Joint Task Force on Universal Health Care Study

Group Discussion Research Synopsis

Lara Media Services
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Introduction

In 2019, the Oregon Legislative Assembly passed Senate Bill 770, which established the Joint Task Force on Universal Health Care (Task Force). The Task Force is charged with recommending a universal health care system that offers equitable, affordable, comprehensive, high quality, publicly funded health care to all Oregon residents. The Task Force began meeting in July 2020 and submitted an interim status report to the Legislature in June 2021. As a result of an extension granted under Senate Bill 428 (2021), the Task Force will submit their final recommendation for a Health Care for All Oregon Plan no later than September 2022.

The Task Force's goal was to hear from historically underserved communities, including Black, indigenous, people of color, rural, people with disabilities, and mental health issues. They wanted to hear and understand their views, opinions, hopes, and challenges related to meeting their health care needs. They hired Lara Media Services (LMS) for their just, equitable, inclusive, and culturally responsive approach and research techniques. 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. 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.

Systemic racism and generational (social, economic, political, and environmental) inequities result in poor health outcomes. Systemic racism has a detrimental effect on the quality of care that communities of color receive. Additionally, access to healthcare and health care outcomes are worse for communities that live in rural areas. Health Care should not only be accessible to all Oregonian residents, but it should be well funded, comprehensive, and culturally responsive. Participants were resoundingly clear when they expressed that they reject (or don't want) the same access to 'Affordable Health Care' some are receiving now. They want health care where nobody is excluded due to their background, location, ethnicity, racial identity, gender, religion, or lack of documentation. They seek health care where systematic racism is eliminated through adequate funding and policies that center people, prioritize health equity, and offer community-driven approaches. Affordability without equity will multiply the painful and negative outcomes they are experiencing now.

This report summarizes the core findings and data gathered in the first phase derived from the outlined methods. It presents these findings in a logical sequence.

Goal

LMS' goal was to gather qualitative data from the Task Force's target audiences about their health care needs, experiences, and barriers when receiving health care and report the findings to the Task Force.

Methodology

LMS coordinated, conducted, and facilitated focus groups for this project. Focus groups are exploratory research methods that provide vast qualitative data. This method is used when exploring issues in-depth and understanding thoughts, feelings, challenges, aspirations, and aspirations. LMS encourages participants to be fully engaged and empowers them to let their voices be heard. Trust is built throughout the session, as each person's opinion is vital. LMS aims to have diverse participants to capture the sentiment of multiple perspectives.

These are our methods.

1. LMS and the Task Force identified priority audiences and essential considerations to develop the discussion guide.
    a. Geographic Region included:
        i. Coastal Region
        ii. Central OR
        iii. Eastern OR
        iv. Southern OR, including the Lane County/Willamette Valley region
        v. Portland Metro Area/Salem/Woodburn/Marion
    b. Demographic Diversity included
        i. Latinos/as/x that speak Spanish
        ii. Blacks and African American
        iii. Native Americans
        iv. Pacific Islanders
        v. Oregonians needing disability services and long-term care services
        vi. Oregonians who navigate the behavioral health system
        vii. Rural Oregonians
2. The Ad Hoc Public Engagement Workgroup drafted question topics and developed the questions.:
    a. Affordability
    b. Coverage
    c. Eligibility
    d. Enrollment
    e. Governance
    f. Financing
    g. Social Determinants of Health (SDOH)
    h. Provider participation
3. LMS and the Task Force developed a discussion guide including topics and expected outcomes.
4. Priority audiences were invited to participate in the discussion.
    a. Monday, January 31, 2022, from 5:30 pm – 7:30 pm
        i. Latino/a/x (conducted in Spanish)
        ii. Black and African American

   b. Tuesday, February 1, 2022, from 5:30 pm – 7:30 pm
      i. Pacific Islanders
      ii. Native Americans
   c. Wednesday, February 2, 2022, from 5:30 pm – 7:30 pm
      i. Rural Oregonians
      ii. People with disabilities and Long-term care needs (English)
         1. People with disabilities and Long-term care needs (Spanish)
   d. Thursday, February 3, 2022, from 5:30 pm – 7:30 pm
      i. People with Mental and Behavioral health needs (English)
      ii. People with Mental and Behavioral health needs (Spanish)
5. LMS recruited participants for each group. LMS found participants through social media, with the help of community advocates, and through existing relationships with the community built over the last 20+ years. LMS contacted over 150 potential focus group participants
6. For confirmed participants, LMS offered to lend tablets if participants needed electronic devices. Upon registering, one (1) requested the use of a device. LMS also offered Zoom Video conferencing training to all participants who requested assistance; three (3) requested.
7. LMS coordinated and virtually hosted and facilitated seven (7) focus groups
8. This report summarizes the information gathered in the focus groups.

Focus Group Participants

Spanish

The group was composed of ten Latinx participants. The regions represented were: Coastal region (Lincoln County), Eastern region (Umatilla, Malheur), Mount Hood and Columbia River Gorge region, Southern region (Jackson County), and Portland Metro region (Multnomah, Yamhill, Washington)

Black & African-American

The group was composed of eight Black and African participants living in the Portland Metro region (Multnomah, Washington.)

Pacific Islander

The group was comprised of ten Pacific Islanders from the Portland Metro Region (Clackamas, Marion, Multnomah, Washington)

Native American

The group was composed of nine Native Americans. The regions represented were Coastal Region (Lincoln), Central (Deschutes), Southern (Lane), and Portland and Salem Metro region (Marion, Multnomah).

Rural Communities

The group was composed of five Oregonians. Three participants identified as Latinx, one identified as white Caucasian, and one identified as Black. The regions represented were four from the Eastern region (Grant, Malheur, Umatilla) and one from the Southern region (Klamath).

People with Disabilities or Long-term Care Needs

The group was composed of nine participants from the Portland Metro region (Clackamas, Marion, Multnomah, Washington.) Five identified as Latinx, one as Asian, one as African American, and two as biracial (Irish and indigenous, Black and Caucasian)

People with Mental or Behavioral Health Needs

The community discussion consisted of eighteen participants. LMS broke down the group into two groups, English and Spanish. The English group consisted of eleven Oregonians from Mount Hood and Columbia River Region, Portland Metro (Clackamas, Multnomah, Washington), and the Southern region (Lane). Three participants identified as Asian, one as Pacific Islander, three as Latinx, three as White, and one as Biracial (Indigenous and African American).

The Spanish group was composed of seven Latinx individuals from the Eastern region (Umatilla), from the Southern region (Jackson), and the Portland Metro region (Multnomah, Washington.)

Findings

Affordability

- “Affordability means the ability to pay for or care and interventions without having to consider things like whether you are able to marry or… need to divorce someone to access care where one doesn't have to choose between pain, rent, food utilities, or access to appropriate medical intervention or care.” - Mental and Behavioral Health Group Member.

When discussing affordable healthcare, participants' responses tended to be very diverse and covered a whole spectrum of experiences and approaches to affordability. Participants' responses, for example, ranged from 'affordable health care is free healthcare' to 'everyone should pay based on what they make, and their situation allows.' Similarly, their recent experiences with healthcare also cover a broad spectrum, from affordable to downright impossible to pay off. Participants' emotional reactions to this question followed a similar trend. Some trusted that affordable health care for people like them as possible. In contrast, others expressed utter disbelief that the powers that be would ever make this fundamental right possible for people with their histories and backgrounds. Many were also caught in the middle, with all participants offering distinct and dissimilar views.

Most participants defined affordable health care as not having to worry about paying their health care bills, whether because they would not have to pay or there would be a flexible and affordable payment system. Many expressed confusion about the idea that the healthcare program would not have “premiums, co-pays, deductibles, or any other form of cost-sharing to access care.” Overall, there was some hope but a larger sense of disillusionment with the system.

- “I’m not doing bad with paying when I go have a doctor’s visit, but it’s not the best. It could definitely be better. I can't really say what's affordable. What? $5 a visit would be affordable, I guess. But, the high deductibles [are] what I'm working with right now, which makes me think about, do I really wanna go to the emergency room? Do I really need this ambulance ride before I actually do it? Because I’m worried about the high deductibles and what that bill's gonna look like.” - Black and African American Group Member

A core theme throughout the session was the financial burden that many health care services pose to participants. The affordability of services depends on available funds. Many participants echoed the sentiments in this quote, “you only get the care you can afford, not what you need.” The current affordability limitations commonly result in people picking and choosing what services to access. Parents might sacrifice their health to ensure their kids have access to healthcare, or an individual might avoid all but the most necessary of services. Costly medical attention often results in people only using their healthcare for the gravest of illnesses, not knowing that their health issues would have been easily preventable had these individuals received preventative care.

Consequently, many participants believe that what people pay should be based on how much they can afford to pay. They wish to see a “more human side” to the healthcare system, where people's situations are considered. Affordability, they say, is different for everyone. The Task Force is asked to take all of the financial stressors many people face in their daily lives into account. Rent payments, family situations, and the general cost of living pile up. Many people are not left with enough money to pay for essential medical treatment and medications. Many participants believe that healthcare is a “fundamental human right, not a privilege.” The majority believed it should be free, especially for those who have trouble meeting their basic health needs. They were clear in their desire for the system to include treating people with preexisting conditions, grievous health issues, severe illness, disabilities, or those requiring emergency care who would otherwise be unable to access it properly.

Participants want a healthcare system that will meet their needs, dignify them, and provide good quality care which does not penalize them for their current circumstances or ability to pay. Many have to pay high prices for insurance that only provides them limited coverage and does not allow them the coverage of care they desperately need.

Individuals who do not have access to services such as the Oregon Health Plan (OHP) have struggled to retain relevant access to health care services. Many cannot access adequate insurance, making too much to be put on low-income programs like OHP or rely on community health clinics, but do not have enough to purchase private health care coverage. This often leaves them in a difficult middle ground having to pay for treatment out of pocket and struggling to earn enough to cover their premiums. Or inversely, leave them limiting their income to access a health care plan, such as those with disabilities or mental health issues.

Those who rely on OHP face discrimination from healthcare providers and colleagues alike for their type of healthcare. This type of stigma can be damaging. Their treatment has led several to believe they have a lesser version of the healthcare others experience. They, too, wish to feel like they enjoy the same quality of care everyone else seems to receive. Many others hope that this program will provide people with the high quality and low-cost care they deserve, providing more far-reaching and equal care that meets their basic needs.

Some suggested that insurance companies and providers allow their clients the flexibility to pay back the cost of their care in multiple low-level installments or give them multiple options to choose a payment system that works for the individual. They believe this will lessen the effect and stress that any payment may have on an individual, allowing people to feel less of a financial burden when accessing their healthcare, maybe freeing them to use their coverage more consistently.

Participants also suggested lowering the price of medication and healthcare premiums. They believe these are some of the most common financial stressors people face when paying for their healthcare. Many people don't want to pay or can't cover the costs of prescriptions without sacrificing other essential expenses.

Coverage

The variety of services that need to be covered is comprehensive. They are unwilling to resort to limitations, arguing that every type of health care needs to be included. Participants agree no one person will require the same type of care, and those needs differ by age, race, location, etc. If one group of people or needs is prioritized over another, many participants fear the community's health will suffer.

- “We need to have the same quality of healthcare across the board. It can't be that the people of color or the native communities get the like brand-new people outta school or people who are outdated, that everybody gets the same quality of care as everyone. And that we get a universal like medical, I mean, for your dental, your eyes, everything, not just one thing. And we shouldn't have to go get referrals cuz that takes months, sometimes weeks. Cuz if the insurance gets the wrong paper, I've waited three months to try to even get an appointment for physical therapy. I think it's, they just need to care about the people and give us the best quality, not like the rich get the best doctors and the poor get the crap. I, it shouldn't be like that should be just equal across the board for me." - Native American Group Member.

Participants advocated that coverage be extended to many different types of healthcare services under this new program, especially those participants believed to be essential parts of health care, such as dental, vision, and hearing; all services commonly used by a large part of the population. Other services, such as family planning, fertility services, and testing services, were also requested by some participants because these services can at times be costly and hard to access. Several also felt that they could easily be considered preventive services as both types of care can profoundly impact people's long-term health. Many believe that natural and alternative medicine should be considered when determining which health care services are covered under this new program. Several communities rely on alternative healthcare options for culturally acceptable healthcare services. Participants believe that including them under the program's coverage will help people obtain more culturally appropriate care and help normalize the beliefs and practices of diverse communities often underrepresented in western medicine.

- "Now that I am just strictly an OHP patient, there are certain things that I had for being an OHP like dental, I think, is something that we overlook all the time. And actually shouldn't be because like one of the main leading risks for heart attack is actually dental cavities. You know, like so teeth and eyes are just not expendable, you know like, and but most of the time, in terms of affording for health care they are treated as such." - Pacific Islander Group Member.

Many participants claim that they have little idea of the services and care available through their current providers because the information was not well explained. They believe that some services already provided by healthcare insurance companies have workarounds to make things more affordable. Still, they are often inaccessible because people often don't know how to ask for the help they need, or insurance companies aren't willing to provide this to them. Coverage clarity can be a big issue for those needing expensive/specialized care or medication. They usually do not understand the process medical offices undergo to get specific treatments and prescriptions covered, making the process frustrating and overwhelming. They believe that more resources should be made available for clients to understand better the health insurance system and better advocate for the care they need.

However, some participants made concessions, believing that if care is limited, those with the most access to services should be the most vulnerable communities among them, prioritizing groups such as the elderly, the disabled, families, and young children. Others disagree, saying that the only limitations should be cosmetic treatments or that the program should operate at a loss rather than limit the care of any person. And still, others argue that all residents should be provided with essential and preventative healthcare services but be allowed to choose from among the range of services that will and won't be covered to best tailor the care received to individual needs.

Many participants also requested more coverage for compound and standard medication, long-term care, and chronic diseases (diabetes, cancer, and asthma). Medication is closely tied to the theme of long-term and chronic disease and often is one of the most significant expenditures related to treatment. Thus, many people find medication expensive, especially long-term or compound medication. These are some of the most common forms of health care needed by the public. Many health plans only offer partial coverage if they offer the service. As a result, many participants struggle to pay for medications they urgently need, making it one of the most necessary forms of coverage requested by Oregon's new health plan. Participants also requested complete coverage for those services to benefit those put in difficult, stressful positions by heavy financial burdens at a time of significant physical and emotional vulnerability. They believe that this new universal health care program should make specialized and emergency services more widely available and affordable for all.

However, out of all the healthcare services recommended for increased coverage, the most prevalent was mental health. Many communities feel that mental health has been stigmatized by their and other cultures for far too long. People need a holistic health system, but mental health is commonly ignored, and this ignorance and stigmatization can cause more damage to those suffering greatly from its effects. This is especially true in recent times when circumstances surrounding COVID-19 and the increasing houseless population have increased depression and social isolation. It has also become more critical in an increasingly multicultural society where the differences in cultural backgrounds, experiences, and intergenerational trauma have collided, causing emotional turmoil in the lives of immigrants and their children due to differences in experience and emotional burdens.

Eligibility

Eligibility was a big concern for many participants, especially those who have and have had difficulty accessing healthcare. The biggest issue that participants brought up was the struggle of undocumented immigrants to gain access to the health care system. Since they are considered unlawful non-citizens of the United States, many are scared to show any kind of personal information for fear of alerting the authorities to their presence in the country. Thus, they are left without protection. Because of their migratory status, others have been discriminated against by service providers or subjected to expensive and low-quality care. Participants do not believe that status should dictate a person's eligibility for Oregon's new health care program. They advocated that as long as a person is a contributing member of society and can pay taxes, there is no reason anyone living in Oregon should not have access to comprehensive healthcare.

- “I, I wonder if, um, eligibility would also include folks who don't have documents, right? Like, undocumented folks are folks who might be houseless and, for whatever reason,

> don't have those documents… and might not have Oregon residency, but they're, they're here. If they show up at an ER, are they gonna be taken care of, so I guess I'd be curious like how we define eligibility as well." - Mental and Behavioral Health Group Member.

Some believe the best way to avoid this issue is to enforce less stringent eligibility requirements; this will help specific groups (houseless) when accessing health care services, while a few participants fear that lessening requirements will result in the system being abused by others. These participants are worried that people from neighboring states will attempt to/fake Oregon residency to access the free health care available for all Oregonians. Some suggested using proof of residency as an eligibility requirement. Others believed that determining the proper allotment of time before residents became eligible for Oregon's health care program became difficult if residency were to be used as a requirement. People might find it difficult to get urgent care or address emergency healthcare needs if pushed too far.

Others suggested that the DMV Identification (ID) system should be used as an eligibility requirement in addition to or instead of proof of residency. In most cases, opinions on using the system varied and were similar to those on proof of residency. Some believed that utilizing IDs would be beneficial as most people could produce them (Drivers license, tribal ID, Oregon ID, etc.). Others were against the system claiming that licenses and IDs are problematic because not all communities can produce or obtain them for various reasons. Another idea was to have those eligible or enrolled in the program receive a unique form of ID that would allow them to access the Task Force's new health plan, and similar to rolling over those already enrolled in healthcare, rollover people's IDs from the DMV and other organizations.

However, throughout this discussion, there seemed to be an inherent confusion about who qualified as "everyone residing in Oregon, regardless of employment, income, immigration status, or tribal membership." Even when participants wished to see a system where everyone had coverage and no one was discriminated against based on status, race, residency, or income, they were hesitant to believe that everyone would be eligible for the new health care plan.

Their main concern was that the system would be flooded by Oregonians wishing to receive medical attention with eligibility standards lowered, making it more difficult for anyone to use services with providers being overwhelmed by patients. This is a particular worry for communities with limited access to providers, as they worried that their small number of service providers would be quickly overwhelmed. Potentially, this could cause them, and eventually many Oregonian residents, to have to travel long distances or even out of state to receive necessary health treatment. This ordeal would all but invalidate the system the Task Force is now trying to introduce. Others worry that the system will be slow and ineffective at dealing with many participants. Or additionally, as a result of so many people in need of medical attention, the quality of services would drop, providing widespread but inadequate healthcare.

- “I think that's where we start talking about equity… I guess just the political side of me when you say, you know, everyone, regardless of income or employment or anything like that. While I think that would work in an ideal world economically, I don't see that [as] very feasible… and I'm concerned that that might overwhelm our healthcare personnel if everybody's covered.” Rural Group Member

These concerns raised questions for many participants looking to understand better how the Health Care for All Oregon plan would be intended to function and what measurements they would take prior to prevent failure and more damage to their communities. Many did not wish to be rushed into accepting a system they were unsure would even work to their benefit and would continue harming their families and communities.

Some questions from the participants included:

- Would the program's eligibility be based solely on residency? Or would all willing participants also be required to fill out an application of sorts before their eligibility could be considered?
- Would Oregonian residents be forced to opt into this system of healthcare? Or would they be able to opt-out if they preferred to keep their current insurance, or the quality of the healthcare provided does not measure up to their standards?
- Would and should out-of-state students be eligible for this plan if they are studying here sometimes for years on end but are not technically considered residents of the state?
- Under the new system, would people who were not Oregon residents still receive medical attention if they needed urgent/emergency care? Or would they be rejected for lacking coverage under Oregon's new health plan?
- Specifically, what happens if people have family visiting from out of state that needs medical attention? Would they also be provided healthcare? Or, if not, would any financial support be available for people having to pay for the cost of their family members’ medical attention?

Enrollment

The Enrollment section closely followed the themes set in the eligibility discussion, with participants expressing similar questions and concerns. Again, some were worried about the program's effectiveness, mainly how the enrollment process would be accessible to the houseless population/others for whom residency and IDs present a barrier. Others also asked if people covered by OHP would be automatically enrolled in the new health plan and if a similar process could be achieved for those on TRICARE or Medicare. In short, they did not trust that the enrollment process would be as straightforward as the Task Force was making it seem.

- “I was just thinking there shouldn't be a really big enrollment process. I mean, you're gonna ask a couple of basic questions… but if everyone's gonna be able to have healthcare, then make it everyone. I don't think it should be no long, drawn-out process. It shouldn't be that hard. Like I said, you didn't make it that hard for people to get

> vaccinated. So it shouldn't be that hard for people to get healthcare." - Black and African American Group Member.

Since the plan did not clearly define the enrollment process in the discussion guide, many participants geared their initial conversation to different ways that the enrollment process could increase its efficiency. They agreed that the biggest problem would be effectively spreading information about the Health Care for All Oregon plan and its enrollment process to their communities. They also agreed that the enrollment process should be simple and clear to allow all residents potential access to healthcare. Some believed that the Census should enroll citizens or that the county could do enrollment. Others believed that to increase efficiency and accessibility, it would be best to have both impersonal and online applications handy.

Participants thought it best to model the enrollment system for the in-person registration after other systems had already shown to work well. Participants recommended copying the SNAP programs registration system, the census' system (with volunteers going door to door), or the pop-up sites used to distribute vaccines during the COVID-19 pandemic, making application portals available in public or community spaces. They also suggested that volunteers be available when administering these applications to help people navigate the paperwork and provide them with further information about the health care plan.

Some participants explained that they had experienced the ease and cost-effectiveness of receiving care without insurance when previously living in other countries. Being able to just show up to provider offices, hospitals, etc., and receive proper medical attention without filling out tons of paperwork and knowing that it would be affordable allowed them to access medical care when and as needed. Allowing a similar process to exist under Oregon's new health care system, they argued, could also make medical services more accessible for those visiting from out of state without having to enroll in Oregon's health plan. Oregon could instead pave the way for a new type of healthcare system in the US, and hopefully, other states would follow suit.

There were varied ideas about the best enrollment timeframes; most comments about timeframes advocated for immediate access, while only a few thought there should be a minimum requirement for residency. There was a debate between participants about whether it would be better to have seasonal enrollment periods or simply keep the enrollment time open year-round.

Beyond the enrollment process, many participants also shared their concerns and issues when navigating the current insurance system, hoping that bringing these concerns to the Task Force would help resolve future issues. Most participants have had difficult or frustrating experiences navigating the healthcare system, especially first-generation immigrants. The language barrier has been a challenging obstacle to getting access to services and understanding the types of care available for them. Many wish to see multilingual and multicultural resources and services dedicated to helping them better navigate the medical system, whether in person or over the phone, or help from an advocate or customer service office.

- “[I]t would be nice to both have online and in-person to have like a designated place for people who don't have who don't understand if they need translation services. Or also if they need transportation services to that location to help these people. And then another thing that would help is probably for the online version, like a video that in detail describes how to apply.” - Pacific Islander Group Member.

Several ideas have been brought forth for how to correct this issue. Some believe that it would be most beneficial to have volunteers and nonprofit organizations dedicated to spreading this education and resources to the public to help them when navigating the system. Others believe that Medical providers and insurance companies should create a customer service office dedicated to guiding clients through the process. But most, however, believe that adding advocates to the system; a person dedicated to helping one or several clients navigate the system/access the care they need; would be most beneficial. Several participants already have stories about how health advocates have helped them receive urgent or necessary treatment that they would have otherwise never received from their insurance companies. These people have helped them receive their care faster and feel like they are honestly being heard and have a voice in their healthcare, and participants wish to see that experience repeated for others. They believe the service is truly needed if patients get the most out of their insurance programs, whether online or in-person.

Participants' need for information also carries over to other aspects of healthcare, such as full disclosure on the type of coverage that a health plan offers and thorough explanations of medical diagnostics. They want this system to provide coverage that will follow them through life and help give them the information and resources they need and access to medical resources that have previously been unreachable by leveraging personal aid and interactions.

Other accessibility concerns involved the long wait time that participants often had to endure when writing referrals or the feeling that the system they navigate is ineffective and slow to meet their needs. Many advocated the need for a better system that is easier to physically access. Participants also suggest that the new system avoids referrals because, at times, it might take months to get access to much-needed medical services due to the paperwork one has to navigate. In place of this, they suggest that the plan might find a speedier form of service by updating the health plan's online accessibility. According to participants, the OHP website is old and clunky, with applications and materials hard to navigate and fill out. By creating a newer interface for their new health plan and adding features that allow people to fill out materials over the phone in an app, they believe the process will become more streamlined and information more accessible.

Governance

Governance is one subject in which participants explored the many moving parts that would facilitate the organization and create an Oregon Health Insurance Board of Directors. They expressed that for the board to be and remain relevant, it must reflect the state’s diversity, especially of the communities that had experienced harm by the current health care system in the state.

- “I would say [that] the board needs to be very diverse and knowledgeable about different groups, but the more diverse, the better.” - People with Disabilities and Long-term care Group Member.

One of the most significant concerns in this topic was the belief that ethnic-specific, regionally-specific, and diverse representatives would be missing from the board's operation. Many participants agree that they often felt that their communities were brushed aside on essential matters and that representatives for other boards and legislative matters do not accurately represent the people and their needs objectively. In sum, they advocated that more representatives should come from BIPOC and historically marginalized groups with diverse ages, backgrounds, education, and experience. Certain groups – Native Americans, those with disabilities, those with Mental Health issues, and those living in rural areas – requested the consideration of members of their communities to be on the board, as they are often the least sought after when filling positions or those whose needs are most ignored.

- “I think that there should be a good representation of who the community is, because when it's time to vote, [the representatives] have to have legal immigration status and social status [to be influential], and you also need to be knowledgeable about the community needs when you’re voting. So, I also think that it [the board] could work with representatives from a base of organizations that work with our communities and that of other immigrants, like IRCO and Latino Network. That way, various organizations around the state could do what you are already doing, gather the people in the community and from there go and represent them all.” - Spanish Group Member.

Beyond diverse demographics, many participants also felt strongly that diverse backgrounds were necessary to form a holistic approach to healthcare. Many advocated that members of the houseless population be allowed to serve, and the governing body should include community leaders and representatives from influential community organizations. They believe that community leaders and members of the community or nonprofit organizations with a background of working with underprivileged or underserved communities will significantly help improve the communities trust and hold the board accountable.

Participants also recommended that those with personal experience navigating the healthcare system or everyday members of their community be included on the Board, not only those with professional backgrounds in health care or the medical field, such as healthcare providers and experts in health care law and medical professionals. They want members whose personal experiences reflect both their own and other communities; middle to lower-earning individuals who have struggled to obtain healthcare in the past or have experienced negative outcomes navigating the healthcare system themselves can personally empathize with the hardships faced while navigating a system many believe is not tailored to fill their community's needs. They worry that the process of choosing these representatives will not be equitable and restrained to those with PHDs or who, by their profession and socioeconomic status, are far removed from the everyday communities needing representation.

Although most participants believe that community oversight is essential in the selection process, participants remain divided on the best course of action to create the board. Many feel that the solution is to allow participants to vote to fill these positions, even suggesting that those unable to vote due to immigration status, lack of residence, or ID, should be allowed to vote through community organizations that represent them.

Fear, however, remains of this process not being equitable. Participants stress that some community groups are small and will likely continue to be underrepresented. It would require extensive resources to prepare to participate or vote on participants. Many people believe that it would be more prudent to have potential candidates fill out applications and complete an interview process in front of their communities before being selected for the board. However, they do not believe that those processes should be too strenuous or it will still cater to only having the most educated apply. If there was one thing that most participants agree on, the government should not be a single authority deciding who gets a seat for integrity. And in addition, members' time required on the board should have clear limits and expectations.

Additionally, participants were torn on providing compensation; while most believe that compensation is a fundamental job requirement, some believe otherwise. Those in favor argue that these positions are government positions, so compensation is necessary, if only for the time and effort that board members would invest in the program. Those opposed believe that any form of compensation would diminish the goodwill of those in power and would leave candidates seeking to work not for the general public's well-being but for personal gain. However, both wish to see the board work with integrity to fulfill the communities needs and create a healthcare program they can trust and rely on to give them the best possible care and coverage.

Many participants also stressed transparency, culturally responsive outreach, and engagement are critical factors when creating and running the directors' board. They firmly believed that constant community input and scrutiny would achieve the best results, informing the populace of ongoing changes that might better help them navigate the new health care system and keeping the board accountable and relevant. Some participants suggested setting up a directory/office, email, and hotline for this purpose. Others also suggested that having board members interact with the community directly through regular town hall meetings or zoom meetings would help keep the public informed and encourage their familiarization with their board members. They think this would also bring forth any questions, problems, or petitions that would help inform the board of their community needs.

Financing

Discussing the program's financing exposed a lot of passion from participants simply because many participants had varying opinions about how to best fund Oregon's new healthcare program. Significant themes throughout the discussion were the need for transparency and the heavy impact of taxes on small businesses and those who make less money.

One common trend throughout the community groups was that many participants faced heavy financial burdens due to everyday stressors like low incomes and inflation. Many also expressed they already struggle to pay taxes and keep their households out of poverty. They fear that a rise in taxes might worsen their current conditions and keep them from affording quality health care coverage. When presented with the topic of a payroll tax, many individuals praised the idea, identifying progressive taxes as a counter to the inherent inequities present in the current tax system.

The idea of a progressive tax that puts the duty on those who make more money, where taxes have had less impact proportionally, was more attractive. Participants want a tax that more heavily impacts those of higher socioeconomic status to help balance the impact of taxes so that people with low incomes are not too financially burdened. However, participants were skeptical that the payroll tax achieved that goal, and many could not support it. Several wished to see funding achieved through other methods, such as Federal grant funding, so that medical payments could be 100% tax-deductible and to have more tax breaks for small businesses and independent contractors.

One can see a similar division when discussing the implementation of sales taxes. Except for a few participants, all condemn the idea of a sales tax and regard it as a regressive tax which places a higher burden on the lower socioeconomic class and much of the BIPOC community. However, many are willing to implement it on a more limited scale with a more significant focus on “luxury items” – such as yachts and large estates. Suggested targets include commonly taxed items such as alcohol, tobacco, marijuana, other recreational drugs, cars, electronics, lottery winnings, dispensaries, luxury clothing articles, jewelry, and other luxury items.

However, participants are unwilling to commit to any form of funding until the community has been fully informed and clearly understands the potential impacts of any of these proposed taxes. They worry that despite their taxes being considered lower than those for the ‘rich,’ they will still be too heavily/negatively impacted. They are hesitant to trust the vague wording in the section's explanations without real numbers that could help them calculate these taxes' real impact on their incomes. Several suggested that the best course of action would be to outreach, inform, and educate the community on the inner workings of these tax systems using specific numbers to help them make a better-informed decision when considering their communities' needs.

This request and mistrust stem from participants who do not understand the funding process. Several were worried that undocumented immigrants would not be eligible for the program even though they pay taxes. Others felt that these additional taxes might not be fair to those who want to keep their private insurance. They would have to pay for a service they prefer not to opt into or might not be complementary to their current plan, and, in addition, subject them to heavy financial burdens. Some questioned how the system would affect those without income or jobs-such as the retired, disabled, houseless, and unemployed. Few participants knew how the system might work around these issues, spurring more interest in a community education session/program with more specific information.

Participants agreed that all future undertakings must be transparent and open to public scrutiny. They emphasized the need for clarity regarding funding needs, resources, sources, expenditures, and efficacy of costs and impacts on the community. This way, the state can assure community members that their tax dollars are being used responsibly and effectively.

Social Determinants of Health

- "I don't know the extent [of SDOH programs that need to be implemented], but it does need to be done… There's a lot of disparities that our culture goes through that others don't — I'll say black, brown, whoever goes through. And if we had access to a lot of those things that others do, we wouldn't have a lot of the health problems that we do have. So I know that they're trying to do things to try to organize places more and more for us to have fresh fruits and vegetables and things like that. And you know, I tell people all the time on a regular daily basis that [with] the disparities that we go through just going to the store is different than if somebody else is going to the store. We don't know what we may encounter. [It's] just some simple tasks that we could do, but [when] we go, it could be stressful for us when it may not be stressful for another, a different ethnicity. So I really believe that if those things are worked on as well, it makes our life a little easier, we would have less of the health issues like high blood pressure and, and, and diabetes and things like that because they're brought on by a lot of the stressors of life." Black and African American Group Member

Social Determinants of Health (SDOH) was a section filled with many diverse topics of conversation, as participants considered a wide variety of aspects important to their overall health. Already adamant about the necessity of an affordable and effective health care system, they emphasized the need for aid in areas ranging from access to health education, such as proper housing and everything in between.

Education, particularly health literacy, is one of the most common services that participants designated as a community need. By increasing the community's access to culturally appropriate health guides, information, and resources, they believe awareness of healthy lifestyle choices and eating habits will increase. Many also advocate for more information on exercise, mental health, drug addiction/rehabilitation, preventable illnesses, and community-specific health complications. Additionally, some participants have also advocated for more community education on health care insurance so that more people will know how to navigate the system. Others also wish to see the government invest more heavily in the traditional/public education system, unsatisfied with the current education system in place. The Native American community was an influential proponent of this, advocating for free education for their community due to the United State's history of isolating, damaging, and marginalizing their families.

- “I think that [SDOH] should be their number one priority; social determinants of health are everywhere. It is literally everything in our lives… right down to education, transportation, our roads… one thing leads to another. It's like the domino effect… if I don't have a car, I can't get to a job. If I can't [get] the job, I can't qualify for services. If I can't qualify for services, I can't go to the doctor, et cetera, etcetera.” - Rural Group Member

Access to affordable and nutritious foods is another area where many participants ask for attention. Many lack access to healthy eating education services. Quality food is expensive, and cheaper alternatives are often damaging to people's health. Ideas for providing this aid vary. Some suggest healthier school lunches and increased access to community food gardens. In contrast, others argue that Oregon should implement a program so that those with low incomes can use food stamps to receive food delivery services. However, despite these differences in opinion, most believed Oregon must increase aid to Oregon residents to obtain quality foods, not just increase awareness of healthy eating habits.

Another frequently discussed topic was the need for transportation to and from appointments. Many of Oregon's residents live in rural or isolated areas. Many often do not have adequate transportation needed to transport themselves or loved ones to and from appointments. Transportation is particularly an issue for those who lack health care providers in their areas, limiting their access to emergency and specialized services. Without adequate transport, many people in rural communities rely on inadequate forms of treatment, like over-the-counter painkillers, and miss the chance to catch medical issues early. In more severe cases, relying on unqualified or inexperienced personnel to provide much-needed medical services runs the risk of developing worse health conditions later. Thus, participants suggested that Oregon either help provide transportation or compensation for travel expenses for those needing to venture long distances to obtain necessary aid. While others questioned if the Task Force could not also use this program to help establish more health care providers nearer to communities lacking access to essential health care services.

Similarly, other participants also argued that more access to green spaces, nature, and parks is vital for urban residents to improve their mental and physical health. Some focused on the importance of providing access and building gyms and cultural and community centers near their communities to encourage healthy lifestyles and provide for people's mental well-being. For others, however, such as the Pacific Islander. Latino/a/x and Native American communities, green space, and natural areas held more social and cultural importance. Many Indigenous participants stressed the close link their community had to nature and urged the creation of more programs to protect the planet's health alongside their ancestral lands. Many Pacific islanders responded in kind, urging that they be provided more access to the Ocean, a culturally significant part of their holistic and spiritual well-being.

Participants also discussed the growing rate of houseless individuals under SDOH. Several participants feel that this problem is growing out of control. They are distressed at the condition of their streets and city, which they find increasingly full of trash and dangerous to travel. They thought that if better preventative health care were offered, more people would be able to stay in their homes and not lose stable residency due to medical debt or untreated mental health needs. Participants acknowledged housing as an SDOH and that affordable housing should be a factor in the plan due to the increase of houseless people.

However, others argue that the problem is more profound, with a lack of affordable and adequate housing also heavily impacting their communities. They claim that affordable housing is not available to everyone. Many urban areas are currently experiencing a housing crisis, and many cannot afford to live anywhere else. Affordable housing is especially troubling for large families, who often have to contend with housing restrictions limiting the number of occupants one residence can have at a time while not having the funds to afford better than a two or three-bedroom apartment.

Provider Participation

Participants unanimously agreed that they wanted to choose a provider over being assigned to one. The central concept informing their decision seemed to be that the best care from professionals is from someone they trust, not just someone deemed competent and available in their field. They want to have the chance to select someone who can provide dignified care rather than hoping that the provider they are assigned to will provide them that service. This was true for participants on both sides of this spectrum. Those who had experienced poor relationships with providers and those who had providers with whom they felt truly seen wanted control of this decision. For some, this means having the ability to know a doctor's rating, background, and experience to help choose the best practitioner to provide the services they need. Others emphasized the need to choose culturally appropriate services and culturally, linguistically relevant providers to better help them navigate the healthcare system and their health needs.

Participants constantly expressed this need for cultural competence training in healthcare throughout the focus groups. Many participants were from diverse cultural backgrounds and felt that traditional western medical treatment has not considered their communities' unique medical needs. They stressed that this healthcare system should make holistic, open-minded, culturally competent, and trauma-informed healthcare and providers accessible to their communities.

- “I want someone who speaks Spanish, because I do speak English but not perfectly, and well not any technical language. So, I think that it is important that people have that possibility, to choose a person who they already know, who knows their medical history, and who obviously speaks the same language that you speak, that speaks Spanish.” - Spanish Group Member.

It is imperative for many participants to work with providers who respect and understand their backgrounds, cultural norms, and experiences. Many immigrants feel that their care has been more dignifying when their providers are multicultural or come from communities of color. Others find it reaffirming when providers can provide them with culturally appropriate care, considering their cultural diets, helping them find new practices or alternative treatments that can integrate into their lifestyles. Participants find that it validates their beliefs and experiences and avoids normalizing the Western medical treatments that some communities, like the indigenous communities, found harmful. Many hope that this new system will give them the best quality care and services.

- “I work at a school… in disabilities services, and I've heard from so many students I've worked with that they have hesitation with engaging with providers because of poor past experiences… people have had really bad experiences with providers, to be being able to have agency and feel empowered to make those choices when it comes to your body and your health, I think is absolutely critical.” People with Disabilities and Long-term care Group Member

The discussion guide provides the following description for this section of the discussion: ‘All providers would be required to participate in the Health Care for All Oregon plan.’ Although most functioned under the assumption that it included all providers regardless of field, some participants questioned if this included alternative health services like acupuncturists and other culturally relevant services that are not well known or much used in western medical practice. Many asked if this new system would still need referrals, and they hoped that it would not. Several expressed hope that this system would change things for the better; they believed that this requirement for all providers to participate in the program would help relieve the overcrowding issue and lessen the stigma and lack of accessibility to specialist care that many OHP clients faced.

By far, however, the most complex field of inquiry came from Oregonians in the rural, mental health, and Spanish-speaking disabilities sessions, who questioned if this availability to providers will extend to those outside of Oregon. With most specialists and large health care providers in Portland and the greater Willamette Valley, many participants living in rural areas or outside the Willamette Valley have to travel long distances to reach specialized or even essential health care providers within their insurance program. This flexibility, they argue, will allow them to have easier access to healthcare providers and save them time and money they would otherwise need to spend on long-distance travel. Others expressed that this might also make obtaining emergency care and specialized care safer and less stressful for those involved; giving them more healthcare options might save them from relying on inexperienced or low-quality healthcare providers.

Specific Group Findings

Spanish

Latinos/as/x in Oregon see healthcare as a social and human right. Participants were used to accessible healthcare systems and affordable medications in their native countries. Even if they struggle to access health services, they are facing affordability struggles and discrimination in hospitals and clinics. Participants shared many stories of being misunderstood and misdiagnosed, harmed, and attributed some of the issues to racism, cultural competency, and language barriers. Several also focused on the lack of preventative care accessible to their families. However, they see this new program as a chance to provide a more accessible and affordable healthcare system to their communities.

Even though mental health and mental illness are typically stigmatized in the Latino community, access to these services was clearly emphasized as a significant need for this group. Whether it was due to the individual and family trauma of the immigration and acculturation process or the heavy emotional burden of families having mixed status, mental health and support were identified.

Latinos/as/xs see this plan as a benefit to all of Oregon and are not as concerned as other groups about the plan's funding or taxes they might incur. However, they are worried that this new service might burden those who already pay for health insurance. Some participants suggested that access to the new Healthcare plan be optional to allow people to keep their current health plans and that income taxes be limited to those using the system. Participants expressed the following concerns:

- Would the services offered by Oregon’s new health plan be complementary to their current plans?
- Would their medical bills for this new system cost less than what they currently spend on healthcare?

Many participants in the Spanish group believed that having services offered by big institutions might be detrimental to the Latino/a/x community. Many are scared to get mixed up in a governance system due to past trauma and mixed-status families and might not feel safe entering these large buildings. They suggested having these services in community centers and organizations that the community already trusts or having health consultants stationed in public areas like local pharmacies and other areas frequented by their community.

Black and African American

Due to past health inequalities, hardships, and mistreatment by the healthcare system, this group cared about ensuring flexibility in the payment process and having affordability tailored to an individual's situation – i.e., not stressing about a bill, not having to choose between eating, paying the rent or getting health needed services worrying about getting good care, receiving accurate and quality care, and having access to needed medications.

- “I have family members that will tell me, ‘oh, you're on an Oregon Health Plan. You're not gonna get good care because you're on Oregon Health Plan’ and I don't wanna feel like that. I don't want to feel like I can't get good care because it's Oregon Health Plan.” - Black and African American Group Member.

For Black and African Americans, they mentioned many ways they were treated differently or adversely affected by certain health care situations. They mentioned having care providers not caring for or meeting their specific ethnic and health needs. They mentioned the difficulty of having lower incomes yet paying the same amounts. They said they had not received the appropriate information required to make necessary decisions and experienced providers not trying particularly hard to find helpful health solutions. Then when they have to return for more and more appointments, they still have to pay for each appointment. They also said they would trust the medical system more if more medical professionals looked like them.

Participants want access to information that details what is covered and what additional resources are available to help them in a clear and easy-to-read format, whether payment plans to pay for coverage or supplemental resources to help with everyday expenses like transportation. Because every situation is different, participants want a healthcare plan where they don't have to worry about coverage when stepping into a medical office and not being discriminated against based on superficial pretenses when seeking care or medication.

However, participants also mentioned that a system where everyone is covered creates more access-to-care challenges, such as longer waiting times to see a physician, and allows individuals to abuse the system. Their main concern was the possible misuse of drugs if people had more accessible access to prescription drugs. Many participants also struggled with the idea of this system being all-encompassing and available to all; they had experienced under-care, racism, and mistreatment by the system and thought this program would increase the demand and the inability to offer care to them, their thought process is grounded in the current systems and their lack of accessibility. There was an absence of trust that this program will have the capacity to provide adequate and quality health care and that there will not be enough providers to attend to the demand of services or these will not authentically care or either have the competence to provide the needed care.

Several participants requested a customer service office where one can either schedule an appointment or walk-in and receive personal guidance on filling out and understanding the paperwork needed for the healthcare system.

Finally, people in this group were apprehensive about trusting the system and the governing body to do right by them, which also affected how they approached the creation of this new healthcare plan. Participants wanted direct contact with the proposed administrative board and requested the ability to have personal meetings or a hotline with their board members. They also highly distrusted the idea of raising taxes, with one participant commenting that the government already receives a lot of money, but their community does not see investments in their communities.

Pacific Islander

The Pacific Islander group had many concerns centering around culturally relevant services and care. As a whole, they seemed to feel that their community lacked the necessary support and knowledge necessary to navigate the healthcare system and tended to focus on services that would allow that care to become more accessible to their community.

It was not so much affordability for many participants that was the issue when considering healthcare but accessibility. Many Pacific Islanders are either first or second-generation immigrants. This, while not a problem in and of itself, has left their community lacking knowledge and experience when navigating the healthcare system. Many first-generation immigrants are only experienced with the health care systems used in their native countries, along with what many consider an ineffective and needlessly complex system that has made it difficult for many to get good healthcare. Similarly, many second-generation immigrants are also inexperienced in using America's healthcare system due to their youth and a confusing system.

- “[T]he states you have responsibility to care for our members, you know they reside within the state, because there are those, you know like, speaking from my community where some of us are undocumented. But we're here working. We are contributing economic wise, regardless what it is. Yes, we might be working under the table, but we are making a fair wage we are working. We're earning an honest living, you know, and we're contributing to society. But we're not eligible to basic your basic needs, as humans which is held, like, you know, and I think we should. Everybody should be eligible regardless of their immigration status as long as you're within the say covers to be, you know, extended it to cover all resident of the state." - Pacific Islander Group Member

This resulting lack of access to adequate medical attention has fueled these participants' desire for more guided aid, with participants requesting services that provide more “hand-holding” when navigating the healthcare system; i.e., community classes, customer service offices/hotlines (for one on one aid), healthcare advocates, etc., to help them understand the services they are getting, how to fill out paperwork, and provide help getting the care they need. Some participants particularly wanted help locating culturally competent providers and culturally appropriate services.

- “[E]ven as me who I would like to believe on the English, proficient speaker has a very difficult time understanding what specific things that needs to be filled out for folks that even have access to affordable health care, and I've been. I… take a lot of time to try to help understand myself so I could help, different family members understand what things we need to fill out to be able to access these things.” - Pacific Islander Group Member

Pacific Islanders wanted there to be a particular focus on the health and living conditions of their community. Since they are often grouped in with (all) other Asian communities, their health statistics often seem better than what they would be if you looked only at the statistics of the Pacific Islander group. They want more awareness of the harmful effects of cultural, racial, and socioeconomic factors on their health and help get their community to a healthier state. Such as providing awareness of culturally/ethnically specific common health issues and then helping provide easier access to resources to help prevent those issues.

Access to nature was crucial to this community; Parks are often regarded as areas for social gatherings, and access to the ocean is seen by the community as an integral part of their spiritual and holistic health, making it a vital service to consider when considering the communities holistic health.

Many also felt that legal immigration status was a significant barrier to holistic health care coverage for their community, leaving many people in their community unable to access a large portion of healthcare services, and scared of deportation when they attempt to seek medical attention.

The group also expressed concern that finding adequate and holistic representatives for the Pacific Islander community for the health plan’s board of directors would be difficult since their community is so diverse. The term Pacific Islanders covers many different islands, cultures, and languages. For this reason, several suggested finding representatives that could represent their community's cultural and ethnic background and values, but that could emphasize the experience that their and other immigrant communities have had in navigating the healthcare system. Several also suggested that the board of members should leverage their community's culturally traditional education and wisdom and the cultural dynamic between their elders and youth to better assist and help tailor services towards their community.

- "I speak on my own experience with my mom. She was paying for the premium assistance, and then she just like never know how to use it. She was like, What am I paying for when I don't even know what I have access to, you know, so it's like, and then it was kind of like a time limit because then she had to move back, you know, to my country, because she was paying for something that she didn't know how to access it.” - Pacific Islander Group Member

Native American

Participants from the Native American community feel betrayed and left behind by the healthcare system. They have been adversely generationally impacted by affordable but poorly run and funded healthcare. They shared dreadful stories of the inequities in their health care that have increased their mistrust of the system. They finished by sharing the hope that the government could offer the actual healthcare they need. Although their healthcare is supposedly free, they are unable to access it because they can’t afford many of the additional services they need for their conditions. They don’t want more ‘affordable health care’ if it is similar to what they have received until now. If this new system wants to be affordable, they suggest providing culturally competent and humanly accessible essential services for all residents regardless of income, race, or status.

They are adamant that quality control is essential to this new program; everyone should be provided the same quality medical services and equitable care for all communities. The health care provided to the indigenous community has been demeaning, uncaring, and disrespectful, with many developing worse health issues or not being provided proper treatment for their illness. They have been discriminated against by providers and doctors on many of their reservations. Participants shared they are consistently undertreated for pain because of the false belief that all Natives abuse painkillers and have a higher tolerance. They shared harrowing stories of how providers refused to give them pain medication that worsened their condition. Because of the low quality of the aid they have previously obtained, many no longer trust any form of government to give them dignified or quality health care.

In addition, many indigenous communities have turned to alternative or natural forms of treatment due to these past experiences. They believe that alternative healthcare options should also be provided for under the coverage of Oregon's new healthcare system as not all of their beliefs and cultural norms/practices are provided or accounted for under Western Medical practices.

Many participants also believed that enrollment should not be necessary, even if all Oregonians are eligible for this new health plan. They do not want to be forced back into a system they fear will hurt them (physically, emotionally, or mentally) or ignore their needs as it has in the past.

One essential step towards this goal was the equitable representation of Native Americans on the health plans board. As one of the most historically underrepresented and marginalized groups in our country, they believe that to have adequate representation of their community, the board should include two Native American representatives, one from the reservation and another from an urban area- or one representative with experience who has experienced both.

Another was providing quality aid from SDOH programs to their community, such as better education for their youth and wealth management services for their elders.

- “I have the very strong urge to just like call attention to how kind of ridiculous that question is. Um, of like, to what extent should we make sure that everyone has breathable air and that populations live like, are you serious? Like, I'm not sure what kind of answer they're looking for. And maybe the question could have been worded differently, and I'm not throwing shade at like whoever made this question or anything. I just think it's absolutely asinine to ask something like this. Um, because it's all one and the same of overall healthcare is making sure we have affordable housing, making sure that we have drinkable water. Like it's basic, it's so basic…. And we are being asked how much we prioritize that in a financial way or whatever, which is just absolutely ridiculous to me.” - Native American Group Member.

This group of participants was also against paying any taxes for this healthcare system. It is their right as Native Americans to have free healthcare in front of the US government, and they wanted more information on the effects of this financing plan on their community. Since the indigenous community does not pay taxes, would they now be forced to pay state taxes, or would they be required to pay through some other method to be allowed access to this new healthcare system? How did they fit into the States plan to finance their new healthcare system?

Participants from the Native American community feel betrayed and left behind by the healthcare system. They have been adversely generationally impacted by affordable but poorly run and funded healthcare. Although their healthcare is meant to be free, they are unable to access it because they can't afford many of the additional services they need for their conditions. They don't want more affordable health care if it is similar to what they have received until now.

Rural

Most participants suggested that travel expenses should be covered or partially covered due to lack of availability for specific healthcare services in their region, having to incur travel expenses to the nearest town to get the attention they need, making healthcare less affordable, and stressing their household finances.

This group also expressed that "Just because you are eligible, does it really mean you are getting the services?" Due to their remote location and attractions, providers sometimes leave town and move to more populated areas, rendering their services more scarce and making the program have less coverage. Moreover, participants who live near state borders hoped that their coverage would extend to out-of-state providers. This would help them overcome their frequent lack of transportation, the limited local number of local doctors and long distances to instate providers.

Rural participants suggested that if or when the new health plan sought to verify people's income, they should not consider people's savings accounts as often those do not contribute to their income and are usually set aside for a purpose.

Some participants also showed concern about neighboring states receiving attention from Oregon and how this situation could stress the medical care system. At the same time, they still want the requirements not to defer support for the already underserved and vulnerable communities.

Rural participants were very aware that they make up the minority of Oregonians and that many of their needs have been disregarded and underrepresented. They would like board members to be regionally diverse to be able to represent their needs equally. They know that many of the decisions have been made to support people in the Portland area, not theirs.

Participants also suggested that the board set up a mailing address so that those without access to technology may still reach out to board members remotely. The rural group did not like the idea of sales taxes unless, as participants agreed, they could compensate the community in another manner, such as increasing Oregon's wages or lowering and setting limitations on the cost of rent or groceries.

There were conflicting ideas within the rural community on the best use of SDOH programs to help Oregon's residents. One participant requested that these programs be long-term aids, like universal basic income, to help the neediest of Oregonians. Another, however, advocated that these SDOH programs be treated as a chance to help those using them build themselves up to sustain themselves and not rely on the healthcare plan for the long term for stability.

Several participants in this community believed that if the federal government was to help fund Oregon's Universal health care, their funding should come from existing funding for pre-existing programs, such as America's military spending or the international affairs budget.

People with Disabilities/Long-term Care

Many participants in the disabilities and long-term care sessions focused on understanding the overall impacts of Oregon’s new health care system, especially about meeting the diverse medical needs of their community. One topic only heard in this group pertained to obtaining loans to pay for treatment. During the discussion on affordability, participants in this group were adamant that obtaining loans should be easier to receive and should not be based on credit score when needing to pay for medical issues.

- “I have really high cost of healthcare. I get really costly infusions that without any insurance, it would cost 30,000 a month just for my infusions… that's not something that I would be able to afford without health insurance… and I think like one thing that keeps me at my job is my fear that I will lose the good health insurance I have or that I'll have to go through another process where like insurance could deny it... So affordable for me is something that's reasonable more than like half that I make in a year in one month is not reasonable.” - People with Disabilities and Long-term care Group Member

Several participants also believe that people with disabilities, especially children or families caring for someone with disabilities, should get broader and priority coverage for medical services as insurance limitations often affect this community’s health negatively at a higher rate. Additionally, equipment or medication needed for life-sustaining should be covered, as it is often expensive to cover but necessary for many people to live a good life.

Participants suggested that the plan provide information about the program's coverage limitations and a clear and straightforward appeal process related to understanding coverage. For example, the appeal process could involve a letter, proof of the disability, and a letter from the provider for those to appeal denial of coverage who might need specialized or urgent care. One participant stated, “If there are limitations, I would appreciate that there also be an easy-to-understand, accessible, and transparent process to appeal a decision.”

Most believe that insurance companies' current enrollment requirements are complicated, and too much information is required of people to be enrolled with a provider. Many also recommended that more information about the program and how to enroll should be available – especially to immigrants who might be afraid of getting medical service or just arrived so that they can take advantage of the Statewide program.

This group also highlighted the need for accountability from the board, stressing that his program needed to continue working despite difficulties, be sustainable, and have continuity plans as some individuals/ communities would heavily depend on it. The board cannot be held up to deliver on their jobs during member transitions, lack of staff, etc. Additionally, participants suggested those on the board receive constant equity and cultural competency training and information about the community's needs and situations. They want a board that can understand what their communities are going through and make decisions representing everyone's best interests.

- “I believe that the board should… have literature to read… for equity and courageous conversations, um, literature that will let them be more diverse within the community… they need to be committed for, or be on the board for two straight years, maybe three, maybe the first year complete a course of all that literature and then two years on the board and then, and that's about it. And then you have the incoming people who wanna go for the board, finish that literature, that list, and open that literature for everybody what's recommended” - People with Disabilities and Long-term care Group Member.

Thus, participants suggest that the populace should be informed whenever changes are made or occurring and what services will be available to them to voice their opinions and help the board keep their needs in mind. One participant also suggested using surveys to collect public opinion, whether online or in person. At the same time, others suggested using a TV or radio campaign or similar tactics to reach their community and spread information about the board to all of Oregon.

Finally, one participant expressed curiosity about how this program would contribute to climate justice and racial justice initiatives already at work or in progress.

Mental and Behavioral Health

The Mental and Behavioral Health group had younger participants who had experience meeting some of their health care needs while on their parents' insurance or other participants who had met their needs with the help of an advocate. There was a focus on affordable cost and accessibility in language, systems, and platforms. Many of them had more optimism that a universal healthcare program would help all Oregonians than many other groups.

Responses for what affordable health care meant to them ranged from “free” to “ease” to “open, transparent, and digestible.” One participant who self-identified as a former houseless youth in Oregon and Washington said sliding scales helped her understand if the worst-case scenarios were financially feasible. This helped her know whether to access services or just suffer through it since medical debt could accumulate rapidly.

- “I have never been reminded of my status as often since I lost health care [at 26 years old].” Mental and Behavioral Group Member.

Participants thought the plan should cover everything, including biologics, specialists, alternative care, telehealth, mobile phlebotomy services, mental health, rare diseases, severe health conditions, dental care, and eye health. There were direct requests for “respectful and culturally competent care” and “Treating people with dignity.”

For eligibility, this community focused on the benefits this system might bring to their community and was relatively unworried about abuse, believing that its benefits outweigh the costs. They do wish for eligibility to be immediate so that visitors to the state or people in need of urgent care in other states might have access to immediate emergency care in Oregon. Participants commented that this immediate care was needed for seasonal field workers and those working heavy labor jobs. Some also believed that this could change people's perception of medical attention from a luxury to a necessity, which would help ensure access to healthcare in the long term.

For Governance, there was a big push for representation, including houseless people. There was a desire for a simple system with a basic application and interview that somehow didn't only limit the board to being highly educated. Some participants recommended using technology to help people stay connected and share their opinions. Such as creating Facebook/social media groups and web pages to help facilitate communication with board members.

There were comments that people who make more money should contribute more, and people who make less pay less. The fear about a payroll tax is that it would hurt small businesses and wage earners. Overall, there was a desire to understand the possibilities more and who they would affect. There was a fear that if the money were an added tax, it would not be ‘affordable’ for many.

Due to their past issues with healthcare systems, many participants advocated that legal help or lawyers be provided for by SDOH services, particularly for health care issues. Previously many have seen people with some specific diseases or who need intense, specialized care or accommodations, subject to discrimination by their providers and insurance companies when their insurances are unwilling to help them access the services they need. Providers will often drop their patients rather than fight the insurance company. This is a significant barrier for this community to reach the aid they need, as most people do not have access to navigators that can bridge health care and need accommodations due to their health issues. Participants also believe that mobile resources should help people access SDOH programs/services more easily and help the Task Force better collaborate with other organizations on this project.

- “I’ve actually taken my insurance company to several CMS Administrative Law Judge Hearings representing myself to get my care approved and paid for. It was me against a panel of in-house attorneys, outside counsel, medical director, and administrative personnel. I won 4 out of 5 hearings, and the insurance company was forced to pay for my care.” - Mental and Behavioral Health Group

Free choice of providers was universally agreed upon, with many participants providing examples of bad experiences with the ‘wrong’ practitioner. Having the opportunity to have a relationship with the provider was very important, and the ability to leave a provider that does not treat them with dignity was essential.

Recommendations

Discrimination, including racism embedded in the Oregon health system has physically and psychologically harmed the communities with the least access to health care. This includes BIPOC, rural, those living with disabilities, and those navigating the behavioral health system. Structurally discriminatory and racist health policies have resulted in an ever-increasing legacy of health disparities for these Oregon residents.

After deeply listening, analyzing, and reflecting on what participants shared with us, we recommend the following for the Oregon Universal Healthcare System:

- Provide defined parameters regarding what type of care is available or covered by the program; the program should include vision, dental, mental health, and alternative care to fit the public’s desire for comprehensive healthcare.
- Provide defined and inclusive parameters regarding who is eligible and where Oregonians can seek care.
- Provide flexibility for rural communities to access the closest provider, even if that means out-of-state care.
- Provide adequate time and financial resources to work in rural and remote areas with hard-to-reach populations, including non-native English speakers.
- Facilitate access and accessible enrollment protocols to health care systems. The enrollment process needs to minimize the number of possible barriers to provide accessibility (i.e., be simple and straightforward).
- Facilitate a Board that truly reflects the true breadth of Oregon residents.
- Avoid increasing taxes to fund this program.
- Avoid placing taxes that have more significant impacts on moderate to low-income families and individuals. A tax is not progressive if it applies to everyone equally.
- Consider placing luxury taxes on items and higher taxes on products that negatively impact health (i.e., carbon, tobacco, alcohol, cannabis, etc.)
- Provide defined parameters regarding the type of SDOH programs available through the program and resources to help Oregonians access new and currently available SDOH programs.

- Invest in public education and community health literacy. This includes continuous investment in local school systems for education and providing community health education on various topics: eating healthy, exercise, mental health, stress, behavioral health, drug addiction, medicine, and community-specific health complications and preventable illness.

- To make healthcare more accessible, it is important to consider the following:
    a) Providing affordable healthcare based on each individual's means
    b) access to healthcare facilities via public transit
    c) financial assistance for those who need to travel long distances to see a provider.
    d) access to gyms and resources to help people become/be more active.
    e) greater access to healthy foods through community gardens, healthier school lunches, and dietary services for those on food stamps or low incomes to receive dietary services
    f) freedom to choose a culturally and bilingual provider

- Integrate authentic cultural interventions alongside existing healthcare promotional efforts that address health disparities as a whole to ensure a culturally tailored and relevant approach to health promotion and healthcare delivery for BIPOC groups.

- Educate health care providers about the reality of structural racism that hinders health and progress in BIPOC communities. If possible, mandate antiracism training by BIPOC consultants to help establish the WHY (the importance) of using an equity lens.

- Establish accountability methods with specific actions and clear benchmarks that respect, value, and promote diversity and cultural responsiveness.

- Support, recognize and utilize culturally aligned health teachings and traditional wisdom and interventions within BIPOC communities to strategically implement their health and well-being.

- Reallocate considerable resources to serve, heal and make reparations to the communities harmed.

- Continue to make safer and more accountable spaces for deep listening, learning, and understanding of behaviors, cultural responses, and barriers for the most marginalized residents.

- Last but not least, celebrate the equity journey that will dismantle barriers to hundreds of thousands of Oregon Residents.

Closing Remarks

When the Task Force set out to inquire about a universal healthcare system for Oregon, their goal was to include the study's findings in their recommendations to the legislature about implementing a single payer healthcare system, better known as Universal Access to

Healthcare. The communities interviewed have made it clear that the current system's mode of operation is dysfunctional and provides many stressors and barriers to the healthcare they consider a necessary and fundamental right.

Throughout the community discussion period, it has also become pertinent to consider the effect of barriers to accessibility on the health care received by all groups involved. In the past, this lack of accessibility has often been a core factor in propagating the disparities that many communities have experienced when seeking healthcare services, directly affecting their health and advancing a system of systemic racism and generational inequity. Now, most communities see accessibility as being closely linked with the equitable, affordable, comprehensive, and high-quality healthcare system they have been promised; making accessibility to health services, relevant information, SDOH programs, or providers necessary considerations for the Task Force when providing recommendations on a universal healthcare system that will provide Oregon's residents with adequate and dignified care.

Their current healthcare system does not offer them the affordability, coverage, dignity, or ease of care they are seeking. The processes in place to help them access or mitigate those services have not been equitable and have instead enforced a system of degradation. These communities, including Black, Indigenous, People of Color, rural communities, and people with disabilities and mental health issues, are now looking for a new affordable health care system that will provide inclusive, flexible, comprehensive, and culturally responsive care.

They advocate that more equitable approaches be applied to this new health care system so that every community can participate, regardless of background, location, ethnicity, racial identity, gender, religion, or lack of documentation. They seek health care where systematic racism is eliminated through adequate funding and policies that center people, prioritize health equity, and offer community-driven approaches that make quality care accessible to their communities.

LMS supports and values the task force's commitment to being an outspoken advocate for social, economic, and racial justice. Thank you for working to reduce future public harm by taking a deep look at the lived experiences the health care system has inflicted on our Oregon residents.

Appendix

Task Force on Universal Healthcare Discussion Guide

Virtual Round Table discussion (2 hrs)

Part 1. Welcome and Introduction

Slide 1: Welcome screen

Description of Oregon's project (this part is read to participants at the beginning of the exercise):

The current system of healthcare is difficult and costly and still results in poor health outcomes. The system has a great amount of administrative waste and often results in people delaying health care because of cost. Many services such as mental health, vision, dental, and hearing are not covered. Overall, the system is unfair so there is a need to change the system.

In 2019, Oregon legislators created the Joint Task Force on Universal Health Care (Senate Bill 770). The Task Force was charged with designing a publicly financed healthcare system that is equitable, affordable, and available to all residing in Oregon; a system that recognizes health care as a fundamental element of a just society, and improves the health of Oregonians. A single payer system is a mechanism for achieving those purposes. In a single-payer system, everyone has one health plan that is paid for with public dollars.

Your public input is needed to help create a better healthcare system. Your input will be used to guide the Task Force in its final report to the legislature.

With the Health Care for All Oregon plan that the Task Force is currently developing, all those residing in Oregon regardless of where they work, would be covered by the plan. It is suggested that the plan benefits would be similar to benefits that state employees currently have, including behavioral health care. The plan would allow any patient to see any licensed provider able to see them. All licensed providers would be required to participate in the system.

Under the current proposal, the plan would pool all current spending on healthcare into a single health care fund. There would be no copays, deductibles, or premiums. Instead, there will likely be new taxes. If there are new taxes, those taxes would not be higher than what most Oregonians currently spend on healthcare. Oregon residents would no longer have to worry about how they are going to pay for medical care or be at risk of bankruptcy due to costly medical services.

Part 2. Roundtable Discussion Questions

Affordability.

In the Health Care for All Oregon plan, Oregon residents would not pay premiums, co-pays, deductibles, or any other form of cost-sharing to access care.

1. Based on your lived experiences, how do you define “affordable healthcare” and why do you define it this way?

2. What would make healthcare today more affordable?

Coverage.

3. What are the most important services that need to be covered by the Health Care for All Oregon plan so that it meets your and your family’s needs?

4. If there are going to be limitations to covered services, what should they be?

Eligibility.

In the Health Care for All Oregon plan, everyone residing in Oregon, regardless of employment, income, immigration status, or tribal membership, would be eligible for the Plan. Any eligible person would be automatically enrolled in the Plan; “opting out” would not be a relevant concept for the Plan. Eligibility would be tracked in a centralized database to which all providers would have access. Eligibility for Oregonians would no longer be connected with employment or employment status.

5. As we have talked about eligibility, what is your feedback, what is missing, or what do you want to add?

6. How would you like to see eligibility verified?

Enrollment.

There would be no waiting period or minimum residency duration required to enroll in the Health Care for All Oregon plan. Enrollment would be simple and straightforward. For people enrolled in OHP, Medicare, or TRICARE, you would be seamlessly integrated into the Plan.

7. What thoughts or concerns do you have about the enrollment process?

Governance.

The Health Care for All Oregon Plan would be a public entity, governed by a board, with reporting responsibility to the Oregon Legislative Assembly and Governor.

8. In establishing a governing board for the Health Care for All Oregon plan, what recommendations do you have to ensure consumer representation and participation in decision-making?

Financing.

The Health Care for All Oregon plan would pool all current spending by government programs into a single health care fund. Additionally, all current family spending would be replaced with a series of progressive taxes, including an increased income tax and payroll tax, and, if needed, the addition of a sales tax. Most Oregonians would be paying the same or less than they currently pay for their health care.

9. What kinds of financing would you recommend and why?

SDOH (Social Determinants of Health).

10. To what extent should the government prioritize spending money on things that prevent health problems, like access to housing, healthy foods, or green spaces?

Provider participation.

All providers would be required to participate in the Health Care for All Oregon plan.

11. Is free choice of provider important to you and why?