Joint Task Force on Universal Health Care Study | Phase Two

Community Listening Session Research Synopsis

Lara Media Services
August 2022

Table of Contents

Introduction

“Universal Health Coverage means healthier societies and communities, essential for sustainable growth and development” - Dr. Carissa F. Etienne, Director, Pan American Health Organization.

In 2019, Oregon’s Legislative Assembly passed Senate Bill 770, establishing the Task Force on Universal Health Care (Task Force) to provide recommendations for a publicly funded, equitable, affordable, comprehensive and high-quality health care plan to all residents of Oregon. The Task Force embarked on developing a plan that reached these criteria and sought feedback from Oregonians with diverse backgrounds and circumstances from all regions of the state. The Task Force committed to developing a system that could sufficiently meet the needs of Oregon’s increasingly diverse populations.

The Task Force hired Lara Media Services (LMS) to support the learning phase of this process. LMS is known for its ability to reach specified communities, deeply listen, authentically engage, and amplify the voices, desires, and stories needed to create more equitable outcomes and futures. Together, the Task Force and LMS have a shared commitment and passion for amplifying and understanding the voices of the communities that are most often neglected.

LMS is a certified MBE, WBE, DBE, ESB firm (Certification #7923), and B-Corp. LMS is Latina-owned, and 100% of the team is multicultural and multilingual.

Methodology

LMS coordinated, conducted and facilitated community listening sessions that encouraged participants to be fully engaged and let their voices be heard. Community listening sessions are informative community engagement methods that allow facilitators to build trust with the communities they intend to engage. This method is used to present in-depth information to target audiences and better understand their thoughts, feelings, challenges, and aspirations. LMS uses this approach to provide an accessible opportunity for the Oregon public to engage effectively with the Task Force.

Planning for these community listening sessions led to meetings for each region of the state and a session where the Task Force members presented and engaged with predominantly Spanish speakers of Oregon. These were the methods used by LMS for the community listening sessions:

1. LMS and the Task Force identified priority audiences and essential considerations to develop the discussion guide.
    a. Geographic Regions included:
        i. Coastal Region

ii. Central OR

iii. Eastern OR

iv. Southern OR

v. Portland Metro Area

vi. Willamette Valley

vii. Statewide (Spanish)

2. The Task Force developed the presentation and accompanying documents and identified 11 areas of interest to influence policy recommendations for the universal health care plan.
    a. Access and Affordability
    b. Insurance Companies
    c. Coverage and Benefits
    d. Health Care Providers
    e. Employers and Employees
    f. Governance
    g. Cost and Funding
    h. Medicare and Medicaid
    i. Eligibility and Enrollment
    j. Focus on Equity
3. LMS and the Task Force developed the Community Listening Session agenda.
4. Priority audiences were invited to participate in the various discussions.
    a. Coastal Region | Saturday, June 11 - 10:30 am to 12:30 pm
    b. Central Region | Tuesday, June 14 - 5:30 pm to 7:30 pm
    c. Eastern Region | Wednesday, June 15 - 5:30 pm to 7:30 pm
    d. Southern Region | Saturday, June 18 - 10:30 am to 12:30 pm
    e. Portland Metro | Tuesday, June 21 - 5:30 pm to 7:30 pm
    f. Willamette Valley | Saturday, June 25 - 10:30 am to 12:30 pm
    g. En Español | Tuesday, June 28 - 5:30 pm to 7:30 pm

5. Seven virtual community listening sessions were held for participants to share their thoughts and feelings. The Task Force, LMS, and various community partners invited Oregonians for the first six (6) sessions.

6. LMS recruited participants for the Spanish session (Session 7).

    a. For Session 7, participants were found through social media, with the help of community advocates, and existing relationships with the community built over the last 20+ years. Over 80 potential community listening session participants were contacted, and 35 participants were confirmed. Thirty-two native Spanish-speaking participants arrived at the session.

    b. For confirmed participants, LMS offered to lend tablets if participants needed electronic devices. Upon registering, none requested the use of a device. LMS also offered Zoom Video conferencing training to all participants who requested assistance; two (2) participants from the Spanish-specific session requested training.

7. LMS coordinated and virtually hosted and facilitated all seven (7) community listening sessions.

    a. Six were held in English with ASL and Spanish translation. One was held in Spanish with English translation. Invitations were sent in seven languages for these community listening sessions.

8. After the discussions, LMS gathered data to create a comprehensive report on key findings to provide final recommendations. This report summarizes the information gathered in the community listening sessions.

Community Listening Session Participants

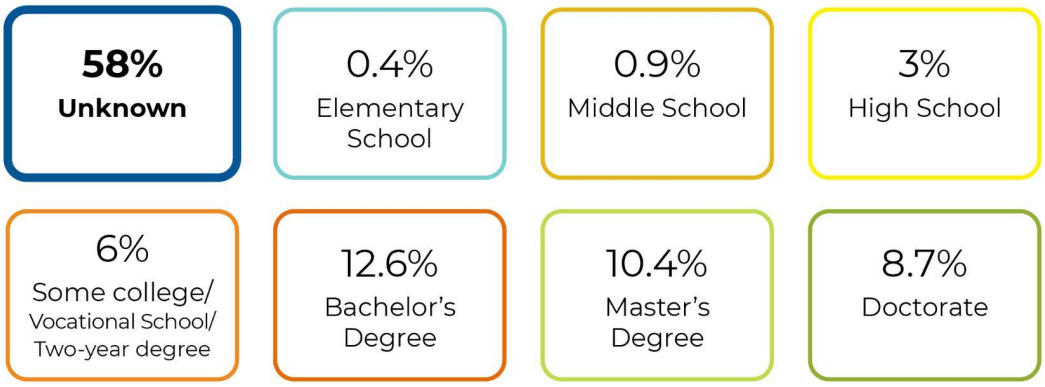
General Regions

Two hundred and thirty-one (231) total individuals participated in LMS's regional community sessions, with ninety-seven (97) participants responding to the optional survey (42% survey response rate).

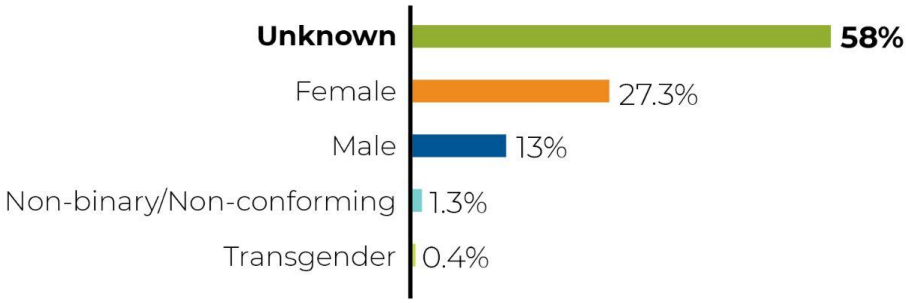
What city do you live in?

City	Percentage	City	Percentage	City	Percentage
Unknown	**58.01%**	Junction City	0.87%	Hermiston	0.43%
Portland	15.58%	Lake Oswego	0.87%	Hillsboro	0.43%
Corvalis	2.60%	Ontario	0.87%	Klamath Falls	0.43%
Eugene	2.16%	Redmond	0.87%	La Pine	0.43%
Salem	2.16%	Silverton	0.87%	Madras	0.43%
Ashland	1.73%	Umatilla	0.87%	McMinnville	0.43%
Beaverton	1.73%	Cannon Beach	0.43%	Nyssa	0.43%
Gresham	1.30%	Clackamas	0.43%	Roseburg	0.43%
Albany	0.87%	Cornelius	0.43%	Sublimity	0.43%
Bend	0.87%	Damascus	0.43%	Sweet Home	0.43%
Fairview	0.87%	Happy Valley	0.43%	Union	0.43%

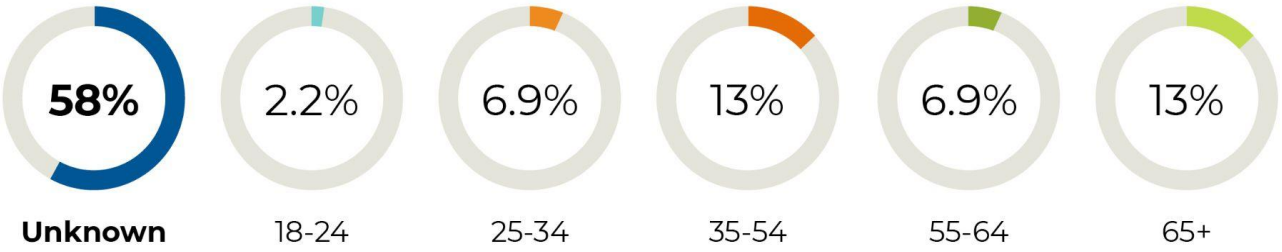
What is your highest level of education completed?



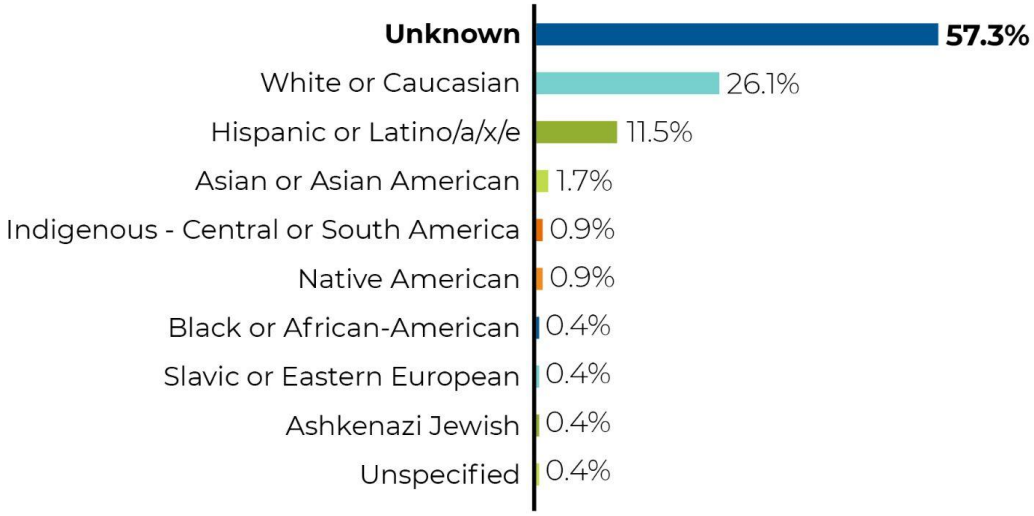
Which of the following best describe your gender?



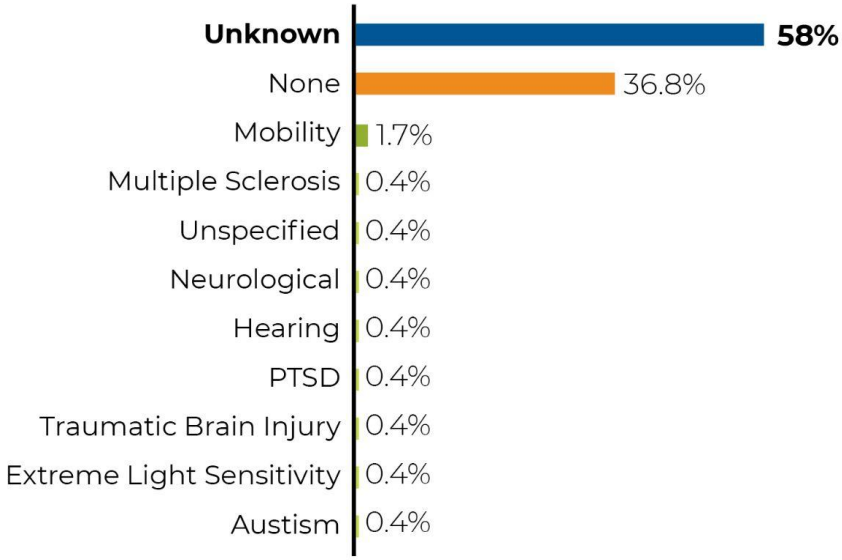
Which category below includes your age?



Which of the following best describes your ethnicity or race? (Select all that apply)



Do you live with a disability?



Coastal Region

The Coastal session was composed of six participants: four of whom responded to the optional survey. Of the individuals that responded to the survey, all represented different cities: one lived in Portland, one in Silverton, one in Cannon Beach, and one in Eugene. They were, however, quite similar in age: One was between 25 to 34 years old, another 55 to 66 years old, and two were over 65 years old. Three of these participants were female, and one was male.

Furthermore, three participants were White/Caucasian, and one was Slavic or Eastern European. In education, one participant had some college, vocational school, or a two-year

degree, two participants had master's degrees, and one had a doctorate—none of the participants identified with having a disability.

Central Oregon

The Central Oregon session was composed of sixteen (16) participants; eight out of sixteen (16) responded to the optional survey. These participants represented seven different cities: two from Bend and one from Redmond, Madras, La Pine, Silverton, Albany, and Beaverton. Three participants were 35 to 54 years old, four were 55 to 64, and one was over 65. Five of the participants were females, and three were males.

Furthermore, one participant was Latino/a/x/e, one was Native American, and seven were White/Caucasian. In education, one participant had some college, vocational school, or a two-year degree, three had bachelor's degrees, three had a master's degree, and one had a doctorate. Three participants identified as having disabilities: one identified with a mobility disability, another identified with Multiple Sclerosis, and the third did not specify which disability they identified.

Eastern Oregon

The Eastern Oregon session was composed of eighteen (18) participants; four out of eighteen responded to the optional survey. Those who responded were from four different cities in Eastern Oregon: Ontario, Nyssa, Union, and Portland. One participant was 25 to 34 years old, two were 35 to 54, and one was over 65. Two participants were female, one male, and one identified as non-binary or non-conforming.

Furthermore, one participant was Native American, another was White/Caucasian, one was Meso American, and one preferred not to respond. One participant had finished high school, one had some college, vocational school, or two-year degree, and two had bachelor's degrees. One participant in this group identified as disabled, having a neurological disability.

Southern Oregon

The Eastern Oregon session was composed of fifteen (15) participants; six out of fifteen responded to the optional survey. These participants represented three cities: four lived in Ashland, one in Roseburg and one in Portland. Besides being geographically similar, many participants shared similar age ranges: One participant was 55 to 64, and five were over 65. Four participants were female and two male.

Furthermore, the six participants that responded to the survey were White/ Caucasian. Two participants had bachelor's degrees, two had master's degrees, and two had doctorates. One participant identified as disabled, having a mobility disability.

Portland Metro

The Portland Metro session was composed of eighty-five (85) participants. In this group, thirty-six (36) out of eighty-five (85) participants responded to the optional survey. Those that responded lived in six different areas: Twenty-seven (27) live in Portland, two in Beaverton, and one in Hillsboro, Gresham, Lake Oswego, and Klamath Falls. Two participants were 18 to 24 years old, five were 25 to 34, 10 were 35 to 54, six were 55 to 64, and thirteen (13) were over 65. Twenty-two (22) participants were female, eleven (11) were male, two identified as non-binary or non-conforming, and one was transgender.

Furthermore, four participants were Hispanic or Latino/a/x/e, one was Black or African American, thirty-one were White or Caucasian, and one was Asian American. Five participants had some college, vocational school or a two-year degree, seven had bachelor's degrees, fourteen (14) had master's degrees, and ten (10) had doctorates. Of these thirty-six (36) participants, three identified with disabilities: one with a hearing disability, one with PTSD, and one with a traumatic brain injury.

Willamette Valley

The Willamette Valley session was composed of fifty-nine (59) participants; seventeen (17) of fifty-nine (59) responded to the optional survey. Those who responded lived in seven different areas of the Willamette Valley: six lived in Corvallis, four in Salem, three in Eugene, one in Portland, Happy Valley, Sublimity, and Sweet Home. Three participants were 25 to 34 years old, five were 35 to 54, three were 55 to 64, and six were over 65. Ten participants were female, and seven were male.

One participant was Hispanic or Latino/a/x/e, one was Black or African American, twelve (12) were White or Caucasian, three were Asian American, and one was of Ashkenazi Jewish descent. Regarding education, ten (10) participants had bachelor's degrees, two had master's degrees, and one had a doctorate. Furthermore, out of the sixteen participants that responded to the survey, five identified with disabilities: Two identified with a mobility disability, one identified with extensive and extreme reactions and injuries from LED lighting, one was on the autistic spectrum, and one preferred not to share their disability.

Spanish Specific

Thirty-two (32) participants attended the Spanic-specific session; twenty (20) responded to the optional survey. Those that responded lived in fourteen different cities across Oregon. Two were from Portland, two from Junction City, two from Gresham, two from Umatilla, two from Fairview, and one was from McMinnville, another from Ontario, one from Cornelius, one from Salem, one from Hermiston, one from Redmond, one from Albany, one from Beaverton, and one was from Damascus. Three participants were 18 to 24 years old, five were 26 to 34, nine were 35 to 54, one was 55 to 64, and two were over 65. Fifteen (15) participants were female, and five were male.

Furthermore, of the twenty, eighteen (18) participants were Hispanic or Latino/a/x/e, two were Indigenous from Central or South America, one identified as White or Caucasian, and one identified as Hispanic with red hair. Regarding their education, one participant had an Elementary School level of education, one had a Middle school level, six had a High School level, five had some college, vocational school, or a two-year degree, five had bachelor's degrees, one had a master's degree, and one had a doctorate. In this group, no individuals identified as having a disability.

Results and Findings

Key Findings by Areas of Interest from Listening Sessions

Access and Affordability

When discussing access and affordability, the community's questions focused on the accessibility of care when traveling out of state and abroad, access to care when the state is experiencing provider shortages and participants' concerns about selecting a provider.

Throughout the various sessions, participants voiced their concerns about how the Universal Health Care Plan (UHCP) would cover individuals when traveling to a foreign country or a different state, how far this coverage would extend and what services would be covered. In addition, there were also concerns about what would happen if participants were forced to keep paying into the system after moving to different states. Similarly, participants questioned if this new system would be more accessible than Oregon's current healthcare system. Their questions focused on who would be insured and how long it would take for an individual to get an appointment due to COVID-19 and the potential collapse of the health care system. But ultimately, they worried that this new system would result in more extended waiting periods and discrimination.

Participants expressed concern about the current shortage of providers within Oregon and questioned how the state of Oregon would manage more people if this were currently an issue. Similar concerns were also raised about the effect that authorization procedures might have on the accessibility and speed of care. Participants wanted to know if the plan would take measures to remedy staff shortages and long wait times and what services would be affected.

Insurance Companies

Many participants expressed concerns about the changes the Universal Health Care Plan would have on the range and cost of services insurance companies cover within Oregon.

Participants worried that services not covered by the Universal Health Care plan would increase in cost and that private companies would take advantage of these changes to overcharge individuals with more expensive premiums. Most regions also voiced concerns about how the Task Force would integrate insurance companies and other existing health plans into the UHCP - like Kaiser and Veterans' Affairs, what these new plans would look like, and what new benefits

this plan would provide. Furthermore, several community sessions raised concerns about the plan receiving pushback from insurance companies, mentioning how one of the biggest obstacles the Task Force would face would be bringing private insurance on board since most for-profit companies would lose money.

Coverage and Benefits

Throughout the different community sessions, people mentioned how medical treatment and health were one of the most critical aspects of their lives and decision-making. For that reason, participants raised questions about who would be covered by this new Universal Health Care Plan; participants wanted to know if gender-affirming individuals, undocumented immigrants, and houseless people would be covered.

Participants asked and advocated for various alternative care services. Not only did they ask and advocate for services like chiropractors, acupuncture, massage, nutrition, and physical therapy, but there were also multiple requests for non-licensed peer-type services like lactation consultants.

Additionally, participants raised several questions regarding long-term care and chronic illnesses, concerned about whether the new plan would consider long-term care and organ transplants. These were similar to concerns raised by the Latino/a/x/e community about access to treatment and good health care providers for diabetes and other chronic illnesses that their community faces. Lastly, individuals also questioned what type of hearing benefits the new plan would provide, as well as whether it would cover pharmaceuticals and how much they would cost.

Health Care Providers

The Health Care Providers section revolved around the effect of mandatory participation on providers, changes to providers' payment, the implementation of a more effective administrative system, and participants' concerns about privatization.

With the current shortage of specialists in the state, there were many questions about the ability of doctors and providers to opt out and how the state of Oregon would prevent doctors from crossing state lines. Similarly, participants asked how the new system would work around the lack of providers to ensure people had optimal coverage and how limited individuals would be when choosing a provider. Participants also voiced concerns about whether there would be incentives to use urgent or primary care providers instead of more expensive emergency rooms: while others questioned if participating providers would have to adhere to practice guidelines by illness, age, medical understanding, and population address.

In addition, individuals questioned how providers would get paid and how the new plan rates would compare to current ones for healthcare providers. Participants discouraged the Task Force from using a value-based payment model. Instead, they suggested that when applying this new plan, the Task Force should consider how most countries with successful Universal

Health Care systems still use a fee-for-service system. Likewise, several participants had questions about whether providers' incomes would drop and how providers would be recruited.

Furthermore, participants addressed how the health care administration would need effective plan management to succeed, with concerns being raised about whether there would be intentional efforts to reduce the burden of paperwork and documentation since this was a challenge for most individuals when applying for health insurance. Community sessions also raised concerns about privatization; individuals wondered if hospitals would continue to be privately owned and, if yes, would they be allowed to turn patients away.

Employers and Employees

The employers and employees section focused on two main questions: How the new plan would benefit employees and how it would work when implemented.

Participants had questions about this new health plan's cost, benefits, and coverage. Most individuals wanted to know if it would be a better option for employers and employees than the current plan they pay today. In addition, participants questioned what would happen to their current insurance if the new health care plan were to pass; would employees have to switch insurances? How would the government manage this? Moreover, would the Task Force eliminate employer-based insurance?

Governance

When discussing governance, participants' questions revolved around four major areas: how the plan would be effectively implemented, whether other states would soon implement universal health care plans, whether the UHCPs governing board would ensure diverse representation within the system, and whether community groups and organizations would be able to give their feedback as the plan progressed. Many participants were also highly concerned about the type of opposition the plan would face and interested in how they could support it.

Most of the questions raised in this section were about who would be in charge of the plans of implementation and whether there would be an alternative plan if the Universal Health Care Plan did not pass. While most participants were impressed with the Task Force's work, some individuals had questions regarding the proposals made and wondered if there would be a need for a much more robust and sustainable public health care system. Several also suggested that this plan would need an effective management system because issues would emerge after implementation. They recommended being very careful with the planning and leaving room to adjust the plan.

In addition, many individuals questioned if Oregon was the first state to try and implement this new plan or if other states were trying to apply the single-payer health care system. They wanted to know if they should expect other UHCP to be implemented and whether the state government would oversee the plans.

Most individuals also wanted to know who would be on the governing board and how many people would be part of it. Some individuals commented that there was a need for more community engagement and input from the Black, Indigenous, and People of Color (BIPOC), as well as the disabled and veteran community. In contrast, others believed that the Task Force should receive feedback from employers, hospitals, providers, and statewide health counselors. In short, many recommended that the board represent a diverse community, with some suggesting that community-based organizations (CBOs) and unions be used to reach out to marginalized communities. Participants also recommended that the board receive input from CBOs and statewide health counselors and address business-model concerns of private providers and policy-makers: since the former group helped individuals sign up for health care, and both had a vested interest in the new health care system.

Finally, participants were very concerned with the opposition the plan might receive, with many questioning if the Task Force was ready for pushback. Most of the questions touched on the possible barriers the Task Force would face when talking to legislators and how much pushback the Task Force would receive from the federal government and groups in the private sector. Likewise, several people also questioned what response this plan would receive from groups with wealth and political power since this plan would affect those groups most. But despite the focus on opposition, the plan also had the support of many participants who wanted to know how they could help get this plan passed through legislation and pressure congress when trying to pass this bill.

Cost and Funding

Throughout every regional session, the Task Force received many inquiries about their new plan's financial inner workings. Many questions revolved around the taxes the plan would implement and whether these taxes were fair or how to improve them. Participants also asked about the system's blended funding and whether the Task Force had calculated risk-based expenditures and overutilization costs.

The program's cost and funding received much attention from participants interested in understanding the payroll taxes Oregon's new health care plan would require. Most of the questions participants raised touched on who and what would be taxed and whether the state and/or the individual would be paying more for this new system than they would in Oregon's current health care market. A few specific questions included whether Roth Individual Retirement Account (IRA) distributions would be counted as income and whether the payroll tax would include people hired out of state. Furthermore, participants questioned if people who had retired were on a fixed income and had Medicare would also be taxed.

Other questions revolved around the equity of the Universal Health Care Plan's (UHCP) progressive tax system, with participants questioning how the Task Force would ensure fair and equitable taxes for all Oregonians. Many debated whether this put too much burden on people with higher incomes, whether this would disincentivize people from earning more money, and if the tax was sustainable. They feared that this plan would cause an unequal distribution of the burden to pay for health care, suggesting that UHCP experiment with a flat tax rate or consider

implementing a tiered income threshold for taxing interest and dividends. That way, seniors or low-income individuals who could not afford the plan would still be able to afford to pay their taxes at the end of the year. In addition, several participants stated they were troubled by the Task Force's high reliance on W-2 income because of the ease with which people could avoid classifying the money they live on as official earned income.

Participants also expressed concern over the plans' blended funding. Since UHCP is funded by a mixture of Federal dollars, payroll taxes, and state health care revenue, several participants worried about how the program would integrate federal money and whether or not this would make UHCP overly reliant on Federal funding. They questioned what the Task Force would do if this funding ended or was reduced.

Additionally, several participants questioned the sustainability of UHCPs proposed funding and expenditure plan, asking how or if the Task Force planned to face an increase in risk-based expenditures and system usage. Participants were concerned about how risk-based expenses would be calculated and affect the ordinary person. They did not like the idea of paying for people whose behavior places them in active harm and thought it unfair to those using the system responsibly. Participants worried that greater access to medical services would increase the cost of healthcare due to a rise in risk-based expenditures and system abuse. If unchecked, many feared that this could lead the system to bankruptcy. Instead, they suggested the Task Force hold individuals accountable for overutilizing the system, monitor excess costs, and control or limit overspending.

Medicare and Medicaid

When confronted with Oregon's plan for a single-payer health care system, many participants expressed confusion over how the plan would integrate Medicare and Medicaid and whether participants would still have to pay Medicare or Medicaid premiums.

At the regional community sessions, the Task Force shared their plan to integrate Medicare and Medicaid into their new single-payer system. However, Medicare and Medicaid cover a large percentage of people in Oregon, and many expressed concerns that the coverage extended to them by these federal health care plans would not carry over to UHCP. They fear that this could leave them without necessary health care coverage or paying taxes and premiums for plans and services that may or may not still be available. Many also fear that these changes to the health care system would disrupt their current health care plans, making it harder to access providers and easier for providers to deny them care based on their health care status.

Eligibility and Enrollment

The Eligibility section had various questions consistently come to the forefront, including who was eligible for UHCP, how this plan would handle people moving from out of state, and whether this plan would ensure the safety of Oregon residents without legal residency or immigration status.

UHCP expects equal health care coverage for all Oregon residents regardless of age, race, income, or preexisting conditions. However, when discussing the program's eligibility, the most notable question was who would receive coverage and what level of coverage participants would receive. Although the specifics vary by session and individual, there were comments and concerns mentioned for the following groups: out-of-state employees and non-residents, seniors, private patients, houseless individuals, elected officials, Native Americans, those with chronic diseases or pre-existing conditions, unemployed residents and those without economic support, migrants, seasonal workers and/or residents, undocumented immigrants, out-of-state students, and communities of color. Underlying these questions appeared genuine confusion about who would be eligible for what.

Participants were also greatly concerned about the prospect of large groups of people moving into Oregon for free health care. Many believed this would result in large waiting lists and increased operating costs. But overall, most people wanted to know if these incoming residents would be eligible for health care and how UHCP's enrollment process would keep non-residents from abusing the healthcare system.

Finally, since UHCP would cover all Oregon residents, participants have expressed concern about how Oregon residents without legal residency would be protected in this plan. Participants worry that people would be automatically enrolled, allowing the federal government to access or demand their information since federal dollars partially fund the program. They want more specific information on how the Task Force plans to protect these participants upon enrollment.

Focus on Equity

Throughout the sessions, participants questioned the equity of the UHCP policy plan. These questions centered around the lack of equity many BIPOC communities see in current health care systems and how these issues could be resolved.

Participants believed equity was essential when creating a new health care system, applying it to everything from payroll taxes to access and accessibility. However, the core of their equity concerns has always been centered around the participation and integration of BIPOC and communities of color into Oregon's new healthcare system. With UHCP seeking to enroll and cover all Oregon citizens, many participants believed this system was taking steps toward providing Oregon with more well-rounded and equitable healthcare coverage. However, many still believe it would take time to implement a genuinely equitable system for all communities. "This change in the program is not going to fix racism/discrimination in healthcare," stated one participant, and others agreed: "Any time we want to change the system, it leads to premature deaths from minorities," "[t]here will not be a complete solution to all of our current problems." However, they hope that UHCP will find a way to ensure all communities' needs are met and managed, suggesting that the Task Force meets with communities of color to consider the needs the plan should meet and how it should be delivered.

Survey Results and Findings

The community sessions that Lara Media Services facilitated helped participants better understand what the Task Force has been working on regarding the UHCP. After the presentation, participants had the opportunity to respond to an optional survey provided to address questions, comments, and concerns that might not have been discussed at the community session. Consequently, most individuals focused on crucial points that revolved around Access and Affordability, Eligibility and Enrollment, Coverage and Benefits, Health Care Providers, Insurance Companies, Governance, Focus Equity, Cost and Funding, Employers and Employees, and Medicare and Medicaid.

Access and Affordability

When gathering the survey's general information on access and affordability, the community's questions focused on the barriers that health care workers face when doing administrative work, the lack of education and misinformation regarding access and affordability, how the task force would ensure there were enough providers to operate the system, whether those providers would be held accountable for charging reasonable prices and not being allowed to overcharge, and whether social determinants of health would be considered when determining medical care.

One participant shared a personal experience about her administrative work as an assistant at a physical therapy clinic. She emphasized that the administrative work practitioners do in the new UHCP must be drastically reduced and streamlined. The process of submitting paperwork for authorizations is painful, she said, adding that the wait to get visits authorized is too long for patients, especially post-operation when time is of the essence for the success of their surgery. Moreover, she mentioned how, as a small practice, providers often see patients with Oregon Dental Services (ODS), Oregon Health Plan (OHP), or Eastern Oregon Coordinated Care Organization (EOCCO) without authorization because it is in the patient's best interest for positive outcomes. However, this can cause them to have large write-offs. She also raised concerns about whether UHCP would be a better option for her practice. Since they are a small practice, she worried they would go out of business due to increased waiting time for patient authorizations and the long process of claims. She suggested that the Task Force research the impact of the new plan on rural providers in small practices.

Another participant raised concerns about whether the plan would be held accountable for ensuring that real-time access was provided to patients. They mentioned that as a Medicare and Medicaid advocate, it could be challenging to get providers to provide the services one was eligible for, especially for urgent needs. His example specified how difficult it could be to obtain services such as dental services under Oregon Health Plan (OHP) and that, more recently, it had been difficult for individuals to access their benefits for counseling due to provider shortages. For this reason, he expressed deep concern that a new healthcare system would continue to be dysfunctional due to provider shortages.

Multiple participants commented that the Task Force must consider the many determinants of health beyond direct medical care, such as adequate housing and education. Participants were

particularly concerned about this latter point since most Oregonians lack education when discussing health care. They questioned which steps the Task Force would follow to ensure that individuals were better informed about the UHCP when it came out.

Overall, participants were very appreciative of the changes being made by UHPC, believing accessibility to be a crucial issue in today's healthcare system. Many wanted more information and requested the chance to contact the Task Force to discuss further their propositions for more changes or issues they perceived within the policies. One participant asked when Oregon would implement the program.

Coverage and Benefits

Participants that responded to the optional survey raised many concerns about coverage and benefits. Several participants questioned which type of services the UHCP would cover, the balance between using and overloading providers and physical resources and whether individuals could keep their current providers.

Participants wanted to know if the new UHCP would cover midwifery services, home births, lactation consultants, acupuncture, chiropractic and therapeutic massages. Furthermore, two participants wanted to know what steps the Task Force would follow to balance between use and overload of providers and physical resources. They were concerned about reimbursements and the wait times being too long. Participants also questioned how the Task Force would ensure supply and demand were met with fixed prices and whether the current shortage of therapists and psychiatrists would create multiple challenges, such as long waits and insufficient providers to meet patients' demands. Lastly, several participants questioned if the new UHCP would allow them to keep the same providers and coverage that they currently have and whether the new plan would include all reproductive and gender-affirming care.

Health Care Providers

In this section, the survey reflected participants' concerns about providers treating diseases.

Many participants questioned whether the Task Force would focus on disease prevention or treatment, concerned that with everyone having access to a UHCP provider and treatment being so widely available, fewer patients would be incentivized to focus on prevention services. For this reason, they questioned how the Task Force would incentivize people to stay healthy rather than wait to get sick and follow up with treatment.

Employers and Employees

The survey reflected that several participants had questions regarding whether employers would no longer need to provide health insurance and what would happen to self-employed individuals.

Participants questioned if employers would no longer need to provide their employees' health insurance and how they would benefit from it. One also expressed concerns about how this new

plan would affect self-employed individuals, questioning if and what type of taxes they would have to pay. Likewise, another participant asked how the system would cover Oregon employees that were also Idaho residents and whether these individuals would have double coverage or if they would waive the UHCP.

Governance

Many concerns raised in the survey revolved around governance; participants were particularly concerned about the representation of different communities on UHCP's leadership board and how the needs of different groups would be addressed. Moreover, participants questioned if there was a similar precedent of a plan in a different state or country.

Several participants were concerned about who would govern the system and what the Task Force meant when using the word Community Voices. Some participants mentioned that most Eastern Oregonians gain representation on boards and groups through their connections, degrees, or occupational professional licensing. Many expressed concern that similar methods would be used to fill UCHPs governing board and regional advisory groups, questioning how the Task Force would guarantee that citizens' concerns and voices would be represented when boards and groups were usually composed of a select group of individuals and not an overall representation of lay citizens.

Individuals also questioned if the Task Force had any idea if different states, countries or entities have adopted similar systems to the one being implemented in Oregon and mentioned that it would be helpful to have a reference of a system already implemented to help people understand how the new plan would work.

Cost and Funding

Most of the participants that responded to the survey also raised concerns about the cost and funding for the UHCP. Most of these concerns focused on the equity and specifics of UHCP's taxes and whether the program would become more accessible and cost-effective if it did not rely on income taxes.

Although most participants liked the project and wanted more information regarding its implementation, participants clashed about what would be equitable when taxing residents. One participant commented that charging those individuals who can pay was equitable while charging the sick simply because they were sick was immoral. Another individual disagreed, saying that it would not be fair to charge individuals with higher incomes more since it would encourage people to earn less, causing a change in our economic system. They also suggested that there should be a cap on what people might need to pay in taxes to fund the UHCP.

Other questions asked by participants included whether insurance taxes would be counted as deductions for individuals and businesses, if the UHCP would allow the negotiation of bulk prescription prices and whether the program would become "more socialized to the general public" (this participant seemed to be asking about overall benefits to the public). There were

several concerns regarding the cost that retired people would have to pay with this new UHCP and how they would be affected due to their fixed income.

One participant who responded was an attorney who had fought insurance companies over medical care issues for 30 years. He said he saw a massive need for Universal Health Care and was very impressed with the Task Force's work. However, he was concerned about the system's heavy reliance on income taxes for funding, adding that an entire economy in Oregon goes unreported in ways that minimize the tax revenue that the Task Force projects. He was also concerned that the current plan would create a massive incentive for the wealthy to fight this program, as their health care cost could quickly go from $10,000.00 up to $50,000.00 or more.

Medicare and Medicaid

In the survey, participants acknowledged the need for the UHCP in our community. However, they also questioned whether the plan would meet the care standards set by Medicaid and provide sufficient benefits for seniors.

Participants questioned if the UHCP would provide equivalent or better coverage than the Medicare Advantage program currently available to seniors and if seniors would be able to access the standard plans without penalty.

Additionally, one participant commented that the system model usually touted as Medicare was inadequately designed for the community. He mentioned that this was because the United States healthcare system was not built to lessen the amount individuals were supposed to pay for services. He gave an example of how Medicare does not provide all the services seniors need. For example, usually individuals need more vision, dental and mental health services, but Medicaid excludes all of those. Instead, a person has to pay extra to get coverage that should be part of their plan. For that reason, he suggested he would like to see a form of coverage similar to the one used in other countries, although the U.S. tax structure would have to be entirely redesigned for that to happen.

Eligibility and Enrollment

Several participants were unsure whether UCHP would equitably cover groups like federally elected officials, undocumented immigrants, and those on low or limited incomes.

Several participants questioned whether the federally elected officials from Oregon would automatically be enrolled in the Oregon Plan. They were worried that although the plan is marketed as eligible for all, it would short-change the federally elected leaders in charge of facilitating the process. If they would cover federal officials, one participant suggested the Task Force should provide a basis for exemption and any citations the committee relied upon exempting them from Constitutional mandates.

Likewise, other participants also had reservations about UHCP’s eligibility process; one questioned if the UHCP would ensure the safety of undocumented workers and their families. Additionally, while folks were talking about eligibility, the confusion about qualifications and

affordability came through with the following comment; “consider the expenses, rent, groceries, etc., when determining eligibility based on income.”

Focus on Equity

Most participants questioned how the Task Force would ensure the plan would be equitable for marginalized communities.

During the survey, a participant commented that one of the biggest problems he saw with Oregon’s current healthcare system was that every aspect prioritizes making money over providing services. As an educator, he said, he sees how communities of privilege maintain the inequalities of an underfunded system and that this system did not prevent the marginalization of communities like houseless, mentally ill, differently disabled, and BIPOC communities despite the laws and policies in place. His concern was that this new plan would not help mitigate this issue, nor did he believe it would help relieve the stress of underfunded medical personnel, educators, and other professionals. “My point,” he commented, “ is that at the same time we are changing Oregon's health care system, we must also change the perverse incentives for casual cruelty.”

Community Session - Specific Findings by Region

Coastal Region Findings

Access and Affordability

During the Coastal community session, participants disputed who would qualify for this new plan, what documents would be needed to qualify, and the requirements individuals would need to follow. Another question raised by participants was what would happen with the Consolidated Omnibus Budget Reconciliation Act (COBRA) and if this new system would eliminate it. In addition, participants commented on Oregon’s current health care entities competing with each other by leveling the playing field. They questioned if, by having this new plan, the competition would decrease the need for mergers because the system would be focused on health instead of profits. Similarly, several participants commented that in 2021, the Oregon legislature passed a bill to allow the Oregon Health Authority (OHA) to review and possibly veto mergers and acquisitions of hospitals. For that reason, participants emphasized that while fewer institutions exist, their value has increased.

Health Care Providers

When discussing health care providers and participation during the Coastal community session, participants focused on whether the new health care plan would affect how services were provided: Several questioned if the new plan would affect the ability to bring medical providers to the state of Oregon. Participants were also concerned about the likelihood that some provider groups would end up not having an entity to work for, causing a decreased workforce without consolidation, and how the new plan would affect training programs for new health care providers.

Likewise, individuals wanted to know what the plan defined as an alternative provider and if it would include unlicensed health care providers in the new plan. If unlicensed health care providers were included, participants were concerned about how this group would get paid and how the Task Force would ensure that these and other providers were not charging an extra fee to customers.

Coverage and Benefits

Most coverage and benefits questions focused on the type of services alternative health care providers could cover and what this coverage would look like. In addition, individuals also expressed gratitude to the Task Force for emphasizing primary care in this new plan.

Governance

The topic of governance raised many questions for participants, particularly if this new plan would help decrease fraud and, if yes, how fraud would be tracked. Likewise, participants questioned whether workers' compensation would disappear and how the Task Force would ensure that medical companies would not increase their costs.

Cost and Funding

The discussion around cost and funding mainly focused on the new plan's cost and if it would be based on income range.

Medicare and Medicaid

During the Coastal session, participants did not ask many questions regarding Medicare and Medicaid. However, participants were grateful that Medicare and Medicaid were considered in the new health care plan.

Focus on Equity

Participants suggested that the new healthcare plan focuses on equity and the Social Determinants of Health (SDOH). They also commented that the Task Force should tell individuals to remember this when comparing this system to welfare; no matter how much individuals made, they would end up getting the same care and benefits.

Central Oregon Findings

Access and Affordability

During the Central Oregon community session, participants focused on the potential obstacles the Task Force might face when implementing the new health care system and, if passed, how long it would take for this plan to be implemented. They wanted to know the most significant obstacles the Task Force was currently facing and if the Task Force foresaw these obstacles derailing the plan. Several also touched on the need for more health care due to climate change and transportation for low-income individuals unable to commute to appointments. However, most were

thankful that something was being done to better the system and make it more equitable for everyone.

Coverage and Benefits

Comments on coverage and benefits generally concerned the difference between behavioral and mental health and the need for both. Most participants also wanted to know which services would be covered with the new health care plan and if it would be more expensive than their current one.

Health Care Providers and Participation

Participants recommended that health care billing and insurance professionals receive retraining and career advancement assistance with this new plan when discussing health care providers. In addition, several wanted to know if this plan would attract more multicultural staff, especially in the mental health area.

Employers and Employees

Discussion around employees and employers generally focused on whether employers would have the choice of providing other health plans to their employees and, if yes, what that would look like. Moreover, participants acknowledged that private employers would save money with this new health care plan and questioned if public employers would be able to do the same. They wondered if, by implementing the Universal Health Care plan, communities would be able to save more money.

Medicaid and Medicare

Participants' questions about Medicare and Medicaid focused on how the new plan’s changes would affect Medicaid and Medicare participants and whether there would be government agreements for individuals so that people could have some reimbursement for Medicare and Medicaid.

Eastern Oregon Findings

Access and Affordability

Participants from this session had several questions, asking what date the Task Force would implement the UHCP program and whether there would be subsidies for transportation and services to appointments. Meanwhile, other participants were concerned about the health system being flooded with patients, making the system ultimately inaccessible.

Several participants also expressed gratitude for exposing the American health care system's inequalities and the barriers that vulnerable communities face when getting health care services. “In America,” said one participant, “access to quality health care so often depends on income, employment and status.” However, they hoped this plan would help eliminate significant barriers to lifesaving medical treatment for large population segments and ultimately benefit

Oregon's population. One participant was pleased about having less paperwork flowing throughout the system. In rural areas, health care means waiting for services and providers and having a more predictable and effective administrative system could help ease that burden.

Insurance Companies

There were not a lot of session-specific comments in this section. However, one participant did ask if insurance premiums would continue to be an allowed deduction for individuals and businesses, considering that UHCP would cover most Oregonians.

Health Care Providers

With many living in rural areas with little access to providers, participants' primary concern was how the program would recruit providers to remedy Oregon’s current provider shortage in these areas.

Employers and Employees

Participants commented that many employers might mourn that they cannot continue to provide their employees with health insurance options. They reasoned that in our current system, many employees often seek work with benefits like health insurance. However, this system works against business owners: hiring staff is a costly endeavor, as many businesses, especially small ones, must constantly retrain staff to replace the ones they lose. It also works against communities' economic growth, as costly health insurance often prevents businesses from ensuring a healthy workforce: particularly if they cannot provide their employees with health insurance. Participants worry that this would impact employers' support for Oregon's UHCP.

Governance

Many participants believe UHCP's governing policies could be an essential step towards fixing the current "mess" of health care in Oregon and the US by getting all residents under one plan. They believe this system would benefit Oregon in the long run, even with a bumpy transition period. It could help create a system where residents go to the doctor more consistently and enjoy primary care benefits. For them, this was a chance to improve the system's equity and quality of care. However, others were concerned about pushback from our current political climate. They recommend the Task Force consider what that opposition would look like before continuing their plans.

Cost and Funding

Participants stated that financial barriers to healthcare access have always been a problem. One of the most common barriers cited was OHP’s refusal to cover anyone that earns more than 133 percent of the Federal poverty level. In the past, this has left countless individuals who are unable to afford to pay commercial rates without health care because they made more than OHP allowed. Additionally, one participant felt that this practice had restrained those earning lower incomes from earning more out of fear of losing OHP’s health coverage. However, with

UHCP revamping Oregon's health care system, many participants have expressed hope that this and other financial accessibility barriers would be rectified.

Participants also had many questions about the new taxes the Task Force sought to apply. They were interested in the cost and financing of the system's development and maintenance. With health insurance no longer being tied to individuals' work, several participants were worried about what the tax would be tied to, individual gross or net income, and if these taxes would help keep health care services lower. Additionally, several participants expressed worry that those with high incomes might bear more of the burden for funding the system: although some did argue that these taxes were justified and would help those in need of costly medical assistance access cost-effective care.

Southern Oregon Findings

Access and Affordability

When discussing access and affordability, the Southern Oregon session asked how the new plan would affect individuals with felonies and those who were unemployed. Similarly, although most participants liked the plan, many suggested that the Task Force emphasize prevention and health instead of the treatment of diseases. In this way, the plan would enforce proactive and preventative health measures. Several participants also mentioned that the average person did not understand how the healthcare system worked and suggested that the Task Force help educate individuals on this to make the plan more accessible. They were concerned about the specific health care plans this system would offer and how the system functioned.

Coverage and Benefits

Participants generally focused on the benefits they would receive from the new health care plan when discussing coverage. They suggested that the Task Force should focus on dental, vision, and baby health care services, emphasizing the need for families with newborns to have the option of providers visiting their homes. In addition, some participants recommended that the plan cover prevention services for the first 1,000 days of a baby's life. These additions would ensure that all residents were more fully covered and help provide for one of Oregon's most vulnerable communities.

Health Care Providers

Participants focused on how the new health care plan would lessen the administrative red tape providers must address to free up time to treat patients. Additionally, participants questioned what would happen if many clinics refused to participate and insisted on only seeing "private" or self-pay patients. They were concerned about the potential effect this could have on the new system and questioned if the Task Force could prevent this from happening by mandating that providers and clinics accept patients covered in UHCP. In addition, participants wondered if there were ways to minimize the social stratification and economic setback the system would have on public users compared to private patients.

Employers and Employees

Throughout the session, there was a lot of focus on how the new system would account for and integrate employer-based health care plans. Participants questioned whether the Task Force was reaching out to employees and how they envisioned this plan coordinating with workers' compensation. Furthermore, most participants raised concerns about health care prices for the workforce. They liked the plan presented by the Task Force, but the process of getting there worried them.

Governance

During the community session in Southern Oregon, questions on governance revolved around how the Task Force would be referring to Affordable Care Act (ACA) provisions that have been watered down or removed. In addition, participants wanted to know why the amount contributed for the federal portion would increase by $2.5 billion. Despite their concerns, most participants liked the plan and wanted to see if it would be approved at the state and federal levels.

Cost and Funding

The Southern Oregon community session mainly focused on how payment rates would look based on the region when discussing cost and funding. Participants mentioned that it was clear that this new plan would cost less but raised concerns about the misinformation individuals have when hearing about this new plan. They wanted to know how the Task Force would address these communication issues with the community. In addition, participants suggested that the Task Force should be wary of unintended consequences that the new plan could have, suggesting that they consider the plan’s effect on neighborhoods at the sub-county level, not just the regional. Lastly, individuals commented that the Task Force should be interfacing with the Public Health system to get their ideas and clarify if sharing taxes would cost participants more.

Eligibility and Enrollment

During the Southern Oregon community session, participants’ questions focused on the Oregon Department of Human Services (ODHS). Participants were concerned about whether “ODHS/Aging & People with Disabilities [would] no longer be tasked with determining medical eligibility for consumers of Long Term Services and Supports,” and whether those savings had been quantified. Furthermore, several questioned whether parents could be paid as caregivers for their sick or disabled children as they had been during the pandemic but not before. One mother mentioned that when she started being her son's primary caregiver, he stopped going to the hospital, where he had been going back and forth every couple of months. Since the time spent caring for her son was costly, she could not continue caring for him after the pandemic ended. She hopes that if this new system allows parents to be paid as caregivers, she and other parents would be able to take more time off of work and care for their children full time.

Focus on Equity and SDOH

Many participants in the Southern Oregon session focused on equity and SDOH, wanting to know how the plan's outcomes would be equitable for people with disabilities. Individuals questioned whom the system would be regulated by and wondered if that would include an Americans with Disabilities Act (ADA) enforcer. If not, they questioned how this policy would be enforced and how they would accommodate people with disabilities due to some individuals needing different accommodations. Lastly, participants wanted to know how the Task Force was planning to establish trust among marginalized communities and if this new plan would help provide patients with resources necessary for healthier lifestyles.

Portland Metro Findings

Access and Affordability

Throughout the session, participants expressed concerns about keeping the plan affordable for Oregon's residents. Although most of these questions were centered around the cost of funding Oregon's health care plan, some participants also expressed concern about the involvement of private investors. They recommended looking into ACO REACH and Direct Contracting Entities, an initiative begun in the Trump administration that would "privatize Medicare to the benefit of investors." They were concerned that if UHCP were not careful, this initiative would allow private investors to interfere with their proceedings and bring about long-term consequences for Oregon's health care plan: such as making the plan unaffordable for the average resident.

Lesser concerns in this area included technical questions about information accessibility, with participants asking about UHCP's website and where to find more information.

Coverage and Benefits

Participants primarily focused on the need to expand the behavioral and mental health field in Oregon to meet community needs.

Health Care Providers

With Oregon currently suffering from a shortage of healthcare providers, participants were concerned that there would not be enough providers to serve Oregon's residents. They were especially concerned that forcing provider participation would result in many leaving the state or refusing to practice under the new system, leaving Oregon with a more significant shortage. Additionally, participants questioned if providers would be compensated enough under the new plan to incentivize and attract potential providers; they fear that a drop in income could disincentivize individuals to become providers or make them harder to recruit.

Similarly, other participants asked if the Task Force had written up the minimum required best practices guidelines for the plan's providers to follow, as it would be difficult to quantify the quality of care provided by providers under UHCP without them. They worry that a lack of practice guidelines would allow health care provided by UHCP to drop below standards, making it difficult for the plan to compete with private health care plans. Some participants also argue

that a lack of practice guidelines would make it difficult to promote or integrate new providers, such as nurses and doctors, as there would be no standard to judge their operating practices.

Governance

While participants appreciated the Task Force's efforts with UHCP so far, participants expressed many concerns about UHCP's planned governance policies: Their foremost concern was UHCP's need for solid success metrics to shape the plan's internal structure. As one participant commented, “good intentions have led to bad structural interventions and worse outcomes when existing delivery systems and dominant political and economic forces overwhelm citizen input despite claims of equity in [the] process.” They fear something similar would happen within this new health care system should its success metrics not ensure adequate public participation and administrative governance. Participants recommend that if the Task Force has not yet implemented such measures, they should be planned and implemented early to ensure that the program may grow and mature effectively.

Participants expressed a similar concern about implementing safety measures within UHCP’s policy plans. They were worried about the health care system’s impact on Oregon’s population and recommended that a set of safety measures be implemented to keep the community whole throughout the program’s trial period and beyond. Others also suggested that safety measures be implemented to help address external threats to residents’ health, such as natural disasters, economic crises, increased population, and war.

Despite these suggestions, several participants had reservations about the Task Force's definition of a single-payer plan, claiming that the presented plan seemed to model a multi-payer one instead. Their concerns hinged on several policy measures implemented, but mainly the recommendation that the Task Force continue moving the plan forward even though the necessary Federal waivers and/or Federal enabling legislation had not been passed. One participant commented, “This recommendation means that the plan may leave out Medicare recipients and others among the most vulnerable Oregonians. That would not be a single payer plan and would reinforce current inequities.” They believe this would create “an inadequate system that would become unpopular and politically untenable, and lead to backsliding.” Many participants suggested that the current plan be reevaluated and the vote revisited. They also suggested that the financial analysis on UHCP be repeated as it accounted for a single-payer plan, believing that the Task Force has instead designed a multi-payer plan that is more expensive and less equitable than the original.

Lastly, some participants suggested that the Task Force research other single-payer plans and UHCP systems while they finalize their program's policies. The most controversial of these recommendations seemed to be the Veterans Affairs (VA) health care plan, which some participants felt was fragmented and wasteful. One participant gave their experience with the VA, claiming that this model led to lower income and FQHCs (Federally Qualified Health Centers) closing down rather than being boosted up in their expertise in providing care to people with less coverage and high need complex patients.

Cost and Funding

This section was a mixed bag of questions. While one participant asked how upstream investments would be streamed, several others questioned the savings enabled by the plan's blended funding. Another participant seemed concerned by the projection that only 990 billion dollars would be saved, believing that the plan ought to produce more significant savings if Oregon could run it at a 2% overhead rate similar to Medicare. Likewise, one participant wanted more specific information about where UHCP would keep savings and when they would collect income taxes for the program. Their main concern was that the blended funding would allow legislators to siphon funds to pay for other legislative expenses.

Medicare and Medicaid

The Portland Metro session asked many questions concerning Medicare and Medicaid. Several participants wished to know how UHCP would interact with Medicare and Medicaid and if it would be possible for seniors and other clients to opt out of using UHCP in favor of their current health care plan. Some believe this plan would cost more for seniors with passive income and were worried about Medicare and Medicaid users being overburdened by their current health care taxes and those implemented by Oregon's new plan.

Other participants expressed their disregard for Medicaid estate recovery, asking if UHCP would continue this program or, if not mandated by the federal government, would they eliminate it from their policy plan?

Focus on Equity

Portland's regional session also focused on accurately implementing equity and social determinants of health (SDOH) into the program. Their main concern was whether or not UHCP would include resources for SDOH and the impact this would have on Portland's houseless population. While the policies presented to participants never clearly stated if this plan would work towards helping improve the houseless population's circumstances, many seemed to believe this would be the case.

Willamette Valley Findings

Access and Affordability

In the Willamette Valley, the community asked how the new system would assure doctors more time to meet with their patients to practice preventative care and provide necessary services without being based on a proof system that denies care. They were worried that allowing more time to individuals would slow the process down for everyone and ultimately contribute to accessibility issues. One participant wanted to know if the new plan would cover consultations outside the state, referring to rare conditions and diseases where there are few experts or facilities in the nation able to provide proper treatment. Other individuals also asked how they would get a provider or a hospital of their choice and how narrowly limited the plan would be in terms of providers, questioning how the program would ensure enough capacity for everyone to be served.

Insurance Companies

During the community session in the Willamette Valley, questions around insurance companies focused on how Oregon UHCP would integrate with the Federal government and Veterans' health care systems and what the new health care plan would cover.

Coverage and Benefits

When discussing coverage and benefits, participants focused on the type of services the plan would offer, such as how people with disabilities or chronic diseases would be covered and how the Task Force would ensure they get the appropriate care. Individuals questioned if the new health care plan would cover a diagnosis like autism and whether it would employ case managers. Additionally, most participants raised concerns about how COVID-19 has affected individuals and how it would keep affecting them. Many wanted to know if this plan would implement more effective processes for administering vaccines and COVID-19 treatment.

Health Care Providers and Participation

This section received many questions from participants about how the system would deal with privately owned hospitals and providers. Many wanted to know if private providers were likely to support the new system, expressing concerns about the pushback this plan could receive from private entities. Likewise, participants wanted to know if hospitals would continue to be privately owned and if they would be allowed to turn away patients. Finally, individuals wanted to know how this new plan would promote integrated physical/behavioral health care; they were concerned about the current system’s struggle to meet the needs of patients and questioned if UHCP could improve their care.

Employers and Employees

During the Willamette Valley session, this topic did not receive much attention from participants. However, one participant did express concern about the financial impact of covering out-of-state residents who work for Oregon employers.

Governance

The governance section received a wide range of questions from the Willamette valley session. Questions ranged from how out-of-state residents working in Oregon would affect the new plan to whether the task force had already considered how to handle the need to provide UHCP's administration with a copy of their last year's Fed/State tax return as required by those who utilize Oregon's Insurance Marketplace and receive an ACA tax credit. Likewise, other administrative questions included how the wisdom of these last few years would be used to rebuild the BH (behavioral health) system and how the Task Force was approaching the need to address business-model concerns of private providers and policymakers. Furthermore, the participants wanted to know the Task Force's thoughts on creating a truly effective management system for single payers in Oregon and if there would be intentional efforts to reduce the burden of paperwork and documentation in this new plan.

Besides these questions, participants also left a lot of comments and suggestions on improving UHCP's processes. One participant, for example, commented that using the State Accident Insurance Fraud (SAIF) program as a model for UHCP would be a horrible mistake since SAIF was based on the idea and philosophy of denying claims and care. Instead, participants suggested developing the equivalent of the United Kingdom's National Institute for Comparative Effectiveness since the state of Oregon could pass such legislation before it approved the Universal Health Care System.

Participants also recommended that UHCP's record system be flexible since the current electronic records systems have severe limitations resulting in distorted and inaccurate records. An example mentioned at the meeting was that the current system had allowed providers to detail allergies. However, it has not allowed providers to recognize genetic information, including specific known issues like Cytochrome P450 (CYP450) enzyme information or family health issues. Ultimately, these have been pushed into categories where they do not belong— causing a family history of an abdominal aortic aneurysm to end up recorded as though one was suffering from this condition rather than as if a patient were simply vulnerable to chronic disease.

Furthermore, participants suggested that the plan should be more equitable, voicing their opinion that the Task Force should not use today's model of value-based payments. They mentioned that fee-for-service percent was not the main problem with today's health care system and that most countries with successful Universal Health Care systems still use fee-for-service in equitable enforceable ways. Instead, participants emphasized that today's value-based payment models only add inequity by incentivizing providers to avoid high-risk patients and reduce services. They commented that the Task Force justifiably emphasizes creating an equitable system that allows all residents access to care. For that reason, participants suggested that Oregon's system must fit into a national economy and be palatable to policymakers in charge of approving the spending of federal funds on Oregon's Universal Health Care Plan.

Cost and Funding

The Willamette valley session had two main concerns around cost and funding. What type of financial philosophy would the plan be centered on? How would COVID-19 affect the plan's viability?

When creating a new health care system, participants agreed that establishing a robust culture of guiding ideas, ethics, philosophies, goals and more was an early critical step toward preventing future issues. However, many worry about what form that culture would take. Participants took steps to warn the Task Force against establishing their new system around profit and cost/loss. The current system was founded on a similar philosophy and, in their eyes, was based on denying care under the guise of minimizing costs: a process that maximizes the harm to people and ultimately maximizes costs and harms.

Likewise, as the nation's experience with COVID evolves, participants have noticed long-term chronic health issues become more prominent. Participants worried that if insurance companies

did not prepare for this spike in chronic issues, there was a real possibility they would collapse under future financial load. They questioned how UHCP planned to deal with this dilemma and whether or not they were prepared to take on this future burden. One participant also questioned whether the plan had considered the possibility of paying for health outcomes with "cared-out incentives."

Medicare and Medicaid

During the Willamette Valley session, most of the questions on Medicare and Medicaid revolved around whether the Task Force would negotiate with the federal government to use Medicaid funds and specifications on how the new plan was related to Medicare.

Spanish Session Findings

Access and Affordability

In the accessibility section, participants focused on outreach to indigenous communities and accessible care for migrant workers. The latter questioned how migrant workers would be enrolled since they were neither long-term Oregon residents nor did they work exclusively in Oregon state: many often travel to work in nearby states. This transitioned into asking about the accessibility of care for other Oregon residents who do not work in Oregon year-round or who find it easier to receive health care in nearby states due to a lack of in-state providers or their closer proximity to out-of-state services.

Outreach to indigenous communities was also a key topic of conversation as many Hispanic participants with indigenous roots attended this community session. They asked to make information and resources more accessible when reaching out to their communities. They noted that indigenous Latino/a/x/e communities were so diverse and widespread that government organizations often overlooked their communities when seeking to inform people about important topics or projects like UHCP.

Participants first asked the Task Force to consider the complex language barrier surrounding their community. Although indigenous Latino/a/x/e communities have often been considered part of the Hispanic community, this is not always the case. Those who speak Spanish often speak it as a second language, one which many speak with difficulty and often do not read or write. Those who do not speak Spanish often prefer to communicate in their native languages or dialects, which are often only spoken. Additionally, few Indigenous Latino/a/x/e community members use online resources due to technological and linguistic barriers, making it difficult to reach these communities through written pamphlets, flyers, or online resources.

Instead, participants suggested using community forums and informative meetings in native languages and speaking to these communities through interpreters and trusted community members. This was the process used in the Census and one that participants found to be effective when seeking to make resources and information accessible to indigenous communities: a process many considered challenging due to the number of languages and dialects spoken by the indigenous Latio/a/x/e community. Overall, participants believed that

targeted outreach was crucial for their communities. A lack of access to critical information, government resources, and complex language barriers have left their communities vulnerable when navigating a system not tailored to meet their needs.

Insurance Companies

Participants' primary concern was that if insurance companies were left to cover the services that UHCP did not, they would start overcharging on premiums. They were especially concerned that any essential services would continue to go uncovered, fearing that allowing insurance companies to set the price of these services/premiums would prove disastrous.

Coverage and Benefits

Participants focused on the benefits and services UHCP's coverage plan would offer. They asked about the inclusion of transplants in their basic medical care and suggested adding orthodontics to the plan: due to its perceived impact on mental health. They also questioned if the plan would cover medical expenses for disabled participants and were interested in knowing if it would cover brand-name medication or only generic prescription drugs.

Employers and Employees

When discussing the financial implications of Oregon's new health care system, many participants were concerned about the impact this would have on employers. Several worried these new taxes would be a burden, especially if employers were expected to pay for all of their employees' treatments. They fear these taxes would destroy many small and local businesses by making them unprofitable, leading to many people losing their livelihood and increasing the control large corporations already have over the economy.

Governance

When discussing the plan’s governance policies, several participants suggested beefing up the language of the UHCP to help protect the health care for life project now that many of the project’s rights are under attack.

Focus on Equity

Participants were curious about how UHCP would support vulnerable communities when discussing the plan's equity policies. One participant asked how older people would get economic support if UHCP did not support this within the new program. Another suggested that UHCP speak with indigenous groups to get their perspective on their system’s policies.

Conclusion

For many, healthcare is not seen as a benefit but as an intrinsic right directly correlating to survival. Over 200 participants from all corners of Oregon attended the seven virtual listening sessions in June and July of 2022. Those who participated conveyed that it is urgent to change health care in Oregon and overcome the inertia of an uncoordinated, fragmented system that

emphasizes intervention rather than prevention and is exclusively accessible to high-income individuals. They expressed that it is imperative to improve the quality of Oregon's healthcare system and for care to become available to all Oregonians.

Overall, participants showed excitement, interest and hope for a more inclusive and human-centered system that would allow them to take care of their needs and the needs of their loved ones. They believe ensuring access to affordable, quality health services is essential to living a happy and prosperous life. Several health providers participated, sharing that if the new system emphasizes primary care, providers could practice care as they intended when they pursue their careers: by helping others instead of dealing with insurance companies.

Participants agreed that the current system is collapsing and is not helping but hurting low-income, BIPOC and rural communities with its inequities and insufficiencies of care. Almost everyone that participated expressed their opinion in favor of change and agreed that universal health care access would better facilitate and encourage sustainable preventive health practices and be better for the long-term public health of Oregonians. Health care costs are challenging for many in the current system. Removing the fear and possibility of bankruptcy due to health care would be a game changer.

Along with the positive outlook on what this plan can accomplish, many expressed their concerns about the new plan. Some participants were concerned that the plan would not be ready to cover all Oregonians, resulting in extra long wait times for patients. They were worried about the possibility of larger forces as powerful health insurance companies, pharmaceutical industries and hospitals would be against it and inhibit change. Many see this plan as a positive change, but not possible to implement due to the inherent distrust in our governmental procedures. Many lack hope and vision for the public to see this plan as too good to be true.

Despite this, participants were eager to learn more about how universal health care would work, suggesting that the Task Force continue engaging with the community using transparency as a critical element in the process. They were very interested in learning more specifics and had many questions that the Task Force took the time to explain and answer one by one. Most were interested in knowing more specifics of how they will be able to pay for the plan and what the plan will cover. Some were also interested in what will happen to the workforce that now depends on the current system. They brought their ideas on how the system should work and what the task force should do. There was much willingness to continue learning and engaging with the Task Force.

The following are recommendations from LMS and participants from the community listening sessions.

Recommendations

- Continue to let the community know about the plan and establish the channels to continue the conversation. It is essential for the Task Force to continue to listen and learn from those closest to the problems, for they are closest to the solution.

    - Continue investing in community engagement through virtual town halls and roundtable conversations.
    - Develop a simple and short toolkit that includes the presentation and Q&A to be distributed among CBO and other community groups.
    - Develop a marketing plan and share the channels for the public to provide feedback and support.
    - Create a short podcast with Task Force's latest news and distribute it to keep the community informed.
    - Continue to engage with the community using social media, emails, and CBOs.
- Be more explicit about the cost of coverage, eligibility, and the benefit that Oregonians would receive through this system.
    - Spell out who would be eligible for the system and explain the philosophy of "Everybody in; nobody out."
    - Create a universal language to explain how much health care will cost, using graphics and less jargon, explaining how people/families will pay for the plan.
    - Use the COVID-19 pandemic as an example for the plan and explain how the program will benefit Oregonians in the event of a future epidemic or pandemic.
- Draw a process map explaining how long the process will take and why it requires years to be able to take form.
- Include in your planning how this new system will offer training and provide workforce development for those whose roles will become obsolete under the new UHCP.
- Continue learning from the failures and successes of national and international health care systems.
- Train all members of the Task Force, associated community advocates and other trusted community members to be ambassadors of Universal Health Care in the community.
- Celebrate the work done thus far.

It will continue to be essential for the Task Force to provide a platform for ongoing discourse with all Oregonians and allow participants to bring unique insight to and from their communities' needs, wants, and challenges.

Appendix

Appendix A

Synthesized Notes | Universal Health Care Plan | General Questions and Comments 2022

<u>Access and Affordability</u>

Traveling:

- Will the Oregon Health Plan be available while in a foreign country?
- How will snowbirds obtain care when out of state?
- Will I be covered if I travel out of state/country? Because my current INS does cover me. I am retired and plan to travel.
- What happens when a patient moves out of state? (traveling/ moves)
- Would consultations outside the state be covered by the plan?
- Are there any plans on expanding this plan to allow it to cover providers in other states?
    - There is a very limited number of providers, and unless they go to Portland, most people have no option but to go to Idaho.
- How will care be provided/covered for care needed when traveling out of state?
- Live in Ontario (border of Idaho). I didn't hear that this will be replacing the OHP. Are there any plans for expanding and allowing this plan to cover providers in other states?

Lack of access:

- If it's tough to get care now, how are you going to make it better?
- Right now, we have long waits for appointments due to covid, sometimes up to 6 months. What thoughts does the committee have about this problem? Will it be short-term?
- Does it mean that there will be longer lines and longer waits because everyone will be insured? Don't you think this can increase discrimination?

Provider shortage:

- Do we have enough providers?
- If there are provider shortages, could some of the funds be used to pay scholarships for medical students?
- There is a serious shortage of many specialties in Oregon today (Rheumatologists, Endocrinologists, and others). How will the new system address and remedy this?
- I see much negative speculation about this plan. I'm thinking that the lower administrative costs will lure specialists to practice in Oregon. Am I naive?
- Do we have enough providers to serve all these folks?
- If everyone has equal access, there will surely be shortages of providers etc., not criticism, just reality as already there are often long waits for specialists and surgeries.
- There's a tremendous workforce shortage, so how will you promote nurses and nurse practitioners and address the need to get caregivers and family support to get people a palette of care away from the hospital?

- Is there anything that encourages, say, increasing providers of primary care, such as advanced practice RNs?
- The physician and nursing shortage could be partly resolved by allowing the thousands of well-trained physicians in other countries who apply for entry to the USA be allowed in.

Authorization:
- Will there be authorization for procedures?
- Will there be prior authorizations required for some care?

<u>Insurance Companies</u>
Increased costs:
- Not all services will be covered under this plan, and private services will target those services that the Universal Health Insurance doesn't cover. Do you think they would take advantage of this and overcharge their premium?

Integration:
- How will insurance companies be part of the system?
- What are you envisioning current health plans providing?
- How will the Oregon DHP be incorporated with the veteran insurance?
- Currently, there is the Oregon Health Plan, Marketplace Plans and then other programs providing care at low or no cost. How will this Plan change and integrate all into one? and what would that system look like?
- How would this work with groups like Kaiser, who insure and provide? Are groups like Kaiser willing to take UHP?

Pushback from Insurance companies:
- I think that this will be an uphill battle and that there might be a lot of people or insurance companies who aren't onboard with this.
- I think the biggest obstacle is the fight back that will come from corporate, for-profit health care. It will be a huge battle. The money will pour into the campaign against...
- Statewide there is increasing activity and influence of for-profit private equity groups from outside of the state becoming the owners of health care accessibility, governance and clients. It seems logical to assume that these for-profit groups would present significant pushback since statewide UHCP would no doubt threaten their profit as well as disbursements to investors. As the Task Force continues on its work, how do you see the impact of these groups with their wealth and political power?
- When Oregon citizens got a universal health care measure on the ballot, it was soundly defeated by the mass amount of money the insurance medical industry put into the opposition.

<u>Coverage and Benefits</u>
General sentiment:
- Medical treatment is the most important thing for me.

Transgender care:

- Will gender affirming be covered?

Alternative care:

- Will alternative medicine such as naturopathic doctors, chiropractic, acupuncture, massage, etc., be covered?
- Are nutrition, physical therapy, and chiropractic services going to be covered?
- Will alternative medicine be covered?
- Are non-licensed peer-type services covered?
- Would this plan include other types of treatment like alt treatments that people find in their own countries or that we can't find here?
- Will this plan include alternative/homeopathic care?
- We need to make sure that non-traditional care is covered, acupuncture, chiropractor, and Chinese herbs.

Long-term care/ chronic illnesses:

- Is long-term care being considered?
- Would this plan include heart surgery?
- Will this plan include treatment for lupus, cancer, and heart attacks/diseases?
- What about transplants? Would this get covered right now (I understand that it might not)?
- Public Employees' Benefit Board does one wonderful thing that I hope you will replicate: All diabetes supplies are covered 100%. That includes many different types of blood sugar monitors, including very expensive continuous glucose monitors. Not cheap, but still cheaper than trying to repair us when we can't afford good maintenance.
- Lots of older people and Latinos have diabetes and don't have a lot of access to money or health services. If this passes, would this help people access wheelchairs and prosthetics because this can lead to a lot of health issues when unchecked, and a lot of people have to have their legs amputated because of this?

Drug coverage:

- Is there a consideration of prior authorizations for drugs covered under the system?
- Does the plan cover pharmaceuticals?
- Will all medicines be covered?
- Will this plan include medicine?
- Does the plan cover pharmacy? Some drugs are incredibly expensive. Will all drugs be covered? If not, who will decide who gets that pricey drug and who dies?
- I wish that medicine received more attention.
- My husband's cancer drug costs $15,495 per month. Will the Plan be able to reduce drug costs?

Hearing Benefit:

- Is there a hearing benefit?

- Will hearing aids be covered?
    - Why were hearing benefits not included? The cost of hearing aids is quite high.

<u>Healthcare Providers and Payment to Providers</u>

Mandatory Participation:

- Will the participation of all Doctors and providers be mandatory?
- What will stop doctors from crossing state lines to practice?
- Will some providers completely opt out?
- Will there be an incentive for people to use urgent care or primary care providers rather than more expensive emergency rooms?
- What happens if providers opt out?
    - If providers may opt out, how can this system work? How can we get the provider of our choice? Will we be narrowly limited in terms of providers in the system?
- How will this solve the shortage of specialists in the state?

Participation Standards:

- Excellent concept and plan. Will there be required minimum standard components for all participating providers based on best practice guidelines by acuity, illness, and population to address QD?
- I hope that this plan will allow for guaranteed minimum required best practices: guidelines for participating providers by age, illness, and population, such as well, child care, prenatal care and other issues. If you didn't provide a certain minimum standard, you couldn't participate. I'm wondering if that's something that would be considered?

Payment to Providers:

- (On Central Oregon's health council) Will this plan pay a higher rate to providers than Oregon Health Plan's 35%?
- If there is a drop in provider income, then less desired harder to recruit providers?
    - I am also worried about a drop in provider income that might be a disincentive to recruiting providers.
- Comment: Under a global budget that is recommended in the Task Force proposal, regional healthcare administrators can choose how to reimburse providers in ways that satisfy and maintain the workforce, whether this is through fee-for-service or fee-for-time.
- Comment: Please don't use today's model of value-based payments.
- Fee-for-service percent is not the main problem with today's healthcare system. Most countries with successful universal healthcare systems still use fee-for-service but in equitable, enforceable ways.

Administration/ Effective Management:

- Will there be intentional efforts to reduce the burden of paperwork and documentation?
- Comment: Providers will see a decrease in expenditures. Considering the aggregate spending for administrative overhead.

Privatization:

- We are seeing a lot of privatization; should this be a concern?
- Will hospitals continue to be privately owned? Will they be allowed to turn away patients?
- Will there be oversight of private hospitals?
    - Over a month's time, my daughter was turned away by the emergency rooms of hospitals run by one business until she finally developed a life-threatening condition that has left her using a walker due to brain damage. They kept refusing to hospitalize her.

Employers and Employees

- Will this eliminate employer-based insurance?
- What happens to people like myself, who are currently ensured through an employer?

Governance

Technical Concerns About Federal Legislation:

- Does the implementation of this plan depend on the Federal Government making changes or passing laws? If so, what is the plan if we can't get those changes?
- Impressed with the work of the Task Force, however, in order to pass or implement a single payer, federal legislation [is] needed. Will the Task Force recommend legislation to support single payer universal care?
- How do these proposals fit in with the need for a much more robust and sustainable public health system?
- In regard to being prepped for pushback, do we need federal approval once this bill is passed in the state?

Effective system management:

- Much needs to be planned, and other issues will not come out until after implementation. I support HCAO with very careful planning and room to adjust as necessary; thanks.
- I understand a public-private entity such as the SAIF program is being contemplated [to govern this program]. What are the Task Force's thoughts on how to create a truly effective management system for single payer in Oregon?

Governance board:

- Who will be on the governing board?
- How many people will be on the governing board, and how will you make sure it is diverse?
- We need more community engagement and input from the BIPOC, Disabled and Veteran community etc., for the success of the single payer program.
    - Diverse voices must be represented strongly on the governing board for the plan to work.
- Who will be the governing board?
- I recommend the Board be representative of the diverse community and an oversight system of diverse communities as well for the success of the single plan.

Other States:

- Are there lessons from other states?
- Do you know of any other state using a single-payer plan?
    - Are those plans being overseen by the state government?
- Is Oregon the first state to have this system?
- Have there been conversations about Universal Health Care with Washington State and California - perhaps a regional program?
- It'd be great if every state had a Universal program, but that's not [a] reality for now.

CBO Participation:

- We hope that community-based organizations already doing this work will be included in that outreach- very important for helping people sign up for HC.
- Has there been any feedback from employers, hospitals, and providers about whether or not they support these measures?
- Who from the provider community has been involved in discussions regarding this plan?
- The Task Force is justifiably emphasizing [the] creation of a system that is equitable and allows all residents access to care. Meanwhile, you know that the Oregon system will need to fit into a national economy and will need to be palatable to policymakers who will or won't approve spending federal funds on the Oregon UHP. How is the Task Force approaching the need to address business-model concerns of private providers and policy-makers?
- Do you plan to talk with the statewide health councils?
- Have you reached out to the Oregon Latino Health Coalition and other CBOs that serve the community?
- Are unions involved?
    - Where are unions on this?
    - It seems pretty important for Unions to be onboard. I would be really interested in what they would say would be important in order to protect their people. As being a member of a teacher's union – it would be amazing to not have to bargain on health care. [I] would rather focus on other things, like class size. Talking with unions will be really important in advance. Unions will be super important.
    - Among unions, I would not expect all having the same views/concerns etc. Often there is a difference between [the] public sector and private sector unions, and some unions have members in both sectors.
- Will the Task Force meet with Canadian and Scandinavian government experts to learn from them about how to best implement this system?

Concerns about Opposition:

- What do you see as the barriers that would come out of the legislation?
- What do we do if those who believe the government should not provide for its people take over the federal government?
- I don't know if this will pass in the federal gov: have there been talks about getting past federal pushback and/or lawsuits?

- Considering the role of private equity, DCE's and dark money in politics, I do see additional pushback against implementation from out-of-state employers who have OR employees.
- Do we have enough money to counter the forces on the other side?
- In regards to being prepped for pushback: the pdf that was sent out said that once it's passed in the state, it would need federal approval. Imagine it would pass in Oregon but does not have faith in the federal government, given the times we are living in. Have there been discussions regarding federal pushback?

Suggestions/Questions about supporting the plan:

- What do you encourage us to do to help get this through legislation?
- [I] want people to help put pressure on Congress to pass the bill that would allow the Federal Government to sign waivers to give us funds for single payer healthcare systems.
- When it's time to take it up to legislation, find folks who are general community members to testify in support of the bill. This is great work being done and making sure the community is informed.
- A more aggressive marketing campaign will spur a marketing campaign by the for-profit medical industry. Please think [about] how we could inoculate this plan against big corporate money.
- How can we help protect this plan? In light of the fact that we have had an attack on a lot of these rights, are we going to beef up the legal language of HCAO?
- I would strongly urge finding community members to testify in support of the bill.

<u>Cost and Funding</u>

Taxes:

- What will be taxed?
- Will Roth IRA distributions count as income for this tax? (I'm not sure I care, but this may be related to the opt-out question.)
- What will we pay?
- Will we end up paying more?
- Will state taxes increase?
- Are taxes going to increase?
- Who will be taxed?
- Who is taxed when a person does not have any employer since you said employers pay tax on wages?
- Will the payroll tax include people who are hired out of state?
- Will retired people on Medicare be taxed?
- How can we make this fair?
- Comment: I am a huge fan of universal health care and will fight for it, but I am troubled by the Task Force's high reliance on W-2 Income because it is so easy for so many to avoid classifying the money they live on as W-2. I'm not just talking about the huge "under the table" and "unreported income" economy, but also the rich who have the option of reclassifying the money they live on as dividends or loans on appreciating

assets rather than W-2 income. The temptation to do this for someone facing $40,000.00 for a 10% tax on a $400,000.00 income. How do you plan to have these people pay their fair share for our universal health care?
- How can you guarantee that this will be equitable or cost me less as an individual Oregonian?
- Those who make more will be burdened by the expense of funding the program?
- When CCOs were implemented in OR, it put the burden on those who make more who then don't want to work as much if it is not fair. What is equity? Those who make more pay more. There is an incentive to earn less money.
- Very supportive of universal care in Oregon. Thinks that the new system will incentivize people to earn less money. Deeply concerned that those who make more will bear the brunt of the cost. Not fair if those who make more money will pay $500 or $600/ month.
- If I make a higher wage right now, I have the choice to choose a higher deductible plan, as I am a healthy individual. From this presentation, it sounds like I will not have a choice on a plan and will be forced to pay a tax that will cover everyone at a rate that is higher for those in a higher income bracket. It sounds like this plan will actually cost more for some individuals, and they will not have a choice. This is not an equitable model.

Suggestions:
- Say if employers and individuals are playing in on a flat basis where you don't have progressive taxes. So if the contribution is already flat, like 5% of our payroll, then there is already a discrepancy in the amount that people pay into it even if the utility is the same. We are already very dependent on the upper half of the income taxes. If you double down on that too much, and the people you're hoping to provide care to fall into that category too much, you could lose what you're trying to gain. So what would it look like if you went flat (on the taxation rate), that'd be the suggestion with taxation.
    - Oregon state tax is essentially flat/ Fix tax is regressive == evil.
- So to follow up on that, maybe, like the Federal tax, we can have a limit on the taxes paid. We could disregard the first X dollars of people's income and then have people start paying so that many of our seniors who can’t afford it or those on low income will still be able to afford paying their taxes at the end of the year.
- Has the Task Force considered a tiered income threshold for taxing interest and dividends earned above a defined upper cap?

Blended Funding:
- Part of the funding comes from federal programs. What if that funding is reduced or ended?
- Does the Plan have to negotiate with the Federal Government to use Medicaid funds? How is the Plan related to Medicare?

Risk-based expenditures:
- How do we calculate the risk-based expense, like other types of insurance?
- Why should we pay for people whose behavior places them in active harm?

- Also, in other plans, everyone has a card, and they have ways to make sure that overutilizers are held accountable. We need to have that; I think it can be important to have some system to decide on what treatments or procedures are applications and which are not.
- How do we navigate for voluntary high-risk behaviors - i.e., tobacco use and things that contribute to poor health outcomes? Is risk-based being considered? Why are we paying for healthcare who [is] contributing to their own poor outcomes?

Utilization costs/ over-stretching our program:

- How can we see the modeling of cost and utilization? My concern is that the proposed coverage far exceeds what I have had while using the very best coverage I have been able to access that is likely on the more robust and comprehensive end of the spectrum.
- Excess utilization from patients with unaddressed illness and overutilization bankrupted some med advantage plans that had rapid rollouts. How will utilization be monitored and controlled to avoid excess costs?
- Containment and utilization – so many sick people entered into the systems, so many companies went bankrupt- how will you effectively provide care without going bankrupt?
- I'm concerned that people might come here to get expensive procedures done, and if too many people do that, our taxes and other funding won't be enough to cover the costs.
- As our global experience of Covid evolves, we are also seeing long-term chronic health challenges becoming part of our health care program in the future. There is the possibility that current health insurance companies [will] collapse under the financial load.
    - As our global experience of Covid evolves, will our current provider system collapse? There are many going bankrupt to pay for the treatments needed after covid.
- How will they be prepared so that the program doesn't collapse (with an influx of more people)?

<u>Medicare and Medicaid</u>

Will those on Medicaid still have to pay premiums?

- Would those eligible for medicare still pay the federal part a premium?
- Would People already using medicare pay income-based tax for Universal Healthcare?
- For those of us on Medicare, would we continue to pay Part B premiums and premiums for drug coverage?

Confusion over what the plan will cover vs. Medicaid:

- I had Public Employees' Benefit Board before I retired. It had a tier system for RX payments. On my Medicare Advantage plan, there is another tier system, but it pays less for some meds. Would the Medicare Advantage plans change?
- Also worried that this will make it harder for people on Medicare to get help if providers can refuse to help them due to financial motivation.
- Will this replace Medicaid and OHP?

- Medicare is very specific about what they do and don't cover. Do you have an idea if they are open to negotiation?

Eligibility and Enrollment

- Does this cover houseless individuals or non-residents?
- Will Federal Elected Officials from Oregon automatically be enrolled in the Oregon Plan?
- How does this affect Native Americans if they have said they have no interest in Universal Health care but just to fund treaties?
- What are private patients in this program?
- Will people with chronic diseases be covered?
- Will the payroll tax include out-of-state employers who employ Oregon Residents?
- Do you intend to cover every Nike employee worldwide since they are based in Beaverton, Oregon?
- What if you don't have a job? Are you still eligible?
- How would enrollment work for migrants and seasonal workers? For those who move in and out of state or are not here year-round? Would they be eligible for the program?
- Would undocumented people or individuals without SSNs would be covered by this plan? What about people on work or student visas?
- Have you figured out how this will cater to seniors? Or people who have no economic support?
- [A] true blessing if this will happen, especially for people who are undocumented.

Concern for Residents without legal status:

- Concerned about mixing federal money and the community's money to fund programs because people without legal status might get in trouble with the federal government.
- What forms of identification will be needed?
- How does this plan ensure the safety of people without SSNs or who don't have legal status?

People moving in from out of state:

- How [do they] handle when non-residents come in to get free health care?
- How do we make sure people don't move to Oregon for free healthcare?
- Is there a way to make sure that residents of other states can't claim to be an Oregon resident to get free care?
- How will we keep track of those coming into the state to receive free health care? Once a year? But what about those that move out of state?
- [I'm] worried about incentives, overutilization with people migration from other states wanting free healthcare.
- Triage and waiting lists? People moving in and out of State - If one leaves Oregon, does the individual immediately lose insurance? If one comes from out of State, what is the waiting period, if any, to get the insurance?
- It seems like this new program can be like a magnet to attract people from other states. Have you considered the increase in people that the state of Oregon will have?

- It seems that this new program can be a magnet to attract a lot of people from other states. Are you considering the risk that the state of Oregon will have? How will they be prepared so that the program doesn't collapse?

Focus on Equity and SDOH

Lack of Equity to Underserved/Overburdened:

- The suggestion I have is how the committee is engaging with communities of color and other communities in the metro area not represented on this call.
- Comment: The community participants, any time we want to change the system, it leads to premature deaths from minorities. Think about the delivery of the new plan. The strategies must be considered in regards to DEIB and the arguments presented to legislators. There will not be a complete solution to all of our current problems. As a Task Force, they need to design a system for an equitable solution.
- Comment: This change in [the] program is not going to fix racism/discrimination in healthcare for sure.

Comments/Suggestions:

- Lots of participants in the Metro, Spanish, and Willamette groups included appreciative messages for this new HC plan. I don't know if this carried over to other groups as well, but I think that it is safe to assume that a lot of participants in these sessions, regardless of where they came from, were appreciative of the plan and of the community session itself for bringing about what they consider is a change for the better in health care and for informing them of the current plans specifics/benefits for the community.

Outreach/ Plan Rollout

- [Are there] plans moving forward?
- Also, a few comments would be appreciated about the steps beyond this really rather theoretical design process of the next steps for potential implementation.

Suggestions for Outreach:

- My initial suggestion would be to have a more assertive marketing campaign regarding this Task Force. I only stumbled upon information about it purely by accident, and everyone I have talked to is unaware of it--and I'm in healthcare.
- Marketing may have been a poor term... It's hard to get feedback when people don't know about the work of the Task Force and therefore don't know how to attend a meeting to give feedback.
- Has the Task Force interacted and spoken with indigenous groups before?
    - If not, do so.
- Create new programs so that people can become health promoters and help people learn about the plan.
- Use community organizations and use simple language for all materials.
- Recommends using CBOs for outreach and education.
- Focus on giving a lot of information about the benefits of this plan; that's what's most important. You have to make the benefits clear, not just the inner workings of the system.

    - Translation and interpretation needs to be simple but very accurate.
- It is also important to make sure the community is informed and educated about this so that they can testify and accept this bill once it's passed.

Suggestions for Rollout:

- How can education lead to understanding of all these complicated health care issues and an explanation of the proposed plan?
- A smooth conversion from the current system to the new system is essential. The State has previously failed miserably on large database projects. What is being done to ensure that a smooth staged conversion occurs?
- Effective roll-out and management of a universal system will be key. Several state agencies, such as the unemployment system, failed to get benefits out during the pandemic in a timely manner.
- We've got to get Oregonians on board and understand what they're gonna pay, what this will cost them, and the benefits of this plan early on. Don't wait to educate them until you're out the gate and ready to go to the Legislature. I think that as much education as you can start rolling out about this like you did with covid and the vaccines will be important so that by the time that you start rolling this out, it won't be a foreign concept, and people will know how to engage with this system and be supportive of it.
- Suggest to use health promoters to communicate about the new plan. Create a program for people to become health promoters and help more.
- Once this passes, put information out in both Spanish and English
- How can Covid be used to explain the benefits of this plan? From acquiring PPE to mixed messages sent to the public, is this an area we could do better?

More information:

- This is a blessing for the Latino community, undocumented people, and families of mixed status. But how will we keep in touch? What are your next steps? How will we stay informed or keep the Latinx community engaged with this program?
- Will the recording be available to view later for all? For those who have registered?
- How will those who submitted written testimony know it was received?
- Will the slides be available for us to share with those who couldn't attend?
- You mentioned an anonymous survey request for those present today. Will you provide that in that chat again for those who did not see it?

Appendix B

Coastal Oregon | Community Listening Session Notes 06/10/2022

Access and Affordability

Questions:

- For people who qualify in Oregon - do they need an address? Does this cover houseless people? Does this cover visiting family members?
- Will this eliminate the need for COBRA?

Comments:

- The current healthcare entities compete with each other by leveling the playing field; it will decrease the need for mergers because it will be a system focused on health instead of profits.
- In 2021, the Oregon legislature passed a bill to allow OHA to review and possibly veto mergers and acquisitions of hospitals. There are less institutions, but the value of the institutions has gotten larger and larger.

Coverage and Benefits

Questions:

- What do alternative care providers cover?

Comments:

- I am glad that there's an emphasis on primary care.

Governance

Questions:

- Can someone explain how this will decrease fraud?
- How can you track fraud?
- Based on this response, will the workman's comp go away?
- How can you ensure that medical companies won't increase costs to the state?

Healthcare Providers and Participation

Questions:

- Will this affect the way services are provided?
- Will this affect our ability to bring medical providers to Oregon?
- Is it likely that some provider groups will end up without an entity to work for and will then end up with a decreased workforce?
    - Is it possible that some of these providers could end up without an entity to work for? Will this stop the consolidation?
- Is there a set definition of what an alternative provider is?
- How will this plan affect training programs for health care providers?
- How can you ensure that providers will not charge an additional fee?
- How will unlicensed healthcare providers be paid for their services?

Cost and Funding

Questions:

- Is there a draft of what this will cost based on income range?

Medicare and Medicaid

Comments:

- I am glad to hear that Medicare and Medicaid are both included.

Focus on Equity and SDOH

Comments:

- Comparing this system to welfare. No matter how much you make, you still get the same great care.

Appendix C

Central Oregon Community Listening Session Notes 6/14/2022

Access and Affordability

Questions:

- What is the biggest obstacle we need to worry about that could derail this?
- If this plan passes, when will it be available to Oregonians?

Comments:

- Thankful for hard work and glad to hear they will work on transition - a grassroots activist in health care, mental health, and the environment. We will need more health care with climate change - i.e., smoke, heat …
- Championing Single payer health care and her partner is in the ER. Reasons why this is great. We are so excited about what you are doing. Healthcare professionals encounter so much stress working with patients who are deciding whether or not they can get the care they need. This state will attract people. Also, people delaying care is so much more expensive.
- Also, transportation is a big issue - see people on FB (in La Pine) asking on FB for transport to medical transport.

Coverage and Benefits:

Questions:

- [What is the] difference between behavioral health and mental health?

Healthcare Providers and Participation:

Questions:

- Has there been discussion on including a recommendation that Healthcare billing and insurance professionals receive retraining and career advancement assistance?
- Will this plan attract more multicultural staff - especially in the mental health area?

Employers and Employees

Questions:

- Employers can still provide other plans. What does that look like and mean?
- Private employers will probably save money; what about public employers? Would this help communities to have more money?

Comments:

- Thinking about the small employers (possibly family-run - restaurants, food providers, food carts with small profits.) Imagine that health insurance companies are not excited about this.

Governance

Questions:

- What are the main substantive arguments of legislators who oppose this plan?

Comments:

- I think it's really important to have a solid platform for managing patient records. I hope you are considering how to not lose data for someone who currently has insurance and has years with the same insurer and then also how to capture all patient info in one Single payer platform online.

Medicaid and Medicare:

Comments:

- I hope the government agreements have some sort of reimbursements for Medicare and Medicaid.

Appendix D

Eastern Oregon Community Listening Session Notes 6/15/22

Access and Affordability

Questions:

- What is the date that the Task Force is wanting to implement this program?
- Will there be subsidies for transportation and services to appointments?

Comments:

- Universal healthcare would not be a good idea; it would flood the systems and make it more inaccessible.
- Nothing quite exposes the inequalities that exist in American society more than the health care system. It's a complex combination of private insurance, public programs and politics that drives up costs, creating significant barriers to lifesaving medical treatment for large segments of the population. In America, access to quality health care so often depends on income, employment and status. Your work has truly exposed these vulnerabilities Oregon residents face and how the plan can and would usher in a new generation of HOPE for everyone. Thank you to the Task Force, Staff and Everyone for your hard work and dedication to this proposal.

Insurance Companies

Questions:

- Would Insurance Premiums continue to be an allowed deduction for individuals and businesses?

Healthcare Providers and Participation:

Comments:

- Can you provide any comments on the recruitment of providers to participate in regards to the provider shortages that are common in rural areas? You may have touched on this when you talked about the different reimbursement rates for different insurance programs.

Employers and Employees

Comments:

- When the Task Force talks to business owners, they may find that many employers mourn the fact that they cannot provide employees with health insurance options. Our current system of costly health insurance prevents businesses from ensuring that they have a healthy workforce and many good employees leave to seek health insurance benefits. This is not good for our communities economic growth. Business owners have talked about losing staff that they have trained. It's discouraging, especially for small businesses.

Governance:

Comments:

- This will be the first important step in transforming the current “mess” that is healthcare in Oregon and the US. Getting everyone “under the same” tent” will allow other changes to improve equity and quality for all. Happy to pay increased taxes if it assures care for everyone!
- I think about the pushback of the political climate we are in now- it would be great for the Task Force to see what that pushback will be like if we move forward. There will be more demand. Her experience in another country is they go to the doctor a lot (more than we do here), and they get things diagnosed early! We may have some clumsy years of pushback, but in the long run, the preventative care benefits and how it will affect our behavior as us as consumers.

Cost and Funding

Questions:

- Is Oregon's universal healthcare expected to come down in price over the years, more in line with Europe?
- Would the healthcare tax be based on gross or net income?

Comments:

- Being rich enough and healthy enough to resent paying more without reaping immediate benefits can change with one diagnosis as well as with just aging. I know it happened to me. Having no fear of bankruptcy is worth paying more for the assurance that care will not break one's bank account--or prevent getting care at all.
- [My son]... is 31 years old and works hard to stay under hours to qualify for the Oregon health plan. [He] can not go over because the employer provides expensive health care premiums and can not afford it. [I] appreciate that the plan being proposed is not tied to the work that you do. [My] family in Canada has good healthcare with no waits.

Medicare and Medicaid

Comments:

- No bills and the transition to medicare, admin costs, etc.- that is the best thing, NO BILLS! Rural healthcare means waiting, and you don’t usually see your provider. Likes that you won’t have to deal with INS companies and a more predictable system for employers.

Appendix E

Southern Oregon Community Listening Session Notes 6/18/22

Access and Affordability

Questions:

- How will this plan affect folks with felonies and those who don't work?

Comments:

- Likes the plan. Want to make sure that the emphasis is on prevention and health, not a disease. Wants the plan to be proactive and preventative.
- Based on the folks I know, people are very confused about health care. I'm not sure the average person even conceives the meaning "Everybody In and Nobody Out."

Coverage and Benefits

Comments:

- Benefits - really should call out dental and vision for medicare. Should have prevention; first 1000 days of life care for babies. Every new family should have health care providers visiting their homes.

Employers and Employees

Questions:

- What outreach are you doing to reach out to employees?
- How is it envisioned this plan will be coordinated with work-related injuries & workers' compensation?

Comments:

- [I] recently retired from health care in Medford – [I'm] concerned about health care prices for the workforce – what outreach are you doing to reach out to employees? I love this plan. It is the process of getting there that concerns me.

Governance

Questions:

- How will your plan redress the other provisions of the ACA that have been watered down or removed?
- Why would the amount contributed [from] the federal portion increase by $2.5B? Is it a likely stumbling block for the opposition? Would it not be better to move this to households and employers?

Comments:

- [I] love this plan. [I] want to see it approved at the state and federal levels.
- I am severely disabled and live in rural Jackson County. I advocate for seniors, people with disabilities, the deaf & hard of hearing. The ACA was watered down by the prior administration, especially the 1551 provisions on effective communication.

Cost and Funding

Questions:

- What will payment rates look like based on region?
- The presentation is clear that this will cost less. But so many of the middle folks have been convinced that it will cost much more. What is the Task Force's plan to address the communication issues?

Comments:

- Be wary of unintended consequences - [I don't] want a 9% rate affecting new Blazers team members, but perhaps a property tax surcharge of physical investments that have a value of 100K or more. [I] want to find a way to get at CEOs who live in Menlo Park.
- Foundational issue – dedicated a primary part of savings going to communities to be driven by community leader councils and have them come up with innovative preventative strategies for the communities (use 50% of the savings for this) (many other countries spend 30% on prevention and in the general US only spends 3% on prevention) Really think about neighborhoods in sub-county level, not just region.
- I hope you are interfacing with the Public Health system to get their ideas. Think of the money saved by the decrease in tobacco.
- [I] wanted to clarify that sharing savings would equal higher taxes. What if we save $450M and invest $450M in the state - this would go a long way. This would really be a benefit. [I] will submit in writing property tax, ERISA, … and for savings – [I] need to think about the medical component of savings for workers comp cost to employers.

Eligibility and Enrollment

Questions:

- Will ODHS/Aging & People with Disabilities no longer be tasked with determining medical eligibility for consumers of Long Term Services and Supports? Has that savings been quantified?

Comments:

- [I have] a kid – quadriplegic – and pre-pandemic parents were not allowed to be paid to be the caregiver. [My] son has never gone more than a couple [of] months out of the hospital, but when [I] was the primary caregiver, he hasn't been in the hospital.

Healthcare Providers and Participation

Questions:

- How will your plan lessen the administrative red tape providers must address so that they can free up time to treat patients?
- Will we see many clinics refuse to participate and insist on only seeing "private" or self-pay patients? Is there a way to prevent this from happening entirely, or is it going to be an expected side effect? If it is, can we minimize its social stratification of participants (vs. private patients) and the economic setback it will have on the risk pool of public insureds?

Comments:

- I would like an explanation on whether or not universal single-payer health care (USPHC) can mandate that providers and clinics accept patients covered in USPHC.

Focus on Equity and SDOH

Questions:

- How is this fair? How are outcomes for these people going to be equitable (people with disabilities)? In your plan, will there be an ADA enforcer? How will the ADA be enforced?
- How are you planning to establish trust, especially among communities that have been left behind?
- Will this plan address healthier lifestyles?

Comments:

- The ADA has been around for over 30 years. Yet providers still are reluctant to accommodate people with disabilities in many ways. I cannot be examined like other patients in my provider's exam room because there are no lifts to transfer me from my wheelchair. Deaf people are required to use Video Relay Interpretation that freezes or has an interpreter that cannot be understood. There are no hearing loops for [the] hard of hearing who often are told to communicate and understand their providers by writing on a tablet.

Appendix F

Portland Metro Community Listening Session Notes 6/21/22

Access and Affordability

Questions:

- Does the Task Force have a website?

Comments:

- If we hope to keep a plan affordable, we must keep private investors out of it. Check out ACO REACH, previously Direct Contracting Entities. Begun in the Trump administration and [is] ongoing in the current administration. Once again, please learn about ACO REACH and Direct Contracting Entities. That initiative would finally privatize Medicare to the benefit of investors.

Coverage and Benefits:

Comments:

- We have a long way to go for behavioral health and mental health in our state.

Healthcare Providers and Participants:

Questions:

- Retired DR question- enough providers? If there is a drop in provider income, then less desired harder to recruit providers?
- [Minimum] required best practices guidelines- if you don't provide the same quality standard, how will you promote nurses and docs etc.?

Governance

Success criteria:

- Good intentions have led to bad structural interventions and worse outcomes when existing delivery systems and dominant political and economic forces overwhelm citizen input despite claims of equity in [the] process. Your regional system echoes the old HSA, which was a disaster; you will need metrics to ensure effective public participation.
- Success metrics are important! Success metrics are crucial, and they need to be planned for and implemented early. They may mature, but they can't be pushed off till later.
- What are/will be the "success criteria" which will manage the plan, and when/how will they be implemented?

Questions:

- How would these events impact the healthcare system, and what systems and safety measures will be put in place to keep the communities whole?

Comments:

- We need to take into account uncontrollable events such as climate, economy, crisis, increased population and war.

- The plan you did the financial analysis on was single payer. After that, votes have been taken on the structure of the plan that made it not [a] single payer. So the multi-payer plan you are designing is more expensive and less equitable than the plan you did the financial analysis on.
- Sorry to say, but VA operates in a wasteful and fragmented way. [This is based on] personal experience compared to several other systems within which I have worked. The model, unfortunately, led to lower income and FQHCs closing down rather than being boosted up in their expertise in providing care to lower covered people and high-need complex patients.

Cost and Funding

Questions:

- How upstream investments will be streamed?
- Savings? Where will they go? Legislators have sticky hands! How will you pay for it? Once a year? But what about those that move out of state? A separate fund dedicated and only spent on universal health care governed by the board and not the legislator.

Comments:

- I can envision how income from state and federal tax streams could be blended and then used to pay for the services projected to be available. I'm astonished at the actuary's projection that a mere $990 billion would be saved since CMMS runs Medicare at a 2% overhead rate, and if we can do as well, it ought to produce greater savings. What would destroy the savings would be to permit private, for-profit "management" companies into the mix.

Medicare and Medicaid

Questions:

- Can seniors opt out & stay with Medicare? I think this plan will cost seniors with passive income more than they pay now.
- Do retired people pay income-based tax for universal healthcare? People [are] already using medicare.
- Will Medicaid estate recovery - mandated by the feds, be continued?
- Where and when will we get details about how the Oregon plan will interact with Medicare?
- If you are on medicare, will you be able to opt-out? - No.
- Are you going to seek total elimination of Medicaid state recovery?

Focus on Equity and SDOH

Questions:

- Will this address the homeless problem in some way? By the homeless problem, I meant the SDOH.

Comments:

- Oregon will become an even better place for houseless people around the country.

Appendix G

Willamette Valley | Community Listening Session Notes 06/25/22

Access and Affordability

Questions:

- How will the new system assure doctors more time to meet with their patients to practice preventative care and to do the needed tests without being based on a proof system that denies care?
- Availability of medical staff with a shift in incentives, and how will the program ensure there is enough capacity?
- I have a rare condition, Waldenstrom's Macroglobulinemia; the experts are at the Mayo Clinic in Minnesota and the Dana- Farber Cancer Clinic in Boston. Would consultations with out-of-state experts be covered?
- How can we get the provider of our choice? Will we be narrowly limited in terms of providers in the system?
- Will all folks who are covered under the plan be able to select hospitals, specialists, and other care providers in Portland if they live in a county outside the Portland metro area?

Insurance Companies:

Questions:

- How will the Oregon UHP integrate with the Federal government? Veterans' health care system?

Coverage and Benefits

Questions:

- Will there be any diagnoses that are not covered (autism)?
- Will the plan employ case managers?
- Along that line of thought (long COVID), it is clear now that SARS-CoV-2 will be with us for the long term. And the disease comes in waves as mutation of the virus occurs in 38+ species. The first round of vaccines are no longer effective. New vaccines are essential. The waves of COVID are clearly occurring at the same frequency as the fading of adaptive immunity from the vaccines or from recovering from the disease. As a result, to prevent most illnesses and long COVID will require vaccination with current working vaccines three times a year. To reduce severe disease and death, they need to be twice a year. The current belief that annual vaccination is in any way adequate is completely invalid. The immunologists and epidemiologists are having a hell of a time culturally in overcoming their training to recognize this. The public has no chance of understanding and accepting this until they do. What can be done to fix this? OHA has been utterly useless in this regard.

Comments:

- If we stop paying for the ABA Industrial Complex under [the] current OHP setup, the state would save a huge amount of money both on the 20-40 hours a week of services and on the PTSD that most Autistic Adults say they got from ABA. I know parents

pushed for this, but it has been proven to cause harm and not be effective, and the VA has done a study and stopped paying for it for active duty families. Early support of AAC devices for nonspeakers, SLP, and OT have been shown to be more effective with less harm.

Employers and Employees

Questions:

- I am concerned about the financial impact of covering out-of-state residents who work for Oregon employers.

Governance

Questions:

- How do out-of-state residents working in OR come into play? Ex: Nike employees.
- Has the Task Force considered the requirement to provide the Oregon administrator for the UHCP plan a copy of their last year's Fed/State tax return, as is required by those who utilize the Marketplace and receive an ACA tax credit?
- The behavioral health system is in deep trouble and is inadequate to meet the current needs. How will the wisdom of what we have learned in the past years be used to rebuild the BH system?
- How is the Task Force approaching the need to address business-model concerns of private providers and policy-makers?
- What are the Task Force's thoughts on how to create a truly effective management system for single payer in Oregon?
- Will there be intentional efforts to reduce the burden of paperwork and documentation?

Comments:

- I understand a public-private entity such as the SAIF program is being contemplated.
- There is a suggestion to use SAIF as a model or to base the organization on SAIF. This would be a horrific mistake. SAIF is based on the idea and philosophy of denying claims and care. Using SAIF or incorporating SAIF will be corrosive and destructive.
- Outcomes are more related to the ZIP Code of the patient and the provider than to meet VBP metrics. Incentives remain to up-code, cherry pick, and lemon drop. Under a global budget that is recommended in the Task Force proposal, regional healthcare administrators can choose how to reimburse providers in ways that satisfy and maintain the workforce, whether this is through fee-for-service or fee-for-time. Many countries with high-quality outcomes and population satisfaction still require low premiums or co-pays, or for selective services are usually not for primary care.
- For our state, let’s develop the equivalent of the United Kingdom’s National Institute for Comparative Effectiveness. We can pass such legislation before we approve a universal healthcare system.
- I would encourage recommending that the records system be flexible. The current electronic records systems have severe limitations that result in distorted and inaccurate records. For example, the systems include detailing allergies. But they do not allow for recognizing genetic information or including specific known issues like CYP450 enzyme information or family health issues. These end up having to be pushed into categories

where they do not belong. e.g., Having a family history of an abdominal aortic aneurysm can end up being recorded as having that issue rather than as having a vulnerability to it that needs to be watched for. A much better, more flexible record system is needed.
- Please don't use today's model of value-based payments. Fee-for-service percent is not the main problem with today's healthcare system. Most countries with successful universal healthcare systems still use fee-for-service but in equitable enforceable ways. Today's value-based payment models add inequity by incentivizing providers to avoid high-risk patients and reduce services. The metrics that we now use may not be predictive of good quality outcomes.
- The Task Force is justifiably emphasizing [the] creation of a system that is equitable and allows all residents access to care. Meanwhile, you know that the Oregon system will need to fit into a national economy and will need to be palatable to policymakers who will or won't approve spending federal funds on the Oregon UHP.

Cost and Funding

Questions:

- Is there a possibility of paying for health outcomes with care-out incentives?

Comments:

- One of the early critical issues in creating the new organization will be establishing a robust culture that addresses many issues from the start. This needs to include ideas, ethics, philosophies, goals, and more. It absolutely must be based on profit and cost/loss, not being a controlling philosophy. The current system is based on denying care under the guise of minimizing costs. This maximizes [the] harm to people and ultimately maximizes costs and harms.
- As our global experience of Covid evolves, we are also seeing long-term chronic health challenges becoming part of our health care program in the future. There is the possibility that current health insurance companies [will] collapse under the financial load.

Medicare and Medicaid

Questions:

- Does the Plan have to negotiate with the Federal Government to use Medicaid funds? How is the Plan related to Medicare?

Eligibility and Enrollment

Questions:

- How will people with disability or chronic disease be covered, and how can we assure that they get appropriate care (and not the medical gas lighting that often happens now)?
- How will the care of participants with more health complications be incentivized?

Healthcare Providers and Participation

Questions:

- What have privately owned hospitals and providers thought about the system? Will they support it? Dynamics of wealth and power and privately owned hospitals will likely push back against this.
- Will hospitals continue to be privately owned? Will they be allowed to turn away patients?
- How does this promote integrated physical/behavioral health care?

Appendix H

Spanish | Community Listening Session Notes 06/28/22

Access and Affordability

Questions:

- How would enrollment work for immigrants, people who leave the state, or people who aren't here the entire year in Oregon? Sometimes here and sometimes in other states?

Comments:

- Over in the far east [fo Oregon] with very limited providers. I have no option other than going to Idaho; Boise is an hour away. [We] are at a huge disadvantage for providers since the ones from Idaho don't typically accept it.

Outreach to indigenous groups:

- Good information. It's a pleasure to hear good things. Recommendation: please, when it's time for people to apply, keep in mind people who are indigenous.
    - Need interpreters for the community
    - Most vulnerable because of language barriers and not speaking Spanish as well
    - Difficult to find a clinic because [we] do not know; it is scary
    - Sometimes people do not understand Spanish, [my] native language is not Spanish
    - If they have a chronic disease, they will not apply because of barriers.
- Put [the information] in English or Spanish online. In [my] experience, the indigenous community does not use the internet. [My] experience as a community worker is community forums/informative meetings in native languages with people they trust. They did it with the census. Many indigenous people don't know how to read and write. When people come from a small town, people can't even write their own names.
- [It is a] privilege to have the program and be here. [I] agree with the recommendation for indigenous people. [I] had the opportunity to learn Spanish. Unfortunately, many people do not have that same opportunity. Give people communication that they have this benefit. It would be best to take the information in their language so they can understand and be informed, words that are clear and easy to understand.

Insurance Companies:

Questions:

- Not all services will be covered. Private insurances will target specific services that will not be covered. Do you foresee them overcharging on premiums because this plan does not cover them?

Coverage and Benefits

Questions:

- Some people with disabilities still have to work to pay medical costs and expenses. Will this plan cover the cost? Are taxes going to increase?

- Could it include orthodontics as well? It could be considered aesthetics. Sometimes parents don't have the opportunity to take their children.
- Question about transplants.[Will this include transplants?}
- Will they utilize generic medicine or original brands of medicines?

Employers and Employees

Questions:

- [It] could be an inconvenience for employers. What if you do not have a job?
- Will taxes that employers pay be increased too? Could [it] destroy many small businesses?
- Would employers need to pay [for their employees' treatment]?

Governance

Questions:

- Has the Task Force interacted or spoken with indigenous groups before this meeting?
- How are we going to protect HC4L in light of the fact that we have had an attack on a lot of these rights? Are we going to beef up the legal language of Healthcare for all of Oregon?

Focus on Equity and SDOH

Questions:

- How do older people get economic support if they do not have any within the new program?

Appendix I

Survey Results | Community Listening Session

Central OR Survey Comments

- If you can't convince our health councils, I don't think this proposal has much of a chance. I will take this issue and proposal to our Central Oregon Health Council and ask that we have a meaningful discussion about it.
- I do hope that there is a recommendation to provide career training and placement for healthcare billing and insurance professionals that have to change their professions.

Eastern OR Survey Comments

- I would like to emphasize that the administrative work that practitioners would need to fill out and submit would need to be drastically reduced and streamlined. I work for a physical therapist and submitting paperwork for authorizations is painful. The wait to get visits authorized is too long for patients, especially post-op when time is of the essence for the success of their surgery. As a small practice, we often see patients with ODS OHP or EOCCO, WITHOUT authorizations and hope for the best because it is in the patient's best interest for positive outcomes. We occasionally get burned and have large write offs because we have always been more concerned with our patients' needs. I can see if we have to get authorizations for EVERY patient we see in Oregon that we might not be able to make it as a small practice, not only the waiting time to get authorizations but also the time to process our claims if all our patients had EOCCO would likely put us out of business. Please research the impact of this on rural providers in small practices. We might be forced to close up our business and find work at a large practice or the hospital.
- Will Universal Health Care cover services such as Midwifery services, home-births, and lactation consultants?
- It's said that employers no longer need to provide health insurance to their employees if Universal Health care happens. My concern is that a significant amount of Oregon employees are Idaho residents that may or may not have coverage through their spouse, medicare or medicaid in Idaho. Is this double coverage or do they waive the Oregon Universal Health Care?
- 1) The Constitution requires that Members of the House live in the state they represent (though not necessarily the same district). Will Federal Elected Officials from Oregon

automatically be enrolled in the Oregon Plan? If not please provide basis for exemption and any citations the committee relied upon exempting them from the Constitutional mandates. 2) Health Plan Proposal-June 2022 Document: Pg 3."Who Would Govern" Question: Please define "Community Voices" as used in the proposal? 3) Health Care Tax costs as a deduction for both individuals and businesses. Question: Would Insurance Tax be an allowed deduction for individuals and businesses? 4) A concern arises that for the majority of Eastern Oregonians, gaining representation on boards and groups is provided first to those having connections, then to those with degrees followed by occupational or professional licensing. Question: When determining the Regional Groups how will citizens know their concerns and voices are actually being represented if the Boards and Groups are composed of only select individuals and not a representation of lay citizens?

Southern OR Survey Comments

- I would like to make sure that providers are incentivized to keep people healthy rather than just treat diseases.
- Concerns is about accountability for making sure real timely access is provided. As a Medicaid & Medicare advocate, it has been a struggle to get providers, most notably those via managed chare plans, to actually provide the services one is eligible for. The biggest nightmare was access to timely restorative dental services under OHP. More recently access to mental health therapy is a nightmare in communities like mine for anyone without OHP due to provider shortages. Promising great services is wonderful but without real access to providers makes it all a hallow promise.

Portland Metro Survey Comments

- What about self-employed individuals? What taxes do they pay?
- One of the biggest problems I see is that every aspect of our systems prioritize making money over providing services; as an educator, I see how communities of privilege maintain the inequities of an underfunded system. Our systems also treat many groups--houseless, mentally ill, the differently abled, etc. I see how BIPoC are marginalized in ways that persist despite laws and policies, and I don't see how this change to the system will relieve the stress of medical personnel, educators, and other professionals who are underfunded. (My point is that at the same time we are changing

Oregon's health care system, we must also change the perverse incentives for casual cruelty.)

- I really hope that you'll put a cap on what people will have to pay in taxes to fund this plan.
- Will the plan be able to negotiate bulk prescription pricing? How can this program become more socialized to the general public? The local news doesn't seem to be talking about it.
- Several attendees mentioned entities who have adopted a plan like this and how, afterward, they were all happier/satisfied/wouldn't go back in time. It would be great to know some examples of these entities - are they other states in the U.S.? Entire countries? Other types of regions? It seems like those stories would be very helpful for us to understand.
- How does the task force propose to balance utilization load with providers and physical resources? Let's say the reimbursement for MRI is too low and the waits are long and there is not enough cost incentive to build more MRI centers. How do you propose to right size the supply and demand with fixed prices?
- I think my main concern is that it won't happen (particularly because it requires federal approval). I'm a psychologist and am also interested in understanding how reimbursement will be determined for therapists and, very importantly, for psychiatric prescribers (we don't have enough to meet demand, which makes the work therapists do more challenging)
- Cost for retired people
- how can i support your efforts as a geriatric physician with both policy and planning skills in geriatric care, ohsu assist. prof and past president of the Oregon geriatric society
- I am a Master's of Public Administration student with a focus on Healthcare Administration at Portland State University. I have been studying ways to bring universal health care to Oregon. I think this proposal is a very good plan and I would like to support it in any way I can. I have an opportunity for field experience from January - June 2023. What are some ways I could support the taskforce (or OHA) with my 150 hour graduate level field experience?
- I hope that it will also include all reproductive and gender-affirming care. (And dialysis, despite today's SCOTUS decision!) I also hope that it becomes a reality--and soon. I have some concerns about the private administration idea (will that be as much of a mess as the 'OR aca marketplace' disaster?)

Willamette Valley Survey Comments

- In the community, the Model for this is often touted as Medicare. This is a BAD design model. Giving the design to government...in America...always lessens the product and this is a good example...Medicare for an age group that ends up needing more vision, dental and mental health care (everything above the neck, essentially) yet it is EXCLUDED from coverage...a person has to pay extra to get those coverages. What a bad design that was! I would like to see a form of coverage similar to one used in other countries, (and a number of them are doing reasonably well (though the naysayers need to be paid attention to), but the US tax structure is going to have to be entirely redesigned. Good luck with that. I'm not sure UHC is possible in a capitalistic society such as ours...democracy yes, capitalism no. I'm not optimistic!
- I am an attorney who has fought insurance companies over medical care issues for 30 years and I see a huge need for Universal Health Care. I have reviewed the plan and I am very impressed with your work. However, I am concerned about the heavy reliance on financing through taxes on reported income. There is an entire economy in Oregon that goes unreported or reported in ways that avoids or minimizes the tax revenue you are projecting. Borrowing against appreciating assets is just one example. Avoiding employer matching taxes by reclassifying W2 income as shareholder distributions is another. The current plan will create a huge incentive by the wealthy to fight this program as their cost for health care can easily go from $10,000.00 to $50,000.00 or more. I would like to help the task force if possible and i would like to talk to Dr. Goldberg about some ideas on how to deal with these issues if he can give me a call. 503-304-4886.
- I understand the need to consider the many determinants of health beyond direct medical care such as adequate housing, and education. It is not clear to me how the JTUHC would define "the edges" of the new UHC plan in relation to those other determinants of health? Those other factors are presently funded (to the level they are) by other tax revenue streams and are administered by other Oregon departments. This may be pertinent to the comment raised in the meeting about the potential benefit of incremental rollout of the new UHC plan.
- My biggest concern is that health insurance companies, pharmaceutical companies and other lobbying groups will spend $Billion$ to stop a universal health care plan.

- Will the Oregon plan provide equivalent or better coverage than the Medicare Advantage programs currently available to seniors? If seniors use the new Oregon plan, then have to move later will they be able to access the standard plans without penalty?
- Having a Black Autistic Non-binary teen with chronic disease (EDS/POTS) I have been impressed with the level of support OHP (they get via Kplan through DDS).
- Please cover alternative health care options fully without additional cost such as acupuncture, chiropractic care, therapeutic massage.

Spanish Survey Comments (Translated)

- ¿Podremos conservar el mismo médico que lleva nuestro cuidado?
    - *Can we keep the same doctor that has been taking care of us?*
- no tengo conocimiento acerca la cobertura médica por el momento
    - *I don't understand the medical coverage at the moment*
- Debería ser para todos
    - *This should be for everyone*
- ¿Cómo planea HCAO garantizar que los trabajadores indocumentados puedan recibir atención médica para sus familias y para ellos mismos? ¿Qué tan pronto espera que HCAO entre en vigencia?
    - *How is the HCAO planning to ensure undocumented workers can receive health care for themselves and their families? How soon do you expect the HCAO to go into effect?*
- Que es una idea excelente para los residentes de Oregon
    - *That this is an excellent idea for Oregon residents*
- Debería ser gratuita a todos los que la necesiten. El costó medical, cuidados, medicina, etc. es muy costoso. Si de por sí nos quitan taxes, deberían de ser buen uso de ellos.
    - *This should be free for everyone who needs it. The cost of medical care, appointments, medicine, etc., is very costly. If my taxes are being used [for this program], they would be of good use.*
- Que tomen en cuenta gastos, renta, dispensas, etc., cuando determinen la elegibilidad basado en ingresos.
    - *Consider the expenses, rent, groceries, etc., when determining eligibility based on income.*

Appendix J

Survey Questions | Community Listening Session

- Which session did you attend?
    - Saturday, June 11
    - Tuesday, June 14
    - Wednesday, June 15
    - Saturday, June 18
    - Tuesday, June 21
    - Saturday, June 25
    - Tuesday, June 28
- What State do you live in?
    - Oregon
    - Washington
    - Idaho
    - Other
- What is your Zip Code?
- Which of the following age ranges includes your age?
    - 18-24
    - 25-34
    - 35-54
    - 55-64
    - 65+
- Which of the following best describe your gender?
    - Female
    - Male
    - Non-binary/non-conforming
    - Transgender
    - I most identify with: (Please Specify)
- Which of the following best describes your ethnicity or race?
    - Hispanic or Latino/a/x/e
    - Indigenous -Central or South America
    - African

    - Black or African-American
    - Middle Eastern, North African, or Arab American
    - Native American
    - Indigenous - Canada or Alaska
    - White or Caucasian
    - Slavic or Eastern European
    - Asian or Asian American
    - Pacific Islander or Native Hawaiian
    - Please Describe
- What is your highest level of education completed?
    - Elementary School
    - Middle School
    - High School
    - Some College/Vocational school/ 2-year degress
    - Bachelor's degree
    - Master's degree
    - Doctorate degree
- Do you live with a disability?
    - Yes
    - No
    - Prefer not to share
- How do disabilities impact you?
    - Hearing
    - Mobility
    - Sight
    - Learning
    - Speech
    - I prefer not to share
    - Please describe
- Optional: Do you have any Concerns/Comments/Suggestions for the Task Force on Universal Health Care?
- Optional: Please share your Email Address for follow up and updates