To: The Oregon Legislative Assembly

From: Glendora Claybrooks
2019 Joint Task Force Member on Universal Health Care

Re: Minority Report

Date: September 29, 2022

Dear Legislative Assembly:

I, Glendora Claybrooks, Public Member Representative, am submitting this Minority Report to recommend a single-payer alternative financing method. This submission is because this alternative plan was excluded from the 2019 Senate Bill (SB) Joint Task Force (TF) on Universal Health Care's agenda. Consequently, it was without mention in the final recommendations of the Majority Report. This exclusion was due to its perceived late introduction to the process.

Therefore, the purpose of this minority report is to offer another set of comprehensive recommendations supporting an alternative method for financing a single-payer healthcare plan model for you to consider. It is the expectation that if this recommended plan is adopted and approved by you, it will better serve the public's health and unmet healthcare needs as described in SB 770.

This minority report is not intended to reverse, appeal, or augment the suggested goals and objectives identified and described in the Majority Report. Nor is it meant to dispute the expected benefits and services in the TF design plan. Instead, it strengthens the Majority Report's suggestions for the elimination of the current barriers serving as challenges to accessing and affording fair, just, and adequate quality of care services for all Oregonians.

Executive Summary

The goal of the Joint Task Force (TF) on Universal Health Care was to recommend a design for the Health Care for All Oregon Plan to the Legislative Assembly. Its primary purpose was to ensure a publicly funded, equitable, affordable, comprehensive, and high-value quality single-payer universal health care plan for all Oregonians. The expectation was that a Health Care of All Oregon Board would then administer the program.

Minority Report Content:

This opinion weighs in with anticipated program goals and objective outcomes, the advantages and disadvantages of the possibilities of a renewed and robust comprehensive healthcare plan design. It addresses the SB 770 goals, principles, and values that benefit the state's economic needs, population health, and the equitable distribution of healthcare services for all Oregonians. The contents of this report will reflect the public discourse, special interest

groups' accusations and opposing positions, the author's background, and other stakeholders' concerns.

Lastly, it reflects the recommended alternative financing plan for a single-payer system. This opinion also describes the expected functions and benefits of the recommended alternative model and other existing health plan policies, operational activities, program objectives, and procedures functioning as a viable and reliable universal health care delivery system. From an analytical equity perspective, modifying these different federal and state coverage plans will suffice as a substantive and feasible holistic alternative financing model for securing a single-payer healthcare plan for all Oregonians.

Implementing these considerations and recommendations associated with determinants of health conditions and disproportionate poor health outcomes would reflect effective and efficient provision management. Many of these circumstances stem from the inability of private health insurance, employer-sponsored healthcare, and current fragmented services. Uncoupling this feature makes fair practices and services tenable in sustaining high-performing accessible, appropriate, linguistic quality of care based on affordable healthcare delivery and reimbursement structured patterns.

This alternative model focuses on reconciling cost with quality with priority attention on implementing a system that addresses qualitative lived experiences, as indicated in the Lara public engagement feedback. This perspective sustains support for an economical approach using this recommended alternative method of status quo practices of prioritizations of modifying problematic areas to address the social health needs of all Oregonians and our state's economic status. Effecting this outcome requires insight into the pre- and post-impacts and challenges of and from the COVID pandemic crisis.

This report emphasizes a system that would perhaps result in purposeful outcomes. Such outcomes would represent an appropriate comprehensive health benefits insurance package with design elements contributing to our state's economy while enforcing and sustaining a just society. Therefore, I am suggesting additional considerations in alternative financing solutions in designing a single-payer universal healthcare plan that would better complement SB 770's enactment.

However, this alternative recommendation requires a thorough analysis of existing healthcare policies, financial activities, social and economic issues, interventions, and healthcare consumer impacts.

Using a broad brush to examine this alternative method by evaluating conscious efforts and applications of principles and policies has the potential to better address and understand administrative ineffectiveness and inefficiencies. This measure would reflect poor financial oversight stemming from often poor program planning, monitoring, maintenance, and allocation of scarce resources resulting in unintended increased healthcare costs, low quality of care, and less access to care services.

To impede these impactful outcomes and to improve these systems of practices, policies, and programs requires a robust approach. This tactic includes identifying, strategizing, analyzing, and aligning affordable and accessible high-value quality of care services. Such services would consist of appropriate, timely, and culturally competent incentivized healthcare coverage benefit plans.

With these expectations in mind, this alternative method enables holistic services and activities that support implementing resolve in this single-payer financial model. It is evidenced that this measure better aligns with SB 770 requirements. As such, it creates and expands the necessary community resources toward helping eliminate minority health disparities, intersectionality, immigration status, and rural barriers, such as too few and distant healthcare facilities and inadequate access to digital technologies.

This proposal is important because of the assumptions underlying these recommendations based on reconciling costs and quality of care services received. Statistical evidence indicates that incorporating and prioritizing the quality of care delivered better enables accurate estimates of savings while controlling costs. This equity perspective ensures the untapped feasible, doable, and sustainable possibilities.

Therefore, for your consideration, I am proposing this equitable alternative recommendation financing plan to implement a single-payer universal plan of services and benefits with the most promise of rendering healthier outcomes. This alternative recommended financial approach better addresses the socioeconomic frameworks identified in SB 770 policy requirements, goals, purpose, plan benefits, and other SDOH and equity elements. Achieving this feat requires a grandiose approach to alleviate increasing healthcare costs and delivering appropriate, culturally incentivized, patient-centered quality of care services with the expectation of providing equal and equitable access to necessary medical pharmaceuticals, timely treatments, and interventions.

Justification

The justifications for considering this report are evidence-based realities embedded in qualitative and quantitative facts. Firstly, its tactics and strategies are deserving of consideration and discussion as a possible viable solution addressing the SB 770 enactment. Secondly, it presents good attributes for implementing a single-payer universal healthcare design plan. Thirdly, its resolution and rationale are consistent with SB 770's best means and requirements to establish a principled and functional Health Care for All Oregon Plan.

Lastly, it exemplifies and supports the significant values and principles reflecting the critical needs based on diverse communities' public engagements and stakeholder feedback. These participants expressed their concerns about the health and healthcare issues such as access to ongoing medical necessities, employer-sponsored premiums, business, job loss, health provider recruitment, training, financial reimbursements, out-of-pocket cost, and other health consumer impacts and outcomes.

Alternative financing Model Recommendations

Because there is no blueprint for designing, developing, and attaining a brand-new single-payer universal healthcare system. This alternative method makes it necessary and admirable to create a plan the nation can choose to embrace. This action requires rethinking the motivations driving the policies, principles, values, and services to reflect priority and to invest or not invest in transforming the healthcare delivery system. This behavioral intervention is vital to sustaining our society and healthcare needs by modifying health policies and practices. We must invest in activities resulting in the interest and best outcomes for all Oregonians to produce a formidable robust product of goods and services. A spin-off from which the proceeds will benefit the entire population, our communities, and the private and public sectors.

Why? Because access to healthcare is an inalienable human right, the government must assume the responsibility of ensuring that all citizens are protected. It is neither practical nor prudent to view healthcare services as a commodity to be sold based on one's ability to afford them by purchasing its services from the private market at unreasonable price rates. Without a single-payer model, this sales approach perpetuates unnecessary human suffering.

Navigating through these fragmented and complex multiple systems of care services include understanding the federal ERISA enactments, achieving congruency in bipartisan agreements, and combatting conglomerate lobbyist dollars influencing political policy decision-making. So, the question becomes what recommendations and considerations must we entertain in determining how best to establish, design, finance, manage, deliver, and implement a robust and innovative system?

Therefore, our current healthcare delivery system must no longer be tolerated or expected for the private health insurance market to be the primary insurer and keeper of the susceptible population to diseases, famine, and illnesses. Preventing human suffrage requires addressing this ongoing problem of health inequity and inequality as this is not normal behavior for individuals, rich or poor or otherwise, to die prematurely. No longer must society ignore the human cries for help to thrive and survive.

Turning a blind eye to the possibility of achieving a single-payer healthcare plan is an inhumane, neglectful, uncaring, amoral, and immoral response to involuntary emotional and human health needs. These behavioral responses often result from our influenced worldviews and inability to assist, atone, and attain sufficient social and financial means to effectively share and sustain others' quality of life and improved health status.

Operating under the premise of accomplishing a single-payer system that is publicly funded, comprehensive, affordable, equitable, and accessible is a noble awareness and a painstaking unprecedented effort. However, given the complexity and difficulties we face with the appropriate focus, there are many challenges in seeking viable methods of financing a single-payer healthcare system. It is essential to realize the historical trends, efforts, and legal constraints in utilizing federal and state dollars to fund a comprehensive healthcare plan for all citizens.

This proposed opinion recommends an alternative financing model to be considered. This design requires examining the federal and state policies of the Medicaid Oregon Health Plan (OHP), Children's Health Insurance Program (CHIP), Medicare, TRICARE Select, and Oregon's nine Native American Tribal designs. The expectation is that after conducting these existing policies, there can be discoveries by which we can use to finance a single-payer universal healthcare plan as described in the SB 770 enactment.

The difference between Medicare and Medicaid is that Medicare is a federal program that provides healthcare coverage for people aged 65 and over or disabled despite income status. Medicaid is a joint health coverage program funded by state and federal plans for the low-and no-income populations.

CHIP is also a federal and state-financed joint venture designed to provide health care coverage to low-income, uninsured children and families whose incomes do not meet the eligibility criteria for Medicaid coverage. It is state-administered based on federal guidelines established by the Centers for Medicare and Medicaid Services (CMS). CHIP was implemented based on community health assessment findings evolving from studies on health-related needs and available community resources.

TRICARE Select is a government-sponsored healthcare insurance plan, the Department of Defense's leading healthcare program. In 1993, Its name was changed from the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program. Its primary plan provides immediate access to medical care for all its 9.6 million worldwide beneficiaries. The beneficiaries of this plan do not incur a cost for the benefits received. TRICARE is the secondary payer of reimbursements for its health benefits and insurance plans, excluding Medicaid. However, it does supplement the Indian Health Service and other identified programs by the Defense Health Agency (DHA).

Its health coverage plan is a comprehensive design based on serving only the military active-duty service members and families. This plan includes survivors, spouses, the National Guard, Reserve, and retirees worldwide. It provides full coverage, including varying health plans such as TRICARE Select in America, TRICARE Select abroad, US Family Health Plan, and TRICARE For Life. It offers wraparound coverage for those aging eligibles qualifying for Medicare Part A & B benefits.

TRICARE's health program is managed regionally. It combines its military hospital resources by networking with private facilities and civilian healthcare providers, thereby expanding increased access to medical services. Its Military healthcare facilities, including hospitals and clinics, are part of its system. This design presents multiple full benefits. It provides comprehensive, affordable healthcare coverage with several health plan options, significant pharmaceutical benefits, dental choices, and other desired services.

Its non-benefits are based on the exclusion of services and supplies deemed not medically or psychologically necessary. For example, suppose diagnostic treatments are not evidence-based to be justifiable covered conditions, including mental disorders, injuries, pregnancies, or well-child examinations. In that case, services and supplies are not rendered. Conversely, not all veterans are qualified for TRICARE benefits. The personnel and non-qualified veterans are referred to the Veteran Administration health system for medical services.

Based on these combined federal and state health care plan's benefits, coverage and services, I believe they are rife with opportunities and possibilities. It is worthy to seek ways to glean information from these principled concepts, practices, and programs that might benefit the financing design of our transformative single-payer health plan system.

Eligibility and Enrollment Processes:

The moral question driving this recommendation is the realization that federal and state-designed healthcare plans are sufficient enough for the federally defined poverty and underemployed and unemployed populations. Then why isn't it good enough for all Oregonians, notwithstanding social and economic status, wealth, earned income and wages, or onset of diseases and illnesses?

Many provisions are needed to design and finance a comprehensive single-payer system. These developed programs already have requirements to meet financial eligibility and enrollment processes. Requesting federal waivers to redistribute funds to assist with financing a single-payer process lends to the benefit of having not to reinvent the wheel or start from scratch. Much can be gleaned from these existing jointed federal and state health plan policies, including the Patient Protection and Affordable Care Act (PPACA). This recommended plan allows the benefit of not having to start at ground zero to achieve a much-needed transformational change in developing a single-payer universal health care plan based on the policy requirements of SB 770.

For example, the American Medical Association, the World Health Organization, and the Centers for Medicare and Medicaid (CMS) produce diagnostic and treatment coding tracking measures such as the CPT, ICD-10, and HCPCS. This process helps identify and justify associated costs with medical visits, types of illnesses, and time-based services. This strategy determines the dollar charges to reimburse providers for covered services. The benefit of this task indicates its usefulness in designing a single-payer system to provide universal services without incurring additional administrative expenses.

Functioning within these parameters of provisions would lower administrative costs, thereby contributing to a viable and reliable systematic method. An additional surplus of financing a sustainable healthcare system presents phenomenal savings from not having to incorporate a new expenditure in the design element planning stage. This established practice determines medical necessity activities to address the system's efficiency needs according to predetermined payment rates based on time duration,

justification, procedures, provider specialty, and consumer health needs seeking medical intervention services.

This process can consider aligning an existing feature as a valuable and measurable tracking tool to streamline and compare economic costs with the quality-of-care practices and procedures. This system's financing approach benefits the process by substituting and eliminating excessive spending while acquiring meaningful healthcare coverage in services rendered. This measure would help rid Oregon of substantial expenditures paying for value-based incentivized care services through the private employer-sponsored healthcare insurance benefits plans. This approach would also relieve financial burdens by dismantling the managed coordinated care systems that have demonstrated unsuccessful financial management efficiencies in their practices. These funds can be better utilized in financing revenues toward a single-payer system designed to benefit all Oregonians.

Therefore, replacing these four health plan entities with the current OHA functioning under the auspices of a qualified governing board overseeing the model of a well-designed system is a significant achievement. Designing and developing convoluted policy provisions and procedures to address the unmet health and healthcare servicing needs of its entire population deserves national attention. The ultimate benefit is maximizing medical care services, rendering profound leadership in providing the blueprint no other state has dared to accomplish.

Governance:

To oversee OHP would require a state-appointed health administrator to manage the plan's benefits. The **OHA's** administrative role would be to work with its internal departments and heads of state as the primary provider of the benefits and services. This strategy ensures the plan's objectives meet state regulations of other government entities' expectations, including the judicial, executive, and legislative branches. The administrator's responsibilities entail developing policy, including identifying necessary augmentations to guide other health organizations and practitioners' timely reimbursements.

These tasks would benefit healthcare consumers by assisting with quality improvements, expedited and sufficient reimbursement amounts, and diverse cultural recruiting, retention, and training to enhance the transformation of the newly designed structures of the single-payer healthcare system. Reevaluate the eligibility and enrollment processes that are already in place.

The Oregon Health Authority (OHA) agency remains the role and responsibilities as appointed by the Governor. As such, the primary duties will include the position of administrative leadership overseeing the operational activities, including the budgeting and allocations of equipment and supplies, community health and human resources, implementation, evaluation, and monitoring of programmatic outcomes ensuring fair and just practices of its policies, procedures, interventions, and other administrative decision-making processes. The administrator's role will also include maintaining sufficient staff

to promote effective and efficient management, purchasing, tracking, and measuring employee performance.

These tasks will engender adequate and appropriate statewide delivery of healthcare services and fair distributions of health information using digital technology shared access. The oversight of these objective outcomes ensures successful efforts in assuring equal access to high-value quality health care goods and services. Other responsibilities include following the state agency's public health safety standardizations, critical elements of its department of human resources (HR) hiring strategies, qualifications, background experiences, and expectations reflecting levels of health readiness, recruitment, and training practices. This effort maintains updated professional workforce credentials and compliance with state-required licensure, certifications, and health vocational program certificates. It helps to provide consistency and the alignment of the rule of law in sustaining public health safety guidelines.

Such HR provisions would ensure intentional diversity, equity, and inclusionary cultural opportunities with physical and psychological health benefits reflective of those identified in Maslow's Hierarchy of Needs triangle. Considerations of this magnitude enhance social and emotional connectedness resulting in the reduced onset of diseases and illnesses brought on by high levels of preventable stressors. Lastly, administrators are expected to enforce compliance with federal enactments and regulations, including state ORS, rules, and guidelines.

Financial analysis

A thorough assessment must be performed to determine and implement strategized and tactical means that are reasonable, fair, and equal in guiding operational policies, practices, and processes. The identified strategies and tactics must develop from unraveling and examining the complex socioeconomic intertwined provisions of federal and Oregon state laws, health insurance policies, and programs.

This method calls for broad modifications to these multiple designed healthcare programs and policies, focusing on determining estimated cost savings and overall benefits. This strategic activity atones for preserving and enhancing Oregon, and its resident's socioeconomic health status can be achieved by requesting federal waivers and bipartisan state enactments. The expected savings will benefit Oregon's economy, population health, scarce community resources, and provider reimbursement. These tactical considerations are anticipated to deliver significant outcomes.

This alternative model will help design and sustain a transformative system because of its potential to lower administrative healthcare costs, cost sharing, and increase the quality of care. It simultaneously expands unlimited access to medical services and will assist in stabilizing Oregon's economic status. The findings will inform us of the implementation cost to affect a changed system with better outcomes upon appropriate financial analysis of this current multiple payer system model. This changed outcome depends on several objective tactical strategies thought best to achieve this purpose. The best way to accomplish this anticipated outcome is by eliminating the

coordinated managed care systems, decoupling private health insurance from employer-sponsored contractual care, terminating out-of-pocket expenditures, and promoting increased preventative diagnostic and patient-centered care services.

This holistic approach requires public engagement, feedback, and legislative buy-in of the necessities of supporting complete financial investments, political courage, and economic analysis of other related entities and issues. Its findings must reveal existing statistical support informing of the importance of establishing a centralized single-payer healthcare delivery, financial, management and reimbursement systems. It must represent a structured functional design to deliver and distribute equal and systematic healthcare plan benefits that are feasible, equitable, and serviceable.

Benefits, Expectations, and Outcomes

It must stipulate advantages and disadvantages in the combined Tribes, Medicaid, Medicare, and Tricare design policy elements. These shared findings must emphasize its healthcare programmatic services' tangible and non-tangible benefits. For example, its analysis must demonstrate the moral benefits of providing for incomparable basic human needs. This aspect is vital when determining prioritization, medical necessities, and the total costs, including opportunity costs.

This procedure will ensure and secure public health safety measures and enhance the quality of life while generating cost savings. This opinion recommends that the priority of public health safety and meeting human needs are the responsibilities of the government. Therefore, the decision and the beneficial outcomes must outweigh the cost concerns of designing and delivering a system guaranteeing equal and equitable access to preserve inalienable rights and expectations. This expectation includes the government providing an appropriate and adequate medical care system as a product of its public goods and services.

These transparent activities help sustain and maintain Oregon's population health status and economy, as well as address community health needs and meet the stakeholder's and public's concerns. This process must reflect estimated and anticipated costs of improvements to affect the quality of care received toward achieving and delivering health equity and eliminating health disparity outcomes.

The decision to retain the Oregon Health Plan's (OHP) title would replace the often-perceived socially associated stigmatized title, *"Medicaid."* These stigmas create unhealthy social divides and psychological and emotional disorders such as embarrassment, anxiety, peer rejection, and other unnecessary non-disclosures resulting from government subsidies addressing the various determinants of basic human health needs.

The Oregon Health Plan (OHP) has statewide recognition. As such, it presents minimal marketing tactics and yet offers huge equalizing social benefits. For example, healthcare providers, legislators, businesses, administrative professionals, and healthcare consumers already identify with this state health plan. There will not be existing identities

resulting in labeling and stigmas contributing to classism, socialism, and other socially debilitating and de-characterizing human worth.

These are essential socialized concepts to consider as they are significant factors affecting healthcare consumers' emotional, psychological, physical, and spiritual health. A significant benefit is that Medicaid and its quality of services will no longer be connected to specific poverty-defined populations. This openness helps eliminate social classism classifications resulting in dehumanizing labeling as the poor, indigent, or public aid recipients. These aspects are crucial to consider because of their significant health plan benefits in receiving the appropriate culturally competent quality of care services.

Conclusion

In conclusion, this alternative method presents many opportunities, possibilities, and benefits in developing a sustainable, feasible, fair, just, and equal system of healthcare plans as an alternative funding approach for the Joint Legislative body to consider and discuss. Its intended content reveals and represents the public's interests and concerns. These strategies best represent and consider the complex scope of SB 770s identified problems and principles. This opinion identifies key elements beneficial to the financing and implementing of a strong, sustainable, maintainable, functional, and operational comprehensive single-payer universal healthcare benefit plan. This expanded, well-defined, and aligned design allows for significant feasibility for all Oregon-eligible and enrolled residents.