August 15th Meeting of the Universal Health Plan Governance Board

Universal Health Plan
Governance Board

Welcome Remarks – Chair Bellanca

- Tech Check
- Roll Call and Introductions
- Written Public Comment
- Agenda Review

Approve July 18, Meeting Minutes

- Chair Bellanca

Executive Director’s Report

- Director Cowling

Universal Health Care Financing Models

Jennifer Donovan, Senior Policy Analyst
August 15, 2024

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Governance Board

Agenda

- Four Health Care & Financing Models
- Defining Single-Payer
- SB 1089
- Single-Payer Models
- Multi-Payer Models
- Unified Financing
- Resources
- Questions
- Motion

Four Health Care & Financing Models

The Beveridge Model (National Health Service)

- Universal coverage with government as single-payer.
- Taxes are collected by the government to support the system.
- Most providers work for the government.
- UK, Spain, New Zealand, Cuba

The National Health Insurance Model

- Universal coverage with government as single-payer
- Funded through government taxation or mandatory contribution.
- Government regulates costs and services
- Providers are private.
- Canada, South Korea, Taiwan

Four Health Care and Financing Models

The Bismarck Model (Social Insurance)

- Universal coverage, multi-payer system
- Funds paid into by employer and employee contributions based on ability to pay. Specific to occupational or social groups.
- Funds “sickness funds”) are administered by non-profits or private groups not permitted to collect a profit.
- Funds and fees schedules are regulated by the government.
- Providers are private.
- Germany, France, Japan

The Fee-for-Service Model

- No universal care system
- Funds are not collected and pooled
- Providers are private

Defining Single-Payer

Origination

- Coined in the 1990's to describe Canada's system of health care
- Used to avoid the term "socialized medicine"

Current Use is Broad

- Does not implicitly mean government as the payer
- Does not denote universal care
- Does not mandate a specific delivery system

Single-Payer defined by SB 1089

SECTION 2. (1) As used in this section, “single payer health care financing system” means a universal system used by the state to pay the cost of health care services and goods in which:

(a) Institutional providers are paid directly for health care services or goods by the state or paid by an administrator that does not bear risk in contracting with the state;

(b) Institutional providers are paid with global budgets that separate capital budgets, established through regional planning, and operational budgets;

(c) Group practices are paid directly for health care services or goods by the state, by an administrator that does not bear risk in contracting with the state, by the employer of the group practice or by an institutional provider; and

(d) Individual health care providers are paid directly for health care services or goods by the state, by their employers, by an administrator that does not bear risk in contracting with the state, by an institutional provider or by a group practice.

Single-Payer Models

Canada

- National Health Insurance Model
- Funded by general tax revenue
- Administered by Canadian provinces and territories
- Private providers

UK

- National Health Service (Beveridge Model)
- Funded by general tax revenue
- Administered by the government
- Providers employed by the government

Taiwan

- National Health Insurance Model
- Funded by payroll-based premiums with government subsidies
- Administered by the government
- Private providers with some public hospitals

Multi-Payer Models

Germany

- Bismarck Model
- Funded primarily by employer and employee contributions
- Mandatory enrollment in statutory health insurance (SHI) or a private plan
- Federal government has regulatory power but is not directly involved in delivery.
- The Federal Association of Sickness Funds, the Federal Association of SHI Physicians and the German Hospital Federation develops fee schedules for sickness funds and the diagnosis-related group (DRG) catalog, which are then adopted by bilateral joint committees.

Japan

- Bismarck Model
- Funded by employer and employee taxes and individual contributions
- Mandatory enrollment in an employer-based or residence-based insurance plan with coinsurance and some co-pays
- National government sets fee schedules. Regionally developed delivery systems.
- Providers are mostly private.

Unified Financing

California and Washington legislation require a universal health care system with Unified Financing.

- Unified financing is not clearly defined
- Anticipates a system with Medicaid waiver; possibly Medicare waiver
- Taxes – general and payroll considered
- Could be single-payer or multi-payer

Resources

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6775897/pdf/AJPH.2019.305295.pdf
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6775939/pdf/AJPH.2019.305312.pdf
- Reducing administrative costs in US health care: Assessing single payer and its alternatives (nih.gov)
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5481251/
- https://www.weforum.org/agenda/2020/10/covid-19-healthcare-health-service-vaccine-health-insurance-pandemic/
- https://www.mdclarity.com/glossary/social-insurance-bismarck-model#:~:text=In%20the%20Bismarck%20model%2C%20healthcare,contributions%20from%20employers%20and%20employees
- https://www.commonwealthfund.org/international-health-policy-center/countries/japan

Resources Continued

- https://www.commonwealthfund.org/international-health-policy-center/countries/germany
- https://www.sciencedirect.com/science/article/pii/S0014292124000849
- https://www.canada.ca/en/health-canada/services/canada-health-care-system.html#a2
- https://www.commonwealthfund.org/international-health-policy-center/countries/taiwan
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3596027/
- https://www.hca.wa.gov/about-hca/who-we-are/universal-health-care/universal-health-care-commission#reports
- https://www.chhs.ca.gov/wp-content/uploads/2022/04/Key-Design-Considerations_April-2022_Final-Report-for-Distribution.pdf
- https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5399-S2.SL.pdf?q=20210610134716

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QUESTIONS?

PROPOSED MOTION

Appoint the following [members] to a Financial Models Workgroup to make recommendations to the board on the type of financing structure to adopt, and how to invest savings created by the Universal Health Plan.

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Questions?

Values and Principles Workgroup Recommendations

Michelle Glass
August 15, 2024

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Work Group

The Values & Principles Workgroup was created to allow the members of the board to work together to create recommendation on values & principles, in addition to those in SB 1089, to the guide the board's work. The group met five times. Three times prior to the June Board meeting, once between the June and July meetings and one additional time in August.

Members:
Warren George, Facilitator
Michelle Glass
Amy Fellows
Debra Diaz
Dr. Chunhuei Chi

May 29, 2024, meeting minutes
June 5, 2024, meeting minutes
June 12, 2024, meeting minutes
June 27, 2024, meeting minutes
August 5, 2024 meeting minutes

Review of Public Comment

- The board received as public comment a document incorporating the principles and values from SB 1089 under the overarching principles recommended by the Workgroup

- The Workroup reviewed the document and incorporated the values and principles from SB 1089 and the supporting language crafted by the Workgroup into a recommendation for board consideration.

Workgroup Recommendations

Recommended Five Overarching Principles

1. Health Equity
2. Maximize Health
3. Fair Distribution of Medical Resources
4. Minimize Financial Hardship for Individuals and Families from Medical Costs
5. Community Sense of Ownership and Governance

Overarching Principles Supporting Statements

1. Health Equity
2. Maximize Health
    a) Individual Fulfillment
    b) Population Measures
3. Fair Distribution of Medical Resources
4. Minimize the financial hardship from medical bills on individuals and families.
5. Community Sense of Ownership and Governance
    a) Community Sense of Ownership
    b) Community Economic Stewardship
    c) Principles of Good Governance

Workgroup Considerations

Meaningful public participation: Community engagement should always seek to:

a. Be inclusive of all people
b. Provide the community details on the background and current thinking relating to a particular issue or project.
c. Present community members with and asks them to consider alternatives and make a judgment as to the most attractive alternative for the community
d. Consider community feedback as the guiding perspective in defining terms and decision making

Targeted Universalism: Within a targeted universalism framework, universal goals are established for all groups concerned. The strategies developed to achieve those goals are targeted, based upon how different groups are situated within structures, culture, and across geographies to obtain the universal goal.

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Questions?

Proposed Motion

Adoption of the Five Overarching Principles and Supporting Statements as outlined in the Values and Principles Workgroup Recommendations dated August 15, 2024.

Break

We will reconvene at 10:30 am

There is a “grab ‘n go” café located on the basement level

Preliminary Structure of the Universal Health Plan

- Chair Bellanca

Preliminary Structure of the Plan

Goal:

1. Review and approve a preliminary structure* of the plan that the committees and staff/ contractors can work from
2. Meet SB 1089 recommendations to “consider the Join Task Force recommendations”

* The Governance Board may make changes in the future; this is the starting place for this work.

Board Member Feedback:

- Add to next steps a point that says, “Clarify the role of TPAs and regional payment authorities”
- Looks good. No further edits.
- I agree with the additions and the structure as written. No additional suggested changes.

- More time needed to discuss problem statement.
  - Are there problems identified in the statement of the problem which shouldn’t be there?
  - Are there problems which the Task Force didn’t address, or which are new?
  - Problem statement suggestion: “Costs continue to rise (labor and other components). Providers going bankrupt and/or closing. Consolidation and corporatization leaves people with less sense of control. Acute shortage of providers in specific areas such as primary care, regional care, and behavioral health.”
- The purpose of the Task Force Recommendations discussion is less clear to me.
- The action item of “Next Steps” seems at odds with the workplan.

Statement of the problem

Oregon's current health care is inefficient, expensive, and complex.
It relies on multiple private, public, and taxpayer-subsidized insurance plans.
It relies primarily on employment for health care insurance and access. It uses different benefits, different provider networks, and different insurance plans. Each year thousands of Oregonians are without insurance when their employment or family status changes.

Health care in Oregon is inequitably delivered. Too many Oregonians endure unequal access, varied care quality, and wide-ranging outcomes because of race, age, income, geography, or insurance. High health care costs generate debt and bankruptcy for many Oregonians.

Recent consolidation and corporatization leaves people with less sense of control. Acute shortage of providers in specific areas such as primary care, regional care, and behavioral health.

Citation: Joint Task Force on Universal Health Care Final Report and Recommendations September 2022

Discussion Question

Does this problem statement adequately capture the challenges we are trying to address in building a Universal Health Plan?

Preliminary Structure Recommendations:

1. All people who live in Oregon qualify for the Universal Health Plan. The plan will clarify eligibility requirements, including for people who live out of state but work in Oregon.
2. The plan will be based on current PEBB benefits and will expand behavioral health benefits.
3. People who qualify for long-term supports and services will continue to receive benefits and services through Medicaid and the Oregon Department of Human Services (DHS). The plan will explore coverage of some skilled nursing and home health care.
4. The plan will not require patients to pay when receiving care. There shall be no co-pays, deductibles, or co-insurance. Instead, there will be new revenue sources that will fund the services while protecting families and businesses from financial hardship.
5. People who qualify for Medicare will be covered by the Universal Health Plan to the extent allowed by federal law.

Preliminary Structure Recommendations cont.:

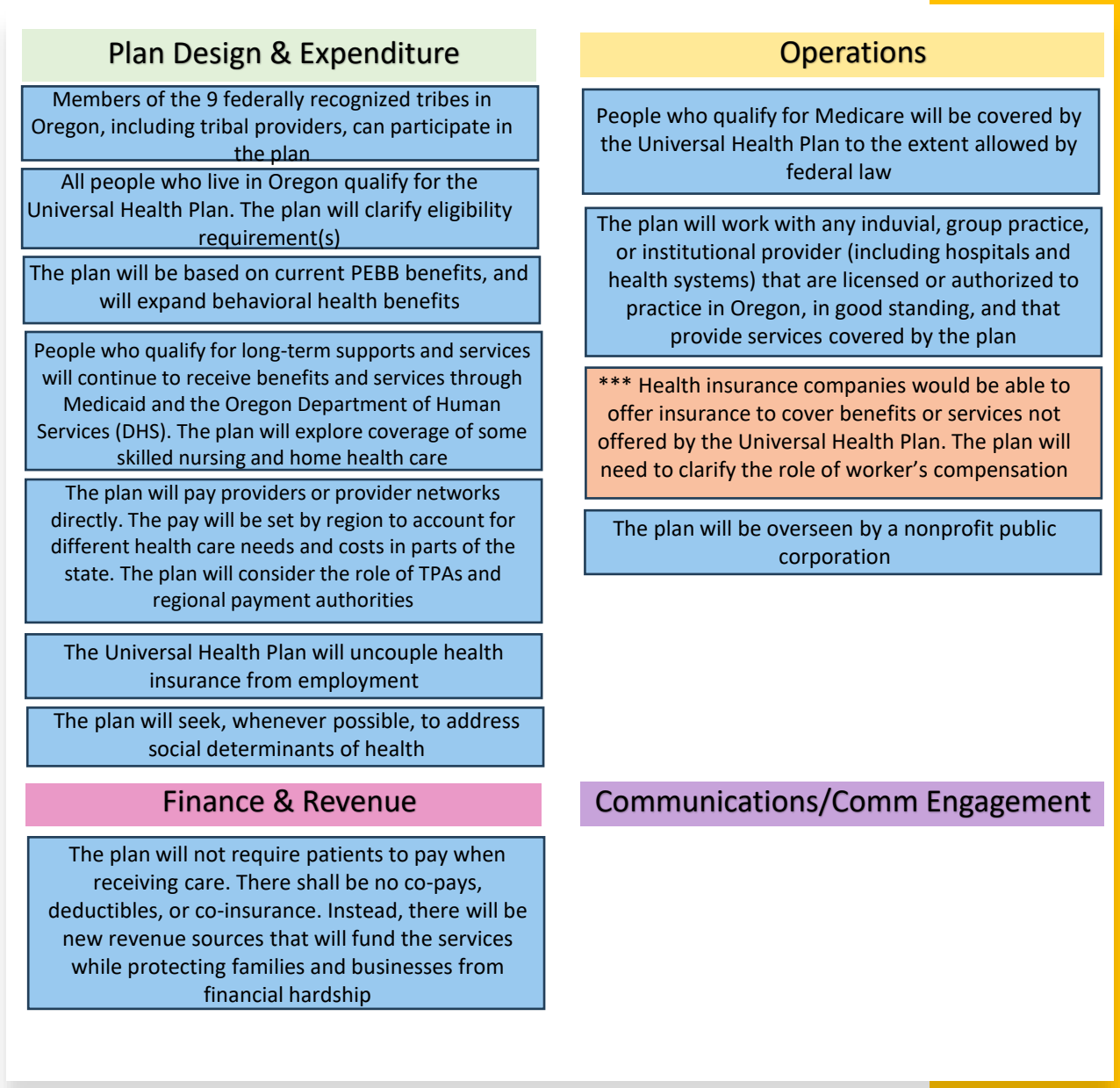
6. The plan will work with any individual, group practice, or institutional provider (including hospitals and health systems) that are licensed or authorized to practice in Oregon, in good standing, and that provide services covered by the plan.
7. The plan will pay providers, or provider networks, directly. The rates of pay will be set up by region to account for different health care needs and costs in parts of the state. The plan will consider the role of TPAs and regional payment authorities.
8. Health insurance companies would only be able to offer insurance to cover benefits or services not offered by the Universal Health Plan. The plan will need to clarify the role of workers compensation insurance.
9. The Universal Health Plan will uncouple health insurance from employment.
10. The plan will seek, whenever possible, to address social determinants of health.
11. Members of the 9 federally recognized tribes, including tribal providers, in Oregon have the option to participate in the plan.
12. The plan will be overseen by a nonprofit corporation.

Proposed Motion

The Governance Board adopts the 12 recommendations as a preliminary structure for the Universal Health Plan.

Assigning Recommendations to Committees:

- Preliminary Structure by workstream shows there is a lot of work to be done in Finance and Revenue, Operations and Community Engagement to catch up to Plan Design and Expenditure.
- Senate Bill 1089 deliverables are focused on Finance, Operations and Community Engagement workstreams.
- Are these the best committees to take-up these recommendations?



Discussion

Are these the best starting committees for these recommendations?

Is the recommendation in orange assigned to the best committee?

Considerations ahead:

There are big challenges ahead that need to be solved:

- Create a unified financing plan that incorporates all federal and state health care dollars, as well as other revenue sources as permitted by law
- Clearly spell out covered benefits, particularly in Behavioral Health services and long-term support services, or identify options for each
- Clarify options related to Medicare and Medicaid waivers that may be needed
- Create several financial models for revenue streams that will not cause financial hardship for families or small businesses
- Explore options for employers that do not violate ERISA
- Work with hospitals and clinicians on a plan for a simplified payment strategy for services that accounts for regional differences and saves money
- Engage health care entities, businesses, tribes and communities in the development of the plan
- Build a clear transition plan that moves the current system to the one in the plan

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Committee Recruitment Update

- Director Cowling

Status Report Due to Legislature

- Director Cowling

Board Outreach

- Chair Bellanca

Public Comment

Adjourn

“Since the world is round, there is no way to talk away from each other, for even then we are coming back together. Some distances, if allowed to grow, are merely the greatest proximities.”

- Amanda Gorman, *Call Us What We Carry*