employment income tax base). Both the wages and self-employment portions of the payroll tax base are subject to the same tax brackets and rates. The tax base of wages includes both private and public sector employers and excludes federal employees.

Revenue Estimates

The revenue estimates contained here are based on baseline forecasts made in 2022. Economic forecasters are projecting, with varying degrees of probability, a possible recession within the next year or so. Any changes to the projected economic landscape could have a significant effect on the revenue estimates. The payroll tax is comprised of two marginal tax brackets as displayed in the table. Payroll bracket is based on wages paid and self-employment (SE) income paid to an individual, meaning the first $160,000 in wages and/or SE income paid is subject to a 7.25% tax rate. For example, if an individual were paid $200,000 by an employer, then the first $160,000 in income is subject to the 7.25% tax rate with the remaining $40,000 taxed at 10.50%.

Payroll Tax	
Payroll Bracket	Tax Rate
< 160K	7.25%
160K+	10.50%

The proposed income tax also uses a marginal tax rate/bracket approach. As displayed in the table, brackets for the income tax are based on a taxing unit's income as a percent of FPL. A taxing unit is comprised of all individuals on an income tax return. For taxpayers with income below 200% of FPL, no tax is imposed as the tax rate is 0%. For taxpayers with income exceeding 200% of FPL, the first 200% of income is subject to the 0% tax rate, with remaining income subject to the increasing marginal rates.

Personal Income Tax	
Income as Pct. of FPL	Tax Rate
< 200%	0%
200 - 250%	1.00%
250 - 300%	1.75%
300 - 400%	2.50%
400%+	8.20%

The table below displays the estimated tax revenue in 2026 for the respective taxes. Combined revenue in 2026 is estimated to be $19.9 billion.

Estimated Tax Revenue - 2026	
Payroll Tax	$12.3
Income Tax	$7.6
Total	**$19.9B**

It's important to note that these estimates are "static estimates". This means that other changes to the state economy and behavioral responses are not incorporated here. Restructuring the health care system would be a significant change to the Oregon economy. As context, according to the Center for Medicare and Medicated Services, national health expenditures accounted for 19.7 percent of U.S. GDP in 2020. To explore and better understand the full impact of changes to the health care and revenue systems, what is known as a "dynamic analysis" is required. With a broad goal of better health outcomes for Oregonians at a lower cost (compared to current expenditures), the potential consequences and impact on economic efficiencies could be significant. Presumably, increased access to health care should lead to improved health outcomes, collectively speaking. As the policy discussion and debate move forward, it would likely be of significant interest to explore what such a dynamic analysis could contribute to the policy discourse. Undertaking such an analysis would presumably be predicated on broad agreement for any new funding sources.

As for the proposed income tax, the top rate included here is 8.2 percent. If combined with the top tax rates of the existing personal income tax, the combined top income tax rates would be 18.1 percent (8.2%

plus 9.9%). A comparative impact of state revenue systems would likely be of interest to a variety of stakeholders.

Lastly, given that these revenue sources are meant to help the conversation move forward and may be considered examples of a sort, administrative considerations and revenue volatility should not be ignored. The administrative costs of these systems are not expected to be significant compared to the revenue raised, but some attention should be paid to potential consequences. For example, if a new income tax were to be adopted, stakeholders would likely want to know of any potential implications for the existing personal income tax. Similarly, Oregon currently has multiple statewide payroll taxes, including Unemployment Insurance, Workers Benefit Fund, Paid Family Medical Leave (beginning 2023), and Statewide Transit Taxes.

Appendix D **Phase One: Group Discussion Research Synopsis**
Lara Media Services

Joint Task Force on Universal Health Care Study

Group Discussion Research Synopsis

Lara Media Services
April 22, 2022

Table of Contents

Introduction

In 2019, the Oregon Legislative Assembly passed Senate Bill 770, which established the Joint Task Force on Universal Health Care (Task Force). The Task Force is charged with recommending a universal health care system that offers equitable, affordable, comprehensive, high quality, publicly funded health care to all Oregon residents. The Task Force began meeting in July 2020 and submitted an interim status report to the Legislature in June 2021. As a result of an extension granted under Senate Bill 428 (2021), the Task Force will submit their final recommendation for a Health Care for All Oregon Plan no later than September 2022.

The Task Force's goal was to hear from historically underserved communities, including Black, indigenous, people of color, rural, people with disabilities, and mental health issues. They wanted to hear and understand their views, opinions, hopes, and challenges related to meeting their health care needs. They hired Lara Media Services (LMS) for their just, equitable, inclusive, and culturally responsive approach and research techniques. LMS is a certified MBE, WBE, DBE, ESB firm (Certification #7923), and B-Corp. LMS is Latina-owned, and 100% of the team is multicultural and multilingual. Together, the Task Force and LMS have a shared commitment and passion for amplifying and understanding the voices of the communities that are most often neglected.

Systemic racism and generational (social, economic, political, and environmental) inequities result in poor health outcomes. Systemic racism has a detrimental effect on the quality of care that communities of color receive. Additionally, access to healthcare and health care outcomes are worse for communities that live in rural areas. Health Care should not only be accessible to all Oregonian residents, but it should be well funded, comprehensive, and culturally responsive. Participants were resoundingly clear when they expressed that they reject (or don't want) the same access to 'Affordable Health Care' some are receiving now. They want health care where nobody is excluded due to their background, location, ethnicity, racial identity, gender, religion, or lack of documentation. They seek health care where systematic racism is eliminated through adequate funding and policies that center people, prioritize health equity, and offer community-driven approaches. Affordability without equity will multiply the painful and negative outcomes they are experiencing now.

This report summarizes the core findings and data gathered in the first phase derived from the outlined methods. It presents these findings in a logical sequence.

Goal

LMS' goal was to gather qualitative data from the Task Force's target audiences about their health care needs, experiences, and barriers when receiving health care and report the findings to the Task Force.

Methodology

LMS coordinated, conducted, and facilitated focus groups for this project. Focus groups are exploratory research methods that provide vast qualitative data. This method is used when exploring issues in-depth and understanding thoughts, feelings, challenges, aspirations, and aspirations. LMS encourages participants to be fully engaged and empowers them to let their voices be heard. Trust is built throughout the session, as each person's opinion is vital. LMS aims to have diverse participants to capture the sentiment of multiple perspectives.

These are our methods.

1. LMS and the Task Force identified priority audiences and essential considerations to develop the discussion guide.

    a. Geographic Region included:
        i. Coastal Region
        ii. Central OR
        iii. Eastern OR
        iv. Southern OR, including the Lane County/Willamette Valley region
        v. Portland Metro Area/Salem/Woodburn/Marion
    b. Demographic Diversity included
        i. Latinos/as/x that speak Spanish
        ii. Blacks and African American
        iii. Native Americans
        iv. Pacific Islanders
        v. Oregonians needing disability services and long-term care services
        vi. Oregonians who navigate the behavioral health system
        vii. Rural Oregonians
2. The Ad Hoc Public Engagement Workgroup drafted question topics and developed the questions.:
    a. Affordability
    b. Coverage
    c. Eligibility
    d. Enrollment
    e. Governance
    f. Financing
    g. Social Determinants of Health (SDOH)
    h. Provider participation
3. LMS and the Task Force developed a discussion guide including topics and expected outcomes.
4. Priority audiences were invited to participate in the discussion.
    a. Monday, January 31, 2022, from 5:30 pm – 7:30 pm
        i. Latino/a/x (conducted in Spanish)
        ii. Black and African American

   b. Tuesday, February 1, 2022, from 5:30 pm – 7:30 pm
      i. Pacific Islanders
      ii. Native Americans
   c. Wednesday, February 2, 2022, from 5:30 pm – 7:30 pm
      i. Rural Oregonians
      ii. People with disabilities and Long-term care needs (English)
         1. People with disabilities and Long-term care needs (Spanish)
   d. Thursday, February 3, 2022, from 5:30 pm – 7:30 pm
      i. People with Mental and Behavioral health needs (English)
      ii. People with Mental and Behavioral health needs (Spanish)
5. LMS recruited participants for each group. LMS found participants through social media, with the help of community advocates, and through existing relationships with the community built over the last 20+ years. LMS contacted over 150 potential focus group participants
6. For confirmed participants, LMS offered to lend tablets if participants needed electronic devices. Upon registering, one (1) requested the use of a device. LMS also offered Zoom Video conferencing training to all participants who requested assistance; three (3) requested.
7. LMS coordinated and virtually hosted and facilitated seven (7) focus groups
8. This report summarizes the information gathered in the focus groups.

Focus Group Participants

Spanish

The group was composed of ten Latinx participants. The regions represented were: Coastal region (Lincoln County), Eastern region (Umatilla, Malheur), Mount Hood and Columbia River Gorge region, Southern region (Jackson County), and Portland Metro region (Multnomah, Yamhill, Washington)

Black & African-American

The group was composed of eight Black and African participants living in the Portland Metro region (Multnomah, Washington.)

Pacific Islander

The group was comprised of ten Pacific Islanders from the Portland Metro Region (Clackamas, Marion, Multnomah, Washington)

Native American

The group was composed of nine Native Americans. The regions represented were Coastal Region (Lincoln), Central (Deschutes), Southern (Lane), and Portland and Salem Metro region (Marion, Multnomah).

Rural Communities

The group was composed of five Oregonians. Three participants identified as Latinx, one identified as white Caucasian, and one identified as Black. The regions represented were four from the Eastern region (Grant, Malheur, Umatilla) and one from the Southern region (Klamath).

People with Disabilities or Long-term Care Needs

The group was composed of nine participants from the Portland Metro region (Clackamas, Marion, Multnomah, Washington.) Five identified as Latinx, one as Asian, one as African American, and two as biracial (Irish and indigenous, Black and Caucasian)

People with Mental or Behavioral Health Needs

The community discussion consisted of eighteen participants. LMS broke down the group into two groups, English and Spanish. The English group consisted of eleven Oregonians from Mount Hood and Columbia River Region, Portland Metro (Clackamas, Multnomah, Washington), and the Southern region (Lane). Three participants identified as Asian, one as Pacific Islander, three as Latinx, three as White, and one as Biracial (Indigenous and African American).

The Spanish group was composed of seven Latinx individuals from the Eastern region (Umatilla), from the Southern region (Jackson), and the Portland Metro region (Multnomah, Washington.)

Findings

Affordability

- “Affordability means the ability to pay for or care and interventions without having to consider things like whether you are able to marry or… need to divorce someone to access care where one doesn't have to choose between pain, rent, food utilities, or access to appropriate medical intervention or care.” - Mental and Behavioral Health Group Member.

When discussing affordable healthcare, participants' responses tended to be very diverse and covered a whole spectrum of experiences and approaches to affordability. Participants' responses, for example, ranged from 'affordable health care is free healthcare' to 'everyone

should pay based on what they make, and their situation allows.' Similarly, their recent experiences with healthcare also cover a broad spectrum, from affordable to downright impossible to pay off. Participants' emotional reactions to this question followed a similar trend. Some trusted that affordable health care for people like them as possible. In contrast, others expressed utter disbelief that the powers that be would ever make this fundamental right possible for people with their histories and backgrounds. Many were also caught in the middle, with all participants offering distinct and dissimilar views.

Most participants defined affordable health care as not having to worry about paying their health care bills, whether because they would not have to pay or there would be a flexible and affordable payment system. Many expressed confusion about the idea that the healthcare program would not have “premiums, co-pays, deductibles, or any other form of cost-sharing to access care.” Overall, there was some hope but a larger sense of disillusionment with the system.

- “I’m not doing bad with paying when I go have a doctor’s visit, but it’s not the best. It could definitely be better. I can't really say what's affordable. What? $5 a visit would be affordable, I guess. But, the high deductibles [are] what I'm working with right now, which makes me think about, do I really wanna go to the emergency room? Do I really need this ambulance ride before I actually do it? Because I’m worried about the high deductibles and what that bill's gonna look like.” - Black and African American Group Member

A core theme throughout the session was the financial burden that many health care services pose to participants. The affordability of services depends on available funds. Many participants echoed the sentiments in this quote, “you only get the care you can afford, not what you need.” The current affordability limitations commonly result in people picking and choosing what services to access. Parents might sacrifice their health to ensure their kids have access to healthcare, or an individual might avoid all but the most necessary of services. Costly medical attention often results in people only using their healthcare for the gravest of illnesses, not knowing that their health issues would have been easily preventable had these individuals received preventative care.

Consequently, many participants believe that what people pay should be based on how much they can afford to pay. They wish to see a “more human side” to the healthcare system, where people's situations are considered. Affordability, they say, is different for everyone. The Task Force is asked to take all of the financial stressors many people face in their daily lives into account. Rent payments, family situations, and the general cost of living pile up. Many people are not left with enough money to pay for essential medical treatment and medications. Many participants believe that healthcare is a “fundamental human right, not a privilege.” The majority believed it should be free, especially for those who have trouble meeting their basic health needs. They were clear in their desire for the system to include treating people with preexisting conditions, grievous health issues, severe illness, disabilities, or those requiring emergency care who would otherwise be unable to access it properly.

Participants want a healthcare system that will meet their needs, dignify them, and provide good quality care which does not penalize them for their current circumstances or ability to pay. Many have to pay high prices for insurance that only provides them limited coverage and does not allow them the coverage of care they desperately need.

Individuals who do not have access to services such as the Oregon Health Plan (OHP) have struggled to retain relevant access to health care services. Many cannot access adequate insurance, making too much to be put on low-income programs like OHP or rely on community health clinics, but do not have enough to purchase private health care coverage. This often leaves them in a difficult middle ground having to pay for treatment out of pocket and struggling to earn enough to cover their premiums. Or inversely, leave them limiting their income to access a health care plan, such as those with disabilities or mental health issues.

Those who rely on OHP face discrimination from healthcare providers and colleagues alike for their type of healthcare. This type of stigma can be damaging. Their treatment has led several to believe they have a lesser version of the healthcare others experience. They, too, wish to feel like they enjoy the same quality of care everyone else seems to receive. Many others hope that this program will provide people with the high quality and low-cost care they deserve, providing more far-reaching and equal care that meets their basic needs.

Some suggested that insurance companies and providers allow their clients the flexibility to pay back the cost of their care in multiple low-level installments or give them multiple options to choose a payment system that works for the individual. They believe this will lessen the effect and stress that any payment may have on an individual, allowing people to feel less of a financial burden when accessing their healthcare, maybe freeing them to use their coverage more consistently.

Participants also suggested lowering the price of medication and healthcare premiums. They believe these are some of the most common financial stressors people face when paying for their healthcare. Many people don't want to pay or can't cover the costs of prescriptions without sacrificing other essential expenses.

Coverage

The variety of services that need to be covered is comprehensive. They are unwilling to resort to limitations, arguing that every type of health care needs to be included. Participants agree no one person will require the same type of care, and those needs differ by age, race, location, etc. If one group of people or needs is prioritized over another, many participants fear the community's health will suffer.

- “We need to have the same quality of healthcare across the board. It can't be that the people of color or the native communities get the like brand-new people outta school or people who are outdated, that everybody gets the same quality of care as everyone. And

> that we get a universal like medical, I mean, for your dental, your eyes, everything, not just one thing. And we shouldn't have to go get referrals cuz that takes months, sometimes weeks. Cuz if the insurance gets the wrong paper, I've waited three months to try to even get an appointment for physical therapy. I think it's, they just need to care about the people and give us the best quality, not like the rich get the best doctors and the poor get the crap. I, it shouldn't be like that should be just equal across the board for me." - Native American Group Member.

Participants advocated that coverage be extended to many different types of healthcare services under this new program, especially those participants believed to be essential parts of health care, such as dental, vision, and hearing; all services commonly used by a large part of the population. Other services, such as family planning, fertility services, and testing services, were also requested by some participants because these services can at times be costly and hard to access. Several also felt that they could easily be considered preventive services as both types of care can profoundly impact people's long-term health. Many believe that natural and alternative medicine should be considered when determining which health care services are covered under this new program. Several communities rely on alternative healthcare options for culturally acceptable healthcare services. Participants believe that including them under the program's coverage will help people obtain more culturally appropriate care and help normalize the beliefs and practices of diverse communities often underrepresented in western medicine.

- "Now that I am just strictly an OHP patient, there are certain things that I had for being an OHP like dental, I think, is something that we overlook all the time. And actually shouldn't be because like one of the main leading risks for heart attack is actually dental cavities. You know, like so teeth and eyes are just not expendable, you know like, and but most of the time, in terms of affording for health care they are treated as such." - Pacific Islander Group Member.

Many participants claim that they have little idea of the services and care available through their current providers because the information was not well explained. They believe that some services already provided by healthcare insurance companies have workarounds to make things more affordable. Still, they are often inaccessible because people often don't know how to ask for the help they need, or insurance companies aren't willing to provide this to them. Coverage clarity can be a big issue for those needing expensive/specialized care or medication. They usually do not understand the process medical offices undergo to get specific treatments and prescriptions covered, making the process frustrating and overwhelming. They believe that more resources should be made available for clients to understand better the health insurance system and better advocate for the care they need.

However, some participants made concessions, believing that if care is limited, those with the most access to services should be the most vulnerable communities among them, prioritizing groups such as the elderly, the disabled, families, and young children. Others disagree, saying that the only limitations should be cosmetic treatments or that the program should operate at a loss rather than limit the care of any person. And still, others argue that all residents should be

provided with essential and preventative healthcare services but be allowed to choose from among the range of services that will and won't be covered to best tailor the care received to individual needs.

Many participants also requested more coverage for compound and standard medication, long-term care, and chronic diseases (diabetes, cancer, and asthma). Medication is closely tied to the theme of long-term and chronic disease and often is one of the most significant expenditures related to treatment. Thus, many people find medication expensive, especially long-term or compound medication. These are some of the most common forms of health care needed by the public. Many health plans only offer partial coverage if they offer the service. As a result, many participants struggle to pay for medications they urgently need, making it one of the most necessary forms of coverage requested by Oregon's new health plan. Participants also requested complete coverage for those services to benefit those put in difficult, stressful positions by heavy financial burdens at a time of significant physical and emotional vulnerability. They believe that this new universal health care program should make specialized and emergency services more widely available and affordable for all.

However, out of all the healthcare services recommended for increased coverage, the most prevalent was mental health. Many communities feel that mental health has been stigmatized by their and other cultures for far too long. People need a holistic health system, but mental health is commonly ignored, and this ignorance and stigmatization can cause more damage to those suffering greatly from its effects. This is especially true in recent times when circumstances surrounding COVID-19 and the increasing houseless population have increased depression and social isolation. It has also become more critical in an increasingly multicultural society where the differences in cultural backgrounds, experiences, and intergenerational trauma have collided, causing emotional turmoil in the lives of immigrants and their children due to differences in experience and emotional burdens.

Eligibility

Eligibility was a big concern for many participants, especially those who have and have had difficulty accessing healthcare. The biggest issue that participants brought up was the struggle of undocumented immigrants to gain access to the health care system. Since they are considered unlawful non-citizens of the United States, many are scared to show any kind of personal information for fear of alerting the authorities to their presence in the country. Thus, they are left without protection. Because of their migratory status, others have been discriminated against by service providers or subjected to expensive and low-quality care. Participants do not believe that status should dictate a person's eligibility for Oregon's new health care program. They advocated that as long as a person is a contributing member of society and can pay taxes, there is no reason anyone living in Oregon should not have access to comprehensive healthcare.

- “I, I wonder if, um, eligibility would also include folks who don't have documents, right? Like, undocumented folks are folks who might be houseless and, for whatever reason,

> don't have those documents… and might not have Oregon residency, but they're, they're here. If they show up at an ER, are they gonna be taken care of, so I guess I'd be curious like how we define eligibility as well." - Mental and Behavioral Health Group Member.

Some believe the best way to avoid this issue is to enforce less stringent eligibility requirements; this will help specific groups (houseless) when accessing health care services, while a few participants fear that lessening requirements will result in the system being abused by others. These participants are worried that people from neighboring states will attempt to/fake Oregon residency to access the free health care available for all Oregonians. Some suggested using proof of residency as an eligibility requirement. Others believed that determining the proper allotment of time before residents became eligible for Oregon's health care program became difficult if residency were to be used as a requirement. People might find it difficult to get urgent care or address emergency healthcare needs if pushed too far.

Others suggested that the DMV Identification (ID) system should be used as an eligibility requirement in addition to or instead of proof of residency. In most cases, opinions on using the system varied and were similar to those on proof of residency. Some believed that utilizing IDs would be beneficial as most people could produce them (Drivers license, tribal ID, Oregon ID, etc.). Others were against the system claiming that licenses and IDs are problematic because not all communities can produce or obtain them for various reasons. Another idea was to have those eligible or enrolled in the program receive a unique form of ID that would allow them to access the Task Force's new health plan, and similar to rolling over those already enrolled in healthcare, rollover people's IDs from the DMV and other organizations.

However, throughout this discussion, there seemed to be an inherent confusion about who qualified as "everyone residing in Oregon, regardless of employment, income, immigration status, or tribal membership." Even when participants wished to see a system where everyone had coverage and no one was discriminated against based on status, race, residency, or income, they were hesitant to believe that everyone would be eligible for the new health care plan.

Their main concern was that the system would be flooded by Oregonians wishing to receive medical attention with eligibility standards lowered, making it more difficult for anyone to use services with providers being overwhelmed by patients. This is a particular worry for communities with limited access to providers, as they worried that their small number of service providers would be quickly overwhelmed. Potentially, this could cause them, and eventually many Oregonian residents, to have to travel long distances or even out of state to receive necessary health treatment. This ordeal would all but invalidate the system the Task Force is now trying to introduce. Others worry that the system will be slow and ineffective at dealing with many participants. Or additionally, as a result of so many people in need of medical attention, the quality of services would drop, providing widespread but inadequate healthcare.

- “I think that's where we start talking about equity… I guess just the political side of me when you say, you know, everyone, regardless of income or employment or anything like that. While I think that would work in an ideal world economically, I don't see that [as] very feasible… and I'm concerned that that might overwhelm our healthcare personnel if everybody's covered.” Rural Group Member

These concerns raised questions for many participants looking to understand better how the Health Care for All Oregon plan would be intended to function and what measurements they would take prior to prevent failure and more damage to their communities. Many did not wish to be rushed into accepting a system they were unsure would even work to their benefit and would continue harming their families and communities.

Some questions from the participants included:

- Would the program's eligibility be based solely on residency? Or would all willing participants also be required to fill out an application of sorts before their eligibility could be considered?
- Would Oregonian residents be forced to opt into this system of healthcare? Or would they be able to opt-out if they preferred to keep their current insurance, or the quality of the healthcare provided does not measure up to their standards?
- Would and should out-of-state students be eligible for this plan if they are studying here sometimes for years on end but are not technically considered residents of the state?
- Under the new system, would people who were not Oregon residents still receive medical attention if they needed urgent/emergency care? Or would they be rejected for lacking coverage under Oregon's new health plan?
- Specifically, what happens if people have family visiting from out of state that needs medical attention? Would they also be provided healthcare? Or, if not, would any financial support be available for people having to pay for the cost of their family members’ medical attention?

Enrollment

The Enrollment section closely followed the themes set in the eligibility discussion, with participants expressing similar questions and concerns. Again, some were worried about the program's effectiveness, mainly how the enrollment process would be accessible to the houseless population/others for whom residency and IDs present a barrier. Others also asked if people covered by OHP would be automatically enrolled in the new health plan and if a similar process could be achieved for those on TRICARE or Medicare. In short, they did not trust that the enrollment process would be as straightforward as the Task Force was making it seem.

- “I was just thinking there shouldn't be a really big enrollment process. I mean, you're gonna ask a couple of basic questions… but if everyone's gonna be able to have healthcare, then make it everyone. I don't think it should be no long, drawn-out process. It shouldn't be that hard. Like I said, you didn't make it that hard for people to get

> vaccinated. So it shouldn't be that hard for people to get healthcare.” - Black and African American Group Member.

Since the plan did not clearly define the enrollment process in the discussion guide, many participants geared their initial conversation to different ways that the enrollment process could increase its efficiency. They agreed that the biggest problem would be effectively spreading information about the Health Care for All Oregon plan and its enrollment process to their communities. They also agreed that the enrollment process should be simple and clear to allow all residents potential access to healthcare. Some believed that the Census should enroll citizens or that the county could do enrollment. Others believed that to increase efficiency and accessibility, it would be best to have both impersonal and online applications handy.

Participants thought it best to model the enrollment system for the in-person registration after other systems had already shown to work well. Participants recommended copying the SNAP programs registration system, the census’ system (with volunteers going door to door), or the pop-up sites used to distribute vaccines during the COVID-19 pandemic, making application portals available in public or community spaces. They also suggested that volunteers be available when administering these applications to help people navigate the paperwork and provide them with further information about the health care plan.

Some participants explained that they had experienced the ease and cost-effectiveness of receiving care without insurance when previously living in other countries. Being able to just show up to provider offices, hospitals, etc., and receive proper medical attention without filling out tons of paperwork and knowing that it would be affordable allowed them to access medical care when and as needed. Allowing a similar process to exist under Oregon's new health care system, they argued, could also make medical services more accessible for those visiting from out of state without having to enroll in Oregon’s health plan. Oregon could instead pave the way for a new type of healthcare system in the US, and hopefully, other states would follow suit.

There were varied ideas about the best enrollment timeframes; most comments about timeframes advocated for immediate access, while only a few thought there should be a minimum requirement for residency. There was a debate between participants about whether it would be better to have seasonal enrollment periods or simply keep the enrollment time open year-round.

Beyond the enrollment process, many participants also shared their concerns and issues when navigating the current insurance system, hoping that bringing these concerns to the Task Force would help resolve future issues. Most participants have had difficult or frustrating experiences navigating the healthcare system, especially first-generation immigrants. The language barrier has been a challenging obstacle to getting access to services and understanding the types of care available for them. Many wish to see multilingual and multicultural resources and services dedicated to helping them better navigate the medical system, whether in person or over the phone, or help from an advocate or customer service office.

- “[I]t would be nice to both have online and in-person to have like a designated place for people who don't have who don't understand if they need translation services. Or also if they need transportation services to that location to help these people. And then another thing that would help is probably for the online version, like a video that in detail describes how to apply.” - Pacific Islander Group Member.

Several ideas have been brought forth for how to correct this issue. Some believe that it would be most beneficial to have volunteers and nonprofit organizations dedicated to spreading this education and resources to the public to help them when navigating the system. Others believe that Medical providers and insurance companies should create a customer service office dedicated to guiding clients through the process. But most, however, believe that adding advocates to the system; a person dedicated to helping one or several clients navigate the system/access the care they need; would be most beneficial. Several participants already have stories about how health advocates have helped them receive urgent or necessary treatment that they would have otherwise never received from their insurance companies. These people have helped them receive their care faster and feel like they are honestly being heard and have a voice in their healthcare, and participants wish to see that experience repeated for others. They believe the service is truly needed if patients get the most out of their insurance programs, whether online or in-person.

Participants' need for information also carries over to other aspects of healthcare, such as full disclosure on the type of coverage that a health plan offers and thorough explanations of medical diagnostics. They want this system to provide coverage that will follow them through life and help give them the information and resources they need and access to medical resources that have previously been unreachable by leveraging personal aid and interactions.

Other accessibility concerns involved the long wait time that participants often had to endure when writing referrals or the feeling that the system they navigate is ineffective and slow to meet their needs. Many advocated the need for a better system that is easier to physically access. Participants also suggest that the new system avoids referrals because, at times, it might take months to get access to much-needed medical services due to the paperwork one has to navigate. In place of this, they suggest that the plan might find a speedier form of service by updating the health plan's online accessibility. According to participants, the OHP website is old and clunky, with applications and materials hard to navigate and fill out. By creating a newer interface for their new health plan and adding features that allow people to fill out materials over the phone in an app, they believe the process will become more streamlined and information more accessible.

Governance

Governance is one subject in which participants explored the many moving parts that would facilitate the organization and create an Oregon Health Insurance Board of Directors. They expressed that for the board to be and remain relevant, it must reflect the state’s diversity,

especially of the communities that had experienced harm by the current health care system in the state.

- “I would say [that] the board needs to be very diverse and knowledgeable about different groups, but the more diverse, the better.” - People with Disabilities and Long-term care Group Member.

One of the most significant concerns in this topic was the belief that ethnic-specific, regionally-specific, and diverse representatives would be missing from the board's operation. Many participants agree that they often felt that their communities were brushed aside on essential matters and that representatives for other boards and legislative matters do not accurately represent the people and their needs objectively. In sum, they advocated that more representatives should come from BIPOC and historically marginalized groups with diverse ages, backgrounds, education, and experience. Certain groups – Native Americans, those with disabilities, those with Mental Health issues, and those living in rural areas – requested the consideration of members of their communities to be on the board, as they are often the least sought after when filling positions or those whose needs are most ignored.

- “I think that there should be a good representation of who the community is, because when it's time to vote, [the representatives] have to have legal immigration status and social status [to be influential], and you also need to be knowledgeable about the community needs when you’re voting. So, I also think that it [the board] could work with representatives from a base of organizations that work with our communities and that of other immigrants, like IRCO and Latino Network. That way, various organizations around the state could do what you are already doing, gather the people in the community and from there go and represent them all.” - Spanish Group Member.

Beyond diverse demographics, many participants also felt strongly that diverse backgrounds were necessary to form a holistic approach to healthcare. Many advocated that members of the houseless population be allowed to serve, and the governing body should include community leaders and representatives from influential community organizations. They believe that community leaders and members of the community or nonprofit organizations with a background of working with underprivileged or underserved communities will significantly help improve the communities trust and hold the board accountable.

Participants also recommended that those with personal experience navigating the healthcare system or everyday members of their community be included on the Board, not only those with professional backgrounds in health care or the medical field, such as healthcare providers and experts in health care law and medical professionals. They want members whose personal experiences reflect both their own and other communities; middle to lower-earning individuals who have struggled to obtain healthcare in the past or have experienced negative outcomes navigating the healthcare system themselves can personally empathize with the hardships faced while navigating a system many believe is not tailored to fill their community's needs. They worry that the process of choosing these representatives will not be equitable and

restrained to those with PHDs or who, by their profession and socioeconomic status, are far removed from the everyday communities needing representation.

Although most participants believe that community oversight is essential in the selection process, participants remain divided on the best course of action to create the board. Many feel that the solution is to allow participants to vote to fill these positions, even suggesting that those unable to vote due to immigration status, lack of residence, or ID, should be allowed to vote through community organizations that represent them.

Fear, however, remains of this process not being equitable. Participants stress that some community groups are small and will likely continue to be underrepresented. It would require extensive resources to prepare to participate or vote on participants. Many people believe that it would be more prudent to have potential candidates fill out applications and complete an interview process in front of their communities before being selected for the board. However, they do not believe that those processes should be too strenuous or it will still cater to only having the most educated apply. If there was one thing that most participants agree on, the government should not be a single authority deciding who gets a seat for integrity. And in addition, members' time required on the board should have clear limits and expectations.

Additionally, participants were torn on providing compensation; while most believe that compensation is a fundamental job requirement, some believe otherwise. Those in favor argue that these positions are government positions, so compensation is necessary, if only for the time and effort that board members would invest in the program. Those opposed believe that any form of compensation would diminish the goodwill of those in power and would leave candidates seeking to work not for the general public's well-being but for personal gain. However, both wish to see the board work with integrity to fulfill the communities needs and create a healthcare program they can trust and rely on to give them the best possible care and coverage.

Many participants also stressed transparency, culturally responsive outreach, and engagement are critical factors when creating and running the directors' board. They firmly believed that constant community input and scrutiny would achieve the best results, informing the populace of ongoing changes that might better help them navigate the new health care system and keeping the board accountable and relevant. Some participants suggested setting up a directory/office, email, and hotline for this purpose. Others also suggested that having board members interact with the community directly through regular town hall meetings or zoom meetings would help keep the public informed and encourage their familiarization with their board members. They think this would also bring forth any questions, problems, or petitions that would help inform the board of their community needs.

Financing

Discussing the program’s financing exposed a lot of passion from participants simply because many participants had varying opinions about how to best fund Oregon's new healthcare

program. Significant themes throughout the discussion were the need for transparency and the heavy impact of taxes on small businesses and those who make less money.

One common trend throughout the community groups was that many participants faced heavy financial burdens due to everyday stressors like low incomes and inflation. Many also expressed they already struggle to pay taxes and keep their households out of poverty. They fear that a rise in taxes might worsen their current conditions and keep them from affording quality health care coverage. When presented with the topic of a payroll tax, many individuals praised the idea, identifying progressive taxes as a counter to the inherent inequities present in the current tax system.

The idea of a progressive tax that puts the duty on those who make more money, where taxes have had less impact proportionally, was more attractive. Participants want a tax that more heavily impacts those of higher socioeconomic status to help balance the impact of taxes so that people with low incomes are not too financially burdened. However, participants were skeptical that the payroll tax achieved that goal, and many could not support it. Several wished to see funding achieved through other methods, such as Federal grant funding, so that medical payments could be 100% tax-deductible and to have more tax breaks for small businesses and independent contractors.

One can see a similar division when discussing the implementation of sales taxes. Except for a few participants, all condemn the idea of a sales tax and regard it as a regressive tax which places a higher burden on the lower socioeconomic class and much of the BIPOC community. However, many are willing to implement it on a more limited scale with a more significant focus on “luxury items” – such as yachts and large estates. Suggested targets include commonly taxed items such as alcohol, tobacco, marijuana, other recreational drugs, cars, electronics, lottery winnings, dispensaries, luxury clothing articles, jewelry, and other luxury items.

However, participants are unwilling to commit to any form of funding until the community has been fully informed and clearly understands the potential impacts of any of these proposed taxes. They worry that despite their taxes being considered lower than those for the ‘rich,’ they will still be too heavily/negatively impacted. They are hesitant to trust the vague wording in the section's explanations without real numbers that could help them calculate these taxes' real impact on their incomes. Several suggested that the best course of action would be to outreach, inform, and educate the community on the inner workings of these tax systems using specific numbers to help them make a better-informed decision when considering their communities' needs.

This request and mistrust stem from participants who do not understand the funding process. Several were worried that undocumented immigrants would not be eligible for the program even though they pay taxes. Others felt that these additional taxes might not be fair to those who want to keep their private insurance. They would have to pay for a service they prefer not to opt into or might not be complementary to their current plan, and, in addition, subject them to heavy financial burdens. Some questioned how the system would affect those without income or jobs-

such as the retired, disabled, houseless, and unemployed. Few participants knew how the system might work around these issues, spurring more interest in a community education session/program with more specific information.

Participants agreed that all future undertakings must be transparent and open to public scrutiny. They emphasized the need for clarity regarding funding needs, resources, sources, expenditures, and efficacy of costs and impacts on the community. This way, the state can assure community members that their tax dollars are being used responsibly and effectively.

Social Determinants of Health

- “I don't know the extent [of SDOH programs that need to be implemented], but it does need to be done… There's a lot of disparities that our culture goes through that others don't — I'll say black, brown, whoever goes through. And if we had access to a lot of those things that others do, we wouldn't have a lot of the health problems that we do have. So I know that they're trying to do things to try to organize places more and more for us to have fresh fruits and vegetables and things like that. And you know, I tell people all the time on a regular daily basis that [with] the disparities that we go through just going to the store is different than if somebody else is going to the store. We don't know what we may encounter. [It's] just some simple tasks that we could do, but [when] we go, it could be stressful for us when it may not be stressful for another, a different ethnicity. So I really believe that if those things are worked on as well, it makes our life a little easier, we would have less of the health issues like high blood pressure and, and, and diabetes and things like that because they're brought on by a lot of the stressors of life.” Black and African American Group Member

Social Determinants of Health (SDOH) was a section filled with many diverse topics of conversation, as participants considered a wide variety of aspects important to their overall health. Already adamant about the necessity of an affordable and effective health care system, they emphasized the need for aid in areas ranging from access to health education, such as proper housing and everything in between.

Education, particularly health literacy, is one of the most common services that participants designated as a community need. By increasing the community's access to culturally appropriate health guides, information, and resources, they believe awareness of healthy lifestyle choices and eating habits will increase. Many also advocate for more information on exercise, mental health, drug addiction/rehabilitation, preventable illnesses, and community-specific health complications. Additionally, some participants have also advocated for more community education on health care insurance so that more people will know how to navigate the system. Others also wish to see the government invest more heavily in the traditional/public education system, unsatisfied with the current education system in place. The Native American community was an influential proponent of this, advocating for free education for their community due to the United State’s history of isolating, damaging, and marginalizing their families.

- “I think that [SDOH] should be their number one priority; social determinants of health are everywhere. It is literally everything in our lives… right down to education, transportation, our roads… one thing leads to another. It's like the domino effect… if I don't have a car, I can't get to a job. If I can't [get] the job, I can't qualify for services. If I can't qualify for services, I can't go to the doctor, et cetera, etcetera.” - Rural Group Member

Access to affordable and nutritious foods is another area where many participants ask for attention. Many lack access to healthy eating education services. Quality food is expensive, and cheaper alternatives are often damaging to people's health. Ideas for providing this aid vary. Some suggest healthier school lunches and increased access to community food gardens. In contrast, others argue that Oregon should implement a program so that those with low incomes can use food stamps to receive food delivery services. However, despite these differences in opinion, most believed Oregon must increase aid to Oregon residents to obtain quality foods, not just increase awareness of healthy eating habits.

Another frequently discussed topic was the need for transportation to and from appointments. Many of Oregon's residents live in rural or isolated areas. Many often do not have adequate transportation needed to transport themselves or loved ones to and from appointments. Transportation is particularly an issue for those who lack health care providers in their areas, limiting their access to emergency and specialized services. Without adequate transport, many people in rural communities rely on inadequate forms of treatment, like over-the-counter painkillers, and miss the chance to catch medical issues early. In more severe cases, relying on unqualified or inexperienced personnel to provide much-needed medical services runs the risk of developing worse health conditions later. Thus, participants suggested that Oregon either help provide transportation or compensation for travel expenses for those needing to venture long distances to obtain necessary aid. While others questioned if the Task Force could not also use this program to help establish more health care providers nearer to communities lacking access to essential health care services.

Similarly, other participants also argued that more access to green spaces, nature, and parks is vital for urban residents to improve their mental and physical health. Some focused on the importance of providing access and building gyms and cultural and community centers near their communities to encourage healthy lifestyles and provide for people's mental well-being. For others, however, such as the Pacific Islander. Latino/a/x and Native American communities, green space, and natural areas held more social and cultural importance. Many Indigenous participants stressed the close link their community had to nature and urged the creation of more programs to protect the planet's health alongside their ancestral lands. Many Pacific islanders responded in kind, urging that they be provided more access to the Ocean, a culturally significant part of their holistic and spiritual well-being.

Participants also discussed the growing rate of houseless individuals under SDOH. Several participants feel that this problem is growing out of control. They are distressed at the condition

of their streets and city, which they find increasingly full of trash and dangerous to travel. They thought that if better preventative health care were offered, more people would be able to stay in their homes and not lose stable residency due to medical debt or untreated mental health needs. Participants acknowledged housing as an SDOH and that affordable housing should be a factor in the plan due to the increase of houseless people.

However, others argue that the problem is more profound, with a lack of affordable and adequate housing also heavily impacting their communities. They claim that affordable housing is not available to everyone. Many urban areas are currently experiencing a housing crisis, and many cannot afford to live anywhere else. Affordable housing is especially troubling for large families, who often have to contend with housing restrictions limiting the number of occupants one residence can have at a time while not having the funds to afford better than a two or three-bedroom apartment.

Provider Participation

Participants unanimously agreed that they wanted to choose a provider over being assigned to one. The central concept informing their decision seemed to be that the best care from professionals is from someone they trust, not just someone deemed competent and available in their field. They want to have the chance to select someone who can provide dignified care rather than hoping that the provider they are assigned to will provide them that service. This was true for participants on both sides of this spectrum. Those who had experienced poor relationships with providers and those who had providers with whom they felt truly seen wanted control of this decision. For some, this means having the ability to know a doctor's rating, background, and experience to help choose the best practitioner to provide the services they need. Others emphasized the need to choose culturally appropriate services and culturally, linguistically relevant providers to better help them navigate the healthcare system and their health needs.

Participants constantly expressed this need for cultural competence training in healthcare throughout the focus groups. Many participants were from diverse cultural backgrounds and felt that traditional western medical treatment has not considered their communities' unique medical needs. They stressed that this healthcare system should make holistic, open-minded, culturally competent, and trauma-informed healthcare and providers accessible to their communities.

- “I want someone who speaks Spanish, because I do speak English but not perfectly, and well not any technical language. So, I think that it is important that people have that possibility, to choose a person who they already know, who knows their medical history, and who obviously speaks the same language that you speak, that speaks Spanish.” - Spanish Group Member.

It is imperative for many participants to work with providers who respect and understand their backgrounds, cultural norms, and experiences. Many immigrants feel that their care has been more dignifying when their providers are multicultural or come from communities of color. Others

find it reaffirming when providers can provide them with culturally appropriate care, considering their cultural diets, helping them find new practices or alternative treatments that can integrate into their lifestyles. Participants find that it validates their beliefs and experiences and avoids normalizing the Western medical treatments that some communities, like the indigenous communities, found harmful. Many hope that this new system will give them the best quality care and services.

- “I work at a school… in disabilities services, and I've heard from so many students I've worked with that they have hesitation with engaging with providers because of poor past experiences… people have had really bad experiences with providers, to be being able to have agency and feel empowered to make those choices when it comes to your body and your health, I think is absolutely critical.” People with Disabilities and Long-term care Group Member

The discussion guide provides the following description for this section of the discussion: ‘All providers would be required to participate in the Health Care for All Oregon plan.’ Although most functioned under the assumption that it included all providers regardless of field, some participants questioned if this included alternative health services like acupuncturists and other culturally relevant services that are not well known or much used in western medical practice. Many asked if this new system would still need referrals, and they hoped that it would not. Several expressed hope that this system would change things for the better; they believed that this requirement for all providers to participate in the program would help relieve the overcrowding issue and lessen the stigma and lack of accessibility to specialist care that many OHP clients faced.

By far, however, the most complex field of inquiry came from Oregonians in the rural, mental health, and Spanish-speaking disabilities sessions, who questioned if this availability to providers will extend to those outside of Oregon. With most specialists and large health care providers in Portland and the greater Willamette Valley, many participants living in rural areas or outside the Willamette Valley have to travel long distances to reach specialized or even essential health care providers within their insurance program. This flexibility, they argue, will allow them to have easier access to healthcare providers and save them time and money they would otherwise need to spend on long-distance travel. Others expressed that this might also make obtaining emergency care and specialized care safer and less stressful for those involved; giving them more healthcare options might save them from relying on inexperienced or low-quality healthcare providers.

Specific Group Findings

Spanish

Latinos/as/x in Oregon see healthcare as a social and human right. Participants were used to accessible healthcare systems and affordable medications in their native countries. Even if they

struggle to access health services, they are facing affordability struggles and discrimination in hospitals and clinics. Participants shared many stories of being misunderstood and misdiagnosed, harmed, and attributed some of the issues to racism, cultural competency, and language barriers. Several also focused on the lack of preventative care accessible to their families. However, they see this new program as a chance to provide a more accessible and affordable healthcare system to their communities.

Even though mental health and mental illness are typically stigmatized in the Latino community, access to these services was clearly emphasized as a significant need for this group. Whether it was due to the individual and family trauma of the immigration and acculturation process or the heavy emotional burden of families having mixed status, mental health and support were identified.

Latinos/as/xs see this plan as a benefit to all of Oregon and are not as concerned as other groups about the plan's funding or taxes they might incur. However, they are worried that this new service might burden those who already pay for health insurance. Some participants suggested that access to the new Healthcare plan be optional to allow people to keep their current health plans and that income taxes be limited to those using the system. Participants expressed the following concerns:

- Would the services offered by Oregon's new health plan be complementary to their current plans?
- Would their medical bills for this new system cost less than what they currently spend on healthcare?

Many participants in the Spanish group believed that having services offered by big institutions might be detrimental to the Latino/a/x community. Many are scared to get mixed up in a governance system due to past trauma and mixed-status families and might not feel safe entering these large buildings. They suggested having these services in community centers and organizations that the community already trusts or having health consultants stationed in public areas like local pharmacies and other areas frequented by their community.

Black and African American

Due to past health inequalities, hardships, and mistreatment by the healthcare system, this group cared about ensuring flexibility in the payment process and having affordability tailored to an individual's situation – i.e., not stressing about a bill, not having to choose between eating, paying the rent or getting health needed services worrying about getting good care, receiving accurate and quality care, and having access to needed medications.

- "I have family members that will tell me, 'oh, you're on an Oregon Health Plan. You're not gonna get good care because you're on Oregon Health Plan' and I don't wanna feel like that. I don't want to feel like I can't get good care because it's Oregon Health Plan." - Black and African American Group Member.

For Black and African Americans, they mentioned many ways they were treated differently or adversely affected by certain health care situations. They mentioned having care providers not caring for or meeting their specific ethnic and health needs. They mentioned the difficulty of having lower incomes yet paying the same amounts. They said they had not received the appropriate information required to make necessary decisions and experienced providers not trying particularly hard to find helpful health solutions. Then when they have to return for more and more appointments, they still have to pay for each appointment. They also said they would trust the medical system more if more medical professionals looked like them.

Participants want access to information that details what is covered and what additional resources are available to help them in a clear and easy-to-read format, whether payment plans to pay for coverage or supplemental resources to help with everyday expenses like transportation. Because every situation is different, participants want a healthcare plan where they don't have to worry about coverage when stepping into a medical office and not being discriminated against based on superficial pretenses when seeking care or medication.

However, participants also mentioned that a system where everyone is covered creates more access-to-care challenges, such as longer waiting times to see a physician, and allows individuals to abuse the system. Their main concern was the possible misuse of drugs if people had more accessible access to prescription drugs. Many participants also struggled with the idea of this system being all-encompassing and available to all; they had experienced under-care, racism, and mistreatment by the system and thought this program would increase the demand and the inability to offer care to them, their thought process is grounded in the current systems and their lack of accessibility. There was an absence of trust that this program will have the capacity to provide adequate and quality health care and that there will not be enough providers to attend to the demand of services or these will not authentically care or either have the competence to provide the needed care.

Several participants requested a customer service office where one can either schedule an appointment or walk-in and receive personal guidance on filling out and understanding the paperwork needed for the healthcare system.

Finally, people in this group were apprehensive about trusting the system and the governing body to do right by them, which also affected how they approached the creation of this new healthcare plan. Participants wanted direct contact with the proposed administrative board and requested the ability to have personal meetings or a hotline with their board members. They also highly distrusted the idea of raising taxes, with one participant commenting that the government already receives a lot of money, but their community does not see investments in their communities.

Pacific Islander

The Pacific Islander group had many concerns centering around culturally relevant services and care. As a whole, they seemed to feel that their community lacked the necessary support and

knowledge necessary to navigate the healthcare system and tended to focus on services that would allow that care to become more accessible to their community.

It was not so much affordability for many participants that was the issue when considering healthcare but accessibility. Many Pacific Islanders are either first or second-generation immigrants. This, while not a problem in and of itself, has left their community lacking knowledge and experience when navigating the healthcare system. Many first-generation immigrants are only experienced with the health care systems used in their native countries, along with what many consider an ineffective and needlessly complex system that has made it difficult for many to get good healthcare. Similarly, many second-generation immigrants are also inexperienced in using America's healthcare system due to their youth and a confusing system.

- “[T]he states you have responsibility to care for our members, you know they reside within the state, because there are those, you know like, speaking from my community where some of us are undocumented. But we're here working. We are contributing economic wise, regardless what it is. Yes, we might be working under the table, but we are making a fair wage we are working. We're earning an honest living, you know, and we're contributing to society. But we're not eligible to basic your basic needs, as humans which is held, like, you know, and I think we should. Everybody should be eligible regardless of their immigration status as long as you're within the say covers to be, you know, extended it to cover all resident of the state." - Pacific Islander Group Member

This resulting lack of access to adequate medical attention has fueled these participants' desire for more guided aid, with participants requesting services that provide more “hand-holding” when navigating the healthcare system; i.e., community classes, customer service offices/hotlines (for one on one aid), healthcare advocates, etc., to help them understand the services they are getting, how to fill out paperwork, and provide help getting the care they need. Some participants particularly wanted help locating culturally competent providers and culturally appropriate services.

- “[E]ven as me who I would like to believe on the English, proficient speaker has a very difficult time understanding what specific things that needs to be filled out for folks that even have access to affordable health care, and I've been. I… take a lot of time to try to help understand myself so I could help, different family members understand what things we need to fill out to be able to access these things.” - Pacific Islander Group Member

Pacific Islanders wanted there to be a particular focus on the health and living conditions of their community. Since they are often grouped in with (all) other Asian communities, their health statistics often seem better than what they would be if you looked only at the statistics of the Pacific Islander group. They want more awareness of the harmful effects of cultural, racial, and socioeconomic factors on their health and help get their community to a healthier state. Such as providing awareness of culturally/ethnically specific common health issues and then helping provide easier access to resources to help prevent those issues.

Access to nature was crucial to this community; Parks are often regarded as areas for social gatherings, and access to the ocean is seen by the community as an integral part of their spiritual and holistic health, making it a vital service to consider when considering the communities holistic health.

Many also felt that legal immigration status was a significant barrier to holistic health care coverage for their community, leaving many people in their community unable to access a large portion of healthcare services, and scared of deportation when they attempt to seek medical attention.

The group also expressed concern that finding adequate and holistic representatives for the Pacific Islander community for the health plan's board of directors would be difficult since their community is so diverse. The term Pacific Islanders covers many different islands, cultures, and languages. For this reason, several suggested finding representatives that could represent their community's cultural and ethnic background and values, but that could emphasize the experience that their and other immigrant communities have had in navigating the healthcare system. Several also suggested that the board of members should leverage their community's culturally traditional education and wisdom and the cultural dynamic between their elders and youth to better assist and help tailor services towards their community.

- "I speak on my own experience with my mom. She was paying for the premium assistance, and then she just like never know how to use it. She was like, What am I paying for when I don't even know what I have access to, you know, so it's like, and then it was kind of like a time limit because then she had to move back, you know, to my country, because she was paying for something that she didn't know how to access it." - Pacific Islander Group Member

Native American

Participants from the Native American community feel betrayed and left behind by the healthcare system. They have been adversely generationally impacted by affordable but poorly run and funded healthcare. They shared dreadful stories of the inequities in their health care that have increased their mistrust of the system. They finished by sharing the hope that the government could offer the actual healthcare they need. Although their healthcare is supposedly free, they are unable to access it because they can't afford many of the additional services they need for their conditions. They don't want more 'affordable health care' if it is similar to what they have received until now. If this new system wants to be affordable, they suggest providing culturally competent and humanly accessible essential services for all residents regardless of income, race, or status.

They are adamant that quality control is essential to this new program; everyone should be provided the same quality medical services and equitable care for all communities. The health care provided to the indigenous community has been demeaning, uncaring, and disrespectful, with many developing worse health issues or not being provided proper treatment for their

illness. They have been discriminated against by providers and doctors on many of their reservations. Participants shared they are consistently undertreated for pain because of the false belief that all Natives abuse painkillers and have a higher tolerance. They shared harrowing stories of how providers refused to give them pain medication that worsened their condition. Because of the low quality of the aid they have previously obtained, many no longer trust any form of government to give them dignified or quality health care.

In addition, many indigenous communities have turned to alternative or natural forms of treatment due to these past experiences. They believe that alternative healthcare options should also be provided for under the coverage of Oregon's new healthcare system as not all of their beliefs and cultural norms/practices are provided or accounted for under Western Medical practices.

Many participants also believed that enrollment should not be necessary, even if all Oregonians are eligible for this new health plan. They do not want to be forced back into a system they fear will hurt them (physically, emotionally, or mentally) or ignore their needs as it has in the past.

One essential step towards this goal was the equitable representation of Native Americans on the health plans board. As one of the most historically underrepresented and marginalized groups in our country, they believe that to have adequate representation of their community, the board should include two Native American representatives, one from the reservation and another from an urban area- or one representative with experience who has experienced both.

Another was providing quality aid from SDOH programs to their community, such as better education for their youth and wealth management services for their elders.

- “I have the very strong urge to just like call attention to how kind of ridiculous that question is. Um, of like, to what extent should we make sure that everyone has breathable air and that populations live like, are you serious? Like, I'm not sure what kind of answer they're looking for. And maybe the question could have been worded differently, and I'm not throwing shade at like whoever made this question or anything. I just think it's absolutely asinine to ask something like this. Um, because it's all one and the same of overall healthcare is making sure we have affordable housing, making sure that we have drinkable water. Like it's basic, it's so basic.… And we are being asked how much we prioritize that in a financial way or whatever, which is just absolutely ridiculous to me.” - Native American Group Member.

This group of participants was also against paying any taxes for this healthcare system. It is their right as Native Americans to have free healthcare in front of the US government, and they wanted more information on the effects of this financing plan on their community. Since the indigenous community does not pay taxes, would they now be forced to pay state taxes, or would they be required to pay through some other method to be allowed access to this new healthcare system? How did they fit into the States plan to finance their new healthcare system?

Participants from the Native American community feel betrayed and left behind by the healthcare system. They have been adversely generationally impacted by affordable but poorly run and funded healthcare. Although their healthcare is meant to be free, they are unable to access it because they can't afford many of the additional services they need for their conditions. They don't want more affordable health care if it is similar to what they have received until now.

Rural

Most participants suggested that travel expenses should be covered or partially covered due to lack of availability for specific healthcare services in their region, having to incur travel expenses to the nearest town to get the attention they need, making healthcare less affordable, and stressing their household finances.

This group also expressed that "Just because you are eligible, does it really mean you are getting the services?" Due to their remote location and attractions, providers sometimes leave town and move to more populated areas, rendering their services more scarce and making the program have less coverage. Moreover, participants who live near state borders hoped that their coverage would extend to out-of-state providers. This would help them overcome their frequent lack of transportation, the limited local number of local doctors and long distances to instate providers.

Rural participants suggested that if or when the new health plan sought to verify people's income, they should not consider people's savings accounts as often those do not contribute to their income and are usually set aside for a purpose.

Some participants also showed concern about neighboring states receiving attention from Oregon and how this situation could stress the medical care system. At the same time, they still want the requirements not to defer support for the already underserved and vulnerable communities.

Rural participants were very aware that they make up the minority of Oregonians and that many of their needs have been disregarded and underrepresented. They would like board members to be regionally diverse to be able to represent their needs equally. They know that many of the decisions have been made to support people in the Portland area, not theirs.

Participants also suggested that the board set up a mailing address so that those without access to technology may still reach out to board members remotely. The rural group did not like the idea of sales taxes unless, as participants agreed, they could compensate the community in another manner, such as increasing Oregon's wages or lowering and setting limitations on the cost of rent or groceries.

There were conflicting ideas within the rural community on the best use of SDOH programs to help Oregon's residents. One participant requested that these programs be long-term aids, like

universal basic income, to help the neediest of Oregonians. Another, however, advocated that these SDOH programs be treated as a chance to help those using them build themselves up to sustain themselves and not rely on the healthcare plan for the long term for stability.

Several participants in this community believed that if the federal government was to help fund Oregon's Universal health care, their funding should come from existing funding for pre-existing programs, such as America's military spending or the international affairs budget.

People with Disabilities/Long-term Care

Many participants in the disabilities and long-term care sessions focused on understanding the overall impacts of Oregon's new health care system, especially about meeting the diverse medical needs of their community. One topic only heard in this group pertained to obtaining loans to pay for treatment. During the discussion on affordability, participants in this group were adamant that obtaining loans should be easier to receive and should not be based on credit score when needing to pay for medical issues.

- "I have really high cost of healthcare. I get really costly infusions that without any insurance, it would cost 30,000 a month just for my infusions… that's not something that I would be able to afford without health insurance… and I think like one thing that keeps me at my job is my fear that I will lose the good health insurance I have or that I'll have to go through another process where like insurance could deny it... So affordable for me is something that's reasonable more than like half that I make in a year in one month is not reasonable." - People with Disabilities and Long-term care Group Member

Several participants also believe that people with disabilities, especially children or families caring for someone with disabilities, should get broader and priority coverage for medical services as insurance limitations often affect this community's health negatively at a higher rate. Additionally, equipment or medication needed for life-sustaining should be covered, as it is often expensive to cover but necessary for many people to live a good life.

Participants suggested that the plan provide information about the program's coverage limitations and a clear and straightforward appeal process related to understanding coverage. For example, the appeal process could involve a letter, proof of the disability, and a letter from the provider for those to appeal denial of coverage who might need specialized or urgent care. One participant stated, "If there are limitations, I would appreciate that there also be an easy-to-understand, accessible, and transparent process to appeal a decision."

Most believe that insurance companies' current enrollment requirements are complicated, and too much information is required of people to be enrolled with a provider. Many also recommended that more information about the program and how to enroll should be available – especially to immigrants who might be afraid of getting medical service or just arrived so that they can take advantage of the Statewide program.

This group also highlighted the need for accountability from the board, stressing that his program needed to continue working despite difficulties, be sustainable, and have continuity plans as some individuals/ communities would heavily depend on it. The board cannot be held up to deliver on their jobs during member transitions, lack of staff, etc. Additionally, participants suggested those on the board receive constant equity and cultural competency training and information about the community's needs and situations. They want a board that can understand what their communities are going through and make decisions representing everyone's best interests.

- “I believe that the board should… have literature to read… for equity and courageous conversations, um, literature that will let them be more diverse within the community… they need to be committed for, or be on the board for two straight years, maybe three, maybe the first year complete a course of all that literature and then two years on the board and then, and that's about it. And then you have the incoming people who wanna go for the board, finish that literature, that list, and open that literature for everybody what's recommended” - People with Disabilities and Long-term care Group Member.

Thus, participants suggest that the populace should be informed whenever changes are made or occurring and what services will be available to them to voice their opinions and help the board keep their needs in mind. One participant also suggested using surveys to collect public opinion, whether online or in person. At the same time, others suggested using a TV or radio campaign or similar tactics to reach their community and spread information about the board to all of Oregon.

Finally, one participant expressed curiosity about how this program would contribute to climate justice and racial justice initiatives already at work or in progress.

Mental and Behavioral Health

The Mental and Behavioral Health group had younger participants who had experience meeting some of their health care needs while on their parents' insurance or other participants who had met their needs with the help of an advocate. There was a focus on affordable cost and accessibility in language, systems, and platforms. Many of them had more optimism that a universal healthcare program would help all Oregonians than many other groups.

Responses for what affordable health care meant to them ranged from “free” to “ease” to “open, transparent, and digestible.” One participant who self-identified as a former houseless youth in Oregon and Washington said sliding scales helped her understand if the worst-case scenarios were financially feasible. This helped her know whether to access services or just suffer through it since medical debt could accumulate rapidly.

- “I have never been reminded of my status as often since I lost health care [at 26 years old].” Mental and Behavioral Group Member.

Participants thought the plan should cover everything, including biologics, specialists, alternative care, telehealth, mobile phlebotomy services, mental health, rare diseases, severe health conditions, dental care, and eye health. There were direct requests for “respectful and culturally competent care” and “Treating people with dignity.”

For eligibility, this community focused on the benefits this system might bring to their community and was relatively unworried about abuse, believing that its benefits outweigh the costs. They do wish for eligibility to be immediate so that visitors to the state or people in need of urgent care in other states might have access to immediate emergency care in Oregon. Participants commented that this immediate care was needed for seasonal field workers and those working heavy labor jobs. Some also believed that this could change people's perception of medical attention from a luxury to a necessity, which would help ensure access to healthcare in the long term.

For Governance, there was a big push for representation, including houseless people. There was a desire for a simple system with a basic application and interview that somehow didn't only limit the board to being highly educated. Some participants recommended using technology to help people stay connected and share their opinions. Such as creating Facebook/social media groups and web pages to help facilitate communication with board members.

There were comments that people who make more money should contribute more, and people who make less pay less. The fear about a payroll tax is that it would hurt small businesses and wage earners. Overall, there was a desire to understand the possibilities more and who they would affect. There was a fear that if the money were an added tax, it would not be ‘affordable’ for many.

Due to their past issues with healthcare systems, many participants advocated that legal help or lawyers be provided for by SDOH services, particularly for health care issues. Previously many have seen people with some specific diseases or who need intense, specialized care or accommodations, subject to discrimination by their providers and insurance companies when their insurances are unwilling to help them access the services they need. Providers will often drop their patients rather than fight the insurance company. This is a significant barrier for this community to reach the aid they need, as most people do not have access to navigators that can bridge health care and need accommodations due to their health issues. Participants also believe that mobile resources should help people access SDOH programs/services more easily and help the Task Force better collaborate with other organizations on this project.

- “I’ve actually taken my insurance company to several CMS Administrative Law Judge Hearings representing myself to get my care approved and paid for. It was me against a panel of in-house attorneys, outside counsel, medical director, and administrative personnel. I won 4 out of 5 hearings, and the insurance company was forced to pay for my care.” - Mental and Behavioral Health Group

Free choice of providers was universally agreed upon, with many participants providing examples of bad experiences with the 'wrong' practitioner. Having the opportunity to have a relationship with the provider was very important, and the ability to leave a provider that does not treat them with dignity was essential.

Recommendations

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.

After deeply listening, analyzing, and reflecting on what participants shared with us, we recommend the following for the Oregon Universal Healthcare System:

- Provide defined parameters regarding what type of care is available or covered by the program; the program should include vision, dental, mental health, and alternative care to fit the public's desire for comprehensive healthcare.
- Provide defined and inclusive parameters regarding who is eligible and where Oregonians can seek care.
- Provide flexibility for rural communities to access the closest provider, even if that means out-of-state care.
- Provide adequate time and financial resources to work in rural and remote areas with hard-to-reach populations, including non-native English speakers.
- Facilitate access and accessible enrollment protocols to health care systems. The enrollment process needs to minimize the number of possible barriers to provide accessibility (i.e., be simple and straightforward).
- Facilitate a Board that truly reflects the true breadth of Oregon residents.
- Avoid increasing taxes to fund this program.
- Avoid placing taxes that have more significant impacts on moderate to low-income families and individuals. A tax is not progressive if it applies to everyone equally.
- Consider placing luxury taxes on items and higher taxes on products that negatively impact health (i.e., carbon, tobacco, alcohol, cannabis, etc.)
- Provide defined parameters regarding the type of SDOH programs available through the program and resources to help Oregonians access new and currently available SDOH programs.

- Invest in public education and community health literacy. This includes continuous investment in local school systems for education and providing community health education on various topics: eating healthy, exercise, mental health, stress, behavioral health, drug addiction, medicine, and community-specific health complications and preventable illness.
- To make healthcare more accessible, it is important to consider the following:
    a) Providing affordable healthcare based on each individual's means
    b) access to healthcare facilities via public transit
    c) financial assistance for those who need to travel long distances to see a provider.
    d) access to gyms and resources to help people become/be more active.
    e) greater access to healthy foods through community gardens, healthier school lunches, and dietary services for those on food stamps or low incomes to receive dietary services
    f) freedom to choose a culturally and bilingual provider
- Integrate authentic cultural interventions alongside existing healthcare promotional efforts that address health disparities as a whole to ensure a culturally tailored and relevant approach to health promotion and healthcare delivery for BIPOC groups.
- Educate health care providers about the reality of structural racism that hinders health and progress in BIPOC communities. If possible, mandate antiracism training by BIPOC consultants to help establish the WHY (the importance) of using an equity lens.
- Establish accountability methods with specific actions and clear benchmarks that respect, value, and promote diversity and cultural responsiveness.
- Support, recognize and utilize culturally aligned health teachings and traditional wisdom and interventions within BIPOC communities to strategically implement their health and well-being.
- Reallocate considerable resources to serve, heal and make reparations to the communities harmed.
- Continue to make safer and more accountable spaces for deep listening, learning, and understanding of behaviors, cultural responses, and barriers for the most marginalized residents.
- Last but not least, celebrate the equity journey that will dismantle barriers to hundreds of thousands of Oregon Residents.

Closing Remarks

When the Task Force set out to inquire about a universal healthcare system for Oregon, their goal was to include the study's findings in their recommendations to the legislature about implementing a single payer healthcare system, better known as Universal Access to

Healthcare. The communities interviewed have made it clear that the current system's mode of operation is dysfunctional and provides many stressors and barriers to the healthcare they consider a necessary and fundamental right.

Throughout the community discussion period, it has also become pertinent to consider the effect of barriers to accessibility on the health care received by all groups involved. In the past, this lack of accessibility has often been a core factor in propagating the disparities that many communities have experienced when seeking healthcare services, directly affecting their health and advancing a system of systemic racism and generational inequity. Now, most communities see accessibility as being closely linked with the equitable, affordable, comprehensive, and high-quality healthcare system they have been promised; making accessibility to health services, relevant information, SDOH programs, or providers necessary considerations for the Task Force when providing recommendations on a universal healthcare system that will provide Oregon's residents with adequate and dignified care.

Their current healthcare system does not offer them the affordability, coverage, dignity, or ease of care they are seeking. The processes in place to help them access or mitigate those services have not been equitable and have instead enforced a system of degradation. These communities, including Black, Indigenous, People of Color, rural communities, and people with disabilities and mental health issues, are now looking for a new affordable health care system that will provide inclusive, flexible, comprehensive, and culturally responsive care.

They advocate that more equitable approaches be applied to this new health care system so that every community can participate, regardless of background, location, ethnicity, racial identity, gender, religion, or lack of documentation. They seek health care where systematic racism is eliminated through adequate funding and policies that center people, prioritize health equity, and offer community-driven approaches that make quality care accessible to their communities.

LMS supports and values the task force's commitment to being an outspoken advocate for social, economic, and racial justice. Thank you for working to reduce future public harm by taking a deep look at the lived experiences the health care system has inflicted on our Oregon residents.

Appendix

Task Force on Universal Healthcare Discussion Guide

Virtual Round Table discussion (2 hrs)

Part 1. Welcome and Introduction

Slide 1: Welcome screen

Description of Oregon's project (this part is read to participants at the beginning of the exercise):

The current system of healthcare is difficult and costly and still results in poor health outcomes. The system has a great amount of administrative waste and often results in people delaying health care because of cost. Many services such as mental health, vision, dental, and hearing are not covered. Overall, the system is unfair so there is a need to change the system.

In 2019, Oregon legislators created the Joint Task Force on Universal Health Care (Senate Bill 770). The Task Force was charged with designing a publicly financed healthcare system that is equitable, affordable, and available to all residing in Oregon; a system that recognizes health care as a fundamental element of a just society, and improves the health of Oregonians. A single payer system is a mechanism for achieving those purposes. In a single-payer system, everyone has one health plan that is paid for with public dollars.

Your public input is needed to help create a better healthcare system. Your input will be used to guide the Task Force in its final report to the legislature.

With the Health Care for All Oregon plan that the Task Force is currently developing, all those residing in Oregon regardless of where they work, would be covered by the plan. It is suggested that the plan benefits would be similar to benefits that state employees currently have, including behavioral health care. The plan would allow any patient to see any licensed provider able to see them. All licensed providers would be required to participate in the system.

Under the current proposal, the plan would pool all current spending on healthcare into a single health care fund. There would be no copays, deductibles, or premiums. Instead, there will likely be new taxes. If there are new taxes, those taxes would not be higher than what most Oregonians currently spend on healthcare. Oregon residents would no longer have to worry about how they are going to pay for medical care or be at risk of bankruptcy due to costly medical services.

Part 2. Roundtable Discussion Questions

Affordability.

In the Health Care for All Oregon plan, Oregon residents would not pay premiums, co-pays, deductibles, or any other form of cost-sharing to access care.

1. Based on your lived experiences, how do you define "affordable healthcare" and why do you define it this way?

2. What would make healthcare today more affordable?

Coverage.

3. What are the most important services that need to be covered by the Health Care for All Oregon plan so that it meets your and your family's needs?

4. If there are going to be limitations to covered services, what should they be?

Eligibility.

In the Health Care for All Oregon plan, everyone residing in Oregon, regardless of employment, income, immigration status, or tribal membership, would be eligible for the Plan. Any eligible person would be automatically enrolled in the Plan; "opting out" would not be a relevant concept for the Plan. Eligibility would be tracked in a centralized database to which all providers would have access. Eligibility for Oregonians would no longer be connected with employment or employment status.

5. As we have talked about eligibility, what is your feedback, what is missing, or what do you want to add?

6. How would you like to see eligibility verified?

Enrollment.

There would be no waiting period or minimum residency duration required to enroll in the Health Care for All Oregon plan. Enrollment would be simple and straightforward. For people enrolled in OHP, Medicare, or TRICARE, you would be seamlessly integrated into the Plan.

7. What thoughts or concerns do you have about the enrollment process?

Governance.

The Health Care for All Oregon Plan would be a public entity, governed by a board, with reporting responsibility to the Oregon Legislative Assembly and Governor.

8. In establishing a governing board for the Health Care for All Oregon plan, what recommendations do you have to ensure consumer representation and participation in decision-making?

Financing.

The Health Care for All Oregon plan would pool all current spending by government programs into a single health care fund. Additionally, all current family spending would be replaced with a series of progressive taxes, including an increased income tax and payroll tax, and, if needed, the addition of a sales tax. Most Oregonians would be paying the same or less than they currently pay for their health care.

9. What kinds of financing would you recommend and why?

SDOH (Social Determinants of Health).

10. To what extent should the government prioritize spending money on things that prevent health problems, like access to housing, healthy foods, or green spaces?

Provider participation.

All providers would be required to participate in the Health Care for All Oregon plan.

11. Is free choice of provider important to you and why?

Appendix E **Phase Two Community Listening Session Research Synopsis**
Lara Media Services

Joint Task Force on Universal Health Care Study | Phase Two

Community Listening Session Research Synopsis

Lara Media Services
August 2022

Table of Contents

Introduction

“Universal Health Coverage means healthier societies and communities, essential for sustainable growth and development” - Dr. Carissa F. Etienne, Director, Pan American Health Organization.

In 2019, Oregon’s Legislative Assembly passed Senate Bill 770, establishing the Task Force on Universal Health Care (Task Force) to provide recommendations for a publicly funded, equitable, affordable, comprehensive and high-quality health care plan to all residents of Oregon. The Task Force embarked on developing a plan that reached these criteria and sought feedback from Oregonians with diverse backgrounds and circumstances from all regions of the state. The Task Force committed to developing a system that could sufficiently meet the needs of Oregon’s increasingly diverse populations.

The Task Force hired Lara Media Services (LMS) to support the learning phase of this process. LMS is known for its ability to reach specified communities, deeply listen, authentically engage, and amplify the voices, desires, and stories needed to create more equitable outcomes and futures. Together, the Task Force and LMS have a shared commitment and passion for amplifying and understanding the voices of the communities that are most often neglected.

LMS is a certified MBE, WBE, DBE, ESB firm (Certification #7923), and B-Corp. LMS is Latina-owned, and 100% of the team is multicultural and multilingual.

Methodology

LMS coordinated, conducted and facilitated community listening sessions that encouraged participants to be fully engaged and let their voices be heard. Community listening sessions are informative community engagement methods that allow facilitators to build trust with the communities they intend to engage. This method is used to present in-depth information to target audiences and better understand their thoughts, feelings, challenges, and aspirations. LMS uses this approach to provide an accessible opportunity for the Oregon public to engage effectively with the Task Force.

Planning for these community listening sessions led to meetings for each region of the state and a session where the Task Force members presented and engaged with predominantly Spanish speakers of Oregon. These were the methods used by LMS for the community listening sessions:

1. LMS and the Task Force identified priority audiences and essential considerations to develop the discussion guide.
    a. Geographic Regions included:
        i. Coastal Region

ii. Central OR

iii. Eastern OR

iv. Southern OR

v. Portland Metro Area

vi. Willamette Valley

vii. Statewide (Spanish)

2. The Task Force developed the presentation and accompanying documents and identified 11 areas of interest to influence policy recommendations for the universal health care plan.
    a. Access and Affordability
    b. Insurance Companies
    c. Coverage and Benefits
    d. Health Care Providers
    e. Employers and Employees
    f. Governance
    g. Cost and Funding
    h. Medicare and Medicaid
    i. Eligibility and Enrollment
    j. Focus on Equity
3. LMS and the Task Force developed the Community Listening Session agenda.
4. Priority audiences were invited to participate in the various discussions.
    a. Coastal Region | Saturday, June 11 - 10:30 am to 12:30 pm
    b. Central Region | Tuesday, June 14 - 5:30 pm to 7:30 pm
    c. Eastern Region | Wednesday, June 15 - 5:30 pm to 7:30 pm
    d. Southern Region | Saturday, June 18 - 10:30 am to 12:30 pm
    e. Portland Metro | Tuesday, June 21 - 5:30 pm to 7:30 pm
    f. Willamette Valley | Saturday, June 25 - 10:30 am to 12:30 pm
    g. En Español | Tuesday, June 28 - 5:30 pm to 7:30 pm

5. Seven virtual community listening sessions were held for participants to share their thoughts and feelings. The Task Force, LMS, and various community partners invited Oregonians for the first six (6) sessions.

6. LMS recruited participants for the Spanish session (Session 7).

    a. For Session 7, participants were found through social media, with the help of community advocates, and existing relationships with the community built over the last 20+ years. Over 80 potential community listening session participants were contacted, and 35 participants were confirmed. Thirty-two native Spanish-speaking participants arrived at the session.

    b. For confirmed participants, LMS offered to lend tablets if participants needed electronic devices. Upon registering, none requested the use of a device. LMS also offered Zoom Video conferencing training to all participants who requested assistance; two (2) participants from the Spanish-specific session requested training.

7. LMS coordinated and virtually hosted and facilitated all seven (7) community listening sessions.

    a. Six were held in English with ASL and Spanish translation. One was held in Spanish with English translation. Invitations were sent in seven languages for these community listening sessions.

8. After the discussions, LMS gathered data to create a comprehensive report on key findings to provide final recommendations. This report summarizes the information gathered in the community listening sessions.

Community Listening Session Participants

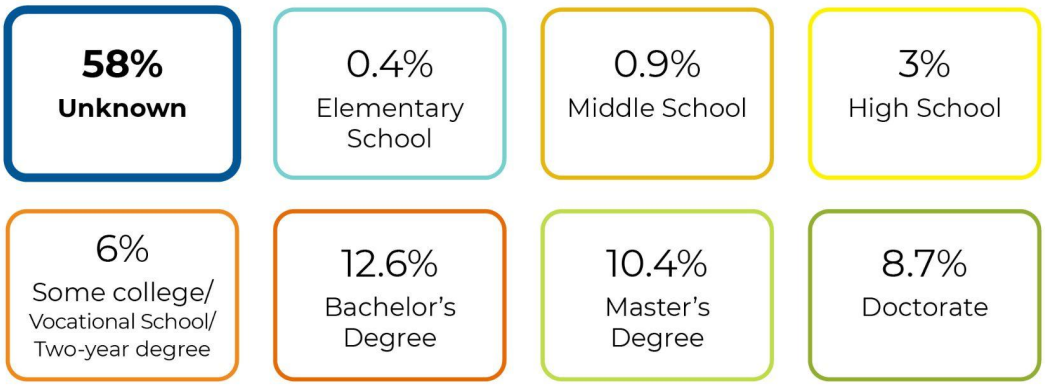
General Regions

Two hundred and thirty-one (231) total individuals participated in LMS's regional community sessions, with ninety-seven (97) participants responding to the optional survey (42% survey response rate).

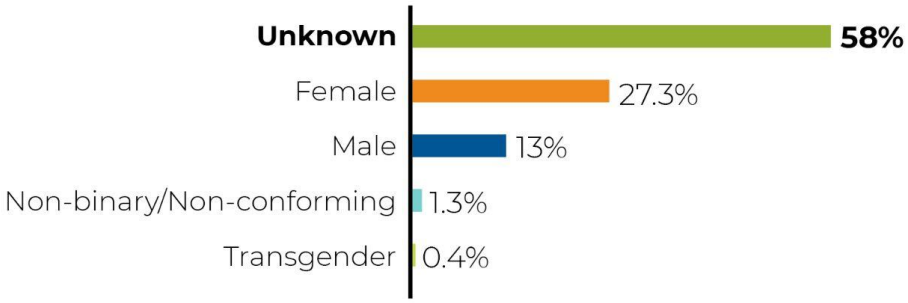
What city do you live in?

City	Percentage	City	Percentage	City	Percentage
Unknown	**58.01%**	Junction City	0.87%	Hermiston	0.43%
Portland	15.58%	Lake Oswego	0.87%	Hillsboro	0.43%
Corvalis	2.60%	Ontario	0.87%	Klamath Falls	0.43%
Eugene	2.16%	Redmond	0.87%	La Pine	0.43%
Salem	2.16%	Silverton	0.87%	Madras	0.43%
Ashland	1.73%	Umatilla	0.87%	McMinnville	0.43%
Beaverton	1.73%	Cannon Beach	0.43%	Nyssa	0.43%
Gresham	1.30%	Clackamas	0.43%	Roseburg	0.43%
Albany	0.87%	Cornelius	0.43%	Sublimity	0.43%
Bend	0.87%	Damascus	0.43%	Sweet Home	0.43%
Fairview	0.87%	Happy Valley	0.43%	Union	0.43%

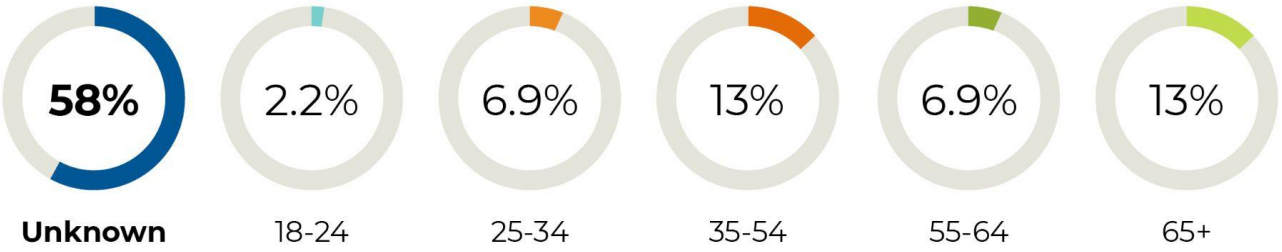
What is your highest level of education completed?



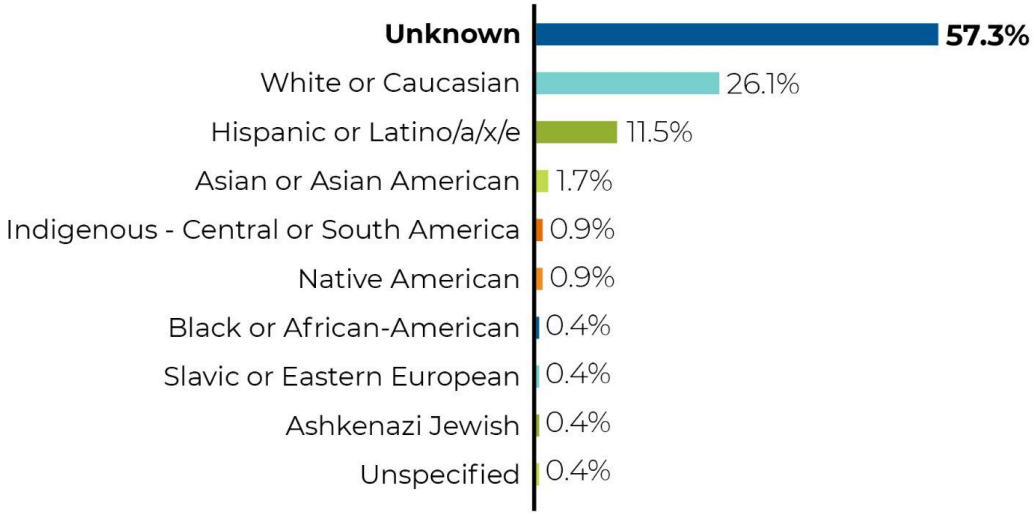
Which of the following best describe your gender?



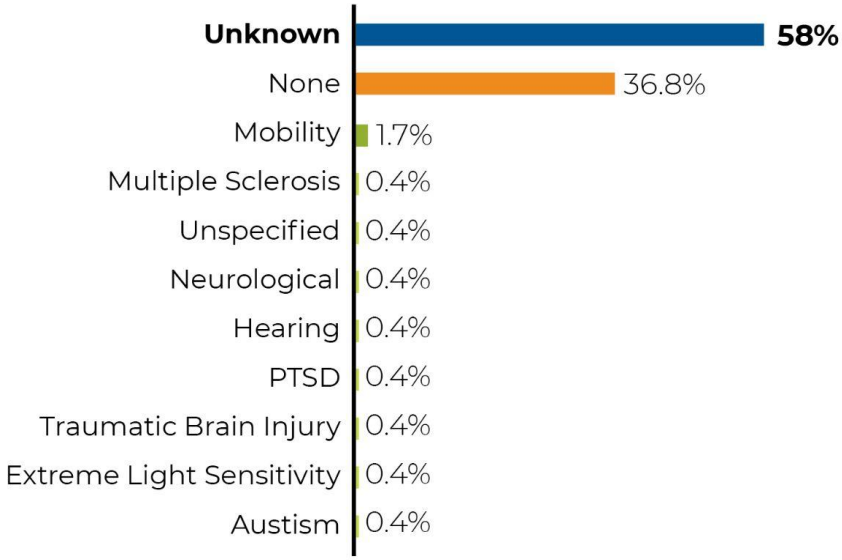
Which category below includes your age?



Which of the following best describes your ethnicity or race? (Select all that apply)



Do you live with a disability?



Coastal Region

The Coastal session was composed of six participants: four of whom responded to the optional survey. Of the individuals that responded to the survey, all represented different cities: one lived in Portland, one in Silverton, one in Cannon Beach, and one in Eugene. They were, however, quite similar in age: One was between 25 to 34 years old, another 55 to 66 years old, and two were over 65 years old. Three of these participants were female, and one was male.

Furthermore, three participants were White/Caucasian, and one was Slavic or Eastern European. In education, one participant had some college, vocational school, or a two-year

degree, two participants had master's degrees, and one had a doctorate—none of the participants identified with having a disability.

Central Oregon

The Central Oregon session was composed of sixteen (16) participants; eight out of sixteen (16) responded to the optional survey. These participants represented seven different cities: two from Bend and one from Redmond, Madras, La Pine, Silverton, Albany, and Beaverton. Three participants were 35 to 54 years old, four were 55 to 64, and one was over 65. Five of the participants were females, and three were males.

Furthermore, one participant was Latino/a/x/e, one was Native American, and seven were White/Caucasian. In education, one participant had some college, vocational school, or a two-year degree, three had bachelor's degrees, three had a master's degree, and one had a doctorate. Three participants identified as having disabilities: one identified with a mobility disability, another identified with Multiple Sclerosis, and the third did not specify which disability they identified.

Eastern Oregon

The Eastern Oregon session was composed of eighteen (18) participants; four out of eighteen responded to the optional survey. Those who responded were from four different cities in Eastern Oregon: Ontario, Nyssa, Union, and Portland. One participant was 25 to 34 years old, two were 35 to 54, and one was over 65. Two participants were female, one male, and one identified as non-binary or non-conforming.

Furthermore, one participant was Native American, another was White/Caucasian, one was Meso American, and one preferred not to respond. One participant had finished high school, one had some college, vocational school, or two-year degree, and two had bachelor's degrees. One participant in this group identified as disabled, having a neurological disability.

Southern Oregon

The Eastern Oregon session was composed of fifteen (15) participants; six out of fifteen responded to the optional survey. These participants represented three cities: four lived in Ashland, one in Roseburg and one in Portland. Besides being geographically similar, many participants shared similar age ranges: One participant was 55 to 64, and five were over 65. Four participants were female and two male.

Furthermore, the six participants that responded to the survey were White/ Caucasian. Two participants had bachelor's degrees, two had master's degrees, and two had doctorates. One participant identified as disabled, having a mobility disability.

Portland Metro

The Portland Metro session was composed of eighty-five (85) participants. In this group, thirty-six (36) out of eighty-five (85) participants responded to the optional survey. Those that responded lived in six different areas: Twenty-seven (27) live in Portland, two in Beaverton, and one in Hillsboro, Gresham, Lake Oswego, and Klamath Falls. Two participants were 18 to 24 years old, five were 25 to 34, 10 were 35 to 54, six were 55 to 64, and thirteen (13) were over 65. Twenty-two (22) participants were female, eleven (11) were male, two identified as non-binary or non-conforming, and one was transgender.

Furthermore, four participants were Hispanic or Latino/a/x/e, one was Black or African American, thirty-one were White or Caucasian, and one was Asian American. Five participants had some college, vocational school or a two-year degree, seven had bachelor's degrees, fourteen (14) had master's degrees, and ten (10) had doctorates. Of these thirty-six (36) participants, three identified with disabilities: one with a hearing disability, one with PTSD, and one with a traumatic brain injury.

Willamette Valley

The Willamette Valley session was composed of fifty-nine (59) participants; seventeen (17) of fifty-nine (59) responded to the optional survey. Those who responded lived in seven different areas of the Willamette Valley: six lived in Corvallis, four in Salem, three in Eugene, one in Portland, Happy Valley, Sublimity, and Sweet Home. Three participants were 25 to 34 years old, five were 35 to 54, three were 55 to 64, and six were over 65. Ten participants were female, and seven were male.

One participant was Hispanic or Latino/a/x/e, one was Black or African American, twelve (12) were White or Caucasian, three were Asian American, and one was of Ashkenazi Jewish descent. Regarding education, ten (10) participants had bachelor's degrees, two had master's degrees, and one had a doctorate. Furthermore, out of the sixteen participants that responded to the survey, five identified with disabilities: Two identified with a mobility disability, one identified with extensive and extreme reactions and injuries from LED lighting, one was on the autistic spectrum, and one preferred not to share their disability.

Spanish Specific

Thirty-two (32) participants attended the Spanic-specific session; twenty (20) responded to the optional survey. Those that responded lived in fourteen different cities across Oregon. Two were from Portland, two from Junction City, two from Gresham, two from Umatilla, two from Fairview, and one was from McMinnville, another from Ontario, one from Cornelius, one from Salem, one from Hermiston, one from Redmond, one from Albany, one from Beaverton, and one was from Damascus. Three participants were 18 to 24 years old, five were 26 to 34, nine were 35 to 54, one was 55 to 64, and two were over 65. Fifteen (15) participants were female, and five were male.

Furthermore, of the twenty, eighteen (18) participants were Hispanic or Latino/a/x/e, two were Indigenous from Central or South America, one identified as White or Caucasian, and one identified as Hispanic with red hair. Regarding their education, one participant had an Elementary School level of education, one had a Middle school level, six had a High School level, five had some college, vocational school, or a two-year degree, five had bachelor's degrees, one had a master's degree, and one had a doctorate. In this group, no individuals identified as having a disability.

Results and Findings

Key Findings by Areas of Interest from Listening Sessions

Access and Affordability

When discussing access and affordability, the community's questions focused on the accessibility of care when traveling out of state and abroad, access to care when the state is experiencing provider shortages and participants' concerns about selecting a provider.

Throughout the various sessions, participants voiced their concerns about how the Universal Health Care Plan (UHCP) would cover individuals when traveling to a foreign country or a different state, how far this coverage would extend and what services would be covered. In addition, there were also concerns about what would happen if participants were forced to keep paying into the system after moving to different states. Similarly, participants questioned if this new system would be more accessible than Oregon's current healthcare system. Their questions focused on who would be insured and how long it would take for an individual to get an appointment due to COVID-19 and the potential collapse of the health care system. But ultimately, they worried that this new system would result in more extended waiting periods and discrimination.

Participants expressed concern about the current shortage of providers within Oregon and questioned how the state of Oregon would manage more people if this were currently an issue. Similar concerns were also raised about the effect that authorization procedures might have on the accessibility and speed of care. Participants wanted to know if the plan would take measures to remedy staff shortages and long wait times and what services would be affected.

Insurance Companies

Many participants expressed concerns about the changes the Universal Health Care Plan would have on the range and cost of services insurance companies cover within Oregon.

Participants worried that services not covered by the Universal Health Care plan would increase in cost and that private companies would take advantage of these changes to overcharge individuals with more expensive premiums. Most regions also voiced concerns about how the Task Force would integrate insurance companies and other existing health plans into the UHCP - like Kaiser and Veterans' Affairs, what these new plans would look like, and what new benefits

this plan would provide. Furthermore, several community sessions raised concerns about the plan receiving pushback from insurance companies, mentioning how one of the biggest obstacles the Task Force would face would be bringing private insurance on board since most for-profit companies would lose money.

Coverage and Benefits

Throughout the different community sessions, people mentioned how medical treatment and health were one of the most critical aspects of their lives and decision-making. For that reason, participants raised questions about who would be covered by this new Universal Health Care Plan; participants wanted to know if gender-affirming individuals, undocumented immigrants, and houseless people would be covered.

Participants asked and advocated for various alternative care services. Not only did they ask and advocate for services like chiropractors, acupuncture, massage, nutrition, and physical therapy, but there were also multiple requests for non-licensed peer-type services like lactation consultants.

Additionally, participants raised several questions regarding long-term care and chronic illnesses, concerned about whether the new plan would consider long-term care and organ transplants. These were similar to concerns raised by the Latino/a/x/e community about access to treatment and good health care providers for diabetes and other chronic illnesses that their community faces. Lastly, individuals also questioned what type of hearing benefits the new plan would provide, as well as whether it would cover pharmaceuticals and how much they would cost.

Health Care Providers

The Health Care Providers section revolved around the effect of mandatory participation on providers, changes to providers' payment, the implementation of a more effective administrative system, and participants' concerns about privatization.

With the current shortage of specialists in the state, there were many questions about the ability of doctors and providers to opt out and how the state of Oregon would prevent doctors from crossing state lines. Similarly, participants asked how the new system would work around the lack of providers to ensure people had optimal coverage and how limited individuals would be when choosing a provider. Participants also voiced concerns about whether there would be incentives to use urgent or primary care providers instead of more expensive emergency rooms: while others questioned if participating providers would have to adhere to practice guidelines by illness, age, medical understanding, and population address.

In addition, individuals questioned how providers would get paid and how the new plan rates would compare to current ones for healthcare providers. Participants discouraged the Task Force from using a value-based payment model. Instead, they suggested that when applying this new plan, the Task Force should consider how most countries with successful Universal

Health Care systems still use a fee-for-service system. Likewise, several participants had questions about whether providers' incomes would drop and how providers would be recruited.

Furthermore, participants addressed how the health care administration would need effective plan management to succeed, with concerns being raised about whether there would be intentional efforts to reduce the burden of paperwork and documentation since this was a challenge for most individuals when applying for health insurance. Community sessions also raised concerns about privatization; individuals wondered if hospitals would continue to be privately owned and, if yes, would they be allowed to turn patients away.

Employers and Employees

The employers and employees section focused on two main questions: How the new plan would benefit employees and how it would work when implemented.

Participants had questions about this new health plan's cost, benefits, and coverage. Most individuals wanted to know if it would be a better option for employers and employees than the current plan they pay today. In addition, participants questioned what would happen to their current insurance if the new health care plan were to pass; would employees have to switch insurances? How would the government manage this? Moreover, would the Task Force eliminate employer-based insurance?

Governance

When discussing governance, participants' questions revolved around four major areas: how the plan would be effectively implemented, whether other states would soon implement universal health care plans, whether the UHCPs governing board would ensure diverse representation within the system, and whether community groups and organizations would be able to give their feedback as the plan progressed. Many participants were also highly concerned about the type of opposition the plan would face and interested in how they could support it.

Most of the questions raised in this section were about who would be in charge of the plans of implementation and whether there would be an alternative plan if the Universal Health Care Plan did not pass. While most participants were impressed with the Task Force's work, some individuals had questions regarding the proposals made and wondered if there would be a need for a much more robust and sustainable public health care system. Several also suggested that this plan would need an effective management system because issues would emerge after implementation. They recommended being very careful with the planning and leaving room to adjust the plan.

In addition, many individuals questioned if Oregon was the first state to try and implement this new plan or if other states were trying to apply the single-payer health care system. They wanted to know if they should expect other UHCP to be implemented and whether the state government would oversee the plans.

Most individuals also wanted to know who would be on the governing board and how many people would be part of it. Some individuals commented that there was a need for more community engagement and input from the Black, Indigenous, and People of Color (BIPOC), as well as the disabled and veteran community. In contrast, others believed that the Task Force should receive feedback from employers, hospitals, providers, and statewide health counselors. In short, many recommended that the board represent a diverse community, with some suggesting that community-based organizations (CBOs) and unions be used to reach out to marginalized communities. Participants also recommended that the board receive input from CBOs and statewide health counselors and address business-model concerns of private providers and policy-makers: since the former group helped individuals sign up for health care, and both had a vested interest in the new health care system.

Finally, participants were very concerned with the opposition the plan might receive, with many questioning if the Task Force was ready for pushback. Most of the questions touched on the possible barriers the Task Force would face when talking to legislators and how much pushback the Task Force would receive from the federal government and groups in the private sector. Likewise, several people also questioned what response this plan would receive from groups with wealth and political power since this plan would affect those groups most. But despite the focus on opposition, the plan also had the support of many participants who wanted to know how they could help get this plan passed through legislation and pressure congress when trying to pass this bill.

Cost and Funding

Throughout every regional session, the Task Force received many inquiries about their new plan's financial inner workings. Many questions revolved around the taxes the plan would implement and whether these taxes were fair or how to improve them. Participants also asked about the system's blended funding and whether the Task Force had calculated risk-based expenditures and overutilization costs.

The program's cost and funding received much attention from participants interested in understanding the payroll taxes Oregon's new health care plan would require. Most of the questions participants raised touched on who and what would be taxed and whether the state and/or the individual would be paying more for this new system than they would in Oregon's current health care market. A few specific questions included whether Roth Individual Retirement Account (IRA) distributions would be counted as income and whether the payroll tax would include people hired out of state. Furthermore, participants questioned if people who had retired were on a fixed income and had Medicare would also be taxed.

Other questions revolved around the equity of the Universal Health Care Plan's (UHCP) progressive tax system, with participants questioning how the Task Force would ensure fair and equitable taxes for all Oregonians. Many debated whether this put too much burden on people with higher incomes, whether this would disincentivize people from earning more money, and if the tax was sustainable. They feared that this plan would cause an unequal distribution of the burden to pay for health care, suggesting that UHCP experiment with a flat tax rate or consider

implementing a tiered income threshold for taxing interest and dividends. That way, seniors or low-income individuals who could not afford the plan would still be able to afford to pay their taxes at the end of the year. In addition, several participants stated they were troubled by the Task Force's high reliance on W-2 income because of the ease with which people could avoid classifying the money they live on as official earned income.

Participants also expressed concern over the plans' blended funding. Since UHCP is funded by a mixture of Federal dollars, payroll taxes, and state health care revenue, several participants worried about how the program would integrate federal money and whether or not this would make UHCP overly reliant on Federal funding. They questioned what the Task Force would do if this funding ended or was reduced.

Additionally, several participants questioned the sustainability of UHCPs proposed funding and expenditure plan, asking how or if the Task Force planned to face an increase in risk-based expenditures and system usage. Participants were concerned about how risk-based expenses would be calculated and affect the ordinary person. They did not like the idea of paying for people whose behavior places them in active harm and thought it unfair to those using the system responsibly. Participants worried that greater access to medical services would increase the cost of healthcare due to a rise in risk-based expenditures and system abuse. If unchecked, many feared that this could lead the system to bankruptcy. Instead, they suggested the Task Force hold individuals accountable for overutilizing the system, monitor excess costs, and control or limit overspending.

Medicare and Medicaid

When confronted with Oregon's plan for a single-payer health care system, many participants expressed confusion over how the plan would integrate Medicare and Medicaid and whether participants would still have to pay Medicare or Medicaid premiums.

At the regional community sessions, the Task Force shared their plan to integrate Medicare and Medicaid into their new single-payer system. However, Medicare and Medicaid cover a large percentage of people in Oregon, and many expressed concerns that the coverage extended to them by these federal health care plans would not carry over to UHCP. They fear that this could leave them without necessary health care coverage or paying taxes and premiums for plans and services that may or may not still be available. Many also fear that these changes to the health care system would disrupt their current health care plans, making it harder to access providers and easier for providers to deny them care based on their health care status.

Eligibility and Enrollment

The Eligibility section had various questions consistently come to the forefront, including who was eligible for UHCP, how this plan would handle people moving from out of state, and whether this plan would ensure the safety of Oregon residents without legal residency or immigration status.

UHCP expects equal health care coverage for all Oregon residents regardless of age, race, income, or preexisting conditions. However, when discussing the program's eligibility, the most notable question was who would receive coverage and what level of coverage participants would receive. Although the specifics vary by session and individual, there were comments and concerns mentioned for the following groups: out-of-state employees and non-residents, seniors, private patients, houseless individuals, elected officials, Native Americans, those with chronic diseases or pre-existing conditions, unemployed residents and those without economic support, migrants, seasonal workers and/or residents, undocumented immigrants, out-of-state students, and communities of color. Underlying these questions appeared genuine confusion about who would be eligible for what.

Participants were also greatly concerned about the prospect of large groups of people moving into Oregon for free health care. Many believed this would result in large waiting lists and increased operating costs. But overall, most people wanted to know if these incoming residents would be eligible for health care and how UHCP's enrollment process would keep non-residents from abusing the healthcare system.

Finally, since UHCP would cover all Oregon residents, participants have expressed concern about how Oregon residents without legal residency would be protected in this plan. Participants worry that people would be automatically enrolled, allowing the federal government to access or demand their information since federal dollars partially fund the program. They want more specific information on how the Task Force plans to protect these participants upon enrollment.

Focus on Equity

Throughout the sessions, participants questioned the equity of the UHCP policy plan. These questions centered around the lack of equity many BIPOC communities see in current health care systems and how these issues could be resolved.

Participants believed equity was essential when creating a new health care system, applying it to everything from payroll taxes to access and accessibility. However, the core of their equity concerns has always been centered around the participation and integration of BIPOC and communities of color into Oregon's new healthcare system. With UHCP seeking to enroll and cover all Oregon citizens, many participants believed this system was taking steps toward providing Oregon with more well-rounded and equitable healthcare coverage. However, many still believe it would take time to implement a genuinely equitable system for all communities. "This change in the program is not going to fix racism/discrimination in healthcare," stated one participant, and others agreed: "Any time we want to change the system, it leads to premature deaths from minorities," "[t]here will not be a complete solution to all of our current problems." However, they hope that UHCP will find a way to ensure all communities' needs are met and managed, suggesting that the Task Force meets with communities of color to consider the needs the plan should meet and how it should be delivered.

Survey Results and Findings

The community sessions that Lara Media Services facilitated helped participants better understand what the Task Force has been working on regarding the UHCP. After the presentation, participants had the opportunity to respond to an optional survey provided to address questions, comments, and concerns that might not have been discussed at the community session. Consequently, most individuals focused on crucial points that revolved around Access and Affordability, Eligibility and Enrollment, Coverage and Benefits, Health Care Providers, Insurance Companies, Governance, Focus Equity, Cost and Funding, Employers and Employees, and Medicare and Medicaid.

Access and Affordability

When gathering the survey's general information on access and affordability, the community's questions focused on the barriers that health care workers face when doing administrative work, the lack of education and misinformation regarding access and affordability, how the task force would ensure there were enough providers to operate the system, whether those providers would be held accountable for charging reasonable prices and not being allowed to overcharge, and whether social determinants of health would be considered when determining medical care.

One participant shared a personal experience about her administrative work as an assistant at a physical therapy clinic. She emphasized that the administrative work practitioners do in the new UHCP must be drastically reduced and streamlined. The process of submitting paperwork for authorizations is painful, she said, adding that the wait to get visits authorized is too long for patients, especially post-operation when time is of the essence for the success of their surgery. Moreover, she mentioned how, as a small practice, providers often see patients with Oregon Dental Services (ODS), Oregon Health Plan (OHP), or Eastern Oregon Coordinated Care Organization (EOCCO) without authorization because it is in the patient's best interest for positive outcomes. However, this can cause them to have large write-offs. She also raised concerns about whether UHCP would be a better option for her practice. Since they are a small practice, she worried they would go out of business due to increased waiting time for patient authorizations and the long process of claims. She suggested that the Task Force research the impact of the new plan on rural providers in small practices.

Another participant raised concerns about whether the plan would be held accountable for ensuring that real-time access was provided to patients. They mentioned that as a Medicare and Medicaid advocate, it could be challenging to get providers to provide the services one was eligible for, especially for urgent needs. His example specified how difficult it could be to obtain services such as dental services under Oregon Health Plan (OHP) and that, more recently, it had been difficult for individuals to access their benefits for counseling due to provider shortages. For this reason, he expressed deep concern that a new healthcare system would continue to be dysfunctional due to provider shortages.

Multiple participants commented that the Task Force must consider the many determinants of health beyond direct medical care, such as adequate housing and education. Participants were

particularly concerned about this latter point since most Oregonians lack education when discussing health care. They questioned which steps the Task Force would follow to ensure that individuals were better informed about the UHCP when it came out.

Overall, participants were very appreciative of the changes being made by UHPC, believing accessibility to be a crucial issue in today's healthcare system. Many wanted more information and requested the chance to contact the Task Force to discuss further their propositions for more changes or issues they perceived within the policies. One participant asked when Oregon would implement the program.

Coverage and Benefits

Participants that responded to the optional survey raised many concerns about coverage and benefits. Several participants questioned which type of services the UHCP would cover, the balance between using and overloading providers and physical resources and whether individuals could keep their current providers.

Participants wanted to know if the new UHCP would cover midwifery services, home births, lactation consultants, acupuncture, chiropractic and therapeutic massages. Furthermore, two participants wanted to know what steps the Task Force would follow to balance between use and overload of providers and physical resources. They were concerned about reimbursements and the wait times being too long. Participants also questioned how the Task Force would ensure supply and demand were met with fixed prices and whether the current shortage of therapists and psychiatrists would create multiple challenges, such as long waits and insufficient providers to meet patients' demands. Lastly, several participants questioned if the new UHCP would allow them to keep the same providers and coverage that they currently have and whether the new plan would include all reproductive and gender-affirming care.

Health Care Providers

In this section, the survey reflected participants' concerns about providers treating diseases.

Many participants questioned whether the Task Force would focus on disease prevention or treatment, concerned that with everyone having access to a UHCP provider and treatment being so widely available, fewer patients would be incentivized to focus on prevention services. For this reason, they questioned how the Task Force would incentivize people to stay healthy rather than wait to get sick and follow up with treatment.

Employers and Employees

The survey reflected that several participants had questions regarding whether employers would no longer need to provide health insurance and what would happen to self-employed individuals.

Participants questioned if employers would no longer need to provide their employees' health insurance and how they would benefit from it. One also expressed concerns about how this new

plan would affect self-employed individuals, questioning if and what type of taxes they would have to pay. Likewise, another participant asked how the system would cover Oregon employees that were also Idaho residents and whether these individuals would have double coverage or if they would waive the UHCP.

Governance

Many concerns raised in the survey revolved around governance; participants were particularly concerned about the representation of different communities on UHCP's leadership board and how the needs of different groups would be addressed. Moreover, participants questioned if there was a similar precedent of a plan in a different state or country.

Several participants were concerned about who would govern the system and what the Task Force meant when using the word Community Voices. Some participants mentioned that most Eastern Oregonians gain representation on boards and groups through their connections, degrees, or occupational professional licensing. Many expressed concern that similar methods would be used to fill UCHPs governing board and regional advisory groups, questioning how the Task Force would guarantee that citizens' concerns and voices would be represented when boards and groups were usually composed of a select group of individuals and not an overall representation of lay citizens.

Individuals also questioned if the Task Force had any idea if different states, countries or entities have adopted similar systems to the one being implemented in Oregon and mentioned that it would be helpful to have a reference of a system already implemented to help people understand how the new plan would work.

Cost and Funding

Most of the participants that responded to the survey also raised concerns about the cost and funding for the UHCP. Most of these concerns focused on the equity and specifics of UHCP's taxes and whether the program would become more accessible and cost-effective if it did not rely on income taxes.

Although most participants liked the project and wanted more information regarding its implementation, participants clashed about what would be equitable when taxing residents. One participant commented that charging those individuals who can pay was equitable while charging the sick simply because they were sick was immoral. Another individual disagreed, saying that it would not be fair to charge individuals with higher incomes more since it would encourage people to earn less, causing a change in our economic system. They also suggested that there should be a cap on what people might need to pay in taxes to fund the UHCP.

Other questions asked by participants included whether insurance taxes would be counted as deductions for individuals and businesses, if the UHCP would allow the negotiation of bulk prescription prices and whether the program would become "more socialized to the general public" (this participant seemed to be asking about overall benefits to the public). There were

several concerns regarding the cost that retired people would have to pay with this new UHCP and how they would be affected due to their fixed income.

One participant who responded was an attorney who had fought insurance companies over medical care issues for 30 years. He said he saw a massive need for Universal Health Care and was very impressed with the Task Force's work. However, he was concerned about the system's heavy reliance on income taxes for funding, adding that an entire economy in Oregon goes unreported in ways that minimize the tax revenue that the Task Force projects. He was also concerned that the current plan would create a massive incentive for the wealthy to fight this program, as their health care cost could quickly go from $10,000.00 up to $50,000.00 or more.

Medicare and Medicaid

In the survey, participants acknowledged the need for the UHCP in our community. However, they also questioned whether the plan would meet the care standards set by Medicaid and provide sufficient benefits for seniors.

Participants questioned if the UHCP would provide equivalent or better coverage than the Medicare Advantage program currently available to seniors and if seniors would be able to access the standard plans without penalty.

Additionally, one participant commented that the system model usually touted as Medicare was inadequately designed for the community. He mentioned that this was because the United States healthcare system was not built to lessen the amount individuals were supposed to pay for services. He gave an example of how Medicare does not provide all the services seniors need. For example, usually individuals need more vision, dental and mental health services, but Medicaid excludes all of those. Instead, a person has to pay extra to get coverage that should be part of their plan. For that reason, he suggested he would like to see a form of coverage similar to the one used in other countries, although the U.S. tax structure would have to be entirely redesigned for that to happen.

Eligibility and Enrollment

Several participants were unsure whether UCHP would equitably cover groups like federally elected officials, undocumented immigrants, and those on low or limited incomes.

Several participants questioned whether the federally elected officials from Oregon would automatically be enrolled in the Oregon Plan. They were worried that although the plan is marketed as eligible for all, it would short-change the federally elected leaders in charge of facilitating the process. If they would cover federal officials, one participant suggested the Task Force should provide a basis for exemption and any citations the committee relied upon exempting them from Constitutional mandates.

Likewise, other participants also had reservations about UHCP’s eligibility process; one questioned if the UHCP would ensure the safety of undocumented workers and their families. Additionally, while folks were talking about eligibility, the confusion about qualifications and

affordability came through with the following comment; “consider the expenses, rent, groceries, etc., when determining eligibility based on income.”

Focus on Equity

Most participants questioned how the Task Force would ensure the plan would be equitable for marginalized communities.

During the survey, a participant commented that one of the biggest problems he saw with Oregon’s current healthcare system was that every aspect prioritizes making money over providing services. As an educator, he said, he sees how communities of privilege maintain the inequalities of an underfunded system and that this system did not prevent the marginalization of communities like houseless, mentally ill, differently disabled, and BIPOC communities despite the laws and policies in place. His concern was that this new plan would not help mitigate this issue, nor did he believe it would help relieve the stress of underfunded medical personnel, educators, and other professionals. “My point,” he commented, “ is that at the same time we are changing Oregon's health care system, we must also change the perverse incentives for casual cruelty.”

Community Session - Specific Findings by Region

Coastal Region Findings

Access and Affordability

During the Coastal community session, participants disputed who would qualify for this new plan, what documents would be needed to qualify, and the requirements individuals would need to follow. Another question raised by participants was what would happen with the Consolidated Omnibus Budget Reconciliation Act (COBRA) and if this new system would eliminate it. In addition, participants commented on Oregon’s current health care entities competing with each other by leveling the playing field. They questioned if, by having this new plan, the competition would decrease the need for mergers because the system would be focused on health instead of profits. Similarly, several participants commented that in 2021, the Oregon legislature passed a bill to allow the Oregon Health Authority (OHA) to review and possibly veto mergers and acquisitions of hospitals. For that reason, participants emphasized that while fewer institutions exist, their value has increased.

Health Care Providers

When discussing health care providers and participation during the Coastal community session, participants focused on whether the new health care plan would affect how services were provided: Several questioned if the new plan would affect the ability to bring medical providers to the state of Oregon. Participants were also concerned about the likelihood that some provider groups would end up not having an entity to work for, causing a decreased workforce without consolidation, and how the new plan would affect training programs for new health care providers.

Likewise, individuals wanted to know what the plan defined as an alternative provider and if it would include unlicensed health care providers in the new plan. If unlicensed health care providers were included, participants were concerned about how this group would get paid and how the Task Force would ensure that these and other providers were not charging an extra fee to customers.

Coverage and Benefits

Most coverage and benefits questions focused on the type of services alternative health care providers could cover and what this coverage would look like. In addition, individuals also expressed gratitude to the Task Force for emphasizing primary care in this new plan.

Governance

The topic of governance raised many questions for participants, particularly if this new plan would help decrease fraud and, if yes, how fraud would be tracked. Likewise, participants questioned whether workers' compensation would disappear and how the Task Force would ensure that medical companies would not increase their costs.

Cost and Funding

The discussion around cost and funding mainly focused on the new plan's cost and if it would be based on income range.

Medicare and Medicaid

During the Coastal session, participants did not ask many questions regarding Medicare and Medicaid. However, participants were grateful that Medicare and Medicaid were considered in the new health care plan.

Focus on Equity

Participants suggested that the new healthcare plan focuses on equity and the Social Determinants of Health (SDOH). They also commented that the Task Force should tell individuals to remember this when comparing this system to welfare; no matter how much individuals made, they would end up getting the same care and benefits.

Central Oregon Findings

Access and Affordability

During the Central Oregon community session, participants focused on the potential obstacles the Task Force might face when implementing the new health care system and, if passed, how long it would take for this plan to be implemented. They wanted to know the most significant obstacles the Task Force was currently facing and if the Task Force foresaw these obstacles derailing the plan. Several also touched on the need for more health care due to climate change and transportation for low-income individuals unable to commute to appointments. However, most were

thankful that something was being done to better the system and make it more equitable for everyone.

Coverage and Benefits

Comments on coverage and benefits generally concerned the difference between behavioral and mental health and the need for both. Most participants also wanted to know which services would be covered with the new health care plan and if it would be more expensive than their current one.

Health Care Providers and Participation

Participants recommended that health care billing and insurance professionals receive retraining and career advancement assistance with this new plan when discussing health care providers. In addition, several wanted to know if this plan would attract more multicultural staff, especially in the mental health area.

Employers and Employees

Discussion around employees and employers generally focused on whether employers would have the choice of providing other health plans to their employees and, if yes, what that would look like. Moreover, participants acknowledged that private employers would save money with this new health care plan and questioned if public employers would be able to do the same. They wondered if, by implementing the Universal Health Care plan, communities would be able to save more money.

Medicaid and Medicare

Participants' questions about Medicare and Medicaid focused on how the new plan’s changes would affect Medicaid and Medicare participants and whether there would be government agreements for individuals so that people could have some reimbursement for Medicare and Medicaid.

Eastern Oregon Findings

Access and Affordability

Participants from this session had several questions, asking what date the Task Force would implement the UHCP program and whether there would be subsidies for transportation and services to appointments. Meanwhile, other participants were concerned about the health system being flooded with patients, making the system ultimately inaccessible.

Several participants also expressed gratitude for exposing the American health care system's inequalities and the barriers that vulnerable communities face when getting health care services. “In America,” said one participant, “access to quality health care so often depends on income, employment and status.” However, they hoped this plan would help eliminate significant barriers to lifesaving medical treatment for large population segments and ultimately benefit

Oregon's population. One participant was pleased about having less paperwork flowing throughout the system. In rural areas, health care means waiting for services and providers and having a more predictable and effective administrative system could help ease that burden.

Insurance Companies

There were not a lot of session-specific comments in this section. However, one participant did ask if insurance premiums would continue to be an allowed deduction for individuals and businesses, considering that UHCP would cover most Oregonians.

Health Care Providers

With many living in rural areas with little access to providers, participants' primary concern was how the program would recruit providers to remedy Oregon’s current provider shortage in these areas.

Employers and Employees

Participants commented that many employers might mourn that they cannot continue to provide their employees with health insurance options. They reasoned that in our current system, many employees often seek work with benefits like health insurance. However, this system works against business owners: hiring staff is a costly endeavor, as many businesses, especially small ones, must constantly retrain staff to replace the ones they lose. It also works against communities' economic growth, as costly health insurance often prevents businesses from ensuring a healthy workforce: particularly if they cannot provide their employees with health insurance. Participants worry that this would impact employers' support for Oregon's UHCP.

Governance

Many participants believe UHCP's governing policies could be an essential step towards fixing the current "mess" of health care in Oregon and the US by getting all residents under one plan. They believe this system would benefit Oregon in the long run, even with a bumpy transition period. It could help create a system where residents go to the doctor more consistently and enjoy primary care benefits. For them, this was a chance to improve the system's equity and quality of care. However, others were concerned about pushback from our current political climate. They recommend the Task Force consider what that opposition would look like before continuing their plans.

Cost and Funding

Participants stated that financial barriers to healthcare access have always been a problem. One of the most common barriers cited was OHP’s refusal to cover anyone that earns more than 133 percent of the Federal poverty level. In the past, this has left countless individuals who are unable to afford to pay commercial rates without health care because they made more than OHP allowed. Additionally, one participant felt that this practice had restrained those earning lower incomes from earning more out of fear of losing OHP’s health coverage. However, with

UHCP revamping Oregon's health care system, many participants have expressed hope that this and other financial accessibility barriers would be rectified.

Participants also had many questions about the new taxes the Task Force sought to apply. They were interested in the cost and financing of the system's development and maintenance. With health insurance no longer being tied to individuals' work, several participants were worried about what the tax would be tied to, individual gross or net income, and if these taxes would help keep health care services lower. Additionally, several participants expressed worry that those with high incomes might bear more of the burden for funding the system: although some did argue that these taxes were justified and would help those in need of costly medical assistance access cost-effective care.

Southern Oregon Findings

Access and Affordability

When discussing access and affordability, the Southern Oregon session asked how the new plan would affect individuals with felonies and those who were unemployed. Similarly, although most participants liked the plan, many suggested that the Task Force emphasize prevention and health instead of the treatment of diseases. In this way, the plan would enforce proactive and preventative health measures. Several participants also mentioned that the average person did not understand how the healthcare system worked and suggested that the Task Force help educate individuals on this to make the plan more accessible. They were concerned about the specific health care plans this system would offer and how the system functioned.

Coverage and Benefits

Participants generally focused on the benefits they would receive from the new health care plan when discussing coverage. They suggested that the Task Force should focus on dental, vision, and baby health care services, emphasizing the need for families with newborns to have the option of providers visiting their homes. In addition, some participants recommended that the plan cover prevention services for the first 1,000 days of a baby's life. These additions would ensure that all residents were more fully covered and help provide for one of Oregon's most vulnerable communities.

Health Care Providers

Participants focused on how the new health care plan would lessen the administrative red tape providers must address to free up time to treat patients. Additionally, participants questioned what would happen if many clinics refused to participate and insisted on only seeing "private" or self-pay patients. They were concerned about the potential effect this could have on the new system and questioned if the Task Force could prevent this from happening by mandating that providers and clinics accept patients covered in UHCP. In addition, participants wondered if there were ways to minimize the social stratification and economic setback the system would have on public users compared to private patients.

Employers and Employees

Throughout the session, there was a lot of focus on how the new system would account for and integrate employer-based health care plans. Participants questioned whether the Task Force was reaching out to employees and how they envisioned this plan coordinating with workers' compensation. Furthermore, most participants raised concerns about health care prices for the workforce. They liked the plan presented by the Task Force, but the process of getting there worried them.

Governance

During the community session in Southern Oregon, questions on governance revolved around how the Task Force would be referring to Affordable Care Act (ACA) provisions that have been watered down or removed. In addition, participants wanted to know why the amount contributed for the federal portion would increase by $2.5 billion. Despite their concerns, most participants liked the plan and wanted to see if it would be approved at the state and federal levels.

Cost and Funding

The Southern Oregon community session mainly focused on how payment rates would look based on the region when discussing cost and funding. Participants mentioned that it was clear that this new plan would cost less but raised concerns about the misinformation individuals have when hearing about this new plan. They wanted to know how the Task Force would address these communication issues with the community. In addition, participants suggested that the Task Force should be wary of unintended consequences that the new plan could have, suggesting that they consider the plan’s effect on neighborhoods at the sub-county level, not just the regional. Lastly, individuals commented that the Task Force should be interfacing with the Public Health system to get their ideas and clarify if sharing taxes would cost participants more.

Eligibility and Enrollment

During the Southern Oregon community session, participants’ questions focused on the Oregon Department of Human Services (ODHS). Participants were concerned about whether “ODHS/Aging & People with Disabilities [would] no longer be tasked with determining medical eligibility for consumers of Long Term Services and Supports,” and whether those savings had been quantified. Furthermore, several questioned whether parents could be paid as caregivers for their sick or disabled children as they had been during the pandemic but not before. One mother mentioned that when she started being her son's primary caregiver, he stopped going to the hospital, where he had been going back and forth every couple of months. Since the time spent caring for her son was costly, she could not continue caring for him after the pandemic ended. She hopes that if this new system allows parents to be paid as caregivers, she and other parents would be able to take more time off of work and care for their children full time.

Focus on Equity and SDOH

Many participants in the Southern Oregon session focused on equity and SDOH, wanting to know how the plan's outcomes would be equitable for people with disabilities. Individuals questioned whom the system would be regulated by and wondered if that would include an Americans with Disabilities Act (ADA) enforcer. If not, they questioned how this policy would be enforced and how they would accommodate people with disabilities due to some individuals needing different accommodations. Lastly, participants wanted to know how the Task Force was planning to establish trust among marginalized communities and if this new plan would help provide patients with resources necessary for healthier lifestyles.

Portland Metro Findings

Access and Affordability

Throughout the session, participants expressed concerns about keeping the plan affordable for Oregon's residents. Although most of these questions were centered around the cost of funding Oregon's health care plan, some participants also expressed concern about the involvement of private investors. They recommended looking into ACO REACH and Direct Contracting Entities, an initiative begun in the Trump administration that would "privatize Medicare to the benefit of investors." They were concerned that if UHCP were not careful, this initiative would allow private investors to interfere with their proceedings and bring about long-term consequences for Oregon's health care plan: such as making the plan unaffordable for the average resident.

Lesser concerns in this area included technical questions about information accessibility, with participants asking about UHCP's website and where to find more information.

Coverage and Benefits

Participants primarily focused on the need to expand the behavioral and mental health field in Oregon to meet community needs.

Health Care Providers

With Oregon currently suffering from a shortage of healthcare providers, participants were concerned that there would not be enough providers to serve Oregon's residents. They were especially concerned that forcing provider participation would result in many leaving the state or refusing to practice under the new system, leaving Oregon with a more significant shortage. Additionally, participants questioned if providers would be compensated enough under the new plan to incentivize and attract potential providers; they fear that a drop in income could disincentivize individuals to become providers or make them harder to recruit.

Similarly, other participants asked if the Task Force had written up the minimum required best practices guidelines for the plan's providers to follow, as it would be difficult to quantify the quality of care provided by providers under UHCP without them. They worry that a lack of practice guidelines would allow health care provided by UHCP to drop below standards, making it difficult for the plan to compete with private health care plans. Some participants also argue

that a lack of practice guidelines would make it difficult to promote or integrate new providers, such as nurses and doctors, as there would be no standard to judge their operating practices.

Governance

While participants appreciated the Task Force's efforts with UHCP so far, participants expressed many concerns about UHCP's planned governance policies: Their foremost concern was UHCP's need for solid success metrics to shape the plan's internal structure. As one participant commented, “good intentions have led to bad structural interventions and worse outcomes when existing delivery systems and dominant political and economic forces overwhelm citizen input despite claims of equity in [the] process.” They fear something similar would happen within this new health care system should its success metrics not ensure adequate public participation and administrative governance. Participants recommend that if the Task Force has not yet implemented such measures, they should be planned and implemented early to ensure that the program may grow and mature effectively.

Participants expressed a similar concern about implementing safety measures within UHCP’s policy plans. They were worried about the health care system’s impact on Oregon’s population and recommended that a set of safety measures be implemented to keep the community whole throughout the program’s trial period and beyond. Others also suggested that safety measures be implemented to help address external threats to residents’ health, such as natural disasters, economic crises, increased population, and war.

Despite these suggestions, several participants had reservations about the Task Force's definition of a single-payer plan, claiming that the presented plan seemed to model a multi-payer one instead. Their concerns hinged on several policy measures implemented, but mainly the recommendation that the Task Force continue moving the plan forward even though the necessary Federal waivers and/or Federal enabling legislation had not been passed. One participant commented, “This recommendation means that the plan may leave out Medicare recipients and others among the most vulnerable Oregonians. That would not be a single payer plan and would reinforce current inequities.” They believe this would create “an inadequate system that would become unpopular and politically untenable, and lead to backsliding.” Many participants suggested that the current plan be reevaluated and the vote revisited. They also suggested that the financial analysis on UHCP be repeated as it accounted for a single-payer plan, believing that the Task Force has instead designed a multi-payer plan that is more expensive and less equitable than the original.

Lastly, some participants suggested that the Task Force research other single-payer plans and UHCP systems while they finalize their program's policies. The most controversial of these recommendations seemed to be the Veterans Affairs (VA) health care plan, which some participants felt was fragmented and wasteful. One participant gave their experience with the VA, claiming that this model led to lower income and FQHCs (Federally Qualified Health Centers) closing down rather than being boosted up in their expertise in providing care to people with less coverage and high need complex patients.

Cost and Funding

This section was a mixed bag of questions. While one participant asked how upstream investments would be streamed, several others questioned the savings enabled by the plan's blended funding. Another participant seemed concerned by the projection that only 990 billion dollars would be saved, believing that the plan ought to produce more significant savings if Oregon could run it at a 2% overhead rate similar to Medicare. Likewise, one participant wanted more specific information about where UHCP would keep savings and when they would collect income taxes for the program. Their main concern was that the blended funding would allow legislators to siphon funds to pay for other legislative expenses.

Medicare and Medicaid

The Portland Metro session asked many questions concerning Medicare and Medicaid. Several participants wished to know how UHCP would interact with Medicare and Medicaid and if it would be possible for seniors and other clients to opt out of using UHCP in favor of their current health care plan. Some believe this plan would cost more for seniors with passive income and were worried about Medicare and Medicaid users being overburdened by their current health care taxes and those implemented by Oregon's new plan.

Other participants expressed their disregard for Medicaid estate recovery, asking if UHCP would continue this program or, if not mandated by the federal government, would they eliminate it from their policy plan?

Focus on Equity

Portland's regional session also focused on accurately implementing equity and social determinants of health (SDOH) into the program. Their main concern was whether or not UHCP would include resources for SDOH and the impact this would have on Portland's houseless population. While the policies presented to participants never clearly stated if this plan would work towards helping improve the houseless population's circumstances, many seemed to believe this would be the case.

Willamette Valley Findings

Access and Affordability

In the Willamette Valley, the community asked how the new system would assure doctors more time to meet with their patients to practice preventative care and provide necessary services without being based on a proof system that denies care. They were worried that allowing more time to individuals would slow the process down for everyone and ultimately contribute to accessibility issues. One participant wanted to know if the new plan would cover consultations outside the state, referring to rare conditions and diseases where there are few experts or facilities in the nation able to provide proper treatment. Other individuals also asked how they would get a provider or a hospital of their choice and how narrowly limited the plan would be in terms of providers, questioning how the program would ensure enough capacity for everyone to be served.

Insurance Companies

During the community session in the Willamette Valley, questions around insurance companies focused on how Oregon UHCP would integrate with the Federal government and Veterans' health care systems and what the new health care plan would cover.

Coverage and Benefits

When discussing coverage and benefits, participants focused on the type of services the plan would offer, such as how people with disabilities or chronic diseases would be covered and how the Task Force would ensure they get the appropriate care. Individuals questioned if the new health care plan would cover a diagnosis like autism and whether it would employ case managers. Additionally, most participants raised concerns about how COVID-19 has affected individuals and how it would keep affecting them. Many wanted to know if this plan would implement more effective processes for administering vaccines and COVID-19 treatment.

Health Care Providers and Participation

This section received many questions from participants about how the system would deal with privately owned hospitals and providers. Many wanted to know if private providers were likely to support the new system, expressing concerns about the pushback this plan could receive from private entities. Likewise, participants wanted to know if hospitals would continue to be privately owned and if they would be allowed to turn away patients. Finally, individuals wanted to know how this new plan would promote integrated physical/behavioral health care; they were concerned about the current system’s struggle to meet the needs of patients and questioned if UHCP could improve their care.

Employers and Employees

During the Willamette Valley session, this topic did not receive much attention from participants. However, one participant did express concern about the financial impact of covering out-of-state residents who work for Oregon employers.

Governance

The governance section received a wide range of questions from the Willamette valley session. Questions ranged from how out-of-state residents working in Oregon would affect the new plan to whether the task force had already considered how to handle the need to provide UHCP's administration with a copy of their last year's Fed/State tax return as required by those who utilize Oregon's Insurance Marketplace and receive an ACA tax credit. Likewise, other administrative questions included how the wisdom of these last few years would be used to rebuild the BH (behavioral health) system and how the Task Force was approaching the need to address business-model concerns of private providers and policymakers. Furthermore, the participants wanted to know the Task Force's thoughts on creating a truly effective management system for single payers in Oregon and if there would be intentional efforts to reduce the burden of paperwork and documentation in this new plan.

Besides these questions, participants also left a lot of comments and suggestions on improving UHCP's processes. One participant, for example, commented that using the State Accident Insurance Fraud (SAIF) program as a model for UHCP would be a horrible mistake since SAIF was based on the idea and philosophy of denying claims and care. Instead, participants suggested developing the equivalent of the United Kingdom's National Institute for Comparative Effectiveness since the state of Oregon could pass such legislation before it approved the Universal Health Care System.

Participants also recommended that UHCP's record system be flexible since the current electronic records systems have severe limitations resulting in distorted and inaccurate records. An example mentioned at the meeting was that the current system had allowed providers to detail allergies. However, it has not allowed providers to recognize genetic information, including specific known issues like Cytochrome P450 (CYP450) enzyme information or family health issues. Ultimately, these have been pushed into categories where they do not belong— causing a family history of an abdominal aortic aneurysm to end up recorded as though one was suffering from this condition rather than as if a patient were simply vulnerable to chronic disease.

Furthermore, participants suggested that the plan should be more equitable, voicing their opinion that the Task Force should not use today's model of value-based payments. They mentioned that fee-for-service percent was not the main problem with today's health care system and that most countries with successful Universal Health Care systems still use fee-for-service in equitable enforceable ways. Instead, participants emphasized that today's value-based payment models only add inequity by incentivizing providers to avoid high-risk patients and reduce services. They commented that the Task Force justifiably emphasizes creating an equitable system that allows all residents access to care. For that reason, participants suggested that Oregon's system must fit into a national economy and be palatable to policymakers in charge of approving the spending of federal funds on Oregon's Universal Health Care Plan.

Cost and Funding

The Willamette valley session had two main concerns around cost and funding. What type of financial philosophy would the plan be centered on? How would COVID-19 affect the plan's viability?

When creating a new health care system, participants agreed that establishing a robust culture of guiding ideas, ethics, philosophies, goals and more was an early critical step toward preventing future issues. However, many worry about what form that culture would take. Participants took steps to warn the Task Force against establishing their new system around profit and cost/loss. The current system was founded on a similar philosophy and, in their eyes, was based on denying care under the guise of minimizing costs: a process that maximizes the harm to people and ultimately maximizes costs and harms.

Likewise, as the nation's experience with COVID evolves, participants have noticed long-term chronic health issues become more prominent. Participants worried that if insurance companies

did not prepare for this spike in chronic issues, there was a real possibility they would collapse under future financial load. They questioned how UHCP planned to deal with this dilemma and whether or not they were prepared to take on this future burden. One participant also questioned whether the plan had considered the possibility of paying for health outcomes with "cared-out incentives."

Medicare and Medicaid

During the Willamette Valley session, most of the questions on Medicare and Medicaid revolved around whether the Task Force would negotiate with the federal government to use Medicaid funds and specifications on how the new plan was related to Medicare.

Spanish Session Findings

Access and Affordability

In the accessibility section, participants focused on outreach to indigenous communities and accessible care for migrant workers. The latter questioned how migrant workers would be enrolled since they were neither long-term Oregon residents nor did they work exclusively in Oregon state: many often travel to work in nearby states. This transitioned into asking about the accessibility of care for other Oregon residents who do not work in Oregon year-round or who find it easier to receive health care in nearby states due to a lack of in-state providers or their closer proximity to out-of-state services.

Outreach to indigenous communities was also a key topic of conversation as many Hispanic participants with indigenous roots attended this community session. They asked to make information and resources more accessible when reaching out to their communities. They noted that indigenous Latino/a/x/e communities were so diverse and widespread that government organizations often overlooked their communities when seeking to inform people about important topics or projects like UHCP.

Participants first asked the Task Force to consider the complex language barrier surrounding their community. Although indigenous Latino/a/x/e communities have often been considered part of the Hispanic community, this is not always the case. Those who speak Spanish often speak it as a second language, one which many speak with difficulty and often do not read or write. Those who do not speak Spanish often prefer to communicate in their native languages or dialects, which are often only spoken. Additionally, few Indigenous Latino/a/x/e community members use online resources due to technological and linguistic barriers, making it difficult to reach these communities through written pamphlets, flyers, or online resources.

Instead, participants suggested using community forums and informative meetings in native languages and speaking to these communities through interpreters and trusted community members. This was the process used in the Census and one that participants found to be effective when seeking to make resources and information accessible to indigenous communities: a process many considered challenging due to the number of languages and dialects spoken by the indigenous Latio/a/x/e community. Overall, participants believed that

targeted outreach was crucial for their communities. A lack of access to critical information, government resources, and complex language barriers have left their communities vulnerable when navigating a system not tailored to meet their needs.

Insurance Companies

Participants' primary concern was that if insurance companies were left to cover the services that UHCP did not, they would start overcharging on premiums. They were especially concerned that any essential services would continue to go uncovered, fearing that allowing insurance companies to set the price of these services/premiums would prove disastrous.

Coverage and Benefits

Participants focused on the benefits and services UHCP's coverage plan would offer. They asked about the inclusion of transplants in their basic medical care and suggested adding orthodontics to the plan: due to its perceived impact on mental health. They also questioned if the plan would cover medical expenses for disabled participants and were interested in knowing if it would cover brand-name medication or only generic prescription drugs.

Employers and Employees

When discussing the financial implications of Oregon's new health care system, many participants were concerned about the impact this would have on employers. Several worried these new taxes would be a burden, especially if employers were expected to pay for all of their employees' treatments. They fear these taxes would destroy many small and local businesses by making them unprofitable, leading to many people losing their livelihood and increasing the control large corporations already have over the economy.

Governance

When discussing the plan’s governance policies, several participants suggested beefing up the language of the UHCP to help protect the health care for life project now that many of the project’s rights are under attack.

Focus on Equity

Participants were curious about how UHCP would support vulnerable communities when discussing the plan's equity policies. One participant asked how older people would get economic support if UHCP did not support this within the new program. Another suggested that UHCP speak with indigenous groups to get their perspective on their system’s policies.

Conclusion

For many, healthcare is not seen as a benefit but as an intrinsic right directly correlating to survival. Over 200 participants from all corners of Oregon attended the seven virtual listening sessions in June and July of 2022. Those who participated conveyed that it is urgent to change health care in Oregon and overcome the inertia of an uncoordinated, fragmented system that

emphasizes intervention rather than prevention and is exclusively accessible to high-income individuals. They expressed that it is imperative to improve the quality of Oregon's healthcare system and for care to become available to all Oregonians.

Overall, participants showed excitement, interest and hope for a more inclusive and human-centered system that would allow them to take care of their needs and the needs of their loved ones. They believe ensuring access to affordable, quality health services is essential to living a happy and prosperous life. Several health providers participated, sharing that if the new system emphasizes primary care, providers could practice care as they intended when they pursue their careers: by helping others instead of dealing with insurance companies.

Participants agreed that the current system is collapsing and is not helping but hurting low-income, BIPOC and rural communities with its inequities and insufficiencies of care. Almost everyone that participated expressed their opinion in favor of change and agreed that universal health care access would better facilitate and encourage sustainable preventive health practices and be better for the long-term public health of Oregonians. Health care costs are challenging for many in the current system. Removing the fear and possibility of bankruptcy due to health care would be a game changer.

Along with the positive outlook on what this plan can accomplish, many expressed their concerns about the new plan. Some participants were concerned that the plan would not be ready to cover all Oregonians, resulting in extra long wait times for patients. They were worried about the possibility of larger forces as powerful health insurance companies, pharmaceutical industries and hospitals would be against it and inhibit change. Many see this plan as a positive change, but not possible to implement due to the inherent distrust in our governmental procedures. Many lack hope and vision for the public to see this plan as too good to be true.

Despite this, participants were eager to learn more about how universal health care would work, suggesting that the Task Force continue engaging with the community using transparency as a critical element in the process. They were very interested in learning more specifics and had many questions that the Task Force took the time to explain and answer one by one. Most were interested in knowing more specifics of how they will be able to pay for the plan and what the plan will cover. Some were also interested in what will happen to the workforce that now depends on the current system. They brought their ideas on how the system should work and what the task force should do. There was much willingness to continue learning and engaging with the Task Force.

The following are recommendations from LMS and participants from the community listening sessions.

Recommendations

- Continue to let the community know about the plan and establish the channels to continue the conversation. It is essential for the Task Force to continue to listen and learn from those closest to the problems, for they are closest to the solution.

    - Continue investing in community engagement through virtual town halls and roundtable conversations.
    - Develop a simple and short toolkit that includes the presentation and Q&A to be distributed among CBO and other community groups.
    - Develop a marketing plan and share the channels for the public to provide feedback and support.
    - Create a short podcast with Task Force's latest news and distribute it to keep the community informed.
    - Continue to engage with the community using social media, emails, and CBOs.
- Be more explicit about the cost of coverage, eligibility, and the benefit that Oregonians would receive through this system.
    - Spell out who would be eligible for the system and explain the philosophy of "Everybody in; nobody out."
    - Create a universal language to explain how much health care will cost, using graphics and less jargon, explaining how people/families will pay for the plan.
    - Use the COVID-19 pandemic as an example for the plan and explain how the program will benefit Oregonians in the event of a future epidemic or pandemic.
- Draw a process map explaining how long the process will take and why it requires years to be able to take form.
- Include in your planning how this new system will offer training and provide workforce development for those whose roles will become obsolete under the new UHCP.
- Continue learning from the failures and successes of national and international health care systems.
- Train all members of the Task Force, associated community advocates and other trusted community members to be ambassadors of Universal Health Care in the community.
- Celebrate the work done thus far.

It will continue to be essential for the Task Force to provide a platform for ongoing discourse with all Oregonians and allow participants to bring unique insight to and from their communities' needs, wants, and challenges.

Appendix

Appendix A

Synthesized Notes | Universal Health Care Plan | General Questions and Comments 2022

<u>Access and Affordability</u>

Traveling:

- Will the Oregon Health Plan be available while in a foreign country?
- How will snowbirds obtain care when out of state?
- Will I be covered if I travel out of state/country? Because my current INS does cover me. I am retired and plan to travel.
- What happens when a patient moves out of state? (traveling/ moves)
- Would consultations outside the state be covered by the plan?
- Are there any plans on expanding this plan to allow it to cover providers in other states?
    - There is a very limited number of providers, and unless they go to Portland, most people have no option but to go to Idaho.
- How will care be provided/covered for care needed when traveling out of state?
- Live in Ontario (border of Idaho). I didn't hear that this will be replacing the OHP. Are there any plans for expanding and allowing this plan to cover providers in other states?

Lack of access:

- If it's tough to get care now, how are you going to make it better?
- Right now, we have long waits for appointments due to covid, sometimes up to 6 months. What thoughts does the committee have about this problem? Will it be short-term?
- Does it mean that there will be longer lines and longer waits because everyone will be insured? Don't you think this can increase discrimination?

Provider shortage:

- Do we have enough providers?
- If there are provider shortages, could some of the funds be used to pay scholarships for medical students?
- There is a serious shortage of many specialties in Oregon today (Rheumatologists, Endocrinologists, and others). How will the new system address and remedy this?
- I see much negative speculation about this plan. I'm thinking that the lower administrative costs will lure specialists to practice in Oregon. Am I naive?
- Do we have enough providers to serve all these folks?
- If everyone has equal access, there will surely be shortages of providers etc., not criticism, just reality as already there are often long waits for specialists and surgeries.
- There's a tremendous workforce shortage, so how will you promote nurses and nurse practitioners and address the need to get caregivers and family support to get people a palette of care away from the hospital?

- Is there anything that encourages, say, increasing providers of primary care, such as advanced practice RNs?
- The physician and nursing shortage could be partly resolved by allowing the thousands of well-trained physicians in other countries who apply for entry to the USA be allowed in.

Authorization:
- Will there be authorization for procedures?
- Will there be prior authorizations required for some care?

<u>Insurance Companies</u>
Increased costs:
- Not all services will be covered under this plan, and private services will target those services that the Universal Health Insurance doesn't cover. Do you think they would take advantage of this and overcharge their premium?

Integration:
- How will insurance companies be part of the system?
- What are you envisioning current health plans providing?
- How will the Oregon DHP be incorporated with the veteran insurance?
- Currently, there is the Oregon Health Plan, Marketplace Plans and then other programs providing care at low or no cost. How will this Plan change and integrate all into one? and what would that system look like?
- How would this work with groups like Kaiser, who insure and provide? Are groups like Kaiser willing to take UHP?

Pushback from Insurance companies:
- I think that this will be an uphill battle and that there might be a lot of people or insurance companies who aren't onboard with this.
- I think the biggest obstacle is the fight back that will come from corporate, for-profit health care. It will be a huge battle. The money will pour into the campaign against...
- Statewide there is increasing activity and influence of for-profit private equity groups from outside of the state becoming the owners of health care accessibility, governance and clients. It seems logical to assume that these for-profit groups would present significant pushback since statewide UHCP would no doubt threaten their profit as well as disbursements to investors. As the Task Force continues on its work, how do you see the impact of these groups with their wealth and political power?
- When Oregon citizens got a universal health care measure on the ballot, it was soundly defeated by the mass amount of money the insurance medical industry put into the opposition.

<u>Coverage and Benefits</u>
General sentiment:
- Medical treatment is the most important thing for me.

Transgender care:

- Will gender affirming be covered?

Alternative care:

- Will alternative medicine such as naturopathic doctors, chiropractic, acupuncture, massage, etc., be covered?
- Are nutrition, physical therapy, and chiropractic services going to be covered?
- Will alternative medicine be covered?
- Are non-licensed peer-type services covered?
- Would this plan include other types of treatment like alt treatments that people find in their own countries or that we can't find here?
- Will this plan include alternative/homeopathic care?
- We need to make sure that non-traditional care is covered, acupuncture, chiropractor, and Chinese herbs.

Long-term care/ chronic illnesses:

- Is long-term care being considered?
- Would this plan include heart surgery?
- Will this plan include treatment for lupus, cancer, and heart attacks/diseases?
- What about transplants? Would this get covered right now (I understand that it might not)?
- Public Employees' Benefit Board does one wonderful thing that I hope you will replicate: All diabetes supplies are covered 100%. That includes many different types of blood sugar monitors, including very expensive continuous glucose monitors. Not cheap, but still cheaper than trying to repair us when we can't afford good maintenance.
- Lots of older people and Latinos have diabetes and don't have a lot of access to money or health services. If this passes, would this help people access wheelchairs and prosthetics because this can lead to a lot of health issues when unchecked, and a lot of people have to have their legs amputated because of this?

Drug coverage:

- Is there a consideration of prior authorizations for drugs covered under the system?
- Does the plan cover pharmaceuticals?
- Will all medicines be covered?
- Will this plan include medicine?
- Does the plan cover pharmacy? Some drugs are incredibly expensive. Will all drugs be covered? If not, who will decide who gets that pricey drug and who dies?
- I wish that medicine received more attention.
- My husband's cancer drug costs $15,495 per month. Will the Plan be able to reduce drug costs?

Hearing Benefit:

- Is there a hearing benefit?

- Will hearing aids be covered?
    - Why were hearing benefits not included? The cost of hearing aids is quite high.

<u>Healthcare Providers and Payment to Providers</u>

Mandatory Participation:

- Will the participation of all Doctors and providers be mandatory?
- What will stop doctors from crossing state lines to practice?
- Will some providers completely opt out?
- Will there be an incentive for people to use urgent care or primary care providers rather than more expensive emergency rooms?
- What happens if providers opt out?
    - If providers may opt out, how can this system work? How can we get the provider of our choice? Will we be narrowly limited in terms of providers in the system?
- How will this solve the shortage of specialists in the state?

Participation Standards:

- Excellent concept and plan. Will there be required minimum standard components for all participating providers based on best practice guidelines by acuity, illness, and population to address QD?
- I hope that this plan will allow for guaranteed minimum required best practices: guidelines for participating providers by age, illness, and population, such as well, child care, prenatal care and other issues. If you didn't provide a certain minimum standard, you couldn't participate. I'm wondering if that's something that would be considered?

Payment to Providers:

- (On Central Oregon's health council) Will this plan pay a higher rate to providers than Oregon Health Plan's 35%?
- If there is a drop in provider income, then less desired harder to recruit providers?
    - I am also worried about a drop in provider income that might be a disincentive to recruiting providers.
- Comment: Under a global budget that is recommended in the Task Force proposal, regional healthcare administrators can choose how to reimburse providers in ways that satisfy and maintain the workforce, whether this is through fee-for-service or fee-for-time.
- Comment: Please don't use today's model of value-based payments.
- Fee-for-service percent is not the main problem with today's healthcare system. Most countries with successful universal healthcare systems still use fee-for-service but in equitable, enforceable ways.

Administration/ Effective Management:

- Will there be intentional efforts to reduce the burden of paperwork and documentation?
- Comment: Providers will see a decrease in expenditures. Considering the aggregate spending for administrative overhead.

Privatization:

- We are seeing a lot of privatization; should this be a concern?
- Will hospitals continue to be privately owned? Will they be allowed to turn away patients?
- Will there be oversight of private hospitals?
    - Over a month's time, my daughter was turned away by the emergency rooms of hospitals run by one business until she finally developed a life-threatening condition that has left her using a walker due to brain damage. They kept refusing to hospitalize her.

Employers and Employees

- Will this eliminate employer-based insurance?
- What happens to people like myself, who are currently ensured through an employer?

Governance

Technical Concerns About Federal Legislation:

- Does the implementation of this plan depend on the Federal Government making changes or passing laws? If so, what is the plan if we can't get those changes?
- Impressed with the work of the Task Force, however, in order to pass or implement a single payer, federal legislation [is] needed. Will the Task Force recommend legislation to support single payer universal care?
- How do these proposals fit in with the need for a much more robust and sustainable public health system?
- In regard to being prepped for pushback, do we need federal approval once this bill is passed in the state?

Effective system management:

- Much needs to be planned, and other issues will not come out until after implementation. I support HCAO with very careful planning and room to adjust as necessary; thanks.
- I understand a public-private entity such as the SAIF program is being contemplated [to govern this program]. What are the Task Force's thoughts on how to create a truly effective management system for single payer in Oregon?

Governance board:

- Who will be on the governing board?
- How many people will be on the governing board, and how will you make sure it is diverse?
- We need more community engagement and input from the BIPOC, Disabled and Veteran community etc., for the success of the single payer program.
    - Diverse voices must be represented strongly on the governing board for the plan to work.
- Who will be the governing board?
- I recommend the Board be representative of the diverse community and an oversight system of diverse communities as well for the success of the single plan.

Other States:

- Are there lessons from other states?
- Do you know of any other state using a single-payer plan?
    - Are those plans being overseen by the state government?
- Is Oregon the first state to have this system?
- Have there been conversations about Universal Health Care with Washington State and California - perhaps a regional program?
- It'd be great if every state had a Universal program, but that's not [a] reality for now.

CBO Participation:

- We hope that community-based organizations already doing this work will be included in that outreach- very important for helping people sign up for HC.
- Has there been any feedback from employers, hospitals, and providers about whether or not they support these measures?
- Who from the provider community has been involved in discussions regarding this plan?
- The Task Force is justifiably emphasizing [the] creation of a system that is equitable and allows all residents access to care. Meanwhile, you know that the Oregon system will need to fit into a national economy and will need to be palatable to policymakers who will or won't approve spending federal funds on the Oregon UHP. How is the Task Force approaching the need to address business-model concerns of private providers and policy-makers?
- Do you plan to talk with the statewide health councils?
- Have you reached out to the Oregon Latino Health Coalition and other CBOs that serve the community?
- Are unions involved?
    - Where are unions on this?
    - It seems pretty important for Unions to be onboard. I would be really interested in what they would say would be important in order to protect their people. As being a member of a teacher's union – it would be amazing to not have to bargain on health care. [I] would rather focus on other things, like class size. Talking with unions will be really important in advance. Unions will be super important.
    - Among unions, I would not expect all having the same views/concerns etc. Often there is a difference between [the] public sector and private sector unions, and some unions have members in both sectors.
- Will the Task Force meet with Canadian and Scandinavian government experts to learn from them about how to best implement this system?

Concerns about Opposition:

- What do you see as the barriers that would come out of the legislation?
- What do we do if those who believe the government should not provide for its people take over the federal government?
- I don't know if this will pass in the federal gov: have there been talks about getting past federal pushback and/or lawsuits?

- Considering the role of private equity, DCE's and dark money in politics, I do see additional pushback against implementation from out-of-state employers who have OR employees.
- Do we have enough money to counter the forces on the other side?
- In regards to being prepped for pushback: the pdf that was sent out said that once it's passed in the state, it would need federal approval. Imagine it would pass in Oregon but does not have faith in the federal government, given the times we are living in. Have there been discussions regarding federal pushback?

Suggestions/Questions about supporting the plan:

- What do you encourage us to do to help get this through legislation?
- [I] want people to help put pressure on Congress to pass the bill that would allow the Federal Government to sign waivers to give us funds for single payer healthcare systems.
- When it's time to take it up to legislation, find folks who are general community members to testify in support of the bill. This is great work being done and making sure the community is informed.
- A more aggressive marketing campaign will spur a marketing campaign by the for-profit medical industry. Please think [about] how we could inoculate this plan against big corporate money.
- How can we help protect this plan? In light of the fact that we have had an attack on a lot of these rights, are we going to beef up the legal language of HCAO?
- I would strongly urge finding community members to testify in support of the bill.

<u>Cost and Funding</u>

Taxes:

- What will be taxed?
- Will Roth IRA distributions count as income for this tax? (I'm not sure I care, but this may be related to the opt-out question.)
- What will we pay?
- Will we end up paying more?
- Will state taxes increase?
- Are taxes going to increase?
- Who will be taxed?
- Who is taxed when a person does not have any employer since you said employers pay tax on wages?
- Will the payroll tax include people who are hired out of state?
- Will retired people on Medicare be taxed?
- How can we make this fair?
- Comment: I am a huge fan of universal health care and will fight for it, but I am troubled by the Task Force's high reliance on W-2 Income because it is so easy for so many to avoid classifying the money they live on as W-2. I'm not just talking about the huge "under the table" and "unreported income" economy, but also the rich who have the option of reclassifying the money they live on as dividends or loans on appreciating

assets rather than W-2 income. The temptation to do this for someone facing $40,000.00 for a 10% tax on a $400,000.00 income. How do you plan to have these people pay their fair share for our universal health care?
- How can you guarantee that this will be equitable or cost me less as an individual Oregonian?
- Those who make more will be burdened by the expense of funding the program?
- When CCOs were implemented in OR, it put the burden on those who make more who then don't want to work as much if it is not fair. What is equity? Those who make more pay more. There is an incentive to earn less money.
- Very supportive of universal care in Oregon. Thinks that the new system will incentivize people to earn less money. Deeply concerned that those who make more will bear the brunt of the cost. Not fair if those who make more money will pay $500 or $600/ month.
- If I make a higher wage right now, I have the choice to choose a higher deductible plan, as I am a healthy individual. From this presentation, it sounds like I will not have a choice on a plan and will be forced to pay a tax that will cover everyone at a rate that is higher for those in a higher income bracket. It sounds like this plan will actually cost more for some individuals, and they will not have a choice. This is not an equitable model.

Suggestions:
- Say if employers and individuals are playing in on a flat basis where you don't have progressive taxes. So if the contribution is already flat, like 5% of our payroll, then there is already a discrepancy in the amount that people pay into it even if the utility is the same. We are already very dependent on the upper half of the income taxes. If you double down on that too much, and the people you're hoping to provide care to fall into that category too much, you could lose what you're trying to gain. So what would it look like if you went flat (on the taxation rate), that'd be the suggestion with taxation.
    - Oregon state tax is essentially flat/ Fix tax is regressive == evil.
- So to follow up on that, maybe, like the Federal tax, we can have a limit on the taxes paid. We could disregard the first X dollars of people's income and then have people start paying so that many of our seniors who can’t afford it or those on low income will still be able to afford paying their taxes at the end of the year.
- Has the Task Force considered a tiered income threshold for taxing interest and dividends earned above a defined upper cap?

Blended Funding:
- Part of the funding comes from federal programs. What if that funding is reduced or ended?
- Does the Plan have to negotiate with the Federal Government to use Medicaid funds? How is the Plan related to Medicare?

Risk-based expenditures:
- How do we calculate the risk-based expense, like other types of insurance?
- Why should we pay for people whose behavior places them in active harm?

- Also, in other plans, everyone has a card, and they have ways to make sure that overutilizers are held accountable. We need to have that; I think it can be important to have some system to decide on what treatments or procedures are applications and which are not.
- How do we navigate for voluntary high-risk behaviors - i.e., tobacco use and things that contribute to poor health outcomes? Is risk-based being considered? Why are we paying for healthcare who [is] contributing to their own poor outcomes?

Utilization costs/ over-stretching our program:

- How can we see the modeling of cost and utilization? My concern is that the proposed coverage far exceeds what I have had while using the very best coverage I have been able to access that is likely on the more robust and comprehensive end of the spectrum.
- Excess utilization from patients with unaddressed illness and overutilization bankrupted some med advantage plans that had rapid rollouts. How will utilization be monitored and controlled to avoid excess costs?
- Containment and utilization – so many sick people entered into the systems, so many companies went bankrupt- how will you effectively provide care without going bankrupt?
- I'm concerned that people might come here to get expensive procedures done, and if too many people do that, our taxes and other funding won't be enough to cover the costs.
- As our global experience of Covid evolves, we are also seeing long-term chronic health challenges becoming part of our health care program in the future. There is the possibility that current health insurance companies [will] collapse under the financial load.
    - As our global experience of Covid evolves, will our current provider system collapse? There are many going bankrupt to pay for the treatments needed after covid.
- How will they be prepared so that the program doesn't collapse (with an influx of more people)?

<u>Medicare and Medicaid</u>

Will those on Medicaid still have to pay premiums?

- Would those eligible for medicare still pay the federal part a premium?
- Would People already using medicare pay income-based tax for Universal Healthcare?
- For those of us on Medicare, would we continue to pay Part B premiums and premiums for drug coverage?

Confusion over what the plan will cover vs. Medicaid:

- I had Public Employees' Benefit Board before I retired. It had a tier system for RX payments. On my Medicare Advantage plan, there is another tier system, but it pays less for some meds. Would the Medicare Advantage plans change?
- Also worried that this will make it harder for people on Medicare to get help if providers can refuse to help them due to financial motivation.
- Will this replace Medicaid and OHP?

- Medicare is very specific about what they do and don't cover. Do you have an idea if they are open to negotiation?

Eligibility and Enrollment

- Does this cover houseless individuals or non-residents?
- Will Federal Elected Officials from Oregon automatically be enrolled in the Oregon Plan?
- How does this affect Native Americans if they have said they have no interest in Universal Health care but just to fund treaties?
- What are private patients in this program?
- Will people with chronic diseases be covered?
- Will the payroll tax include out-of-state employers who employ Oregon Residents?
- Do you intend to cover every Nike employee worldwide since they are based in Beaverton, Oregon?
- What if you don't have a job? Are you still eligible?
- How would enrollment work for migrants and seasonal workers? For those who move in and out of state or are not here year-round? Would they be eligible for the program?
- Would undocumented people or individuals without SSNs would be covered by this plan? What about people on work or student visas?
- Have you figured out how this will cater to seniors? Or people who have no economic support?
- [A] true blessing if this will happen, especially for people who are undocumented.

Concern for Residents without legal status:

- Concerned about mixing federal money and the community's money to fund programs because people without legal status might get in trouble with the federal government.
- What forms of identification will be needed?
- How does this plan ensure the safety of people without SSNs or who don't have legal status?

People moving in from out of state:

- How [do they] handle when non-residents come in to get free health care?
- How do we make sure people don't move to Oregon for free healthcare?
- Is there a way to make sure that residents of other states can't claim to be an Oregon resident to get free care?
- How will we keep track of those coming into the state to receive free health care? Once a year? But what about those that move out of state?
- [I'm] worried about incentives, overutilization with people migration from other states wanting free healthcare.
- Triage and waiting lists? People moving in and out of State - If one leaves Oregon, does the individual immediately lose insurance? If one comes from out of State, what is the waiting period, if any, to get the insurance?
- It seems like this new program can be like a magnet to attract people from other states. Have you considered the increase in people that the state of Oregon will have?

- It seems that this new program can be a magnet to attract a lot of people from other states. Are you considering the risk that the state of Oregon will have? How will they be prepared so that the program doesn't collapse?

Focus on Equity and SDOH

Lack of Equity to Underserved/Overburdened:

- The suggestion I have is how the committee is engaging with communities of color and other communities in the metro area not represented on this call.
- Comment: The community participants, any time we want to change the system, it leads to premature deaths from minorities. Think about the delivery of the new plan. The strategies must be considered in regards to DEIB and the arguments presented to legislators. There will not be a complete solution to all of our current problems. As a Task Force, they need to design a system for an equitable solution.
- Comment: This change in [the] program is not going to fix racism/discrimination in healthcare for sure.

Comments/Suggestions:

- Lots of participants in the Metro, Spanish, and Willamette groups included appreciative messages for this new HC plan. I don't know if this carried over to other groups as well, but I think that it is safe to assume that a lot of participants in these sessions, regardless of where they came from, were appreciative of the plan and of the community session itself for bringing about what they consider is a change for the better in health care and for informing them of the current plans specifics/benefits for the community.

Outreach/ Plan Rollout

- [Are there] plans moving forward?
- Also, a few comments would be appreciated about the steps beyond this really rather theoretical design process of the next steps for potential implementation.

Suggestions for Outreach:

- My initial suggestion would be to have a more assertive marketing campaign regarding this Task Force. I only stumbled upon information about it purely by accident, and everyone I have talked to is unaware of it--and I'm in healthcare.
- Marketing may have been a poor term... It's hard to get feedback when people don't know about the work of the Task Force and therefore don't know how to attend a meeting to give feedback.
- Has the Task Force interacted and spoken with indigenous groups before?
    - If not, do so.
- Create new programs so that people can become health promoters and help people learn about the plan.
- Use community organizations and use simple language for all materials.
- Recommends using CBOs for outreach and education.
- Focus on giving a lot of information about the benefits of this plan; that's what's most important. You have to make the benefits clear, not just the inner workings of the system.

    - Translation and interpretation needs to be simple but very accurate.
- It is also important to make sure the community is informed and educated about this so that they can testify and accept this bill once it's passed.

Suggestions for Rollout:

- How can education lead to understanding of all these complicated health care issues and an explanation of the proposed plan?
- A smooth conversion from the current system to the new system is essential. The State has previously failed miserably on large database projects. What is being done to ensure that a smooth staged conversion occurs?
- Effective roll-out and management of a universal system will be key. Several state agencies, such as the unemployment system, failed to get benefits out during the pandemic in a timely manner.
- We've got to get Oregonians on board and understand what they're gonna pay, what this will cost them, and the benefits of this plan early on. Don't wait to educate them until you're out the gate and ready to go to the Legislature. I think that as much education as you can start rolling out about this like you did with covid and the vaccines will be important so that by the time that you start rolling this out, it won't be a foreign concept, and people will know how to engage with this system and be supportive of it.
- Suggest to use health promoters to communicate about the new plan. Create a program for people to become health promoters and help more.
- Once this passes, put information out in both Spanish and English
- How can Covid be used to explain the benefits of this plan? From acquiring PPE to mixed messages sent to the public, is this an area we could do better?

More information:

- This is a blessing for the Latino community, undocumented people, and families of mixed status. But how will we keep in touch? What are your next steps? How will we stay informed or keep the Latinx community engaged with this program?
- Will the recording be available to view later for all? For those who have registered?
- How will those who submitted written testimony know it was received?
- Will the slides be available for us to share with those who couldn't attend?
- You mentioned an anonymous survey request for those present today. Will you provide that in that chat again for those who did not see it?

Appendix B

Coastal Oregon | Community Listening Session Notes 06/10/2022

Access and Affordability

Questions:

- For people who qualify in Oregon - do they need an address? Does this cover houseless people? Does this cover visiting family members?
- Will this eliminate the need for COBRA?

Comments:

- The current healthcare entities compete with each other by leveling the playing field; it will decrease the need for mergers because it will be a system focused on health instead of profits.
- In 2021, the Oregon legislature passed a bill to allow OHA to review and possibly veto mergers and acquisitions of hospitals. There are less institutions, but the value of the institutions has gotten larger and larger.

Coverage and Benefits

Questions:

- What do alternative care providers cover?

Comments:

- I am glad that there's an emphasis on primary care.

Governance

Questions:

- Can someone explain how this will decrease fraud?
- How can you track fraud?
- Based on this response, will the workman's comp go away?
- How can you ensure that medical companies won't increase costs to the state?

Healthcare Providers and Participation

Questions:

- Will this affect the way services are provided?
- Will this affect our ability to bring medical providers to Oregon?
- Is it likely that some provider groups will end up without an entity to work for and will then end up with a decreased workforce?
    - Is it possible that some of these providers could end up without an entity to work for? Will this stop the consolidation?
- Is there a set definition of what an alternative provider is?
- How will this plan affect training programs for health care providers?
- How can you ensure that providers will not charge an additional fee?
- How will unlicensed healthcare providers be paid for their services?

Cost and Funding

Questions:

- Is there a draft of what this will cost based on income range?

Medicare and Medicaid

Comments:

- I am glad to hear that Medicare and Medicaid are both included.

Focus on Equity and SDOH

Comments:

- Comparing this system to welfare. No matter how much you make, you still get the same great care.

Appendix C

Central Oregon Community Listening Session Notes 6/14/2022

Access and Affordability

Questions:

- What is the biggest obstacle we need to worry about that could derail this?
- If this plan passes, when will it be available to Oregonians?

Comments:

- Thankful for hard work and glad to hear they will work on transition - a grassroots activist in health care, mental health, and the environment. We will need more health care with climate change - i.e., smoke, heat …
- Championing Single payer health care and her partner is in the ER. Reasons why this is great. We are so excited about what you are doing. Healthcare professionals encounter so much stress working with patients who are deciding whether or not they can get the care they need. This state will attract people. Also, people delaying care is so much more expensive.
- Also, transportation is a big issue - see people on FB (in La Pine) asking on FB for transport to medical transport.

Coverage and Benefits:

Questions:

- [What is the] difference between behavioral health and mental health?

Healthcare Providers and Participation:

Questions:

- Has there been discussion on including a recommendation that Healthcare billing and insurance professionals receive retraining and career advancement assistance?
- Will this plan attract more multicultural staff - especially in the mental health area?

Employers and Employees

Questions:

- Employers can still provide other plans. What does that look like and mean?
- Private employers will probably save money; what about public employers? Would this help communities to have more money?

Comments:

- Thinking about the small employers (possibly family-run - restaurants, food providers, food carts with small profits.) Imagine that health insurance companies are not excited about this.

Governance

Questions:

- What are the main substantive arguments of legislators who oppose this plan?

Comments:

- I think it's really important to have a solid platform for managing patient records. I hope you are considering how to not lose data for someone who currently has insurance and has years with the same insurer and then also how to capture all patient info in one Single payer platform online.

Medicaid and Medicare:

Comments:

- I hope the government agreements have some sort of reimbursements for Medicare and Medicaid.

Appendix D

Eastern Oregon Community Listening Session Notes 6/15/22

Access and Affordability

Questions:

- What is the date that the Task Force is wanting to implement this program?
- Will there be subsidies for transportation and services to appointments?

Comments:

- Universal healthcare would not be a good idea; it would flood the systems and make it more inaccessible.
- Nothing quite exposes the inequalities that exist in American society more than the health care system. It's a complex combination of private insurance, public programs and politics that drives up costs, creating significant barriers to lifesaving medical treatment for large segments of the population. In America, access to quality health care so often depends on income, employment and status. Your work has truly exposed these vulnerabilities Oregon residents face and how the plan can and would usher in a new generation of HOPE for everyone. Thank you to the Task Force, Staff and Everyone for your hard work and dedication to this proposal.

Insurance Companies

Questions:

- Would Insurance Premiums continue to be an allowed deduction for individuals and businesses?

Healthcare Providers and Participation:

Comments:

- Can you provide any comments on the recruitment of providers to participate in regards to the provider shortages that are common in rural areas? You may have touched on this when you talked about the different reimbursement rates for different insurance programs.

Employers and Employees

Comments:

- When the Task Force talks to business owners, they may find that many employers mourn the fact that they cannot provide employees with health insurance options. Our current system of costly health insurance prevents businesses from ensuring that they have a healthy workforce and many good employees leave to seek health insurance benefits. This is not good for our communities economic growth. Business owners have talked about losing staff that they have trained. It's discouraging, especially for small businesses.

Governance:

Comments:

- This will be the first important step in transforming the current “mess” that is healthcare in Oregon and the US. Getting everyone “under the same” tent” will allow other changes to improve equity and quality for all. Happy to pay increased taxes if it assures care for everyone!
- I think about the pushback of the political climate we are in now- it would be great for the Task Force to see what that pushback will be like if we move forward. There will be more demand. Her experience in another country is they go to the doctor a lot (more than we do here), and they get things diagnosed early! We may have some clumsy years of pushback, but in the long run, the preventative care benefits and how it will affect our behavior as us as consumers.

Cost and Funding

Questions:

- Is Oregon's universal healthcare expected to come down in price over the years, more in line with Europe?
- Would the healthcare tax be based on gross or net income?

Comments:

- Being rich enough and healthy enough to resent paying more without reaping immediate benefits can change with one diagnosis as well as with just aging. I know it happened to me. Having no fear of bankruptcy is worth paying more for the assurance that care will not break one's bank account--or prevent getting care at all.
- [My son]... is 31 years old and works hard to stay under hours to qualify for the Oregon health plan. [He] can not go over because the employer provides expensive health care premiums and can not afford it. [I] appreciate that the plan being proposed is not tied to the work that you do. [My] family in Canada has good healthcare with no waits.

Medicare and Medicaid

Comments:

- No bills and the transition to medicare, admin costs, etc.- that is the best thing, NO BILLS! Rural healthcare means waiting, and you don’t usually see your provider. Likes that you won’t have to deal with INS companies and a more predictable system for employers.

Appendix E

Southern Oregon Community Listening Session Notes 6/18/22

Access and Affordability

Questions:

- How will this plan affect folks with felonies and those who don't work?

Comments:

- Likes the plan. Want to make sure that the emphasis is on prevention and health, not a disease. Wants the plan to be proactive and preventative.
- Based on the folks I know, people are very confused about health care. I'm not sure the average person even conceives the meaning "Everybody In and Nobody Out."

Coverage and Benefits

Comments:

- Benefits - really should call out dental and vision for medicare. Should have prevention; first 1000 days of life care for babies. Every new family should have health care providers visiting their homes.

Employers and Employees

Questions:

- What outreach are you doing to reach out to employees?
- How is it envisioned this plan will be coordinated with work-related injuries & workers' compensation?

Comments:

- [I] recently retired from health care in Medford – [I'm] concerned about health care prices for the workforce – what outreach are you doing to reach out to employees? I love this plan. It is the process of getting there that concerns me.

Governance

Questions:

- How will your plan redress the other provisions of the ACA that have been watered down or removed?
- Why would the amount contributed [from] the federal portion increase by $2.5B? Is it a likely stumbling block for the opposition? Would it not be better to move this to households and employers?

Comments:

- [I] love this plan. [I] want to see it approved at the state and federal levels.
- I am severely disabled and live in rural Jackson County. I advocate for seniors, people with disabilities, the deaf & hard of hearing. The ACA was watered down by the prior administration, especially the 1551 provisions on effective communication.

Cost and Funding

Questions:

- What will payment rates look like based on region?
- The presentation is clear that this will cost less. But so many of the middle folks have been convinced that it will cost much more. What is the Task Force's plan to address the communication issues?

Comments:

- Be wary of unintended consequences - [I don't] want a 9% rate affecting new Blazers team members, but perhaps a property tax surcharge of physical investments that have a value of 100K or more. [I] want to find a way to get at CEOs who live in Menlo Park.
- Foundational issue – dedicated a primary part of savings going to communities to be driven by community leader councils and have them come up with innovative preventative strategies for the communities (use 50% of the savings for this) (many other countries spend 30% on prevention and in the general US only spends 3% on prevention) Really think about neighborhoods in sub-county level, not just region.
- I hope you are interfacing with the Public Health system to get their ideas. Think of the money saved by the decrease in tobacco.
- [I] wanted to clarify that sharing savings would equal higher taxes. What if we save $450M and invest $450M in the state - this would go a long way. This would really be a benefit. [I] will submit in writing property tax, ERISA, … and for savings – [I] need to think about the medical component of savings for workers comp cost to employers.

Eligibility and Enrollment

Questions:

- Will ODHS/Aging & People with Disabilities no longer be tasked with determining medical eligibility for consumers of Long Term Services and Supports? Has that savings been quantified?

Comments:

- [I have] a kid – quadriplegic – and pre-pandemic parents were not allowed to be paid to be the caregiver. [My] son has never gone more than a couple [of] months out of the hospital, but when [I] was the primary caregiver, he hasn't been in the hospital.

Healthcare Providers and Participation

Questions:

- How will your plan lessen the administrative red tape providers must address so that they can free up time to treat patients?
- Will we see many clinics refuse to participate and insist on only seeing "private" or self-pay patients? Is there a way to prevent this from happening entirely, or is it going to be an expected side effect? If it is, can we minimize its social stratification of participants (vs. private patients) and the economic setback it will have on the risk pool of public insureds?

Comments:

- I would like an explanation on whether or not universal single-payer health care (USPHC) can mandate that providers and clinics accept patients covered in USPHC.

Focus on Equity and SDOH

Questions:

- How is this fair? How are outcomes for these people going to be equitable (people with disabilities)? In your plan, will there be an ADA enforcer? How will the ADA be enforced?
- How are you planning to establish trust, especially among communities that have been left behind?
- Will this plan address healthier lifestyles?

Comments:

- The ADA has been around for over 30 years. Yet providers still are reluctant to accommodate people with disabilities in many ways. I cannot be examined like other patients in my provider's exam room because there are no lifts to transfer me from my wheelchair. Deaf people are required to use Video Relay Interpretation that freezes or has an interpreter that cannot be understood. There are no hearing loops for [the] hard of hearing who often are told to communicate and understand their providers by writing on a tablet.

Appendix F

Portland Metro Community Listening Session Notes 6/21/22

Access and Affordability

Questions:

- Does the Task Force have a website?

Comments:

- If we hope to keep a plan affordable, we must keep private investors out of it. Check out ACO REACH, previously Direct Contracting Entities. Begun in the Trump administration and [is] ongoing in the current administration. Once again, please learn about ACO REACH and Direct Contracting Entities. That initiative would finally privatize Medicare to the benefit of investors.

Coverage and Benefits:

Comments:

- We have a long way to go for behavioral health and mental health in our state.

Healthcare Providers and Participants:

Questions:

- Retired DR question- enough providers? If there is a drop in provider income, then less desired harder to recruit providers?
- [Minimum] required best practices guidelines- if you don't provide the same quality standard, how will you promote nurses and docs etc.?

Governance

Success criteria:

- Good intentions have led to bad structural interventions and worse outcomes when existing delivery systems and dominant political and economic forces overwhelm citizen input despite claims of equity in [the] process. Your regional system echoes the old HSA, which was a disaster; you will need metrics to ensure effective public participation.
- Success metrics are important! Success metrics are crucial, and they need to be planned for and implemented early. They may mature, but they can't be pushed off till later.
- What are/will be the "success criteria" which will manage the plan, and when/how will they be implemented?

Questions:

- How would these events impact the healthcare system, and what systems and safety measures will be put in place to keep the communities whole?

Comments:

- We need to take into account uncontrollable events such as climate, economy, crisis, increased population and war.

- The plan you did the financial analysis on was single payer. After that, votes have been taken on the structure of the plan that made it not [a] single payer. So the multi-payer plan you are designing is more expensive and less equitable than the plan you did the financial analysis on.
- Sorry to say, but VA operates in a wasteful and fragmented way. [This is based on] personal experience compared to several other systems within which I have worked. The model, unfortunately, led to lower income and FQHCs closing down rather than being boosted up in their expertise in providing care to lower covered people and high-need complex patients.

Cost and Funding

Questions:

- How upstream investments will be streamed?
- Savings? Where will they go? Legislators have sticky hands! How will you pay for it? Once a year? But what about those that move out of state? A separate fund dedicated and only spent on universal health care governed by the board and not the legislator.

Comments:

- I can envision how income from state and federal tax streams could be blended and then used to pay for the services projected to be available. I'm astonished at the actuary's projection that a mere $990 billion would be saved since CMMS runs Medicare at a 2% overhead rate, and if we can do as well, it ought to produce greater savings. What would destroy the savings would be to permit private, for-profit "management" companies into the mix.

Medicare and Medicaid

Questions:

- Can seniors opt out & stay with Medicare? I think this plan will cost seniors with passive income more than they pay now.
- Do retired people pay income-based tax for universal healthcare? People [are] already using medicare.
- Will Medicaid estate recovery - mandated by the feds, be continued?
- Where and when will we get details about how the Oregon plan will interact with Medicare?
- If you are on medicare, will you be able to opt-out? - No.
- Are you going to seek total elimination of Medicaid state recovery?

Focus on Equity and SDOH

Questions:

- Will this address the homeless problem in some way? By the homeless problem, I meant the SDOH.

Comments:

- Oregon will become an even better place for houseless people around the country.

Appendix G

Willamette Valley | Community Listening Session Notes 06/25/22

Access and Affordability

Questions:

- How will the new system assure doctors more time to meet with their patients to practice preventative care and to do the needed tests without being based on a proof system that denies care?
- Availability of medical staff with a shift in incentives, and how will the program ensure there is enough capacity?
- I have a rare condition, Waldenstrom's Macroglobulinemia; the experts are at the Mayo Clinic in Minnesota and the Dana- Farber Cancer Clinic in Boston. Would consultations with out-of-state experts be covered?
- How can we get the provider of our choice? Will we be narrowly limited in terms of providers in the system?
- Will all folks who are covered under the plan be able to select hospitals, specialists, and other care providers in Portland if they live in a county outside the Portland metro area?

Insurance Companies:

Questions:

- How will the Oregon UHP integrate with the Federal government? Veterans' health care system?

Coverage and Benefits

Questions:

- Will there be any diagnoses that are not covered (autism)?
- Will the plan employ case managers?
- Along that line of thought (long COVID), it is clear now that SARS-CoV-2 will be with us for the long term. And the disease comes in waves as mutation of the virus occurs in 38+ species. The first round of vaccines are no longer effective. New vaccines are essential. The waves of COVID are clearly occurring at the same frequency as the fading of adaptive immunity from the vaccines or from recovering from the disease. As a result, to prevent most illnesses and long COVID will require vaccination with current working vaccines three times a year. To reduce severe disease and death, they need to be twice a year. The current belief that annual vaccination is in any way adequate is completely invalid. The immunologists and epidemiologists are having a hell of a time culturally in overcoming their training to recognize this. The public has no chance of understanding and accepting this until they do. What can be done to fix this? OHA has been utterly useless in this regard.

Comments:

- If we stop paying for the ABA Industrial Complex under [the] current OHP setup, the state would save a huge amount of money both on the 20-40 hours a week of services and on the PTSD that most Autistic Adults say they got from ABA. I know parents

pushed for this, but it has been proven to cause harm and not be effective, and the VA has done a study and stopped paying for it for active duty families. Early support of AAC devices for nonspeakers, SLP, and OT have been shown to be more effective with less harm.

Employers and Employees

Questions:

- I am concerned about the financial impact of covering out-of-state residents who work for Oregon employers.

Governance

Questions:

- How do out-of-state residents working in OR come into play? Ex: Nike employees.
- Has the Task Force considered the requirement to provide the Oregon administrator for the UHCP plan a copy of their last year's Fed/State tax return, as is required by those who utilize the Marketplace and receive an ACA tax credit?
- The behavioral health system is in deep trouble and is inadequate to meet the current needs. How will the wisdom of what we have learned in the past years be used to rebuild the BH system?
- How is the Task Force approaching the need to address business-model concerns of private providers and policy-makers?
- What are the Task Force's thoughts on how to create a truly effective management system for single payer in Oregon?
- Will there be intentional efforts to reduce the burden of paperwork and documentation?

Comments:

- I understand a public-private entity such as the SAIF program is being contemplated.
- There is a suggestion to use SAIF as a model or to base the organization on SAIF. This would be a horrific mistake. SAIF is based on the idea and philosophy of denying claims and care. Using SAIF or incorporating SAIF will be corrosive and destructive.
- Outcomes are more related to the ZIP Code of the patient and the provider than to meet VBP metrics. Incentives remain to up-code, cherry pick, and lemon drop. Under a global budget that is recommended in the Task Force proposal, regional healthcare administrators can choose how to reimburse providers in ways that satisfy and maintain the workforce, whether this is through fee-for-service or fee-for-time. Many countries with high-quality outcomes and population satisfaction still require low premiums or co-pays, or for selective services are usually not for primary care.
- For our state, let’s develop the equivalent of the United Kingdom’s National Institute for Comparative Effectiveness. We can pass such legislation before we approve a universal healthcare system.
- I would encourage recommending that the records system be flexible. The current electronic records systems have severe limitations that result in distorted and inaccurate records. For example, the systems include detailing allergies. But they do not allow for recognizing genetic information or including specific known issues like CYP450 enzyme information or family health issues. These end up having to be pushed into categories

where they do not belong. e.g., Having a family history of an abdominal aortic aneurysm can end up being recorded as having that issue rather than as having a vulnerability to it that needs to be watched for. A much better, more flexible record system is needed.
- Please don't use today's model of value-based payments. Fee-for-service percent is not the main problem with today's healthcare system. Most countries with successful universal healthcare systems still use fee-for-service but in equitable enforceable ways. Today's value-based payment models add inequity by incentivizing providers to avoid high-risk patients and reduce services. The metrics that we now use may not be predictive of good quality outcomes.
- The Task Force is justifiably emphasizing [the] creation of a system that is equitable and allows all residents access to care. Meanwhile, you know that the Oregon system will need to fit into a national economy and will need to be palatable to policymakers who will or won't approve spending federal funds on the Oregon UHP.

Cost and Funding

Questions:

- Is there a possibility of paying for health outcomes with care-out incentives?

Comments:

- One of the early critical issues in creating the new organization will be establishing a robust culture that addresses many issues from the start. This needs to include ideas, ethics, philosophies, goals, and more. It absolutely must be based on profit and cost/loss, not being a controlling philosophy. The current system is based on denying care under the guise of minimizing costs. This maximizes [the] harm to people and ultimately maximizes costs and harms.
- As our global experience of Covid evolves, we are also seeing long-term chronic health challenges becoming part of our health care program in the future. There is the possibility that current health insurance companies [will] collapse under the financial load.

Medicare and Medicaid

Questions:

- Does the Plan have to negotiate with the Federal Government to use Medicaid funds? How is the Plan related to Medicare?

Eligibility and Enrollment

Questions:

- How will people with disability or chronic disease be covered, and how can we assure that they get appropriate care (and not the medical gas lighting that often happens now)?
- How will the care of participants with more health complications be incentivized?

Healthcare Providers and Participation

Questions:

- What have privately owned hospitals and providers thought about the system? Will they support it? Dynamics of wealth and power and privately owned hospitals will likely push back against this.
- Will hospitals continue to be privately owned? Will they be allowed to turn away patients?
- How does this promote integrated physical/behavioral health care?

Appendix H

Spanish | Community Listening Session Notes 06/28/22

Access and Affordability

Questions:

- How would enrollment work for immigrants, people who leave the state, or people who aren't here the entire year in Oregon? Sometimes here and sometimes in other states?

Comments:

- Over in the far east [fo Oregon] with very limited providers. I have no option other than going to Idaho; Boise is an hour away. [We] are at a huge disadvantage for providers since the ones from Idaho don't typically accept it.

Outreach to indigenous groups:

- Good information. It's a pleasure to hear good things. Recommendation: please, when it's time for people to apply, keep in mind people who are indigenous.
    - Need interpreters for the community
    - Most vulnerable because of language barriers and not speaking Spanish as well
    - Difficult to find a clinic because [we] do not know; it is scary
    - Sometimes people do not understand Spanish, [my] native language is not Spanish
    - If they have a chronic disease, they will not apply because of barriers.
- Put [the information] in English or Spanish online. In [my] experience, the indigenous community does not use the internet. [My] experience as a community worker is community forums/informative meetings in native languages with people they trust. They did it with the census. Many indigenous people don't know how to read and write. When people come from a small town, people can't even write their own names.
- [It is a] privilege to have the program and be here. [I] agree with the recommendation for indigenous people. [I] had the opportunity to learn Spanish. Unfortunately, many people do not have that same opportunity. Give people communication that they have this benefit. It would be best to take the information in their language so they can understand and be informed, words that are clear and easy to understand.

Insurance Companies:

Questions:

- Not all services will be covered. Private insurances will target specific services that will not be covered. Do you foresee them overcharging on premiums because this plan does not cover them?

Coverage and Benefits

Questions:

- Some people with disabilities still have to work to pay medical costs and expenses. Will this plan cover the cost? Are taxes going to increase?

- Could it include orthodontics as well? It could be considered aesthetics. Sometimes parents don't have the opportunity to take their children.
- Question about transplants.[Will this include transplants?}
- Will they utilize generic medicine or original brands of medicines?

Employers and Employees

Questions:

- [It] could be an inconvenience for employers. What if you do not have a job?
- Will taxes that employers pay be increased too? Could [it] destroy many small businesses?
- Would employers need to pay [for their employees' treatment]?

Governance

Questions:

- Has the Task Force interacted or spoken with indigenous groups before this meeting?
- How are we going to protect HC4L in light of the fact that we have had an attack on a lot of these rights? Are we going to beef up the legal language of Healthcare for all of Oregon?

Focus on Equity and SDOH

Questions:

- How do older people get economic support if they do not have any within the new program?

Appendix I

Survey Results | Community Listening Session

Central OR Survey Comments

- If you can't convince our health councils, I don't think this proposal has much of a chance. I will take this issue and proposal to our Central Oregon Health Council and ask that we have a meaningful discussion about it.
- I do hope that there is a recommendation to provide career training and placement for healthcare billing and insurance professionals that have to change their professions.

Eastern OR Survey Comments

- I would like to emphasize that the administrative work that practitioners would need to fill out and submit would need to be drastically reduced and streamlined. I work for a physical therapist and submitting paperwork for authorizations is painful. The wait to get visits authorized is too long for patients, especially post-op when time is of the essence for the success of their surgery. As a small practice, we often see patients with ODS OHP or EOCCO, WITHOUT authorizations and hope for the best because it is in the patient's best interest for positive outcomes. We occasionally get burned and have large write offs because we have always been more concerned with our patients' needs. I can see if we have to get authorizations for EVERY patient we see in Oregon that we might not be able to make it as a small practice, not only the waiting time to get authorizations but also the time to process our claims if all our patients had EOCCO would likely put us out of business. Please research the impact of this on rural providers in small practices. We might be forced to close up our business and find work at a large practice or the hospital.
- Will Universal Health Care cover services such as Midwifery services, home-births, and lactation consultants?
- It's said that employers no longer need to provide health insurance to their employees if Universal Health care happens. My concern is that a significant amount of Oregon employees are Idaho residents that may or may not have coverage through their spouse, medicare or medicaid in Idaho. Is this double coverage or do they waive the Oregon Universal Health Care?
- 1) The Constitution requires that Members of the House live in the state they represent (though not necessarily the same district). Will Federal Elected Officials from Oregon

automatically be enrolled in the Oregon Plan? If not please provide basis for exemption and any citations the committee relied upon exempting them from the Constitutional mandates. 2) Health Plan Proposal-June 2022 Document: Pg 3."Who Would Govern" Question: Please define "Community Voices" as used in the proposal? 3) Health Care Tax costs as a deduction for both individuals and businesses. Question: Would Insurance Tax be an allowed deduction for individuals and businesses? 4) A concern arises that for the majority of Eastern Oregonians, gaining representation on boards and groups is provided first to those having connections, then to those with degrees followed by occupational or professional licensing. Question: When determining the Regional Groups how will citizens know their concerns and voices are actually being represented if the Boards and Groups are composed of only select individuals and not a representation of lay citizens?

Southern OR Survey Comments

- I would like to make sure that providers are incentivized to keep people healthy rather than just treat diseases.
- Concerns is about accountability for making sure real timely access is provided. As a Medicaid & Medicare advocate, it has been a struggle to get providers, most notably those via managed chare plans, to actually provide the services one is eligible for. The biggest nightmare was access to timely restorative dental services under OHP. More recently access to mental health therapy is a nightmare in communities like mine for anyone without OHP due to provider shortages. Promising great services is wonderful but without real access to providers makes it all a hallow promise.

Portland Metro Survey Comments

- What about self-employed individuals? What taxes do they pay?
- One of the biggest problems I see is that every aspect of our systems prioritize making money over providing services; as an educator, I see how communities of privilege maintain the inequities of an underfunded system. Our systems also treat many groups--houseless, mentally ill, the differently abled, etc. I see how BIPoC are marginalized in ways that persist despite laws and policies, and I don't see how this change to the system will relieve the stress of medical personnel, educators, and other professionals who are underfunded. (My point is that at the same time we are changing

Oregon's health care system, we must also change the perverse incentives for casual cruelty.)

- I really hope that you'll put a cap on what people will have to pay in taxes to fund this plan.
- Will the plan be able to negotiate bulk prescription pricing? How can this program become more socialized to the general public? The local news doesn't seem to be talking about it.
- Several attendees mentioned entities who have adopted a plan like this and how, afterward, they were all happier/satisfied/wouldn't go back in time. It would be great to know some examples of these entities - are they other states in the U.S.? Entire countries? Other types of regions? It seems like those stories would be very helpful for us to understand.
- How does the task force propose to balance utilization load with providers and physical resources? Let's say the reimbursement for MRI is too low and the waits are long and there is not enough cost incentive to build more MRI centers. How do you propose to right size the supply and demand with fixed prices?
- I think my main concern is that it won't happen (particularly because it requires federal approval). I'm a psychologist and am also interested in understanding how reimbursement will be determined for therapists and, very importantly, for psychiatric prescribers (we don't have enough to meet demand, which makes the work therapists do more challenging)
- Cost for retired people
- how can i support your efforts as a geriatric physician with both policy and planning skills in geriatric care, ohsu assist. prof and past president of the Oregon geriatric society
- I am a Master's of Public Administration student with a focus on Healthcare Administration at Portland State University. I have been studying ways to bring universal health care to Oregon. I think this proposal is a very good plan and I would like to support it in any way I can. I have an opportunity for field experience from January - June 2023. What are some ways I could support the taskforce (or OHA) with my 150 hour graduate level field experience?
- I hope that it will also include all reproductive and gender-affirming care. (And dialysis, despite today's SCOTUS decision!) I also hope that it becomes a reality--and soon. I have some concerns about the private administration idea (will that be as much of a mess as the 'OR aca marketplace' disaster?)

Willamette Valley Survey Comments

- In the community, the Model for this is often touted as Medicare. This is a BAD design model. Giving the design to government...in America...always lessens the product and this is a good example...Medicare for an age group that ends up needing more vision, dental and mental health care (everything above the neck, essentially) yet it is EXCLUDED from coverage...a person has to pay extra to get those coverages. What a bad design that was! I would like to see a form of coverage similar to one used in other countries, (and a number of them are doing reasonably well (though the naysayers need to be paid attention to), but the US tax structure is going to have to be entirely redesigned. Good luck with that. I'm not sure UHC is possible in a capitalistic society such as ours...democracy yes, capitalism no. I'm not optimistic!
- I am an attorney who has fought insurance companies over medical care issues for 30 years and I see a huge need for Universal Health Care. I have reviewed the plan and I am very impressed with your work. However, I am concerned about the heavy reliance on financing through taxes on reported income. There is an entire economy in Oregon that goes unreported or reported in ways that avoids or minimizes the tax revenue you are projecting. Borrowing against appreciating assets is just one example. Avoiding employer matching taxes by reclassifying W2 income as shareholder distributions is another. The current plan will create a huge incentive by the wealthy to fight this program as their cost for health care can easily go from $10,000.00 to $50,000.00 or more. I would like to help the task force if possible and i would like to talk to Dr. Goldberg about some ideas on how to deal with these issues if he can give me a call. 503-304-4886.
- I understand the need to consider the many determinants of health beyond direct medical care such as adequate housing, and education. It is not clear to me how the JTUHC would define "the edges" of the new UHC plan in relation to those other determinants of health? Those other factors are presently funded (to the level they are) by other tax revenue streams and are administered by other Oregon departments. This may be pertinent to the comment raised in the meeting about the potential benefit of incremental rollout of the new UHC plan.
- My biggest concern is that health insurance companies, pharmaceutical companies and other lobbying groups will spend $Billion$ to stop a universal health care plan.

- Will the Oregon plan provide equivalent or better coverage than the Medicare Advantage programs currently available to seniors? If seniors use the new Oregon plan, then have to move later will they be able to access the standard plans without penalty?
- Having a Black Autistic Non-binary teen with chronic disease (EDS/POTS) I have been impressed with the level of support OHP (they get via Kplan through DDS).
- Please cover alternative health care options fully without additional cost such as acupuncture, chiropractic care, therapeutic massage.

Spanish Survey Comments (Translated)

- ¿Podremos conservar el mismo médico que lleva nuestro cuidado?
    - *Can we keep the same doctor that has been taking care of us?*
- no tengo conocimiento acerca la cobertura médica por el momento
    - *I don't understand the medical coverage at the moment*
- Debería ser para todos
    - *This should be for everyone*
- ¿Cómo planea HCAO garantizar que los trabajadores indocumentados puedan recibir atención médica para sus familias y para ellos mismos? ¿Qué tan pronto espera que HCAO entre en vigencia?
    - *How is the HCAO planning to ensure undocumented workers can receive health care for themselves and their families? How soon do you expect the HCAO to go into effect?*
- Que es una idea excelente para los residentes de Oregon
    - *That this is an excellent idea for Oregon residents*
- Debería ser gratuita a todos los que la necesiten. El costó medical, cuidados, medicina, etc. es muy costoso. Si de por sí nos quitan taxes, deberían de ser buen uso de ellos.
    - *This should be free for everyone who needs it. The cost of medical care, appointments, medicine, etc., is very costly. If my taxes are being used [for this program], they would be of good use.*
- Que tomen en cuenta gastos, renta, dispensas, etc., cuando determinen la elegibilidad basado en ingresos.
    - *Consider the expenses, rent, groceries, etc., when determining eligibility based on income.*

Appendix J

Survey Questions | Community Listening Session

- Which session did you attend?
    - Saturday, June 11
    - Tuesday, June 14
    - Wednesday, June 15
    - Saturday, June 18
    - Tuesday, June 21
    - Saturday, June 25
    - Tuesday, June 28
- What State do you live in?
    - Oregon
    - Washington
    - Idaho
    - Other
- What is your Zip Code?
- Which of the following age ranges includes your age?
    - 18-24
    - 25-34
    - 35-54
    - 55-64
    - 65+
- Which of the following best describe your gender?
    - Female
    - Male
    - Non-binary/non-conforming
    - Transgender
    - I most identify with: (Please Specify)
- Which of the following best describes your ethnicity or race?
    - Hispanic or Latino/a/x/e
    - Indigenous -Central or South America
    - African

    - Black or African-American
    - Middle Eastern, North African, or Arab American
    - Native American
    - Indigenous - Canada or Alaska
    - White or Caucasian
    - Slavic or Eastern European
    - Asian or Asian American
    - Pacific Islander or Native Hawaiian
    - Please Describe
- What is your highest level of education completed?
    - Elementary School
    - Middle School
    - High School
    - Some College/Vocational school/ 2-year degress
    - Bachelor's degree
    - Master's degree
    - Doctorate degree
- Do you live with a disability?
    - Yes
    - No
    - Prefer not to share
- How do disabilities impact you?
    - Hearing
    - Mobility
    - Sight
    - Learning
    - Speech
    - I prefer not to share
    - Please describe
- Optional: Do you have any Concerns/Comments/Suggestions for the Task Force on Universal Health Care?
- Optional: Please share your Email Address for follow up and updates

Appendix F **Specialty Interest Forum Summary Report**
Artemis Consulting and SB 770 Project Team Staff

SPECIALTY INTEREST FORUMS SUMMARY REPORT

Summary
The Joint Task Force on Universal Health Care held seven *Specialty Interest Forums* for the business community and health care industry from June through August 2022 to solicit feedback on the Task Force's proposal for a universal health plan in Oregon. These two-hour virtual discussions sought input and discussion about the proposal and its potential impact on a variety of entities and sectors. The forums were planned by a subgroup of Task Force members with assistance from staff and a consultant specializing in facilitation and community engagement. In seeking broad participation, staff and Task Force members sent invitations to a variety of professional organizations, including but not limited to AFL-CIO, Oregon Business Council, and the Oregon Association of Hospitals and Health Systems

The Task Force planned three forums for the health care industry:

- Health care professionals
- Insurance carriers and CCOs
- Health systems and hospitals

Similarly, the Task Force organized forums for three groups from the business community:

- Large employers
- Small employers
- Unions

The Task Force got input from 37 participants across the seven forums. Insurance carriers opted to share their feedback via a letter in lieu of attending a forum.

In each forum, participants provided feedback about the following questions:

1) What excites you about the Task Force's proposal?
2) What challenges does the proposal present for your sector?
3) What changes would you like to see in the final proposal?
4) What do you want the Task Force to know as they move towards finalizing their recommendations?

Forum Themes

The table below outlines high-level themes from forum input.

Areas of alignment with current proposal *Forum participants appreciated certain components of the Task Force's proposal*	**Feedback for Task Force consideration** *Forum participants provided constructive input about various aspects of the proposal*
• Improved access to health care • No co-pay or deductible • Full coverage and benefits • Decoupling employment and insurance • Simplifying insurance and administration • Potential to improve capacity in the system • Regional and local input and engagement • Attention to equity and social determinants of health	• Prioritize a robust workforce, including focusing on health system capacity and potential provider shortage • Need for a clear transition, administration, and implementation plan • Ensuring quality of health care and patient safety • Simple in-state and out of state payment processes • Tax burden on businesses and individuals • ERISA plausibility • Clear understanding of utilization and needs of younger adults • Inclusion of long term care • Evidence-based decision making • Impact on multi-state employers • Mitigate the impact to Oregon's farming and agricultural industry

Input by participant group (See Appendix TK for more detailed notes)

Health Care Professionals/Providers

Eight providers and health care professionals shared feedback around access, workforce, information technology, and implementation. Highlights from the input included the following:

- General consensus around the benefits of streamlining administrative functions and increasing access and reducing costs to patients.
- Concern around having adequate workforce and infrastructure for the increased health care usage expected under the proposal.
- The importance of funding for information technology including Electronic Health Records (EHR) and training.
- Interest in using evidence-based decision making in the formation and future implementation of the universal health care.
- Concern around ensuring patient safety and health care quality.
  - Quality and safety shouldn't be sacrificed as the proposal is implemented and there should be a smooth transition for patients.
- Avoid recreating current challenges in a new system.

Health Care Systems and Hospitals

Five participants provided input on a variety of topics with a focus on workforce, the transition to a universal health plan, and implementation of the proposal.

- Workforce concerns centered on the challenges of ensuring a robust workforce to meet the increased utilization that would occur with universal health care. This included building a stable infrastructure and attracting and retaining providers in underserved areas of the state.
- Given the significance of the change under the Task Force's proposal, participants discussed the need for a clear and practical transition plan from the current health care system. Key considerations raised include the costs to transition the workforce, mechanisms to continue local and regional accountability and involvement, and a process to ensure collaboration and dialogue with hospitals and health systems.
- Implementation concerns included how the proposal meshed with numerous health reform initiatives underway and how the health care system would balance those efforts with the implementation of the proposal. Another implementation question was around how youth on their parent's coverage would transition to the plan.
- There was general consensus that the proposal would need clear guidelines for navigating relationships with out of state insurers and managing out of state payments.

Insurance Carriers and CCOs

In lieu of attendance at a forum, a group of carriers and CCOs provided written feedback to the Task Force. Insurers expressed ERISA concerns and the plausibility of true cost savings from the Plan. Their feedback also focused on the burden of taxes, the need for a macro economic analysis of the impact of the Plan on Oregon, potential job losses, federal approval of Medicare, among many others.

Unions

Eleven participants representing unions provided input centered on four issues: benefits, multi-state employers, wages and taxes, and access and equity. Highlights of the input included the following:

- General agreement with the proposal's inclusion of a comprehensive benefits package, which includes dental and vision. Participants requested the Task Force consider expanding benefits to include culturally specific systems of care, i.e. indigenous health care systems and "alternative" health care, and additional LGBTQ+ benefits and coverage.
- Support for the proposal's focus on access and equity, including access to coverage and care for all as well as the inclusion of the social determinants of health.
- An emphasis on the strong linkage between health benefits and union contracts. Participants expressed concern that benefits under the proposal would be less, in both quantity and quality, than the benefits many unions have negotiated.
- Feedback around the challenges some unions would have to navigate in contracts with multi-state employers. Relatedly, participants shared the complexities around employment in noncontiguous states, traveling workforces, and funding and compensation connected to where a person lives rather than where they work.
- Desire that more consideration be given to the balance of wages, taxes, and costs of the proposal. Participants asked for clarity around the income breakdown for household contributions and the impact increased taxes would have on wages.

- Interest in the possibility of a progressive co-pay system where wealthier people paid more to balance concerns of younger adults who have lower utilization and may not want to be taxed more.
- Queries about the impact of costs and benefits on employers that continued to offer ERISA plans.

Small Employers

Eight participants representing small business owners and associations provided feedback around access, decoupling insurance from benefits, impacts on taxes and wages, small business costs, and competition with large businesses. Their input included the following:

- Recognition of the benefits of universal access to health care and access and decoupling insurance from employment.
- Concern about the tax burden on small businesses and how that would impact wages. Participants highlighted that increased costs would be especially challenging for those businesses that do not offer health insurance. They also felt that the burden of the business tax would fall inordinately on small businesses.
- Emphasis on the variability in taxes based on employment status - part-time, full-time, seasonal employees, etc..
- The varying administrative and financial burden on small businesses given the variety of types of small businesses.
- Concern about competition with large businesses that might offer ERISA or supplementary plans.

Large Employers

We held two forums for large employers due to low turnout at the first session.

- The first forum for large employers was attended by an Oregon farmer and the focus was on the agricultural community in the state. Input included concern about the impact of additional taxes on the farming community, rising costs, the challenges of having seasonal workers, and how large farms have a mix of large and small business qualities. The participant asked that the Task Force consider the labor-intensive nature of farming as it considers new taxes and regulatory costs.

The second session for large employers allowed for additional input on the proposal.

- Participants were excited about the possibilities for universal health care and decoupling employment from health insurance.
- Participants observed that the current system is unsustainable, and the proposal addressed many of the current challenges. Some participants expressed optimism about the proposal's potential to control health care cost growth.
- Major concerns included the high-income tax for some individuals, additional taxes on businesses, and ERISA plausibility and challenges. Participants also questioned the feasibility of such a large overhaul of the health care system and shared anxiety about potential repercussions on the economy, impacts on Oregonians, and possible ramifications on the growth of business in the state.
- Participants suggested the Task Force reconsider copays to channel people away from low-value/ high-cost health care to high-value/ low-cost care.
- The group also suggested further actuarial analysis on the broader financial impact for the state and a study of the political practicality of creating a single payer system.

Appendix G **Questions & Answers**
JTFUHC Communications Work Group

OREGON JOINT TASK FORCE ON UNIVERSAL HEALTH CARE

QUESTIONS AND ANSWERS

We are the Oregon Task Force on Universal Health Care.

To help the people of Oregon understand our complex task, we produced this Questions and Answers Sheet. It can help you understand our work and respond to it. We will update answers based on feedback and future changes to the Plan.

You can send questions and comments to us by email at JTFUHC.Exhibits@oregonlegislature.gov. Or you can call us at (503) 986-1813.

What is Universal Health Care?
Universal health care is a system in which all people receive health care when they need it. This means people get the health care they need no matter their job, age, or how much money they have.

What is the Joint Task Force on Universal Health Care?
The Joint Task Force on Universal Health Care began in 2019. This was when the Oregon Legislature passed Senate Bill 770.

Our task is to design a statewide single payer health care system for all the people of Oregon. This system would offer public health care that is:

- Equitable
- Affordable
- Comprehensive
- High quality

Our Task Force includes 13 voting members. They were appointed by the Governor and confirmed by the Oregon Senate. The 13 voting members represent many geographic, ethnic, professional, and cultural views.
Non-voting members include legislators from both the House and the Senate and staff from government agencies. Our Task Force is called “Joint” because it is an effort of both the House and the Senate.

To view our Interim Status Report on our work, you can click here.

Our Final Report is due to the legislature in September 2022.

BASIC OVERVIEW

What is a Single Payer?

A single payer is a different way to pay for health care. Our current way is confusing because it has many different policies, benefits, and networks. A single payer would replace the current way. It would collect funds from state and federal taxes and then pay providers directly.

How would the people of Oregon benefit from a Single Sayer plan?

We call our single payer plan the Universal Health Plan.

Single payer plans provide better care to more people for less money. They achieve this because they:

- Reduce complexity
- Encourage people to seek care when they need it
- Reduce administrative costs

Is a single payer plan possible in Oregon?

To have a state based single payer system, Oregon would need to pass legislation first. Then it would need federal permission to carry out the plan.

How would people in Oregon pay for the Universal Health Plan?

The Plan would receive funding that now goes to Medicare, Medicaid, and other federal and state health care programs. The funding system would also replace what Oregon families and employers spend now on premiums, deductibles, and co-pays. The new system would be based on what households and employers pay for health care costs in a way that would be fair and equal.

We expect the total extra taxes would be less than what people in Oregon pay now for health care.

Will the Universal Health Plan be designed with health equity in mind?

Yes. Health equity means that all people have a fair and just chance to be as healthy as possible. It also means that we fix injustices in systems. We have designed a Universal Health Plan to cover all people, with the same benefits and services.

ELIGIBILITY AND ENROLLMENT

Would I qualify for the proposed Universal Health Plan?
All people who live in Oregon would qualify. There would be:

- No waiting periods to qualify
- No income limits
- No financial qualifications

How would I enroll in the plan?
It would be a simple process for you to enroll in the Universal Health Plan. You would be able to enroll quickly. You could enroll at health care offices.

When you would enroll, we would have to ask you questions to help our state receive funding from federal health care programs. We would ask for that in as simple a way as possible.

Could I keep my current health insurance plan if I wanted to?
There would be no reason to pay for and keep your current insurance plan. This is because your benefits would be provided by the Universal Health Plan. You may be able to purchase extra insurance for the rare service not covered.

If I lost my job would I still have health insurance?
Yes. This is because you and your family would qualify for the Universal Health Plan based on living in Oregon and not your job. A person's job would only be a factor for people who live out of state, work for Oregon employers, and pay income taxes.

Could people in Oregon opt out of the Universal Health Plan?
No. Opting out is not relevant since all residents qualify automatically. If someone did not want to use the health care from the Plan, they would not have to.

What if a visitor comes to Oregon and needs health care?
Visitors to Oregon would have access to the single payer's urgent and emergency health care services. Visitors would need to pay for health care they receive in Oregon.

COVERED BENEFITS

What would my benefits be?
Benefits would be like the ones that public employees and those of large private employers enjoy now. Benefits would include:

- Ambulatory and emergency services
- Hospitalization
- Maternity and newborn care
- Behavioral health
- Prescription drugs
- Dental and vision care
- And more

Also, the plan would encourage more primary, preventive, and behavioral health care than many plans now do.

Long-term care benefits would not change. People who qualify for Medicaid would keep qualifying for long term care services. All others would receive skilled care benefits that state employees get now with their health plan.

Would dental, mental, substance use, and vision services be covered by the Universal Health Plan?
Yes.

Would home health care be covered?
Yes. It would be like the home health care coverage that public employees and those of large private employers enjoy now.

What if I wanted benefits that might not be covered by the Plan?
People who live in Oregon would be able to purchase insurance or pay out of pocket for services or benefits not included in the Plan.

What if I needed health care while traveling out of the state?
The Universal Health Plan would cover emergency and urgent health care needs of Oregonians when traveling out of the state. This is what many private health insurance plans do now.

PAYING FOR HEALTH CARE - AFFORDABILITY

Would I have to pay anything when I see a health care provider?
No. You would not need to pay copays or deductibles.

Who would pay for my family's health care?
The Universal Health Plan would pool current spending by government programs into a single health care trust fund. This trust fund would be a state fund set up only to fund the Universal Health Plan. It would be separate from the state's general fund. Also, we would replace current family, individual, and employer spending on health care with a tax system that is based on ability to pay.

Would my health care costs go up?
The Task Force is working to set up a plan that would reduce the cost of health care for most people in Oregon. The new Plan would also seek to slow down or stop the increases in health care costs we have seen over the years. We will be able to offer you more information about this after we finish the financial analysis.

Would I need to pay more taxes?
Yes. This is because the new taxes would replace what you pay today in premiums and out of pocket expenses. Out of pocket expenses can be copays, deductibles, and employer deductions. But please note that for most, the total new taxes you would pay would be less than what you or your employer spend on health care now.

What type of new taxes might replace insurance premiums, copays, and deductibles?
We have explored a payroll tax and income tax. Under each situation, people in Oregon who have low incomes would pay less. Also, employers would contribute to the health of all Oregon residents by paying a progressive payroll tax.

Would the Universal Health Plan help reduce future bankruptcy due to health care costs?
Yes. For services provided under the Universal Health Plan, medical debt for covered services would no longer exist. All covered services would be fully paid by the Universal Health Plan.

GETTING CARE

I've heard that in countries with universal health care there can be long waits for some health care services. Would that happen here if we adopted a universal, single payer system?

Our current health care system has delays now. These delays are due to pre-authorization requirements and the complex and always changing insurance system.

The Universal Health Plan seeks to reduce waiting times. It would achieve this by making access, enrollment, and payment less complicated for providers and the people they serve.

Would I be able to travel out of state to get health care from an expert at a nationally known facility?

The Universal Health Plan board would address when that would be covered. The Plan would have arrangements with out of state health care groups for unusual services or special situations.

HEALTH CARE PROVIDERS

Would I be restricted in my choice of providers?
The Universal Health Plan would allow you to see any licensed or certified health care provider on the Plan. Health care providers who deliver services covered by the Plan would be able to participate.

The Universal Health Plan Board would work to have the number of providers needed.

Would I be able to find a provider who understands my needs?
The Universal Health Plan Board would work with partners across the state to have a broad pool of providers with diverse professional and cultural backgrounds.

ADMINISTERING THE PLAN

Who Would Govern the Universal Health Plan?
The Universal Health Plan would be a public program. A board would govern it. That board would report to the Oregon Legislature and Governor.

Board members would represent a variety of health care professionals and community voices. Regional groups would advise the Plan to respond to the unique needs of the diverse communities across Oregon.

This would be a government funded health care system. So, does that mean the government would be making my health care decisions?
No. While the program would be publicly funded, your health care decisions would be a private matter between you and your provider. The two of you would make all medical and other health decisions together. These decisions would be based on your individual health care needs.

Would private health insurance no longer exist?
No. Private insurance companies would be allowed to offer policies for health care procedures or benefits not covered by the Universal Health Plan. Insurers would not be allowed to sell policies for benefits covered by the Plan to people in Oregon.

What would the relationship be between the Universal Health Plan and Oregon Tribes?
The Board overseeing the Universal Health Plan would have a government to government relationship with the Tribes. Oregon Tribal members would have the choice to enroll in the Plan. Tribal health care providers would be able to participate in the Plan.

Would this Plan disrupt any services we have now for native people?
No. This would not disrupt any services that Tribal or Indian Health Services offer now.

SHARE YOUR IDEAS

How can I share my opinions with the Task Force?
All meetings of the task force and its work groups are public. Meetings have time for public comment. We also invite written comments.

You can view our past meetings here and here (there are two separate pages on www.oregonlegislature.gov).

You can receive notice of future meetings here.

We have been and will be doing outreach to the public. This outreach includes:

- Seven small group talks that we held from January to March. There were 8 to 10 participants. They were chosen with diversity in mind. You can view the report from these sessions here.
- Six statewide online community talks that we will hold in June with people across the state.
- Six forums with the business community and health care industry in June and July.

Could Task Force members come present to a group I am a part of?
Yes. Please invite us into your community or group. You can ask for a presentation about our work via email at JTFUHC.Exhibits@oregonlegislature.gov. Or you can call (503) 986-1813.

CONTACT

Joint Task Force on Universal Health Care
Legislative Policy and Research Office
503.986.1813
Email: jtfuhc.exhibits@oregonlegislature.gov
https://www.oregon.gov/oha/HPA/HP/Pages/Task-Force-Universal-Health-Care.aspx

OREGON JOINT TASK FORCE ON UNIVERSAL HEALTH CARE

TOP 10 CHANGES FOR INDIVIDUALS

The Universal Health Plan would transform the way that people in Oregon get health care. Here are some of biggest changes.

1. **Every Oregon resident is eligible**
   No matter what, you would be covered.

2. **No premiums, deductibles, or co-pays**
   You would never need to avoid or delay care you can't afford. This also means no bills or medical debt.

3. **Contribute based on how much you make**
   Instead of paying for premiums, copays, or deductibles, you would contribute based on how much you make.

4. **See any participating provider**
   You would no longer be limited to certain clinics or providers based on what kind of insurance you have.

5. **Funding for equitable, high-quality health care**
   In the current system, provider pay varies across insurance plans. The Universal Health Plan would equalize reimbursement across providers for the same high-quality care for everyone.

6. **Everyone gets comprehensive health benefits**

7. **Better access to behavioral and alternative care**
   The Universal Health Plan would be designed to make additional investments in different kinds of care to increase coverage and access statewide.

8. **Dental coverage for all Oregonians**
   Everyone would have coverage of dental benefits like state employees have in the current system.

9. **Insurance does not depend on employment**
   Whether or not you have a job with health benefits, you would be eligible for the Universal Health Plan.

10. **Transparent public board focused on equity and health**