JOINT TASK FORCE ON UNIVERSAL HEALTH CARE
SUMMARY REPORT

SUMMARY AND KEY TAKEAWAYS

In 2019 Oregon's legislature created the Joint Task Force on Universal Health Care (the Task Force). The enabling legislation, Senate Bill 770, charged the Task Force with recommending to the Legislative Assembly the design of a "universal health care system . . . that is equitable, affordable and comprehensive, provides high quality health care and is publicly funded and available to every individual residing in Oregon." This is a summary of the final report to the Legislative Assembly.

The need for a universal health care system is clear. The financing and delivery of health care today is financially unsustainable, harmfully complex, and socially unjust.

Health care today is financially unsustainable because the cost of health care has risen steadily faster than income, diminishing the fraction of the population that can afford its own care, and at the same time straining public and private resources to provide services for indigent and other subsidized populations.

Health care today is harmfully complex because the complexity intimidates many populations from seeking care and drastically drives up costs while aggravating the problem of provider shortages. Pre-approvals, limited networks, the inability of the consumer to compare the prices of alternative procedures or supplies in advance, and unreadable medical bills each contribute to high frustration for patients and medical providers alike, delays in needed care, and unnecessary procedures and expenses. This contributes to providers choosing to leave medical practices.

Health care today is socially unjust because provider reimbursement rates that vary by who is paying the bill discourage care to Medicaid and Medicare patients while leaving some Oregon residents without care altogether. Financial burdens placed on sick and injured patients cause high financial stress and bankruptcy and add to differences in access to care. Coupling our expensive health care insurance with employment has led to employers hiring fewer people. Current financial incentives have resulted in providers choosing practice specialties where they can make more money instead of specialties in areas where health care is needed. Cultural obstacles built into the system and racism result in worse medical outcomes for minorities. Insurance plans that divide the population into different risk pools creates unjust winners and losers.

Health care in Oregon is inequitably delivered. Too many Oregonians, because of their race, age, income, geography, or insurance, endure vastly different health care access, varied health care quality, and wide-ranging health outcomes. Despite the Hippocratic Oath, the health care playing field is stained by racism.

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

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

The Task Force's plan has six key takeaways:

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

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

   The universal health care plan in this report establishes a single payer system that will develop policies, practices, and strategies that are equitable and lead to health care that benefits all Oregonians.

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

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

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

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

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

   This plan requires preservation of all current state and federal health care spending, including behavioral health care. Oregonians would no longer pay premiums to insurance companies, deductibles, co-pays, co-insurance, or other out of pocket spending. Instead, the legislature will enact new taxes to more equitably collect the funds. The Task Force tax plan contains an example of tax rates and tax bases to raise the necessary revenue with taxes on payroll and income. The Task Force calls on the legislature to base its decision on setting and collecting new revenue on Oregonians' ability to pay. The universal health care plan will also need adequate reserves, and it may need to issue a bond to build the necessary reserves.

   All state and federal revenues for health care will go directly into the single payer's dedicated trust account, not the state General Fund. Dedicated funding and independent but accountable governance by the single payer board are critical for establishing public trust. Dedicated funding coupled with independent accountable governance are necessary to best weather pandemics and economic downturns.

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

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

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

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

6. **This plan calls on the 2023 Legislature to create a universal health care plan board of directors using the Task Force plan as a guide.**

   The Task Force calls on the 2023 legislature to create and fund the universal health care plan's first governance board to supervise key transition efforts, such as seeking federal waivers needed to fully operate the plan and work with Oregon's delivery system to transition to the single payer system. The Task Force deliberately focused on the main components of a single payer system and outlined values and principles that guided their work. SB 770 and the Task Force's principles give the single payer board direction for addressing the many details, including the provider payments for particular services, as well as implementation decisions.

KEY ELEMENTS OF THE UNIVERSAL HEALTH CARE PLAN

KEY ELEMENT: ELIGIBILITY AND ENROLLMENT

SB 770 directed the Task Force to cover all Oregon residents with the universal health care plan. The Task Force recommends that all people who live in Oregon will qualify for the plan and be enrolled automatically and through a simple and easy to understand process. This recommendation is to cover all residents regardless of housing, citizenship, or employment status. Oregonians already enrolled in Medicare and Medicaid will be quickly automatically enrolled in the new universal health care plan.

Because the single payer entity will need to maximize the use of federal health care dollars, the single payer entity will need to collect other information about the residents using the single payer system, such as their identity, age, income, or proof of enrollment in Medicare or Medicaid. While health care providers will not be burdened with determining residency status and will provide their services to all, providers may need to inquire about residency and some other information (1) to help identify non-residents who the single payer entity will need to bill for reimbursement and (2) to identify those Oregon residents who need to be fully and properly enrolled by the single payer entity in the universal health care plan.

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

For those Oregonians not automatically enrolled, the Task Force recommends a simple and easy enrollment process that ensures there is "no wrong door" for seeking enrollment – no incorrect time or place to be enrolled. For example, when people move to Oregon there will be no waiting period for enrollment. Once a person is a resident, the person is eligible to be covered.

To get all residents fully enrolled, the universal health care plan's governing board will need to work with, and initially may need to expand the workforce of, people who today assist Oregonians in enrolling for health insurance.

KEY ELEMENT: HEALTH CARE BENEFITS OREGONIANS WILL ENJOY

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

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

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

The universal health plan board is directed to include cultural, geographic, and specialty parity in the reimbursement system and is encouraged to ensure availability of traditional health care workers who work at the direction of health providers to provide critical services and care.

A Regional Delivery System.

In accordance with SB770, the Task Force embraced the establishment of a delivery system with geographic regions. Each region will have a regionally sensitive global budget. Only one regional entity will serve a geographic area. The regional entities must be designed and operated to enhance health equity while being responsive to the needs of their region. The regional entities will be encouraged by the statewide single payer board of directors to apply to

the statewide entity for supplemental funding for demonstration project funding to test new strategies to address longstanding inequities and problems. The regions will be responsible for evaluating and reporting to the statewide entity on the demonstration efforts as part of the regions' normal, periodic reporting.

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

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

Optional and Exclusive Provider Eligibility.

All providers will be presumptively eligible to participate in the single payer plan, and if they choose to do so they will have to agree not to participate in other plans or practices that offer the same benefits as the single payer plan that may be created. And they will have to agree not to ever bill an Oregonian for services or goods provided under the single payer plan. Providers could, however, participate in plans or practices providing services not covered by the single payer plan. The single payer system will require the single payer entity and the State of Oregon to increase the number of health care providers serving currently underserved communities and individuals.

Residents needing health care in other states.

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

Capital Expenditures.

The Task Force plan proposes that all providers will be responsible for their own routine organizational capital expenditures. The statewide universal health care entity will, however, allocate to regions a budget for exceptional or large-scale medical capital investments such as purchasing MRI machines or building hospital expansions. The allocations by the statewide entity will be based on community needs assessments conducted by the regional entities. The single payer entity will need to address today's disparity in investment accounts of hospital and health systems to ensure equity.

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

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

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

KEY ELEMENT: GOVERNANCE AND TRANSITION

The Task Force recommends to the legislature that the most important task for the 2023 legislative session is to establish the governance approach guiding the start-up and accountable operation of the universal health care plan. The single payer entity – the universal health care plan – will be a nonprofit public corporation that relies on a trust fund managed through the state treasurer's office separate and distinct from the General Fund to pay for Oregonians' health care. Prior to the creation of the nonprofit, public corporation that is single payer entity, the first governing board of directors will be within the Department of Administrative Services and report to the Governor.

First Universal Health Care Entity Board.

The Task Force recommends that the 2023 Legislative Assembly create the first board of directors for the universal health plan entity and confirm the appointment of members in 2023. The first board should reflect the values and structure of the universal health plan as described in the body of this report, including regional diversity and having board members who each have an authentic community voice.

Initial activities of the first board should be to develop, in collaboration with a representative health care delivery advisory committee, a plan to organize Oregon's health care system to deliver care in a single payer system which is in alignment with the purposes, values and principles of SB 770, organize and draft Medicaid, Medicare, and other necessary federal waivers, , a macroeconomic analysis of the implementation approaches to be pursued, and organize a constant process of engagement with Oregon's patient and taxpayer communities. The first board of directors needs to define and initiate the government-to-government relationship with Oregon Tribes and assess and maintain intergovernmental relationships with Oregon counties. The board's planning should prioritize health equity, community investment and equitable distribution of resources.

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

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

Transparency and Accountability.

All of the board of directors' work should be transparent and subject to Oregon's government ethics, public records, administrative procedures, and meetings laws. Decision making should not only occur in public but should also include input from the public that is sought in a timely fashion. The board must be held accountable for its work by Oregonians and the Legislative Assembly. Board members should prioritize health equity, community investment, and equitable distribution of resources in ways that improve the health status of individuals, families, and communities.

Composition of First Board of Directors.

The founding board should be composed of nine (9) members, appointed by the Governor and approved by the Senate. The membership should reflect the diversity of Oregon's population. Members will be State of Oregon employees and responsible for the day-to-day operations of the start-up phase of the universal health care plan. The board members' education and experience should reflect expertise in organizational start up, public agency operations and reorganizations, public finance, health care provider relations, Medicare and Medicaid waivers, actuarial analysis, and public (population) health.

Four (4) members should focus on public engagement with Oregonians and provide advice and feedback on a continual basis to the full board and the staff working to implement the plan. As a group the four should bring the following experiences to the job: experience as a Medicaid patient, experience as a Medicare patient, experience as an advocate for children, experience as an advocate for behavioral health.

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

The founding board will select two (2) co-chairs, with one coming from the four members focused on public engagement. All Oregonians from diverse cultural, linguistic, ethnic, racial, and gender communities, health care providers and professionals, community health and health care advocates and activists should be encouraged to apply.

KEY ELEMENT: COST

An independent actuary calculated the overall costs of our single payer plan and estimated that the costs of the new plan would be about $980 million less than the cost of our current health care system (see technical report for details).

The basic elements of total health care costs are the number and demographics of the people who are served, the health care services they receive, and the cost of providing those health care services. The actuary used those elements to project the costs for the different populations served under two scenarios: under the status quo, or no change from the current system and under the universal health care plan as the Task Force designed it, covering all Oregonians with a generous benefit plan.

The actuary estimated that the quantity of care being provided to Oregonians will increase as people have full access to care unincumbered by co-pays, deductibles, and other out-of-pocket expenditures, and as more services, such as dental and hearing, are provided. The increased

costs of providing more health care, however, will be more than offset by savings from reduced administrative costs. Besides reducing the costs of billing and insurance "paperwork," other savings identified by the actuary include savings from increased purchasing power for drugs and medical devices, economies of scale, elimination of insurance marketing, profit margins, and commissions costs, and a reduction of fraud, waste, and abuse, which are harder to combat in today's complex health care structure.

KEY ELEMENT: FUNDING

At the heart of the single payer system is a revised system to fund paying for Oregonians' health care. In the current system, individuals, employers, and local, state, and federal governments all pay for health care. In the new model, all federal, local, and state revenues would be combined into a single dedicated trust fund to pay for health care.

The Task Force envisions funds to pay for the universal health care system will come from three places: (1) funds spent on health care from both existing state government revenues and from federal sources would go directly to the new universal health plan's trust fund; (2) projected savings in the health care system by creation of the more efficient single payer model essentially create revenue by reducing the need to raise revenue; and (3) new public revenues in the form of tax contributions to replace current premiums and out of pocket expenditures.

Redirection of Existing Revenues.

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

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

Honor Actuarial Assumptions About Savings.

The actuaries hired by the Task Force assumed that the change to a single payer system will have cost reductions or savings. A portion of those savings are assumed to be used to limit the amount of new revenue which would otherwise be required to replace insurance premiums and out of pocket expenses. The single payer entity will need to be held accountable for hitting the actuaries' savings goals.

New Revenue.

The tax plan suggested by the Task Force is only an example. The Task Force encourages the legislature to create a progressive tax plan that provides sufficient revenue to the trust fund to fully implement the plan.

After reviewing a comprehensive list of possible taxes, the Task Force focused on three types of taxes that could be used to raise revenues: a tax on payroll applied at the employer level, a tax on personal income, and a sales tax. These tax types were selected because of the size of their tax bases and the tax rates that would be needed to raise the amount of revenue needed to fund universal health care. The Task Force took a tax on corporate profits off the table because little revenue can be gained by a reasonable tax rate on the small tax base (profits).

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

This left the Task Force with considering the combination of a payroll tax and a tax on Oregonian's household income. The Task Force developed an experimental tax proposal for use in public input sessions and collected input on that experimental proposal. That proposal is described in the staff report. That said, the legislature is certainly free to put a sales tax or a corporate profits tax, or both, back on the table.

The payroll tax rate example considered by the Task Force would increase for higher income workers so it would be less regressive than the flat and capped federal payroll taxes. The Task Force considered a 7.25 percent tax on wages up to $160,000 and10.5 percent on wages in excess of $160,000. This payroll tax would, like health insurance for employees, be an ordinary and necessary business expense that employers could use to reduce profits subject to state and federal taxation.

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

The new tax on personal income in the example considered by the Task Force would gradually increase for households with higher incomes because Oregon's personal income tax scheme is supposed to reflect the ability to pay (i.e., progressive) and Oregon' overall taxation system would better reflect on Oregonians' ability to pay.

The marginal rates and income brackets for the new personal income tax the Task Force considered are:

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

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

Because there is no shortage of options for how to design a payroll or income tax and the decision is ultimately one to be made by the legislature (and possibly voters), the Task Force

chose to consider what it developed and discussed as examples – not a Task Force formal proposal – that can give initial guidance to the legislature.

Before settling on a revenue raising scheme, the founding board and the legislature will need to discuss a number of issues that the Task Force did not have the time or financial/staff resources to explore, such as startup costs for the new single payer entity, reserve accounts, reinsurance, and bonding needs. Each of those will impact the amount of money needed to be raised.

After listening to public concerns, the Task Force reached consensus that while the experimental tax proposal has been useful for consideration of the issues, further evaluation and design of taxation should be left to the legislature which has the authority and greater resources to design the final revenue proposal.

KEY ELEMENT: MEDICARE

The universal health care plan designed by the Task Force will be unique in terms of its approach to Medicare. All Medicare patients who are Oregon residents would be eligible. All Oregonians should be treated equitably when it comes to access and navigation of the health care system, including Oregonians with Medicare. While the Task Force's single payer approach borrows efficiencies from the Medicare system it is also less complex for Medicare eligible seniors because it does not include multiple payers (e.g., Medicare and a plethora of supplemental and Medicare Advantage plans to choose from) and multiple benefit plans among those choices. Incorporating Medicare is uniquely difficult because virtually all of the funding for Medicare comes from the federal government and about 900,000 Oregonians who are Medicare participants.

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

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

Due to the need at the federal level to stabilize Medicare funding by 2026, Medicare will be undergoing significant changes in the same time frame as the universal health care plan design comes together. Oregon needs to be ready with a transformative proposal. In a number of states, the federal government has recognized transformative approaches for Medicare. The current federal administration has strongly signaled an interest in Medicare transformations that will improve health equity, increase involvement of patients and providers, and increase transparency. There is no health plan design in use today in any state that can match the Task Force design when it comes to equity, patient and provider involvement, and transparency. The federal government's need to stabilize Medicare and its interest in transformative approaches

makes it an appropriate time to meet with the federal Medicare agency, the Centers for Medicare & Medicaid Services (CMS), about this design.

There are multiple potential pathways for Oregon's universal health care plan to include all Medicare patients. The most likely pathway is for Oregon to offer a low-cost but high benefit Medicare Advantage plan within the universal health plan that all Medicare eligible Oregonians could enroll in. As is proposed by the Task Force for other Oregon populations, Oregon would seek federal approval to prohibit insurers from offering any benefit plans that duplicate the universal health plan's benefits for Medicare-eligible Oregonians. In other words, for example, supplemental Medicare insurance sold in Oregon could not cover benefits that are included in the universal health care plan. While it is possible that other Medicare options, including traditional Medicare approaches, could be employed by the single payer entity to reach equity with the universal health plan design, these approaches would be more challenging to administer.

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

KEY ELEMENT: EQUITY

The Task Force's plan will provide a universal set of health care benefits to all Oregonians; ensure every Oregonian has access to behavioral, vision, hearing, and dental care; and, eliminate the need for Oregonians to pay premiums and out of pocket costs. The plan eliminates differences in payment to providers based on source (insurance or client payments) and makes it so that providers in a region are paid the same regardless of an individual's financial or health care coverage circumstances.

This plan addresses an aspiration of health equity. Today, health inequity exists in all aspects of our society. Oregon's current Medicaid, Medicare, employer-sponsored health insurance coverage partnerships and Coordinated Care Organizations have not adequately addressed health inequities. The current insurance and delivery systems are comprised of the wealthy, privileged, powerful, and well-positioned stakeholders who created our existing inequitable social structures. As currently structured, these entities have led to growing public concerns about an unequal and inequitable healthcare delivery system.

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

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

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

KEY ELEMENT: HEALTH CARE WORKFORCE

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

The universal health care entity's board must work to address education and licensing programs and play an active role in increasing the training capacity of those entities that train the health care workforce, especially in the nursing and therapists arenas. The effort should include exploring ways to reduce the cost of educating and training health care workers so that more people can enter the field and there are an adequate number of slots in the educational and training institutions. Additionally, the board must encourage geographically diverse investments in health care workforce training, and support wages needed to supply the necessary instructors to educate and train the future health care workforce.

KEY ELEMENT: COMPLIANCE WITH ERISA

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

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

Employers would no longer need to provide health insurance benefits, and they would still have the option to offer self-funded plans. The Task Force plan allows employers and individuals to buy complementary insurance, which is coverage for those services and costs not covered by the universal plan. Employers could offer complementary coverage as an employee benefit – either by purchasing it from an insurer or by self-funding this coverage. Thus, the proposal preserves meaningful choices for employers. Employers can choose to offer employees self-

funded duplicative coverage, to offer complementary coverage, or to rely entirely on the universal health care plan to take care of the health of their employees.

Finally, all licensed or authorized providers in good standing will be eligible to be participating providers in the universal health care plan. Participating providers will agree not to participate in substitutive plans offering benefits covered by the universal health care plan and not to ever bill an Oregonian for services or goods provided under the universal health care plan. The state universal health care plan will pay providers directly. The universal health care plan will be secondary to any forms of substitutive coverage employers choose to offer.

A memo from the Task Force's ERISA experts, Elizabeth McCuskey and Erin Fuse Brown, attached as Appendix A, provides additional details of how the plan properly avoids running afoul of ERISA.

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

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

KEY ELEMENT: FEDERAL WAIVERS AND COOPERATION

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

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

All Medicaid recipients would be enrolled in and covered by the universal health care plan. The one exception is that Medicaid recipients would continue to receive the required Medicaid benefit package which provides some additional services beyond the universal health care plan benefit package. Providers would be paid the prevailing universal health care plan rate. Medicaid long-term care would continue to be provided as a benefit to Medicaid recipients and the Oregon Department of Human Services would continue to administer Medicaid long-term care benefits.

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