Date Submitted: July 18, 2024

Public Comment Submission from:
Charlie Swanson

Organization: Health Care for All Oregon-Action

Topic:
Task Force Recommendations

Will oral comments be provided as well:
Yes

Comments regarding UHPGB July 18 meeting

From Charlie Swanson

The comments below relate to the Task Force Recommendations, which supply a starting point for consideration by the UHPGB. I will make comments in the order they appear in the slide deck for the meeting. The notion of changing the word from "recommendations" is appropriate. The yellow highlighted words below are the most important to change to create an equitable and cost-effective goal.

Slide 43

The Plan will be based on current PEBB benefits, and will include all services currently covered by Medicaid, Medicare and ACA plans –

> These words were chosen because PEBB benefits are among the most comprehensive. The added words are there because it is possible that something covered by Medicaid, Medicare, or ACA plans is not covered by PEBB. The Task Force did not compare benefits carefully enough to make sure. The intent was to have benefits that are as generous as PEBB while making sure that everything that is covered by Medicaid and Medicare is covered, even if PEBB does not cover it. In order to roll in Medicaid and Medicare, covering what they cover is required for current federal waivers or any equitable waivers that might be available in the future. The exception is long term services and supports, which are covered by Medicaid but were not recommended to be part of the plan.

People who qualify for long-term care will continue to receive benefits and services through Medicaid and the Oregon Department of Human Services (DHS). The Plan will cover some skilled nursing and home health care.

> While it made sense because of time and resources for the Task Force to make this recommendation, it is not appropriate for the Governance Board to do so at this time. SB 770 directed the Task Force to set up an advisory committee to carefully consider long-term care – see section 6(4)(p) and section 6(5) beginning on p. 7 of SB 770. Section 6(5) outlines the sort of people who should be on the advisory committee. Because of time and resource constraints, the Task Force did not set up this committee. It would be a travesty if the Governance Board chose to do the same. If resources are a problem, this is something to ask Sen. Manning to help with. This is a very important issue for equity, especially for disability justice. While the Governance Board may eventually make the same decision regarding long-term care that the Task Force did, it should only be through careful consideration along the lines outlined in SB 770.

People who qualify for Medicare will be covered by the Universal Health Plan to the extent allowed by federal law.

This is perhaps the most controversial recommendation made by the Task Force. Three members voted against these words. If federal law does not allow those who qualify for Medicare to be equitably included in the plan, perhaps the best choice is to propose a decent plan anyway and use the public pressure to get appropriate changes to federal law. Note that the Governance Board will be making legislative recommendations likely at least two years before Oregon will be applying for federal waivers for the plan,[1] so creating a weak plan because the correct waiver authority does not yet exist is probably not the best option.

Appropriately including Medicare is critically important for both affordability and equitability. Among the most basic equity principles is section 2(2)(f) on p. 2 of SB 1089:

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

Medicare generally reimburses providers at a much lower rate than private insurance or than what would be expected by a reasonable Oregon state plan. From an equity standpoint, this would be unacceptable to continue. The Board needs to propose a plan that allows appropriate reimbursement even when treating a patient who is eligible for Medicare.

This is not just an equity issue. About 34% of hospital patients are covered by Medicare. It will be most cost-effective to pay hospitals with a global budget rather than fee-for-service – likely saving up to 12% of total costs.[2] If a third of their patients are not part of the system paying the global budget, such a payment system is unlikely to work, and the savings will not be realized.

Better wording for a goal –

> **People who qualify for Medicare will be equitably included in the proposed state system.**

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

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[1] The Governance Board will submit recommendations in September 2026, likely to be considered by the 2027 legislature. The plan will require tax increases, so almost surely will go to the voters – probably in the 2028 general election. If passed, Oregon can then apply for waivers, likely early 2029. The Board should not put forth an inequitable and more expensive plan because federal law does not allow appropriate waivers by 2026.

[2] https://pubmed.ncbi.nlm.nih.gov/25201663/

From what Cherryl Ramirez presented, many behavioral and mental health providers are not licensed. Are they otherwise authorized? Does the wording of this need to change?

Slide 46

Determine how the Plan will define and verify residency in a way that does not undermine its intention to increase access for all Oregonians. With regard to residency, any implications for those who may telework (e.g. employed in Oregon but living elsewhere)

Perhaps the most important residency issue is devising a way to not pay for those seeking care in Oregon through health care tourism (coming to Oregon just to get care) while not undermining its intention to increase access for all Oregonians. A fair way to do this is not obvious.

It does not seem important to think about covering those who may telework. It does seem appropriate to consider optional coverage for non-residents who spend much of their life in Oregon because they work full-time (or nearly full-time?) here. If they are physically in Oregon much of the time, it may be much more convenient to get care here than at their residence. Current Oregon tax law would already have that person paying other Oregon income taxes. Including such people would couple insurance with employment for some people, something the Board probably wants to avoid – so an appropriate decision is not obvious. But it should not be decided without deliberation and discussion.

If a non-resident working full-time in Oregon is not covered by the Oregon plan, fairness would dictate that neither they nor their employer should pay new health care taxes on their wages. I would expect that the taxes raised from an employed person would usually be substantially more than the health care costs for that person. If that is not generally true, then the plan will be unaffordable. Including these people will likely make financing easier and decrease the burden on residents.

Date Submitted: July 23, 2024

Public Comment Submission from:
Samuel Metz

Organization: Oregon Physicians for a National Health Program

Topic:
Single Payer Healthcare: Oregon PNHP submitted the attached letter to Gov. Kotek. Please consider this letter when you discuss the format of universal healthcare in Oregon.

Will oral comments be provided as well:
No

August 28th, 2023

The Honorable Tina Kotek
Governor of Oregon
Suite 254, State Capitol
Salem OR 97301

The Honorable Rob Wagner
President of the Senate
S-201 State Capitol
Salem OR 97301

The Honorable Dan Rayfield
Speaker of the House
H-269 State Capitol
Salem OR 97301

Re: SB 1089 governance board, its goals and membership

Dear Governor Kotek, President Wagner, and Speaker Rayfield,

Oregon Physicians for a National Health Program (PNHP) strongly advocates that Gov. Kotek charge the SB 1089 governance board with design of a state-based single payer plan.

The single payer plan should contain three elements:

- A benefit package stating services and drugs that patients will receive.
- A payment plan accommodating revenue needs of individual practitioners, clinics, and hospitals.
- An administrative structure including electronic medical records, quality metrics, fraud detection, pharmacy purchase, trust fund, and other essential administrative needs.

The plan should state these conditions required to permit implementation:

- The amount of new taxes needed to replace lost revenue when premiums and other out-of-pocket payments are eliminated by the single payer plan.
- Necessary waivers from federal programs overseeing healthcare spending in Oregon. A single payer plan may require new federal legislation.

Recruited board members should demonstrate:

- Competency in benefit plans, healthcare delivery, and healthcare administration.
- Credibility to Oregon's business community, healthcare providers, legislature, and voters.
- Commitment to a single payer plan.

Oregon PNHP believes a state-based single payer plan is consistent with the language and spirit of SB 1089. We urge the legislature to provide full funding for completion of this task.

Respectfully,

Samuel Metz

Samuel Metz, MD, Vice President, Oregon Physicians for a National Health Program

Cc: Representative Rob Nosse, Senators James Manning Jr., Deb Patterson, Elizabeth Steiner

Date Submitted: July 29, 2024

Public Comment Submission from:Tom Sincic

Topic: UHP Governance Board Budget

Will oral comments be provided as well: Yes

To: Members of the Universal Health Plan Governance Board and Executive Director Morgan Cowling
From: Tom Sincic, MSN, FNP-Retired
Date: 7/29/2024

I mentioned the following during the 7/18 UHPGB meeting and sent a similar email before the meeting that was not part of my previous written public testimony.

There was and remains concern that the UHPGB does not have the current funding needed to **advance the work in the statute timeline**. As background, see the information below which outlined that the needed funding was not provided when the bill was passed.

There is now understanding that because of the late start in hires and board creation some money may have been saved. However, **is there enough money now to hire needed additional staff and contractors with expertise now to move the work forward in a timely way?** The expertise is needed now to be able to bring information to and work with the board and various public committees. Because of the late start, getting the people on board ASAP is even more important.

It was also stated that months will pass before the consultants can be hired. If the timeline is to be met, this is unacceptable. **If the money is there, it is time to spend it. A path must be found for hiring sooner rather than later.** Relying on OHA is not the solution. OHA has a different role in this work but not the deep extended investigated research needed. There was a reason that the work was put inside DCBS.

This was discussed with Sen. Manning and others in Dec. but the delay basically put the answer into a budget analysis after the appointments and ED hire. If more money is needed now in order to meet the statutory requirement, this should be stated and a path created to find that money.

Both for now and the future, a budget must be created and the ask made to be able to achieve the goals outlined in SB 1089.

Here was the information discussed at the Dec. meeting.

"SB1089 as adopted did not contain the necessary funding to fully achieve its goals. Here is a proposal for 2024.

Background: The approved budget for SB1089 creates the Board and sustains it through the 2023-2025 biennium may only enable some very general delivery system work to be done and begin very basic discussions with public employers and potentially further describe some Medicare strategies. An actuary can be chosen and begin to build a model in anticipation of further work. Governor Kotek has acknowledged that more funding is needed. An additional $500,000 in this biennium would enable the following necessary work:

a. **Provide an additional $175,000 for this biennium** and double that in a full biennium to create a full time financial position with experience in delivery system finance and administrative issues to assist in the negotiation with delivery system. This position will also support and inform the necessary in-depth discussions with public employers and self insured private employers. *(It will be crucial that the delivery system acknowledges the significant funds going to administrative services that will disappear with a single*

payer---no revenue to collect because no cost sharing, one benefit design, and minimal pre-authorization mostly for drugs at this time.)

b. **Provide an additional $175,000 for this biennium** and double that in full biennium to create a full time delivery system engagement position that will take the lead on organizing a series of discussions with delivery system elements to develop a more detailed plan for funding the delivery system, reducing admin costs, and improving equity and quality. *(This individual should have significant experience with delivery systems and be very credible. The Executive Director can lead this effort with support from the financial position and the already funded policy analyst. The goal will be to develop a convincing delivery system plan that significant portions of the Oregon health delivery system supports by the due date of report to the 2025 legislature.)*
c. **Provide additional $150,000 in consulting funding to engage a revenue consulting firm.** This firm would provide a revenue orientation to the Board and then work with the Board to identify innovative revenue approaches depending on the outcome of the delivery system discussions and the employer discussions.
d. **Overall $500,000 additional this biennium** and double that next biennium.

Work already with current funds provided the above is funded.

a. Begin discussion with large self-insured employers around ERISA. Executive Director takes lead with support from financial and policy staff. Some revenue analysis needed. Likely no commitment but agreement that single payer is potentially possible for self-insured employers. **No additional funds**.
b. Engage public employers like PEBB, OEBB, Cities/counties and the unions associated with them and identify the design features they like and dislike when it comes to single payer. Work with them to determine the cost savings they will experience with a single payer versus the possible employer payroll taxes they will pay. Likely the Executive Director takes the lead with support from the finance person and policy analyst. The actuary and the revenue consultant will be key. **No additional funds.**

One goal is for the Universal Health Plan Governance Board to show the 2025 legislature significant progress made with delivery system and administrative costs that will reduce total cost to taxpayers, progress on a plan with public employers that would be workable and start of discussion with self - insured employers."

In closing, I strongly recommend that the UHPGB determine and advocate for the resources needed to complete their work.

With Gratitude,

Tom Sincic, MSN, Family Nurse Practitioner-Retired
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