To: Oregon House Committee on Health Care

Re: HB 2010 and 2010-1 Analysis and Concerns

From: Tom Sincic, President of Health Care for All Oregon

Dear Chair Prusak, Vice Chair Hayden, Vice Chair Salinas, and Members of the Committee:

HCAO realizes that the transformation healthcare is big undertaking. The good news is that Oregon is leading on this in many ways. The work of the Task Force on Universal Health Care is one such area that is being watched by the nation with much interest. There are a number of other bills in this session that are transformative that actually decrease barriers and/or may decrease cost. Telehealth is one example. Bills related to dental and mental health access need to be at the forefront along with cost of prescriptions and bills that keep those with disabilities from losing coverage and access to care. Cover All People is another to be addressed. This legislature may want to carefully consider whether it is a good idea to spend dollars on another study, especially one that is very unlikely to achieve the hope for results as outlined in HB 2010-1. We offer this further commentary and analysis.

Impact of HB 2010 to Establish a Public Option or HB 2010-1 to Study a Public Option on the Movement to Universal Healthcare and Health Equity

This is an item-by-item assessment with commentary of how a public option would impact Oregon's progress towards universal health care and health equity under the Purposes, Values, and Principles of ORS Chapter 629 of 2019 created by SB 770. How might it advance, have no impact, or inhibit/derail the movement to universal health care? It is also important to ask what is the problem you are trying to solve and also what problems that this might create.

HB 2010-1 now proposes the study of a public health insurance option that would compete with private insurance plans in a statewide marketplace. Additional details in the measure are sorely lacking. On the face of it, the examining the entrance of the State of Oregon into the insurance market might seem like a step towards universal health care, however this approach will build on an already flawed and failed business model by continuing to treat access to healthcare as a market commodity instead of a right.

The Rand Study which the state commissioned already showed that a single payer system is the only one that can cover everyone with what is already being spent without even considering the additional savings of administrative costs at provider offices and in hospitals.

There is nothing new in the recently referenced Manatt Report to show cost saving in a public option or that a public option will have any impact on the health of Oregonians. Do we need another costly and time delaying study to show that the savings will not be manifested. The attempt at doing this in Washington State is already revealing that.

Pursuing a public option as a step on the way to universal healthcare presents several potential risks and may be detrimental to ultimate objective of universal health care access:

- The mere fact that this is a proposal to examine offering two plans shows that inequity will persist and not be addressed. This includes continued means testing with consumer burden and administrative waste.
- The study may be just a wasteful expenditure of dollars. The state has already set a pathway for addressing the primary issues with the creation of the Task Force on Universal Health Care.
- There will be costs related to launching any program proposed by the study as well as considerable administrative costs of such a program including the potential of going back to a complex state-based exchange that already failed once.
- This will detract resources from getting to universal healthcare.
- May ultimately cause to once again erode the public's confidence in the state and in particular OHA.

A public option's likely impact as written in 2010 and to be studied for feasibility in 2010-1 follows each item in red. Language from ORS Chapter 629 or 2019 appears in black. The red text represents an assessment of how HB 2010-1 to look at establishment of a public option would or would not contribute to each objective.

Purpose . The Task Force on Universal Health Care shall produce findings and recommendations for a well-functioning single payer health care financing system that is responsive to the needs and expectations of the residents of this state by:	Expected Effect
(1) Improving the health status of individuals, families, and communities;	No impact
(2) Defending against threats to the health of the residents of this state	No impact
(3) Protecting individuals from the financial consequences of ill health;	No impact
(4) Providing equitable access to person-centered care;	Inhibit/derail
(5) Removing cost as a barrier to accessing health care;	No impact
(6) Removing any financial incentive for a health care practitioner to provide care to one patient rather than another;	Inhibit/derail
(7) Making it possible for individuals to participate in decisions affecting their health and the health system;	No impact
(8) Establishing measurable health care goals and guidelines that align with other state and federal health standards; and	No impact
(9) Promoting continuous quality improvement and fostering inter-organizational collaboration.	No impact
SECTION 4. Values. The Task Force on Universal Health Care, in developing its recommendations to the Legislative Assembly for the Health Care for All Oregon Plan, shall consider, at a minimum, the following values:	Expected Effect
(1) Health care, as a fundamental element of a just society, is to be secured for all individuals on an equitable basis by public means, similar to public education, public safety and other public infrastructure;	Inhibit/derail
(2) Access to a distribution of health care resources and services according to each individual's needs and location within the state should be available. Race, color, national origin, age, disability, wealth, income, citizenship status, primary language use, genetic conditions, previous or existing medical conditions, religion or sex, including sex stereotyping, gender identity, sexual orientation and pregnancy and related medical conditions, including termination of pregnancy, may not create any barriers to health care nor disparities in health outcomes due to access to care;	Inhibit/derail
(3) The components of the system must be accountable and fully transparent to the public with regard to information, decision-making and management through meaningful public participation in decisions affecting people's health care; and	Inhibit/derail
(4) Funding for the Health Care for All Oregon Plan is a public trust and any savings or excess revenue are to be returned to that public trust.	Inhibit/derail
SECTION 5. Principles. The Task Force on Universal Health Care, in developing its recommendations for the Health Care for All Oregon Plan, shall consider at a minimum the following principles:	Expected Effect
(1) A participant in the plan may choose any individual provider who is licensed, certified or registered in this state or any group practice.	Inhibit/derail
(2) The 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.	Inhibit/derail
(3) 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 participant.	No impact
(4) The plan will cover services from birth to death, based on evidence-informed decisions as determined by the Health Care for All Oregon Board.	Inhibit/derail

Purpose. The Task Force on Universal Health Care shall produce findings and recommendations for a well-functioning single payer health care financing system that is responsive to the needs and expectations of the residents of this state by:
Public Option: Not at all responsive to the needs of residents for equity and the savings and redistribution of dollars that a single payer plan offers are not realized. The status quo of a poorly functioning system costly administratively complex system that burdens individuals and communities will remain. It could distract significant resources from the effort. COULD DERAIL

(1) Improving the health status of individuals, families, and communities;
Public Option: There is no evidence as the only measure is one of cost. Without administrative savings and focus on public health there will be no dollars for the social determinants of health mentioned in the bill and there will be no overall improvement in health. There is likely to be loss of providers seeing patients with certain coverage. So called "health navigators" will continue to be insurance navigators helping through the stressful complex system.

(2) Defending against threats to the health of the residents of this state
Public Option: Does not require cooperation with public health. This builds on the flawed business model that focuses on a disjointed system of clinical care. This does not steer any savings to coordinated public health programs necessary to defend against threats to public health. This includes people delaying seeking treatment for or prevention of communicable diseases as they wonder how much it will cost. Even during this pandemic people are asking if they will have to pay for testing and the vaccine and wondering where they should seek care.

(3) Protecting individuals from the financial consequences of ill health;
Public Option: This will apply to a very small segment of the population who chose to pay premiums they cannot afford as they continue shop for one plan versus another. There is no evidence that these plans will be affordable for individuals or small businesses. Future savings unlikely as health care costs will continue to rise anyway.

(4) Providing equitable access to person-centered care;
Public Option: There is nothing about the provision of equitable access to person centered care or even moving in that direction. Rural could be adversely impacted as they lose equitable access. Systemic inequities will still exist in clinical care as lack of choice of a culturally sensitive provider will remain. Does not deal with systemic injustice and racism in the system. Also set up a structural barrier to the undocumented who will remain fearful of signing up. Exacerbates the public charge.

(5) Removing cost as a barrier to accessing health care;
Public Option: As long as people and businesses have to shop for coverage cost will remain a barrier. As wages change and employment changes people will worry about losing coverage. Churn will continue. There will be many who year after year will have to buy a plan many which will have costs at point of service including deductibles and copays. Of course, costs will continue to rise as cost drivers remain.

(6) Removing any financial incentive for a health care practitioner to provide care to one patient rather than another;

Public Option: With varied reimbursement rates this may actually have the opposite impact as providers may stop taking certain types of insurance or close to new patients.

(7) Making it possible for individuals to participate in decisions affecting their health and the health system;

Public Option: This is a top down approach with no patient engagement in this. Current law calls for extensive public engagement in designing the system. First thing is to start with a real choice of providers that meets their culturally specific needs as called for in the ORS Chapter 629 of 2019.

(8) Establishing measurable health care goals and guidelines that align with other state and federal health standards; and

Public Option: This is no evidence that this is being looked at all.

(9) Promoting continuous quality improvement and fostering inter-organizational collaboration.

Public Option: There is no evidence that this will create any kind of collaboration that leads to continuous quality improvement.

SECTION 4. Values. The Task Force on Universal Health Care, in developing its recommendations to the Legislative Assembly for the Health Care for All Oregon Plan, shall consider, at a minimum, the following values:

Public Option: There is no adherence to these minimum values and these are the minimum values.

(1) Health care, as a fundamental element of a just society, is to be secured for all individuals on an equitable basis by public means, similar to public education, public safety and other public infrastructure;

Public Option: This proposal does not secure health care as a right or by public means but continues to treat healthcare as a commodity to be shopped for.

(2) Access to a distribution of health care resources and services according to each individual's needs and location within the state should be available. Race, color, national origin, age, disability, wealth, income, citizenship status, primary language use, genetic conditions, previous or existing medical conditions, religion or sex, including sex stereotyping, gender identity, sexual orientation and pregnancy and related medical conditions, including termination of pregnancy, may not create any barriers to health care nor disparities in health outcomes due to access to care;

Public Option: This proposal does not do this as the various plans are not equal and not according to need. It maintains a system that is still based on economic and geographic status i.e. how much can you afford, who is your employer and where you live and other situations of status.

(3) The components of the system must be accountable and fully transparent to the public with regard to information, decision-making and management through meaningful public participation in decisions affecting people's health care; and
Public Option: This proposal is not seeking meaningful public participation that ORS 629 of 2019 calls for in establishing a universal healthcare system. In fact, it seems like the planning for this has largely been behind closed doors so no evidence of transparency at all.

(4) Funding for the Health Care for All Oregon Plan is a public trust and any savings or excess revenue are to be returned to that public trust.
Public Option: This proposal does not create a system of a public trust.

SECTION 5. Principles. The Task Force on Universal Health Care, in developing its recommendations for the Health Care for All Oregon Plan, shall consider at a minimum the following principles:
Public Option: There is no adherence to these minimum principles and these are the minimum principles.

(1) A participant in the plan may choose any individual provider who is licensed, certified or registered in this state or any group practice.
Public Option: This has the opposite impact as there will still be paneling, limited networks, zero portability, silent on out of state or network limits, etc. It will exclude choosing a provider who does not go along taking lower payments. It will continue to restrict provider types that a patient may prefer. Although it calls for access to community health workers. There must be the savings in the system to support this.

(2) The 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.
Public Option: The opposite may occur if plans pick and choose who you can see especially in area of mental health, chiropractic, naturopathic, midwifery and dental care as examples.

(3) 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 participant.
Public Option: This proposal does not relieve the burden of prior authorizations as plans will continue to be different and the insurers be able to deny treatment and payment.

(4) The plan will cover services from birth to death, based on evidence-informed decisions as determined by the Health Care for All Oregon Board.
Public Option: This proposal does not help and may inhibit.

Summary: The study of a public option proposal keeps Oregon in a system based on a flawed and failed business model and continues to treat access to healthcare as a market commodity instead of a right. This study proposal includes no true community input required for any successful health policy changes.

The disparities, complexities and costs will continue to impact the most vulnerable. Any extended timetable will push back instituting a single payer universal healthcare system needed for true healthcare transformation. Oregon will continue to struggle to fund the public health programs necessary for "improving the health status of individuals, families, and communities" and "defending against threats to the health of the residents of this state" through addressing health inequities and the social determinants of health.

Again, we must ask: What is the problem that is trying to be solved in a time of health and economic crisis? There is a myriad of other bills that this legislature could address that actually decrease barriers and/or may decrease cost. I repeat the bills that have promise of transformation: telehealth, bills related to dental and mental health access which need to be at the forefront, Cover All People, racism as public health crisis, the bills that keep those with disabilities from losing coverage and access to care, and those dealing with controlling the cost prescriptions,

It is already well known that coverage does not mean actual access to care. The goal is equitable access not coverage that does not significantly reduce barriers.

The time frame given in HB 2010-1 of 2022 and then 2024 is just not any better than that needed by the Task Force on Universal Health Care which is set to deliver the design of a plan for an equitable universal healthcare plan based on equity to the legislature in 2022. The Task Force is already considering interim steps and is ready to engage the business community as required in the already passed legislation as part of the essential public engagement process. Health Care for All Oregon is already pursuing a path to getting needed waivers. A plan that will set the stage for necessary systemic transformation to really having an impact on the health of individuals, families and communities. OHA and DCBS already participate in the Task Force. (It is problematic that neither version considers this work.) Would it not be better if any funding for OHA and DCBS be directed to the work that these agencies are already engaged in and not to another wasteful study?